



Round Rock Medical Center

**Community Health Needs Assessment
December 2022**



Community Health Needs Assessment

Hospital Facility Geography

December 2022

The following spreadsheet shows the county of residence of patients served by St. David's HealthCare facilities. Based on this data, the four St. David's facilities include the following county Community Health Needs Assessments:

Bastrop, Caldwell, Hays, Travis, and Williamson

Implementation Plans Per Medical Center to Follow in April 2023

CY 2020 St. David's Patients by County

County	ST. DAVID'S MEDICAL CENTER		SOUTH AUSTIN MEDICAL CENTER		NORTH AUSTIN MEDICAL CENTER		ROUND ROCK MEDICAL CENTER		TOTALS	Percent	% Excl. Unk.
Travis	81,896	52%	68,480	66%	83,242	67%	13,924	22%	247,542	54.86%	55.07%
Williamson	41,007	26%	2,773	3%	28,608	23%	42,615	66%	115,003	25.49%	25.59%
Bastrop	6,752	4%	14,267	14%	3,850	3%	632	1%	25,501	5.65%	5.67%
Hays	9,187	6%	8,233	8%	1,726	1%	232	0%	19,378	4.29%	4.31%
Caldwell	1,659	1%	1,771	2%	324	0%	77	0%	3,831	0.85%	0.85%
Burnet	1,634	1%	276	0%	577	0%	1,632	3%	4,119	0.91%	0.92%
Bell	2,127	1%	249	0%	896	1%	758	1%	4,030	0.89%	0.90%
All Other Counties	13,724	9%	6,797	7%	5,311	4%	4,238	7%	30,070	6.66%	6.69%
None/Unknown	165	0%	1,297	1%	252	0%	31	0%	1,745	0.39%	n/a
	158,151		104,143		124,786		64,139		451,219		

Notes:

St. David's Medical Center includes Georgetown and Heart Hospital. Surgical Center excluded.

Counties highlighted in yellow are included in each facility's CHNA due to at least 1% of patients residing in that county. Although Caldwell makes up slightly less than 1%, it is included to complete the entire Austin-Round Rock MSA

Each of the counties that make up "All Other Counties" represent less than 1% of total patients across hospital facilities

BASTROP COUNTY, TEXAS

2021-2022

Community Health Needs Assessment

About Texas Health Institute

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

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The 2021-22 Bastrop County Community Health Needs Assessment (CHNA) represents the commitment of many partners who have contributed their expertise, resources, and time in support of a shared mission—to make Central Texas the healthiest community for all its residents.

The data collection methodology was co-created through a partnership of health system partners to provide a comprehensive assessment of conditions and opportunities that exist to improve health in Bastrop County, Texas. We recognize all of our CHNA partners including St. David's Foundation, Georgetown Health Foundation and Ascension Seton.

Most importantly, we recognize the many community organizations, agencies, churches, leaders, and community members who assisted with outreach and engagement and shared their time and experience. Texas Health Institute acknowledges the following organizations' contributions to this report:

Community Input Partners

Ascension
Advocacy Outreach
Ascension Catholic Church
Bastrop Food Pantry
Bastrop County Cares
City of Smithville
Central Texas Interfaith
Community Health Centers of South Central Texas
Combined Community Action, Inc.
Smithville Community Clinic

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Executive Summary

PURPOSE AND METHODS

As part of a collaboration of local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The current CHNA is the fourth one St. David's HealthCare has conducted for Bastrop County. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act.

CHNAs provide deeper understanding of community health needs—particularly those faced by historically-underserved community members—and are used to inform health care system triennial planning efforts. This report provides an overview of the process and methods used to identify social determinants of health and health needs in Bastrop County, community assets, and a summary of community member recommendations to address the identified needs.

THI carried out this CHNA between August and December 2021 during an unprecedented time due to COVID-19 and the movement for racial justice. To explore critical health issues, structural factors and underlying causes, THI used a mix of quantitative and qualitative methods including the analysis of publicly available data sets, key informant interviews and focus groups with underserved community members

FINDINGS

Key themes emerged both from community input and a review of quantitative data. In addition, several sub-themes emerged in the review of data that were not raised by participants.

GROWTH

Bastrop County is growing rapidly, becoming more diverse and less affordable. All these changes have an effect on health care and access and outcomes for underserved community members. Bastrop County has experienced rapid population growth over the past decade, with an increased population of Hispanic/Latinx residents.

- The county's population grew 31.3% between 2010 and 2020 from 74,171 to 97,216 residents. One forth (25.4%) of residents are children ages 0-18.
- Hispanic/Latinx residents are the largest minority (32.6%) and also accounted for 75% of the total population growth in the county between 2010 and 2020.

- An estimated 14% of Bastrop County residents were born in a country other than the U.S. Of these, 71% are non-citizens.
- Among residents ages 5 and older, 9.4% have limited English proficiency; the vast majority of these speak Spanish as their primary language.

POVERTY

More than half of Bastrop County households have insufficient assets and income to meet basic cost of living needs.

- Around 11.2% of Bastrop County residents lived below the federal poverty level (2015-2019) and additional 43% of households are ALICE, meaning asset limited and income constrained, even though residents are employed.¹
- Black/African American and Hispanic/Latinx residents are more likely to live in poverty than their white counterparts (24.5%, 11.9%, and 9.2% respectively).
- Between 38% to 50% of households in each Bastrop County ZIP code tabulation area (ZCTA) have insufficient assets and income to meet basic cost of living needs in Bastrop County.

HOUSING

Affordable housing and poor housing conditions are a major concern, leading to physical and mental health issues. Key informants and focus group participants identified a heightened housing affordability crisis that has unfolded during the last two years. Participants noted residents experience long waiting lists for public housing vouchers and poor housing conditions, leading to physical and mental health issues.

- Housing costs have skyrocketed over the last decade and then continued a rapid increase during the COVID-19 pandemic. The median price of homes sold in Bastrop County increased 32.2% to \$345,000 in a single year (November 2020 to November 2021).
- Median gross rent grew 23% between 2010-14 and 2015-19, while the median value of owner-occupied homes increased 41.6% over the same period.
- On average, county residents spend 23% of their monthly income on housing costs. However, 11.1% of households spend more than 50% of their monthly income, limiting their ability to afford necessities such as food, transportation, and health care.

¹ ALICE: an acronym for Asset Limited, Income Constrained, Employed. ALICE typically describes those who live above the poverty line but earn less than the basic cost of living for their area. For more information on the ALICE methodology and data, visit unitedforalice.org.

COVID-19 and Housing

The COVID-19 pandemic coupled with the rapidly rising cost of housing coupled with job losses has exacerbated financial insecurity for lower-income residents.

Focus group participants and key informants noted that many lower-income residents struggled to pay rent or housing fees, experienced increased financial and food insecurity, and saw negative effects on mental health. Unemployment, while lower than in some other parts of the U.S., quadrupled during the early stages of the pandemic from 3.1% in January 2020 to a high of 10.4% in April 2020 and remained above 5% through March 2021.

Housing instability (having missed or deferred housing payments or being in serious delinquency) increased during the pandemic from 0.84% of occupied housing units being at risk in January 2020 to 3.5% being at risk in September and October 2021. In total, around 895 households in Bastrop County were at-risk of losing their homes due to failure to make housing payments. Food insecurity also increased during the COVID-19 pandemic from 12.1% of Bastrop County residents in 2019 to 14.2% in 2021.

TRANSPORTATION

Lack of public transportation options limits access to health care and food. Participants in the focus groups and key informant interviews identified transportation as a leading barrier to health care and food for many residents of Bastrop County. In addition to the lack of public transportation options, participants noted that many residents of Bastrop County do not have access to personal transportation. In fact, 4.5% of households in Bastrop County do not own a personal vehicle.

Participants also noted that residents of Elgin or Stony Point have to travel 20 miles to access the nearest grocery store, pharmacy, or doctor's office, limiting access to services due to the lack of public transportation options.

COMMUNITY ASSETS AND STRENGTHS

Bastrop County has several community assets and strengths, including a close-knit and resilient community. Community members noted that churches, nonprofits, and school base district are key players, often providing health care services and resources to community members.

HEALTH CARE ORGANIZATIONS

Bastrop County is home to the Ascension Seton Bastrop Hospital and the St. David's Emergency Center-Bastrop, as well as five federally qualified health centers (FQHCs) that

provide comprehensive primary and specialty care. In addition, the county is also home to various clinics that provide primary and specialty care.

NONPROFITS AND COMMUNITY ORGANIZATIONS

Bastrop County is home to multiple nonprofits and community organizations that play a vital role in building healthy communities by providing educational, health, and social services to community members. Focus group participants shared that nonprofits in the area have been instrumental in promoting community reconciliation and providing pandemic resources. The Bastrop Emergency Food Pantry, Meals on Wheels, and Bastrop County Care are some of the nonprofits and community organizations mentioned by participants.

CHURCHES AND FAITH-BASED ORGANIZATIONS

Key informants also expressed gratitude for the tremendous impact of churches and faith-based organizations that participate in community outreach, advocacy, and support of homeless population. Churches mentioned by participants include Cedar Creek United Methodist Church, Iglesia San Juan Diego, and Sacred Heart Catholic Church in Elgin among others.

PARKS

Bastrop County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. In the Bastrop and Elgin ZCTA's, over half of all residents live within a 10-minute walk of a park (57% and 71%, respectively); meanwhile only 36% of Smithville residents do so. In addition to several local and county parks, Bastrop is home to Bastrop State Park, providing residents multiple areas of recreation.

PRIORITY HEALTH ISSUES

Community members and leaders identified several priority health issues including treatment for chronic conditions, behavioral health needs, and dental care. Additionally, cancer emerged as a priority health concern in the quantitative analyses.

DIABETES

The prevalence of diagnosed diabetes among adults in Bastrop County is 13.3% among adults, higher than the state and national prevalence rate (12.2% and 10.7% respectively). Actual prevalence is likely higher as many adults are likely living with early-stage undiagnosed diabetes due to not having regular access to care. Socioeconomic differences in diagnosed diabetes prevalence exist with those having less than a high school education being over two

and three times more likely to have diabetes than their more educated counterparts. Similarly, those earning less than \$50,000 per year are more than twice as likely to have diabetes than those who earn \$50,000 or more annually.

HYPERTENSION

Hypertension was mentioned by key informants and focus group participants as a priority health issue for the county. Data from 2019 shows that the prevalence of hypertension among adults in Bastrop County is slightly higher than the statewide rate (31.8% vs. 30.8%). This means that almost 1 in every 3 adults in Bastrop County have high blood pressure putting them at risk of suffering a stroke. Participants noted that the cost of medication to treat chronic diseases are very expensive and therefore a barrier to ongoing care.

OBESITY

Obesity is a priority health concern that is linked to both diabetes and hypertension. The prevalence of obesity among adults in Bastrop County is higher than the national rate (39.7% vs. 31.9%). Participants noted a lack of access to healthy food options and exercise facilities due to transportation barriers, poor nutrition habits, and lack of nutrition education as contributing factors.

MENTAL HEALTH

In 2019 almost 1 in 5 (19.9%) Bastrop County adults reported having a depressive disorder diagnosis at some point in their lives, and 14.1% reported their mental health was “not good” during 14 days or more in the past 30 days. Data from the Household Pulse Survey supports this, estimating that 29.5% of Texas adults experienced symptoms of anxiety disorder or depressive disorder in December 2021. This number has been as high as 43.4% of Texas adults in January 2021.

DENTAL CARE

Access to affordable dental care is a concern in Bastrop County, particularly for underserved community members. Participants reported that high out-of-pocket expenses make dental care unaffordable for many low-income residents and low-cost dental services are often limited for people that are either uninsured or underinsured. A key informant also mentioned the increase in dental patients seeking services for tooth decay attributed to the use of crystal methamphetamines. According to modeling using 2018 BRFSS data, 51.2% of Bastrop County adults reported a dental visit in the last 12 months, which is lower than most other counties in the Austin-Round Rock MSA.

CANCER

While not a major topic amongst focus group participants and key interviews, 2018 data reports that a high incidence rate of cancer among Bastrop County residents, 432.9 per 100,000 residents. A number higher than the Texas and U.S. incidence rate. The incidence rate varies per racial and ethnicity group and cancer type. The cancer incidence rate is higher among Black/African American, 503.8 per 100,000 residents, and lower among Hispanic/Latinx residents, 363.6 per 100,000 residents. Colon cancer incidence rate is higher among Bastrop County residents, 45.7 per 100,000, compared to 38.0 per 100,000 statewide. Bastrop County has a high incidence of breast cancer with a 131.4 per 100,000 compared to 115.2 per 100,000 statewide.

Participants highlighted several barriers that impede the ability of historically underserved residents to effectively manage and treat these health conditions.

Multiple indicators demonstrate that a significant portion of county residents experience barriers to care. Approximately 16.5% of adult residents reported delaying needed health care due to cost in the past year in 2017 (the most recent year this data is available at the county and sub-county level). In addition, the rate of hospital visits for conditions that could be treated in an ambulatory (e.g., non-hospital) environment rose by 25.4 % since 2012 for Medicare beneficiaries to 4,211 per 100,000 beneficiaries in 2018.

BARRIERS TO ACCESS

Community members and leaders identified lack of insurance coverage and the cost of care as two key barriers to managing and treating health conditions. Participants described the challenges that many underserved, low-income, and minority community members face regarding health care, including lack of access to primary and specialty care and cultural barriers.

In Bastrop County, 22.7% of residents under the age of 65 (and 26.2% of adults ages 19 to 64) are uninsured, and lower income residents are most likely to be uninsured. Many community members travel distances of 20 or more miles to access affordable health care. Participants also noted that some Bastrop County residents falsify address information to receive Medical Access Program benefits from Travis County, as Bastrop County residents do not qualify for the program.

Access to primary and specialty care is an important barrier to care, particularly for underserved communities, with many residents in need of specialty care experiencing inadequate transportation to larger cities. Bastrop County is designated as a health professional shortage area for both primary care and mental health. The number of residents per primary care physician grew by 12.1% between 2010 and 2018 from 3,232 to 3,624. The supplies of non-primary care providers, mental health providers, and dentists is also lower than those of the

state as a whole and the U.S. Participants reported traveling to Smithville, Round Rock, Austin, College Station, Bryan, or Kyle to receive primary care services, care for more complex health conditions, or specialty care services, including for cardiology, obstetrics and gynecology, endocrinology, or pediatric care.

Health care services often feel inaccessible because they are not culturally or linguistically appropriate. Language barriers, poor health literacy, lack of awareness of available resources, and fear of deportation due to immigration laws often result in barriers to health care. Further, a lack of minority health care providers that look like their patients and can relate to their cultural needs leaves community members feeling uncomfortable with their health care providers.

RECOMMENDATIONS

Community members interviewed provided a number of recommendations about actions the health care system could take to address health-related needs:

IMPROVE HEALTH CARE ACCESS

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

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

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

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

INCREASE CULTURALLY COMPETENT HEALTH CARE

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

Culturally competent workforce: To increase compassionate and non-judgmental care, community members recommended expanding cultural sensitivity training for all providers and

hospital staff to better equip them to serve underrepresented and minority populations. Participants also highlighted the need to diversify the workforce by hiring additional providers from underrepresented populations.

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

STRENGTHEN ENGAGEMENT AND OUTREACH

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

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

Introduction

St. David's Foundation, on behalf of St. David's HealthCare, is pleased to present the 2021-22 Community Health Needs Assessment (CHNA) for Bastrop County, TX.

The Patient Protection and Affordable Care Act of 2010 requires all nonprofit health care systems to complete a CHNA every three years. CHNAs provide deeper understanding of community health needs, in particular those faced by historically-underserved community members, and are used to inform health care system triennial planning efforts. The purpose of this CHNA is to offer a comprehensive understanding of the health and social determinant of health needs in the St. David's HealthCare facilities serving Bastrop County residents, and guide the hospitals' planning efforts to address those needs. St. David's HealthCare has multiple facilities that serve Bastrop County residents, including St. David's Medical Center, St. David's South Austin Medical Center, St. David's North Austin Medical Center, and Round Rock Medical Center.

This report provides an overview of the process and methods used to identify priority health and social determinants of health needs of residents in Bastrop County, along with community assets and recommendations from community members to address the identified needs. The report focuses special attention on the needs of underserved populations, unmet health or social determinants of health, needs and gaps in services, and input from community members and leaders. This assessment recognizes that the social and economic determinants that are the primary drivers of health—as the relative contribution of medical care to health and well-being is only 10-20%—and emphasizes the living conditions are upstream of and surround personal behaviors, disease, and death.

Texas Health Institute (THI) carried out this CHNA between August and December 2021. THI used a mix of quantitative and qualitative methods to identify community health needs, including the analysis of publicly available data sets (Appendix A), key informant interviews, and focus groups (Appendix B) with underserved community members. Content gathered through community focus groups and interview participants is integrated into each report section to which it relates. The quotes reflect the opinion of one or more community members. Findings from this report will be used to identify and develop efforts to improve the health and wellbeing of residents in the community.

METHODS

The 2021-2022 CHNA uses both primary and secondary data to identify the community's priority health needs and strengths through a social determinants of health framework. Health is not only affected by people's genes and lifestyles but by upstream factors such as employment status, housing quality, and policies. In addition, the influences of race, ethnicity, income, and

geography on health patterns are often intertwined. As a result, data was analyzed using an equity lens when possible.

Primary data include qualitative data collected for the purposes of the CHNA. These data were collected directly from the community through focus groups, key informant interviews, and Photovoice interviews. Secondary data include quantitative data collected through publicly available federal and state agencies databases. Federal and state agencies collected these data through surveys or electronic health records.

PRIMARY DATA COLLECTION AND ANALYSIS

Between August and October 2021, THI virtually conducted eight key informant interviews and three community focus groups in Bastrop County. In addition, THI virtually conducted one targeted Photovoice project and associated discussion session. The goal of this work was to learn about local priority health needs and assets and how they think community health and well-being can be improved.

Focus group participants self-identified as people who are medically underserved, low-income, and members of minority populations, or living with chronic disease needs. Adult focus group participants were between 18-65 years old, while Photovoice participants were between ages 15-16 years old.

Key informants (Appendix B) included representatives from health care organizations, community-based organizations, and the local government. THI engaged key informants based on their leadership roles and experience working with medically underserved, low-income, or minority communities served by the hospital system.

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

SECONDARY DATA SOURCES AND ANALYSIS

All quantitative data used for this report is secondary data² and includes data on approximately 35 indicators, many broken down by geography or demographic characteristics when available. Indicator sources are cited for figures, tables, and graphs in this CHNA. Publicly available data sources used:

- American Community Survey

² Data that have already been collected for another purpose.

- Argonne National Laboratory: Housing Stability Index
- Austin Board of REALTORS®
- Behavioral Risk Factor Surveillance System
- Centers for Medicare and Medicaid: National Provider Identifier Standard
- Center for Neighborhood Technology: Housing, + Transportation Affordability Index
- Dignity Health and IBM Watson Health: Community Needs Index
- Feeding America: Map the Meal Gap Study
- Health Resources and Services Administration
- Centers for Disease Control and Prevention (CDC)
- Household Pulse Survey – COVID-19
- National Center for Health Statistics
- Social Vulnerability Index
- U.S. Diabetes Surveillance System
- Substance Abuse and Mental Health Services Administration: National Survey on Drug Use and Health
- United for ALICE
- U.S. Bureau of Labor Statistics
- U.S. Department of Agriculture: Food Access Research Atlas
- U.S. Census Bureau
 - Small Area Income and Poverty Estimates (SAIPE) Program
 - Small Area Health Insurance Estimates (SAHIE) Program

The original sources collected data through surveys or electronic health record systems, and results are often a snapshot in time. The data are self-reported unless otherwise indicated. Each indicator used the most recent data point available for each data source. Multiple years of data were used to calculate the estimates with a larger sample size and more precision. The estimates were calculated by the original data source for all secondary data.

THI selected quantitative data for inclusion in this report based on the availability of confidence intervals at the state and national levels, which allowed THI staff to determine statistical significance (i.e., whether the county-level value was better or worse than the state or national value). For some variables, such as “Adult Obesity,” the confidence intervals were not available at the state or national levels. Consequently, statistical significance could not be calculated. If, however, the county-level value was notably higher than the state and national average, the value was included in this report.

Confidence intervals are included in graphs when data for an indicator has a small population sample. The smaller the population sample, the less certainty about the actual number for the total population, resulting in overlapping confidence intervals. It can be hard to determine any significant change when confidence intervals overlap between categories, such as race and ethnic groups. Some indicators are broken down by geography based ZCTAs, as ZIP code is a common variable across many local and state datasets. A reference map is included in the demographics section. The data analysis typically consisted of calculating proportions and rates, with a 95% confidence interval where appropriate.

SENSEMAKING SESSIONS

THI facilitated a series of three sensemaking sessions with SDF in January and February 2022. These sessions were iterative and included SDF staff and board members, and at least one community leader from Bastrop, Caldwell, and Hays Counties. The sensemaking process provided a structured opportunity for SDF staff, board, and community leaders to begin to sort and make sense of a large amount of information included in the CHNA, and to develop a shared understanding of possible needs and actions. It also provided an opportunity for feedback prior to finalization of the 2021-22 final report.

DATA CONSIDERATIONS AND LIMITATIONS

As with all data collection, there are several limitations that should be acknowledged. Different data sources use different ways of measuring similar variables. There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific groups or at the granular geographic level due to the small sample size.

Crucially, most quantitative data used were collected prior to 2020 and the COVID-19 pandemic, whereas qualitative data were collected in fall 2021. This asynchronicity should be considered when applying the findings of this report, as some quantitative values may have changed between the most recently available year and fall 2021.

Additionally, qualitative data collection occurred through virtual key informant interviews and focus groups for the safety of staff and participants. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. THI staff did extensive outreach to various leaders of community-based organizations in Bastrop County and potential participants; organizational leaders and residents alike frequently declined participation for a variety of reasons, including research fatigue and fear of exploitation.

In addition, internet access or access to a device that would allow for zoom inhibited some potential focus group participants. Furthermore, in some instances interviews were cancelled due to COVID-19 exposure or infection.

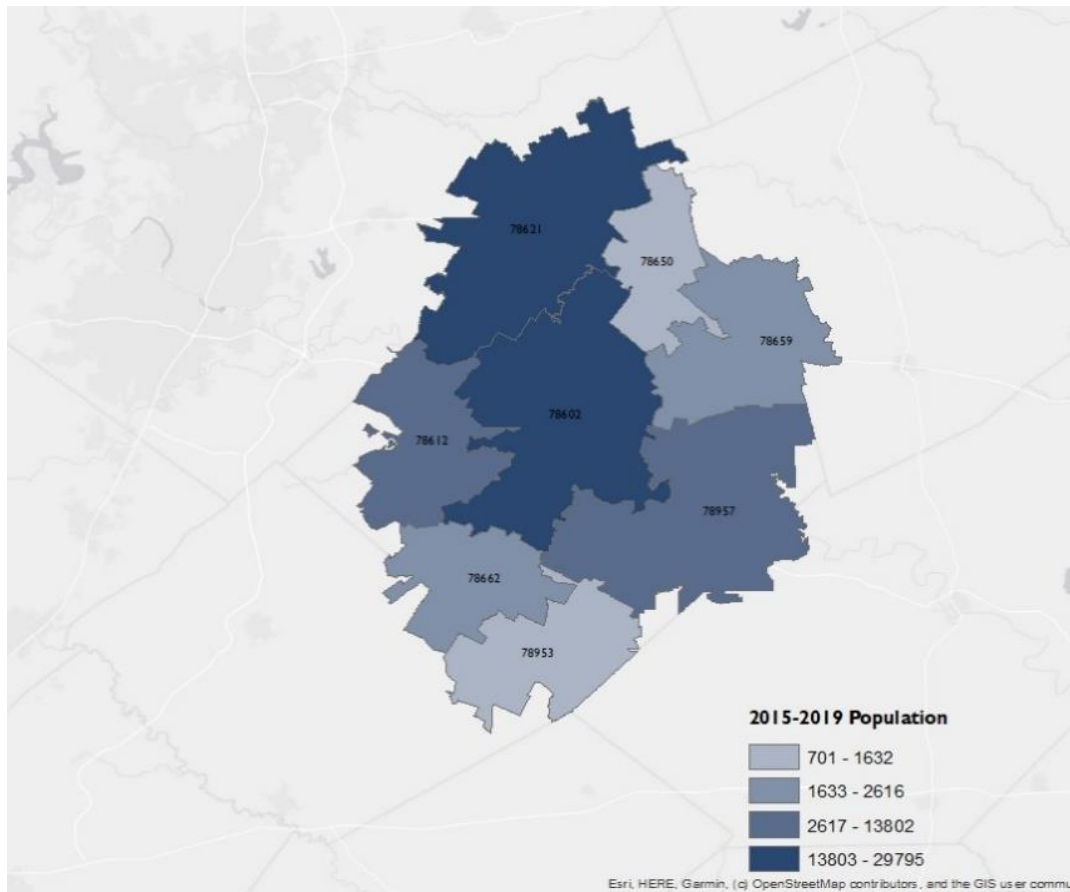
LANDSCAPE AND CONTEXT

Bastrop County, located 30 miles southeast of Austin, is a fast growing rural county part of the Austin-Round Rock Metropolitan Statistical Area (MSA). Bastrop County borders the northwest edge of Travis County in Central Texas and shares borders with Williamson, Lee, Fayette, and Caldwell Counties. Bastrop, the county seat, is located about 30 miles southeast of Austin.

Eight ZCTAs are primarily located within its boundaries: Bastrop (78602), Cedar Creek (78612), Elgin (78621), McDade (78650), Paige (78659), Red Rock (78662), Rosanky (78953), and Smithville (78957). Figure 1 shows the boundaries of these eight ZCTAs. These ZCTAs are the basis of sub-county analyses throughout this report.

Figure 1

Bastrop County ZIP Code Tabulation Area



Source. U.S. Census Bureau.

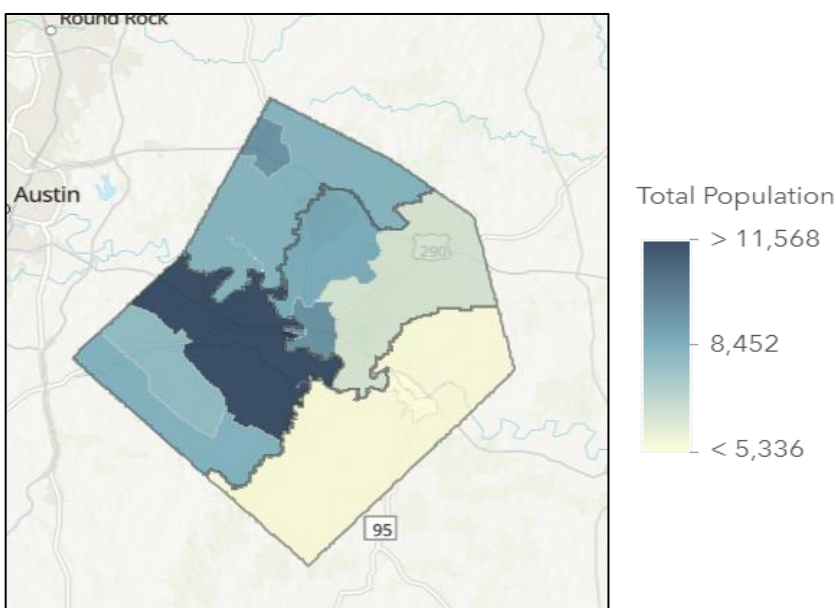
Demographics

Demographics of the community significantly affect its health profile as different race/ethnicity, age, and socioeconomic groups have unique needs and require different approaches to health improvement efforts. All demographic estimates are sourced from U.S. Census Bureau American Community Surveys unless otherwise indicated.

POPULATION

In 2020, 97,216 people called Bastrop County home, an increase from 74,171 in 2010. Bastrop County has experienced rapid growth (31.1%) over the past decade. Over the same period, Texas grew 8.3%, and the United States as a whole grew 7.4%. Travis County, the most populous county in the MSA, grew by 26% over the same period.

Figure 2
Population Concentration by Census Tract – Bastrop County

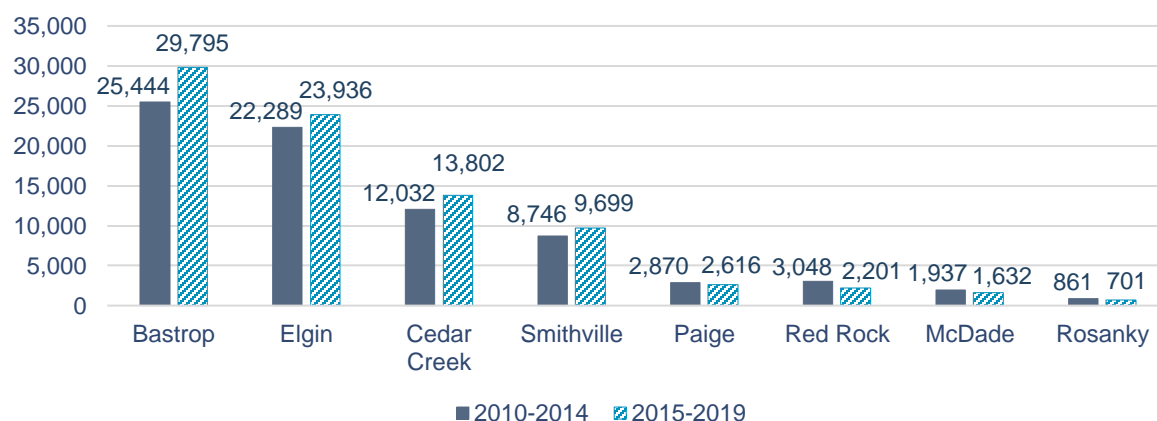


Source. American Community Survey, 2019. Map built with ArcGIS.com.

In the county, the Bastrop ZCTA is by far the most populous with 29,795 residents, followed by Elgin (23,936) and Cedar Creek (13,802). The population of Bastrop has increased by 17.1% in the last five years between 2010-2014 and 2015-2019 followed by Cedar Creek with a population increase of 14.7%. Elgin and Smithville have seen a slower increase with 7.4% and 10.9% respectively. However, not all ZCTAs have experienced growth, McDade, Paige, Red Rock, and Rosanky have seen a decrease in population between 2010-2014 and 2015-2019.

Figure 3

Population by ZCTA, 2010-2014 and 2015-2019



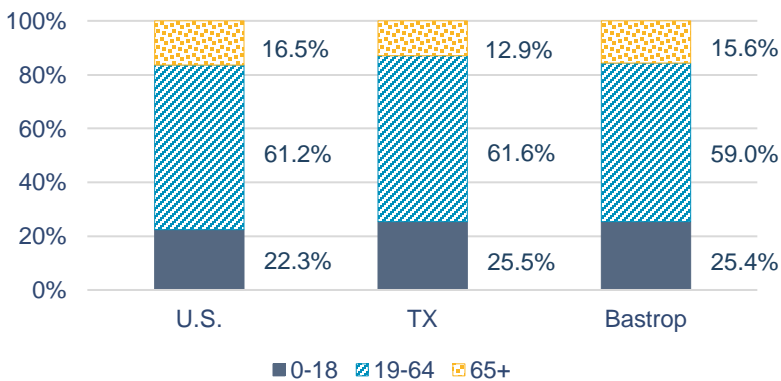
Source. U.S. Census Bureau, American Community Survey, 2010-2014 and 2015-2019.

AGE

Bastrop County's age distribution is similar to that of the United States. Bastrop County's population consists of a larger portion of children (0-18) than the United States (25.4% and 22.3% respectively) and a slightly smaller portion of adults of working age (19-64) than both Texas and the United States as a whole (59.0% vs. 61.6% and 61.2%, respectively). It also has a slightly larger elderly population (15.6%) than Texas (12.9%) but smaller the United States (16.5%).

Figure 4

Age Distribution of Population for Bastrop County, Texas and the U.S.



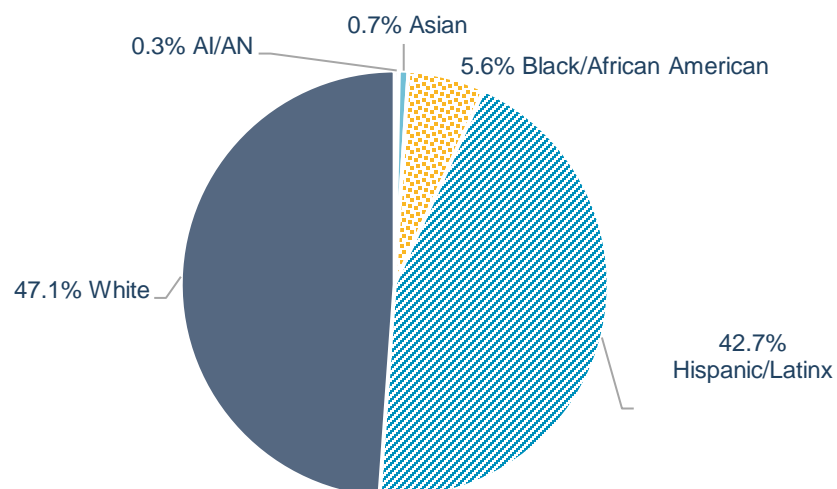
Source. U.S. Census Bureau Population Estimates, 2019.

RACE AND ETHNICITY

Bastrop County has also become more diverse as the population has grown, visually represented in Table 1. While all racial and ethnic groups increased in absolute size between 2010 and 2020, non-Hispanic whites, the majority population, saw their share of the population decline from 57.2% to 47.1%. Hispanic/Latinx populations accounted for almost 75% of the total population growth adding 17,294 persons, while non-Hispanic whites accounted for 14% adding 3,305.

As the population of Bastrop County grows more diverse, it does not appear to be getting more segregated as measured by the white / non-white Dissimilarity Index.³ The index value for Bastrop County is 34 compared to 40 for the state and 47 for the nation.

³ The dissimilarity index is a measure of residential segregation whereby higher values indicate greater segregation between residents of two population groups, ranging from zero (complete integration) to 100 (complete segregation). If an area's white / non-white dissimilarity index is 65, this means that 65% of white people would need to move to another area to make whites and Blacks evenly distributed across all areas.

Figure 5*Race and Ethnicity of Bastrop County Residents, 2020*

Source. U.S. Census Bureau 2020 Decennial Census Population Estimates.

Table 1*Bastrop County Grew More Diverse During 2010-2020*

Race or Ethnicity	2010	2020	
American Indian/Alaska Native (Non-Hispanic)	0.4%	0.30%	↓
Asian (Non-Hispanic)	0.6%	0.70%	↑
Black (Non-Hispanic)	7.5%	5.60%	↓
Hispanic	32.6%	42.70%	↑
White (Non-Hispanic)	57.2%	47.10%	↑

Source. U.S. Census Bureau 2010 and 2020 Decennial Census Population Estimates.

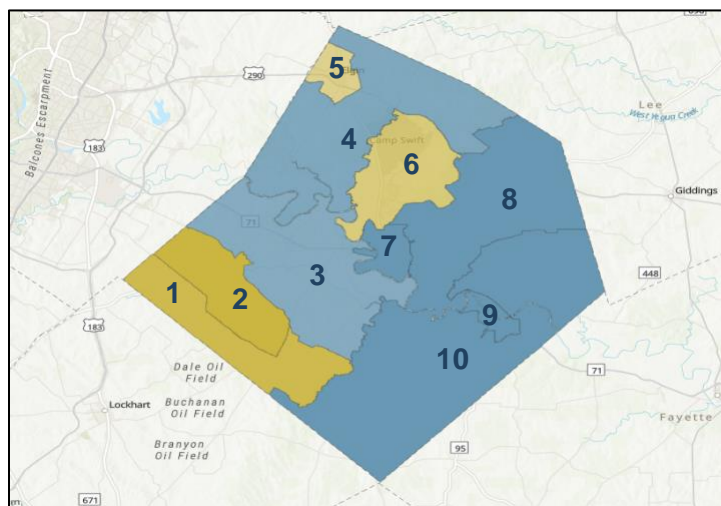
IMMIGRATION, PRIMARY LANGUAGE AND LIMITED ENGLISH PROFICIENT

An estimated 14% of Bastrop County residents were born in a country other than the U.S. Of these, 71% are non-citizens. Figure 6 displays the location of non-Hispanic white and Hispanic/Latinx population by census tracts in Bastrop County. The colors indicate the racial or ethnic group of people with the highest proportion of the population within the given tract.

For example, the southwest area of the county is predominately composed of Hispanic/Latinx population. Only the two racial and ethnic groups with the highest proportion of the population are displayed.

Figure 6

White Population is the Predominant Racial/Ethnic Population in the Majority of Bastrop County Census Tracts



Source. American Community Survey, 2015-2019. Map built with ArcGIS.com View online: <https://arcg.is/1XjaGH>.

Census Tract	% Hispanic/Latinx	% White
1	68.2%	29.6%
2	76.3%	19.2%
3	30.9%	58.6%
4	32.1%	61.3%
5*	45.4%	26.6%
6	51.0%	41.1%
7	15.3%	75.5%
8	14.9%	80.3%
9	13.3%	71.0%
10	14.1%	76.9%

* ZCTA 5 has a higher proportion of Black population compared to white, at 27.8%

English is the dominant language spoken in Bastrop County. However, 5.4% of households (and 9.4% of residents ages 5 and older) have limited English proficiency. Most (95%) of those who have limited English proficiency speak Spanish as their primary language and live in the Bastrop, Cedar Creek, and Elgin ZCTAs.

Social Determinants of Health

The communities in Bastrop County are impacted by many social determinants of health. Social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

SOCIAL VULNERABILITY AND COMMUNITY NEEDS INDEX

Center for Disease Control developed the **Social Vulnerability Index (SVI)** to measure the potential negative effect on communities caused by external stresses, such as disease outbreaks or human-caused disasters. A number of factors, such as poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss during a disaster. These factors are known as measures of social vulnerability.

CDC uses 15 U.S. census variables to help local leaders identify communities that may need support before, during, and after a natural or human-caused disaster or disease outbreak. These 15 variables are grouped into four separate vulnerability indices across: (a) housing and transportation measures, (b) minority status and language measures, (c) household composition measures, and (d) socioeconomic measures. The four indices are also combined to create an overall index. The index ranges from 0 to 1, with 0 indicating the lowest vulnerability and 1 the highest vulnerability.

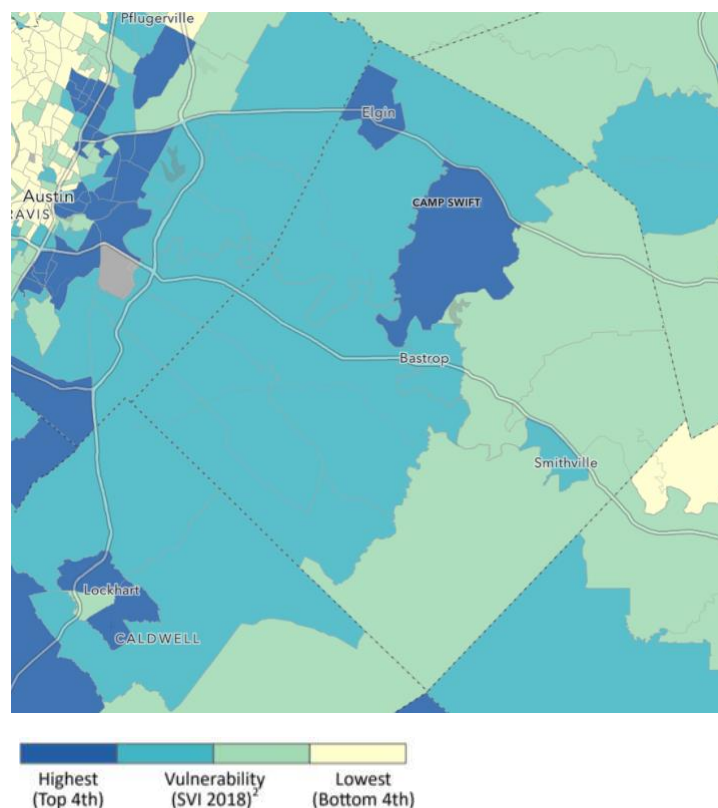
Bastrop County's **SVI of 0.7459 indicates a moderate- to high- level of vulnerability**. However, there is some variability within the county, ranging from a very high vulnerability of 0.9360 in the northeast part of the county, to a very low vulnerability of 0.3756 in the eastern part of the county.



Social Determinants of Health

Source. Centers for Disease Control and Prevention.

Figure 7
Social Vulnerability Index in Bastrop County



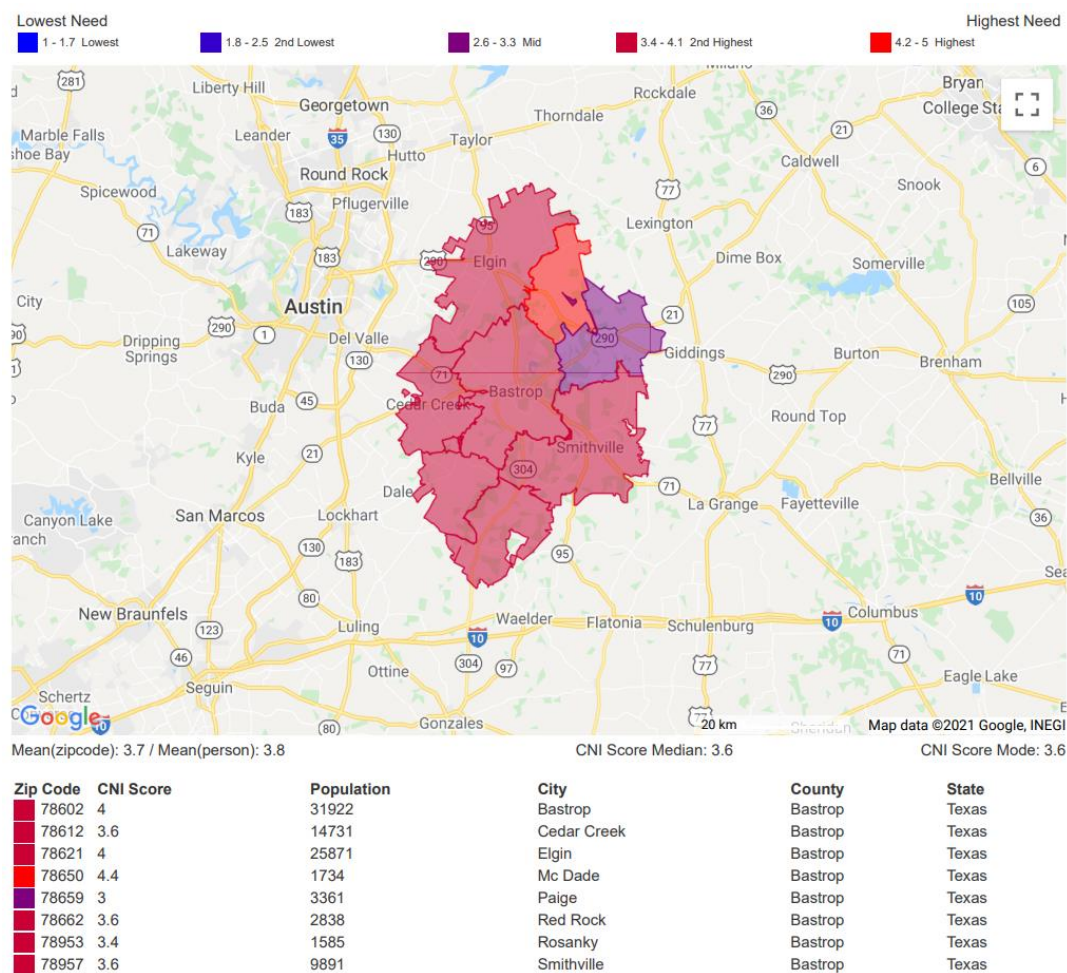
Source. Centers for Disease Control and Prevention.

The [Community Needs Index](#) (CNI) was jointly developed by Dignity Health and IBM Watson Health™ to assist in the process of gathering vital socio-economic factors in a community. Based on demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the US national average (score of 3.0). The CNI is strongly linked to variations in community health care needs and is a good indicator of a community's demand for a range of health care services. The CNI score is an average of five different barrier scores (income, cultural, education, insurance, and housing) that measure various socio-economic indicators of each community using the 2021 source data.

- Every populated ZIP code in the United States is assigned a barrier score of 1-5 depending upon the ZIP code national rank (quintile).
- A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally.

For all barriers, ZIP codes with scores of 1 or 2 have a smaller percentage of the population facing the barrier than the national average, while ZIP codes with a score of 4 or 5 have a higher percentage. ZIP codes with a score of 3 have a similar percentage.

Figure 8
Community Needs Index, Bastrop County



Source: Dignity Health and IBM Watson.

INCOME

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median incomes are likely to have a greater share of educated residents and lower unemployment rates.

- The median household income in Bastrop County was \$74,612 in 2020, which was higher than the Texas median (\$66,048) and the U.S. as a whole (\$67,340). The median income in Bastrop County rose \$11,985 in a single year—from \$62,627 in 2019—and was previously lower than both the Texas and U.S. median. Bastrop County also had the largest increase in median income in the Austin-Round Rock MSA between 2019-20.
- The median household income for Bastrop County is lower than other counties in the Austin-Round Rock MSA, including Hays (\$77,511), Travis (\$82,605), and Williamson (\$91,507), but higher than Caldwell (\$66,128).
- Although there are differences in median income between population groups defined by race and ethnicity, the differences are not considered significant.

POVERTY AND ALICE

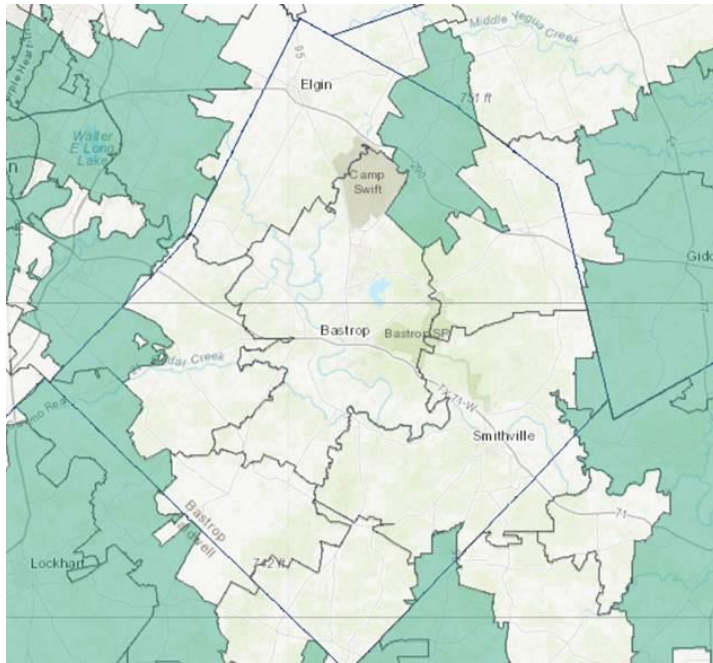
The Census Bureau sets federal poverty thresholds every year and varies by size of family and ages of family members. A high poverty rate is both a cause and consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased tax revenue to the county, poverty correlates with lower quality schools and decreased business survival.

At the individual level, 11.2% of Bastrop County residents live below the federal poverty level. This percentage is lower than the Texas (14.7%) and the U.S. (13.4%). Furthermore, Asian American Pacific Islander (AAPI) residents are less likely to live in poverty when compared to their Black/African American, white, and Hispanic/Latinx counterparts (24.5%, 9.2%, 11.9% respectively).

Within Bastrop County, the Elgin, McDade, and Smithville ZCTAs have the highest proportion of people living in poverty. As displayed in Figure 9, these ZCTAs have 12% or more of the population living below the FPL. This threshold indicates a higher rate of people living in poverty, compared to the county average (11.2%).

Figure 9

ZCTAs in Bastrop County with Greater Than or Equal to 12% of Households Living Below FPL



Source. American Community Survey, 2015-2019. Retrieved from UDS Mapper.

In addition to poverty, it is also important to understand the portion of residents who live above the poverty line but who earn less than the basic cost of living for Bastrop County, measured as ALICE.⁴

ALICE is an important indicator of economic insecurity because it identifies the prevalence of households who struggle to afford essentials like food, housing, or health care, and yet do not meet income qualifications for public assistance programs, such as Supplemental Nutrition Assistance Plan (SNAP). Basic costs of living are defined as the bare-minimum costs for housing, child care, food, transportation, health care, and a smartphone plan.

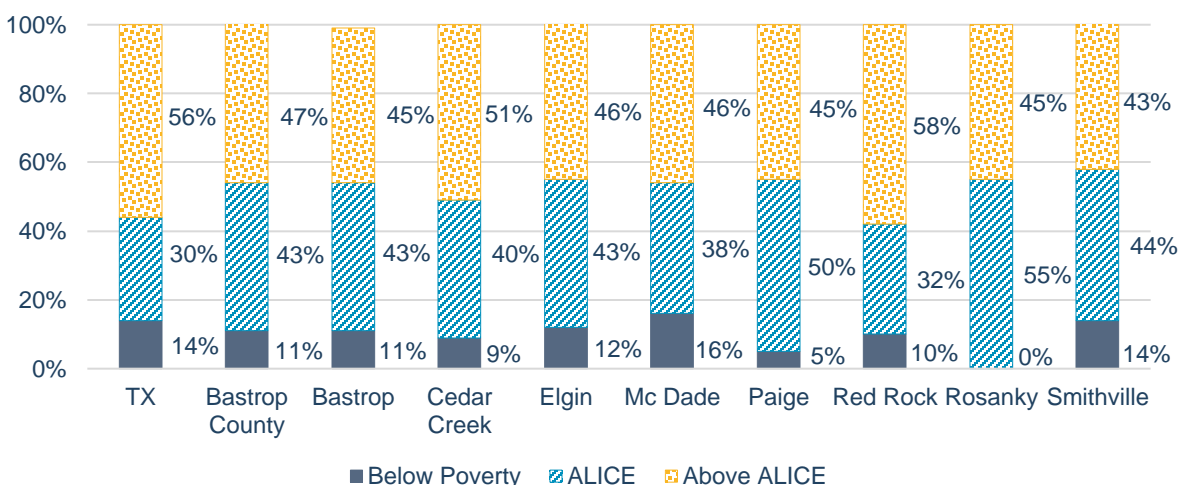
- In 2018, 11% of Bastrop County households fell below the poverty line while another 43% were ALICE.
- Single person and cohabitating households with no children are most likely to fall below the ALICE threshold in Bastrop County due to either living in poverty or being ALICE (80%).
- Households headed by individuals 65 years and older are most likely to fall into the ALICE category (38%).

⁴ ALICE: an acronym for Asset Limited, Income Constrained, Employed. ALICE typically describes those who live above the poverty line but earn less than the basic cost of living for their area. For more information on the ALICE methodology and data, visit unitedforalice.org.

Overall, ZCTA level distribution of ALICE households mirrors the County-level ALICE data as shown in Figure 10 below. Although most ZCTAs have an ALICE score below 43%, it is important to note that in the Paige ZCTA, 5% of households live in poverty while an additional 50% are ALICE, a pattern that is also visible in the Rosanky ZCTA where 0% of households live in poverty while 55% are ALICE. Consequently, 38% to 50% of households in each Bastrop County ZCTA have insufficient assets and income to meet basic cost of living needs in Bastrop County.

Figure 10

The Percentage of Bastrop County Households Living Below the Poverty Level and ALICE Threshold



Source. United for ALICE.

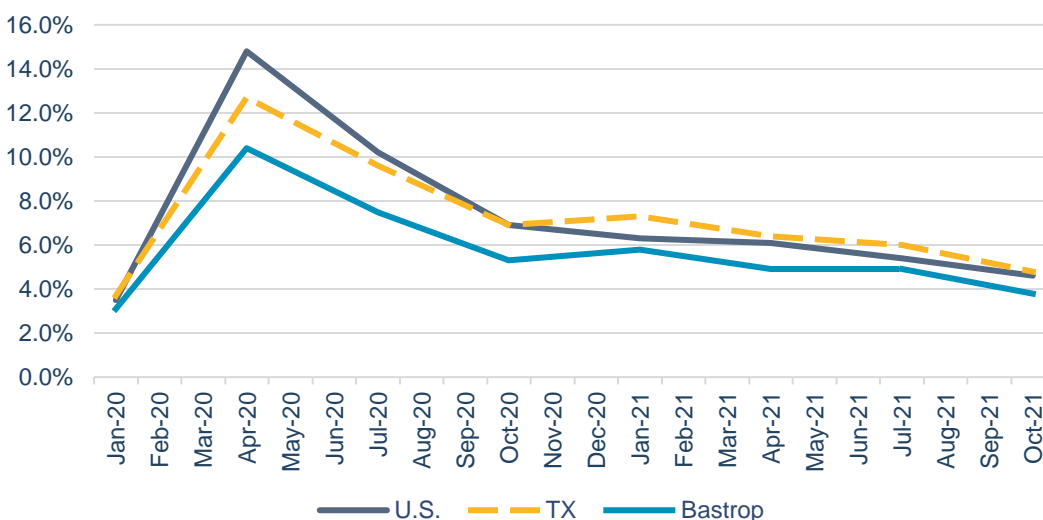
UNEMPLOYMENT

The rate of unemployment is an indicator of economic insecurity experienced by a community. Unemployment can affect an individual's physical and mental health, as well as their ability to access and engage with health care services.

As with most of the state, unemployment was low through March 2020, increased early in the COVID-19 pandemic and then began to fall (Figure 11). However, as of October 2021, the county is still experiencing higher levels of unemployment than prior to the pandemic. In January 2020, the county unemployment rate was 3.1%. It jumped to a high of 10.4% in April 2020 and remained above 5% through March 2021. It was still hovering around 3.8% in October 2021.

Figure 11

Unemployment, January 2020-September 2021: Bastrop County, Texas and U.S.



Source. U.S. Bureau of Labor Statistics.

Those most impacted by the pandemic were workers in service industries. While local data is not available, at the national level, Hispanic women (21%), immigrants of all races and ethnicities (19%), young adults ages 16-24 years old (25%) and those without any college education (21%) experienced the greatest job loss during the initial surge in unemployment early in the pandemic.⁵ Focus group participants noted that the prevalence of unemployment during the pandemic intensified financial insecurity, especially among Hispanic/Latinx community members.

HOUSING

Key informants and focus group participants identified the lack of affordable housing available within Bastrop County as one of the most complicated issues for the community. Participants noted residents experience long waiting lists for public housing vouchers and poor housing conditions, leading to physical and mental health issues. Participants also highlighted the growing homeless population with untreated mental health issues and their inability to obtain documentation that would allow them to receive free or reduced price health care.

⁵ Kochhar, R. (2020). *Hispanic women, immigrants, young adults, those with less education hit hardest by COVID-19 job losses*. Pew Research Center. <https://www.pewresearch.org/fact-tank/2020/06/09/hispanic-women-immigrants-young-adults-those-with-less-education-hit-hardest-by-covid-19-job-losses/>.

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

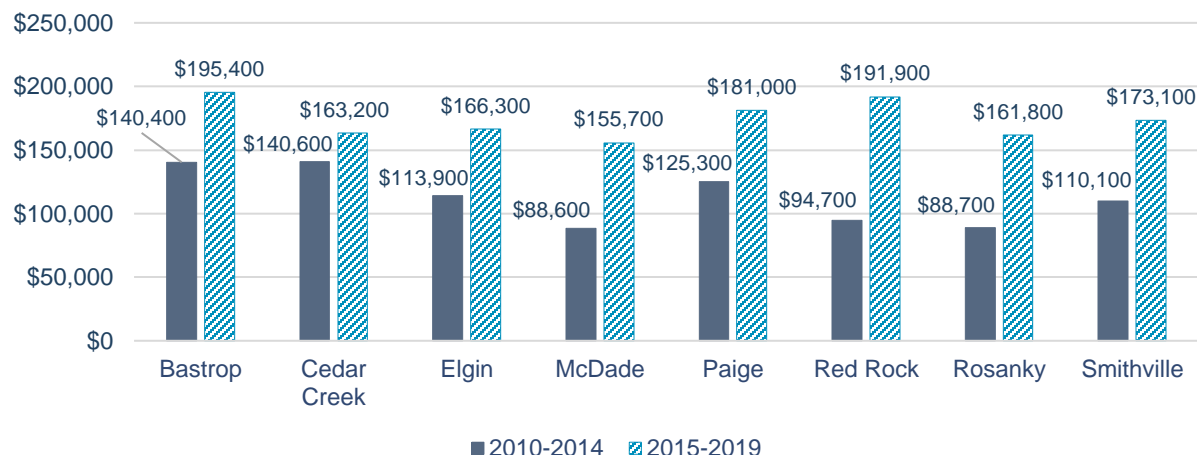
– Key Informant

Note: Due to the lag of 1-2 years in the availability of housing data, we can only provide a partial picture of the rising cost of housing up until 2019. The focus groups and key informant interviews highlighted a more heightened housing affordability crisis that has unfolded during the last two years (2020-21) because of the influx of Travis County residents in search for lower housing costs.

- Both median rents and the value of owner-occupied homes in Bastrop County have skyrocketed in the past five years (2010-2014 to 2015-2019).
 - While median rent in the county was \$856/month on average between 2010-2014, it has increased 23% to \$1,056/ month over the latter five-year period.
 - The median value of owner-occupied homes increased 41.6% over the same period from \$121,500 to \$172,000.
- Important differences exist at the ZCTA level.
 - The Red Rock ZCTA experienced the greatest 5-year growth doubling its in median home value (2015-2019 median home value is \$191,900).
 - Median gross rent for all types of units saw the greatest growth in Rosanky (154.7%) who also has the highest median gross rent (\$1,401) in 2015-2019. Figures 12 and 13 depict these changes over time.
- Recent data from the Austin Board of Realtors is more indicative of the housing affordability crisis over the last two years:
 - Between November 2020 and 2021, the median price of homes sold in Bastrop County increased 32.2% to \$345,000. In November 2019, the median price of homes sold in the county was \$245,015.

Figure 12

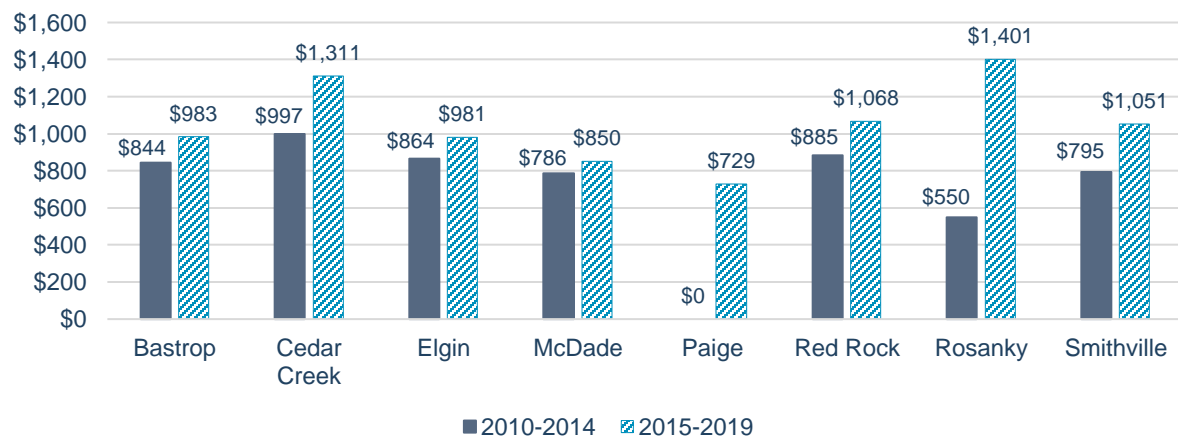
Median Value of Owner-Occupied Homes in Bastrop County, 2010-2014 vs. 2015-2019



Source. U.S. Census Bureau American Community Survey.

Figure 13

Median Gross Rent in Bastrop County, 2010-2014 vs. 2015-2019



Source. U.S. Census Bureau, American Community Survey.

Increased housing costs are not harmful, in and of themselves, so long as residents experience similar increases in income. The increased home prices and rents are driven largely by residents moving out of Travis County in search of more affordable housing. However, it is quickly making areas that were once considered affordable options no longer feasible for lower-income populations.

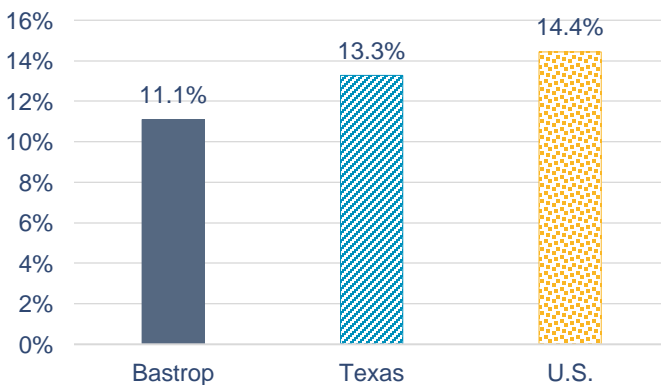
SEVERE HOUSING BURDEN

Severe Housing Burden is the percentage of households that spend 50% or more of their household income on housing. On average, Bastrop County residents spend 23% of their monthly income on housing costs. However, 11.1% spend more than 50% of their monthly income on housing costs limiting their ability to afford necessities such as food, transportation, and health care. This rate is lower than the Texas and U.S. average (13.3% and 14.4% respectively). While this rate has hold steady during the last five years, the number of households experiencing “severe housing cost burden” has increased.

- In 2015-2019, 2,838 households in Bastrop County spent more than 50% of their monthly income on housing, compared to 2,633 in 2010-2016, an increase of 205 households.
- 17% of households in Bastrop County experience one or more of the following: overcrowding, housing costs that are greater than 50% of monthly income, lack of kitchen facilities or lack of plumbing facilities.

Furthermore, participants in key interviews and focus groups shared that some populations experience poor housing conditions. Hispanic/Latinx immigrants often live in overcrowded conditions, in homes or apartments with limited plumbing or no access to sewer system.

Figure 14
Severe Housing Cost Burden



Source. U.S. Census Bureau, American Community Survey, 2015-2019.

HOUSING INSTABILITY

The Housing Stability Index (HSI) quantifies the extent of housing stability in either renter- or owner-occupied units due to missed or deferred housing payments, such as rent or mortgage. If an area is considered “at risk,” this indicates that a high percentage of residents are unable to make regular housing payments and may face eviction and homelessness. The HSI compares stability to a baseline period of January 2020, which was prior to the COVID-19 pandemic in the U.S.

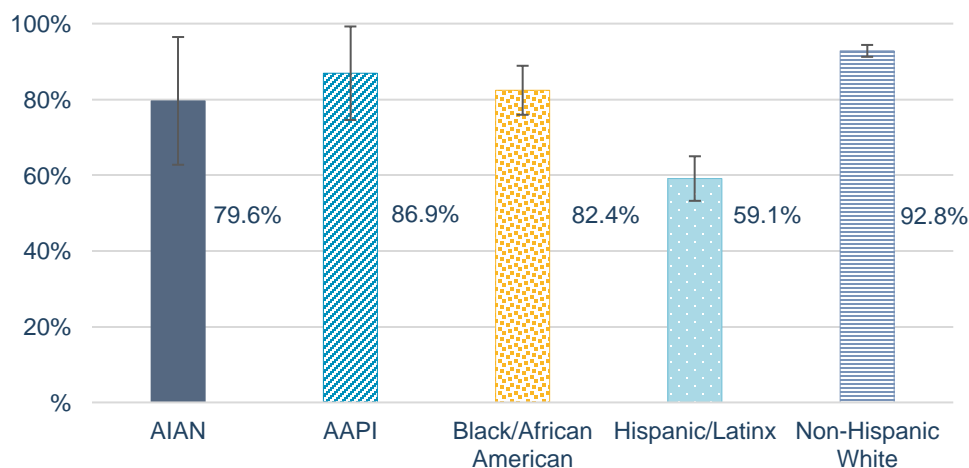
Although affordable housing has been an issue across the county for a while, the pandemic increased housing instability. Prior to the pandemic, 0.84% of occupied housing units were at risk of disruption (2.9% of renter occupied units and 0.24% of owner-occupied units). This rate increased to 3.5% in September and October 2021. This equates approximately 895 households in Bastrop County at risk-of losing their homes due to failure to make housing payments.

EDUCATION

Educational attainment is relatively high in Bastrop County with 81.9% of adults 25 years and older having completed at least high school and 20.7% having a college degree or higher compared to 83.7% and 29.9%, respectively, statewide and 88% and 32.2% at the national level. However, less than 60% of Hispanic/Latinx adults completed high school (59.1%) county-wide, and in Elgin, about half have done so (53.7%).

Figure 15

Hispanic/Latinx Residents of Bastrop County are the Least Likely to Graduate from High School



Source. U.S. Census Bureau, American Community Survey, 2015-2019.

TRANSPORTATION

Participants in the focus groups and key informant interviews identified transportation as a leading barrier to health care for many residents of Bastrop County. Residents spend, on average, 25% of monthly income on transportation. Participants noted that despite having the Capital Area Service Transportation System (CARTS), Bastrop County residents have difficulty navigating the system. In addition, even when residents have personal vehicles, the lack of money for gas prevent some from accessing primary care, specialty health care, or pharmacy visits.

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

– Focus Group Participant

In addition to the lack of public transportation options, participants noted that many residents of Bastrop County do not have access to personal transportation. In fact, 4.5% of households in Bastrop County do not own a personal vehicle, ranging from 0.0% (78662) to 5.8% (78602). Participants also noted that residents of Elgin or Stony Point have to travel 20 miles to access the nearest grocery store, pharmacy, or doctor's office, limiting access to services due to the lack of public transportation options.

FOOD INSECURITY

Many residents of Bastrop County do not have adequate access to healthy food, which may be a function of low income or high geographic distance to quality grocery store. Data from 2019, the most recent year available at the county level, indicate that 12.1% of Bastrop County residents lack adequate access to food. This is slightly lower than the statewide rate (14.1%) but higher than the rate for the U.S. as a whole (10.9%). Food insecurity impacts health in two ways:

1. By making it difficult for individuals to maintain healthy diets that are instrumental to managing chronic conditions such as diabetes; and
2. By leading individuals to forgo costly medication in order to feed their families.

Food insecurity increased during the COVID-19 pandemic, and the current rate is likely higher than it was two years ago. Projections from Feeding America's Map the Meal Gap study projects an increase in overall food insecurity in Bastrop County in 2021 to 14.2% and child food insecurity of 20.3%

Focus groups participants mentioned the inaccessibility of healthy food as a significant barrier to health, citing the high costs of healthy food and the long distance traveled to access it as main root causes. Another key informant expressed that working families often have challenges finding the time and resources to prepare healthy meals.

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

– Key Informant

There is also a general cycle of food insecurity, where multigenerational families seek emergency food from food pantries. However, food pantries cannot keep up with the demand as one key informant mentioned, “We have a great food bank in Bastrop County, but they can't get to everybody all the time.”

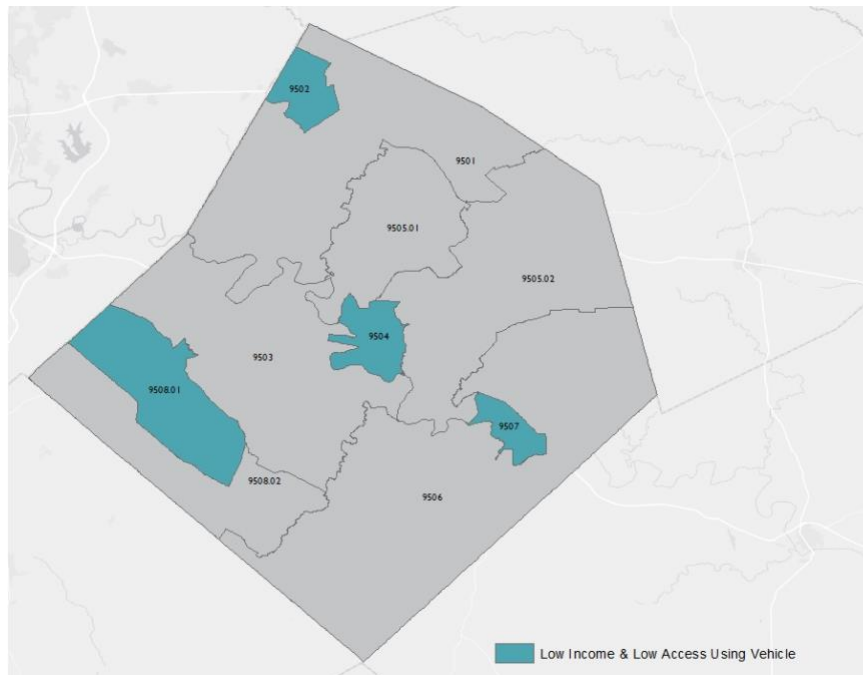
“People are kind of also in panic because there's been word of a food shortage going on. The price of groceries is going up.”

– Key Informant

Figure 16 highlights the four Bastrop County neighborhoods are officially designated by the U.S. Department of Agriculture as neighborhoods that are low income, have limited food access and at least 100 households are located more than ½-mile from the nearest supermarket and have no vehicle availability. This includes Red Rock and Cedar Creek, rural areas of Bastrop County that are considered food deserts, disproportionately affecting Hispanic/Latinx and senior populations.

Figure 16

Low Income and Low Access Neighborhoods Using Vehicle



Source. U.S. Department of Agriculture, Food Access Research Atlas, 2019.

INTERNET ACCESS

Increasingly, activities of daily life require a stable, fast broadband connection. This became ever more important during the recent COVID-19 pandemic when schools transitioned to remote learning and many employees began to work from home. Families residing in rural areas of Bastrop County frequently do not have access to the internet or social media, which limits their awareness about available health care services or community events and creates a barrier to participation in telehealth appointments. Furthermore, participants in the focus groups and key informant interviews noted that lack of internet access and computer literacy, particularly not having an email address, was a barrier to COVID-19 vaccine access in the county.

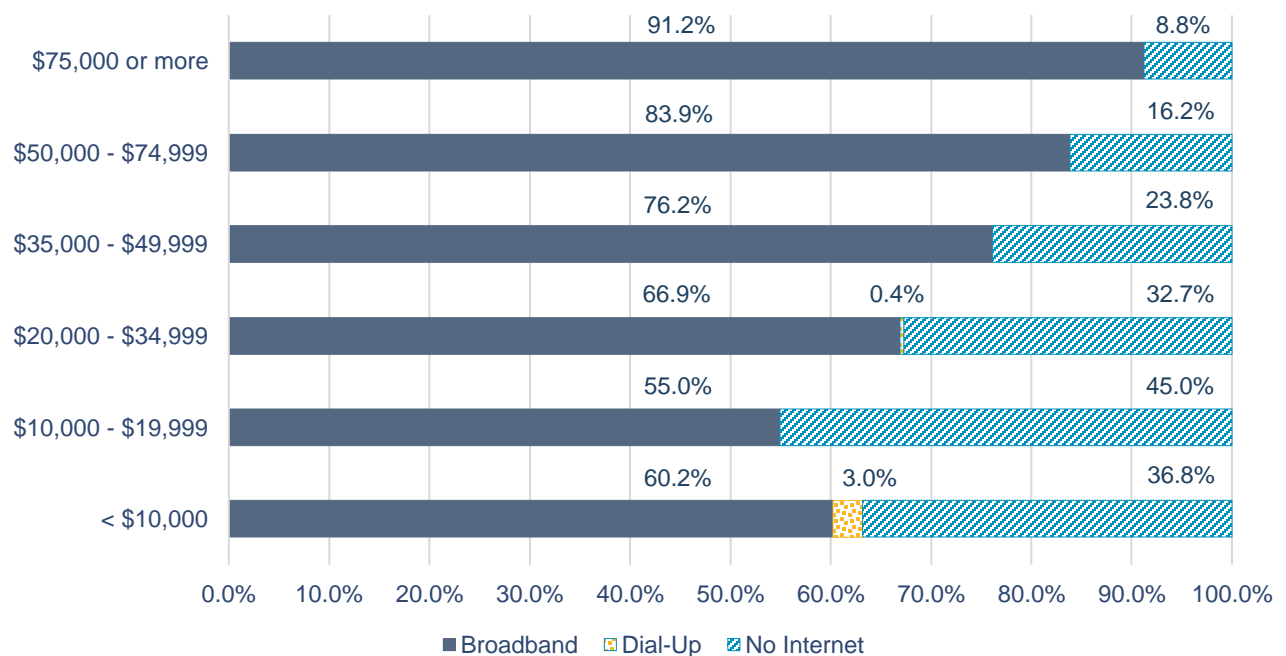
“We tried to do a whole lot more telehealth for our folks. That was limited, mostly by the lack of internet accessibility. We were limited in a lot of areas just to phone conversations rather than actual tele-video. In Bastrop County, there's a lot of dead spots. Even with the phone, there's a lot of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

– Key Informant

- In Bastrop County, data from 2015-2019 indicate that 49.2% of households have broadband access (defined as having a DSL, fiber optic or cable internet subscription).
- About 16.9% of households have no internet connection at all and another 18.2% access the internet solely via a cellular data plan.
- Economic gradients exist in both the likelihood of having no internet connection at all as well as having a broadband connection.
 - While 91.2% of households with income \$75,000 or greater have broadband access, far fewer of those earning less than \$10,000 have access (60.2%).
 - Over 35% of households earning less than \$20,000 have no internet connection at all, while only 8.8% of those earning \$75,000 and greater do so.
 - Black/African American households are more likely to live in households lacking internet access (33.5%) compared to white (14.0%) and Hispanic/Latinx (15.9%).

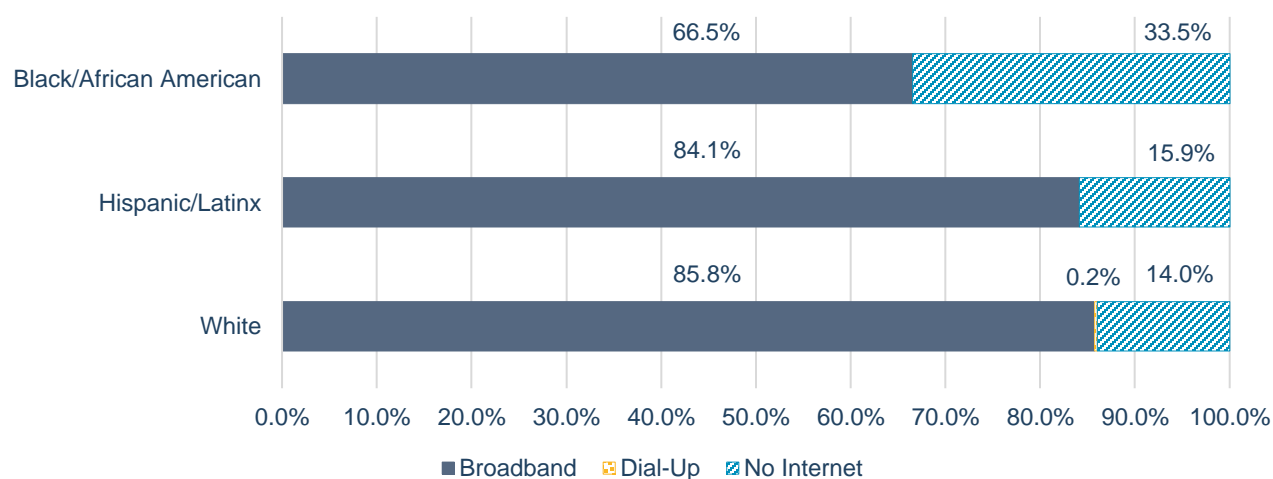
Figures 17 and 18 below highlight the variation in internet access that exists by income and race and ethnicity).

Figure 17
Internet Access by Household Income



Source. U.S. Census Bureau, American Community Survey, 2015-2019.

Figure 18
Internet Access by Race and Ethnicity



Source. U.S. Census Bureau, American Community Survey, 2015-2019.

RACISM AND DISCRIMINATION

The recent racial unrest in the country has highlighted how racism is embedded in systems across the U.S. Participants in the focus groups shared their experiences with racism and discrimination in the county. Participants mentioned witnessing racism in county hearings related to the symbolism and removal of Confederate monuments and the hesitation of some residents to drive into Bastrop County due to experiences of being racially profiled and targeted by the county sheriff.

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

– Key Informant

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

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

– Focus Group Participant

Community Assets and Strengths

Bastrop County has several community assets and strengths that should be considered as they can be used to meet the needs of the community and improve quality of life. Participants noted the close-knit and resilient community. Churches, nonprofits, and school base district are key players, often providing health care services and resources to community members.

Key informants expressed excitement about the numerous nonprofit organizations and community-based organizations that have been instrumental in promoting community reconciliation and providing pandemic resources. Services provided by the nonprofits and community-based organizations range from child abuse support, to recreation, workforce development, transportation, and food pantry services, among others.

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

HEALTH CARE ORGANIZATIONS

Bastrop County is home to the Ascension Seton Bastrop Hospital and the St. David's Emergency Center-Bastrop, as well as five federally qualified health centers (FQHCs) that provide comprehensive primary and specialty care. The following are the FQHCs available in the area:

- Bastrop Community Health Center
- Bastrop ISD Health Center
- Bastrop Women's Health Center
- Lone Star Circle of Care at Bastrop
- Family Health Center at Elgin

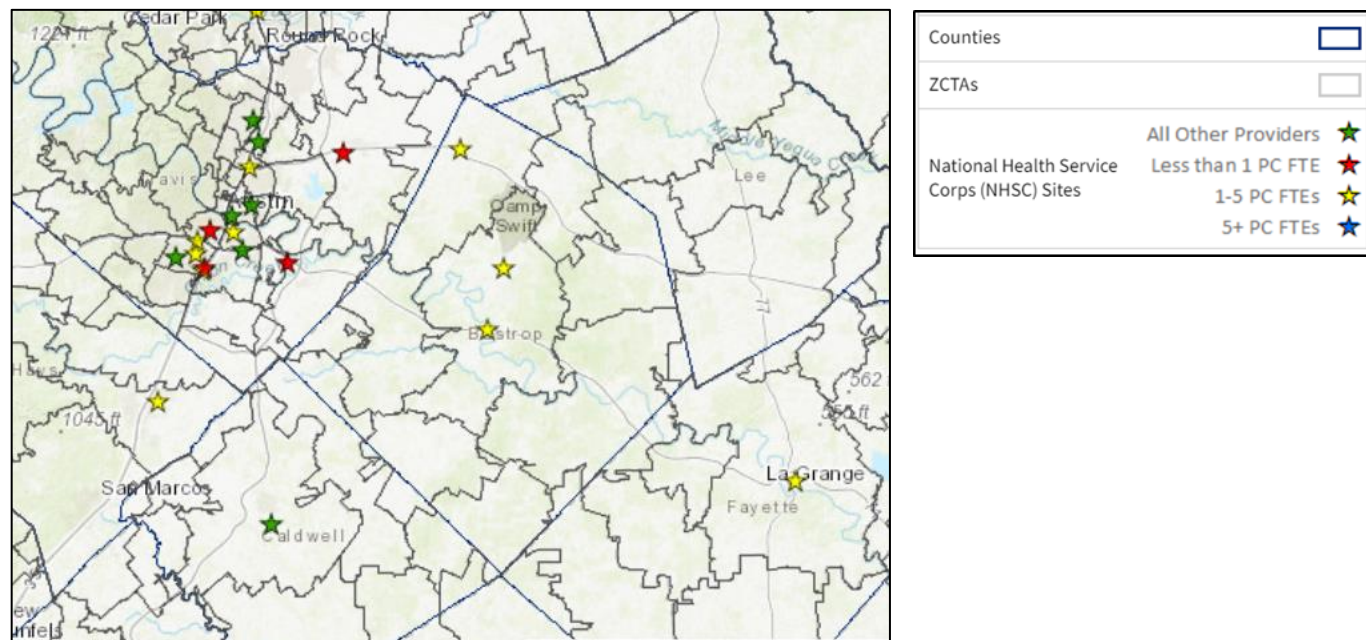
In addition, the county is also home to various clinics that provide primary and specialty care. The following were mentioned by focus group participants:

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

Bastrop County has three National Health Service Corps (NHSC) sites. This designation is given by HRSA for a clinical site, typically a federally qualified health center, which is located within a Health Professional Shortage Area (HPSA) and can provide services to people without regard for their ability to pay. Of the three NHSC sites in Bastrop County, two are open to the public: Lonestar Circle of Care Family Care Center at Bastrop and Family Health Center at Elgin. Additionally, the Federal Correctional Institution Bastrop is considered a NHSC site.

Figure 19

National Health Service Corps Sites in Bastrop and Surrounding Areas



Source. Health Resources and Services Administration, 2021. Map built with UDSMapper.org.

NONPROFITS AND COMMUNITY ORGANIZATIONS

Nonprofits and community-based organizations in Bastrop County play a vital role in building healthy communities by providing educational, health, and social services to community members. Focus group participants shared that nonprofits in the area have been instrumental in promoting community reconciliation and providing pandemic resources.

Below is a list of nonprofits and community-based organizations mentioned by participants:

- Area Agency on Aging (Austin)
- Bastrop County Cares (Early Childhood Coalition and Network Weaving)
- Bastrop County Emergency Food Pantry
- Capital Area Council of Governments

- Capitol Area Rural Transportation System
- Drive a Senior Program
- Combined Community Action
- Community Cupboard (Elgin)
- Elgin and Bastrop Parks and Recreation Services (Fisherman's Park in Bastrop and Bryant Park)
- Hunger Free Communities – Bastrop
- IT'S TIME TEXAS
- Master Gardeners
- Meals on Wheels Rural Capital Area
- Sand Hollow Farm
- Smithville Community Gardens
- Smithville Food Pantry
- Smithville Workforce Training Center

CHURCHES AND FAITH-BASED ORGANIZATIONS

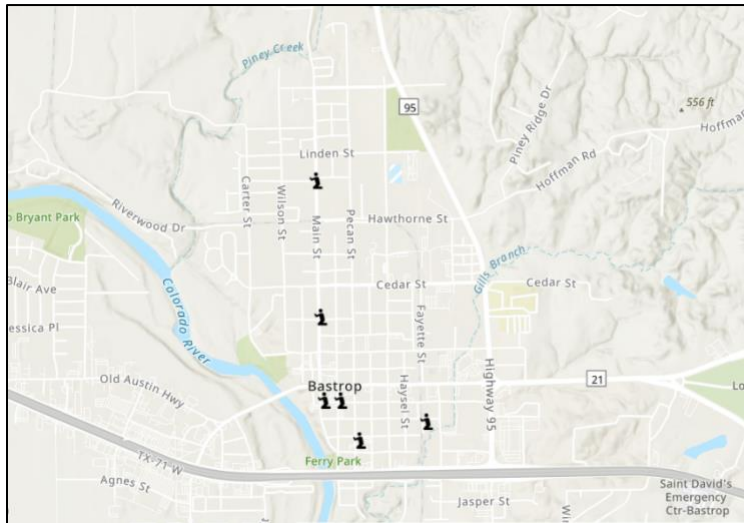
Key informants also expressed gratitude for the tremendous impact of churches and faith-based organizations that participate in community outreach, advocacy, and support of homeless population. The following churches and faith-based organizations were mentioned as valuable resources for the community:

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

In addition, the map below displays the geographic distributions of places of worship within the City of Bastrop.

Figure 20

Places of Worship in the City of Bastrop



Source. OpenStreetMap Amenities for North America. Retrieved December 17, 2021.

PARKS

Bastrop County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. In the Bastrop and Elgin ZCTA's, over half of all residents live within a 10-minute walk of a park (57% and 71%, respectively); meanwhile only 36% of Smithville residents do so. Data is not available on park access for Cedar Creek, McDade, Paige, Rosanky, and Red Rock. The following parks are available in Bastrop County:

- Cedar Creek Park
- Stony Point Neighborhood Park
- Bastrop County Nature Park
- Bastrop State Park

Priority Health Needs and Barriers to Care

The health issues and barriers to health care access and healthy lifestyles experienced by Bastrop County residents could be influenced by St. David's HealthCare through policy or system-level changes and collaboration with community partners.

KEY HEALTH ISSUES

Bastrop County residents are doing well relative to the state as a whole and the nation on several health outcomes. They have lower rates of lack of access to prenatal care, low birthweight, infant mortality, child mortality, and drug overdose deaths (Appendix A). There are, however, several health issues which deserve attention.

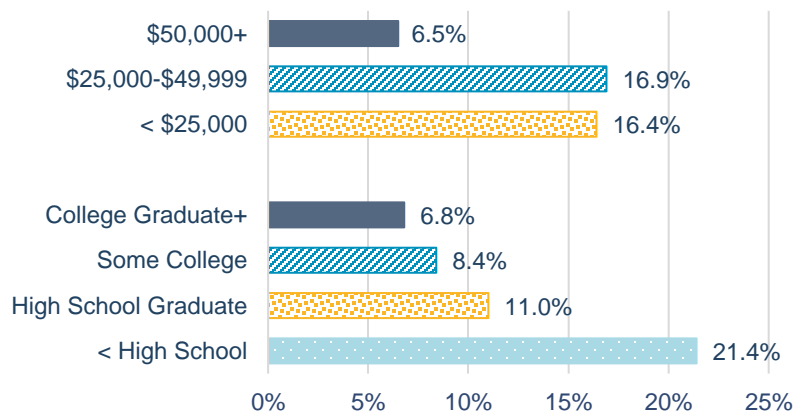
DIABETES

Participants in focus groups and key informant interviews identified diabetes as a priority health condition in their community, noting a perceived higher prevalence of diabetes in Black/African American communities of the county. The prevalence of diagnosed diabetes among adults in Bastrop County is 12.7% among adults 20 years and older, worse than the state and national prevalence rate (10.2% and 10.5% respectively). However, quantitative data for Public Health Region 7 (the region in which Bastrop County is located) indicate the underpinnings of these differences are likely socioeconomic in nature, rather than due to race and ethnicity as seen in Figure 21:

- Texan adults with less than a high school education (21.4%) are over two and three times more likely to have diabetes than those with at least some college education (8.4%) and those who have graduated college (6.8%), respectively.
- Texans earn less than \$50,000 per year are more than twice as likely to have diabetes as those who earn more \$50,000 or more annually (16.5-16.8% vs. 6.5%).

Figure 21

TX Public Health Region 7: Diabetes Prevalence by Income and Education Attainment, Adults

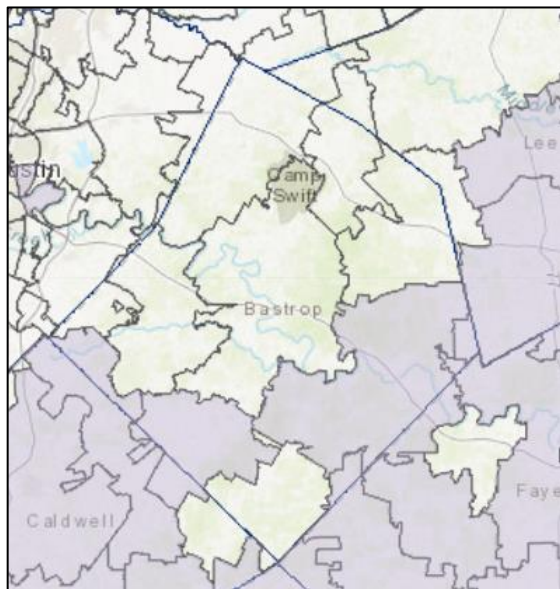


Source. U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.

This map displays Bastrop County and the surrounding areas, with ZCTAs outlined. ZCTAs that are colored indicate that 13% or more of the population over 18 years has ever been told they have diabetes, which is higher than the county-level prevalence (12.7%). These areas, located mostly in eastern Bastrop County, could be prioritized for interventions related to diabetes.

Figure 22

Areas of Bastrop County with the Highest Prevalence of Diabetes



Source. Behavioral Risk Factor Surveillance System, 2018; American Community Survey, 2015-2019.
Map built with UDSMapper.org.

Participants noted the inability to afford healthy food options or medications due to poor socioeconomic status, and forgoing doctor visits due to lack of insurance as contributing factors to diabetes.

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

– Focus Group Participant

HYPERTENSION

Hypertension was mentioned by key informants and focus group participants as a priority health issue for the county. Data from 2019 shows that the prevalence of hypertension among adults in Bastrop County is slightly higher than the statewide rate (31.8% vs. 30.8%). This means that almost 1 in every 3 adults in Bastrop County have high blood pressure putting them at risk of suffering a stroke. Participants noted that the cost of medication to treat chronic diseases are very expensive and therefore a barrier to ongoing care.

OBESITY

The second identified health priority was obesity, a condition linked to diabetes and hypertension. Data from 2019 shows that the prevalence of obesity among adults in Bastrop County is higher than the statewide rate (39.7% vs. 35.8%). Both local and state prevalence rates are higher than the U.S. (31.9%); however, with almost 1 in every 3 adults in the U.S. being obese, it's a common issue everywhere. Participants noted a lack of access to healthy food options and exercise facilities due to transportation barriers, poor nutrition habits, and lack of nutrition education as contributing factors. In addition, it was noted that the high costs of healthy food discourage residents from purchasing them, as quantity of food is preferred over quality of food to survive.

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

– Focus Group Participant

MENTAL HEALTH

Participants identified mental health as a health priority for Bastrop County, particularly in Elgin. Overall anxiety, depression, bipolar disorder, schizophrenia, and the overall negative impact of stress were identified as the most common mental health concerns of the community.

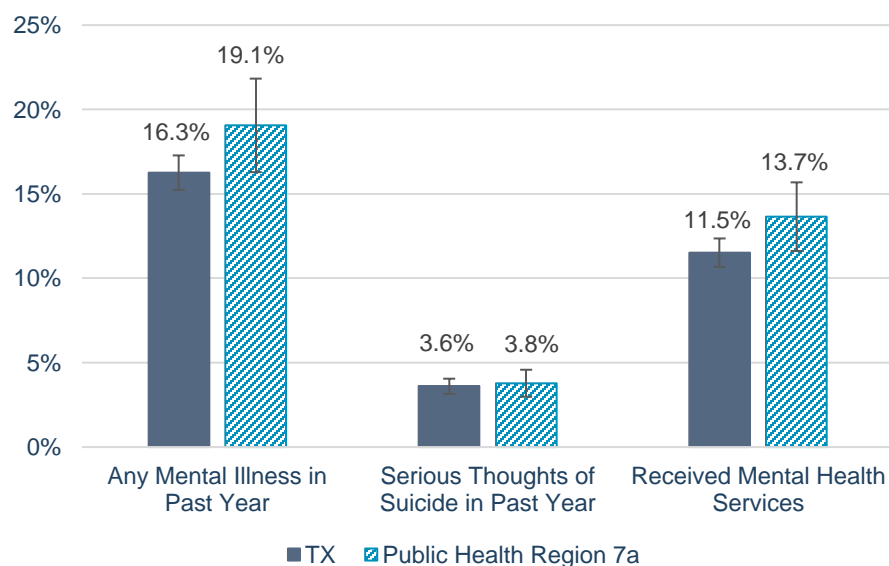
- According to modeling using 2019 BRFSS data, 19.9% adult Bastrop County residents have been diagnosed with a depressive disorder at some point in their lives.
- In 2019, 14.1% of Bastrop County adults reported their mental health as being “not good” 14 days or more in the past 30 days, a rate slightly higher than the state and national average (12.2% and 13.8% respectively).
- Rates of mental illness, thoughts of suicide and receipt of mental health services are similar in Public Health Region 7a (including Bastrop County) as Texas. Data for these measures are not available at a county level.

The prevalence of poor mental health is likely higher than the most recent available BRFSS data, given the impact of the COVID-19 pandemic. Estimates from the Household Pulse Survey, which CDC has administered on a rolling basis throughout the COVID-19 pandemic, estimates that 29.5% of Texas adults experienced symptoms of anxiety disorder or depressive disorder as recently as December 2021. This percentage was previously as high as 43.4% of Texas adults in January 2021.⁶ At the national level, women reported higher rates of symptoms than men (33.8% vs. 27.5%), and adults ages 18-29 had rates substantially higher than all other age categories (44.5%).

⁶ Household Pulse Survey. *Anxiety and Depression*. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>.

Figure 23

Rates of Mental Illness, Thoughts of Suicide and Mental Health Services in Public Health Region 7a Are Similar to Texas



Source. Substance Abuse and Mental Health Services Administration, National Survey of Drug Use and Health, 2016-2018.

Participants in the focus groups and key informant interviews identified lack of access to mental health services as a major unmet need of Bastrop County. Key concerns include:

- Affordability and accessibility: many health providers do not accept insurance, which makes mental health care difficult to afford. One community member mentioned that there is a “lack of a sustainable mental health service structure and a need to provide services on a consistent basis rather than on one visit.”
- Culturally appropriate services: there is significant negative stigma about mental illnesses that inhibits individuals and families from seeking treatment and support, especially among Black/African American and Hispanic/Latinx communities.
- Homeless people struggle the most with mental illness and substance use disorders.
- There is a need to increase mental health crisis training among medical providers, police officers, first responders, school personnel, and families.
- The county’s population-to-mental health provider ratio is 1,740:1 whereas it is 827:1 across the state. Both are much higher than the national ratio of 383:1.

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

– Key Informant

ORAL HEALTH CARE

Access to affordable oral health care is a concern in Bastrop County, particularly for underserved community members. Participants reported that high out-of-pocket expenses make oral health care unaffordable for many low-income residents and low-cost dental services are often limited for people that are either uninsured or underinsured. As a result, it is common for Hispanic/Latinx families to travel to Mexico for emergency dental appointments. A key informant also mentioned the increase in dental patients seeking services for tooth decay attributed to the use of crystal methamphetamines

According to modeling using 2018 BRFSS data, 51.2% of Bastrop County adults reported a dental visit in the last 12 months, which is lower than most other counties in the Austin-Round Rock MSA. In addition, it is estimated that as of 2018, 16.3% adults 65 and older Bastrop County residents have lost all their teeth compared to 13.7% for the state.

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

– Focus Group Participant

BARRIERS TO HEALTH CARE

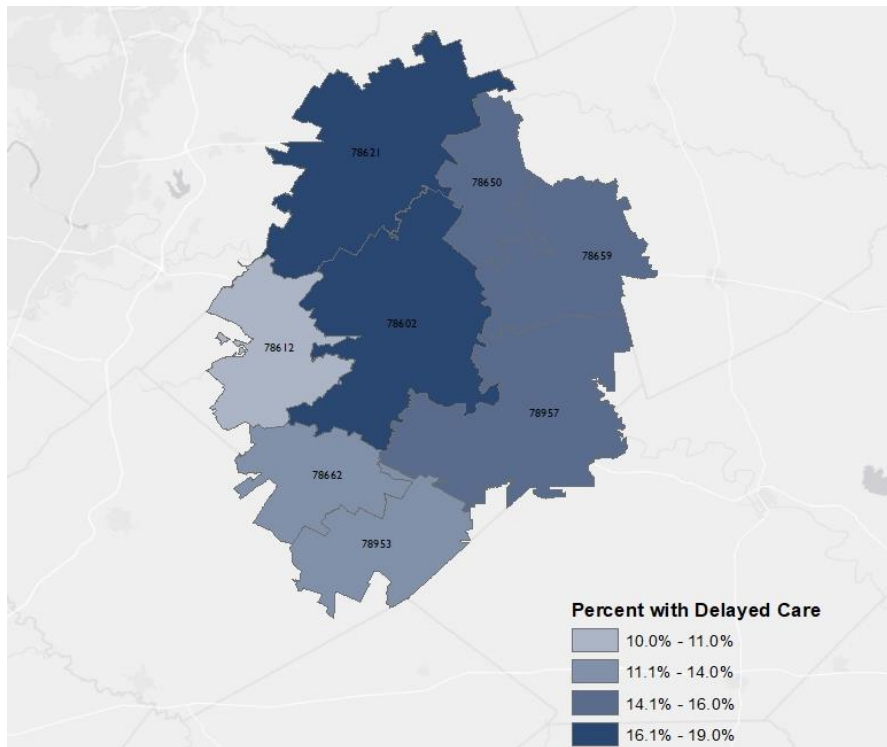
The affordability and availability of needed health care services and providers have a direct impact on access to health care. The following section discusses the use of health care and other services, barriers to accessing these services, and the health professional landscape in the county.

DELAYED CARE AND PREVENTABLE HOSPITAL STAYS

Key informant and focus group participants indicated that barriers to health care affect low-income families and minority residents the most. In 2017, the most recent year this data is available at the county or sub-county level, approximately 16.5% of Bastrop County adult residents reported there being a time in the prior year when they needed care but could not afford it. The rates vary across ZCTAs as shown in Figure 24 below. The portion reporting delaying care was highest in the Elgin ZCTA (19.0%) and lowest in Cedar Creek (10.7%).

Figure 24

Delayed Care Rates by ZCTA



Source. Behavioral Risk Surveillance System, 2017.

Another indicator of challenges with health care access is the rate of hospital visits for conditions that could be treated in the ambulatory (e.g., non-hospital) setting. Such visits are typically costlier when treated in the hospital environment. Treatment, especially for the management of chronic conditions, can be sub-optimal if received through emergency departments due to the short-term, triage focus of that venue.

- In Bastrop County, the rate of preventable hospital stays among Medicare enrollees in 2018 was 4,211 per 100,000 Medicare beneficiaries. This is slightly lower than the state and national rates (4,793 per 100,000 and 4,236 per 100,000 respectively).
- The rate of preventable hospital stays has decreased county wide by 25.4% since 2012.
- Black/African American Medicare enrollees are 1.8 times more likely to use the hospital for ambulatory-sensitive conditions than are white and Hispanic/Latinx residents.

UNINSURED AND UNDERINSURED

Insurance coverage improves access to care and care seeking by lowering the out-of-pocket costs. It also improves rates of preventive care (e.g., screenings and vaccinations).

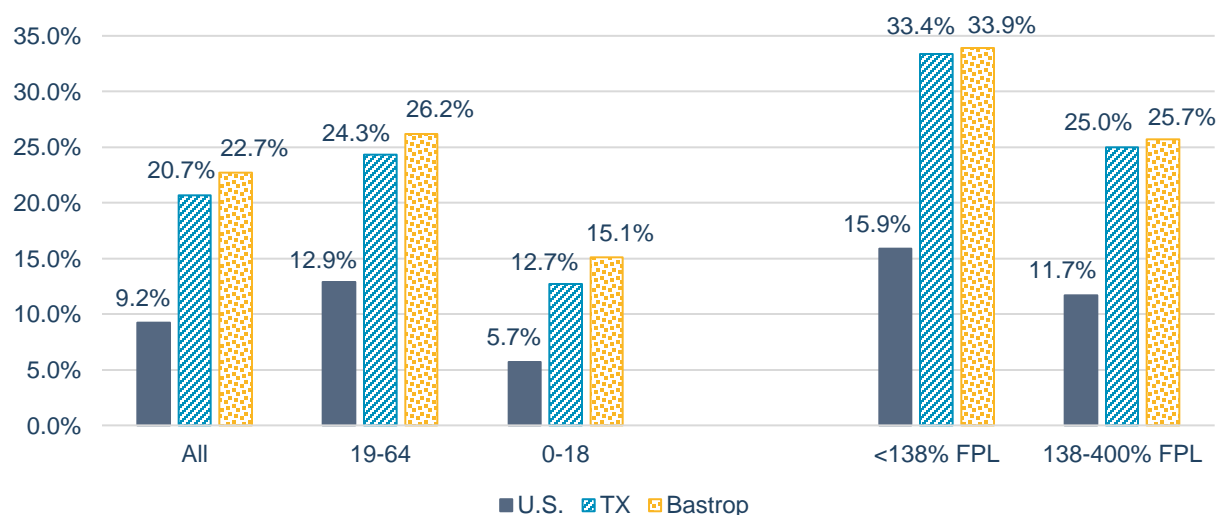
- As a state, in 2019 Texas had a higher percentage of residents under the age of 65 who are uninsured (20.7%) than any other state. This is also twice the portion of residents nationally who are uninsured (9.2%).
- In Bastrop County, 22.7% of residents under the age of 65 are uninsured; this is higher than the state and national average, and higher than most counties in the Austin-Round Rock MSA. In comparison, Caldwell County (25.7%) has a higher uninsured rate, and Hays County (16.7%), Travis (16.5%), and Williamson (12.4%) had the lower rates of uninsured than Bastrop County.
- As of 2019, 26.2% of Bastrop County adults ages 19 to 64 are uninsured while 15.1% of children under the age of 19 do not have health insurance coverage.
- In Texas, Hispanic/Latinx adults ages 19-64 are more likely to be uninsured (30.5%) than Black/African American (16.2%) or white, non-Hispanic/Latinx (12.9%) (disaggregated data not available at the county level)
- Rates of uninsured mask a larger problem of underinsurance. Although no data is available at the county level, national data indicates that two out of five working age adults (ages 19-64) are inadequately insured (43.4%).^{7,8}
- Differences in insurance coverage exist by income as shown in Figure 25 below.

⁷ The Commonwealth Fund determines people to be underinsured if they are insured all year and they meet one of the following criteria: (a) their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10% or more of household income, (b) their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5% or more of household income for individuals living under 200% of the federal poverty level (\$25,520 for an individual or \$52,400 for a family of four in 2020), or (c) their deductible constitutes 5% or more of household income.

⁸ Collins, S., Gunja, M. Z., Aboulafia, G. N. (2020) *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>.

Figure 25

Rates of Uninsured by Age and Income for the Bastrop County, Texas and U.S.



Source. U.S. Census Bureau, Small Area Health Insurance Estimates Program and American Community Survey, 2019.

ACCESS TO AFFORDABLE CARE

Participants described the challenges that many underserved, low-income, and minority community members face regarding health care; while many receive lesser quality care due to financial insecurity or being uninsured or underinsured, many more will forgo care entirely because of the costs. Participants noted the following:

- Many community members travel distances of 20 or more miles to access affordable health care.
- Low-income families are not able to afford medications, especially diabetes medication.
- Uninsured or underinsured community members often avoid preventive care due to cost.
- Oral health care is expensive, and many community members have significant oral health needs but do not have dental insurance.

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

– Key Informant

Although data is not available at the county-level avoided care due to cost, 13.3% of adults in the Austin-Round-Rock MSA reported delaying care due to cost in 2020, which was lower than Texas (15.2%). At the state level, Hispanic adults (20.3%) and women (17.2%) were more likely to report avoiding care due to cost.

Participants noted the lack of options for primary care that accept public insurance and the lack of availability of the Medical Access Program as key barriers to access to care. As a result, many community members will use the emergency room for minor health issues and travel to Smithville, Round Rock, Austin, College Station, Bryan, or Kyle to receive primary or specialty care services. Furthermore, because the Medical Access Program is available to low-income Travis County residents, some Bastrop County residents falsify address information to receive benefits from Travis County.

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

– Key Informant

ACCESS TO PRIMARY AND SPECIALTY CARE

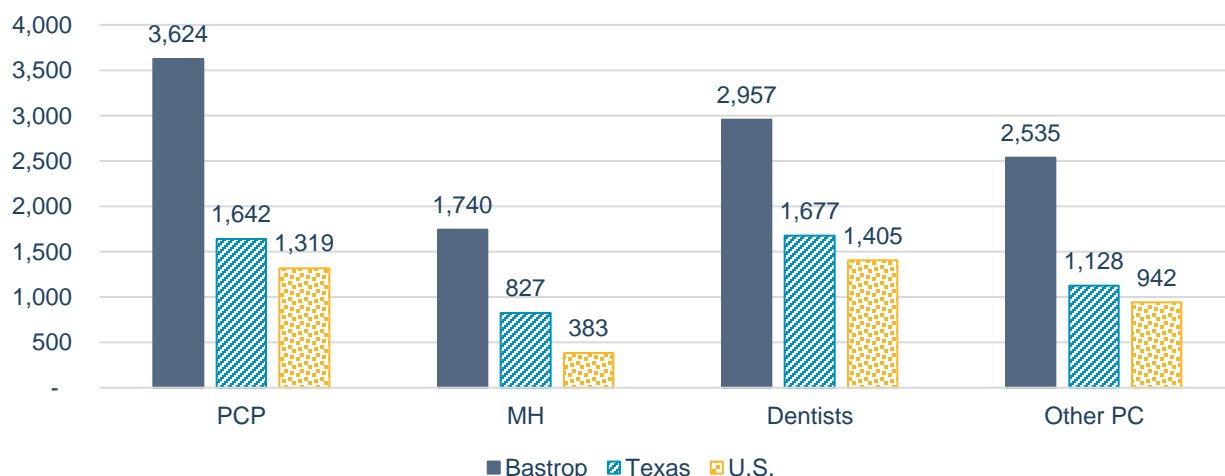
A short supply of providers can be another barrier to care as it increases the time it takes to get an appointment or received appropriate care. Participants reported traveling to Smithville, Round Rock, Austin, College Station, Bryan, or Kyle to receive primary care services, care for more complex health conditions, or specialty care services, including for cardiology, obstetrics and gynecology, endocrinology, or pediatric care.

Bastrop County is designated as a health professional shortage area for both primary care and mental health by the U.S. Health Resources and Services Administration. (It is not for dental care, however). For both primary and mental health care, the supply of providers has not kept pace with population growth. The number of residents per primary care physicians grew by 12.1% between 2010 and 2018 from 3,232 to 3,624. This is a far larger number of residents per primary care physician than the state as a whole and nationally.

The supply of non-physician primary care providers is also lower than that of the state as a whole and the U.S., as is the supply of dentists and mental health providers, respectively as shown in the Figure 26 below.

Figure 26

Number of Residents per Provider for Bastrop County, Texas, and U.S.



Source. U.S. Health Resources and Services Administration Area Health Resources File, 2019 and Centers for Medicare and Medicaid National Provider Identification System, 2020. Note: PCP – Primary Care Physician; MH – Mental Health Provider; Other PC – Other Primary Care Providers.

While the availability of dentists relative to the population is lower than that for the state and nationally, this is one area where supply has improved since 2010. In 2010, there were 4,955 residents per dentist; in 2018, there were 2,957. However, as focus group participants pointed out, availability does not mean care is affordable; thus, oral health care still remains inaccessible for low-income populations.

CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

Focus group participants and key informants noted that health care services often feel inaccessible, because they are not culturally or linguistically appropriate. In addition, language barriers, poor health literacy, lack of awareness of available resources, and fear of deportation due to immigration laws often result in barriers to health care. Further, a lack of minority health care providers that look like their patients and can relate to their cultural needs leaves community members feeling uncomfortable with their health care providers.

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

– Focus Group Participant

Key informants and focus group participants shared barriers regarding the lack of health care workforce diversity and language, noting an insufficient number of Black/African American or Spanish-speaking providers. Participants noted that there are limited services for those who speak Spanish. For example, Hispanic/Latinx populations in Bastrop County often encounter language barriers due to the lack of interpreters and translated material.

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

– Key Informant

Other Health Needs

The following additional significant health needs emerged from a review of the publicly available quantitative data for Bastrop County. While these topics did not specifically emerge as priority areas in the focus groups and key informant interviews, they are worth noting.

CANCER

While not a major topic amongst focus group participants and key interviews, 2018 data reports that a high incidence rate of cancer among Bastrop County residents, 432.9 per 100,000 residents. A number higher than the Texas and U.S. incidence rate. The incidence rate varies per racial and ethnic group and cancer type.

- The cancer incidence rate is higher among Black/African American, 503.8 per 100,000 residents, and lower among Hispanic/Latinx residents, 363.6 per 100,000 residents.
- Colon cancer incidence rate is higher among Bastrop County residents, 45.7 per 100,000, compared to 38.0 per 100,000 statewide.
- Bastrop County has a high incidence of breast cancer with a 131.4 per 100,000 compared to 115.2 per 100,000 statewide.

DISABILITY

Individuals with disabilities are at greater risk for poor general health and wellbeing and may face greater barriers to access to health care services. Between 2015-2019 estimates that 13.6% of Bastrop County residents are disabled. This rate is higher than the Texas and U.S. average (11.4% and 12.6%). Disability inclusion is critical to achieving better health and wellbeing outcomes. Having an understanding on how people interact with the environment is key to making sure that everybody has the same opportunities to participate in every aspect of life to the best of their abilities and desires.

PHYSICAL INACTIVITY AND ACCESS TO EXERCISE OPPORTUNITIES

Data from 2019 shows that a much lower percentage of Bastrop County community members have access to adequate locations for physical activity (47.5%) than in Texas (80.5%) or the U.S. (84.2%). Furthermore, according to modeling using 2019 BRFSS data, 32.1% of Bastrop County adults 18 and older reported no leisure-time physical activity. This rate is higher than the Texas and U.S. average (27.2% and 26.0% respectively). Such numbers are concerning, considering the high rate of adult obesity in the county.

Conclusion

As part of a collaboration with local hospital systems, St. David's Foundation contracted with THI to compile and analyze quantitative data for Bastrop County for the 2021-2022 CHNA process. Additionally, THI conducted seven virtual key informant interviews, three virtual community focus groups, and once virtual Photovoice project to qualitatively understand the health priorities for Bastrop County.

Both quantitative and qualitative data indicate that Bastrop County has many significant assets and strengths, including an embedded sense of collaboration to meet the needs of others, as well as a history of resiliency. The county also has a strong network of churches and faith-based organization, as well as nonprofits and community-based organizations that collaborate and provide support services to residents.

Many community members, however, experience barriers to health care and healthy lifestyles. Bastrop County has experienced rapid population growth over the past decade, resulting in high housing costs and a lack of affordable housing. The population growth has also resulted in an increased demand for health care providers resulting an increased barrier to care among lower-income populations. In addition, culturally and linguistically appropriate care, lack of transportation, and access to healthy foods are key drivers of health for Bastrop County residents.

Many of these barriers can be reduced or eliminated, either directly through policy and system change, or via collaboration with community partners. Focus group participants and key informants provided a number of recommendations about actions a health care system could take to address the concerns they identified in Bastrop County. The recommendations focused on three primary outcomes: (a) improve health care access, (b) increase culturally competent health care, and (c) strengthen engagement and outreach.

IMPROVE HEALTH CARE ACCESS

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

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

Knowledge and awareness: Provide additional community education by hosting fitness and nutrition classes, cooking demonstrations, and classes to demonstrate healthy grocery shopping

on a budget. Disseminate information through pamphlets, booklets, or program flyers at community events.

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

INCREASE CULTURALLY COMPETENT HEALTH CARE

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

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

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

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

– Focus Group Participant

STRENGTHEN ENGAGEMENT AND OUTREACH

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

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

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

– Key Informant

Evaluation of 2019 CHNA

St. David's Foundation last completed Community Health Needs Assessment and Implementation Plans in 2019. Below are the highlights of accomplishments since 2019 that support St. David's Foundation Community Improvement Plans (CHIP).

Priority Area: Improve the health and well-being of children

Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Foster the conditions that create positive early experiences for young children, knowing these early experiences are the foundation for later health, social, and economic outcomes.	<p>Inform the public by promoting the science of brain development to guide clinical practice, public policy, and resource decisions.</p> <p>Screen at key intercept points such as pediatric clinics for childhood adversity, relational health, and other related factors.</p> <p>Treat children through a strong therapeutic web that includes specialized treatments that incorporate research on the effects of trauma and adversity, as well as tools to build resiliency, such as parenting supports.</p> <p>Prevent adversity and build resiliency, using avenues such as parent engagement and education campaigns, and engaging children and their communities in their own healing.</p>	<p>Families are supported and have the key services they need to remove sources of stress, strengthen core life skills, and foster positive relationships between children and caregivers.</p> <p>Communities are connected, with built environments and norms that promote social interaction among community members.</p> <p>Stakeholders are informed about the science behind brain development. These stakeholders include practitioners, policy makers, and the general public.</p>	<p>In 2020, access to treatment to address trauma and adversity services more than doubled (123%). This translates to a total of 12,292 children under 18 who received services.</p> <p>In 2020, the number of practitioners trained in trauma-informed care best practices more than doubled (143%). This is equivalent to 460 clinicians utilizing trauma-informed best practices.</p> <p>By 2020, St. David's Foundation increased Brain Story Certifications statewide by 30%.</p> <p>By 2020, St. David's Foundation increased the proportion of local school districts that have incorporated social-emotional learning (SEL).</p> <p>St. David's Foundation is on track to increase home visiting slots in Central Texas by 10%.</p>

Priority Area: Improve the health and well-being of women			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Ensure women and girls are supported with the resources, respect, and conditions vital for equitable health and wellbeing.	<p>Establish Central Texas as a women's health and perinatal safe zone. Lead and join a shared community commitment to protecting women's resources, respect, and conditions regardless of what happens in the broader environment.</p> <p>Center women of color (e.g., listen to them, step back while they drive the agenda, include them at key tables, enable them to tell their own stories, invest in their leadership).</p> <p>Fills gaps in the fragmented safety net women's health system and fund select innovations.</p>	<p>Women and girls of color experience birth equity (including but not limited to equitable outcomes in perinatal care, maternal morbidity and mortality, and newborn outcomes).</p> <p>Women's health safety net policies and programs are less fragmented, resulting in continuity of access between primary care, sexual and reproductive health care, and perinatal care.</p> <p>Women and girls can obtain low-barrier family planning and contraceptive care, including the most effective methods, in clinical and community settings.</p> <p>Communities are empowered to share their own narratives and stories.</p> <p>St David's Foundation women's health work aligns with other issues and movements relevant to the health of women and girls (e.g. improving conditions for caregivers, gender-based violence), expanding intersectional partners and community impact.</p>	<p>By 2020, access to family planning and contraceptive care increased more than doubled (115% and 5,311 people).</p> <p>In 2020, access to comprehensive sex education and pregnancy prevention programming for young adults increased by 29%.</p> <p>By 2020, St. David's Foundation increased the number of leaders attending SDF Women's Health convenings.</p> <p>As of 2020, St. David's Foundation is on track to increase the number of women of color included in key stakeholder convenings and the proportion of grant partner organizations led by women of color.</p> <p>As of 2020, St. David's Foundation is on track to complete the Perinatal Safe Zone engagement plan.</p>

Priority Area: Improve the health and well-being of older adults			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Increase support for older adults to live safely and independently in their own community.	<p>Directly fund services and support the health of organizations providing services to older adults.</p> <p>Build evidence for new models by piloting and evaluating innovative services in Central Texas and demonstrating the “double impact” of intergenerational approaches.</p> <p>Lead new payment models and public system improvement by advocating to MCOs and legislators on the cost-effectiveness of adopting evidence-based services, advocating for increased appropriations for Medicaid services for older adults, and engaging local organizations to advocate for supportive aging policies.</p> <p>Engage and activate community around aging issues.</p>	<p>Older adults remain safe and independent in their homes as they age.</p> <p>Older adults have a better end of life experience.</p> <p>Central Texas supports older adults and engages them as a vital part of the community.</p> <p>Central Texas has an adequate supply of accessible, high quality services for older adults.</p>	<p>By 2020, there was a 74% increase in access to services for older adults to assist them in aging in place. This is equivalent to 22,067 older adults receiving core services such as meals, transportation, and home repair.</p> <p>As of 2020, St. David’s foundation has made progress on the adoption of the CAPABLE model by Central Texas urban and rural counties.</p> <p>As of 2020, St. David’s Foundation added a new metric to increase awareness of the importance of end-of-life discussions and documenting plans.</p> <p>Additional work needs to be done to increase the number of caregivers receiving training and resources and increase access to programs that reduce social isolation.</p>

Priority Area: Improve the health and well-being of rural communities			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Build community capacity while co-creating and investing in long term place-based solutions.	<p>Engage and empower rural communities to strengthen networks and transform policies, practices, and alignment of resources to address prioritized social determinants of health.</p> <p>Build the capacity of people and places including formal and informal leaders within communities and organizations.</p> <p>Strategically invest in solutions that harness community assets to support innovation, ecosystem building, and other promising rural-relevant approaches that can be scaled.</p>	<p>Rural communities have a culture of health that transcends beyond health care access.</p> <p>Rural residents experience strong social connections and are engaged in thriving cross-sector, community-based networks that promote health and well-being.</p> <p>Rural systems undergo change that includes policy, practices, behaviors, and resources to promote health and well-being.</p> <p>Rural organizations have a strong infrastructure in place with adequate capacity.</p> <p>Rural residents are engaged and empowered by diverse civic leadership to activate and improve community well-being.</p>	<p>By 2020, St. David's Foundation established the Bastrop County resident advisory groups for two key issues and develop work plans.</p> <p>As of 2020, the development of a leadership training program co-designed with national and local capacity building organizations is on track.</p> <p>As of 2020, the number of proposals from rural communities across all portfolios has increased.</p> <p>As of 2020, progress has been made to increase philanthropic resources to Central Texas rural communities through the dissemination of network weaving assessments to local and national rural funders.</p> <p>As of 2020, progress has been made to increase capacity of a local nonprofit to serve as a backbone organization for community-led efforts.</p>

Priority Area: Health clinics to become community hubs for health			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Facilitate growth of infrastructure and capacity as clinics transition to serve as community hubs for health.	<p>Provide access to primary care and behavioral health services for the uninsured.</p> <p>Expand capacity of clinics to provide activities, processes, and strategies to improve the care delivery model.</p> <p>Encourage clinics to look outside of their four walls to develop and strengthen community linkages to improve community health and well-being.</p>	<p>The uninsured and underinsured have access to high quality care.</p> <p>Clinics are prepared to incorporate necessary changes to their care models to be able to succeed in new payment approaches that reward value over volume.</p> <p>Patients are satisfied with their experiences as they interact with the primary care health system.</p> <p>Clinics deliver comprehensive primary care and interact effectively outside the clinic to strengthen community linkages and ultimately improve the health and well-being of patients and the population overall.</p>	<p>By 2020, there was an 18% increase in uninsured patients receiving medical care.</p> <p>By 2020, there was a 76% increase in adults receiving dental care.</p> <p>By 2020, the number of patients receiving care coordination services more than tripled (375%).</p> <p>As of 2020, St. David's Foundation is on track to develop and implement a care coordination approach at partner clinics.</p> <p>As of 2020, progress has been made on the proportion of patients receiving care coordination, engagement activities, and medication management at partner sites.</p> <p>Additional work needs to be done to increase the number of partner clinics implementing social determinants of health screening of patients.</p>

Appendix A

	Measurement Period	Bastrop	Texas	U.S.
Demographics				
Total population	2020	97,216	29,145,505	331,449,281
Population by age				
Population 18 and under	2015-2019	25.4%	25.5%	22.3%
Population 19-64	2015-2019	59.0%	61.6%	61.2%
Population 65+	2015-2019	15.6%	12.9%	16.5%
Population by race and ethnicity				
AI/AN, NH	2020	0.3%	0.3%	0.7%
Asian, NH	2020	0.7%	5.4%	5.9%
Black, NH	2020	5.6%	11.8%	12.1%
Hispanic	2020	42.7%	39.3%	18.7%
White, NH	2020	47.1%	39.7%	57.8%
Population in poverty	2015-2019	11.2%	14.7%	13.4%
Households below poverty	2018	11.0%	14.0%	13.0%
ALICE households	2018	43.0%	30.0%	29.0%
Not proficient in English, population	2015-2019	12.0%	13.7%	8.4%
Disabled population	2015-2019	13.6%	11.5%	12.6%
Medicaid coverage	2015-2019	17.1%	16.8%	20.2%
Access to Care				
Uninsured	2019	22.7%	20.7%	9.2%
Uninsured adults	2019	26.2%	24.3%	12.9%
Uninsured children	2019	15.1%	12.7%	5.7%
Lack of prenatal care	2017	25.0%	40.0%	-
Dental visit in past 12 months	2018	51.2%	60.7%	67.6%
Preventable hospital stays	2018	4,211	4,793	4,236
Primary care physicians	2018	3,624	1,642	1,319
Dentists	2019	2,957	1,677	1,405
Mental health provider access	2020	1,740	827	383
Other primary care providers	2020	2,535	1,128	942
Health Behaviors				
Physical inactivity	2016-2018	27.3%	23.2%	22.7%

	Measurement Period	Bastrop	Texas	U.S.
Excessive drinking	2019	20.5%	19.0%	19.2%
Binge drinking	2019	18.4%	17.9%	16.8%
Health Outcomes				
Low birthweight	2013-2019	7.6%	8.4%	8.2%
Infant mortality per 1,000 live births	2013-2019	4.6	5.7	5.8
Child mortality per 100,000 under 18 years	2016-2019	46	50	49
Poor or fair health	2019	23.4%	24.3%	24.6%
Frequent physical distress	2019	13.7%	10.7%	12.6%
Adult obesity	2019	39.7%	35.8%	31.9%
Diabetes prevalence	2019	13.3%	12.2%	10.7%
High blood pressure awareness	2019	31.8%	31.7%	32.3%
New cancer cases	2019	432.9	409.5	449
Poor mental health days	2018	4.4	3.8	4.1
Frequent mental distress	2019	14.1%	12.2%	13.8%
Drug overdose deaths	2017-2019	9	11	21
Suicides	2015-2019	15.4	13.1	13.8
Depression	2019	19.8%	17.7%	19.2%
Suicidal thoughts ⁹	2016-2018	3.8%	3.6%	4.2%
Premature mortality per 100,000 under 75 yr	2017-2019	363	339	339
Premature death (YYPL under 75 years)	2017-2019	7,492	6,620	6,907
Life expectancy	2017-2019	78.3	79.2	79.2
Housing				
Homeownership	2015-2019	77.7%	62.0%	64.0%
Severe housing cost burden	2015-2019	11.1%	13.3%	14.4%
Severe housing problems	2013-2017	17.0%	17.0%	17.5%
Housing stability index	Sept/Oct 2021	97.0%	-	-
Housing and transportation affordability ¹⁰		47.0%	-	53.0%
Broadband access	2015-2019	49.2%	64.4%	68.9%
Black, NH	2015-2019	66.5%	80.0%	78.7%
Hispanic	2015-2019	84.1%	78.0%	82.6%
White, NH	2015-2019	85.8%	84.4%	87.2%
Infrastructure for Healthy Living				

⁹ County value is for Texas Public Health Region 7.

¹⁰ Measurement period not provided.

	Measurement Period	Bastrop	Texas	U.S.
Food environment index	2015 & 2018	7	6	8
Food insecurity	2019	12.1%	14.1%	10.9%
Limited access to healthy foods	2015	11.4%	8.7%	5.9%
Access to exercise opportunities	2010 & 2019	47.5%	80.5%	84.2%
Social vulnerability index	2018	0.7459	-	-
Community needs index	2021	3.6	-	-
Racism				
Dissimilarity index - Black / White	2015-2019	35	53	61
Dissimilarity index - Non-White / White	2015-2019	34	40	47
Socioeconomic				
High school completion	2015-2019	81.9%	83.7%	88.0%
American Indians and Alaska Natives	2015-2019	79.6%	80.3%	80.3%
Asians	2015-2019	86.9%	88.2%	87.1%
Blacks / African Americans	2015-2019	82.4%	89.8%	86.0%
Hispanics	2015-2019	59.1%	66.4%	68.7%
Non-Hispanic Whites	2015-2019	92.8%	93.9%	92.9%
College graduation	2015-2019	20.6%	29.9%	32.2%
American Indians and Alaska Natives	2015-2019	16.9% ¹¹	21.2%	15.0%
Asians	2015-2019	62.3%	59.1%	54.3%
Blacks / African Americans	2015-2019	13.9% ¹²	24.6%	21.6%
Hispanics	2015-2019	9.7%	15.0%	16.4%
Non-Hispanic Whites	2015-2019	26.4%	38.7%	35.8%
Unemployment	Oct 2021	3.8%	4.8%	4.6%
Income inequality	2015-2019	4.5	4.8	4.9
Median HH income	2020	\$ 74,612	\$ 66,048	\$ 67,340
Transportation				
No car access	2015-2019	4.5%	5.30%	8.6%
Transportation affordability ¹³		25.0%	-	27.0%

¹¹ Value has large standard error and confidence interval. Interpret with caution.

¹² Value has large standard error and confidence interval. Interpret with caution.

¹³ Measurement period not provided.

Appendix B

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

Table 1: Description of Key Informants	
Key Informant	Community Input Sector
Patricia Alford <i>Project Coordinator for Accountable Communities Health Initiative</i> Bastrop County Cares	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Edie Clark <i>Leader</i> Central Texas Interfaith	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Rafael De La Paz <i>Chief Executive Officer</i> Community Health Centers of South Central Texas	<ul style="list-style-type: none"> • Person with special knowledge or expertise in public health • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
Kelly Franke <i>Executive Director</i> Combined Community Action, Inc.	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
Beth Rolingson <i>Executive Director</i> Advocacy Outreach	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility

Key Informant	Community Input Sector
Jill Strube <i>Director of Economic Development and Grants Administration</i> City of Smithville	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Monique Vasquez <i>Organizer</i> Central Texas Interfaith	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility

The following table describes the focus group participants in aggregate:

Table 2: Description of Focus Group Participants				
Focus Group	Community Input Sector	Description	Number	Language
1	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female and male residents of ZIP codes 78602, 78621, and 78612 with ages ranging from 50-65+. Participants self-identified as Black/African American, White, and Not Hispanic/Latinx or Hispanic/Latinx.	5	English
2	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents of ZIP codes 78602 and 78621 with ages ranging from 18-65+. All participants self-identified as Black/African American.	5	English
3	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female and male residents of ZIP codes 78602 and 78957 with ages ranging from 30-65. Participants self-identified as Hispanic/Latinx and Mexican, Mexican American or Chicano.	6	Spanish
Photovoice (Youth)	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included three female residents and one male, all of whom live in ZIP code 78602. Participants were between 15 and 16 years old. All participants self-identified as Mexican, Mexican American, or Chicano.	4	English

CALDWELL COUNTY, TEXAS

2021-2022 Community Health Needs Assessment

About Texas Health Institute

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

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Rachelle Johnsson Chiang	Texas Health Institute
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Kimberly J. Wilson	Texas Health Institute

The 2021-22 Caldwell County Community Health Needs Assessment (CHNA) represents the commitment of many partners who have contributed their expertise, resources, and time in support of a shared mission—to make Central Texas the healthiest community for all its residents.

The data collection methodology was co-created through a partnership of health system partners to provide a comprehensive assessment of conditions and opportunities that exist to improve health in Caldwell County, Texas. We recognize all of our CHNA partners including St. David's Foundation, Georgetown Health Foundation, and Ascension Seton.

Most importantly, we recognize the many community organizations, agencies, churches, leaders, and community members who assisted with outreach and engagement and shared their time and experience. Texas Health Institute acknowledges the following organizations' contributions to this report:

Community Input Partners

4:12 Kids

District One Pride Association

Golden Age Home – Lockhart

Luling City Council

Lockhart Independent School District

St. John's Lutheran Church in Uhland

Texas Department of State Health Services - Luling

Wesley Nurse program at First United Methodist Church of Luling

Where We Thrive

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Executive Summary

PURPOSE AND METHODS

As part of a collaboration of local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The current CHNA is the third one St. David's HealthCare has conducted for Caldwell County. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act.

CHNAs provide deeper understanding of community health needs—particularly those faced by historically-underserved community members—and are used to inform health care system triennial planning efforts. This report provides an overview of the process and methods used to identify social determinants of health and health needs in Caldwell County, community assets, and a summary of community member recommendations to address the identified needs.

THI carried out this CHNA between August and December 2021 during an unprecedented time due to COVID-19 and the movement for racial justice. To explore critical health issues, structural factors and underlying causes, THI used a mix of quantitative and qualitative methods including the analysis of publicly available data sets, key informant interviews and focus groups with underserved community members

FINDINGS

Key themes emerged both from community input and a review of quantitative data. In addition, several sub-themes emerged in the review of data that were not raised by participants.

GROWTH

In recent years, Caldwell County has experienced population growth and changes in demographic characteristics. The growth in Caldwell and surrounding areas has affected the affordability of the county, including housing costs, which affects health care access and outcomes.

The demographic characteristics of Caldwell County have changed over the last decade.

- Caldwell County grew 12.6% between 2010 and 2019.
- The Lockhart area is the most populous area of Caldwell County.

- The Hispanic/Latinx population is the largest racial or ethnic group of Caldwell County. This group population experienced the most growth of all racial and ethnic groups between 2010 and 2020, going from 47.1% to 55.5% of the population.
- In Caldwell County, 11.1% of people were born in a country other than the U.S. and approximately 8% of people in Caldwell County are not U.S. citizens.
- About 35% of households primarily speak Spanish at home and 12% of people over 5-years old have limited English proficiency.

POVERTY

Caldwell County has areas of concentrated poverty and households who live above the federal poverty line but earn less than the basic costs of living for the county.

- At \$66,128, Caldwell County has a lower household income than both Texas (\$66,048) and the U.S. (\$67,340).
- In 2019, Black/African American and Hispanic/Latinx households in Caldwell County had the lowest median income.
- 15% of people in Caldwell County lived below the federal poverty level (2015-2019). Black/African Americans and Hispanic/Latinx populations are most likely to live below the poverty level (40.1% of Black/African and 22.0% of Hispanic/Latinx individuals).
- An additional 39% of households are ALICE, meaning asset limited and income constrained, even though residents are employed.¹
- The Luling and Maxwell ZIP code tabulation areas (ZCTAs) have the highest proportion of people living in poverty.

HOUSING

Affordable housing is a key concern in Caldwell County, which affects people's ability to be healthy and engage in health care.

Focus group participants and key informants noted that housing has become increasingly unaffordable in the county, largely due to the surge in the nearby Austin housing market. With more people moving into Caldwell County, costs of living and property prices have become unaffordable to long-time residents, especially Black/African American and Hispanic/Latinx community members.

- 14% of households spend more than 50% of their household income on housing expenses.

¹ ALICE: an acronym for Asset Limited, Income Constrained, Employed. ALICE typically describes those who live above the poverty line but earn less than the basic cost of living for their area. For more information on the ALICE methodology and data, visit unitedforalice.org.

- The average home price in Caldwell County increased 7.1% in 2020 and 29.3% in 2021.
- More households are experiencing housing instability and may be at risk for eviction or foreclosure, compared to January 2020.

COMMUNITY ASSETS

Caldwell County has many community assets and strengths, including a history of resiliency and individuals who see the needs of the area and genuinely desire to help.

HEALTH CARE ORGANIZATIONS

Caldwell County is home to three Ascension Seton health care sites, including two in Lockhart and one in Luling. In Lockhart, the Ascension Seton Health Center on Church Street provides primary care and diagnostic services and the Ascension Seton Lockhart Health Center on Colorado Street provides routine care. The Edgar B. Davis Hospital in Luling is a general acute facility with a 24/7 emergency room. In addition, the county is also home to one FQHC and three National Health Service Corps (NHSC) sites.

CHURCHES AND FAITH-BASED ORGANIZATIONS

Another notable strength of Caldwell County is the network of churches from many denominations that often work together to meet community needs, including by distributing food and clothing and conducting home visits to struggling or isolated community members. The following churches and faith-based organizations were mentioned as valuable resources for the community: Caldwell County Christian Ministries and Caldwell County Foodbank, Lamb and Sheep Ministries, First United Methodist Church of Luling (Wesley Nurse program), St. Vincent DePaul ministry at St. Mary's Catholic Church, and St. John the Evangelist Catholic Church of Luling.

NONPROFITS AND COMMUNITY ORGANIZATIONS

Caldwell County is home to multiple nonprofit and community organizations that play a vital role in building healthy communities by providing educational, health, and social services to community members. Focus group participants identified various local organizations and agencies that have been instrumental in providing resources to address general needs as well as needs that have arisen during the pandemic. Lockhart Independent School District, Lockhart Learning Center, Meals on Wheels, and the Texas Workforce Commission are some of the nonprofits and community organizations mentioned by participants.

PARKS

Caldwell County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. In Luling, 62% of people live within a ten-minute walk of a park and in Lockhart, 27% of people live within this radius. Although, this data suggests there is broad access to natural spaces, it is important to note that focus group participants described a desired for more air-conditioned indoor spaces, like gyms or a recreational center that could provide exercise classes, sport events, or cooking classes.

PRIORITY HEALTH ISSUES

Several priority health issues were identified by focus group participants and key informants, including diabetes, hypertension, obesity, mental illness and substance use, and oral health. Additionally, low birth weight and premature death emerged within quantitative data as priority health concerns.

DIABETES, HYPERTENSION, AND OBESITY

Diabetes was the most commonly mentioned health condition in focus groups and interviews. Caldwell County has a higher prevalence of adults aged 20 and above who report having diagnosed diabetes (13%), compared to Texas (10%). Diabetes disproportionately affects the Luling area of Caldwell County. According to qualitative findings, diabetes drives a lot of emergency department visits and hospitalizations in Caldwell County. Additionally, participants noted seeing diabetes and prediabetes across generations, with younger age groups showing early risk factors.

Approximately 34.6% of adults in Caldwell County have ever been told they have high blood pressure. This percentage is higher in the Luling ZCTA (37.7%) compared to the Lockhart ZCTA (33.8%). As with diabetes, focus group participants and key informants noted a high prevalence of hypertension is often due to barriers such as a lack of affordable preventative health care and food insecurity.

Caldwell County has a higher prevalence of obesity (38.1%), compared to both Texas (31.4%) and the U.S. (29.7%). The Martindale, Maxwell, and Dale ZCTAs have the highest prevalence of obesity within Caldwell County. Key informants and focus group participants noted seeing obesity across age groups.

MENTAL HEALTH AND SUBSTANCE USE

Data from 2018 indicates that people in Caldwell County experience more poor mental health days (4.4.) compared to both Texas (3.8 days) and the U.S. (4.1 days). In 2018 nearly 15% of adults in Caldwell County reported experiencing frequent mental distress.

Focus group participants and key informants suggested that the prevalence of mental illnesses seems to be “worse than ever,” largely due to increased loneliness, desperation, trauma, and lack of support throughout the pandemic. Participants also described that there is a lack of affordable, culturally appropriate mental health care providers, especially for Black/African American and Hispanic/Latinx populations. Regarding substance use, focus group participants mentioned seeing issues with prescription drugs and alcoholism most commonly.

ORAL HEALTH CARE

Focus group participants and key informants described the lack of sufficient dental providers in their community, particularly dentists with low-cost services. Costs for even routine dental cleanings are considered inaccessible for people without dental insurance or using self-pay. Additionally, participants noted that the free mobile dental clinic in Luling (no specific name given) is helpful, although its services have been reduced and canceled during the pandemic. These barriers to oral health care in Caldwell County result in frequent emergency room visits related to dental issues and other chronic health conditions.

LOW BIRTH WEIGHT AND PREMATURE DEATH

In Caldwell County, 8.6% of babies are born with low birth weight, which is similar to Texas (8.4%) and the U.S. (8.2%). Black/African American community members, however, have a low birth weight rate of 17.8%, which is more than twice as high as Hispanic/Latinx (8.1%) or white (8.4%) populations in the county.

Caldwell County has a higher number of premature deaths (8,256 years of life lost), compared to both Texas and the U.S. Black/African American populations in Caldwell County are most likely to experience premature death (11,400 years of life lost before age 75).

The COVID-19 pandemic has made many of these health conditions worse and has also intensified other challenges faced by community members in Caldwell County.

FOOD INSECURITY

Nearly 15% of people in Caldwell County experience food insecurity, and 13.7% of the eligible population uses Supplemental Nutritional Assistance Program (SNAP) for financial assistance in purchasing food. Projections indicate an increase in food security to nearly 17% by the end of 2021.

Focus group participants and key informants noted that the pandemic has limited free food services, such as Meals on Wheels or school-based lunch programs, increasing the prevalence of food insecurity. Additionally, participants reported that the cost of food has become especially burdensome and organic food options are the most cost-prohibitive. Many community members find that gas stations or dollar stores are more accessible financially, or transportation-wise, compared to grocery stores like Wal-Mart or H-E-B.

UNEMPLOYMENT

As with most of the state and nation, the rate of unemployment in Caldwell County peaked in April 2020 due to the COVID-19 pandemic. At this highest point, the unemployment rate in the county was 10.4%. As of October 2021, the unemployment rate was 4.0%.

Focus group participants and key informants described that many community members have lost their jobs or had reduced hours during the pandemic. This has created financial vulnerabilities and impacted mental health for many community members.

BARRIERS TO ACCESS

Several barriers—including cost of care, insurance coverage, provider availability, cultural barriers, and lack of transportation—inhibit people’s ability to access health care to treat or prevent these health conditions. Multiple indicators demonstrate that a significant portion of county residents experience barriers to care, supported by input from focus group participants and key informants.

Health care is unaffordable to many due to insurance coverage and costs of care. Almost 19% of adults in Caldwell County have not sought care due to costs. Additionally, 28.2% of adults reported having no usual source of health care. Nearly 22% of the population under 65 years old is uninsured. Over one-quarter (25.6%) of adults (ages 19-64) in the county are uninsured and 11.8% of children (ages 0-19). Focus group participants and key informants mentioned that many community members will forgo health care, including preventative screenings or tests, due to costs.

Provider availability is a key barrier to care, especially for historically underserved communities. Additionally, participants mentioned that there are too few providers who accept Medicaid or have other reduced-cost programs for people who use self-pay or are uninsured. Participants indicated that health care costs are most unaffordable for Hispanic/Latinx and Black/African American community members.

- Caldwell County is designated as both a Primary Care Health Professional Shortage Area (HPSA) and a Mental Health HPSA. This indicates that there are an insufficient number of primary care providers and mental health providers in the county.

- Qualitative findings suggested that Caldwell County lacks specialists, such as OB-GYNs, in addition to primary care providers. Focus group participants and key informants also noted that there is an insufficient number of Spanish-speaking providers or providers who will provide translation services.

Additionally, qualitative findings indicate a need for providers and services that are more accommodating and informed in serving racial and ethnic minorities, especially Black/African American and Hispanic/Latinx populations.

Lack of public transportation significantly limits people's access to health care and other services that affect their ability to be healthy.

- Caldwell County has no public transit infrastructure. This greatly inhibits people's ability to get to grocery stores, jobs, social engagements, and health care appointments. Focus group participants mentioned that costs are the main inhibitor for personal transportation.
- On average, of 24% of household income in Caldwell County is spent on transportation costs. The Luling and Lockhart ZCTAs have the highest rate of households without access to personal transportation (5.9% and 5.6%, respectively).

RECOMMENDATIONS

Community members interviewed provided a number of recommendations about actions the health care system could take to address health-related needs:

IMPROVE ACCESS TO CARE

To address barriers within the health care system that inhibit the ability to receive affordable, culturally appropriate care that includes urgent and specialty care:

Mobile clinics in rural areas: Offer mobile clinics to better reach rural communities and eliminate transportation barriers.

Urgent care: Establish an urgent care to offer after-hours and weekend emergent care.

Mental health: Improve and expand access to mental health services.

ADDRESS BARRIERS TO OVERALL HEALTH

Environmental, social, and structural barriers to health in Caldwell County include insufficient public transportation, food insecurity, lack of safe green spaces, and unaffordable housing.

These barriers inhibit the ability to participate in health care services and to live healthy lifestyles. To address barriers to overall health:

Recreation space: Establish a recreation center that offers free or low-cost classes, work out equipment, and meeting spaces for community activities and physical fitness.

Food: Expand access to affordable and healthy food.

Public spaces: Clean up community parks to make them safer and more accessible across the county.

Public transportation: Improve public transportation services, including through hospital-sponsored buses or vans to connect communities and clinics.

STRENGTHEN COMMUNITY TRUST

Racism and discrimination against immigrant communities pervades both health care and the community in general. This impacts health care access and outcomes, especially among Black/African American and Hispanic/Latinx community members. To strengthen community trust between the health care system and historically marginalized populations:

Partnerships: Engage grassroot organizations who are trusted by the community.

Engagement: Involve local council members to engage historically excluded communities.

Culturally competent workforce: Expand cultural sensitivity training for all providers and hospital staff.

Introduction

St. David's Foundation, on behalf of St. David's HealthCare, is pleased to present the 2021-22 Community Health Needs Assessment (CHNA) for Caldwell County, TX.

The Patient Protection and Affordable Care Act of 2010 requires all nonprofit health care systems to complete a CHNA every three years. CHNAs provide deeper understanding of community health needs, in particular those faced by historically-underserved community members, and are used to inform health care system triennial planning efforts. The purpose of this CHNA is to offer a comprehensive understanding of the health and social determinant of health needs in the St. David's HealthCare facilities serving Caldwell County residents, and guide the hospitals' planning efforts to address those needs. St. David's HealthCare has multiple facilities that serve Caldwell County residents, including St. David's Medical Center and St. David's South Austin Medical Center.

This CHNA report provides an overview of the process and methods used to identify priority health and social determinants of health needs of residents in Caldwell County, along with community assets and recommendations from community members to address the identified needs. The report focuses special attention on the needs of underserved populations, unmet health or social determinants of health needs and gaps in services, and input from community members and leaders. This assessment recognizes that the social and economic determinants that are the primary drivers of health, as the relative contribution of medical care to health and well-being is only 10-20%, and emphasizes the living conditions are upstream of and surround personal behaviors, disease, and death.

Texas Health Institute (THI) carried out this CHNA between August and December 2021. THI used a mix of quantitative and qualitative methods to identify community health needs, including the analysis of publicly available data sets (Appendix A), key informant interviews, and focus groups (Appendix B) with underserved community members. Content gathered through community focus groups and interview participants is integrated into each report section to which it relates. The quotes reflect the opinion of one or more community members. Findings from this report will be used to identify and develop efforts to improve the health and wellbeing of residents in the community.

METHODS

The 2021-2022 CHNA uses both primary and secondary data to identify the community's priority health needs and strengths through a social determinants of health framework. Health is not only affected by people's genes and lifestyles but by upstream factors such as employment status, housing quality, and policies. In addition, the influences of race, ethnicity, income, and

geography on health patterns are often intertwined. As a result, data was analyzed using an equity lens when possible.

Primary data include qualitative data collected for the purposes of the CHNA. These data were collected directly from the community through focus groups, key informant interviews, and Photovoice interviews. Secondary data include quantitative data collected through publicly available federal and state agencies databases. Federal and state agencies collected these data through surveys or electronic health records.

PRIMARY DATA COLLECTION AND ANALYSIS

Between August and October 2021, THI virtually conducted five key informant interviews and three community focus groups with Caldwell County residents. In addition, THI virtually conducted one Photovoice project and associated focus group. The goal of this work was to learn about local priority health needs and assets and how they think community health and well-being can be improved.

Focus group participants self-identified as people who are medically underserved, low income, members of minority populations, or living with chronic disease needs. Adult focus group participants were between 30-65 years old, while Photovoice participants were between ages 14-18 years old.

Key informants (Appendix B) included representatives from health care organizations, community-based organizations, and the local government. THI key informants based on their leadership roles and experience working with medically underserved, low-income, or minority communities served by the hospital system.

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

SECONDARY DATA SOURCES AND ANALYSIS

All quantitative data used for this report is secondary data² and includes data on approximately 35 indicators, many broken down by geography or demographic characteristics when available. Indicator sources are cited for figures, tables, and graphs in this CHNA. Publicly available data sources used:

² Data that have already been collected for another purpose.

- American Community Survey
- Argonne National Laboratory: Housing Stability Index
- Austin Board of REALTORS®
- Behavioral Risk Factor Surveillance System
- Centers for Medicare and Medicaid: National Provider Identifier Standard
- Center for Neighborhood Technology: Housing, + Transportation Affordability Index
- Dignity Health and IBM Watson Health: Community Needs Index
- Feeding America: Map the Meal Gap Study
- Health Resources and Services Administration
- Centers for Disease Control and Prevention (CDC)
- Household Pulse Survey – COVID-19
- National Center for Health Statistics
- Social Vulnerability Index
- U.S. Diabetes Surveillance System
- Substance Abuse and Mental Health Services Administration: National Survey on Drug Use and Health
- United for ALICE
- U.S. Bureau of Labor Statistics
- U.S. Department of Agriculture: Food Access Research Atlas
- U.S. Census Bureau
 - Small Area Income and Poverty Estimates (SAIPE) Program
 - Small Area Health Insurance Estimates (SAHIE) Program

The original sources collected data through surveys or electronic health record systems, and results are often a snapshot in time. The data are self-reported unless otherwise indicated. Each indicator used the most recent data point available for each data source. Multiple years of data were used to calculate the estimates with a larger sample size and more precision. The estimates were calculated by the original data source for all secondary data.

THI selected quantitative data for inclusion in this report based on the availability of confidence intervals at the state and national levels, which allowed THI staff to determine statistical significance (e.g., whether the county-level value was better or worse than the state or national value). For some variables, such as “Adult Obesity,” the confidence intervals were not available at the state or national levels. Consequently, statistical significance could not be calculated. If, however, the county-level value was notably higher than the state and national average, the value was included in this report.

Confidence intervals are included in graphs when data for an indicator has a small population sample. The smaller the population sample, the less certainty about the actual number for the total population, resulting in overlapping confidence intervals. It can be hard to determine any significant change when confidence intervals overlap between categories, such as race and ethnic groups. Some indicators are broken down by geography based on ZCTAs, as ZIP code is a common variable across many local and state datasets. A reference map is included in the demographics section. The data analysis typically consisted of calculating proportions and rates, with a 95% confidence interval where appropriate.

SENSEMAKING SESSIONS

THI facilitated a series of three sensemaking sessions with SDF in January and February 2022. These sessions were iterative and included SDF staff and board members and at least one community leader from Bastrop, Caldwell, and Hays Counties. The sensemaking process provided a structured opportunity for SDF staff, board, and community leaders to begin to sort and make sense of a large amount of information included in the CHNA and to develop a shared understanding of possible needs and actions. It also provided an opportunity for feedback prior to finalization of the 2021-22 final report.

DATA CONSIDERATIONS AND LIMITATIONS

As with all data collection, there are several limitations that should be acknowledged. Different data sources use different ways of measuring similar variables. There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific groups or at the granular geographic level due to the small sample size.

Crucially, most quantitative data used were collected prior to 2020 and the COVID-19 pandemic, whereas qualitative data were collected in fall 2021. This asynchronicity should be considered when applying the findings of this report, as some quantitative values may have changed between the most recently available year and fall 2021.

Additionally, qualitative data collection occurred through virtual key informant interviews and focus groups for the safety of staff and participants. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. THI staff did extensive outreach to various leaders of community-based organizations in Caldwell County and potential participants; organizational leaders and residents alike frequently declined participation for a variety of reasons, including research fatigue and fear of exploitation.

In addition, internet access or access to a device that would allow for zoom inhibited some potential focus group participants. Furthermore, in some instances interviews were cancelled due to COVID-19 exposure or infection.

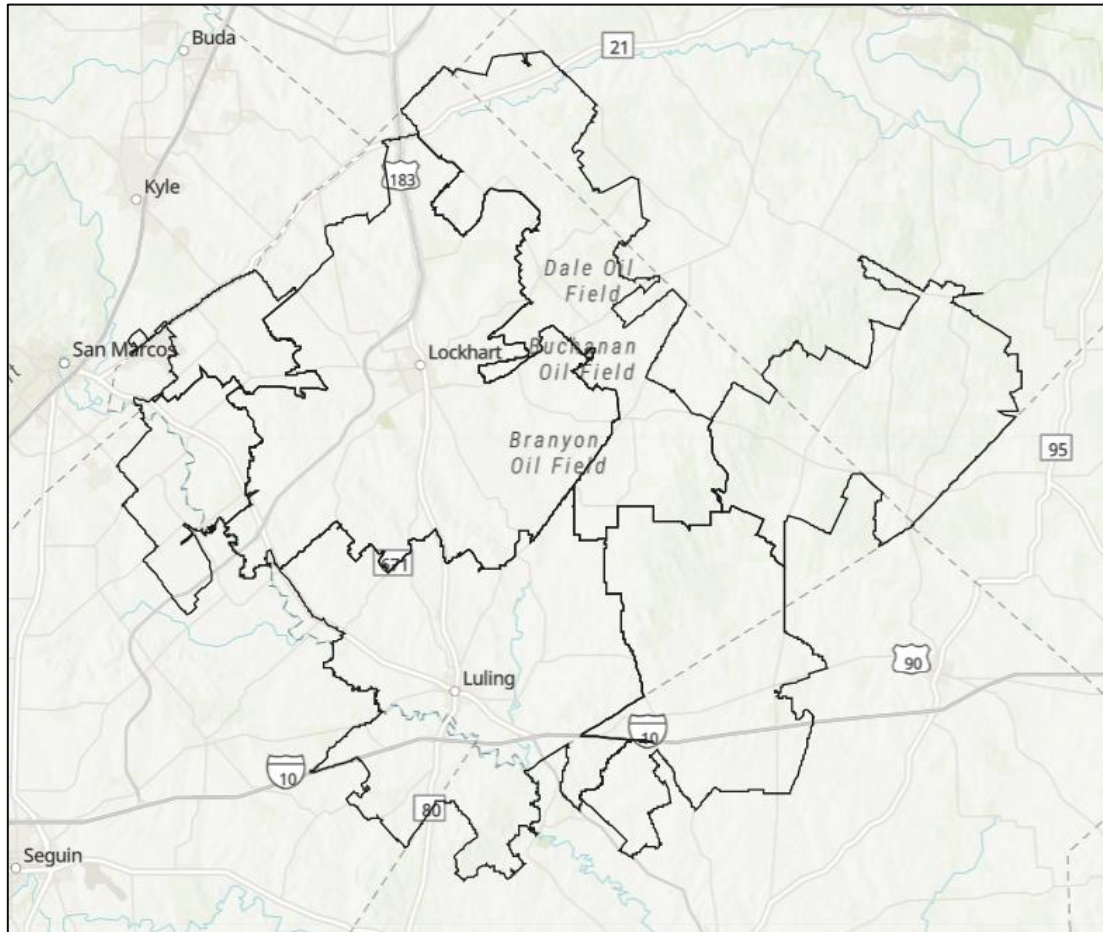
LANDSCAPE AND CONTEXT

Caldwell County is located at the southern tip of Travis County and shares borders with Hays, Bastrop, Gonzales, and Guadalupe counties. There are three county subdivisions: Lockhart (north), Martindale (west), and Luling (southeast). Lockhart is the county seat. Seven ZCTAs are primarily located within Caldwell County's boundaries: 78616 (Dale), 78632 (Harwood), 78644 (Lockhart), 78648 (Luling), 78653 (Rosanky), and 78756 (Maxwell).

Figure 1 shows the boundaries of these seven ZCTAs. These ZCTAs are the basis of sub-county analysis throughout this report.

Figure 1

Caldwell County ZIP Code Tabulation Areas



Source. U.S. Census Bureau, 2021. Map built with ArcGIS.com.

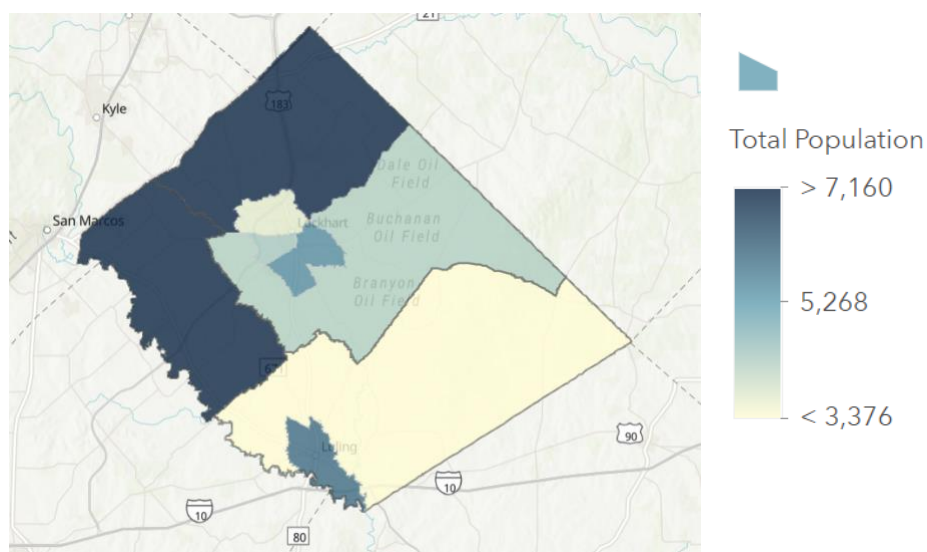
Demographics

Demographics of the community significantly affect its health profile as different race/ethnicity, age, and socioeconomic groups have unique needs and require different approaches to health improvement efforts. All demographic estimates are sourced from U.S. Census Bureau American Community Surveys unless otherwise indicated.

POPULATION

In 2020, 45,883 people called Caldwell County home, an increase of 7,817 people from 2010. Figure 2 displays the total population density by Census tract of households in Caldwell County. The larger dots indicate a greater number of people in that tract area. The Lockhart county subdivision has the greatest number of people in the county.

Figure 2
Population Concentration by Census Tract



Source. American Community Survey, 2019. Map built with ArcGIS.com.

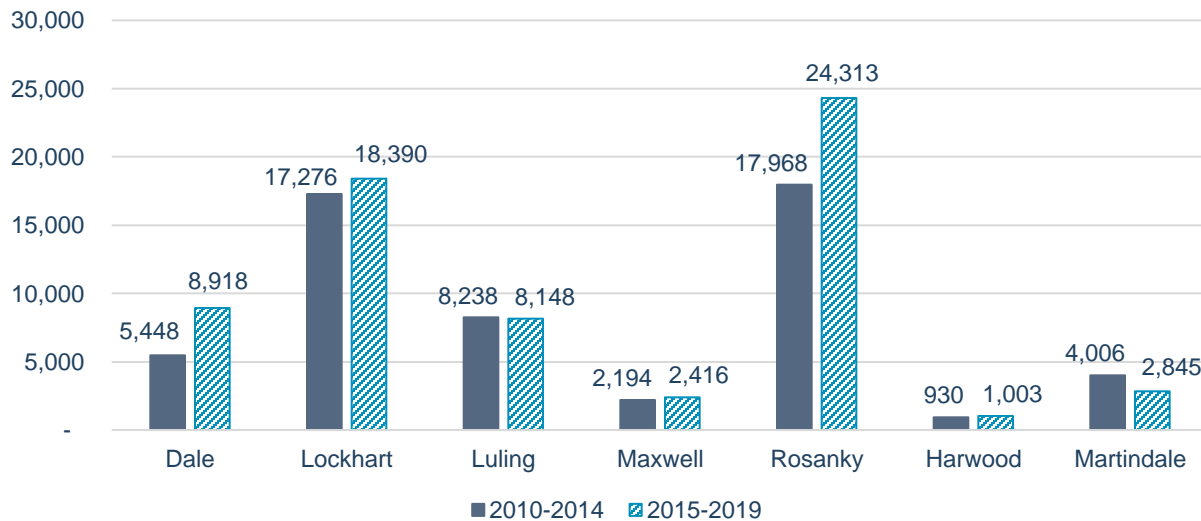
Between 2010 and 2019, Caldwell County experienced a 12.6% rate of growth in population size. This growth rate is nearly twice as high as the national average (6.8%) for the same time period, although lower than Texas (16.2%).

The Rosanky ZCTA has a population of 24,313, although the majority of this ZCTA is located in Bastrop County. The Lockhart ZCTA is the most populous ZCTA that is fully within Caldwell County, with 18,390 people as of 2019. The next two largest ZCTAs are Dale (8,918 people)

and Luling (8,148 people). The Dale ZCTA has experienced the highest rate of growth (63.7%) between 2010-2014 and 2015-2019. The Rosanky ZCTA grew by 35.3% and the Maxwell ZCTA by 10.1%. Between 2010-2014 and 201-2019, two ZCTAs experienced a decline in population size: including Martindale (-29.0%) and Luling (-1.1%).

Figure 3

Population by ZCTA, 2010-2014 and 2015-2019



Source. U.S. Census Bureau, American Community Survey, 2010-2014 and 2015-2019.

This data is consistent with qualitative findings from focus groups and key informant interviews. Participants noted the population growth in Caldwell County due to the surge in the nearby Austin housing market. As that housing market grows, there have been more people moving into the county and purchasing properties at rates that make the property values and general costs of living unaffordable to long-time residents, especially Black/African American and Hispanic/Latinx community members.

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

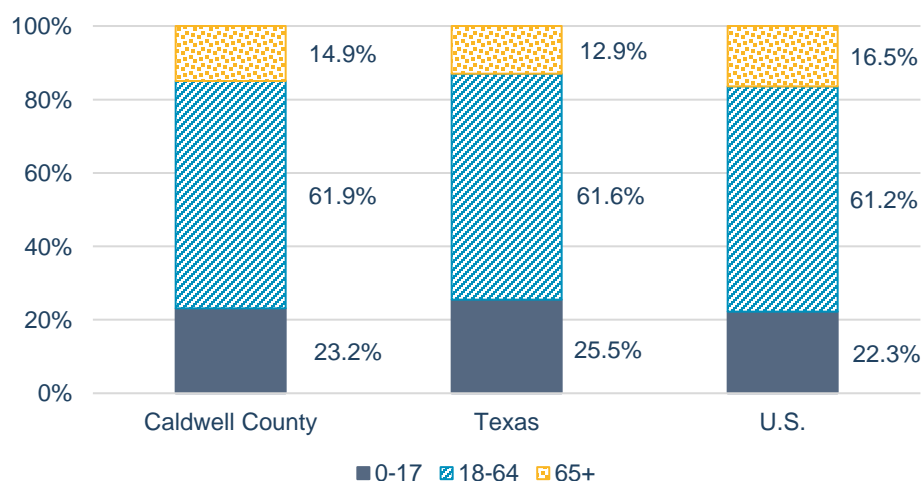
-Key Informant

AGE

As shown in Figure 4, 23.2% of Caldwell County is under 18-years old, which is slightly higher than the United States (U.S.) (22.3%) and lower than Texas (25.5%). Additionally, 14.9% of Caldwell County is over 65-years old, which is smaller than the U.S. (16.5%) and slightly greater than Texas (12.9%).

Figure 4

Age Distributions: Caldwell County, Texas, and U.S.



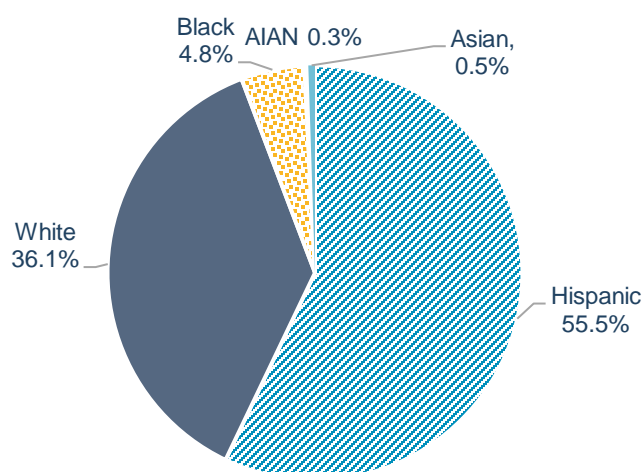
Source. U.S. Census Bureau Population Estimates Program, 2020.

RACE AND ETHNICITY

Figure 5 displays the racial and ethnic composition of Caldwell County, with 55.5% of people identifying as Hispanic/Latinx; 36.1% of people identifying as White/Non-Hispanic; 4.8% of people identifying as Black/African American; % of people identifying as Asian; and 0.3 % of people identifying as American Indian/Alaska Native (AIAN).

In 2010, people who identified as Hispanic/Latinx represented 47.2% of the total population in Caldwell County, while in 2020 this group represented 55.5% of the county's population. Conversely, the White/Non-Hispanic population of Caldwell County was 44.2% in 2010 and 36.1% in 2020. The American Indian and Alaska Native (AI/AN) population experienced the largest percentage of growth (43.3%; 90 to 129 people), followed by the Hispanic/Latinx population (42.1%; 17,922 to 25,468 people).

Figure 5
Race and Ethnicity of Caldwell County Residents



Source. U.S. Census Bureau 2020 Decennial Census Population Estimates.

Table 1
The Hispanic/Latinx Population Experienced the Most Growth in Caldwell County During 2010-2020

Race or Ethnicity	2010	2020	
American Indian / Alaska Native	0.2%	0.3%	↑
Asian	0.9%	0.5%	↑
Black	6.5%	4.8%	↓
Hispanic	47.1%	55.5%	↑
White	44.2%	36.1%	↓

Source. U.S. Census Bureau 2010 and 2020 Decennial Census Population Estimates.

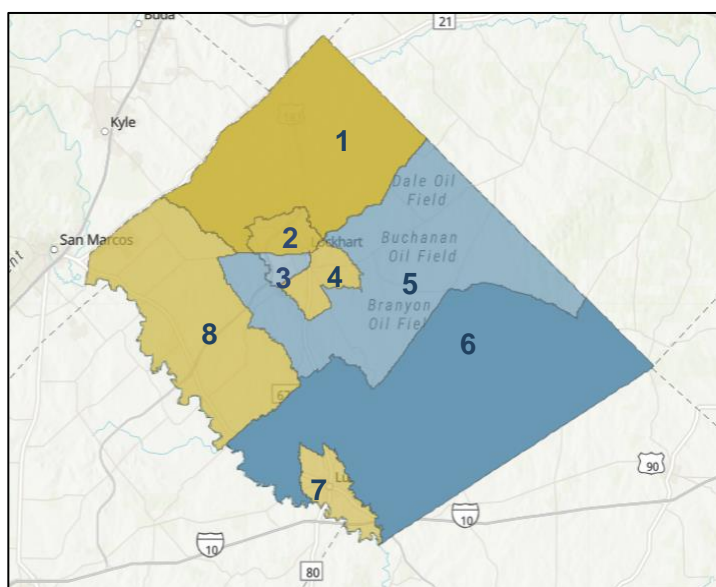
IMMIGRATION, PRIMARY LANGUAGE, AND LIMITED ENGLISH PROFICIENCY

In Caldwell County, 11.2% of people were born in a country other than the U.S. Of these, 70.4% are not a U.S. citizen. This indicates that 7.9% of people in Caldwell County are not U.S. citizens. This map displays Caldwell County by Census tract. The colors indicate the racial or ethnic group of people with the highest proportion of the population within the given tract.

For example, in the northern area of the county, Hispanic/Latinx people make up the largest proportion of the population. Only the two racial and ethnic groups with the highest proportion of the population are displayed.

Figure 6

Hispanic/Latinx Population is the Predominant Racial/Ethnic Population in Half of Caldwell County Census Tracts



Census Tract	% Hispanic/Latinx	% White
1	68.7%	28.0%
2	63.4%	27.9%
3	43.8%	45.6%
4	54.3%	34.0%
5	40.0%	52.1%
6	18.0%	79.4%
7	48.7%	41.4%
8	53.7%	36.8%

Source. American Community Survey, 2015-2019. Map built with ArcGIS.com View online: <https://arcg.is/1uSXDuo0>.

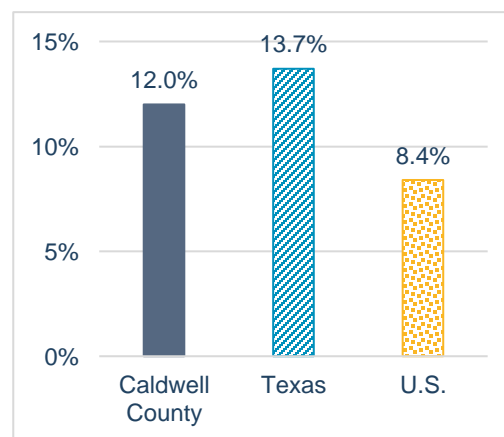
English is the most common language spoken at home (64% of households), followed by Spanish (35.2%). Additionally, 12.0% of people in the county over 5-years old reported having limited English proficiency. This is slightly less than Texas (13.7%), but higher than the U.S. (8.4%) (see Figure 7).

These findings augment the qualitative findings, which indicated that many Spanish-speaking community members in Caldwell County face language barriers. Focus group participants reported needing more

Spanish-speaking providers, or providers with accommodating translation services. Additionally, participants mentioned that health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply.

Figure 7

Residents 5-Years and Older who are Limited English Speaking: Caldwell County, Texas and U.S.



Source. American Community Survey, 2015-2019.

Social Determinants of Health

The communities in Caldwell County are impacted by many social determinants of health. Social determinants of health are the conditions in which people are born, grow, work, live, and age, as well as the wider set of systems and structures that shape daily life

SOCIAL VULNERABILITY AND COMMUNITY NEEDS INDICES

The Center for Disease Control developed the **Social Vulnerability Index (SVI)** to measure the potential negative effect on communities caused by external stresses, such as disease outbreaks or human-caused disasters. A number of factors, such as poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss during a disaster. These factors are known as measures of social vulnerability.

CDC uses 15 U.S. census variables to help local leaders identify communities that may need support before, during, and after a natural or human-caused disaster or disease outbreak. These 15 variables are grouped into four separate vulnerability indices across: (a) housing and transportation measures, (b) minority status and language measures, (c) household composition measures, and (d) socioeconomic measures. The four indices are also combined to create an overall index. The index ranges from 0 to 1, with 0 indicating the lowest vulnerability and 1 the highest vulnerability.

Caldwell County's **SVI score of 0.8732** indicates a high level of vulnerability. The indices with the highest level of vulnerability in the county are the socioeconomic measures (0.9631) and household composition measures (0.9583). There is variability within the county, with scores ranging from high vulnerability in the Luling, Maxwell, and northern Lockhart areas, to low-to-moderate vulnerability in southwest Lockhart and the eastern edge of the county (Figure 8).

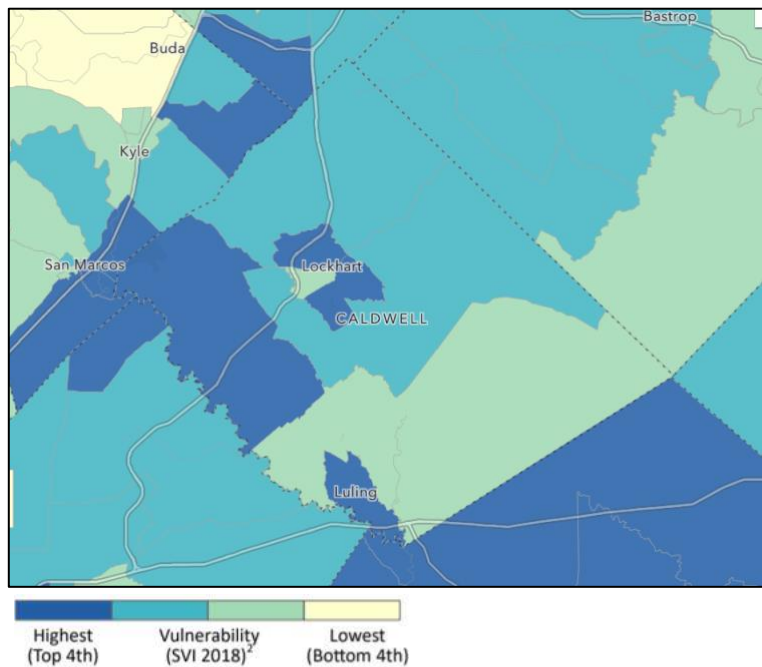


Social Determinants of Health

Source. Centers for Disease Control and Prevention.

Figure 8

Social Vulnerability Index in Caldwell County

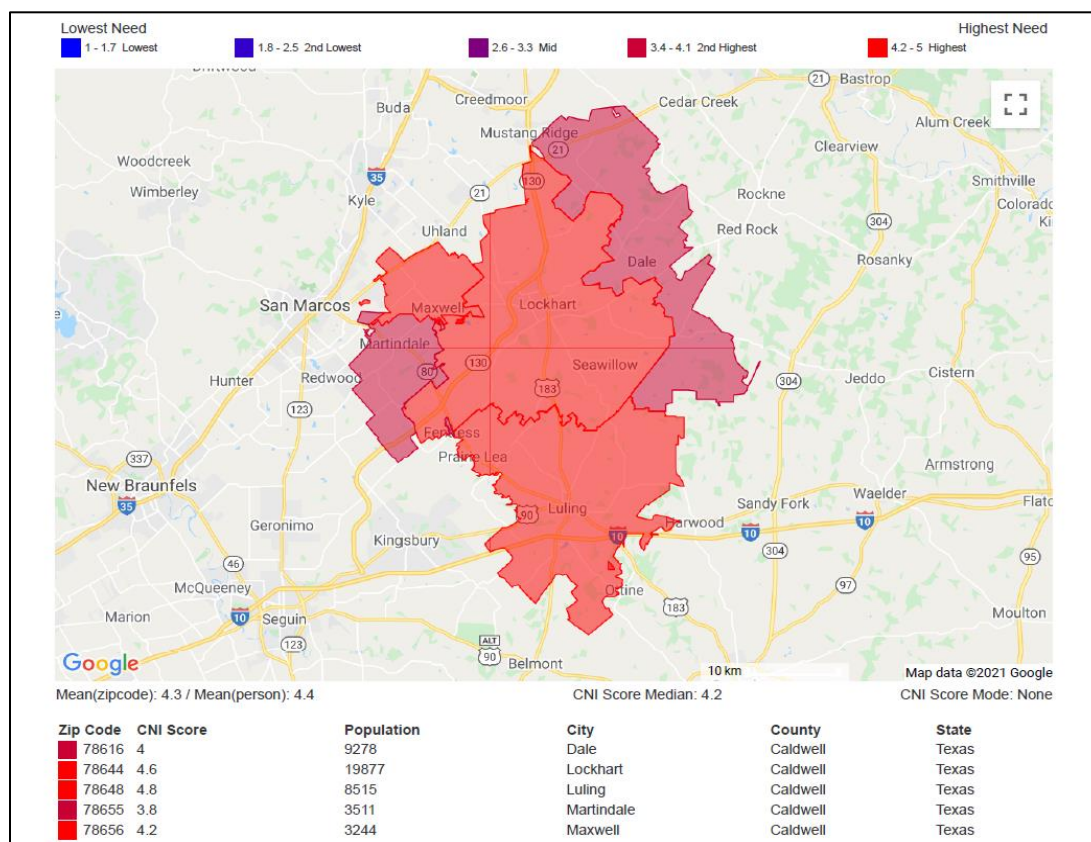


Source. Centers for Disease Control and Prevention.

The [Community Needs Index](#) (CNI) was jointly developed by Dignity Health and IBM Watson Health™ to assist in gathering vital socio-economic factors in a community. Based on demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the U.S. national average (score of 3.0). The CNI is strongly linked to variations in community health care needs and is a good indicator of a community's demand for a range of health care services. The CNI score is an average of five different barrier scores (income, cultural, education, insurance, and housing) that measure various socio-economic indicators of each community using the 2021 source data.

- Every populated ZIP code in the United States is assigned a barrier score of 1-5 depending upon the ZIP code national rank (quintile).
- A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally.
- For all barriers, ZIP codes with scores of 1 or 2 have a smaller percentage of the population facing the barrier than the national average, while ZIP codes with a score of 4 or 5 have a higher percentage. ZIP codes with a score of 3 have a similar percentage of the population as the national average.

Figure 9
Caldwell County Community Needs Index



Source. Dignity Health Community Needs Index, 2021. Retrieved from CNI.DignityHealth.org.

INCOME

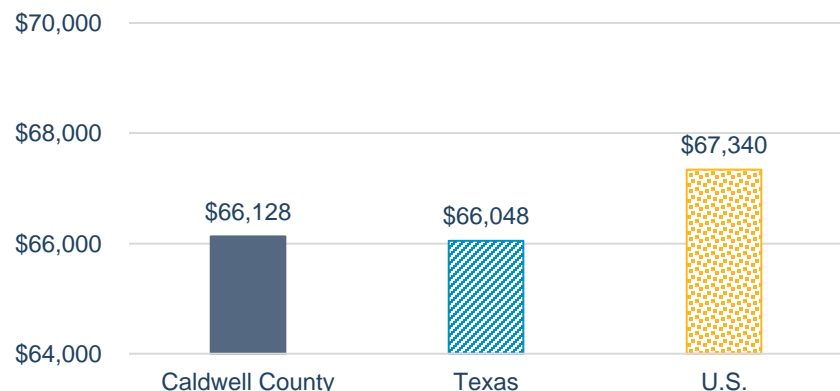
Median household income reflects the relative affluence and economic prosperity of an area. Areas with higher median household incomes are more likely to have a greater share of educated residents and lower unemployment rates, compared to areas with lower median household income.

Figure 10 displays the median household income of Caldwell County compared to Texas and the U.S. The median household income in Caldwell County was \$66,128 in 2020, which was higher than the Texas median (\$66,048) but lower than the U.S. as a whole (\$67,340). The median income in Caldwell County rose \$10,827 in a single year, from \$55,301 in 2019, and was previously lower than both the Texas and U.S. median.

The median household income in Caldwell County is lowest among all the other counties in the Austin-Round Rock Metropolitan Service Area, including Hays (\$77,511), Travis (\$82,605), Williamson (\$91,507), and Bastrop (\$74,612).

Figure 10

Median Household Income in Caldwell County was Lower than Both Texas and U.S. in 2020

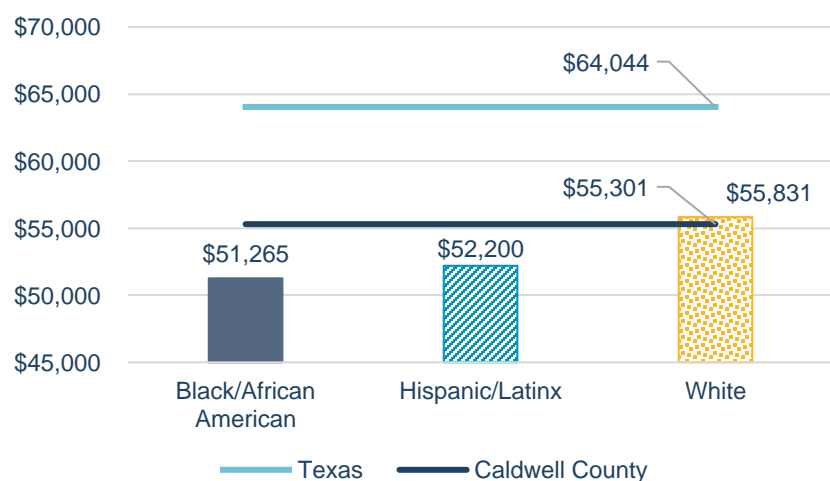


Source. U.S. Census Small Area Income and Poverty Estimates Program, 2020.

There are income disparities between racial and ethnic populations in Caldwell County. In 2019, the most recent year where household income by race and ethnicity is available at the county level, median household income for Hispanic/Latinx households was \$52,200, which was lower than both Texas and the U.S. Similarly, white households in Caldwell County had a median income of \$55,831, which was lower than both Texas and the U.S. Black/African American households in Caldwell County had a median income of \$51,265 in 2019, which was similar to Black/African American households in Texas and the U.S., but was the lowest of the racial and ethnic groups in Caldwell County.

Figure 11

In 2019, Black/African American and Hispanic/Latinx Households in Caldwell County Had the Lowest Median Income



Source. U.S. Census Small Area Income and Poverty Estimates Program, 2020.

POVERTY AND ALICE

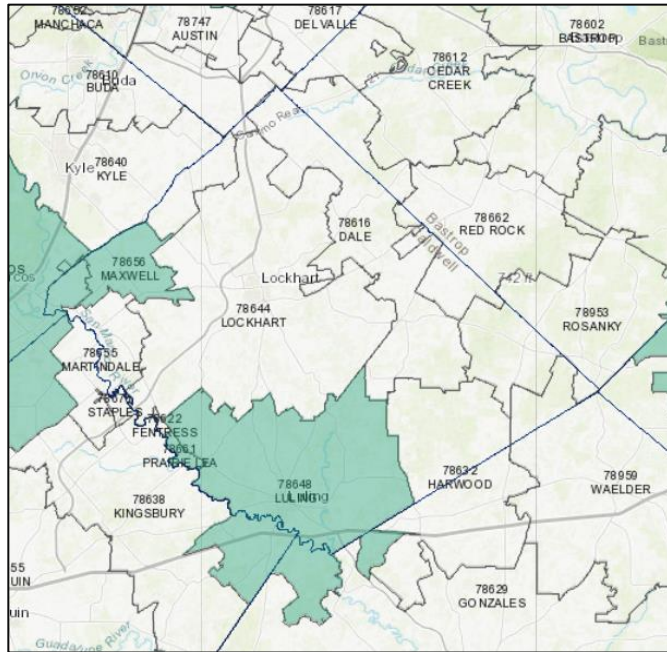
The U.S. Census Bureau sets federal poverty thresholds every year, which vary by size of family and ages of family members. A high poverty rate is both a cause and consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased tax revenue to the county, poverty correlates with lower quality schools and decreased business survival.

Caldwell County has a higher percentage of households living below the Federal Poverty Level (FPL) (15%) than both Texas (14%) and the U.S. (13%). At the individual level, a higher percentage of Black/African American (40.1%) and Hispanic/Latinx individuals (22.0%) live below the poverty level in Caldwell County compared to Texas or the U.S. which affects health outcomes and access to health care for Black/African American and Hispanic/Latinx residents. Although similar to state and national poverty rates, the Caldwell County Average masks important differences at the sub-county ZCTA level.

Within Caldwell County, the Luling and Maxwell ZCTAs have the highest proportion of people living in poverty. As displayed in Figure 12, these ZCTAs have more than 15% of households living below FPL. This map displays Caldwell County and the surrounding areas, with ZCTAs outlined in black. The ZCTAs in green indicate an area where more than 15% of the population lives below the FPL. This threshold indicates a higher rate of people living in poverty, compared to the county average (15%). In Caldwell County, the Luling and Maxwell ZCTAs have the highest rate of people living in poverty.

Figure 12

ZCTAs in Caldwell County with Greater than 15% of Households Living Below FPL



Source. American Community Survey, 2015-2019. Retrieved from UDS Mapper.

While poverty is an important measure, it is also important to understand the portion of residents who live below the federal poverty level but who earn less than the basic cost of living for Caldwell County, measured as ALICE.

ALICE is an important indicator of economic insecurity because it identifies the prevalence of households who struggle to afford essentials like food, housing, or health care, and yet do not meet income qualifications for public assistance programs, such as Supplemental Nutrition Assistance Plan (SNAP). Basic costs of living are defined as the bare-minimum costs for housing, childcare, food, transportation, health care, and a smartphone plan.

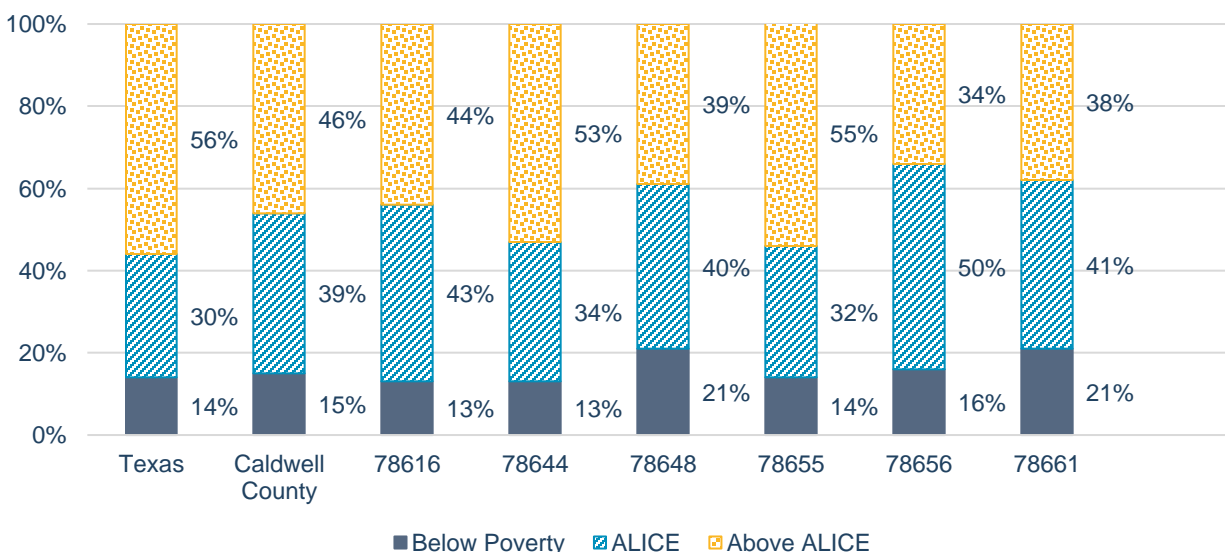
- In 2018, 15% of Caldwell County households fell below the poverty line while another 39% of were in the ALICE category. In total, over half of the households in Caldwell County (54%) live below the ALICE threshold.
- Families with children are most likely to fall below the ALICE threshold in Caldwell County due to either living in poverty or being ALICE (56%).

County-level ALICE data masks important intra-county differences. The Luling area in the south of Caldwell County has the greatest percentage of households living below the ALICE threshold (58%), followed by Martindale (56%) and Lockhart (52%). This information may be used to target priority areas for initiatives directed at addressing economic disparities that affect health care access and outcomes.

This data is also consistent with qualitative findings, which indicated that the Luling area has a greater need for free and reduced-cost health care services.

Figure 13

The Percentage of Caldwell County Households Living Below the Poverty Level and ALICE Threshold is Highest in ZCTA 78656



Source. United for ALICE.

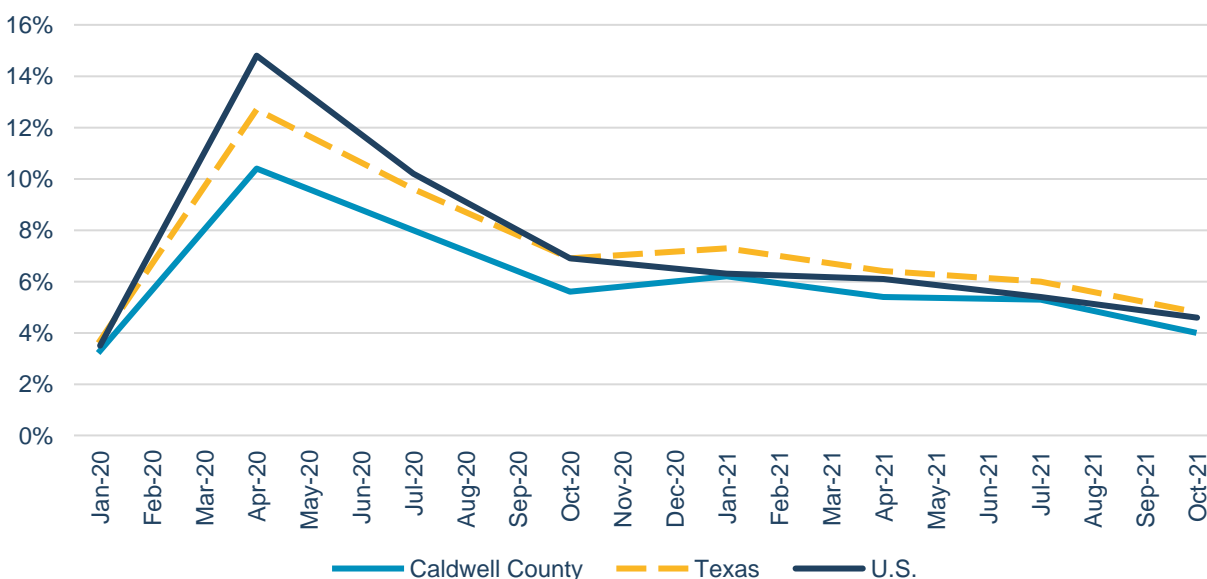
UNEMPLOYMENT

The rate of unemployment is an indicator of economic insecurity experienced by a community. Unemployment can affect an individual's physical and mental health, as well as their ability to access and engage with health care services.

As with most of the state and nation, the rate of unemployment in Caldwell County peaked in April 2020 due to the COVID-19 pandemic. At this highest point, the unemployment rate was 10.4% in Caldwell County, compared to 12.9% in Texas and 14.8% in the U.S. Since April 2020, the rate of unemployment in Caldwell County closely followed both the state and national trends, with rates of unemployment steadily declining through October 2021. As of October 2021, the unemployment rate in Caldwell County was 4.0%, compared to 5.4% in Texas and 4.6% in the U.S.

Figure 14

Unemployment in Caldwell County, Texas and U.S.: January 2020-October 2021



Source. U.S. Bureau of Labor Statistics.

Those most impacted by the pandemic have been workers in service industries. While local data is not available, at the national level, Hispanic/Latinx women (21%), immigrants of all races and ethnicities (19%), young adults ages 16-24 years old (25%), and those without any college education (21%) have experienced the greatest job loss during the initial surge in unemployment early in the pandemic.³

Workers in service industries were the most affected by loss of employment due to the pandemic. While local unemployment data is not available for race and ethnicity, at the national level, Hispanic women (21%), immigrants of all races and ethnicities (19%), young adults ages 16-24 years old (25%) and those without any college education (21%) experienced the greatest job loss during the initial surge in unemployment early in the pandemic.³ These data are supported by qualitative findings in Caldwell County. Focus group participants and key informants described that many community members have lost their jobs or had reduced hours during the pandemic. This has created financial vulnerabilities and impacted mental health for many community members.

³ Kochhar, R. (2020). *Hispanic women, immigrants, young adults, those with less education hit hardest by COVID-19 job losses*. Pew Research Center. <https://www.pewresearch.org/fact-tank/2020/06/09/hispanic-women-immigrants-young-adults-those-with-less-education-hit-hardest-by-covid-19-job-losses/>.

HOUSING

Focus group participants and key informants frequently mentioned the lack of affordable housing in Caldwell County as a key concern. Participants noted that housing has become increasingly unaffordable in the county, largely due to the surge in the nearby Austin housing market. As that market grows, there have been more people moving into Caldwell County and purchasing properties at rates that make the property values and general costs of living unaffordable to long-time residents. This has especially affected Black/African American and Hispanic/Latinx community members.

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

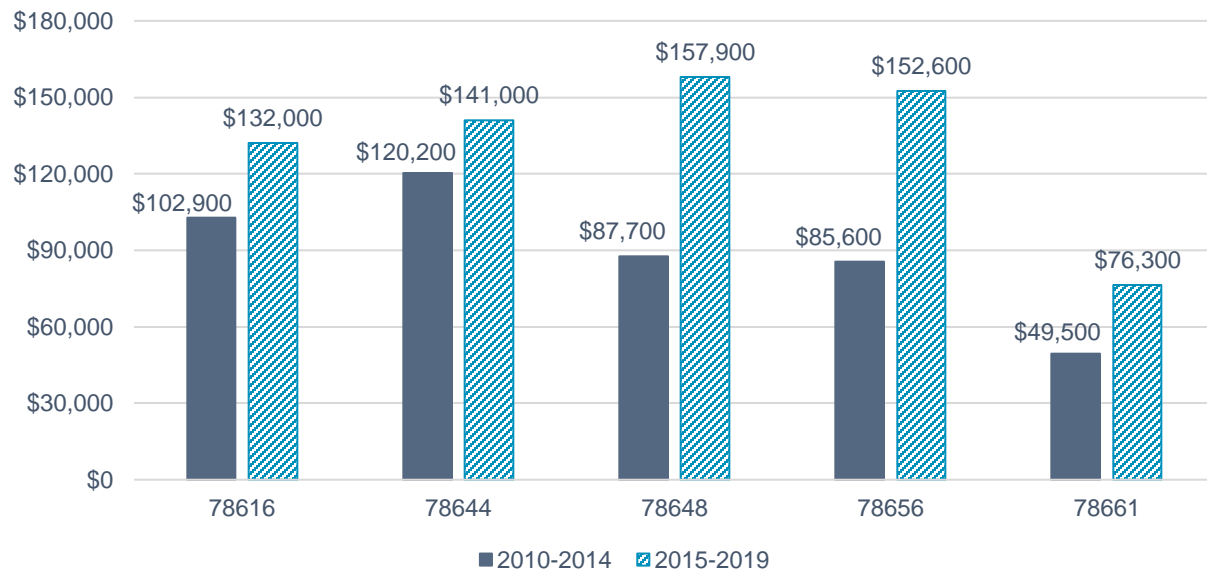
– Key Informant

Note: Due to the lag of 1-2 years in the availability of housing data, we can only provide a partial picture of the rising cost of housing up until 2019. The focus groups and key informant interviews highlighted a more heightened housing affordability crisis that has unfolded during the last two years (2020-21) because of the influx of residents from nearby counties in search of lower housing costs.

- Both median rents and the value of owner-occupied homes in Caldwell County have risen significant in the past five years (2010-2014 to 2015-2019).
- While median rent in the county was \$776/month on average between 2010-2014, it has increased 18.6% to \$920/month over the latter five-year period.
- The median value of owner-occupied homes increased 36.5% over the same period from \$106,100 to \$144,800.
- Important differences exist at the ZCTA level.
 - The 78648 ZCTA (Luling) experienced the greatest 5-year growth doubling its in median home value (2015-2019 median home value was \$157,900).
 - Median gross rent for all types of units saw the greatest growth in 78656 (70.9%), although 78616 had the highest median gross rent in (\$1,032) in 2015-2019. Figures 15 and 16 depict these changes over time.
- Recent data from the Austin Board of Realtors is more indicative of the housing affordability crisis over the last two years:
 - Between November 2020 and 2021, the median price of homes sold in Caldwell County increased 29.0% to \$265,109. In November 2019, the median price of homes sold in the county was \$185,000.

Figure 15

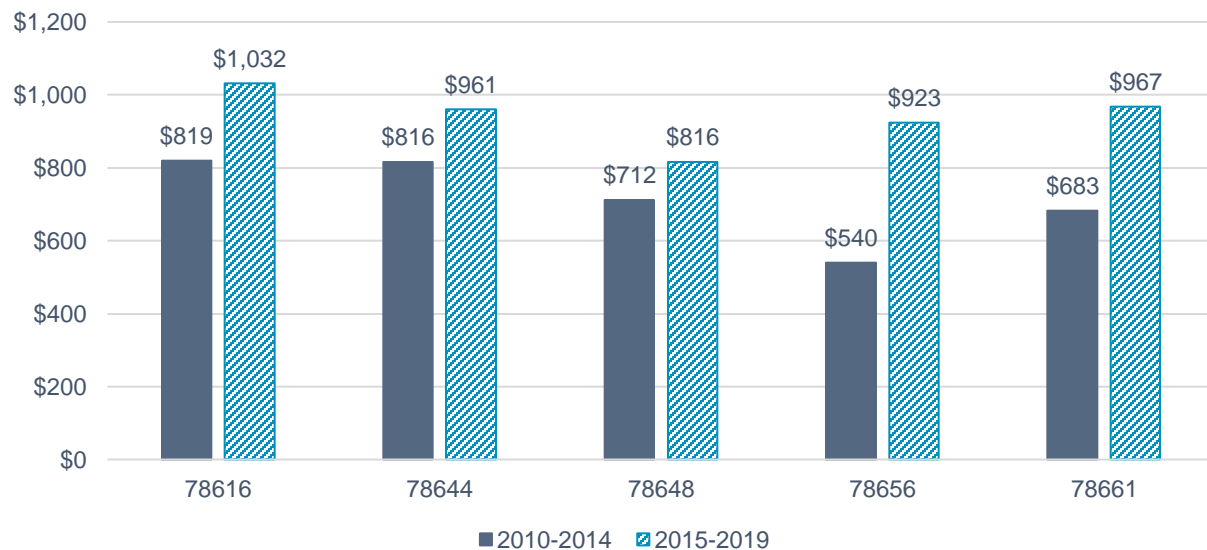
Median Value of Owner-Occupied Homes in Caldwell County, 2010-2014 vs. 2015-2019



Source. U.S. Bureau of Labor Statistics.

Figure 16

Median Gross Rent in Caldwell County, 2010-2014 vs. 2015-2019



Source. U.S. Bureau of Labor Statistics.

SEVERE HOUSING BURDEN

On average, Caldwell County Residents spend 20% of their monthly income on housing costs. However, 14% spend more than 50% of their monthly income on housing costs, limiting their ability to afford necessities such as food, transportation and health care. This rate has increased 17.3% in the past five years, with 509 more households experiencing “severe housing cost burden” in 2015-2019 compared to 2010-2014.

- In 2015-2019, an estimated 1,884 households in Caldwell County spent more than 50% of their monthly income on housing. This is an increase of 511 households, from 1,373 households in 2010-2014.
- 17% of households in Caldwell County experience one or more of the following: overcrowding, housing costs that are greater than 50% of monthly income, lack of kitchen facilities or lack of plumbing facilities (2013-2017).

HOUSING INSTABILITY

The Housing Stability Index (HSI) quantifies the extent of housing stability in either renter- or owner-occupied units due to missed or deferred housing payments, such as rent or mortgage. If an area is considered “at risk,” this indicates that a high percentage of residents are unable to make regular housing payments and may face eviction and homelessness. The HSI compares stability to a baseline period of January 2020, which was prior to the COVID-19 pandemic in the U.S.

In Caldwell County, the HSI value is 0.96 as of September and October 2021. This indicates that 4% fewer households are considered stable, compared to January 2020, and may therefore be at risk of eviction or foreclosure. The majority (3.1%) of these households are renters, versus owners.

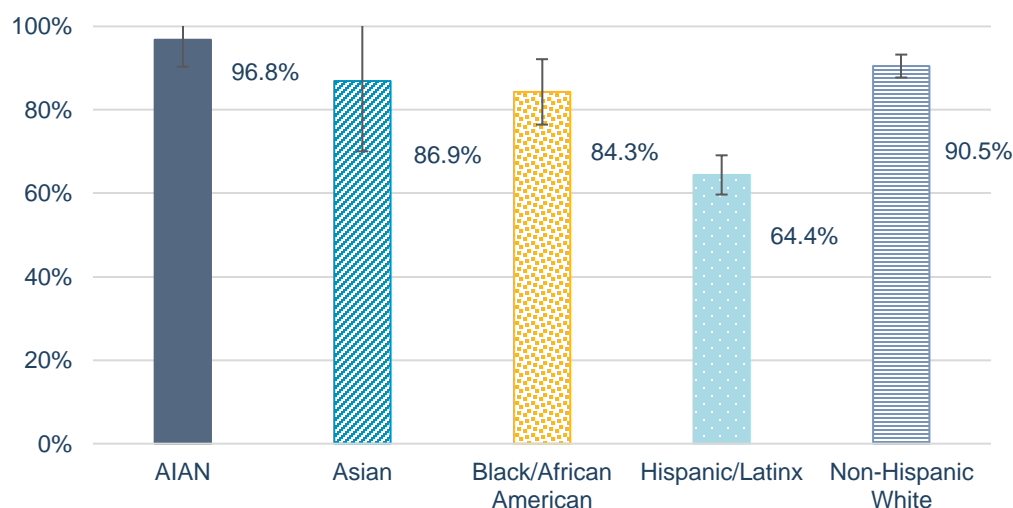
The implication of this data is that more households in Caldwell County are experiencing housing instability due to costs, compared to recent years. This is consistent with qualitative findings. Focus group participants and key informants reported that the lack of affordable housing in the county has increased financial stress for many families, which impacts physical and mental health.

EDUCATION

In Caldwell County, fewer adults 25 years and older have a high school degree or higher (78.2%) compared to Texas (83.7%) or the U.S. (88.0%). Furthermore, there are racial and ethnic disparities in educational attainment. Only 64.4% of Hispanic/Latinx adults 25 or older have completed at least high school, compared to 84.3% of Black/African American and 90.5% of white community members in Caldwell County.

Figure 17

Hispanic/Latinx residents of Caldwell County are the Least Likely to Graduate from High School



Source. American Community Survey, 2015-2019.

Note: With the exception of Non-Hispanic whites, all other racial groups include individuals who identify as both Hispanic and Non-Hispanic.

TRANSPORTATION

Transportation barriers, specifically the lack of transportation services available, was the most frequently mentioned structural barrier by focus group participants. In fact, Caldwell County has a Transit Connectivity Index score of zero, which indicates the county has the lowest possible public transit infrastructure.

The lack of public transit options inhibits people's ability to get to grocery stores, jobs, social engagements, and health care appointments. When asked how community members typically get to doctor's appointments, one focus group participant said, "We have to find an Uber or whatever we can each time, because we always need someone to take us. In reality, there is no transportation." A key informant said, "The lack of transportation impacts [people's] ability to get specialized care that maybe they need, and the ability to [do] follow-up care."

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

– Key Informant

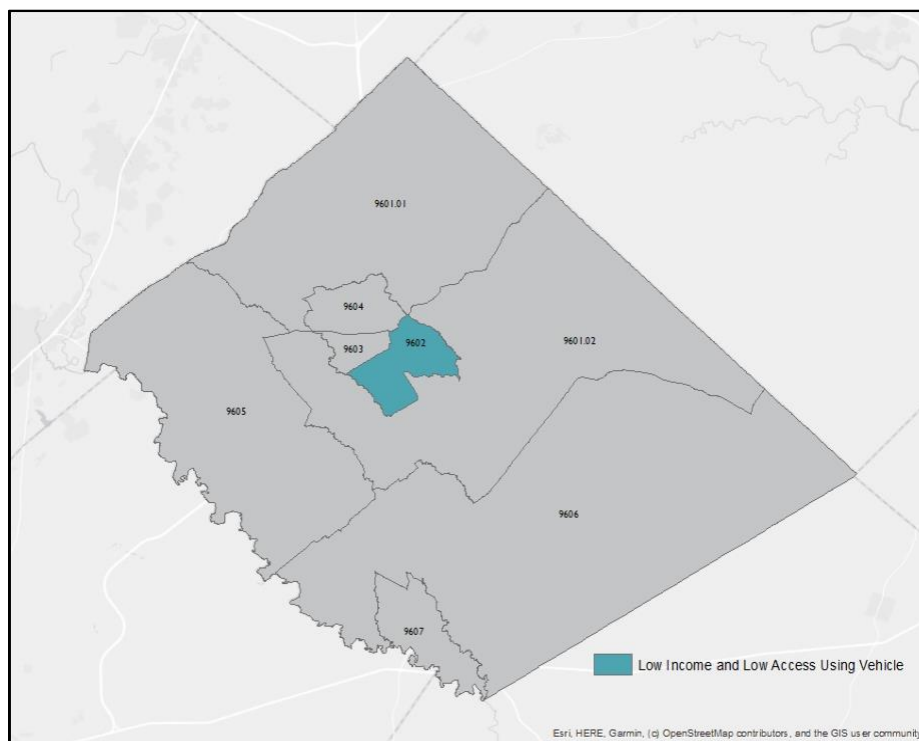
Despite a lack of public transit options, an estimated 4.3% of households in Caldwell County do not have access to personal transportation. This rate is higher in the Luling area (78648), at 5.9%, followed by the Lockhart area (78644) at 5.6%. Focus group participants mentioned that

costs are the main inhibitor for personal transportation. On average, of 24% of household income in Caldwell County is spent on transportation costs.⁴ As a result of expensive personal transportation costs, in combination with a lack of public transportation options, it is common for community members to use ambulances to get to the hospital for non-emergent illnesses.

Figure 18 highlights the Lockhart area ZCTA that is officially designated by the U.S. Department of Agriculture as a neighborhood that is low income, has limited food access, and at least 100 households are located more than ½-mile from the nearest supermarket and have no vehicle availability.

Figure 18

Lockhart Area Designated as Low Income, No Vehicle Availability, and Low Access to Supermarkets



Source. U.S. Department of Agriculture, Food Access Research Atlas, 2019.

⁴ Household transportation costs are calculated as the sum of auto ownership costs, auto use costs, and public transit costs. This calculation illustrates the transportation cost burden placed on a typical household. Source. <https://htaindex.cnt.org/>

FOOD INSECURITY

Food insecurity is defined by the ACS as the percentage of the population who lack adequate access to food. Food insecurity impacts health in two primary ways:

1. By making it difficult for individuals to maintain healthy diets that are instrumental to managing and preventing chronic conditions, such as diabetes; and
2. By leading individuals to forgo costly medications in order to feed their families. A further indication of food insecurity is the percentage of the population who uses SNAP, which provides financial support for purchasing food.

In 2019, 14.8 % of Caldwell County residents lacked adequate access to food, amounting to approximately 6,230 food insecure people. This is slightly more than the statewide rate (14.1%) but higher than the rate for the U.S. as a whole (10.9%).

The pandemic has had a notable impact on food insecurity. The number of people experiencing food insecurity has fluctuated greatly since January 2020 due to the impact of the loss of life or increased unemployment, followed by an increase in federal protections like the American Rescue Plan Act of 2021 (ARPA) or eviction moratoriums.

- At the national level, the number of adults going without enough food has changed from 9.5% in April 2020, to 13.4% in December 2020, then to 8% in April 2021.
- As of March 2021, Texas had the highest projected number of people living in food-insecure households for 2021 (4.7 million people), compared to all other states. This represents a 16.5% rate of projected food insecurity for Texans in 2021.
- Specific to Caldwell County, projections from Feeding America's Map the Meal Gap study indicate an increase in food insecurity from 14.8% in 2019 to 16.9% in 2021.

Qualitative findings in Caldwell County also suggest that the pandemic has limited free food services, such as Meals on Wheels or school-based lunch programs, increasing the prevalence of food insecurity. Furthermore, focus group participants and key informants said that food pantries often have too many barriers, including limited hours or requirements for identification and paperwork. Participants also reported that the cost of food is a barrier to many community members and organic food options are especially cost-prohibitive. Many community members find that gas stations or dollar stores are more accessible financially, or transportation-wise, compared to grocery stores like Wal-Mart or H-E-B.

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

– Key Informant

INTERNET ACCESS

Broadband internet connection allows an individual to connect to the Internet without relying on cell phone data, which is more expensive. Additionally, the technological infrastructure for wi-fi does not yet exist in many rural communities. Measuring access to the internet is an important indicator for equity because a person's ability to connect to the internet will directly affects their access to employment, education, social engagement, public benefits, health care, and more.

Focus groups and key informant interviews indicated that some areas of Caldwell County do not have reliable broadband access or mobile services that allow Internet connection. Participants described that this inhibits people's ability access telehealth visits, virtual school, or social gatherings.

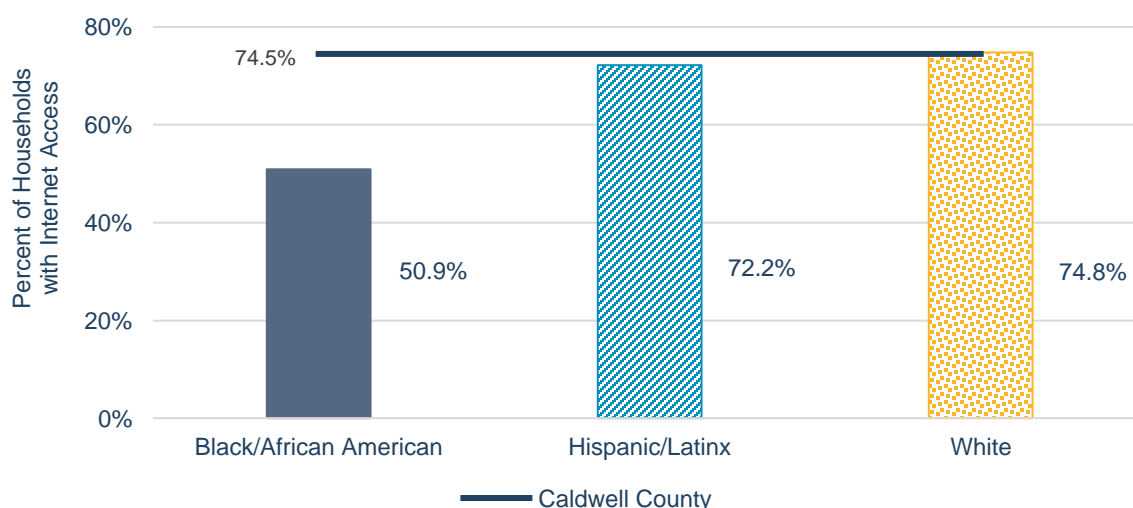
DISPARITIES IN INTERNET ACCESS

Quantitative data illustrates that there is a significant disparity in broadband internet access in Caldwell County.

- While 40.3% of the population has Internet access via broadband, access is highest among white community members (74.4%), compared to 50.1% of Black/African American and 71.7% of Hispanic/Latinx community members.
- One-quarter (25.5%) of households in Caldwell County do not have any internet access, meaning no one in the house can connect to the internet using a paid or free service (such as Broadband or a public library, respectively).

Figure 19

Black/African American Households in Caldwell County Have the Lowest Rates of Internet Access



Source. American Community Survey, 2015-2019.

Half of the households without Internet access are Black/African American, while only 27.2% of the households are Hispanic/Latinx and 25.2% of the households are white. This indicates that Black/African American households in Caldwell County experience the greatest disparities regarding Internet access. This may lead to disparate access to resources, socialization, and other opportunities for Black/African American community members in Caldwell County.

RACISM AND DISCRIMINATION

While there is not quantitative data regarding the prevalence of racism and discrimination in Caldwell County, findings from the key informant interviews and focus groups suggest many community members face significant issues in this area. Participants described the history of race-based discrimination throughout the community, which has included segregation, police brutality, and inadequate access to services like parks and hospitals in areas with more people of color.

One participant described the negative impact of local leaders or organizations who are uneducated about cultural priorities and histories of Black/African American communities in Caldwell County. As an example, the participant observed that organizational leaders or health care providers who are white have acted “intimidated” by Black/African American communities or insisted on police presence at clinics in historically Black neighborhoods, which further erodes trust in health care providers among Black community members.

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

– Key Informant

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

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

– Focus Group Participant

Community Assets and Strengths

Caldwell County has many community assets that should be considered as part of the community health needs assessment. In interviews and focus groups, participants mentioned that the community has a history of resiliency after experiencing various natural disasters over recent years. One key informant said that Caldwell County is full of individuals who see the needs of the area and genuinely desire to help.

HEALTH CARE ORGANIZATIONS

Caldwell County is home to three Ascension Seton health care sites, including two in Lockhart and one in Luling. In Lockhart, the Ascension Seton Health Center on Church Street provides primary care and diagnostic services and the Ascension Seton Lockhart Health Center on Colorado Street provides routine care. The Edgar B. Davis Hospital in Luling is a general acute facility with a 24/7 emergency room. Also, although not in Caldwell County, focus group participants also noted driving long distances to CommuniCare Clinics in Kyle, San Marcos and Austin to access affordable health care.

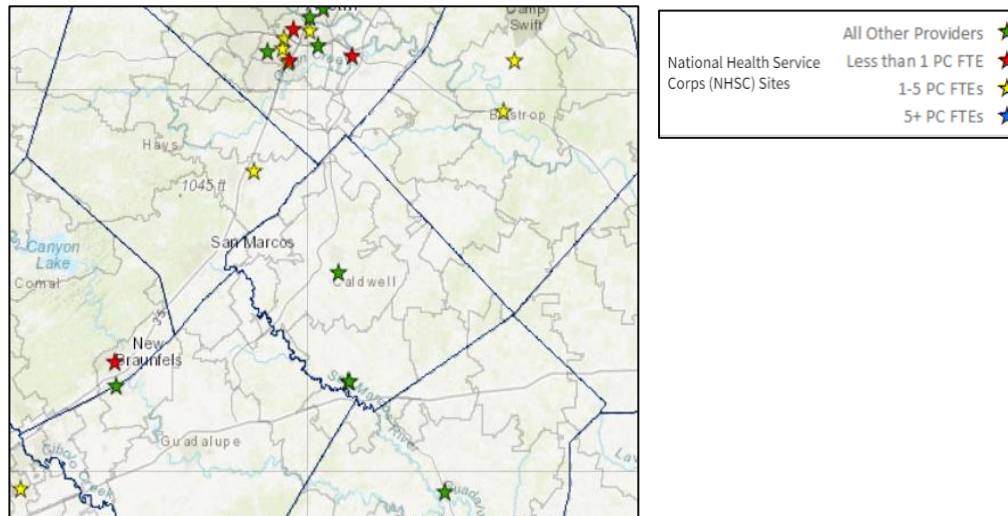
Additionally, Caldwell County has three National Health Service Corps (NHSC) sites. This designation is given by HRSA for a clinical site, typically an FQHC, which is located within a Health Professional Shortage Area (HPSA) and can provide services to people without regard for their ability to pay. The NHSC sites in Caldwell County are:

- Lockhart Family Practice Center
- Luling Community Health Center
- Luling Community Dental Center

Lockhart Family Practice Center, operated By Community Health Centers of South Central Texas, Inc., is the only FQHC in Caldwell County.

Figure 20

National Health Service Corps sites in Lockhart and Luling



Source. Health Resources and Services Administration, 2021. Map built with UDSMapper.org.

CHURCHES AND FAITH-BASED ORGANIZATIONS

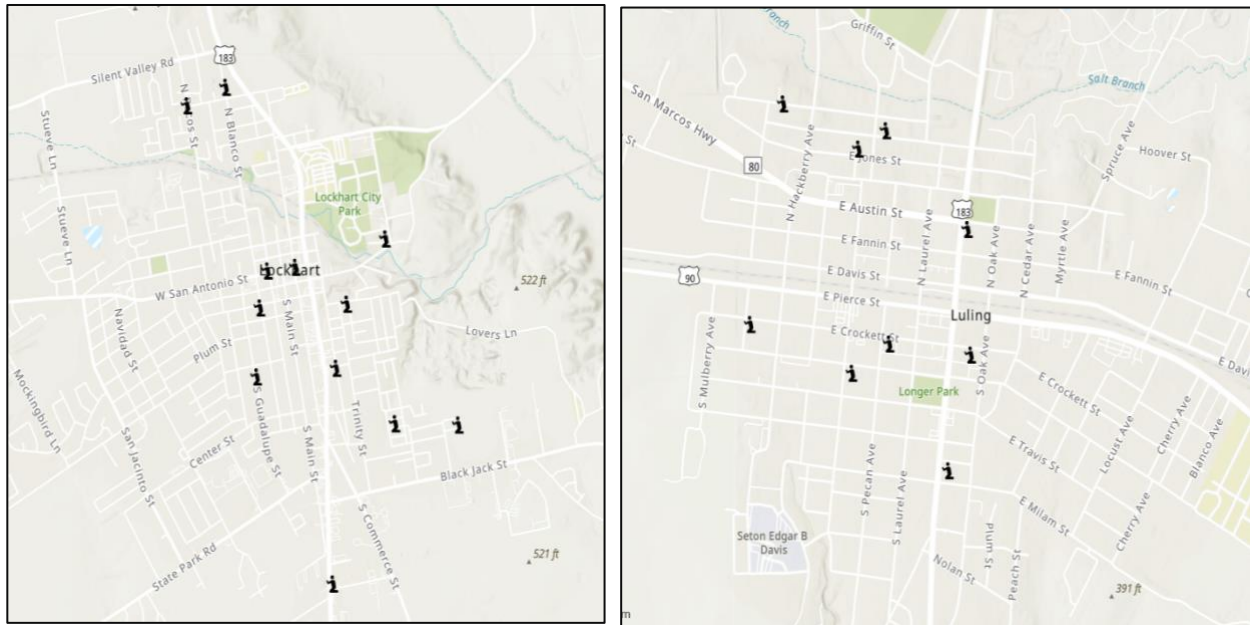
Focus group participants said one strength of the county is the network of churches from many denominations that often work together to meet community needs, including by distributing food and clothing and conducting home visits to struggling or isolated community members. The following churches and faith-based organizations were mentioned as valuable resources for the community:

- Caldwell County Christian Ministries and Caldwell County Foodbank
- Lamb and Sheep Ministries
- First United Methodist Church of Luling (Wesley Nurse program)
- St. Vincent DePaul ministry at St. Mary's Catholic Church
- St. John the Evangelist Catholic Church of Luling

The maps below display the geographic distributions of places of worship within Lockhart and Luling.

Figure 21

Places of Worship in Lockhart (left) and Luling (right)



Source. OpenStreetMap Amenities for North America. Retrieved December 17, 2021.

NONPROFITS AND COMMUNITY ORGANIZATIONS

Nonprofits and community-based organizations in Caldwell County play a vital role in building healthy communities by providing educational, health, and social services to community members. Focus group participants identified various local organizations and agencies that have been instrumental in providing resources to address general needs as well as needs that have arisen during the pandemic. Below is a list of organizations identified by participants:

- Lockhart Independent School District
- Lockhart Learning Center
- Meals on Wheels
- Texas Workforce Commission

PARKS

Caldwell County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. In Luling, 62% of people live within a ten-minute walk of a park and in Lockhart, 27% of people live within this radius. Although, this data suggests there is broad access to natural spaces, it is important to note that qualitative findings provide more context.

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

Priority Health Needs and Barriers to Care

The following section highlights health issues and barriers to health care access and healthy lifestyles experienced people in Caldwell County that St. David's HealthCare could potentially influence through policy or system-level changes and collaboration with community partners.

KEY HEALTH ISSUES

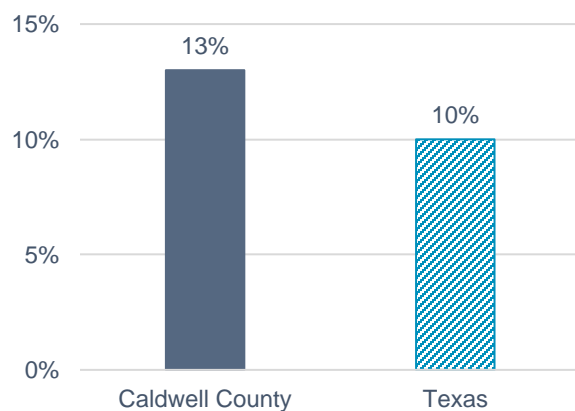
Both qualitative and quantitative data highlight similar priorities related to prominent health issues and chronic diseases in Caldwell County.

DIABETES

Diabetes was the most commonly mentioned health condition in focus groups and interviews. According to the United States Diabetes Surveillance System (USDSS), Caldwell County has a higher prevalence of adults aged 20 and above who report having diagnosed diabetes (13%), compared to Texas (10%).

Figure 22

More Adults Living with Diabetes in Caldwell County Compared to Texas



Source. United States Diabetes Surveillance System, 2017.

Focus group participants and key informants alike frequently mentioned diabetes in relation to other issues within the county, such as lack of affordable preventative health care or lack of affordable, healthy food. One key informant described that diabetes, as well as hypertension, “drive a lot of our ED [emergency department] visits, as well as hospitalizations.”

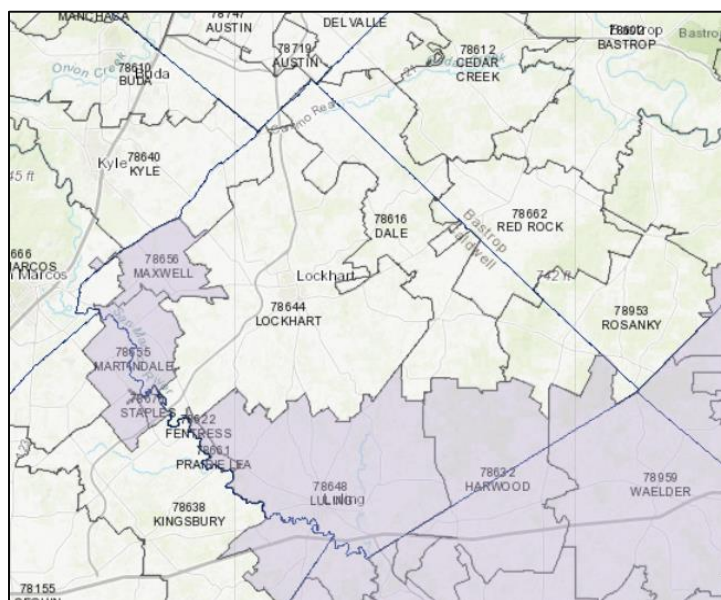
Another informant mentioned that diabetes is perceived as most prevalent among the “African American populations, the Hispanic [populations], and minorities in the southern part of the county,” as well across generations, with younger age groups showing early risk factors. The geographic burden of diabetes is displayed in Figure 23, which confirms qualitative findings that suggest the southern region of the county has the highest prevalence.

In addition, quantitative data for Public Health Region 7 (the region in which Caldwell County is located) indicate the underpinnings of these differences are likely socioeconomic in nature, rather than due to race and ethnicity.

- Texan adults in Public Health Region 7 with less than a high school education (21.4%) are over two and three times more likely to have diabetes than those with at least some college education (8.4%) and those who have graduated college (6.8%), respectively.
- Adults earning less than \$50,000 per year are more than twice as likely to have diabetes as those who earn more than \$50,000 or more annually (16.5-16.8% vs. 6.5%).

Figure 23

Areas of Caldwell County with the Highest Prevalence of Diabetes

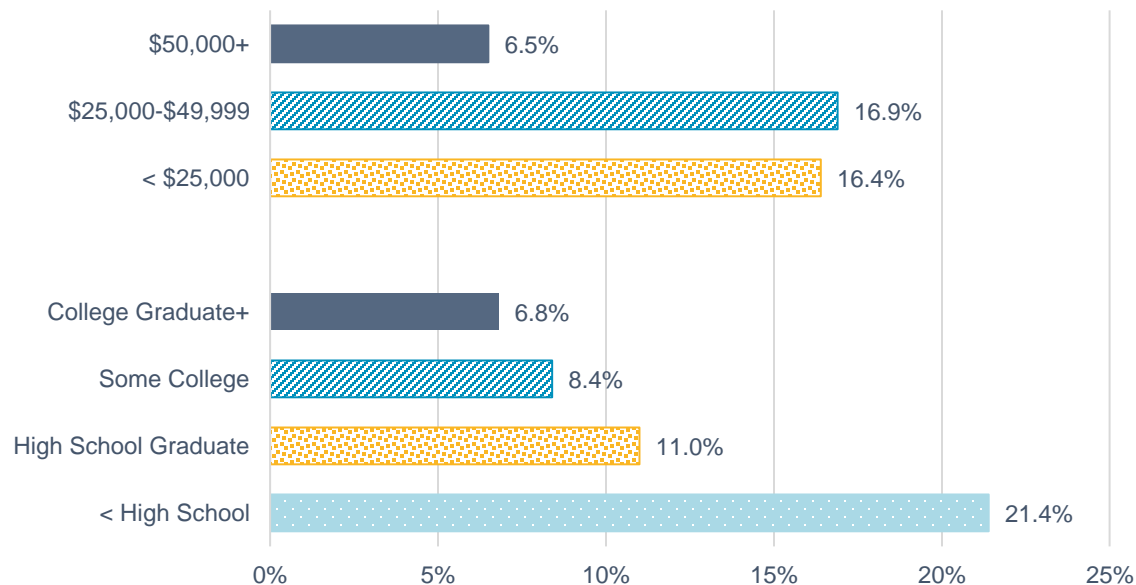


Source. Behavioral Risk Factor Surveillance System, 2018; American Community Survey, 2015-2019. Map built with UDSMapper.org.

This map displays Caldwell County and the surrounding areas, with ZCTAs outlined. ZCTAs that are colored indicate that more than 13% of the population over 18 years has ever been told they have diabetes, which is higher than the county-level prevalence. These areas could be prioritized for interventions related to diabetes.

Figure 24

Diabetes Prevalence by Income and Education Attainment, Adults: TX Public Health Region 7



Source. U.S. Centers for Disease Control & Prevention, Behavioral Risk Factor Surveillance System, 2018.

HYPERTENSION

Hypertension was mentioned second most frequently by key informants and focus group participants as a priority health issue for the county. As with diabetes, participants noted that a high prevalence of hypertension is often due to barriers such as lack of affordable preventative health care and food insecurity. Additionally, hypertension was noted as common across generations but seemed to be the most prevalent among Black/African American and Hispanic/Latinx community members.

Approximately 34.6% of adults in Caldwell County have ever been told they have high blood pressure, according to data from BRFSS (2019). This percentage is higher in the Luling ZCTA (37.7%) compared to the Lockhart ZCTA (33.8%), which confirms qualitative findings that suggested a greater burden of hypertension in the southern part of the county.

OBESITY

Focus group participants and key informants also mentioned obesity as a priority health concern in the county, although it was mentioned less frequently than diabetes or hypertension.

- In 2019, the prevalence of obesity among adults ages 18+ in Caldwell County was 38.1%, which is higher than Texas (31.4%) and the U.S. (29.7%); however, with almost 1 in every 3 adults in the U.S. being obese, it is a common issue everywhere.
- Caldwell County's rate of adults with obesity has risen more quickly than Texas or the U.S. over the last decade – in 2013 the county rate was 26%.
- The Dale, Maxwell, and Martindale ZCTAs have a higher prevalence of obesity compared to the county overall.

MENTAL HEALTH AND SUBSTANCE USE

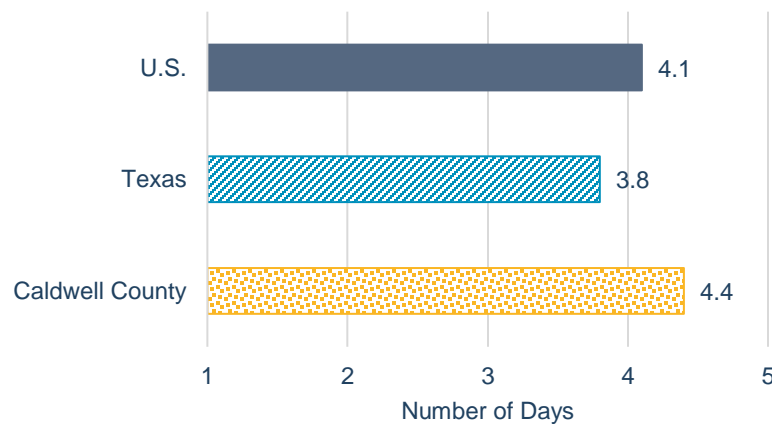
Participants frequently mentioned concerns about mental illness, including depression, anxiety, or substance use disorders. Notably, participants reported that the prevalence of mental illnesses seems to be “worse than ever,” largely due to increased loneliness, desperation, trauma, and lack of support throughout the COVID-19 pandemic. According to participants, younger community members like children and teens are experiencing depression and anxiety at very high rates. Furthermore, participants described that there is a general stigma around mental health care, particularly among Black/African American and Hispanic/Latinx populations.

- According to modeling using 2019 BRFSS data, almost 1 in 5 (19.8%) adults in Caldwell County have been diagnosed with a depressive disorder at some point in their lives. Hispanic adults are less likely to report a depression diagnosis than white adults.
- In 2019, 15.0% of Caldwell County adults reported their mental health as being “not good” 14 days or more in the past 30 days, a rate slightly higher than the state and national average (12.2% and 13.8% respectively).
- Rates of mental illness, thoughts of suicide and receipt of mental health services are similar in Public Health Region 7a (of which Caldwell County is a part) as Texas. Data for these indicators are not available at a county level.

Another measurement from BRFSS is the average number of days people report having poor mental health within the last 30 days. A higher number of mentally unhealthy days may indicate that an individual has a mental disorder, whether diagnosed or undiagnosed, which could interfere with their quality of life. The average number of poor mental health days reported in Caldwell County in 2018 was 4.4 days, which is higher than the average of 3.8 days for Texas and 4.1 days for the U.S.

Figure 20

People in Caldwell County Experience More Poor Mental Health Days Compared to Texas and U.S



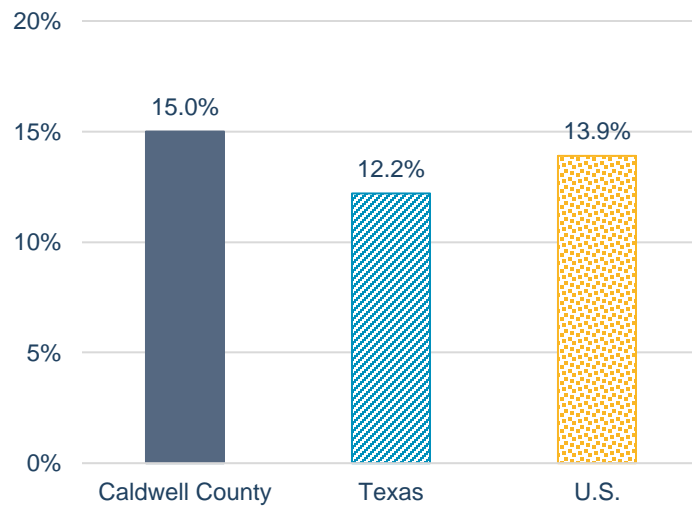
Source. Behavioral Risk Factor Surveillance System, 2018.

The prevalence of poor mental health is likely higher than the most recently available BRFSS data, given the impact of the COVID-19 pandemic. Estimates from the Household Pulse Survey, which CDC has administered on a rolling basis throughout the COVID-19 pandemic, indicate that 29.5% of Texas adults experienced symptoms of anxiety disorder or depressive disorder as recently as December 2021. This percentage was previously as high as 43.4% of Texas adults in January 2021.⁵ At the national level, women reported higher rates of symptoms than men (33.8% vs. 27.5%), and adults ages 18-29 had rates substantially higher than all other age categories (44.5%).

⁵ Household Pulse Survey. *Anxiety and Depression*. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>.

Figure 26

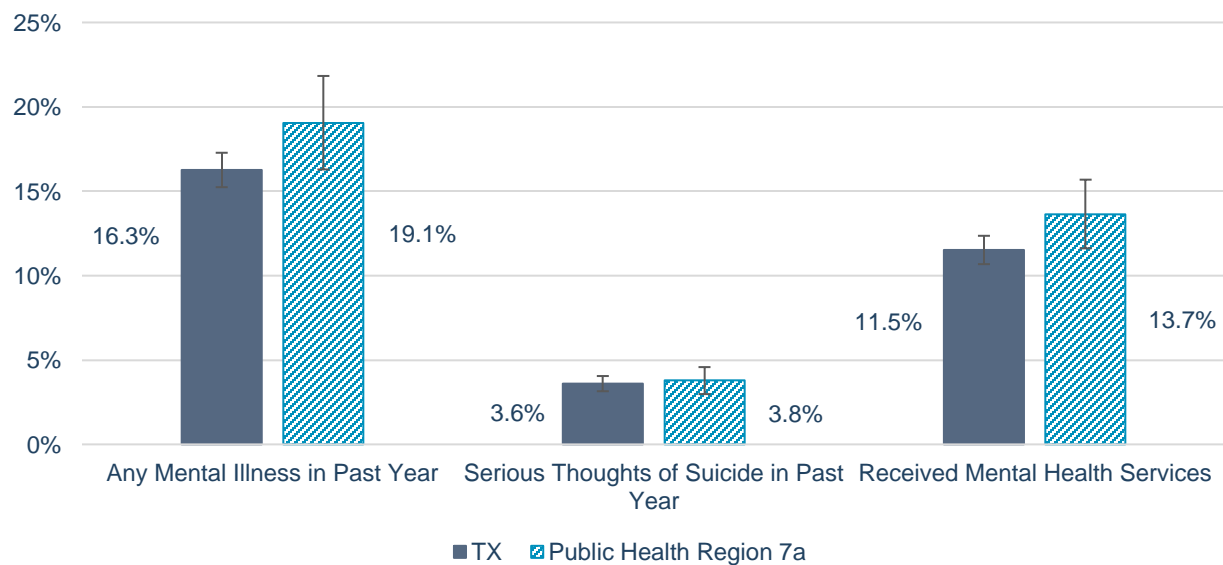
Adults in Caldwell County Report More Frequent Mental Distress Compared to Texas and U.S.



Source. Behavioral Risk Factor Surveillance System, 2019.

Figure 27

Rates of Mental Illness, Thoughts of Suicide and Mental Health Services in Public Health Region 7a are Similar to Texas



Source. Substance Abuse and Mental Health Services Administration, National Survey of Drug Use and Health, 2016-2018.

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

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

– Key Informant

ORAL HEALTH CARE

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

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

– Focus Group Participant

BARRIERS TO HEALTH CARE

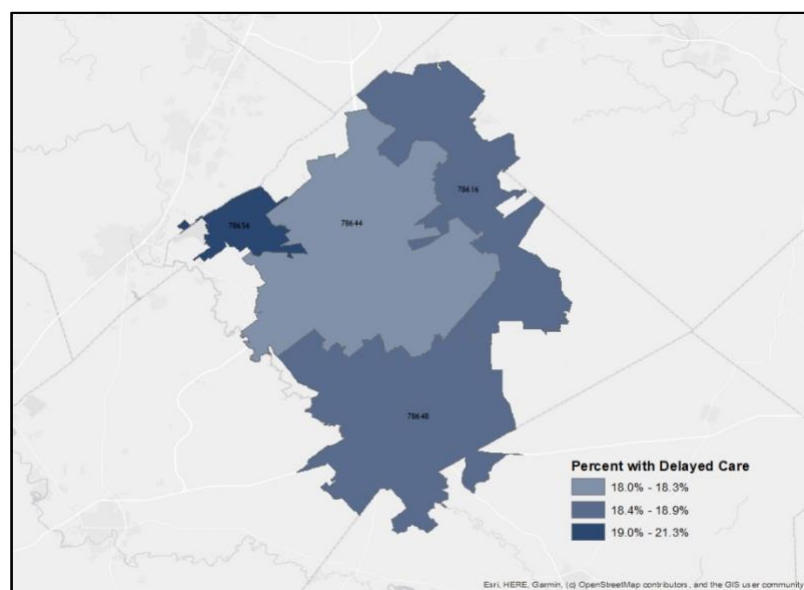
According to BRFSS data from 2017, the most recently available year of data for Caldwell County, 18.5% of adults in the county did not seek care due to costs. Additionally, 28.2% of adults reported having no usual source of health care.

The affordability and availability of needed health care affects when and whether or not individuals seek care. Focus group participants and key informants indicated that barriers exist in both of these areas. Specifically, participants described issues that make services inaccessible or insufficient, including unaffordable costs, insurance-status, or general financial insecurity. Participants also described that health care services are often culturally inappropriate or insensitive, particularly to Hispanic/Latinx and Black/African American populations.

Furthermore, participants noted the lack of specialist providers in Caldwell County, including the lack of urgent care centers.

Figure 28

Caldwell County Adults Delaying Care Due to Cost



Source. Behavioral Risk Factor Surveillance System, 2015-2017.

AFFORDABILITY OF HEALTH CARE

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

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

– Focus Group Participant

UNINSURED

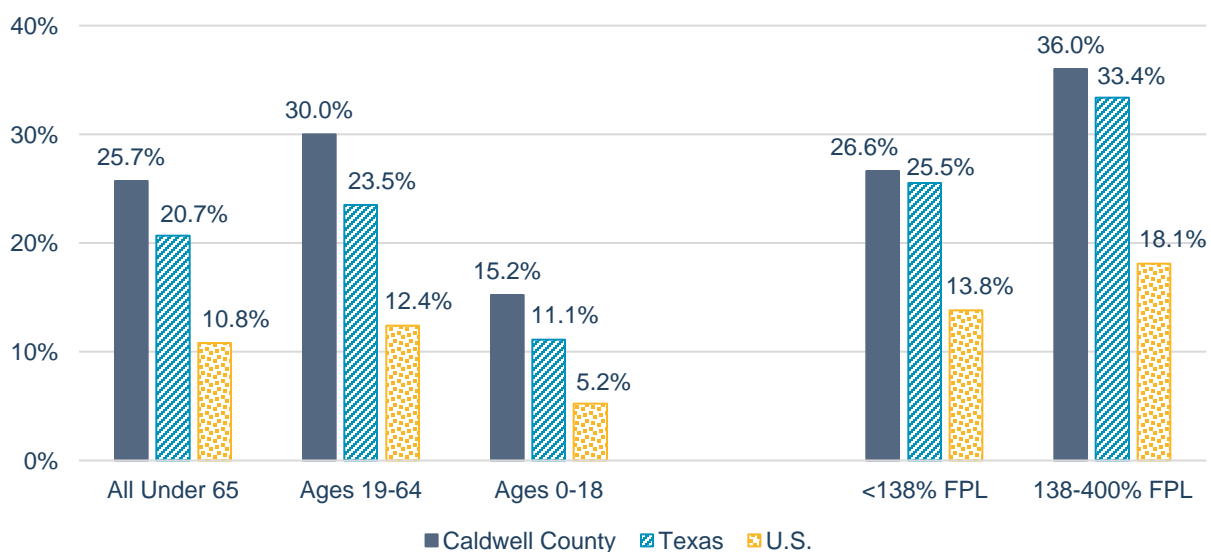
Insurance status is closely related to the lack of affordable health care options in Caldwell County. Focus group findings suggest that many providers in the county do not accept Medicaid. Furthermore, participants described a need for payment plans or discounted services, due to their lack of insurance and overall financial inability to pay full price out-of-pocket. Many people who are uninsured or underinsured avoid preventative care entirely due to costs. Additionally, qualitative participants reported that many low-income community members will travel to Austin, San Antonio, or Kyle to receive free or affordable health care, including dental care.

Insurance coverage improves access to care and care seeking by lowering the out-of-pocket costs. It also improves rates of preventive care (e.g., screenings and vaccinations).

- As a state, Texas had a higher percentage of residents under the age of 65 who are uninsured (20.7%) than any other state in 2019. This is also twice the portion of residents nationally who are uninsured (10.8%).
- In Caldwell County, 25.7% of the population under 65 years old is uninsured (2019). This is higher than Texas, and twice as high as the national average.
- Relative to other counties in the Austin-Round Rock MSA, Caldwell County has the highest percentage of residents under 65 are uninsured compared to Travis County (16.5%), Bastrop (22.7%), Hays (16.7%), and Williamson (12.4%).
- Caldwell County has a higher percentage of uninsured children (ages 0-18) (15.2%) compared to the Texas (11.1%) and the U.S. (5.2%).

Figure 29

Nearly One-Quarter of Caldwell County Adults are Uninsured



Source. Small Area Health Insurance Estimates Program, 2019.

These rates do not take into account the disruptions that low-income families have in their health care due to irregular insurance access. Rates of uninsured mask a larger problem of underinsurance. Although no data is available at the county level, national data indicates that two out of five working age adults (ages 19-64) are inadequately insured (43.4%).⁶

PROVIDER AVAILABILITY AND ABILITY TO PROVIDE APPROPRIATE CARE

Focus group participants and key informants also described provider-level barriers to health care. Most commonly described was that health care services often feel inaccessible because they are not culturally or linguistically appropriate. Participants noted there are an insufficient number of Spanish-speaking providers in Caldwell County. They also shared experiences where providers refused to find accommodations for patients who needed translation. Furthermore, participants described that health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply.

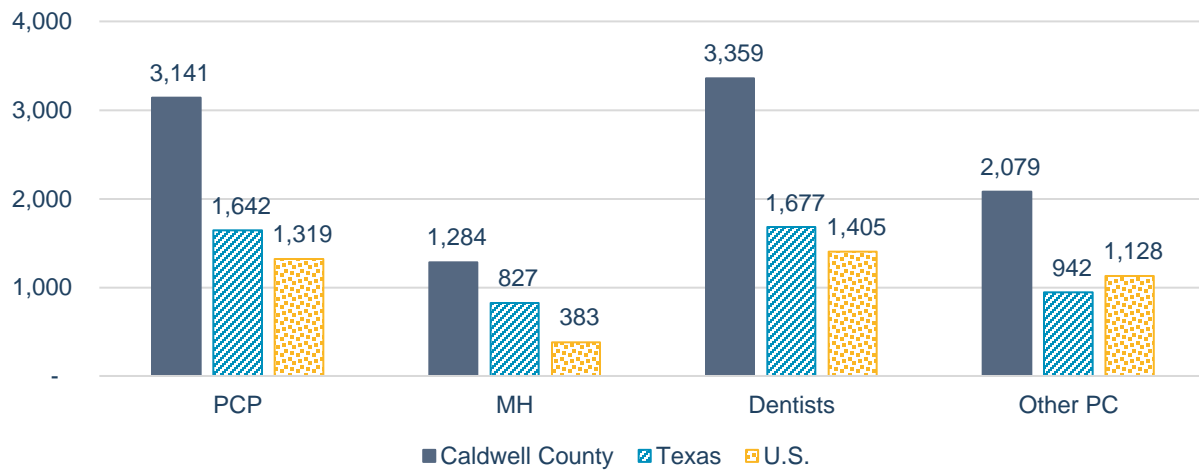
In addition to linguistic accessibility of providers, participants described how community members have encountered health care providers who use “a very colonial...white supremacist approach to pathologizing Black bodies and bodies of color.” Overall, qualitative findings indicate a need for providers and services that are more accommodating and informed in serving racial and ethnic minority populations, as well as people who do not speak English.

Caldwell County is designated as both a Primary Care HPSA and a Mental Health HPSA. This indicates that there are an insufficient number of primary care providers and mental health providers in the county. This data is consistent with the qualitative findings. Focus group participants and key informants reported that there are not enough primary and mental health providers in Caldwell County. Participants also mentioned that more specialists, such as OB-GYNs, are needed in the county.

⁶ The Commonwealth Fund determines people to be underinsured if they are insured all year and they meet one of the following criteria: (a) their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10% or more of household income, (b) their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5% or more of household income for individuals living under 200% of the federal poverty level (\$25,520 for an individual or \$52,400 for a family of four in 2020), or (c) their deductible constitutes 5% or more of household income.

Figure 30

Caldwell County has Fewer Health Professionals per Resident than Texas or U.S.



Source. U.S. Health Resources and Services Administration Area Health Resources File and Centers for Medicare and Medicaid National Provider Identification System, 2019. Note. PCP= Primary Care Provider, MH=Mental Health Provider, Other PC= Other Primary Care Providers.

Other Health Needs

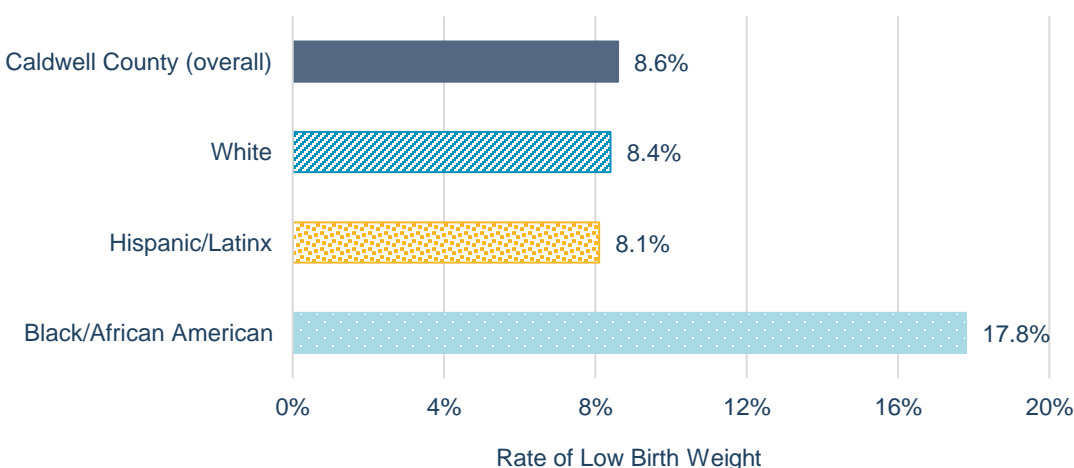
The following significant health needs emerged from a review of the publicly available quantitative data for Caldwell County. While these topics did not specifically emerge as priority areas in the focus groups and key informant interviews, they are worth noting.

BIRTH WEIGHT

Although focus group participants and key informants did not discuss low birth weight, data suggests that low birth weight is a priority issue for Caldwell County due to the disparities present among racial and ethnic groups. Low birth weight is defined as less than 5 lbs., 5 oz. A baby born with a low birth weight can be at risk for complications including respiratory problems and infections in infancy and even chronic illnesses later in life, such as high blood pressure, diabetes, and obesity.

Figure 31

Black/African American Populations in Caldwell County Have Higher Rates of Low Birth Weight



Source. National Center for Health Statistics, 2013-2019.

In Caldwell County, 8.6% of babies are born with low birth weight, which is similar to Texas (8.4%) and the U.S. (8.2%). Black/African American community members, however, have a low birth weight rate of 17.8%, which is more than twice as high as Hispanic/Latinx (8.1%) or white (8.4%) populations in Caldwell County. This data suggests that Black/African American mothers in Caldwell County may face disproportionate barriers to appropriate prenatal care and OB/GYN services, as well as other disparities that impact maternal and fetal health, such as food insecurity.

DISABILITY STATUS

People with disabilities are more likely to lack access to health care providers, go without routine care, and have unmet health care needs due to cost, compared to people who are not disabled.⁷ Consequently, a high rate of people who are disabled may result in greater health disparities in the county. In Caldwell County, there is a higher portion (14.2%) of disabled people compared to both Texas (11.5%) and the United States (12.6%).

FREQUENT PHYSICAL DISTRESS

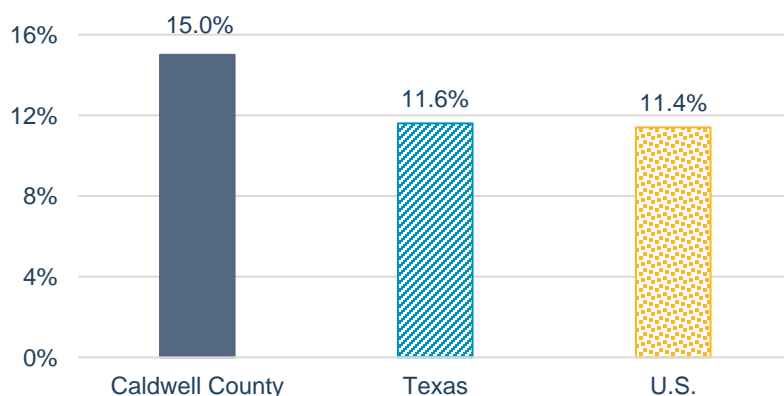
Frequent physical distress is defined as having more than 14 days, in the last 30 days, during which an individual's physical health was considered "not good." A higher proportion of people who report having frequent physical distress may indicate that many people in the community have poor health to the extent that it may inhibit their ability to engage with community life, employment, education, and more.

Although qualitative findings did not explicitly address this indicator, participants described many indicators that may lead to experiences of overall physical distress, including chronic illness or inadequate resources.

In Caldwell County, 15% of adults reported experiencing frequent physical distress, which is higher than Texas (11.6%) and the U.S. (11.4%).

Figure 32

Caldwell County Adults Experience More Frequent Physical Distress Compared to Texas and U.S.



Source. Behavioral Risk Factor Surveillance System, 2018 (Texas and U.S.) and 2019 (Caldwell County).

⁷ Centers for Disease Control and Prevention. (2020) *Disability Impacts All of Us*. Center for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>

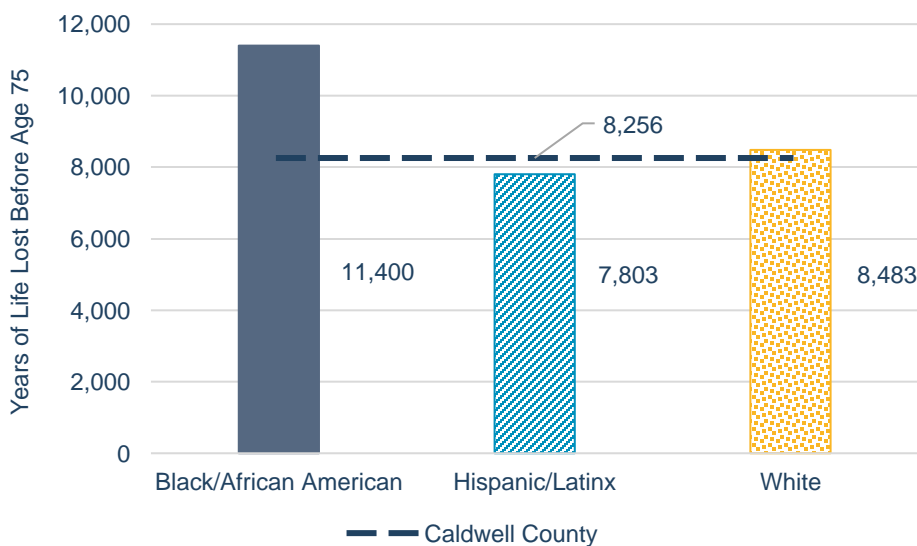
PREMATURE DEATH

The rate of premature deaths is another indicator that was not explicitly discussed in qualitative interviews, but which is notable in quantitative data. Premature death is defined as the years of potential life lost before age 75, per 100,000 people, adjusted for age. A high rate of premature death may indicate additional disparities, such as access to health care, which result in potentially preventable deaths.

Caldwell County has a higher number of premature deaths (8,256 years of life lost), compared to both Texas (6,620 years) and the U.S. (6,907 years). Furthermore, there are racial and ethnic disparities of premature deaths in the county. Black/African American community members in Caldwell County have a rate of 11,400 years of life lost and white community members have a rate of 8,483 years lost. These findings suggest that Black/African American community members may face the greatest barriers to health and wellness, compared to all other racial and ethnic groups in the county.

Figure 213

Black/African American Populations in Caldwell County Have Higher Rates of Premature Death Compared to Other Races and Ethnicities or County Overall



Source. National Center for Health Statistics, 2017-2019.

Conclusion

As part of a collaboration with local hospital systems, SDF contracted with THI to compile and analyze quantitative data for Caldwell County for the 2021-2022 CHNA process. Additionally, THI conducted five virtual key informant interviews, three virtual community focus groups, and one virtual Photovoice project to qualitatively understand the health priorities for Caldwell County.

Both quantitative and qualitative data indicate that Caldwell County has many significant assets and strengths, including an embedded sense of collaboration to meet the needs of others, as well as a history of resiliency. The county also has a strong network of churches and nonprofits that frequently collaborate.

Many community members, however, experience barriers to health care and healthy lifestyles. Caldwell County faces high housing costs, food insecurity, transportation barriers, and racism and discrimination. These factors, plus additional health care-specific barriers, negatively affect health care access for many in Caldwell County. Health care-specific barriers include high costs of care, insufficient provider availability, and a lack of culturally and linguistically appropriate services or providers. Furthermore, Black/African American and Hispanic/Latinx populations in Caldwell County face disproportionate outcomes, such as rates of poverty, Internet access, low birth weight, and premature death. The Luling region (southern Caldwell County) faces disproportionate access to green spaces, transportation, and has worse rates of diabetes and hypertension.

Focus group participants and key informants provided recommendations for health care systems to address the concerns they identified. The recommendations focused on three primary outcomes: (a) improve access to care, (b) address barriers to overall health, and (c) strengthen community trust.

IMPROVE ACCESS TO CARE

To address barriers within the health care system that inhibit the ability to receive affordable, culturally appropriate care that includes urgent and specialty care:

Mobile clinics in rural areas: Offer mobile clinics to better reach rural communities and eliminate transportation barriers.

Urgent care: Establish an urgent care to offer after-hours and weekend emergent care.

Mental health: Improve and expand access to mental health services.

ADDRESS BARRIERS TO OVERALL HEALTH

Environmental, social, and structural barriers to health in Caldwell County include insufficient public transportation, food insecurity, lack of safe green spaces, and unaffordable housing. These barriers inhibit the ability to participate in health care services and to live healthy lifestyles. To address barriers to overall health:

Recreation space: Establish a recreation center that offers free or low-cost classes, work out equipment, and meeting spaces for community activities and physical fitness.

Food: Expand access to affordable and healthy food.

Public spaces: Clean up community parks to make them safer and more accessible across the county.

Public transportation: Improve public transportation services, including through hospital-sponsored buses or vans to connect communities and clinics.

STRENGTHEN COMMUNITY TRUST

Racism and discrimination against immigrant communities pervades both health care and the community in general. This impacts health care access and outcomes, especially among Black/African American and Hispanic/Latinx community members. To strengthen community trust between the health care system and historically marginalized populations:

Partnerships: Engage grassroot organizations who are trusted by the community.

Engagement: Involve local council members to engage historically excluded communities.

Culturally competent workforce: Expand cultural sensitivity training for all providers and hospital staff.

Evaluation of 2019 CHNA

St. David's Foundation last completed Community Health Needs Assessment and Implementation Plans in 2019. Below are the highlights of accomplishments since 2019 that support St. David's Foundation Community Improvement Plans (CHIP).

Priority Area: Improve the health and well-being of children			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Foster the conditions that create positive early experiences for young children, knowing these early experiences are the foundation for later health, social, and economic outcomes.	<p>Inform the public by promoting the science of brain development to guide clinical practice, public policy, and resource decisions.</p> <p>Screen at key intercept points such as pediatric clinics for childhood adversity, relational health, and other related factors.</p> <p>Treat children through a strong therapeutic web that includes specialized treatments that incorporate research on the effects of trauma and adversity, as well as tools to build resiliency, such as parenting supports.</p> <p>Prevent adversity and build resiliency, using avenues such as parent engagement and education campaigns, and engaging children and their communities in their own healing.</p>	<p>Families are supported and have the key services they need to remove sources of stress, strengthen core life skills, and foster positive relationships between children and caregivers.</p> <p>Communities are connected, with built environments and norms that promote social interaction among community members.</p> <p>Stakeholders are informed about the science behind brain development. These stakeholders include practitioners, policy makers, and the general public.</p>	<p>In 2020, access to treatment to address trauma and adversity services more than doubled (123%). This translates to a total of 12,292 children under 18 who received services.</p> <p>In 2020, the number of practitioners trained in trauma-informed care best practices more than doubled (143%). This is equivalent to 460 clinicians utilizing trauma-informed best practices.</p> <p>By 2020, St. David's Foundation increased Brain Story Certifications statewide by 30%.</p> <p>By 2020, St. David's Foundation increased the proportion of local school districts that have incorporated social-emotional learning (SEL).</p> <p>St. David's Foundation is on track to increase home visiting slots in Central Texas by 10%.</p>

Priority Area: Improve the health and well-being of women			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Ensure women and girls are supported with the resources, respect, and conditions vital for equitable health and wellbeing.	<p>Establish Central Texas as a women's health and perinatal safe zone. Lead and join a shared community commitment to protecting women's resources, respect, and conditions regardless of what happens in the broader environment.</p> <p>Center women of color (e.g., listen to them, step back while they drive the agenda, include them at key tables, enable them to tell their own stories, invest in their leadership).</p> <p>Fills gaps in the fragmented safety net women's health system and fund select innovations.</p>	<p>Women and girls of color experience birth equity (including but not limited to equitable outcomes in perinatal care, maternal morbidity and mortality, and newborn outcomes).</p> <p>Women's health safety net policies and programs are less fragmented, resulting in continuity of access between primary care, sexual and reproductive health care, and perinatal care.</p> <p>Women and girls can obtain low-barrier family planning and contraceptive care, including the most effective methods, in clinical and community settings.</p> <p>Communities are empowered to share their own narratives and stories.</p> <p>St David's Foundation women's health work aligns with other issues and movements relevant to the health of women and girls (e.g., improving conditions for caregivers, gender-based violence), expanding intersectional partners and community impact.</p>	<p>By 2020, access to family planning and contraceptive care increased more than doubled (115% and 5,311 people).</p> <p>In 2020, access to comprehensive sex education and pregnancy prevention programming for young adults increased by 29%.</p> <p>By 2020, St. David's Foundation increased the number of leaders attending SDF Women's Health convenings.</p> <p>As of 2020, St. David's Foundation is on track to increase the number of women of color included in key stakeholder convenings and the proportion of grant partner organizations led by women of color.</p> <p>As of 2020, St. David's Foundation is on track to complete the Perinatal Safe Zone engagement plan.</p>

Priority Area: Improve the health and well-being of older adults			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Increase support for older adults to live safely and independently in their own community.	<p>Directly fund services and support the health of organizations providing services to older adults.</p> <p>Build evidence for new models by piloting and evaluating innovative services in Central Texas and demonstrating the “double impact” of intergenerational approaches.</p> <p>Lead new payment models and public system improvement by advocating to MCOs and legislators on the cost-effectiveness of adopting evidence-based services, advocating for increased appropriations for Medicaid services for older adults, and engaging local organizations to advocate for supportive aging policies.</p> <p>Engage and activate community around aging issues.</p>	<p>Older adults remain safe and independent in their homes as they age.</p> <p>Older adults have a better end of life experience.</p> <p>Central Texas supports older adults and engages them as a vital part of the community.</p> <p>Central Texas has an adequate supply of accessible, high quality services for older adults.</p>	<p>By 2020, there was a 74% increase in access to services for older adults to assist them in aging in place. This is equivalent to 22,067 older adults receiving core services such as meals, transportation, and home repair.</p> <p>As of 2020, St. David’s foundation has made progress on the adoption of the CAPABLE model by Central Texas urban and rural counties.</p> <p>As of 2020, St. David’s Foundation added a new metric to increase awareness of the importance of end-of-life discussions and documenting plans.</p> <p>Additional work needs to be done to increase the number of caregivers receiving training and resources and increase access to programs that reduce social isolation.</p>

Priority Area: Improve the health and well-being of rural communities			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Build community capacity while co-creating and investing in long term place-based solutions.	<p>Engage and empower rural communities to strengthen networks and transform policies, practices, and alignment of resources to address prioritized social determinants of health.</p> <p>Build the capacity of people and places including formal and informal leaders within communities and organizations.</p> <p>Strategically invest in solutions that harness community assets to support innovation, ecosystem building, and other promising rural-relevant approaches that can be scaled.</p>	<p>Rural communities have a culture of health that transcends beyond health care access.</p> <p>Rural residents experience strong social connections and are engaged in thriving cross-sector, community-based networks that promote health and well-being.</p> <p>Rural systems undergo change that includes policy, practices, behaviors, and resources to promote health and well-being.</p> <p>Rural organizations have a strong infrastructure in place with adequate capacity.</p> <p>Rural residents are engaged and empowered by diverse civic leadership to activate and improve community well-being.</p>	<p>By 2020, St. David's Foundation established the Bastrop County resident advisory groups for two key issues and develop work plans.</p> <p>As of 2020, the development of a leadership training program co-designed with national and local capacity building organizations is on track.</p> <p>As of 2020, the number of proposals from rural communities across all portfolios has increased.</p> <p>As of 2020, progress has been made to increase philanthropic resources to Central Texas rural communities through the dissemination of network weaving assessments to local and national rural funders.</p> <p>As of 2020, progress has been made to increase capacity of a local nonprofit to serve as a backbone organization for community-led efforts.</p>

Priority Area: Health clinics to become community hubs for health			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Facilitate growth of infrastructure and capacity as clinics transition to serve as community hubs for health.	<p>Provide access to primary care and behavioral health services for the uninsured.</p> <p>Expand capacity of clinics to provide activities, processes, and strategies to improve the care delivery model.</p> <p>Encourage clinics to look outside of their four walls to develop and strengthen community linkages to improve community health and well-being.</p>	<p>The uninsured and underinsured have access to high quality care.</p> <p>Clinics are prepared to incorporate necessary changes to their care models to be able to succeed in new payment approaches that reward value over volume.</p> <p>Patients are satisfied with their experiences as they interact with the primary care health system.</p> <p>Clinics deliver comprehensive primary care and interact effectively outside the clinic to strengthen community linkages and ultimately improve the health and well-being of patients and the population overall.</p>	<p>By 2020, there was an 18% increase in uninsured patients receiving medical care.</p> <p>By 2020, there was a 76% increase in adults receiving dental care.</p> <p>By 2020, the number of patients receiving care coordination services more than tripled (375%).</p> <p>As of 2020, St. David's Foundation is on track to develop and implement a care coordination approach at partner clinics.</p> <p>As of 2020, progress has been made on the proportion of patients receiving care coordination, engagement activities, and medication management at partner sites.</p> <p>Additional work needs to be done to increase the number of partner clinics implementing social determinants of health screening of patients.</p>

Appendix A

	Measurement Period	Caldwell	Texas	U.S.
Demographics				
Total population	2020	45,883	29,145,505	331,449,281
Population by age				
Population 18 and under	2015-2019	23.2%	25.5%	22.3%
Population 19-64	2015-2019	61.9%	61.6%	61.2%
Population 65+	2015-2019	14.9%	12.9%	16.5%
Population by race and ethnicity				
AI/AN, NH	2020	0.3%	0.3%	0.7%
Asian, NH	2020	0.5%	5.4%	5.9%
Black, NH	2020	4.8%	11.8%	12.1%
Hispanic	2020	55.5%	39.3%	18.7%
White, NH	2020	36.1%	39.7%	57.8%
Population in poverty	2015-2019	18.9%	14.7%	13.4%
Households below poverty	2018	15.0%	14.0%	13.0%
ALICE households	2018	39.0%	30.0%	29.0%
Not proficient in English, population	2015-2019	12.0%	13.7%	8.4%
Disabled population	2015-2019	14.2%	11.5%	12.6%
Medicaid coverage	2015-2019	17.5%	16.8%	20.2%
Access to Care				
Uninsured	2019	25.7%	20.7%	9.2%
Uninsured adults	2019	30.0%	24.3%	12.9%
Uninsured children	2019	15.2%	12.7%	5.7%
Lack of prenatal care	2017	32.8%	40.0%	
Dental visit in past 12 months	2018	51.3%	60.7%	67.6%
Preventable hospital stays	2018	6,002	4,793	4,236
Primary care physicians	2018	3,604	1,642	1,319
Dentists	2019	3,359	1,677	1,405
Mental health provider access	2020	1,284	827	383
Other primary care providers	2020	2,079	1,128	942
Health Behaviors				
Physical inactivity	2016-2018	23.3%	23.2%	22.7%
Excessive drinking	2019	18.6%	19.0%	19.2%

	Measurement Period	Caldwell	Texas	U.S.
Binge drinking	2019	17.0%	17.9%	16.8%
Health Outcomes				
Low birthweight	2013-2019	8.6%	8.4%	8.2%
Infant mortality per 1,000 live births	2013-2019	-	5.7	5.8
Child mortality per 100,000 under 18 years	2016-2019	45	50	49
Poor or fair health	2019	28.5%	24.3%	24.6%
Frequent physical distress	2019	15.0%	10.7%	12.6%
Adult obesity	2019	38.1%	35.8%	31.9%
Diabetes prevalence	2019	14.8%	12.2%	10.7%
High blood pressure awareness	2019	34.6%	31.7%	32.3%
New cancer cases	2019	375.9	409.5	449
Poor mental health days	2018	4.4	3.8	4.1
Frequent mental distress	2019	15.0%	12.3%	13.8%
Drug overdose deaths	2017-2019	-	11	21
Suicides	2015-2019	14.3	13.1	13.8
Depression	2019	19.7%	17.7%	19.2%
Suicidal thoughts ⁸	2016-2018	3.8%	3.6%	4.2%
Premature mortality per 100,000 under 75 yr	2017-2019	426	339	339
Premature death (yypl under 75 years)	2017-2019	8,256	6,620	6,907
Life expectancy	2017-2019	77.3	79.2	79.2
Housing				
Homeownership	2015-2019	67.4%	62.0%	64.0%
Severe housing cost burden	2015-2019	14.0%	13.3%	14.4%
Severe housing problems	2013-2017	17.0%	17.0%	17.5%
Housing stability index	2015-2019	0.96	-	-
Housing and transportation affordability ⁹		44.0%	-	53.0%
Broadband access	2015-2019	40.3%	64.4%	68.9%
Black, NH	2015-2019	50.1%	80.0%	78.7%
Hispanic	2015-2019	71.7%	78.0%	82.6%
White, NH	2015-2019	74.4%	84.4%	87.2%
Infrastructure for Healthy Living				
Food environment index	2015 & 2018	7	6	8

⁸ County value is for Texas Public Health Region 7.

⁹ Measurement period not provided.

	Measurement Period	Caldwell	Texas	U.S.
Food insecurity	2019	14.8%	14.1%	10.9%
Limited access to healthy foods	2015	7.7%	8.7%	5.9%
Access to exercise opportunities	2010 & 2019	58.7%	80.5%	84.2%
Social vulnerability index	2018	0.8732	-	-
Community needs index	2021	3.6	-	-
Racism				
Dissimilarity index - Black / White	2015-2019	41	53	61
Dissimilarity index - Non-White / White	2015-2019	21	40	47
Socioeconomic				
High school completion	2015-2019	78.2%	83.7%	88.0%
American Indians and Alaska Natives	2015-2019	96.8%	80.3%	80.3%
Asians	2015-2019	86.9%	88.2%	87.1%
Blacks / African Americans	2015-2019	84.3%	89.8%	86.0%
Hispanics	2015-2019	64.4%	66.4%	68.7%
Non-Hispanic Whites	2015-2019	90.5%	93.9%	92.9%
College graduation	2015-2019	14.6%	29.9%	32.2%
American Indians and Alaska Natives	2015-2019	18.4%	21.2%	15.0%
Asians	2015-2019	13.1%	59.1%	54.3%
Blacks / African Americans	2015-2019	6.9%	24.6%	21.6%
Hispanics	2015-2019	5.6%	15.0%	16.4%
Non-Hispanic Whites	2015-2019	24.4%	38.7%	35.8%
Unemployment	Oct 2021	4.0%	4.8%	4.6%
Income inequality	2015-2019	4.4	4.8	4.9
Median HH income	2020	\$66,128	\$66,048	\$67,340
Transportation				
No car access	2015-2019	4.3%	5.30%	8.6%
Transportation affordability ¹⁰		24.0%	-	27.0%

¹⁰ Measurement period not provided.

Appendix B

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

Table 1: Description of Key Informants	
Key Informant	Community Input Sector
Amy Adams <i>Nurse</i> Texas Department of State Health Services	<ul style="list-style-type: none"> Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
Margaret Carter <i>Community Member</i>	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Apryl Haynes (Germany) <i>Chief Administrative and Nursing Officer</i> Ascension Seton Edgar B. Davis Hospital	<ul style="list-style-type: none"> Persons with special knowledge or expertise in public health
Charity Kittrell <i>Executive Director</i> 4:12 Kids	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Lee Rust <i>Ward 2 Council Member</i> Luling City Council	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Dr. Skyller Walkes <i>Chief of Staff</i> Where We Thrive	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility

The following table describes the focus group participants in aggregate:

Table 2: Description of Focus Group Participants				
Focus Group	Community Input Sector	Description	Number	Language
Lockhart, Texas	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included male and female residents of ZIP codes 78640 and 78644, ages 30-65+, with the majority of participants over 65. Participants self-identified as Mexican/Mexican American/Chicano, Hispanic/Latinx/Spanish origin, and White, Not Hispanic/Latinx.	12	English
Dale and Luling, Texas	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included male and female residents of ZIP codes 78648 and 78616, with ages ranging from 30-65. Participants self-identified as Mexican/Mexican American/Chicano, Hispanic/Latinx/Spanish origin, White, Not Hispanic/Latinx and Black/African American.	6	English
Spanish-speakers	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents in ZIP codes 78616 and 78108, with ages ranging from 30-65. Four participants identified as Mexican, Mexican American, or Chicano and one as Hispanic/Latinx and Spanish origin.	5	Spanish
Photovoice (Youth)	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents in ZIP codes 78644 and 78616. Participants were between 15 and 18 years old. One identified as Mexican, Mexican American or Chicano, one as Hispanic/Latinx and Spanish origin, and one as Black/African American.	3	English

HAYS COUNTY, TEXAS

2021-2022 Community Health Needs Assessment

About Texas Health Institute

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

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Emily Peterson Johnson	Texas Health Institute
Kimberly J. Wilson	Texas Health Institute

The 2021-22 Hays County Community Health Needs Assessment (CHNA) represents the commitment of many partners who have contributed their expertise, resources, and time in support of a shared mission—to make Central Texas the healthiest community for all its residents.

The data collection methodology was co-created through a partnership of health system partners to provide a comprehensive assessment of conditions and opportunities that exist to improve health in Hays County, Texas.

We recognize all of our CHNA partners including St. David's Foundation, Georgetown Health Foundation, Ascension Seton, and Baylor Scott & White. Most importantly, we recognize the many community organizations, agencies, churches, leaders, and community members who assisted with outreach and engagement and shared their time and experience. Texas Health Institute acknowledges the following organizations' contributions to this report:

Community Input Partners

Amigos de Jesús
Barnabas Connection
Buda Food Pantry
First United Methodist Church San Marcos
Hays County Commissioners court
Hays County Food Bank
Hays County Health Department
Hays County ISD (Youth Photovoice)

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Executive Summary

PURPOSE AND METHODS

As part of a collaboration of local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The current CHNA is the fourth one St. David's HealthCare has conducted for Hays County. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act.

CHNAs provide deeper understanding of community health needs—particularly those faced by historically-underserved community members—and are used to inform health care system triennial planning efforts. This report provides an overview of the process and methods used to identify social determinants of health and health needs in Hays County, community assets, and a summary of community member recommendations to address the identified needs.

THI carried out this CHNA between August and December 2021 during an unprecedented time due to COVID-19 and the movement for racial justice. To explore critical health issues, structural factors and underlying causes, THI used a mix of quantitative and qualitative methods including the analysis of publicly available data sets, key informant interviews and focus groups with underserved community members

FINDINGS

Key themes emerged both from community input and a review of quantitative data. In addition, several sub-themes emerged in the review of data that were not raised by participants.

GROWTH

Hays County is growing rapidly, becoming more diverse but also less affordable. All of these changes have an effect on health care access and outcomes for underserved community members. The number of people living in Hays County has grown more rapidly over the past decade than all other counties in the U.S. with populations over 100,000.

- The county's population grew 53% between 2010 and 2020 from 157,377 to 241,067 residents. Almost two-thirds (65.8%) of residents are adults ages 19-64.
- Hispanic/Latinx residents are the largest minority (38.5%) and also accounted for 45% of the total population growth in the county between 2010 and 2020.

- All racial and ethnic groups saw their share of the population grow between 2010 and 2020 except American Indian/Alaska Native and non-Hispanic whites.
- Approximately 1 in 10 Hays County residents were born in a country other than the U.S. Of these, 64% are non-citizens.
- Among residents ages 5 and older, 6.7% have limited English proficiency; the vast majority of these speak Spanish as their primary language.

POVERTY

Hays County has areas of concentrated poverty and households who live above the federal poverty line but earn less than the basic cost of living for the county.

- In 2015 to 2019, 13.7% of residents lived below the federal poverty level, and an additional 30% of households are ALICE, meaning asset limited and income constrained, even though residents are employed.¹
- Hispanic residents are more likely to live in poverty than their white counterparts (17.1% vs. 11.4%).
- The highest concentration of lower income households is in the San Marcos ZIP code tabulation area (ZCTA) with 28% below the poverty line, and an additional 39% of households are ALICE. Seventy percent of Hays County residents living in poverty reside in the San Marcos ZCTA.

HOUSING

Affordable housing affects people's abilities to be healthy and engage with health care. Qualitative participants identified the lack of affordable housing as an important barrier to health in Hays County, especially over the last few years. Participants noted the cost of housing reduced people's ability to be healthy, engage with health care, or pay for other basic costs of living.

- Housing costs have skyrocketed over the last decade and then continued a rapid increase during the COVID-19 pandemic. The median price of homes sold in Hays County increased 27.9% to \$390,000 in a single year (November 2020 to November 2021).
- Median gross rent grew 21% between 2010-14 and 2015-19, while the median value of owner-occupied homes increased 35.9% over the same period.

¹ ALICE: an acronym for Asset Limited, Income Constrained, Employed. ALICE typically describes those who live above the poverty line but earn less than the basic cost of living for their area. For more information on the ALICE methodology and data, visit unitedforalice.org.

- On average, county residents spend 27% of their monthly income on housing costs. However, 15.7% of households spend more than 50% of their monthly income, limiting their ability to afford necessities such as food, transportation, and health care.

COVID-19 and Housing

The COVID-19 pandemic coupled with the rapidly rising cost of housing coupled with job losses has exacerbated financial insecurity for lower-income residents. Focus group participants and key informants noted that many lower-income residents are experiencing increasing rents and home prices, increased financial and food insecurity, and negative effects on mental health. Unemployment, while lower than in some other parts of the U.S., quadrupled during the early stages of the pandemic from 2.7% in February 2020 to a high of 12.3% in April 2020 and remained above 5% through March 2021.

Housing instability (having missed or deferred housing payments or being in serious delinquency) increased during the pandemic from 1.5% of occupied housing units being at risk in January 2020 to 5% being at risk in September and October 2021. In total, around 4,625 households in Hays County are at-risk of losing their homes due to failure to make housing payments. Food insecurity also increased during the COVID-19 pandemic from 12.0% of Hays County residents in 2019 to a projected 14.1% in 2021.

TRANSPORTATION

Lack of public transportation limits access to jobs, health care, and food. While Hays County is one of the fastest growing counties in the nation, participants noted that public transportation options are limited, creating a barrier for accessing health care and food for low-income residents who do not have regular access to a personal vehicle.

Three percent of households do not own a vehicle; for households with only one vehicle family members are limited in their ability to work or access affordable health care services. For several neighborhoods in the San Marcos ZCTA, accessing healthy food is particularly challenging due to a high portion of households not having a vehicle and being located more than ½ mile from the nearest supermarket.

COMMUNITY ASSETS AND STRENGTHS

Hays County has several community assets and strengths, including a strong sense of community. Individuals, local nonprofit organizations, and churches from various denominations are well-networked and coordinate with each other to distribute food and provide social services.

HEALTH CARE ORGANIZATIONS

Hays County's health care resources are located primarily along the I-35 corridor on the southeastern side of the county. Hays County is home to six hospitals in addition to several clinics that serve low-income residents.

NONPROFITS AND COMMUNITY ORGANIZATIONS

Hays County is home to multiple nonprofits and community organizations that play a vital role in building healthy communities by providing educational, health, and social services to community members. Focus group participants identified various local organizations and agencies that have been instrumental in providing resources to address general needs as well as needs that have arisen during the pandemic. Any Baby Can, Hays County Food Bank, Meals on Wheels, and Hays County Independent School District are some of the nonprofits and community organizations mentioned by participants.

CHURCHES AND FAITH-BASED ORGANIZATIONS

Focus group participants noted three churches that provide valuable services historically-underserved community members including: Connection Church, Santa Cruz Catholic Church and the Vincent de Paul ministry of St. Anthony's Catholic Church.

PARKS

Hays County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. Focus group participants mentioned this as an asset for many residents of Hays County. In the Buda and Kyle ZCTA's, over half of all residents live within a 10-minute walk of a park (61% and 73%, respectively); in San Marcos, 45% live walking distance from a park; meanwhile, only 17% of Wimberley residents do so.

PRIORITY HEALTH ISSUES

Community members and leaders identified several priority health issues including depression and anxiety (exacerbated by the pandemic), diabetes, hypertension, obesity, and cancer. Additionally, binge drinking among young adults emerged as a priority health concern in the quantitative analyses.

MENTAL HEALTH

In 2019, almost 1 in 5 (18.7%) Hays County adults reported having a depressive disorder diagnosis at some point in their lives, and 13.4% reported their mental health was “not good” during 14 days or more of the past 30 days. Participants noted the COVID-19 pandemic has exacerbated mental health issues in the community. Data from the Household Pulse Survey supports this, estimating that 29.5% of Texas adults experienced symptoms of anxiety disorder or depressive disorder in December 2021. This number has been as high as 43.4% of Texas adults in January 2021.

DIABETES, HYPERTENSION, AND OBESITY

Eight percent of adults in Hays County have been diagnosed with diabetes. Actual prevalence is likely higher as many adults may be living with early-stage diabetes, undiagnosed due to not having regular access to care. Socioeconomic differences persist with those having less than a high school education being up to three times more likely to have diabetes than their more educated counterparts. Similarly, those earning less than \$50,000 per year are more than twice as likely to have diabetes than those who earn \$50,000 or more annually.

Almost 30% of adult community members in Hays County have diagnosed high blood pressure. Similar to diabetes, the actual prevalence is likely higher due to many living with undiagnosed hypertension. Untreated hypertension can lead to heart attacks, strokes, and other complications.

Obesity is a priority health concern linked to both diabetes and hypertension. Almost one-third (31.7%) of Hays County adult residents are obese, a rate similar to the statewide rate. While county-level data is not available on child obesity, key informants note it is a common issue that would likely lead to diabetes and high blood pressure.

CANCER

Cancer was noted by a few participants as a health issue of concern. While the rate of new cancers as a whole in Hays County (401.3 per 100,000 persons) is slightly lower than the state rate and notably below the national average (449.0), non-Hispanic white residents have a higher rate of prostate cancer than their counterparts statewide (114.2 vs. 98.4).

Additionally, while incidence data for common cancers is not available for Black/African American residents in Hays County, only 3.7% of the population, their rate of cancer deaths is notably higher than that of white and Hispanic/Latinx residents (207.1 vs. 141.3 and 122.6, respectively).

BINGE DRINKING

Almost one-third (32.3%) of Hays County adults ages 18-29 report recent binge drinking, a rate that is more than two times that of 45-64 year-olds and 10 times higher than those over the age of 64.

BARRIERS TO ACCESS

Several barriers impede the ability of historically underserved residents to effectively manage and treat these health conditions. Community members and leaders identified the cost of care and a lack of insurance coverage as two key barriers, along with provider availability. Multiple indicators demonstrate that a significant portion of county residents experience barriers to care.

In 2017, almost 17% of adult residents reported delaying needed health care due to cost in the past year. In addition, the rate of hospital visits for conditions that could be treated in an ambulatory (e.g., non-hospital) environment rose by 20.2% since 2012 for Medicare beneficiaries to 4,243 per 100,000 beneficiaries in 2018.

In Hays County, 16.7% of residents under the age of 65 (and 18.8% of adults ages 19 to 64) are uninsured, and lower income residents are most likely to be uninsured. Underinsurance and irregular insurance are other barriers noted by key informants. Limited options exist for low- or no-cost care and, for adults, are all located along the I-35 corridor, making them difficult to access for low-income residents who do not live in San Marcos or Kyle.

Participants also noted dental care is cost-prohibitive for many with the CommuniCare Health Center – Kyle being the sole option for low-cost basic oral health care in the county.

Provider availability is an important barrier to care, particularly for underserved communities. Hays County is designated as a health professional shortage area for both primary care and mental health. The number of residents per primary care physician grew by 3.7% between 2010 and 2018 from 2,261 to 2,343. The supplies of non-primary care providers, mental health providers, and dentists is also lower than those of the state as a whole and the U.S

RECOMMENDATIONS

Community members interviewed provided a number of recommendations about actions the health care system could take to address the health-related needs:

BUILD TRUST

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

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

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

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

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

INCREASE AFFORDABILITY AND ACCESS

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

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

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

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

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

REDUCE BARRIERS IN THE COMMUNITY

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

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

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

Introduction

St. David's Foundation, on behalf of St. David's HealthCare, is pleased to present the 2021-22 Community Health Needs Assessment (CHNA) for Hays County, TX.

The Patient Protection and Affordable Care Act of 2010 requires all nonprofit health care systems to complete a CHNA every three years. CHNAs provide deeper understanding of community health needs, in particular those faced by historically-underserved community members, and are used to inform health care system triennial planning efforts. The purpose of this CHNA is to offer a comprehensive understanding of the health and social determinant of health needs in the St. David's HealthCare facilities serving Hays County residents and guide the hospitals' planning efforts to address those needs.

St. David's HealthCare has multiple facilities that serve Hays County residents, including St. David's Medical Center, St. David's South Austin Medical Center, and St. David's North Austin Medical Center.

This report provides an overview of the process and methods used to identify priority health and social determinants of health needs of residents in Hays County, along with community assets and recommendations from community members to address the identified needs. The report focuses special attention on the needs of underserved populations, unmet health or social determinants of health, needs and gaps in services, and input from community members and leaders. This assessment recognizes that the social and economic determinants that are the primary drivers of health, as the relative contribution of medical care to health and well-being is only 10-20%, and emphasizes the living conditions are upstream of and surround personal behaviors, disease, and death.

Texas Health Institute (THI) carried out this CHNA between August and December 2021. THI used a mix of quantitative and qualitative methods to identify community health needs, including the analysis of publicly available data sets (Appendix A), key informant interviews, and focus groups (Appendix B) with underserved community members. Content gathered through community focus groups and interview participants is integrated into each report section to which it relates. The quotes reflect the opinion of one or more community members. Findings from this report will be used to identify and develop efforts to improve the health and wellbeing of residents in the community.

METHODS

The 2021-2022 CHNA uses both primary and secondary data to identify the community's priority health needs and strengths through a social determinants of health framework. Health is not only affected by people's genes and lifestyles but by upstream factors such as employment status, housing quality, and policies. In addition, the influences of race, ethnicity, income, and

geography on health patterns are often intertwined. As a result, data was analyzed using an equity lens when possible.

Primary data include qualitative data collected for the purposes of the CHNA. These data were collected directly from the community through focus groups, key informant interviews, and Photovoice interviews. Secondary data include quantitative data collected through publicly available federal and state agencies' databases. Federal and state agencies collected these data through surveys or electronic health records.

PRIMARY DATA COLLECTION AND ANALYSIS

Between August and October 2021, THI virtually conducted eight key informant interviews and two community focus groups with Hays County residents. In addition, THI virtually conducted one Photovoice project and associated focus group. The goal of this work was to learn about local priority health needs and assets and how residents think community health and well-being can be improved.

Focus group participants self-identified as people who are medically underserved, low-income, members of minority populations, or living with chronic disease needs. Adult focus group participants were between 30-65 years old, while Photovoice participants were between ages 14-18 years old.

Key informants (Appendix B) included representatives from health care organizations, community-based organizations, and the local government. THI engaged key informants based on their leadership roles and experience working with medically underserved, low-income, or minority communities served by the hospital system.

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

SECONDARY DATA SOURCES AND ANALYSIS

All quantitative data used for this report is secondary data² and includes data on approximately 35 indicators, many broken down by geography or demographic characteristics when available. Indicator sources are cited for figures, tables, and graphs in this CHNA. Publicly available data sources used:

- American Community Survey

² Data that have already been collected for another purpose.

- Argonne National Laboratory: Housing Stability Index
- Austin Board of REALTORS®
- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Medicare and Medicaid National Provider Identifier Standard
- Center for Neighborhood Technology: Housing +Transportation Affordability Index
- Dignity Health and IBM Watson Health: Community Needs Index
- Feeding America: Map the Meal Gap Study
- Health Resources and Services Administration (HRSA)
- Centers for Disease Control and Prevention (CDC)
- Household Pulse Survey – COVID-19
- National Center for Health Statistics
- Social Vulnerability Index
- U.S. Diabetes Surveillance System
- Substance Abuse and Mental Health Services Administration: National Survey on Drug Use and Health
- United for ALICE
- U.S. Bureau of Labor Statistics
- U.S. Department of Agriculture: Food Access Research Atlas
- U.S. Census Bureau
 - Small Area Income and Poverty Estimates (SAIPE) Program
 - Small Area Health Insurance Estimates (SAHIE) Program

The original sources collected data through surveys or electronic health record systems, and results are often a snapshot in time. The data are self-reported unless otherwise indicated. Each indicator used the most recent data point available for each data source. Multiple years of data were used to calculate the estimates with a larger sample size and more precision. The estimates were calculated by the original data source for all secondary data.

THI selected quantitative data for inclusion in this report based on the availability of confidence intervals at the state and national levels, which allowed THI staff to determine statistical significance (e.g., whether the county-level value was better or worse than the state or national value). For some variables, such as “Adult Obesity,” the confidence intervals were not available at the state or national levels. Consequently, statistical significance could not be calculated. If, however, the county-level value was notably higher than the state and national average, the value was included in this report.

Confidence intervals are included in graphs when data for an indicator has a small population sample. The smaller the population sample, the less certainty about the actual number for the total population, resulting in overlapping confidence intervals. It can be hard to determine any significant change when confidence intervals overlap between categories, such as race and ethnic groups.

Some indicators are broken down by geography based on ZIP Code Tract Areas (ZCTAs), as ZIP code is a common variable across many local and state datasets. A reference map is included in the demographics section. The data analysis typically consisted of calculating proportions and rates, with a 95% confidence interval where appropriate.

SENSEMAKING SESSIONS

THI facilitated a series of three sensemaking sessions with SDF in January and February 2022. These sessions were iterative and included SDF staff and board members, and at least one community leader from Bastrop, Caldwell, and Hays Counties. The sensemaking process provided a structured opportunity for SDF staff, board, and community leaders to begin to sort and make sense of a large amount of information included in the CHNA, and to develop a shared understanding of possible needs and actions. It also provided an opportunity for feedback prior to finalization of the 2021-22 final report.

DATA CONSIDERATIONS AND LIMITATIONS

As with all data collection, there are several limitations that should be acknowledged. Different data sources use different ways of measuring similar variables. There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific groups or at the granular geographic level due to the small sample size.

Crucially, most quantitative data used were collected prior to 2020 and the COVID-19 pandemic, whereas qualitative data were collected in fall 2021. This asynchronicity should be considered when applying the findings of this report, as some quantitative values may have changed between the most recently available year and fall 2021.

Additionally, qualitative data collection occurred through virtual key informant interviews and focus groups for the safety of staff and participants. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. THI staff did extensive outreach to various leaders of community-based organizations in Hays County and potential participants; organizational leaders and residents alike frequently declined participation for a variety of reasons, including research fatigue and fear of exploitation.

In addition, internet access or access to a device that would allow for zoom inhibited some potential focus group participants. Furthermore, in some instances interviews were cancelled due to COVID-19 exposure or infection.

LANDSCAPE AND CONTEXT

Hays County is part of the Austin-Round Rock Metropolitan Statistical Area (MSA). It borders the southern edge of Travis County in Central Texas and also shares borders with Blanco, Caldwell, Comal and Guadalupe Counties. San Marcos, the county seat, is located in the southeastern corner of the county and is approximately equidistant from both San Antonio and Austin.

Six ZCTAs are primarily located within its boundaries: Buda (78610), Driftwood (78619), Dripping Springs (78620), Kyle (78640), San Marcos (78666), and Wimberley (78676). Figure 1 shows the boundaries of these six ZCTAs. These ZCTAs are the basis of sub-county analyses throughout this report.

Figure 1
Hays County ZIP Code Tabulation Area



Source. U.S. Census Bureau, 2021. Map built with ArcGIS.com.

Demographics

The following section explores the demographic profiles of residents of Hays County. Demographics of the community significantly affect its health profile as different race/ethnicity, age, and socioeconomic groups have unique needs and require different approaches to health improvement efforts. All demographic estimates are sourced from U.S. Census Bureau American Community Surveys unless otherwise indicated.

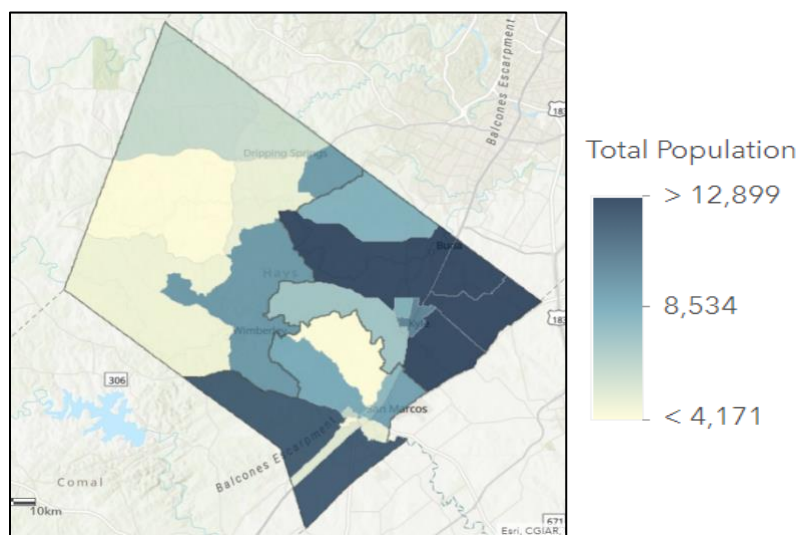
POPULATION

In 2020, 241,067 people called Hays County home, an increase of 83,960 from 2010.

POPULATION GROWTH

Hays County has experienced rapid growth over the past decade. In fact, out of all counties in the U.S. with populations over 100,000, Hays County experienced greatest growth (53%) between 2010 and 2020. Over the same period, Texas grew 8.3% and the United States as a whole grew 7.4%. Travis County, the most populous county in the MSA grew by 26% over the same period. In 2020, 241,067 people called Hays County home, an increase of 83,960 from 2010.

Figure 2
Population Concentration by Census Tract – Hays County

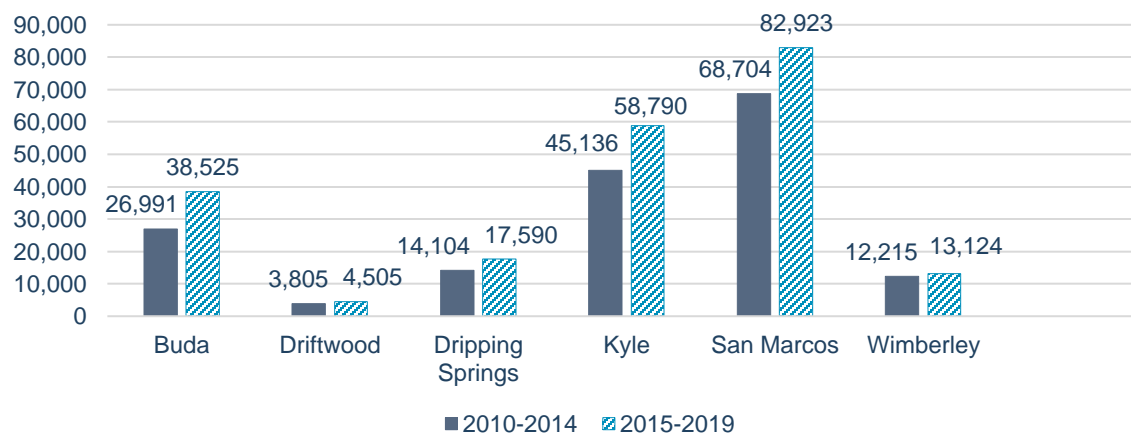


Source. American Community Survey, 2019. Map built with ArcGIS.com.

The San Marcos ZCTA is by far the most populous with 82,923 residents, followed by the two most rapidly growing ZCTAs, Kyle (58,790) and Buda (38,525), both located along the I-35 corridor. Between 2010-14 and 2015-19, San Marcos has grown by 20.7%; Kyle, by 30.3%; Buda by 42.7%; Dripping Springs by 24.7%; Driftwood by 18.4%; and Wimberley by 7.4%, far slower than the others.

Figure 3

Population by ZCTA, 2010-2014 and 2015-2019



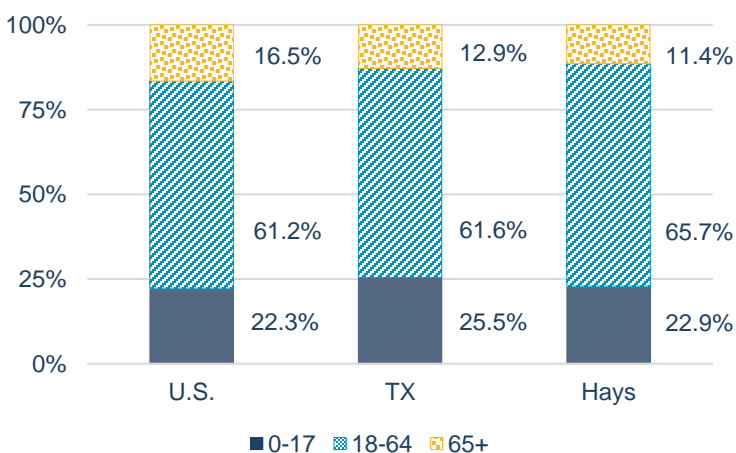
Source. U.S. Census Bureau, American Community Survey, 2010-2014 and 2015-2019.

AGE

Hays County's population consists of a larger portion of adults of working age (19-64) than both Texas and the United States as a whole (65.8% vs. 61.6% and 61.3%, respectively). It also has a slightly smaller elderly population (11.4%) than Texas (12.9%) and the United States (16.5%).

Figure 4

Age Distribution of Population for Hays, Texas and the U.S.



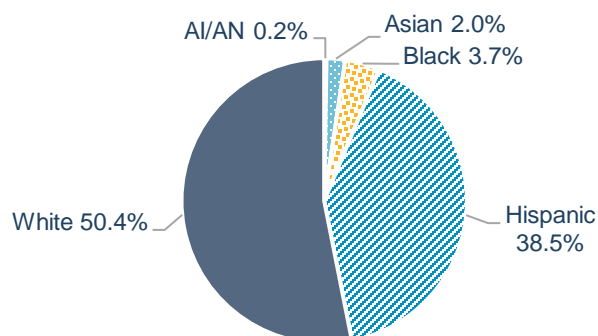
Source. U.S. Census Bureau Population Estimates, 2019.

RACE AND ETHNICITY

Hays County has also become more diverse as the population has grown, visually represented in Figure 5 and Table 1 below. While all racial and ethnic groups increased in absolute size between 2010 and 2020, non-Hispanic whites, the majority population, saw their share of the population decline from 58.6% to 50.4%. Hispanic/Latinx populations accounted for almost 45% of the total population growth adding 37,470 persons, while non-Hispanic whites accounted for 35% adding 29,506.

As the population of Hays County grows more diverse, it does not appear to be getting more segregated as measured by the white/non-white Dissimilarity Index.³ The index value for Hays County is 21 compared to 40 for the state and 47 for the nation.

³ The dissimilarity index is a measure of residential segregation whereby higher values indicate greater segregation between residents of two population groups, ranging from zero (complete integration) to 100 (complete segregation). If an area's white / non-white dissimilarity index is 65, this means that 65% of white people would need to move to another area to make whites and Blacks evenly distributed across all areas. A lower number means a more even distribution.

Figure 5*Race and Ethnicity of Hays County Residents, 2020*

Source. U.S. Census Bureau 2020 Decennial Census Population Estimates.

Table 1*Hays County Grew More Diverse During 2010-2020*

Race or Ethnicity	2010	2020	
American Indian / Alaska Native	0.3%	0.2%	↓
Asian	1.1%	2.0%	↑
Black	3.2%	3.7%	↑
Hispanic	35.3%	38.5%	↑
White	58.6%	50.4%	↓

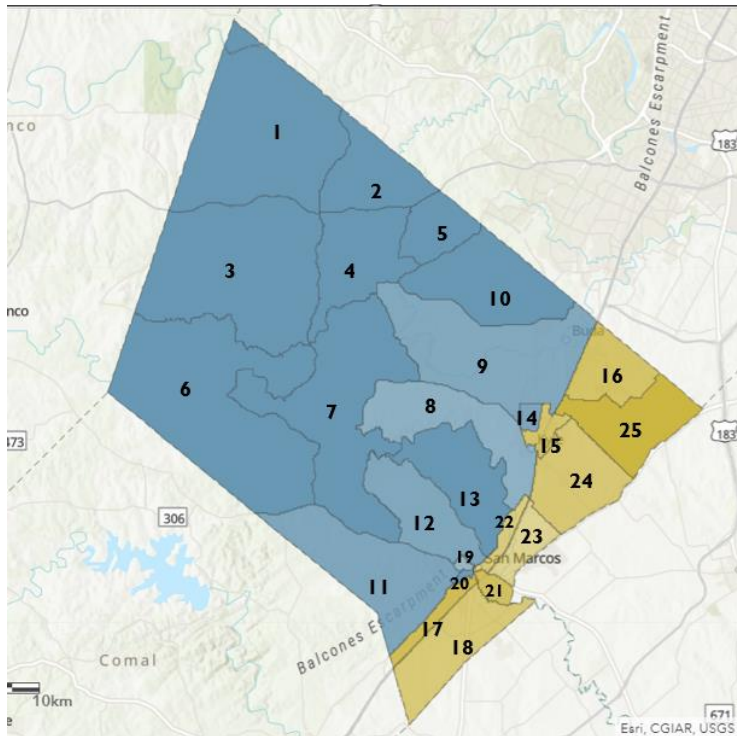
Source. U.S. Census Bureau 2010 and 2020 Decennial Census Population Estimates.

IMMIGRATION, PRIMARY LANGUAGE, AND LIMITED ENGLISH PROFICIENT

An estimated 9% of Hays County residents were born in a country other than the U.S. Of these, 64% are non-citizens. English is the dominant language spoken in Hays County. However, 3.7% of households (and 6.7% of residents ages 5 and older) have limited English proficiency (LEP). Most (85%) of those who have limited English proficiency speak Spanish as their primary language and live in the San Marcos, Kyle, and Buda ZCTAs. The second most common primary language spoken by LEP residents is Arabic (4.7% of LEP residents).

Figure 6

Hispanic/Latinx is the Predominant Racial/Ethnic Population in Hays County Census Tracts Along the 1-35 Corridor



Source. American Community Survey, 2015-2019. Map built with ArcGIS.com View online: <https://arcg.is/0S0zzr>.

Census Tract	% Hispanic / Latinx	% White
1	18.3%	79.3%
2	13.0%	82.2%
3	16.6%	82.2%
4	17.1%	81.4%
5	11.6%	78.4%
6	6.8%	90.8%
7	12.3%	86.1%
8	38.8%	55.0%
9	32.6%	59.4%
10	15.2%	80.7%
11	32.7%	61.3%
12	30.4%	62.2%
13	19.7%	76.1%
14	33.6%	61.0%
15	55.8%	37.4%
16	58.7%	31.5%
17	63.1%	31.8%
18	53.0%	37.1%
19	33.8%	47.2%
20	24.5%	69.0%
21	60.6%	32.0%
22	49.3%	41.8%
23	42.7%	40.2%
24	53.8%	37.3%
25	71.9%	24.7%

Social Determinants of Health

The communities in Hays County are impacted by many social determinants of health, which St. David's HealthCare could affect. Social determinants of health are the conditions in which people are born, grow, work, live, and age, in addition to the wider set of forces and systems shaping the conditions of daily life.

SOCIAL VULNERABILITY AND COMMUNITY NEEDS INDEX

The Centers for Disease Control developed the Social Vulnerability Index (SVI) to measure the potential negative effect on communities caused by external stresses, such as disease outbreaks or human-caused disasters. A number of factors, such as poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss during a disaster. These factors are known as measures of social vulnerability.

CDC uses 15 U.S. census variables to help local leaders identify communities that may need support before, during, and after a natural or human-caused disaster or disease outbreak. These 15 variables are grouped into four separate vulnerability indices across: (a) housing and transportation measures, (b) minority status and language measures, (c) household composition measures, and (d) socioeconomic measures. The four indices are also combined to create an overall index. The index ranges from 0 to 1, with 0 indicating the lowest vulnerability and 1 the highest vulnerability.

Hays County's SVI of 0.4924 indicates a low- to moderate- level of vulnerability. However, there is significant variability within the county, ranging from a very high vulnerability of 0.8794 in the most southern part of the county, to a very low vulnerability of 0.0106 in the northeastern part of the county.

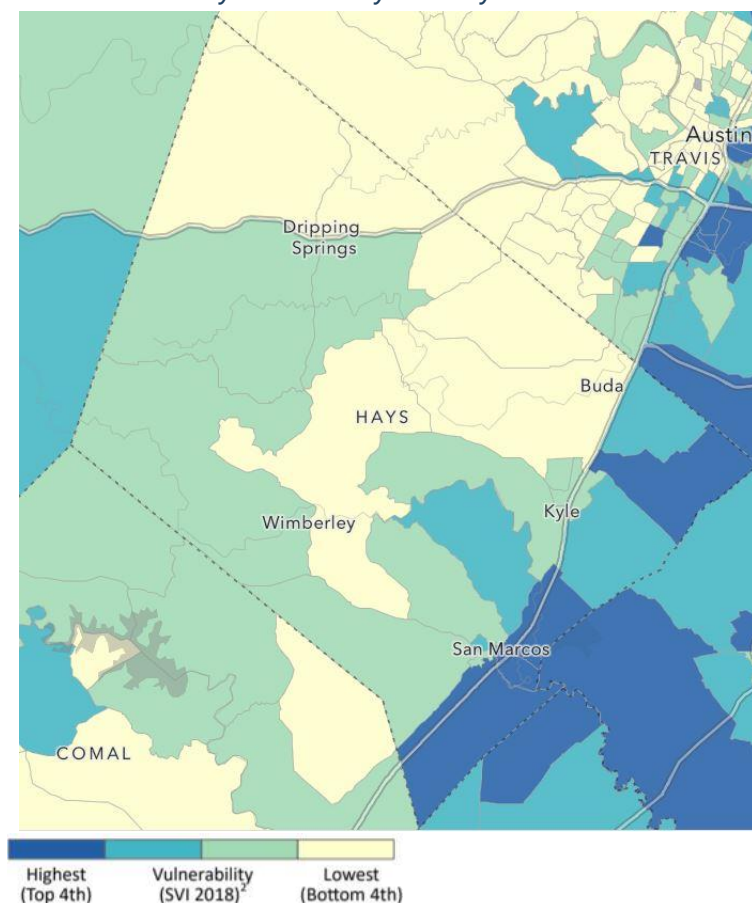


Social Determinants of Health

Source. Centers for Disease Control and Prevention.

Figure 7

Social Vulnerability Index in Hays County



Source. Centers for Disease Control and Prevention.

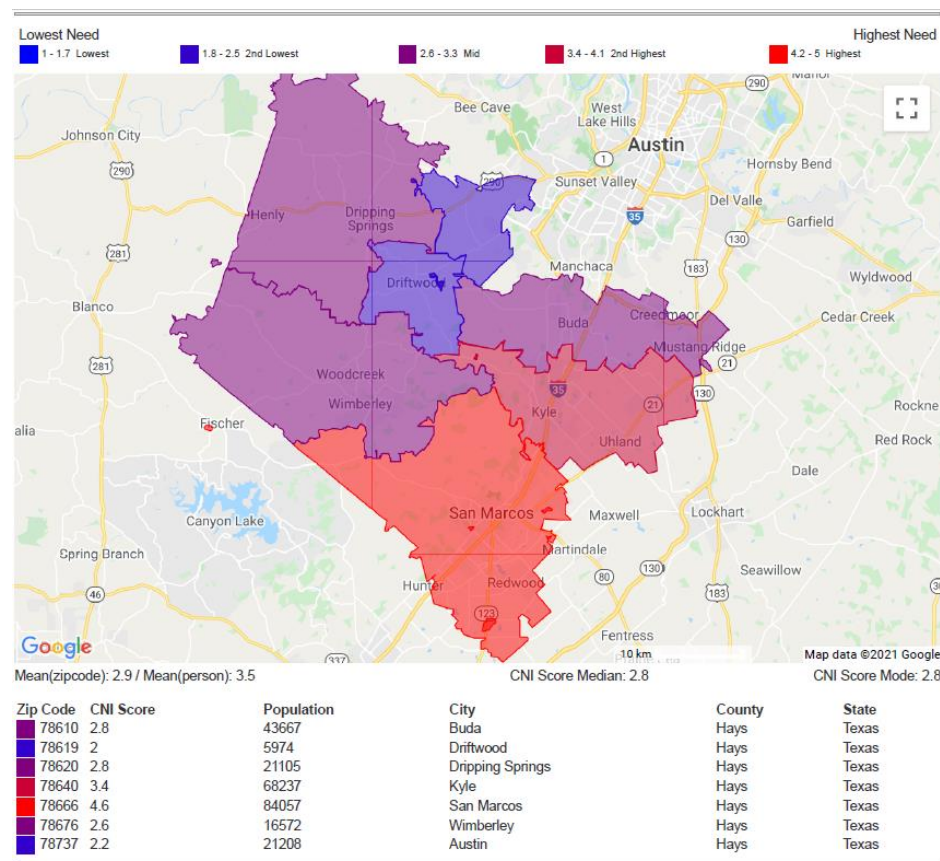
The [Community Needs Index](#) (CNI) was jointly developed by Dignity Health and IBM Watson Health™ to assist in the process of gathering vital socio-economic factors in a community. Based on demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the US national average (score of 3.0).

The CNI is strongly linked to variations in community health care needs and is a good indicator of a community's demand for a range of health care services. The CNI score is an average of five different barrier scores (income, cultural, education, insurance, and housing) that measure various socio-economic indicators of each community using the 2021 source data.

- Every populated ZIP code in the United States is assigned a barrier score of 1-5 depending upon the ZIP code national rank (quintile).

- A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally.
- For all barriers, ZIP codes with scores of 1 or 2 have a smaller percentage of the population facing the barriers than the national average, while ZIP codes with a score of 4 or 5 have a higher percentage, and ZIP codes with a score of 3 have a similar percentage.

Figure 8
Community Needs Index for ZCTAs in Hays County



Source. Dignity Health and IBM Watson.

INCOME

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median incomes are likely to have a greater share of educated residents and lower unemployment rates.

- The median household income in Hays County was \$77,511 in 2020, which was notably higher than the Texas median (\$66,048) and the U.S. as a whole (\$67,340).

- The median household income for Hays County is lower than other counties in the Austin-Round Rock MSA, including Travis (\$82,605) and Williamson (\$91,507), but higher than Bastrop (\$74,612) and Caldwell (\$66,128).
- Differences exist across groups defined by race and ethnicity in particular for Hispanic/Latinx households who have a median household income that is approximately \$12,000 per year lower than that of non-Hispanic whites in 2019 (\$59,625 vs. \$75,082).
- Large differences exist within the county, with median household incomes ranging from \$44,159 in the San Marcos ZCTA to \$132,568 in the Driftwood ZCTA. The large population of college students in San Marcos attending Texas State University could partially explain these differences in household income (37,800 students in 2020).

POVERTY AND ALICE

The Census Bureau sets federal poverty thresholds every year and varies by size of family and ages of family members. A high poverty rate is both a cause and consequence of poor economic conditions. A high poverty rate also indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased tax revenue to the county, poverty correlates with lower quality schools and decreased business survival.

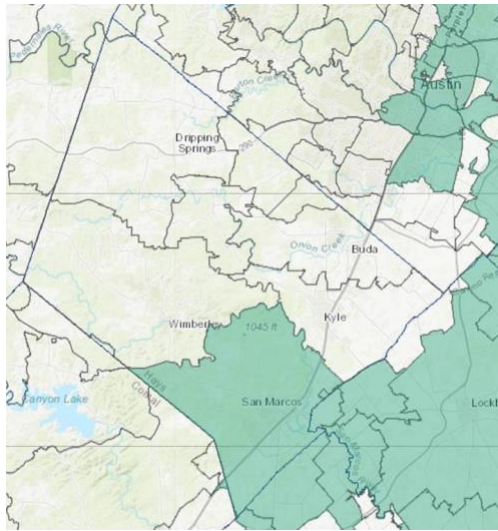
At the individual level, 13.7% of Hays County residents live below the federal poverty level. From 2015 to 2019, Hispanic/Latinx residents were more likely to live in poverty than their white counterparts (17.1% vs. 11.4%,). Although similar to state and national poverty rates, the Hays County average masks important differences at the sub-county ZCTA level.

Within Hays County, the San Marcos ZCTA has the highest proportion of people living in poverty. As displayed in Figure 9, this ZCTA has 14% or more of the population living below the FPL (shown in green). This is a higher percentage than the county-level prevalence of 13.7%.

- The poverty rate in San Marcos is 28% compared to between 4.2% and 9.2% for all other ZCTAs.
- As San Marcos is also the most populous ZCTA, 70% of Hays County residents living in poverty reside in the San Marcos ZCTA.

Figure 9

ZCTAs in Hays County with Greater than or Equal to 14% of Households Living Below FPL



Source. American Community Survey, 2015-2019. Retrieved from UDS Mapper.

In addition to poverty, it is also important to understand the portion of residents who live above the federal poverty level but earn less than the cost of living in their area, measured as ALICE.⁴

ALICE is an important indicator of economic insecurity because it identifies the prevalence of households who struggle to afford essentials like food, housing, or health care, and yet do not meet income qualifications for public assistance programs, such as Supplemental Nutrition Assistance Plan (SNAP). Basic costs of living are defined as the bare-minimum costs for housing, child care, food, transportation, health care, and a smartphone plan.

- In 2018, 14% of Hays County households fell below the poverty level and 30% were ALICE.
- Single person and cohabitating households with no children are most likely to fall below the ALICE threshold in Hays County due to either living in poverty or being ALICE (50%).
- Households headed by individuals 65 years and older are most likely to fall into the ALICE category (38%).

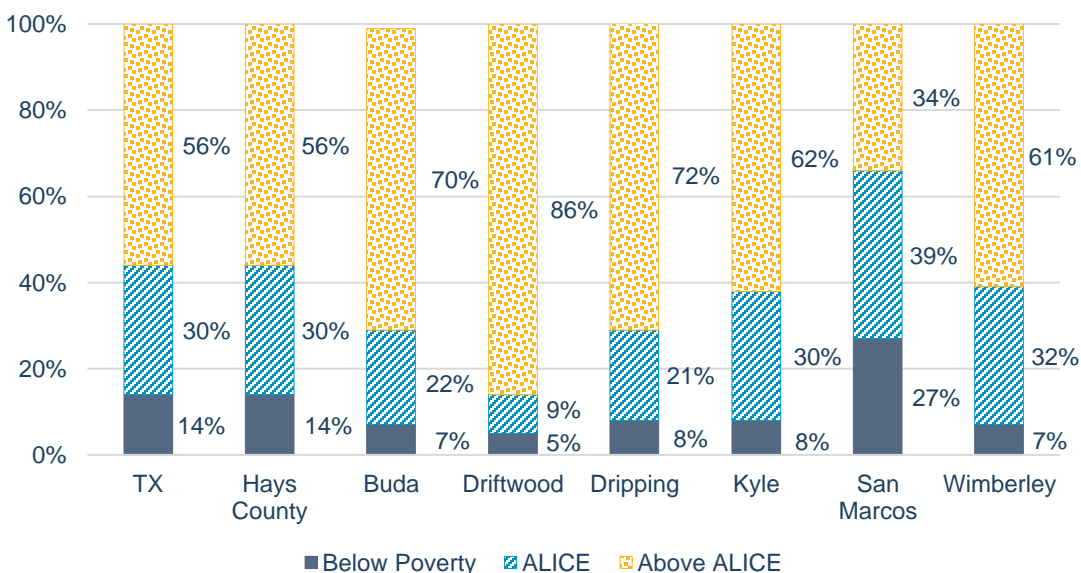
County-level ALICE data masks important intra-county differences as shown in Figure 10. In the San Marcos ZCTA, 27% of households live in poverty while an additional 39% are ALICE; thus, two-thirds of San Marcos households have insufficient assets and income to meet basic cost of

⁴ ALICE: an acronym for Asset Limited, Income Constrained, Employed. ALICE typically describes those who live above the poverty line but earn less than the basic cost of living for their area. For more information on the ALICE methodology and data, visit unitedforalice.org.

living needs in Hays County. This far exceeds other ZCTAs where between 14% and 38% of households fall below the ALICE threshold.

Figure 10

The Percentage of Hays County Households Living Below the Poverty Level and ALICE Threshold is Highest in San Marcos



Source. United for ALICE.

UNEMPLOYMENT

As with many areas of Texas, unemployment in Hays County was low through March 2020, increased early in the COVID-19 pandemic, and then began to fall (Figure 11). However, as of October 2021, Hays County was still experiencing higher levels of unemployment than prior to the pandemic. In February 2020, the Hays County unemployment rate was 2.7%. It jumped to a high of 12.3% in April 2020 and remained above 5% through March 2021. It was still hovering around 3.5% in October 2021.

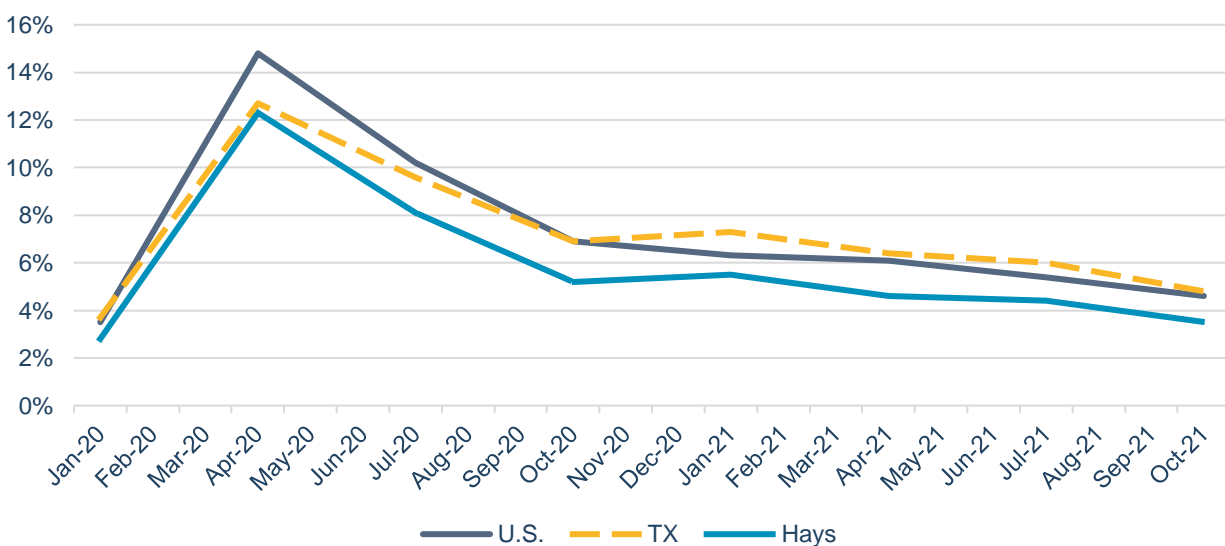
Workers in service industries were the most affected by loss of employment due to the pandemic. While local unemployment data is not available for race and ethnicity, at the national level, Hispanic women (21%), immigrants of all races and ethnicities (19%), young adults ages 16-24 years old (25%), and those without any college education (21%) experienced the greatest job loss during the initial surge in unemployment early in the pandemic.⁵

⁵ Kochhar, R. (2020). *Hispanic women, immigrants, young adults, those with less education hit hardest by COVID-19 job losses*. Pew Research Center. <https://www.pewresearch.org/fact-tank/2020/06/09/hispanic-women-immigrants-young-adults-those-with-less-education-hit-hardest-by-covid-19-job-losses/>.

Focus group participants noted that the prevalence of unemployment during the pandemic intensified financial insecurity, especially among Hispanic/Latinx community members.

Figure 11

Unemployment in Hays County, Texas and U.S.: January 2020 - Oct 2021



Source. U.S. Bureau of Labor Statistics.

HOUSING

Participants in the focus groups and key informant interviews identified the lack of affordable housing as an important barrier to health in Hays County, especially over the last few years. Participants noted that because housing is increasingly unaffordable, people’s ability to be healthy, engage with health care, or pay for other basic costs of living is inhibited. The cumulative effect of these stressors is increased mental stress.

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

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

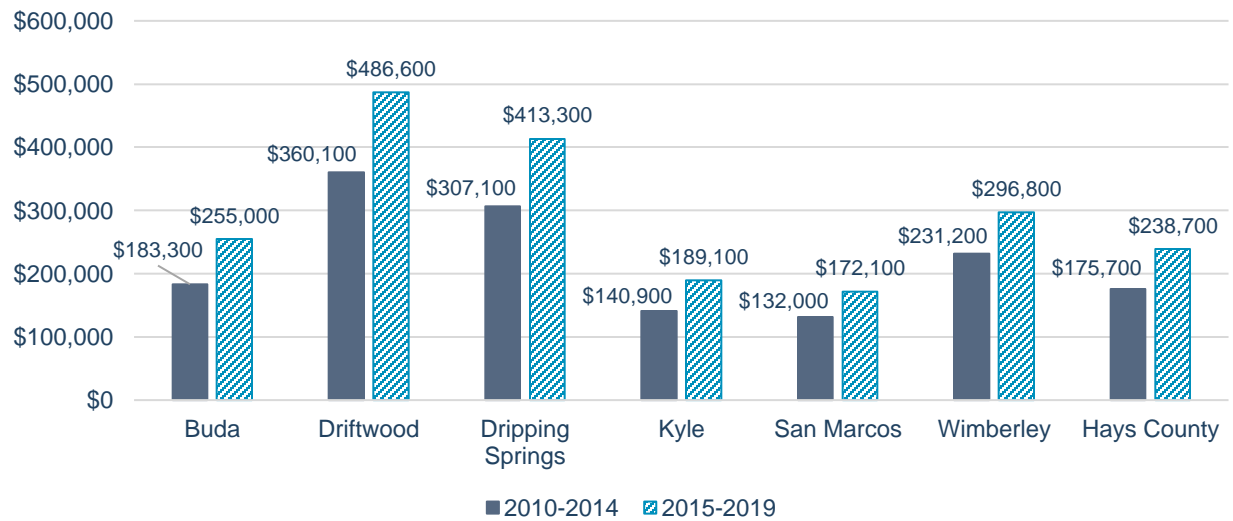
– Key Informant

Note: Due to the lag of 1-2 years in the availability of housing data, we can only provide a partial picture of the rising cost of housing up until 2019. The focus groups and key informant interviews highlighted a more heightened housing affordability crisis that has unfolded during the last two years (2020-21).

- Both median rents and the values of owner-occupied homes in Hays County have skyrocketed in the past five years (2010-2014 to 2015-2019).
 - While median rent in the county was \$954/month on average between 2010-2014, it has increased 21% to \$1,154/ month over the latter five-year period.
 - The median value of owner-occupied homes increased 35.9% over the same period from \$175,700 to \$238,000.
- Important differences in median home values exist at the ZCTA level:
 - The Buda ZCTA experienced the greatest 5-year growth in median home value at 39.1% (current median home value \$255,000).
 - The highest median home values are in the Dripping Springs and Driftwood ZCTAs (\$413,300 and \$486,600, respectively).
- Median gross rent for all types of units saw the greatest growth in Wimberley (33.8%) and Buda (27.2%); Buda (\$1,316) and Kyle (\$1,406) had the highest median rents in 2015-2019. Figures 12 and 13 depict these changes over time.
- Recent data from the Austin Board of Realtors is more indicative of the housing affordability crisis over the last two years:
 - Between November 2020 and 2021, the median price of homes sold in Hays County increased 27.9% year-to-year to \$390,000. In November 2019, the median price of homes sold was \$260,000 (i.e., a 50% growth in median price of homes sold over two years).

Figure 12

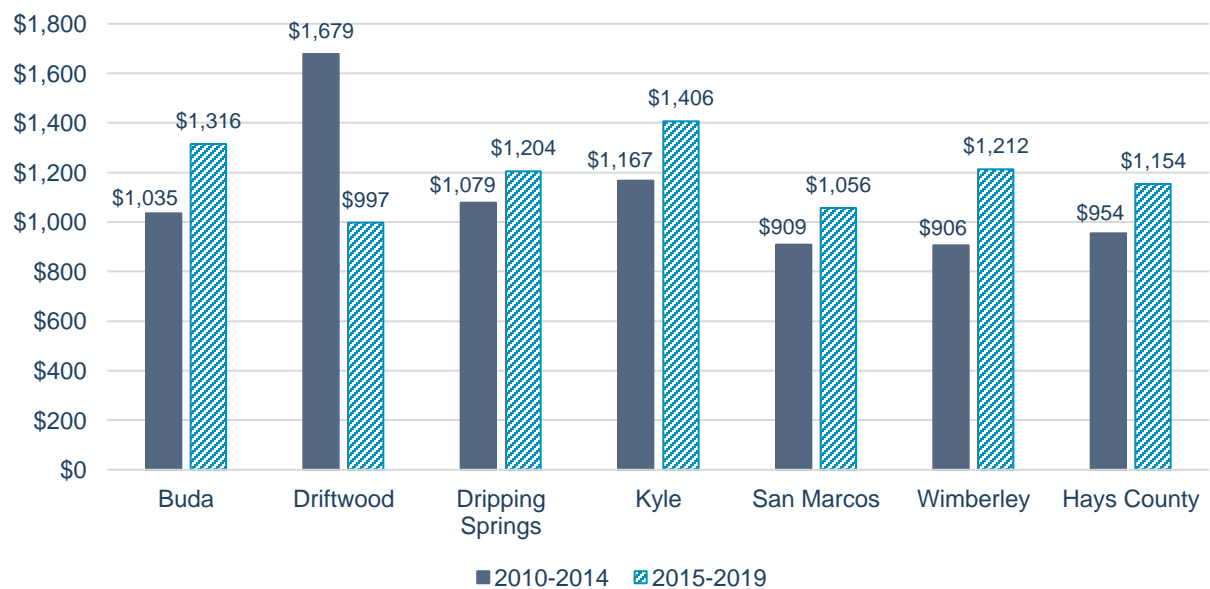
Median Value of Owner-Occupied Homes, 2010-2014 vs. 2015-2019



Source. U.S. Census Bureau American Community Survey.

Figure 13

Median Gross Rent, 2010-2014 vs. 2015-2019



Source. U.S. Census Bureau, American Community Survey.

Increased housing costs become problematic when residents do not experience a similar increase in income, such as in Hays County. The increased home prices and rents are driven largely by area residents moving out of Travis County in search of more affordable housing. However, it is quickly making areas of Hays County that were once considered affordable no longer feasible for lower-income populations.

SEVERE HOUSING BURDEN

On average, Hays County residents spend 27% of their monthly income on housing costs. However, 15.7% experience a severe housing cost burden, defined as spending more than 50% of their monthly income on housing costs. This limits residents' ability to afford necessities such as food, transportation and health care. While this rate has decreased from 19.63% five years ago, the absolute number of households experiencing a severe housing cost burden has stayed approximately the same.

- In 2010-2014 an estimated 12,846 households in Hays County spent more than 50% of their monthly income on housing, while in 2015-2019, 12,358 did so.
- Around 20% of households in Hays County experience one or more of the following: overcrowding, housing costs that are greater than 50% of monthly income, lack of kitchen facilities or lack of plumbing facilities.

Immigrant community members specifically face poor housing conditions, according to participants in the key informant interviews and focus groups. In addition, the growing costs of housing have increased homelessness.

HOUSING INSTABILITY

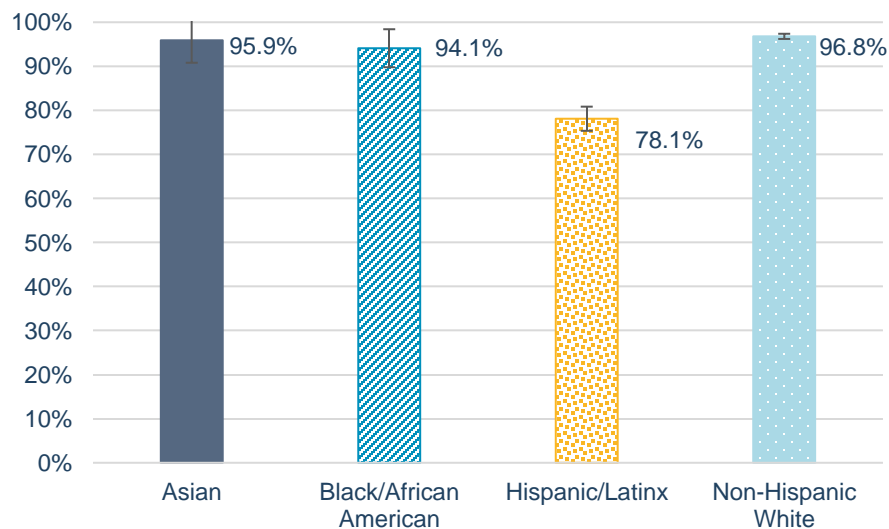
More recently, there is evidence that the COVID-19 pandemic increased housing instability, defined as either having missed or deferred housing payments or being in serious delinquency. Prior to the pandemic (January 2020), 1.5% of occupied housing units were at risk of disruption (3.4% of renter-occupied units and 0.3% of owner-occupied units). In September and October of 2021, 5% were so. This equates to approximately 4,625 households in Hays County being at risk of losing their homes due to failure to make payments.

EDUCATION

Educational attainment is relatively high in Hays County with 90.1% of adults 25 years and older having completed at least high school and 37.2% having a college degree or higher compared to 83.7% and 29.9%, respectively, statewide and 88% and 32.2% at the national level. However, less than 80% of Hispanic adults completed high school (78.1%) county-wide, and in Dripping Springs, less than two-thirds have done so (65.2%). Education attainment varies by race and ethnicity at the county-level as shown in Figure 14 below.

Figure 14

Hispanic/Latinx Residents of Hays County are the Least Likely to Have Graduated from High School

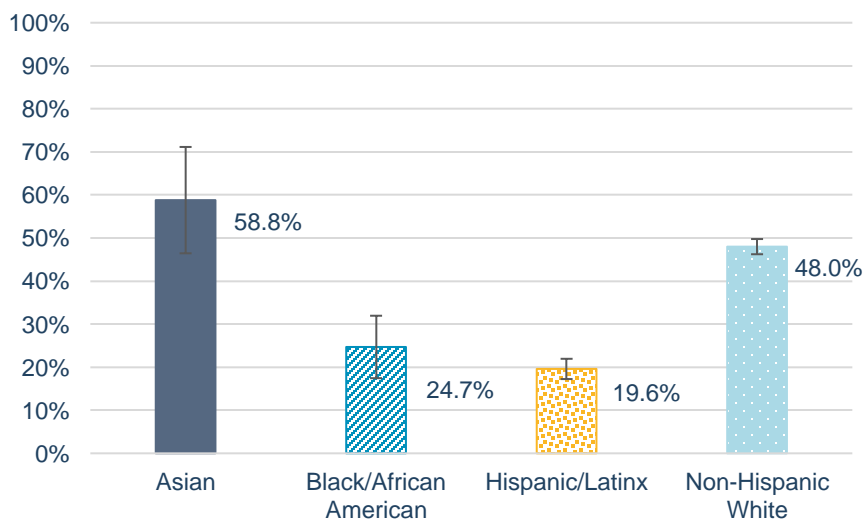


Source. American Community Survey, 2015-2019.

Note: With the exception of Non-Hispanic whites, all other racial groups include individuals who identify as both Hispanic and Non-Hispanic.

Figure 15

Black/African American and Hispanic/Latinx Residents of Hays County are Less Likely to be College Graduates



Source. American Community Survey, 2015-2019.

TRANSPORTATION

Participants identified transportation as a common barrier to health care for many residents of Hays County. Residents spend, on average, 23% of monthly income on transportation. One key informant noted that, although Hays County is one of the fastest growing counties in the nation, there is extremely limited public transportation infrastructure. The Capital Area Service Transportation System (CARTS) service is limited in both hours and available routes (e.g., available during limited windows one to two days per week for routes within the county), and there are no other public options. In addition, the CARTS Interurban Coach, which runs between cities in the 10-county region, runs solely out of San Marcos, on the southeast side of the county.

Furthermore, one key informant noted, “There is no transportation available for someone with a wheelchair in Hays County to go the doctor.” Consequently, disabled community members experience disproportionate barriers to health care access and are more affected by transportation barriers and access to services.

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

– Focus Group Participant

In addition to the lack of public transportation options, participants noted that many residents of Hays County do not have access to personal transportation. In fact, 2.9% of households in Hays County do not own a personal vehicle, ranging from 0.4% (78676) to 5.6% (78666). Even in households that own one vehicle, if someone needs it to get to work, other household members have no transportation to travel to grocery stores or doctor’s appointments. This leads to relying on neighbors or friends for transportation. It is common for multiple households to ride together to pick up food from the food pantry, for example.

“We’ve stuffed four families’ worth of stuff into one car because only one person had access to a car that day.”

– Focus Group Participant

For vehicle-limited households, lack of access to public transportation can also limit people’s ability to work, especially if multiple family members from household need to travel to work. For those who do have access to vehicles, gas and repairs are an additional financial burden. Therefore, needing to drive to San Marcos for affordable health care services at CommuniCare Health Center can be a barrier for many.

FOOD INSECURITY

Data from 2018 indicate that 12.1% of Hays County residents lack adequate access to food. This is slightly lower than the statewide rate (15.0%) but higher than the rate for the U.S. as a whole (11.5%). Food insecurity affects health in two ways:

1. By making it difficult for individuals to maintain healthy diets that are instrumental to managing chronic conditions such as diabetes; and
2. By leading individuals to forgo costly medication in order to feed their families.

Food insecurity increased during the COVID-19 pandemic, and the current rate is likely higher than it was three years ago. Projections from Feeding America's Map the Meal Gap study indicates an increase in food insecurity in Hays County in 2021 to 14.1%, affecting an additional 4,540 people.

Focus group participants identified general financial insecurity and geographic division of food access as two root causes of food insecurity. They also identified food insecurity as a common barrier to health. Participants noted that many residents could not afford healthy food or enough food for their family. One key informant said, "People are making hard choices between medications and eating, or whether or not their kids eat." As a result, families often resort to buying cheaper food even though it is less healthy.

"A lot of times, eating less expensive food is the way to fill your stomach."

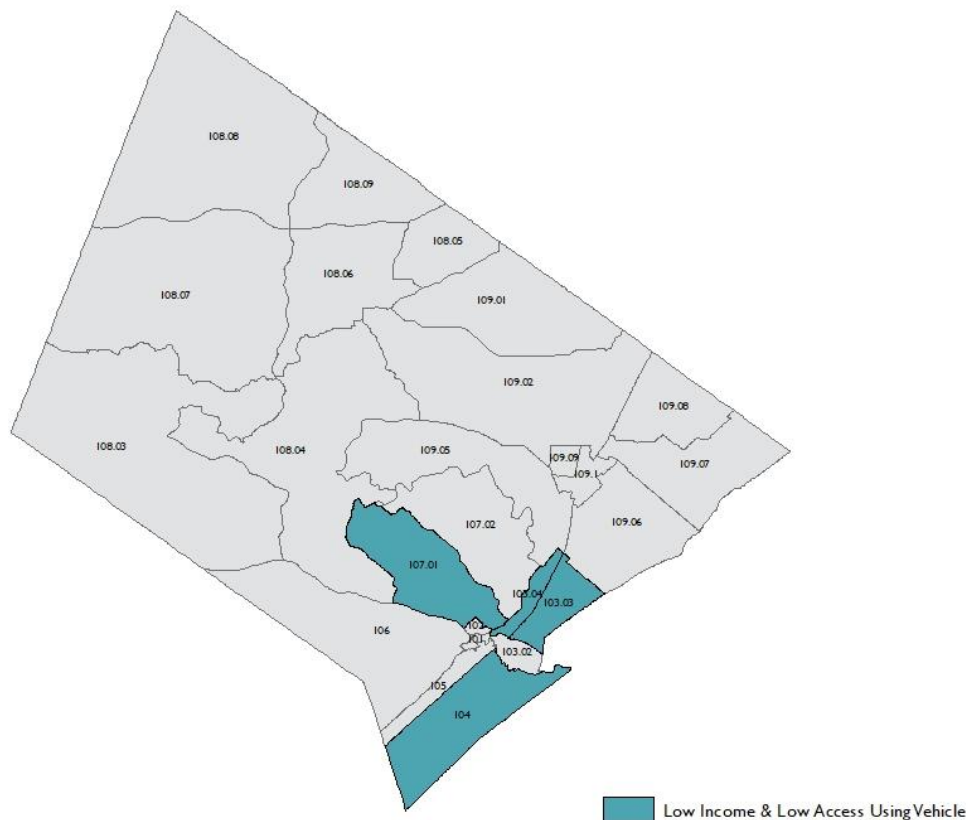
– Key Informant

While many community members use the Hays County Food bank, which makes an effort to include fresh produce and healthy options with each distribution, the quantity of food provided does not meet the needs of larger families. Similarly, school districts distributed breakfast and lunches for families during remote learning for the 2020-21 school year, but many families struggled to take advantage of this because "there's only one vehicle in the household, and whoever takes that to work has the vehicle," according to one key informant.

In addition to the food pantries, some community members are able to get assistance with food through public benefits such as SNAP—Supplemental Nutrition Assistance Program. Yet, while some families qualify for benefits based on income, many families are not able to access SNAP due to their immigration status. For example, in November 2021 6,155 Hays County residents received SNAP benefits while 14,364 were eligible to do so, according to the Texas Health and Human Services Commission web site.

With respect to geographic access, participants noted that communities on the eastern side of I-35 have fewer groceries stores compared to those on the western side. Three neighborhoods in particular are officially designated by the U.S. Department of Agriculture as low income with

Figure 16
Hays County Census Tracts that are Low Income with Low Food Access



Source. U.S. Department of Agriculture, 2019.

INTERNET ACCESS

Increasingly, activities of daily life require a stable, fast broadband connection. This became even more important during the COVID-19 pandemic when schools transitioned to remote learning, the use of telehealth increased, and many employees began to work from home.

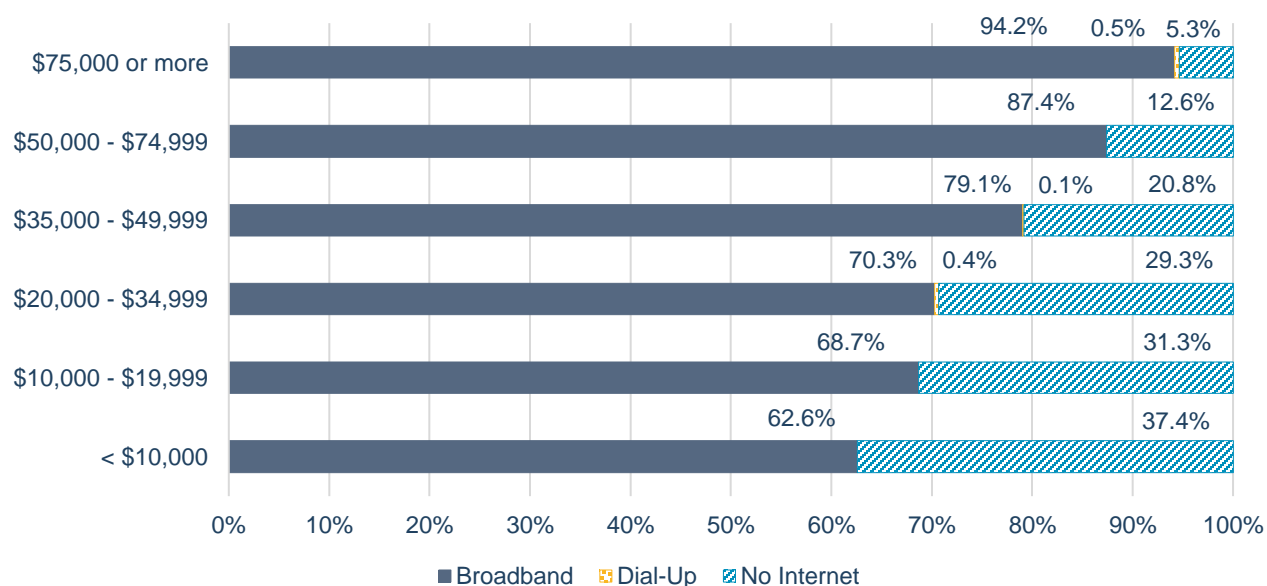
- In Hays County, 72.3% of households had broadband access, defined as having a DSL, fiber optic or cable internet subscription, in 2015-2019.
- About 1 in 10 households in Hays County (9.8%) have no internet connection at all and another 8.3% access the internet solely via a cellular data plan.
- There are differences in internet access by income and race/ethnicity:
 - While 94.2% of households with income \$75,000 or greater have broadband access, those earning less than \$10,000 are far less likely to have access (62.6%).

- Over 30% of households earning less than \$20,000 have no internet connection at all, while only 5.3% of those earning \$75,000 and greater lack a connection.
- Hispanic/Latinx and Black/African American residents are more likely to live in households lacking internet access: 20.5% and 35.4% respectively.

Figures 17 and 18 below highlight variation in internet access by income and race and ethnicity.

Figure 17

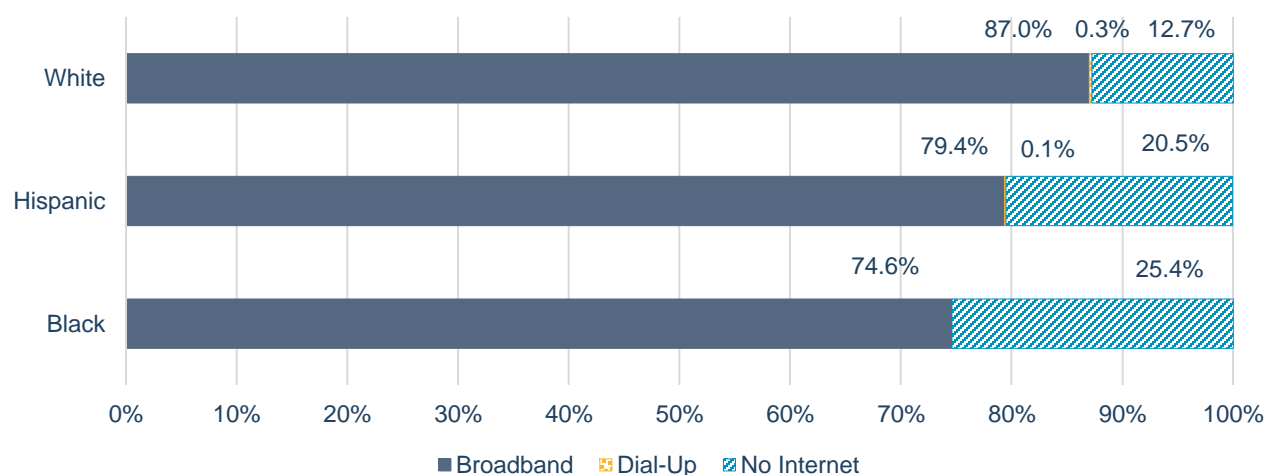
Low-Income Households in Hays County are the Least Likely to Have Internet Access



Source. U.S. Census Bureau, American Community Survey.

Figure 18

Black/African American and Hispanic/Latinx Households are Less Likely to have Internet Access



Source. U.S. Census Bureau, American Community Survey.

RACISM AND DISCRIMINATION

Based on input from focus group participants and key informant interviews, lack of cultural knowledge and sensitivity of health care providers is an issue faced by many minority community residents. Participants highlighted situations where they have encountered discriminatory speech and treatment from health care providers due to their immigration status. Other participants mentioned immigrants may be reluctant to give out personal information for health care or social services because of fears of deportation and consequently, will not visit doctors or social service agencies. Such interactions with providers can reduce the likelihood that individuals seek needed care in the future.

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

– Focus Group Participant

Additionally, LGBTQ+ people in Hays County experience discrimination in health care settings, and transgender residents in particular face significant challenges because “they will receive poor treatment, or no treatment, or inappropriate treatment.” This may include being misgendered, having hormone therapy disrupted “without any good reason,” or being ridiculed by providers.

There is a need for more health care providers who are responsive to LGBTQ+ culture (e.g., knowledgeable about pronoun preference) and equipped to treat health issues specific to the LGBTQ+ community and transgender residents (e.g., hormone replacement therapy).

Community Assets and Strengths

Hays County has several community assets that should be considered as part of any community health needs assessment. Focus group and interview participants noted that Hays County has a strong sense of community and residents demonstrate a priority to take care of each other. Individuals, local nonprofit organizations and churches from various denominations are well-networked and coordinate with each other to distribute food and provide social services. Focus group participants noted that the county's population growth has brought in more financial resources. The influx of people with higher incomes presents an opportunity to tap into private wealth for the greater good. Finally, participants noted that Hays County is home to a wide age range of people. With large populations of both college students and retirees, the generational diversity can be leveraged to strengthen the networking and mutual aid happening in the area.

HEALTH CARE ORGANIZATIONS

Hays County's health care resources are located primarily along the I-35 corridor on the southeastern side of the county. They include several hospitals:

- Ascension Seton Hays
- Baylor Scott and White Medical Center – Buda
- CHRISTUS Santa Rosa Health System – San Marcos
- Kyle ER and Hospital
- Warm Springs Rehabilitation Hospital of Kyle
- Wellbridge Hospital of San Marcos

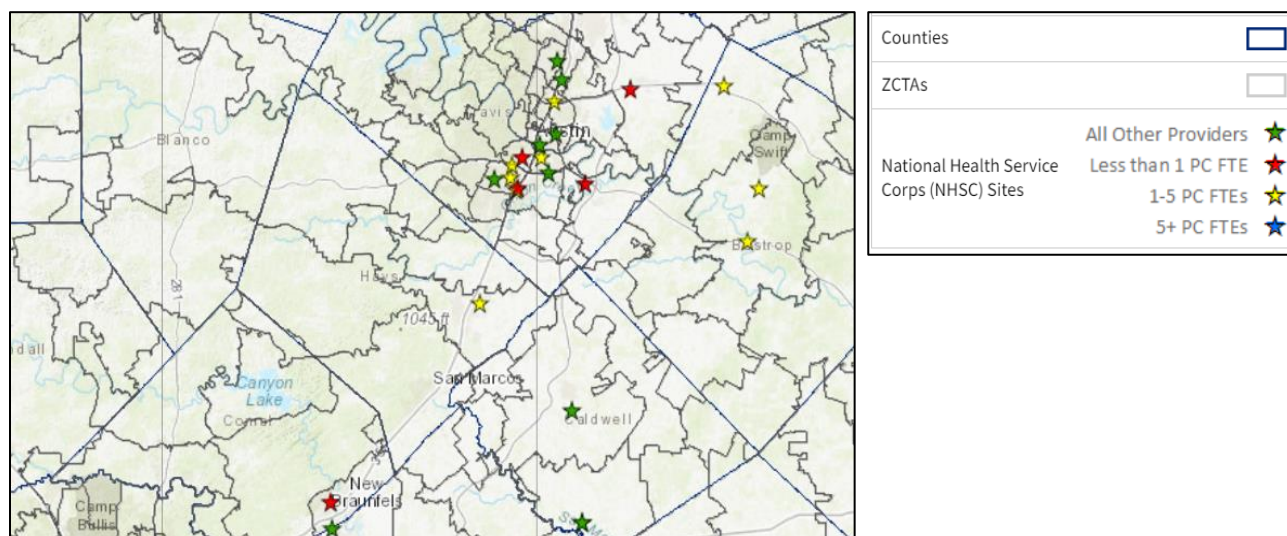
The county is also home to a number of clinics that serve low-income residents. The following were mentioned specifically by focus group participants:

- CHRISTUS Trinity Clinic (San Marcos)
- CommuniCare Clinics (San Marcos and Kyle)
- CommuniCare Clinic (Wimberley – provides pediatric care only)
- Live Oak Clinic (San Marcos)

In addition, Hays County has one National Health Service Corps (NHSC) site, CommuniCare Health Center in Kyle. The NHSC designation is given by HRSA for a clinical site, typically a federally qualified health center, which is located within a Health Professional Shortage Area (HPSA) and can provide services to people without regard for their ability to pay.

Figure 19

National Health Service Center Sites in Hays County and Surrounding Areas



Source: Health Resources and Services Administration, 2021. Map built with UDSMapper.org.

NONPROFITS AND COMMUNITY ORGANIZATIONS

Nonprofits and community-based organizations in Hays County play a vital role in building healthy communities by providing educational, health, and social services to community members. Focus group participants identified various local organizations and agencies that have been instrumental in providing resources to address general needs as well as needs that have arisen during the pandemic. Below is a list of organizations identified by participants:

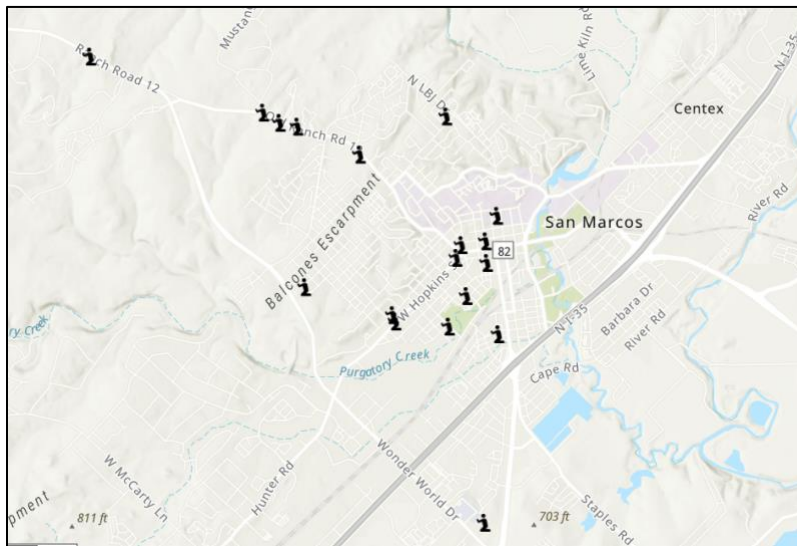
- Amigos de Jesus Mercado
- Any Baby Can
- Barnabas Connection
- City of San Marcos
- Community Action
- Greater San Marcos Youth Council
- Hays-Caldwell Women's Center
- Hays County Independent School District
- Hays County Food Bank
- Hill Country Mental Health and Developmental Disabilities Center
- Meals on Wheels
- Out Youth in Austin, TX
- Southside Community Center
- Women, Infants, and Children (WIC)

Planned Parenthood was also noted as a valuable resource. However, the closest location is in South Austin (Travis County).

CHURCHES AND FAITH-BASED ORGANIZATIONS

Focus group participants noted three churches that provide valuable services historically-underserved community members including: Connection Church, Santa Cruz Catholic Church and the Vincent de Paul ministry of St. Anthony's Catholic Church. In addition, the map below displays the geographic distributions of places of worship within the City of San Marcos, which has the highest concentration of poverty in Hays County.

Figure 20
Places of Worship in San Marcos



Source. OpenStreetMap Amenities for North America. Retrieved December 17, 2021.

PARKS

Hays County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. Focus group participants mentioned this as an asset for many residents of Hays County. In the Buda and Kyle ZCTA's, over half of all residents live within a 10-minute walk of a park (61% and 73%, respectively); in San Marcos, 45% live walking distance from a park; meanwhile, only 17% of Wimberley residents do so. Data is not available on park access for Driftwood and Dripping Springs.

Priority Health Needs and Barriers to Care

The health issues and barriers to health care access and healthy lifestyles experienced by Hays County residents could be influenced by St. David's HealthCare through policy or system-level changes and collaboration with community partners.

KEY HEALTH ISSUES

Hays County residents are doing well relative to the state of Texas and the nation on a number of health outcomes. They have lower rates of premature mortality, child mortality, drug overdoses, infant mortality, child mortality, and low birthweight (Appendix A). There are, however, several health issues which merit attention.

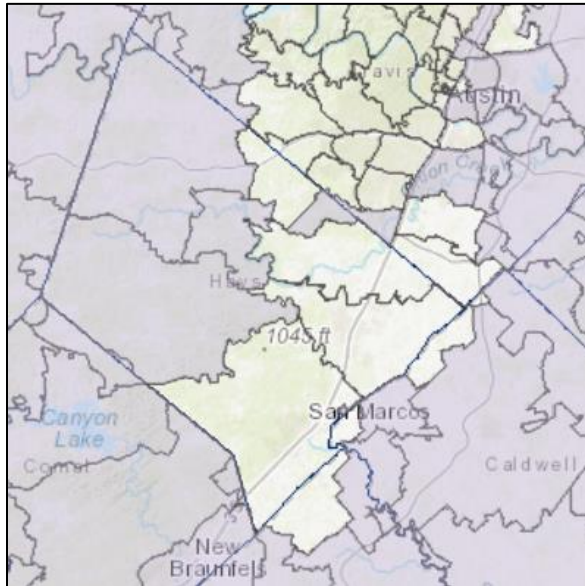
DIABETES

Participants in focus groups and key informant interviews identified diabetes as a priority health condition in their community, noting a perceived higher prevalence of diabetes in both Hispanic/Latinx and Black/African American communities of the county. The prevalence of diagnosed diabetes among adults in Hays County is 8.3% among adults 20 years and older, which is 2 percentage points lower than the state prevalence. However, quantitative data for Public Health Region 7 (the region in which Hays County is located) indicate the underpinnings of these differences are likely socioeconomic in nature, rather than due to race and ethnicity.

- Texas adults in Public Health Region 7 with less than a high school education (21.4%) are over two and three times more likely to have diabetes than those with at least some college education (8.4%) and those who have graduated college (6.8%), respectively.
- Adults earning less than \$50,000 per year are more than twice as likely to have diabetes as those who earn more \$50,000 or more annually (16.5-16.8% vs. 6.5%).

Figure 21

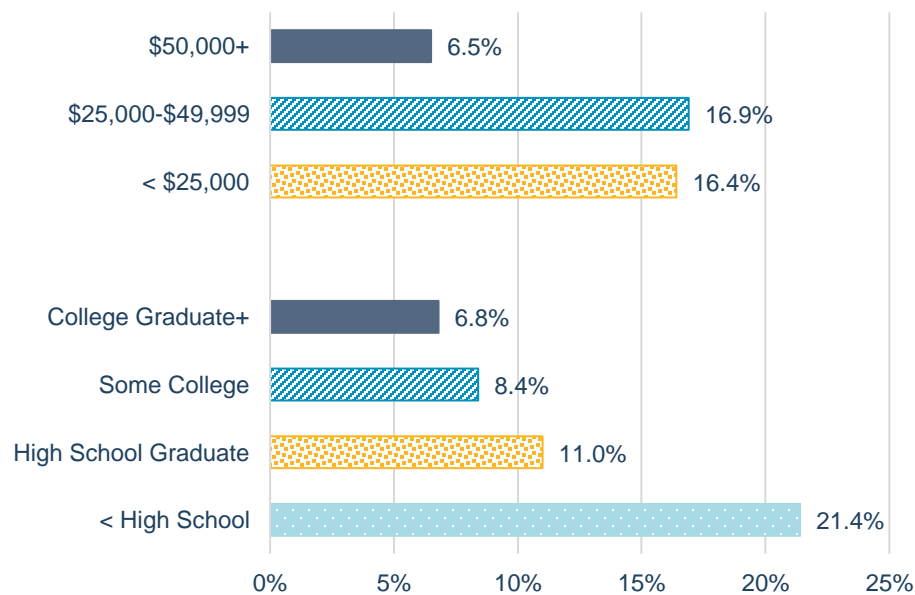
Areas of Hays County with the Highest Prevalence of Diabetes



Source. Behavioral Risk Factor Surveillance System, 2018; American Community Survey, 2015-2019. Map built with UDSMapper.org.

Figure 22

Diabetes Prevalence by Income and Education Attainment, Adults: TX Public Health Region 7



Source. U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.

The connection to race and ethnicity is that Hispanic/Latinx and Black/African American community members are more likely to fall into lower income and education strata than white community members. Participants noted that the primary driver behind the higher rates of diabetes in their community was challenges with nutrition and food insecurity and difficulty affording diabetes medications.

Note: The rates in Figure 21 are for diagnosed diabetes. Where communities experience barriers to accessing health care, rates of undiagnosed diabetes and prediabetes can be significant. This is important, as it is possible to reverse prediabetes through medication and lifestyle changes. In addition, diabetes identified at earlier stages is easier to treat and results in delaying or preventing the onset of complications that lower quality of life and are expensive to treat.

HYPERTENSION

The second most commonly identified health priority was hypertension. Participants noted hypertension is common among the entire population, including younger community members, an observation corroborated by the quantitative data. According to BRFSS data, slightly less than one third (29.0%) of community members report having been told they have high blood pressure by a health care professional. This is equivalent to the rate in Texas, but slightly lower than the rate nationally (32.3%).

However, because hypertension is generally asymptomatic, knowing that one has it is dependent upon having regular access to health care, which, as will be discussed in the next section, is not the norm for many community members in Hays County. Thus, many residents likely have high blood pressure and are not aware of it. Diagnosing and treating hypertension is not difficult or expensive. Untreated hypertension, on the other hand, can lead to heart attacks, strokes, and other complications.

OBESITY

Obesity is another priority health condition linked to both diabetes and hypertension. The prevalence in Hays County among adults is similar to the state rate (31.7% vs. 31.4%). Both are higher than the rate nationally (29.7%). Participants noted it being an issue in younger community members, as well. One key informant said, “I’m seeing obesity a lot in the younger population. So they don’t have other conditions [like diabetes or hypertension] yet, but they will soon.”

Other participants described increased incidences of weight gain among school-aged children specifically as a result of the COVID-19 pandemic, which has increased food insecurity, intensified chronic stress, and led to fewer activities being done outside the home.

MENTAL HEALTH

Participants in the focus groups and key informant interviews identified mental health as another health priority for Hays County, specifically challenges with anxiety and depression. They noted that the rising needs of mental health directly relate to the COVID-19 pandemic.

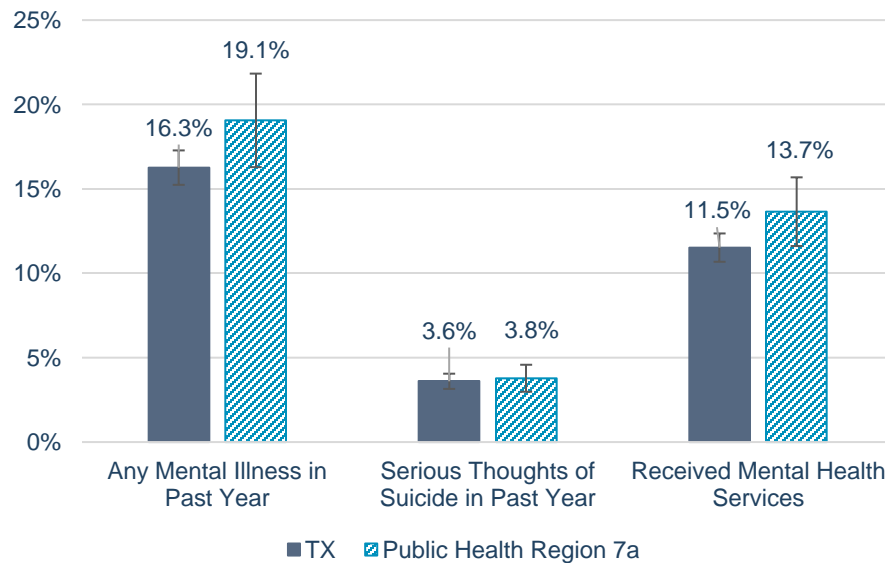
- According to modeling using 2019 BRFSS data, almost 1 in 5 (18.7%) adult community members in Hays County have been diagnosed with a depressive disorder at some point in their lives. Hispanic adults are less likely to report a depression diagnosis than white adults.
- In 2019, 13.4% of Hays County adults reported their mental health as being “not good” 14 days or more in the past 30 days.
- Rates of mental illness, thoughts of suicide, and receipt of mental health services are similar in Public Health Region 7a (including Hays County) compared to the rest of Texas. Data for these indicators are not available at a county level.

The prevalence of poor mental health is likely higher than the most recent available BRFSS data, given the impact of the COVID-19 pandemic. Estimates from the Household Pulse Survey, which CDC has administered on a rolling basis throughout the COVID-19 pandemic, estimates that 29.5% of Texas adults experienced symptoms of anxiety disorder or depressive disorder as recently as December 2021. This percentage was previously as high as 43.4% of Texas adults in January 2021.⁶ At the national level, women reported higher rates of symptoms than men (33.8% vs. 27.5%), and adults ages 18-29 had rates substantially higher than all other age categories (44.5%).

⁶ Household Pulse Survey. *Anxiety and Depression*. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>.

Figure 23

Rates of Mental Illness, Thoughts of Suicide and Mental Health Services in Public Health Region 7a are Similar to Texas



Source. Substance Abuse and Mental Health Services Administration, National Survey of Drug Use and Health, 2016-2018.

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

– Key Informant

When asked to identify the root causes of mental health-related challenges, participants noted three factors:

Residents face general financial insecurity; one Spanish-speaking focus group participant said, “I think many people have depression because of the pressure they face in paying rent, bills, car insurance, and their phone bills.”

Isolation increased due to COVID-19; one key informant noted that isolation brought on by the pandemic “has been very difficult even for people who were previously pretty healthy.”

There is a lack of mental health providers in Hays County, especially providers who accept Medicaid or offer affordable self-pay options.

- There is one dedicated mental health treatment facility in the county, located in San Marcos. Access to mental health providers is a statewide problem.
- The county’s population-to-mental health provider ratio is 971:1 whereas it is 827:1 across the state. Both are much higher than the national ratio of 383:1.

- Given these supply issues, waitlists for available providers are often multiple months long, making their services inaccessible for many community members.

CANCER

Some participants mentioned cancer as a health issue of concern in Hays County, but it did not rise to the level of being a priority in the qualitative analyses. Similarly, the rate of new cancers in Hays County is slightly lower than that of the state as a whole (401.3 per 100,000 persons vs. 408) and notably below the national rate (449 per 100,000).

- Hispanic/Latinx community members have lower rates of overall cancer incidence than white and Black/African American members, as well as lower rates of breast (94.9), lung (22.7), prostate (76.4) and colorectal (43.5) cancer than do non-Hispanic white residents (134.3, 48.0, 114.2 and 33.1, respectively) in 2014-2018.
- Non-Hispanic white residents of Hays County have a higher prostate cancer incidence than their counterparts statewide (114.2 vs. 98.4 per 100,000) while lung cancer incidence is lower than that found across the state (48.0 vs. 58.6).

Incidence data for these common cancers is not available for Black/African American residents for Hays County. However, the rate of cancer deaths (all cancers) is notably higher for Black/African American residents than it is for the other two groups (207.1 vs. 141.3 and 122.6 for white and Hispanic/Latinx residents, respectively). While Black/African American residents make up only 3.7% of the population in Hays County, this higher rate of death is indicative likely of either later stage diagnosis or lower quality care and merits a mention.

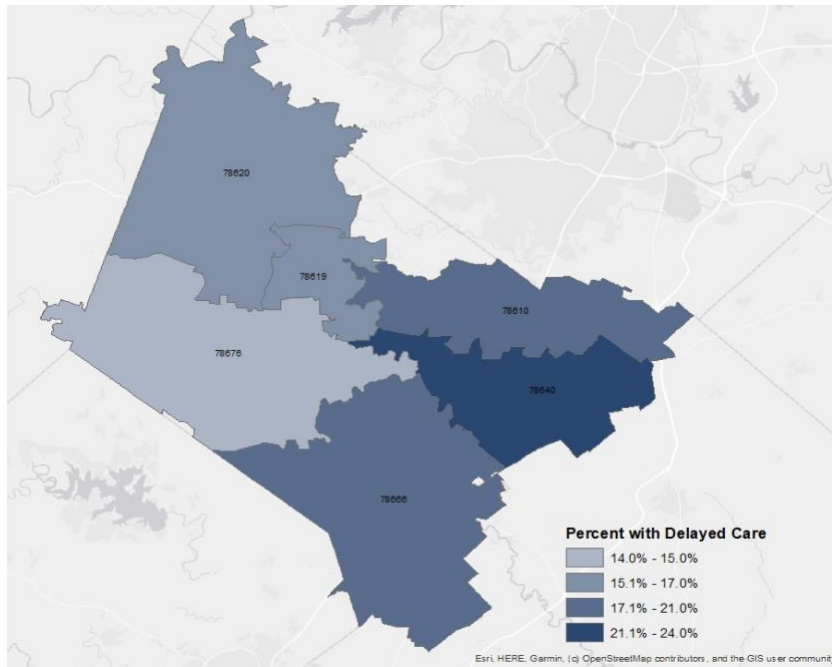
BARRIERS TO HEALTH CARE

The affordability and availability of needed health care affect when and whether or not people seek care. Focus group participants and interviewees indicated that barriers exist in both of these areas, in particular for more underserved populations. In 2017, the most recent year this data is available at the county or sub-county level, approximately 17% of Hays County adult residents reported there being a time in the prior year when they needed care but could not afford it. The rates vary across ZCTAs, as shown in Figure 24 below. The portion reporting delaying care was highest in the Kyle ZCTA (23.6%) and lowest in Wimberley (14.2%).

Another indicator of challenges with health care access is the rate of hospital visits for conditions that are treatable in the ambulatory (e.g., non-hospital) environment. Such visits are typically more expensive when treated in the hospital environment. Treatment, especially for the management of chronic conditions, can be sub-optimal if received through emergency departments due to the short-term, triage focus of that venue.

Figure 24

A Higher Percentage of Adults in Eastern Hays County Delay Care Due to Cost



Source. Behavioral Risk Surveillance System, 2017.

- In Hays County, the rate of preventable hospital stays among Medicare enrollees in 2018 was 4,243 per 100,000 Medicare beneficiaries. This is comparable to the state and national rates.
- The rate of preventable hospital stays has increased county wide by 20.2% since 2012.
- Hispanic/Latinx Medicare enrollees are 1.8 times more likely to use the hospital for ambulatory-sensitive conditions than are white and Black/African American residents.

UNINSURED

Participants described the challenges that many underserved, low-income, and minority community members face regarding health care; while many receive lesser quality care due to financial insecurity or being un- or underinsured, many more forgo care entirely because of the costs. Participants noted:

- People often avoid preventive care because the cost of regular lab tests is prohibitive.
- The opportunity costs associated with missing work to see a provider are too high for underserved and low-income community members.
- Many people rely on the emergency room for their health care needs, which ultimately results in large medical bills that could have been mitigated with more frequent health care access.

Families end up “running around, trying to get [their] files from this [provider] to that one] when insurance coverage changes]...Then, things fall through the cracks.”

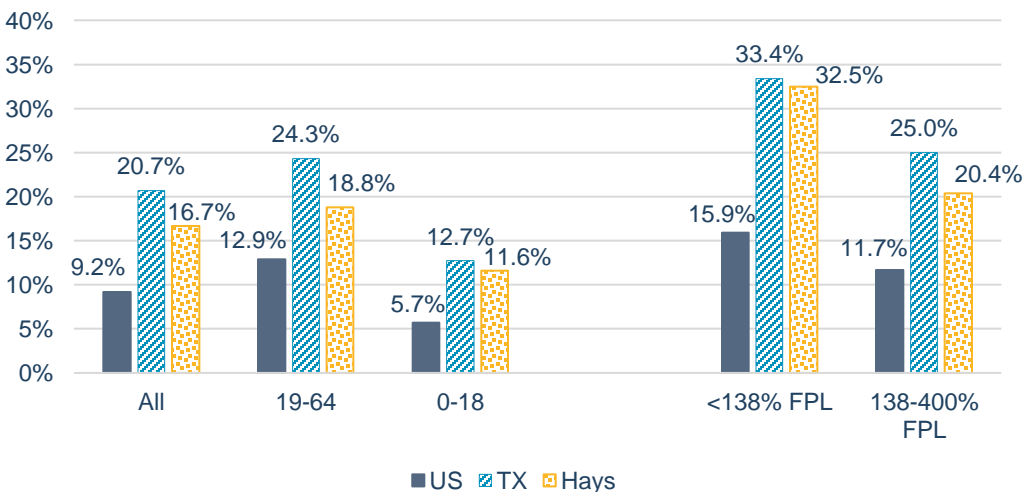
– Key informant

Insurance coverage improves access to care and care seeking by lowering the out-of-pocket costs. It also improves rates of preventive care (e.g., screenings and vaccinations).

- As a state, Texas had a higher percentage of residents under the age of 65 who are uninsured (20.7%) than any other state in 2019. This is also twice the portion of residents nationally who are uninsured (9.2%).
- In Hays County, 16.7% of residents under the age of 65 are uninsured; this is lower than the portion of residents statewide who are uninsured, but higher than the national average.
- Relative to other counties in the Austin–Round Rock MSA, Hays County has a comparable portion of residents under the age of 65 who are uninsured as Travis County (16.5%), and fewer than those in Bastrop (22.7%) and Caldwell (25.7%) Counties. However, the rate of uninsured is higher in Hays County than in Williamson County (12.4%).
- Around 18.8% of Hays County adults ages 19 to 64 are uninsured, while 11.6% of children under the age of 19 do not have health insurance coverage.
- Differences in insurance coverage exist by income as shown in Figure 25 below.

Figure 25

Rates of Uninsured by Age and Income: Hays County, Texas and U.S.



Source. U.S. Census Bureau, Small Area Health Insurance Estimates Program and American Community Survey, 2019.

These rates do not take into account the disruptions that low-income families have in their health care due to irregular insurance access. Although no data is available at the county level, national data indicates that two out of five working age adults (ages 19-64) are underinsured (43.4%).^{7,8}

ACCESS TO LOW-COST CARE

Providers offering low- or no-cost care are few and located on the southeast side of the county. The only two federally qualified health centers, or FQHCs, serving adults in Hays County are located in San Marcos and Kyle. The CommuniCare clinic in Wimberley offers pediatric care only. Other affordable care options (e.g., the local health department, Live Oak Clinic and Corridor Primary Care) are all located along the I-35 corridor as well. Given the lack of public transportation in the county and personal transportation challenges experienced by many low-income community residents, this limits access to low-cost care options for residents who do not live in San Marcos or Kyle.

Participants also reported traveling to Austin or San Antonio to visit specialists with affordable, sliding-scale options. However, traveling even to San Marcos or Kyle is inaccessible for many due to not having a personal vehicle, expenses of travel (e.g., gas), or opportunity and financial costs associated with missing work.

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

– Spanish-speaking Focus Group Participant

Key informants also noted that additional issues including few providers accepting Medicaid, which directly affects care affordability for low-income residents and that dental care is cost-prohibitive for many in the county, with the CommuniCare clinic in Kyle being the sole option for low-cost basic oral care in the county.

⁷ The Commonwealth Fund determines people to be underinsured if they are insured all year and they meet one of the following criteria: (a) their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10% or more of household income, (b) their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5% or more of household income for individuals living under 200% of the federal poverty level (\$25,520 for an individual or \$52,400 for a family of four in 2020), or (c) their deductible constitutes 5% or more of household income.

⁸ Collins, S., Gunja, M. Z., Aboulafia, G. N. (2020) *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>.

PROVIDER AVAILABILITY

A short supply of providers can be another barrier to care as it increases the time it takes to get an appointment. In particular, focus group participants noted that waitlists for mental health care providers are often multiple months long, making their services inaccessible for many community members.

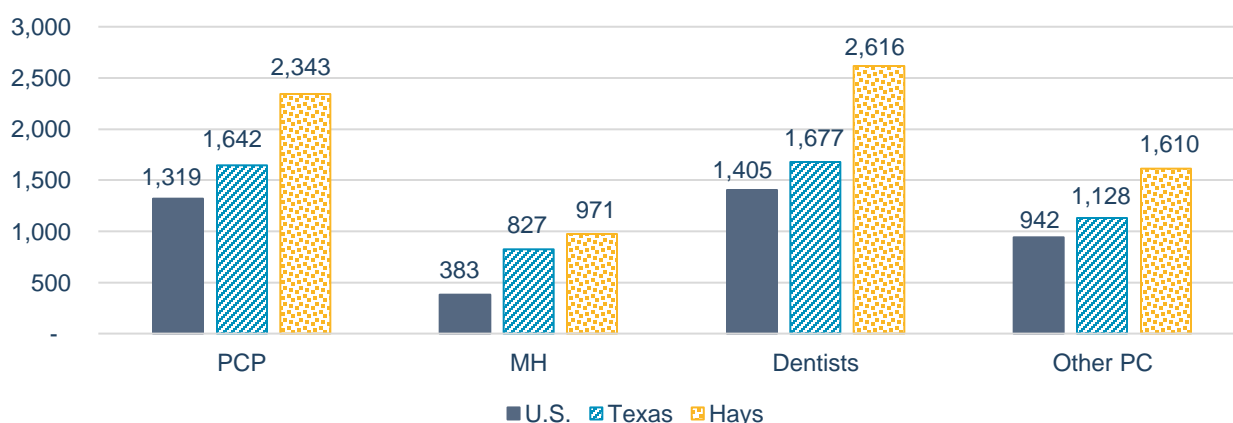
“Even if people do have insurance, it’s hard to get in to see [a mental health provider]. But for the people without insurance, it’s pretty much not even an option.”

– Key Informant

Hays County is designated as a health professional shortage area for both primary care and mental health by HRSA. (It is not for dental care, however). For both primary and mental health care, the supply of providers has not kept pace with population growth. The number of residents per primary care physicians grew by 3.7% between 2010 and 2018 from 2,261 to 2,343. This is a far larger number of residents per primary care physician than the state as a whole and nationally. The supply of non-physician primary care providers is also lower than that of the state as a whole and the U.S., as is the supply of dentists and mental health providers, as shown in the Figure 26.

Figure 26

Number of Residents per Provider: Hays County, Texas and U.S.



Sources: U.S. Health Resources and Services Administration Area Health Resources File and Centers for Medicare and Medicaid National Provider Identification system. Note: PCP – Primary Care Physician; MH – Mental Health Provider; Other PC – Other Primary Care Providers.

While the availability of dentists relative to the population is lower than that for the state and nationally, availability has improved in Hays County from 3,043 residents per dentist in 2010 to 2,616 in 2018. However, as focus group participants pointed out, availability does not mean care is affordable; thus, dental care still remains inaccessible for low-income populations.

Other Health Needs

The following additional significant health need emerged from a review of the publicly available quantitative data for Hays County. While this topic did not specifically emerge as priority areas in the focus groups and key informant interviews, they are worth noting.

BINGE DRINKING AMONG YOUNGER COMMUNITY MEMBERS

While not mentioned by focus group participants, data indicate that heavy and binge drinking is more common in Hays County than it is statewide and for the nation as a whole.

- Slightly less than 1 out of 4 residents 18 years and older report either heavy or binge drinking compared to 1 in 5 across the state and nationally.
- Binge drinking is more prevalent than heavy drinking. This may be due to the county being home to a large state university as there are large age and marital status differences in likelihood of binge drinking, specifically, with younger, unmarried community members being more likely to report recent binge drinking than their older or married counterparts.
- Almost one-third of community members ages 18-29 reported recent binge drinking (32.3%), a rate that is more than two times that of those 45-64 years old and 10 times higher than community members over the age of 64.
- Around 25.3% of unmarried adults binge drink compared to 14.4% of married adults. Similarly, unmarried community members are more likely to report heavy alcohol consumption than are married community members (8.8% vs. 5.5%).

Conclusion

As part of a collaboration with local hospital systems, SDF contracted with THI to compile and analyze quantitative data for Hays for the 2021-2022 CHNA process. Additionally, THI conducted eight virtual key informant interviews, two virtual community focus groups, and one virtual Photovoice project to qualitatively understand the health priorities for Hays County.

Both quantitative and qualitative data indicate that Hays County many assets and strengths, including a strong sense of community and residents demonstrate a priority to take care of each other. Individuals, local nonprofit organizations and churches from various denominations are well-networked and coordinate with each other to distribute food and provide social services. At the same time, Hays County has experienced tremendous population growth over the past decade, which has created issues both with affordability, in general, and housing-related, in particular. The growth has also affected provider availability, and lower-income and underserved populations continue to experience high rates of health issues such as diabetes, obesity, hypertension and mental illness, as well as significant barriers to access to health care and living healthy lifestyles. Regionally, the eastern and southern parts of Hays County have higher rates of poverty, diabetes, delayed care, and generally higher vulnerability. Finally, lack of cultural knowledge and sensitivity of health care providers is an issue faced by many minority and LGBTQ+ residents.

Focus group participants and key informants provided a number of recommendations about actions a health care system could take to address the concerns they identified. The recommendations focused on three primary outcomes: (a) building trust to improve outcomes among underserved communities, (b) increasing affordability and access, and (c) reducing community barriers.

BUILD TRUST

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

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

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

Language and translation services: Ensure that materials are linguistically accessible and consider using non-print communication such as radio broadcasts. Increase the number of

providers who speak Spanish or have accessible translation services. Include language on office doors and hospital marketing materials that explicitly welcomes historically excluded populations such as people who are LGBTQ+, immigrants, and Black/African American.

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

INCREASE AFFORDABILITY AND ACCESS

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

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

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

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

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

REDUCE BARRIERS IN THE COMMUNITY

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

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

– Key Informant

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

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

Evaluation of 2019 CHNA

St. David's Foundation last completed Community Health Needs Assessment and Implementation Plans in 2019. Below are the highlights of accomplishments since 2019 that support St. David's Foundation Community Improvement Plans (CHIP).

Priority Area: Improve the health and well-being of children			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Foster the conditions that create positive early experiences for young children, knowing these early experiences are the foundation for later health, social, and economic outcomes.	<p>Inform the public by promoting the science of brain development to guide clinical practice, public policy, and resource decisions.</p> <p>Screen at key intercept points such as pediatric clinics for childhood adversity, relational health, and other related factors.</p> <p>Treat children through a strong therapeutic web that includes specialized treatments that incorporate research on the effects of trauma and adversity, as well as tools to build resiliency, such as parenting supports.</p> <p>Prevent adversity and build resiliency, using avenues such as parent engagement and education campaigns, and engaging children and their communities in their own healing.</p>	<p>Families are supported and have the key services they need to remove sources of stress, strengthen core life skills, and foster positive relationships between children and caregivers.</p> <p>Communities are connected, with built environments and norms that promote social interaction among community members.</p> <p>Stakeholders are informed about the science behind brain development. These stakeholders include practitioners, policy makers, and the general public.</p>	<p>In 2020, access to treatment to address trauma and adversity services more than doubled (123%). This translates to a total of 12,292 children under 18 who received services.</p> <p>In 2020, the number of practitioners trained in trauma-informed care best practices more than doubled (143%). This is equivalent to 460 clinicians utilizing trauma-informed best practices.</p> <p>By 2020, St. David's Foundation increased Brain Story Certifications statewide by 30%.</p> <p>By 2020, St. David's Foundation increased the proportion of local school districts that have incorporated social-emotional learning (SEL).</p> <p>St. David's Foundation is on track to increase home visiting slots in Central Texas by 10%.</p>

Priority Area: Improve the health and well-being of women			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Ensure women and girls are supported with the resources, respect, and conditions vital for equitable health and wellbeing.	<p>Establish Central Texas as a women's health and perinatal safe zone. Lead and join a shared community commitment to protecting women's resources, respect, and conditions regardless of what happens in the broader environment.</p> <p>Center women of color (e.g., listen to them, step back while they drive the agenda, include them at key tables, enable them to tell their own stories, invest in their leadership).</p> <p>Fills gaps in the fragmented safety net women's health system and fund select innovations.</p>	<p>Women and girls of color experience birth equity (including but not limited to equitable outcomes in perinatal care, maternal morbidity and mortality, and newborn outcomes).</p> <p>Women's health safety net policies and programs are less fragmented, resulting in continuity of access between primary care, sexual and reproductive health care, and perinatal care.</p> <p>Women and girls can obtain low-barrier family planning and contraceptive care, including the most effective methods, in clinical and community settings.</p> <p>Communities are empowered to share their own narratives and stories.</p> <p>St David's Foundation women's health work aligns with other issues and movements relevant to the health of women and girls (e.g., improving conditions for caregivers, gender-based violence), expanding intersectional partners and community impact.</p>	<p>By 2020, access to family planning and contraceptive care increased more than doubled (115% and 5,311 people).</p> <p>In 2020, access to comprehensive sex education and pregnancy prevention programming for young adults increased by 29%.</p> <p>By 2020, St. David's Foundation increased the number of leaders attending SDF Women's Health convenings.</p> <p>As of 2020, St. David's Foundation is on track to increase the number of women of color included in key stakeholder convenings and the proportion of grant partner organizations led by women of color.</p> <p>As of 2020, St. David's Foundation is on track to complete the Perinatal Safe Zone engagement plan.</p>

Priority Area: Improve the health and well-being of older adults			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Increase support for older adults to live safely and independently in their own community.	<p>Directly fund services and support the health of organizations providing services to older adults.</p> <p>Build evidence for new models by piloting and evaluating innovative services in Central Texas and demonstrating the “double impact” of intergenerational approaches.</p> <p>Lead new payment models and public system improvement by advocating to MCOs and legislators on the cost-effectiveness of adopting evidence-based services, advocating for increased appropriations for Medicaid services for older adults, and engaging local organizations to advocate for supportive aging policies.</p> <p>Engage and activate community around aging issues.</p>	<p>Older adults remain safe and independent in their homes as they age.</p> <p>Older adults have a better end of life experience.</p> <p>Central Texas supports older adults and engages them as a vital part of the community.</p> <p>Central Texas has an adequate supply of accessible, high quality services for older adults.</p>	<p>By 2020, there was a 74% increase in access to services for older adults to assist them in aging in place. This is equivalent to 22,067 older adults receiving core services such as meals, transportation, and home repair.</p> <p>As of 2020, St. David’s foundation has made progress on the adoption of the CAPABLE model by Central Texas urban and rural counties.</p> <p>As of 2020, St. David’s Foundation added a new metric to increase awareness of the importance of end-of-life discussions and documenting plans.</p> <p>Additional work needs to be done to increase the number of caregivers receiving training and resources and increase access to programs that reduce social isolation.</p>

Priority Area: Improve the health and well-being of rural communities			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Build community capacity while co-creating and investing in long term place-based solutions.	<p>Engage and empower rural communities to strengthen networks and transform policies, practices, and alignment of resources to address prioritized social determinants of health.</p> <p>Build the capacity of people and places including formal and informal leaders within communities and organizations.</p> <p>Strategically invest in solutions that harness community assets to support innovation, ecosystem building, and other promising rural-relevant approaches that can be scaled.</p>	<p>Rural communities have a culture of health that transcends beyond health care access.</p> <p>Rural residents experience strong social connections and are engaged in thriving cross-sector, community-based networks that promote health and well-being.</p> <p>Rural systems undergo change that includes policy, practices, behaviors, and resources to promote health and well-being.</p> <p>Rural organizations have a strong infrastructure in place with adequate capacity.</p> <p>Rural residents are engaged and empowered by diverse civic leadership to activate and improve community well-being.</p>	<p>By 2020, St. David's Foundation established the Bastrop County resident advisory groups for two key issues and develop work plans.</p> <p>As of 2020, the development of a leadership training program co-designed with national and local capacity building organizations is on track.</p> <p>As of 2020, the number of proposals from rural communities across all portfolios has increased.</p> <p>As of 2020, progress has been made to increase philanthropic resources to Central Texas rural communities through the dissemination of network weaving assessments to local and national rural funders.</p> <p>As of 2020, progress has been made to increase capacity of a local nonprofit to serve as a backbone organization for community-led efforts.</p>

Priority Area: Health clinics to become community hubs for health			
Goal from 2019 Implementation Plan	Description of Objectives	Vision of Success	Progress, Impact, and Outcomes
Facilitate growth of infrastructure and capacity as clinics transition to serve as community hubs for health.	<p>Provide access to primary care and behavioral health services for the uninsured.</p> <p>Expand capacity of clinics to provide activities, processes, and strategies to improve the care delivery model.</p> <p>Encourage clinics to look outside of their four walls to develop and strengthen community linkages to improve community health and well-being.</p>	<p>The uninsured and underinsured have access to high quality care.</p> <p>Clinics are prepared to incorporate necessary changes to their care models to be able to succeed in new payment approaches that reward value over volume.</p> <p>Patients are satisfied with their experiences as they interact with the primary care health system.</p> <p>Clinics deliver comprehensive primary care and interact effectively outside the clinic to strengthen community linkages and ultimately improve the health and well-being of patients and the population overall.</p>	<p>By 2020, there was an 18% increase in uninsured patients receiving medical care.</p> <p>By 2020, there was a 76% increase in adults receiving dental care.</p> <p>By 2020, the number of patients receiving care coordination services more than tripled (375%).</p> <p>As of 2020, St. David's Foundation is on track to develop and implement a care coordination approach at partner clinics.</p> <p>As of 2020, progress has been made on the proportion of patients receiving care coordination, engagement activities, and medication management at partner sites.</p> <p>Additional work needs to be done to increase the number of partner clinics implementing social determinants of health screening of patients.</p>

Appendix A

	Measurement Period	Hays	Texas	U.S.
Demographics				
Total population	2020	241,067	29,145,505	331,449,281
Population by age				
Population 18 and under	2015-2019	22.9%	25.5%	22.3%
Population 19-64	2015-2019	65.8%	61.6%	61.2%
Population 65+	2015-2019	11.4%	12.9%	16.5%
Population by race and ethnicity				
AI/AN, NH	2020	0.2%	0.3%	0.7%
Asian, NH	2020	2.0%	5.4%	5.9%
Black, NH	2020	3.7%	11.8%	12.1%
Hispanic	2020	38.5%	39.3%	18.7%
White, NH	2020	50.4%	39.7%	57.8%
Population in poverty	2015-2019	13.7%	14.7%	13.4%
Households below poverty	2018	14.0%	14.0%	13.0%
ALICE households	2018	30.0%	30.0%	29.0%
Not proficient in English, population	2015-2019	9.4%	13.7%	8.4%
Disabled population	2015-2019	9.3%	11.5%	12.6%
Medicaid coverage	2015-2019	9.4%	16.8%	20.2%
Access to Care				
Uninsured	2019	16.7%	20.7%	9.2%
Uninsured adults	2019	18.8%	24.3%	12.9%
Uninsured children	2019	11.6%	12.7%	5.7%
Lack of prenatal care	2017	27.8%	40.0%	17.0%
Dental visit in past 12 months	2018	61.7%	60.7%	67.6%
Preventable hospital stays	2018	4,243	4,793	4,236
Primary care physicians	2018	2,343	1,642	1,319
Dentists	2019	2,616	1,677	1,405
Mental health provider access	2020	971	827	383
Other primary care providers	2020	1,610	1,128	942
Health Behaviors				
Physical inactivity	2019	25.9%	27.2%	26.0%
Excessive drinking	2019	22.2%	19.0%	19.2%

	Measurement Period	Hays	Texas	U.S.
Binge drinking	2019	22.0%	17.9%	16.8%
Health Outcomes				
Low birthweight	2013-2019	7.2%	8.4%	8.2%
Infant mortality per 1,000 live births	2013-2019	3.8	5.7	5.8
Child mortality per 100,000 under 18 years	2016-2019	38	50	49
Poor or fair health	2019	20.1%	24.3%	24.6%
Frequent physical distress	2019	10.8%	10.7%	12.6%
Adult obesity	2019	33.4%	35.8%	31.9%
Diabetes prevalence	2019	11.3%	12.2%	10.7%
High blood pressure awareness	2019	29.0%	31.7%	32.3%
New cancer cases	2019	401.3	409.5	449
Poor mental health days	2018	4.3	3.8	4.1
Frequent mental distress	2019	12.7%	12.3%	13.8%
Drug overdose deaths	2017-2019	8	11	21
Suicides	2015-2019	12.8	13.1	13.8
Depression	2019	18.7%	17.7%	19.2%
Suicidal thoughts ⁹	2016-2018	3.8%	3.6%	4.2%
Premature mortality per 100,000 under 75 yr	2017-2019	257	339	339
Premature death (YYPL under 75 years)	2017-2019	4,886	6,620	6,907
Life expectancy	2017-2019	80.7	79.2	79.2
Housing				
Homeownership	2015-2019	62.3%	62.0%	64.0%
Severe housing cost burden	2015-2019	15.7%	13.3%	14.4%
Severe housing problems	2013-2017	20.0%	17.0%	17.5%
Housing stability index	Sept/Oct 2021	96.0%	-	-
Housing and transportation affordability ¹⁰		50.0%	-	57.0%
Broadband access	2015-2019	72.3%	64.4%	68.9%
Black, NH	2015-2019	91.1%	80.0%	78.7%
Hispanic	2015-2019	79.4%	78.0%	82.6%
White, NH	2015-2019	87.0%	84.4%	87.2%
Infrastructure for Healthy Living				
Food environment index	2015 and 2018	8	6	8

⁹ County value is for Texas Public Health Region 7.

¹⁰ Measurement period not provided.

	Measurement Period	Hays	Texas	U.S.
Food insecurity	2019	12.0%	14.1%	10.9%
Limited access to healthy foods	2015	6.2%	8.7%	5.9%
Access to exercise opportunities	2010 and 2019	72.4%	80.5%	84.2%
Social vulnerability index	2018	0.4924	-	-
Community needs index	2021	2.8	-	-
Racism				
Dissimilarity index - Black / White	2015-2019	35	53	61
Dissimilarity index - Non-White / White	2015-2019	21	40	47
Socioeconomic				
High school completion	2015-2019	90.1%	83.7%	88.0%
American Indians and Alaska Natives	2015-2019	96.4%	80.3%	80.3%
Asians	2015-2019	95.9%	88.2%	87.1%
Blacks / African Americans	2015-2019	94.1%	89.8%	86.0%
Hispanics	2015-2019	78.1%	66.4%	68.7%
Non-Hispanic Whites	2015-2019	96.8%	93.9%	92.9%
College graduation	2015-2019	37.2%	29.9%	32.2%
American Indians and Alaska Natives	2015-2019	20.7%	21.2%	15.0%
Asians	2015-2019	58.8%	59.1%	54.3%
Blacks / African Americans	2015-2019	24.7%	24.6%	21.6%
Hispanics	2015-2019	19.6%	15.0%	16.4%
Non-Hispanic Whites	2015-2019	48.0%	38.7%	35.8%
Unemployment	Oct 2021	3.5%	4.8%	4.6%
Income inequality	2015-2019	4.4%	4.8	4.9
Median HH income	2020	\$ 77,511	\$ 66,048	\$ 67,340
Transportation				
No car access	2015-2019	2.9%	5.30%	8.6%
Transportation affordability ¹¹		23.0%	-	27.0%

¹¹ Measurement period not provided.

Appendix B

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

Table 1: Description of Key Informants	
Key Informant	Community Input Sector
Claire Bow <i>Attorney and Transgender Advocate</i>	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Debbie Gonzales Ingalsbe <i>County Commissioner Precinct 1</i>	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Eleanor Owen <i>Executive Director</i> Hays County Food Bank	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Margie Rodriguez <i>Clinic Manager</i> Hays County Indigent Health Care Program	<ul style="list-style-type: none"> Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
Albert Sander <i>Director</i> Amigos de Jesús	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Carrie Stofa <i>Wesley Nurse</i> First United Methodist Church San Marcos	<ul style="list-style-type: none"> Person with special knowledge or expertise in public health
Diana Woods <i>Social Services Coordinator</i> Buda Food Pantry	<ul style="list-style-type: none"> Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Name withheld per request <i>School District in Hays County</i>	<ul style="list-style-type: none"> Persons with special knowledge or expertise in public health

The following table describes the focus group participants in aggregate:

Table 2: Description of Focus Group Participants				
Focus Group	Community Input Sector	Description	Number	Language
Spanish-speakers	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female and male residents in ZIP codes 78676, 78619, and 78737, with ages ranging from 30-65. All participants identified as Mexican, Mexican American, or Chicano.	9	Spanish
English-speakers	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Female resident of ZIP code 78610. Additional demographic data withheld to protect anonymity.	1	English
Photovoice (Youth)	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents in ZIP codes 78640, 78619 and 78640. Participants were between 16 and 18 years old. Two identified as Mexican, Mexican American, or Chicano, one as Hispanic/Latinx and Spanish origin.	3	English



2022 Community Health Assessment

Austin/Travis County,
Texas
May 2022



Together We Thrive
Austin/Travis County Community Health Plan

Photos on the front and back cover of this report were submitted by community members on Facebook, Twitter, and Instagram with the hashtag #LiveHealthyATX in response to the question, “What makes you healthy?”

This social media campaign was used as a creative method to gather public input for the Austin/Travis County Community Health Assessment (CHA).

To our Organizing Partners

- Ascension Seton
- Austin Public Health
- Austin Transportation Department
- Baylor Scott & White Health
- Capital Metro
- Central Health
- Integral Care
- St. David's Foundation
- Travis County Health and Human Services
- The University of Texas at Austin Dell Medical School
- The University of Texas Health Science Center at Houston (UT Health) School of Public Health in Austin

Thank you!



Austin Travis County 2022 CHNA Draft Report

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Contigo Wellness
Dove Springs Proud
El Buen Samaritano
Healthy Williamson County

Housing Authority of the City of Austin (HACA)
Korean American Association of Greater Austin
LifeWorks
Light & Salt Services of Austin
Manor Independent School District
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EXECUTIVE SUMMARY

BACKGROUND

The 2022 Austin/Travis County Community Health Assessment (2022 CHA) involved a number of stakeholders, including health centers, hospitals, university partners, local school districts, community-based organizations, foundations, governmental agencies, and Austin Public Health.

The overarching goals of the 2022 Austin/Travis County Community Health Assessment were to:

- Examine the current health status across Austin/Travis County as compared to state and national indicators
- Explore the current health priorities among Austin/Travis County residents within the social context of their communities
- Identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County

To support the 2022 CHA, Austin Public Health hired Health Resources in Action (HRIA), a non-profit public health organization, as a consultant to support and provide strategic guidance on the community engagement and planning process and the collection and analysis of data, and to develop the report.

METHODS

The 2022 CHA leverages a social determinants of health framework. Health is not only affected by genes and lifestyle factors, but by upstream factors such as employment status, quality of housing, and economic policies.

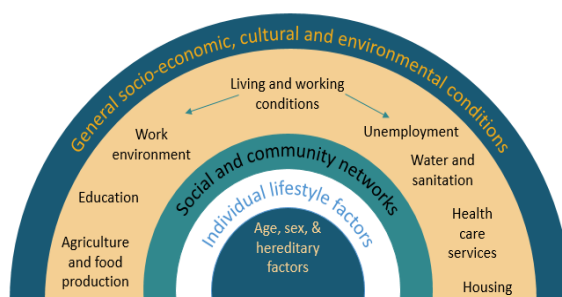
Informed by the Mobilizing for Action through Planning and Partnership (MAPP) framework, developed by the National Association of County and City Health Officials (NACCHO), the 2022 CHA includes three main assessments:

The **Community Partner Assessment** included a summit (n=27) to identify the organizations to involve in the community health planning process. This process identified the priority of engaging direct service providers, organizations affiliated with school districts, resident volunteers or ambassadors, grass-roots initiatives, and faith-based organizations. Participants prioritized focusing on older adults; Black, Indigenous, and People of Color (BIPOC) and Asian communities; and behavioral health.

The **Community Status Assessment** involved the analysis of existing social and health data. These data were drawn from state, county, and local sources, such as the U.S. Census, County Health Rankings, Texas Department of State Health Services, Austin Area Sustainability Indicators Project, Behavioral Risk Factor Surveillance System (BRFSS), and vital statistics based on birth and death records.

The **Community Context Assessment** involved several qualitative methods, including key informant interviews with community leaders (n=20), in-depth interviews with community members (n=2), seven

Social Determinants of Health Framework



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

focus groups with community members (n=48), a radio talk show (n=3), a virtual community forum with community members and leaders (n=16), and photo outreach campaign (n=23) to elicit perceptions of community strengths, needs, and opportunities for change. Content analysis of local assessments provided important context regarding priority communities and topics.

LIMITATIONS

As with all data collection efforts, there are several limitations to the 2022 CHA. Secondary data involve a time lag from the time period of data collection to data availability and some data are not available for specific population groups or at more granular geographic levels due to small sample sizes. In some cases, quantitative data across multiple years need to be aggregated to provide more accurate estimates for a specific group or geographic area. The COVID-19 pandemic introduced some challenges for community outreach and completion of focus groups. Several communities were underrepresented, including refugees, youth, indigenous communities, people with disabilities, and faith leaders.

FINDINGS

POPULATION CHARACTERISTICS

Travis County and Austin experienced an estimated population growth of 26.0% and 20.0%, respectively, from 2010 to 2020, exceeding population growth for Texas (15.9%) and the US (7.4%) during the same period. Several focus group participants and community leaders described the Austin and Travis County region as growing substantially in recent years and perceived that higher income residents were the largest segment of new residents. One focus group participant shared, *“There are no more people born and raised from Austin because they were all priced out.”*

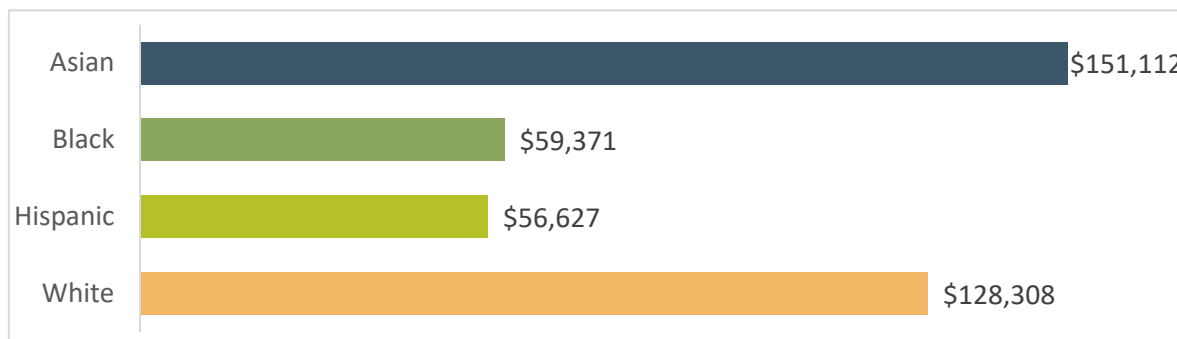
The Austin-Round Rock-Georgetown metropolitan area had the 3rd largest percentage of LGBTQIA+ people in the U.S., with about 5.0% or 90,000 people identifying as LGBTQIA+. About half of residents in Travis County (52.2%) identified as people of color. More than one-third, 34.8%, of Travis County residents identified as Hispanic/Latino, 8.2% identified as Black/African American, and 6.6% identified as Asian. Nearly one-third (30.8%) of residents in Travis County speak a language other than English at home. Several community members and leaders noted the importance of ensuring that information about health and available resources are provided in residents’ primary language. One community leader shared: *“Language access is key. If you don’t have any material to educate yourself about a health disease, then changes can’t really be made.”* Legal status emerged as a barrier to accessing services and resources for undocumented immigrants.

COMMUNITY SOCIAL AND ECONOMIC CONTEXT

Economic Indicators

Income influences where people live, their ability to access higher education and skills training, and their access to resources to help them cope with stressors and health-promoting resources such as healthy food and health care. Low community wealth is linked with more limited educational and job opportunities, greater community violence, environmental pollution and disinvestment in essential infrastructure and resources. In 2019, the median household income in Travis County was \$80,726, a 14.6% increase between 2015 and 2019. The median household income for White households was 2.2 times the household income for Black/African American households and 2.3 times the household income for Hispanic/Latino households in 2019. An estimated one-quarter (25.0%) of LGBTQIA+ survey respondents reported having incomes less than \$24,000. About 13.6% of Travis County children lived in poverty.

Median Household Income, by Race/Ethnicity, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Many community members and leaders described the cost of living in the area as high and rising and disproportionately affecting low-income residents, residents of color, and older adults. One community leader described, *“If you look at some of our communities, there is no quality of life, it’s just survival.”* Several community members and leaders described residents who work in low-wage jobs that are stressful, hard to get, and offer limited incomes and discussed job loss and reduced hours for low-wage workers during the COVID-19 pandemic. Regarding childcare needs for working individuals, about two-fifths of Black/African American (42.9%) and Hispanic/Latino (41.1%) respondents and 34.2% of White respondents reported difficulty finding affordable childcare.

Education

Education improves employment opportunities, economic and social resources, and health literacy, which shapes understanding of medical information and enables patients to advocate for themselves. Low-income communities and communities of color are affected by inequities in educational funding and access to educational resources. The majority (90.4%) of Travis County adults have a high school degree or higher and 53.0% have a bachelor’s degree or higher. The Hispanic/Latino population has the highest percentage of population without a high school diploma (26.6%). Among students who dropped out of high school, 8.2% were Black/African American, followed by Hispanic/Latino students (6.4%).

Housing

Home and neighborhood environments may promote health or be a source of exposures that may increase the risk of adverse health outcomes. Housing is generally the largest household expense. A key theme was the high and rising cost of housing that disproportionately affects low-income residents, residents of color, older adults, and persons with disabilities and displaced residents from urban areas to rural areas. One community leader shared, *“[B]ecause of [the] increasing cost of living in central core in Austin and due to gentrification, elderly and disabled [residents] are now in more rural areas.”* According to a Housing Market Analysis, about 65% of respondents reported spending greater than or equal to 30% of their monthly income on housing and 17% reported spending greater than or equal to 50% of their monthly income on housing – a severe cost burden. In Austin, White households faced severe cost burden 15% of the time, compared to 25% for Black/African American households; 23% for Hispanic/Latino households; and 20% for Asian households. As such, people of color are more vulnerable to the negative consequences of rising housing costs. Homelessness was an area of concern and disproportionate among LGBTQIA+ youth, people of color, and, more specifically, queer and transgender people of color. Additionally, Travis County census tracts with higher proportions of Black/African American residents have high community-level homelessness risk factors.

Built Environment and Neighborhood

Air, water, and land quality in rural areas and access to grocery stores and community and recreational centers in both urban and rural areas emerged as features of the built environment of concern. Several community members described development as stressful and affecting health. One community member shared, “[There is] demolition across the street [...] the dust coming into the apartment.” The growth of businesses that primarily serve high income residents contributed to the need to travel further to access affordable food and some community members described feeling excluded by the neighborhood design. Several community members and leaders discussed the need to improve access to services, including banks, pharmacies, grocery stores, and urgent care clinics in low-income communities.

Internet and Computer Access and Training

Residents described internet and computer accessibility and training as important for accessing information and resources, staying connected, and participating in remote education. Some community members and leaders noted that internet and computer access was more difficult for low-income residents and rural communities and was critical during the COVID-19 pandemic and Winter Storm Uri.

Transportation

Transportation emerged as a barrier for conducting day-to-day activities such as getting groceries, going to school, and going to the doctor. In 2019, an estimated 60% of Travis County residents spent <30 minutes commuting, around one-third (33%) spent 30-60 minutes commuting and 7% spent over an hour commuting. Community members and leaders described several barriers to using public transit and limited public transportation and medical or senior transit options in rural areas. Senior community members noted that medical ride services were limited and made for long and exhausting travel.

Access to Healthy Food and Food Security

In 2019, around 15.6% of Travis County residents reported consuming 5+ servings of fruits and vegetables daily, which is lower than patterns in 2011 (22.6%). Focus group participants described the high cost of healthy foods, affordability and accessibility of fast foods, and long work hours as barriers to healthy eating. Nearly one-quarter (23.0%) of LGBTQIA+ survey respondents reported that they experienced food insecurity, compared to 13.0% of respondents who did not identify as LGBTQIA+. Several community members and leaders shared that it was more difficult to eat healthy foods during the COVID-19 pandemic and observed an increased need for food assistance.

Physical Activity

Many community members and leaders described active living and exercise as important for health. Some residents described safe access to green space as facilitating physical activity. As one focus group participant shared, “[I]f you have a park close by you have more initiative to go out instead of staying in the house.” About one-third of Travis County adults reported being highly active in 2011-2019.

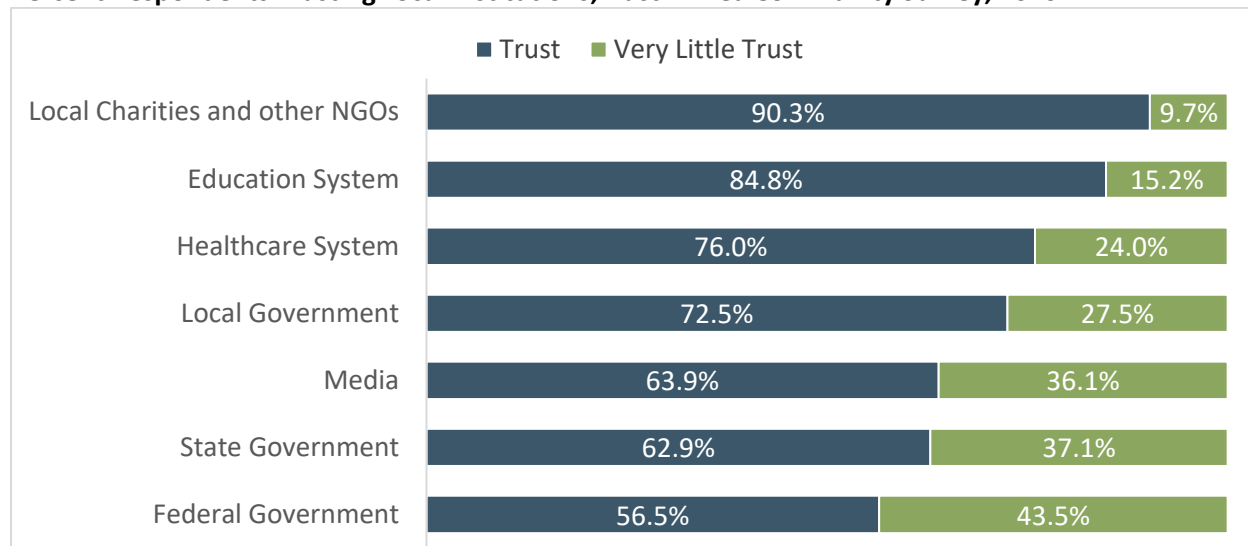
Social and Community Context

Community Connectedness and Civic Engagement

Relationships are important for physical and mental well-being, including encouraging positive healthy behaviors. Conversely, discrimination as part of one’s social environment can negatively affect health. In Travis County in 2015-2019, 5.7% of teens aged 16-19 years were disconnected, defined as teens neither in school nor working. In 2018, 6.3% of Travis County residents aged 65+ lived alone. When asked about trust in institutions, the highest percentage of respondents reported trusting local charities and non-governmental organizations (90.3%) and the education system (84.8%), with less trust towards the

federal (56.5%) and state (62.9%) government and media (63.9%). Over half of respondents felt informed about neighborhood issues (70.5%) and agreed that neighbors are improving the area (60.5%).

Percent Respondents Trusting Local Institutions, Austin Area Community Survey, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: This data combines the survey responses of "Some", "Quite a lot", and "A great deal" as "Trust".

Safety

Crime and safety are additional aspects of community health related to the social environment. Crime rates remained similar in 2019 compared to 2015. In 2019, the property crime rate (3,244.9 crimes/100,000 population) was higher than the violent crime rate (381.6 crimes/100,000 population). A few community members described concerns about physical violence, including gun violence, vandalism, break-ins, and robberies, and police violence.

Racism and Discrimination

Some community leaders described institutional racism as an important factor that shapes adverse childhood experiences and trauma, access to jobs, educational experiences, housing, family cohesion, where residents can live, and trust towards the government, which they linked with health. One community leader shared, *"We have to first accept that racism is real; we see it every day."* Some community leaders described community-based and faith-based organizations as bridges between historically marginalized groups and the government. Some community members cited incidents of hate, including verbal attacks and physical violence towards people of color and of non-Christian faith.

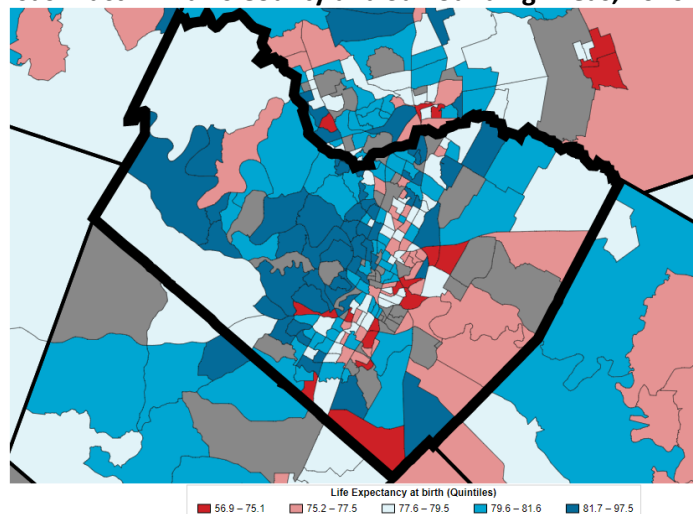
COMMUNITY HEALTH OUTCOMES AND BEHAVIORS

General Health Outcomes

The leading causes of death in Travis County in 2020 were heart disease, cancer, unintentional injuries, and COVID-19. Life expectancy in Travis County and surrounding areas ranges from 68.6 years to 88.9 years, and is highest in northern and western census tracts. In 2018, 16.2% of Travis County adults reported fair or poor health. Almost half (47.3%) of LGBTQIA+ respondents reported poor or fair physical health. In 2020, on average LGBTQIA+ respondents reported 6.0 days of poor physical health in the last month. In 2019, 13.8% of Del Valle residents and 11.3% of Montopolis residents reported poor physical health for 14 days+ of the last 30 days, compared to 9.6% of Austin residents. Several community members and leaders described health as including happiness, quality of life, safety, spiritual well-being,

access to healthy foods, an active lifestyle, and limited stressful life circumstances, which are referred to as social determinants of health.

Life Expectancy, by Census Tract in Travis County and Surrounding Areas, 2010-2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, 2010-2015

Maternal and Child Health

In 2013-2019, the rate of births among females aged 15-19 in Travis County (23.8 per 1,000 population) was lower than the teen birth rate across Texas (31.4 per 1,000 population). The teen birth rate from 2013-2019 was higher for Hispanic/Latino teens (43.0 per 1,000 population) than other racial/ethnic groups. In 2019, 7.6% of infants in Travis County were born with a low birth weight.

Chronic Disease

About one-fifth (22.4%) of Travis County residents have been diagnosed with diabetes. From 2011 to 2019, a higher percentage of Hispanic/Latino residents and those aged 65 and over reported being diagnosed with diabetes compared to their counterparts. In 2017, the heart disease and stroke mortality rate in Travis County (121.6 and 28.8 deaths per 100,000 population, respectively) was lower than that in Texas (163.4 and 39.0 deaths per 100,000 population, respectively).

Cancer

Overall cancer incidence in 2013-2017 in Travis County was 391.9 per 100,000 population. Prostate and lung cancer had the highest incidence rates compared to colon and female breast cancer. The female breast cancer incidence rate in Travis County (32.5 per 100,000 population) was higher than Texas and the US (22.5 and 29.8 per 100,000 population, respectively). In 2017, the cancer mortality rate was lower in Travis County (117.0 per 100,000 population) compared Texas and the US (141.4 and 146.2 per 100,000 population, respectively).

Behavioral Health Outcomes

In 2017-2019, the rate of drug poisonings, also referred to as overdoses, was 12.6 deaths per 100,000 population in Travis County. Substance use disorders and mental illness are closely linked and often co-occurring. Among Travis County residents, the suicide rate was 12.2 deaths per 100,000 population and highest among males (18.5 deaths per 100,000 population) and White residents (17.1 deaths per 100,000 population) in 2016-2020. In 2020, a higher percentage of females (33.0%) compared to males (20.9%) reported poor mental health, and the prevalence of poor mental health days has increased

overall for both genders. In the same year, a higher percent of Hispanic/Latino adults (31.5%) reported poor mental health compared to White (26.3%) and Black/African American (22.9%) adults. In 2020, the highest proportion of adults experiencing poor mental health was seen among adults aged 18-29 (32.6%) and 30-44 years of age (34.3%). Significant mental health needs, stigma around mental health, and limited access to mental health care were common themes among community members and leaders. Some residents perceived an increase in mental health issues during the COVID-19 pandemic, which they linked with the stress and trauma of the COVID-19 pandemic, social isolation, and economic suffering. One community leader shared, *“Then we look at the physical piece: depression and anxiety are at an all-time high which affect our physical health. The brain-body connection is huge and I cannot stress that enough.”*

General Health Behaviors

In 2018, about one-fifth (22.2%) of Travis County adults reported binge drinking in the past 30 days and 12.7% reported that they currently smoke. The majority of Travis County adults reported using a seatbelt (females: 95.0%, males: 91.9%).

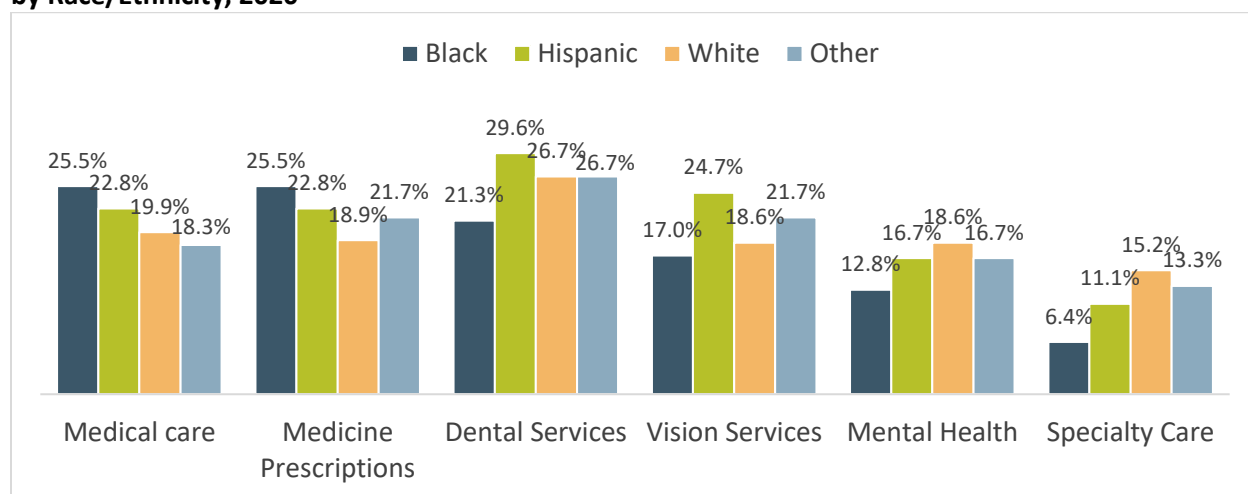
Sexual Health

The rate of HIV was 14.5 per 100,000 population, and the rate of AIDS was 6.2 per 100,000 in Travis County in 2019; a decline from 2015. In Travis County, the syphilis, gonorrhea, and chlamydia rates increased from 2014 to 2018. Black/African American residents and 15-24 year olds generally had the highest rates of these infections. In 2021, 20% of LGBTQIA+ survey respondents reported receiving sexual health education without content specific to LGBTQIA+ populations, 16% received abstinence-only education, and 17% reported receiving no comprehensive sex education.

HEALTH CARE ACCESS

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. In 2019, 14% of Travis County residents were without health insurance. Nearly one-quarter of LGBTQIA+ respondents reported lacking health insurance (23.0%). Almost half (48.6%) of LGBTQIA+ respondents reported not seeking care when having a health problem, followed by nearly one-quarter (24.3%) of respondents who reported going to a public clinic. The high cost of healthcare and insurance were the most commonly cited barriers to medical care. About 29.2% of Hispanic/Latino survey respondents and 26.7% of White respondents were not able to access dental services. Approximately 25.5% of Black/African American respondents reported being unable to receive medical care and medical prescriptions. Nearly one-quarter (24.7%) of Hispanic/Latino respondents listed barriers to accessing vision care.

Percent Unable to Receive Healthcare Services among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

When discussing access to health care, common themes were gaps in health insurance coverage for low-income residents, including lapses of health insurance coverage, few providers who accept Medicare, and difficulty accessing preventive care (e.g., primary, vision, dental), emergency services, specialists, and providers who care for older adults. According to participants, the Medical Access Program (MAP) is helpful for accessing health care services for qualifying low-income, uninsured Travis County residents. However, some participants felt that there were bureaucratic barriers to accessing MAP.

Discrimination, Culturally Sensitive Care, and Interpretation Services in Health Care Settings

Experiences of discrimination in health care settings also emerged among some community members and leaders, who described how past experiences of racial discrimination shaped distrust in health care providers for residents of color and cited experiences of limited culturally sensitive care for patients of color and low-income patients. A lack of bilingual health providers and interpretation services emerged as a health care barrier among some focus group participants and community leaders, including in primary care, specialty services and home health assistance.

Delays in Health Care Use Due to the COVID-19 Pandemic

Some community members and leaders described delays in accessing health care services and screenings due to the COVID-19 pandemic, which they noted may have consequences for late diagnoses. Vaccinations emerged as another gap in health care that was aggravated by the COVID-19 pandemic.

Preventive Care

Just over half of adults in Del Valle (57.6%) and Montopolis (50.5%) reported receiving screening for cholesterol, compared to 70.7% of Austin adults. About two-thirds Travis County adults (65.7%-68.6%) reported being up-to-date on colorectal cancer screenings in 2020.

Women's Health Care

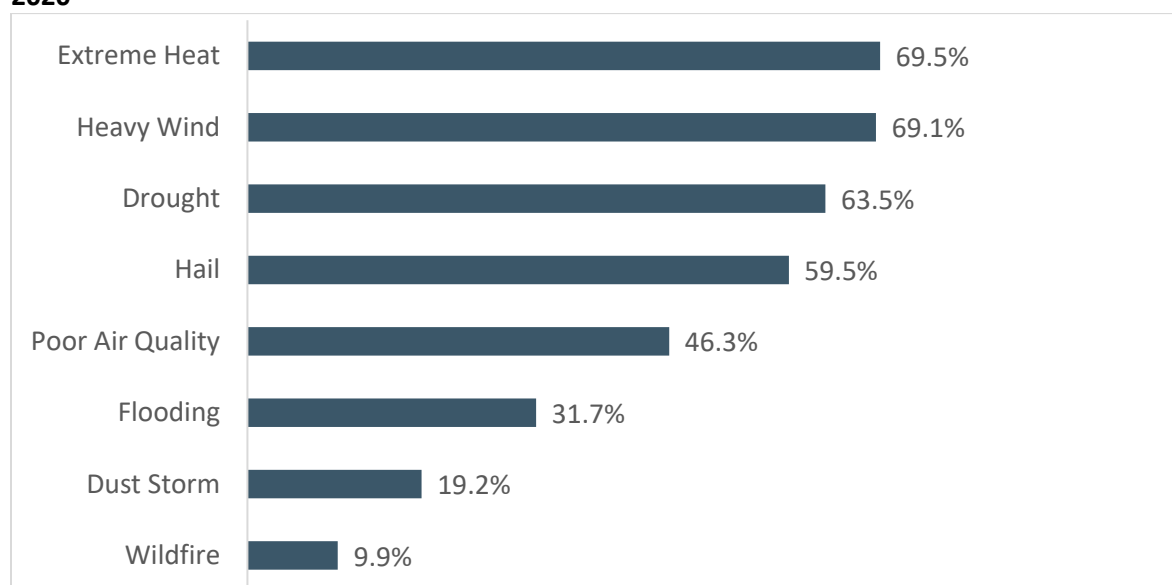
In 2016, about three-quarters (75.7%) of childbearing individuals in Travis County reported receiving prenatal care in the first trimester. Around three-fifths (62.8%) of females aged 18+ reported having a pap smear within the past 3 years in Austin in 2020, marking a decline from pap smear patterns in 2012

through 2018. About 70.2% of females aged 40+ reported having a mammogram within the past 2 years in Austin in 2020. A slightly higher percentage of White females (76.6%) reported having a mammogram compared to Hispanic/Latino females (61.3%) in 2020.

EMERGENCY PREPAREDNESS

Given the COVID-19 pandemic, heat waves and Winter Storm Uri, emergency preparedness was top of mind for many assessment participants. From the Austin Area Community Survey, the majority of survey respondents reported experiencing emergencies of extreme heat (69.5%), heavy wind (69.1%), drought (63.5%) and hail (59.5%) in the last 10 years. About three-fifths (60.8%) of White respondents agreed that they had a safe place to shelter; this was slightly lower among Black/African American (57.6%) and Hispanic/Latino respondents (53.1%).

Percent Experienced Emergency in Last 10 Years among Austin Area Community Survey Respondents, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

COVID-19

The COVID-19 pandemic has had broad and deep impacts on Travis County residents. In Travis County, COVID-19 vaccination completion was highest among Asian (65.5%) residents, followed by White residents (57.0%) and Hispanic/Latino residents (47.6%) and lowest among Black/African American residents (34.3%) in 2021. Several community members and leaders noted that the COVID-19 pandemic has worsened economic suffering, increased social isolation, exacerbated mental health issues, and highlighted barriers to accessing information and health care resources for lower-income residents, residents for whom English is not their primary language, and communities of color.

WINTER STORM URI/EMERGENCY PREPAREDNESS

Some residents described Winter Storm Uri as traumatic and increasing social isolation and technological barriers to accessing pressing information and resources. Several community members described struggling to meet basic needs such as food and electricity during the storm. One interview participant shared: *"I didn't have money and the ATM was down, and when I went to the store to get gas*

there was no gas, so I starved through the winter storm.” Some residents described an ongoing and significant financial toll of Winter Storm Uri, including disruptions of income and high utility bills.

COMMUNITY RESOURCES

Some community leaders cited resident support for each other, including sharing resources and information, as an important community strength. According to community leaders, community health workers, community-based organizations, faith-based organizations, and established community networks have been central to meeting the needs of residents most affected by health inequities. One community leader shared, “...As an organizer I feel that the power is at the bottom, and we should all be working to disassemble the hierarchy and [distribute] power. People give me energy.” Many community leaders and some community members described cross-sectoral partnerships as important community strengths. One focus group participant described: “We go out of our way to build partnerships.”

VISION FOR THE FUTURE

Building on the perceived community assets and thinking ahead to the future, assessment participants outlined the following suggestions for making Austin and Travis County overall a healthier place.

LONG-TERM HEALTH EQUITY PLANNING PROCESSES

Many community leaders recommended that the City of Austin and Travis County deepen their relationships with communities across the region, including building relationships with and incorporating into planning processes community leaders from diverse geographic communities, such as communities on the outskirts of Austin, and identity-based communities, such as racially minoritized groups. Given sizable population growth across the region and displacement of longstanding residents, some residents recommended intentionally including long-time residents in planning processes, not just relatively new residents. According to community leaders, there is a need to improve quality of outreach to residents when engaging them in planning processes, including ensuring that information about resident engagement opportunities reaches residents through realistic and culturally appropriate communication channels and in residents’ primary language.

In terms of priority areas, some community leaders discussed the need to address systemic racism in criminal justice, education, and health care sectors and build capacity to counteract hate. Several community members and leaders recommended expanding community gardens programs, food pantries, and farmer’s markets. Some community leaders highlighted the need to expand Medicaid to improve access to health care for low-income residents and recommended improving the capacity of clinics that currently serve low-income residents to expand their hours and days of operation. Another recommendation included coordinating the release from the hospital for people who are homeless by bringing together hospitals, EMS, and organizations who serve people who are experiencing homelessness. The need to address bureaucratic barriers to expanding mental health supports, improve funding for mental health services, and to make mental health services available to people who are experiencing homelessness and low-income residents also emerged. Some community members and leaders cited the need to coordinate health care across specialties in order to strengthen chronic disease management and the need to support older adults and residents with significant health needs for aging in place.

FOSTER COLLABORATIONS AND COMMUNICATION ACROSS ORGANIZATIONS

Community leaders recommended leveraging collaborative planning spaces as opportunities to build connections and relationships across local community-based health equity organizations since many organizations reported that they did not know each other. They noted that this process had potential to build collective strategies and action and coordinate efforts and discussed the importance of shifting from a competitive environment among non-profit organizations.

FUNDING EQUITY

Shifting the funding model when supporting the work of small community-based organizations and racial equity organizations was a common theme among many individuals representing community-based organizations. Another funding recommendation included re-hauling the current reimbursement model to enable the City and County to meaningfully partner with smaller organizations who have smaller reserves and who cannot wait for reimbursement. One community leader shared, *“Building capacity in orgs. and smaller orgs. There needs to be a concerted efforts to strengthen orgs, because if we strengthen these organizations, they strengthen us.”* A few community leaders noted the need to be more transparent about how funding priorities are made. Some community forum participants observed that racism, patriarchy, other systemic factors, and the historical underinvestment in public health create and maintain inequities that affect community health.

KEY THEMES

This assessment included a review of secondary data and collection of primary data to shed light on the social and economic context, community health issues, and community visions of residents Austin/Travis County. The following key themes emerged through this synthesis:

- ***Social determinants of health, such as access to healthy food and financial security required to be healthy, were viewed as more pressing concerns than health outcomes themselves.*** While some chronic health issues were discussed and are of concern, assessment participants focused on upstream issues of daily life, which are referred to as social determinants of health.
- ***Housing affordability continues to be concerns in Austin/Travis County.*** Due in large part to significant population growth, a key theme was the high and rising cost of housing that disproportionately affects low-income residents, residents of color, older adults, and persons with disabilities, and displaced residents from urban areas to rural areas. While median income has steadily increased in recent years, cost of living in the area is high and increasing as well.
- ***The COVID-19 pandemic has had substantial impact on the lives and the physical and mental health of residents in Austin/Travis County.*** The COVID-19 pandemic has exacerbated many of the issues that existed as well as highlighted new issues. COVID-19 pandemic has worsened food security, economic suffering, increased social isolation, exacerbated mental health issues, and highlighted barriers to accessing information and health care resources for lower-income residents, residents for whom English is not their primary language, and communities of color.
- ***Emergency preparedness is an emerging public health issue in the region.*** Given the COVID-19 pandemic, heat waves and Winter Storm Uri, emergency preparedness was top of mind for many assessment participants. Most residents reported experiencing a natural disaster emergency in the past decade and many described the immediate and ongoing personal and community challenges these emergencies have caused.

- ***Mental health was identified as a important community health concern.*** Significant mental health needs, stigma around mental health, and limited access to mental health care were common themes among community members and leaders. Some residents perceived an increase in mental health issues during the COVID-19 pandemic, which they linked with the stress and trauma of the COVID-19 pandemic, social isolation, and economic suffering.
- ***Healthcare access – specifically high cost of healthcare and insurance – is a significant concern in Austin/Travis County, especially among people of color.*** When discussing access to health care, common themes were gaps in health insurance coverage for low-income residents, including lapses of health insurance coverage, few providers who accept Medicare, and difficulty accessing preventive care (e.g., primary, vision, dental), emergency services, specialists, and providers who care for older adults.
- ***A strength of Austin/Travis County are the strong network of residents and organizations in the area.*** Community residents are supportive of each other and generous with sharing resources and information. Cross-sector partnerships among schools, community-based organizations, private companies and others also represent a community strength. Community-based institutions were seen as important access points for information and access to services. Faith-based organizations were highlighted as a key strength and a bridge between historically marginalized communities and local/county government.

BACKGROUND

INTRODUCTION

Health is affected by where and how we live, work, play, and learn.¹ Understanding these factors and how they influence health is critical to efforts aimed to improve the health of the community. Identifying the health issues of an area and their larger context and then developing a plan to address them are key steps in the larger health planning process. To accomplish these goals, a collaboration among various community partners, including Austin Public Health, Travis County Health and Human Services, Central Health, St. David's Foundation, Central Metro, Austin Transportation Department, Integral Care, Ascension Seton, Baylor Scott & White Health, UTHealth School of Public Health in Austin, and UT Dell Medical School is leading a comprehensive community health planning effort to measurably improve the health of Austin/Travis County, TX residents, the Austin/Travis County Community Health Plan. This effort entails two major phases:

1. A community health assessment (CHA) to identify the health-related needs and strengths of Austin/Travis County
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific strategies to be implemented in a coordinated way across the Austin/Travis County

In addition to guiding future services, programs, and policies for these agencies and the area overall, the CHA and CHIP are also prerequisites for the health department to earn accreditation from the Public Health Accreditation Board (PHAB), which indicates that the agency is meeting national standards.

This report presents the findings from the 2022 Assessment for Austin/Travis County, which was conducted July – December 2021 using a collaborative, participatory approach. These findings will inform discussions and priority areas for the CHIP, scheduled to take place August 2022 – February 2023.

PURPOSE AND GEOGRAPHIC SCOPE OF THE AUSTIN/TRAVIS COUNTY COMMUNITY HEALTH ASSESSMENT

The 2022 Austin/Travis County CHA was conducted to fulfill several overarching goals, specifically:

- To examine the current health status across Austin/Travis County as compared to state and national indicators
- To explore the current health priorities among Austin/Travis County residents within the social context of their communities
- To identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County

This CHA focuses on Travis County, which is home to numerous communities, including Austin, Texas state capital. While the largest proportion of the population in Travis County ("the County") resides in the City of Austin, given the fluidity of where people work and live in the County and that numerous social service and health organizations in the area serve individuals across the County, a focused effort was made to include data and the community voice from across the County.

This community health assessment provides a snapshot in time of community strengths, needs, and perceptions. It should be acknowledged that there are numerous community initiatives and plans, expansion of health and social services, and improvements in programs and services that have recently been undertaken. This report does not delve into these areas, but further examination of these initiatives will occur during the CHIP process when discussions focus on specific health issues.

METHODS

With the aim of better understanding not only the priority health needs of the Austin/Travis County community- but the social factors that influence these needs as presented in Figure 10, a mixed methods approach based in qualitative and quantitative assessment methods of inquiry formed the foundation of the 2022CHA. Guided by a stakeholder-engaged, collaborative approach assessment aimed to identify both the strengths and needs of Austin/Travis County community residents via the following methods: secondary analysis of existing health and social data; primary data collection via focus groups, interviews, and community forums; and content analysis of existing local partners' assessment reports.

MAPP FRAMEWORK

In guiding the 2022 CHA, we followed the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-driven strategic planning process developed and hosted by the National Association of County and City Health Officials (NACCHO). This framework was helpful for guiding the 2012 and 2017 Austin/Travis County CHAs and the 2022 CHA builds on the organizational infrastructure established in previous cycles, while incorporating changes made to the framework in the latest, MAPP 2.0 version. The new process centers three main assessments [see Appendix H for further information]:

- Community Partner Assessment: reflective assessment by community partners to look critically within their own systems and processes and assess their role in the community's health and well-being.
- Community Status Assessment: quantitative description of the status of the community, including community demographics, health status, contributing factors (e.g., social/structural determinants), health equity indicators, and across all these variables, existing inequities.
- Community Context Assessment: focus on perspectives from community members with lived experience, as well as a deep analysis of historical, systemic, and structural information which elucidate the root causes of inequity.

Components of all three assessments are incorporated throughout the report to provide a more contextualized narrative of health and well-being for the Austin/Travis County area.

Table 1. Components & Methodologies of Assessments

Assessment	Methodology used to Address
Community Partner Assessment	Community Partner Assessment Summit Community Partner Survey (not included due to low response rate)
Community Status Assessment	Secondary Data Collection Content Analysis
Community Context Assessment	Primary Data Collection Content Analysis Historical Overview

SECONDARY DATA

To develop a social, economic, and health portrait of Austin/Travis County through a social determinants of health framework, existing data were drawn from state, county, and local sources. Sources of data included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, County Health Rankings, Texas Department of State Health Services, Austin Area Sustainability Indicators Project, and Quality of Life Reports. Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS), public health disease surveillance data, as well as vital statistics based on birth and death records. The BRFSS, a telephone survey of adult residents, asks respondents about their behaviors that influence health, as well as whether they have had or currently have specific conditions.

The Data & Research Sub-Committee, composed of subject-matter experts from partner organizations, reviewed past indicators and provided updates and recommendations for inclusion in the 2022 CHA. A variety of partners gathered data for this report, including Austin Public Health, CAN, Integral Care, LBJ School of Public Policy, and Travis County HHS. Additionally, IBM Watson Consultants provided data as part of a larger realignment between APH's CHA and hospital partners' Community Health Needs Assessments (CHNAs). The secondary data collection, compilation and analyses addressed one of the goals of this assessment—to examine the current health status across Austin/Travis County as compared to state and national indicators.

Local assessments informed the 2022 CHA by providing further context for specific priority communities and topics. Several organizations shared their reports for inclusion which staff then reviewed for relevant data. Citations for these reports can be found in Appendix K.

PRIMARY DATA: INPUT FROM COMMUNITY REPRESENTATIVES

This assessment sought to elevate community voices and gather input from a diverse and representative group of individuals. Local community leaders and organizations, participants of the Community Engagement Sub-Committee, assisted in developing materials and identifying and targeting residents for outreach for focus groups, In-depth interviews, Key interviews, and possible community forums. The Community Engagement Sub-Committee also reviewed 2017 CHA Interview guides and provided updates and edits for the 2022 CHA interview guides [see Appendix D]. A variety of qualitative data collection methods were employed in the 2022 CHA (Table 2) and are further detailed below.

Table 2. Overview of Qualitative Data Collection

Type of Outreach	Target Population	# of events	# of Participants
Community Partner Assessment	Health Stakeholders	1 Event	27 Participants
General Key Interviews	Community Leaders	17 Interviews	20 Participants
In-Depth Interviews	Community Members	2 Interviews	2 Participants
Focus Groups	Community Members	7 Focus Groups	48 Participants
Virtual Community Forum	Community Members and Leaders	1 Event	16 Participants
Radio Talk-Show	Community Members	1 Event	3 Participants
Photo Outreach Campaign	Community Members	41 Submissions	23 Participants
Total			139 Participants

Community Partner Assessment Summit

In the fall of 2021, partners attended a Community Partner Assessment Summit as a part of the 2022 Community Health Assessment efforts. The event was a component of the new Mobilizing for Action through Partnerships and Participation Evolution process (i.e. MAPP 2.0) and took place on Sept. 10, 2021 via a virtual Teams meeting with 27 individuals representing 21 unique organizations.

As part of the Summit, participants completed a “Circles of Involvement” activity in which participants provided feedback on which organizations to involve in the community health planning efforts and how to do so efficiently.

Major themes in the responses included:

- organizations and/or providers that provide direct care, including CHWs, Primary Care Physicians (PCP), Doulas, Caregivers, FQHCs, etc.
- Organizations involved in school districts, including School Health Advisory Council, PTAs, and Parent Support Specialists as well as CATCH (Coordinated Approach to Child Health) nights at schools.
- Participants also highlighted the need to engage with residents in a variety of capacities, engaging retired volunteers as paid engagement ambassadors; similarly, grassroots efforts and organizations were also mentioned as a point of focus.
- Other major themes included a focus on older adults and behavioral health and engagement with faith-based organizations and/or churches. Significantly, several coalitions were cited, drawing attention to the importance of aligning community health planning efforts with existing collaboratives and alliances. Specific communities were also identified in the exercise, such as focusing on Black, Indigenous, and People of Color (BIPOC) and the Asian communities.

Participants also shared the following **barriers to community representation**:

- participant fatigue,
- lack of representation,
- lack of participation from residents directly impacted by services provided, e.g. “...many people who plan transit don’t rely on transit (should get more representation from the people that receive the services; giving a paid consulting position to community members that use these services)...”

- Other concerns included language barriers and the lack of translated materials as well as digital divides and tailoring work to meet community needs, e.g. work schedule, financial needs, transportation, etc.

Discussion about how the community factors into the process included mentions of youth, church leaders, schools, and pregnant individuals' partners: *"Sexual health efforts are mostly being led by professionals right now... trying to amend by creating more opportunities for youth to participate."* Additionally, one participant challenged assumptions of "community" and expanding on those limitations. Additionally, references were made regarding "trust" and the use of existing networks as critical to reaching communities of color. Several participants declared the need for increased community involvement overall.

Participants also discussed **lessons learned** from COVID and the need to be creative with solutions as well as the need to listen to people and meet them "where they are."

- One participant shared that *"Thinking about flexibility as we had to change a lot of the way we do things with a huge shift to virtual events and appointments."*
- Another also noted the benefits of having online applications that individuals can access through mobile as very successful.
- One participant noted the role funding plays in ensuring collaboration and providing incentives to share data.
- Other data concerns mentioned by organizations included duplication of efforts and sharing data. *"When you are funded by different agencies with different data requirements for each then you can burden the data services and cause the data to become a barrier and it is no longer streamlined."* They shared how different data requirements lead to information that cannot be used across different programs.

In addition to the Community Partner Assessment Summit, several qualitative methods were employed to gather complementary data.

Interviews

After identifying target communities, Austin Public Health contacted individuals and organizations for potential participation in the interview process. Staff from Austin Public Health and Travis County assisted with the data collection, completing 19 total interviews (Key and In-Depth), either in person or virtually. Interviewers and support staff completed outreach to community leaders and other participants via e-mail to schedule interviews and completed note-taking during the meetings. Only in-depth interviewees received \$20 Target gift cards for their participation.

Focus Groups

The Community Engagement Sub-Committee assisted with identifying 13 preliminary communities for focus groups based on under-representation, being underserved communities, or lack of existing information. Austin Public Health completed seven focus groups ranging from 4 to 12 individuals, either in-person or virtually, with the following groups: Latino individuals (English and Spanish sessions), older adults, subsidized-housing residents, parent support specialists, and Pflugerville representatives. Focus group residents not acting in a professional capacity received \$20 Target gift cards for their participation. IBM Watson and Community Coalition for Health (C2H) also provided focus group findings from community health leaders and the African American male population respectively.

Radio Talk Show

In an effort to improve outreach and engage with a greater variety of audiences, Austin Public Health collaborated with KAZI FM, a radio station predominantly serving the African American community, to host a call-in radio program and gather community input regarding major health concerns and priorities. The radio station promoted the event ahead of time as did Austin Public Health. The night of the program, hosts introduced the segment and prompted community members to call in with their responses. Unfortunately, hosts only received three calls, too small of a sample size that the call contents could not be included in this report.

Community Forum

A virtual community forum was organized to allow community members to provide their insight with regards to 1) barriers, 2) available resources, and 3) solutions for healthy living. City of Austin, Austin Public Health, and partner organizations promoted the event in three languages, English, Spanish, and Vietnamese ahead of the event. 16 forum participants joined break-out groups, divided by language and facilitated by community partners, and utilized Google slides to document their input for incorporation in the assessment.

Photo Outreach

In the summer of 2021, Austin Public Health engaged with the public for their LiveHealthyATX Photo Outreach project where they encouraged Austin and Travis County residents to submit photos via social media sites answering the question “What Makes You Healthy?” APH produced materials in English, Spanish, Vietnamese, and Chinese to engage with a diverse population and offered the top “liked” images gift cards for their submissions as well as publication in our 2022 Assessment. The project received 41 submissions by 23 unique participants. Images contained in this report were selected from individuals’ submissions.

Qualitative Data Analysis

The qualitative data from interviews, focus groups and the community forum were coded and then analyzed thematically for main categories and sub-themes using NVivo, Version 12. Data analysts identified key themes that emerged across all discussions as well as unique issues noted by specific individuals or groups. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While regional or other differences are noted where relevant, analyses emphasized findings common across Travis County. Illustrative quotes (paraphrased and direct) are presented throughout this report.

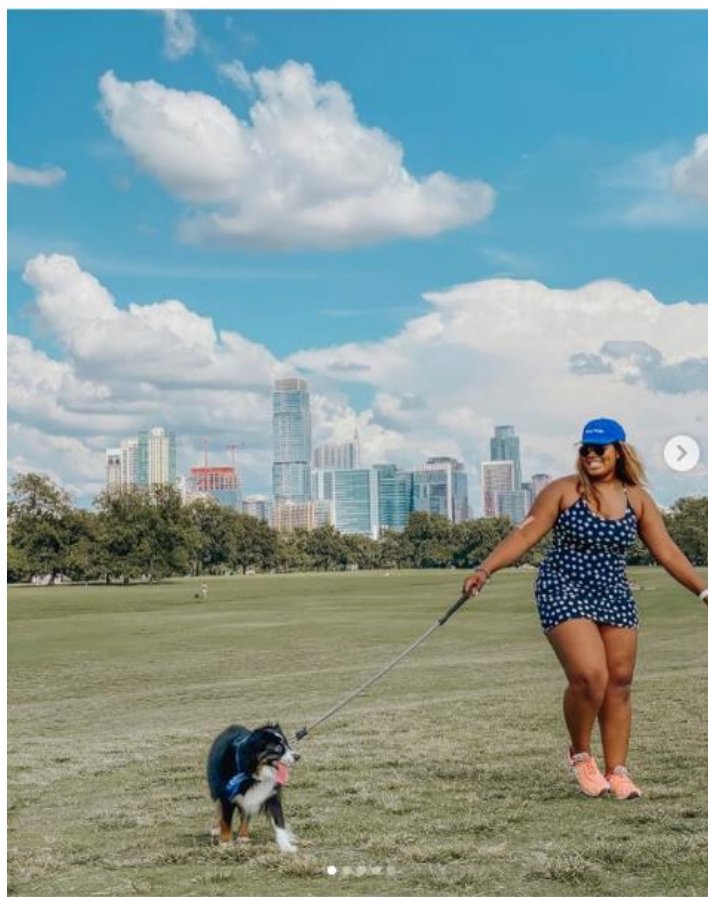
LIMITATIONS

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., city or zip code) due to small sub-sample sizes. Data visualizations may exclude categories or data labels for values under 5%. Some data for the population are estimates based on data collected from a subset of the total population. In some cases, data from multiple years may have been aggregated to allow for more accurate data estimates at a more granular level or among specific groups.

There were also severe limitations to outreach work and ability to complete focus groups due to the ongoing COVID pandemic; instead, researchers sought to connect with representatives and service providers targeting specific communities as well as pull information from local assessments and reports to supplement primary data collection. Communities that were underrepresented in data collection efforts for this assessment include refugee communities, youth, indigenous communities, people with disabilities, and faith leaders.

FINDINGS

FINDINGS: POPULATION CHARACTERISTICS



POPULATION CHARACTERISTICS

The following section provides a demographic overview of Austin and Travis County.

Overall Demographics

The most current figures from the 2020 Decennial Census show that the population experienced a growth nationally, in Texas, Travis County and Austin compared to the 2010 Decennial Census (Table 3). Texas experienced a 15.9% increase in population, resulting in a total population of 29,145,505. Travis County and Austin experienced population growth of 20.0% or more. Notably, the population growth in Texas from 2010 to 2020 was more than double the percent increase in population seen nationwide during this same period. In Travis County and Austin, the percent increase in population was approximately three times the percent increase in population across the US from 2010 to 2020.

Table 3. Total Population, by US, State, County and City, 2010 and 2020

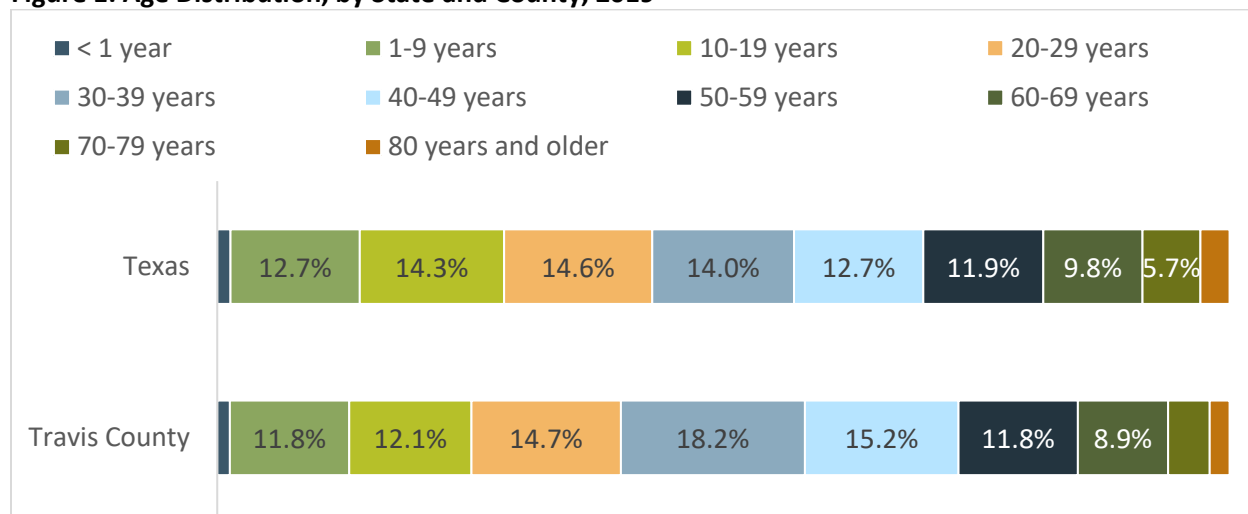
	2010	2020	% Population Change from 2010 to 2020
United States	308,745,538	331,449,281	7.4%
Texas	25,145,561	29,145,505	15.9%
Travis County	1,024,266	1,290,188	26.0%
Austin	801,829	961,855	20.0%

DATA SOURCE: U.S. Census Bureau, Decennial Census of Population and Housing, 2010 and 2020

Several focus group participants and community leaders described the Austin and Travis County region as growing substantially in recent years. When discussing population growth in recent years, several focus group participants suggested that higher income residents were the largest segment of new residents in the region. Several participants noted that the region has a transient feeling linked with growth of the population. One focus group participant observed, *“There are no more people born and raised from Austin because they were all priced out.”*

Age

In Travis County, about one-quarter (25.1%) of the population was under 19 years of age in 2019, which is slightly lower compared to the state of Texas (28.3%) (Figure 1). About half (48.1%) of Travis County’s population is comprised of residents aged 20-49 years, higher than in Texas overall (41.3%).

Figure 1. Age Distribution, by State and County, 2019


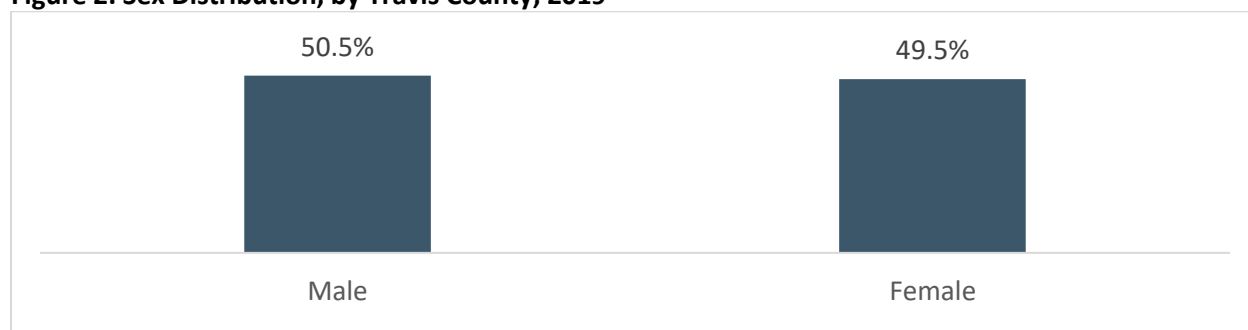
DATA SOURCE: Texas Demographic Center, University of Texas at San Antonio, 2019

NOTE: Data labels ≤ 5% not shown

A focus group participant explained that health issues are common among older adults: “[There are] many issues that hit you as you age. Always one thing or another.” Several focus group participants and community leaders also discussed the importance of providing more health care and social supports for older adults, which is discussed later in this assessment.

Gender and Sexual Orientation

According to the 2015-2019 Community Survey (U.S. Census), Travis County was comprised evenly of male (50.5%) and female (49.5%) residents (Figure 2).

Figure 2. Sex Distribution, by Travis County, 2019


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

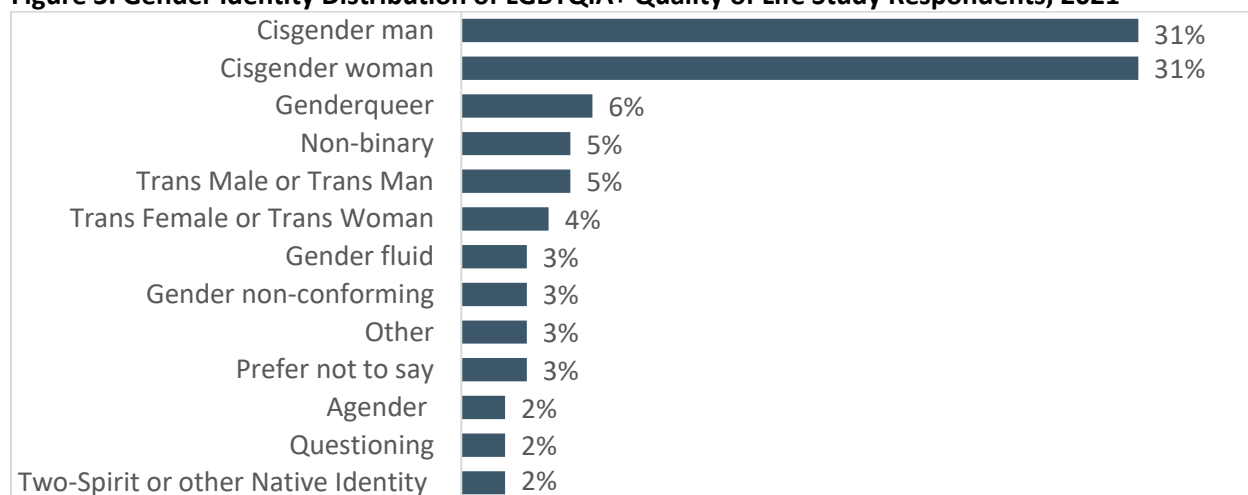
LGBTQIA+ Community in Austin

LGBTQIA+ is an acronym that brings together many different gender and sexual identities that often face marginalization across society. The acronym stands for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and the + holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities. In a March 2021 report, the Williams Institute estimates that the Austin-Round Rock-Georgetown metropolitan area had the 3rd largest percentage of LGBTQIA+ people (relative to the overall population size of the metro area) in the

country; they estimate that about 5.0% or 90,000 people in Austin-Round Rock-Georgetown metropolitan area identify as LGBTQIA+.

The ShoutOut Austin LGBTQIA+ Quality of Life Study gender identity definitions can be found in Appendix B: Gender Identity Definitions. Cisgender men and cisgender women each comprised 31% of survey respondents, followed by 6% genderqueer people (Figure 3). Note that respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

Figure 3. Gender Identity Distribution of LGBTQIA+ Quality of Life Study Respondents, 2021

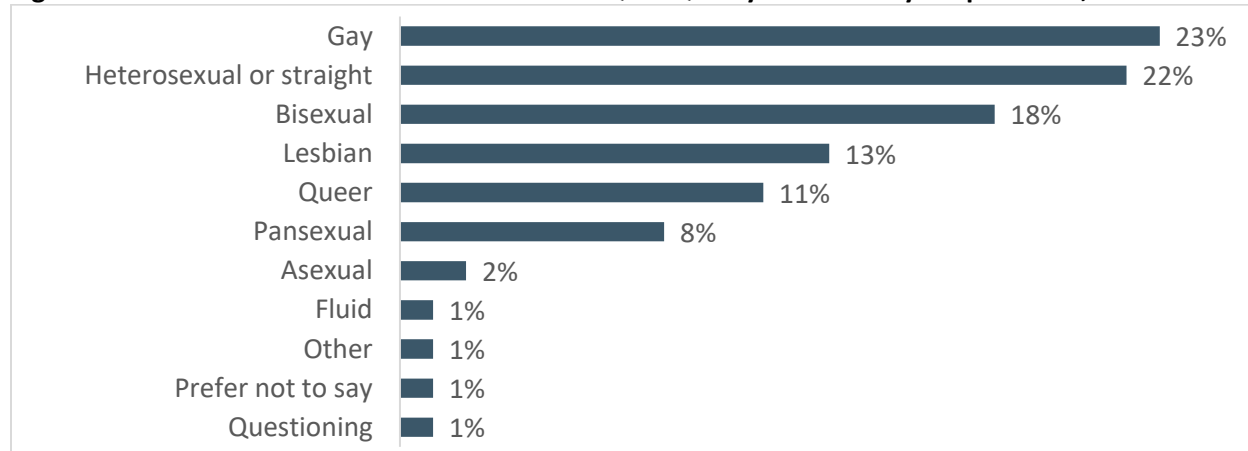


DATA SOURCE: City of Austin, Equity Office and LGBTQIA+Q Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

About one-fifth of respondents to the LGBTQIA+ Quality of Life Study identified as either gay (23.0%), heterosexual or straight (22.0%) or bisexual (18.0%) (Figure 4).

Figure 4. Sexual Orientation Distribution of LGBTQIA+ Quality of Life Study Respondents, 2021



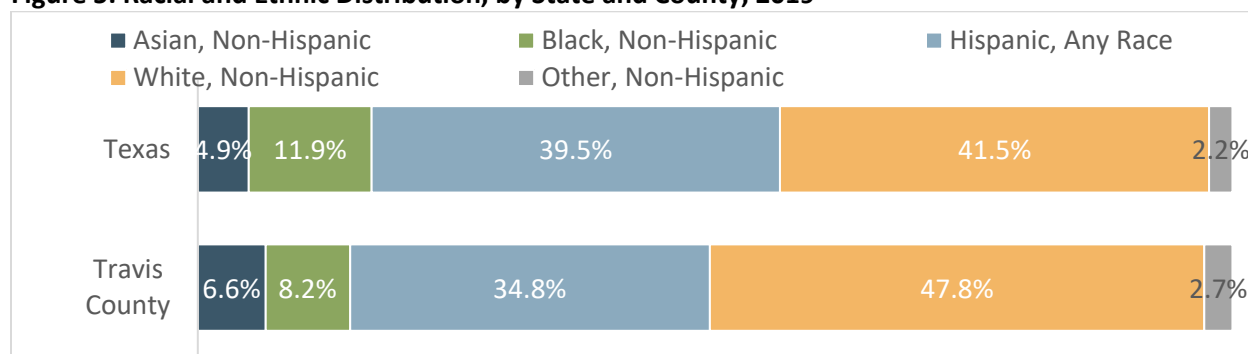
DATA SOURCE: City of Austin, Equity Office and LGBTQIA+ Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

Race/Ethnicity

In addition to gender and sexual orientation, population data were examined by race/ethnicity. More than half of residents in Travis County (52.2%) identified as people of color, a proportion that was slightly lower than across Texas (59.5%) (Figure 5). Almost half (47.8%) of Travis County residents identified as non-Hispanic White (henceforth, *White*), which was slightly higher than the percent of Texas residents (41.5%) who identified as White. More than one-third (34.8%) of Travis County residents and almost two-fifths (39.5%) of Texas residents identified as Hispanic/Latino. Non-Hispanic Black/African American (henceforth, *Black/African American*) residents made up 8.2% of Travis County and 11.9% of Texas populations; non-Hispanic Asian residents (henceforth, *Asian*) made up around 7% of the Travis County and less than 5% of Texas populations.¹

Figure 5. Racial and Ethnic Distribution, by State and County, 2019



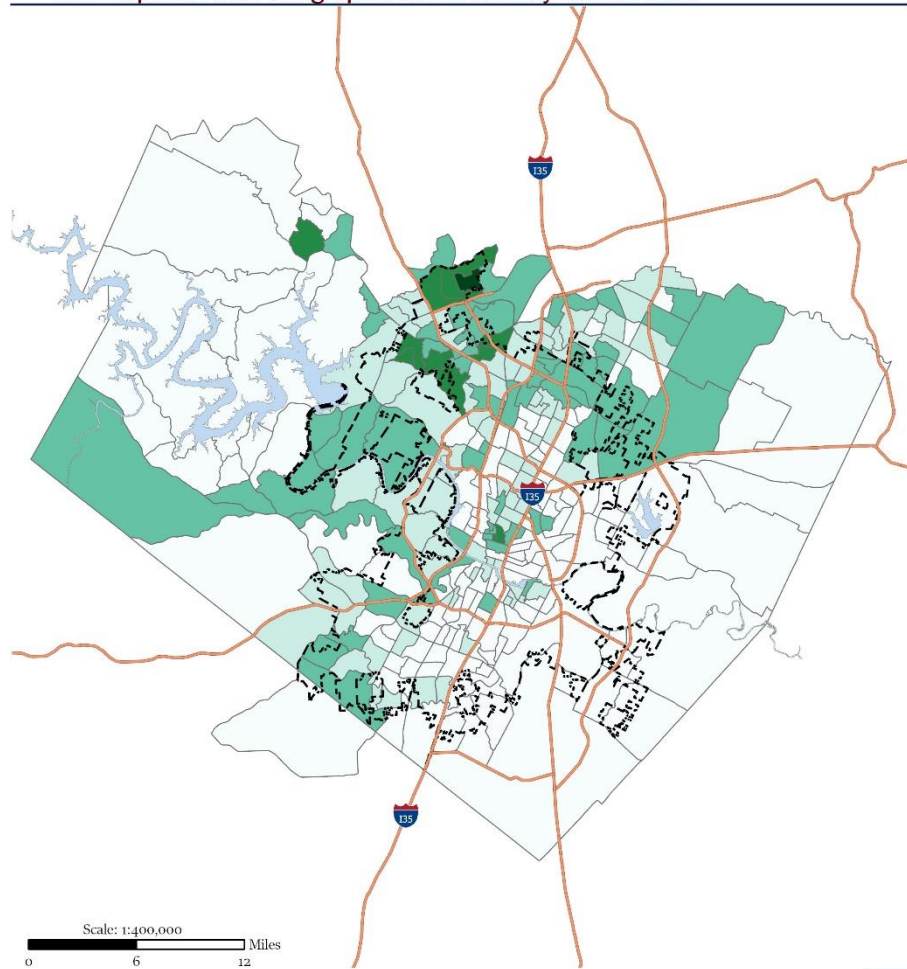
DATA SOURCE: Texas Demographic Center, The University of Texas at San Antonio, 2019

While the total population in Travis County increased by 26.0% from 2010 to 2020 according to the U.S. Decennial Census, when examining Travis County by census tract, there were varying percent changes in population by race/ethnicity.

¹ **Racial and ethnic terminology:** The term “Hispanic/Latino” is used to refer to persons who identify as Hispanic or Latina/o/x. The terms Black, White, and Asian to refer to non-Hispanic persons who identify with these racial/ethnic groups.

Census 2020, Travis County, TX

Non-Hispanic Asian Geographic Distribution by Census Tract



Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

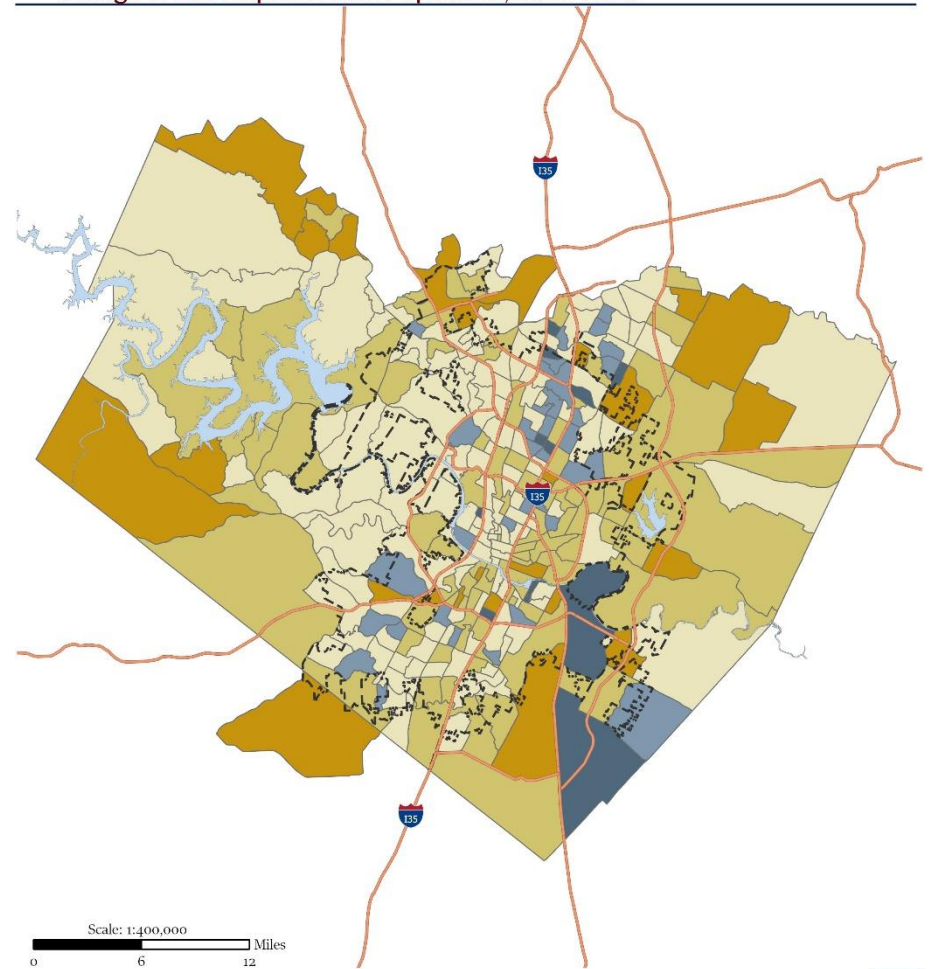
Non-Hispanic Asian Population
Percent of Total
Census Tract

- 5% and below
- 6% to 10%
- 11% to 25%
- 26% to 50%
- 50% and above

— Austin City Limits

Census 2020, Austin TX MSA

Change in Non-Hispanic Asian Population, 2010-2020



Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

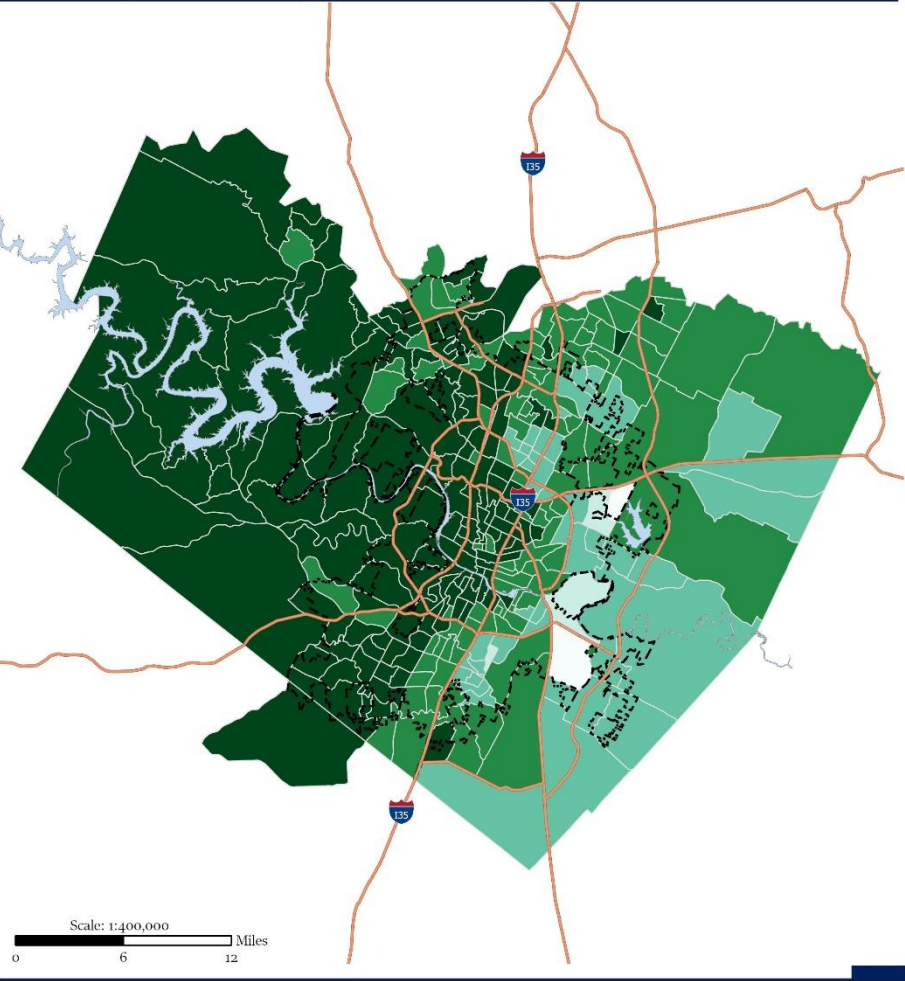
Non-Hispanic Asian
Population Change per
Census Tract

- 100% to 25%
- 24% to 0%
- 1% to 100%
- 101% to 500%
- 501% and above

— Austin City Limits

Census 2020, Travis County, TX

Non-Hispanic White Geographic Distribution by Census Tract



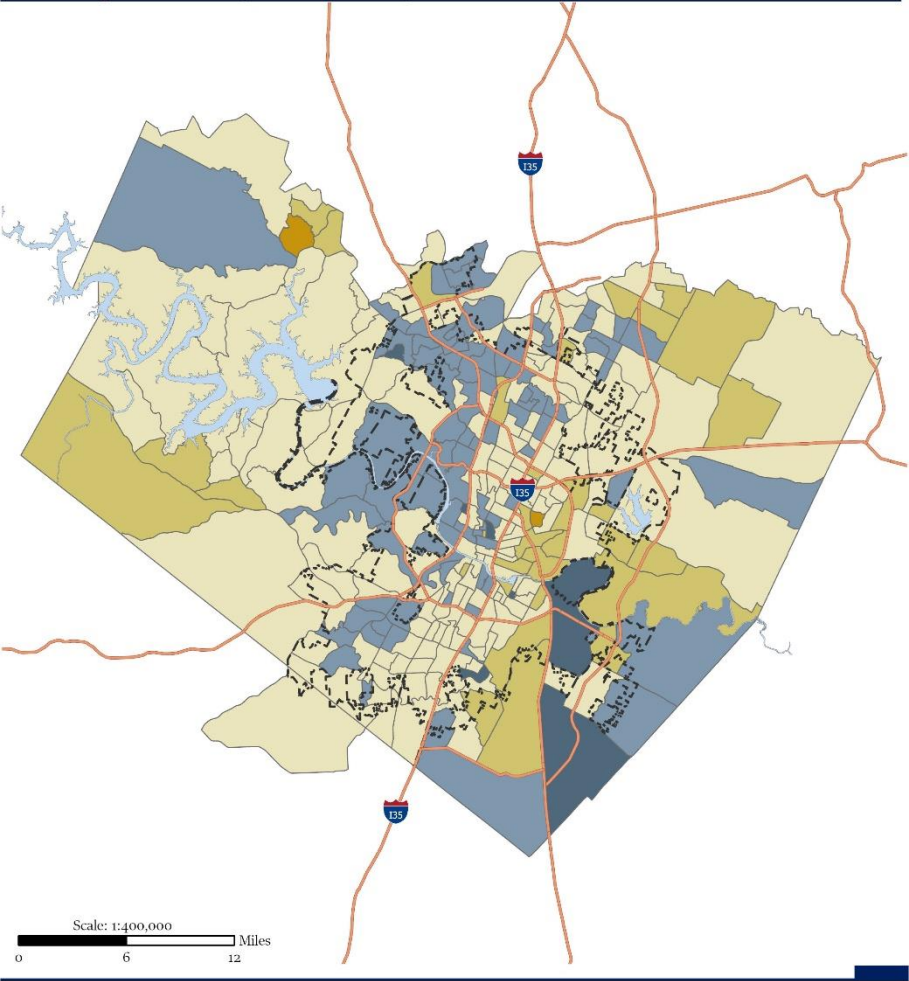
Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Non-Hispanic White Population
Percent of Total
Census Tract



Census 2020, Travis County, TX

Change in Non-Hispanic White Population, 2010-2020



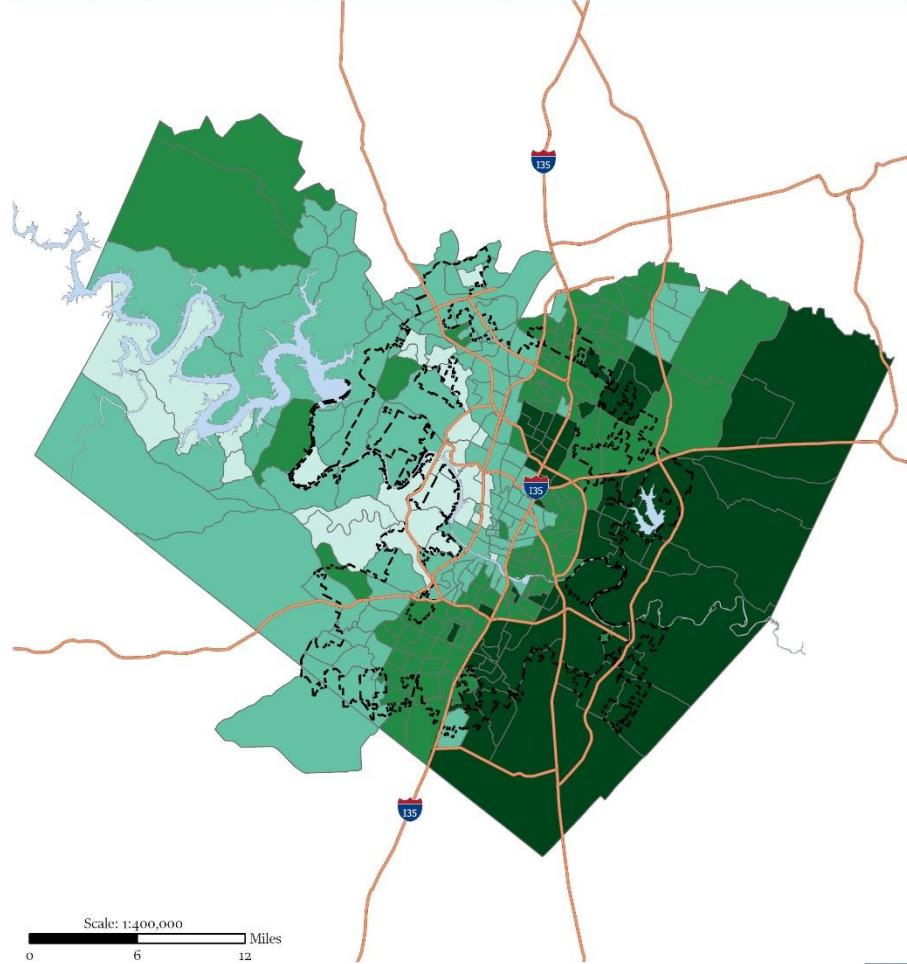
Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Non-Hispanic White
Population Change per
Census Tract

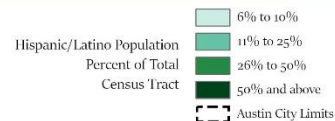


Census 2020, Travis County, TX

Hispanic/Latino Geographic Distribution by Census Tract

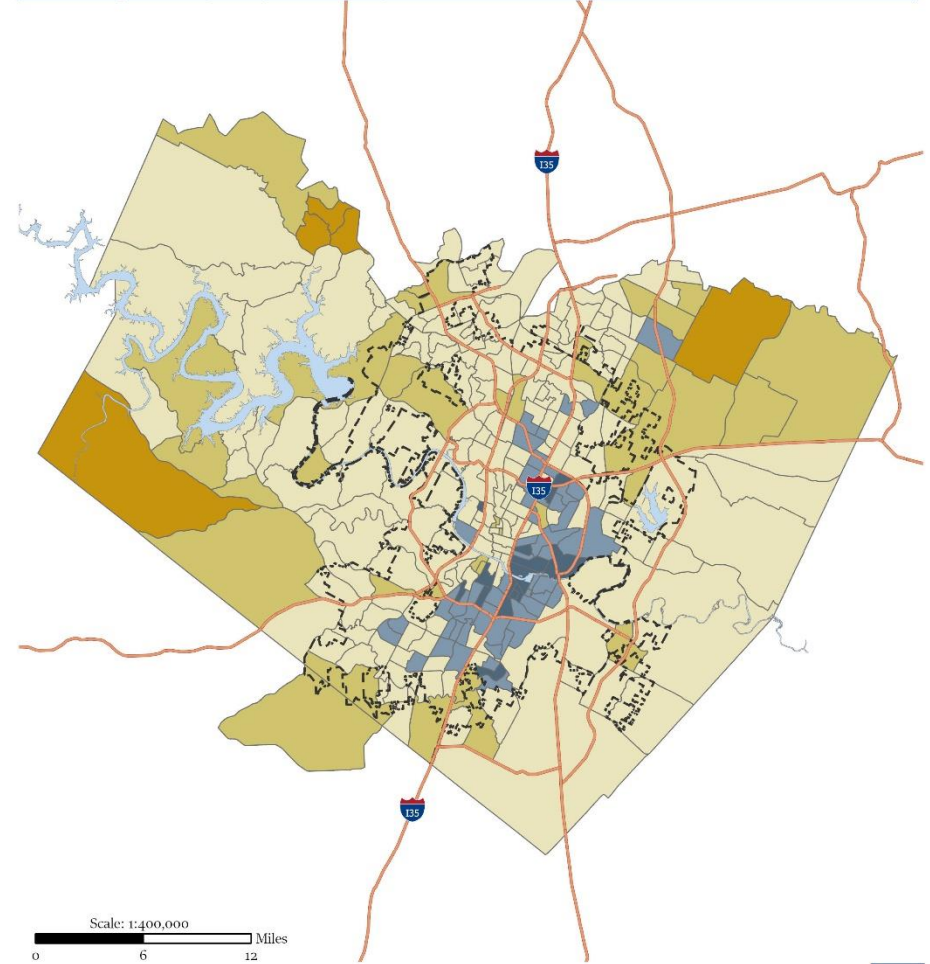


Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

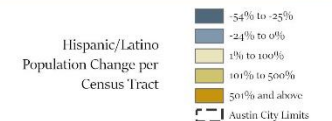


Census 2020, Travis County, TX

Change in Hispanic/Latino Population, 2010-2020

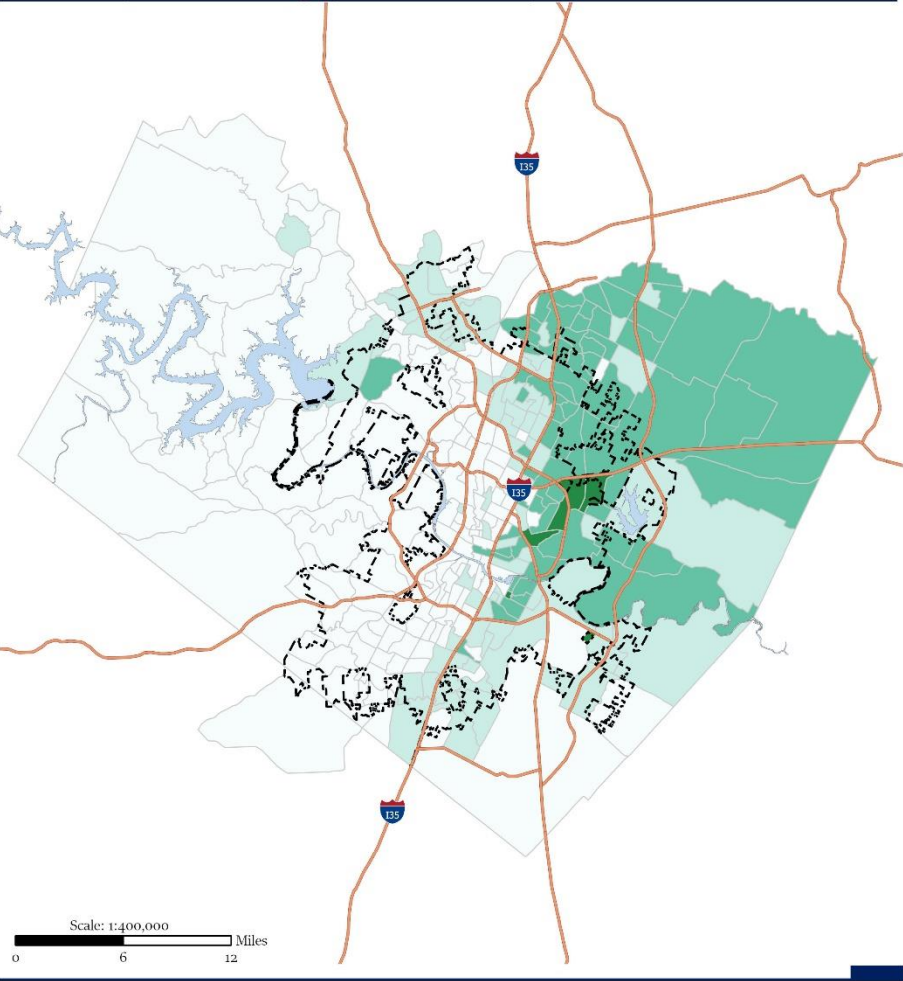


Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

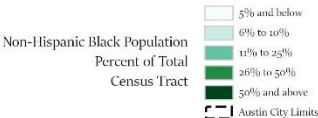


Census 2020, Travis County, TX

Non-Hispanic Black Geographic Distribution by Census Tract

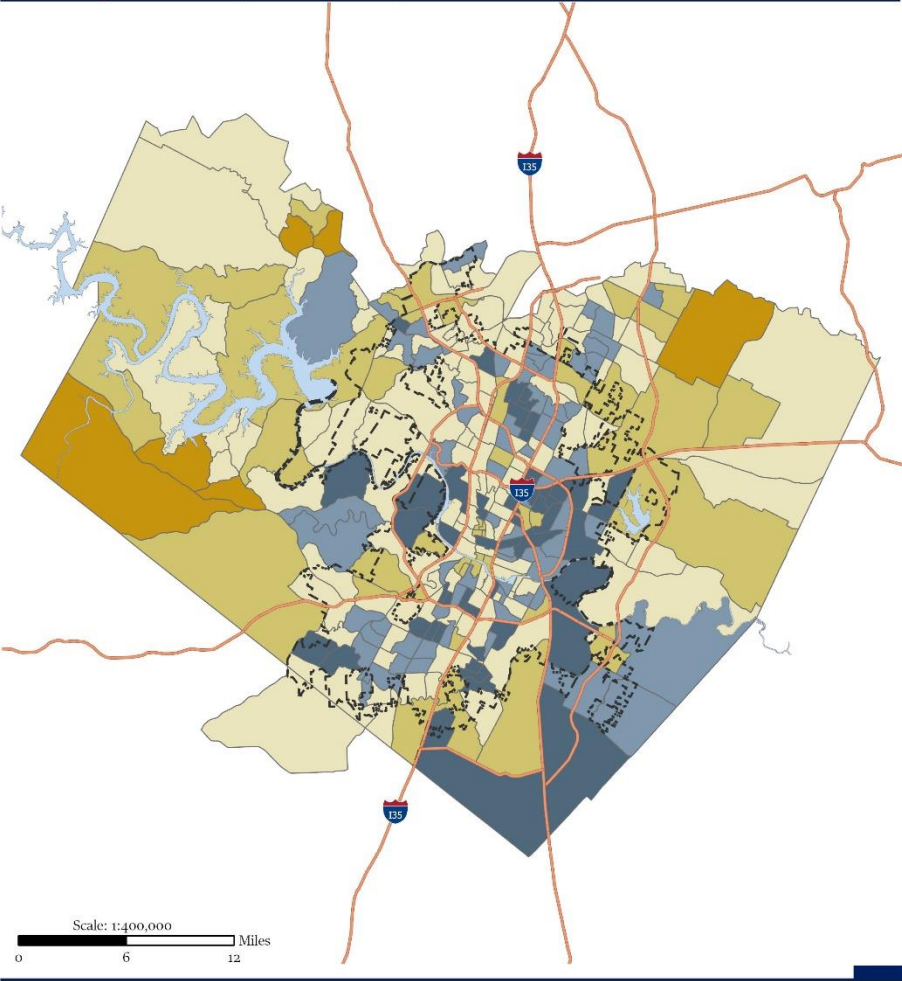


Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

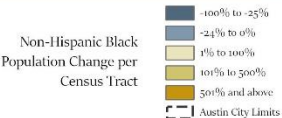


Census 2020, Travis County, TX

Change in Non-Hispanic Black Population, 2010-2020

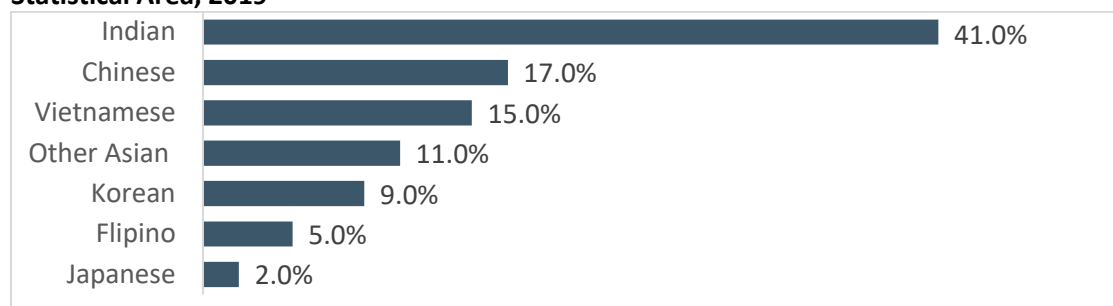


Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File



According to ACS data (U.S Census) cited by Greater Austin Asian Chamber of Commerce, Asian Americans in Austin are the fastest growing demographic group, with the Asian population doubling every twelve years.² About 8% of residents in the Austin metropolitan statistical area (MSA) identified as Asian American, with the highest percentage of the Asian population originating or descending from India (41.0%) and China (17.0%) (Figure 6). In addition to the groups listed in Figure 6, Austin is home to emerging refugee populations from Nepal, Burma, Cambodia and Laos.

Figure 6. Percent Asian Population by Countries of Origin, by Austin Round Rock Metropolitan Statistical Area, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey; as cited by Greater Austin Asian Chamber of Commerce, 2019

When asked to describe the population in the Austin and Travis County region, focus group participants and community leaders described the population as very diverse racially and ethnically, including Hispanic/Latino, South Asian, Black/African American, and Korean residents. Several community leaders and focus group participants observed growing socioeconomic inequities in the region that particularly affect residents of color.

One community leader described outlying regions of Travis County where Korean communities are established: *“There are some [Koreans] in Pflugerville, Round Rock, Cedar Park, Georgetown ... Many Koreans including some older populations live here, [they are a] population of less than 10,000, but more are moving in.”*

Another community leader described the Muslim community in the area as socioeconomically diverse: *“It is a very diverse population economically with people who have lucrative careers or are more financially well-off, but you also have recent arrivals of refugees.”*

According to another community leader, there is a need for greater support for African American residents in the area: *“In the African American community, ‘we need everything,’ it’s alignment of services, awareness, mak[ing] sure [that] services are where and when they need to be. That they’re communicated how they need to be to those most in need. We see a lot of gaps to the most vulnerable populations. It’s not just diabetes, it’s holistically.”* – Community leader

Immigration and Language Needs

According to community leaders, the immigrant populations in the region includes Hispanic/Latino immigrants and some refugees from Middle Eastern and Asian countries. One community leader observed that the growth of the refugee community has slowed due to federal immigration restrictions in recent years that limited refugee migration to the United States (US).

Several participants described growth of the bilingual population in the region and a sizable population for whom English is not their first language. One focus group participant observed, *“The population is growing a lot, wherever you go there are bilingual people.”* Inadequate access to information and social and health care services in residents’ primary language emerged as a barrier to getting COVID-19 information, health information, and accessing social services and health care, which is discussed in later sections of this assessment.

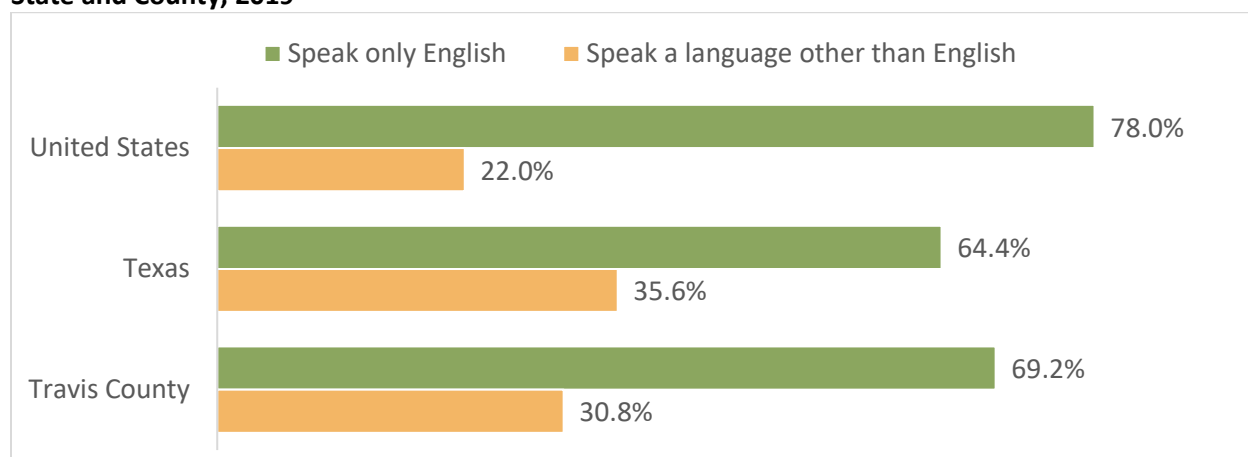
Some community leaders noted that a sizable proportion of Hispanic/Latino immigrants primarily speak Spanish, citing a need for services and information available in Spanish. One community leader who provides health care services to low-income residents described their patient population: *“75 to 85% of patients are Hispanic, most are immigrants, about 75% prefer Spanish, which is the best indicator for high rate of immigrants.”*

One community leader observed that the expansion of several tech industries in the area has attracted Asian immigrants who are fluent in English and/or whose educational experiences have prepared them for high-income careers that are booming in the region. Another community leader echoed that growth of immigrant communities linked with tech industries in the area have attracted younger immigrant workers who are fluent in English.

In contrast, according to one community leader, refugees are generally less likely to be fluent in English. This community leader emphasized the importance of investing in bilingual education programs for refugee communities: *“I want a language program [...] to teach English to our refugee population. Most immigrants who are non-refugees are here because they have an advanced skill set already. A big component of their community is those who are in the IT industry already.”*

According to Census data, a higher proportion of residents in Travis County (30.8%) and Texas (35.6%) speak a language other than English at home compared to the U.S. overall (22.0%) (Figure 7).

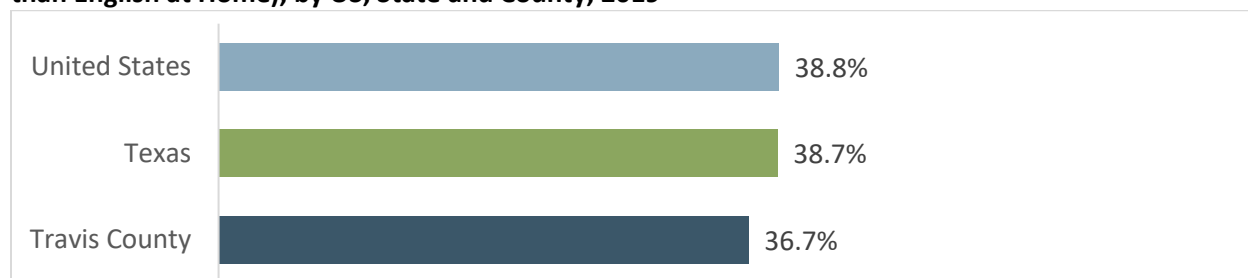
Figure 7. Percent Households Speaking Only English or Language Other than English at Home, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

About one-third of households in Travis County (36.7%) and Texas (38.7%) that speak a language other than English at home are considered non-English speaking households, defined as households that speak English less than “very well”; this percentage was similar for households across the US (38.8%) (Figure 8).

Figure 8. Percent Households Non-English Speaking (Among Households Speaking a Language Other than English at Home), by US, State and County, 2019

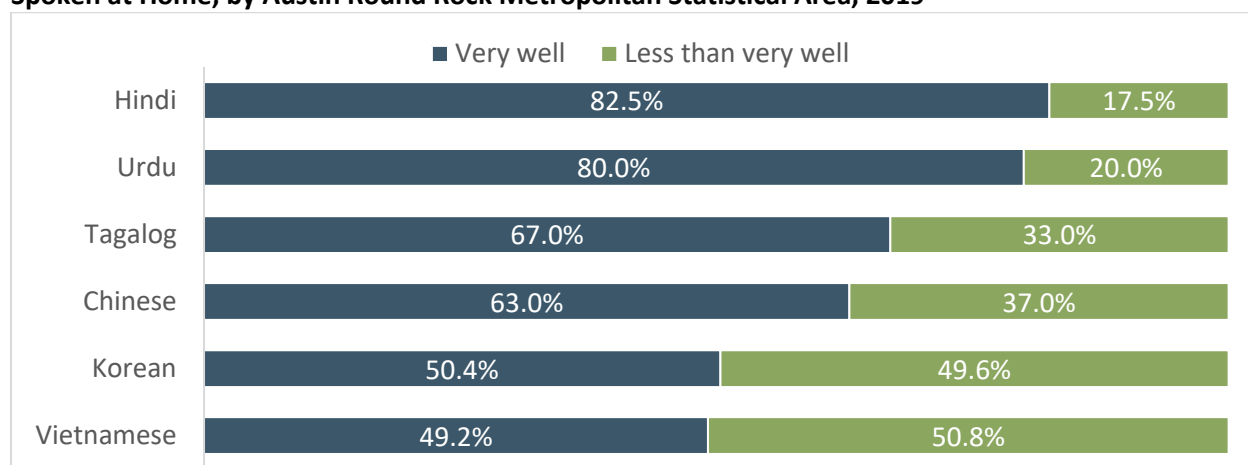


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

NOTE: Percentage of households that speak English less than “very well” within all households that “speak a language other than English”

Among Asian American households in the Austin Round Rock MSA, the percentage of households who speak English “less than very well” was highest among Vietnamese speaking (50.8%) and Korean speaking (49.6%) households and lowest among households that speak Hindi (17.5%) and Urdu (20.0%) at home (Figure 9).

Figure 9. Percent Households Speaking English “Very Well” and “Less than Very Well,” by Language Spoken at Home, by Austin Round Rock Metropolitan Statistical Area, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey; as cited by Greater Austin Asian Chamber of Commerce, 2019

NOTE: The primary Chinese dialects are Mandarin and Chinese

Several community leaders and focus group participants noted the importance of making sure that information about health and available resources, as well as services, are readily available in residents’ primary language. One community leader highlighted the centrality of providing information in language: *“Language access is key. If you don’t have any material to educate yourself about a health disease, then changes can’t really be made. Each community has a very nuanced way of looking at wellbeing.”* Another community leader echoed the need for language justice to promote health equity, *“Language is a barrier to the people that need resources the most.”*

Community forum participants concurred. Language access emerged as an important barrier to information about resources and to receiving quality services for community members for whom English is not their primary language. Forum participants recommended improving outreach efforts by ensuring that information is available in residents’ primary language, using in-person modes of communication, and leveraging the language skills of community-based organizations to address language gaps in public health services and information.

One community leader characterized the current limited state of **language support** from local governmental leaders, a gap which their organization has had to fill to address information and resource gaps that affect the diverse Asian and Pacific Islander community in the region: *“We have no language support from the city. We have about 40 different [Asian and Pacific Islander] languages spoken in Travis County.”* One community leader described the importance of local governmental representatives collaborating with and supporting community-based initiatives in **improving access to information** and resources in residents’ primary language. To address the gap in information available in residents’ primary language, one community leader shared how Korean communities in the region rely on information made available by other cities:

“We are intertwined with other cities with Korean associations. We don’t get our information from Austin. We get our information from other cities, so I think this association will take a good role in this

community and it would be nice to be a part of what the city is trying to do. It is very important how the city supports us.” – Community Leader

One community leader identified the need to **improve outreach** to Spanish-speaking communities who are increasingly living in the outskirts of the City.

“I think trying to continue to reach Spanish speaking and organizations that provide or cater to Spanish speaking population. A lot of them may exist in Central and East Austin, but [you] don’t see many providing services as far out here [Del Valle]. So, how can we get them out here doing more targeted work?” – Community leader

Another community leader emphasized that **translation of information** must be culturally tailored: *“Translation must also relate to the cultures, such as having community outreach things such as fliers being made by people from that community.”*

Some Hispanic/Latino focus group participants and some community leader described **legal status as a barrier** to accessing services and resources.

“I know that not having it [authorized US presence], being scared to ask for services, it’s about what they will ask [for]. If they ask for your Social Security card, that could be an impediment for a person seeking additional services, because they fear what if they ask me for it and I don’t have one. What if something happens and... I think it could be a factor that keeps them from looking for additional services.” – Focus Group Participant

Some Hispanic/Latino focus group participants mentioned not being able to access federal stimulus payments linked with the COVID-19 pandemic due to their **legal status**, including assistance for US citizen children. One focus group participant shared, *“They [...] also said that the parents of children who were citizens were going to obtain some of the money through the children, for me that is not true because they never sent us anything.”* A community leader elaborated on the challenges that undocumented communities face in accessing financial assistance that to which they are entitled:

“[For] undocumented people in Del Valle, [there is] a lot of misinformation about ability to apply for financial assistance. If they don’t qualify for federal dollars, other pots of money are available, with their account; water and gas, even with no documentation, there are still services available.” – Community Leader

One focus group participant explained how state-issued government identification card policies that exclude undocumented immigrants from accessing a usual state ID or driver’s license make it difficult to access resources linked with having a current state ID and also limit one’s sense of belonging. They explained:

“I would like it if we were all treated equally. Even the ID they used to issue here in Texas they no longer do it. There are places where they ask for a Texas ID, they don’t accept registration, so you feel bad. And they forbid it, because one feels like a second-class person because we are

not the same as those who can show their driver's license or identification. In that I have felt quite [excluded].” – Focus Group Participant

Notably, in-depth interview participants also discussed at length the challenges of navigating day-to-day activities, such as seeing a doctor or securing housing, due to lack of a current state-issued ID or driver’s license.

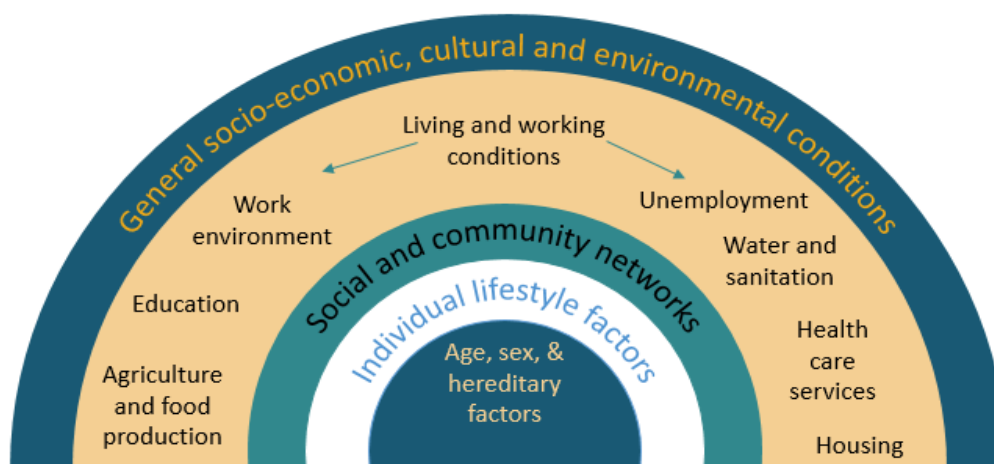
FINDINGS: COMMUNITY SOCIAL AND ECONOMIC CONTEXT



COMMUNITY SOCIAL AND ECONOMIC CONTEXT

As noted previously, this assessment focused on the social and economic issues that affect a community's health. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing, and economic policies. Figure 10 provides a visual representation of these relationships.

Figure 10. Social Determinants of Health Framework



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

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to understand the current health status of residents and the multitude of factors that influence their health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Economic Indicators

Income is a powerful social determinant of health. At an individual level, income influences where people live, their ability to access higher education and skills training, and their access to resources to help them cope with stressors, all of which affect health and well-being. Income also shapes access to health-promoting resources such as healthy food, health care, and technological advances (e.g., new medical treatments).³ Compared to their higher income counterparts, low-income individuals have higher rates of smoking, obesity, and physical inactivity; more limited access to healthy foods, opportunities for physical activity, and healthy environments; higher rates of physical limitations, heart disease, diabetes, stroke, and other chronic conditions; and more limited access to health care.⁴ At a community level, regardless of individual level of income, low community wealth often correlates with more limited educational and job opportunities, greater community violence, environmental pollution and disinvestment in essential infrastructure and resources.⁵ While income, education, and employment are all associated with health outcomes in slightly different ways, many of the same population groups—communities of color, women, immigrants, and others—experience the compounded

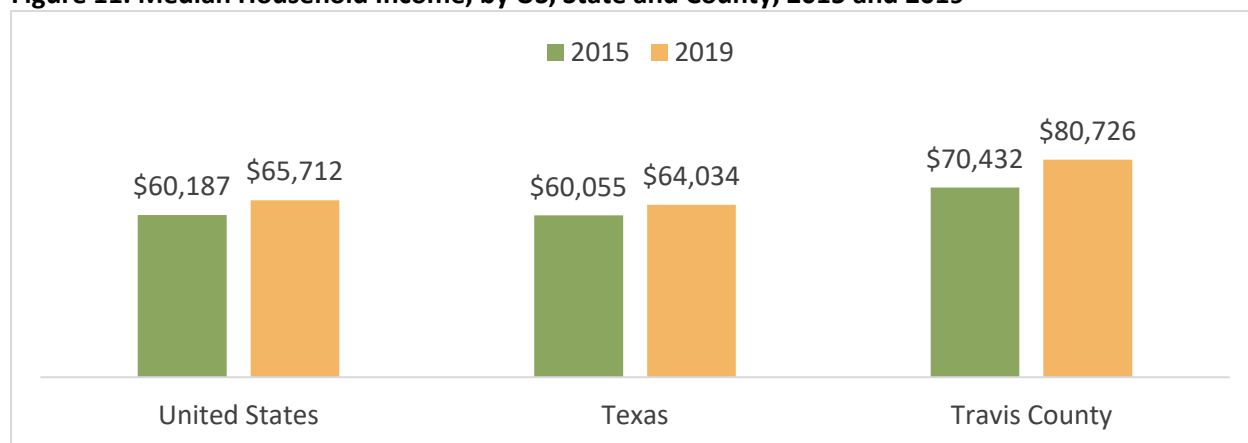
challenges and structural inequities across the myriad of systems related to economic advancement and upward mobility.

Austin’s history is rooted in **the exploitation of the labor of many communities of color**, which has led to the devaluation of the labor of these communities. Austin’s history, like many other communities in this country, was shaped by public policies that invested in wealth-generating opportunities for white communities while excluding communities of color from the same resources. Additionally, the role of housing in wealth generation for or wealth stripping from communities was split largely along racial and socioeconomic lines. More recently with the 2008 recession, Black communities were targeted for subprime mortgages, and the result of the crash was that many Black households have even less equity through homeownership than before 2008.⁶

“And the deal is, those problems [financial stress] how do they trickle [sic] down to the child: lack of food, diapers, lack of healthcare, lack of a job, the ability to have the necessary education, or tablet, so they can be ready for school, first day grade one reading on grade level.” –
Community Leader

American Community Survey (U.S Census) estimates from 2019 indicate that the median household income was higher in Travis County (\$80,726) and slightly lower in Texas (\$64,034) compared to the US overall (\$65,712) (Figure 11). Between 2015 and 2019, median household incomes increased the least in Texas (6.6%) and the most in Travis County (14.6%).

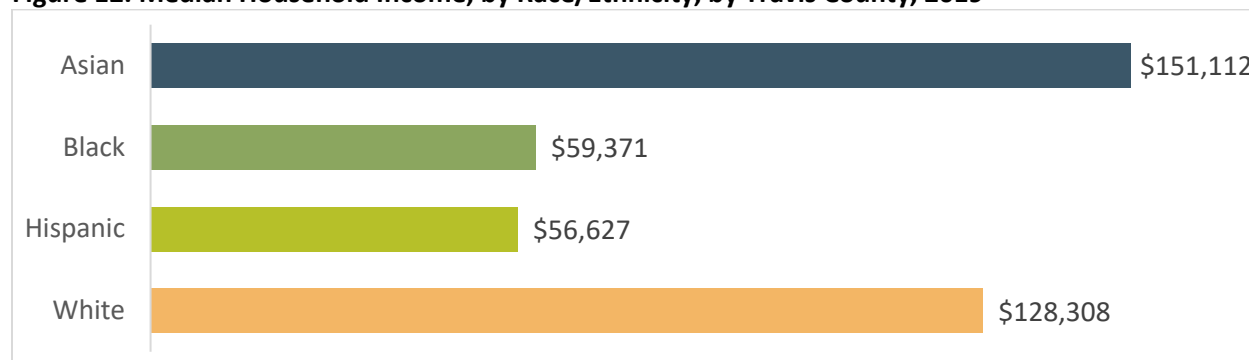
Figure 11. Median Household Income, by US, State and County, 2015 and 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2015 and 2019

When comparing median household income by race/ethnicity in Travis County, Asian households had the highest median household income (\$151,112), followed by White households (\$128,308) (Figure 12). In contrast, the median household income for White households was 2.2 times the household income for Black/African American households and 2.3 times the household income for Hispanic/Latino households in 2019.

Figure 12. Median Household Income, by Race/Ethnicity, by Travis County, 2019

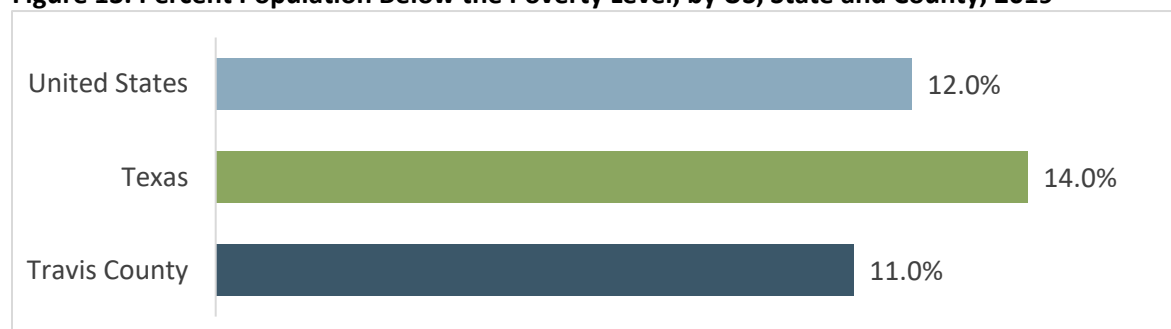


DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Additionally, about one-quarter (25.0%) of LGBTQIA+ respondents to the LGBTQIA+ Quality of Life Study survey reported having incomes below \$24,000, compared to nearly one-fifth (18.0%) of non-LGBTQIA+ respondents.

More than one-tenth of the population in Travis County (11%), Texas (14%), and the US (12%) lived below the federal poverty line, according to 2019 ACS estimates (Figure 14). In Travis County, 143,785 residents lived below the federal poverty level (data not shown).

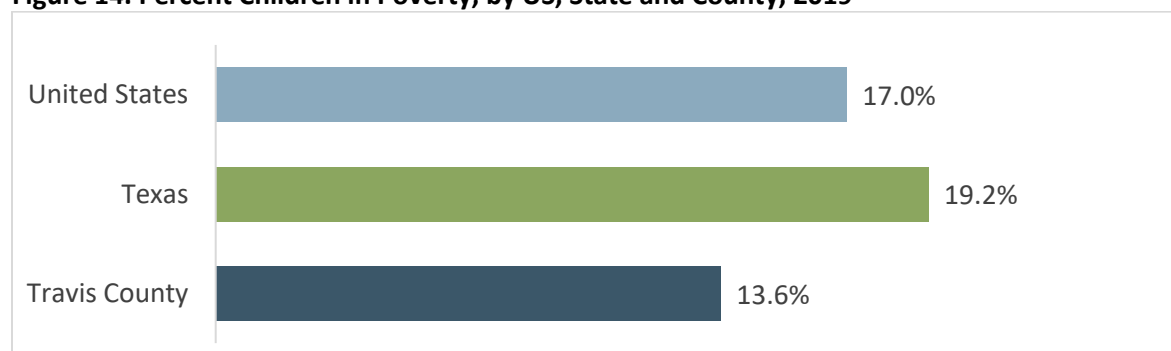
Figure 13. Percent Population Below the Poverty Level, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2019

According to 2019 County Health Rankings data, almost one-fifth of children in the US (17.0%) and Texas (19.2%) lived in poverty; this percentage was slightly lower in Travis County (13.6%) (Figure 14).

Figure 14. Percent Children in Poverty, by US, State and County, 2019



DATA SOURCE: Small Area Health Insurance Estimates (SAHIE), U.S. Census Bureau; as cited by County Health Rankings & Roadmaps, 2019

Many focus group participants, community leaders, and in-depth interview participants described the **cost of living** in the area as high and rising, which they linked with the **growing tech industry**. Several participants perceived that companies coming to the area were getting a tax break, while residents were experiencing increases in taxes. One Hispanic/Latino focus group participant who has lived in Austin for decades shared their experience with the rising cost of living:

“[T]he cost of living in Austin, I’ve been here 40+ years and it keeps going up. Austin keeps asking companies to come and they are coming and coming, but they’re not giving us regular people here a break, because taxes keep going up, I don’t know if this is part of health, but it is stressful, so I guess it is health. But they’re giving them a lot of [tax] break[s], where they’re putting the burden back on the taxpayer. They’re making a lot of the older residents where they don’t want to be here.”
– Focus Group Participant

One community leader characterized the day-to-day experiences of low-income residents as **survival**: *“If you look at some of our communities, there is no quality of life, it’s just survival.”* Another community leader described how due to rising gas costs in their neighborhood, they often traveled farther to fill up their gas tank, highlighting the day-to-day impacts and adjustments that residents are making due to the rising cost of living.

Some focus group participants and community leaders described the impossible equation of living on income from minimum wage jobs and paying for rent, childcare, and transportation. One community leader described this dilemma for a low-income family with young kids, particularly for single parents:

“[F]or the families, childcare cost is a problem. And a living wage. For example, a single mother with four kids, they can’t have a 15 or 16 dollar an hour job, and be able to afford an apartment in Austin. The high cost of apartments, if you have 3-4 kids in childcare, a car payment, rent, you are struggling. [...] Some of the mothers are trying to work 2 and 3 jobs. How do you work 2-3 jobs and not get caught up with CPS [Child Protective Services] looking at you to see if you’re a fit mother or a fit household. That’s the reality.” – Community Leader

According to focus group participants and several community leaders, **limited income and rising costs of living** are very stressful and negatively affect health for low-income residents, residents of color, and older adults across the region. One community leader described how Asian residents are often overlooked when thinking about low-income residents in the region.

Key informants identified several socioeconomic challenges that immigrants navigate, including securing work opportunities and responsibilities to financially support their kin networks. One community leader shared, *“Many immigrants are still trying to find work, [experiencing] language barriers.”* According to one community leader, barriers to job opportunities are compounded by economic responsibilities to family and communities in the United States and in their home countries. This community leader shared, *“You have an additional responsibility as well as an opportunity [regarding immigrants who are wanting to just work and send money home] to be a contributing member of this community that is now your community.”*

One Hispanic/Latino focus group participant highlighted the irony that Hispanic/Latino immigrants are employed in industries that are classified as “**essential work**” during the COVID-19 pandemic. This resident noted that construction industry in particular has been central to sustaining the growth across the region, yet their income and treatment does not honor these contributions.

Several focus group participants and community leaders described their communities and/or the communities they serve as including residents who work in low-wage jobs that are stressful, hard to get, and with incomes that make it difficult to make ends meet, while also observing a growth in high-income job opportunities that are attracting residents outside of the region. One community leader described the community in which they work:

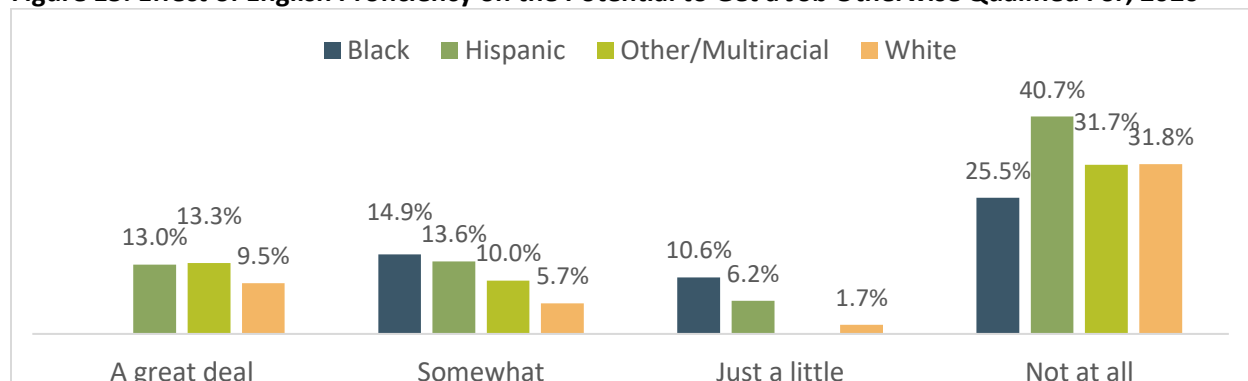
“Dove Springs is a working-class neighborhood, so these things mentioned affect everyone and the residents work all kinds of shifts due to their blue collar jobs.” – Community Leader

The perception of the **availability of quality education, professional development or training for jobs** remained roughly the same between 2008 and 2018, although a higher percentage of people (57%) viewed this kind of training as “usually available,” rather than “very available” than in past years. A higher percentage of Black/African American (26%) and Hispanic/Latino (19%) residents did not believe trainings for the kinds of jobs they sought were available, as compared to other racial/ethnic categories.⁷

One in-depth interview participant described how prison vocational programs inadequately prepare people to re-enter the workforce once they have been released from prison, making it difficult to re-integrate into society. *“...If the prison system is not going to help reentering citizens develop marketable skills, it’s to the advantage the community to do so. The more successful people are at reintegrating back into society the less of a threat they are, the more they will desire to integrate into norms of society.”*

When examining the effect of English proficiency on the potential to get a job they are otherwise qualified for, about two-fifths of Hispanic respondents (40.7%) reported that the lack of English proficiency did not affect them. In contrast, the highest percentages of Hispanic (26.2%) and Other/Multiracial (23.3%) respondents somewhat or a great deal affected their potential to get a job they would be otherwise qualified for (Figure 15). These findings could underscore the need for enhanced educational support for English training and other additional language support.

Figure 15. Effect of English Proficiency on the Potential to Get a Job Otherwise Qualified For, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: No response or N/A responses are excluded.

When discussing work, often focus group participants and several community leaders discussed the **impact of COVID-19 on work and stress** for low-wage workers. One focus group participant described how stress levels for residents working in low-wage jobs have worsened with the COVID-19 pandemic and contribute to increases in chronic disease:

“I see people that are working in construction almost all day and with a very low salary and they are the only ones that are outside, they are essential workers, all of them, many in restaurants, and lately with the pandemic, stress is building up. This is leading to more chronic diseases or, as I said before, it causes triglycerides to skyrocket, this is also a reason why we are seeing a poor diet, sleeplessness, and hard work.” – Focus Group Participant

Regarding **childcare needs for working individuals**, among Austin Area Community survey respondents with children under 6 years of age in the household, approximately one quarter (24.1%) of parents reported having difficulty finding childcare, with 36.0% reporting difficulty finding childcare during the evening or weekend. According to respondents, approximately two-fifths (42.9%) of Black/African American (42.9%), and (41.1%) of Hispanic/Latino (41.1%) respondents and 34.2% of White respondents reported that they had trouble finding affordable childcare not provided by a relative in the past two years. Some focus group participants and community leaders mentioned the role of older adults in caregiving to young children, and the importance of supporting older adults in their caregiving roles. One focus group participant explained, *“We have a lot of older people taking care of younger kids (children with their grandparents). [T]hey don’t have the resources or energy to take care of the kids, and we don’t have any specific support for that.”*

Some focus group participants and community leaders also discussed **limited supports for childcare**, including insufficient day care options, particularly in areas where the population is growing. One focus group participant in a rural community that was experiencing population growth explained the importance of investing in infrastructure to support families with young children:

“We need to have more daycares as well to make sure that as our community grows, we are able to meet some of those demands for our families. The more opportunities we open up for families to where Manor is self-sustaining and not needing to head to other towns/cities [would be helpful], because for now all of our families travel.” – Community leader

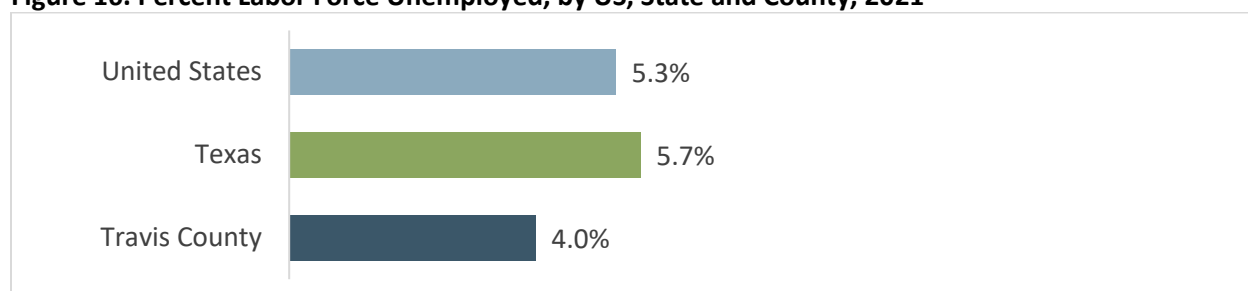
One community leader discussed the importance of providing **affordable childcare** for low-income households, many of whom rely on unlicensed childcare providers:

“We also work with unlicensed childcare providers. The reason being a single parent cannot afford to pay 500-800 a child in childcare. So someone that is unlicensed, on Social Security or disability, a big mama, a big papa, somebody in that apartment complex is taking care of those kids. Nine times out of ten, a lot of those parents are dropping kids off with not enough pampers, with not enough milk, with not enough food, so we try to support those unlicensed childcare centers.” – Community Leader

Unemployment

In 2019, the unemployment rate was 2.6% in Travis County, 3.5% in Texas, and 3.7% in US overall. Despite high employment levels of 96% to 95% of the working population in Del Valle and Montopolis, respectively, one out of four residents of Del Valle and one out of three residents in Montopolis lived in poverty.⁸ This low unemployment rate - taken together with the high level of residents living in poverty - may point to a major structural barrier for health and well-being for Del Valle and Montopolis families and residents: the lack of a living wage that allows people to move out of poverty while employed.⁹ Notably, the unemployment rate fluctuated during the COVID-19 pandemic and in 2021, the rate was 4.0% in Travis County, 5.7% in Texas and 5.3% in the US overall (Figure 16). Unemployment varied by race/ethnicity and in the US in 2021, Black residents had the highest rate of unemployment at 8.6%, followed by Hispanic at 6.8%; the unemployment rate was 5.0% for the Asian population and 4.7% for the White population.

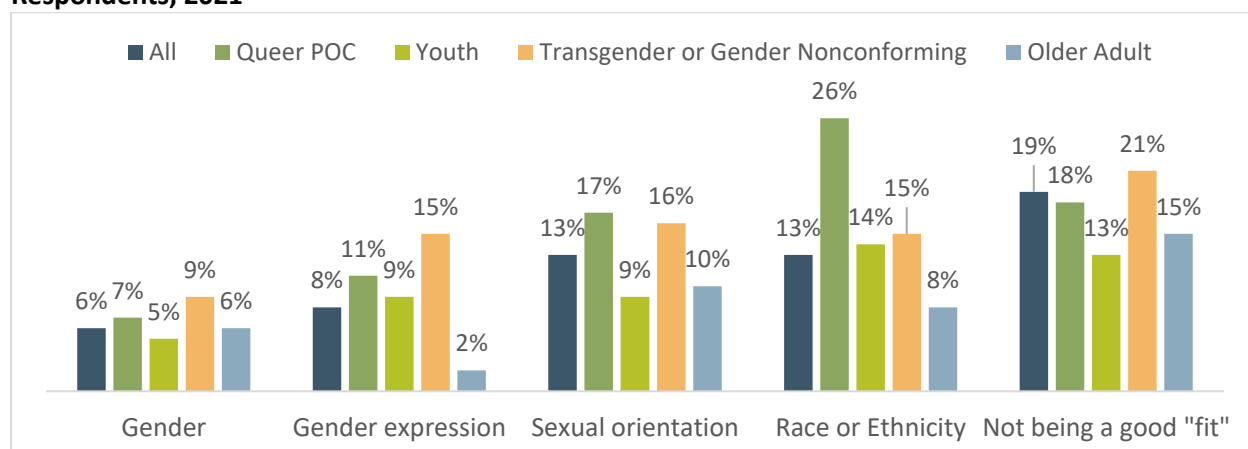
Figure 16. Percent Labor Force Unemployed, by US, State and County, 2021



DATA SOURCE: Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics; as cited by Texas Labor Market Information, 2021

A slightly higher percent of LGBTQIA+ respondents (7.0%) to the LGBTQIA+ Quality of Life Study survey reported being unemployed, compared to non-LGBTQIA+ respondents (5.0%). When respondents to the LGBTQIA+ Quality of Life Study survey were asked about reasons they were denied employment, queer people of color (POC) and transgender or gender nonconforming respondents indicated higher percentages of employment denials/terminations compared to all respondents. Queer POC cited that race or ethnicity (26%) and not being a good “fit” (18%) were the most common reasons for denial or termination of employment while transgender or gender nonconforming respondents indicated that not being a good “fit” (21%), sexual orientation (16%), gender expression (15%), and race/ethnicity (15%) were the most common reasons (Figure 17).

Figure 17. Reasons Denied Employment or Terminated of LGBTQIA+ Quality of Life Study Respondents, 2021



DATA SOURCE: City of Austin, Equity Office and LGBTQIA+Q Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

Several focus group participants and an in-depth interview participant mentioned that they had **job loss or had their work hours reduced** due to the COVID-19 pandemic. One focus group participant shared, *"We have been affected during the pandemic because many of us have lost our jobs."* A community leader also highlighted how small business owners and workers have been affected by the COVID-19 pandemic: *"[Many] restaurants [...] lost revenue, they had to shut down many times so I'm not so sure how they have been handling it."* One community leader mentioned difficulty hiring staff as small businesses reopen:

"They [Korean businesses] are struggling to find employees now that they are opening again, so that is one of the challenges right now. One of my friends owned a shop and she couldn't find employees to release her, so she had to shut down for a day to get some rest. I think it's just for everyone, not just the Korean stores." – Community Leader

Education

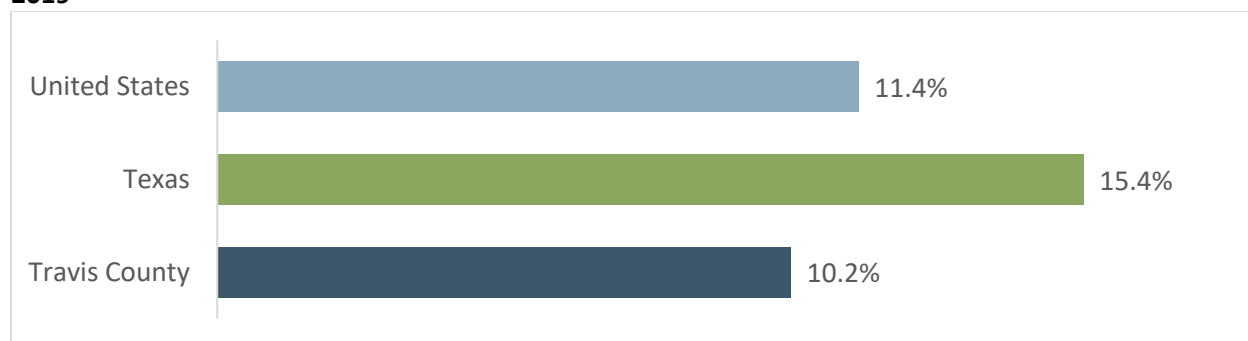
Education affects health in multiple ways. Individuals of lower educational attainment generally have less favorable health profiles compared to their counterparts with greater educational attainment.¹⁰ Most directly, education increases economic and social resources.¹¹ Those with higher levels of education are less likely to experience unemployment and economic hardship and have more social connections than those with lower levels. Those with lower levels of education are more likely to be engaged in jobs that are lower paying or unstable, lack employer-provided health insurance benefits, or that are more risky or unsafe. Research has also found that adults with higher educational levels have higher levels of health literacy, causing them to better comprehend medical instructions, understand medications, and advocate for themselves with health providers than their counterparts with lower educational attainment.¹² Inequities in educational funding and unequal access to key educational resources, including culturally-appropriate teachers and quality curriculum, are concentrated in low-

income communities and communities of color and are interconnected with the unequitable and discriminatory housing and neighborhood policies these same communities experience.¹³

The history of housing and services segregation in Austin has direct ties to the segregation of Austin's schools. The closure of old Anderson High School is also an example of the way that systemic racism shifts the burdens of desegregation on Black communities – i.e. the closure of a predominantly Black school and then the division of its student body and bussing them to separate white schools across the city. The closure of this school also had an impact on the community cohesion and sense of place for East Austin's Black community. There is also a history of unequal educational offerings across Austin's schools, related to the Chicano Civil Rights movement and how that looked in schools in East Austin. East Austin high schools have vocational programs that routed students into technical programs such as printmaking and brick laying while high schools in West Austin were preparing students for college careers and work in the rapidly developing technology sectors.¹⁴

One tenth of adults aged 25 years or older in Travis County (10.2%) and the US (11.4%) do not have a high school degree; this percentage is slightly higher across Texas (15.4%) (Figure 18)

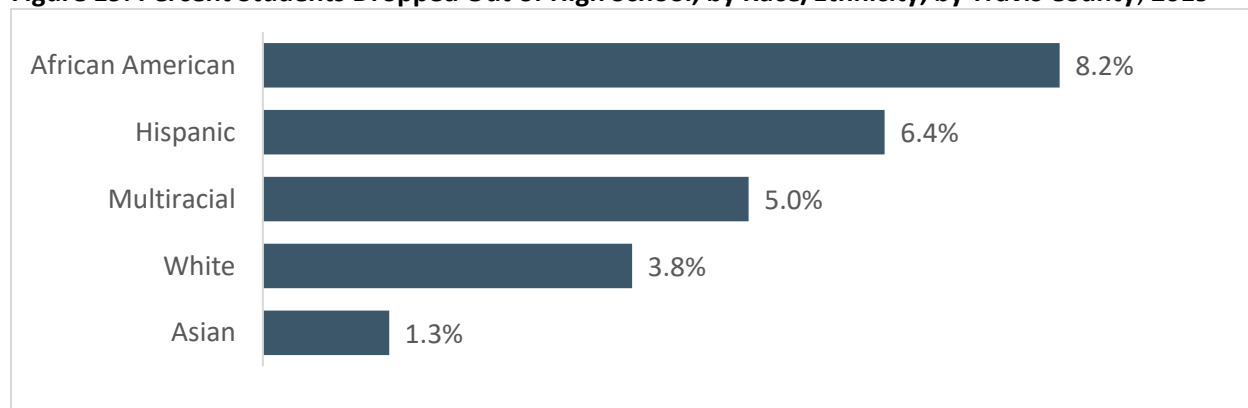
Figure 18. Population Aged 25+ With Less Than a High School Degree, by US, State and Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Of students who dropped out of high school, dropout patterns were highest among students of color. For example, among students who dropped out of high school, 8.2% were Black/African American, followed by 6.4% Hispanic/Latino and 5.0% multiracial students (Figure 19).

Figure 19. Percent Students Dropped Out of High School, by Race/Ethnicity, by Travis County, 2019



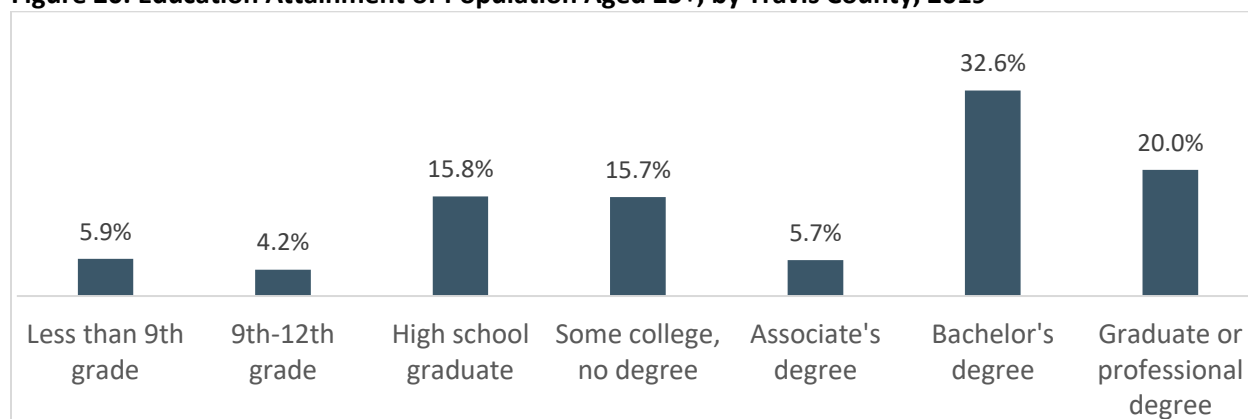
DATA SOURCE: Texas Education Agency, 2019

One community leader cited educational opportunity gaps for Black/African American boys in the Austin Independent School District (AISD), highlighting high levels of suspension, disciplinary action, and policing of Black/African American youth and the importance of a trauma-informed approach to supporting Black/African American youth:

“Back in 2006, -07, 08, the stats were-, with the Higher Education Coordinating Board, that they could only track less than 100 boys coming from AISD, for three consecutive years. But those same years, you could track more than 1,000 going to department of correction. [...] Black kids make up less than 10% [of students], but ¼ of arrests this year alone were Black kids. [...] So bottom line, we gotta say, are we really doing everything we can? Are we doing an assessment to find out why they’re acting [the way] they’re acting today? Is there a lack of something? Is there a lack of utilities, food, etc. Something that caused me to act this way today? Trauma is real.” – Community Leader

The majority of adults aged 25 or older in Travis County have a high school degree or higher (90.4%), similar to patterns across Texas (90.0%) and slightly higher than the average across the US (88.6%). Over half (53.0%) of Travis County residents have a bachelor’s degree or higher (Figure 20).

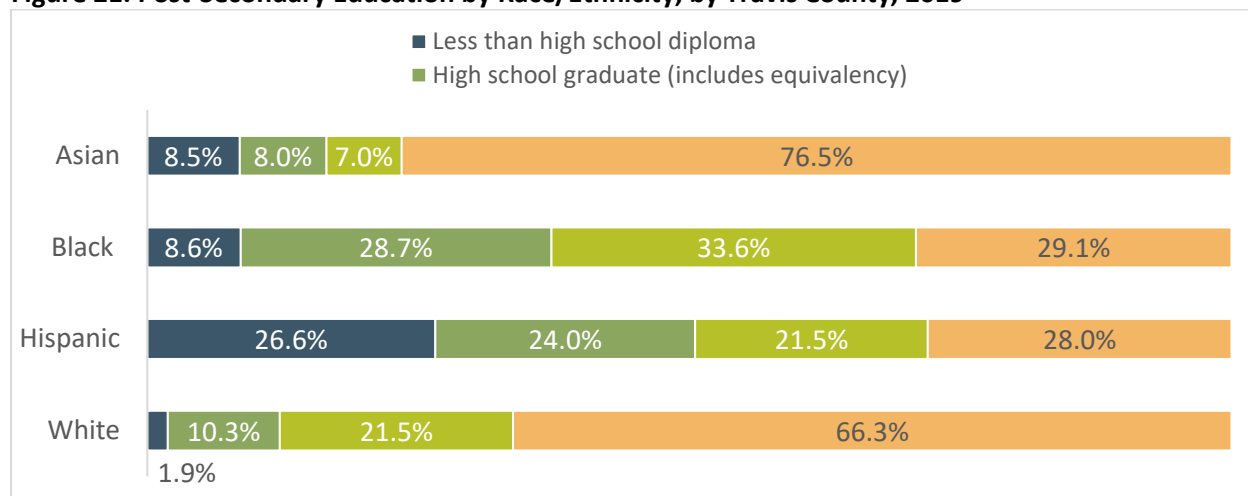
Figure 20. Education Attainment of Population Aged 25+, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

The majority of Asian (76.5%) and White (66.3%) populations have a bachelor’s degree or higher; however, the Hispanic/Latino population has the highest percentage of population without a high school diploma (26.6%), with a relatively similar percentage of Hispanics/Latinos with only a high school diploma (24.0%), some college education (21.5%) or a bachelor’s degree or higher (28.0%). About one-third of the Black/African American population has some college or associate’s degree (33.6%), bachelor’s degree or higher (29.1%) or high school diploma (28.7%).

Figure 21. Post-Secondary Education by Race/Ethnicity, by Travis County, 2019



DATA SOURCE: E3 Alliance, 2019

Several focus group participants, community leaders, and in-depth interview participants described the importance of education. One community leader noted that members of their community have to “*create their own resources*” to compensate for underfunded schools and libraries in low-income communities. Several community leaders described working class communities served by their organizations and the importance of investing in educational and career pathways to ensure that people of color are represented in service sectors and in upper-level administrative roles at school and beyond. One community leader explained:

“We need to focus on getting more Black teachers, more Black administrators in the school, not just janitors. Work on building a staff-, if you’re going to be a service provider, make sure the service providers look like those that you’re providing service too.” – Community leader

For a resident who previously experienced incarceration, the use of educational technology such as computers and software created a barrier when pursuing higher education after being released from prison. This resident described their experience:

“[I] [w]ent to student services and found it difficult to tell [...] them about changes in technology and how to navigate (hadn’t been on cell phone or internet before) and it got overwhelming really quickly. Disabled services at universities or other agencies need to be trained to deal with people in recovery including people that were formerly incarcerated.” – In-Depth Interview Participant

Housing

Where people live is integral to their daily lives, health, and well-being. The conditions in the home and neighborhood environment may promote health or be a source of exposures that may increase the risk of adverse health outcomes.¹⁵ Housing is generally the largest household expense. For homeowners, it can be an important source of wealth.¹⁶ However, housing instability and stress of housing affordability have been found to be associated with poorer mental health outcomes and disruptions in work, school,

and day care arrangements.¹⁷ Housing instability has been associated with poorer outcomes for children related to risk for developmental delays, being underweight, and lower school attendance. Poor housing quality can have direct negative health impacts such as respiratory conditions (e.g., asthma) due primarily to poor indoor air quality—and can be one of the strongest drivers for asthma-related emergency department visits among children. Housing conditions can also result in cognitive delays in children from exposure to neurotoxins (e.g., lead), and accidents and injuries as a result of structural deficiencies.¹⁸

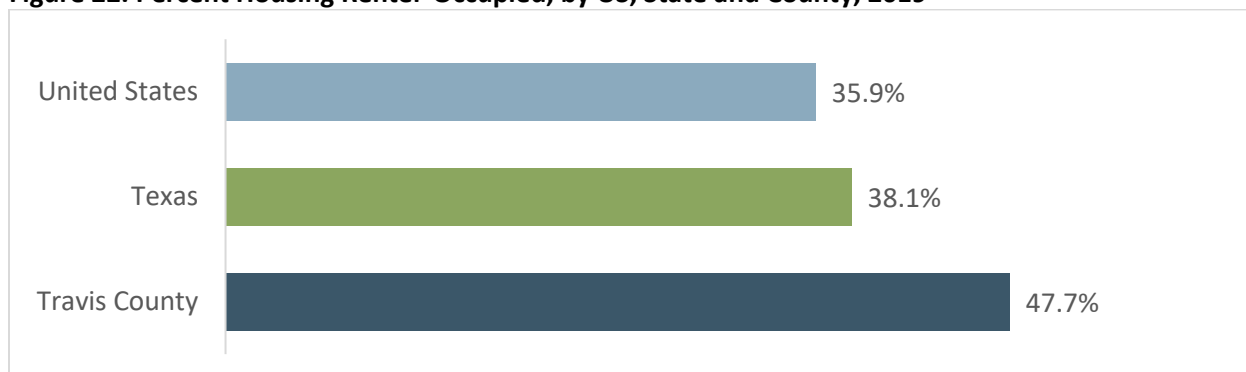
Years of structural racism have contributed to inequities in Austin’s environmental and housing policies, contributing to environmental health hazards and risk factors being concentrated into low-income and communities of color; examples of discriminatory historical planning efforts include the 1928 Plan, the 1957 Industrial Development Plan, siting of the Austin airport, the placement of Interstate Highway 35, Tank Farm, BFI Recycling Facilities, and the Pure Castings facilities to name several. Historical context allows us to gain a clearer understanding of the foundational roots of housing inequities that continue in Austin today, including the East/West divide, along with increasing gentrification² and displacement: “The metro area has one of the highest rates of income segregation in the country, a factor that could ultimately limit the ability of Austin’s youth to climb the income ladder and bolster the region’s future prosperity.”¹⁹

Cost burden is an important indicator of how well households can manage housing costs. According to the City of Austin Comprehensive Housing Market Analysis, about 65% (1,166) of total respondents reported spending 30% or more of their monthly income on housing and 17% (307) reported spending 50% or more of their monthly income on housing. Severe cost burden (paying more than 50% of monthly gross income on a household rent or mortgage plus basic utilities helps determine which households may be at-risk of losing their housing. This measure of need can also help identify which residents are disproportionately affected by lack of affordable housing. In Austin, White households faced severe cost burden 15% of the time. This compares to 25% of the time for Black/African American households; 23% for Hispanic/Latino households; and 20% for Asian households. As such, people of color in the City are much more vulnerable to the negative consequences of rapidly rising housing costs.²⁰ Also, the availability of affordable housing and space for the LGBTQIA+ community emerged as a priority among interviewees. Specifically, homelessness was an area of concern and disproportionate among LGBTQIA+ youth, people of color, and particularly queer and transgender people of color.²¹

In Travis County, almost half (47.7%) of housing units were renter-occupied, which was higher than in Texas (38.1%) and the US overall (35.9%) in 2019 (Figure 22).

² Gentrification is often defined as the transformation of neighborhoods from low value to high value. This change has the potential to cause displacement of long-time residents and businesses. Displacement happens when long-time or original neighborhood residents move from a gentrified area because of higher rents, mortgages, and property taxes. [CDC - Healthy Places - Health Effects of Gentrification](#)

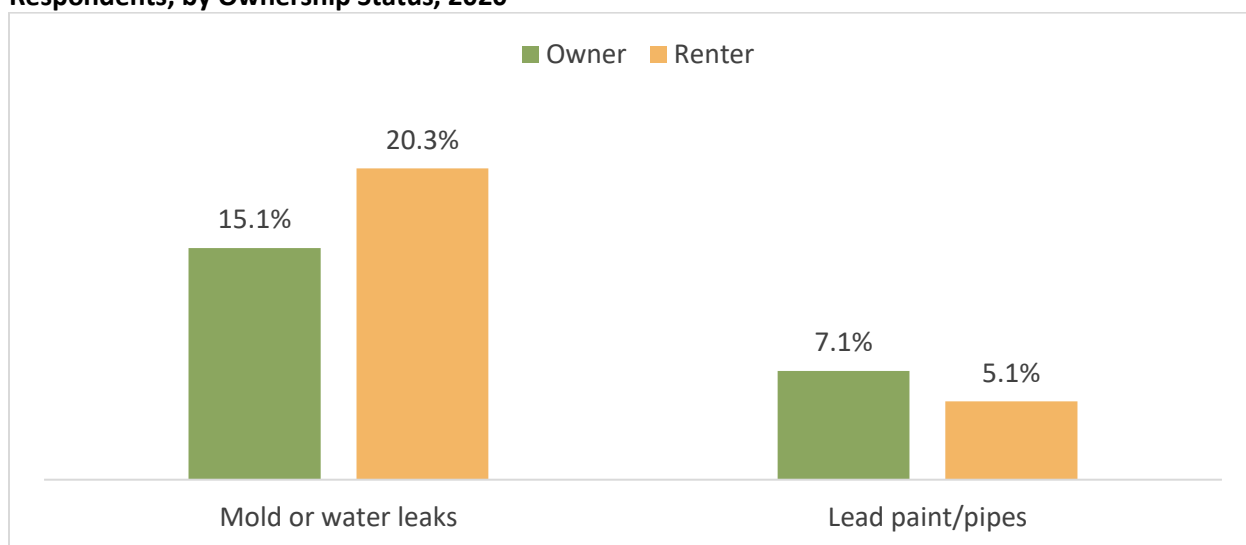
Figure 22. Percent Housing Renter-Occupied, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Both owner and renter respondents to the Austin Area Community Survey cited mold or water leaks (owners: 15.1%, renters: 20.3%) as the top severe housing problem, followed by lead paint/pipes (owners: 7.1%, renters: 5.1%) (Figure 23).

Figure 23. Percent Households with Severe Housing Problems among Austin Area Community Survey Respondents, by Ownership Status, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Housing Affordability

Several focus group participants and some community leaders explained that **industry and population growth** in the region have contributed to rising housing costs. One community leader explained how population growth has accompanied the growth of several industries in the area:

"[It is a] fast evolving community, we have a Tesla plant opening in our backyard. [The] influx of industry will change and provide job opportunities but it also creates more competition for resources as well. Land resources [and] housing, when we're already seeing [a] large influx to rising cost of living in the central core and gentrification. 1,000 employees [are] seeking resources along with those under FPL [Federal Poverty Level], [which] creates housing scarcity. [There is] a lot of space,

but limited ability to find safe accommodating and adequate housing. It's hard to be within proper distance to available resources.” – Community leader

Several focus group participants, community leaders, and both in-depth interview participants described the **high and rising cost of housing** that is not meeting the needs of longstanding and low-income residents in the area and the displacement of residents from the region due to a lack of affordable housing. A focus group participant observed, *“Something that I’ve heard is people struggling to pay rent.”* One focus group participant explained, *“Housing prices [are] too high, [which is] pushing out families.”* As a consequence of high housing costs in the region, some residents described housing arrangements where multiple families live together to make ends meet. One focus group participant shared, *“More families are renting a room from a family. That is definitely happening more.”*

Residents described mixed experiences with rental assistance during the COVID-19 pandemic, with some reporting rental assistance support that they attributed to being linked with the City of Austin. Others were familiar with rental assistance programs that were linked with non-profit organizations. For example, one focus group participant described receiving rental and utility assistance through City of Austin as well as local non-profit Austin Voices. Another focus group participant shared how their family benefited from a City rental assistance program after getting sick with COVID-19 affected the earnings of the major breadwinner in their family.

While some focus group participants and community leaders mentioned the importance of rental assistance that they received during the COVID-19 pandemic, others mentioned that rents increased during the COVID-19 pandemic and they struggled to find assistance.

“I sought help from the city to pay the rent because those of us who made money for our household, meaning my wife and I, both got sick (with COVID). And we knocked on the door of various places and they didn't serve us, they didn't help us.” – Focus Group Participant

One community leader described difficulty connecting low-income renters with rental assistance programs:

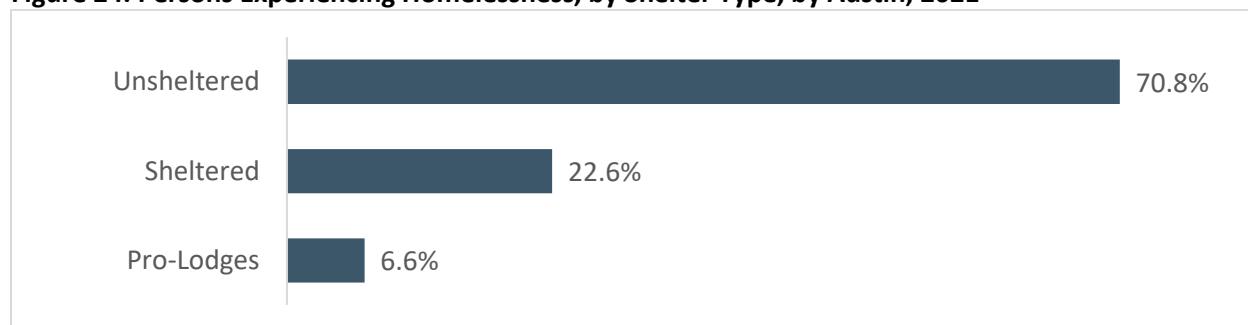
“We were wondering where the help was, and we knew there was help but we could not get connected. For example, I saw news on the TV say that they offer rental benefits, but our community, especially the poor community, did not have anyone from the city to reach out and see if any of us need rental help. We also found out later that COA [City of Austin] provided utility bill support.” – Community leader

Another focus group participant observed limits on the level of rental and other assistance for residents experiencing chronic economic challenges: *“[T]hey’ve applied to different programs and sometimes they already applied and can’t apply again and they’re struggling to find ways to cover the rent.”* One focus group participant noted the importance of partnerships to increase access to housing vouchers: *“HACA could partner with a lot of our homeowners to offer section 8 vouchers, because I looked on the HACA booklet and there was only one place in Manor currently.”*

Homelessness

According to the Ending Community Homelessness Coalition (ECHO), the Austin/Travis County Continuum of Care lead agency that plans and coordinates community-wide strategies to end homelessness in Austin and Travis County, there were 3,160 individuals experiencing homelessness during the 2021 count in January 2021.²² Among respondents experiencing homelessness, 70.8% were unsheltered and 22.6% were sheltered (Figure 24).

Figure 24. Persons Experiencing Homelessness, by Shelter Type, by Austin, 2021

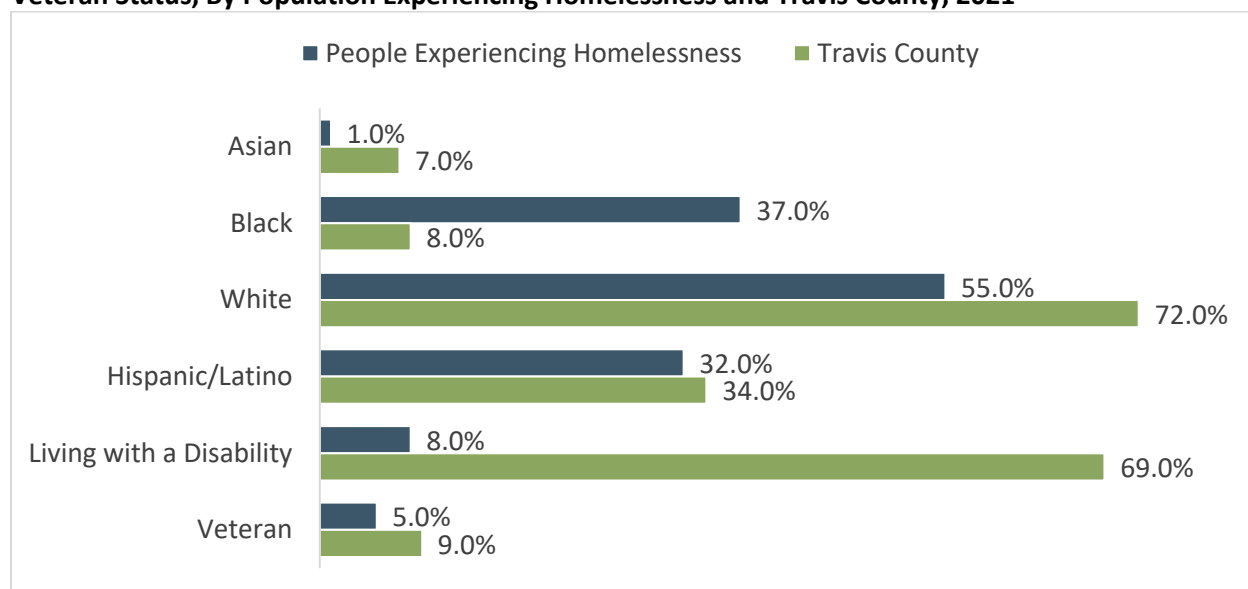


DATA SOURCE: Homeless Management Information System; as cited by Ending Community Homelessness Coalition (ECHO), 2021

NOTE: Data represents a single day snapshot

Figure 25 displays the percent of people experiencing homelessness by selected indicators relative to the Travis County population in 2021. Notably, the Black/African American population in Austin/Travis County was overrepresented among people experiencing homelessness more than any other racial/ethnic group. The probability of experiencing homelessness in Travis County for a Black/African American person was approximately six times higher than that of a White person.

Figure 25. Percent of People Experiencing Homelessness by Race, Ethnicity, Disability Status, and Veteran Status, By Population Experiencing Homelessness and Travis County, 2021



DATA SOURCE: American Community Survey and Homeless Management Information System; as cited by Ending Community Homelessness Coalition (ECHO), 2021

Additionally, Black/African American and Hispanic/Latino clients who obtained stable housing after participating in a permanent housing program lost their housing and returned to homelessness faster than White clients. Among clients who returned to homelessness within one year of exiting from a Permanent Housing program (Rapid Re-Housing or Permanent Supportive Housing) to a permanent housing destination in 2019, Black/African American and Hispanic/Latino clients returned to the system within a shorter period of time than White clients. This suggests not only unsustainable housing instability in the long term for non-White and/or Hispanic/Latino clients, but in the short term as well.²³

In Travis County, census tracts with higher proportions of the population who are Black/African American have heightened levels of all community-level homelessness risk factors analyzed: lower median income, greater proportion experiencing rent burden and overcrowded rental units, higher eviction rates, higher likelihood of gentrification, and lower percent with health insurance (Table 4). As a consequence, Black/African American people in Austin/Travis County are likely to be at higher risk of falling into homelessness than any other racial or ethnic group.

Table 4. Median Values of Community Level Indicators of Homelessness Risk, By Census Tract in Travis County, 2016

	Census tracts with higher proportion Black/African American population	Census tracts with lower proportion Black/African American population	Travis County
Median population size	5,514	4,522	4,794
% Black African American	10.0%	1.8%	4.9%
Median Income	\$59,401	\$80,813	\$68,769
% Rent Burdened	31.8%	28.7%	29.6%
% Over-crowded rentals	2.4%	0.0%	1.0%
Annual eviction rate	2.0%	0.8%	1.4%
% Tracts potentially gentrifying	46.2%	30.6%	38.1%
% w/o health insurance	25.7%	13.3%	18.1%

DATA SOURCE: United States Bureau 2018 American Community Survey 5-Year Estimates, Centers for Disease Control and Prevention 2019 National Health Interview Survey, Eviction Lab 2016 Eviction Rate Data

Some in-depth interview participants and a community leader highlighted **barriers to securing stable housing** for individuals who were formerly incarcerated, experienced homelessness, or lack identifying documents. For example, one in-depth interview participant described the difficulties of renting an apartment given their record of incarceration:

“Barriers to housing are massive. When I got on my feet financially, I looked for apartments and all 30 I visited wouldn’t take anyone that was on parole and they have to have been off parole for 10 years. It is easier to buy a house than it is to rent.” – In-Depth Interview Participant

This participant also highlighted the connections between histories of incarceration, difficulties accessing housing after incarceration, and experiencing homelessness and noted that experiencing homelessness is considered a parole violation:

“There are a number of formerly incarcerated [people] that are homeless that find a friend that register that person’s address as their formal address but are actually homeless. [The] [a]ddress is for parole. A lot are homeless/semi-homeless and couch surfing.” – In-Depth Interview Participant

Urbanicity

In addition to housing affordability and access emerging as a central theme across interviews and focus groups, some community leaders and focus group participants highlighted the **unique issues in rural areas**. Focus group participants across the region shared how rising housing costs linked with population growth contributed to the displacement of long-term residents – mostly low-income residents, older adults, and people with health issues or disabilities – from dense urban areas to rural areas on the outskirts of Travis County. One focus group participant explained, *“Where [population growth] is affecting us is that the rent is more expensive, it is difficult to live in the city. Many people are forced to go to the outskirts in order to have a home.”* One community leader echoed, *“[B]ecause of [the] increasing cost of living in central core in Austin and due to gentrification, elderly and disabled [residents] are now in more rural areas.”* Another focus group participant echoed, *“Manor is not the rural town that it was years ago. It has grown and is projected to continue growing.”*

Focus group participants in the Manor region described their community as rural, with **limited access to the internet and healthy, affordable food options**. One focus group participant noted, *“Food as well, we only have a Walmart as a place to shop for food, so it is kind of like a food desert.”* Another focus group participant explained, *“Internet connection is another thing that our families struggle with especially in our more rural areas.”* One participant described the underlying context of limited allocation of resources and social services to their rural community: *“We feel like we’re still kind of forgotten about. It has improved in its recognition from when I moved to Austin 17 years ago, but we are still very much a bedroom community.”*

One community leader emphasized the importance of investing in planning for rural communities that are rapidly growing, noting that investing in rural areas with growing populations should be a public health priority:

“If we look at the trends and where people are being shoved to, we need to be intentional about the planning in our rural communities that are not in Austin proper but maybe in Travis County. [Y]ou know that by looking at demographics, these issues are going to be prevalent in those areas, because that’s where people are being force[d] to move just because of the economics. And so what are we doing so that unincorporated areas have the services that we know will be needed in those area[s], or those numbers will skyrocket for mortality and morbidities. [W]e’ll be acting in a reactionary-mode, and trying to deal with unincorporated areas that haven’t been involved. Now Travis County, what’s the plan for that situation we know is about to happen?”
– Community leader

Built Environment and Neighborhood

Community leaders and focus group participants described several features of the built environment as areas that would benefit from improvement, including air, water, and land quality in rural areas and access to grocery stores and community and recreational centers in both urban and rural areas.

One community leader described how low-income residents of color in rural communities are affected by a host of environmental challenges such as poor **water and air quality** and live on land that is vulnerable to **climate disasters** such as flooding and droughts. This community leader shared:

“[We] [s]ee and hear complaints about water and air quality in Del Valle [...] We hear there’s a lot of desert and swamps where marginalized community is being pushed to live. Choices are not good there in terms of food quality and lifestyle. There’s environmental racism, economic issues. All of these critical health factors and how this structure is set-up is having an adverse effect.” – Community Leader

Several focus group participants described **development** in the area as stressful and making their day-to-day routines more difficult. One focus group participant elaborated on the stress that development in the region and increased traffic has added to their daily routine:

“Stress that we have, just going back five years, [development] has grown so much and there is no... the plan that they made they didn’t think about... now we get stressed about the traffic. All the time that we spend on the streets nowadays, whatever used to take me 15 minutes to get to work, now takes me half an hour.” – Focus Group Participant

Some focus group participants described **construction and development** as a health issue. One participant shared, “[There is] demolition across the street. All the dust. Watching them pulverize the concrete and the dust coming into the apartment.” Another resident echoed, “[Construction is an issue] especially those of us that have allergies. As soon as I step out of my house, I have a mask on.”

In addition to the growth of businesses that primarily serve high income residents contributing to the need to travel further to access affordable food, some focus group participants described how they felt **excluded by the neighborhood design**. One participant shared: “The neighborhood is built for yuppies and is catered towards the tech savvy young group.” Another participant recalled, “They brought scooters and I can’t get on a scooter. They were pushing that for us, and I can’t use that due to health issues. They’re trying to build another beer garden and that’s not what we need. [W]e need a ma and pop store. The bus to the HEB takes an hour to go when [the store is] only 5 minutes away.” According to one focus group participant: “...once [the neighborhood] got gentrified, they forgot the elderly and the poor and built beer gardens and expensive restaurants/stores.” Another focus group participant echoed: “The Whole Foods is too expensive, so most of the residents can’t cook a healthy meal.”

Several focus group participants and community leaders discussed the need to **improve access to services**, including banks, ATM machines, pharmacies, and urgent care clinics in low-income communities, which residents noted are critical basic resources linked to health. One community leader described their community as “like a third world country” because of limited access to basic resources. According to one community leader, “[the] biggest ‘lack’ in the community is a nearby grocery store

lack [of a] pharmacy, as well as emergency care clinic, and ‘basic needs.’” Another community leader observed that when services are available in a community, the working hours are not usually flexible enough for residents to access them: “And when the facilities are put there, the hours of the facilities don’t line up with need and they are placed in obscure locations, the population doesn’t flow there.”

A couple of community leaders identified the need for community pools, recreation centers, libraries, and safe walking paths in their communities. According to some residents, access to these resources was difficult during the early phase of the COVID-19 pandemic, and is particularly important during the summer given the hot climate. One focus group participant explained:

“Another thing was there were lots of closures of pools in the summer and given brutal Texas summers it’s hard to keep your kids indoors. I’m young and healthy and could go and drive to Lady Bird Lake and take my kids out there but not everyone has that opportunity.” – Focus Group Participant

Another community leader described their community as having “a nice recreation center, swimming pool, park, and library,” while also noting that “[the community’s recreational] center doesn’t have things like a pool or walking area, and they have had to push to add things like that ... they always have to ‘fight’ to add resources.”

Internet and Computer Access and Training

Another facet of the environment frequently discussed was **internet accessibility**. Many focus group participants, community leaders, and in-depth interview participants described stable access to the internet and a computer at home as an important resource for accessing information and resources, staying connected, and participating in remote education. According to residents and community leaders limited internet access was an issue for low-income residents across the region. Additionally, some community leaders and focus group participants observed that internet access was more difficult in rural areas. One focus group participant shared, “Internet connection is another thing that our families struggle with, especially in our more rural areas.” One focus group participant and a community leader noted that where they live, internet was temporarily provided as a free service, which they were able to use to access virtual health care services: “Now that you have free Google fiber you can schedule virtual appointments.”

According to participants, internet and computer access have become increasingly important during the **COVID-19 pandemic** given the need to stay at home and during **Winter Storm Uri**. One focus group participant described the ongoing challenges and stress of adjusting to working online: “[W]e have to switch our live[s] completely from being present at work [to] working online. That was a lot to learn in a quick time and we’re still learning.” Another focus group participant who was an older adult described the importance of internet access during the COVID-19 pandemic for continuing adult education: “I’d liked to do learning, but I can’t leave my home [because] my doctor doesn’t want me to. But if I can do it over the internet or something; I need to learn how to use the internet.”

The COVID-19 pandemic and Winter Storm Uri highlighted the need to have **stable internet access** to access critical and changing emergency information:

“That’s what the pandemic has taught us, especially the winter storm, is that we can’t rely on our normal old landline phone to be our lifeline

anymore, we really need to get everybody connected because that's where all those resources are. Society has moved to the web, but it's left too many people behind who either can't afford it or who don't know how to do it." – Focus Group Participant

Additionally, children's education was referenced as a challenge due to the reliance on **online education** during the early phase of the COVID-19 pandemic. According to one focus group participant, limited computer and internet access, and limited familiarity with these tools posed a challenge for children during online learning when schools were operating in remote teaching mode due to the COVID-19 pandemic:

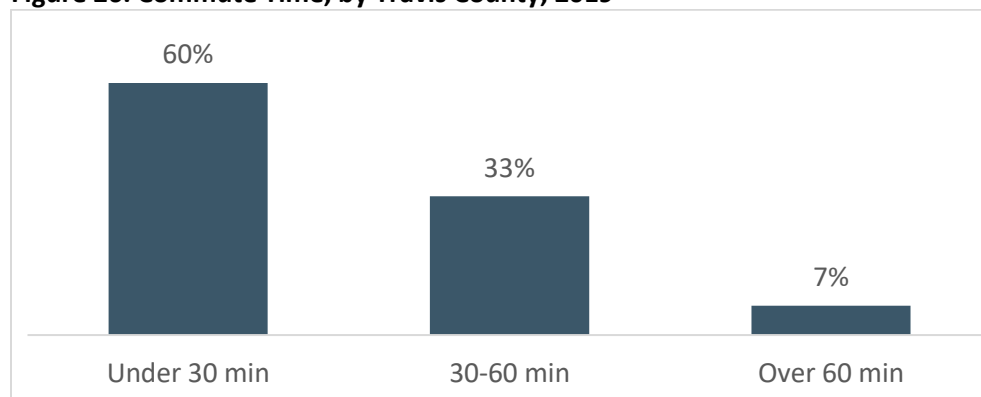
"Prior to kids going back to school there were lots of issues of students not having laptops or internet to access school or didn't have the knowledge to use that equipment if they had it. They weren't learning. [We] had working parents that couldn't get their child to sit down and do online school." – Focus Group Participant

One in-depth interview participant who experienced homelessness described school hotspots and services that provide computers as key to continuing their education during COVID-19: *"I have been given a little portable hotspot provided by school, so I've been using that because my Wi-Fi was cut off. My school provided a computer and LifeWorks also provided me with my own personal computer. [...] I took some technology classes with it."*

Transportation

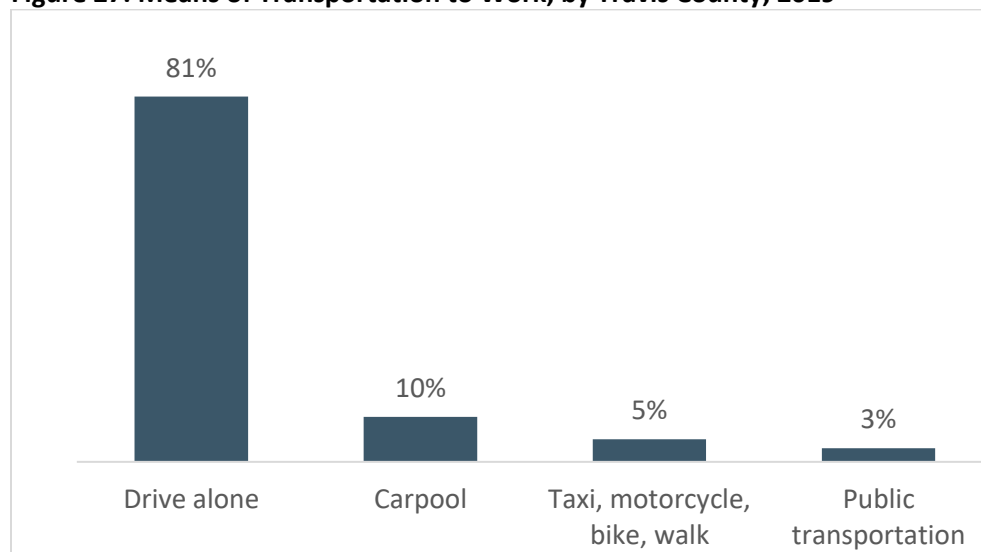
Transportation emerged as an important component of the environment and a barrier for conducting day-to-day activities such as getting groceries, going to school, and going to the doctor. According to 2019 ACS estimates, about 60% of Travis County residents spent under 30 minutes commuting, around one-third (33%) spent 30-60 minutes commuting and 7% spent over an hour commuting (Figure 26). The majority (81%) of commuters drove alone to work (Figure 27).

Figure 26. Commute Time, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Figure 27. Means of Transportation to Work, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Focus group participants and community leaders described **limited public transportation** and medical or senior transit options in more rural areas, including Pflugerville, Manor, and Del Valle. One focus group participant described the importance of transportation to their community that had limited public transportation options, “*Transportation is such a big issue out in Manor because we don’t have [access to] transportation.*” One community leader described the lengths that residents have to take in order to get to where they need to go:

“There’s limited transportation for individuals. For example, the Drive a Senior program: if you look at map on website, it does not include Del Valle. [It] includes other outlying areas. [I am] [n]ot sure why, but [it] is a service for other communities to get by on. The bus line is cumbersome. People walk down the highway, to the other side of 71 to the route that can access more routes. Those not able-bodied may not be able to make that trek.” – Community Leader

One community leader described the difficulties of getting around in their rural community, and how limited access to grocery stores are made even more difficult by limited public transportation routes:

“[My community is] just outside of city limits. Cap Metro comes 7 days a week, but [it is] still challenging; HEB (grocery store) takes 3 hours and is a two-bus ride; [if they need to go] anywhere else in the city, [they] will be gone the whole day.” – Community Leader

Barriers to accessing and using public transportation for residents who did not have access to a vehicle included the following: limited and reduced bus routes, concerns about safety on the bus, overcrowded buses, financial barriers to paying for public transportation, difficulty using the bus system on hot days, and concerns about COVID-19 protocols (e.g., physical distancing, sanitizing seats). One interview participant shared, “*Transportation is another thing. I ride the city bus a lot. [T]hey don’t follow the*

social distancing rule, don't wipe down seats." One in-depth interview participant noted that the app for the city bus was useful though other changes, such as route changes, were a barrier:

"I currently either walk or use public transit to get around. [I have] been impressed with Austin public transit system. I was more impressed before some major changes happened to redo and remove some routes. There are some parts of town I can't get to but in general it is reliable, [I] can look at the app, and it's only off by maximum of 5 minutes. I've been able to get a discount on bus passes due to my disability." – In-Depth Interview Participant

Seniors also described experiencing issues with the **bus routes**, including changes to bus routes, not knowing where to go, and the significant time that it takes to travel by bus. Several older adult focus group participants noted that current transportation options for accessing medical care, such as ride services, were limited and made for long and exhausting days traveling to and from their appointments and ride services were difficult to schedule on short notice. Some focus group participants shared:

"Bus transportation [is] helpful for people who want to gather and go to the same place together. But, it's not practical for people who just need to go to the doctor. When you have six people and they are going to six different doctors, they're on the bus for so long they're worn out. Just the transportation time wears them out." – Focus Group Participant

"I have access to Metro Access for rides to the doctors/grocery store, things like that, but I still have need for transportation when I don't have a whole day to set it up, if I need transportation within a few hours ahead of time. It's hard to know a day ahead of time that you're going to need it." – Focus Group Participant

Another focus group participant explained that **transportation benefits** are insufficient to provide access to all of the medical appointments that a patient may need in a given year. This participant described their experience: *"For seniors a lot of insurances provide 12 rides per year. And they are not reliable, they can leave you out there 2-3 hours. It's gotten more prevalent because they don't have enough drivers."*

With limited public transportation options for residents who do not have a car, one community leader observed informal support from others as an important resource: *"[I see] a lot of informal assistance, people giving others rides. There are informal support networks to find transportation."*

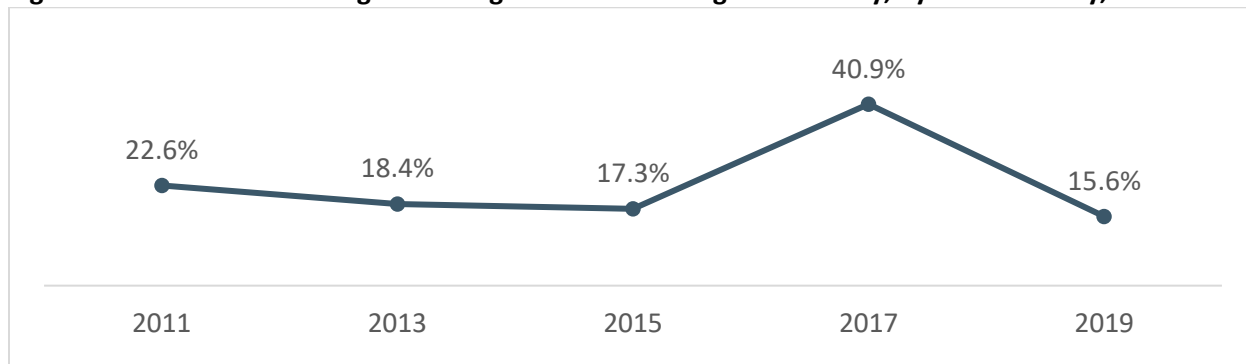
Focus group participants and community leaders identified several areas of improvement for pedestrian and public transportation, ranging from creating pedestrian bridges over major highways, to improving streets [See Appendix G for more information on Project Connect a local public transit improvement initiative].

Access to Healthy Food and Food Security

In 2019, around 15.6% of Travis County residents reported consuming 5 or more servings of fruits and vegetables daily; this percentage is lower than reported from 2011-2017 and indicates a gradual decline

from 2011, with the exception of 2017, when the percentage was much higher at 40.9%. Trends were similar when examining these patterns by gender, race/ethnicity and age. Of note, in most years a slightly higher proportion of female adults than male adults reported eating 5+ servings of fruits and vegetables daily. In 2019, self-reported fruit and vegetable consumption was highest among adults 65 years of age and older (21.4%) and lowest among adults 45-64 years of age (12.2%).

Figure 28. Percent Consuming 5+ Servings of Fruits and Vegetables Daily, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

One focus group participant described how a healthy lifestyle is a challenge particularly for Hispanic/Latino residents due to the financial burden of healthy organic foods. Another focus group participant explained how they wanted to eat healthy, organic food, but only fast food was affordable and accessible:

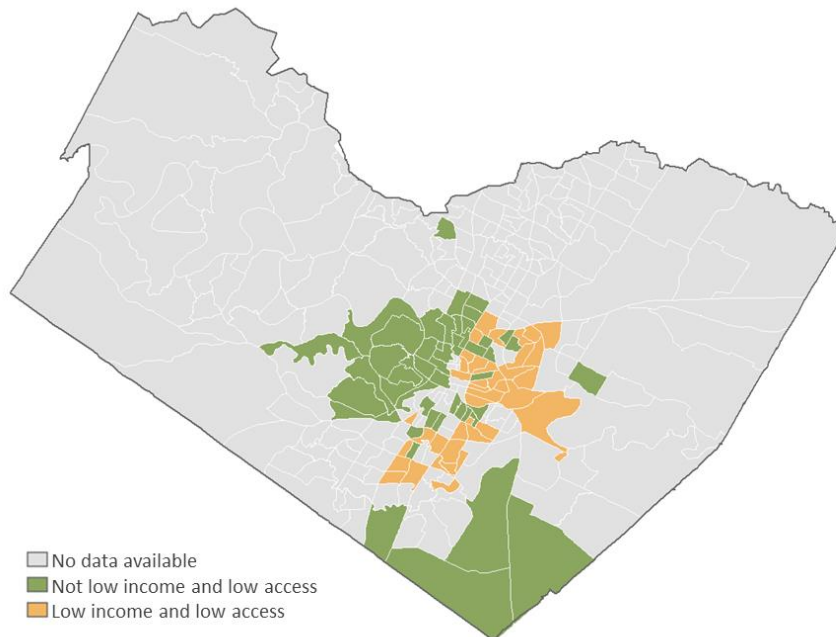
“One of the most important obstacles is organic food, the kind that could help us, is very expensive. So, the more practical option is to eat fast food and we know that in the long run that could cause problems for our health. But it is what we have most accessible to us [...] because it's fast, for all of us that work outside the home.” – Focus Group Participant

Some Hispanic/Latino focus group participants explained how working multiple jobs and long hours makes it difficult to prepare healthy meals. For example, one focus group participant explained, *“I’d say that an important factor is the amount of hours that a person works. It could impede or cut into their sleep time or the hours it takes to arrive at an appropriate time to fix something for dinner. So it is faster to buy something to take home instead of cooking.”* Another focus group participant in a more rural community observed an increase in fast-food options in their community in recent years:

“[W]e have been fortunate that in the last few years we have had a lot more restaurants pop up, but it is more fast-food options. It would be nice to have more restaurants that have healthy options. It would offer more jobs and things for families to go out and eat.” – Focus Group Participant

Figure 29 shows areas of Travis County considered low income and having low access to healthy food, characterized as being half a mile or more away from a supermarket, supercenter, or larger grocery store for urban areas, and 10-miles or more for rural areas and considers vehicle availability for all tracts.

Figure 29. Low Income and Low Access to Healthy Food by Census Tract, by Travis County, 2019

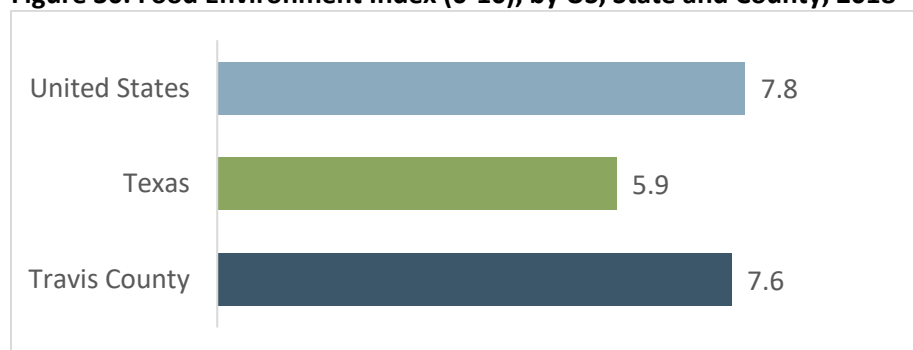


DATA SOURCE: U.S. Department of Agriculture (USDA), Economic Research Service (ERS), 2019

NOTE: Low income and low access tract measured at 1/2 mile for urban areas and 10 miles for rural areas

Low-income census tracts with a substantial number or share of residents with low levels of access to retail outlets selling healthy and affordable foods are defined as food deserts. The food environment index accounts for proximity to healthy foods and income, with a higher number indicating a better food environment (Figure 30). Food deserts are correlated with high prevalence of overweight, obesity and premature death.

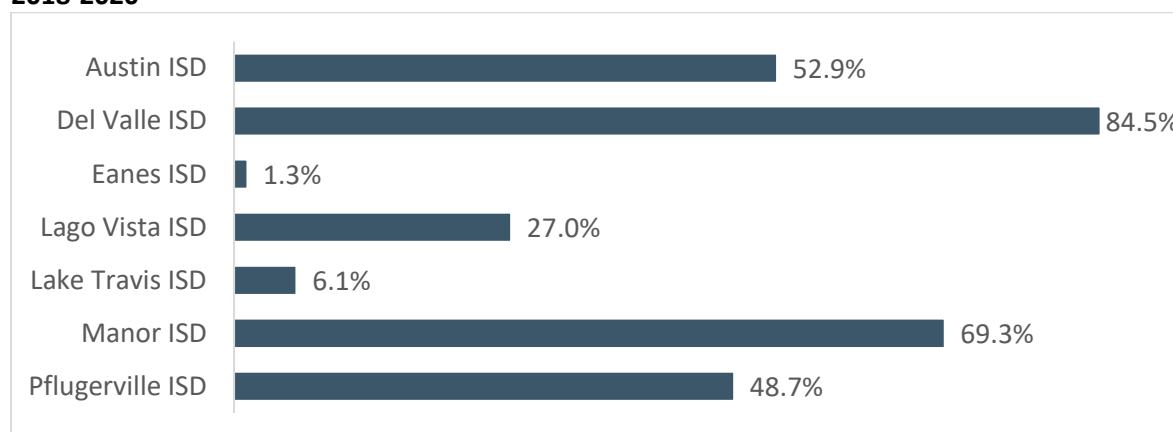
Figure 30. Food Environment Index (0-10), by US, State and County, 2018



DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA), as cited by County Health Rankings & Roadmaps, 2018

Among Travis County independent school districts (ISD), the majority of students in the Del Valle (84.5%) and Manor (69.3%) districts and about half of students in the Austin (52.9%) and Pflugerville (48.7%) districts received free or reduced lunch in 2018-2020 (Figure 31).

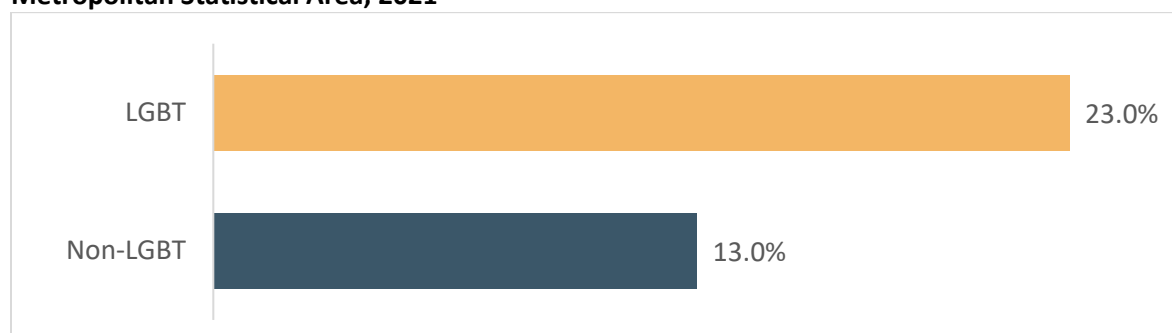
Figure 31. Percent Students Receiving Free or Reduced Lunch, by Independent School District (ISD), 2018-2020



DATA SOURCE: Texas Education Agency, 2018-2020

Nearly one-quarter (23.0%) of LGBTQIA+ respondents to the LGBTQIA+ Quality of Life Study survey reported that they experienced food insecurity, compared to 13.0% of respondents who did not identify as LGBTQIA+ (Figure 32).

Figure 32. Percent Food Insecure for LGBTQIA+ vs non-LGBTQIA+ Population, Austin-Round Rock Metropolitan Statistical Area, 2021



DATA SOURCE: Gallup Daily Tracking Survey, as cited by City of Austin, Equity Office and LGBTQIA+ Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

Several residents noted that healthy eating is important to promoting health, and also described several **barriers to accessing healthy food**. Focus group participants shared that healthy food is expensive and difficult to access, noting that low-income residents often live in food deserts.

"[A] [m]ajor need is food access, food insecurity; lack of fresh food, food desert, no grocery stores. I went recently to Dollar General and it had a small produce section but it was mostly sold out; they had some fruit. ... We provide some fresh fruit and veggies at [the] food pantry as available, but it's not enough." – Community leader

Several community leaders and focus group participants shared that it was more difficult to eat healthy foods during the COVID-19 pandemic and observed a substantial increase in residents requesting food assistance. While focus group participants mentioned food banks as important sources of support, residents also noted that food banks often only distributed non-perishable foods and food often ran out

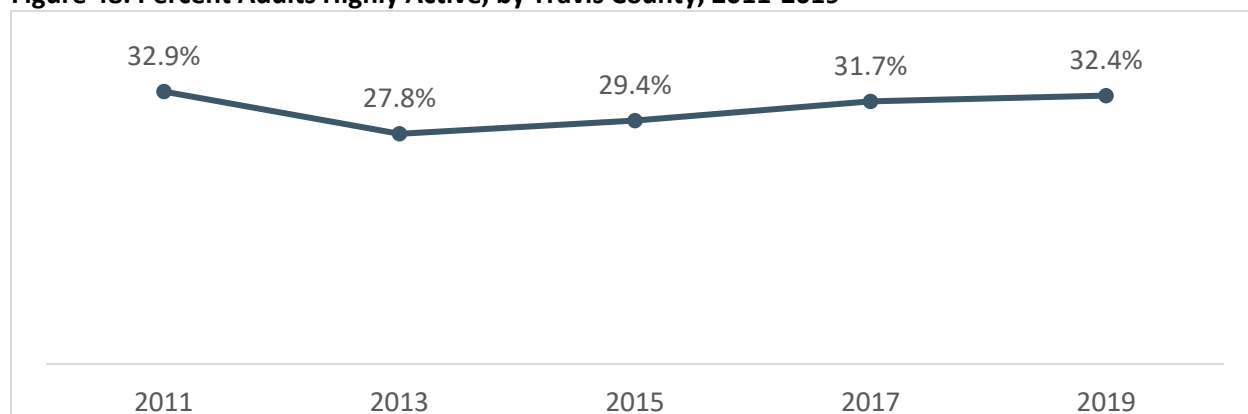
at during food drives. According to one older focus group participant, “Food pantries set up at senior apartment complexes cleaned out quickly.”

Other comments included insight into the quality of the food and access to food pantries; “I have gone to the food banks but the food that they give us is to get full, it is not healthy food.” Another noted that the Central Texas Food Bank was too far way, and only visited once monthly, which was too infrequent. One in-depth interview participant who previously experienced homelessness highlighted how lack of a current state-issued ID or driver’s license posed a significant barrier to accessing food through food pantries that require ID, and public transportation makes it difficult to bring food home. They also described other difficulties in accessing food benefits, including declined food benefit applications and the significant time and effort that it takes to talk with a case worker.

Physical Activity

Along with access to healthy foods, physical activity is a key component of a healthy lifestyle. About one-third of Travis County adults reported being highly active in 2011-2019, with men being more highly active than women. When looking at patterns by race/ethnicity, about one-third of White adults (36.0% in 2019) in Travis County reported being highly active, slightly higher than Hispanic/Latino and Black/African American adults. Older adults 65+ reported being more active than other age groups.

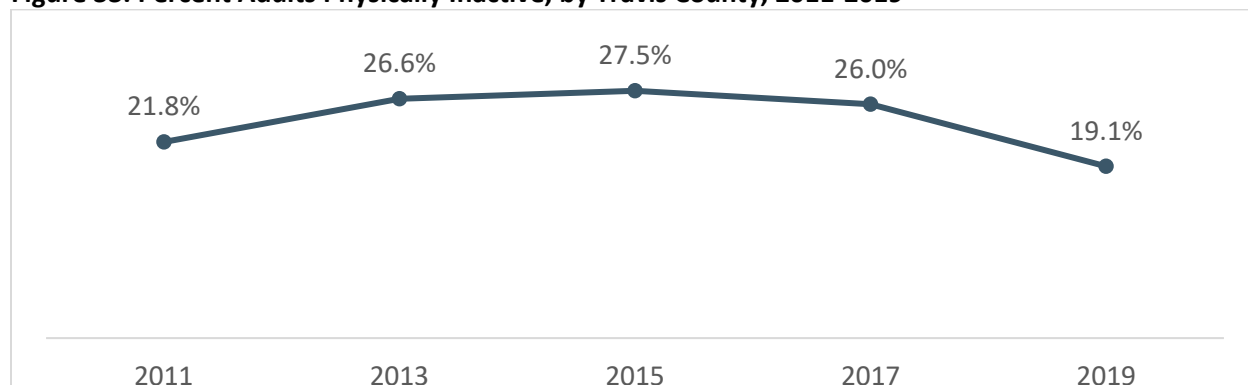
Figure 48. Percent Adults Highly Active, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

When examining self-reported physical inactivity patterns in Travis County from 2011-2019, the percent of adults who reported being physically inactive remained around 20% (Figure 33) with men being slightly less active than women and White adults less active than non-White adults.

Figure 33. Percent Adults Physically Inactive, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Physical inactivity defined as adults aged 20 and over reporting no leisure-time physical activity.

Many focus group participants and community leaders described **active living and exercise** as important for promoting health. One focus group participant described their routine: “[I] [w]alk my dogs once a day. Just walking around, getting to know the area, getting muscles moving.” Some residents described access to green space as a factor that makes it easier to be physically active. As one focus group participant shared, “Communities like green areas around where we live, I feel like if you have a park close by you have more initiative to go out instead of staying in the house.” Another focus group participant described how not every community has access to a safe green space or park:

“...Although there are parks they are not accessible to everyone, I mean, the parks that have more...hmm, that are integrated with more things are not close to the areas with all the people, the whole community.” – Focus Group Participant

Several Hispanic/Latino focus group participants described how long work schedules made it difficult to exercise. As one focus group participant shared, “Another factor is also that when the two of us in the house work, we get home late and tired and I get home to make food and we eat late so we end up not exercising, that also adds to us being overweight.” Other barriers to physical activity included the COVID-19 pandemic restrictions, hot weather, and neighborhood safety.

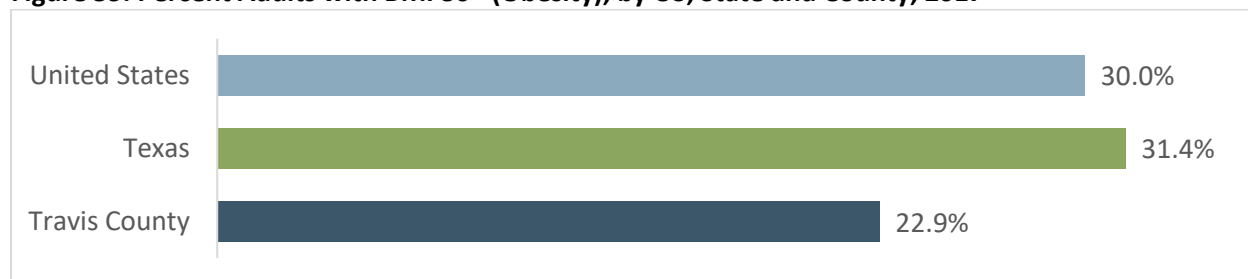
One focus group participant described **feeling unsafe trying to exercise in their neighborhood** in the evenings: “Winter was hard because I got home after work around 6 and it was getting dark and I wasn’t going to walk in my neighborhood because I don’t feel safe, because I kept hearing about what was happening.” According to the Austin Area Sustainability Indicators report, crime was the top reason for feeling afraid to walk outside. Other reasons included vehicles driving too fast and lack of sidewalks.

Residents offered some solutions, including walking in the mall and pedestrian barriers that were set up in the street to enable more active living during early phases of the COVID-19 pandemic. One focus group participant shared her experience:

“You can go walking, [it] is one of my favorite things. [W]hen it is not hot you can go walk in the park. Even in this weather, you can go to the mall. My husband used to hate that, but I didn’t mind going to walk in the mall, you’re still walking.” – Focus Group Participant

The built environment and its associations with healthy eating and active living are strongly linked to body weight. In 2017, about one-fifth (22.9%) of adults in Travis County were categorized as having obesity, defined as having body mass index of 30 or more; a proportion that was lower than the percent of adults classified as obese across Texas (31.4%) and the US overall (30.0%) (Figure 59).

Figure 59. Percent Adults with BMI 30+ (Obesity), by US, State and County, 2017



DATA SOURCE: CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System; as cited by County Health Rankings, 2017

Social and Community Context

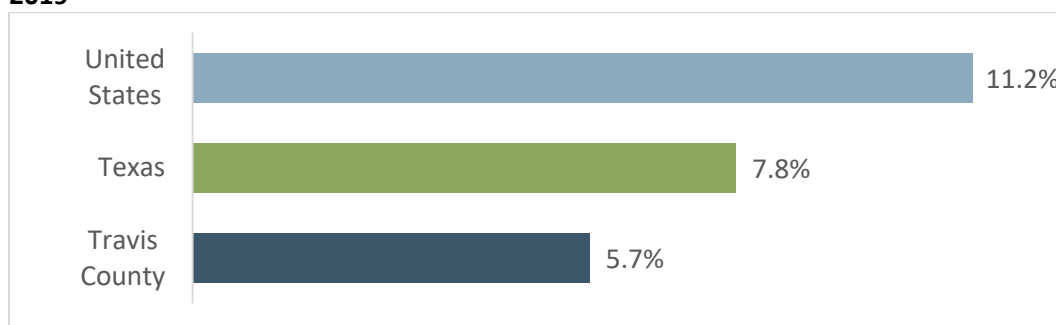
Relationships are important for physical and mental well-being. At an individual level, social networks spread social behaviors: social support can help encourage people to engage in more positive healthy behaviors.²⁴ By contrast, lack of connectedness has been shown to be linked to depression and is a risk factor for early mortality.²⁵

At the community level, the cohesiveness of a community has been shown to be positively related to self-reported health and mortality.²⁶ Conversely, discrimination as part of one's social environment can have a negative impact on health. Structural discrimination such as segregation, inequitable access to quality education, and disparities in incarceration rates can limit opportunities, resources, and well-being of less privileged groups.²⁷ Individual discrimination may have high physical and emotional health costs as well. Research suggests that routine discrimination can be a chronic stressor and increase vulnerability to physical illness.^{28,29} The report "Those Who Left: Austin's Declining African American Population" outlines the steady decline of the Austin African American population, greatly outpacing other major cities. Among the top reasons for leaving was racism and feeling unwelcome in their neighborhoods.³⁰

Community Connectedness and Cohesion

The strength of social connections, feelings of inclusion and support in individual and community relationships, is integral to health. Connectedness is particularly important for youth and older adults. In Travis County, 5.7% of teens aged 16-19 years were disconnected, defined as teens neither in school nor working, according to aggregated data from 2015-2019 (Figure 34). The proportion of disconnected teens was slightly higher in Texas (7.8%) and in the US (11.2%).

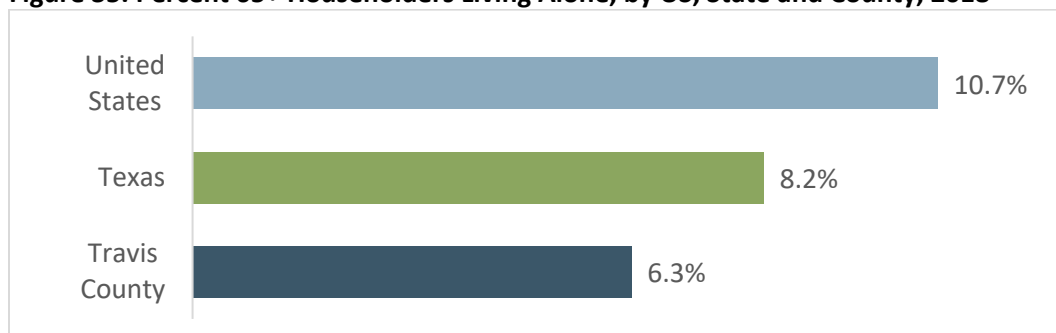
Figure 34. Percent Teens (16-19) Disconnected (Not in School or Work), by US, State and County, 2015-2019



DATA SOURCE: Measure of America; as cited by County Health Rankings, 2015-2019

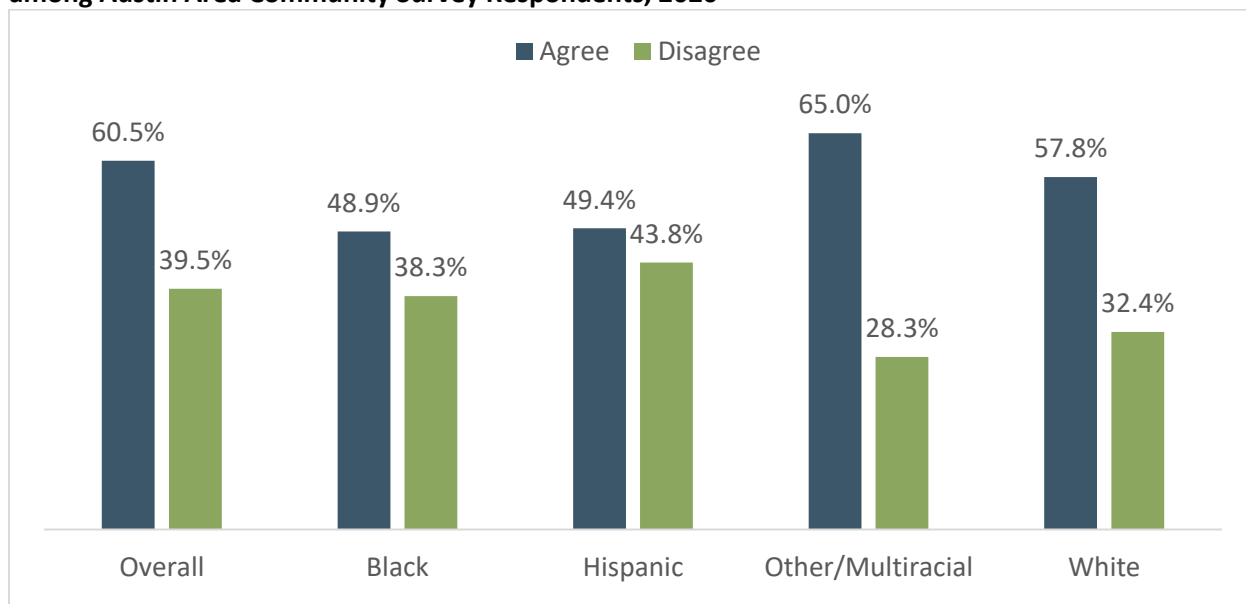
According to 2018 ACS data, a slightly lower proportion of the population aged 65 and over in Travis County (6.3%) and Texas (8.2%) were living alone, compared to about one-tenth (10.7%) of older adults in the US (Figure 35).

Figure 35. Percent 65+ Householders Living Alone, by US, State and County, 2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018

Figure 36. Percent Perceiving Neighbors Working Together Towards Local Community Improvement among Austin Area Community Survey Respondents, 2020

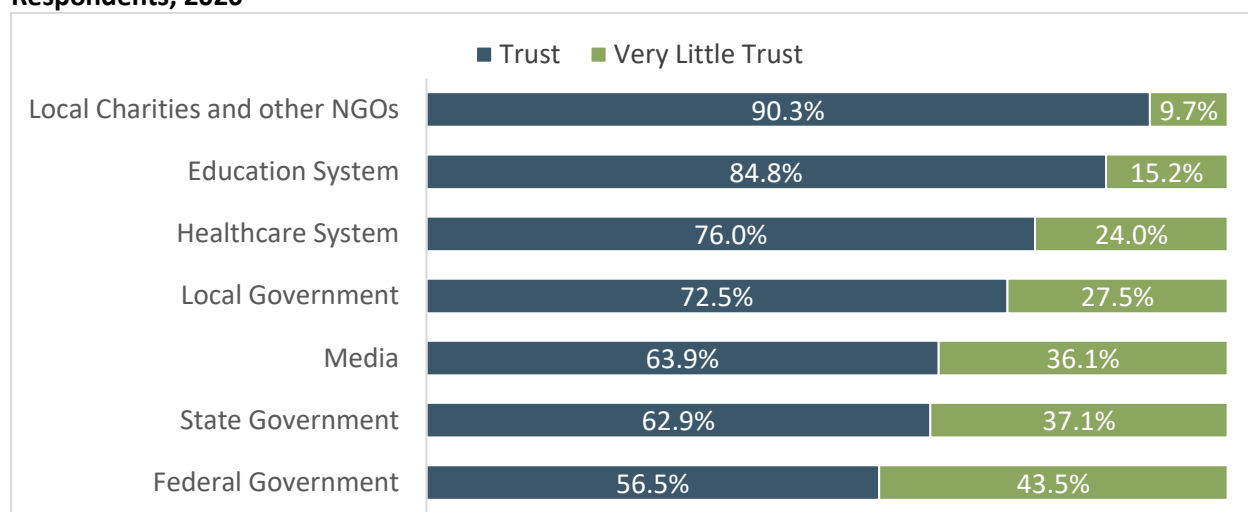


DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Community forum participants discussed the importance of social connections, including relationships with family members and friends and connections to networks and organizations such as faith-based and community-based organizations. Such connections, according to forum participants, support healthy lifestyles and connect residents with community resources.

Another facet of community connectedness is trust in local institutions. When Austin Area Community Survey respondents were asked about their trust in local institutions, the highest percentage of respondents reported trusting local charities and other non-governmental organizations (NGOs) (90.3%) and the education system (84.8%) (Figure 37). About three-quarters (76.0%) of respondents reported trusting the healthcare system. In contrast, there was less trust among respondents towards the federal (56.5%) and state (62.9%) government and the media (63.9%).

Figure 37. Percent Respondents Trusting Local Institutions among Austin Area Community Survey Respondents, 2020



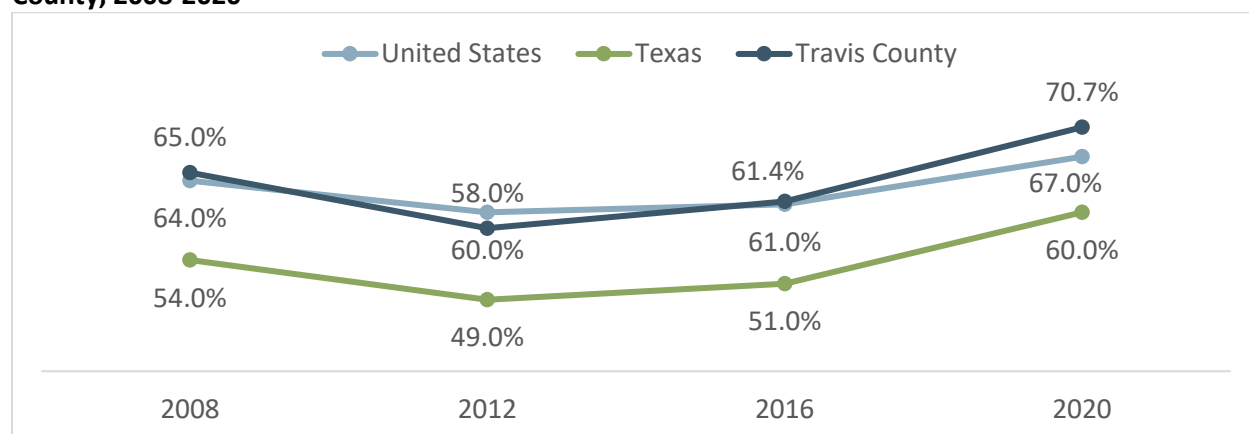
DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: This data combines the survey responses of "Some", "Quite a lot", and "A great deal" as "Trust".

Civic Engagement

Higher civic engagement – voting, volunteering, social organizing and such activities – is linked to population health. In 2020, 70.7% of Travis County residents who were eligible to vote cast a ballot in a national election; this percent was lower in the US overall (67.0%) and in Texas (60.0%) (Figure 38). Throughout the 2008-2020 elections, the percentage of voters who voted in a national election dipped in all noted geographies in 2012 and slightly increased both in 2016 and 2020.

Figure 38. Percent of Voting Eligible Population Who Vote in National Elections, by US, State and County, 2008-2020



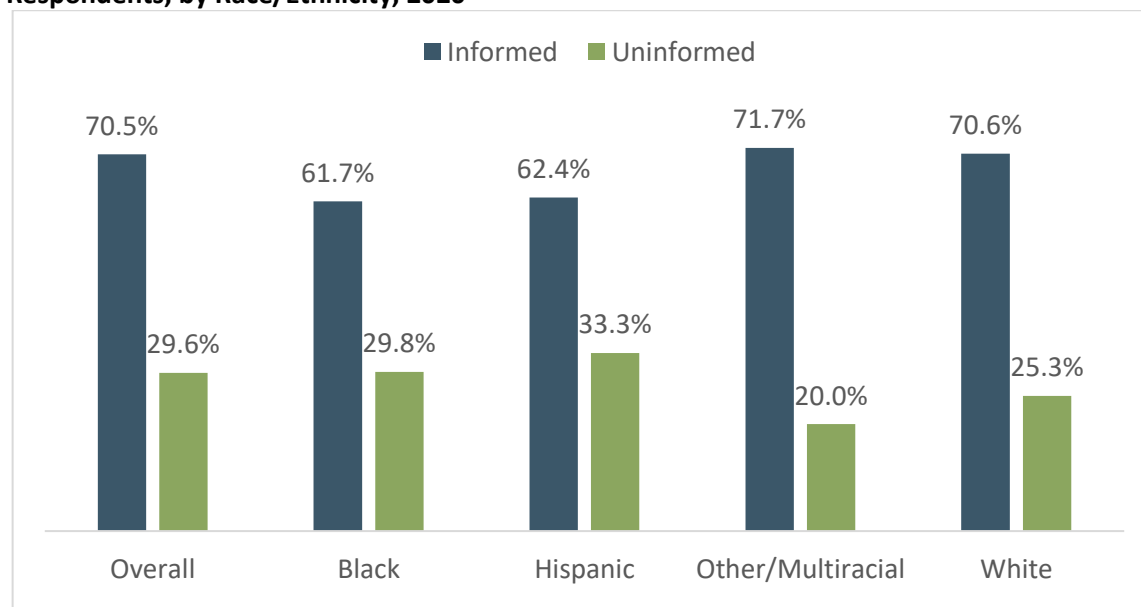
DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2008-2020

NOTE: The percentage reported represents 'Total Ballots Cast' as a percentage of the Voting Eligible Population, where this number was available. For cases in which 'Total Ballots Cast' was unavailable, votes for 'Highest Office' as a percentage of the Voting Eligible Population was used instead.

Limited Awareness of Existing Resources

Of Austin Area Community Survey respondents, 70.5% reported feeling informed about key issues in the neighborhood (Figure 39) and three-fifths (60.5%) of respondents agreed that neighbors are working together towards local community improvement; this percentage was similar across race/ethnicities with the highest percentage of Other/ Multiracial respondents feeling informed (71.7%). The percentage of resident respondents who reported trusting their neighbors declined slightly from 2018 (90.4%) to 2020 (84.5%).

Figure 39. Percent Informed on Key Issues in Neighborhood among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

As discussed earlier, **internet access** emerged as an important barrier to accessing information about resources as well. According to one focus group participant, *“I think a big problem has to do with access, like internet access, for communication, and getting the word out about stuff so you know what’s available.”* In addition to improving internet access, another focus group participant explained the importance of supporting residents in learning how to use resources available on the internet: *“Internet access too, just providing people access when you’re completely computer illiterate, you need personal one-on-one live-in help almost to learn how to use some of these features.”*

Language emerged as another barrier to accessing information that is usually available on the internet. One community leader shared their vision for making information available on the internet more accessible to residents whose primary language is not English: *“[We need] technology that allows access. We serve older adults and a lot of them were left out. One button access to a person that speaks your language, you can trust, and understands your culture is very important.”*

One community leader shared their vision of **improving internet and technology access across the life course**, enabling everyone to access resources and tools needed that are increasingly available via the internet, and to also stay connected and share information and resources with loved ones:

“Getting at least one technology piece per family and allowing them to easily contact someone they can trust. We have some funding for this right now. Goal of intergenerationally connecting the entire family to resources. Seniors in the family could become the source of support in the family given proper technology to connect during the pandemic.” – Community Leader

Despite these technological barriers to accessing information about safety net resources and social services, some participants cited churches as an important source of information. One focus group participant described their experience in the COVID-19 pandemic, *“But also the churches, when we have access to them, they have information too. And sometime during the pandemic they were contacting members to make sure they had what they needed.”*

Additional Information and Resource Barriers

While one community leader recommended improving outreach and education to promote **2-1-1** as a strategy for residents to learn about available resources and services, residents shared mixed experiences with information hotlines such as 2-1-1, with some residents noting that it was an occasional resource and others reporting the hotline as difficult to navigate. One older focus group participant recalled being aware of 2-1-1 and using the service occasionally: *“I might call once in a blue moon; a lot of people need it.”* Another shared that they have not used the information hotline but know that it is available: *“We need a hotline that will direct people where you-, I know 3-1-1 is supposed to help with that, but I haven’t used it enough to know how.”*

One older focus group participant shared, *“I’ve never been able to get any help from that [local information hotline] and it takes hours to get ahold of anybody and then you wasted your time.”* One participant described the complexity of the information menus, *“My experience with 2-1-1 is that those menus are so complicated, level after level.”* In addition to difficulty accessing the menus, another participant observed that the 2-1-1 representatives do not always have information available to share

As discussed previously, some residents who previously experienced homelessness or incarceration or knew someone with an undocumented legal status discussed the importance of having a **state-issued identification card**, like a state ID or driver's license. They described state IDs as critical identifying documents to secure housing and health care resources. One in-depth interview participant who previously experienced homelessness explained the difficulty of accessing health care providers without ID. This participant described the catch-22 of needing identifying documents in order to get a state ID, and the difficulty of getting these identifying documents with a history of homelessness and past catastrophic events.

Some focus group participants described **limited access to safe recreational spaces for young children** to play in their rural community. One focus group participant observed that the area lacked a library, organized sports for young children, and safe activities for teens:

"A place for a recreation center, boys and girls club, or YMCA to have something for the kids/community to do. I see it posted all the time new families moving here that ask what to do here. There's no real community center unless you are a senior citizen." – Community Leader

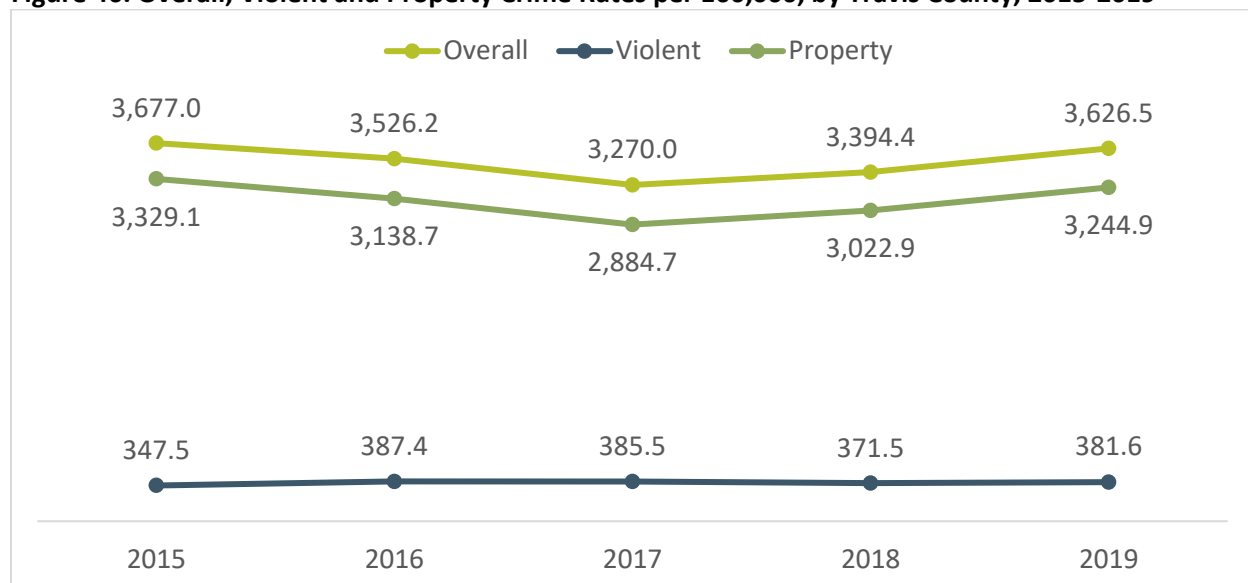
Another community leader shared, *"They need to provide more after-school programs for kids, to keep them busy and 'out of trouble.'"* One focus group participant shared their vision for improving community-based recreational opportunities for children and young families:

"There is a lack of designated recreation centers for our scholars to have access to. If we are going to grow, we should grow to add skate parks and greener type facilities to decrease our carbon footprint and start to teach our younger generation how to take care of what we have left." – Focus Group Participant

An important subgroup of youth identified as needing more resources was LGBTQIA+QIA youth. The need to improve supports for LGBTQIA+QIA students emerged among some focus group participants in more rural communities and some community leaders. One focus group participant shared *"We also don't have resources for LGBTQIA+QIA here. Which I really wish we had more of a listed department in our school district to support our students."* Another focus group participant noted that residents had to travel quite far to access resources: *"We do have access to LGBTQIA+QIA services, but you have to go all the way to Camina la Costa through People's Community Clinic."*

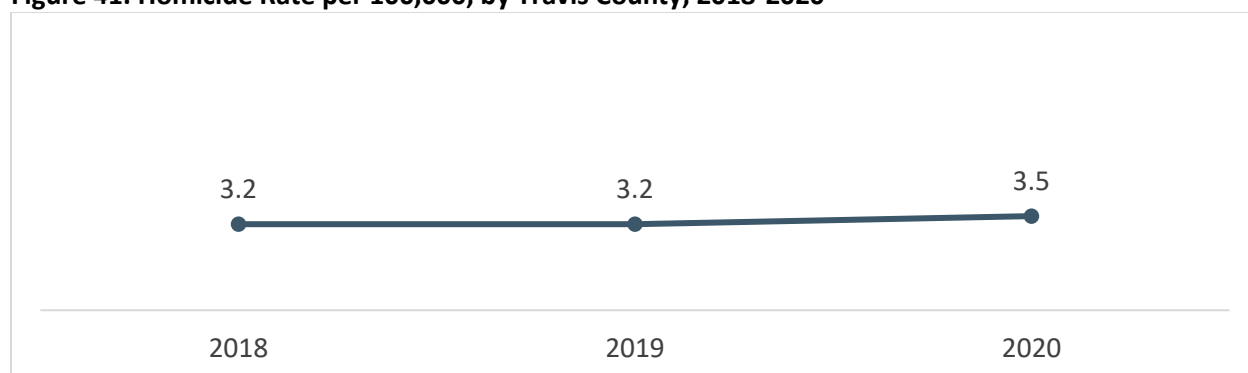
Safety

Crime and safety are additional aspects of community health related to the social environment. Crime data reported by the Texas Department of Public Safety Crime Reports indicate that crime rates remained similar in 2019 compared to 2015 (Figure 40). According to 2019 data, the overall crime rate was 3,626.5 crimes per 100,000 population in Travis County, with a much higher property crime rate (3,244.9 crimes per 100,000 population) compared to violent crime rate (381.6 crimes per 100,000 population).

Figure 40. Overall, Violent and Property Crime Rates per 100,000, by Travis County, 2015-2019

DATA SOURCE: Texas Department of Public Safety Crime Reports, Crime by Jurisdiction, 2015-2019

According to CDC Wonder data, the homicide rate is 3.5 per 100,000 population in Travis County, remaining similar from 2018 through 2020 (Figure 41).

Figure 41. Homicide Rate per 100,000, by Travis County, 2018-2020

DATA SOURCE: CDC Wonder, 2018-2020

When probed about safety, one Hispanic/Latino focus group participant had a **holistic definition of safety**, sharing: *“When I hear safety, or safety net, what comes to my mind is community. Feeling safe with people that I’m familiar, you’re engaged with your community. You feel in Familia. Knowing who is in my community and or the people that protect/care for us.”* A few focus group participants described **concerns about physical violence**, including gun violence, vandalism, break-ins, and robberies. One focus group participant noted, *“[E]ven in my neighborhood, I know there are break-ins and things that happen, and robberies.”* One focus group participant shared their concern about gun violence with the state’s open carry laws, with particular concern about the safety of children in school:

“Now that it’s legal to open carry weapons, we have heard of more people bringing weapons or guns to school, that is a bit scary and we have to be cautious. Like a lot of caution. Those of us who are parents

have an interest and an obligation to be more present, but if we do not have the tools it is more complicated.” – Focus Group Participant

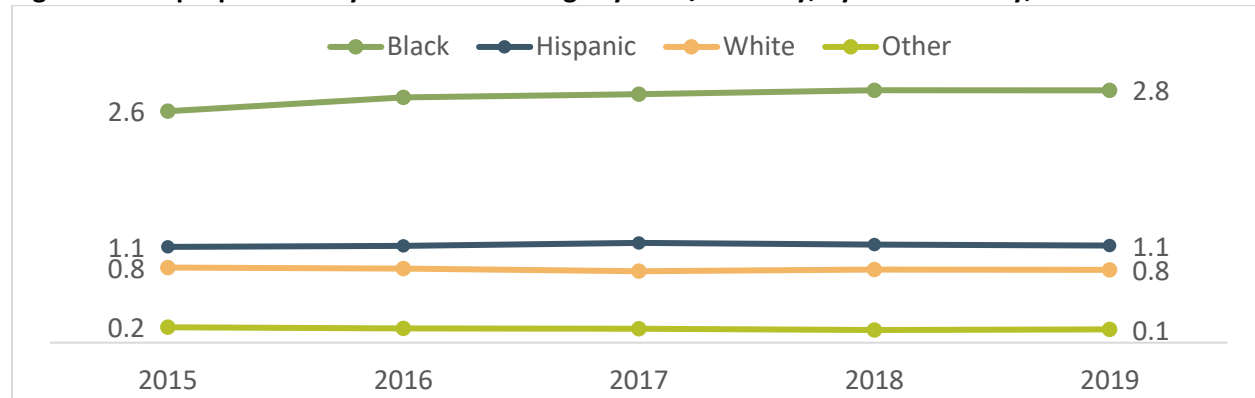
A couple of Hispanic/Latino focus group participants and a resident who previously experienced incarceration described **police violence as a safety concern**, and one focus group participant described an incident of police violence. Another focus group participant explained: *“Young men being affected by policing and policing that is not done right. I’ve seen young men of color being murdered in our streets.”* An in-depth interview participant who was previously incarcerated also expressed concern about interactions with police given their history of incarceration:

“[W]hen on parole or formerly incarcerated, you are almost kind of scared to have any involvement with law enforcement. Any “adverse” event goes against parole, so you worry how perception of former incarceration affects things. So, you always worry about what will happen when they run your ID and they see you are formerly incarcerated.” – In-Depth Interview Participant

One Hispanic/Latino focus group participant perceived that darker skin residents are more vulnerable to police attention and violence, sharing: *“I’m going to be honest, thankfully my skin is light enough that people ask me if I am American. I am a proud to be Mexican, thankfully I have lighter skin and I don’t have to go through those experiences [tearing up]”.*

Shown in Figure 42 is the ratio of the percent of crime bookings by the percent of the racial/ethnic population over 18 years of age in Travis County. This ratio was consistently highest among the Black/African American population (2.8 in 2019), followed by the Hispanic/Latino population (1.1 in 2019) in Travis County.

Figure 42. Disproportionality of Crime Bookings by Race/Ethnicity, by Travis County, 2015-2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates and Travis County Sheriff's Office, 2015-2019

NOTE: Ratio calculated as percentage of bookings by percentage of racial population over 18.

Racism and Discrimination

Acknowledging the **history of systemic racism** in Austin is critical to understanding the unequal landscape of social determinants of health in our community and disparities in health outcomes. Many of the racial inequities that exist today are a direct result of past and current laws, ordinances, and city planning efforts. Understanding this history helps us to better understand the root causes of

disparities in our community today, which is a foundational step towards improving the health and quality of life of all Austinites and working towards healing in our community. *“We have to first accept that racism is real; we see it every day.”* – Community Leader

Some community leaders described **institutional racism** as an important factor that shapes adverse childhood experiences and trauma, access to jobs, educational experiences, housing, family cohesion, where residents can live, and trust towards the government, which they linked with health. One community leader shared:

“One of the biggest issues Black and Brown folks face, especially African Americans, is racism, institutional racism. [I]t causes all sorts of disruptions in the household, from jobs... you know, if you face discriminatory practices day in and out, every week, month after month, it affects your health, it affects the kids.” – Community Leader

One community leader described Asian communities’ **distrust of the government**, such as cities, and cited the importance of community-based organizations as a bridge between historically marginalized racial groups and government services: *“The trust that forms between two communities [city vs. Asian Americans] is a huge barrier. [They] may rather go to [a] nonprofit than the city.”*

One participant described an experience when emergency medical responders diminished the health needs and pain of their Black/African American partner when they had a health emergency: *“The problem was with EMS, which came because [my boyfriend] twisted his ankle. EMS was asking if he wanted to be taken to the hospital, when they were speaking, they were saying he was a Black dude and was stronger than that and could wait.”*

Another community leader described distrust of African American communities towards the government, which they linked with past experiences of discrimination and broken promises from governmental organizations:

“There’s frustrations and mistrust, from what we hear. Broken promises about what’s coming, and it takes years to come if ever. Critical era, trust is at zero for African American and faith community, they trust their leadership and pastors. There’s an oversight from powers that be to direct services without not tapping into their relational networks.” – Community Leader

When residents discussed racism and discrimination, some cited incidents of hate, including verbal attacks and physical violence towards people of color and residents of non-Christian faiths. One participant from a minority religion described their experience of being verbally and physically attacked on public transportation. Another community leader discussed ongoing hate towards Asians that they described as increasing since the COVID-19 pandemic. This community leader went on to describe the longer-term mental health and community impacts of anti-Asian sentiments and hate:

“After COVID, the mental health, anxiety, uncertainty and safety are barriers that will haunt us for the next 2-3 years. Our community feels like we are being targeted all the time. This is historical. We have been attacked throughout history.” – Community Leader

FINDINGS: COMMUNITY HEALTH OUTCOMES AND BEHAVIORS



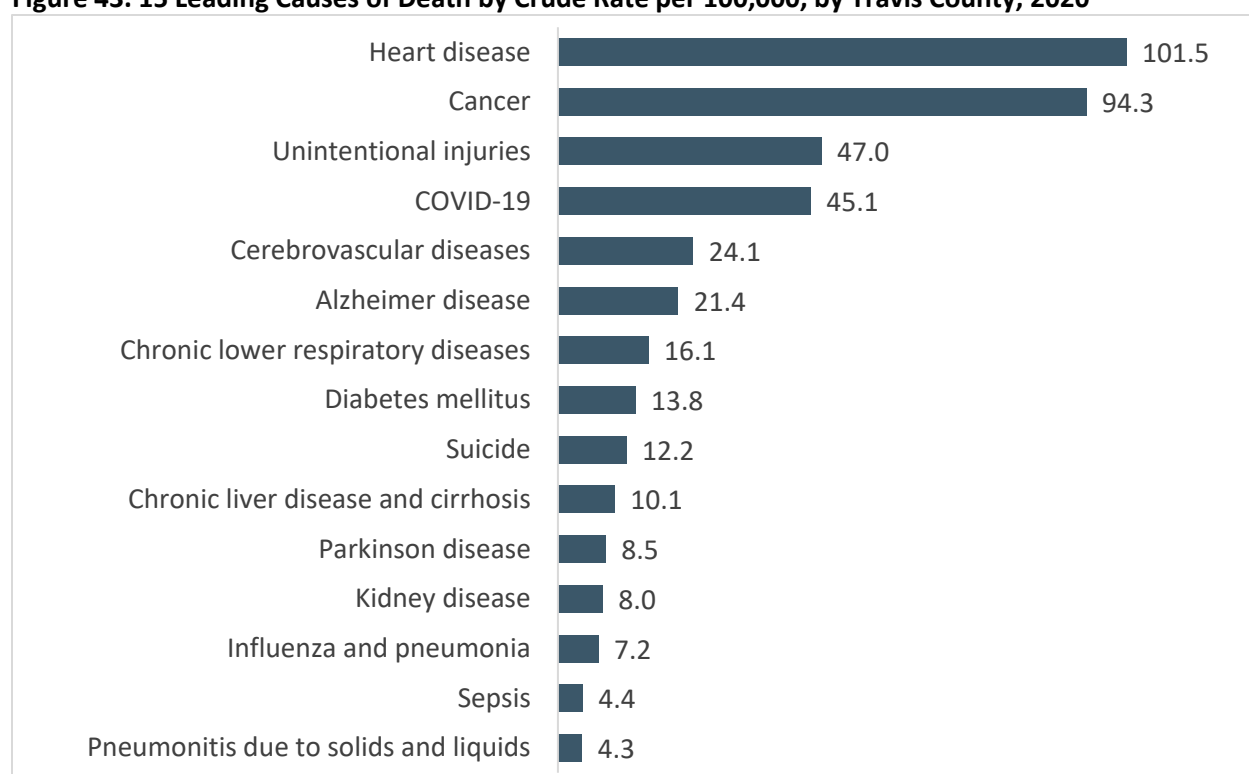
COMMUNITY HEALTH OUTCOMES AND BEHAVIORS

General Health Outcomes

The following section provides an overview of the population's general health outcomes including the leading causes of death, life expectancy, current health status, and community perceptions of health.

According to 2020 data from the CDC wonder, the top leading causes of death (according to crude rates per 100,000 population) in Travis County were heart disease (101.5 deaths per 100,000 population), and cancer (94.3 deaths per 100,000 population), followed by unintentional injuries (47.0 deaths per 100,000 population) and COVID-19 (45.1 deaths per 100,000 population) (Figure 43).

Figure 43. 15 Leading Causes of Death by Crude Rate per 100,000, by Travis County, 2020



DATA SOURCE: CDC Wonder, 2020

When examining crude death rates in 2020 by race/ethnicity, cancer was among the top two causes of death among all race/ethnicities shown among Travis County residents (Figure 44). In 2020, the leading cause of death was COVID-19 for the Hispanic/Latino population and heart disease was the leading cause of death for the White population.

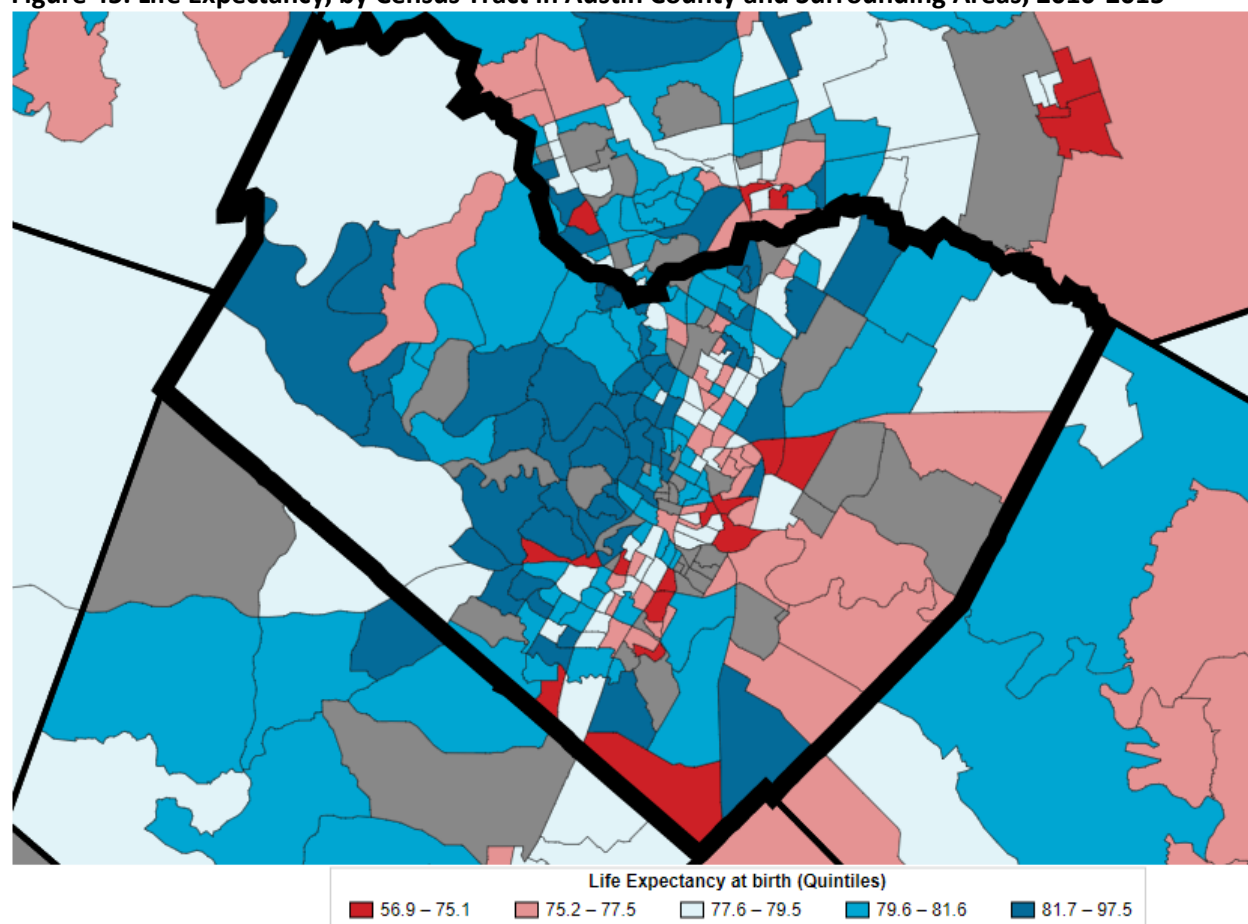
Figure 44. Leading Causes of Death (Crude Rate per 100,000), by Race/Ethnicity, by Travis County, 2020

Asian	Black	Hispanic	White
Cancer (42.0)	Cancer (116.3)	COVID-19 (65.3)	Heart Disease (107.3)
Heart disease (29.0)	Unintentional Injuries (57.7)	Cancer (54.0)	Cancer (100.9)
N/A	COVID-19 (50.1)	Heart Disease (45.2)	Unintentional Injuries (51.1)
N/A	Cerebrovascular diseases (43.3)	Unintentional Injuries (36.7)	COVID-19 (50.1)
N/A	Diabetes mellitus (30.6)	Cerebrovascular Diseases (16.2)	Cerebrovascular Diseases (24.2)

DATA SOURCE: CDC Wonder, 2020

Life expectancy by census tract in Austin County and surrounding areas is depicted below (Figure 45); among these census tracts, expectancy ranges between 68.6 years and 88.9 years.

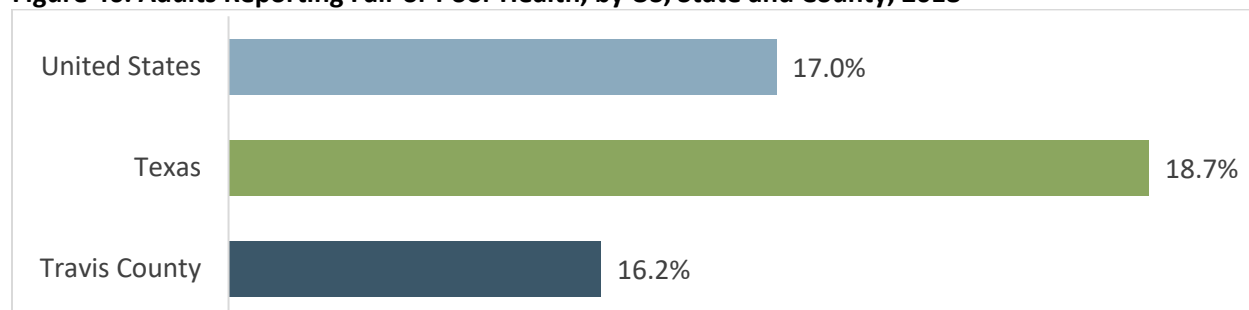
Figure 45. Life Expectancy, by Census Tract in Austin County and Surrounding Areas, 2010-2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, 2010-2015

NOTE: Geographic areas with no data available are filled in gray.

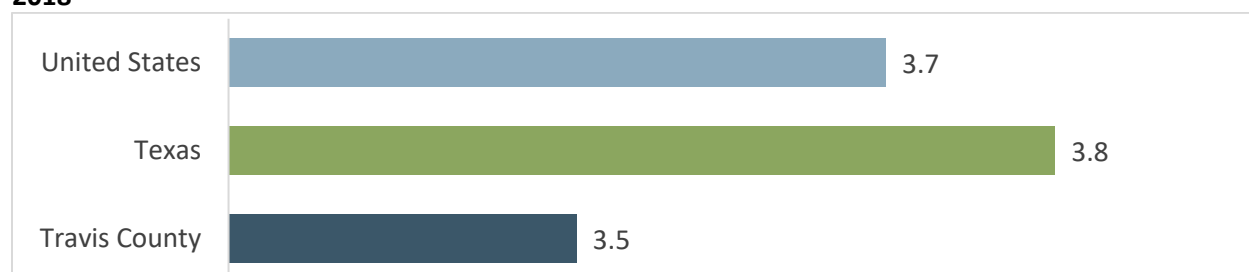
Figure 46. Adults Reporting Fair or Poor Health, by US, State and County, 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings, 2018

In 2018, 16.2% of Travis County adults reported fair or poor health, a proportion that was slightly lower than that across Texas (18.7%) and the US overall (17.0%) (Figure 46). By comparison, according to the LGBTQIA+ QWELL Wellbeing survey of respondents in the Greater Austin area, almost half (47.3%) of LGBTQIA+ respondents in Greater Austin reported poor or fair physical health. In 2019, on average LGBTQIA+ respondents reported 4.8 days of poor physical health in the last month; this number increased to 6.0 days in 2020.³¹ Travis County, Texas, and US adults had an average of almost 4 self-reported days of physically unhealthy days in the past month in 2018 (Figure 47).

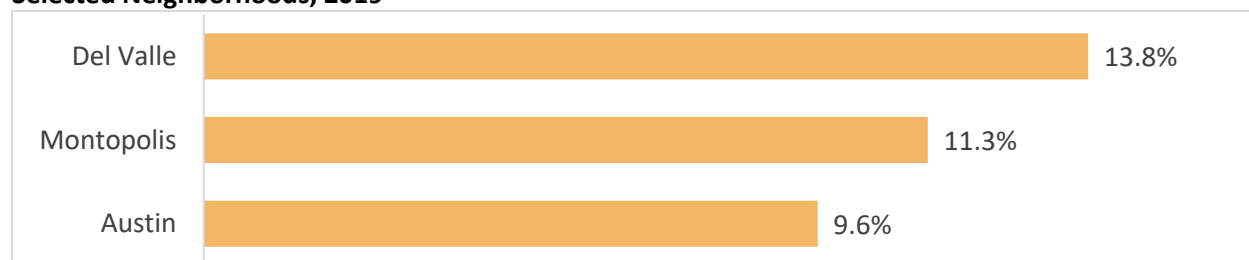
Figure 47. Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted), 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings, 2018

In 2019, 13.8% of Del Valle residents and 11.3% of Montopolis residents reported poor physical health for at least 14 days of the last 30 days, compared to 9.6% of Austin residents, highlighting disproportionate adverse health outcomes in Del Valle (Figure 48).

Figure 48. Residents Reporting Poor Physical Health for More Than 14 Days in the Past 30 Days, by Selected Neighborhoods, 2019

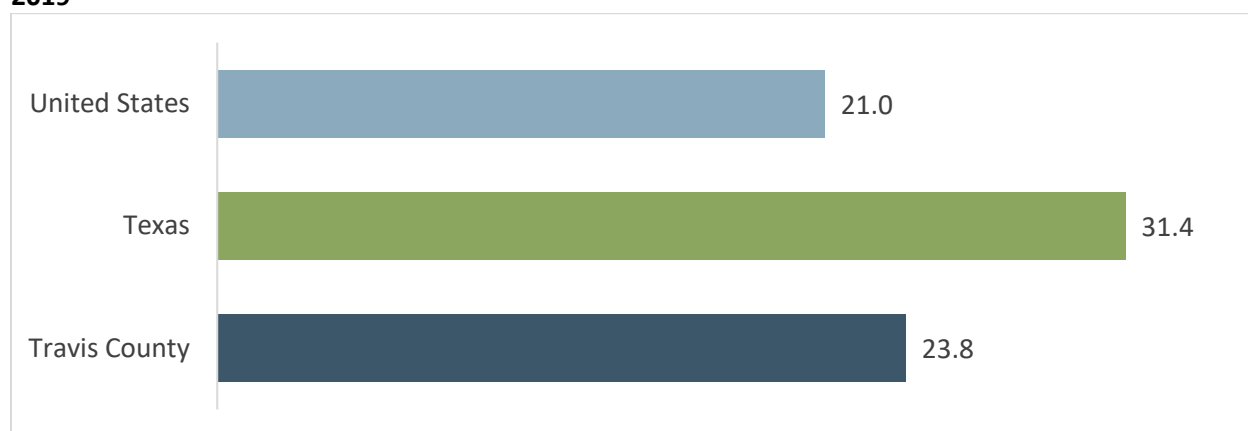


DATA SOURCE: Community Health Indicator Analysis (Del Valle & Montopolis), 2019

Maternal and Child Health

The rate of teen births among females aged 15-19 in Travis County (23.8) was similar to the teen birth rate nationwide (21.0), and lower than the teen birth rate across Texas (31.4) according to 2013-2019 aggregated data (Figure 49).

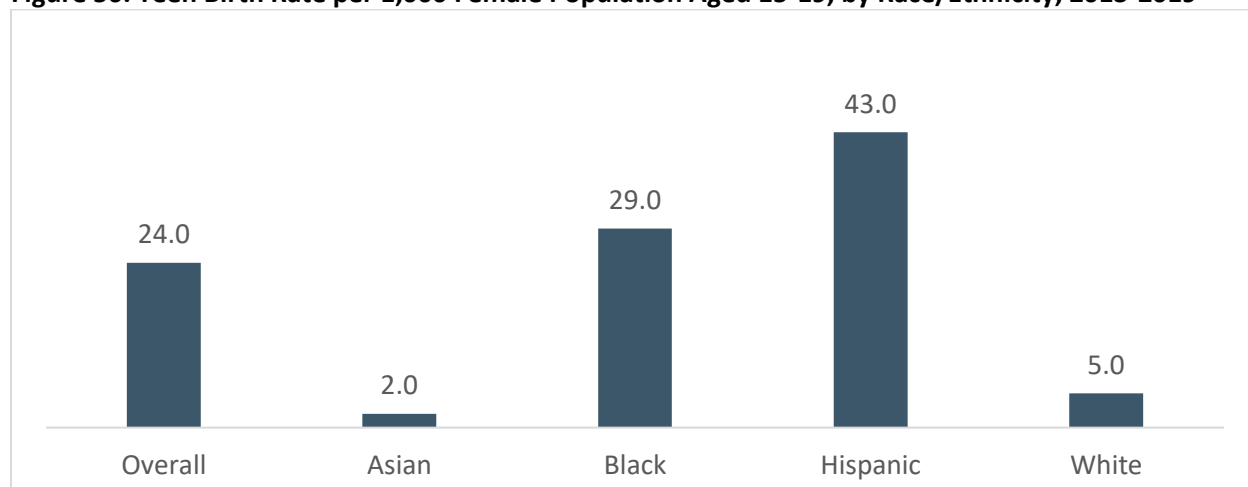
Figure 49. Teen Birth Rate per 1,000 Female Population Aged 15-19, by US, State and County, 2013-2019



DATA SOURCE: National Center for Health Statistics, Natality files, National Vital Statistics System (NVSS); as cited by County Health Rankings, 2013-2019

From 2013-2019 the teen birth rate was significantly higher for Hispanic teens than other racial and ethnic groups as well as the population overall.

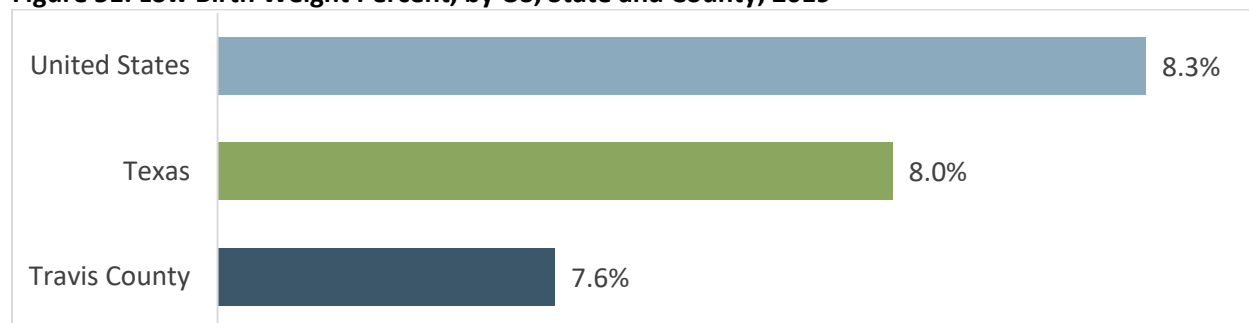
Figure 50. Teen Birth Rate per 1,000 Female Population Aged 15-19, by Race/Ethnicity, 2013-2019



DATA SOURCE: 2021 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)

In 2019, 7.6% of infants in Travis County were born with a low birth weight, meaning they weighed less than 2,500 grams; this proportion was similar in Texas (8.0%) and the US (8.3%) (Figure 51).

Figure 51. Low Birth Weight Percent, by US, State and County, 2019



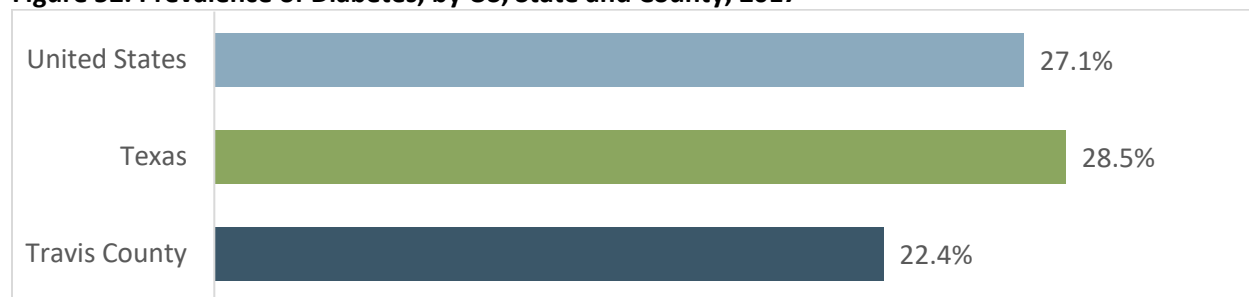
DATA SOURCE: Texas Certificates of Live Birth, 2019

NOTE: Low birth weight is defined as babies who are born weighing less than 2,500 grams

Chronic Disease

According to 2017 County Health Rankings data, about one-fifth (22.4%) of Travis County residents have been diagnosed with diabetes, which is slightly lower than the prevalence in Texas (28.5%) and the US overall (27.1%), where more than one-quarter of residents have been diagnosed with diabetes (Figure 52).

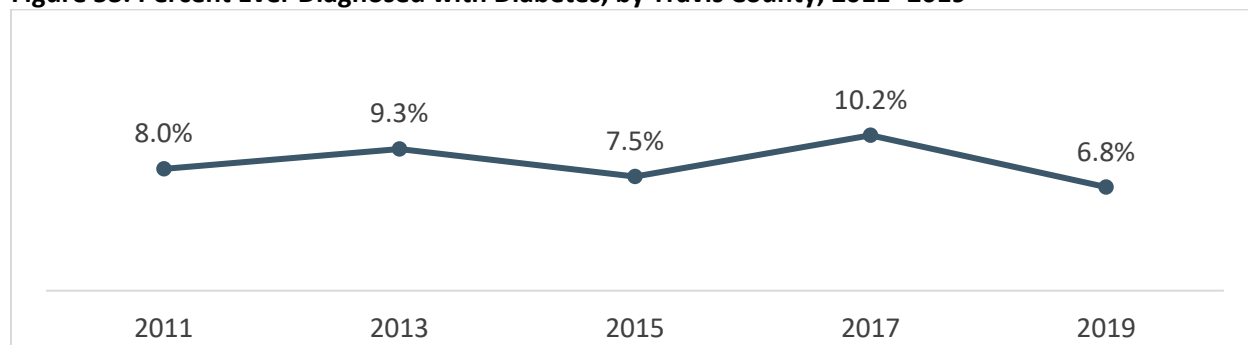
Figure 52. Prevalence of Diabetes, by US, State and County, 2017



DATA SOURCE: CDC Diabetes Interactive Atlas; as cited by County Health Rankings, 2017

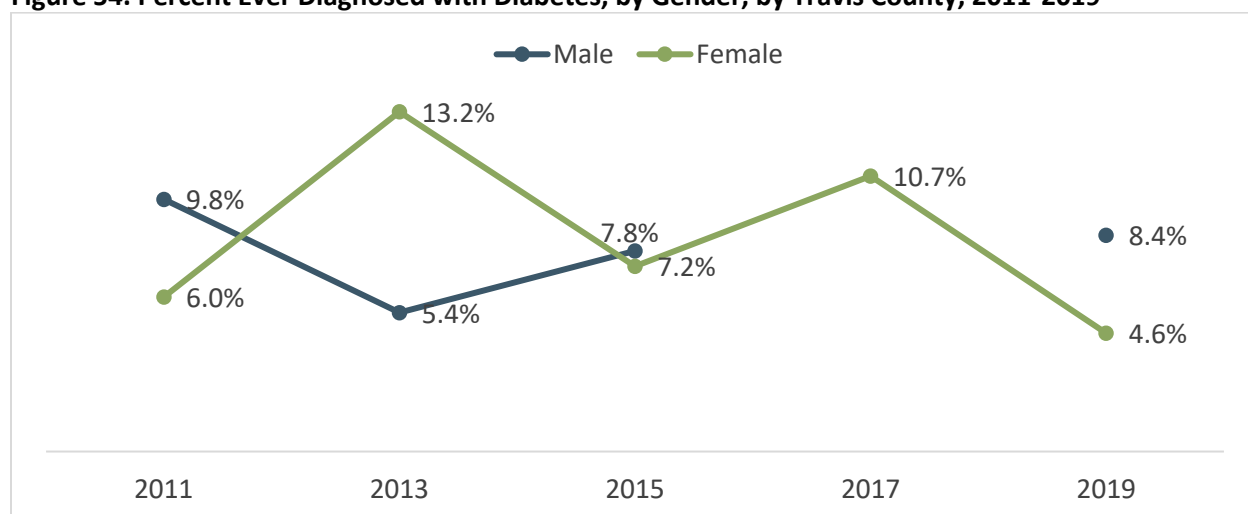
The percent of Travis County residents who report ever being diagnosed with diabetes in 2019 was 6.8%, which is slightly lower than the prevalence from 2011 to 2017 (Figure 53). The percent of adults reporting a diabetes diagnoses varied by gender and over time, ranging from a high of 9.8% in 2011 to a low of 5.4% in 2013 for males and a high of 13.2% in 2013 to a low of 4.6% in 2019 for females (Figure 54). From 2011 to 2019, a higher percentage of Hispanic/Latino residents (Figure 55) and those aged 65 and over (Figure 56) reported being diagnosed with diabetes compared to other groups in those stratifications. For example, in 2019, approximately one-tenth (10.0%) of Hispanic/Latino adults reported a diabetes diagnosis, compared to 4.6% of White adults. In 2019, about one-fifth (21.6%) of adults 65+ years of age reported being diagnosed with diabetes, followed by 8.0% of adults 45-64 years of age.

Figure 53. Percent Ever Diagnosed with Diabetes, by Travis County, 2011 -2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

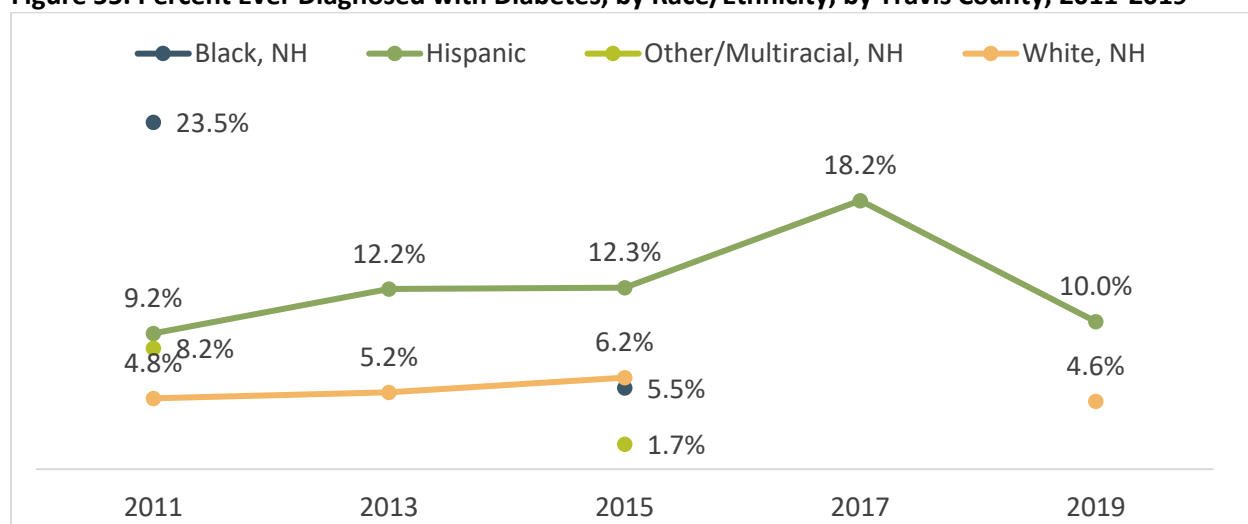
Figure 54. Percent Ever Diagnosed with Diabetes, by Gender, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Missing data points indicate unreliable data.

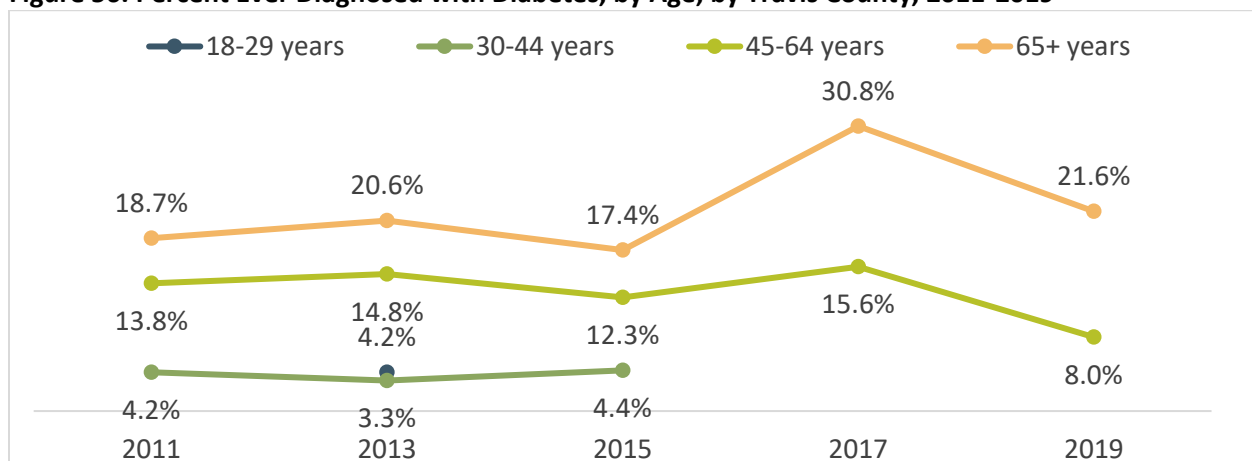
Figure 55. Percent Ever Diagnosed with Diabetes, by Race/Ethnicity, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Missing data points indicate unreliable data.

Figure 56. Percent Ever Diagnosed with Diabetes, by Age, by Travis County, 2011-2019

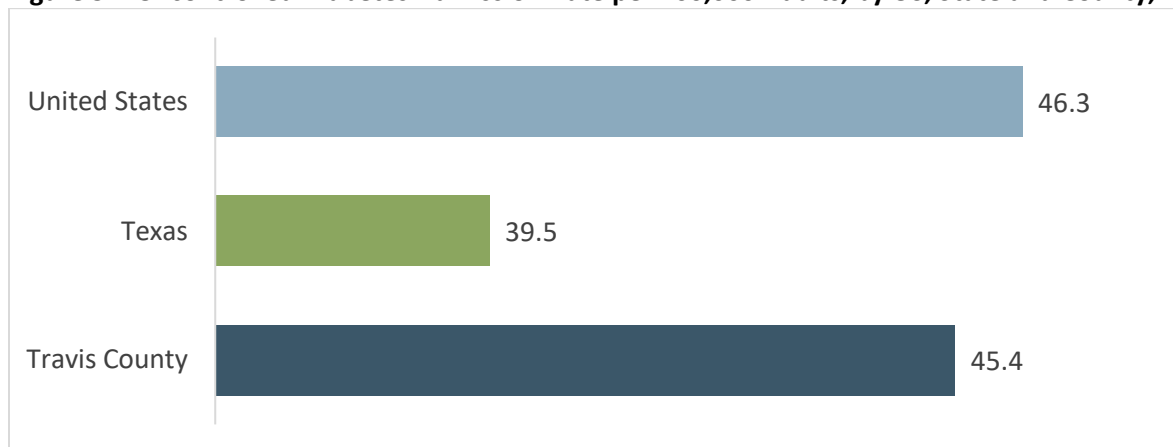


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Missing data points indicate unreliable data.

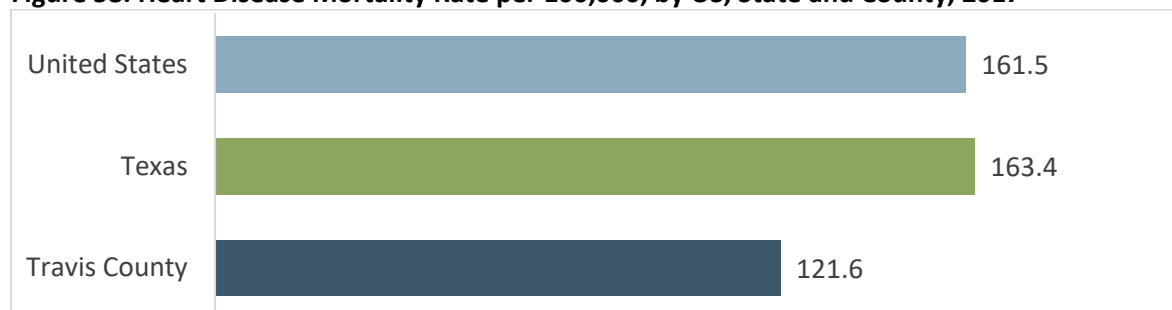
The uncontrolled diabetes hospital admission rate in Travis County and the US overall (45.4 and 46.3 admissions per 100,000 adults, respectively) was slightly higher than the rate in Texas (39.5 admissions per 100,000 adults) in 2018 (Figure 57).

Figure 57. Uncontrolled Diabetes Admission Rate per 100,000 Adults, by US, State and County, 2018



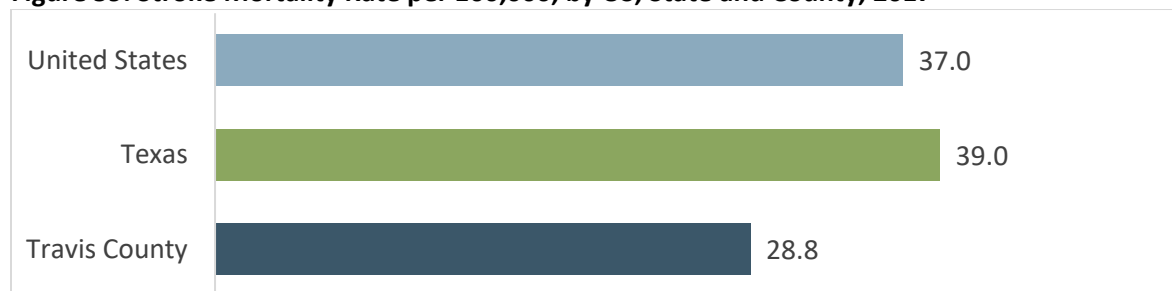
DATA SOURCE: Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations, 2018

In 2017, the heart disease mortality rate in Travis County (121.6 deaths per 100,000 population) was lower than that in Texas and the US overall (163.4 and 161.5 deaths per 100,000 population, respectively) (Figure 58).

Figure 58. Heart Disease Mortality Rate per 100,000, by US, State and County, 2017

DATA SOURCE: Texas Health Data, Center for Health Statistics, Texas Department of State Health Services, 2017

The stroke mortality rate in Travis County (28.8 deaths per 100,000 population) was lower than that for Texas and the US (39.0 and 37.0 deaths per 100,000 population, respectively) in 2017 (Figure 59).

Figure 59. Stroke Mortality Rate per 100,000, by US, State and County, 2017

DATA SOURCE: Texas Health Data, Center for Health Statistics, Texas Department of State Health Services, 2017

Cancer

Overall cancer incidence in 2013-2017 aggregated data was lowest in Travis County (391.9 per 100,000 population), followed by Texas (407.7 per 100,000 population) and the US (448.7 per 100,000 population) (Table 5). Prostate and lung cancer generally had the highest rates of incidence compared to colon and female breast cancer in these geographies. The female breast cancer incidence rate in Travis County (32.5 per 100,000 population) was higher than Texas and the US (22.5 and 29.8 per 100,000 population, respectively).

Table 5. Cancer Incidence per 100,000, by US, State and County, 2013-2017

	Overall	Female Breast	Colon	Lung	Prostate
United States	448.7	29.8	38.4	58.3	104.5
Texas	407.7	22.5	37.6	50.6	94.0
Travis County	391.9	32.5	32.9	41.7	92.2

DATA SOURCE: State Cancer Profiles, National Cancer Institute (CDC), 2013-2017

The cancer mortality rate was slightly lower in Travis County (117.0 deaths per 100,000 population) compared to that for Texas and the US (141.4 and 146.2 deaths per 100,000 population, respectively) in 2017 (Figure 60).

Figure 60. Cancer Mortality Rate per 100,000, by US, State and County, 2017



DATA SOURCE: Texas Health Data, Center for Health Statistics, Texas Department of State Health Services, 2017

Community Perceptions of General Health

When asked “What does health meant to you?” several residents described a **holistic definition of health**, which they mentioned included happiness, quality of life, safety, spiritual well-being, as well as living an active lifestyle. One focus group participant described health as *“Being happy in your family life, work life; all together happy in your community and safe.”* Another focus group participant shared, *“If going to mass, or a religious service is good for my emotional health, then that is a part of health.”* According to one community leader, health is influenced by several factors outside of the health care setting: *“I have a broad definition of health and if someone feels safe and comforted, then that is health. I am invested and interested in what happens outside the clinic.”* Many participants and community leaders described mental and physical health as linked. One focus group participant shared: *“For me, it’s mentally, physically, all of it, one does not outweigh the other one. If you’re not physically healthy then mentally, you can[not] bring yourself from that. It all ties into one thing.”*

For several focus group participants, healthy lifestyle and access to health-promoting resources such as **healthy foods and spaces to be physically active** were important for promoting health. One focus group participant explained, *“Eating healthy, exercising, going to the doctor regularly, having control over all diseases, and especially sleeping well and having zero stress although it is difficult to avoid stress but you must go get a checkup at the doctor regularly.”* Some focus group participants mentioned the importance of sufficient and high quality of sleep. One focus group participant shared, *“Resting and sleeping well, that also counts a lot.”*

“Daily walks, for those of us who can. Access to a store with fruits and vegetables, close by.” – Focus Group Participant

“For me, [health] means wellbeing, eating healthy, getting medical checkups, trying to be well and in good health.” – Focus Group Participant

Stress was a common theme among Hispanic/Latino focus group participants, who noted that stress is connected with health and observed the importance of limiting stressful circumstances. As one focus group participant shared, *“Maintaining a low level of stress is very important for me.”* Another focus group participant shared how multiple responsibilities and strains on time make it difficult to prioritize health: *“I also think that time is a factor because we work a lot and we don’t have time to take the time to take care of our health.”*

One in-depth interview participant who had previously been incarcerated cited the **structural conditions** of people's lives, including incarceration, as shaping health. This resident noted, *"At some point they will have to recognize long-term incarceration as a disability."*

Some focus group participants described **health insurance** and access to medical and dental providers as important supports for health. One focus group participant explained, *"Good health insurance [is important] so when you get sick you can go to the doctor and get treated."* Another focus group participant shared, *"[Health] requires care like doctors' visits, healthcare visits, visits with specialists."* A couple of participants mentioned acupuncture and water therapy as important forms of support for health. One provider serving primarily low-income and Hispanic/Latino described significant oral health needs for patients in their clinic:

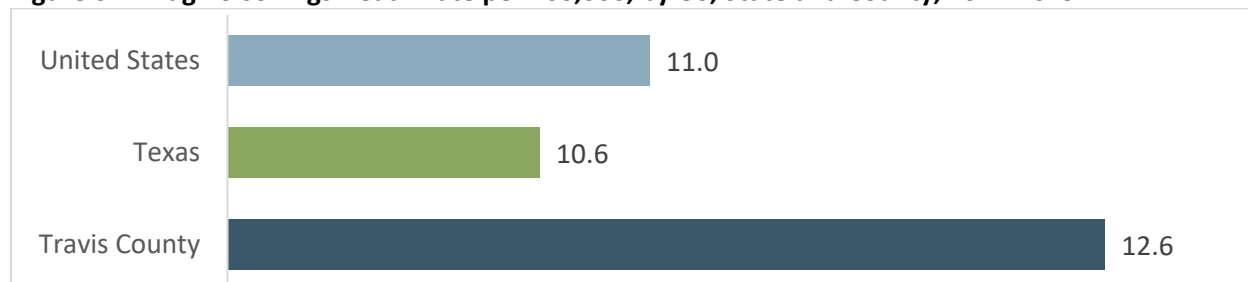
"Before dentistry, we had patients with complex dental needs because they have been without dental care for so long. We are getting people up to speed, stasis, and need a lot of restorative dental services." – Community Leader

Behavioral Health Outcomes

In addition to general health outcomes discussed above, the following section describes outcomes related to behavioral health, including substance use and mental health, as well as community perceptions of behavioral health.

In 2017-2019 aggregated data, the rate of drug poisonings, also referred to as overdoses, was 12.6 deaths per 100,000 population in Travis County, which was slightly higher than Texas and the US (10.6 and 11.0 deaths per 100,000, respectively) (Figure 61).

Figure 61. Drug Poisonings Death Rate per 100,000, by US, State and County, 2017-2019



DATA SOURCE: CDC WONDER Mortality Data; as cited by County Health Rankings, 2017-2019

Substance use was not widely discussed in interviews or focus groups. However, some residents and community leaders did describe the importance of de-stigmatizing addiction. One focus group participant observed that addiction is often invisible and stigmatized, which contributes to limited supports for people living with addiction:

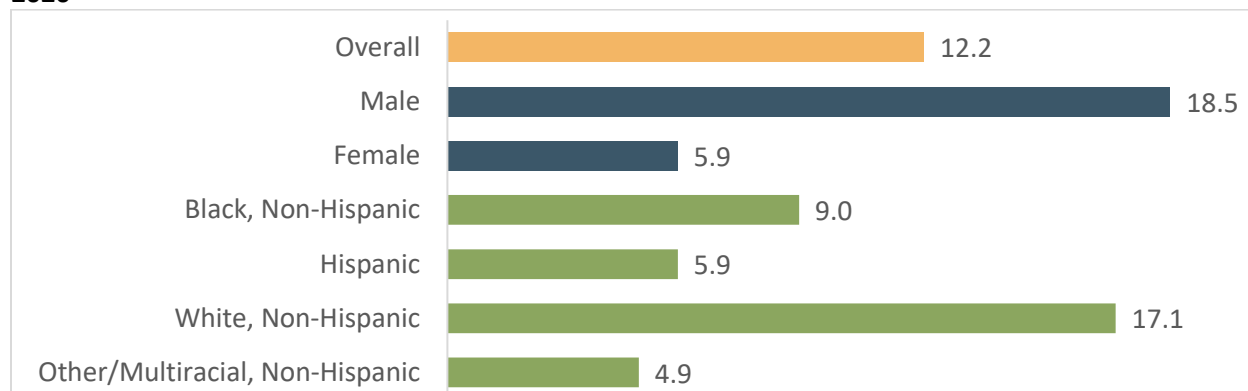
"...[I]t doesn't always show, so many people out there [with addiction], we need to have programs where people feel safe coming forward and there's no stigma involved. People who were prescribed and then became addicted, they shouldn't be blamed for that." – Focus Group Participant

One in-depth interview participant who was previously incarcerated highlighted the intersections of stigma towards people who have been incarcerated and people who struggle with addiction, highlighting how current group addiction support programs can be unwelcoming for people who have been incarcerated, even if their attendance is mandatory:

“[It is] [m]andatory for everyone to go to AA [Alcoholics Anonymous] first, but they find out you’re formerly incarcerated and the members of AA are often unwelcoming (shame and stigma). I had a woman (who had been in that group for a few years) tell me that because I was formerly incarcerated, I wasn’t welcome at the AA meeting.” – In-Depth Interview Participant

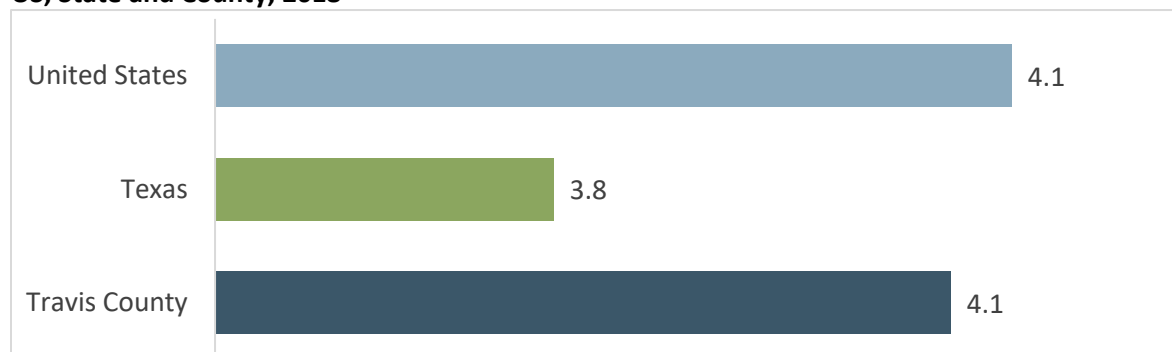
Substance use disorders and mental illness are closely linked and often co-occurring. Among Travis County residents, the suicide rate was 12.2 deaths per 100,000 population and highest among males (18.5 deaths per 100,000 population) and White residents (17.1 deaths per 100,000 population) in data aggregated from 2016-2020 (Figure 62).

Figure 62. Suicide Rate by 100,000, Overall and by Gender and Race/Ethnicity, by Travis County, 2016-2020



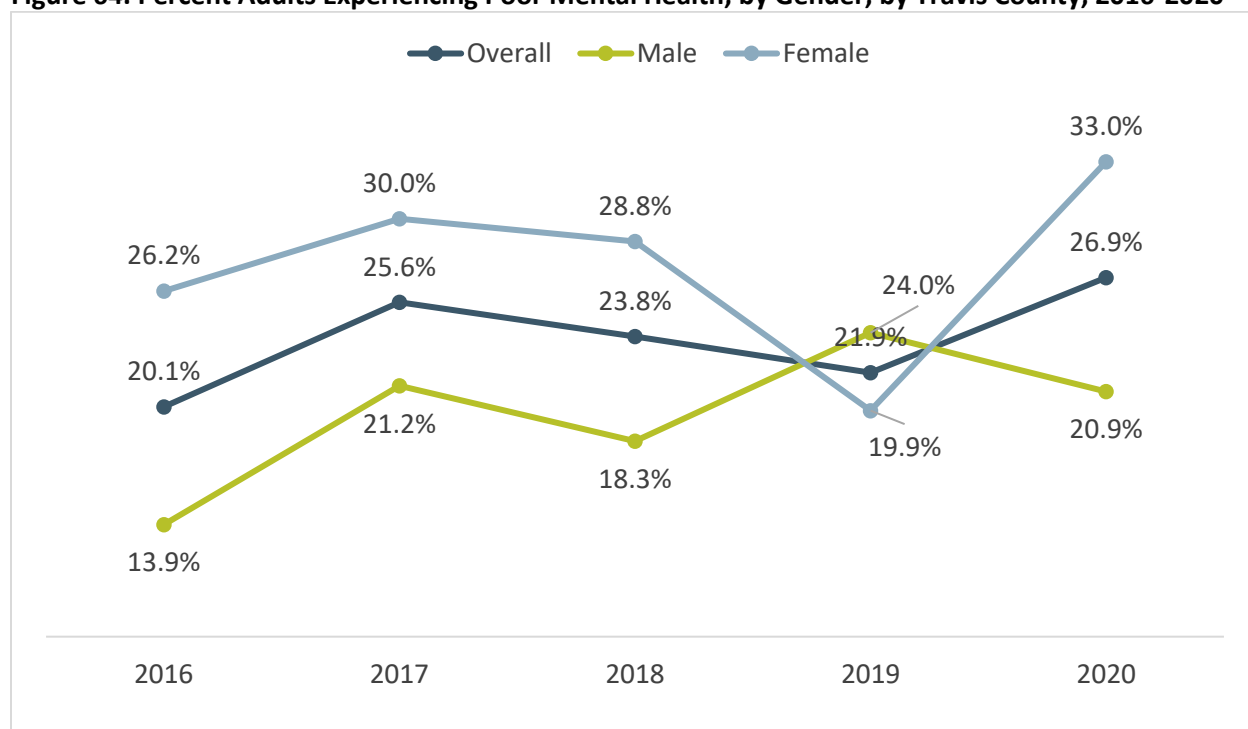
DATA SOURCE: CDC Wonder, 2016-2020

In 2018, the average number of **mentally unhealthy days** reported in the past 30 days was relatively similar in Travis County, Texas, and the US overall, at around 4 days (Figure 63).

Figure 63. Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted), by US, State and County, 2018

DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings & Roadmaps, 2021

With the exception of 2019, throughout 2016 to 2020 a higher percentage of females (33.0% in 2020) compared to males (20.9% in 2020) reported poor mental health, defined as having 5 or more days of poor mental health in the past 30 days (Figure 64). Since 2016, the prevalence of poor mental health days has increased overall for both genders.

Figure 64. Percent Adults Experiencing Poor Mental Health, by Gender, by Travis County, 2016-2020

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2016-2020

NOTE: Adults who self-report 5 or more days of poor mental health in the past 30 days.

Over one-fifth of adults in all race/ethnicity categories reported poor mental health in 2020 (Table 6). In the same year, a higher percent of Hispanic/Latino adults (31.5%) reported poor mental health compared to White (26.3%) and Black/African American (22.9%) adults.

Table 6. Percent Adults Experiencing Poor Mental Health, by Gender, Race/Ethnicity, Age, by Travis County, 2016-2020

	2016	2017	2018	2019	2020
Overall	20.1%	25.6%	23.8%	21.9%	26.9%
Male	13.9%	21.2%	18.3%	24.0%	20.9%
Female	26.2%	30.0%	28.8%	19.9%	33.0%
Black, Non-Hispanic	-	-	26.5%	-	22.9%
Hispanic	19.6%	30.4%	20.0%	25.7%	31.5%
Other/Multiracial, Non-Hispanic	-	-	-	-	-
White, Non-Hispanic	22.5%	24.9%	25.8%	23.4%	26.3%
18 to 29	29.0%	36.6%	39.7%	34.4%	32.6%
30 to 44	18.1%	30.4%	19.6%	22.8%	34.3%
45 to 64	18.2%	18.6%	23.6%	16.3%	22.0%
65+	13.6%	-	11.2%	12.7%	17.5%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2016-2020

NOTE: Adults who self-report 5 or more days of poor mental health in the past 30 days; dashes (-) indicate unreliable estimates or inadequate number of responses.

Over one-fifth of adults younger than 65 years of age reported poor mental health in 2020 (Table 6). Generally, the highest proportion of adults experiencing poor mental health was seen among adults aged 18-29 (32.6% in 2020) and 30-44 years of age (34.3% in 2020), while reports of poor mental health were lowest among adults 65+ years of age (17.5% in 2020) (Table 6).

Significant mental health needs, **stigma** around mental health, and **limited access to mental health care** was a common theme among community leaders, focus group participants, community forum participants, and in-depth interview participants. Residents cited mental health issues affecting older adults, children, young and middle-aged adults, LGBTQIA+Q residents, residents of color, and people experiencing homelessness. One community leader described the importance of governmental support for sharing information about mental health resources:

“I don’t feel like there are mental health resources for the Asian community. We lack support from government and other local channels. This is why I feel like your assessment is important, we need to be connected. Resources don’t always have to be money, sometimes they are communication channels and learning who to reach out: doctors, psychiatrists, etc.” – Community Leader

As discussed above, some residents perceived an increase in mental health issues during the COVID-19 pandemic, including depression and anxiety, which they linked with the **stress and trauma of the COVID-19 pandemic**, loss of loved ones, social isolation, and economic suffering. One community leader characterized the mental health crisis facing residents during the ongoing COVID-19 pandemic:

“Then we look at the physical piece: depression and anxiety are at an all-time high which affect our physical health. The brain-body connection is huge and I cannot stress that enough.” – Community Leader

One community leader also mentioned the importance of addressing addiction and mental health issues affecting people who are experiencing homelessness: *“Dealing with mental health is a huge issue and dealing with addiction and there is nothing that really helps with that.”* Several residents described mental health as stigmatized. One focus group participant shared: *“I think [...] one [issue] that is taboo is mental health.”* A couple of community leaders also discussed stigma around mental health. One community leader observed, *“Mental health support is difficult because nobody likes to talk about their mental health struggles.”*

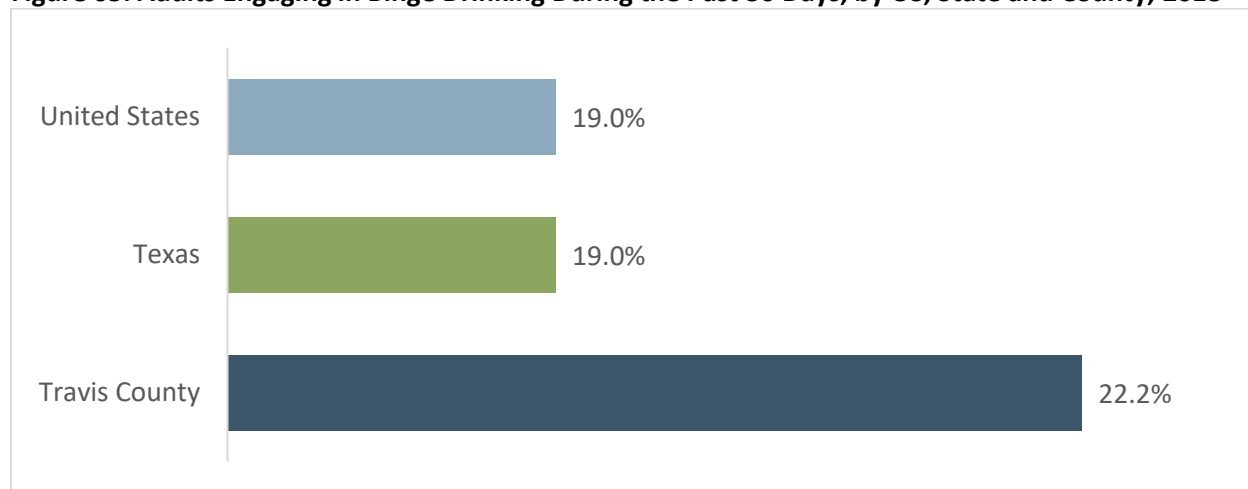
In reflecting on community mental health, community forum participants cited several strategies to improve mental health, including improving funding for mental health, providing culturally appropriate mental health services, increasing the number of mental health providers, and delivering mental health services for children through schools. Some participants also noted that a positive coping strategy, such as mindfulness, getting outside, and laughing, can help to reduce stress.

General Health Behaviors

The following section provides a snapshot of general health behaviors of the population, including substance use, seatbelt use and sexual health indicators.

Approximately one-fifth of adults across Travis County (22.2%), Texas (19.0%), and the US overall (19.0%) reported binge drinking in the past 30 days according to 2018 data (Figure 65).

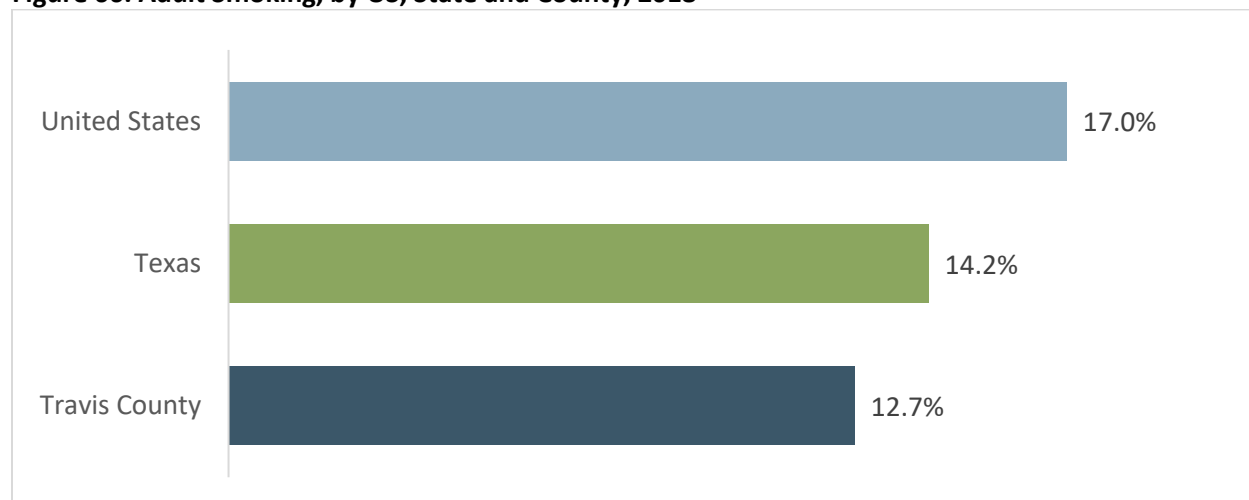
Figure 65. Adults Engaging in Binge Drinking During the Past 30 Days, by US, State and County, 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings & Roadmaps, 2021

In 2018, about one-tenth (12.7%) of Travis County adults reported that they currently smoke, a proportion that is slightly lower than patterns across Texas (14.2%) and lower than the percent of US adults who report smoking (17.0%) (Figure 66).

Figure 66. Adult Smoking, by US, State and County, 2018

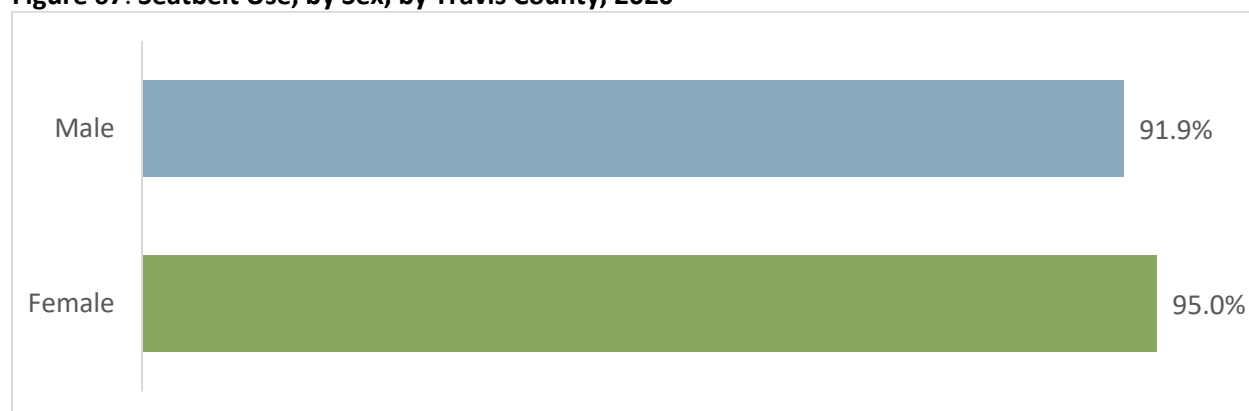


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings, 2018

NOTE: Percentage of the adult population who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime.

The majority of Travis County adults reported using a seatbelt. The percent of Travis County adults reporting seatbelt use was slightly higher among females (95.0%) compared to males (91.9%) (Figure 67).

Figure 67. Seatbelt Use, by Sex, by Travis County, 2020

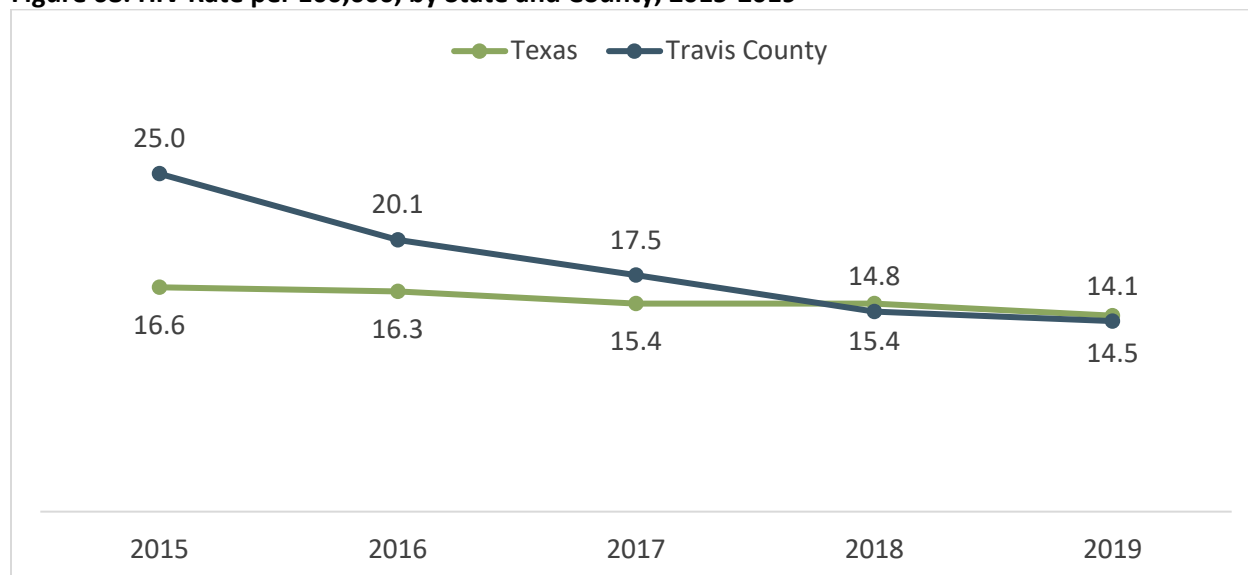


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2020

Sexual Health

The rate of HIV was around 14 per 100,000 population (Figure 68), and the rate of AIDS was around 6 per 100,000 in both Texas and Travis County in 2019 (Figure 69); these rates declined from 2015.

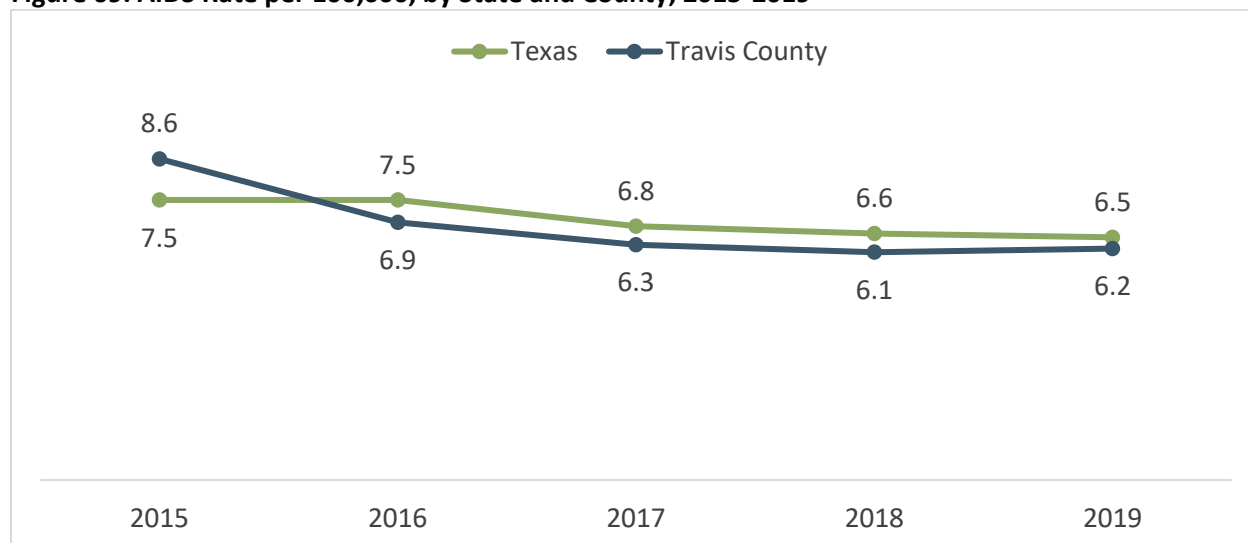
Figure 68. HIV Rate per 100,000, by State and County, 2015-2019



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2015-2019

The AIDS rate decreased slightly in Travis County, from 8.6 cases per 100,000 population in 2015 to 6.2 cases per 100,000 population in 2019, more closely mirroring the rate across Texas in 2019 (6.5 cases per 100,000 population).

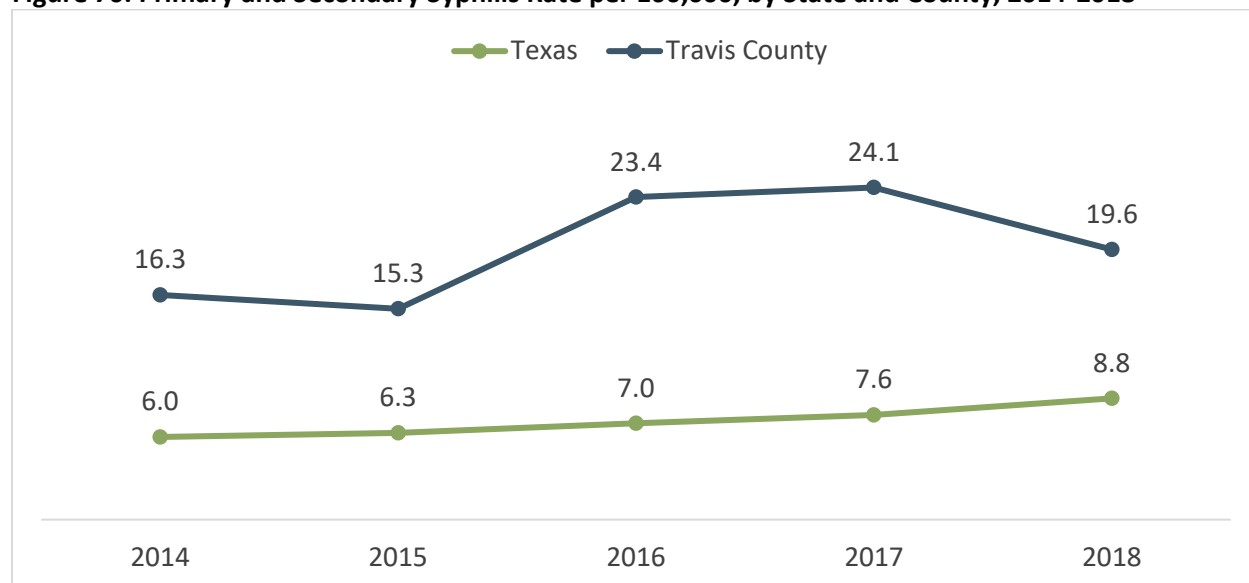
Figure 69. AIDS Rate per 100,000, by State and County, 2015-2019



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2015-2019

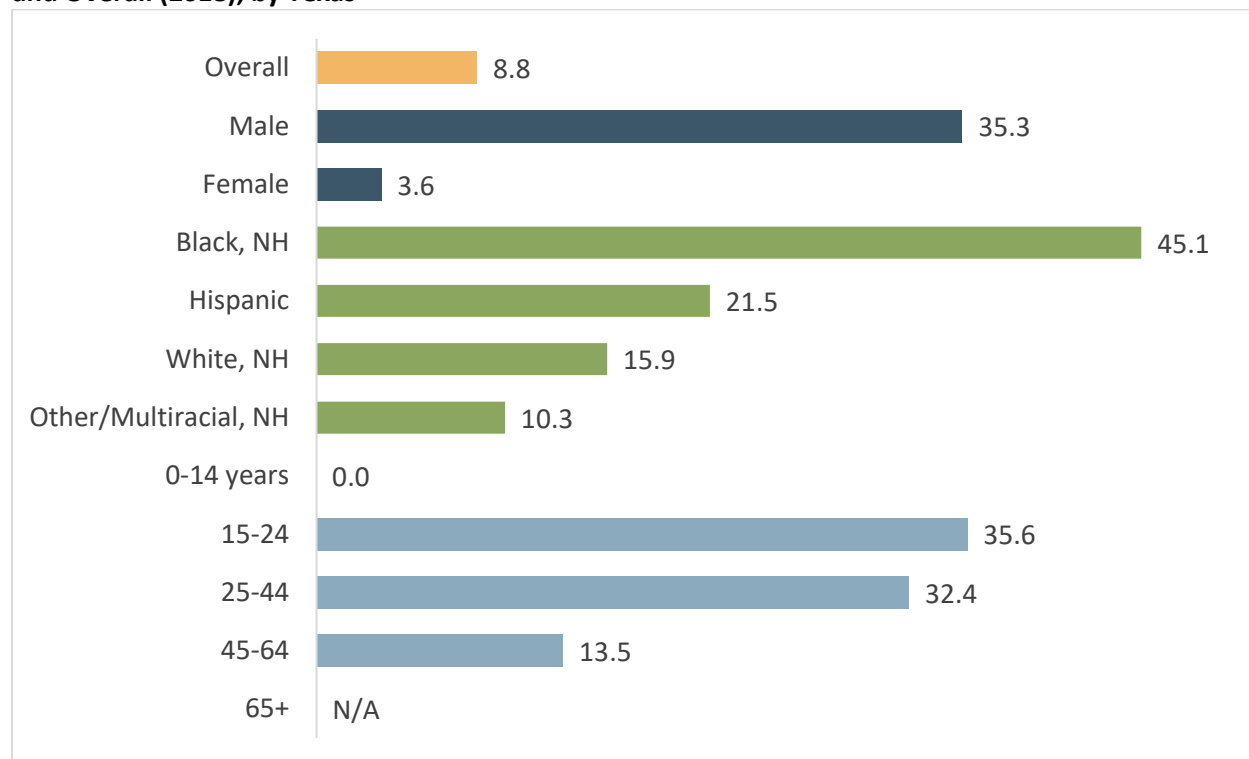
In 2018, the rate of syphilis was higher in Travis County than Texas (19.6 and 8.8 cases per 100,000 population, respectively) (Figure 70). In Travis County, the syphilis rate increased slightly from 2014 to 2018. Aggregated 2014-2018 data show that in Texas, Black/African American residents (45.1 cases per 100,000 population), 15-24 year olds (35.6 cases per 100,000 population), males (35.3 cases per 100,000 population), and 25-44 year olds (32.4 cases per 100,000 population) had the highest rates of syphilis (Figure 71).

Figure 70. Primary and Secondary Syphilis Rate per 100,000, by State and County, 2014-2018



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

Figure 71. Syphilis (Primary and Secondary) Rate per 100,000, by Selected Stratifications (2014-2018) and Overall (2018), by Texas



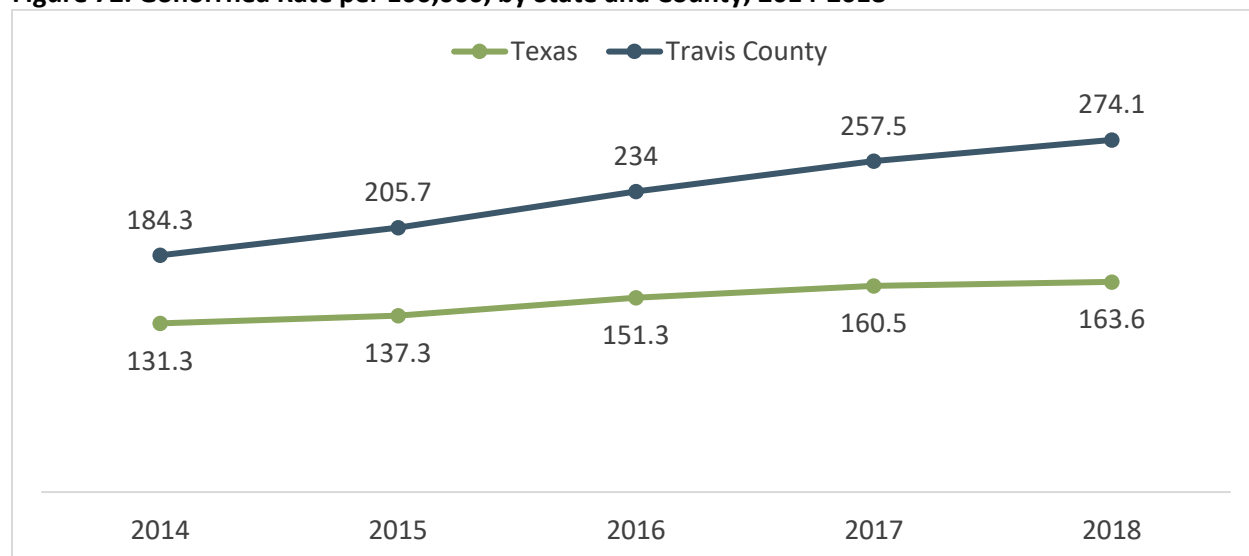
DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

NOTE: 245 cases with unknown age.

From 2014 to 2018, the rate of gonorrhea was higher in Travis County than in Texas (274.1 and 163.6 cases per 100,000 population, respectively in 2018) (Figure 72). Over this same period, the gonorrhea rate increased by about 49% in Travis County, compared to 25% across Texas. Aggregated 2014-2018

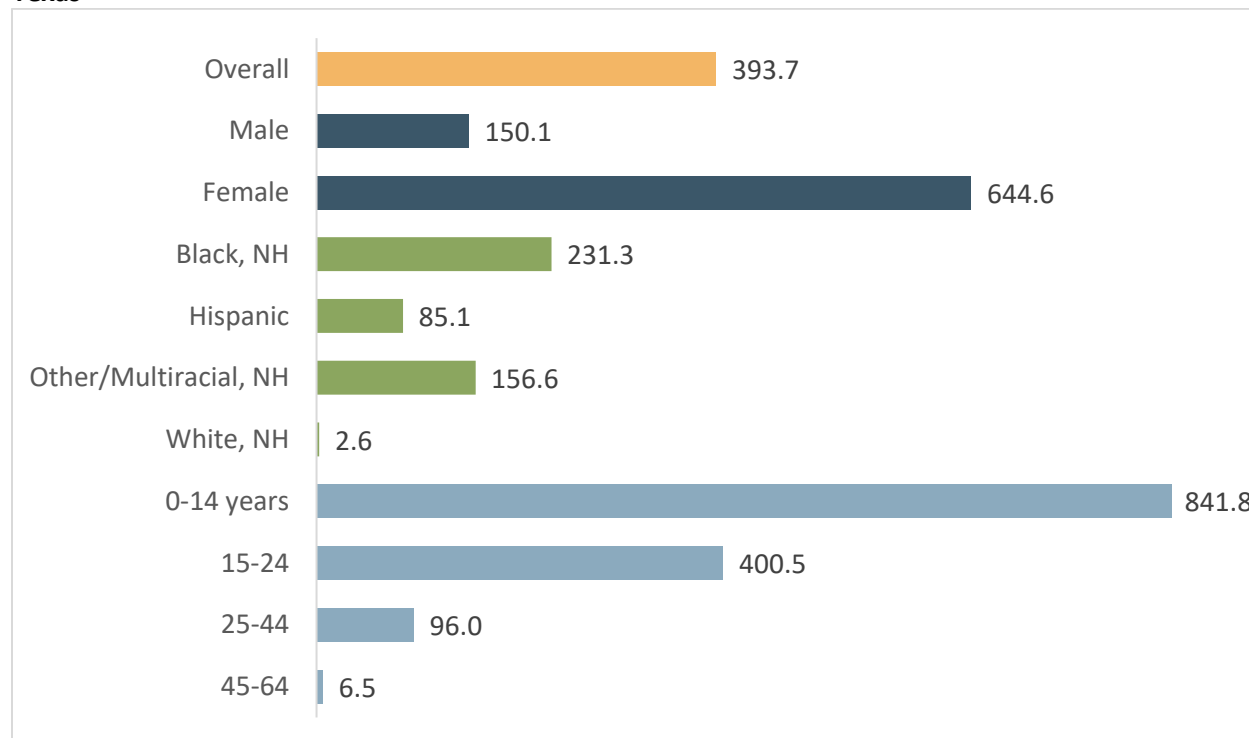
data across Texas show that 15-24 year olds (841.8 cases per 100,000 population) and female residents (644.6 cases per 100,000 population) had the highest rates of gonorrhea (Figure 73).

Figure 72. Gonorrhea Rate per 100,000, by State and County, 2014-2018



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

Figure 73. Gonorrhea Rate per 100,000, by Selected Stratifications (2014-2018) and Overall (2018), by Texas



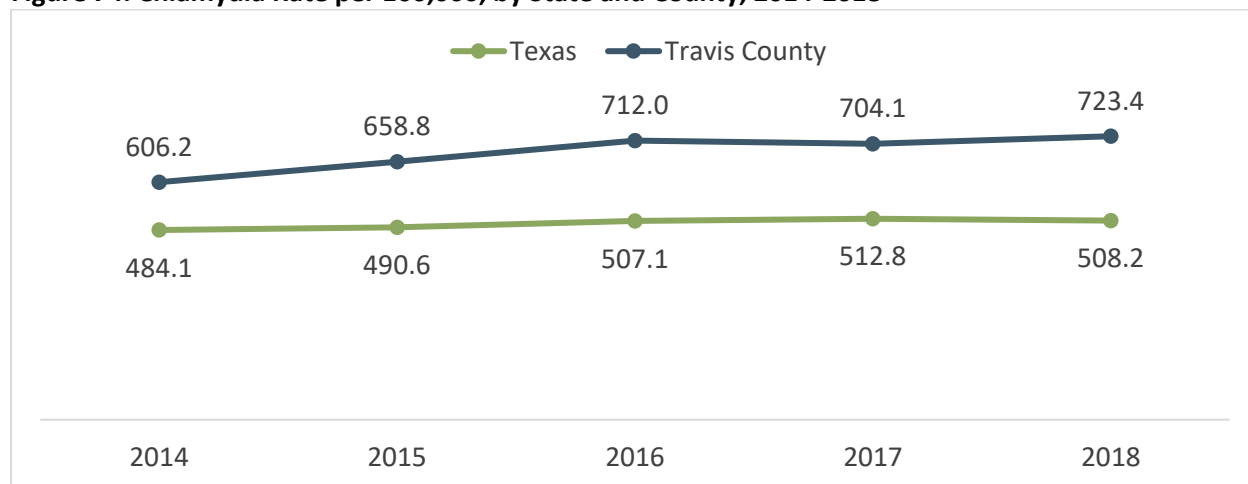
DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

NOTE: 748 cases with unknown race or ethnicity

From 2014 to 2018, the chlamydia rate was higher in Travis County than in Texas (723.4 and 508.2 cases per 100,000 population in 2018) (Figure 74). Chlamydia rates increased from 2014 to 2018, representing

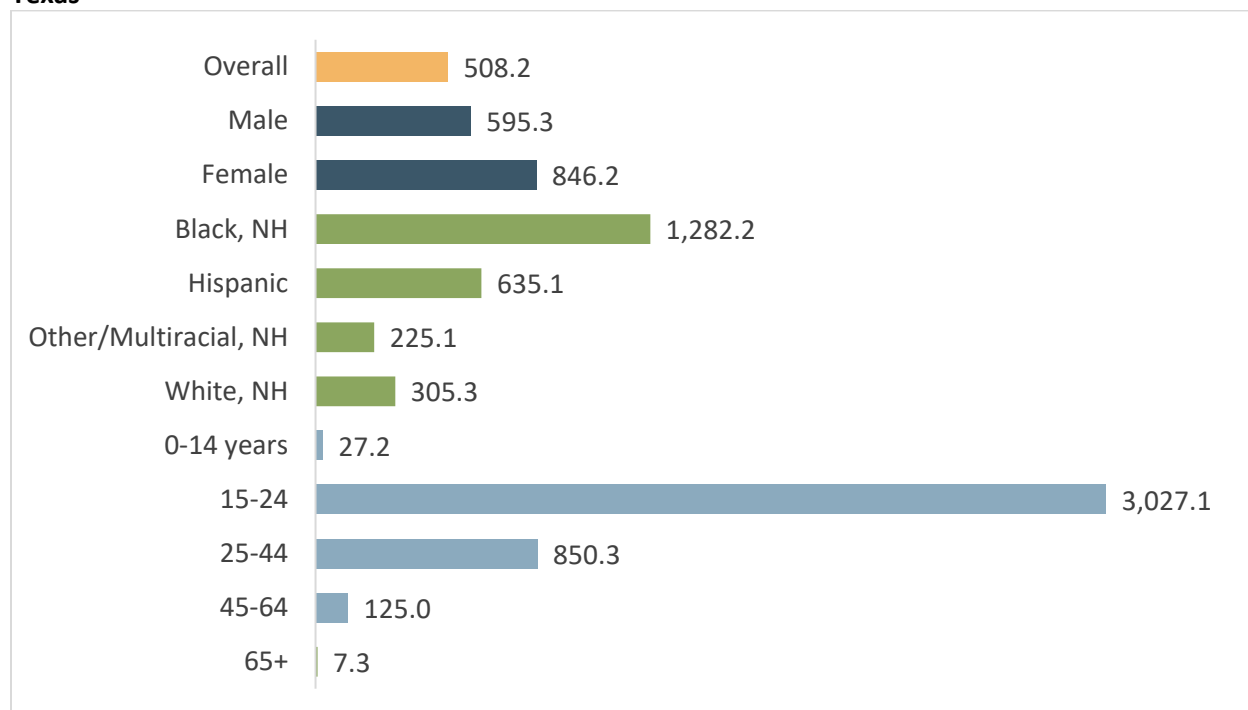
about a 19% increase in Travis County and a 5% increase across Texas. Aggregated 2014-2018 data across Texas show that 15-24 year olds (3,027.1 cases per 100,000 population) and Black/African American residents (1,282.2 cases per 100,000 population) had the highest rates of chlamydia (Figure 75).

Figure 74. Chlamydia Rate per 100,000, by State and County, 2014-2018



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

Figure 75. Chlamydia Rate per 100,000, by Selected Stratifications (2014-2018) and Overall (2018), by Texas

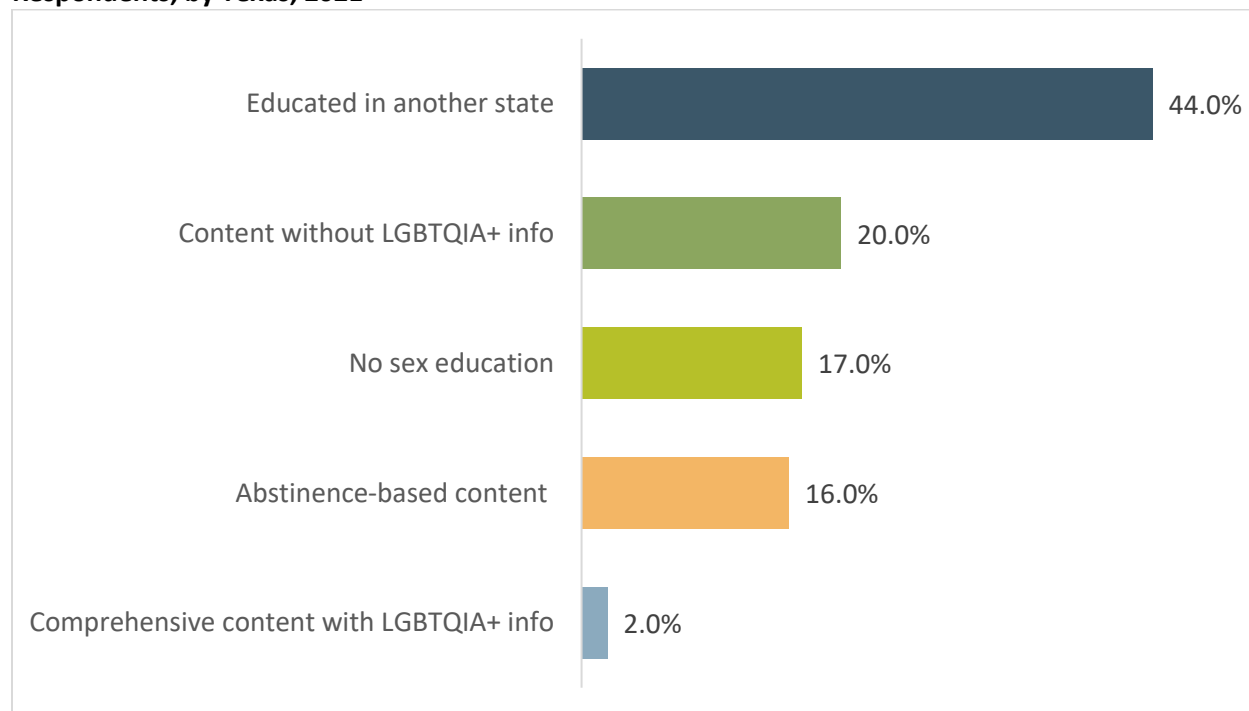


DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

LGBTQIA+ Quality of Life Study surveyed participants about their access to sexual education and 44% of respondents receiving sex education outside of the state and 20% reported getting education without content specific to LGBTQIA+ populations (Figure 76). Further, 17% of respondents did not receive

comprehensive sex education at any point and 16% received abstinence-only education. Of these respondents who engaged in sex in the past 12 months (1,512), 56% did not use either internal or external condoms.

Figure 76. Percent Respondents Receiving Sex Education of LGBTQIA+ Quality of Life Study Respondents, by Texas, 2021



DATA SOURCE: City of Austin, Equity Office and LGBTQIA+Q Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

FINDINGS: HEALTH CARE ACCESS AND UTILIZATION

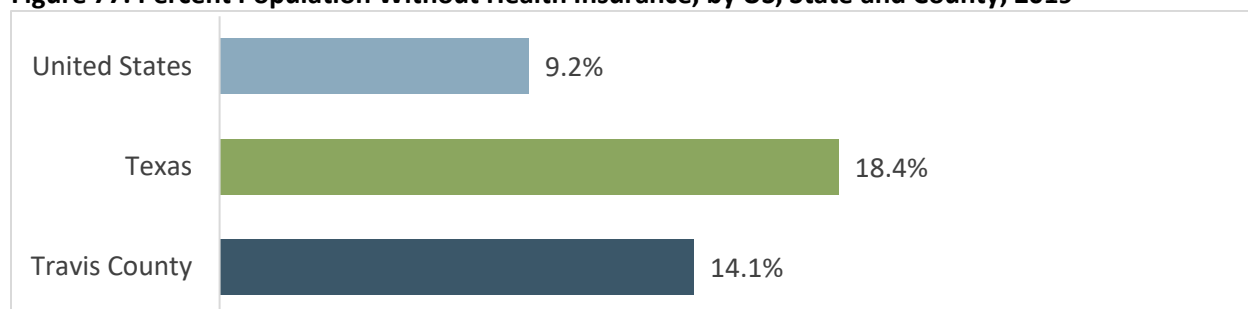


HEALTH CARE ACCESS AND UTILIZATION

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. Access is multi-faceted and includes components such as the ability to enter the health care system (largely by having insurance coverage), having a regular source of health care, and being able to access health care services when needed.³² However, inequities exist and not all who need high quality health care are able to access it. Those who face barriers to access are less likely to receive medical care, more likely to delay care, and less likely to use prevention services, resulting in poorer health status and outcomes. From a community perspective, lack of access may result in increased incidence of preventable diseases, excessive and inappropriate use of hospital emergency rooms, and higher overall health care costs.

Fourteen percent of Travis County residents were without health insurance in 2019, which is slightly below the percent of Texas residents who are uninsured (18.4%) and higher than the US uninsured population (9.2%) (Figure 77). And according to the LGBTQIA+ Quality of Life Study Survey nearly one-quarter of LGBTQIA+ respondents reported lacking health insurance (23.0%), compared to 17% of non-LGBTQIA+ respondents in 2021.

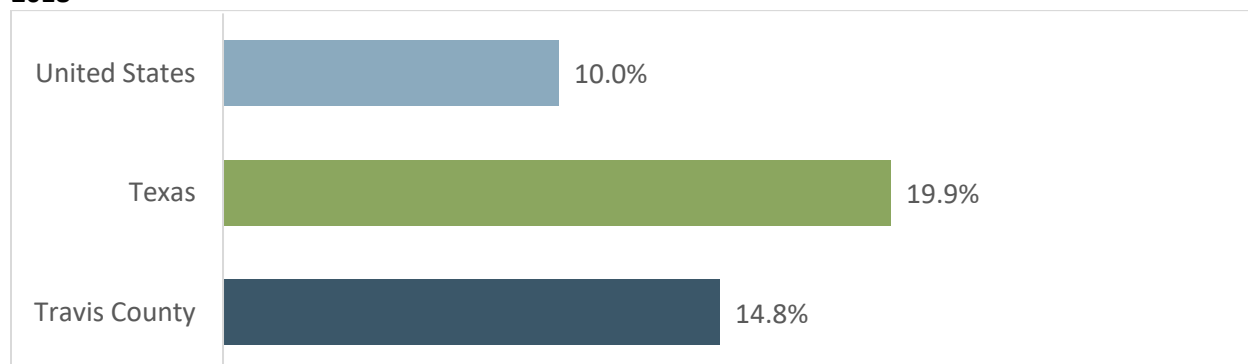
Figure 77. Percent Population Without Health Insurance, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

In 2018, 14.8% of the population under 65 years of age was without health insurance, a proportion that is lower than the uninsured population in Texas (19.9%) and higher than the uninsured population across the US (10.0%) (Figure 78).

Figure 78. Percent of Population Under Age 65 without Health Insurance, by US, State and County, 2018



DATA SOURCE: Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; as cited by County Health Rankings, 2018

Locally, Central Health’s Medical Access Program (MAP) and MAP BASIC provide coverage for low-income residents in need of primary care and prescription services (Table 7). Additionally, the Premium Assistance Program covers health insurance premium costs for musicians and other chronically ill patients.

Table 7. Central Health Medical Access Program (MAP) Enrollment, 2018-2021

	MAP	MAP Basic	Premium Assistance
2018	46,750	--	2,267+
2019	47,532	27,415*	1,883
2020	47,973	54,559	2,271
2021	47,641	60,661	2,081

DATA SOURCE: Central Health, MAP Enrollment, 2018-2021

NOTE: Plus (+) indicates premium Assistance plan expanded to provide insurance to chronically ill patients along with musicians; Asterisk (*) indicates that a new program launched in April 2019.

According to the LGBTQIA+ QWELL Wellbeing survey conducted in Greater Austin, almost half (48.6%) of LGBTQIA+ respondents reported not seeking care when having a health problem, followed by nearly one-quarter (24.3%) of respondents who reported going to a public clinic.

Health Insurance for Low-Income Residents

When discussing access to health care, a common theme among participants across interviews, focus groups, and community forums were **gaps in health insurance coverage for low-income residents and residents of color**. One community leader who works with residents who have experienced homelessness emphasized the importance of addressing socioeconomic barriers to health care: *“Preventative care is difficult to establish. Situations such as getting your yearly flu shot, how to properly take your medications, how to manage your chronic diseases properly.”* One focus group participant described fragility of health insurance coverage, noting the possibility of health insurance coverage lapsing:

“A lapse in health insurance can happen also during a job change. For me, because I work, they give me health insurance, but if I for some reason couldn’t work, that benefit goes away. Both go away, which can be a health and economic problem. Because you don’t have an income or access to health insurance.” – Focus Group Participant

Some focus group participants mentioned that **few providers accept adults who have Medicare** coverage and described Medicare as complicated. One focus group participant shared their experience: *“Nowadays its hard if you’re over 65 to find a new physician. They don’t get enough money from Medicare.”*

According to participants, MAP is helpful for accessing health care services, the **Medical Access Program (MAP)** and MAP Basic are local programs provided by Central Health that covers medical care for qualifying low-income, uninsured Travis County residents. One focus group participant explained: *“If you have a MAP card they do take care of you at the dentist and at the doctor.”*

One focus group participant described how the Medical Access Program was critical to supporting their hospital and rehabilitation care when they were recovering from COVID-19, though they also had

remaining health care costs that are difficult to pay down because of limited work opportunities and low wages:

“[Laboratory bills] have been a bit difficult because my husband’s workload also went down, but the good thing is that they told me that I could send \$10, or \$20, however I could pay those bills. And since I don’t work, sometimes my husband would, to pay the rent, to pay other ‘bills’ and because of that we have, I have gotten behind because of that. But the big ‘bills’ are paid by MAP.”

However the coverage program comes with specific requirements for renewing coverage, many of which are mandated by the State of Texas, and as a result, some participants felt that there were **bureaucratic barriers to accessing MAP**, particularly for renewing coverage, or in accessing healthcare services with their cards, , *“[They] gave me an appointment for my teeth, and the card expired and they refused to see me because they told me that my card was expired. They told me that I had to apply again for MAP for them to be able to see me.”* One community leader discussed difficulties securing and renewing health insurance coverage under the Medical Access Program:

“Even trying to sign people up for MAP, it’s a long process and it’s not integrated into a system that’s accessible to community. Then they have to wait for a letter from Central Health if they don’t qualify, no one is going to pick [up] that letter.” – Community Leader

A community leader implicated a lack of health insurance expansion, racism, and anti-immigrant sentiments as contributing to the difficult patchwork of subsidized health insurance for low-income residents:

“Lack of expansion to [Medicaid] and other legislative barriers are very clear in Texas. There is a lot of racism that goes behind that. Anti-immigrant rhetoric and marginalization of these communities are active challenges that we have to acknowledge and face and address.” – Community Leader

Some focus group participants and community leaders discussed how **socioeconomic factors** and limited to no health insurance coverage served as barriers to getting needed care, including primary care, emergency services, vision care, dental care, and specialists such as cardiologists and endocrinologists. Although about 80% of the population Central Health and CommUnityCare’s populations serve are people of color the perception of one community leader was that health care services are often not in close proximity to where low-income residents and people of color live or are otherwise inaccessible to them for socioeconomic reasons (see also Appendix F):

“Besides clinics which are few and far between; how many equitable places are there? How many have access within a 5-10 mile car ride? How accessible? Central Health and CommUnityCare try, but it’s not accessible by non-Whites.” – Community Leaders

A community leader cited the need **to improve access to health care** for low-income residents in order to reduce the use of emergency services for preventable emergencies:

“Increase access to healthcare, primary and specialty care. [Residents] [c]hronically call EMS and are taken to emergency. [They] mainly [have] negative experiences which leads to a lack of trust and suspicion in the healthcare system, still have lack of access to (primary) medical care and this becomes more of an issue as we grow.” – Community Leader

One focus group participant cited concerns about extensive **medical expenses** as a barrier to seeking health care and emergency services:

“...that is what people are very afraid of, not wanting to go to the hospital, even if they are very ill because they know that it will be too much, especially if they start off with not a lot of money. We know from the moment one enters the emergency room, it generates an expense.” – Focus Group Participant

Provider Supply

Another facet of access to health care is provider availability. Travis County had more providers per capita compared to Texas overall and the US for primary care, dental care, and mental health care (Table 8). For example, according to most recent estimates, there was one primary care physician per 1,158 residents, one dentist per 1,385 residents, and one mental health provider per 343 residents.

Table 8. Ratio of Physician and Non-Physician Primary Care Providers, Dentist and Mental Health Providers, by US, State and County

	Primary Care Physician (2018)	Non-Physician Primary Care Provider (2020)	Dentist (2019)	Mental Health Provider (2020)
United States	1,320	-	1,400	380
Texas	1,642	1,128	1,677	827
Travis County	1,158	1,000	1,385	343

DATA SOURCE: Primary Care Physician: Area Health Resource File/American Medical Association, Non-Physician Primary Care Provider, Dentist and Mental Health Provider: CMS, National Provider Identification Registry (NPPES). As cited by County Health Rankings, 2018-2020

NOTE: Primary care physicians include practicing non-federal physicians (M.D.s and D.O.s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. Non-physician primary care providers include nurse practitioners, physician assistants, and clinical nurse specialists. Registered dentists with a National Provider Identification are counted. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care.

Additionally, one focus group participant described the mental health care landscape as having *“almost no mental health [providers].”* Another focus group participant noted, *“We also don’t have a lot of organizations for mental health support or counseling. That is a huge gap in service that we really need.”* Residents also observed that there was limited access to social workers and peer-support services to help address mental health needs and connect residents with resources.

Several residents mentioned difficulty finding and affording home care support for low-income older residents. One community leader cited a discrepancy between the low rate of pay and intense physical labor of home care attendants, which they perceived contributed to workforce shortages and barriers to affording this form of regular care for low-income residents:

“Another thing to solve is the hard time we face getting personal care attendants out here. One of the seemingly big reasons is that they are paid crappy wages; a little above minimum wage where you could go to McDonalds and get 15/hr, attendants get paid 8 or less an hour. These are hard jobs, cleaning up people with difficulties going to the restroom, cleaning up feces, sheets with accidents, light housework like washing sheets or other various housework or just trying to be their friend. Let’s figure out a way to pay people good living wages to take care of people in need.” – Community Leader

Other barriers to health care that residents cited included that the health care system is not growing with the population growth in the region and the health care system is difficult to navigate.

Discrimination, Culturally Sensitive Care, and Interpretation Services in Health Care Settings

Experiences of **discrimination in health care settings** also emerged among some community leaders and residents. One in-depth interview participant described their Black/African American partner’s hesitance to see providers based on past experiences of racial discrimination:

“My boyfriend doesn’t want to go to hospitals even with me because he doesn’t trust the hospital because of their prejudice. It took me a minute to kind of understand it [...] Even going into hospitals or doctor’s appointments it’s not a willing thing, I have to beg him to come in because of stuff like that. Prejudiced people target people thinking they’re strong and can take on pain of certain things. [...] Stuff like that causes people to not trust health care providers, even vaccines and stuff like that. I know a lot of people that are like that.” – In-Depth Interview Participant

One community leader also shared about a friend’s hesitance to see providers out of concern about discrimination: *“An [Asian] family friend was stranded in Austin but was afraid to seek medical care because of a lack of insurance and fear from physical harassment due to discrimination.”*

Some focus group participants and several community leaders cited experiences of **limited culturally sensitive care** for patients of color and low-income patients. One community leader shared, *“[My] long-term [vision] is primary care physicians [being] culturally competent to serve clients. White doctors only provide good care if you have a certain financial status. If [you are a] Medicare/Medicaid patient, you don’t get the best care.”* Another community leader linked linguistically congruent care and taking time to ensure that patients understand their health condition and treatment plan as central to high quality care:

“People are not into who is giving care, but how. They want to be treated as a person and not cattle, not in and out. Would like to healthcare organizations to speak their languages: ‘explain why I’m taking this medicine so I can understand. Explain to me so I can understand.’ One thing we’re teaching people is, don’t leave until your questions are answered. We find that people are taking things because they are told to, not knowing why.” – Community Leader

Another community leader described the need for providers to improve their understanding of the experiences of low-income residents and residents experiencing homelessness in order to improve interactions with patients, “...[We need] [m]ore relational vs. transactional [interactions] in the doctors’ offices and [providers who] really care about that person.”

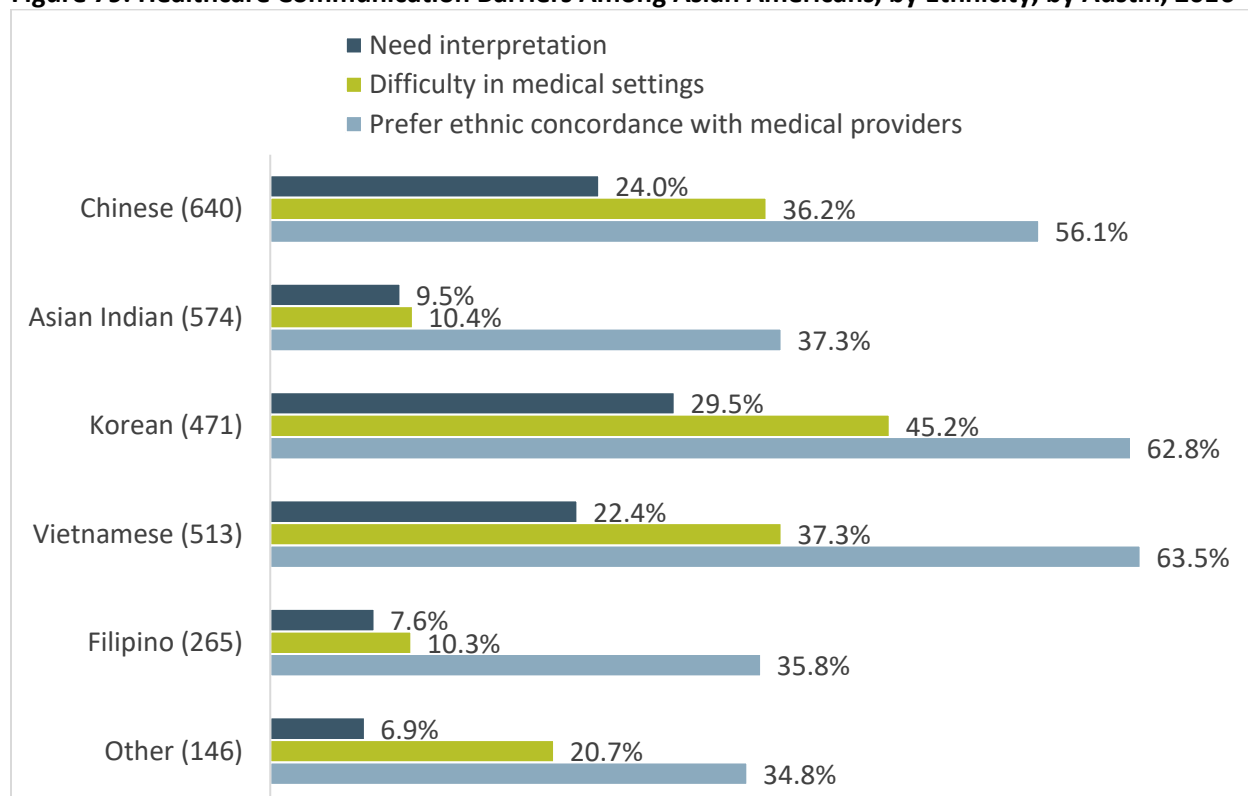
A **lack of bilingual health providers and interpretation services** emerged as a health care barrier among some focus group participants and community leaders, including in primary care and specialty services and home health assistance. One bilingual focus group participant noted that while it is not their responsibility, they are often called up on to provide ad hoc interpretation services in clinical settings, and observed delays in receipt of health care Spanish-speaking patients:

“Because I’m bilingual they look for me, ‘Hey, can you translate’ then I say ‘Yes but... is there no one in your department that can do that?’ [They say] ‘No.’ Let’s say that in a clinic with 100 people I am the only one that can translate. It depends on whether the person is a patient, or whether they are looking for health services, I feel that they could lack certain types of people that could interpret. They do find them, but there is a higher waiting time to receive medical care if the person only speaks Spanish.” – Focus Group Participant

Another community leader shared, “It is difficult to find home health aides that speak their language.” Notably, one focus group participant noted that a health care clinic they frequent regularly employs bilingual staff: “There are more bilingual people in the clinics we visit. [...] There are bilingual people working there all the time.”

Healthcare communication barriers among Asian Americans in Austin are depicted in Figure 79. For each aspect of healthcare communication, Chinese, Korean, and Vietnamese respondents reported the highest level of healthcare communication barriers. About three-fifths of Vietnamese (63.5%) and Korean (62.8%) respondents and more than half of Chinese respondents (56.1%) reported preferring ethnic concordance with medical providers. More than one-fifth of Korean (29.5%), Chinese (24.0%), and Vietnamese (22.4%) respondents report needing interpretation services in healthcare settings. Additionally, more than two-fifths (45.2%) of Korean respondents and one-third of Vietnamese (37.3%) and Chinese (36.2%) respondents report experiencing difficulty in medical settings.³³

Figure 79. Healthcare Communication Barriers Among Asian Americans, by Ethnicity, by Austin, 2016



DATA SOURCE: Asian American Quality of Life Survey, 2016

Additional Healthcare Services

Some community leaders and focus group participants described dental care in the region as very limited, particularly for low-income residents, and cited limited funding for dental care as a critical barrier to promoting oral health. One focus group participant described how **lack of access to dental care** affected oral health and was also linked with other health outcomes: “If you don’t get those services, you can’t eat or chew. If you have cavities that can get into your heart.” Another community leader characterized the difficulties of getting dental care and the severity of oral health issues that low-income residents experience, which they also noted affects nutrition:

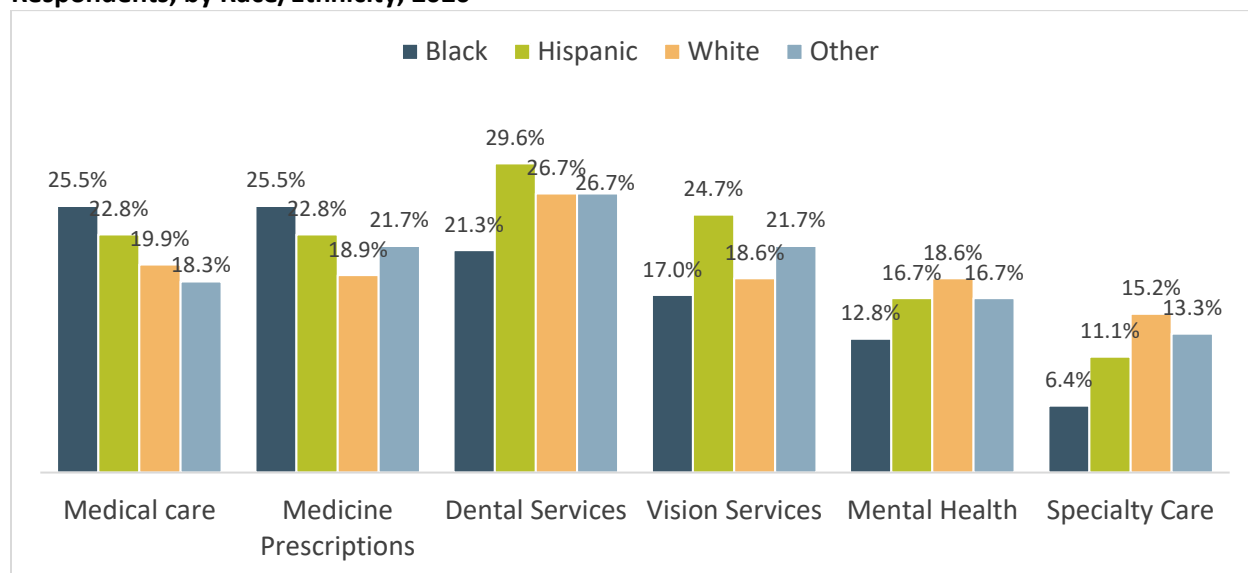
“Dental is ginormous. [It] [s]eems like you have to wait forever to get in if you need dental work. If their teeth are all pulled, which is usually the case, they get the cheapest dentures (about \$250) where they are incompatible. The quality of these dentures is very low. Our neighbors deserve comfortable teeth. Having such discomfort provides difficulty and challenge in obtaining adequate nutrition if they are in pain from chewing.” – Community leader

Access to optometry and/or ophthalmology providers and glasses emerged as an unmet need for homeless residents and low-income residents of color. One focus group participant shared: “What a Hispanic person struggles with most, it’s finding an eye doctor or a dentist because we don’t have medical insurance and these services are very expensive for us.”

Some community leaders and focus group participants discussed the need for more specialized providers, including those who specialize in caring for older adults. Community leader described the patchwork of systems designed to fill gaps in specialty care, such as oncology, for low-income adults and noted that a systems change is needed given the multitude of health conditions among low-income residents that necessitate the care of a specialist.

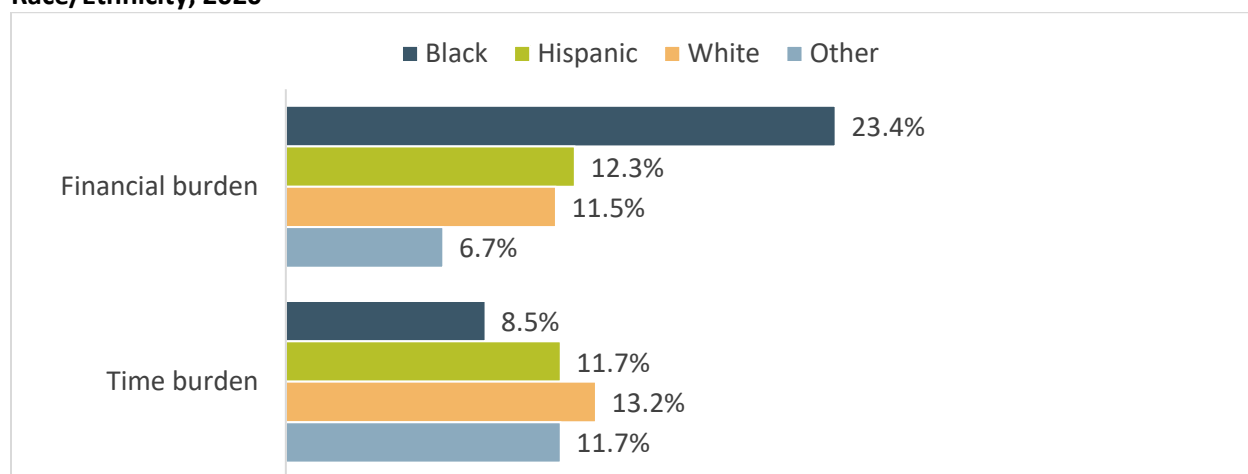
According to Austin Area Community Survey respondents, about 30.2% of Hispanic/Latino respondents and 27.1% of White respondents were not able to access dental services (Figure 80). Approximately 25.5% of Black/African American respondents reported being unable to receive medical care and medical prescriptions. Nearly one-quarter (24.7%) of Hispanic/Latino respondents noted an inability to access vision care. The cost of healthcare and insurance and the time burden in accessing care were the most cited barriers to healthy living (Figure 81). More than one-fifth of Black respondents cited financial burden (23.4%) as a barrier, followed by 12.3% of Hispanic and 11.5% of White respondents; time burden was also cited as a barrier, with highest percentages of White (13.2%), Hispanic and Other race/ethnicity (11.7%) populations considering time a barrier.

Figure 80. Percent Unable to Receive Healthcare Services among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Figure 81. Barriers to Healthy Living among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Delays in Health Care Use Due to the COVID-19 Pandemic

Some focus group participants and community leader described **delays in accessing health care services** and screenings due to the COVID-19 pandemic, which they noted may have consequences for late diagnoses of health conditions. One focus group participant shared their experience of delays in preventive services: *“You can’t get medical checkups as often as we used to. I haven’t had a mammogram in a couple years because COVID impacted the health system.”* A community leader also highlighted the consequences of the COVID-19 pandemic on the delivery of preventive care services and early detection of medical conditions because health care settings have been operating at limited patient capacity:

“Currently, because of COVID a lot of our patients have fallen behind on wellness visits. During peak of COVID, no one was brought into the building at all. It was not possible to do well-child, well-women visits to get people caught up. Otherwise, you’ll end up with more severe diagnoses later on like cancer in later stages.” – Community Leader

Vaccinations emerged as another gap in health care that was aggravated by the COVID-19 pandemic. One community leader shared how updating residents on their vaccinations needs to be a priority: *“For general health, it is about getting people back for regular wellness checks, doing vaccines and boosters and working the way everyone else is to get people immunized.”* Residents noted that it was important to build upon strategies to bring health care services in to the community, including making vaccination sites available beyond the walls of doctor’s offices.

One community leader described significant strains of the COVID-19 pandemic on health care providers and staff, which affects the overall health care system. This community leader observed declining **morale among health care providers** and staff and the **outmigration of providers** and staff from the field. They perceived that long work hours and changing needs throughout the COVID-19 pandemic added to the difficulties of the high cost of living in the region, as well as some staff’s opposition to vaccine mandates, may have contributed to an exodus of trained staff and the need to increase wages. They shared:

“At the outset of COVID, there is this real esprit de corps where people in a crisis worked together where people worked long hours, and experienced fast changes. I was extremely proud of the organization and all we were able to accomplish. But, the longer something drags on, and more changes, and more anxiety there is, it takes a real toll on personnel. A lot of people are leaving healthcare and looking for other jobs. There is high turnover and hard to fill positions. We have had to raise base pay. [...] A lot of our frontline can’t afford Austin anymore and do not live in Austin. So they are left with longer commutes.” – Community Leader

Preventive Care

While the percent of adults who reported receiving cholesterol screening in Austin (70.7%) was similar to the state average (69.6%), just over half of adults in Del Valle (57.6%) and Montopolis (50.5%) reported receiving screening for cholesterol (Figure 82).

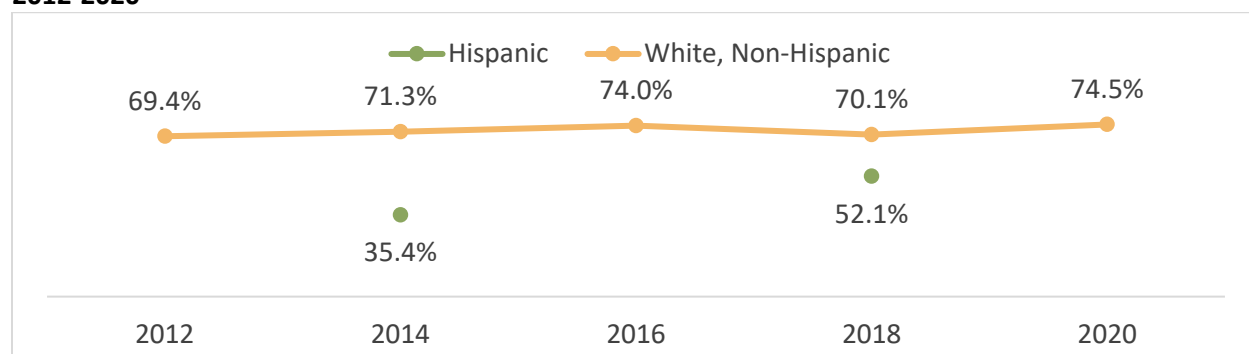
Figure 82. Percent Screened for Cholesterol, by State and Selected Geographies, 2018



DATA SOURCE: CDC 500 Cities, 2018

About two-thirds of male (65.7%) and female (68.6%) residents in Travis County reported being up-to-date on colorectal cancer screenings in 2020; this percent increased slightly since 2012 (62.0% and 61.3%, respectively). When examining self-reported up-to-date colorectal cancer screenings by race/ethnicity, in 2018 about 70.1% of White adults reported having an up-to-date colorectal screening compared to just half (52.1%) of Hispanic/Latino adults (Figure 83). When stratified by age groups, only two-thirds (66.6%) of adults aged 50-64 reported having up-to-date colorectal screenings compared to more than four-fifths (87.2%) of those 65-75 years of age (Figure 84).

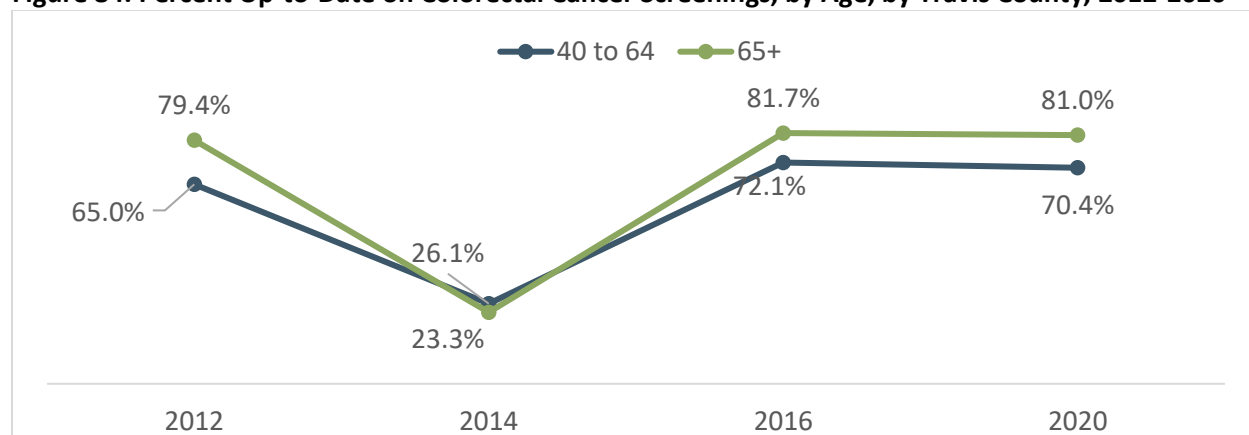
Figure 83. Percent Up-to-Date on Colorectal Cancer Screenings, by Race/Ethnicity, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

NOTE: Missing data points indicate unreliable data.

Figure 84. Percent Up-to-Date on Colorectal Cancer Screenings, by Age, by Travis County, 2012-2020

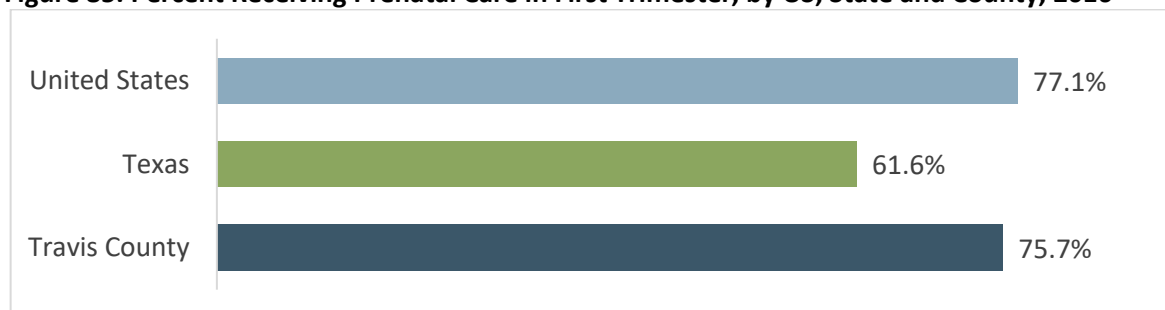


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

Some focus group participants mentioned the importance of vaccines for supporting health, and references to vaccines were both general and specific to COVID-19. When asked about things that keep them healthy, one focus group participant shared: *“Get your yearly flu shot, vaccines you need to keep safe. Take consideration of if there is a vaccine that will help you, it’s in your best interest to get it.”* One focus group participant noted a need to improve access to immunizations for children and another focus group participant linked low vaccination rates to medical mistrust and barriers to accessing health information.

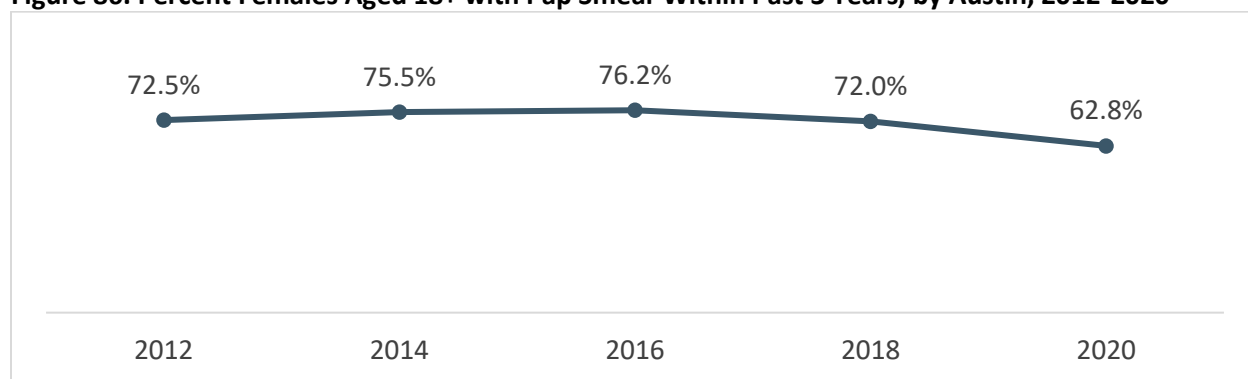
Women’s Health Care

In 2016, about three-quarters (75.7%) of childbearing individuals in Travis County reported receiving prenatal care in the first trimester, which is similar to patterns across the US (77.1%) and above prenatal care patterns for Texas (61.6%) (Figure 85).

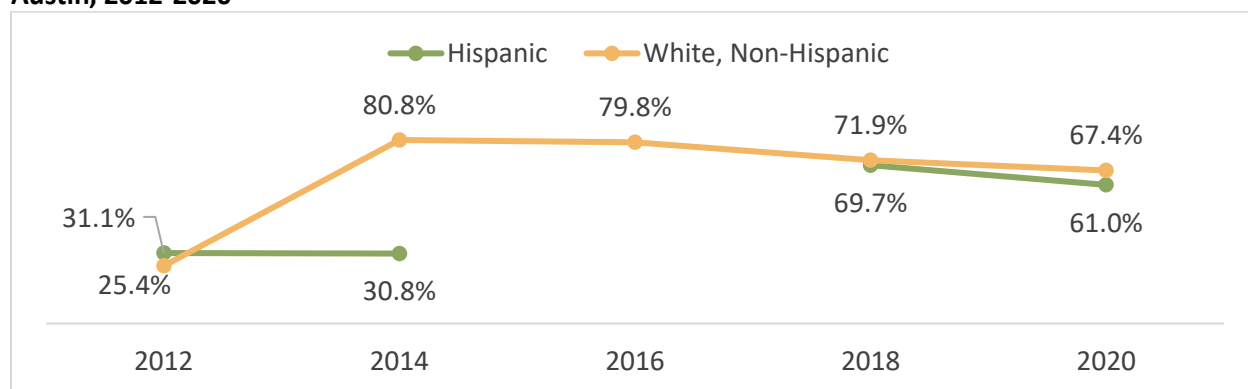
Figure 85. Percent Receiving Prenatal Care in First Trimester, by US, State and County, 2016

DATA SOURCE: Texas Health and Human Services, Vital Statistics Annual Report, 2020

Around three-fifths (62.8%) of females aged 18 and over reported having a pap smear within the past 3 years in Austin in 2020, marking a decline from pap smear patterns in 2012 through 2018 (Figure 86). When examining pap smear patterns by race/ethnicity, in 2020 a slightly higher percentage of White females (67.4%) reported having a pap smear compared to Hispanic/Latino females (61.0%) (Figure 87). Notably, reported pap smear tests increased among Hispanic/Latino females, from a low of 30.8% in 2014 to a high of 69.7% in 2018 (in years in which data were available). When stratified by age groups, a higher proportion of females 30-44 years of age (73.0%) and 45-64 years of age (71.8%) reported having a pap smear compared to females 18-29 years of age (49.9%) and females over 65 years of age (46.2%) (Figure 88).

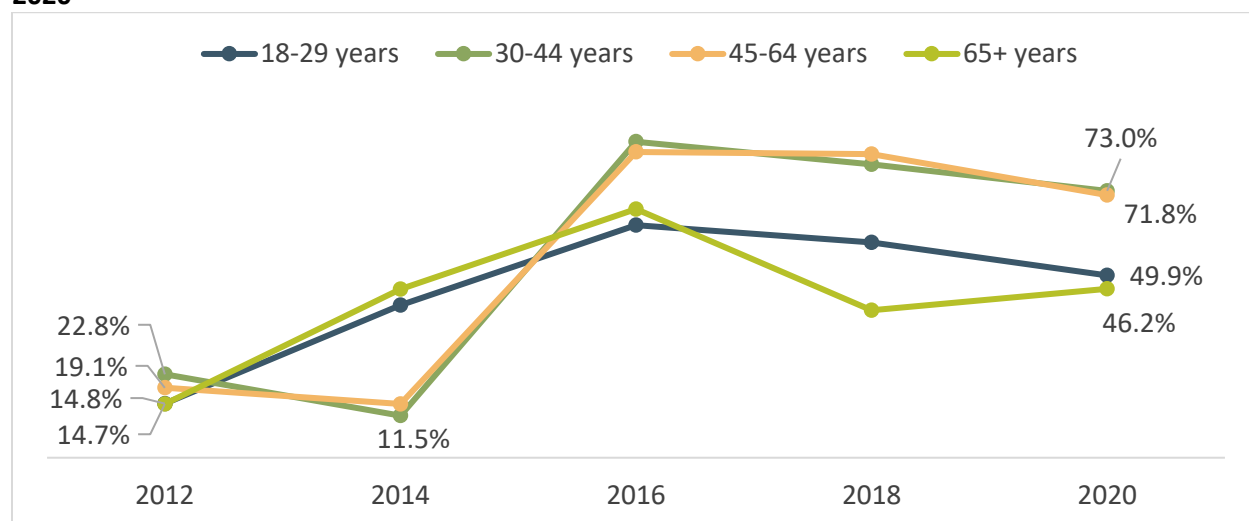
Figure 86. Percent Females Aged 18+ with Pap Smear Within Past 3 Years, by Austin, 2012-2020

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

Figure 87. Percent Females Aged 18+ with Pap Smear Within Past 3 Years, by Race/Ethnicity, by Austin, 2012-2020

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

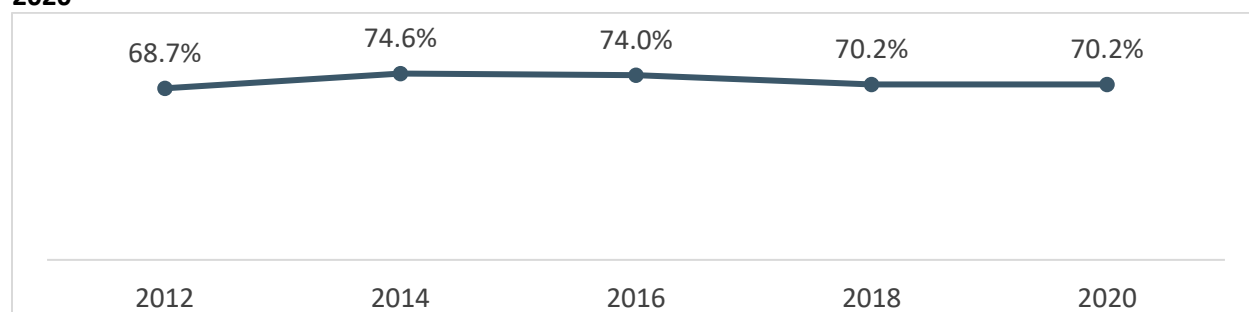
Figure 88. Percent Females Aged 18+ with Pap Smear Within Past 3 Years, by Age, by Austin, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

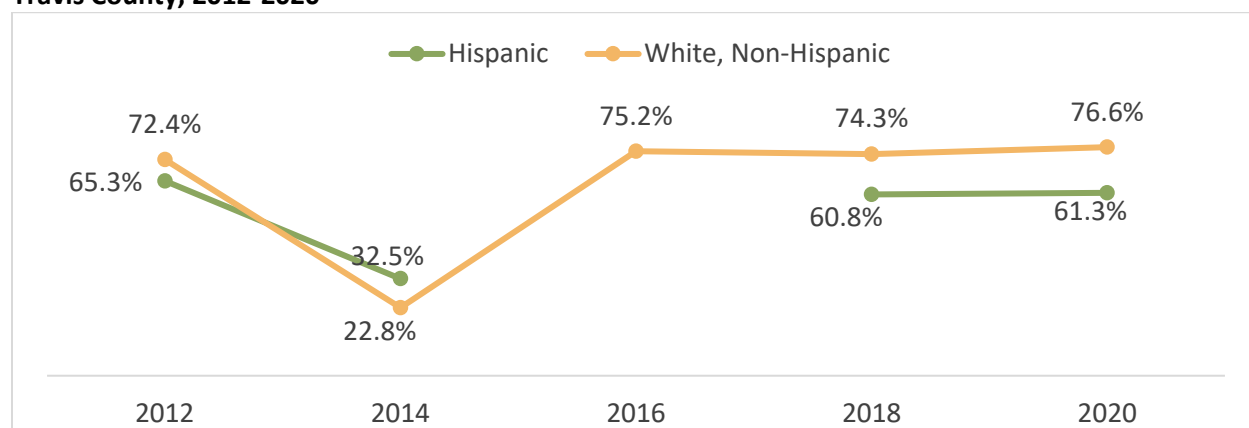
About 70.2% of females aged 40 and over reported having a mammogram within the past 2 years in Austin in 2020, compared to 68.7% in 2012 (Figure 89). When examining the percent of females who reported receiving a mammogram by race/ethnicity, a slightly higher percentage of White females (76.6% in 2020) reported having a mammogram compared to Hispanic/Latino females (61.3% in 2020) (Figure 90). When stratified by age groups, in 2020 81.0% of females aged 65 and older reported having a mammogram compared to 70.4% of females 40-64 years of age (Figure 91).

Figure 89. Percent Females Aged 40+ with Mammogram Within Past 2 Years, by Travis County, 2012-2020



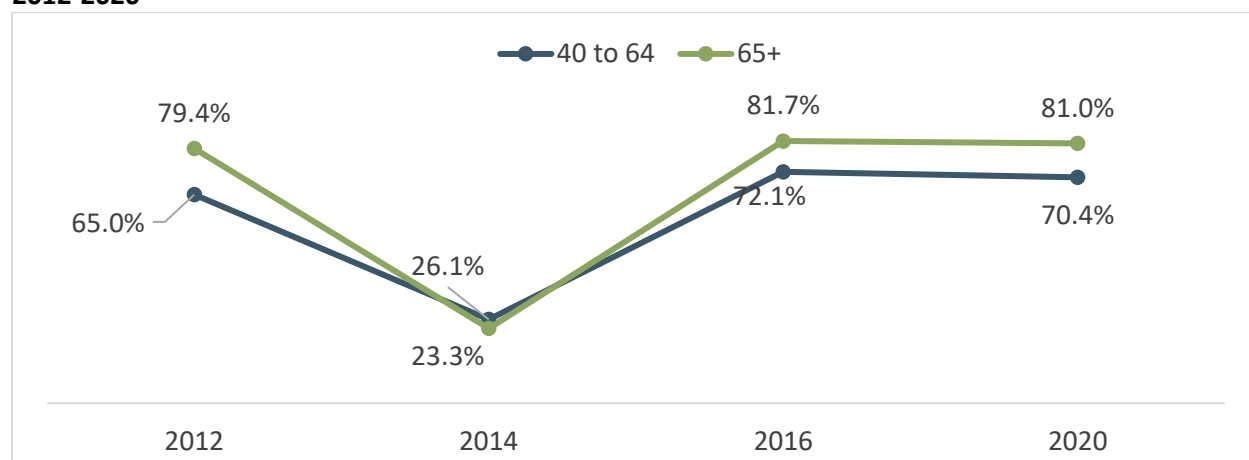
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

Figure 90. Percent Females Aged 40+ with Mammogram Within Past 2 Years, by Race/Ethnicity, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

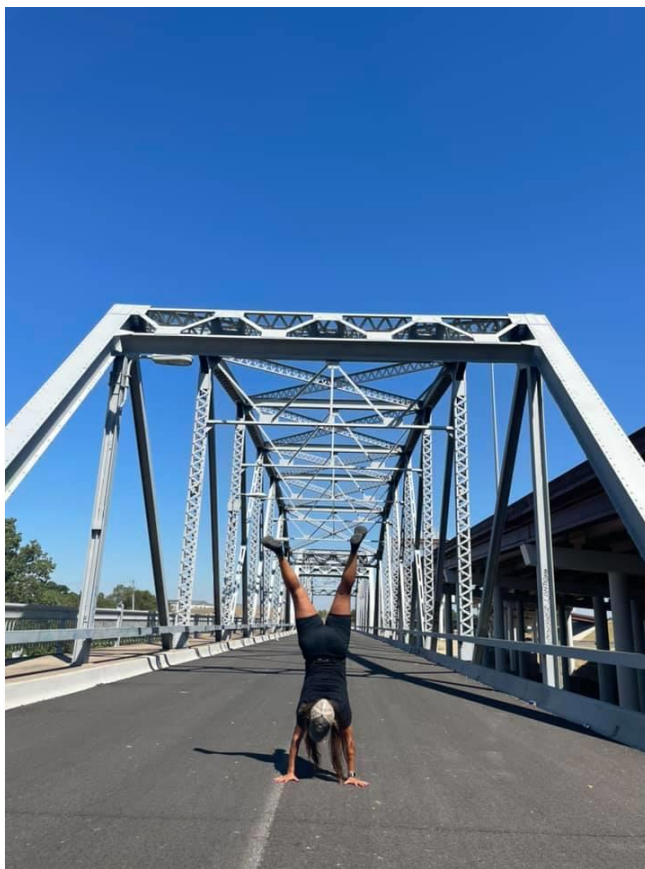
Figure 91. Percent Females Aged 40+ with Mammogram Within Past 2 Years, by Age, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

NOTE: The indicator's corresponding question was not asked in the 2018 BRFSS Survey.

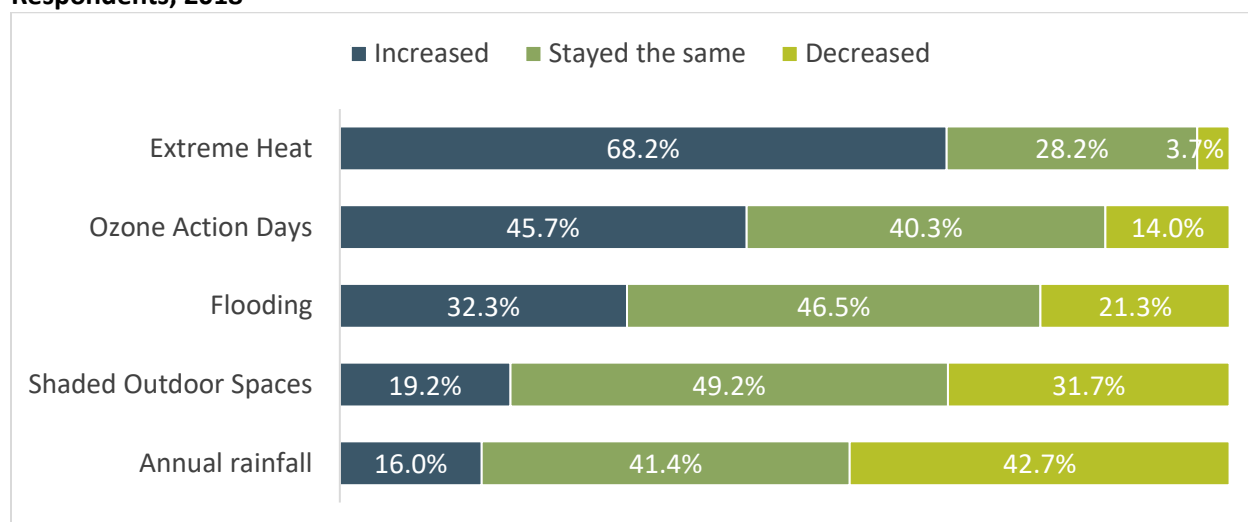
FINDINGS: EMERGENCY PREPAREDNESS



EMERGENCY PREPAREDNESS

When Austin Area Community Survey respondents were asked their perception of increases in types of emergencies, the majority of respondents indicated that they believed there was an increase in extreme heat (68.2%); followed by ozone action days (45.7%) and flooding (32.3%) (Figure 92). Relatedly, respondents perceived a decrease in annual rainfall (42.7%) and shaded outdoor spaces (31.7%).

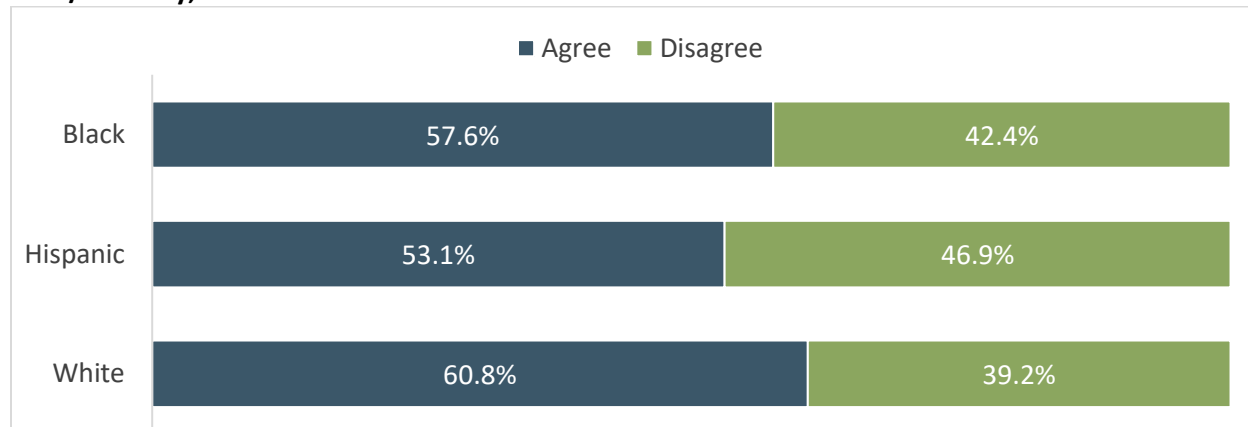
Figure 92. Percent Perceived Increase in Emergencies among Austin Area Community Survey Respondents, 2018



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2018

Among Austin Area Community Survey respondents, about three-fifths (60.8%) of White respondents agreed that they had a safe place to shelter; this was slightly lower among Black/African American (57.6%) and Hispanic/Latino respondents (53.1%) (Figure 93).

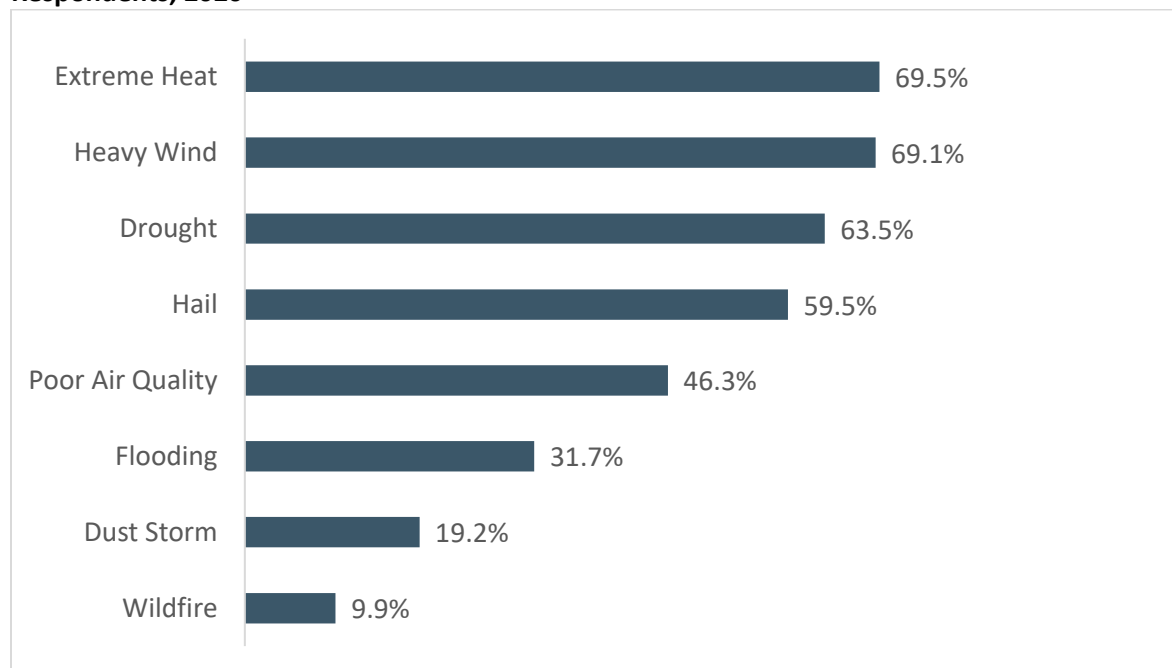
Figure 93. Percent with Safe Place to Shelter among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Among Austin Area Community Survey respondents, the majority reported experiencing emergencies of extreme heat (69.5%), heavy wind (69.1%), drought (63.5%) and hail (59.5%) in the last 10 years (Figure 94).

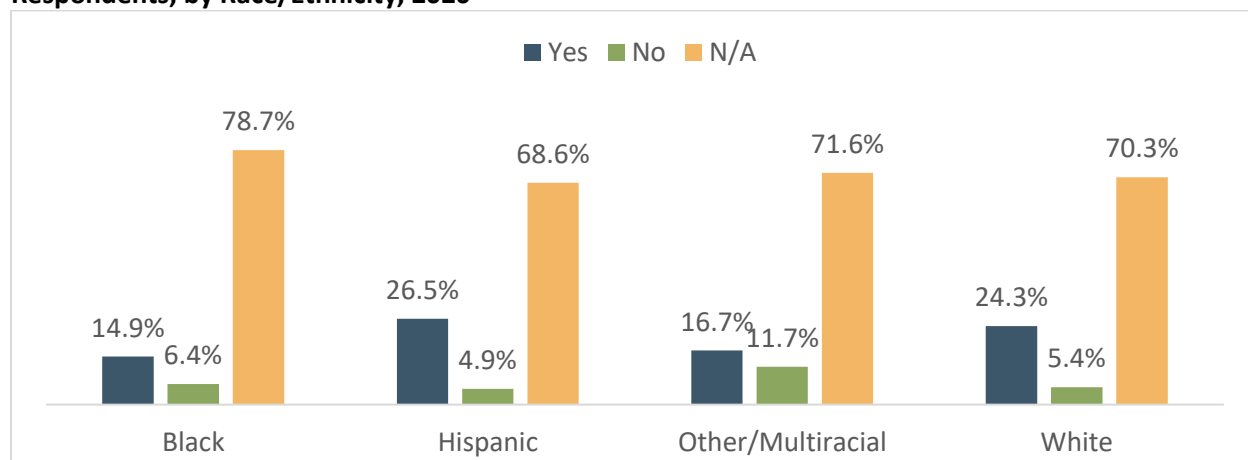
Figure 94. Percent Experienced Emergency in Last 10 Years among Austin Area Community Survey Respondents, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Among Austin Area Community Survey respondents Hispanic (26.5%) and White (24.3%) respondents represented the highest proportion of respondents who were registered to receive alerts (Figure 95); among all race/ethnicities, the majority of respondents had not signed up for or did not answer the question which could mean they are not signed up to receive alerts.

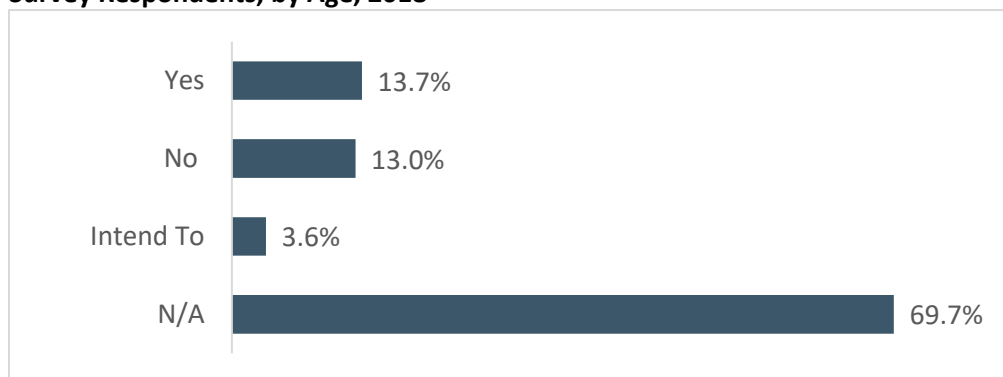
Figure 95. Percent Registered to Receive Emergency Alerts among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: N/A represents not applicable, signifying that the respondent did not respond to question.

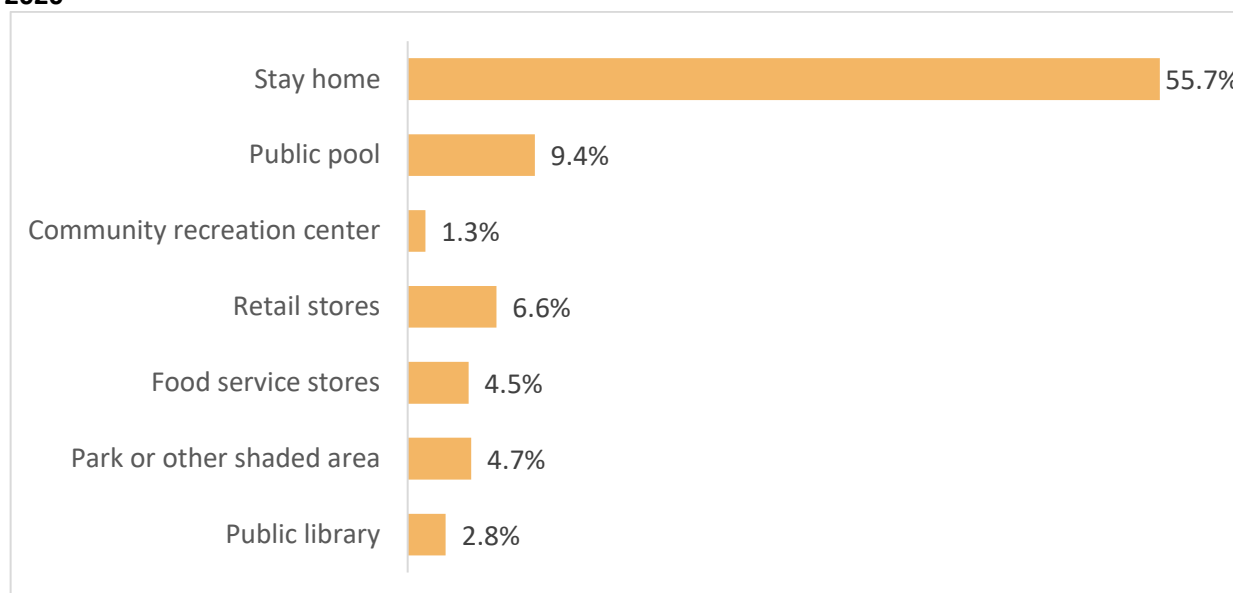
Figure 96. Percent With a Household Disaster Preparedness Plan among Austin Area Community Survey Respondents, by Age, 2018



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2018

When asked about preferred locations to be during extreme heat, the majority of respondents across all age groups indicated that they preferred to be at home during extreme heat (Figure 97). The second choice for seeking reprieve during extreme heat varied by age, with younger adults and respondents 65+ years of age preferring a public pool and respondents aged 45-54 and 55-64 years of age preferring retail stores.

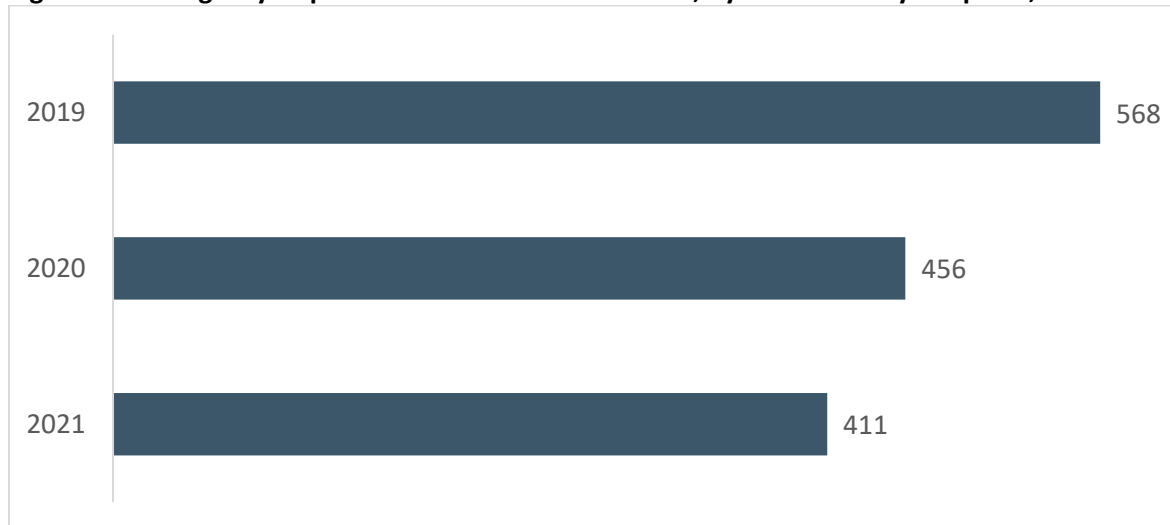
Figure 97. Preferred Locations in Extreme Heat among Austin Area Community Survey Respondents, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Among Travis County hospitals, there were 568 emergency department visits related to heat in 2019, 456 in 2020 and 411 in 2021 according to data from Travis County Hospitals.³⁴ These visits represent patients who had an initial complaint, concern or discharge related to heat and likely represent severe cases.

Figure 98. Emergency Department Visits Related to Heat, by Travis County Hospitals, 2019-2021



DATA SOURCE: Travis County Hospitals, Biosense Platform, 2019-2021

NOTE: These numbers represent people who visited emergency rooms with either an initial complaint or discharge related to heat. This isn't considered diagnostic and these cases are likely more severe, necessitating hospitalization.

FINDINGS: COVID-19

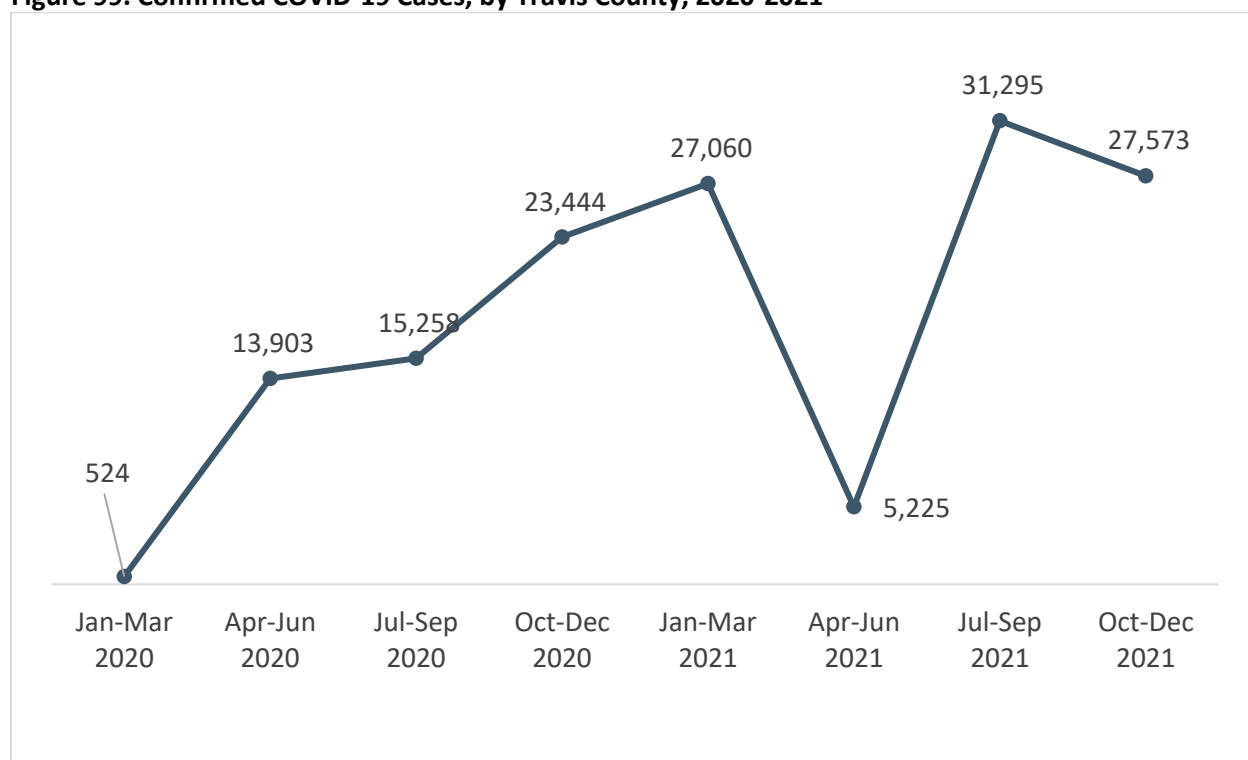


COVID-19

COVID-19 is a contagious respiratory disease caused by SARS-CoV-2. On March 6th, 2020, the City of Austin declared a disaster and the city confirmed its first COVID-19 cases on March 13, 2020, and its first fatality two weeks later.³⁵ In the two years that followed, the COVID-19 pandemic has had substantial impact on the lives of residents in Austin and Travis County.

From January to March 2020, there were around 524 confirmed cases of COVID-19 in Travis County. Confirmed COVID-19 cases fluctuated throughout the rest of 2020 and 2021: confirmed COVID-19 cases increased through December 2020, reached a low point in April-June 2021, then rose to the highest number of confirmed cases in July-September 2021 (Figure 99). Deaths due to COVID-19 followed a similar pattern, with the highest number of deaths in a three-month period occurring July-September 2021 (285 deaths) (Figure 100).

Figure 99. Confirmed COVID-19 Cases, by Travis County, 2020-2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2020-2021

Figure 100. Confirmed COVID-19 Deaths, by Travis County, 2020-2021

DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2020-2021

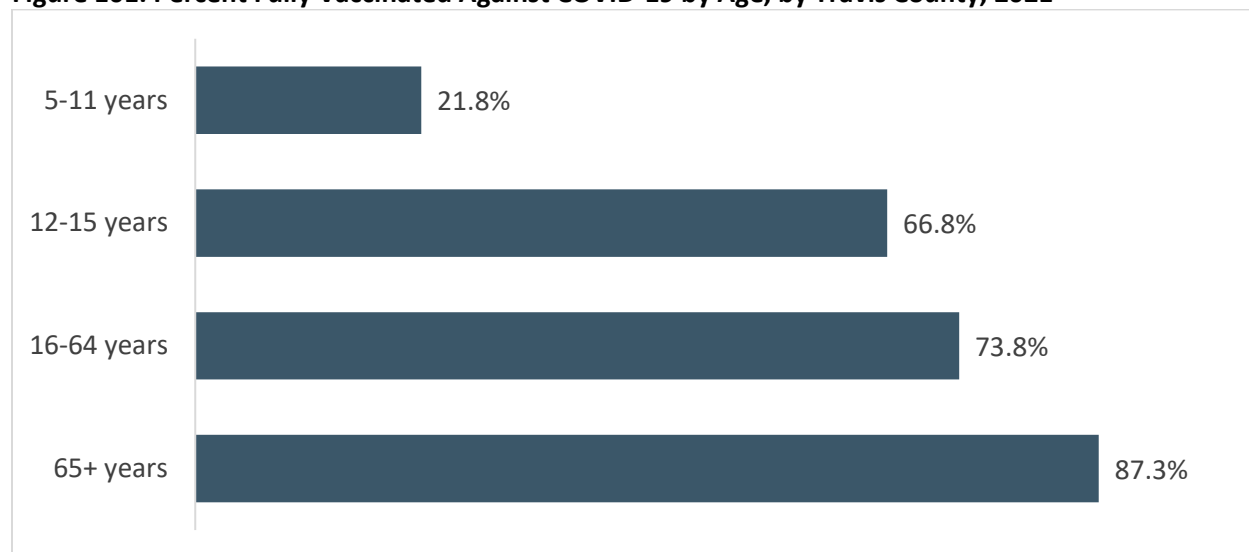
Some focus group participants mentioned that they got sick with COVID-19 early in the pandemic and in one case a focus group participant mentioned getting sick with COVID-19 more than once. One focus group participant described the long-lasting effects of COVID-19 on their health and finances:

“Well it has impacted us really hard, unfortunately I got COVID. I was in the hospital for almost three months. You do lose a lot of control. Financially, mentally, in every aspect. But we are getting out of it little by little and recovering as well. Because after COVID, you are not the same. [...] I struggle to walk, I feel my legs, I don't have strength in my hands. No, it's a whole thing... I'm using oxygen at night. It's not the same. It affected me - unfortunately.” – Focus Group Participant

“It will never go back to normal, there is no after-pandemic. [It] has made a huge impact and changed our lives. Somehow... there will be something on our minds and we'll never forget. It was impactful.” – Focus Group Participant

The percent of the Travis County population who received the COVID-19 vaccine as of December 2021 was highest among residents over 65 years of age (87.3%) and 16-64 years old (73.8%). Differences in COVID-19 vaccine completion patterns should be interpreted cautiously, as they may be influenced by vaccine eligibility requirements (Figure 101). At the time this reported was completed, vaccines were available for people 5 years and older.

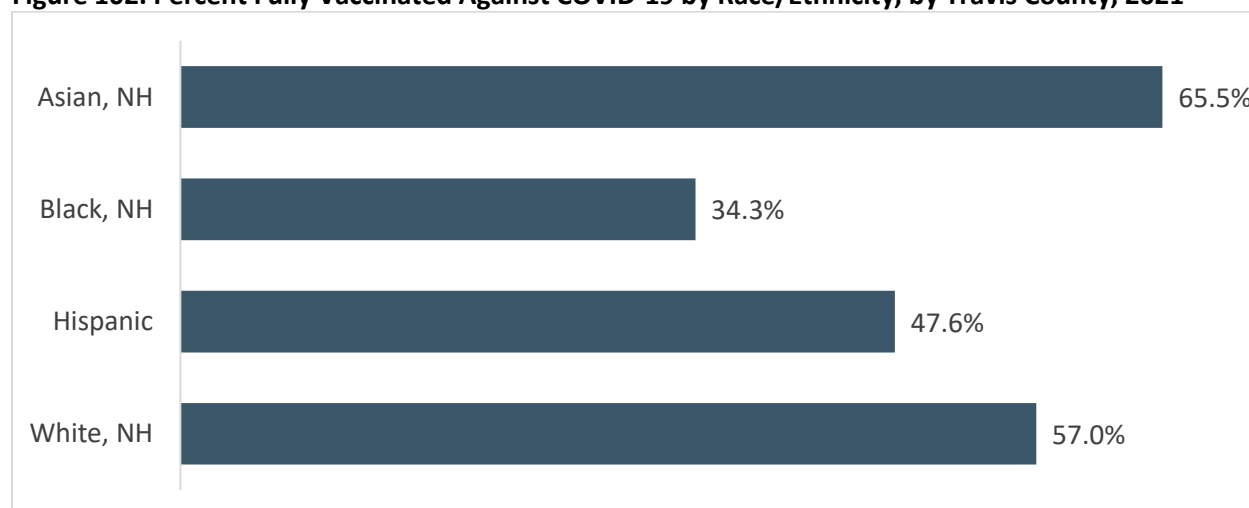
Figure 101. Percent Fully Vaccinated Against COVID-19 by Age, by Travis County, 2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2021

In Travis County, COVID-19 vaccination completion was highest among Asian (65.5%) residents, followed by White residents (57.0%) and Hispanic/Latino residents (47.6%) and lowest among Black/African American residents (34.3%) in 2021 (Figure 102).

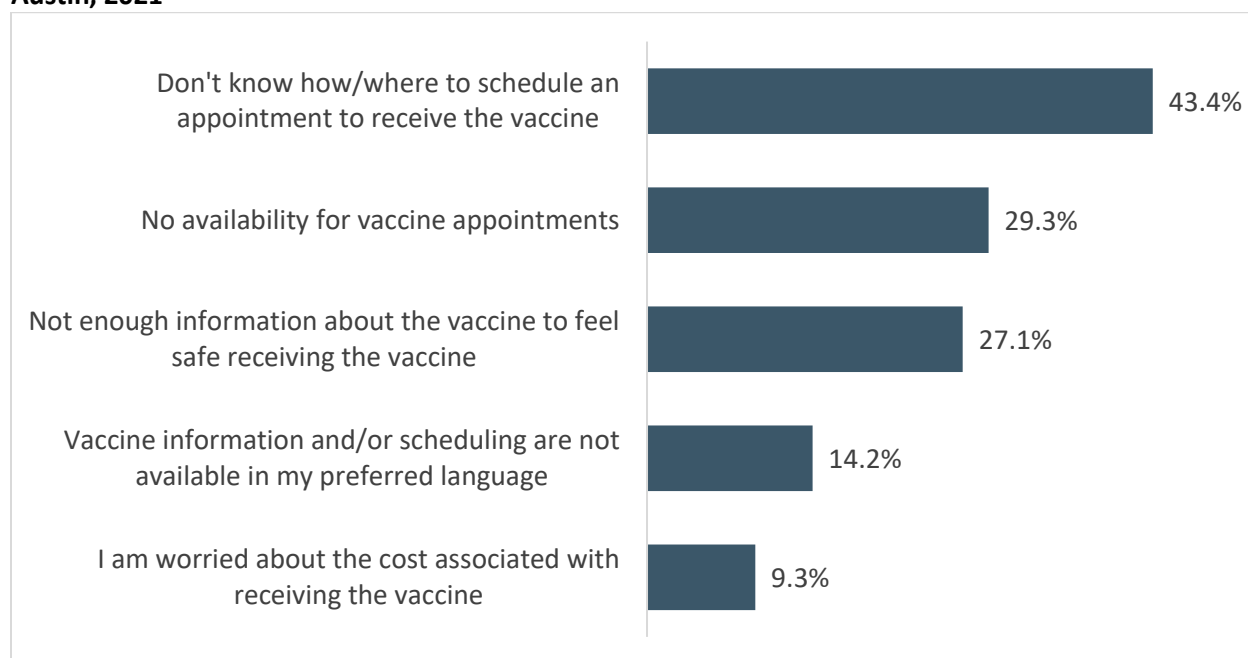
Figure 102. Percent Fully Vaccinated Against COVID-19 by Race/Ethnicity, by Travis County, 2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2021

Among Asian Americans (according to the Austin Asian Community Health Initiative Survey³⁶), top barriers for accessing COVID-19 vaccines included not knowing how or where to schedule an appointment (43.4%) and no availability for vaccine appointments (29.3%) (Figure 103). About one-quarter (27.1%) of Asian American respondents identified having insufficient information about the vaccine as a barrier to feeling safe to receive the vaccine.

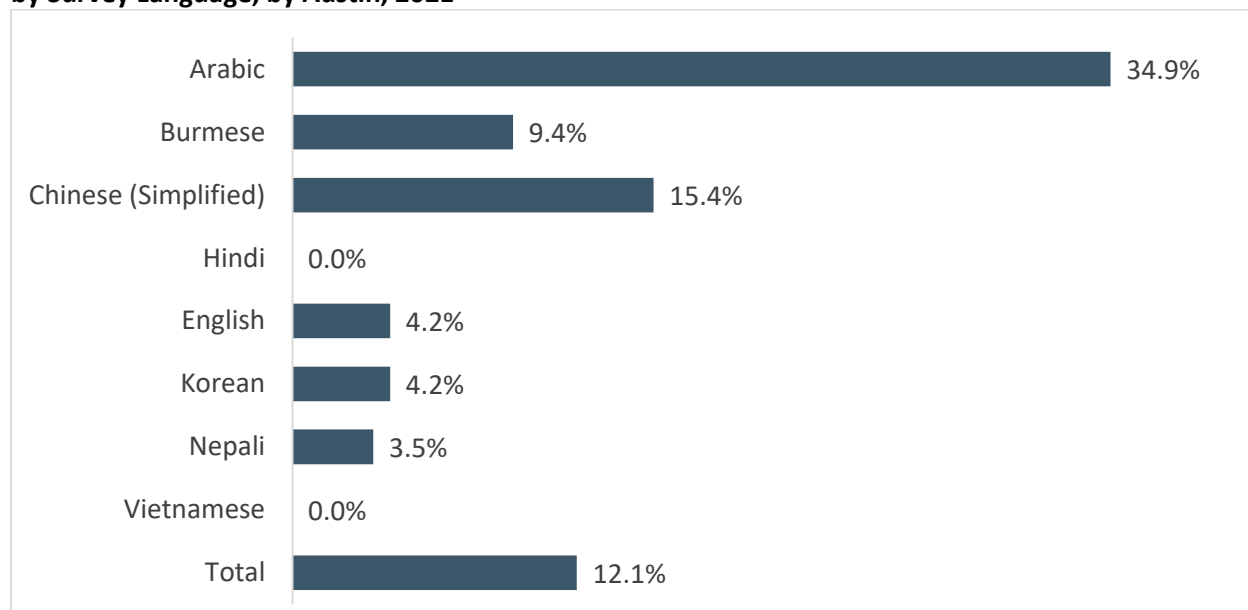
Figure 103. Top Barriers to Accessing COVID-19 Vaccines Among Asian American Population, by Austin, 2021



DATA SOURCE: Austin Asian Community Health Initiative Survey, 2021

Among Asian American respondents (according to the Austin Asian Community Health Initiative Survey), disinterest in getting the COVID-19 vaccine was highest among Arabic (34.9%) and Chinese (15.4%) residents (Figure 104).

Figure 104. Percent Not Interested in Receiving COVID-19 Vaccines Among Asian American Population, by Survey Language, by Austin, 2021



DATA SOURCE: Austin Asian Community Health Initiative Survey, 2021

Community Perceptions of the COVID-19 Pandemic

Managing Ongoing COVID-19 Risks

COVID-19 **safety precautions**, such as wearing a mask, practicing physical distancing in public, avoiding large crowds, and frequent hand washing, emerged among residents as important steps to prevent the spread of the virus that causes COVID-19. One in-depth interview participant characterized COVID-19 safety measures as critical to health: *“Health is also about safety. In particular, safety given the pandemic right now, the first thing that comes to mind when I think about health is COVID, like safety measures, washing hands, and things like that.”* Additionally, one older adult focus group participant described the importance of taking protective measures such as staying home and keeping a safe distance, particularly to protect the health of older adults, though at the cost of social isolation: *“You just have to stay isolated. You’re going to have to go out, but then you’re paranoid. Greg Abbott should shut some of this down. At our age, we can get it faster. Right now, you’re trying it on us. If you’re older it’s a paranoid thing.”*

When probed about safety, several Hispanic/Latino focus group participants cited the importance of continuing to practice COVID-19 safety measures such as wearing a face mask. One focus group participant shared: *“Specifically, now with COVID [s]afety, I take precautions, even though I have my shots I still wear my mask. Thinking of safety, not only for yourself but for other people.”* Another focus group participant described the steps that they take to protect themselves and their family during the pandemic: *“I continue to do the things the same, wear my mask when I am supposed to. Trying not to go home with the virus, staying healthy and away from groups of people. Take whatever medication I need to, to stay healthy.”* One focus group participant highlighted how they feel less safe in public now that distancing and masking requirements are relaxed and there are highly contagious variants circulating, despite being vaccinated:

“It was getting better because I was getting out a little more after getting vaccinated, now we’re in Stage 5, I’m having more problems, because I know there’s a Delta variant, and there’s a real risk involved. I go to the stores, and I’m finding not everyone’s back to wearing masks, it’s almost like I have to isolate all over again.” – Focus Group Participant

Some older adult focus group participants expressed concern about others not taking COVID precautions. One older focus group participant described how they did not feel safe with lax masking practices in their apartment complex. This participant explained, *“[People are] [g]etting in the elevator unmasked. Happens every day in the resident building.”* Participants also shared how they felt disrespected when others did not practice COVID-19 safety measures and felt that safety came down to a matter of personal responsibility.

COVID-19 Pandemic Worsens Economic Suffering

Several participants noted that the COVID-19 pandemic has worsened economic suffering for residents, which they characterized as ongoing and long lasting. One focus group participant explained:

“Things were not too great beforehand. [...] [M]aybe during COVID, but I think happening before, younger people having to move in with their

families because of cost of living, inflation, and low-pay rates. There was a lot going on before COVID and it got pushed behind because [...] the virus [...] add[ed] to poverty and a whole lot of other things.” – Focus Group Participant

According to residents, **job loss and reduced work hours** were some of the primary ways in which the COVID-19 pandemic affected income. Additionally, some residents mentioned not being eligible for, but needing, stimulus checks, or experiencing a disruption in work hours. One participant who described the lasting impact of both reduced work hours and delayed stimulus payments: *“I had to get my car repossessed because I didn’t have enough money between hours cutting back and late stimulus checks.”*

One focus group participant described how the economic toll of the pandemic made it additionally challenging to access and eat healthy food due to the economic impact and many losing their jobs. Another focus group participant described how the stress of making ends meet and feeding one’s family in the COVID-19 pandemic affect health: *“It adds up, mental health, stress... not having enough money, not having food on the table, all this at the end of the day, it will impact your health. Little by little we might focus on something, but if you keep adding, your health itself is being impacted at large.”*

Social Isolation and Social Support During the COVID-19 Pandemic

Social isolation emerged as a key theme when discussing the COVID-19 pandemic. According to several focus group participants, the need to stay at home and **avoid gatherings** increased social isolation, including connection with family, friends, and neighbors, and access to tangible forms of support that they would typically share, such as emotional support, information, and meals.

“I feel isolated. My daughter comes to stay with me once in a while, but I’m a widow, my husband passed away a year ago. So you feel isolated, I do. I have a lot of friends and we call each other and try to keep it touch so you don’t feel so by yourself. But it has made it harder because you can’t go out and meet with your friends.” – Focus Group Participant

Some focus group participants shared how **losing access to established gathering** opportunities and spaces to connect with neighbors contributed to their isolation. As one focus group participant explained: *“Another thing we saw, some of these elderly properties [...] [were not] permitting visitors or socializing in common areas. I can understand that, but at the same time you now have isolated elderly who are falling into bigger depression because they can’t have family visiting to drop of meals or come for holidays.”*

Churches emerged as an important source of support during the COVID-19 pandemic, and some focus group participants described phone and video calls as important ways to stay connected to church members and church services. *“There is always someone in my [church] group that we can call and talk to each other, bring ourselves up, my church and my friends have been a real good support.”*

COVID-19 Pandemic Affects Mental Health

Related to social isolation, according to several community leaders, focus group participants, and both in-depth interview participants, the need to practice physical distancing to prevent the spread of the virus that causes COVID-19 contributed to and/or **worsened mental health issues**. One focus group

participant recalled the mental health impacts on their community, “During COVID we couldn’t have our resident council meetings, so we miss fellowship, social gatherings. It meant a great deal to have that, by the time we did go out I would see people who would say they were depressed.” One interview participant observed the toll on their mental health and challenge of re-integrating socially as society opens back up, “COVID has made my depression worse, social isolation has been brutal. [...] Me trying to go back to normal now is way harder with being around other people.” One community leader cited **mental health assistance** as a key priority given the high levels of anxiety, depression, domestic violence, and family deaths in the community they serve.

One resident described the mental health impacts on children and their caregivers, which they anticipated also affects other chronic conditions:

“Everything that we hold on to and also our kids that couldn’t go to school last year [...]. All of that leads to a lot of depression [...] if they had a job or if they ate, how the rent was paid, one situation after another. And then having no access to healthcare. You are getting sick little by little inside, right? That is more mental health related [...] And everything is a little more complicated and everything happening now will lead in the long term to more chronic illnesses.” – Focus Group Participant

A community leader emphasized the importance of addressing the mental health of children in the aftermath of the COVID-19 pandemic:

“Mental health/behavioral health particularly through the year of COVID where kids were out of school and families [were] juggling multiple responsibilities. There is more kids in need of mental health support. I don’t have statistics, but my impression is that it’s true for adults as well.” – Community Leader

Some participants discussed **loss of loved ones** due to COVID-19. One community leader highlighted the importance of remembering the toll of losing loved ones due to the COVID-19 pandemic, particularly for communities who have been disproportionately impacted by deaths due to COVID-19. Another community leader described the need for a **public health approach to addressing the mental health** toll of the pandemic, ranging from intensive mental health services to counseling for children and adults alike.

Changing COVID-19 Information and Supporting Resources

Several focus group participants and community leaders described how the COVID-19 pandemic highlighted and worsened **barriers to accessing information** for lower-income residents and residents for whom English is not their primary language. Several residents described a need for more health information and for information about resources to promote health. As one focus group participant shared, “I think there are many resources, but I also think that we suffer due to a lack of information. Many of us don’t have the information and others also don’t inform us of the resources there are.”

A couple of community leaders described the **difficulties of delivering services** to and engaging with low-income residents when they needed to restrict the number of residents or patients who frequented

their building to minimize the risk of virus transmission. One community leader described the challenge of connecting residents with safety net resources when their community center was off-limits to residents due to the COVID-19 pandemic:

“Right now, it’s tough, and [I] understand the decision-making, but our community centers are not open to the public right now. And I do think that’s a concern for some people, because while people can still drop off [an] application, we’re lacking the ability to really provide effective [...] assistance for residents of Travis County. We don’t get them in our lobby and sit down with them and help them fill out applications. And that’s a COVID Barrier.” – Community Leader

Community-based organizations, food banks, and grassroots initiatives emerged as critical providers of COVID-19 information, COVID-19 resources (e.g., testing, vaccines), and food and rental assistance during the pandemic. Some focus group participants shared about transportation services or delivery of groceries for older adults.

Vaccine Distribution Efforts

Some focus group participants and several community leaders described initial COVID-19 vaccine distribution efforts as chaotic and initially overlooking low-income residents and residents of color. An older adult focus group participant described the **difficulties of trying to access the COVID-19 vaccine** when they became available to older adults given that vaccine scheduling systems were largely only available online:

“During the first part of the pandemic, when they first started offering vaccines through APH, if you didn’t have internet access you couldn’t really get on, you couldn’t call them and try to sign up and it was very hard to do even with internet access, so I think there should be an easier way for that to happen and a way to have it happen without using the internet.” – Focus Group Participant

Additionally, vaccine distribution efforts were impeded by Winter Storm Uri, including **physical damage to vaccine distribution sites** and the ability to preserve the vaccines during power outages and distribution delays.

Other barriers also included confusion about how to access vaccines: *“Not knowing where to search/where to go [for vaccines]. We were getting the information from other resources, word of mouth, nothing directly from a health clinic.”* One community leader observed **inequities in where COVID-19 vaccine sites were located** and how frequently vaccine sites were open, particularly for low-income communities and communities of color.

Despite these initial challenges, one focus group participant observed improved access to COVID-19 testing and vaccination as the pandemic has gone on: *“There have been more places to get tested for COVID and to get vaccinated It’s a good change.”* One focus group participant praised Austin Public Health’s (APH) collaboration with local community-based organizations to deliver COVID-19 and flu vaccines to residents, a novel model that made health care resources available to residents outside of clinics:

“I want to thank APH for collaborating with us and providing COVID/flu vaccines. The ability to bring vaccines to our sites has been great. It’s been a new thing, I’ve been with HACA for 3 years and it was a pivot with COVID, and right away we overcame the barriers of transportation.” – Focus Group Participant

Several community leaders representing community-based initiatives also noted that **small community-based institutions** were critical to ensuring that low-income residents and people of color had access to the COVID-19 vaccine. One community leader shared, *“And we noted that even when we did vaccination clinic, we had higher numbers if not the highest in the city for [number] of vaccinations given that day.”*

FINDINGS: WINTER STORM URI/EMERGENCY PREPAREDNESS



WINTER STORM URI/EMERGENCY PREPAREDNESS

In February of 2021, a series of winter and ice storms referred to as Winter Storm Uri impacted the Austin/Travis County area overlapping with the COVID-19 pandemic and drastically impacting individuals' access to power, water, transportation, access to communications, and livelihoods. At this time, emergency responses staff, residents, neighbors, community-based organizations, private sector groups all worked together to provide food, water, shelter, and other services. The winter storm lasted from February 10 through the 18th.³⁷

Ongoing Trauma from Winter Storm Uri

Some residents described Winter Storm Uri as traumatic, a trauma that they characterized as ongoing. Some also recalled significant health-related needs during the storm, which was worsened by uncertainty about the duration of the storm, power outages, and lack of safe, fresh water. As one focus group participant described:

"We weren't positive what the next day held. It was a scary moment for everyone. Being without power or water... electricity, cellphone. I didn't have a cellphone for 3-4 days. It was a second nightmare for some people. I have anxiety and depression and it was a scary time for myself and whole lot of other people." – Focus Group Participant

Another focus group participant described their anxiety and health needs during the storm: *"At one point I thought I was having a heart attack because of the anxiety."* Several older adult focus group participants also described trauma from the storm and characterized their trauma as ongoing, particularly with uncertainty about when the next storm or crisis will occur and what supports will be available.

Difficulties Meeting Basic Needs During Winter Storm Uri

One in-depth interview participant described their **struggle to meet basic needs** and their hunger during the storm, sharing: *"I didn't have money and the ATM was down, and when I went to the store to get gas there was no gas, so I starved through the winter storm."* Another focus group participant recalled their difficulty getting out of their house and making do with the limited food they had in stock during the storm.

Some residents described **food insecurity** during Winter Storm Uri as being traumatic and affecting children and adults, with one focus group participant noting the importance of ensuring kids had access to free lunch during the storm. One focus group participant described the emotional toll of food shortages during Winter Storm Uri:

"I sat down after the 3rd day and cried. I had people up in Philadelphia sending me packets. I waited in line at Trader Joe's for an hour and when I finally got to the front there was nothing. I came home and just cried." – Focus Group Participant

In addition to struggling to meet basic needs during the storm, some residents described a significant **financial toll** of Winter Storm Uri. For example, one focus group participant mentioned needing to take out a loan to cover electricity and other basic needs because of mounting costs and limited income linked with the COVID-19 pandemic and winter storm:

“Financially it did affect us a lot because we went 15 days without working and those are the only resources we have, the money we make is from working and well I do have many several bills to pay. And we asked for help with the electricity bill, because it was too high and nobody helped us, even though my wife is a citizen of the U.S. And she requested several [forms of support], but nobody listened.” – Focus Group Participant

Social Isolation and Social Support During Winter Storm Uri

Many residents described significant **social isolation** during the storm, at a time when they needed support the most. For example, some older adult focus group participants described lacking any support during Winter Storm Uri. One focus group participant recalled: *“I was stuck here for the whole time and nobody stopped to see if I was ok. I had to fend for myself, I had no phone. What stuck with me is nobody came to check with me until after the electricity came back on.”* Another focus group participant described how the winter storm prevented residents from supporting each other: *“Nobody checked on anybody, they wanted to, but nobody could do it.”*

Several focus group participants noted that many residents did not learn about resources such as **warming centers** available to help survive the storm until they had emerged out of the worst of the storm. One older adult focus group participant shared:

“I didn’t know until after the storm was over, that I found out that there was a warming center a few blocks away. Because of the steep hills where I live, I don’t know that I would have tried to go there, but if the power had been out for an extended period, I probably would have, but didn’t find out until everything was over.” – Focus Group Participant

Another older adult focus group participant explained how smartphones were critical to **accessing information** about resources to support residents during the storm, and lack of access to a smartphone worsened socioeconomic and age-related barriers to time-sensitive information. Indeed, one Hispanic/Latino focus group participant shared how access to social media was critical for connecting with other residents to exchange goods:

“I don’t know how to drive in the snow, so how can I make it to where they’re distributing food if I can’t navigate in the storm? So it was helpful to make use of the Facebook groups [...] Being able to be in communication with my neighbors helped a lot. When we needed food, you saw people exchanging goods for other goods.” – Focus Group Participant

Similarly, several residents described **neighbors coming together** during the storm to support each other in the **perceived absence of governmental support and information** about other social services during the worst days of the storm. One focus group participant shared:

“I think [Winter Storm Uri] brought us together. [W]e’re in a little community of several condos. One lady had her daughter drop off food and water at the bottom of the hill because we’re on the top of a very steep hill. We all got to know each other, we were charging our cellphones, and giving logs to people with power still out and offering to give them more meals. In our little community, we got closer.” – Focus Group Participant

Another focus group participant described how **community response efforts**, both locally and from outside of the region, were helpful for meeting basic needs during the winter storm:

“After the snowstorm there was not a lot of reaction here from [name of organization], immediately from the city, but a group came from Wisconsin and helped us with water and we distributed food and water. A lot of times it is very difficult to access this type of help because it comes with many requirements. That’s when you realized that it was the people themselves, the community itself, that was aiding each other.” – Focus Group Participant

Government Distrust

When recalling Winter Storm Uri, several residents described a **slow government response**. One participant described how groups had to fill the gaps, “[we] had to organize aid, [it was] not automatic.” Another focus group participant shared, “volunteers helped, but [the] county needed to be quicker and more helpful.” Another older adult focus group participant explained how difficult it was to get information from the local government during the storm:

“Information is not always the best in the city as far as when we’re having disasters; there’s a lot of things you can get help with, even with the pandemic still going on, but if you don’t know... what are you supposed to do?” – Focus Group Participant

Several residents discussed how their experiences of a slow government response and social isolation during Winter Storm Uri, combined with the COVID-19 pandemic response, contributed to **growing mistrust towards the government**. For example, one Hispanic/Latino focus group participant described their growing sense of mistrust towards the government in times of crisis:

“For me it would be knowing that in extreme times of weather or pandemic or stuff like that, we as a community can’t be too dependent on our city or our federal government. Because when help does get here, I know sometimes it’s too late and I know people died because of the winter storm. We can’t be too dependent on the government, because we’ve seen too many times, they can’t give us all the help we need.” – Focus Group Participant

Another focus group participant shared how they observed an increase in gun ownership among young adults after the COVID-19 pandemic and winter storm, which they perceived as a response to **inadequate sense of safety** and delayed governmental responses during both crises.

Significant and Longstanding Physical Damage to Residences

Some focus group participants and an in-depth interview participant described **longstanding damage to residences** due to the storm. One participant shared that senior living facilities flooded and the damage to residences still needed to be addressed. Another participant described the damage to their apartment during the storm, which prompted them to stay with a friend: *“My apartment got flooded because a water pipe burst, it messed up my appliances (fridge, blender, microwave), and my clothes got all wet.”* A couple of focus group participants described unaddressed damage on mobile homes: *“My mobile home’s roof was damaged and it is still leaking. I have not been able to solve that because fixing the roof is too expensive.”* Another focus group participant described:

“I don’t know why they [the City] waited to respond to the needs of the community. I think still today there are people suffering from the storm, not able to fix their places at 100%, especially when it comes to mobile homes [there are] still a lot of struggles for people in need and [who are] still unable to get a positive response.” – Focus Group Participant

According to some focus group participants, rental units are still damaged from the storm.

Preparing for Future Emergencies

While residents and community leaders described several gaps in the COVID-19 and Winter Storm Uri response, one community leader praised the public health response to COVID-19:

“I think it [Public Health] is taken for granted by the general population and generally undervalued. I think this pandemic has illustrated the importance for a need for a good public health system. We had fewer deaths, and I think it’s because of leadership and because the system functioned well and worked collaboratively. There will be other events, HIV, SARS, Ebola, etc. There will always be something on the horizon. If we can value pieces of our government that are working effectively, the better.” – Community leader

One community leader described several gaps in emergency preparedness efforts, which were illuminated by the COVID-19 pandemic. This community leader cited a **high level of turnover** among public health emergency preparedness leadership, few permanent emergency preparedness staff, and an understaffed environment when COVID-19 crisis was escalating, which they attributed in part to hiring freezes. This community leader also described the emergency preparedness team as growing and having demonstrated significant resourcefulness despite these challenges. They also recalled that regulations to prevent overtime made it difficult for the understaffed emergency preparedness department to meet the needs of the moment, noting that this policy resulted in a lot of unpaid work

that may have contributed to staff turnover during the COVID-19 pandemic: *“These policies need to be refined, I feel they contributed to the burnout and loss of employees during the initial pandemic start.”*

This community leader also observed that despite emergency planning, advance emergency preparedness planning was not very effective because partner organizations were not accustomed to major crises or emergencies. They recalled: *“We have not used a lot of the plans we created. This is a common thread. When there [are] no emergencies happening it’s hard to get people on board. A lot of people were not familiar with plans we already had developed, and we couldn’t use them.”*

Another barrier to responses by the emergency preparedness office included needing to rely on **contract agencies** who were not versed in emergency response during surge capacity events. Other barriers included dependence on federal funding for emergency response, barriers to coordinating emergency response efforts with other City departments or organizations, and limited emergency preparedness among other departments within the city so they can readily be deployed in emergencies.

One recommendation for strengthening emergency preparedness included **exchanging information with and other large cities** such as Houston and Dallas to learn about and share best practices and support each other. Additionally, this community leader emphasized the importance of ensuring that the emergency preparedness department and planning processes are attuned to community realities to inform the development and deployment of feasible and locally relevant emergency preparedness responses:

“We need to remain connected to the people being served so we understand the issue/needs and not responding to issues that don’t exist. Don’t assume what their needs are, ask what they are. Go out and have a discussion with people you are trying to help.” – Community Leader

Other recommendations that emerged included preparing for the City or County to be a mass distributor and providing more **training in emergency response** to build local capacity. This community leader shared:

“We need more training and more access to training for people that aren’t necessarily in emergency response. I hope this issue highlights the need for preparation and is taken more seriously and to understand why we teach Incident Command System. There should be more required/mandated trainings and that’s a policy decision. Further, these trainings should reflect relevant disaster possibilities within our community. Emergency preparedness should take these trainings and make them more accessible to the public.” – Community Leader

COMMUNITY RESOURCES

Some community leaders cited resident support for each other, including **sharing resources and information**, as an important community strength. According to one community leader:

“Community supports one another; they help each other. One person hears about one resource: they use their phone tree to connect others. It’s people that have lived out here for generations. They share resources to the best of their ability.” – Community leader

One focus group participant echoed:

“The pandemic affected us all and changed our lives, but we also realized that we are a community, we are quite united, there are resources but sometimes we don’t know where to go or where to ask for them.” – Focus Group Participant

According to some community leaders, **community health workers** have been central to meeting the needs of residents most affected by health inequities. One community leader shared, *“I get inspired by the work that all community health workers do. I wish that every working group of the CHA-CHIP had a community health worker.”* This community leader also shared, *“...As an organizer I feel that the power is at the bottom, and we should all be working to disassemble the hierarchy and [distribute] power. People give me energy.”*

Another community leader described how Asian residents organized to address needs at different moments of the COVID-19 pandemic, including supporting health care professionals, providing access to food, and vaccine outreach:

“I am proud of the Asian community [being] willing to give, to save, and support the community. We supported our frontline workers with PPE [personal protective equipment] in places such as hospitals, ERs, [and the] police force. [We supported] food distribution for homeless [residents and] refugees. Now we are doing vaccine outreach and we are trying to connect with our community despite the barriers and attacks.” – Community Leader

This community leader also described established networks in the Asian community as important sources of information and support: *“Our community is very strong connected. If I want to reach out to the Korean community we will reach out to a leader and they will get the message out [through] social media, newsletter or whatever channel. We are DEEPLY connected.”*

Another community leader described the **faith-based community** as an important resource that brings disparate groups together:

“Another asset is the diversity in the socioeconomic class. You could be next to someone in a sermon who is a millionaire and across from them is someone who is homeless, standing foot to foot, shoulder to shoulder.”

That feeling of a social contract with your fellow Muslim's is strong.” -
Community Leader

One in-depth interview participant who previously experienced incarceration also highlighted the importance of faith-based communities and other forms of social support:

“Engaging with my spiritual community, finding support groups [...] Finding a healthy social network is the single most important thing. I find most of my social network through my spiritual community and yoga community.” – In-Depth Interview Participant

PARTNERSHIPS

Many community leaders and some focus group participants described several **cross-sectoral partnerships** as important community strengths. They cited partnerships between organizations representing the City of Austin and/or Travis County (e.g., Austin Public Health, Emergency Medical Services) and community-based organizations; community-based organizations and private companies; community-based organizations and programs at the University of Texas at Austin; and across community- and/or faith-based organizations. One focus group participant characterized this environment: *“We go out of our way to build partnerships.”* Another community leader described the importance of partnering with community-based organizations to implement COVID-19 response efforts, such as testing sites and information: *“Relying on these partners is incredibly important. As we have grants or money available, we will do some grant making (giving grant money) to help push response efforts out through community-based organizations to be effective in reaching priority community.”* Another community leader praised a partnership between Austin Public Health, health care services, and community-based organizations: *“Pilot and reinvest in the right way. APH partnered with Urban League and Allied Health institute. [The] same thing with RENT and direct support relief. [It is the] [p]erfect combination, I can trust APH.”*

One community leader described a set of collaborations with **academic partners** as *“a lot of collaborations and partnerships that will [take] a long-term or [be] far-reaching. [We’re] not looking to be reactionary in totality, we’re looking to be people who impact the bottom line of wellbeing. That’s a paradigm shift.”* These collaborative planning processes focus on, for example, infrastructure investments such as renewable energy, as well as jobs and economic development.

One focus group participant described a partnership between **local schools and a private company**: *“[W]e do have Samsung and Applied Materials, which partner really closely to our schools and help us out with materials. Last year they helped us out with a big grant and they usually help us out with holidays.”* Another community leader cited a partnership between an organization working alongside people experiencing homelessness and EMS services, which has been helpful for addressing health care barriers for people experiencing homelessness:

“What makes relationship with EMS so successful [is they] have come out, they know who we are. They are passionate about people. It is a great partnership and were open to having someone on property to help work through solving some of those 9-1-1 calls and helping educate neighbors. They understand the plight of our neighbors. This level of competency helps because you can’t just say stop it, they need more in-

depth help and assistance. Navigating complicated world of healthcare is complicated, even for college educated. People without healthcare in early years now have problems because no preventative care. This is a new exposure to healthcare industry for them.” – Community Leader

COMMUNITY-BASED INSTITUTIONS

Several focus group participants and community leaders described community-based organizations, faith-based organizations, libraries, schools, and community health centers as important access points for information and access to services such as rental assistance, nutritional assistance, health care, and other resources. Many residents and community leaders recalled that community-based resources incorporated COVID-19 response efforts into their day-to-day work, including mutual aid and community-based COVID-19 testing and vaccination sites. For example, some residents mentioned the role of schools in providing free/reduced lunch for children and as a food distribution resource. One community leader shared, *“Regular food drives that happen at elementary schools [is a strength].”* One focus group participant echoed, *“And in my kids' school they helped us, at both schools. Thank God, there were also many people that would bring boxes of food here to my husband, they would bring him a plate of food, but thank God, we had a lot of help.”*

VISION FOR THE FUTURE

Building on the perceived community assets and thinking ahead to the future, assessment participants outlined the following suggestions for making Austin and Travis County overall a healthier place.

LONG-TERM HEALTH EQUITY PLANNING PROCESSES

“Along the lines of trust, having members and leaders from the community involved in decision making is important. Ideally, hire someone from the neighborhood you serve.” – Community Leader

Many community leaders recommended that the City of Austin and Travis County **deepen their relationships with communities** across the region. Some community leaders identified the need to build relationships with representatives from diverse geographic communities, such as communities on the outskirts of Austin, and identity-based communities, such as racially minoritized groups. One community leader described the current state, sharing: “[There is] distrust of the City. [A] [n]eed to build rapport with the African American community.” Some community leaders emphasized the importance of bringing community leaders to the table for planning discussions across sectors given that multiple sectors such as housing, development, and energy are deeply connected with health. One community leader described the **importance of incorporating community-based leaders and community voices into planning processes** for a range of issues that affect health and health equity:

“There’s structural barriers within the city. As an organization we have to start working with Office of Sustainability, the Equity office. We have to get in discussions about housing, and infrastructure, energy, and travel. Those elements put us in a position where we can plan for longer-term sustainability for those marginalized communities. But we need to move the powers that be to understand that we need to be in those discussions. Because we can help them when they’re making decisions about planning, travel infrastructure, that we end up having to fix 15 yrs. later. That structural inertia of ‘we’ll get to them, but they don’t need to be on this level,’ we need to be communicating on that level so we can avoid long-term outgrowth of plans that didn’t consider certain things, that’s a structural thing.” – Community Leader

As a first step in bringing together community leaders to guide health equity planning, one recommendation included **conducting an asset map of organizations leading health equity work** in the region and bringing those organizations to the planning table. One community leader described the importance of ensuring that organizations that center members of impacted communities – not just major non-profit organizations – are incorporated into collaborative opportunities:

“Many non-profits try to serve people and have no idea, it is paternalistic, disrespectful, and disconnected. I serve on advisory boards and one of my first questions is show me the leadership team of this organization and if they form part of the community. [...] It all goes to a lack of critical analysis. We need to step back and say that this is a system where these institutions benefit from this unequal distribution of

resources and power. We need to distribute the power and wealth and establish democratizing decision making through community inclusion.”
– Community Leader

Given sizable population growth across the region and displacement of longstanding residents, some residents recommended the need to intentionally **include long-time residents** in planning processes, not just relatively new residents. In addition to bringing community-based organizations to the table, some community leaders noted the importance of strengthening mechanisms to elevate the voices of residents and the need for sustained investments to support communities at large. One community leader explained that the success of programs, practices, and policies that emerge from planning processes is contingent on the extent to which residents are engaged in the design:

“Many times, when people say community engagement they refer to planning 2-3 interventions and then taking them to the community, But then the community does not like any of the options.” – Community Leader

According to community leaders, there is a need to **improve quality of outreach** to residents when engaging them in planning processes, including ensuring that information about resident engagement opportunities reaches residents through realistic and culturally appropriate communication channels and in residents’ primary language. *“The people believe their leaders. They trust the leaders that speak their language. I don’t speak some languages, but I know who does and who can pass the message along. It is important to have these outreach channels.”* One community leader noted the importance of reflecting on current outreach strategies that may not be reaching residents, particularly when it comes to enrolling in services. This community leader shared:

“We do a lot of, did you get the -email, they didn’t fill out the e-mail, then things are taken away. If African Americans and Latinos don’t respond to something, the assumption is they don’t care or they don’t need it. The case is they didn’t receive how they need it so they can respond to how they feel about it. A lot of time it’s ‘Apparently they don’t want it.’ But that’s not true, maybe you didn’t ask them right, maybe you didn’t make it accessible to understand. We get e-mails from APH and Central Health, it’s like you have to comb through them to find out where meetings are, what time they are, what are you asking us for, it’s a Where’s Waldo.” – Community Leader

FOSTER COLLABORATIONS AND COMMUNICATION ACROSS ORGANIZATIONS

Another recommendation included **leveraging collaborative planning spaces** as opportunities to build connections and relationships across local community-based health equity organizations since many organizations reported that they did not know each other. While several community leaders characterized cross-sectoral partnerships and inter-faith collaborations as an important strength, several community leaders representing community-based organizations described limited familiarity with other community-based organizations and initiatives. Accordingly, several community leaders recommended **fostering collaborations and communication across organizations** to build collective strategies and action and coordinate efforts. One community leader described the current state of limited familiarity with other organizations:

“There’s a lot of ‘this org [is] doing this, this org is doing this...’ I don’t even know if we are getting close enough where toes are getting stepped on. I just know they’re not cohesive with community and their needs. So, we know what’s wrong, if you help us, we’ll help. If you give us the infrastructure, we’ll work it.” – Community Leader

Community leaders discussed the importance of **shifting from a competitive environment** among non-profit organizations, which is linked with limited funding, to bringing organizations working with a range of racially minoritized communities together to build community power, collaborate, and improve efficiencies:

“Black organizations that have connections in the community, Latino organizations, there needs to be concerted efforts, to not have them fight over the crumbs but to build a model that promotes collaboration and not competition amongst them. Like bringing in Latino Healthcare Forum, LULAC, may have a voice. I don’t know that there’s a forum where there’s intentional collaboration to where health is holistically addressed. It’s segmented off, here’s some money go do food sustainability, housing. There’s no comprehensive plan that brings them all together and makes money and work more efficient and then tells us how to work directly with organizations.” – Community Leader

Relatedly, one community leader perceived that by building a collaboration across sectors, the City and County could transform current dynamics with research partners. This community leader perceived an opportunity to encourage research partners to invest in action to promote community health:

“All [university] wants to do is research but they don’t want to do any practical work with the information they gathered, so how do we make all these entities come together with all their power money and resources to develop a comprehensive plan that can make Austin a better place for everybody.” – Community Leader

Also, some community leaders discussed the importance of providing data to guide community-based health equity work to better inform collaborative processes.

FUNDING EQUITY

Shifting the funding model when supporting the work of small community-based organizations and racial equity organizations was a common theme among many individuals representing community-based organizations. Some community leaders and community forum participants discussed inequitable funding relationships between community-based organizations and the City and County and identified the need to **shift how funding operates** to improve health equity. For example, one community leader stressed the importance of equitably bringing community partners to the table by inviting them to planning meetings, and compensating them for their time: *“Because we don’t have time nor energy and resources to drive around and be at all of these meetings for free [...] So we’re spending a lot of time at tables where our knowledge is needed without getting supplemented for it [...] We were at one meeting where we asked for funds, and they pretty much laughed at us. We’re the only ones at this table not*

being paid and we're here just like you." Another funding recommendation included **re-hauling the current reimbursement model** to enable the City and County to meaningfully partner with smaller organizations who have smaller reserves and who cannot wait for reimbursement. Community leaders shared:

"The structure of the funding in the city: [you] can't have a reimbursement-oriented structure. That doesn't work unless you've been around for X amount of year[s] and you have all this money in reserves. [T]he reason we don't have reserves is because there's still a need and we spend on the need." – Community Leader

Relatedly, some community leaders recommended providing more information about funding opportunities particularly to small or newer community-based organizations. Additionally, a few community leaders noted the need to **be more transparent about how funding priorities are made**. As one community leader shared:

"We have applied and received a few grants. We don't have a specific person responsible (grant writer), the grant application process and access needs to be more transparent and intentionally reached out to organizations who could fulfill them. Collaboration to other agencies to help inform them about funding opportunities. Accessing the grants is our largest barrier." – Community Leader

Some community leaders noted that strengthening relationships between the City, County, and local community-based organizations and even places of worship could improve channels of communication with residents and could improve trust in City and County programs and information:

"A partnership where when we are helping someone here, we let them know the City also has this help and this is how you get access to it. They will hopefully feel a sense of trust that when they hear it from the mosque it becomes more legitimate and there is a responsiveness to them when seeking that help." – Community Leader

Another community leader envisioned that **investing in these collaborations and strengthening funding models** would build the capacity of small community-based organizations: *"Building capacity in orgs. and smaller orgs. There needs to be a concerted efforts to strengthen orgs, because if we strengthen these organizations, they strengthen us."*

ADDRESS SYSTEMIC RACISM

Some community leaders discussed the need to *"lead with race"* and address systemic racism in criminal justice, education, and health care sectors and build capacity to counteract hate. Additionally, one community leader described role of bystander trainings in sharpening residents' ability to address ongoing anti-Asian hate: *"We have bystander trainings: teaching people to do something when they see something that is not right."* In addition to bystander trainings, this community leader cited the need for policies to address rising hate towards Asian communities.

To address systemic racism in healthcare settings, one community leader shared their vision for appropriately staffing clinics to meet the health care needs of residents across multiple racial identities: *“Equity, 4 mobile clinics, clinics that cater to Black, Brown, Asian, and White communities; “straightforward talk” we need cultural relevance and competence. A Black doctor to tell me what I need to do; Black nurse practitioners.”*

IMPROVE FOOD SYSTEMS AND THE FOOD ENVIRONMENT

Several focus group participants and community leaders recommended strategies for improving food systems and the food environment, taking a long-term view to improving access to healthy food. One community leader described the current food environment in a food desert: *“We haven’t figured out long-term solutions: we want to incentivize a grocer to come out in some way like Austin incentivized Tesla to come out. How do we get social services, food grocers, food providers, more options for community?”* Residents also suggested expanding community gardens programs, food pantries, and farmer’s markets. A focus group participant shared their vision for a community garden: *“Garden center where you could go and work on your own project and get fresh food.”* Another focus group participant remarked, *“It would be helpful to have a farmers’ market close by.”*

IMPROVE QUALITY OF AND ACCESS TO HEALTH CARE, WITH A FOCUS ON LOW-INCOME RESIDENTS

The need to address lack of or limited access to health care for low-income residents emerged in interviews, focus group, and community forum discussions. Some community leaders highlighted the **need to expand Medicaid** to improve access to health care for low-income residents. One community leader described the importance of state or local-level strategies to **expand health insurance coverage** for low-income residents:

“The state absolutely needs to expand Medicaid. It’s a crime, a sin, an embarrassment that Texas hasn’t done this. They don’t need to call it Medicaid expansion, God forbid it is politically incorrect. Oklahoma and Arkansas have gotten it passed and it would ensure better quality of care for people throughout the state. ...That would be the number one priority if that’s an option where the city and county get to that. It would go the farthest in affecting people.” –
Community Leader

Community forum participants cited the importance of supporting residents in enrolling in health insurance through the marketplace during open enrollment, ensuring that these supports are available in residents’ primary languages to enable them to understand benefits and policies. Participants also recommended reducing wait times at community clinics and making resources available during later hours.

Some community leaders recommended a short-term strategy for improving access to health care for low-income residents by **improving the capacity of clinics** that currently serve low-income residents to **expand their hours and days of operation**. One community leader recommended **mobile clinics** as a

short-term solution to addressing limited access to health care for low-income residents and residents of color through having a regular presence at an established community location located along public transit lines.

Another recommendation included coordinating the release from the hospital for people who are homeless by bringing together hospitals, EMS, and organizations who serve people who are experiencing homelessness. One community leader described the need to collaborate with hospitals to deepen their understanding of the need to **coordinate discharge** so that patients have continuity of services once out of the hospital.

The need to address bureaucratic barriers to expanding mental health supports, improve funding for mental health services, and to make mental health services available to people who are experiencing homelessness and low-income residents also emerged from interviews and focus group discussions. One community leader highlighted the importance of **community-based mental health** models:

“We want to help meet mental health needs through various grants. People come to the mosque before the psychiatrist. No assigned social worker or mental health specialist at the mosque. Would like a part-time person to be the figure we can refer to for mental health needs.” –
Community leader

Some community leaders and focus group participants cited the need to **coordinate health care across specialties** in order to strengthen chronic disease management. One community leader described the importance of coordinating care:

“If somehow in the healthcare system there was a way to be more holistic, where say you have a cardiologist, neurologist, orthopedist, those people don’t necessarily talk to one another and each one is prescribing something different, and this disconnect of communication could be better. This might lead to better hope for chronic disease management. Transition of care has a lot of room for improvement.” – Community Leader

This community leader also observed that different electronic health care platforms pose a barrier to coordinating care across providers. *“Everyone has different software for health records. The solve is coming up with a platform where hospitals talk to one another, and everyone has access within reason and rights and utilizes the same software.”*

SUPPORT AGING IN PLACE

Some focus group participants mentioned the need to **support older adults** and residents with significant health needs for aging in place and keeping them out of institutions such as assisted living and nursing homes for as long as possible. One community leader noted that **planning for aging in place** was particularly important for residents who do not have family nearby. One focus group participant shared about why an aging in place model was important for them: *“I’m in a wheelchair, I don’t need nursing care at all, I need someone to help with the dishwashing and getting groceries and things like that.”* One community leader shared their vision for aging in place:

“Aging in place: neighbors to stay in place; attendants that can help in location [...] to help with housework, laundry, hygiene issues, grocery shopping and help when folks need to go to a skilled facility; more access to respite care.” – Community Leader

A community leader identified the need to build partnerships across organizations that serve older adults: *“We don’t have that partnership available; I know that Meals on Wheels provides some level of service for those that used to drop in, but now it’s hard to engage and learn their needs for folks not able to come into the center.”*

KEY THEMES AND PRIORITY HEALTH NEEDS OF THE COMMUNITY

KEY THEMES

This assessment included a review of secondary data and collection of primary data to shed light on the social and economic context, community health issues, and community visions of residents Austin/Travis County. The following key themes emerged through this synthesis:

- ***Social determinants of health, such as access to healthy food and financial security required to be healthy, were viewed as more pressing concerns than health outcomes themselves.*** While some chronic health issues were discussed and are of concern, assessment participants focused on upstream issues of daily life.
- ***Housing affordability continues to be concerns in Austin/Travis County.*** Due in large part to significant population growth, a key theme was the high and rising cost of housing that disproportionately affects low-income residents, residents of color, older adults, and persons with disabilities, and displaced residents from urban areas to rural areas. While median income has steadily increased in recent years, cost of living in the area is high and increasing as well.
- ***The COVID-19 pandemic has had substantial impact on the lives and the physical and mental health of residents in Austin/Travis County.*** The COVID-19 pandemic has exacerbated many of the issues that existed as well as highlighted new issues. COVID-19 pandemic has worsened food security, economic suffering, increased social isolation, exacerbated mental health issues, and highlighted barriers to accessing information and health care resources for lower-income residents, residents for whom English is not their primary language, and communities of color.
- ***Emergency preparedness is an emerging public health issue in the region.*** Given the COVID-19 pandemic, heat waves and Winter Storm Uri, emergency preparedness was top of mind for many assessment participants. Most residents reported experiencing a natural disaster emergency in the past decade and many described the immediate and ongoing personal and community challenges these emergencies have caused.
- ***Mental health was identified as a important community health concern.*** Significant mental health needs, stigma around mental health, and limited access to mental health care were common themes among community members and leaders. Some residents perceived an increase in mental health issues during the COVID-19 pandemic, which they linked with the stress and trauma of the COVID-19 pandemic, social isolation, and economic suffering.
- ***Healthcare access – specifically high cost of healthcare and insurance – is a significant concern in Austin/Travis County, especially among people of color.*** When discussing access to health care, common themes were gaps in health insurance coverage for low-income residents, including lapses of health insurance coverage, few providers who accept Medicare, and difficulty accessing preventive care (e.g., primary, vision, dental), emergency services, specialists, and providers who care for older adults.

- ***A strength of Austin/Travis County are the residents and organizations in the area.*** Community residents are supportive of each other and generous with sharing resources and information. Cross-sector partnerships among schools, community-based organizations, private companies and others also represent a community strength. Community-based institutions were seen as important access points for information and access to services. Faith-based organizations were highlighted as a key strength and a bridge between historically marginalized communities and local/county government.

PROCESS AND CRITERIA FOR PRIORITIZATION

Findings from this report will guide the upcoming 2023 Community Health Improvement Plan development process, set to begin August of 2022 and to be completed by February of 2023. Key Themes as well as further community input from residents, partners, stakeholders, etc. will inform the prioritization processes and the development of goals, objectives, and strategies. The 2023 Improvement Plan will be the Community Health Plan's guiding document for the following three years during which working groups, comprised of partner organizations, will work together to implement the proposed goals until the following 2025-2026 Assessment/Implementation cycle.

APPENDICES



APPENDIX A: ADDITIONAL DATA

Table 9. Percent Adults Consuming 5+ Servings of Fruits and Vegetables Daily, by Gender, Race/Ethnicity, Age, by Travis County, 2011-2019

	2011	2013	2015	2017	2019
Male	18.7%	19.0%	14.9%	38.6%	13.6%
Female	26.7%	17.9%	19.7%	43.4%	17.8%
Black, Non-Hispanic	23.5%	-	15.6%	-	-
Hispanic	23.2%	18.9%	18.0%	48.0%	13.4%
White, Non-Hispanic	12.6%	16.7%	17.5%	41.7%	16.1%
Other/Multiracial, Non-Hispanic	26.8%	-	11.4%	-	-
18 to 29	14.8%	14.8%	14.2%	33.6%	-
30 to 44	22.8%	22.8%	16.5%	37.0%	18.8%
45 to 64	19.1%	19.1%	19.9%	41.8%	12.2%
65+	14.7%	14.7%	19.8%	58.0%	21.4%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Dashes (-) indicate unreliable data or an inadequate number of respondents.

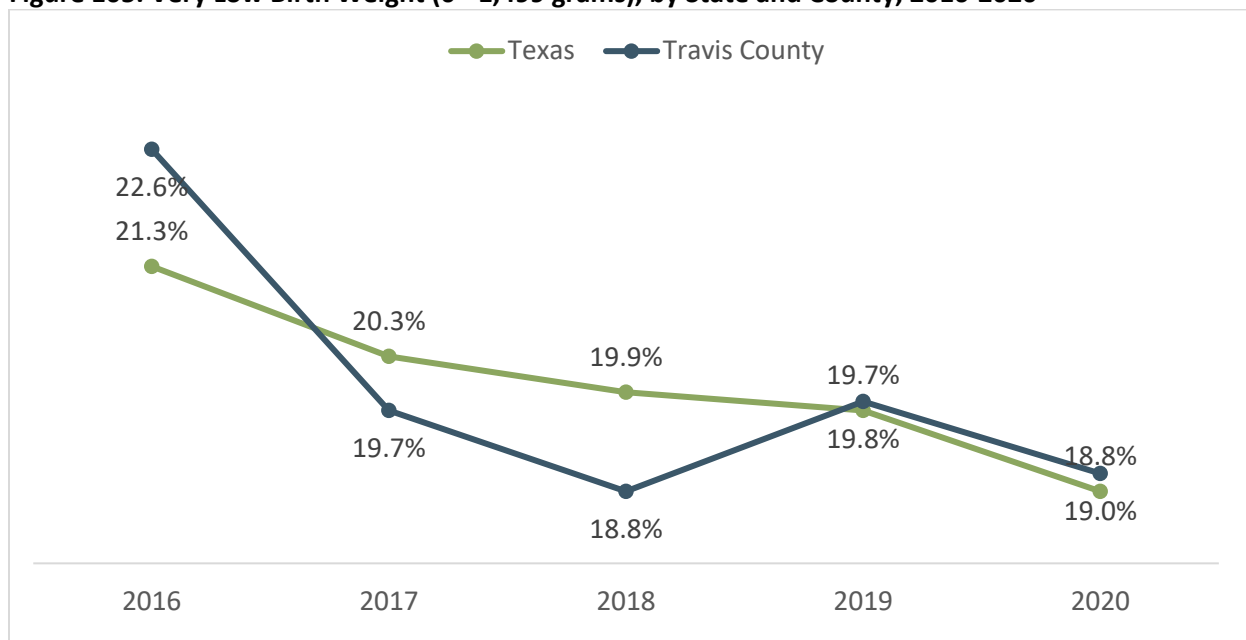
Table 10. Percent Adults Physically Inactive, by Gender, Race/Ethnicity, Age, by Travis County, 2011-2019

	2011	2013	2015	2017	2019
Male	22.3%	31.4%	29.3%	23.1%	17.8%
Female	21.4%	22.0%	25.9%	29.0%	20.4%
Black, Non-Hispanic	21.3%	-	23.6%	31.4%	-
Hispanic	30.7%	22.4%	25.9%	24.2%	30.0%
White, Non-Hispanic	35.4%	31.3%	31.6%	37.4%	36.0%
Other/Multiracial, Non-Hispanic	35.2%	-	32.9%	-	-
18 to 29	12.6%	23.6%	24.6%	22.1%	16.8%
30 to 44	23.5%	27.9%	25.4%	26.5%	20.4%
45 to 64	23.2%	23.3%	30.4%	28.2%	17.8%
65+	26.8%	38.2%	27.7%	23.4%	21.2%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

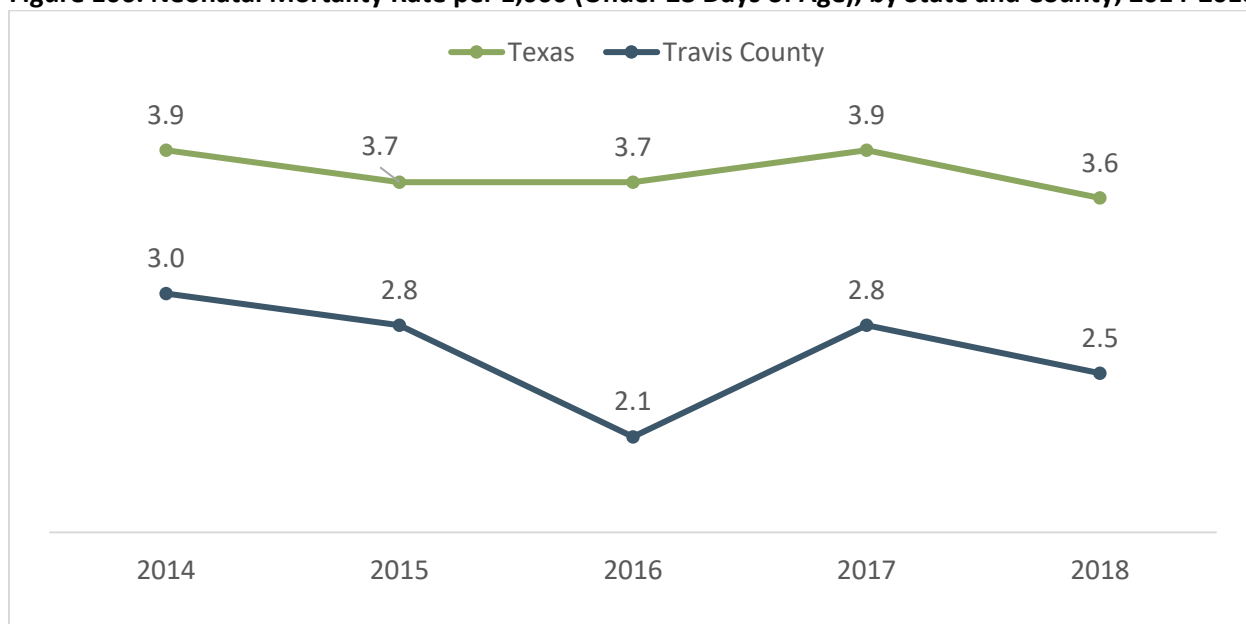
NOTE: Physical inactivity defined as adults aged 20 and over reporting no leisure-time physical activity.

Figure 105. Very Low Birth Weight (0 - 1,499 grams), by State and County, 2016-2020



DATA SOURCE: CDC Wonder, Natality expanded results, 2016-2020

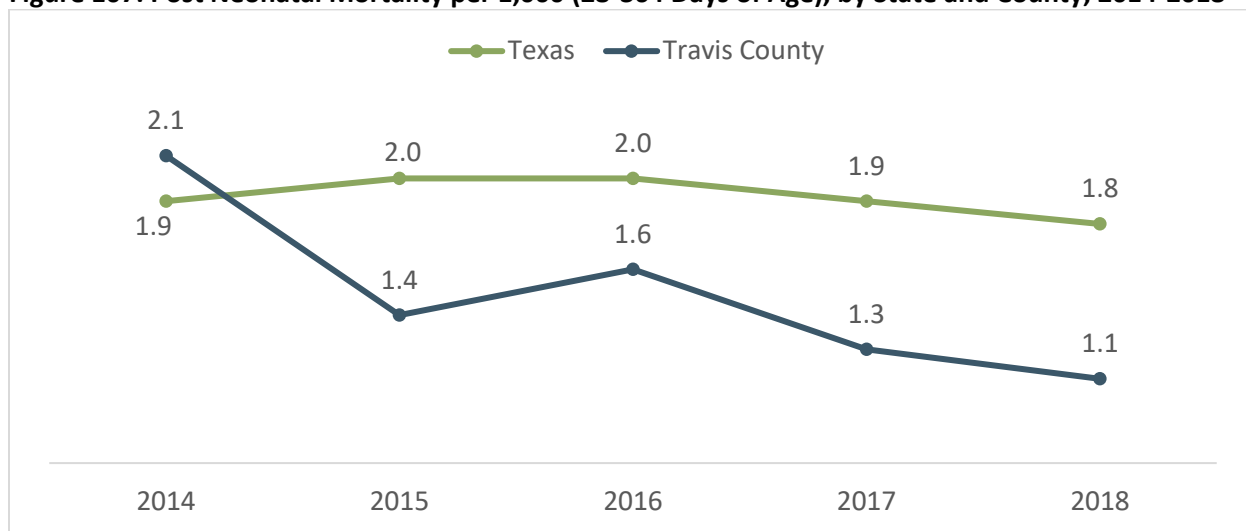
Figure 106. Neonatal Mortality Rate per 1,000 (Under 28 Days of Age), by State and County, 2014-2018



DATA SOURCE: CDC Wonder, 2014-2018

NOTE: Neonatal mortality represents the number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period.

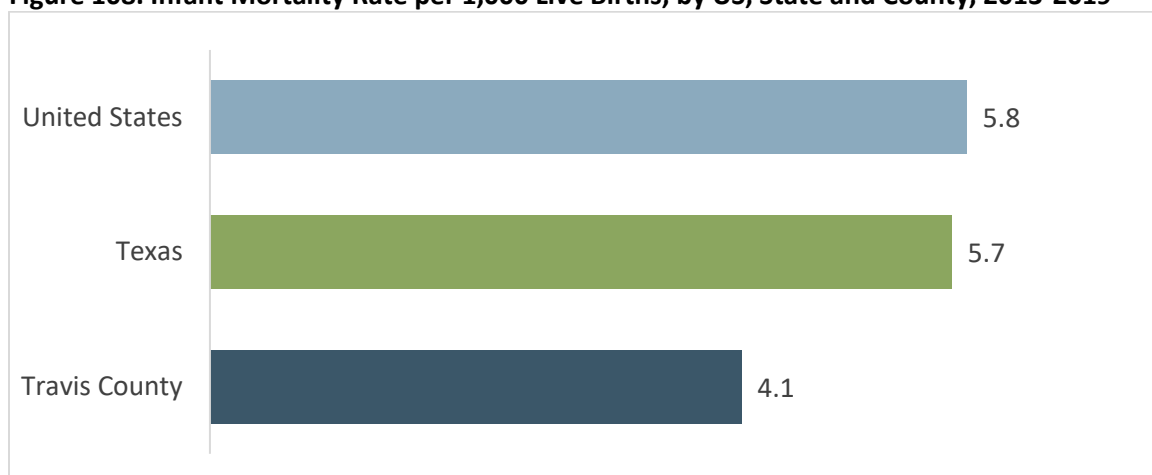
Figure 107. Post Neonatal Mortality per 1,000 (28-364 Days of Age), by State and County, 2014-2018



DATA SOURCE: CDC Wonder, 2014-2018

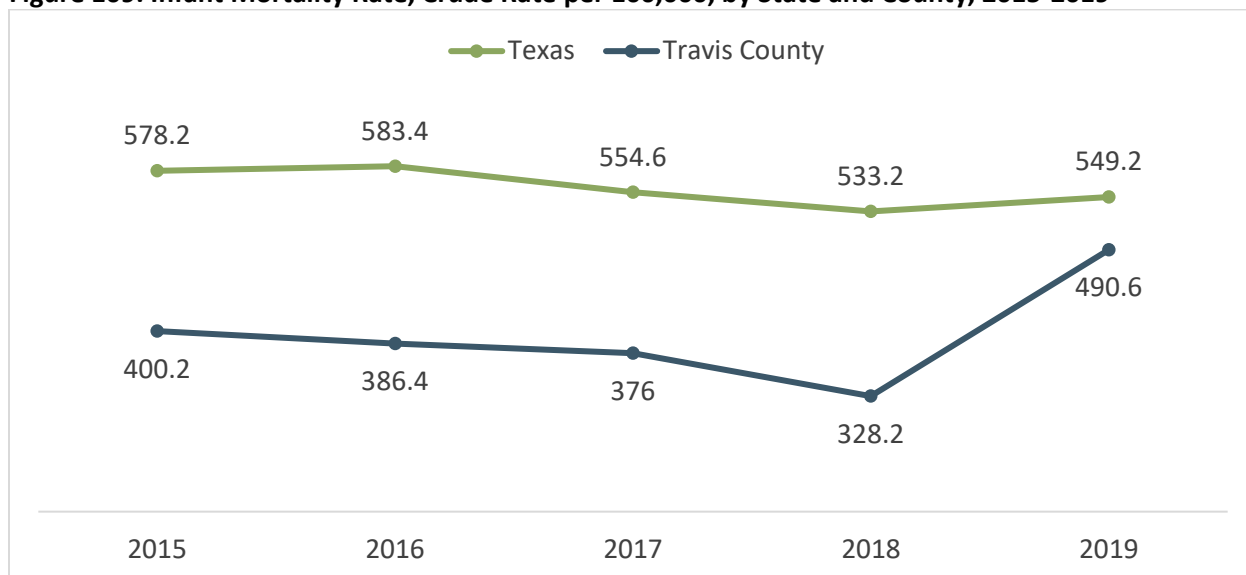
NOTE: Post neonatal mortality represents the number of deaths during 28-364 completed days of life per 1000 live births in a given year or other period.

Figure 108. Infant Mortality Rate per 1,000 Live Births, by US, State and County, 2013-2019



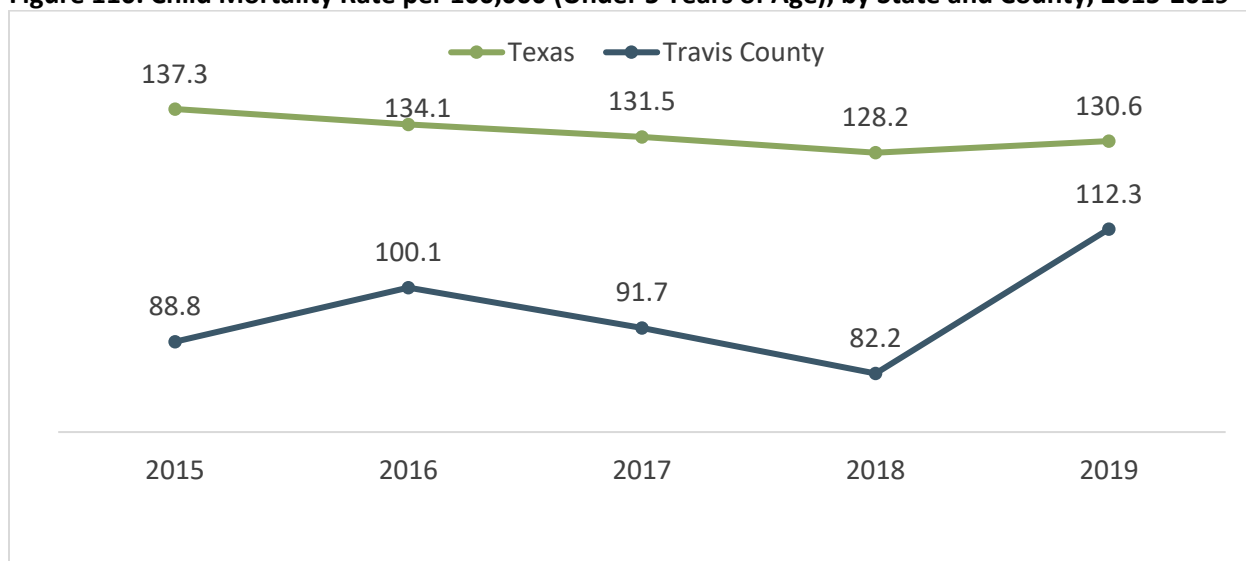
DATA SOURCE: CDC WONDER Mortality Data; as cited by County Health Rankings & Roadmaps, 2013-2019

Figure 109. Infant Mortality Rate, Crude Rate per 100,000, by State and County, 2015-2019



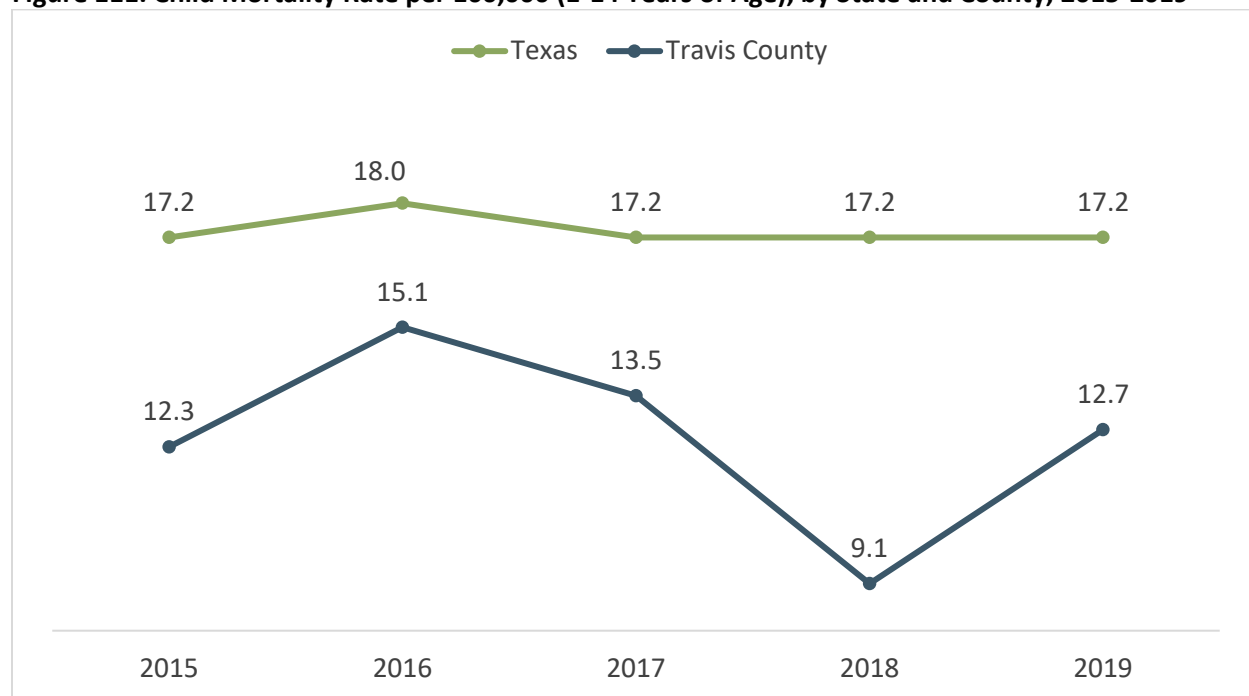
DATA SOURCE: CDC Wonder, 2015-2019

Figure 110. Child Mortality Rate per 100,000 (Under 5 Years of Age), by State and County, 2015-2019



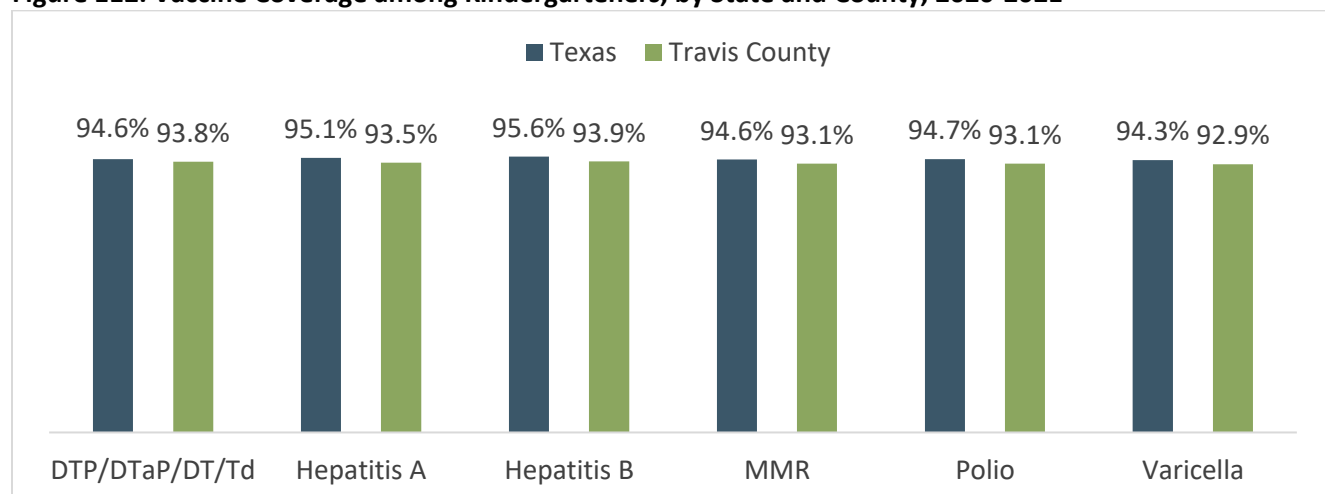
DATA SOURCE: CDC Wonder, 2015-2019

Figure 111. Child Mortality Rate per 100,000 (1-14 Years of Age), by State and County, 2015-2019



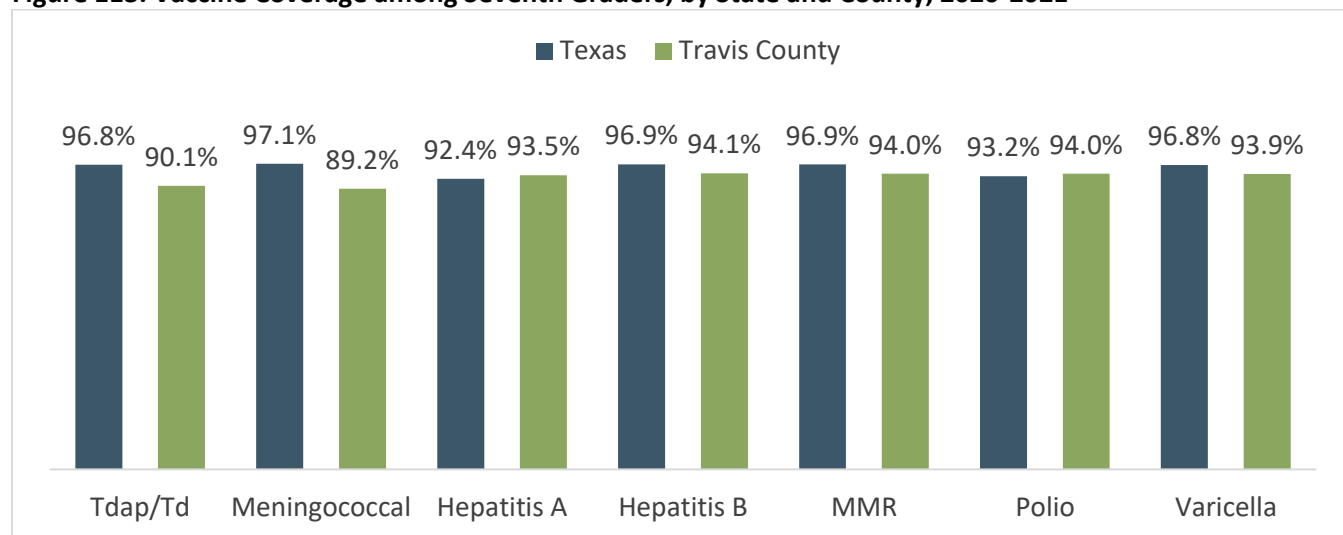
DATA SOURCE: CDC Wonder, 2015-2019

Figure 112. Vaccine Coverage among Kindergarteners, by State and County, 2020-2021



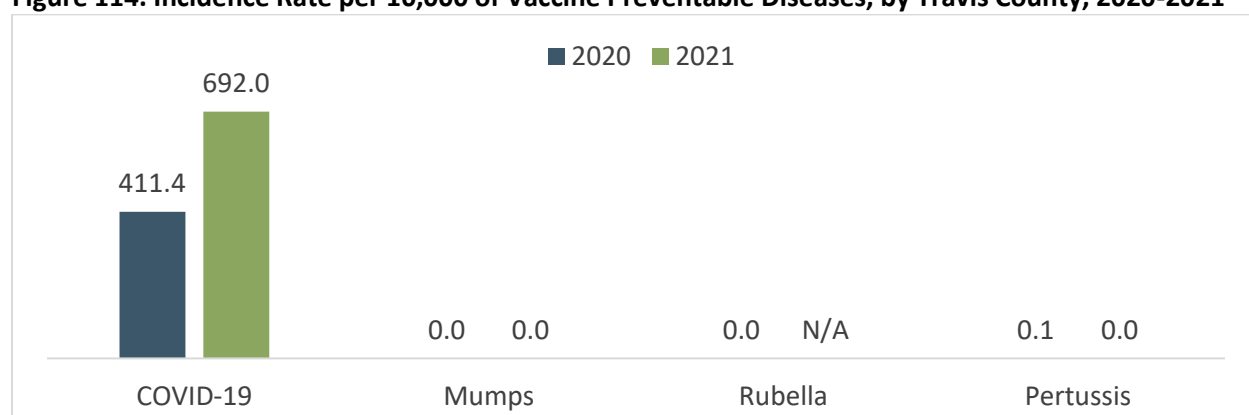
DATA SOURCE: Austin Public Health, 2020-2021

Figure 113. Vaccine Coverage among Seventh Graders, by State and County, 2020-2021



DATA SOURCE: Austin Public Health, 2020-2021

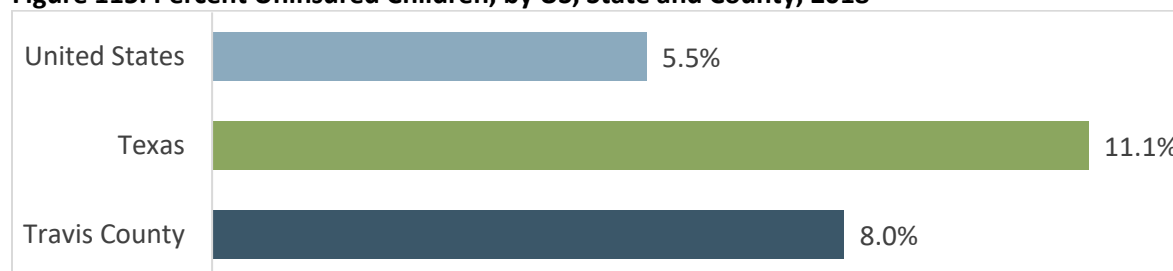
Figure 114. Incidence Rate per 10,000 of Vaccine Preventable Diseases, by Travis County, 2020-2021



DATA SOURCE: Austin Public Health, Epidemiology and Disease Surveillance Unit, 2/10/2022

NOTE: 2021 case counts are provisional and subject to change.

Figure 115. Percent Uninsured Children, by US, State and County, 2018



DATA SOURCE: Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; as cited by County Health Rankings, 2018

APPENDIX B: GENDER IDENTITY DEFINITIONS³⁸

Agender	Denoting or relating to a person who does not have a gender identity or identifies as gender neutral.
Cisgender	A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.
Gender-fluid	A person who does not identify with a single fixed gender or has a fluid or unfixed gender identity.
Genderqueer	A term used to describe people who typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. People who identify as "genderqueer" may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.
Gender non-conforming	A broad term referring to people who do not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category. While many also identify as transgender, not all gender nonconforming people do.
Transgender	An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.
Two-spirit or other Native Identity	Refers to a person who identifies as having both a masculine and a feminine spirit and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity.
Questioning	A term used to describe people who are in the process of exploring their sexual orientation or gender identity.

APPENDIX C: FOCUS GROUP/IN-DEPTH INTERVIEW GUIDE

FOCUS GROUP/IN-DEPTH INTERVIEW GUIDE

Introduction

Thank you very much for joining us today! I am [your name] from [name of organization]. We are working with Austin Public Health to conduct a Community Health Assessment, which is a process developed with a collaborative group of community partner organizations working toward the common goal of a healthy community for all. This process was previously completed every 5 years but is now moving to a 3-year cycle and the previous assessment was completed in 2017. We want to get your perspective on the health of your community and the health-related needs of your community. We would like this discussion to be informal, honest, and thoughtful. We want to hear from everyone in the room. Ideally, we the facilitators will hardly talk at all. Our role is to ask questions, keep us on topic, and help keep the discussion flowing.

Consent:

What is said in this room is confidential and will not be reported out except in general themes or anonymous comments. We are recording this conversation so we can listen again for context and clarity. What you tell us will be summarized into a report, however, no names will be attached to any of the experiences, opinions, or suggestions. The questions I will ask do not have right or wrong answers. They are about your experiences and opinions, so do not hesitate to speak.

Your participation is entirely voluntary and you can decide to leave at any point. If you could please let us know if you consent to this discussion with a verbal “yes.”

[Go over [Focus Group Rules](#)]

Intro:

Before we start asking you some questions, I would like each of you to introduce yourself with **only your first name** (or a name you would like to be referred to as) and how long you have lived in Austin/Travis County.

[Health Behavior and Environment – 30 minutes]

1. What does health mean to you?

Probes:

- a. physical health
- b. mental health

2. What do you do to stay healthy?

3. What do you see as the major health-related problems in your community?

4. What does a healthy community mean to you? Sometimes there are factors that can help people to be healthy or prevent them from being healthy.

- a) What are the things that help YOU to be healthy?
- b) What are the things that make it harder for YOU to be healthy?

Probes:

- a. Access to healthy foods
- b. Access to places for physical activity
- c. Safety
- d. Access to doctor’s office
- e. Access to mental health providers

- f. Exposure to lots of advertisements for alcohol/tobacco
- g. Housing
- h. Income and Employment
- i. Affordability
- j. Education
- k. Transportation
- l. Immigration Status
- m. Access to services in your primary Language
- n. Isolation
- o. Drug Use
- p. Access to Child Care (safety/affordability)

5. How has your race or ethnicity impacted your physical and/or mental health?

[Additional Questions – 20 minutes]

- 6. What impact has the COVID-19 pandemic had in your life?
 - How has your life changed since before the pandemic?
 - What were the resources, people, agencies that helped support you during the pandemic?
 - What, if any, ongoing effects are you experiencing from the pandemic?
- 7. What impact did Winter Storm Uri have on your life?
 - What were the resources, people, agencies, that helped support you during the winter storm?
 - What, if any, ongoing effects are you experiencing from the storm?

[Challenges in Health Services – 15 minutes]

- 8. What are other health services that you need but do not receive currently? [Probe on medical care, mental care, drug use treatment and services]
- 9. What has prevented you from receiving them? What are the greatest challenges to you in accessing health services?
- 10. If you cannot find services, where do you get help?
 - What are the consequences of not being able to get help?
- 11. What other resources would you suggest that are not currently available? In other words, what are some solutions to these problems?

[Strengths in Health Services – 10 minutes]

- 12. What are the strengths (good things) of the health services available in your community?
- 13. What resources (e.g., agencies, institutions, programs, services, people, etc.) do we have in the community that seem to be working to address the health-related problems you see? In other words, what has worked for you, your family or someone you know?

[Changes over time – 10 minutes]

- 14. Have you noticed any change in the quality of health services and opportunities and the way in which they are provided in the past five years?
 - How has it changed?
 - What impact has the change had on you?

Wrap-Up

- 15. Is there any other issue impacting your physical or mental health that you'd like to discuss/share?

APPENDIX D: GENERAL STAKEHOLDER INTERVIEW GUIDE

GENERAL STAKEHOLDER INTERVIEW GUIDE

Thank you very much for meeting with me today. I am working with Austin Public Health to complete their regular Community Health Assessment, which is a process previously completed every 5 years, the previous assessment was completed in 2017, but transitioning to a 3-year cycle. The assessment is completed in collaboration with a group of community partners working toward the common goal of a healthy community. We want to get your perspective on the health status and needs of Austin/Travis County.

What is said in this interview is confidential and will not be reported out except as part of general themes or anonymous comments. What you tell us will be summarized into a report. However, no names will be attached to any of the experiences, opinions, or suggestions.

[Organization's Basics]

1. Can you tell me about what your organization does and how that relates to the health of Austin/Travis County residents?
 - a. Please tell me your role at this organization.
2. What communities or audiences does your organization serve? (geographic, race/ethnicity, age, socio-economic status, gender, specific health condition)

[Organizational Evaluation]

3. How does your organization measure success? How are the programs/services in your organization evaluated? (What does success look like?)
4. What are the most significant accomplishments of your organization in service to the community over the past 3-5 years?
 - a. What significant accomplishments did you have during the past year and a half during COVID?
5. What are the most significant barriers the organization is facing in the next few years?
 - a. How prepared is the organization to meet those challenges?

[Community Needs]

6. What are the greatest assets of the clients/community you serve?
7. What are the health and social concerns you see most often in the community you serve?
8. What are the unmet needs or barriers in the community you work with that most affect your clients? (social determinants of health).
 - a. How does your organization select which barriers to address? How do you determine how to address them?
 - b. How would you prioritize the needs you have listed?

9. What changes are needed in the short-term to meet those needs? Who is responsible for making those changes?
 - a. What policies or resources are needed to help address the top needs?
10. What changes are needed In the long-term to meet those needs? Who is responsible for making those changes?
 - a. What policies or resources are needed to help address the top needs?

[Level of Engagement with larger Community Health Plan]

The Austin/Travis County Community Health Plan is a collaborative planning effort that brings community partners together to address community health needs. We'd like to learn more about your organization's connections to other partners and opportunities for linkage and additional support.

11. What types of support does your organization need to be successful?

Probes:

 - a. If they mention funding, funding for what needs?
 - b. Resources
 - c. Partner connections
12. How connected is your organization to others doing similar work?
 - a. Which partners do you regularly work with and in what capacity?

APPENDIX E: COMMUNITY FORUM MATERIALS

Austin Public Health held a virtual community forum on Thursday, November 18, 2021, to allow community members to provide their insight on major community health needs and priorities.

Forum Agenda:

Time	Topic	Speakers	Notes
6:30 - 6:40 pm (10 min)	Welcome & Housekeeping	Planner	Interpretation required
6:40 – 6:50 pm (10 min)	Orientation- Overview of the Community Health Plan and the 2022 Assessment	Planner	Interpretation required
6:50 - 7:40 pm (45 min)	Break-Out Sessions (by Language) Question 1: Barriers Question 2: Resources Question 3: Solutions	Guest Facilitators	Break-out groups by language
7:40 – 7:55 pm (15 min)	Debriefing	Guest Facilitators	Interpretation Required
7:55 – 8 pm (5 min)	Wrap-Up & Next Steps	Planner	Interpretation required

16 forum participants joined break-out groups, divided by language and facilitated by community partners, and utilized Google Slides to document their input with regards to 1) barriers, 2) available resources, and 3) solutions for healthy living. Participants used “sticky notes” to first generate ideas and then used stars to prioritize answers as a group. For those unable to access the online Google Slides, notetakers documented verbal input as well as comments in the Zoom chat.

Participants answered the following questions per slide:

Barriers to Healthy Living:

1. What makes it hard to stay healthy?
2. What makes your neighborhood unhealthy? What barriers exist in your community that make it more difficult to live a healthier life?
3. What is difficult about using services in your neighborhood?

Resources for Healthy Living

1. What helps you stay healthy?
2. What makes your neighborhood healthy?
3. What is good about the services in your neighborhood?

Solutions for Healthier Living

1. What could make services in your neighborhood better?

What improvements to services have you seen that work well?

APPENDIX F: CENTRAL HEALTH SAFETY NET COMMUNITY HEALTH NEEDS ASSESSMENT REPORT EXCERPT



CENTRAL HEALTH

Safety Net Community Health Needs Assessment Report – EXCERPT

February 10, 2022

Today, Central Health serves approximately 100,000 patients each year through the Medical Access Program (MAP) and Medical Access Program - Basic (MAP-Basic). A comprehensive review of Travis County's safety-net population found Central Health-enrolled patients represent a little more than one-half of those that may be eligible for services. Significant opportunity exists to expand reach and strengthen the impact on health and wellness for those that are low-income and particularly the most marginalized populations across Travis County.

Central Health patients face high poverty rates, unemployment rates, and metrics of poor health. The assessments conducted to develop this Equity-focused Service Delivery Strategic Plan indicate Central Health's patient population fares worse than Travis County and Texas averages in a number of measures of health. With significant health care access challenges across Travis County, patients struggle to receive essential preventive, primary, and specialty care services across the care continuum, and often use the Emergency Department in place of these services due to limited access and transportation barriers. Further, educational opportunities and access to healthy, affordable food, and housing are scarce and act as additional barriers to health.

In 2018, Central Health worked closely with community members to identify and refine the healthcare district's strategic objectives for the years ahead. These objectives are defined as follows:



Figure 1.

Central Health Strategic Plan Objectives FY2019-FY2024

Recognizing that economic opportunities, environmental factors, and social networks are key determinants of health, Central Health continues to focus on opportunities that will expand access to critically needed health care services across the continuum of care – while building health equity and improving outcomes for the low-income populations that are currently Central Health patients or are potentially eligible for services.

To support this effort, Central Health completed a comprehensive Equity-focused Service Delivery Strategic Plan to best position itself to meet the immediate and evolving health-related needs of its eligible population and work toward long-term solutions that maximize use of community resources to improve the health of those populations. Central Health conducted an in-depth safety-net community health needs assessment (CHNA), a voice of the community analysis, and a capabilities and gap analyses in collaboration with community members, activists, stakeholders, and partners to systematically identify and prioritize health needs in low-income populations and to understand the safety-net health care delivery system across Travis County. The outputs of these assessments are foundational to the comprehensiveness and effectiveness of an Equity-focused Service Delivery Strategic Plan.

Our Community

For the purposes of the safety-net CHNA, Central Health divided Travis County into 14 planning and assessment regions to understand health care needs at a more local level. These planning and assessment regions were developed based on census tract analysis and other characteristics, including geographic borders, level of urbanization, transportation resources, and population density.

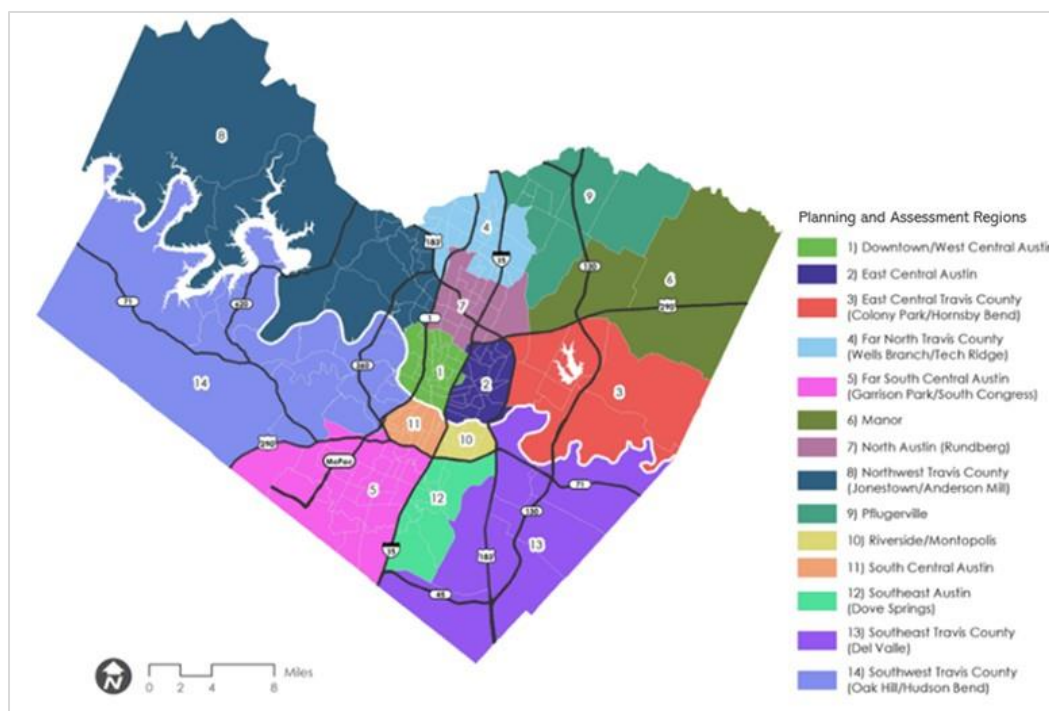


Figure 2. Central Health Planning and Assessment Regions

Source: Planning and assessment regions defined by Central Health

Core to this analysis is understanding the scope, scale and severity of health care needs of low-income Travis County populations at the local level. The map below illustrates the geographic distribution of the healthcare district's low-income population, specifically those with incomes less than or equal to 200% of the FPIL, across each of the 14 planning and assessment regions.

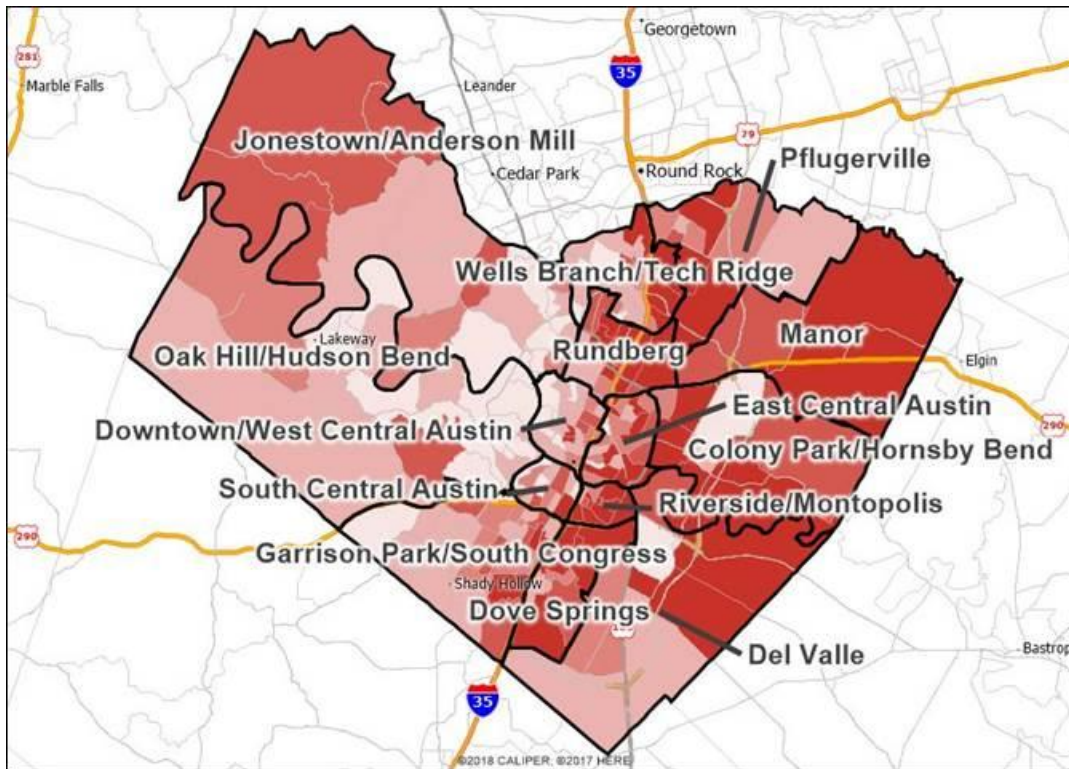


Figure 3. Absolute Population below 200% of FPIIL by Census Tract

Source: American Community Survey (ASC) 2015 -2019

74% of Travis County's 241,774 residents with incomes below 200% FPIIL reside in the I-35 corridor. Central Health's current enrollment is highest (*total and percent eligible enrolled*) in this I-35 corridor focus area. This focus area also represents the area with the greatest opportunity to expand Central Health's enrollment to low-income residents (69,230 residents), as home to approximately 75% of additional currently unenrolled residents who may be eligible for Central Health or other safety-net services in Travis County.

Planning and Assessment Region		# of Census Tracts	Square Miles	Total Population - 2021	Enrolled Population - FY20	Families in Poverty - 2025	% of Population Below 200% FPIIL - 2019	Enrollment Opportunity
I-35 Corridor	Rundberg	20	25.4	127,323	21,022	4,905	17.2%	16,233
	Garrison Park/South Congress	31	67.0	199,593	8,335	2,406	11.2%	12,683
	East Central Austin	20	17.5	80,803	7,161	2,968	9.3%	8,550
	Dove Springs	11	27.9	72,963	10,701	2,219	8.2%	8,331
	Wells Branch/Tech Ridge	24	30.6	120,717	8,471	1,944	8.1%	8,558
	Downtown/West Central Austin	22	16.3	97,596	1,259	770	8.1%	2,433
	Riverside/Montopolis	10	7.5	53,514	7,487	1,938	8.0%	6,720
	South Central Austin	12	9.7	56,025	2,459	850	3.7%	5,722
East Travis County	Pflugerville	9	63.0	112,254	7,311	1,431	6.2%	5,334
	Colony Park/Hornsby Bend	7	81.8	43,465	9,207	1,632	5.9%	4,792
	Del Valle	8	120.4	32,432	8,353*	1,044	3.2%	2,025
	Manor	3	100.0	28,253	3,532	781	2.3%	1,255
West Travis County	Jonestown/Anderson Mill	22	218.6	155,652	2,681	1,188	5.1%	3,267
	Oak Hill/Hudson Bend	19	206.4	127,318	2,606	1,211	3.3%	5,192
Grand Total		218	992.2	1,307,908	100,585	25,287	100.0%	91,095

Figure 4. Central Health Enrollment and Opportunities for Enrollment Expansion by Planning and Assessment Region

Sources: Central Health Census Tract Planning and Assessment Region; Land area data obtained from the U.S. Census Bureau. Total population of families in poverty data obtained from Claritas ©. Population <200% FPL data obtained from American Community Survey (ACS) Table S1701.

Notes: Enrolled population counts are based on patients with addresses that could be geocoded. Consequently, the Downtown/West Central Austin Planning and Assessment Region likely represents an undercount of enrolled patients. * Travis County Correctional Complex/Austin Transitional Center is in Del Valle and a significant number of inmates were enrolled into MAP when they didn't have a permanent address

Summary of Significant Health Needs from the Safety-Net Community Health Assessment

The primary objective of the safety-net CHNA is to understand the magnitude and distribution of health care needs of Travis County's low-income, safety-net population. Using various sources, the CHNA evaluated quantitative data and trends for Central Health's current patient population and low-income residents who are potentially eligible patients to identify opportunities to better serve these communities. Significant areas impacting health needs were identified based on a comprehensive review of publicly available and proprietary quantitative data collected throughout the CHNA process. Areas for significant opportunity impacting health needs are:

<p>1. Access to primary and preventative, and specialty care across the continuum</p> <p>Health outcomes data indicates Travis County's safety-net population is vastly underserved and experiences greater challenges trying to access health care services. Large shortages of physicians and access points, result in limited timely and inadequate access to critical preventative, primary, and specialty care services, including hospital-based, for safety-net patients</p> <p><i>Ex: Central Health patients residing in East Travis County and along the I-35 Corridor have proportionally fewer opportunities because of the density of need for primary prevention services, including annual check-ups, dental care, mammograms, pap smears, and colorectal screenings. For Central Health patients in total, screening rates for breast cancer, cervical cancer, and colorectal cancer are lower than Healthy People 2030 Program targets</i></p>	<p>2. Management of Chronic Health Conditions</p> <p>Patients served by Central Health have higher rates of chronic disease and delayed receipt of critical health care services; opportunities exist to improve population health and chronic disease management through advancement of care models</p> <p><i>Ex: Central Health patients who reside along the I-35 Corridor had the highest rates of chronic conditions, thereby demonstrating a greater need for access to health care services in these locations</i></p>
<p>3. Behavioral Health</p> <p>Many factors leading to mental health episodes and substance abuse disproportionately impact patients served by Central Health. Further, stigma related to behavioral health in a highly minority community affects residents' willingness to seek help from mental health care providers specifically (as opposed to within a primary care model)</p> <p><i>Ex: Central Health patients in West Travis County have higher prevalence rates of behavioral health issues and substance abuse when compared to County averages. This is not aligned with the health status of the total patient population in West Travis County</i></p>	<p>4. Social Determinants of Health ("SDOH")</p> <p>Racial and ethnic minority populations are more likely to be socially vulnerable due to their increased likelihood to have an income below FPL, to live in substandard housing, and to have low access to health care providers and services</p> <p><i>Ex: Regions where 50% or more of the population is Hispanic (i.e., Del Valle, Dove Springs, Colony Park/Hornsby Bend, and Riverside/Montopolis) face greater SDOH-related needs than other regions</i></p>

Figure 5. Summary of Significant Health Needs for the Safety-Net Community in Travis County

- 1. Access to preventative, primary, and specialty care across the continuum:** Health outcomes data indicates Travis County's safety-net population experiences greater challenges trying to access health care services compared to other populations in the county. Major disparities and health care inequities continue to exist across the care continuum for Central Health's patients, making it nearly impossible to achieve the objectives of the Institute for Healthcare Improvement's Triple Aim™ Initiative of better health outcomes, improved patient experiences, and lower costs of health care. The health care disparities faced by the safety-net population in Travis County continue to be substantial and include:
 - An overall and increasing need for more comprehensive, multidisciplinary health care, treatment planning and care coordination across providers and settings for the safety-net population. Overall capacity for primary care including walk-in and same day access should be increased to meet more

of the enrolled population's needs. More robust post-acute services are needed, especially in East and West Travis County.

- Large shortages of physicians exist in some primary and across most medical and surgical specialties and will most likely increase in the future across all payors and patients seeking medical services. The shortage will be exacerbated for the safety-net system as it attempts to compete for the necessary level of physicians to meet the service levels required for patient care. Shortages will limit timely access to critical preventative, primary, and specialty care services for safety-net patients, which will likely result in undesirable health outcomes. This is demonstrated on a micro-level, with patients residing in East Travis County and along the I-35 Corridor having lower utilization for preventive services, including annual check-ups, dental care, mammograms, pap smears, and colorectal screenings. For Central Health patients in particular, screening rates for breast cancer (64.0%), cervical cancer (73.5%) and colorectal cancer (47.0%) are lower than target rates set by the Healthy People 2030 Program (77.1%, 84.3% and 74.4%, respectively).⁵
- A limited number of health care providers: (1) treat the safety-net population, which results in delays in care; and (2) demographically resemble the diverse nature of Travis County's safety-net population today and can care for residents in their language and through their specific cultural lens.
- 74% of Travis County's residents (241,774) with incomes below 200% FPL reside in the I-35 Corridor. By a significant margin, the Rundberg area is home to the highest number of residents below 200% FPL in Travis County (56,132 individuals). As Central Health considers strategies that expand access to care for Travis County's safety-net community, it must ensure that geographic distribution and health care needs of its patient population are aligned with sufficient access to meet demand for services.

2. Management of Chronic Health Conditions:

- Patients served by Central Health need additional resources to address chronic diseases. From a geographic perspective, Central Health patients who reside along the I-35 Corridor had the highest rates of chronic conditions, thereby demonstrating a greater need for access to health care services in these locations.
- Further, there is a need to expand comprehensive, multi-disciplinary care, treatment planning, and care coordination across care settings and providers to facilitate individualized care management planning with seamless coordination across settings. This is further compounded by the fact that there is not a central electronic health record or robustly utilized health information exchange to tie providers together through data sharing and encourage seamless transitions in care. Additionally, opportunities exist to improve population health and chronic disease management by leveraging advanced care models for the safety-net population.

3. Behavioral Health: Many factors leading to mental distress and substance abuse impact patients served by Central Health disproportionately. Inequity, low-income, poor physical health, unemployment, and high cost of living are common in the county. The prevalence, incidence and severity of these illnesses has been exacerbated further by the ongoing COVID pandemic. On a micro level:

- Most of the regions in the I-35 Corridor (five out of eight) and all regions in East Travis County have a lower rate of local mental health providers per 100,000 residents (i.e., credentialed professionals specializing in psychiatry, psychology, counselling, child, adolescent, or adult

mental health, or clinical social work) than the county overall. However, these areas represent some of the highest needs for mental health services in the county.

- The safety-net population needs additional access to behavioral health services. In East and West Travis County, access and capacity to serve the safety-net are limited.
 - Central Health patients residing in the West Travis County communities of Jonestown/Anderson Mill and Oak Hill/Hudson Bend have less access to substance abuse providers when compared to the overall patient average, yet these patients have some of the highest substance abuse rates among the organization's patient population.
4. **Social Determinants of Health:** Safety-net patients are facing many social and economic disparities impacting physical and mental wellness. Regions where 50% or more of the population is Hispanic (i.e., Del Valle, Dove Springs, Colony Park/Hornsby Bend, and Riverside/Montopolis) face greater SDoH-related needs than other regions. Specific to the communities served by Central Health:
- Lower median income, high unemployment rates, and high rate of households below FPIL in the I-35 Corridor and East Travis County are indicative of populations that may have limited access to adequate preventative care and lack other necessary resources to achieve health and wellness.
 - A larger proportion of adults in East Travis County and in the I-35 Corridor do not have high school diplomas. Research shows that not having a high school diploma is an indicator of limited ability to secure employment resulting in lower wages, and poverty, and can lead to negative health outcomes.
 - High housing costs, substandard housing, and overcrowding are prominent issues in Riverside/Montopolis (I-35 Corridor) and Colony Park/Hornsby Bend (East Travis County). These challenges can exacerbate certain chronic illnesses as they often limit a household's ability to allocate sufficient income to necessities, such as food and health resources, in addition to creating housing instability and potential homelessness.
 - A large portion of patients residing in East Travis County and along the I-35 Corridor speak Spanish as their primary language. It is important that health care providers offer written medical information in different languages, including Spanish, to ensure patients can read and understand health care information that is critical to improving their health (e.g., discharge instructions, treatment plans, phone numbers for providers so that patients can ask follow-up questions).
 - Households in the I-35 Corridor and East Travis County are less likely to have stable access to computers and the internet. These challenges must be considered as Central Health's network of providers begin to deploy innovative technologies to expand access to health services for safety-net communities.

To access the full report, please visit: <https://www.centralhealth.net/knowledge-base/healthcare-equity-plan/>

APPENDIX G: PROJECT CONNECT

Project Connect is a public transportation network project designed for the entire Central Texas region, including new light rail, a subway under downtown and an accessible bus system to better connect neighborhoods in and outside our great city. Project Connect is designed to improve access to essential jobs, health care and education—making our communities more livable, equitable and sustainable. Capital Metro and the City of Austin have formed the Austin Transit Partnership (ATP), an independent organization that will guide the Project Connect investment with transparency and accountability throughout the program.

Through the development process and recognizing that displacement and demographic shifts are ongoing in Austin, the City of Austin Housing and Planning Department developed a mapping tool to guide affordable housing investments and retain existing residents along transit corridors. This dashboard illustrates demographic characteristics of areas within 1 mile of a Project Connect stations in communities with vulnerable, active, and chronic displacement risk. To determine displacement risk, researchers at the University of Texas conducted a three-part analysis: the presence of vulnerable populations, residential market appreciation, and demographic change.

Definitions:

Vulnerable: Neighborhoods in this category include areas with vulnerable residents and no significant demographic change. Some neighborhoods are near or contain areas with high property values and/or high rates of appreciation.

Active Displacement Risk: Neighborhoods in this category include areas with vulnerable residents, active demographic change, and accelerating or appreciating housing market.

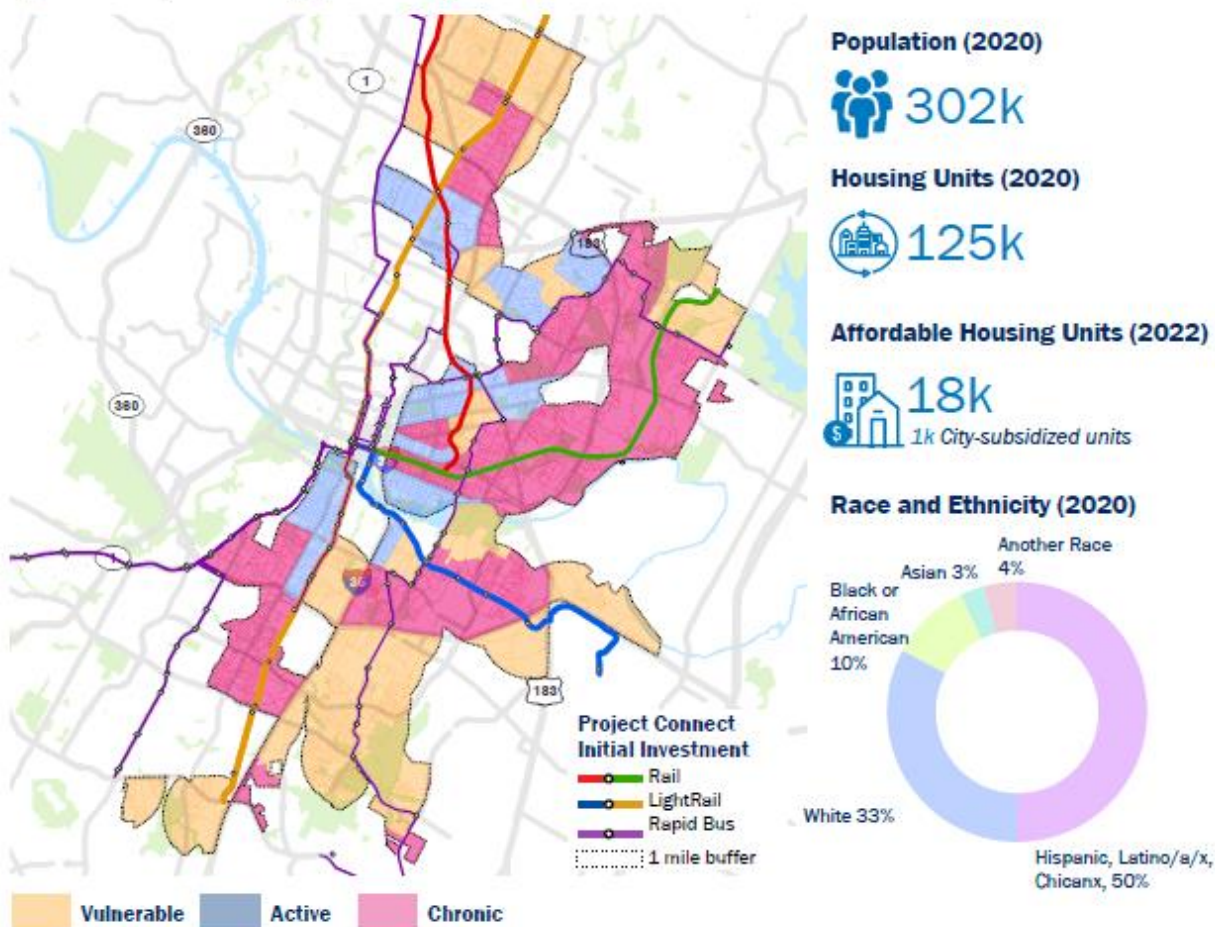
Chronic Displacement Risk: Neighborhoods in this category include areas where vulnerable residents have been displaced, significant demographic change has occurred, and the housing market is high value and appreciated.

Displacement Risk Areas within 1 mile of Project Connect



HOUSING & PLANNING

To determine displacement risk, researchers at the University of Texas conducted a three-part analysis: the presence of vulnerable populations, residential market appreciation, and demographic change.



Indicators of vulnerability (2019)

Five factors were used to determine a neighborhood's vulnerability to displacement as a result of rising housing costs. The presence of more factors increases vulnerability.



APPENDIX H: MAPP PROCESS

In guiding the 2022 CHA, we followed the Mobilizing for Action through Planning and Partnership (MAPP) framework. This framework had been previously used to inform the 2012 and 2017 Austin/Travis County CHAs:

“Developed in 2001, the National Association of County and City Health Officials (NACCHO’s) Mobilizing for Action through Planning and Partnerships (MAPP) framework is now one of the most widely used and reputable community health improvement (CHI) frameworks in the field. MAPP provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action...”

Although a health equity supplement had been added in 2014, NACCHO sought to incorporate social determinants of health and root causes of health inequities more explicitly into the foundation of the MAPP framework. In 2020, NACCHO began discussions for how best to implement health equity efforts and improve engagement and partnerships with those most impacted by inequities. “It is imperative that public health work with other sectors to move beyond traditional and more remedial health and human services to policy, systems, and environmental (PSE) change.” MAPP 2.0 (aka MAPP Evolution) has begun redesigning assessment strategies to further support and integrate health equity into MAPP with formal supports and guidance to facilitate success across diverse communities.

The 2022 CHA builds on the organizational infrastructure established in previous cycles, while incorporating changes made to the framework in the latest, MAPP 2.0. Main changes are succinctly summarized in the following table:

Alignment Across Revised and Historical MAPP Phases	
Historical MAPP Framework	Revised MAPP Framework
Phase 1: Organize for Success Phase 2: Visioning	Phase 1: Build the CHI Foundation
Phase 3: Conduct the Assessments <ul style="list-style-type: none">• Community Health Status• Local Public Health System• Community Themes and Strengths• Forces of Change	Phase 2: Tell the Community Story <ul style="list-style-type: none">• Community Status• Community Partner• Community Context
Phase 4: Identify Strategic Issues Phase 5: Develop Goals & Strategies Phase 6: The Action Cycle	Phase 3: Continuously Improve the Community

DATA SOURCE: National Association of County and City Health Officials (NACCHO), MAPP Evolution Blueprint Executive Summary, November 2020.

<https://www.naccho.org/uploads/downloadable-resources/MAPP-Evolution-Blueprint-Executive-Summary-V3-FINAL.pdf>

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2022 WILLIAMSON COUNTY
community
HEALTH
assessment



Acknowledgments

The dedication, expertise, and leadership of many agencies and people made the 2022 Williamson County Community Health Assessment (CHA) possible. This collaboratively developed plan engaged the community to produce a comprehensive assessment that will be used to develop the 2023–2025 Community Health Improvement Plan. Williamson County and Cities Health District led this CHA effort in collaboration with strong community partners, including Ascension Seton, Baylor Scott & White Health, Bluebonnet Trails Community Services, Georgetown Health Foundation, Healthy Williamson County Coalition, Lone Star Circle of Care, Opportunities for Williamson and Burnet Counties, St. David's Foundation, United Way of Williamson County (which merged with United Way for Greater Austin during the CHA process), and Williamson County. An important aspect of this project was the opportunity it provided for hospital systems and local public health agencies to collaboratively assess the health needs of the community we all serve. This shared ownership of community health among diverse stakeholders enhances coordination and use of resources across entities to improve the community's health. The following organizations graciously supported this project:

Ascension Seton
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 Bluebonnet Trails Community Services
 Georgetown Health Foundation
 Healthy Williamson County Coalition
 Lone Star Circle of Care
 Opportunities for Williamson & Burnet Counties
 St. David's Foundation
 United Way of Williamson County
 Williamson County and Cities Health District
 Williamson County

Organizations that participated in data collection methods include:

Asian American Community Health Initiative	LifePark Center
Baylor Scott and White Health	Lone Star Circle of Care
Bluebonn Trails Community Services	Opportunities for Williamson and Burnet Counties
Boys and Girls Club	Partners in Hope
Catalyst Collective	Pavilion Clubhouse of Williamson County
City of Taylor	Sacred Heart Community Clinic
Community Resource Centers of Texas	The Caring Place
Dickey Museum & Multipurpose Center	The Georgetown Project
Faith in Action Georgetown	United Way for Greater Austin
Georgetown Chamber of Commerce (Hispanic Owned Business Circle)	United Way of Williamson County (now merged with United Way for Greater Austin)
Georgetown Health Foundation	Williamson County and Cities Health District
Georgetown Independent School District	Williamson County Children's Advocacy Center
Hill Country Community Ministries	Williamson County EMS Mobile Outreach Team
Interagency Support Council of Eastern Williamson County, Inc.	Williamson County Juvenile Services
	Workforce Solutions Rural Capital Area

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Executive Summary

Overview

To strategically address health issues within the community, it is vital to sustain broad community partnerships first and develop a shared vision and goals for the future. Led by Williamson County and Cities Health District, the 2022 Williamson County Community Health Assessment (CHA) was developed by a strong task force of community partners (CHA Task Force): Ascension Seton, Baylor Scott & White Health, Bluebonnet Trails Community Services, Georgetown Health Foundation, Healthy Williamson County Coalition, Lone Star Circle of Care, Opportunities for Williamson and Burnet Counties, St. David's Foundation, United Way of Williamson County, and Williamson County. The 2022 CHA is designed to collect and analyze data to educate and mobilize communities, develop priorities, gather resources, plan actions to improve population health, and enable evidence-based goal setting and decision making for Williamson County.

Methodology

The CHA Task Force used a modified format of the Mobilizing for Action through Planning and Partnerships (MAPP) process from the National Association of County and City Health Officials. The MAPP process is a proven systematic framework for identifying community health needs and the resources to meet them. The CHA Task Force used two assessments from the MAPP process: the Community Health Status Assessment and the Community Themes and Strengths Assessment.¹ The findings from each assessment are included as individual sections in the report. Together, the two assessments provide a comprehensive view of the factors influencing the community's health and guide the community's determination of priority areas.

The assessment process involved both quantitative data (e.g., numbers) and qualitative data (e.g., voices of the community) collection through various methods:

- Community Health Survey
- Photovoice (also known as "Youth with Cameras")
- Community and stakeholder focus groups
- Key informant interviews
- Primary and secondary data analysis
- Social Determinants of Health and COVID-19 Vaccine Survey

Community Health Status Assessment

The Community Health Status Assessment (CHSA) explores aggregated, population-level data to define the health status of the county and provide key findings to residents and stakeholders. Indicators are divided into 11 broad categories based on the Mobilizing for Action through Planning and Partnerships framework's "Core Indicator List." The CHSA draws comparisons between Williamson County and Texas health indicators, as well as applicable targets from the U.S. Department of Health and Human Services' Healthy People 2030 initiative.² The CHA Task Force obtained data from many primary and secondary sources at the local, state, and national levels. Significant secondary data sources include American Community Survey, Texas Department of State Health Services, and the U.S. Department of Agriculture. Local organizations, including Bluebonnet Trails Community Services, Hill Country Community Ministries, and Lone Star Circle of Care, also provided primary data.

In 2020, the **TOP 10 CAUSES OF DEATH** in Williamson County were³:

- | | |
|-----------------------------------|---------------------------------------|
| 1. Heart diseases | 6. Unintentional Injuries |
| 2. Cancer | 7. Chronic lower respiratory diseases |
| 3. Alzheimer's disease | 8. Parkinson's disease |
| 4. Coronavirus disease (COVID-19) | 9. Suicide |
| 5. Cerebrovascular diseases | 10. Influenza and pneumonia |

¹ "Phase 3: Collecting and Analyzing Data."

² "Healthy People 2030."

³ "Underlying Cause of Death 1999-2020: 15 Leading Causes of Death: Williamson County, TX on CDC WONDER Online Database."

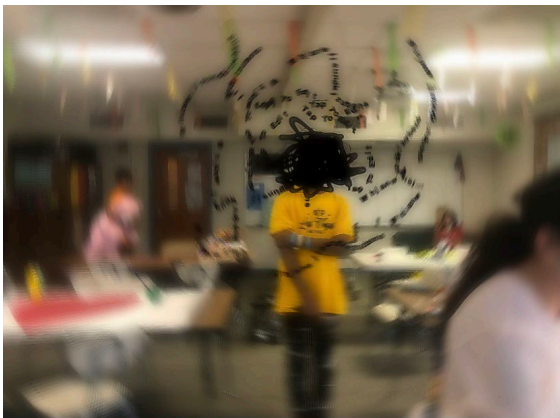
Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment (CTSA) identifies current community concerns, perceptions about quality of life, and community strengths and assets through feedback from community stakeholders and the public. The concerns the CTSA found reveal four common themes: 1) the importance of engaging the community to improve health, 2) the connection to mental health, which was found to be woven throughout all the health concerns; 3) the impact of disparities, which exist in health across the county; and 4) effects of the COVID-19 pandemic, which has changed people's lives and opportunities to achieve health in many ways.



STRENGTHS AND ASSETS

- Communication and collaboration between agencies that provide community resources
- Availability of quality healthcare services
- Availability of community programs and services
- Availability of fresh food
- Availability of parks, green spaces, and opportunities for exercise
- Low crime/safe neighborhoods
- Good schools
- Mental health awareness
- Local assets and wealth



CONCERNS

Access to Healthcare

- Affordable healthcare for publicly insured or uninsured
- Awareness of resources and support for navigating healthcare system
- Lack of medical insurance
- Culturally and linguistically appropriate care and services

Social and Structural Determinants of Health

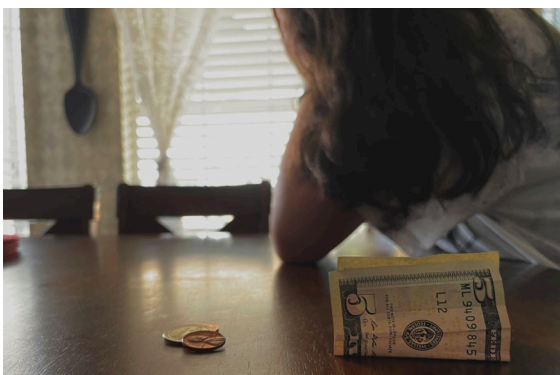
- Housing and homelessness
- Transportation
- Cost of living, affordability, and low socioeconomic status
- Broadband or internet access
- Ethnic and racial segregation

Community Health Needs

- Challenges related to aging
- Chronic disease and chronic disease risk factors
- Dental care
- Mental health, isolation, and substance use

Children's Health

- Child abuse
- Intellectual disabilities
- Mental health



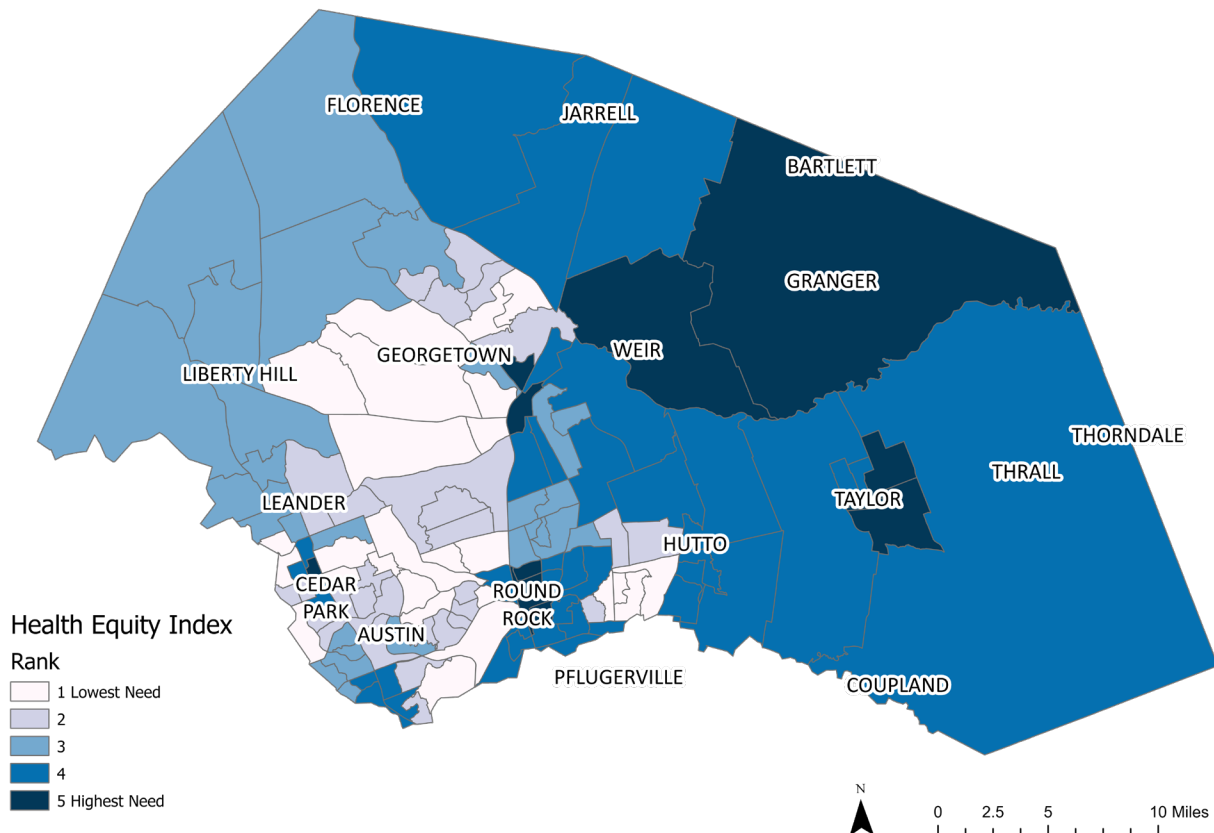
Health Equity Zones

In 2021, Robert Wood Johnson Foundation ranked Williamson County as the second healthiest county in Texas, yet disparities in health and wellness persist.⁴

⁴ "County Health Rankings: Texas."

According to the Robert Wood Johnson Foundation, health equity “means that everyone has a fair and just opportunity to be as healthy as possible.” Health equity is a critical factor that contributes to the economic prosperity, safety, and security of all county residents.⁵

The 2021 Health Equity Index is a measure of socioeconomic need that is correlated with poor health outcomes. In Williamson County, census tracts are ranked from 1 (low need) to 5 (high need) based on their index value relative to similar locations within the county.⁶ Using the index, five health equity zones (HEZs) were identified in Williamson County. These are census tract areas that tend to have higher-than-average health risks and burdens. The HEZs in Williamson County include census tracts in northern rural Williamson County (Bartlett/Granger/Weir), Taylor, Georgetown, Round Rock, and Cedar Park.



Top Health Priorities

The Community Health Assessment (CHA) is just the first step of the community health improvement process. The companion document, the Community Health Improvement Plan, will be the community’s action plan for addressing the top health priorities and coordinating countywide efforts for the next three years. Through feedback and prioritization from residents, stakeholders, and the two Mobilizing for Action through Planning and Partnerships assessments, the CHA identified four health focus areas for decision makers to prioritize to improve health and wellness for all.

Unlike the health priorities in the past two CHAs, these are not ranked, as doing so would neglect the intertwined nature of the top health priorities. Quantitative and qualitative data show the importance of taking a whole-person- and whole-community-centered approach to improving health, for example, supporting holistic healthcare that includes mental health and basic needs, like transportation and housing. Furthermore, data show that the needs of the communities, cities, regions, and neighborhoods in Williamson County differ.

⁵ “What Is Health Equity?”

⁶ “2021 Health Equity Index.”

In developing solutions to health disparities, groups should focus not only on countywide efforts, but also on efforts targeted to each community, neighborhood, and region. More importantly, communities' needs are often better met by equipping them to make decisions that will impact health. By including community members in planning and by facilitating community-led efforts, groups can ensure their resources are used for appropriate and sustainable interventions.

The following are the top health priorities as identified by the 2022 CHA.



Social and structural determinants of health

Focus on improving basic needs (housing, transportation, broadband or internet access, and living wages) for all and eliminating ethnic and racial segregation.

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



Mental health and well-being

Focus on building resilience by improving mental health for children and youth and mitigating the impact of the COVID-19 pandemic.

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



Chronic disease and chronic disease risk factors

Focus on increasing healthy food access and physical activity.

Junk food is widely marketed, available almost everywhere, and is offered at unbeatably low prices, making it a contributing factor to high obesity rates. Healthy foods tend to be much more expensive than unhealthy food. It is difficult to eat healthily when unhealthy foods, such as donuts and cake, are cheaper than healthy food, such as apples. — Summary of discussion with youth Photovoice participant



Access to healthcare

Focus on increasing access to culturally and linguistically appropriate care and dental care for vulnerable populations (e.g., older adults, people of color, and people experiencing homelessness).

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

Conclusion and Implications for Williamson County

The 2022 Community Health Assessment is a comprehensive snapshot of the health and quality of life of Williamson County residents. Though the county consistently ranks among the healthiest in Texas, inequity persists — that is, health is not equally accessible for all community members. Community partners will use this assessment to guide the development of the Community Health Improvement Plan, the community's action plan to address the top health priorities and areas of need in the county. The CHA Task Force hopes this assessment will increase engagement in supporting the health of all who live, learn, work, play, worship, or age in the county and inspire efforts to build a resilient Williamson County.

Introduction

Many factors shape the health and wellness of an individual and a community. According to the County Health Rankings, health is shaped 10% by the physical environment, 40% by social and economic factors, 20% by clinical care, and 30% by health behaviors.⁷

The U.S. Department of Health and Human Services' Healthy People 2030 initiative emphasizes the importance of addressing the social determinants of health to achieving health equity.⁸ Social determinants of health are "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Among the social determinants of health are economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.⁹ To improve the health of all Williamson County residents, the county must improve the places and conditions in which people live.

Sustained and widespread community involvement is necessary to strategically address the health issues within the community. These efforts require the resources of multiple agencies and individuals in a shared ownership structure that offers better mobilization and use of resources to improve community health. The first step in this community health improvement process is the Community Health Assessment (CHA).¹⁰

The CHA is designed to:

1. Collect, analyze, and use data to educate and mobilize communities, develop priorities, gather resources, and plan actions to improve population health
2. Provide a foundation of data to be used for evidence-based goal setting and decision making

Williamson County Community Health Assessment

Williamson County and Cities Health District led the CHA in collaboration with strong community partners. The 2022 Williamson County CHA Task Force (hereafter known as the CHA Task Force) included Ascension Seton, Baylor Scott & White Health, Bluebonnet Trails Community Services, Georgetown Health Foundation, Healthy Williamson County Coalition, Lone Star Circle of Care, Opportunities for Williamson and Burnet Counties, St. David's Foundation, United Way of Williamson County, and Williamson County.

The goals of the CHA Task Force were to:

1. Identify existing and emerging community health needs
2. Identify the strengths and assets available to improve health
3. Determine key issues that affect quality of life
4. Identify top health priorities for future health improvement efforts
5. Identify the ways COVID-19 has impacted the community

Community Description

Williamson County, Texas is bounded by Burnet County to the West, Bell County to the North, Milam and Lee Counties to the East, and Travis and Bastrop Counties to the South. The second healthiest county in Texas, Williamson County has an estimated population of 613,104 residents — a number that has grown by about 38.7% over the past ten years.^{11,12} Austin's continued increase in population and development has fueled local growth, with more Williamson County residents commuting into Austin for work each day.

Williamson County is an economic magnet with major employers such as Dell, Sears Teleserv, Emerson, Round Rock Premium Outlets, Baylor Scott & White Health, St. David's Round Rock Medical Center and Georgetown Hospital, Ascension Seton

⁷ "County Health Rankings Model."

⁸ "Healthy People 2030."

⁹ "Social Determinants of Health."

¹⁰ "Phase 3: Collecting and Analyzing Data."

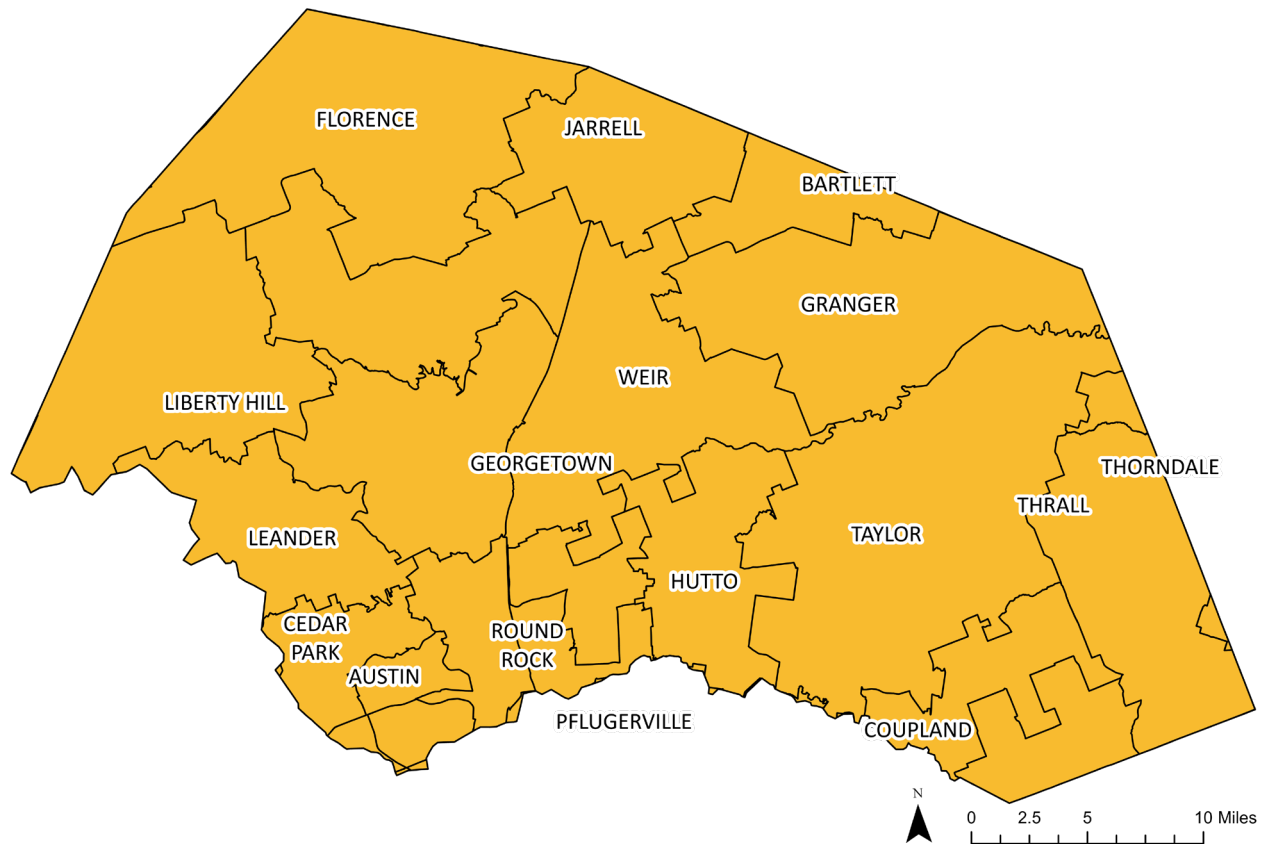
¹¹ "County Health Rankings: Texas."

¹² "2021 Demographics: Williamson County."

Medical Center Williamson, Cedar Park Regional Medical Center, Southwestern University, Texas A&M Health Science Center Round Rock, Texas State University, and TECO Westinghouse.

Figure 1 is a map of Williamson County with city labels and ZIP code outlines.

Figure 1: Map of Williamson County, Texas



Methodology

The Mobilizing for Action through Planning and Partnerships Framework

The Mobilizing for Action through Planning and Partnerships (MAPP) framework from the National Association of County and City Health Officials is a proven, systematic, and outcome-oriented process for the ongoing engagement of community stakeholders. The framework helps communities prioritize public health issues, identify resources available, and act. The CHA Task Force used this process to provide an update to the 2019 report. The MAPP framework (Figure 2) includes four assessments that offer important information for improving community health. Because of time constraints and resource limitations due to COVID-19, the CHA Task Force conducted two of the four assessments to provide a comprehensive understanding of the community's health.¹³ These were:





- The **Community Health Status Assessment (CHSA)**, which identifies priority health issues in the community and looks at health outcomes and health behaviors. Questions answered by this assessment include “How healthy are Williamson County residents?” and “What does the health status of our community look like?”
- The **Community Themes and Strengths Assessment (CTSA)**, which identifies important issues in the community and answers the questions “What is important to our community?” and “What assets do we have that can be used to improve community health?”

Figure 2: MAPP Framework





Data Collection Methods


The CHA Task Force used both quantitative and qualitative data from primary and secondary data sources to compile the two MAPP assessments and determine health priorities.

	Method	Time Frame	Participants	Results	Assessment
	Community Health Survey	5/3/2021–5/16/2021	1,009 Community residents	Appendix F: Community Health Survey Results	CTSA
	Photovoice (also known as “Youth with Cameras”)	6/10/2021–7/8/2021	8 Youth photographers (Williamson County)	Appendix G: “Youth with Cameras” Photovoice Results	CTSA
	Community and Stakeholder Focus Groups	8/2021–11/2021	21 Community residents and stakeholders	Appendix I: Community Focus Group and Key Informant Results — Texas Health Institute Appendix J: Community Focus Group and Key Informant Results — IBM Watson Health	CTSA
	Key Informant Interviews	8/2021–11/2021	11 Stakeholders	Appendices I and J	CTSA

¹³ “Phase 3: Collecting and Analyzing Data.”

	Primary and Secondary Data Analysis	Dependent on data source	Dependent on data source	Community Health Status Assessment	
				Appendix D: Conduent Healthy Communities Institute Data Scoring Tool Methodology and Results	CHSA
	Social Determinants of Health and COVID-19 Vaccine Survey	10/1/2020–2/12/2021	370 Survey respondents	Appendix H: Social Determinants of Health and COVID-19 Vaccine Survey	CHSA

Community Health Survey

 A countywide Community Health Survey kicked off the first phase of data collection in May 2021. The purpose of the survey was to understand resident perspectives on health and health-related needs, and the results guided topics for subsequent CHA data collection. Survey questions were adapted from the 2018 Community Health Survey, distributed during the 2019 Community Health Assessment process. The CHA Task Force piloted the community survey and adjusted it based on feedback. The Community Health Survey was translated into Spanish, Simplified Chinese, Vietnamese, and Korean. A copy of the Community Health Survey (English) can be found in Appendix E: Community Health Survey. The survey comprised five required questions, four optional demographic questions, and one health leader question. Because of time constraints and COVID-19 restrictions, surveys were disseminated mostly through digital methods: convenience sampling, media distribution, and the NextDoor app.

1. Convenience Sampling — The CHA Task Force partnered with Hill Country Community Ministries to distribute surveys during food distributions and with Williamson County and Cities Health District to distribute surveys at the COVID-19 vaccine distribution site in Taylor.
2. Media Distribution — Links to the electronic survey in English, Spanish, Simplified Chinese, Vietnamese, and Korean were made available on the HealthyWilliamsonCounty.org/CHA website. Organizations included links to the electronic survey in press releases, newsletters, and social media. Advertisements were placed on Community Impact and Healthy Williamson County's Facebook page.
3. NextDoor App — The NextDoor app is a private social network for neighborhoods. Individuals can connect with their neighbors and engage their local community.

The CHA Task Force collected 923 surveys (91.4% of total collected) with a Williamson County ZIP code. Of these, 785 were electronic (85%) and 138 were paper (15%).

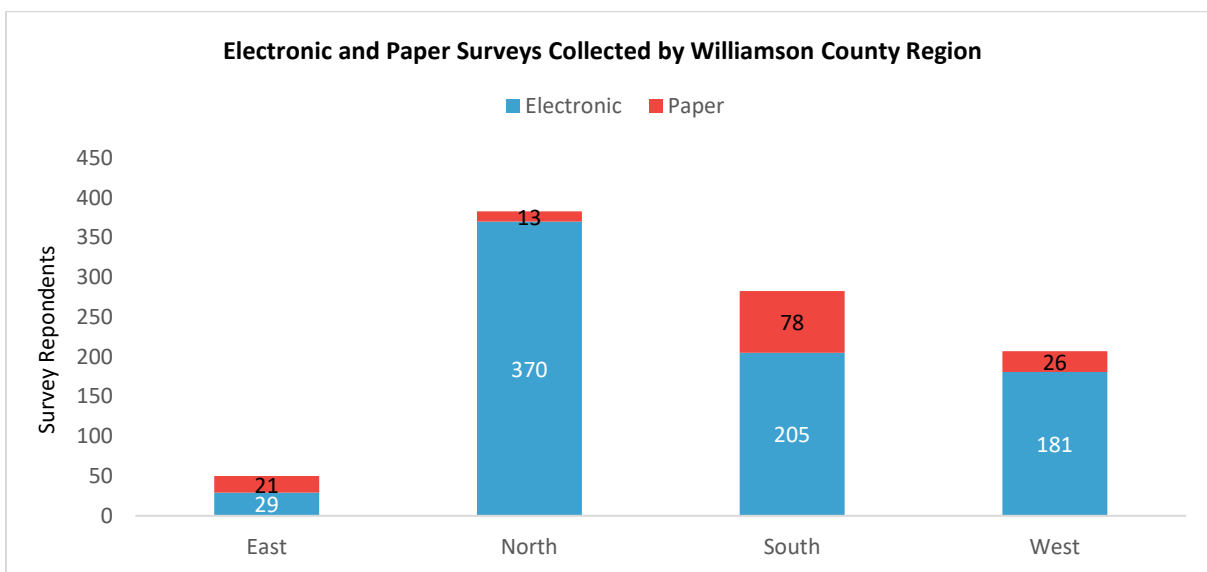
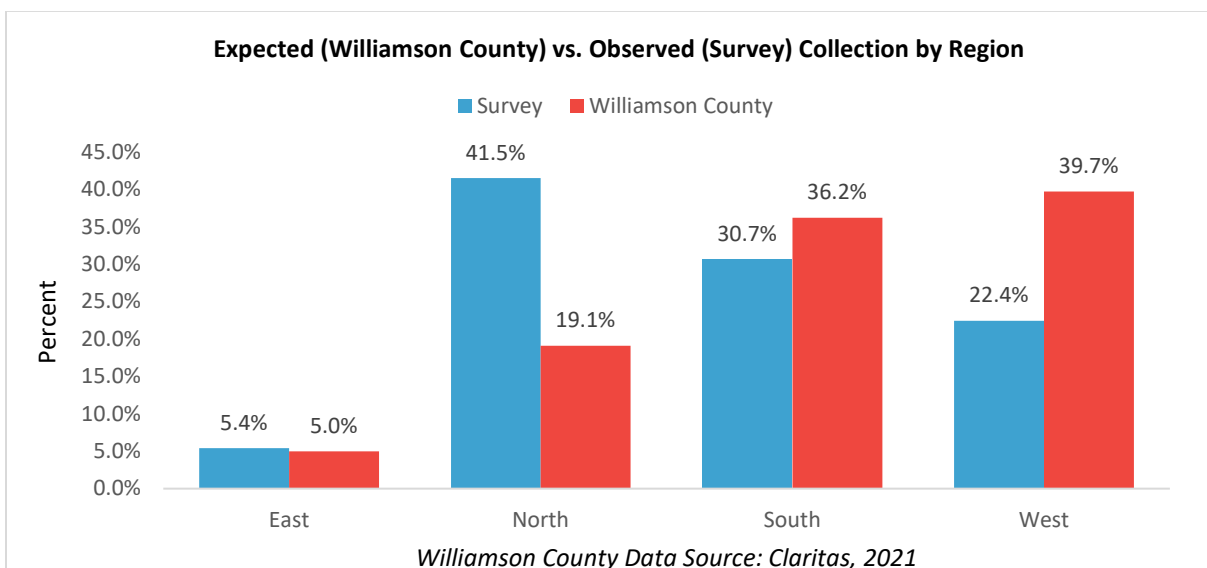
Almost all the surveys (98.0%) collected were in English (Table 1). About 3% of households in Williamson County are linguistically isolated and have difficulty accessing services that are available to fluent English speakers. Linguistic isolation prevents some households from accessing transportation, medical, and social services, as well as employment and educational opportunities. A household is considered linguistically isolated if all adults (those ages 14 and older) in the household speak a language other than English and none speaks English at the level of “very well.”¹⁴

The surveys were separated by region, revealing that the North provided the most surveys (383), followed by the South (283) and the West (207). Paper surveys constituted 42% of surveys collected in the East (Figure 3). The percentage of surveys collected was highest in the North (41.5%), where only 19.1% of the population lives, yet in the West, where 39.7% of residents live, only 22.4% of residents completed a survey (Figure 4). Additional survey results are in Appendix F: Community Health Survey Results.

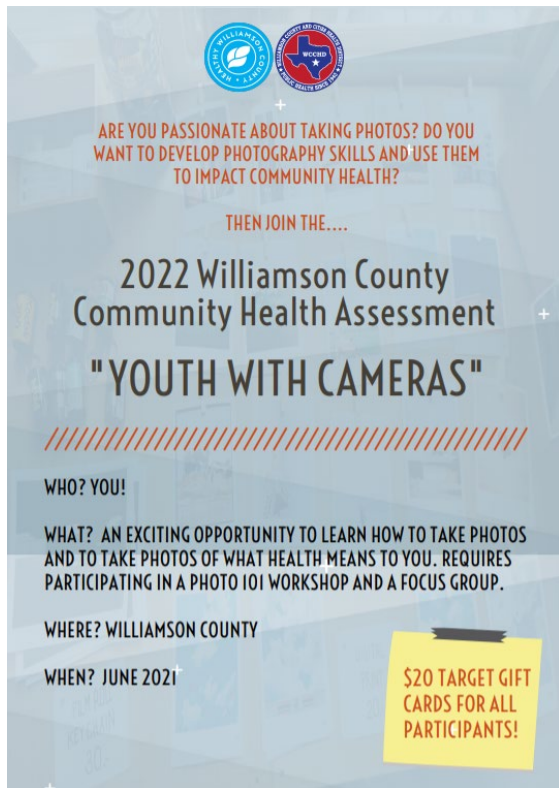
¹⁴ “Linguistic Isolation.”

Table 1: Total Surveys Collected in Williamson County

Survey Type	Count	Percent
Electronic	785	85.0%
English	779	84.4%
Chinese	4	0.4%
Korean	1	0.1%
Spanish	1	0.1%
Paper	138	15.0%
English	128	13.9%
Spanish	12	1.3%
Total	923	100%

Figure 3: Electronic and Paper Surveys Collected by Williamson County Region**Figure 4: Expected (Williamson County) versus Observed (Survey) Collection by Williamson County Region**

Photovoice (also known as “Youth with Cameras”)



The Community Health Assessment is designed to gather information from community leaders, experts, and members of all ages. This information is collected through numerous methods, from surveys and key informant interviews to formal data abstraction and analysis. The Community Health Survey conducted in May 2021 identified three areas of focus:

- Mental health and isolation
- Healthy eating and exercise
- Basic needs

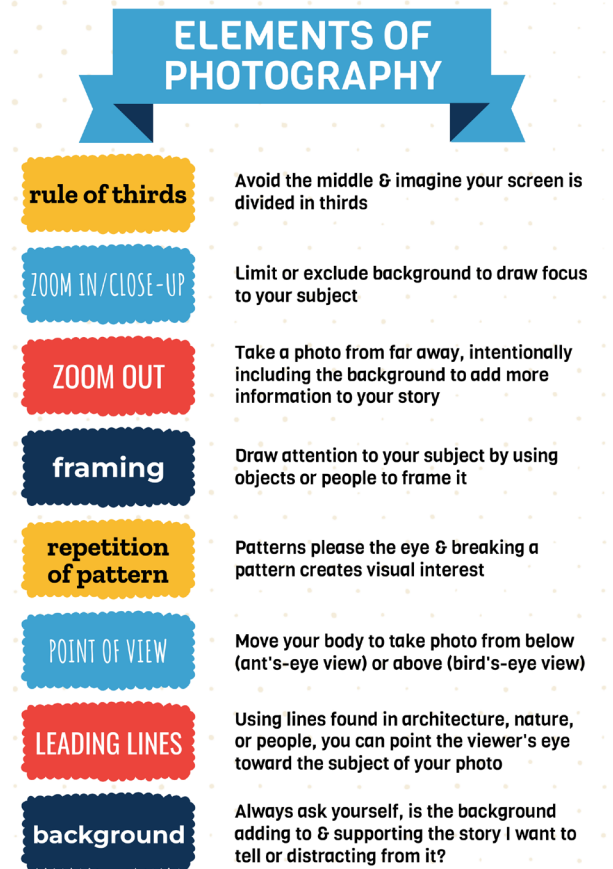
To gain more perspective on these areas, Williamson County and Cities Health District (WCCHD) conducted a Photovoice study in June 2021 to gather insights and ideas from youth in the community. Photovoice is a qualitative method of community-based participatory research that formulates narratives to describe health needs and solutions. WCCHD recruited youth photographers to enhance community leaders' understanding of challenges, strengths, and perspectives faced in the community. This initiative was called “Youth with Cameras” in Williamson County. Youth photographers were given \$20 gift cards for participating.

WCCHD recruited youth by distributing flyers (pictured to the left) through community stakeholders.

Youth photographers were identified through partner organizations: Catalyst Collective, Boys and Girls Club of Georgetown, and The Georgetown Project.

- Catalyst Collective exists to help the next generation bring their unique purpose to life.
- Boys and Girls Club of Georgetown provides a safe space for youth to learn and grow, build relationships with adult professionals, and engage in life-enhancing programs and character development experiences.
- The Georgetown Project's NEST Empowerment Center is a safe haven that offers basic needs, counseling, academic, and enrichment support for Georgetown Independent School District high school students who are homeless, at risk, or living in transition.

After registration and parental consent were complete, there were two Zoom meetings with the photographers. The first was an introductory meeting, in which Meg Green of Safe Austin conducted a 90-minute “Photo 101” workshop to teach ten youth about photography composition and methods to capture meaningful pictures. Green's presentation was summarized in the “Elements of Photography” handout for students (pictured to the right).



Following the workshop, WCCHD investigators explained the three areas of focus that should serve as themes for photographers' pictures from their neighborhoods, home, and local community. Eight youth submitted their photographs to WCCHD over the next two weeks.

The second Zoom meeting was a one-hour focus group with the eight youth who submitted photographs. Three separate focus groups were held: two for youth in the Boys and Girls Club of Georgetown and The Georgetown Project, and one for youth in Catalyst Collective. During these focus groups, photographers were encouraged to use the SHOWD acronym to describe their pictures:

- S: What do you **see**? What is the first thing you notice?
- H: What is really **happening**?
- O: How is this related to **our** lives? Make it personal.
- W: **Why** does this condition exist?
- D: What are some things we can **do** about it?

Additional prompts for the discussions were:

- How does ____ affect you?
- Does ____ affect your community?
- What would you like to see done in your neighborhood? What is on your wish list?

Focus group discussions were recorded, transcribed, and analyzed in Appendix G: "Youth with Cameras" Photovoice Results.

Community and Stakeholder Focus Groups



An outside consultant, Texas Health Institute (THI), conducted two English-speaking focus groups of four to five individuals. A total of nine community residents participated across the county. Focus groups capturing lived experiences and voices were conducted among the following population groups:

- Participants included female residents of ZIP codes 78634 and 78628 with ages ranging from 30 to 65. Participants self-identified as Black/African American, White, and Not Hispanic/Latinx.
- Participants included male and female residents of ZIP codes 78729, 78681, and 78634 with ages ranging from 40 to 65+. Participants self-identified as Mexican/Mexican American/Chicano, Hispanic/Latinx/Spanish origin, White, Not Hispanic/Latinx, and Black/African American.

The CHA Task Force partnered with trusted organizations in the community to recruit participants, who received a \$25 gift card for participating. Facilitators asked open-ended questions to allow participants to share their stories of health and wellness in the community.

A variety of potential focus groups were promoted during the months of September and October through community partners; however, there were many limitations that prevented them from being held. The COVID-19 pandemic has hampered the ability to hold in-person focus groups, limiting the participation of older adults and individuals with digital access issues. Many community partners have reduced participation from the community in their programs and services, resulting in their inability to recruit for focus groups. There is a general sense of COVID-19 fatigue among stakeholders and community members. Results of the focus groups are in Appendix I: Community Focus Group and Key Informant Results — Texas Health Institute.

Another outside consultant, IBM Watson Health — which facilitates health research using digital tools and analytics — conducted one stakeholder focus group of ten to 14 stakeholders. Stakeholders discussed strengths in and challenges to the community's health, access and barriers to good health, community partnerships, and opportunities to improve health in the community, then prioritized community health needs. Summaries are in Appendix J: Community Focus Group and Key Informant Results — IBM Watson Health.

Key Informant Interviews



Texas Health Institute conducted key informant interviews with nine stakeholders from the following organizations:

- Asian American Community Health Initiative
- Workforce Solutions Rural Capital Area
- Georgetown Chamber of Commerce (Hispanic Owned Business Circle)
- Williamson County Children's Advocacy Center
- Williamson County Indigent Care Program at WCCHD
- Dickey Museum & Multipurpose Center
- Georgetown Independent School District
- Harris-Ross Head Start

Key informants discussed strengths in and challenges to the community's health, access and barriers to good health, community partnerships, and opportunities to improve health in the community. Key informant notes are summarized in Appendix I: Community Focus Group and Key Informant Results — Texas Health Institute.

IBM Watson Health conducted seven additional surveys and conducted interviews with the following organizations to supplement the stakeholder focus group:

- Bluebonnet Trails Community Services
- City of Taylor
- Baylor Scott & White Health
- Community Resource Centers of Texas
- LifePark Center
- Sacred Heart Community Clinic
- United Way for Greater Austin

The COVID-19 pandemic required IBM Watson Health to conduct virtual focus groups, web-based video interviews, and telephone interviews as well as expand outreach through a web-based survey. Even with these additional efforts, many key informants were unable to participate due to the later surge of COVID-19 cases (including Delta variant cases) requiring their management, attention, and time. Key informants discussed strengths in and challenges to the community's health, access and barriers to good health, community partnerships, and opportunities to improve health in the community, then prioritized community health needs. Key informant notes are in Appendix J: Community Focus Group and Key Informant Results — IBM Watson Health.

Primary and Secondary Data Analysis



The CHA team obtained data from many secondary sources at the local, state, and national levels. Significant secondary data sources included:

- American Community Survey (ACS)
- Area Health Resource File (AHRF)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Medicare & Medicaid Services (CMS)
- County Business Patterns (CBP)
- Feeding America
- Healthy Communities Institute (Conduent)
- National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
- National Vital Statistics System (NVSS)
- Nielsen Claritas and SiteReports
- Texas Department of Family and Protective Services
- Texas Department of State Health Services (DSHS)
- Texas Education Agency (TEA)
- Texas Office of the State Demographer (OSD)
- Uniform Crime Reporting — FBI
- U.S. Census Bureau (Census)
- U.S. Department of Agriculture (USDA)

Primary data were also obtained from local organizations (listed below) and through the Social Determinants of Health and COVID-19 Vaccine Survey.

- Bluebonnet Trails Community Services
- Hill Country Community Ministries
- Lone Star Circle of Care
- United Way of Williamson County 2-1-1 Hotline
- Findhelp (formerly Aunt Bertha)

The CHA team used the Conduent Healthy Communities Institute (HCI) Data Scoring Tool to rank health topic areas from data on the Healthy Williamson County website, from which most secondary data were gathered. The tool provides a summary of indicator comparisons, which can be used to compare health and health-related issues in a specific community. Scores for indicators and topics are calculated by Conduent HCI's Indicator Management System. The results and methodology are in Appendix D: Conduent Healthy Communities Institute Data Scoring Tool Methodology and Results.

Prioritization of Health Equity Zones and Top Health Priorities.

The 2019 CHA identified health equity zones (HEZs) from available census tract-level measures related to poorer health outcomes. New HEZs will be updated once 2020 Census data are released. Health priorities were selected based on themes identified through the two Mobilizing for Action through Planning and Partnerships assessments as well as prioritization by the community and stakeholders through the Community Health Survey, focus groups, and key informant interviews.

Data Limitations

Community Health Status Assessment

The availability of data sources was the most significant limitation to the Community Health Status Assessment. The lengthy process of data collection, aggregation, and publication by multiple sources prevented access to comprehensive, recent data for the assessment. For some health indicators, the available data were several years old and may no longer be representative of the community. Data may be suppressed and/or limited for certain racial and ethnic groups due to small numbers of significant health events. This restricts the ability to identify disparities among subgroups, namely Asian Americans, American Indians/Alaska Natives, and Native Hawaiians/Pacific Islanders.

The CHA Task Force strived to include the most up-to-date data available, incorporating local data from the most recent full calendar year and certain secondary data from the past two years. However, the most recent data from some secondary data sources were collected more than two years before, limiting the ability to draw full conclusions based on recent data. While there was greater representation of local data from community organizations than in past Community Health Assessments, the CHA Task Force would like to include more local data to provide a truly comprehensive snapshot of health status in Williamson County.

The surveys collected were not geographically representative of Williamson County's population: the proportion of surveys collected from the North region is twice its share of the population, while the proportion of surveys collected from the West region is almost half its share of the population. The proportion of surveys collected from the South and East regions were more representative of their shares of the population.

Community Themes and Strengths Assessment

For the Community Themes and Strengths Assessment, assuring representation from all population groups and sectors in Williamson County proved challenging. Respondents to the Community Health Survey tended to be older, female, and White compared to the demographics of Williamson County. The survey lacked representation from vulnerable populations and minority groups and prevented individuals who have barriers to using the internet or technology from responding.

In accordance with social distancing guidelines during the COVID-19 pandemic, it was necessary to conduct virtual focus groups, which limited individuals with barriers to internet access from participating. Furthermore, it was very difficult to recruit participants despite promotion through community organizations, social media, and press releases. The CHA Task Force sought to conduct focus groups in Eastern Williamson County and among the Spanish-speaking population; however, participation was low, and no focus group was held solely in Spanish. The CHA Task Force planned to hold four community focus groups with Texas Health Institute, of which only two were held.

To compensate for the lack of representation of various populations, key informant interviews with stakeholders were held. Despite holding these virtually, many key informants were unable to participate due to the later surge of COVID-19 cases (including Delta variant cases) requiring their management, attention, and time. Bias in stakeholders' responses should be considered.

COMMUNITY HEALTH STATUS ASSESSMENT



CORE INDICATORS

Based on the NACCHO MAPP Framework

- C1. Demographic Characteristics
- C2. Socioeconomic Characteristics
- C3. Health Resource Availability
- C4. Quality of Life
- C5. Behavioral Risk Factors
- C6. Environmental Health Indicators
- C7. Social and Mental Health
- C8. Maternal and Child Health
- C9. Death, Illness, and Injury
- C10. Communicable Disease
- C11. Sentinel Events
- C12. COVID-19

Overview

The Community Health Status Assessment (CHSA) presents aggregate population-level data in the form of statistics, graphs, charts, and maps to define the health status of Williamson County. Data were obtained from many primary and secondary sources at the local, state, and national levels. The CHA Task Force collected primary data through online and household surveys as well as through focus groups, listening sessions, and Photovoice. Quotes from focus groups are included to provide lived experiences and real-world context to supplement quantitative findings. Secondary data include health indicators, which have been analyzed to compare rates or trends of health outcomes and determinants. The most up-to-date secondary data can be found at the Healthy Williamson County website (www.healthywilliamsoncounty.org). Rankings of topic areas of secondary health data highlighted on the website are found in Appendix D: Conduent Healthy Communities Institute Data Scoring Tool Methodology and Results.

The CHSA divides indicators into 11 broad categories based on the Mobilizing for Action for Planning and Partnerships framework's "Core Indicator List," with a 12th category for COVID-19. Comparisons are drawn between Williamson County and Texas health indicators, as well as

applicable Healthy People 2030 targets. Healthy People 2030 is a nationwide set of ten-year health promotion and disease prevention goals established by the United States Department of Health and Human Services.¹⁵ Achievements and gaps in health status are identified among race, ethnicity, age, gender, or socioeconomic groups within the county. Key findings are summarized at the end of each section to help stakeholders plan, implement, and establish evidence-based health improvements for specific geographic areas and residents of Williamson County.

For the purposes of this assessment, the non-Hispanic White population was referred to as "White," the non-Hispanic African American population was referred to as "Black," and the Asian American population as "Asian." The term "Hispanic" is used and does not distinguish by race, although the definition by the U.S. Census is "Hispanic White."

C1. Demographic Characteristics

The population of Williamson County continues to grow and expand as more people move to Central Texas. Williamson County's growth rate from 2011 to 2021 was 2.5 times that of the state of Texas. This rapid population growth results in a changing population landscape, which will influence the availability of health resources and services.

The tables, maps, and discussions in this section examine three key topic areas: demographic distribution, population change, and population projection. Demographic distribution describes gender, age, race, and ethnicity of Williamson County residents. Population change identifies growth and migration in the county, specifically by city and ZIP code. Lastly, population projection predicts county growth by 2050 for gender, age, race, and ethnicity. The continuous tracking of demographic trends will assist strategic planning and program development to address the health status of all Williamson County residents.

Demographic Distribution

The gender distribution in Williamson County is comparable to the gender distribution in Texas, with slightly more females (50.8%) than males (49.2%) in the county (Table 2).

Individuals ages 25 to 44 years make up the largest age group in the county (28.5%) and in Texas (27.5%) (Table 3). Additionally, individuals younger than age 18 years make up 24.9% of the county's population, like they do Texas' (25.5%).

In 2018, the largest racial/ethnic group in Williamson County was White (72.4%), followed by Asian American (8.2%), Other (7.7%), Black/African American (7.0%), American Indian/Alaska Native (0.7%) and Native Hawaiian/Pacific Islander (0.1%)

¹⁵ "Healthy People 2030."

(Table 2). About one in four persons was Hispanic (25.7%). Compared to Texas', Williamson County's population has a higher percentage of White and Asian American persons and a lower percentage of Black/African American, Hispanic/Latino, and Other persons.

Table 2: Demographic Characteristics of Williamson County and Texas, 2021

Demographic Characteristics of Williamson County and Texas, 2021		
Population	Williamson County	Texas
Population Count	613,104	29,570,729
Percent Growth from April 1, 2011, to January 2021	38.7%	15.3%
Sex		
Male	49.2%	49.6%
Female	50.8%	50.4%
Age		
<18	24.9%	25.6%
18-24	8.7%	9.9%
25-44	28.5%	27.5%
45-64	25.0%	23.6%
65+	12.9%	13.5%
Race		
White	72.4%	66.7%
Black/African American	7.0%	12.3%
Asian American	8.2%	5.3%
American Indian/Alaska Native	0.7%	0.7%
Native Hawaiian/Pacific Islander	0.1%	0.1%
Other	7.7%	11.6%
2+ Races	3.9%	3.3%
Ethnicity		
Hispanic/Latino	25.7%	40.9%
Non-Hispanic/Latino	74.3%	59.1%

Data Source: Claritas, 2021

Population Change

Between 2010 and 2020, the county's population grew by 45.6%, which is more than double the growth within Texas (17.8%) (Table 3). Liberty Hill, Leander, and Hutto lead the county in growth, with Liberty Hill reaching growth that is more than seven times the county growth rate and almost 20 times the state growth rate.

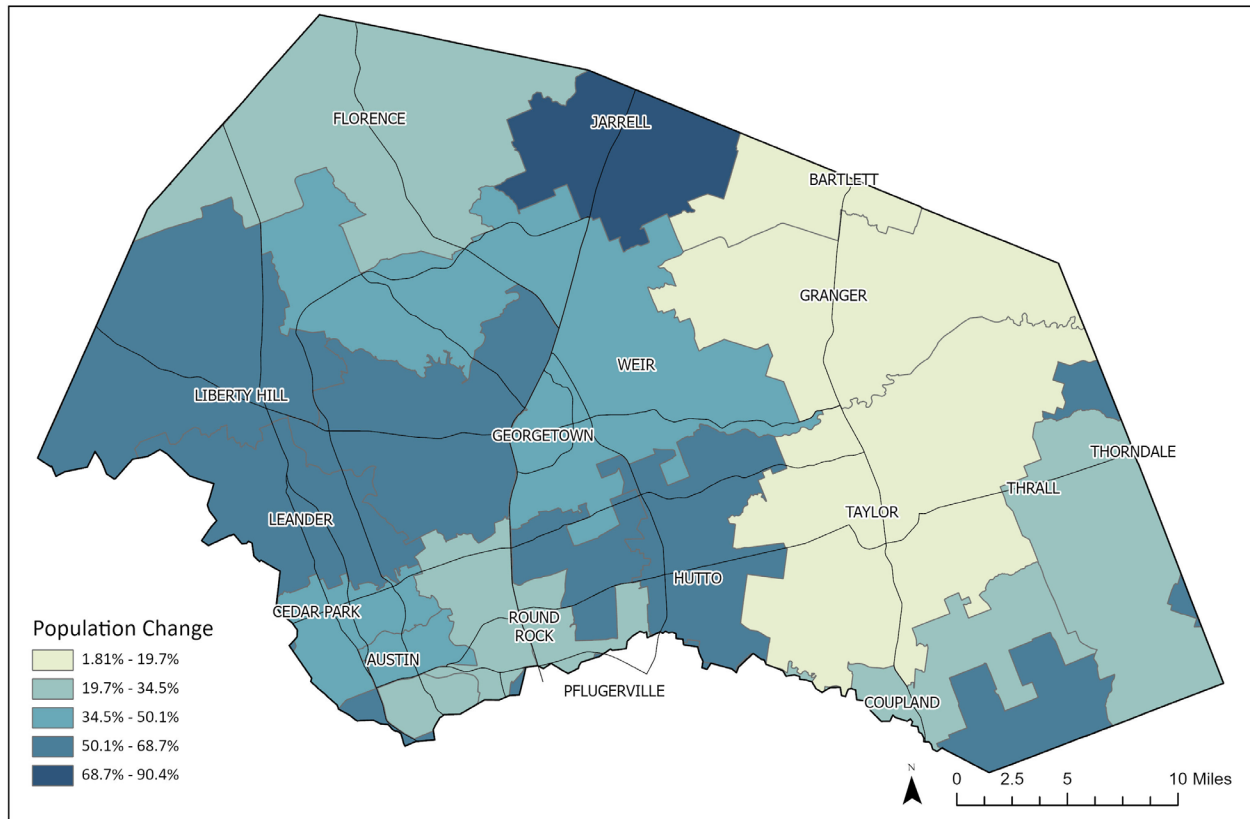
Table 3: Population Change in Williamson County and Texas, 2010–2020

Population Change in Williamson County and Texas, 2010–2020			
Geographic Area	2010 Pop. ¹	2020 Pop. ²	% Growth 2010–2020
Texas	24,311,891	28,635,442	17.8%
Williamson County	391,715	570,437	45.6%
Cedar Park	44,877	77,181	72.0%
Georgetown	44,109	75,470	71.1%
Hutto	12,306	26,778	117.6%
Leander	23,295	60,613	160.2%
Liberty Hill	1,028	4,633	350.7%
Round Rock	93,092	128,812	38.4%
Taylor	14,928	17,291	15.8%

Data Sources: ¹American Community Survey (ACS), 2006–2010; ²ACS, 2016–2020

Population change in Williamson County is broken down by ZIP code in Figure 5. All ZIP codes within Williamson County have experienced population growth from 2010 to 2021, ranging from 1.8% in 76511 (Bartlett) to 90.4% in 76537 (Jarrell). Other growing ZIP codes include 78634 (Hutto) at 65.0%, 78665 (Round Rock) at 68.7%, 78641 (Leander) at 60.3%, and 78642 (Liberty Hill) at 61.4%.

Figure 5: Population Change by ZIP Code in Williamson County, 2010–2021



Data Source: Claritas, 2021

Date Created: 7/22/2021

Population Projection

At the current rate of growth, the Office of the State Demographer predicts that the county's population will reach nearly 1.7 million residents by 2050 (Table 4). Williamson County is projected to experience population growth among multiple age, gender, and racial/ethnic groups. The percentage of females is projected to increase from 50.8% to 51.5% by 2050. Among the age groups, only the "65+" population is projected to increase, growing from 12.9% to 18.1%. The percentage of the population that is Hispanic/Latino is projected to increase from 24.4% to 27.1% by 2050, while the percentage of the population that is Asian American is projected to triple, from 6.8% to 25.5%. The percentage of the population that is White Non-Hispanic is projected to decrease from 59.4% to 36.3%.

Table 4: Population Projection by Demographic Characteristics in Williamson County, 2021 and 2050

Population Projection by Demographic Characteristics in Williamson County, 2021 and 2050		
	2021¹	2050²
Population	613,104	1,645,982
Sex		
Male	49.2%	48.5%
Female	50.8%	51.5%
Age		
<18	24.9%	23.9%
18–24	8.7%	7.6%
25–44	28.5%	28.1%
45–64	25.0%	22.3%
65+	12.9%	18.1%
Race/Ethnicity	2019³	2050
White (Non-Hispanic)	59.4%	36.3%
Hispanic/Latino	24.4%	27.1%
Black/African American (Non-Hispanic)	6.1%	6.6%
Asian American (Non-Hispanic)	6.8%	25.5%
Total Other	3.3%	4.5%
American Indian/Alaska Native (Non-Hispanic)	0.2%	N/A
Native Hawaiian/Pacific Islander (Non-Hispanic)	0.1%	N/A
Other	3.0%	N/A

Notes: *Population Projections: 1.0 Migration Rate; N/A: Population Percentages and Projections Not Available.

Data Sources: ¹Claritas, 2021; ²Office of the State Demographer, 2050; ³American Community Survey 5 Year Estimate, 2015–2019

The figures below display population pyramids for Williamson County in 2019 (Figure 6) and 2050 (Figure 7). Population pyramids are used to display population distribution and predict population growth by gender and age groups.

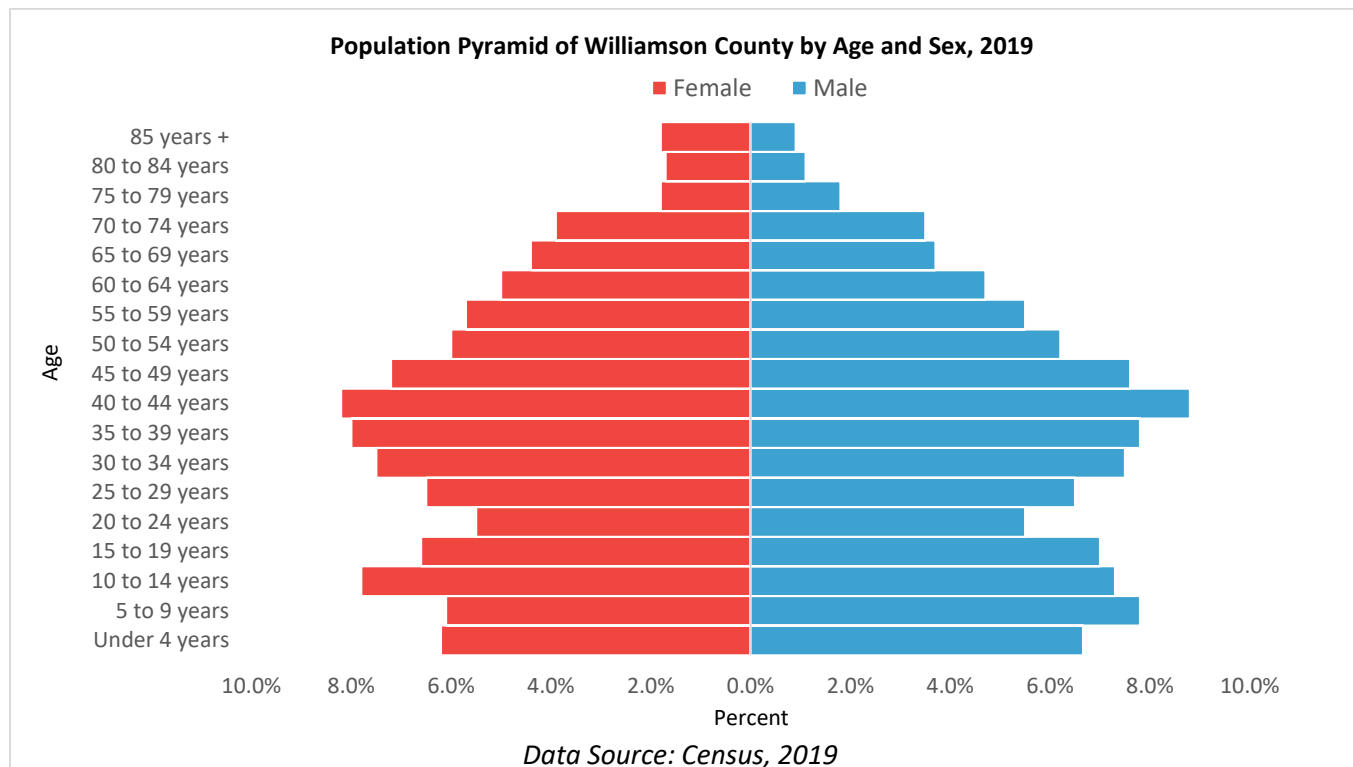
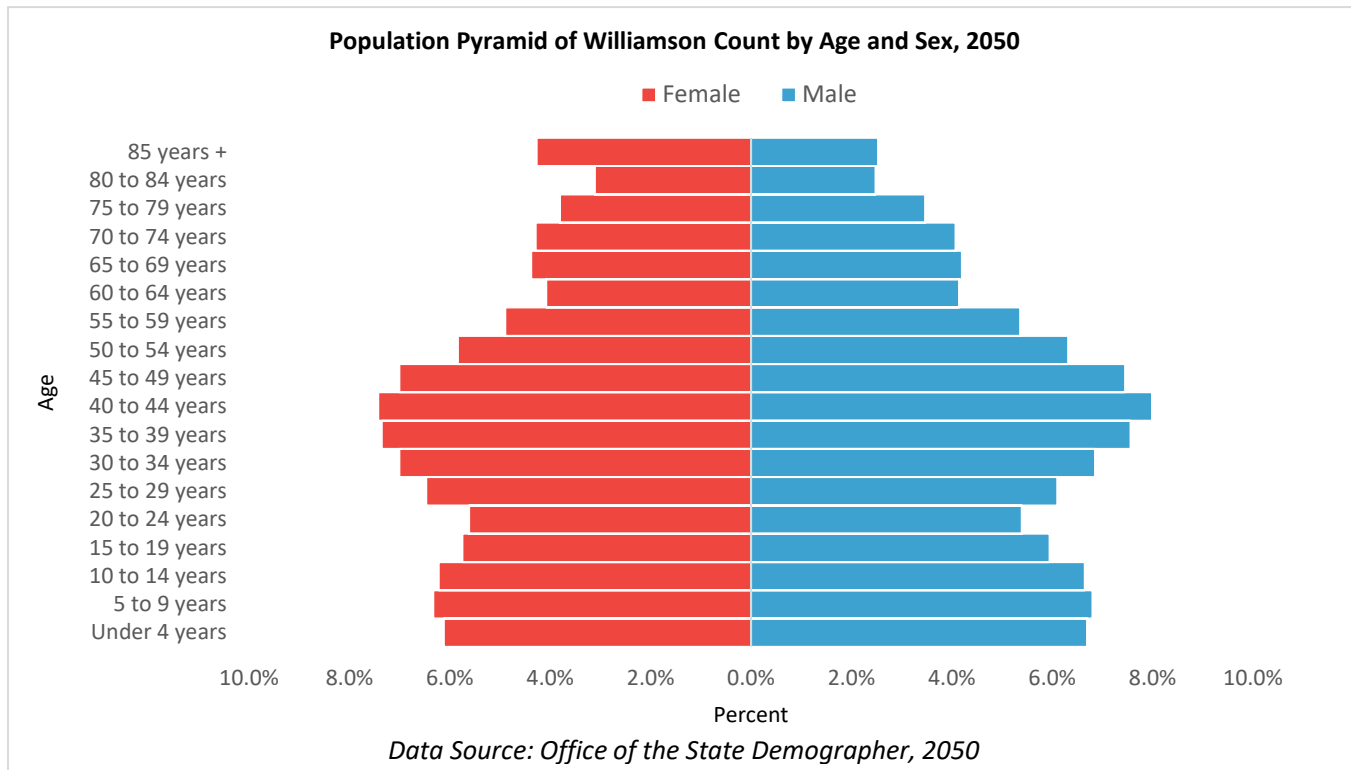
Figure 6: Population Pyramid of Williamson County by Age and Sex, 2019

Figure 7: Population Pyramid of Williamson County by Age and Sex, 2050

Language Spoken at Home

A large majority (73.7%) of Williamson County residents over the age of 5 years speak English at home, as compared to 62.2% of Texas residents (Table 5). Of the Williamson County residents who speak a language other than English at home (26.3%), 18.5% speak Spanish.

Table 5: Language Spoken at Home (Ages 5 and Over) in Williamson County and Texas, 2021

Language Spoken at Home (Ages 5 and Over) in Williamson County and Texas, 2021		
Indicator	Williamson County	Texas
Speak only English	73.7%	62.2%
Speak a language other than English	26.3%	37.8%
Spanish	18.5%	31.7%

Data Source: Claritas, 2021

Key Findings

Williamson County has experienced rapid growth over the past 11 years and will continue to experience significant growth over the next three decades. This growth has the potential to cause a shortage of providers and services, placing greater demands on the healthcare system. In addition, health resources and programs will need to be structured around age, race, ethnicity, culture, language, and geography to accommodate residents of Williamson County. Below are key considerations for stakeholders responsible for healthcare system planning and development.

- **Growing numbers of people are moving to the county, especially to rural areas.** Those living in rural areas cite transportation as a major barrier to healthcare access. A lack of adequate transportation may result in rescheduled or missed appointments, delayed care, and missed or delayed medication use. This ultimately leads to poor management of chronic illness and health outcomes.¹⁶ Programs should strongly consider expanding their services to rural areas to increase healthcare coverage and access.
- **Population growth is expected for those ages 65 and older.** This will increase the prevalence of chronic diseases in Williamson County, since “it has been well established that the incidence of chronic disease rises sharply with age

¹⁶ Syed, Gerber, and Sharp, “Traveling towards Disease: Transportation Barriers to Health Care Access.”

and that the majority of patients with a chronic ailment are over the age of 65 years.”¹⁷ Population aging is associated with an increasing healthcare expenditure. Future planning should consider chronic disease management, quality of life resources, and preventive healthcare for the aging population.

- **The Asian population is expected to triple and the White population is expected to decrease by 23 percentage points by 2050.** These findings should be considered when planning health improvement and intervention strategies. Although White and Asian populations have the same leading cause of morbidity and mortality, programs must be tailored to the target populations, which can be done by designing culturally competent interventions to strengthen awareness, knowledge, and access to clinical and preventive health resources and services.¹⁸

C2. Socioeconomic Characteristics

Socioeconomic characteristics include indicators that affect health status, such as median household income, poverty, unemployment, and education. When examined together, these indicators describe an individual’s socioeconomic status. Research shows that socioeconomic status “is a consistent and reliable predictor of a vast array of outcomes across the life span, including physical and psychological health.”¹⁹

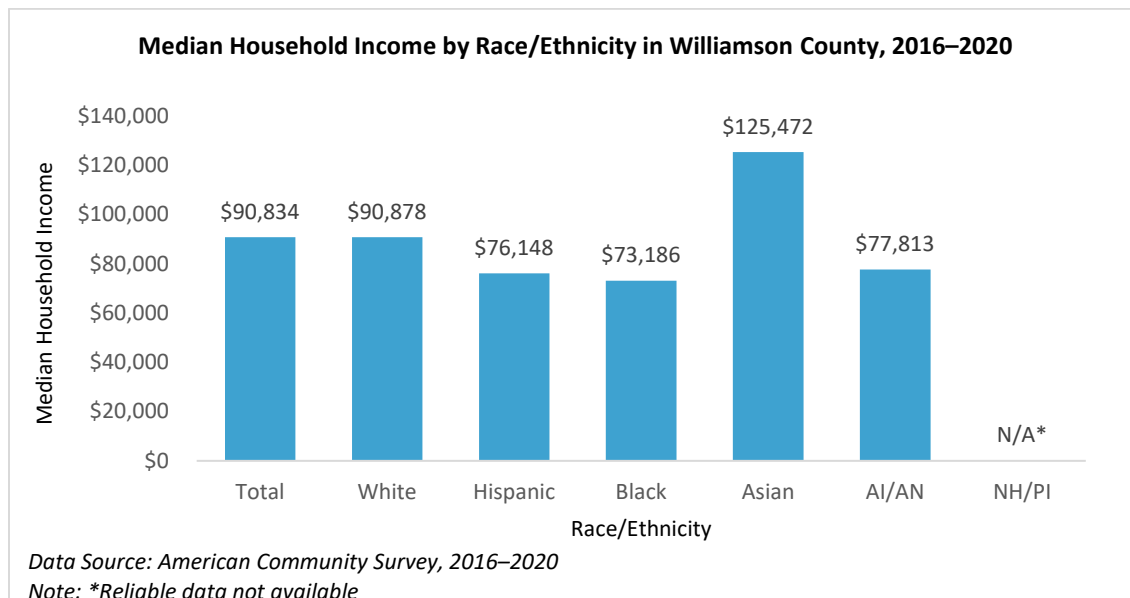
Median Household Income

Why is this important?

“Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. Higher employment rates lead to better access to health care and better health outcomes because many families get their health insurance through the employer. Areas with higher median household incomes also have higher home values and their residents enjoy more disposable income.”²⁰

Williamson County has a median household income of \$90,834, which is about \$27,000 more than the median household income for Texas (\$63,826) (Figure 8).²¹ The White (\$90,878) and Asian (\$125,472) populations have median household incomes above the Williamson County total. The Hispanic (\$76,148), Black (\$73,186), and American Indian and Alaska Native (AI/AN) (\$77,813) populations have median household incomes below the county total.

Figure 8: Median Household Income by Race/Ethnicity in Williamson County, 2016–2020



¹⁷ Prasad, Sung, and Aggarwal, “Age-Associated Chronic Diseases Require Age-Old Medicine: Role of Chronic Inflammation.”

¹⁸ “Profile: Asian Americans.”

¹⁹ “Work, Stress, Health and Socioeconomic Status.”

²⁰ “Median Household Income.”

²¹ “Median Income in the Past 12 Months (in 2020 Inflation-Adjusted Dollars).”

More than one in five (22.5%) Williamson County households earn more than \$150,000, while about one in eight (14.2%) households earns less than \$35,000 (Figure 9). Additionally, more than one in three (36.8%) households earn between \$75,000 and \$149,000, and about one in four (26.5%) households earns between \$35,000 and \$74,999. Compared to Texas, Williamson County has a higher percentage of households that earn \$75,000 or more, while Texas has a higher percentage of households that earn less than \$75,000 (Figure 9 and Figure 10).

Figure 9: Household Income Distribution in Williamson County, 2016–2020

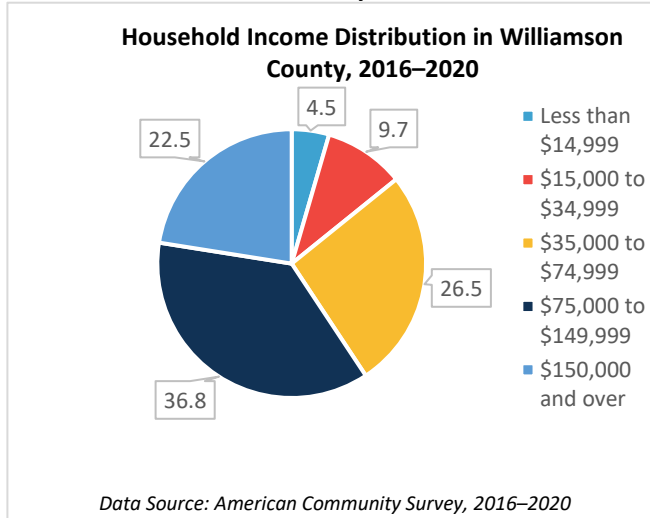
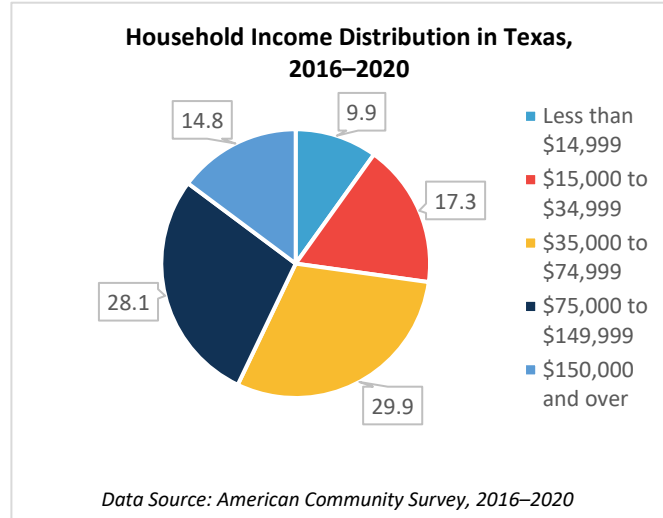


Figure 10: Household Income Distribution in Texas, 2016–2020



Poverty

Why is this important?

“A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased taxes and buying power, poverty is associated with lower-quality schools and decreased business survival.”²²

Williamson County has a lower percentage (6.1%) of individuals living below the federal poverty line compared to Texas (14.2%) (Table 6). The percentage of adults ages 65 and older who are living in poverty is 5.4% in Williamson County and 10.7% in Texas. Of Williamson County adults ages 18 to 64 with any disability, 10.2% are living in poverty; in Texas, 20.0% are living in poverty. The percentage of youth under age 18 who are living in poverty is 6.3% in Williamson County and 20.0% in Texas.

Table 6: Percent of Residents Living Below the Federal Poverty Line (FPL) in Williamson County and Texas, 2016–2020

Percent of Residents Living Below the Federal Poverty Line (FPL) in Williamson County and Texas, 2016–2020		
Indicator	Williamson County	Texas
People Living Below FPL	6.1%	14.2%
People 65+ Living Below FPL	5.4%	10.7%
People with a Disability Living Below FPL	10.2%	20.0%
Children Under 18 Living Below FPL	6.3%	20.0%

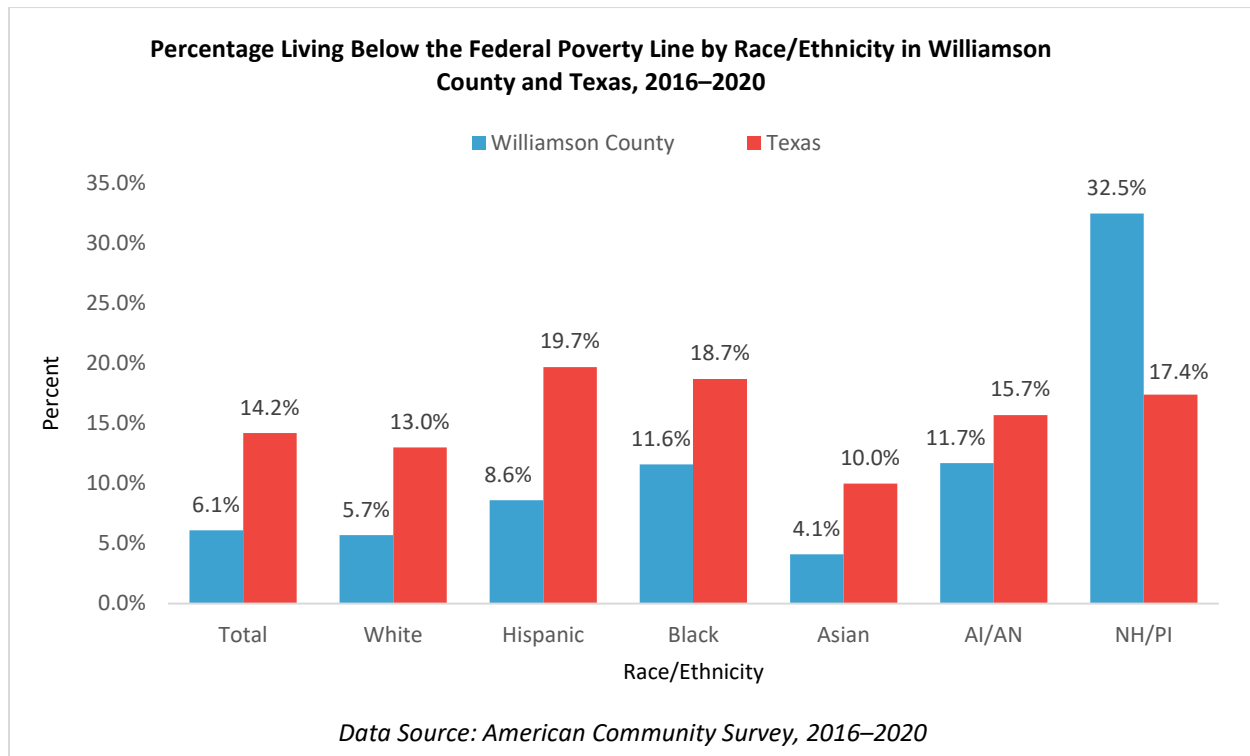
Data Source: American Community Survey, 2016–2020

Williamson County has lower percentages of residents living below the federal poverty line across most racial/ethnic groups compared to Texas (Figure 11). In Williamson County, the percentages of residents living in poverty among the White (5.7%) and Asian (4.1%) populations are lower than the overall county value of 6.1% (Figure 11). In contrast, the percentages of residents living in poverty among the Hispanic (8.6%), Black (11.6%), American Indian and Alaska Native (AI/AN) (11.7%), and Native Hawaiian and Pacific Islander (NH/PI) (32.5%) populations in Williamson County are higher than the overall county

²² “Families Living Below Poverty Level.”

value. The percentage of the NH/PI population that is living in poverty is far higher than the percentages among all other racial/ethnic groups and is the only racial/ethnic group of which the percentage of the population living in poverty is higher than that in Texas (17.4%).

Figure 11: Percentage Living Below the Federal Poverty Line by Race/Ethnicity in Williamson County and Texas, 2016–2020



Unemployment

Why is this important?

On the effects of unemployment, Healthy Williamson County writes:

The unemployment rate is a key indicator of the local economy. Unemployment occurs when local businesses are not able to supply enough and/or appropriate jobs for local employees and/or when the labor force is not able to supply appropriate skills to employers. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.²³

About five percent (4.5%) of the Williamson County workforce ages 16 and older is unemployed, compared to 6.4% in Texas (Table 7). Williamson County has the same percentage of veterans unemployed (4.6%) as Texas (4.6%).

Table 7: Percentage of Civilian Workforce Unemployed in Williamson County and Texas, 2021

Percentage of Civilian Workforce Unemployed in Williamson County and Texas, 2021		
Indicator	Williamson County	Texas
Unemployment-civilian* ¹	4.5%	6.4%
Unemployment-Veterans ²	4.6%	4.6%

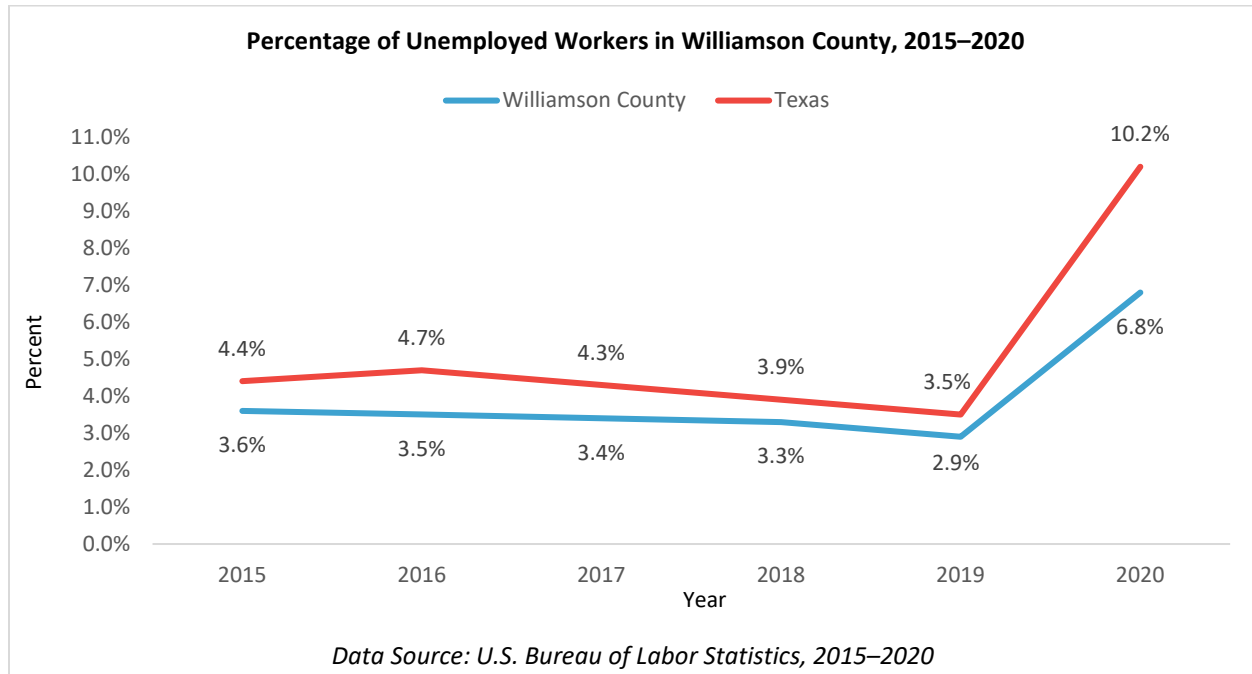
*Notes: *Unemployment Rate as of April 1st, 2021*

Data Sources: ¹U.S. Bureau of Labor Statistics, 2021; ²American Community Survey, 2016–2020

²³ “Unemployed Workers in Civilian Labor Force.”

Between 2015 and 2020, unemployment rates among the civilian workforce were lower in Williamson County than in Texas (Figure 12). However, the percentage of unemployed workers in Williamson County increased from 3.6% in 2013 to 6.8% in 2020.

Figure 12: Percentage of Unemployed Workers in Williamson County and Texas, 2015–2020



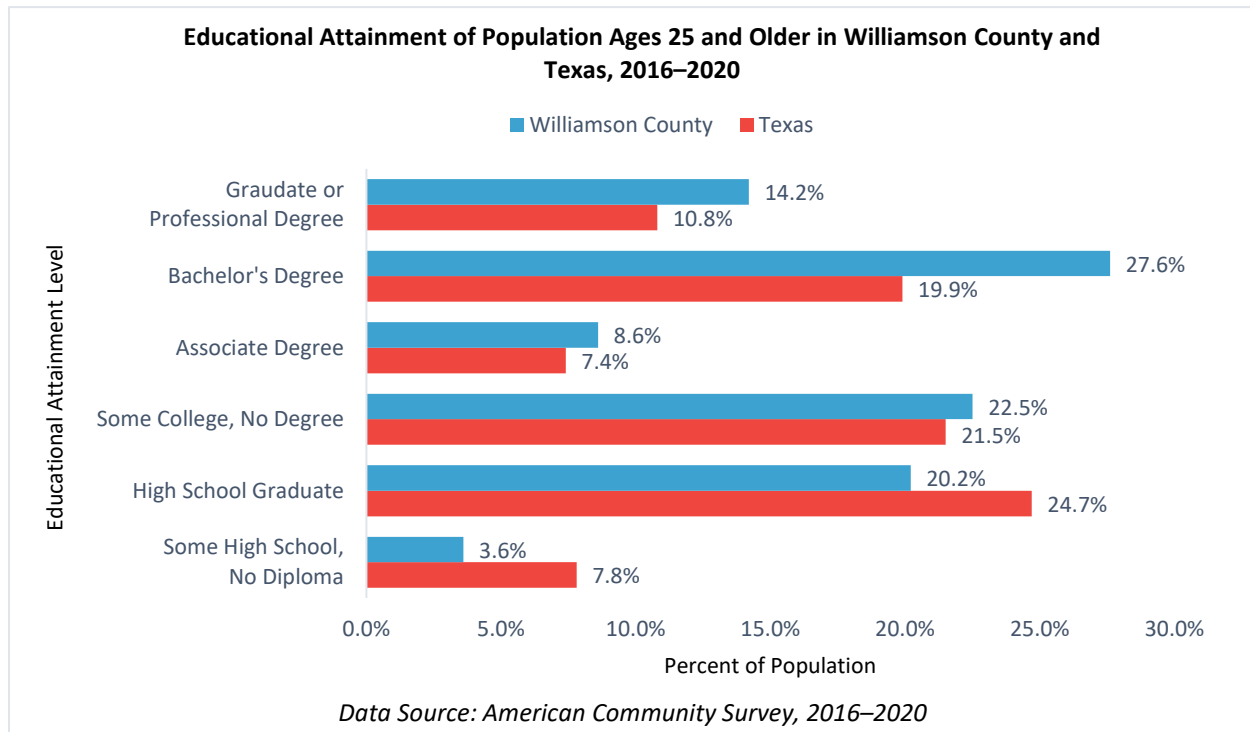
Educational Attainment

Why is this important?

“Graduating high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates are also an important indicator of the performance of the educational system.”²⁴

About 73% of Williamson County adults ages 25 years and older have attained some college- or higher-level education (combined percentages with a graduate or professional, bachelor's, or associate degree, or some college), which is higher than Texas (about 60%) (Figure 13). In Williamson County, about one in 25 residents has some high school education but no diploma (3.6%), and about one in five residents has obtained a high school diploma (20.2%). About one in four residents has some college experience but no degree (22.5%). About one in twelve has an associate degree (8.6%), one in four has a bachelor's degree (27.6%), and one in seven has a master's or doctoral degree (14.2%).

²⁴ “Veterans With a High School Degree or Higher.”

Figure 13: Educational Attainment of Population Ages 25 and Older in Williamson County and Texas, 2016–2020

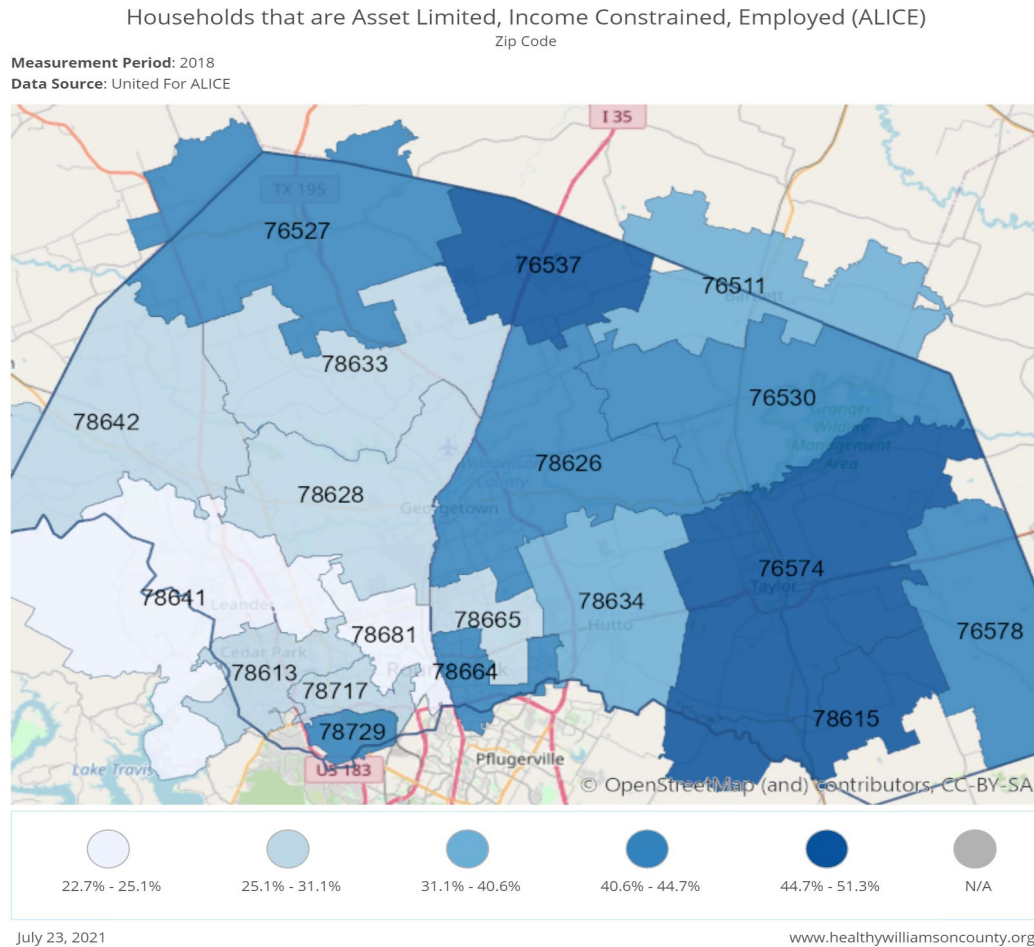
Basic Needs

Why are these important?

The abbreviation ALICE stands for Asset Limited, Income Constrained, Employed. “ALICE households represent men and women of all ages and races who are working but unable to afford the basic necessities of housing, food, childcare, health care, and transportation due to the lack of jobs that can support basic necessities and increases in the basic cost of living.”²⁵ In Williamson County, 33.1% of households are ALICE, which is higher than the Texas value (30.0%).

According to Figure 14, there are higher percentages of ALICE households east of Interstate 35. The highest percentages of households that are ALICE are in ZIP codes 76574 (51.3%), 78615 (49.7%), and 76537 (48.5%).

²⁵ “Households That Are Asset Limited, Income Constrained, Employed (ALICE).”

Figure 14: Households that are Asset Limited, Income Constrained, Employed (ALICE), 2018

Local Spotlight: United Way of Williamson County 2-1-1 Hotline

United Way of Williamson County is focused on “the health, financial stability and education of every person in every Williamson County community.” They do so “by strategically investing in education, financial stability, health and basic needs programs and resources that serve people [and] communities.”²⁶ The 2-1-1 hotline, operated by United Ways across Texas, connects “people with services and resources in their local communities, including people who need financial or other assistance as a result of lost wages from event cancellations, business closures, and quarantines.”²⁷

In the first and second quarters of 2021, 2-1-1 received calls for 8,967 needs in Williamson County. The top needs are listed in Table 8. Figure 15 shows the number of calls by Williamson County ZIP code in 2020. The highest number of calls is from ZIP code 78664, followed by 78613 and 78641.

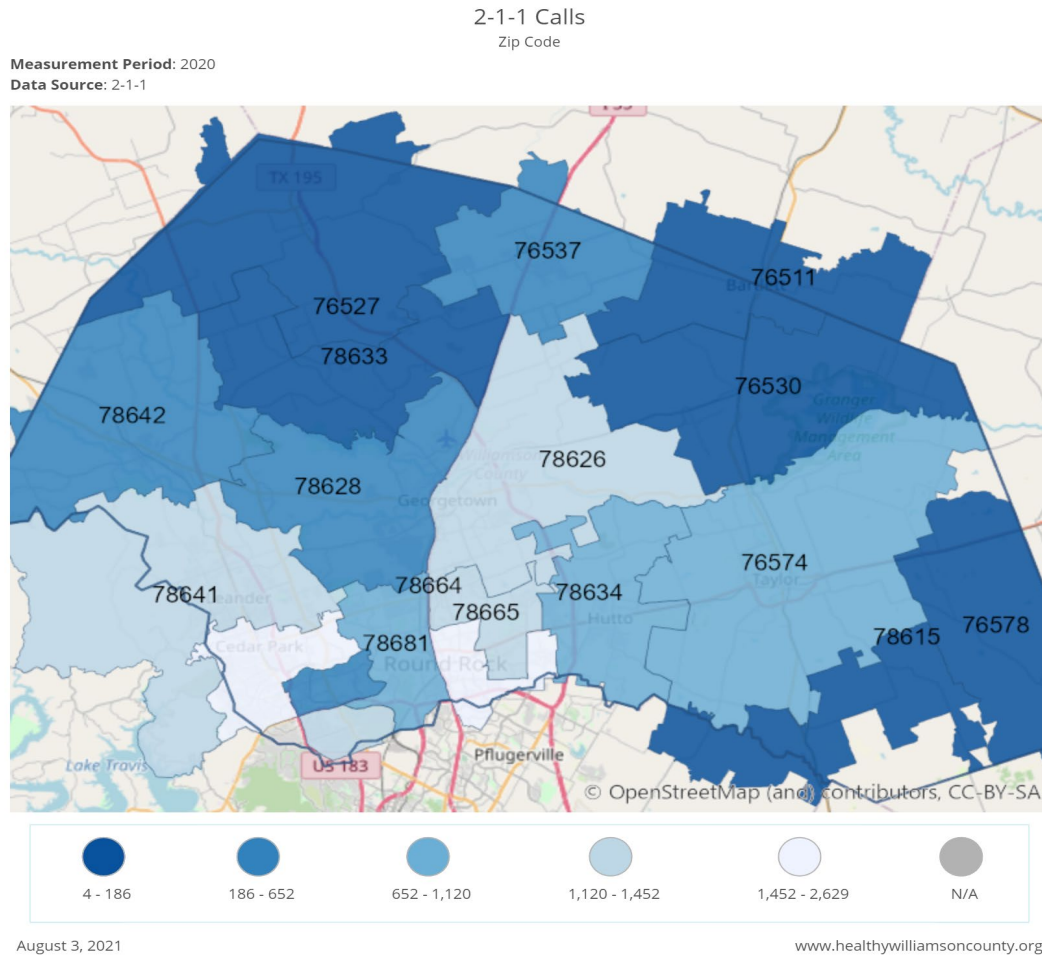
Table 8: Top 2-1-1 Needs in Williamson County, 2021

Top 2-1-1 Needs in Williamson County, 2021	
Top Needs	Number of Calls
COVID-19 Immunization Clinics	1067
Rent Payment Assistance	669
Rent Payment Assistance * COVID-19	625
Vaccine Information * COVID-19	578
Electric Service Payment Assistance	468

Data Source: United Way of Williamson County, January–June 2021

²⁶ “Frequently Asked Questions.”

²⁷ “211 Is Here for Texas Information.”

Figure 15: 2-1-1 Calls by ZIP Code in Williamson County, 2020

Local Spotlight: findhelp

Findhelp (formerly Aunt Bertha) is “a community resource and social services finder often used by Williamson County organizations and residents searching for support services.”²⁸ In the first and second quarters of 2021, people conducted 19,910 searches on findhelp. The top search terms are in Table 9.

Table 9: Most Common Search Terms in findhelp, 2021

Most Common Search Terms in findhelp, 2021	
Top Search Terms	Number of Searches
Help pay for housing	1,130
Help pay for utilities	501
Help find housing	381
Housing vouchers	260
Emergency food	213

Data Source: findhelp, January–June 2021

Figure 16 displays the number of findhelp searches in each ZIP code of Williamson County. The highest number of searches was in ZIP code 78664, followed by 78626 and 78665. Figure 17 displays the percentage of findhelp searches by category in Williamson County. The top categories include housing (43%) and health (21%).

²⁸ “Aunt Bertha Searches.”

Figure 16: Findhelp Searches by ZIP Code in Williamson County, 2018–2020

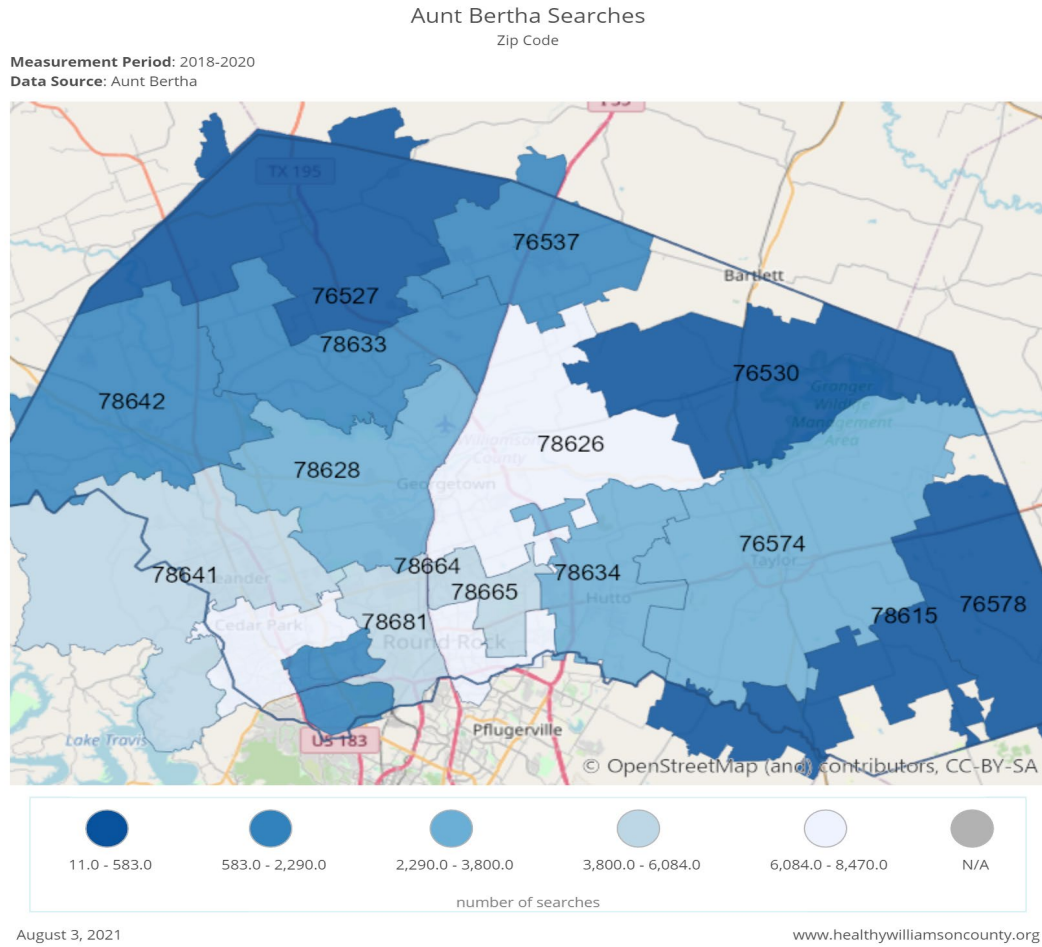
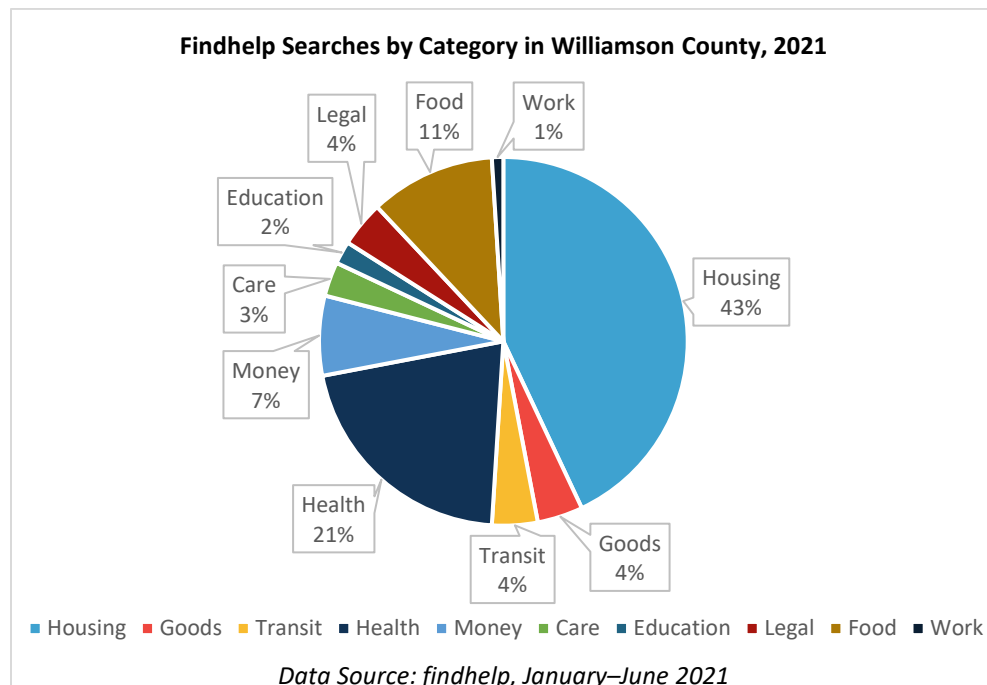


Figure 17: Findhelp Searches by Category in Williamson County, 2021



Key Findings

Although Williamson County fares better than Texas in terms of median household income, poverty, unemployment, and education, many socioeconomic factors should still be considered and addressed. Certain populations have substantially worse socioeconomic status compared to others. This is described in further detail below.

- **One out of three households in the county works but cannot afford basic needs.** “These households struggle to manage even their most basic needs — housing, food, transportation, childcare, health care, and necessary technology.”²⁹ Many people using the 2-1-1 hotline and findhelp need help with COVID-19, housing, rent, utilities, and food.
- **Nearly twice as many adults with disabilities live below the poverty line as the general adult population.** “Persons with a disability are more likely to live in poverty as compared to the rest of the population. The poverty rate is especially high among persons with long-term disabilities. Without adequate income, individuals with disabilities may not be able to afford necessary expenses, such as rent or mortgage, utility bills, medical and dental care, and food. People with disabilities living below the poverty level are more likely to experience material hardship in comparison to others living in poverty.”³⁰
- **6.3% of youth experience poverty, which equates to 10,544 children.** “Family income has been shown to affect a child's well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems like low birth weight or lead poisoning and are more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.”³¹
- **5.4% of older adults experience poverty, which equates to 3,728 people ages 65 years and older.** Older adults “who live in poverty are an especially vulnerable group due to increased physical limitations, medical needs, and social isolation. [Older adults] often live on a fixed income from pensions or other retirement plans and social security. If this income is insufficient in the face of increasing prescription costs and other costs of living, most [older adults] have no way to supplement their income. Retirement plans may be vulnerable to fluctuations in the stock market as well; the increasing reliance of retirees on stock market–based retirement plans may explain why more [older adults] nationwide are now slipping into poverty.”³²
- **The Native Hawaiian and Pacific Islander, American Indian and Alaska Native, Black, and Hispanic populations have the highest rates of poverty.** These groups have median household incomes below the overall county value and/or higher percentages of the population living in poverty than the overall population of Williamson County. “Income inequality is the largest factor contributing to higher poverty rates.”³³

The findings in this section provide evidence for increased efforts to reduce poverty among high-risk groups.

C3. Health Resource Availability

Indicators in this section include the availability of healthcare providers and Federally Qualified Health Centers (FQHCs), preventable hospitalizations, and health insurance coverage. Deficiencies in these areas of the healthcare system may cause delayed or missed care, leading to serious and potentially fatal health outcomes.

Provider Access

Why is this important?

Access to healthcare providers — specifically primary care physicians, mental health providers, and dentists — increases the likelihood that individuals will receive preventive care that mitigates long-term health complications. Increasing healthcare provider access is an important step in reducing health disparities.

²⁹ “Frequently Asked Questions.”

³⁰ “Persons With a Disability.”

³¹ “Children Living Below Poverty Level.”

³² “People 65+ Living Below Poverty Level.”

³³ “Quick Facts.”

Table 10: Provider Access in Williamson County and Texas

Provider Access in Williamson County and Texas		
Indicator	Williamson County	Texas
Primary Care Provider Ratio ¹	1,430:1	1,640:1
Dentist Ratio ²	1,770:1	1,680:1
Mental Health Provider Ratio ³	830:1	830:1

Data Sources: ¹County Health Rankings, 2018; ²County Health Rankings, 2019; ³County Health Rankings, 2020

Findings based on Table 10:

- For every primary care provider in Williamson County, there are 1,430 residents, which is lower than the ratio in Texas (1,640:1).
- For every dentist in Williamson County, there are 1,770 residents, which is higher than the ratio in Texas (1,680:1).
- For every mental health provider in Williamson County, there are 830 residents, which is equal to the ratio in Texas (830:1).

Federally Qualified Health Centers

Why are these important?

Federally Qualified Health Centers (FQHCs) “provide comprehensive health care services to underserved communities. Many of the Texans they serve are indigent, uninsured and underserved. Increasingly more FQHCs offer additional services, such as dental, mental health and/or substance use disorder treatment. Services are provided to Medicare, Medicaid, CHIP, Insured and Uninsured individuals. Patients may be eligible for discounted services on a Sliding Fee Scale based on their family size and income. Additionally, FQHCs cannot deny services due to an inability to pay.”³⁴

Local Spotlight: Lone Star Circle of Care

In Williamson County, Lone Star Circle of Care (LSCC) is the local Federally Qualified Health Center with many locations across the county. In 2020, LSCC served 38,414 residents in Williamson County. Out of 133,735 encounters, one in three was related to pediatrics and one in five was related to each of family practice and mental health (Table 11).

About half of LSCC’s patients were Hispanic (51.5%) (Table 12), and almost two in three were White, Hispanic or Non-Hispanic (Table 13). About one in three was uninsured (29.3%), and two in five had Medicaid or the Children’s Health Insurance Program (CHIP) (44.2%) (Table 14). The top medical conditions treated were overweight and obesity, followed by depression and anxiety (Table 15).

Table 11: Total Number of Encounters for Williamson County Patients by Service Line at Lone Star Circle of Care, 2020

Total Number of Encounters for Williamson County Patients by Service Line at Lone Star Circle of Care, 2020		
Service Line	Count	Percent
Mental Health	24,060	18.0%
Pediatrics	45,151	33.8%
Convenient Care	1,769	1.3%
Senior	4,739	3.5%
Family Practice	27,820	20.8%
OBGYN	21,579	16.1%
Dental	7,254	5.4%
Optometry	1,373	1.0%
Total	133,745	100%

Data Source: Lone Star Circle of Care, 2020

³⁴ “Texas Primary Care Office (TPCO) - Federally Qualified Health Centers.”

Table 12: Ethnicity of Lone Star Circle of Care Patients in Williamson County, 2020**Ethnicity of Lone Star Circle of Care Patients in Williamson County, 2020**

Ethnicity	Count	Percent
Not Hispanic or Latino	16,500	43.0%
Hispanic or Latino	19,802	51.5%
Unreported/Refused To Report	2,112	5.5%
Total	38,414	100%

*Data Source: Lone Star Circle of Care, 2020***Table 13: Race of Lone Star Circle of Care Patients in Williamson County, 2020****Race of Lone Star Circle of Care Patients in Williamson County, 2020**

Race	Count	Percent
Black or African American	3,925	10.2%
American Indian or Alaska Native	436	1.1%
White	23,936	62.3%
Native Hawaiian/Other Pacific Islander	84	0.2%
Unreported/Refused To Report	7,711	20.1%
More Than One Race	931	2.4%
Asian	1,391	3.6%
Total	38,414	100%

*Data Source: Lone Star Circle of Care, 2020***Table 14: Insurance Status of Lone Star Circle of Care Patients in Williamson County, 2020****Insurance Status of Lone Star Circle of Care Patients in Williamson County, 2020**

Insurance	Count	Percent
Uninsured	11,263	29.3%
Medicaid	14,867	38.7%
CHIP	2,129	5.5%
Commercial	8,193	21.3%
Medicare	1,962	5.1%
Total	38,414	100%

*Data Source: Lone Star Circle of Care, 2020***Table 15: Medical Conditions Treated by Lone Star Circle of Care in Williamson County, 2020****Medical Conditions Treated by Lone Star Circle of Care in Williamson County, 2020**

Condition	Patient Count	Encounter Count
Asthma	1,858	2,902
Chronic obstructive pulmonary diseases	404	660
Diabetes	2,599	6,416
Heart Disease	506	838
Hypertension	4,672	9,691
Overweight and Obesity	14,101	25,199
Depression	3,557	16,888
Anxiety	3,056	14,937
Other Mental Disorders	2,615	8,725

Data Source: Lone Star Circle of Care, 2020

Between August 2020 and July 2021, LSCC evaluated social determinants of health (basic and mental health needs) of their patients through the PRAPARE survey tool (Table 16). Lone Star Circle of Care surveyed 9,116 individuals and identified 8,424 needs. Most surveys were collected through clinics in Round Rock, followed by Georgetown and Cedar Park. The top identified needs for all survey participants were mental health needs: social isolation (30.9%) and stress (26.7%). Following those were basic needs: financial (8.9%), housing (8.7%), and transportation (5.6%).

Table 16: Mental Health and Basic Needs Identified through PRAPARE Survey, 2020–2021

	Georgetown		Round Rock		Hutto		Taylor		Cedar Park		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Mental Health Needs												
Social Isolation	826	29.3%	1,265	32.0%	2	22.2%	163	30.2%	346	31.2%	2,602	30.9%
Stress	770	27.4%	1,037	26.2%	4	44.4%	138	25.6%	298	26.8%	2,247	26.7%
Basic Needs												
Transportation	171	6.1%	217	5.5%	1	11.1%	27	5.0%	56	5.0%	472	5.6%
Housing	244	8.7%	337	8.5%	-	0.0%	56	10.4%	93	8.4%	730	8.7%
Financial	234	8.3%	358	9.1%	-	0.0%	58	10.8%	103	9.3%	753	8.9%
Food	110	3.9%	141	3.6%	1	11.1%	15	2.8%	42	3.8%	309	3.7%
Phone	86	3.1%	97	2.5%	-	0.0%	15	2.8%	28	2.5%	226	2.7%
Utilities	102	3.6%	135	3.4%	1	11.1%	21	3.9%	41	3.7%	300	3.6%
Clothing	93	3.3%	120	3.0%	-	0.0%	14	2.6%	35	3.2%	262	3.1%
Healthcare	139	4.9%	199	5.0%	-	0.0%	25	4.6%	52	4.7%	415	4.9%
Childcare	40	1.4%	45	1.1%	-	0.0%	7	1.3%	16	1.4%	108	1.3%
Total Identified Needs	2,815		3,951		9		539		1,110		8,424	
Total # Surveys	2,996		4,236		5		676		1,203		9,116	

Data Source: Lone Star Circle of Care PRAPARE Social Determinants of Health Survey, August 2020–July 2021

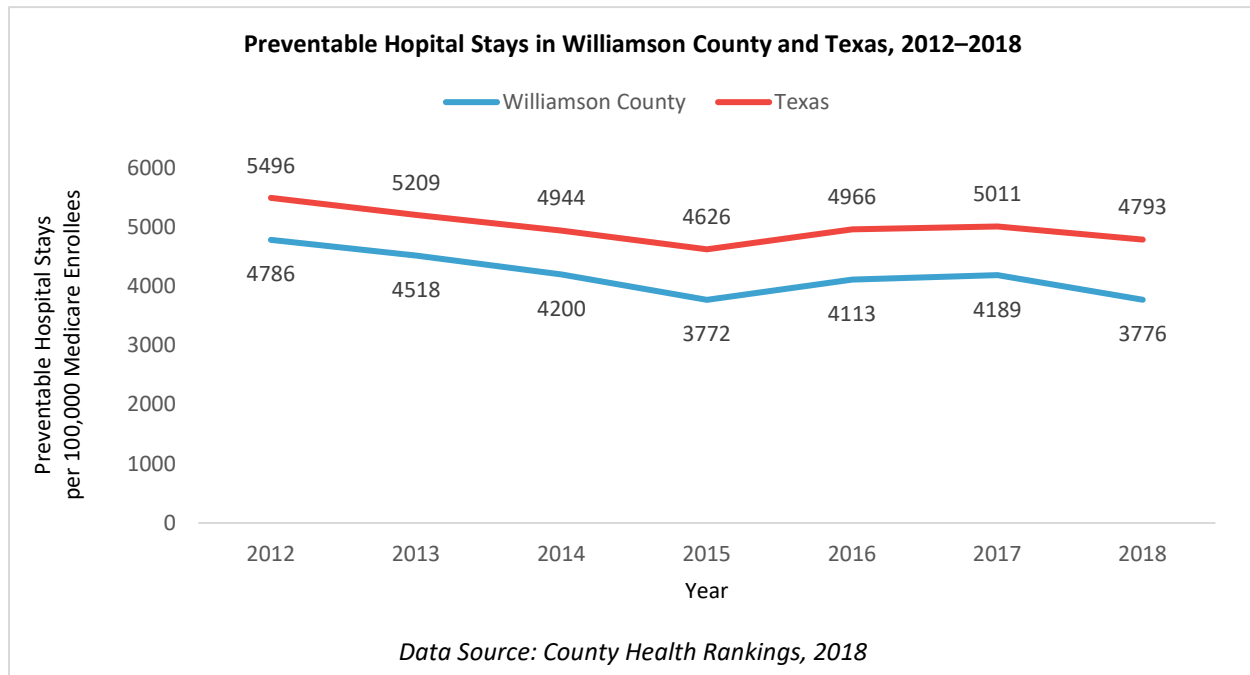
Preventable Hospitalizations

Why is this important?

“Hospitalization for ambulatory-care sensitive conditions, diagnoses usually treatable in outpatient settings, suggests that the quality of care provided in the outpatient setting was less than ideal. This measure may also represent a tendency to overuse emergency rooms and urgent care as a main source of care.”³⁵

In 2018, there were 3,776 preventable hospital stays per 100,000 fee-for-service Medicare enrollees in Williamson County, which is lower than the rate in Texas (4,793 per 100,000 fee-for-service Medicare enrollees) (Figure 18). Annual reported preventable hospital stays for Medicare enrollees in Williamson County have remained lower than Texas rates from 2012 to 2018. Furthermore, both Williamson County and Texas have seen an overall decrease in preventable hospital stays.

³⁵ “Preventable Hospital Stays.”

Figure 18: Preventable Hospital Stays in Williamson County and Texas, 2012–2018

Health Insurance

Why is this important?

Health insurance is important to improving access to care. In the United States, medical costs are exceptionally high, so “people without health insurance may not be able to afford important medical treatments or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat.” People often receive health insurance through their employer, but “many small businesses are unable to offer health insurance to their employees due to rising health insurance premiums.”³⁶

Figure 19 displays the percentage of the population that is without health insurance in Williamson County (9.3%) and Texas (17.2%). When stratified by race/ethnicity, 15.7% of the Hispanic population in Williamson County did not have health insurance, as compared to 9.4% of the White population, 7.1% of the Asian population, and 10% of the Black population.

Figure 20 displays the percentage of the population under age 18 that is without health insurance in Williamson County (6.1%) and Texas (10.9%).

³⁶ “Adults with Health Insurance.”

Figure 19: Percentage of Population without Insurance by Race/Ethnicity in Williamson County and Texas, 2015–2019

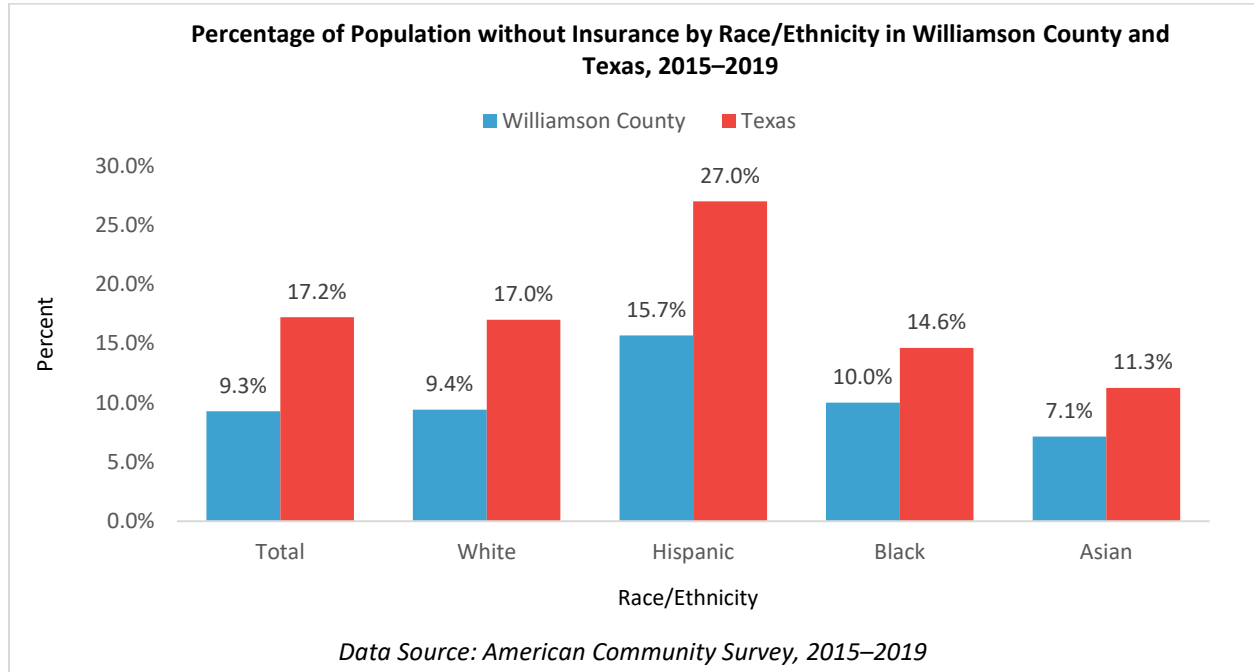


Figure 20: Percentage of Population without Insurance for Children and Persons in Williamson County and Texas, 2015–2019

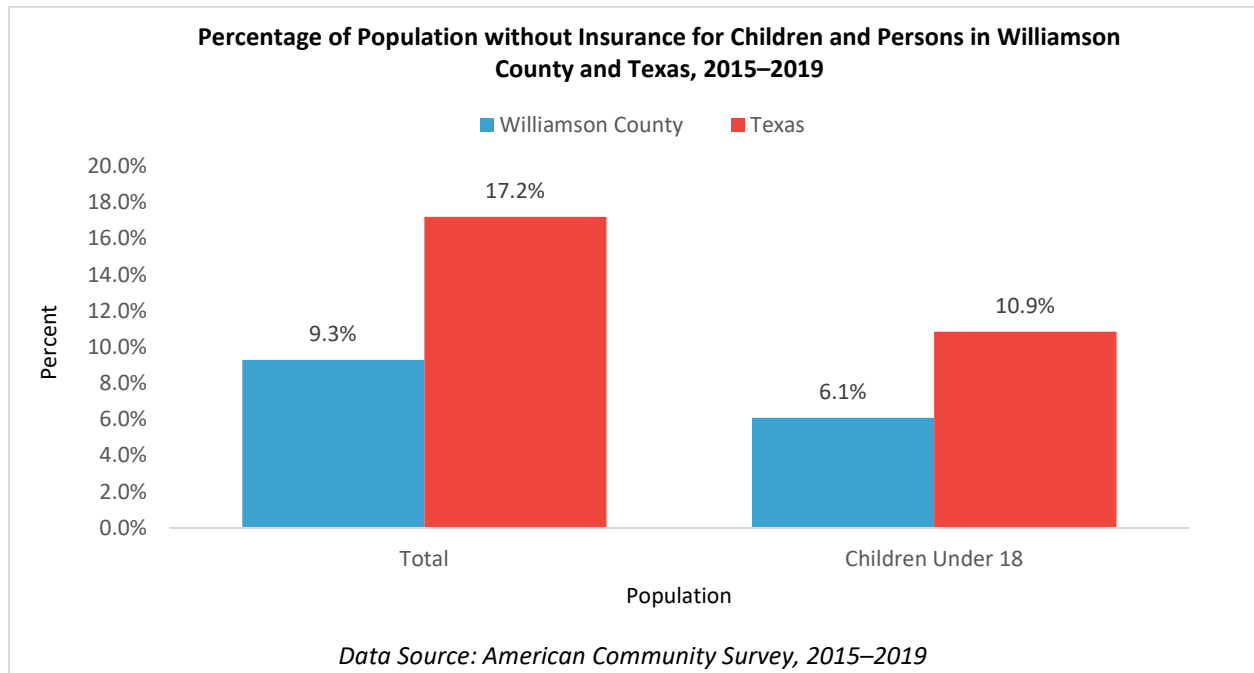


Figure 21 examines the total population without health insurance across various income levels in Williamson County and Texas. In Williamson County, 20% of households with an income below \$25,000 do not have health insurance, compared to 26.1% in Texas. The percentage of the population that is uninsured increases as household income decreases.

Figure 21: Percentage of Households without Insurance by Household Income in Williamson County and Texas, 2015–2019

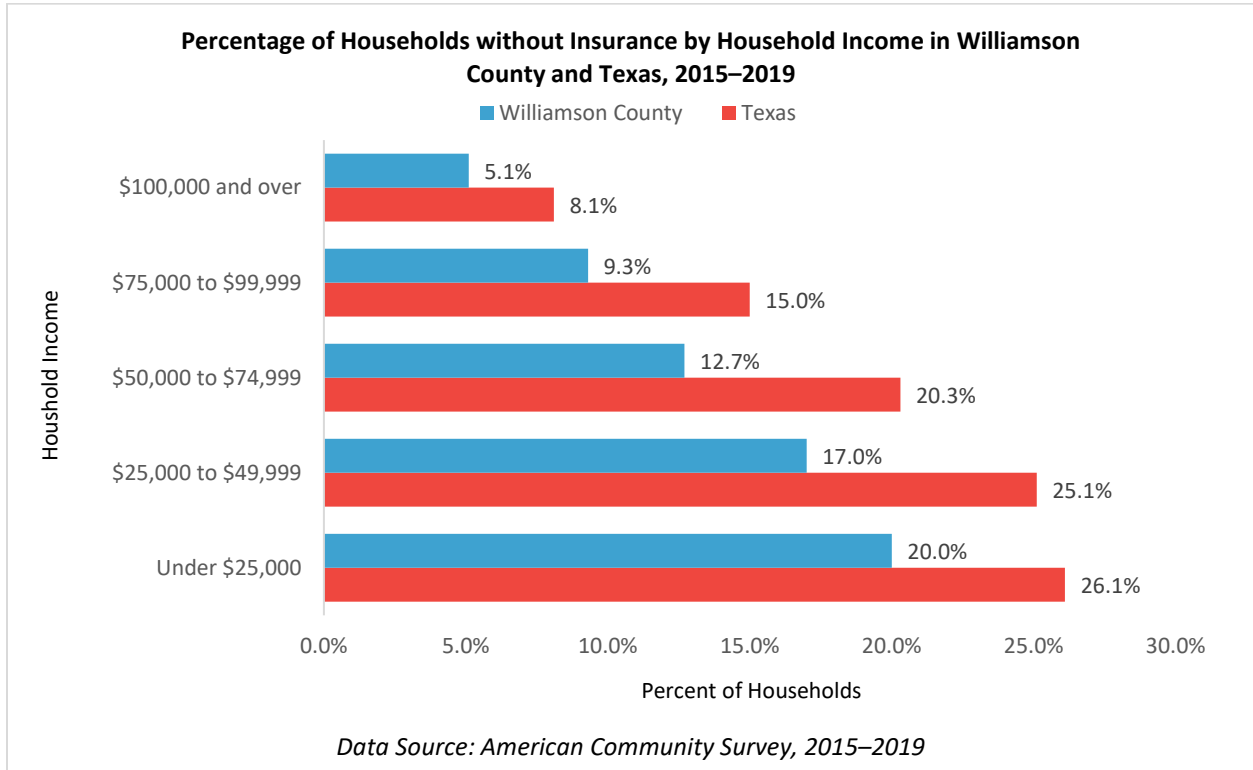
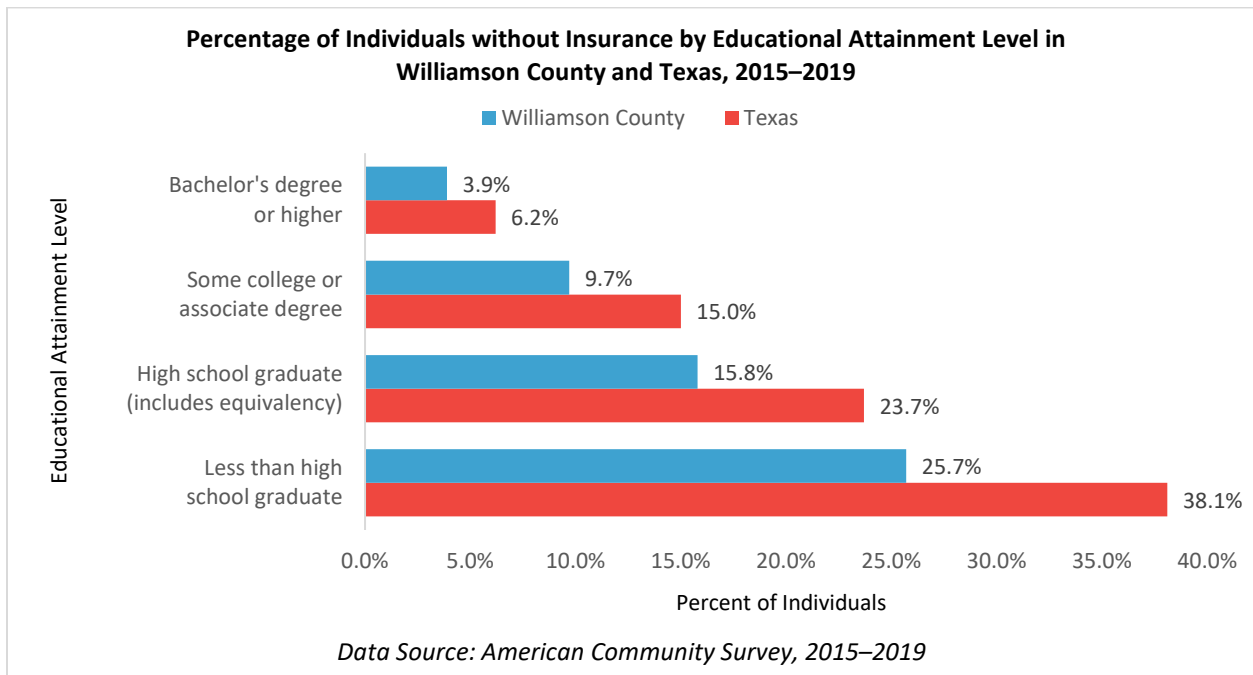


Figure 22 examines the adult population (ages 26 and older) without health insurance across various educational attainment levels in Williamson County and Texas. Of those with less than a high school diploma in Williamson County, 25.7% do not have health insurance, compared to 38.1% in Texas. Percent uninsured increases as educational attainment level decreases.

Figure 22: Percentage of Individuals without Insurance by Educational Attainment Level in Williamson County and Texas, 2015–2019



Key Findings

When the CHA Task Force examined healthcare resource availability in Williamson County, multiple gaps stood out. These should be addressed by stakeholders within the healthcare system as well as those who develop policies regarding healthcare and health insurance.

- **The ratio of dental providers is worse in the county than in Texas.** “Oral diseases—which range from cavities to gum disease to oral cancers—cause pain and disability for millions of Americans.”³⁷ “Professional dental care helps to maintain the overall health of the teeth and mouth and provides for early detection of pre-cancerous or cancerous lesions. People living in areas with low rates of dentists may have difficulty accessing the dental care they need.”³⁸
- **Hispanic residents are the most uninsured group in the county.** The Hispanic population has the highest uninsured rate (16%), followed by Black (10%) and White (9%) residents. Those with a high school diploma as their highest level of educational attainment and who are living in poverty are more likely to lack health insurance.
- **The top medical conditions treated by the local Federally Qualified Health Center are overweight and obesity, followed by depression and anxiety.** Federally Qualified Health Centers (FQHCs) “provide comprehensive health care services to underserved communities. Many of the Texans they serve are indigent, uninsured and underserved. Increasingly more FQHCs offer additional services, such as dental, mental health and/or substance use disorder treatment.”³⁹

Williamson County should celebrate these successes in improving population health:

- **The ratio of primary care providers is better than the state average.** “Sufficient availability of primary care physicians is essential for preventive and primary care, and, when needed, referrals to appropriate specialty care.”⁴⁰
- **The county has 21% fewer preventable hospital stays than the state.** Since 2012, the county has consistently had a lower rate, suggesting that the quality of outpatient care is strong and that emergency rooms and urgent care are not used for primary care. These are indicators of decent quality of and access to healthcare in Williamson County.⁴¹
- **The county has significantly lower rates of uninsured residents than the state.** The percentage of persons and children without insurance increases as household income decreases.

C4. Quality of Life

According to the Centers for Disease Control and Prevention, health-related quality of life (HRQoL) is defined as “an individual’s or group’s perceived physical and mental health over time...On the individual level, HRQoL includes physical and mental health perceptions (e.g., energy level, mood) and their correlates—including health risks and conditions, functional status, social support, and socioeconomic status. On the community level, HRQoL includes community-level resources, conditions, policies, and practices that influence a population’s health perceptions and functional status.”⁴² Although health is one of the important domains of overall quality of life, there are other domains, such as jobs, housing, schools, and neighborhood.

The data in this section describe individual-level quality of life indicators (health status and physical/mental health perceptions) and community-level quality of life indicators (disability, transportation, housing, social/civic engagement, and Head Start facilities).

Self-Reported Health

Why is this important?

Self-reported health status is based on survey responses to the question “In general, would you say that your health is excellent, very good, good, fair, or poor?”

³⁷ “Division of Oral Health at a Glance.”

³⁸ “Dentist Rate.”

³⁹ “Texas Primary Care Office (TPCO) - Federally Qualified Health Centers.”

⁴⁰ “Primary Care Physicians.”

⁴¹ “Preventable Hospital Stays.”

⁴² “HRQoL Concepts.”

Poor Physical Health Days is based on survey responses to the question “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”

Poor Mental Health Days is based on survey responses to the question “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

Together, these measures determine health-related quality of life. “Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population.”⁴³

Table 17: Self-Reported Health of Adults in Williamson County and Texas, 2018

Self-Reported Health of Adults in Williamson County and Texas, 2018		
Indicator	Williamson County	Texas
Poor or fair health ¹	15%	19%
Poor physical health days ²	3.3	3.8
Poor mental health days ²	3.7	3.8

Data Source: ¹Behavioral Risk Factor Surveillance System, 2018; ²County Health Rankings, 2020

Findings based on Table 17:

- Adults in Williamson County reported a better health status than adults in Texas. Approximately 15% of adults in the county rated their health as poor or fair as compared to 19% in the state.
- Adults in Williamson County reported an average of 3.3 poor physical health days in the past 30 days, while adults in Texas reported an average of 3.7 days.
- Adults in Williamson County reported an average of 3.7 poor mental health days in the past 30 days, while adults in Texas reported an average of 3.8 days.

Disability

Why is this important?

“People with a disability have difficulties performing activities due to a physical, mental, or emotional condition. The extent to which a person is limited by a disability is heavily dependent on the social and physical environment in which he or she lives. Without sufficient accommodations, people with disabilities may have difficulties living independently or fulfilling work responsibilities.”⁴⁴

From 2009 to 2019, the percentage of individuals with a disability was constant at around 9.5% (Figure 23). From 2015 to 2019, the percentage of Williamson County’s population with a disability was 10%, compared to 11.5% in Texas (Figure 24).

The percentage of individuals with a disability increases as age increases, as seen in Figure 24. Residents ages 75 and older had the highest percentage of disability (47.8%), followed by those ages 65 to 75 years (22.8%) and those ages 35 to 64 years (9.4%).

In Williamson County, the American Indian and Alaska Native (AI/AN) population had the highest percentage of disability (14.6%), followed by the Black population (12.5%) and White population (11.2%) (Figure 25). Moreover, these populations had percentages of disability higher than the overall county value.

⁴³ “Poor or Fair Health.”

⁴⁴ “Persons With a Disability.”

Figure 23: Percentage of Individuals with a Disability by Five-Year Rolling Average in Williamson County, 2009–2019

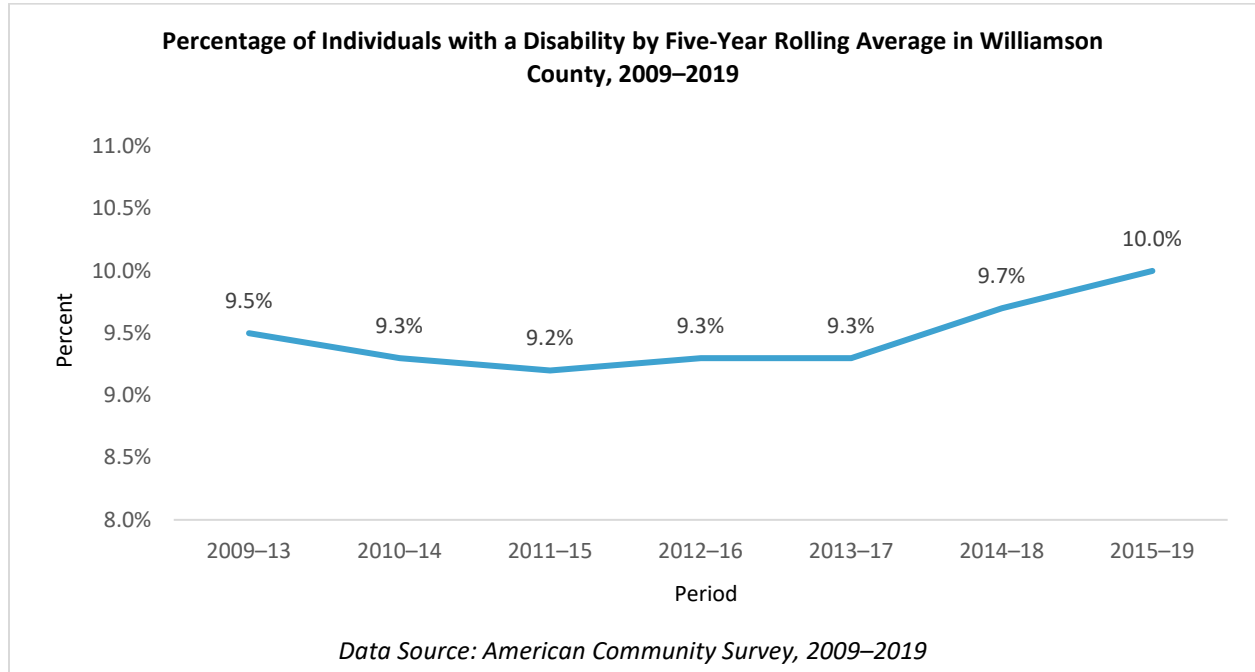


Figure 24: Percentage of Individuals with a Disability by Age in Williamson County and Texas, 2015–2019

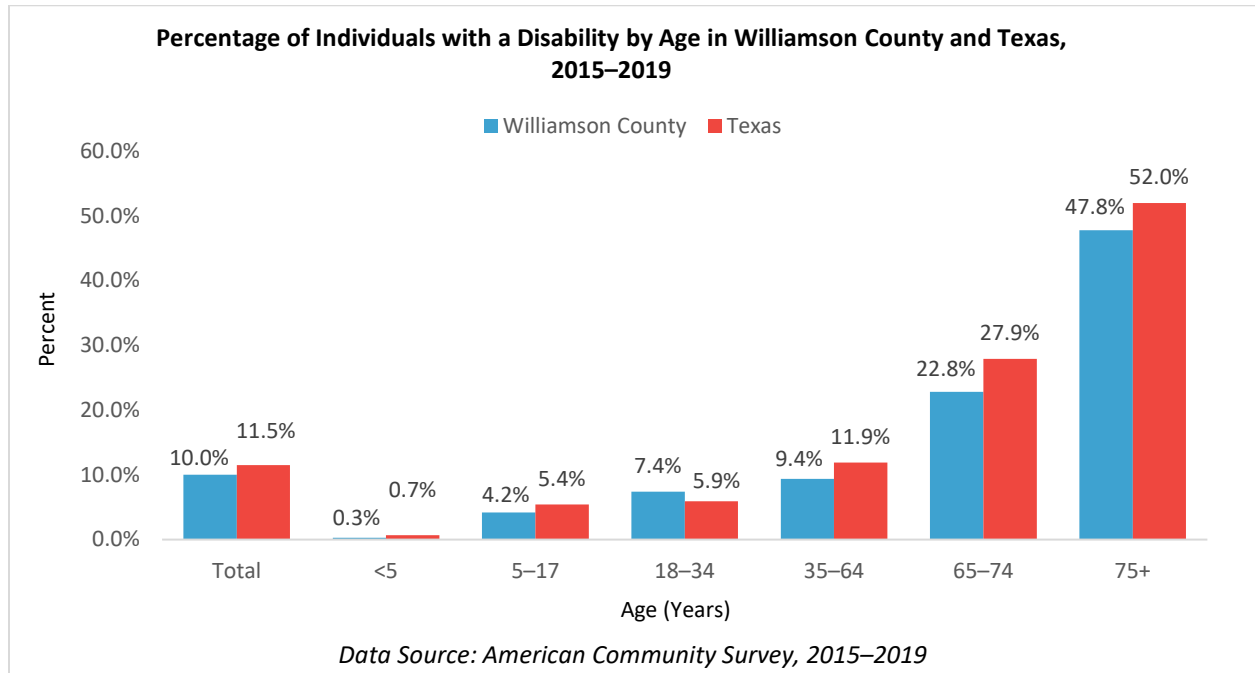
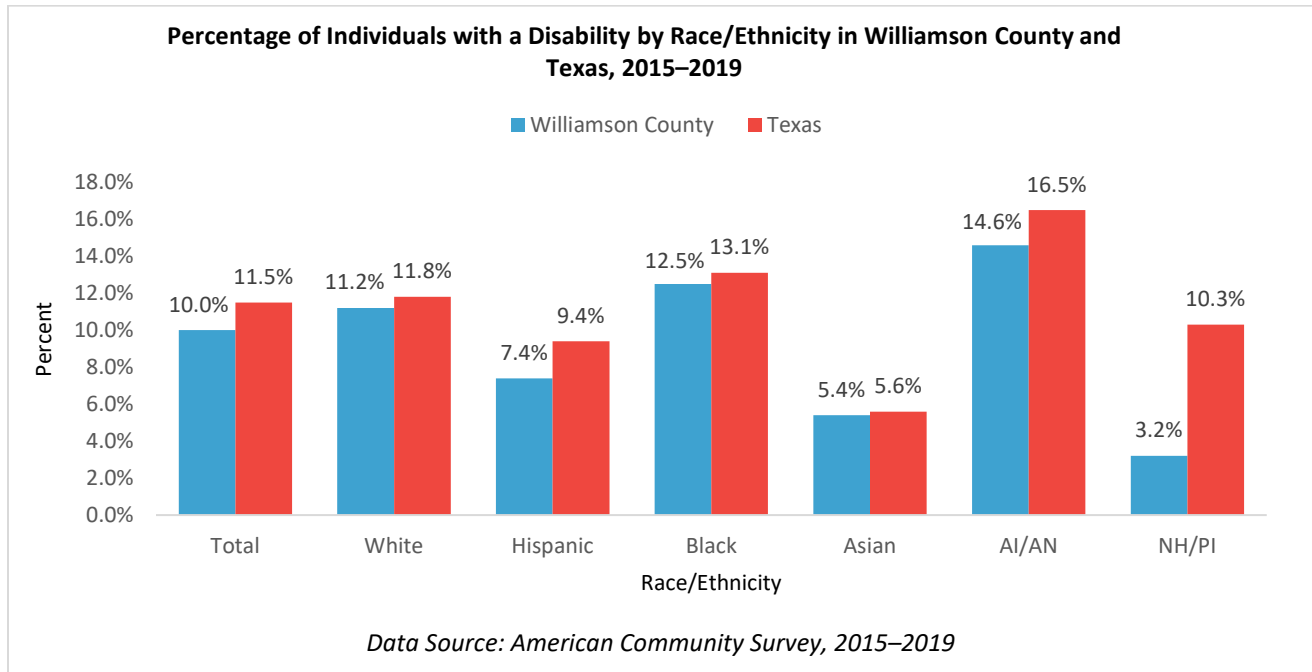


Figure 25: Percentage of Individuals with a Disability by Race/Ethnicity in Williamson County and Texas, 2015–2019



Transportation

Why is this important?

There are many options for travel to work. The most common include driving alone in a personal vehicle, walking, or using public transportation. Driving alone increases traffic congestion and air pollution, especially in areas of greater population density, and causes “decreased levels of physical activity and cardiorespiratory health, and increased BMI and hypertension.”⁴⁵ Additionally, “lengthy commutes to work cut into workers’ free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure. Longer commutes require workers to consume more fuel which is both expensive for workers and damaging to the environment.”⁴⁶

Alternatively, public transportation and walking to work offer more benefits. “Public transportation offers mobility to U.S. residents, particularly people without cars.” All modes of public transportation are safer than personal modes of transportation. “Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public transportation is also beneficial because it reduces fuel consumption, minimizes air pollution, and relieves traffic congestion.”⁴⁷

“Walking to work is a good way to incorporate exercise into a daily routine. In addition to the health benefits, walking helps people get in touch with their communities, reduces commute costs, and helps protect the environment by reducing air pollution from car trips. Furthermore, studies have shown that walking to work improves employees’ overall attitude and morale, and reduces stress in the workplace.”⁴⁸

Many households do not have a vehicle, which “is directly related to the ability to travel...In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car. This limits their access to essential local services such as supermarkets, post offices, doctors’ offices, and hospitals. Most households with above-average incomes have a car while only half of low-income households do.”⁴⁹

⁴⁵ “Solo Drivers With a Long Commute.”

⁴⁶ “Mean Travel Time to Work.”

⁴⁷ “Workers Commuting by Public Transportation.”

⁴⁸ “Workers Who Walk to Work.”

⁴⁹ “Households without a Vehicle.”

Table 18: Transportation Indicators in Williamson County and Texas, 2015–2019

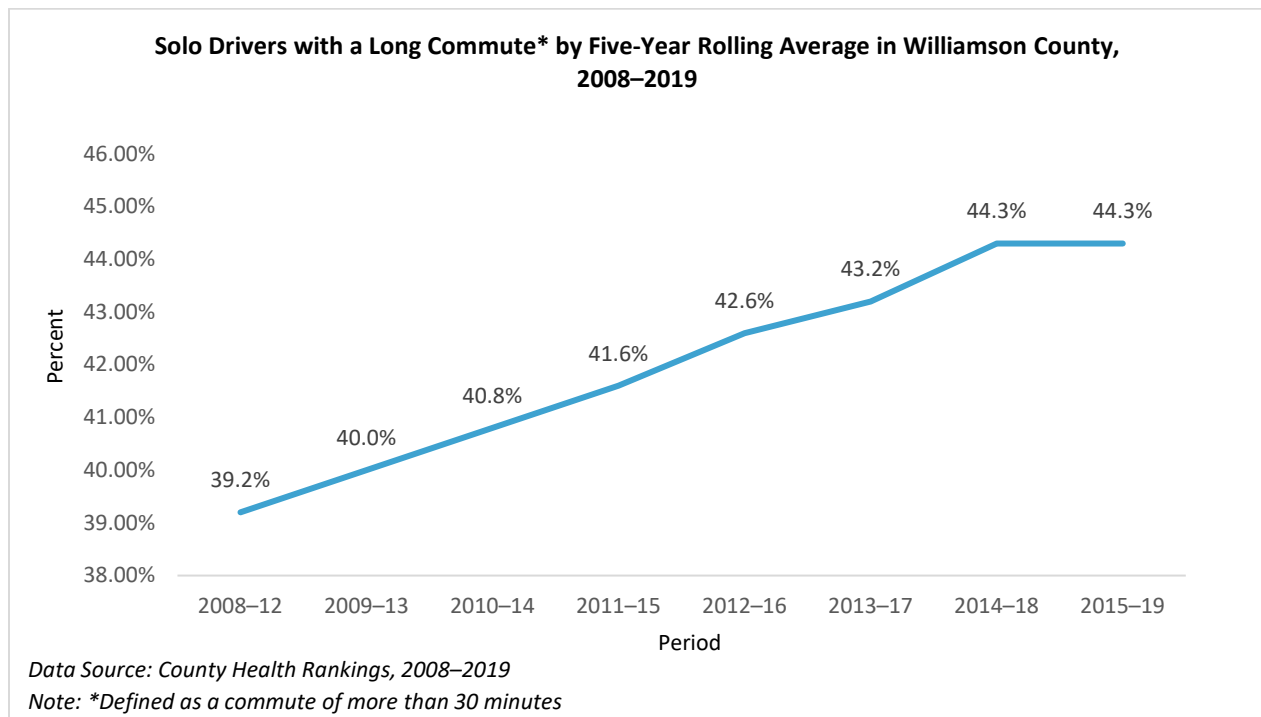
Transportation Indicators in Williamson County and Texas, 2015–2019		
Indicator	Williamson County	Texas
Mean Travel Time to Work (minutes)	28.4	26.7
Percentage of Workers Who Drive to Work Alone	79.4%	80.5%
Percentage of Workers Who Walk to Work	0.9%	1.5%
Percentage of Workers Who Commute to Work by Public Transportation	0.9%	1.4%
Percentage of Workers Who Worked from Home	8.5%	5.0%
Percentage of Households without a Vehicle	2.3%	5.3%

Data Source: American Community Survey, 2015–2019

Findings based on Table 18:

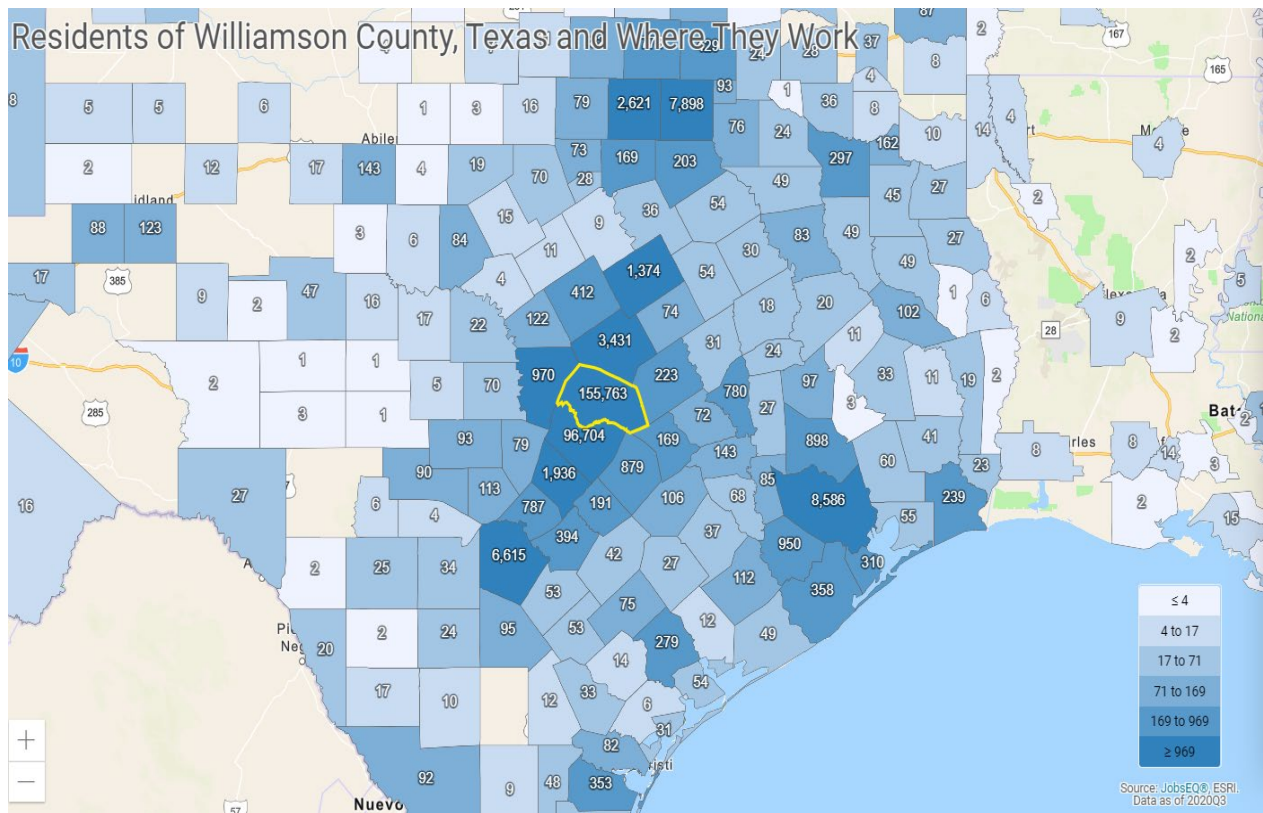
- In Williamson County, average daily travel time to work for workers ages 16 and older is 28.4 minutes, which is longer than the average in Texas (26.7 minutes).
- The percentage of workers ages 16 and older who drive alone to work in Williamson County is 79.4% or roughly 487,000 persons, compared to 80.5% or roughly 23.8 million persons in Texas.
- The percentage of workers ages 16 and older who walk to work in Williamson County is 0.9% or roughly 5,500 persons, compared to 1.5% or roughly 444,000 persons in Texas.
- The percentage of workers ages 16 and older who commute to work by public transportation in Williamson County is 0.9% or roughly 5,500 persons, compared to 1.4% or roughly 414,000 persons in Texas.
- The percentage of workers ages 16 and older who work from home in Williamson County is 8.5% or roughly 52,000 persons, compared to 5.0% or roughly 31,500 persons in Texas.
- The percentage of households without a vehicle in Williamson County is 2.3% or roughly 4,144 households, compared to 5.3% or roughly 513,657 households in Texas.

As Figure 26 shows, the percentage of solo drivers with a long commute (more than 30 minutes) increased from 39.2% (2008–2012) to 44.3% (2015–2019).

Figure 26: Solo Drivers with a Long Commute by Five-Year Rolling Average in Williamson County, 2008–2019

Many Williamson County residents commute to Travis County for work. Figure 27 shows that as of the third quarter of 2020, 96,704 Williamson County residents commuted to Travis County for work, while 155,763 residents worked and lived in Williamson County.

Figure 27: Residents of Williamson County and Where They Work, 2020



Housing

Why is this important?

Housing is “one of the best-researched social determinants of health.”⁵⁰ Individuals and families can be affected by many factors, including housing instability, housing quality, housing affordability, and neighborhood surroundings. Housing instability is associated with increased risk of teen pregnancy, early drug use, and depression among youth. Housing foreclosures are associated with depression, anxiety, increased alcohol use, psychological distress, and suicide. Researchers have found that “the availability of resources such as public transportation to one’s job, grocery stores with nutritious foods, and safe spaces to exercise are all correlated with improved health outcomes.”⁵¹ Spending a high percentage of household income on housing may result in less income available for basic needs, such as food, clothing, transportation, medicine, and healthcare.

Between 2015 and 2019, household income increased by 15% in Williamson County and 13.5% in Texas (Figure 28). Rent in Williamson County increased by 18.5%, compared to 14.7% in Texas. However, Williamson County had a higher increase in home values compared to Texas, at 25.3% and 20.9%, respectively.

Housing prices have soared over the past year. According to the Austin Board of Realtors, the median sales price of houses in Williamson County has increased 47% to \$450,000 as of June 2021. The number of closed sales has increased 11%, the average number of days on the market has decreased by 41 days, and the total sales dollar volume has increased 62% to \$764 million (Figure 29).

⁵⁰ “Housing and Health: An Overview of the Literature.”

⁵¹ Ibid.

Figure 28: Percent Increase in Household Income, Rent and Home Values in Williamson County and Texas, 2015–2019

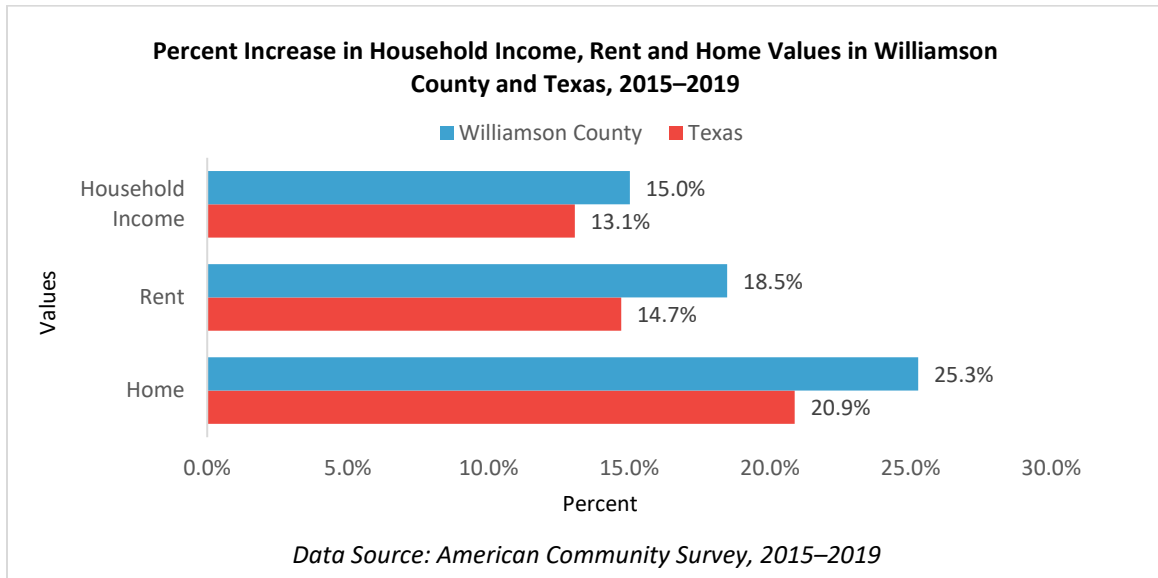
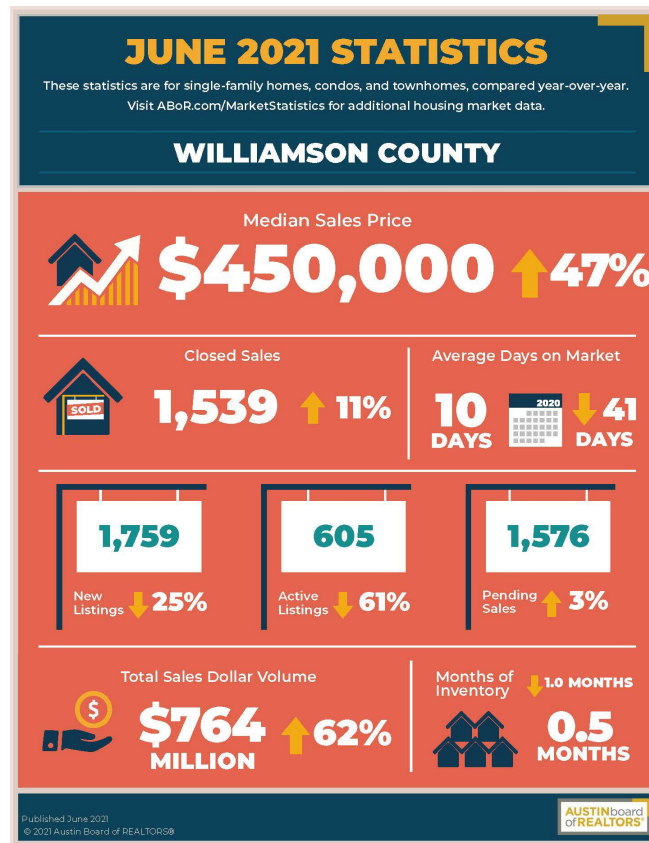
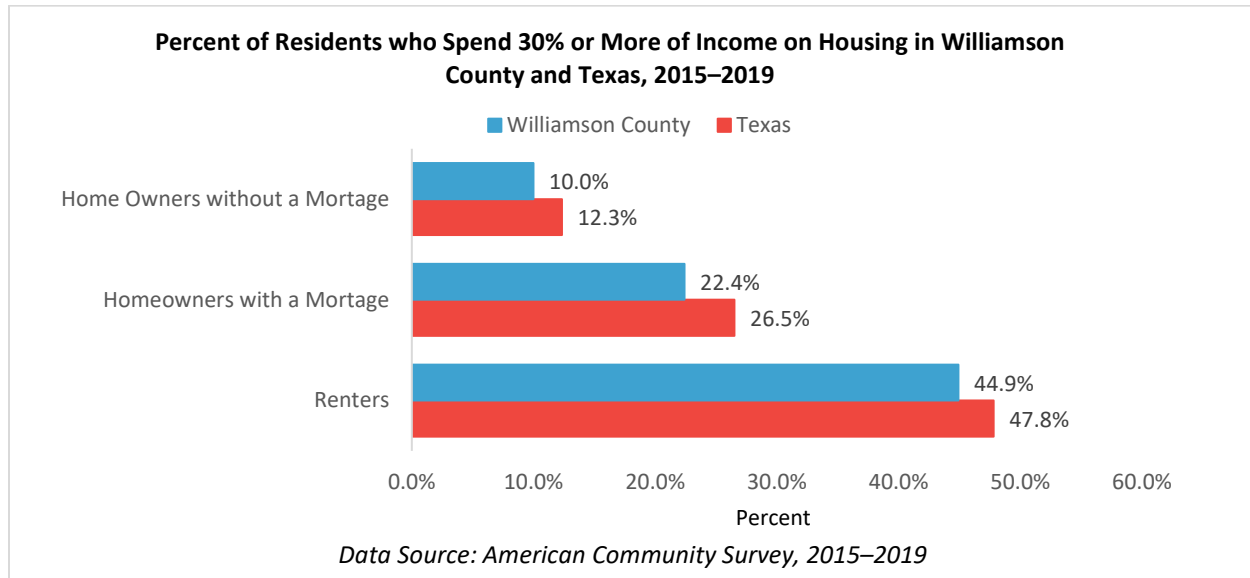


Figure 29: Williamson County Austin Board of Realtors Housing Statistics, June 2021



Compared to Texas, a smaller proportion of renters and homeowners in Williamson County spend 30% or more of their household income on housing costs (Figure 30). Almost half (44.9%) of renters in Williamson County spend 30% or more of their income on housing, which is much higher than the percentages among homeowners with a mortgage (22.4%) and homeowners without a mortgage (10%).

Figure 30: Percent of Residents Who Spent 30% or More of Income on Housing in Williamson County and Texas, 2015–2019



Residential Segregation

Why is this important?

County Health Rankings describes residential segregation and its effects:

Although most overtly discriminatory policies and practices promoting segregation, such as separate schools or seating on public transportation or in restaurants based on race, have been illegal for decades, segregation caused by structural, institutional, and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted acts of racism, but has had little effect on structural racism, like residential segregation, resulting in lingering structural inequalities. Residential segregation is a key determinant of racial differences in socioeconomic mobility and, additionally, can create social and physical risks in residential environments that adversely affect health. Although this area of research is gaining interest, structural forms of racism and their relationship to health inequities remain under-studied.

Residential segregation remains prevalent in many areas of the country and may influence both personal and community well-being. Residential segregation of Black [or non-White] and White residents is considered a fundamental cause of health disparities in the US and has been linked to poor health outcomes, including mortality, a wide variety of reproductive, infectious, and chronic diseases, and other adverse conditions. Structural racism is also linked to poor-quality housing and disproportionate exposure to environmental toxins. Individuals living in segregated neighborhoods often experience increased violence, reduced educational and employment opportunities, limited access to quality health care and restrictions to upward mobility.⁵²

Describing how residential segregation is measured, County Health Rankings also writes:

Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (Black [or non-White] residents and White residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case).

The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black [or non-White] or White residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.⁵³

⁵² "Residential Segregation - Black/White."

⁵³ Ibid.

Table 19: Residential Segregation in Williamson County and Texas

Residential Segregation in Williamson County and Texas		
Indicator	Williamson County	Texas
Residential Segregation – Black/White	32	53
Residential Segregation – Non-White/White	25	40

Data Source: American Community Survey, 2015–2019

Findings based on Table 19:

- On the index of dissimilarity “where higher values indicate greater residential segregation between Black and White county residents,” Williamson County had a score of 32, compared to a score of 53 for Texas. According to the County Health Rankings, top U.S. performers had a score of 26.⁵⁴
- On the index of dissimilarity “where higher values indicate greater residential segregation between non-White and White county residents,” Williamson County had a score of 25, compared to a score of 40 for Texas. According to the County Health Rankings, top U.S. performers had a score of 14.⁵⁵

Social and Civic Engagement

Why is this important?

Poor or no social interaction between people in a community is associated with increased morbidity and early mortality. Research has found that “people living in areas with high levels of social trust [trust between people] are less likely to rate their health status as fair or poor than people living in areas with low levels of social trust.”⁵⁶

Civic engagement is also important for communities. “Voting is one of the most fundamental rights of a democratic society. Exercising this right allows a nation to choose elected officials and hold them accountable. Voting ensures that all citizens can voice their opinions on issues such as the use of tax dollars, civil rights and foreign policy. By voting, individuals shape their communities and influence the next generation of society. A high level of turnout indicates that citizens are involved and interested in who represents them in the political system.”⁵⁷

Table 20: Social and Civic Engagement in Williamson County and Texas

Social and Civic Engagement in Williamson County and Texas		
Indicator	Williamson County	Texas
Presidential Voter Turnout ¹	76.22%	66.73%
Number of social associations per 10,000 population ²	6.4	7.5

Data Sources: ¹Texas Secretary of State, 2020; ²County Business Patterns, 2021

Findings based on Table 20:

- The number of social associations per 10,000 population is 6.4 in Williamson County, compared to 7.5 in Texas. Associations include civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations.
- Compared to Texas, Williamson County had higher voter turnout in the most recent presidential election. In the 2020 presidential election, 76.22% of registered voters in Williamson County voted, compared to 66.73% in Texas.

Key Findings

Challenges to monitor and address through surveillance and interventions:

- **The percentage of individuals who are affected by a disability will likely continue to increase as the population over age 65 grows.** The aging population, as well as racial and ethnic groups with higher percentages of disability, should be considered when implementing policies, distributing funds, and developing programs for those with disabilities.

⁵⁴ Ibid.

⁵⁵ “Residential Segregation - Non-White/White.”

⁵⁶ “Social Associations.”

⁵⁷ “Voter Turnout: Presidential Election.”

- **Transportation indicators in Williamson County are comparable to Texas.** Alternatives to driving alone to work, such as public transportation and walking, should be promoted and prioritized to decrease traffic congestion, air pollution, and risk of chronic disease. Increasing public transportation options will also assist households who do not own a vehicle as well as commuters who may not currently have convenient access to public transportation.
- **Home and rent values are increasing faster than incomes.** Household incomes — but also rent and home values — increased faster in the county than in the state from 2015 to 2019. The price of housing has increased almost 50%. The continued trend of increases in cost of living outpacing increases in income poses challenges not only for housing, but also for other determinants of health. More affordable housing options for low-income residents should be offered.
- **The county lacks social associations and needs to develop more.** This includes physical places, like sports clubs and recreation centers, as well as civic, political, religious, labor, business, and professional organizations. Opportunities to engage socially increase social interaction and improve health outcomes.

Williamson County should be proud of its accomplishments:

- Self-reported health status as well as physical and mental health perceptions of Williamson County residents indicate that **individual-level quality of life is above satisfactory**. According to the CDC, health-related quality of life indicators make it possible to scientifically demonstrate the impact of health on quality of life and are a valid measure of unmet needs and intervention outcomes.⁵⁸
- **The county's level of civic engagement in presidential elections is higher than the state's level.** Active citizenship is associated with better morbidity and mortality outcomes.

C5. Behavioral Risk Factors

Certain health-related behaviors, known as behavioral risk factors, contribute to injury and chronic disease, resulting in increased risk of morbidity and mortality. This section outlines significant risk factors, which include obesity and overweight, physical inactivity, tobacco use, excessive drinking, and cancer screening.

Obese and Overweight Adults

Why is this important?

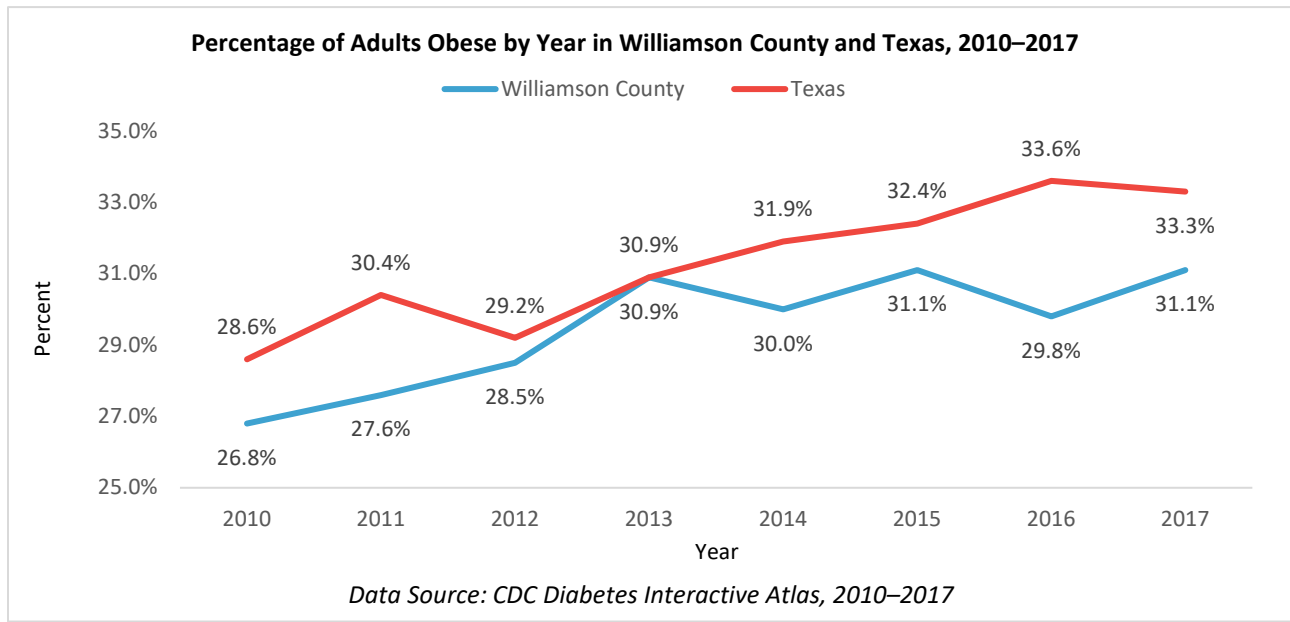
"The percentage of overweight and obese adults is an indicator of the overall health and lifestyle of a community."⁵⁹ Overweight individuals have a body mass index (BMI) of 25.0 to 29.9, while obese individuals have a BMI greater than or equal to 30.0. "Being overweight or obese affects quality of life and puts individuals at risk for developing many diseases, especially heart disease, stroke, diabetes, and cancer. Losing weight helps to prevent and control these diseases. Being overweight or obese also carries significant economic costs due to increased healthcare spending and lost earnings."⁶⁰

The proportion of adults in Williamson County who are obese has increased, from 26.8% in 2010 to 31.1% in 2017 (Figure 31). While the percentage of obese adults in Williamson County was lower than that in Texas for most of this period, Williamson County's value matched Texas' at 30.9% in 2013. As of 2018, both Williamson County and Texas had high percentages of adults who are overweight or obese, at 66.0% and 69.5%, respectively.

⁵⁸ "HRQoL Concepts."

⁵⁹ "Adults Who Are Overweight or Obese."

⁶⁰ Ibid.

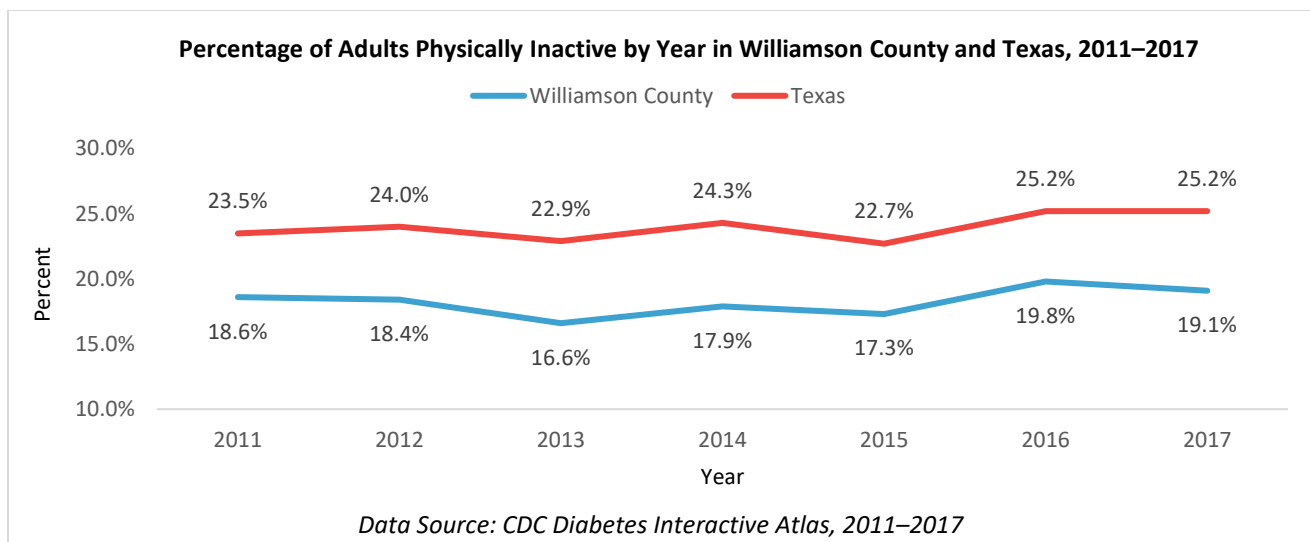
Figure 31: Percentage of Adults Obese by Year in Williamson County and Texas, 2010–2017

Physical Inactivity

Why is this important?

Adults who are physically inactive (i.e., “get no physical activity beyond that of daily living”) are at an increased risk of many serious health conditions.⁶¹ “These conditions include obesity, heart disease, diabetes, colon cancer, and high blood pressure. In addition, physical activity improves mood and promotes healthy sleep patterns. The American College of Sports Medicine (ACSM) recommends that adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. The ACSM also recommends that you include strength and flexibility training in your exercise program.”⁶²

The percentage of adults in Williamson County and Texas who are physically inactive has remained relatively stagnant from 2011 to 2017 (Figure 32). As of 2017, 19.1% of adults in Williamson County and 25.2% of adults in Texas do not participate in any physical activity or exercise.

Figure 32: Percentage of Adults Physically Inactive by Year in Williamson County and Texas, 2011–2017

⁶¹ “Lack of Physical Activity.”

⁶² “Adults 20+ Who Are Sedentary.”

Tobacco Use

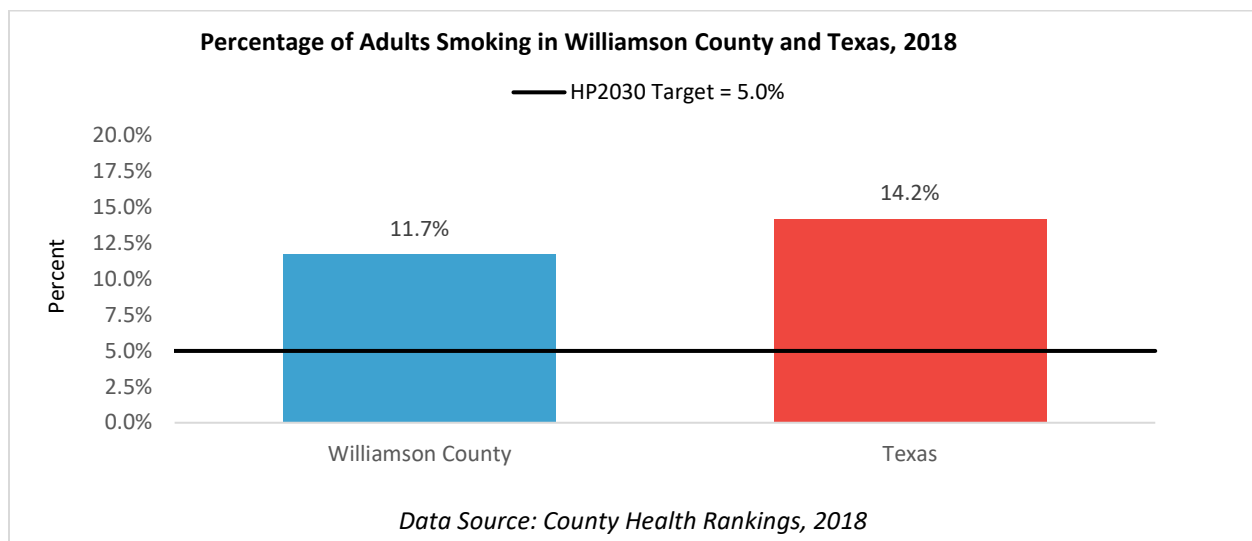
Why is this important?

Describing the health effects of tobacco use, Healthy Williamson County writes:

Tobacco is the agent most responsible for avoidable illness and death in America today. According to the Centers for Disease Control and Prevention, tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. The World Health Organization states that approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers, which can cause or exacerbate a wide range of adverse health effects such as cancer, respiratory infections, and asthma.⁶³

Adults ages 18 and older in Williamson County had lower rates of smoking (11.7%) compared to Texas (14.2%) (Figure 33). Both Texas and Williamson County have smoking rates that surpass the Healthy People 2030 target of 5.0%.

Figure 33: Percentage of Adults Smoking in Williamson County and Texas, 2018



Drinking Excessively

Why is this important?

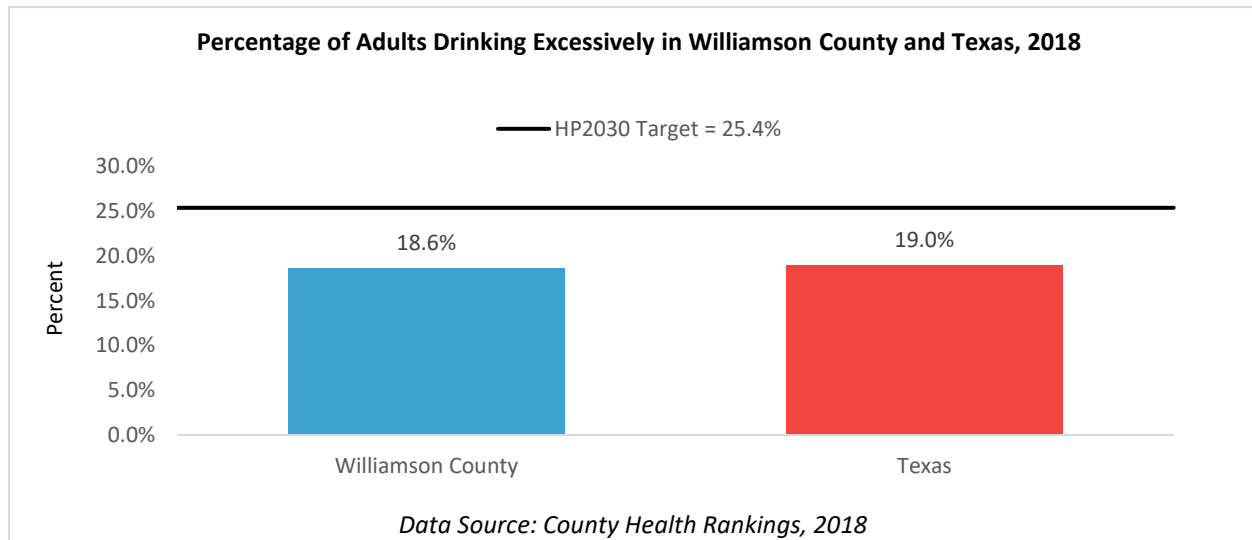
Healthy Williamson County explains the risks associated with excessive drinking, writing:

Drinking alcohol has immediate physiological effects on all tissues of the body, including those in the brain. Alcohol is a depressant that impairs vision, coordination, reaction time, judgment, and decision making, which may in turn lead to harmful behaviors. According to the Centers for Disease Control and Prevention, excessive alcohol use, either in the form of heavy drinking (drinking more than 15 drinks per week on average for men or more than eight drinks per week on average for women), or binge drinking (drinking more than five drinks during a single occasion for men or more than four drinks during a single occasion for women), can lead to increased risk of health problems, such as liver disease and unintentional injuries. Alcohol abuse is also associated with a variety of other negative outcomes, including employment problems, legal difficulties, financial loss, family disputes, and other interpersonal issues.⁶⁴

In 2018, the percentage of adults ages 18 and older who drink excessively was lower in Williamson County (18.6%) compared to Texas (19.0%) (Figure 34). Both Texas and Williamson County have excessive drinking rates that are below the Healthy People 2030 target of 25.4%.

⁶³ "Adults Who Smoke."

⁶⁴ "Adults Who Drink Excessively."

Figure 34: Percentage of Adults Drinking Excessively in Williamson County and Texas, 2018

Cancer Screening

Why is this important?

According to the Centers for Disease Control and Prevention (CDC), colorectal cancer — cancer of the colon or rectum — is one of the most diagnosed cancers and the second leading cancer killer in the United States. The CDC estimates that if all adults ages 50 and older had regular screening tests for the disease, as many as 60% of colorectal cancer deaths could be prevented. The U.S. Preventive Services Task Force recommends that people receive screenings from age 50 until age 75. Certain factors, however, indicate that testing may need to start earlier or be more frequent, including a family history of colorectal cancer and a previous diagnosis of inflammatory bowel disease.⁶⁵

Additionally, the CDC states that “breast cancer is the second most common type of cancer among women in the United States.”⁶⁶ A mammogram is an X-ray picture of the breast which can help catch abnormalities early and reduce the chances of developing breast cancer.⁶⁷ The U.S. Preventive Services Task Force recommends that females receive mammograms from age 50 until age 74. Certain factors, however, indicate that a person may benefit from starting mammograms earlier, such as a mutation in either of two specific genes or a family history that indicates a person is at higher risk for breast cancer.⁶⁸

Table 21: Routine Cancer Screening in Williamson County and Texas

Routine Cancer Screening in Williamson County and Texas		
Indicator	Williamson County	Texas
Colonoscopy ¹	70.2%	61.6%
Mammogram Among Female Medicare Enrollees ²	46%	37%

Data Sources: ¹Texas Behavioral Risk Factor Surveillance System, 2018; ²Centers for Medicare and Medicaid Office of Minority Health, 2018

Findings based on Table 21:

- The percentage of adults ages 50 and older in Williamson County who have ever had a colonoscopy is 70.2%, which is higher than Texas (61.6%).
- Approximately 46% of female Medicare enrollees ages 65 to 74 in Williamson County received an annual mammogram, compared to 37% in Texas.

⁶⁵ “Colon Cancer Screening.”

⁶⁶ “Breast Cancer Statistics.”

⁶⁷ “What Is a Mammogram?”

⁶⁸ “Recommendation: Breast Cancer: Screening.”

Key Findings

Research shows that unhealthy behaviors significantly increase the likelihood of injury, disease, and death. Fortunately, behavioral risk factors are modifiable with corrective action. The most concerning behavioral risk factors in Williamson County are discussed below, as well as recommendations for future data collection.

- **Nearly one-third of adults are obese, with an obesity trend that has continued to rise since 2004.** Limited data are available to examine correlated factors, such as high cholesterol and high blood pressure. Additionally, there is a lack of obesity and overweight data stratified by age, race/ethnicity, and social/economic factors. Increased surveillance and data collection are needed to identify long-term solutions to decrease the rate of adults who are overweight or obese in Williamson County.
- **One-fifth of adults are physically inactive, with no improvement trend for almost a decade.** Interventions should be designed and evaluated to target the physically inactive population.
- **Smoking among adults has surpassed the Healthy People 2030 goal by more than double.** Additionally, the use of electronic cigarettes (e-cigarettes) has been increasingly popular since their introduction to the market in the mid-2000s. With the launch of the JUUL brand of e-cigarette in 2015, e-cigarette use increased greatly, especially among youth.⁶⁹ More data are needed to examine this emerging trend among the youth population since the habit of smoking is usually established during teenage years.
- **The rate of excessive drinking among adults in Williamson County is comparable to the rate in Texas.** “The Community Preventive Services Task Force recommends several evidence-based community strategies to reduce harmful alcohol use.” These strategies include regulation of alcohol outlet density, increasing alcohol taxes, dram shop liability, maintaining limits on days and hours of sale, electronic screening and brief intervention, and enhanced enforcement of laws prohibiting sales to minors.⁷⁰ Ultimately, increased monitoring of excessive drinking is necessary to learn more about at-risk populations, such as underage adults and youth.
- It should be noted that Williamson County’s rates of colonoscopies (general population) and mammograms (Medicare population) are significantly higher than those of the state.

C6. Environmental Health Indicators

Environmental health indicators “impact a wide range of health, functioning, and quality of life outcomes.”⁷¹ These indicators are part of the built environment and include the location and number of recreational facilities, fast-food restaurants, grocery stores, Supplemental Nutrition Assistance Program (SNAP) retailers, and alcohol retailers. The built environment in a community will increase or decrease the likelihood of certain health behaviors, such as physical activity, healthy eating, and excessive drinking.

Access to Exercise Opportunities

Why is this important?

“Proximity to exercise opportunities, such as parks and recreation facilities, has been linked to an increase in physical activity among residents. Regular physical activity has a wide array of health benefits including weight control, muscle and bone strengthening, improved mental health and mood, and improved life expectancy. Furthermore, exercise reduces the risk of cardiovascular disease, type 2 diabetes and metabolic syndrome, and some cancers.”⁷²

From 2016 to 2020, Williamson County and Texas experienced similar trends regarding access to exercise opportunities (Figure 35). For both the county and the state, the percentage of individuals who live reasonably close to a physical activity location decreased from 2016 to 2020. As of 2020, Williamson County had a higher percentage of individuals with access to exercise opportunities (87%) compared to Texas (81%).

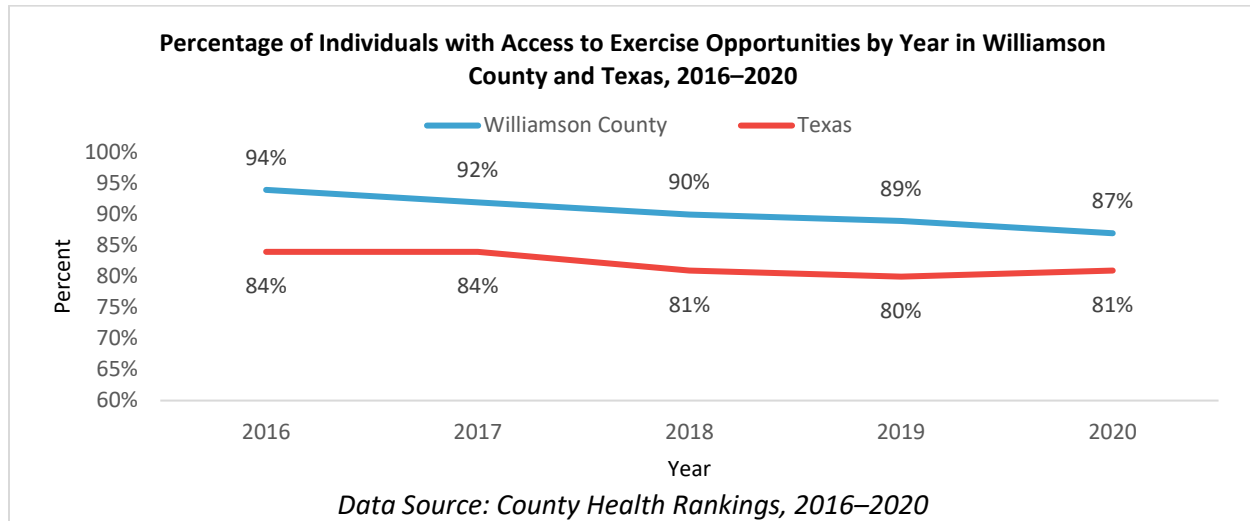
⁶⁹ “JUUL and Youth: Rising E-Cigarette Popularity.”

⁷⁰ “Preventing Excessive Alcohol Use.”

⁷¹ “Determinants of Health.”

⁷² “Access to Exercise Opportunities.”

Figure 35: Percentage of Individuals with Access to Exercise Opportunities by Year in Williamson County and Texas, 2016–2020



Healthy Eating Environment

Why is this important?

Discussing the health impacts of the quality of food options available in communities, Healthy Williamson County writes:

The accessibility, availability, and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. A diet composed of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer, and diabetes, and is essential to maintain a healthy body weight and prevent obesity. Low-income and underserved areas often have limited numbers of stores that sell healthy foods. People living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast-food outlets...Fast-food outlets are more common in low-income neighborhoods and studies suggest that they strongly contribute to the high incidence of obesity and obesity-related health problems in these communities.⁷³

The Supplemental Nutrition Assistance Program (SNAP), “previously called the Food Stamp Program, is a federal-assistance program that provides low-income families with electronic benefit transfers...that can be used to purchase food. The purpose of the program is to assist low-income households in obtaining adequate and nutritious diets. According to the program, over 45 million people from over 20 million households [in the U.S.] receive SNAP benefits.”⁷⁴ Retail stores must either stock multiple varieties of staple foods or derive most of their sales from staple foods to be authorized as a SNAP retailer. In areas where SNAP clients have very limited food access, stores that do not meet these requirements can still be authorized.⁷⁵

Table 22: Healthy Eating Environment Indicators in Williamson County and Texas, 2018

Healthy Eating Environment Indicators in Williamson County and Texas, 2018		
Indicator	Williamson County	Texas
Food Insecurity ¹	11.2%	15.0%
Child Food Insecurity ¹	16.0%	21.6%
SNAP Authorized Retailer Rate* ²	40.9	63.9
Fast Food Restaurants Rate* ²	67.6	61.6
Grocery Store Rate* ²	7.8	12.4

*Notes: *per 100,000 population*

Data Sources: ¹Feeding America, 2018; ²U.S. Department of Agriculture – Food Environmental Atlas, 2018

⁷³ “Fast Food Restaurant Density.”

⁷⁴ “SNAP Certified Stores.”

⁷⁵ “Is My Store Eligible?”

Findings based on Table 22:

- 11.2% of the population in Williamson County experiences food insecurity, compared to 15.0% in Texas.
- About one in six (16.0%) children in Williamson County experiences food insecurity, compared to about one in five children (21.6%) in Texas.
- In Williamson County, there are 40.9 Supplemental Nutrition Assistance Program (SNAP) retailers per 100,000 population, which are fewer than in Texas (63.9 per 100,000 population). Moreover, almost all SNAP retailers in Williamson County reside within convenience stores, gas stations, mini-marts, fast-food restaurants, and pharmacies.
- Williamson County has 67.6 fast-food restaurants per 100,000 population, which is higher than in Texas (61.6 per 100,000 population).
- Compared to Texas, which has a grocery store rate of 12.4 per 100,000 population, Williamson County has a lower grocery store rate (7.8 per 100,000 population).

If an individual resides in an urban area of the county and lives more than one mile from a grocery store, the individual is considered to have low grocery store access. The same is true for an individual residing in a rural area of the county and living more than ten miles from a grocery store.

Table 23: Grocery Store Access in Williamson County, 2015

Grocery Store Access in Williamson County, 2015	
Indicator	Williamson County
People with Low Grocery Store Access	33.7%
People with Low Income and Low Access to Grocery Store	8.0%
Households with No Car and Low Grocery Store Access	1.3%

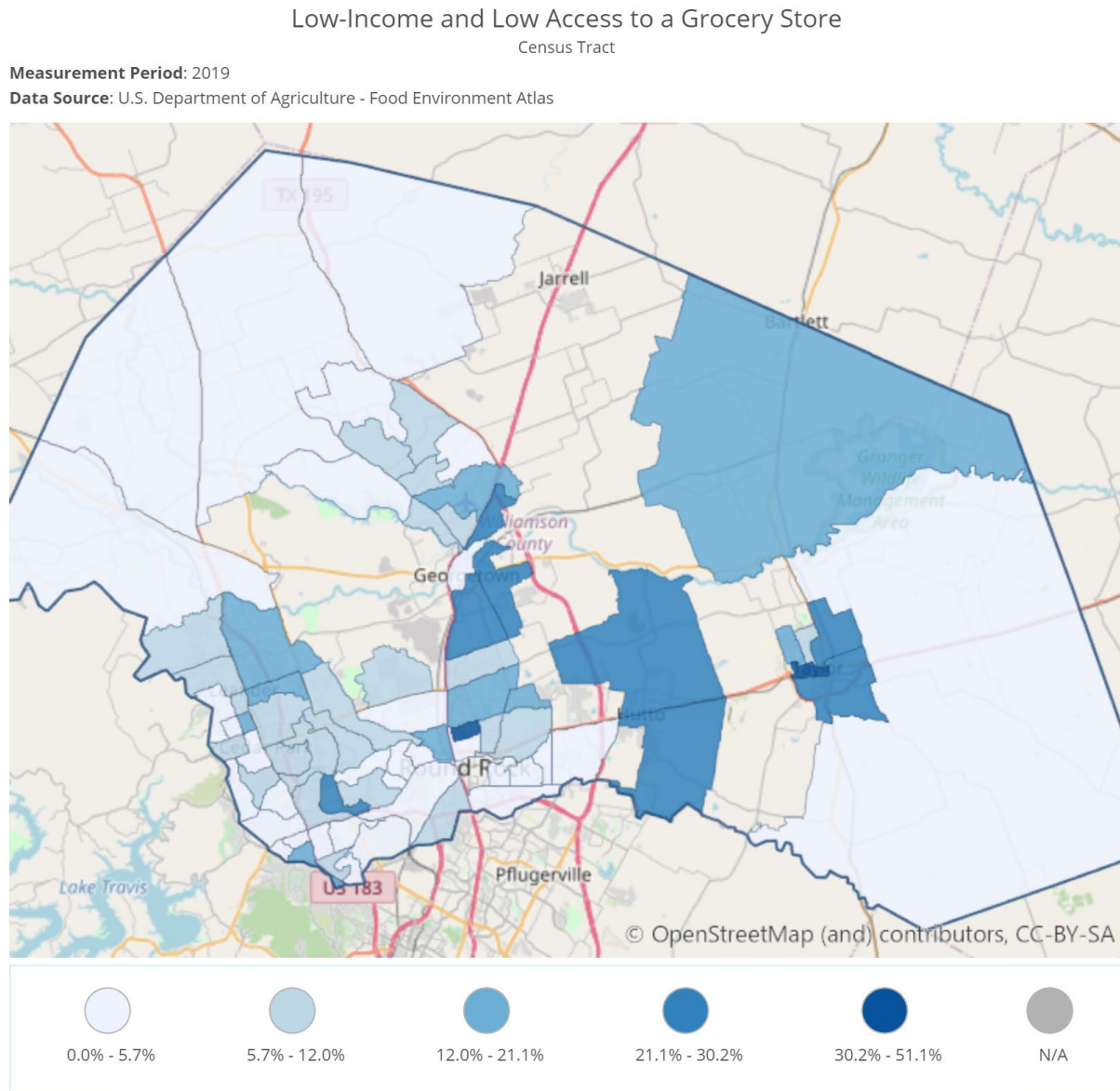
Data Source: U.S. Department of Agriculture – Food Access Research Atlas, 2015

Findings based on Table 23:

- As of 2015, about one-third (33.7%) of Williamson County residents live far from a grocery store or supermarket.
- Approximately one out of ten (8.0%) people in Williamson County lives far from a grocery store *and* has low income.
- A small percentage (1.3%) of households in Williamson County live far from a grocery store *and* do not have a vehicle.

Census tracts near Round Rock and Taylor have the highest proportions (40.5% to 51.1%) of the population with low income and low grocery store access (Figure 36). Near Taylor and Georgetown, 6.6–11.9% of households have no car and low grocery store access (Figure 37).

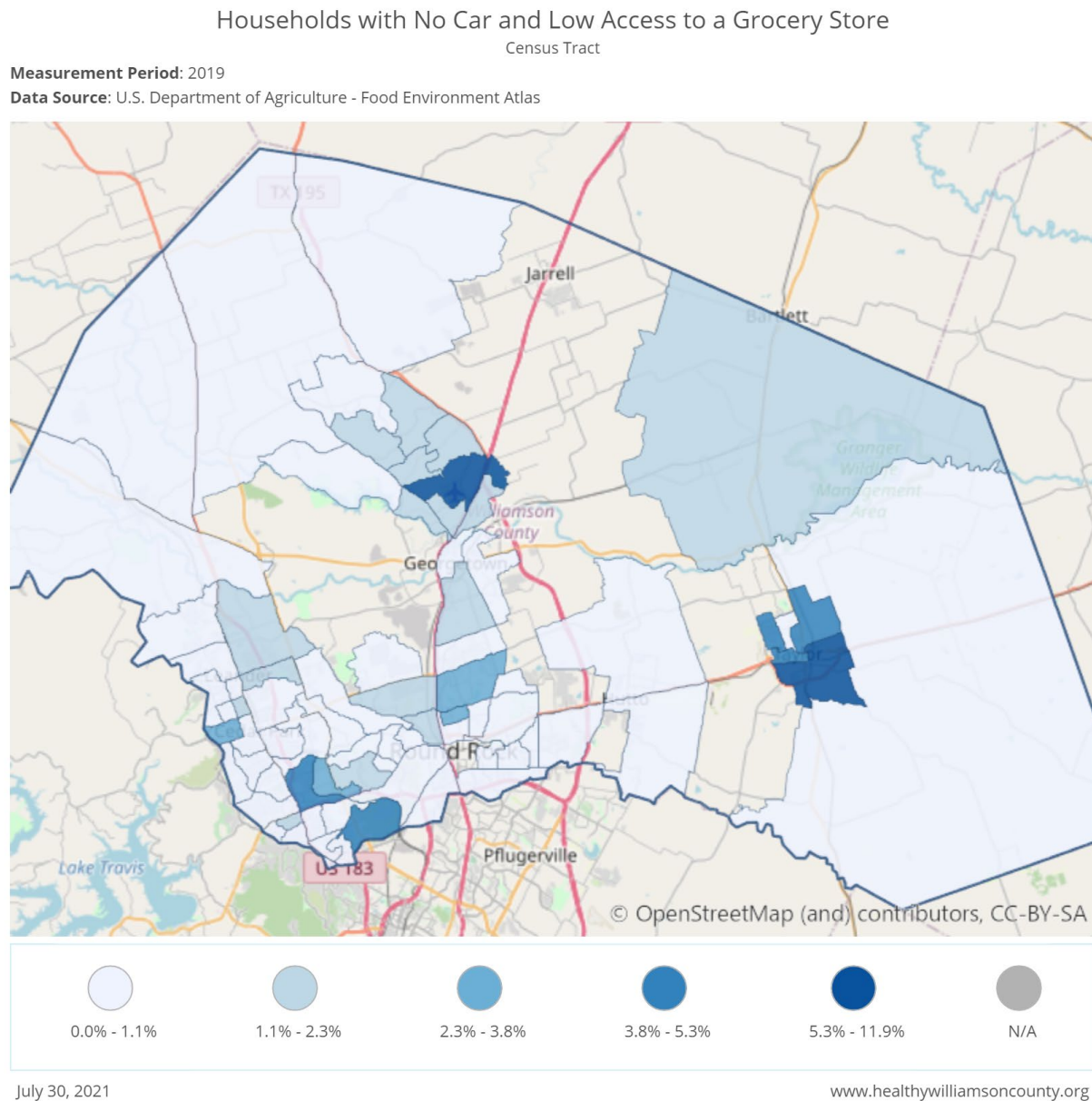
Figure 36: Percentage of Population with Low Income and Low Access to a Grocery Store by Census Tract in Williamson County, 2019



July 30, 2021

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Figure 37: Percentage of Households with No Car and Low Access to a Grocery Store by Census Tract in Williamson County, 2019

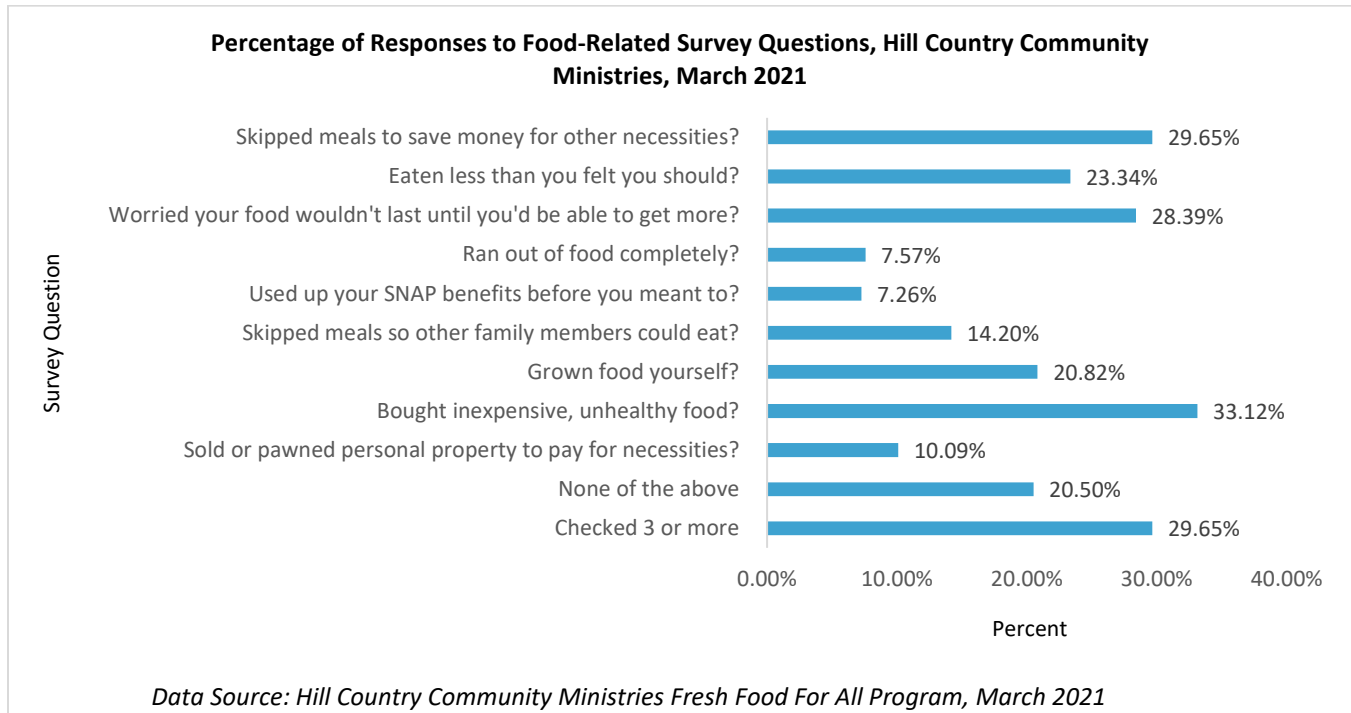


Local Spotlight: Hill Country Community Ministries

Hill Country Community Ministries (HCCM) is a local nonprofit dedicated to serving Williamson County residents most in need, providing food, clothing, and other assistance. Those who received assistance from HCCM's Fresh Food for All program in Williamson County ZIP codes were surveyed regarding food-related behaviors, perceptions, and barriers (Figure 38).

- 33.12% of respondents (n=317) reported that in the past three months they had bought inexpensive, unhealthy food.
- 29.65% of respondents reported that they skipped meals to save money for other necessities.
- 28.39% of respondents reported that in the past three months they worried their food would not last until they would be able to get more.
- 23.34% of respondents reported that in the past three months they had eaten less than they felt they should.

Figure 38: Percentage of Responses to Food-Related Survey Questions, Hill Country Community Ministries, March 2021



Alcohol Retailers Rate

Why is this important?

Healthy Williamson County discusses the significance of alcohol outlet density in communities:

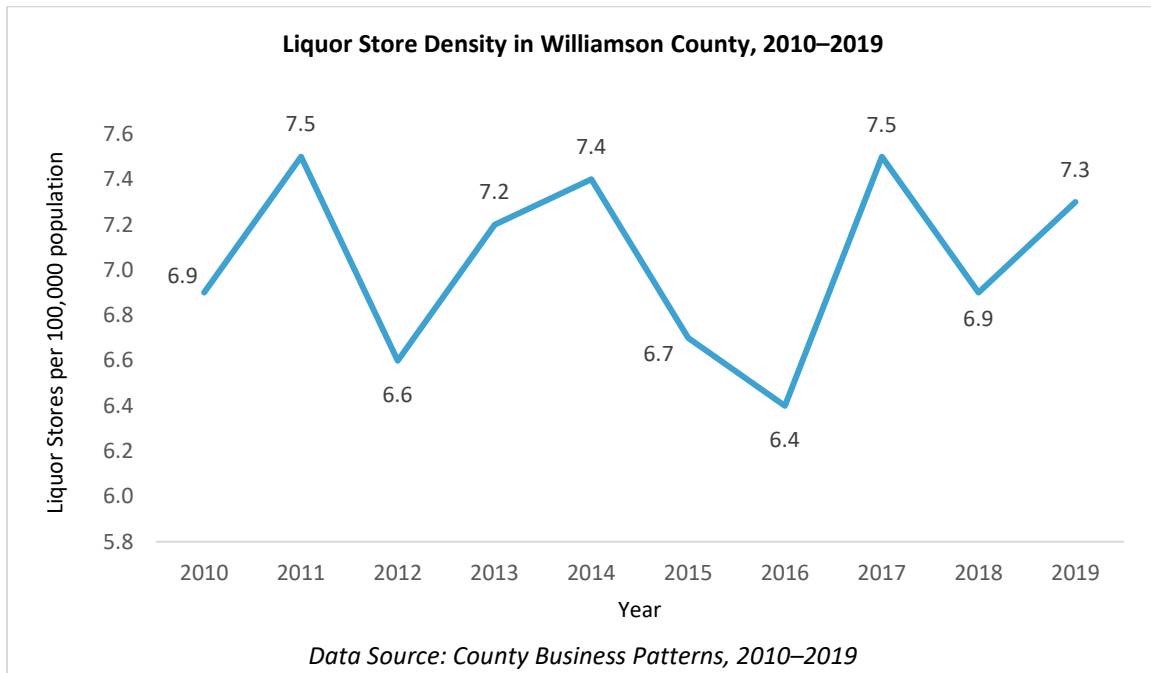
Studies have shown that neighborhoods with a high density of alcohol outlets are associated with higher rates of violence, regardless of other community characteristics such as poverty and age of residents. High alcohol outlet density has been shown to be related to increased rates of drinking and driving, motor vehicle-related pedestrian injuries, and child abuse and neglect. In addition, liquor stores frequently sell food and other goods that are unhealthy and expensive. Setting rules that mandate minimum distances between alcohol outlets, limiting the number of new licenses in areas that already have a high number of outlets, and closing down outlets that repeatedly violate liquor laws can all help control and reduce liquor store density.⁷⁶

In 2019, Williamson County had a rate of 7.3 liquor stores per 100,000 population (Figure 39), which is higher than Texas' (6.9 per 100,000 population).⁷⁷

⁷⁶ "Liquor Store Density."

⁷⁷ Ibid.

Figure 39: Liquor Store Density in Williamson County, 2010–2019



Key Findings

Many factors contribute to a healthy built environment in Williamson County. Nearly nine out of ten residents live in proximity to a recreational facility, creating an environment that promotes physical activity. However, improving the healthy eating and exercise environment in Williamson County remains a crucial element in decreasing outcomes such as obesity, heart disease, and diabetes. Gaps that should be addressed in reforming healthy food access in Williamson County include:

- **Increase grocery store access for low-income populations and households with no vehicle.**
 - People of all ages in Williamson County may experience food insecurity, which is defined by the U.S. Department of Agriculture as “limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways.”⁷⁸ Moreover, “low-income and underserved areas often have limited numbers of stores that sell healthy foods. People living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast-food outlets.” Food insecurity is associated with chronic diseases such as diabetes, heart disease, high blood pressure, high blood cholesterol, and obesity, as well as mental health issues like major depression.⁷⁹
 - “Vehicle ownership is directly related to the ability to travel [e.g., to a grocery store]. In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car.”⁸⁰
- **Increase the number of Supplemental Nutrition Assistance Program (SNAP) retailers within grocery stores and farmer’s markets.** Most SNAP retailers in Williamson County reside within convenience stores, gas stations, mini-marts, fast-food restaurants, and pharmacies, rather than grocery stores and farmer’s markets. Fast food often lacks nutritional value but is rich in fat and calories, so “frequent consumption of these foods and an insufficient consumption of fresh fruits and vegetables increase the risk of overweight and obesity. Individuals who are overweight or obese are at increased risk for serious health conditions, including coronary heart disease, type-2 diabetes, multiple cancers, hypertension, stroke, premature death, and other chronic conditions.” Research suggests

⁷⁸ “Food Insecurity Rate.”

⁷⁹ “Food Environment Index.”

⁸⁰ “Households without a Vehicle.”

that the greater density of fast-food outlets in low-income neighborhoods contributes substantially to the “high incidence of obesity and obesity-related health problems in these communities.”⁸¹

C7. Social and Mental Health

“Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.”⁸²

Mental Health Indicators

Table 24: Mental Health Indicators in Williamson County and Texas

Mental Health Indicators in Williamson County and Texas		
Indicator	Williamson County	Texas
Alcohol Impaired Driving Deaths ¹	27.4%	25.7%
Drug Overdose Mortality Rate* ²	5.8	10.4
Child Abuse Rate ³	4.7	9.1
Violent Crime Rate* ⁴	165.0	420.0
Firearm Fatality Rate ⁵	10.0	12.0
Homicide Rate ⁶	1.0	5.0
Depression Among the Medicare Population ⁷	18.9%	18.2%

*Notes: *per 100,000 population; [†]per 1,000 children*

Data Sources: ¹County Health Rankings, 2015–2019; ²CDC Compressed Mortality File, 2016–2018;

³Texas Department of Family and Protective Services, 2020; ⁴Uniform Crime Reporting-FBI; CDC WONDER, ⁵2014–2018, ⁶2012–2018; ⁷Centers for Medicare and Medicaid Services, 2018

Findings based on Table 24:

- In Williamson County, 27.4% of motor vehicle crash deaths involved alcohol, compared to 25.7% in Texas.
- Williamson County had a drug overdose mortality rate of 5.8 per 100,000 population, which was lower than the rate in Texas (10.4 per 100,000 population).
- In Williamson County, there were 4.7 children under age 18 who experienced abuse or neglect per 1,000 children. This rate is lower than Texas’ rate of 9.1 per 1,000 children.
- Violent crime includes homicide, forcible rape, robbery, and aggravated assault. The total violent crime rate per 100,000 population in Williamson County was 165.0 crimes, which is significantly lower than the rate in Texas (420.0).
 - The rate of firearm deaths per 100,000 population in Williamson County was 10.0, compared to 12.0 in Texas.
 - The rate of homicide deaths per 100,000 population in Williamson County was 1.0, compared to 5.0 in Texas.
- Medicare is the federal health insurance program for persons ages 65 and older, persons under age 65 with certain disabilities, and persons of any age with end-stage renal disease. As of 2015, an estimated 18.9% of Medicare beneficiaries in Williamson County were treated for depression, which is higher than in Texas (18.0%).

Suicide Mortality

Why is this important?

Suicide is a leading cause of death and a major, preventable public health problem in the United States. According to the Centers for Disease Control and Prevention, more than 47,500 people in the U.S. died by suicide in 2019. Suicide deaths are

⁸¹ “Fast Food Restaurant Density.”

⁸² “What Is Mental Health?”

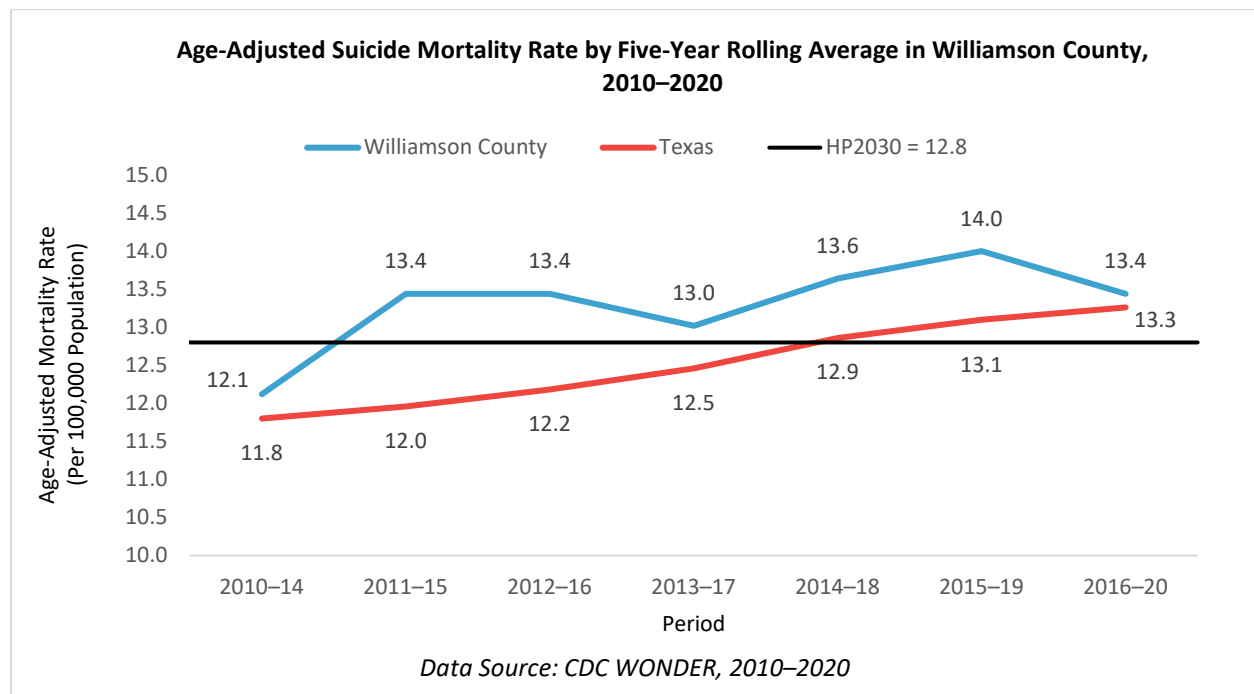
only one part of the problem; for every suicide death in 2019, there were approximately 29 suicide attempts.⁸³ On suicide deaths, impacts, and distribution in the United States, Healthy Williamson County writes:

[T]hose who survive suicide may have serious injuries, in addition to having depression and other mental problems. Other repercussions of suicide include the combined medical and lost work costs on the community, totaling to over \$30 billion for all suicides in a year, and the emotional toll on family and friends. Men are about four times more likely than women to die of suicide, but three times more women than men report attempting suicide. Suicide occurs at a disproportionately higher rate among adults 75 years and older.⁸⁴

Between 2010 and 2020, the age-adjusted suicide mortality rate rose in Williamson County and Texas (Figure 40).

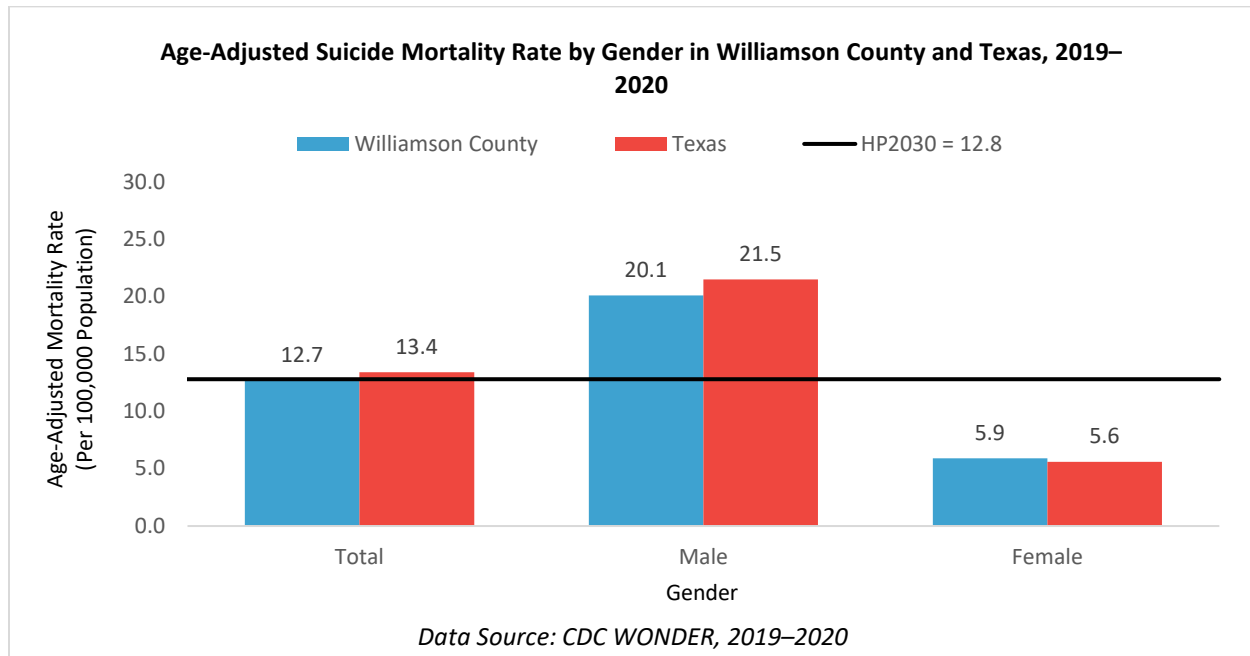
Age-adjusted suicide mortality in Williamson County was higher among males (20.1 deaths per 100,000 population) than females (5.9 per 100,000 population) (Figure 41). While the overall age-adjusted suicide mortality rate in Williamson County (12.7 deaths per 100,000 population) met the Healthy People 2030 target (12.8 per 100,000 population), the overall rate in Texas (13.4 per 100,000 population) did not.

Figure 40: Age-Adjusted Suicide Mortality Rate by Five-Year Rolling Average in Williamson County and Texas. 2010–2020



⁸³ "Facts About Suicide."

⁸⁴ "Age-Adjusted Death Rate Due to Suicide."

Figure 41: Age-Adjusted Suicide Mortality Rate by Gender in Williamson County and Texas, 2019

Mental Health Hospitalizations

Why is this important?

“According to the National Center for Health Statistics, treatment for mental disorders is a major cause of hospitalization for children and adolescents between the ages of 10 and 21 years.”⁸⁵ “It is important to recognize and address potential psychological issues before they become critical, particularly because the greatest opportunity for prevention is among young people.”⁸⁶

Healthy Williamson County discusses the factors influencing mental health and the burden of mental illness in the United States, writing:

Mental disorders are one of the leading causes of disability in the United States. In any given year, approximately 13 million American adults have a seriously debilitating mental illness. Furthermore, unstable mental health can lead to suicide...An individual’s mental health is affected by a combination of factors, including biology (genes/brain chemistry), life experiences (trauma/abuse), and family history regarding mental health problems. Due to the complex interplay between so many factors, it is especially important to recognize early warning signs, such as too much or too little sleep, rapid weight loss or weight gain, lack of energy and motivation in talking to people or participating in usual activities, or feelings of helplessness.⁸⁷

Table 25: Mental Health Hospitalizations in Williamson County and Texas, 2017–2019

Mental Health Hospitalizations in Williamson County and Texas, 2017–2019		
Age-Adjusted Hospitalization Rate per 10,000	Williamson County	Texas
Due to Adult Mental Health	21.6	36.1
Due to Pediatric Mental Health	43.8	45.0

Notes: Hospitalizations include adjustment disorders; anxiety disorders; attention deficit conduct and disruptive behavior disorders; delirium, dementia, amnesic and other cognitive disorders; disorders usually diagnosed in infancy, childhood, or adolescence; mood disorders; personality disorders; schizophrenia and other psychotic disorders; and impulse control disorders not elsewhere classified.

Data Source: Texas Department of State Health Services, 2017–2019

⁸⁵ “Age-Adjusted Hospitalization Rate Due to Pediatric Mental Health.”

⁸⁶ “Age-Adjusted Hospitalization Rate Due to Adult Mental Health.”

⁸⁷ Ibid.

Findings based on Table 25:

- From 2017 to 2019, there were 21.6 mental health–related hospitalizations per 10,000 population ages 18 and older in Williamson County. This age-adjusted rate is lower than Texas’ rate of 36.1 mental health–related hospitalizations per 10,000 population.
- From 2017 to 2019, there were 43.8 pediatric mental health–related hospitalizations per 10,000 population under age 18 in Williamson County. This age-adjusted rate is lower than Texas’ rate of 45.0 pediatric mental health–related hospitalizations per 10,000 population.

Local Spotlight: Bluebonnet Trails Community Services

In Williamson County, the largest mental health provider is Bluebonnet Trails Community Services (BTCS). Below is an overview of BTCS which includes the number of services provided by category and the most diagnosed mental health disorders in 2020.

In 2020 at BTCS, two in three encounters were for mental health, followed by intellectual and developmental disability and early childhood intervention and autism (Table 26). BTCS served almost 4,000 persons experiencing a major depressive disorder, almost 2,000 experiencing bipolar disorder, and about 1,700 individuals with autism or an intellectual disability (Figure 42).

Table 26: Total Numbers of Encounters for Williamson County Patients Served at Bluebonnet Trails Community Services, 2020

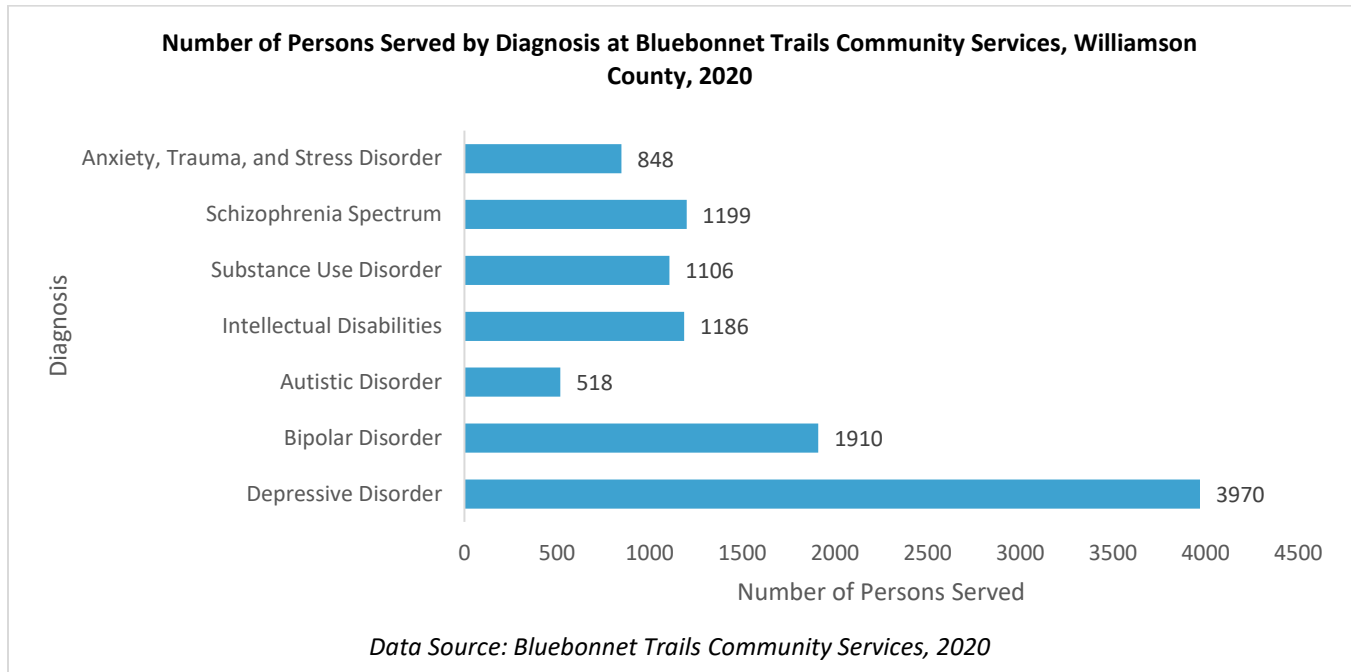
Total Numbers of Encounters for Williamson County Patients Served at Bluebonnet Trails Community Services, 2020		
Service Category	Count	Percent
Mental Health	98,296	64.1%
Substance Use	8,462	5.5%
Intellectual and Developmental Disability	24,306	15.8%
Early Childhood Intervention and Autism	22,318	14.6%
Total	153,382	100%

Data Source: Bluebonnet Trails Community Services, 2020

Findings based on Table 26:

- In 2020, there were 98,296 mental health encounters for Williamson County patients served at Bluebonnet Trails Community Services. Mental health accounted for 64.1% of all encounters.
- In 2020, there were 8,462 substance abuse encounters for Williamson County patients served at Bluebonnet Trails Community Services. Substance abuse accounted for 5.5% of all encounters.
- In 2020, there were 24,306 intellectual and developmental disability encounters for Williamson County patients served at Bluebonnet Trails Community Services. Intellectual and developmental disability accounted for 15.8% of all encounters.
- In 2020, there were 22,318 Early childhood intervention and autism encounters for Williamson County patients served at Bluebonnet Trails Community Services. Early childhood intervention and autism accounted for 14.6% of all encounters.

Figure 42: Number of Persons Served by Diagnosis at Bluebonnet Trails Community Services, Williamson County, 2020



Key Findings

Certain mental health indicators stood out for having mortality rates that are not only high, but higher than the overall Texas value. These indicators are described in full detail with future recommendations:

- **Alcohol-impaired driving death rates are higher in the county than in the state.** Evidence-based efforts should be made to decrease the number of alcohol-related motor-vehicle deaths in Williamson County.
- **Suicide mortality has risen over time in Williamson County, though the most recent rate was below the Healthy People 2030 target and the state's rate. Males die from suicide at disproportionately high rates as compared to females.** Preventing suicide involves everyone in the community, including the state, healthcare systems, employers, communities, schools, media, and individuals. When public health departments bring together community partners to solve this issue, the likelihood of preventing suicide is greater.⁸⁸ However, additional data are needed to determine the specific attributes of at-risk groups in Williamson County.
- **Williamson County has drug overdose mortality rates, child abuse rates, violent crime rates, and adult mental health hospitalization rates that are significantly lower than the state's rates.**

C8. Maternal and Child Health

The prenatal care a mother receives heavily determines health outcomes of infants and children, who make up an especially vulnerable population. "Safe motherhood begins before conception with proper nutrition and a healthy lifestyle. Planned pregnancy, appropriate prenatal care, prevention of complications when possible, and early and effective treatment of complications when they occur are all essential elements of maternal care."⁸⁹ Prioritizing maternal health can help ensure full-term pregnancies without complications, delivery of a healthy infant, and a positive environment of support for the needs of mothers, infants, and families.

Low Birth Weight

Why is this important?

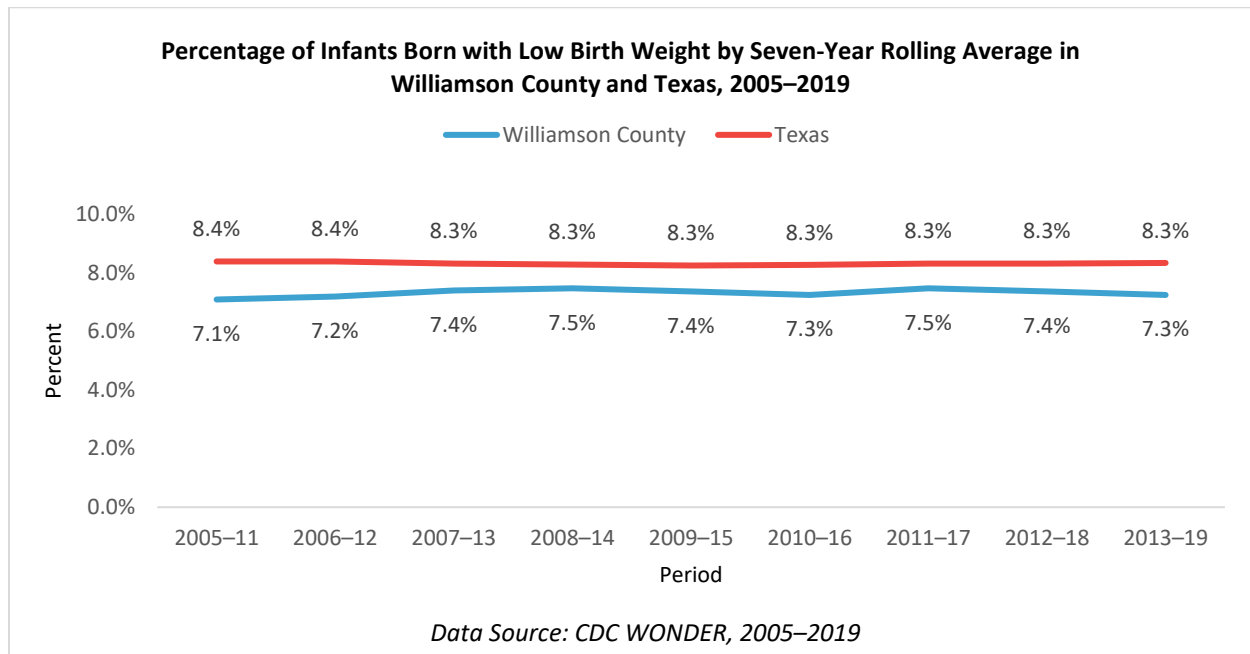
"Babies born with low birth weight are more likely than babies of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. Low birth weight is typically caused by premature birth and fetal

⁸⁸ "Suicide Rising Across the US."

⁸⁹ "The New Public Health."

growth restriction, both of which are influenced by a mother's health and genetics.”⁹⁰ From 2005 to 2019, Williamson County and Texas experienced similar trends in infants born with low birth weight (Figure 43).

Figure 43: Percentage of Infants Born with Low Birth Weight by Seven-Year Rolling Average in Williamson County and Texas, 2005–2019



Preterm Birth

Why is this important?

“A full-term pregnancy lasts about 40 weeks, giving the baby the time it needs to fully develop. In some pregnancies, women go into labor too early, a complication known as ‘preterm’ or premature labor. Labor is considered preterm if it starts before 37 weeks of pregnancy.”⁹¹ “Babies born premature[ly] are likely to require specialized medical care, and oftentimes must stay in intensive care nurseries. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability.”⁹²

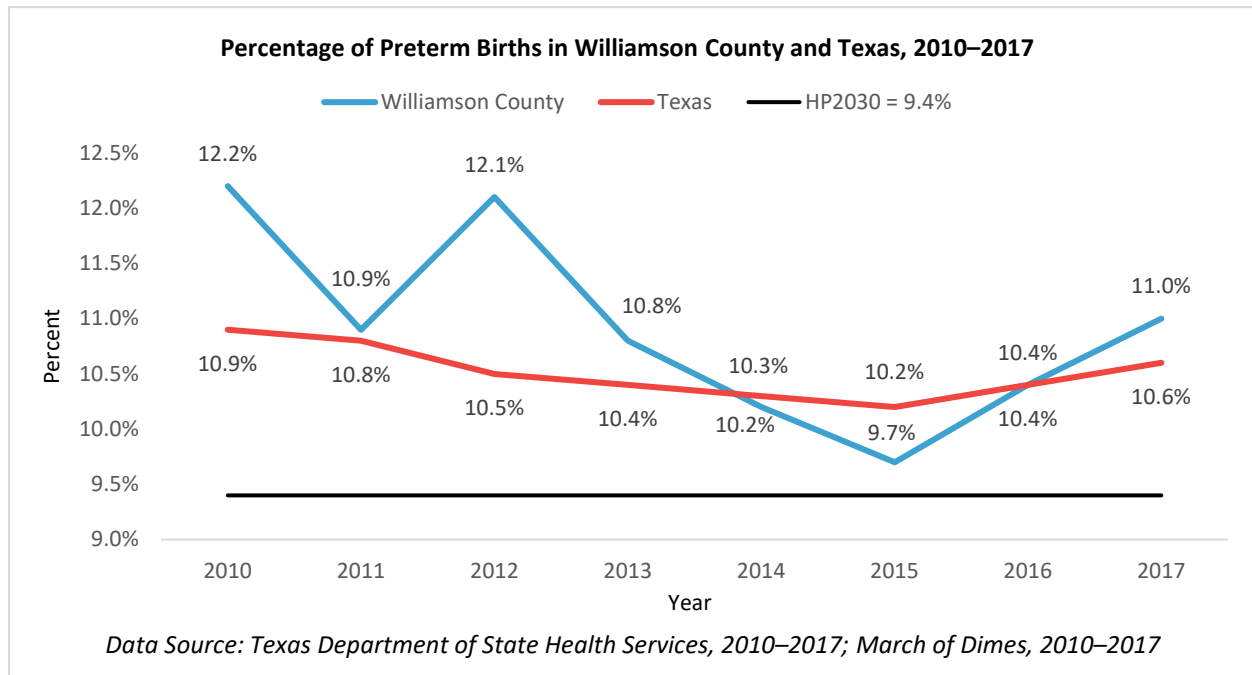
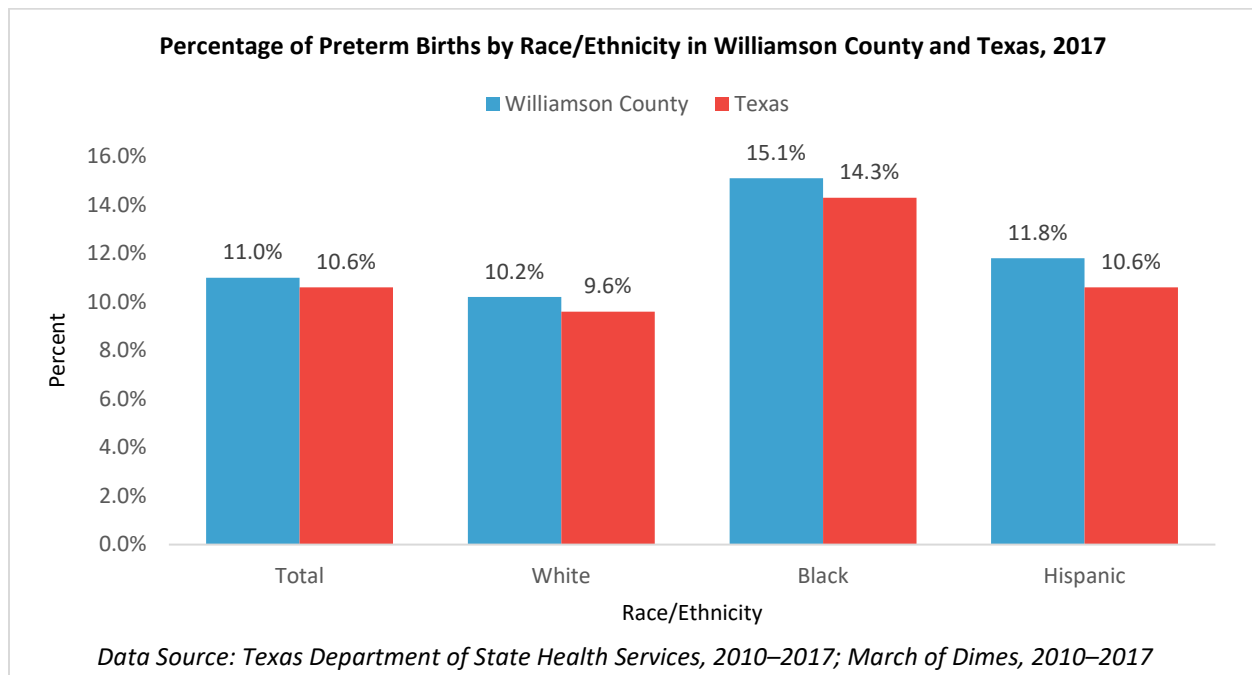
From 2010 to 2017, Williamson County experienced a varying trend in percentage of preterm births, while Texas experienced a fairly consistent trend (Figure 44). The percentage of preterm births in Williamson County decreased marginally from 12.2% in 2010 to 11.0% in 2017. Both Williamson County and Texas have consistently had rates of preterm birth above the Healthy People 2030 target (9.4%).

In 2017, the percentages of preterm births across the White, Black, and Hispanic populations in Williamson County were higher than in Texas (Figure 45). The Black population had the highest percentage (15.1%), followed by the Hispanic population (11.8%) and the White population (10.2%). The percentages of preterm births among the Black and Hispanic populations were higher than the overall county value (11.0%).

⁹⁰ “Babies With Low Birth Weight.”

⁹¹ “Preterm Labor & Preterm Birth.”

⁹² “Preterm Births.”

Figure 44: Percentage of Preterm Births in Williamson County and Texas, 2010–2017**Figure 45: Percentage of Preterm Births by Race/Ethnicity in Williamson County and Texas, 2017**

Infant and Child Mortality

Why is this important?

“Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, preterm delivery, low birth weight, sudden infant death syndrome (SIDS), and maternal complications during pregnancy.”⁹³

⁹³ “Infant Mortality Rate.”

Unintentional injury is the leading cause of death for children and youth in the U.S. Among children, the leading causes of unintentional injury are motor-vehicle traffic, poisoning, drowning, suffocation, burns, and falls.⁹⁴ Because it occurs at an early age, child mortality has a large impact on years of potential life lost, a measure that estimates the average number of additional years a person would have lived had the person not died prematurely.⁹⁵

Table 27: Child and Infant Mortality in Williamson County and Texas

Child and Infant Mortality in Williamson County and Texas		
Indicator	Williamson County	Texas
Infant Mortality Rate* ¹	4.2	5.5
Child Mortality Rate* ²	30.0	50.0

Notes: *per 1,000 live births; †per 100,000 children

Data Source: ¹CDC WONDER, 2017–2018; ²County Health Ranking, 2016–2019

Findings based on Table 27:

- Among infants less than 1 year old, the mortality rate in Williamson County (4.2 per 1,000 live births) is lower than both the Texas rate (5.5 per 1,000 live births) and the Healthy People 2030 target (5.0 per 1,000 live births).
- Among children ages 1 to 17, the mortality rate in Williamson County (30.0 per 100,000 population) is lower than the Texas rate (50.0 per 100,000 population).

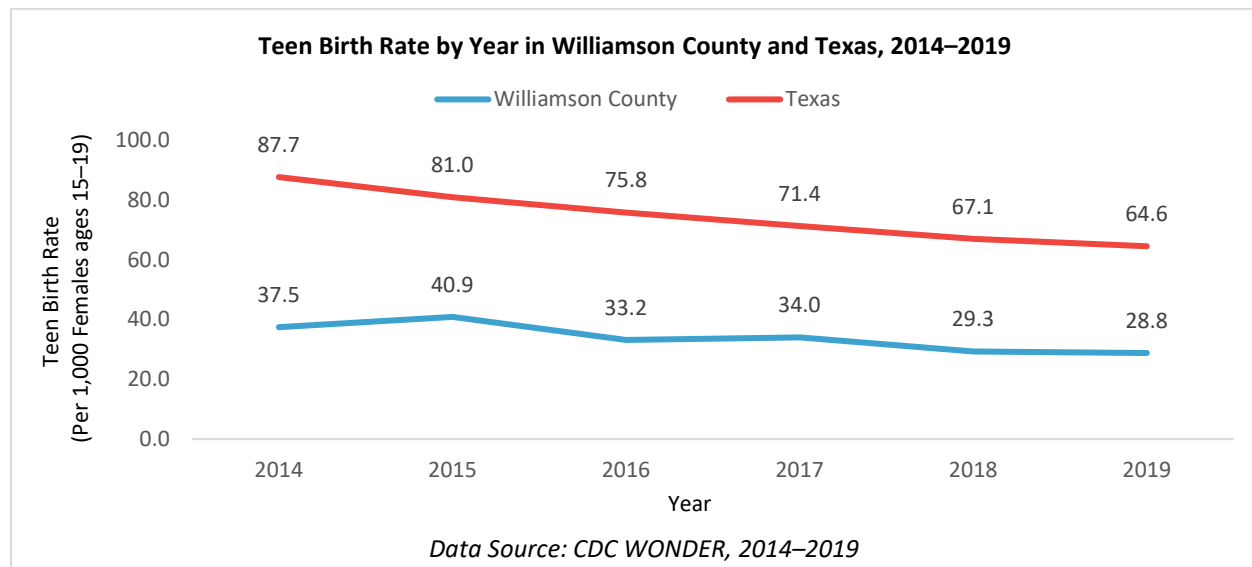
Teen Birth Rate

Why is this important?

“Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mothers, children, families, and communities...Teenage women who bear a child are much less likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress.”⁹⁶

For both Williamson County and Texas, the birth rate among women ages 15 to 19 decreased greatly from 2014 to 2019 (Figure 46). In 2019, the teen birth rate in the county was 28.8 per 1,000 females, which is a 23% decrease from the rate in 2014 (37.5 per 1,000 females ages 15 to 19).

Figure 46: Teen Birth Rate by Year in Williamson County and Texas, 2014–2019



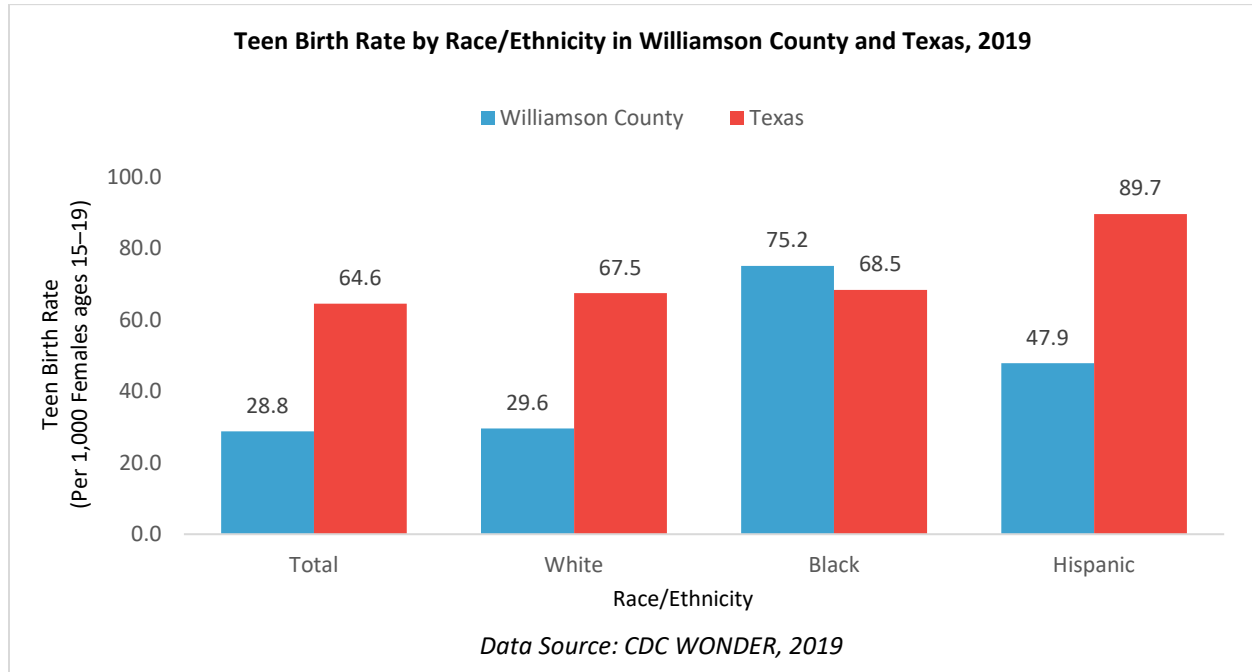
⁹⁴ West et al., “Unintentional Injury Deaths in Children and Youth, 2010–2019.”

⁹⁵ “Child Mortality.”

⁹⁶ “Teen Births.”

Among the White and Hispanic populations, Williamson County has lower teen birth rates than Texas; among the Black population, Williamson County's rate is higher than Texas' (Figure 47). However, the teen birth rates of the White (29.6 per 1,000 females ages 15 to 19), Black (75.2 per 1,000), and Hispanic (47.9 per 1,000 females) populations in Williamson County are higher than the overall county rate (28.8 per 1,000).

Figure 47: Teen Birth Rate by Race/Ethnicity in Williamson County and Texas, 2019



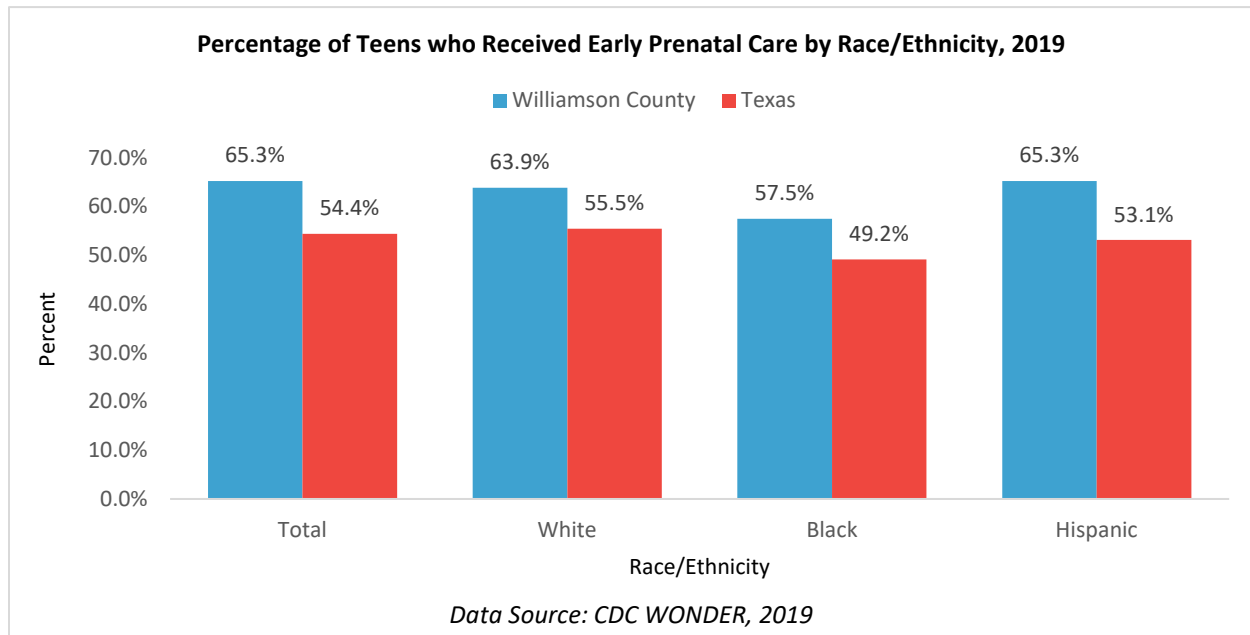
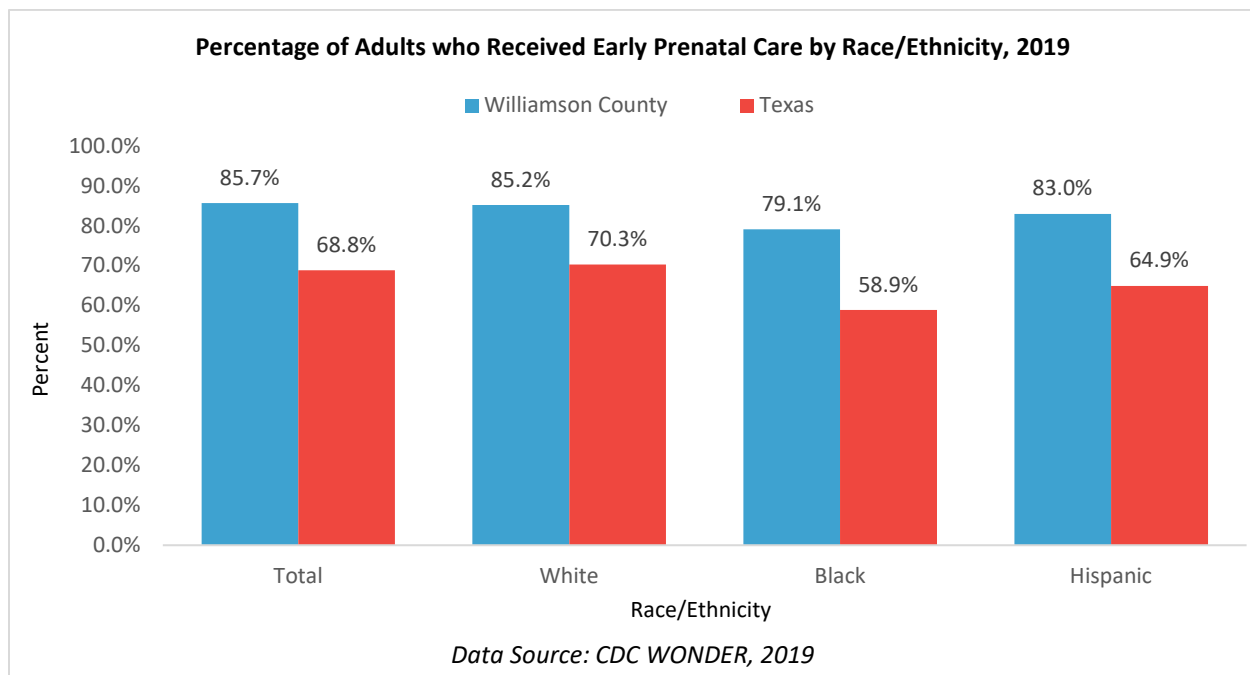
Prenatal Care

Why is this important?

"Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Early prenatal care (i.e., care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development."⁹⁷

In Williamson County, the percentages of teen and adult mothers who received early prenatal care was higher than in Texas across all racial/ethnic groups (Figure 48 and Figure 49). Among teens in Williamson County, the percentages of White (63.9%) and Black (57.5%) mothers who received early prenatal care were below the overall county value (65.3%) (Figure 48). A similar trend is seen among adult mothers in Williamson County: the percentages of White (85.2%), Hispanic (83.0%), and Black (79.1%) mothers who received early prenatal care were lower than the overall county value (85.7%) (Figure 49). In addition, the percentage of teen mothers who received early prenatal care was lower than that of adult mothers across all racial/ethnic groups.

⁹⁷ "Mothers Who Received Early Prenatal Care."

Figure 48: Percentage of Teens who Received Early Prenatal Care by Race/Ethnicity, 2019**Figure 49: Percentage of Adults who Received Early Prenatal Care by Race/Ethnicity, 2019**

Key Findings

Williamson County has many notable strengths regarding maternal and infant health. These include low rates of low birth weight and child mortality and a declining teen birth rate.

In contrast, these trends in maternal, infant, and child health outcomes demand greater attention:

- The Black and Hispanic populations in Williamson County have **preterm and teen birth rates that are higher than the county's overall**.
- The Black population has the **highest percentage of preterm and teen births** and the **lowest percentage of teens and adults who received prenatal care**. Increasing prenatal care among teen and adult mothers can improve birth outcomes such as low birth weight and infant mortality.

- **Preterm births have increased since 2015**, surpassing the state rate and remaining higher than the Healthy People 2030 goal. Preterm birth is more likely to increase healthcare costs and health challenges.

C9. Death, Illness, and Injury

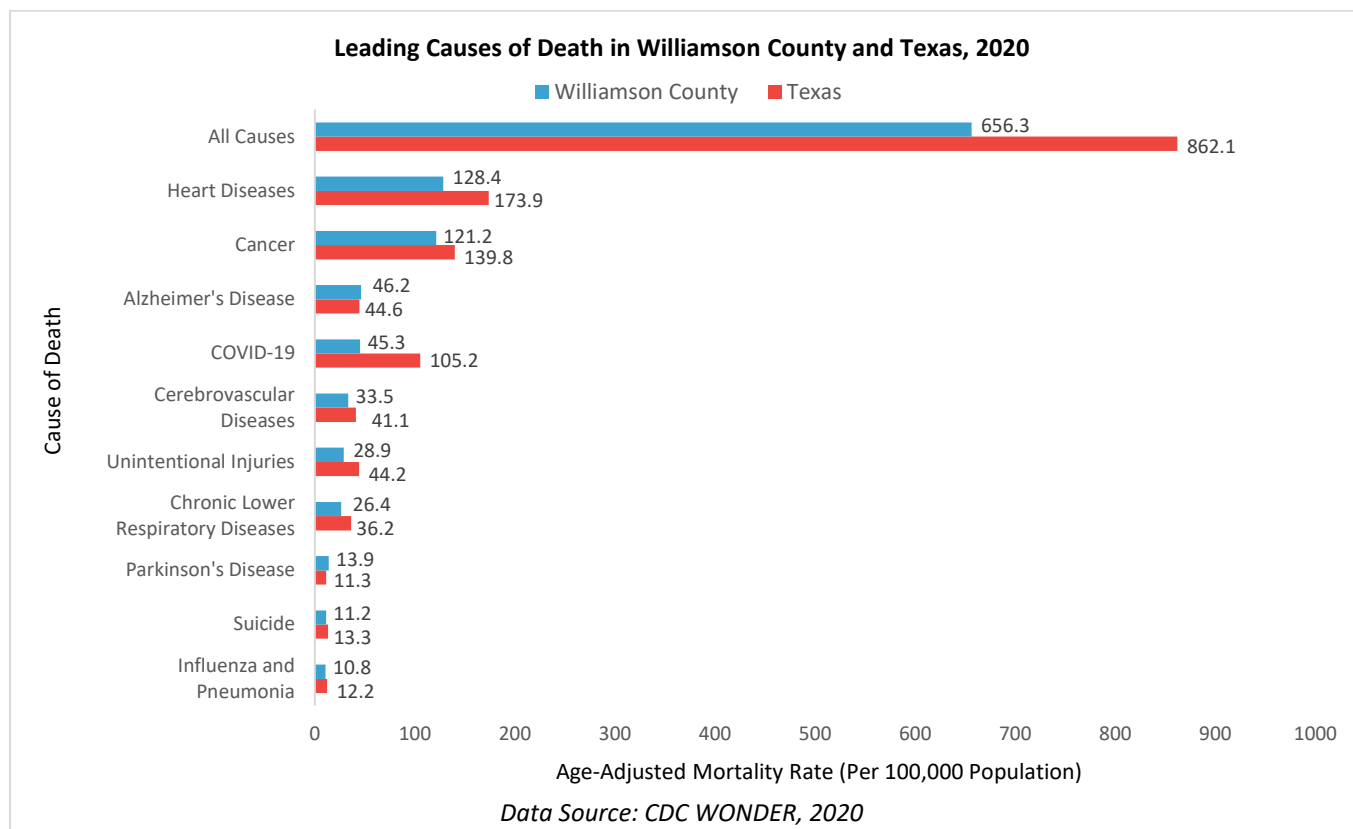
Mortality (rates of death within a population) and morbidity (rates of incidence and prevalence of disease) measure health status in a community. In 2020, the top ten causes of death in Williamson County were⁹⁸:

1. Heart diseases
2. Cancer
3. Alzheimer's disease
4. Coronavirus disease (COVID-19)
5. Cerebrovascular diseases
6. Unintentional Injuries
7. Chronic lower respiratory diseases
8. Parkinson's disease
9. Suicide
10. Influenza and pneumonia

This section examines the relationship between gender, race/ethnicity, and mortality among the top causes of death in Williamson County.

Figure 50 displays age-adjusted mortality rates for the top ten causes of death in Williamson County and Texas in 2020. For all causes of death, Williamson County had a lower age-adjusted mortality rate (656.3 deaths per 100,000 population) than Texas (862.1 deaths per 100,000 population).^{99;100} Compared to Texas, Williamson County had higher age-adjusted mortality rates for Alzheimer's disease (44.6 for Texas and 46.2 for Williamson County per 100,000 population) and Parkinson's disease (11.3 and 13.9 per 100,000 population, respectively). Coronavirus disease (COVID-19) became the third leading cause of death in Texas and the fourth leading cause of death in Williamson County in 2020, the first year of the ongoing global pandemic. In 2020, the leading cause of death in both Williamson County and Texas was heart diseases.

Figure 50: Leading Causes of Death in Williamson County and Texas, 2020



⁹⁸ "Underlying Cause of Death 1999-2020: 15 Leading Causes of Death: Williamson County, TX on CDC WONDER Online Database."

⁹⁹ "Underlying Cause of Death 1999-2020: Williamson County, TX on CDC WONDER Online Database."

¹⁰⁰ "Underlying Cause of Death 1999-2020: Texas on CDC WONDER Online Database."

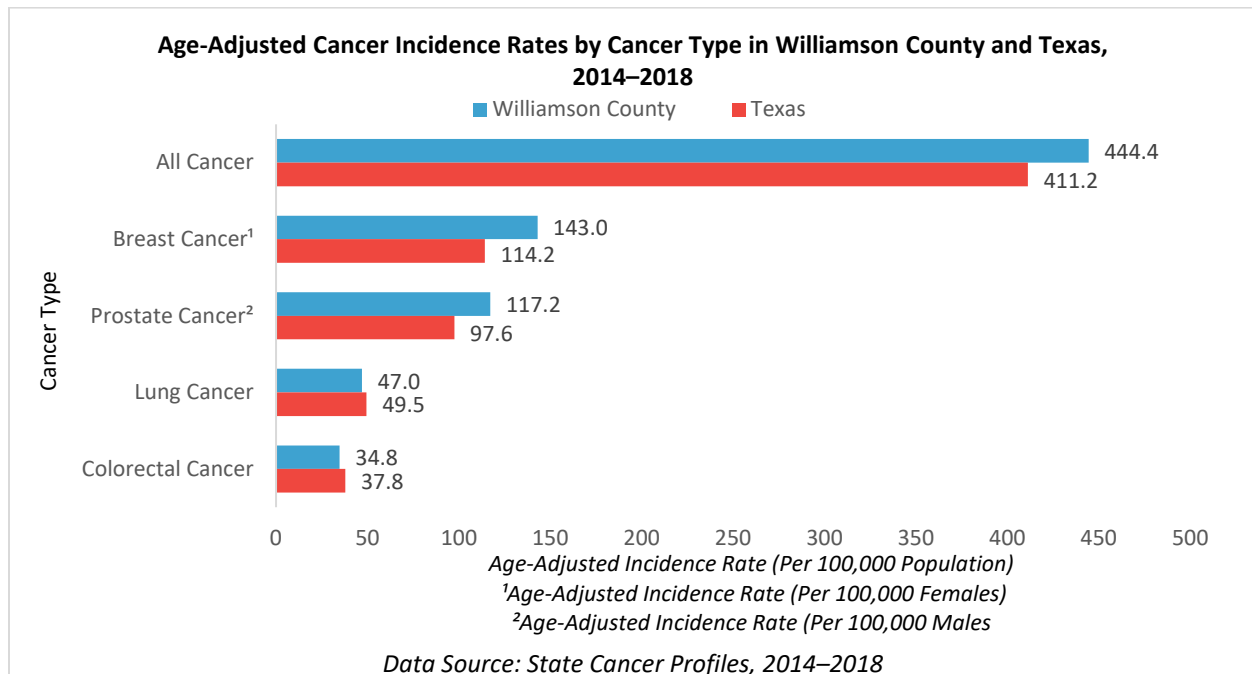
Cancer

Why is this important?

“The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and are able to invade other tissues. According to the NCI there are over 100 different types of cancer, but breast, colon, lung, pancreatic, prostate, and rectal cancer lead to the greatest number of annual deaths. Risk factors of cancer include but are not limited to age, alcohol use, tobacco use, a poor diet, certain hormones, and sun exposure.” Certain risk factors (i.e., age) are unavoidable, but reducing exposure to others, such as alcohol use and sun exposure, may decrease the risk for some cancers.¹⁰¹

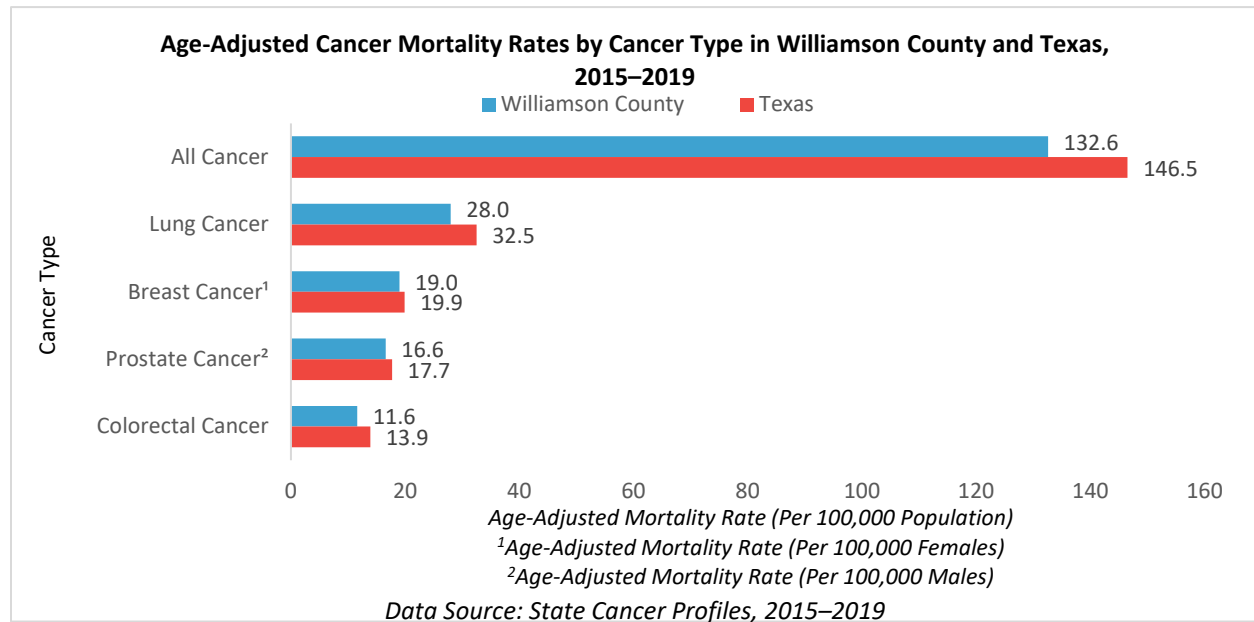
The age-adjusted cancer incidence rate, which describes newly diagnosed cases, was higher in Williamson County (444.4 per 100,000 population) than in Texas (411.2 per 100,000 population) (Figure 51). Of all cancer types, breast cancer had the highest incidence rate in Williamson County (143.0 per 100,000 females), followed by prostate cancer (117.2 per 100,000 males). The incidence rate of each was higher in Williamson County than in Texas (114.2 newly diagnosed breast cancer cases per 100,000 females and 97.6 newly diagnosed prostate cancer cases per 100,000 males). In contrast, both lung and colorectal cancer incidence rates were lower in Williamson County than in Texas.

Figure 51: Age-Adjusted Cancer Incidence Rates by Cancer Type in Williamson County and Texas, 2014–2018



The age-adjusted cancer mortality rate was lower in Williamson County (132.6 deaths per 100,000 population) than in Texas (146.5 per 100,000 population) (Figure 52). In Williamson County, lung cancer had the highest mortality rate (28.0 per 100,000 population), followed by breast cancer (19.0 per 100,000 females).

¹⁰¹ “Adults with Cancer.”

Figure 52: Age-Adjusted Cancer Mortality Rates by Cancer Type in Williamson County and Texas, 2015–2019

From 2010 to 2020, the age-adjusted all-cancer mortality rate in Williamson County was relatively consistent, while the rate in Texas steadily decreased (Figure 53). In Williamson County, the 2010–2014 rate was 134.8 deaths per 100,000 population and the 2016–2020 rate was 127.8 per 100,000 population.

Males and females in Williamson County had lower age-adjusted all-cancer mortality rates (150.7 and 107.6 deaths per 100,000 population, respectively), compared to males and females in Texas (168.5 and 119.5 deaths per 100,000 population, respectively) (Figure 54). Only the age-adjusted all-cancer mortality rates for females in Williamson County and Texas were below the Healthy People 2030 target of 122.7 deaths per 100,000 population.

Williamson County and Texas had slightly differing trends in age-adjusted all-cancer mortality rate based on race/ethnicity (Figure 55). The White population had the highest mortality rate in Williamson County (129.9 deaths per 100,000 population), followed by the Black population (126.2). In Texas, the Black population had the highest rate (169.9), followed by the White population (141.1). In both Williamson County and Texas, the Hispanic population had the second lowest rates (87.6 in Williamson County and 111.5 in Texas), and the Asian population had the lowest rates (62.5 and 83.6). The rates for both the Hispanic and Asian populations in Williamson County and in Texas were below the Healthy People 2030 target of 122.7 deaths per 100,000 population.

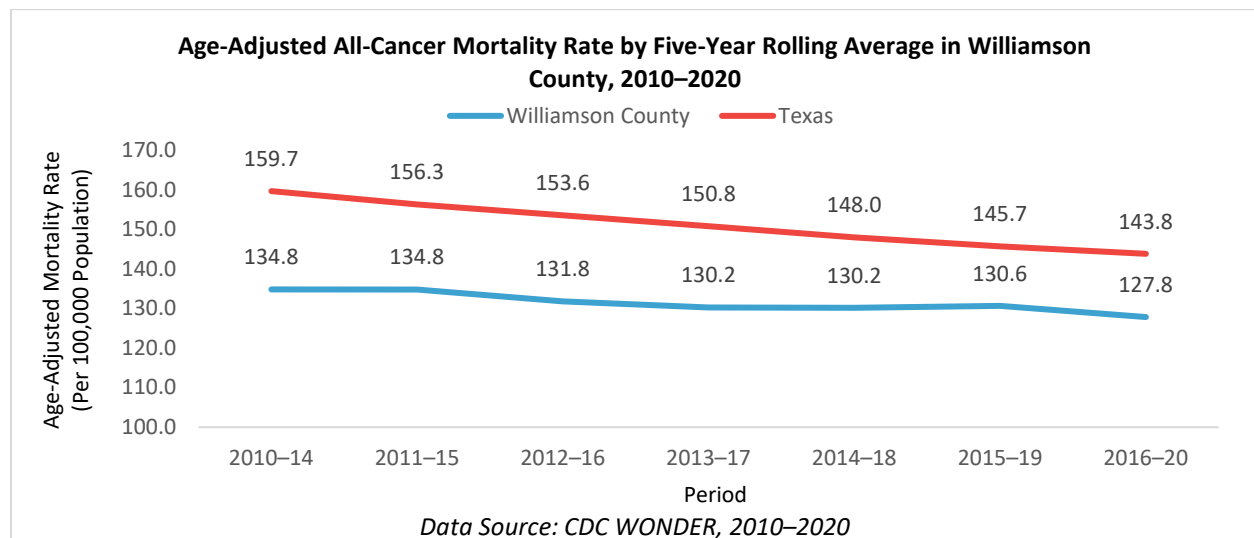
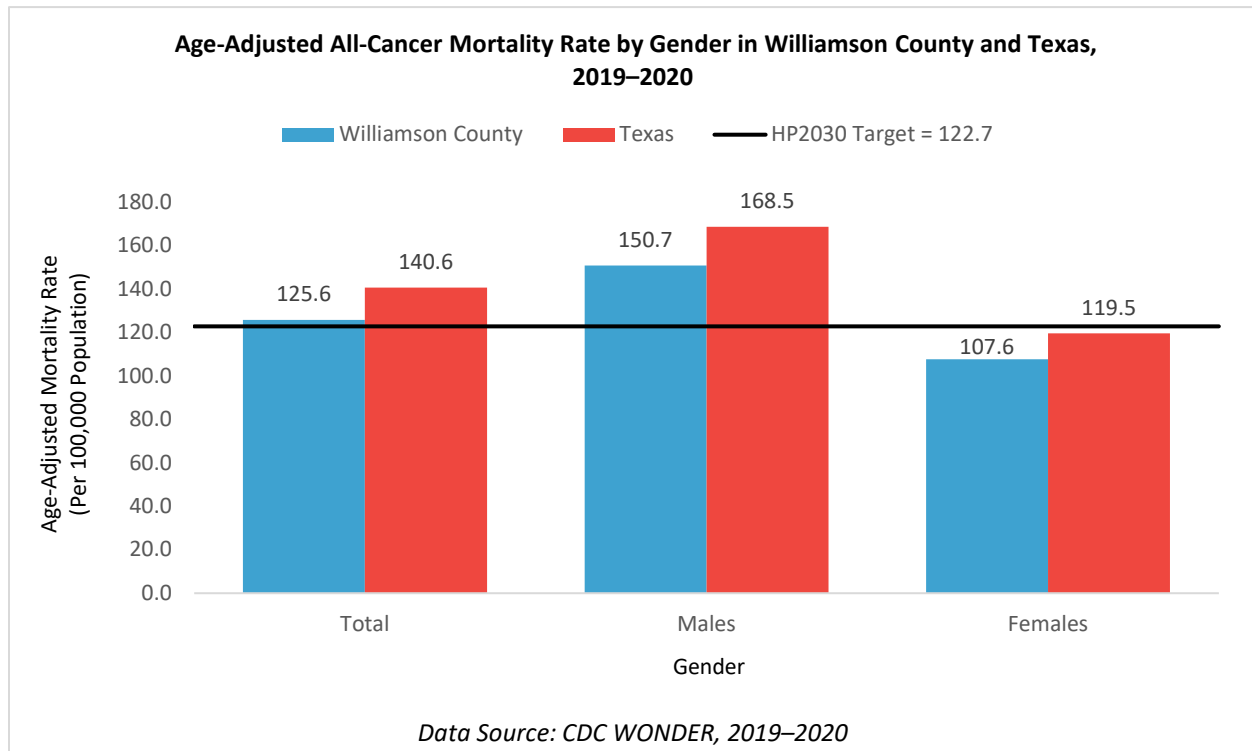
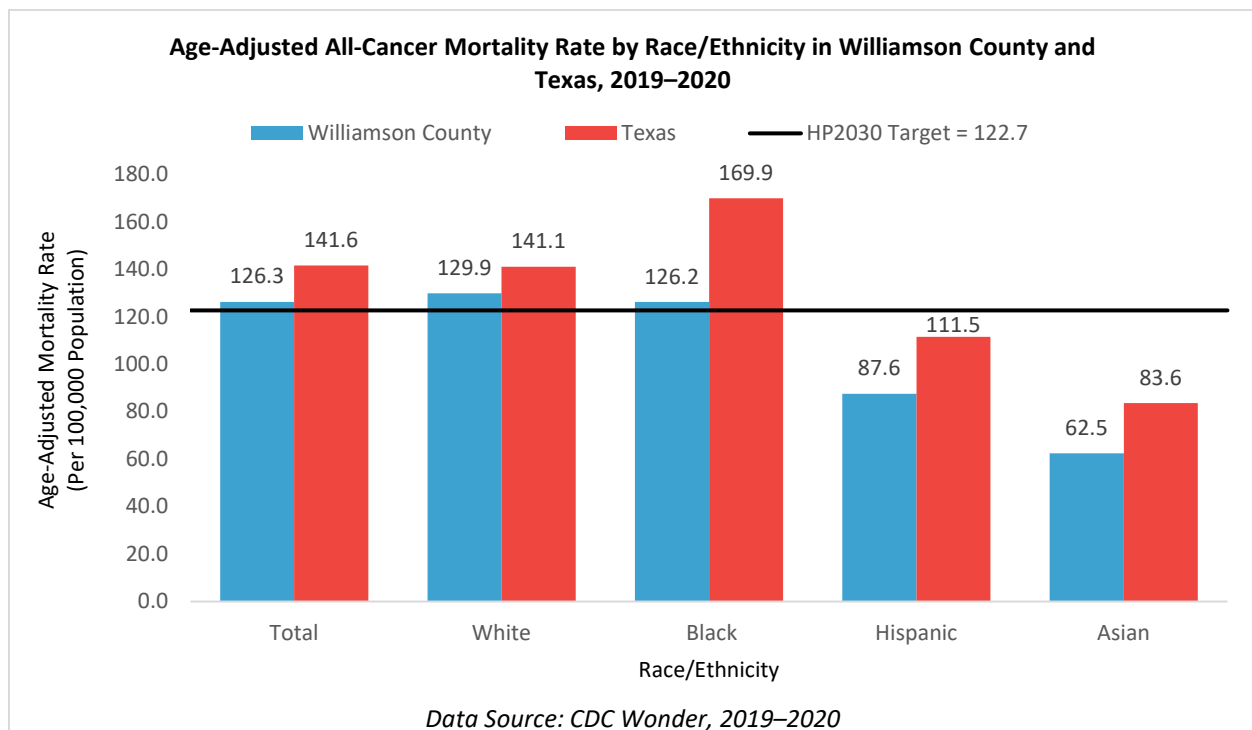
Figure 53: Age-Adjusted All-Cancer Mortality Rate by Five-Year Rolling Average in Williamson County, 2010–2020

Figure 54: Age-Adjusted All-Cancer Mortality Rate by Gender in Williamson County and Texas, 2019–2020**Figure 55: Age-Adjusted All-Cancer Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2019–2020**

Heart Diseases

Why are these important?

“Cardiovascular diseases, including heart disease and stroke, account for more than one-third of all U.S. deaths and a leading cause of disability. Heart disease is a term that encompasses a variety of different diseases affecting the heart. The most common type in the United States is coronary artery disease, which can cause heart attack, angina, heart failure, and

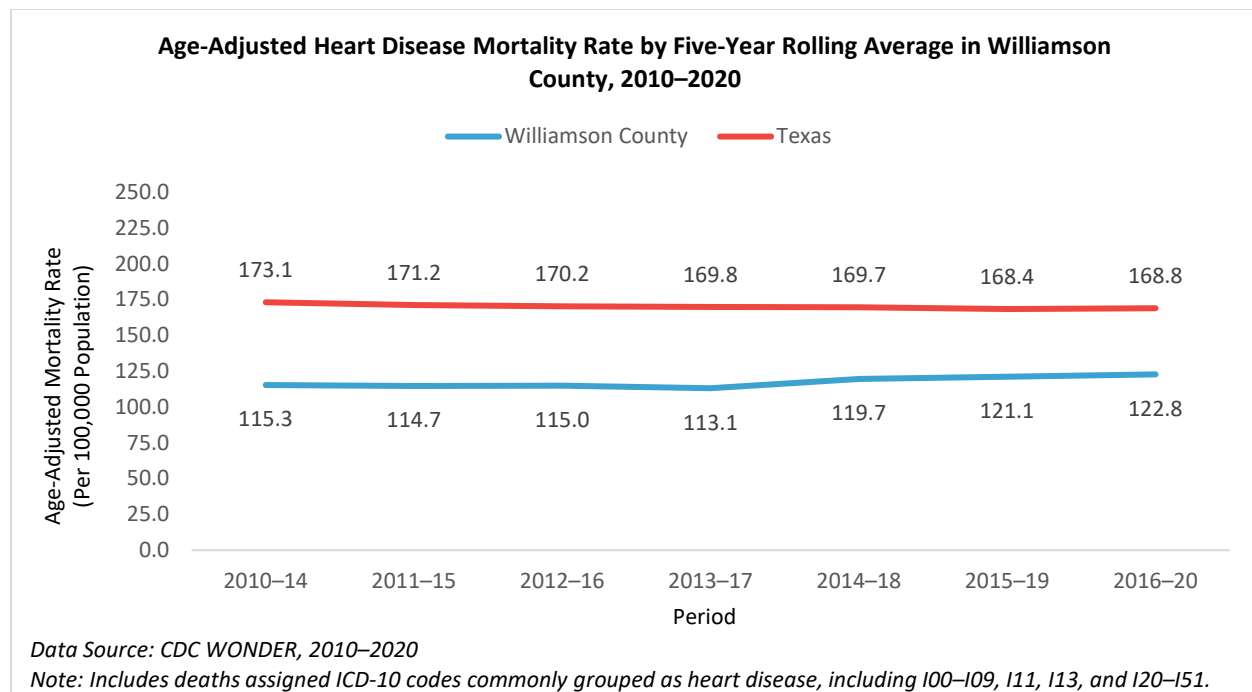
arrhythmias. There are many modifiable risk factors for heart disease and stroke including tobacco smoking, obesity, sedentary lifestyle, and poor diet. Controlling high blood pressure and cholesterol are also important prevention strategies.”¹⁰² Note that the data in this subsection include only those for heart diseases and exclude those for other circulatory system diseases, like stroke.

From 2010 to 2020, Williamson County consistently had a lower age-adjusted heart disease mortality rate than Texas (Figure 56). However, while the mortality rate in Texas decreased over the 11-year period, the mortality rate in Williamson County increased from 115.3 per 100,000 population in 2010–2014 to 122.8 per 100,000 population in 2016–2020.

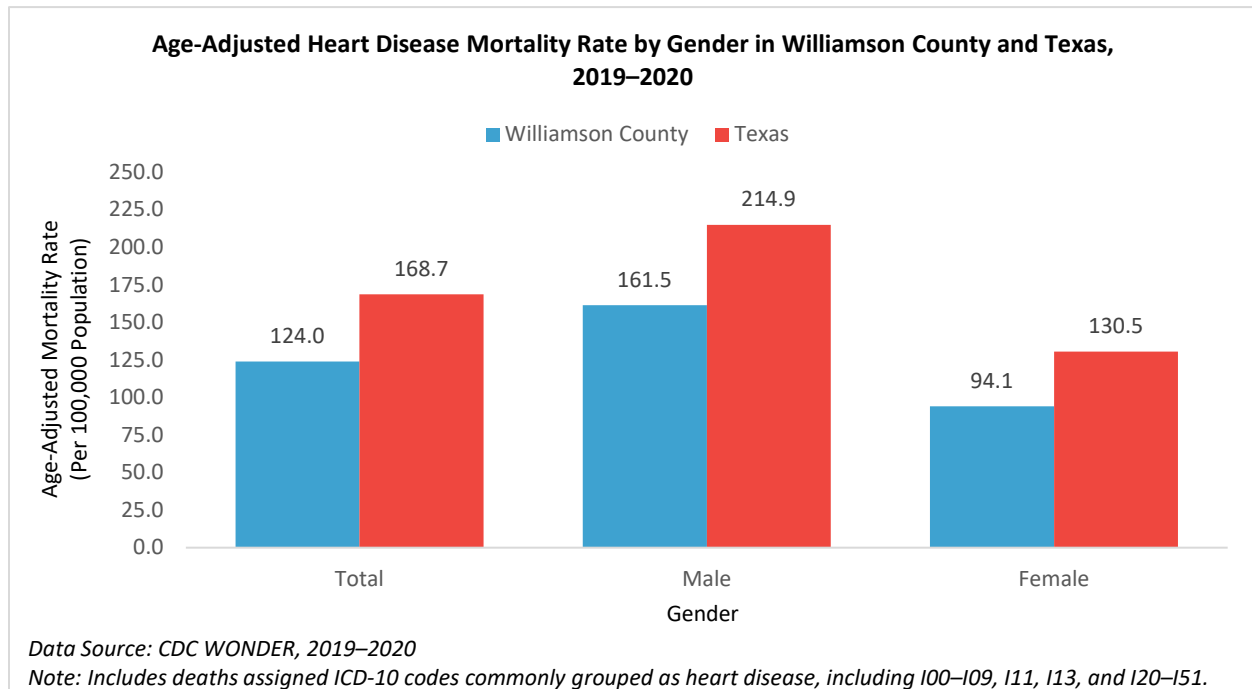
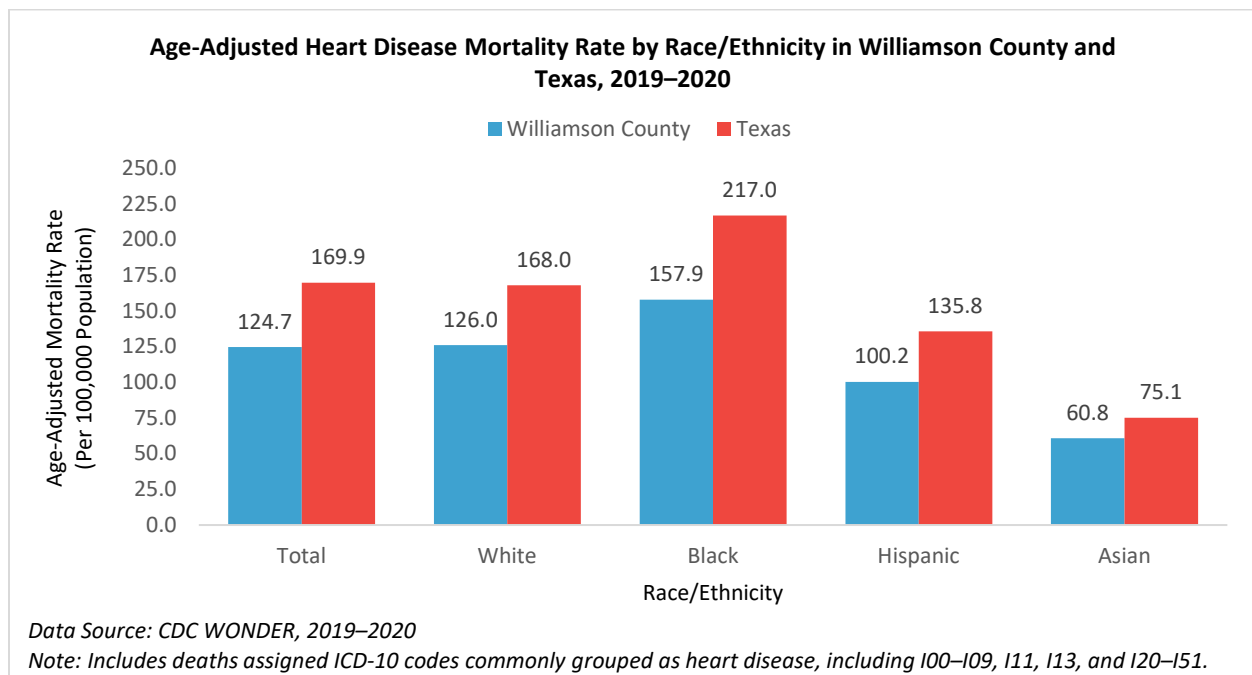
Males and females in Williamson County had lower age-adjusted heart disease mortality rates compared to males and females in Texas: 161.5 and 94.1 per 100,000 population for males and females, respectively, in Williamson County, as compared to 214.9 and 130.5 per 100,000 population for males and females, respectively, in Texas (Figure 57).

Williamson County and Texas had similar profiles regarding age-adjusted heart disease mortality rate based on race/ethnicity (Figure 58). The Black population had the highest mortality rate (157.9 deaths in Williamson County and 217.0 deaths in Texas per 100,000 population), followed by the White (126.0 and 168.0, respectively), Hispanic (100.2 and 135.8, respectively), and Asian (60.8 and 75.1, respectively) populations.

Figure 56: Age-Adjusted Heart Disease Mortality Rate by Five-Year Rolling Average in Williamson County, 2010–2020



¹⁰² “Adults Who Experienced Coronary Heart Disease.”

Figure 57: Age-Adjusted Heart Disease Mortality Rate by Gender in Williamson County and Texas, 2019–2020**Figure 58: Age-Adjusted Heart Disease Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2019–2020**

Alzheimer's Disease

Why is this important?

Healthy Williamson County describes Alzheimer's disease and its toll:

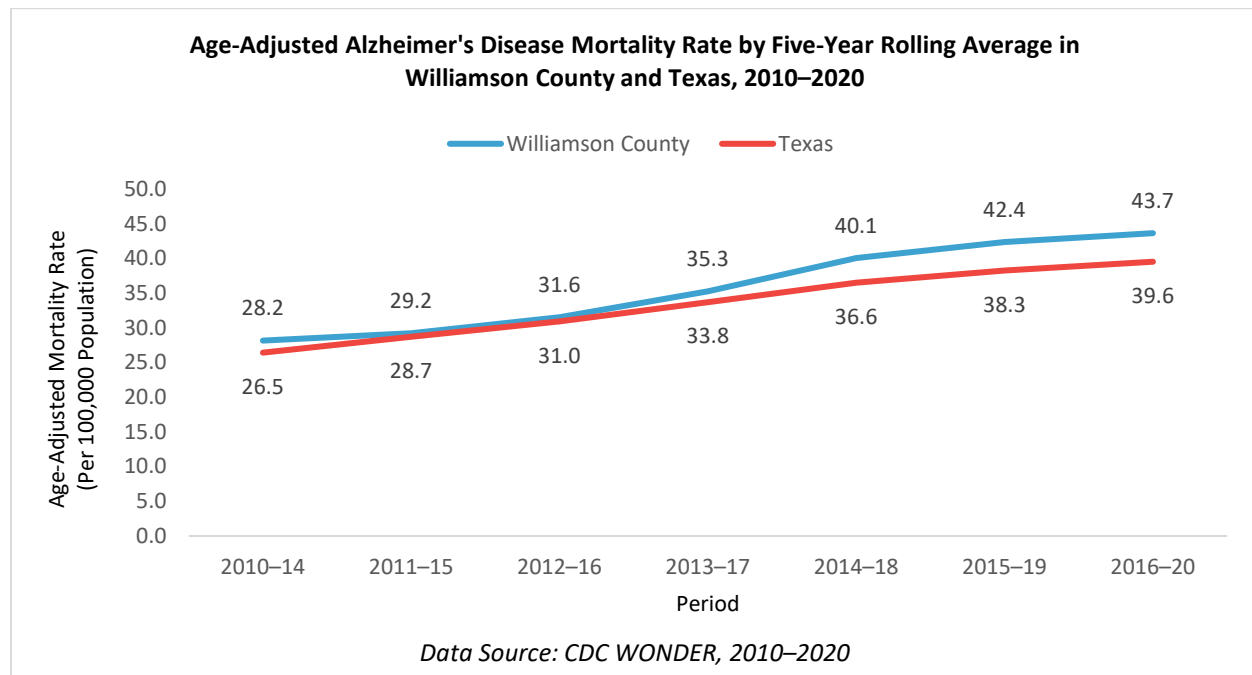
Alzheimer's disease is the most common form of dementia among older people. It is a progressive and irreversible disease that impairs memory and affects thinking and behavior, to the point of eventually interfering with daily tasks. The greatest risk factor currently known is increasing age. After age 65, the likelihood of developing the disease doubles every five years; the risk is nearly 50% after age 85. Alzheimer's imposes heavy emotional and financial

burdens on families. While there is currently no cure, there are treatments that can slow the progression of Alzheimer's and improve the quality of life for people with Alzheimer's and their caregivers.¹⁰³

From 2010 to 2020, Williamson County and Texas experienced similar trends in age-adjusted Alzheimer's disease mortality rate, with both increasing during the 11-year period (Figure 59).

In Williamson County, the age-adjusted Alzheimer's disease mortality rate was higher among females (48.6 deaths per 100,000 population) compared to males (34.0 per 100,000 population) (Figure 60). Moreover, the rate among females was higher than the overall county value (43.2 per 100,000 population). The White population in Williamson County had the highest age-adjusted Alzheimer's disease mortality rate (44.8 per 100,000 population), followed by the Black (33.8 per 100,000 population) and Hispanic (28.7 per 100,000 population) populations (Figure 61). Note that the age-adjusted Alzheimer's disease mortality rates by gender and race/ethnicity are based on data from 2015–2020, while the mortality rates for the other causes of death in this section are based on data from 2019–2020. This is due to a lack of reliable data for the Alzheimer's disease mortality reporting categories from 2019–2020 data alone.

Figure 59: Age-Adjusted Alzheimer's Disease Mortality Rate by Five-Year Rolling Average in Williamson County and Texas, 2010–2020



¹⁰³ "Age-Adjusted Death Rate Due to Alzheimer's Disease."

Figure 60: Age-Adjusted Alzheimer's Disease Mortality Rate by Gender in Williamson County and Texas, 2015–2020

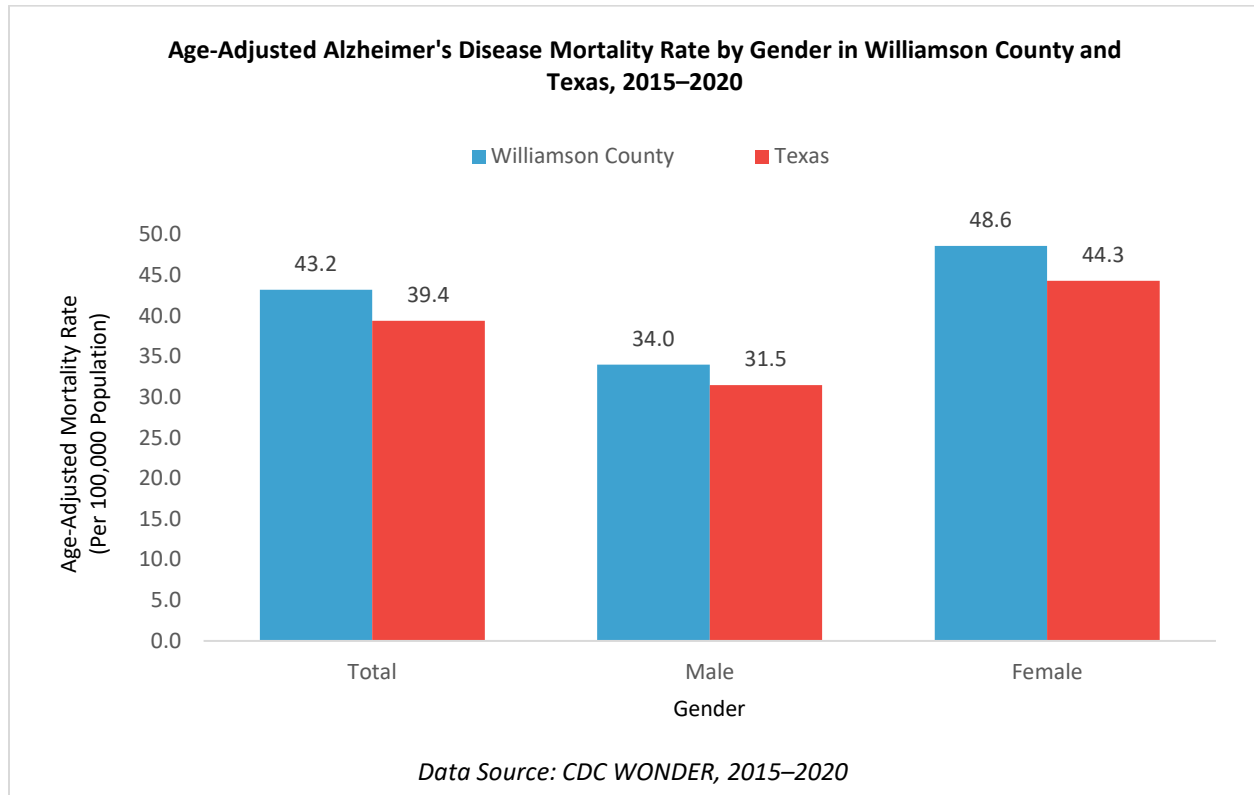
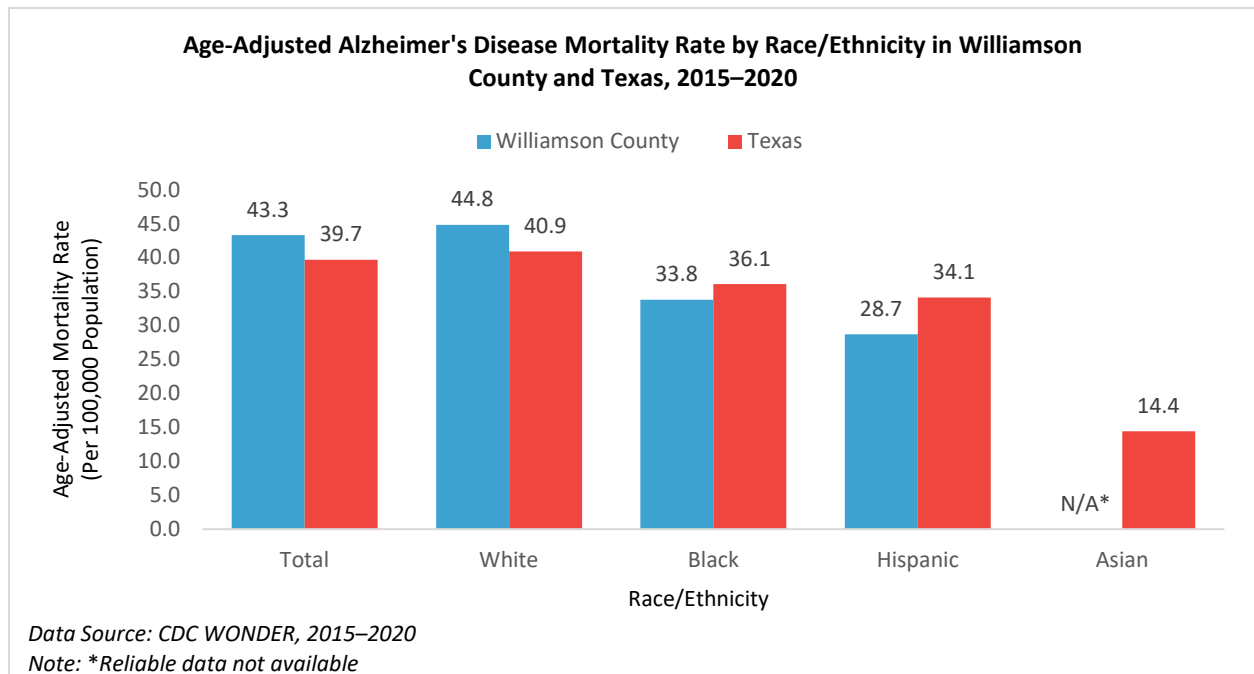


Figure 61: Age-Adjusted Alzheimer's Disease Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2015–2020



Unintentional Injuries

Why are these important?

Injuries affect everyone regardless of age, economic status, or race. According to the Centers for Disease Control and Prevention, “In the first half of life, more Americans die from injuries...than from any other cause, including cancer, HIV, or

the flu.” Unintentional injuries — including unintentional poisoning (e.g., drug overdose), motor-vehicle crashes, unintentional drowning, and unintentional falls, among others — are the leading cause of death for Americans ages 1 to 44.¹⁰⁴

From 2010 to 2020, Williamson County and Texas experienced similar trends in unintentional injury mortality rate (Figure 62).

In Williamson County, the age-adjusted unintentional injury mortality rate was lower among females (19.2 deaths per 100,000 population) compared to males (40.9 per 100,000 population) (Figure 63). Moreover, the rate among males was higher than the overall county value (29.6 per 100,000 population). The Black population in Williamson County had the highest age-adjusted unintentional injury mortality rate (45.6 deaths per 100,000 population), which also exceeded the overall county value (29.8 per 100,000 population) (Figure 64).

Figure 62: Age-Adjusted Unintentional Injury Mortality Rate by Five-Year Rolling Average in Williamson County and Texas, 2010–2020

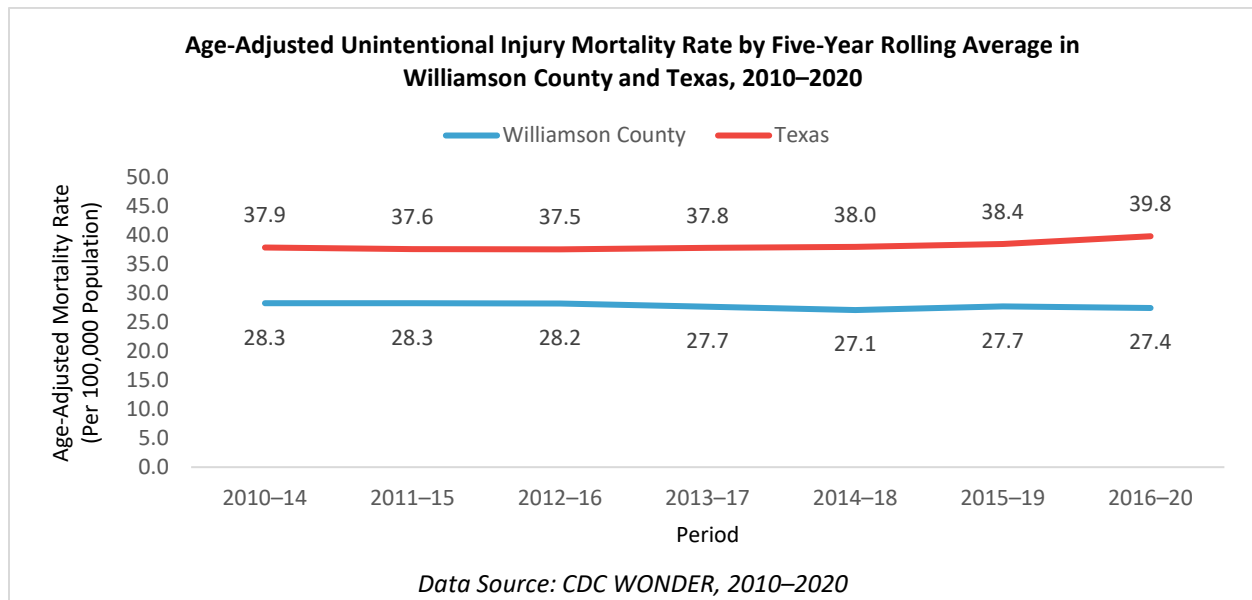
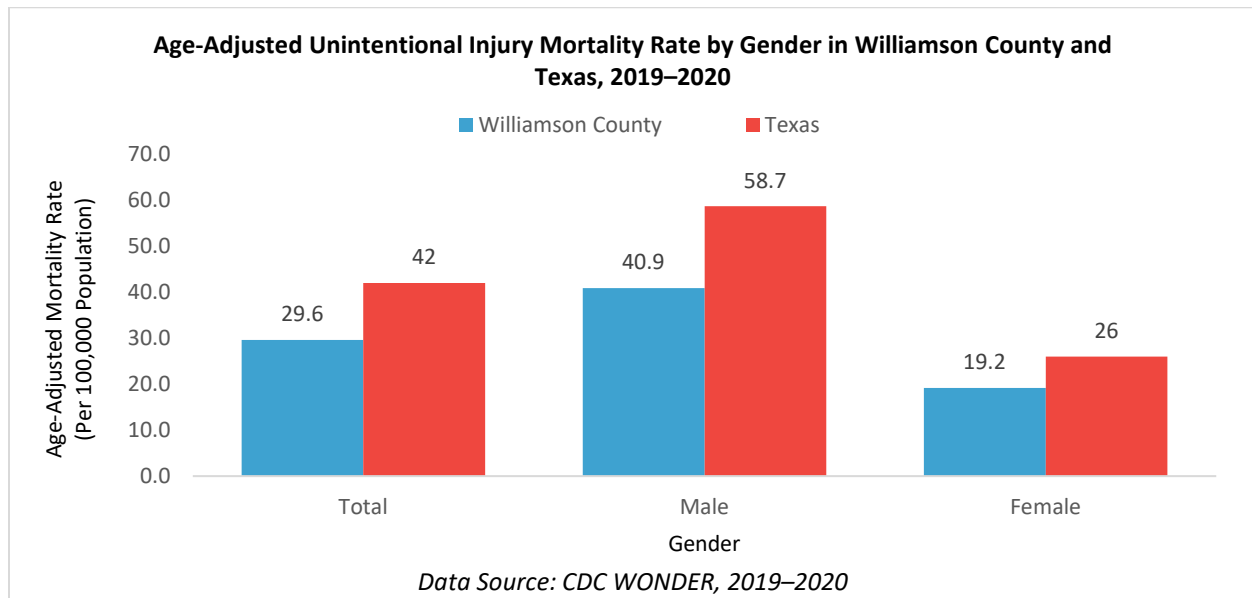
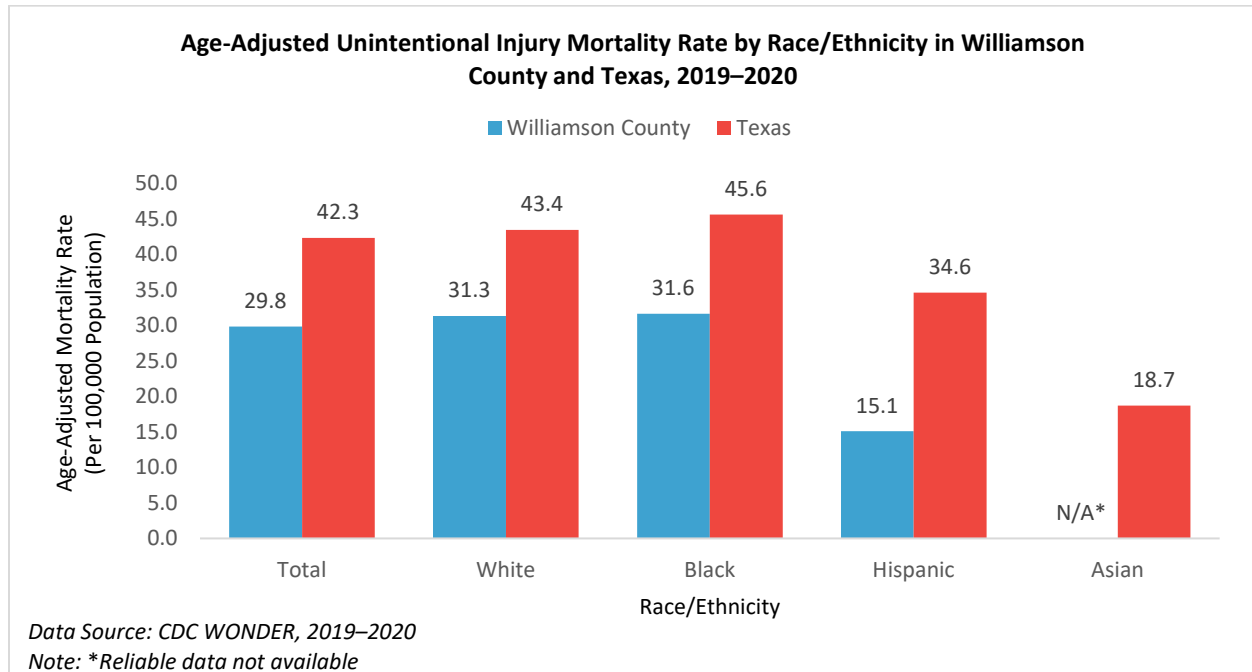


Figure 63: Age-Adjusted Unintentional Injury Mortality Rate by Gender in Williamson County and Texas, 2019–2020



¹⁰⁴ “Injuries and Violence Are Leading Causes of Death.”

Figure 64: Age-Adjusted Unintentional Injury Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2019–2020



Key Findings

Although Williamson County has lower rates of mortality compared to Texas for most of the leading causes of death, there are specific populations that carry a higher burden of disease and should be considered when developing interventions, programs, and services.

- **Cancer incidence rates are overall higher than the state’s rates.** Cancer screening should be prioritized to diagnose cancer during early stages before it becomes fatal. Recent incidence data are needed to inform early cancer detection and prevention activities in Williamson County.
- **Since heart diseases and cancer are the leading causes of death in Williamson County,** program and service planning should consider high-risk populations, which include Black, White, and Hispanic males.
- **Alzheimer’s disease is the third leading cause of death in Williamson County, with increasing mortality rates that are higher in the county than in Texas.** The female, Black, and White populations have disproportionately high rates of death from Alzheimer’s disease.
- **Unintentional injuries are the sixth leading cause of death in Williamson County,** with higher rates in males. However, unintentional injury mortality rates in the county are lower than in Texas.

Notably, Williamson County has heart disease mortality rates that are substantially lower than the state’s rates.

C10. Communicable Disease

Communicable diseases, which include sexually transmitted infections and tuberculosis, pose a significant public health concern worldwide. Fortunately, there are ways to mitigate the spread of communicable diseases. Persons with these diseases — including, but not limited to, syphilis, chlamydia, gonorrhea, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS) — can prevent the spread of infection by practicing abstinence or using proper protection during sexual intercourse.¹⁰⁵ Individuals with tuberculosis should avoid physical contact with others, practice frequent handwashing, and take prescribed medicine as directed by a health professional.¹⁰⁶

Most of the data in this section come from a passive disease surveillance system which collects diseases from the “Texas

¹⁰⁵ “STD Prevention.”

¹⁰⁶ “Tuberculosis-How TB Spreads.”

Notifiable Conditions 2021” list. Texas law requires that healthcare providers, hospitals, laboratories, and others report select conditions to local health departments, who then submit data to the Texas Department of State Health Services, and ultimately to the Centers for Disease Control and Prevention (CDC). Since this surveillance system only captures diseases reported to health departments, there are cases that go undetected or unreported. Consequently, the data in this section may not completely represent the actual burden of disease but still offer insight regarding disease trends and affected population groups.

Syphilis

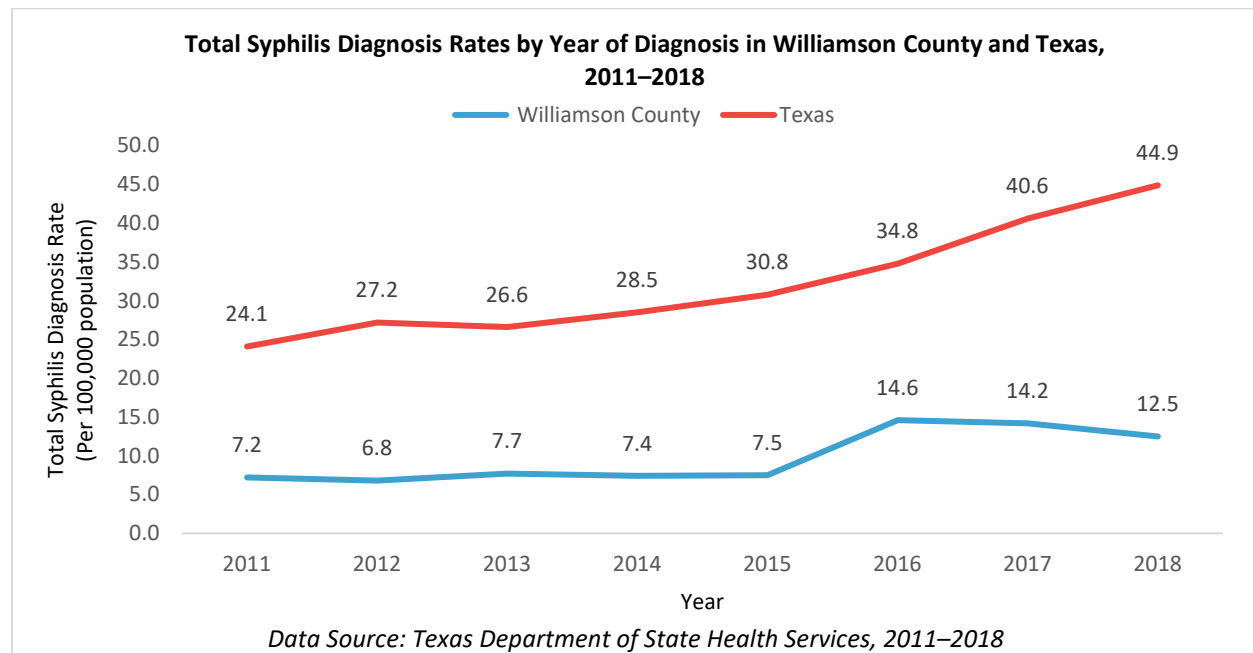
Why is this important?

Syphilis is a sexually transmitted infection that, if untreated, can cause serious health problems. Syphilis is divided into stages, which include primary and secondary (P&S, mild signs and symptoms), latent (no signs or symptoms), and tertiary (associated with severe medical complications).¹⁰⁷

Pregnant women with untreated syphilis can pass the infection to the unborn baby. The infection can lead to a low-birth-weight baby and make it more likely that the woman will deliver her baby too early or stillborn (born dead). “An infected baby may be born without signs or symptoms of disease. However, if not treated immediately, the baby may develop serious problems within a few weeks. Untreated babies can have health problems such as cataracts, deafness, or seizures, and can die.”¹⁰⁸ Women should be tested for syphilis at least once during pregnancy and receive immediate treatment if they test positive.

Annual reported syphilis diagnosis rates in Williamson County, which include P&S and total (all stages), remained lower than Texas rates from 2011 to 2018 (Figure 65 and Figure 66). However, the reported total syphilis diagnosis rate in Williamson County almost doubled between 2015 (7.5 infections per 100,000 population) and 2016 (14.6 infections per 100,000 population) (Figure 65). Moreover, reported P&S syphilis diagnosis rates in Williamson County rose from 1.4 infections per 100,000 population in 2011 to 3.7 infections per 100,000 population in 2018 (Figure 66).

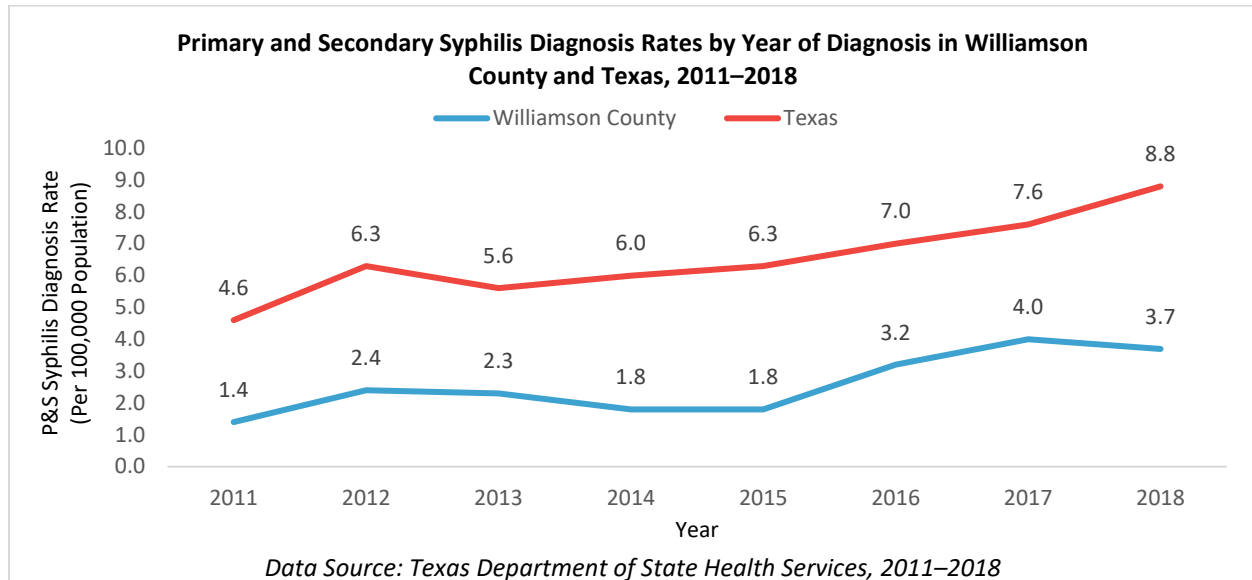
Figure 65: Total Syphilis Diagnosis Rates by Year of Diagnosis in Williamson County and Texas, 2011–2018



¹⁰⁷ “STD Facts- Syphilis.”

¹⁰⁸ Ibid.

Figure 66: Primary and Secondary Syphilis Diagnosis Rates by Year of Diagnosis in Williamson County and Texas, 2011–2018



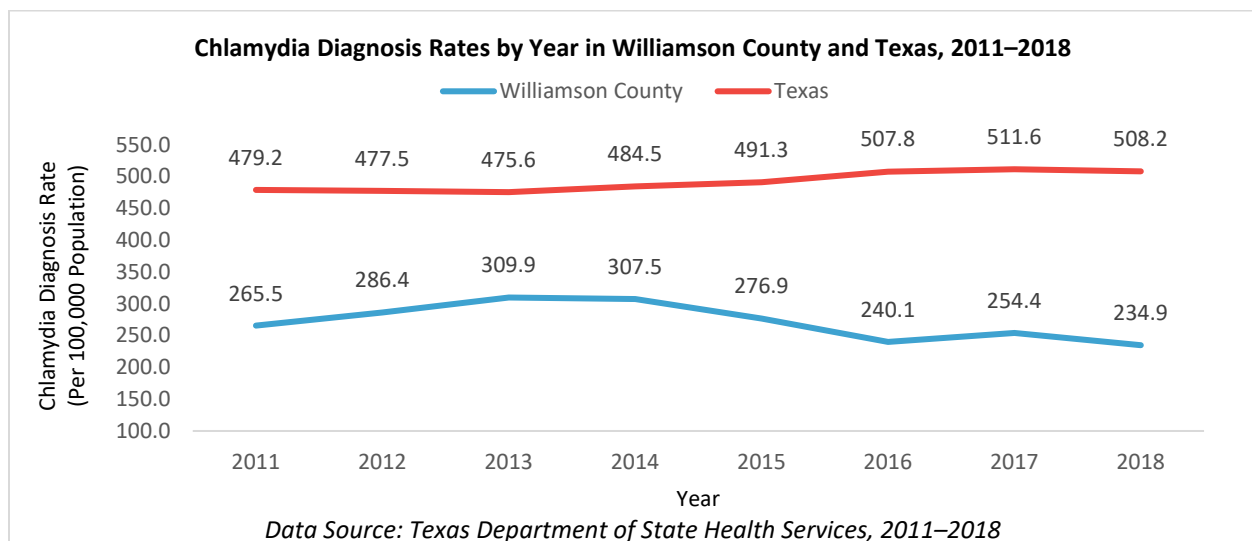
Chlamydia

Why is this important?

According to the CDC, chlamydia is the most frequently reported bacterial sexually transmitted infection in the U.S.¹⁰⁹ Although chlamydia can infect both men and women, it is most common in women ages 15 to 24. Most individuals with chlamydia do not display symptoms, but for those who do, it might not be for several weeks after infection. This may result in many cases going unreported. Lack of screening to identify the infection may result in serious complications, “including pelvic inflammatory disease (PID), tubal factor infertility, ectopic pregnancy, and chronic pelvic pain.”¹¹⁰ Pregnant women can pass the infection to the baby during delivery, which can cause an eye infection or pneumonia in the newborn. Chlamydia also makes it more likely that the baby will be born prematurely.

From 2011 to 2018, reported chlamydia diagnosis rates in Williamson County remained lower than rates in Texas (Figure 67). Chlamydia diagnosis rates in Williamson County have mostly declined since a peak in 2013.

Figure 67: Chlamydia Diagnosis Rates by Year in Williamson County and Texas, 2011–2018



¹⁰⁹ “Chlamydia Statistics.”

¹¹⁰ “Chlamydia Basic Fact Sheet.”

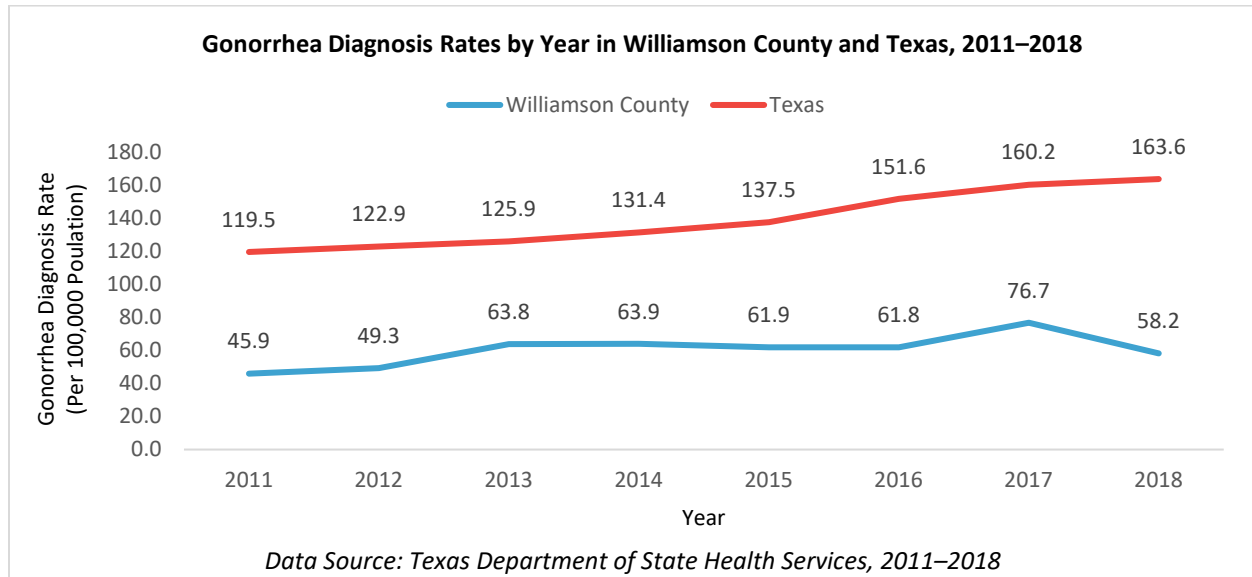
Gonorrhea

Why is this important?

Gonorrhea is a very common sexually transmitted infection that occurs most often among men and women ages 15 to 24.¹¹¹ “Gonorrhea has progressively developed resistance to the antibiotic drugs prescribed to treat it.”¹¹² If untreated, gonorrhea can cause serious complications, such as infertility in both men and women. Additionally, there can be serious complications for a pregnant woman’s baby during childbirth if the woman does not seek treatment in a timely manner.

Reported diagnosis rates of gonorrhea between 2011 and 2018 were lower in Williamson County compared to Texas (Figure 68). However, Williamson County rates have increased over this seven-year period, from 45.9 per 100,000 population to 58.2 per 100,000 population.

Figure 68: Gonorrhea Diagnosis Rates by Year in Williamson County and Texas, 2011–2018



HIV and AIDS Diagnosis

Why is this important?

Describing HIV and AIDS, Healthy Williamson County writes:

The human immunodeficiency virus (HIV) damages the immune system, eventually leading infected individuals to develop acquired immunodeficiency syndrome (AIDS), a chronic and potentially life-threatening condition. People infected with HIV may develop mild infections or chronic symptoms like fever, fatigue, shortness of breath, and weight loss. If left untreated, HIV typically progresses to AIDS in about 10 years, at which point the immune system is weakened to the point of being unable to fight infections. Men who have sex with men of all races, African Americans, and Hispanics/Latinos are disproportionately affected by HIV.¹¹³

More people than ever before are living with HIV or AIDS because today’s better treatments enable people with HIV or AIDS to live longer than they did in the past. “While the total number of people living with HIV in the U.S. is increasing, the number of annual new HIV infections has remained stable in recent years.”¹¹⁴

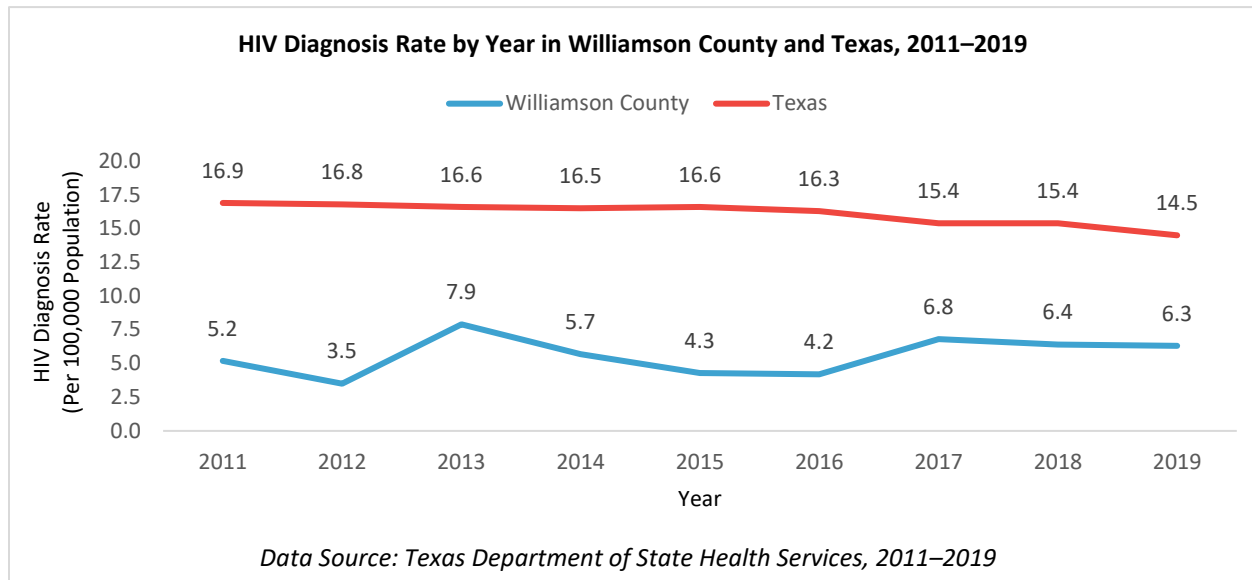
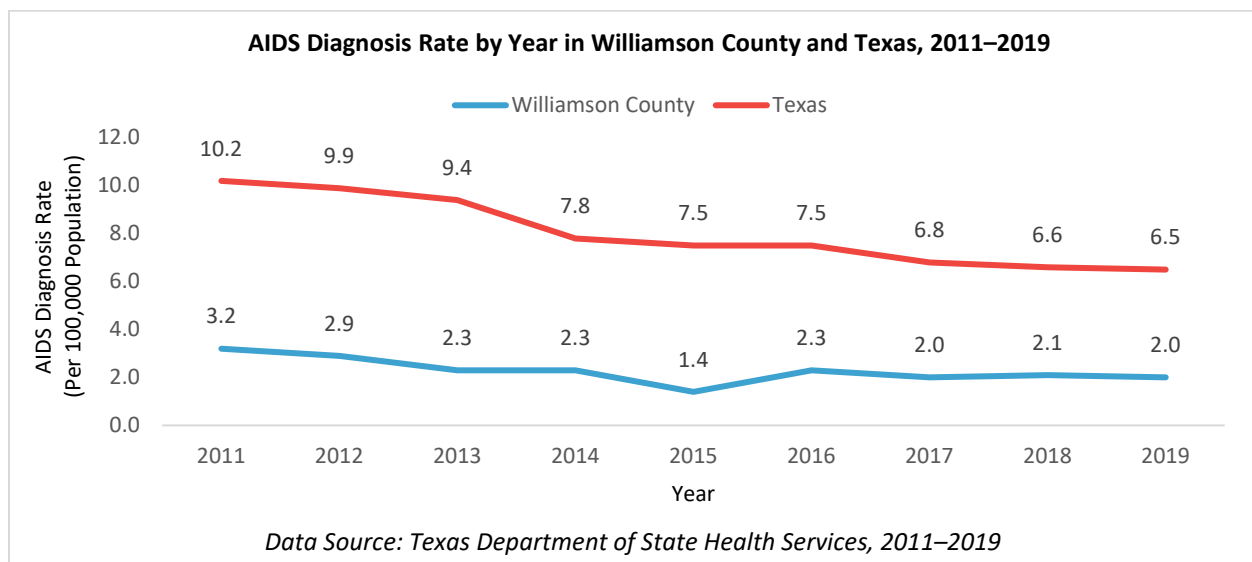
From 2011 to 2018, reported rates of newly diagnosed HIV infection and AIDS were lower in Williamson County compared to Texas (Figure 69 and Figure 70). In Williamson County, the rate of HIV diagnoses peaked at 7.9 per 100,000 population in 2013 (Figure 69). During the same period, AIDS diagnoses in Williamson County remained stable (Figure 70).

¹¹¹ “STD Facts- Gonorrhea.”

¹¹² “Gonorrhea-Antibiotic Resistance.”

¹¹³ “HIV Diagnosis Rate.”

¹¹⁴ Ibid.

Figure 69: HIV Diagnosis Rate by Year in Williamson County and Texas, 2011–2019**Figure 70: AIDS Diagnosis Rate by Year in Williamson County and Texas, 2011–2019**

Tuberculosis

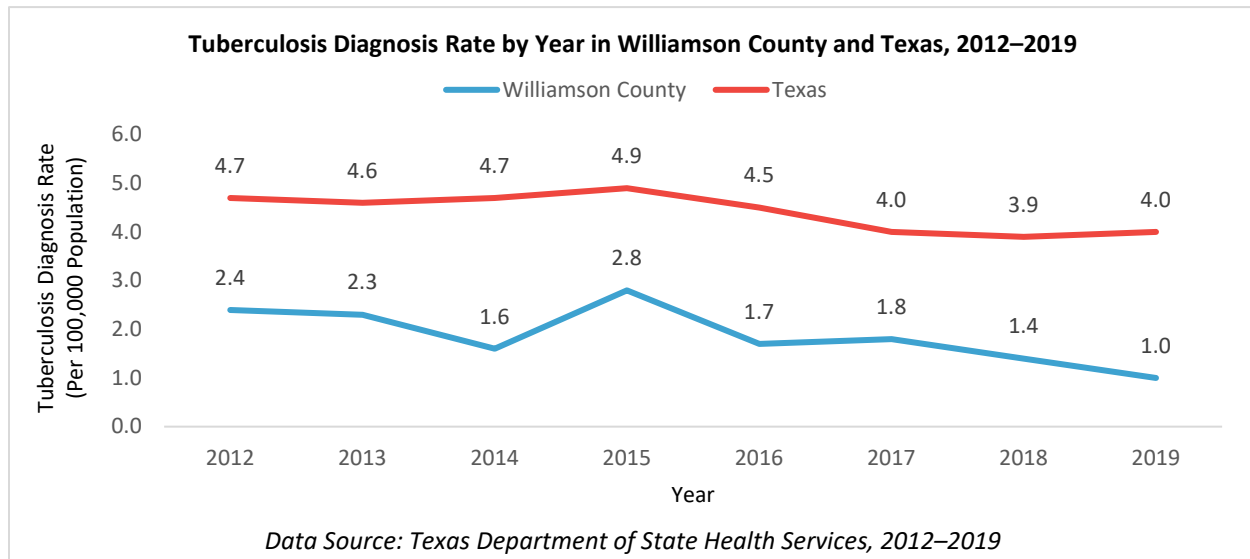
Why is this important?

Tuberculosis (TB) is a bacterial disease that usually affects the lungs but can also affect other parts of the body (e.g., the brain and kidneys).¹¹⁵ The TB bacteria are spread through the air from person to person when someone with untreated pulmonary TB coughs, speaks, or sneezes. Tuberculosis is not spread by shaking someone's hand, sharing food or drink, touching bed linens or toilet seats, sharing toothbrushes, or kissing. "People with TB disease are most likely to spread it to people they spend time with every day," including family members, friends, and coworkers or schoolmates.¹¹⁶

Compared to Texas, Williamson County had lower reported TB diagnosis rates from 2012 to 2019 (Figure 71). Reported rates of TB in Williamson County peaked at 2.8 per 100,000 population in 2015 but decreased to 1.0 per 100,000 population in 2019.

¹¹⁵ "Basic TB Facts."

¹¹⁶ "Tuberculosis-How TB Spreads."

Figure 71: Tuberculosis Rate by Year in Williamson County and Texas, 2012–2019

Key Findings

Rates of communicable diseases in Williamson County are lower than statewide rates. Still, the data reveal areas of concern, particularly syphilis. Despite a decrease from 2017 to 2018, primary and secondary syphilis rates were significantly higher in 2018 than before 2017. HIV and AIDS diagnosis rates have remained relatively stable, with slight decreases.

These findings are encouraging:

- Syphilis rates in Williamson County have been continually lower than in the state.
- Chlamydia rates in Williamson County were the lowest in 2018 compared to the previous eight years.
- Gonorrhea rates sharply decreased from 2017 to 2018, while the state rates continue to climb.
- Tuberculosis rates have decreased in the county since 2017.

C11. Sentinel Events

The data in this section highlight vaccine-preventable diseases, which include measles, mumps, rubella, tetanus, and pertussis. Each of these diseases is classified as a sentinel event, which is “a preventable disease, disability, or untimely death whose occurrence serves as a warning signal that the quality of preventive and/or therapeutic medical care may need to be improved.”¹¹⁷ Additionally, this section provides immunization data for adults and children as well as the trend of conscientious exemptions in Williamson County and Texas.

Vaccine-Preventable Diseases

Why are these important?

The Centers for Disease Control and Prevention (CDC) recommend that people get the MMR (measles-mumps-rubella) vaccine to protect against measles, mumps, and rubella. This is especially important for children, who should get one dose of MMR vaccine at age 12 to 15 months and the second dose at age 4 to 6 years. “One dose of MMR vaccine is 93% effective against measles, 78% effective against mumps, and 97% effective against rubella. Two doses of MMR vaccine are 97% effective against measles and 88% effective against mumps.”¹¹⁸

Additionally, recommendations for tetanus and pertussis include DTaP (diphtheria, tetanus, and acellular pertussis) vaccines for children younger than seven and Tdap (combined tetanus, diphtheria, and acellular pertussis) vaccines for adolescents and adults.¹¹⁹

¹¹⁷ Rutstein et al., “Sentinel Health Events (Occupational).”

¹¹⁸ “Measles, Mumps, and Rubella (MMR) Vaccination: What Everyone Should Know.”

¹¹⁹ “Vaccine Safety-Diphtheria, Tetanus, and Pertussis Vaccines.”

Table 28: Cases of Vaccine-Preventable Diseases in Williamson County, 2010–2020

Cases of Vaccine-Preventable Diseases in Williamson County, 2010–2020											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Measles	0	0	0	0	0	0	0	0	0	0	0
Mumps	0	1	0	0	0	0	3	1	6	12	3
Rubella	0	0	0	0	0	0	0	0	0	0	0
Tetanus	0	0	0	0	1	0	0	0	0	0	0
Pertussis	725	92	85	94	74	44	60	59	22	18	0

Data Source: Texas Department of State Health Services, 2010–2017; WCCHD, 2018–2020

Findings based on Table 28:

- **Measles:** There have been no confirmed cases of measles in Williamson County since 1999, when two cases were reported.
- **Mumps:** In 2011, Williamson County had one reported case of mumps, after which no new cases were reported until 2016. Three cases of mumps were reported in 2016 and again in 2020.
- **Rubella:** From 2010 to 2020, there were no confirmed cases of rubella in Williamson County.
- **Tetanus:** In 2014, one case of tetanus was reported in Williamson County.
- **Pertussis:** Rates of pertussis in Williamson County were stable until 2010, when WCCHD detected 725 cases. Since then, pertussis rates have decreased, reaching zero cases as of 2020.

Adult Immunizations

Why are these important?

Influenza — also known as flu — is a “contagious respiratory illness caused by influenza viruses.” Groups at high risk of developing serious flu-related complications include “people 65 years and older, people of any age with certain chronic medical conditions (such as asthma, diabetes, or heart disease), pregnant women, and children younger than 5 years.” Complications of flu can include “bacterial pneumonia, ear infections, sinus infections and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.” The CDC estimates that in the U.S., 5 to 20% of the population on average gets the flu.¹²⁰ The CDC also estimates that influenza “has resulted in 9 million – 41 million illnesses, 140,000 – 710,000 hospitalizations and 12,000 – 52,000 deaths annually between 2010 and 2020.”¹²¹ The seasonal influenza vaccine can prevent serious illness and death. The CDC recommends annual vaccinations for everyone ages 6 months and older to prevent the spread of influenza.¹²²

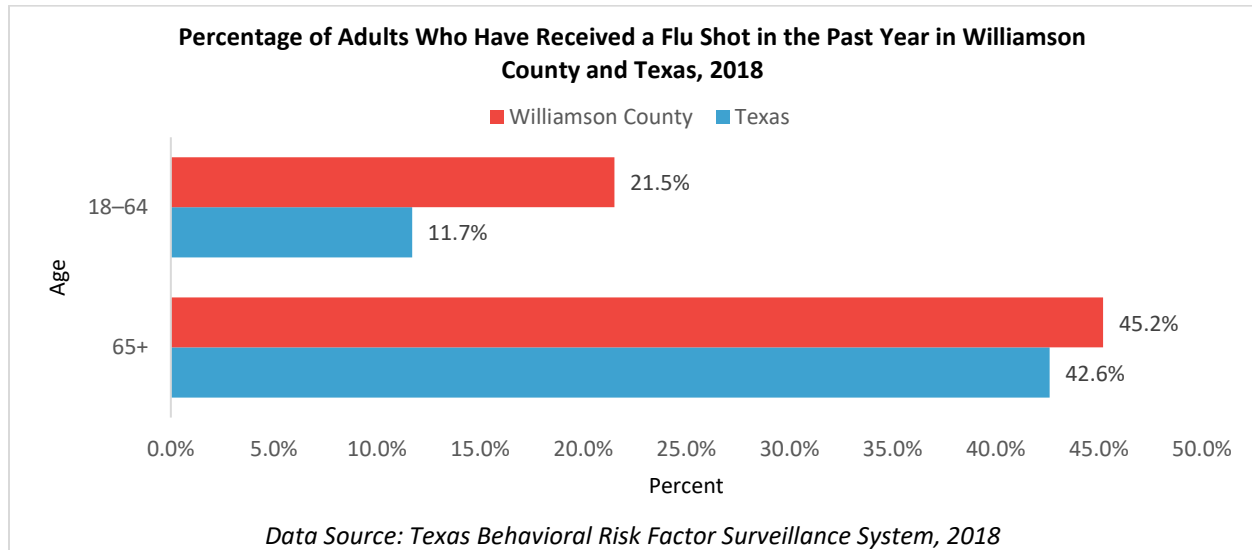
In 2018, 21.5% of adults ages 18 to 64 in Williamson County reported that they had received a flu shot in the past year, which is nearly double the rate in Texas (11.7%) (Figure 72). The percentage of adults ages 65 and older in Williamson County who had received a flu shot in the past year (45.2%) was slightly higher than in Texas (42.6%).

¹²⁰ “Key Facts About Influenza (Flu).”

¹²¹ “Burden of Influenza.”

¹²² “Who Needs a Flu Vaccine.”

Figure 72: Percentage of Adults Who Have Received a Flu Shot in the Past Year in Williamson County and Texas, 2018



Child Immunizations

Why are these important?

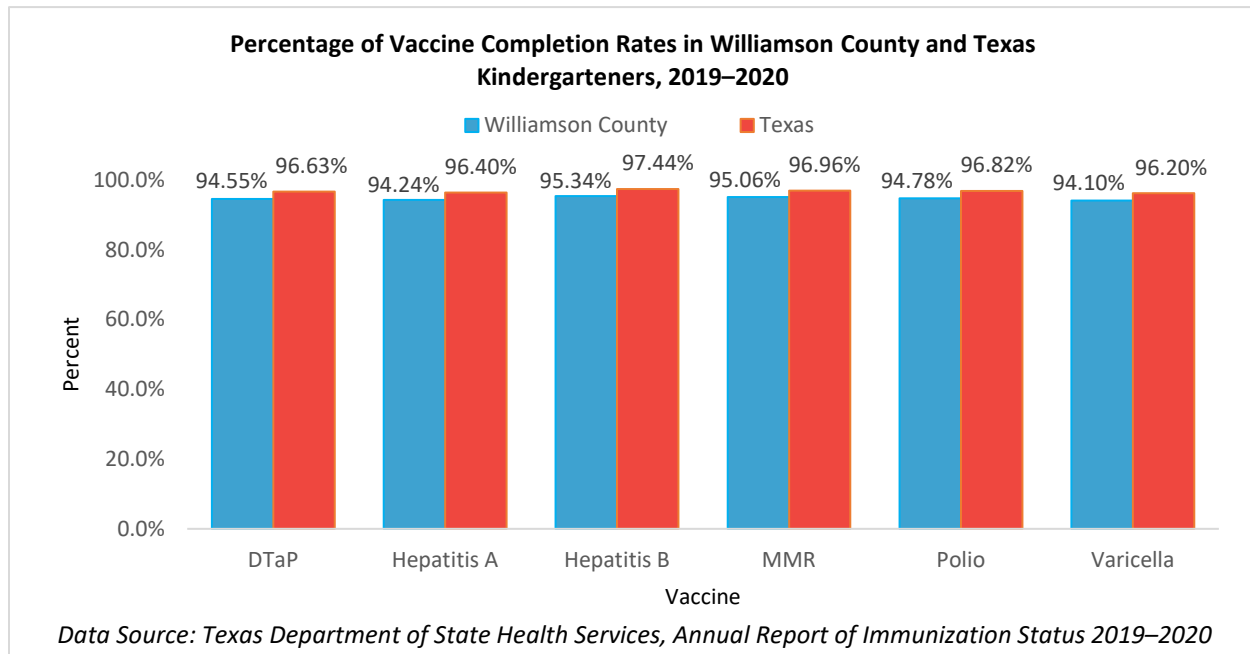
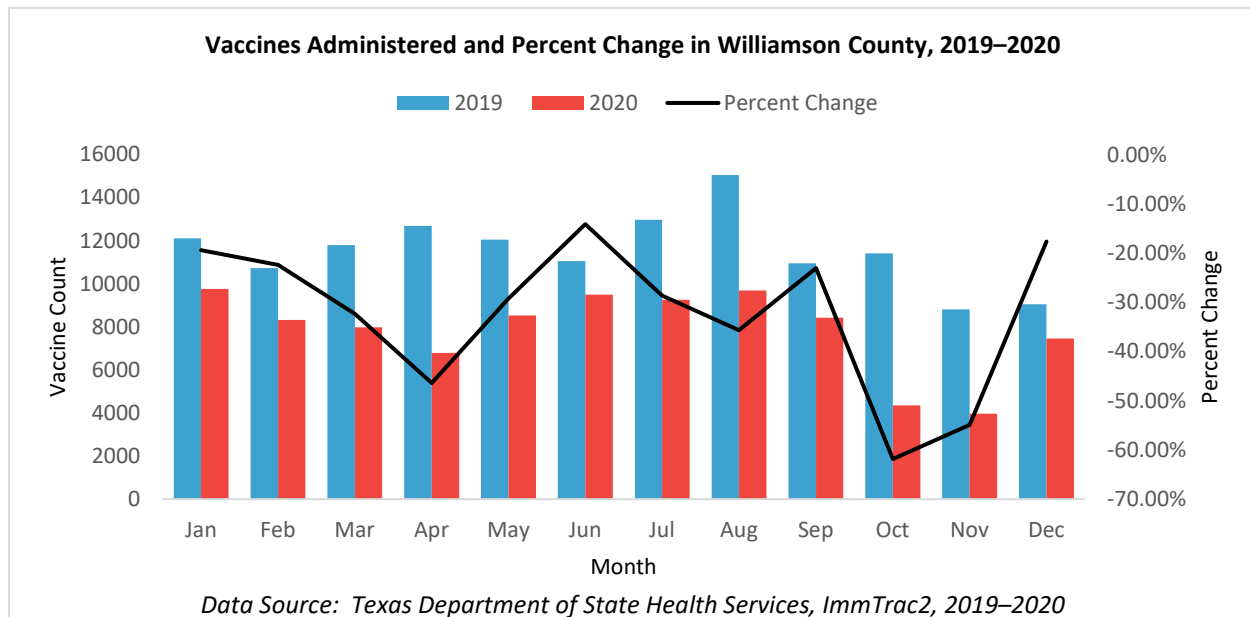
“Most parents vaccinate their children according to the CDC’s recommended immunization schedule, protecting them from 14 potentially serious diseases before their second birthday. Vaccinating children on time protects them and anyone around them with a weakened immune system.”¹²³ Completion of all doses of a vaccine on the recommended vaccine schedule provides the best protection for young children against harmful disease outbreaks.

The data in Figure 73 are reported from ImmTrac2, the Texas immunization registry maintained by the Texas Department of State Health Services. ImmTrac2 is an opt-in registry that is free to use and provides a secure and confidential way to store vaccine information electronically for Texans of all ages.¹²⁴ Healthcare providers are required to report childhood immunizations to ImmTrac2 but must obtain parental consent before doing so. However, children are often not registered for ImmTrac2 until they enter kindergarten, when schools require verification of a complete vaccination history. Due to this delay in entry and the incompleteness of vaccine records for children in ImmTrac2, the Community Health Assessment team retrospectively examined vaccination rates of five-year-old children to assess their status at age two years.

In the period from 2019 to 2020, the percentage of kindergartners in Williamson County with a completed vaccine was lower for each of the measured vaccines than that of Texas kindergartners overall. Additionally, the number of administered vaccines registered in ImmTrac2 was lower in all months of 2020 than in 2019 (Figure 74).

¹²³ “Follow Immunization Schedule.”

¹²⁴ “ImmTrac2 Registry Home.”

Figure 73: Percentage of Vaccine Completion Rates in Williamson County and Texas Kindergarteners, 2019–2020**Figure 74: Vaccines Administered and Percent Change in Williamson County, 2019–2020**

Conscientious Exemptions

Why are these important?

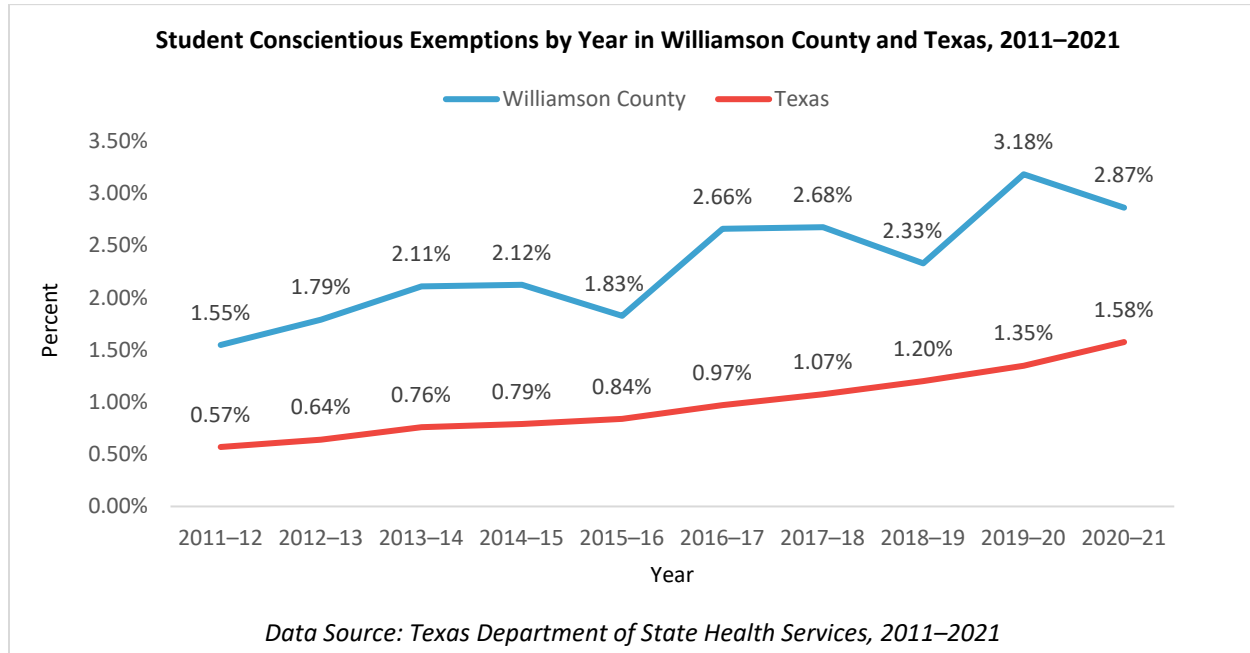
“In accordance with Texas Administrative Code §97.62, Texas law allows for an exemption from immunizations for reasons of conscience, including a religious belief.”¹²⁵ As the percentage of conscientious exemptions increases, the percentage of individuals at risk for disease also increases. In contrast, when a large percentage of the population is vaccinated, it indirectly offers a protective effect (herd immunity) to individuals who cannot be vaccinated for medical reasons or because vaccination was not successful. “Herd immunity occurs when a large portion of a community (the herd) becomes immune to a disease, making the spread of disease from person to person unlikely.” A percentage of the population often must be susceptible to an infectious disease for the disease to spread. If the percentage of the population that is immune to the disease exceeds this

¹²⁵ “Statistics on Conscientious Exemptions to School Immunizations.”

threshold, the spread of the infectious disease will decline. The percentage of a community that needs to be immune to achieve herd immunity varies from disease to disease and depends on factors such as how contagious a disease is. “As a result [of herd immunity], the whole community becomes protected — not just those who are immune.”¹²⁶

From 2011 to 2021, the percentages of conscientious exemptions among students in kindergarten to 12th grade (K–12) were consistently higher in Williamson County compared to Texas (Figure 75).

Figure 75: Student Conscientious Exemptions by School Year in Williamson County and Texas, 2011–2021



Key Findings

Although many vaccine-preventable diseases have been contained in Williamson County, it is crucial that immunization efforts focus on the key findings below to maintain progress and reduce the risk of future disease transmission.

- **Increase the number of adults who receive an annual flu shot, especially for adults ages 65 and older.** This population has the highest flu-related mortality of all age groups since the human immune system becomes weaker with age.¹²⁷ People ages 65 and older had twice the vaccination rate of those ages 18 to 64. Interventions should target all populations to increase vaccination so that transmission decreases throughout the community.
- **Decrease the number of conscientious exemptions among K–12 students.** Williamson County has lower kindergartener vaccination rates than the state. Children of all ages should receive vaccinations to help ensure their own long-term health as well as the health of their classmates, teachers, and others in the community.
- **Launch vaccine reminder and confidence campaigns.** The number of vaccines administered in Williamson County significantly decreased from 2019 to 2020. This is likely due to the COVID-19 pandemic, which limited healthcare access and preventive care. Extra efforts are now needed to encourage residents to seek preventive care and all recommended vaccinations, particularly as socialization increases.

C12. COVID-19

Coronavirus Disease 2019 (COVID-19) is a disease caused by a novel coronavirus named SARS-CoV-2, discovered in December 2019 in Wuhan, China. It is very contagious and has quickly spread around the world. COVID-19 most often causes respiratory symptoms that can feel much like a cold, flu, or pneumonia. This section examines the impact COVID-19 had on Williamson County through case counts, death counts, and cluster-associated cases in schools. Additionally, this section will provide

¹²⁶ “Herd Immunity.”

¹²⁷ “Flu & People 65 Years and Older.”

COVID-19 immunization data as well as breakthrough cases that occurred in individuals after they were fully vaccinated. Only laboratory-confirmed cases were included in these data.¹²⁸

Impact on Community

“The coronavirus pandemic has had unprecedented, widespread impacts on households across America, raising concerns about our ability to weather long-term health and financial harms.”¹²⁹ Williamson County and Cities Health District assessed the impact of COVID-19 on the Williamson County community’s mental health status and ability to access basic needs. Findings are shown in [Appendix H: Social Determinants of Health and COVID-19 Vaccine Survey](#).

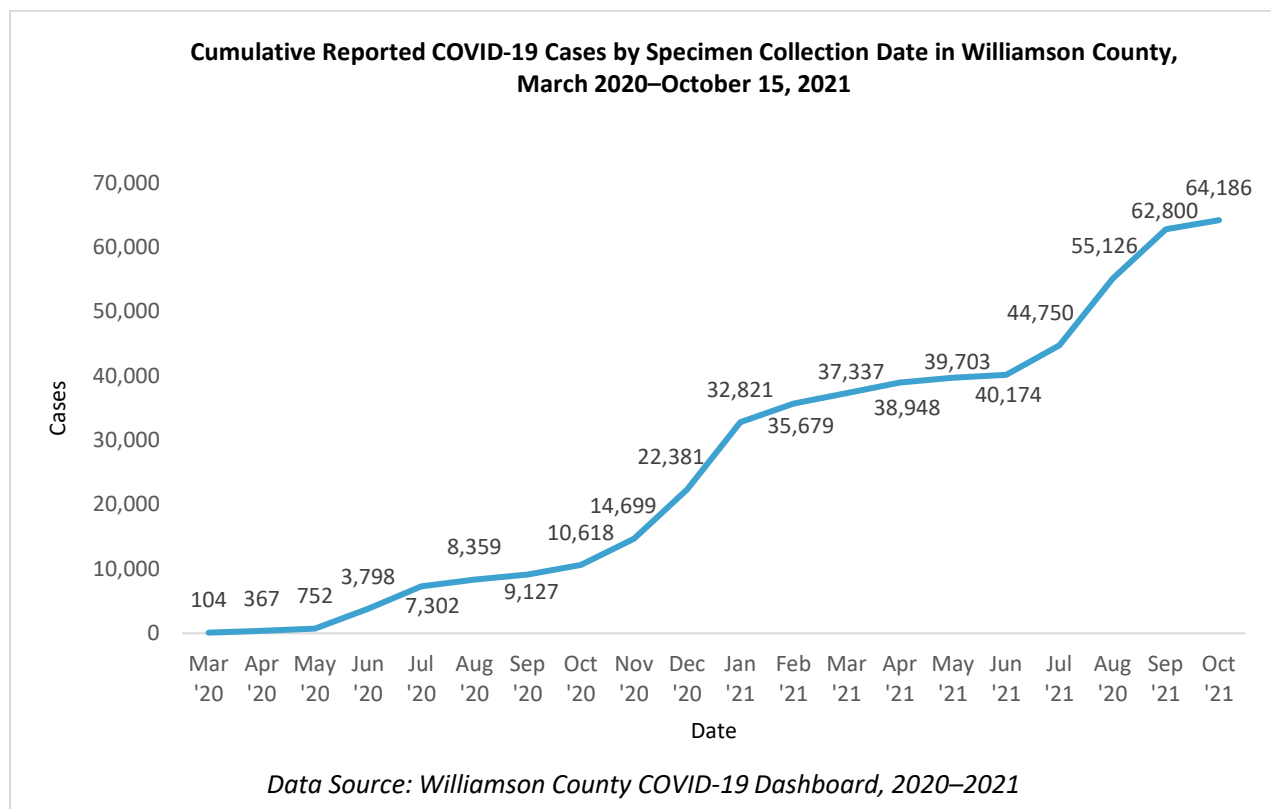
Case Count

Why is this important?

Public health surveillance collects data on over 120 diseases and conditions nationally.¹³⁰ The goal of this surveillance is to protect the public from infectious diseases and other health threats, and it is especially important for new diseases such as COVID-19.¹³¹ The information collected helps identify similarities and differences among cases based on information like demographic characteristics, clinical factors, epidemiologic characteristics, exposure and contact history, and the courses of clinical illness and care received. Hospitals, healthcare providers, and laboratories collect data and report them to public health departments as required by state disease reporting laws.

As of October 15, 2021, a total of 64,186 confirmed cases of COVID-19 were reported in Williamson County (Figure 76). The daily seven-day average incidence rate in Williamson County reached a high of 77.72 infections per 100,000 population on September 1, 2021, while Texas reached its highest incidence rate of 65.69 infections per 100,000 population on January 17, 2021 (Figure 77). Figure 78 displays the total number of cases by age group.

Figure 76: Reported COVID-19 Cases Over Time in Williamson County, March 2020–October 15, 2021



¹²⁸ “Basics of COVID-19.”

¹²⁹ “The Impact of Coronavirus on Households Across America.”

¹³⁰ “FAQ: COVID-19 Data and Surveillance.”

¹³¹ “Estimated COVID-19 Burden.”

Figure 77: COVID-19 Daily Seven-Day Average Incidence Rate in Williamson County, March 12, 2020–October 15, 2021

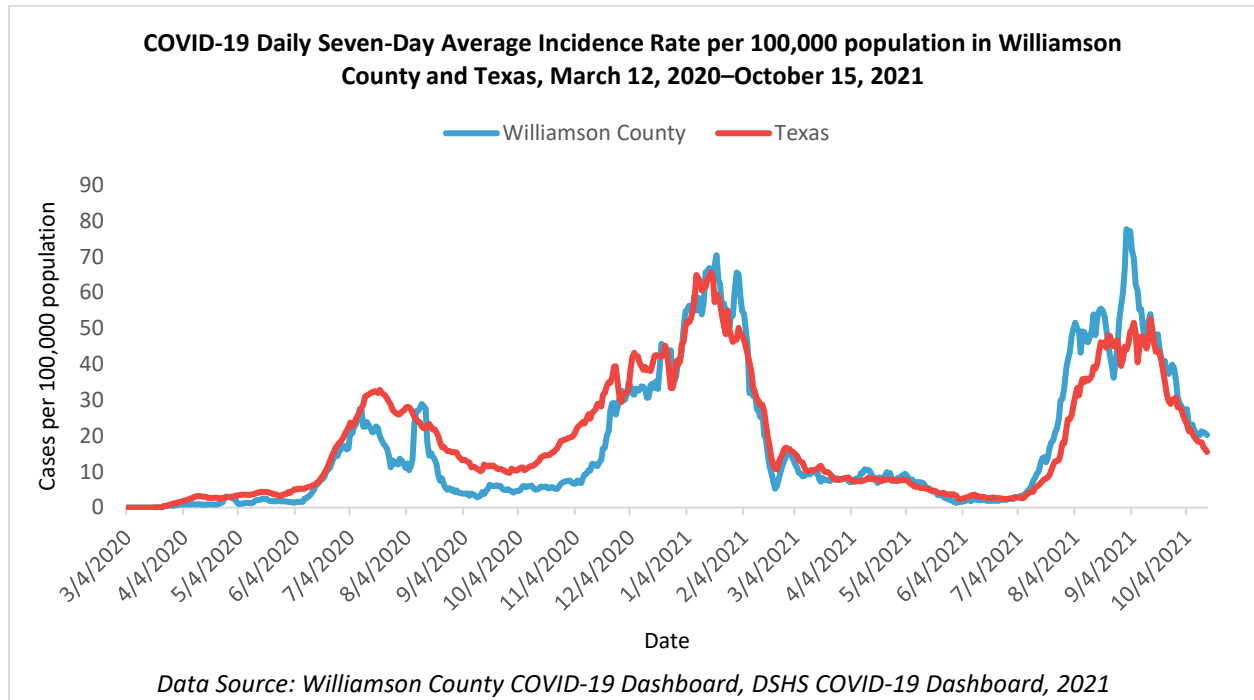


Figure 78: Reported Confirmed COVID-19 Cases by Age Group in Williamson County, March 12, 2020–October 15, 2021

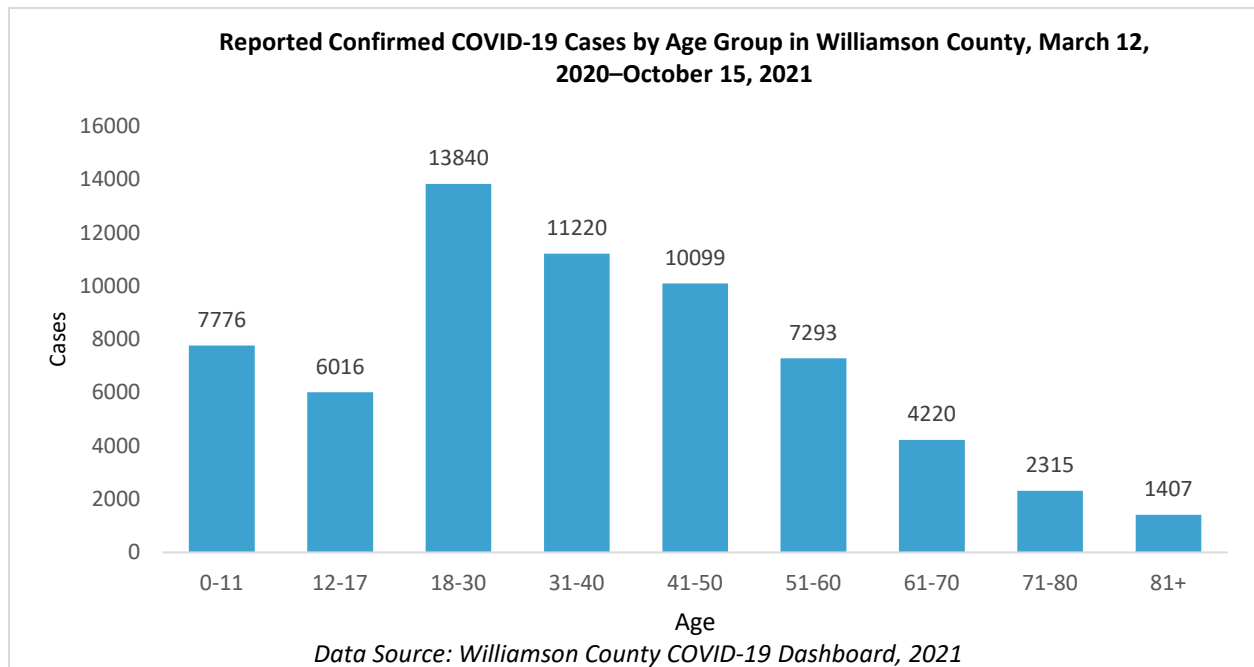
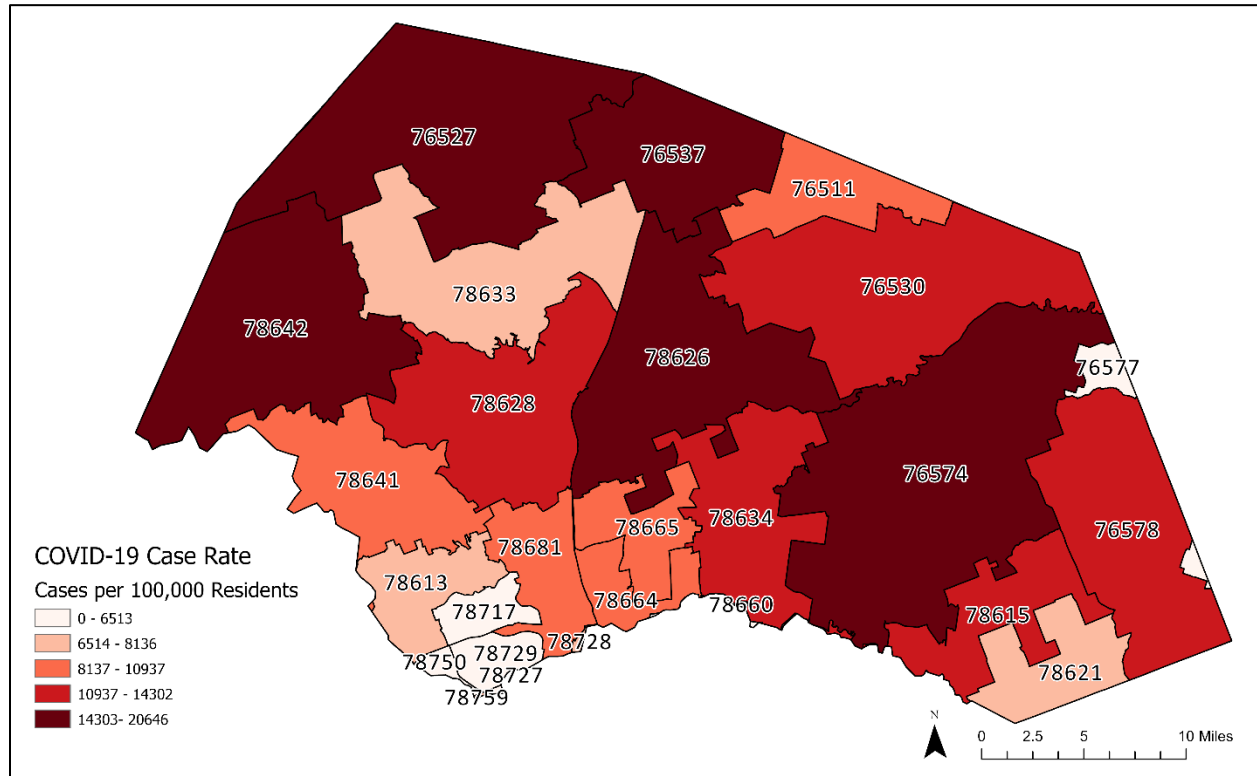


Figure 79 displays the COVID-19 infection rate in each ZIP code in Williamson County. Table 29 displays the five ZIP codes with the highest COVID-19 infection rates and the five ZIP codes with the lowest rates. Only ZIP codes with a population over 1,000 in Williamson County were included. The ZIP codes highlighted in blue also have one of the five highest vaccination rates in the county, while the ZIP codes highlighted in red have one of the five lowest vaccination rates.

Figure 79: COVID-19 Case Rate per 100,000 Population by ZIP Code in Williamson County, March 12, 2020–October 15, 2021



Data Source: Texas Department of State Health Services, 2021

Date Created: 10/29/2021

Table 29: Williamson County ZIP Codes with Lowest and Highest COVID-19 Infection Rates, 2020–2021

Williamson County ZIP Codes with Lowest and Highest COVID-19 Infection Rates, 2020–2021

ZIP Code	Cases per 100,000 residents	ZIP Code	Cases per 100,000 residents
78750	4,345	76537	20,646
78717	5,789	78626	15,589
78729	6,513	76574	15,390
78728	7,264	76527	15,019
78613	7,612	78642	14,718

Data Source: Williamson County COVID-19 Dashboard and Texas Department of State Health Services, ImmTrac2, 2020–2021

Death Count

Why is this important?

Mortality data are monitored and routinely used to detect cases of infectious diseases that might signal a larger public health emergency, monitor specific preventable deaths, raise awareness of issues, and inform the creation of public health responses to prevent additional deaths.¹³² It is important to record deaths from COVID-19 for several reasons: COVID-19 has become a leading cause of death; the risk of death from COVID-19 differs based on age and comorbidities; deaths from COVID-19 will prolong the stagnant trend in life expectancy in the United States; and many, if not most, COVID-19–related deaths

¹³² Koh, Geller, and VanderWeele, “Deaths From COVID-19.”

could have been prevented, showing that critical public health strategies must remain in society's focus during and after the COVID-19 pandemic.¹³³

Figure 80 displays the COVID-19 daily average case-fatality rate per 100 cases. The highest daily average case-fatality rate for Williamson County was 9.4 deaths per 100 cases and occurred on April 10, 2020. The overall average case-fatality rate was 1.3 deaths per 100 cases. As of October 15, 2021, there were 699 deaths from COVID-19 in Williamson County, with more deaths (249) occurring in people ages 81 and older than in any other age group (Figure 81).

Figure 80: COVID-19 Daily Average Case-Fatality Rate in Williamson County, March 2020–October 15, 2021

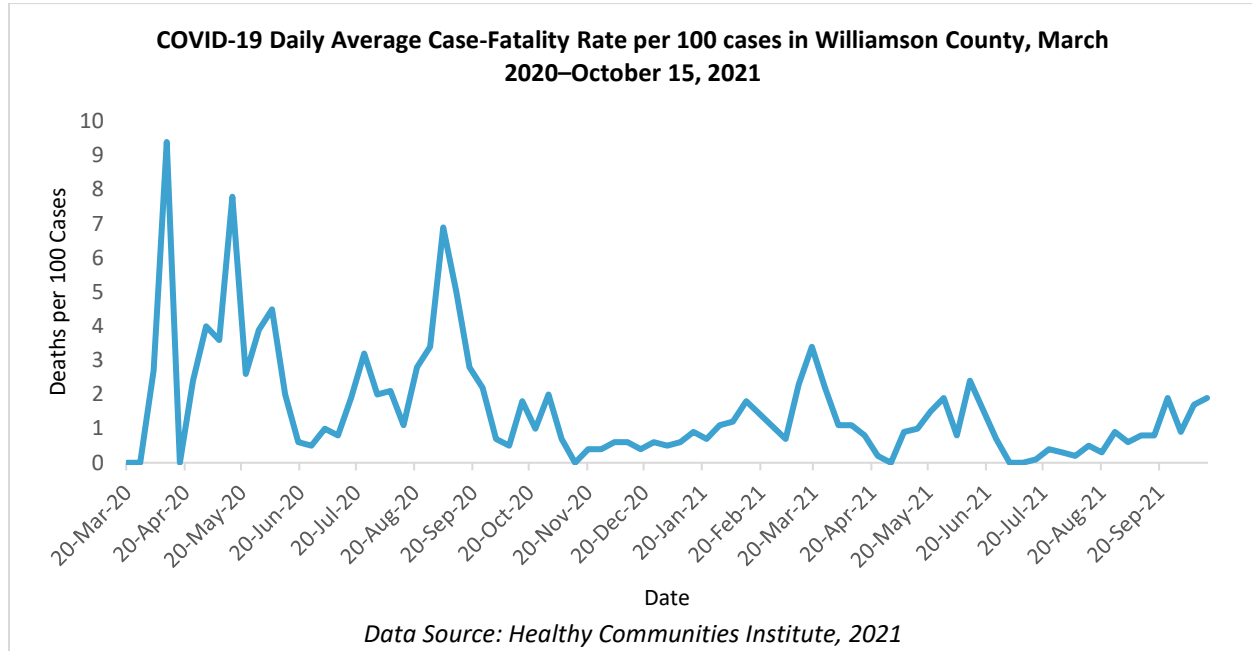
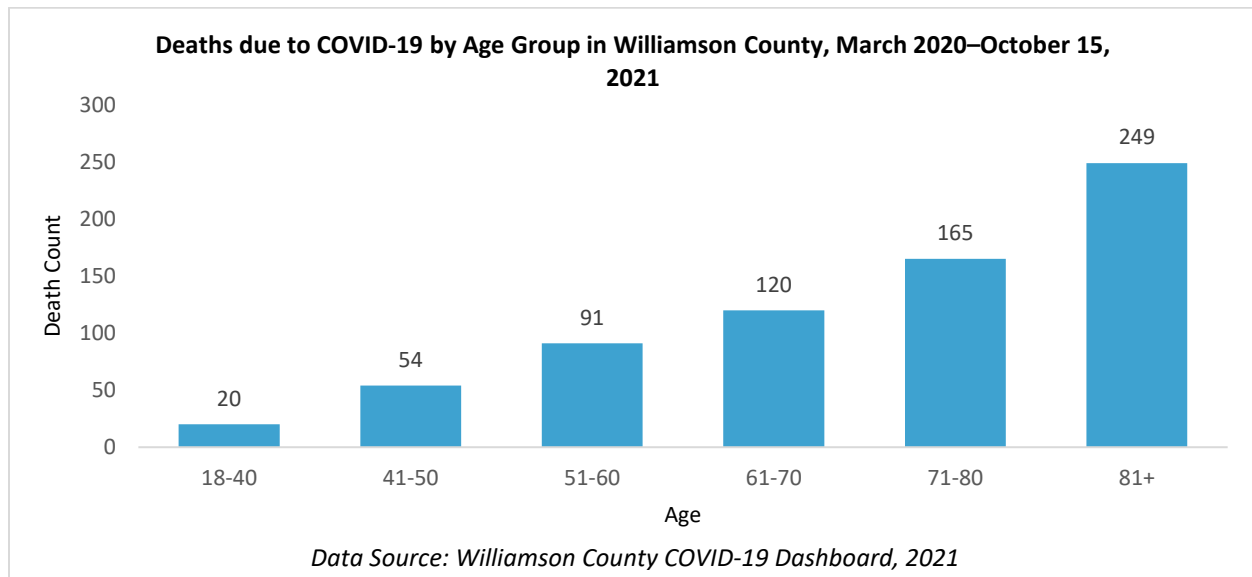


Figure 81: Deaths Due to COVID-19 by Age Group in Williamson County by October 15, 2021



¹³³ "Surveillance Strategy Report — Modernizing Mortality Reporting."

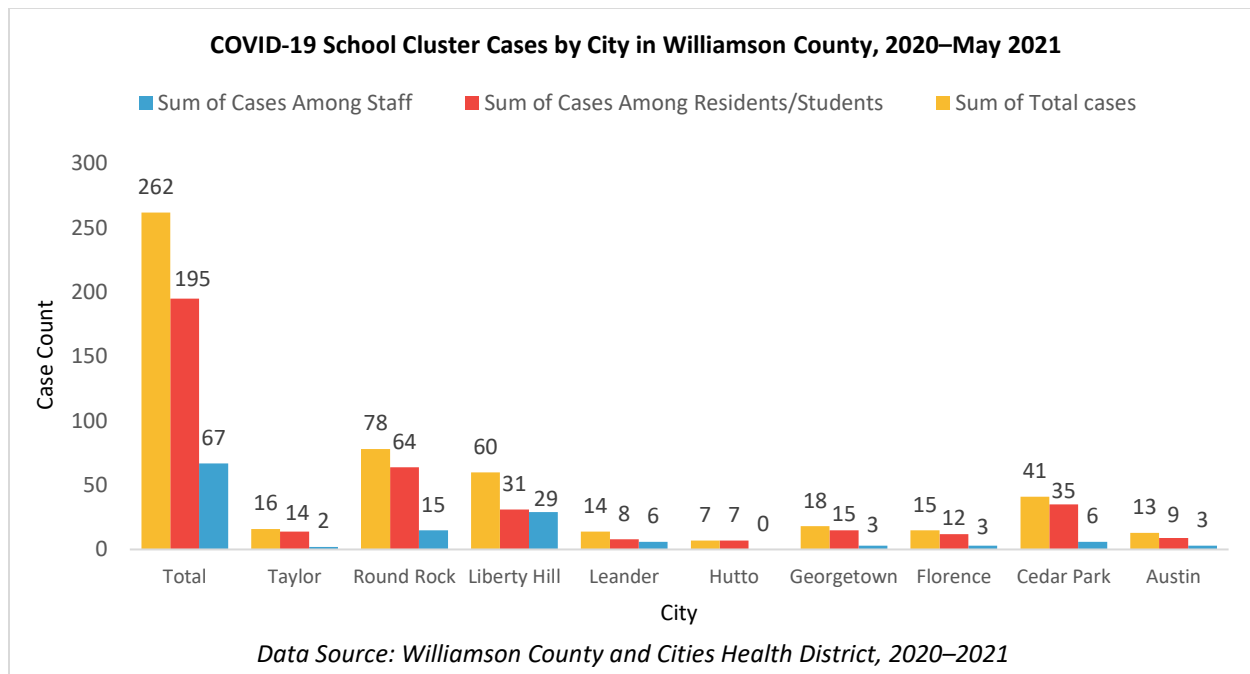
School Clusters

Why are these important?

Early in the COVID-19 pandemic, children and adolescents were not commonly identified as index cases for clusters, meaning they were not often known to spread COVID-19 to others. However, outbreaks among adolescents and children attending daycare, schools, and extracurricular activities have demonstrated that children and adolescents can transmit SARS-CoV-2 to others. Multiple studies have shown that transmission within school settings is typically lower than, or at least similar to, levels of community transmission when prevention strategies are in place in schools.¹³⁴ Epidemiologists from Williamson County and Cities Health District worked closely with school nurses and staff at the public schools, private schools, and daycares in the county to ensure proper mitigation strategies and reporting methods were in place.

Through May 2021, there were a total of 262 COVID-19 cases associated with clusters in schools. Clusters were defined by five or more linked cases. The school district with the highest number of school cluster cases (78) was Round Rock (Figure 82).

Figure 82: COVID-19 School Cluster Cases by City in Williamson County, 2020–2021



Vaccines

Why are these important?

"The COVID-19 global pandemic has greatly impacted society and every part of life. As a way to transition out of this global pandemic and protect people from serious illness, hospitalization, or death, the COVID-19 vaccination has been made available. According to the Centers for Disease Control and Prevention (CDC), vaccination is an act of introducing vaccine into the body to produce immunity. By showing and tracking percentage of vaccinations, communities can monitor trends across counties and allocate resources as needed."¹³⁵

There are currently three authorized vaccines in the United States that prevent COVID-19. The Pfizer-BioNTech and Moderna mRNA COVID-19 vaccines and Johnson & Johnson's Janssen viral vector vaccine can all lower the risk of contracting and spreading the virus that causes COVID-19 and may help keep people from getting seriously ill even if they do get COVID-19. Being fully vaccinated against COVID-19 allows people to resume many activities they did before the pandemic, and the CDC

¹³⁴ "Science Brief: Transmission of SARS-CoV-2 in K-12 Schools and Early Care and Education Programs – Updated."

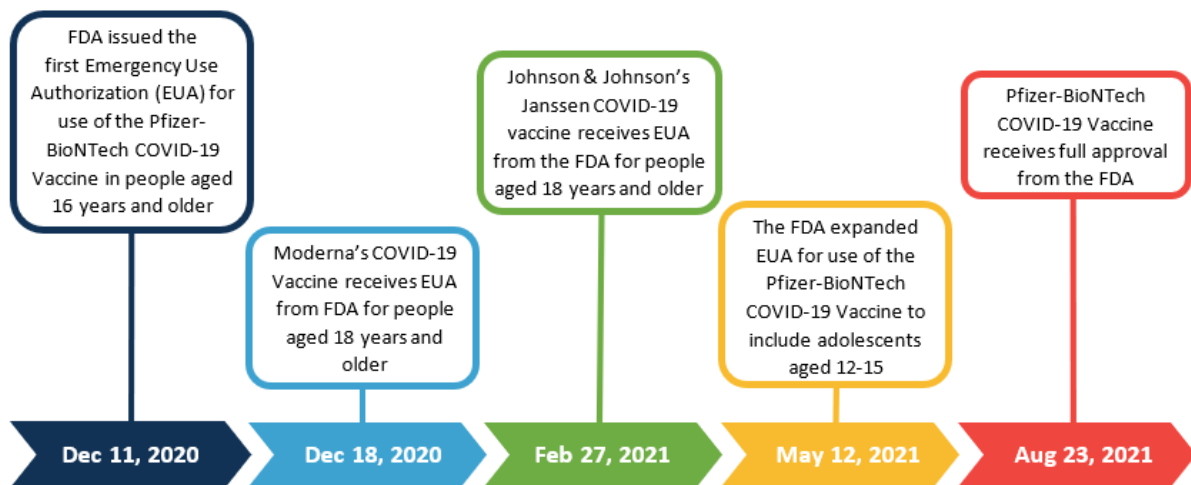
¹³⁵ "Persons Fully Vaccinated Against COVID-19."

lists vaccination as a key component for population immunity against COVID-19.^{136,137} As of November 3, 2021, the CDC recommends vaccination against COVID-19 for everyone ages 5 years and older.¹³⁸

COVID-19 vaccine distribution in Texas followed a phased approach set by the Texas Department of State Health Services.¹³⁹

- **December 14, 2020:** Phase 1A (frontline healthcare workers and residents at long-term care facilities)
- **December 29, 2020:** Phase 1B (people 65+ or people 16+ with a health condition that increases risk of severe COVID-19 illness)
- **March 3, 2021:** School and licensed childcare personnel
- **March 15, 2021:** Phase 1C (people 50 to 64 years of age)
- **March 29, 2021:** Everyone 16 years old and older
- **May 12, 2021:** Everyone 12 years old and older
- **November 3, 2021:** Everyone 5 years old and older¹⁴⁰

Figure 83: Authorization and Approval Timeline for COVID-19 Vaccines in the United States



Vaccination Rates

As of October 15, 2021, 69.32% of Williamson County's COVID-19 vaccine-eligible population (then people ages 12 years and older) had been fully vaccinated, and 78.10% had received at least one dose (Figure 84). Williamson County has a higher percentage of the population fully or partially vaccinated than Texas overall. Vaccination rates in Williamson County are broken down by percentage of the eligible population by ZIP code, as shown in Figure 85.

¹³⁶ "Benefits of Getting a COVID-19 Vaccine."

¹³⁷ "Science Brief: SARS-CoV-2 Infection-Induced and Vaccine-Induced Immunity."

¹³⁸ "Key Things to Know About COVID-19 Vaccines."

¹³⁹ "COVID-19 Vaccine Information."

¹⁴⁰ "How CDC Is Making COVID-19 Vaccine Recommendations."

Figure 84: Percentage of Eligible Population that is Vaccinated against COVID-19 in Williamson County and Texas, 2020–2021

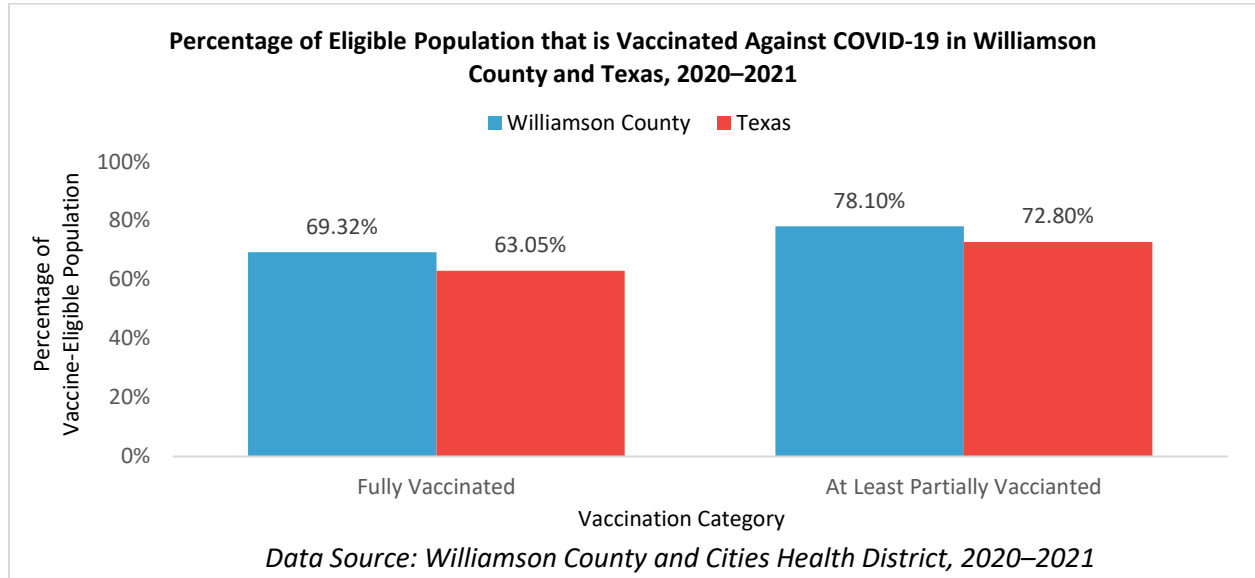
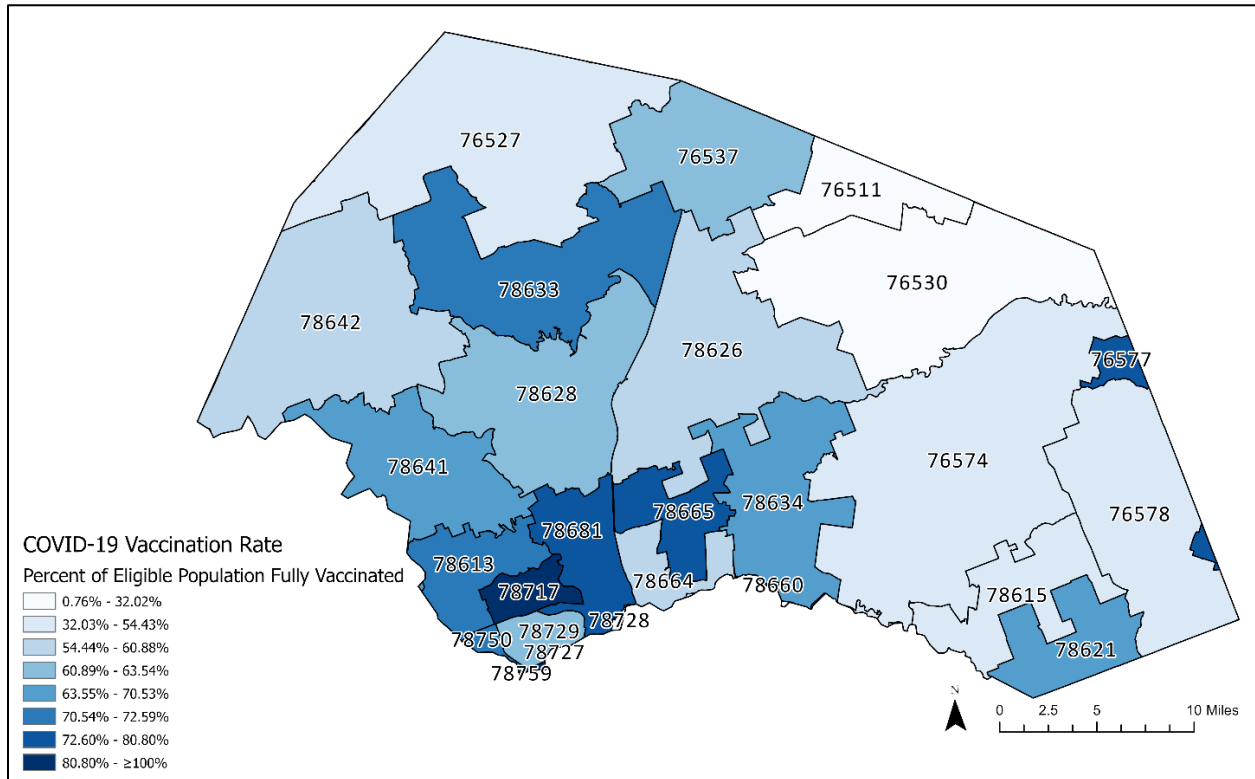


Figure 85: COVID-19 Vaccination Rate by ZIP Code in Williamson County, December 15, 2020–October 15, 2021



Data Source: Texas Department of State Health Services, ImmTrac2, 2021

Date Created: 10/29/2021

Vaccine Breakthrough Cases

Why are these important?

Although all three vaccines are proven highly effective at preventing COVID-19, no vaccine is 100% protective, meaning that infection can still occur in people who are fully vaccinated. Breakthrough cases are cases that occur in individuals who are fully vaccinated. These cases typically cause mild or moderate illness, rarely resulting in hospitalization or death due to severe COVID-19. Increased case counts and the increasing presence of the Delta coronavirus variant led to an increase in breakthrough cases.¹⁴¹ As of October 15, 2021, there were 3,414 confirmed breakthrough COVID-19 cases in Williamson County (Figure 86 and Figure 87).

Figure 86: Reported Confirmed Breakthrough Cases in Williamson County by Age Group, 2021

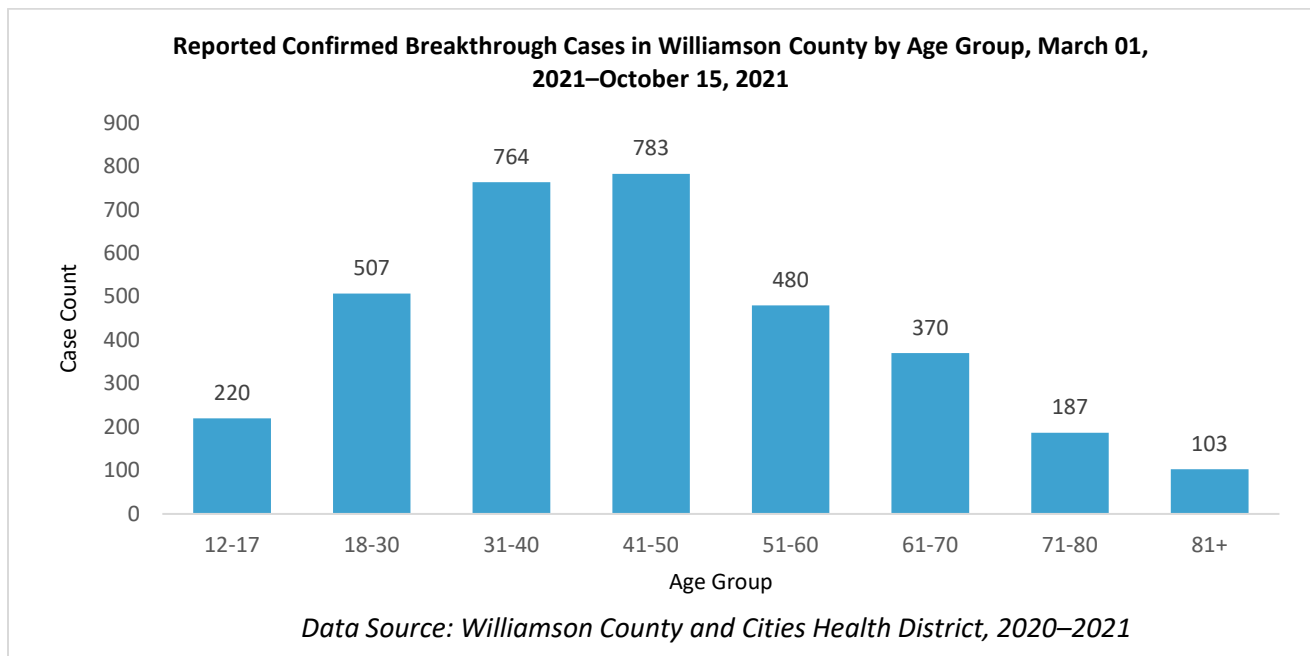
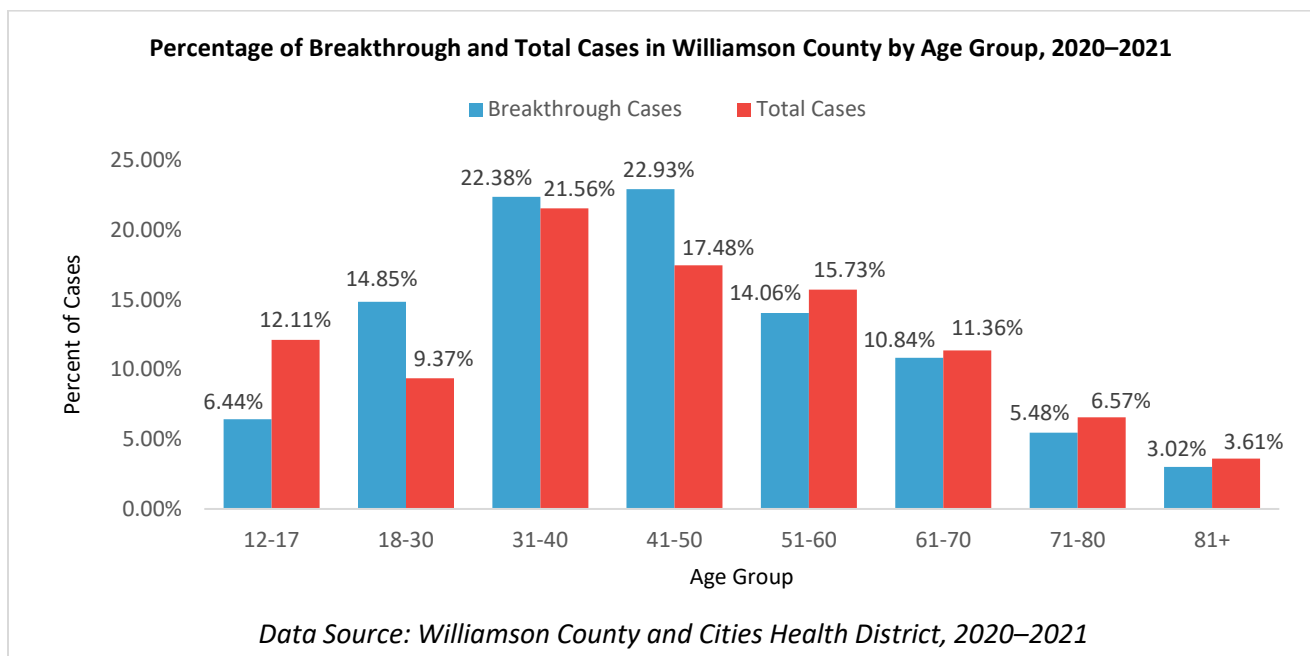


Figure 87: Percentage of Breakthrough and Total Cases in Williamson County by Age Group, 2020–2021



¹⁴¹ "COVID-19 Vaccine Effectiveness."

COMMUNITY THEMES AND STRENGTHS ASSESSMENT



QUESTIONS ANSWERED IN THIS ASSESSMENT

What community barriers
affect quality of life?

How is quality of life
perceived in the community?

What assets are available to
improve community health?

Overview

The Community Themes and Strengths Assessment (CTSA) identifies current community concerns, perceptions about quality of life, and community strengths and assets through feedback from community stakeholders and the public. The questions listed to the left are valuable for multiple reasons. First, community members become invested in the community health improvement process when they have a sense of ownership and responsibility for the outcomes. This occurs when their concerns are genuinely considered and visibly affect the process. Additionally, the themes and issues identified by asking these questions offer insight into the information and statistics from the other assessments. Furthermore, communities must leverage their strengths and assets to improve health.

Community Strengths and Assets

Through the CTSA process, residents and stakeholders identified the following strengths and assets.

Communication and collaboration between agencies that provide community resources

Discussing collaboration between Williamson County agencies in its report

(Appendix I: Community Focus Group and Key Informant Results — Texas Health Institute), Texas Health Institute (THI) writes:

When asked to describe the assets and strengths of Williamson County, participants frequently mentioned that the community has a strong sense of altruism and members often come together to help each other. One key informant expressed their gratitude for the reliability of nonprofit agencies within the community. Another key informant expressed excitement about emerging diversification efforts that are promoting growth opportunities and resources for underrepresented populations. Key informants and focus group participants also emphasized the tremendous support and impact of strong school districts promoting social emotional learning and trauma-informed care as a strength. In addition, participants mentioned a strong network of churches with resources for food distribution, utility support, COVID-19 support, dental care, and other social services.

Availability of quality healthcare services

Williamson County is home to a network of hospitals, clinics, a Federally Qualified Health Center, a local mental health authority, and health professions universities. According to the Community Health Survey, access to healthcare was ranked as the fourth greatest strength in the county.

Availability of community programs and services

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

There are many community programs and services (e.g., support groups, senior centers, nonprofits) in Williamson County which are accessible via navigation platforms such as findhelp (formerly Aunt Bertha) and United Way of Williamson County’s 2-1-1 hotline.

Availability of fresh food

Community stakeholders identified the availability of fresh foods through farmers' markets and the Meals on Wheels program as an important strength in the community. Through Photovoice, youth discussed healthy eating habits, such as consuming fruits and vegetables and drinking water.

Availability of parks, green spaces, and opportunities for exercise

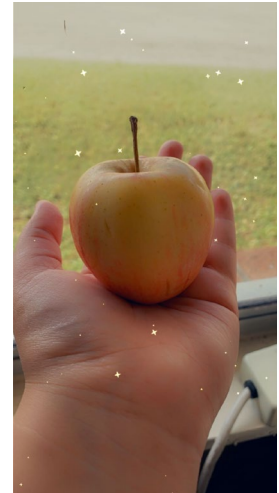
According to the Community Health Survey (CHS), parks and recreation was ranked as the second greatest strength in the county. Community members and stakeholders highlighted walking trails, vast park spaces, outdoor exercise equipment, splash parks/playgrounds, and open spaces as strengths in the community. Youth participated in community sports and exercised using school gyms.

Low crime/safe neighborhoods

According to the CHS, low crime/safe neighborhoods was ranked as the greatest strength in the county, with nearly half of survey participants believing it to be a top strength.

Good schools

Through the CHS, residents indicated that the county was considered a good place to raise children. Furthermore, the West and South indicated that good schools were top strengths in each region. "Key informants and focus group participants also emphasized the tremendous support and impact of strong school districts promoting social emotional learning and trauma-informed care as a strength," as well as many school-based behavioral health services and clinics.



Mental health awareness

Since the COVID-19 pandemic exacerbated mental health challenges, community members recognized the importance of building resilience in improved mental health efforts. Through Photovoice, youth expressed greater awareness and consideration of complex mental health topics. Youth learned self-regulation techniques (e.g., walks, runs, movies) and self-care methods (e.g., being outside in the open by oneself while listening to music or lying in the grass), which they use to improve their mood and support their mental health.

Some youth found growth opportunities in social distancing during the COVID-19 pandemic. They benefited from practicing mental health improvement behaviors, such as adapting and learning through isolation. Youth photographers also recognized social interaction as a basic need and that without it, people may experience stress or anxiety in unfamiliar social situations.

Local assets and wealth

Williamson County has a median household income of \$87,337, which is about \$25,000 more than the median household income in Texas (\$61,874). According to the Community Health Survey, 51.4% of survey respondents indicated that they were prepared with at least three months of emergency funds for rent, utilities, groceries, and supplies. According to a nationwide 2021 survey, more than half of Americans have less than three months' worth of expenses prepared for an emergency.¹⁴²

Some youth felt very grateful to have financial stability, as they had observed people they knew living with financial limitations. For example, a youth photographer who saw multiple families with broken refrigerators reported finding it difficult to understand such living conditions and gaining perspective on their own privilege.

Concerns Identified and Solutions Proposed

Through the Community Themes and Strengths Assessment process, residents and stakeholders identified the following concerns, which can be grouped into four categories: access to healthcare, social and structural determinants of health, community health needs, and children's health.

¹⁴² Foster, "Survey: More Than Half Of Americans Couldn't Cover Three Months of Expenses With Emergency Savings."

Access to Healthcare

Affordable healthcare for publicly insured or uninsured patients

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

— Key Informant

According to the THI report:

Community members frequently indicated an insufficient [number] of primary and specialty care providers creates a barrier to accessing health care, particularly as it relates to providers that accept public insurance. One focus group participant said that despite having four Federally Qualified Health Centers in Taylor, Round Rock, Cedar Park, and Georgetown, appointments are limited to certain days of the week, especially during the pandemic. Some Taylor residents travel to Round Rock and Georgetown to receive primary care services or x-rays. Medicaid beneficiaries lack [enough] primary care or specialty providers that accept their insurance, and people enrolled in WilCo Care (WCCHD's indigent care program) struggle to find physicians, particularly specialists. As a result, residents tend to over-utilize emergency rooms. One key informant stated that one of her recent clients enrolled in WilCo Care was referred to surgery after an emergency room visit but could not have the procedure due to the unavailability of specialty surgeons [who are participating administrators]. In addition, focus group participants recalled the difficulties in locating local mental health providers such as psychiatrists or psychologists who accept insurance to provide mental health care.

Stakeholders also highlighted this challenge in the IBM Watson Health report (Appendix J: Community Focus Group and Key Informant Results — IBM Watson Health), in which limited access to dental care and to primary healthcare providers for uninsured and underinsured patients ranked as the second and fifth most important challenges, respectively, within Williamson County.

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

Awareness of resources and support for navigating healthcare system

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

Texas Health Institute describes this concern, writing:

Community participants frequently mentioned the lack of awareness and support for navigating through the health care system as a barrier to accessing care. Many underrepresented populations with cultural and language barriers, such as Hispanic/Latinx and AAPI [Asian American and Pacific Islander] low-income residents, do not know about health facilities that provide services at a minimal cost. This lack of awareness of available resources also makes it difficult for patients, family members, and caregivers to advocate for their needs. In addition, strict HIPAA-related requirements on who can...contact providers on behalf of the patient [increase] barriers to access, especially among non-English-speaking patients. While health navigators at...WCCHD [Williamson County and Cities Health District] can provide assistance, office closures prevented them from helping clients with documentation support during the COVID-19 pandemic, and many clients were unenrolled from support programs as a result.

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

Lack of medical insurance

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

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

Culturally and linguistically appropriate care and services

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

According to the THI report:

Participants shared that health care services often feel inaccessible because they are not culturally or linguistically appropriate. Key informants and focus group participants shared barriers regarding language, noting an insufficient number of Spanish-speaking or Korean-speaking providers. For example, Hispanic/Latinx and Asian American [and] Pacific Islander (AAPI) populations in Williamson County often encounter language barriers due to the lack of interpreters and translated material. In addition, children and grandchildren often feel pressured to provide interpretation and assist senior populations with complex paperwork, because health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply. Furthermore, participants described how the inability to adapt to the predominant culture or navigate the health care system as an immigrant is a source of ongoing stress. Participants noted that many also [forgo] both health care services and other services due to the fear of deportation based on immigration laws.

This challenge also appeared in the IBM Watson Health report. Stakeholders noted that cultural competence, language barriers, fear or distrust of the healthcare system, and lack of diversity among healthcare and service providers were barriers to accessing services.

Proposed solutions:

- “Language and translation services: Hire Spanish and Korean [and other language] translators and interpreters. Provide dual-language websites, social media, pamphlets, etc.
- “Culturally competent workforce: To increase compassionate and non-judgmental care, community members recommended expanding cultural sensitivity training for all providers and hospital staff to better equip them to serve underrepresented and minority populations. Participants also recommended [diversifying] the workforce by hiring additional providers from underrepresented populations.”

Social and Structural Determinants of Health

Housing and homelessness

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

On housing and homelessness, THI writes:

Recent economic development and population growth [have] caused housing prices to skyrocket in Williamson County over the last few years. Key informants and focus group participants revealed that the lack of affordable housing available within the county is probably one of the most complicated issues for the community. Despite the existence of local housing authorities and Section 8 housing vouchers, people in need of low-income housing often experience long waiting lists. In addition, participants shared that emergency and transitional housing is unavailable in Williamson County. Furthermore, there is a growing population of people experiencing homelessness with untreated mental health issues.

Community Health Survey respondents ranked affordable housing as the area of greatest need for additional or improved services in the county.

Transportation

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

The THI report discusses transportation, writing:

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

Community Health Survey respondents ranked transportation as the second greatest area of need for additional or improved services in the county.

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

Cost of living, affordability, and low socioeconomic status

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

Texas Health Institute describes the effects of low socioeconomic status in Williamson County:

Low-income communities within Williamson County face the most barriers to accessing various services. Participants noted that Hispanic/Latinx residents tend to have higher rates of poverty, and wages for those with less than a high

school education or GED are much lower and do not support the cost of living in the county. Furthermore, due to strict income eligibility criteria, even low-income families still may not qualify for WilCo Care. Having low or no income inhibits families' ability to afford healthy food options, medications, or transportation and fuel. The quality of health care and therapeutic services also declines when residents are not able to provide private-pay.

Furthermore, high cost of living has affected quality of life in the county, especially for people living in poverty, people of color, older adults, and people with disabilities. According to United for ALICE, one out of three households in the county (especially east of Interstate 35) is considered an ALICE (asset limited, income constrained, employed) household, which means it cannot afford to fulfill basic needs such as housing, rent, utilities, and food.¹⁴³

Broadband or internet access

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

On challenges associated with the lack of broadband or internet access, THI writes:

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

Ethnic and racial segregation

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

According to the THI report:

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

Furthermore, Community Health Survey respondents identified efforts to address racism as the fifth greatest area of need for improvement in Williamson County.

¹⁴³ "Households That Are Asset Limited, Income Constrained, Employed (ALICE)."

Community Health Needs

Challenges related to aging

Through the Community Health Survey, residents identified problems related to aging as the second greatest challenge in the community. Community members living in the North ranked aging as their top concern and services for older adults as the fourth greatest area of need for additional or improved services. Key informants also identified an aging population and high cost of medications as important challenges within Williamson County.

Chronic disease and chronic disease risk factors

Discussing chronic diseases and their contributing factors in Williamson County, THI writes:

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

Community Health Survey respondents identified obesity as the third greatest challenge and lack of exercise as the fifth greatest challenge in the community.

Through Photovoice, youth expressed concern for healthy eating and exercise. Unhealthy food options, like baked goods, are readily available and less expensive than healthy food options like produce, making it difficult to eat healthily. Youth indicated that unhealthy food is “widely marketed” and “offered at unbeatably low prices” in the community, which contributes to obesity rates. Consequently, youth felt they would benefit from information about food labels and marketing, as they believed these can be manipulative.

Youth also emphasized the importance of eating disorder resources for all genders. One youth photographer shared his experience with anorexia and the importance of overcoming eating disorders for health.

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

Dental care

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

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



Mental health, isolation, and substance use

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

The THI report describes concerns for mental health, isolation, and substance use in Williamson County:



Community members identified the increasing need for and lack of affordable and available mental health services within Williamson County. Common mental illnesses discussed included stress, anxiety, and depression. Participants noted that low-income families, Medicaid recipients, or families seeking services on a sliding fee scale often struggle the most with navigating resources to address mental health concerns, because very few psychiatrists and psychologists accept insurance. One community member mentioned community crime has also increased due to stress as “people are crying and screaming for help and don't know how to go about getting it.” Participants also indicated the need to address negative stigma associated with mental illness through community education and advocacy. Increased substance use and alcoholism was highlighted as a concern in the community as well. In addition to the lack of treatment providers available, community participants mentioned that it is very difficult to find recovery support services such as Alcoholics Anonymous, Narcotics Anonymous, or other support groups.

Through the Community Health Survey, mental health was ranked as the greatest challenge in Williamson County and counseling, mental health services, and support groups as the third greatest area of need for additional or improved services in the county.

COVID-19 has had a major impact on mental health. From the Social Determinants of Health and COVID-19 Vaccine Survey, the top four responses regarding the impact of COVID-19 on the respondent and on household members were anxiety (86.2% of respondents reported that they had experienced anxiety since the COVID-19 pandemic began; 78.6% of respondents reported that a member of their household had experienced anxiety since the pandemic began), stress (84.6%; 78.4%), depression (50.8%; 55.9%), and isolation (47.3%; 48.6%). “Other” responses included having had job hours and/or salaries reduced, feeling frustrated, and having had difficulty focusing and concentrating. Stakeholders also identified social isolation as a concern for older adults living in rural areas.

Children’s Health

Child abuse

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

According to the THI report:

Participants mentioned the high prevalence of child abuse, including physical abuse and sexual abuse within Williamson County. They described how sexual abuse affected all children regardless of race, ethnicity, or

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

Physical and intellectual disabilities

"I know a lot of our parents, especially with medically fragile children end up spending a lot more time in Austin." — Focus Group Participant

Texas Health Institute describes concerns for physical and intellectual disabilities among youth, writing:

Participants also mentioned the need to increase special programs for youth with physical and intellectual disabilities such as cerebral palsy, deafness, blindness, autism, Down syndrome, and dyslexia. Participants noted that there are few to no public programs available that facilitate talk therapy with autistic youth in Williamson County. They also mentioned that [some behavioral health facilities in Williamson County do] not accept youth with intellectual disabilities for treatment. As a result, most families in Williamson County need to travel to Austin to access services. In addition, participants mentioned that local respite services or music therapy are not available in Williamson County to decrease burnout among families.

Mental health

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

On mental health in youth, THI writes:

Participants highlighted the need to make both mental health services and education available, accessible, and destigmatized for youth. Not only is there a lack of resources for child and youth mental health services, but parents also lack the knowledge and awareness of their child's mental illness. Common youth mental illnesses mentioned among participants included suicidal ideation, attention deficit hyperactivity disorder, anxiety, depression, and bipolar disorder. Additionally, amid the pandemic, participants noted an increase in severe mental health concerns among younger children, along with the difficulty of accessing mental health facilities and assistance for children under the age of thirteen. Although key informants expressed the benefits of integrating social emotional learning into the academic curriculum, they also underlined the school districts' opposition and resistance to providing platforms to discuss youth suicide prevention and social emotional learning.

Through Photovoice, youth expressed that they had experienced a decline in mental health from 2020 to 2021 because they were socially isolated, unable to interact with peers through social gatherings and group sports. Students were frustrated that hybrid education platforms required teachers to attend to the whole class, as the diminished attention to individual students resulted in students feeling alone and left behind. As a result, youth felt stressed and anxious in academic and social settings both at home and elsewhere. Youth indicated a need for increased availability and accessibility of mental health resources because high stress — not always recognized by adults — can result in insomnia.

Overarching Themes

The concerns the Community Themes and Strengths Assessment found reveal four common themes: 1) the importance of engaging the community to improve health, 2) the connection to mental health, which was found to be woven throughout all the health concerns, 3) the impact of disparities, which exist in health across the county, and 4) effects of the COVID-19 pandemic, which has changed people's lives and opportunities to achieve health in many ways.

Community Engagement and Outreach

One important theme identified through the data was the need to improve health by “increasing community visibility” and engaging “with community members and grassroots organizations to understand their perspectives. For example, [focus group participants suggested hosting] a town hall meeting to share the community's insight with municipal/county leadership, funders, and hospital administrators.”

Connection to Mental Health

Mental health is connected to all health concerns identified through the Community Themes and Strengths Assessment, including access to healthcare, ethnic and racial segregation, chronic disease, and child abuse. To improve mental health for all residents of Williamson County, all these concerns need to be addressed.

Impact of Health Disparities

A major theme of stakeholders' and residents' comments was disparity. Differences in income, wealth, access, and resources lead to highly varied lived experiences and health outcomes in the county. Members of vulnerable and underserved populations — such as people with low income, people with disabilities, people of color, uninsured/underinsured people, older adults, and people experiencing homelessness — tended to have less access to community resources and services.

Effects of the COVID-19 Pandemic

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

The THI report describes the effects of the COVID-19 pandemic in Williamson County:

The COVID-19 pandemic has had a multi-faceted impact on Williamson County residents. Issues such as stress, anxiety, depression, and fear associated with social isolation and the spread of COVID-19 have significantly affected the lives of all community members, irrespective of gender, age, socioeconomic status, or race. Key informants and focus group participants noted the disproportionate effects of COVID-19 on minority populations in Williamson County, including residents with lower educational attainment. For example, participants described how layoffs from restaurants and retail at the beginning of the pandemic significantly and disproportionately affected low-income residents, most of whom had a high school diploma or less and limited employment options. Because of increasing unemployment, many residents struggled to pay rent or housing fees and had to move in with family members. Participants also described how Hispanic/Latinx and Black/African American populations experienced higher rates of COVID-19 diagnoses and death. Food insecurity worsened, and many school-aged children lacked breakfast, lunch, and snacks due to school closures. At the same time, some participants noted how the pandemic has had a bit of a “silver lining” for some for some school-aged children. For example, in some cases, the pandemic has allowed parents and the school community to see a struggling child up-close, leading to students receiving the help they have needed for a long time. In addition, participants noted an increase in access to counseling, as many school counselors opened up private virtual counseling practices to meet the needs of students and families.

TOP HEALTH PRIORITIES AND HEALTH EQUITY ZONES



PRIORITY AREAS AND ISSUES

With so many competing needs in the community, determining health priorities will help direct resources and collaborative efforts to the issues that matter most to the community and that will have the greatest impact on health status.

Top Health Priorities and Health Equity Zones

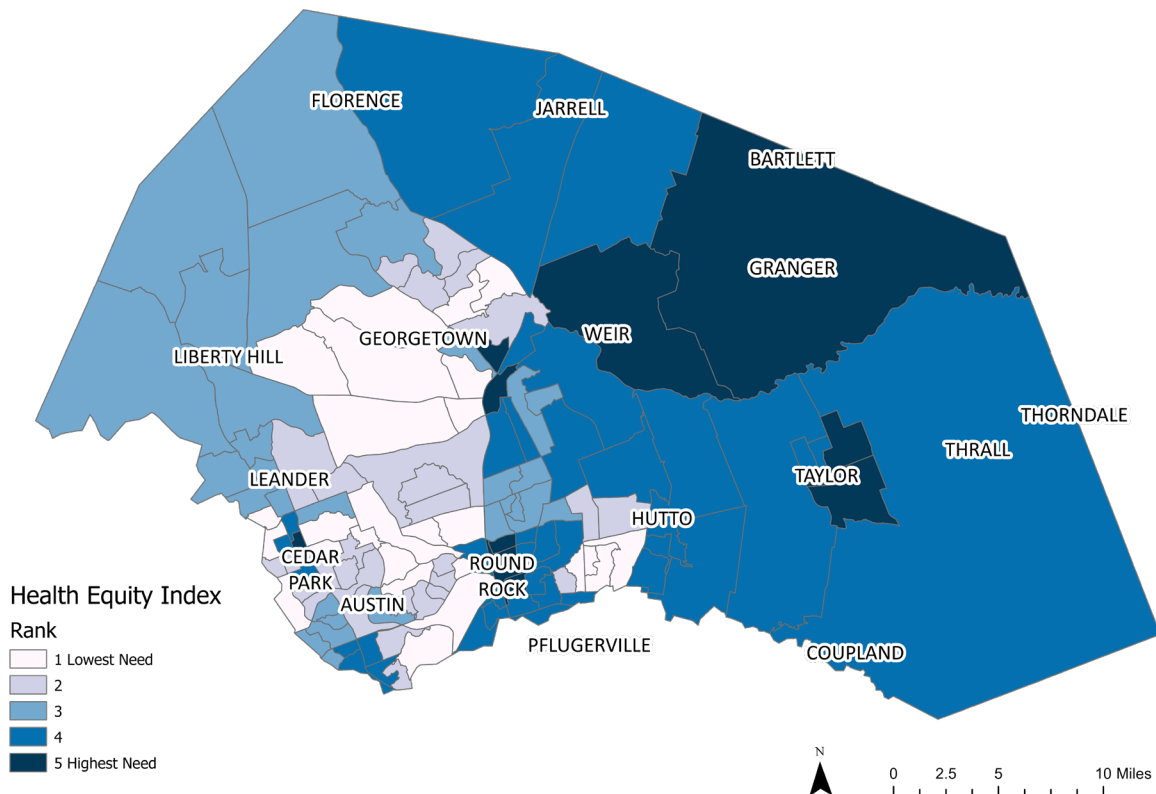
The Community Health Assessment (CHA) Task Force used the qualitative and quantitative data collected and analyzed by the two Mobilizing for Action through Planning and Partnerships assessments — the Community Health Status Assessment and the Community Themes and Strengths Assessment — to identify health equity zones and health priorities.

Health Equity Zones

The 2021 Health Equity Index is a measure of socioeconomic need that is correlated with poor health outcomes. In Williamson County, census tracts are ranked from 1 (low need) to 5 (high need) based on their index value relative to similar locations within the county.¹⁴⁴ Using the index, five health equity zones (HEZs) were identified in Williamson County. These are census tract areas that tend to have higher-than-average health risks and burdens. The HEZs in Williamson County include census tracts in the following areas (Figure 88):

- Northern rural Williamson County (Bartlett/Granger/Weir)
- Taylor
- Georgetown
- Round Rock
- Cedar Park

Figure 88: Williamson County, Texas Health Equity Zones



¹⁴⁴ "2021 Health Equity Index."

Health Priorities

Through the two Mobilizing for Action through Planning and Partnerships assessments and prioritization by residents and stakeholders, the Community Health Assessment (CHA) Task Force identified health priorities to improve health and wellness in Williamson County from 2023 to 2025. This section summarizes the task force's analysis of the health issues and determination of priority areas.

CHA Task Force Sensemaking Session

On December 9, 2021, the CHA Task Force members, Texas Health Institute, and stakeholders from past key informant interviews and focus groups participated in a partners sensemaking session facilitated by Alpinista Consulting to discuss themes, strengths, and challenges. Participants in the sensemaking session were sent a copy of the Community Themes and Strengths Assessment prior to discussion.

The purposes of the sensemaking session were to:

1. Bring together various groups that have contributed data to the CHA and/or will localize the results to their specific context, community, or organization,
2. Notice implications and make sense of patterns embedded within the CHA datasets, and
3. Begin to prioritize the health needs of Williamson County.

Participants in the sensemaking session identified the following themes from the CHA datasets:

1. Developing solutions to health disparities not only across the whole county, but also in the individual communities, neighborhoods, and regions,
2. Addressing the rural-urban divide despite limited resources,
3. Changing policy and directing resources to solve health issues upstream, and
4. Supporting holistic healthcare that includes mental health and basic needs, like transportation and housing.

The CHA Task Force did not determine rankings of the health topics (how priorities are typically determined) during the sensemaking session. The sensemaking session did, however, help the task force make sense of the data to guide future decision making at each agency.

Determination of Priorities

Priorities were determined using the four datasets:

- Residents' responses to the Community Health Survey,
- Overarching themes from the key informant interviews and focus groups conducted by Texas Health Institute (THI),
- Overarching themes from the key informant interviews and focus groups conducted by IBM Watson Health, and
- The Conduent Healthy Communities Institute (HCI) Data Scoring Tool, which processes quantitative health data to produce a ranking of indicator scores.

The priority matrix (Table 30) displays the topic areas as ranked from each of the four datasets.

Table 30: Priority Matrix

COMMUNITY		COMMUNITY/STAKEHOLDERS		QUANTITATIVE DATA
Community Health Survey		THI Focus Groups (FG) and Key Informant Interviews (KII)	IBM Watson FG and KII	Conduent HCI Data Scoring Tool
Health Challenges (Ranked)	Need for Additional or Improved Services (Ranked)	Overarching Themes (Not Ranked)	Overarching Themes (Not Ranked)	Topic Scores (Ranked)
#1: Mental health problems	#1: Affordable housing	Access to Healthcare <ul style="list-style-type: none"> Affordable healthcare and Access to Primary and Specialty Care for Publicly Insured or Uninsured Insurance Culturally and Linguistically Appropriate Care Support for Navigating the Healthcare System Social and Structural Determinants of Health <ul style="list-style-type: none"> Low Socioeconomic Status Housing and Homelessness Transportation Broadband or Internet Access Ethnic and Racial Segregation Priority Health Needs <ul style="list-style-type: none"> Mental Health and Substance Use Chronic Disease Dental care Children's Health <ul style="list-style-type: none"> Child abuse Intellectual Disabilities Mental Health 	Transportation	#1: Physical Activity
#2: Problems related to aging	#2: Transportation options			#2: Mental Health & Mental Disorders
#3: Obesity	#3: Counseling/mental health services/support groups		Housing	#3: Older Adults
#4: Feeling isolated or alone	#4: Road safety		Access to Healthcare	#4: Women's Health
#5: Lack of exercise	#5: Efforts to address racism			#5: Children's Health

Considering all the rankings in the matrix, four priorities were identified:

- **Social and structural determinants of health:** Focus on improving basic needs (housing, transportation, broadband or internet access, and living wages) for all and eliminating ethnic and racial segregation
- **Mental health and well-being:** Focus on building resilience by improving mental health for children and youth and mitigating the impact of the COVID-19 pandemic
- **Chronic disease and chronic disease risk factors:** Focus on increasing healthy food access and physical activity
- **Access to healthcare:** Focus on increasing access to culturally and linguistically appropriate care and dental care for vulnerable populations (e.g., older adults, people of color, and people experiencing homelessness)

Unlike the top health priorities in the past two Community Health Assessments, these are not ranked, as doing so would neglect their intertwined nature. Quantitative and qualitative data show the importance of taking a whole-person- and whole-community-centered approach to improving health, for example, supporting holistic healthcare that includes mental health and basic needs, like transportation and housing. Furthermore, data show that the needs of the neighborhoods, communities, cities, and regions in Williamson County differ. In developing solutions to health disparities, groups should focus not only on countywide efforts, but also on efforts targeted to each region, community, and neighborhood.

CONCLUSION AND IMPLICATIONS FOR WILLIAMSON COUNTY







Conclusion and Implications for Williamson County

The 2022 Community Health Assessment (CHA) provides an updated analysis of available data to describe how the health and quality of life of Williamson County residents have changed since the last assessment in 2019. Throughout the 2022 assessment process, the CHA Task Force engaged with residents and stakeholders, who were active participants. Along with quantitative data, their feedback describes the status of and shared perceptions about the health and well-being of Williamson County, Texas.

The 2022 CHA is the evidence-based foundational document for Williamson County and Cities Health District, community partners, decision makers, and — most importantly — residents to develop health-related policy. The assessment will be used to educate and mobilize community partners and residents, guide strategy, gather resources, and plan actions to improve health. The top health priorities for future improvement efforts are defined in Table 31.

Table 31: Top Health Priorities for 2023–2025 in Williamson County, Texas

Icon	Health Priority
	Social and structural determinants of health <i>Focus on improving basic needs (housing, transportation, broadband or internet access, and living wages) for all and eliminating ethnic and racial segregation.</i>
	Mental health and well-being <i>Focus on building resilience by improving mental health for children and youth and mitigating the impact of the COVID-19 pandemic.</i>
	Chronic disease and chronic disease risk factors <i>Focus on increasing healthy food access and physical activity.</i>
	Access to healthcare <i>Focus on increasing access to culturally and linguistically appropriate care and dental care for vulnerable populations (e.g., older adults, people of color, and people experiencing homelessness).</i>

The determination of priorities is the first step in improving the health of the community. Future steps involve developing action plans with the community during the Community Health Improvement Plan process to address each of these priorities. This collaborative effort provides a common agenda the county will use to improve the health of all residents. Additionally, the 2022 CHA and recommendations can be used in developing the following:

- Community health changes and trends
- Hospital-based community benefit and implementation strategy plans
- Organizational strategic plans
- Evidence for grant applications

The CHA Task Force hopes this CHA will spur engagement in supporting the health of the people of Williamson County and aid efforts to become the healthiest county in Texas. Sustained and broad community involvement is necessary to strategically address the health issues in Williamson County, and the solutions will require the combined resources and efforts of partners from all sectors. This shared ownership of community health among diverse stakeholders improves the deployment of resources to achieve our goals. Together, we can make Williamson County a healthy place for residents to live, learn, work, play, worship, and age.

Appendices

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Appendix C: List of Abbreviations

AAPI: Asian American and Pacific Islander

ACE: Adverse Childhood Experience

AI/AN: American Indian and Alaska Native

BTCS: Bluebonnet Trails Community Services

CDC: Centers for Disease Control and Prevention

CHA: Community Health Assessment

CHIP: Community Health Improvement Plan

CHS: Community Health Survey

CHSA: Community Health Status Assessment

CTSA: Community Themes and Strengths Assessment

HCCM: Hill Country Community Ministries

HEZ: Health Equity Zone

LSCC: Lone Star Circle of Care

MAPP: Mobilizing for Action through Planning and Partnerships

NACCHO: National Association of County and City Health Officials

NH/PI: Native Hawaiian and Pacific Islander

THI: Texas Health Institute

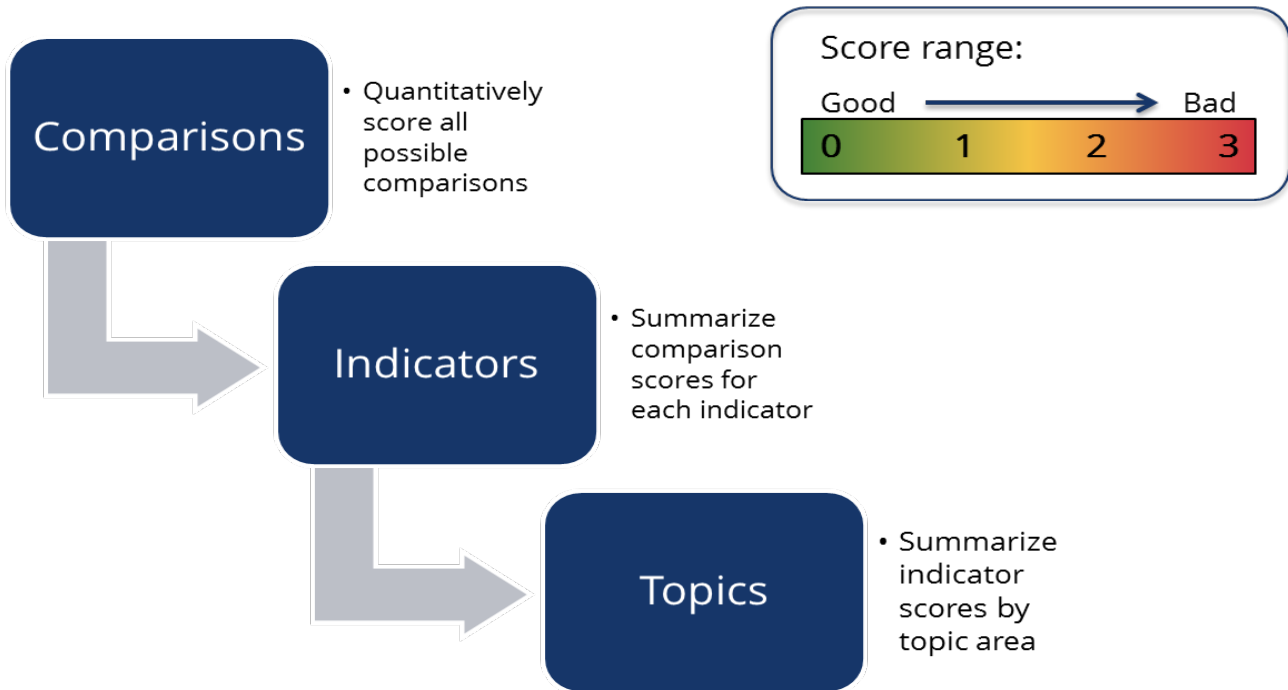
WCCHD: Williamson County and Cities Health District

Appendix D: Conduent Healthy Communities Institute Data Scoring Tool Methodology and Results

Conduent Healthy Communities Institute Data Scoring Tool - Methodology

Scoring Method

Data Scoring is done in three stages:



For each indicator, county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.



County: Williamson
Williamson County and Cities Health
District

Total indicators: 193
Friday, 7th of January 2022

Topic	Indicators	Score
Physical Activity	18	1.58
Mental Health & Mental Disorders	10	1.44
Older Adults	29	1.43
Women's Health	5	1.43
Children's Health	8	1.42
Environmental Health	28	1.38
Cancer	18	1.36
Alcohol & Drug Use	7	1.25
Health Care Access & Quality	10	1.24
Oral Health	4	1.21
Other Conditions	7	1.21
Immunizations & Infectious Diseases	15	1.17
Heart Disease & Stroke	17	1.16
Respiratory Diseases	19	1.12
Prevention & Safety	7	1.08
Sexually Transmitted Infections	4	1.06
Community	26	0.98
Wellness & Lifestyle	6	0.94
Economy	33	0.90
Diabetes	8	0.89
Mortality Data	20	0.89
Maternal, Fetal & Infant Health	7	0.85
Education	5	0.83

Appendix E: Community Health Survey

Please take a few minutes to complete the survey below. The purpose of this survey is to get your opinions about health in Williamson County. The Williamson County Community Health Assessment (CHA) Task Force will use the results of this survey and other information to identify the most pressing problems which can be addressed through community action. If you have previously completed a 2022 CHA survey, please ignore this. Remember... your opinion is important! Thank you and if you have any questions, please visit our website at www.healthywilliamsoncounty.org/cha.

1. What are the **three “strengths”** in your neighborhood or community? **Select only three.**

- | | |
|---|--|
| <input type="checkbox"/> Access to health care (e.g., family doctor) | <input type="checkbox"/> Good schools |
| <input type="checkbox"/> Access to public transportation | <input type="checkbox"/> Health behaviors and lifestyles |
| <input type="checkbox"/> Affordable housing | <input type="checkbox"/> Low adult death and disease rates |
| <input type="checkbox"/> Arts and cultural events | <input type="checkbox"/> Low crime/safe neighborhoods |
| <input type="checkbox"/> Clean environment | <input type="checkbox"/> Low infant deaths |
| <input type="checkbox"/> Community resources (e.g., nonprofits, libraries, food pantries) | <input type="checkbox"/> Parks and recreation |
| <input type="checkbox"/> Good jobs and healthy economy | <input type="checkbox"/> Prepared for natural and man-made disasters and other emergencies |
| <input type="checkbox"/> Good place to raise children | <input type="checkbox"/> Religious or spiritual values |
| <input type="checkbox"/> Good relationships between different race/ethnic groups | <input type="checkbox"/> Other _____ |

2. What are the **three most important “challenges”** in your neighborhood or community? **Select only three.**

- | | | |
|--|---|---|
| <input type="checkbox"/> Access to basic needs | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rape/sexual assault |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Respiratory/lung disease |
| <input type="checkbox"/> Child abuse | <input type="checkbox"/> Other infectious diseases (e.g., Hepatitis, TB) | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Infant death | <input type="checkbox"/> Sex Trafficking |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Suicide/Intentional Harm |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Mental health problems (e.g., anxiety, stress, depression, etc.) | <input type="checkbox"/> Teenage pregnancy |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Motor vehicle crash injuries | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Excessive drinking | <input type="checkbox"/> Obesity | <input type="checkbox"/> Violent crime and deaths |
| <input type="checkbox"/> Feeling isolated or alone | <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart disease and stroke | <input type="checkbox"/> Problems related to aging | |

3. Which **three services** would you like to see more of or improved in your neighborhood or community? **Select only three.**

- | | |
|---|--|
| <input type="checkbox"/> Affordable housing | <input type="checkbox"/> More jobs |
| <input type="checkbox"/> Childcare options | <input type="checkbox"/> Parks, trails, community centers |
| <input type="checkbox"/> Communication and services from officials during emergencies | <input type="checkbox"/> Positive youth activities |
| <input type="checkbox"/> Counseling/mental health services/support groups | <input type="checkbox"/> Road safety |
| <input type="checkbox"/> Culturally appropriate health services | <input type="checkbox"/> Services for people with disabilities |
| <input type="checkbox"/> Efforts to address racism | <input type="checkbox"/> Services for people who are homebound |
| <input type="checkbox"/> Healthy food choices | <input type="checkbox"/> Services for seniors |
| <input type="checkbox"/> Help finding services | <input type="checkbox"/> Transportation options |
| <input type="checkbox"/> Low-cost health services | <input type="checkbox"/> Other _____ |

4. How do you expect COVID-19 to affect you or your household in the future? **Select all that apply.**

- | | |
|---|--|
| <input type="checkbox"/> Wages and employment | <input type="checkbox"/> Expenses or ability to meet basic needs |
| <input type="checkbox"/> Health and ability to seek care (feeling hopeless, stressed, getting medical care, getting prescriptions refilled) | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Not sure |

☐ School and education

☐ I do not expect COVID-19 to affect me or my household in the future.

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

☐ Do not have enough saved for one month

☐ Three months

☐ One month

☐ More than three months

☐ Two months

☐ Not sure

We strive to create programs and services that represent the full diversity of the Williamson County community. We are asking the following questions about ZIP code, age, race, and ethnicity to ensure that we are meeting this goal.

6. What ZIP code do you live in? _____

7. What is your age? _____

8. Which of the following best describes you? **Select one answer.**

☐ Woman

☐ Agender

☐ Man

☐ Gender fluid

☐ Transgender woman

☐ Gender queer

☐ Transgender man

☐ Prefer to self-describe _____

☐ Non-binary

☐ Prefer not to answer

9. Which of the following best describes you? **Select all that apply.**

☐ African American or Black

☐ Native Hawaiian or Pacific Islander

☐ Asian or Asian American

☐ White or Caucasian

☐ Hispanic or Latino

☐ Prefer to self-describe _____

☐ Middle Eastern or North African

☐ Prefer not to answer

☐ Native American or Alaska Native

10. Are you interested in becoming a health leader in your neighborhood or community? **Please enter email or phone number if interested.**

Name: _____

Phone Number/Email: _____

Appendix F: Community Health Survey Results

Demographics

The CHA Task Force focused on collecting surveys from individuals 18 years and older (Figure 89). The average age of survey respondents was 53.8 years old, compared to the overall county average of 37.4 years old. The average age among participants who reside in Northern Williamson County was highest at 59.6, and the average age among participants who reside in Southern Williamson County was lowest at 47.6 years old. Three out of four survey respondents were female (Figure 90). The majority of respondents identified as White or Caucasian (Table 32).

Figure 89: Age Distribution of Community Health Survey Respondents

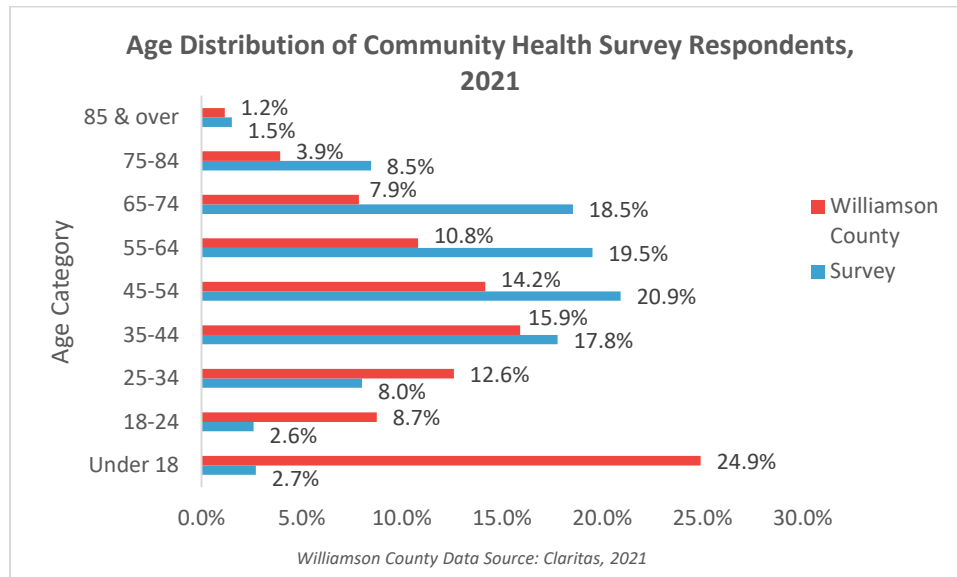


Figure 90: Gender Distribution of Community Health Survey Respondents

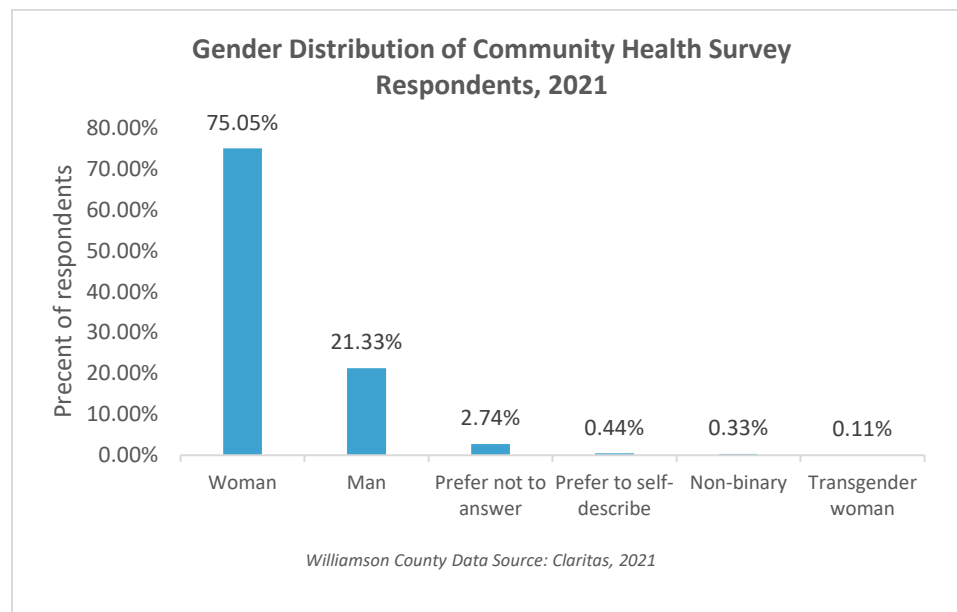


Table 32: Race/Ethnicity of Community Health Survey Respondents, 2021

RACE / ETHNICITY	COUNT
White or Caucasian	646
Hispanic or Latino	135
Prefer not to answer	57
African American or Black	40
Asian or Asian American	34
Prefer to self-describe	29
Native American or Alaska Native	8
Native Hawaiian or Pacific Islander	5
Middle Eastern or North African	0

Note: 39 respondents identified as multiple races/ethnicities.

10 respondents did not indicate race/ethnicity.

913 respondents reported their race/ethnicity.

Responses

Strengths of Williamson County

Survey respondents were asked, “What are the three ‘strengths’ in your neighborhood or community?” and 918 residents responded. Nearly half of survey respondents ranked low crime and safe neighborhoods as a top strength. Respondents ranked the following strengths almost equally: parks and recreation, good place to raise children, access to healthcare, and arts and cultural events (Table 33). Resident perceptions of top strengths in Williamson County are broken down by region in Figure 91.

Table 33: Resident Perceptions of Strengths of Williamson County

RANK	STRENGTHS IN COMMUNITY	COUNT	PERCENT
1	Low crime / safe neighborhoods	440	47.9%
2	Parks and recreation	333	36.3%
3	Good place to raise children	330	35.9%
4	Access to healthcare	325	35.4%
5	Arts and cultural events	325	35.4%

Note: n=918

Figure 91: Resident Perceptions of Strengths in Williamson County by Region

North		
1. Low crime / safe neighborhoods		
2. Parks and recreation		
3. Access to healthcare		
4. Community resources		
5. Clean environment		
West	Williamson County	East
1. Good place to raise children	1. Low crime / safe neighborhoods	1. Low crime / safe neighborhoods
2. Good schools	2. Parks and recreation	2. Good place to raise children
3. Low crime / safe neighborhoods	3. Good place to raise children	3. Access to healthcare
4. Access to healthcare	4. Access to healthcare	4. Parks and recreation
5. Parks and recreation	5. Arts and cultural events	5. Clean environment
South		
1. Good place to raise children		
2. Low crime / safe neighborhoods		
3. Good schools		
4. Parks and recreation		
5. Prepared for natural & manmade disasters & other emergencies		

Community Challenges

Survey respondents were asked, “What are the three most important ‘challenges’ in your neighborhood or community?” and 918 individuals responded. The #1 challenge identified in the community survey, by far, was mental health problems (Table 34). Resident perceptions of health problems in Williamson County are broken down by region in Figure 92.

Table 34: Resident Perceptions of Top Challenges in Neighborhoods and Communities in Williamson County

RANK	CHALLENGES IN COMMUNITY	COUNT	PERCENT
1	Mental health problems	363	39.5%
2	Problems related to aging	244	26.6%
3	Obesity	200	21.8%
4	Feeling isolated or alone	196	21.4%
5	Lack of exercise	177	19.3%

Note: n=918

Figure 92: Resident Perceptions of Top Challenges in Neighborhoods and Communities in Williamson County by Region

<u>North</u>		
1. Problems related to aging		
2. Mental health problems		
3. Obesity		
4. Feeling isolated or alone		
5. Lack of exercise		
<u>West</u>	<u>Williamson County</u>	<u>East</u>
1. Mental health problems	1. Mental health problems	1. Mental health problems
2. Feeling isolated or alone	2. Problems related to aging	2. Poor eating habits
3. Obesity	3. Obesity	2. Access to basic needs
4. Problems related to aging	4. Feeling isolated or alone	3. Drug use
5. Other	5. Lack of exercise	4. Excessive drinking
<u>South</u>		
1. Mental health problems		
2. Poor eating habits		
3. Lack of exercise		
4. Obesity		
5. Feeling isolated or alone		

Need for Additional or Improved Services in Williamson County

Survey respondents were asked, “Which three services would you like to see more of or improved in your neighborhood or community?” and 916 individuals responded. The leading service in need of improvement or additions was affordable housing (Table 35). Resident perceptions of need for additional or improved services in Williamson County are broken down by region (Figure 93).

Table 35: Resident Perceptions of Need for Additional or Improved Services in Williamson County

RANK	SERVICE	COUNT	PERCENT
1	Affordable housing	284	31.0%
2	Transportation options	239	26.1%
3	Counseling / mental health services / support groups	232	25.3%
4	Road safety	210	22.9%
5	Efforts to address racism	192	21.0%

Note: n=916

Figure 93: Resident Perceptions of Need for Additional or Improved Services in Williamson County by Region

North		
<ol style="list-style-type: none"> 1. Transportation options 2. Road safety 3. Affordable housing 4. Services for seniors 5. Counseling / mental health services / support groups 		
West	Williamson County	East
<ol style="list-style-type: none"> 1. Affordable housing 2. Counseling / mental health services / support groups 3. Transportation options 4. Parks, trails, community centers 5. Services for seniors 	<ol style="list-style-type: none"> 1. Affordable housing 2. Transportation options 3. Counseling / mental health services / support groups 4. Road safety 5. Efforts to address racism 	<ol style="list-style-type: none"> 1. Low-cost health services 2. Counseling / mental health services / support groups 3. More jobs 4. Positive youth activities 5. Healthy food choices
South		
<ol style="list-style-type: none"> 1. Affordable housing 2. Counseling / mental health services / support groups 3. Efforts to address racism 4. Parks, trails, community centers 5. Transportation options 		

COVID-19 Impact on Household

Survey respondents were asked, “How do you expect COVID-19 to affect you or your household in the future?” and 922 individuals responded. The leading answer, indicated by 31% of residents, was that there was no expectation for COVID-19 to affect their households, followed by expected impacts on school and education, as well as health and ability to seek care (Table 36). Resident expectations of COVID-19’s effect on households in Williamson County are broken down by region (Figure 94).

Table 36: Resident Expectations of COVID-19’s Effect on Households in Williamson County

RANK	EXPECTATION	COUNT	PERCENT
1	I do not expect COVID-19 to affect me or my household in the future	283	30.7%
2	School and education	259	28.1%
3	Health and ability to seek care	234	25.4%
4	Not sure	222	24.1%
5	Wages and employment	214	23.2%

Note: n=922

Figure 94: Resident Expectations of COVID-19's Effect on Households in Williamson County by Region

North		
<ol style="list-style-type: none"> 1. I do not expect COVID-19 to affect me or my household in the future 2. Not sure 3. Health and ability to seek care 4. Wages and employment 5. School and education 		
West	Williamson County	East
<ol style="list-style-type: none"> 1. School and education 2. Health and ability to seek care 3. Wages and employment 4. I do not expect COVID-19 to affect me or my household in the future 5. Not sure 	<ol style="list-style-type: none"> 1. I do not expect COVID-19 to affect me or my household in the future 2. School and education 3. Health and ability to seek care 4. Not sure 5. Wages and employment 	<ol style="list-style-type: none"> 1. I do not expect COVID-19 to affect me or my household in the future 2. Health and ability to seek care 3. Wages and employment 4. School and education 5. Not sure
South		
<ol style="list-style-type: none"> 1. School and education 2. Wages and employment 3. Health and ability to seek care 4. I do not expect COVID-19 to affect me or my household in the future 5. Expenses or ability to meet basic needs 		

Financial Emergency Preparedness

Survey respondents were asked, "In case of an emergency, my household has enough money saved up for how many months of expenses (rent, utilities, groceries, basic supplies)?" and 922 individuals responded. Slightly more than half of respondents reported having more than three months of expenses saved for an emergency (Table 37). Resident's emergency savings in Williamson County are broken down by region (Figure 95).

Table 37: Residents' Emergency Savings in Williamson County

RANK	EMERGENCY SAVINGS FOR:	COUNT	PERCENT
1	More than three months	474	51.4%
2	Three months	108	11.7%
3	Two months	90	9.8%
4	Do not have enough saved for one month	89	9.7%
5	One month	89	9.7%

Note: n=922

Figure 95: Residents' Emergency Savings in Williamson County by Region

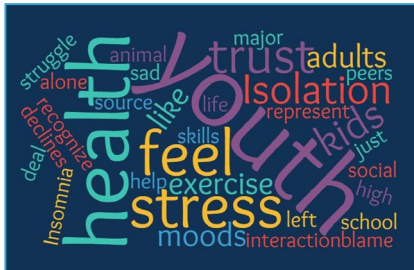
<u>North</u> 1. More than three months 2. Three months 3. One month 4. Not sure 5. Do not have enough saved for one month		
<u>West</u> 1. More than three months 2. Three months 3. Do not have enough saved for one month 4. One month 5. Two months	<u>Williamson County</u> 1. More than three months 2. Three months 3. Two months 4. Do not have enough saved for one month 5. One month	<u>East</u> 1. More than three months 2. Do not have enough saved for one month 3. Three months 4. Two months 5. Not sure
<u>South</u> 1. More than three months 2. Two months 3. One month 4. Three months 5. Do not have enough saved for one month		

Appendix G: “Youth with Cameras” Photovoice Results

The three youth photographers from Catalyst Collective will begin 10th grade at the end of summer. Of the five youth photographers from The Georgetown Project and Boys and Girls Club of Georgetown, one will be in 8th grade, two will be 9th grade, and two will be in 11th grade for the 2021–2022 school year. Gender and race data were not collected.

The descriptions accompanying each picture are paraphrased remarks each photographer shared about their photo submissions. The word clouds for each section were created with the descriptions’ text.

Results from the focus groups concluded the following overarching challenges and themes:



Mental Health and Isolation

- Stress and anxiety, stemming from home and school
- Body image and unrealistic beauty expectations
- Social isolation during the COVID-19 pandemic
- Social anxiety
- Insomnia
- Access to mental health resources



Healthy Eating and Exercise

- Unhealthy food options
- Expense of healthy foods
- Understanding food labels and marketing
- Water consumption
- Pollution
- Eating disorder resources
- Weightlifting and walking



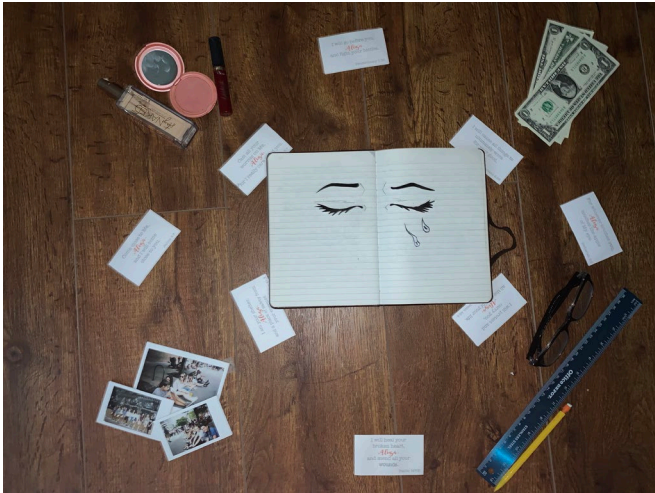
Basic Needs

- Life skills not taught in school
- Financial challenges
- Food and utility expenses
- Exercise
- Social interaction

Two additional themes were introduced during focus groups with the youth photographers.

- **Safety and trust:** Youth lacked trust in most people due to stories that have made them feel unsafe. Multiple youth expressed concerns about the dangers of public transportation, from Uber to public buses. Fears of kidnapping were expressed, as well as concerns regarding public transportation sanitation and health safety.
- **Respect:** Youth expressed the need for people to share respect for others, citing COVID-19-related tensions as an example. Youth photographers recognized the importance of acceptance, open minds, and education to have constructive, meaningful, fact-based conversations in respectful manners.

Theme 1: Mental Health and Isolation



Scattered Brain (Photo by Catalyst Collective youth photographer)

Journaling is a stress outlet. Objects in this picture surrounding the journal represent topics that cause stress or anxiety. Beauty standards are a source of major stress for girls who feel extensive pressure to “fit into unrealistic standards” just because they’re popular. Other primary sources of stress are sports, family, and school. Students are frustrated that teachers must tend to the whole class and not just one student, resulting in students feeling alone and left behind. Students recognize that teachers earn low salaries and do not blame teachers for causing them to feel left behind. Students recognize a need for more time and learning accommodations. Students also feel that school only teaches them some necessary life skills. Bible verses can be a source of solace.

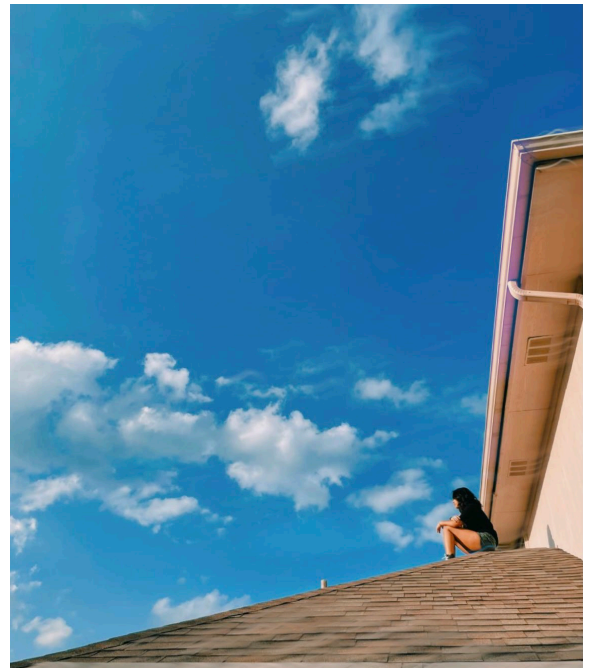
Isolation (Photo by Catalyst Collective youth photographer)

One method of self-care and boosting spirits is be outside in the open by oneself, sometimes while listening to music. Many youth have experienced a decline in mental health from 2020 to 2021, because they were isolated and unable to interact with peers. Social media is to blame for this decline in mental health; youth get “trapped in their phones and do not realize the world surrounding them.”



Release (Photo by Catalyst Collective youth photographer)

When stressed or feeling sad, laying in the grass, face-down, can boost moods. This photographer put a dead flower in her hair to emphasize the sad mood. The beginning of quarantine was full of sudden, big changes, which was tough at first. Since then, youth have adapted and learned the importance of isolation to “pick up your thoughts and keep moving.” Self-regulation techniques to improve moods and mental health that youth learned during quarantine include walks, runs, and movies. Some youth view learning mental health improvement skills and behaviors as a major benefit of quarantine during the COVID-19 pandemic.



Isolation

(Photo by Boys & Girls Club of Georgetown youth photographer)

This teddy bear is alone in the room to represent the sadness and challenges that come with isolation when people are blocked from interaction with the world.



Social Anxiety

(Photo by Boys & Girls Club of Georgetown youth photographer)

Social anxiety is a mental illness that is not commonly spoken about, yet frequently experienced. Those with social anxiety feel a constant spotlight on them and sense that people always talk about them everywhere they go, which can cause their minds to go into a swirl. This condition is not easy to deal with, even with help and support. Since COVID-19 quarantine has limited social interaction, people are no longer acclimated to group settings and the associated pressures that may come with such circumstances.



Insomnia

(Photo by Boys & Girls Club of Georgetown youth photographer)

Insomnia is a condition that affects some youth and adults. Difficulty sleeping can be caused by stress, high emotions, or restlessness that youth and adults both experience. The high levels of stress that youth experience is not always recognized by adults. To cope with insomnia and related stresses, youth try to be calm or do an activity or technique to make them feel happy and lift their mood.





A Helping Hand (Photo by Boys & Girls Club of Georgetown youth photographer)

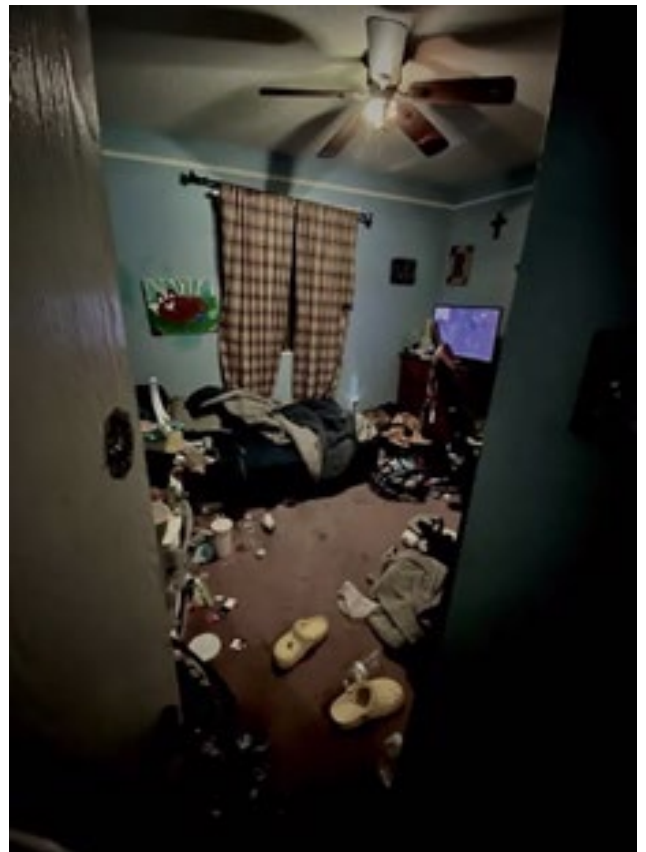
In this photo, youth are at a farm doing a teamwork exercise where a mouse is passed from person to person, exhibiting the importance of **trust**. A lot of people do not like mice, but this exercise taught the youth and animal alike the importance of trust for connecting with others to execute a task and grow stronger independently and as a team. This exercise was very eye-opening to youth so that they could learn what building trust feels like and looks like.

When it comes to mental health, a lack of confidence to trust is a key reason people struggle. When someone does not trust people, they inadvertently push away human contact, which “breeds loneliness” and exacerbates existing challenges in one’s life.

Behind Every Door, There’s a Different Story

(Photo by Boys & Girls Club of Georgetown youth photographer)

One’s bedroom is representative of their mental health. This room is clean, but also dirty. Every person has challenges that they deal with – regardless of how they present themselves – and a lot of youth struggle with achieving good mental health. If more help and resources were available and easier to access, more people would attain stable mental health. Mental health is largely dependent upon one’s surroundings.



Theme 2: Healthy Eating and Exercise



America's Health Grows on Trees

(Photo by Catalyst Collective youth photographer)

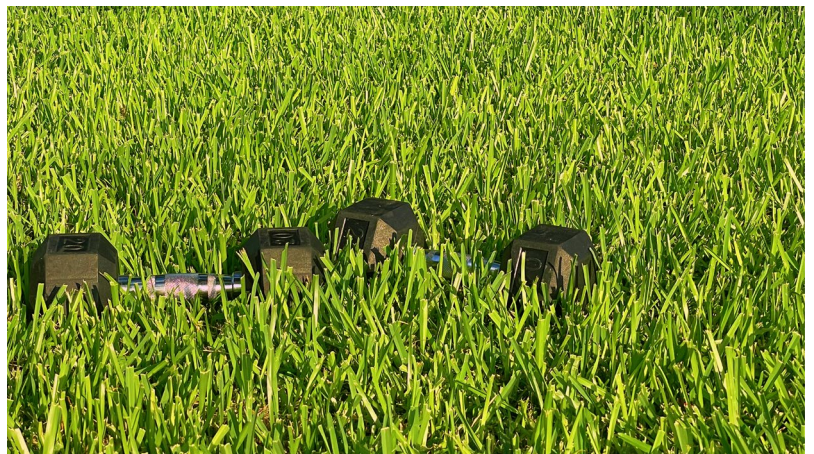
Junk food is widely marketed, available almost everywhere, and is offered at unbeatably low prices, making it a contributing factor to high obesity rates. Healthy foods tend to be much more expensive than unhealthy food. It is difficult to eat healthy when unhealthy foods, such as donuts and cake, are cheaper than healthy food, such as apples. The apples hung in the picture represent the last item this youth photographer saw at the store.

Food labels are confusing and can be quite manipulative, which make it difficult to understand what you are consuming. Some people chose to eat unhealthy food because they believe working out is sufficient to be healthy. It can be super challenging to eat healthy for those who want to, especially for those with limited to no healthy food options, and more options to eat unhealthy food.

Weights

(Photo by Catalyst Collective youth photographer)

This youth photographer says that weightlifting with their school's soccer team really improved their health. The pandemic has changed the way group sports, like soccer, are offered to students. Fortunately, students can still use the weight room at the school gym. Additionally, the green grass can boost moods.



Drink Up *(Photo by Catalyst Collective youth photographer)*

Water is very important for people, and a great prompt for exercise. This youth photographer loves water and believes water is the most important thing that one can have.

Cheetos Trash

(Photo by Boys & Girls Club of Georgetown youth photographer)

Empty food bags are left lying around frequently. Trash in the community and environment has a negative impact on people, and youth do not usually want to be outside where there is lots of trash, which they often see in their community.



Apple

(Photo by Boys & Girls Club of Georgetown youth photographer)



Apples are an example of healthy food. Mangoes are this student's favorite fruit, followed by apples, but she prefers vegetables over fruit. This student eats fruit a couple of times a week, but it is hard.

Eating Watermelon Like It's Water

(Photo by Boys & Girls Club of Georgetown youth photographer)

This youth photographer thought their friend who chose healthy watermelon over the unhealthy choices available to them was a fantastic example of discipline and self-control to better herself. This friend inspired the photographer to make a healthy choice amidst a breadth of unhealthy food and showed the photographer that you can be social and healthy (since many social events center around food). That said, being healthy is about more than food; it is about feeling nice, exercising and feeling confident.





Just Because There's a Bow Doesn't Mean It's Perfect (Photo by Boys & Girls Club of Georgetown youth photographer)

This student had overcome anorexia, which has provided them with an enlightened perspective on youth mental health. For one, the image of healthy is based on pure looks, not internal/biological health, which can quickly foster physical and mental toxicity. It is important for society to recognize that mental health, body image, and eating disorders are challenges for people other than just women. Health and eating habits cannot be evaluated by how one's body appears. The youth photographer's finger on the tape-measure bow tassel portrays their desire to pull the bow away, yet they keep looking at it.

Theme 3: Basic Needs

Hidden Education (Photo by Catalyst Collective youth photographer)

Young adults feel they face major challenges due to a lack of basic education (need) for real-world topics, like car maintenance, investments, and taxes. Every single student would benefit from semester-long high school classes on these topics; it would be wise to make such courses mandatory.

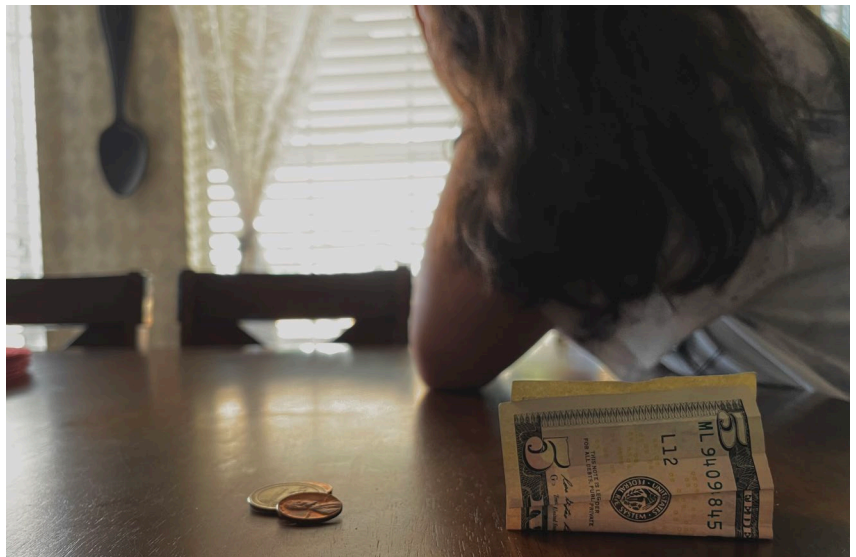


Equal (Photo by Catalyst Collective youth photographer)

Money is a big issue for a lot of people, largely caused by inequality in pay. This picture represents how everyone wants to be treated equally. Money is not often talked about. There are sometimes micro-aggressions about money-related topics.

Struggle (Photo by Catalyst Collective youth photographer)

Money is one of the biggest struggles that people have with regards to basic needs. People struggle to keep up with paying the bills. The background of this photo is filled with disappointment, stress, and struggle. The money on the table represents having little, despite large efforts. This youth photographer feels very grateful to have enough money, after seeing homeless people and friends who have sub-optimal lifestyles due to financial limitations.





Equal (Photo by Boys & Girls Club of Georgetown youth photographer)

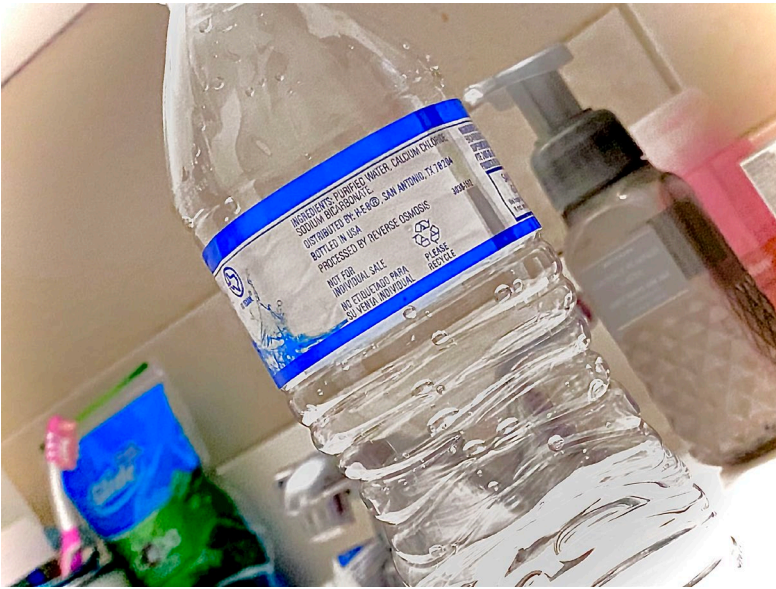
Social interaction is a basic need. Without it, people may experience stress and/or anxiety in social situations since they are not used to it. The pandemic has changed how people interact. In general, people who lack basic needs early in life tend to value such needs more later on and use them more wisely.

It's Not Easy to Get Basic Needs

(Photo by Boys & Girls Club of Georgetown youth photographer)

Food is necessary for survival, as it provides energy and nutrients throughout the day. Not every household has electricity, food, or a fridge full of food. Some people have to eat fast food because they cannot afford fresh food. This youth photographer has seen inoperable fridges a few times and found it quite difficult to process because it puts their privilege to basic needs into perspective. It is not easy to get basic needs.





With Every Drop, There's a Light

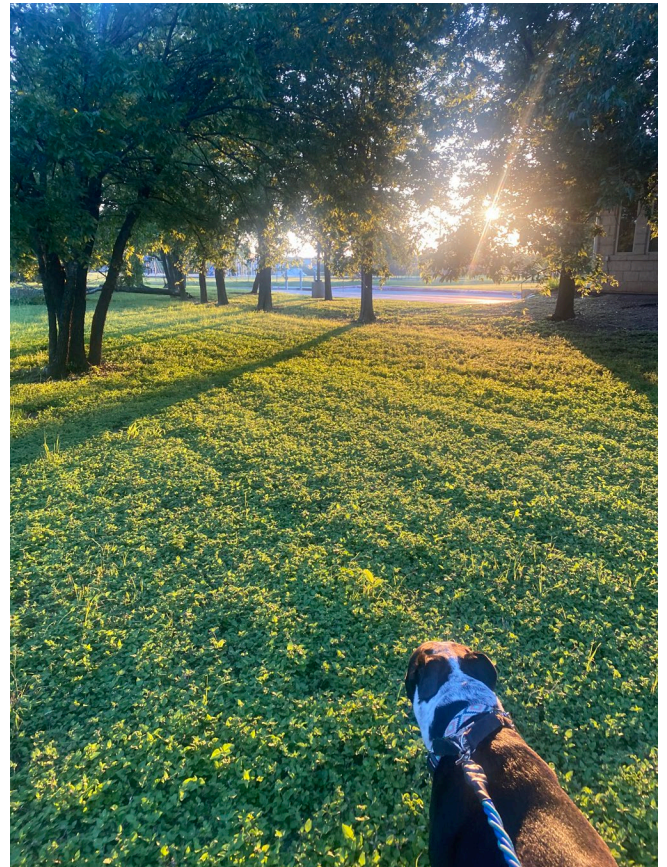
(Photo by Boys & Girls Club of Georgetown youth photographer)

Some people are half-empty spirits; others are half-full. Some people do not have water, enough food, or other basic needs. For some people, basic needs are really hard to attain. Some peers' parents work multiple jobs just to pay the rent – which can cause other issues outside of having a place to live.

Another aspect of this photograph is the negative health impacts and quality of life issues that pollutants, like trash, play in our environment.

Once Something Becomes a Daily Habit, It Becomes a Basic Need *(Photo by Boys & Girls Club of Georgetown youth photographer)*

Basic needs are more extensive than just food, water, and shelter; they also include components to maintain positive mental health, which can look different for everyone. For this student, a daily walk with their dog in fresh air, out in the open, is a necessity for both his physical and mental health.



Successes, Limitations, and Moving Forward

Successes

The youth photographers provided high levels of feedback and grassroots perspectives of their age demographic. The youth varied in home life, education, and geography, providing well-rounded feedback on most areas within Williamson County. Their feedback serves to inform WCCHD and stakeholder efforts throughout the region, aiming to keep Williamson County the 3rd healthiest county in Texas. The study design required minimal financial investment, thereby making it easy to repeat in the future.

Limitations

The sample size of youth photographers only provided 10 perspectives. If data collection using Photovoice were to be repeated, WCCHD would recommend that a greater sample size is selected, with a wider age range (including younger ages) and geographic span.

Moving Forward: The Wish List

After the youth photographers shared their photographs, they were asked to brainstorm ideal solutions to the challenges they discussed. The word cloud on the right highlights common themes presented in the wish list.

The mental health solution wish list was comprised of:

- **Beauty Standards:** Eliminate socially-established beauty standards that teens compare themselves with, on social media and other sources.
- **Free Therapy:** Access to no-cost and stigma-free therapy; help families and schools talk about therapy with a positive connotation.



The healthy eating and exercise solution wish list included:

- **Food Education:** Teach reality of healthy/unhealthy foods and how to discern deceptive food marketing and “fad diets”; advertise more healthy food.
- **Healthy Options:** Offer more healthy food options and provide healthy alternatives when junk food is offered; regular access to healthy food for every meal would make a big difference.
- **It Takes Two:** Teach people from a young age that being healthy entails a nutritious diet *and* exercise; exercise is not justification to eat unhealthily, and vice-versa.
- **Clean, Safe Environment:** Create or maintain safe public spaces for recreation; install more streetlights and other safety measures; and provide more trash cans to avoid litter and pollution.
- **Eating Disorders:** Raise awareness and provide more resources for *all* genders experiencing eating disorders.
- **Removing Ideals:** Not allow media and society to dictate the “ideal” body type, which poorly affects mental health and causes insecurities.
- **Affordable Health:** Make healthy food less expensive and easier to access; do not let unhealthy food be the most viable option.

The basic needs solution wish list had the following suggestions:

- **Redefine Basic Education:** Provide mandatory classes that teach real-life basic skills to high schoolers, including car maintenance, taxes, and investments/finances.
- **Self-Defense:** Teach students how to walk safely by themselves and equip them with basic self-defense skills. Some students requested pepper spray keychains.
- **Easier Access:** Facilitate and advertise easier access to basic need resources; remove barriers (including turnaround time), provide transportation to resources, and reduce stigma about accepting assistance.

Appendix H: Social Determinants of Health and COVID-19 Vaccine Survey

OVERVIEW

Two of the top five health priorities for Williamson County, as a result of the 2019 Community Health Assessment (CHA), were behavioral health, stress, and well-being, and the social determinants of health:

What are the Top Five Health Priorities?

1. Behavioral Health, Stress, and Well-being
2. Chronic Disease Risk Factors
3. Social Determinants of Health (Housing, Transportation, and Workforce Development)
4. Access and Affordability of Healthcare
5. Building a Resilient Williamson County

To gain additional data to have a deeper understanding of how these factors affect the community's health status due to the COVID-19 pandemic, WCCHD published the Social Determinants of Health and COVID-19 Vaccine Survey. The survey aimed to assess the COVID-19 impact on the Williamson County community's ability to access basic needs, as well as mental health status. According to the World Health Organization and Healthy People 2030, the social determinants of health are, "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, such as the safety and affordability of housing, discrimination, job opportunities or job security, and access to nutritious foods. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries." The survey also aimed to capture this community's perceptions about the COVID-19 vaccine to help WCCHD plan vaccination education and communication campaigns.

METHODS

WCCHD staff designed the survey in conjunction with Austin Public Health (APH). To ensure that the survey was accessible for various literacy levels, WCCHD and APH collaborated to write survey questions at a 6th grade reading level. Once the survey questions (see Appendices B and C) were finalized, WCCHD staff translated the survey into Spanish. Staff imported two versions of the survey—English and Spanish—into SurveyMonkey. Austin Public Health shared the survey on their social media pages, leaving the survey open from October 1st, 2020 – December 1st, 2020. To increase the response rate among Williamson County residents, WCCHD posted the survey on our respective Facebook and Twitter pages, leaving the survey open from January 21st, 2020 – February 12th, 2021 (Appendices D and E).

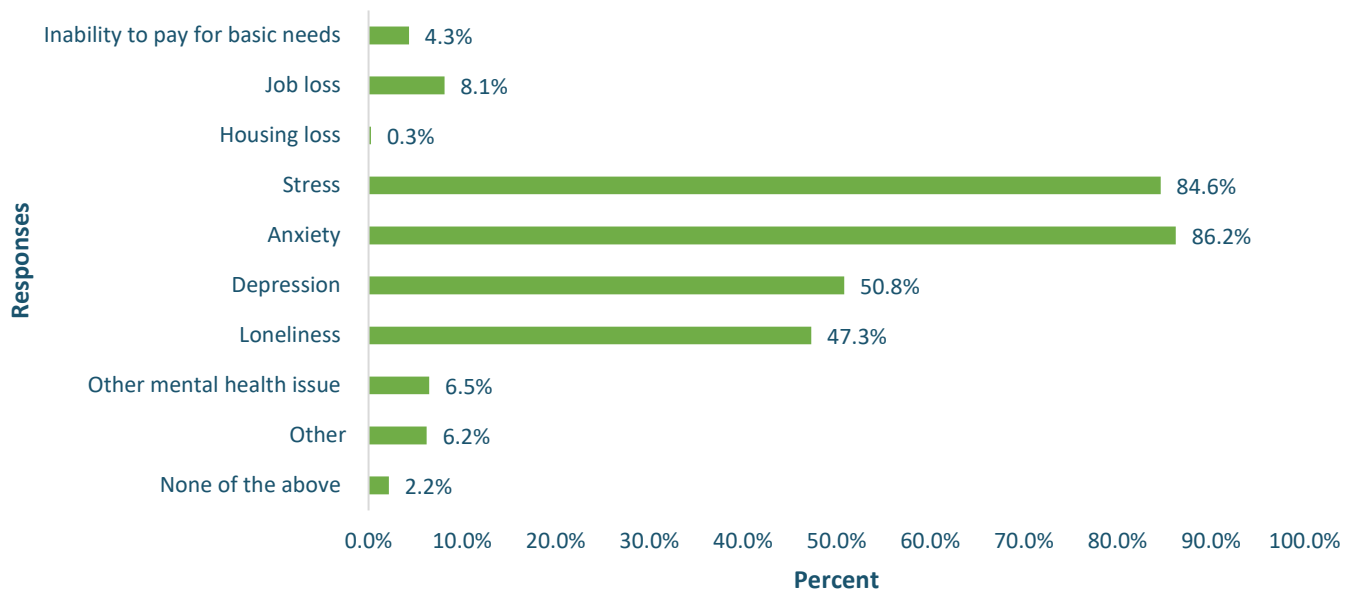
RESULTS

Through Facebook, the survey post received 5,558 views and 705 clicks. On Twitter, the survey post had 400 impressions and 25 engagements. In total, 370 surveys were collected for Williamson County. Only surveys in which participants indicated they reside in Williamson County were used for analysis. Analysis was performed on the first three questions of the survey and results are presented below in Figures 1-3.

For Question 1 (regarding COVID-19's impact on one's mental health), the top three responses among participants were anxiety (86.2%), stress (84.6%), and depression (50.8%) (Figure 1). In reviewing "Other" responses for Question 1, survey participants stated they had job hours and/or salaries reduced, felt frustrated, and had difficulty focusing and concentrating. The top three responses for Question 2 (regarding COVID-19's impact on a household member's mental health) were anxiety (78.6%), stress (78.4%), and depression (55.9%) (Figure 2). Examples of "Other" responses for Question 2 are weight gain, anger, and excessive alcohol intake. Anxiety, stress, and depression were found to be the most reported at both the individual and household level. Results from Question 3 (regarding one's willingness to get the COVID-19 vaccine) show that 75% of the survey participants in Williamson County would definitely get a COVID-19 vaccine if available (Figure 3). 11% of participants indicated they would probably or possibly get a COVID-19 vaccine if available, while 8% of participants indicated they would probably not or definitely not get a COVID-19 vaccine if available (Figure 3).

Figure 1. Question 1. Check all that apply. Since March 2020, I have experienced:

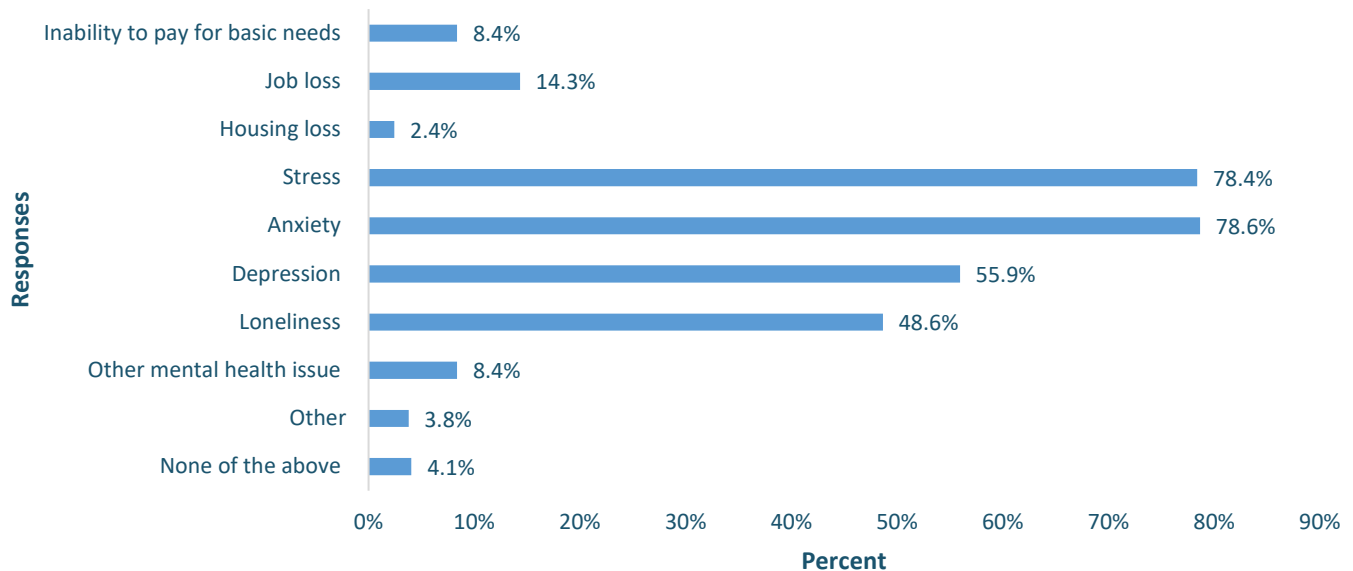
Question 1. Check all that apply. Since March 2020, I have experienced:



Data Source: Social Determinants of Health and COVID-19 Vaccine Survey, 2020-2021

Figure 2. Question 2. Check all that apply. Since March 2020, a member of my household has experienced:

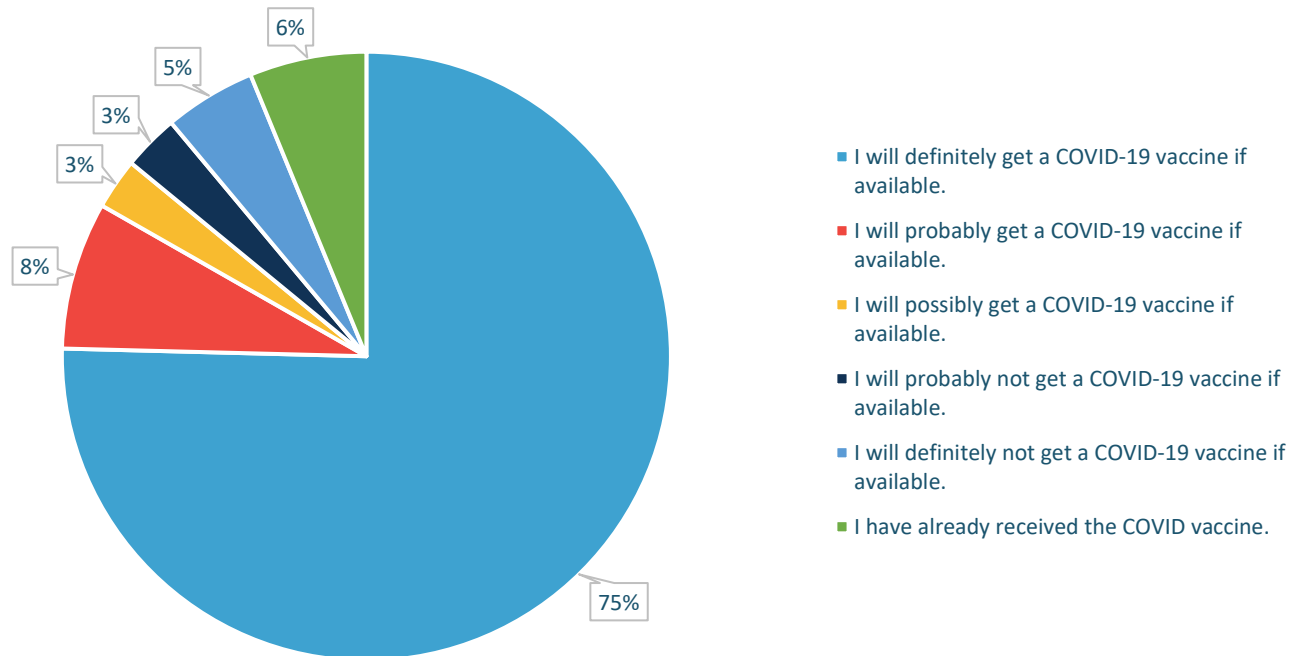
Question 2. Check all that apply. Since March 2020, a member of my household has experienced:



Data source: Social Determinants of Health and COVID-19 Vaccine Survey, 2020-2021

Figure 3. Question 3. Check the sentence that is true for you. Only check one sentence.

Question 3. Check the sentence that is true for you. Only check one sentence.



Data Source: Social Determinants of Health and COVID-19 Vaccine Survey, 2020-2021

CONCLUSIONS

When comparing the impact of COVID-19 on the community's access to basic needs versus the impact on mental health, participants indicated that COVID-19 had a higher impact on their mental health or the mental health of a member of their household. Vaccine education and misinformation efforts should be targeted towards the 11% of participants who selected that they would probably or possibly get a COVID-19 vaccine if available. Research shows that addressing vaccine confidence and misinformation among the "moveable middle" (i.e., those who are concerned, cautious, or disengaged) is more effective than focusing on those who are doubtful or dismissive.

One limitation of this survey is the use of convenience sampling; this survey was promoted to individuals who follow WCCHD social media accounts and may see public health efforts in a more favorable light compared to the general public. The survey was only accessible electronically and no paper surveys were administered, which excludes participants with technological barriers and/or no internet access. Another limitation of the survey is the small sample size (n=370). The sample size of 370 only accounts for 0.06% of the county's population (population size=613,104) and falls between 90-95% confidence. To achieve 95% confidence with a 5% margin of error, the ideal sample size would have been 384 surveys. For 90% confidence and a 10% margin of error, the sample size needed to be 271. Overall, the results from this survey highlight the need for mental health support and educational interventions that target vaccine confidence and misinformation among those considering getting a COVID-19 vaccine.

APPENDICES

Appendix A: Works Cited

1. Social Determinants of Health [Internet]. World Health Organization [cited 2021]. Available from: <https://www.who.int/gender-equity-rights/understanding/sdh-definition/en/>
2. Social Determinants of Health [Internet]. Healthy People 2030 [cited 2021]. Available from: <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

Appendix B: Social Determinants of Health and COVID-19 Vaccine Survey-English Version

Please help us better understand the impact of COVID-19 on your ability to access basic needs and mental health, and your perceptions about the COVID-19 vaccine. Your opinion is important to us! Participation in this survey is completely voluntary. Individual responses will be kept confidential. Thank you!

1.) Check all that apply. Since March of 2020, I have experienced:

- Inability to pay for basic needs
- Job loss
- Housing loss
- Stress
- Anxiety
- Depression
- Loneliness
- Other mental health issue
- Other: _____
- None of the above

2.) Check all that apply. Since March of 2020, a member of my household has experienced:

- Inability to pay for basic needs
- Job loss
- Housing loss
- Stress
- Anxiety
- Depression
- Loneliness
- Other mental health issue
- Other: _____
- None of the above

3.) Check the sentence that is true for you. Check only one sentence.

- I will definitely get a COVID-19 vaccine if available.
- I will probably get a COVID-19 vaccine if available.
- I will possibly get a COVID-19 vaccine if available.
- I will probably not get a COVID-19 vaccine if available.
- I will definitely not get a COVID-19 vaccine if available.
- I have already received the COVID vaccine.

4.) Which County do you currently reside in?

- Williamson
- Travis
- Bastrop
- Other: _____

5.) Would you like Williamson County and Cities Health District to contact you to help you or a member of your household?

Yes/No

6.) If you answered yes to the previous question, please provide some contact information.

First and Last Name: _____

Email Address: _____

Phone Number: _____

COMMUNITY INPUT SUMMARY REPORT:

**Williamson County
2021-22 Community Health Needs Assessment**



ABOUT TEXAS HEALTH INSTITUTE

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

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

BACKGROUND AND METHODS

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

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

METHODS

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

Key Informant Interviews

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

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

Focus Groups

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

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

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

HEALTH EQUITY

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

Key informant interview guide:

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

Focus group guide:

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

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

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

THEMES

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

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

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

ACCESS TO HEALTH CARE

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

Access to Primary and Specialty Care for Publicly Insured or Uninsured

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

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

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

– Key Informant

Sub-themes:

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

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

– Focus Group Participant

Insurance

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

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

– Focus Group Participant

Culturally and Linguistically Appropriate Care

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

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

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

– Key Informant

Sub-themes:

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

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

– Key Informant

Support for Navigating the Health Care System

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

– Focus Group Participant

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

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

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

– Key Informant

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

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

Low Socioeconomic Status

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

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

– Focus Group Participant

Sub-themes:

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

Housing and Homelessness

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

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

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

– Key Informant

Sub-themes:

- Population growth due to the influx of Austin residents is making property values, cost of housing, and general cost of living rise, pushing out long-time Williamson County residents.
- Due to increased housing costs, multiple generations often live together in one home.
- Residents seeking housing vouchers experience 2-3 year waitlists.
- The Cedar Park area near the I 83 corridor has a large population of people who are homeless.

Transportation

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

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

– Focus Group Participant

Sub-themes:

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

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

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

– Focus Group Participant

Broadband or Internet Access

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

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

– Key Informant

Sub-themes:

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

Ethnic and Racial Segregation

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

– Key Informant

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

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

-Key Informant

PRIORITY HEALTH NEEDS

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

Chronic Disease

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

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

Sub-themes:

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

Mental Health and Substance Use

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

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

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

– Key Informant

Sub-themes:

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

Dental Care

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

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

– Focus Group Participant

CHILDREN'S HEALTH

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

Abuse

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

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

– Key Informant

Sub-themes:

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

Intellectual Disabilities

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

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

– Focus Group Participant

Mental Health

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

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

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

– Focus Group Participant

IMPACT OF COVID-19

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

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

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

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

– Key Informant

COMMUNITY ASSETS AND STRENGTHS

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

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

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

– Focus Group Participant

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

Health Care Organizations

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

Churches and Faith-Based Organizations

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

Nonprofits and Community-Based Organizations

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

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

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

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

– Focus Group Participant

PROPOSED SOLUTIONS AND ACTIONS FOR HOSPITALS

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

IMPROVE HEALTH CARE ACCESS

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

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

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

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

INCREASE CULTURALLY COMPETENT HEALTH CARE

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

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

REDUCE SILOS AND INCREASE COLLABORATION

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

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

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

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

– Focus Group Participant

LIMITATIONS

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

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

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

CONCLUSION

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

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

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

TABLES

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

Table 1

Description of Key Informants

Key Informant	Community Input Sector
Cara DiMattina-Ryan Chief Strategy Officer Workforce Solutions Rural Capital Area	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Jennifer Harris President Dickey Museum & Multipurpose Center	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Carlos Hernandez Leader of Hispanic Owned Business Circle Georgetown Chamber of Commerce	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Dawn Jennings Special Education Parent Liaison Georgetown Independent School District	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Yumi Kang Korean Community Health Navigator Austin Asian Community Health Initiative	<ul style="list-style-type: none"> • Person with special knowledge or expertise in public health • Leader, representative, or member of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility

Key Informant	Community Input Sector
<p>Aurora Maldonado Program Navigator Williamson County Indigent Care Program</p>	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
<p>Jessica Morales Program Navigator Supervisor Williamson County Indigent Care Program</p>	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
<p>Gloria Roberson Director Harris-Ross Head Start</p>	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
<p>Kerrie Stannell Chief Executive Officer Williamson County Child Advocacy Center</p>	<ul style="list-style-type: none"> • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility

The following table describes the focus group participants in aggregate:

Table 2

Description of Focus Group Participants

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

APPENDIX A: KEY INFORMANT INTERVIEW GUIDE

2021-22 Williamson County SDF CHNA Key Informant Interview Guide

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

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

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

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

APPENDIX B: FOCUS GROUP GUIDE

2021-22 Williamson County SDF CHNA Focus Group Guide

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

Appendix J: Community Focus Group and Key Informant Results — IBM Watson Health



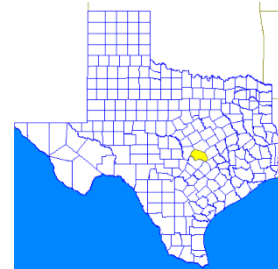
IBM Watson Health™



WILLIAMSON COUNTY AND CITIES HEALTH DISTRICT COMMUNITY HEALTH NEEDS ASSESSMENT

FOCUS GROUP SUMMARY:

WILLIAMSON COUNTY, TEXAS



PART A. OVERVIEW

Williamson County and Cities Health District collaborated with Baylor Scott & White Health to engage IBM Watson Health to conduct a series of focus groups to facilitate and assess the perception of the health needs in the Texas communities they serve, specifically Williamson County, Texas.

Participants were invited based on their involvement with public health or their work with medically underserved, chronic disease, low-income or minority populations. Participation was also sought from community leaders, other healthcare and social service providers and representatives of vulnerable and underserved populations.

A team from IBM Watson Health facilitated a focus group for the larger health community that included Williamson County and conducted it in three parts. The session started with the entire group providing a description of the community and determining an overall health score. During the second part, participants were divided into two smaller groups for more detailed discussions.

1. Describe the community and score the current health status on a scale of 1-5 (1 worst – 5 best).
2. Identify the factors for the score and separate into strengths and weaknesses.
3. Discuss the underlying barriers to health that contribute to the weaknesses.
4. Discuss community strengths that can create opportunities for improving health.
5. Identify and rank the criteria for prioritization.

The Williamson County in-person focus group was held on June 15, 2021 and included thirteen (13) participants representing Williamson County. In addition to the in-person focus group, IBM Watson Health

gathered additional input from key informant interviews (2) and surveys (5). The group included representatives from county government, church organizations, providers, local non-profits, and other community-based organizations. Most of the participants work with at-risk populations; the group at-large serve low-income populations, minorities, the medically under-served and homeless populations.

The unprecedented public health emergency of COVID-19 impacted these communities and their community health leaders requiring them to develop innovative solutions to address new and inflated health and resource needs.

PART B. COMMUNITY HEALTH NEEDS DISCUSSION SUMMARY

This focus group, key informant interviews and surveys included organizations serving Williamson County. Even though the participants described Williamson County as beautiful and a great place to call home, they scored the health of its residents slightly below average. Outdoor recreational amenities are plentiful in Williamson County with many public parks, miles of trails, outdoor exercise equipment, splash parks and child playgrounds.

The participants agreed that the community was growing in population but that the growth outpaced the ability to integrate the community or provide enough health resources. The COVID pandemic brought forward and increased the awareness that inequity existed in the community. Programs like Aunt Bertha are helping to connect people in need to community resources and programs.

The top health barriers in the community described by the focus group participants and key informants were organized into three major areas: transportation, housing and access to healthcare. The participants collaborated on opportunities to address each of these areas as well.

Transportation

Historically and currently the number one barrier in the county is transportation. The county is large and transportation resources and services are scattered and insufficient, with many areas lacking public transportation. Many don't drive and can't afford the cost of maintaining or owning a vehicle of their own. In rural communities, freedom of travel was described as the biggest problem. In addition to rural residents, the most affected included senior citizens and people with disabilities. Participants cited efforts were made to provide vouchers for those willing to drive those who need rides to healthcare providers or to get groceries. However, this was not sufficient for the growing need for transportation, which was also exacerbated by the pandemic.

Housing

As housing prices in Williamson County increased each year, affordable housing for current residents was a challenge. Gentrification occurred with people being priced out of homes they had been living in for a long time. The participants cited that there was no visible plan across the county to provide affordable housing. They stated that there were people living in tents in many parts of the community and that the county had no plan to deal with the situation, claiming some affordable housing had a six-year waiting list. In addition, restrictions requiring all residents over 18 to have good credit made it more difficult for many to find housing. Other requirements, such as criminal background checks that prohibit people with a history of substance abuse rehabilitation or incarceration added to the housing challenge. Participants felt strongly that there was an opportunity to advocate locally for more affordable housing.

Access to Healthcare

According to the group, despite the fact that the community had a core of innovative health systems in the area, the county lacked sufficient numbers of mental health, specialist and primary health providers to adequately serve the population. Some of the access was tied to transportation but even those that could access it could not afford it even with health insurance. Affordability was a problem especially for those seeking preventative care. Emergency behavioral health calls increased as well as opioid overdose rates and adult suicides. There was simply a low ratio of healthcare professionals to people in need. To make matters worse, the huge turnover rates of hospital resources caused a disconnect on information to help patients in need. An innovative opportunity suggested by one key informant was to run patient resources as a business, and offer free or reduced rent to service providers in a resource center on or near the hospital campus. The resource center would offer patients the ability to walk over to receive follow up services immediately upon their discharge from inpatient care. In addition, it would likely increase the patient's ability to comply with hospital caseworker's discharge recommendations designed to reduce readmissions.

PART C. FOCUS GROUP DISCUSSION DETAIL

These are additional details and comments captured during the in-person focus group participant discussions by each exercise topic.

EXERCISE 1A: HOW WOULD YOU DESCRIBE THIS COMMUNITY?

Participants described the community as follows:

WILLIAMSON COUNTY:

- Isolated and needy

- Fast growing/uncontrollable growth- many people moving to Williamson County
- Rural meets suburban, has small-town community living
- Inequitable and changing
- Ample job opportunities
- Burgeoning, beautiful and a great place to call home
- Water deficits/water deprived
- Governments not cohesive
- Extreme disparities within the county

EXERCISE 1B: HOW DO YOU SCORE THE HEALTH OF THIS COMMUNITY ON A SCALE OF 1-5 (1 WORST – 5 BEST)?

The overall community health score given by the group was 2.8 for Williamson County.

WILLIAMSON COUNTY SCORE:

Score	5	4	3	2.5	2	1
Participant Response	0	1	6	2	2	0

EXERCISE 2: IDENTIFY THE FACTORS YOU CONSIDERED FOR THE SCORE YOU GAVE AS STRENGTHS AND CHALLENGES.

Participants were asked to identify the factors they considered when scoring the community as strengths and challenges:

WILLIAMSON COUNTY STRENGTHS:

- **Access**
 - Good support groups available (GAPS Program).
 - Opportunities to improve self-care are free and available.
 - Good number of specialty care providers– no need to drive to Austin for care.
 - Good core of innovative health systems that in the area
 - Some innovative programs don't last – for example in Taylor, there was a provider who offered excellent mental health programs for under-insured but he left and became private.
- **Healthy Living**
 - Public parks are a place to be active with no entrance fees
 - Miles of trails, outdoor exercise equipment, splash parks, playgrounds.

- Senior center is popular within certain communities.

- **Government**

- Lots of personal resources such as funds/schools/buildings that can address community needs. If people see something working they can get behind it.
- Some elected leadership are very positive influencers of health decisions, especially with COVID vaccination.

- **Transportation**

- On demand service in Taylor area - CARTS (Capital Area Rural Transit Services) provides buses and vans with a 15-minute turn around.
- Ride Health was piloted in Taylor and some other sites which is a good way to get people home after services from hospital.

- **Education**

- School-based behavioral health worked well.
 - Seven school districts, west side districts invest in staff to provide school based mental health (Pre-K-12).
 - Have a family therapist as well.
- School-based clinics were a successful model Once every 3 weeks, practitioner comes that can see kids and prescribe medication. However recent loss of funding has made it challenging to continue.

- **Food**

- Farmers markets in town available.
- Meal on wheels programs available.

WILLIAMSON COUNTY CHALLENGES:

- **Transportation**

- People don't have access to cars:
 - High cost of maintaining cars.
 - High cost of gas.
 - High number of people who don't drive.
- There is no access to any transportation in some areas and/or very limited public transportation.

- People did not use the transportation services available. It takes a long time to change community behavior. For example, Taylor got a grant for CARTS to run this route but no one got on the bus. It was discontinued after six months.
 - In Georgetown, ridership on buses was poor because the bus didn't go where most people lived nor did it go where they needed to go.
 - Poor road infrastructure.
 - Long commutes because there are no expressways for many to get to work.
- **Access to resources for services/ access to services**
 - Lack of healthcare providers.
 - Growth outpacing supply of physicians and causing lack of physician access.
 - Preventative screenings down/delayed due to lack of access and unwillingness to seek care.
 - Lack of behavioral health resources- professionals to people ratio is "ridiculous."
 - Challenges with behavioral health and addiction.
 - Once they come to the hospital it's hard to find placement for services.
 - Navigating services is a barrier to access to care/resources.
 - Hard for people to navigate online resources to find providers or services -- don't have skills to find those things
 - Huge turnover rates of hospital case workers means that information gets lost.
 - Health inequity by insurance status.
- **Government**
 - Disinterested leadership.
 - Leaders don't care about the poor.
 - 2020-2021 municipality restrictions exposed the lack of concern for the disadvantaged.
- **Digital Divide**
 - People assume that everyone can access the internet, but rural communities don't all have access.
 - Digital divide is due to lack of connectivity.
 - Poor connections as people may not have equipment to access internet or not able to pay for internet.
- **Food**
 - Poor food choices are abundant and inexpensive.

- Food deserts especially in rural parts.
- Eastern Williamson County is worse for food insecurity.

- **Social issues**

- Housing
 - Homelessness- there is no shelter for those that are unhoused.
 - Lack of affordable housing.
- Mental health is on the decline, more violence in the home, drug abuse increasing, child abuse increasing.
 - Increase in substance abuse and OPIOD overdoses.
- Youth suicide rates are increasing.
- Large senior population.
 - Social isolation (for seniors) especially in rural parts.
- Literacy is an issue.
- Racism, especially in Georgetown.
- Spiritual health is poor.
- Limited childcare options/affordability.

- **Education**

- Need more than a high school degree to earn enough cover living expenses.
 - If you have resources you can go to school, but if you don't have resources, it's difficult.

- **Housing**

- Housing affordability/housing options.
- Growth outpaces ability to integrate community.

EXERCISE 3: WHAT ARE THE BARRIERS TO GOOD HEALTH IN THIS COMMUNITY?

Participants discussed the barriers to good health in the community:

WILLIAMSON COUNTY BARRIERS:

- **Social**

- Lack of affordable housing.
 - High numbers of people in extended stay, camp sites, homelessness.
- Social isolation (especially due to COVID).
 - Lack of activities during COVID had profound negative impact on children.

- **Digital Divide**

- Many with no internet access because they can't afford equipment and service.

- **Food**
 - Food deserts/lack of food stores.
- **Education**
 - Lack of structure/activities at school had a profound negative impact on kids.
- **Transportation**
 - Limited public transportation.
- **Financial**
 - Many can't earn a living wage (39% of population are not able to earn enough to support themselves).
- **Access**
 - Navigating services is a barrier to access to care/resources.
 - Time is a barrier.
 - Not enough after-hours services to meet need of working people.
 - Often difficult for working parents to find time to access preventative services for themselves.
 - Fewer resources/ volunteers (fear of COVID).
 - Shortage of funding for staff.
 - Lack of knowledge about services available for uninsured and how to access them.

Each person voted for what they consider to be the 3 greatest BARRIERS. Results are listed below, ranked according to votes.

WILLIAMSON COUNTY BARRIERS RANK:

WILLIAMSON BARRIERS	Score
Lack of affordable housing	11
Access to transportation	11
Shortage of funding for staff	6
Digital access	6
Lack of living wage	3
Lack of structure/activities had profound impact on kids	3

EXERCISE 4: WHAT ARE THE OPPORTUNITIES TO IMPROVE HEALTH IN THIS COMMUNITY?

Participants discussed opportunities to improve health in the community:

- **Government**
 - Lobby state government to pick up more responsibility/provide more resources to help community health efforts.
 - Encourage health systems and organizations to collaborate more when offering services.
- **Digital Divide**
 - Increase and improve communication methods/access/proximity.
- **Food**
 - Incentivize developers of healthier choices versus fast food/unhealthy options.
 - Encourage barter system at farmers' market.
- **Access**
 - Increase use of telemedicine, but don't rely on it exclusively.
 - Leverage collaborative efforts to bring more resources in.
 - Pursue joint grants for healthcare needs (referencing prior success with joint grant submissions).

WILLIAMSON COUNTY OPPORTUNITIES:

- **Access**
 - Build stronger connections to bridge clinical and social services.
 - Add resources to address person not just issues.
 - Hire more community health workers (don't even need a high school diploma for community health workers) who are trusted to walk alongside people in their communities and help direct them to available services.
 - Expand nursing services within faith-based organizations similar to the Wesleyan program and Parish Nurses Group seeing patients within the church.
 - Expand phone referral services since connecting with a live person is best way to help someone navigate the system.

- Enhance combination of engagement and education to improve health.
 - Increase telepsychology and telehealth service offerings.
 - Provide more community based mental health and cancer support.
 - Model programs using best practices/successful ones such as Aunt Bertha and 211.
- **Government**
 - Use Community Task Force approach for new coalitions/create cross section coalitions to address barriers to health.
 - Increase support for existing programs that work well.
 - Keep goals clear as a key to success.
- **Food**
 - Provide more online groceries and delivery volunteers.
 - Increase rural food distribution.
- **Digital Divide**
 - Improve digital access within rural communities.
 - Provide education, training and support for digital access.
 - Subsidize device and linkage costs.
 - Provide Wi-Fi along with support at senior housing.
- **Faith Based**
 - Work with faith-based support groups to increase services in community.
- **Housing**
 - Advocate locally for more affordable housing.

Each person voted for what they consider to be the 3 greatest OPPORTUNITIES. Results are listed below, ranked according to votes.

WILLIAMSON COUNTY OPPORTUNITIES RANK:

WILLIAMSON OPPORTUNITIES	Score
Increase telehealth – especially psych by improving digital access & maintain CMS standards	10
Advocate locally for more affordable housing	9
Increase staffing/social workers/admin	8
Online grocery delivery using volunteers/ rural food distribution	7

EXERCISE 5: RANK THE CRITERIA FOR PRIORITIZATION

Each person voted for the top criteria to be used for prioritization of this communities identified needs.

WILLIAMSON COUNTY PRIORITIZATION VOTE:

Prioritization Criteria	Definition	Vote:
Magnitude (Size of Problem)	How many persons does the problem affect, either actually or potentially?	5
Severity (Outcome if Ignored)	What degree of disability or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens?	1
Feasibility/ Cost	Is the problem amenable to interventions? What technology, knowledge, or resources are necessary to effect a change? Is the problem preventable? Is it too expensive for the community to tackle?	1
Community Capacity or Strengths	Does the community have the capacity to act on the issue, including any economic, social, cultural, or political consideration? Extent to which initiatives that address the health issue can build on the community's existing strengths and resources? Availability of local expertise regarding the health need	5
Root Cause	Is the issue a root cause of other problems - thereby possibly affecting multiple issues?	10
Quick Success	The probability of quick success. Is the problem "low-hanging fruit"?	3
Social Justice	Is the problem more concentrated to a specific vulnerable population? Does addressing this issue lead to unfair social benefit? Are we equitable to all vulnerable populations in our approach?	5

PART D. PARTICIPATING ORGANIZATIONS

Representatives from the following organizations participated in the focus group:

WILLIAMSON COUNTY PARTICIPATING ORGANIZATIONS:

- Baylor Scott & White Health
- City of Taylor
- Faith in Action Georgetown
- Georgetown Health Foundation
- Interagency Support Council of Eastern Williamson County, Inc.
- Lone Star Circle of Care
- Mobile Outreach Team Williamson County Emergency Services
- Partners in Hope
- Pavilion Clubhouse of Williamson County
- The Caring Place
- United Way of Williamson County
- Williamson County and Cities Health District

PART E. ADDITIONAL KEY INFORMANT/PARTICIPANT INPUT

The COVID-19 pandemic forced the team to think creatively about collecting community feedback because standard approaches, such as conducting in-person focus groups, were not feasible throughout the Community Health Needs Assessment project due to social distancing guidelines during the pandemic . As a result, there was a need to conduct virtual focus groups, web-based video interviews, telephone interviews and to expand outreach through a web-based survey. Even with these additional efforts, many key informants were unable to participate due to the later surge of COVID cases (including Delta variant cases) requiring their management attention and time.

- Seven additional surveys and interviews representing Williamson County were obtained from representatives of:
 - Bluebonnet Trails Community Services
 - City of Taylor
 - Baylor Scott & White Health
 - Community Resource Centers of Texas
 - LifePark Center
 - Sacred Heart Community Clinic

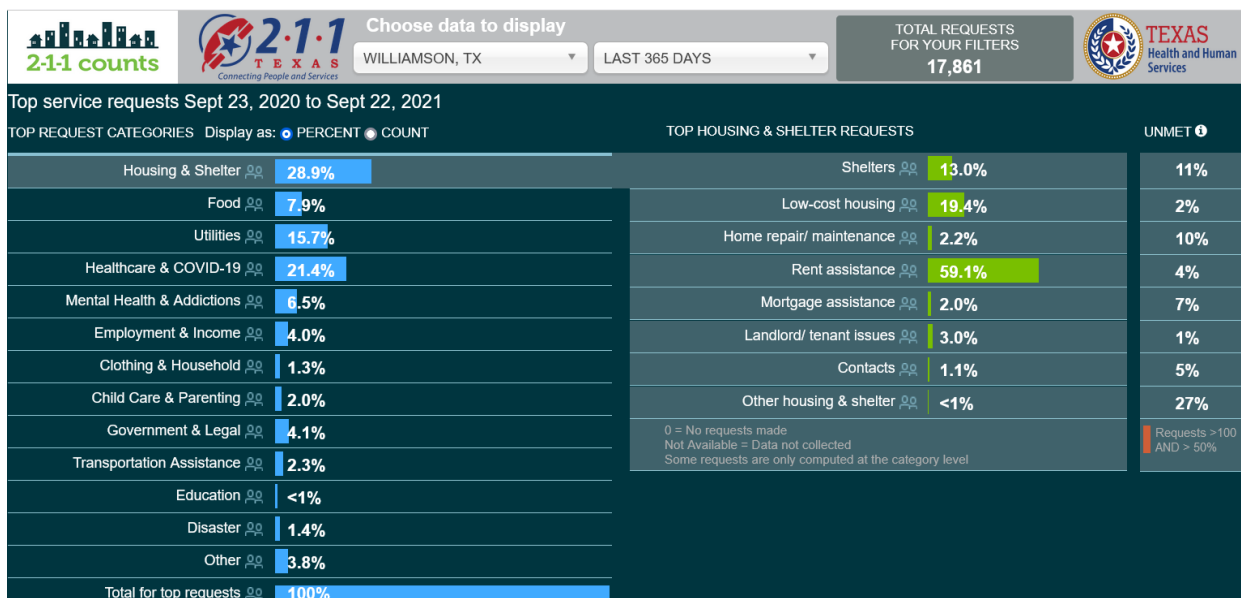
- United Way for Greater Austin
- The participants rated the health of the community as a 4 out of 5.
- The participants named the same strengths of the community as the larger group:
 - Walking trails/parks
 - Community pride
 - Local leadership or local government
 - Telehealth/telemedicine
 - Quality healthcare/providers
 - Agencies willing to work together
 - Availability of fresh food
 - Community clinics
 - Emergency services
 - Communication
- The participants' community challenges, which were similar to those from the focus group, are listed below in descending order of importance:
 - Limited affordable housing options
 - Limited access to dental care for uninsured or underinsured
 - Limited access to mental/behavioral health care (for uninsured or underinsured)
 - Lack of affordable childcare
 - Limited access to primary health care providers (for uninsured or underinsured)
 - Lack of public transportation
 - Aging population
 - High cost of medications
 - Limited access to mental/behavioral health care (for whole community)
 - Limited access to specialty health care
 - Lack of diversity among healthcare providers
 - Poor high speed internet coverage
 - Limited access to primary health care providers (for whole community)
 - No county hospital/health department
 - Lack of coordination among agencies who serve those in need
 - No county services for crisis intervention
 - Limited access to healthy food options

- The barriers causing the challenges faced by community members that the participants cited included the following in descending order of importance:
 - Lack of knowledge about services available for uninsured and how to access them
 - Access to primary health care (for uninsured)
 - Lack of reliable and affordable transportation
 - Lack of health care knowledge/low health literacy such as importance of preventative care, nutrition
 - Poverty
 - Cultural influence on health behaviors in community
 - Access to mental/behavioral health care(for uninsured)
 - Lack of health insurance
 - Social isolation
 - Access to primary health care (for whole community)
 - Access to mental/behavioral health care(for whole community)
 - Access to specialty health care services
 - Access to affordable care after hours
 - Fear/distrust of healthcare system
 - Language barriers
- The participants identified the following opportunities in the community in descending order of importance.
 - Coordination of efforts across agencies (improved communication between agencies)
 - Expand poverty definitions to increase funding for indigent care
 - Education on resources (increase community education how to access available community resources)
 - Leverage rideshares for community services (secure creative funding such as vouchers)
 - Hire/recruit volunteer community health advocates to provide trustworthy education and referral to services
 - Greater access to internet connectivity and technology
 - Expand hours of social services availability (after hours, etc.)
 - Improve access to healthy foods (perhaps in coordination with local food stores)
 - Centralized/integrated Resources (one stop shop for individuals to obtain services)
 - Diversify health profession and social work forces (add diversity to workforce to mirror communities)

- Telehealth/Telemedicine (increase usage and reimbursement)
- The top criteria (in descending votes) that the participants suggested should be used when prioritizing the various opportunities for improving the health of people in the community were:
 - Community Capacity or Strengths
 - Feasibility/Cost
 - Quick Success
 - Social Justice
 - Magnitude (Size of Problem)
 - Severity (Outcome if Ignored)
 - Root Cause
- According to the participants' opinion, the largest impacts that COVID had on the community the past year were as follows: lack of access; finding new ways to deal and solve issues (i.e. internet, zoom, etc.); heightened political/social divisions; fear (of interacting with others); and it caused people to stay indoors and away from trusted connections, leaving them vulnerable to depression, overeating, falls and other health and spiritual challenges.

PART F. ADDITIONAL INFORMATION

Participants cited 2-1-1 throughout many of the focus groups, interviews and surveys . People in the United States dial 2-1-1 for help with basic needs like food and shelter or emergency services. In Williamson County, Housing & Shelter along with Healthcare & COVID-19 were the top requested categories from September 2020 to September 2021.



Source: 2-1-1 Counts, Texas Health and Human Services, 2021.

Appendix K: Acknowledgments

The following organizations and individuals graciously supported the 2022 Williamson County Community Health Assessment (CHA).

2022 CHA Task Force

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Ascension Seton
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Bluebonnet Trails Community Services
Georgetown Health Foundation
Lone Star Circle of Care
Opportunities for Williamson and Burnet Counties
Opportunities for Williamson and Burnet Counties
St. David's Foundation
St. David's Foundation
United Way of Williamson County
Healthy Williamson County Coalition
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Organizations that Participated in Data Collection Methods

Asian American Community Health Initiative
 Baylor Scott and White Health
 Bluebonnet Trails Community Services
 Boys and Girls Club
 Catalyst Collective
 City of Taylor
 Community Resource Centers of Texas
 Dickey Museum & Multipurpose Center
 Faith in Action Georgetown
 Georgetown Chamber of Commerce (Hispanic Owned Business Circle)
 Georgetown Health Foundation
 Georgetown Independent School District
 Hill Country Community Ministries
 Interagency Support Council of Eastern Williamson County, Inc.

LifePark Center
 Lone Star Circle of Care
 Opportunities for Williamson and Burnet Counties
 Partners in Hope
 Pavilion Clubhouse of Williamson County
 Sacred Heart Community Clinic
 The Caring Place
 The Georgetown Project
 United Way for Greater Austin
 United Way of Williamson County (now merged with United Way for Greater Austin)
 Williamson County and Cities Health District
 Williamson County Children's Advocacy Center
 Williamson County EMS Mobile Outreach Team
 Williamson County Juvenile Services
 Workforce Solutions Rural Capital Area