Health Collaborative
Bexar County's Community Health Leadership

GrowHealthy Together
Bexar County

2016 Bexar County Community Health Needs Assessment Report

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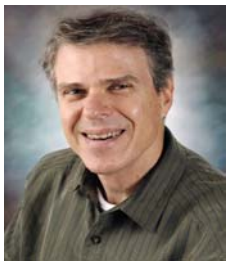

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Executive Director

Respected Leaders,

In keeping with our mission to improve the health status of our community through collaborative means, it is our pleasure to present the 2016 Bexar County Community Health Needs Assessment.

This report is the result of a formal community assessment that reflects over 24 months of collaborative work with agency partners and community stakeholders to establish a shared vision, select relevant indicators, and prepare a document that addresses the important drivers of health in our community.

In keeping with the national movement in public health to focus more sharply on the root causes of health outcomes, the report devotes significant space to describing social, economic, and environmental conditions. The framework used to organize the report, developed by the Bay Area Regional Health Inequalities Initiative, moves from population characteristics to living conditions, to health behaviors and risk factors, and finally to prevalence of specific diseases and causes of death.

We hope this framework helps readers consider connections among people, places, circumstances and health outcomes. Ultimately, a health needs assessment helps answer the question “What matters for health?”
And it points to potential responses to a second question, “What can be done about it?”

True progress requires as many County residents and stakeholders as possible to be engaged in answering those questions. We will therefore continue to make this report freely accessible to all who live, learn, work, and play in Bexar County. We would be happy to receive feedback and suggestions from those who use the report.

We thank the many stakeholders and partners from multiple sectors and the expert technical assistance provided by CI:Now and Dr. Laura McKieran.
A special thank you is also due to the Board of Directors of the Health Collaborative, whose leadership and guidance contribute substantially to a high quality report.

The health of a community’s residents offers a stark accounting of how effectively it functions. No other metric captures more vital information. We hope that the data collected here help point the way to policy and community action to create conditions in which all Bexar County residents have real opportunities to flourish.

Sincerely,

Robert L. Ferrer, MD, MPH
Health Collaborative
Board Chair

Stephen K. Blanchard
Health Collaborative
Data Committee Chair

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Executive Summary

About the Assessment

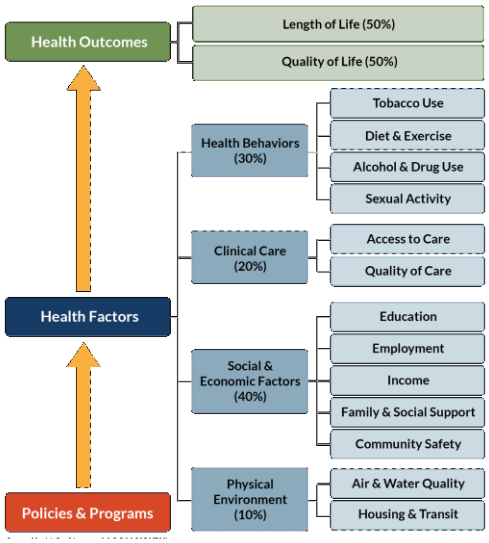
The Health Collaborative is pleased to present the *2016 Bexar County Community Health Needs Assessment*. The 2016 Assessment seeks to support Bexar County partners in moving from knowing about local health needs and outcomes to changing those outcomes. This emphasis resulted in three key changes.

➔ Creation of an interactive online data portal. To address the varying issues that different people face and improve our county's health overall, we must "drill down" to a greater level of detail than a report can give. The Health Collaborative for the first time this year will make publicly available a larger collection of data for exploration and download through an interactive online data portal.

➔ Stronger integration with the Community Health Improvement Plan (CHIP). Last updated in 2014, the CHIP is the community-wide action plan to improve health and well-being in five priority areas: Healthy Eating and Active Living, Healthy Child and Family Development, Safe Communities, Behavioral and Mental Well-Being, and Sexual Health. The 2016 Assessment will inform the review and revision, if necessary, of these five focus areas and of the associated objectives and performance measures.

Model of Population Health

Figure 1. County Health Rankings Model



Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2016. (http://www.countyhealthrankings.org/)

➔ Looking at health with an equity lens. It is now widely accepted that the relative contribution of medical care to health and well-being is small – an estimated 10% to 20%[1]. That means that the greater share of disparities in health and life expectancy for different populations can be traced not so much to differences in access to and use of medical care, but to stark differences in the social, economic, and environmental conditions in which people are

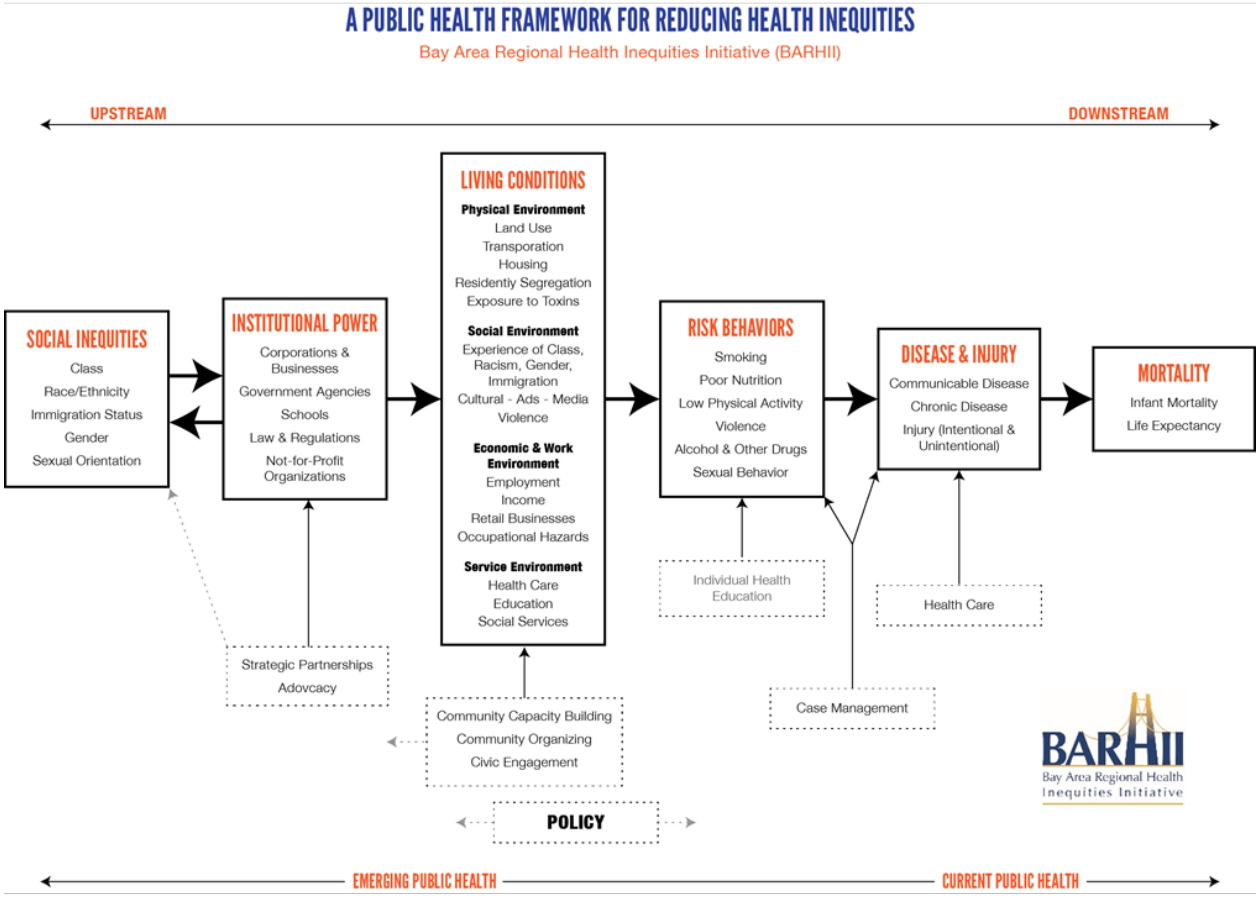
born, grow up and grow old, work and play. Improving health and well-being will mean both *improving those conditions* and *explicitly addressing the effects those conditions have already had* on so many members of our community. While equality means that everyone has *the same resources*, equity means everyone has *the resources they need* to thrive. One way to eliminate disparities is for those doing well to do poorly instead, although of course that is not our intent. A health equity lens brings the explicit intent that those who have been thriving continue to thrive, and that those who have not thrive, too.

What Makes Us Healthy?

Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[2] The Bay Area Regional Health Inequities Initiative (BARHII) in San Francisco, California created a framework (Figure 2) to show the links between disparities in conditions and disparities in health. As shown in the figure,

Social Inequalities & Health

Figure 2. The BARHII Framework



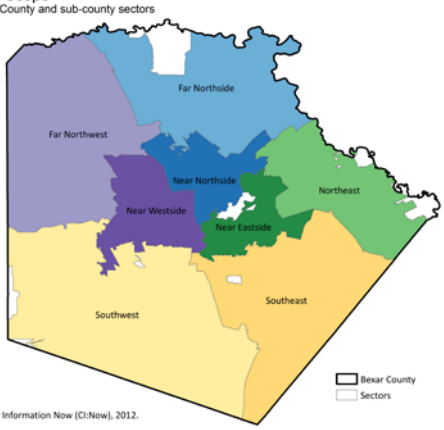
Source: Bay Area Health Inequities Initiative (http://barhii.org/).

"upstream" factors and conditions lead to "downstream" factors and conditions, and public health and healthcare alike are recognizing the need to intervene further "upstream" than people's risk behaviors. The lower section of the figure shows that the types of action that are effective upstream are very different from those that are effective downstream, and policy is key at every point. Data on both health-affecting conditions and health outcomes will be anchored to this framework throughout the assessment.

Notable Trends and Patterns

The 2016 Assessment contains quantitative and qualitative data on approximately 150 indicators for Bexar County. Many indicators are broken out by demographic characteristic or geography, typically zip code or sub-county sector. These eight sectors (Figure 3) were developed for the 2013 Assessment in response to the problem of small sample sizes, particularly with regard to the BRFSS dataset.

Geographic Scope
Figure 3. Bexar County and sub-county sectors



Source: Community Information Now (CI:Now), 2012.

Following are a few especially noteworthy trends, patterns, and driving forces. Please refer to the full document for data points and sources.

People & Place

A major driving force of change in Bexar County is population growth, with the 2050 population projected to be half again the 2010 total, and disproportionate growth in certain subpopulations. The growth rate is by far the steepest among Hispanics, mirroring state and national trends. Given racial/ethnic disparities in educational attainment, income, and health outcomes, that growth has major implications for the county as a whole. The population is also aging, with the senior population 65 and older – another vulnerable population subgroup – projected to exceed half a million by 2050, nearly triple the 2010 total. Population density in the county is growing despite sprawl, and population growth is steepest in the central city, the northside, and the northwest side.

Environment & Living Conditions

Two key themes emerge from a close look at environment and living conditions. First, fundamental social determinants of health like poverty and educational attainment remain stubbornly unchanged. Some, like income inequality and segregation, are getting worse, and Bexar County's income inequality now resembles that of China and the Dominican Republic.

Second, these social determinants vary by race/ethnicity, and even more strikingly by neighborhood. Median household and family incomes have risen slightly overall, but low income and poverty are overwhelmingly concentrated in westside, eastside, and southside neighborhoods. Four in 10 renter-occupied

households overall are housing cost-burdened, paying 35% or more of household income to cover housing costs, but the proportion is as high as six in 10 on the eastside and southside. Unemployment has dropped overall, but the highest unemployment rates in central-city neighborhoods are eight times those on the far northside. Uninsured rates are declining, but the eastside and westside are more likely than other areas of the county to have a high rate of uninsured.

Health-Related Behaviors & Early Outcomes

Our understanding of health-related behavior trends and patterns in Bexar County is stymied by heavy reliance on population surveys. Wide confidence intervals for estimates generated from the BRFSS dataset make it almost impossible to have certainty about either county trends over time or about current demographic and geographic differences. New YRBS data for youth is not available at all for this assessment.

For those trends we can consider trustworthy, the news is mixed. No improvement in fruit or vegetable consumption, physical activity, or smoking is apparent. But the percent of adults reporting that they never drink sugar-sweetened beverages has increased, possibly to a substantial degree.

Healthy behaviors like vaccination, routine screening and testing, safer sex and drug injection behaviors, and early and adequate prenatal care all play a role in reducing the incidence of communicable disease. The past few years have seen continuing declines in the incidence of some reportable communicable diseases, namely Hepatitis B, chlamydia, and gonorrhea, and a reversal of recent spikes in congenital syphilis and HIV incidence. Pertussis or whooping cough incidence has declined but remains higher than 2010.

The overall teen birthrate continues to decline dramatically, driven by reduced birthrates among Hispanic and black or African-American girls. There appears to be a decline in the proportion of total births that followed early and adequate prenatal care, though, and possibly an accompanying increase in hospitalizations for pregnancy-related complications.

Health & Well-Being

As with social determinants and health-related behaviors, many health outcomes have seen no clear progress in recent years, including percent of adults who report good or excellent health, report being diagnosed with diabetes, or are overweight or obese. The high degree of year-to-year overlap in BRFSS confidence intervals means that although the point estimate has declined slightly from 2010, there is no evidence of true decrease in the percent of adults who are overweight or obese.

Some indicators vary quite a bit by age group. The asthma hospitalization rate has declined significantly for seniors, but not for children and teens. Of all principal diagnoses examined, the only hospitalization rate that has increased dramatically from 2010 is for mental illness, primarily among youth and to a lesser degree among adults. Whether this increase is real or reflects substantive change in diagnosis coding practice is not clear.

But the single most striking theme in health outcomes is inequity. Again, disparities are often evident when comparing racial/ethnic subgroups. Self-reported health status and overweight/obesity are much worse among Hispanics versus non-Hispanic whites.

When comparing neighborhoods, though, the disparity is especially dramatic, with clear differences in self-reported health status. And the difference in life expectancy between prosperous and poor neighborhoods is a staggering 20 years.

Priority Issues & Implications for Action

Taking all of the quantitative and qualitative data and information together, a number of common themes and high-priority issues emerge.

➔ Issues with Technical Fixes. These are issues that can be addressed by relatively straightforward policy or practice changes supported by a strong evidence base.

Vaccination against communicable disease, most notably HPV vaccination of both girls and boys and vaccination of seniors against influenza and pneumonia.

Trauma-informed care. At its most basic, a trauma-informed approach changes the question from "What's wrong with you?" to "What's happened to you?"[3]

Policy for a healthy food environment. Tax abatements to retailers of healthy food can support a healthy food environment as well.[4]

➔ Complex Problems Requiring Complex Solutions. These issues call for long-term, complex, multi-sector interventions.

Mental illness and substance use. This set of interrelated issues includes mild to severe mental illness including depression and post-traumatic stress disorder (PTSD), problem drinking, and problem drug use, including prescribed medications.

Physical inactivity. Physical activity is a lever of some kind – a contributor to or an effective intervention for – a number of other important health issues like depression, overweight and obesity, and chronic physical illness and disability.

Unhealthy eating and hunger. Unhealthy eating contributes in different ways to a number of health issues, notably overweight and obesity, diabetes, and heart disease and stroke. Hunger is one of the single greatest threats to the well-being of low-income seniors and remains a serious problem for children as well.

Senior whole-life well-being. Rapid growth in the senior population will place increasingly significant demands on local health care and social service systems. A completely different approach to senior well-being is needed if this large segment of the county population is to thrive with a high quality of life, not simply survive until an advanced age.

Unplanned pregnancy. Reducing unplanned pregnancy can only yield improvements in birth outcomes, maternal health and well-being, the prevalence of adverse childhood experiences, and a host of other issues.

Interpersonal violence. Child abuse, family violence, and street violence are common in Bexar County and do serious harm to health and well-being.

Premature mortality among people of color and low-income people. Particularly for lower-income males of color, Bexar County's premature mortality is striking. Premature death is an inarguable metric and the inevitable conclusion of years or decades of health inequity.

➔ Root Causes. Four key root causes interact with each other in a vicious cycle, within and across generations, and contribute to high-risk environments, unhealthy behaviors, and injury, illness, and death. The list of all root causes could be much longer, but these four are core for Bexar County.

Low income and poverty, including income inequality and segregation.

Educational attainment, including low literacy and health literacy.

Criminal and juvenile justice, including barriers to employment and exposure to violence.

Adverse childhood experiences (ACE), including direct victimization and exposure.

➔ System-Level Barriers to Effective Action. These issues hinder effective action to improve health outcomes and the environment in which health outcomes develop.

Systemic, persistent underfunding of prevention and interventions targeting root causes. Despite knowing that the relative contribution of medical care to health and well-being is small – an estimated 10% to 20%[5], very little funding is available for prevention and other interventions to address the "upstream" factors that contribute the remaining 80% to 90%. The U.S. spends proportionally less on social root causes than other nations with better population health outcomes.[6]

Gaps and disparities in data quality. One pattern that emerges very clearly throughout this assessment is the disparity not just in health determinants and outcomes, but also in the quality of the data about those determinants and outcomes.

Working effectively across organizations and sectors. The collective impact approach is being deployed in a number of local initiatives. Health impact investing is an emerging approach to collaboratively financing efforts to improve health outcomes.[7]

Improving Data-Driven Decision-Making

The Health Collaborative believes the time is right to create a portal to access detailed local data online, knowing that the portal's features and content will need to evolve over time in response to changing local needs and data availability. The Health Collaborative has partnered with Community Information Now (CI:Now) a local data intermediary serving south central Texas, to create and maintain this portal. The portal will let the user:

➔ **Visually explore data** for different populations and geographic areas using maps, line charts, bar charts, and other graphics.

➔ **Understand the data** and use it more effectively. Graphics and notes in the platform will show and explain critical concepts like margin of error and multi-year average rates.

➔ **Export maps and charts** with title, legend, data years, and source intact.

➔ **Export aggregate data tables**, with metadata intact, for further processing or analysis.

Taking Action: Community Health Improvement Plan

This year will mark the third iteration of the Community Health Improvement Plan (CHIP), a community plan that identifies five priority areas, establishes objectives for change in those areas, identifies needed partners, and lays out strategies for each objective.

- ➔ **Healthy Eating and Active Living**
- ➔ **Healthy Child and Family Development**
- ➔ **Safe Communities**
- ➔ **Behavioral and Mental Well-Being**
- ➔ **Sexual Health**

This assessment is the foundation for the 2016 CHIP process that will begin in fall 2016. The quantitative and qualitative data presented here will inform the review of the five focus areas and the associated objectives and performance measures that emerged in the 2014 CHIP process. That data-driven review will almost certainly result in changes to the objectives and performance measures, and possibly to the five focus areas as well.

The emphasis in 2016 will be on moving from planning and consensus-building to collaborative action. Effective action will likely require infrastructure and community capacity to support active performance management or collective impact, including tracking strategies and near-term outcomes or milestones that indicate progress or the need for mid-course corrections.

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[1] See for example, McGovern, L., Miller, G., & Hughes-Cromwick, P. (2014, August 21). Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

[2] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2010). *Healthy People 2020.* Washington, D.C. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[3] See for example, U.S. D.H.H.S. Administration for Children and Families. (2012). Asking: "What's Happened to You?" A Focus on Trauma-informed Care. http://www.acf.hhs.gov/programs/fysb/resource/exchange-trauma-informed-care

[4] Centers for Disease Control and Prevention. (2014). *Healthier food retail: An action guide for public health practitioners*. http://www.cdc.gov/nccdphp/dnpao/state-local-programs/healthier-food-retail.html.

[5] See for example, McGovern, L., Miller, G., & Hughes-Cromwick, P. (2014, August 21). Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

[6] Bradley E.H. et al. (2011). Health and social services expenditures: associations with health outcomes. *BMJ Qual Saf*. 20(10):826-831

[7] Centers for Disease Control and Prevention, Division of Community Health. (n.d.). *An introduction to impact investing in public health.* http://www.cdc.gov/nccdphp/dch/pdfs/impact-investing-public-health.pdf

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About the Assessment

The Health Collaborative is pleased to present the *2016 Bexar County Community Health Needs Assessment*. This assessment is the sixth since 1998, when local hospitals and other partners first agreed to work together to gather, analyze, and distribute data about Bexar County's health needs with a shared mission of collaboration and community engagement. Over the past 18 years, the goal of the assessment has grown beyond simply presenting relevant, recent, accurate data. Each assessment aims to challenge our local thinking about our community's well-being and how we all work to improve it.

More so than earlier work, the 2016 Assessment seeks to support Bexar County partners in moving from knowing about local conditions and health outcomes to changing those conditions and outcomes. This emphasis resulted in three key changes.

➔ **Creation of an interactive online data portal.** To address the varying issues that different people face and improve our county's health overall, we must "drill down" to a greater level of detail than a report can give. To respond to this community need for better data about specific neighborhoods and specific populations, the Health Collaborative for the first time this year will make publicly available a larger collection of data for exploration and download through an interactive online data portal. More information about this portal appears in the **Implications for Action** section of the assessment.

➔ **Stronger integration with the Community Health Improvement Plan (CHIP).** Last updated in 2014, the CHIP is the community-wide action plan to improve health and well-being in five priority areas: Healthy Eating and Active Living, Healthy Child and Family Development, Safe Communities, Behavioral and Mental Well-Being, and Sexual Health. The **Implications for Action** section talks about the role of the CHIP and how it relates to the 2016 Assessment. The **CHIP Objectives** section of the Appendix quickly locates CHIP-related information throughout the Assessment.

➔ **Looking at health with an equity lens.** It is now widely accepted that the relative contribution of medical care to health and well-being is small – an estimated 10% to 20%[1]. That means that the greater share of disparities in health and life expectancy for different populations can be traced not so much to differences in access to and use of medical care, but to stark differences in the conditions in which people are born, grow up and grow old, work and play.

The **What Makes Us Healthy?** section of this assessment describes health equity and a framework for the plan to achieve it, developed by the Bay Area Health Inequities Initiative (BARHII) in San Francisco, California. The content of this assessment is organized around the health equity framework, an emerging model that is increasingly used by health departments and other health initiatives across the country.

People & Place, including population demographics, projections, and geographic distribution

Environment & Living Conditions, including built and natural environment, socioeconomic conditions, and access to care and services

Health-Related Behaviors & Early Outcomes, including healthy eating, physical activity, alcohol and substance use, reproductive and sexual health, and preventive care and self-management

Health & Well-Being, including quality of life, illness and injury, and death

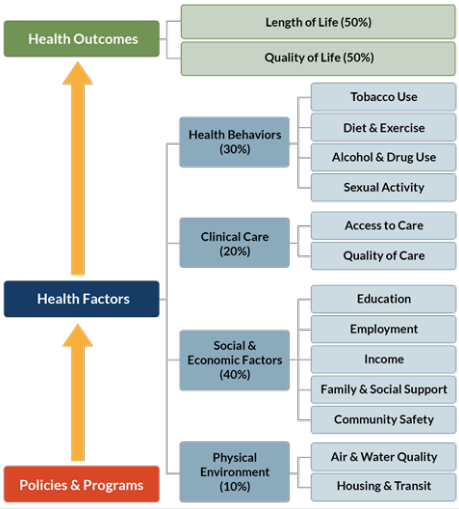
The **Implications for Action** section discusses themes that emerge from the data, potential health priorities, the CHIP, and the online data portal to be deployed later in 2016. An **Index of Topics** helps quickly locate specific issues in the assessment. Finally, the **Technical Notes** section of the Appendix provides detailed information on methods, including community input; data sources and limitations; and the roles of the staff, contractors, volunteers, and interview and discussion group participants who generously gave their time to this assessment.

As in the past, the 2016 Assessment presents both quantitative and qualitative information on population, social and economic determinants of health, and health outcomes. Most data are presented for Bexar County, though some data are available only for San Antonio.

Benchmarking against other geographies – other counties, Texas, or the United States – was beyond the scope of this assessment. Geographic comparisons for a number of key indicators are available through the Robert Wood Johnson Foundation's *County Health Rankings & Roadmaps* (Figure 1) and most state and national data query tools.

Model of Population Health

Figure 1. County Health Rankings Model



Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2016. (http://www.countyhealthrankings.org/)

Indicators are trended over time where possible. Within the constraints of space and data availability, selected indicators continue to be broken out by key factors like race/ethnicity, age group, sex, and neighborhood or geography. These breakouts show very clearly that Bexar County residents continue to shoulder serious health disparities and that place and social and economic conditions do matter.

Actual quotes from interview and discussion group participants appear throughout the narrative. These quotes reflect the opinion of the community member quoted and not necessarily that of The Health Collaborative. The **Appendix** includes a complete summary of all qualitative information provided through the interviews and discussion groups.

[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

What Makes Us Healthy?

While equality means that everyone has *the same resources*, equity means everyone has *the resources they need* to thrive. Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[1]

Improving health and well-being will mean both *improving those conditions* and *explicitly addressing the effects those conditions have already had* on so many members of our community. One way to eliminate disparities is for those doing well to do poorly instead, although of course that is not our intent. A health equity lens brings the explicit intent that those who have been thriving continue to thrive, and that those who have not thrive, too.

The Bay Area Regional Health Inequities Initiative (BARHII) in San Francisco, California created a framework (Figure 1.1) to show the links between disparities in conditions and disparities in health. Although many useful frameworks have been developed over the past few decades[2], this framework has come into wide use in recent years by state and local health departments and community collaboratives working to improve health.

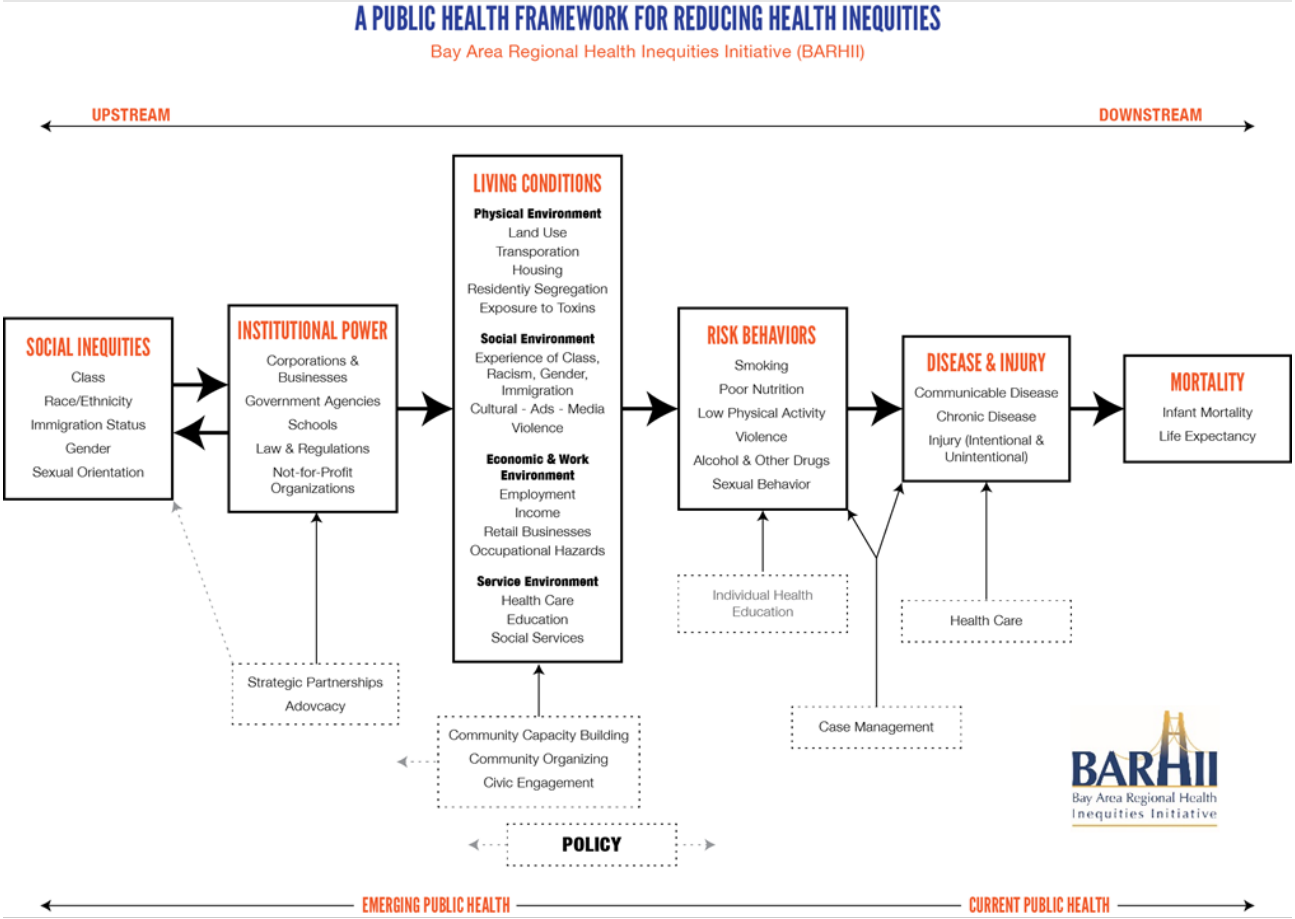
As shown in the figure, "upstream" factors and conditions lead to "downstream" factors and conditions, and public health and healthcare alike are recognizing the need to intervene further "upstream" than people's risk behaviors. The lower section of the figure shows that the types of action that are effective upstream are very different from those that are effective downstream. Data on both health-affecting living conditions and health outcomes will be anchored to this framework throughout the assessment.

Policy – from public policy down to organizational policy – is key at every point in this upstream-downstream health equity framework. Policy can support or harm health directly; can create or eliminate harmful environmental, social, and economic determinants of health; and can support or hinder health-related interventions.

Not explicitly included in this framework is health literacy, "the ability to obtain, process, and understand basic health information and services that are needed to make suitable health decisions."[3] Health literacy is considered a stronger predictor of health outcomes than income, employment status, education level, race/ethnicity, and age.[4] Poor health literacy disproportionately affects those with lower education, lower income, older adults, and minority and immigrant populations, and can therefore reinforce existing health disparities.[5]

Social Inequalities & Health

Figure 1.1 The BARHII Framework



Source: Bay Area Health Inequities Initiative (http://barhii.org/)

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[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2010). *Healthy People 2020.* Washington, D.C. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[2] See for example Seattle/King County's equity infographic (http://www.kingcounty.gov/elected/executive/constantine/priorities/building-equity/infographic.aspx) and the Healthy People 2020 Social Determinants of Health framework (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health)

[3] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) *America's Health Literacy: Why we need accessible health information*. http://health.gov/communication/literacy/issuebrief/

[4] World Health Organization. (2013). *Health literacy: The solid facts*. http://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf

[5] National Network of Libraries of Medicine. (2013). *Health Literacy.* https://nnlm.gov/outreach/consumer/hlthlit.html

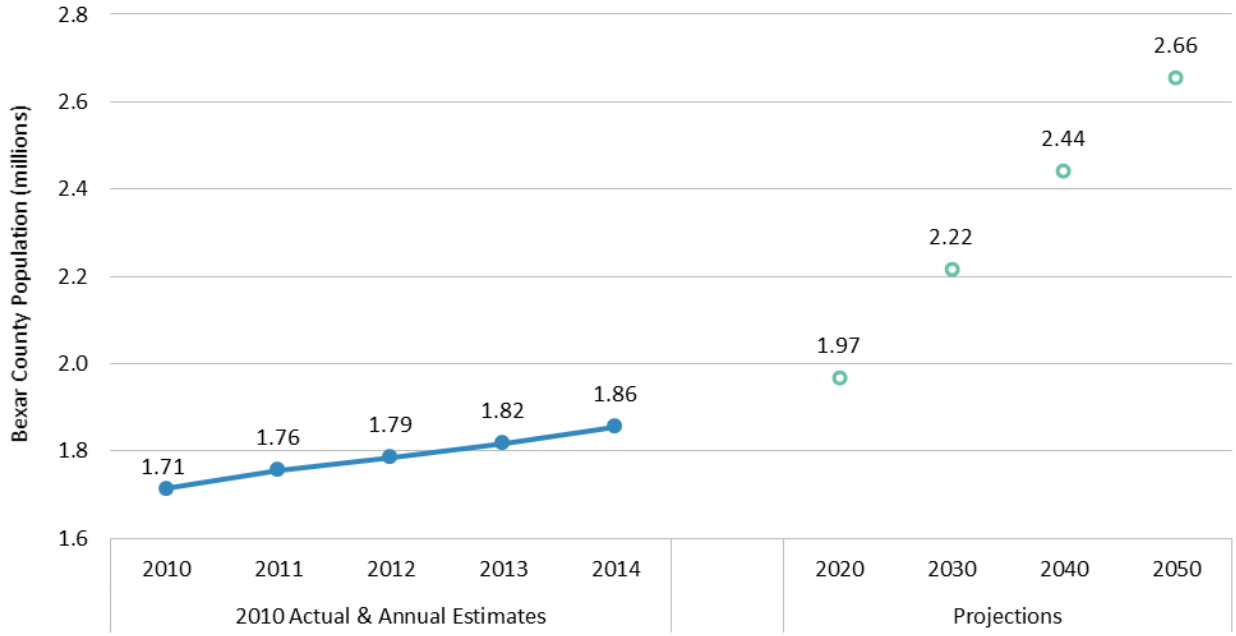
People & Place

Current and Future Demographics

Bexar County's population has grown dramatically and shows no signs of slowing in coming decades. The population is projected to increase by nearly one million people from 2010 to 2050, a 56% increase (Figure 2.1; Figure 2.2). While partly a positive sign of a strong economy and low cost of living relative to most other major U.S. cities, rapid population growth can strain community infrastructure that impacts health, including housing, schools, transportation, and health care. Short- and long-range planning for this growth is critical, as is a regional perspective. Texas' population growth is expected to be strongest along the I-35 corridor and in the urban core counties of the "Texas Triangle" between San Antonio, Dallas, and Houston. That growth pattern will almost certainly expand the functional boundaries of the "San Antonio region" as it is understood today.

Total Population

Figure 2.1 Bexar County total & projected population



Source: U.S. Census Bureau; 2010 Census, DP-1 & 2011-2014 ACS 1-Year Estimates, Table DP05. Texas State Data Center; Projections of the Population for 2010-2050, 2014.

Projected Population Growth

Figure 2.2 Bexar County population percent change

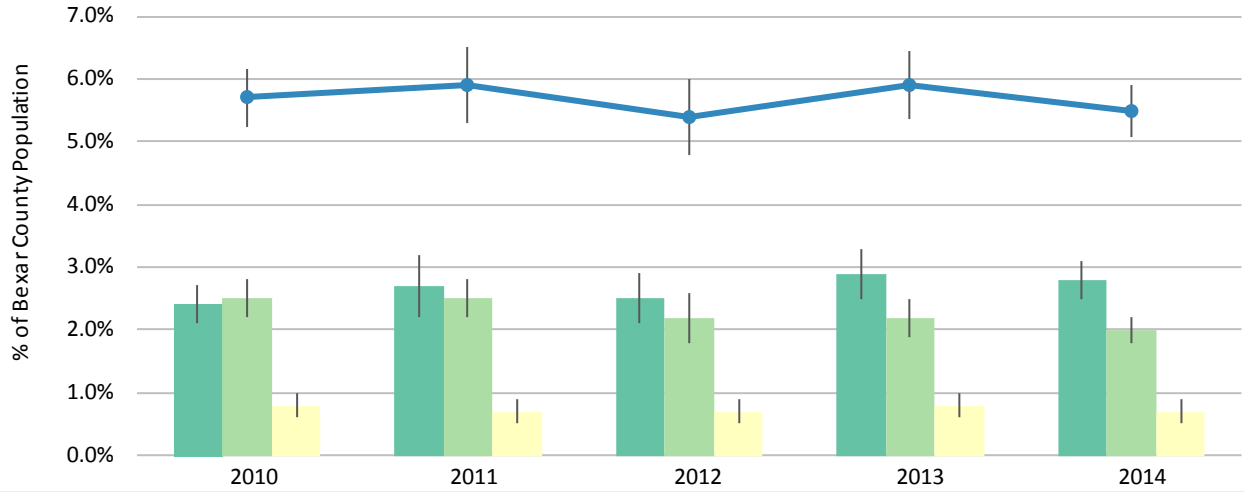
	Population	Projected Population	% Change from 2010
2010	**1,714,773**		
2020		1,967,590	14.7%
2030		2,216,912	29.3%
2040		2,442,098	42.4%
2050		2,656,573	54.9%

Source: U.S. Census Bureau; 2010 Census, DP-1 & 2011-2014 ACS 1-Year Estimates, Table DP05. Texas State Data Center; Projections of the Population for 2010-2050, 2014.

Local population growth is driven by both birth rates (see **Health-Related Behaviors & Early Outcomes: Reproductive & Sexual Health**) and in-migration. Just over five percent of Bexar County residents lived outside of Bexar County one year ago (Figure 2.3), a figure that has held steady since 2010. Half of that in-migration is from other Texas counties; only 13% is from another country, primarily Mexico. The proportion of the Bexar County population who are non-U.S. citizens has remained flat over the past five years at about eight percent (Figure 2.4). Immigration status is one factor at the root of health disparities and inequality. Undocumented immigrants have poorer access to societal resources and greater exposure to harmful social and environmental conditions, putting them at greater risk for health conditions that could be avoided or managed with preventive care.

Population Moving-In Annually

Figure 2.3 Bexar County population with non-Bexar County residence 1 year ago by previous residence



	2010	2011	2012	2013	2014
Overall	5.7% (±0.5%)	5.9% (±0.6%)	5.4% (±0.6%)	5.9% (±0.5%)	5.5% (±0.4%)
TX County	2.4% (±0.3%)	2.7% (±0.5%)	2.5% (±0.4%)	2.9% (±0.4%)	2.8% (±0.3%)
Other State	2.5% (±0.3%)	2.5% (±0.3%)	2.2% (±0.4%)	2.2% (±0.3%)	2.0% (±0.2%)
Other Country	0.8% (±0.2%)	0.7% (±0.2%)	0.7% (±0.2%)	0.8% (±0.2%)	0.7% (±0.2%)

Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S0701.

Citizenship Status

Figure 2.4 Bexar County population with US & non-US citizenship

	Non-US Citizen	Naturalized US Citizen	US Citizen by Birth
2010	8.4% (±0.6%)	5.1% (±0.3%)	86.5% (±0.7%)
2011	8.2% (±0.7%)	4.9% (±0.3%)	86.9% (±0.8%)
2012	8.3% (±0.6%)	5.3% (±0.3%)	86.5% (±0.7%)
2013	8.2% (±0.6%)	5.0% (±0.3%)	86.9% (±0.7%)
2014	7.9% (±0.5%)	5.2% (±0.3%)	86.8% (±0.7%)

Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table C05001.

Introducing Error Bars

Many of the charts in this assessment show vertical "error bars" cutting through the line connecting the data points over time. These error bars appear whenever the only data available comes from a survey or other sample rather than from complete counts. The smaller the population sample, the less certainty about the true number for the full population.

Unless otherwise noted, the error bars show *margins of error* or *confidence intervals* at a 95% *confidence level*. In simple terms, that means that we are 95% sure that the true number lies somewhere between the two ends of the error bars, but we can't know exactly where. So estimates with wide error bars are less trustworthy than those with narrow error bars. Even if the estimate – the point on the line – rises or drops sharply from one year to the next, if the error bars overlap each other, we can't be sure there was any change at all, or that it wasn't actually in the other direction from what it appears.

Bexar County's population is roughly 59% Hispanic, 29% non-Hispanic white, 7% black or African-American, and 3% Asian (Figure 2.5). The remaining 2% are American Indian, Native Hawaiian, some other race, or multiple races.

Demographic Characteristics

Figure 2.5 Bexar County population demographic characteristics

	2014
Sex	
Male	49.2% (±0.1%)
Female	50.8% (±0.1%)
Race & Ethnicity	
White	29.0% (±0.1%)
Black	7.1% (±0.2%)
Hispanic	59.3% (x)
Asian	2.6% (±0.1%)
American Indian	0.2% (±0.1%)
Native Hawaiian	0.0% (±0.1%)
Other	0.1% (±0.1%)
2+ Races	1.6% (±0.2%)
Age Groups	
Under 5 years	7.2% (±0.0%)
5 to 9 years	7.6% (±0.3%)
10 to 14 years	7.0% (±0.3%)
15 to 19 years	7.2% (±0.0%)
20 to 24 years	7.8% (±0.0%)
25 to 34 years	15.6% (±0.0%)
35 to 44 years	13.3% (±0.0%)
45 to 54 years	12.5% (±0.0%)
55 to 59 years	5.7% (±0.2%)
60 to 64 years	4.8% (±0.2%)
65 to 74 years	6.5% (±0.0%)
75 to 84 years	3.4% (±0.1%)
85 years and over	1.4% (±0.1%)

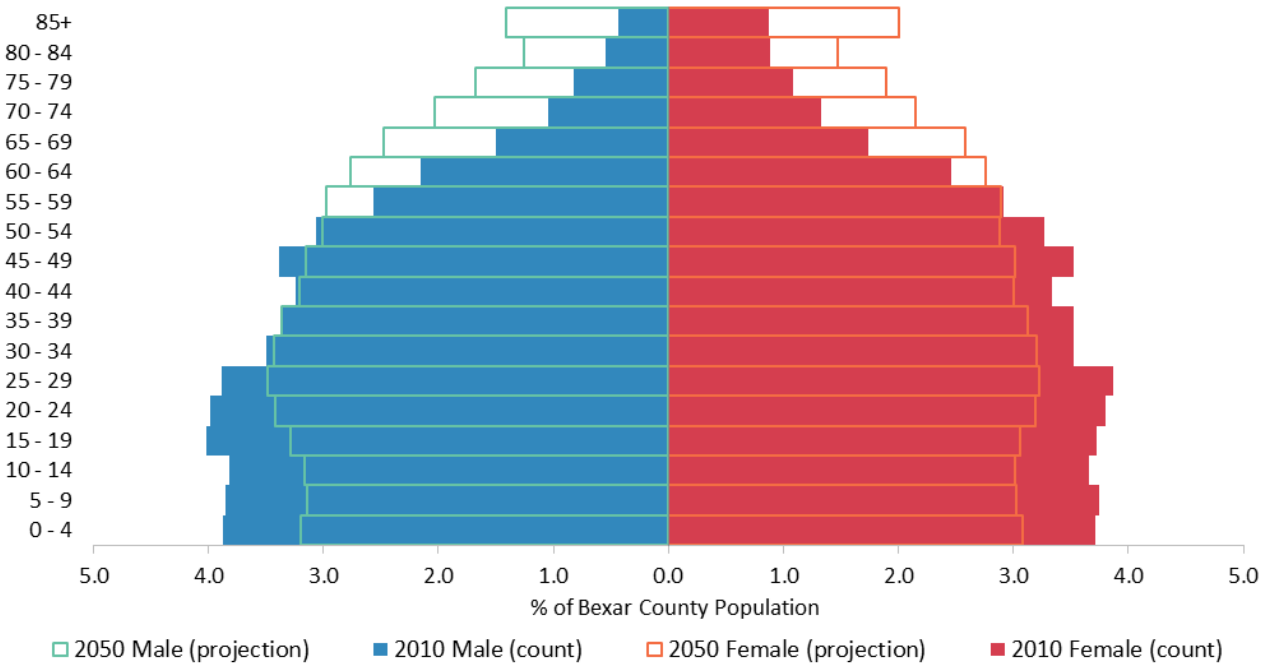
Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table DP05. (x) No margin of error.

The solid-colored area of population pyramid in Figure 2.6 is two back-to-back bar graphs showing the age breakdown for Bexar County males (blue) and females (red). The percent of the total population that each sex/age group makes up is shown along the bottom of the figure; the wider the bar, the greater the percent of total population that age group represents. Bexar County has a relatively young population, so the bars are wider at the lower end of the shape, and solid area overall looks a bit like a house with a pitched roof. The outlined bars show what the population "shape" is projected to look like in 2050 – much closer to a square. People 55 and older will make up a much higher portion of the total county population, while youth will make up a much lower portion. Because of population growth, however, the actual *number* of youth will continue to grow. The most dramatic proportional increase is expected to be in the population 85 and older, greatly increasing demand for health care, housing, and other services for the very old. As will be shown later, poverty and other factors that harm health and well-being are more common in the elderly as well.

The pattern of change in the population age breakdown is dramatically different for different racial/ethnic groups. That change is presented for Hispanics and non-Hispanic whites, Bexar County's two largest racial/ethnic groups. The non-Hispanic white population (Figure 2.7) skews much older than the total population in both 2010 and 2050. The Hispanic population skews much younger (Figure 2.8) than the total population in 2010, with a very large fraction of the population being younger than 20. By 2050, however, the Hispanic age distribution is expected to resemble the total population much more closely.

Current & Projected Age Structure

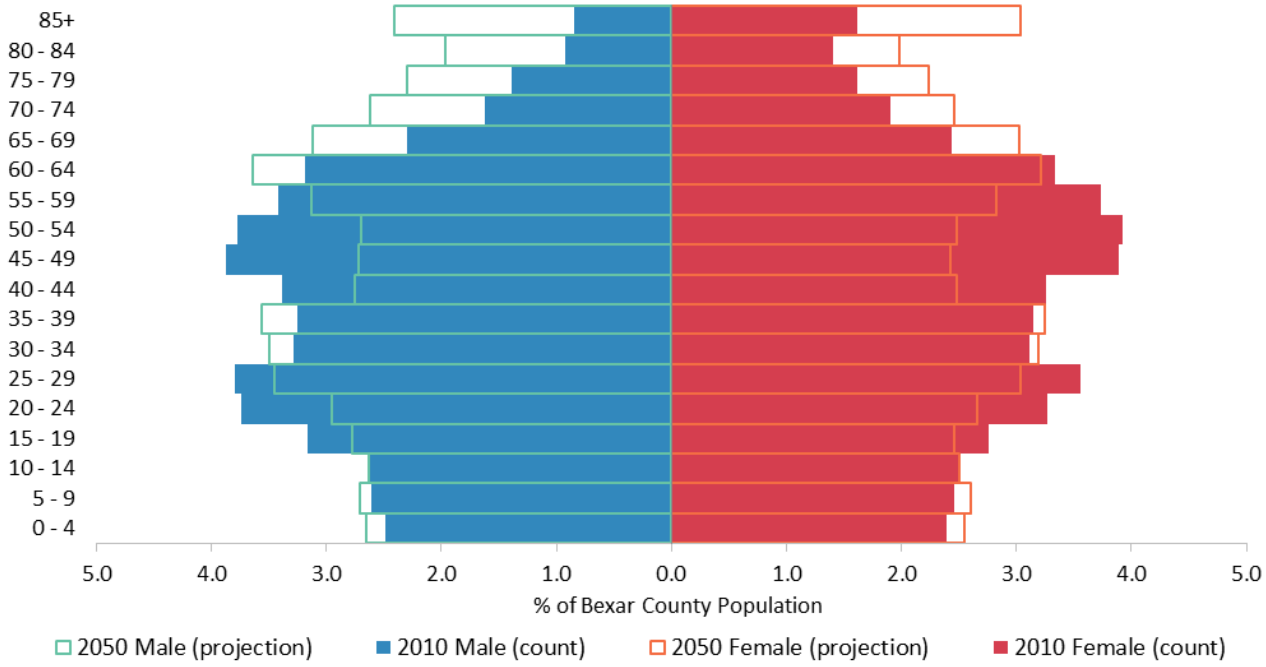
Figure 2.6 Bexar County 2010 & 2050 population percentages by age and sex



Source: U.S. Census Bureau; 2010 Census, QT-P1. Texas State Data Center; Projections of the Population for 2050, 2014.

Current & Projected Age Structure of Non-Hispanic White Population

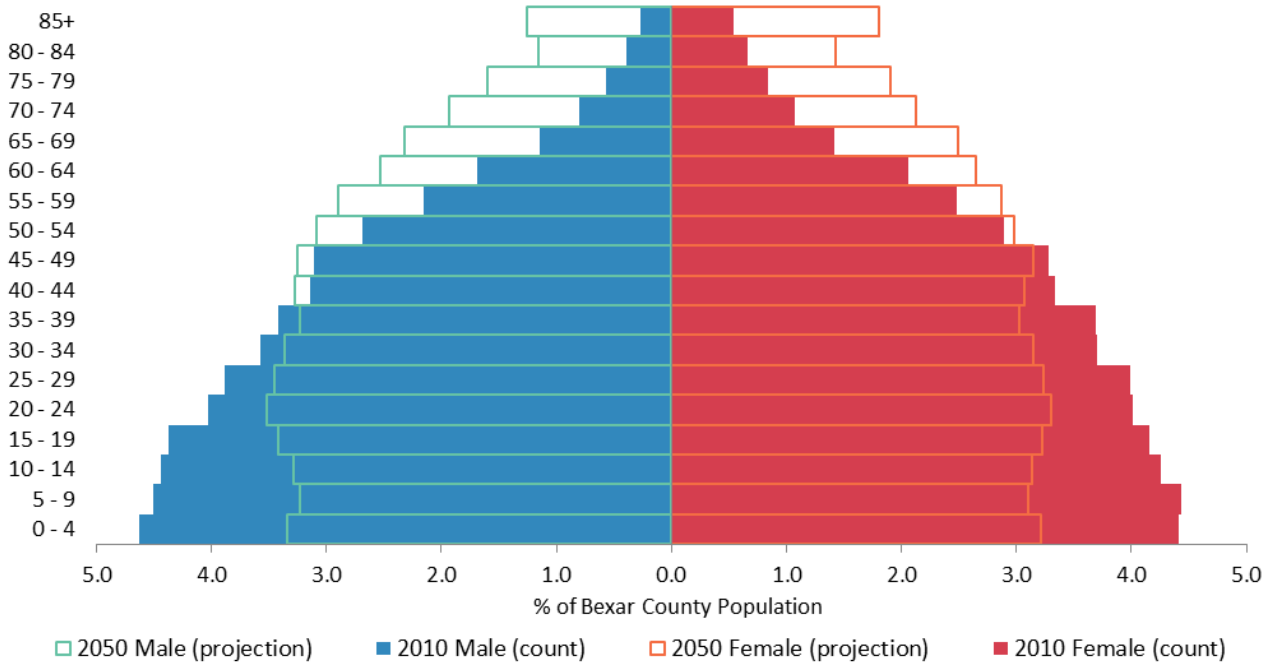
Figure 2.7 Bexar County 2010 & 2050 non-Hispanic white population percentages by age and sex



Source: U.S. Census Bureau; 2010 Census, QT-P1. Texas State Data Center; Projections of the Population for 2050, 2014.

Current & Projected Age Structure of Hispanic Population

Figure 2.8 Bexar County 2010 & 2050 Hispanic population percentages by age and sex



Source: U.S. Census Bureau; 2010 Census, QT-P1. Texas State Data Center; Projections of the Population for 2050, 2014.

Overall population growth differs dramatically as well. Hispanics make up about 59% of the Bexar County population. By 2050, that figure could increase to 66%, or about 2.1 million people. In contrast, the non-Hispanic white population is projected to *decrease,* dropping from 519,000 in 2010 to close to 438,000 in 2050, at which point it will make up only about 13% of the total county population. Hispanics already outnumber non-Hispanic whites in the population 37 and younger. [1]

Bexar County's Hispanic population is by no means homogenous, with a diversity of incomes, educational attainment and skills, and other factors. But as a group, Hispanics experience more conditions that harm health than do non-Hispanic whites, and face structural and systematic barriers to resources and well-being. For these reasons the rapid growth of the Hispanic population is one of the single most important drivers of the current and future health and well-being of the Bexar County population overall. And although this demographic change is happening earlier in Bexar County, Texas and the nation are following the same trend, so Bexar County's experience paints a picture of the future of Texas and, in time, the nation as a whole. Bexar County has the opportunity to respond to this trend in a way that serves as a positive model for Texas and the country.

Breakdowns by Race/Ethnicity

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 are collapsed into one to protect privacy. Where possible, numbers in this report are presented for Hispanics (all races), non-Hispanic Whites, non-Hispanic Blacks, and other and multiple non-Hispanic races. Unfortunately, the Census Bureau's American Community Survey, often the best or only source for an indicator, does not provide data specific to non-Hispanics of any race other than White. That means that where data come from American Community Survey, data for non-Hispanic Blacks cannot be separated from data for other non-Hispanic races, so data can only be presented for "Non-Hispanic Black or Other Race(s)". That group of non-Hispanic races totals about 11.7% of Bexar County's overall population (Figure 2.5), with non-Hispanic Blacks making up 7.1% and the other 4.6% composed of Asians, American Indians, and other and multiple races. But that proportion will vary by indicator in ways that we often do not know.

"expanding the community health worker's role brings **cultural sensitivity**; the population they serve can relate to them"

- Health Literacy Discussion Group

Zip Code Labels on Maps

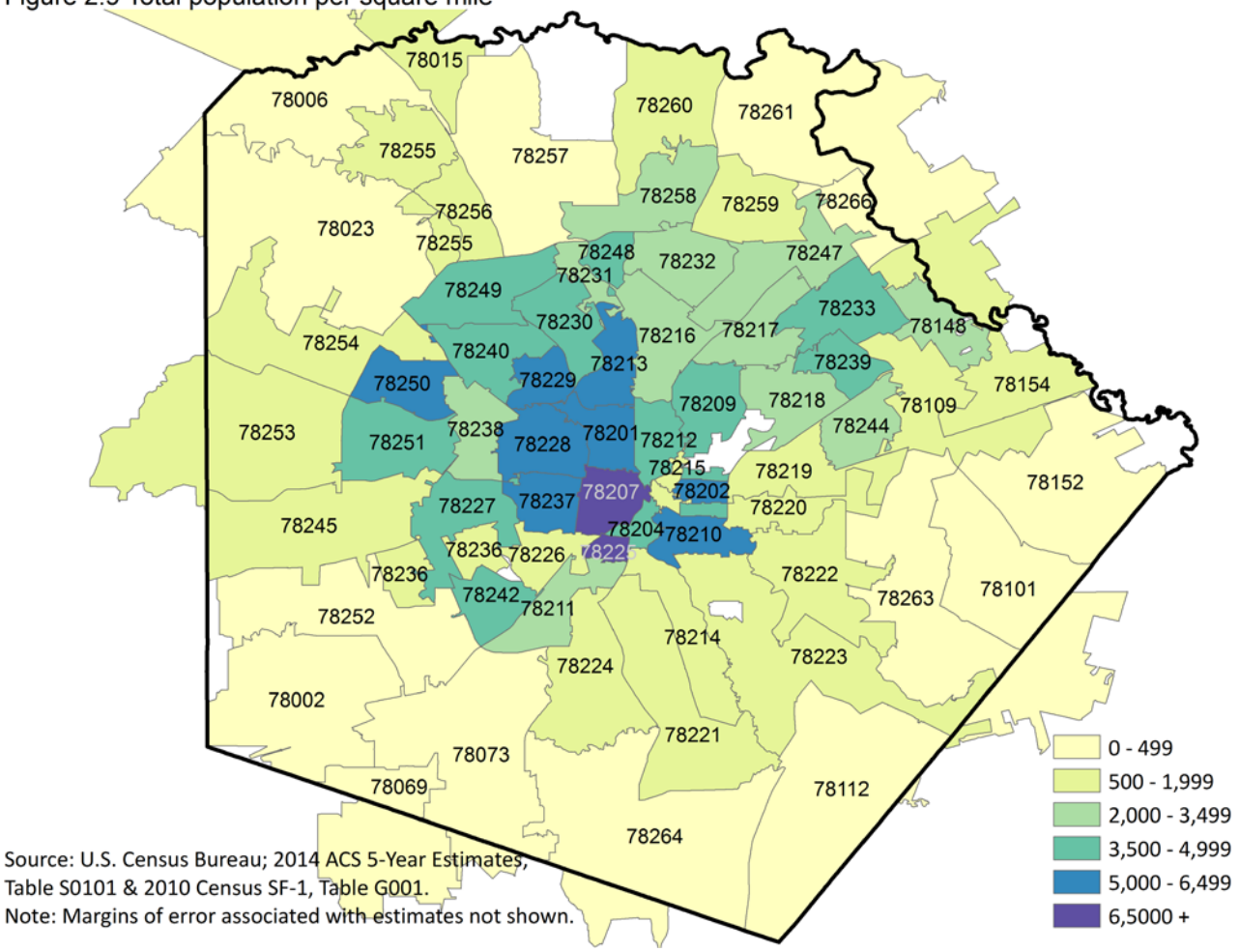
Zip codes 78203 and 78205 are not labelled on the maps by zip code in this report. Those two zip codes and those surrounding them are very small, and labels were omitted to make it easier to see the boundaries and colors. Zip code 78205 is San Antonio's downtown; it lies between 78215 to the north and 78210 to the south, immediately east of 78207. Zip code 78203 is on the near eastside, bounded by 78202 to the north and 78210 to the south. Unlabeled white areas are military bases.

Geographic Population Characteristics

Despite continuing sprawl, Bexar County's overall population density has grown from 1,383 people per square mile in 2010 to 1,497 in 2014[2], with the fastest growth in the central city, the northside, and most especially the area between Bandera Road and U.S. 90 outside Loop 1604.[3] The population is not evenly distributed, throughout the county (Figure 2.9) and is mobile. In 2014, approximately, 18.5% of residents

Population Density by Zip Code

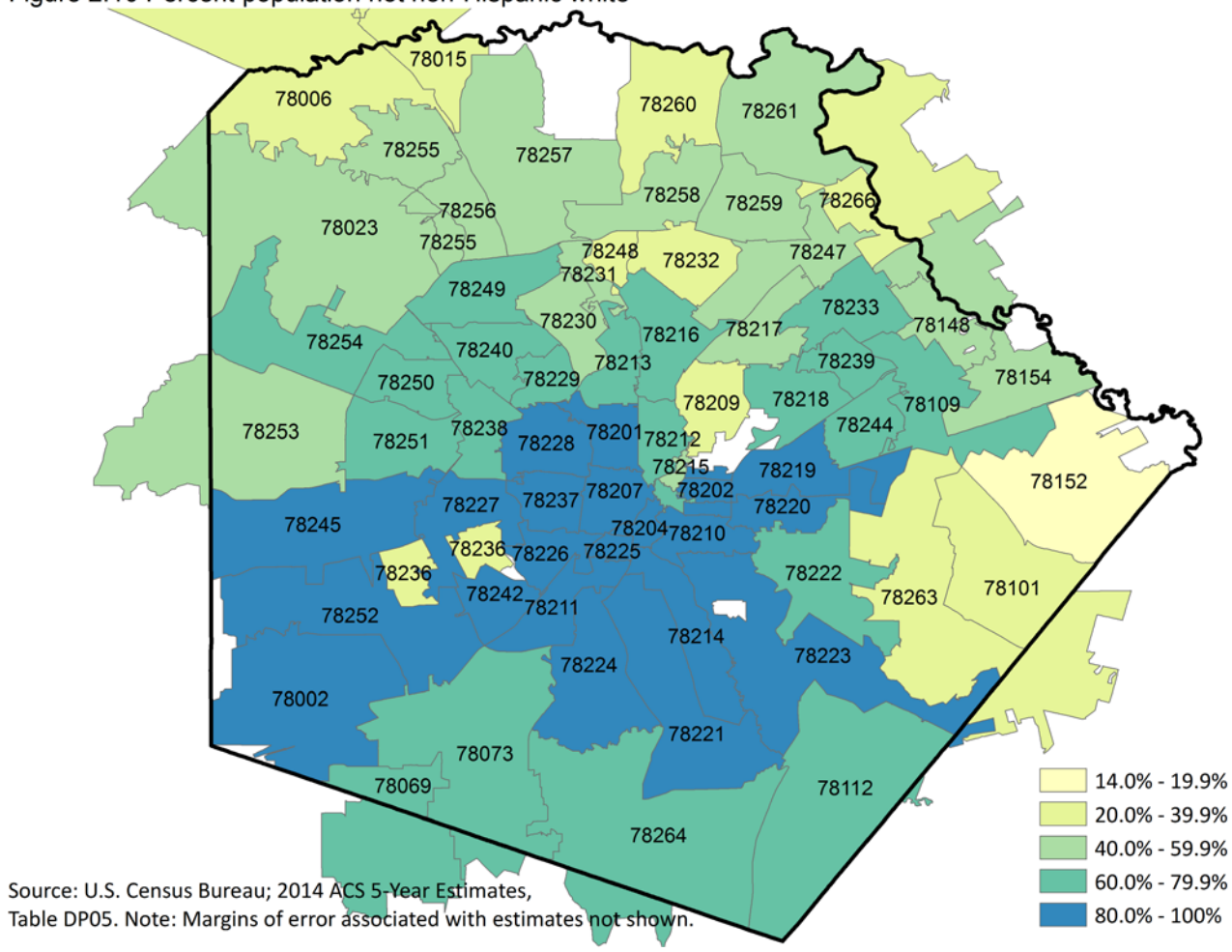
Figure 2.9 Total population per square mile



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S0101 & 2010 Census SF-1, Table G001.
Note: Margins of error associated with estimates not shown.

Racial/Ethnic Minority Population by Zip Code

Figure 2.10 Percent population not non-Hispanic white



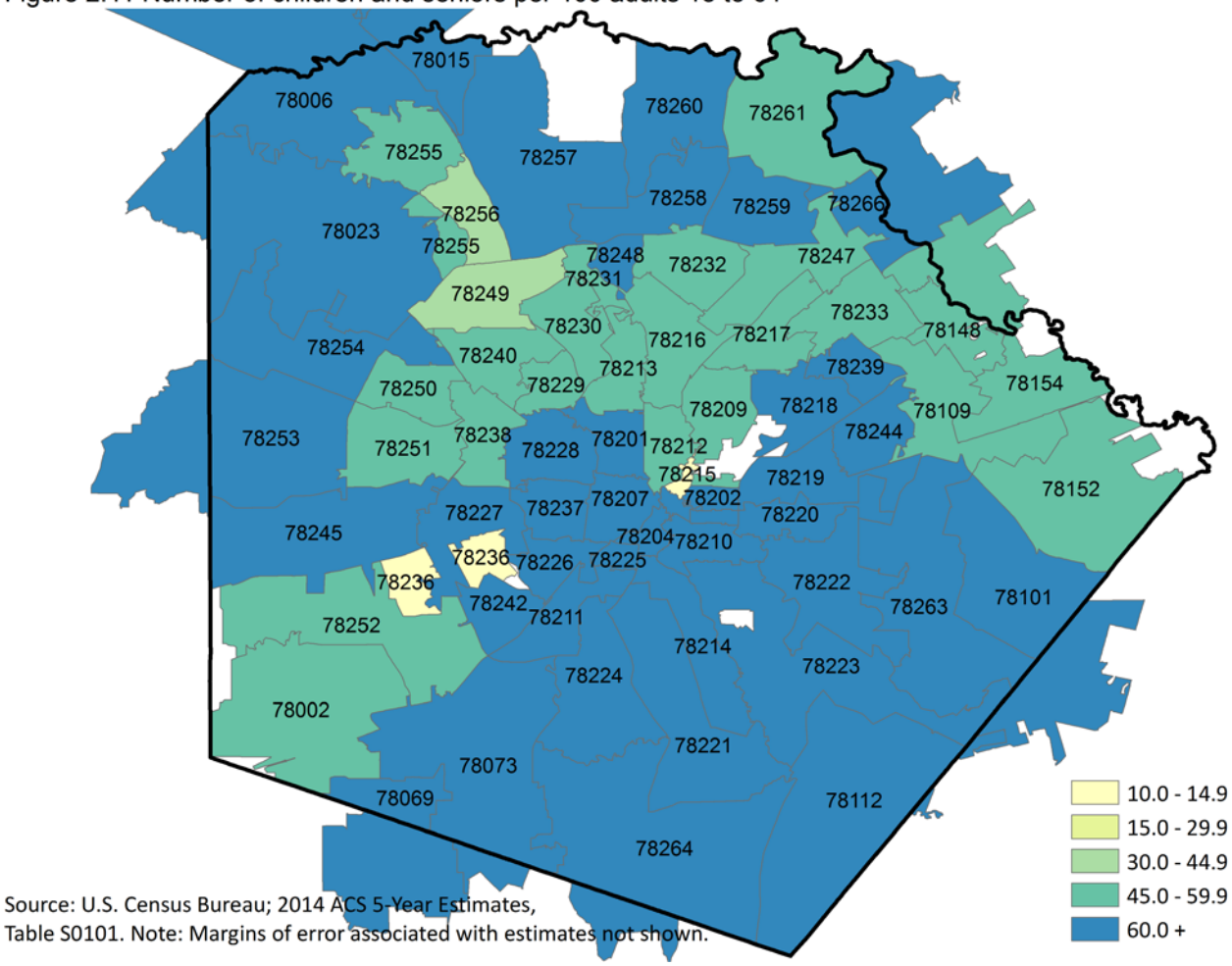
Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates,
Table DP05. Note: Margins of error associated with estimates not shown.

report living in a different home than they did in 2013 with 13% moving within the county.[4] Currently the greatest population density is in zip codes 78207 and 78225 just west and south, respectively, of downtown. Downtown and the area just to the north have historically been sparsely populated, although this pattern is changing with heavy residential development along lower Broadway and the Museum Reach of the San Antonio River. Far south and far east Bexar County south of I-10 remain semi-rural, although greater residential development is expected to occur in the southern half of the county in coming years.[5]

Different demographic groups are unevenly distributed across the county as well. Non-Hispanic whites are much more heavily represented in the northern half of the county, particularly outside Loop 1604 (Figure 2.10). Figure 2.11 maps the age dependency ratio, which describes the relationship between the "dependent population" not likely to be in the labor force and the "working age population." The yellow and white areas on the map represent military bases and the downtown area. This measure can be a useful indicator for the economic and social health of a population and the strain on the service system and the non-

Age Dependency Ratio by Zip Code

Figure 2.11 Number of children and seniors per 100 adults 18 to 64



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S0101. Note: Margins of error associated with estimates not shown.

dependent people who are serving as caregivers, often to both children and seniors. For Bexar County overall, the age dependency ratio is 59.9, or about 60 children and seniors per 100 adults age 18 to 64.[6]

Special Population Demographics

This section highlights the demographics of four key groups who likely have different health issues and different resources for and barriers to health: people in poverty, youth, seniors, and military veterans. While trustworthy data on health-related behaviors and outcomes are more difficult to find for the total populations of people living in poverty and military veterans, as we tend to know most about those who are already engaged in services, data specific to youth and seniors is easily available and provided throughout this narrative. Neighborhood of residence is often a good proxy measure for poverty, and key issues are shown by sub-county geography throughout this document wherever the data are available and trustworthy. It should be noted, though, that zip codes are much larger in the southern portion of the county and tend to stretch in a narrow band that

captures both central-city neighborhoods and the semi-rural areas along and south of Loop 1604. Although poverty and other issues are likely different in these two environments, those differences cannot be seen in data at the zip code and larger levels.

People in Poverty

Poverty is one of the single most powerful "up-stream" factors harming health and well-being, and that holds true both for people who are themselves poor and people with higher incomes who are living in a low-income neighborhood. The estimated percent of the Bexar County population in poverty has remained relatively flat since 2010 and currently stands at 18.4%, or more than 335,000 people (Figure 2.12). Females, minorities, and children (com

Demographic Characteristics

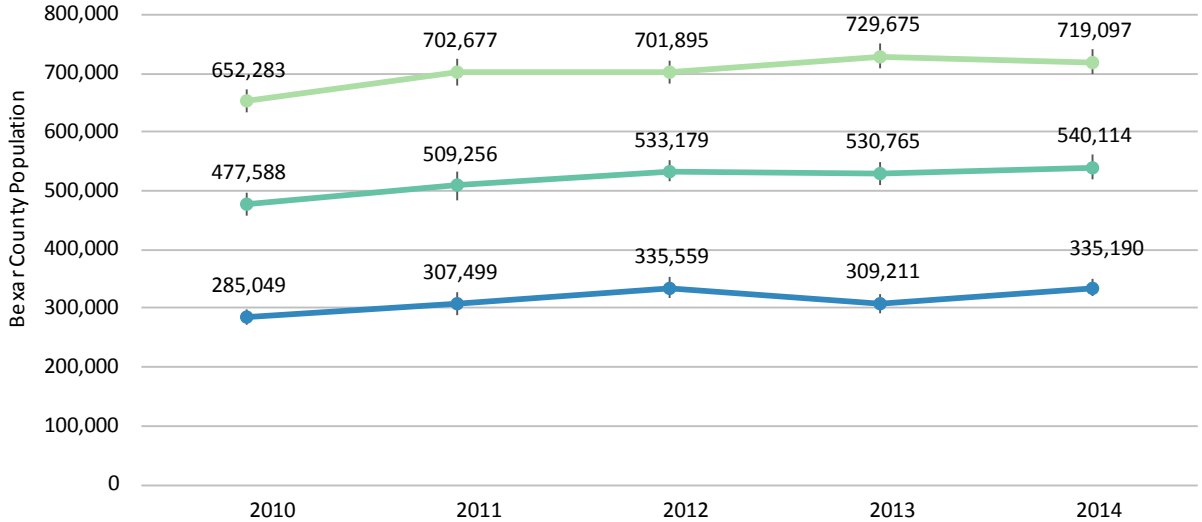
Figure 2.13 Population below 100% poverty level demographic characteristics

	2014
Total Population Below 100% Poverty	**335,190 (±14,917)**
Sex	
Male	44.8% (±1.7%)
Female	55.2% (±1.0%)
Race & Ethnicity	
Hispanic (of any race)	72.2% (±2.8%)
Non-Hispanic White	16.0% (±1.5%)
Non-Hispanic Black or Other Race(s)	11.8% (±2.4%)
Age Groups	
Under 18 years	38.6% (±1.9%)
18 to 64 years	54.6% (±1.3%)
65 years and over	6.8% (±0.8%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S1701.

Population Living In Poverty

Figure 2.12 Bexar County population below 100%, 150%, & 200% poverty level (cumulative)



	2010	2011	2012	2013	2014
Below 100% (MOE)	**16.9% (±0.8%)**	**17.9% (±1.1%)**	**19.2% (±0.9%)**	**17.3% (±0.9%)**	**18.4% (±0.8%)**
Below 150% (MOE)	28.4% (±1.2%)	29.6% (±1.4%)	30.5% (±1.0%)	29.8% (±1.1%)	29.7% (±1.1%)
Below 200% (MOE)	38.8% (±1.1%)	40.9% (±1.3%)	40.1% (±1.1%)	40.9% (±1.2%)	39.5% (±1.1%)

Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S1701.

Adults and Families in Poverty

Figure 2.14 Population below 100% poverty level social characteristics

	2014
Educational Attainment (25 years and over)	
Less than HS	35.6% (±2.6%)
HS or Equivalency	30.3% (±2.4%)
Some College/Associate's Degree	24.5% (±2.0%)
Bachelor's Degree or Higher	9.6% (±1.3%)
Employment Status (20-64 years)	
Employed/In Armed Forces	42.6% (±2.3%)
Unemployed	9.9% (±1.4%)
Not in labor force	47.5% (±2.4%)
Disability Status (20-64 years)	
Disability	21.5% (±2.5%)
No Disability	78.5% (±2.1%)
Family Type (families)	
Married Couple	35.3% (±2.6%)
Single Male	10.5% (±2.4%)
Single Female	54.2% (±3.8%)
Children Present (families)	
No Children	19.8% (±2.6%)
1 or 2 children	47.6% (±3.3%)
3 or 4 children	28.9% (±3.1%)
5 or more children	3.7% (±1.4%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S1701, B17012, & B23024.

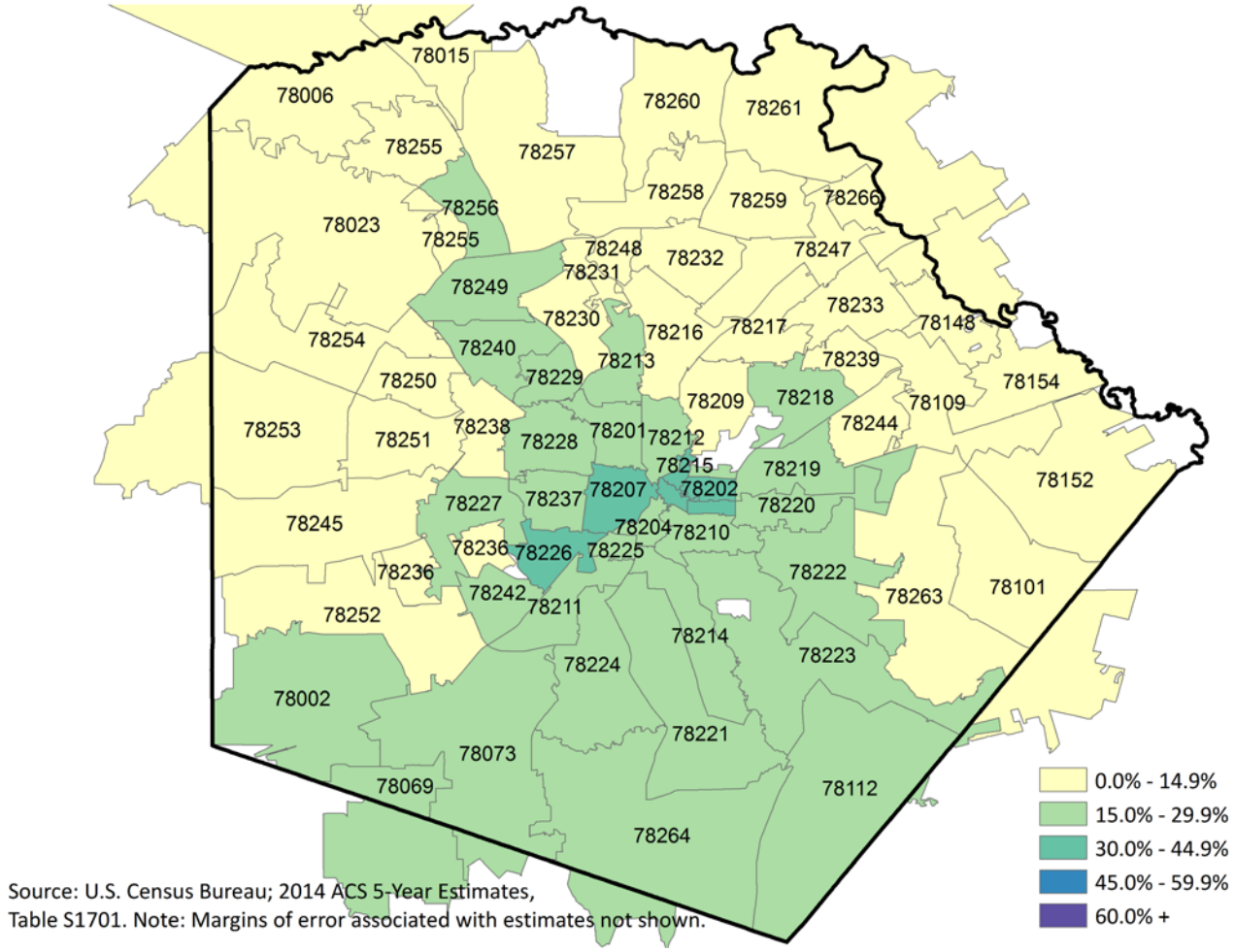
pared to seniors) are disproportionately represented (Figure 2.13). Also over-represented are people with less than a high school diploma or GED, those not in the labor force (i.e., neither employed nor seeking work), and those living in single female headed families (Figure 2.14).

Different age groups clearly assume different burdens of poverty. Among the total population living 100% below the poverty line, over half were adults 18 to 64 and only 6.8% (± 0.8%) were seniors. Nearly 40% of those living in poverty were children under 18 years old.

The highest rates of poverty among working-age adults are found on the near eastside and westside (Figure 2.15). Among seniors, the poverty rate is highest in zip code 78207 (Figure 2.16) on the near westside. Although zip code 78205 also shows a high rate, it is located in the less populated central downtown area that has a very small senior population. (Again, map labels for zip codes 78203 and 78205 have been omitted for readability. Zip code 78205 is immediately east of 78207; 78203 is immediately south of 78202.)

Adults 18-64 Living In Poverty by Zip Code

Figure 2.15 Percent adults 18-64 below 100% poverty level

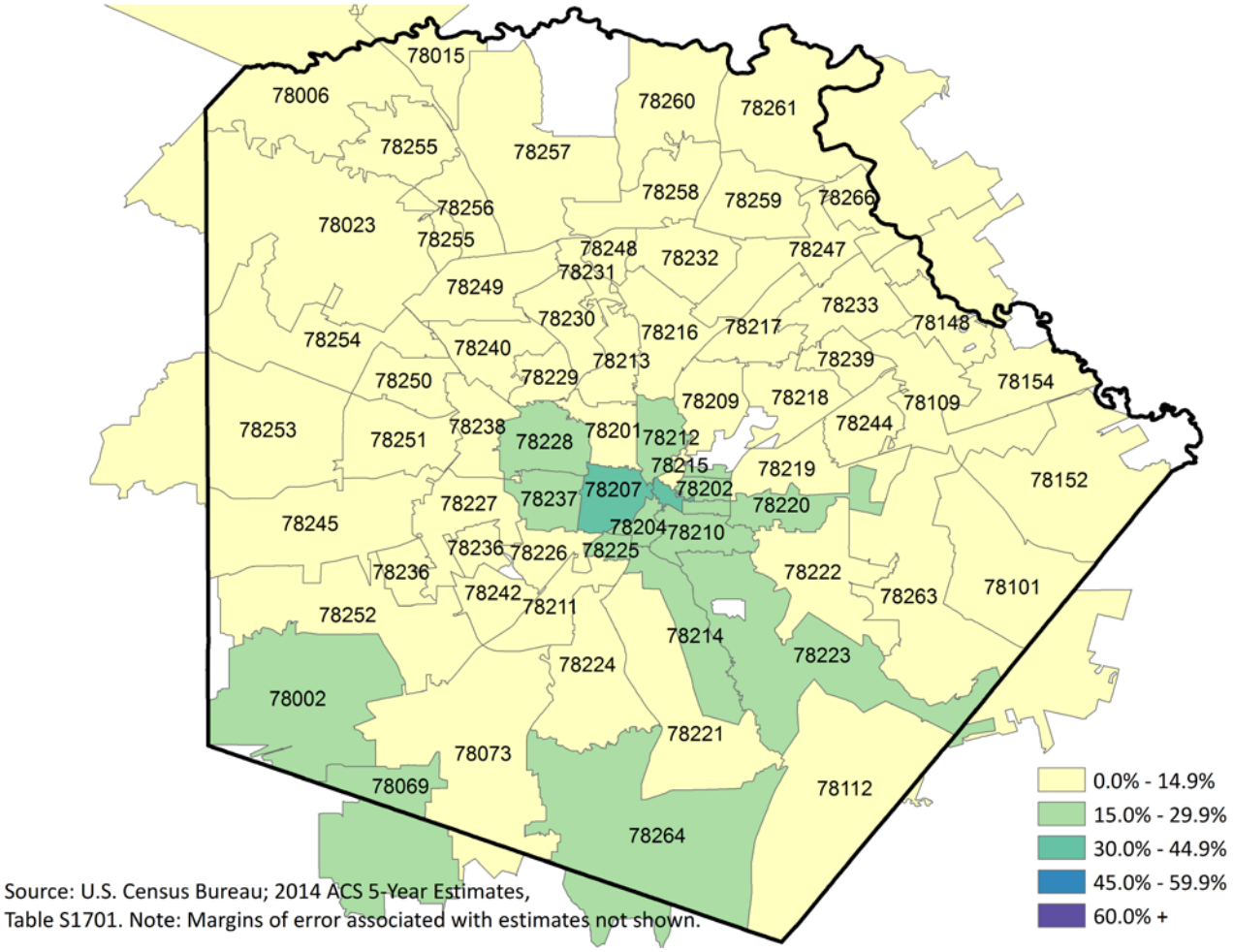


Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates,
Table S1701. Note: Margins of error associated with estimates not shown.

Among children, the very highest rates of poverty – 60% and higher – are in zip codes 78203, on the near eastside below E. Commerce St., and 78215, which stretches from north downtown up to Mahncke Park along the lower Broadway corridor (Figure 2.17). Zip code 78215 is sparsely populated by children, though, whereas 78203, part of the EastPoint neighborhood with the federal Promise and Choice Neighborhood initiatives, has a much larger number of children. In general, the lowest rates of child poverty – below 15% – are in the far north and northwest areas of the county outside Loop 410.

Seniors Living In Poverty by Zip Code

Figure 2.16 Percent adults 65+ below 100% poverty level



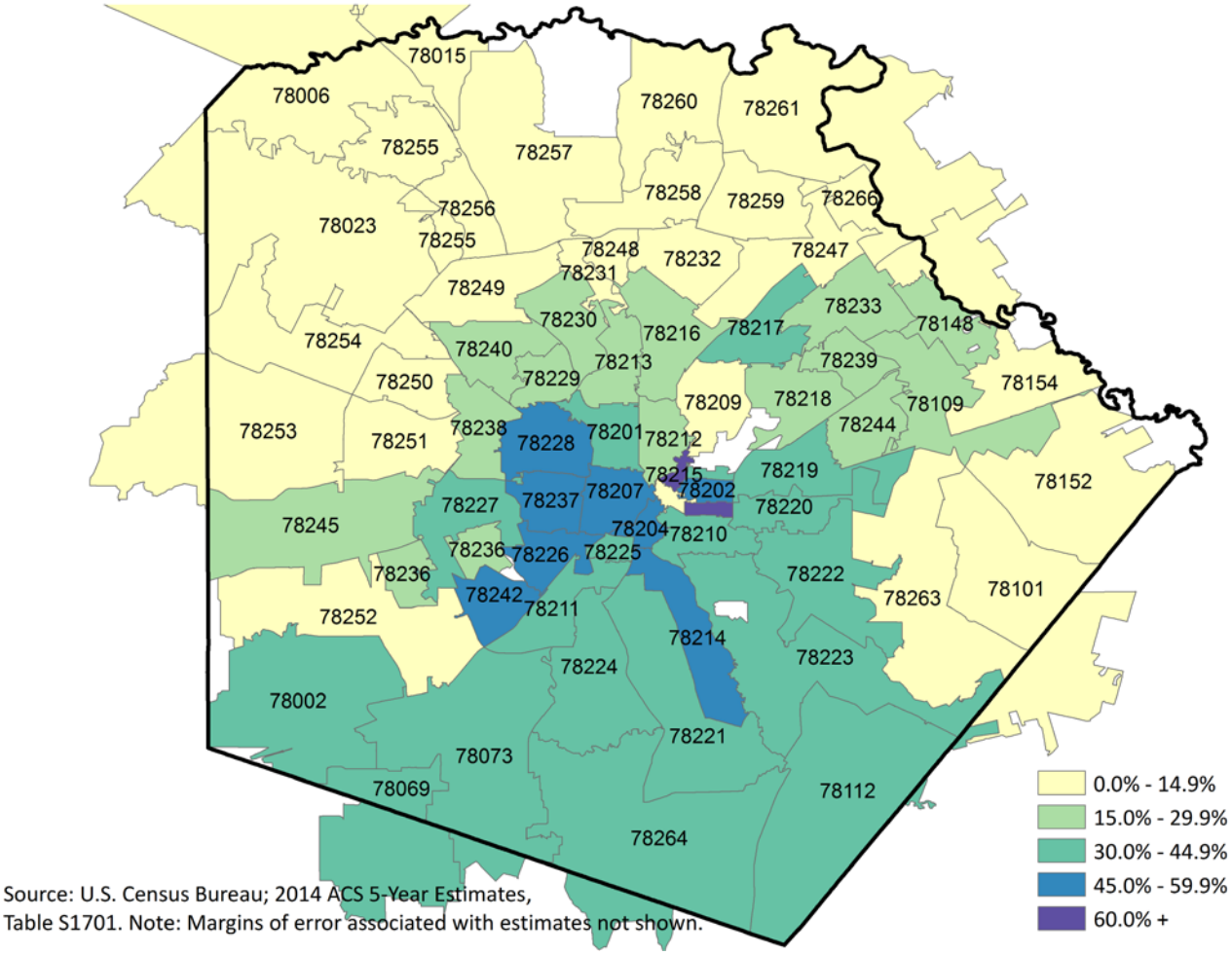
Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates,
Table S1701. Note: Margins of error associated with estimates not shown.

"educated people come and go
because they have options, but the **poor**
uneducated people tend to **accumulate** and you
get this **intergenerational poverty**"

- Anonymous

Children Living In Poverty by Zip Code

Figure 2.17 Percent children below 100% poverty level



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates,
Table S1701. Note: Margins of error associated with estimates not shown.

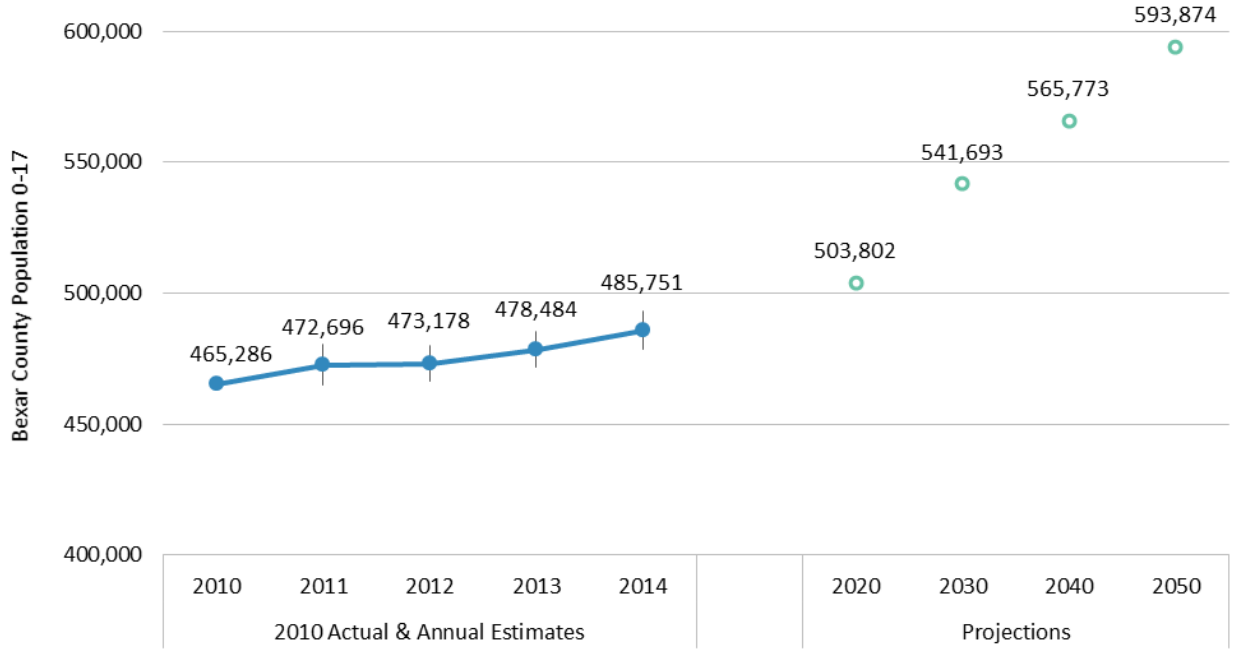
Youth

The child and teen population is exposed to health risks and circumstances daily that directly relate and influence lifelong patterns of health behavior. The current population of youth under 18 is estimated at 485,751 and is projected to reach 593,874 in 2050, a nearly 28% increase over 2010 (Figure 2.18).

At about 20%, a smaller proportion of the youth population is non-Hispanic White (Figure 2.19) compared to the total population (29%). About 28% of youth are under five years of age, 40% are age five to 11, and 32% are age 12 to 17. Even though the overall poverty rate is 18.4%, 27% of children live in poverty (Figure 2.20). Six in 10 children live in a household headed by a married couple and one in 10 are in households headed by a grandparent or another relative other than a parent.

Youth Population

Figure 2.18 Bexar County total & projected population 0-17



Source: U.S. Census Bureau; 2010 Census, QT-P1 & 2011-2014 ACS 1-Year Estimates, Table B01001. Texas State Data Center; Projections of the Population for 2010-2050, 2014.

Youth are dependent on the working population to support them, care for them, and access health care and other resources for them, so the size and distribution of this population affects the socioeconomic status and health of the county as a whole. Bexar County's overall age dependency ratio is decreasing, dropping from 43.3 (±0.1) children per 100 adults age 18 to 64 (±0.1) in 2010 to 41.9 in 2014.[7] The ratio of children to working-age adults varies across the county (Figure 2.21), but not following the same pattern as race/ethnicity, poverty, and other factors. Highest ratios are found in southern, far northern, and northwestern Bexar County. But two stretches extend from the central city, one north of I-90 from the near westside out past Loop 1604, and another south of FM 78/Gibbs Sprawl Road from the near eastside out to Converse.

"access to childcare is one of the main challenges. Residents do not use formal childcare because they are not aware of the options"

- Richard Milk

Demographic Characteristics

Figure 2.19 Population under 18 years demographic characteristics

	2014
Total Population Under 18	**485,751 (x)**
In Households	99.8% (±0.1%)
In Group Quarters	0.2% (±0.1%)
Sex	
Male	50.8% (±0.7%)
Female	49.2% (±0.8%)
Race & Ethnicity	
Hispanic (of any race)	68.1% (±1.9%)
Non-Hispanic White	20.4% (±2.1%)
Non-Hispanic Black or Other Race(s)	11.5% (±2.8%)
Age Groups	
0 to 4 years	27.7% (±0.9%)
5 to 11 years	39.9% (±1.3%)
12 to 17 years	32.4% (±0.8%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table B09001, B01001, & S0901. (x) No margin of error.

Social Characteristics

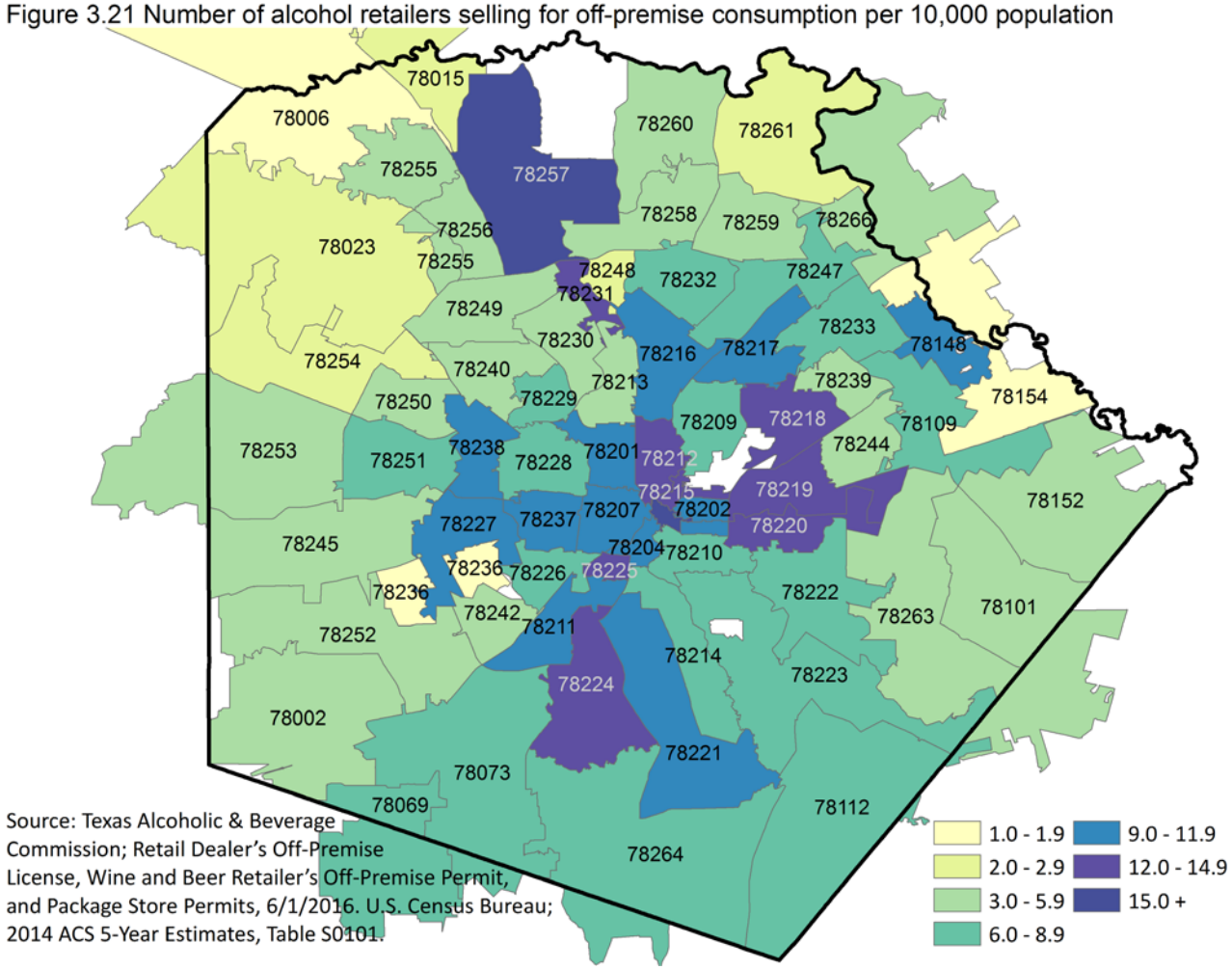
Figure 2.20 Population under 18 years social characteristics

	2014
Relationship to Householder	
Own Child (biological, step, adopted)	5.1% (±0.9%)
Grandchild	19.3% (±1.8%)
Other Relatives	44.0% (±2.1%)
Foster/Unrelated	31.6% (±2.0%)
Family Type (own children)	
Married	63.1% (±1.9%)
Single Male	7.3% (±0.9%)
Single Female	29.6% (±1.6%)
Poverty Status	
Below 100% Poverty Level	27.0% (±1.2%)
Above 100% Poverty Level	73.0% (±0.7%)
School Enrollment by Age	
3 to 4 years	35.5% (±4.0%)
5 to 9 years	96.0% (±0.8%)
10 to 14 years	99.0% (±0.6%)
15 to 17 years	95.9% (±1.2%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S0901, B09002, S1401.

Alcohol Retailer Density by Zip Code

Figure 3.21 Number of alcohol retailers selling for off-premise consumption per 10,000 population

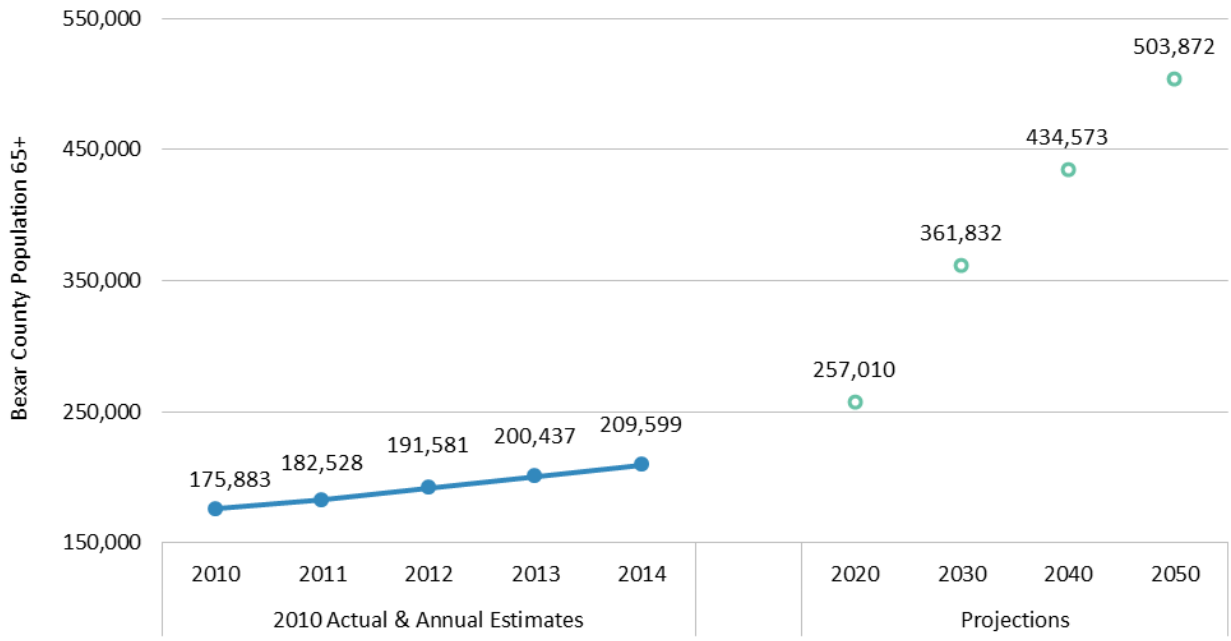


Seniors

Seniors, like youth, are exposed to different health-related factors and are often dependent to varying degrees on family caregivers. On the whole, people are living longer than they ever have, which increases demands on health, assisted housing, transportation, and many other services. The current population of seniors age 65 and older is estimated at 209,599 and is projected to rise sharply in coming decades, reaching 503,872 in 2050, nearly triple the 2010 population (Figure 2.22).

Senior Population

Figure 2.22 Bexar County total & projected population 65+



Source: U.S. Census Bureau; 2010 Census, QT-P1 & 2011-2014 ACS 1-Year Estimates, Table B01001. Texas State Data Center; Projections of the Population for 2010-2050, 2014.

At 57% of the senior population, females significantly outnumber males in the 65 and older age group (Figure 2.23). Hispanics are dramatically under-represented among the senior population. Not surprisingly, seniors are less likely than the total population to be in the labor force (Figure 2.24), although many may have kept working past traditional retirement age. Less than half of the senior population have a disability and about one in 10 lives below the poverty level – an annual income of less than $11,800 for a person living alone.[8]

Demographic Characteristics

Figure 2.23 Senior population 65+ demographic characteristics

	2014
Total Senior Population 65+	**209,599 (±286)**
Sex	
Male	43.0% (±0.1%)
Female	57.0% (±0.1%)
Race & Ethnicity	
Hispanic (of any race)	45.4% (±0.1%)
Non-Hispanic White	45.4% (±0.1%)
Non-Hispanic Black or Other Race(s)	9.2% (±0.1%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S0103.

The population of grandparents living with their own grandchildren under 18 years of age has remained relatively flat in recent years (Figure 2.25). However, most of those grandparents are not seniors, with only about a third being 60 years or older.

Bexar County's old-age dependency ratio has grown from 16.5 (±0.1) seniors per 100 adults age 18 to 64 in 2010 to 18.1 (±0.1) in 2014.[9] If population projections hold true, by 2050 that figure will have climbed to 32.3.[10] The old-age dependency ratio differs across the county, though not as strongly as the child dependency ratio (Figure 2.26).

Social Characteristics

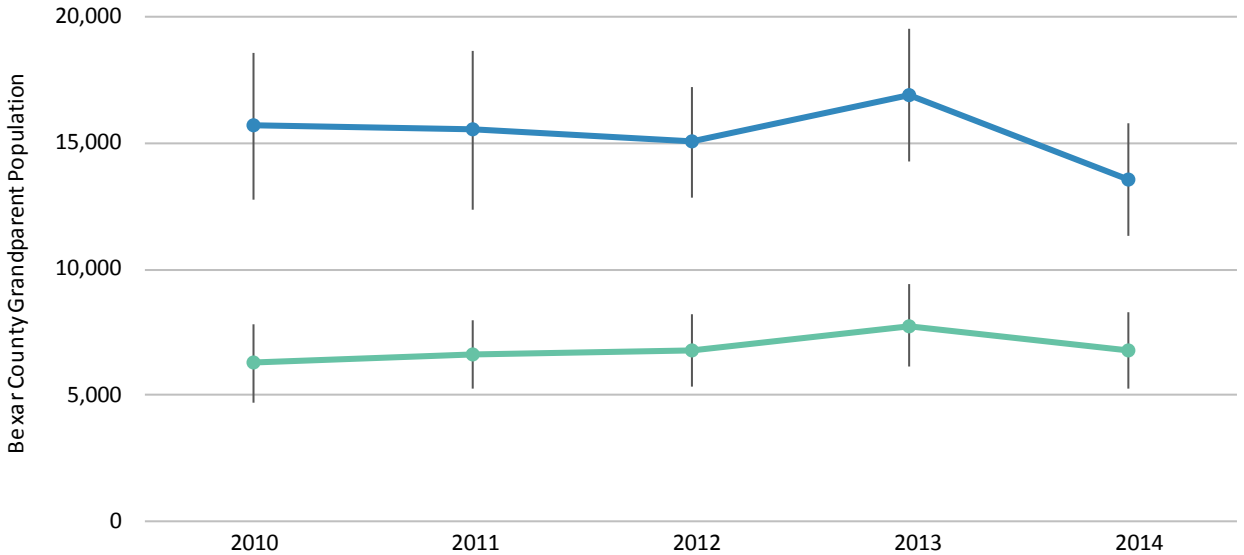
Figure 2.24 Senior population 65+ social characteristics

	2014
Educational Attainment	
Less than HS	24.3% (±1.4%)
HS or Equivalency	25.0% (±1.3%)
Some College/Associate's Degree	25.9% (±1.4%)
Bachelor's Degree or Higher	24.8% (±1.4%)
Employment Status	
Employed	16.6% (±1.3%)
Unemployed	0.8% (±0.4%)
Not in labor force	82.6% (±1.4%)
Disability Status	
Disability	43.1% (±1.5%)
No Disability	56.9% (±1.5%)
Poverty Status	
Below 100% Poverty Level	11.1% (±1.4%)
100-149% Poverty Level	11.2% (±1.2%)
Above 150% Poverty Level	77.7% (±1.7%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S0103.

Grandparents Living with Grandchildren

Figure 2.25 Population living with their own grandchildren under 18 years by age group

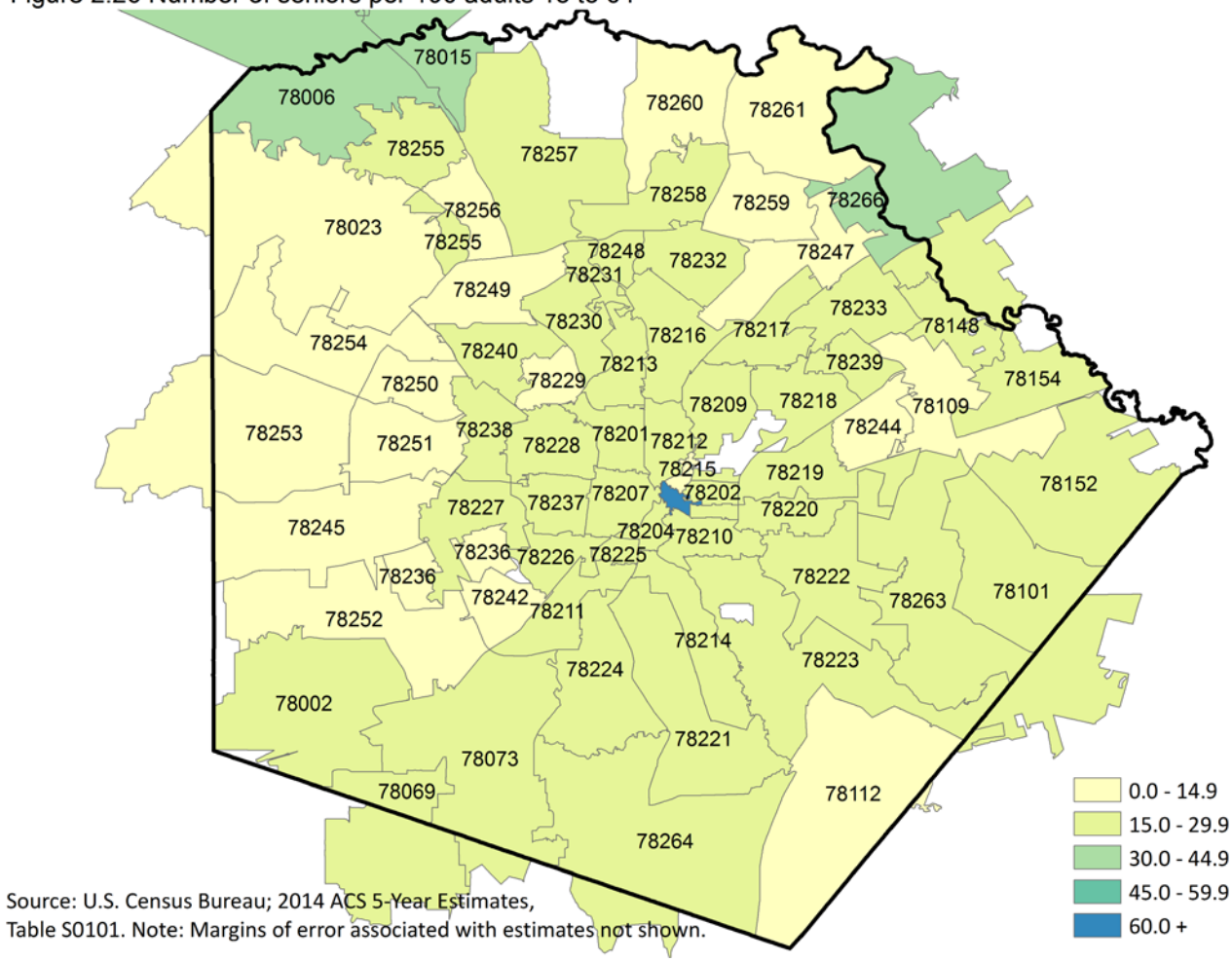


	2010	2011	2012	2013	2014
30-59 years	15,695 (±2,901)	15,519 (±3,154)	15,046 (±2,172)	16,900 (±2,608)	13,574 (±2,219)
60+ years	6,287 (±1,537)	6,622 (±1,341)	6,754 (±1,436)	7,780 (±1,632)	6,789 (±1,523)

Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S1002.

Old-Age Dependency Ratio by Zip Code

Figure 2.26 Number of seniors per 100 adults 18 to 64



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S0101. Note: Margins of error associated with estimates not shown.

Veterans

San Antonio has one of the country's largest active and retired military populations[11], and this group has both different health-related risks and protective factors. Veterans also have access to different health-related resources to support health, such as the Veterans Administration (VA) health care system. The size of the veteran population – civilians 18 years and older who are military veterans – has held fairly steady since 2010, currently an estimated 153,212 (± 5,957), but has decreased slightly as a percent of the total population (Figure 2.27).

The veteran population is most heavily concentrated along Loop 1604 north of Highway 90 and I-10 (Figure 2.28). Zip codes 78245 and

78251, near Lackland AFB and along the Potranco Road corridor, are home to a combined total of almost 13,000 veterans.

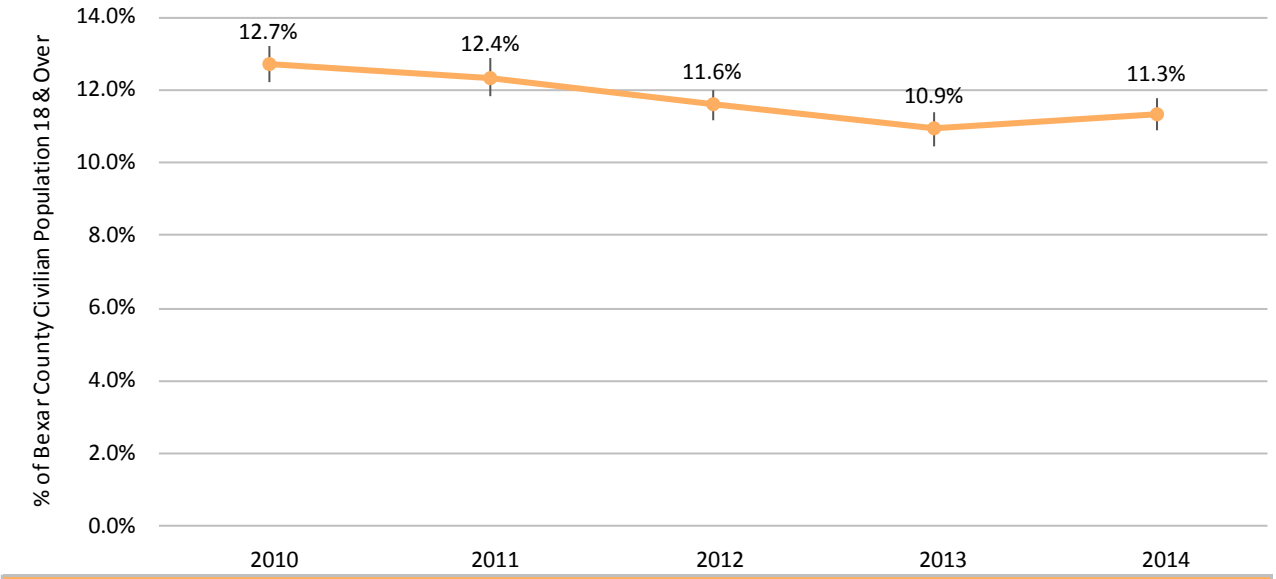
About 85% of Bexar County veterans are male. Almost half are non-Hispanic White, 36% are Hispanic, and 17% are another non-Hispanic minority – including African-American (Figure 2.29). A third of veterans are 65 years of age or older, as compared to about 11% of the general population.

The veteran population as a whole has relatively high educational attainment and income and a low poverty rate. Only 5.1% (± 0.9%) of veterans have less than a high school degree and 31.6% (± 2.0%) have a bachelor's degree or higher (Figure 2.30). The veteran population has an estimated median income of about $42,165 (± $1,510), as compared to an estimated $22,927 (± $535) for the non-veteran civilian population. An estimated 6.2% (± 1.1%) of veterans live in poverty, as compared to 16.6% (± 0.8%) of non-veteran civilians.[12]

About three in 10 veterans have a disability of some kind, although the Census Bureau's definition of disability may not effectively capture disabling mental illness like post-traumatic stress disorder (PTSD) or depression.[13]

Veteran Population

Figure 2.27 Bexar County civilian population 18 years and over that are veterans

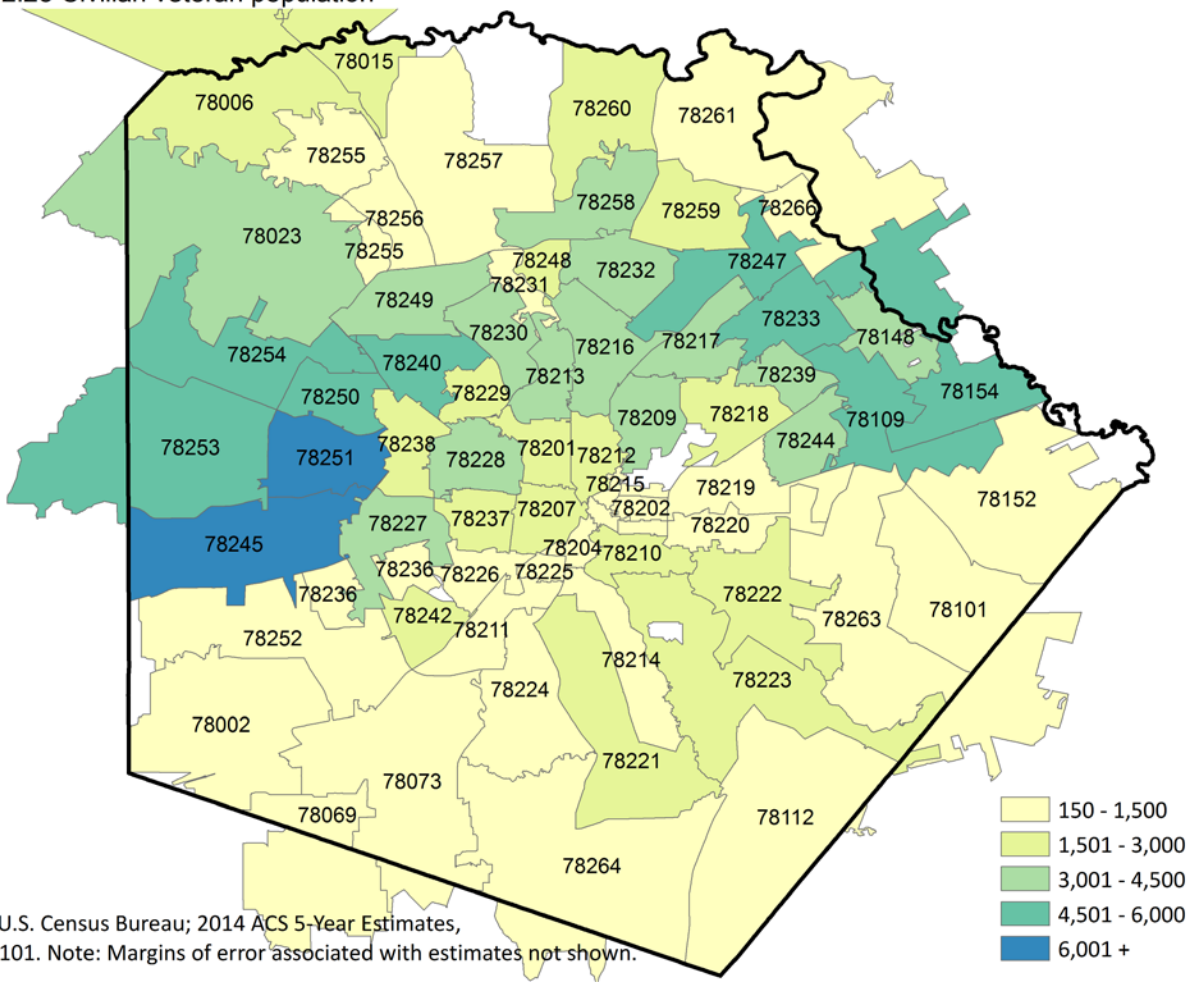


	2010	2011	2012	2013	2014
Veterans	156,465	155,712	150,082	144,791	153,212
(MOE)	(±6,143)	(±6,719)	(±5,635)	(±6,352)	(±5,957)

Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S2101.

Veterans by Zip Code

Figure 2.28 Civilian veteran population



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S0101. Note: Margins of error associated with estimates not shown.

Demographic Characteristics

Figure 2.29 Civilian veteran population demographic characteristics

	2014
Total Civilian Veteran Population	**153,212 (±5,957)**
Sex	
Male	84.8% (±1.4%)
Female	15.2% (±1.4%)
Race & Ethnicity	
Hispanic (of any race)	35.6% (±1.9%)
Non-Hispanic White	47.3% (±2.1%)
Non-Hispanic Black or Other Race(s)	17.1% (±2.8%)
Age Groups	
18 to 34 years	15.2% (±1.3%)
35 to 54 years	31.6% (±1.8%)
55 to 64 years	20.2% (±1.3%)
65 to 74 years	18.3% (±1.2%)
75 years and over	14.8% (±0.9%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S2101.

Social Characteristics

Figure 2.30 Veteran population social characteristics

	2014
Educational Attainment (25 years and over)	
Less than HS	5.1% (±0.9%)
HS or Equivalency	19.3% (±1.8%)
Some College/Associate's Degree	44.0% (±2.1%)
Bachelor's Degree or Higher	31.6% (±2.0%)
Employment Status (18-64 years)	
Labor Force Participation	76.3% (±1.9%)
Unemployed	6.1% (±1.8%)
Disability Status	
Disability	29.8% (±1.6%)
No Disability	70.2% (±1.6%)
Poverty Status	
Below 100% Poverty Level	6.2% (±1.1%)
Above 100% Poverty Level	93.8% (±1.1%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S2101.

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[1] Davila, V. (2015, September 25). Bexar County, regional population expected to keep booming. *San Antonio Express-News*. http://www.mysanantonio.com/150years/article/Bexar-County-regional-population-expected-to-6529803.php

[2] U.S. Census Bureau; 2010 Census SF-1, Table G001, DP-1 & 2014 ACS 1-Year Estimates, Table DP05.

[3] Davila, V. (2015, September 25). Bexar County, regional population expected to keep booming. *San Antonio Express-News*. http://www.mysanantonio.com/150years/article/Bexar-County-regional-population-expected-to-6529803.php

[4] U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S0701.

[5] Davila, V. (2015, September 25). Bexar County, regional population expected to keep booming. *San Antonio Express-News*. http://www.mysanantonio.com/150years/article/Bexar-County-regional-population-expected-to-6529803.php

[6] U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S0101.

[7] U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S0101.

[8] U.S. Department of Health and Human Services (2016). U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs. https://aspe.hhs.gov/poverty-guidelines

[9] U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S0101.

[10] Texas State Data Center; Projections of the Population for 2010-2050, 2014.

[11] San Antonio Convention & Visitors Bureau (2015). Military City USA. http://visitsanantonio.com/MILITARY

[12] U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S2101.

[13] U.S. Census Bureau (2014). American Community Survey Disability Definitions. http://www.census.gov/people/disability/methodology/acs.html

Environment & Living Conditions

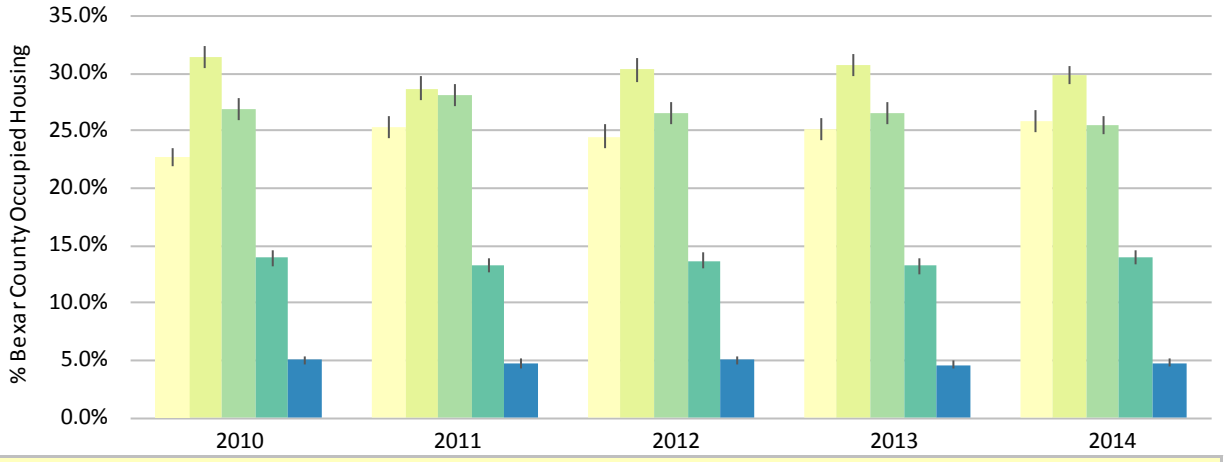
Built & Natural Environment

Quality housing is important to health and well-being, as substandard housing is associated with an increased risk of injury and respiratory diseases. Close to half of Bexar County's housing was built before 1980 (Figure 3.1), but the condition of these older homes varies not just by neighborhood but often by block. 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.[1]

Scattered infill notwithstanding, most housing built since 2000 is concentrated outside Loop 1604 to the north and northwest. The county's oldest housing stock is concentrated in neighborhoods immediately south, east, and north of downtown, with median year built falling in the 1930s and 1940s (Figure 3.2). The character and quality of the housing stock vary significantly across this central-city area, particularly in neighborhoods currently undergoing rapid change. While many homes in these areas

Time Period of Housing Construction

Figure 3.1 Percent of occupied housing units by year built

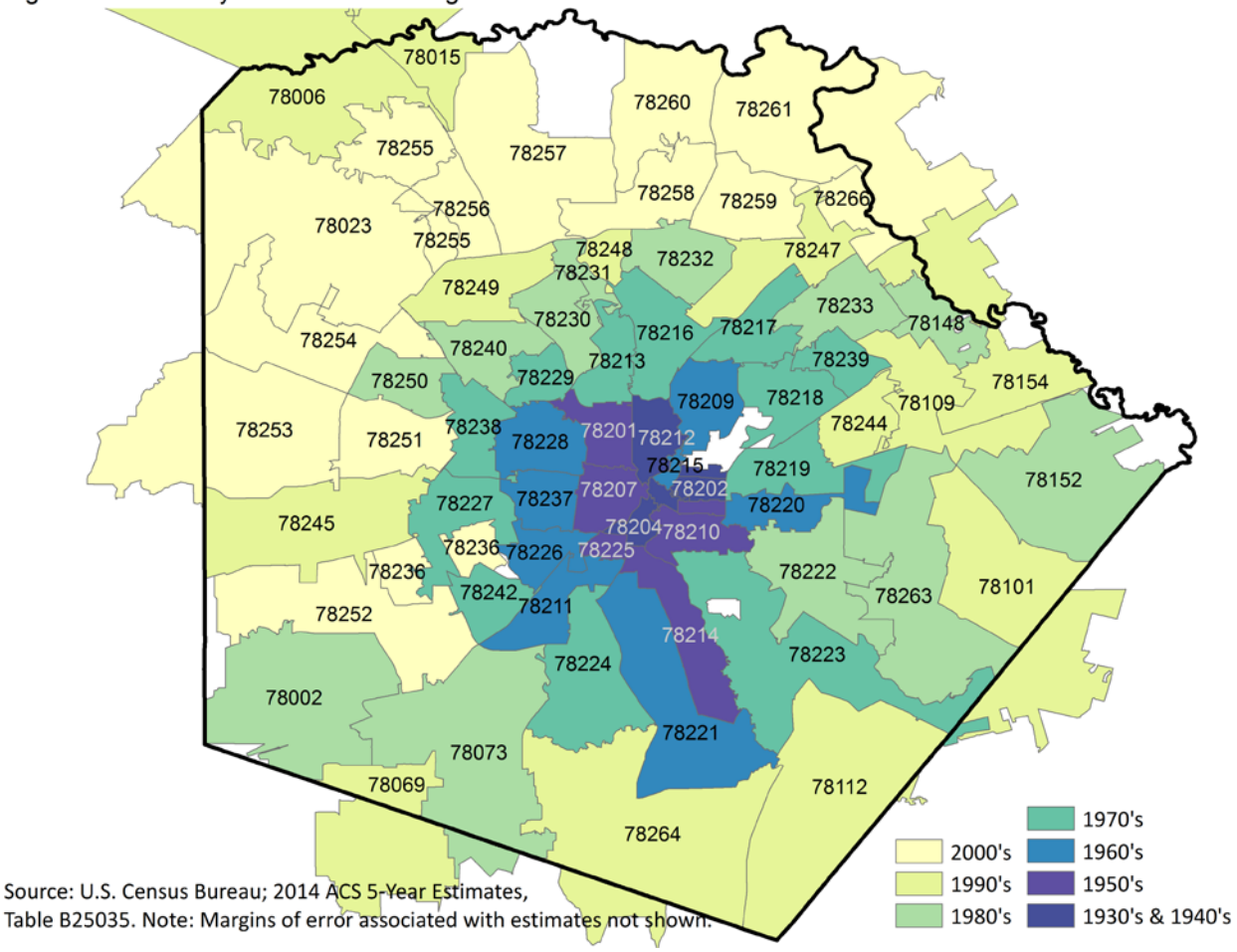


	2010	2011	2012	2013	2014
2000 or later	22.7% (±0.8%)	25.3% (±1.0%)	24.5% (±1.0%)	25.1% (±1.0%)	25.8% (±1.0%)
1980 -1999	31.4% (±1.0%)	28.7% (±1.0%)	30.3% (±1.0%)	30.7% (±0.9%)	29.8% (±0.8%)
1960 -1979	26.9% (±1.0%)	28.1% (±1.0%)	26.5% (±0.9%)	26.5% (±0.9%)	25.5% (±0.8%)
1940 -1959	13.9% (±0.7%)	13.2% (±0.6%)	13.7% (±0.7%)	13.2% (±0.7%)	14.0% (±0.6%)
1939 or earlier	5.0% (±0.4%)	4.7% (±0.4%)	5.0% (±0.4%)	4.6% (±0.4%)	4.8% (±0.4%)

Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S2504.

Time Period of Housing Construction by Zip Code

Figure 3.2 Median year built for housing structures



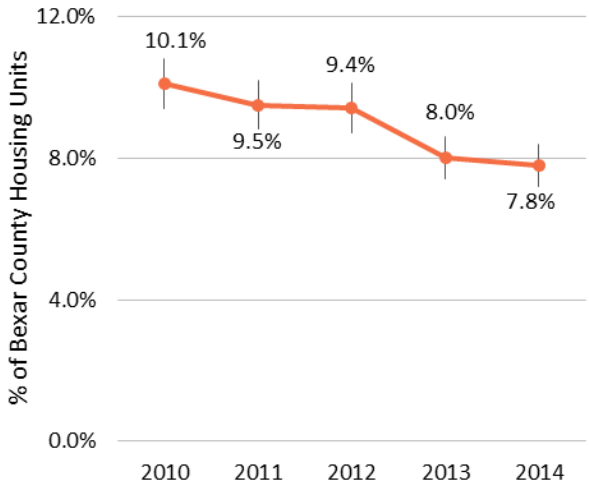
Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table B25035. Note: Margins of error associated with estimates not shown.

have been well-maintained over time or are recently restored, others suffer from decades of deferred maintenance and have serious issues that negatively affect health, like inadequate plumbing, insects and rodents, and rotting porches or steps that present a safety hazard.

Depending on neighborhood social and economic conditions, housing unit vacancy can invite vagrants, fire hazards, crime, and free-roaming animals. Very low vacancy rates, particularly in newer and well-maintained neighborhoods, mean a shortage of affordable housing. Bexar County's overall vacancy rate 2014, likely due to strong population growth

Residential Vacancy Rate

Figure 3.3 Percent vacant housing units



Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table DP04.

combined with a significant slowdown in new housing construction that has continued since the recession hit.

Bexar County's highest vacancy rates are downtown (Figure 3.4), although the total number of units in that area is relatively low, and in Government Hill (zip code 78208). Other areas of the map showing very high vacancy rates are Camp Bullis (78257) and the "toxic triangle" adjacent to Kelly Air Force Base (78226).

Neighborhood walkability is another important contributor to health and well-being. San Antonio's Walk Score®, a proprietary index of walkability (Figure 3.5), has decreased since 2010

Walkability

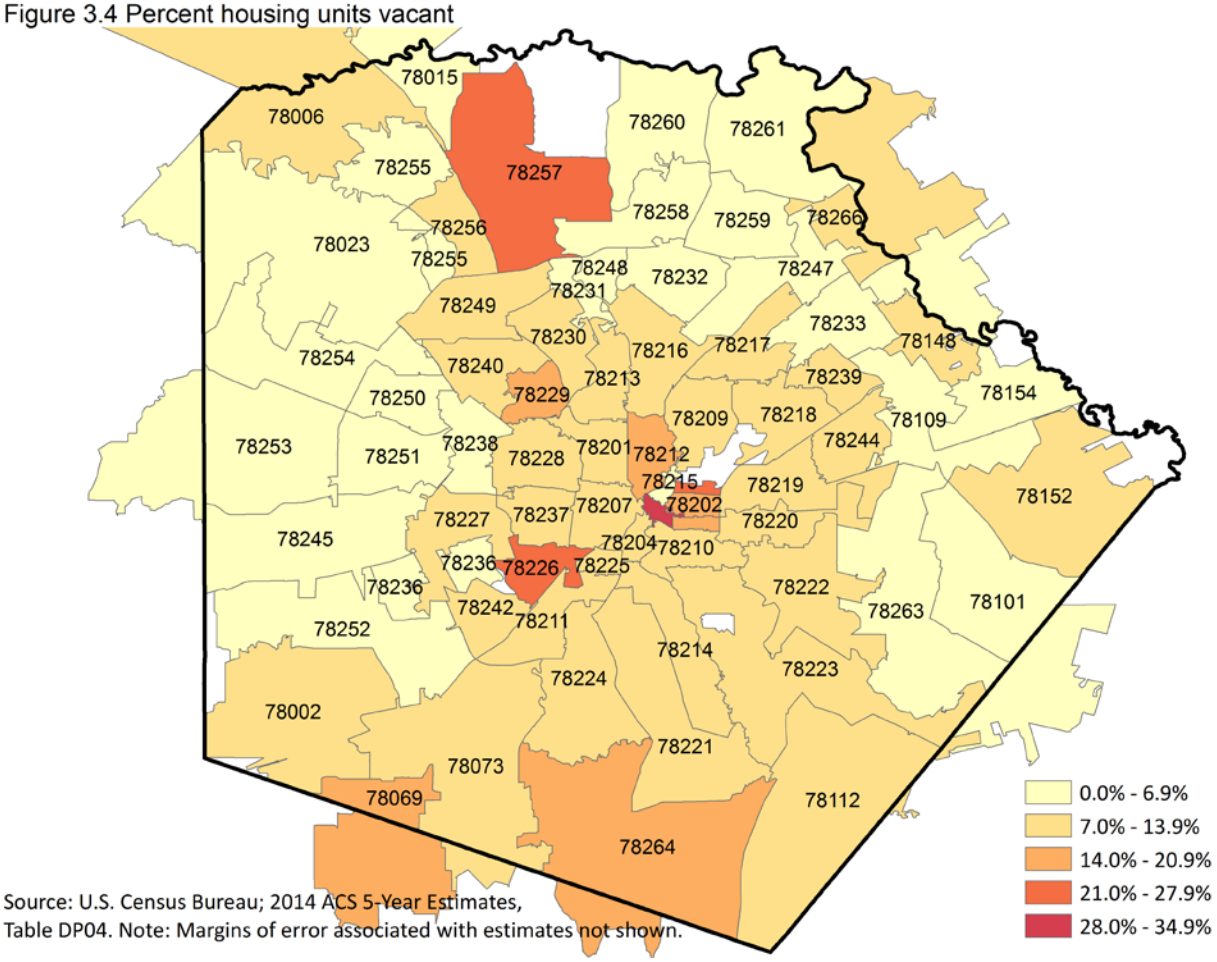
Figure 3.5 San Antonio's Walk Score®

	Walk Score
2010	44
2011	41
2012	***
2013	34
2014	34
2015	34

Source: Walk Score, 2010-2015 (walkscore.com).
***Not applicable.

Vacant Housing by Zip Code

Figure 3.4 Percent housing units vacant



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table DP04. Note: Margins of error associated with estimates not shown.

from 44 to 34 (of 100), with only five neighborhoods now considered walkable[2]. San Antonio remains a car-dependent economy, with about eight in 10 workers aged 16 and older driving alone to their jobs and one in 10 carpooling (Figure 3.6). The mode of transportation to work does appear related to vehicle access. Of those who commute using public transportation, 41.5% (±6.4%) have no access to a vehicle, as compared to 3.6% (±1.1%) of those who carpool.

Bexar County's air quality is a serious health issue. After a trend of improvement, San Antonio is currently "out of attainment," with three-year average ozone levels higher than the threshold set in 2015 – a somewhat stricter standard than before – by the Environmental Protection Agency[3]. San Antonio's Air Quality Index (AQI)

Air Quality

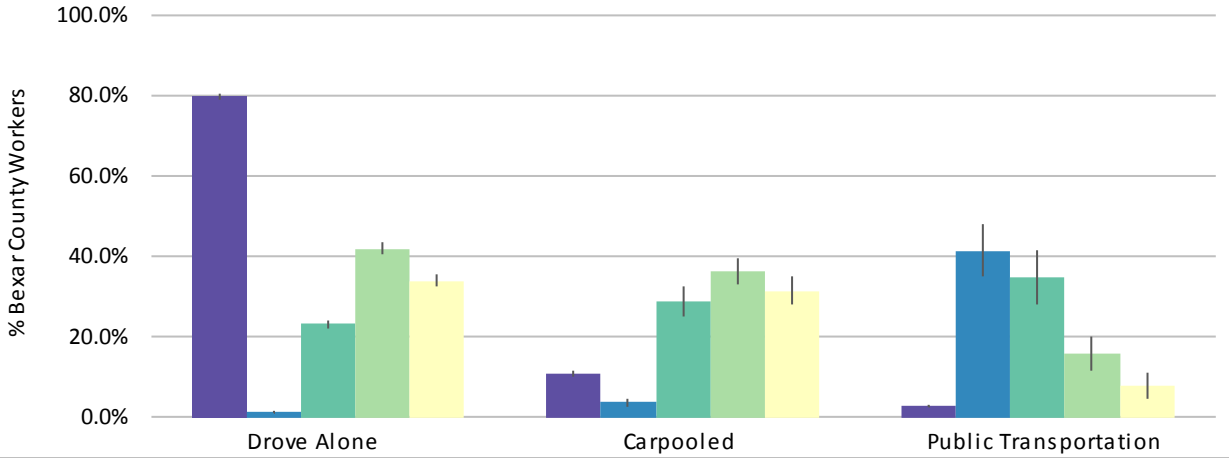
Figure 3.7 San Antonio air quality

	Air Quality Index (AQI)	Days AQI 100+ (weighted by population)
2010	75 ppb	11,012,956
2011	75 ppb	11,628,449
2012	80 ppb	15,448,147
2013	81 ppb	19,784,731
2014	80 ppb	14,895,362
2015	78 ppb	***

Source: Texas Commission on Environmental Quality, 2010-2015. Environmental Protection Agency; Air Quality System, 2008-2014.***Not applicable.

Transportation to Work by Vehicle Access

Figure 3.6 Percent of workers 16+ by mode of transportation used and vehicle access



	Drove Alone	Carpooled	Public Transportation
% of all workers	79.7% (±0.9%)	10.9% (±0.7%)	2.6% (±0.3%)
0 vehicles	1.2% (±0.3%)	3.6% (±1.1%)	41.5% (±6.4%)
1 vehicle	23.1% (±0.9%)	28.7% (±3.8%)	34.8% (±6.7%)
2 vehicles	41.8% (±1.5%)	36.3% (±3.3%)	15.9% (±4.2%)
3+ vehicles	33.9% (±1.6%)	31.4% (±3.6%)	7.8% (±3.2%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S0802.

stood at 78 parts per billion (Figure 3.7) in 2015. Also presented is the Healthy People 2020 measure of the number of days that the AQI exceeds 100 weighted by population to capture severity and number of people affected.

Basic sanitation is a problem in Bexar County neighborhoods without municipal trash pickup, as Bexar County has no legal means to compel landlords to ensure private trash pickup service.

Camelot II, a low-income neighborhood just south of Windcrest on Bexar County's near-northeast side, is currently home to a trash pickup pilot program under an agreement between Bexar County and the City of San Antonio. Camelot II was buried under mounds of household garbage, furniture, mattresses, and other debris for years, and other neighborhoods remain so.[4]

"this is contributing to ozone development causing **heat islands** that ae in the middle of these socioeconomically stressed communities"

- Dr. Vincent Nathan

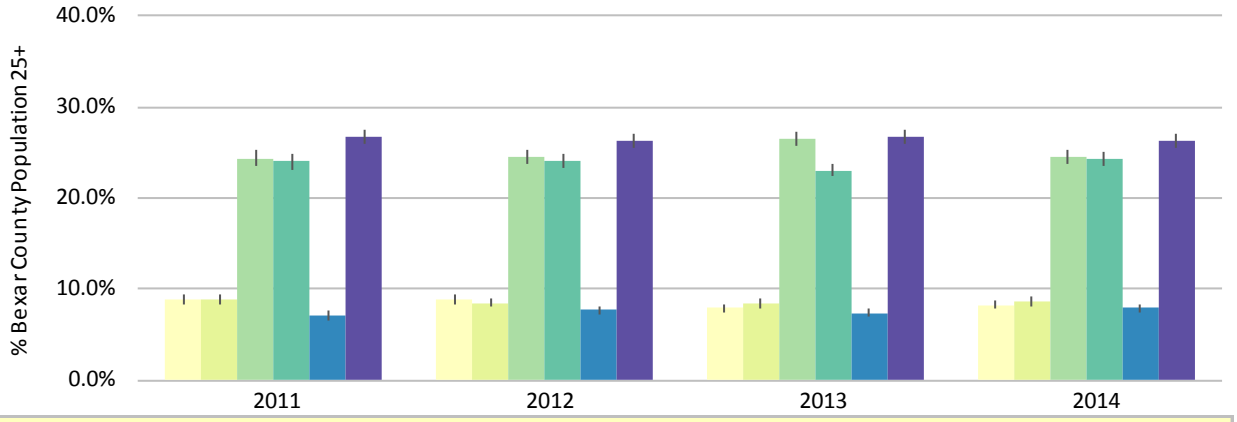
Social Conditions

Along with poverty, education is one of the single most powerful determinants of health outcomes, affecting income, employment, access to care, health literacy, and a host of other factors contributing to health and well-being. The educational attainment of one's neighborhood also affects one's health and well-being through mediating factors like poverty, and some types of crime and violence. Bexar County's educational attainment has remained flat in recent years (Figure 3.8). Most recently about 17% of Bexar County residents 25 and older did not complete high school, and about half of those did not complete 9th grade. The four-year longitudinal dropout rate – percent of 9th-graders who dropout before their expected graduation – decreased somewhat since 2010 (Figure 3.9).

Certificates and certifications are newer types of educational credentials that are critical in certain higher-wage occupations like information technology. These programs are a more streamlined approach to developing a skillset or knowledge base for a career that can increase earning potential for a non-college degreed student. Trend data on certificate participation and completion is scarce, but these credential programs are increasing in availability in Bexar County.[5] since 2010 (Figure 3.9). Certificates and certifications are newer types of educational credentials that are critical in certain higher-wage occupations like information technology. These programs are a more streamlined approach to developing a skillset or knowledge base for a career that can increase earning potential for a non-college degreed student. Trend data on certificate participation and

Educational Attainment

Figure 3.8 Pecent of population 25+ by highest level of education completed



	2011	2012	2013	2014
< 9th Grade	8.9% (±0.6%)	8.9% (±0.6%)	7.9% (±0.4%)	8.3% (±0.5%)
9th-12th Grade	8.9% (±0.6%)	8.5% (±0.4%)	8.4% (±0.5%)	8.7% (±0.5%)
High School	24.4% (±0.8%)	24.5% (±0.7%)	26.5% (±0.8%)	24.5% (±0.8%)
Some College	24.0% (±0.8%)	24.1% (±0.7%)	23.1% (±0.7%)	24.3% (±0.7%)
Associate's	7.1% (±0.6%)	7.7% (±0.5%)	7.4% (±0.5%)	7.9% (±0.4%)
Bachelor's +	26.7% (±0.8%)	26.3% (±0.7%)	26.7% (±0.8%)	26.3% (±0.8%)

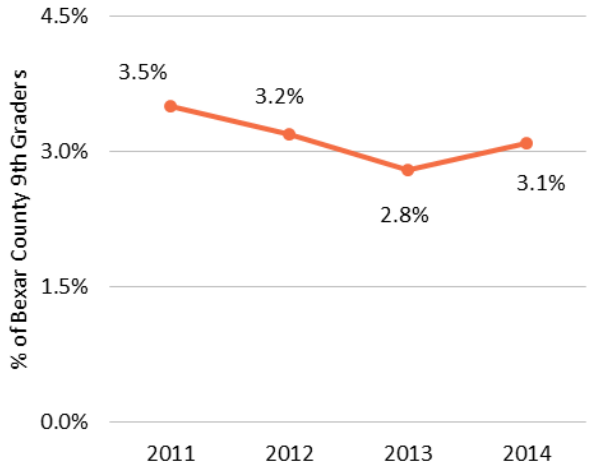
Source: U.S. Census Bureau; 2011-2014 ACS 1-Year Estimates, Table S1501.

completion is scarce, but these credential programs are increasing in availability in Bexar County.[6]

About four in 10 Bexar County residents age five and older speak a language other than English at home (Figure 3.10). Of those, nine in 10 speak Spanish. About 30% of that group speak English "less than very well". In a community that speaks predominantly English, speaking poor English has implications for their ability to secure and retain higher-wage employment, conduct banking transactions, interact with health care providers, and develop the knowledge and skills to manage complex chronic health conditions. This group tends to be older and thus more likely to have one or more chronic illnesses, compounding the problem.[7]

High School Dropout Rate

Figure 3.9 Bexar County 4-year longitudinal dropout rate (grades 9-12)



Source: Texas Education Agency, 2011-2014.

Language Spoken at Home

Figure 3.10 Percent of population 5+ by language spoken at home and ability to speak English

	% of Total Population	% of Speakers Who...	
		Speak English "Very Well"	Speak English Less Than "Very Well"
Only English	**59.6%**	***	***
	(±0.8%)	***	***
Any Other Language	**40.4%**	**69.0%**	**31.0%**
	(±0.8%)	**(±1.3%)**	**(±1.3%)**
Spanish	36.9%	69.6%	30.4%
	(±0.7%)	(±1.4%)	(±1.4%)
Indo-European	1.4%	75.5%	24.5%
	(±0.2%)	(±6.1%)	(±6.1%)
Asian	1.6%	53.4%	46.6%
	(±0.2%)	(±5.7%)	(±5.7%)
Other	0.5%	54.5%	45.5%
	(±0.1%)	(±10.7%)	(±10.7%)

Source: U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S1601. ***Not applicable.

"non-English speaking community members are hesitant to attend programs or ask for services"

- Sexual Health Discussion Group

Health literacy is defined by the U.S. Department of Health and Human Services as "the ability to obtain, process, and understand basic health information and services that are needed to make suitable health decisions."[8] Healthy People 2020 identifies health literacy as a critical component in the social determinants of health.[9] Whether or not explicitly stated, health-literacy is key in every section of this assessment. It plays a key role in how residents will effectively use health information to prevent disease, manage existing health conditions, and navigate the health care system. Low health literacy is associated with greater emergency room visits and hospitalizations, and premature death.[10]

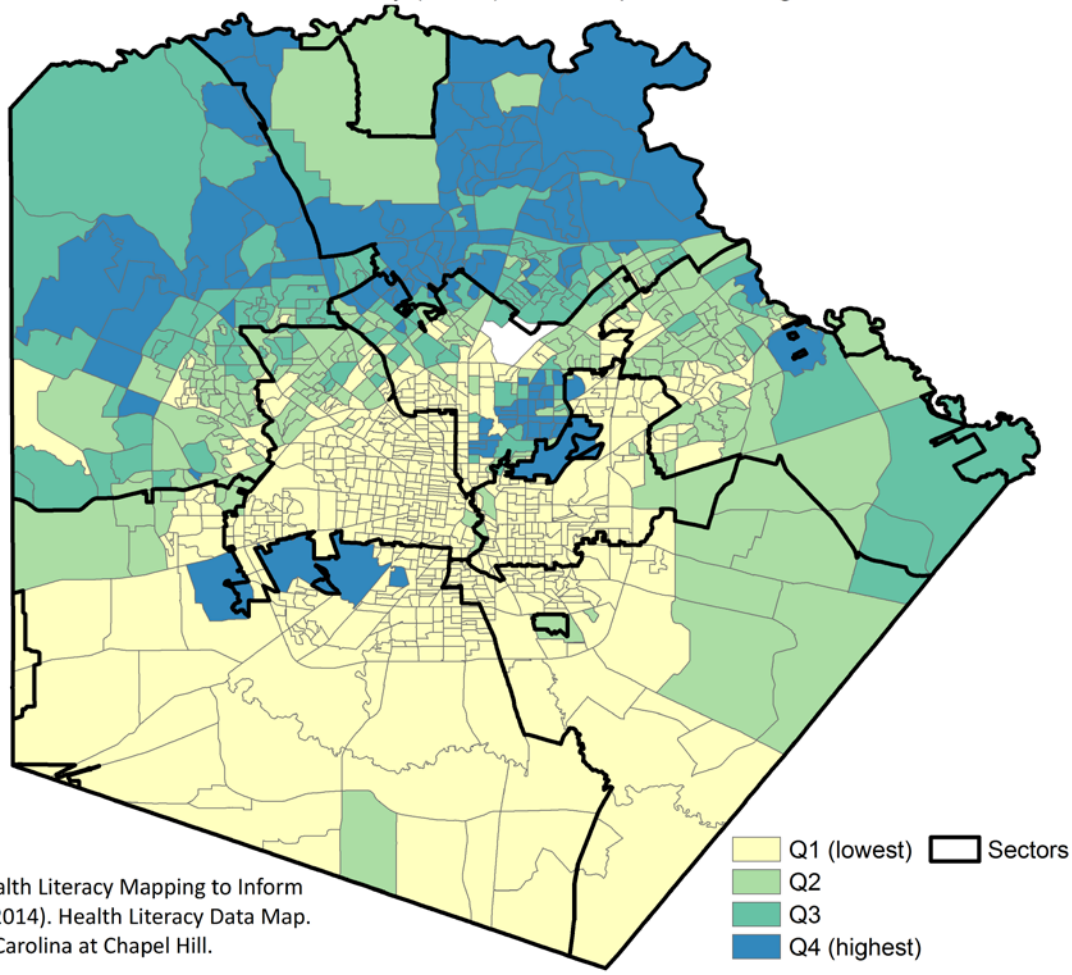
Health literacy goes beyond individual health behavior to affect the environmental, political and social factors that determine health.[11]

Health literacy is considered a stronger predictor of an individual's health status than income, employment status, education level, and racial/ethnic group.[12] Poor health literacy disproportionately affects those with lower education, lower income, older adults, and minority and immigrant populations, and can therefore reinforce existing health disparities.[13]

No health literacy assessment has yet been conducted in Bexar County and local data are not available. A national survey estimated that more than a quarter of Medicaid and Medicare beneficiaries lacked basic health literacy.[14] It has been estimated that 17% (8.5%-29.6%) of Bexar County residents aged 16 and older lack even basic prose literacy skills.[15] Figure 3.10a shows census tract-level estimates of health literacy constructed from the National Assessment of Adult Literacy (NAAL).

Adult Health Literacy by Census Block Group

Figure 3.10a National Assessment of Adult Literacy (NAAL) national quartile ranking



Source: National Health Literacy Mapping to Inform Health Care Policy (2014). Health Literacy Data Map. University of North Carolina at Chapel Hill.

Both direct victimization and exposure to neighborhood crime and violence harm health and well-being. Crime was captured as a Community Health Improvement Plan (CHIP) objective in 2014 and measured via number of crimes reported to the Bexar County Sheriff's Office. That number has dropped dramatically since 2010 (Figure 3.11), which could reflect an actual decrease in crime, a decrease in reporting without a change in the crime level, or reporting of crimes to another jurisdiction such as the San Antonio Police Department or other municipal police department. This change in reporting jurisdiction is a likely scenario due to San Antonio's annexation since 2010 of substantial tracts of land in southern and northwestern Bexar County.[16]

Across all jurisdictions in Bexar County, the total violent crime rate dropped from 2010 to 2012, rose in 2013, and dropped somewhat in 2014 (Figure 3.12) – a volatile trend that may or may not overstate actual changes in crime level. The same volatility or "bounce" is seen in rates for specific crimes like family violence

Violent Crimes Reported

Figure 3.11 Number of violent crimes reported to Bexar County Sheriff's Office

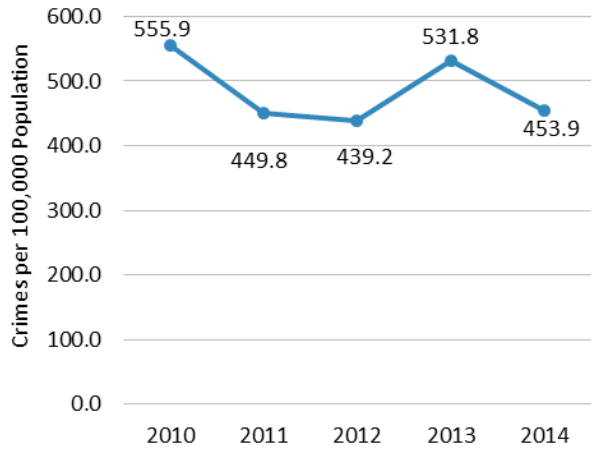
	Violent Crimes
2010	546
2011	496
2012	487
2013	452
2014	424

Source: Bexar County Sheriff's Office, 2010-2014

(Figure 3.13), murder (Figure 3.14), and assault. The reported rape rate rose significantly in 2013 and skyrocketed in 2014. This tremendous change is a reflection of an important 2013 change in the FBI Uniform Crime Report's 80-year-old definition of rape.[17] For the first time, the definition now clearly captures rape of males, of any bodily orifice, with objects,

Violent Crime Rate

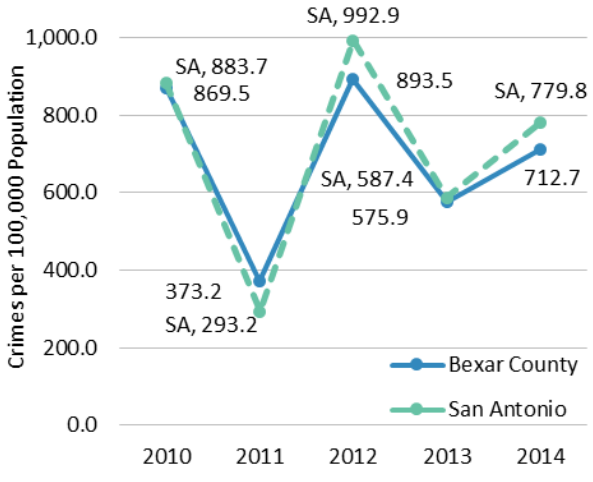
Figure 3.12 Bexar County violent crimes committed per 100,000 population



Source: Texas Department of Public Safety, 2010-2014.

Family Violence Crime Rate

Figure 3.13 Family violence crimes committed per 100,000 population



Source: Texas Department of Public Safety, 2010-2014.

Specific Violent Crime Rates

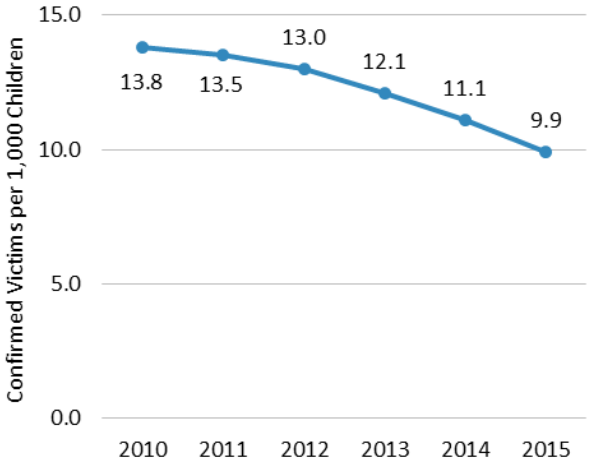
Figure 3.14 Bexar County violent crimes committed per 100,000 population

	Murder	Rape	Assault	Juvenile
2010	5.5	34.0	362.8	81.0
2011	5.9	33.0	299.3	52.0
2012	5.7	36.5	282.8	49.0
2013	5.3	41.9	355.7	***
2014	6.2	65.2	279.4	***

Source: Texas Department of Public Safety, 2010-2014.

Child Abuse and Neglect

Figure 3.15 Confirmed victims of abuse and neglect per 1,000 child population



Source: Texas Department of Family and Protective Services, 2010-2015.

and without physical force. Lack of physical force is typical when the victim of the rape is a child, physically or mentally disabled, incapacitated by alcohol or drugs, or fearful of fighting back.

The number of confirmed victims of child abuse or neglect per 1,000 children has declined significantly from 2010 (Figure 3.15), but this figure is misleading, as it is dependent upon the abuse or neglect being reported, the report being investigated, and the investigation being closed with a determination of some kind. 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.[18] The percent of intakes alleging abuse or neglect per 1,000 children dropped from 53.9 in 2010 to 48.5 in 2015 (Figure 3.16). The percent of intakes assigned for investigation dropped from 87% in 2010 to 71% in 2015, and the per-

Child Abuse

Figure 3.16 Percent change of child abuse investigations

	2010	2015	Percent Change
Alleged victims per 1,000	59.3	47.0	-20.7%
Alleged victims in unconfirmed investigations per 1,000	43.9	35.6	-18.9%
Initial intakes alleging abuse/neglect per 1,000	53.9	48.5	-10.0%
Percent reports assigned	87.2%	70.9%	-18.6%
Percent investigations completed	62.9%	57.2%	-9.0%
Percent investigations confirmed	22.6%	21.3%	-5.8%
Confirmed victims per 1,000	13.8	9.9	-28.3%

Source: Texas Department of Family and Protective Services, 2010-2015.

cent of assigned investigations completed dropped from 63% to 57%. The revictimization rate – the percent of confirmed victims who are confirmed as victimized again within five years – has held steady during that time period at about 20%. [19]

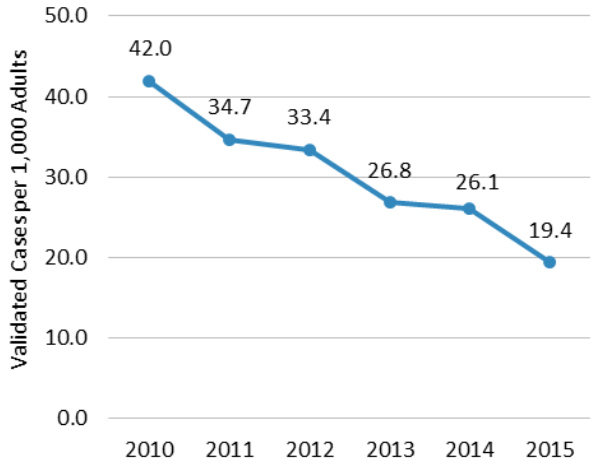
Adverse childhood experiences (ACE) have emerged over the past two decades as a strong predictor of health-related challenges and poor health outcomes later in life.[20] The original ACE Study looked at the most common ACEs, including having been a victim of physical, sexual, or verbal abuse or physical or emotional neglect, and having an alcoholic parent, a family member with a mental illness, a mother who was a victim of domestic violence, a family member in jail, and the loss of a parent through abandonment, divorce, or death.

Among the study population of generally middle-class, middle-aged, college-educated HMO members, those who reported having experienced at least four of 10 categories of ACE 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. Unfortunately, these adverse childhood experiences are quite common. In the ACE Study population, 53.7% of men and 45.4% of women reported at least one ACE category. Over eight percent of women reported four or more ACE categories, more than double the percent of men.[21] Although that study population does not closely match the general Bexar County population, we can be sure that a large proportion of the Bexar population has a history of adverse childhood experiences that continue to harm their health and well-being. Screening for ACE and adopting a model of trauma-informed care are important for service providers working with both sexes, all age groups, and all races/ethnicities, most especially those who can be expected to have had a higher exposure to ACE. (The ACE screening instrument is not copyrighted and is freely available online from the CDC and elsewhere.[22])

Adult abuse and neglect are a growing public health concern. The rate of validated Adult Protective Services investigations declined significantly in the past six years, from 42.0 in 2010 to 19.4 in 2015 (Figure 3.17). The questions posed above about the validity of the rate of confirmed victims of child abuse and neglect also apply here. The final rate of validated investigations is dependent upon the abuse or neglect being reported, the report being investigated, and the investigation being closed with a determination of some kind (Figure 3.18).

Adult Maltreatment

Figure 3.17 Validated cases of maltreatment per 1,000 adult population



Source: Texas Department of Family and Protective Services, 2010-2015.

Adult Maltreatment

Figure 3.18 Percent change of adult maltreatment investigations

	2010	2015	Percent Change
Total eligible population (elderly or disabled)	277,254	350,054	26.3%
Total APS intakes	9,382	9,528	1.6%
Intakes per 1,000 eligible population	33.8	27.2	-19.6%
Total APS completed investigations	7,272	6,261	-13.9%
Ratio of completed investigations to intakes	0.78	0.66	-15.2%
Total validated APS Investigations	4,610	2,665	-42.2%
Percent of completed investigations validated	63%	43%	-32.9%
Validated investigations per 1,000 population	42.0	19.4	-53.7%

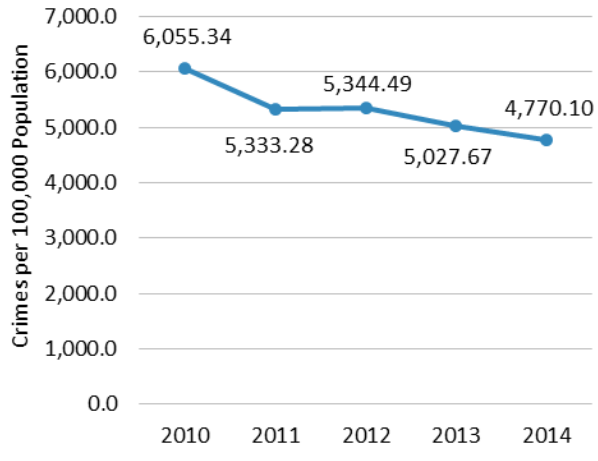
Source: Texas Department of Family and Protective Services, 2010-2015.

Bexar County's property crime rate declined 21% from 2010 (Figure 3.19). Community attendance at San Antonio Police Department (SAPD) safety trainings more than tripled between 2011 and 2014 after training offerings were greatly expanded (Figure 3.20). Sixty-six percent of respondents to the City of San Antonio Community Survey in 2014 reported feeling safe in their neighborhoods.[23]

The density of liquor stores in a neighborhood is associated with higher rates of motor vehicle crashes, violence, and sexually transmitted diseases. Bexar County averages 0.9 liquor stores per square mile[24], but the distribution varies widely across the county. In terms of access

Property Crime Rate

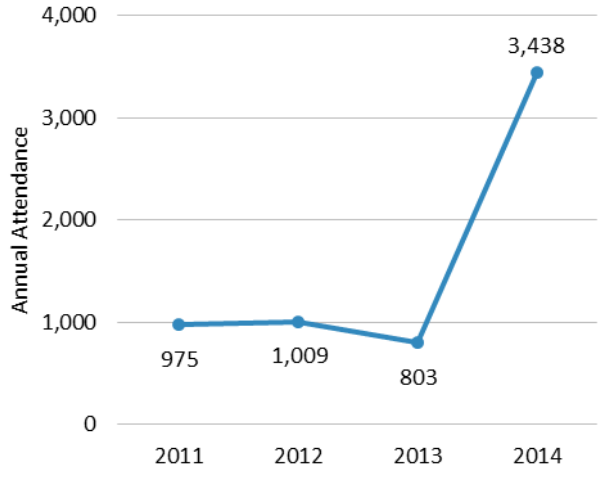
Figure 3.19 Bexar County property crimes committed per 100,000 population



Source: Texas Department of Public Safety, 2010-2014.

Community Safety Trainings

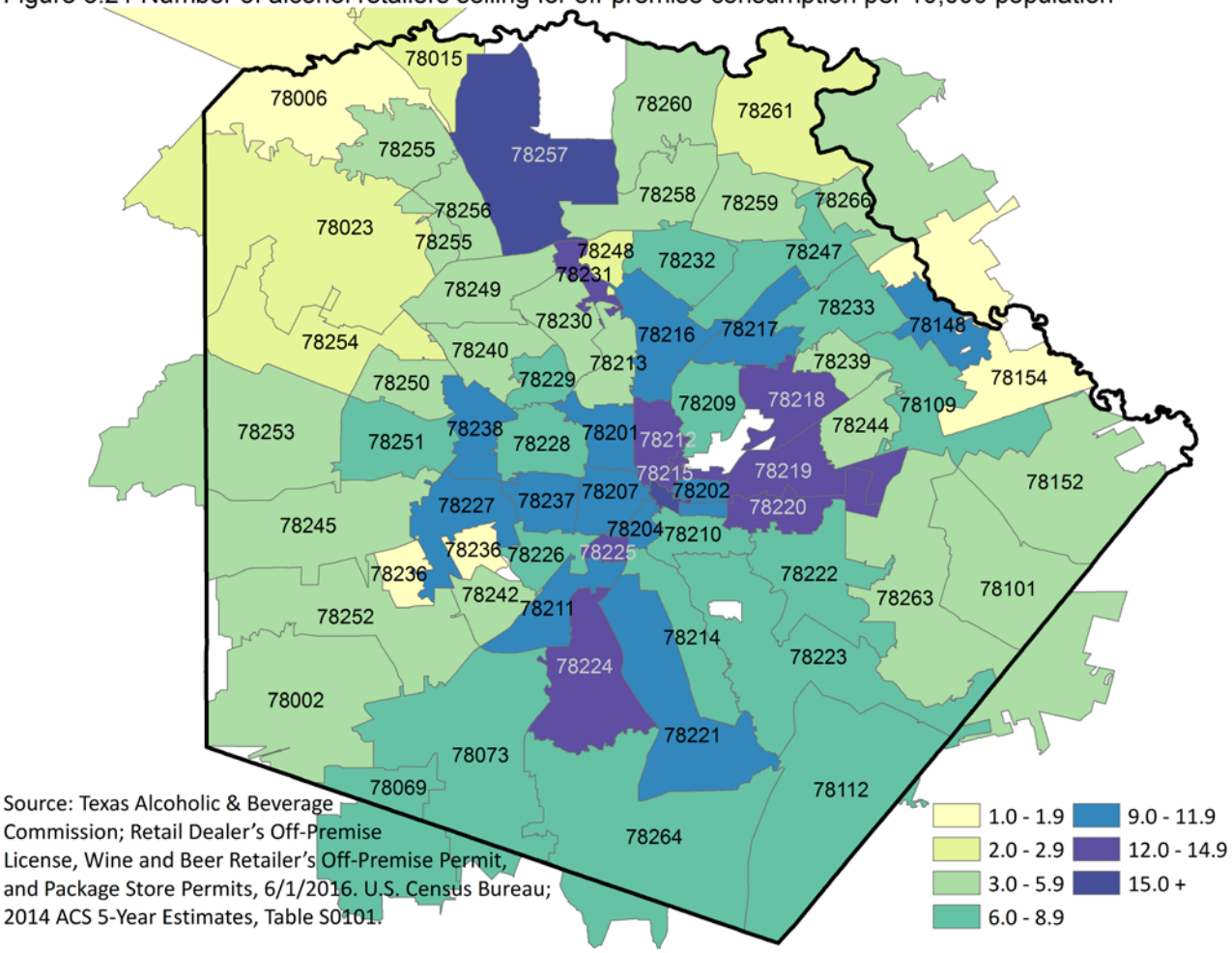
Figure 3.20 Annual attendance at SAPD community safety trainings



Source: San Antonio Police Department, 2010-2014.

Alcohol Retailer Density by Zip Code

Figure 3.21 Number of alcohol retailers selling for off-premise consumption per 10,000 population

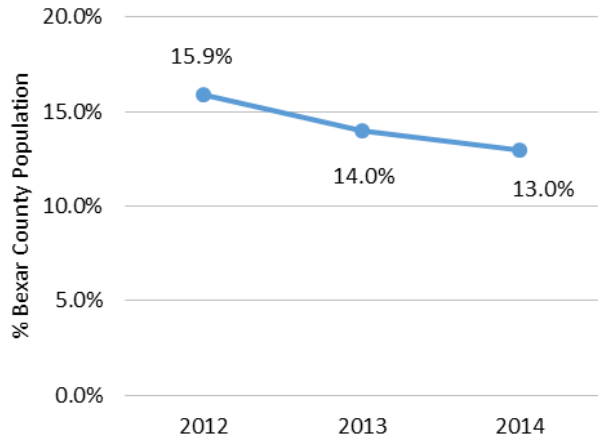


to alcohol (Figure 3.21), the very highest densities of retailers selling alcohol for off-site consumption are downtown and in zip code 78257, but the latter area is Camp Bullis and has a very small population. Among residential neighborhoods, the highest rates are in central-city neighborhoods, notably a large swath of the near-northeast side bordered by Walzem Road on the north and Highway 87 on the south.

Not all Bexar County residents have sufficient access to healthy food, which may be a function of low income or high geographic distance to quality grocery stores or farmers markets. An estimated 31% of the Bexar County population lacks geographic access to a grocery store.[25] The proportion of Bexar County residents considered to be food-insecure has dropped somewhat in recent years, but still, one in eight lack access to enough food for an active and healthy life (Figure 3.22).

Food Insecurity

Figure 3.22 Population lacking access to enough food for an active and healthy life



Source: Feeding America; Map the Meal Gap 2016: Food Insecurity and Child Food Insecurity Estimates at the County Level, 2016.

Economic Conditions

The proportion of Bexar County families living in poverty has remained fairly flat over recent years (Figure 3.23). For 2016, poverty is defined as an income of less than $24,300 for a family of four.[26] In comparison, the actual annual income needed by a family of four is estimated at $59,507 (2014 dollars).[27]

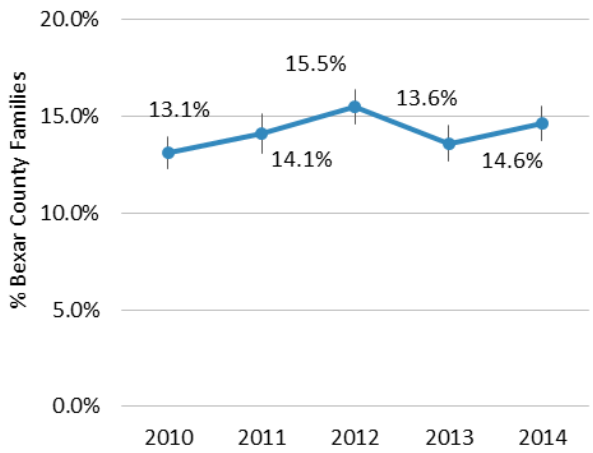
Bexar County's median family income is $59,392 (± $1,807), up seven percent since 2010.[28] Median family income differs dramatically across the county, with the highest median family incomes – $105,000 or more – on Bexar County's far north side (Figure 3.24). The lowest median family incomes, in the $15,000 to $29,000 range, are in zip codes 78226, 78207 on the near westside, downtown, and 78202 and 78203 on the near eastside.

"it does not matter if a person receives the message of healthy eating, if they do not have a reasonable convenient affordable option at close proximity of their work place, people will do what they have to do to get their lunch and get back to work"

- Bob Rivard

Families Living in Poverty

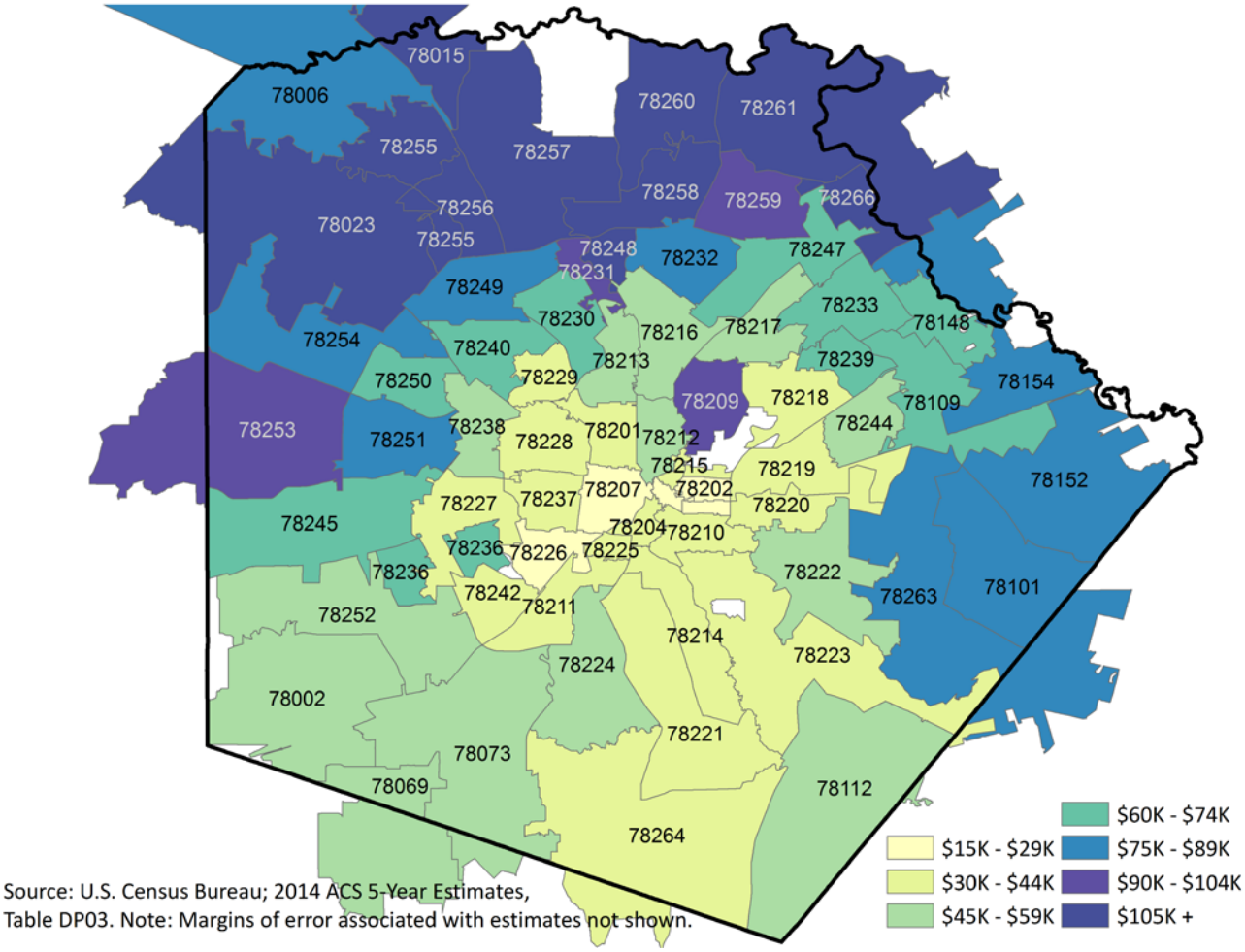
Figure 3.23 Percent families below 100% poverty level



Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S1702.

Family Income by Zip Code

Figure 3.24 Median family income



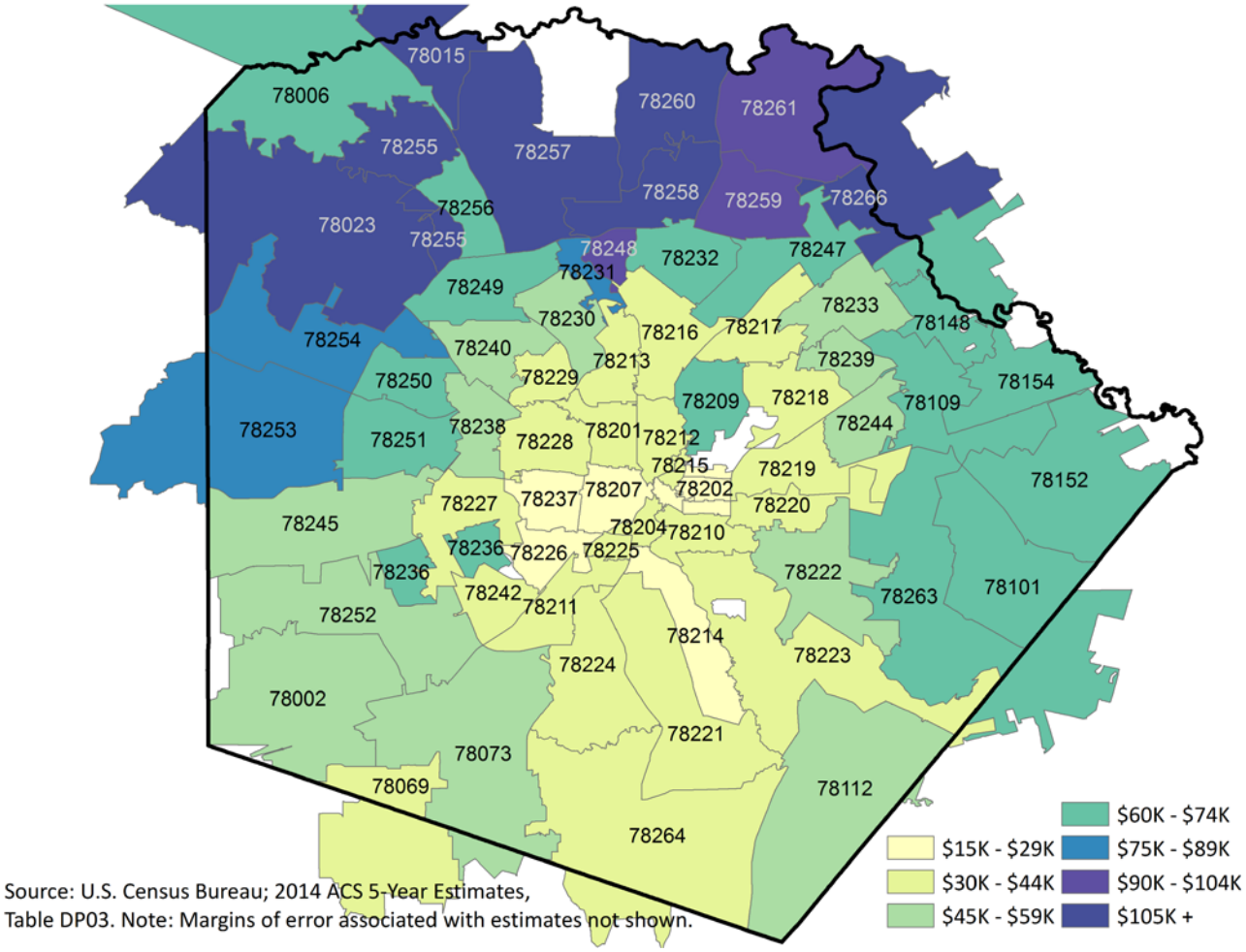
Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table DP03. Note: Margins of error associated with estimates not shown.

Median household income has risen somewhat as well, from $47,921 (± $1,235) in 2010 to $50,760 (± $929) in 2014.[29] Median household income is geographically distributed along the same pattern as median family income, with the highest incomes concentrated in far northern Bexar County (Figure 3.25).

The unemployment rate measures the percentage of people aged 16 and older who are part of the labor force and seeking employment. Bexar County and Texas overall weathered the recession better than most areas of the country, with unemployment in the San Antonio-New Braunfels metropolitan area reaching a high of

Household Income by Zip Code

Figure 3.25 Median houshold income



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates,
Table DP03. Note: Margins of error associated with estimates not shown.

"there is a **cause and effect relationship between where you grew up as a child and your income as an adult.** If true, an argument can be made to use social impact bonds to fund additional housing vouchers to help people move to better neighborhoods that will directly impact their future income"

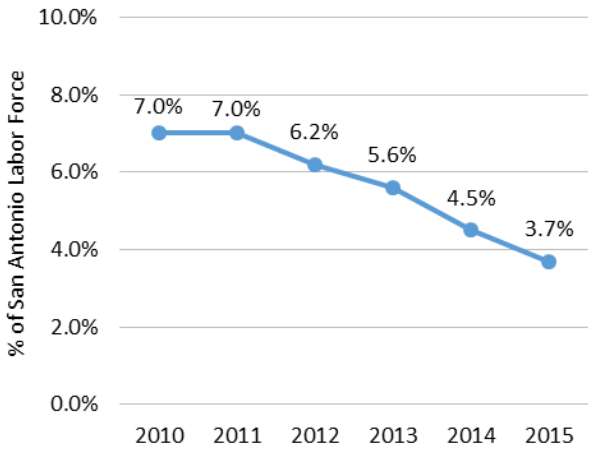
- Richard Milk

7.0% in 2010 and 2011, decreasing thereafter by almost half and reaching 3.7% in 2015 (Figure 3.26). Unemployment, like most other social and economic issues, is not evenly distributed across the county (Figure 3.27). Unemployment rates of the working age population are highest, ranging from 12% to 16%, in 78202 (near eastside), 78207 (near westside), 78226 and 78211 (southside), and 78069 (Somerset).

The unemployment measure can be deceiving, however, as it does not capture the proportion of the population that is not seeking work for any number of possible reasons. About 35% of

San Antonio Unemployment

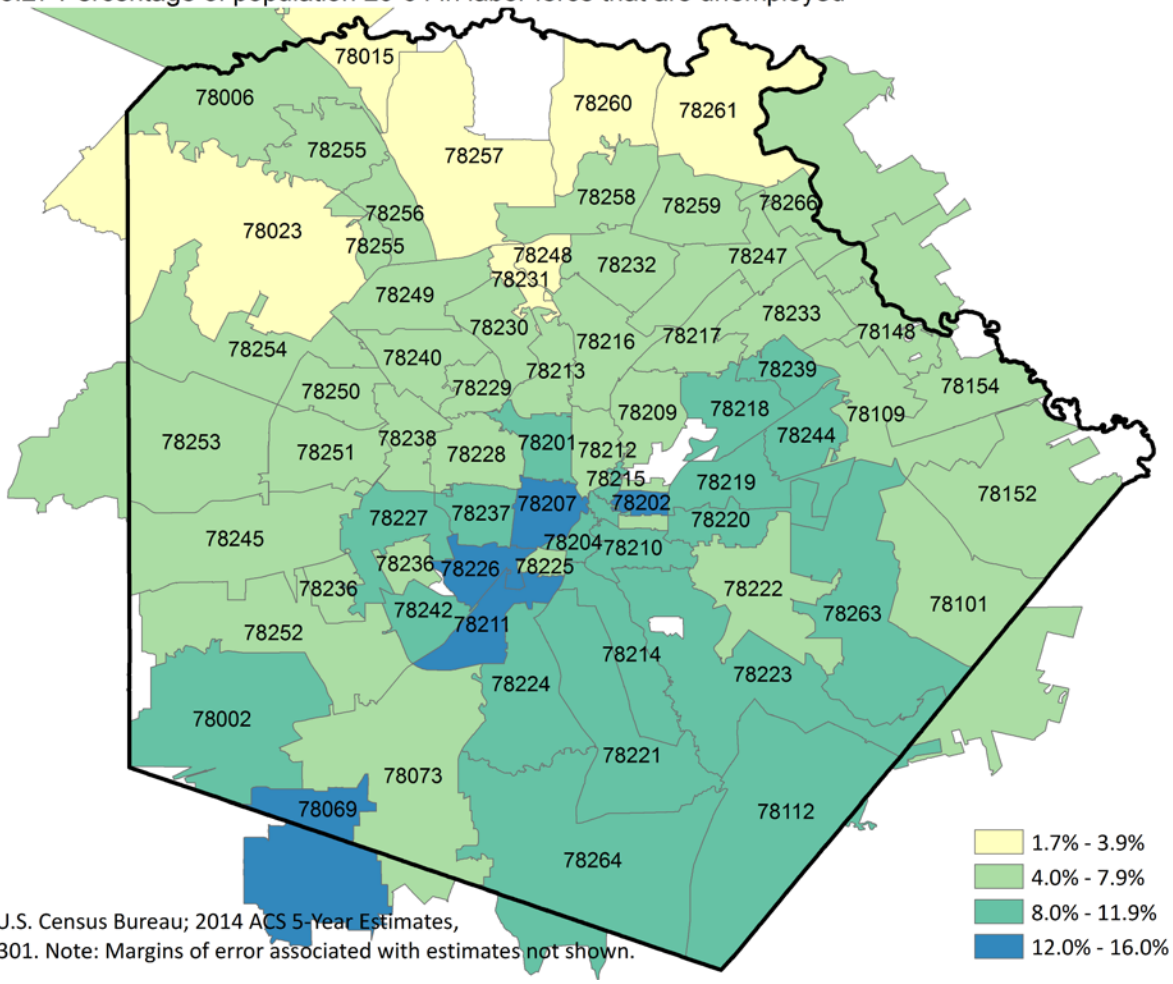
Figure 3.26 Percentage of population in labor force that are unemployed



Source: Bureau of Labor and Statistics; Local Area Unemployment Statistics, 2010-2015.

Working Age Unemployment by Zip Code

Figure 3.27 Percentage of population 20-64 in labor force that are unemployed



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S2301. Note: Margins of error associated with estimates not shown.

the civilian population 16 and older is not in the labor force.[30] That group includes retired people 65 and older, people who are staying at home as caregivers to children or elderly family members, and non-elderly who do not want to work. But it also includes those who want to work but cannot because of a prior criminal conviction, disability, depression or problem drinking, or some other reason, as well as those who after a long period of unemployment have simply stopped seeking it altogether. Conversely, there are those who are not counted in the labor force but are working in a cash economy, generally through some form of entrepreneurship.

In theory, employment means both a good wage and health insurance. In reality, though, the minimum wage cannot sustain a family, and affordable health insurance coverage is far from assured. Unemployment is associated with poor health, longer-term illnesses, higher incidence of risky health behavior (such as alcohol and smoking), mental health problems (anxiety, stress and depression); and increased mortality.[31]

"Unemployment and low wages make it very hard for SAHA (San Antonio Housing Authority) residents to improve their economic status. Many of the SAHA residents are living below the living wage. This tends to be at the core of the issues that the residents of SAHA face"

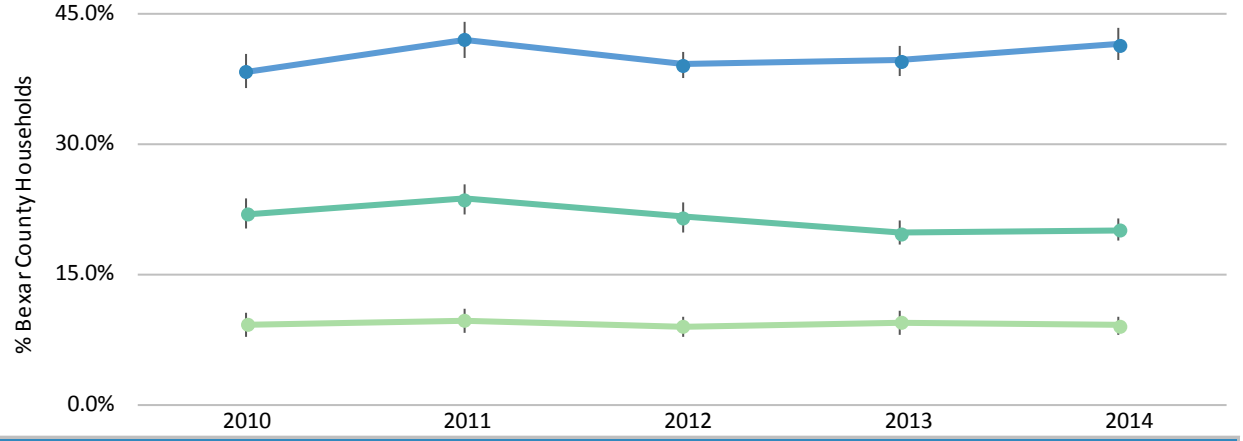
- Active Living Council Discussion Group

Housing affordability and cost burden is critical not just to maintaining stable housing but also to freeing up resources for healthy food, health care and human services, and leisure time and activities that are important to mental and emotional well-being. The conventional measure of housing affordability holds that households that spend more than 30% to 35% of total household income on housing costs, typically the largest single expense in a household's budget, are "housing cost burdened."[32] The negative effects of high housing cost burden can extend beyond those living in a home and induce a downward spiral of concentrated poverty in a community.[33] As of 2014, the proportion of households that were cost burdened was trending flat for those without a mortgage and had decreased slightly from 2011 for those with a mortgage (Figure 3.28). Not surprisingly, those with a mortgage are twice as likely to be cost-burdened as those without. The proportion doubles again for those households paying rent, with four in ten cost-burdened in 2014 after a slightly upward trend.

The proportion of households that are cost-burdened by rent payments varies across the county. Half or more of rent-paying households are cost-burdened on the near eastside and certain southside zip codes (Figure 3.29). With a tight housing supply and increasing rent and sale prices,[34] 2015 and 2016 data will almost certainly show a rise in the proportion of both rent- and mortgage-paying households that are cost-burdened.

Affordable Housing Costs

Figure 3.28 Percent of households by mortgage status where housing costs or rent is 35%+ of household income



	2010	2011	2012	2013	2014
Rented	38.4% (±1.9%)	42.0% (±2.0%)	39.2% (±1.5%)	39.6% (±1.8%)	41.5% (±1.8%)
With Mortgage	22.0% (±1.6%)	23.7% (±1.7%)	21.6% (±1.7%)	19.8% (±1.3%)	20.1% (±1.3%)
Without Mortgage	9.2% (±1.3%)	9.7% (±1.4%)	9.0% (±1.2%)	9.5% (±1.4%)	9.1% (±1.0%)

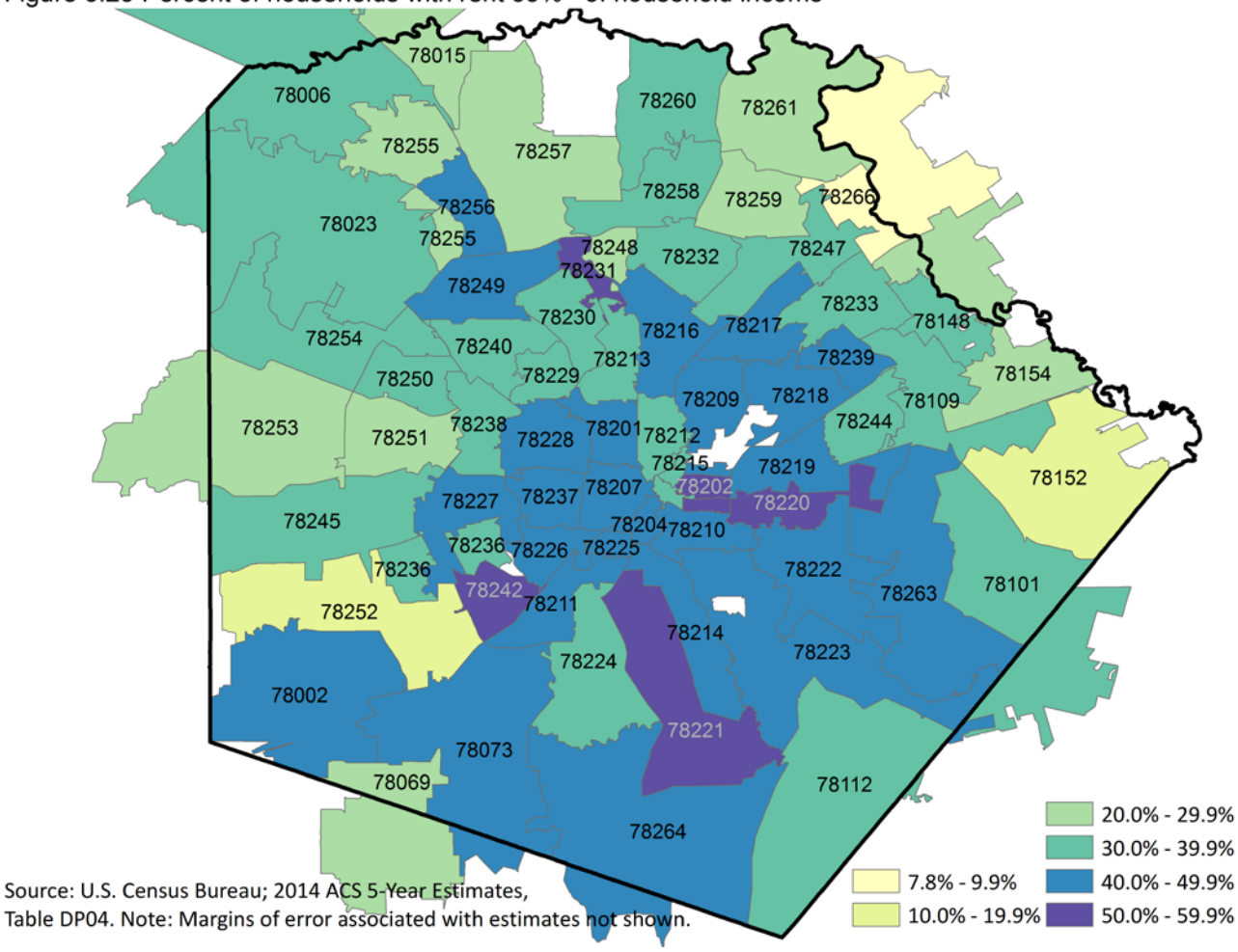
Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table DP04.

The foreclosure rate dropped slightly from 3.1% in 2012 to 2.6% in 2013,[35] and more recent data by month indicate that both foreclosure and mortgage delinquency rates continue to decline.[36] Mortgage foreclosures are more common in neighborhoods with newer homes; tax foreclosures are more common in older central-city neighborhoods where a larger proportion of homes are owned free and clear.

According to the point in time count, the best data available, the number of people who are homeless rose through 2013 and then began a steady decline (Figure 3.30). Definitions of homelessness vary, and this figure does not capture the substantial number of people who are less visible but not securely or permanently housed, including those who are "doubling up" with friends or family or "couch surfing." Chronic homelessness, in particular, is associated with serious economic, social, and physical health risks, poor access to health care, and poor health status, including a high rate of injury, mental illness, alcohol and substance abuse, chronic illnesses like cardiovascular disease for which self-management is critical, and premature death. But even temporary homelessness and doubling up take a toll on physical and mental health and well-being and important upstream determinants like education and employment.

Affordable Rental Costs by Zip Code

Figure 3.29 Percent of households with rent 35%+ of household income



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table DP04. Note: Margins of error associated with estimates not shown.

Income inequality exists where the difference between the lowest and highest incomes is extreme. Income segregation exists where wealth and poverty are both highly concentrated. Both deepen poverty and prevent Bexar County families from achieving and sustaining health and well-being. Income inequality and segregation reduce economic mobility, shortchange children in lower-income school districts, and many other negative effects. Although the role of race remains unclear, an area's income inequality in itself appears to harm overall population health. And the harm does not accrue solely to those in poverty.[37]

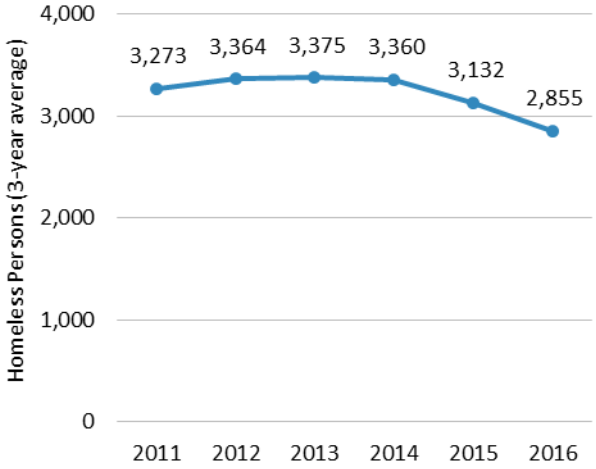
One well-recognized measure of income inequality across a geographic area is the Gini index, a score between zero and one. In a geographic area with a Gini value of zero, every household owns an equal share of income, resulting in perfect income equality. A Gini value of one signifies that a single household owns all of the income in the area, so the higher the Gini score, the greater the income inequality. Bexar County's Gini scores by zip code are highest on

the near northside and in zip codes 78229 and 78230, around the Texas Medical Center and I-10/Wurzbach (Figure 3.31). The Gini index for Bexar County overall rose from 0.454 in 2010 to 0.470 in 2014[38], a level of income inequality comparable to China and the Dominican Republic.[39]

The San Antonio area ranks near the top of U.S. cities with acute income inequality and segregation by nearly any measure, and the problem is worsening over time. The maximum

Homeless Population

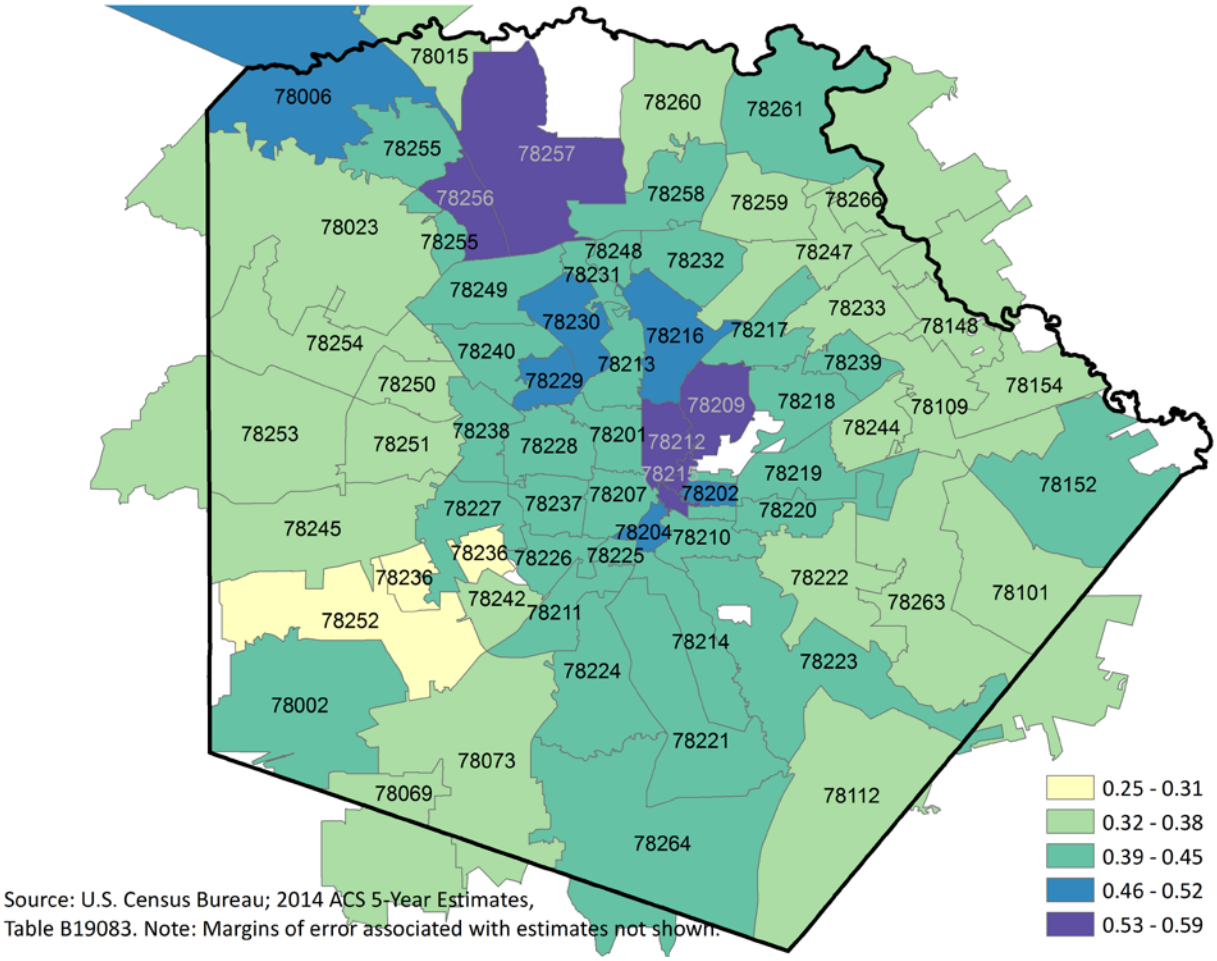
Figure 3.30 Number of sheltered and unsheltered homeless persons (3-year moving average)



Source: South Alamo Regional Alliance for the Homeless; Point-In-Time Count Reports, 2008-2016.

Income Inequality by Zip Code

Figure 3.31 Gini Index



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table B19083. Note: Margins of error associated with estimates not shown.

possible score for the Residential Income Segregation Index (RISI) is 200. A metropolitan area with that score would be perfectly income-segregated, with 100% of lower-income households being in a census tract with a majority of lower-income households, and 100% of upper-income households being in a census tract where the majority of households were upper-income.

Among the nation's 30 largest metropolitan areas in 2010, the San Antonio-New Braunfels area was the single most income-segregated with a RISI of 63, up from 39 in 1980. In comparison, the national RISI stands at 46, and the Portland-Vancouver-Hillsboro RISI at only 25.[40] Income inequality might matter less if economic mobility were a reality. In San Antonio, however, a child raised in the bottom fifth of the income range only has a 6.4% chance of reaching the top fifth of the income range.[41]

"Healthcare 'deserts' exist in the community"

- Health Literacy Discussion Group

Services & Access to Care

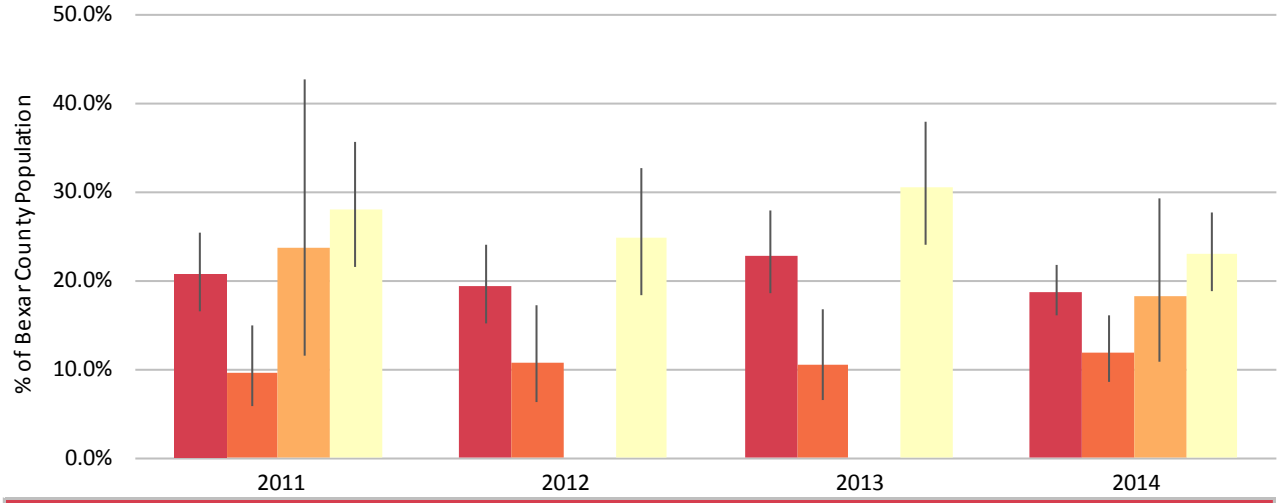
Much of the data presented from this point forward comes from the Behavioral Risk Factor Surveillance System (BRFSS), a random-sample survey of adults conducted by telephone. Because the sample is small relative to the size of the total population, the uncertainty of the estimate is in many cases very high. The estimate is a statistical "best guess," but the vertical error bars in the chart represent the range one can feel confident that the true value falls within. The error bars will be wider for subgroups (e.g., racial/ethnic groups, age groups, or sub-county geographies) than for Bexar County as a whole. The wider the error bars, the less trustworthy the estimate. In some cases, the estimate is not presented at all because the uncertainty is so great, but the error bars are displayed to show the difference even in range of estimate between different population subgroups and areas of the county.

Cost, geographic barriers, provider availability, language barriers, and difficulty navigating a complex system affect a person's ability to access healthcare and social services. Across Bexar County as a whole, almost one in five adults reports having delayed getting health care because of cost in the past year (Figure 3.32). These figures are dramatically higher for Hispanics and Blacks than for non-Hispanic Whites. Because there is no overlap in error bars when comparing Hispanics with non-Hispanic Whites, one can be sure that the difference is real.

About 75% of Bexar County residents have some form of healthcare coverage (Figure 3.33), with non-Hispanic Whites being much more likely than Blacks or Hispanics to have coverage. These BRFSS figures remain flat through 2014. Census Bureau data show a 20% decrease in percent uninsured in 2014

Delayed Care

Figure 3.32 Percent of adults that delayed care in the past 12 months because of cost

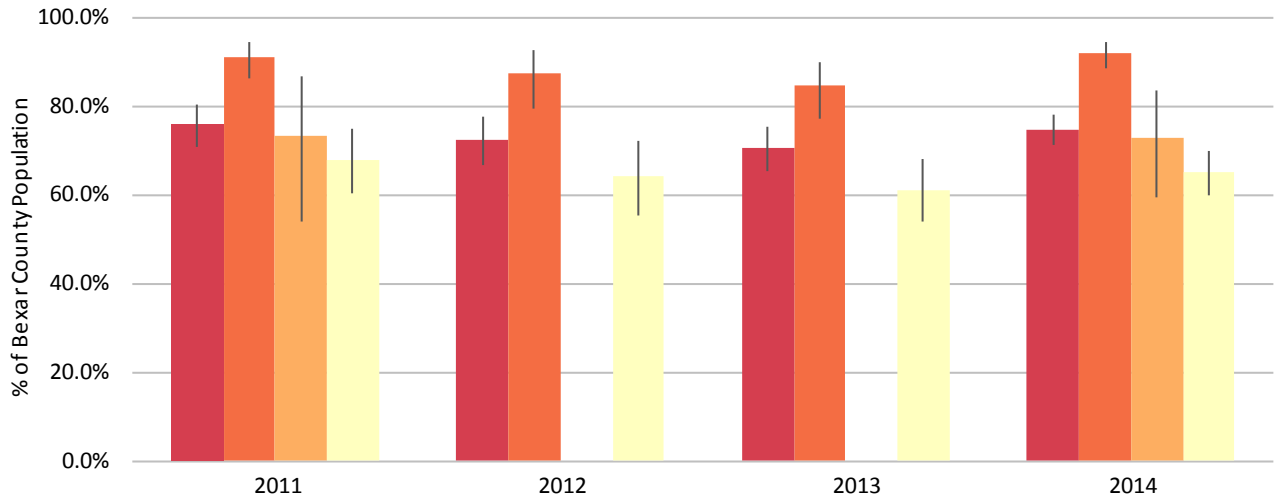


	2011	2012	2013	2014
Overall	**20.8% (16.7%-25.5%)**	**19.4% (15.2%-24.0%)**	**22.9% (18.6%-27.9%)**	**18.8% (16.1%-21.8%)**
White	9.7% (6.0%-15.1%)	10.7% (6.4%-17.3%)	10.6% (6.5%-16.9%)	11.9% (8.7%-16.1%)
Black	23.8% (11.6%-42.7%)	**	**	18.4% (10.9%-29.3%)
Hispanic	28.1% (21.6%-35.6%)	24.9% (18.4%-32.8%)	30.6% (24.0%-38.0%)	23.0% (18.8%-27.7%)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

Any Healthcare Coverage

Figure 3.33 Percentage of adults with any kind of healthcare coverage



	2011	2012	2013	2014
Overall	**76.1% (71.1%-80.5%)**	**72.6% (66.7%-77.8%)**	**70.6% (65.5%-75.3%)**	**74.9% (71.5%-78.1%)**
White	91.2% (86.3%-94.5%)	87.5% (79.7%-92.6%)	84.8% (77.4%-90.1%)	92.2% (88.8%-94.6%)
Black	73.6% (53.9%-87.0%)	**	**	73.2% (59.7%-83.5%)
Hispanic	68.1% (60.3%-74.9%)	64.4% (55.6%-72.3%)	61.3% (53.9%-68.3%)	65.4% (60.2%-70.2%)

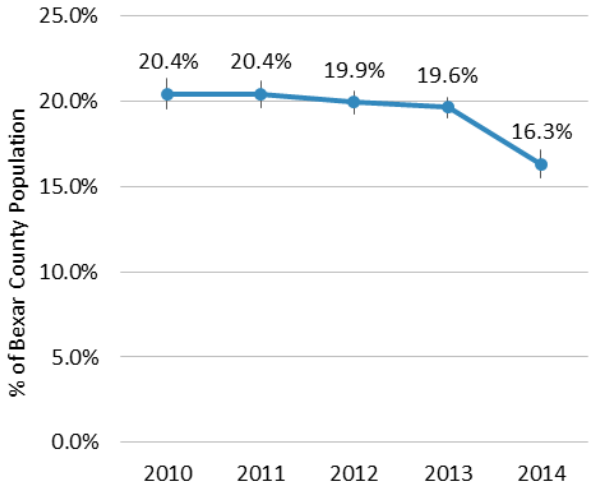
Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

from 2010 (Figure 3.34) likely resulting from the Affordable Care Act (ACA). Uninsurance tracks closely with poverty, and the rates of uninsured are highest on the near eastside, westside, and southside (Figure 3.35).

Uninsurance differs significantly by age group, with a rate of 7.9% (±1.0%) among birth to 17 year olds, 30.6% (±2.2%) among 19 to 25 year olds, and only 2.0% (±0.6%) among those 65 and older.[42] Children and teenagers have better access to health insurance than do adults because of Medicaid and CHIP, while most

Uninsured Population

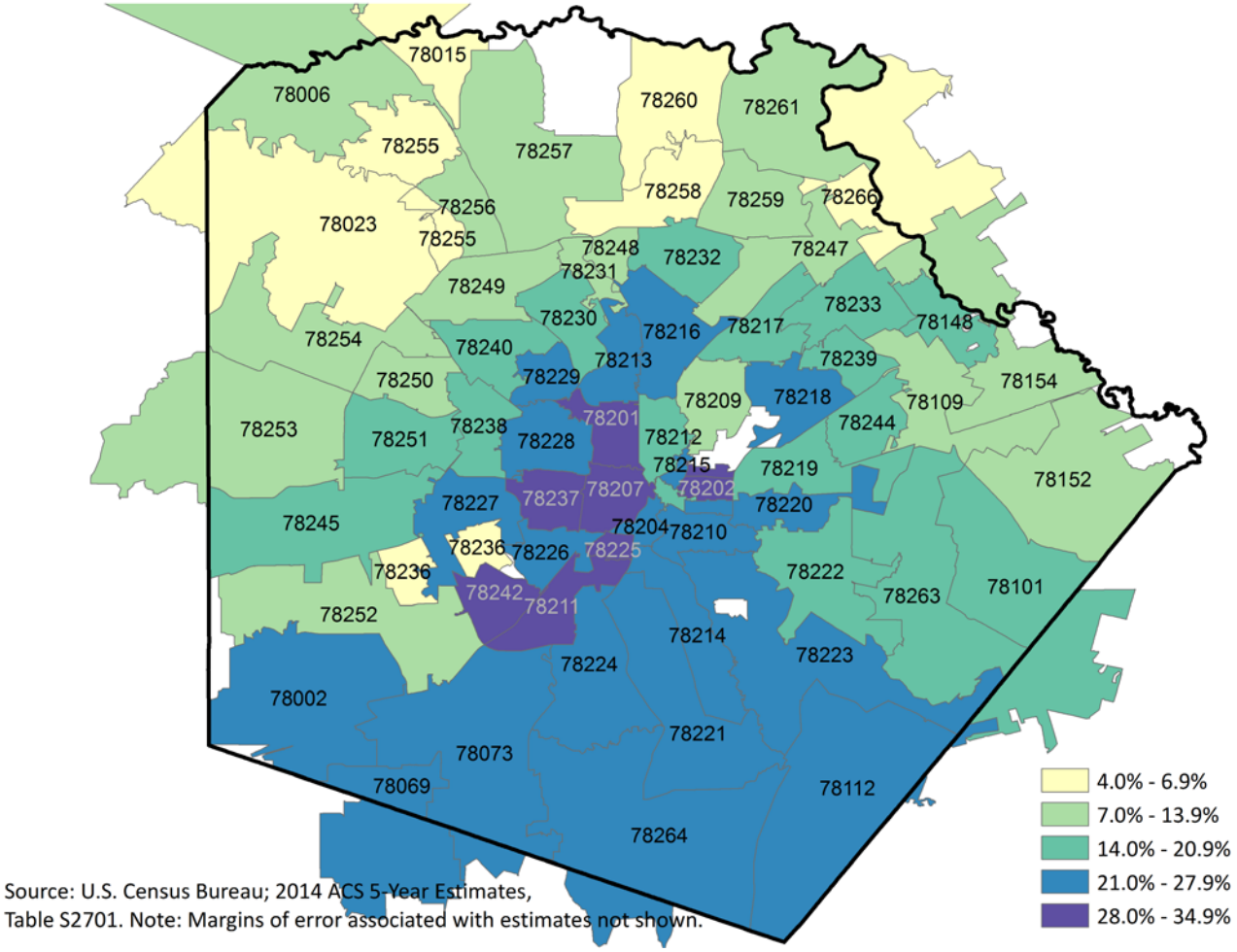
Figure 3.34 Percent of population uninsured



Source: U.S. Census Bureau; 2010-2014 ACS 1-Year Estimates, Table S2701.

Uninsured Population by Zip Code

Figure 3.35 Percent of population uninsured



Source: U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S2701. Note: Margins of error associated with estimates not shown.

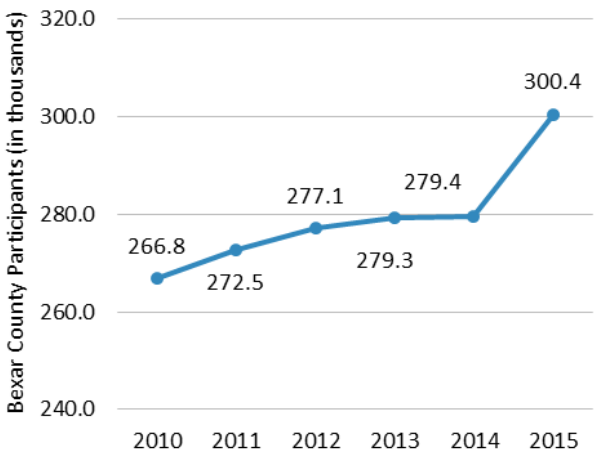
seniors have access to Medicare. The young adult group has largely aged out of Medicaid eligibility, may not have a job that offers health insurance, and very often does not see a need for health insurance. Among adults 25 and older, uninsured rates range from 6.5% (±0.9%) among those with a bachelor's degree or higher to 32.7% (±2.5%) among those without a high school diploma or GED. Roughly half of non-citizens are uninsured, as are half of the unemployed,[43] although more recent data, when available, may show an ACA-driven decrease in this figure.

Among those who do have insurance, 48.6% (±1.1%) have employment-based coverage, 10.7% (±0.6%) have direct-purchase coverage, 7.8% (±0.6%) have TRICARE/military coverage, and 3.4% (±0.2%) have VA Health Care. Public coverage is important, with Medicare covering 13.3% (±0.2%) of the insured and Medicaid 19.7% (±0.7%).[44] (Coverage figures add up to more than 100% because it is possible to have multiple sources of coverage.)

Another public benefit critical to health and well-being is food assistance. The number of Bexar County households participating in the Supplemental Nutrition Assistance Program (SNAP) continues to climb (Figure 3.36).

SNAP Participation

Figure 3.36 Monthly average participation in supplemental nutrition assistance program



Source: Texas Health and Human Services Comission, 2010-2015.

Healthcare Professionals

Figure 3.37 Number of healthcare professionals per 100,000 population

	Professionals	Rate per 100,000
Medical Doctor & Doctor of Osteopathy	**5,522**	**293.3**
Primary Care	1,928	102.4
Psychiatrists	**269**	**14.3**
Child & Adolescent Psychiatrists	39	2.1
Clinical Psychologists	**207**	**11.0**
Clinical Psychologists	180	9.6
Child Clinical Psychologists	27	1.4
Counselors and Social Workers		
Licensed Professional Counselors	1,891	100.4
Licensed Chemical Dependency Counselor	713	37.9
Marriage & Family Therapists	284	15.1
Licensed Clinical Social Worker	589	31.3

Source: Texas Department of State Health Services, 2015. Texas Medical Board, 2015.

Figure 3.37 summarizes the availability of licensed healthcare professionals by type. These professionals are, of course, not evenly distributed throughout the county. The count of professionals fails to capture capacity completely, as practicing providers may be semi-retired or otherwise maintaining a part-time practice. Bexar County's total licensed acute and psychiatric hospital beds are shown in Figure 3.38.

Acute and Psychiatric Care Facilities

Figure 3.38 Number of acute and psychiatric hospitals and beds

	2014	2015
Acute Care		
Hospitals	25	24
Beds	7,369	7,361
Psychiatric		
Hospitals	4	4
Beds	670	684

Source: Texas Department of State Health Services, 2014-2015.

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[23]The City of San Antonio; City of San Antonio Community Survey, 2014

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[43] U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S2701

[44] U.S. Census Bureau; 2014 ACS 1-Year Estimates, Table S2701

Health-Related Behaviors & Early Outcomes

Healthy Eating

People who eat more vegetables and fruits as part of an overall healthy diet are likely to have better health and a reduced risk of some chronic diseases. The percentage of Bexar County adults who consumed fruits and vegetables five or more times per day has remained flat over recent years, estimated at 17.1% (14.2%-20.5%) in 2011 and 15.4% (11.8%-19.8%) in 2013.[1] Although the point estimate is lower in 2013, the confidence intervals overlap almost completely, meaning there was actually little or no real change among BRFSS respondents. The news is better for sugar-sweetened drinks (Figure 4.1), with the percent of adults reporting that they never drink sugar-sweetened beverages increasing from 22.7% (16.9%-29.7%) in 2012 to 36.0% (31.2%-41.1%) in 2014. Because the confidence intervals do not overlap at all, there clearly was a true increase among respondents.

No new data on healthy eating and consumption of sugar-sweetened beverages among youth are available from the YRBSS survey, the usual source of information on these issues. One local dataset of interest, however, has been generated through the Witte Museum's *H-E-B Body Adventure Powered by University Health System*. As visitors move through a series of networked interactive exhibition components, anonymous data are generated for that visitor that is used to generate a POWERprofile summary card for the visitor to take home and, if desired, compare with future visits. The visitor does enter his or her own zip code, race/ethnicity, and sex, enabling the aggregate dataset to be examined for geographic and demographic differences. Only a few key measures are presented here; much more data from this dataset is available from the Witte Museum.[2]

Of the roughly 12,000 Bexar County residents aged 13 to 18 years who visited the *H-E-B Body Adventure Powered by University Health System* and for whom data were generated in the exhibit's first year, 38% reported that they drink at least one soda per day, 35% reported eating "no vegetables" the previous day, and 20% reported eating "no fruit" the previous day. Of those aged eight to 18, 45% were either overweight or obese.[3]

Sugar Sweetened Drinks

Figure 4.1 Percentage of adults who do not drink sugar sweetened beverages

	% of Adults	(95% CI)
2012	22.7%	(16.9-29.7)
2014	36.0%	(31.2-41.1)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2012 & 2014 (with 95% CI).
**Sample too small to report.

One 2014 CHIP objective was to increase the number of schools participating in the Healthy After School Program. The Healthy Schools Initiative seeks to improve nutrition and physical activity in San Antonio schools. Among other interventions, the Communities Putting Prevention to Work (CPPW) initiative, for which funding ended in 2012, provided teachers in 361 schools throughout San Antonio with access to workshops, training tools, and physical activity equipment resources to increase the quality and frequency of physical education in schools, reaching more than 365,000 students.[4] A Healthy Schools Summit convened superintendents and other school district senior leadership in 2014.[5]

THC's 2013 assessment included much information about health-related behaviors and risk and protective factors among youth, including healthy eating, drawn from the Youth Risk Behavior Survey (YRBS). No new data are available for this 2016 assessment as Bexar County school districts did not participate in the last round of YRBS administration.

Physical Activity

Physical activity is critical to well-being, reducing the risk of depression, obesity, and a number of other factors. It is influenced by both personal factors like disability and depression and environmental factors like neighborhood safety and the availability of green spaces and affordable fitness facilities and programming. The percent of Bexar County adults reporting participating in 150 minutes or more of aerobic physical activity per week has remained flat in recent years, estimated at 47.2% (42.4%-52.1%) in 2011 and 44.1% (38.8%-49.5%) in 2013.[6] Again, the overlapping confidence intervals suggest no significant change may have occurred.

Substance Use

Problem or heavy drinking, whether binge or chronic, is a serious issue in San Antonio. BRFSS data appear to show a decrease in heavy drinking recently, declining from 10.1% (7.1%-14.1%) in 2011 to 6.3% in 2014 (4.8%-8.3%). The confidence intervals do overlap slightly, though, casting doubt on whether a true decline occurred. The estimated percentage of adults who report having driven after drinking alcohol in the past 30 days has *increased* recently (Figure 4.2), with no overlap of confidence intervals.

Alcohol and Driving

Figure 4.2 Percentage of adults who drove after drinking alcohol in the past 30 days

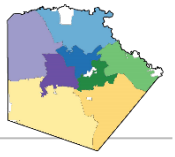
	% of Adults	(95% CI)
2012	1.1%	(0.5-2.4)
2014	4.2%	(2.5-6.9)

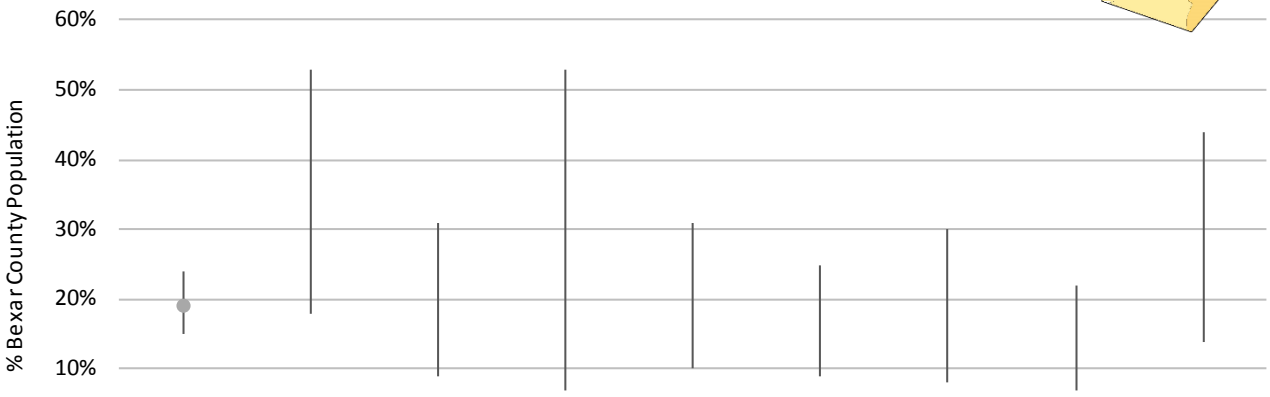
Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2012 & 2014 (with 95% CI). **Sample too small

Tobacco use remains common in Bexar County, with about one in five adults reporting that they are current smokers (Figure 4.3). In an effort to look at differences in health-related behaviors across the county, the three-year average rates were calculated from the BRFSS data for eight sub-county sectors. The resulting sample sizes were too small to generate a trustworthy point estimate, but the confidence intervals are shown. Current smoking by race/ethnicity is shown in Figure 4.4. Only a small percentage of Bexar County adults use smokeless tobacco (Figure 4.5).

Adult Smokers

Figure 4.3 Percentage of adults who currently smoke



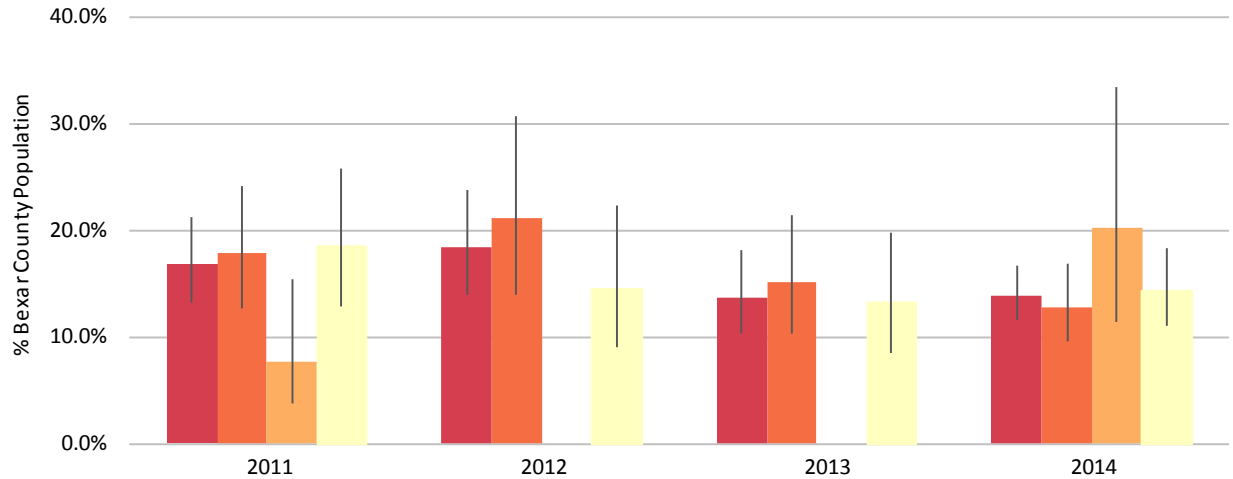


Bexar County	Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
19% (15%-24%)	* (18%-53%)	* (9%-31%)	* (7%-53%)	* (10%-31%)	* (9%-25%)	* (8%-30%)	* (7%-22%)	* (14%-44%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Adult Smokers

Figure 4.4 Percentage of adults who currently smoke by race/ethnicity



	2011	2012	2013	2014
Overall	**16.8% (13.3%-21.2%)**	**18.5% (14.0%-23.9%)**	**13.8% (10.4%-18.1%)**	**14.0% (11.7%-16.7%)**
White	17.9% (12.8%-24.2%)	21.1% (14.0%-30.7%)	15.1% (10.3%-21.5%)	12.9% (9.7%-17.0%)
Black	7.8% (3.8%-15.5%)	**	**	20.3% (11.5%-33.5%)
Hispanic	18.6% (13.0%-25.9%)	14.5% (9.1%-22.3%)	13.2% (8.6%-19.8%)	14.4% (11.1%-18.4%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

Many local municipalities are regulating smoking to varying degrees. The City of San Antonio is 100% smoke-free, with no smoking allowed in municipal worksites, private worksites, restaurants, bars in restaurants, or bars not in restaurants (see **Policy Highlight: Local Smoking Ordinance Overview**). In that ordinance overview, "limited coverage" means that designated smoking areas are allowed or required, and "moderate coverage" means that designated smoking areas are allowed if separately ventilated.

Bexar County-specific data on the prevalence of using other drugs like marijuana, cocaine, and opiates is not available. Texas' Region 8 Prevention Resource Center (PRC), housed by the San Antonio Council on Alcohol and Drug Abuse (SACADA), collects and publishes available data related to alcohol, tobacco, and other drugs, for Region 8 and Texas as a whole.

Smokeless Tobacco

Figure 4.5 Percentage of adults who use smokeless tobacco products

	2013	2014
Daily	0.8% (0.4-2.0)	0.6% (0.3-1.4)
Some Days	0.6% (0.2-1.9)	2.2% (1.4-3.5)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2013 & 2014 (with 95% CI).
**Sample too small to report.

Policy Highlight: Local Smoking Ordinance Overview

The Texas Smoke-Free Ordinance Database evaluates the restrictions on smoking in public places for each municipality in Texas with a population greater than 5,000 and provides a scoring system to determine the level of exposure to secondhand smoke. The interactive database website allows users to download the text of local ordinances for Bexar County.

	Municipal Worksites	Private Worksites	Restaurants	Bars In Restaurants	Bars Not In Restaurants
San Antonio	100% Smoke-Free	100% Smoke-Free	100% Smoke-Free	100% Smoke-Free	100% Smoke-Free
Helotes	100% Smoke-Free	No Coverage	Limited Coverage	Limited Coverage	No Coverage
Leon Valley	Limited Coverage	Limited Coverage	Limited Coverage	No Coverage	No Coverage
Schertz	No Coverage	Limited Coverage	Moderate Coverage	Moderate Coverage	Limited Coverage
Kirby, Live Oak, Windcrest	100% Smoke-Free	No Coverage	No Coverage	No Coverage	No Coverage
Alamo Heights, Converse, Fair Oaks Ranch, Selma, Terrell Hills, Universal City	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage

Source: University of Houston School of Law, Texas Smoke-Free Ordinance Data-

The assessment provides useful information on demographics, risk and protective factors, drug-related crime, and treatment, as well as Texas School Survey results. The PRC's annual assessment is available online in both English and Spanish.[7]

Reproductive & Sexual Health

The incidence, or number of new cases diagnosed per year, of acute Hepatitis B continues to decline (Figure 4.6). However, the steep drop from 2010 to 2011 is an artifact of a change in surveillance case definition and related investigative requirements, resulting in a lower and more accurate rate. HIV incidence declined in 2014 after a spike in 2013, but as with any rate calculated from a relatively small number of cases, the trend likely has "bounce" that may not reflect a true increase or decrease (Figure 4.7).

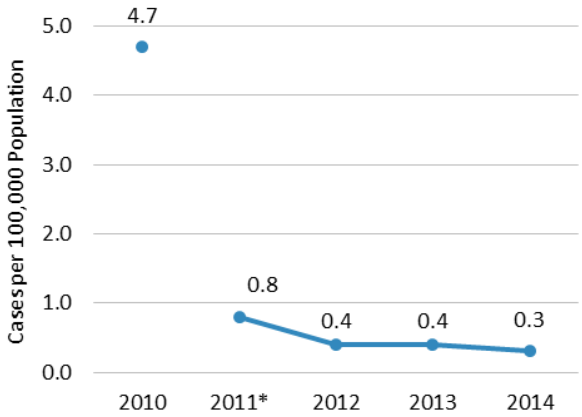
HIV incidence is much higher among younger people. Data for the Ryan White four-county San Antonio Transitional Grant Area (SATGA, including Bexar, Comal, Guadalupe, and Wilson) show a 2014 rate of 40.5 cases per 100,000 among 25- to 34-year-olds and 28.9 per 100,000 among 13- to 24-year-olds, as compared to only 14.6 and 15.1 per 100,000 among 35- to 44-year-olds and 45- to 54-year-olds, respectively.[8]

HIV prevalence (total cases regardless of when diagnosed) in the SATGA was 115.9 cases per 100,000 population in 2013.9 The overwhelming majority of these cases are in Bexar County. The population of people living with HIV is 83% male, 56% Hispanic, 23% non-Hispanic white, and 17% African-American. AIDS prevalence was 148.0 cases per 100,000 population. Sixty percent are Hispanic, 23% non-Hispanic white, and 14% African-American.

Only about four in 10 Bexar County adults has ever been tested for HIV, a proportion that has remained flat for several years (Figure 4.8). The SATGA has a substantial population of "late testers," with 28% of those testing positive being diagnosed with AIDS within one year.

Hepatitis B Incidence

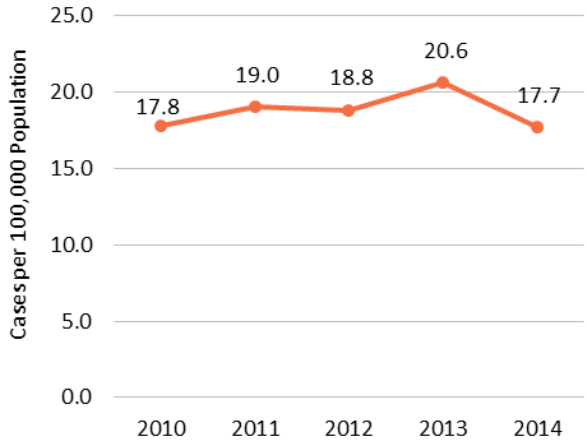
Figure 4.6 Number of cases per 100,000 population



Source: Texas Department of State Health Services, 2010-2014. *Change in surveillance case definition effective 2011. 2010 is not directly comparable with 2011-2014.

HIV Incidence

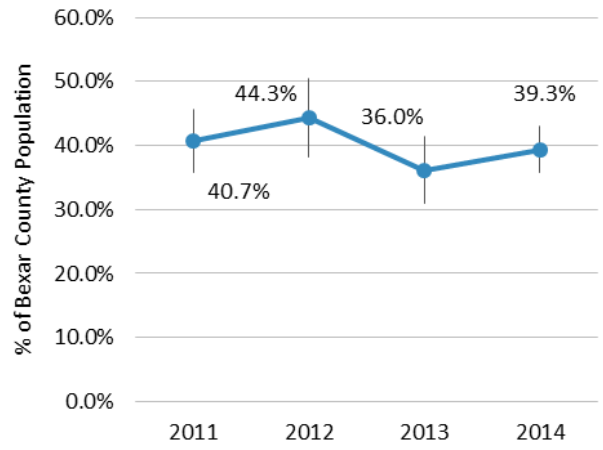
Figure 4.7 Number of cases per 100,000 population



Source: Texas Department of State Health Services, 2010-2014.

HIV Tests

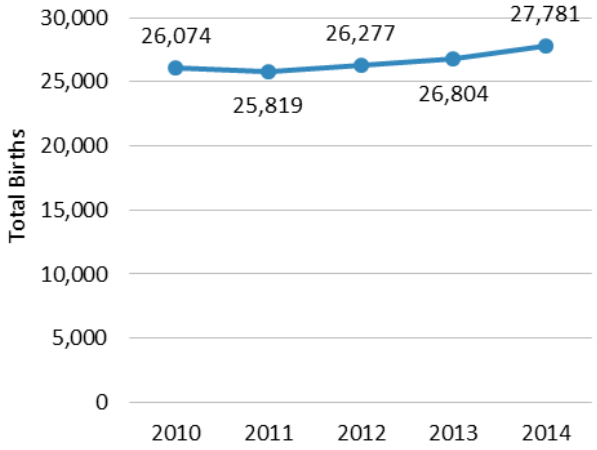
Figure 4.8 Percentage of adults ever tested for HIV



Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014.

Total Births

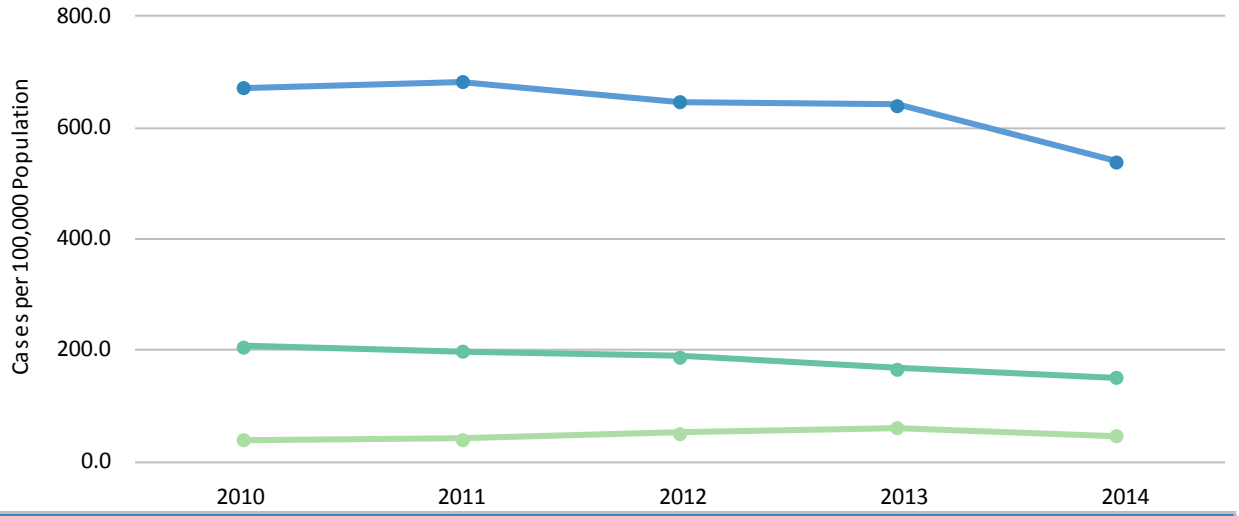
Figure 4.10 Number of total births



Source: Texas Department of State Health Services, 2010-2014 as reported on 6-30-2016.

Sexually Transmitted Disease

Figure 4.9 Number of cases per 100,000 population



	2010	2011	2012	2013	2014
Chlamydia	670.1	682.6	646.7	641.9	539.6
Gonorrhea	207.4	198.1	188.9	167.1	151.6
Syphilis	38.5	40.3	52.2	61.3	47.1

Source: Texas Department of State Health Services, 2010-2014.

Both chlamydia and gonorrhea incidence have declined significantly since 2010 (Figure 4.9), although preliminary numbers from San Antonio Metropolitan Health District indicate that both may have risen in 2015.[10] Despite a decline from 2013, the area continues to struggle with syphilis, with 2014 incidence still 22% higher than 2010.

The number of total births is rising[11] (Figure 4.10), although not in proportion to total population growth. The birthrate among females aged 15 to 19 continues to decline (Figure 4.11), driven by steep decreases among Hispanic and Black females. The overall downward trend mirrors the trend seen in Texas and the U.S. in recent years.[12] The proportion of births that were to single mothers and to women who were obese at birth has remained flat in recent years (Figure 4.12).

Mother's Characteristics

Figure 4.12 Percentage of births to mothers by characteristic

	Single Mothers	Mothers BMI ≥30
2010	46%	26%
2011	44%	27%
2012	45%	28%
2013	44%	29%
2014	44%	28%

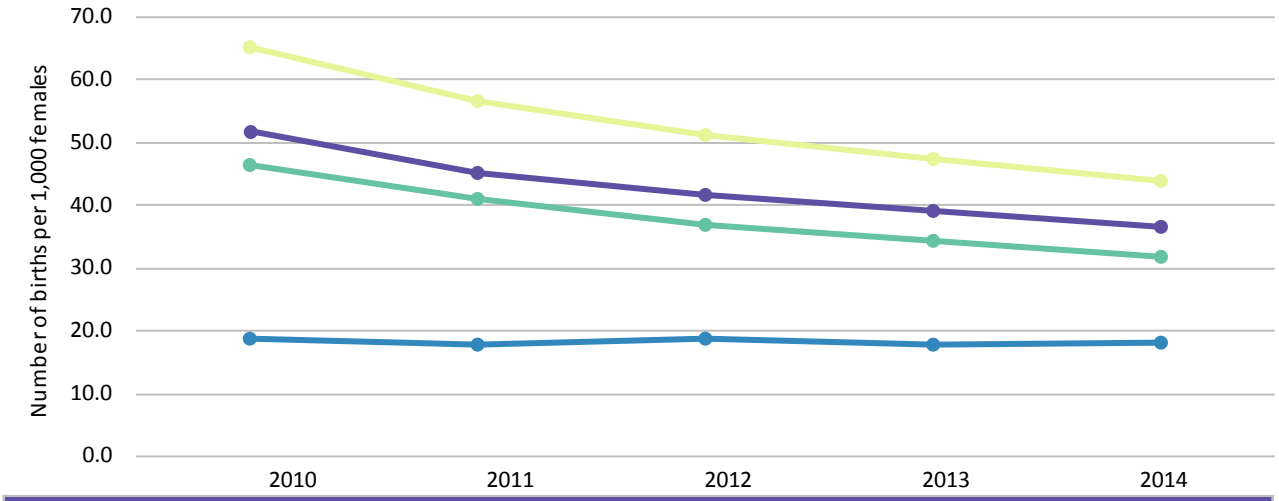
Source: Texas Department of State Health Services, 2010-2014 as reported on 6-30-2016

Unfortunately, the proportion of births that followed early and adequate prenatal care has dropped steadily since 2010 (Figure 4.13).

The rate of congenital syphilis nearly doubled from 2011 to 2012 (Figure 4.14). After aggressive outreach to physicians and patients to encourage syphilis screening as part of routine prenatal care, the number of new congenital syphilis cases reported is down from 18 in 2012

Teen Birthrate

Figure 4.11 Number of births to mother aged 15-19 years per 1,000 females



	2010	2011	2012	2013	2014
Overall	**51.8**	**45.2**	**41.7**	**39.3**	**36.5**
White	18.9	17.8	18.8	17.9	18.0
Black	46.6	40.9	36.8	34.4	31.8
Hispanic	65.4	56.5	51.2	47.3	43.8

Source: Texas Department of State Health Services, 2010-2014 as reported on 6-30-2016

to 10 in 2015. Eight of the 10 cases reported in 2015 had limited or no prenatal care.[13]

The rate of hospitalizations for complications of pregnancy or childbirth appears to have increased since 2010 (Figure 4.15). The "up-down-up" trend should be interpreted with caution, but given the falloff in proportion of births following early and adequate prenatal care, there may well be a true increase.

Prenatal Care

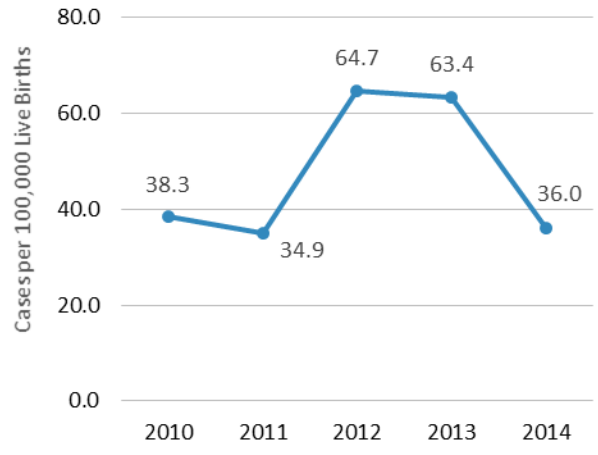
Figure 4.13 Percentage of births to mothers receiving prenatal care in the first trimester

	Percentage of Births
2010	60.4%
2011	61.7%
2012	60.3%
2013	56.1%
2014	57.1%

Source: Texas Department of State Health Services, 2010-2014 as reported on 6-30-2016

Congenital Syphilis

Figure 4.14 Number of cases per 100,000 live births



Source: Texas Department of State Health Services, 2010-2014.

The percent of births that were premature or low birth weight has remained flat over the past several years (Figure 4.16). No new data are available, but a 2010 analysis estimated that more than six in 10 pregnancies among Bexar County adults aged 18 to 29 were unplanned.[14]

Infant microcephaly associated with maternal Zika virus infection is currently in the spotlight. Depending on the severity, microcephaly may result in developmental delays, intellectual disability, and problems with hearing, vision, and movement and balance.[15] As of early June 2016, San Antonio has seven confirmed cases of Zika virus infection, all acquired abroad, with 16 possible cases under investigation.[16]

Pregnancy/Childbirth Complications

Figure 4.15 Number of hospitalizations per 10,000 women age 15-44

	Hospitalizations per 10,000
2010	405.5
2011	406.3
2012	423.7
2013	414.1
2014	425.4

Source: Texas Department of State Health Services, 2010-2014.

Birth Outcomes

Figure 4.16 Percentage of birth by birth outcome

	Low Birth Weight	Pre-term Births
2010	9.4%	14.4%
2011	9.2%	13.4%
2012	9.2%	13.4%
2013	9.0%	12.4%
2014	8.9%	12.1%

Source: Texas Department of State Health Services, 2010-2014 as reported on 6-30-2016

Preventive Care & Self-Management

Vaccination rates for children under three years old vary considerably by recommended vaccine. About two-thirds have had the combined 4:3:1:3*:3:1:4 series,[17] an increase over 2010 (Figure 4.17). Figure 4.18 summarizes trends in communicable diseases for which reporting is required. While pertussis, or whooping cough, declined from a five-year high of 6.7 diagnosed cases per 100,000 population in 2013, the 2014 rate of 4.8 per 100,000 is still more than triple the 2010 rate. Hepatitis B and mumps both declined since 2010.

HPV is the most common sexually transmitted disease in the U.S. Persistent HPV infections can lead to cervical cancer in women and other cancers in men. The percent of youth aged 13 to 17 years who have received the three-dose HPV vaccine increased since 2011. It is estimated that 72.9% (±14.1%) of females and 53.7% (±21.1%) of males have received all three HPV doses (Figure 4.19).

"There is an apathy... poor health is just the way it is."

- Discussion Group Participant

Childhood Vaccines

Figure 4.17 Rates of vaccines among children 0-3

	2010	2011	2012	2013	2014
4+ DTaP	83.2 (±5.4)	77.0 (±6.3)	77.5 (±6.4)	79.4 (±6.5)	79.0 (±6.1)
3+ Polio	93.4 (±3.6)	89.4 (±4.8)	89.7 (±4.8)	92.6 (±4.1)	90.6 (±4.5)
1+ MMR	94.6 (±2.8)	91.5 (±4.1)	90.9 (±4.0)	93.0 (±3.7)	92.3 (±4.2)
Hib	62.6 (±7.1)	78.9 (±5.9)	76.5 (±6.7)	79.3 (±6.3)	76.8 (±6.3)
3+ Hepatitis B	95.7 (±2.9)	88.5 (±4.7)	89.2 (±4.4)	90.8 (±4.3)	88.3 (±5.2)
Hepatits B (birth)	59.9 (±6.7)	61.9 (±7.1)	65.8 (±6.8)	80.7 (±6.9)	78.0 (±6.1)
1+ Varicella	92.4 (±3.8)	94.1 (±3.4)	93.3 (±3.3)	92.3 (±3.9)	96.6 (±2.1)
4+ PCV	79.5 (±6.0)	83.6 (±5.6)	81.4 (±5.9)	81.5 (±6.2)	79.6 (±6.2)
2+ Hepatitis A	53.5 (±7.0)	55.2 (±7.1)	62.6 (±7.6)	64.3 (±7.2)	67.9 (±7.0)
Rotavirus	62.0 (±7.1)	69.1 (±6.6)	67.5 (±7.4)	67.2 (±7.5)	70.9 (±7.1)
4:3:1:3*:3:1:4	57.3 (±7.2)	67.4 (±6.8)	65.7 (±7.5)	70.6 (±7.1)	66.4 (±7.0)

Source: Texas Department of State Health Services, 2010-2014.

Vaccine-Preventable Disease

Figure 4.18 Number of new cases of reportable vaccine-preventable disease per 100,000 population

	2010	2011	2012	2013	2014
Varicella	5.6	5.5	3.6	5.2	4.8
Pertussis	1.5	1.4	4.1	6.7	4.8
Mumps	2.7	0.8	0.1	0.1	0.1
Measles	0.0	0.0	0.0	0.0	0.0
Polio	0.0	0.0	0.0	0.1	0.0
Hepatitis A	0.4	0.4	0.1	0.5	0.5
Hepatitis B	4.7*	0.8	0.4	0.4	0.3
Hib	0.0	0.0	0.0	0.1	0.1

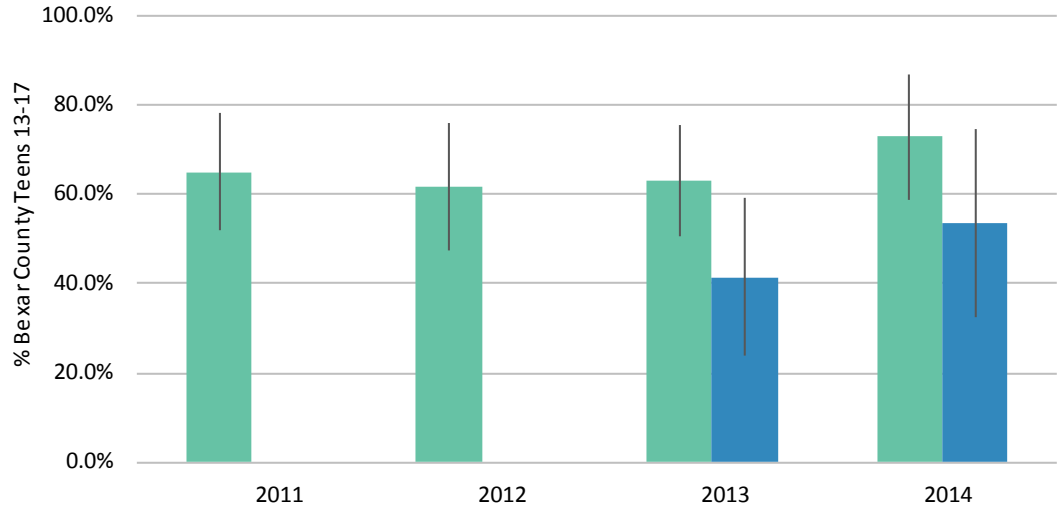
Source: Texas Department of State Health Services, 2010-2014.
*The Hepatitis B 2010 figure cannot be trended with 2011-2014 as it reflects cases reported under a different case definition.

The percent of BRFSS survey respondents reporting having had a tetanus vaccination since 2005 appears to have risen slightly (Figure 4.20). However, because the confidence intervals overlap, and because the 2014 question asks about vaccination in a nine-year period as compared to an eight-year period in 2013, the vaccination rate likely has not increased.

An annual influenza vaccination is recommended for everyone six months old and up, but flu shots are especially important for people 65 years and older. The immune system declines with age, making seniors more likely than healthy younger adults to have serious complications from the flu, including death. An estimated 80% to

HPV Vaccination

Figure 4.19 HPV vaccination 3 dose completion among teens 13-17 years



	2011	2012	2013	2014
Females	65.0% (±13.1%)	61.9% (±14.3%)	63.1% (±12.6%)	72.9% (±14.1%)
Males	***	***	41.4% (±17.7%)	53.7% (±21.1%)

Source: Centers for Disease Control and Prevention; NIS-Teen Vaccination Coverage Table Data, 2014.
***Not applicable.

Tetanus Shots

Figure 4.20 Percentage of adults receiving a tetanus shot since 2005

	% of Adults	(95% CI)
2013	20.2%	(16.3-24.8)
2014	25.6%	(20.9-31.0)

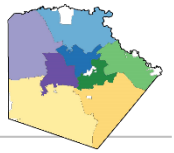
Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2013 & 2014 (with 95% CI).
**Sample too small to report.

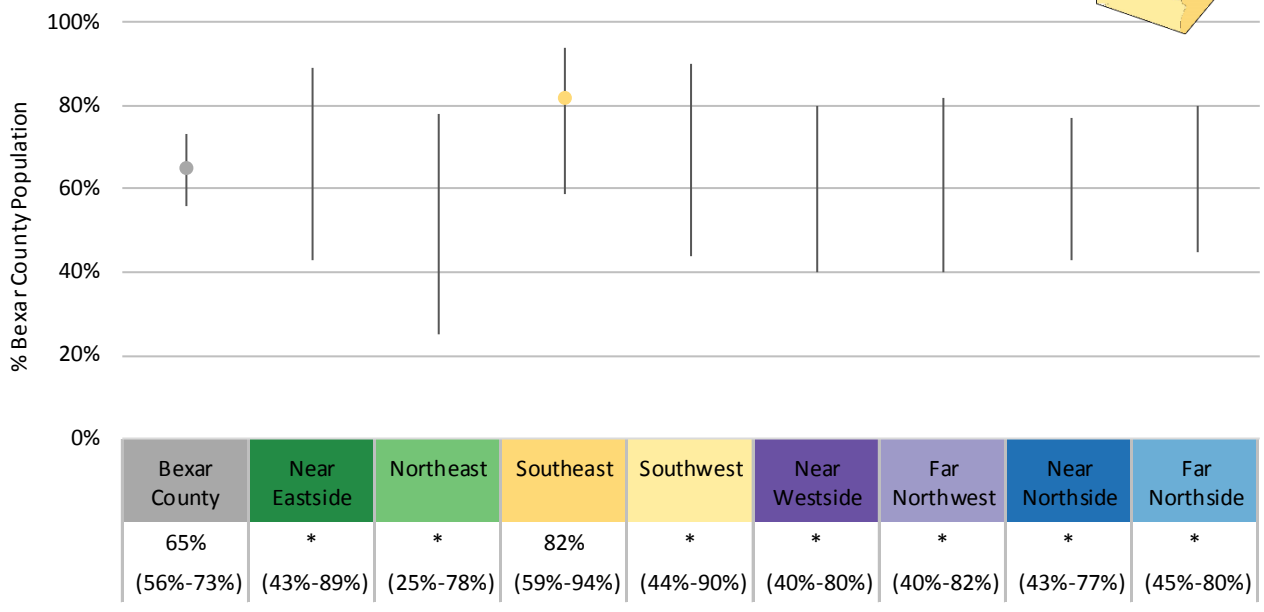
90% of seasonal flu-related deaths, and an estimated 50% to 70% of seasonal flu-related hospitalizations have been among people 65 and older.[18] An estimated 65% of Bexar County seniors (56%-73%) report having had a flu shot in the past year (Figure 4.21), and an estimated 73% (65%-81%) report ever having had the pneumonia vaccination (Figure 4.22), which is only needed once in one's lifetime. Neither flu nor pneumonia vaccination rates among seniors appear to vary much across the county.

Although rates of specific screenings and other preventive services are better indicators of appropriate care, the routine checkup offers some idea of whether people are getting preventive care. About two-thirds of Bexar County adults report having seen a doctor in the past year for a routine checkup (Figure 4.23). Differences by race/ethnicity

Senior Flu Shot

Figure 4.21 Percentage of seniors who have had a flu shot within the past year



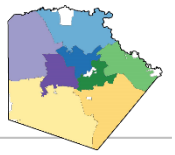


Bexar County	Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
65% (56%-73%)	* (43%-89%)	* (25%-78%)	82% (59%-94%)	* (44%-90%)	* (40%-80%)	* (40%-82%)	* (43%-77%)	* (45%-80%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Senior Pneumonia Vaccination

Figure 4.22 Percentage of seniors who have ever had a pneumonia vaccination

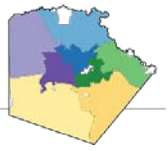


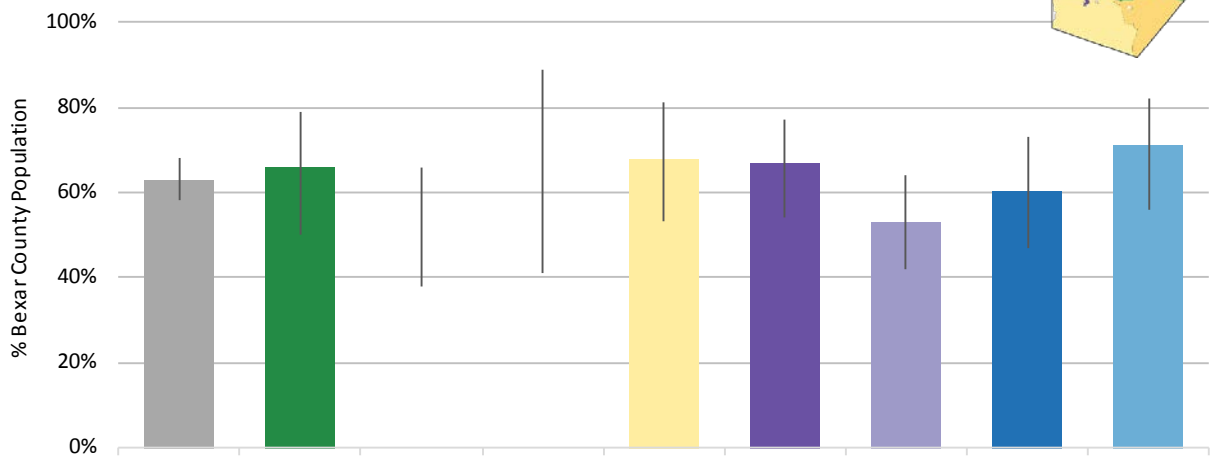
Bexar County	Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
73% (65%-81%)	* (44%-89%)	* (33%-87%)	* (31%-84%)	* (41%-96%)	* (51%-92%)	85% (59%-95%)	* (46%-81%)	81% (64%-91%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Routine Check-Ups

Figure 4.23 Percentage of adults seeing a doctor last year for a routine check-up by sector





Bexar County	Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
63% (58%-68%)	66% (50%-79%)	* (38%-66%)	* (41%-89%)	68% (53%-81%)	67% (54%-77%)	53% (42%-64%)	60% (47%-73%)	71% (56%-82%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

do emerge, though, with 74.3% (69.5%-78.6%) of non-Hispanic Whites having had a routine checkup, as compared to only 61.0% (55.7%-66.0%) of Hispanics. Small sample sizes and wide confidence intervals make it unclear how that proportion varies across the county (Figure 4.24). (The county-wide number varies from that presented in Figure 4.23 because it uses a three-year average with a different confidence level.) The percentage of Bexar County adults reporting having visited a dentist within the past year stands at a 63.6% (60.2%-66.9%), with non-Hispanic Whites again more likely than Hispanics to have done so (Figure 4.25).

Dental Visits

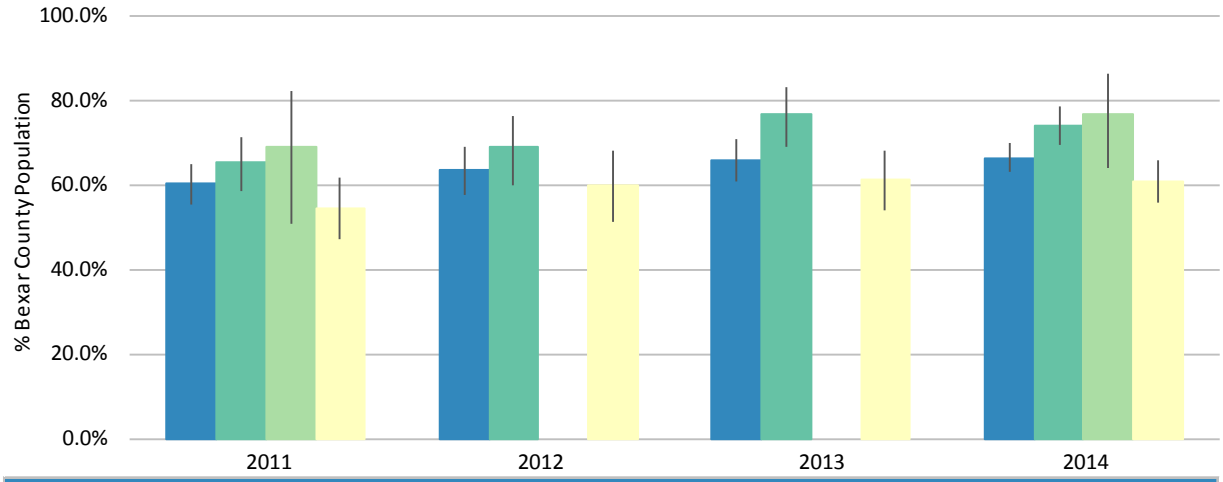
Figure 4.25 Percentage of adults seeing a dentist within the year

	2012	2014
Total	**60.0%**	**63.6%**
	(54.1-65.6)	**(60.2-66.9)**
White	68.5%	70.2%
	(60.0-75.9)	(65.4-74.7)
Black	**	65.9%
	**	(53.7-76.3)
Hispanic	56.5%	60.0%
	(47.8-64.8)	(54.9-64.9)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2012 & 2014 (with 95% CI). **Sample too small to report.

Routine Check-Ups

Figure 4.24 Percentage of adults that visited a doctor last year for a routine checkup by race/ethnicity



Overall	**60.5% (55.5%-65.2%)**	**63.7% (57.7%-69.2%)**	**66.0% (61.0%-70.8%)**	**66.5% (63.0%-69.9%)**
White	65.3% (58.7%-71.3%)	68.9% (60.2%-76.4%)	77.0% (69.3%-83.2%)	74.3% (69.5%-78.6%)
Black	69.0% (51.1%-82.5%)	**	**	77.0% (64.3%-86.2%)
Hispanic	54.7% (47.2%-62.0%)	60.1% (51.3%-68.3%)	61.2% (53.9%-68.0%)	61.0% (55.7%-66.0%)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

Cancer screening rates are mixed. About three-quarters of Bexar County women 40 and older report having had a mammogram in the past two years, with no clear differences emerging by race/ethnicity (Figure 4.26). The percentage of women reporting having ever had a Pap test (Figure 4.27), which screens for cervical cancer, stands at 86.5% (81.6%-90.3%), although "ever" is too infrequent for most sexually active women. About 69% (64.8%-73.0%) of adults aged 50 and older report having a sigmoid or colonoscopy test and 13.6% (10.9%-16.7%) report having had a blood stool test in the past two years.[19]

Regular care and self-management are critical for those with chronic disease, the rates of which are covered in the **Illness and Injury** section. Among BRFSS adult respondents with diabetes, 18.3% (9.8%-31.7%) report having not seen a doctor for diabetes in the past year (Figure 4.28), and 24.8% (14.7%-38.8%) report not having had their hemoglobin A1c checked to measure their blood sugar levels. An estimated half report having had a course in self-management, half report checking their feet daily for lost sensation or wounds, and six in ten report checking their blood sugar daily.

"it is very hard for the community to overcome the advertising and the food that is put in front of them"

- Judge Nelson Wolff

Mammogram

Figure 4.26 Percentage of women 40+ who have had a mammogram in the past 2 years

	2012	2014
Total	**67.9%**	**76.0%**
	(58.7-75.8)	**(71.3-80.1)**
White	70.7%	76.0%
	(58.9-80.3)	(69.4-81.5)
Black	**	**
	**	**
Hispanic	66.7%	74.6%
	(52.5-78.4)	(67.0-81.0)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2012 & 2014 (with 95% CI). **Sample too small to report.

Pap Test

Figure 4.27 Percentage of women who have ever had a pap test

	2012	2014
Total	**94.2%**	**86.5%**
	(89.5-96.9)	**(81.6-90.3)**
White	95.3%	92.6%
	(86.8-98.4)	(85.2-96.4)
Black	**	81.7%
	**	(57.1-93.8)
Hispanic	92.3%	83.6%
	(84.5-96.3)	(76.1-89.1)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2012 & 2014 (with 95% CI). **Sample too small to report.

Diabetic Care

Figure 4.28 Percentage of adult diabetics

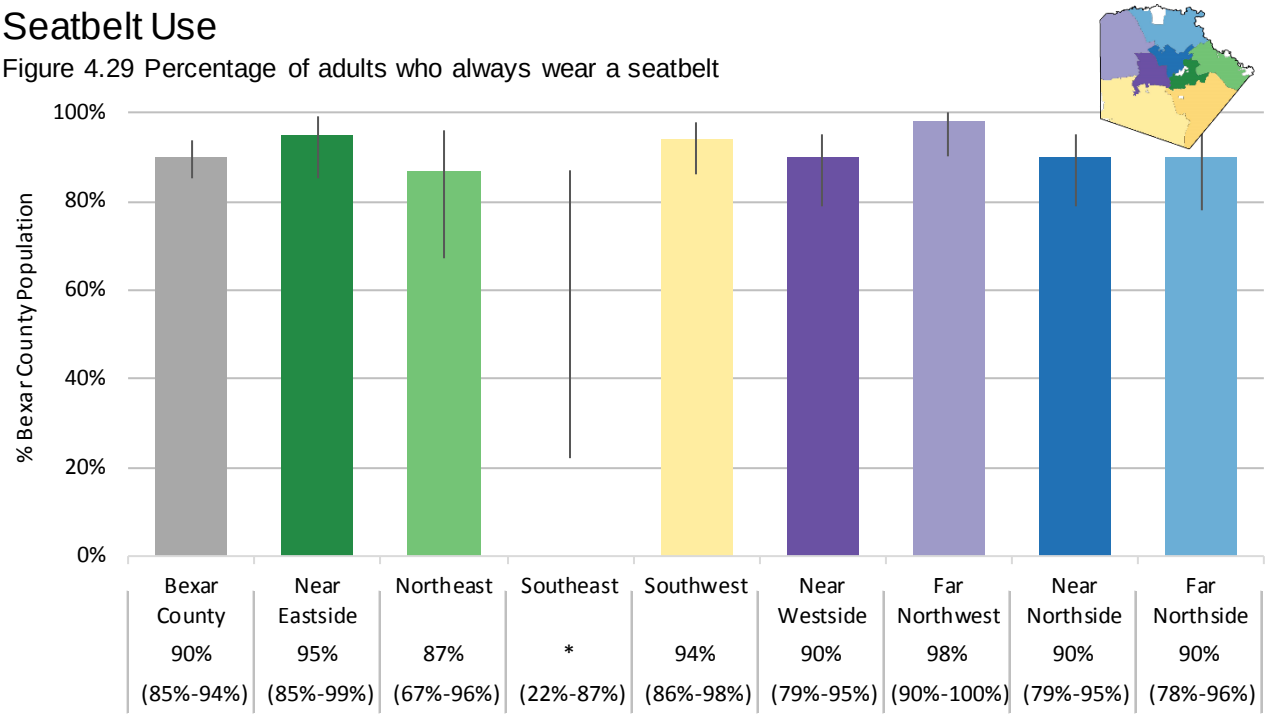
	2013	2014
Did not see a doctor for diabetes in past year	10.1% (2.9-29.7)	18.3% (9.8-31.7)
Did not have A1c checked in the past year	*** ***	24.8% (14.7-38.8)
Had a course in self-management	50.0% (31.9-68.1)	48.6% (37.9-59.5)
Check blood sugar daily	69.7% (51.5-83.3)	62.6% (51.7-72.4)
Check feet daily	60.0% (40.0-77.2)	51.1% (40.0-62.1)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2013 & 2014 (with 95% CI). ***Not applicable.

Finally, 90% (85%-94%) of BRFSS respondents say they always wear a seatbelt (Figure 4.29), a remarkable achievement. Although the sample size was too small to result in an estimate that can be displayed, the southeast area of the county appears to lag in seatbelt use. Motor vehicle crashes are a leading cause of death among teenagers and young adults. Adult seat belt use is the most effective way to save lives and reduce injuries in crashes.[20]

Seatbelt Use

Figure 4.29 Percentage of adults who always wear a seatbelt



Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

[1] Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011 & 2013.

[2] The Witte Museum (2016). H-E-B Body Adventure. Retrieved June 21, 2016 from https://www.wittemuseum.org/exhibitions/exhibitions/h-e-b-body-adventure

[3] The Witte Museum (2015). *H-E-B Body Adventure: Celebrating the Witte Museum's H-E-B Body Adventure Powered by University Health System: First Year Baseline Report 2015*. Available online at https://www.wittemuseum.org/exhibitions/exhibitions/h-e-b-body-adventure

[4] Centers for Disease Control and Prevention (2013). CPPW Community Profile: San Antonio, Texas. http://www.cdc.gov/nccdphp/dch/programs/communitiesputtingpreventiontowork/communities/profiles/obesity-tx_sanantonio.htm

[5] Mayor's Fitness Council (n.d.). *The Healthy Schools Initiative*. http://www.fitcitysa.com/at-school/healthy-schools-initiative.html

[6] Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011 & 2013.

[7] Prevention Resource Center - Region 8 (2016). http://prcregion8.org/data/

[8] Texas Department of State Health Services, unpublished data provided by the Bexar County Department of Community Resources, Community Health Division, received June 29, 2016.

[9] San Antonio HIV Health Services Planning Council/The Provado Group, Inc. (2015.) *Comprehensive HIV Assessment 2014-2015: San Antonio Transitional Grant Area*. http://www.hiv210.org/index.php?option=com_content&view=article&id=40&Itemid=120

[10] San Antonio Metropolitan Health Department (2016, May 18). *News release: Metro Health continues making strides in the battle against syphilis*. http://www.sanantonio.gov/Health/News/NewsReleases/TabId/1626/ArtMID/9362/ArticleID/7526/Metro-Health-Continues-Making-Strides-in-Battle-against-Syphilis.aspx

[11] Vital statistics categorization criteria and calculation methods can vary by data source. These data were provided by the Texas Department of State Health Services (TDSHS) as of June 30, 2016. Birth outcomes are reported by mother's county of residence.

[12] See for example, Centers for Disease Control and Prevention, National Center for Health Statistics (2016). *Teen births*. http://www.cdc.gov/nchs/fastats/teenbirths.htm

[13] San Antonio Metropolitan Health Department. (2016, May 18). *News release: Metro Health continues making strides in the battle against syphilis*. Retrieved May 26, 2016 from http://www.sanantonio.gov/Health/News/NewsReleases/TabId/1626/ArtMID/9362/ArticleID/7526/Metro-Health-Continues-Making-Strides-in-Battle-against-Syphilis.aspx.

[14] Stoeltje, M.F. (2010, April 23). Unplanned pregnancies 'epidemic'. San Antonio Express-News. http://www.mysanantonio.com/news/local_news/article/Unplanned-pregnancies-epidemic-790442.php

[15] Centers for Disease Control and Prevention (2016). *Birth defects: Facts about microcephaly*. http://www.cdc.gov/ncbddd/birthdefects/microcephaly.html

[16] San Antonio Metropolitan Health District (2016, June 9). *News release: Metro Health releases latest Zika test numbers*. http://www.sanantonio.gov/Health/News/NewsReleases.aspx

[17] The 4:3:1:3*:3:1:4 vaccine series includes at least four doses of DTaP/diphtheria and tetanus toxoids vaccine/diphtheria, tetanus toxoids, and pertussis vaccine; at least three doses of poliovirus vaccine; at least one dose of measles-containing vaccine; at least three (or at least four, depending on which vaccine product type is used) doses of Hib; at least three doses of HepB; at least one dose of varicella vaccine; and at least four doses of PCV.

[18] Centers for Disease Control and Prevention (2016). *What You Should Know and Do this Flu Season If You Are 65 Years and Older.* http://www.cdc.gov/flu/about/disease/65over.htm

[19] Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2014.

[20] Centers for Disease Control and Prevention (2015). Injury Prevention & Control: Motor Vehicle Safety. http://www.cdc.gov/motorvehiclesafety/seatbelts/

Health & Well-Being

Much of the data in this section comes from the BRFSS survey. As discussed in greater detail in the **Implications for Action: Priority Issues** section, BRFSS and survey data, in general, has some serious limitations. Because the people most likely to have poor health and multiple risk behaviors are, in general, the least likely to respond to a long survey of any kind, all estimates from BRFSS data should be considered to be the best-case scenario. Moreover, questions about disease prevalence typically ask the respondent whether he or she has ever been told by a healthcare provider that he or she has a particular condition such as diabetes. That means that those who have the disease but have never been diagnosed will not show up in the data, nor will those who *have* been diagnosed but did not understand what they were told or do not remember it. For all of these reasons, the figures presented here almost certainly underestimate any given problem to a degree that we cannot know with available data.

Another dataset used heavily for this section is the Texas Inpatient Public Use Data File, a de-identified dataset of non-military hospital utilization data. As of 2014, state law requires that all state licensed hospitals report data, but prior to that year, hospitals meeting certain criteria were exempt from reporting. This category included hospitals not seeking insurance payment or government reimbursement, as well as hospitals meeting specific criteria of rurality.[1] Even for those hospitals required to report, however, the number of facilities represented in the dataset appears to vary within about five percent of the five-year average. The facility identifier is masked for privacy reasons when the number of reported discharges is small, so that masked category likely accounts for some of the variation.

Well-Being & Quality of Life

BRFSS respondents report quite different perceptions of their own health. The lowest percent of adults reporting that they have good or excellent health is in the southwest sector of the county (Figure 5.1) at 61% (47%-74%). This proportion is far below the 92% (86%-96%) seen in the far northside sector. With a 12 percentage point gap between the southwest and far northside confidence intervals, this disparity is clear. The proportion is also clearly smaller for the near eastside and the near westside than for the far northside. The near northside appears to differ as well compared to the far northside, although the disparity is less severe.

The disparity is evident, too, when the data are broken out by race/ethnicity (Figure 5.2). Confidence intervals are, unfortunately, quite wide for the Black population. But a lower proportion of the Hispanic population reports having good or excellent health as compared to the non-Hispanic White population.

It is worth noting that the disparities are much more striking when the data are examined by geographic area than by race/ethnicity. That fact highlights the importance of place in a

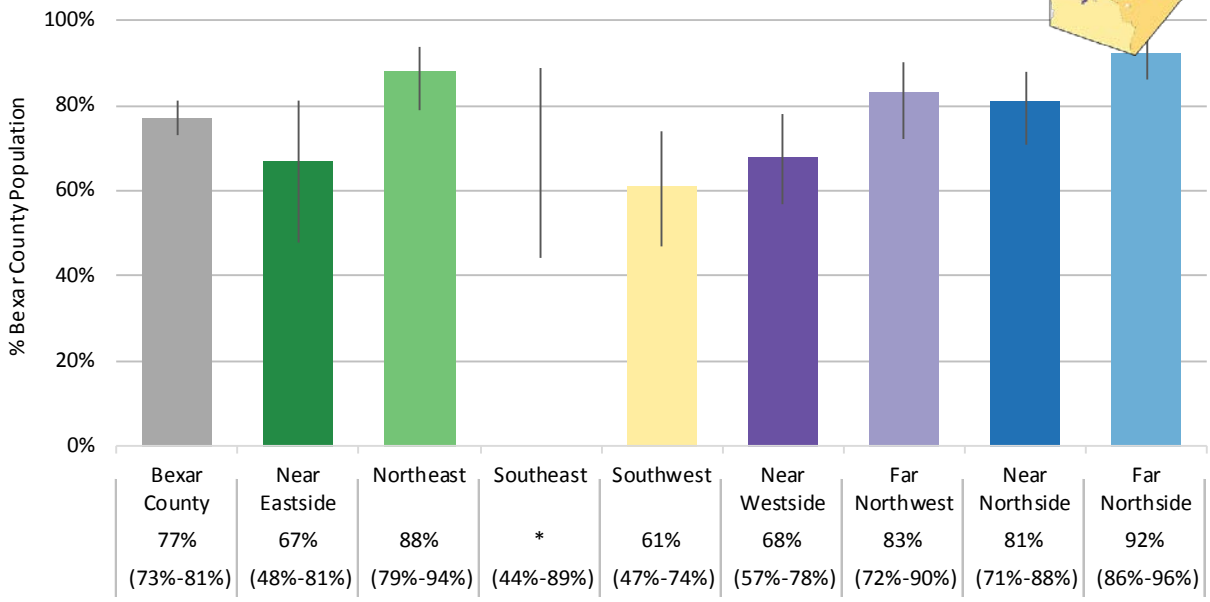
county where Hispanics are the largest population group and are not homogenous on determinants of health like income and educational attainment.

Mental health and well-being is a major issue for Bexar County, as it influences and is influenced by almost everything else health-related. General hospitals, not just psychiatric hospitals, are bearing a great burden of care for which they are generally not best-positioned to provide. Hospital staff anecdotally report a large number of emergency department (ED) visits related in some way to mental health and substance use. The same is true to a lesser extent for hospitalizations, many stemming from ED visits.

The reported hospitalization rates for mental illness and drug and alcohol dependence are presented by age group in Figure 5.3. These rates do not include overdoses from either prescription or illegal drugs, but that group of diagnoses is included in Figure 5.17 near the end of this section. Particularly given that reporting has been in the past been voluntary for some hospitals, rates that "bounce around" within a limited range, as do most of these rates, should not be considered a true trend. There does appear to be a steady increase in the mental illness-related hospitalization rate between 2010 and 2014. This increase might reflect an actual increase in the burden of illness. However, it also might reflect changes in behavior by health care providers who are simply increasingly likely to hospitalize young people presenting with mental illness in the ER and other health care settings.

General Health Rating

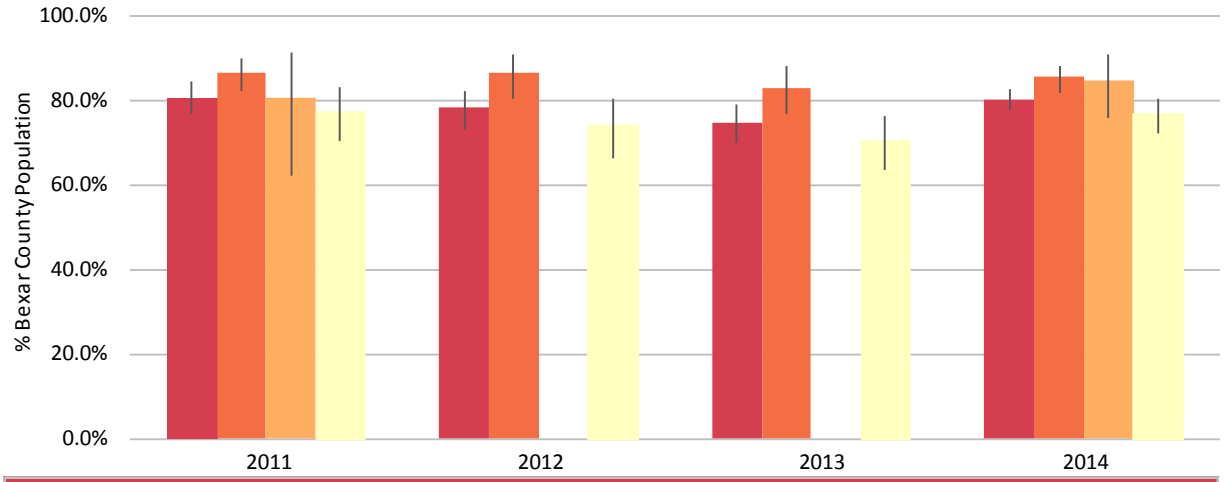
Figure 5.1 Percentage of adults with self-reported good or excellent health by sector



Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

General Health Rating

Figure 5.2 Percentage of adults with self-reported good or excellent health by race/ethnicity



	2011	2012	2013	2014
Overall	**80.9% (76.8%-84.5%)**	**78.3% (73.3%-82.5%)**	**74.9% (70.2%-79.1%)**	**80.3% (77.6%-82.8%)**
White	86.7% (82.5%-90.0%)	86.6% (80.3%-91.1%)	83.2% (77.0%-88.1%)	85.5% (82.0%-88.4%)
Black	80.6% (62.4%-91.2%)	**	**	84.8% (75.9%-90.8%)
Hispanic	77.5% (70.7%-83.1%)	73.9% (66.3%-80.3%)	70.4% (63.5%-76.5%)	76.8% (72.4%-80.6%)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

Behavioral Hospitalizations

Figure 5.3 Number of hospitalizations related to mental illness or alcohol or drug use per 10,000 by age group

	Mental Disorders			Drug & Alcohol		
	0-17	18-64	65+	0-17	18-64	65+
2010	64.5	104.2	53.4	0.4	11.2	3.2
2011	67.0	109.9	56.3	0.3	10.9	2.1
2012	70.9	111.8	52.5	0.2	11.4	3.1
2013	77.2	108.3	50.5	0.2	10.1	3.7
2014	87.3	112.8	58.2	0.2	10.8	2.8

Source: Texas Department of State Health Services, 2010-2014.

The local Early Development Instrument (EDI) kinder-readiness dataset, a United Way-led collaboration among multiple local public school districts,[2] assesses kinder-readiness for the area child population rather than individual children. It offers some interesting insight into the mental health and well-being of children in first grade in a group of local public schools, although the data cannot be generalized to the county as a whole. Of the children in these primarily central-city school districts, between eight percent and 10% of kindergarten students were considered to be "vulnerable" on measures of physical health and well-being, social competence, or emotional maturity (Figure 5.4).[3] ("Vulnerable" as defined here means that a child scored in the lowest 10th percentile of the national sample. Children with scores at or above the 25th percentile are considered "on track" and at or above the 75th percentile are "very ready.")

Among BRFSS survey respondents in Bexar County overall, 18% (14%-22%) report that poor physical or mental health kept them from their usual activities five or more days in the past month (Figure 5.5). While the sample sizes are too small to calculate trustworthy estimates, the non-overlapping confidence intervals point to real differences among different areas of the county. This is a much smaller percentage of residents of the far northside sector reporting being kept from their usual activities than residents of the near westside, southwest, and southeast sectors.

Kindergarten Readiness

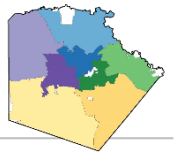
Figure 5.4 Percent of students accessed in multiple developmental domains

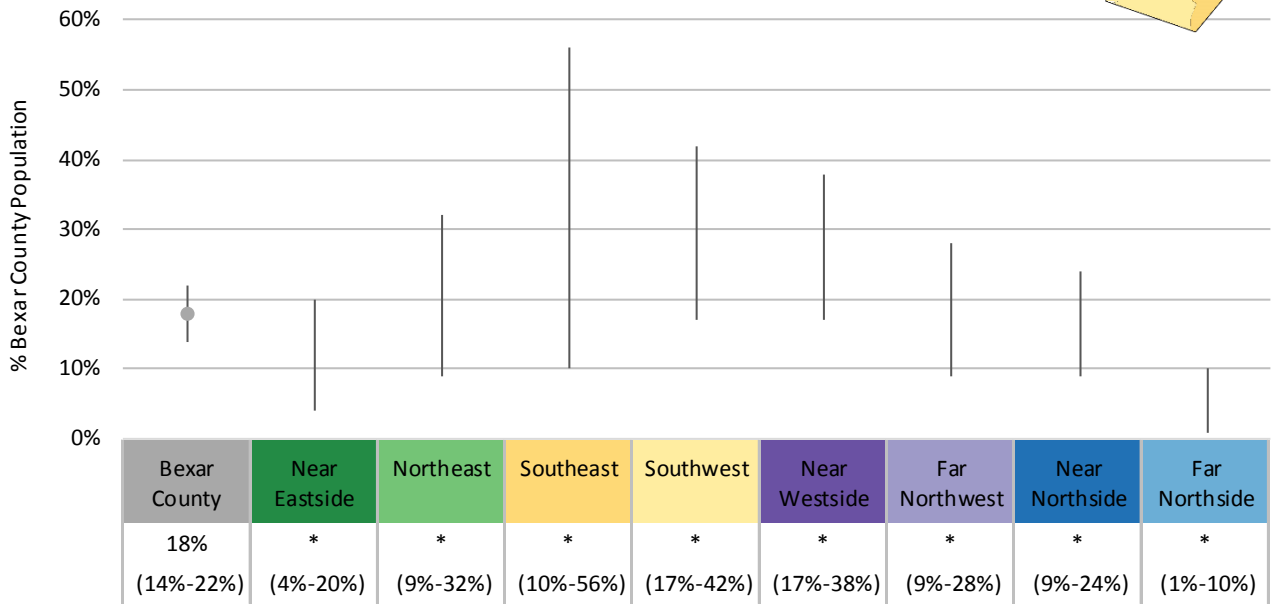
	Vulnerable	On-Track	Very Ready
Physical Health & Well-being	10.0	75.5	34.5
Social Competence	8.6	77.0	31.7
Emotional Maturity	8.3	80.4	39.9

Source: Transforming Early Childhood Community Systems; Early Development Instrument, 2015.

Activities Interrupted by Poor Health

Figure 5.5 Percent of population kept from usual activities for 5+ days a month due to poor physical or mental health





Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Autism is another condition that manifests and develops in widely varying ways depending on the severity and appropriate intervention. A local assessment of autism prevalence and local service capacity has just been released. Extensive analysis to determine autism prevalence yielded an estimate of approximately 23,400 people (all ages) living with autism in Bexar County, a number that translates to one in every 81 people, or 126.3 per 10,000 population. [4] The report estimated that 77% of those living with autism are male.

Disability by no means determines well-being and quality of life, but it affects both in multiple ways. The nature and severity of disability varies widely by type of disability and by age. We can expect that the disparities in access to health care experienced by people from different areas of the county, different income groups, and different racial/ethnic groups also exist with regard to resources that help Bexar County residents with disabilities thrive. For Bexar County overall, about two in 10 respondents report having a disability of some kind (Figure 5.6). Roughly one in seven report difficulty walking and one in 10 report difficulty concentrating. The rate of certain kinds of disability in the total Bexar County population can be expected to increase, of course, as the county population ages.

Adults with Disabilities

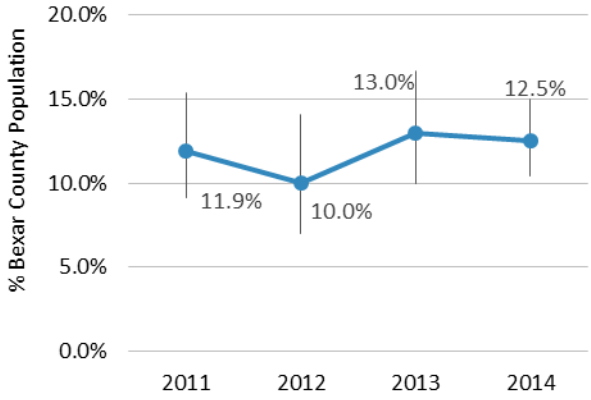
Figure 5.6 Percentage of adults with a disability by type

	2013	2014
Total	**21.9%**	**21.6%**
	(18.2-26.0)	**(19.0-24.3)**
Blind	5.2%	5.3%
	(3.3-7.9)	(4.2-6.8)
Difficulty Walking	12.7%	13.9%
	(10.1-15.9)	(12.0-16.1)
Difficulty Concentrating	9.2%	9.8%
	(6.8-12.3)	(8.0-12.0)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2013 & 2014 (with 95% CI).
**Sample too small to report.

Adult Asthma

Figure 5.7 Percentage of adults diagnosed with asthma



Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014.

Illness & Injury

Oral health is a good general indicator of the overall health of a population, but unfortunately, data on the oral health of the county population is sparse. Thirty seven percent (33.8%-40.4%) of BRFSS respondents report having had one or more teeth pulled.[5]

About one in eight BRFSS respondents report having been diagnosed with asthma (Figure 5.7). BRFSS respondents with children report that 6.2% of those children have asthma, but the confidence interval for that estimate is wide – 3.1% to 12.2%.[6] The asthma hospitalization rate among children and teenagers appears flat since 2010 (Figure 5.8). The hospitalization rate among seniors 65 and older, however, de-creased substantially from 2010 and 2011 rates.

Asthma Hospitalizations

Figure 5.8 Number of recorded asthma-related hospitalizations per 10,000

	0-17	18-64	65+
2010	20.6	7.4	20.9
2011	20.5	6.4	21.0
2012	21.3	7.3	17.1
2013	19.1	6.0	15.7
2014	19.4	5.6	13.1

Source: Texas Department of State Health Services, 2010-2014.

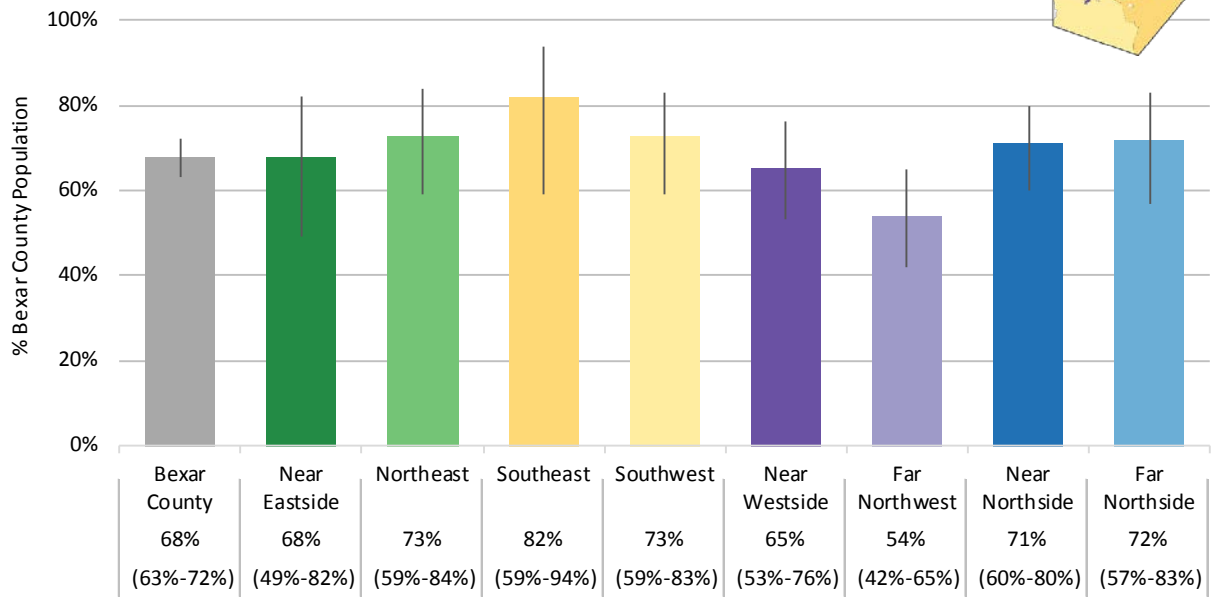
The proportion of adults who are overweight or obese appears to vary across the county (Figure 5.9). The differences are not as stark as with overall health status, though, and in this case, it is the far northwest sector that appears to have a lower rate than several other sectors. One clear difference is that a lower proportion of the non-Hispanic White population is overweight or obese compared to the Hispanic population (Figure 5.10). About seven in 10 adults are overweight or obese, but the overlapping confidence intervals mean that no clear year-to-year change is apparent.

"it's a symptom of modern life to have unlimited calories available to you whenever you want them and not having to work physically very hard to do day-to-day activities"

- Janet Realini

Overweight or Obese Adults

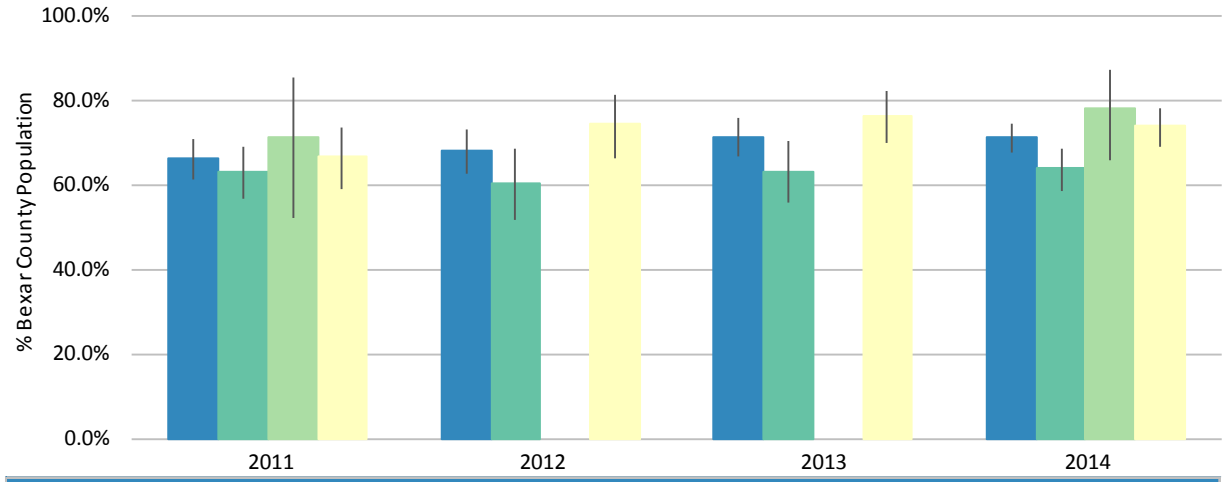
Figure 5.9 Percentage of adults overweight or obese by sector



Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Overweight or Obese Adults

Figure 5.10 Percentage of adults overweight or obese by race/ethnicity



	2011	2012	2013	2014
Overall	**66.3% (61.4%-70.9%)**	**68.3% (62.6%-73.3%)**	**71.6% (66.8%-75.9%)**	**71.3% (67.9%-74.4%)**
White	63.2% (56.7%-69.3%)	60.5% (51.7%-68.7%)	63.3% (55.7%-70.3%)	63.9% (58.8%-68.7%)
Black	71.5% (52.1%-85.3%)	**	**	78.4% (66.1%-87.1%)
Hispanic	66.7% (58.9%-73.7%)	74.7% (66.6%-81.5%)	76.5% (69.8%-82.1%)	73.9% (68.9%-78.4%)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

Somewhere between 5% and 13% of Bexar County BRFSS respondents report having been told by a healthcare provider that they are pre-diabetic or borderline diabetic (Figure 5.11). The sample is too small to calculate a trustworthy estimate, but as with overweight and obesity, it appears that the far northwest sector may have a lower proportion than other sectors.

For the percent of respondents who report having been told by a healthcare provider that they have been diagnosed with diabetes, the geographic disparity that emerges is between the far northside sector and the near westside sector (Figure 5.12). For Bexar County, overall it is 14.2% (12.2%-16.4%) (Figure 5.13). (The county-wide number varies from that presented in Figure 5.12 because it uses a three-year average with a different confidence level.)

Pre-Diabetic or Borderline Diabetic

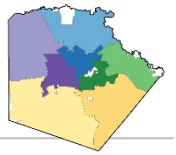
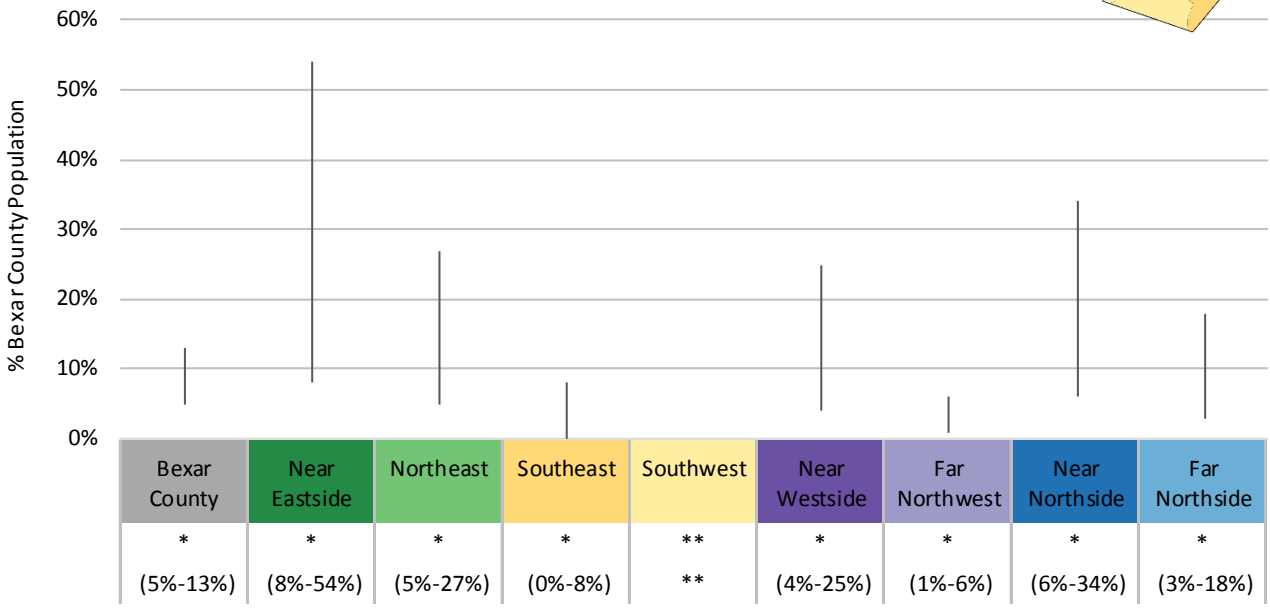


Figure 5.11 Percentage of adults told by a provider they are pre-diabetic or borderline diabetic



Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate. **Sample too small to report.

Adult Diabetes

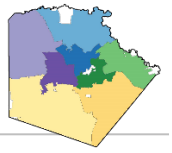
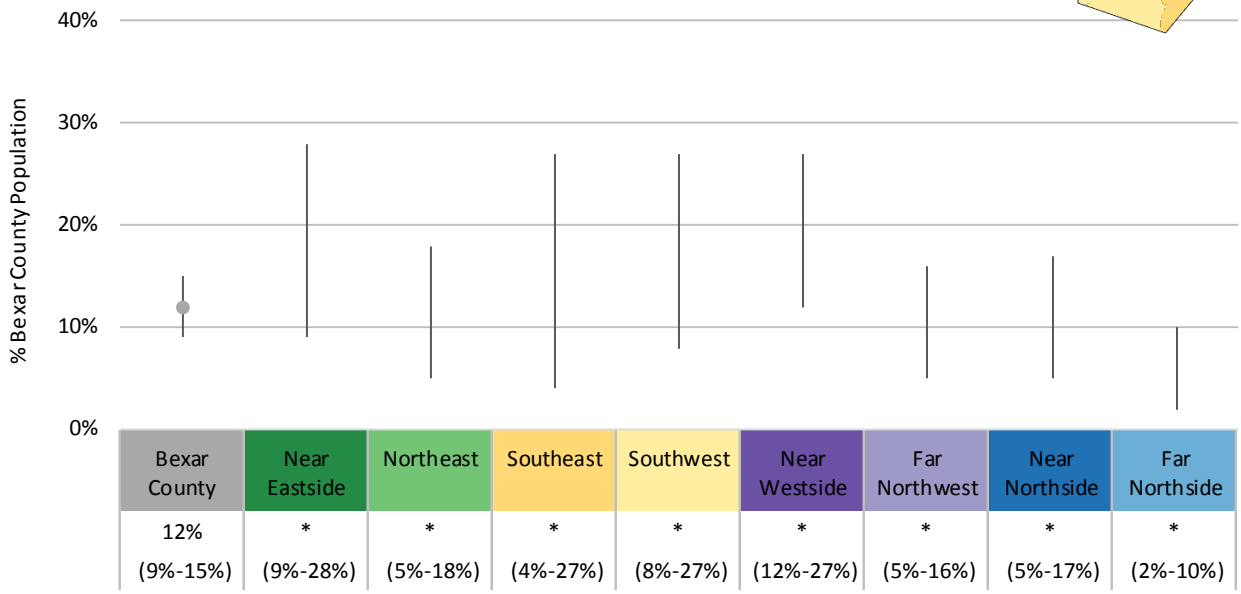


Figure 5.12 Percentage of adults diagnosed with diabetes by sector



Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Adult Diabetes

Figure 5.13 Percentage of adults diagnosed with diabetes by race/ethnicity

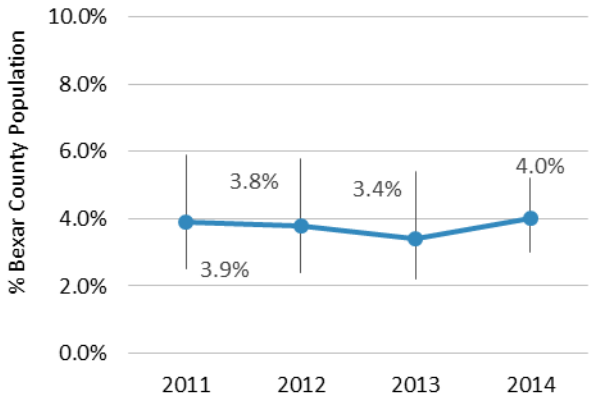
	2011	2012	2013	2014
Overall	**13.1% (10.5%-16.2%)**	**11.4% (8.7%-14.7%)**	**12.7% (9.7%-16.6%)**	**14.2% (12.2%-16.4%)**
White	10.4% (7.6%-14.0%)	8.0% (5.1%-12.5%)	7.7% (5.1%-11.3%)	12.0% (9.5%-15.1%)
Black	11.6% (6.4%-20.2%)	**	**	15.1% (9.0%-24.3%)
Hispanic	15.4% (11.2%-20.9%)	13.7% (9.6%-19.2%)	16.0% (11.2%-22.2%)	15.1% (12.2%-18.5%)

Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

About four percent of BRFSS respondents report having been told they have had a heart attack (Figure 5.14). About two percent report having been told they have had a stroke (Figure 5.15). There may be a geographic difference in those who report having been told they had heart diseases, a heart attack, or stroke (Figure 5.16), but it is not certain. Among Bexar County respondents overall that figure is 6.0% (5.0%-8.0%).

Heart Attack

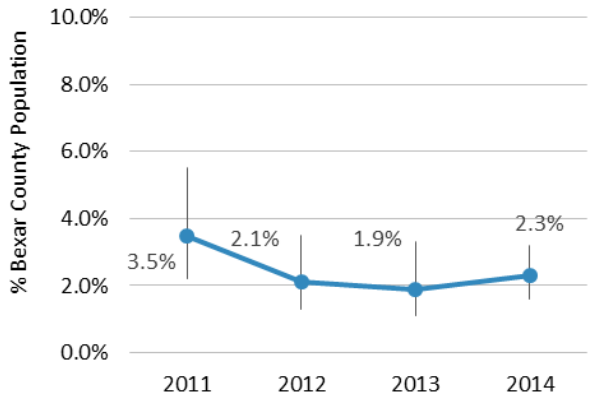
Figure 5.14 Percentage of adults who have ever had a heart attack



Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014.

Stroke

Figure 5.15 Percentage of adults who have ever had a stroke



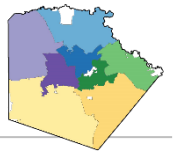
Source: Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, 2011-2014.

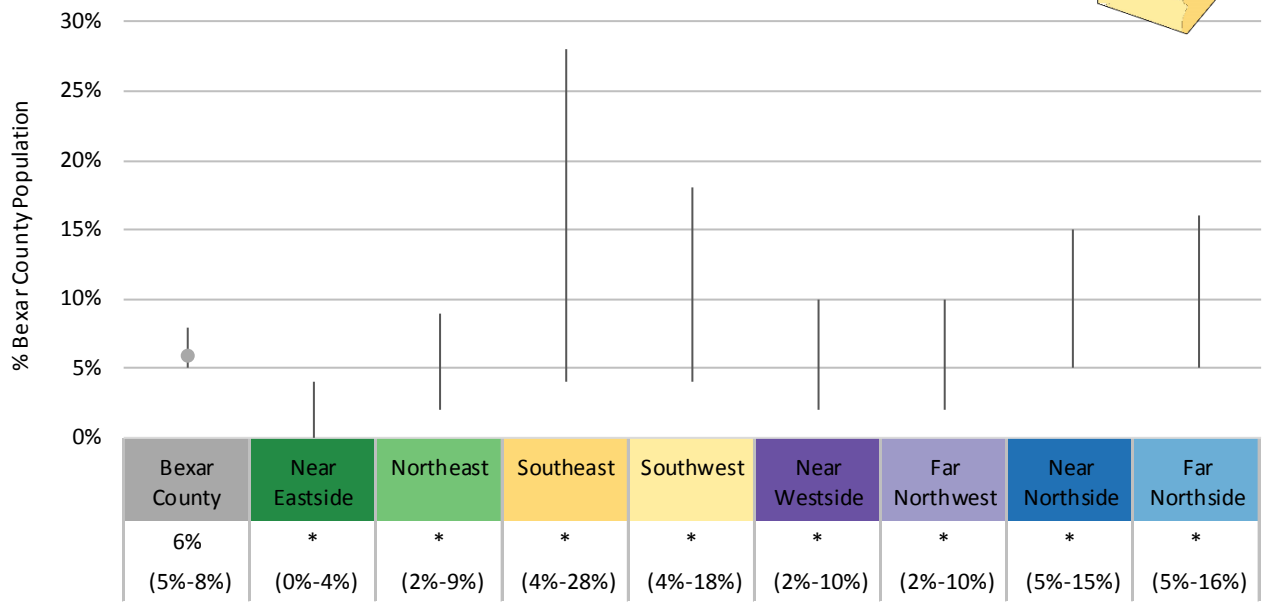
Figure 5.17 summarizes hospitalization rates for selected principal diagnoses and age groups. It is worth noting that of all diagnoses presented, hospitalization rates have clearly increased from 2010 only for mental illness. That increase appears in the youth age group and to a lesser degree in the 18- to 64-year-old age group.

Hospitalization rates appear to be decreasing among seniors for several diagnoses, including breast cancer, colon cancer, ischemic heart disease, hypertension, asthma, injury, and possibly cerebrovascular disease. Among adults aged 18 to 64 years, rates appear to be decreasing for prostate cancer, asthma, and possibly ischemic heart disease and poisoning, which includes prescription drug overdose. Despite the decrease in asthma hospitalization rate among adults and seniors, the rate among young people birth to 17 years old remains frustratingly flat.

Cardiovascular Disease

Figure 5.16 Percentage of adults with cardiovascular disease





Bexar County	Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
6% (5%-8%)	* (0%-4%)	* (2%-9%)	* (4%-28%)	* (4%-18%)	* (2%-10%)	* (2%-10%)	* (5%-15%)	* (5%-16%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

Hospitalizations

Figure 5.17 Number of recorded non-military hospitalizations per 10,000 by age group *

		2010	2011	2012	2013	2014
Cancer						
Breast	18-64	4.5	4.1	4.5	4.1	3.2
	65+	11.6	12.2	11.6	8.3	6.7
Ovarian	18-64	1.3	1.2	1.3	1.4	1.3
	65+	3.6	2.9	5.1	2.9	2.8
Prostate	18-64	3.1	3.1	2.3	2.0	2.1
	65+	15.9	15.8	9.2	11.6	13.2
Colon	18-64	1.4	1.5	1.7	1.7	1.4
	65+	12.6	10.7	11.4	12.1	8.7
Lung	18-64	1.4	1.4	1.2	1.2	1.1
	65+	12.7	13.5	11.6	11.5	12.5
Heart Disease & Diabetes						
Cerebrovascular	18-64	1.2	1.2	1.3	1.4	1.2
	65+	9.8	7.7	7.4	6.3	7.0
Ischemic	18-64	24.0	20.3	21.3	19.5	18.9
	65+	152.8	134.1	132.3	116.0	106.2
Hypertension	18-64	11.4	10.0	10.3	9.7	9.7
	65+	48.6	46.3	44.5	40.5	39.1
Diabetes	18-64	24.2	24.1	24.9	23.4	25.4
	65+	45.8	50.1	48.7	42.6	43.5
Respiratory						
Asthma	0-17	20.6	20.5	21.3	19.1	19.4
	18-64	7.4	6.4	7.3	6.0	5.6
	65+	20.9	21.0	17.1	15.7	13.1
Injury & Poisoning						
Injury	0-17	12.0	11.2	12.2	10.7	10.1
	18-64	24.7	26.0	26.3	23.3	22.6
	65+	155.5	151.4	151.4	147.9	144.6
Poisoning	0-17	3.6	3.7	3.8	3.5	2.8
	18-64	13.7	12.4	12.9	10.5	10.5
	65+	8.2	6.9	8.2	8.0	7.9
Behavioral						
Mental Disorders	0-17	64.5	67.0	70.9	77.2	87.3
	18-64	104.2	109.9	111.8	108.3	112.8
	65+	53.4	56.3	52.5	50.5	58.2
Drug & Alcohol	0-17	0.4	0.3	0.2	0.2	0.2
	18-64	11.2	10.9	11.4	10.1	10.8
	65+	3.2	2.1	3.1	3.7	2.8

Source: Texas Department of State Health Services, 2010-2014.
*Reporting hospitals and data completeness vary by year

Death

Because the annual number of infant deaths is small, one-year infant mortality rates are unstable. Looking at three-year moving averages, the infant mortality rate is fairly flat for Bexar County as a whole, for non-Hispanic Whites, and for Hispanics (Figure 5.18). It appears to have declined significantly among Black infants since 2010, but that trend should be interpreted with caution because the population is small. The most common causes of death among infants are birth defects (congenital malformation), problems related to premature birth and low birthweight, and sudden infant death syndrome (Figure 5.19).

Causes of Infant Death

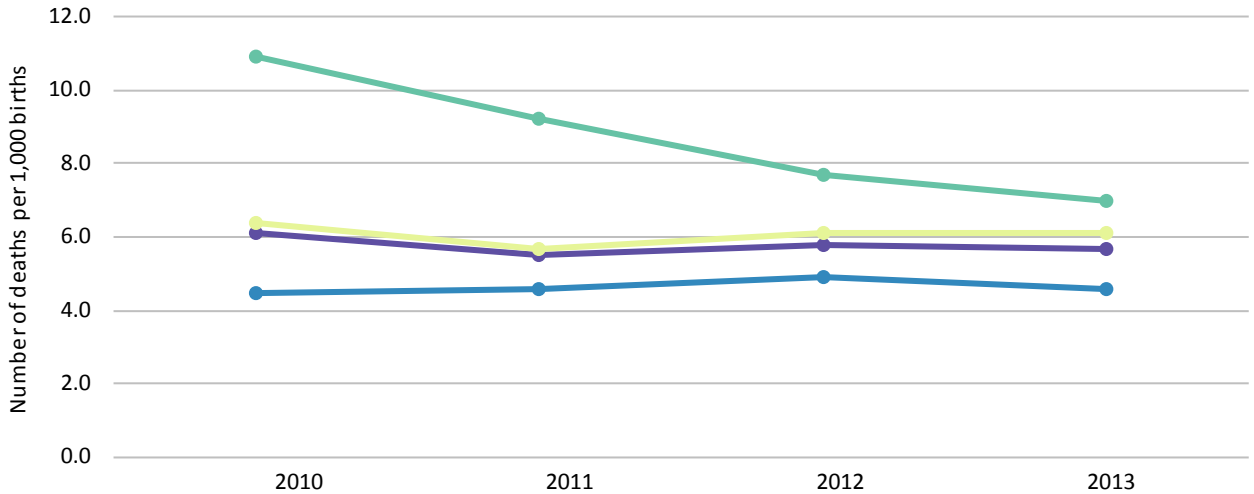
Figure 5.19 Number of deaths per 100,000 live births

	Congenital Malformation	Short Gestation & Low Birth Weight	Sudden Infant Death Syndrome
2010	140.0	70.0	30.0
2011	125.8	59.0	47.2
2012	169.6	92.5	50.1
2013	135.4	120.3	71.5

Source: San Antonio Metropolitan Health District, 2010-2013.

Infant Mortality Rate

Figure 5.18 Number of deaths per 1,000 births (3-year moving average)



	2010	2011	2012	2013
Overall	**6.10**	**5.50**	**5.80**	**5.70**
White	4.50	4.60	4.90	4.60
Black	10.90	9.20	7.70	7.00
Hispanic	6.40	5.70	6.10	6.10

Source: Health Profiles, City of San Antonio Metropolitan Health District, 2010-2013.

Causes of Death Among Children & Young Adults

Figure 5.20 Leading causes of death [ICD-10] for birth to 24 from 2010-2013

Less than 1 Year

Effects of Low birth Weight and Prematurity [P00-P96]

Birth Defects [Q00-Q99]

1-4 Years

Motor Vehicle Accidents [selected Vxx.x codes]

Birth Defects [Q00-Q99]

Malignant Neoplasms [C00C-97]

Assault Homicide [X85-Y09, Y87.1]

Major Cardiovascular Diseases [I00-I78]

5-14 Years

Malignant Neoplasms [C00C-97]

Motor Vehicle Accidents [selected Vxx.x codes]

Birth Defects [Q00-Q99]

Assault Homicide [X85-Y09, Y87.1]

Major Cardiovascular Diseases [I00-I78]

15-24 Years

Motor Vehicle Accidents [selected Vxx.x codes]

Accidental Poisoning and Exposure to Noxious Substances [X40-X49]

Assault Homicide [X85-Y09, Y87.1]

Intentional Self-Harm Suicide [X60-X84, Y87.0]

Malignant Neoplasms [C00C-97]

Source: Texas Department of State Health Services, 2010-2013.

Causes of Death Among Adults

Figure 5.21 Leading causes of death [ICD-10] for adults 25-64 from 2010-2013

25-44 Years

Major Cardiovascular Diseases [I00-I78]

Malignant Neoplasms [C00C-97]

Accidental Poisoning and Exposure to Noxious Substances [X40-X49]

Intentional Self-Harm Suicide [X60-X84, Y87.0]

Motor Vehicle Accidents [selected Vxx.x codes]

45-64 Years

Malignant Neoplasms [C00C-97]

Major Cardiovascular Diseases [I00-I78]

Chronic Liver Disease and Cirrhosis [K70, K73-K74]

Diabetes Mellitus [E10-E14]

Accidental Poisoning and Exposure to Noxious Substances [X40-X49]

Source: Texas Department of State Health Services, 2010-2013.

Causes of Death Among Seniors

Figure 5.22 Leading causes of death [ICD-10] for adults 65+ from 2010-2013

Age 65+
Major Cardiovascular Diseases [I00-I78]
Malignant Neoplasms [C00C-97]
Chronic Lower Respiratory Diseases [J40-J47]
Diabetes Mellitus [E10-E14]
Alzheimer's Disease [G30]

Source: Texas Department of State Health Services, 2010-2013.

As of this writing, 2013 is the most recent year for which death data are available. The most common causes of child death by age group in years 2010 through 2013 are shown in Figure 5.20. Motor vehicle accidents are a common cause of death among children age one to 14, pointing to the importance of child safety seats and seat belts as well as adult and older teen driver behaviors. Homicide is also a common cause in those age groups. Overdose (accidental poisoning) with prescription or illegal drugs rises to the top of the list of causes of death for adults aged 25 to 64 (Figure 5.21), as do cancer, cardiovascular disease, and diabetes. Suicide emerges as a major cause of death among youth and adults aged 15 to 44 years. Chronic lower respiratory disease and Alzheimer's disease figure prominently in death rates among seniors 65 and older (Figure 5.22). Suicide rates by age group are presented in Figure 5.23. The rate of bicycle fatalities is low (Figure 5.24) – hence the wide variability year to year – but are a serious issue given community efforts to increase physical activity and make San Antonio a bicycle-friendly city.[7]

Suicide Rates

Figure 5.23 Number of suicides per 100,000 by age group

	Age-Adjusted	15-24	25-64	65+
2010	8.0	10.1	12.1	14.8
2011	6.7	4.8	13.0	11.0
2012	8.5	11.7	12.8	14.6
2013	8.1	8.3	13.1	14.0

Source: San Antonio Metropolitan Health District, 2010-2013.

Bicyclist Fatalities

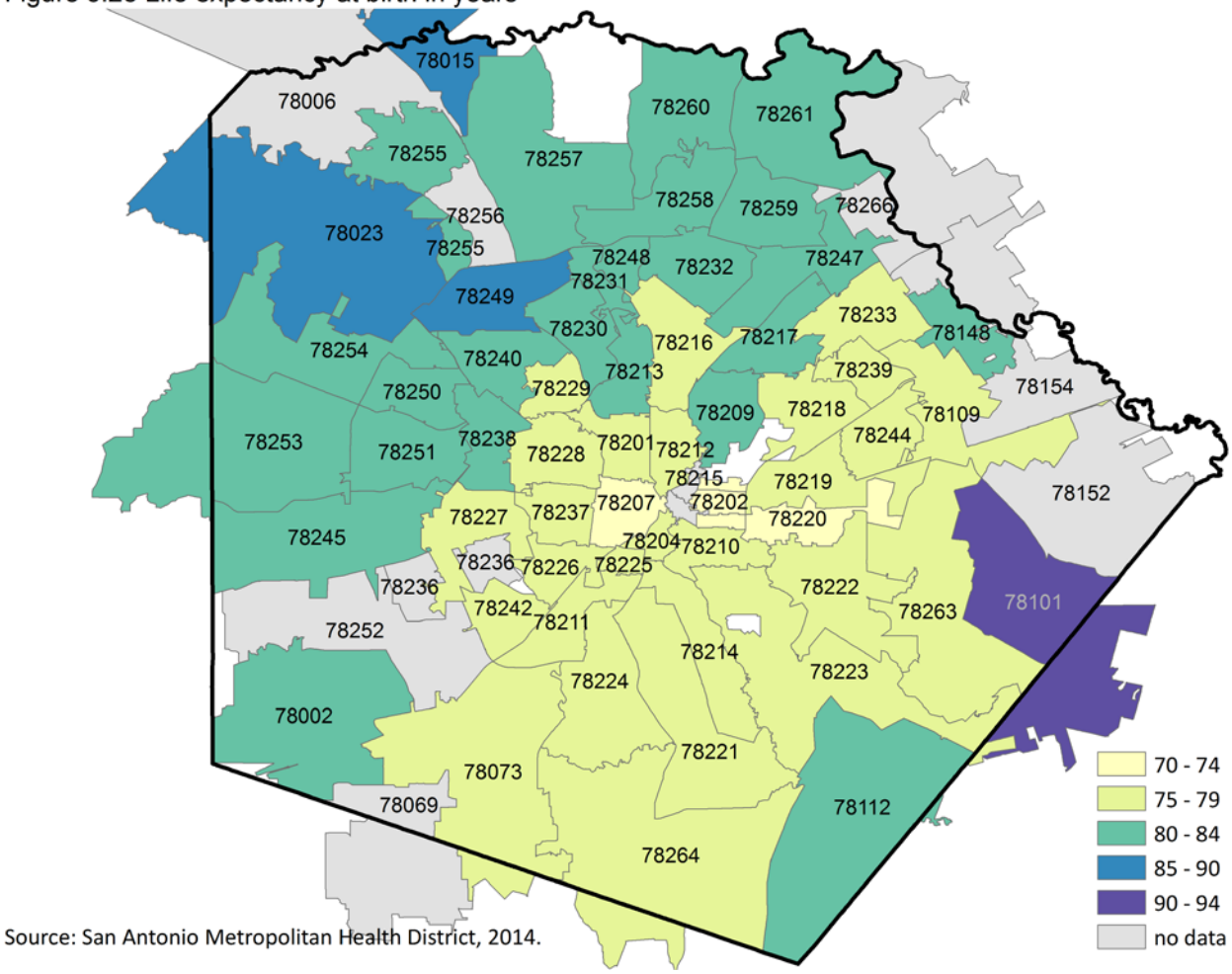
Figure 5.24 Number of bicyclist fatalities per 100,000 population

	Fatalities
2010	0.12
2011	0.06
2012	0.22
2013	0.27
2014	0.05

Source: National Highway Traffic Safety Administration, 2010-2014.

Life Expectancy by Zip Code

Figure 5.25 Life expectancy at birth in years



Source: San Antonio Metropolitan Health District, 2014.

The Bexar County neighborhood one lives in predicts one's life expectancy. The near eastside and near westside have a life expectancy at birth of 70 to 74 years (Figure 5.25). Far northwest and southeast Bexar County have a life expectancy of 90 or older – a staggering difference of 20 years.

Figure 5.26 shows years of potential life lost or YPLL, a measure of premature death, for common causes of death. With an average life expectancy of 75 years, a person who died of cancer at age 45 would contribute 30 years to Bexar County's total YPLL.

Years of Potential Life Lost

Figure 5.26 Years lost (YPLL) before age 75 per 100,000 population by cause

	YPLL
Suicide	390
Cancer	5,121
Coronary Heart Disease	3,953
Diabetes	814
Homicide	228
Motor Vehicle Crashes	351
Unintentional Injury	727

Source: San Antonio Metropolitan Health District, 2013.

[1] Texas Department of State Health Services (2016). Texas Inpatient Public Use Data File (PUDF). https://dshs.texas.gov/thcic/hospitals/Inpatientpudf.shtm

[2] The school districts that participated in 2015 were Edgewood, Harlandale, North East, Northside, San Antonio, and Southwest Independent School Districts.

[3] Detailed information about the domains, subdomains, and reliability and validity of the Early Development Instrument is available from the Offord Centre at https://edi.offordcentre.com/researchers/

[4] Capital Healthcare Planning/Kronkosky Charitable Foundation (2016, March 23). *Autism prevalence assessment: San Antonio CBSA*. http://www.kronkosky.org/Initiatives. Population count for rate denominator from U.S. Census Bureau, American Community Survey 2014 1-Year Estimates.

[5] Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2014.

[6] Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2013.

[7] See for example, Rivard, R. (2015, October 29). Take the city's cycling survey, then ride with caution. *The Rivard Report.* http://therivardreport.com/take-the-citys-cycling-survey-then-ride-with-caution/

Implications for Action

Priority Issues

Taking all of the foregoing Bexar County data and information together, a number of common themes and high-priority issues emerge. Those themes and issues differ widely in nature, so they are grouped in the following way:

➔ **Issues with technical fixes.** These are issues that can be addressed by relatively straightforward policy or practice changes supported by a strong evidence base. The interventions that reversed the sharp upward trend in congenital syphilis fall in this category. Although not necessarily easy or quick, this group of issues might be considered the "low-hanging fruit" of this section.

➔ **Complex problems requiring complex solutions.** These issues have no technical fix of evidence-based practice; they call for long-term, complex, multi-sector interventions. All are familiar, and few have seen any meaningful improvement in recent years. All map quite well to the five priority areas identified in the 2014 Community Health Improvement Plan.

➔ **Root causes.** These foundational issues interact with each other and with the environment, health-related behaviors, and health outcomes. The likelihood is slim of making significant progress on anything "downstream" without effectively addressing these root causes.

➔ **System-level barriers to effective action.** These issues hinder effective action to improve health outcomes and the environment in which health outcomes develop.

Each group of issues is briefly described below. Related data are not repeated here, but the document section in which that data appears is noted for reference.

Issues with Technical Fixes

Vaccine-preventable diseases. Several vaccine-preventable diseases (see **Health-Related Behaviors & Early Outcomes**) emerge as issues with a clear technical fix. Perhaps the single greatest missed opportunity at present is prevention of cervical cancer through HPV vaccination. Despite a strong recommendation from the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) that both girls and boys be vaccinated no later than 11 or 12 years old,[1] clinicians are still offering and communicating with patients and parents about the vaccine in ways that are systematically different from other recommended childhood vaccines.[2] Because HPV is a sexually-transmitted infection, physicians and parents alike may be inclined to delay or avoid vaccination of children of either sex. However, providers routinely and strongly recommend – and parents routinely agree to – vaccination against Hepatitis B as part of the *4:3*:1:3*:3:1:4 *series. Provider-parent conversations about the combined vaccination series do not typically involve* consideration of whether the child is having unprotected sex or

sharing needles or will be more likely to do so because of vaccination.

The overwhelming majority of seasonal influenza- and pneumonia-related deaths occur among seniors. The flu vaccine must be given annually, but the pneumonia vaccine need only be administered once. Given the proportion of Bexar County households that are multigenerational, vaccination of seniors will also protect pregnant women and young children, who are at higher risk of serious complications.[3]

Trauma-informed care. While not at present a formal recommendation of the U.S. Clinical and Preventive Services Task Force (USPSTF), trauma-informed care has emerged as a better way of approaching health care, social service, and even education, particularly in light of the prevalence and effects of adverse childhood experiences (see **Environment & Living Conditions**). At its most basic, a trauma-informed approach changes the question from "What's wrong with you?" to "What's happened to you?"[4] Although it encompasses much more, trauma-informed care is grounded in four basic principles: [5]

1. ***Realize*** the prevalence of traumatic events and the widespread impact of trauma;
2. ***Recognize*** the signs and symptoms of trauma;
3. ***Respond*** by integrating knowledge about trauma into policies, procedures, and practices; and
4. seek to actively ***Resist Re-traumatization***.

Social prescribing. The U.S. Preventive Services Task Force stresses the importance of systematically linking clinical and community-based settings by prescribing particular behaviors or resources.[6] Often called “social prescribing”, formal recommendations by physicians and other health care providers put healthy behaviors like exercise on par with pharmaceutical interventions.[7]

Policy for a healthy food environment. Finally, tax abatements commonly provide incentives to businesses, housing developers, and the like to locate or expand in a particular geographic area, and this concept can be applied to develop healthier environments. Several states have begun offering tax abatements to retailers of healthy food,[8] but the CDC notes that local tax policy can support a healthy food environment as well.[9] A related local policy issue currently in the spotlight is fire inspection fees for booth vendors who prepare and serve ready-to-eat food at farmers markets.[10]

Complex Problems Requiring Complex Solutions

Mental illness and substance use. This set of interrelated issues includes mild to severe mental illness including depression and post-traumatic stress disorder (PTSD), problem drinking, and problem drug use, including prescribed medications (see **Health-Related Behaviors & Early Outcomes** and **Health & Well-Being**).

Physical inactivity. Physical activity is a lever of some kind – a contributor to or an effective intervention for – a number of other important health issues like depression, overweight and obesity, and chronic physical illness and disability (see **Health-Related Behaviors & Early Outcomes**).

Unhealthy eating and hunger. Unhealthy eating (see **Health-Related Behaviors & Early Outcomes**) contributes in different ways to a number of health issues, notably overweight and obesity, diabetes, and heart disease and stroke. Hunger is one of the single greatest

threats to the well-being of low-income seniors. Hunger remains a serious problem for children as well, particularly during summer and winter breaks when food is not available through school breakfasts, lunches, and after-school programs. Better marketing of summer food programs, particularly through social media, would help connect more families to existing and underutilized programs serving children.

Senior whole-life well-being. The senior population is growing disproportionately quickly compared to other age groups and will place increasingly significant demands on local health care and social service systems. The local response must go beyond "do a lot more of what we're doing now." A completely different approach to senior well-being is needed if this large segment of the county population is to thrive with a high quality of life, not simply survive until an advanced age.

Unplanned pregnancy. While an unplanned pregnancy – extremely common in Bexar County – is quite often a wanted pregnancy, it is rarely a well-prepared-for pregnancy (see **Health-Related Behaviors & Early Outcomes**). This issue is not nearly so high-profile as is teen pregnancy. But reducing unplanned pregnancy can only yield improvements in birth outcomes, maternal health and well-being, the prevalence of adverse childhood experiences, and a host of other health and social issues.

Interpersonal violence. Child abuse, family violence, and street violence are common in Bexar County and do serious harm to health and well-being (see **Health-Related Behaviors & Early Outcomes** and **Health & Well-Being**). That remains the case whether one is the direct victim of violence or is only exposed to it in the home or the neighborhood, and the harm may begin immediately and continue until death.

Premature mortality among people of color and low-income people. Particularly for lower-income males of color, Bexar County's premature mortality is striking (**Health & Well-Being**). Premature death is an inarguable metric and the inevitable conclusion of years or decades of health inequity.

Root Causes

Four key root causes interact with each other in a vicious cycle, within and across generations, and contribute to high-risk environments, unhealthy behaviors, and injury, illness, and death. The list of all root causes could be much longer, but these four are core for Bexar County.

Low income and poverty. Low-income and poverty increase acute and chronic stress and the risk for depression, drug abuse, and problem drinking; the likelihood of exposure to neighborhood violence; and the risk of unsafe or unstable housing and insufficient or unhealthy food. The related issues of income inequality and income segregation harm local education and service systems and the community overall.

Educational attainment. Low educational attainment harms one's ability to secure and retain livable-wage employment. Low literacy contributes directly to low health literacy and increased challenges in the prevention and self-management of chronic illnesses like diabetes and recurring illnesses like depression. School dropout and other poor educational outcomes are heavily driven by chronic absenteeism, which is inter-related both upstream and downstream from health. Evidence-based interventions are available to address the issue, and chronic absence by individual and population is knowable with locally available data.

Criminal and juvenile justice. Justice system involvement for even low-level offenses dramatically reduces the universe of possible employment, exposes people to violence in justice facilities, and greatly increases the risk of PTSD and other mental illness. Parental incarceration can harm families through increased stress, reduced income, and other factors.

Adverse childhood experiences (ACE). Child sexual abuse and physical and emotional abuse or neglect; family violence; loss of a parent to divorce, abandonment, or incarceration; and exposure to mental illness or substance are all common in varying degrees in Bexar County. All have been shown to have an effect on health and well-being and on health-related behaviors, mostly especially depression, alcoholism, substance abuse, suicide, smoking, and risky sexual behaviors. Although not assessed in the ACE Study itself, childhood poverty is also a critical adverse childhood experience common in Bexar County.

System-Level Barriers to Effective Action

A common thread across both the quantitative data and the qualitative data – interviews and discussion groups – is how little improvement the Bexar County community has been able to achieve on key important health issues ranging from early and adequate prenatal care to vaccination across the lifecycle to healthy eating, physical activity, and overweight/obesity issues. Poverty has not budged, and it's unlikely that child abuse has decreased by even a fraction of the degree reflected in the most commonly-used indicator.

There is no single solution that will make the needle move in the right direction for any health-related problem. But addressing two key system-level issues would likely help: improving the data available to inform decisions and actions, and developing more effective ways of working together across organizations and sectors.

Systemic, persistent underfunding of prevention and interventions targeting root causes. Despite knowing that the relative contribution of medical care to health and well-being is small – an estimated 10% to 20%[11], very little funding is available for prevention and other interventions to address the "upstream" factors that contribute the remaining 80% to 90%. For example, personal health care spending per capita in 2014 was $9,523. In contrast, combined federal and state public health funding per capita was $248 — just 2.5% of health-related spending.[12] And the U.S. spends proportionally less on social root causes than other nations with better population health outcomes.[13]

Gaps and disparities in data quality. One pattern that emerges very clearly throughout this assessment is the disparity not just in health determinants and outcomes, but also in the quality of the data about those determinants and outcomes. The limitations of surveys – at least, as they are currently administered – are so great that the data are frequently unusable below the county level. Race/ethnicity, sex, age group, income level, and neighborhood are all critical factors in both understanding the nature of the issue and in deploying appropriate interventions to address it. Very little information about the health of Bexar County's African American and other non-Hispanic non-white populations can be gleaned from BRFSS dataset; the same is true for geographic areas with lower population densities. Even at the county level, confidence intervals are wide enough that short-term trends cannot be accurately identified. Unless the margin of error or

confidence interval is very narrow, small and moderate change in a point estimate cannot be trusted to mean a true change in the scope or severity of the issue.

Survey administrators and researchers also know that specific groups of people are systematically missing in the data collected. The list of reasons why those most likely to have health-related disparities are the people least likely to respond to 40- to 60-minute long surveys via *any* method of administration – self or interview, in person or online or by landline or mobile phone – is long. Just a few reasons relevant to this assessment are mental illness, including depression and PTSD; alcohol and substance use; lack of time because of multiple jobs and three-hour bus rides; fear of discovery of undocumented status or other justice system involvement; a disability related to sight, hearing, mobility, or cognition; general distrust and privacy concerns; fear of answering the door as a person living alone; and not speaking the language of the survey.

Changes in survey approach can help, although there is no magic bullet. Given that change occurs slowly in most issues, perhaps resources would be better spent if administrations were less frequent, enabling samples to be larger or incentives offered. The Bexar County community could certainly make much better use than it does of administrative data – data generated in the everyday course of doing business – like health care visit information and school absence information.

The legal and regulatory protections around data are important and the barriers they erect are significant – and also surmountable. Healthcare Access San Antonio (HASA), the region's health information exchange, has been working since 2006 to establish data-sharing agreements among local health care providers and to solve the technical challenges of integrating health care data. The Eastside Promise and Wheatley Choice Neighborhoods, as well as other education-related initiatives, have begun doing the same kind of work with education, housing, and other human service data. Absent broad community buy-in and political will, progress on both fronts will be slow.

Working effectively across organizations and sectors. Bexar County has a reputation for being much more collaborative than most major cities, with turf and competition often taking a backseat – if temporarily – to cooperation to solve specific problems. Here and across the country, though, many practitioners and policymakers are coming to the conclusion that collaboration as it usually looks is not sufficient. Again, there is no magic bullet. And unfortunately, without a robust evidence base like that for many clinical interventions, "best practices" is too often code for "things other communities are doing that are getting good press."

Having said that, certain principles and practices do appear to make a real difference. Several of these principles have been bundled and adopted in communities across the country as the *collective impact* approach to solving complex, adaptive problems that do not have a clear and straightforward technical solution. In 2011 Kania and Kramer proposed that initiatives that achieve meaningful results have five conditions in common: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.[14] In many ways the collective impact approach resembles time-tested quality and performance improvement approaches that, when deployed well, can make a tremendous impact on outcomes within an organization.

Several collaborations in Bexar County identify as collective impact initiatives and work to sustain all five conditions. There are others focused on education and other issues, but a few that focus in varying degree on health and well-being are the Autism Roundtable, Promise and Choice Together (PaCT), SA2020, the Teen Pregnancy Prevention Coalition (TPPC), and the SALSA (Successfully Aging and Living in San Antonio) initiative around senior well-being.

Even where implemented faithfully and with good results, the collective impact approach has already garnered a fair bit of criticism across the country. Whether or not collective impact as a "branded" approach is of interest, though, its core principles are all worth a serious look. Some of these principles are being incorporated with intentionality into the Community Health Improvement Plan and process.

Health impact investing is an emerging approach to collaboratively financing efforts to improve health outcomes.[15] An adaption of the social impact bond and Pay for Performance approaches,[16] health impact investing assembles funds from private investors to finance evidence-based interventions, usually in "upstream" drivers of health outcomes. A share of the resulting savings is returned to impact investors to cover principal and interest.[17]

Improving Data-Driven Decision-Making

The need for data for specific groups and geographic areas, not just for the county as a whole, has been clear for decades. Responding to that need, though, is an expensive challenge. Data availability and tools have grown tremendously in the past decade, but it usually is not clear what data and what tools to choose given limited budgets. The Bexar County Community Health Needs Assessment is used by a wide range of people with different priorities and different levels of technical skill, data literacy, and internet access.

Opening Up Access to Data

The Health Collaborative believes the time is right to create a portal to access detailed local data online, knowing that the portal's features and content will need to evolve over time in response to changing local needs and data availability. The Health Collaborative has partnered with Community Information Now (CI:Now) a local data intermediary serving south central Texas, to create and maintain this portal.

CI:Now provides neutral, accurate, timely data to the general public and to a wide range of public and private organizations working in many different issue areas, including health, early childhood development, education, workforce development, housing, and economic development. More information about CI:Now can be found at CINow.info.

The power of this partnership is that because CI:Now gathers data across many different issue areas, data collected for other initiatives and purposes will be integrated with the community health needs assessment data and available to health assessment users. There is no cost to access the portal.

The portal will let the user:

➔ **Visually explore data** for different populations and sub-county geographic areas using maps, line charts, bar charts, and other graphics. A user could, for example, explore all available data for the Bexar County Hispanic population or for zip code 78208, or animate a map to show changes in the rate and geographic distribution of an indicator like teen pregnancy.

➔ **Understand the data** and use it more effectively. Graphics and notes in the platform will show and explain critical concepts like margin of error and multi-year average rates. The user will be warned if for some reason the data should be used with caution.

➔ **Export maps and charts** with title, legend, data years, and source intact. These visualizations can then be dropped into a planning document or grant application without any further editing or potential loss of information.

➔ **Export aggregate data tables**, with metadata intact, for further processing or analysis. For example, a nonprofit planner or grant writer might want to calculate a rate for the nonprofit's seven-zip code service area as a whole or to map the data just for the service area.

The image below is a sample layout. The portal design, layout, and content will be different, but the image gives a sense of what the portal will look like and do. Each visualization – map, chart, or table – is linked and interactive. For example, a zip code selected in a map will be highlighted in the bar chart and table.

Limits of the Portal

The portal will almost certainly not meet the needs of every health assessment user, now or in the future. Users can expect to encounter these issues:

➔ **Not all indicators or social and demographic breakdowns of interest will be available.** At launch, the portal will include only the data collected as part of the 2016 Assessment, and not all indicators in this narrative report will be included.

Some indicators are not available for any geography smaller than the county, city, or MSA. Some indicators, most notably those calculated from the Behavioral Risk Factor Surveillance

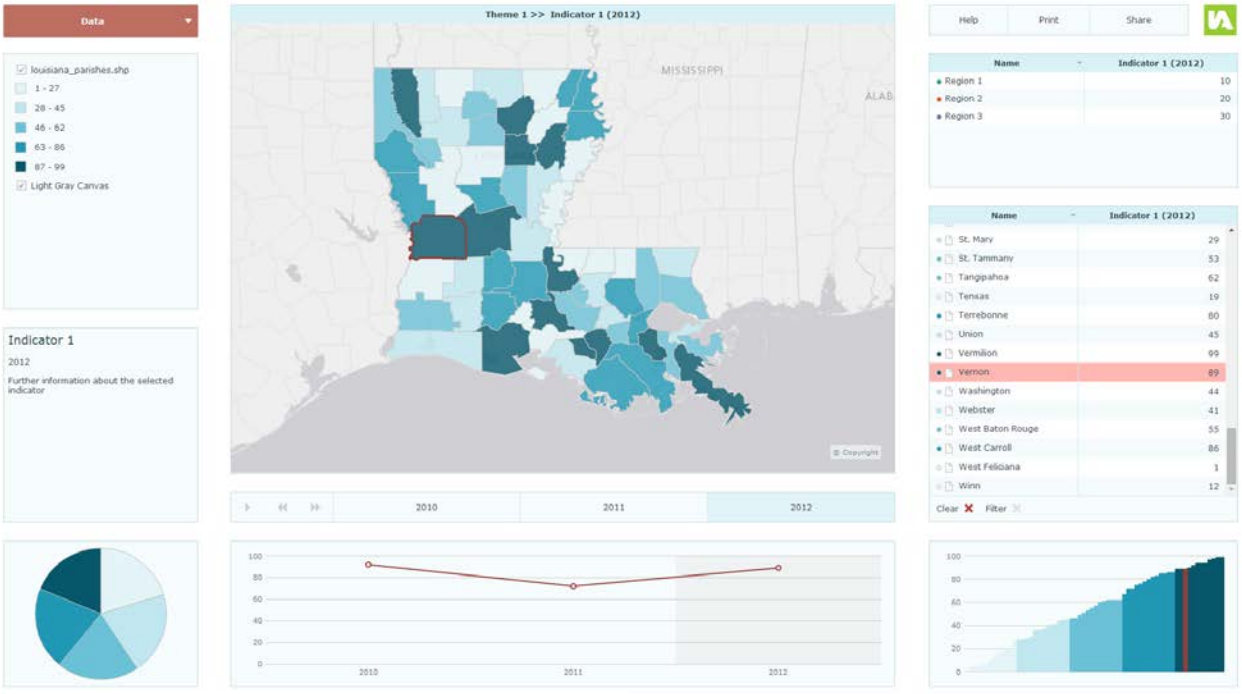


Image courtesy of InstantAtlas. Used with permission.

System (BRFSS) dataset, cannot be shown for small geographies. The small sample size of the survey leads to unstable rates and very wide margins of error.

To start, data will be presented at only two sub-county geographies: zip codes and sectors, which are groupings of zip codes. Although data for many indicators is available for geographies like census tract or school district, zip codes and sectors have been selected to enable comparison across indicators.

➔ **No record-level data will be available through the portal.** To protect the privacy of the real people for which this data are collected, all data will be grouped or aggregated by zip code, sector, race/ethnicity, sex, age group, or some other factor. If the total number is very small even after being grouped, the number will not be displayed or downloadable.

➔ **Not everyone will find the portal easy to use, even with training.** The people who are working to improve Bexar County's health and well-being vary a lot in their comfort level with technology and with data, as well as in the complexity of their data needs. This portal is intended to serve primarily people with a "middle" comfort level and data need.

The device will also affect ease of use. On smaller tablets and smartphones, of course, visualizations and portal navigation buttons will be harder to see. Export functions will work much less predictably than on a computer, and depending on device, will not work at all. Users will find the portal slower to load on a mobile data connection than on a broadband connection.

Taking Action: Community Health Improvement Plan

The Bexar County community health needs assessment and Community Health Improvement Plan (CHIP) serve multiple purposes for a variety of audiences. Among these purposes, the assessment and CHIP enable The Health Collaborative and its community partners to:

1. Explore current health status and determinants of health, health priorities, and new and emerging health concerns among Bexar County residents within the social context of their communities
2. Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
3. Understand the shifting patterns of these health issues over time in Bexar County, with particular focus on vulnerable populations and geographic variations within and across neighborhoods
4. Identify community strengths and resources as well as gaps in services in order to help The Health Collaborative, the San Antonio Metropolitan Health District, and any other partners set funding and programming priorities
5. Fulfill the community health needs assessment requirements for hospitals mandated by Texas State Department of Health Services
6. Fulfill the community engagement component of the assessment portion of the community health needs assessment and implementation plan of the Affordable Care Act and the requirements outlined by Internal Revenue Service Notice 2015-5

7. Fulfill the community health assessment requirements for the local public health department mandated by the Public Health Accreditation Board
8. Enable The Health Collaborative to use the quantitative and qualitative data gathered to engage its members, partners, and the community in an action planning process

This year will mark the third iteration of the Community Health Improvement Plan (CHIP), a community plan that identifies priority areas, establishes objectives for change in those areas, identifies needed partners, and lays out strategies for each objective. Released in 2012, the first CHIP was developed by The Health Collaborative and the San Antonio Metropolitan Health District with the input of more than 50 community leaders.

The 2014 CHIP was developed with broader community participation over the course of about six months. A Core Planning Group and Work Groups were established, with members representing different community sectors and different expertise and perspectives. Five focus areas and goals emerged from the process as high priorities. These focus areas and goals are outlined in the table on the following page along with a reference to the section of this assessment that covers related data.

This assessment is the foundation for the 2016 CHIP process that will begin in fall 2016. The quantitative and qualitative data presented here will inform the review of the five focus areas and the associated objectives and performance measures that emerged in the 2014 CHIP process. That data-driven review will almost certainly result in changes to the objectives and performance measures, and possibly to the five focus areas as well.

Beginning in 2016, the emphasis will be on moving from planning and consensus-building to collaborative action. Each objective must be "owned" by a local organization or collaborative for meaningful progress to occur. The work must be data-driven, supported by accurate, timely local data and general theory of change or local model. Effective action will likely require infrastructure and community capacity to support active performance management or collective impact, including tracking strategies and near-term outcomes or milestones that indicate progress or the need for mid-course corrections.

CHIP planning and action take place in the context of tremendous local change and a number of other community planning and collective impact initiatives. As in the past, The Health Collaborative will work to coordinate with national and key local plans, including Healthy People 2020, SA2020, and SA Tomorrow, the City of San Antonio-led three-pronged comprehensive community plan for smart, sustainable growth through 2040.

2014 CHIP Focus Area	Related Section(s) of 2016 Assessment
Healthy Eating and Active Living. Foster systemic and social change to support equity in healthy eating, active living, and wellness to enable all community members to make healthy choices and lead healthy lives.	**Environment & Living Conditions** (all) **Health-Related Behaviors & Early Outcomes: Healthy Eating, Physical Activity**
Healthy Child and Family Development. Promote access and utilization of preventive healthcare across the lifespan to improve healthy child and family development.	**Health-Related Behaviors & Early Outcomes: Services & Access to Care** **Health-Related Behaviors & Early Outcomes: Preventive Care & Self-Management**
Safe Communities. Develop community defined safe neighborhoods by identifying and implementing local and global best practices through community empowerment.	**Environment & Living Conditions: Social Conditions, Economic Conditions**
Behavioral and Mental Well-Being. Improve and expand a comprehensive, integrated behavioral health system to provide holistic services with access for all.	**Health-Related Behaviors & Early Outcomes: Services & Access to Care** **Health & Well-being: Well-Being & Quality of Life**
Sexual Health. Ensure all Bexar County community members of any sexual orientation or gender identification have access to culturally appropriate education and resources to promote sexual health.	**Health-Related Behaviors & Early Outcomes: Reproductive & Sexual Health**

[1] Centers for Disease Control and Prevention. (2016). Human papilloma virus (HPV): *Vaccination schedules and recommendations*. http://www.cdc.gov/hpv/hcp/schedules-recommendations.html

[2] See for example, National Cancer Institute. (2014). *Accelerating HPV vaccine uptake: Urgency for action to prevent cancer. A report to the President of the United States from the President's Cancer Panel*. Bethesda, MD. Available online from http://deainfo.nci.nih.gov/advisory/pcp/annualReports/HPV/index.htm

[3] Centers for Disease Control and Prevention, Advisory Committee for Immunization Practices (ACIP). (2015). *Influenza ACIP vaccine recommendations*. http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html

4 See for example, U.S. D.H.H.S. Administration for Children and Families. (2012). Asking: "What's Happened to You?" A Focus on Trauma-informed Care. http://www.acf.hhs.gov/programs/fysb/resource/exchange-trauma-informed-care

[5] Agency for Healthcare Research and Quality. (2015). *Preventive services and trauma-informed care fact sheets: Trauma-informed care*. http://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/index.html

[6] Ockene, J.K. et al. (2007). Integrating evidence-based clinical and community strategies to improve health. *American Journal of Preventive Medicine* 32:244-252. Available from http://www.uspreventiveservicestaskforce.org/Page/Name/integrating-evidence-based-clinical-and-community-strategies-to-improve-health

[7] American College of Sports Medicine. (2016). *Exercise is medicine: A global health initiative*. http://www.exerciseismedicine.org/

[8] Centers for Disease Control and Prevention. (n.d.). *State initiatives supporting healthier food retail: An overview of the national landscape.* http://www.cdc.gov/obesity/downloads/healthier_food_retail.pdf

[9] Centers for Disease Control and Prevention. (2014). *Healthier food retail: An action guide for public health practitioners*. http://www.cdc.gov/nccdphp/dnpao/state-local-programs/healthier-food-retail.html

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Index of Topics

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Appendices

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Appendix A. Summary of Community Voice

Below is a summary of the common themes that emerged from interviews and discussion groups. The quotes that appear in this section are direct transcriptions of statements made by interview and discussion group participants and should not be taken to represent the views of The Health Collaborative. Please see the **Technical Notes: Data Sources and Analysis** section for more information about how this information was gathered and who participated.

Community Description

Racial and ethnic diversity. Focus group members and interviewees described the communities of Bexar as racially and ethnically diverse, with Latinos comprising the largest proportion of the minority population. Many respondents reported that these residents experienced health disparities, noting substantially higher rates of chronic disease and teen pregnancy, and lower levels of utilization of prenatal care and access to health care, among those of diverse backgrounds. Undocumented individuals were especially singled out for their lack of access to care and poor health outcomes.

Strong social cohesion. A key strength of the community, according to focus group members and interviewees, was the strength of family and community bonds among residents. As one interviewee stated, *"the family bond and the want to create a better life for their families…is very strong among these communities and is considered a huge strength."* (community member) Another interviewee shared a similar perspective, saying, *"[in San Antonio] there it's such a warm, caring, and welcoming community."* (community member) This social cohesion extended, according to some respondents, to a willingness to help others among community members and organizations. One interviewee shared that a strength of the community is *"the ability to help each other out and advocate for each other."* (community member) Additionally, San Antonio was described by a couple of respondents as a philanthropic community. As one community leader explained, *"when a need is identified, we are fast to approach the need."* (community member)

Resilient residents. While many residents in Bexar County were reported to face substantial challenges in their lives, including poverty, lack of education, poor health, and unsafe neighborhoods, they were also described as resilient. As one focus group member explained, *"[community members are] resourceful with the limited resources they have."* (focus group participant)

Collaboration among organizations. Several respondents reported that collaboration among organizations working in the region was strong. Examples of this cited included partnerships between schools and health organizations, between housing agencies and private landlords, in the sexual health arena among provider organizations. As one interviewee described, *"an*

asset to the community is that there is a diversity of people coming together to help people who suffer from mental illness." (focus group participant) Another person echoed this saying, *"although there are lots of hospital competitors, they work together and their partnerships are valuable to making community changes."* (focus group participant) However, not all respondents agreed with this, noting that stronger collaboration was needed. As one person noted, *"there is not a lack of programs or resources but a lack of collaboration and a similar focus between organizations."* (focus group participant)

Overall Community Challenges

When asked about overall challenges faced by residents in the region, several common themes emerged:

Poverty. Among the challenges faced by residents in the region, economic hardship was most often mentioned by focus group members and interviewees. Respondents largely described their communities and the communities they serve as low-income with high rates of poverty, including many children who receive free and reduced lunch. Lower levels of education, lack of well-paying job opportunities for residents, lack of transportation, and language barriers contribute to poverty in the region. As one informant explained, *"unemployment and low wages make it very hard for SAHA (San Antonio Housing Authority) residents to improve their economic status. Many of the SAHA residents are living below the living wage. This tends to be at the core of the issues that the residents of SAHA face."* (community member) Several respondents also mentioned that the region experiences economic segregation, with wealthier neighborhoods distinguished from far lower-resourced ones. As one focus group member stated, "*San Antonio is segregated into sub-communities."* (focus group participant)

Many respondents identified poverty as a fundamental factor contributing to the poor health of residents. They pointed to the challenges poorer residents face in paying rent, buying food, accessing transportation, and obtaining health insurance or healthcare. They also explained that parents struggling to meet basic family needs have little time to pay attention to their children's education or health. As one interviewee summed up, *"it's a downward spiral that begins at poverty."* (community member)

Low levels of educational attainment. Respondents also pointed to the low levels of education including literacy among many residents as a substantial concern for the community, contributing to poverty and limited employment opportunities. As a result, one informant observed, *"educated people come and go because they have options, but the poor uneducated people tend to accumulate and you get this intergenerational poverty."* (community member) Several respondents attributed varying educational outcomes to unequal distribution of funding across schools. The state of Texas, according to a couple of respondents, has one of the lowest levels of funding for public schools across the nation. At a local level, respondents stated that some of the highest need schools in the region are under resourced compared to those in wealthier communities.

Several interviewees saw a need for greater partnership with the region's school districts to ensure a qualified future workforce. The need for literacy and math and technology competencies was specifically noted.

Lack of affordable housing. Lack of affordable housing emerged as a theme across focus groups and interviews. Respondents expressed

concern about housing being unavailable or unaffordable for some segments of the population and noted an increase in homelessness and transience among residents. According to housing advocates/providers, housing for the homeless and those suffering from mental illness is in short supply, with insufficient transitional and permanent housing options. At the same time, a couple of informants noted that development of higher-end housing and corporate development in the region continues.

Lack of childcare. Numerous respondents pointed to the lack of childcare as a substantial challenge for parents in the community. Many lower income residents work late hours and have few affordable childcare options. As one respondent noted, *"access to childcare is one of the main challenges. Residents do not use formal childcare because they are not aware of the options."* (community member) The lack of childcare options for low-income parents also makes it difficult, according to respondents, for parents to enroll in higher education.

Lack of transportation. Focus group members and interviewees reported that private cars are the prominent means of transportation and those who do not have cars, most notably seniors and low-income residents, face substantial transportation challenges. Residents described a limited public transportation infrastructure in the region, making it difficult for some residents to get to work, access healthy food, make health appointments, and attend school events. As one housing provider explained, *"the lack of walkable neighborhoods also creates many challenges to getting to work, to the grocery store, doctors' appointments, and etc. Some residents have cars, but not all. Many rely on bikes and the transit system."* (community member) Although bus transportation exists, this was reported to be challenging for residents because travel takes a long time and schedules are not always convenient. Additionally, a couple of respondents noted that flooding causes problems for public transportation.

Violence. Violence and concerns about safety were also cited by respondents as challenges in the community. Respondents shared many examples of violence including crime and drive-by shootings. Domestic violence, including child abuse, was a concern shared in numerous focus groups and interviews. Violence in the home was attributed to the stress of living in poverty as well as mental health or substance use issues. In one focus group, the prevalence of bullying among children and youth was raised as a topic of community concern (SH) Residents also shared concerns about neighborhood safety. They noted that in some neighborhoods, parks and playgrounds are unsafe due to drugs, unleashed dogs, and strangers.

Built environment. Concerns about the physical environment were also expressed by several focus group members and interviewees. Residents described limited infrastructure for walking and biking, due to lack of sidewalks and bike paths. Air pollution due to traffic was also mentioned. These factors affect health, as one member of the community health workers focus group described: *"the unsafe conditions prevent many individuals in the community from living an active lifestyle."* (focus group participant)

Pressing Health Concerns

When asked about pressing health concerns in the region, respondents pointed to several including obesity and chronic disease, behavioral health, teenage pregnancy, and sexually transmitted infections.

Obesity & Chronic Disease

Obesity. Almost all focus group paticipants and key informant interviewees named obesity as a major issue in the community, alongside chronic illness such as diabetes and heart disease. Obesity, according to respondents, is driven by unhealthy eating habits and low levels of physical activity. As one person stated, *"it's a symptom of modern life to have unlimited calories available to you whenever you want them and not having to work physically very hard to do day-to-day activities."* (community member) Numerous respondents expressed particularly concern about obesity in children and youth, such as one who explained, *"parents working too much and not paying attention to their child's diet and exercise schedule plays a huge role in the community issue at large."* (community member)

Chronic disease. Chronic illness is also of substantial concern to the residents of Bexar County. Respondents pointed to high rates of diabetes among residents, especially uncontrolled diabetes, which was attributed to a lack of access to healthcare and lack of understanding about how to prevent the disease. Some respondents expressed concern about rising rates of chronic disease, such as Type 2 diabetes and even hypertension, among children. Several respondents noted high rates of cancer among residents in the region. Asthma was also identified as a concern, especially in low-income communities. One informant attributed this to the explosion in development in the region and the need to travel long distances to commute, which causes more emissions. As this informant stated, *"this is contributing to ozone development causing heat islands that are in the middle of these socioeconomically stressed communities."* (community member)

The higher prevalence of chronic disease in minority populations was noted by several focus group members and interviewees. Health providers, especially those who serve lower-income patients, reported rising rates of obesity, heart disease, asthma, and diabetes in their patient populations as well as a rise in the prevalence of multiple chronic diseases.

Lack of awareness about the preventative nature of many chronic illnesses and steps to prevent illness was also cited as a concern. Respondents attributed this to attitudes about health in the community as well as challenges to accessing care. Community members' perspectives about the nature of chronic illness and the importance of taking preventative steps are a barrier to good health, according to respondents. For example, one interviewee explained that many in the community believe diabetes is generational, and that children of adults who have diabetes or other chronic illnesses will automatically get the same health issues and nothing can be done: *"there is an apathy… poor health is just the way it is."* (focus group participant) Providers noted that lower income residents will forego annual exams and screenings if they are feeling healthy so they do not need to pay for these services. This can lead to a late diagnosis of illness, which means delayed care and sicker patients. As one provider remarked, *"people often wait until they are truly sick to seek help, it then becomes harder to find them the help that they need."* (community member)

Healthy Eating & Physical Activity

Healthy eating and food access. Poor eating habits among some community members emerged as a common theme across interviews and focus groups. This was attributed to poor access to healthy foods, the low cost of fast

food, cultural food norms, and lack of understanding about nutrition.

Access to and affordability of healthy food was identified as a substantial barrier to healthy eating in the community. Several respondents reported that many residents in the region face food insecurity and hunger was identified as a problem in local schools. Several respondents identified the lack of grocery stores and low-cost healthy food options as a substantial challenge in some neighborhoods, which is exacerbated for those who face transportation barriers. As one interviewee explained, *"eating healthy is expensive; it is cheaper to buy McDonalds. There are more liquor stores, barber shops and McDonalds than there are grocery stores."* (community member) Another echoed this saying, *"the majority of what is in shopping baskets is processed foods."* (focus group participant) For some, the strong marketing of processed foods is a key driver of unhealthy eating behaviors. As one person stated, *"it is very hard for the community to overcome the advertising and the food that is put in front of them."* (community member val)

Lack of knowledge about healthy eating and how to prepare healthy meals was also seen as contributing to poor eating habits. Informants mentioned that there is little health education in schools, and many parents do not know how to prepare healthy meals on a budget. They cited a need for more community education about nutrition.

Respondents noted that community-based efforts to address healthy eating are growing. They cited efforts to promote urban gardening and to expand farmer's markets and offer fresh produce in health clinics. Several organizations, such as the Texas Diabetes Institute, the San Antonio Food Bank, and an effort by H-E-B, offer nutrition and cooking programs. A couple mentioned a local restaurant initiative (Por Vida) designed to promote healthier menu items in restaurants.

Physical Activity. In addition to healthy eating, physical activity was frequently discussed in focus groups and by interviewees. Overall, residents reported a lack of infrastructure that supports physical activity, including sidewalks and parks. As one person mentioned, *"sidewalk infrastructure is a huge concern."* (community member) Several respondents also reported that many schools do not offer physical education classes to students. As with healthy eating, lack of understanding about the importance of physical activity was also a contributing factor.

When asked about existing initiatives in the community focused on promoting physical activity, respondents mentioned efforts by the Mayor's Fitness Council and the Health Collaborative, as well as work to increase green space and promote community fitness programs such as through 5K, 10K and biking events and walking to school programs. They also mentioned policy-focused efforts such as such as indoor smoking ordinances, bicycle master plan policies, and pedestrian safety policies.

Behavioral Health

Mental health. Focus group participants and key informants identified mental health and lack of access to mental health services as a major unmet need in the Bexar region. Overall, stress, anxiety, and depression were identified as the most common mental health concerns in the community, although rates of trauma/PTSD were reported to be rising. Respondents shared that mental health issues have contributed to rising rates of child abuse and domestic violence. As one person stated, "*in [the] community day-to-day members are dealing with past conflicts that have led them to depression and hopelessness."* (community member) Focus

group participants and key informants reported that children and youth are at high risk for mental health problems, and that the response to their needs is inadequate.

Key informants reported that the region lacks enough mental health providers of all kinds to address the need, especially those who serve lower-income populations and those who serve children and youth. Respondents identified several mental health service providers in the region including Laurel Ridge Treatment Center, Clarity Child Guidance Center, and the San Antonio Clubhouse, however they also reported that the availability of behavioral health services is far less than the need. As a result, those who need services must wait long periods to access them or go untreated. Mental health providers attribute rising teen suicide rates in the region to undiagnosed and untreated mental illness. (focus group participant)

The cost of mental health care was also seen as important concern because many lower income people lack health insurance and cannot afford the out-of-pocket expense of mental health care or medications. One respondent mentioned that managed care organizations will not pay for the services or take part in mental health issues. (focus group participant)

An additional barrier to care for those with mental health issues, according to mental health provider respondents, is lack of involvement in and awareness of behavioral health issues by primary care providers and pediatricians. Respondents noted that these providers often lack training in behavioral health and often do not have access to staff who have expertise in these issues. Many are also not connected to behavioral health resources in the community. Yet, respondents also noted, only physicians can refer patients to a psychiatrist. As a result, mental health providers observed, there is a heavy reliance on medication for those with behavioral health issues, when other interventions may be more effective. As one informant explained, *"PCP's are not involved with mental health issues and that causes people who suffer from mental health issues to not be referred out to psychiatrists or therapists."* (focus group participant)

Finally, a number of focus group members and interviewees stated that the stigma associated with mental illness prevents many from seeking care. Mental health providers noted that this challenge is exacerbated by the prevailing view that mental illness is inextricably linked to violence. As one focus group member explained, *"that label and lack of knowledge causes there to be very little or no social and community support to the people who need it most."* (focus group participant) Rising teen suicide rates are a growing community concern, according to mental health providers, making it especially important to address stigma among youth. As one observed, *"teens do not think it is acceptable to talk about mental health issues, there is a stigma against mental health."* (focus group participant)

Substance use. Several respondents noted that substance use is a concern for the community. They mentioned high use of alcohol and well as other drugs. Abuse of alcohol was mentioned as a concern among high school and college students, including drinking and driving. Substance use among younger youth was identified as a concern and was attributed in part to chaos in homes and families. In general, while several individuals and groups of stakeholders noted substance abuse as a concern, they did not speak in great depth about the issue.

Maternal & Child Health

Teen pregnancy. Numerous respondents cited concerns about teen pregnancy in the region, noting that the rates of teen pregnancy in the region exceed those nationally. Teen pregnancy rates on the East Side (of San Antonio) were reported to be four times the national average. (focus group participant) Lack of education about sexual health was one factor contributing to this, according to respondents, as are cultural and religious factors in some communities. A significant barrier identified by respondents is a recent policy change that limits sexual health education offered in schools; as a consequence, one informant explained, *"students are moving from middle to high school with no education on sexual health."* (focus group participant)

Maternal and child health. Lack of prenatal care was cited as a related concern, and was connected to lack of awareness about the importance of prenatal care and access to services. Delayed care for pregnant teens was reported to be very high. As one interviewee explained, *"most teens try to hide it and wait until last minute to seek care which, in turn, has a high cost."* (community member) Education—of youth, mothers, and parents—was seen as critical to addressing this.

Communicable Diseases

Sexually transmitted infections. Focus group members working in the area of sexual health reported that rates of sexually transmitted infections (STIs) are high in Bexar County. Many of the factors contributing to this are similar to those for teen pregnancy and mental health: lack of education and misinformation; barriers to accessing care; and stigma. The recent policy change that limits sexual health education offered in schools is also a substantial barrier, according to respondents. As a result of this, those working to provide children and youth with information about HIV/AIDS and other STIs as well as about teen pregnancy must find other venues in which to reach young people.

Stigma and lack of trust create additional barriers to reaching those at risk or living with HIV/AIDS and other STIs. This contributes to low rates of STI testing and a reluctance to participate in sexual health education. LGBTQ persons, especially youth, face additional barriers that prevent them from being proactive about their sexual health, according to respondents.

Communicable diseases. Few respondents mentioned other communicable diseases as a challenge in the community, although one respondent reported that childhood immunization rates were low in some communities. Another shared that the Vaccines for Children program has been beneficial in supporting successful immunization rates.

Access to Health Care

Access to Health Care. Many focus group members and interviews saw the health and social service infrastructure as a strong asset in the region. They pointed to strong hospital systems and specialty care as well as full-service community clinics, mobile clinics, school-based clinics as well as strong medical and nursing education programs. As one interviewee remarked, *"[we have] an urban advantage of having wide range of accessible health care systems.*" (focus group participant) However, others shared a concern about distribution of these resources across the community, such as one community member who stated, *"health care access is not well distributed. Healthcare 'deserts' exist in the community."* (focus group participant) Additionally, respondents reported that lower income community members face other challenges to accessing health care including lack of insurance, costs, provider availability,

transportation, and lack of knowledge about services and how to navigate the health system. This has consequences for both the health of residents and the larger community; as one person explained when describing delayed care due to lack of healthcare access, *"the community spends too much money on care for sicker individuals. "* (focus group participant)

Lack of health insurance. The lack of expanded Medicaid in Texas was cited as a substantial barrier to health care for people who make too much money for Medicaid but not enough to afford coverage through the ACA marketplace. Lack of insurance and underinsurance has a substantial negative impact on health, according to informants, because people will not seek preventative care and delay treatment even when they are sick.

Costs of healthcare. Affordability of health care is of also of significant concern to many residents in the Bexar County region. Cost of health care prevents some people from getting care in a timely way or taking advantage of prevention programs. Focus group members and interviewees reported that high deductibles and co-pays prevent some from accessing needed care.

A related challenge is the cost of medication, and medical equipment such as glucose strips, some of which are not covered by insurance.

Provider availability and insurance coverage. Several focus group participants and key informants reported that the region lacks both primary care and specialty providers, especially those who serve lower income residents. Some residents spoke about challenges in getting timely appointments and being put on long waitlists. Others shared that they have experienced challenges when their insurance switches and they have fewer provider options or must find new providers. According to focus group respondents and interviewees, the barriers to health care access have led to increased use of emergency departments for health issues that are not emergent. As one respondent shared, *"the most difficult thing for me is actually finding a doctor. I've gotten to the point that I do not have medication and I have to go to the emergency room because doctors are not accepting new patients or they don't accept the affordable care stuff."* (focus group participant)

Language barriers. According to several focus group members and interviewees, non-English speakers face language barriers when seeking health care. Some cited a lack of bilingual providers and reliance on family members, including children, to sometimes communicate health information. Language barriers, according to one focus group member, means that, *"non-English speaking community members are hesitant to attend programs or ask for services."* (focus group participant)

Lack of awareness about health and prevention and services. Lack of awareness about the services that do exist was also mentioned as a barrier by a number of respondents. As one interviewee shared, *"lack of knowledge and awareness as to what the options are in the community is another challenge to accessing services."* (community member) Another respondent echoed this, saying, *"in our community even some well-educated and wealthy people may find themselves in a crisis and don't know who to call. It doesn't necessarily mean there isn't help available, but there is not a one call number that assists the community in finding the solution to their problem."* (community member) Although 211 services were mentioned by several informants, they also shared that many residents may not know about this service. Others wondered about the completeness of the information provided by the service.

Transportation. As discussed earlier, transportation is seen as one of the greatest challenges for the region for those who do not have private vehicles or easy access to public transportation.

Lack of understanding about how to navigate the healthcare system. Another challenge cited by informants has been patients' lack of understanding about what is covered by different insurance products and navigating their health insurance or the healthcare system. This is especially challenging, respondents reported, for those with low levels of education, who don't speak English, and who have never had insurance coverage. As one respondent shared, *"for example, many do not know or understand the benefits and services provided through Medicaid, Medicare, or the ACA. This is true even for the most intelligent consumer."* (focus group participant) Another shared a similar perspective saying, *"I think that families first of all are overwhelmed and quite frankly just don't know what to do. The medical jargon is horrible, navigating the system is tough and on top of that the lack of providers creates a whirlwind of frustration and despair for families that just want to do what is best for their loved ones. It's not easy." [*community member*]*

Vulnerable Populations

When asked about the most vulnerable populations in the region, many respondents pointed to those of lower socioeconomic status, who often have less education, less access to healthcare and other resources, are less able to engage in prevention, and who are disproportionately affected by poor health. Within this group, homeless people and undocumented individuals were seen are particularly vulnerable. Youth and veterans were also mentioned by a few respondents as particularly vulnerable populations.

Gaps & Needs

Focus group members and interviewees identified several needs for the community. As one informant stated, *"for a developed nation and one of the richest states in the country we have extraordinary needs."* (community member) The needs identified by respondents in Bexar County included housing and transportation as well as better jobs, education and childcare, all factors which are important social determinants of health. Specific health needs identified by informants include mental health care, greater access to healthy foods and opportunities for physical activity, better support in connecting to and navigating health services, expanded sexual health education and programming, and engagement of community and community leaders in setting priorities and implementing programs.

Social Determinants of Health: Housing, Childcare, Job Opportunities, Education, & Transportation

Health is directly connected to larger societal factors and institutions. When asked about gaps and needs in the community to improve health, focus group members and interviewees spoke about the importance and need to address several of these. They saw a need to enhance educational opportunities for students in the community, through more equitable funding for education, opportunities for skills training in areas such as math literacy and technology, and for support for adults to attend higher education. This was seen as critical to enabling residents to obtain higher-paying jobs, those with benefits like health insurance. They also reported a need for more childcare options.

The strong connection between housing and health was noted by several respondents who

suggested the development of more mixed income and subsidized housing. This was also seen as a strategy to address the economic segregation that some reported currently exists in the community, and to reduce homelessness. They saw the potential for partners with organizations such as the San Antonio Regional Alliance for the Homeless (SARAH), the Housing Authority of Bexar County, The San Antonio Housing Authority, and the South Alamo Region Alliance for the Homeless. Partnership with landlords and companies like Home Depot for property upgrades were mentioned. Social impact bonds[1] were also mentioned as an innovative approach to addressing housing constraints. As one informant shared, *"there is a cause and effect relationship between where you grew up as a child and your income as an adult. If true, an argument can be made to use social impact bonds to fund additional housing vouchers to help people move to better neighborhoods that will directly impact their future income."* (community member)

Finally, a couple of respondents identified a need to invest in public transportation and engage in efforts that get people out of their cars and using more active modes of transportation.

Across conversations about social determinants of health, stakeholder called for the community to see more policy-oriented solutions to have broader health impact on the population. While not explicitly stated, the idea of health in all policies arose during discussions of using a health lens while working with non-traditional health partners such as housing and transportation officials.

Healthy Living Programs

Policy and program support to encourage healthy lifestyles among residents was a common theme in focus groups and interviews. As one interviewee shared, *"healthier community? We're number 27 and Austin is number 3. What is the difference? They're more active so San Antonio needs to become more active."* (community member)

Respondents saw a need for more prevention-oriented education programs and suggested topics such as nutrition, how to read food labels, how to prepare healthy meals on a budget, and managing chronic disease. More education specifically about diabetes prevention was seen as an important need in the community. Community fitness events were also suggested. Respondents noted that information needs to be at an appropriate literacy level for intended audiences and outreach must extend into communities, including holding events in communities of greatest need so they can be accessed more readily. Parents of younger children were seen as a critically important audience.

On the policy level, focus group members and interviewees suggested more farmers markets and expansion of community and school garden programs, better school food guidelines, better and safer sidewalks and bicycle lanes, tax breaks for businesses that promote healthy living, lighting in sidewalks and parks, and taxes on unhealthy food and beverage items. Several interviewees suggested that primary care physicians and pediatricians become more involved, such as through initiatives in which they write "prescriptions" for physical activity and fresh produce. Expansion and improvement of parks was also suggested, including improving on unused park space. One respondent suggested expanding the successful School Parks (SPARKS) initiative in the region.

Building on existing partnerships with organizations like the YMCA, the Mayor's Fitness Council, H-E-B, and the Diabetes Collaborative, and the Health Collaborative, was also suggested

by respondents. Engagement of local government was seen as critical. Respondents also saw an important role for schools, although several noted that recent changes in legislation makes it difficult for schools to offer health education. One respondent suggested greater youth involvement in healthy living efforts, perhaps playing a role as "ambassadors" for healthy eating messaging. The involvement of parents, especially those of young children, was also seen as necessary.

Respondents acknowledged, however, that sustained improvements in healthy lifestyles requires a fundamental cultural shift—something seen as far more difficult to achieve. As one person stated, *"health needs to be ingrained and embedded in our everyday life."* (focus group participant) To achieve this, several respondents saw a need for visible and consistent messaging in the community, especially to counteract the strong marketing by the food and beverage industry. As one person stated, *"we need more positive marketing about healthy behaviors."* (community member) One person suggested a sustained public relations campaign, similar to that done years ago through the anti-smoking campaign.

Finally, however, some respondents pointed out that any effort to enhance education or norms about healthy living in the community must address issues of access and affordability. As one interviewee stated, *"it does not matter if a person receives the message of healthy eating, if they do not have a reasonable convenient affordable option at close proximity of their work place, people will do what they have to do to get their lunch and get back to work."* (community member) Another informant shared a similar view, saying, *"educating the public is not enough, it has to be affordable for the public."* (focus group participant) This requires, according to respondents, programs that make healthy food options and physical activity programs and services accessible to low-income residents.

Enhanced Case Management/Navigation Services

Given the challenges in understanding and connecting to health care systems and health insurance, especially for those most vulnerable, several respondents suggested that more support be provided to residents. Numerous respondents pointed to the critical role that Community Health Workers (CHWs) (also described as navigators and promotoras) play in educating patients and community members about prevention and in helping to connect them to needed health services. They suggested that these types of programs be expanded. As one person pointed out, *"where navigation programs are in place, access to screenings have been more successful."* (focus group participant) Informants noted that CHWs have strong connections to the community and are more likely to be successful with those traditionally underserved in the community, according to respondents. They are also an important resource for one-to-one education. As one person noted, *"expanding the CHW's role brings cultural sensitivity; the population they serve can relate to them."* (focus group participant)

Sexual Health Programming

Given the high rates of teen pregnancy and STIs in the region, several respondents pointed to the need for expanded sexual health programming, including sexual health education and greater accessibility of sexual health services. Respondents working on sexual health issues in the community identified a need for age-appropriate and evidence-based education programs relative to HIV/AIDs and STIs prevention and reproductive health. As with healthy lifestyles education, respondents stressed that

this information needs to be provided in multiple languages and written at an appropriate literacy level. The use of photo books for non-English speaking (foto novella or jovencitas) or lower literacy populations was also suggested. (SH) Respondents also stressed the importance of location for sexual health education and services—programs need to be provided in places that are accessible to residents, especially youth, and places that are comfortable for them. A related challenge is confidential services for teens, especially relative to sexual health.

Partnerships with schools was reported to be important yet difficult given recent legislation. Respondents reported that physicians and pediatricians as well as youth-oriented programs, such as afterschool programs, can be important partners in reaching youth with sexual health information and programming.

Focus group members and interviewees also noted the importance of messaging to overcome the stigma associated with sexual health, especially STI testing. One suggestion was to include specific programs at the annual San Antonio Health Literacy Initiative (SAHLI) conference to address HIV/AIDS, teen pregnancy, sexual health, and LGBTQ health literacy. (Focus Group) Finally, one respondent also suggested the need for a resource guide of services in the community, especially those that are targeted to specific populations such as youth, LGBTQ, those living with HIV/AIDS.

Behavioral Health Services

The need for more behavioral health services also emerged as a theme in focus groups and interviews. There is a need for more providers, especially for children and youth, as well as more residential treatment centers and crisis care.

Greater engagement of primary care providers in behavioral health was also seen as critical by mental health professions. Suggestions included training for primary care providers and pediatricians about behavioral health and the placement of specialists in physicians' offices to conduct mental health screenings and provide referrals. Partnerships with schools and closer work with families, were also seen as critical to identifying and addressing the mental health needs of children and youth. Partners such as faith institutions were also noted as important. As one mental health provider stated, *"the faith-based ministries are often the first point of contact for a struggling family."* (community member)

There are some efforts to build on, according to respondents. One informant pointed to the opportunities provided by the Parity Act to enhance a focus on prevention.[2] (focus group participant) Another stated Methodist Mental Health Policy Institute recently completed a study of behavioral health systems that includes recommendations for improvements and broader systems changes. (community member) Finally, one respondent shared that the mental health crisis response team at the police department (which includes police officers and mental health professionals) has been recognized as a successful model and wondered whether this could be replicated with other professional groups such as CHWs. (focus group participant)

The need to address the stigma of behavioral health was also identified as a priority for the community and seen as key to identifying and serving those with behavioral health issues. Suggestions included working with the media, advertising in physician offices, and identifying and lifting up mental health "success stories" and testimonials. Engaging elected and community leaders in messaging about mental health was also seen as an important strategy. As one explained, *"we need to talk about is*

shamelessly and without fear. We need to make it ok to talk about mental illness and ok to support it." (community member)

Enhanced Access to Healthcare for Most Vulnerable Populations

Respondents acknowledge that some in the community faces substantial constraints to health care access. As one respondent noted, "*San Antonio has a good start in working together, but needs to build a better 'medical neighborhood' wherein individuals can obtain health care at a lower cost."* (focus group participant) Suggestions to address this varied and included expanding low-cost services in high-demand areas, providing transportation to health services, and expanding evening and weekend hours. A resource guide for consumers and providers that identified affordable medical care information and information about preventive case such as screenings was also suggested.

Several respondents pointed to the need to increase the number of bilingual healthcare providers and also a need to make sure services are culturally relevant. One respondent suggested training for providers in how to talk with patients who are lower income or non-native.

Early linkage to care was mentioned as a key strategy to enhancing health outcomes and reducing health disparities. Respondents saw the use of CHWs as a critical component of this. Some also noted that school nurses can play a vital role and suggested enhanced partnership with and support to them to target children at high risk for health issues like mental health, or chronic disease like diabetes. Finally, several respondents reported that information about existing services—both health and social services—is difficult to obtain, especially for those that most needed. They suggested the development of a resource list/guide that provides user-friendly health information, including free screening and health services.

Greater Community Engagement

Involvement of community members and leaders in the work of creating change was a theme shared by several focus group members and interviewees. They stressed a need for those leading local efforts to go out into communities to speak directly with residents and engage them. As one respondent advised, *"talk more specifically to the audience we are trying to reach. We are not reaching deep into the communities and finding out what they want, and let the community members play a role in addressing their own issues."* (community member) Another respondent shared a similar thought saying, *"[we] need to extend a San Antonio Metro Health program health model to draw out community leaders from high poverty areas and engage them in everyday community problem solving."* (focus group participant) One person suggested the development of community advisory boards comprised of consumers in the community. (focus group participant) Another suggested holding community summits to share information with community residents and enable them to become engaged.

Engaging community institutions was also seen as critical. Numerous potential partners were suggested including churches, social workers and Child Protective Services workers, Head Start programs. School districts and school nurses were also seen as important partners, as were afterschool programs. Greater involvement by the business community was also seen as key. As one focus group member stated about the business community, *"potential involvement is massive but we are not there yet."* (focus group participant) Several respondents also shared that collaboration among existing organizations working in these areas would also

be helpful. The use of common goals and metrics across organizations working on the same issues was suggested by one respondent.

Greater Leadership for Collective Impact

Closely related to the greater involvement of community members is the engagement of leaders. As one person stated, *"leadership needs to champion these initiatives."* (community member) Respondents mentioned the involvement of elected leaders, especially in areas such as funding and policy change.

Several mentioned a critical role for city leadership in promoting overall health and a shared vision of improved community health that should pervade all city and county departments, not just health. As one person stated, *"It takes all of us, but [we] need elected officials to be committed to moving San Antonio from a fat city to a fit city."* (focus group participant) Involvement of community and business leaders was also seen as important. As one interviewee summarized, *"leadership reflects what community will look like."* (community member). Throughout the discussions, stakeholders cited a need to engage with a broad range of partners, taking a collective impact approach to the complex social and health issues that Bexar County faces.

[1] Social impact bonds are a public-private-nonprofit funding model in which the private sector works with governments and philanthropies to fund critical prevention focused social programs that help address the world's most pressing problems. In this public-private partnership, investors are only repaid if and when improved social outcomes are achieved. https://www.rockefellerfoundation.org/our-work/initiatives/social-impact-bonds/

[2] The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. http://www.dol.gov/ebsa/mentalhealthparity/

Appendix B. Technical Notes

Data Sources & Analysis

Quantitative Information

Data Sources

The 2016 Assessment contains quantitative data on approximately 150 indicators, many broken out geographically or by demographic characteristic. This list of indicators was developed over several months in summer and fall 2015. 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, 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 Health Collaborative Data Committee worked as a group to rate each indicator as high, medium, or low priority, and low-priority indicators were cut from the list. All indicators derived from CHIP objectives were retained by default.

After research, not surprisingly, some high- and medium-priority indicators lacked a recent trustworthy data source and so do not appear in the 2016 Assessment. A serious gap emerged for youth-related indicators typically drawn from the Youth Risk Behavior Survey (YRBS), as Bexar County schools did not participate in the survey in 2014.

Each indicator source is cited throughout the assessment. The 2016 Assessment draws from too many data sources to list here, including a number of local private administrative datasets, 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
- Social and economic conditions data from the U.S. Census Bureau American Community Survey One- and Five-Year Estimates
- Crime data from the U.S. Department of Justice Uniform Crime Report
- Vital statistics, Behavioral Risk Factor Surveillance System (BRFSS), injury, hospital discharge, hospital bed, and health professions data from the Texas Department of State Health Services
- Medicaid and public benefits data from the Texas Health and Human Services Commission
- Communicable disease and vital statistics data from the San Antonio Metropolitan Health District

Staff from these and many other local and state agencies spent time, in some cases significant,

pulling data for the 2016 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.

Analysis & Limitations

As no statistical testing was needed for the 2016 Assessment, analysis of the data typically consisted of calculating proportions and rates, with margins of error or confidence intervals where appropriate. Margins of error and confidence intervals are displayed throughout the assessment. Margins of error were minimized where feasible by using multi-year estimates or three-year moving averages. Where no such solution was feasible and margins of error were quite wide, data values were suppressed and noted appropriately.

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 at the end of this section.

These sectors were developed for the 2013 assessment in response to the problem of small sample sizes, particularly with regard to the BRFSS dataset. BRFSS and some other survey data could not be presented at the zip code/ZCTA or smaller level because of small numbers that compromised privacy and resulted in unstable rates and extremely wide confidence intervals. CI:Now used a non-statistical process to group adjacent ZCTAs with median household incomes (from Census

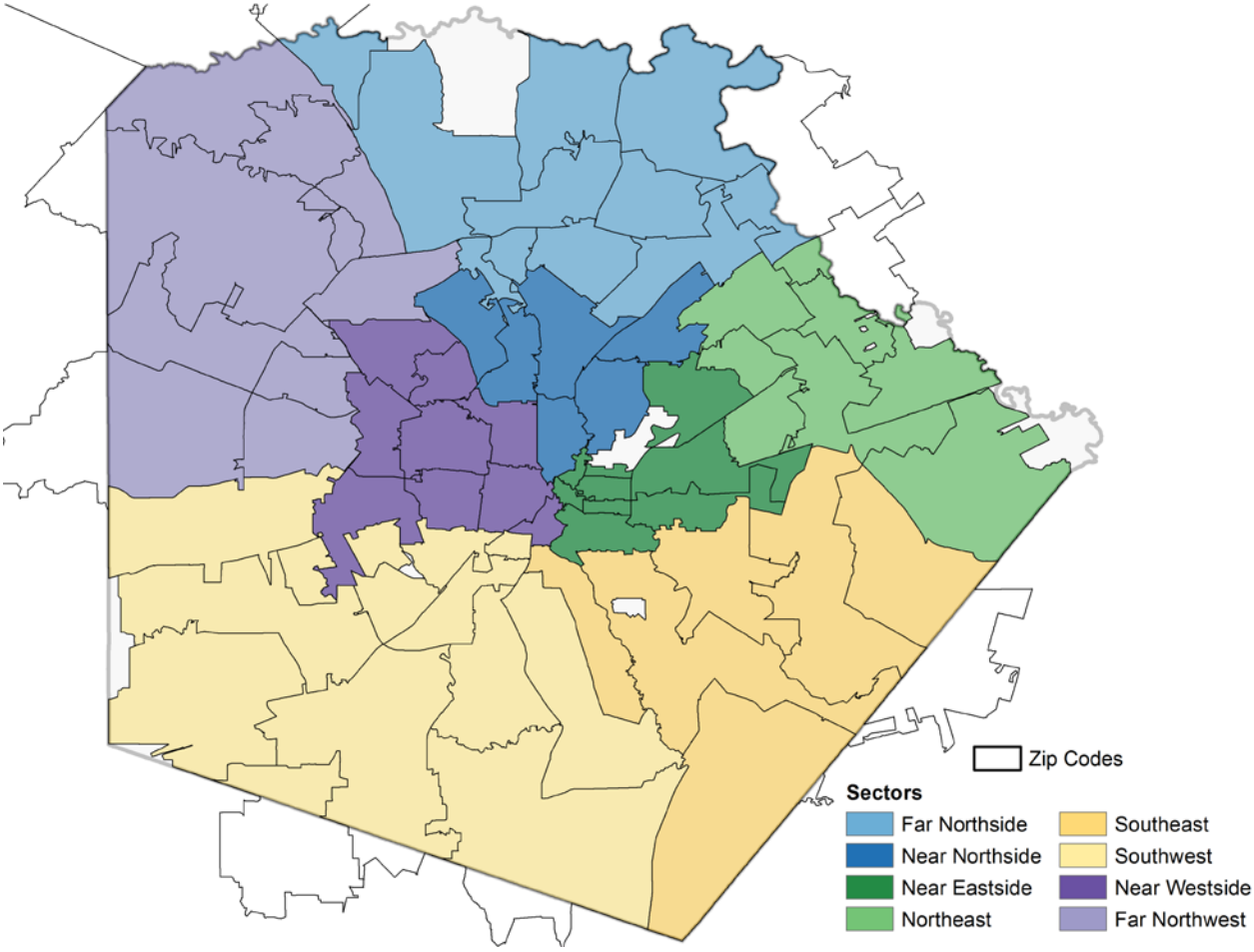
American Community Survey five-year estimates) more similar than not, and with the aim of having a sufficiently large and preferably similar total population size for each sector. The final groupings, though, also took into account our own local understanding of our "parts of town" as reflected in the commonly-used divisions of north-, south-, east-, and westside. While not ideal, the sector groupings appeared to "hold" fairly well during the 2013 assessment and were retained for this assessment.

On the following page is a map of the eight sub-county sectors described above, and a cross-walk between sectors and ZCTAs appears below the map. Other Bexar County reference maps follow with select jurisdictional boundaries overlaid.

[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).

Geographic Reference: Bexar County Zip Codes

Bexar County Zip Codes & Sub-County Sectors

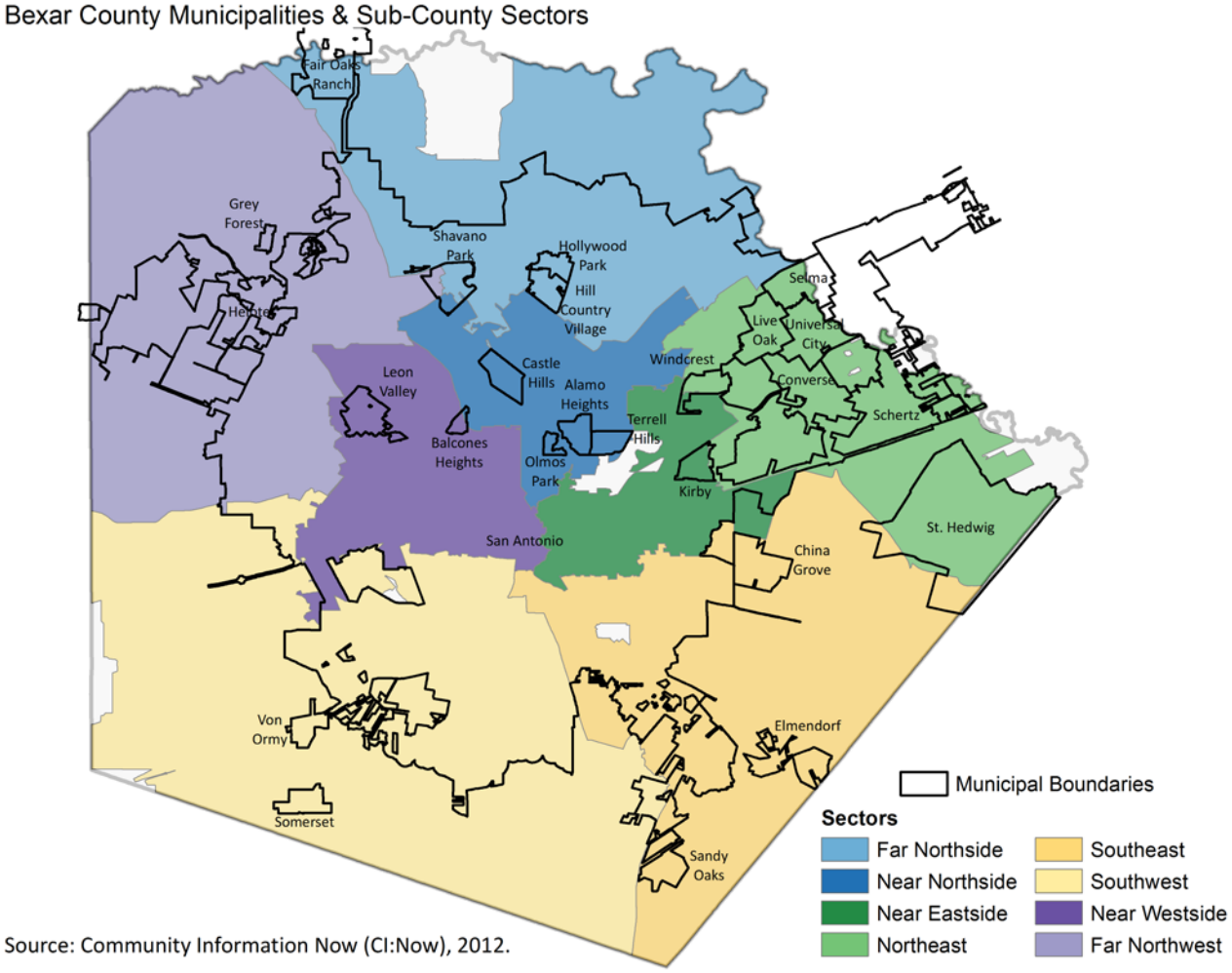


Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
78202	78109	78101	78002	78201	78006	78209	78015
78203	78148	78112	78069	78204	78023	78212	78231
78205	78152	78214	78073	78207	78249	78213	78232
78208	78154	78222	78211	78227	78250	78216	78247
78210	78233	78223	78221	78228	78251	78217	78248
78215	78239	78263	78224	78229	78253	78230	78257
78218	78244		78225	78237	78254		78258
78219			78226	78238	78255		78259
78220			78236	78240	78256		78260
			78242				78261
			78245				78266
			78252				
			78264				

Source: Community Information Now (CI:Now), 2012

Geographic Reference: Bexar County Municipalities

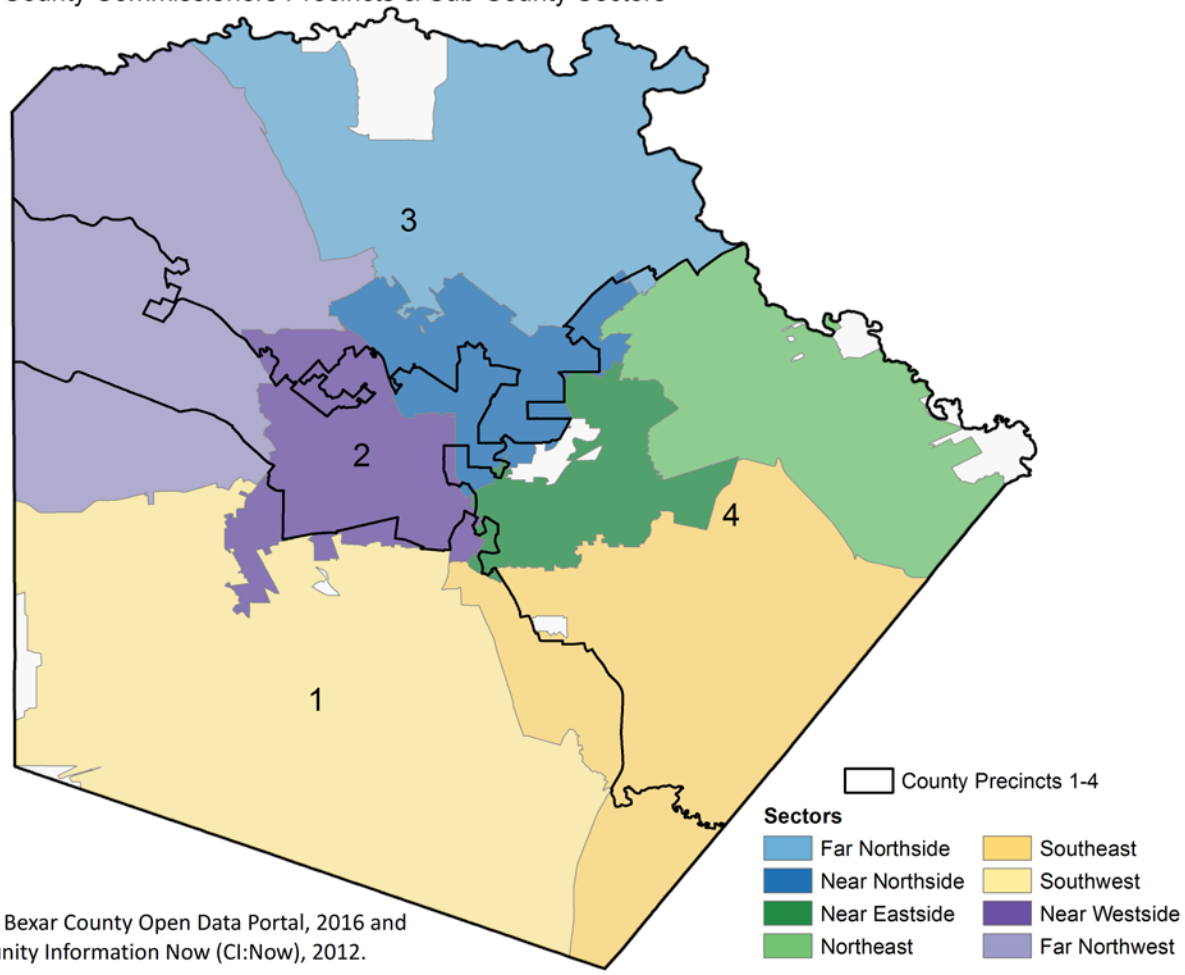
Bexar County Municipalities & Sub-County Sectors



Source: Community Information Now (CI:Now), 2012.

Geographic Reference: Bexar County Commissioners Precincts

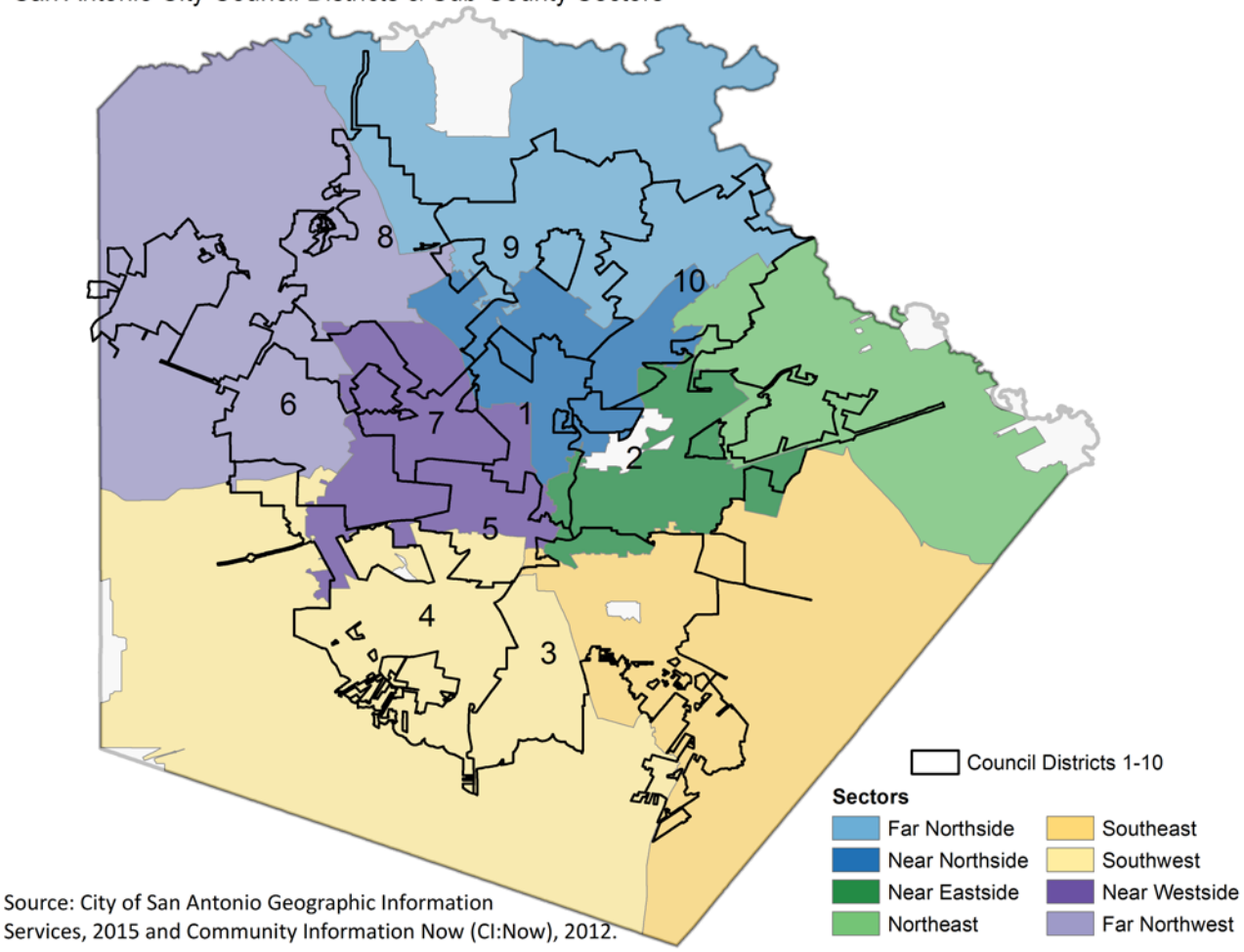
Bexar County Commissioners Precincts & Sub-County Sectors



Source: Bexar County Open Data Portal, 2016 and Community Information Now (CI:Now), 2012.

Geographic Reference: San Antonio City Council Districts

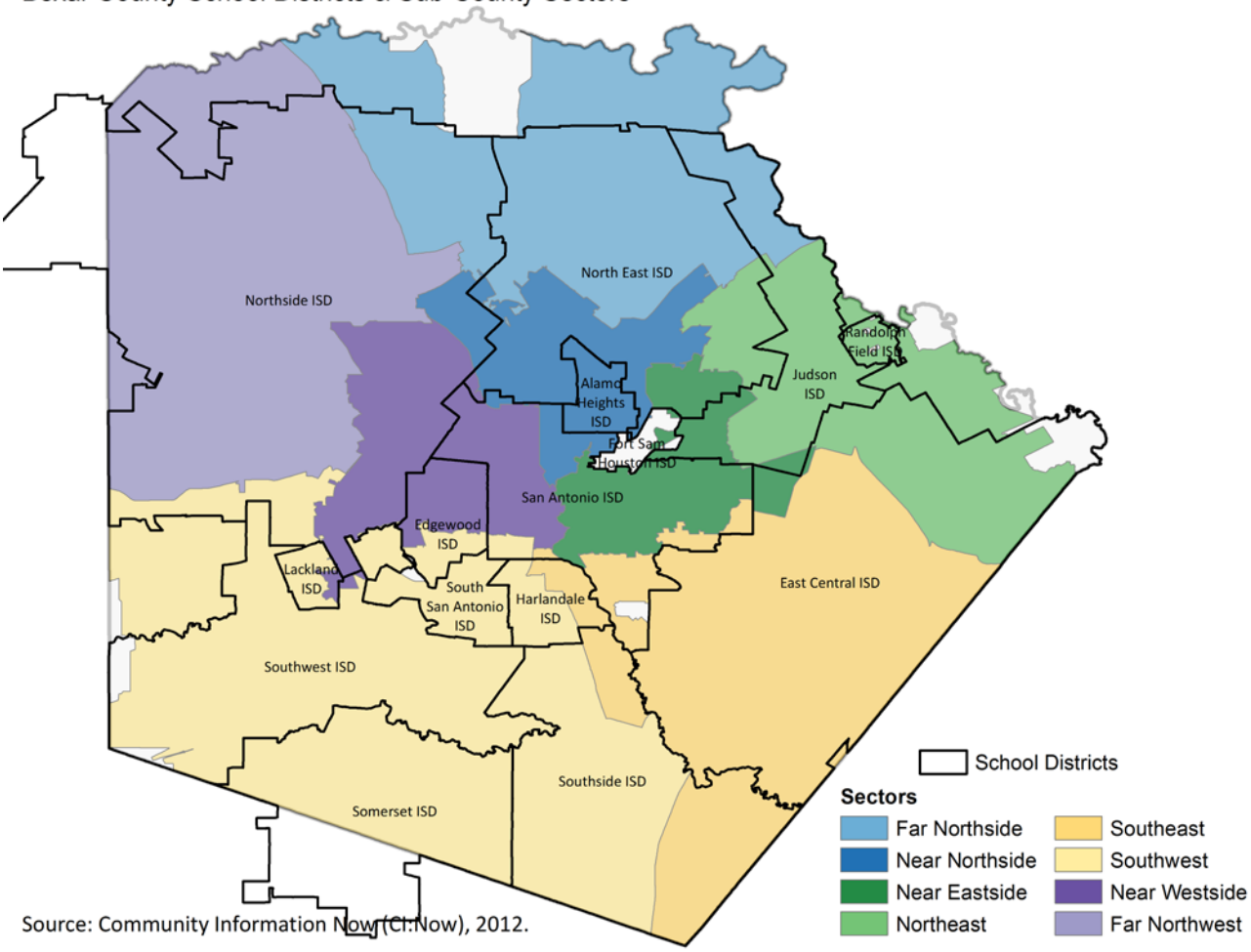
San Antonio City Council Districts & Sub-County Sectors



Source: City of San Antonio Geographic Information Services, 2015 and Community Information Now (CI:Now), 2012.

Geographic Reference: Bexar County School Districts

Bexar County School Districts & Sub-County Sectors



Source: Community Information Now (CI Now), 2012.

Qualitative Information

Data Sources

Qualitative information collected directly from the community is critical both as a primary source of data on community health and well-being, complementing the quantitative information, and as a way to triangulate or "cross-check" the numbers. Individual interviews and group discussions were held with community residents, service providers, government staff and officials, and advocates for the health of Bexar County's low-income, medically-underserved, and minority populations. The goal of this work was to learn what and how these different groups think about local health needs and assets and how they think community health and well-being can be improved.

Qualitative data collection was conducted in March and April 2016 by The Health Collaborative staff and members of its Data Committee and by faculty and students of the San Antonio Regional Campus of the UTHealth School of Public Health. A list of potential participants was generated and roughly prioritized based upon past assessments and input from the Data Committee. In general, that list of potential participants represented two broad groups of people: those with strong knowledge of an issue area, a neighborhood, or a population; and those holding significant influence over policy, resource allocation, or public awareness and opinion. Not everyone invited to participate via interview or discussion group did so, but in total, close to 160 individuals were engaged through 13 interviews and eight discussion groups. A list of all participants is included in the **Assessment Staffing and Participation** section of the Appendices. Interviewees included county and city government officials and hospital and public health officials. The discussion groups were composed of health and social service providers, students, and grandparents.

Analysis and Limitations

The Health Collaborative staff and the Data Committee took detailed notes during discussion groups and interviews, including direct quotes. All interviews and group discussions were audio recorded for backup and used in filling in any gaps in the notes. The full set of notes was provided to HRiA, who then hand-coded the notes and identified common themes that emerged over and over in the interviews and discussions.

As with the quantitative information, this qualitative information has limitations. While the discussion groups and interviews conducted for this assessment provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and small sample size. Recruitment for discussion groups was based on existing groups and meeting times, and participants were those individuals who showed up to that meeting. So it is possible that the responses received provide only one perspective on the issue discussed. In addition, the majority of discussions engaged service providers who were asked to speak about their perceptions of their clients' or community's strengths and needs, not their own individual needs. Finally, it is important to note that data were collected at one point in time and therefore findings, while directional and descriptive, should not be interpreted as definitive.

ASSESSMENT STAFFING AND PARTICIPANTS

The 2016 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 Data Committee provided direction on general approach, scope, and format. A list of Data Committee members with organizational affiliation appears on the inside back over of this assessment.

The Health Collaborative contracted with Community Information Now (CI:Now), a local data intermediary serving south central Texas, for quantitative data collection and analysis and for development of the assessment narrative.

Limited clinical and technical consultation was provided to CI:Now by Vince Fonseca, MD, MPH, FACPM. CI:Now is also contracted to develop and manage the online data portal that complements this report.

The Data Committee designed the approach for the qualitative and community engagement portion of the assessment. The Health Collaborative staff recruited participants for and handled all logistics for the interviews and the discussion groups. The discussion groups and interviews were conducted by The Health Collaborative staff and members of the Data Committee, with participation by faculty and students from the UTHealth School of Public Health San Antonio Regional Campus.

Analysis and synthesis of the interview and discussion group transcripts was contracted to Health Resources in Action (HRiA), a Boston-based nonprofit public health organization dedicated to promoting individual and community health through prevention, health promotion, policy, and support of medical research. HRiA's Research and Evaluation Department has been conducting community health needs assessments across the U.S. since 2000 and was also contracted as part of previous Bexar County assessments and the Community Health Improvement Plan.

The volunteer interview and discussion group participants were selected with an eye toward engaging meaningful and substantive input from medically underserved, low-income, and minority populations and from the service providers and advocates working with and for them. A complete list of interviewees and discussion group participants with organizational affiliation appears on the following pages.

Individuals Interviewed

Scott Ackerson - Haven for Hope
Bryan Alsip, MD - University Health System
Doug Beach - National Alliance on Mental Health Illness
Eric Cooper - San Antonio Food Bank
David Marquez - Bexar County Economic Development
Richard Milk - San Antonio Housing Authority
Carlos Moreno, MD - CommuniCare
Vincent Nathan, PhD - San Antonio Metropolitan Health District
Paul Nguyen, MHA - CommuniCare
Janet Realini, MD - Healthy Futures of Texas
Bob Rivard - The Rivard Report
Bill Wilkinson, MA - Roy Maas Youth Alternatives
Nelson Wolff, JD - Bexar County
Brian Woods, EdD - Northside Independent School District

Discussion Group Participants

Melinda Abrego - CSRA
Linda Aguero - Laurel Ridge Treatment Center
Magdalena Alvarado
Nadia Alvarez - San Antonio Area Foundation
Carmen Amador - Community member
Alberto Barragan - San Antonio AIDS Foundation
Oralia Bazaldua - University of Texas Health Science Center San Antonio
Brian Bowser - American Heart Association
Mercedes Bristol - Community member
Jacqueline Burandt - University Health Systems
Rose Caballero - Community member
Jessica Campbell - CommuniCare
Velma Cantu - Community member
Hortencia Carmona - Prevention Resource Center, Region 8
Margaret Carter - Presa Community Center
Sofia Castillo - CentroMed
David Clear - San Antonio Metropolitan Health District
Debra Colorado
Jennifer Cook - University of Incarnate Word
Dawn Cook - Alamo Area Resource Center
Keeley Cooper - University of Texas at San Antonio
Guadalupe Cornejo
Marisol Cortez - CommuniCare
Michelle Dado - San Antonio Healthy Start/San Antonio Metropolitan Health District
Ashley Davalos - University of Texas at San Antonio
Maria Del Carmen Martinez - Community member
Elisabeth DeLaRosa - University of Texas Health Science Center San Antonio
Rosita Deleon - Community member
Nicole Adele Dierschke - University of Texas Health Science Center San Antonio
Diana DiMeglio - University of Texas at San Antonio
Charlene Doria-Ortiz - Bexar County Department of Community Resources
Veronica Drake - San Antonio Behavioral Health Hospital
Sister JT Dwyer - Daughters of Charity
Maria Escamilla - Community member
Laura Esparza - Community member
Bethany Evans - Healthy Futures of Texas
Mary Falcon - Alamo Area Resource Center
Andrea Figueroa - Martinez Women Center
Andrea Figueroa - Martinez Women Center
Penny Flores - University of Texas Health Science Center San Antonio
Vince Fonseca - Population Health Institute of Texas
Martha Garcia - Community member

Guadalupe Garcia - Community member
Stephanie Garza - Presa Community Center
Martha Gonzales - Community First Health Plans
Gilbert Gonzales - Bexar County Mental Health Department
Nora Gonzales - San Antonio Metropolitan Health District
Ernesto Guajardo - University of Incarnate Word
Kristine Gusman - YMCA of Greater San Antonio
Susan Hancock - Community member
Clarissa Holloway - University Health System
Carmona Hortencia - San Antonio Council on Alcohol and Drug Abuse/PRC Region 8
Danielle Housley - Northside Independent School Districts
Meredith Howe - Project Worth
Joe Ibarra - Community member
Judy Johnson - Community member
Courtney Kukes - University of Texas at San Antonio
Yen Le - University of Texas at San Antonio
Maria Lee - Community member
Marissa Lira - Bexar County Department of Community Resources
Juan Lopez - San Antonio Metropolitan Health District
Elizabeth Lutz - The Health Collaborative
Terri Mabrito - Voices for Children
Elizabeth Manrrique - University of Texas Health Science Center San Antonio
Kate Martin - UTHealth School of Public Health, San Antonio Regional Campus
Mario Martinez - Project Worth
Delia Martinez - Community member
Selma Martinez - Community member
Jerry Mauricio - Healthy Futures of Texas
Amanda Merck - Community member
Nilda Molinas - Community member
Kaela Momtselidze - American Cancer Society
Alan Montemayor - Community member
Slyvia Montes de Oca - Cal Farley's
Dianna Morganti - Community member
Ginger Mullaney - Healthy Futures of Texas
Velma Muñiz - Bexar County Mental Health Department
Michelle Mutchler - University of Texas at San Antonio
MaryKay Newman - Bexar County Ryan White Program
Denholm Oldham - Maximus
Kelsey Olson - Healthy Futures of Texas
Lisa Ortega - Methodist Healthcare Ministries
John Osten - San Antonio Metropolitan Health District
Dean Parra - Alamo Area Resource Center
George Patrin - Serendipity Alliance
Jocabed Peña - Presa Community Center
Jeannette Peña - San Antonio Council on Alcohol and Drug Abuse
Alice Perez - Community member
Sandra Pett - Bexar County Ryan White Program
Caleb Rackley - Community member
Norma Ramirez - Daughters of Charity Services San Antonio
Ruben Ramos - Amerigroup
Pamela Ramsey - Brighton San Antonio
Mrudula Rao - Stone Oak Psychiatry / AFSP
Varda Ratner - The Patient Institute
Jesse Renteria - San Antonio Council on Alcohol and Drug Abuse
Carolina Reyes - Community member
Eric Reynolds - Community member
Clarissa Rivera - University Health System
Laurie Rodriguez - Northside Independent School District
Vanessa Rodriguez - San Antonio Healthy Start/San Antonio Metropolitan Health District
Roger Rodriguez - San Antonio Independent School District
Javier Roman - Community member

Shirleen Romo - SA Clubhouse

Lea Rosenauer - Girls Inc of San Antonio

Kendra Royal - Johnson & Johnson

Thomas Schlenker - Interlex

Eric Schoenfeldt - Community member

Pegeen Seger - University of Texas Health Science Center San Antonio

Kathy Shields - San Antonio Metropolitan Health District

Jeff Skelton - Community member

Sharon Small - Community member

Nicole Solis - Child Protective Services

Luis Solis - Community member

Gloria Soria - Community member

Ellen Spitzen - San Antonio Metro Health District

Teresa Stewart - Community member

Barbara Stocks - San Antonio Independent School District

Mark Stoeltje - SA Clubhouse

Melanie Stone - University of Texas Health Science Center San Antonio

Michelle Swisher - CommuniCare

JoAnn Tampke - Community member

Judith Temple - Community member

Bruce Thompson - Center for Health Care Services, Children's Services

Chris Torres - Texas A&M University San Antonio

Amanda Torres - Community member

Melissa Valerio – UTHealth School of Public Health, San Antonio Regional Campus

Liset Vasquez - Texas A&M University San Antonio

Juanita Vasquez-Lopez - Methodist Healthcare Ministries

Katherine Velasquez - Community member

Chris Velasquez - San Antonio Metropolitan Health District

Laura Villarreal - Girls Inc of San Antonio

Emily Weatherall - Cal Farley

Carolyn Welker - Martinez Street Women’s Center

Irene White - Martinez Street Women’s Center

Linda Williams - SA Clubhouse

Lauren Witt - Nix Health

Leslie Wood - Children's Bereavement Center

Christine Yanas - Methodist Healthcare Ministries

April Yancey - University of Texas at San Antonio

Chris Zapata - Community member

Vanessa Zuniga - San Antonio AIDS Foundation

2016 BEXAR COUNTY
COMMUNITY HEALTH NEEDS ASSESSMENT
DATA COMMITTEE MEMBERS

Stephen K. Blanchard, PhD
Professor of Sociology,
Our Lady of the Lake University
Data Committee Chair

Robert L. Ferrer, MD, MPH
University of Texas Health Science Center San Antonio – Department of Family and Community Medicine
Board Chair

Pilar Oates
The Health Collaborative
Community Board Member

Charlene Doria-Ortiz
Bexar County Department of Community Resources

George Thomas, MBA
Methodist Healthcare Ministries of South Texas Inc.

Palmira Arellano
Methodist Healthcare System

Charles L. Kight, MBA
The Health Collaborative
Community Board Member

Andrea Guajardo, MPH
CHRISTUS Santa Rosa

Thomas Schlenker, MD
Interlex Communications Inc.

Anil T. Mangla, MS, PhD, MPH, FRIPH
San Antonio Metropolitan Health District

Theresa De La Haya, RN
University Health System

COMMUNITY ADVISORY COMMITTEE

Laura C. McKieran, DrPH
UTHealth School of Public Health, San Antonio Regional Campus

Melissa A. Valerio, PhD
UTHealth School of Public Health, San Antonio Regional Campus

Carol Huber, MBA
University Health System,
Regional Healthcare Partnership

RESEARCH PARTNERS

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Thank you to our funding partners

Special thanks to the staff of the Health Collaborative, staff and student interns of the UT School of Public Health San Antonio Regional Campus, the community partners and thought leaders who dedicated time and additional in-kind resources to this effort.

The 2016 Bexar County Community Health Needs Assessment
is presented as a gift to the community by the Board of Directors of the

Health Collaborative

Bexar County's Community Health Leadership

Charles L. Kight
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 :

The Health Collaborative | 1002 N. Flores St, San Antonio, Texas 78212 | (210) 481-2573 | elizabeth.lutz@healthcollaborative.net