# 2019

## Bexar County & Atascosa County

### COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

Health Collaborative
Bexar County's *Community* Health Leadership

GrowHealthy Together
Bexar County

**Revised edition: Aug 28, 2019**

Dear Community Collaborators,

As we move towards a Regional Community Health Needs Assessment (CHNA), we are proud to announce that the 2019 CHNA includes Atascosa County. It is our goal to add a county or two each time we do a CHNA until we have included all seven contiguous counties to Bexar in our assessment. Bexar County and the surrounding counties are rapidly becoming socially and economically integrated into a regional metropolitan unit. We strongly feel, therefore, that the move towards a Regional CHNA will strengthen our efforts to fulfill our mission of improving community health through collaborative means.

You will notice that the community voice has been integrated into the narrative of the Report. This strengthens and validates the 2019 CHNA by providing on going community commentary and reinforces the idea that we are more than just collective data points on a page but rather individuals that experience health outcomes in our daily lives.

The Report reveals numerous health disparities along a number of dimensions, e.g. age, race and ethnicity, education. We invite you to take a pro-active approach by examining the disparities through an equity lens. We believe this pro-active approach will enable all of us as community partners to come to consensus on what must be done to improve the health of our community. A guiding principle for the pro-active approach through an equity lens is to remember that equity and disparity are related: in communities where resources are not equitably distributed, health disparities tend to predominate.

The 2019 CHNA provides a series of maps on a variety of health-related themes that demonstrate the geography of health disparity in our community. The report also includes a number of guides in the form of tables, bar and line graphs that show relationships and trends in the data. As an illustration of how to explore the implications of the report's data relationships and trends, see the section in the conclusion "How do those issues relate to one another".

We wish to thank our Board of Directors, Steering committee, our Executive Director, and CI:Now for their leadership and guidance in the development of this report. We also wish to thank our sponsors whose support is greatly appreciated. We especially thank you, the greater community, for making this report possible.

We hope that together we can make a difference in the communities we serve. Until the next CHNA, it is our greatest desire that you remain a committed stakeholder and community collaborator with us.



Pilar Oates
Board Chair
The Health Collaborative



Steve Blanchard
Data Committee Chair
The Health Collaborative

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# Table of Contents (Continued)

# About This Assessment

Each community health needs assessment commissioned by The Health Collaborative evolves in some way from the last assessment, aiming to challenge how we think about and work to improve our community's health and well-being. The *2016 Bexar County Community Health Needs Assessment* sought to support Bexar County partners in moving from knowledge about local health conditions to improvement of those conditions, using an equity lens and publishing data online for the first time. This *2019 Atascosa and Bexar County Community Health Needs Assessment* represents another step forward in this continuing evolution.

## What's new for this assessment

One major shift from prior assessments is the movement toward a regional community health needs assessment via the addition of Atascosa County to the geographic scope. Adjoining Bexar County immediately to the south, Atascosa differs markedly from Bexar in a number of social determinants, health-related behaviors and risks, and health outcomes. More than anything, though, it differs in the availability of data for many of the indicators traditionally measured in Bexar. Because Atascosa's population is about 2.5% the size of Bexar's, the available data is based on fewer of everything: people surveyed, births, illnesses and injuries, deaths, cars on the road, students in high school, and on and on. Some of the major consequences of these small numbers are that trends often rise and fall like extreme rollercoasters, margins of error and confidence intervals are often so wide as to be nearly meaningless, and disaggregated figures (e.g., the rate for each race/ethnicity group) are missing from charts because the numbers were suppressed by the data owner to protect privacy.

Each and every instance of these challenges presents a judgment call: is this data actually better than nothing? Is it actually *worse* than nothing because it's confusing or misleading?

Wherever possible, the same or similar indicators are presented for both counties, each time accompanied by narrative and callout boxes explaining where and why the data may not be trustworthy. That approach often means compromises in how an indicator is calculated. For example, three-year averages – or in one case, a 19-year average – make trend lines and bar charts easier to make sense of but sacrifice some of the recency of the data. The Behavioral Risk Factor Surveillance System (BRFSS) data for Atascosa was usable only with seven survey years of data and included both Medina and Wilson County responses in the dataset. These choices have been noted in the narrative and footnotes to help the reader decide how to interpret the data.

Another change is much more extensive disaggregation of the data, breaking it out by race/ethnicity group, age group, sex, and smaller-than-county geography. This assessment includes close to four times as many maps and more than twice as many charts and tables as did the 2016 assessment. The purpose of disaggregation is to shine a bright light on differences, disparities, and inequities so that they can be identified, understood, and addressed. Unfortunately, breaking the data down into many categories results in the same problems described above for Atascosa data: volatile or unreliable rates, wide margins of error, and suppressed data. Suppressed data especially hurts disaggregation by race/ethnicity group. Data are consistently available only for Hispanics and non-Hispanic whites, resulting in the loss of so much important information about other members of our community.

Finally, to help assemble a more complete picture of an issue, "Related data" text boxes direct the reader to relevant information covered in a different section of the assessment. As one example, liquor store density might be covered in one section, alcohol-involved motor vehicle crashes in another,  and alcohol-induced deaths in yet another.

# About This Assessment

## What continues with this assessment

As in 2016, this assessment focuses on equity and organizes the content largely consistent with the health equity framework developed by the Bay Area Regional Health Inequities Initiative (BARHII). That framework explicitly recognizes 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% to 20%[1] and emphasizes the living conditions that are upstream of – and entirely surrounding – personal behaviors, disease, and death.
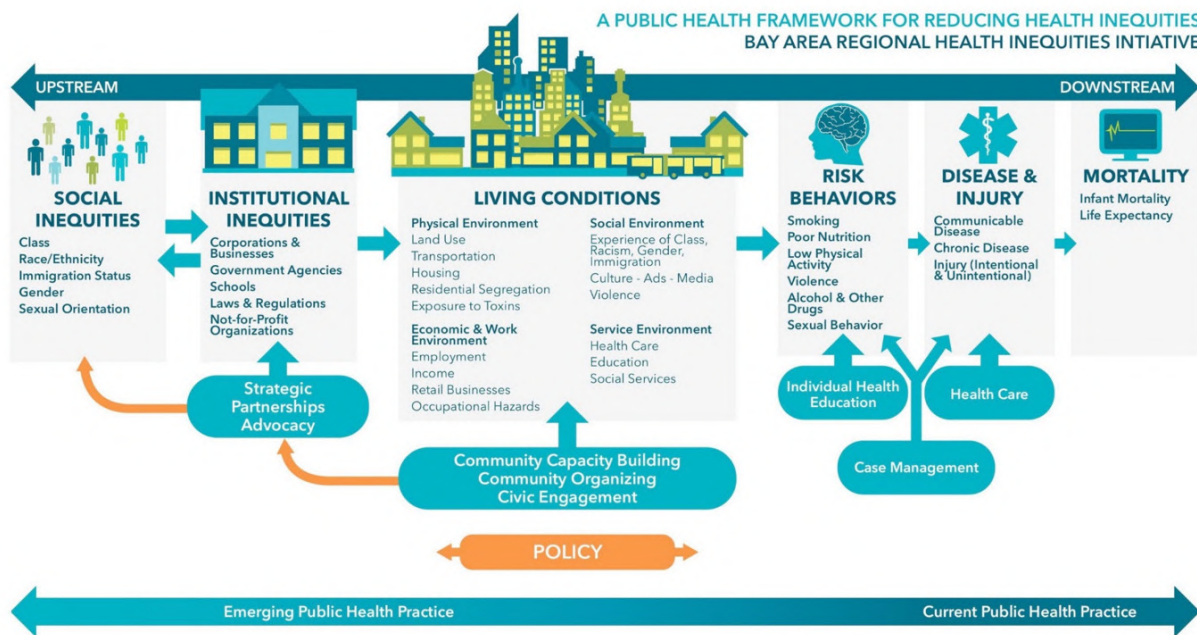


Source: Bay Area Regional Health Inequities Initiative (BARHII)

Once again, benchmarking against other geographies – other counties, Texas, or the United States – was beyond the scope of this assessment, although a few comparisons are embedded in the narrative. Geographic comparisons for a number of key indicators are available through Community Information Now's Viz-a-lyzer online data tool, the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps, and most state and national data query tools.

Content gathered though community focus groups and interview participants is integrated into each report section to which it relates. These quotes reflect the opinion of one or more community members and not necessarily that of The Health Collaborative. Narrative summaries of all qualitative information provided through the interviews and discussion groups are included in the Appendices.

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1. See for example McGovern, L.et al. (2014). Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

# Section 1: Population
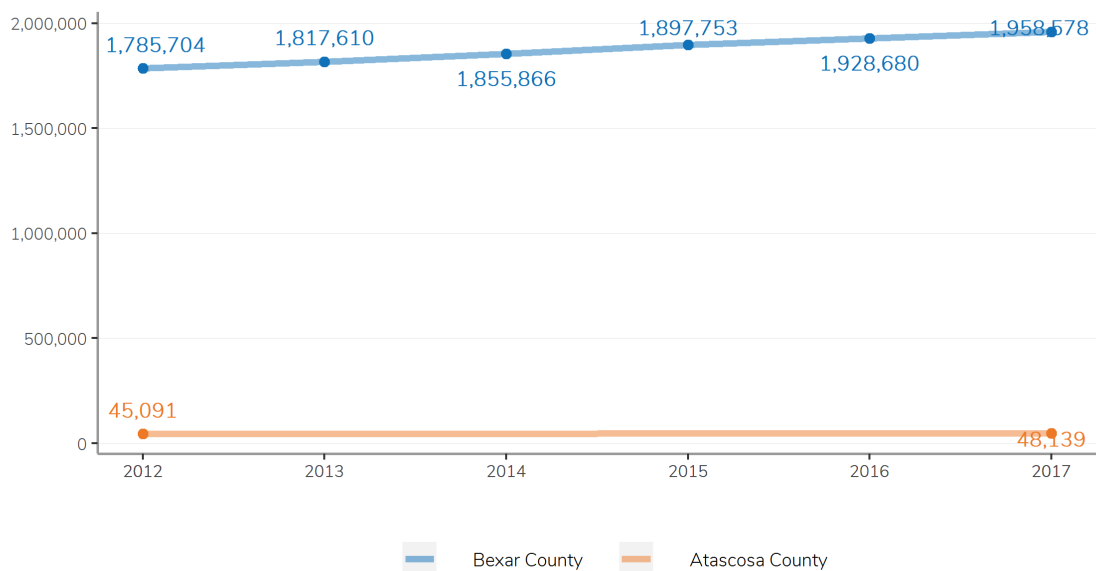
## Growth and distribution

Population growth and geographic distribution – where they live in each county – are both extremely important drivers of needs for physical infrastructure, human services assets like schools and health clinics, and businesses and amenities. Strong population growth in Bexar is old news, but Atascosa is growing as well. While the population size and growth in absolute numbers are vastly different, the *rate* of growth from 2012 to 2017 differs much less (Fig. 1.1). Bexar added about 173,000 people over the past five years alone – a 10% increase – while Atascosa added an estimated 1,200, a roughly 2.5% increase. While Atascosa's rate of growth is not as steep as that of Comal, Guadalupe, and other historically rural and semi-rural counties in metro areas along and east of the I-35 corridor, it does buck the overall trend of continued population decline in rural and semi-rural Texas counties.[1]

Fig. 1.1 Total population



Legend: Bexar County, Atascosa County

Bexar County values: 1,785,704 (2012); 1,817,610 (2013); 1,855,866 (2014); 1,897,753 (2015); 1,928,680 (2016); 1,958,578 (2017)

Atascosa County values: 45,091 (2012); 48,139 (2017)

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B01001
Prepared by CI:Now for THC

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1.Texas Demographic Center. (2018, October 4). Texas population growth focusing on rural communities: Presentation to the Texas Chapter of the American Society of Farm Managers and Rural Appraisers [PDF document]. Retrieved from https://demographics.texas.gov/Resources/Presentations/OSD/2018/2018_10_04_TexasChapteroftheAmericanSocietyofFarmManagersand.pdf

# Section 1: Population

Because Texas' recent growth has been so great and demographic shifts have been so rapid, The Texas Demographic Center's (TDC) population projections for the current year are considered by many to be a better inter-censal population estimate. The population estimates for 2017 are virtually identical to the American Community Survey estimates presented above.[2] TDC projections put Atascosa's 2019 population at 51,048 and Bexar's at 2,053,206, an increase over 2017 of 4% and 5%, respectively. TDC currently projects that Atascosa's population will grow to 60,111 by 2030 and 73,187 by 2050. Bexar's population is expected to grow to 2,502,208 by 2030 and 3,343,929 by 2050.[3]

The population is not evenly distributed in either county (Fig. 1.1.1). Bexar's most populous zip codes are those radiating from the near Westside to the northwest Loop 1604 corridor and beyond, as well as 78223 on the I-37 corridor to the southeast. Unsurprisingly, Atascosa's most populous zip code is 78064 on the I-37 corridor, home to Jourdanton and adjacent to Pleasanton. For reasons discussed below, many Bexar zip codes – not just those on the county outskirts, but also the military bases and San Antonio's city center – also appear sparsely settled.

Zip code size and shape vary tremendously in both counties, though. Looking at population density - number of people per square mile - controls for that variation in zip code size (Fig. 1.1.2). As a result, the near Eastside and areas south of downtown and west of King William join the near Westside and northwest zip codes as having among the highest population densities in the county. Population density in Atascosa and Bexar's outlying zip codes still reflects a semi-rural character, and despite a meaningful uptick over the past decade, downtown San Antonio still has a low number of residents. The other less-dense zip codes are JBSA Lackland and Kelly Field Annex southwest of downtown, JBSA Fort Sam Houston northeast of downtown, and the more industrial areas bounded by Highway 87 to the north and I-10 East to the south.

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**Box 2**
ZIP codes, zip codes, and ZCTAs

In 1963 the U.S. Postal Service created the *Zone Improvement Plan Code* to speed mail delivery. A ZIP code is just a group of mail delivery routes, though, not a clearly-defined geographic area. Around 2000 the U.S. Census Bureau created ZIP Code Tabulation Areas (ZCTAs), which group Census blocks to approximate a ZIP code's delivery area. Most of the maps in this report slice the data by ZCTA, but for readability we just say "zip code."

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**Box 3**
Spotting uncertainty

Box 1 explains that there's always some degree of uncertainty about numbers that come from samples rather than actual counts. In this report, we usually call that uncertainty the margin of error or MOE. Wherever possible we've used methods that reduce the MOE, such as using Census American Community Survey's combined five-year dataset instead of the one-year dataset. High or low, though, you'll always see that MOE in bar charts and line (time trend) charts. In bar charts, MOE is represented with an error bar, a gray line that overlaps the end of the bar. In line charts, MOE is shown as a band of color on either side of the line. In general, the wider the error bar or the color band for an estimate, the more we need to take that estimate with a grain of salt.
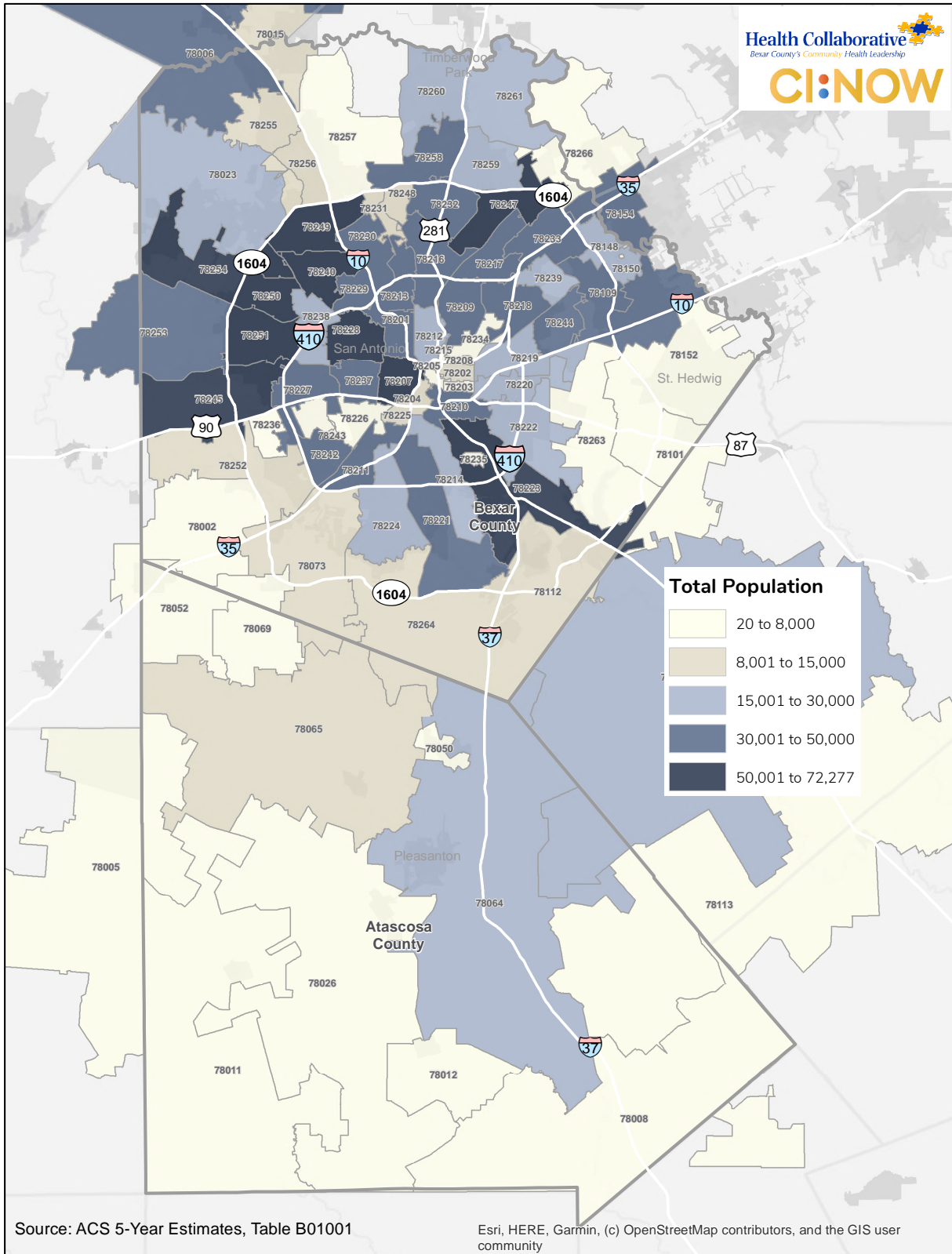
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2. Texas Demographic Center. Population estimates download tool. Retrieved from https://demographics.texas.gov/Download/Estimates.aspx?fid=fe7f5856bd7a41729c796a1b9c145cbb
3. Texas Demographic Center. 2018 Texas population projections data tool. Retrieved from https://demographics.texas.gov/data/TPEPP/Projections/Report.aspx?id=17ea4217d4e348458dabdaccf4777cd5

# Section 1: Population

Fig. 1.1.1 Total population by zip code, 2017



Source: ACS 5-Year Estimates, Table B01001

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

# Section 1: Population

Fig. 1.1.2 Total population per square mile by zip code, 2017



Population Density (per sq. mile)

- 1 to 400
- > 400 to 1,200
- > 1,200 to 3,000
- > 3,000 to 4,500
- > 4,500 to 7,181

Source: ACS 5-Year Estimates, Table B01001

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
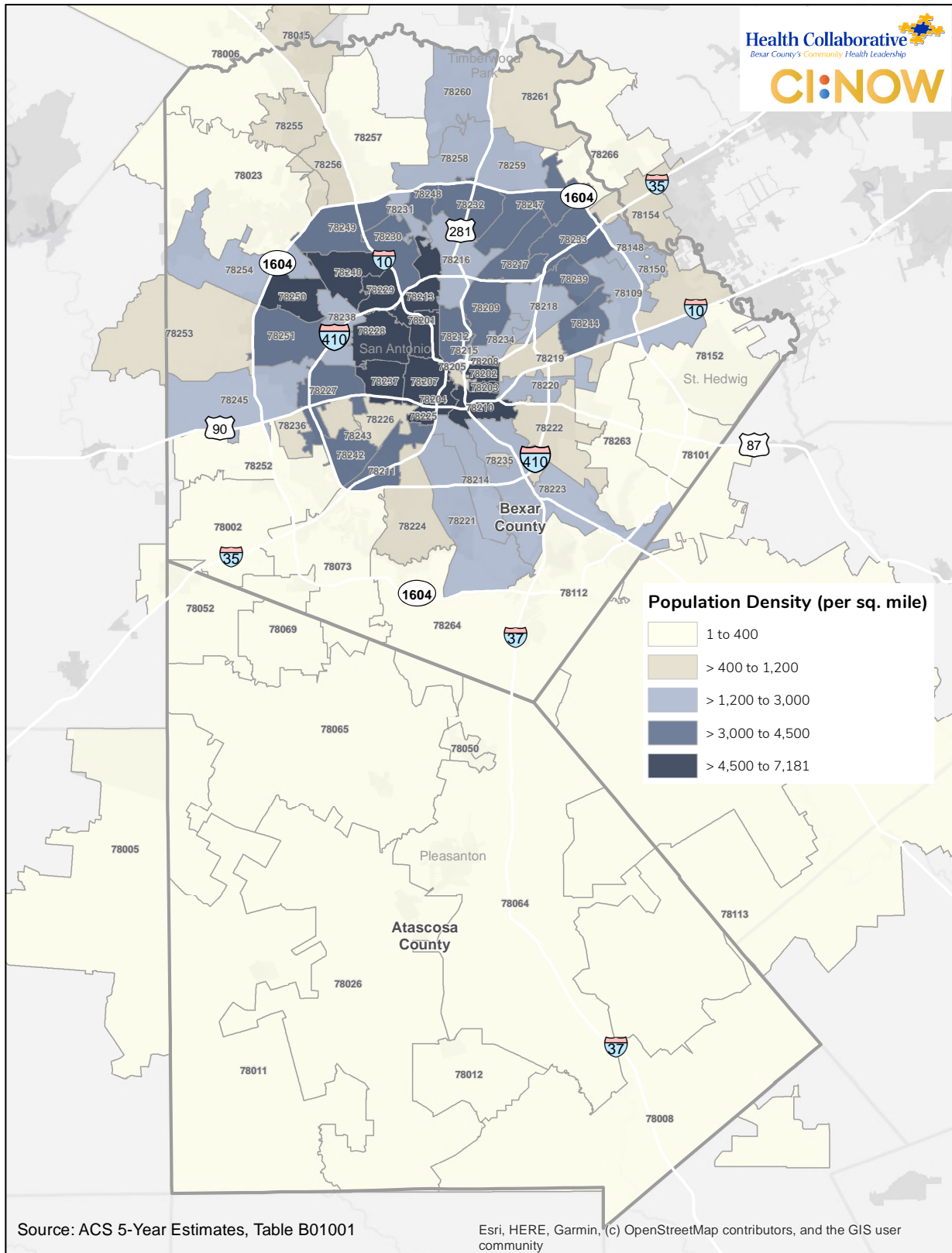
# Section 1: Population

## Composition

The two counties have a similar age distribution (Fig. 1.2) on the whole, particularly when Atascosa's wide margin of error is considered. The notable exception is Bexar's larger percentage of population in the 18- to 34-year-old age group, likely driven at least in part by a sizable population of post-secondary students and recent graduates of Bexar's 15-plus colleges and universities.

Fig. 1.2 Percent of total population by age, 2017
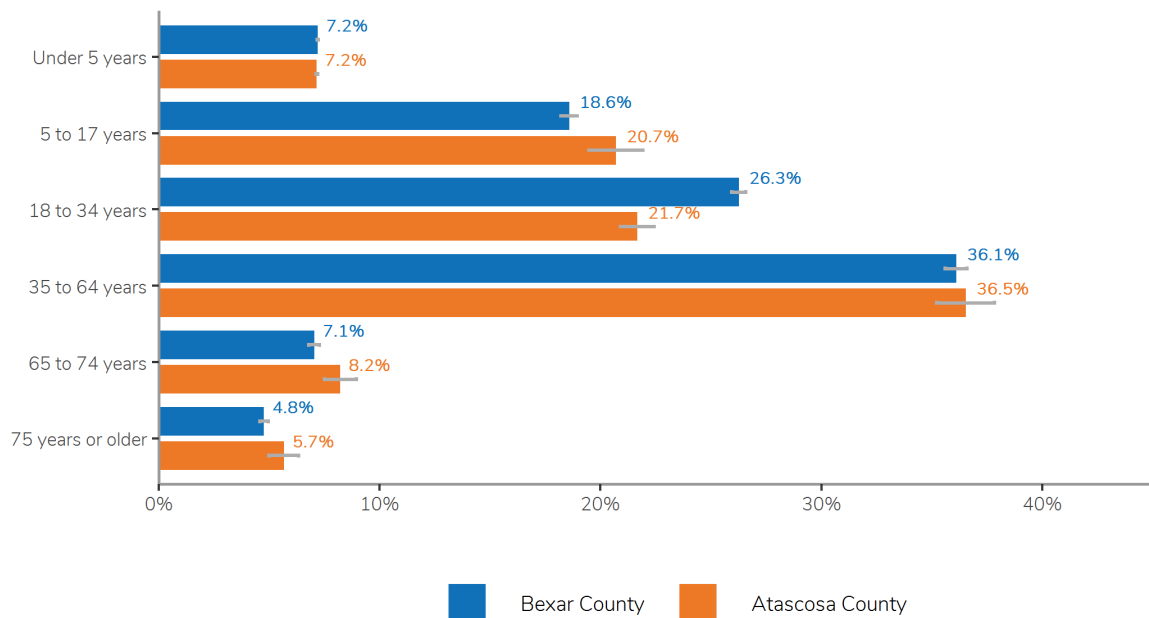


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B01001
Prepared by CI:Now for THC

In each county, about six in 10 people (Fig. 1.2.1) are of Hispanic ethnicity (any race). Of the balance, non-Hispanic whites make up a larger proportion in Atascosa than in Bexar. In Bexar, African-Americans and Asians make up an estimated 7% (± 0.2%) and nearly 3% (± 0.2%), respectively. No other race/ethnicity comprises more than 2% of total population in either county.

# Section 1: Population
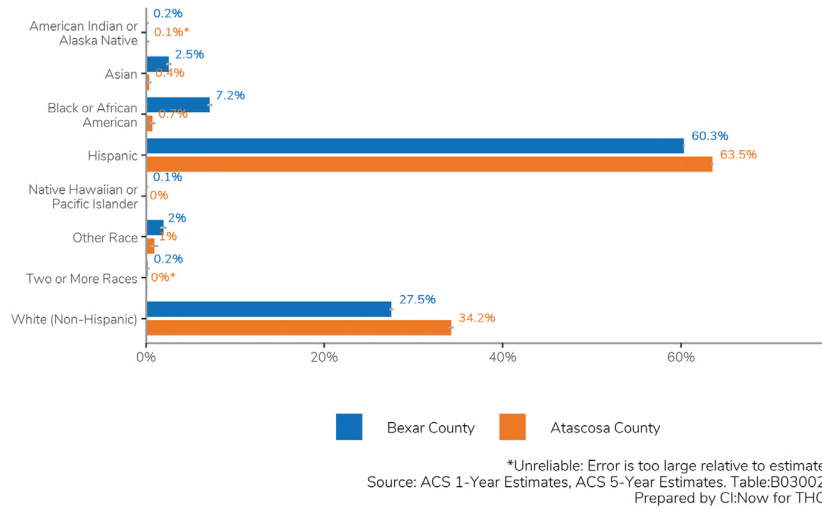
Fig. 1.2.1 Percent of total population by race, 2017



American Indian or Alaska Native: 0.2% / 0.1%*
Asian: 2.5% / 0.4%
Black or African American: 7.2% / 0.7%
Hispanic: 60.3% / 63.5%
Native Hawaiian or Pacific Islander: 0.1% / 0%
Other Race: 2% / 1%
Two or More Races: 0.2% / 0%*
White (Non-Hispanic): 27.5% / 34.2%

■ Bexar County    ■ Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B03002
Prepared by CI:Now for THC

Fig. 1.2.2 and Fig. 1.2.3 visualizes the relative numbers and distribution of both counties' populations by race/ethnicity. The dot density map[4] shows not just where different race/ethnicity groups are concentrated, but also where the population as a *whole* is concentrated; areas with few or no dots are very sparsely populated.

**Box 4**
**About race and ethnicity**

Race and ethnicity are complex and deeply personal concepts. Forms and surveys, however, simplify the options with an instruction to "check one," and there's no standard set of options used everywhere. That means the availability of breakdowns by race (e.g., White, Black, Asian, American Indian) and ethnicity (Hispanic or non-Hispanic) varies among data sources, as does the way that race/ethnicity is categorized. Also, if the number of people is very small, multiple race/ethnicity categories may be collapsed into one to protect privacy and/or reduce the margin of error.

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4. Dots are randomly distributed within a Census tract block group and do not represent actual addresses.

Fig. 1.2.2 Population by race by block group in Bexar County, 2017
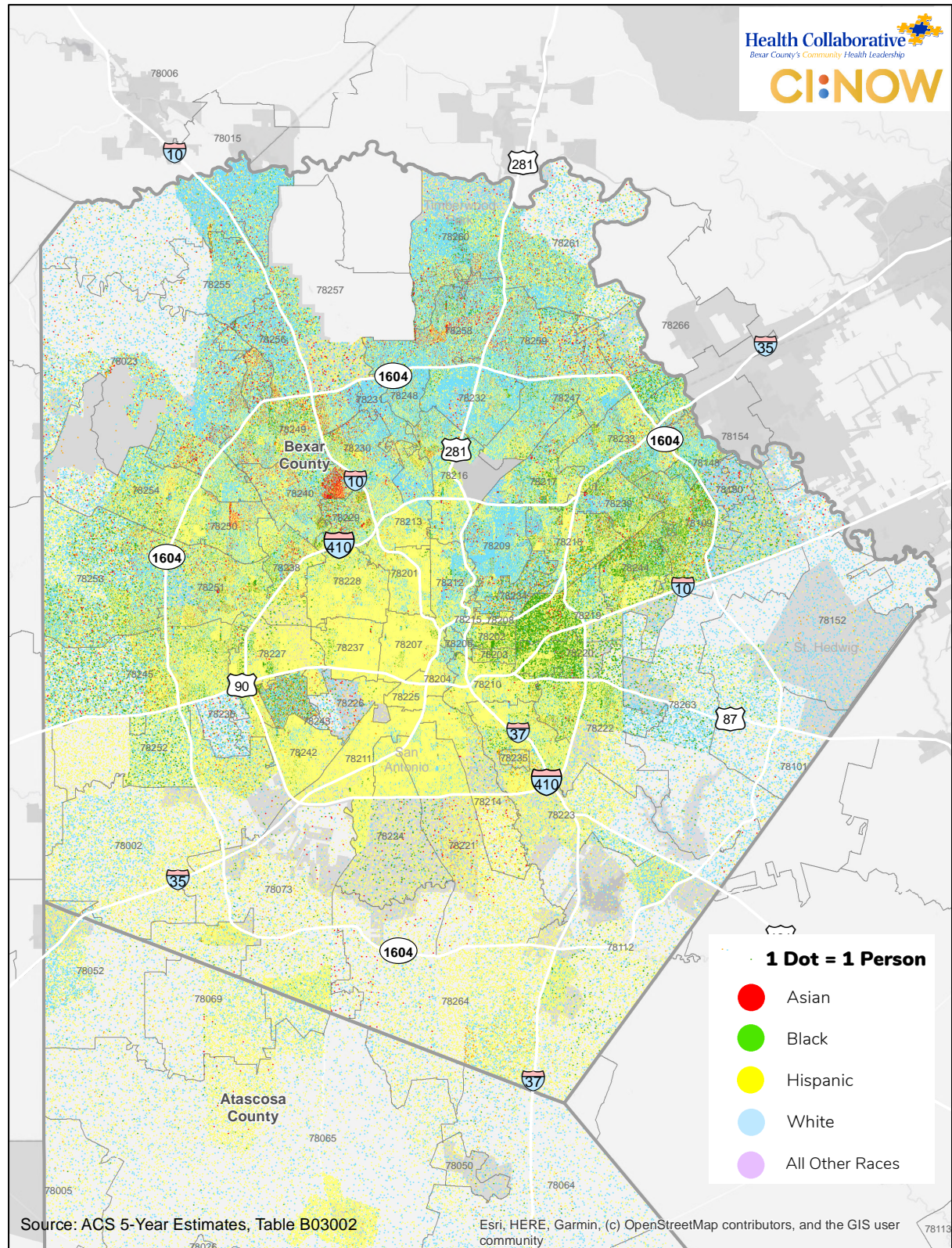


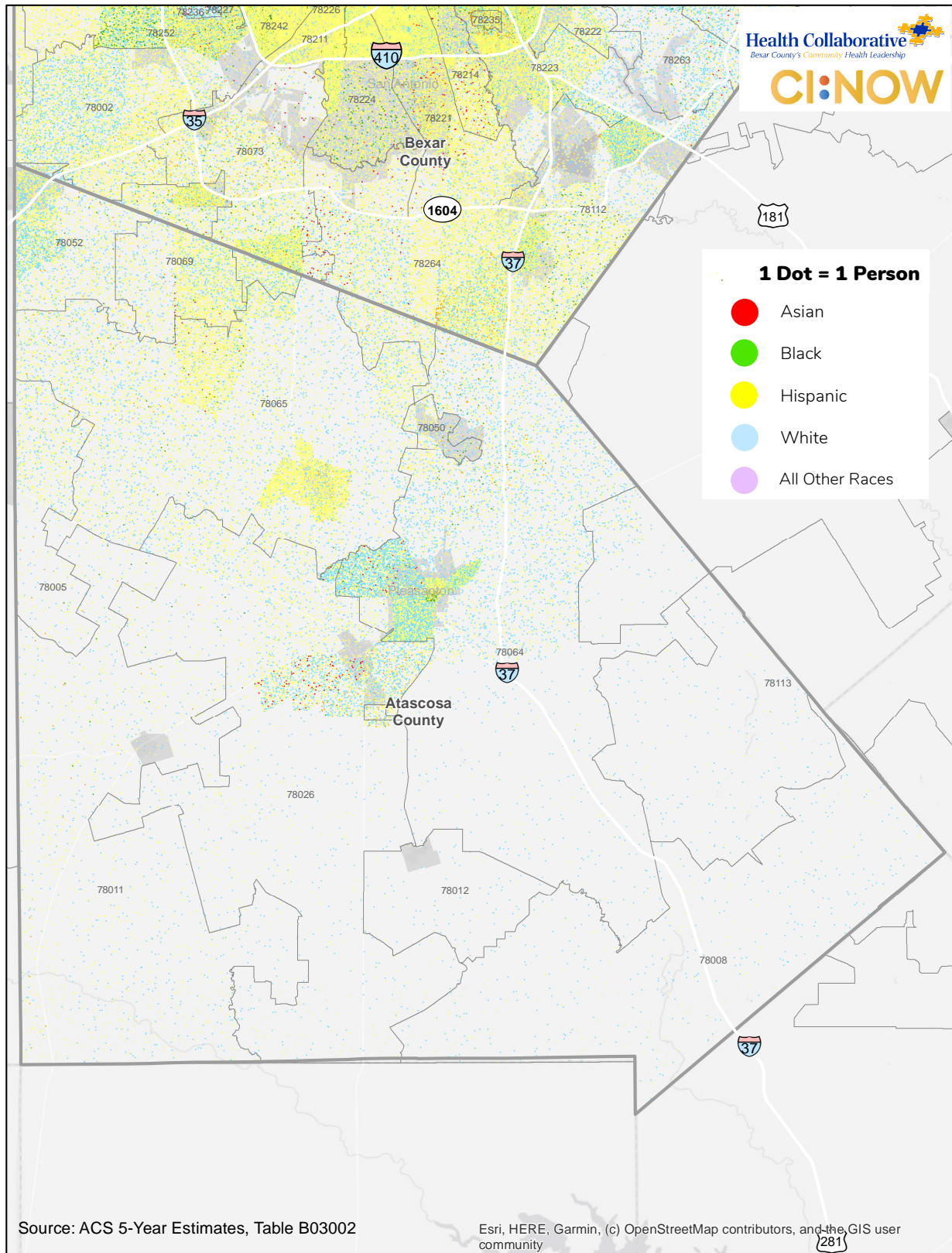Source: ACS 5-Year Estimates, Table B03002

Fig. 1.2.3 Population by race by block group in Atascosa County, 2017



Source: ACS 5-Year Estimates, Table B03002

Fig. 1.2.4 Percent people of color
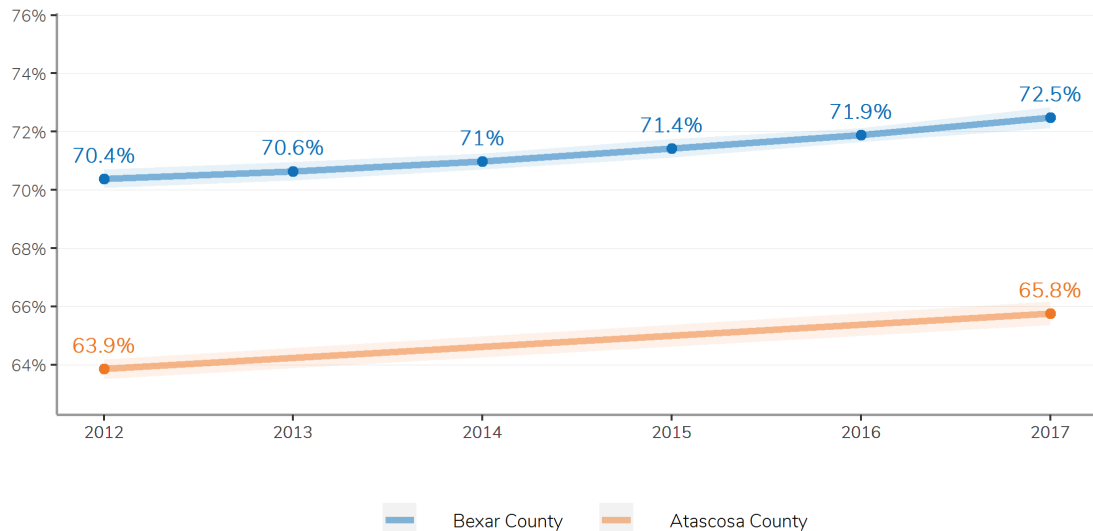


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: C03002, B03002
Prepared by CI:Now for THC

Nearly two-thirds of Atascosa's population and nearly three-quarters of Bexar's population are people of color (a person who is not white or of European parentage), and that proportion is growing in both counties (Fig 1.2.4). The geographic distribution for the population of color differs strikingly between the two counties, however. Zip code 78064, mentioned earlier as the Atascosa zip code with the highest population density, and similarly-dense 78114, the adjacent zip code that includes Floresville, are heavily non-Hispanic white. In Bexar, however, nearly all of the most population-dense zip codes are heavily – and within Loop 410, overwhelmingly – people of color (Fig. 1.2.5).

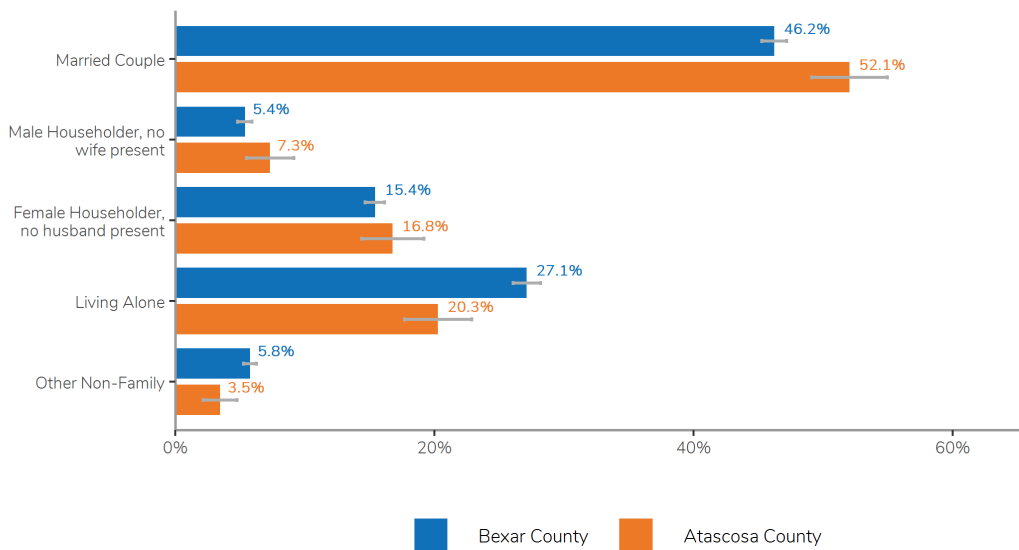Fig. 1.2.5 Percent people of color by zip code, 2017
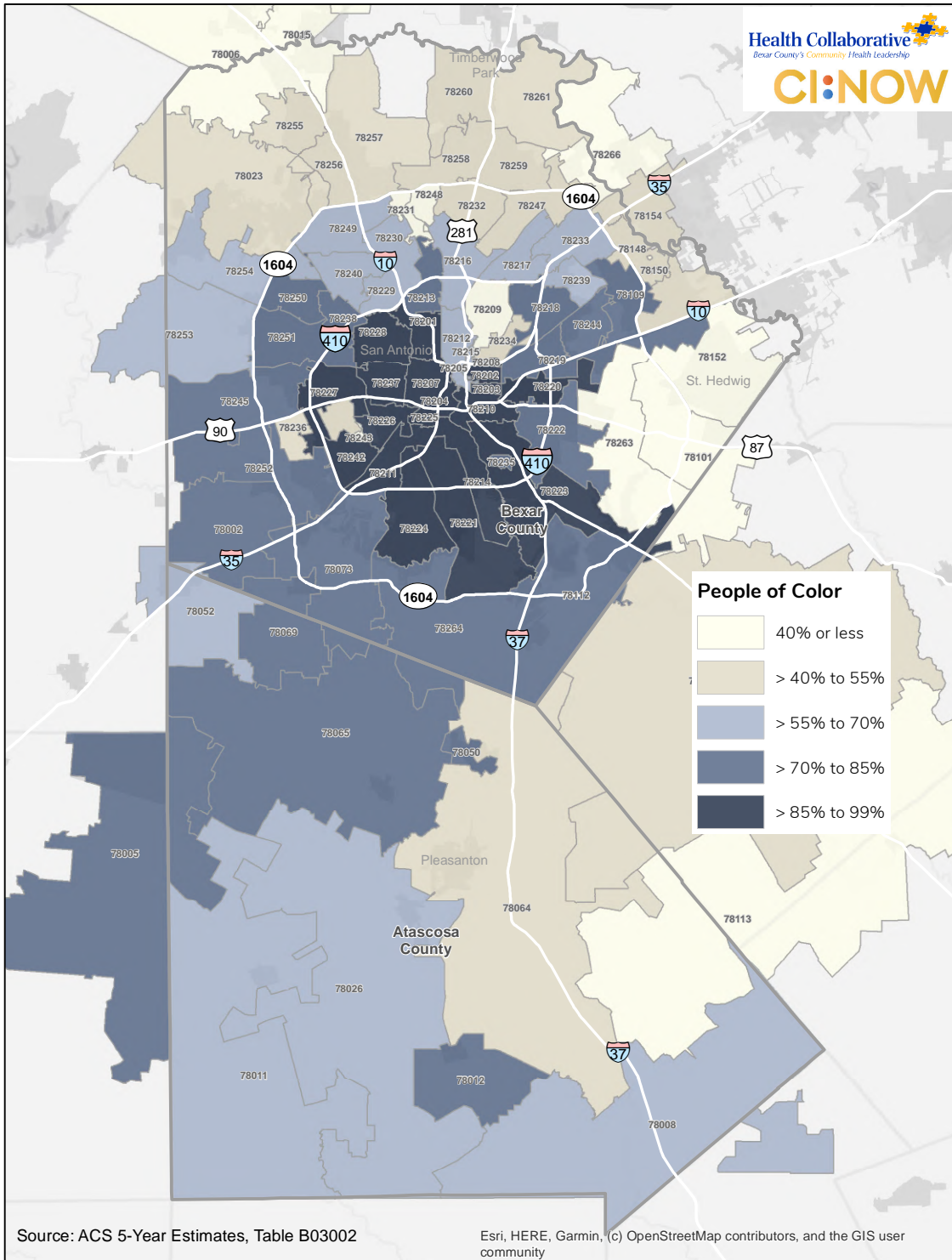
# Section 1: Population

Bexar and Atascosa residents live in a variety of household types, determined by the relationships of household residents to the "householder" as reported by person filling out the Census survey. Married-couple households constitute about half of households in both counties, with the proportion slightly higher in Atascosa (Fig 1.2.6). In both counties about one in seven households has a female householder with no husband present – but not living alone – and about one in 17 has a male householder with no wife present. People living alone make up just over one in four Bexar households, with a smaller proportion (one in five) in Atascosa. The remainder, termed "other non-family" – single-person households are also considered "non-family" – are households where no resident is related to the householder.

Fig. 1.2.6 Percent of total households by type of household, 2017



| | Bexar County | Atascosa County |
|---|---|---|
| Married Couple | 46.2% | 52.1% |
| Male Householder, no wife present | 5.4% | 7.3% |
| Female Householder, no husband present | 15.4% | 16.8% |
| Living Alone | 27.1% | 20.3% |
| Other Non-Family | 5.8% | 3.5% |

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B11001
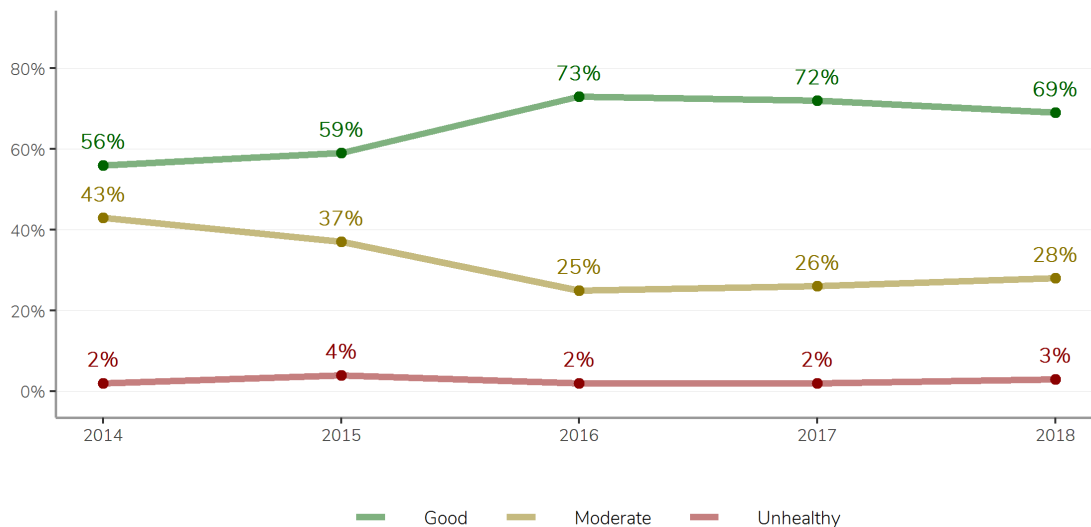Prepared by CI:Now for THC

# Section 2: Physical Environment

## Air quality

Air quality in general and ozone levels in particular continue to be a high-profile issue for the region. The Annual Air Quality Index (AQI) is a summary measure of overall air quality for the year. Atascosa data is not available, but in Bexar, the percent of days when air quality was considered healthy has increased significantly from 2014 to 2017, slightly decreasing since to 69% in 2018 (Fig 2.1). The percent of days air quality was considered unhealthy for sensitive groups or unhealthy for all has hovered around 2% to 3% over the past five years, with only a handful (zero to three) unhealthy days per year. There were no "very unhealthy" or "hazardous days."

Fig. 2.1 Percent of days air quality (AQI) was unhealthy for sensitive groups in San Antonio



*Unreliable: Error is too large relative to estimate
Source: Environmental Protection Agency
Prepared by CI:Now for THC

The most commonly-used measure of ozone levels tracks the average of the fourth-highest daily eight-hour ozone concentration at Bexar's monitoring sites during the March-to-November ozone season. Atascosa has no monitoring sites. Other than a 2015 spike, Bexar's ozone level by this metric has stayed fairly level over the past five years. Translated to the AQI scale, that level is considered *moderate* bordering on *unhealthy for sensitive groups* (Fig. 2.1.1).

Although it has a lower profile in media and policy, the $PM_{2.5}$ pollutant may present an even greater health risk than ozone. $PM_{2.5}$ – particulate matter with a diameter of 2.5 micrometers or less, found in smoke and haze – is the term for extremely small inhalable particles that can get deep into the lungs and possibly even the bloodstream. Depending on how long a person is exposed to particle pollution, it can result in asthma attacks, acute bronchitis, greater risk of respiratory infection, heart attacks and arrhythmias in people with heart disease, chronic bronchitis, and premature death.[1] A commonly-used measure of $PM_{2.5}$ is the 98th percentile of the 24-hour average throughout the year. By that measure Bexar's $PM_{2.5}$ has ranged between 16 and 25 over the past five years with no clear direction to the trend, remaining in the AQI *moderate* category (Fig 2.1.2).

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1. Office of Air and Radiation. (2003). Particle pollution and your health (EPA-452/F-03-001). Retrieved from US Environmental Protection Agency website: https://nepis.epa.gov/Exe/ZyPDF.cgi?Dockey=P1001EX6.txt
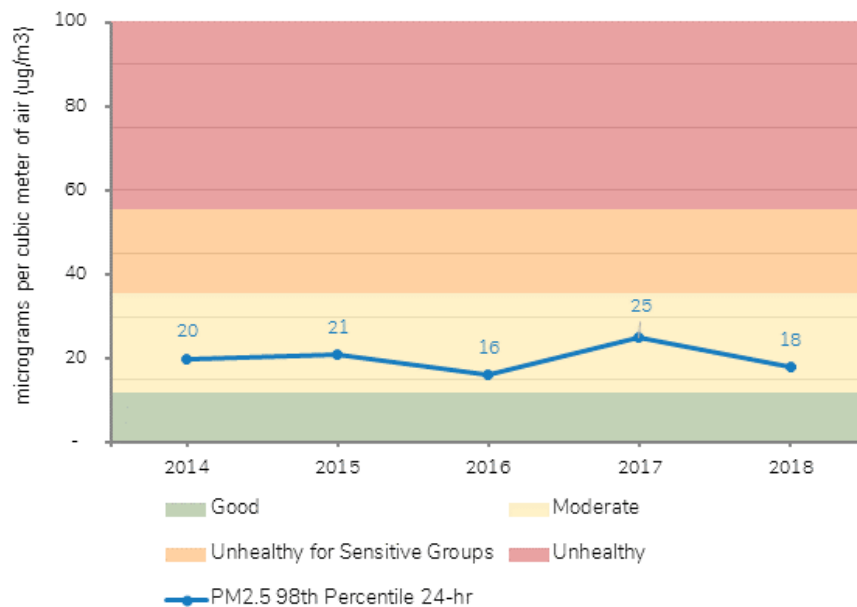
Fig. 2.1.1 Fourth highest 8-hr reading of Ozone level in San Antonio
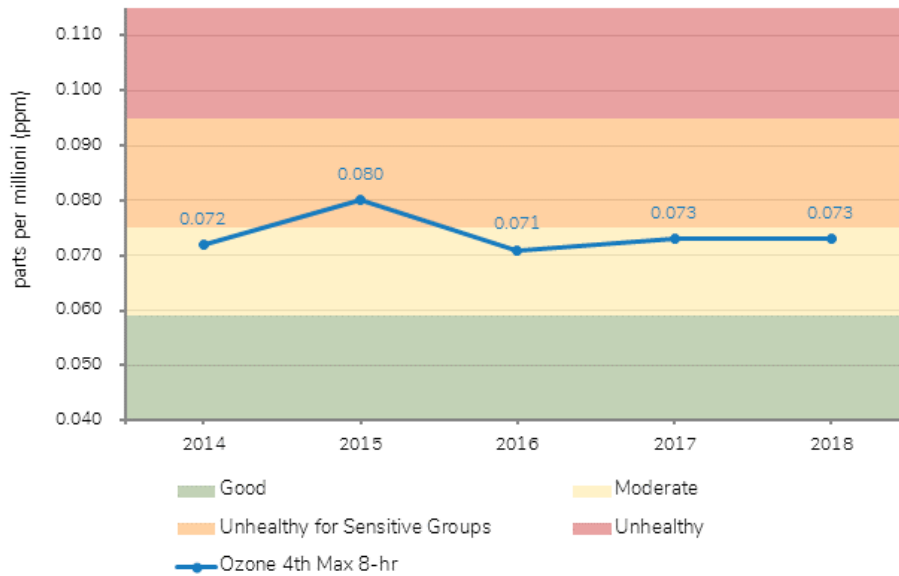


Source: US Environmental Protection Agency. Air Quality System Data Mart available via https://www.epa.gov/airdata. Accessed June 1, 2019.
Prepared by CI:Now for THC

Fig. 2.1.2 98th percentile 24-hr PM$_{2.5}$ reading in San Antonio



Source: US Environmental Protection Agency. Air Quality System Data Mart available via https://www.epa.gov/airdata. Accessed June 1, 2019.
Prepared by CI:Now for THC
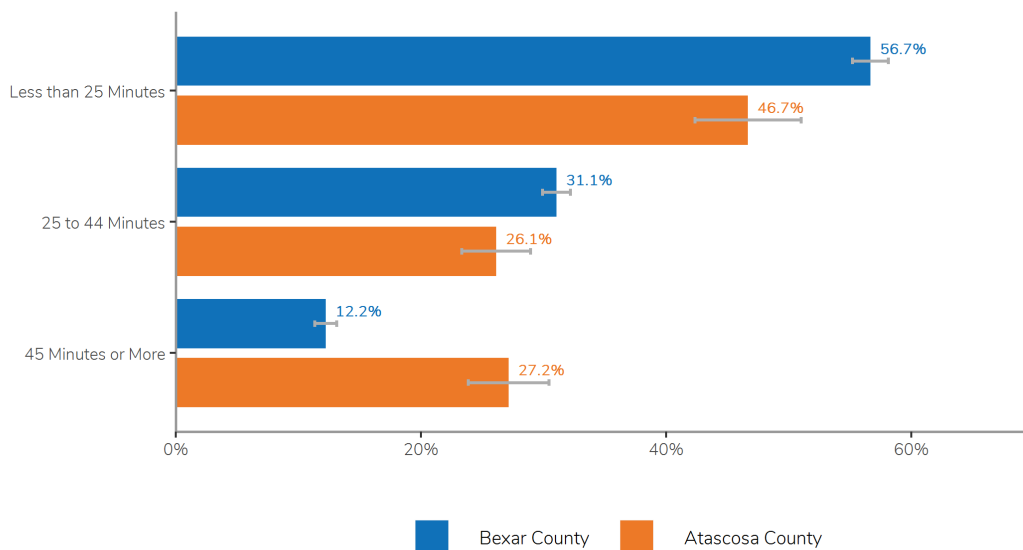
# Section 2: Physical Environment

## Mobility and transportation

Both Bexar and Atascosa are highly car-dependent, with low walkability and limited public transportation. As one would expect of an urban versus semi-rural area, Atascosa residents spend more time getting back and forth to work than do Bexar residents (Fig. 2.2).

Travel time to work is under 25 minutes for an estimated 57% (±1.5%) of Bexar workers, and only 12% (±0.9%) spend 45 minutes or more. More than twice that many Atascosa residents have a travel time of 45 minutes or longer, and only 47% (±4.3%) have a travel time under 25 minutes. After factoring in the margin of error, average travel time in both Atascosa and Bexar counties has remained flat in recent years (Fig.2.2.1), but it's important to remember that an average is a summary measure that hides variations that can be dramatic.

Even looking at an average, dramatic variation is evident when travel time is mapped by zip

Fig. 2.2 Percent of population in households 16 and over by total travel time in minutes, 2017
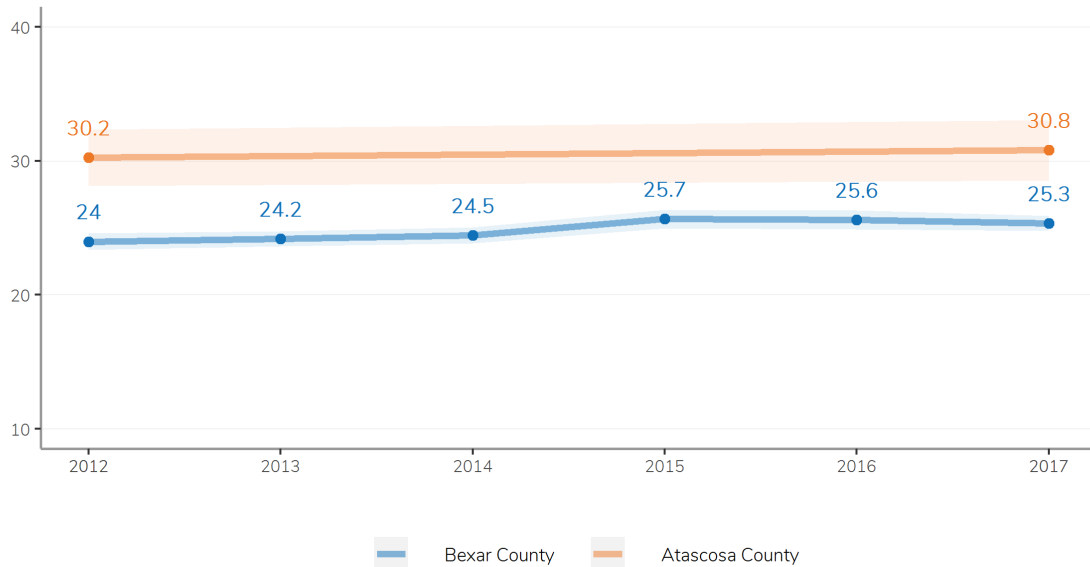


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B08303
Prepared by CI:Now for THC

Fig. 2.2.1 Average travel time to work in minutes

code (Fig. 2.2.2), with outlying zip codes having travel times as much as three to four times as long as north-central neighborhoods. Strikingly, zip code 78202 on the near Eastside – and adjacent zip code 78208 to a lesser degree – have an average travel time comparable to Atascosa and those Bexar zip codes outside Loop 1604.[2] The percent of jobs that are fewer than 10 miles from home is much higher for workers living in 78202 than for Bexar overall, so that long travel time may be due to use of public transportation as a means to get to work. The margins of error are wide at the zip code level, but the percent of 78202 residents commuting via public transportation appears to be nearly twice as high as the percent in similarly low-income 78207 and nearly six times as high as in Bexar County overall.[3]

As measured by Walkscore, which focuses on larger cities, walkability varies within San Antonio but remains low everywhere. Comparable data is not available for any cities in Atascosa. Only 2% of San Antonio residents live in a neighborhood considered "very walkable": Downtown, Five Points, Tobin Hill, King William, Arsenal, or Cattleman Square. Another 30% live in a neighborhood considered "somewhat walkable," with the remaining 68% of residents living in a car-dependent neighborhood. Measuring using a different definition and methodology, only 38% of Bexar residents have walkable access to a park (Fig 2.2.3). Although a common definition of "walkable" includes anything less than a 10-minute or 1.2 mile walk, for many residents even that distance would be unacceptable – and for a significant proportion, not possible.
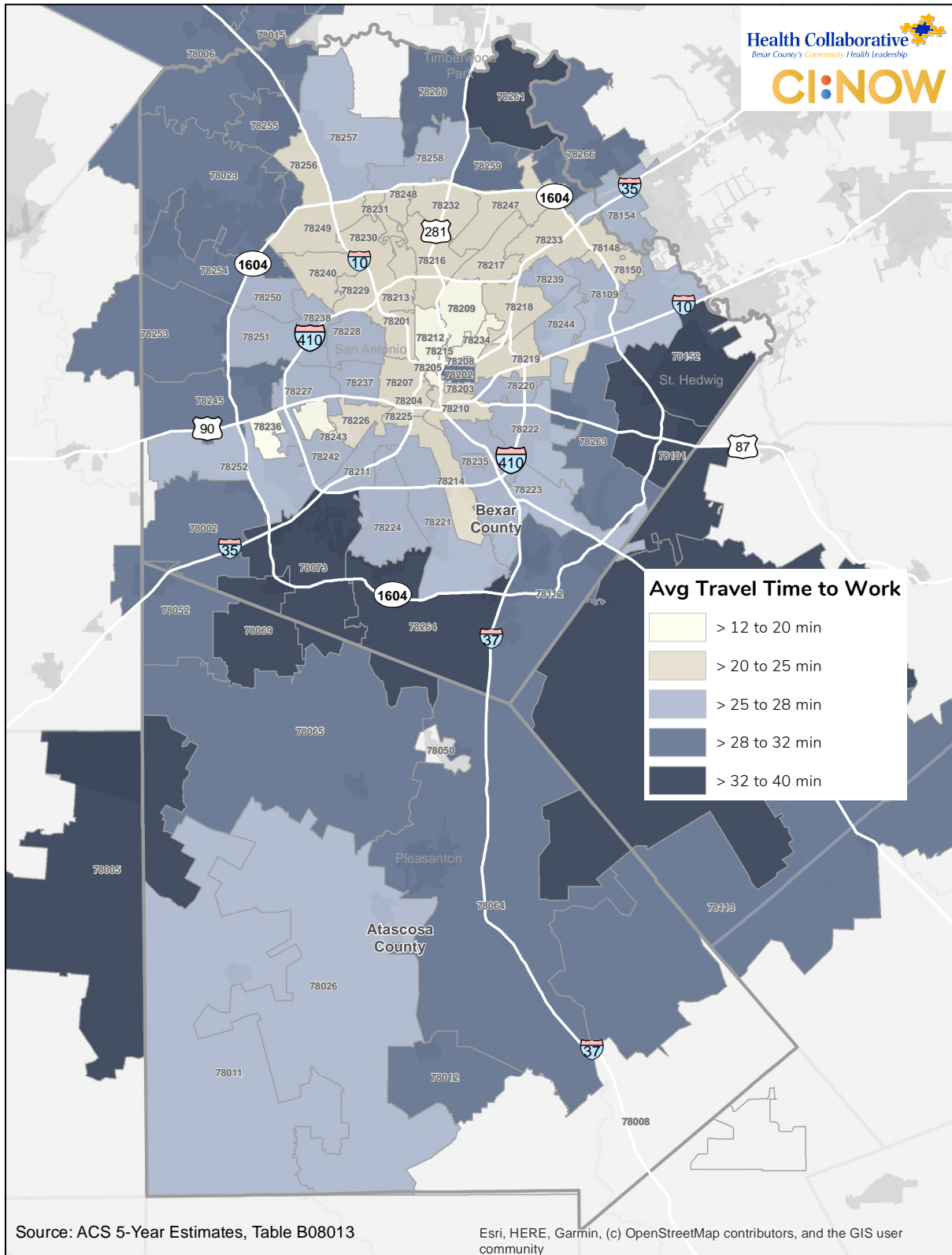
2. Longitudinal Employer-Household Dynamics. On The Map analysis of all jobs and primary jobs only, 78202 and Bexar County, 2013-2015. Retrieved from US Census Bureau website: https://onthemap.ces.census.gov/
3. American Community Survey 2013-2017 5-Year Estimates: Table DP03: Selected economic characteristics. (2018). Retrieved from U.S. Census Bureau website: https://factfinder.census.gov/bkmk/table/1.0/en/ACS/17_5YR/DP03/0500000US48013.86000P|0500000US48029.86000P

Fig. 2.2.2 Average travel time to work in minutes by zip code, 2017



**Avg Travel Time to Work**

- \> 12 to 20 min
- \> 20 to 25 min
- \> 25 to 28 min
- \> 28 to 32 min
- \> 32 to 40 min

Source: ACS 5-Year Estimates, Table B08013

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

Fig. 2.2.3 Percent of population with walkable park access in San Antonio
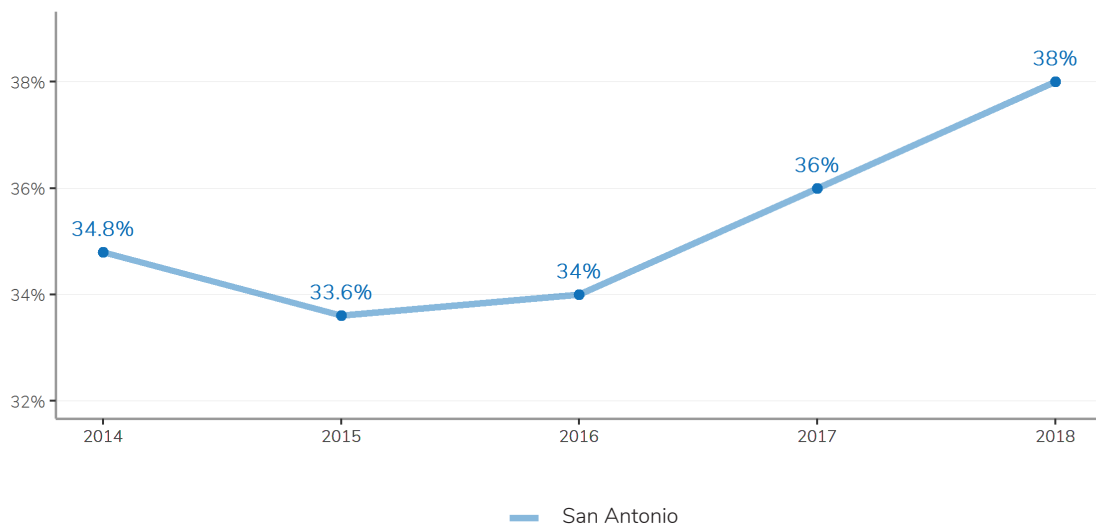


*Unreliable: Error is too large relative to estimate
Source: The Trust for Public Land
Prepared by CI:Now for THC

## Housing stock and vacancy

Depending on income distribution in the neighborhood and the degree and severity of deferred maintenance, the age of occupied housing stock can be an important indicator of health risks at home. One risk is lead exposure in paint, house dust, and soil in the yards of homes built before lead was banned from paint and began to be phased out of gasoline. Most of the housing units from that era are concentrated within Loop 410 in Bexar County and in Atascosa's southernmost zip codes (Fig. 2.3).

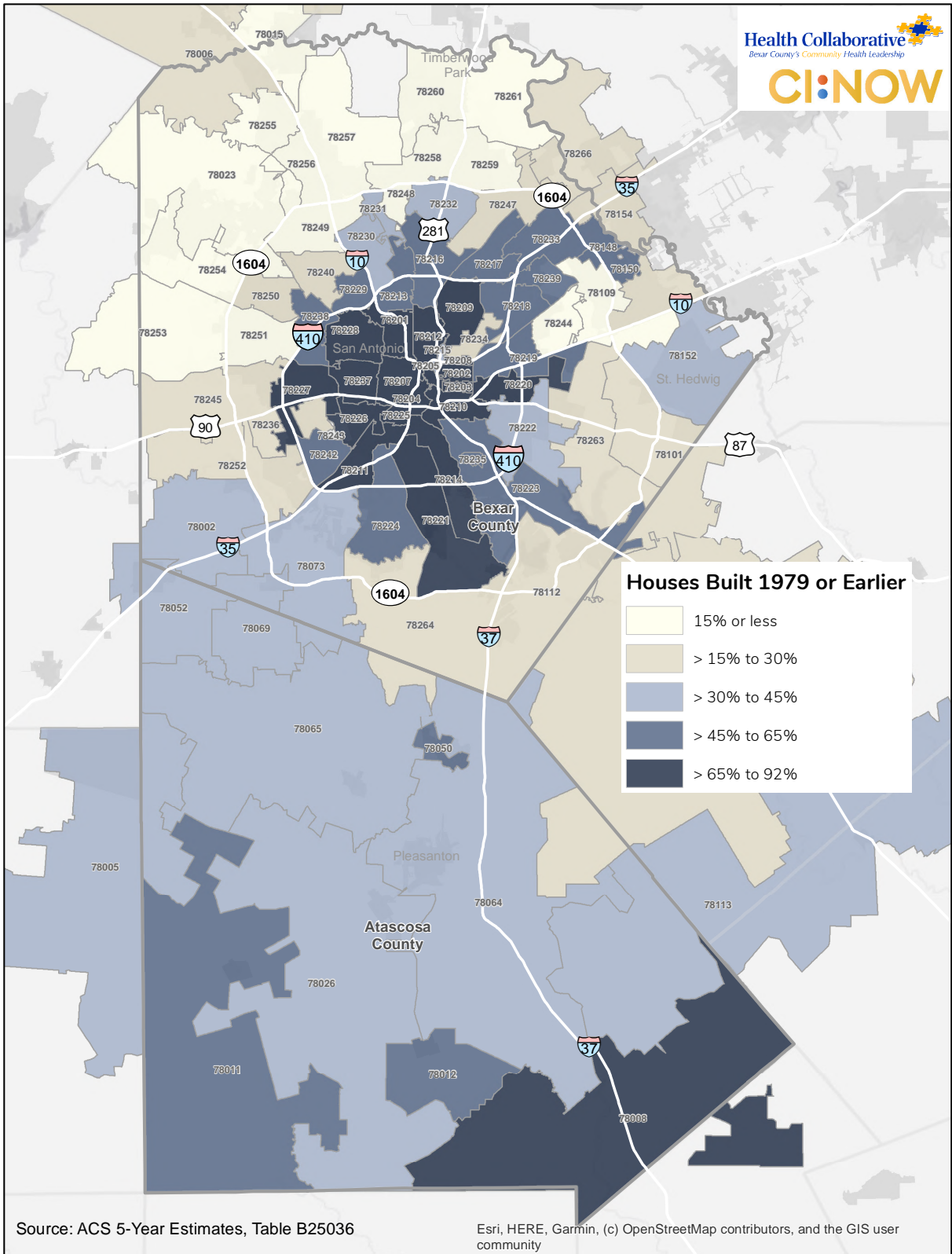In both counties half of housing units were built in the mid-1980s or later (Fig. 2.3.1) After considering margin of error, housing age distribution differs very little between the two counties, with one notable exception. Only an estimated 1% of occupied Atascosa housing units were built in the past five years as compared to about 5% in Bexar (Fig. 2.3.2), likely reflecting very different rates of new housing construction as the area recovered from the effects of the Great Recession. The above figures focused solely on occupied housing units, but Fig. 2.3.3 shifts to vacant units. While fewer years of data are available for Atascosa, the housing vacancy rate appears to be almost twice that of Bexar and consistent over time. In Bexar, vacant housing likely reflects both rapid new construction and neighborhood blight. With both a higher vacancy rate and much less of its housing stock built very recently, though, Atascosa vacancies are much less likely to represent brand-new homes awaiting occupancy.
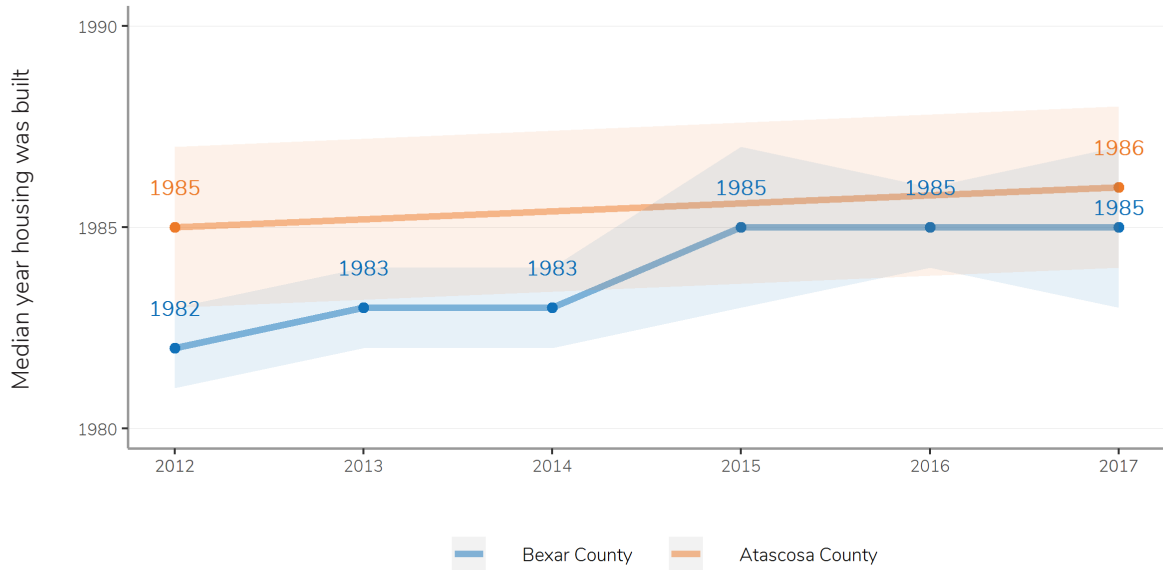
Related data

Social Conditions:
• Housing Stability and Homelessness

Fig. 2.3 Houses built in 1979 or earlier by zip code, 2017



Source: ACS 5-Year Estimates, Table B25036

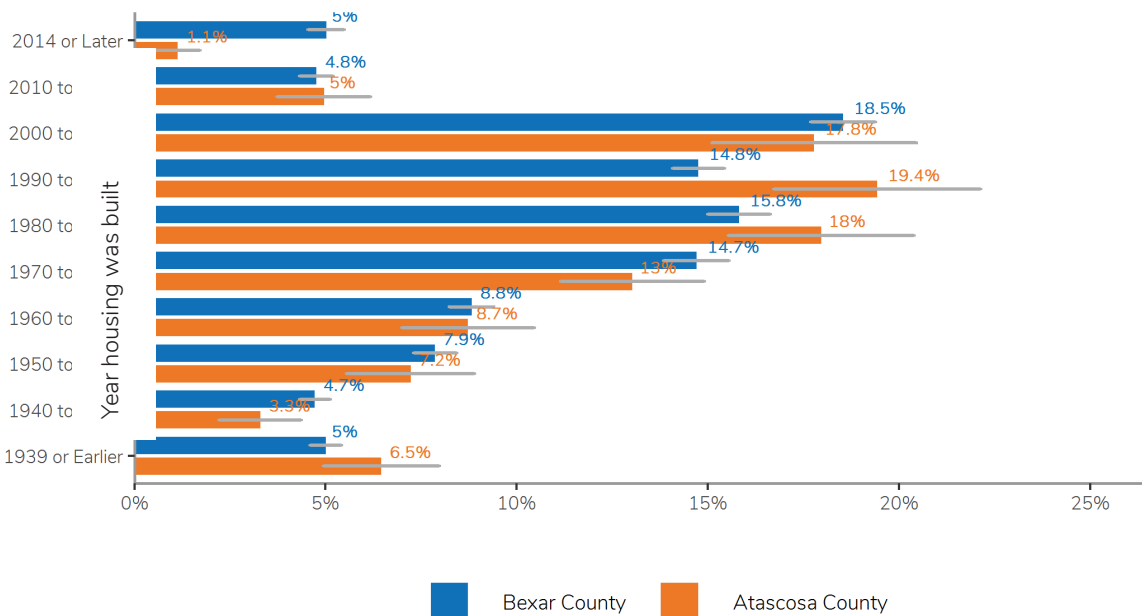Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

Fig. 2.3.1 Median year housing was built



*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B25035
Prepared by CI:Now for THC

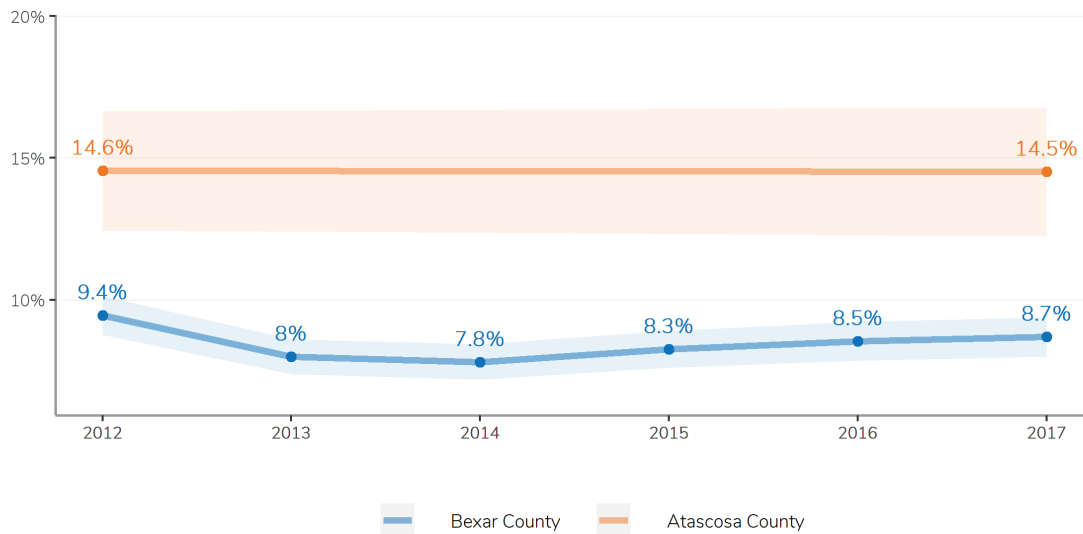Fig. 2.3.2 Percent of occupied housing units by year housing unit was built, 2017



*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B25036
Prepared by CI:Now for THC

Fig. 2.3.3 Percent vacant housing units



*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B25002
Prepared by CI:Now for THC

## Food and alcohol environment

Setting aside income and affordability for now, even geographic access to fresh produce and other healthy food varies greatly within the region. Inequitable geographic food access emerged as a focus group topic,[4] with participants agreeing that some neighborhoods *"like the southeast part of town"* do not have places to buy healthy or organic foods. Key informants also identified the disparity, noting lower access to healthy foods in south Bexar and rural areas. One interviewee argued that grocery stores need to act as partners to address community health goals collaboratively: *"In the places where diabetes is higher, the food in that grocery store needs to be different."*

Focus group participants mentioned farmers' markets and community gardens as sources of free or low-cost and healthy produce. Farmers markets are much less common than community gardens with just 18 in Bexar County. These farmers markets are largely clustered along Hwy. 281 from just south of downtown to Loop 410 (Fig. 2.4). Community gardens are largely concentrated in inner-ring (closest to downtown) neighborhoods and the near Northside (Fig. 2.4.1), although the map does include only Green Spaces Alliance gardens and does not display any garden not funded by or affiliated with Green Spaces Alliance.

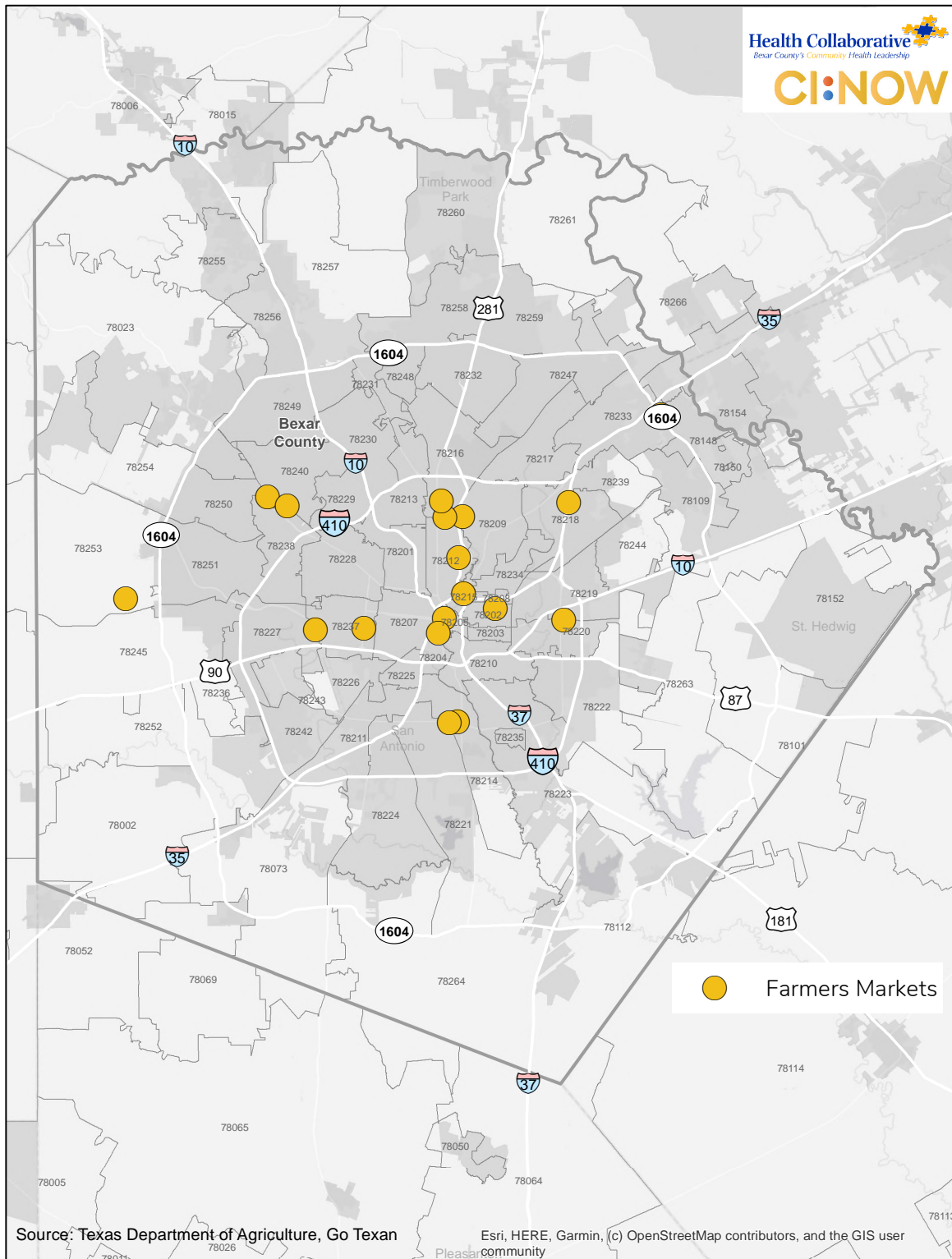**Related data**

Social Conditions:
• Food Insecurity

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Fig. 2.4 Farmers Markets in Bexar County, 2019



Source: Texas Department of Agriculture, Go Texan

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

Fig. 2.4.1 Community gardens by type, 2019
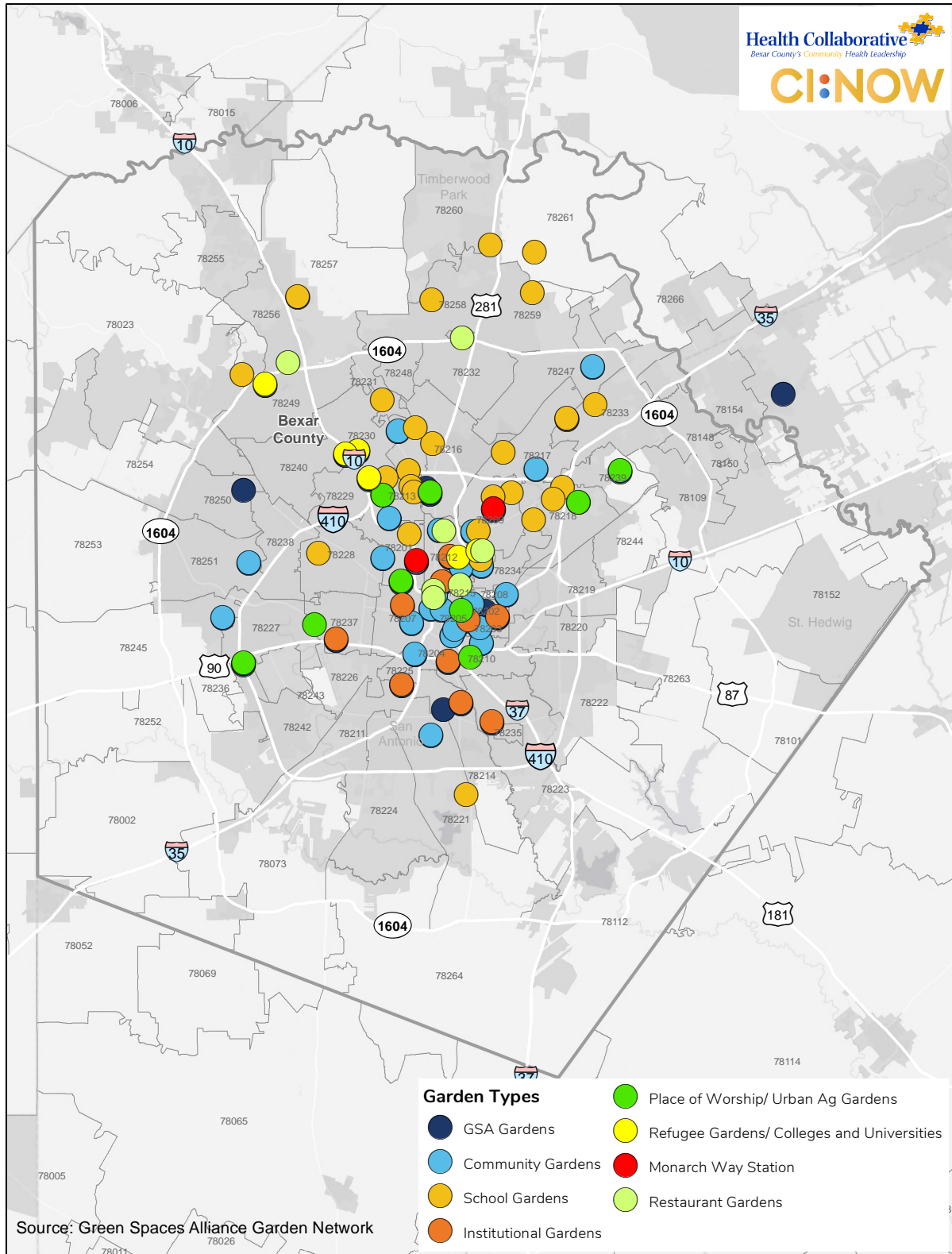
# Section 2: Physical Environment

High alcohol outlet density is known to be an environmental risk factor for excessive drinking and social harms among neighborhoods (e.g. disorderly conduct, public nuisance and property damage). The Guide to Community Preventive Services suggests that regulating alcohol outlets is an effective strategy for reducing excessive alcohol consumption and mitigating the related harms.[5] Retailers that sell alcohol for off-premises consumption – liquor or package stores – tend to be concentrated in certain geographic areas as well, but not the areas one might predict (Fig. 2.4.2). Small population sizes in a zip code have a tremendous effect on this indicator, causing the number of liquor stores per 100,000 population to appear quite high, as is the case for downtown (78205), lower Broadway (78215), and Camp Bullis (78257) in Bexar and the Lytle (78052) and Jourdanton (78026) areas in Atascosa. In a sparsely-populated zip code, even one liquor store appears to be a lot. When measuring alcohol outlet density, it is important to adjust measures based on the demographics of the population that is exposed. Figure 2.4.2 does not include grocery stores, small convenience stores, gas stations or pharmacies where some communities might be more likely to purchase alcohol.

However, in several other areas, the number of liquor stores compared to the population size is a higher ratio. The Pleasanton area (78064) has three liquor stores. Zip codes 78238 (Leon Valley/ Ingram Park), 78217 (Nacogdoches corridor between Loop 410 and Loop 1604), 78216 (Hwy 281/Loop 410), and 78209 (Alamo Heights, Terrell Hills, Mahncke Park) each have six liquor stores. The Stone Oak area (78258) has nine, the highest number in any zip code. A limitation of using a population-based measure is that alcohol outlets may attract customers who live outside the area and means it could be a less precise indicator of actual population at risk of exposure.[5]
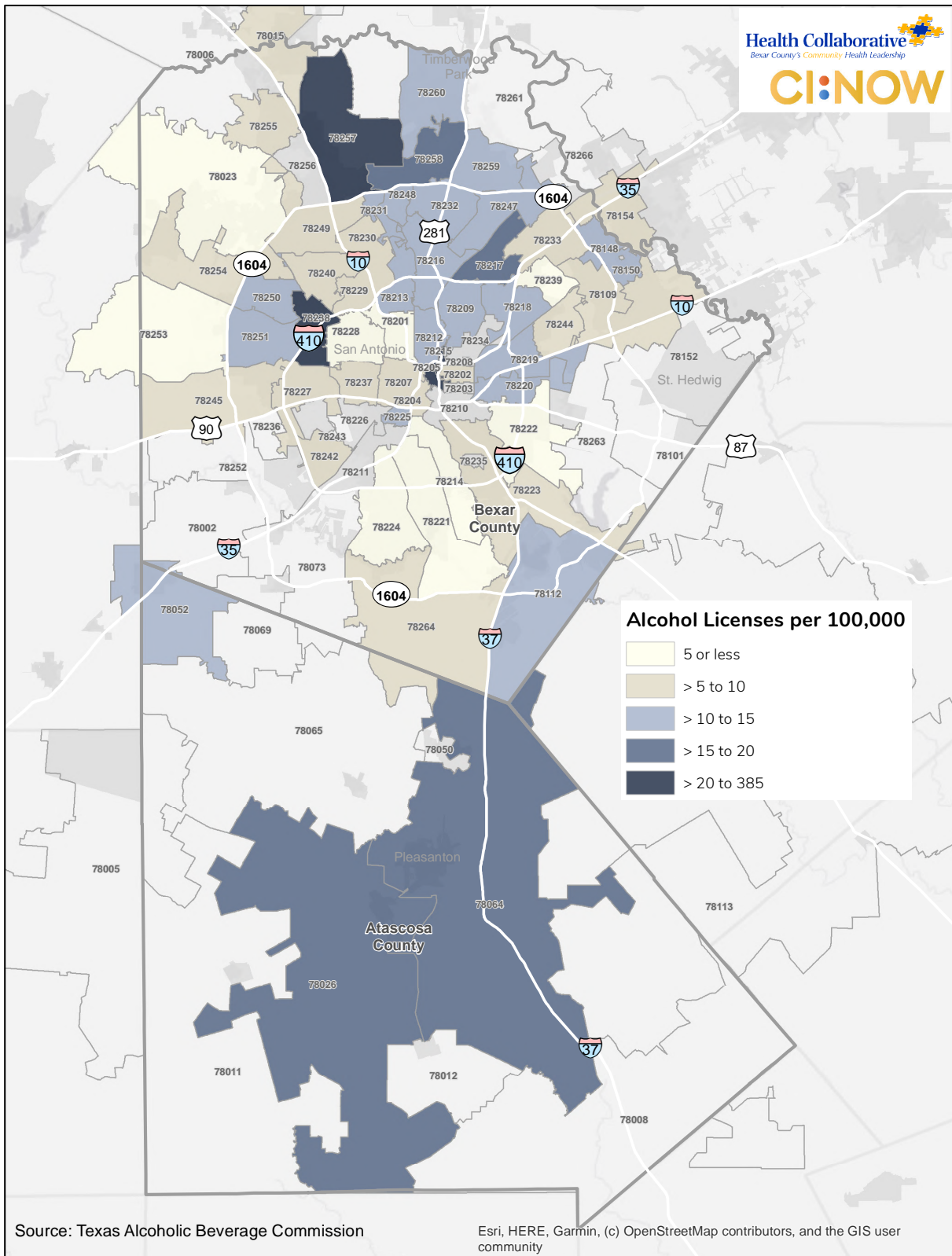
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5. Centers for Disease Control and Prevention. Guide for Measuring Alcohol Outlet Density. Atlanta,GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2017.

Fig. 2.4.2 Number of alcohol retailers selling for off-premise consumption per 100,000 population, 2019



**Alcohol Licenses per 100,000**

- 5 or less
- > 5 to 10
- > 10 to 15
- > 15 to 20
- > 20 to 385

Source: Texas Alcoholic Beverage Commission

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

## Other indicators of physical conditions

Poor sanitation and solid waste – trash – accumulation continue to be a major problem in some Bexar neighborhoods nine years after local media began covering the issue in the Camelot II neighborhood, near Windcrest on the northeast side.[6] Trash pickup has not been mandatory in many of these unincorporated neighborhoods, which have a large proportion of rental units owned by absentee landlords who live elsewhere and rarely visit the property. Without regular trash and bulky item collection, both illegal dumpers and some neighborhood residents leave kitchen waste, dirty diapers, mattresses, tv sets, and other waste to pile up as high as five feet on sidewalks; in yards, vacant lots, and ditches; and in the streets and alleys.[7] Left to rot, the piles give rise to seepage, rat overpopulation, and serious risks to public health and safety.[8] The problem has proved surprisingly difficult to solve.[9]

Focus group participants talked of several other aspects of the built environment that make it relatively easier or harder to be healthy. Safe and accessible spaces support active living and time with family, including neighborhood parks, walking paths and bike trails, sports fields and courts, and outdoor exercise equipment. Free-roaming dogs, poor park maintenance, and broken and missing sidewalks make it more difficult to stay active in the neighborhood. One focus group participant who had reported a bad sidewalk more than a year ago felt "*the city takes too long to change things.*"

Similar themes emerged from key informant interviews: "*there is work to do in the built environment and increase areas for people to be active in places closest to where they live and work,*" including sidewalks, bike lanes, and trails to integrate neighborhoods and parks; places to be physically active; and better geographic access to healthy food. Those interviews also recognized great disparities in physical conditions and assets among neighborhoods.

6. Gonzalez, J. W. (2013, March 27). Legislative push is on to clean up East Bexar. San Antonio Express-News. Retrieved from https://www.mysanantonio.com/news/local_news/article/Legislative-push-is-on-to-clean-up-East-Bexar-4389567.php
7. See for example Express-News Editorial Board. (2015, August 24). Smelly trash woes remain in Camelot II. San Antonio Express-News. Retrieved from https://www.expressnews.com/opinion/editorials/article/Smelly-trash-woes-remain-in-Camelot-II-6458442.php
8. See for example Express-News Editorial Board. (2015, June 29). Neglect at Camelot II spawns public health hazard. San Antonio Express-News. Retrieved from https://www.mysanantonio.com/opinion/editorials/article/Neglect-at-Camelot-II-spawns-public-health-hazard-6352325.php
9. See for example Brodesky, J. (2019, May 4). Why is it so hard to fix Bexar's trash problems? San Antonio Express-News. Retrieved from https://www.houstonchronicle.com/opinion/columnists/josh_brodesky/article/Why-is-it-so-hard-to-fix-Bexar-s-trash-problems-13818165.php

## Educational performance and attainment

Education and health are related. Health literacy is the ability to understand basic health information in order to make health decisions. In general, health literacy tends to be lowest among those with lower education levels, racial/ethnic minorities and the elderly. In fact, over three-quarters of adults with less than a high school degree were at or below the basic level of health literacy according to the National Assessment of Adult Literacy (2003).[1]

As is the case in the U.S. as a whole, Bexar has seen only modest gains in the high school graduation rate in the past five years (Fig. 3.1); Atascosa's improvements have been steeper, but of course with a much smaller number of 9th graders – fewer than 650 students – on which to base that rate. Atascosa's current graduation rate is significantly higher than Bexar's, indicating that the relatively lower educational attainment noted earlier is heavily influenced by the county's older population. Disparities by race/ethnicity are notable in both counties. The Bexar and Atascosa graduation rates are 93% and 98%, respectively, among non-Hispanic white students; 86% and 91% among Hispanic students; and 86% and 100% among African American students.[2] Again, the denominators for Atascosa are quite small, fewer than 50 students for the African American graduation rate, so a small number of students can have a dramatic effect on the graduation rate.

Fig. 3.1 Four-year longitudinal high school graduation rate without exclusions
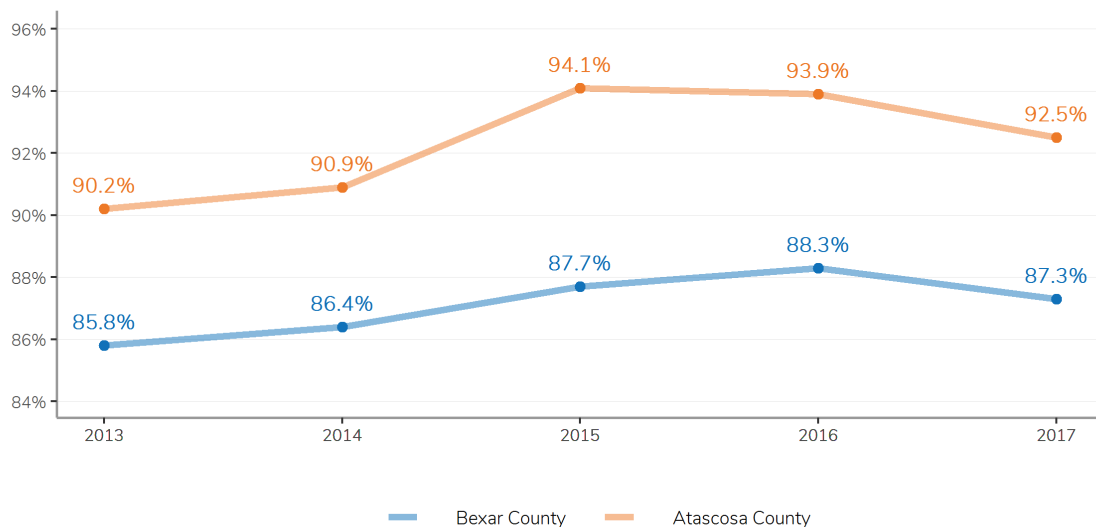


*Unreliable: Error is too large relative to estimate
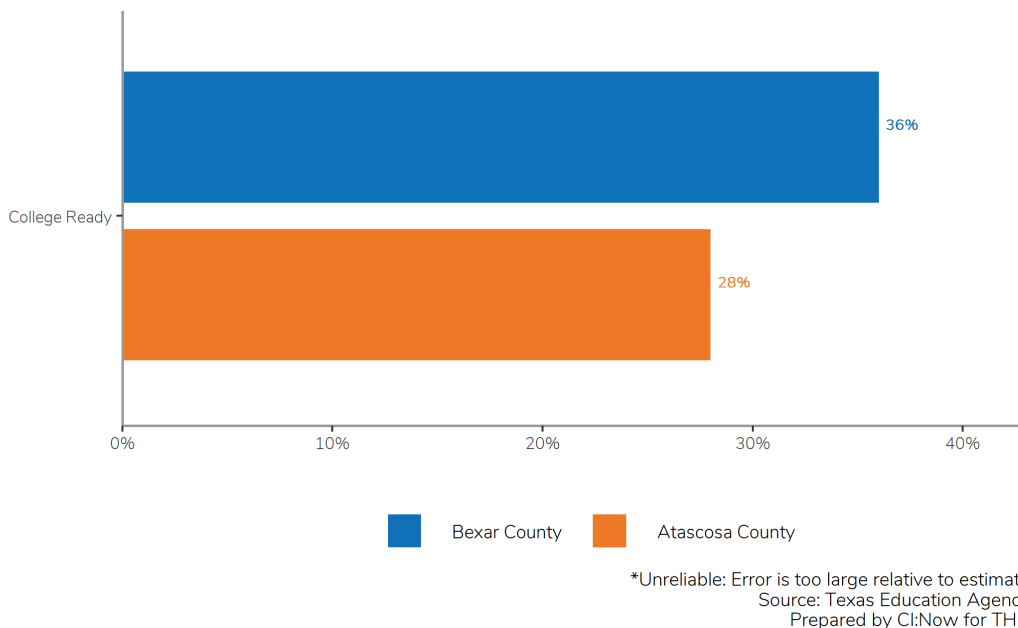Source: Texas Education Agency
Prepared by CI:Now for THC

1. America's Health Literacy: Why We Need Accessible Health Information. Retrieved from https://health.gov/communication/literacy/issuebrief/#lower
2. Completion, Graduation, and Dropouts. (2018, June 12). Retrieved from https://tea.texas.gov/acctres/dropcomp_index.html.

# Section 3: Social Environment

Just over a third of Bexar high school graduates and just over a quarter of Atascosa graduates are considered college-ready in English and math (Fig. 3.1.1). College-readiness cannot be trended because the way the indicator is measured has changed several times in recent years.

Fig. 3.1.1 Percent of high school graduates testing college-ready in English and math, 2018



College Ready

36%

28%

0%    10%    20%    30%    40%

Bexar County        Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Education Agency
Prepared by CI:Now for THC

Health literacy is lowest among the more vulnerable members of our communities. While the data has not been updated from that presented in the 2016 assessment, the geographic distribution of health literacy likely has not changed, with the lowest health literacy scores appearing in Bexar neighborhoods inside Loop 410 (Fig. 3.1.2).

The historical context of educational attainment in the U.S. is helpful to know. Although the proportion of U.S. adults with a high school diploma or GED has climbed dramatically from 14% in 1910 to 88% in 2015, the trend line has flattened almost entirely in the past five years and disparities remain serious.[3]

In 1940, for example, 24% of adult white (non-Hispanic) males and 28% of white females had a high school diploma or GED, as compared to 7% of black males and 8% of black females. Statistics for Hispanics are not available for years prior to 1980. In 2015 those percentages were 93% for white males, 94% for white females, 87% for black males, 88% for black females, 66% for Hispanic males, and 68% for Hispanic females. The overall gap by race/ethnicity has narrowed over the past century, but it has not closed, and disaggregation by neighborhood rather than solely race/ethnicity would likely show a gap as wide as in 1940.
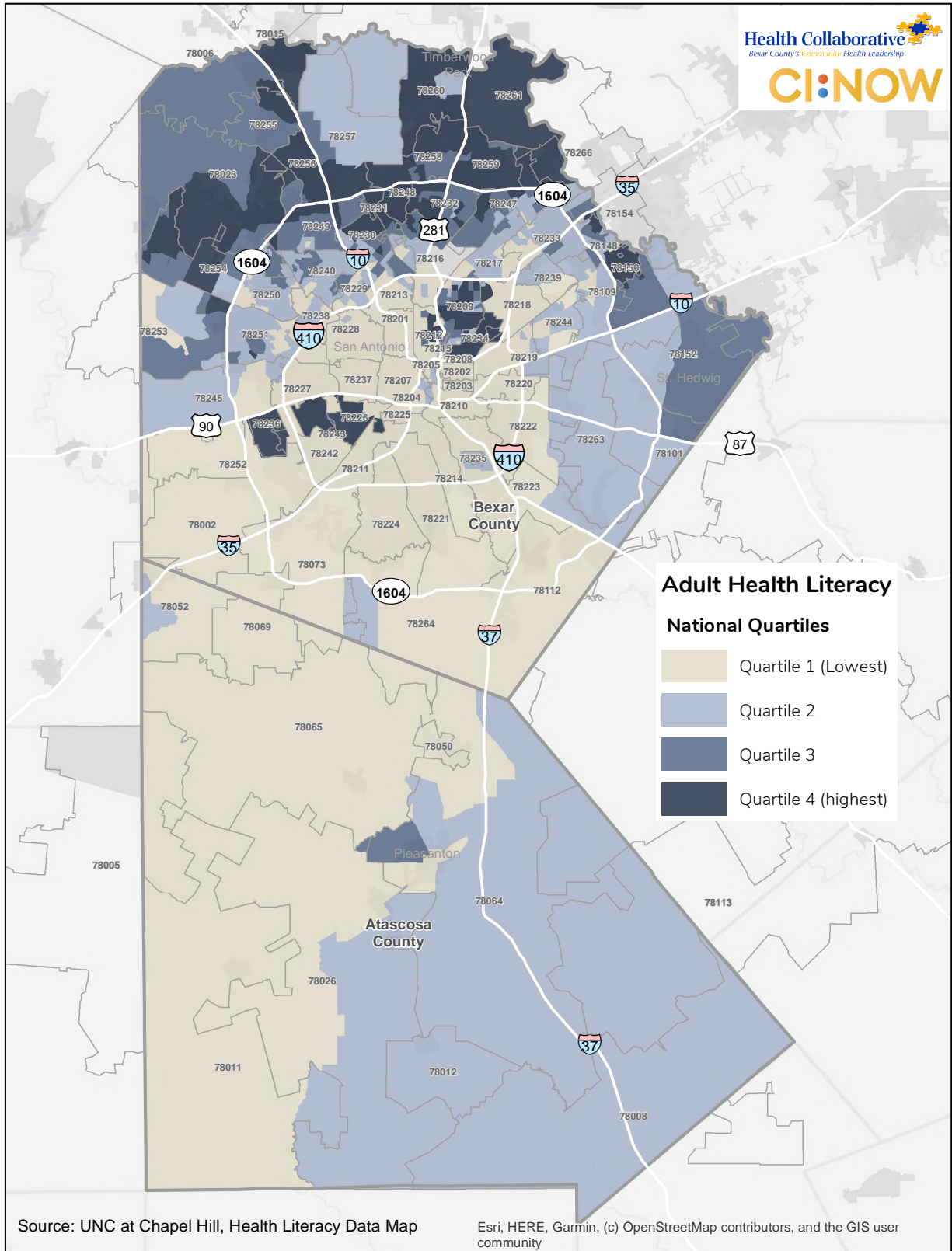
Indeed, an estimated 85% of Bexar adults 25 and older have at least a high school degree or diploma, but that figure is only 75% in Atascosa (Fig. 3.1.3). The proportions of adults with an Associates, Bachelor's, or graduate or professional degree are also higher in Bexar. Combining those groups (Fig. 3.1.4), about one in three Bexar adults and one in six Atascosa adults has an Associates or higher-level degree. When mapped (Fig. 3.1.5), the distribution of educational

3. Snyder, T.D., de Brey, C., and Dillow, S.A. (2016). Digest of Education Statistics 2015 (NCES 2016-014). National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education. Washington, DC.

# Section 3: Social Environment

Fig. 3.1.2 National Assessment of Adult Literacy (NAAL) national quartile ranking by census tract, 2015



**Adult Health Literacy**

**National Quartiles**

- Quartile 1 (Lowest)
- Quartile 2
- Quartile 3
- Quartile 4 (highest)

Source: UNC at Chapel Hill, Health Literacy Data Map

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

attainment closely mirrors the distribution of race/ethnicity in both counties, reflecting the racial/ethnic disparities that have persisted in the U.S. as a whole. The highest percentages of adults with an Associates or higher appear in Bexar and Atascosa zip codes with higher proportions of non-Hispanic whites, and the lowest percentages appearing in zip codes with higher proportions of Hispanics. Again, educational attainment can vary quite dramatically by age within any racial/ethnic group, and a map of educational attainment of people aged 25 to 39 rather than 25 and older might show a very different pattern.

Fig. 3.1.3 Percent of population 25 years and over by highest level of education completed, 2017
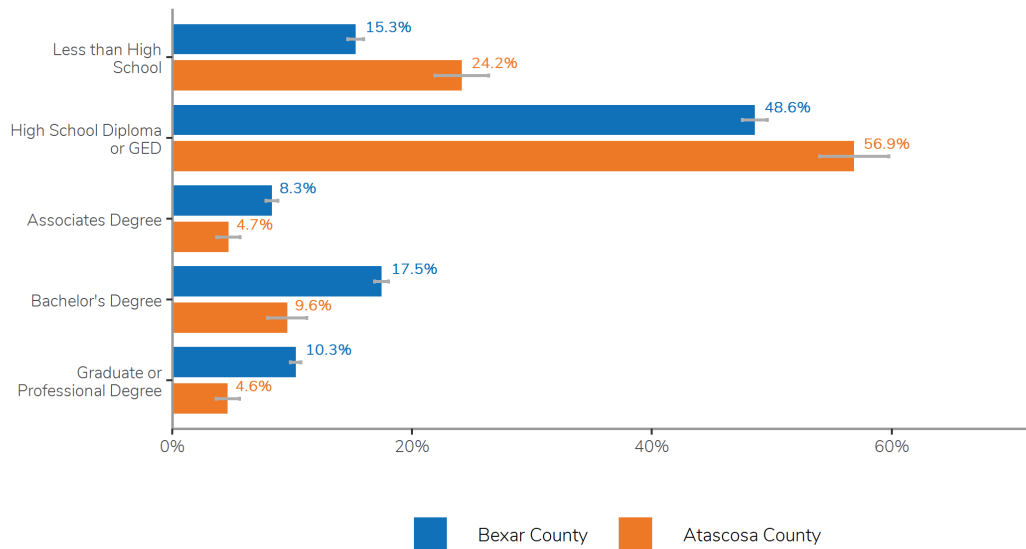


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:C15002, B15003
Prepared by CI:Now for THC

Fig. 3.1.4 Percent of population 25 years and over who earned associates degree or higher
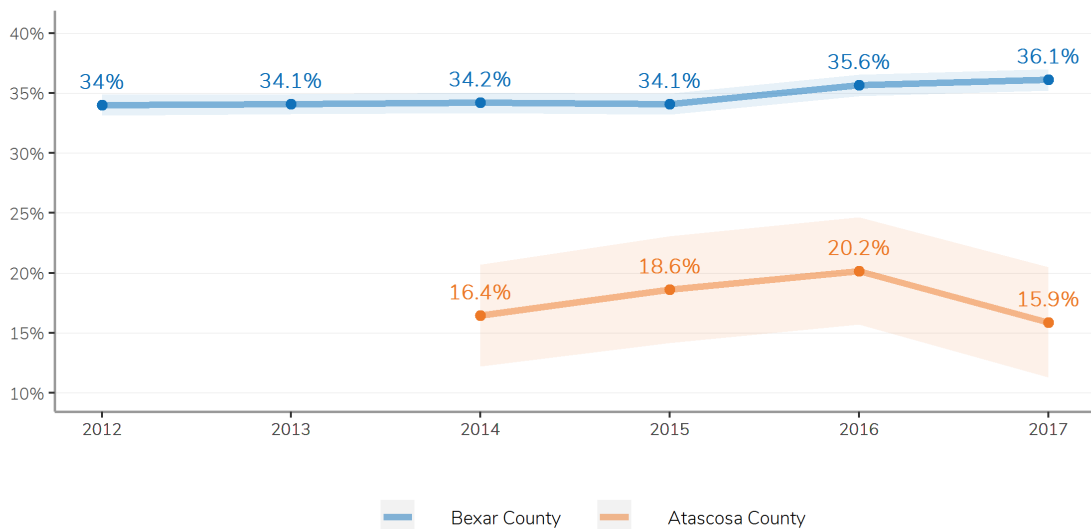


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 1-Year Supplemental Estimates. Table:C15002, B15003, K201501
Prepared by CI:Now for THC

Fig. 3.1.5 Percent of population 25 years and over who earned associates degree or higher by zip code, 2017



Associates Degree or Higher
- > 7% to 16%
- > 16% to 27%
- > 27% to 38%
- > 38% to 53%
- > 53% to 72%

Source: ACS 5-Year Estimates, Table B15002

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
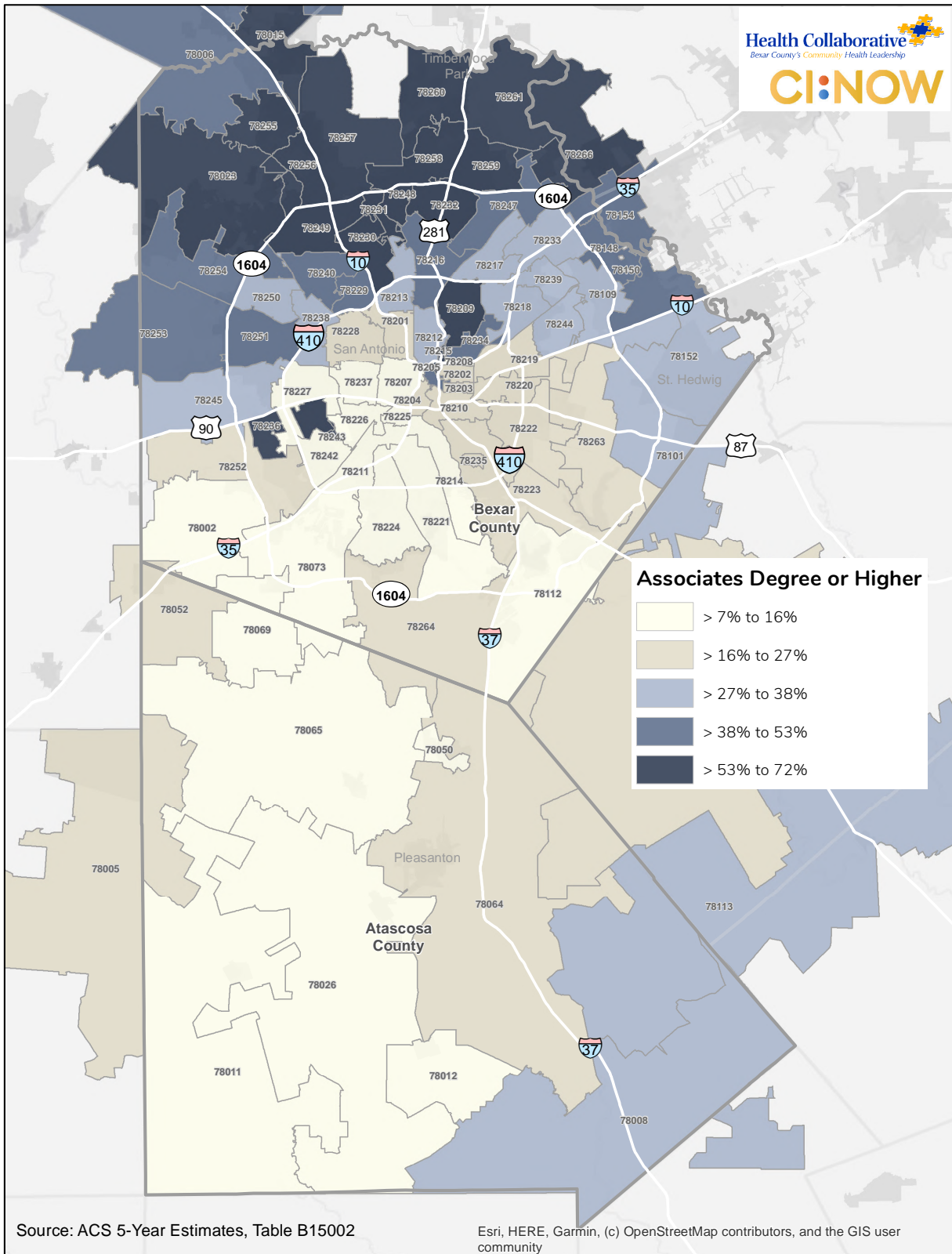
## Housing stability and homelessness

Housing stability and homelessness are also interrelated with health and well-being. The percentage of occupied housing units that are renter-occupied remained stable in Bexar at about four in 10 from 2012 through 2017 (Fig. 3.2) and decreased for Atascosa, dropping to an estimated one in five in 2017. The margin of error is wide, however, making the trend uncertain, and with more recent data available, the percentage might trend upward again.

> **Related data**
>
> Physical Conditions:
> ● Age of Housing

Fig. 3.2 Percent of renter-occupied housing units
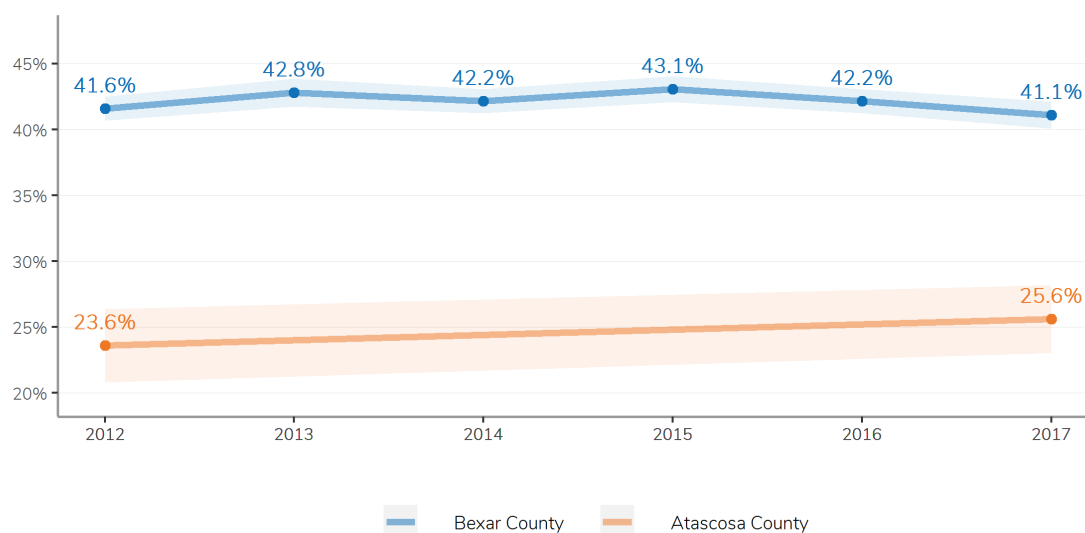


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B25003
Prepared by CI:Now for THC

The zip codes with the highest proportions of renter-occupied units in Bexar appear to be those with an inherently transient population or a large number of apartments or other housing rentals: the military bases, the lower Broadway and Medical Center areas, and the 281 corridor north and south of Loop 1604 (Fig. 3.2.1). Zip code 78065, the Poteet area, has the highest proportion in Atascosa.

While there is no question that Bexar suffers a shortage of affordable housing units, the severity of that shortage can vary quite a bit depending on how affordability is defined and the indicator measured. A recent report prepared for the Mayor's Housing Policy Task Force puts the shortage –"supply/demand mismatch" in that document – at 32,000 rental units for renter households with incomes under 30% of the area median income (AMI), currently $14,780. The report estimated a shortage of 2,400 units relative to demand among renter households between 30% and 60% AMI ($29,561).[4]

The proportion of total households considered cost-burdened, meaning that housing costs consume 30% or more of household income, decreased substantially in Atascosa but remained level in Bexar between 2012 and 2017 (Fig. 3.2.2), although again, once it becomes available,
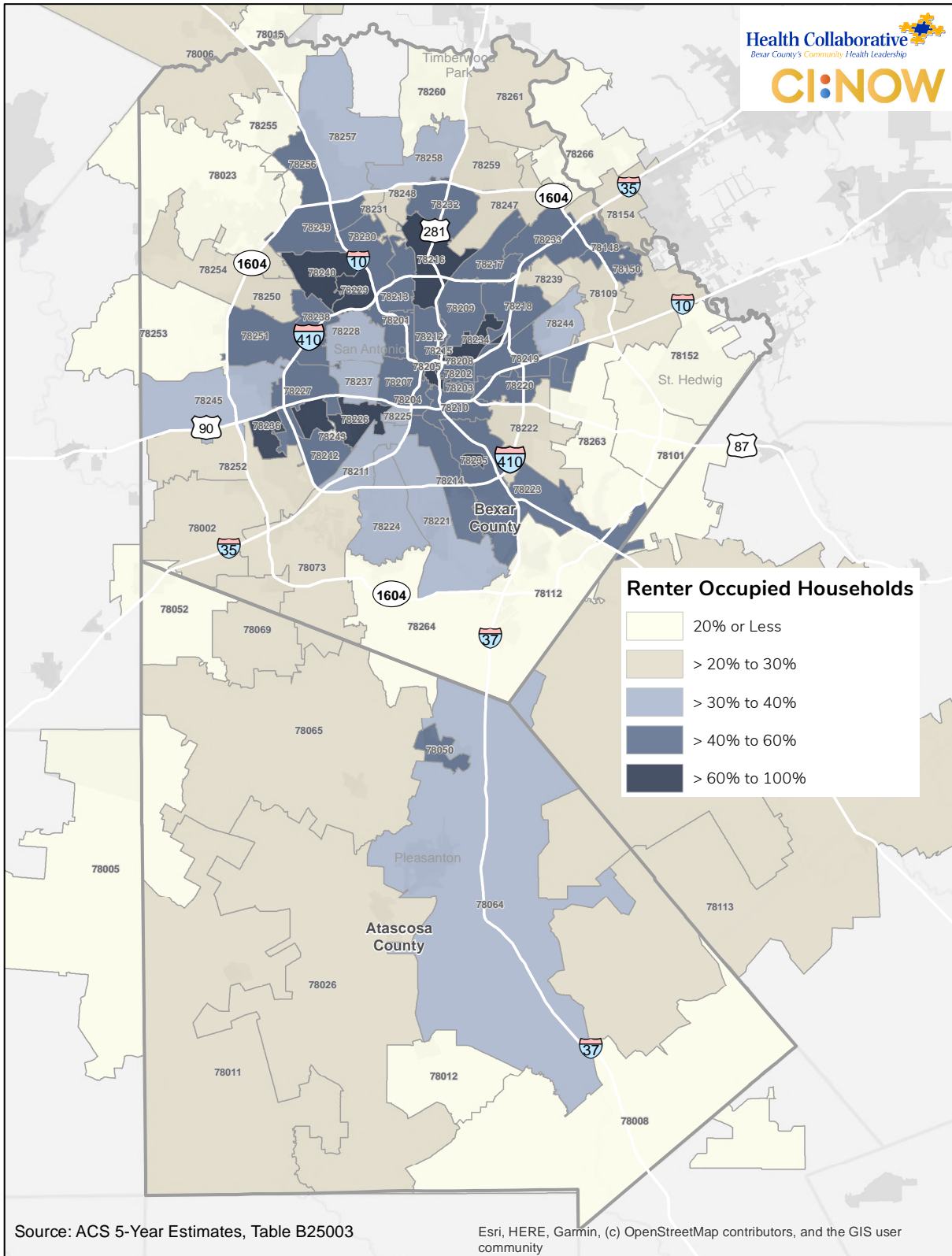
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4. Mayor's Housing Policy Task Force (2018). San Antonio's housing policy framework: The cornerstone of economic development. Retrieved from City of San Antonio website: https://www.sanantonio.gov/Portals/0/Files/HousingPolicy/Resources/SA-HousingPolicyFramework.pdf

Fig. 3.2.1 Percent of renter-occupied housing units, 2017



**Renter Occupied Households**

- 20% or Less
- > 20% to 30%
- > 30% to 40%
- > 40% to 60%
- > 60% to 100%

Source: ACS 5-Year Estimates, Table B25003
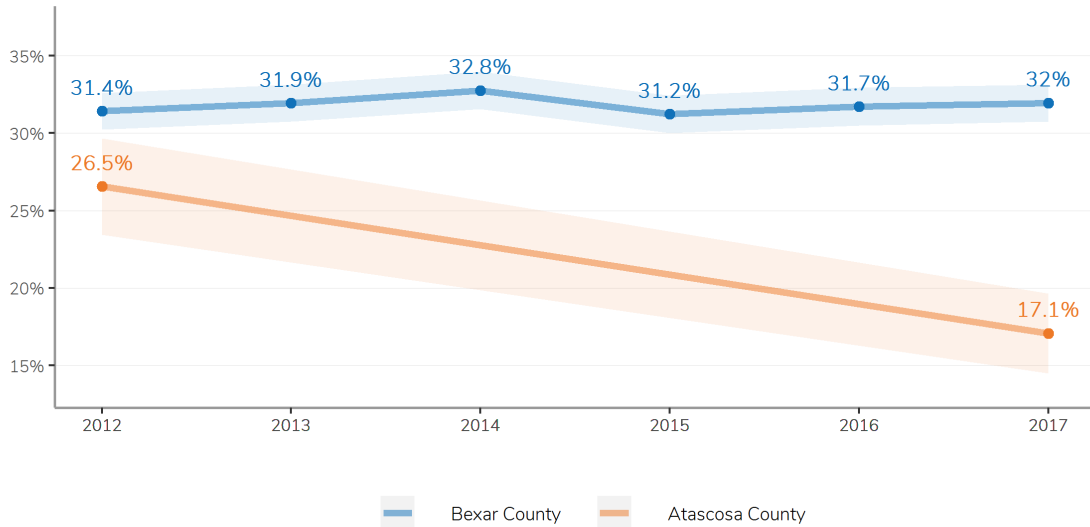
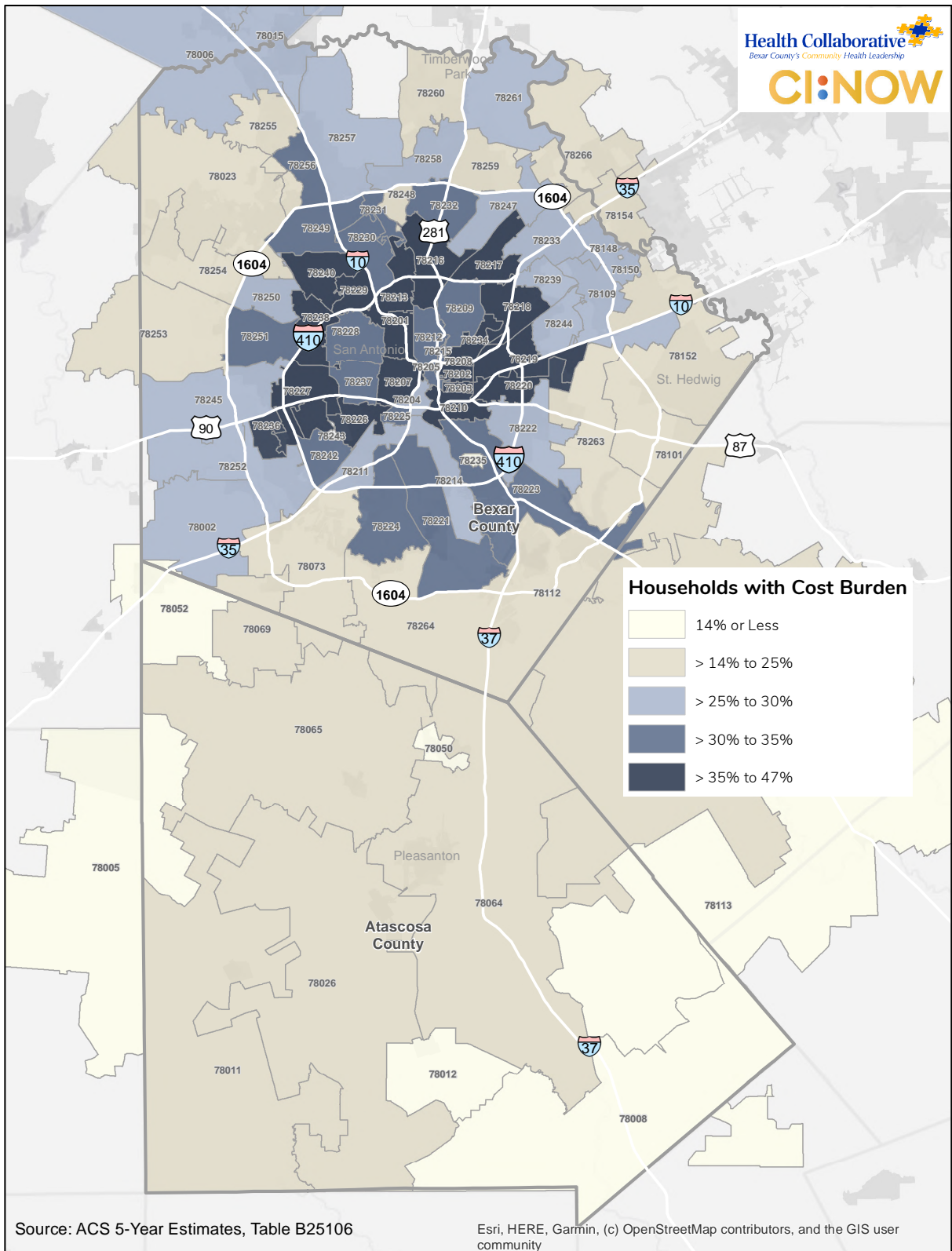Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

more recent data will likely show an uptick in Bexar. The factors behind the decrease in Atascosa are not clear; while household income has risen over the period, housing costs have risen as well.

Fig. 3.2.2 Percent of occupied housing units where housing costs or rent is 30%+ of household income



Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B25106
Prepared by CI:Now for THC

Fig. 3.2.3 Percent of occupied housing units where housing costs or rent is 30%+ of household income by household type, 2017
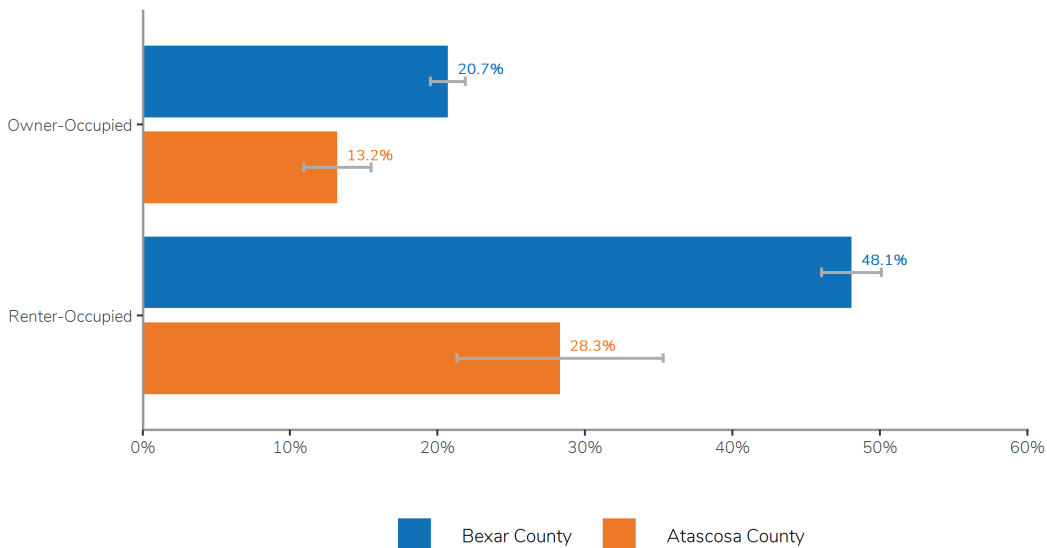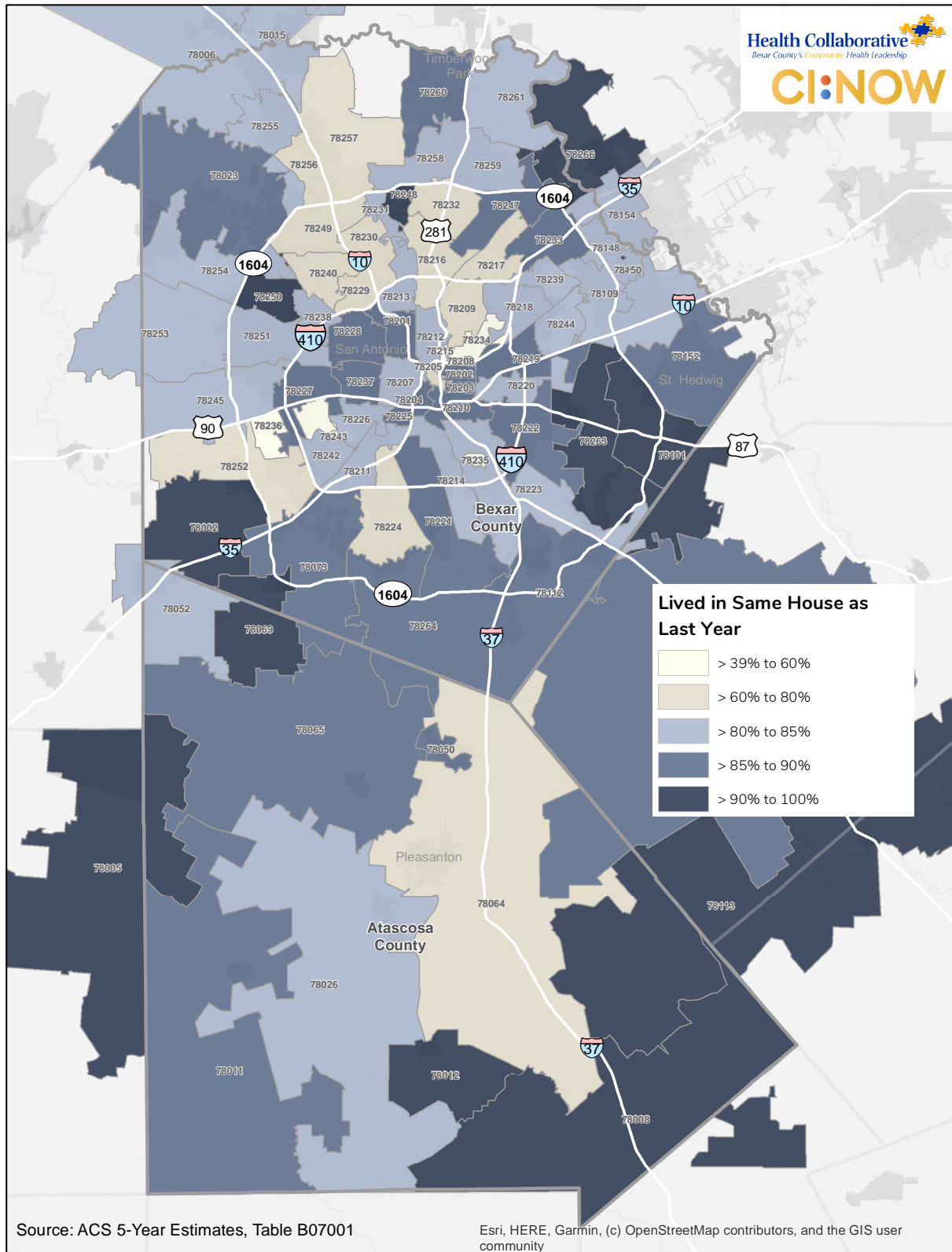


Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B25106
Prepared by CI:Now for THC

Fig. 3.2.4 Percent of occupied housing units where housing costs or rent is 30%+ of household income by zip code, 2017



Households with Cost Burden

- 14% or Less
- > 14% to 25%
- > 25% to 30%
- > 30% to 35%
- > 35% to 47%

Source: ACS 5-Year Estimates, Table B25106

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# Section 3: Social Environment

Half of Bexar renter-occupied households are cost-burdened as compared to only one in five owner-occupied households (Fig. 3.2.3). The same disparity holds in Atascosa as well, although the proportion of households cost-burdened is 35% to 40% lower for both renter- and owner-occupied households.

All Atascosa zip codes and Bexar's outlying zip codes have the lowest percentages of households cost-burdened (Fig. 3.2.4). The Bexar zip codes with the highest percentages are largely north of the Hwy 90/Hwy 87 line. The medium-blue zip codes inside Loop 410 – 78209, 78212, 78228, and 78237 – include an array of neighborhoods that are very different in terms of income,

Fig. 3.2.5 Percent of total population 1 year and older living in the same house within 1 year prior
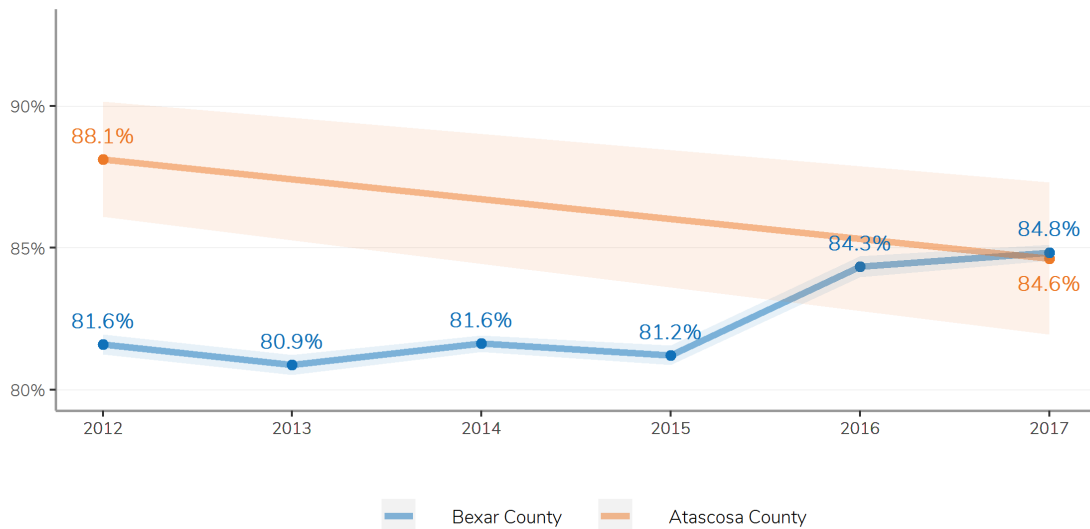


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B07001
Prepared by CI:Now for THC

Fig. 3.2.6 Percent of total population moving in to county by previous residence, 2017
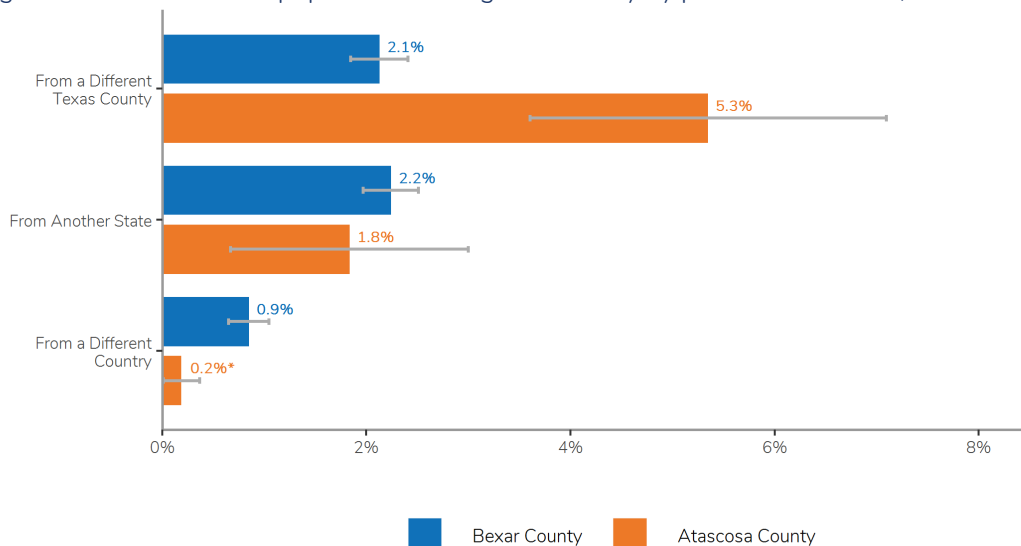


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B07001
Prepared by CI:Now for THC

Fig. 3.2.7 Percent of total population 1 year and older living in the same house within 1 year prior by zip code, 2017



Source: ACS 5-Year Estimates, Table B07001

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

**Lived in Same House as Last Year**

- \> 39% to 60%
- \> 60% to 80%
- \> 80% to 85%
- \> 85% to 90%
- \> 90% to 100%

housing costs, and housing stock. About a third of households are considered cost-burdened in each of these four zip codes, but the factors driving that cost burden likely differ considerably by neighborhood.

Depending on context, residential mobility can be an indicator of housing instability; obviously high mobility rates on a military base, in an older, high-poverty neighborhood, and in a new-construction neighborhood are not all driven by the same factors. As measured by percent of population living in the same house as one year ago, residential mobility appears to be increasing slightly in Bexar and decreasing slightly in Atascosa, both now standing about 85% (Fig. 3.2.5). Of the population that moved to the county within the past year, roughly equal shares of Bexar in-migrants came from a different Texas county versus a different state, while most Atascosa in-migrants came from a different Texas county. In-migration from a different country accounted for a tiny fraction in both counties (Fig. 3.2.6). Outside of Bexar's military bases, the zip codes with the lowest percent of people living in the same house as last year appear to be around the larger towns in Atascosa and around areas of new housing construction, the Medical Center, lower Broadway near the Pearl, and the UT San Antonio and Texas A&M San Antonio campuses (Fig. 3.2.7).

Eviction is gaining attention in Bexar as the rate of increase in housing cost continues to outstrip the rate of income growth. Court-ordered eviction data from the Eviction Lab[5] seem to imply no serious eviction issue in either county (Fig. 3.2.8), but county figures mask large disparities among neighborhoods, with the number of eviction filings per 100 renter homes ranging from zero to more than 15 (Fig. 3.2.9). Eviction data in itself grossly underestimates the true frequency of renters being forced out for falling behind on rent, as most such situations end with the tenant leaving prior to and in anticipation of an eviction filing, or after the filing but before a forcible eviction.
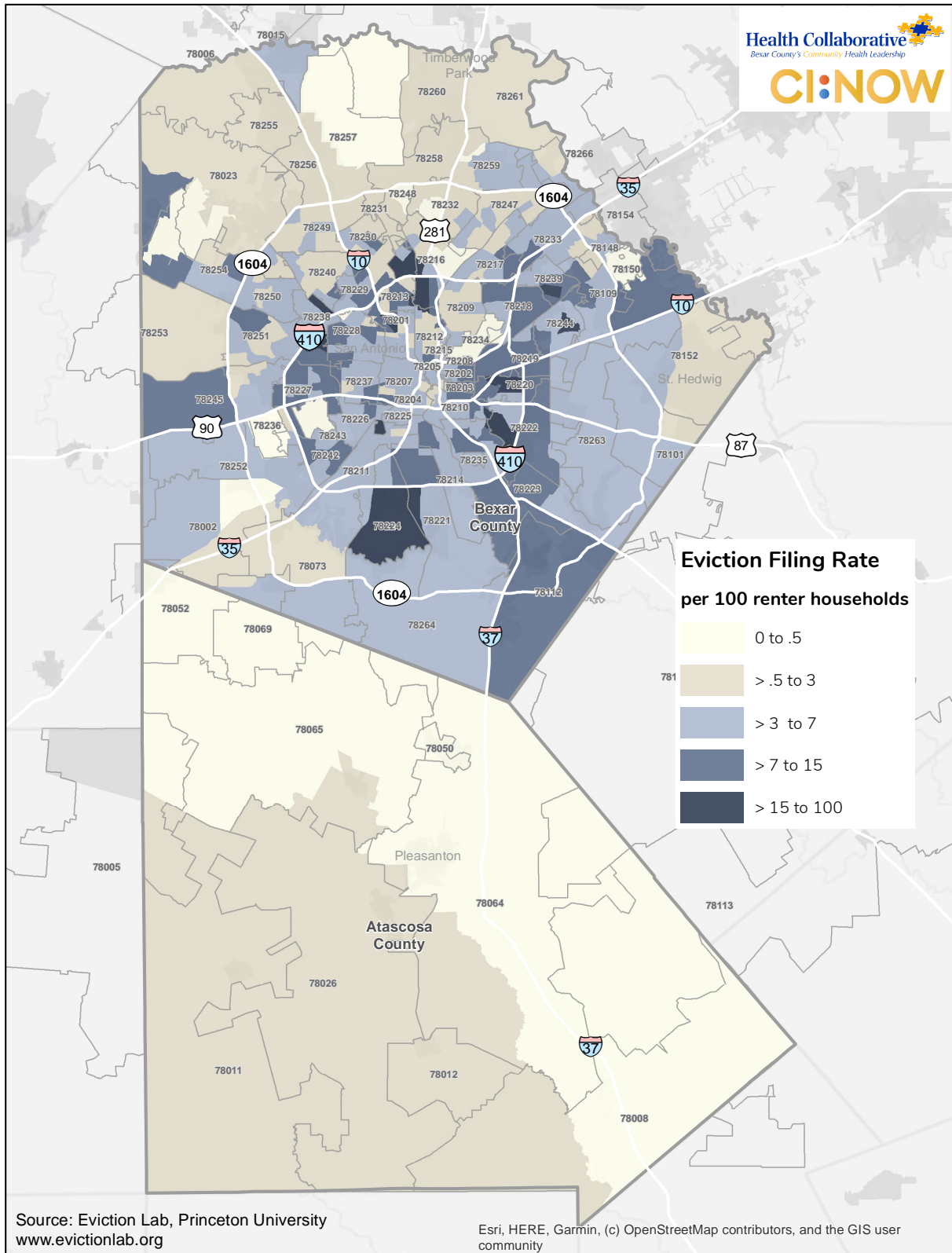
Fig. 3.2.8 Rate of eviction filings per 100 renter homes
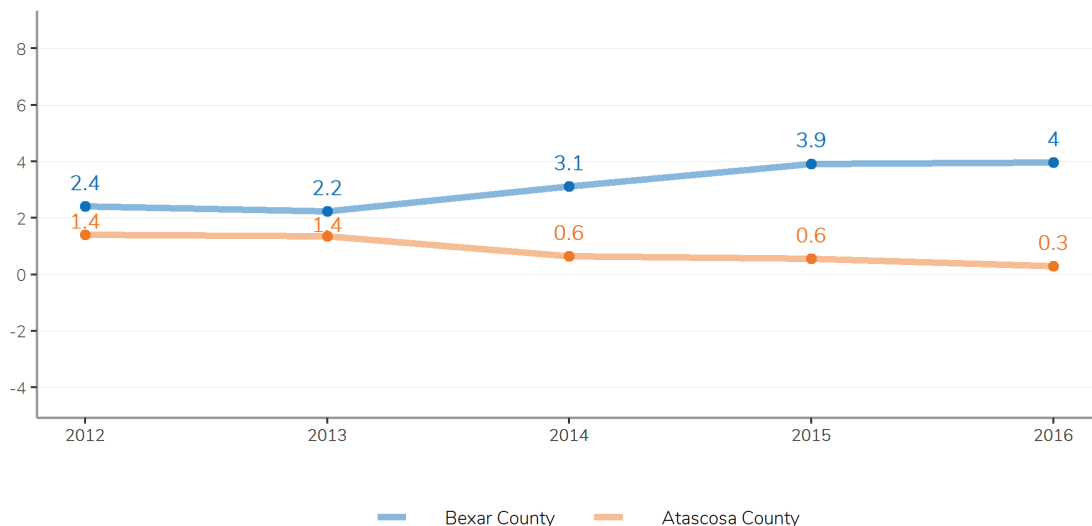


*Unreliable: Error is too large relative to estimate
Source: Eviction Lab, Princeton University, www.evictionlab.org
Prepared by CI:Now for THC

5. Methodology Report: Matthew Desmond, Ashley Gromis, Lavar Edmonds, James Hendrickson, Katie Krywokulski, Lillian Leung, and Adam Porton. Eviction Lab Methodology Report: Version 1.0. Princeton: Princeton University, 2018, www.evictionlab.org/methods.

Fig. 3.2.9 Rate of eviction filings per 100 renter homes by census tract, 2016



Eviction Filing Rate
per 100 renter households

- 0 to .5
- > .5 to 3
- > 3 to 7
- > 7 to 15
- > 15 to 100

Source: Eviction Lab, Princeton University
www.evictionlab.org

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

# Section 3: Social Environment

Homelessness is measured by an annual point-in-time count. It is a one-night snapshot to provide local planners with live data about how many and who is homeless but it can show "bounce" that might not reflect true change in the number. The number of *sheltered* and unsheltered homeless persons has decreased slightly but that should be interpreted with caution (Fig. 3.2.10 and 3.2.11). The total point-in-time count for 2019 includes 274 sheltered and unsheltered families with a combined total of 806 adults and 520 children under 18, about three-quarters of whom were living in an emergency shelter. No such data is available for Atascosa.

Fig. 3.2.10 Number of sheltered homeless persons
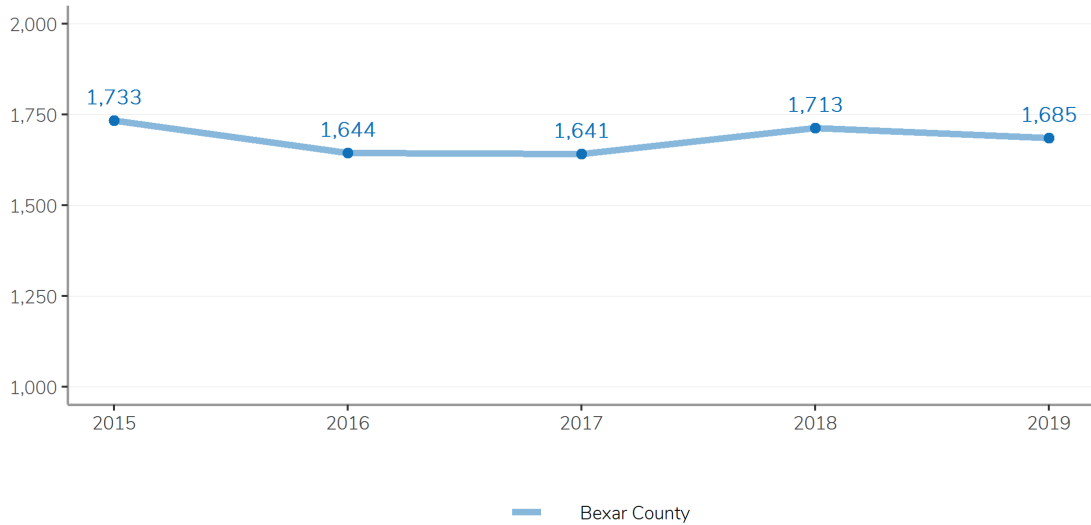


Bexar County

*Unreliable: Error is too large relative to estimate
Source: South Alamo Regional Alliance for the Homeless
Prepared by CI:Now for THC

Fig. 3.2.11 Number of unsheltered homeless persons
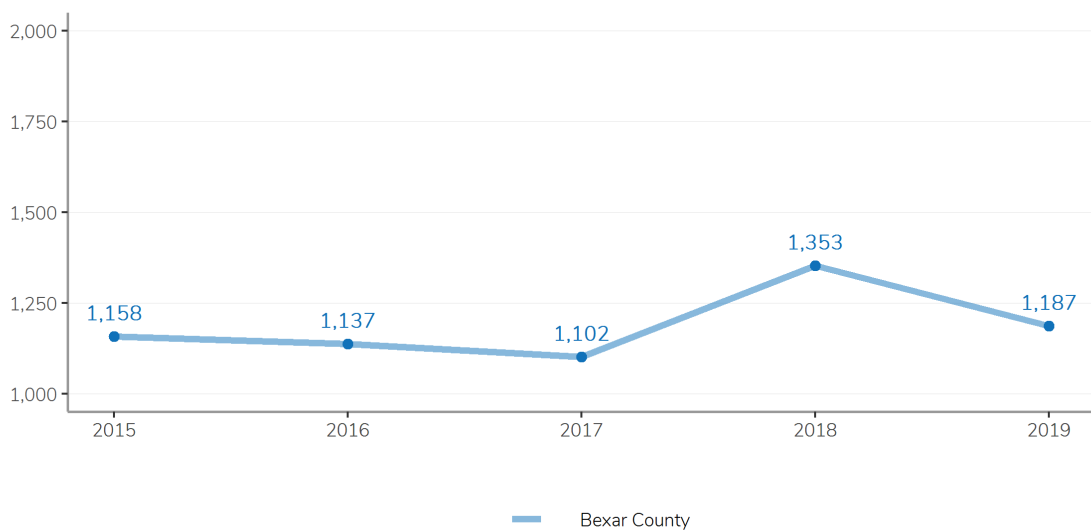


Bexar County

*Unreliable: Error is too large relative to estimate
Source: South Alamo Regional Alliance for the Homeless
Prepared by CI:Now for THC

# Section 3: Social Environment

## Crime and safety

Focus group participants[6] talked about some Bexar County neighborhoods being safer than others, and spoke of living with so much crime that they don't even know what a safe community looks like. Participants mentioned an array of neighborhood safety concerns, including human trafficking, guns, robbery, drug crimes, stray dogs, bad sidewalks, poor lighting, domestic abuse, and sex offenders. Insufficient police surveillance and patrols and slow response time were seen as a problem by some, as was poor trust between neighborhood residents and police.

"Alamo Heights. Only those communities are safe."
"This side of town is not safe compared to other sides of town like the northside. (...) This side is the unsafest part of San Antonio."
"Watch behind your back."

The key informants interviewed also recognized community safety as a priority, listing much the same inventory of issues voiced by focus group participants. They pointed out that there is *"not a lot out there to promote safety – all efforts respond after the violence has occurred."* They also recognized the need to build the community's trust in policy, and for police to build relationships with the community. *"Take domestic violence as an example. Safety is promoted when security officers work with nonprofits to develop the best training and sensitivity to situations and build relationships."*

Before reviewing county crime data, it is important to note some of its limitations. Actual safety and perceived safety often do not go hand-in-hand, crime types and levels vary across neighborhoods, and conditions that are or feel safe to one person may legitimately be or feel *unsafe* to another person.[7]

Mirroring the national figure and exceeding most other large Texas cities, just under six in 10 respondents to a survey[8] conducted on behalf of the City of San Antonio rate their overall feeling of safety as "excellent" or "good" (Fig. 3.3). With a ±3% margin of error, the year-over-year change is small. No such data is available for Atascosa.

Box 5
Numbers, rates, and volatility

A *rate* represents the *number* of events or cases *relative* to the total number of people (or housing units, etc.) who potentially could have experienced that event or case. For example, we want to show number of confirmed victims of child abuse and neglect relative to the number of *children*, not the total population, because an adult by definition cannot be confirmed as a (current) child victim. Otherwise an area with few children, of whom a large proportion are confirmed victims, will appear to have a lower child abuse/neglect rate solely because the number of child abuse/neglect events is "diluted" by a large number of adults.

But it's important to look at the number of events, too, particularly when the rate shows big differences among years, racial/ethnic groups, or age groups. A rate that doubled might represent an increase from one event to two, or from one million events to two million. How we interpret that rate – and how much stock we put in spikes and dips in the trend line – depends a lot on the underlying numbers.

6. See Appendix A for summaries of the focus groups and key informant interviews conducted as part of this assessment. More information about methods and participants can be found in Appendix B.
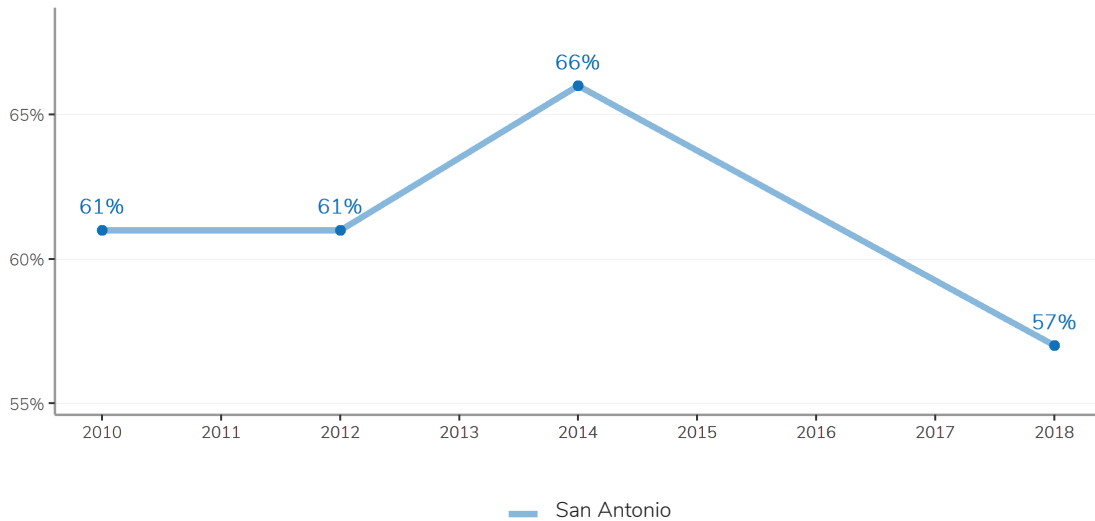7. 5 facts about crime in the U.S. (2019, January 3). Retrieved from https://www.pewresearch.org/fact-tank/2019/01/03/5-facts-about-crime-in-the-u-s/
8. The survey was administered to a random sample of 1,116 residents by mail, internet and phone.

Fig. 3.3 Percent of City of San Antonio residents who feel overall safe

Despite volatility (ups and downs) over time, the total Bexar crime rate has fallen from 5,559 per 100,000 population in 2013 to 4,920 in 2018 – an 11% decrease – while it has remained at about 2,400 in Atascosa (Fig. 3.3.1). Because of Atascosa's smaller population and smaller number of crimes, even minor differences year-to-year appear as major changes in the trend line (see Box 5).

Fig. 3.3.1 Number of crimes reported per 100,000 population
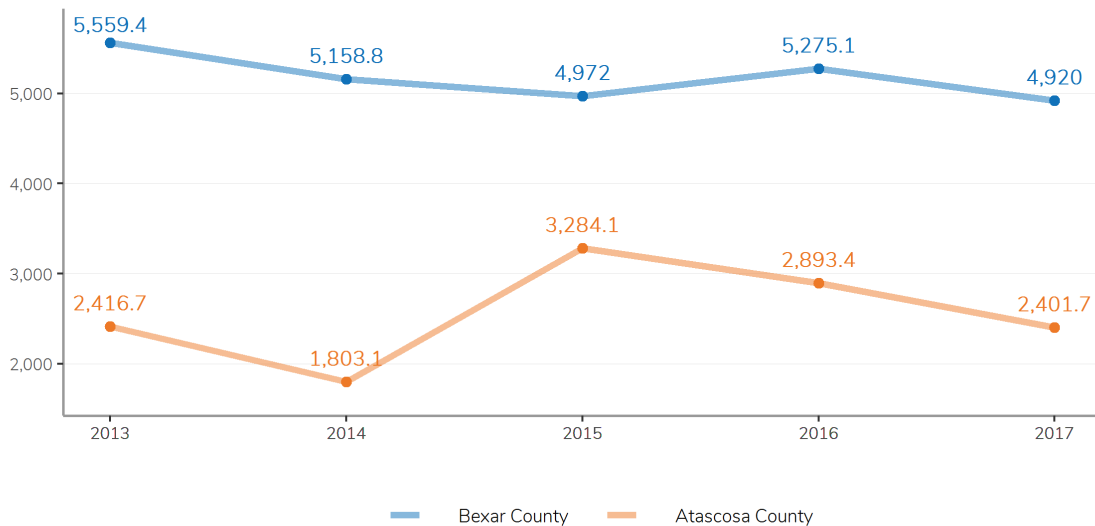
# Section 3: Social Environment

Bexar's total juvenile crime rate declined steadily from 22 per 10,000 juveniles in 2012 to 11 in 2016 (Fig. 3.3.2). Atascosa's juvenile crime rate increased from 15 in 2012 to 18 in 2013 and 2014, thereafter declining to nine in 2016. Once again, the actual number of crimes those Atascosa rate changes represent are likely quite small.

Fig. 3.3.2 Number of crimes by juveniles reported per 10,000 population
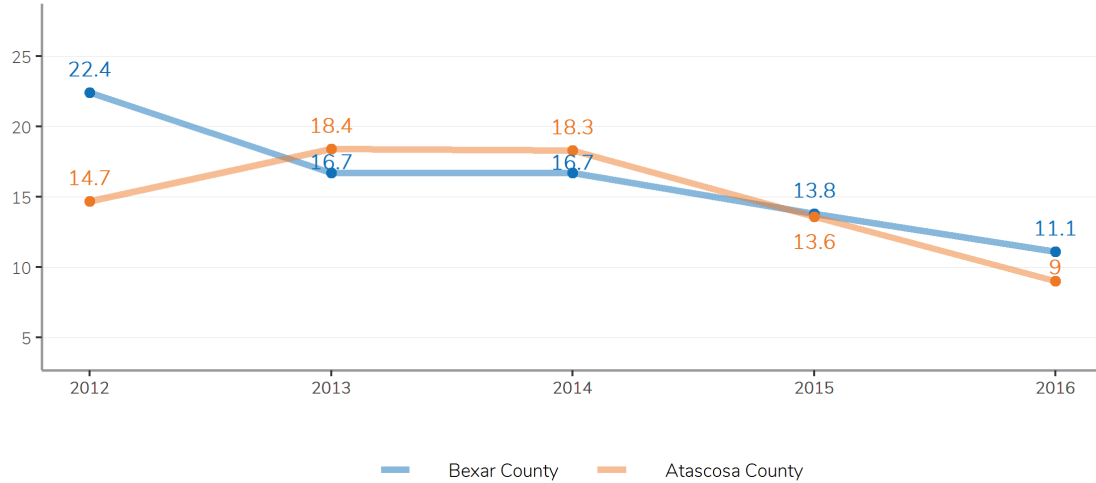


*Unreliable: Error is too large relative to estimate
Source: United States Department of Justice. Federal Bureau of Investigation. Uniform Crime Reporting Program Data. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor]
Prepared by CI:Now for THC

Fig. 3.3.3 Number of arrests for driving while intoxicated (only felonies)
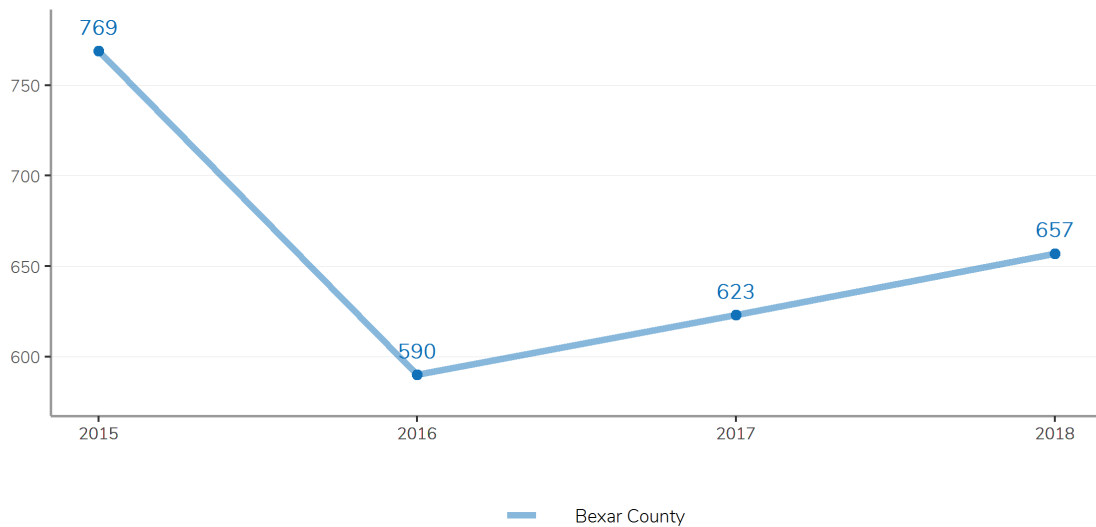


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Transportation
Prepared by CI:Now for THC

# Section 3: Social Environment

The San Antonio Express-News has reported on driving while intoxicated (DWI) felons since 2015. DWI felons include suspects arrested for intoxication assault, intoxication manslaughter, driving while intoxicated with a child under 15 years old and a third or more DWI offense. The annual number of arrests on DWI felony charges has exceeded 600 in every year but 2016 (Fig. 3.3.3).

The FBI defines violent crime as those that involve force or threat of force. The Uniform Crime Reporting Program includes the following offenses: murder and non-negligent manslaughter, rape, robbery and aggravated assault.[9] Bexar experienced a roughly 14% increase in the violent crime rate between 2012 and 2017, although 2015 and 2017 decreased from prior year. The rate of violent crime doubled in Atascosa, but again, the small population size and low "baseline" rate means that a moderate increase in *number* of violent crimes can appear as a tremendous increase in *rate* of violent crimes (Fig. 3.3.4). The assault rate followed roughly the same pattern (Fig. 3.3.5).

Fig. 3.3.4 Number of violent crimes reported per 100,000 population
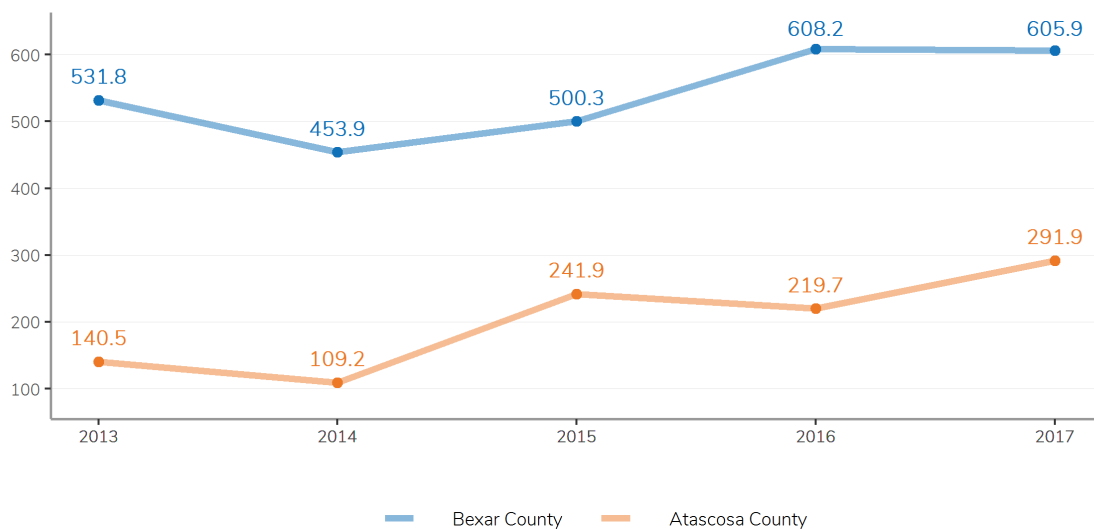


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Public Safety
Prepared by CI:Now for THC

The rate of homicide – a very infrequent event compared to violent crime and especially to total crime – increased by about 37% in Bexar (Fig. 3.3.6). In Atascosa the homicide rate jumped from 2.1 per 100,000 population in 2013 to 12.2 in 2015 and then plummeted to zero in 2017; the actual *number* of homicides in those three years were two, six, and zero.

For national context, the U.S. violent crime rate in 2017 was about the same as 2012, with decreases from prior year in 2013, 2014, and 2017 and sharp upticks in 2015 and 2016. The homicide rate increased somewhat over that period, again with decreases from prior year in 2013, 2014, and 2017 and increases in 2015 and 2016.[10]

9. Violent Crime. Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/violent-crime
10. Crime in the United States by Volume and Rate per 100,000 Inhabitants, 1998–2017. Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-1
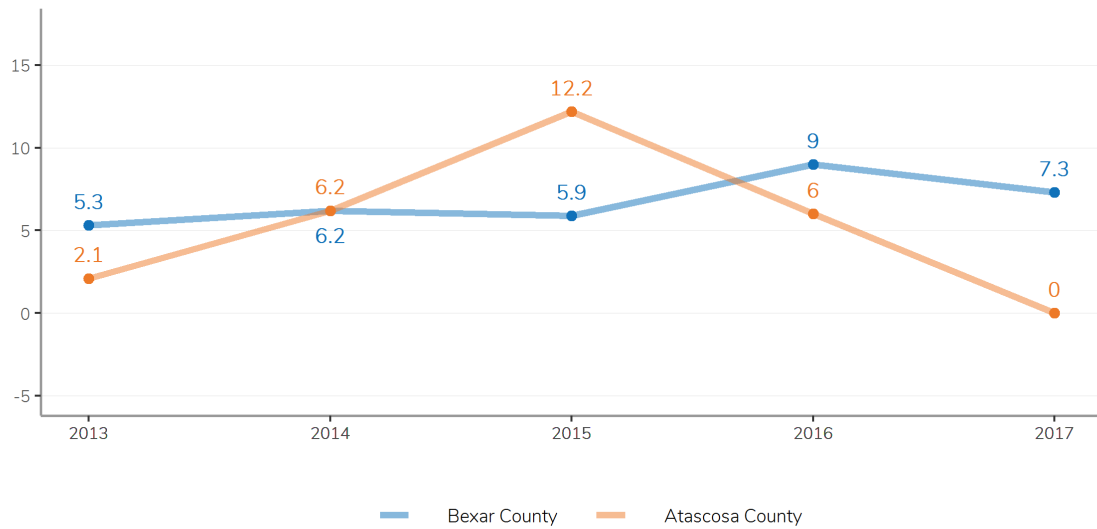
Fig. 3.3.5 Number of assaults reported per 100,000 population
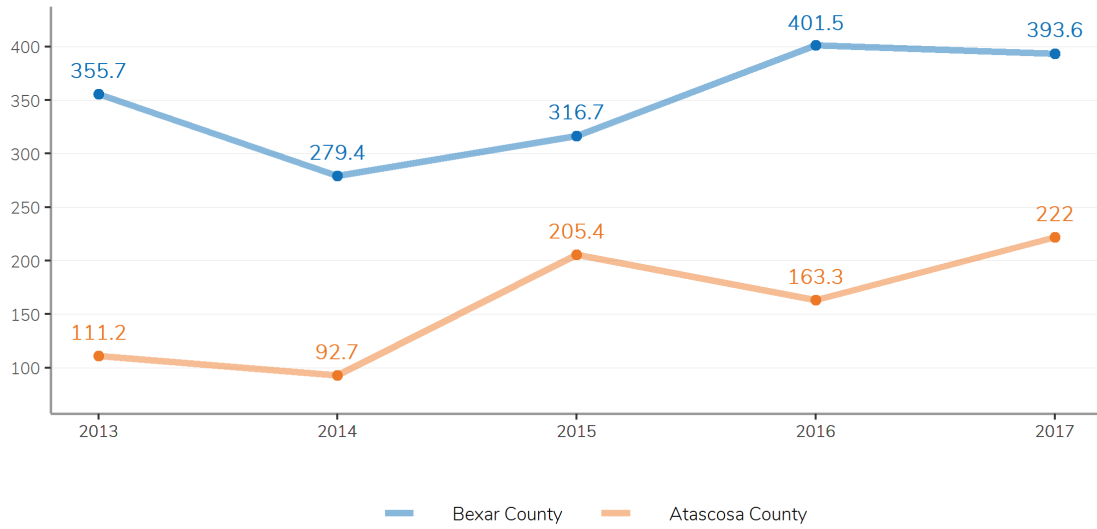


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Public Safety
Prepared by CI:Now for THC

Fig. 3.3.6 Number of homicides per 100,000 population



*Unreliable: Error is too large relative to estimate
Source: Texas Department of Public Safety
Prepared by CI:Now for THC

# Section 3: Social Environment

Comparable data are unavailable for Bexar, Atascosa, or the towns in Atascosa, but for local historical context, the violent crime rate in San Antonio in the 30 years between 1985 and 2014 ranged from a low of 401.7 in 1997 to a high of 817.1 in 2002, with a median rate – half of years higher and half lower – of 621.2. Thirteen of those years saw an increase over prior year; 16 saw a decrease. San Antonio's homicide rate over that period ranged from a low of 5.1 in 2013 to a high of 22.5 in 1992, with a median rate of 8.9. Eleven of those years saw an increase over prior year; 18 saw a decrease.[11]

The three key points here are that violent crime and homicide rates:

1. do vary by place, often quite dramatically; so long as crime is measured in a standardized way everywhere, those geographic comparisons are legitimate and valuable.

2. increase and decrease erratically from year to year – often exaggerated by small population and/or crime numbers – for reasons that are rarely clear, and those erratic changes may not always merit the strong public reaction and breathless media coverage that often follow.

3. cannot accurately be said to be increasing in either San Antonio or the U.S. as a whole.

## Other characteristics of the population

Depending on context, several other person and neighborhood characteristics may indicate vulnerabilities that affect health, even though these characteristics are not at all inherently negative. For example, about eight to nine percent of households in both counties are composed of a person aged 65 or older living alone (Fig. 3.4). Although the data are not available to characterize or quantify subgroups, this group includes highly independent older people who thrive living alone, highly isolated older people who are extremely disconnected from resources and opportunities to engage in the local community, and older people who fall somewhere in between those two extremes. These older adults living alone are not evenly distributed across either county (Fig. 3.4.1). Overlaying this map with other information like poverty, transportation, and housing condition would likely help identify neighborhoods where older people living alone are relatively more likely to benefit from outreach and connection to resources.

11. Uniform Crime Reporting Statistics. Retrieved from https://www.ucrdatatool.gov/Search/Crime/Local/RunCrimeJurisbyJuris.cfm

Fig. 3.4 Percent of total households with adults 65 years and older living alone
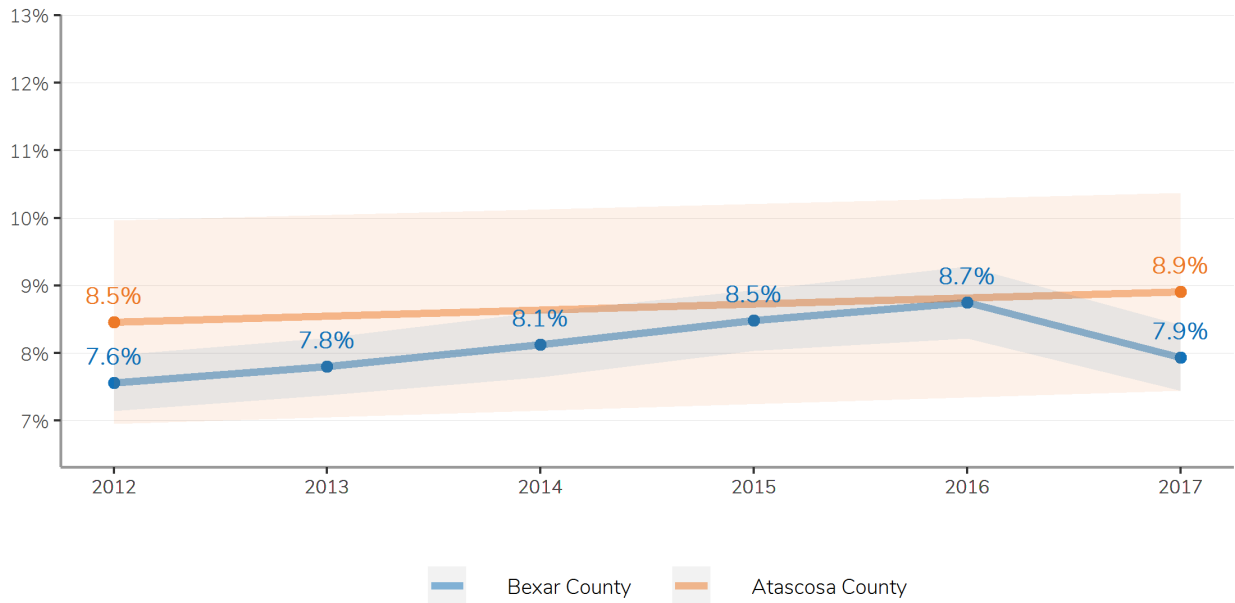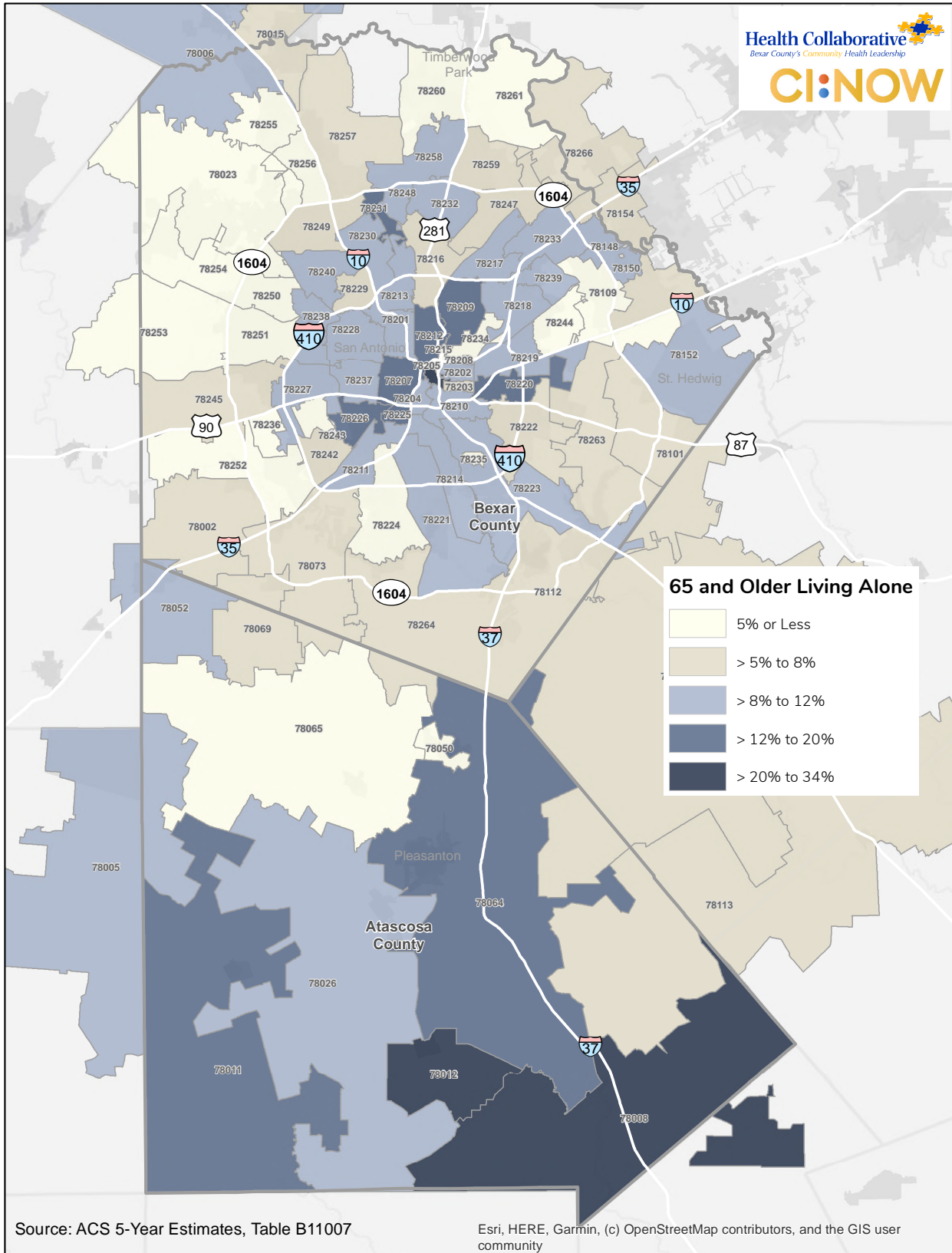


Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B11007
Prepared by CI:Now for THC

Multigenerational households are those in which one or more grandparents, parents, and children live together. That multigenerational character may indicate housing instability, where financial stressors have led people to "double up" with family members; "sandwich generation" households where one or more adults is caring for both children and parents or other older relatives; or households of choice, where several generations choose to live together, sharing caregiving and household responsibilities, contributing to household expenses, and providing strong social support to each other. Multigenerational households represent about five percent of Bexar households and eight percent of Atascosa households, with some indication of a downward trend in Bexar and an upward trend in Atascosa (Fig. 3.4.2)

Fig. 3.4.1 Percent of total households with adults 65 and older living alone, 2017



**65 and Older Living Alone**

- 5% or Less
- > 5% to 8%
- > 8% to 12%
- > 12% to 20%
- > 20% to 34%

Source: ACS 5-Year Estimates, Table B11007

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

# Section 3: Social Environment

Fig. 3.4.2 Percent of total households where a grandparent, parent and child live together
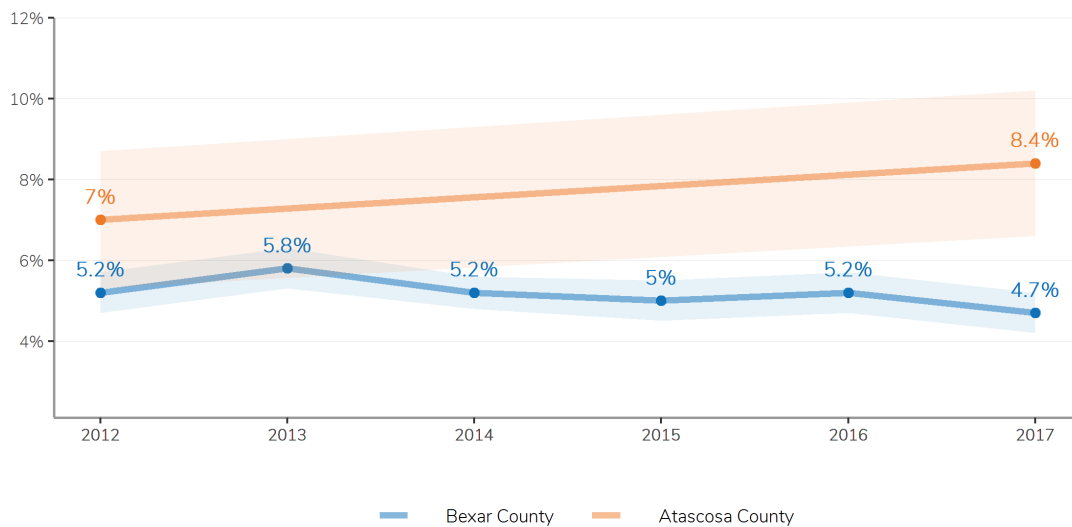


Bexar County  Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates
Prepared by CI:Now for THC

No good local data are available to describe or quantify social bonds – or social capital – within households, among households within neighborhoods, or among social networks that are not home- or neighborhood-based. That asset is known to be important, though, and was mentioned several times by focus group participants, who talked of how health and well-being is affected by strong or weak social bonds and communication among family members and neighborhood residents.

> "Tener una familia unida" [responding to what family well-being means to them]
> "If it weren't for my sister, we wouldn't make it."
> "Get to know your neighbors. Look out for each other."
> "Neighbors don't know their neighbors anymore."
> "...get together to talk about the neighborhood and keep an eye on it."

Although the proportion appears to be declining slightly, about one in 10 adults in both Bexar and Atascosa is a military veteran (Fig. 3.4.3) as compared to about one in 14 in Texas and the U.S.[12] The zip codes with the highest proportions of veterans include the active military bases, of course, but also 78253 outside Loop 1604 on Bexar's far Westside, zip codes outside Loop 1604 on Bexar's far northeast side, and 78005 at Atascosa's western edge (Fig. 3.4.4).

Youth aging out of foster care are a vulnerable group. Although data for that group specifically are not available, an average of about 150 Bexar youth and five Atascosa youth are emancipated each year (Fig. 3.4.5). Emancipation includes aging out at 18 years old as well as legal emancipation prior to turning 18 for reasons like getting married or joining the Armed Forces. Texas youth in foster care are surveyed around their 17th, 19th, and 21st birthdays, and one-quarter of 19-year-old respondents report having experienced homelessness within the previous two years.[13]

12. American Community Survey 2013-2017 5-Year Estimates: Table 2101: Veteran status. (2018). Retrieved from U.S. Census Bureau website: https://factfinder.census.gov/bkmk/table/1.0/en/ACS/17_5YR/S2101/0100000US|0400000US48|0500000US48013|0500000US48029
13. US DHHS ACF Children's Bureau, National Youth in Transition Database Services and Outcomes Reports: Percent reporting experiences with homelessness, February 2018.
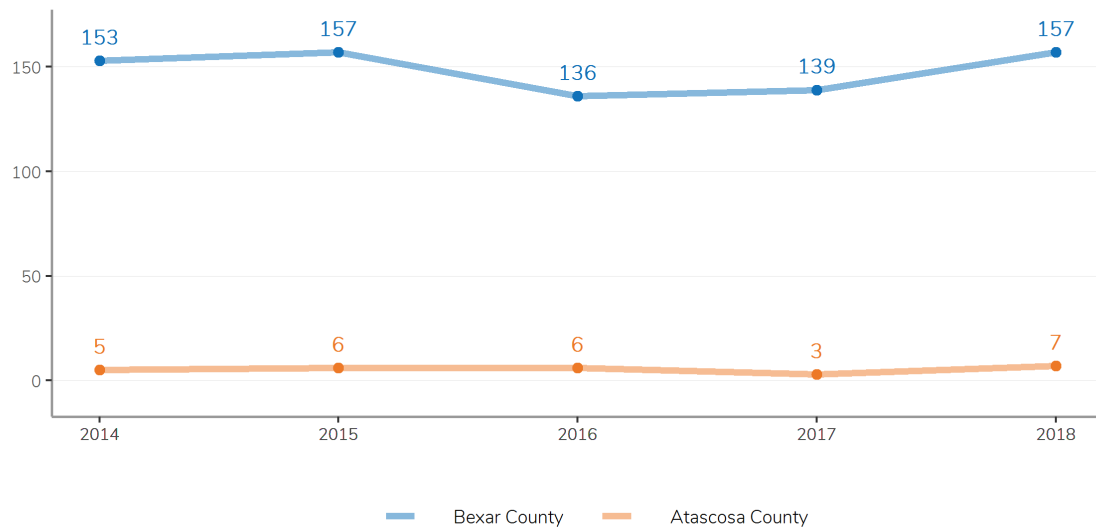
Fig. 3.4.3 Percent of civilian population 18 years and over who are veterans
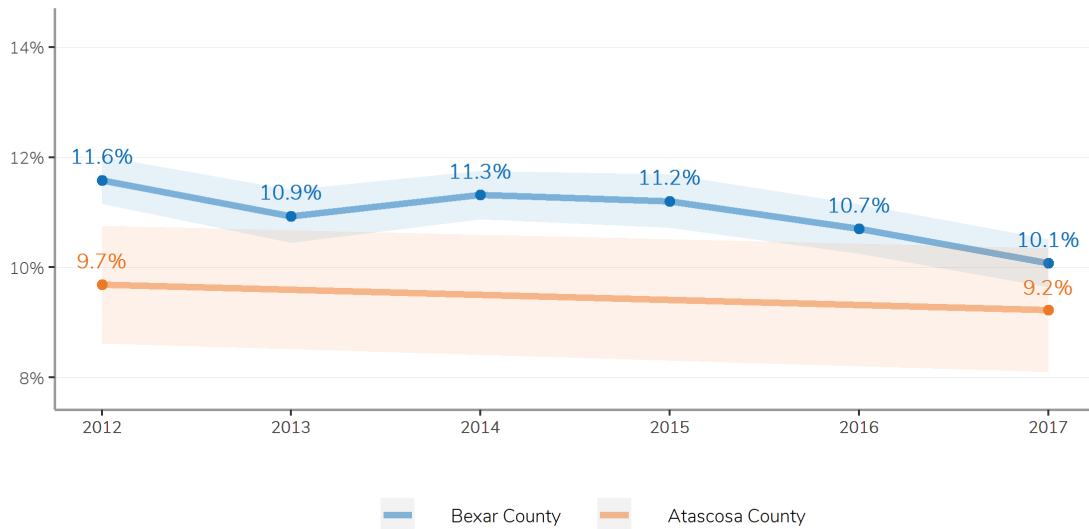
Fig. 3.4.5 Number of foster youth exiting Department of Family and Protective Services legal custody

Fig. 3.4.4 Percent of civilian population 18 years and over who are veterans by zip code, 2017



**Health Collaborative**
*Bexar County's Community Health Leadership*

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**Veterans**

- 8% or Less
- > 8% to 14%
- > 14% to 20%
- > 20% to 27%
- > 27% to 42%

Source: ACS 5-Year Estimates, Table B21001

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
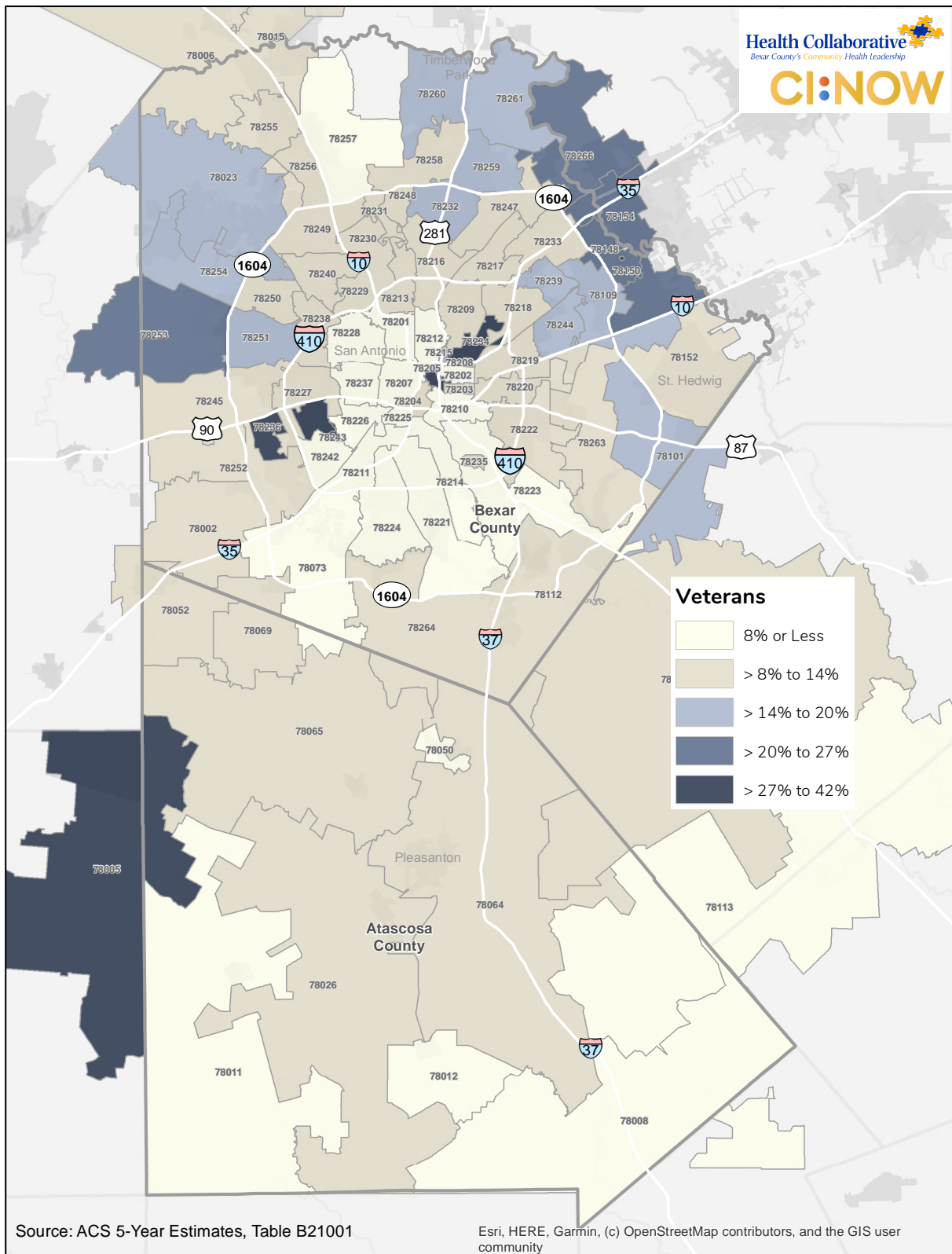
# Section 3: Social Environment

Respondents to the Census American Community Survey report whether household members have one or more disabilities, defined in the survey as "serious difficulty" seeing, hearing, walking or climbing stairs, or remembering and making decisions; and "difficulty" dressing, bathing, or doing errands alone.[14]  The estimated proportion of disabled Bexar residents appears to be rising, while Atascosa is seeing a decline (Fig. 3.4.6). The zip codes with the highest proportions of disabled residents are largely clustered in San Antonio's near Westside, near Eastside, and Southside (Fig. 3.4.7).

Fig. 3.4.6 Percent of civilian non-institutionalized population with a disability
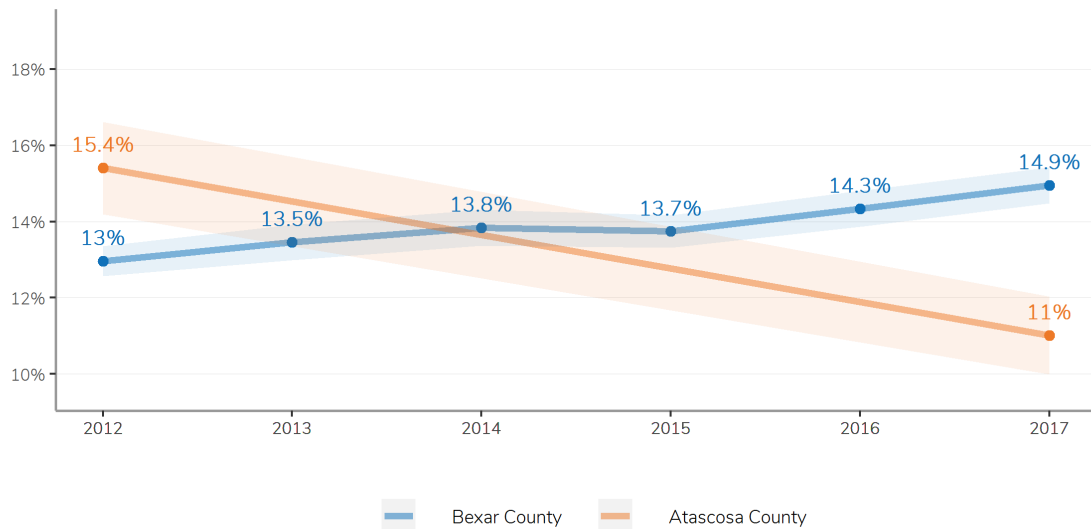


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: C18101, B18101
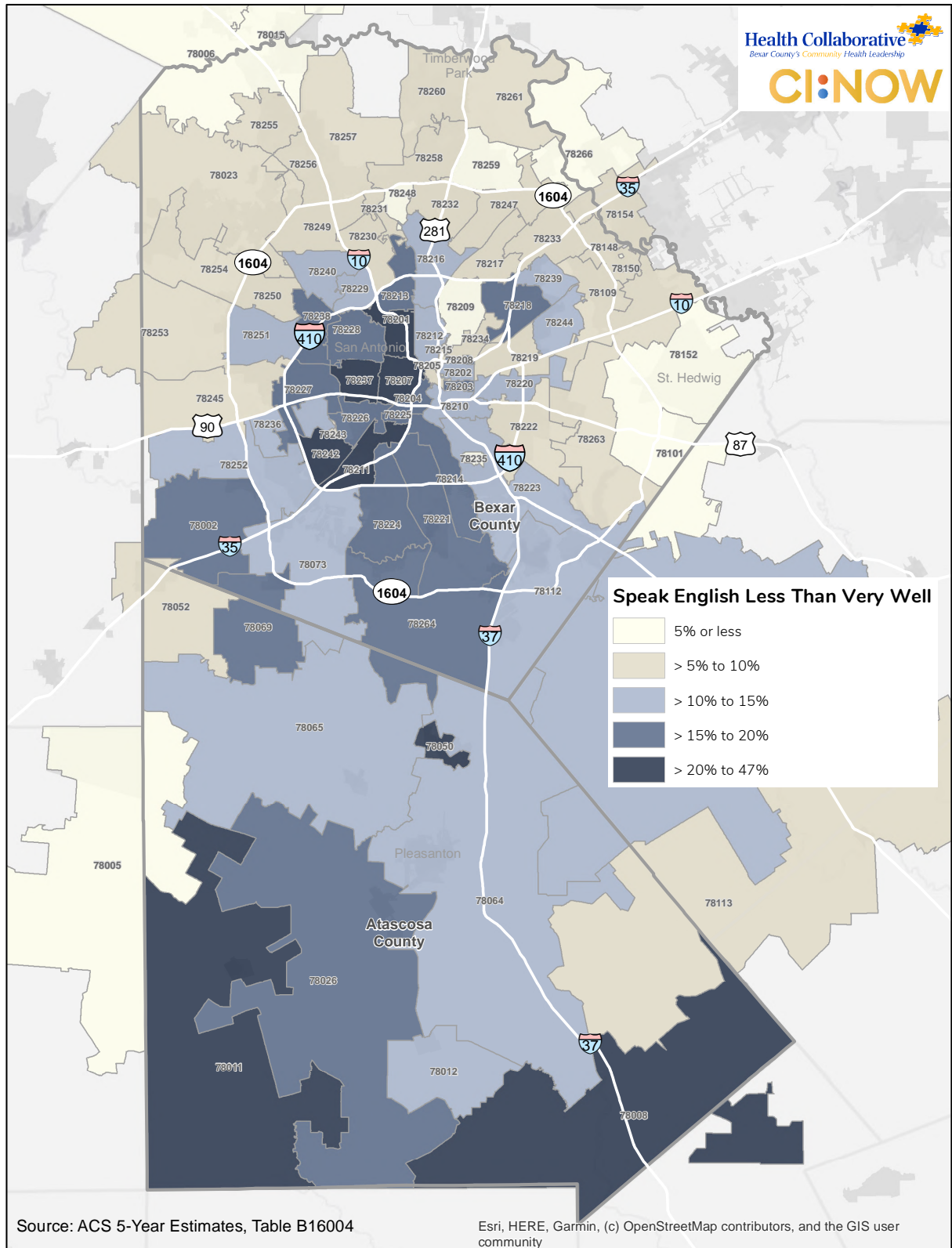Prepared by CI:Now for THC

14. American Community Survey: Why we ask about disability. Retrieved from U.S. Census Bureau website: https://www.census.gov/acs/www/about/why-we-ask-each-question/disability/

Fig. 3.4.7 Percent of civilian non-institutionalized population with a disability by zip code, 2017
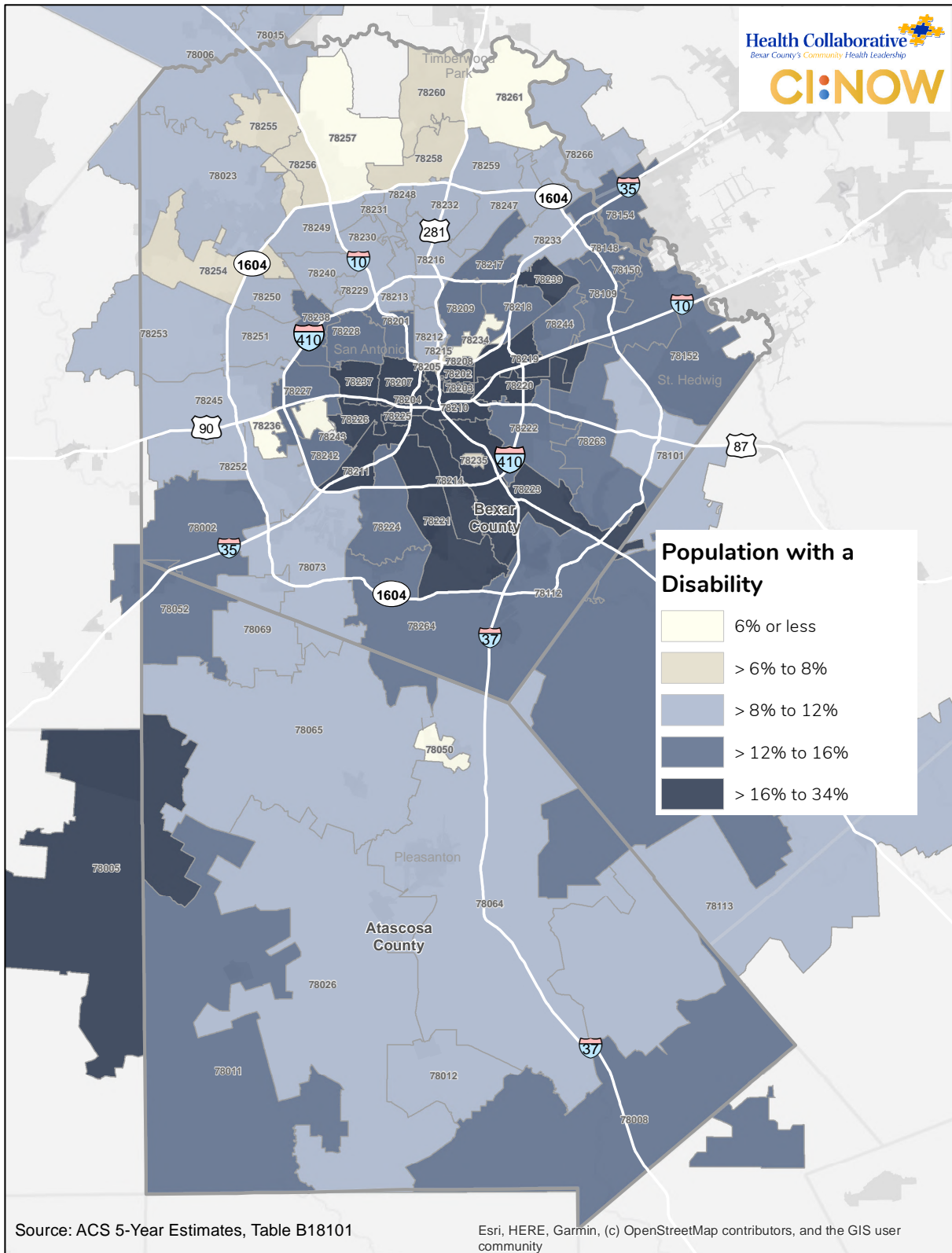
# Section 3: Social Environment

As translation services are often unavailable, lack of proficiency in the English language can increase vulnerability. About one in seven Atascosa residents and one in eight Bexar residents age five and older speak a language other than English at home and speak English less than "very well" (Fig. 3.4.8). Spanish is the language spoken at home by virtually all of that group in Atascosa and about nine in 10 in Bexar, with Asian and Pacific Island languages being the second most common in Bexar. Regardless of the language (other than English) spoken at home, the proportion not proficient in English is highest among older people[15] and highest in the zip codes (Fig. 3.4.9) south of I-10W in Bexar, in far south Atascosa, and in the Leming area of Atascosa (78050).

Fig. 3.4.8 Percent of population 5 years and over who speak English less than "very well"
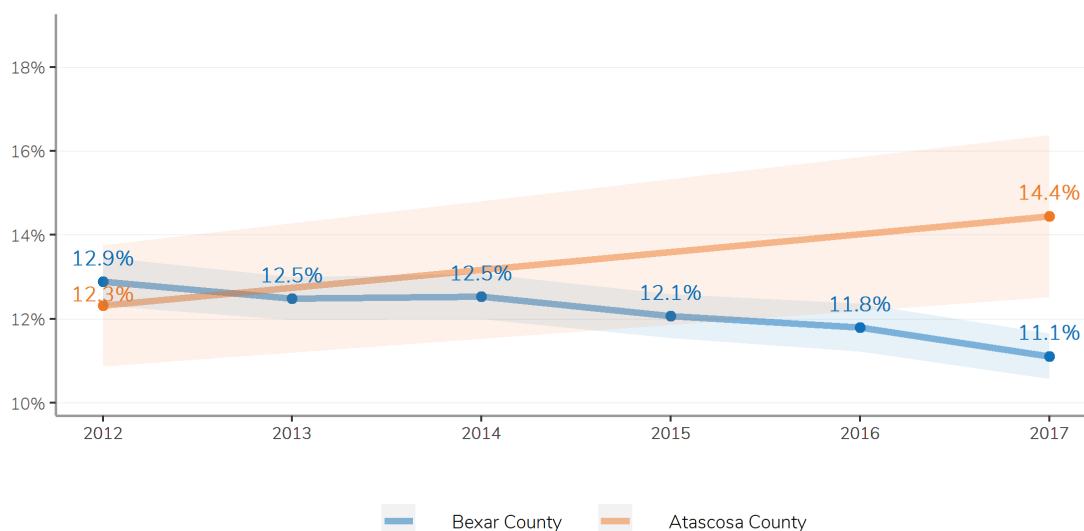


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B16004
Prepared by CI:Now for THC

With the margin of error considered, the proportion of residents who are U.S. citizens is unchanged over recent years, standing at about 96% in Atascosa and 93% in Bexar (Fig. 3.4.10). Of those U.S. citizens, only about six percent in Bexar and two percent in Atascosa are U.S. citizens by naturalization rather than birth (Fig. 3.4.11). The zip codes with the lowest proportion of people who are U.S. citizens are in Bexar, particularly the near Westside (Fig. 3.4.12).

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15. American Community Survey 2013-2017 5-Year Estimates: Table S1601: Poverty status in the past 12 months. (2018). Retrieved from U.S. Census Bureau website: https://factfinder.census.gov/bkmk/table/1.0/en/ACS/17_5YR/S1701/0500000US48013.86000P|0500000US48029.86000P13.

Fig. 3.4.9 Percent of population 5 years and over who speak English less than "very well" by zip code, 2017



**Speak English Less Than Very Well**

- 5% or less
- > 5% to 10%
- > 10% to 15%
- > 15% to 20%
- > 20% to 47%

Source: ACS 5-Year Estimates, Table B16004
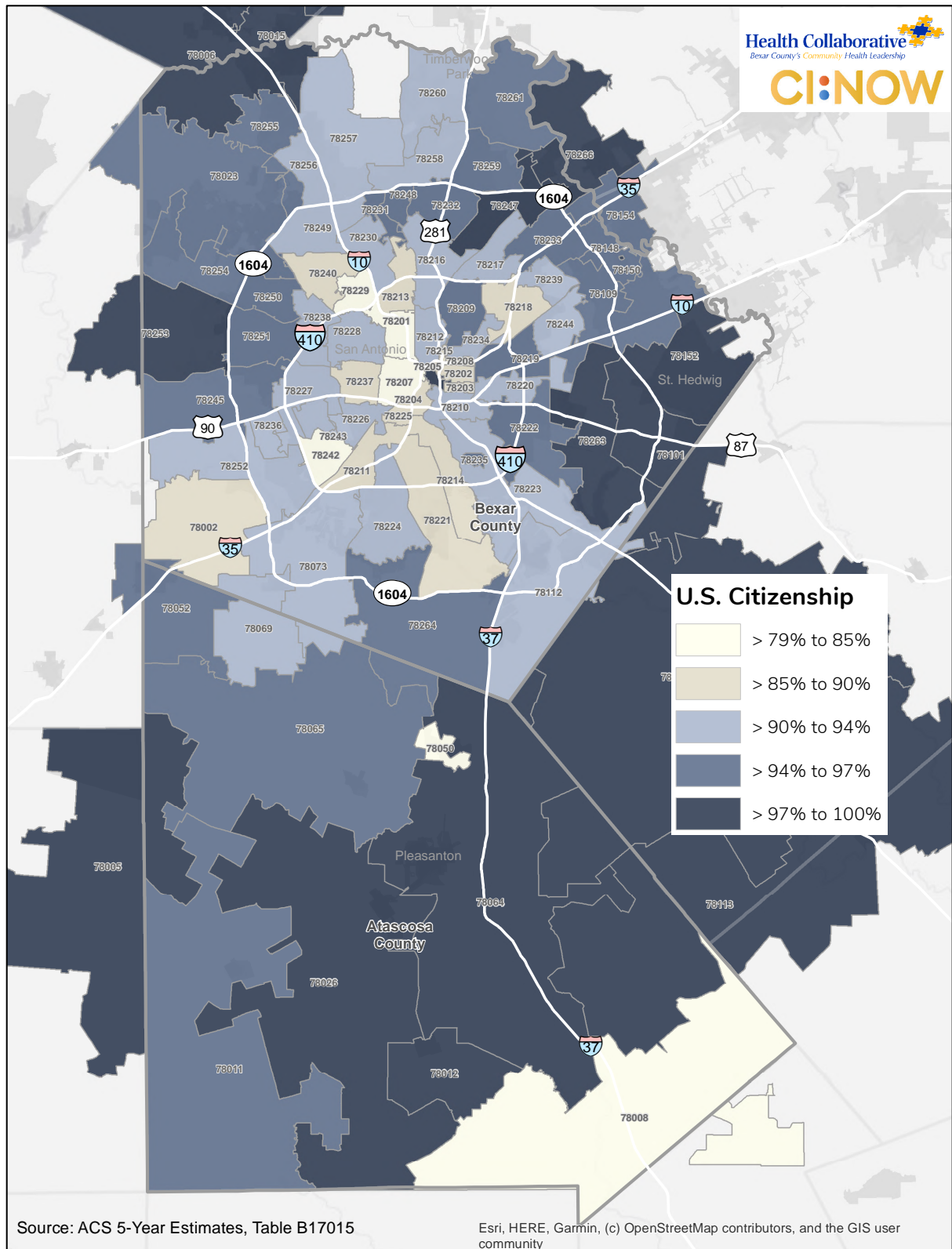
Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

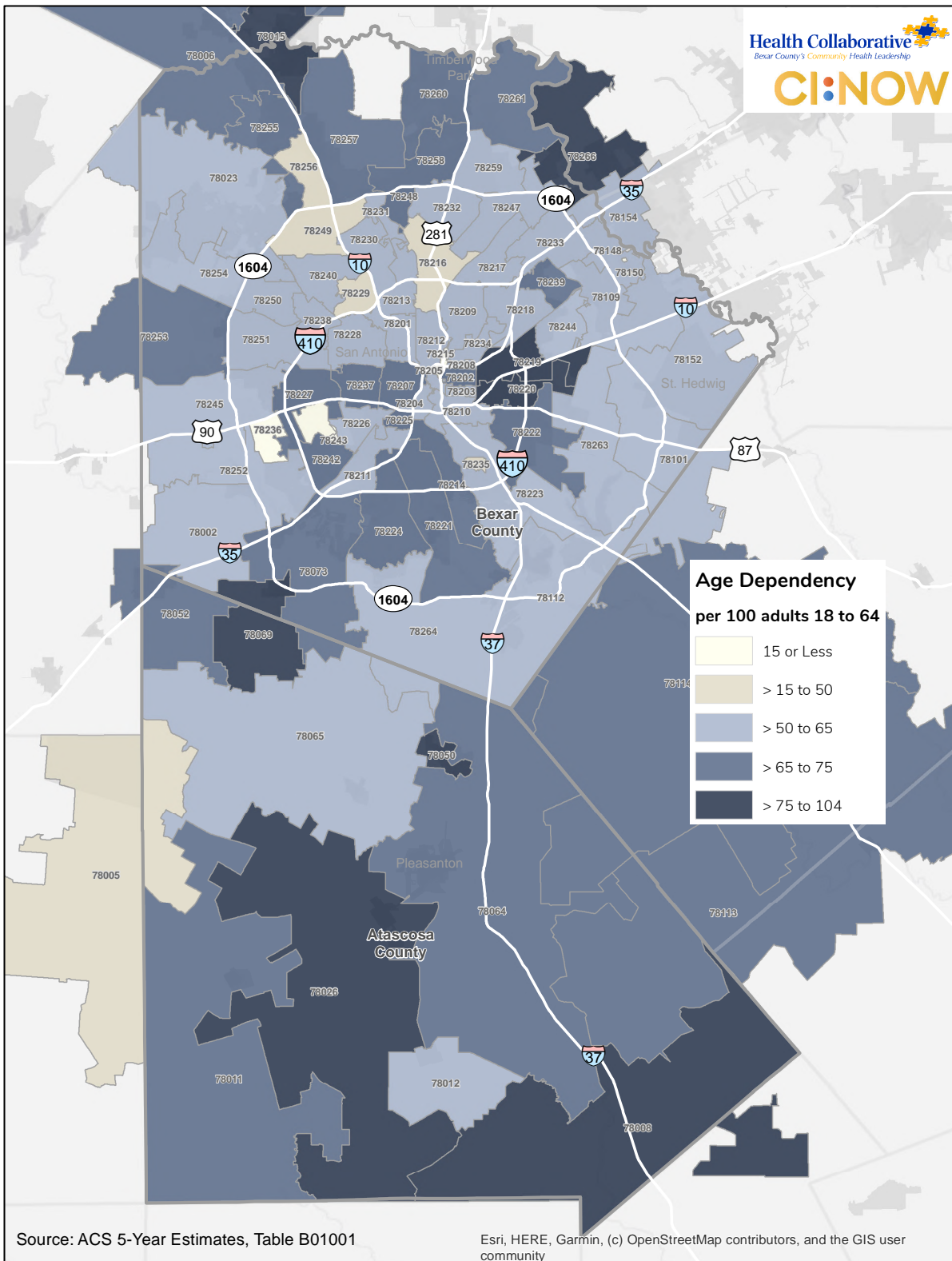Fig. 3.4.10 Percent of total population of U.S. citizens by birth or naturalization
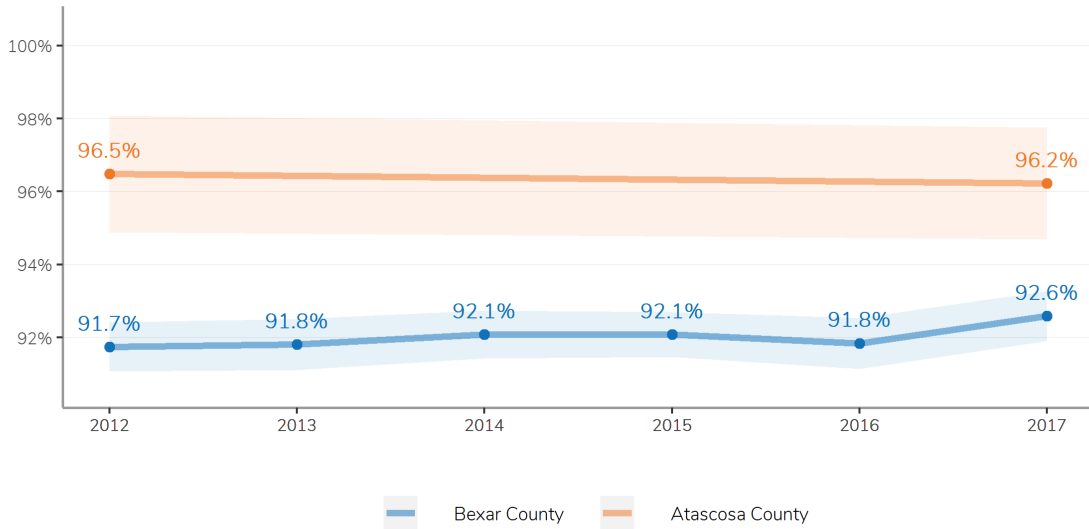


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B05001
Prepared by CI:Now for THC

Fig. 3.4.11 Percent of total population by citizenship status type, 2017
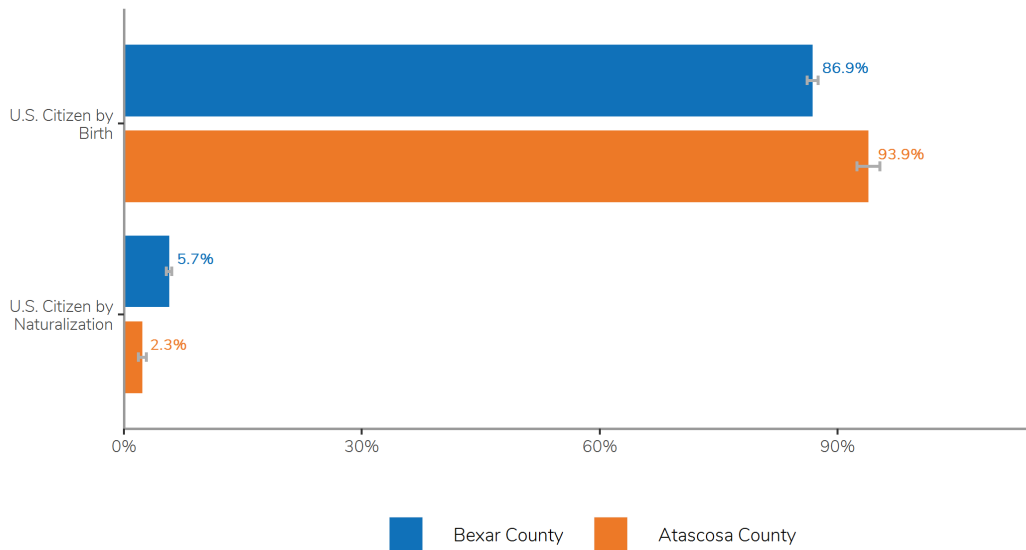


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B05001
Prepared by CI:Now for THC

Fig. 3.4.12 Percent of total population of U.S. citizens by birth or naturalization by zip code, 2017



**U.S. Citizenship**

- > 79% to 85%
- > 85% to 90%
- > 90% to 94%
- > 94% to 97%
- > 97% to 100%

Source: ACS 5-Year Estimates, Table B17015

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## Other characteristics of neighborhoods

The age dependency ratio is measured as number of children (under 18) and older people (65 and over) per adult aged 18 to 64 (Fig. 3.5). Although of course many younger people and older people are employed, the 18-64 age group is considered to be the working-age population, so age dependency ratio has implications for local economic conditions as well.[16]

Fig. 3.5 Age dependency ratio: total dependents to working-age population
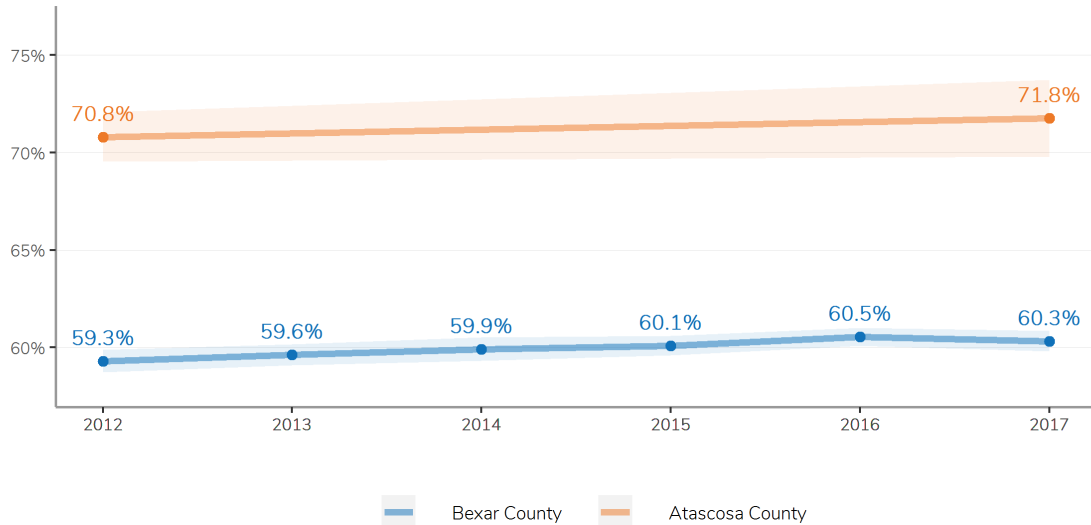


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B01001
Prepared by CI:Now for THC

Fig. 3.5.1 Age dependency ratio: total dependents to working-age population by type
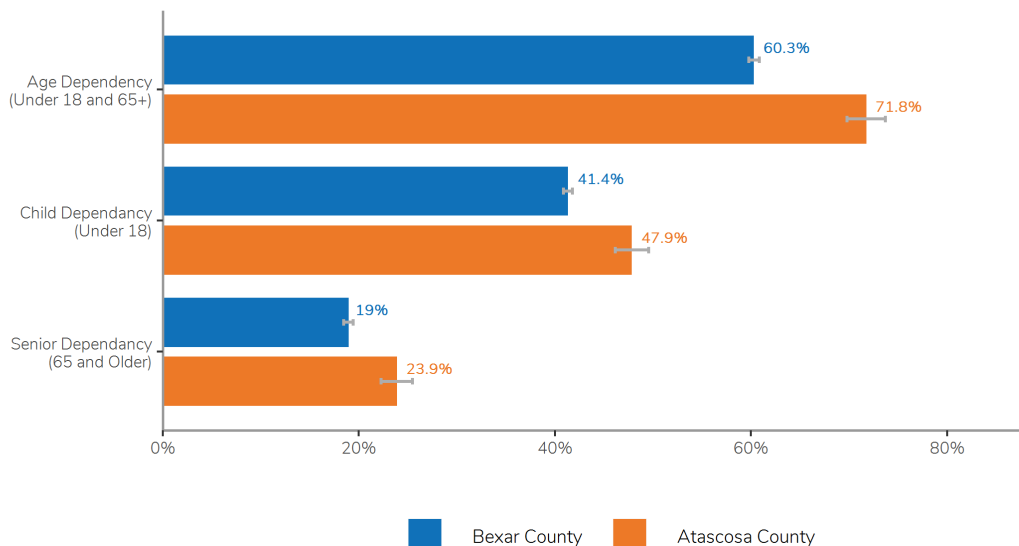


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B01001
Prepared by CI:Now for THC

16. Santacreu, A. M. (2016). Long-run economic effects of changes in the age dependency ratio. Economic Synopses, 2016. Retrieved from https://research.stlouisfed.org/publications/economic-synopses/2016/09/02/long-run-economic-effects-of-changes-in-the-age-dependency-ratio/

Fig. 3.5.2 Age dependency ratio: total dependents to working-age population by zip code, 2017



Source: ACS 5-Year Estimates, Table B01001

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

**Age Dependency**

**per 100 adults 18 to 64**

- 15 or Less
- > 15 to 50
- > 50 to 65
- > 65 to 75
- > 75 to 104

Also, adults aged 18-64 in communities with a high age dependency ratio are more likely than those in communities with a low age dependency ratio (Fig. 3.5.1) to be experiencing the "sandwich generation" concept, caring for both children and parents or other older relatives. Most of Atascosa's zip codes have high age dependency ratios (Fig. 3.5.2).

About eight in 10 Bexar households and just over seven in 10 Atascosa households has a broadband internet subscription (Fig. 3.5.3), which greatly facilitates participation in a digital economy. Although a smartphone suffices for online banking and many other tasks, job applications, school homework, and other more intensive uses are much easier with a larger device and a broadband connection. Unsurprisingly, the zip codes with the highest rates of household broadband subscription are on Bexar's far Northside and active military bases (Fig. 3.5.4). The zip codes with the lowest rates are largely concentrated in Bexar's near Eastside and near Westside and along Atascosa's western and southern boundaries.

Fig. 3.5.3 Percent of households with broadband Internet access, 2017
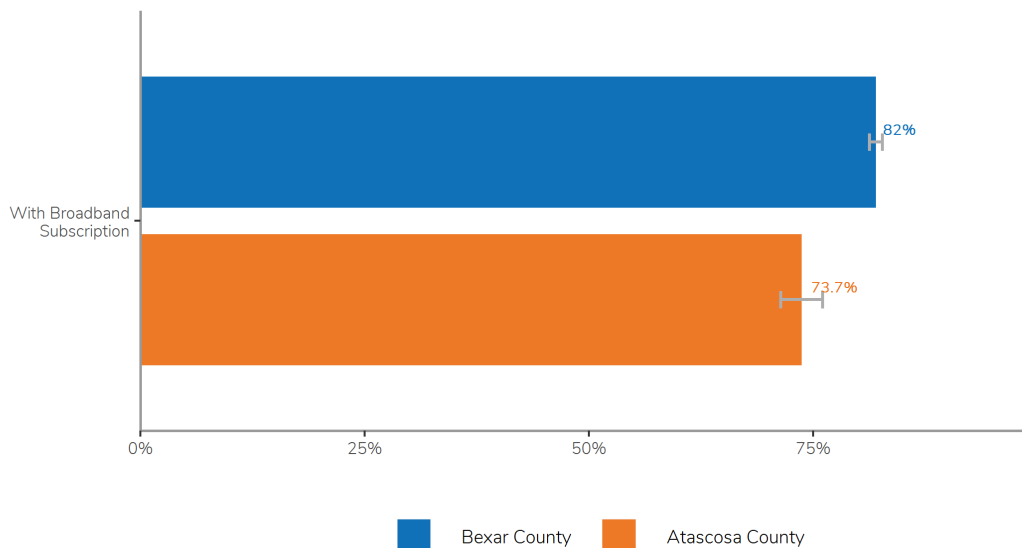


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B28002
Prepared by CI:Now for THC

The past decade has seen a proliferation of indices (indexes) that "roll up" multiple issues into a single number to identify areas of relatively greater opportunity or challenge. These indices are attractive because they distill key factors into a single metric, but it may not be obvious what those key factors are, what relative importance or weight is placed on each in the formula, where the source data come from, and how recent that data is.

Published about six years ago, the Child Opportunity Index ranks neighborhoods in metropolitan areas based on the educational, health and environmental, and social and economic opportunities each neighborhood offers to children.[17] The neighborhoods considered to offer the greatest degree of opportunity are Bexar's active military bases, higher-income municipalities like Alamo Heights, and the far Northside (Fig. 3.5.5).

17. Child Opportunity Index mapping. Retrieved from diversitydatakids.org and Kirwan Institute for the Study of Race and Ethnicity website: http://www.diversitydatakids.org/files/CHILDOI/DOCS/DDK_KIRWAN_CHILDOI_%20OVERVIEW.pdf

Fig. 3.5.4 Percent of households with broadband Internet access by zip code, 2017



Source: ACS 5-Year Estimates, Table B28002

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

**With Broadband Internet**

- > 30% to 58%
- > 58% to 70%
- > 70% to 78%
- > 78% to 89%
- > 89% to 98%
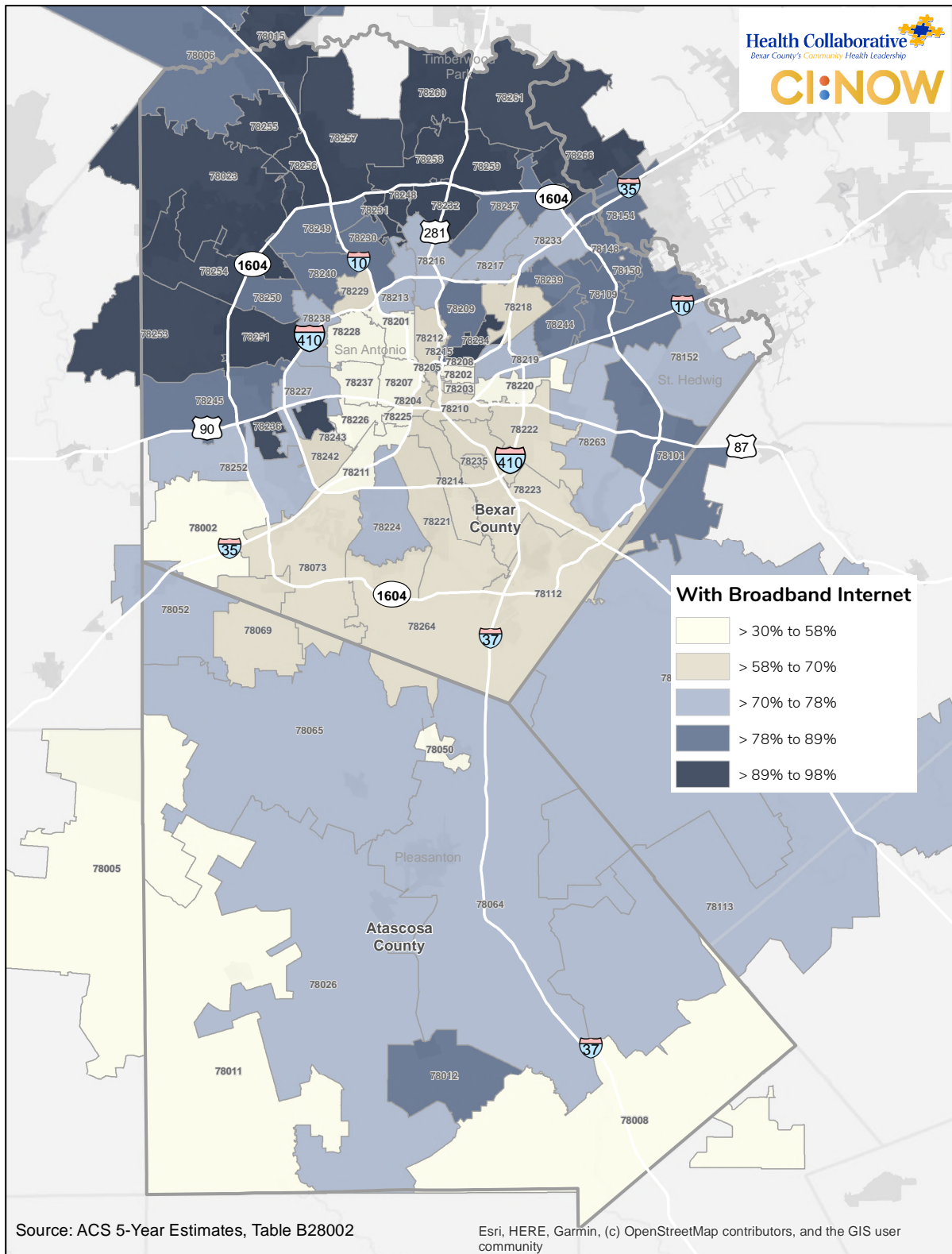
Fig. 3.5.5 Child opportunity index by census tract, 2015



Health Collaborative
Bexar County's Community Health Leadership

CI:NOW

**Child Opportunity Index**

Very Low
Low
Moderate
High
Very High

Source: Brandeis University, The Heller School for Social Policy and Research

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
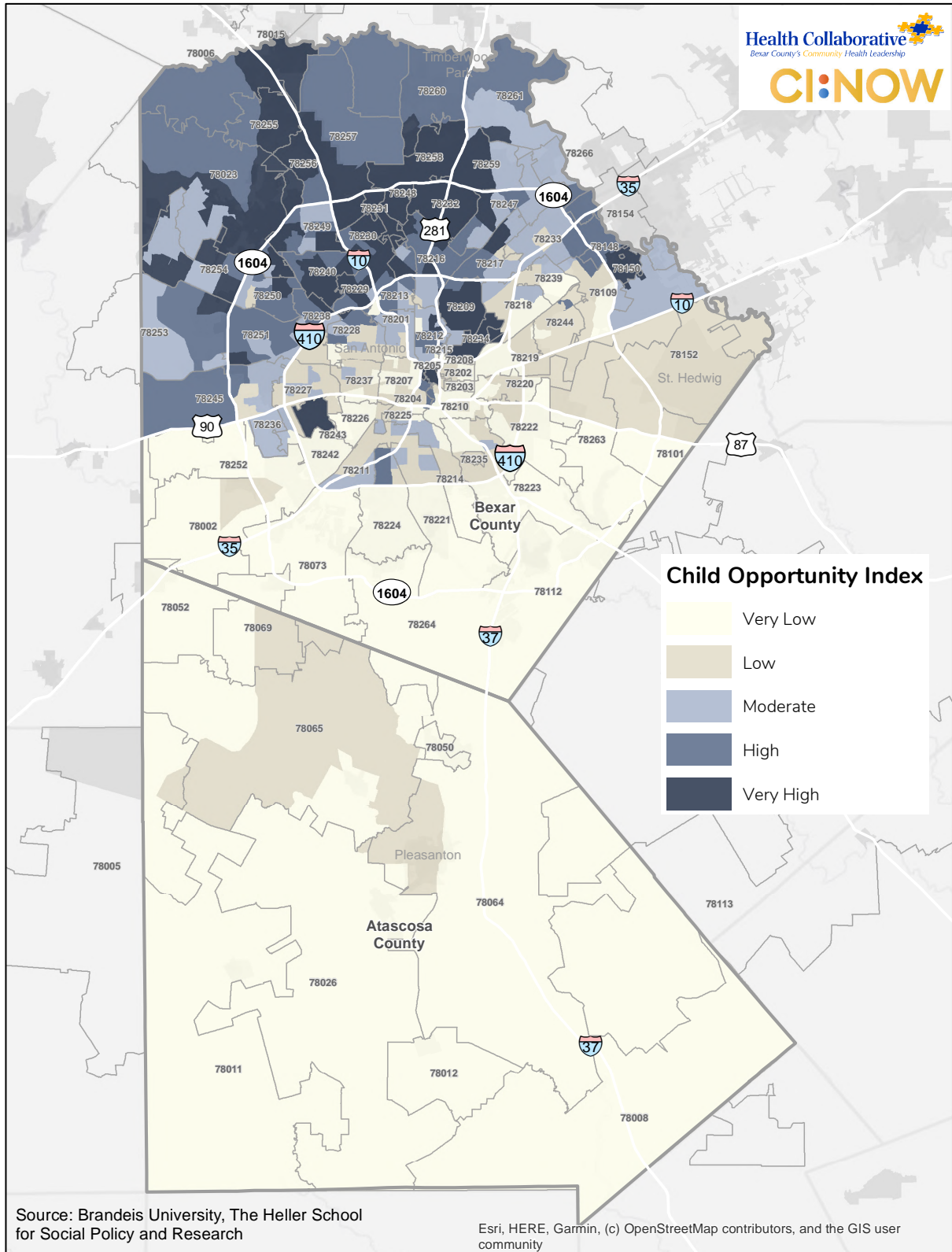
# Section 3: Social Environment

The older Area Deprivation Index, last updated for 2015, quantifies neighborhoods' socioeconomic deprivation using indicators of educational attainment, employment, income and income disparity, housing tenure (owner vs. renter) and costs, and other household characteristics.[18] By that index, the Bexar neighborhoods with the greatest level of deprivation are primarily clustered inside Loop 410, excluding higher-income areas like Monte Vista and Alamo Heights (Fig. 3.5.6). The neighborhoods with the greatest level of deprivation in Atascosa are immediately east of SH 16 north of Pleasanton, and to lesser degree, southwest of Jourdanton.

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### Indicators in the Child Opportunity Index [19]

The Child Opportunity Index is a summary measure that combines score information about the following indicators of neighborhood opportunity into a single number.

Educational opportunity
- Student poverty rates in neighborhood schools (Free/Reduced Price Lunch Eligibility)
- Student math proficiency levels
- Student reading proficiency levels
- Proximity to licensed early childhood education (ECE) centers
- Proximity to high-quality ECE centers
- Participation patterns for ECE
- High school graduation rates
- Adult educational attainment

Health & Environmental Opportunity
- Proximity to health facilities
- Retail healthy food environment index
- Proximity to toxic waste release sites
- Volume of nearby toxic release
- Proximity to parks and open spaces
- Housing vacancy rates

Social & Economic Opportunity
- Foreclosure rates
- Poverty rates
- Unemployment rates
- Public assistance rates
- Proximity to employment

---

### About the Area Deprivation Index (ADI)[18]

The Area Deprivation Index (ADI) is based on a measure created by the Health Resources & Services Administration (HRSA) over two decades ago for primarily county-level use, but refined, adapted, and validated to the Census block group/neighborhood level by Amy Kind, MD, PhD and her research team at the University of Wisconsin-Madison. It allows for rankings of neighborhoods by socioeconomic status disadvantage in a region of interest (e.g. at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

What do the ADI values mean? The ADIs are national percentile rankings constructed by ranking the ADI from low to high for the nation and grouping the block groups/neighborhoods into bins corresponding to each 1% range of the ADI. Group 1 is the lowest ADI and group 100 is the highest ADI. A block group with a ranking of 1 indicates the lowest level of "disadvantage" within the nation and an ADI with a ranking of 100 indicates the highest level of "disadvantage".
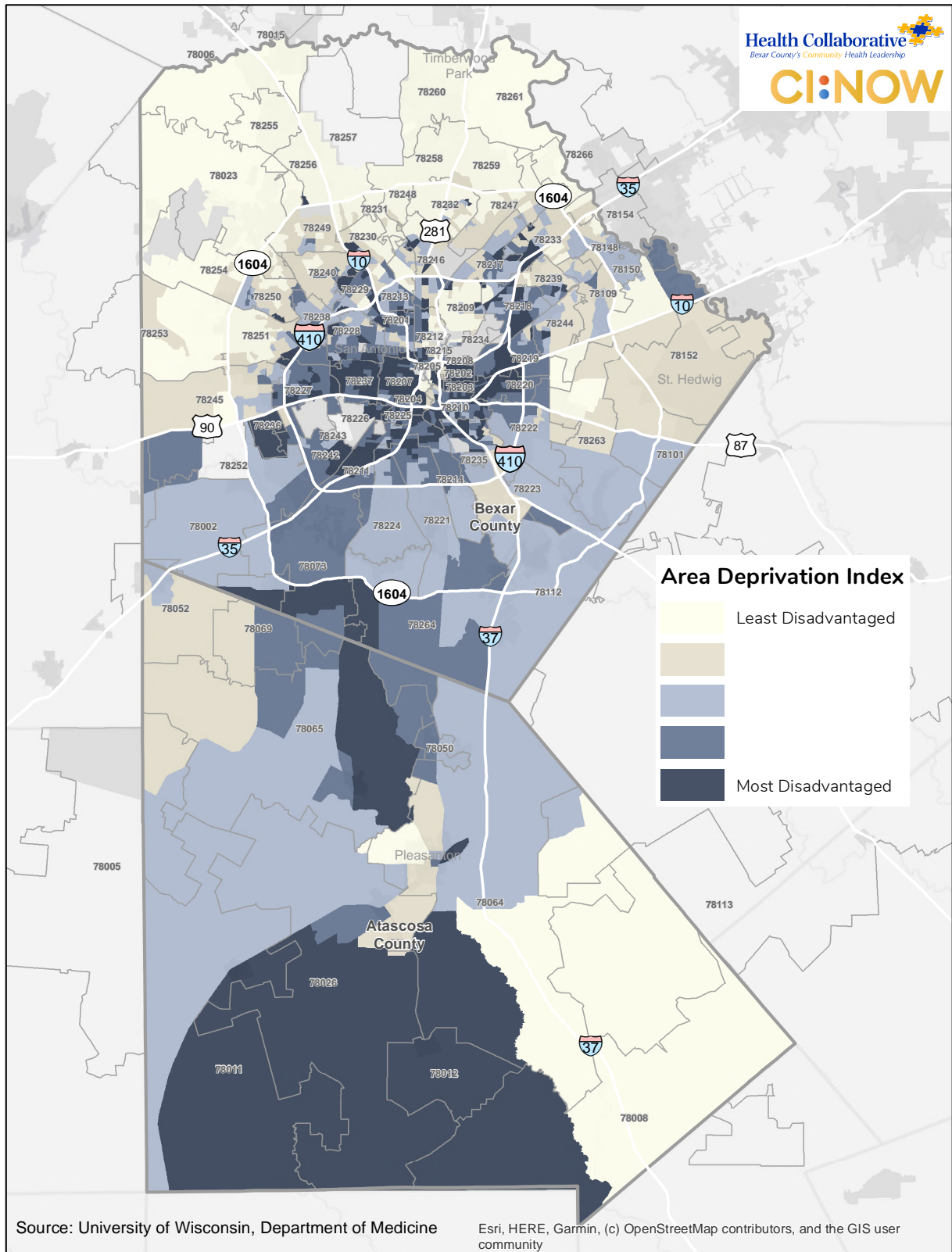
For more information, visit: https://www.neighborhoodatlas.medicine.wisc.edu/

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18. Area Deprivation Index Datasets. (2019, May 21). Retrieved from https://www.hipxchange.org/ADI
19. . Child Opportunity Map Query. Retrieved from http://www.diversitydatakids.org/files/CHILDOI/DOCS/DDK_KIRWAN_CHILDOI_METHODS.pdf

Fig. 3.5.6 Area deprivation index by census tract, 2015

## Employment and labor force participation

Unemployment in both counties fell from five to six percent in 2012 to under four percent in 2017 (Fig. 4.1) and has continued to drop. Tied with three other cities, San Antonio now ranks 10th among the 50 largest cities in the country on lowest annual average unemployment.[1] Most Bexar zip codes with the highest unemployment rates are south of an imaginary line level with Culebra on the Westside and the Union Pacific railroad tracks and Gembler Road on the Eastside (Fig. 4.1.1). In Atascosa, the highest unemployment rates are found in zip codes 78065 and 78069 between Somerset and Pleasanton.

Fig. 4.1 Percent of population 16 and older in labor force who are unemployed



Bexar County    Atascosa County
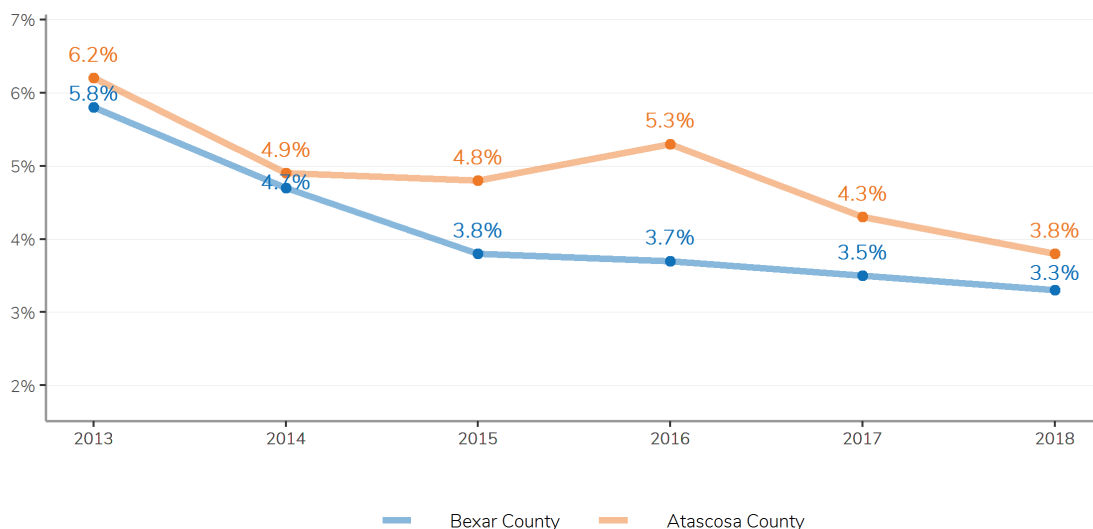
*Unreliable: Error is too large relative to estimate
Source: Bureau of Labor Statistics
Prepared by CI:Now for THC

An important limitation of unemployment data is that it only includes people who are actively seeking work through formal channels. The number unemployed does not include anyone participating in an informal or "underground" labor economy or anyone who has given up finding work because of race, age, or sex discrimination; lack of reliable transportation; lack of affordable childcare through an entire shift; criminal background; illness or disability; or recession conditions in the local economy. Labor force participation varies greatly across population subgroups. Particularly in the strong local economy, unemployment rates appear very low for everyone – one to five percent. Examining employment instability by combining unemployment and absence from the labor force into a single measure paints a very different picture, with instability ranging from 7% to 21% (Fig. 4.1.2).

1. Unemployment Rates for the 50 Largest Cities. (2008, January 1). Retrieved from https://www.bls.gov/lau/lacilg18.htm

# Section 4: Economic Environment

Fig. 4.1.1 Percent of population 16 and older in labor force who are unemployed, 2017
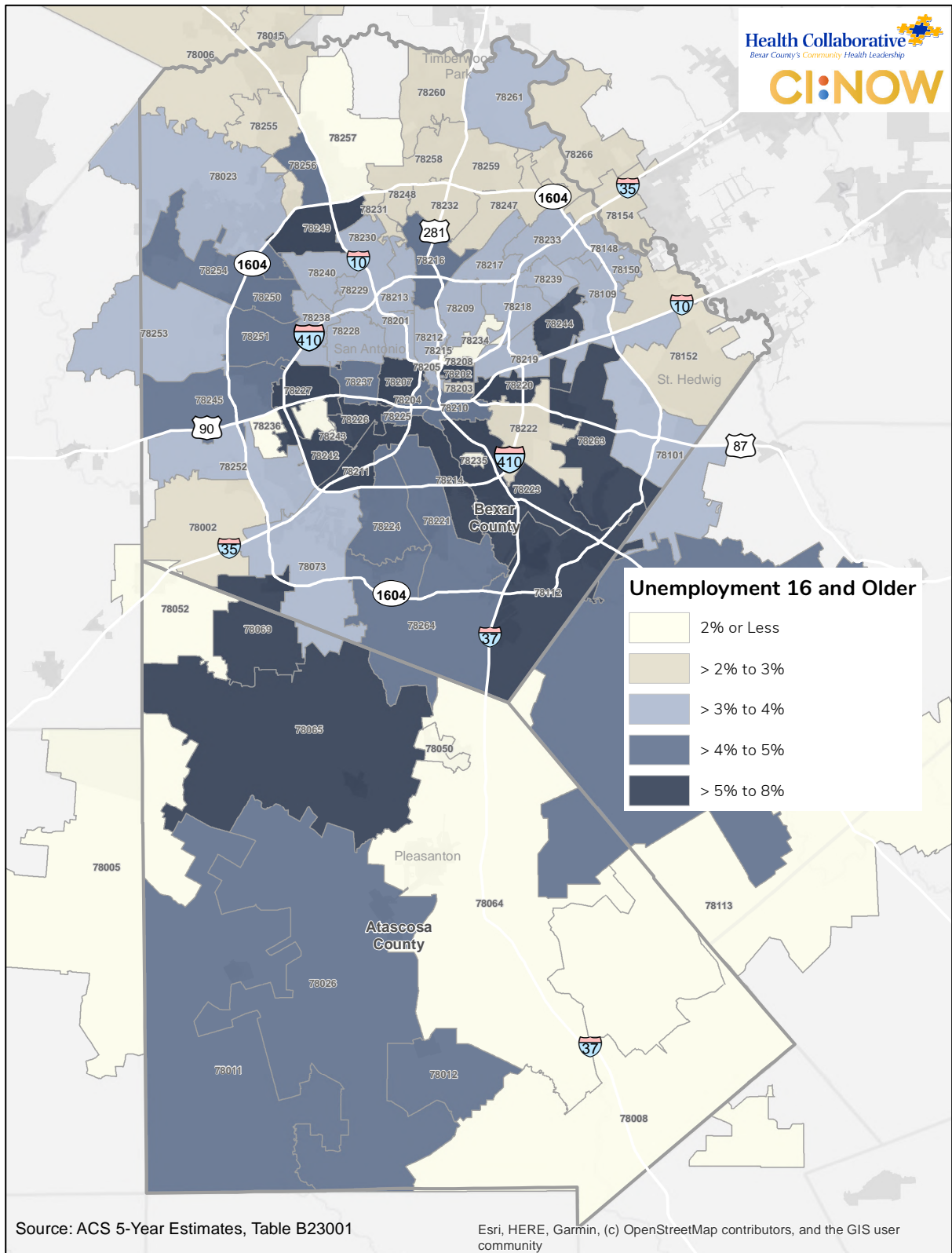
# Section 4: Economic Environment

Fig. 4.1.2 Families experiencing employment instability, Bexar County, 2017

| | Married Couples | | Single Male | | Single Female | |
|---|---|---|---|---|---|---|
| Experiencing Instability | 8,559 (±1,565) | 6.7% (±1.2%) | 2,609 (±889) | 17.7% (±5.3%) | 11,291 (±1,917) | 21.4% (±3.2%) |
| Unemployment | 5,242 (±1,212) | 4.1% (±0.9%) | 670 (±475) | 4.5% (±3.1%) | 2,022 (±988) | 3.8% (±1.8%) |
| No Labor Force Participation | 3,317 (±990) | 2.6% (±0.8%) | 1,939 (±752) | 13.1% (±4.6%) | 9,269 (±1,643) | 17.6% (±2.8%) |
| Families With Own Children | 127,377 (±5,133) | | 14,751 (±2,353) | | 52,738 (±4,298) | |

Source: US Census Bureau; ACS 1-Year Estimates, Table B23007, 2017

## Income and cost of living

Median household income (see Box 6) has risen over recent years in both counties, reaching about $55,000 in 2017 (Fig. 4.2). Factoring in a rough measure of inflation,[2] just over $53,000 is needed in 2017 to have the same buying power as Bexar's 2012 median household income; for Atascosa, that 2017 figure is just under $49,000. Thus the true increase in median household income is not nearly as great as it appears at first glance.

Fig. 4.2 Median household income
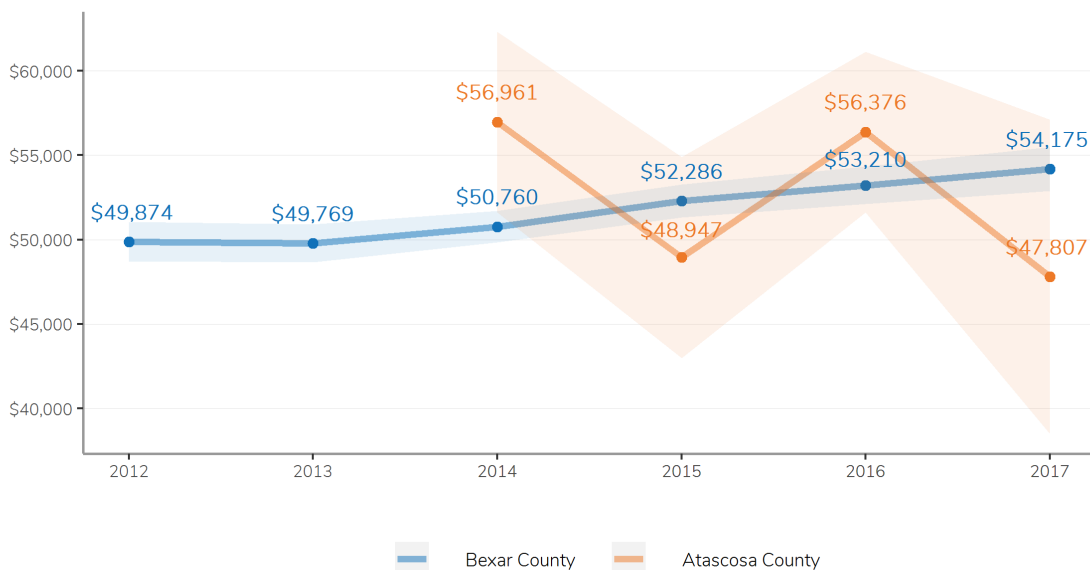


Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 1-Year Supplemental Estimates. Table: B19013, K201902
Prepared by CI:Now for THC

2. CPI Inflation Calculator.Retrieved from https://data.bls.gov/cgi-bin/cpicalc.pl

Fig. 4.2.1 Median household income by family type, 2017
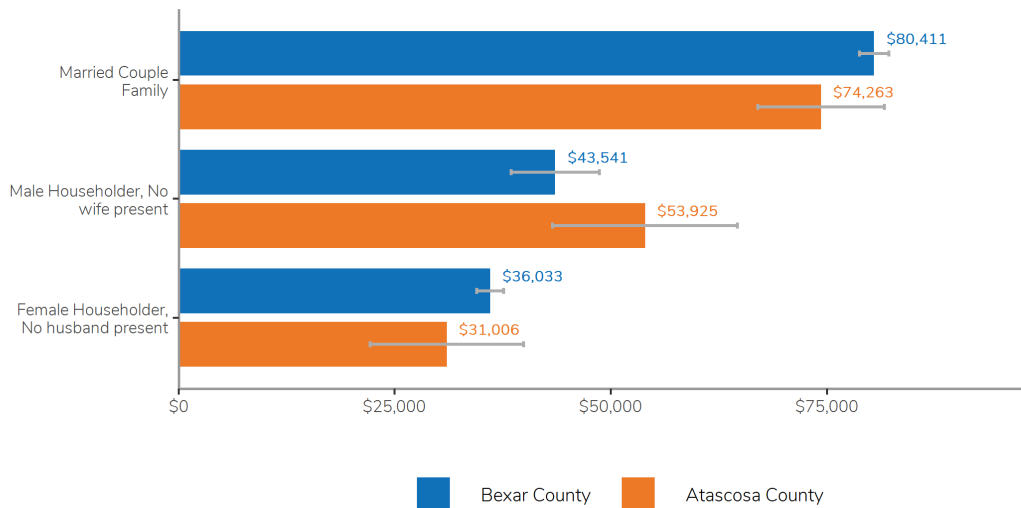


*Unreliable: Error is too large relative to estimate
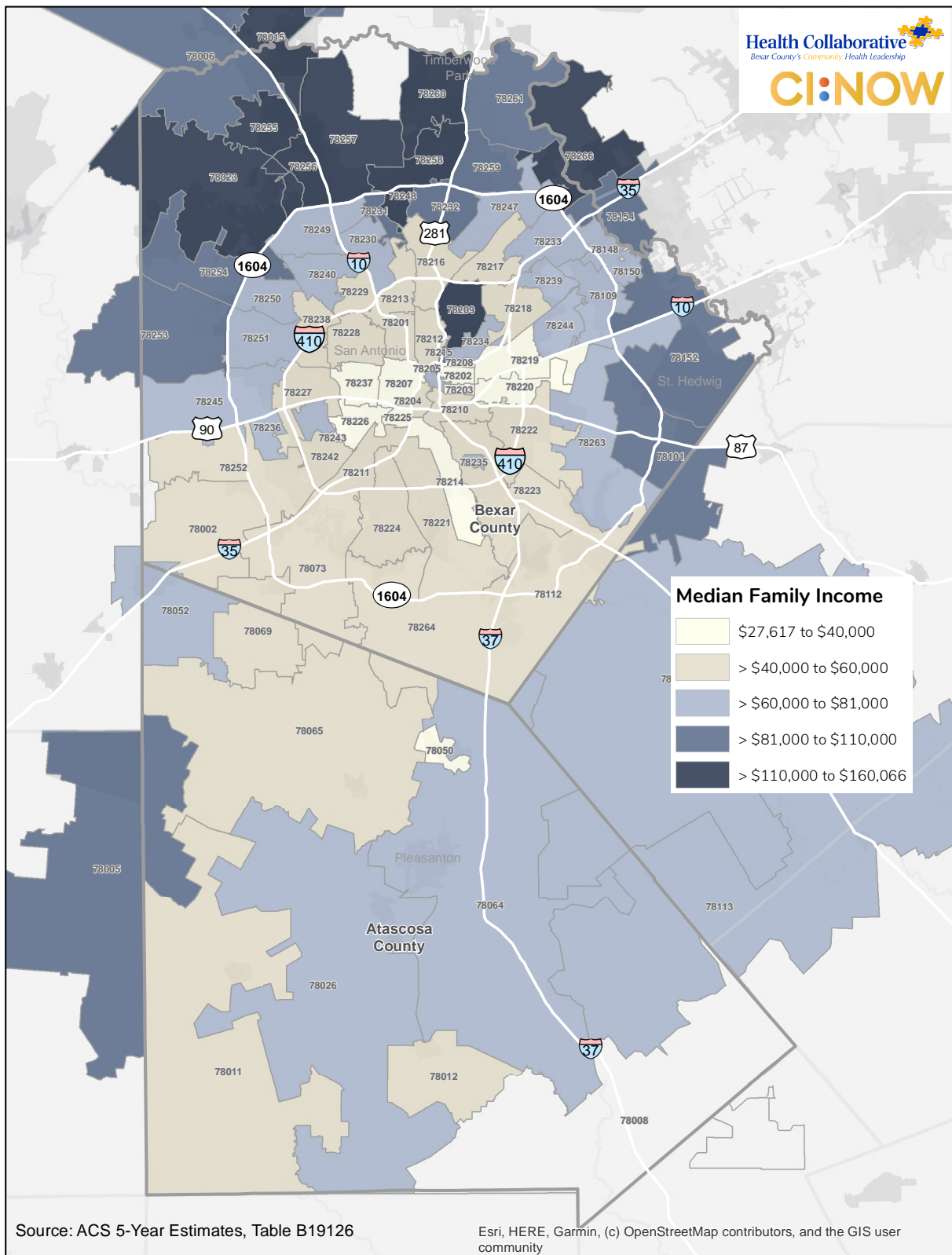Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B19126
Prepared by CI:Now for THC

Married-couple family households have the highest median household income in both counties (Fig. 4.2.1), followed by households with a male householder with no wife present. In both counties the median household income for female householders with no husband present is less than half of that of married-couple families. The zip codes with the highest median household incomes are clustered at the top and bottom of the map (Fig 4.2.2) – Bexar's far-north and -northwest zip codes and 78008 in southeast Atascosa. The highest median household income among those zip codes is five times as high as the lowest median household income shown on the map.

## Box 6
### Medians, means, and averages

When we have to boil all the rich detail and differences into a single number, the most commonly-used measures are the median and the mean. The median is the midpoint in the distribution of values (e.g., annual incomes), where half of values are higher and half are lower. If you had seven people of different ages in a room and lined them up from youngest to oldest, the median age would be the age of the middle (4th) person in the lineup. Mean is another word for average, found by adding up all the values and dividing that total by the number of values. In the age example, we would add up all the ages and divide that total by seven.

The choice to summarize data as a median, a mean, or both depends on the data itself and the goal of the analysis. It's usually better to use median if you have some extreme values in the data that are very different from the rest. Those extreme values can "drag" the mean up or down quite a bit, but don't change the median very much.

What's most important to remember is that both mean and median strip away all the variation. In the age example above, we have to remember that just because the median is 43, that doesn't mean all seven people are 43 – and in the case of the mean, it may be that *no one* in the group is 43.

Fig. 4.2.2 Median household income by zip code, 2017



**Median Household Income**

- $24,744 to $35,000
- > $35,000 to $52,000
- > $52,000 to $65,000
- > $65,000 to $93,000
- > $93,000 to $122,706

Source: ACS 5-Year Estimates, Table B19013

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
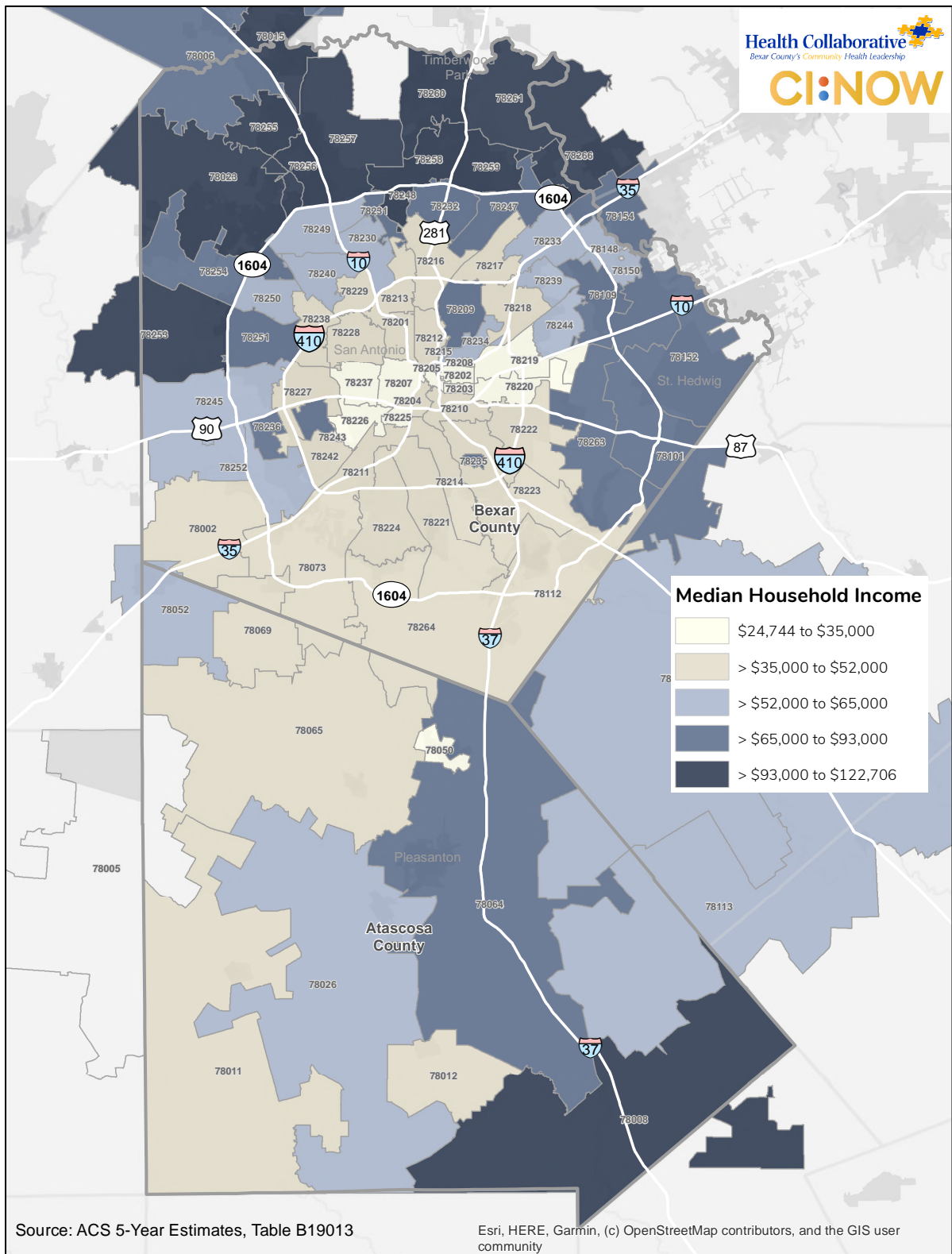
# Section 4: Economic Environment

Like median household income, median family income has risen in both counties (Fig. 4.2.3), but after adjusting for inflation, the true increase is lower than it appears. With the exception of Atascosa zip code 78008, the geographic pattern largely mirrors that of median household income (Fig. 4.2.4). The disparity is even greater; however, the highest median family income among those zip codes is nearly six times as high as the lowest median family income shown on the map.

Fig. 4.2.3 Median family income
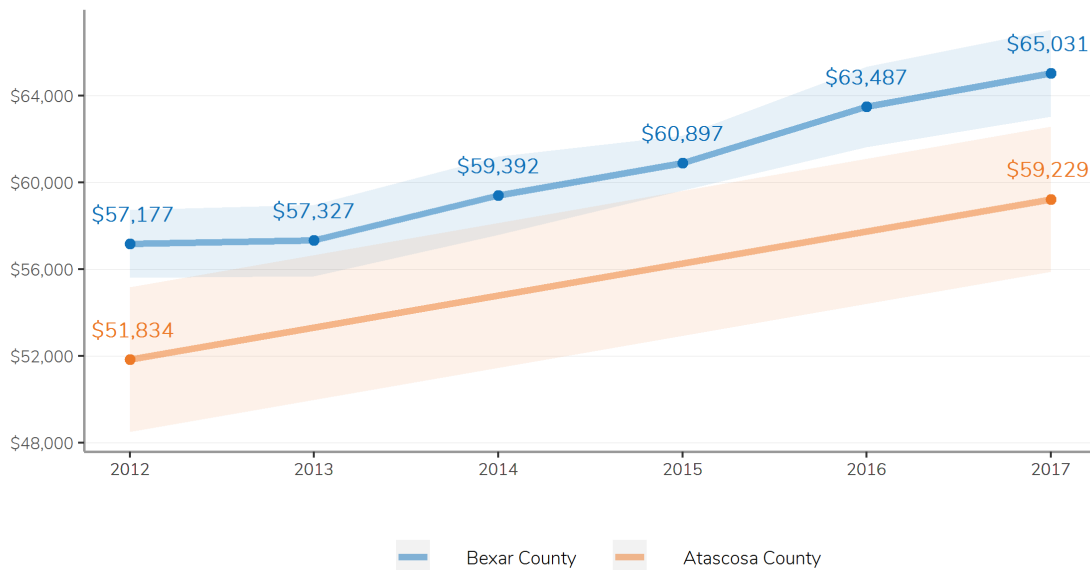
The United Way ALICE (Asset-Limited, Income-Constrained, Employed) model relates income to cost of living to determine what income a household needs just to get by with the very basics. Only recently available in Texas, ALICE estimates for each county and for several household types the "survival" vs. "stability" full-time hourly wage needed given the local costs of housing, child care, food, transportation, and health care (Fig. 4.2.5). The hourly and annual wages required for the ALICE survival and stability budgets are shown below for three example household types. The required wages are somewhat higher in Bexar.[3]

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3. ALICE Texas. Retrieved from https://www.uwtexas.org/sites/uwtexas.org/files/18UW_ALICE_Report_TX_Budgets_8.27.18%20%281%29.pdf

Fig. 4.2.4 Median family income by zip code, 2017



Source: ACS 5-Year Estimates, Table B19126

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

**Median Family Income**

- $27,617 to $40,000
- > $40,000 to $60,000
- > $60,000 to $81,000
- > $81,000 to $110,000
- > $110,000 to $160,066

Fig. 4.2.5 ALICE household survival budget by family type, 2016

| Household Type | Survival Budget Hourly (annual salary) | Stability Budget Hourly (annual salary) |
|---|---|---|
| **Atascosa County** | | |
| Single person | $9.07 ($18,132) | $14.71 ($29,412) |
| One adult with one infant | $16.33 ($32,652) | $31.57 ($63,144) |
| Two adults (one working), infant, and preschooler | $28.24 ($56,484) | $49.08 ($98,160) |
| **Bexar County** | | |
| Single person | $10.10 ($20,196) | $16.87 ($33,744) |
| One adult with one infant | $17.95 ($35,892) | $33.82 ($67,644) |
| Two adults (one working), infant, and preschooler | $29.98 ($69,962) | $50.56 ($101,124) |

Source: ALICE United Way of Texas, 2016

"ALICE households" are those with income below that threshold. Every figure in the table far exceeds minimum wage, and the required wages for family households exceed the $13 to $15 "living wage" thresholds established by multiple San Antonio-area employers. In Bexar, 36% percent of households have income below the ALICE survival threshold, sharply up from a flat trend of 24%-25% between 2010 and 2014 (Fig 4.2.6). In Atascosa, the trend is less stark, at 26%-27% in 2010 and 2016 with a drop to 22% in the intervening years. Bexar ALICE households are a much higher proportion of single/cohabiting (no children) households than of family households (with children) or 65-and-older households (no children) (Fig. 4.2.7). In Atascosa, ALICE households as a percent of total does not vary dramatically across household types.

Box 7
Households vs. Family Households

A household consists of all the people who live in a housing unit (e.g., a house or apartment), regardless of number of people or their relationship to each other. Family households are a subset of all households. Family households by definition consist of multiple people who are related to each other by birth, adoption, or marriage. Non-family households, on the other hand, are those where one person lives alone or where two or more people unrelated to each other live together, including unmarried partners and roommates.

Fig. 4.2.6 Percent of households with income below the ALICE survival threshold
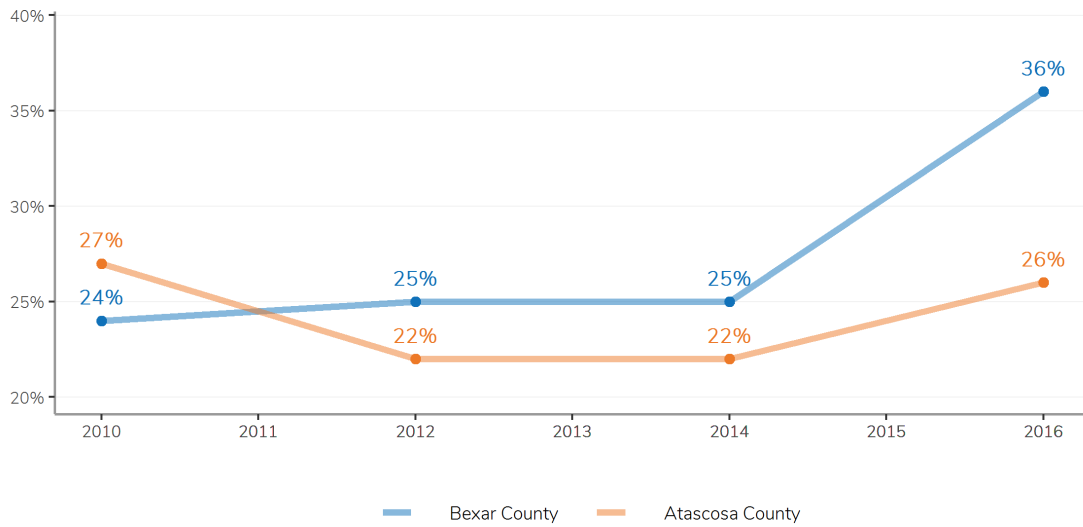




*Unreliable: Error is too large relative to estimate
Source: ALICE United Way of Texas
Prepared by CI:Now for THC

Fig. 4.2.7 Percent of households by type with income below the ALICE survival threshold, 2016
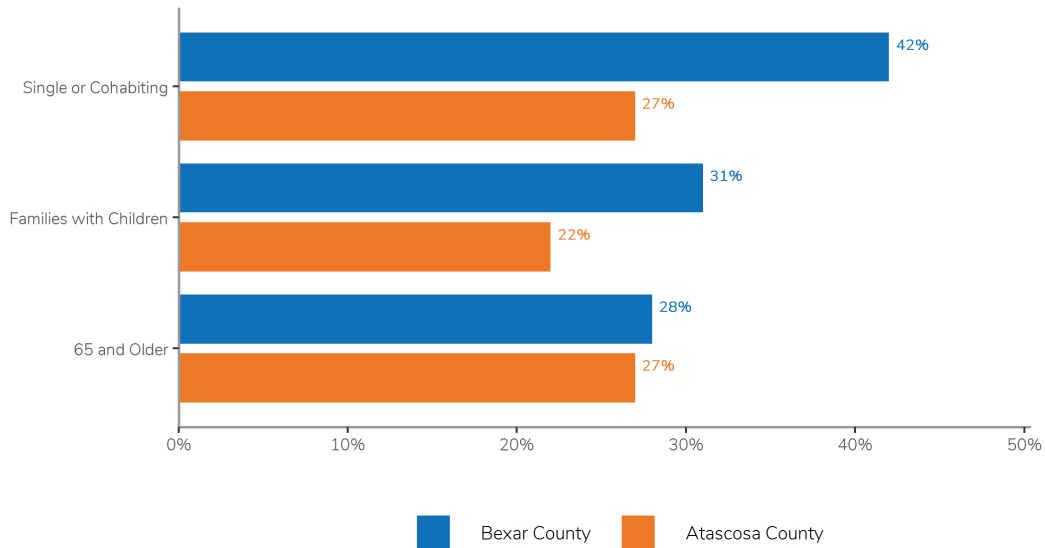


*Unreliable: Error is too large relative to estimate
Source: ALICE United Way of Texas
Prepared by CI:Now for THC

## Poverty

"Poverty" as defined by the U.S. government is currently an annual household income of $12,490 for a one-person household and $25,750 for a family/household of four.[4]  These thresholds – and indeed the entire calculation formula – are widely recognized to be far too low, representing

Fig. 4.3 Percent of population for whom poverty status is determined
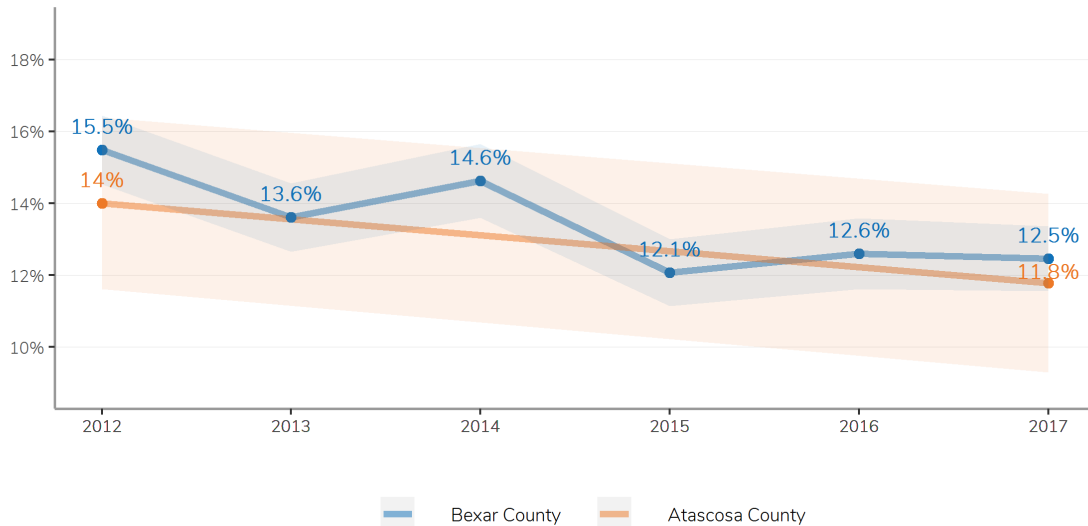


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B17026
Prepared by CI:Now for THC

Fig. 4.3.1 Percent of population for whom poverty status is determined by level of poverty, 2017
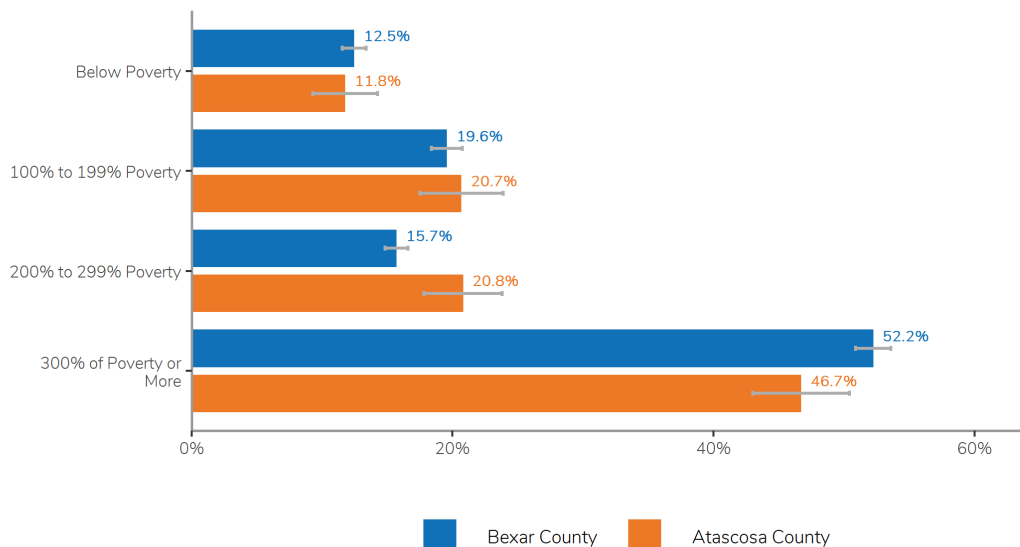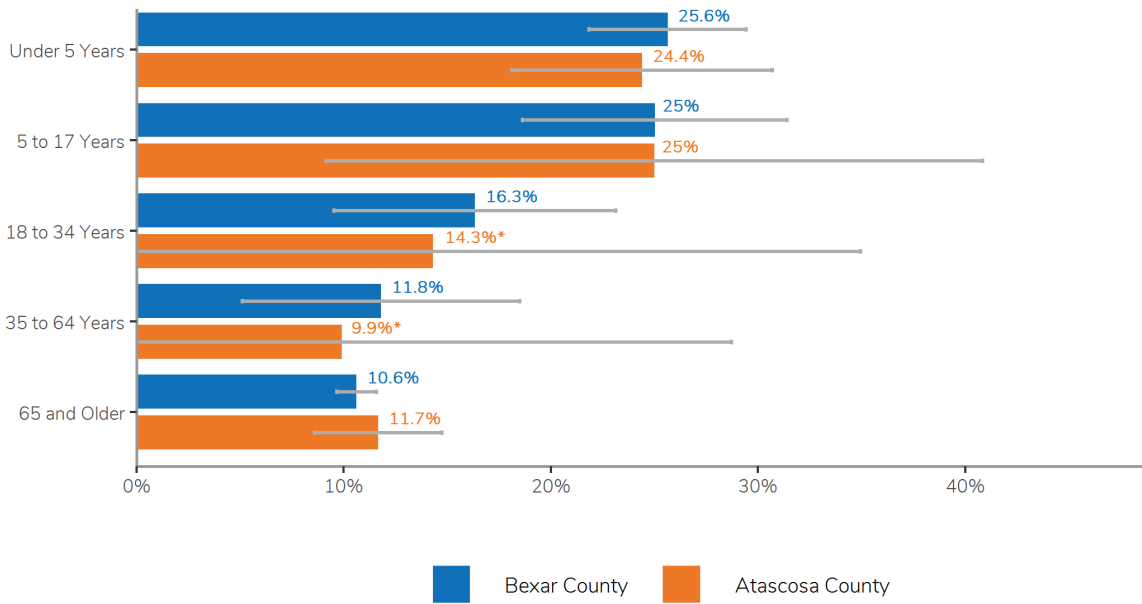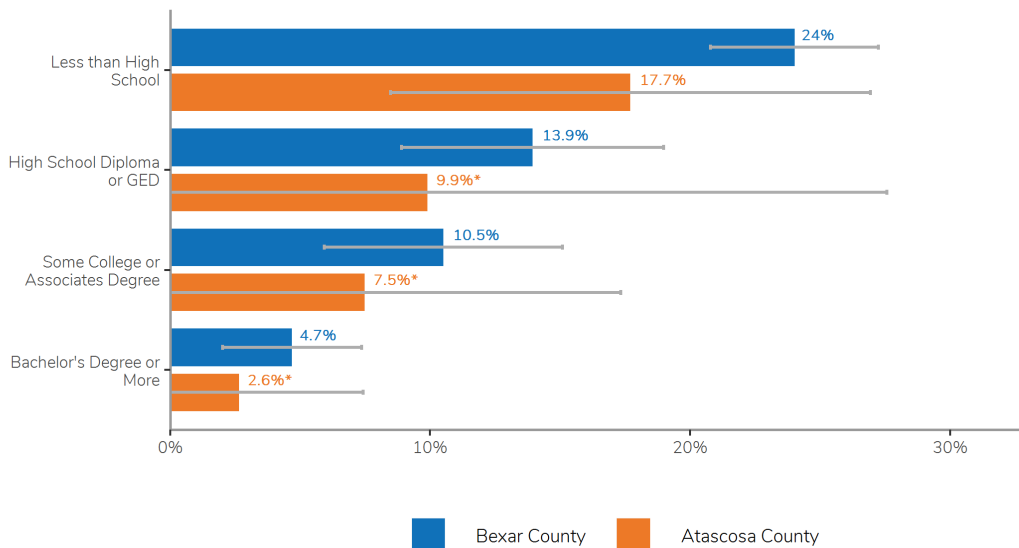


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17026
Prepared by CI:Now for THC

4. Poverty Guidelines. (2019, March 20). Retrieved from https://aspe.hhs.gov/poverty-guidelines

Fig. 4.3.2 Percent of families below 100% poverty level by zip code, 2017



**Families Below Poverty**

- 5% or Less
- > 5% to 10%
- > 10% to 15%
- > 15% to 25%
- > 25% to 39%

Source: ACS 5-Year Estimates, Table B17026

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
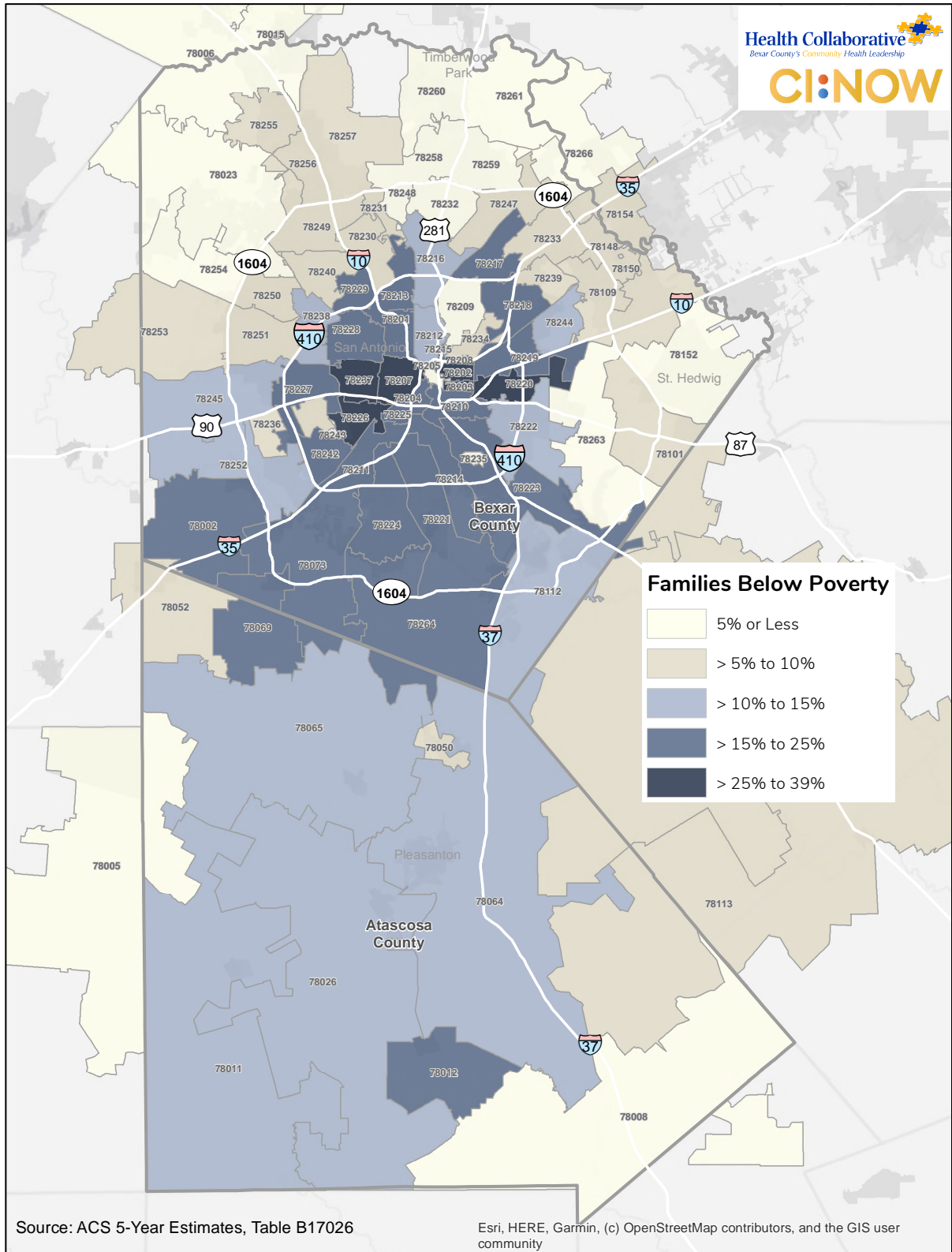
extreme poverty rather than overall poverty.[5]  The margins of error get quite wide, particularly for Atascosa, but the proportion of families with incomes below that very low threshold has declined slightly in Bexar and is either declining slightly or flat in Atascosa (Fig. 4.3). In both counties about 12% of families (Fig. 4.3.1) have an income below 100% of the federal poverty level (FPL), with another 20% between 100% and 200% FPL, or an annual income between $12,490 and $24,980 for a one-person household and between $25,570 and $51,140 for a four-person household. It appears that Atascosa has a slightly greater percentage of families at 200-299% FPL and a slightly lower percentage of families at 300% FPL or higher. The zip codes with the highest proportions of families with incomes under 100% FPL are east and west of downtown in Bexar. Except for 78226 adjacent to JBSA-Kelly Field Annex, all of these zip codes fall within an area bounded by Cupples Rd. to the west, Loop 410 to the east, Culebra and Grayson to the north, and Hwy 90 and Hwy 87 to the south. Within these neighborhoods, between 26% and 39% of families live in (extreme) poverty, as compared to five percent or fewer of families in the lowest-poverty zip codes largely clustered in north Bexar (Fig. 4.3.2).

In general, the higher the number of children in the family, the more likely the family is to be living in poverty. Again, the margins of error are wide for Atascosa, but in both counties the percent of families living in poverty – or rather, extreme poverty – ranges from about one in 20 families with no children to half or more of families with five or more children (Fig. 4.3.3).

Fig. 4.3.3 Percent of families in poverty by number of related children under 18 years, 2017
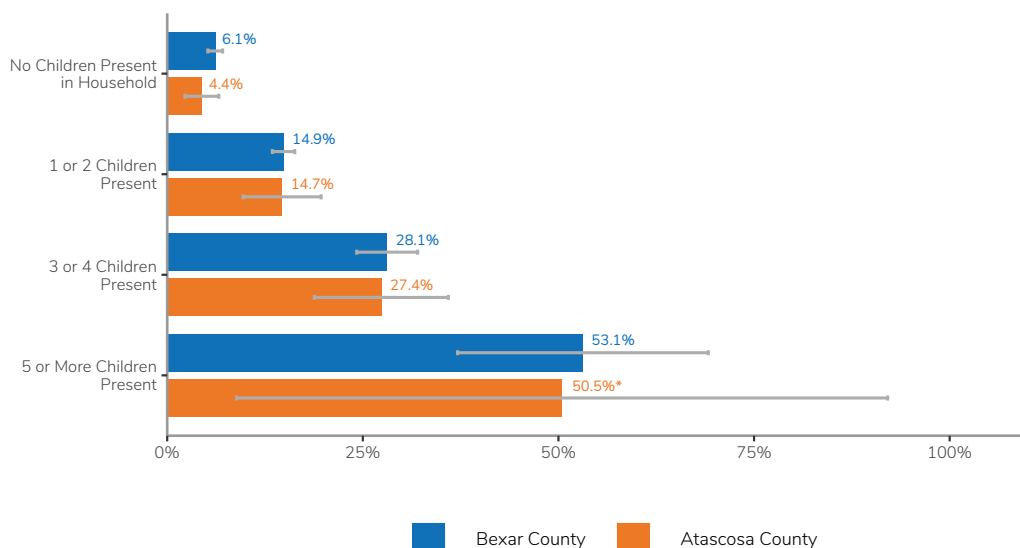


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17012
Prepared by CI:Now for THC

Poverty rates are the lowest among married-couple families (about one in 17) and highest in families with a female householder with no husband present (about one in three, Fig 4.3.4). Poverty rates differ dramatically by race/ethnicity, age group, and educational attainment. The lowest rates are among non-Hispanic whites (both counties) and the highest rate is among American Indians/Alaska Natives in Atascosa (Fig. 4.3.5). In both counties, children under 18

5. See for example O'Brien, R.L. & Pedulla, D.S. (2010). Beyond the poverty line. Stanford Social Innovation Review, 8(4). Retrieved from https://ssir.org/articles/entry/beyond_the_poverty_line

Fig. 4.3.4 Percent of families in poverty by family type, 2017
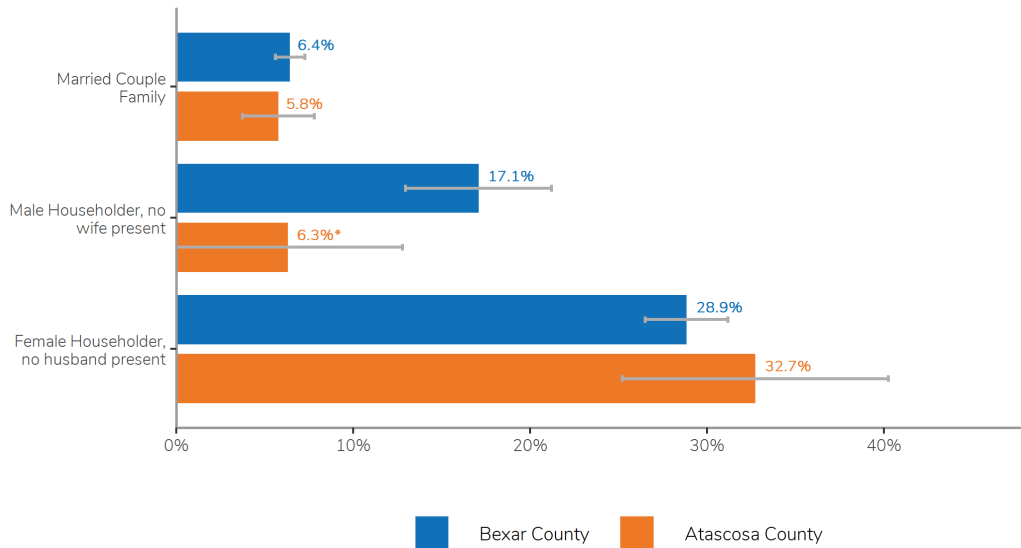


**Bexar County** — **Atascosa County**

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17012
Prepared by CI:Now for THC

Fig. 4.3.5 Percent of total race or ethnic group in poverty, 2017
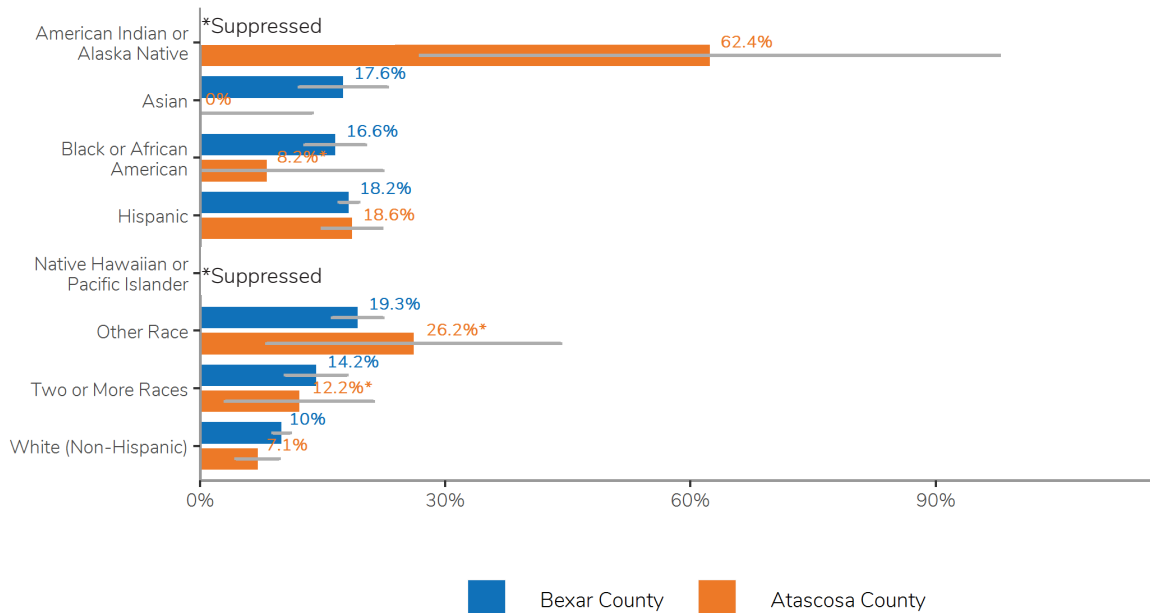


**Bexar County** — **Atascosa County**

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17001BtoI
Prepared by CI:Now for THC

Fig. 4.3.6 Percent of age group in poverty, 2017



Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17001
Prepared by CI:Now for THC

Fig. 4.3.7 Percent of population in poverty by educational attainment, 2017



Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17003
Prepared by CI:Now for THC

are roughly twice as likely to live in poverty as the adults 18 to 64 (Fig. 4.3.6); the child poverty rate is slightly higher than in Texas (21%) and quite a bit higher than the U.S. (18%).[6]  In Bexar the poverty rate among adults (25 and older) varies from an estimated 3% among people with a Bachelor's degree or higher to an estimated 24% among people with less than a high school diploma or GED (Fig. 4.3.7). The Atascosa estimates have wider margins of error, but the same general pattern holds.

A common assumption is that people are living in poverty because they are not working, but the data paints a different picture. In both counties, regardless of family type (married couple, female householder with no husband present, male householder with no wife present), about seventy percent of families living in poverty have at least one worker. That figure is similar to the ninety percent of families that that have at least one worker and are not in poverty.[7]  As one focus group participant put it, health and well-being would benefit from a *"pay raise for parents to work normal hours [so they can] spend quality time with their children."*

## Food insecurity

An estimated 11% of total Bexar population and 21% of child population are food insecure, without consistent access to nutritionally adequate food. Food insecurity can reflect a constant juggling act of whether to pay for food, rent, or medical care, or other basic needs. An estimated 9% of total Atascosa population and 21% of child population are food insecure.[8]  The geographic pattern of food insecurity, defined here as a census tract that is both low-income and low-access,[9] does not look like the geographic pattern of poverty (Fig. 4.4). The Bexar census tracts with the highest food insecurity rates are clustered in two north-south arrays, one west of I-10W and the other stretching from the near Westside and Tobin Hill past Loop 410E. The Atascosa tracts with the highest food insecurity rates are in the Poteet area and in the southwest area of the county.

Focus group participants spoke of the need for healthy food to be affordable. "Why do we all have diabetes and high blood pressure? Because we can't afford all these foods that are healthy." One key informant noted that "The health department is looking at some incentive programs to flip the cost structure– [to] switch things so the healthiest item isn't the most expensive."

6. US Census Bureau; ACS 1-Year Estimates, Table S1701, 2017
7. US Census Bureau; ACS 5-Year Estimates, Table B7014, 2017
8. Map the Meal Gap. Retrieved from https://map.feedingamerica.org/county/2017/overall/texas
9. Access is measured at one mile for urban areas and 10 miles for rural areas; for methodology see https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation/

Fig. 4.4 Census tracts with low income and low access to food by census tract, 2016
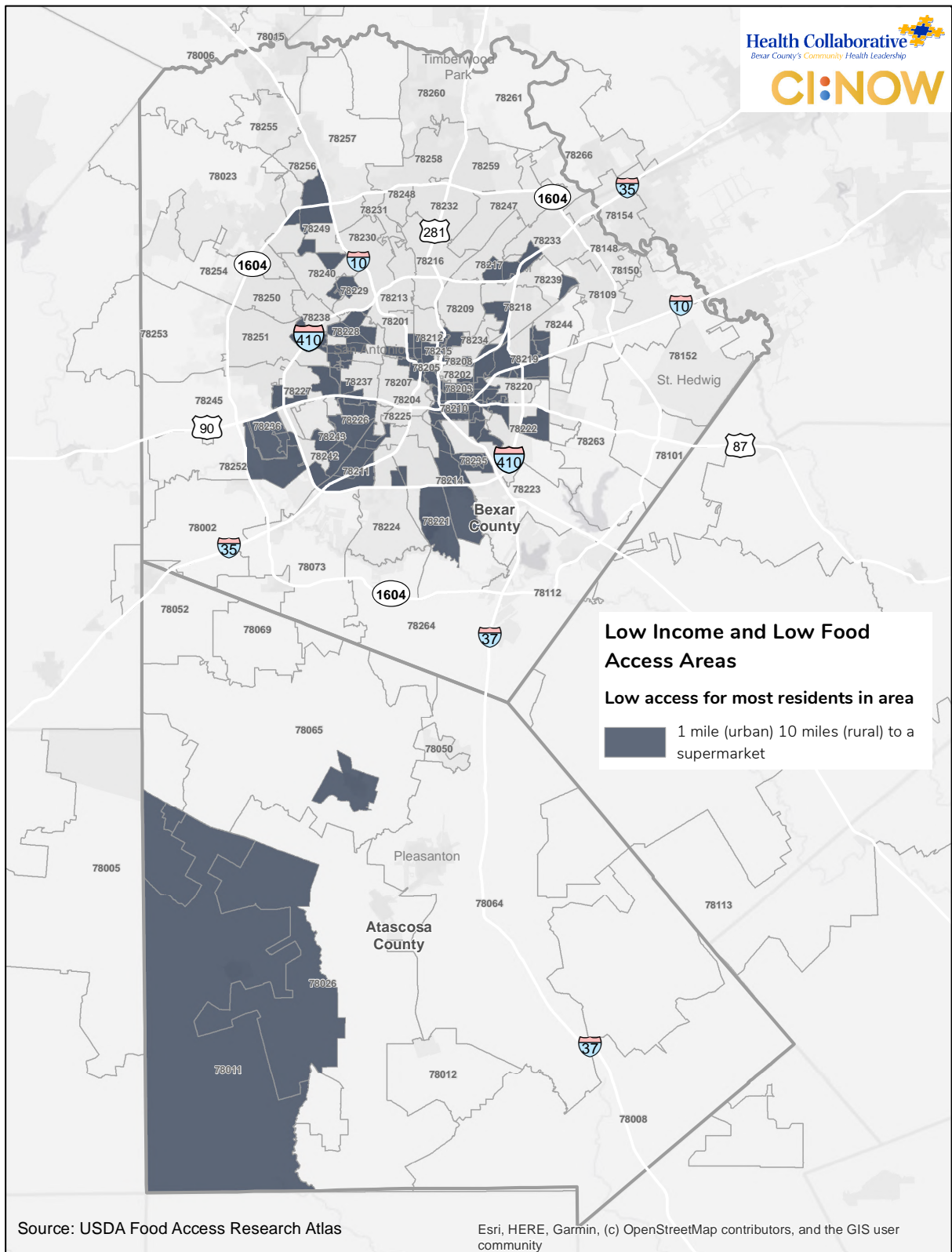
## Income inequality, income segregation and economic mobility

The Pew Research Center's Residential Income Segregation Index[10] measures the degree to which higher-income people live near others with higher incomes and lower-income people live near others with lower incomes. The methodology used in this report only approximates the RISI score because we use the income categories available in the U.S. Census American Community Survey (ACS) dataset, which rarely match up perfectly to the Pew-defined "low-income" and "high-income" cutoffs.[11] Averaging the most recent five years of data to minimize artificial variation introduced by the method, Bexar County's RISI score stands at 61, very similar to San Antonio's Pew-calculated RISI score of 63.

A mounting body of evidence indicates that high income inequality in an economy harms everyone, including those with high incomes.[12] The Gini Index measures income distribution or inequality in a population; a Gini Index of zero would indicate perfect income equality, while 1 (or 100, if displayed as a whole number) would indicate perfect inequality. Bexar's Gini Index is .47 for 2017; Atascosa's is .44 (Fig. 4.5). The zip codes with the highest Gini Indexes –.5 and over – are Atascosa's 78113, which stretches from Cambellton and McCoy northeast through Poth and Falls City (Fig 4.5.1); 78257 (including The Dominion and Leon Springs); 78212 (Tobin Hill, Monte Vista, Kenwood, Edison, Olmos Park Terrace, and Northmoor); 78209 (including Alamo Heights, Mahncke Park, Wilshire Terrace); 78205 (downtown); 78202 (Dignowity Hill, Harvard Place/ Eastlawn, and Jefferson Heights); and 78204 (Arsenal, Lone Star, and Collins Gardens).

Fig. 4.5 Gini index of income inequality
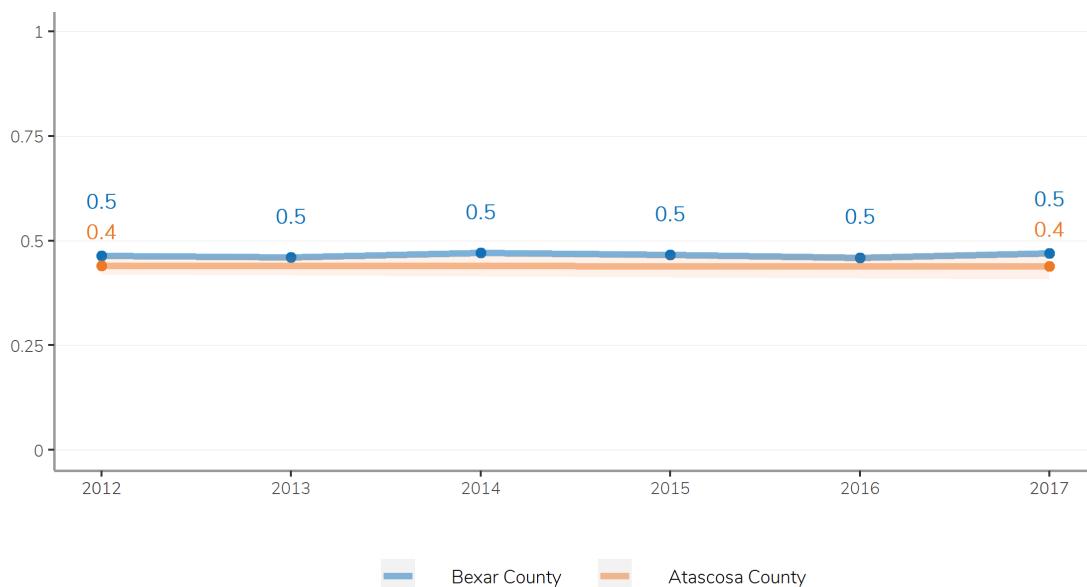


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B19083
Prepared by CI:Now for THC

10. The Rise of Residential Segregation by Income. (2014, April 22). Retrieved from https://www.pewsocialtrends.org/2012/08/01/the-rise-of-residential-segregation-by-income/
11. Pew defines "higher-income" as a household income greater than twice (200% of) the median household income; "lower-income" means a household income less than two-thirds (67%) of the median household income. For example, two-thirds of Bexar's median household income ($53,999) is $35,999, but the best-matching ACS income category is $30,000 to $34,999. Therefore the approximated RISI score excludes or "misses" true-RISI household with incomes between $35,000 and $35,998.
12. See for example Kawachi, I., Kennedy, B.P., & Wilkinson, R.G. (eds.) (1999.) The society and population health reader, vol. I: Income inequality and health. New York: The New Press.

Fig. 4.5.1 Gini index of income inequality by zip code, 2017



**Gini Index**

- > .29 to .35
- > .35 to .40
- > .40 to .45
- > .45 to .50
- > .50 to .59

Source: ACS 5-Year Estimates, Table B19083

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
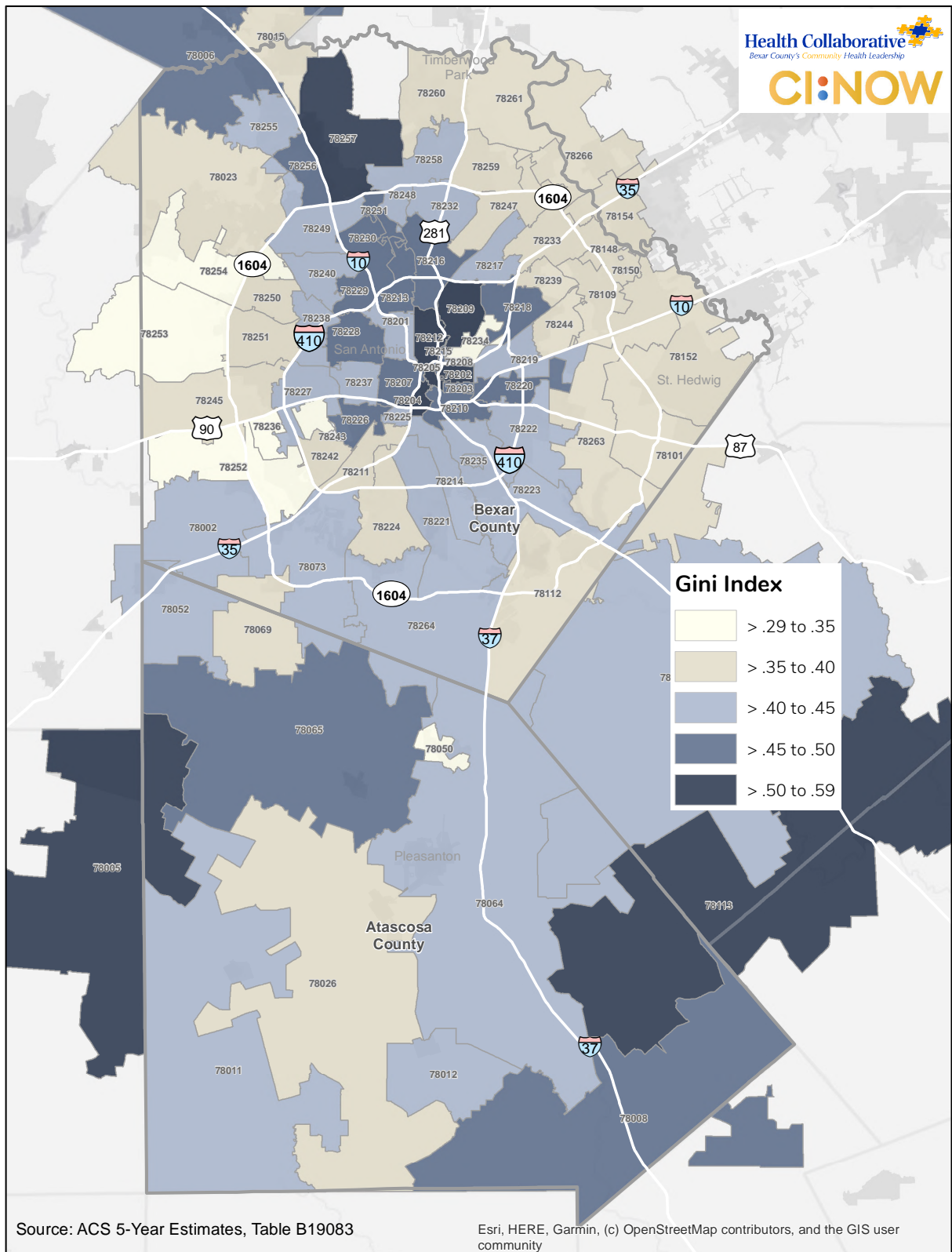
# Section 4: Economic Environment

For context, Texas' Gini Index is .48; the higher Gini scores in Texas are scattered across the state and tend to be non-urban, with many emerging recently in the Eagle Ford Shale area. For example, La Salle County's Gini Index rose from .46 (2006-2010 data) to .60 (2012-2016 data) over five years and Karnes County's rose from .44 to .55. The U.S. Gini Index is .47, with the highest values in New York (.51) and Louisiana (.50).[13]  Countries with a Gini Index similar to Bexar include Bolivia, Honduras, Nicaragua, and the Dominican Republic; those with a Gini Index similar Atascosa include the Central African Republic, Philippines, Iran, and Thailand. The Gini Indexes in Sweden, Germany, Australia, Canada, the United Kingdom, and Russia are .25, .27, .30, .32, .32, and .41, respectively.[14]

It's important to note that the Gini Index measures income distribution rather than wealth distribution. Good local data about household wealth and assets is unavailable, but if wealth other than income could be factored in, local inequalities would almost certainly appear even more stark.

Virtually all neighborhood indices are snapshots of current conditions – or more accurately, recent conditions – but the Opportunity Atlas published in 2018 takes a different approach. For each census tract (or county or commuting zone) the Opportunity Atlas presents average current outcomes for people born between 1978 and 1983 who grew up in that census tract, no matter where they now live as adults. This approach is invaluable for areas like Bexar and Atascosa where a substantial driver of population growth is in-migration, and those in-migrants as a group are higher-income and better-educated than the population born here. Because of that "brain gain" and "wealth gain," county snapshots taken over time will paint a picture of improvement, when in the reality the change may be due entirely to the measurement of different set of people each time.

The Opportunity Atlas presents a wealth of data, but just one key outcome is presented here. A measure of social and economic mobility, that outcome is the percent of low-income children who as of their mid-30s had a household income the top 20% of household incomes nationally for children born in the same year.  Low-income children are defined here as those whose household income as children fell in the bottom 25th percentile; that is, 75% of households at that time had higher household income. The data are drawn from income tax records.[15] Table 4.5.2 below summarizes the variation by sex and race/ethnicity in percent of low-income children who were economically upwardly mobile. The numbers for some Atascosa sex-race/ethnicity combinations were suppressed to protect privacy.

With 30% of low-income children reaching the top 20% of household incomes as adults – four times the percentage for Bexar overall – female Asian/Pacific Islanders were by far the most likely group in either county to be upwardly mobile economically. Bexar black females were the least likely to reach the top 20% of household incomes as adults, just slightly under the fraction of black males. With the notable exception of white females, Atascosa children of all sex-race/ethnicity combinations (non-suppressed) were more likely than their Bexar peers to reach the top 20% of household incomes. In some cases that difference in outcome was substantial: low-income Atascosa white males and Hispanic males were almost twice as likely as low-income Bexar white males and Hispanic males, respectively, to reach the top 20%.

13. Bexar County Gini Index of Income Inequality. (n.d.). Retrieved from https://www.livestories.com/statistics/texas/bexar-county-gini-index-income-inequality
14. The World Factbook — Central Intelligence Agency. (n.d.). Retrieved from https://www.cia.gov/library/publications/the-world-factbook/rankorder/2172rank.html
15. Opportunity Insights. Constructing the Opportunity Atlas: Methodology. (2018). Retrieved from https://opportunityinsights.org/wp-content/uploads/2018/10/Atlas_methods.pdf

# Section 4: Economic Environment

Differences in upward mobility are even more stark when examined by census tract, with the percent of upwardly mobile low-income children ranging from fewer than 1% to around 50%, depending on sex-race/ethnicity combination. The greater magnitude of difference based place highlights the critical and complex role that childhood neighborhood conditions play in a person's life trajectory. Despite structural discrimination existing everywhere, neighborhoods that are good for some children are not good for others,[16] and children of the same sex-race/ethnicity group who grow up with similar family structures and household incomes can experience very different outcomes.[17] Tract level-estimates are not mapped here because slicing the data into so many groupings results in suppression of a large proportion of the estimates, and for the remainder, the margins of error are typically too wide for the estimates to be trustworthy.

Fig. 4.5.2 Percent of low-income children who grew up to have a household income in the top 20%, 2015

|  | Atascosa County | | | Bexar County | | |
|---|---|---|---|---|---|---|
|  | Female | Male | Total | Female | Male | Total |
| American Indian/AN | * | * | * | 7.6% | 10.1% | 9.1% |
| Asian/PI | * | * | * | 30.0% | 20.7% | 25.2% |
| Black | * | * | 6.7% | 4.0% | 4.5% | 4.2% |
| Hispanic | 8.2% | 10.8% | 9.5% | 7.2% | 6.0% | 6.6% |
| White | 14.1% | 22.4% | 18.4% | 16.2% | 13.1% | 14.6% |
| Total | 9.4% | 13.0% | 11.2% | 8.0% | 6.7% | 7.3% |

*Suppressed value
Source: The Opportunity Atlas. Retrieved from https://www.opportunityatlas.org/

16. Chetty, R., Friedman, J., Hendren, N., Jones, M., & Porter, S. (2018). The Opportunity Atlas: Mapping the Childhood Roots of Social Mobility. Retrieved from Opportunity Insights website: https://opportunityinsights.org/wp-content/uploads/2018/10/atlas_paper.pdf
17. Quealy, K. (2018, January 20). Extensive data shows punishing reach of racism for black boys. New York Times. Retrieved from https://www.nytimes.com/interactive/2018/03/19/upshot/race-class-white-and-black-men.html

# Section 5: Service Environment

## Access to healthcare and other services

Focus group participants felt that health care was critical to healthy child and family development, including health insurance, health clinics, immunizations, mental health care, and oral health care. Beyond health care, participants saw a critical need to support families with housing, child care, food, parent education, and after-school activities at school and in the neighborhood. Key informants identified similar needs, including programs for youth aging out of foster care, parent education, community education on adverse childhood experiences, and programs to motivate people to stay physically active. Both focus group participants and key informant interviewees talked about the need for education on healthy eating, parenting, and other issues. Those perspectives are included alongside the quantitative data for each respective issue later in this assessment.

Focus group participants and key informant interviewees saw the need for both greater availability of services – *"Yo no sé de ningún programa que está disponible para nosotros"* – and also better community awareness of the services and resources available now. Focus group participants felt that better marketing could help *"families know what programs are available to them."*

They noted several other barriers to getting health care and other services, including parents' responsibilities and long work hours, wait lists, costs, and eligibility and application policies and practices: *"...when you're just above the poverty line, you're not eligible for services."* One participant contrasted today's geographic barriers with the way it used to be: *"back in the day, the doctor used to go to you."*

The ratio of healthcare professionals to population is a common measure of provider availability, and that ratio differs greatly among specialties and geographically. Bexar has 84.3 primary care providers per 100,000 population, more than twice as many as Atascosa, and 40.9 per 100,000 physician assistants compared to Atascosa's 14.9 (Fig. 5.1). Bexar has over twice as many nurse practitioners (67.9) compared to Atascosa's 26.1. Bexar has only 22 clinical psychologists per 100,000, and Atascosa has virtually none.

Unfortunately, the trends in provider numbers are largely unfavorable. Since 2014 primary care physician availability has increased by just 5% in Bexar (Fig. 5.1.1) and has decreased by 13% in Atascosa. Unsurprisingly, the highest ratio of primary care physicians per population are in the medical center, downtown, and Brooks areas of Bexar County. The relatively high ratio on the near Westside is misleading, as 78207 is home to the University Health System Robert B. Green Campus and the Children's Hospital of San Antonio (Fig. 5.1.2). Otherwise, the Eastside and Westside stand out as lacking primary care availability. As with primary care, the highest ratios of psychiatrists to population are in Bexar's medical center and downtown areas, as well as JBSA Fort Sam Houston (Fig. 5.1.3).

**Related data**

Health Behaviors and Risks:
• Healthy eating

Health Outcomes:
• Birthrates and maternal characteristics

Health Outcomes:
• Mental illness and suicide

# Section 5: Service Environment

Fig. 5.1 Number of healthcare professionals by type per 100,000 population, 2018
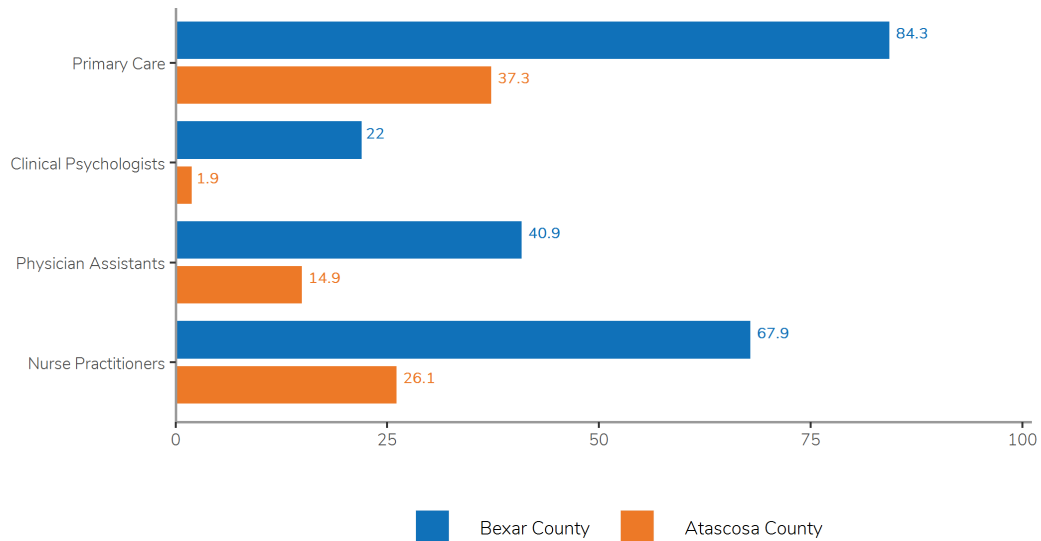


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 5.1.1 Ratio of primary care professionals per 100,000 population
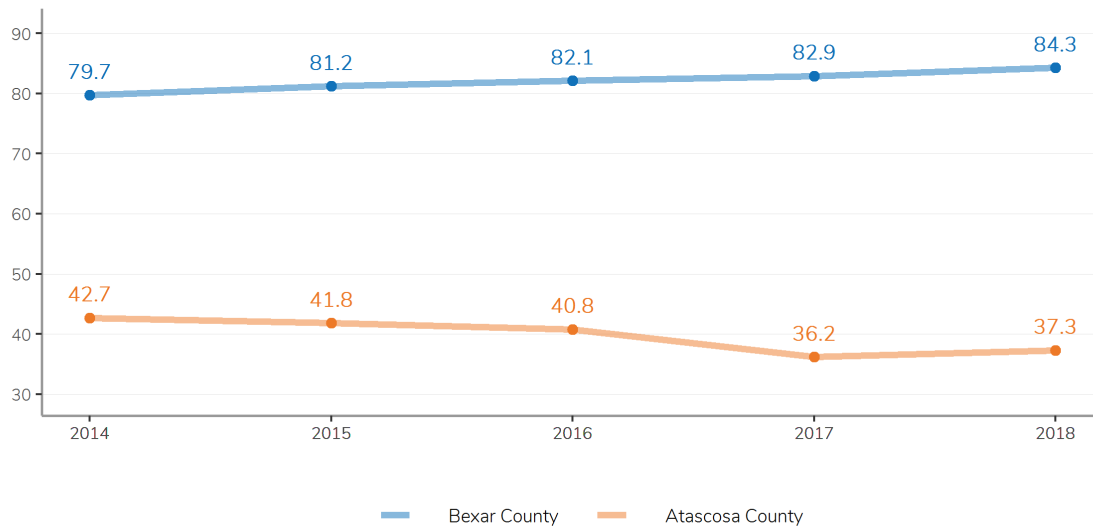


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 5.1.2 Number of primary care professionals per 100,000 by zip code, 2018



**Primary Care Physicians per 100,000**

- 50 or less
- > 50 to 100
- > 100 to 300
- > 300 to 1,000
- > 1,000 to 4,000

Source: Texas Medical Board

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
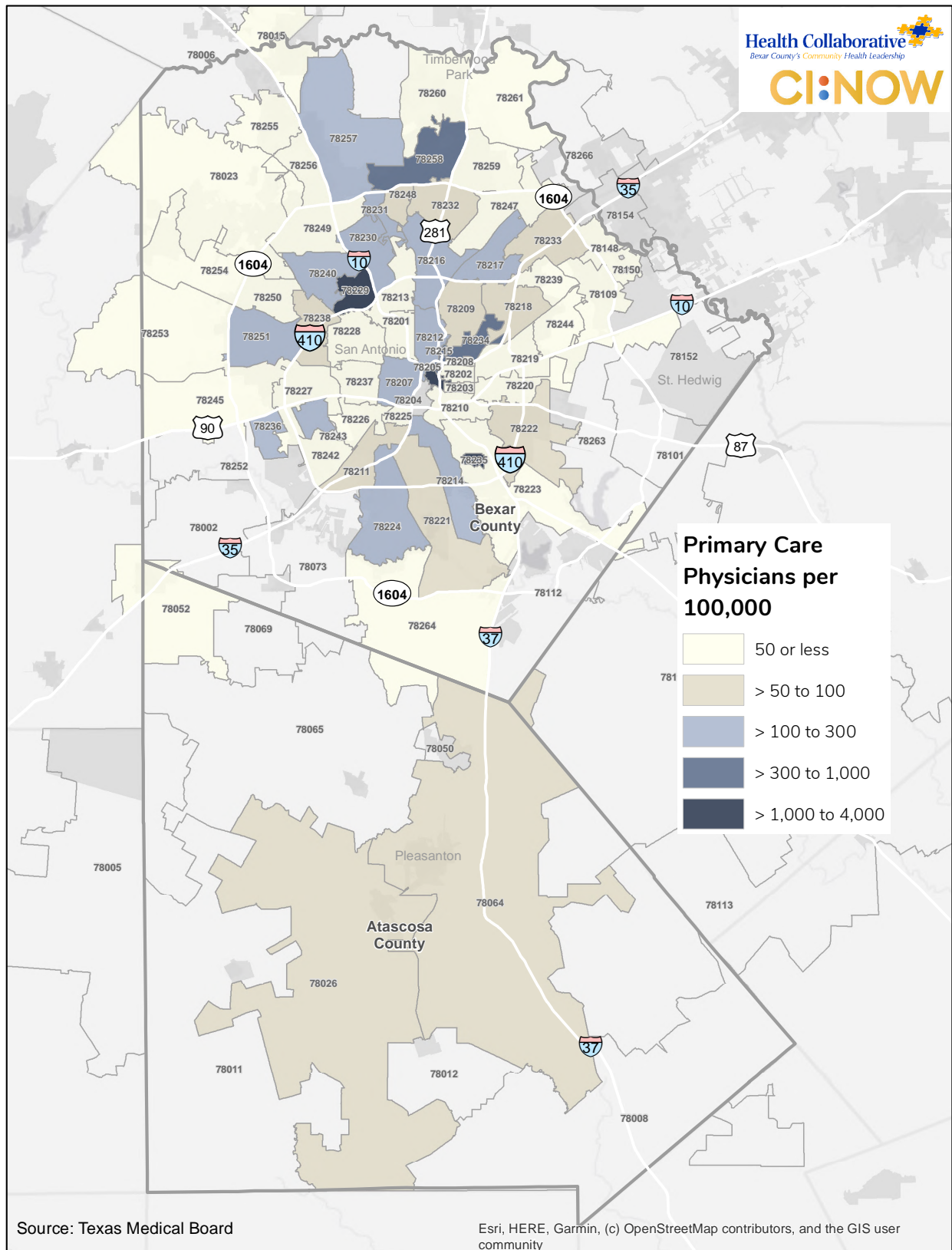
Fig. 5.1.3 Number of psychiatrists per 100,000 by zip code, 2018



**Psychiatrists per 100,000**

- 5 or less
- > 5 to 15
- > 15 to 45
- > 45 to 100
- > 100 to 700

Source: Texas Medical Board

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
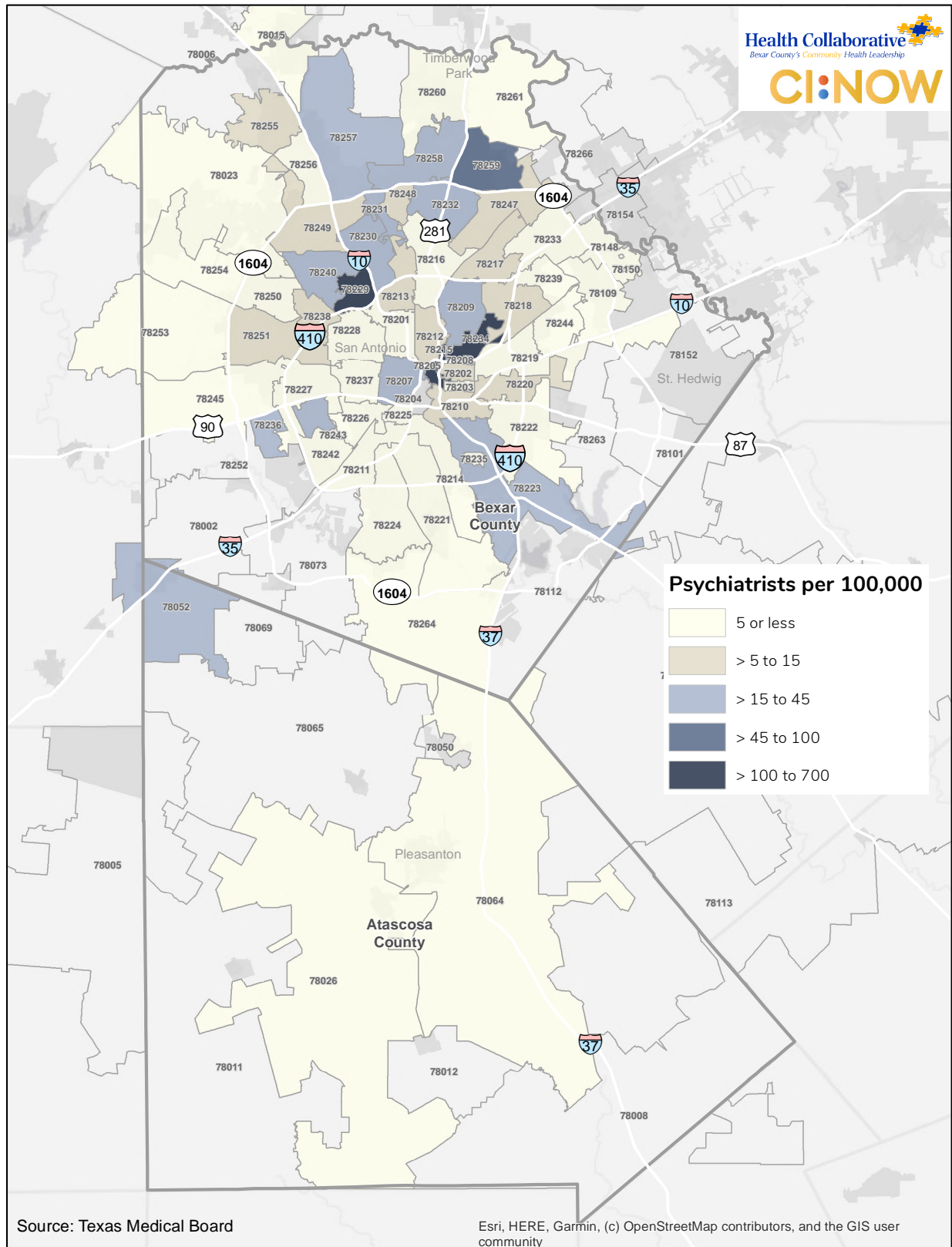
# Section 5: Service Environment

The picture is somewhat brighter for physician assistants, with an 18% increase in Bexar and some increase in Atascosa (Fig. 5.1.4). The numbers are so small in Atascosa that the ratio shows tremendous "bounce" over time, leaving questions about whether the increase is meaningful. The ratio for nurse practitioners has risen by almost fifty percent in Bexar County and more than doubled in Atascosa County since 2014 (Fig. 5.1.5). Clinical psychologists availability appears to have crept up slightly in Bexar but remained flat or decreased slightly in Atascosa (Fig. 5.1.6).

Fig. 5.1.4 Ratio of physician assistants per 100,000 population
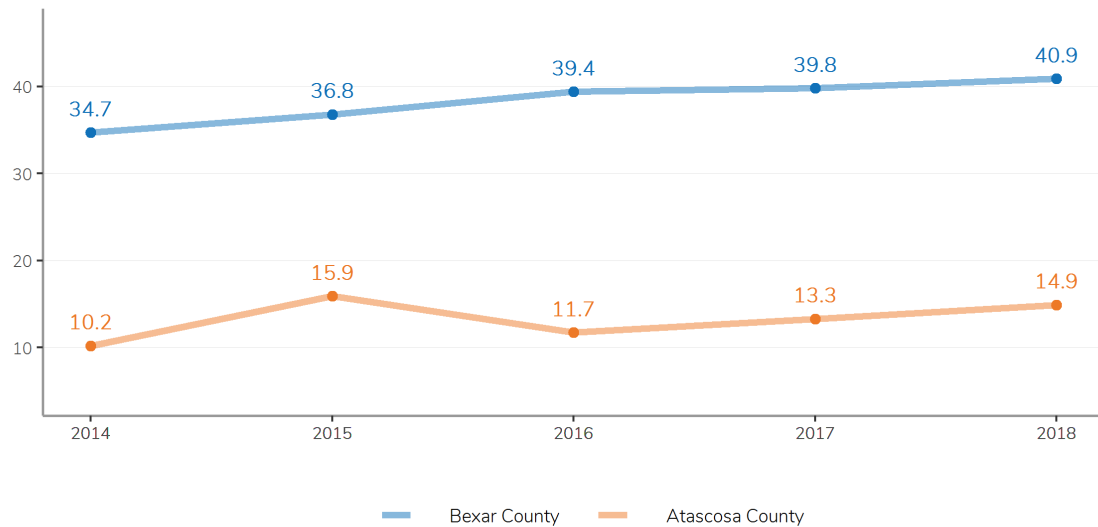


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 5.1.5 Ratio of nurse practitioners per 100,000 population
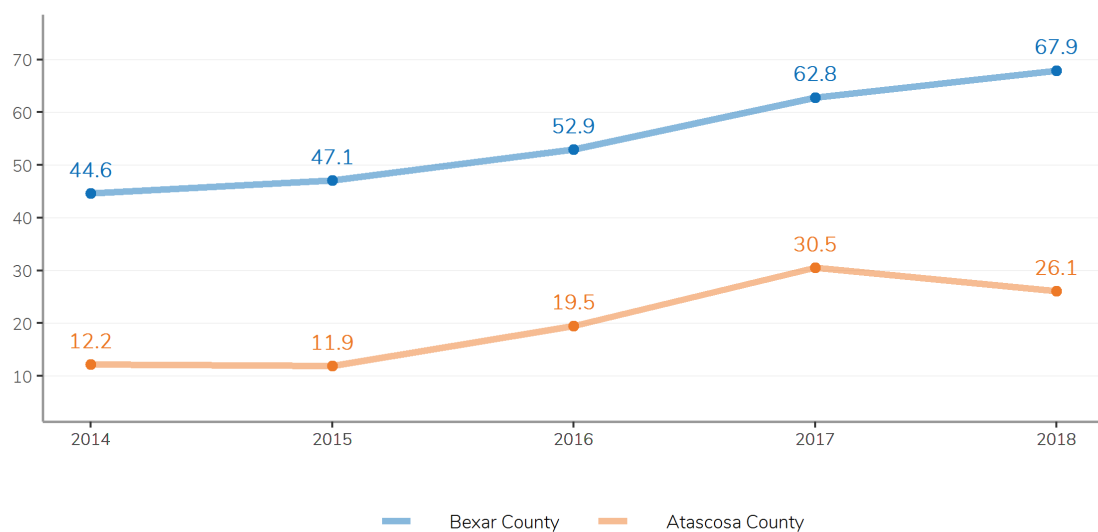


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 5.1.6  Ratio of clinical psychologists per 100,000 population
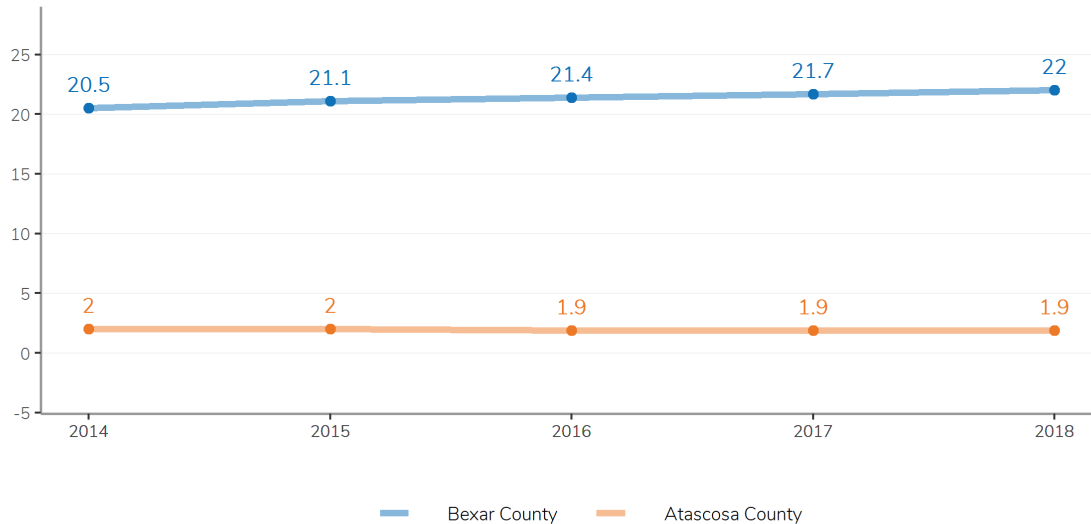


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

In 2016, Bexar had a total of 5,396 licensed acute care beds for a ratio of 28.0 per 10,000 population. Atascosa had 67, or 13.8 per 10,000 population.[1]

Even when a sufficient number of providers and beds are available, cost is an obvious barrier to care for many, and health insurance is critical. The percent of total population with no health insurance coverage dropped by nearly a quarter in Bexar between 2012 and 2017 but the wide margins of error for Atascosa make it difficult to interpret a trend (Fig. 5.1.7). Uninsurance differs by age group (Fig. 5.1.8). Traditionally, children and teenagers have better access to health insurance than adults because of Medicaid and CHIP but there are still about 5-9% of Bexar residents under 19 without health insurance and this rate appears to be higher for Atascosa.  The young adult group has largely aged out of Medicaid eligibility, may not have a job that offers health insurance, and very often does not see a need for health insurance. Among adults in the 19-64 range, there are about 20% uninsured in Bexar. Most seniors have access to Medicare leaving less than 2% without coverage.  For Atascosa, the uninsured for the 19-64 range are higher than Bexar but seniors are about the same as Bexar. About half of people in both counties with health insurance have employer-based insurance, with Medicaid and multiple-source coverage trailing as a distant second- and third-most common (Fig. 5.1.9). The zip codes with the highest rates of uninsurance – the lowest percentage of population with health insurance – are largely clustered within Loop 410 in Bexar, but the Elmendorf (Bexar) and Leming (Atascosa) areas also stand out (Fig. 5.1.10).

1. Department of State Health Services, Annual Hospital Survey Forms. Retrieved from https://dshs.texas.gov/chs/hosp/hosp5/

Fig. 5.1.7 Percent of civilian, non-institutionalized population without health insurance
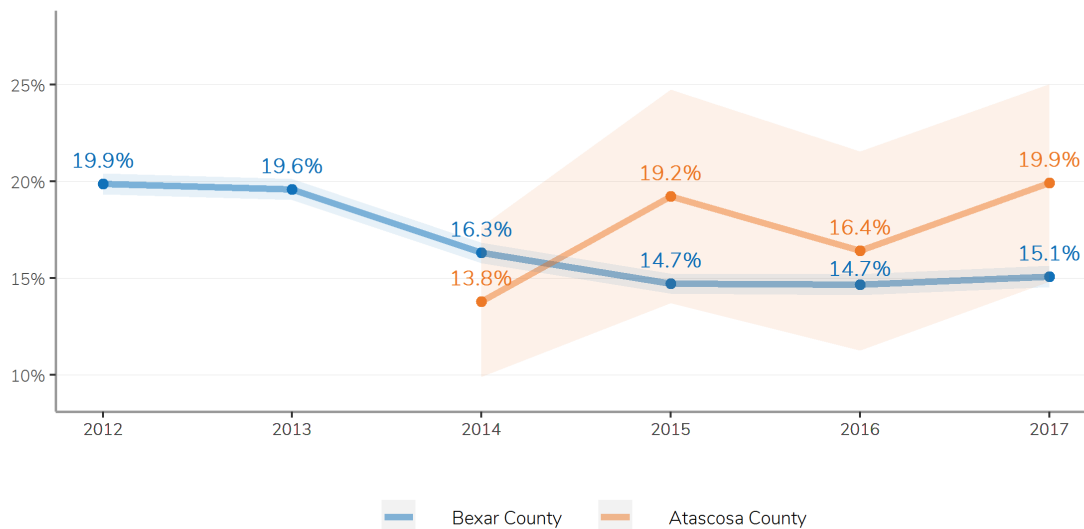


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 1-Year Supplemmental Estimates. Table:B27001, K202701
Prepared by CI:Now for THC

Fig. 5.1.8 Percent of uninsured civilian, non-institutionalized population by age group, 2017
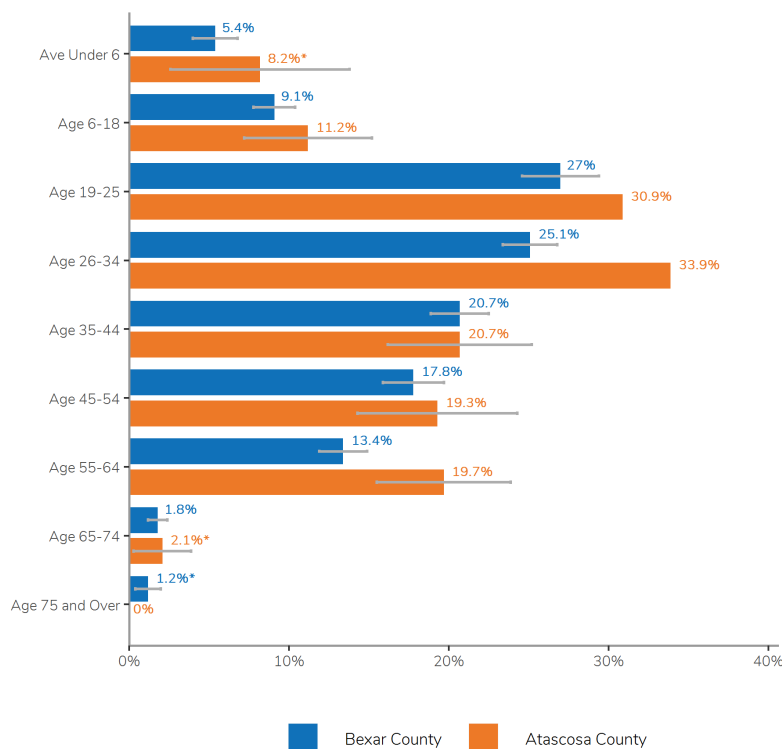


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates Table: B27001
Prepared by CI:Now for THC

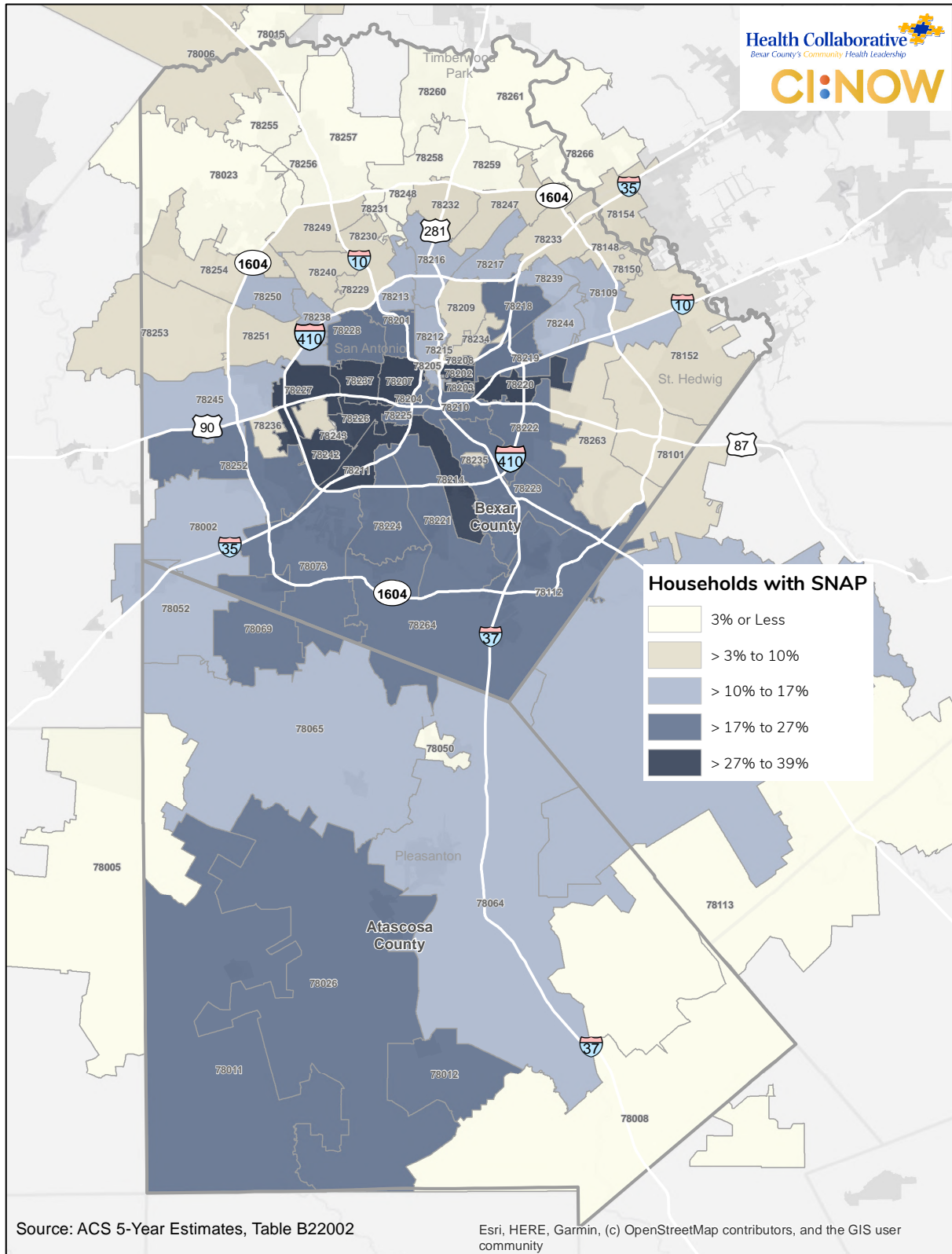Fig. 5.1.9 Percent of insured civilian, non-institutionalized population by type of insurance, 2017
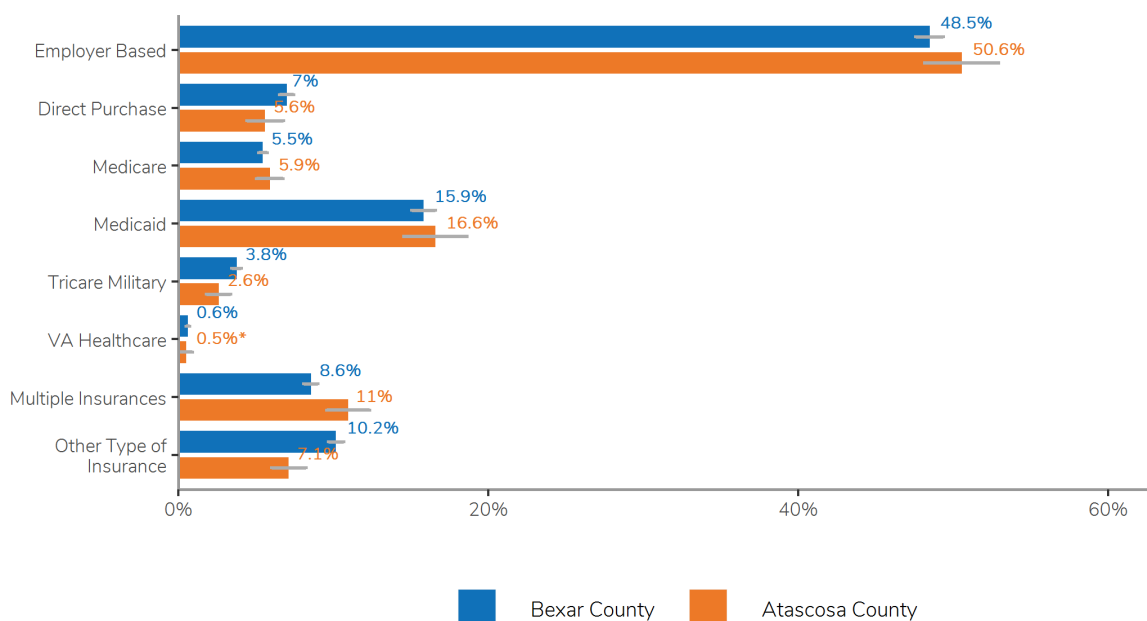


*Unreliable: Error is too large relative to estimate
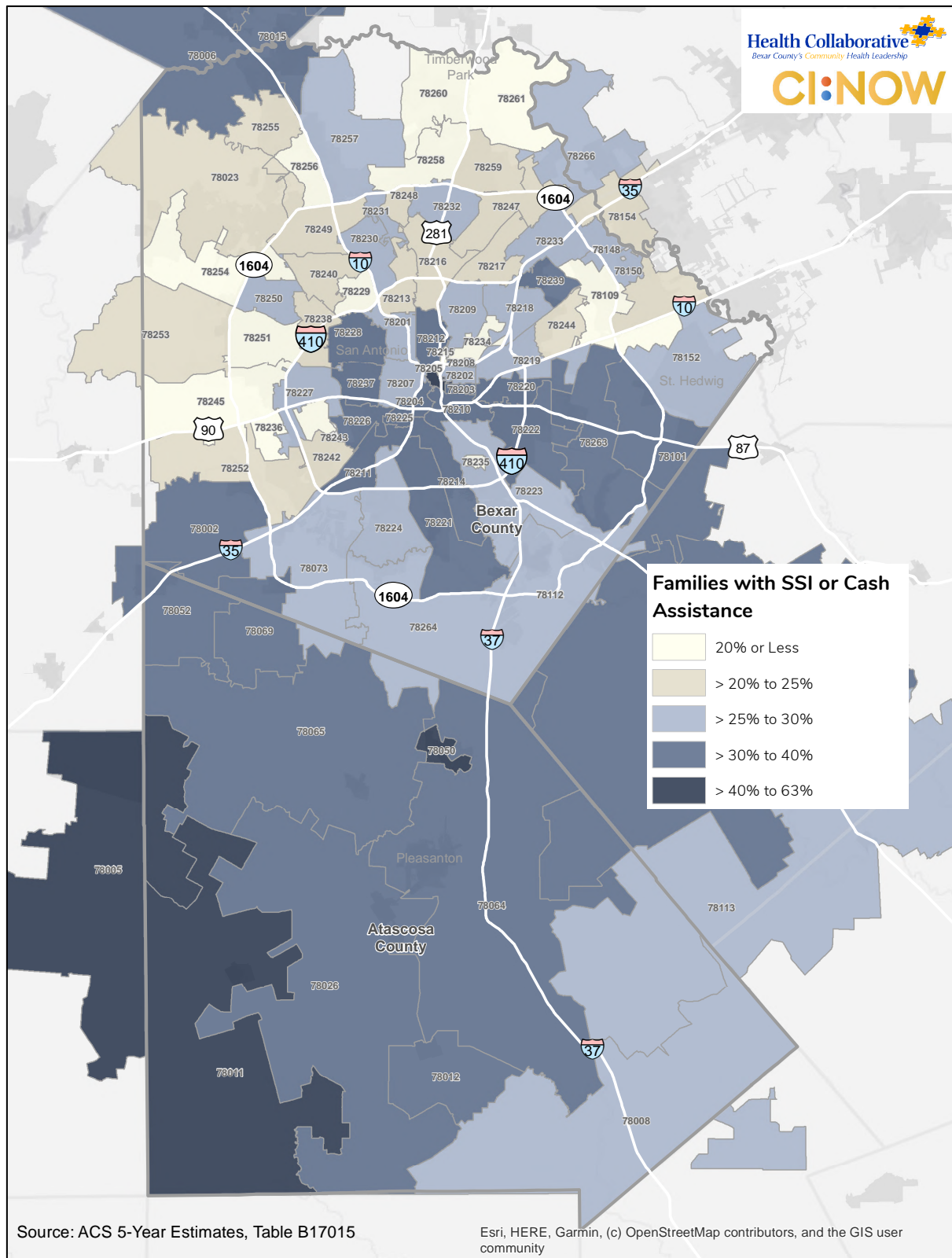Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B27010
Prepared by CI:Now for THC

In both Bexar and the Atascosa area about one in five BRFSS survey respondents (see Box 7) reported that they needed to see a doctor in the past 12 months but could not because of the cost (Fig. 5.1.11). The margins of error are too high to feel confident about the exact percentages, but it appears that cost was a barrier for two to three times as many Hispanics as non-Hispanic whites in both counties (Fig. 5.1.12).

> **Box 7**
> **Interpreting BRFSS Data**
>
> Much of the data in this and later sections of the report use data from the Behavioral Risk Factor Surveillance System (BRFSS).  BRFSS is a random-digit-dial household survey of adults 18 and older, so unless the survey question asks about a child in the household, all data are for adults. As it is administered in this area, BRFSS has a small sample size – too small to look at data by zip code in Bexar or to look at data by county in Atascosa. To work around that problem we "roll up" Bexar BRFSS data for multiple years and into eight sub-county sectors consisting of multiple zip codes.
>
> Atascosa had a sample size of only 146 even after combining seven years of data, so the data provider (Texas Dept. of State Health Services) combined Atascosa's data with that of Medina and Wilson, two Texas counties with similar demographics or population characteristics. Thus all Atascosa information derived from BRFSS in this report is actually combined Atascosa, Medina, and Wilson data.
>
> Bexar did not have to be combined with any other county to get a large-enough sample size.

Fig. 5.1.10 Percent of civilian, non-institutionalized population without health insurance coverage by zip code, 2017



**Uninsured Population**

- 8% or Less
- > 8% to 11%
- > 11% to 16%
- > 16% to 23%
- > 23% to 32%

Source: ACS 5-Year Estimates, Table B27001

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
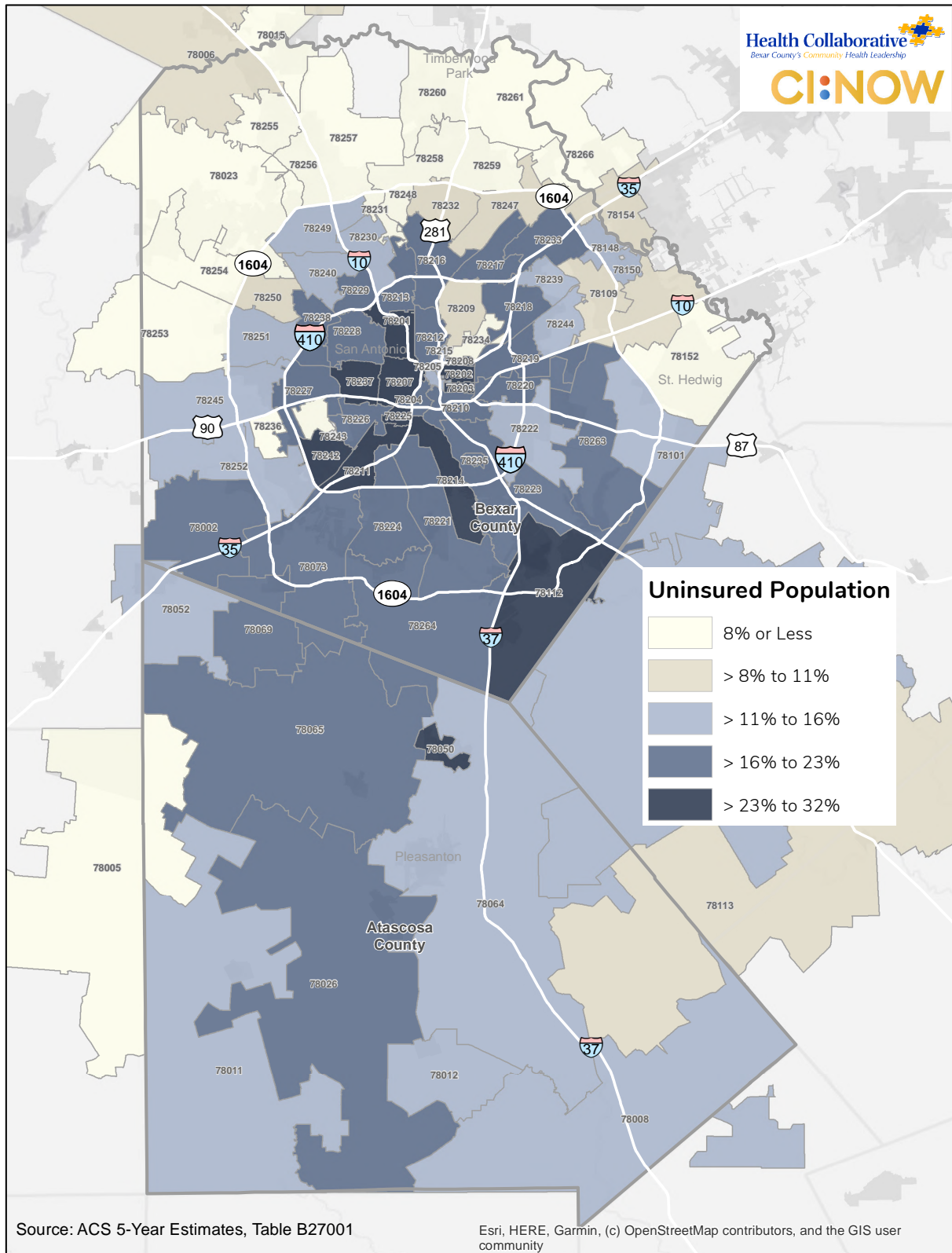
Fig. 5.1.11 Percent of adults that in the past 12 months needed to see a doctor but could not because of cost, 2011-2017
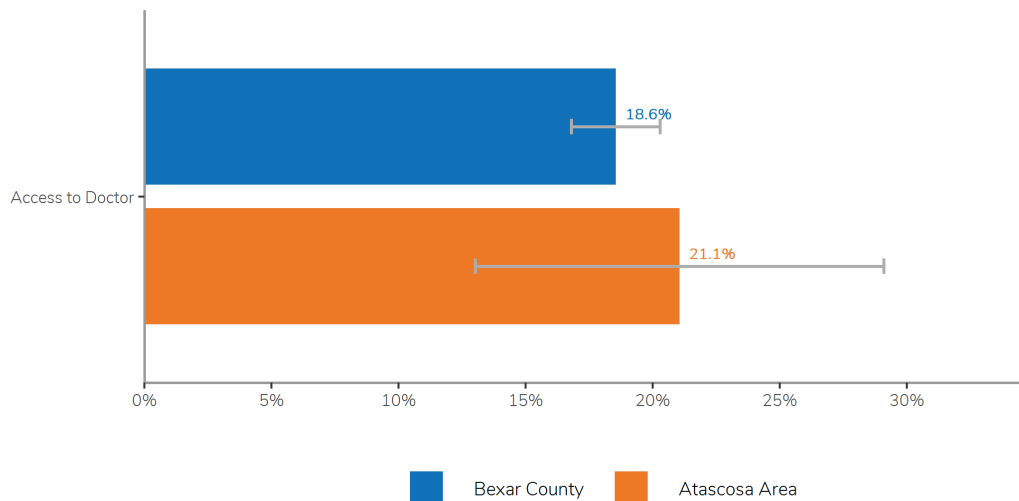


Bexar County    Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 5.1.12 Percent of adults that in the past 12 months needed to see a doctor but could not because of cost by race, 2011-2017
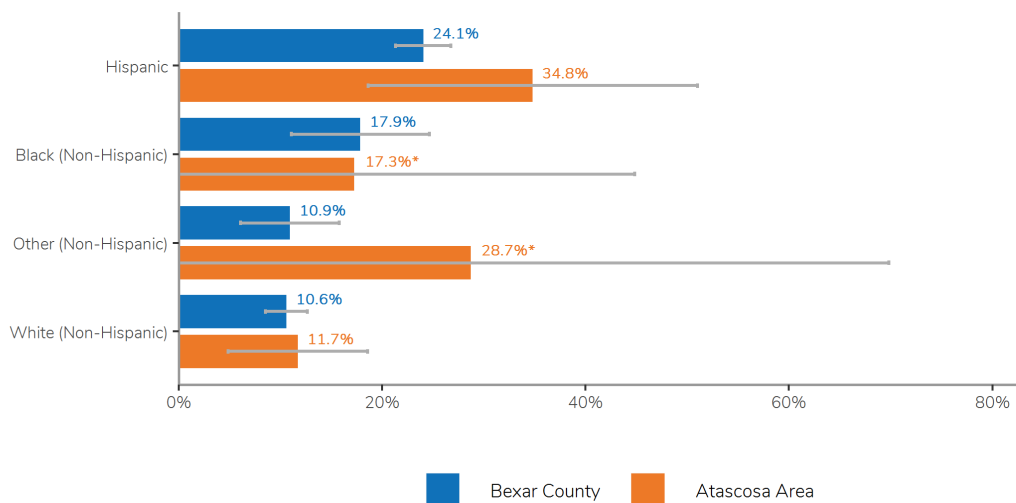


Bexar County    Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 5: Service Environment

Within Bexar, the Far Northside sector had the smallest percentage of respondents reporting cost as a barrier to care, clearly and lower than in any other sector except perhaps Southeast. The highest percentages appear to be in the Near Westside, Near Eastside, and Southwest, but the confidence intervals (margin of error) do overlap with those of other sectors, so the apparent difference may not be trustworthy (Fig. 5.1.13).

Fig. 5.1.13 Percent of adults that in the past 12 months needed to see a doctor but could not because of cost by sector, 2011-2017
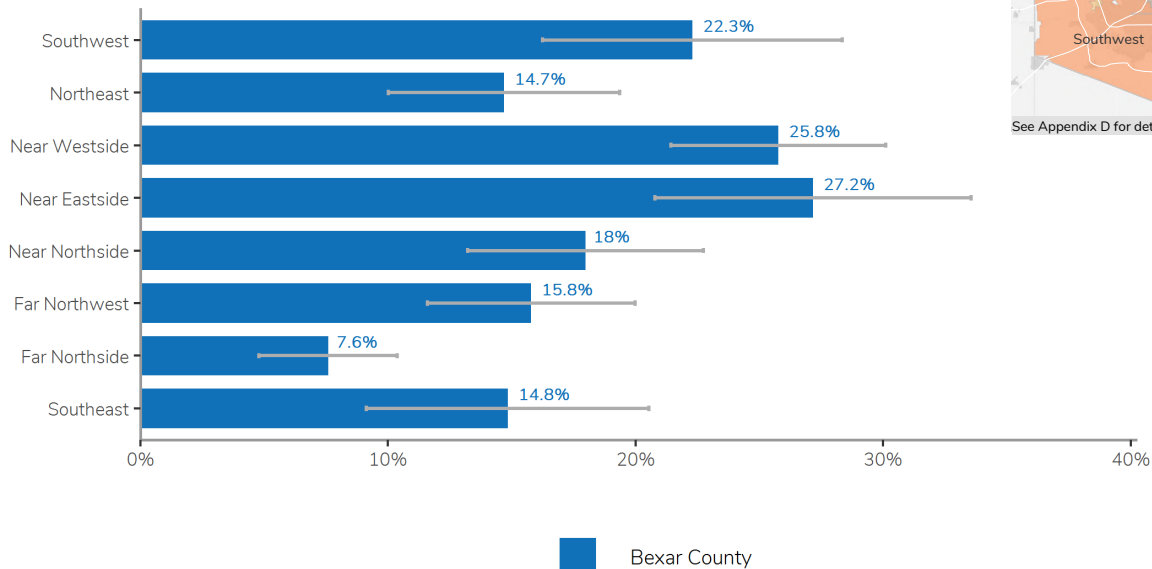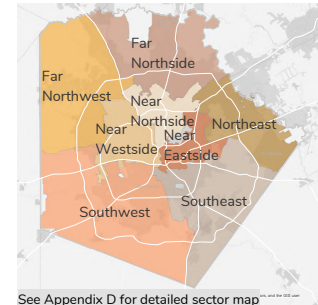


See Appendix D for detailed sector map

Southwest 22.3%
Northeast 14.7%
Near Westside 25.8%
Near Eastside 27.2%
Near Northside 18%
Far Northwest 15.8%
Far Northside 7.6%
Southeast 14.8%

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Public assistance

The percent of population participating in the Supplemental Nutrition Assistance Program (SNAP), often referred to as "food stamps," has increased slightly in Bexar over the past five years but remained flat in Atascosa (Fig. 5.2). A greater proportion of female-headed households participate in SNAP compared to other household types (Fig. 5.2.1), but that figure is still about a third among married-couple households. The geographic pattern of SNAP recipients (Fig. 5.2.2) largely resembles that of uninsured people.

Fig. 5.2 Percent of population participating in Supplemental Nutrition Assistance Program monthly average
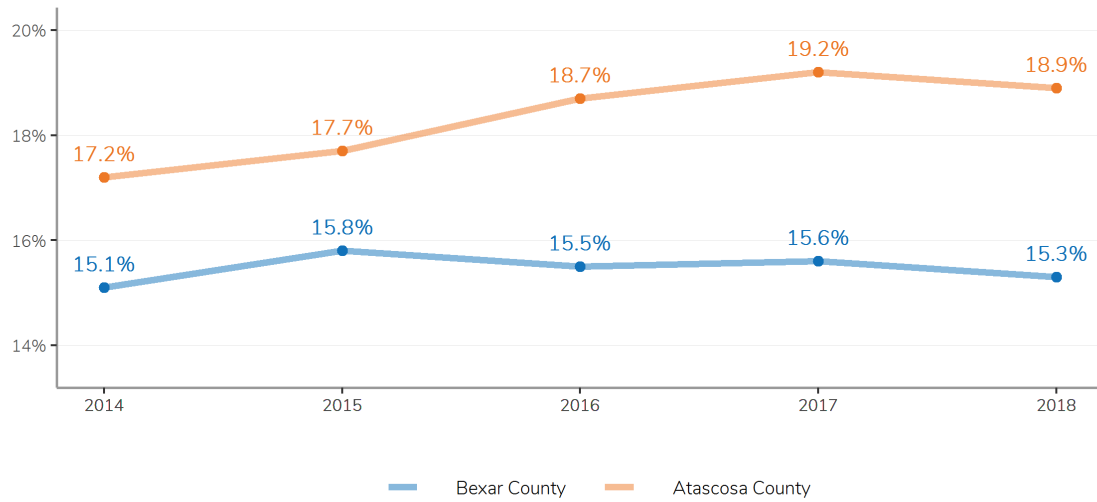


*Unreliable: Error is too large relative to estimate
Source: Texas Health and Human Services
Prepared by CI:Now for THC

Fig. 5.2.1 Percent of SNAP households by family type, 2017
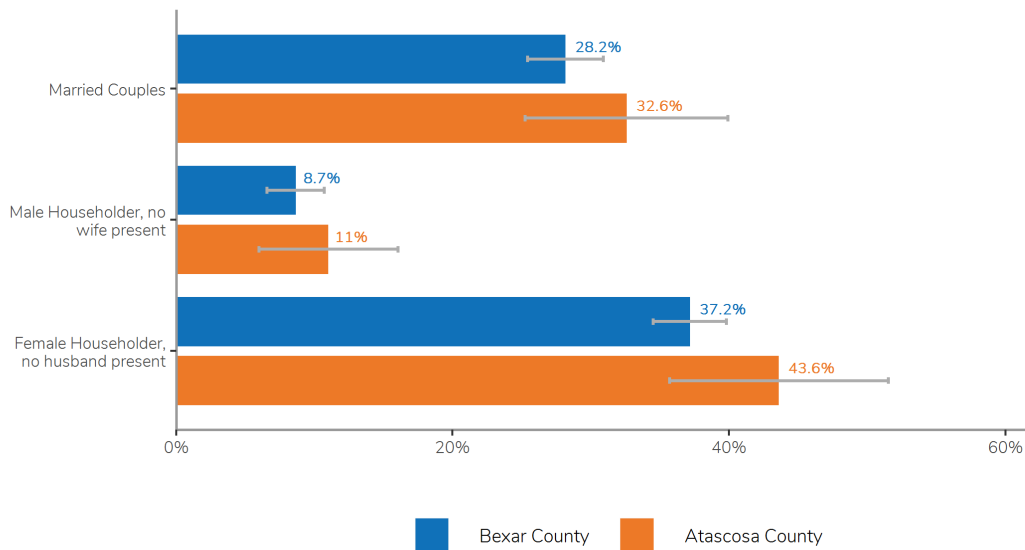


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B22002
Prepared by CI:Now for THC

Fig. 5.2.2 Percent of households with SNAP by zip code, 2017



Source: ACS 5-Year Estimates, Table B22002

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

# Section 5: Service Environment

The Supplemental Security Income (SSI) program is a cash assistance program that provides monthly benefits to low-income aged, blind or disabled persons.[2] After considering the margins of error, the percentage of families receiving SSI appear essentially flat in both Bexar and Atascosa (Fig 5.2.3). Married-couple families are the household type most likely to receive SSI (Fig. 5.2.4), with Atascosa and southern Bexar zip codes having the highest proportion of families receiving SSI (Fig. 5.2.5).

Fig. 5.2.3 Percent of total families with Supplemental Security Income (SSI) benefits
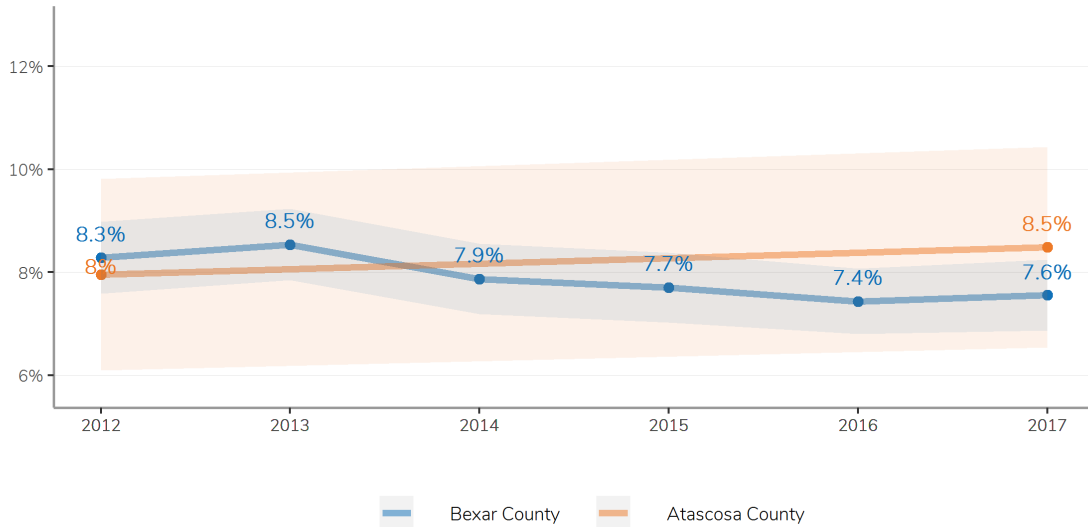


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table: B17015
Prepared by CI:Now for THC

Fig. 5.2.4 Percent of total families with SSI benefits by family type, 2017
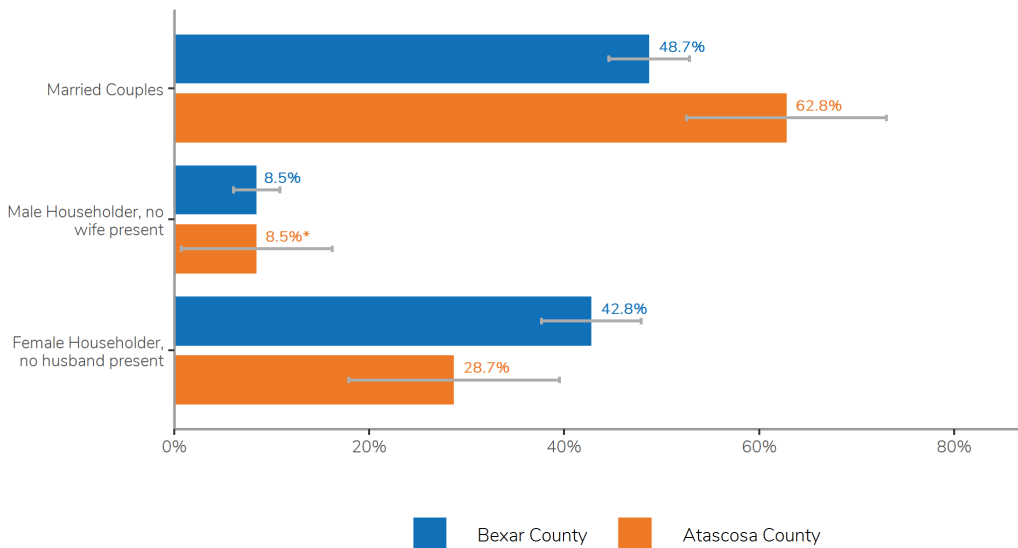


*Unreliable: Error is too large relative to estimate
Source: ACS 1-Year Estimates, ACS 5-Year Estimates. Table:B17015
Prepared by CI:Now for THC

2. Supplemental Security Income (SSI) Benefits | Social Security Administration. Retrieved from https://www.ssa.gov/benefits/ssi/

Fig. 5.2.5 Percent of total families with SSI benefits by zip code, 2017



**Families with SSI or Cash Assistance**

- 20% or Less
- > 20% to 25%
- > 25% to 30%
- > 30% to 40%
- > 40% to 63%

Source: ACS 5-Year Estimates, Table B17015

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community

# Section 5: Service Environment

The Special Supplemental Nutrition Program for Women, Infants, and Children - better known as the WIC Program – provides nutritious foods to supplement diets for low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5.[3] The percent of children age zero to four participating in WIC has declined in both counties by 10% to 15% (Fig. 5.2.6). These figures do not include women participating in WIC.

Fig. 5.2.6 Percent of children aged 0 to 4 who receive Women, Infants and Children (WIC) benefits
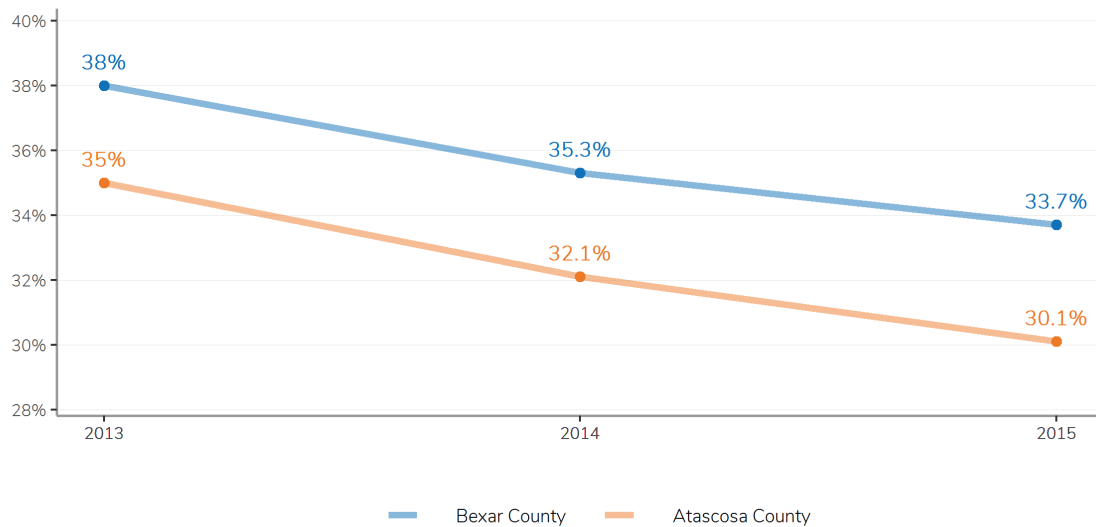


*Unreliable: Error is too large relative to estimate
Source: Texas KIDS COUNT at the Center for Public Policy Priorities
Prepared by CI:Now for THC

---

3. About WIC. Retrieved from https://www.fns.usda.gov/wic/about-wic

# Section 6: Health Behaviors and Risks ———

## E-cigarettes and tobacco

Good data on the prevalence of e-cigarette use is not available below the state level, but for Texas as a whole, current use among adults is estimated at 4.8% and is much more common among males than females, among the 18-29 age group than older groups, and among non-Hispanic whites than other race/ethnicity groups (BRFSS, 2015). Among middle and high school youth, current use is highest among non-Hispanic whites and high schoolers.[1]

Current use in Bexar and Atascosa was estimated by applying state prevalence rates (per a 2018 survey) by race/ethnicity and by age group to Bexar and Atascosa population data, excluding the 65 and older age group, which has very low prevalence. In both counties, prevalence of current use is estimated at 6% of non-Hispanic whites and 5% of Hispanics, blacks, and other races; and at about 7.5% among the 18-29 age group and 4% of the 30-64 age group. Total prevalence among adults 18 to 64 is estimated at 5.1% in both counties, or about 1,500 Atascosa adults and about 62,000 Bexar adults.

Again applying state prevalence rates to Bexar and Atascosa population data, prevalence of current use among middle school and high school youth is estimated at 17% of non-Hispanic whites, 13% of Hispanics, 3% (Atascosa) to 5% (Bexar) of blacks, and 12% (Atascosa) to 13% (Bexar) of other races; and at about 6% among middle schoolers and 19% to 20% among high schoolers. In line with Texas prevalence of 13%, total middle and high school prevalence is estimated at 14% for Atascosa (about 700 youth) and 13% for Bexar (about 25,000 youth).

According to the CDC, middle and high school tobacco users increased 36% between 2017 and 2018 because of a surge in e-cigarette use. Many states have raised the age to purchase tobacco in order to delay the age when young people can begin using so they can reduce the risk of developing an addiction. Senate Bill 21, passed by the 86th Texas Legislature to end the sale of tobacco products to those under 21, goes into effect on September 1, 2019.[2]

An estimated 20% of adults in the Atascosa area and 15% of Bexar adults are current tobacco smokers (Fig. 6.1), but the Atascosa area margins of error are so wide that it is possible that there is no difference between the two counties. The very small sample size makes interpretation of the Atascosa area figures difficult, and in Bexar there appears to be no substantive difference in smoking rates among race/ethnicity groups (Fig. 6.1.1). Estimated smoking rates among sectors range from 10% to 20% (Fig. 6.1.2), but the overlap in confidence intervals is such that the degree of true difference, if any, is unknown.

1. Texas Department of State Health Services. (2019). Electronic nicotine delivery systems (e-cigarette) report. https://www.dshs.texas.gov/legislative/2018-Reports/E-Cigarette-LegislativeReport.pdf
2. Amir Vera, CNN. (2019, June 9). Texas governor signs law increasing the age to buy tobacco products to 21. Retrieved from https://www.cnn.com/2019/06/08/health/texas-new-tobacco-law/index.html?fbclid=IwAR0LS2revWwjo8MVv169KiVMrq7Ks6-77xbUHp-mYxZELVUkrk-wk4_JOX4E

Fig. 6.1 Percent of adults who currently smoke, 2011-2017
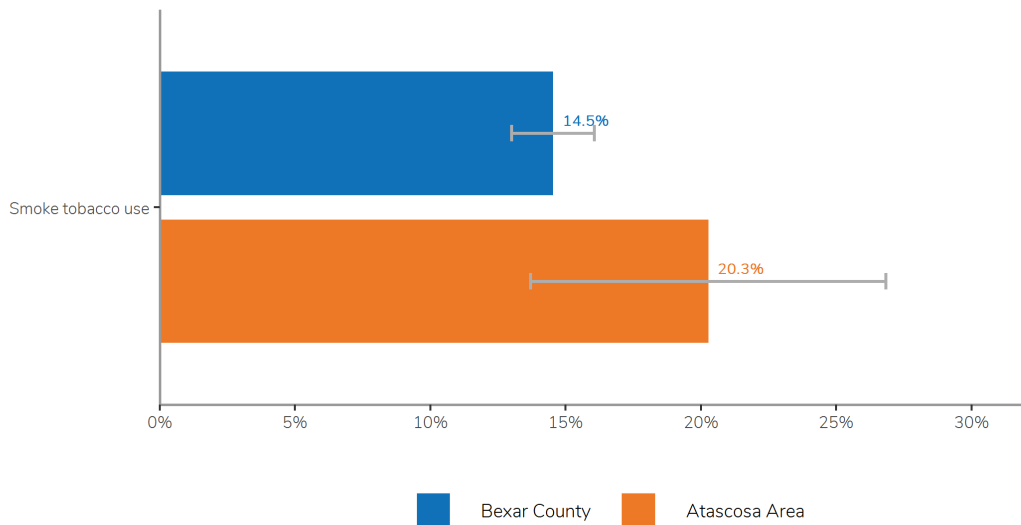
Fig. 6.1.1 Percent of adults who currently smoke by race, 2011-2017
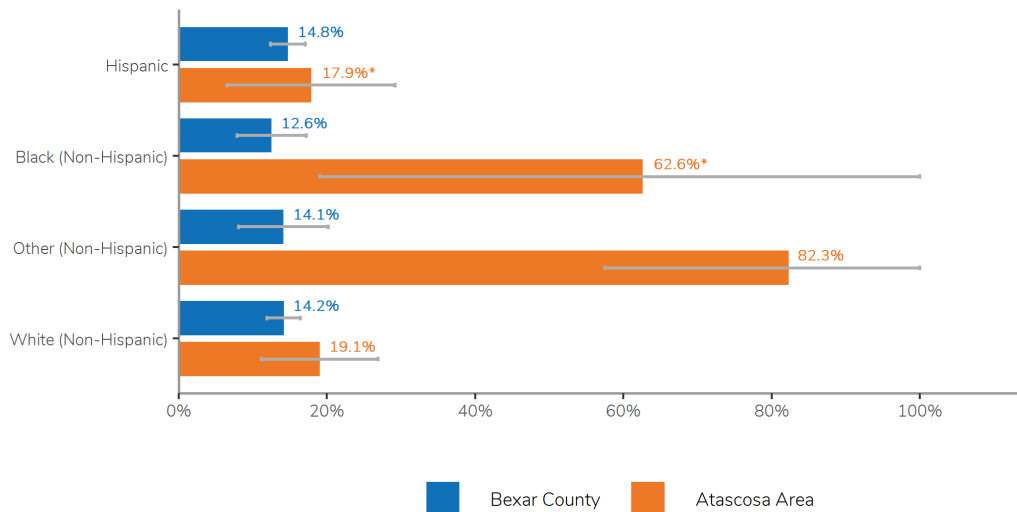
# Section 6: Health Behaviors and Risks

Fig. 6.1.2 Percent of adults who currently smoke by sector, 2011-2017
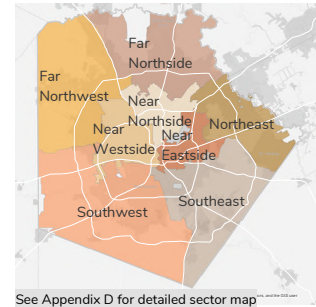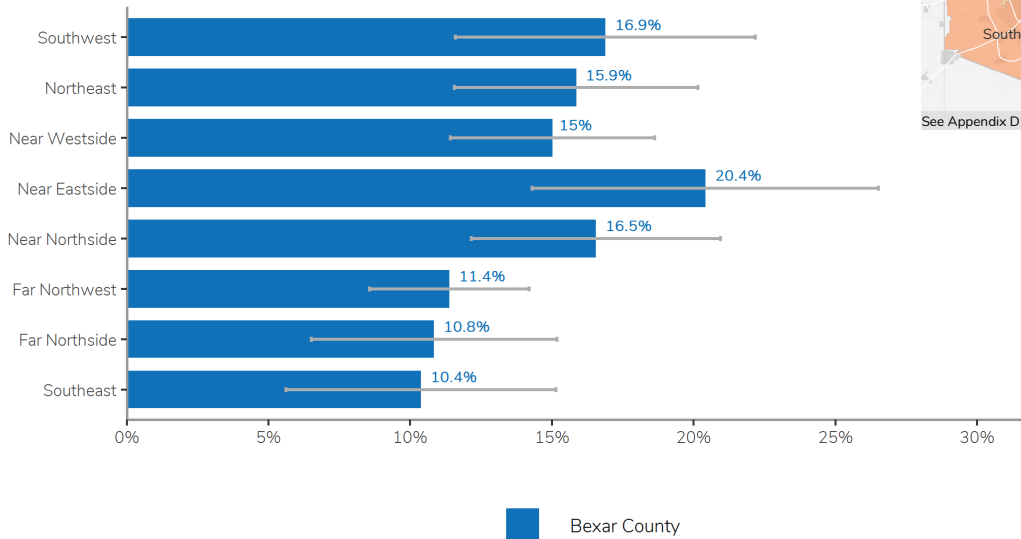


See Appendix D for detailed sector map



Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Alcohol

The available data on percent of adults reporting heavy alcohol use in the past month also comes from the BRFSS data and so is plagued by wide confidence intervals, but the estimated percentage does appear higher in the Atascosa area than Bexar (Fig. 6.2). In both counties, the percentage appears higher among Hispanics and non-Hispanic whites, and because the two confidence intervals do not overlap, the difference between Atascosa and Bexar rates for non-Hispanic whites appears trustworthy (Fig. 6.2.1). As with smoking, rates of heavy alcohol use among sectors appears to vary (Fig. 6.2.2), but the overlap in confidence intervals is such that the degree of true difference, if any, is unknown. Only a tiny percentage of BRFSS survey respondents report having driven in the past month when they had too much to drink (Fig. 6.2.3), and no meaningful variation is apparent among race/ethnicity groups (Fig 6.2.4) or by Bexar sector (Fig. 6.2.5). However, mixed beverage sales in 2018 totaled nearly $629 million in San Antonio alone,[3] and Bexar typically logs more than 600 arrests per year on DWI felony charges (Fig. 3.3.3 from Social Conditions).

> Related data
>
> Quality of Life, Illness, Injury and Death
> • Alcohol and Substance Related Injury and Death

3. Total Mixed Beverage Gross Receipts / By City / Top 20 / 2018. Retrieved from https://data.texas.gov/Government-and-Taxes/Total-Mixed-Beverage-Gross-Receipts-By-City-Top-20/uy5i-6k76

Fig. 6.2 Percent of adults who reported heavy alcohol use in last month, 2011-2017



Bexar County ■ Atascosa Area ■
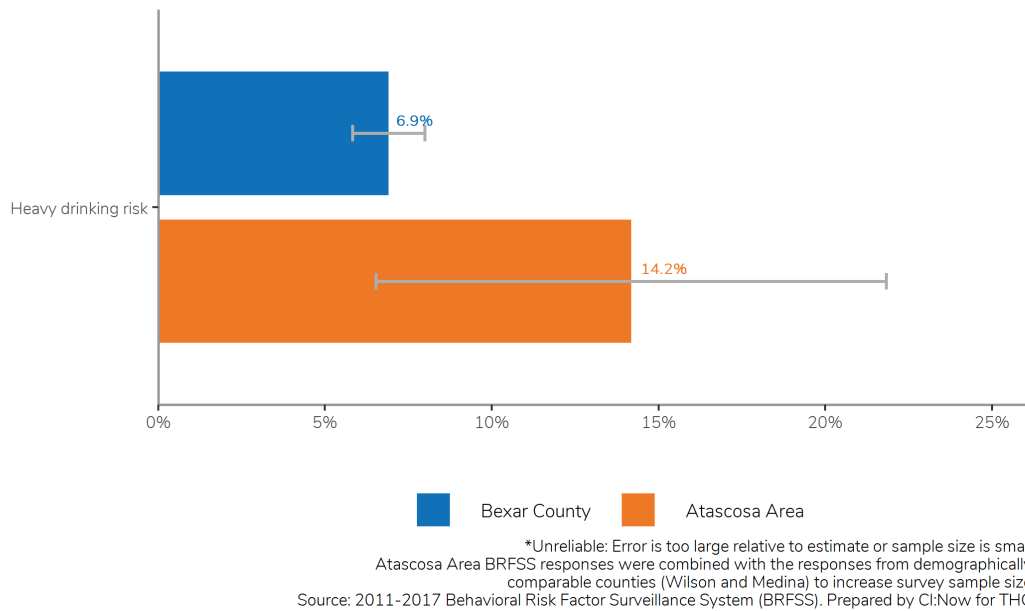
Fig. 6.2.1 Percent of adults who reported heavy alcohol use in last month by race, 2011-2017



Bexar County ■ Atascosa Area ■
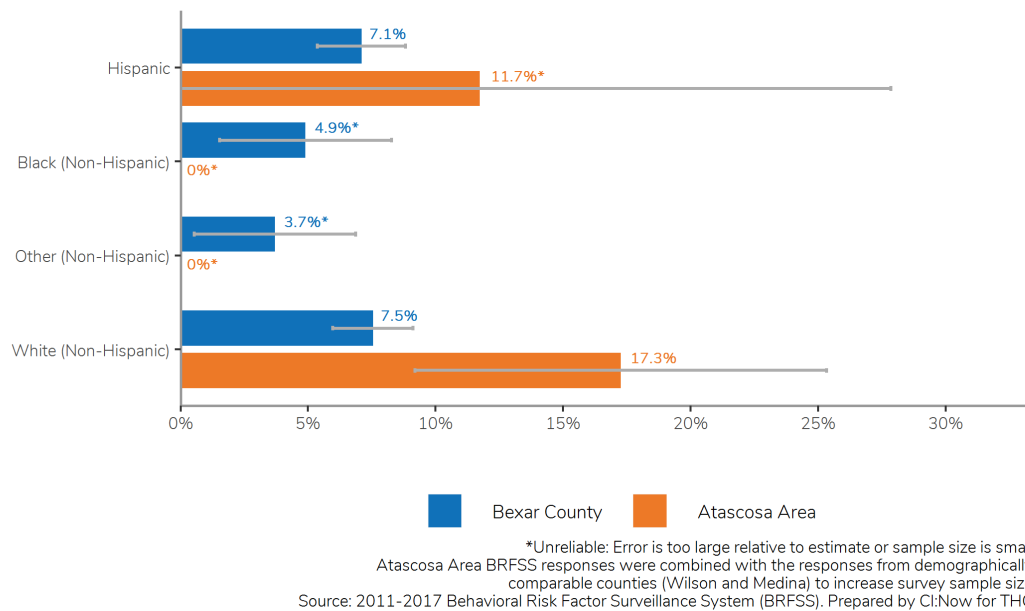
# Section 6: Health Behaviors and Risks

Fig. 6.2.2 Percent of adults who reported heavy alcohol use in last month by sector, 2011-2017
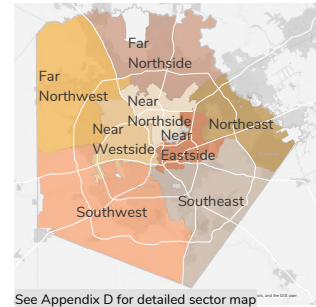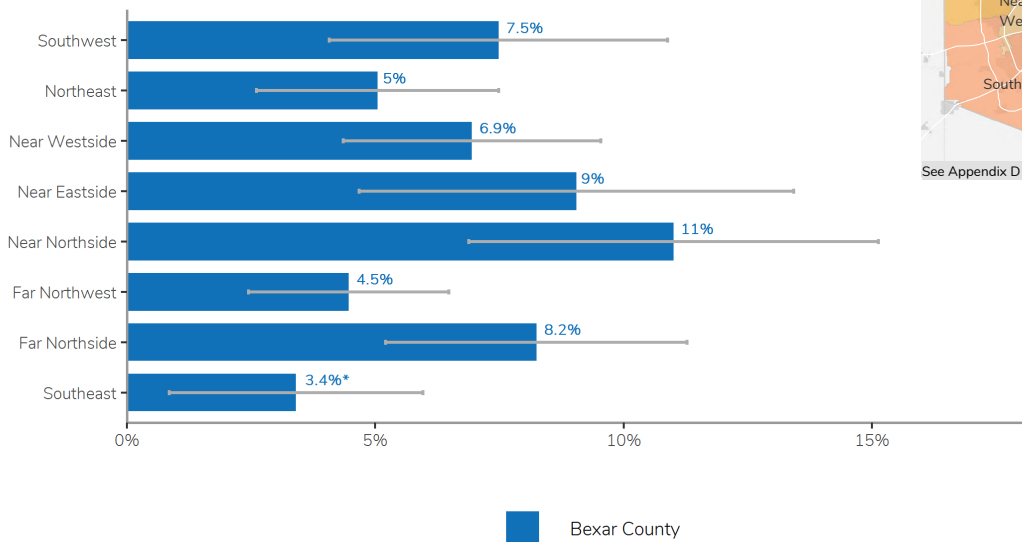


See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.2.3 Percent of adults who drove after drinking alcohol in the past 30 days, 2011-2017
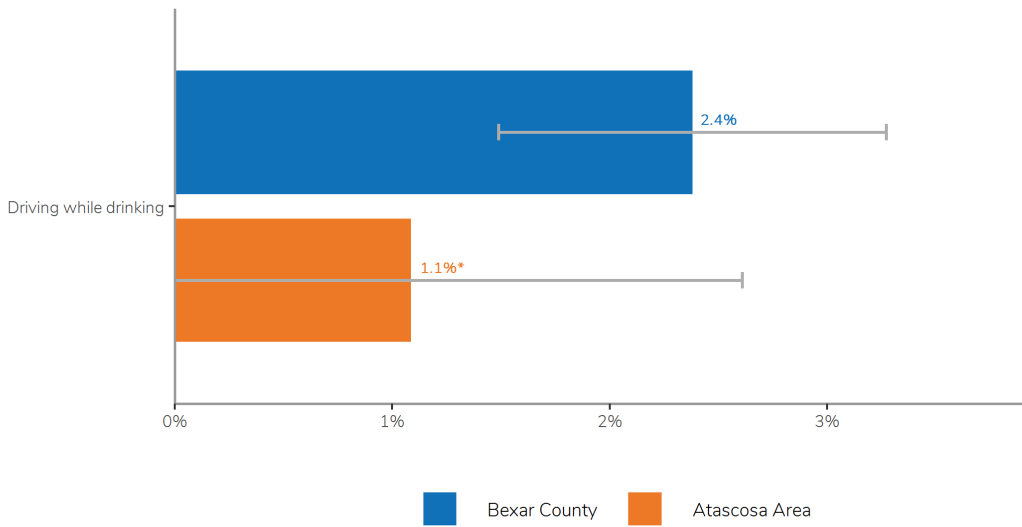


Bexar County     Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.2.4 Percent of adults who drove after drinking alcohol in the past 30 days by race, 2011-2017
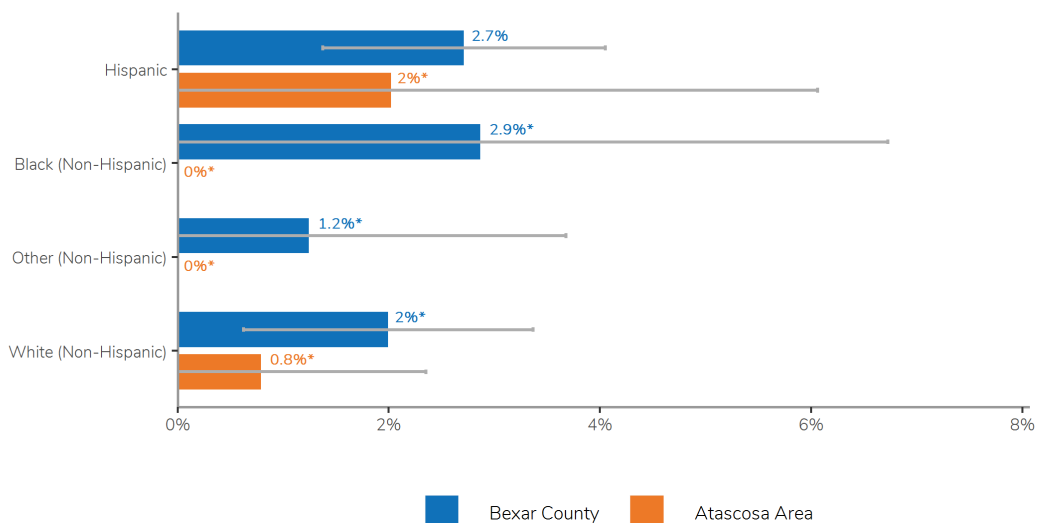


Bexar County    Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.2.5 Percent of adults who drove after drinking alcohol in the past 30 days by sector, 2011-2017
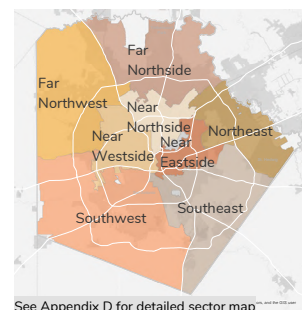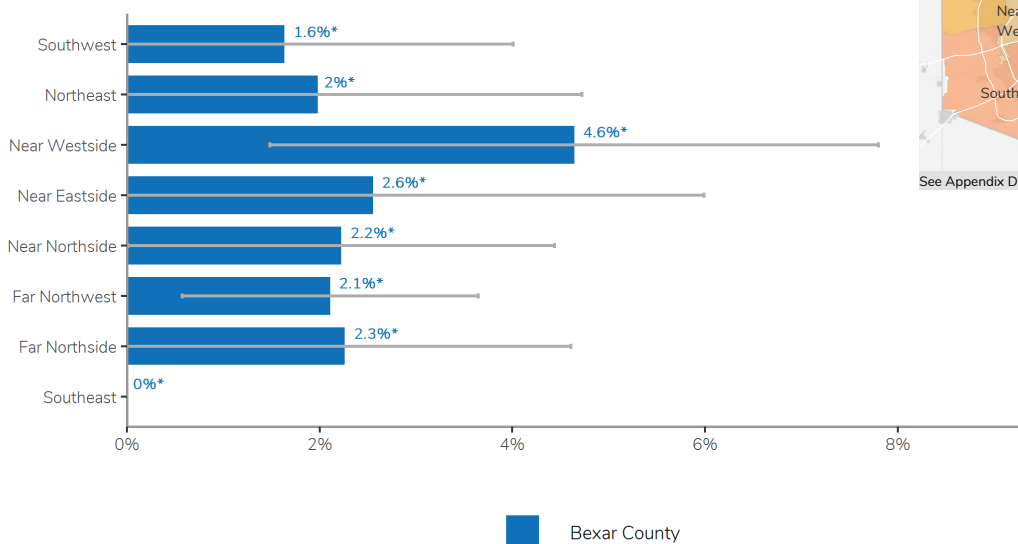


See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks ———

## Opioids and other drugs

No data is currently available to determine how many people receive opioid prescriptions each year. The only data available is number of prescriptions issued in a geographic area, which contains no information about how many people received those prescriptions, or how many prescriptions any specific person received. To account for tremendous differences in county population size, though, the number of prescriptions issued for a county needs be related to the number of people in that county. For that reason the rate is expressed as number of prescriptions dispensed per 1,000 population,[4] with no information about how many of those 1,000 people received a prescription. One person could receive many prescriptions in a year or, of course, none. The prescribing data is based on a sample of non-hospital pharmacies, which dispense nearly 90% of all retail prescriptions in the United States (excluding mail order pharmacy data).[5]

> ### Related data
>
> Health Outcomes
> • Birth Outcomes and Maternal and Infant Mortality
> • Alcohol and Substance Related Injury and Death

The opioid prescription rate is declining in both counties (Fig. 6.3). The Atascosa rate appears much higher than Bexar, although the true difference is uncertain because this rate cannot be adjusted by age. Atascosa's population is somewhat older than Bexar, possibly pointing to a greater need for pain management. It is also possible that a greater share of total opioid prescriptions is captured in the dataset for Atascosa than for Bexar, but neither factor is likely to account fully for the difference in prescribing rate.

Prescription psychotherapeutics include pain relievers, tranquilizers, stimulants, or sedatives and do not include over-the-counter drugs.[6] Not limited just to opioids, an estimated 6,800.0 people per 100,000 Bexar adults misuse psychotherapeutic drugs. At 6,799.7 per 100,000, that rate is only slightly lower for Atascosa.

Fig. 6.3 Rate of opioid prescriptions per 1,000 adults in the past 12 months
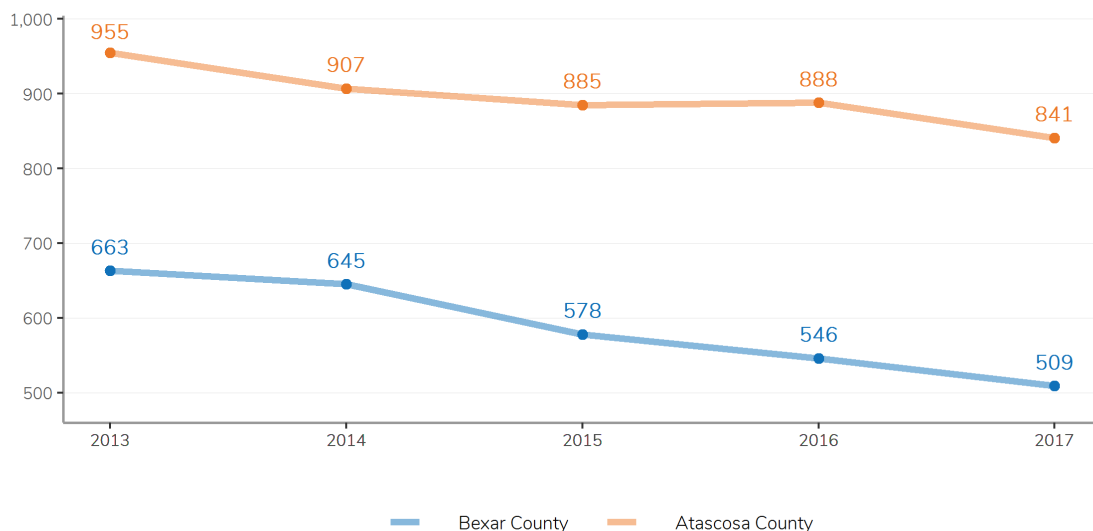


*Unreliable: Error is too large relative to estimate
Source: Centers for Disease Control and Prevention
Prepared by CI:Now for THC

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4. While the Centers for Disease Control and Prevention publishes the rate as prescriptions per 100 persons, it has been converted here to prescriptions per 1,000 persons in an effort to ensure that the measure is not interpreted as percent of people receiving a prescription.
5. U.S. Opioid Prescribing Rate Maps | Drug Overdose | CDC Injury Center. (2018, October 3). Retrieved from https://www.cdc.gov/drugover-dose/maps/rxrate-maps.html
6. 2017 National Survey on Drug Use and Health Detailed Tables. Retrieved from https://www.samhsa.gov/data/report/2017-nsduh-de-tailed-tables

# Section 6: Health Behaviors and Risks

## Healthy eating

Despite the documented and widely-understood importance of healthy eating and physical activity, related local data is scarce, particularly for children and youth. BRFSS is the primary source available for the general population of adults, and because of small sample sizes, the level of uncertainty is so high as to render the estimates almost useless. Disaggregating – "breaking out" – the data by race/ethnicity, sub-county geography, or any other respondent characteristic is essentially impossible. Beyond random sample surveys, the other available sources are administrative data (data generated in the everyday course of business, e.g., patient weight measurements at a primary care practice) and other client/participant data that can't safely be generalized to the entire Bexar or Atascosa population (see Box 9). Unfortunately, the question about general sugar-sweetened beverage consumption changed in 2016 from one question about general sugar-sweetened beverages consumption to a question about soda and another about other sugar-sweetened drinks. The changes were significant enough that the data could not be combined together.

> **Related data**
>
> Physical Conditions:
> • Food and Alcohol Environment
>
> Economic Conditions:
> • Food Insecurity

Of Bexar adults responding to the BRFSS survey, an estimated one in five reports eating fruits and vegetables five or more times a day (Fig. 6.4). Although the margins of error are wide, that proportion is definitely lower in the Atascosa area. The difference appears to hold across all race/ethnicity groups except Other non-Hispanic (Fig. 6.4.1), which around  Atascosa appears to be primarily composed of people who identify as being of more than one race and not as Hispanic. Because it is a very small number of people, any results for that category should be interpreted with caution. None of the Bexar sectors can be certain to differ from the county overall  (Fig. 6.4.2).

Fig. 6.4 Percent of adults who consumed fruits and vegetables 5+ times per day, 2011-2017
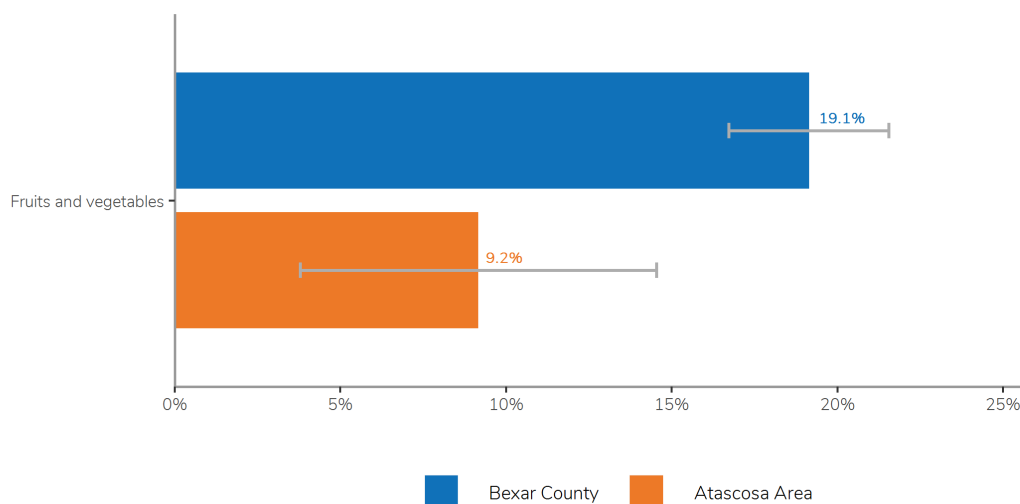


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

Fig. 6.4.1 Percent of adults who consumed fruits and vegetables 5+ times per day by race, 2011-2017
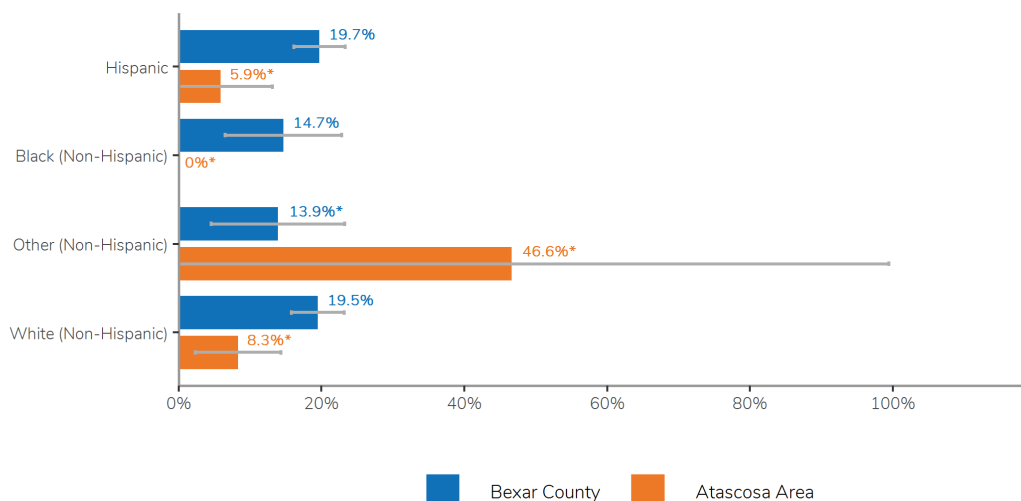


**Bexar County** ■ **Atascosa Area** ■

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.4.2 Percent of adults who consumed fruits and vegetables 5+ times per day by sector, 2011-2017
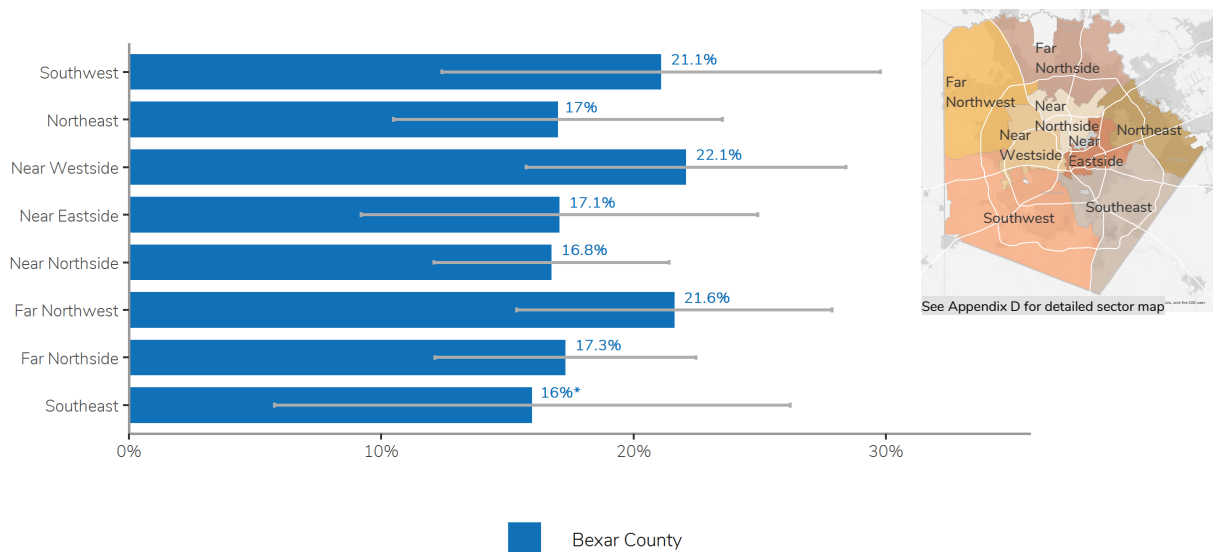


See Appendix D for detailed sector map

**Bexar County** ■

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

The school-based Youth Risk Behavior Surveillance System (YRBSS) is one of the only sources of data on health-related behaviors among youth. Because only Fort Worth and Houston school districts participate, no YRBSS data is available for either Bexar or Atascosa. The only source of local data for healthy eating and physical activity among youth is the Witte Museum's *H-E-B Body Adventure Powered by University Health System.*[7] As visitors move through a series of networked interactive exhibition components, completely anonymous data is generated for that visitor. This data is compiled into a POWERprofile summary card for him or her to take home and, if desired, compare with future visits. The visitor enters his or her own zip code, sex, and (optional) race/ethnicity, enabling the aggregate dataset to be examined for geographic and demographic differences.[8] Data is not available for Atascosa.

A total of 70 Bexar zip codes had at least 20 respondents eight to 12 years old who visited between 2014 and 2018, for a total of about 28,500 youth. Total respondents per question depends on whether a visitor skipped a question, but for the data presented here, the number of respondents per zip code ranges from 21 to about 1,680 with a median of about 334. Of those Bexar youth respondents, 31% reported eating no vegetables yesterday. The zip codes with the highest proportions of respondents not eating vegetables yesterday are scattered across all areas of the county except the far Northside (Fig. 6.4.3). The lowest proportion in any zip code was still about one in five, however, and the median proportion is 34%, so the problem is widespread. The map of percent of respondents reporting drinking one or more sodas per day would appear to paint a brighter picture, with more zip codes in the lowest percentage category (Fig. 6.4.4). But again, the lowest proportion is about one in five, and at 38%, the median proportion is even higher than for "no vegetables." The proportion across all zip codes is 37%. Focus group participants spoke at length about healthy eating, highlighting the need not just for healthy food affordability and accessibility, but also education on how to incorporate healthy foods into more traditional Hispanic meals, with *"beans, tacos, and tortillas"* or *"en un caldito."* They spoke of eating habits that *"go back generations"* and the importance of introducing children to healthy foods early in life to reduce the fear of trying a new food, *"...not liking it and then, there's my money down the drain."* Key informants too spoke of establishing a new norm that healthy food is good food, and incorporating healthy foods in a positive way into family, work, and church celebrations. *"We are losing the battle because we keep telling people what not to do. Deep down in every human being's heart is a rebel."*

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**Related data**

Physical Conditions:
● Mobility and Transportation

Physical Conditions:
● Other Indicators

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**Box 9**
**Does the data represent all?**

When we're measuring a sample rather than everyone in a population, we have to question whether or not the sample is very representative of – *generalizable* to – the population as a whole. What we don't want is for the people whose data we're taking as "truth" to be systematically different from those whose data we don't have. For example, people who aren't comfortable with computers are less likely to answer an online survey.

That's also why we usually can't use client/patient data, which is really just a convenience sample accessed through a service provider. People who are engaged in services are likely to differ in specific consistent ways from those who aren't. Depending on the issue and the service, they might be sicker, higher-income, more likely to be highly fluent in English, or any number of other factors that we often can't predict or identify after the fact.

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Fig. 6.4.3 Percent of youth visitors who consumed no vegetables yesterday by zip code, 2014-2018
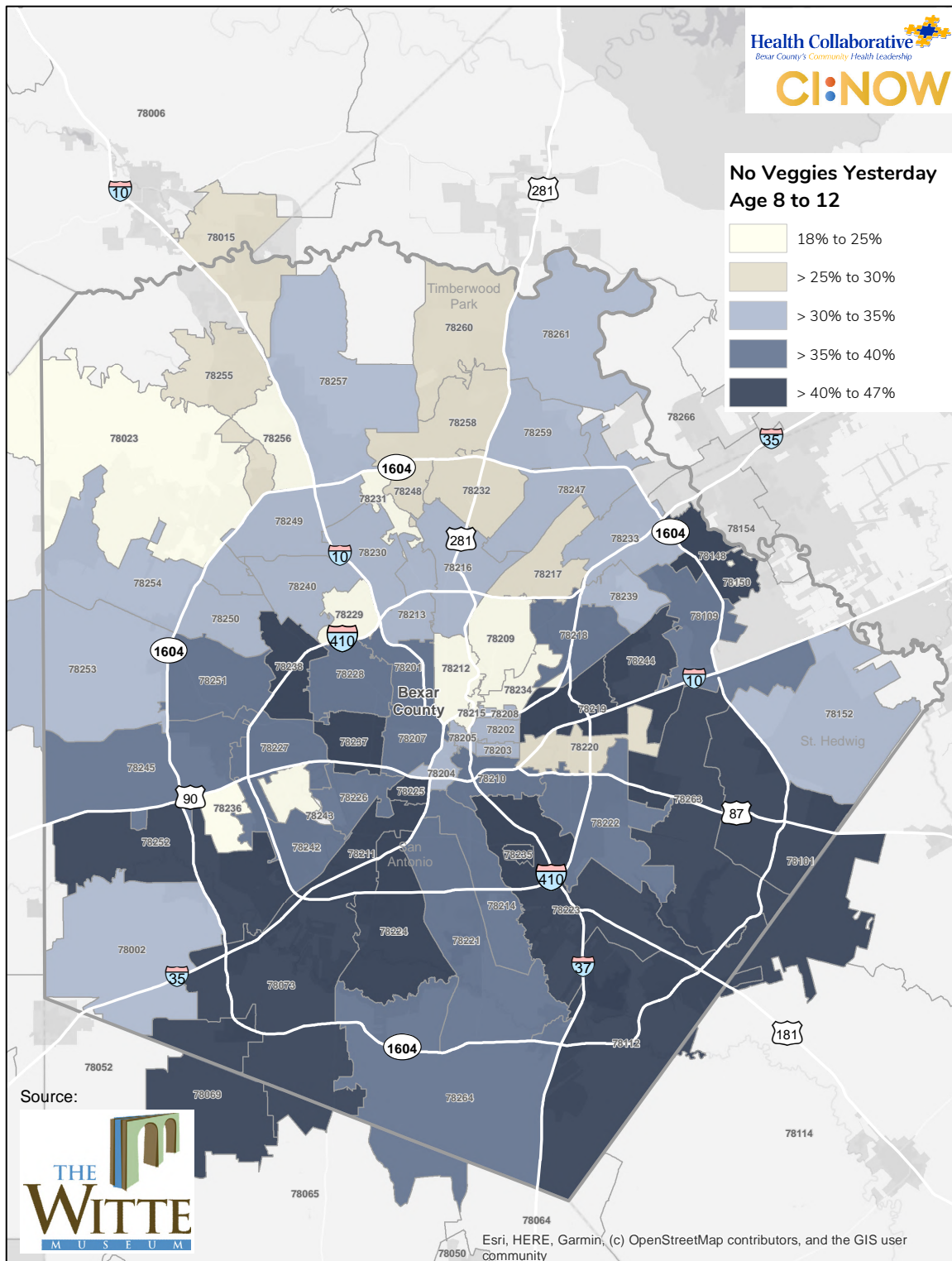
Fig. 6.4.4 Percent of youth visitors who drank 1 or more sodas yesterday by zip code, 2014-2018
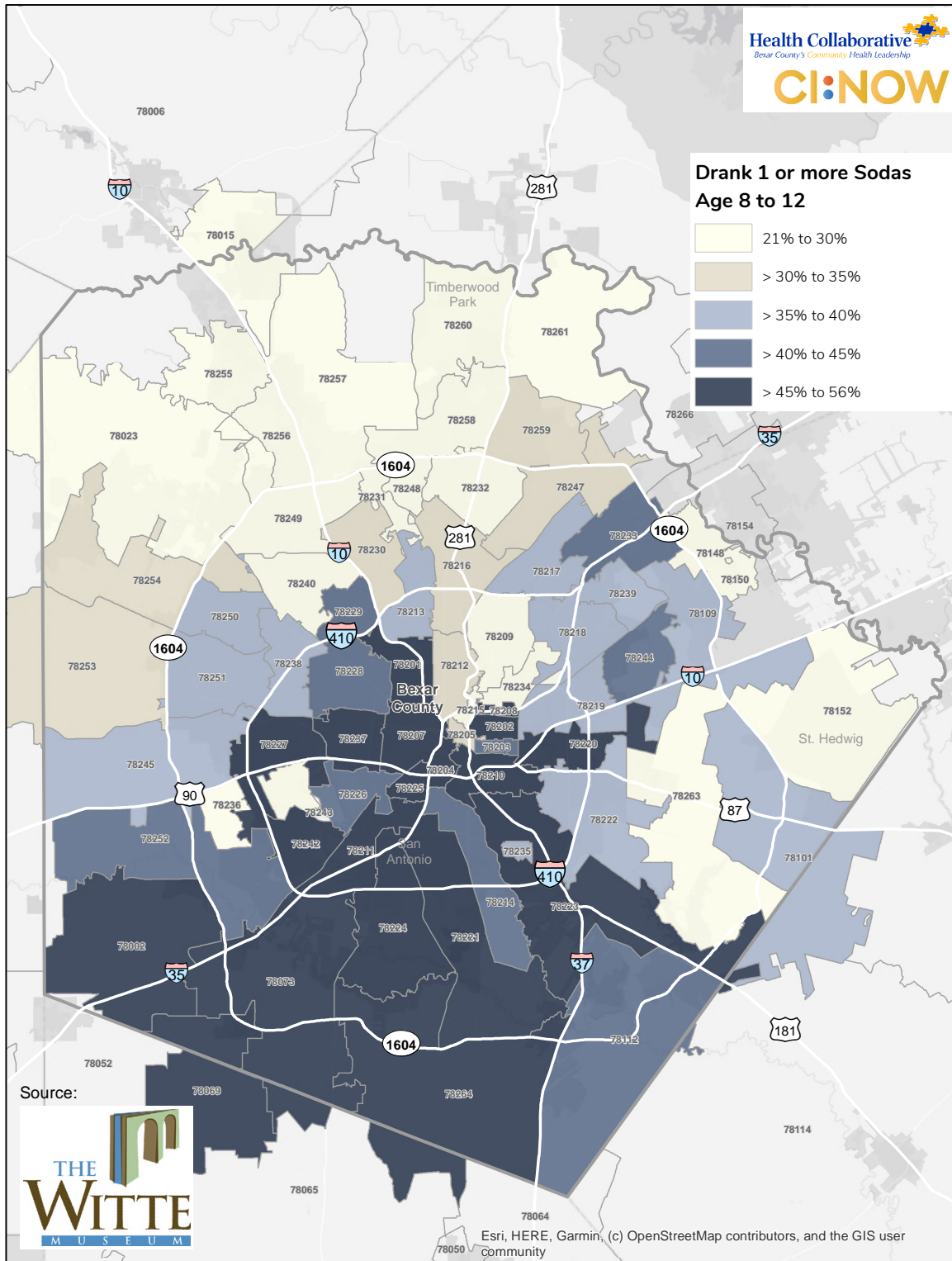
# Section 6: Health Behaviors and Risks

## Physical activity

No data is available for physical activity among youth. Among adults, nearly half of Bexar BRFSS respondents reported participating in at least 150 minutes of aerobic physical activity per week (Fig. 6.5). The margin of error is too wide to be very certain, but the proportion appears be to lower in the Atascosa area. No clear pattern emerges for physical activity by race/ethnicity in either county (Fig. 6.5.1) or by Bexar sector (Fig. 6.5.2), as again the margins of error are quite wide. In addition to having safe areas and facilities for physical activity and having fun, focus group participants saw a need for group activities and support: *"People do more when they have a support group. I won't be sweating out there by myself."* One key informant interviewee echoed that theme: *"It's not that there isn't opportunity. The challenges is getting to the activity and being motivated."*

Another theme that arose from key informant interviews was the hope of building physical activity into the local culture, including Fiesta. *"That's such an important part of our identity as a city. Thinking about drinks and food is fun, but a great leveraging point to begin talking about how do we build on that existing identity to incorporate active living as part of who we are in San Antonio?"*

### Related data

Physical Environment:
• Age of housing stock

Health Behaviors and Risks:
• Screening and testing

Fig. 6.5 Percent of adults participating in 150 minutes or more of aerobic physical activity per week, 2011-2017
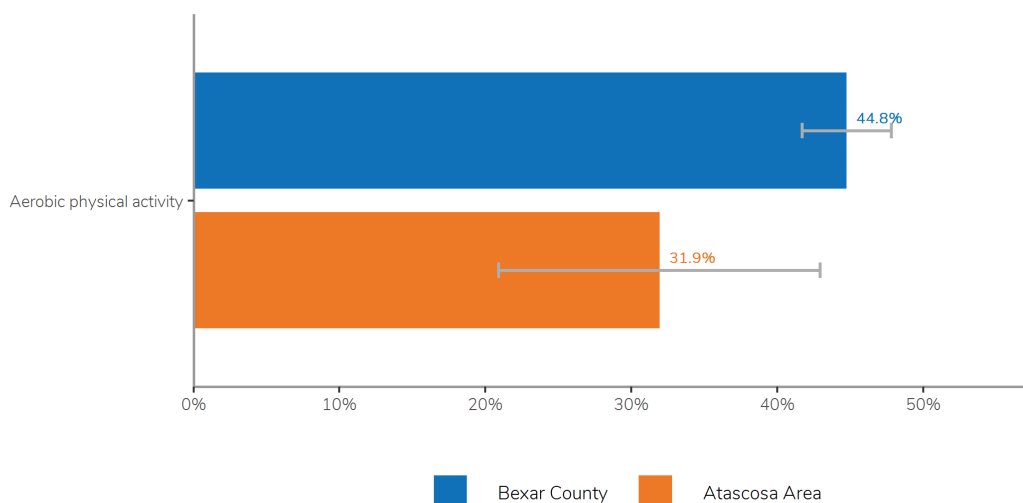


44.8%

31.9%

Aerobic physical activity

0%   10%   20%   30%   40%   50%

■ Bexar County   ■ Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC
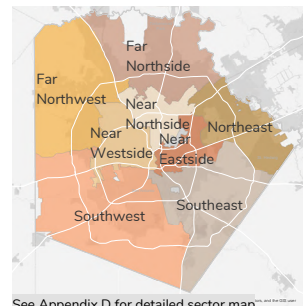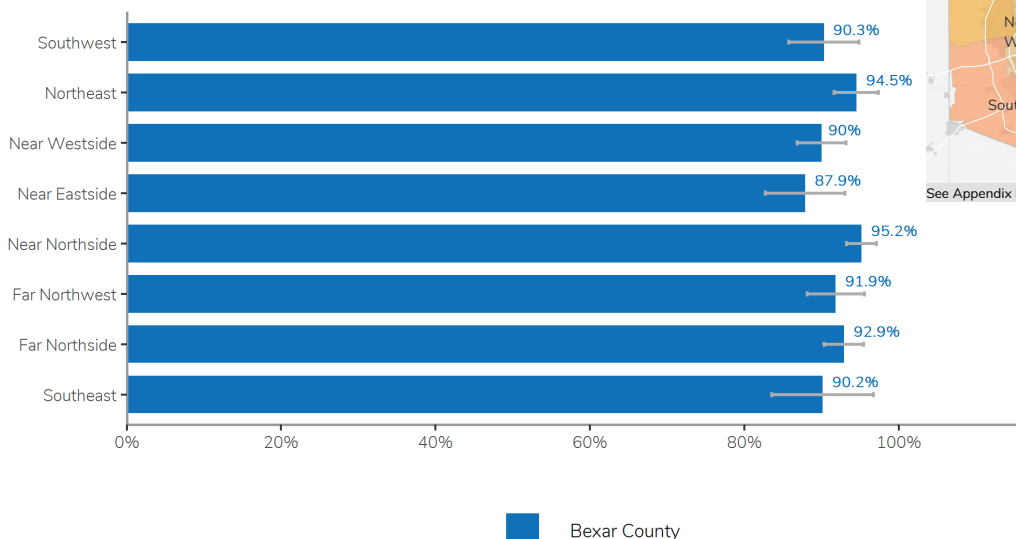
Fig. 6.5.1 Percent of adults participating in 150 minutes or more of aerobic physical activity per week by race, 2011-2017
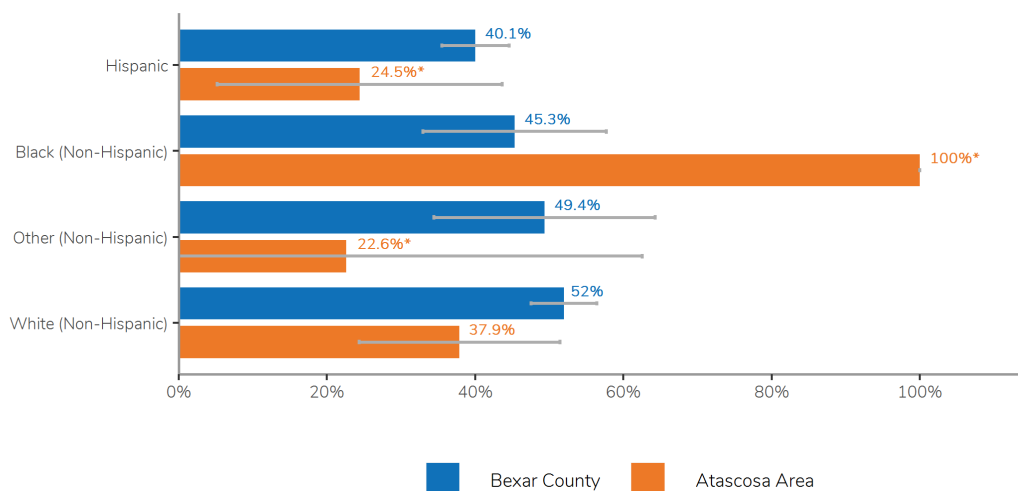


**Bexar County** ■  **Atascosa Area** ■

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.5.2 Percent of adults participating in 150 minutes or more of aerobic physical activity per week by sector, 2011-2017
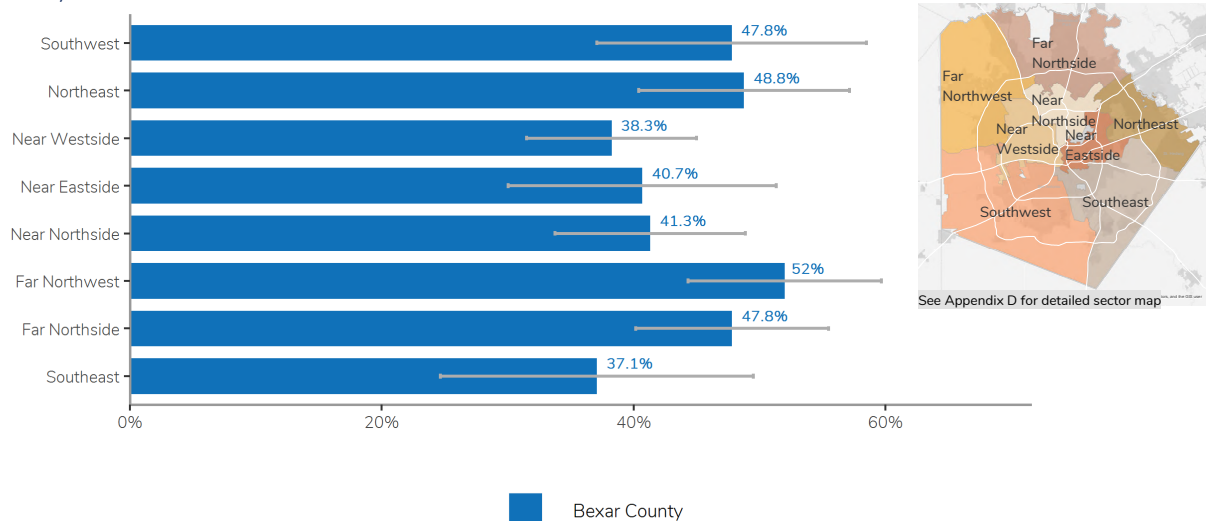


**Bexar County** ■

See Appendix D for detailed sector map

*Unreliable: Error is too large relative to estimate or sample size is small
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Overweight and obesity

About seven in 10 adult BRFSS respondents in both counties report a height and weight that puts their Body Mass Index (BMI) in the overweight or obese range[9] (Fig. 6.6), about the same as Texas[10] and the United States[11] as whole. The breakdown by race/ethnicity groups shows that a higher proportion of both Bexar Hispanics and non-Hispanic whites in the Atascosa area are overweight or obese compared to Bexar non-Hispanic whites (Fig. 6.6.1) with a difference that is statistically significant. Clear differences are also present among Bexar sectors, with a lower proportion of Near Northside respondents overweight or obese compared to the Near Eastside and Southeast, and likely Near Westside and Southwest as well (Fig. 6.6.2).

Fig. 6.6 Percent of adults by Body Mass Index (BMI) category (overweight and obese), 2011-2017
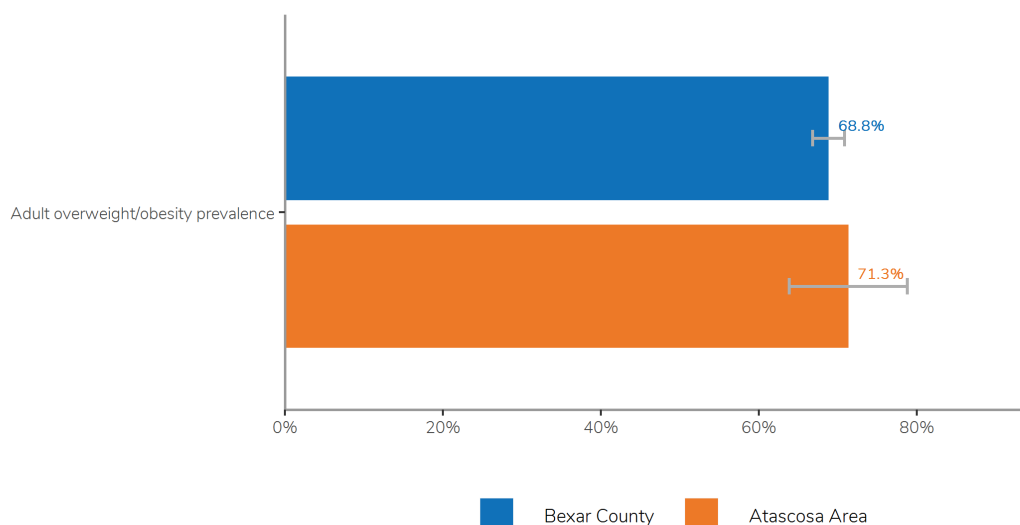


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

9. Defining Adult Overweight and Obesity. (2019, February 7). Retrieved from https://www.cdc.gov/obesity/adult/defining.html
10. Texas Health Data. Retrieved from http://healthdata.dshs.texas.gov/CommunitySurveys/BRFSS
11. Chronic Disease Indicators. (2019, January 21). Retrieved from https://www.cdc.gov/cdi/

Fig. 6.6.1 Percent of adults by BMI category
(overweight and obese) by race, 2011-2017
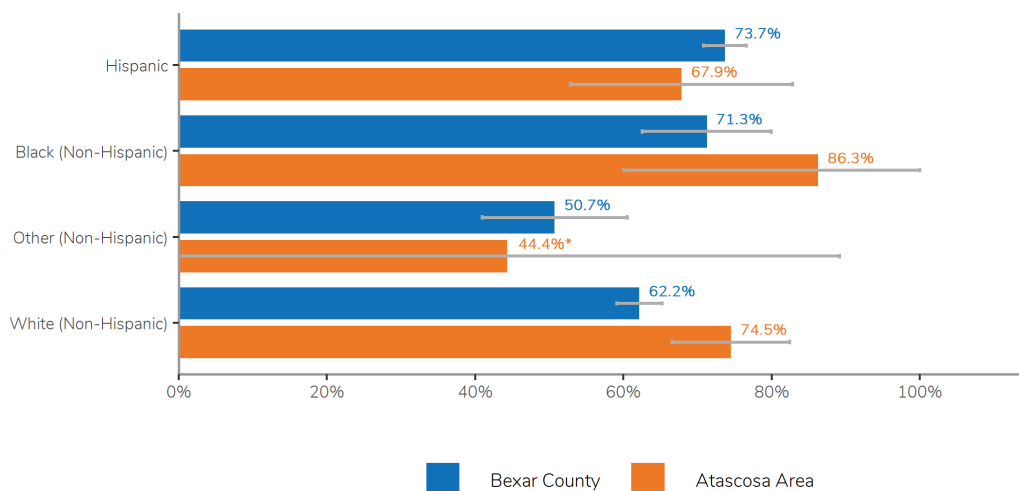


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.6.2 Percent of adults by BMI category
(overweight and obese) by sector, 2011-2017
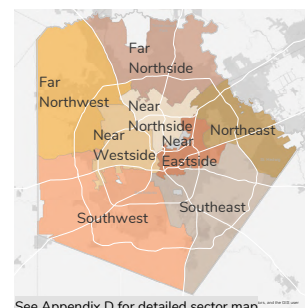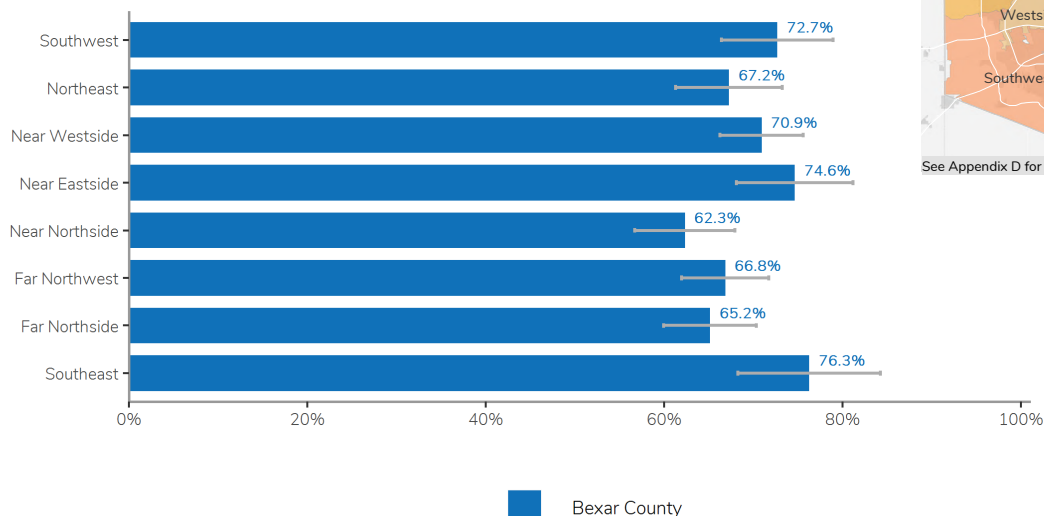


See Appendix D for detailed sector map

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Motor vehicle safety

In 2018 Bexar had 28,424 "distracted driving crashes" as defined by the Texas Department of Transportation, for a rate of 145 crashes per 10,000 population. Atascosa had 382 distracted driving crashes, or 79 per 10,000 population.[12]

About nine in 10 adult BRFSS respondents in both counties report always wearing a seatbelt (Fig. 6.7). No clear differences emerge among the Atascosa area by race/ethnicity groups, but it appears that a lower proportion of non-Hispanic blacks in Bexar report always wearing a seatbelt (Fig. 6.7.1). No significant differences are apparent among Bexar sectors (Fig. 6.7.2).

Fig. 6.7 Percent of adults who always wear a seatbelt, 2011-2017
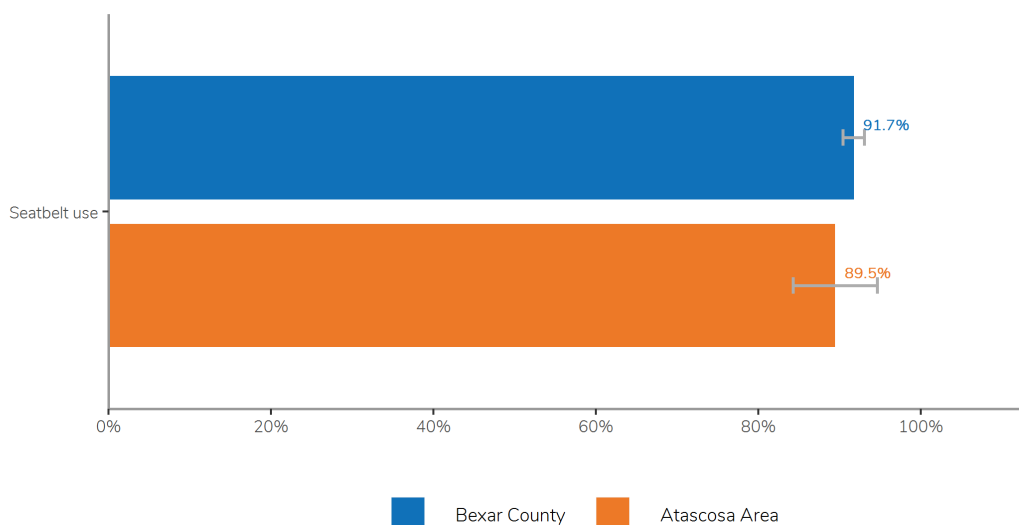


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.7.1 Percent of adults who always wear a seatbelt by race, 2011-2017
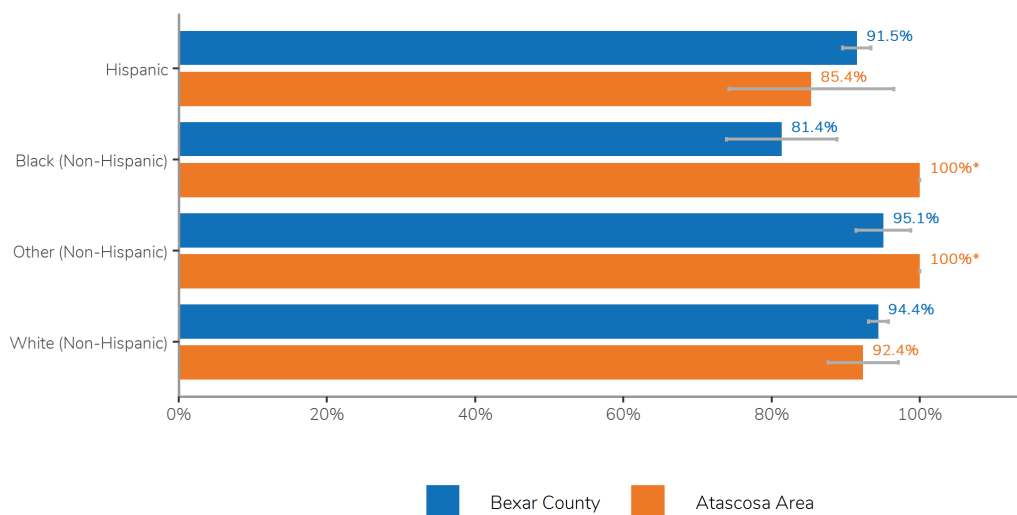


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

12.Crash Records Information System Query. Retrieved from https://cris.dot.state.tx.us/public/Query/app/welcome

Fig. 6.7.2 Percent of adults who always wear a seatbelt by sector, 2011-2017



See Appendix D for detailed sector map

Chart showing percent of adults who always wear a seatbelt by sector:
- Southwest: 90.3%
- Northeast: 94.5%
- Near Westside: 90%
- Near Eastside: 87.9%
- Near Northside: 95.2%
- Far Northwest: 91.9%
- Far Northside: 92.9%
- Southeast: 90.2%

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Sexual health

Focus group participants spoke of the need for education on healthy sexuality and family planning for both parents and youth: *"I didn't know how to talk to my girls about this, to know what you can and cannot say."* They felt parents needed more information about how to talk to their kids openly about girls, boys, LGBTQIA[13] sexuality, emotions, hormones, and sexual activity, as well as how to act as positive role models for their kids. *"Parents can't do what they don't know."* Key informants also pointed to a need for better outreach to the LGBTQIA community, as well as to people of color and people without financial resources: *"...the people who are most vulnerable with sexual health have the least amount of resources"* to access services they need.

More conversations need to happen at home, focus group participants felt, to address the needs of *"kids that need help before they get [pregnant]."* Key informants voiced a similar idea: *"[It] starts with parent/child communication, [a] cultural challenge for us."*

Some participants were critical of how schools address – or do not address – sexual health education: *"They don't teach enough in schools so the kids go and explore to learn more."* Suggested topics to be taught in schools included sex, safe touch, how to care for your body, the consequences of teen pregnancy and sexually transmitted infections, and the effects of pornography and sex in media. Key informants echoed this concern, suggesting that sexual health education be taught in middle school and high school. If school policy prevents that, then community or private programs are needed to fill the gap.

> **Related data**
>
> Health Outcomes:
> • Sexually transmitted infections
>
> Health outcomes:
> • Birthrates and maternal characteristics

13. The letters LGBTQIA refer to lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual or allied.

# Section 6: Health Behaviors and Risks

## Lead poisoning

Lead exposure is unsafe at any age, but the health risks are most serious for infants and young children. On average among those tested, about one in 40 Atascosa and Bexar children five and younger show elevated levels of blood lead, defined as five micrograms per deciliter (μg/dL) or higher (Fig 6.8).

Related data

Physical Environment:
● Age of housing stock

Health Behaviors
and Risks:
● Screening and testing

Fig. 6.8 Percent of children ages 0-5 who tested with elevated levels of lead poisoning
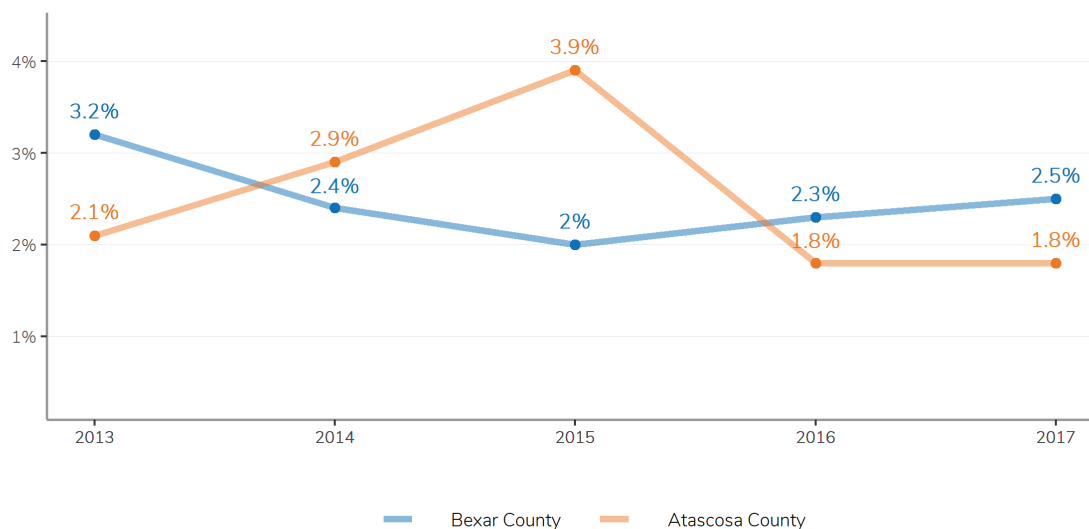


Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

## Adverse childhood experiences

"What happens in childhood—like a child's footprints in wet cement—commonly lasts throughout life. Time does not heal; time conceals." - *Vincent Felitti, original ACE study author*

The most dramatic and tragic cases of childhood suffering make the newspapers, but the evidence is clear that those cases are the pinhead-sized tip of the iceberg of both the range of experiences associated with poor health outcomes and the number of people who had those experiences.   Adverse childhood experiences (ACE) are now known to be a strong predictor of health-related challenges and poor health outcomes later in life. Research consistently finds that as the number of ACE experiences increases, so does the likelihood of poor health outcomes.

The original two-wave ACE Study, with more than 17,000 respondents, looked at the most common ACEs like physical, sexual, or verbal abuse; physical or emotional neglect; having an alcoholic parent, a family member with a mental illness, a mother who was a victim of domestic violence, or a family member in jail; and the loss of a parent through abandonment, divorce, or death. Most of us have had at least one of these experiences, but inequities in the physical, social, and economic conditions in which we grow up mean that the "playing field" is not equally level for all people and across all experiences.[14]

In Wave 1 of the original study, 15% of women and 9% of men reported having experienced four or more out of 10 ACE categories. Those respondents were:

• four to 12 times as likely to have struggled with alcoholism, substance abuse, depression, and suicide attempts;

• two to four times as likely to smoke, to have had 50 sexual intercourse partners, and to have had a sexually transmitted disease; and

• 1.4 or more times as likely to be physically inactive and severely obese.[15]

Taken out of context, Dr. Felitti's quote above sounds fatalistic and hopeless. On the contrary, he and others in the fields of ACE research and trauma-informed care advocate for not just routine ACE screening and appropriate intervention[16] but also primary prevention and early intervention before the child reaches adulthood.[17] Key informants who were interviewed talked of the need to integrate trauma-informed care into existing systems and services, and to educate the community – not just professionals – on adverse childhood experiences.

### Related data

Social Environment:
• Crime and safety

Health Behaviors and Risks:
• Alcohol

Health Behaviors and Risks:
• Opioids and other drugs

Health Outcomes:
• Child abuse and neglect
• Adult maltreatment
• Family violence and sexual assault
• Mental illness and suicide
• Life expectancy and premature death

14. About the CDC-Kaiser ACE Study. (2019, April 11). Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html
15. Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults.  American Journal of Preventive Medicine, Volume 14, Issue 4, 245-258.
16. See for example https://www.acesconnection.com/
17. Adverse Childhood Experiences and Adult Health. Retrieved from http://static1.squarespace.com/static/500ee7f0c4aa5f5d4c9fee39/t/53ec-fab7e4b03cc699a85f97/1408039607750/Adverse+Childhood+Experiences+and+Adult+Health.pdf

# Section 6: Health Behaviors and Risks

## General preventive and primary care

In both counties, about six in 10 adult BRFSS respondents report visiting a doctor within the last year (Fig 6.9), although it should be noted that the question does not specify whether the visit was for preventive care, sick care, or both. Wide and overlapping margins of error prevent determination of differences among race/ethnicity groups (Fig. 6.9.1). Clear differences are apparent among Bexar sectors, though, with Far Northside respondents more likely than other sectors to report visiting a doctor within the past year (Fig. 6.9.2).

Again, the reason for the visit is not known, but about six in 10 adult BRFSS respondents report visiting a dentist or dental ,clinic in the past year (Fig. 6.9.3). As with doctor visits, no clear differences can be identified among race/ethnicity groups (Fig. 6.9.4), but again the Far Northside has the highest proportion of respondents who report visiting a dentist or dental clinic in the past year and shows a statistically significant difference from most other sectors (Fig. 6.9.5).

Box 10
We're Stuck with Labels

This assessment uses different words to describe the same race/ethnicity, e.g., African American, black, and non-Hispanic black. The primary reason for this variation is the desire to be consistent with the words used by the original data source to avoid any misinterpretation of the data. For example, Census data uses the label "Black or African American," the Behavioral Risk Factor Surveillance System (BRFSS) uses "black," and Texas Education Agency data uses "African American." It's also important to remember that race/ethnicity is usually self-reported, and a person's identity with regard to race/ethnicity may be different or more complex than what another person would assume – or what any label can adequately capture. The key point to remember is that unless noted otherwise, different words for a race/ethnicity group shouldn't be taken to mean there's any difference in the way the group is defined in that dataset.

Fig. 6.9 Percent of adults who visited a doctor last year, 2011-2017
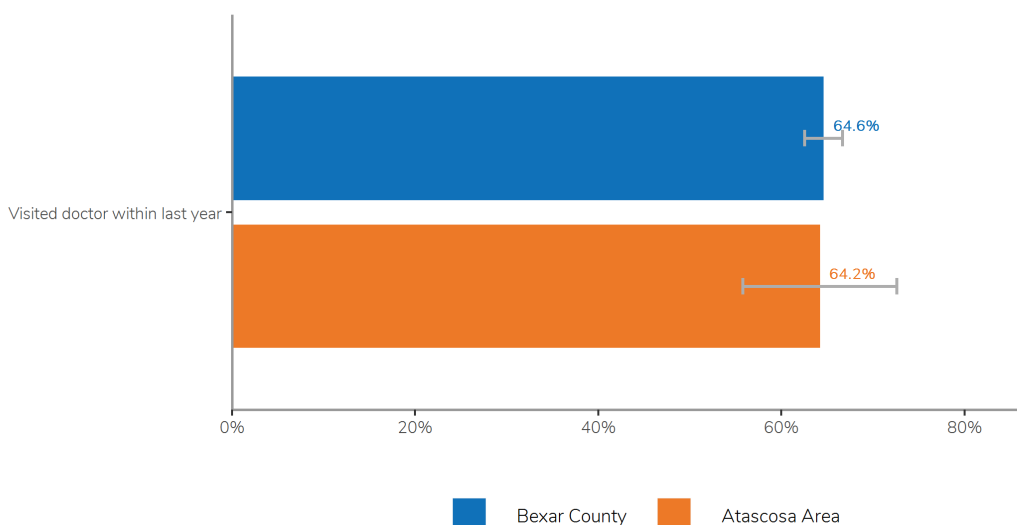


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC
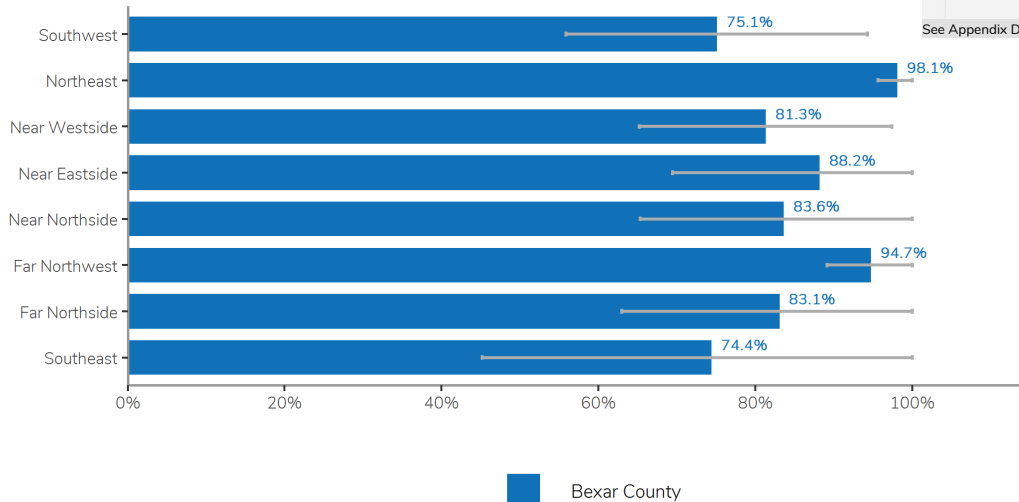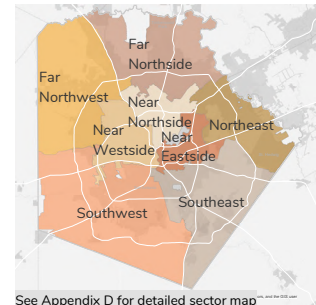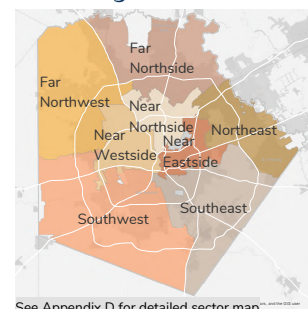
# Section 6: Health Behaviors and Risks

Fig. 6.9.1  Percent of adults who visited a doctor last year by race, 2011-2017
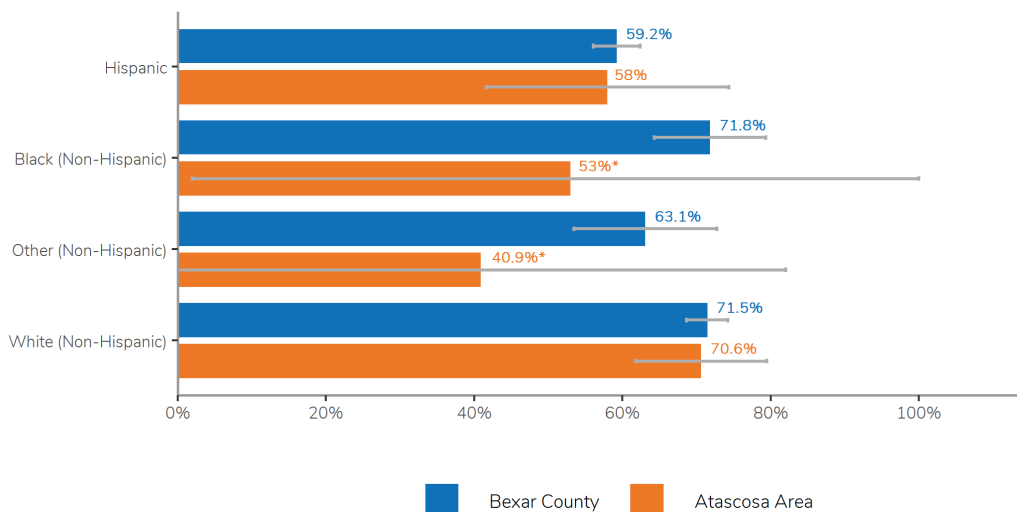


**Hispanic**
- 59.2% (Bexar County)
- 58% (Atascosa Area)

**Black (Non-Hispanic)**
- 71.8% (Bexar County)
- 53%* (Atascosa Area)

**Other (Non-Hispanic)**
- 63.1% (Bexar County)
- 40.9%* (Atascosa Area)

**White (Non-Hispanic)**
- 71.5% (Bexar County)
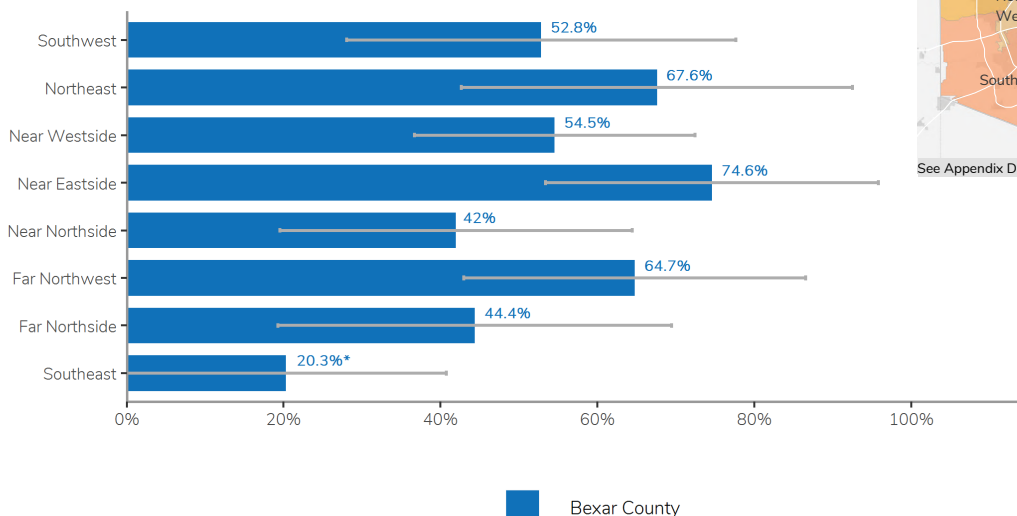- 70.6% (Atascosa Area)

■ Bexar County  ■ Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.9.2  Percent of adults who visited a doctor last year by sector, 2011-2017
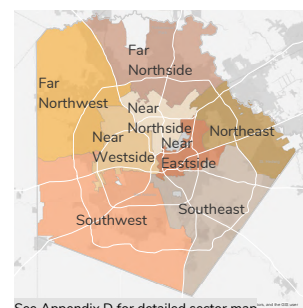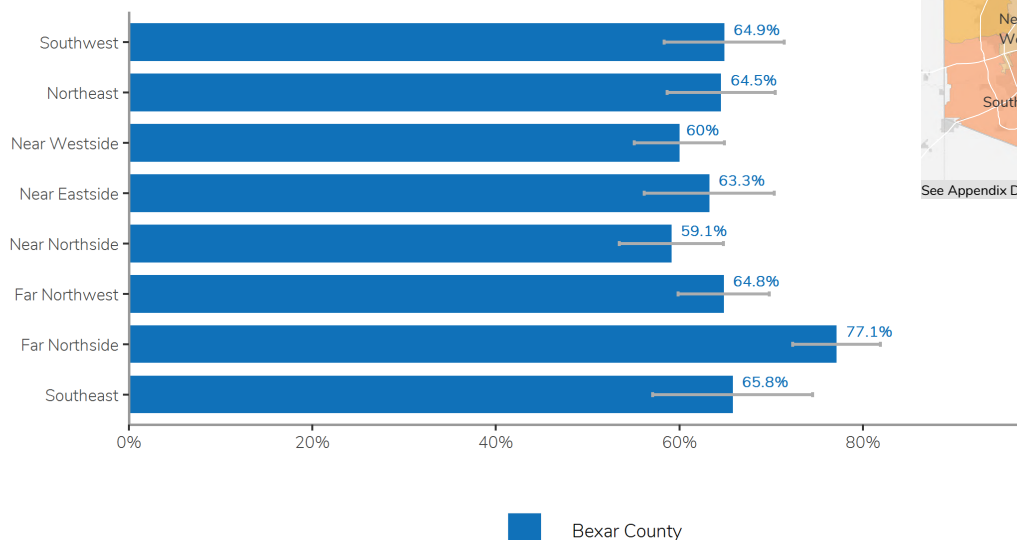


- Southwest: 64.9%
- Northeast: 64.5%
- Near Westside: 60%
- Near Eastside: 63.3%
- Near Northside: 59.1%
- Far Northwest: 64.8%
- Far Northside: 77.1%
- Southeast: 65.8%

■ Bexar County

See Appendix D for detailed sector map
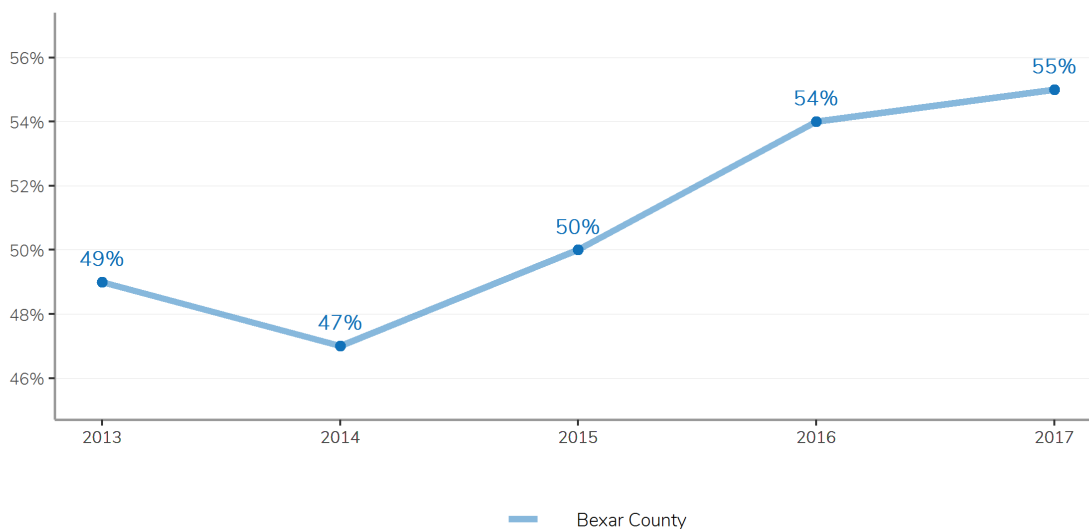
*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.9.3 Percent of adults who visited the dentist last year, 2011-2017
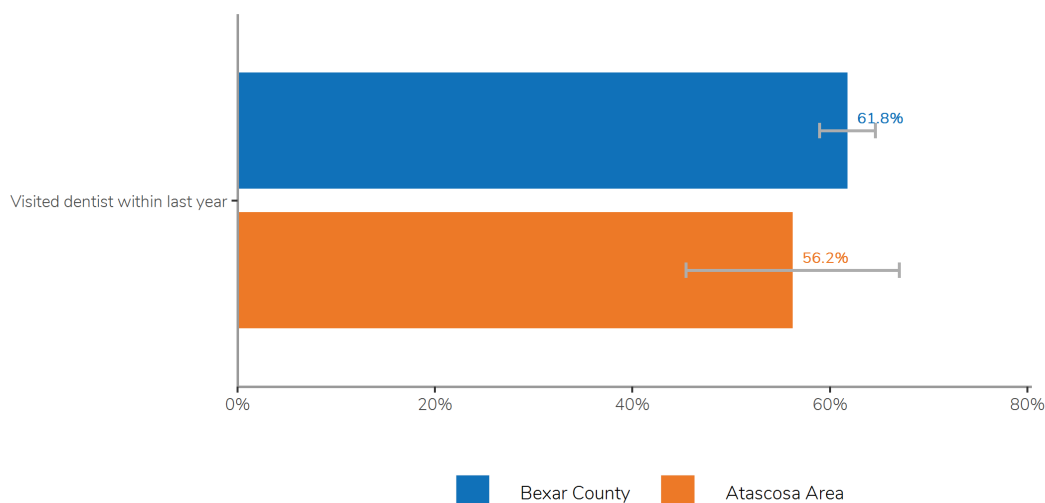


Bexar County  Atascosa Area

Fig. 6.9.4  Percent of adults who visited the dentist last year by race, 2011-2017
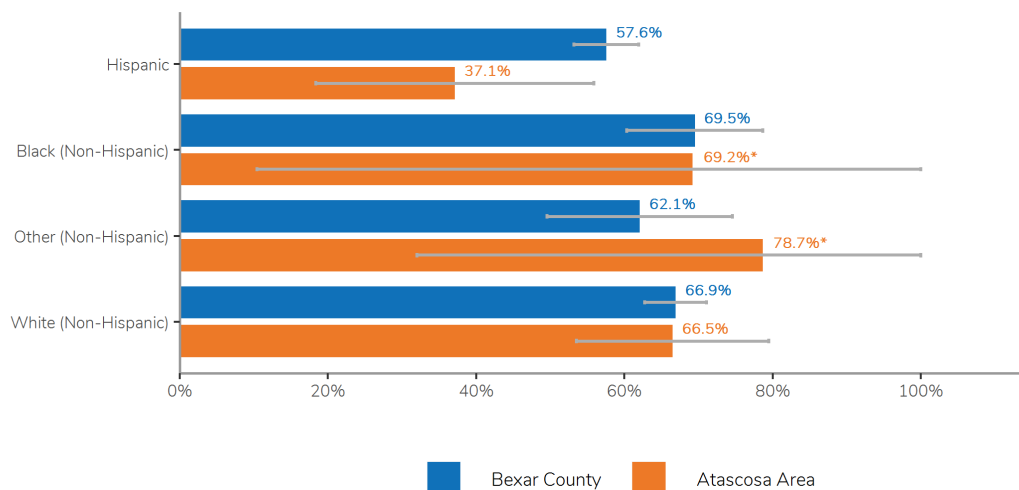


Bexar County  Atascosa Area

Fig. 6.9.5  Percent of adults who visited the dentist last year
by sector, 2011-2017
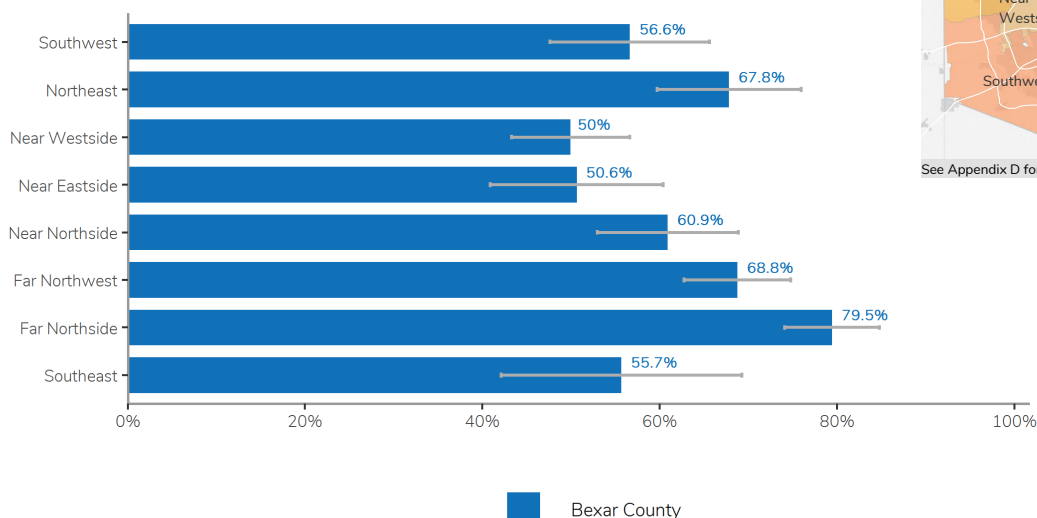


Of adult respondents who report being diabetic, just over eight in 10 report seeing a doctor, nurse, or other health professional for diabetes in the past 12 months (Fig. 6.9.6). For this indicator, there does appear to be a difference among Bexar race/ethnicity groups, with a much higher proportion among black respondents (Fig. 6.9.7). No clear differences emerge among Bexar sectors, though the proportion appears to be relatively higher in the Northeast, Far Northwest, and possibly Near Eastside (Fig. 6.9.8).

**Related data**

Health Outcomes
● Diabetes

Fig. 6.9.6  Percent of adult diabetics seeing a doctor in past year, 2011-2017
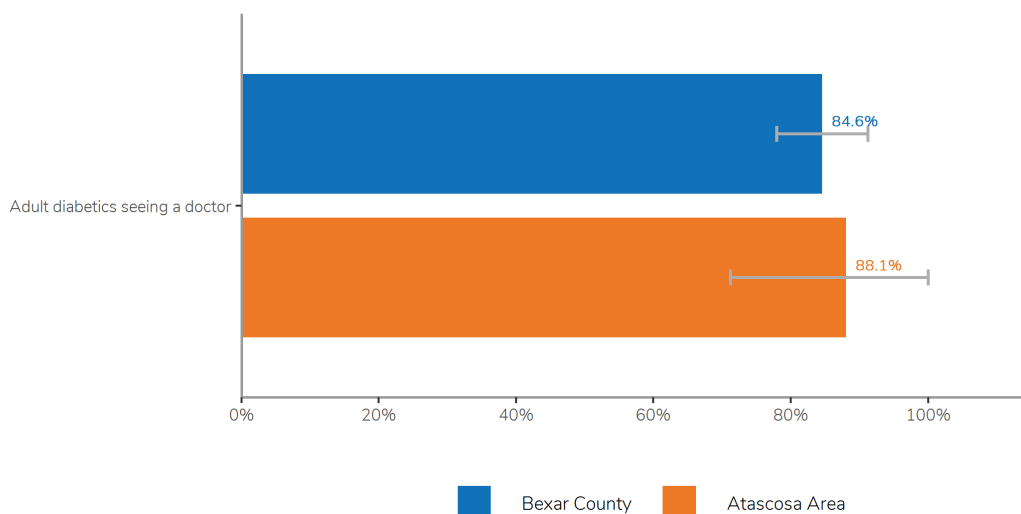


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.9.7  Percent of adult diabetics seeing a doctor in past year by race, 2011-2017
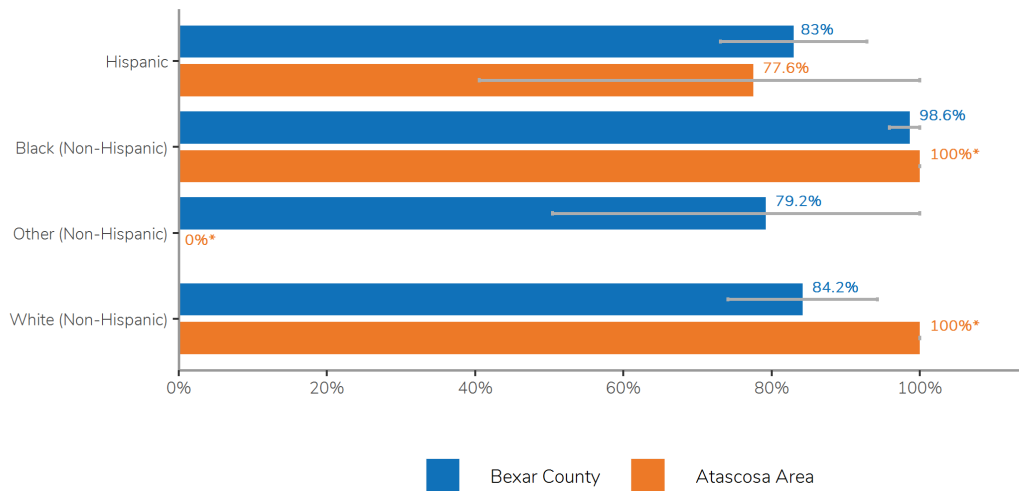


Legend: ■ Bexar County ■ Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.9.8  Percent of adult diabetics seeing a doctor in past year by sector, 2011-2017



See Appendix D for detailed sector map

Legend: ■ Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

Self-management education programs help patients learn skills to manage diabetes by checking blood sugar, learning about healthy diets, how to be active, taking medications as prescribed and how to prevent or reduce diabetes complications. In both counties a much lower percentage of diabetic adult respondents report having had a course in self-management (Fig. 6.9.9). That proportion may once again be higher among black respondents, but the margins of error are too wide to be certain (Fig. 6.9.10). Again the proportions may be higher in the Near Eastside, Northeast, and Far Northwest, but the margins of error are too wide to be certain (Fig. 6.9.11).

Fig. 6.9.9  Percent of adult diabetics who have had a course in self-management, 2011-2017
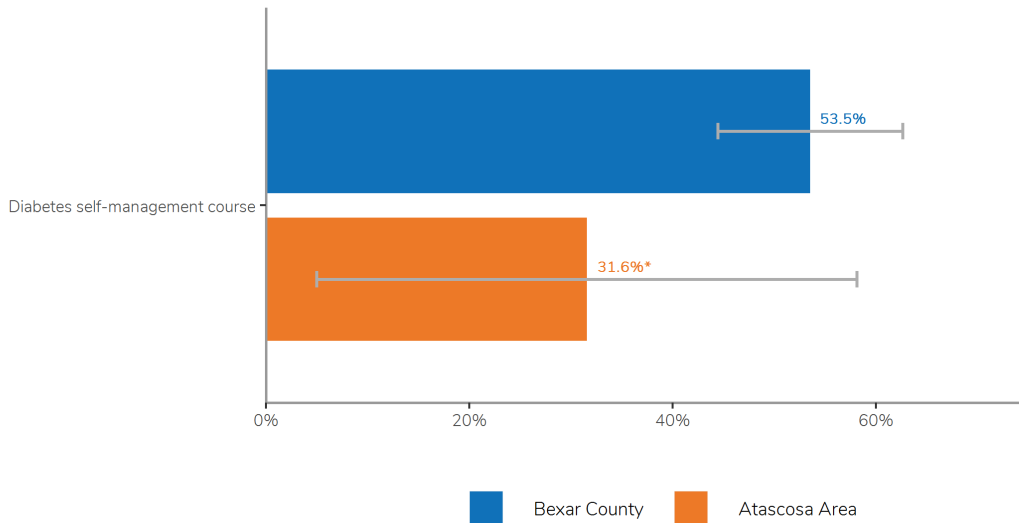


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.9.10  Percent of adult diabetics who have had a course in self-management by race, 2011-2017
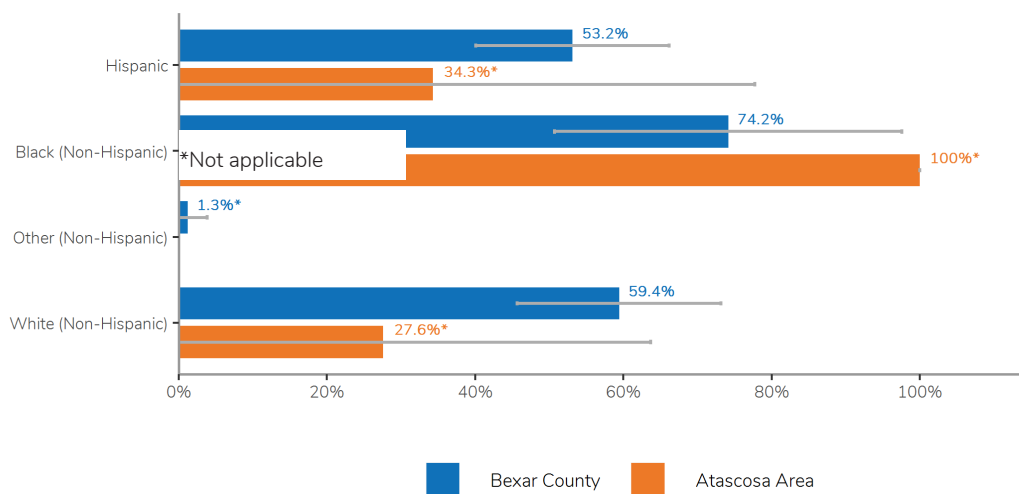


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.9.11 Percent of adult diabetics who have had a course in self-management by sector, 2011-2017



Southwest: 52.8%
Northeast: 67.6%
Near Westside: 54.5%
Near Eastside: 74.6%
Near Northside: 42%
Far Northwest: 64.7%
Far Northside: 44.4%
Southeast: 20.3%*

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

The only data available for children is for Bexar children who are enrolled in Medicaid, which of course means that this data cannot be generalized to the whole county. Data are not easily available for Atascosa. Children who have been enrolled for at least one month are intended to have a Texas HealthSteps preventive care visit, but only about half of those children have actually had the visit (Fig. 6.9.12). The trend does appear to be improving slightly over the past several years.

Fig. 6.9.12 Percent of children enrolled in Medicaid at least one month who have had a Texas HealthSteps visit in the past 12 months



2013: 49%
2014: 47%
2015: 50%
2016: 54%
2017: 55%

Bexar County

*Unreliable: Error is too large relative to estimate
Source: Texas Health and Human Services Commission
Prepared by CI:Now for THC

## Prenatal care

The percent of live births that followed no prenatal care spiked in 2013 and 2014, returning to just above 2012 levels in 2015 (Fig. 6.10). The reasons for that trend are not clear, but one contributing factor may be year-to-year variation in proportion of births with prenatal care information missing or unknown, a possibility that has been suggested in the past.[18] However, even if births following no prenatal care are assumed to be 100% of the difference between total births and the sum of first, second, and third trimester prenatal care births, the Atascosa trend would spike in 2013 and remain high through 2015, while Bexar births would show a flatter version of the trend in Fig. 6.10. It is worth noting that the percent of live births "missing" – not categorized as either following prenatal care (first, second, or third trimester) or following no prenatal care – is significantly higher in Atascosa (median 8.3% over the 2012-2015 period) and Bexar (median 6.3%) than Public Health Region 8 (median 5.4%) or Texas as a whole (median 5.3%).

Fig. 6.10 Percent of births to mothers who received no prenatal care
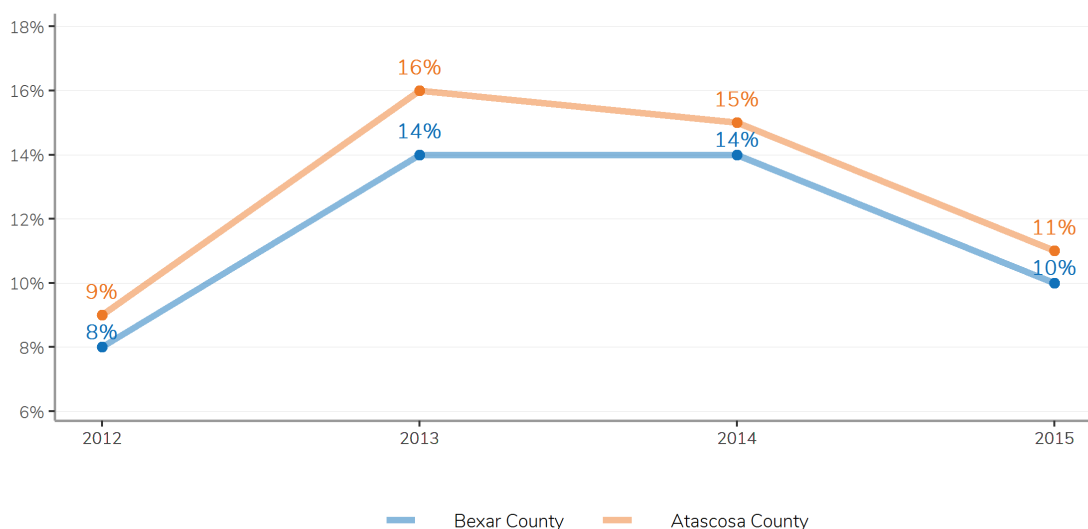


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

In both counties the proportion of births following no prenatal care – measured using a 2015-2017 three-year average to yield more stable percentages – is highest among mothers aged 15 to 19. The difference among age groups in Atascosa is not great, but in Bexar, the proportion of live births following no prenatal care among mothers younger than 20 is twice that of mothers 30 and older (Fig. 6.10.1).

18. Behind from the start: Prenatal care crisis puts babies in Bexar County, Tex., at risk ? Part 1. Retrieved from https://www.centerforhealthjour-nalism.org/fellowships/projects/behind-start-prenatal-care-crisis-puts-bexar-county-babies-risk

# Section 6: Health Behaviors and Risks

The recent trend in proportion of births following first trimester initiation of prenatal care is similarly difficult to interpret, showing a sharp decline in 2013 followed by a recovery to a level just shy of 2012 levels (Fig. 6.10.2). The trend for proportion of births following early and adequate prenatal care as defined by the Kessner Index[19] is roughly the same shape (Fig. 6.10.3). Both trends are essentially inverse mirrors of the trend in proportion of births following no prenatal care. The pattern by age group is also an inverse mirror, with both Atascosa and Bexar mothers 30 and older most likely to begin prenatal care in the first trimester. Again, too, the difference among age groups is greater in Bexar than in Atascosa (Fig. 6.10.4).

Fig. 6.10.1 Percent of births to mothers receiving no prenatal care by age (3-year average), 2013-2015
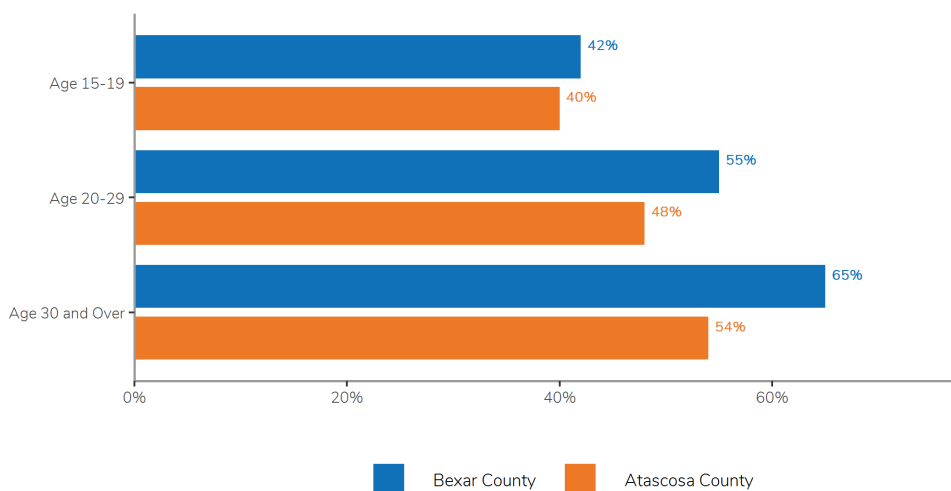


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 6.10.2 Percent of births to mothers receiving prenatal care in first trimester
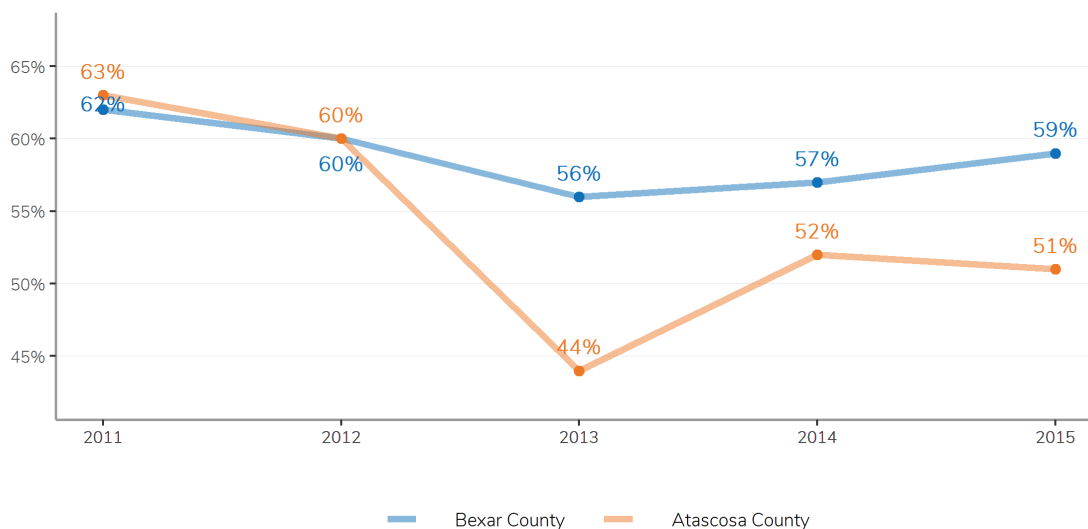


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

19. The Kessner index defines adequate prenatal care by initiation of prenatal care in the first trimester and 9 or more visits.

Fig. 6.10.3 Percent of births to mothers receiving early and adequate prenatal care as defined by the Kessner index
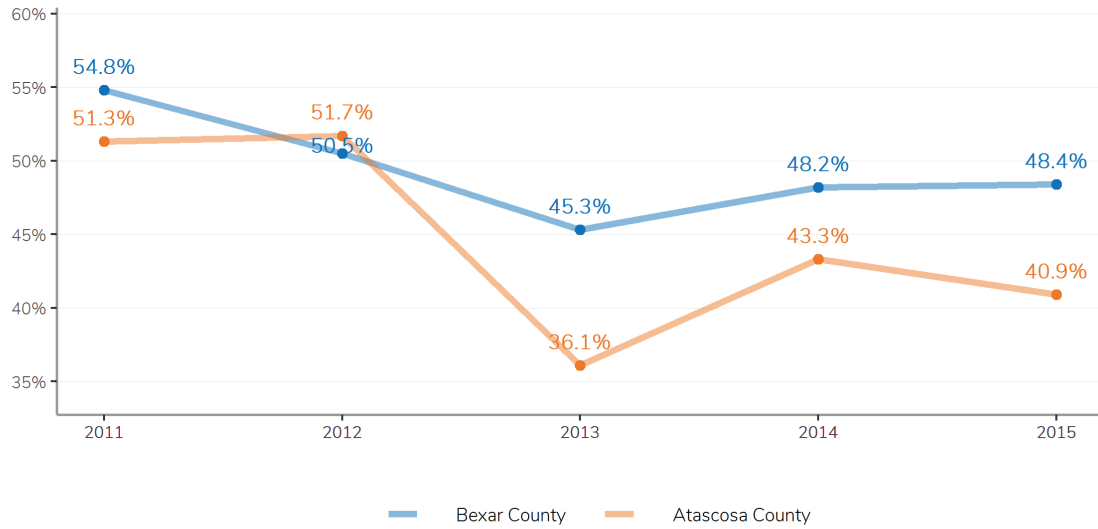


Bexar County — Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 6.10.4 Percent of births to mothers receiving prenatal care in the first trimester by age (3-year average), 2013-2015
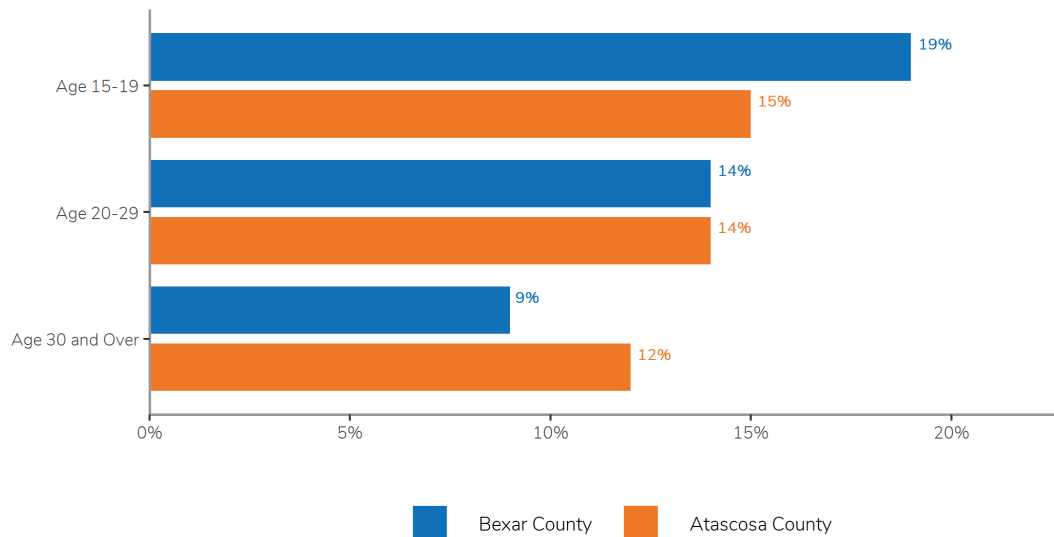


Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

## Vaccinations

About three-quarters of Bexar children aged 19 to 35 months have completed the recommended 4:3:1:3*:3:1:4[20] vaccination series, an increase over prior years (Fig. 6.11). Unfortunately, 4:3:1:3*:3:1:4 completion is not tracked for small Texas counties.[21] Vaccination rates for older children are available by school district for each of several vaccines, but that data cannot be aggregated into a county-level vaccination rate, and it by definition excludes children who are home-schooled or not enrolled in school for some other reason. Depending on vaccine and school district, 2018-19 kindergarten vaccination rates range from 94% to 100% for Atascosa and from 83% to 100% in Bexar.[22] Again, depending on vaccine and school district, 2018-19 vaccination rates among 7th graders range from 79% to 100% in Atascosa and from 21% to 100% in Bexar.[23]

For children kindergarten through 12th grade, the percent of students with a conscientious exemption from school vaccination requirements in 2018-19 ranges from 0% to 0.9% among Atascosa school districts and from 0% to 5.0% among Bexar school districts.[24] Exemption data is also available at the county level: 0.32% of Atascosa students and 0.88% of Bexar students have a conscientious objection, in both counties the highest level since at least the 2010-11 school year. The exemption rate appears to be rising in metropolitan-area counties all over the state, and San Antonio-area counties are disproportionately represented among the highest 20 counties. The 2018-19 exemption rate is now 2.40% in Comal County, 2.56% in Kerr, 3.34% in Kendall, and 3.87% in Gillespie, all of which stood at around 1% in 2010-11.[25]

Fig. 6.11 NIS-Child immunization coverage estimates for the 4:3:1:3*:3:1:4 series
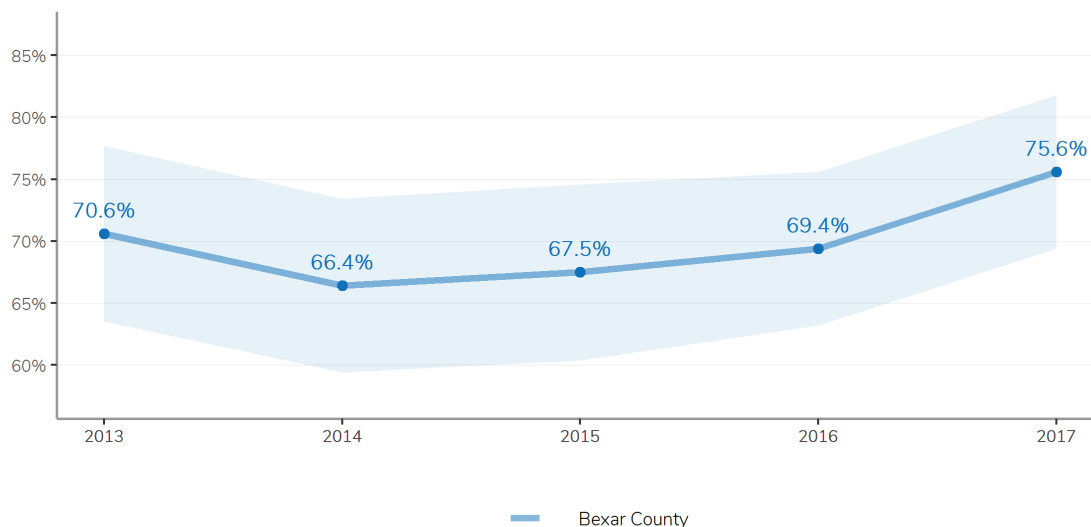


Bexar County

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

20. The 4:3:1:3:3*:1:4 series consists of ≥4 doses of DTaP, ≥3 doses of poliovirus vaccine, ≥1 dose of MMR vaccine, full series of Hib vaccine (≥3 or ≥4 doses, depending on product type), ≥3 doses of HepB, ≥1 dose of varicella vaccine, and ≥4 doses of PCV. This series is intended to protect against diphtheria (breathing problems, paralysis, and heart failure), pertussis (whooping cough), polio, measles, mumps, rubella ("German measles"), Haemophilus influenzae type b (meningitis, pneumonia, and other diseases), Hepatitis B (liver cirrhosis and cancer), varicella (chicken pox), and pneumococcus (pneumonia, meningitis, and middle ear infections).
21. 2017 National Immunization Survey-Child: Texas Perspective. Retrieved from https://www.dshs.texas.gov/immunize/coverage/pdf/2017_NIS_Child_Full_Report/
22. Vaccine Coverage Rates among Kindergarteners in Texas, by School, 2018-2019. Retrieved from https://www.dshs.texas.gov/immunize/coverage/docs/2018-2019-School-Vaccination-Coverage-Levels---Kindergarten-(XLS).pdf
23. Vaccine Coverage Rates among Seventh Graders in Texas, by School, 2018-2019. Retrieved from https://www.dshs.texas.gov/immunize/coverage/docs/2018-2019-School-Vaccination-Coverage---Seventh-Grade-(XLS).pdf
24. Statistics on Conscientious Exemptions to School Immunizations. Retrieved from https://www.dshs.texas.gov/immunize/coverage/Conscientious-Exemptions-Data.shtm#district
25. Statistics on Conscientious Exemptions to School Immunizations. Retrieved from https://www.dshs.texas.gov/immunize/coverage/Conscientious-Exemptions-Data.shtm#county

# Section 6: Health Behaviors and Risks

Human papillomavirus (HPV) vaccination rates are rising but remain quite low, particularly given coverage by public and private insurance, accumulated evidence of safety and long-term effectiveness, and outreach efforts in recent years.[26] Data is not available for Atascosa, but just over four in 10 Bexar 13- to 17-year-olds are appropriately vaccinated against HPV (Fig. 6.11.1). The percent of males 13-17 appropriately vaccinated roughly tripled between 2012 and 2017, but currently stands at fewer than four in 10 (Fig. 6.11.2). The percent of females 13-17 appropriately vaccinated has risen by about three-quarters to over five in 10 (Fig. 6.11.2).

Fig. 6.11.1 Percent of all (13-17) appropriately vaccinated against HPV
(two- or three- dose regiment depending on age)
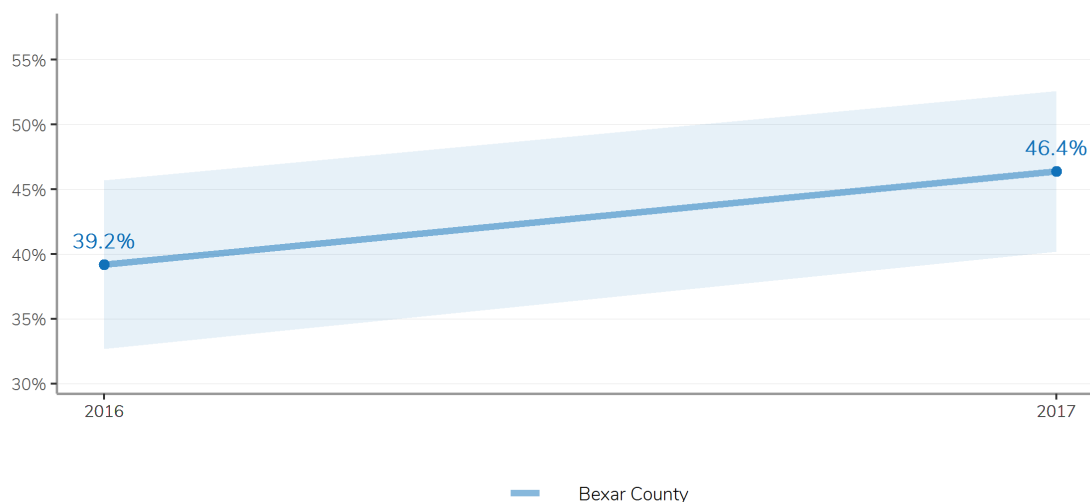


Bexar County

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 6.11.2 Percent of all (13-17) appropriately vaccinated against HPV by sex
(two- or three- dose regiment depending on age)
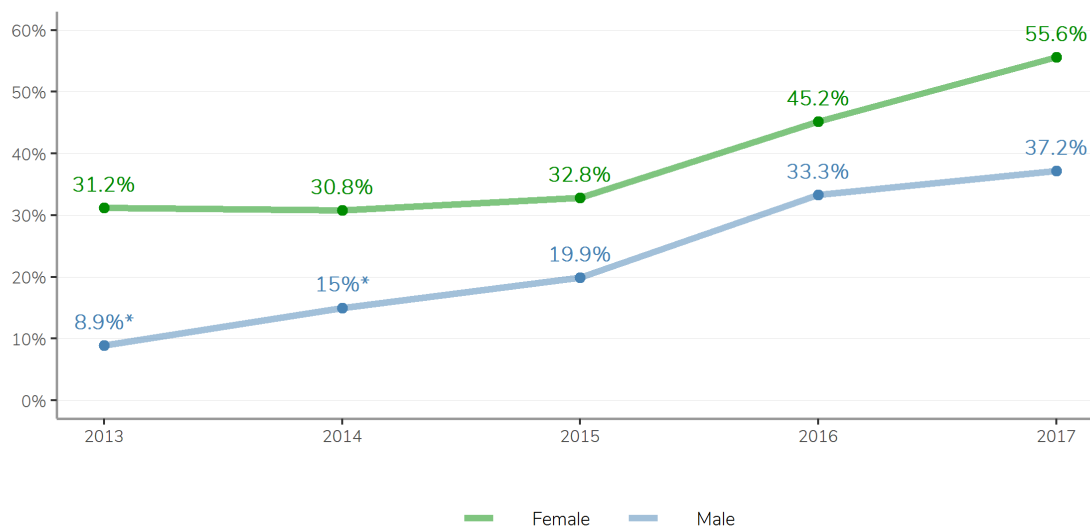


Female          Male

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

26. The HPV Vaccine: Access and Use in the U.S. (2019, June 19). Retrieved from https://www.kff.org/womens-health-policy/fact-sheet/the-hpv-vaccine-access-and-use-in-the-u-s/

# Section 6: Health Behaviors and Risks

Among people 65 and older, just over six in 10 have had a flu shot in the past year (Fig 6.11.3). That proportion does not appear to differ among Bexar race/ethnicity groups; as with other BRFSS-derived data, wide margins of error make the Atascosa area pattern hard to interpret (Fig. 6.11.4). The proportion appears to be virtually identical across Bexar sectors (Fig. 6.11.5).

Fig. 6.11.3 Percent of seniors who had a flu shot within the past year, 2011-2017
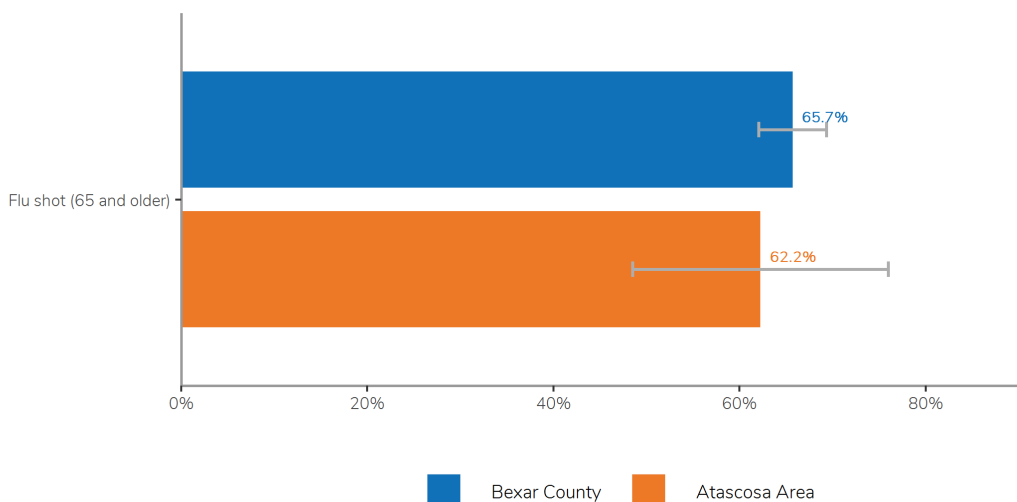


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.11.4 Percent of seniors who had a flu shot within the past year by race, 2011-2017
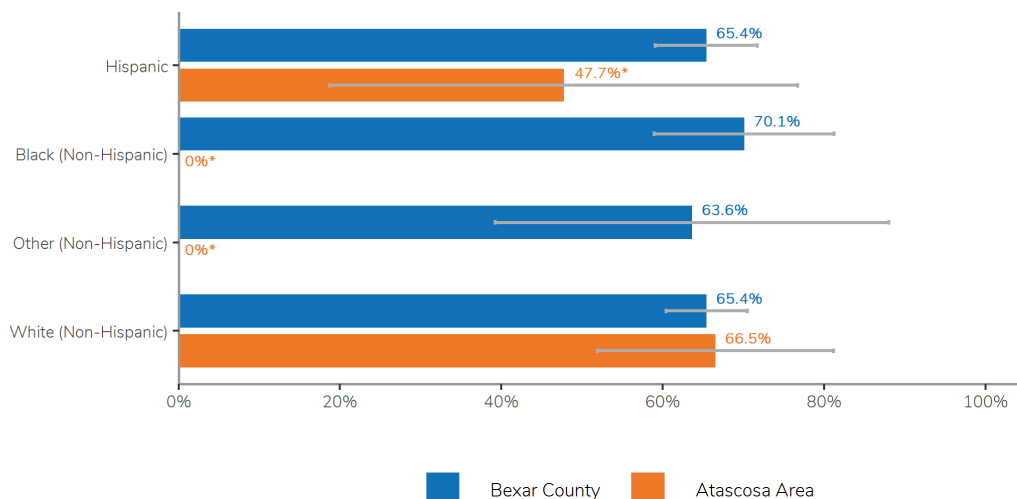


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

Fig. 6.11.5 Percent of seniors who had a flu shot within the past year by sector, 2011-2017
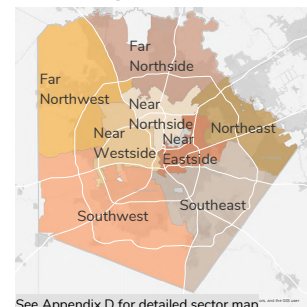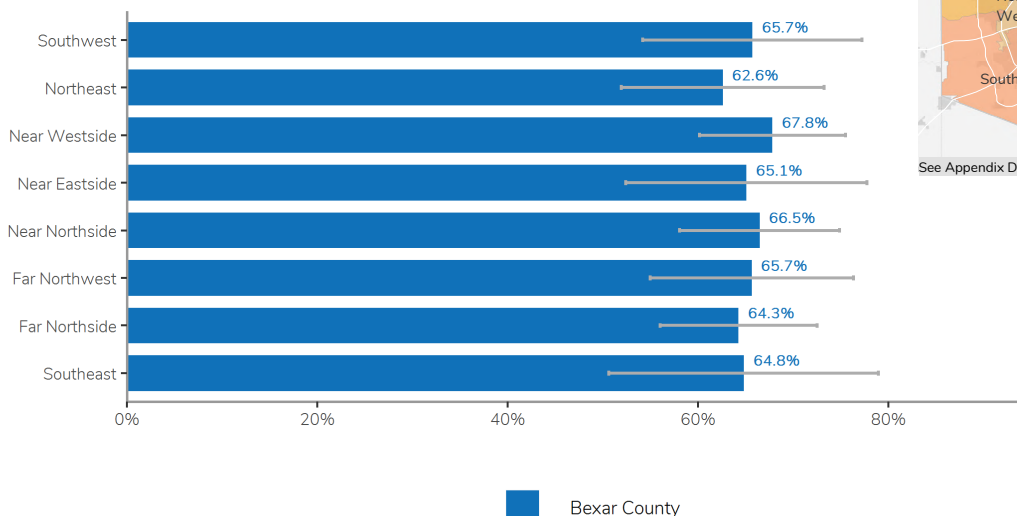


See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

About three-quarters of adults 65 and older in both counties have ever been vaccinated against pneumonia, a vaccination that only needs to be given once rather than annually (Fig. 6.11.6). That percentage may be somewhat higher among non-Hispanic whites and lower among Hispanics (Fig. 6.11.7). The margins of error mean we cannot be sure of any difference among Bexar sectors (Fig. 6.11.8).

Fig. 6.11.6 Percent of seniors who have ever had a pneumonia vaccination, 2011-2017
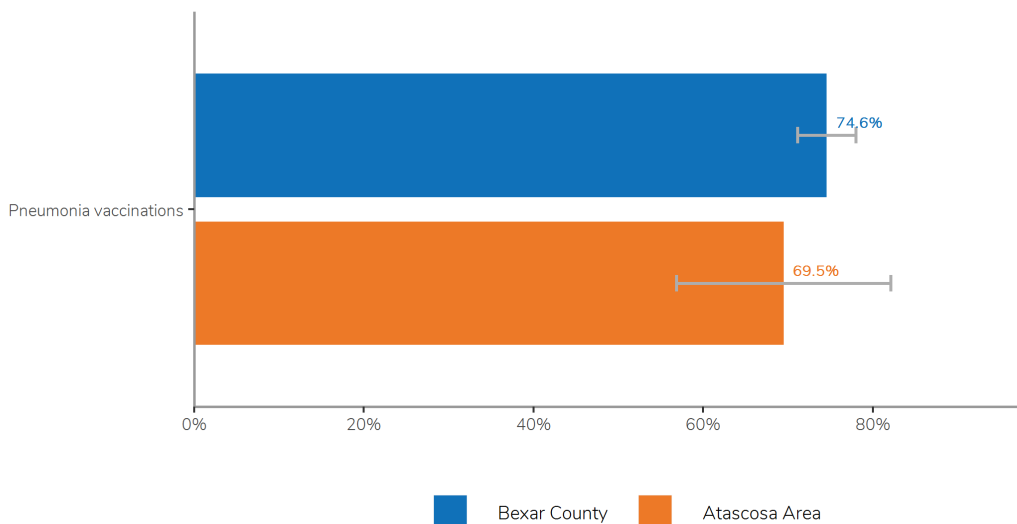


Bexar County     Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
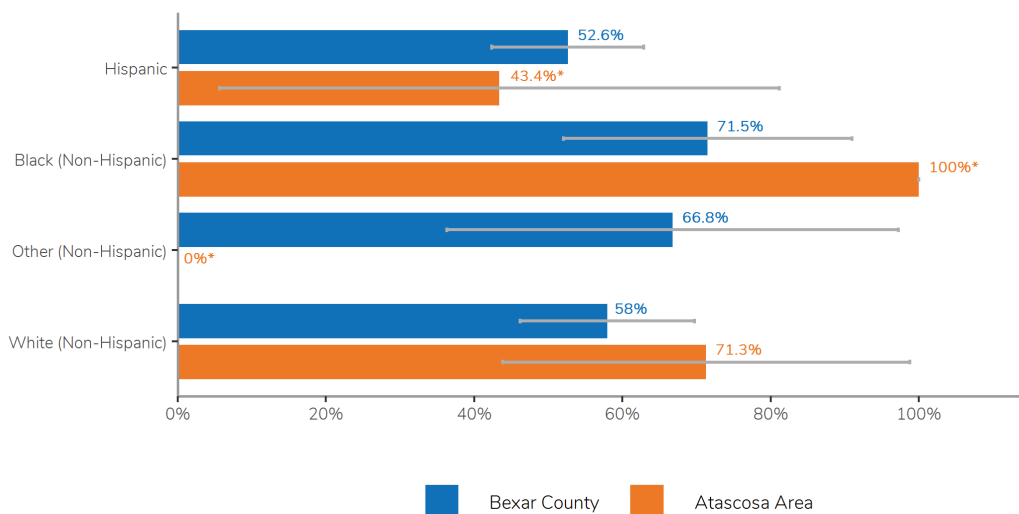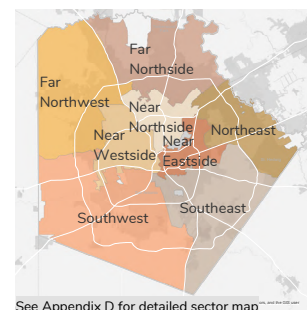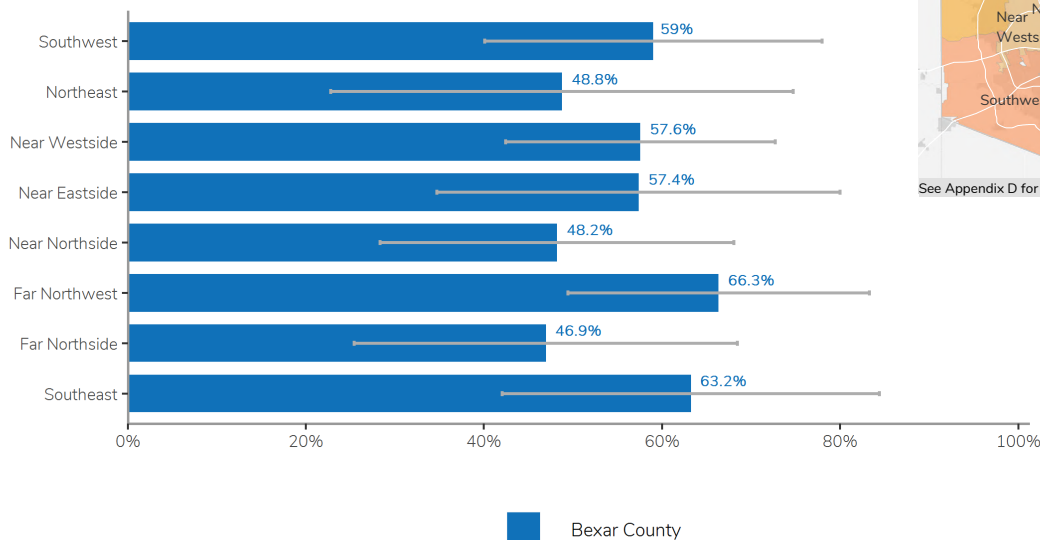Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.11.7 Percent of seniors who have ever had a pneumonia vaccination by race, 2011-2017
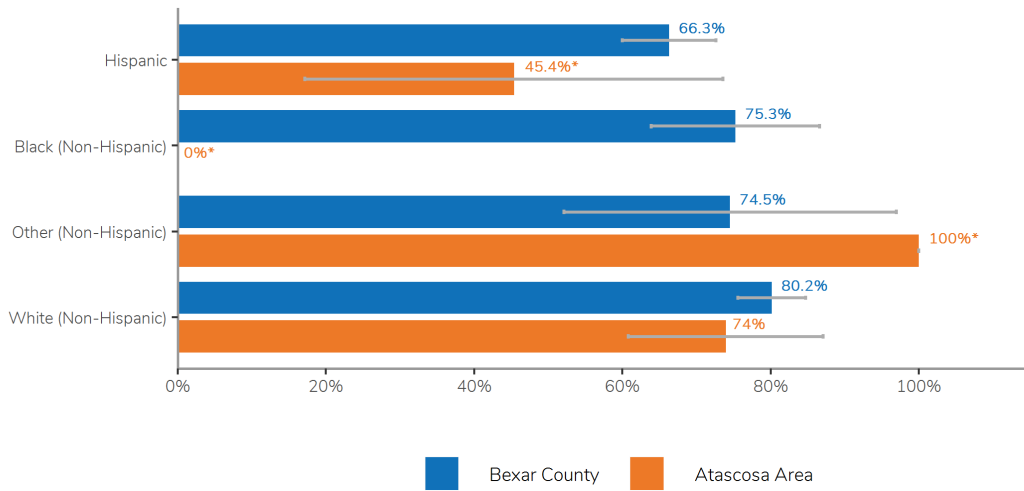


| | Bexar County | Atascosa Area |
|---|---|---|
| Hispanic | 66.3% | 45.4%* |
| Black (Non-Hispanic) | 75.3% | 0%* |
| Other (Non-Hispanic) | 74.5% | 100%* |
| White (Non-Hispanic) | 80.2% | 74% |

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.11.8 Percent of seniors who have ever had a pneumonia vaccination by sector, 2011-2017
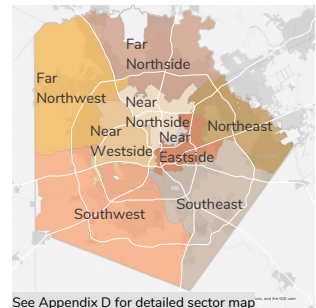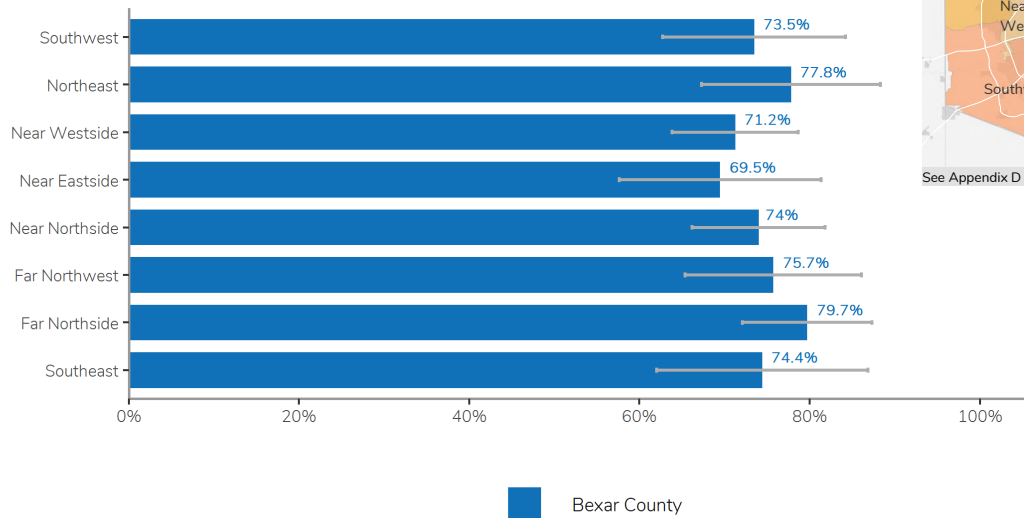


| Sector | Bexar County |
|---|---|
| Southwest | 73.5% |
| Northeast | 77.8% |
| Near Westside | 71.2% |
| Near Eastside | 69.5% |
| Near Northside | 74% |
| Far Northwest | 75.7% |
| Far Northside | 79.7% |
| Southeast | 74.4% |

See Appendix D for detailed sector map

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

## Screening and testing

BRFSS data indicate that just over eight in 10 adult diabetics have had their hemoglobin A1c – a measure of blood sugar level –checked in the past year (Fig. 6.12). That proportion may be lower among Hispanics than other Bexar race/ethnicity groups (Fig. 6.12.1). Although the proportions appear very high for Atascosa Hispanics and blacks, small numbers make for a high degree of uncertainty. No Bexar sector shows a statistically significant difference from the others, but proportion may be higher in the Far Northeast and Far Northside (Fig. 6.12.2).

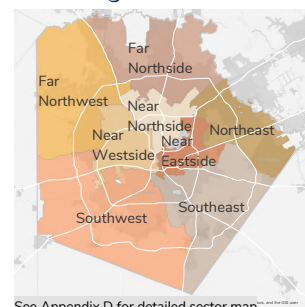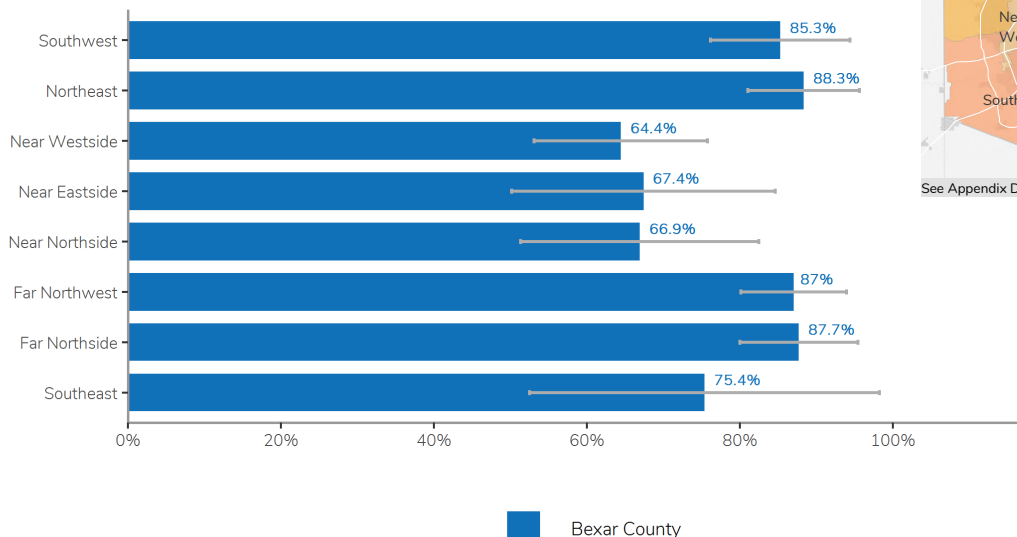Fig. 6.12 Percent of adult diabetics not having Hemoglobin A1c checked in past year, 2011-2017



*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.1 Percent of adult diabetics not having Hemoglobin A1c checked in past year, 2011-2017



*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

Fig. 6.12.2 Percent of adult diabetics not having Hemoglobin A1c checked in past year, 2011-2017
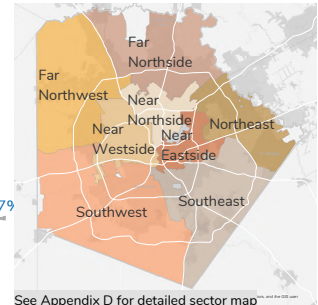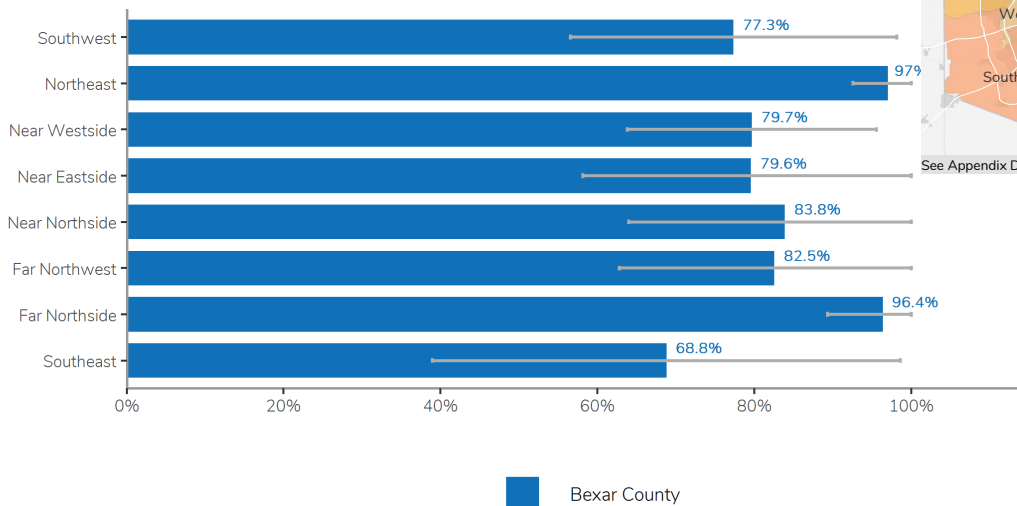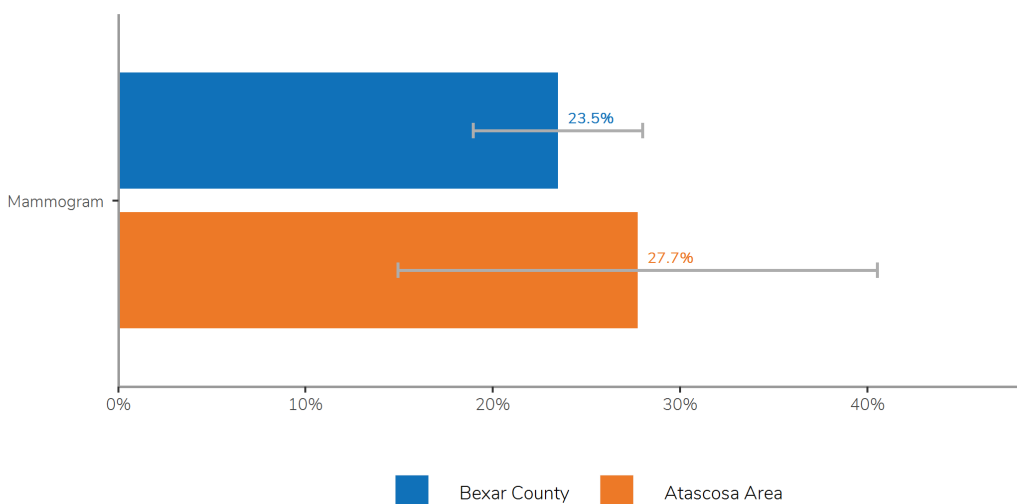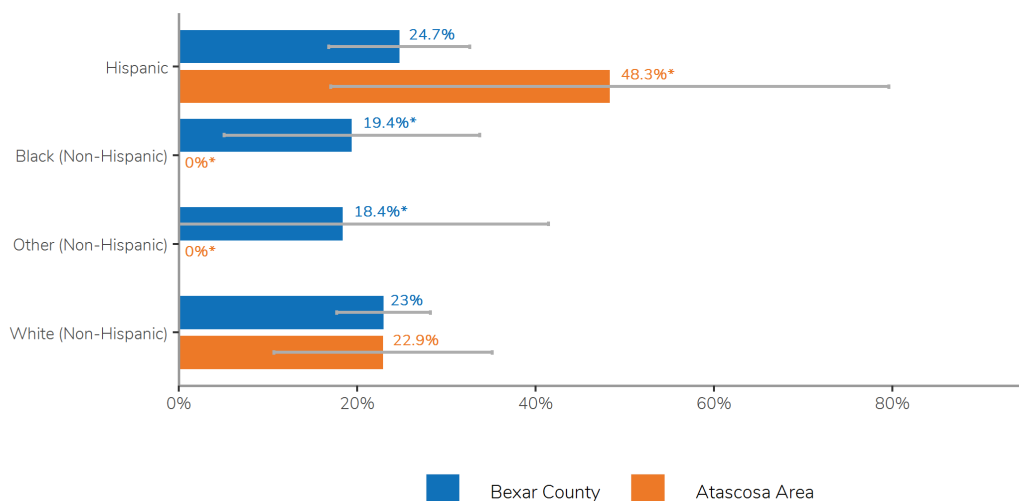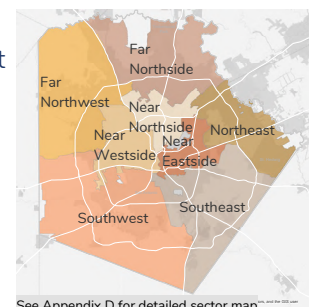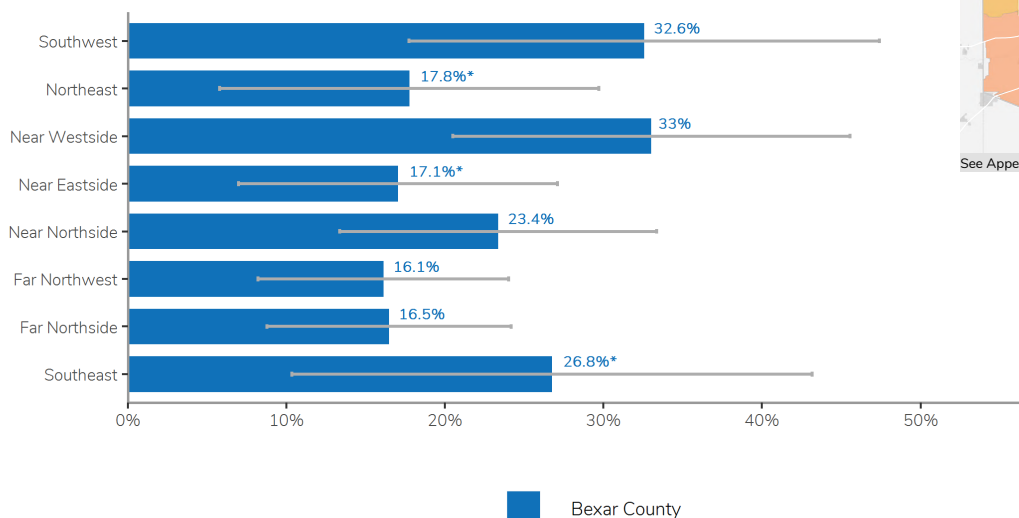


See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Foot problems are common among diabetics because diabetes can lower the blood flow in feet making it harder to heal injuries and diabetes can lead to nerve damage taking away the sense of feeling in feet. The American Diabetes Association recommends checking feet daily for blisters, sores, scratches or changes to prevent amputation and complications. About six in 10 diabetic adults in both counties report checking their feet every day (Fig. 6.12.3). The confidence intervals for race/ethnicity groups (Fig. 6.12.4) and for Bexar sectors (Fig. 6.12.5) are even wider than usual because the percentage for this indicator is close to half. The more extreme the percentage – that is, the closer the percentage is to 0% or 100% – the narrower the interval would be.

Fig. 6.12.3 Percent of adult diabetics who check feet daily, 2011-2017
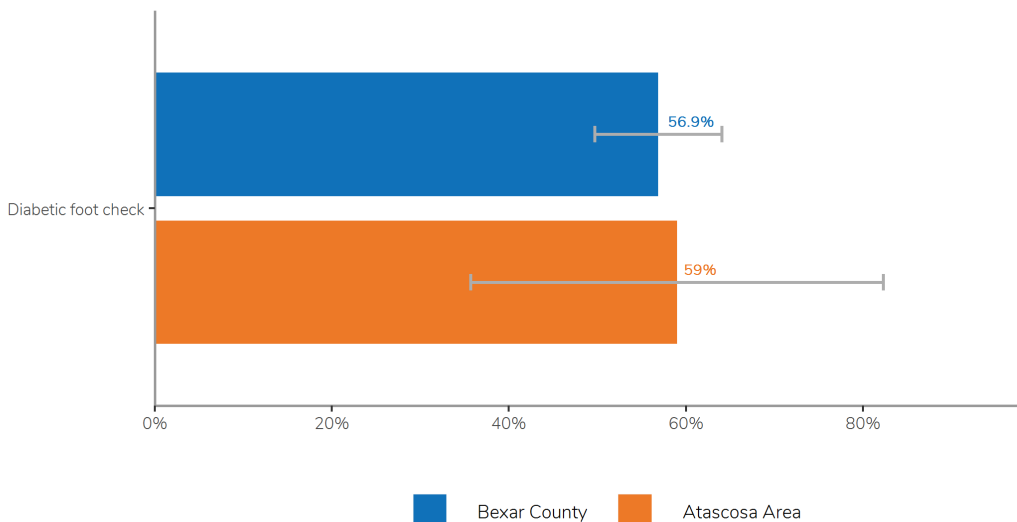


Bexar County     Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.4 Percent of adult diabetics who check feet daily by race, 2011-2017



Hispanic: 52.6%, 43.4%*
Black (Non-Hispanic): 71.5%, 100%*
Other (Non-Hispanic): 66.8%, 0%*
White (Non-Hispanic): 58%, 71.3%

Bexar County    Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.5 Percent of adult diabetics who check feet daily by sector, 2011-2017



Southwest: 59%
Northeast: 48.8%
Near Westside: 57.6%
Near Eastside: 57.4%
Near Northside: 48.2%
Far Northwest: 66.3%
Far Northside: 46.9%
Southeast: 63.2%

See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small
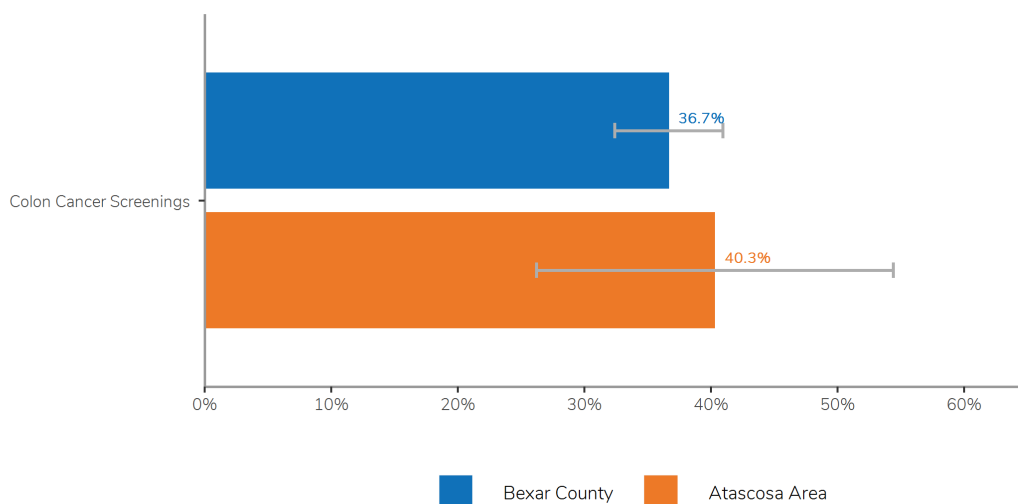Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

Nearly eight in 10 Bexar women aged 21 and older report having ever had a Pap test to screen for cervical cancer (Fig.6.12.6). No clear difference emerges among race/ethnicity groups (Fig. 6.12.7). The proportion does clearly vary among Bexar sectors: the percentage of women 21 and older who have ever had a Pap test is lower in the Near Westside than in the Southwest, Northeast, Far Northwest, and Far Northside (Fig. 6.12.8). Although it is not certain, the percentage may be lower on the Near Eastside and Near Northside as well.

Fig. 6.12.6 Percent of women 21+ who have ever had a pap test, 2011-2017
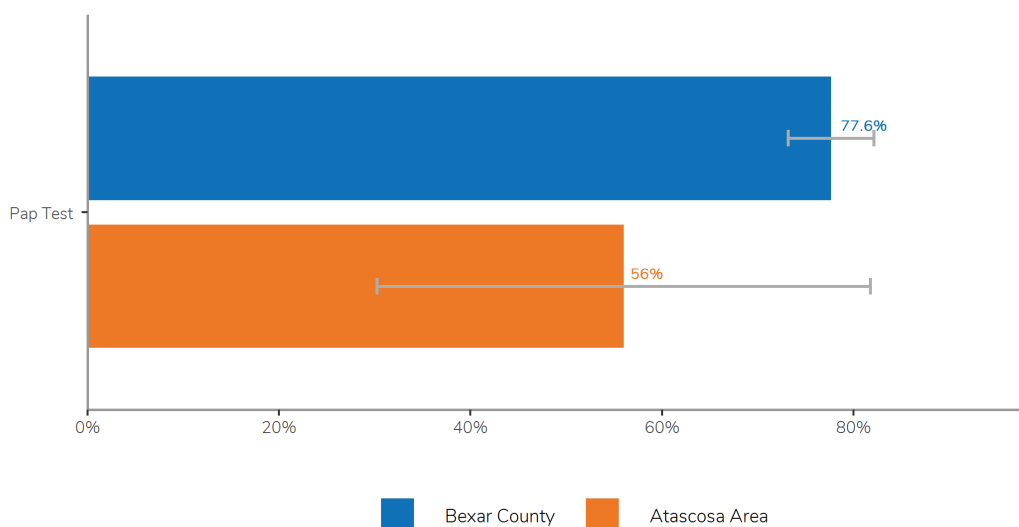
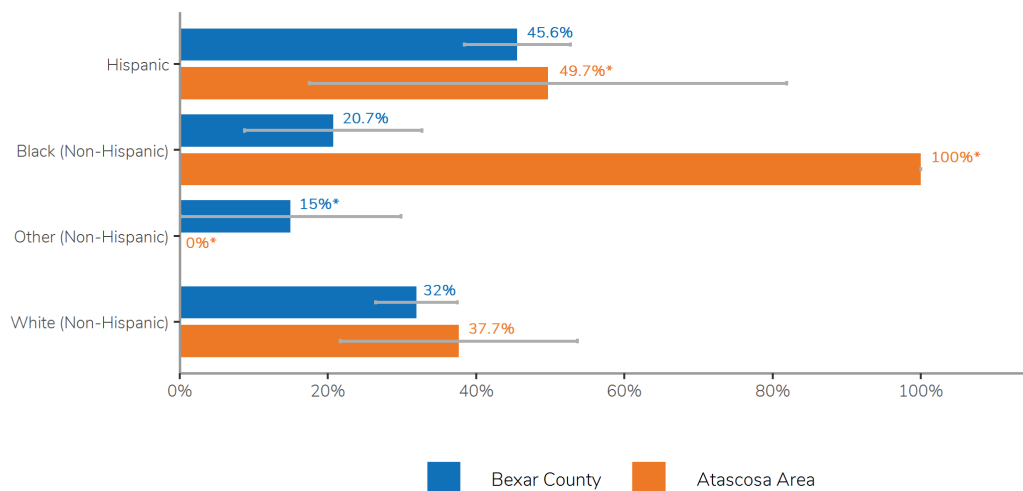

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.7 Percent of women 21+ who have ever had a pap test by race, 2011-2017
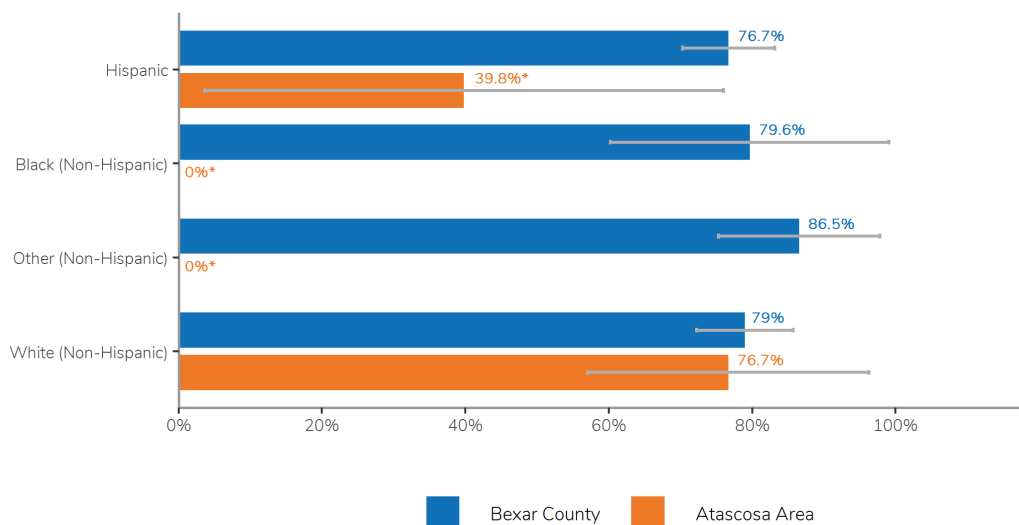


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.8 Percent of women 21+ who have ever had a pap test by sector, 2011-2017



Southwest — 85.3%
Northeast — 88.3%
Near Westside — 64.4%
Near Eastside — 67.4%
Near Northside — 66.9%
Far Northwest — 87%
Far Northside — 87.7%
Southeast — 75.4%
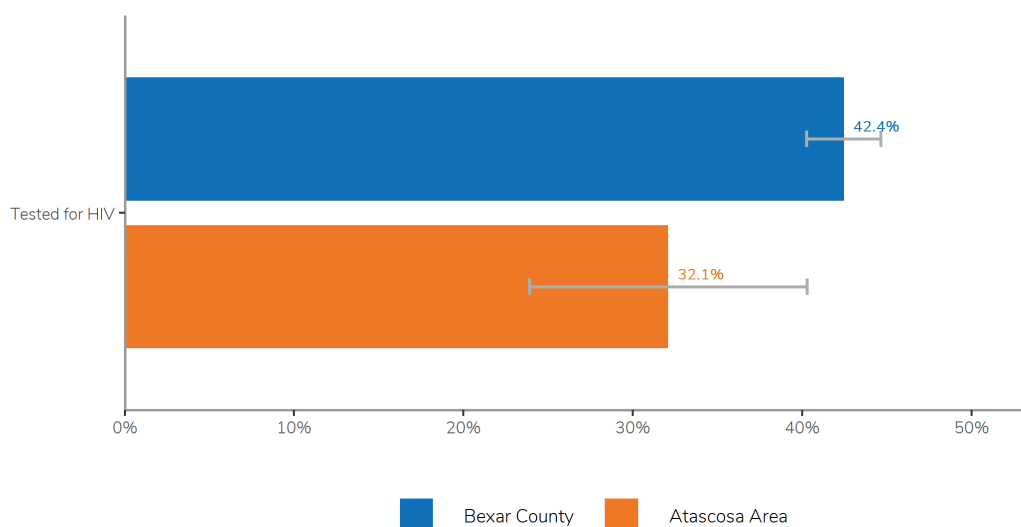
Bexar County

See Appendix D for detailed sector map

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

A quarter of women 50 and older report *not* having a mammogram in the past two years to screen for breast cancer (Fig 6.12.9), with no clear differences among race/ethnicity groups (Fig. 6.12.10). Although the differences are not statistically significant, the Near Westside and Southwest sectors may have lower mammography screening rates (or put another way, higher rates of *not* being appropriately screened) than the Far Northwest and Far Northside (Fig. 6.12.11).

Fig. 6.12.9 Percent of women 50+ who have had a mammogram within the past two years, 2011-2017



Mammogram — 23.5% / 27.7%

Bexar County    Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.10 Percent of women 50+ who have had a mammogram within the past two years by race, 2011-2017



Bexar County    Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
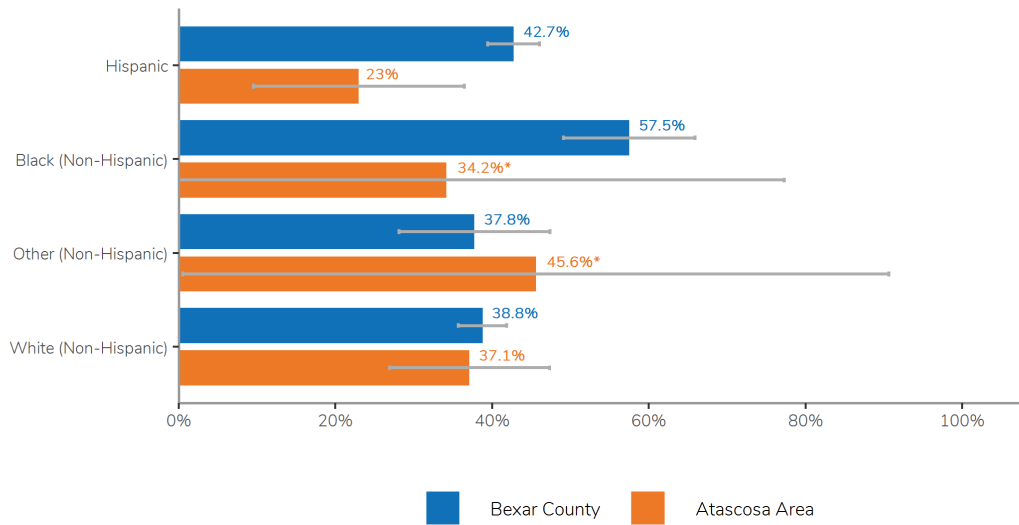Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.11 Percent of women 50+ who have had a mammogram within the past two years by sector, 2011-2017



See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

A recent Susan G. Komen-commissioned study[27] found that out-of-pocket costs for a diagnostic mammogram for Texas patients with private insurance varied from $336 to $836 depending on their insurance and an estimated 10% of screening mammograms required a follow-up diagnostic mammogram.  The Texas Legislature passed HB 170 to reduce the out-of-pocket costs and allow more timely diagnosis and treatment of breast cancer. It goes into effect on September 1, 2019.

About four in 10 adults 50 and older are *not* up to date on recommended colon cancer screening (Fig. 6.12.12), which will vary by interval and method (e.g., stool test or colonoscopy) depending on patient history and risks. It appears that Bexar Hispanics lag other race/ethnicity groups in up-to-date screening (Fig. 6.12.13), and that difference appears trustworthy. Likewise the Southwest Bexar sector and Near Westside are more likely to lag in up-to-date screening than the Far Northwest and Far Northside sectors (Fig. 6.12.14).

Fig. 6.12.12 Percent of adults 50+ who are up to date on recommended screening for colon cancer, 2011-2017
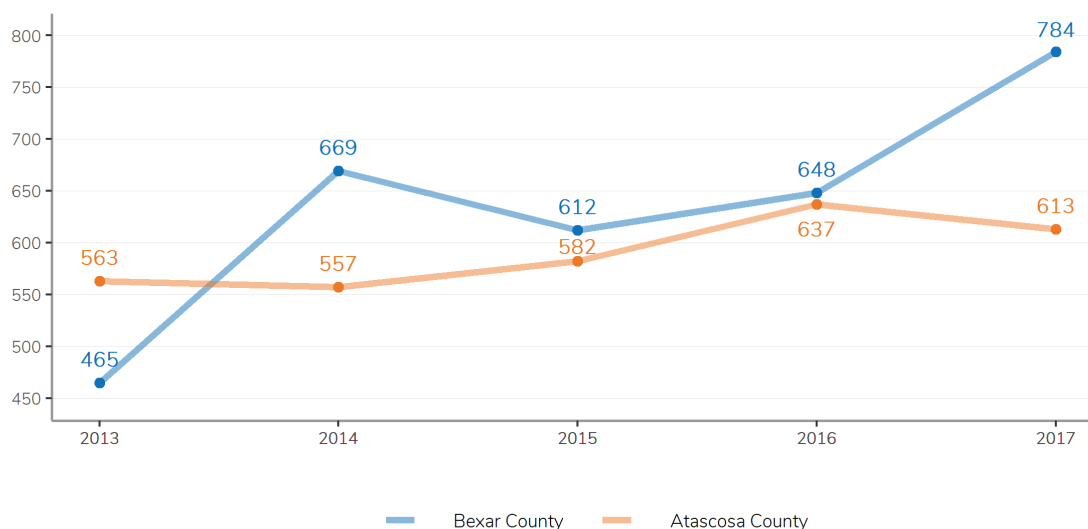


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

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27. Susan G. Komen. Advocacy in Austin. Retrieved from https://komennwtx.org/advocacy-in-austin/

Fig. 6.12.13 Percent of adults 50+ who are up to date on recommended screening for colon cancer by race, 2011-2017



*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 6.12.14 Percent of adults 50+ who are up to date on recommended screening for colon cancer by sector, 2011-2017
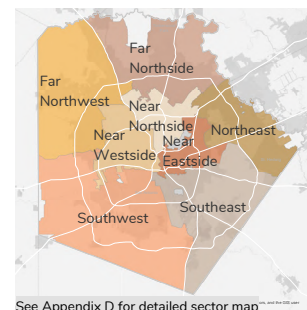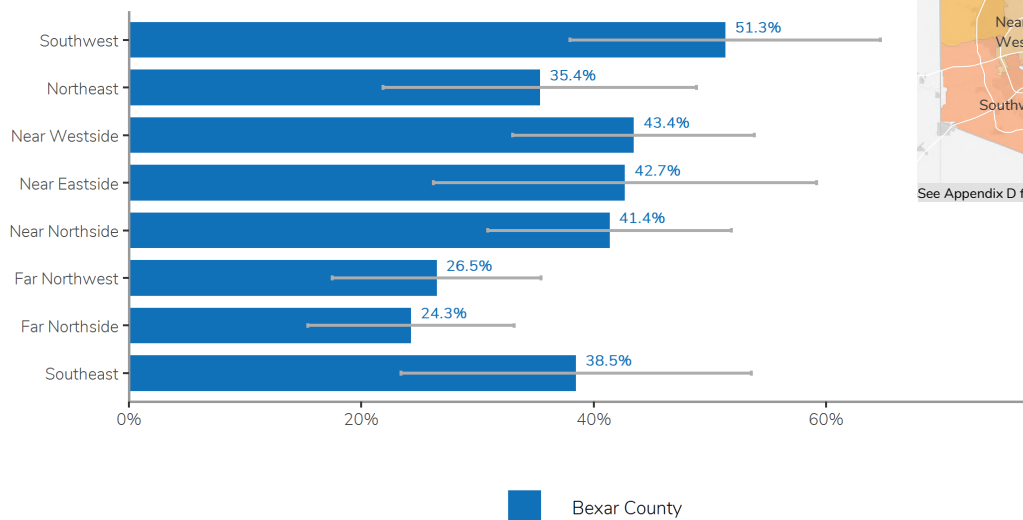


See Appendix D for detailed sector map

*Unreliable: Error is too large relative to estimate or sample size is small
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 6: Health Behaviors and Risks

Four in 10 Bexar adult BRFSS respondents report having been tested for HIV (human immunodeficiency virus) at some point in their lives, but that proportion is closer to three in 10 among Atascosa respondents (Fig. 6.12.15). There are clear and statistically significant differences among race/ethnicity groups in both counties. Although the degree of difference is uncertain, Atascosa Hispanics are less likely than Bexar Hispanics to have ever been tested for HIV (Fig. 6.12.16). Mirroring statewide patterns[28], Black respondents have by far the highest percentage in Bexar, with the next-highest percentage among Hispanics and the lowest among non-Hispanic whites. The differences among Bexar race/ethnicity groups also show up as differences among Bexar sectors. The highest percentage ever-tested for HIV is on the Near Eastside (Fig. 6.12.17), which is historically African American and still has a high percentage of African American residents relative to the rest of the county. The difference between the Near Eastside and the Near Northside, Far Northside, Far Northwest, and Southeast – home to a relatively greater percentage of non-Hispanic whites – is statistically significant. The Northeast, Southwest, and Near Westside sectors, home to relatively higher percentages of black and Hispanic residents, also show a higher percentage (statistically significant) than the Southeast, and possibly the Near Northside as well. Refer back to Fig. 1.2.2 and Fig. 1.2.3 to see the geographic distribution of people by race/ethnicity group.

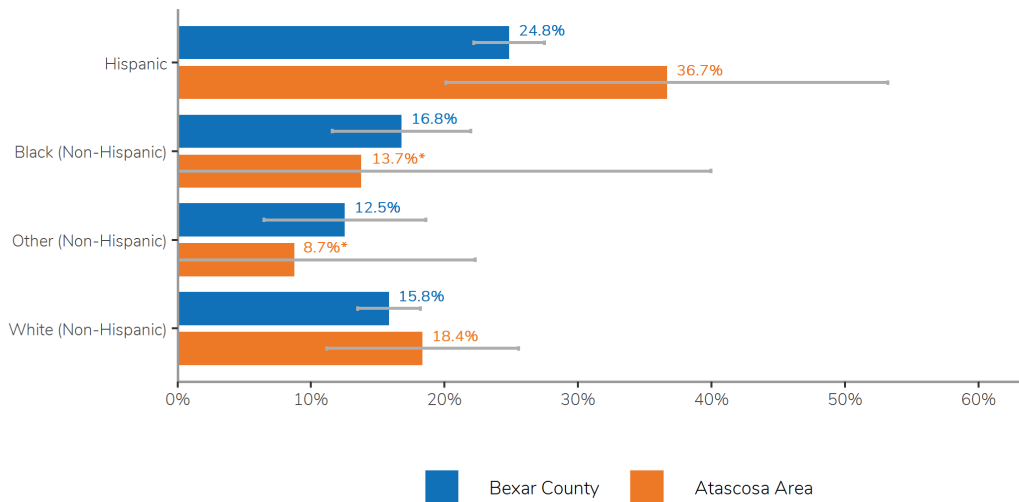Fig. 6.12.15 Percent of adults ever tested for HIV, 2011-2017



*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC
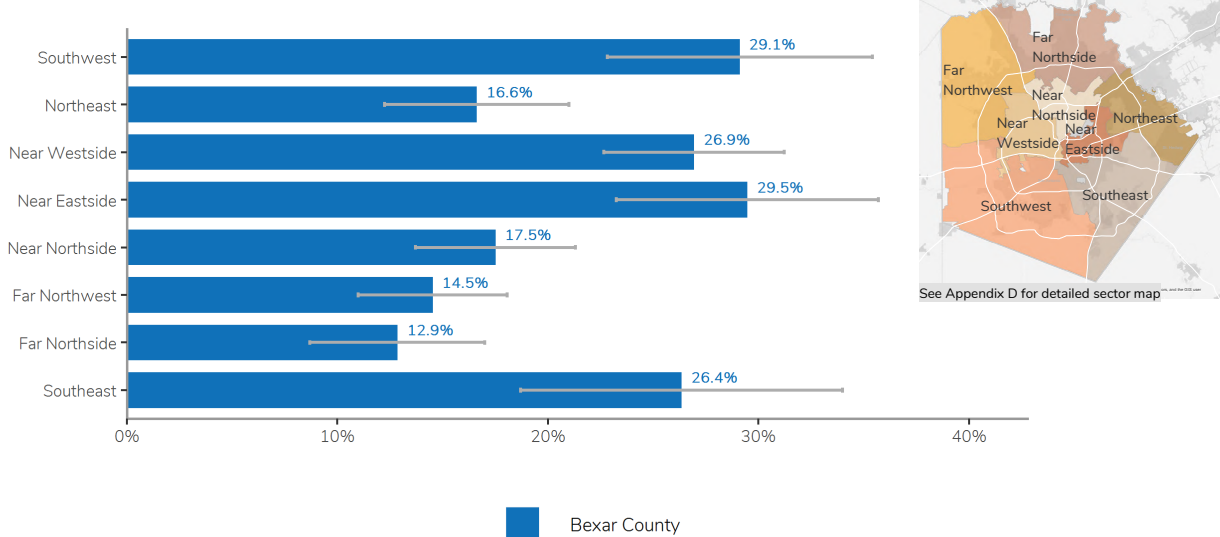
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28. HIV Tests. Retrieved from https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocation-Type=StatesAndMMSA&islClass=CLASS09&islTopic=TOPIC32&islYear=2017&rdRnd=84946

Fig. 6.12.16 Percent of adults ever tested for HIV by race, 2011-2017



**Bexar County**  **Atascosa Area**

Fig. 6.12.17 Percent of adults ever tested for HIV by sector, 2011-2017
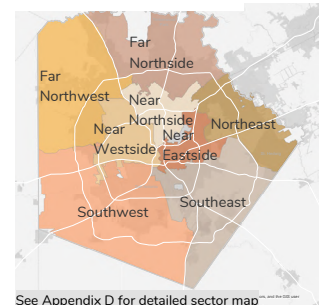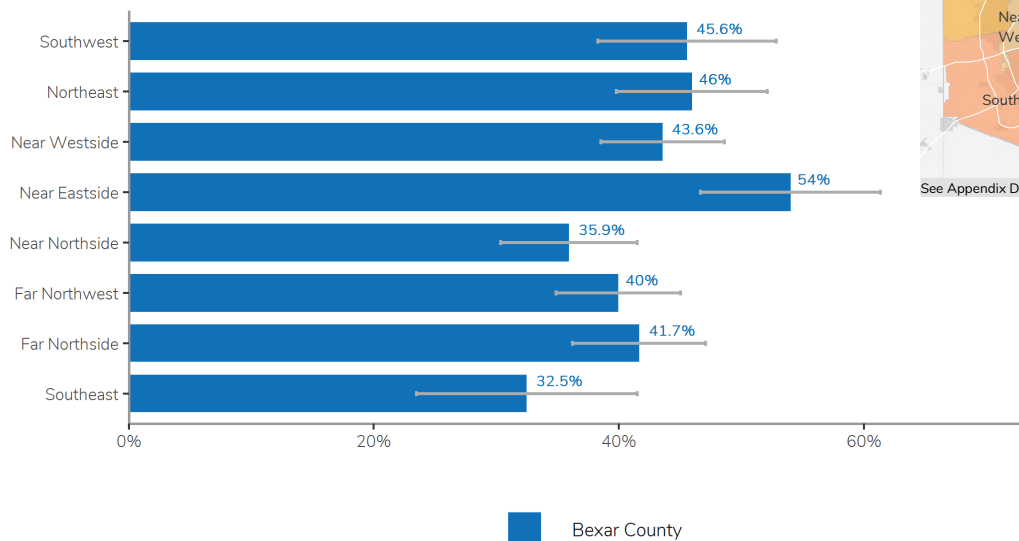


See Appendix D for detailed sector map

**Bexar County**

# Section 6: Health Behaviors and Risks

Housing and neighborhoods built before lead was banned from paint and gasoline, particularly those near highways and other major roads, also carry a higher risk of lead poisoning. Even in well-maintained areas children living in older housing are at greater risk for lead poisoning from lead-based paint and some older types of vinyl window mini-blinds. Typically, lead poisoning has no obvious symptoms, making screening critical to early intervention.[29] Lead screening in children has generally increased over the past few years in both counties, more so in Bexar (Fig. 6.12.18). Texas does not require universal screening for elevated blood lead,[30] though, and very few Atascosa and Bexar children are screened compared to major cities that have uncovered and documented a lead poisoning crisis with far-reaching consequences for mental health,[31] education,[32] crime and violence[33] and other areas of life functioning.

Fig. 6.12.18 Rate of children 0-14 tested for lead poisoning per 10,000 population



*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

29. Childhood Lead Poisoning Prevention Program. (2019, February 4). Retrieved from https://www.cdc.gov/nceh/lead/default.htm
30. State Health Care Delivery Policies Promoting Lead Screening and Treatment for Children and Pregnant Women (5.21.18). (n.d.). Retrieved from https://nashp.org/wp-content/uploads/2018/05/NASHP-Lead-Policy-Scan-5-21-18_updated.pdf
31. See for example https://www.washingtonpost.com/local/freddie-grays-life-a-study-in-the-sad-effects-of-lead-paint-on-poor-blacks/2015/04/29/0be898e6-eea8-11e4-8abc-d6aa3bad79dd_story.html
32. See for example https://case.edu/socialwork/povertycenter/sites/case.edu.povertycenter/files/2019-01/IIC%20Lead%20Report%20Final%2010.17.2018_web.pdf
33. See for example https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5703470/

# Section 7: Health Outcomes

## Overall health status

One in five Bexar BRFSS respondents reports having fair or poor health (Fig. 7.1), a figure that may be slightly higher in the Atascosa area but it does have a wide margin of error. Bexar Hispanics are significantly more likely than non-Hispanic whites to report fair or poor health (Fig. 7.1.1), and although the margins of error are too wide to be certain, the same may be true of the Atascosa area. Bexar's Southwest, Near Westside, Near Eastside, and possibly Southeast sectors are more likely to report fair or poor health than the Far Northside, Far Northwest, and Near Northside, and the differences are statistically significant (Fig. 7.1.2).

<div>
Related data

Health Outcomes:
• Illness and Injury
</div>

Fig. 7.1 Percent of adults with self-reported fair or poor health versus better health, 2011-2017
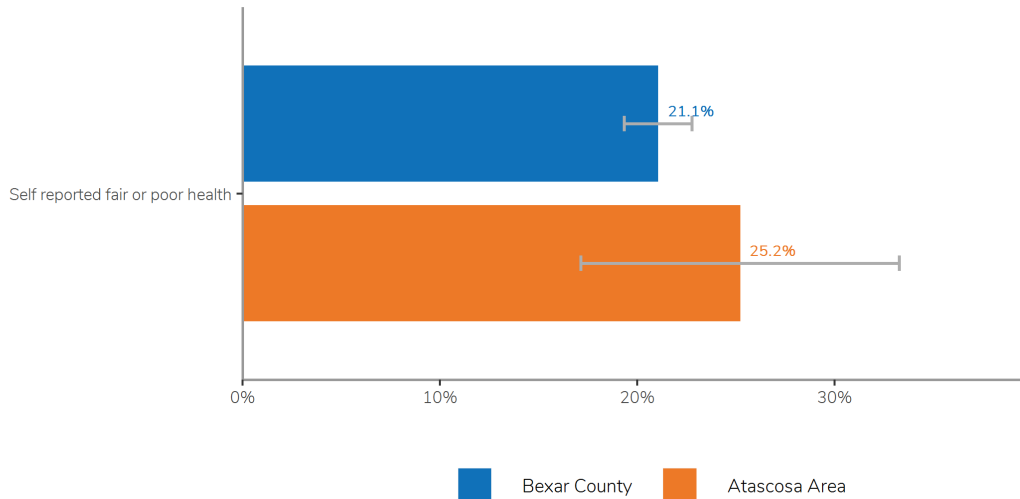


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 7.1.1 Percent of adults with self-reported fair or poor health versus better health by race, 2011-2017



Hispanic — 24.8% (Bexar County), 36.7% (Atascosa Area)
Black (Non-Hispanic) — 16.8% (Bexar County), 13.7%* (Atascosa Area)
Other (Non-Hispanic) — 12.5% (Bexar County), 8.7%* (Atascosa Area)
White (Non-Hispanic) — 15.8% (Bexar County), 18.4% (Atascosa Area)

■ Bexar County   ■ Atascosa Area

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 7.1.2 Percent of adults with self-reported fair or poor health versus better health by sector, 2011-2017



Southwest — 29.1%
Northeast — 16.6%
Near Westside — 26.9%
Near Eastside — 29.5%
Near Northside — 17.5%
Far Northwest — 14.5%
Far Northside — 12.9%
Southeast — 26.4%

See Appendix D for detailed sector map

■ Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 7: Health Outcomes

Just over one in 10 Bexar BRFSS respondents reports being kept from usual activities for five or more days in the past month due to poor physical or mental health (Fig. 7.1.3), and the proportion appears similar for the Atascosa area. The margins of error make interpretation difficult, but no clear differences emerge among race/ethnicity groups in either county (Fig. 7.1.4). There does appear to be differences among Bexar sectors, with Near Westside respondents more likely than Far Northside respondents to report being kept from usual activities (Fig. 7.1.5).

Fig. 7.1.3 Percent of adults kept from usual activities for 5+ days a month due to poor physical or mental health, 2011-2017
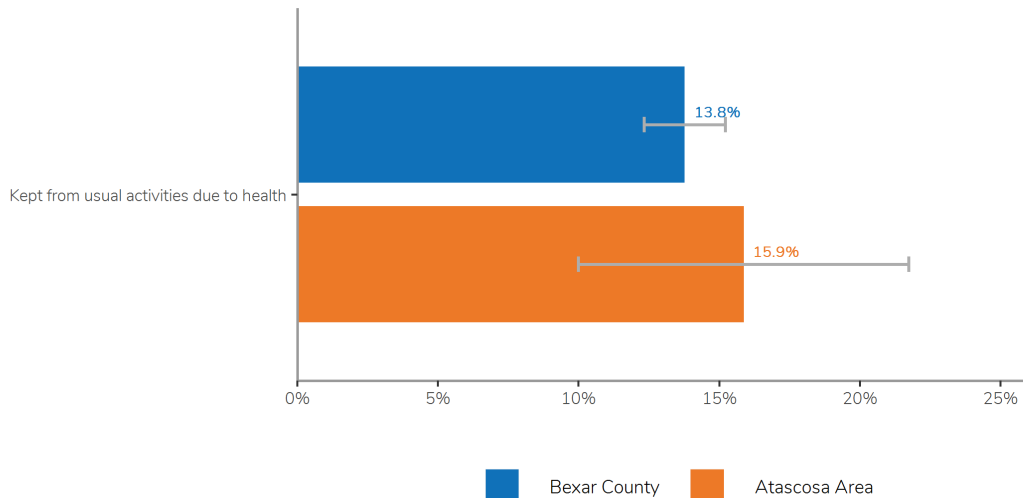
Fig. 7.1.4 Percent of adults kept from usual activities for 5+ days a month due to poor physical or mental health by race, 2011-2017
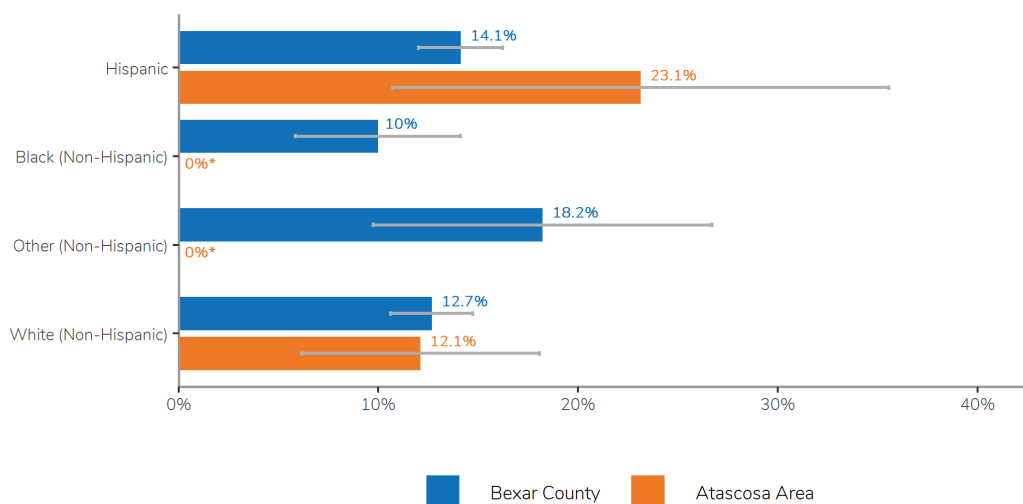
Fig. 7.1.5 Percent of adults kept from usual activities for 5+ days a month due to poor physical or mental health by sector, 2011-2017
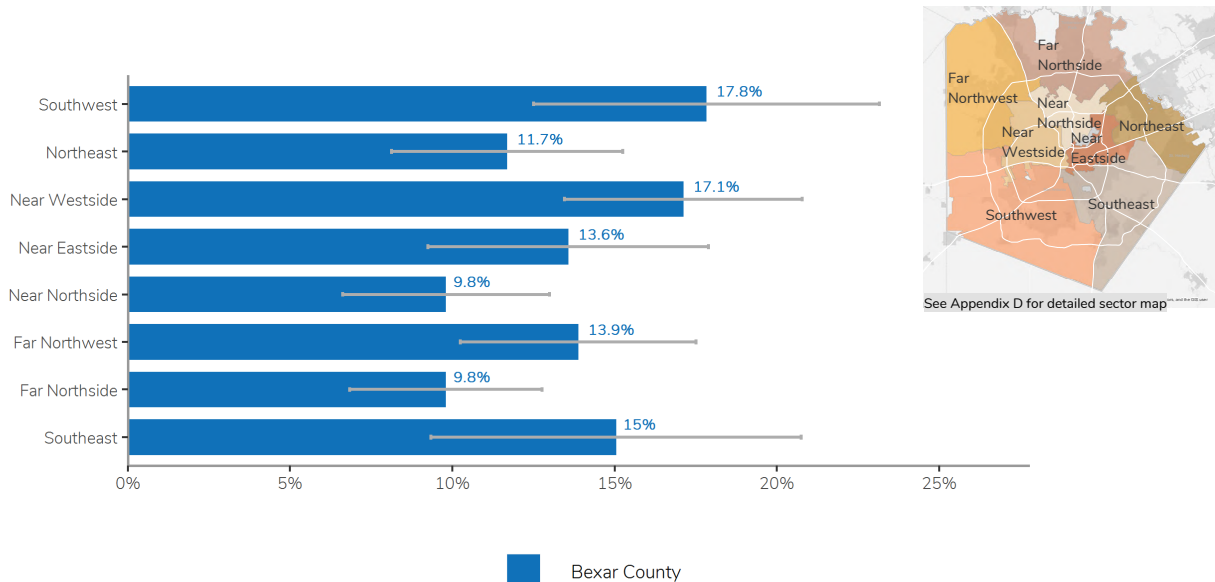
See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Little local data is available regarding the health status of youth, especially younger children. Although it cannot be said to be representative of all of Bexar County, the Early Development Instrument (EDI) kinder-readiness dataset includes neighborhood-level information for 16,013 first graders in eight local school districts.[1] Of the first-graders assessed on Physical Health and Well-Being[2] in the 2017-18 school year, 75% are considered "on track," scoring above the 25th percentile of the reference dataset (Fig. 7.1.6). Another 15% are considered "at risk," scoring between the 10th and 25th percentiles, and 10% are considered "vulnerable," scoring in the lowest percentile. The dataset as a whole cannot be trended over time because additional school districts with varied student demographics have joined the initiative each year. Looking solely at the cohort of census tracts that appeared in the baseline year – 245 of Bexar's 365 census tracts – the percent of children considered "very ready" across all five EDI domains has remained flat over time (Fig. 7.1.7).

---

1. 220 of 224 schools participating from East Central ISD, Edgewood ISD, Harlandale ISD, North East ISD, Northside ISD, San Antonio ISD, Southside ISD, and Southwest ISD
2 The Physical Health and Well-Being domain of the EDI assessment looks at physical readiness for school work, including coming to school late or tired; physical independence, including independence, handedness, and coordination; and gross and fine motor skills and energy level.

Fig. 7.1.6 Percent of students assessed in physical health and well-being domain, 2018
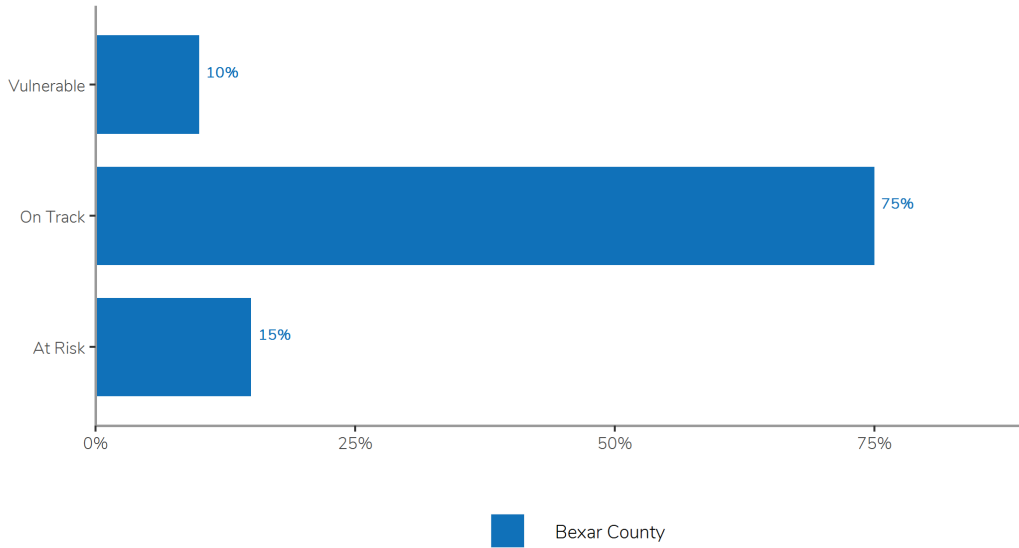


*Unreliable: Error is too large relative to estimate
Source: Transforming Early Childhood Community Systems; Early Development Instrument
Prepared by CI:Now for THC

Fig. 7.1.7 Percent of students developmentally very ready
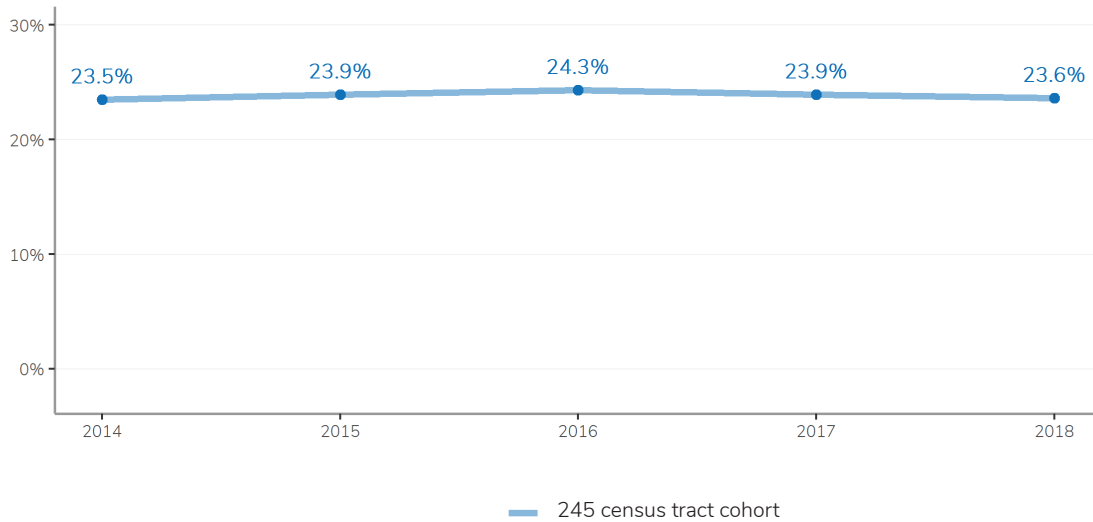


*Unreliable: Error is too large relative to estimate
Source: Transforming Early Childhood Community Systems; Early Development Instrument
Prepared by CI:Now for THC

# Section 7: Health Outcomes

## Birth rates and maternal characteristics

Total births in Bexar and Atascosa rose about 10% between 2011 and 2015 (Fig. 7.2). The fertility rate, or number of births per 1,000 females of childbearing age (15 to 44 years), yields an "apples-to-apples" measure because it accounts for differences between counties and over time in the number of women who could have a live birth in that year. The Atascosa fertility rate was 72.5 in 2012, dropped slightly (71.8) in 2013, spiked in 2014 (77.6), and fell in 2015 (74.5), painting an overall picture of "bounce" in the rate due to small numbers. Bexar's fertility rate is more stable over that period but shows a slight increase over time, from 68.2 in 2012 to 69.5 in 2015. In comparison, Texas' fertility rate hovered around 70, but the state and both counties all saw a slight one-time uptick in 2014.[3]

Fig. 7.2 Number of total births
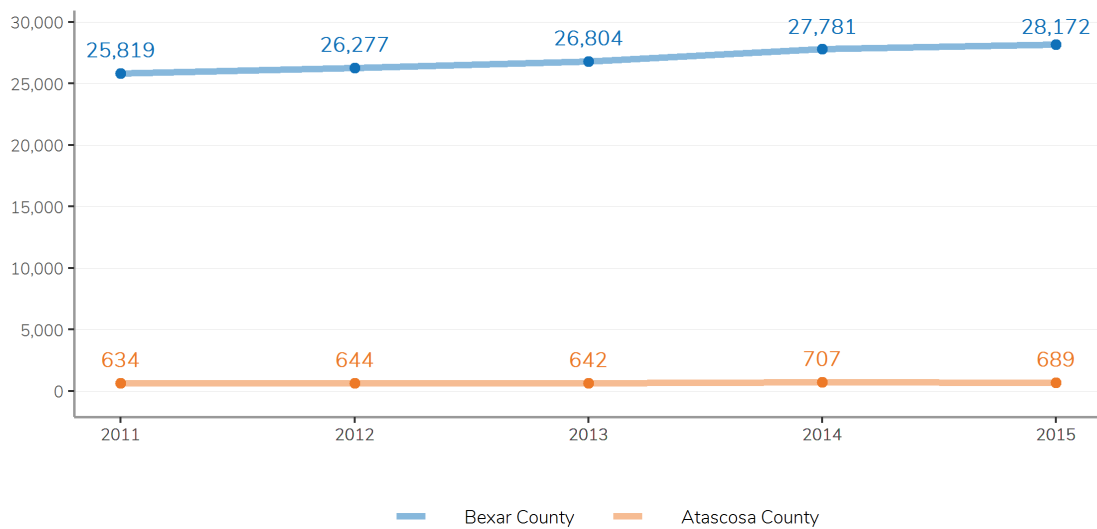


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

The trend in Bexar fertility rate varies by race/ethnicity, but almost all groups saw an upward bump in 2014 (Fig. 7.2.1), with that uptick extending to 2015 among non-Hispanic whites. Parallel data is not available for Atascosa. Fertility rates for all groups in 2017 were at or below 2013 levels. Although the decrease among Bexar American Indian or Alaska Native females appears extreme, it is worth noting that the decrease in rate represents only nine live births.

The teen birthrate – number of live births per 1,000 females aged 15 to 19 – continues to drop steadily in both counties, Texas, and the United States as a whole. From 1996 to 2016 the teen birthrate fell from 74.3 to 35.1 in Atascosa, 74.3 to 29.0 in Bexar, 72.0 to 29.3 in Texas, and 53.5 to 20.3 in the U.S.[4] State and local teen birthrates were significantly higher than the U.S. throughout those two decades, however, and at a ratio of about 1.4:1.0, the width of that gap has not narrowed.

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3. Health Facts Profiles (2014 - 2015). Retrieved from http://healthdata.dshs.texas.gov/HealthFactsProfiles_14_15
4. Teen Birth Data. (2018, May 4). Retrieved from http://txcampaign.org/teen-birth-data/

Fig. 7.2.1 Birth rates by race for all ages per 1,000 females
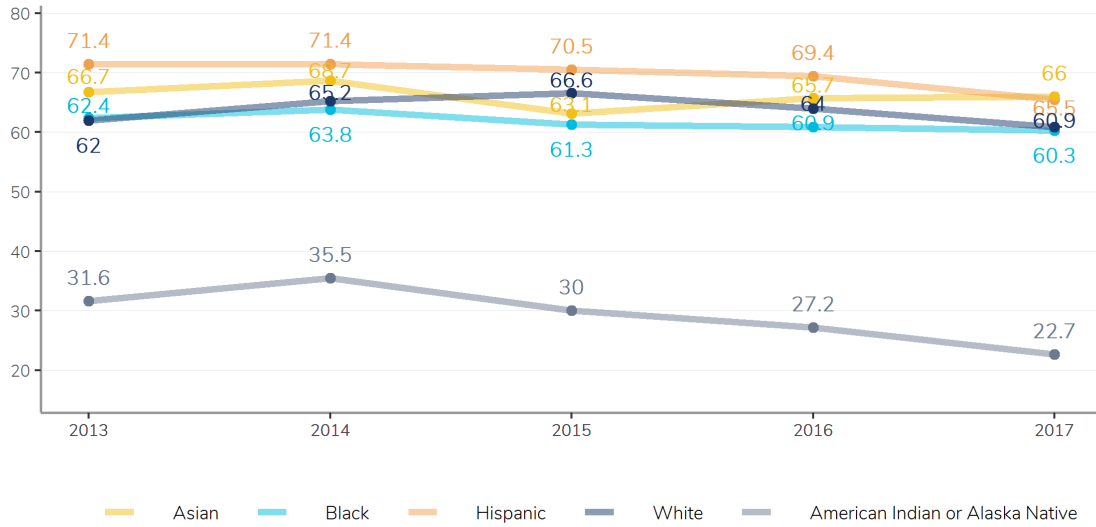


*Unreliable: Error is too large relative to estimate
Source: Center for Disease Control and Prevention
Prepared by CI:Now for THC

The birthrate among Bexar teens aged 15 to 17 decreased by nearly half between 2013 and 2017 (Fig. 7.2.2), although for black and white teens that decrease does represent fewer than two dozen births each as compared to more than 200 among Hispanic teens aged 15 to 17. Although less dramatic than the decrease among younger teens, the birthrate among older Bexar teens (aged 18 to 19) decreased as well by between 25% and 32%, depending on race/ethnicity group (Fig. 7.2.3).

Fig. 7.2.2 Number of births to mothers aged 15-17 per 1,000 females
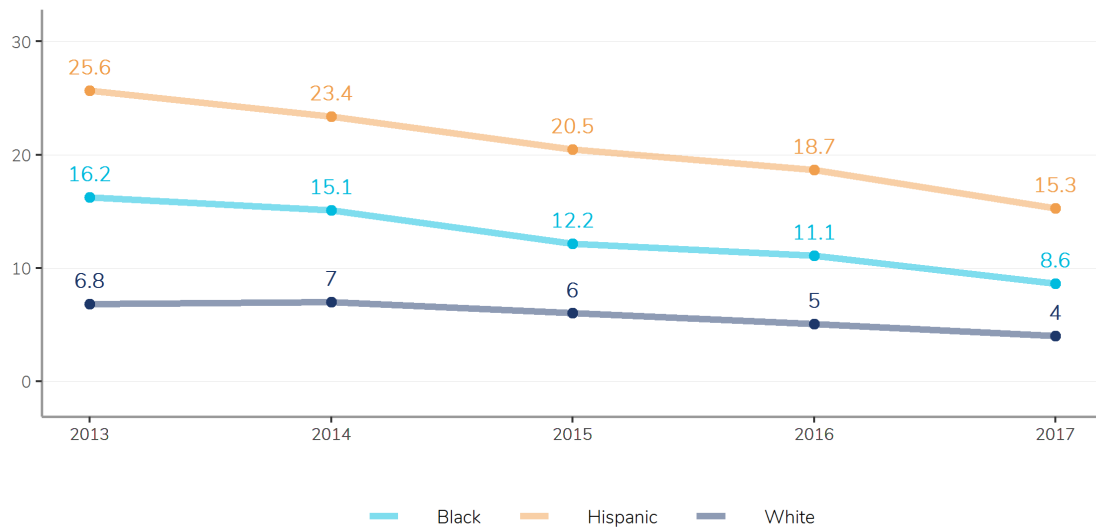


*Unreliable: Error is too large relative to estimate
Source: Center for Disease Control and Prevention
Prepared by CI:Now for THC

Fig. 7.2.3 Number of births to mothers aged 18-19 per 1,000 females
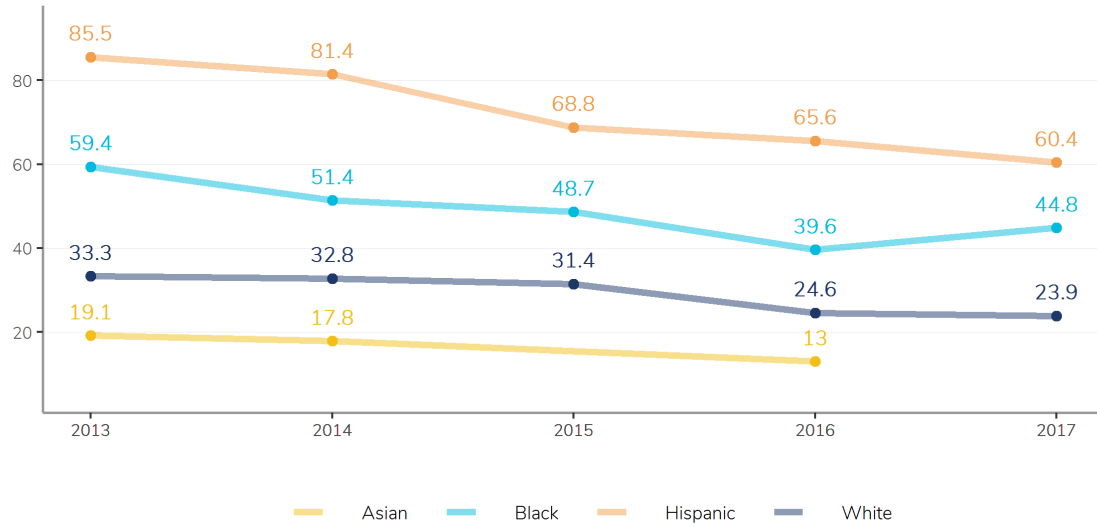


*Unreliable: Error is too large relative to estimate
Source: Center for Disease Control and Prevention
Prepared by CI:Now for THC

The percent of births that were to unmarried mothers has held steady in Atascosa and risen slightly in Bexar (Fig. 7.2.4). About nine in 10 mothers aged 15 to 19 are unmarried as compared to around a quarter of mothers aged 30 and over (Fig. 7.2.5). The breakdown by age group appears similar between the two counties.
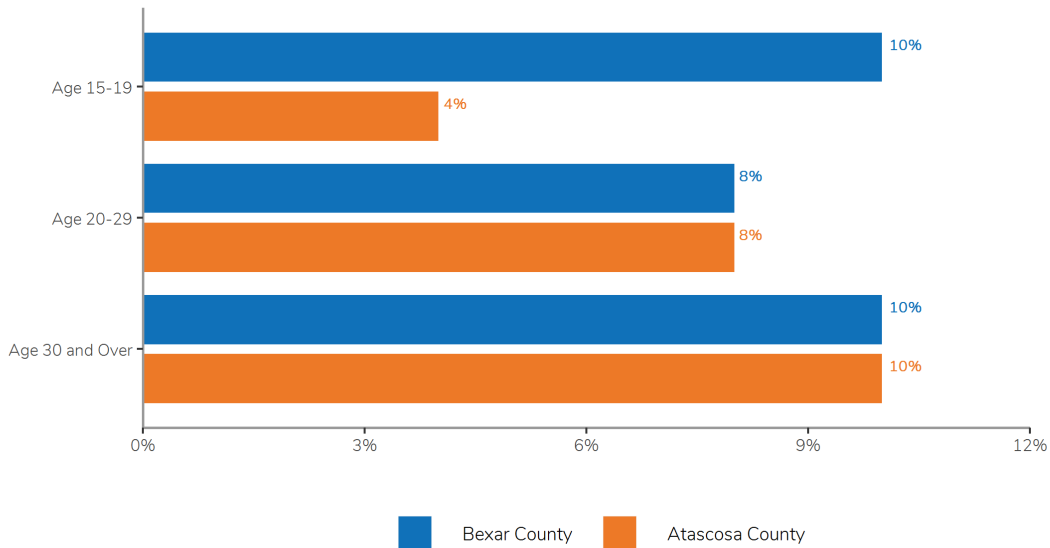
Fig. 7.2.4 Percent of births to unmarried mothers
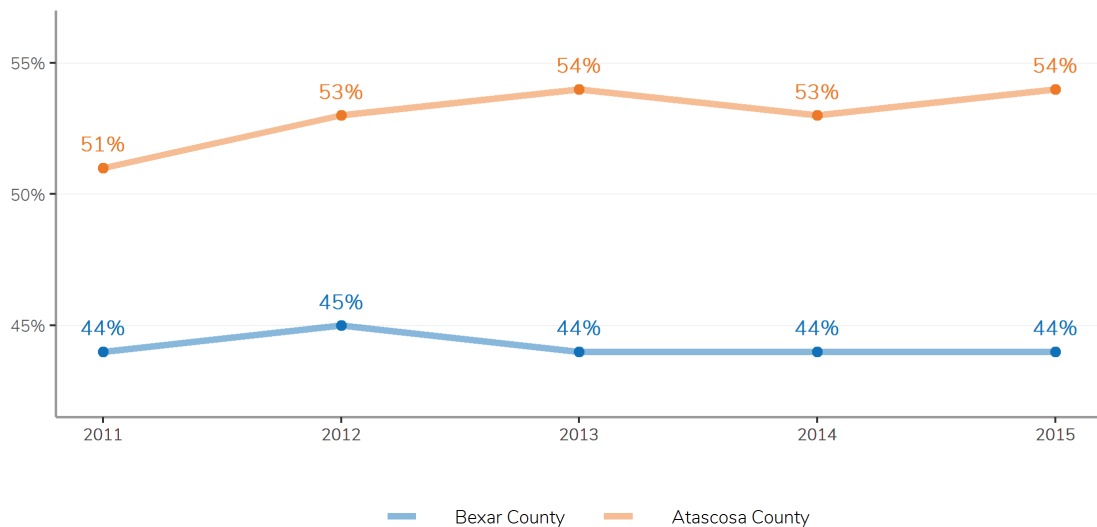


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.2.5 Percent of births to unmarried mothers by age (3-year average), 2013-2015
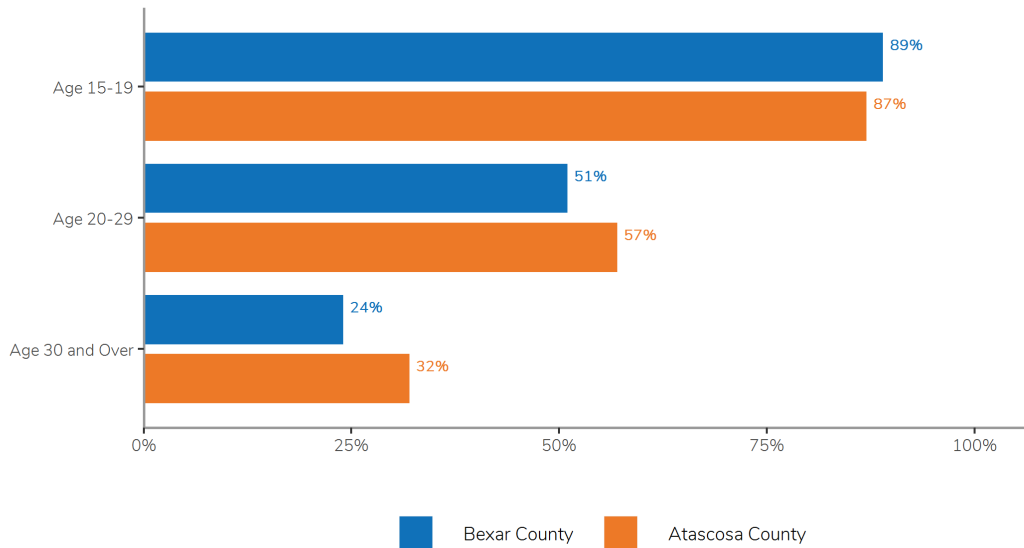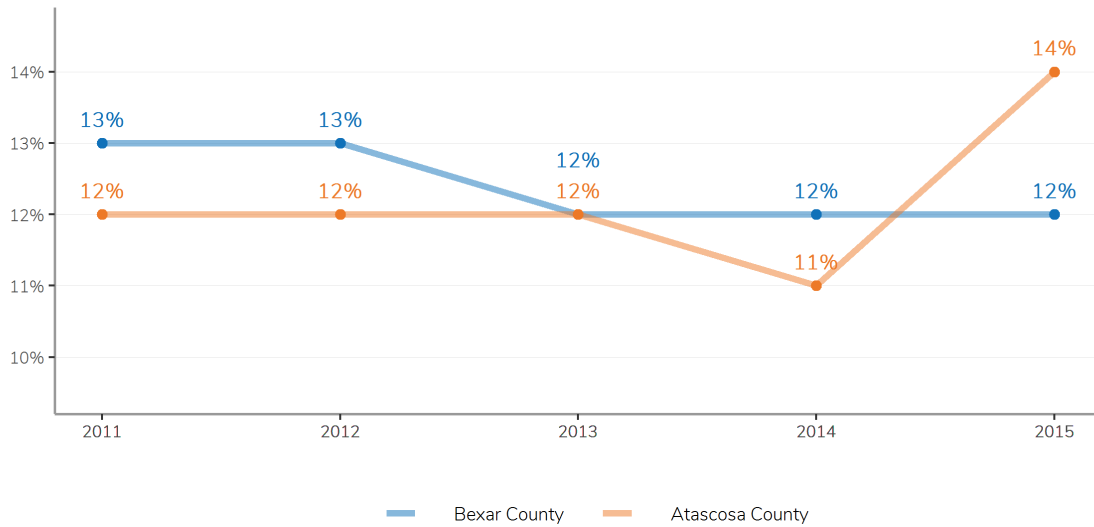


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

The proportion of births to mothers who were overweight (as measured by BMI) before pregnancy hovers around one-quarter in both counties (Fig. 7.2.6). However, the proportion of births to mothers who were obese before pregnancy appears to be rising in both counties, much more steeply in Atascosa (Fig. 7.2.7).

Fig. 7.2.6 Percent of births to mothers with BMI greater than or equal to 25-29 before pregnancy (overweight)
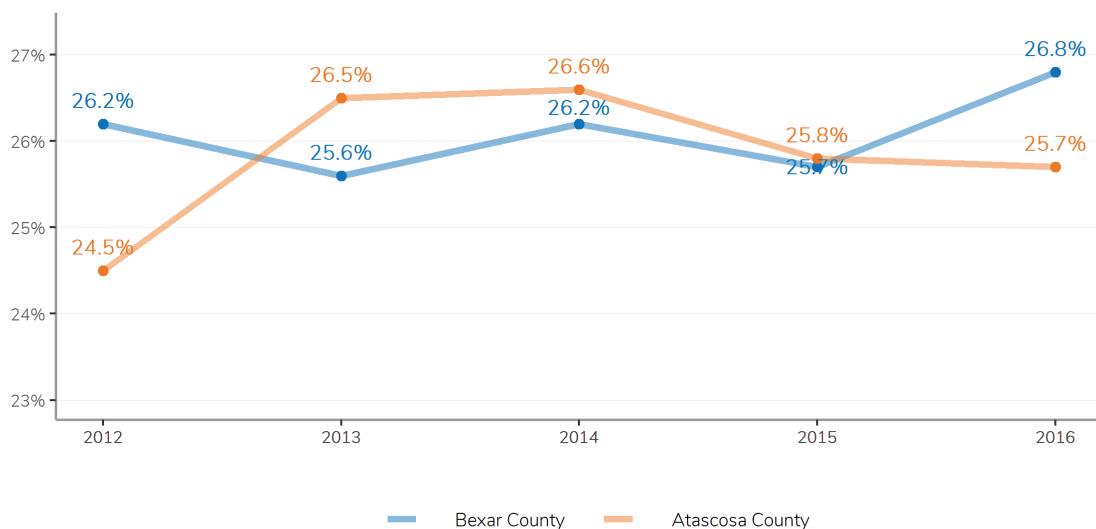


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.2.7 Percent of births to mothers with BMI greater than or equal to 30 before pregnancy (obese)
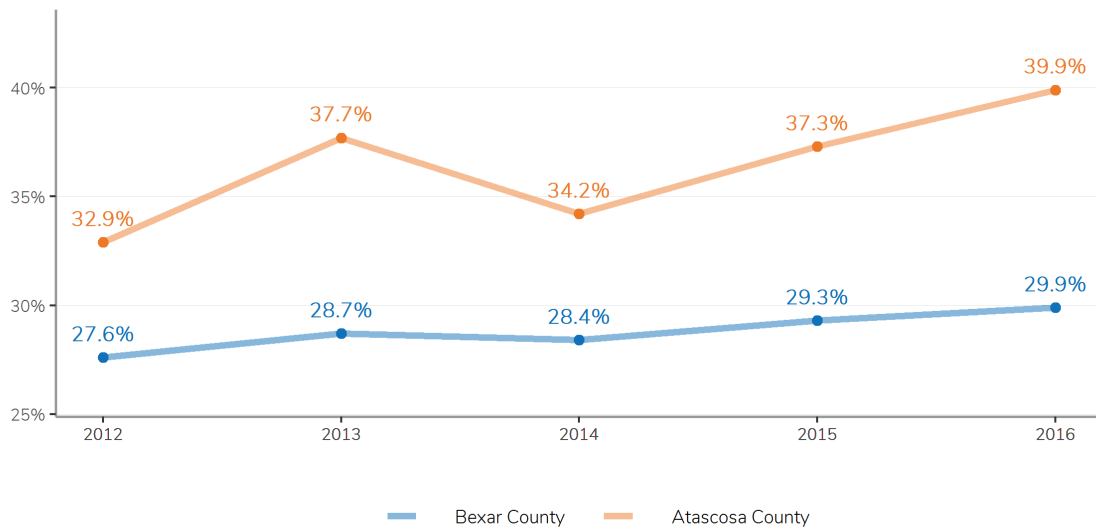


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

## Birth outcomes and maternal and infant mortality

Just under one in 10 live births in both counties is at a low birthweight, defined as lower than 2,500 grams, with no clear trend of change over time (Fig. 7.3). The percent does not vary substantially across age groups or between counties (Fig. 7.3.1).

As a proportion of total live births, pre-term births before 37 complete weeks of gestation spiked in Atascosa 2014 following a sharp decrease in 2014, making that trend difficult to interpret (Fig 7.3.2). The differences are slight, but the percent pre-term appears to decrease with older mother age group in Bexar. The four percentage point difference makes that pattern appear much sharper in Atascosa, but that difference represents fewer than 20 births, making the data hard to interpret (Fig. 7.3.3).

Neonatal abstinence syndrome (NAS) occurs when a newborn is exposed to addictive opiate drugs while in the mother's womb. Bexar County accounts for a third of Texas' Medicaid patients who deliver babies born with NAS and has ranked first in NAS cases among Medicaid births since 2009.[5]  In Fig. 7.3.4, Bexar County has over double the NAS delivery rate than Atascosa County.

### Related data

Health Behaviors and Risks:
• Opioids and other drugs

Health Outcomes

• Alcohol and substance-related injury and death

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5. Bexar County highest in state for babies going through drug withdrawal. (2017, May 31). Retrieved from https://www.expressnews.com/news/local/article/Bexar-County-highest-in-state-for-babies-going-11186935.php
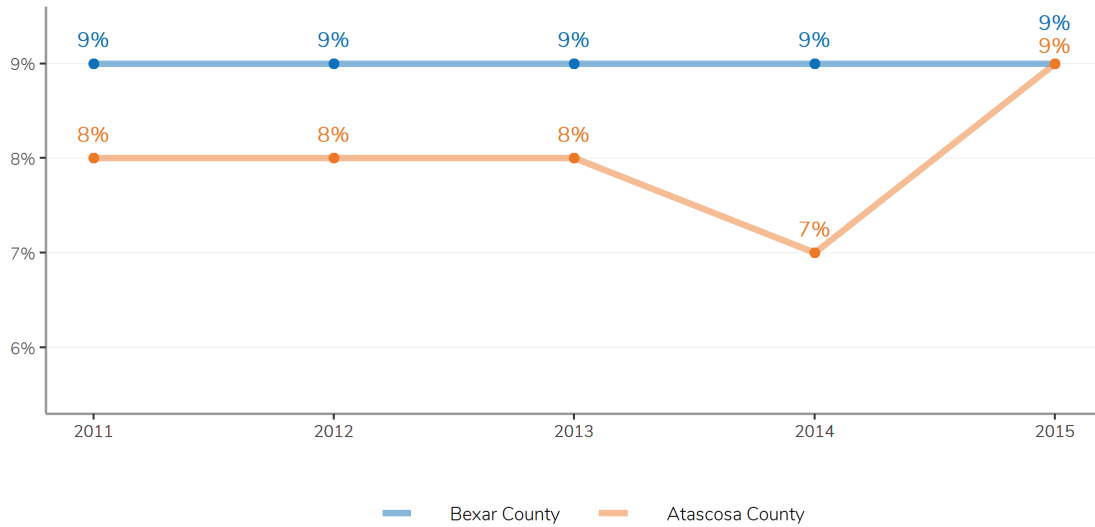
Fig. 7.3 Percent of low birth weight births



*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.3.1 Percent of low birth weight births by age (3-year average), 2013-2015



*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.3.2 Percent of pre-term births



*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.3.3 Percent of pre-term births by age (3-year average), 2013-2015
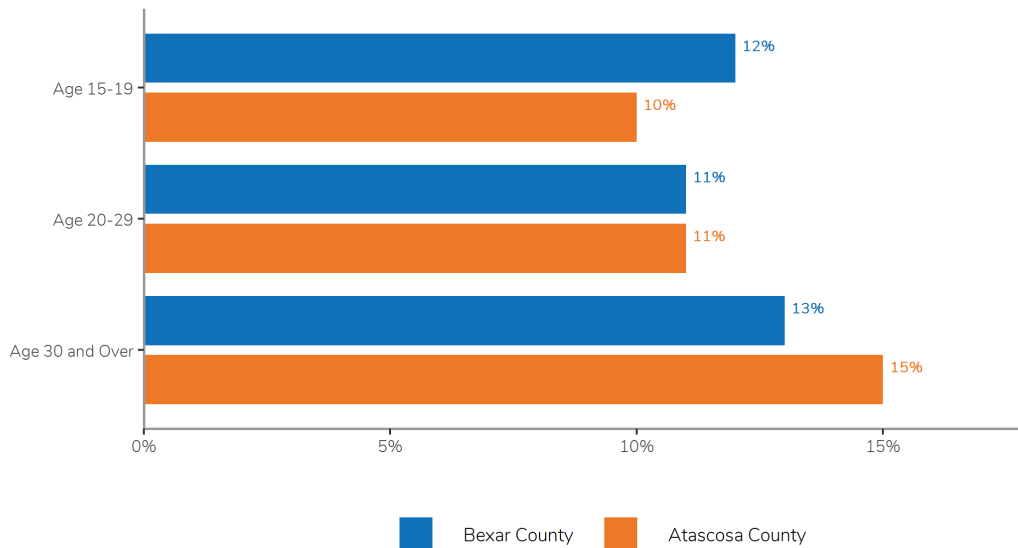


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.3.4 Medicaid Neonatal Abstinence Syndrome (NAS) deliveries
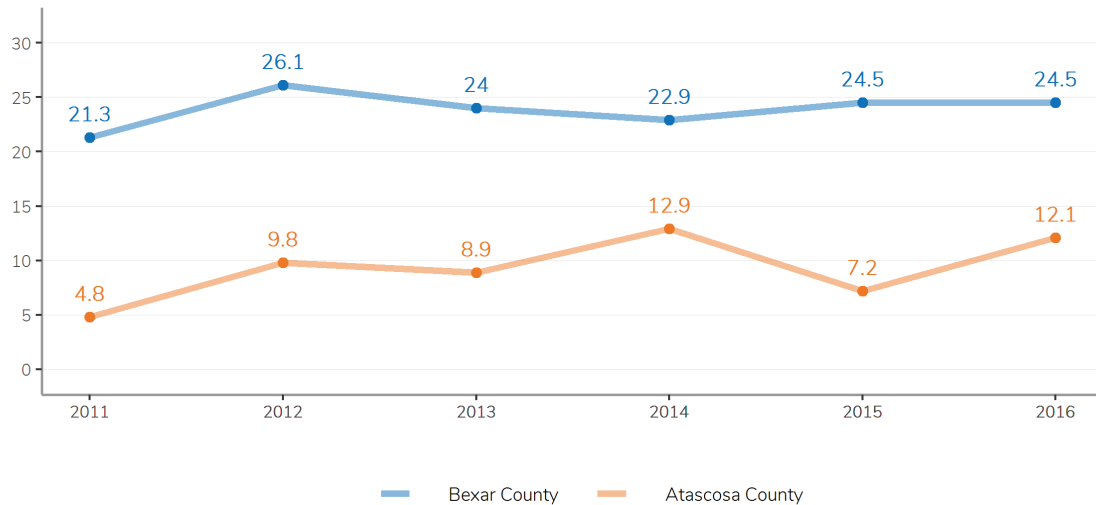
Infant mortality, expressed as a three-year average for a more stable rate, rose steadily in Bexar for several years and appears to have leveled out (Fig. 7.3.5), but remains higher than Texas and the U.S.[6] Infant mortality rates vary considerably by race and ethnicity (Fig. 7.3.6).

Fig. 7.3.5 Number of infant deaths per 1,000 births (3-year average)
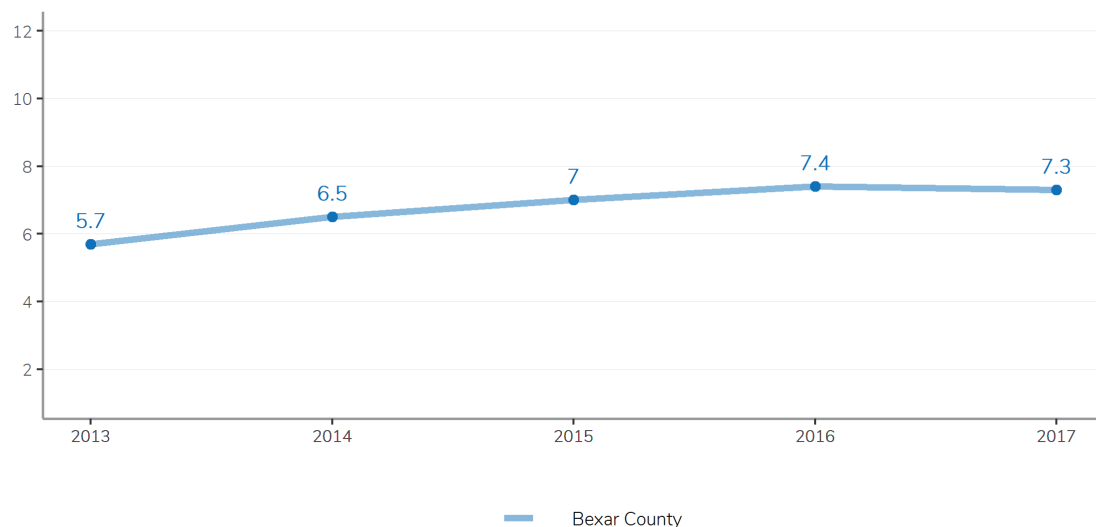
6. Table 12. Infant mortality rates, by race and Hispanic origin of mother, state, and territory: United States and U.S. dependent areas, average annual 1989–1991, 2003–2005, and 2013–2015. Retrieved from https://www.cdc.gov/nchs/data/hus/2017/012.pdf

# Section 7: Health Outcomes

The 2015-2017 highest rate was 9.5 per 1,000 live births for infants of non-Hispanic black mothers. The disparity in infant mortality between black and white women has remained almost double since 2011. The key informants interviewed noted a need for system change to address significant racial disparities in maternal and infant health.

Fig. 7.3.6 Number of infant deaths per 1,000 births (3-year average) by race
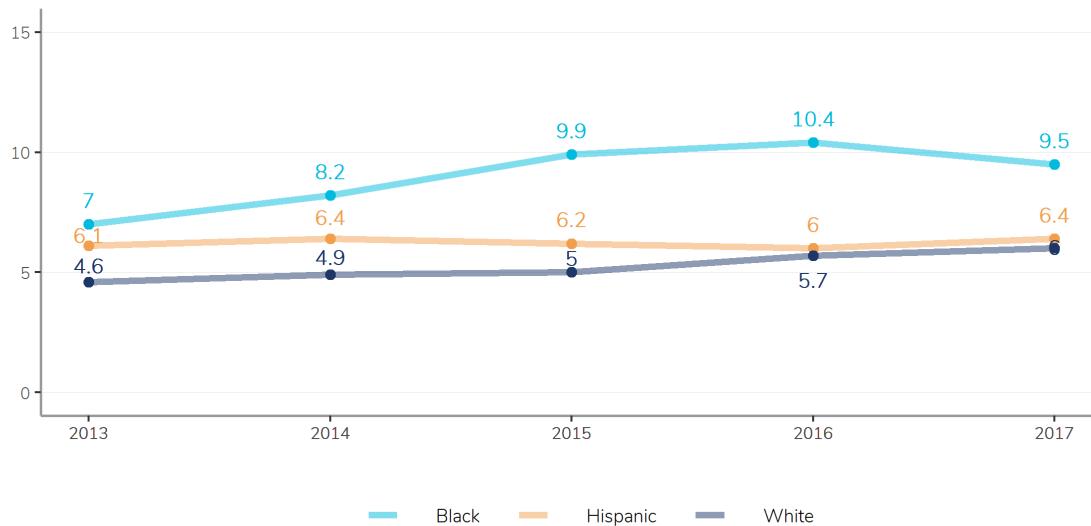


*Unreliable: Error is too large relative to estimate
Source: Centers for Disease Control and Prevention
Prepared by CI:Now for THC

The maternal mortality rate in Texas has generated no shortage of controversy, concern, and questions about data quality in recent years.[7] It is clear, though, that U.S. maternal mortality has climbed fairly steadily over the past 20 years. And for U.S. women overall, the number of pregnancy-related deaths per 100,000 live births is more than three times as high for black women as for Hispanic and non-Hispanic white women.[8]

Analysis of maternal mortality by race/ethnicity at a local level is difficult because the relatively small numbers of deaths are often suppressed, or not released, to protect privacy. Further, in Bexar the pregnancy-related mortality rates among Black or African-American and Asian or Pacific Islander women are published only as confidence intervals because the rate is not considered reliable. In an attempt to develop even a rough estimate of disparities by race/ethnicity that might be generalizable to Bexar, pregnancy-related death data was combined for three major urban counties (Bexar, Dallas, and Harris) for 1999 through 2017, the entire period for which data is available.[9] That large number of years was needed in order to aggregate a sufficient number of deaths for analysis.

That calculation yielded a rate of pregnancy-related deaths that was slightly higher for Hispanic women than the national rate, and slightly lower for African-American and white women. However, the rate among this group of urban Texas African-American women was 3.3 times that of white women, identical to the degree of disparity nationwide. The African-American rate was 2.6 times as high as that of Hispanic women, versus 3.8 nationwide, a difference resulting from the higher rate among this group of Hispanic women as compared to Hispanic women nationwide.

7. See for example https://www.texastribune.org/2018/01/04/maternal-deaths-are-increasing-texas-probably-not-much-officials-thoug/
8. Pregnancy Mortality Surveillance System. (2019, June 5). Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm#ratio
9. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018. Retrieved from http://wonder.cdc.gov/ucd-icd10.html

# Section 7: Health Outcomes

## Child abuse and neglect

The number of confirmed victims of child abuse or neglect per 1,000 children is increasing again in Bexar after reaching a low in 2016, while the trend in Atascosa is difficult to interpret, likely because of small numbers (Fig. 7.4). These figures are misleading, though. Many steps must occur before a child can be confirmed as a victim of abuse or neglect: greatly simplified, Child Protective Services must receive a report, the intake (report) must be assigned for investigation (rather than not assigned or assigned to Alternative Response),[10] the investigation must be completed, and the abuse/neglect must be confirmed (designated Reason to Believe rather than Ruled Out, Unable to Complete, or Unable to Determine). The opening and closing of investigations are highly dependent upon policy and resource-related factors including adequate staff levels, staff training and support, and manageable caseloads – all factors that are frequently in question.[11]

Fig. 7.4 Number of child abuse or neglect reports per 10,000 children aged 0-17
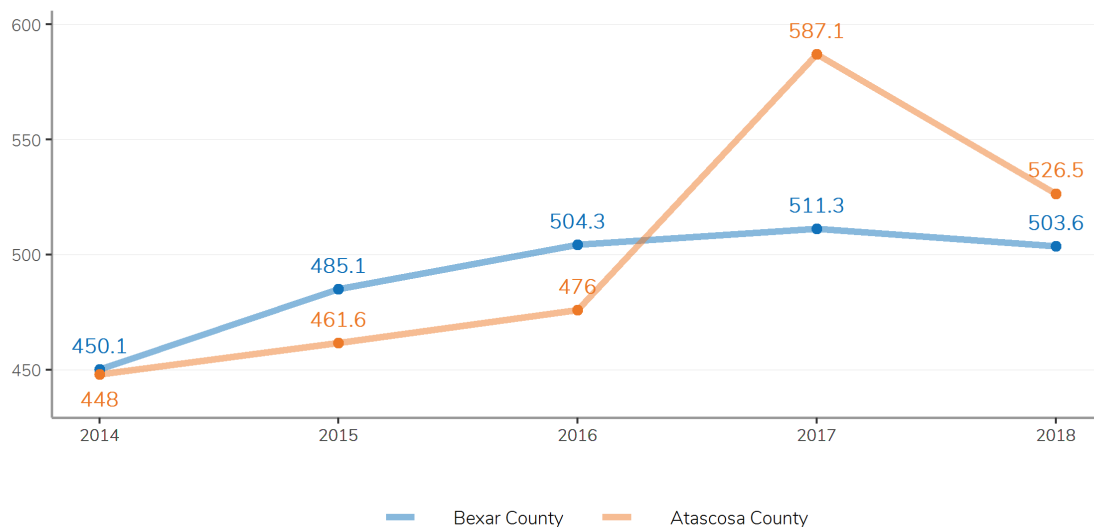


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Family and Protective Services
Prepared by CI:Now for THC

In 2018, the number of Atascosa completed investigations as a percent of initial intakes was 64%, down from 71% in 2010. Bexar was down from 61% in 2010 to 56% in 2018, and Texas as a whole was down from 64% in 2010 to 57% in 2018.[12] Because those percentages have decreased, we would also expect the number of confirmed victims per 1,000 children to have decreased, absent major changes in other factors like the accuracy of the allegation or report. The initial intake rate has not decreased over time and is an important companion measure. That figure is currently 52.7 per 1,000 children in Atascosa, 50.4 in Bexar, and 39.6 in Texas.[13]

10. Texas Department of Family and Protective Services. Data Book: Child Protective Services glossary. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Resources/glossary.asp

11. See for example, Ball, A., & Dexheimer, E. (2015). Missed signs. Fatal consequences. Austin-American Statesman. Retrieved from http://projects.statesman.com/news/cps-missed-signs/

12. Texas Department of Family and Protective Services. Child Protective Investigations (CPI) intakes: Initial priority, screening and assignment. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Intakes.asp; and Texas Department of Family and Protective Services.  Child Protective Investigations (CPI) completed investigations: Activity. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Activity.asp

13. Texas Department of Family and Protective Services. Child Protective Investigations (CPI) intakes: Initial priority, screening and assignment. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Intakes.asp

Fig. 7.4.1 Number of confirmed child abuse cases per 1,000 children aged 0-17 by zip code, 2018



Source: Texas Department of Family and Protective Services    Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
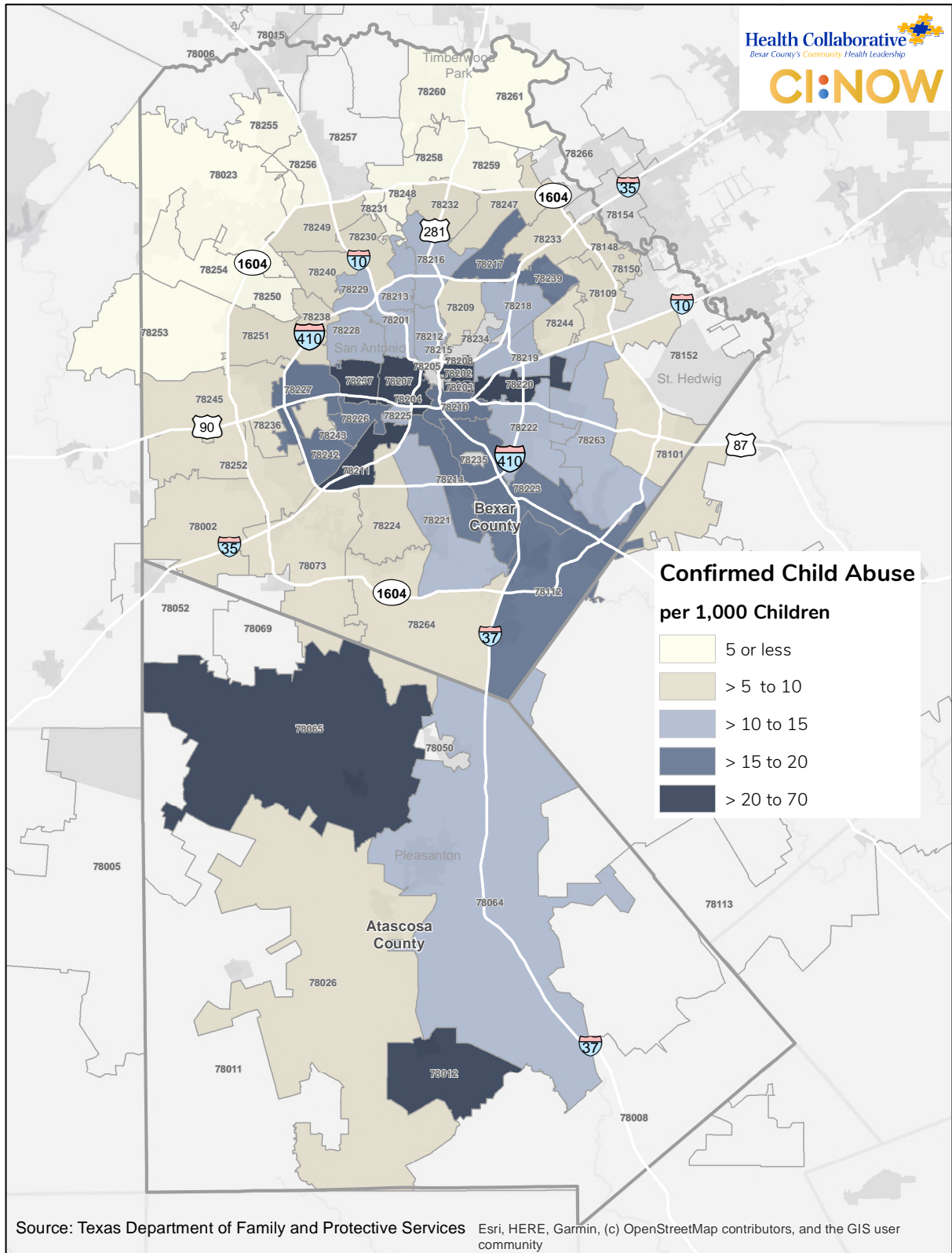
# Section 7: Health Outcomes

The zip codes with the highest rates of confirmed child abuse/neglect are clustered around San Antonio's downtown and in 78065 and 78012 in Atascosa (Fig. 7.4.1). The 78012 zip code in Atascosa had six cases and a child population of 86 thus creating a high rate due to small numbers. Additionally, the confirmed victims rate is highly dependent on what happens upstream of confirmation, and it could be that accurate reports are more likely in these zip codes than in higher-income and more rural zip codes, that the allegations are more serious and thus more likely to be assigned to investigation rather than Alternative Response, or any number of other factors.

*"As a culture, we are taught that in disciplining kids, we scare them,"* noted a key informant. *"You get in trouble when you act out – yelled at, ostracized, hit, or worse, and those things exacerbate trauma. We have to move away from a fear-based approach."*

## Adult maltreatment

The adult maltreatment rate is measured in relation to the total number of adults at risk, defined as people aged 65 or older and people aged 18 to 64 who are disabled.[14] As with child abuse and neglect, the number of confirmed (valid) victims of adult maltreatment per 1,000 adults at risk is increasing in both counties after a drop, but the low occurred in 2015 rather than 2016 (Fig. 7.5). The rate in Texas, in comparison, seems volatile but continues to drop from 2.7 in 2014 to 2.3 in 2018.[15]

Fig. 7.5 Number of adult abuse or neglect reports per 1,000 adults
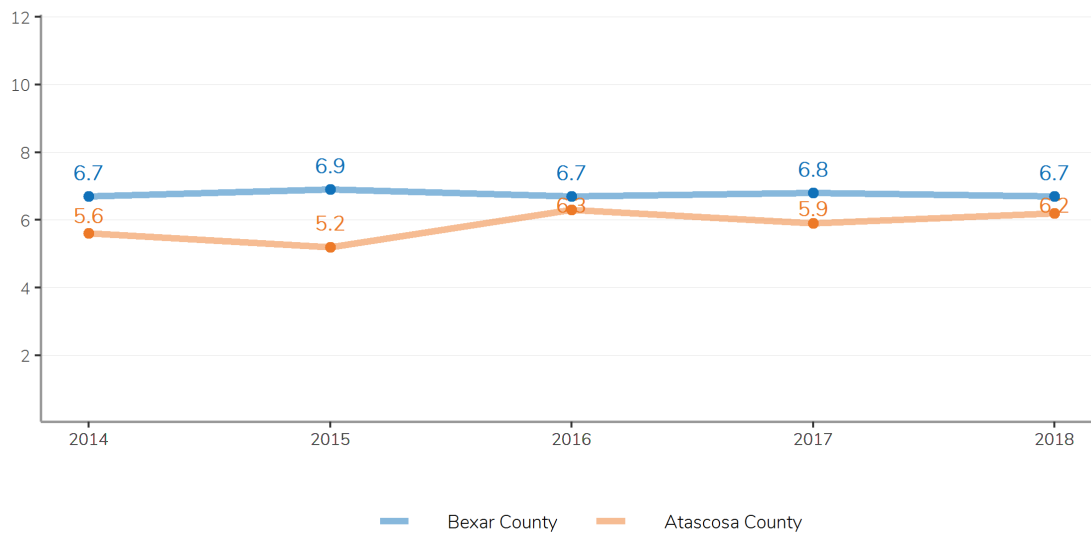


Bexar County ——— Atascosa County ———

*Unreliable: Error is too large relative to estimate
Source: Texas Department of Family and Protective Services
Prepared by CI:Now for THC

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14. Adult Protective Services (APS): Populations at Risk. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Adult_Protective_Services/Populations_at_Risk.asp
15. Adult Protective Services (APS) Investigations: Findings. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Adult_Protective_Services/Investigations/Findings.asp

# Section 7: Health Outcomes

Texas differs from Atascosa and Bexar in that the number of completed investigations as a percent of intake has actually *increased* from 2010, with the initial intake rate per 1,000 adults at risk remaining flat. Bexar's intake rate has dropped from 31.1 in 2010 to 25.5 in 2018 and completed investigations as a percent of intake has dropped from 78% to 71%. As with child abuse and neglect, we would expect the maltreatment rate to drop under those conditions. Atascosa's initial intake rate has not changed substantively since 2010, but completed investigations as a percent of intake has dropped from 78% to 71%.[16]

## Family violence and sexual assault

The family violence crime rate, defined as the number of incidents (occurrences) per 100,000 population, is rising in both counties (Fig. 7.6). One important note is that the number of family violence *victims* is unknown; a single incident could have one or many victims. Family violence is defined in Texas law as including not just biological families but also people related by marriage, in a foster care relationship, people in a romantic or intimate relationship, and members of the same household.[17] The data reported here represent all law enforcement agencies in both counties.

Related data

Social Conditions:
• Crime and safety

Fig. 7.6 Family violence crimes committed per 100,000 population
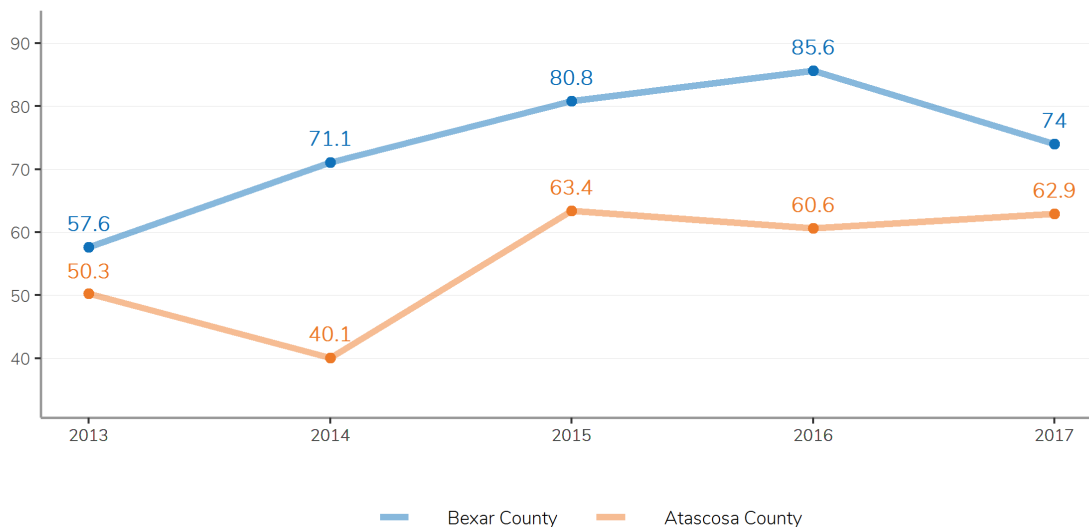


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Public Safety
Prepared by CI:Now for THC

The number of sexual assaults per 100,000 population in Atascosa has more than tripled since 2013 (Fig. 7.6.1), a trend that cannot be put down to the effect of small numbers. These sexual assault rates should not be compared with rape (typically also called sexual assault) rates, as Texas is now required to report six categories of sexual assault: Continuous Sexual Abuse of Young Child, Indecency with a Child by Contact, Indecency with a Child by Exposure, Sexual Assault, Aggravated Sexual Assault, and Sexual Performance by a Child.[18]

16. Adult Protective Services (APS) Intakes: Priority. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Adult_Protective_Services/Intakes/Priority.asp and Adult Protective Services (APS) Investigations: Activity. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Adult_Protective_Services/Investigations/Activity.asp
17. 2017 Crime in Texas. Retrieved from https://www.dps.texas.gov/crimereports/17/citCh5.pdf
18. 2017 Crime in Texas. Retrieved from https://www.dps.texas.gov/crimereports/17/citCh7.pdf

Fig. 7.6.1 Sexual assault crimes committed per 100,000 population
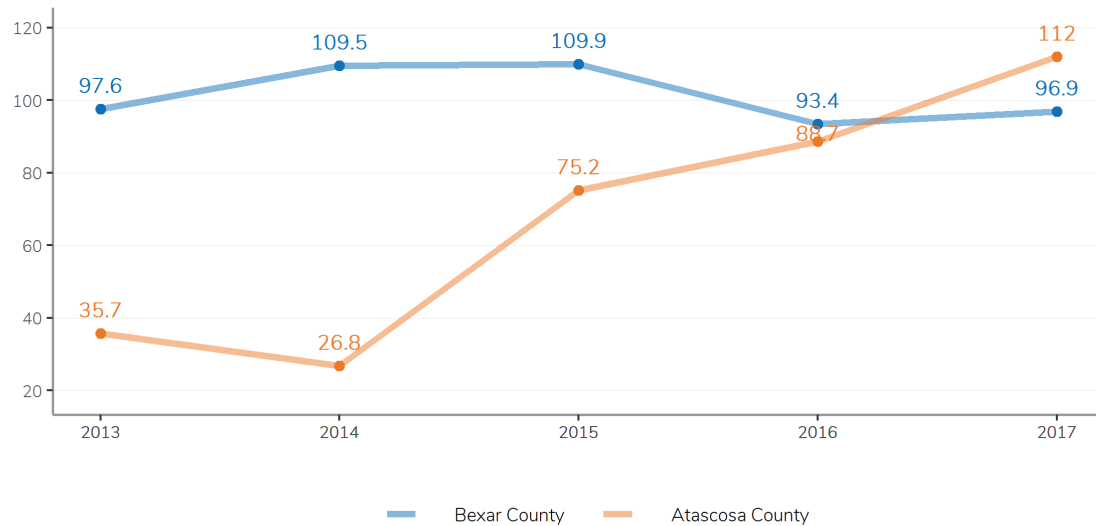


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Public Safety
Prepared by CI:Now for THC

Just as with child abuse and neglect and adult maltreatment – indeed, any crime – investigation and confirmation require that the sexual assault be reported and the investigation initiated and seen through to completion. Estimates vary across sources, populations, and years, but per trustworthy national estimates, only 37% of rape incidents and 12% of child sexual abuse incidents are reported to police.[19] Reported incidents are often not fully investigated. Gov. Greg Abbott has just signed into law a measure meant to end the perennial backlog of "rape kits" left unexamined, numbering nearly 19,000 in Texas in 2017 and now down to just over 2,000.[20]

## Mental illness and suicide

Mental and behavioral health and well-being was one of the important but difficult subjects focus group participants wished they had help talking about and acting on.

*"...parents aren't having the conversations because they don't know  how."*
*"Many parents just walk away because they don't know what to do."*

Participants spoke of not knowing much about mental health or about what contributes to illnesses like depression, but stigma and misperceptions get in the way of reaching out for help for themselves or their families. Parents worried that getting care for a child might result in a formal diagnosis that would go on the child's *"permanent record"* and limit future opportunities for education and employment such as military service. The theme of stigma as a barrier to care also came out of the key informant interviews; the community must establish a *"recognition that mental illness is like any other illness and [there's] no shame in seeking care."*

19. Statistics about sexual violence. Retrieved from https://www.nsvrc.org/sites/default/files/publications_nsvrc_factsheet_media-packet_statistics-about-sexual-violence_0.pdf
20. SB 1636 Sexual Assault Kit Initiative (for pre-August 2011 SAKs). Retrieved from http://www.dps.texas.gov/CrimeLaboratory/documents/sb1636OutsourceStatusRpt.pdf

# Section 7: Health Outcomes

Little local data is available on the prevalence of mental illness in the general population, but the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 18.3% of U.S. adults have experienced any mental illness (AMI) within the past year, and 4.2% have experienced serious mental illness (SMI). Prevalence of AMI is higher among females, older adults, and non-Hispanic whites, while prevalence of SMI is higher among females, younger adults, and people of two or more races, although low numbers may mean the latter figure has a high degree of uncertainty.[21] Both AMI and SMI are defined as a mental, behavioral, or emotional disorder, but AMI includes all diagnosable mental illnesses regardless of type or level of impairment, while SMI is characterized by serious functional impairment.[22]

A recent study of "super utilizers" in Bexar County sought to identify and characterize the "safety net" population meeting at least one of three criteria: three inpatient hospital stays per year, two inpatient stays and a diagnosis of SMI, or more than nine emergency room visits. Of the 3,717 people identified, half had a serious mental illness, one in five had an indication of a substance abuse problem, and one in five was homeless. The number of inpatient admissions ranged from none to 23 per year; emergency department visits per year ranged from none to 71.[23]

Although local data on adults is scarce, even less local data is available for mental illness prevalence in adolescents or children. SAMHSA estimates that 49.5% of U.S. adolescents aged 13 to 18 have ever had a mental disorder of any impairment level and 22.2% have had a mental disorder with severe impairment. Prevalence is higher among older adolescents, but no substantive difference by sex is apparent.[24] Note that this figure is *lifetime* or "ever" prevalence rather than past-year prevalence as was measured for adults.

The Early Development Instrument (EDI) kinder-readiness dataset includes neighborhood-level information for 16,013 first graders in eight local school districts, meaning the data cannot be generalized to Bexar first-graders overall.[25] The Emotional Maturity[26] domain of the EDI assesses prosocial and helping behavior, anxious and fearful behavior, and aggressive behavior. Of the first-graders assessed on Emotional Maturity in the 2017-18 school year, 81% are considered "on track", scoring above the 25th percentile of the reference dataset (Fig. 7.7). Another 10% are considered "at risk," scoring between the 10th and 25th percentiles, and 9% are considered "vulnerable", scoring in the lowest percentile. Of the first-graders assessed on Social Competence[27], 76% are considered "on track," 15% "at risk," and 9% "vulnerable" (Fig. 7.7.1).

21. NIMH » Mental Illness. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154787
22. NIMH » Mental Illness. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154784
23.Planning Report for the Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas - MHM. Retrieved from http://www.mhm.org/library/policy-publications/san-antonio-state-hospital-report-2019
24. NIMH » Mental Illness. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_155771
25. 220 of 224 schools participating from East Central ISD, Edgewood ISD, Harlandale ISD, North East ISD, Northside ISD, San Antonio ISD, Southside ISD, and Southwest ISD
26. The Emotional Maturity domain includes Includes the abilities to think before acting, to fearfulness and impulsiveness, to handle feelings at an age-appropriate level, and to be empathetic.
27. The Social Competence domain includes social skills, cooperative interaction with other children, respect and responsibility, problem solving and ability to adjust to changes in routines, and readiness to explore new things.
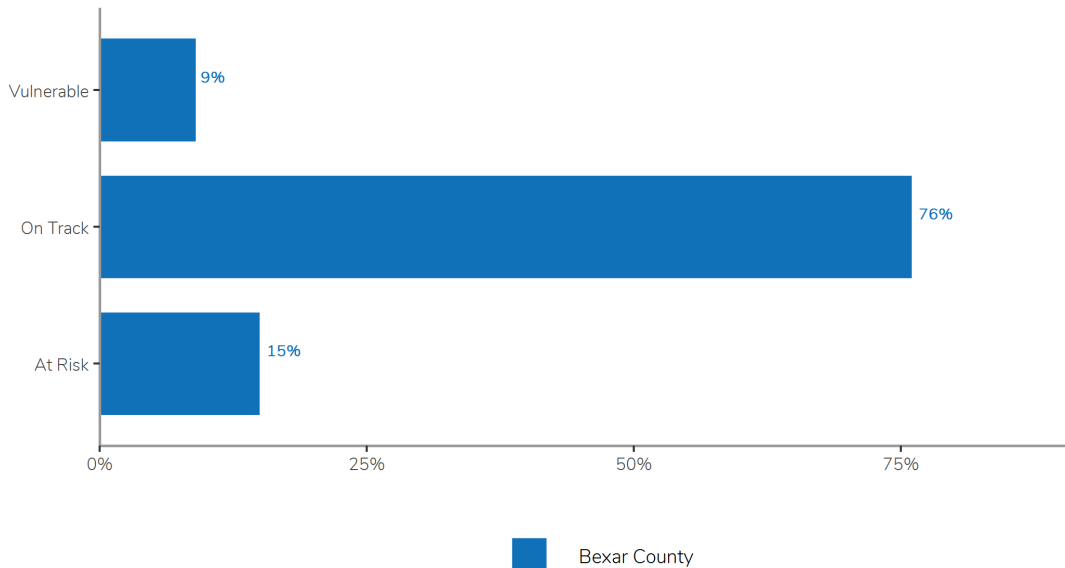
Fig. 7.7 Percent of students assessed in emotional maturity domain, 2018
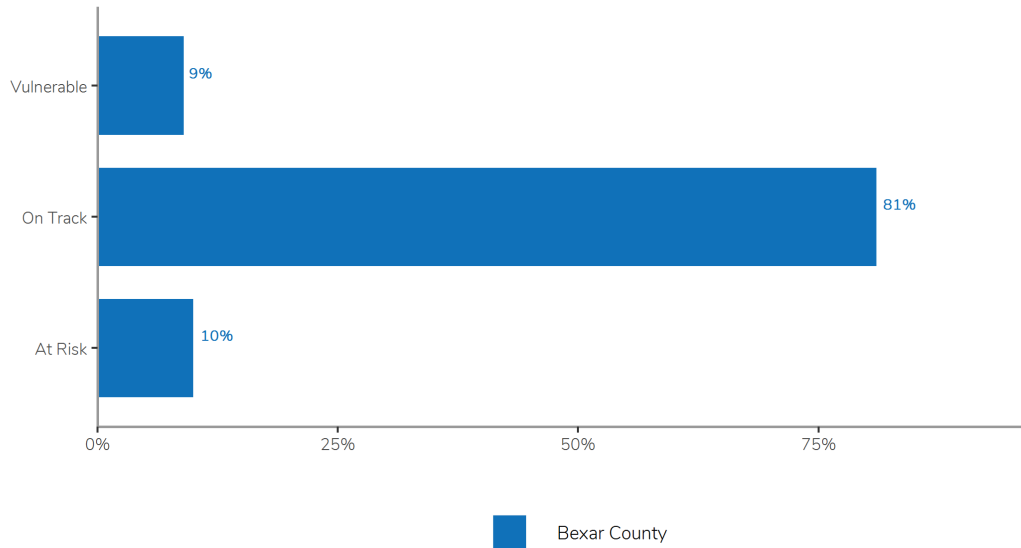


*Unreliable: Error is too large relative to estimate
Source: Transforming Early Childhood Community Systems; Early Development Instrument
Prepared by CI:Now for THC

Fig. 7.7.1 Percent of students assessed in social competence domain, 2018



*Unreliable: Error is too large relative to estimate
Source: Transforming Early Childhood Community Systems; Early Development Instrument
Prepared by CI:Now for THC

# Section 7: Health Outcomes

Because the number of suicides is relatively small, particularly in Atascosa, determining rates typically requires several years of data to be grouped together. The time periods used here were chosen to yield a reliable rate with no data suppression and a confidence interval not wider than about half the estimate. Different time periods were used for different rates, so the two counties should not be directly compared. The time period for each rate is specified in the table below. If a rate is not shown, the data are suppressed for all time periods or the confidence interval was about as wide as the estimate.

All of Atascosa's suicide rates should be interpreted with caution because of the long time period (1999 to 2016) and the fairly wide confidence intervals, which indicate uncertainty (Fig. 7.7.2). The ratios still provide useful information: Atascosa non-Hispanic whites are roughly twice as likely as Hispanics to die of suicide, and males are more than four times as likely as females. The pattern is about the same for Bexar, with no significant differences between age groups and with the rate among African-Americans slightly lower than that of Hispanics (Fig. 7.7.3).

Mental illness prevention measures suggested by focus group participants included communicating with love, patience, and understanding; building skills and positive coping mechanisms; reinforcing positive behaviors through mentorship; and raising awareness that counseling can help. Knowing what services are available would help with treatment, as would expanding the number and capacity of programs. Key informants interviewed saw a need to change the cultural norms of our community; parent education on healthy ways to discipline children was one suggestion. One key informant interviewee noted that having *"parents educated on the importance of seeking services early, having access to early intervention services at no cost to parents, go a long way to preventing mental health crises and expensive crisis interventions."* Key informant interviewees spoke of community education around mental health  as a way to normalize the issue and include it as a part of total well-being and physical health.

Fig. 7.7.2 Suicide age-adjusted rates by sex and race for Atascosa County, 1999-2016

| Atascosa County, 1999-2016 | |
| --- | --- |
| Total | 14.4 (11.7-17.1) |
| Sex | |
| Female | 5.5 (3.4-8.3) |
| Male | 23.9 (19.1-29.6) |
| Race/ethnicity | |
| Hispanic | 9.5 (6.8 - 12.9) |
| White non-Hispanic | 21.6 (16.5 - 27.6) |

Source: CDC WONDER online data, Compressed Mortality, 1999-2016, https://wonder.cdc.gov/mortSQL.html.

Age-adjusted death rates were calculated using the direct method and the 2000 standard population.

Fig. 7.7.3 Suicide age-adjusted rates by sex, age group and race for Bexar County

| Bexar County | |
|---|---|
| Total, 2016 | **12.0** (10.4 - 13.6) |
| Sex and age group, 2016 | |
| Female | **5.9** (4.5 - 7.7) |
| 15 to 34 years (crude) | **8.4** (5.4 - 12.5) |
| 35 to 64 years (crude) | **9.2** (6.3 - 13.0) |
| Male | **18.6** (15.8 - 21.4) |
| 15 to 34 years (crude) | **21.0** (16.2 - 26.9) |
| 35 to 64 years (crude) | **25.7** (20.5 - 31.8) |
| Race/ethnicity, 2014-2016 | |
| African-American | **6.2** (4.0 - 9.3) |
| Hispanic | **7.7** (6.7 - 8.6) |
| White non-Hispanic | **18.6** (16.5 - 20.7) |

Source: CDC WONDER online data, Compressed Mortality, 2014-2016, https://wonder.cdc.gov/mortSQL.html.
Age-adjusted death rates were calculated using the direct method and the 2000 standard population.

*"Mental health is the most dysfunctional system with the word health in it,"* said one key informant. *"Early identification and prevention is needed, access to services... safety net systems have developed around crisis response (suicide) but it is a Band-aid on the crisis and prevention is needed."* As one focus group participant noted, though, large investments would be needed: *"It's going to cost money to have those programs. Nothing is free. How are you going to get it?"*

## Alcohol- and substance-related injury and death

Despite a growing population, the number of alcohol-involved motor vehicle crashes in Bexar dropped by 12% between 2013 and 2017 (Fig. 7.8). Alcohol-involved crashes are much more likely than other crashes to result in injury or death. In 2017, there were 2,016 alcohol-involved crashes and 2.5% were fatal crashes[28] as compared to only 0.3% of total crashes.[29] There were 60.0 suspected serious injuries per 1,000 alcohol-involved crashes, nearly three times as high as the 22.9 per 1,000 among total crashes.

In 2017, about 10 Bexar deaths per 100,000 population (age-adjusted) were from an alcohol-induced cause, somewhat higher than the Texas rate but comparable to the U.S. Cirrhosis of the liver was the cause of the majority of those Bexar deaths. In Atascosa the rate was 5.6 per 100,000 (age-adjusted) for the 2011 to 2017 period, the shortest time period that yielded a reliable estimate.

There were 657 emergency department visits for opioid overdose from Bexar residents in 2017 for a rate of 3.35 visits per 10,000 population, virtually the same as the Texas rate of 3.34. Atascosa residents had 17 visits in 2017, too small a number to calculate a rate or disaggregate further. Just over half of Bexar visits involved commonly-prescribed opioids, while only a quarter involved heroin. A slightly higher percentage of Texas opioid overdose emergency department visits was for commonly-prescribed opioids, with only one in five for heroin.[30]

**Related data**

Health Behaviors and Risks:

• Alcohol

• Opioids and Other Drugs

28.DUI (Alcohol) Crashes and Injuries by County. Retrieved from http://ftp.dot.state.tx.us/pub/txdot-info/trf/crash_statistics/2017/40.pdf
29.Crashes and Injuries by County. Retrieved from http://ftp.dot.state.tx.us/pub/txdot-info/trf/crash_statistics/2017/13.pdf
30. Opioid-Related Inpatient Emergency Department Visits. Retrieved from http://healthdata.dshs.texas.gov/Opioids/EmergencyDepartment

Fig. 7.8 Alcohol involved motor vehicle crashes
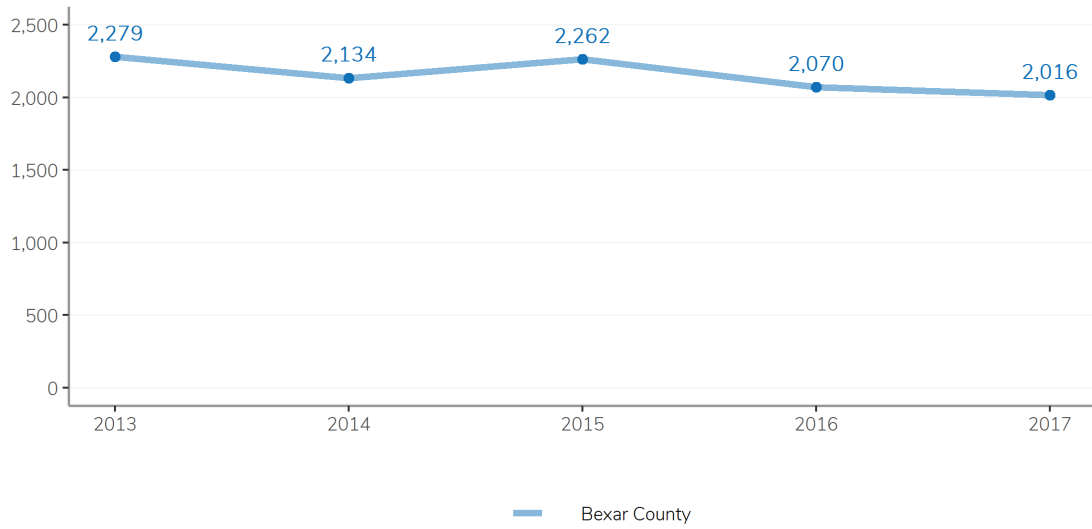
Fig. 7.8.1 Deaths due to poisoning by chemical substance (including drugs)
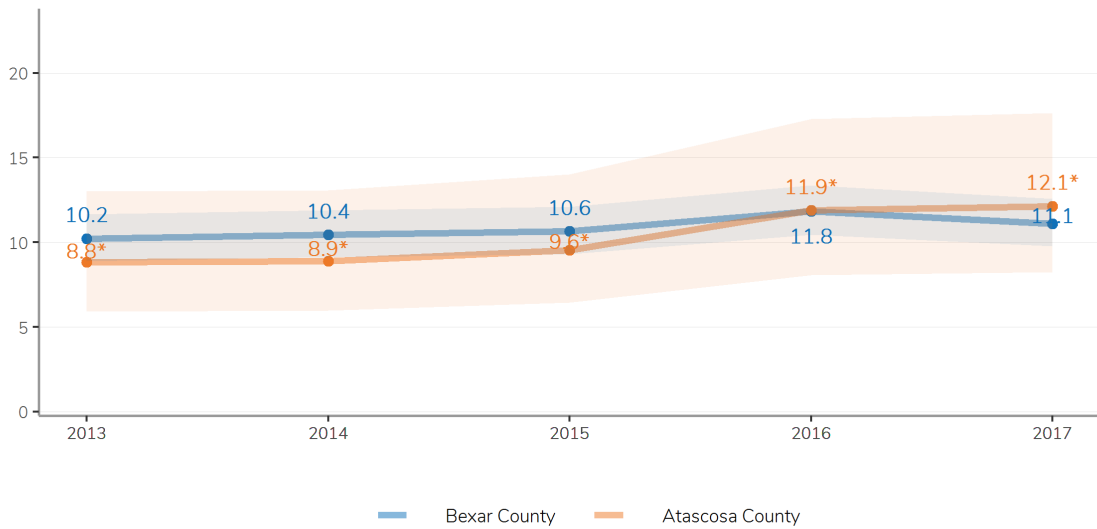
# Section 7: Health Outcomes

Drug-related death rates are difficult to determine because deaths from any substance – legal and illegal drugs, carbon monoxide, pesticides, household cleaners – are all grouped under "poisoning." The Centers for Disease Control and Prevention developed modeled estimates of drug poisoning death rate trends at the county level (Fig 7.8.1). Age-adjusted rates could not be modeled because of the particular statistical method used,[31] so because of their different age distributions, Atascosa and Bexar should not be compared to each other on this measure.

The crude death rate specifically for opioids has increased dramatically over the past 15 years and currently stands at 4.3 per 100,000 population in Texas and 5.7 in Bexar. Of the Bexar opioid-involved deaths, 27% involved commonly-prescribed opioids and 70% involved heroin, as compared to 44% each for prescribed opioids and heroin in Texas.[32]

## Pedestrian and cyclist injury and death

Federal highway safety laws require states to track all crashes that involve motor vehicles on a traffic way that results in injury or death or damage to property to the apparent extent of $1,000. All law enforcement agencies in Bexar and Atascosa report crashes to the Texas Department of Transportation and the data below was requested from the Texas Peace Officer's Crash Reports (CR-3). An incapacitating injury is any injury that prevents the person from walking, driving, or continuing activities that they were capable of performing before the injury occurred. Law enforcement officers have to determine the extent of the injury (suspected serious, non-incapacitating, possible injury, unknown injury or non-injury) when they fill out the crash report at the scene. The data in figures below is most likely underreported for incapacitating injuries because it is based on the officer's judgment and discretion when recording the type of injury from the accident.

No clear trend emerges for the number of Bexar traffic accidents causing incapacitating injury for either cyclists (Fig. 7.9) or pedestrians (Fig. 7.9.1), likely because the numbers are relatively low, and virtually zero in Atascosa. The average number of traffic accidents in the 2016-2018 period causing incapacitating injury for pedestrians is about five times the average for cyclists. Bexar averages about 58 traffic accidents per year causing pedestrian death (Fig. 7.9.2), more than 11 times the average number for cyclists (Fig. 7.9.3).

31.. U.S. Opioid Prescribing Rate Maps | Drug Overdose | CDC Injury Center. (2018, October 3). Retrieved from https://www.cdc.gov/drugover-dose/maps/rxrate-maps.html
32. Texas Health Data. Retrieved from http://healthdata.dshs.texas.gov/Opioids/Deaths

Fig. 7.9 Traffic accidents causing incapacitating injuries for cyclists
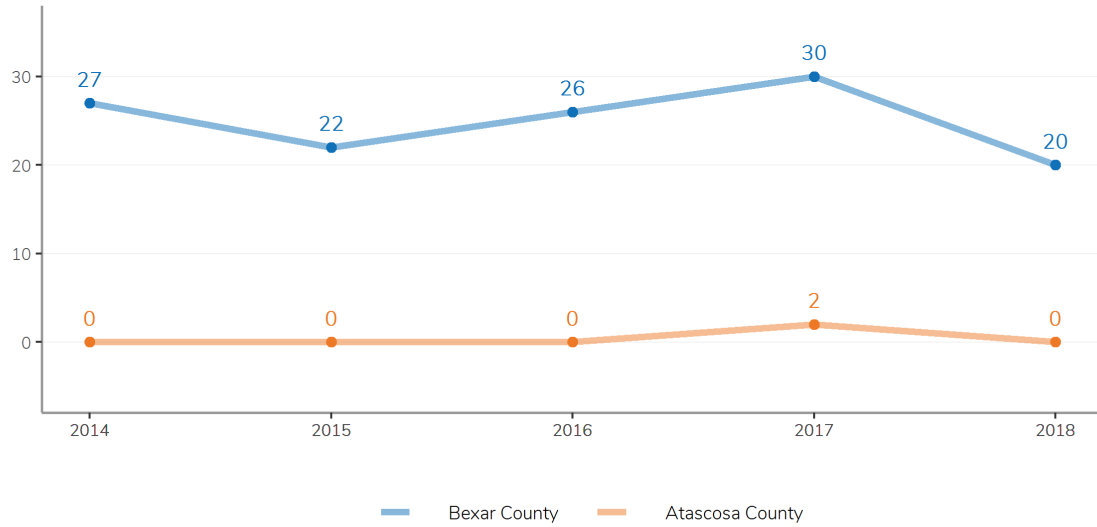
Fig. 7.9.1 Traffic accidents causing incapacitating injuries for pedestrians
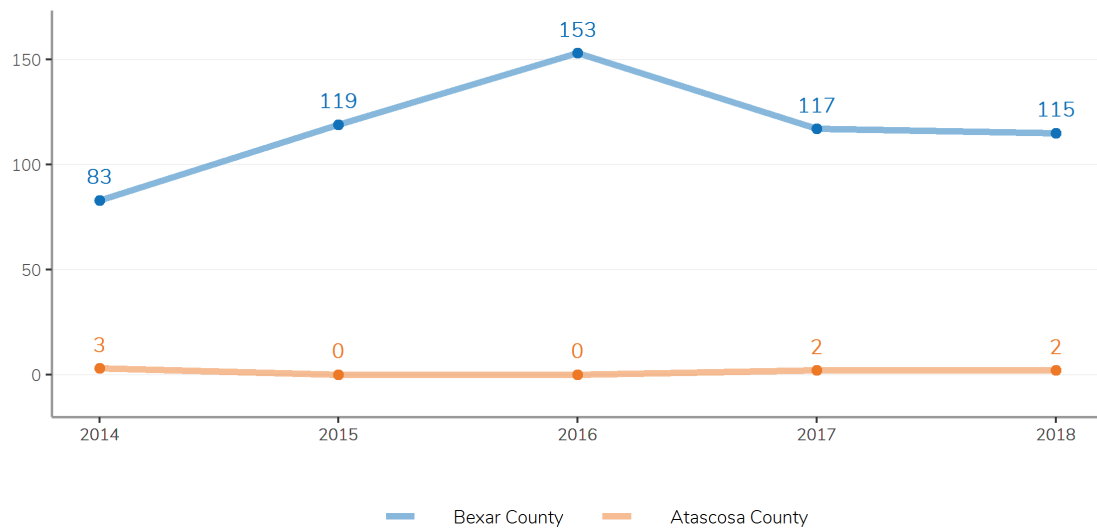
Fig. 7.9.2 Traffic accidents causing fatalities for pedestrians
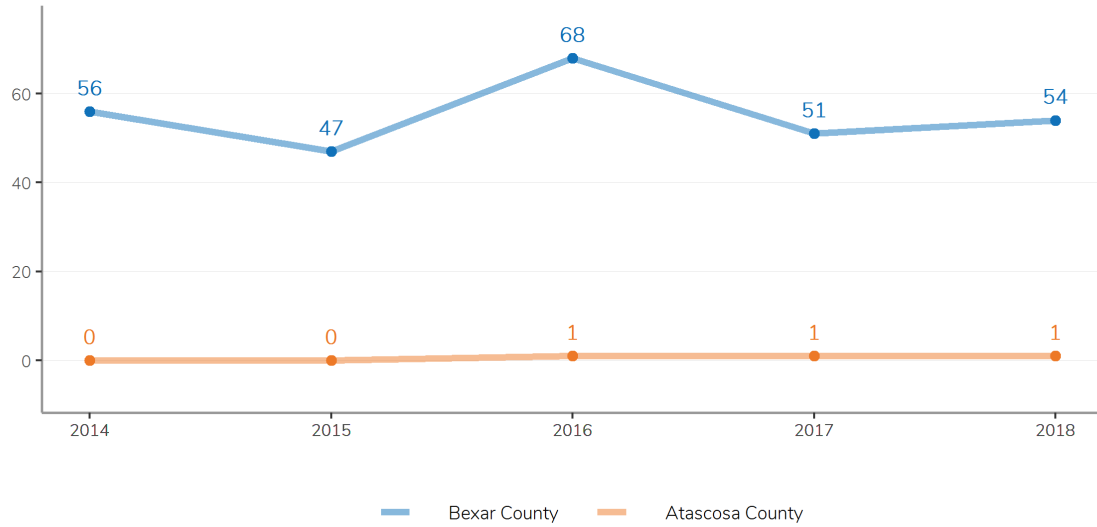


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Transportation
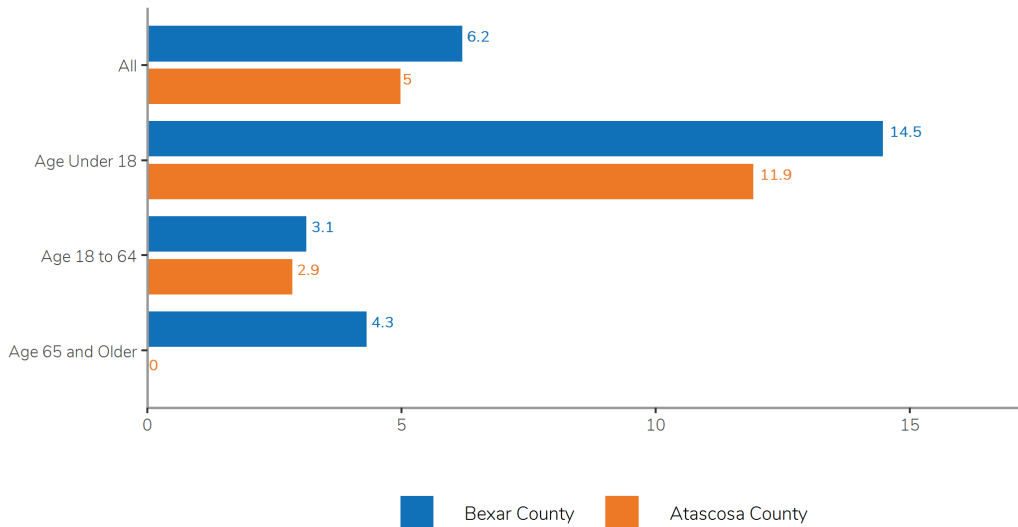Prepared by CI:Now for THC

Fig. 7.9.3 Traffic accidents causing fatalities for cyclists
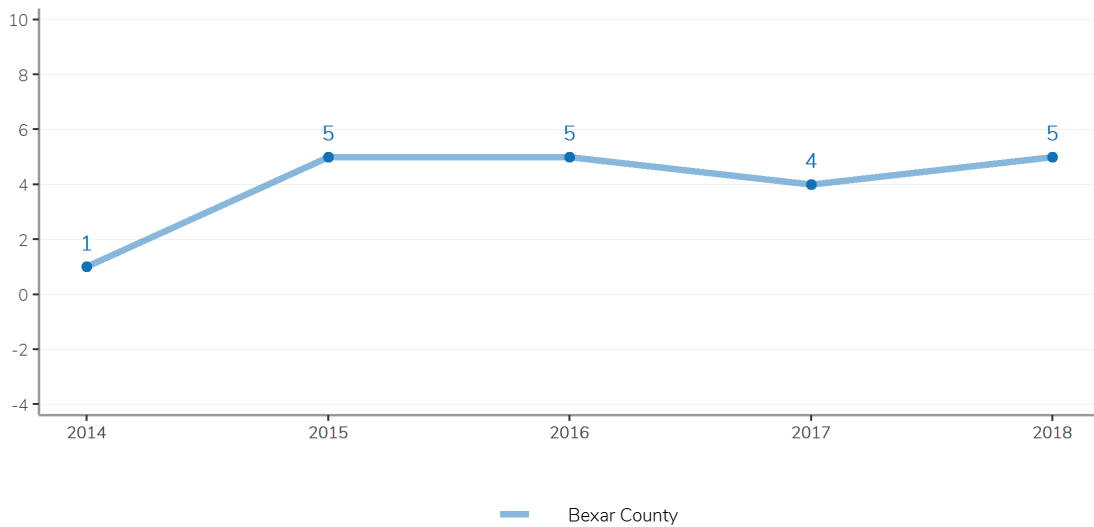


*Unreliable: Error is too large relative to estimate
Source: Texas Department of Transportation
Prepared by CI:Now for THC

# Section 7: Health Outcomes

## Asthma

About one in 10 Bexar adult BRFSS respondents reports ever having been told by a doctor, nurse, or other health professional that they had asthma, roughly the same as percentage for Texas as a whole.[33] That percentage is not available for Atascosa. The rate of hospitalization with a primary discharge diagnosis of asthma was somewhat higher among Bexar children and youth under age 18 compared to Atascosa (Fig. 7.10). The Bexar rate was much higher for adults 65 and older and about the same for adults aged 18 to 64 years.

Fig. 7.10 Rate of hospital discharge for a primary diagnosis of asthma by age group per 10,000 population, 2017



*Unreliable: Error is too large relative to estimate
Source: Texas Hospital Inpatient Discharge Public Use Data File, 2017. Texas Department of State Health Services, Center for Health Statistics, Austin, Texas.
Prepared by CI:Now for THC

## Oral disease

Nearly four in 10 Bexar adult BRFSS respondents report having had one or more teeth removed because of decay or disease (Fig. 7.11), and the proportion may be higher in the Atascosa area, but both appear lower than the 57% (55%-59%) for Texas as a whole.[33] The wide margins of error make Atascosa patterns difficult to interpret, but the percentage appears quite similar across Bexar race/ethnicity groups (Fig.7.11.1). The Near Eastside appears to have a significantly higher percentage than do the Near Northside, Far Northside, and possibly Far Northwest (Fig. 7.11.2).

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33. Texas Health Data. Retrieved from http://healthdata.dshs.texas.gov/CommunitySurveys/BRFSS

Fig. 7.11 Percent of adults having one or more teeth removed because of decay or disease, 2011-2017
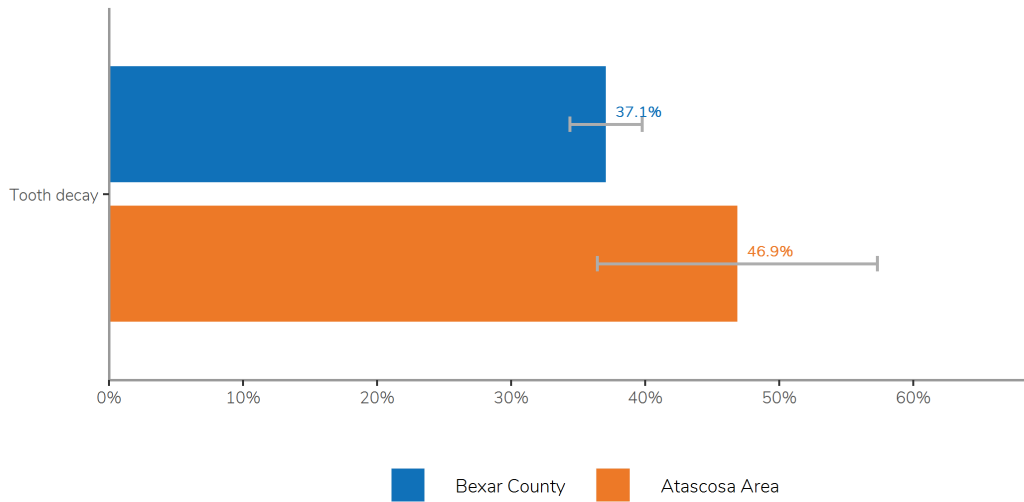


**Bexar County** ■    **Atascosa Area** ■

Fig. 7.11.1 Percent of adults having one or more teeth removed because of decay or disease by race, 2011-2017
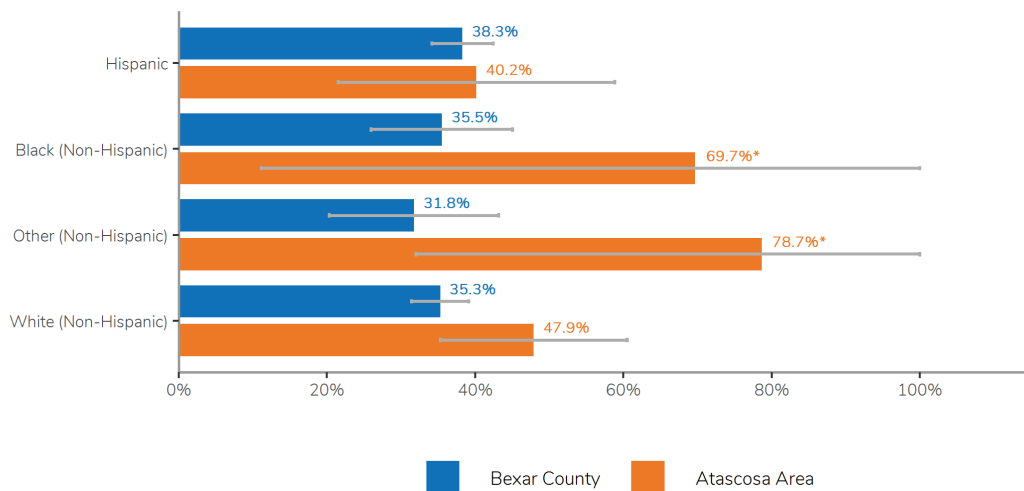


**Bexar County** ■    **Atascosa Area** ■

Fig. 7.11.2 Percent of adults having one or more teeth removed because of decay or disease by sector, 2011-2017
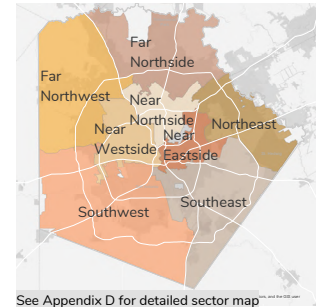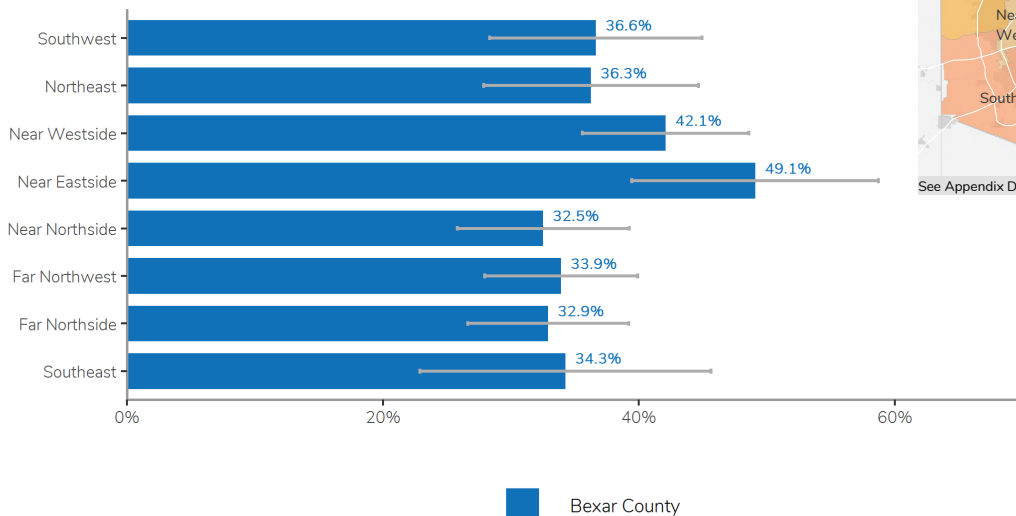


See Appendix D for detailed sector map

Southwest — 36.6%
Northeast — 36.3%
Near Westside — 42.1%
Near Eastside — 49.1%
Near Northside — 32.5%
Far Northwest — 33.9%
Far Northside — 32.9%
Southeast — 34.3%

■ Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Vaccine-preventable disease

Varicella (chicken pox) and pertussis (whooping cough) are the most common of the vaccine-preventable diseases discussed here, but even so, the actual number of newly-diagnosed cases in a year is still small enough to exaggerate the trend line. The actual number of varicella cases between 2013 and 2017 ranged from one to five in Atascosa (Fig. 7.12) and from 83 to 106 in Bexar (Fig. 7.12.1). In Atascosa, though, those five cases and the accompanying rate (9.5 per 100,000) were the highest seen since 2009 and merit attention.

Pertussis (whooping cough) rates generally move up and down in a three- to five-year cycle,[34] and the Bexar and Atascosa rate trends are consistent with that pattern. Atascosa's rate dropped sharply from 35.4 (17 cases) in 2013 to 3.8 (two cases) in 2017, but 2013 marked the high point of the previous cycle in which the rate rose to 27.4 in 2008, fell to 0.0 in in 2010, and then rose to reach the 2013 rate (Fig. 7.12). Roughly the same cycle occurred in Bexar – the 2013 high rate of 6.7 was preceded by a low of 1.4 in 2010 and 2011 – but the relatively larger numbers across the board yield a less dramatic trend line (Fig. 7.12.2).

The sharp 2014 spike in Hepatitis A incidence in Atascosa represents two acute cases (Fig. 7.12). In Bexar, though, the 2016 incidence rate of 1.0 (19 cases) was the highest the county had seen since 2008 and ranked below only Williamson in highest incidence among the largest urban counties (Fig. 7.12.2). Atascosa saw no acute Hepatitis B cases between 2013 and 2017, and neither county saw any cases of measles or polio in the 10-year period ending in 2017.

**Related data**

Health Behaviors and Risks:

• Vaccinations

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34. Pertussis. Retrieved from https://www.dshs.texas.gov/IDCU/disease/pertussis/Pertussis.aspx

Fig. 7.12 Rate of Varicella, Pertussis and Hepatitis A per 100,000 population for Atascosa County
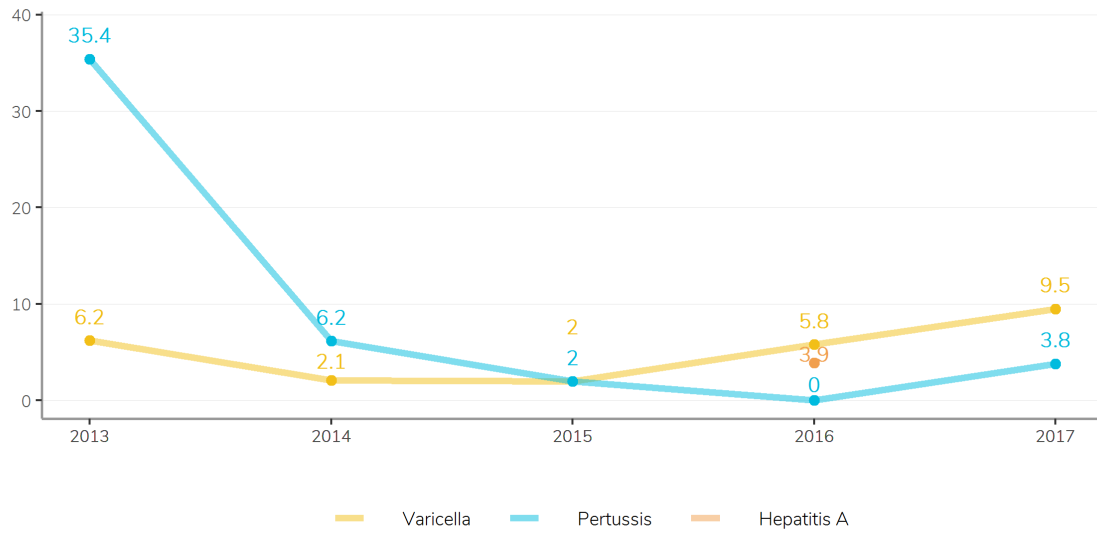


Varicella — Pertussis — Hepatitis A

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.12.1 Rate of Varicella and Mumps per 100,000 population for Bexar County
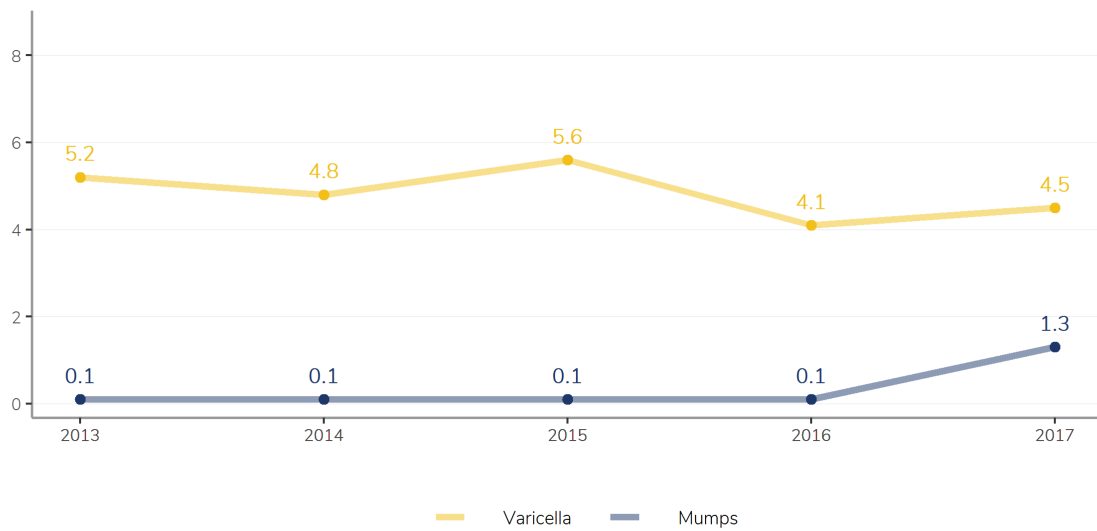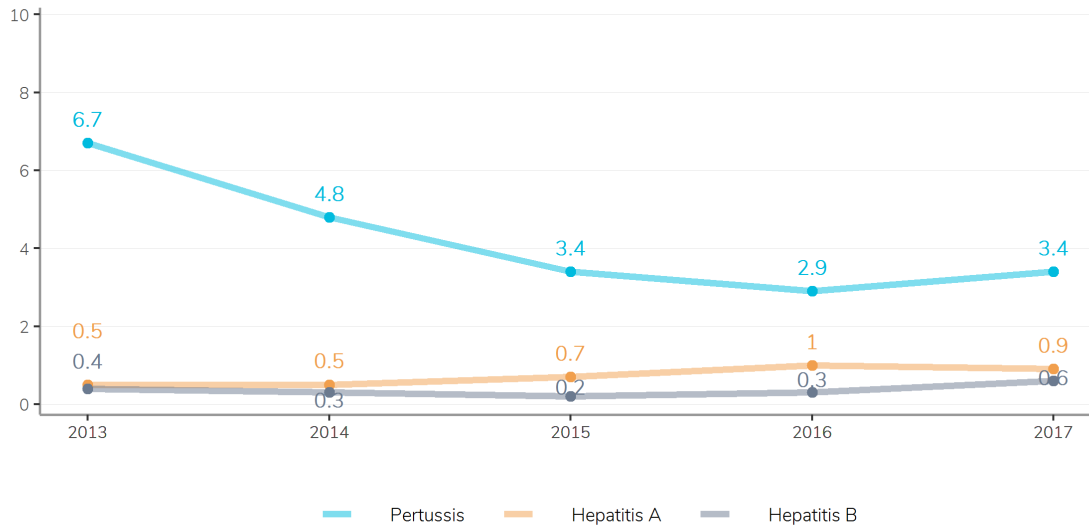


Varicella — Mumps

*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.12.2 Rate of Pertussis, Hepatitis A and Hepatitis B per 100,000 population for Bexar County



*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Both counties have lower rates of parental conscientious objection to school immunization requirements than the state overall. Ranking Texas counties from lowest three-year average objection rate (ranked 1st) to highest (ranked 254th), Atascosa and Bexar rank 35th and 128th, respectively.[35] For 2007-2015, DSHS tracked HIB using Haemophulis influenzae invasive type b cases only and changed the reports to include all serotypes in 2016 going forward therefore it was not trended with the other vaccine preventable diseases.

## Sexually transmitted infections

Chlamydia incidence in Atascosa has increased dramatically since 2015, although again, small numbers likely cause that trend to appear steeper than it truly is (Fig. 7.13). The trend in Bexar appears to be more cyclical, but it is consistently higher than the rate in Texas overall.[36] The pattern is the same for gonorrhea – an increase in Atascosa (Fig. 7.13.1) and a cycle in Bexar that is consistently higher than Texas. In both counties chlamydia incidence is dramatically higher among 18- to 29-year olds than among 30- to 64-year-olds (Fig. 713.2). Although less dramatic, that pattern holds for gonorrhea as well.

35. Statistics on Conscientious Exemptions to School Immunizations. Retrieved from https://www.dshs.texas.gov/immunize/coverage/Conscientious-Exemptions-Data.shtm#county
36. Health Facts Profiles (2014 - 2015). Retrieved from http://healthdata.dshs.texas.gov/HealthFactsProfiles_14_15
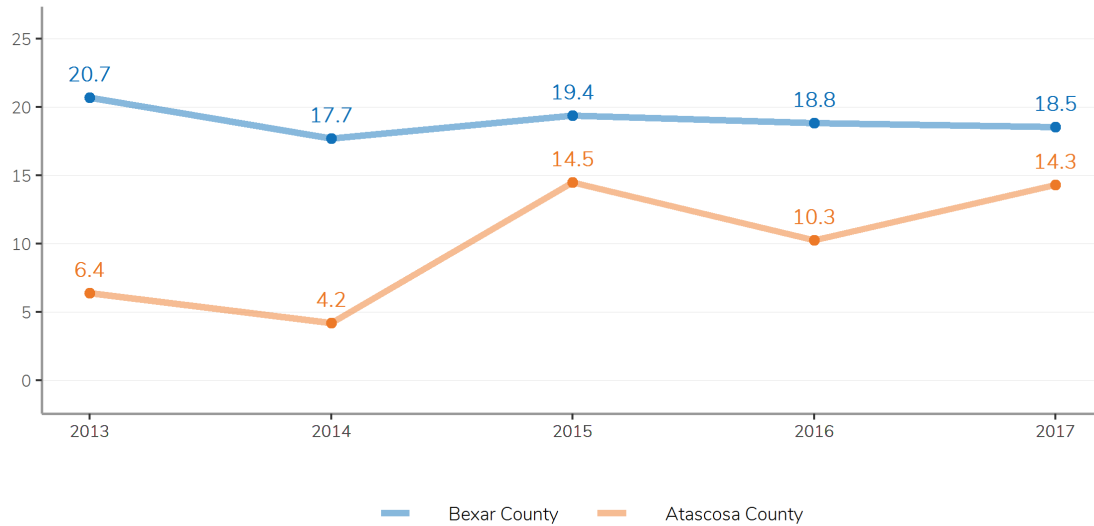
Fig. 7.13 Number of new cases of Chlamydia per 100,000 population
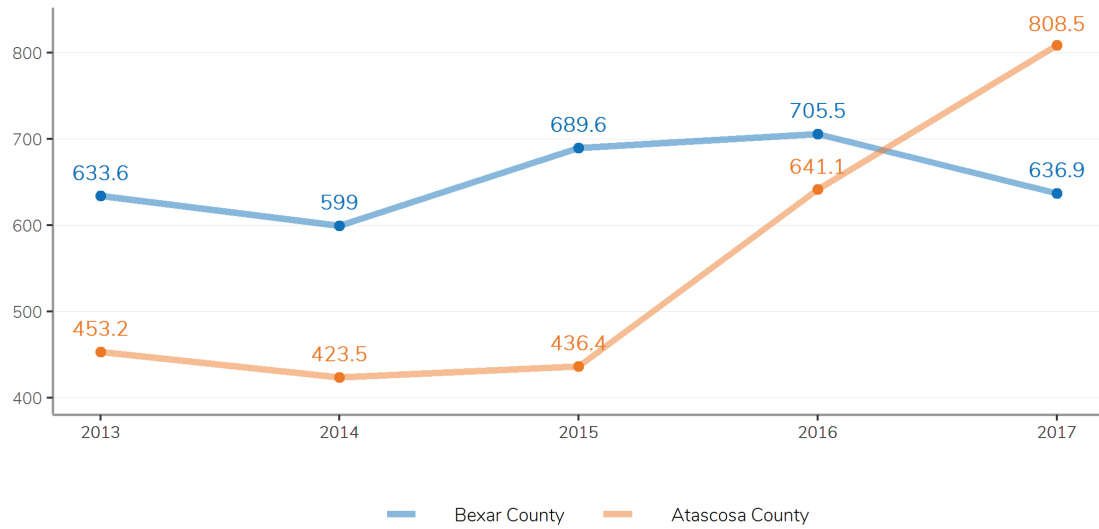


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

Fig. 7.13.1 Number of new cases of Gonorrhea per 100,000 population
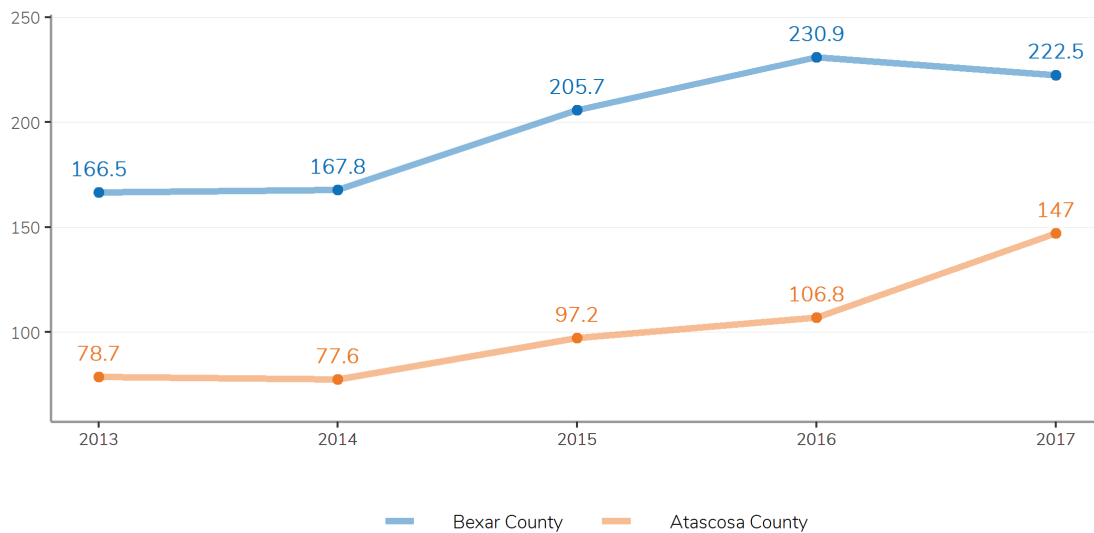


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

# Section 7: Health Outcomes

Fig. 7.13.2 Number of new cases by age per 100,000 population

| | Atascosa | | Bexar | |
|---|---|---|---|---|
| | Age 18-29 | Age 30-64 | Age 18-29 | Age 30-64 |
| Chlamydia | 3,769.1 | 262.8 | 2,423.4 | 267.6 |
| Gonorrhea | 540.3 | 124.3 | 722.4 | 159.0 |
| Syphilis | 171.3 | 114.7 | 160.8 | 76.8 |
| HIV | 39.5 | 19.1 | 39.7 | 24.0 |

Source: Texas Department of State Health Services, unpublished data by request, received March 22, 2019

Syphilis incidence is known to rise and fall on a seven- to 10-year cycle[37] and is still on the upswing in both counties (Fig. 7.13.3). Congenital syphilis incidence is also on the rise in Bexar, nearly reaching the 2013 rate after a five-year low in 2015. Although it represents only 17 cases,[38] Bexar's current rate is 36% higher than Texas and 259% higher than the U.S.[39] The rate is not available for Atascosa.

HIV incidence appears to be very slowly decreasing in Bexar and dramatically increasing in Atascosa (Fig. 7.13.4), but the variation in the Atascosa rate over time represents a range of between two and seven cases. Unsurprisingly, the rate is much higher in the 18-29 age group in both counties.

Fig. 7.13.3 Number of new cases of Syphilis per 100,000 population
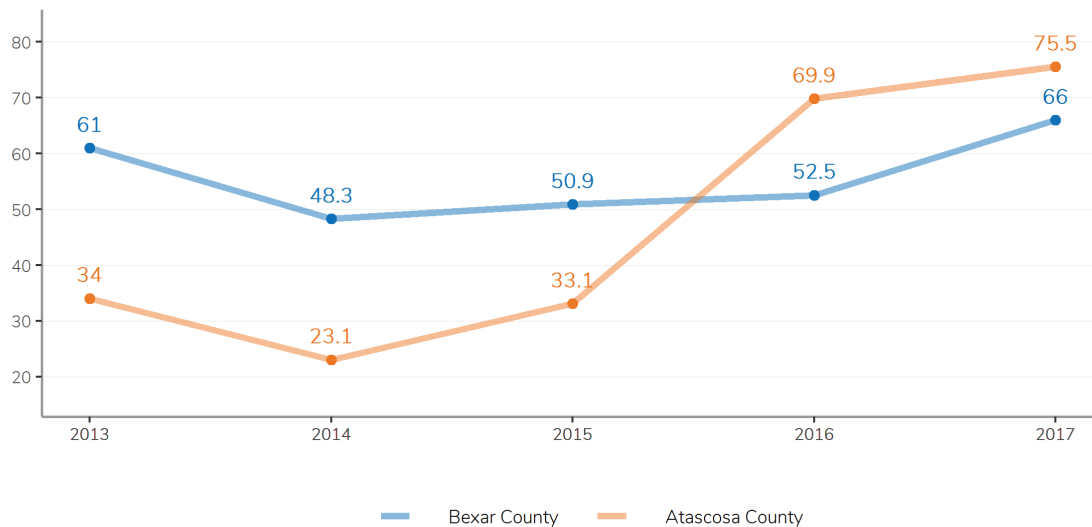


*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

37. The National Plan toEliminate Syphilisfrom the United States. Retrieved from https://www.cdc.gov/stopsyphilis/plan.pdf
38. The State of STDs in Bexar County—2017. Retrieved from https://www.sanantonio.gov/Portals/0/Files/health/News/Reports/2017STDcases-esBCUSonepager09252018.pdf
39. Table 2. Chlamydia — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2017. Retrieved from https://www.cdc.gov/std/stats17/SRtables.pdf

# Section 7: Health Outcomes

Fig. 7.13.4 Number of new cases of HIV per 100,000 population



*Unreliable: Error is too large relative to estimate
Source: Texas Department of State Health Services
Prepared by CI:Now for THC

## Cancer

Age-adjusted incidence (newly-diagnosed cases each year per 100,000 population) and mortality (deaths per 100,000 population) are reviewed here for the four most common cancers. Incidence and mortality are disaggregated by race/ethnicity and sex for both colon and lung cancer, and prostate cancer, of course, is specific to males. Because it is so common among females and so uncommon among males, breast cancer data is presented only for females so as not to misrepresent the impact on either sex.

Wherever a bar is absent from a chart in this section, the number of cases was so low that the rate was suppressed in the published data to safeguard privacy. An asterisk beside an estimated rate indicates that although the rate was not suppressed, the numbers are low enough and the uncertainty great enough that the published rate is considered unreliable and should be used only with caution. Unfortunately, most Atascosa rates in these charts are either suppressed or considered unreliable.

Age-adjusted lung and bronchus cancer incidence and mortality are both much lower among Bexar females than males in any of the three race/ethnicity groups (Fig. 7.14 and Fig. 7.14.1). For both sexes, age-adjusted incidence and mortality are much lower among Hispanics than among blacks or whites, but the difference between sexes is greatest among Hispanics (Fig 7.14.2 and Fig. 7.14.3). These patterns are consistent with data presented earlier in this assessment indicating that smoking is much less prevalent among Hispanics than among other race/ethnicity groups.

> **Related data**
> Health Behaviors and Risks:
>
> • E-Cigarettes and tobacco

Fig. 7.14 Age-adjusted lung and bronchus cancer rate among males by race per 100,000 population, 2016
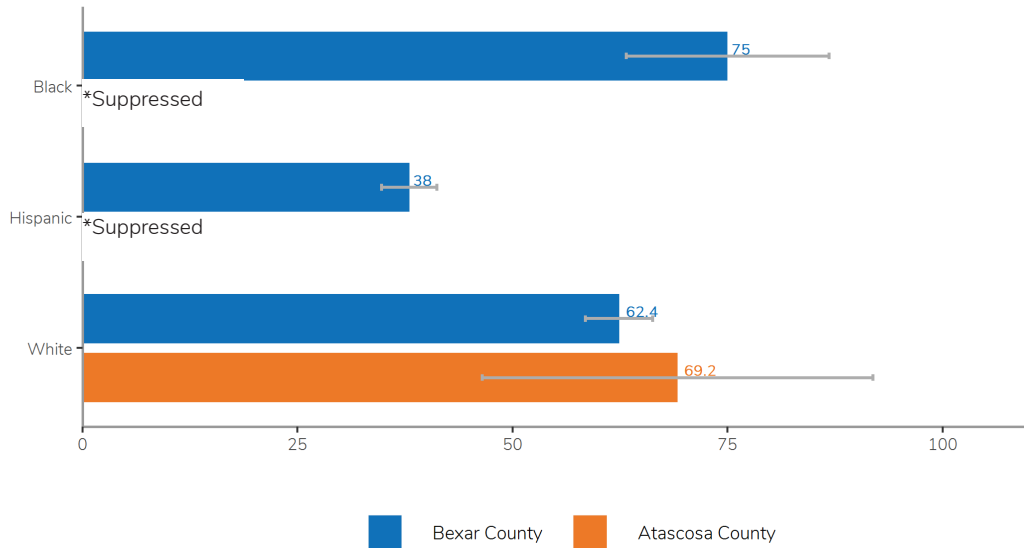


Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC

Fig. 7.14.1 Age-adjusted lung and bronchus cancer rate among females by race per 100,000 population, 2016



Bexar County    Atascosa County
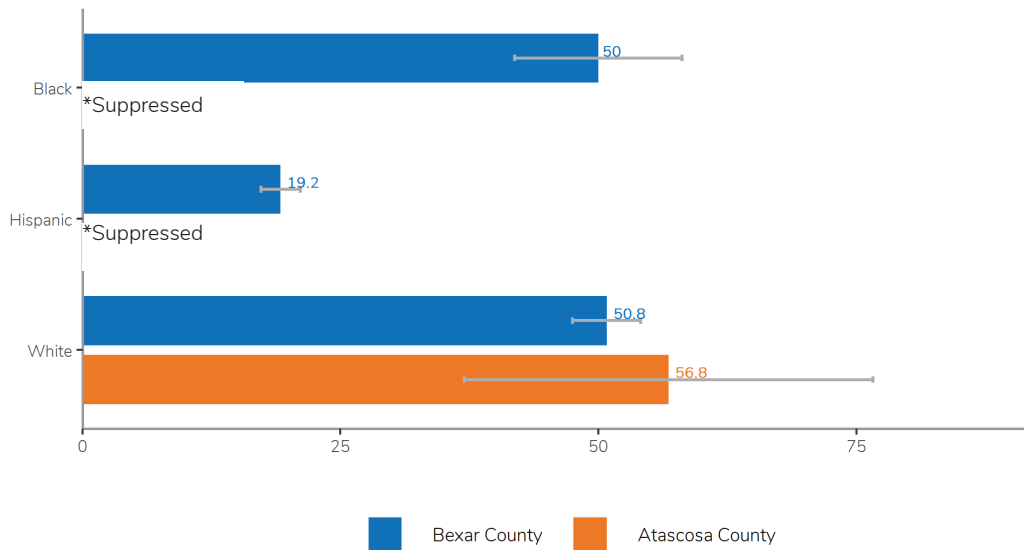
*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC

Fig. 7.14.2 Age-adjusted lung and bronchus cancer mortality rate among males by race per 100,000



Black: 53.1 *Suppressed
Hispanic: 29.1 *Suppressed
White: 4.2* / 54.2

Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
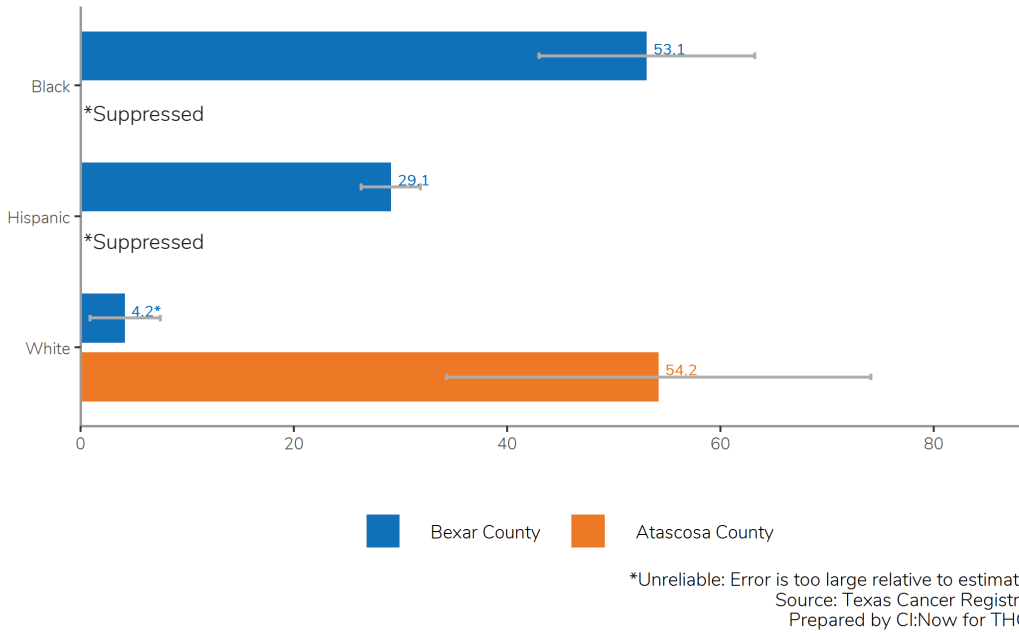
Fig. 7.14.3 Age-adjusted lung and bronchus cancer mortality rate among females by race per 100,000 population, 2016



Black: 31.6 *Suppressed
Hispanic: 12.5 *Suppressed
White: 34.4 / 31*

Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
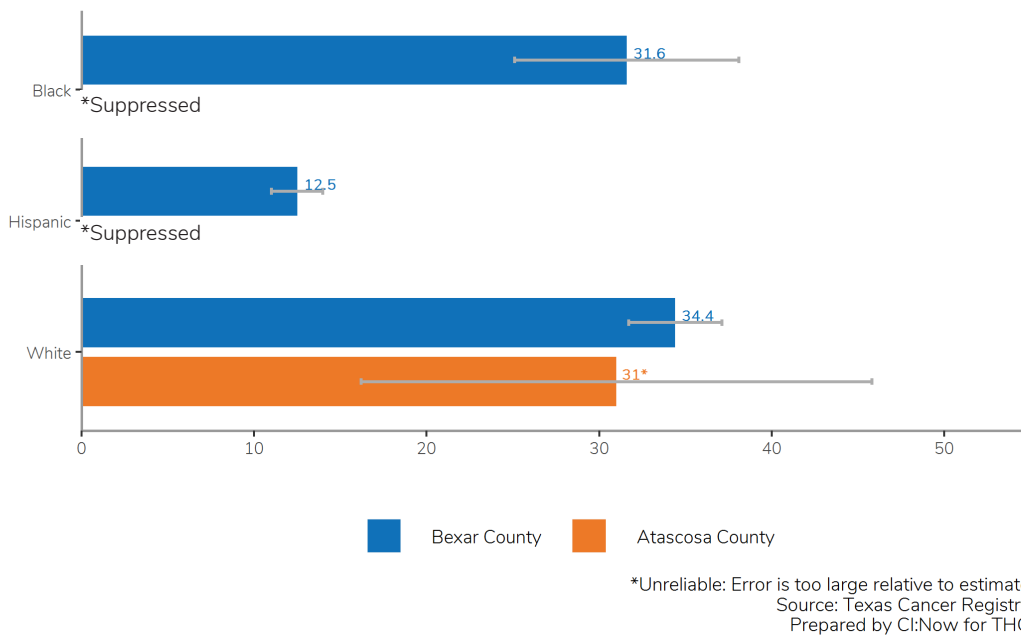
# Section 7: Health Outcomes

Among Bexar females, age-adjusted colon and rectum cancer incidence appears highest among black women (Fig. 7.14.4), with the disparity in mortality rate even more stark (Fig. 7.14.5). Among Bexar males, though, age-adjusted incidence actually appears highest in Hispanics (Fig. 7.14.6). Age-adjusted mortality is relatively lower among whites of both sexes (Fig. 7.14.7).

Fig. 7.14.4 Age-adjusted colon and rectum cancer rate among females by race per 100,000 population, 2016
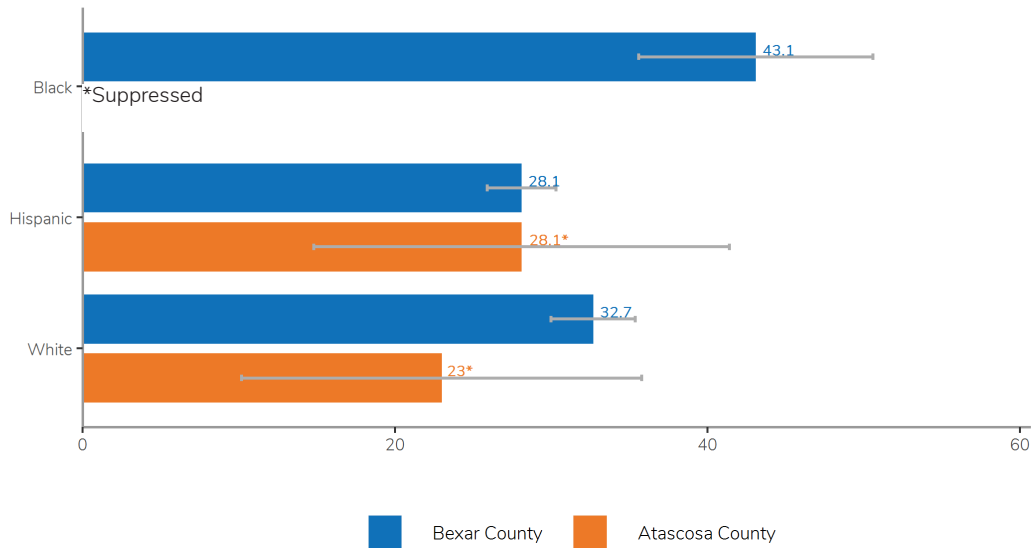


*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC

Fig. 7.14.5 Age-adjusted colon and rectum cancer mortality rate among females by race per 100,000 population, 2016



*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
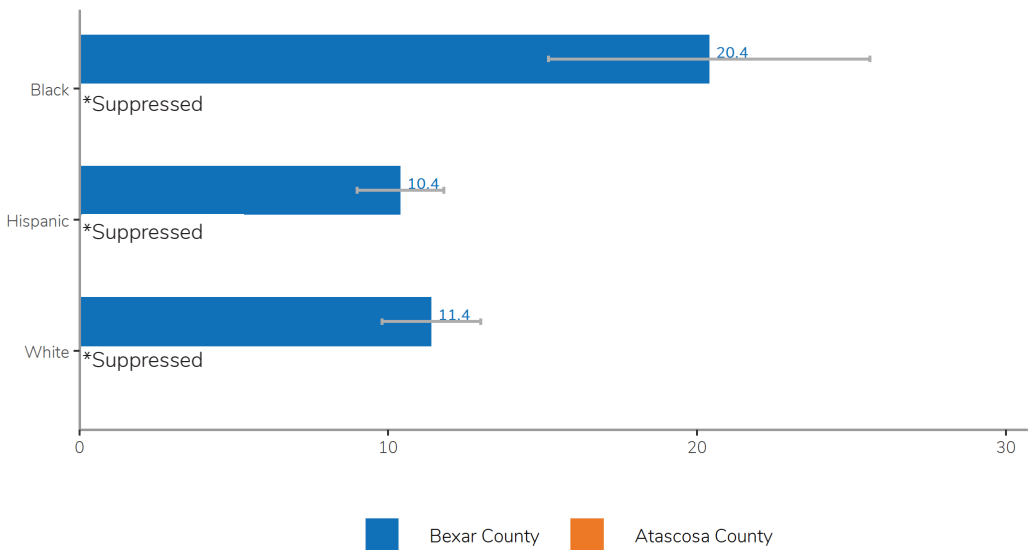
Fig. 7.14.6 Age-adjusted colon and rectum cancer rate among males by race per 100,000 population, 2016



*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
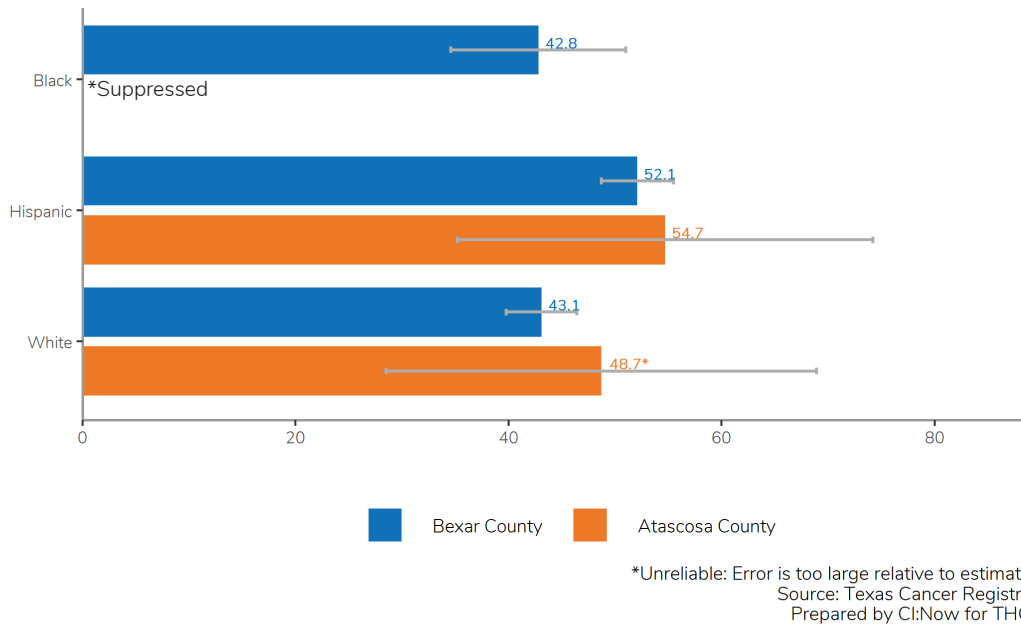
Fig. 7.14.7 Age-adjusted colon and rectum cancer mortality rate among males by race per 100,000 population, 2016



*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
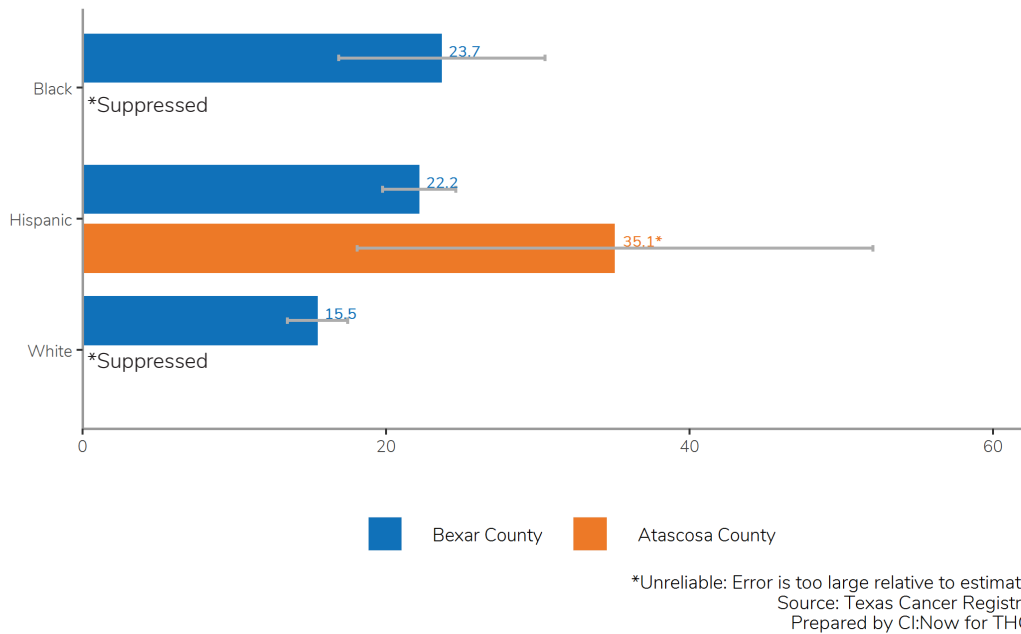
# Section 7: Health Outcomes

Even after taking confidence intervals into account, age-adjusted prostate cancer incidence and mortality are both far higher among blacks in Bexar than either Hispanics or whites (Fig. 7.14.8 and Fig. 7.14.9). The disparity in prostate cancer outcomes between black and white men has been attributed to socioeconomic barriers to care and treatment rather than any genetic factor.[40] Hispanics had the lowest incidence and mortality of the three race/ethnicity groups.

Fig. 7.14.8 Age-adjusted prostate cancer rate among males by race per 100,000 population, 2016



*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
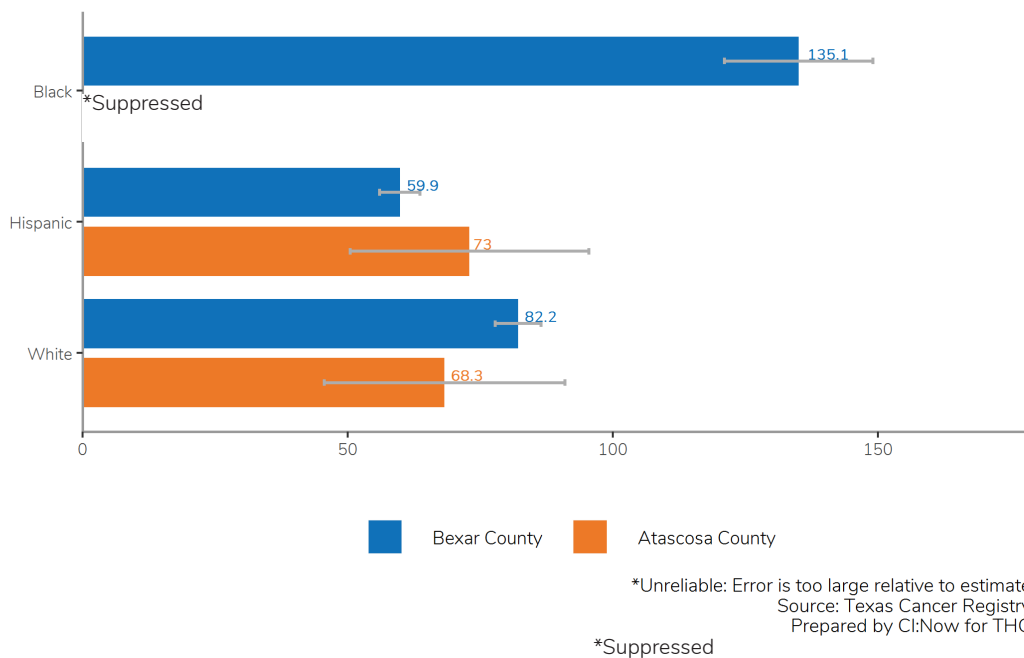
Fig. 7.14.9 Age-adjusted prostate cancer mortality rate among males by race per 100,000 population, 2016



*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
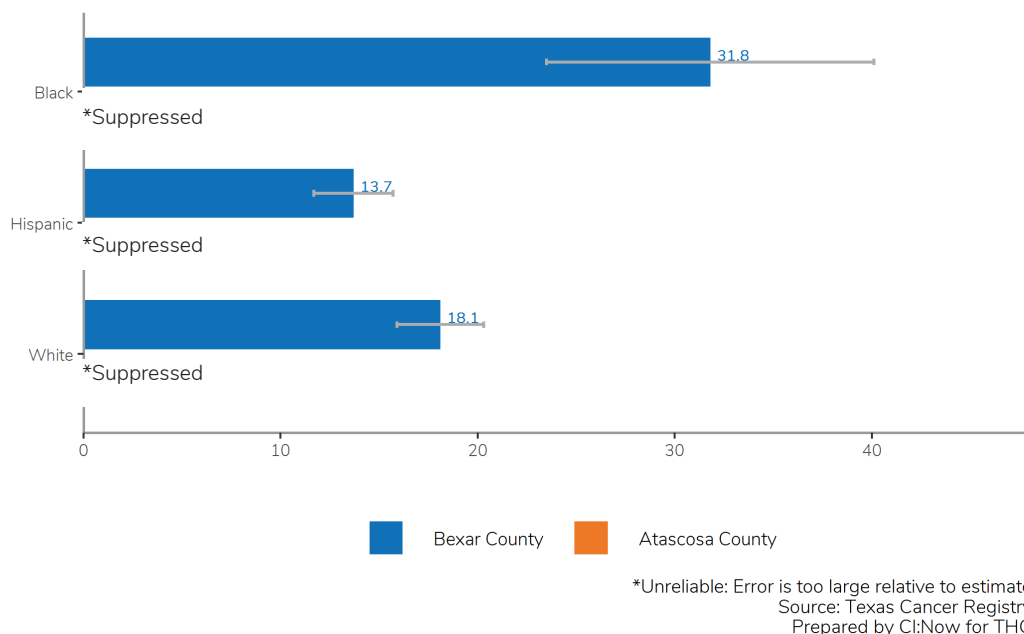
40. See for example Dess RT, Hartman HE, Mahal BA, et al. Association of Black Race With Prostate Cancer–Specific and Other-Cause Mortality. JAMA Oncol. Published online May 23, 20195(7):975–983.

# Section 7: Health Outcomes

Unlike prostate cancer, breast cancer incidence appears lower among black women than among white women, with Hispanic women again having the lowest incidence (Fig. 7.14.10). Yet as with prostate cancer, breast cancer mortality is higher among black women than white or Hispanic women, likely due to a complex set of socioeconomic and genetic factors[41] (Fig. 7.14.11). The degree of disparity appears differ by age group for both prostate and breast cancer, however, offering hope that the gaps can be closed.[42]

Fig. 7.14.10 Age-adjusted breast cancer rate among females by race per 100,000 population, 2016
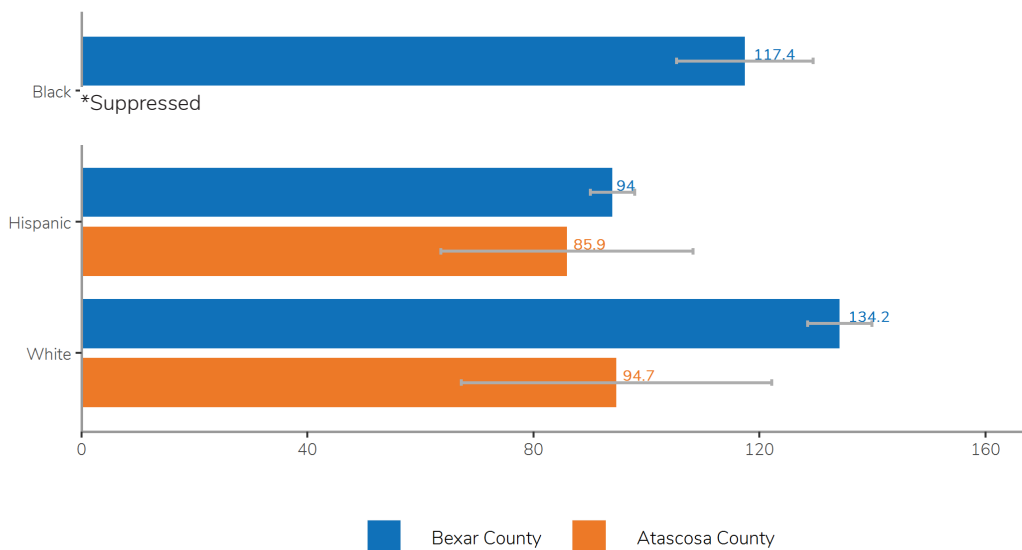


*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC

41. See for example Blau, M. (2019, May 15). Black women more likely to die of breast cancer – especially in the South. Stateline. The Pew Charitable Trusts.
42. DeSantis, C. E., Miller, K. D., Goding Sauer, A. , Jemal, A. and Siegel, R. L. (2019), Cancer statistics for African Americans, 2019. CA A Cancer J Clin, 69: 211-233.

Fig. 7.14.11 Age-adjusted breast cancer mortality rate among females by race per 100,000 population, 2016



*Unreliable: Error is too large relative to estimate
Source: Texas Cancer Registry
Prepared by CI:Now for THC
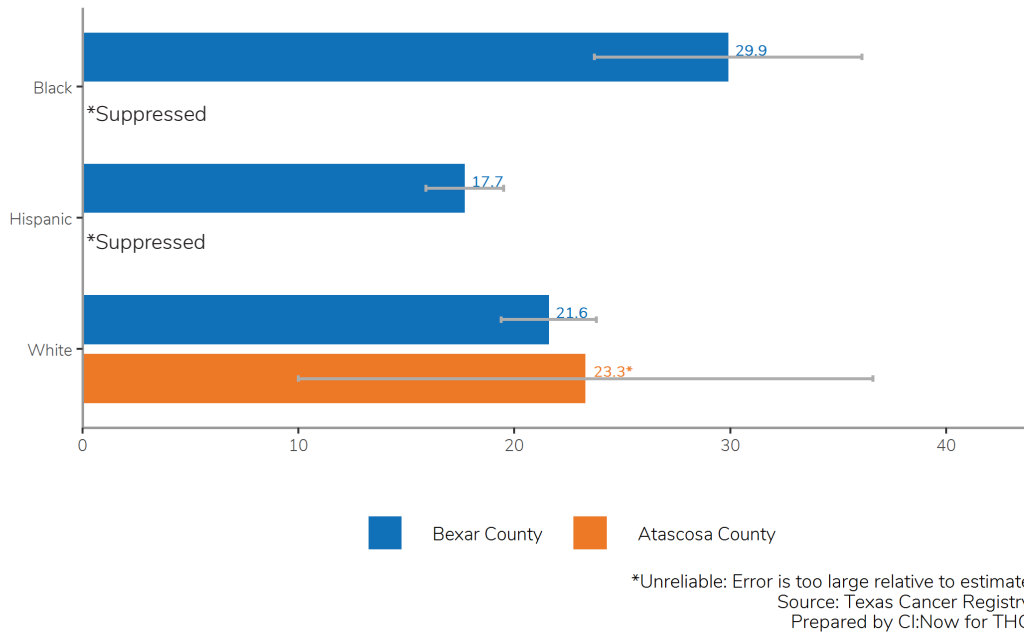
## Diabetes

About one in eight adult BRFSS respondents reported that they had been told by a provider they had diabetes (Fig. 7.15) Although the margins of error are quite wide for the Atascosa area, Bexar Hispanics appear more likely than non-Hispanic whites to have been told they have diabetes (Fig. 7.15.1). Some variation among Bexar sectors is clear. The Near Westside has a higher percentage than the Far Northside, Far Northwest, and Near Northside; the difference is statistically significant (Fig. 7.15.2).

Fig. 7.15 Percent of adults told by a provider they have diabetes, 2011-2017



*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC
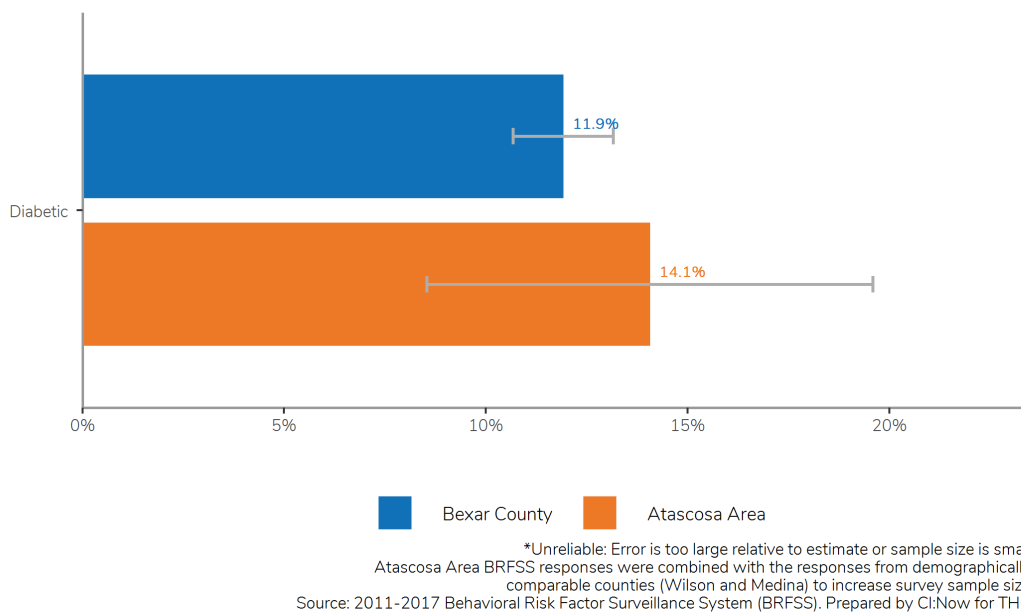
Fig. 7.15.1 Percent of adults told by a provider they have diabetes by race, 2011-2017
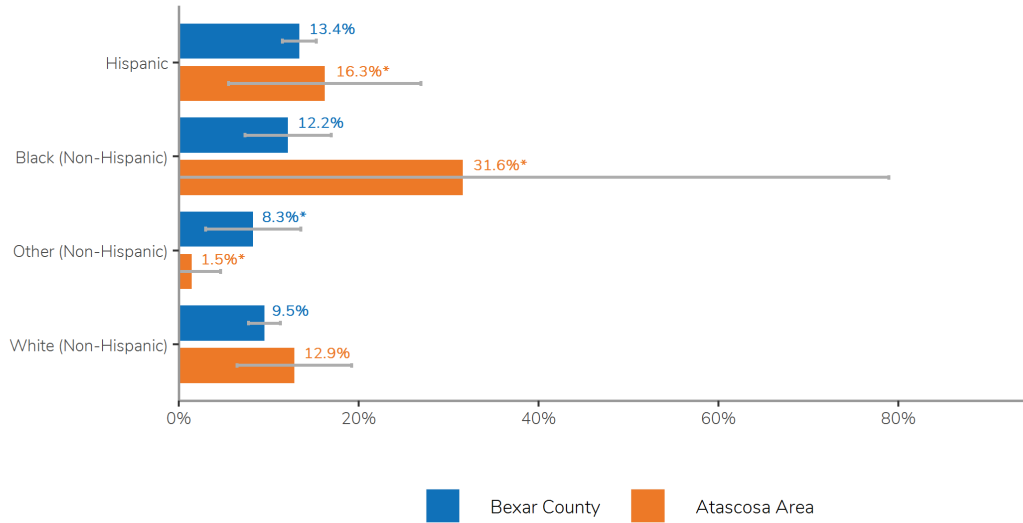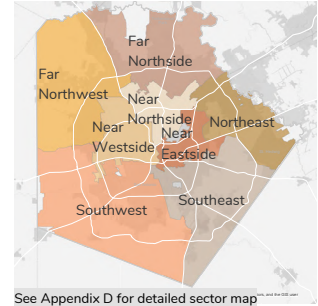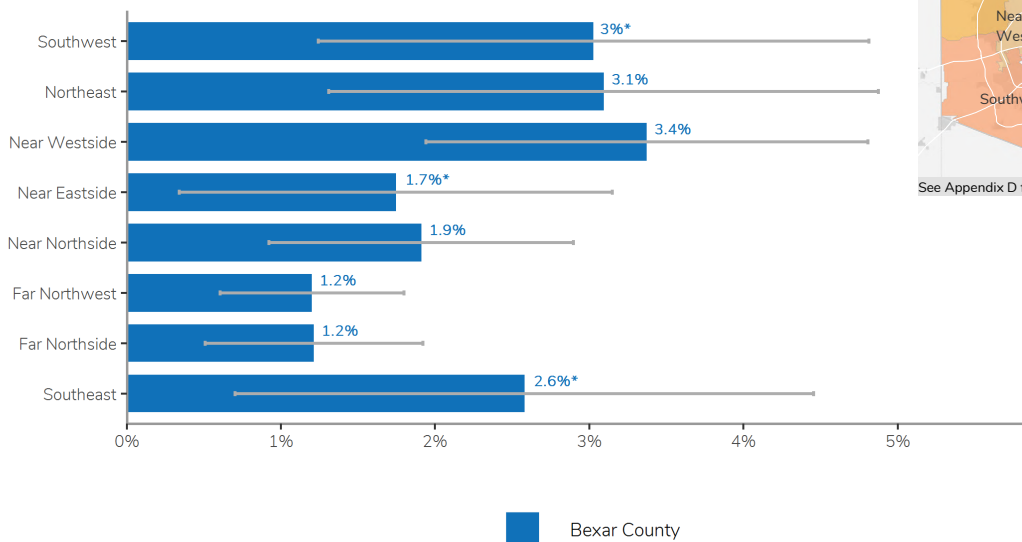


**Bexar County**  **Atascosa Area**

*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 7.15.2 Percent of adults told by a provider they have diabetes by sector, 2011-2017
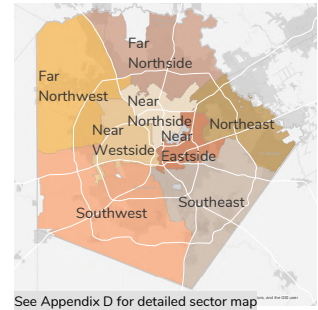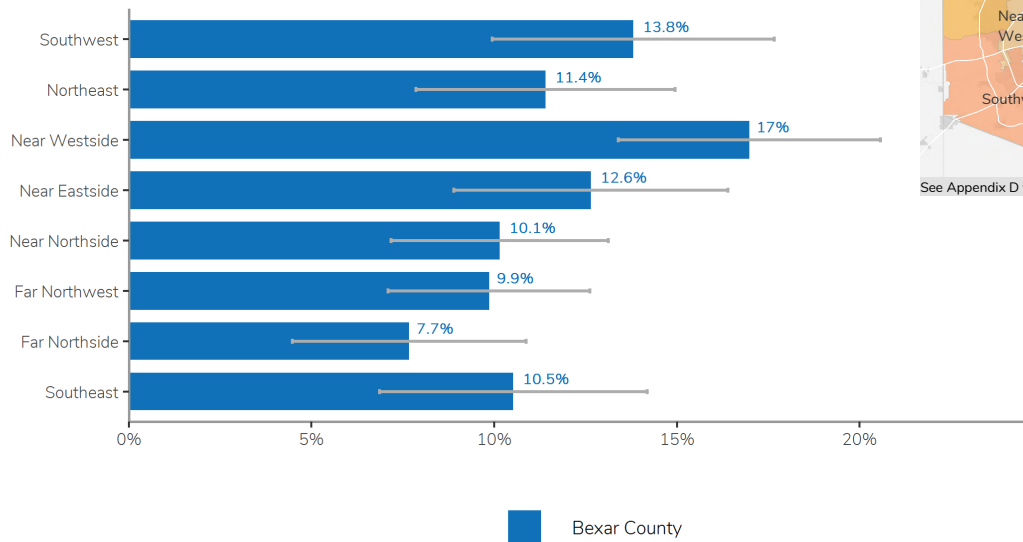


See Appendix D for detailed sector map

**Bexar County**

*Unreliable: Error is too large relative to estimate or sample size is small
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

# Section 7: Health Outcomes

About 34 per 10,000 Bexar older adults and 45 per 10,000 Atascosa older adults were hospitalized with a primary discharge diagnosis of long-term diabetes (Fig. 7.15.3). In both counties, the rate among adults aged 18 to 64 is about half as high as among older adults. Uncontrolled diabetes is a significant primary discharge diagnosis for older adults in both counties, but there are virtually zero among those under 18 years old (Fig. 7.15.4).

Fig. 7.15.3 Percent of hospital discharge for a primary diagnosis of long term diabetes by age group, 2017
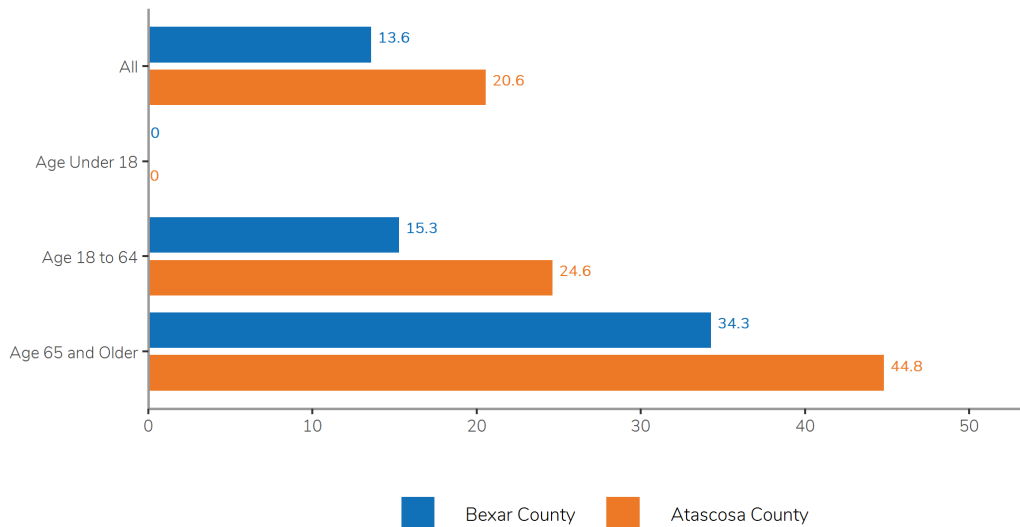


*Unreliable: Error is too large relative to estimate
Source: Texas Hospital Inpatient Discharge Public Use Data File, 2017. Texas Department of State Health Services, Center for Health Statistics, Austin, Texas.
Prepared by CI:Now for THC

Fig. 7.15.4 Percent of hospital discharge for a primary diagnosis of uncontrolled diabetes by age group, 2017
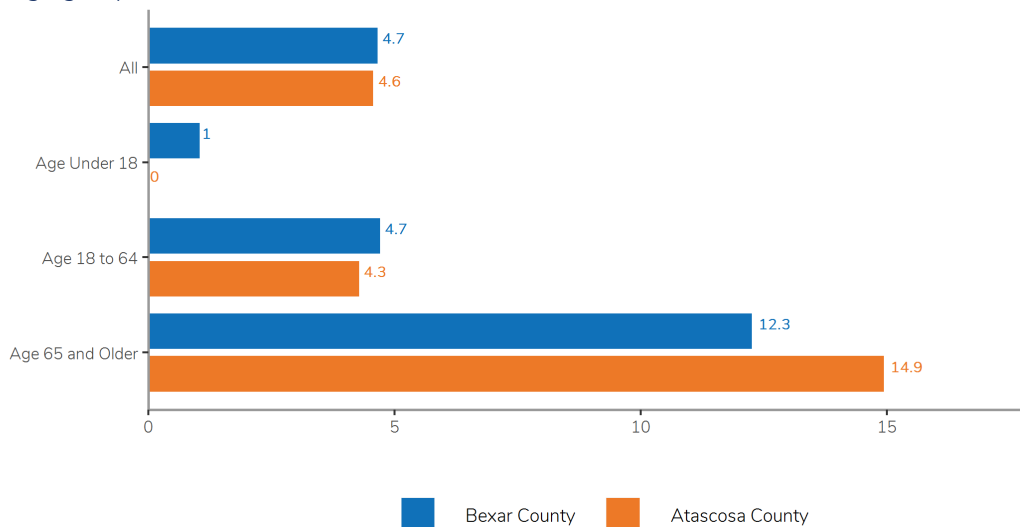


*Unreliable: Error is too large relative to estimate
Source: Texas Hospital Inpatient Discharge Public Use Data File, 2017. Texas Department of State Health Services, Center for Health Statistics, Austin, Texas.
Prepared by CI:Now for THC

## Hypertension, heart disease, and stroke

About two percent of Bexar BRFSS respondents report having ever had a stroke (Fig. 7.16). The margins of error are too wide to identify differences among race/ethnicity groups (Fig. 7.16.1). The Near Westside sector appears to have a greater percentage than do the Far Northwest and Far Northside (Fig. 7.16.2).

Fig. 7.16 Percent of adults who have ever had a stroke, 2011-2017
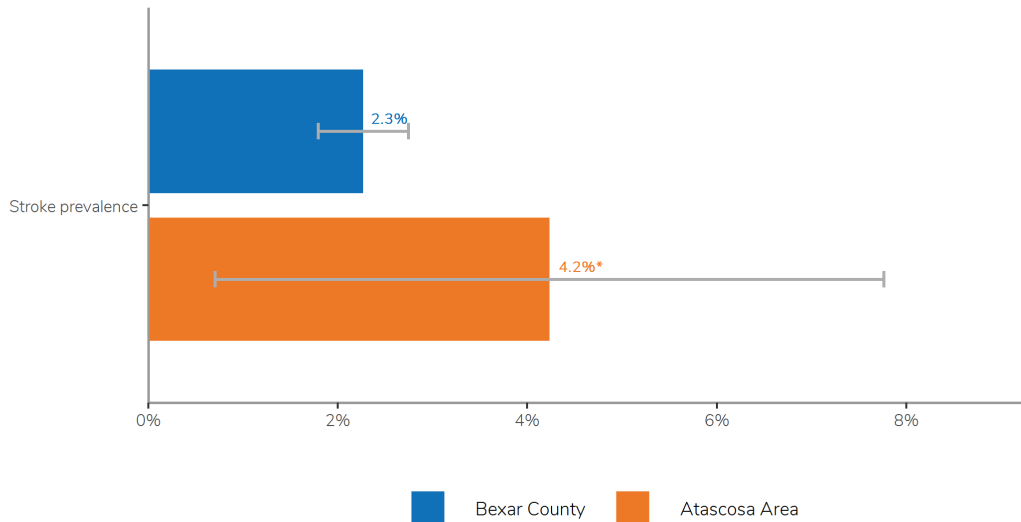


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 7.16.1 Percent of adults who have ever had a stroke by race, 2011-2017
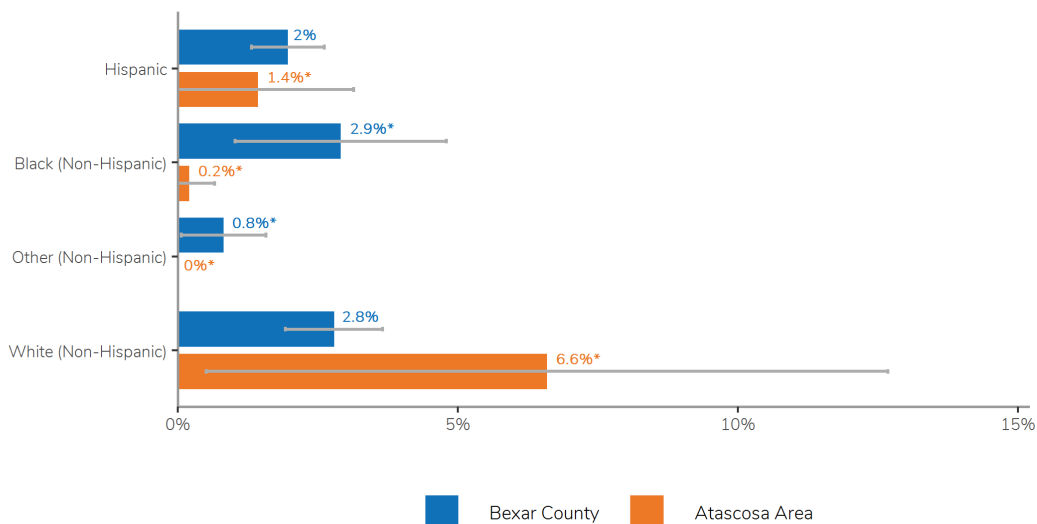


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically
comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

## Fig. 7.16.2 Percent of adults who have ever had a stroke by sector, 2011-2017



Southwest — 3%*
Northeast — 3.1%
Near Westside — 3.4%
Near Eastside — 1.7%*
Near Northside — 1.9%
Far Northwest — 1.2%
Far Northside — 1.2%
Southeast — 2.6%*

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

The cerebrovascular disease hospitalization rate among adults 65 and older is quite high in both counties – four to five times as high as for hypertension, nearly three times as high as for heart failure and diabetes (long-term), and just over twice as high as for asthma. The rate is about 12% higher among older adults in Atascosa compared to Bexar.

## Fig. 7.16.3 Rate of hospital discharge for a primary diagnosis of cerebrovascular disease by age group per 10,000 population, 2017
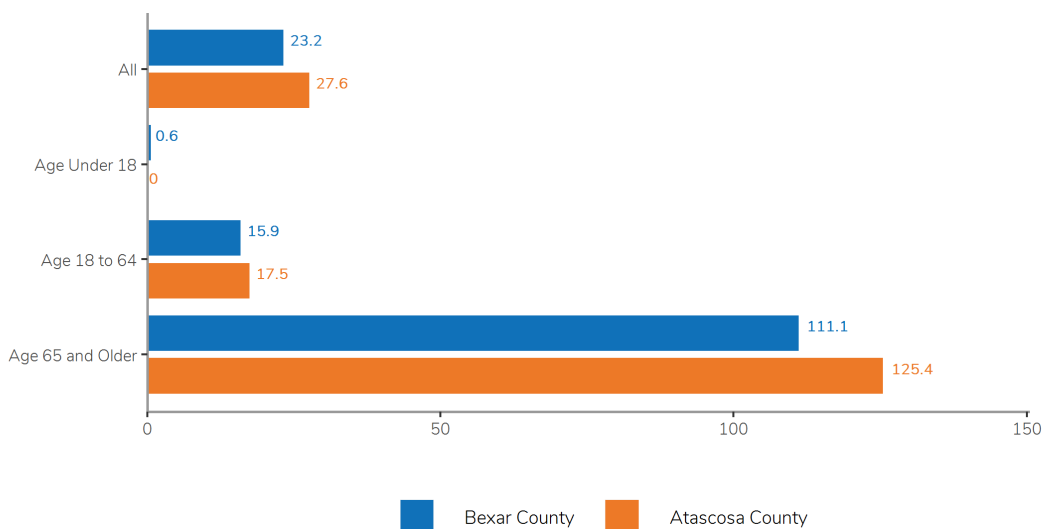


All — 23.2 / 27.6
Age Under 18 — 0.6 / 0
Age 18 to 64 — 15.9 / 17.5
Age 65 and Older — 111.1 / 125.4

Bexar County    Atascosa County

*Unreliable: Error is too large relative to estimate
Source: Texas Hospital Inpatient Discharge Public Use Data File, 2017. Texas Department of State Health Services, Center for Health Statistics, Austin, Texas. Prepared by CI:Now for THC

# Section 7: Health Outcomes

A slightly higher percent of BRFSS respondents report ever being told that they had angina or coronary heart disease (Fig. 7.16.4). The proportion appears significantly higher among non-Hispanic whites in both counties than other race/ethnicity groups (Fig. 7.16.5), but no clear differences emerge among Bexar sectors (Fig. 7.16.6).

Fig. 7.16.4 Percent of adults who have ever been told they had angina or coronary heart disease, 2011-2017
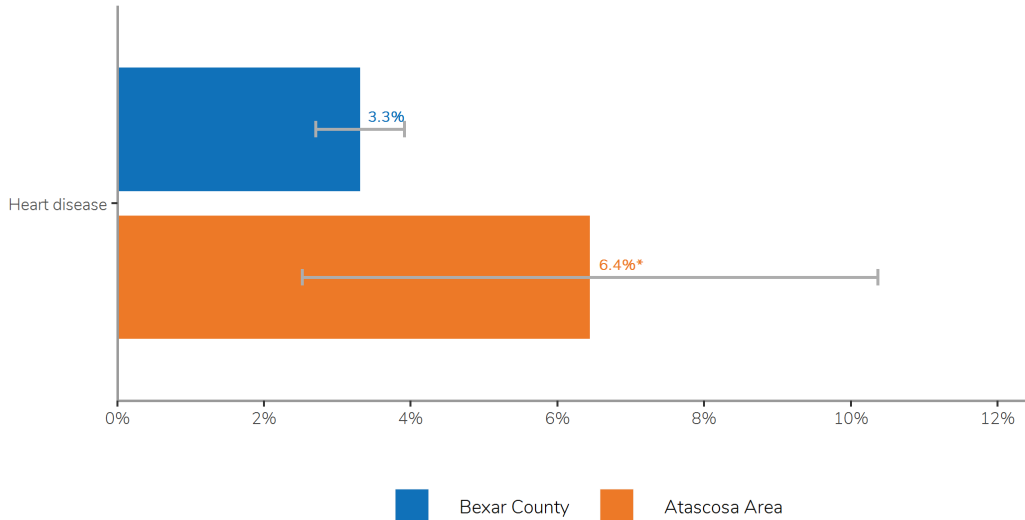


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 7.16.5 Percent of adults who have ever been told they had angina or coronary heart disease by race, 2011-2017
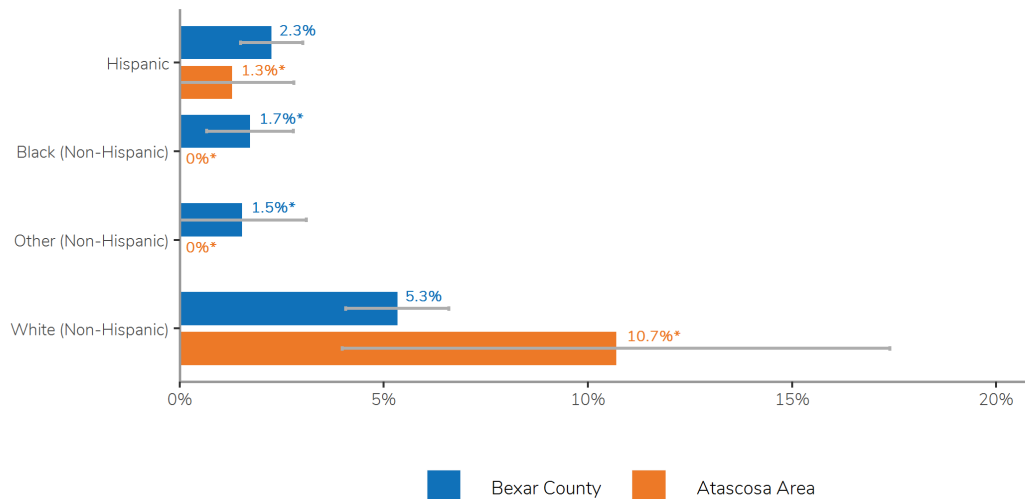


*Unreliable: Error is too large relative to estimate or sample size is small
Atascosa Area BRFSS responses were combined with the responses from demographically comparable counties (Wilson and Medina) to increase survey sample size
Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

Fig. 7.16.6 Percent of adults who have ever been told they had angina or coronary heart disease by sector, 2011-2017
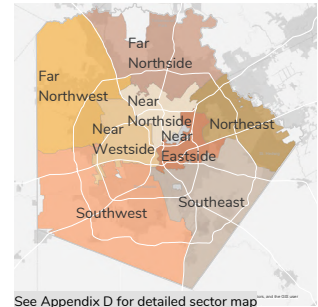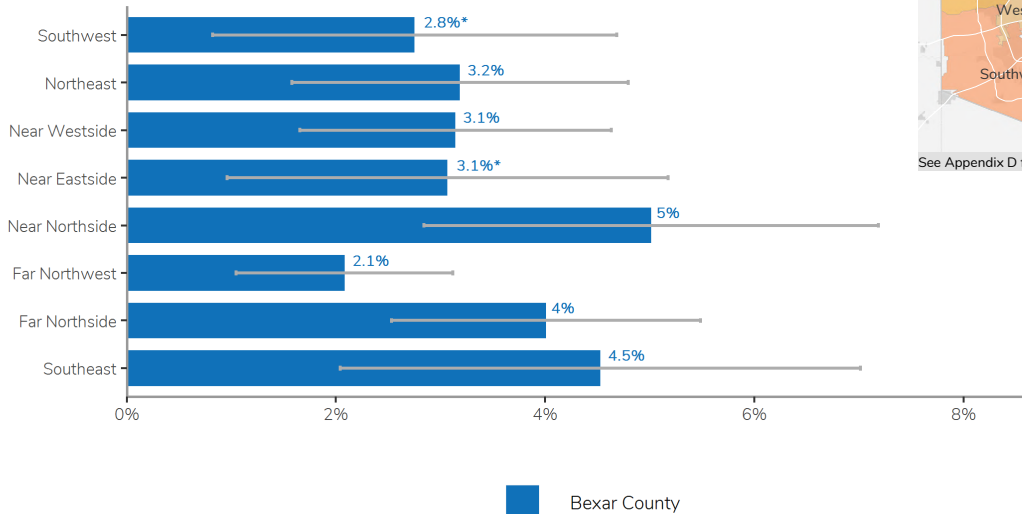


See Appendix D for detailed sector map

Bexar County

*Unreliable: Error is too large relative to estimate or sample size is small

Source: 2011-2017 Behavioral Risk Factor Surveillance System (BRFSS). Prepared by CI:Now for THC

It is worth noting that the Atascosa hospitalization rate among adults 65 and older is higher than among Bexar adults for every primary discharge diagnosis examined: asthma, cerebrovascular disease, both long-term and uncontrolled diabetes, heart failure, and hypertension. The Atascosa hospitalization rate among adults 18 to 64 is higher than Bexar for four of the six primary discharge diagnoses with rates above 1.0 per 10,000: asthma, cerebrovascular disease, and both long-term and uncontrolled diabetes. Conversely, although the rates are quite small for all primary discharge diagnoses except asthma, the child and youth (age 0-17) hospitalization rate is higher in Bexar than Atascosa for four of the five diagnoses with a non-zero rate: asthma, cerebrovascular disease, uncontrolled diabetes, and heart failure.

# Section 7: Health Outcomes

## Leading causes of death

Heart disease and cancer are leading causes of death common to the 18-64 and 65-and-older age groups in both counties (Fig. 7.17). Accidents, suicide, and chronic liver disease and cirrhosis also appear near the top of the list for the 18-64 age group, replaced by cerebrovascular disease, Alzheimer's disease, and chronic lower respiratory disease in the older population.

Fig. 7.17 Leading causes of death and crude death rate per 100,000 population by age group, 2013-2017

| Bexar County, 2013-2017 | Crude Death Rate |
| --- | --- |
| **Less than 1 year** | |
| Certain conditions originating in the perinatal period | 307.3 |
| Congenital malformations, deformations and chromosomal abnormalities | 155.5 |
| Accidents (unintentional injuries) | 15.3 |
| Diseases of heart | Unavailable |
| **1-17 years** | |
| Accidents (unintentional injuries) | 5.4 |
| Malignant neoplasms | 2.5 |
| Assault (homicide) | 2.0 |
| Intentional self-harm (suicide) | 1.8 |
| Congenital malformations, deformations and chromosomal abnormalities | 1.2 |
| **18-64 years** | |
| Malignant neoplasms | 71.7 |
| Diseases of heart | 60.1 |
| Accidents (unintentional injuries) | 35.8 |
| Chronic liver disease and cirrhosis | 18.4 |
| Intentional self-harm (suicide) | 15.3 |
| **65+ years** | |
| Diseases of heart | 1,058.0 |
| Malignant neoplasms | 806.9 |
| Cerebrovascular diseases | 277.7 |
| Alzheimer's disease | 240.3 |
| Chronic lower respiratory diseases | 224.7 |

Source: CDC WONDER online data, Compressed Mortality, 2013-2017, https://wonder.cdc.gov/mortSQL.html.
.

Data are not available for younger people in Atascosa, but unintentional injury (accidents), intentional injury (homicide and suicide), and cancer are among the leading causes of death among Bexar children and adolescents, while perinatal conditions (e.g., consequences of prematurity and low birthweight, pregnancy complications, birth trauma, and infections), birth defects, and accidents top the list for infants younger than one year. Age-specific (crude) death rates per 100,000 population for Atascosa are presented for all of these conditions in Fig. 7.17.1.

Fig. 7.17.1 Leading causes of death and crude death rate per 100,000 population by age group, 2013-2017

| Atascosa County, 2013-2017 | Crude Death Rate |
|---|---|
| **18-64 years** | |
| Diseases of heart | 114.1 |
| Malignant neoplasms | 97.7 |
| Accidents (unintentional injuries) | 49.2 |
| Intentional self-harm (suicide) | 18.5 |
| Chronic liver disease and cirrhosis | 17.8 |
| **65+ years** | |
| Diseases of heart | 1,070.6 |
| Malignant neoplasms | 771.4 |
| Cerebrovascular diseases | 281.6 |
| Alzheimer's disease | 266.9 |
| Chronic lower respiratory diseases | 220.0 |

Source: CDC WONDER online data, Compressed Mortality, 2013-2017, https://wonder.cdc.gov/mortSQL.html.

## Life expectancy and premature death

Years of Potential Life Lost (YPLL) before age 75 is a measure of premature death, defined as death prior to age 75. Although it appears to have risen sharply in Atascosa before falling again, the relatively small number of deaths in each year results in a very wide margin of error that prevents any certainty about that trend (Fig. 7.18). However, the greater YPLL in Atascosa compared to Bexar, Texas, and the U.S. is clear. Overall YPLL is fairly level in Bexar County. It is worth noting that these are trends of three-year averages,[43] meaning that the most recent data point (2015-2017) includes 2016 and 2015 deaths. Similarly, the earliest data point reflects deaths from 2010 through 2012.

Fig. 7.18 Years of potential life lost (YPLL) before age 75 per 100,000 population
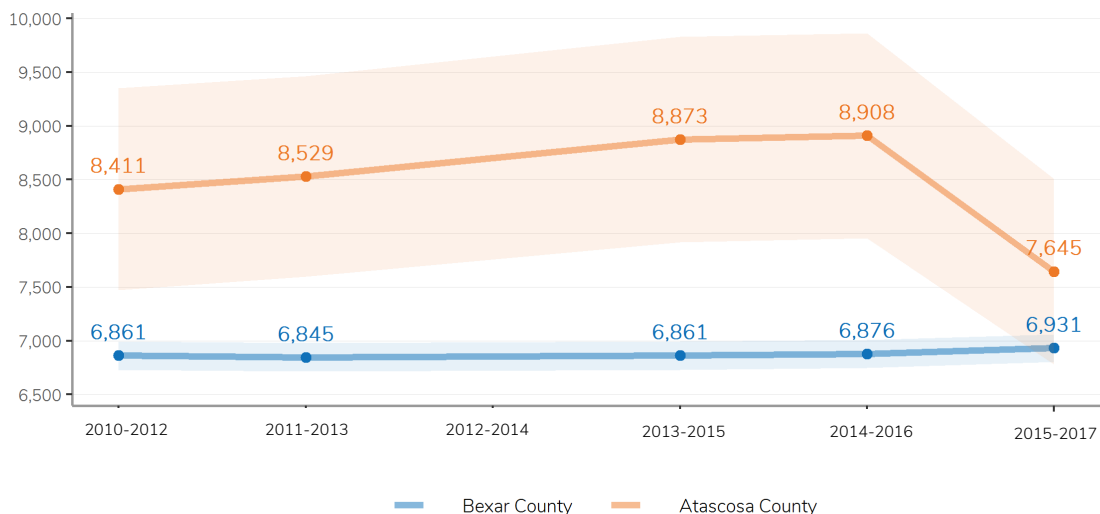


*Unreliable: Error is too large relative to estimate
Source: University of Wisconsin Population Health Institute. County Health Rankings
Prepared by CI:Now for THC

43. County Health Rankings did not publish YPLL for the 2012-2014 three-year period. The 2018 County Health Rankings report calculates the YPLL based on 2013-2015 death data and the 2019 report calculates the YPLL based on death data from 2015-2017. Fig. 7.18 shows the actual periods for YPLL calculations and not the report publication dates.

# Section 7: Health Outcomes

Acute disparities appear when YPLL is examined by race/ethnicity. Current Bexar YPLL stands at 9,503 for African-Americans, 6,934 for Hispanics, and 6,548 for non-Hispanic whites, indicating a tremendously greater degree of premature death among African-Americans than among other race/ethnicity groups. YPLL is about a third higher in Atascosa at 8,943 for Hispanics and 8,813 for non-Hispanic whites. The number of deaths among Atascosa African-Americans was too small to calculate YPLL.

Life expectancy is the number of years a person born today could expect to live if current rates remain constant. Current life expectancy is 78 years for Atascosa, 79 for Bexar, and 79 for Texas. Life expectancy is highest in both counties among Hispanics – 80 in Bexar, 79 in Atascosa – and slightly lower among non-Hispanic whites (79 in Bexar, 78 in Atascosa). Life expectancy among Bexar African-Americans is only 76 years; Atascosa data is not available.[44]

The U.S. Small-area Life Expectancy Estimates Project (USALEEP) has calculated life expectancy at the census tract level, here overlaid with zip code boundaries as a reference point (Fig. 7.18.1). Life expectancy ranges from 69 to 88 years depending on neighborhood; the census tracts with the highest life expectancy are largely clustered on Bexar County's northside. Some census tracts with the highest life expectancy – those around downtown San Antonio and in more rural areas in Atascosa, far east Bexar, and far north Bexar – have a wider standard error or degree of uncertainty. The census tracts with the lowest life expectancy are largely clustered on San Antonio's Westside, Southside, and Eastside, reaching up the Loop 410/I-35 corridor. An area of northern Atascosa stands out as well, covering zip codes 78065 and 78069.

44. County Health Rankings. (2019). Texas: Measures: Life expectancy. Retrieved from https://www.countyhealthrankings.org/app/texas/2019/measure/outcomes/147/data

Fig. 7.18.1 Life expectancy at birth in years by census tract, 2015-2017



**Life Expectancy**

| | |
|---|---|
| | 69 to 74 |
| | > 74 to 77 |
| | > 77 to 79 |
| | > 79 to 81 |
| | > 81 to 88 |

Source: US Small-area Life Expectancy Estimates Project

Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community
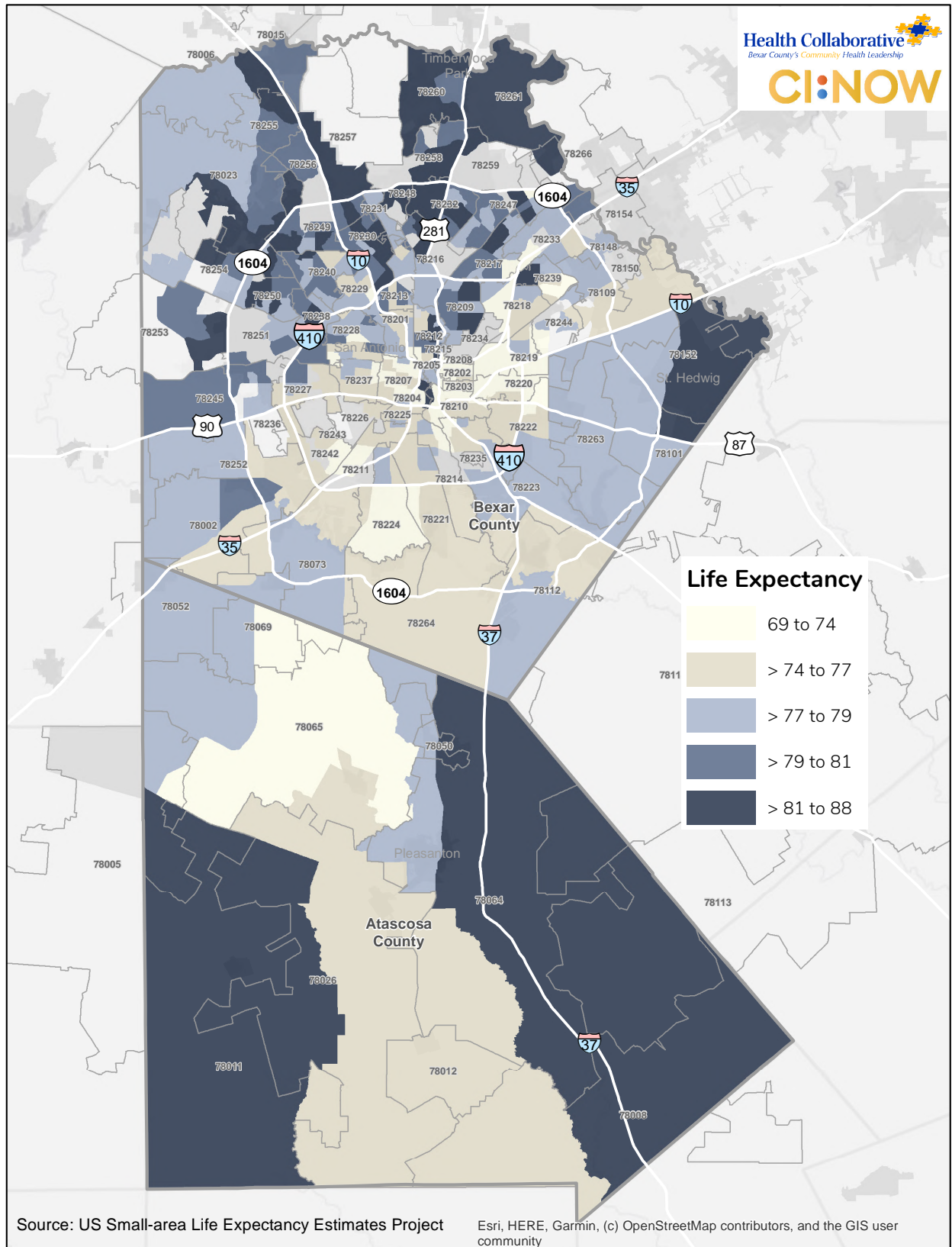
# Conclusion

## What issues stand out?

This assessment explores issues in every section of the BARHII upstream-downstream continuum. Unfortunately, however, no indicators are available to directly measure structural discrimination or implicit bias, and a policy analysis is beyond the scope of the assessment.

Source: Bay Area Regional Health Inequities Initiative. Used with permission.
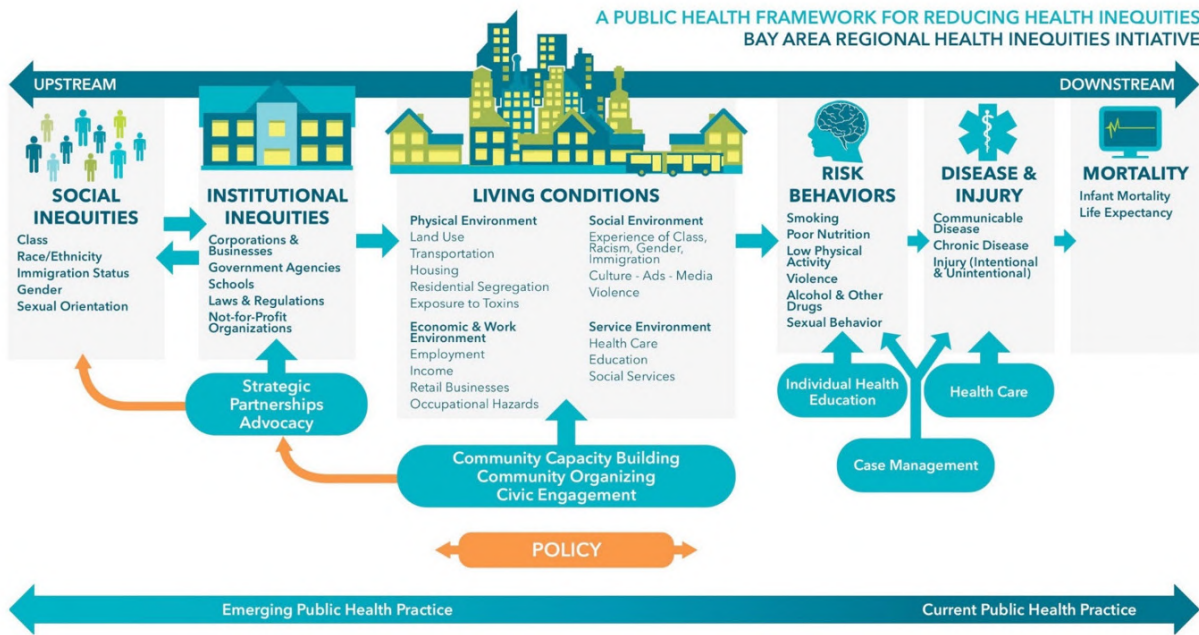


A handful of issues rise to the top[1] in each of the latter four sections, as shown in the table below. Issues in bold type stand apart from the rest for the high degree of consensus on their importance.

| Living Conditions | Health Behaviors & Risks | Disease & Injury | Mortality |
|---|---|---|---|
| **Access to health care, including mental health care** | Healthy eating and physical activity | Quality of life | Life expectancy |
| **Housing stability and homelessness** | Vaccinations | Mental illness | Premature mortality |
| **Income and poverty** | Overweight and obesity | Substance use and abuse | |
| Education and literacy | | | |
| Mobility and transportation | | | |
| Crime and violence | | | |

Notably, all three high-consensus issues were "upstream" issues – Service Environment, Physical Environment, and Economic and Work Environment – rather than the "downstream" issues of disease and death. The downstream issues that rose to the top related largely to disparities in length and quality of life.

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1.Issues to be highlighted in this Conclusion were selected by the Community Health Needs Assessment Steering Committee, with discussion and consensus following individual selection. This work was informed both by a large volume of preliminary assessment data and each member's own understanding of health and well-being in Bexar and Atascosa counties.

# Conclusion

Worth noting, too, is that most of these issues are consistent with – though not entirely inclusive of – major themes that emerged from neighborhood resident focus groups: better access to and awareness of health care, health education, and other services and supports; access to affordable, healthy (and enjoyable) food and opportunities for exercise and recreation; and freedom from crime and safety problems like robbery, family and sexual violence, human trafficking, free-roaming dogs, and broken-up sidewalks. Neighborhood residents also returned again and again to the notions of relationship and communication – among families, among neighborhoods, between residents and police, and between residents and policymakers. Unfortunately, the quantitative data available captures those issues very poorly or not at all.

Key informant interviewees also stressed better access to healthy food and safe and accessible public spaces. Access to health care, health education, and related services was also prioritized, but through a system-change lens, recognizing a need for better collaboration across issues and sectors, a stronger emphasis on prevention, and wider adoption of trauma-informed care and other approaches to mitigate the consequences of adverse childhood experiences. Education, employment, transportation, mental illness, and domestic violence were also identified specifically as factors critical to health and well-being. As one interviewee put it, *"It's hard to pull out what's a health issue and what's an education issue and what's a financial issue, because they're all related."* And like neighborhood residents, interviewees recognized the foundational need for relationships, communication, trust, and strong communities.

## How do those issues relate to each other?

Entire fields of study are devoted to understanding the intersections and relationships among the issues highlighted above, and this assessment will not attempt a review of that body of evidence. Not every intersection is an obvious one, though, and the Community Health Needs Assessment Steering Committee saw value in offering a high-level overview of how a few of the highlighted "upstream" issues relate to each other and to health and well-being. Of the highlighted issues related to Living Conditions, access to health care is the upstream factor that is most widely and traditionally understood to affect health and well-being, so the brief overview below focuses on the other five: income and poverty, housing stability and homelessness, education and literacy, transportation and mobility, and crime and safety.

For each of those five issues, the tables on the following page identify key pathways through which the issue impacts health and well-being, whether the effect is direct or indirect. As a reminder that in real life "upstream-downstream" is a system – a loop rather than a line – the tables also note some of the ways that health in turn appears upstream of the issue. Underlying and constantly interacting with all of these factors, of course, are social and institutional inequities at the starting point of the BARHII model.

**Health behaviors/risks and health outcomes**

## How health is affected by

## Income and poverty

### What's part of this issue?

Labor force participation

Employment

Wages

Ratio of earners to dependents in a household

Benefits

Other assets and wealth

Living expenses and basic needs

### Direct effects on health

Chronic poverty and near-poverty contribute to toxic stress, depression, and substance abuse

Working multiple jobs to make ends meet typically makes it much harder to eat healthy and stay physically active

For people living in poverty and near-poverty, the costs of preventive care – out of pocket costs, lost wages – are a tremendous barrier to services like vaccination and screening

Poverty and near-poverty may lead to engagement in criminal activity to make ends meet, increasing health risks for themselves and others

### How health affects this issue

Depression, substance use, disability, and chronic pain are barriers to labor force participation and employment

For those without paid sick leave, chronic disease or frequent acute illness – their child's or their own – mean lost wages

Chronic disease increases medical care costs, a component of living expenses

### Indirect effects on health

Via access to care: absent employer-sponsored coverage, health insurance is often unaffordable

Via housing stability: low income and increasingly unaffordable housing push people into poor quality housing with health risks or into homelessness; tight budgets result in deferred home maintenance, increasing health risks

Via education and literacy: poverty makes it harder to pursue education and training beyond high school

Via mobility/transportation: without a car it's much harder to get to a grocery with healthy food, to safe places to exercise, or to health care appointments

## Health behaviors/risks and health outcomes

## How health is affected by

# Education and Literacy

## What's part of this issue?

Literacy

Health literacy

Primary and secondary education

Post-secondary education

Informal education and training

On-the-job training

### Direct effects on health

Education and training can build health-related knowledge (e.g., what foods are healthy), attitudes (e.g., whether help-seeking and self-care are important), and beliefs (e.g., whether it's possible to improve one's own health)

Better education – formal or informal – better equips people to understand disease, self-manage chronic illness, and care for family members

Education and training can build problem-solving skills that help people address health challenges and navigate the complex health care system

Education can build perseverance, belief in one's own abilities, and ability to advocate for oneself and one's family

### How health affects this issue

Their own or a family member's health issue may result in a child entering school not ready to learn, creating a gap that is hard to close

Depression, substance use, and pregnancy can interfere with school attendance, learning, and completion of high school or post-secondary education or training

Lead exposure impairs cognitive function, especially in young children

### Indirect effects on health

Via access to care: low education and skills put jobs with affordable employer-sponsored health insurance out of reach

Via income and poverty: low education and skills put higher-wage jobs out of reach and limit one's ability to choose a higher-opportunity neighborhood

Via crime and violence: education can reduce the likelihood of criminal justice involvement, reducing one's own health risks and reducing a key force that disrupts social connections and neighborhood stability

## Health behaviors/risks and health outcomes

How health is affected by

## Housing stability and homelessness

### What's part of this issue?

Housing affordability

Housing quality and condition

Accessibility and universal design

Service-enriched housing

"Doubling up" and other unstable housing

Short-term and chronic homelessness

### Direct effects on health

Housing available to low-income people is more likely to have mold and pest issues that worsen or trigger asthma and other respiratory issues

Exposure to lead in paint, dust, and soil increases the risk of cognitive impairment, especially in young children

Poorly-maintained housing introduces health and safety risks like uneven or rotted flooring, unsafe electrical wiring, or sewage backups

Housing without features like ramps and grab bars increase the risk of injury among frail older people and people with a disability

Housing without climate control increases the risk of heat stroke in summer and electrical fires from space heaters in winter

Frequent moves interrupt social connections and weaken neighborhood networks that support health (e.g., emotional support, group exercise)

Doubling up, couch-surfing, and overcrowding increase health-harming stressors

Living on the street increases risks like injury, infection, and exposure

### How health affects this issue

Depression, substance use, disability, and pain are barriers to employment

Chronic disease increases medical care costs, a component of living expenses

For those without paid sick leave, chronic disease or frequent acute illness – their child's or their own – mean lost wages

### Indirect effects on health

Via income: affordable housing may be far from good jobs, making it harder to secure and sustain employment at a higher wage

Via education: frequent moves create chaos at home and interrupt continuity of instruction, making it harder for students to learn

## How health is affected by

# Mobility and transportation

## What's part of this issue?

Neighborhood walkability

Complete streets

Transportation costs

Public transit

Private vehicles and rideshare

Biking

Dockless vehicles (scooters)

### Direct effects on health

Heavy traffic, particularly in single-passenger cars, increases commute-related stress, likelihood of accidents, and air pollution that harms respiratory health and the climate

Lack of reliable transportation makes it harder to access medical care, healthy food, and safe places to exercise

Long transportation waits and travel times on assisted transportation and public transportation reduce the time and energy available in the day for time spent with family, physical activity, and recreation and hobbies that reduce depression risk

Walking introduces the risk of street harassment and possibly bullying, pressure for gang involvement, and other problems

Complete streets can greatly improve connectivity among homes, schools, businesses, parks, and other resources that support health

### How health affects this issue

Health conditions that reduce mobility or cognitive ability make it hard or impossible to walk any distance, cycle, or use public transportation or scooters/dockless vehicles

Health conditions that reduce ability to function negatively impact employment and wages, reducing dollars available for housing

### Indirect effects on health

Via income and education: lack of transportation or transportation that takes many hours make it harder to get to work and school

Via housing: lack of transportation reduces the housing available to choose from if one must be close to work, school, child care, or family

## Health behaviors/risks and health outcomes

### Direct effects on health

Adverse childhood experiences (ACEs), crime, and violence negatively impact both short- and long-term health-related behaviors and health outcomes

Violence, abuse, maltreatment, and military conflict can directly result in physical and mental illness, physical injury, and death

Family violence not infrequently spills into workplaces and schools, increasing the risk of physical and emotional harm to unrelated people

Crime and violence in the neighborhood introduce or increase toxic stress that negatively impacts health and well-being

### How health affects this issue

Depression, anxiety, post-traumatic stress disorder, and alcohol and substance use can increase the risk of abuse/neglect, maltreatment, family violence, and becoming a victim of trafficking

Children, disabled adults, and older people with poor physical health and high-intensity health needs may be at higher risk of abuse, neglect, and maltreatment

Mental illness and addiction fuel the market for both legal and illegal drugs, increasing drug-related violence, theft, and other crime

### Indirect effects on health

Via education: bullying and the threat of violence can negatively impact learning, and family and neighborhood violence hinder attendance and learning

Via income and poverty: crime and violence can negatively impact ability to get and keep a job

Via housing: criminal activity and family violence can result in homelessness or housing instability through eviction, runaway, or fleeing an abuser

## How health is affected by

# Crime and violence

## What's part of this issue?

Family violence

Child abuse and neglect

Adult maltreatment

Drug-related violence

Human trafficking-related violence

Other assault and homicide

War/military

# Conclusion

## What are the connections to local initiatives?

As with the last discussion about how issues interrelate, there is no way to do justice to a discussion of what work organizations and residents are doing to address each of the foregoing issues locally. In every issue area – one of these five or any other in this assessment – one could identify a dozen or more advocacy initiatives, human service agencies, or both, that have worked relentlessly to deal with the issue and solve related problems. In some cases these initiatives and organizations are strongly grassroots, but in others strongly top-down, but usually a mix of both over time. With every issue area discussed above, any attempt to tie it to current local initiatives with some degree of political or public will behind it is essentially guaranteed to fail to mention ideas, policies, change campaigns, organizations, and people who have worked in the figurative trenches for some time – perhaps decades – and continue to do so.

And yet it is a mistake not to connect any dots among current local initiatives and the issues emerging from this assessment that are perceived by neighborhood residents, key informants, or the CHNA Steering Committee – or all three – to be worth close attention and discussion. Thus this narrative must begin with an ask for forgiveness for all the good and critical work that cannot be covered here. It is hoped that this section will serve not as a final word but as a starting point for ongoing local conversations about what matters and what we will do about it, both individually and together. Going forward, a good assessment of all local initiatives, program capacity, and windows of opportunity would be a valuable complement to a needs-focused assessment like this one.

One of the most noteworthy developments in the area of income and poverty is the growing number of prominent local employers – including the City of San Antonio, Bexar County, and Alamo Colleges –   establishing an internal minimum wage significantly higher than the federal minimum wage.[2] Although the resulting "living wage" of $13 to $15 per hour is likely not truly a living wage for most – particularly those with families – it is a significant boost over minimum and prior wages.

In the education arena, Pre-K 4 SA has been in operation since 2013 and is generally viewed as having positive results, although skeptics and measurement challenges remain.[3] The educational landscape in Bexar County is undergoing radical transformation to strengthen community partnerships, train future educators, expand school choice and ultimately to provide access to quality education for all students no matter where they live.  At the forefront, UTSA launched the Urban Education Institute this year, which will partner closely with twelve school districts in San Antonio on various initiatives to complete longitudinal and impact studies; produce transdisciplinary research that identifies, pilots and scales systemic improvements in public education; and create new approaches and develop solutions to address equity and access across the P-20 educational pipeline.[4]

2. See for example https://www.expressnews.com/news/education/article/Part-of-San-Antonio-trend-trustees-might-raise-13698166.php
3. See for example https://www.texastribune.org/2018/07/16/san-antonio-preschool-program-texas-voters-2020/
4: https://www.utsa.edu/today/2019/01/story/UrbanEducationInstitute.htm

# Conclusion

The ConnectSA nonprofit formed by the City of San Antonio and Bexar County seeks to address current and future transportation challenges through 2040. A draft plan was released in December 2018[5] and ConnectSA is soliciting public input.[6] At the intersection of education and mobility, Alamo Colleges and VIA have partnered to offer free bus fare to Alamo Colleges students.[7]

The Mayor's Housing Policy Task Force was established in 2017 to address a growing shortage of affordable housing[8],and the strategies that came out of that initiative form the Mayor's Housing Policy Task Force Housing Policy Framework. Among the actions taken by the City of San Antonio over the past 18 or so months are the addition of multiple staff to the new Neighborhood and Housing Services Department, approval of funds to support rehab of owner-occupied homes and funds to prevent resident displacement, and a revised and expanded tax incentive policy to encourage construction of affordable housing.[9]

Violence continues to make headlines in San Antonio, particularly with family violence in the last mayoral election,[10] but no clear strategy has emerged to improve local violence prevention and response. City Council was briefed in summer 2018 about possible strategies and policies to reduce gun violence,[11] but the issue has proved contentious.[12]

## What's next?

The next step in the assessment-planning-action cycle is to bring the community back together to explore the data in this assessment, establish community-wide priorities, and create a workplan with action strategies and roles for a wide array of community stakeholders.[13]  That process will begin late in 2019 in preparation for release of the new Healthy Bexar Plan 2020.

5. Proposed Plan – ConnectSA. Retrieved from https://connectsa.com/wp-content/themes/JointsWP-master/assets/images/CSA19_MobilityPlan.pdf
6. Community Input – ConnectSA. Retrieved from https://connectsa.com/about/community-input/
7. Via Bus U-Pass | Alamo Colleges. Retrieved from https://www.alamo.edu/news--events/news/2019/01-january/via-buss-pass/
8. Mayor's Housing Policy Task Force. Retrieved from https://www.sanantonio.gov/Portals/0/Files/HousingPolicy/Resources/SA-HousingPolicy-Framework.pdf
9. See for example https://salud-america.org/san-antonios-daring-new-policies-for-affordable-housing/
10. See for example https://therivardreport.com/new-report-on-status-of-sa-women-show-some-gains-amid-troubling-violence-trends/
11. City Council members debate possible ordinances designed to address gun violence. Retrieved from https://www.mysanantonio.com/news/local/article/City-Council-members-seek-solutions-to-prevent-13027552.php
12. Clarke, D. (2018, October 9). Proposed regulations on gun stores have some City Council members divided. Retrieved from https://www.ksat.com/news/proposed-regulations-on-gun-stores-have-some-council-members-divided
13. Healthy Bexar Plan. Retrieved from https://elutz0413.wixsite.com/chna/2017healthybexarplan

# Appendix A

## Community Voice: Resident Focus Groups

A series of focus group discussions were organized with community members from different sectors of the city in March 2019. The purpose of these focus groups were to ensure that the community's voices and needs were well represented in the 2019 CHNA.

Participants were asked questions about their understanding, needs and barriers for six priority areas: healthy child and family development, healthy eating, active living, safe communities, behavioral and mental well-being, and sexual health. They were then asked to describe existing programs and needed programs to meet their needs. The Technical Notes in Appendix B of this document include more information about the data collection and analysis methods used for the focus groups.

The information and perspectives these residents provided have been woven into each appropriate section of the assessment. The following narrative offers a coherent summary of the themes that came out of the focus groups, organized along the six priority areas mentioned above but not splintered out per detailed issue or indicator.

## Overarching themes

Three main themes emerged from the focus groups conducted in the community. When discussing every focus area, participants mentioned the urgency to have more programs and services to meet their needs. This ranged from parenting education to teach children how to eat healthy or how to avoid pregnancies, to free or low-cost programming for adults and children to stay active, and free counseling services available after school or on weekends. Speaking about behavioral and mental well-being, for example, participants reported not knowing where to go for help: "*Yo no sé de ningún programa que está disponible para nosotros.*" Families in general reported having several unmet needs and wanting more help through community services and programs.

If those programs and services already existed, participants noted wanting to learn more about current programs. Some participants in each group discussion were able to list several organizations currently serving families in the community, including churches, schools, CentroMed, the Wesley Clinic, the Madonna Center, the Martinez Street Women's Center, the YMCA, Roy Maas Youth Alternatives, the Food Bank, the Boys & Girls Club, Communities in Schools, The Neighborhood Place, AVANCE, Morgan's Wonderland, Bexar CARES, and the Battered Women and Children's Shelter, among others. However, other participants had a "*lack of knowledge of what's around.*" Working to increase program marketing and education could help "*families know what programs are available to them.*"

Communication was the third overall emerging theme. Enhancing communication in different contexts, including within the family, in schools, and across the neighborhood was perceived as a crucial need for the community. According to a participant, the key to a healthy child and family development is "*tener buena comunicación entre nosotros y alimentarnos bien.*"

Focus group participants reflected on the role of communication in their family: "*I didn't know how to talk to my girls about this* (sexual health), *to know what you can and cannot say.*" Similarly, for mental health, "*parents aren't having the conversations because they don't know how,*" suggesting the value of communication to reduce stigma. Both examples illustrate how communication can be leveraged to promote health. Communication can also help provide a greater sense of safety in community. A participant recommended to "*have community meetings. Get to know your neighbors. Look out for each other.*" It is a shared responsibility to "*get together to talk about the neighborhood and keep an eye on it.*"

# Appendix A

## Healthy child and family development

When thinking about this focus area, participants mentioned two types of priorities in their families that contribute to a healthy child and family development. For them, health is associated with medical care. Having access to health insurance, health clinics, immunizations, mental health and oral health services, for example, all contribute to child and family health. Some mentioned the need for these services to be available in their community just like "*back in the day, [when] the doctor used to go to you*".

Addressing non-medical issues also play a big role in healthy child and family development. Providing support for families with housing, childcare, free food, parenting education, activities after school and in the neighborhoods are needed for the community to prosper.

Several factors plays a role in whether these medical and non-medical needs are met, including parent responsibilities such as work and time, and accessibility of programs and services including eligibility, application processes, wait lists, costs. For example, one participant mentioned, "*when you're just above the poverty line, you're not eligible for services.*" Another explained that, "*if it weren't for my sister, we wouldn't make it*" illustrating that "*tener una familia unida*" that is available to provide support also contributes to a healthy child and family.

## Healthy eating

Focus group participants highlighted the need for affordability, accessibility, and education related to healthy foods. Participants discussed how their incomes limit the type of food they can purchase. One participant explained, "*Why do we all have diabetes and high blood pressure? Because we can't afford all these foods that are healthy.*" Making healthy foods affordable and accessible can help counter these healthy eating trends that "*go back generations*". Participants agreed that some of their neighborhoods do not have access to healthy or organic foods, "*like the southeast part of town*", but options such as farmers' markets and community gardens can provide free or low cost, healthy produce for the neighborhood. The community also recommends providing nutrition education programs to families. Introducing healthy foods to all age groups, including at a young age, could help to diminish the fear of trying a new food, "*not liking it and then, there's my money down the drain*". Residents could feel more confident in preparing these foods and could also include them in more traditional Hispanic meals, with "*beans, tacos, and tortillas*" or "*en un caldito.*"

## Active living

The use of safe and accessible spaces to engage in physical activity was the main theme that emerged about active living. Participants described how they enjoy exercising indoors during the hot summer months, and take advantage of neighborhood parks, free city fitness programs, walking paths and bike trails, sports fields and courts, and outdoor exercise equipment with their families. Addressing safety issues such as the presence of stray dogs or cats or improving local park maintenance was highlighted as needing urgent attention to promote active living.

A community effort is needed to raise awareness of active living opportunities available. Community support helps motivate people to exercise. As explained by one participant, "*People do more when they have a support group. I won't be sweating out there by myself.*" Participants also urged businesses to get involved in sponsoring free or low-cost physical activity programs in their communities.

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1. See for example McGovern, L.et al. (2014). Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

# Appendix A

## Safe Communities

Focus group participants pinpointed several important needs related to having and living in a safe community, with their current impression represented as one of the quotes of "watch behind your back". Across focus groups, participants reported not knowing what a safe community is because their community currently has too much crime, guns, robbery, drugs, human trafficking, domestic abuse, sex offenders, stray dogs, or bad sidewalks. Several types of suggestions to increase community safety were made, including enhancing police surveillance and patrol including improving their response time and their dedication to knowing the community, as well as having more lights and security cameras. However, residents highlighted what they can do to protect themselves and others. They want to stay informed and educated through community meetings, flyers, free self-defense or active shooter classes, and mentorship programs. More importantly, focus group participants discussed the need to build more community cohesion to address the fact that "*neighbors don't know their neighbors anymore*", so that they can be "*on the lookout*" for one another and keep each other safe.

## Behavioral and mental well-being

For participants, mental health was like an elephant in the room. It was considered important but difficult to discuss in community. A lack of knowledge about mental health, limited understanding about root causes causing certain illnesses like depression, misperceptions, and stigma prevent them from reaching out for help for themselves or their families. A participant clarified, "*Many parents just walk away because they don't know what to do.*" Families also fear that a mental or behavioral health diagnosis at a young age will go on their child's "*permanent record*" and affect future education and employment opportunities such as with the military.

Several suggestions were made to promote behavioral and mental well-being in the community through prevention and treatment. Prevention measures ranged from communicating with love, patience, and understanding, building skills and positive coping mechanisms, using mentorship programs to reinforce positive behaviors, and raising awareness that counseling can help. In terms of treatments, participants want to know where existing programs are located, and recommend expanding mental health programs to meet the needs of different populations across different sectors of the community.

## Sexual health

Participants described the community's need for sexual health education for youth and for parents. Some participants believe that limited sexual education in schools contribute to high rates of pregnancies and sexually transmitted diseases in the community. "*They don't teach enough in school so the kids go and explore to learn more.*" Participants recommend for a broad range of sexual health topics to be discussed with students in schools, including sex, safe touch, how to care for your body, porn, media, and the consequences of teen pregnancies and STDs. These types of prevention programs could "*provide support to young people so they don't feel they have to have a baby at a young age.*"

Education is also warranted for parents to learn how to build trust with their children, show their kids that they are "*loved and cared for*", and be able to talk openly about girls, boys, LGBTQ, emotional feelings, hormones, and sex and act as positive role models for their kids. This need was illustrated by a participant: "*Parents can't do what they don't know.*" More sexual health conversations should take place in the home to help "*kids that need help before they get there (pregnant).*"

## Civic engagement and policy considerations

Focus group participants were not asked to speak specifically about policy considerations or engagement with elected officials, but these issues did crop up. Many policy issues were not directly related to health care and support services. For example, a participant recommended a "*pay raise for parents to work normal hours* (so they can) *spend quality time with their children,*" as a way to improve community health.

Participants recognized that some communities in San Antonio are more safe than others: "*Alamo Heights. Only those communities are safe.*" Another participant indicated, "*This side of town is not safe compared to other sides of town like the northside. (…) This side is the unsafest part of San Antonio.*" However, participants view their elected officials as key players in making their communities safer. They suggested "having *more neighborhood gatherings with local representatives present*", like "*city council people*" and "*hablar con Shirley Gonzalez, District 5*" as a start. One participant who reported a bad sidewalk more than one year ago cautioned, "*The city takes too long to change things.*"

For mental and behavioral well-being, it was also recommended to "o*btener la ayuda de los councilman para que pongan atención en las prioridas de aquí.*" However, another participant suggests that large investments in mental health will be needed: "*It's going to cost money to have those programs. Nothing is free. How are you going to get it?*"

Policy is also embedded in many topics of importance to focus group residents whether or not the policy aspect was discussed. For example, WIC, food stamps/SNAP, and Medicaid were mentioned as existing and effective programs for healthy child and family development, and healthy eating in particular, and all three are heavily subject to state and national policy and politics.

## Community Voice: Key Informant Interviews

Key Informant interviews were organized with community stakeholders from different sectors of the city on May 15 and 17th, 2019. The purpose of these key informant interviews is to collect information from a range of individuals - including community leaders and professionals, who have firsthand knowledge about the community. The unique and informed perspectives of the interviewees can provide insight into the nature of community social and health issues and give recommendations for solutions in the 2019 CHNA.

Interviewees were asked questions about their understanding of, needs and factors impacting the six priority areas – healthy child and family development, healthy eating, active living, safe communities, behavioral and mental well-being, and sexual health. They were then asked to describe existing and needed programs in the community which address each of these priority areas. The Technical Notes in Appendix B of this document include more information about the data collection and analysis methods used for the key informant interviews.

As with the focus group data, the information and perspectives provided by key informants have been woven into each appropriate section of the assessment. The following narrative offers a coherent summary of the themes emerging from each of the six priority areas.

## Overarching Themes

Three main themes emerged from the key informant interviews: *community transformation, education and prevention.* When discussing *community transformation*, interviewees mentioned the need to develop a trauma-informed community, improve the built environment, and redefine cultural norms. Discussion around the first topic ranged from becoming a trauma-informed community (integrating trauma-informed care into all sectors of the county) to creating system-level changes that recognize and address Adverse Childhood Experiences (ACEs). ACEs are far more prevalent in areas of our community where gun violence, domestic abuse and other crimes are more common.

There also emerged a strong desire to make changes needed in the built environment with an emphasis on the sizeable disparities we have across our city's geography. This included efforts such as building more sidewalks and bike lanes to better integrate neighborhoods and parks, and creating access to healthy foods and places to allow for increased physical activity. The interviewees discussed a need to continue to improve the built environment, for example:
"There is work to do in the Built Environment and increase areas for people to be active in places closest to where they live and work."

There was also a strong sentiment among the interviewees around the need to make changes to cultural norms in our community, for example, providing parenting classes on how to discipline children. "There is a disconnect in our communities' cultural norm from what kids need in terms of discipline and what they actually get - as a culture, we are taught that in disciplining kids, we scare them - you get in trouble when you act out - yelled out, ostracized, hit or worse and those things exacerbate trauma; we have to move away from a fear-based approach."

*Education* is the second theme mentioned by interviewees and includes educating the community on adverse childhood experiences and integrating trauma-informed care in a cross-sector representation of organizations throughout the county. In addition, the interviewees discussed an overall need to improve community awareness and recognition about existing programs (Project Worth for teen pregnancy prevention). More and sustained educational programs were suggested to increase resident attention to healthy eating (CHEF Program, Por Vida – healthy menu items at local restaurants). For example, teaching "how to eat and feed their families in healthy way." Education around mental health was discussed as a way to normalize the issue and include it as a part of total well-being and physical health. Interviewees identified cost of programs as an existing barrier to program access, thus hindering residents' access to educational opportunities.

*Prevention* was the third theme that emerged from the interviews. Interviewees discussed the lack of prevention programs in all priority areas (Healthy Child & Family Development, Healthy Eating/Active Living, Safe Communities, Behavioral & Mental Well-being and Sexual Health). Specifically, there was an identified need to reduce stigma about mental health and promote whole (mind and body) wellness.

There was also a concern stated about the limited mental health services for all age groups, "Mental Health is the most dysfunctional system with the word health in it - early identification and prevention is needed; access to services - not insurance parity; safety net systems have developed around crisis response (suicide) but it is a band-aid on the crisis and prevention is needed."

In addition, the need for additional community programs for parenting education and those aging out of foster care were identified. The need to prevent teen pregnancies through changing cultural norms by education and encouraging open and informed conversations between parent and child. The interviewees also discussed educating the community on adverse childhood experiences and integrating trauma informed care to prevent and reduce child abuse and neglect.

## Healthy child and family development

1. Priorities
- Medical Care: Infant & Maternal health; Immunizations
- Social Determinants of Health: employment, education, access to care, transportation; domestic violence. "It's hard to pull out what's a health issue and what's an education issue and what's a financial issue because they're all related."

2. Factors influencing priorities:
- Access to care
- ACES and Trauma Informed Care
- System level changes: "[We need to] work collaboratively across areas that are negatively impacting community - child abuse and gun violence (comprehensive and collaborative way); continue to identify health disparities (infant/maternal)"

## Healthy eating

1. Education
- Teaching the community about healthy eating – changing cultural norms; education about existing programs, "[Teaching] how to eat and feed their families in a healthy way, food deserts and fast foods"

2. Affordability
- Ability to purchase healthy foods. "Health department is looking at some incentive program to flip the cost structure - switch things so the healthiest item isn't the most expensive."

3. Accessibility
- Farmers markets, community gardens, role of the neighborhood – "Access in ability to purchase and access to healthy foods throughout the community (south and rural areas)"

4. Cultural Norms
- Healthy foods at family, work or church celebrations – "Reset cultural norms - good foods are healthy foods. We are losing the battle because we keep telling people what not to do - deep down in every human being's heart is a rebel."
- Talking about healthy eating/active living: "I would love to see active living and fitness become a huge part of Fiesta. That's such an important part of our identity as a city. Thinking about drinks and food is fun but a great leveraging point to begin talking about how do we build on that existing identity to incorporate active living as part of who we are in San Antonio?"

5. Equity
- Grocery store collaborating with community health goals to address health disparities and key issues - "In the places where diabetes is higher, the food in that grocery store needs to be different."

## Active living

### 1. Safe & Accessible Spaces
• The ability to feel safe and access: neighborhood parks, church-organized events, free city fitness programs
• Increased access to: sidewalks, bike lanes, trails
• Need to promote the Parks and Recreation Summer Activities that are free to the community
• Increased non-profit partnerships with schools to provide summer programs

### 2. Cultural Norms
• The need to build physical activity as part of the culture – "the healthiest cities have a culture of physical activity; [we have a] long way to go to create cultural expectation that a Fit City is the norm for San Antonio and not a pie in the sky aspiration"
• Need to motivate the community to be physical active – "It's not that there isn't opportunity, the challenge is getting to the activity and being motivated"

## Safe communities

### 1. Building "Communities without Fear"
• Need for increased opportunities to be safe – child abuse, domestic abuse, gun violence, drugs and other crimes, stray dogs, bad sidewalks, places of worship
• Need to stay informed and educated – (e.g., Trauma informed community) "Trauma informed community would promote safety in Bexar County"
• Need for more safety promotion and prevention efforts - "Not a lot out there to promote safety - all efforts respond after the violence has occurred – I'd like to see us respond to those needs"

### 2. Building Relationships
• Developing relationships and building strong community by knowing your neighbors
• Building trust in police and police building relationships with community - "Take domestic violence as an example; safety is promoted when security officers work with nonprofits to develop the best training and sensitivity to situations and build relationships"

## Behavioral and mental well-being

### 1. Reducing Stigma Associated with Mental Health
• "Stigma with seeking care with Mental Health concerns - recognition that mental illness is like any other illness and no shame in seeking care"
• Pathways to Hope Conference - "learning about health or mental health is not just for social workers, it's for everyone"
• Concerns: Access to timely and affordable services for those uninsured

### 2. The Need for Early Intervention and Diagnosis
• "Parents educated on the importance of seeking services early, having access to early intervention services at no cost to parents - go a long way to preventing mental health crises and expensive crisis interventions."
• More mental health programs and locations are needed (e.g., for early detection in children and treatment).

# Appendix A

## Sexual health

1. Education for youth
- Providing sexual health education in schools - middle and high school:
- "Expanding programming for middle school and teenagers, preventative health in relation to people of color, to break down barriers, outreach to LGBT community"
- Community level or private programming to educate students when public school cannot due to policy limitations.
- Healthy relationships that empower people and prevent domestic abuse

2. Education for parents:
- Cultural norm: "Starts with parent/child communication - cultural challenge for us; talking about it in schools is important; ability to access services at no cost to end user is important because the people who are most vulnerable with sexual health have the least amount of resources"

3. Promotion of services in the community:
- "Project Worth - teen pregnancy prevention programs, STD Clinic to offer services based on STD prevention and intervention; reducing stigma to sexual health issues"

## Acknowledgements

## Glossary of Data Terms

This section defines in easy-to-understand language most of the data terms used in the *2019 Atascosa and Bexar County Community Health Needs Assessment*. This content is excerpted from the larger *Glossary of Common Data Terms* developed by Community Information Now (CI:Now) as a non-technical resource for those interested in expanding their functional data vocabulary.

The full-length glossary is available on CI:Now's website at https://cinow.info/language-of-data/.

**Administrative data:** data generated in the everyday course of business, like sales data in a grocery store, attendance data in a school, or diagnosis data in a doctor's office. Administrative data is a type of secondary data. See Secondary data.

**Age distribution:** the frequency of different ages or age groups in a population.

**Age-adjusted rate:** a rate with a calculation applied to allow an "apples to apples" comparison between populations with different age distributions. For example, an older population may have a higher crude death rate than a younger population, even if the younger population is shouldering a greater burden of lethal issues like drug overdose, severe asthma, breast cancer, or homicide. Age-adjusted rates artificially standardize the two populations' crude rates against a single "reference population" so that the confusing influence of age distribution is removed. These rates are useful for comparison purposes only and should not be used to describe a measure for a single population. See Age distribution, Crude rate, Age-specific rate, and Rate.

**Age-specific rate:** the number of cases or events in a given age group divided by the total population of that age group. See Rate, Age-adjusted rate, and Crude rate.

**Aggregate data:** individual data records that have been "rolled up" to a summary level. Data can be aggregated in many different ways. Data are often aggregated by geography like zip code or by some characteristic like race/ethnicity or age group.

**Average:** the average describes the typical value in a set of values and is calculated as the sum of the values divided by the number of values. It is important to look at the individual values when interpreting because an average can be influenced (skewed) by extreme high or low values in the dataset. The average and Mean are the same thing.

**Comorbidity:** two or more disorders or illnesses occurring in the same person.

**Crude rate:** total number of cases or events in a specific time period and geography divided by the total population in that time period and geography. See Rate, Age-adjusted rate, and Age-specific rate.

**Data:** broad concept that generally means a collection of values or pieces of information. Among other characteristics, data may be quantitative (numerical) or qualitative (non-numerical, like words or images), raw or processed, record-level or aggregated (grouped), and primary (collected/created for the purpose of answering a question) or secondary (created for some other purpose). "Data" and "indicators" are not the same thing; indicators are calculated from data.

**Demography:** the study of population dynamics including size, structure, distribution, and how populations change over time due to births, deaths, migration, and aging.

**Denominator:** number below the line in a common fraction.

# Appendix B

**Ethnicity:** classification of a population based on cultural characteristics such as religion, traditions, language, or national origin. Ethnicity is a different concept from Race and is not determined by biology.

**Extant data:** see Secondary data.

**Fertility rate:** specific rate measuring total number of live births per 1,000 women of reproductive age defined as 15-44 years. See Rate.

**Health information exchange (HIE):** in general, refers to the electronic transfer of health-related information among organizations. The term is commonly used to describe the central database of health-related information as well as the organization that assembles and manages that data.

**ICD-10:** acronym for "International Classification of Diseases, 10th edition". A system for classifying diseases and injuries developed by the World Health Organization (WHO) and used worldwide to improve comparability of cause of death statistics reported from different countries.

**Indicator:** general term for a thing that tells us the state or level of something. "Four-year graduation rate" tells us something about how well kids in a high school do and "temperature" tells us something about how hot or cold it is. An indicator isn't necessarily a good indicator. Often used interchangeably with measure. "Indicator" is not synonymous with "data;" indicators are calculated from data.

**Life expectancy (at birth):** the average number of years a newborn is expected to live based upon the mortality patterns for the geographic area at the time of birth.

**Margin of error:** when we can't measure all of something, like people in a city, we sample them – measure only some to get an idea (estimate) of what's true for everyone. Sampling introduces error and uncertainty, and the margin of error – for example, "plus or minus three percentage points" – is a measure of how much uncertainty there is. The smaller the sample in relation to the total population, generally, the larger the margin of error.

**Mean:** see Average.

**Median:** value in an ordered set of values above and below which there are an equal number of values. This can also be referred to as the 50th percentile.

**Mode:** most common or most frequent value in a set of values

**Morbidity:** can refer to having a disease or a symptom of disease. See Comorbidity. Or, to the amount of disease within a population often expressed as a morbidity rate. See Rate.

**Mortality:** refers to deaths.

**Natality:** refers to births.

**Numerator:** number above the line in a common fraction.

**p-value:** calculated probability that what is being observed in the data has happened by chance. Generally, if the p-value associated with an observation is less than .05 the observation is accepted as statistically significant. A p-value less than .05 indicates a less than 5% chance that what is being observed happened by chance or a more than 95% certainty that chance alone cannot explain the observation. See Statistical significance.

# Appendix B

Percent increase/decrease: one way of describing the difference between your current measurement and a past measurement, relating it to the past measurement. The percent change is the difference between the two values, divided by the past value, and it's usually phrased like "percent decrease from prior year" or "percent increase over prior year." For example, if the percent of the population that smokes cigarettes decreased from 19% in 2014 to 17% in 2015, you'd have a 10.5% (percent) decrease, because the difference between 19 and 17 is two, and two divided by 19 is 10.5%.

Percentage point increase/decrease: one way of describing the difference between your current measurement and a past measurement, without relating the change to the past measurement. It's just the difference between the two values, and it's usually phrased as "decrease of X percentage points." If the percent of the population that smokes cigarettes decreased from 19% in 2014 to 17% in 2015, you'd have a two percentage point decrease, because the difference between 19 and 17 is two.

Population: people in a given area.

Proportion: specific type of ratio in which the denominator always includes the numerator. See Ratio.

Race: a classification of a population based on biological characteristics.

Range: the difference between the lowest and highest values in a set of values calculated by subtracting the lowest value from the highest.

Rate: the number of cases or events in a specified period of time and geography divided by the population who could have experienced – were "at risk" for – the case or event within that same period of time and geography. Rates are often multiplied by a factor of 1,000, 10,000, or 100,000 just to make the numbers easier to read. (A percentage is just a rate multiplied by a factor of 100.) As an example, the male juvenile arrest [case/event] rate in the US [geography] in 2015 [time] was 3,806.2 [frequency] per 100,000 [multiplier] males age 10-17 [population "at risk" of the case/event].

Ratio: relation of one population subgroup to another subgroup, or to the whole population.

Residence data: data attributed geographically to the usual place of residence without regard to the location the event occurred. For example, births are attributed to the mother's usual residence even if the birth occurred in a different geographic location.

Secondary data: existing data that has already been collected by someone else, likely for some purpose different from yours. Two common kinds of secondary data are survey data and administrative data. Also called extant data.

Statistical significance: likelihood that what is being observed in the data has happened by chance. The more statistically significant an observation is, the less likely it occurred by chance. See p-value.

Vital statistics: data on important life events, such as births, deaths, marriages, and migrations.

Years of potential life lost (YPLL75): measure of premature death for a population. YPLL75 is the sum of all the years of life "lost" by individuals in that population who died before age 75. A person who died at age 60 would contribute 15 years to the population's YPLL, a person who died at age 48 would contribute 27 years, and a person who died at 75 or older would contribute zero. The YPLL75 is often reported as a rate. See Rate.

# Appendix C

## Technical Notes

### Quantitative content and sources

This assessment contains quantitative data on approximately 150 indicators, each broken out by race/ethnicity group and sub-county geography (Zip Code Tabulation Area [ZCTA], sector, census tract, or block group) wherever possible. Indicators were also disaggregated by age group and sex where those variables were thought to add critical information.

The list of indicators was developed over several months in summer and fall 2018. An extensive list of candidate indicators and issues was generated using past assessments, the Community Health Improvement Plan, Healthy People 2020, the Agency for Healthcare Research and Quality, County Health Rankings, SA2020, local subject matter experts, and a number of references[1] on the "upstream" social, economic, and environmental conditions that affect health. To narrow the list, the Community Health Needs Assessment Steering Committee used an anonymous digital survey to rate each indicator as high, medium, or low priority, suggesting modifications to the indicator if desired. Indicators rated as low priority with a high level of agreement (about 65% or more of responding members) were dropped without discussion, and high-agreement high-priority indicators were included without discussion. Those without clear consensus were discussed until general agreement was reached. Budget constraints prevented the inclusion of some indicators on which there was agreement but for which the data was especially time-consuming to find, acquire, and/or calculate.

Each indicator source is cited throughout the assessment. The 2016 Assessment draws from too many data sources to list here, but the following sources were used heavily.
• Population and housing data from the U.S. Census Bureau Census 2010 Summary File 1
• Population estimates and projections from the Texas State Demographic Center at the University of Texas at San Antonio
• Physical, social, and economic conditions data from the U.S. Census Bureau American Community Survey One-Year Estimates, Five-Year Estimates, and Supplemental Estimates
• Crime data from the U.S. Department of Justice Uniform Crime Report
• Behavioral Risk Factor Surveillance System (BRFSS), vital statistics, injury, blood lead, hospital discharge, hospital bed, and health professions data from the Texas Department of State Health Services Texas Health Data query system and by special request
• Medicaid and public benefits data from the Texas Health and Human Services Commission
• Mortality data from the CDC WONDER query system
• Motor vehicle crash data from the Texas Department of Transportation
• Communicable disease and vital statistics data from the Texas Department of State Health Services
• The Witte Museum

Staff from these and many other local and state organizations spent considerable time and effort pulling data for the 2019 Assessment and sharing important context and cautions for that data. The Health Collaborative and CI:Now are indebted to these individuals and the agencies who allowed them to share their time and expertise.

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1.See for example, the Bay Area Regional Health Inequities Alliance's Applying Social Determinants of Health Indicators to Advance Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals (2015) and the Centers for Disease Control and Prevention's Data Set Directory of Social Determinants of Health at the Local Level (2004).

# Appendix C

## Quantitative analysis and limitations

Analysis of the data typically consisted of calculating proportions and rates, with margins of error or confidence intervals where appropriate; no statistical testing was required. Margins of error and confidence intervals are displayed throughout the assessment. Margins of error were minimized where feasible by combining multiple years of data. Getting useful BRFSS results for Atascosa required TDSHS staff to aggregate seven years of Atascosa data and combine it with Wilson and Medina County data.

Some indicators are broken out geographically by eight sub-county sectors based on Zip Code Tract Areas (ZCTAs), as zip code is a common variable across many local and state datasets. A sector map and ZCTA cross-walk appears in Appendix D. These sectors were developed for the 2013 assessment in response to the problem of small sample sizes, particularly with regard to the BRFSS dataset. CI:Now used a non-statistical process to group adjacent ZCTAs with median household incomes (from Census American Community Survey five-year estimates) more similar than not, and with the aim of having a sufficiently large and preferably similar total population size for each sector. The final groupings, though, also took into account our own local understanding of our "parts of town" as reflected in the commonly-used divisions of north-, south-, east-, and westside. This process was performed again in 2018 and did not indicate any need for changes. Thus while not ideal, the sector groupings were retained for this assessment.

## Hospitalization technical notes

We call them hospitalization rates for short, but these indicators actually reflect hospital discharges, not admissions. The hospital discharge data was downloaded from the Texas Department of State Health Services and the ICD codes that were used for the analysis are listed below. There are some important limitations to understand with hospital discharge data.

The rates are determined by hospitalizations for the disease as the primary diagnosis, not all hospital discharges with that diagnosis. In the case of the asthma hospitalization rate, for example, the intent is to reflect the rate of hospitalizations for an asthma attack, not hospitalizations for heart attacks or car accidents among people who also happen to have diagnosed asthma unrelated to the reason for the hospitalization.

The rates are not prevalence or incidence of the disease. These hospitalization counts are also not unique visits or people. If the same person in 78205 goes to the hospital three times for asthma in 2014 then all three visits are included if asthma was the primary diagnosis for the admission during that year.

Because the San Antonio Military Health System does not report their hospitalizations to DSHS, the public data files exclude any federal hospital discharges. Because the military hospital systems account for a large portion of our population, the Bexar County hospitalization data should not be compared to other major cities who do not have large federal hospital exclusions in their datasets.

The hospitalization discharge rates were calculated following the Prevention Quality Indicators (PQIs) methodology provided by the Agency for Healthcare Research and Quality (AHQR) for diabetes, hypertension and heart failure. The PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality outpatient care. The PQIs are population based and adjusted for covariates. Asthma hospitalizations followed the San Antonio Metropolitan Health District's methodology for diagnosis codes and cerebrovascular disease followed the CDC's definition for ICD-10 diagnosis codes. All population estimates for the rates were calculated from the American Community Survey 1-Year estimates available in Table B01001.

International classification of diseases (ICD-10 codes) used in analysis were selected based on the following methodologies and sources.

| Disease | Source |
| --- | --- |
| Asthma | J45 per San Antonio Metropolitan Health District |
| Diabetes long term | https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2018/TechSpecs/PQI_03_Diabetes_Long-term_Complications_Admission_Rate.pdf |
| Uncontrolled diabetes | https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2018/TechSpecs/PQI_14_Uncontrolled_Diabetes_Admission_Rate.pdf |
| Hypertension | https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2018/TechSpecs/PQI_07_Hypertension_Admission_Rate.pdf |
| Cerebrovascular diseases | https://wonder.cdc.gov/ucd-icd10.html |
| Heart failure admission rate | https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2018/TechSpecs/PQI_08_Heart_Failure_Admission_Rate.pdf |

## Behavioral Risk Factor Surveillance System technical notes

From the CDC User Guide: The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project between all of the states in the United States and the Centers for Disease Control and Prevention (CDC). The BRFSS is a system of ongoing health-related telephone surveys designed to collect data on health-related risk behaviors, chronic health conditions, and use of preventive services from the noninstitutionalized adult population (≥18 years) residing in the United States. Since 2011, the BRFSS has been conducting both landline telephone-and cellular telephone-based surveys. All the responses were self-reported; proxy interviews are not conducted by the BRFSS.  The data are transmitted to CDC for editing, processing, weighting, and analysis. An edited and weighted data file is provided to each participating state health department for each year of data collection, and summary reports of state-specific data are prepared by CDC. In 2017, an optional module was included to provide a measure for several childhood health and wellness indicators, including asthma prevalence for people aged 17 years or younger.

The BRFSS sample for Bexar County is small.  Between 2011 and 2017, there were approximately 5,500 surveys completed and ideally should be around 3,500 annually in order to look at subpopulations.  The sample sizes were too small to trend annually so multiple years of data were combined for analysis with a new weight applied.  The Texas State Health Department provided three different datasets for Bexar County.  The BRFSS core survey had all years 2011-2017 and the supplemental questions were either asked in odd years (2011, 2013, 2015, 2017) or in even years (2012, 2014, 2016).  The tables are all labeled as 2011-2017 but it depends on which question to determine if it included 7, 4 or 3 years of data.  If questions were changed between years then the responses were excluded from the dataset (e.g. disability status wasn't asked until 2013 and soda consumption changed in 2016).

The sample for Atascosa had 146 responses for all seven years so DSHS combined Atascosa with Wilson and Medina counties to total close to 400 responses in order to disaggregate the data by race.

BRFSS observations marked with an asterisk (*) represent cases in which the Relative Standard Error (RSE) is 30 percent or higher and are statistically unreliable. The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying the result by 100 in order to express it as a percentage. The asterisk (*) may also denote cases with a small sample where we are unable to calculate a RSE.

## Qualitative content and sources

With substantial input as to focus group goals and potential participants from the CHNA Steering Committee, volunteer focus group participants were selected with an eye toward engaging meaningful and substantive input from medically underserved, low-income, and minority populations. The focus group questions were developed by the Health Collaborative, the CHNA Steering Committee, and the UT Health Houston School of Public Health in San Antonio. The Health Collaborative scheduled seven focus groups with the help of its partnering agencies.

The Health Collaborative sent requests to eight community stakeholders and scheduled four key informant interviews. UTHealth facilitated and recorded the interviews. The interview questions were developed by UTHealth School of Public Health, the Health Collaborative, and the CHNA Steering Committee.

## Qualitative analysis and limitations

The School of Public Health led and recorded the focus groups. The Health Collaborative then took the audio files from the focus groups and used a grounded theory approach for analysis[2] that involved open coding of the data, axial coding to identify categories between and across the data, and selective coding to identify the final themes.

As with the focus group content, the Health Collaborative used a grounded theory approach to analyze the recorded key informant interviews. Techniques included open coding of the data, axial coding to identify categories between and across the data, and selective coding to identify the final themes.

As with the quantitative information, this qualitative information has limitations. The focus groups and interviews conducted for this assessment provide valuable insight into the realities of our community members but do not serve to represent the opinions of the entire population. Because the goal was to explore the priority issues in depth rather than cast a broad but shallow net, likely not all issues important to residents or key informants were mentioned. Finally, the data were collected at one point in time and therefore findings, while directional and descriptive, should not be interpreted as definitive.

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2. Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Procedures and techniques for developing grounded theory. Thousand Oaks, CA: Sage.

# Appendix C

## Assessment staffing and participants

The 2019 Bexar and Atascosa Counties Community Health Needs Assessment was conducted by The Health Collaborative, a nonprofit network of citizens, community organizations and businesses working together to solve critical community health problems. The Health Collaborative's membership is composed of a wide array of organizations including Appdiction Studios, the Baptist Health System, Bexar County Department of Community Resources, CHRISTUS Santa Rosa Health System, the City of San Antonio Metropolitan Health District, Community First Health Plans, Interlex Communications, Methodist Healthcare Ministries of South Texas Inc., Methodist Healthcare System, Our Lady of the Lake University, San Antonio Clubhouse, University Health System, the University of the Incarnate Word, the UT Health Science Center at San Antonio Dept. of Family & Community Medicine, the YMCA, and community members at large. Nearly all of these organizations provide health care, human services, education, or peer support to Bexar County's medically underserved, low-income, and minority populations. Those that do not represent the general community; the faith-based community; and small, veteran-, and minority-owned business.

The Health Collaborative's volunteer Community Health Needs Assessment (CHNA) Steering Committee provided direction on general approach, scope, potential data sources, data interpretation and highlights, and media messaging. A list of CHNA Steering Committee members with organizational affiliation appears on the inside back cover of this assessment.

The Health Collaborative contracted with Community Information Now (CI:Now), a nonprofit local data intermediary serving south central Texas, for quantitative data collection and analysis and for development of the assessment narrative. Under the supervision of Dr. Melissa Valerio-Shewmaker, graduate students at the UTHealth Houston School of Public Health in San Antonio assisted in developing the focus group questions and conducting the groups themselves. School of Public Health staff Ms. Kate Martin and Ms. Sonia Ramos conducted the key information interviews. The Health Collaborative staff handled all focus group and key informant interview recruitment and scheduling. All qualitative analysis was conducted by Dr. Caroline Bergeron, Ms. Jordan McIlveen, and Ms. Jennifer Quackenbush at the Health Collaborative.

Following are the organizations and positions of the four key informants interviewed. An additional four interviews were recruited but unable to participate.
- Interim Assistant City Manager - Health, HHS, Parks, Equity and Immigration, City of San Antonio
- CEO, PreK for SA
- Interim Health Director, City of San Antonio Metro Health Department
- Community Faith Based Liaison, Faith Based Community

## Reference Maps

### Bexar County Zip Codes & Sub-County Sectors
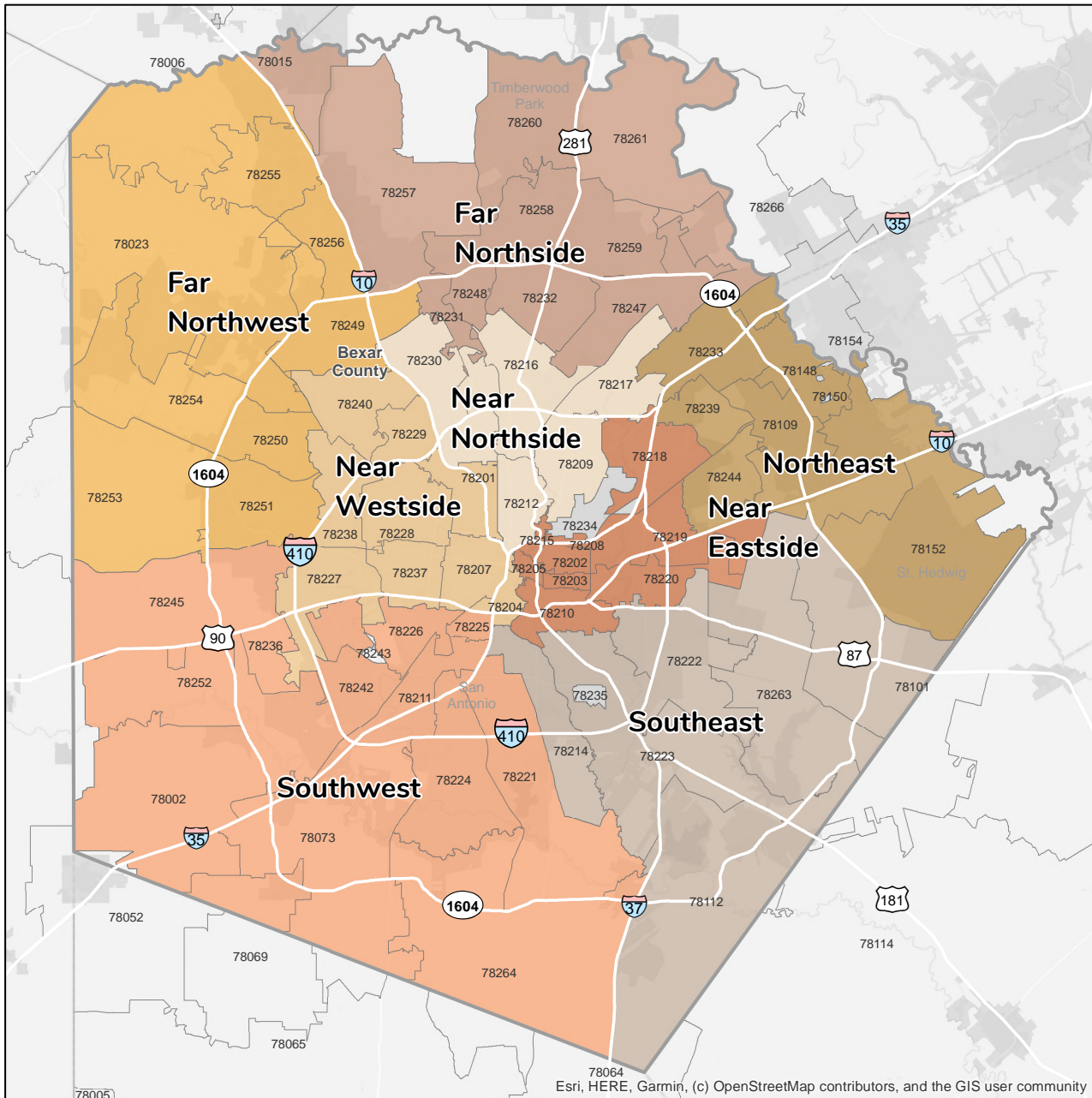


Near Eastside: 78202, 78203, 78205, 78208, 78210, 78215, 78218, 78219, 78220

Northeast: 78109, 78148, 78152, 78154, 78233, 78239, 78244

Southeast: 78101,78112, 78214, 78222, 78223, 78263

Southwest: 78002, 78069, 78073, 78211, 78221, 78224, 78225, 78226, 78236, 78242, 78245, 78252, 78264

Near Westside: 78201, 78204, 78207, 78227, 78228, 78229, 78237, 78238, 78240

Far Northwest: 78006, 78023, 78249, 78250, 78251, 78253, 78254, 78255, 78256

Near Northside: 78209, 78212, 78213, 78216, 78217, 78230

Far Northside: 78015, 78231, 78232, 78247, 78248, 78257, 78258, 78259, 78260, 78261, 78266

## BRFSS Atascosa Area ( Atascosa, Wilson and Medina Counties)

# Appendix E
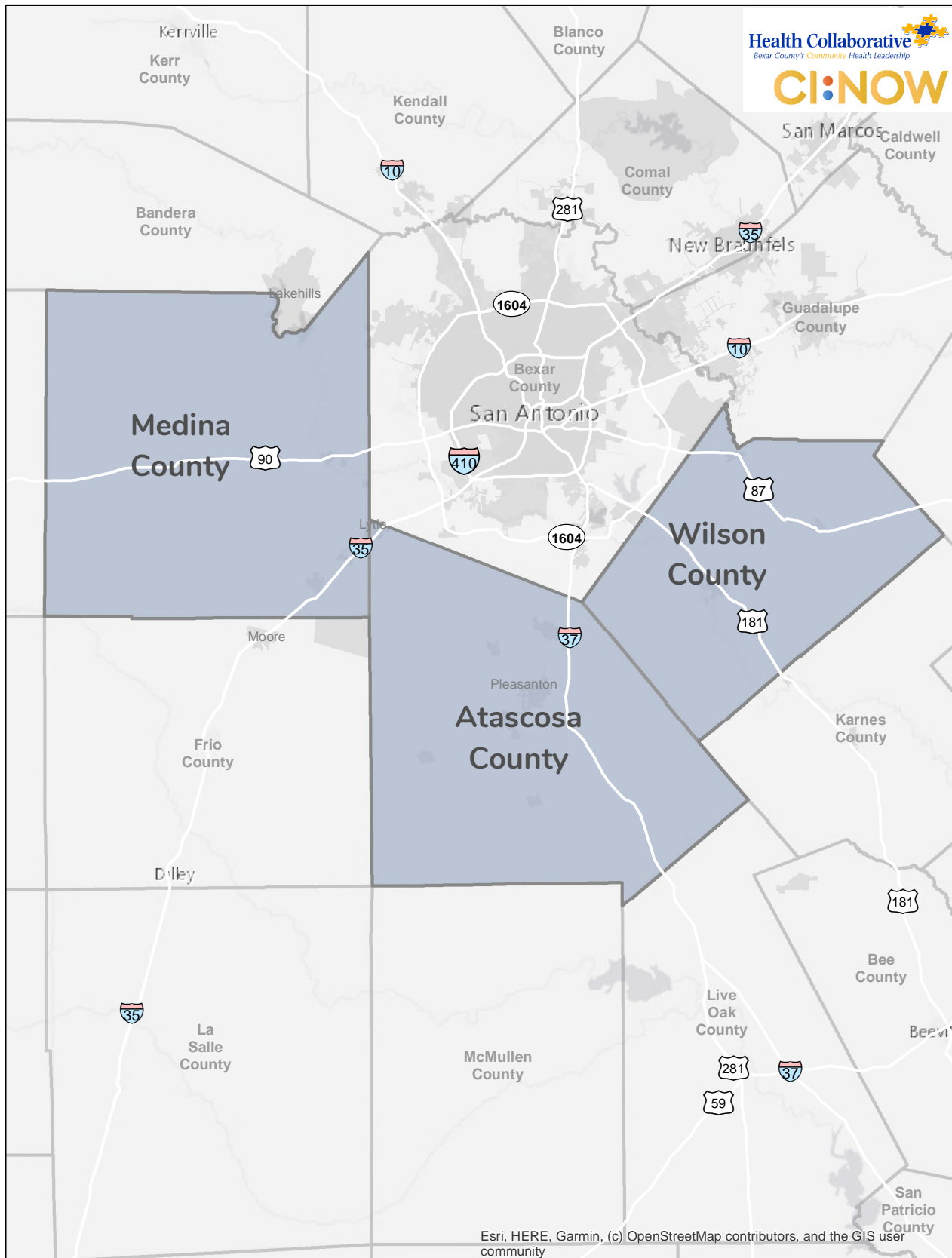
## Index of Topics and Key Related Issues

This assessment is organized by the BARHII framework, first presenting an array environmental conditions, followed by health behaviors and risks, and finally health outcomes. While this approach helps the user see the "upstream-downstream" sequence of factors that lead to health outcomes, it does mean that data on a single topic is typically found in multiple sections of the assessment.

This index is intended to help the user quickly find all data on a topic, as well as data on selected issues related to that topic. These issues are typically "upstream" of the topic at hand, affecting it in some way, or "downstream," affected by it in some way.

**Age**

*For data on this topic, see:*
Section 1: Population Composition

All sections: most indicators are disaggregated by age group

**Children**. See **Age**.

**Accidents** (unintentional injury)
*For data on this topic, see:*
Section 6: Health Behaviors and Risks
Motor vehicle safety
Section 7: Health Outcomes
Alcohol- and substance-related injury and death
Pedestrian and cyclist injury and death
Leading cause of death

*For data on key related issues, see:*
Section 7: Health Outcomes
Birth outcomes and maternal and infant mortality

**Air quality, indoor and outdoor**
*For data on this topic, see:*
Section 2: Physical Environment
Air quality
Section 6: Health Behaviors and Risks
E-cigarettes and tobacco

*For data on key related issues, see:*
Section 7: Health Outcomes
Birth outcomes and maternal and infant mortality
Asthma

Cancer
Hypertension, heart disease, and stroke
Leading cause of death

**Alcohol**
*For data on this topic, see:*
Section 2: Physical Environment
Food and alcohol Environment
Section 3: Social Environment
Crime and safety
Section 6: Health Behaviors and Risks
Alcohol

*For data on key related issues, see:*
Section 6: Health Behaviors and Risks
Adverse childhood experiences
Section 7: Health Outcomes
Birth outcomes and maternal and infant mortality
Alcohol- and substance-related injury and death
Leading cause of death

**Asthma and other respiratory illness**
*For data on this topic, see:*
Section 6: Health Behaviors and Risks
Vaccinations
Section 7: Health Outcomes
Asthma
Cancer
Leading cause of death

*For data on key related issues, see:*
Section 2: Physical Environment
Air quality
Section 6: Health Behaviors and Risks
E-cigarettes and tobacco

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**Births**. See **Sexual and reproductive health**.

**Cancer**

*For data on this topic, see:*
    Section 6: Health Behaviors and Risks
        Vaccinations
        Screening and testing
    Section 7: Health Outcomes
        Cancer
        Leading cause of death

*For data on key related issues, see:*
    Section 6: Health Behaviors and Risks
        E-cigarettes and tobacco
        Alcohol
        Healthy eating
        Physical activity
        Overweight and obesity

**Child abuse and neglect**

*For data on this topic, see:*
    Section 7: Health Outcomes
        Birth outcomes and maternal and infant mortality
        Child abuse and neglect
        Family violence and sexual assault
        Leading cause of death

*For data on key related issues, see:*
    Section 3: Social Environment
        Other characteristics of people
    Section 6: Health Behaviors and Risks
        Adverse childhood experiences

**Crime**. See **Violence**

**Dental health**. See **Oral Health**

**Diabetes**

*For data on this topic, see:*
    Section 6: Health Behaviors and Risks
        General preventive and primary care
        Screening and testing
    Section 7: Health Outcomes
        Diabetes
        Leading cause of death

*For data on key related issues, see:*
    Section 2: Physical Environment
        Mobility and transportation
        Food and alcohol environment
    Section 4: Economic Environment
        Food insecurity
    Section 7: Health Outcomes
        Birth outcomes and maternal and infant mortality

**Digital inclusion**

*For data on this topic, see:*
    Section 3: Social Environment
        Other characteristics of neighborhoods

*For data on key related issues, see:*
    Section 3: Social Environment
        Educational performance and attainment
        Housing stability and homelessness
    Section 4: Economic Environment
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**Disability and different ability**

*For data on this topic, see:*
    Section 3: Social Environment
        Other characteristics of people
    Section 5: Service Environment
        Public assistance

*For data on key related issues, see:*
    Section 7: Health Outcomes
        Overall health status

**Drugs**. See **Opioids and other drugs**

# Appendix E

## Economic opportunity and mobility

*For data on this topic, see:*
>Section 3: Social Environment
>>Other characteristics of neighborhoods
>
>Section 4: Economic Environment
>>Income inequality, income segregation, and economic mobility

*For data on key related issues, see:*
>Section 3: Social Environment
>>Educational performance and attainment
>>Housing stability and homelessness
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>Section 4: Economic Environment
>>Unemployment and labor force participation
>>Income and cost of living
>
>Section 5: Service Environment
>>Access to healthcare and other services
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>Section 7: Health Outcomes
>>Overall health status

## Education and schools

*For data on this topic, see:*
>Section 3: Social Environment
>>Educational performance and attainment
>>Other characteristics of people
>>Other characteristics of neighborhoods
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>Section 6: Health Behaviors and Risks
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*For data on key related issues, see:*
>Section 3: Social Environment
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>
>Section 4: Economic Environment
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>>Food insecurity
>
>Section 6: Health Behaviors and Risks
>>Lead poisoning
>>Adverse childhood experiences
>>Screening and testing
>
>Section 7: Health Outcomes
>>Overall health status
>>Birthrates and maternal characteristics
>>Child abuse and neglect
>>Mental illness and suicide

## Employment and work

*For data on this topic, see:*
>Section 2: Physical Environment
>>Mobility and transportation
>
>Section 4: Economic Environment
>>Unemployment and labor force participation

*For data on key related issues, see:*
>Section 3: Social Environment
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>>Other characteristics of people
>>Other characteristics of neighborhoods
>
>Section 4: Economic Environment
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>
>Section 5: Service Environment
>>Access to healthcare and other services

## Food access and healthy eating

*For data on this topic, see:*
>Section 2: Physical Environment
>>Food and alcohol environment
>
>Section 4: Economic Environment
>>Food insecurity
>
>Section 6: Health Behaviors and Risks
>>Healthy eating

*For data on key related issues, see:*
>Section 4: Economic Environment
>>Income and cost of living
>
>Section 5: Service Environment
>>Public assistance
>
>Section 6: Health Behaviors and Risks
>>Overweight and obesity
>
>Section 7: Health Outcomes
>>Birthrates and maternal characteristics
>>Birth outcomes and maternal and infant mortality
>>Diabetes

# Appendix E

## Housing and homelessness

*For data on this topic, see:*
Section 2: Physical Environment
Housing stock and vacancy
Section 3: Social Environment
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Other characteristics of people

*For data on key related issues, see:*
Section 2: Physical Environment
Mobility and transportation
Section 3: Social Environment
Other characteristics of neighborhoods
Section 4: Economic Environment
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## Hypertension, stroke, and heart disease

*For data on this topic, see:*
Section 7: Health Outcomes
Hypertension, heart disease, and stroke
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*For data on key related issues, see:*
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Physical activity
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Section 7: Health Outcomes
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mortality

## Income and poverty

*For data on this topic, see:*
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Section 4: Economic Environment
Income and cost of living
Income inequality, income segregation,
and economic mobility

*For data on key related issues, see:*
Section 3: Social Environment
Housing stability and homelessness
Section 5: Service Environment
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## Inequity and disparity, summary measures of

*For data on this topic, see:*
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Section 7: Health Outcomes
Life expectancy and premature death

*For data on key related issues, see:*
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Section 4: Economic Environment
Unemployment and labor force
participation
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Food insecurity

## Injury, intentional. See Violence

## Injury, unintentional. See Accidents

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*For data on this topic, see:*
Section 6: Health Behaviors and Risks
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*For data on key related issues, see:*
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Housing stock and vacancy
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## Life expectancy. See Premature death

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## Literacy and language barriers

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> Section 3: Social Environment
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>> Other characteristics of people

*For data on key related issues, see:*
> Section 3: Social Environment
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> Section 5: Service Environment
>> Access to healthcare and other services
> Section 6: Health Behaviors and Risks
>> General preventive and primary care
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## Mental health

*For data on this topic, see:*
> Section 7: Health Outcomes
>> Overall health status
>> Mental illness and suicide
>> Leading cause of death

*For data on key related issues, see:*
> Section 5: Service Environment
>> Access to healthcare and other services
> Section 6: Health Behaviors and Risks
>> Opioids and other drugs
>> Physical activity
>> Lead poisoning
>> Adverse childhood experiences
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> Section 7: Health Outcomes
>> Birth outcomes and maternal and infant mortality
>> Mental illness and suicide
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## Obesity. See Overweight and obesity

## Older population. See Age

## Opioids and other drugs

*For data on this topic, see:*
> Section 6: Health Behaviors and Risks
>> Opioids and other drugs

> Section 7: Health Outcomes
>> Mental illness and suicide
>> Alcohol- and substance-related injury and death

*For data on key related issues, see:*
> Section 6: Health Behaviors and Risks
>> Adverse childhood experiences
> Section 7: Health Outcomes
>> Birth outcomes and maternal and infant mortality
>> Alcohol- and substance-related injury and death
>> Leading cause of death

## Oral health

*For data on this topic, see:*
> Section 7: Health Outcomes
>> Oral disease

*For data on key related issues, see:*
> Section 6: Health Behaviors and Risks
>> E-cigarettes and tobacco
>> Opioids and other drugs
>> Healthy eating
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> Section 7: Health Outcomes
>> Birthrates and maternal characteristics
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## Overweight and obesity

*For data on this topic, see:*
> Section 6: Health Behaviors and Risks
>> Overweight and obesity
> Section 7: Health Outcomes
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*For data on key related issues, see:*
> Section 6: Health Behaviors and Risks
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>> Physical activity
> Section 7: Health Outcomes
>> Cancer
>> Diabetes
>> Hypertension, heart disease, and stroke
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## Pedestrian and cyclist safety

*For data on this topic, see:*
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*For data on key related issues, see:*
> Section 2: Physical Environment
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*For data on this topic, see:*
> Section 6: Health Behaviors and Risks
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*For data on key related issues, see:*
> Section 2: Physical Environment
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>> Birthrates and maternal characteristics
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## Pollution. See Air quality (indoor/outdoor)

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*For data on this topic, see:*
> Section 7: Health Outcomes
>> Birth outcomes and maternal and infant mortality
>> Mental illness and suicide
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*For data on key related issues, see:*
> Section 2: Physical Environment
>> Mobility and transportation
> Section 3: Social Environment
>> Crime and safety
> Section 6: Health Behaviors and Risks
>> Motor vehicle safety
>> Adverse childhood experiences
> Section 7: Health Outcomes
>> Child abuse and neglect
>> Family violence and sexual assault

## Race and ethnicity

*For data on this topic, see:*
> Section 1: Population
>> Composition
> All sections: most indicators are disaggregated by race/ethnicity

## Segregation, summary measures of

*For data on this topic, see:*
> Section 1: Population
>> Composition
> Section 4: Economic Environment
>> Income inequality, income segregation, and economic mobility

*For data on key related issues, see:*
> Section 3: Social Environment
>> Educational performance and attainment
>> Other characteristics of neighborhoods
> Section 4: Economic Environment
>> Income and cost of living

## Sex

*For data on this topic, see:*
> All sections: most indicators are disaggregated by sex

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## Sexual and reproductive health

*For data on this topic, see:*
- Section 6: Health Behaviors and Risks
  - Sexual health
  - Prenatal care
- Section 7: Health Outcomes
  - Birthrates and maternal characteristics
  - Birth outcomes and maternal and infant mortality
  - Family violence and sexual assault
  - Vaccine-preventable disease
  - Sexually-transmitted infections

*For data on key related issues, see:*
- Section 6: Health Behaviors and Risks
  - Vaccinations
  - Screening and testing

## Social support and isolation

*For data on this topic, see:*
- Section 3: Social Environment
  - Other characteristics of people
  - Housing stability and homelessness

*For data on key related issues, see:*
- Section 1: Population
  - Growth and distribution
- Section 2: Physical Environment
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- Section 6: Health Behaviors and Risks
  - Adverse childhood experiences
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  - Child abuse and neglect
  - Adult maltreatment
  - Family violence and sexual assault
  - Mental illness and suicide
  - Alcohol- and substance-related injury and death
  - Leading cause of death

**Substance use**. See **Opioids and other drugs**

## Violence

*For data on this topic, see:*
- Section 3: Social Environment
  - Crime and safety
- Section 7: Health Outcomes
  - Child abuse and neglect
  - Adult maltreatment
  - Family violence and sexual assault
  - Leading cause of death

*For data on key related issues, see:*
- Section 6: Health Behaviors and Risks
  - Adverse childhood experiences
- Section 7: Health Outcomes
  - Birth outcomes and maternal and infant mortality
  - Mental illness and suicide

**Weight**. See **Overweight and obesity**

**Youth**. See **Age**

## ZIP code

*For data on this topic, see:*
- All sections: most indicators are disaggregated by ZIP Code Tract Area (ZCTA)

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## Section 7: Health Outcomes

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## Additional Resources

# 2019 BEXAR COUNTY
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**Pilar Oates**
**Doug Beach**
**Community Members**

The Health Collaborative began informally in 1997 when San Antonio's major healthcare organizations agreed to put aside their competitive business practices to conduct a comprehensive health needs assessment. The evolution in 2000 to an incorporated entity with a long-range strategic plan was in response to the founding members' interest in improving the health status of the community by working together.

The Health Collaborative has developed into a powerful network of citizens, community organizations and businesses. The result is a more robust, less duplicative, more synergistic approach to solving critical community health needs, while efficiently utilizing resources.

For more information about The Health Collaborative, its programs and initiatives, please contact Elizabeth Lutz, Executive Director :

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**Thank you to our funding partners**