Caldwell and Gonzales County Community Health Needs Assessment

November 2012

Prepared on behalf of the Seton Healthcare Family and the Community Health Coalition of Caldwell County. For questions and comments please email kabney@seton.org

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INTRODUCTION

Health is a complicated term developed and impacted by components of genetics, lifestyle, environment, and access to medical services. It is a product of where and how we work, play, and live. By understanding the factors that influence these components of health, the community can create targeted implementations to address those areas that have the greatest need. In order to accomplish this, Seton Healthcare Family and The Community Health Coalition of Caldwell County joined together to conduct a community health needs assessment in order to understand the overall health status of the community. By conducting a community health needs assessment, community health needs can be identified and prioritized by those that are considered most pressing for Caldwell and Gonzales counties.

The importance of community health needs assessments was further reinforced by the 2010 Patient Protection and Affordable Care Act provisions, which requires hospitals designated as tax exempt 501(c)3 non-profit organizations to complete a community health needs assessment every three years. In addition, non-profit hospitals are required to adopt an implementation plan to address the needs identified in the report. These two documents together, create the hospital community benefit plan. Seton Healthcare Family and the Community Health Coalition of Caldwell County joined together to conduct a needs assessment for Caldwell and Gonzales County

This effort was broken into two phases:

1) The collection and analysis of secondary data from publicly available data sources on information for Caldwell and Gonzales counties, and
2) Host a community summit with representation from community stakeholders, community members, and public officials in order to validate the data analysis and/or identify other community needs that were not revealed in the data. In addition, the summit provided participants the opportunity to prioritize the needs identified in order to rank those they feel are most pressing.

Contained within this report are the findings combined in both phases of the community health assessment process. This participatory and collaborative approach was conducted July 2012 – November 2012 and will serve as the basis for Seton Healthcare Family's Community Benefit Plan for Caldwell and Gonzales counties.

When framing a community health needs assessment, it is necessary to place parameters on the community that will be defined. For the purposes of this report, the community was

confined to the geographic boundaries of Caldwell and Gonzales counties. While these communities have differences in population, demographics, and other characteristics, their rural tendencies provide many of the same challenges and health concerns for residents of both counties.

A review of the current healthcare environment revealed that one hospital system, Seton Healthcare Family, provides the only inpatient facility in Caldwell County. In addition, the county also has two safety net clinics available to respond to the health needs of the community. One is a Federally Qualified Health Center operated by Community Health Centers of Central Texas and one is a rural health clinic operated by Seton Healthcare.

I. METHODS

Data Collection:

The Seton Healthcare Family's Community Health Needs Assessment began with a look at the demographics in our service area over the next 30 years. Demographics formed the framework for the other health data we collected and helped us think about patterns and questions we found in the data. Next, we used data collected by Texas Department of State Health Services. We began with broad measures of health such as causes of death, births and other vital statistics and winnowed our focus down to specific diseases such as HIV/AIDS and diabetes. Once the secondary data set was collected, we reviewed data points with our Senior Epidemiologist to identify areas where the data had notable patterns or discrepancies, and we identified gaps in the data. In areas where samples were small, we aggregated data for several counties to more easily understand the metric for a portion of our service area. We also incorporated data from other local Community Health Needs Assessments and other studies of health in our service area. Other studies used include Robert Wood Johnson Foundation's County Health Rankings and the Commonwealth Report Health Scorecard. These studies filled in gaps around metrics that impact health, but are not disease based such as crime rates, access to healthy foods, and unemployment levels. Collaborating with other organizations creating CHNAs within our service area provided more nuanced data in certain areas since some groups approach the CHNA with a more community input based methodology.

Community engagement and prioritization methods:

The Seton Healthcare Family, in collaboration with the Community Health Coalition of Caldwell County, hosted a Community Health Needs Summit for Caldwell and Gonzales counties. The Summit was designed as a way to update the community on progress that has been made since the last CHNA and to provide them with current data to engage in needs identification. The two goals for the summit were for the community to discuss current needs effecting Caldwell and

Gonzales and then prioritize those needs in order of importance. The invitation to the Summit was sent out through local collaborations, partnership, and council list serves with targeted outreach to schools and other key community stakeholders. In attendance was representation from the public health department, hospitals, clinics, school district, and other service providers that serve the community. A complete list of Summit participants can be found in *Appendix 1*.

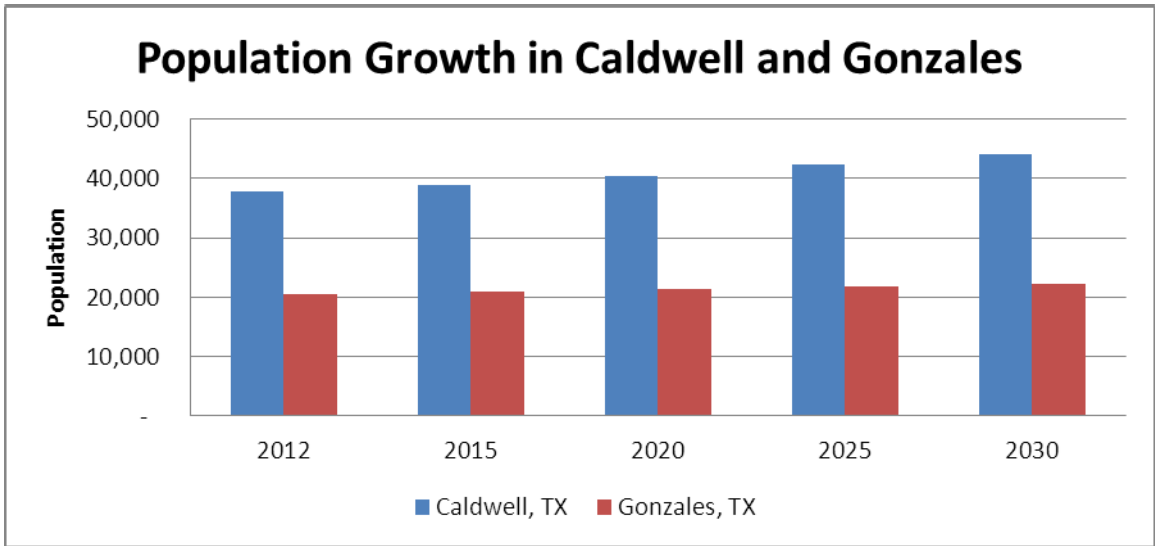
In order to identify the community's needs, Seton Healthcare Family presented current health and demographic data to the Summit participants. Participants then engaged in table discussions regarding what the data revealed to them as well as what other they needs see in the community that did not show up in the data. This collaborative process created a list of needs that were shared with the larger group and categorized by theme. These themes served as the overarching needs that were identified with sub groups identified within each category. Participants then used a dot voting method to express their opinion as to which category was the highest priority need and which sub group was most important within that need. After tallying the results, the participants reviewed the results and further added any remaining thoughts. The following information is a summation of the data analysis coupled with the feedback from the community.

II. CALDWELL AND GONZALES COUNTY DEMOGRAPHICS

The population in Caldwell and Gonzales is growing older and more diverse with time, increasing the percentage of our vulnerable population segments.

- Caldwell has slow and steady population growth projected over the next 18 years, from 37,717 in 2012 to 44,179 in 2030, while Gonzales is projected to hold relatively stable over that same timeframe.

Figure II.1



- This region is growing older and more diverse and is projected to continue on that trend through 2030. According to the U.S. Census, in 2010, Caldwell and Gonzales combined had 8,070 residents between the ages of 65 and 84. By 2030, that number is projected to nearly double to 15,153 residents. In addition, the Hispanic population of these two counties is projected to grow from 50% to 60% over the next 18 years.

Figure II.2

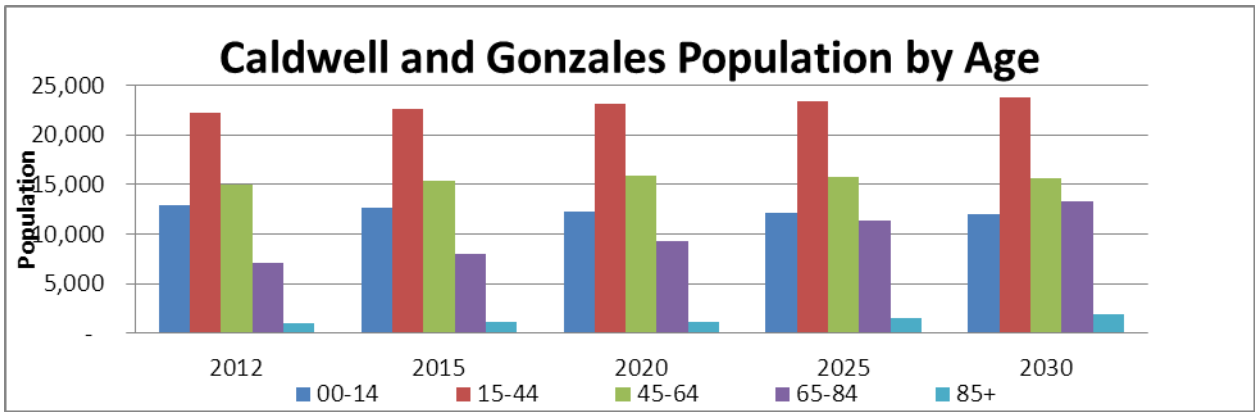
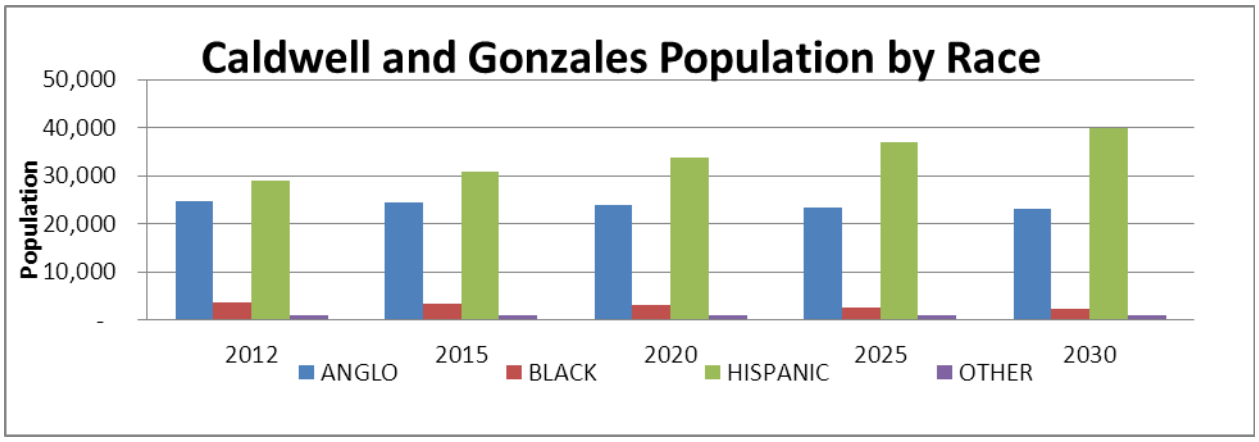


Figure II.3



- Only 33% of the Caldwell population has had some college education. Similarly, 34% of the Gonzales population has some college education. *(Appendix A)*

- There is 8.6% unemployment and 26% of children in Caldwell County are in poverty. Gonzales has a lower unemployment rate of 6.2%, but a higher proportion of children living in poverty with a rate of 32%. *(Appendix A)*

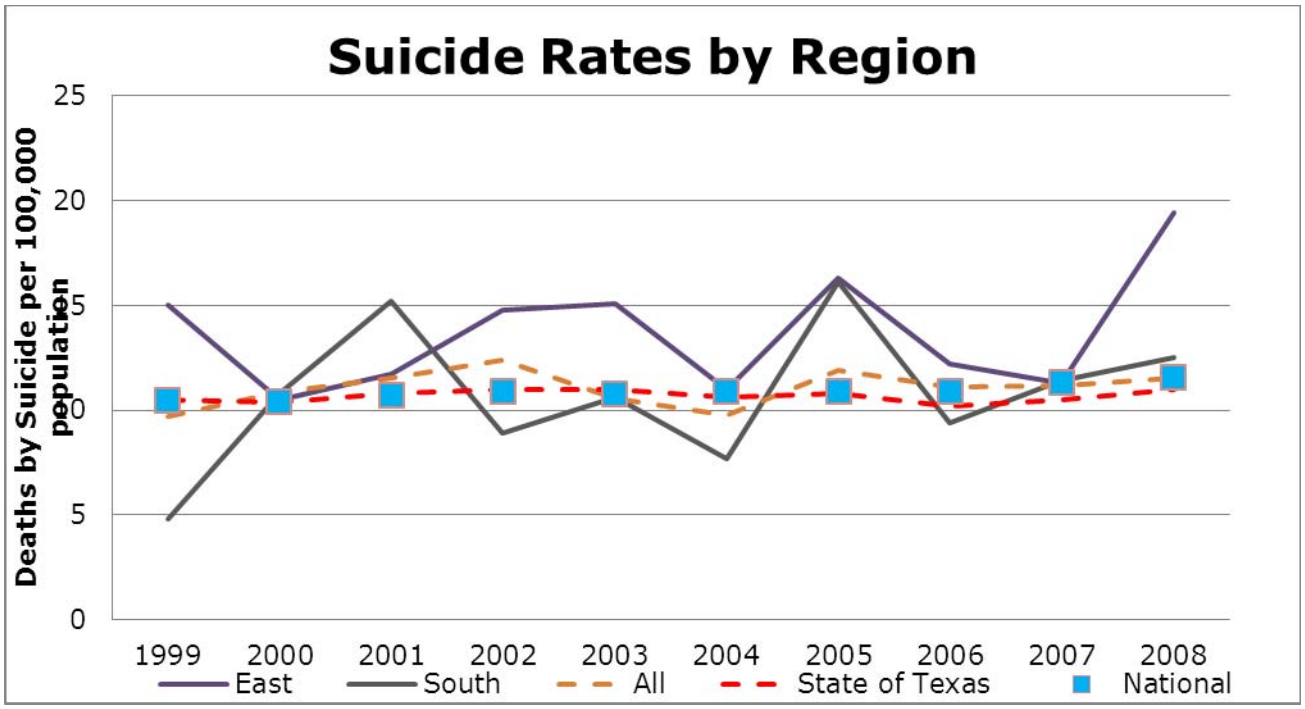
III. BEHAVIORAL HEALTH

Behavioral health services were identified by Summit participants as the highest priority need facing Caldwell and Gonzales counties. With this overarching theme, participants felt that the greatest need was the ability to recruit and retain mental health providers to the area.

With very few behavioral health providers in the both Caldwell and Gonzales, the need for behavioral health services was noted as the top priority by Summit participants. According to a 2011 report created by the Department of State Health Services, no psychiatrists had their primary county of practice in Caldwell or Gonzales. While this does not take into account the number of psychologists and/or counselors in Caldwell and Gonzales or the number of psychiatrists who visit these counties on a part time bases, it further supports the community perspective on the lack of mental health providers in these counties. In addition to the lack of providers, Summit participants expressed the need for long term behavioral health services as well as the need to integrate primary care with behavioral health in order to meet the comprehensive needs of county residents. It was suggested that this could be conducted through the collocation of services such as school health clinics in order to facilitate better access and earlier detection.

- Suicide rates in Caldwell (South)/Gonzales (East) are slightly higher than rates for the state and have increased slowly. The rates for the region as a whole are similar to national averages.

Figure III.1



- Caldwell/Gonzales adults said that in the past month, they experienced around 3.2 poor mental health days. The national 90th percentile benchmark is 2.3 poor mental health days in the past month.

Figure III.2

	National 90th Percentile	Caldwell County	Gonzales County
Poor Mental Health Days	2.30	3.1	3.2

10% - 49% worse than the national benchmark

- As of September 2011, there are no psychiatrists practicing in Caldwell or Gonzales Counties.

IV. ACCESS TO CARE

Access to care was identified as the second highest priority by summit participants. The need for after hours care and extended hours were identified as significant needs while lack of insurance, transportation challenges, and cost related barriers were also cited as community needs.

With the rural nature of both Caldwell and Gonzales County, access to care was a need that was continually discussed by participants at the Summit. While barriers to access can come in many different forms, community stakeholders felt that after-hours care or access to facilities with extended hours should be the highest priority when addressing access to care needs. With individuals living in rural communities having to travel longer distances to and from work/community resources, community members have experienced challenges with making it to their physician's office during standard hours of operation. In a community where residents work up to 50 miles away from home, by the time they leave work and travel back to their community, their physician's office is usually closed.

- The uninsured rate in Caldwell (27%) and Gonzales (32%) is nearly triple the level for the US 90th Percentile Benchmark.
- Both counties have a significantly higher population to primary care providers ratios than the national benchmark with Gonzales (1,773 to 1) having nearly three times the amount of population per primary care provider as the national benchmark (631 to 1).

	National 90th Percentile	**Caldwell**	**Gonzales**
Uninsured rate	11%	27%	32%
Primary Care Physicians	631 to 1	1632 to 1	1773 to 1
Air-pollution ozone days	0	0	0

- Participants repeatedly cited the challenges for low income patients accessing primary care. Per the Texas Medical Association, the number of Texas physicians accepting new Medicaid patients has declined by 36% from 67% in 2000 to 31% in 2012 (Figure IV.1). Over this same time period, the number of physicians accepting new Medicare patients has declined 20%, from 78% to 58% (Figure IV.2).

Figure IV.1

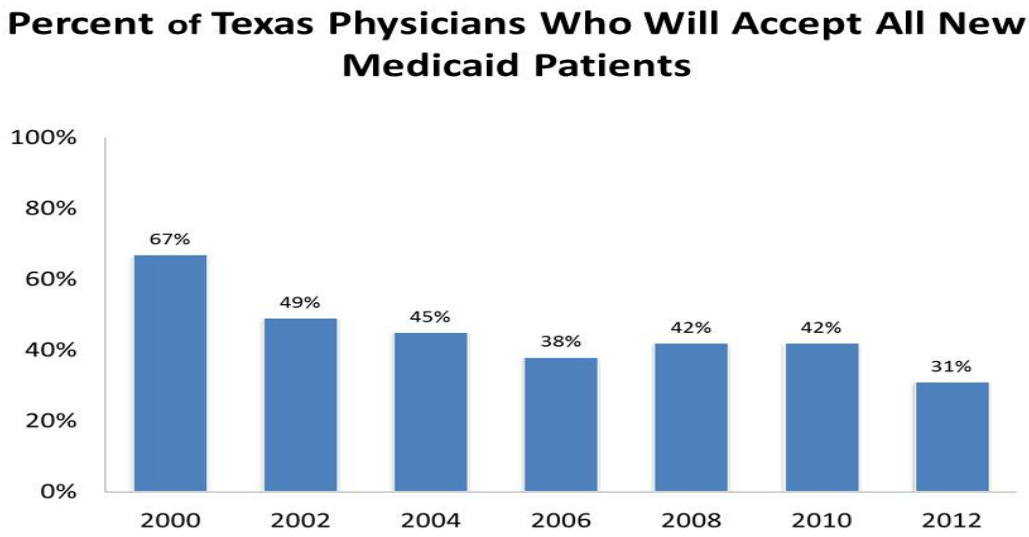
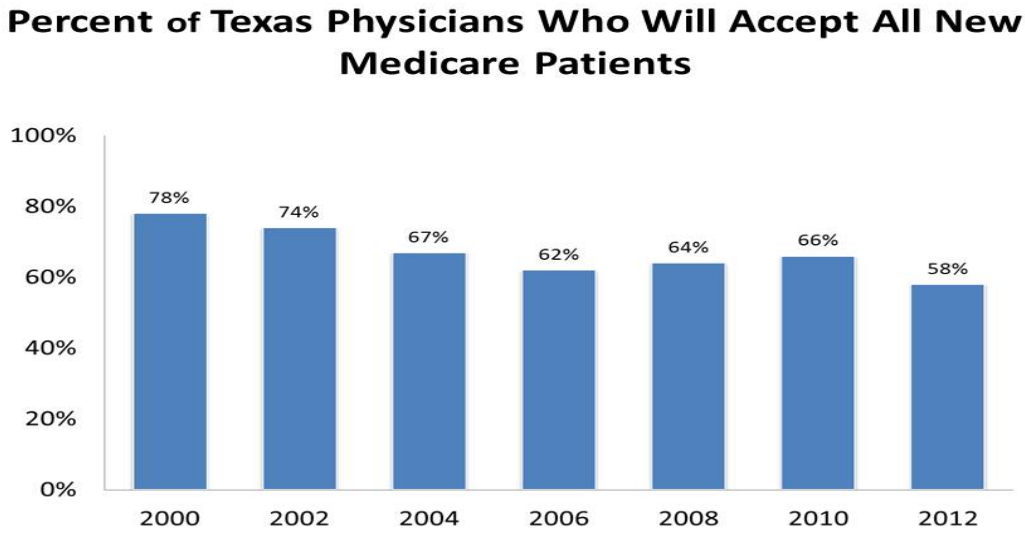


Figure IV.2



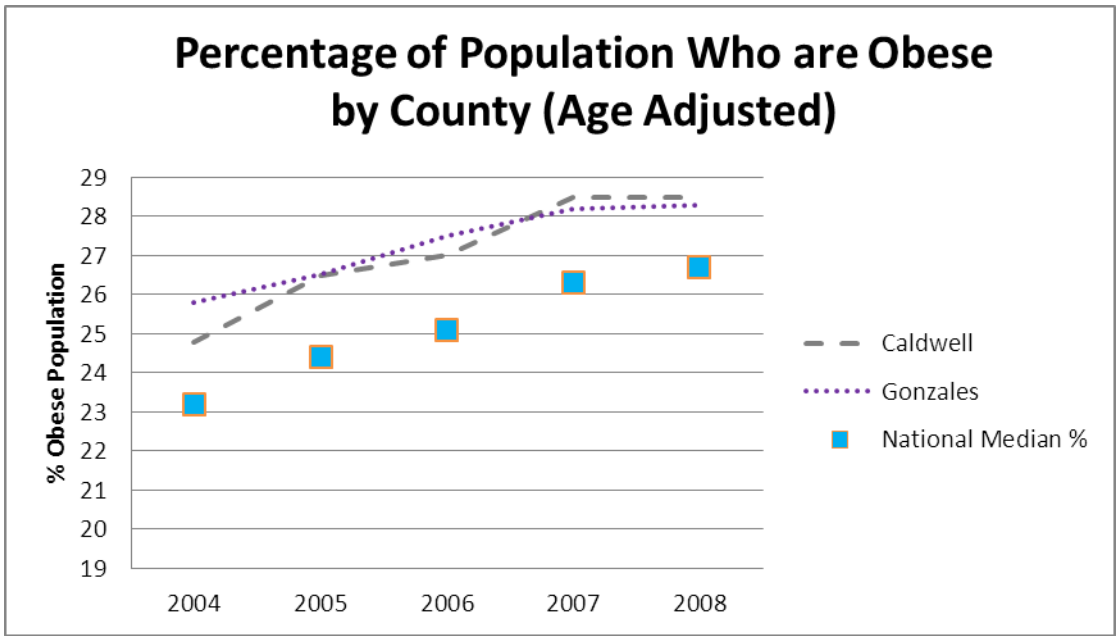
V. OBESITY

A portion of summit participants felt that the obesity epidemic in Caldwell/Gonzales is the most pressing need in the community. Access to healthy food, environments, and other resources was the main topic of focus with additional discussions regarding age appropriate education and more physical activity options available in the community.

With obesity increasing across the area and consistently above the national average, it was no surprise that I was listed as one of the top three priority areas by Summit participants. While many felt that access to healthy foods and healthy environments was the largest need to the area, others felt that the lack of proper education was the greatest need. It was noted by some stakeholders that while healthy lifestyle education may be available in the community, it may not be delivered in an age appropriate manner that is easily understood by children. The need for more physical activity options and the walkability of the community were also discussed as needs but were less of a priority than the access to health resources and education.

- Obesity is increasing across the area and is consistently above the national average for both Caldwell (28.5%) and Gonzales (28.3%)

Figure V.1



- On many metrics examined, Caldwell and Gonzales have worse rates on social and physical environment indicators than the national 90% benchmark. This includes the amount of fast food restaurants in the county and the number of accessible recreational facilities (National 90th Percentile: 16; Caldwell: 5; Gonzales: 10) for community members.

Figure V.2

	National 90th Percentile	Caldwell	Gonzales
Violent Crime Rate	73	431	651
Air-pollution particulate matter days	0	0	0
Air-pollution ozone days	0	0	0
Access to recreational facilities	16	5	10
Limited access to healthy foods	0%	26%	8%
Fast food restaurants	25%	58%	71%

No more than 9% worse than national benchmark

10% - 49% worse than national benchmark

50% or more worse than national benchmark

- Environmental factors such as crime were also identified in the data as potential barriers that can influence healthy behaviors. In Caldwell, the violent crime rate* was 651 per 100,000 population which was well above the rate for Texas (501/100,000).

*Violent crime is represented as an annual rate per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.

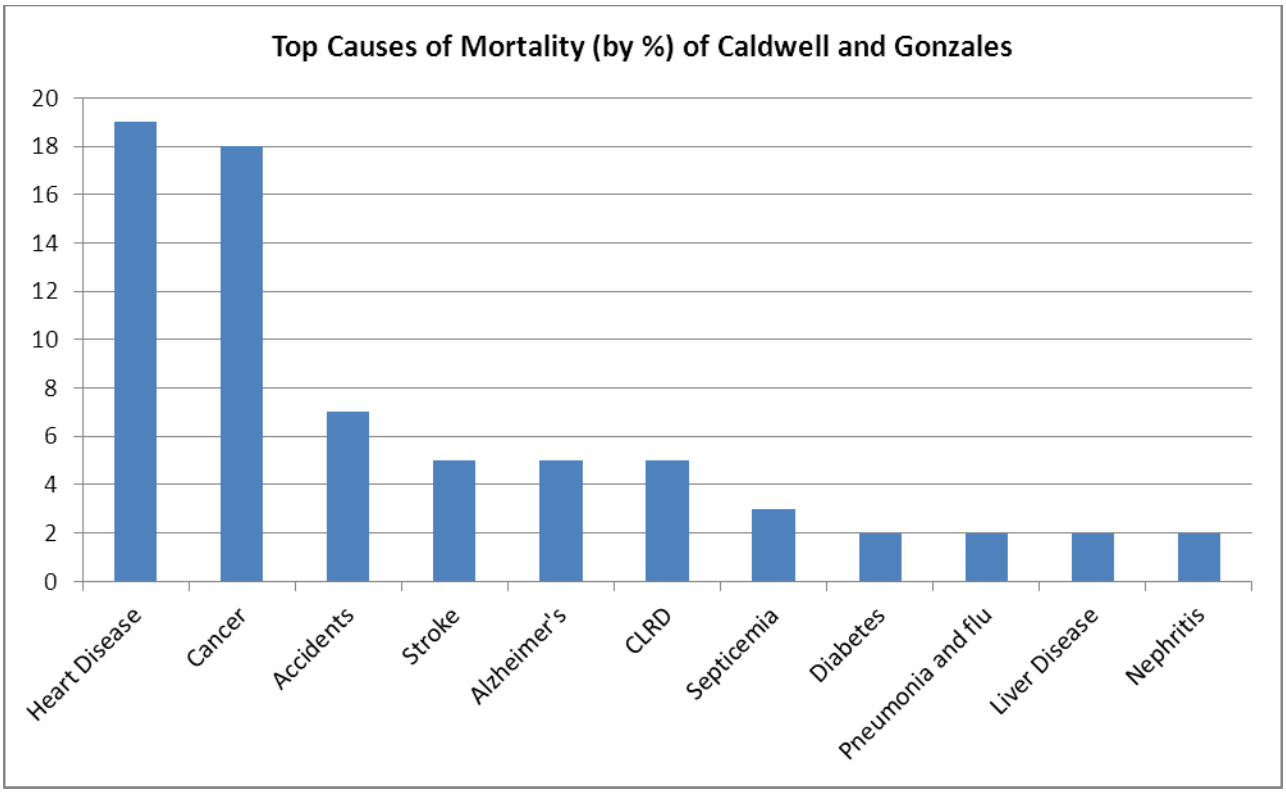
VI. HEALTH OUTCOMES - DISEASE

Chronic diseases emerged as key concern among participants and represent the leading causes of death not only in Caldwell and Gonzales but also in the state of Texas. The identified needs involving health outcomes centered around the need for more chronic disease promotion and education as well as the need to focus on resident's co-morbidities.

As has been the case for many years, cancer and heart disease are the leading causes of death across the Central Texas region. Given this, it comes as no surprise that the one of the priority areas of need identified chronic disease. While this was not prioritized as highly as the other categories, the need for more chronic disease education and awareness promotion was mentioned by community stakeholders as opportunities of improvement related to chronic disease and disease management. The lack of education may also tie to the need to address community member co-morbidities that often plague the most vulnerable in the community.

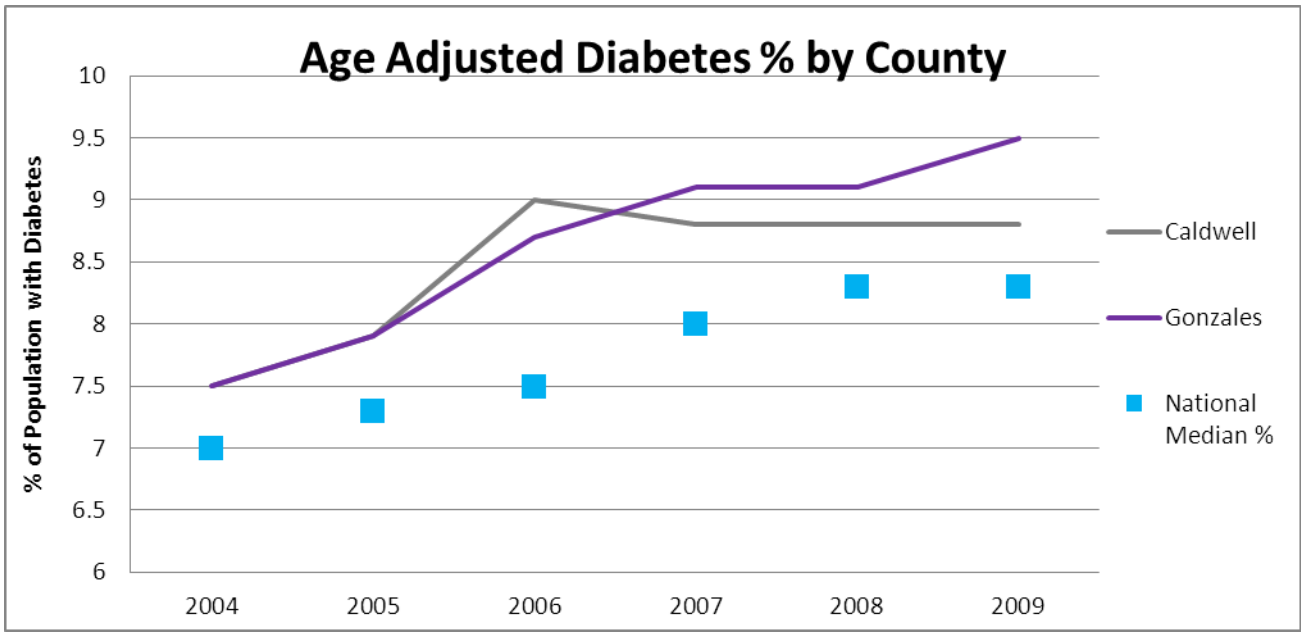
- Consistent with the state and the nation, cancer and heart disease are the leading causes of death in Caldwell/Gonzales.

Figure VI.1



- While the diabetes rate in Caldwell County has been relatively stable since 2007, it is still consistently above the national average while Gonzales County continues to see the diabetes rate climb higher above the national average.

Figure VI.2



- The rate of new HIV cases is increasing in Caldwell but new cases have not been reported in Gonzales. In addition, the number of people living with HIV is increasing while the number of people living with AIDS has leveled off. This suggests that people are living longer with HIV before in converts to AIDS. In addition, new AIDS cases are decreasing which means few people are converting from HIV to AIDS.

Figure VI.3

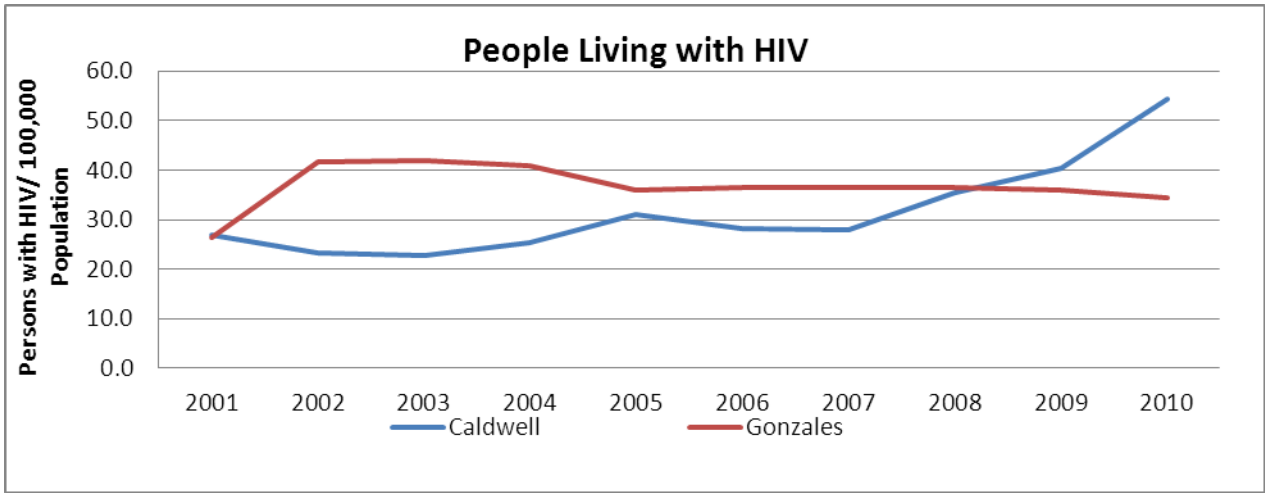
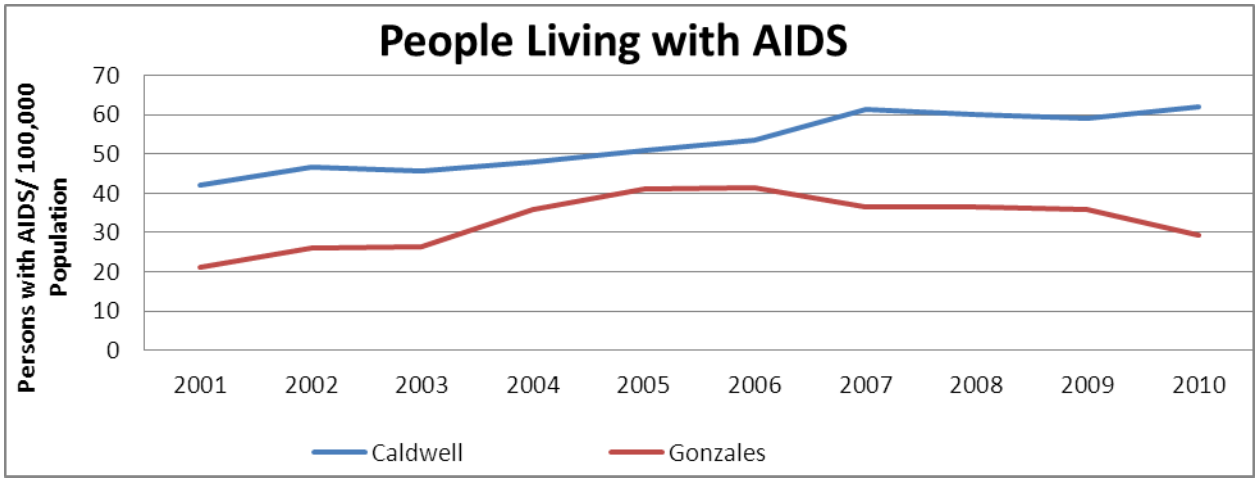


Figure VI.4



VII. PARTNERSHIP AND COLLABORATION

The final need prioritized by Summit participants was the need for increased community partnership and collaboration. The desire to have more community engagement and mobilization as well as an outreach and education mechanism to educate the community on available services was discussed.

- Participants envisioned an integrated community with programs co-located and linked with transportation services to increase community access.

VIII. SUMMARIES: ASSESSMENT AND PRIORITIES

Through a review of secondary social, economic, and public health data coupled with the needs identification and prioritization at the Community Health Needs Summit, this assessment provides an overview of the social and economic environment of the Caldwell/Gonzales region, the health conditions and behaviors that most impact the population, and the community's perception of which needs are most pressing. Recognizing that the community is constrained by time and resources, and all of the needs identified are important for the community, the following list represents a synthesis of the overarching themes in the order they were prioritized by the community:

1) Behavioral health
2) Access to care
3) Obesity
4) Chronic disease
5) Increased partnership and collaboration

IX. APPENDIX A: COUNTY HEALTH RANKINGS

Robert Wood Johnson Foundation's study of counties ranking counties within a state against each other based on data sources including National Center for Health Statistics, BRFSS, National Center for Disease Prevention and Health Promotion, Medicare/Dartmouth Institute, Bureau of Labor Statistics, and the US Environmental Protection Agency. 2012 rankings based on data from 2002-2010.

Each section of the tables below shows how Caldwell and Gonzales compared to National Benchmark Scores in this study and uses the scoring system below:

- No more than 9% worse than national benchmark
- 10% - 49% worse than national benchmark
- 50% or more worse than national benchmark

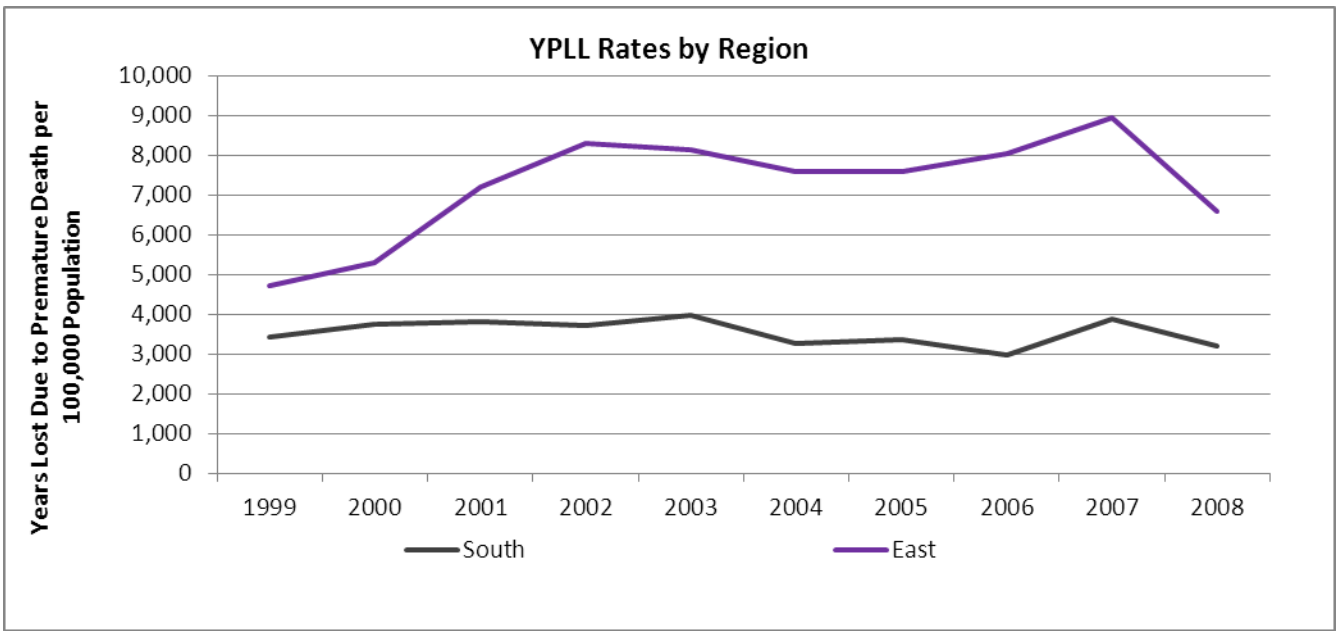
	National 90th Percentile	Caldwell	Gonzales
High school graduation	N/A	90%	89%
Some college	68%	33%	34%
Unemployment	5%	8.6%	6.2%
Children in poverty	13%	26%	32%
Children in single parent households	20%	37%	32%

	National 90th Percentile	Caldwell	Gonzales
Uninsured	11%	27%	32%
Primary Care Physicians	631 to 1	1,632 to 1	1,773 to 1
Preventable Hospital Stays	49	125	115
Diabetic Screening	89%	89%	85%
Mammography Screening	74%	59%	57%

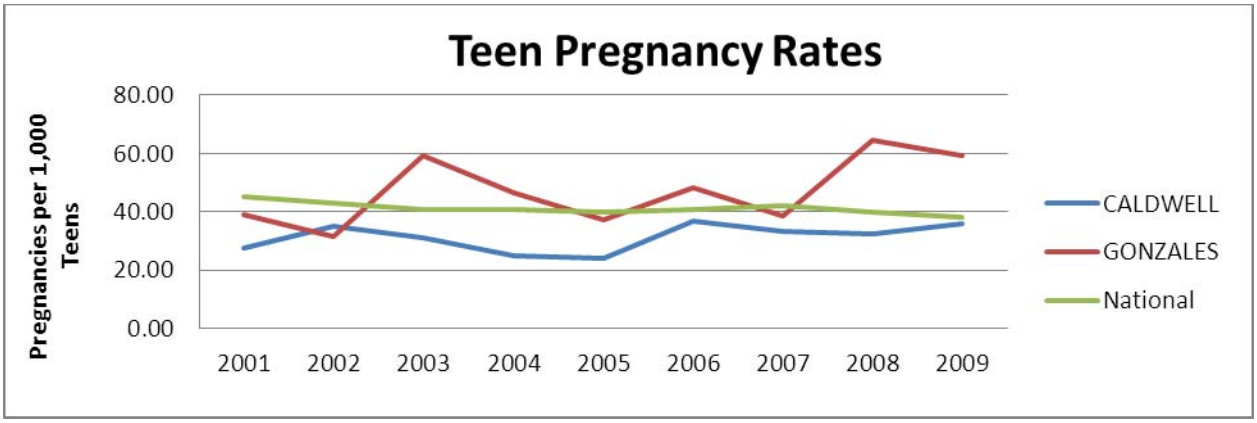
	National 90th Percentile	Caldwell	Gonzales
Premature Death (per 10,000)	5,466	7,021	10,810
Poor of fair health	10%	16%	N/A
Poor physical health days	2.6	3.3	3.3
Poor mental health days	2.3	3.1	3.2
Low birth weight	6.00%	8.20%	7.70%

APPENDIX B: YEARS OF POTENTIAL LIFE LOST

Years of potential life lost is the estimate of how long an average person would had lived had they not died prematurely. The data presented below considers the average person as living to 75.

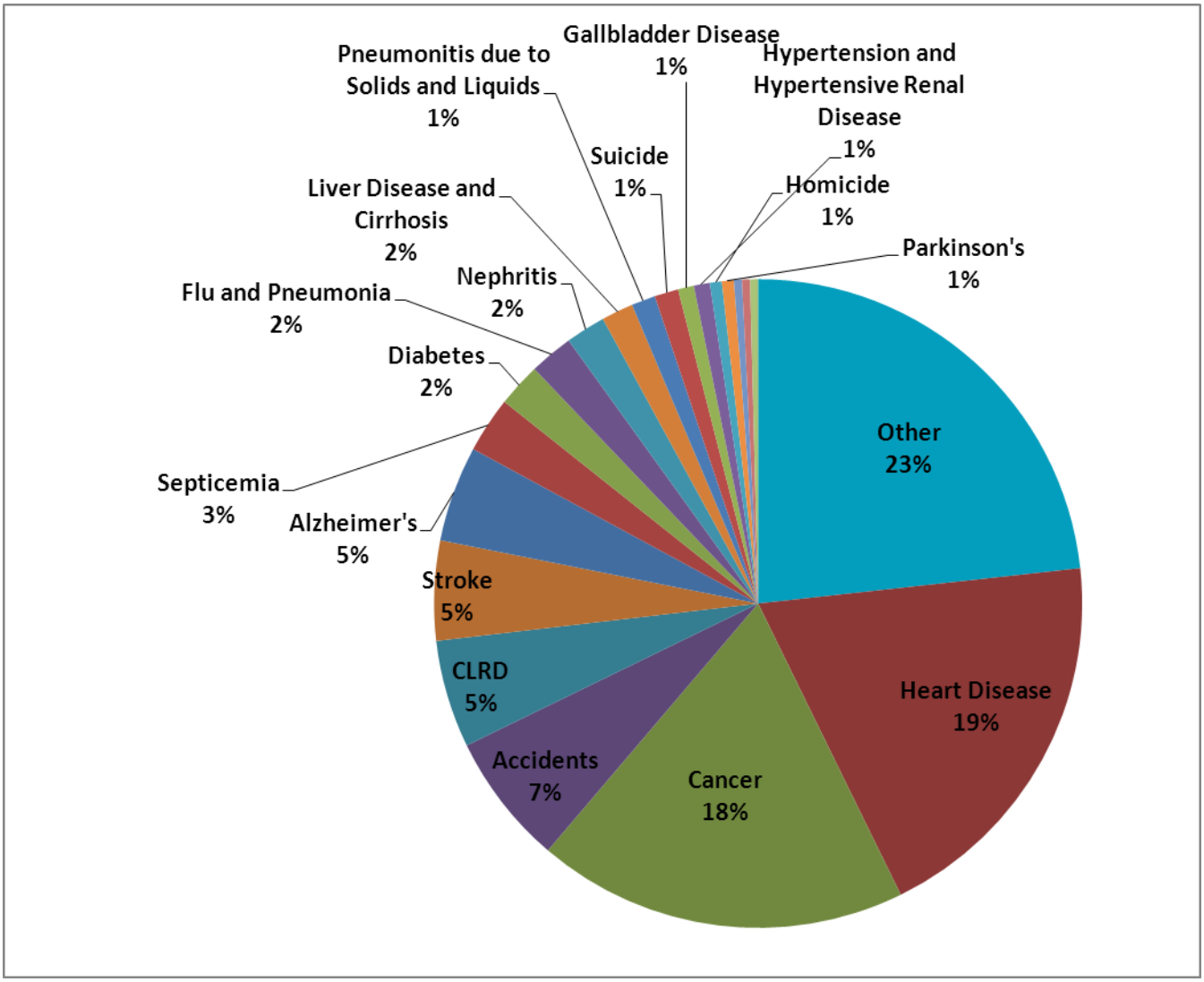


APPENDIX C: TEEN PREGNANCY RATES



APPENDIX D: CAUSES OF DEATH

Causes of Death: 2009



APPENDIX E: GLOSSARY AND REFERENCE MATERIAL

Data was pulled from state sources, national studies and needs assessments conducted by other parties as available (i.e. Travis County).

County Health Rankings: Robert Wood Johnson Foundation's study of counties ranking counties within a state against each other based on data sources including National Center for Health Statistics, BRFSS, National Center for Disease Prevention and Health Promotion, Medicare/Dartmouth Institute, Bureau of Labor Statistics, and the US Environmental Protection Agency. 2012 rankings based on data from 2002-2010.

Behavioral Risk Factor Surveillance System (BRFSS): A phone survey given monthly on a random basis that asks about lifestyle risk factors that contribute to leading causes of death. Data through 2010

Travis County Health Indicators: Austin/Travis County Health and Human Services' inaugural report to show the overall burden of disease in the community and highlight areas for improvement, especially around health disparities in the community. Data through 2010

Commonwealth Report: A scorecard for the Austin region relating Austin to the top 1 percent of hospital referral regions for the selected indicators. Data through 2010

Years of potential life lost (YPLL): Estimated number of years lost by premature death, assuming 65 is the standard age of death. Data through 2008

Data in this assessment are generally incidence rates per 100,000 population, but prevalence rates are included when relevant.

- **Incidence** - Number of new cases per population in a given time period.
- **Prevalence** - Proportion of population found to have a condition

APPENDIX F: METRICS FOR COUNTY HEALTH RANKINGS

Health Outcomes				
Focus Area	**Measure**	**Weight**	**Source**	**Year(s)**
Mortality (50%)	Premature death (years of potential life lost before age 75 per 100,000 pop)	50%	Vital Statistics, National Center for Health Statistics (NCHS)	2006-2008
Morbidity (50%)	Poor or fair health (percent of adults reporting fair or poor health)	10%	Behavioral Risk Factor Surveillance System (BRFSS)	2004-2010
	Poor physical health days (average number in past 30 days)	10%	BRFSS	2004-2010
	Poor mental health days (average number in past 30 days)	10%	BRFSS	2004-2010
	Low birth weight (percent of live births with weight < 2500 grams)	20%	Vital Statistics, NCHS	2002-2008

	Clinical Care (20%)			
Focus Area	**Measure**	**Weight**	**Source**	**Year(s)**
Access to care (10%)	Uninsured (percent of population < age 65 without health insurance)	5%	Census/American Community Survey (ACS)—Small Area Health Insurance Estimates (SAHIE)	2009
	Ratio of population to primary care physicians	5%	Health Resources and Services Administration, Area Resource File (ARF)	2009
Quality of care (10%)	Preventable hospital stays (rate per 1,000 Medicare enrollees)	5%	Medicare claims/Dartmouth Atlas	2009
	Diabetic screening (percent of diabetics that receive HbA1c screening)	5%	Medicare claims/Dartmouth Atlas	2009
	Mammography screening	5%	Medicare claims/Dartmouth Atlas	2009

	Social and Economic Environment (40%)			
Focus Area	**Measure**	**Weight**	**Source**	**Year(s)**
Education (10%)	High school graduation	5%	State sources and the National Center for Education Statistics	Varies by state, 2008-2009 or 2009-2010
	Some college (Percent of adults aged 25-44 years with some post-secondary education)	5%	ACS	2006-2010
Employment (10%)	Unemployment rate (percent of population age 16+ unemployed)	10%	Local Area Unemployment Statistics, Bureau of Labor Statistics	2010
Income (10%)	Children in poverty (percent of children under age 18 in poverty)	10%	Census/CPS—Small Area Income and Poverty Estimates (SAIPE)	2010
Family and social support (5%)	Inadequate social support (percent of adults without social/emotional support)	2.5%	BRFSS	2004-2010
	Percent of children that live in single-parent household	2.5%	ACS	2006-2010
Community safety (5%)	Violent crime rate per 100,000 population	5%	Uniform Crime Reporting, Federal Bureau of Investigation –*State data sources for Illinois*	2007-2009

	Physical Environment (10%)			
Focus Area	**Measure**	**Weight**	**Source**	**Year(s)**
Environmental quality (4%)	Air pollution-particulate matter days (average number of unhealthy air quality days)	2%	CDC-Environmental Protection Agency (EPA) Collaboration *Data not available for Alaska and Hawaii*	2007
	Air pollution-ozone days (average number of unhealthy air quality due to ozone)	2%		
Built environment (6%)	Limited access to health foods (percent of population who lives in poverty and more than 1 or 10	2% (all but AK & HI)	United States Department of Agriculture, Food Environment Atlas *Data not*	2006

	miles from a grocery store)		*available for Alaska and Hawaii*	
	Access to healthy foods (percent of zip codes with healthy food outlets) *for Alaska and Hawaii*	*2% (AK & HI)*	Census Zip Code Business Patterns	2009
	Access to recreational facilities	2%	Census County Business Patterns	2009
	Fast food restaurants (percent of all restaurants that are fast food)	2%	Census County Business Patterns	2009

Health Outcomes				
Focus Area	**Measure**	**Weight**	**Source**	**Year(s)**
Mortality (50%)	Premature death (years of potential life lost before age 75 per 100,000 pop)	50%	Vital Statistics, National Center for Health Statistics (NCHS)	2006-2008

APPENDIX G: SUMMIT PARTICIPANT LIST

Name	Affiliation
Kit Abney Spelce	Insure-a-kid
Flora Amaya	Health Coalition of Caldwell County
Matt Balthazar	Seton Healthcare Family
Amanda Brooks	Health Coalition of Caldwell County
Julie Carter	Seton Lockhart Family Health Center
Steve Conti	Seton Healthcare Family
Gail Courtemanche	Bluebonnet Trails
Dorian Cowan	Health Coalition of Caldwell County
Ashton Cumberbatch	Seton Healthcare Family
Joni Erhardt	Capital Area Rural Transportation System
Louise Fitch	Methodist Healthcare Ministries
Teresa Griffin	Seton Healthcare Family
Percilla Hargraves	City of Lockhart
Julie Hart	Lockhart Independent School District
Liz Johnson	Health Coalition of Caldwell County
Neal Kelly	Seton Edgar B. Davis Hospital
Sandy Martinez Nava	Superior Health Plan
Megan Mullins	Seton Healthcare Family
Carol Peters	Caldwell County Child Welfare Board
Henry Salas	Gonzales Community Health Center
Staci Schley	Bluebonnet Trails
Kelsey Schwartz	Health Coalition of Caldwell County
Brandon Willet	Ageless Living Home Health
Dustin Winkel	Health Coalition of Caldwell County
Mark Ximenez	Bluebonnet Trails