2025 BEXAR COUNTY COMMUNITY HEALTH NEEDS

ASSESSMENT REPORT

Health Collaborative

Bexar County's Community Health Leadership

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August 5, 2025

Dear Community Members, Partners, and Stakeholders,

On behalf of The Health Collaborative and our regional partners, we are proud to present the **2025 Bexar County Community Health Needs Assessment (CHNA)**—the **11th publication** of its kind for Bexar County, and part of a historic milestone in regional health assessment.

For the first time, this CHNA is released alongside assessments from **fi e counties in total—Atascosa, Bexar, Comal, Gillespie, and Guadalupe.** Each report reflects the **unique health needs and priorities** of its community, while also providing a regional perspective that fosters alignment and opens new opportunities to support **rural health** and cross-county collaboration.

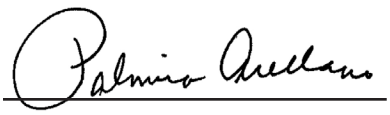
The 2025 CHNA was developed through a community-centered, equity-driven process. Guided by The Health Collaborative's **Board of Directors, CHNA and Data Committee,** and **CHIP Workgroup partners,** the assessment involved interviews with key community leaders, outreach through grassroots and faith-based partners, and resident focus groups facilitated by Community Health Workers (CHWs). Special care was taken to engage individuals with lived experience and to center the voices of those most impacted by health inequities.

This report is designed to be a **shared tool**—usable across sectors including healthcare, public health, education, workforce, housing, philanthropy, and grassroots advocacy. It is intended to inform funding decisions, strategic planning, program development, and system-level change.

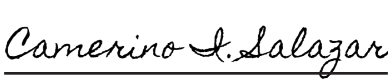
Importantly, the development and publication of the 2025 CHNA was **fully funded by The Health Collaborative (Methodist Healthcare System and CHRISTUS Santa Rosa making additional contributions for other county reports),** with critical **in-kind support provided by partners across the region.** These partners contributed to outreach, engagement, data collection, and local dissemination efforts—making this truly a collaborative process .

We also would like to extend our sincere gratitude to the many individuals and organizations who lent their time, insights, and voices to this effort. This report is not simply a reflection of community need—it is a call to action, and we hope it serves as a valuable foundation for our shared work ahead.

With appreciation,



Palmira Arellano
Vice President, Community Engagement,
Methodist Healthcare System
Chair, Board of Directors
The Health Collaborative



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INTRODUCTION AND SUMMARY

ABOUT THE ASSESSMENT

The 2025 Bexar County Community Health Needs Assessment (CHNA) is the product of collaborative mixed-methods data collection and analysis to understand current and recent patterns in the county population; health-influencing social, economic, and structural factors; risk and protective factors and behaviors; and health status and outcomes. The approach has four components, each intended to serve a specific purpose.

COMPONENT	COMPONENT PURPOSE
Extant Quantitative Data	Use the best available extant administrative and survey data to identify trends, patterns, and disparities in area demographics, social determinants or non-medical drivers of health, health-related behaviors and other risk and protective factors including preventive care utilization, and health outcomes including overall health status, morbidity, and mortality.
Community Resident Survey	Learn how residents rate their health and social connections, what challenges they're living with, what assets they feel are most important to their health and how easily they can access those assets, and how well they're able to access several specific types of health care.
Focus Groups	Learn how people from several vulnerable groups view "healthy", what they need to be healthy, what challenges and barriers they experience, how the COVID-19 pandemic changed their lives, and any other issues they choose to raise.
Key Informant Interviews	Learn from leaders or organizations serving populations with the highest needs what they view as root causes, barriers, and service gaps; learn about any specific challenges or windows of opportunity for the community.

Community assessments and research are so often deficit-oriented, geared to identify problems that need to be addressed. Within the constraints of available data, the assessment team deliberately framed as many indicators as possible as positive rather than negative, such as "percent of adults not currently drinking alcohol heavily." That approach does help identify bright spots, but some readers may find the language somewhat awkward or confusing. The data content of the assessment is organized into four sections:

- Bexar County's Residents;
- What We Need for Health;
- How We're Taking Care of Ourselves; and
- How We're Faring.

PLANNING AND CONDUCTING THE ASSESSMENT

Much more information about the assessment approach and methods is available in **Appendix B Technical Notes**; this Executive Summary provides only a high-level overview. The assessment was developed through a collaborative, equity-centered process that prioritized the voices of those most impacted by poor health and social outcomes. The approach intentionally engaged both organizational stakeholders and community residents to ensure that the final report reflects lived experiences, frontline insights, and actionable guidance. Elements of **stakeholder analysis** were

applied to guide stakeholder selection. These tools helped identify individuals and organizations with deep ties to high-need populations, including those facing homelessness, poverty, chronic illness, housing instability, and systemic barriers to care.

The Health Collaborative contracted with Community Information Now (CINow), a nonprofit local data intermediary serving Bexar County and Texas, for quantitative and qualitative data collection, data analysis, and report development. The two organizations worked closely throughout the roughly 10-month assessment period from October 2024 to August 2025.

The Health Collaborative's board, staff leadership, and CINow drafted a CHNA approach, structure and flow, data collection methods and instruments, list of extant data indicators, and timeline for review by a Steering Committee in January 2025. The overall CHNA approach, timeline, workplan of extant data indicators and charts/maps, focus group guide, key informant interview guide, and proposed report flow were presented to the Bexar County CHNA Steering Committee in January 2025. Members were invited to provide feedback on any component; no concerns were voiced in or outside of the meeting to drive changes in the plans or materials.

Extant data indicators for trending and disaggregation were selected from CINow's inventory of 177 indicators for which relevant data is available for Bexar County. The categories below are based on the Bay Area Regional Health Inequities Initiative model used for several prior Bexar County CHNAs. After some discussion by CINow and The Health Collaborative, 90 extant data indicators were selected, with several related to current Community Health Improvement Plan (CHIP) objectives. A total of 153 individual charts (bar and five-year trend) and maps (typically ZIP code/ZCTA) were designed to visualize those 90 indicators.

As The Health Collaborative and CINow were simultaneously conducting CHNAs in five counties (Atascosa, Bexar, Comal, Gillespie, and Guadalupe), much of the work was done once (e.g., key informant interview guide development) for all counties. Similarly, it was more efficient to gather and analyze extant data for all five counties at the same time. Primary data collection, data analysis, and report development was specific to each county.

Bexar Data Dive

Assessment users are encouraged to visit the free online Bexar Data Dive tool at dive.cinow. info to find ma y additional maps, charts, and other indicators not included in this report.

SHARED AND DIFFERING PRIORITIES

This assessment does not try to rate or rank extant data indicators, but it was possible to qualitatively or quantitatively identify key themes and priorities from participants in the community survey, resident focus groups, and leader key informant interviews. The Health Collaborative's Board of Directors was also invited to review the draft report and identify the 10 or so issues they felt were relatively higher-priority for Bexar County's health and well-being, drawing on both their own experience and expertise and the data they had just reviewed. More information about that process is included in **Appendix B Technical Notes.** When priorities were ranked quantitatively, as in a survey question or a section of the prioritization tool, the top half are included here. Those emerging from qualitative data were identified during the thematic analysis using ATLAS.ti.

The following four tables synthesize and organize the priorities that were identified. Priorities that relate directly to the current Healthy Bexar County Community Health Improvement Plan priorities are shown in **magenta highlight**. This list is not intended to be either all-inclusive or prescriptive, but simply to help organize an enormous and diverse collection of data into information that can inform discussion and action.

CROSS-CUTTING ISSUES

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Disenfranchised and Vulnerable People				
Disabled people	+	+		
Elderly	+	+	+	
Formerly incarcerated or on probation	+	+	+	
Immigrants/refugees		+	+	
People with language barriers		+	+	
People with substance use disorders	+	+	+	
Racial/ethnic minorities	+	+	+	
Rural areas, South Side, West Side, other geographic disparities	+	+	+	
Those in foster care	+			
Unhoused people	+	+	+	
Veterans			+	
Youth	+	+	+	
Disparities & Inequities				
COVID-19 raised awareness of systemic disparities		+	+	
Disparities, inequities				+
Funding and Policy Changes				
COVID-19: Organizational changes and funding/ resources			+	
Federal or state policy and funding environment				+
Local policy and funding environment				+
Organizational funding, and how it's affected by politics and government	+	+	+	
Philanthropy and volunteerism		+	+	
Local Communication & Coordination				
Collaboration between organizations	+	+	+	
Community outreach and participation		+	+	
Good communication with local leadership and knowing my voice is heard	+			
Lack of knowledge of community resources		+	+	
Respect and Discrimination				
Feeling accepted and respected by the people around me	+			
Prejudice (racism, sexism, etc.) or discrimination	+			

Priorities that relate directly to the current Healthy Bexar County Community Health Improvement Plan priorities are shown in magenta highlight .

WHAT WE NEED FOR HEALTH

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Access to Care				
Health care provider shortages		+	+	+
Health insurance and medical costs	+	+	+	+
Quality medical care	+			
Quality mental health care	+			
Climate				
Extreme and hazardous weather	+			
Education, Training				
Education or training after high school	+			
Public libraries and educational programs and events	+			
Quality schools for children	+			
COVID-19 affected educational quality		+	+	
Educational attainment				+
Employment, Income, Financial Literacy				
Stable employment with good pay and benefits	+			
Childcare		+	+	
COVID-19 caused job loss		+	+	
Financial literacy			+	
Income and assets				+
Food				
Healthy fresh foods	+			
Food security	+	+	+	+
Green Spaces and Recreation				
Outdoor greenspaces like parks and public land	+			
Safe spaces to exercise and be physically active	+			
Housing				
Housing availability, affordability, and diversity	+	+	+	
Stable and quality housing				+
Safety				
Safety	+	+		
Feeling and being safe while driving	+			
Social Environment				
Social Determinants and interconnected social issues (including education, employment, economic mobility, healthcare, built environment and infrastructure, transportation, walkable areas, and potable water access)	+	+	+	
Transportation that's easy, safe, reliable	+			

HOW WE'RE TAKING CARE OF OURSELVES

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Access to Care				
Applying for services, meeting service criteria, long waitlists, and lack of knowledge of resource availability		+		
COVID-19 drove telemedicine, remote work, and technology	+	+	+	
Healthy Eating and Weight				
Healthy eating				+
Healthy weight				+
Preventive Care and Self-Management				
Childhood vaccinations				+
Diabetic self-management (e.g., foot & HbA1c checks)				+
Health literacy, preventive care, and coordination of care				
Physical activity				+
Routine checkups / wellness visits				+
Routine dental care				+
Screening for breast cancer				+
Screening for cervical cancer				+
Social Support				
Connections with people I/they can count on for help when I/they need it	+			

Framing Note on Priorities Tables

The tables above reflect input from several groups, including community survey respondents, focus group participants, key informants, and The Health Collaborative (THC) Board of Directors. Differences in where the "X's" appear largely reflect the distinct ways each group was engaged. Residents and stakeholders emphasized lived experiences and immediate needs, while the THC Board was asked to consider both the data and a broader system-level perspective.

The resulting prioritization reflects complementary perspectives: community voices illuminate day-to-day barriers and assets, while the Board highlights policy, funding, and structural levers. Together, these inputs provide a fuller and more nuanced understanding of community priorities, revealing points of convergence around issues such as mental health, food security, housing stability, and access to care, as well as opportunities for coordinated action.

HOW WE'RE FARING				
ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Activity Limitations and Disability				+
Alcohol or Substance Use	+			
Substance abuse				+
Alzheimer's or Other Dementia	+			
Autoimmune Disease (Lupus, MS, Rheumatoid Arthritis, etc.)	+			
Cancer	+			
Breast cancer				+
Colon and rectum cancer				+
Liver cancer				+
Prostate cancer				+
Chronic Pain (Back Pain, Joint Pain, Fibromyalgia)	+			
Dental (Tooth or Gum) Problems	+			
Diabetes	+			+
Heart Disease, Stroke, or High Blood Pressure/ Hypertension	+			+
Maternal & Infant Health				
Early and ongoing prenatal care				+
Infant mortality				+
Severe maternal morbidity, maternal mortality				+
Mental Health				
COVID-19 harmed mental health, stress, social interaction	+	+	+	
Depression, anxiety, PTSD, or chronic stress	+			+
Loneliness or social isolation	+			
Other mental illness				+
Sexually Transmitted Infections				
HIV/AIDS				+
Syphilis, congenital syphilis				+

CONCLUSION

The reader of this community health needs assessment will draw their own conclusions about what most stands out in the wealth of Bexar County information presented here, and what challenges and opportunities present themselves. For the authors of this report, however, a handful of big-picture conclusions emerge.

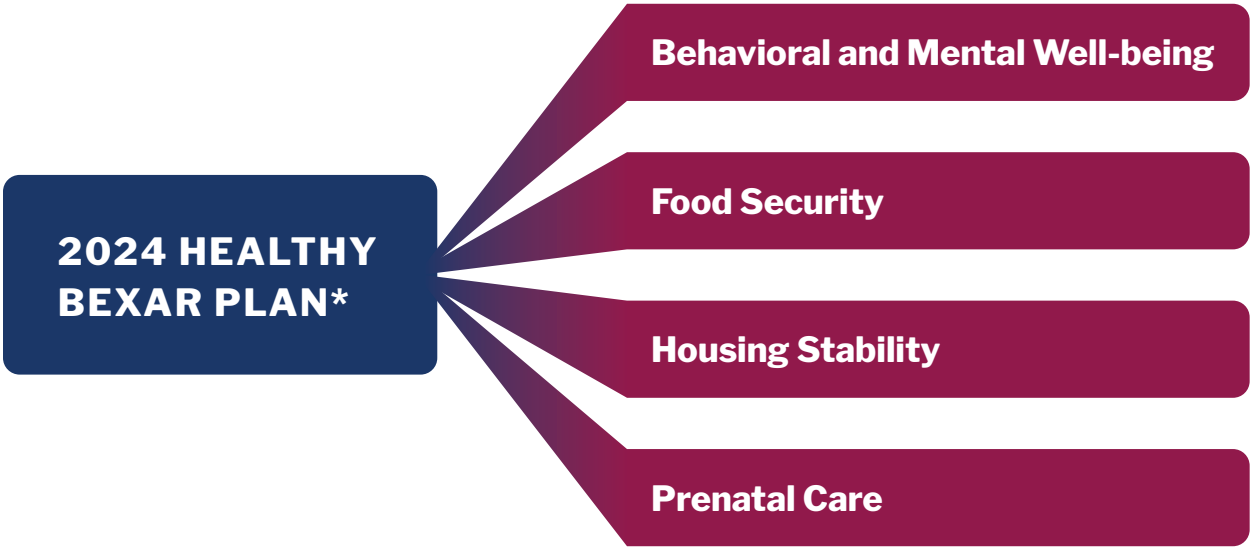
We are far from recovered from the COVID-19 pandemic. Our community continues to suffer the social, economic, and health harms caused directly and indirectly by the pandemic. While it has stopped climbing, the inflation rate

remains stubbornly high, contributing to the high cost of basic goods and services. The housing and job markets remain unbalanced and unstable, and data that paints anything less than a rosy picture is under attack in some quarters. After improving rates of many health-related behaviors in the years leading up to the pandemic – for example, preventive care utilization like prenatal care and school-age vaccinations – those gains have slipped away. Some public health problems are markedly worse than before the pandemic; two ready examples are vaccine hesitancy and pervasive distrust of science and government.

A large proportion of our community is suffering mentally and emotionally. Concern about mental health was a steady drumbeat in survey responses, focus group discussions, and key informant interviews. Mental health challenges are widespread across demographic groups and neighborhoods, and appropriate care is not easy to access even for those with insurance and the means to afford out-of-pocket expenses. And of course, as with chronic physical illness, chronic depression, anxiety, and other mental illness turn the things we most need to do for ourselves – physical movement, for example, and healthy eating and preventive care – the very hardest things to do.

Basic needs and root causes demand our attention. Whether we call them social determinants of health or non-medical drivers of health, we have to talk about them. Issues like food security, decent housing, jobs with a livable wage, and literacy/education are all non-negotiable foundations of health and well-being – not sufficient, but certainly necessary. Like poor mental health, food insecurity and housing instability cropped up again and again in conversations with community members. The same was true for extreme weather, whether unrelenting and concentrated heat, extreme cold as in 2021, or deadly flooding as in recent months. All of these factors intersect, and as a rule, whether a pandemic or a flood or a freeze, it is already-vulnerable people who are hit hardest by disasters and who face the greatest barriers to recovery.

To end on a more positive note, work is already well underway on many of the priorities identified here. Multiple coalitions are tackling mental illness and food insecurity, for example, and several initiatives are addressing varied aspects of the housing shortage. Starting this fall, workgroups will convene around the four priority areas in the **2024 Healthy Bexar Plan:*** behavioral and mental well-being, food security, housing stability, and prenatal care.



* The Health Collaborative, City of San Antonio Metropolitan Health District. (2024). 2024 Healthy Bexar Plan. Retrieved August 11, 2025 from https://www.healthcollaborativechna.com/_files/ugd/67ef5b_fef58731145041308659b12f3aa95653.pdf

BEXAR COUNTY'S RESIDENTS

WHO LIVES IN BEXAR COUNTY

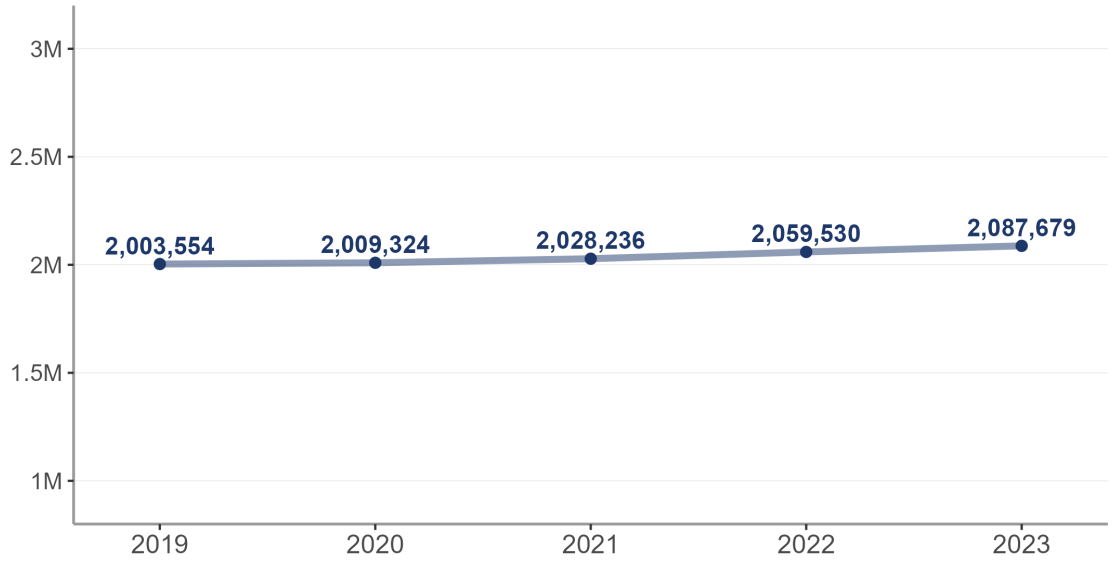
Bexar County, already a vibrant and culturally rich community, continues to experience steady growth. In 2023, the region's largest city, San Antonio, saw the highest population growth of any U.S. city, reaching nearly 1.5 million residents.[1] Yet, the county as a whole includes other surrounding communities and areas, representing a more comprehensive view of trends in the region. This growth reflects the county's welcoming nature, bringing with it shifts in demographics and demands on local infrastructure and services. Understanding who lives in the county is crucial to identifying community needs and supporting the health and well-being of all of its residents.

Population Size and Age

Bexar County's population has grown by over 84,000 residents since 2019, the latest year covered in the report released in 2022, bringing the total to 2,087,679 in 2023 per U.S. Census Bureau American Community Survey estimates (**Fig. 1A.1**).[2] Although the year-to-year change remained positive, the change from 2022 to 2023 (28,149 more residents) was slightly lower than the increase from the prior year, from 2021 to 2022 (31,294 more residents). Notably, the most recent Census population estimate (as of July 1, 2024) for Bexar County puts the population at 2,127,737, suggesting continued growth into the following year.[3]

Fig. 1A.1 Total population

Bexar County, Texas



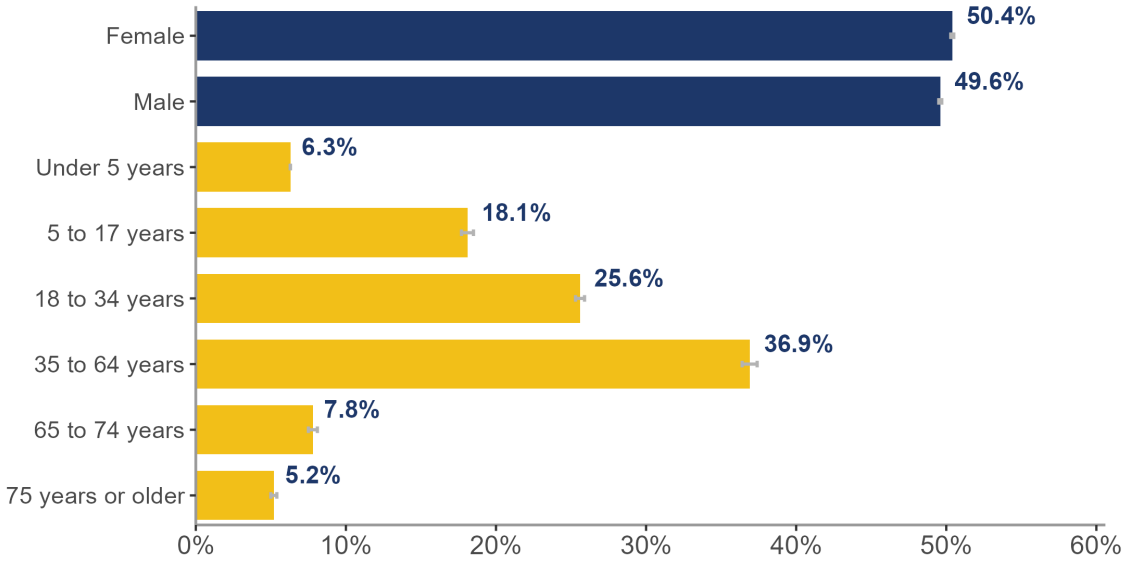
Source: ACS 1-Year Estimates, Table: B01001; 2020 Decennial Census Estimate, Table: DP1
Prepared by CINow for The Health Collaborative

A relatively young population, a majority (63%) of Bexar County residents in 2023 were working-age adults, aged 18 to 64 (**Fig. 1A.2**). Notably, about 18% of the population was school-aged (between five and 17 years old), and about 13% was older residents, aged 65 and older. Female residents made up a slight majority of the population at

50.4%. Unfortunately, the Census Bureau's American Community Survey does not currently collect data on gender identification as a separate concept from sex, nor does it ask respondents about sexual orientation.[4]

Fig. 1A.2 Percent of total population, by sex and age, 2023

Bexar County, Texas



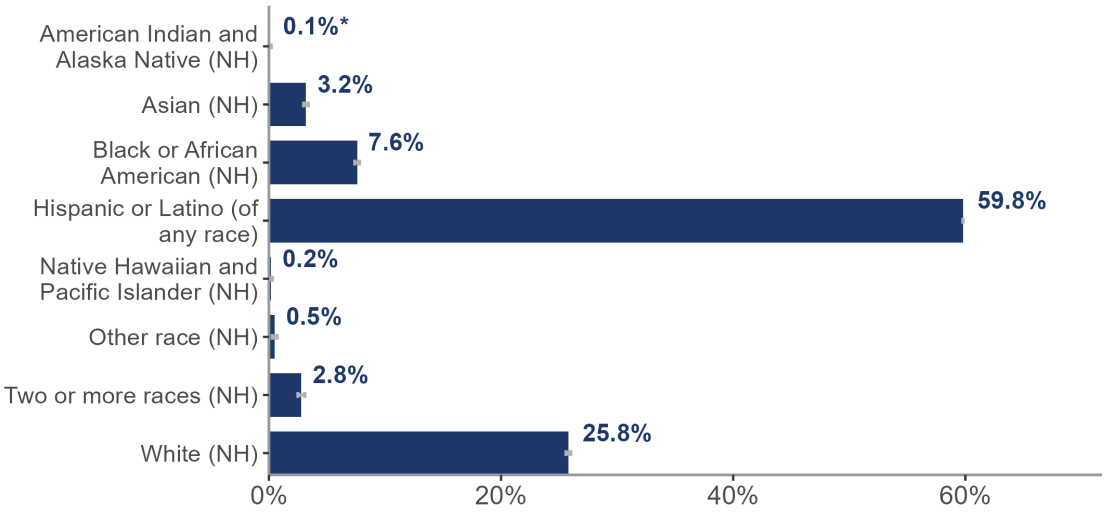
Source: ACS 1-Year Estimates. Table: B01001
Prepared by CINow for The Health Collaborative

Race/Ethnicity and Population Distribution

Almost three-quarters (74%) of Bexar County's population identified as part of a historically underrepresented racial and ethnic group in 2023 **(Fig. 1A.3)**. Still, the county's population lacked significant racial/ethnic diversity,

Fig. 1A.3 Percent of total population, by race/ethnicity, 2023

Bexar County, Texas



NH= Not Hispanic or Latino
*Unreliable: Error is too large relative to estimate.
Source: ACS 1-Year Estimates. Table: DP05
Prepared by CINow for The Health Collaborative

with Hispanic or Latino residents of any race or combination of races making up 60% of the total population. While the non-Hispanic white group was the second largest group, it was less than half the size of the Hispanic or Latino population. Although these groups remained the largest two, each saw a slight decline in their shares of the population since the last report, as the other race/ethnicity groups experienced modest increases in 2023.[5]

ABOUT RACE/ETHNICITY GROUPS

The availability of breakdowns by race (e.g., Asian, American Indian or Alaska Native, Black or African American) and ethnicity (Hispanic or non-Hispanic) depends on how the data source collects and categorizes that information. CINow's general practice is to present the data the same way the data source does, using the same race and/or ethnicity categories, and the same category labels, such as "Latina/o/x" rather than "Hispanic". When the number of people in one or more categories is very small, multiple race/ethnicity categories may be collapsed into one to protect privacy.

The U.S. Census American Community Survey (ACS) typically provides estimates for many detailed race groups, while measuring Hispanic origin separately from race. Where the data allows, CINow's practice is to combine all Hispanic race groups into a single "Hispanic" category that is presented alongside the various non-Hispanic race groups, such as Asian, Black or African American, or Two or More Races. In some charts, the U.S. Census American Community Survey (ACS) provides estimates for Hispanics, for "white alone, not Hispanic or Latino", and for several other single-race groups, for example, "Black or African American alone." In those cases, all race groups except "white alone, not Hispanic or Latino" include both Hispanics and non-Hispanics, which is often noted in the narrative.

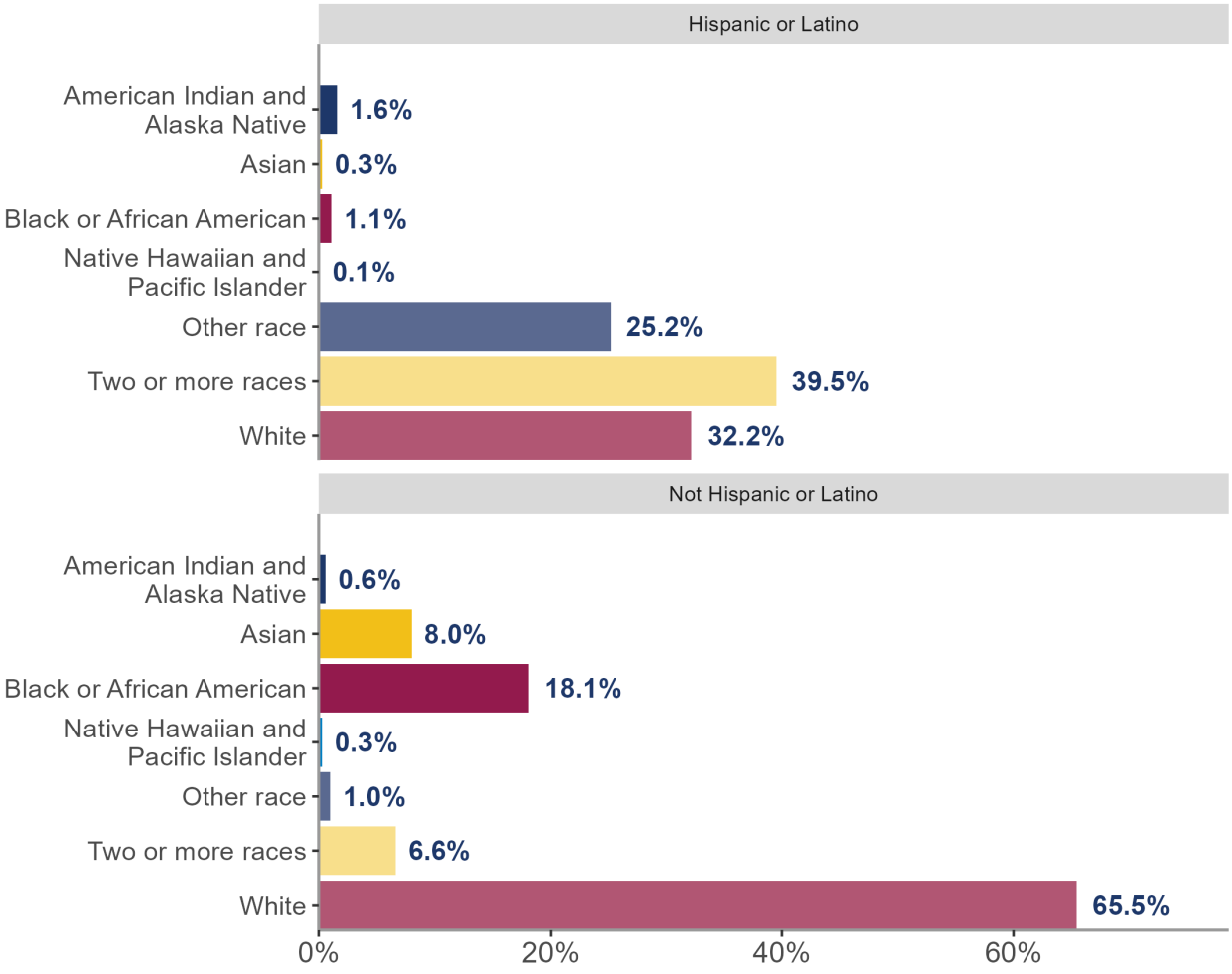
Throughout most of this report and past Bexar County community health needs assessments, Hispanic ethnicity is handled as a parallel category to race categories, and together, all the categories are referred to as "race/ethnicity" groups. New federal guidelines adopted in 2024 will mandate a similar approach nationwide, as well as add Middle Eastern or North African, previously categorized as white, as a new required "minimum reporting" category.[6]

It is important to know, though, that residents of Bexar County who identify as Hispanic vary in how they identify in terms of race. The 2020 Census allowed respondents more flexibility than past Decennial Censes in how they describe themselves in terms of race and ethnicity. About 40% of Hispanic Bexar County residents identified with two or more racial groups (**Fig. 1A.4**), as compared to just 7% of non-Hispanic residents. Although not shown in this chart, "some other race" was part of the racial identity of an estimated 92% of Hispanics who identified as two races.[7] Of note, the proportion of "three or more races" that includes "some other race" is not published by the Census Bureau. Adding that number to the number of Hispanics identifying as "some other race alone", at least 66% of Bexar County

Hispanic residents described their race in whole or in part as “some other race,” compared to just 3% of non-Hispanic residents. It appears that a large majority of Bexar County residents who identify as Hispanic are dissatisfied with the race options available to them in the Census questionnaire.

Fig. 1A.4 Percent of Hispanic and non-Hispanic populations, by race, 2020

Bexar County, Texas

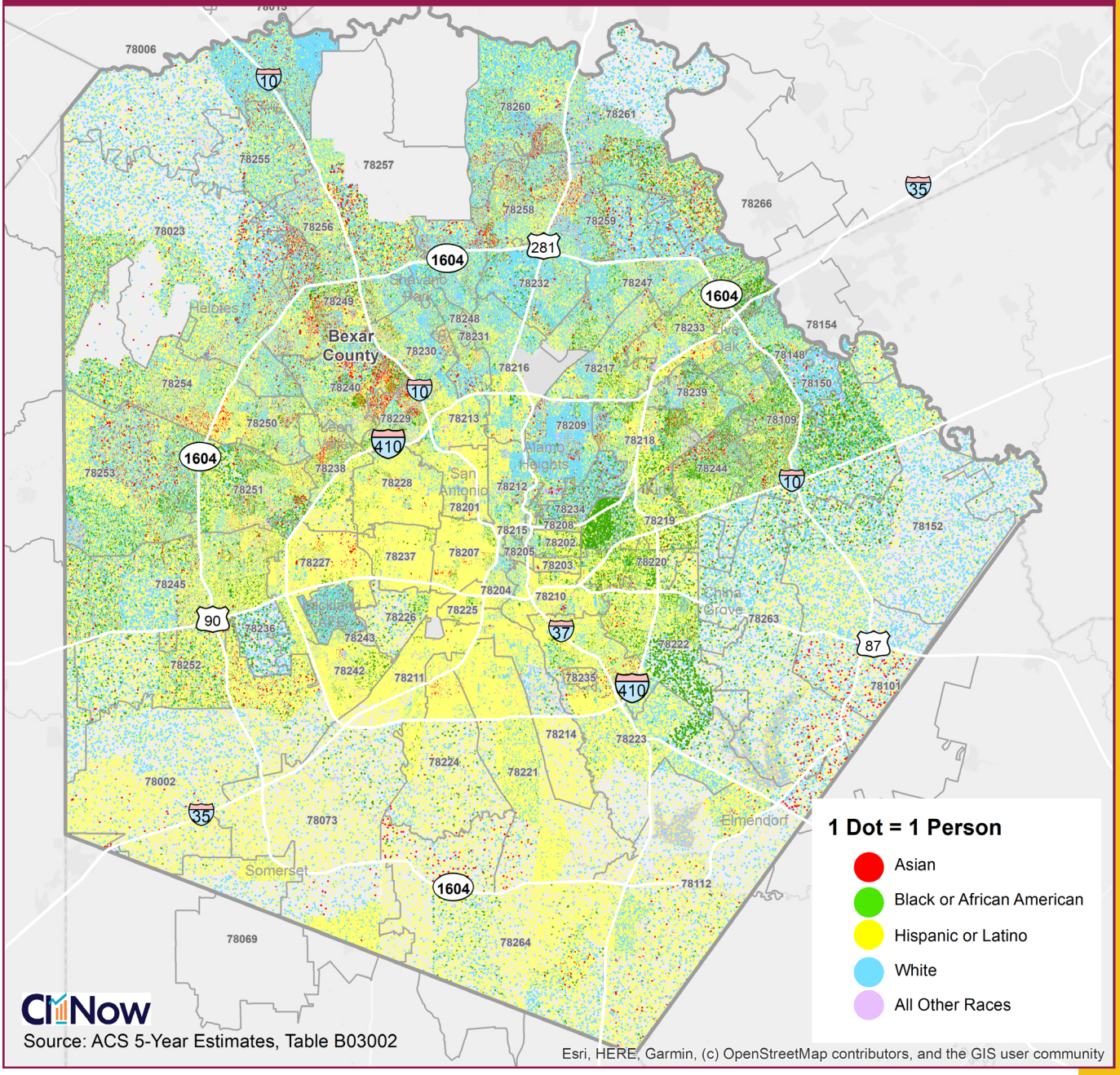


Source: 2020 Decennial Census Estimate. Table: DP1
Prepared by CINow for The Health Collaborative

Race and ethnic geographic distributions in Bexar County remain largely consistent with the last community health needs assessment in 2022. Although the county is not nearly as racially/ethnically segregated as many other urban areas, geographic patterns are still visible, as shown on the following dot-density map (**Fig. 1A.5**). Gray areas on the map indicate Government Canyon State Natural Area, Joint Base San Antonio - Camp Bullis, and the San Antonio International Airport area. Note that the dots show general population patterns and do not represent exact addresses.

- Hispanic residents are found throughout the county, with the highest concentrations inside Loop 410 and on the southside outside of the Loop. The area within Loop, excluding the northeast and southeast corners, shows the least variation in dot colors on the map, indicating a relatively homogenous Hispanic population compared to the rest of the county.

Fig. 1A.5 Population distribution, by race/ethnicity, 2023

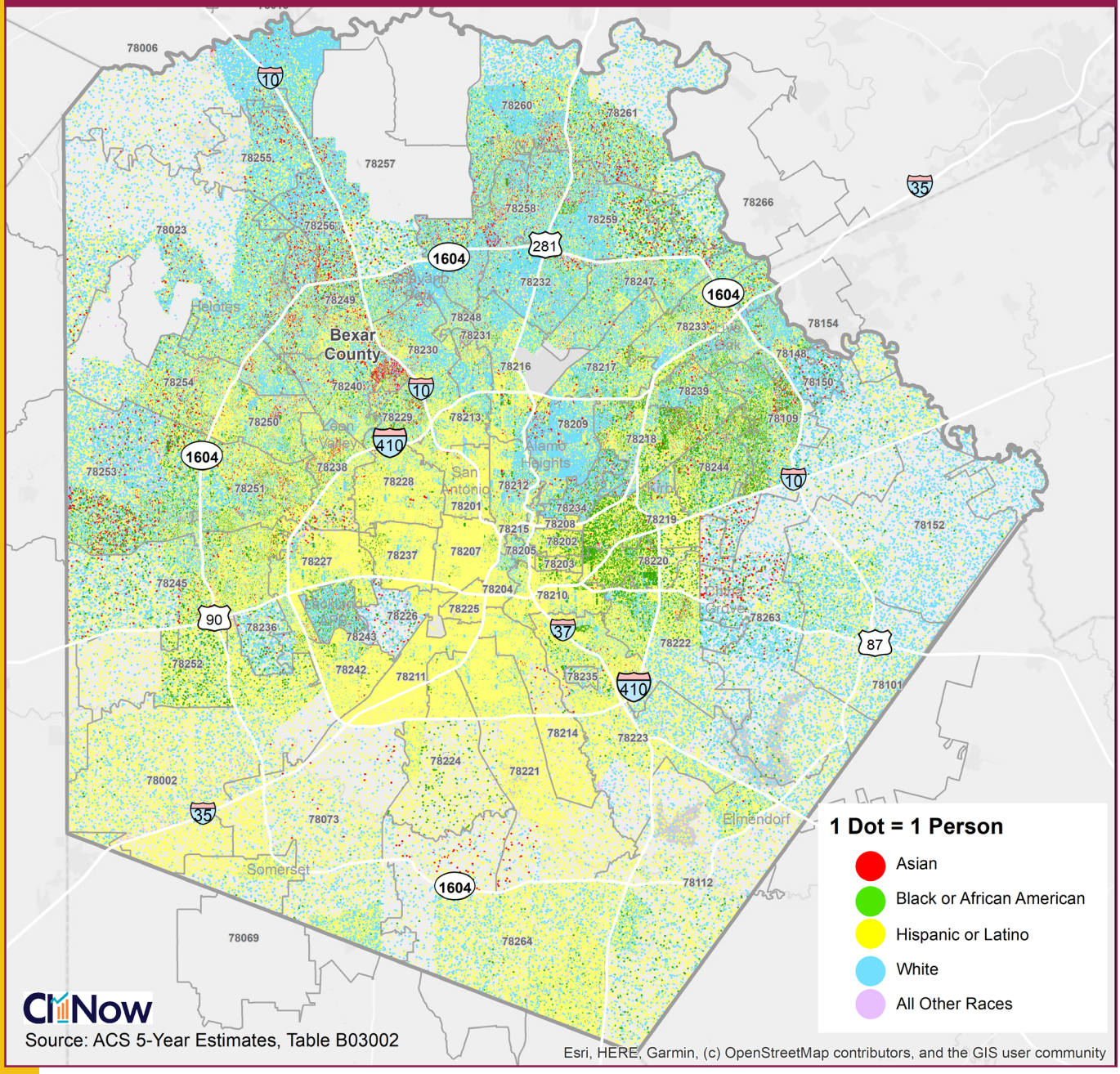


Source: ACS 5-Year Estimates, Table B03002

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

- Asian residents are disproportionately concentrated on the northwest side, particularly near the Medical Center and the University of Texas at San Antonio campus along Loop 1604, with smaller clusters on the edges outside of Loop 1604.
- Black or African American residents are disproportionately represented on the east side, especially in the near east side, northeast, and southeast areas.
- While clusters of white residents are mostly located on the outskirts of the county, beyond Loop 410 and past Loop 1604, there are notable concentrations within Loop 410 as well, particularly near Lackland Air Force Base and in the Alamo Heights areas.

Fig. 1A.6 Population distribution, by race/ethnicity, 2013



The next dot-density map shows the population distribution for the county a decade earlier, in 2013 (**Fig. 1A.6**). A comparison of the two maps, which use American Community Survey five-year estimates, makes it clear both that the county population has grown in that period and that development has spread across the southside and far northside.

EXPLORING SOCIAL CHARACTERISTICS

Beyond the county population's size and makeup, it is also important to explore the social characteristics that shape daily life and influence community needs. Indicators such as language use, veteran status, educational attainment, and other key factors provide valuable insight into the diverse experiences, opportunities, and challenges faced by residents across the county.

Language

The city's efforts to better reach and connect with its diverse population speak to the rich culture and demographic diversity of San Antonio and Bexar County. As the population continues to grow, it is crucial that all residents have access to communications in their preferred language. Language access services, such as translated documents and the provision of interpreters and translation services, are important in ensuring that all residents have equal access to health and well-being services and programs. This is especially important for targeted outreach and communication during emergencies.

The following table screenshot shows the proposed language tiers developed from a 2022 language access study for the City of San Antonio's Diversity, Equity, Accessibility, and Inclusion Department by CINow.[8] The table outlines recommendations for language access services based on the most commonly spoken languages in San Antonio and Bexar County, the neighborhoods where they are most prevalent, and the frequency of resident interaction with city health and school-based systems. Because residents come from many different backgrounds, some languages are not on the list; however, residents can still request language services if needed.

At Tier 1, the most common languages besides English spoken in Bexar County are Spanish and American Sign Language. Other languages, spoken by between about 1,000 and 4,000 residents, include Vietnamese, Arabic, Chinese, Korean, Tagalog, Gujarati, and Pashto.

LANGUAGE TIERS

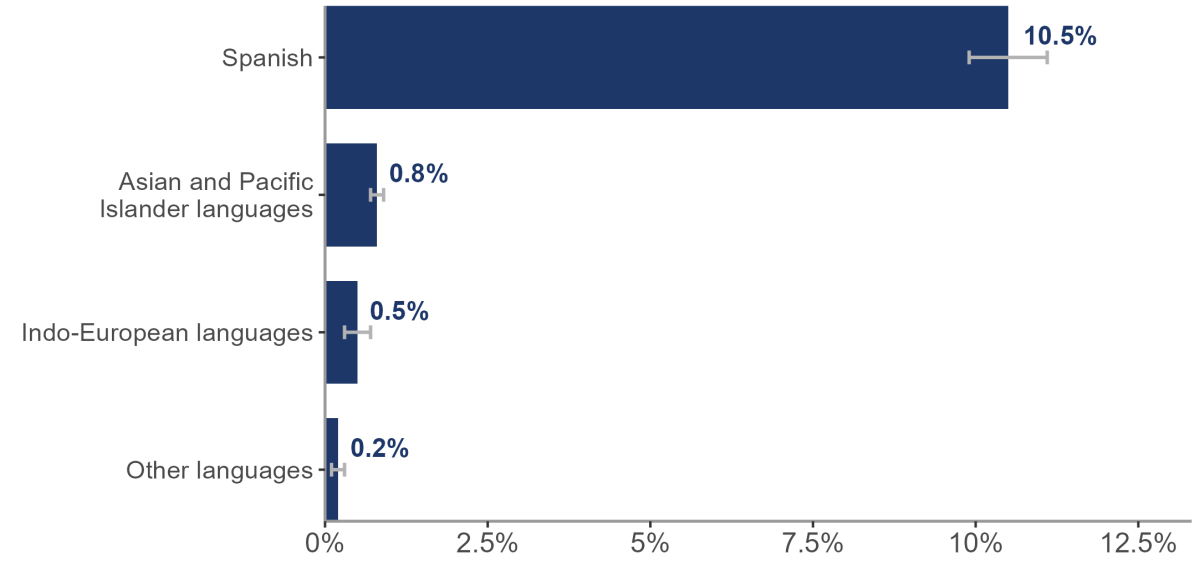
TIER	LANGUAGE	RECOMMENDATION	DETAILS
Tier 1	Spanish & American Sign Language	Translation & Interpretation Required	Vital documents must be translated and needs for interpretation must be anticipated.
Tier 2	Arabic	Translation Recommended & Interpretation Upon Request	If feasible translate vital documents and prioritize translation of materials that affect resident safety. Increased outreach and engagement through partnership is recommended.
	Vietnamese		
	Pashto		
Tier 3	Korean	Translation Encouraged & Interpretation Upon Request	Consider including these languages for translation, prioritize translation of materials that affect safety. Increased outreach and engagement through partnership is recommended.
	Tagalog		
	Chinese		
	Gujarati		

Language Access Office - Diversity, Equity, Inclusion, & Accessibility
Source: City of San Antonio Language Access Office Presentation to City Council, February 2023

Fig. 1B.1 shows the percentage of the population aged five and older who self-reported speaking English less than "very well" in the Census Bureau's American Community Survey (ACS), along with the language group (other than English) spoken at home. In 2023, 12% of all residents over five years old reported speaking English less than "very well," and Spanish was by far the predominant non-English language, spoken at home by 11% of all residents over five years old reported speaking English less than "very well."

Fig. 1B.1 Percent of population aged 5 and older who speak English less than "very well", by other primary language, 2023

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: DP02
Prepared by CINow for The Health Collaborative

Community voices explained how, even though there is an abundance of resources, there are complex and interrelated challenges to accessing them, including language barriers.

"It's difficult for my mom to go to her appointments without my help. She has low literacy and language barriers; also, she is not tech savvy. It can be daunting for folks to check-in on iPad and even park in parking garage. I think that CHWs could help in some of these instances."

– CHNA Community Survey Respondent

Offering a frontline perspective, a key informant from an organization serving vulnerable people in crisis, identified eterans as being one of the most at-risk groups facing barriers to care. They emphasized veterans' need for better access to health services and housing and highlighted how people are part of more than one of these populations, which multiplies their disparities and lack of access to resources and services.

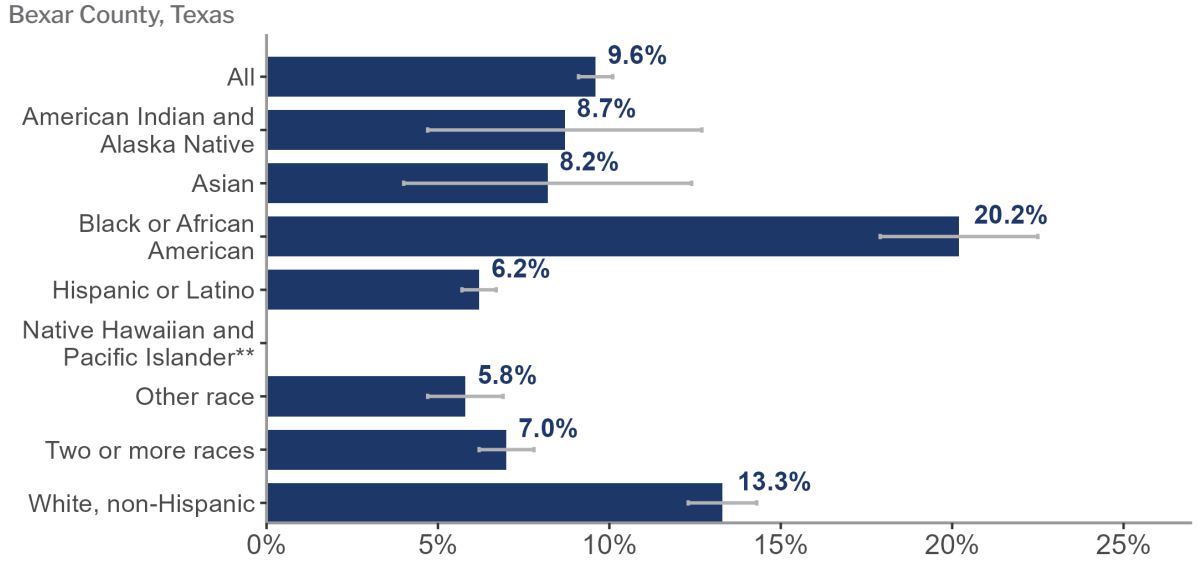
"We serve the most vulnerable populations... We serve homeless, we serve those with substance use disorder, veterans, children. Any people in distress [that] tend to have challenges getting access to services. We serve them."

– CHNA Key Informant representing an organization that serves vulnerable people in crisis

Veterans

About 10% of Bexar County's civilian adult population is military veterans. That proportion is notably higher for Black or African American adults (20%), including both Hispanic and non-Hispanic individuals. Followed by white residents, of whom 13% are veterans, the proportions in these two groups are higher than other race/ethnic groups. Other differences in **Figure 1B.2** should be interpreted with caution given the wide and overlapping margins of error.

Fig. 1B.2 Percent of civilian population aged 18 and older who are veterans, by race/ethnicity, 2023



**Suppressed by data source.
Source: ACS 1-Year Estimates. Tables: B21001, C21001 B-I
Prepared by CINow for The Health Collaborative

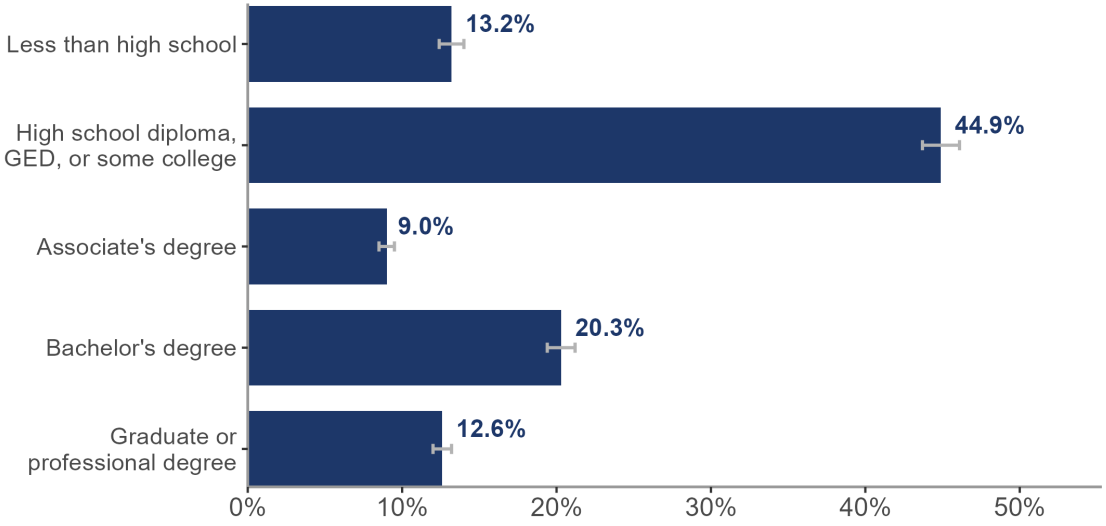
Education

The majority of Bexar County's population aged 25 and over had relatively low educational attainment in 2023 (**Fig. 1B.3**). Nearly half (45%) of residents reported that a high school diploma or GED was their highest level of education, and another 13% had not completed high school. Still, a third of the population completed a Bachelor's degree (20%) and or a graduate or professional degree (13%) as their highest level of education.

Because the American Community Survey (ACS) data does not capture non-degree certificate or certification credentials, it likely underestimates the proportion of the population with some kind of postsecondary education and training outside of traditional degree pathways. Even so, with the link between health and education well-documented, low educational attainment has strong negative implications for Bexar County's health status.[9] Because education shapes access to jobs, income, and health knowledge, higher educational attainment can significantly improve a population's overall health and well-being.

Fig. 1B.3 Percent of population aged 25 and older, by highest level of education completed, 2023

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: DP02
Prepared by CINow for The Health Collaborative

Access to education is further shaped by intersecting social factors, as shown in the following two figures, **Figure 1B.4** and **1B.5**. In these charts, the bars show how education levels break down within specific gender and race/ethnicity groups for 2023. With overlapping margins of error, differences among groups should be interpreted with caution.

Overall, there are some differences between female and male residents where a slightly higher share of females had a Bachelor's degree or higher (34% versus 32%) and Associate's degrees (10% versus 8%). When broken down by race/ethnicity, most trends are consistent with the previous chart.

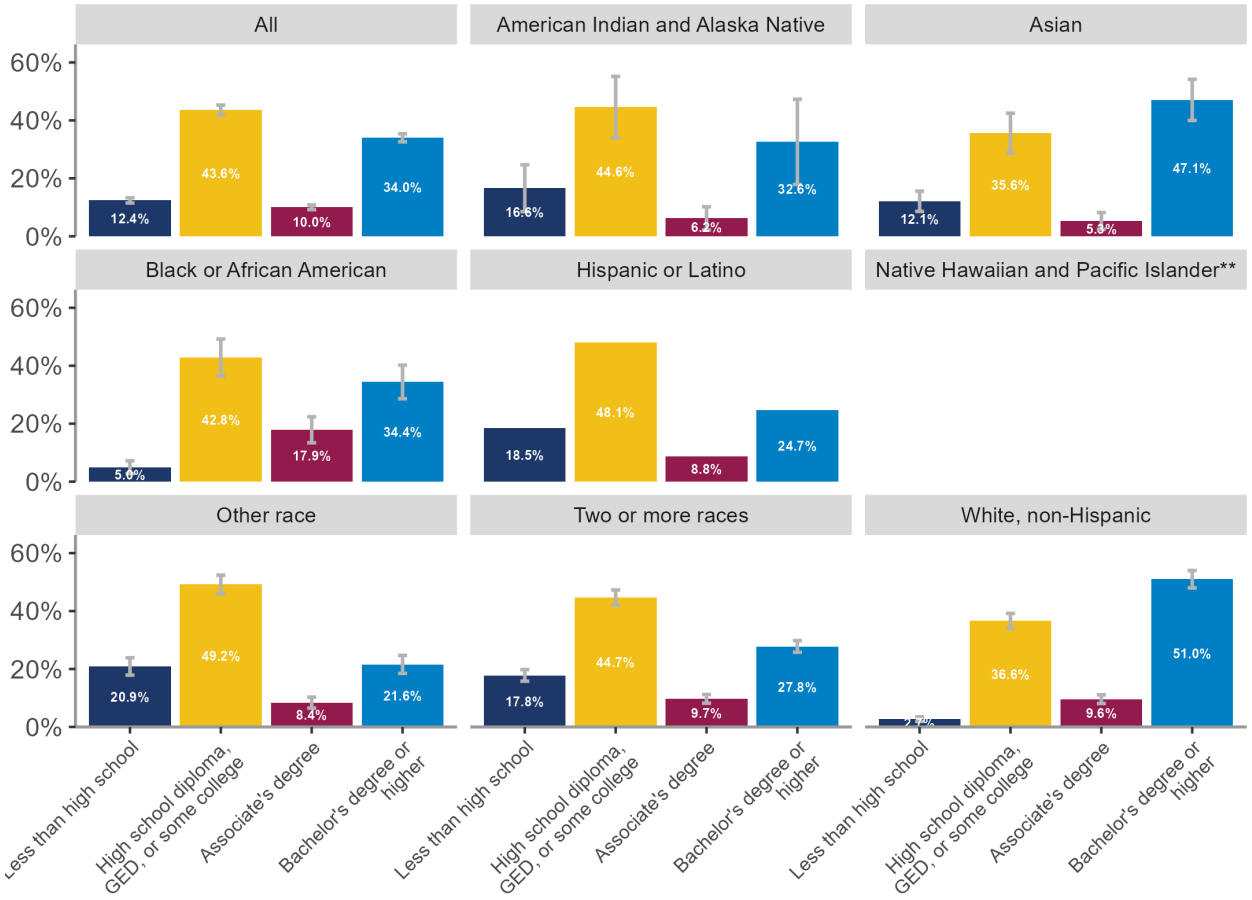
The largest share in most groups holds a high school diploma or GED, followed by a Bachelor's degree or higher—except for white women and men, for whom a Bachelor's degree or higher is the most common education level (51%, 50% respectively). Asian women (47%) and men (46%) have a similar pattern, though their margins of error slightly overlap.

By the same token, compared to the overall population, the smallest shares in most groups hold an Associate's degree, followed by those with less than high school education. Exceptions include Black women, white women, and white men, who are least likely to have less than a high school education (5%, 3%, and 3%, respectively).

Although disparities in access to education contribute to unequal patterns of educational attainment, cases such as the relatively low share of Black women with less than a high school education point to the importance of examining not only where barriers persist, but also where resilience and contextual factors may be contributing to positive outcomes.

Fig. 1B.4 Percent of female population 25 years and older, by race/ethnicity and highest level of education completed, 2023

Bexar County, Texas

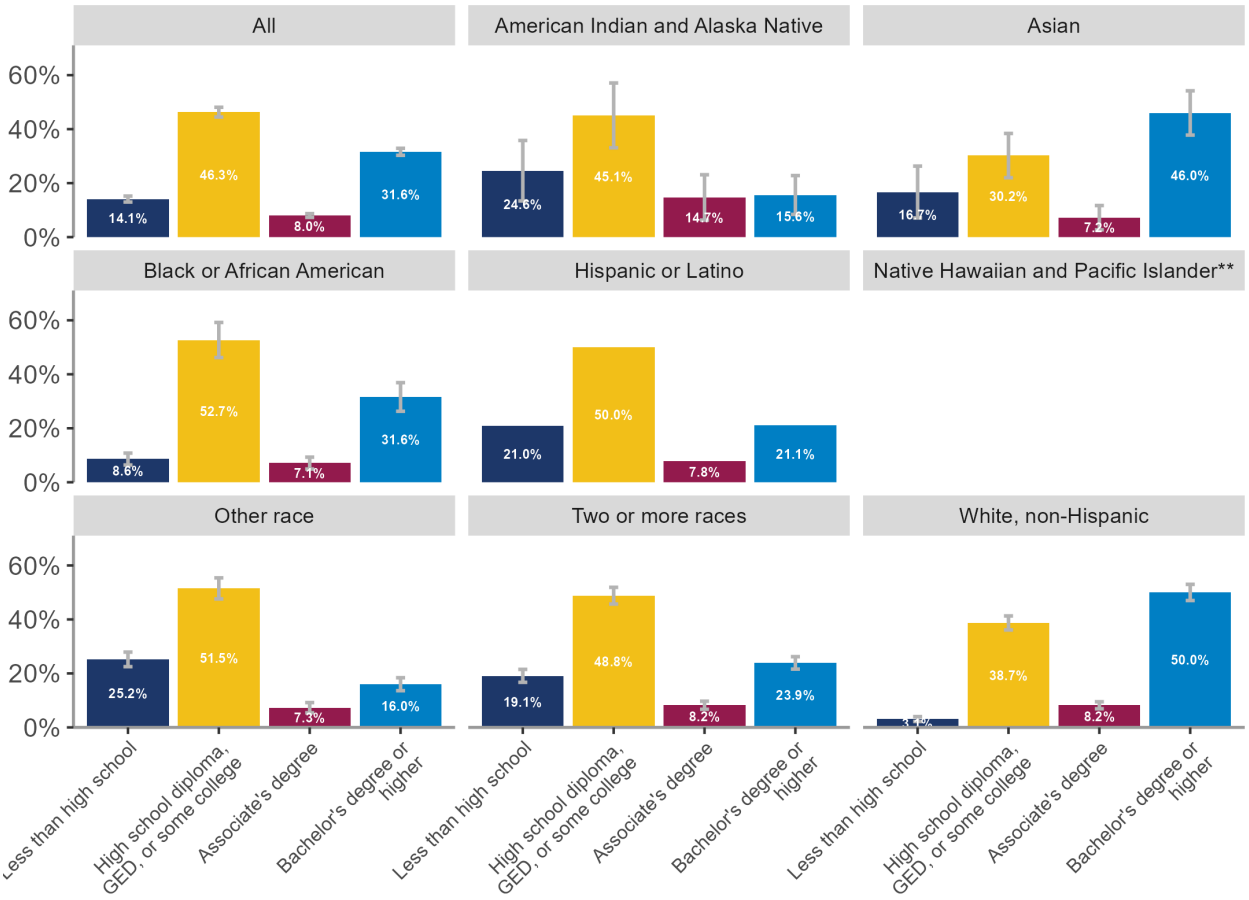


**Suppressed by data source.
Source: ACS 1-Year Estimates. Tables: C15002, B15002 B-I
Prepared by CINow for The Health Collaborative

- Less than high school
- High school diploma, GED, or some college
- Associate's degree
- Bachelor's degree or higher

Fig. 1B.5 Percent of male population 25 years and older, by race/ethnicity and highest level of education completed, 2023

Bexar County, Texas



**Suppressed by data source.
Source: ACS 1-Year Estimates. Tables: C15002, B15002 B-I
Prepared by CINow for The Health Collaborative

- Less than high school
- High school diploma, GED, or some college
- Associate's degree
- Bachelor's degree or higher

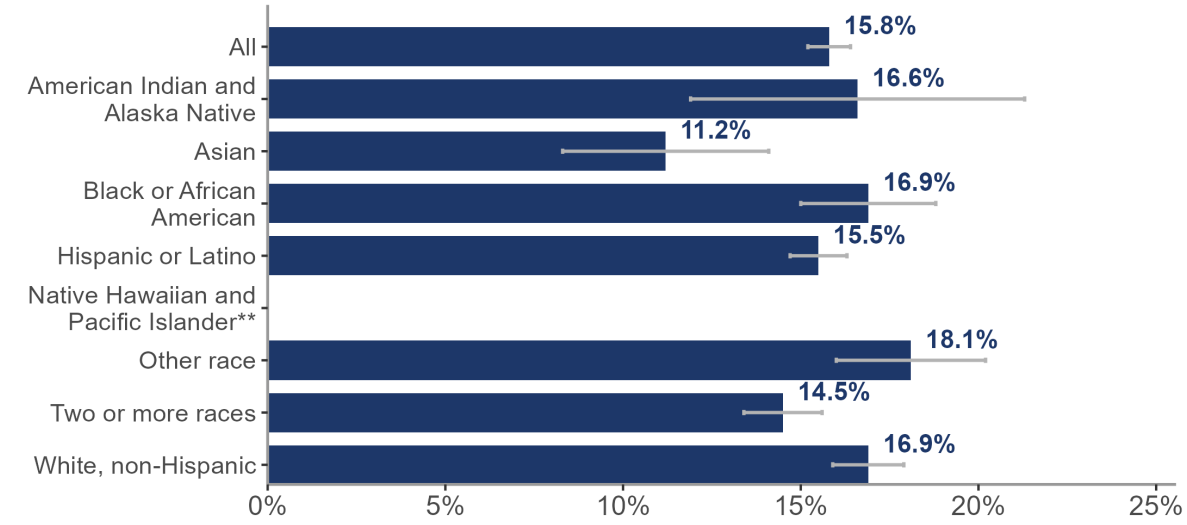
Disability

Among Bexar County's civilian non-institutionalized population (that is, not living in institutions like nursing homes, mental health facilities, or prisons), 16% live with one or more disabilities. That percentage varies by race/ethnicity (**Fig. 1B.6**), and apparent differences among groups may not be real due to overlapping margins of error. The lowest disability rates were among the Asian (11%) and "Two or more races" (15%) groups, with margins of error that did not overlap with several other groups, indicating a statistically significant difference.

Not shown in this chart, Bexar County disability rates are higher than those of Dallas, El Paso, Harris, Tarrant, or Travis Counties in every major age group (under 18, 18 to 64, 65 and older). For example, 14% and 42% of Bexar County residents aged 18 to 64 and 65 or older, respectively, live with one or more disabilities. Among Travis County (Austin area) residents, however, those age group percentages are just 9% and 29% - roughly 30% lower than Bexar County.[10]

Fig. 1B.6 Percent of civilian, non-institutionalized population with a disability, by race/ethnicity, 2023

Bexar County, Texas



**Suppressed by data source.
Source: ACS 1-Year Estimates. Table: S1810
Prepared by CINow for The Health Collaborative

Anytime community voice participants spoke about difficulties surrounding COVID-19, medical barriers, community support and resources, safety, mental health, housing, extreme weather conditions, transportation, food security, or almost any other topic, they also discussed how all of these are exacerbated for disenfranchised, excluded, or "forgotten about" populations, including people with disabilities.

"Access to healthcare that is more affordable for the same reason. A person with a disability who is not eligible for SSI or SSDI should not feel they cannot take care of basic needs such as medical care, food and housing due to not having a way to pay."

– CHNA Community Survey Respondent

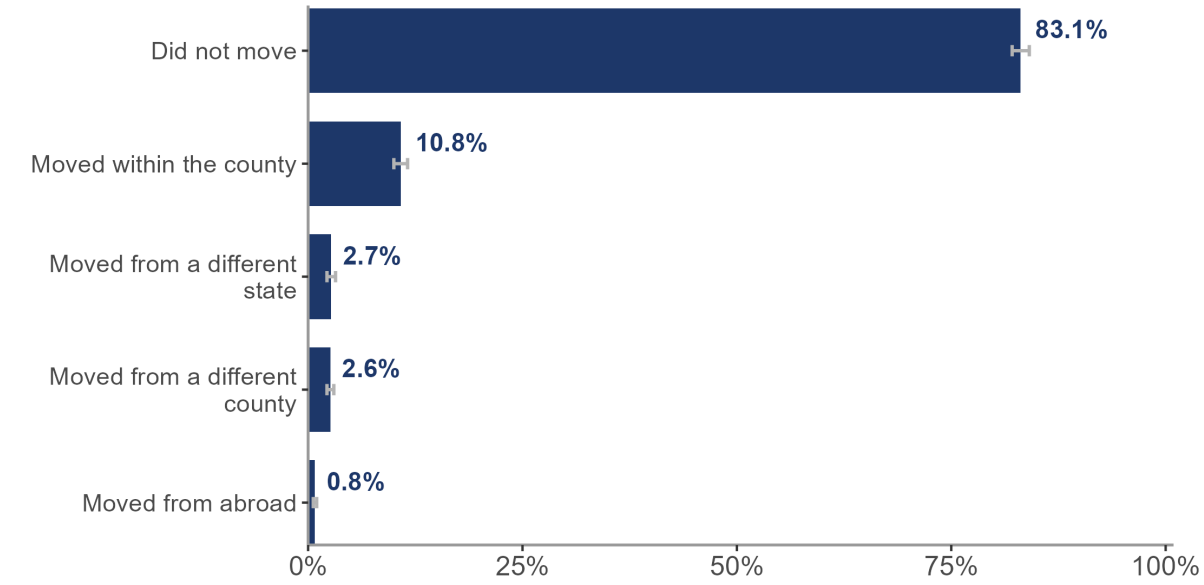
Households

As of 2023, about eight in 10 residents lived in the same place that they were in the year prior (**Fig. 1B.7**). Of those residents who moved during the year, most had moved within the county; only 6% of residents overall moved into Bexar from either a different county, a different state, or abroad. The proportion who moved within the county in the past year (11%) is higher than that proportion in both Texas (6%, also from 2023 Table DP02) and the U.S. overall (7%), which indicates relatively high within-county residential "churn."

While an in-county move can certainly be an indicator of something positive, like moving from an rental to one's first owned home or from one student housing unit to another, it can also be an indicator of moves triggered by high housing costs, eviction, or foreclosure. Looking at percent moving within Bexar County for various demographic groups, rates are highest for young adults aged 18 to 34 (17%), young children under five (16%), people with incomes below the federal poverty line (14%), non-citizens (12%), and renters (19%). Rates are lowest for homeowners (6%), people earning $75,000 or more per year (8%), widowed people (6%), and people aged 75 or older (4%).[11]

Fig. 1B.7 Percent of total population, by residence one year prior, 2023

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: DP02
Prepared by CINow for The Health Collaborative

Though less common than other household types, single-parent households still face unique challenges, as echoed by a focus group participant who refle ted on the struggles of local families in similar situations.

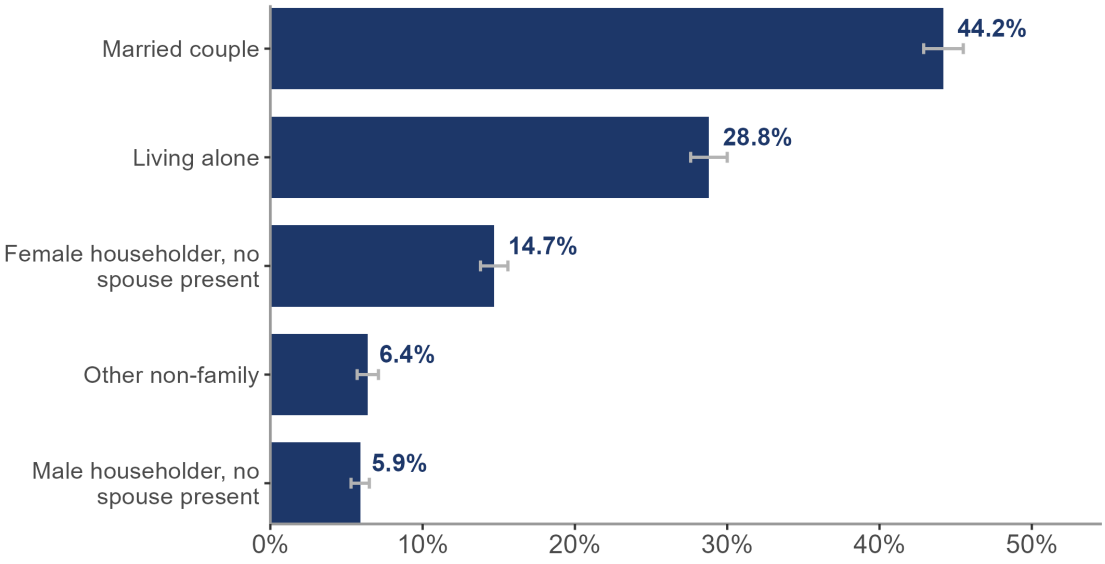
"We did an event, might have been 2 weeks ago or 3 weeks ago. We [the church] went door to door and we got all the kids' shoe sizes, and we had a big event here for the youth, and I was just so overwhelmed and moved [with] how many kids that we had that needed help, and also that a lot of them were single parents in the home. They had 3 or 4 kids, so they're doing the best they can as a mom. And one was a dad that was a single parent. But he's trying to work 2 jobs. So, the kids are basically kind of raising themselves. So, how can we get in as a community and support them?"

– CHNA Focus Group #2 Participant

Figure 1B.8 shows the distribution of household types in Bexar County. Married couple households were the most common type at 44%. The second most common type, at nearly a third of households, was individuals living alone (29%). Even when combined, male or female householders with no spouse present were less common than either of the top two categories. Notably, there were many more single female householders with no spouse present (15%) than their male counterparts (6%), by more than two to one. In fact, single male householder households with no spouse present and other non-family living arrangements remained the least common household type.

Fig. 1B.8 Percent of total households, by household type, 2023

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: B11001
Prepared by CINow for The Health Collaborative

WHAT WE NEED FOR HEALTH

WHAT WE HEARD FROM THE COMMUNITY

As part of the assessment, CINow conducted a community survey to gather qualitative insights and a broader perspective on health and well-being in Bexar County. The Community Health Needs Assessment (CHNA) Community Survey included a range of questions about what matters most to residents and their loved ones when it comes to health. Because it was a convenience sample, meaning that participants were not randomly selected, the results offer meaningful insights but should not be seen as representing the county population as a whole. A total of 162 Bexar County residents participated; the race/ethnicity distribution looked much like Bexar County's, but many ZIP codes were not represented, and respondents were disproportionately female (67%). A profile of respondents' demographic characteristics and geographic distribution can be found in **Appendix B: Technical Notes.**

Resource Priorities and Access

CHNA Community Survey respondents identified the issues or resources they felt made the biggest positive difference to their own and their loved ones' health and well-being. **Figures 2A.1** and **2A.2** show the top 15 resources reported by female and male respondents, respectively. Due to small respondent counts, data for respondents identifying as non-binary is suppressed for privacy in these two charts.

Healthy fresh foods were selected by about 65% of both females and males, but the priority differed by sex for the next 14 resources. Females highly prioritized stable employment with good health benefits (48%), quality mental health care (46%), quality medical care (45%), and clean air and water (43%). Males were more likely to prioritize connections with people who can be counted on for help when needed (56%), outdoor green spaces (51%), clean air and water (49%), and safe spaces to be physically active (47%).

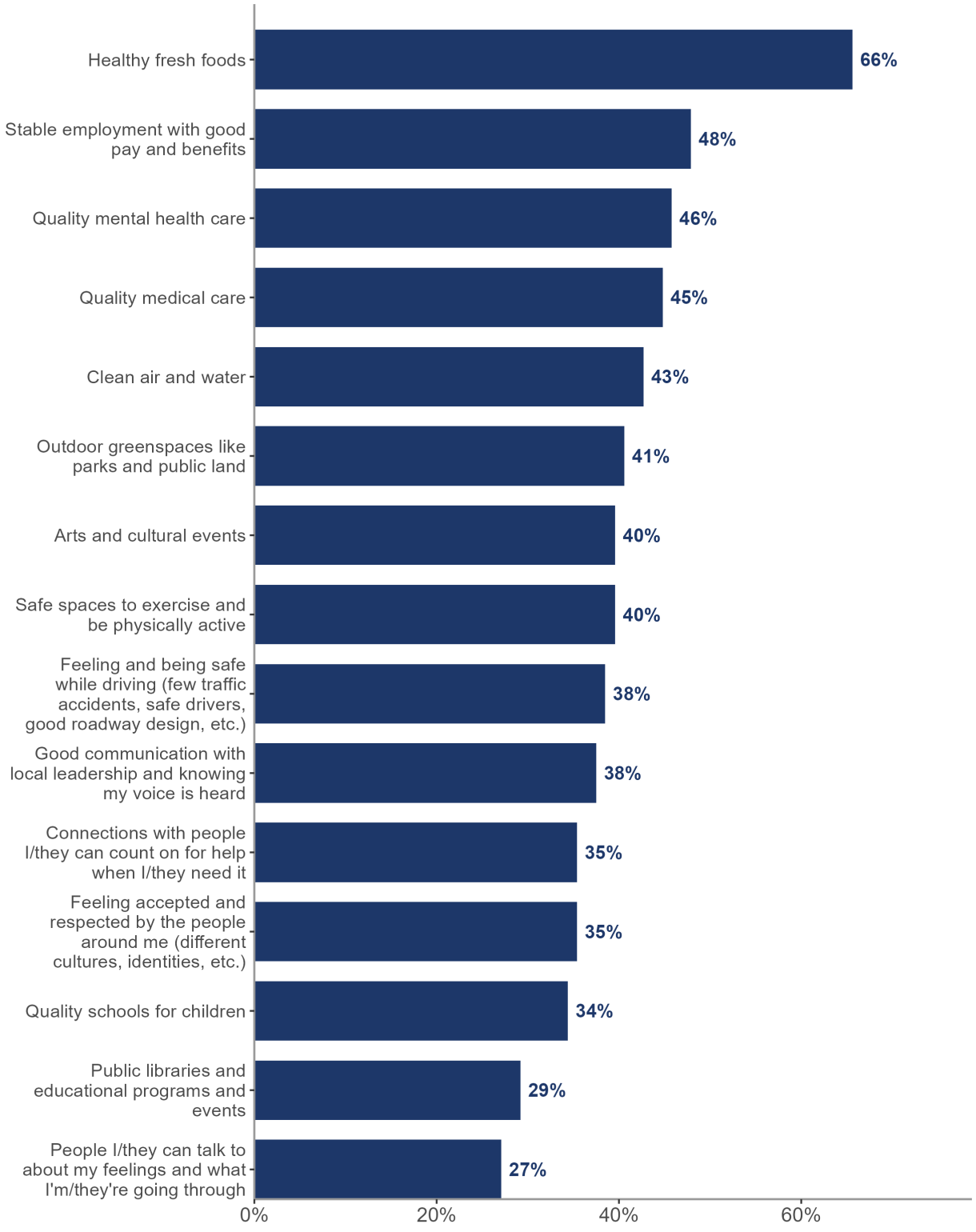
The number of CHNA Community Survey respondents is very small for all race/ethnicity groups except Hispanic or Latino/a/x (n=91, or 55%), white (47, 28%), and Black (11, 7%), mirroring the county population, so the data in **Fig. 2A.3** should be interpreted with caution for those smaller groups.*

- The proportion of Hispanics prioritizing these resources was similar to the all-respondent percentage for each of the five resources.
- White respondents were less likely than respondents overall to prioritize healthy fresh foods (53%) or quality mental health care (38%).
- Black or African American respondents were much more likely to prioritize fresh healthy foods (80%) and clean air and water (70%), and less likely to prioritize stable employment with good pay and benefits (30%).

* Low counts for some race/ethnicity groups or other smaller groups may create "bounce", or fluctuation, that exaggerates differences.

Fig. 2A.1 Top 15 resources female CHNA survey respondents rated as important to their own or their loved ones' health and well-being, 2025

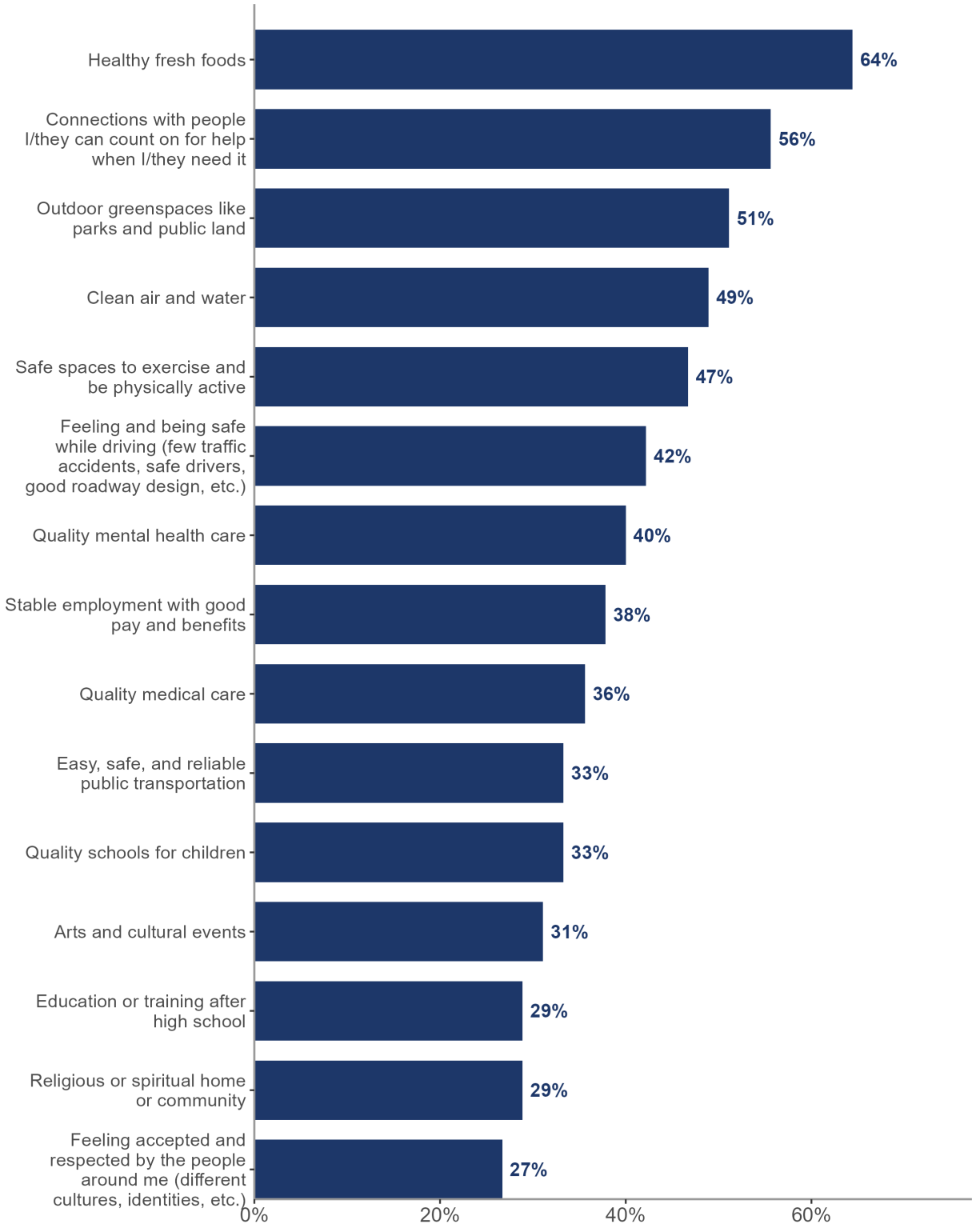
Bexar County, Texas



N= 96 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Fig. 2A.2 Top 15 resources male CHNA survey respondents rated as important to their own or their loved ones' health and well-being, 2025

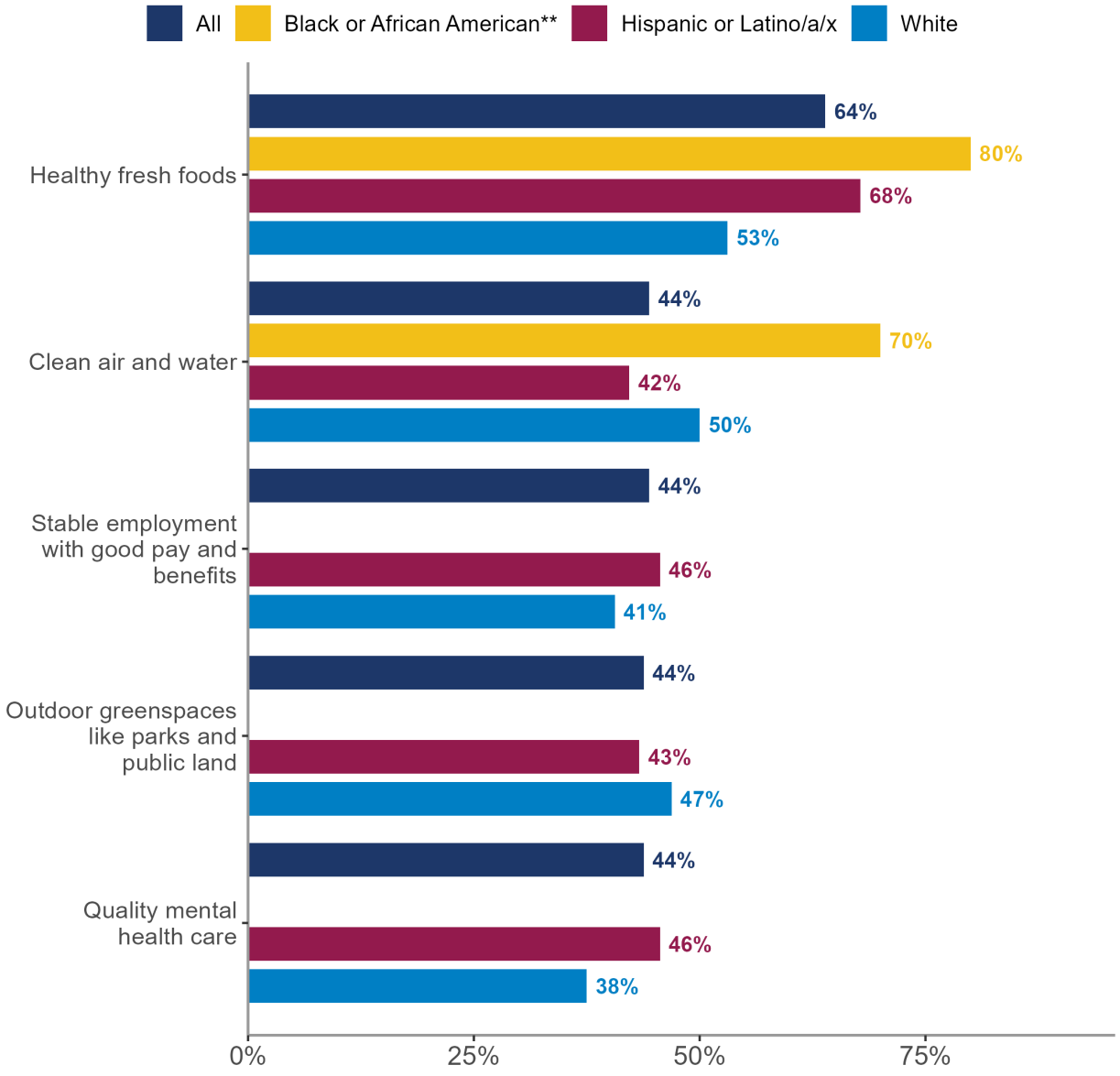
Bexar County, Texas



N= 45 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Fig. 2A.3 Top 5 resources CHNA survey respondents rated as important to their own or their loved ones' health and well-being, by race/ethnicity, 2025

Bexar County, Texas



**Data suppressed for privacy for race/ethnicity groups not shown.
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

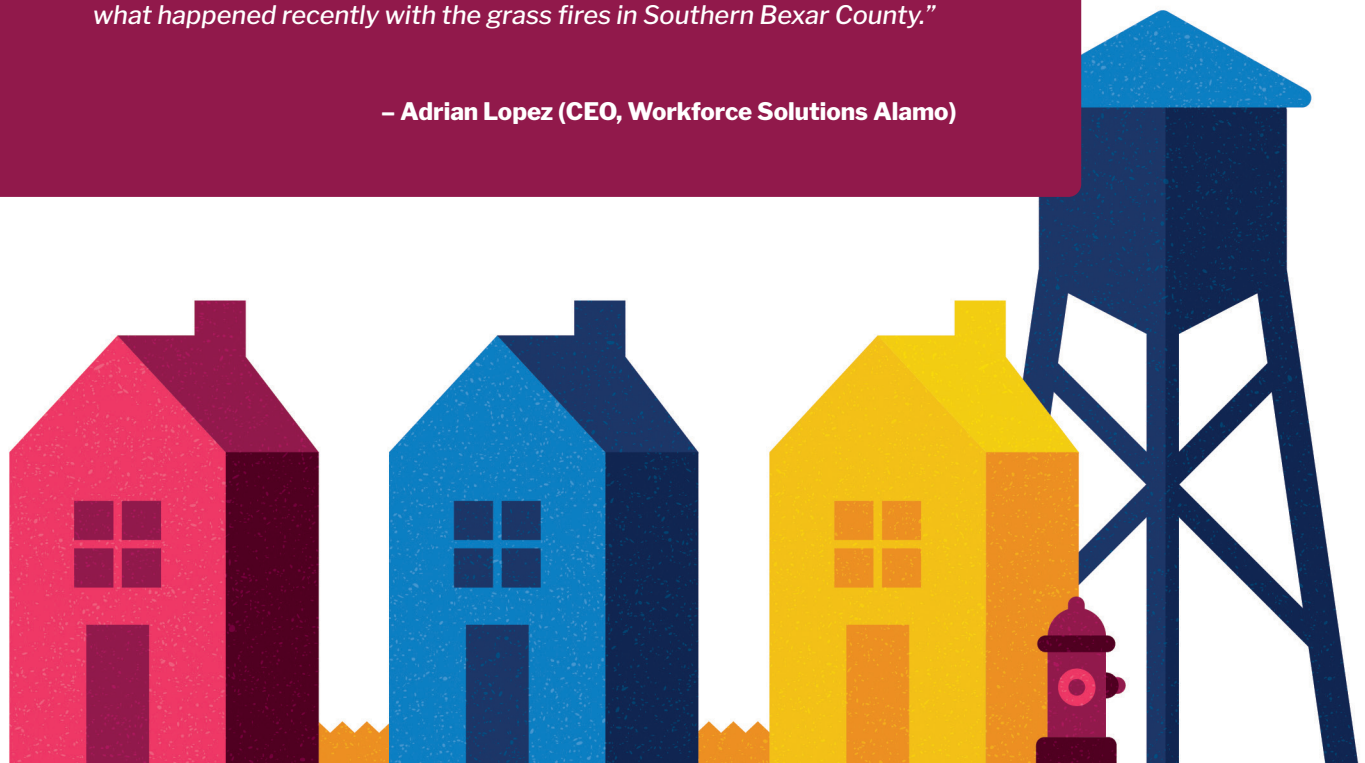
> *"Higher wages to stay up to date with cost of living. Safer parks so folks can actually use them to go on walks. A more organized spay/neuter program to help make our streets safer for outdoor activity. Healthcare for all."*
>
> **– Anonymous respondent to prioritization survey**

Community leader key informants emphasized that the built environment, basic needs, and infrastructure significa tly impact health and well-being and highlighted factors such as city services, walkable areas, potable water, and economic development. Offering an example that illustrated several access issues mentioned by the CHNA Survey respondents, Adrian Lopez underscored the consequences communities face when those needs remain unmet.

"What's happening with the County is a combination of how things were built out. Also, the need for expansion of services for what were largely rural areas. About a month or so ago, there was a huge grass fire that took place in Southern Bexar County. Before the grass fire happened that ultimately burned people's cars and homes, you come to realize that some folks are still living in those same types of conditions. What that requires in some instances is, for example, if you want potable water, you have to go haul it. You go buy the big old plastic things, and go to HEB, fill them up. That's your drinking water. You may have access to water for like showering and toilets, but having to haul water back and forth is a real issue in some parts of the community.

Access to firefighting equipment and infrastructure like fire hydrants does affect some parts of the community that may not have access to that, those types of utilities, which affects insurance rates, and it affects somebody's livelihood. Because if your home cannot get insured because those utilities don't exist and it burns down, guess what? You're out of luck, you just lost everything, and you're now having to figure it out. How do I recover from that? That's a really good example, is to think about what happened recently with the grass fires in Southern Bexar County."

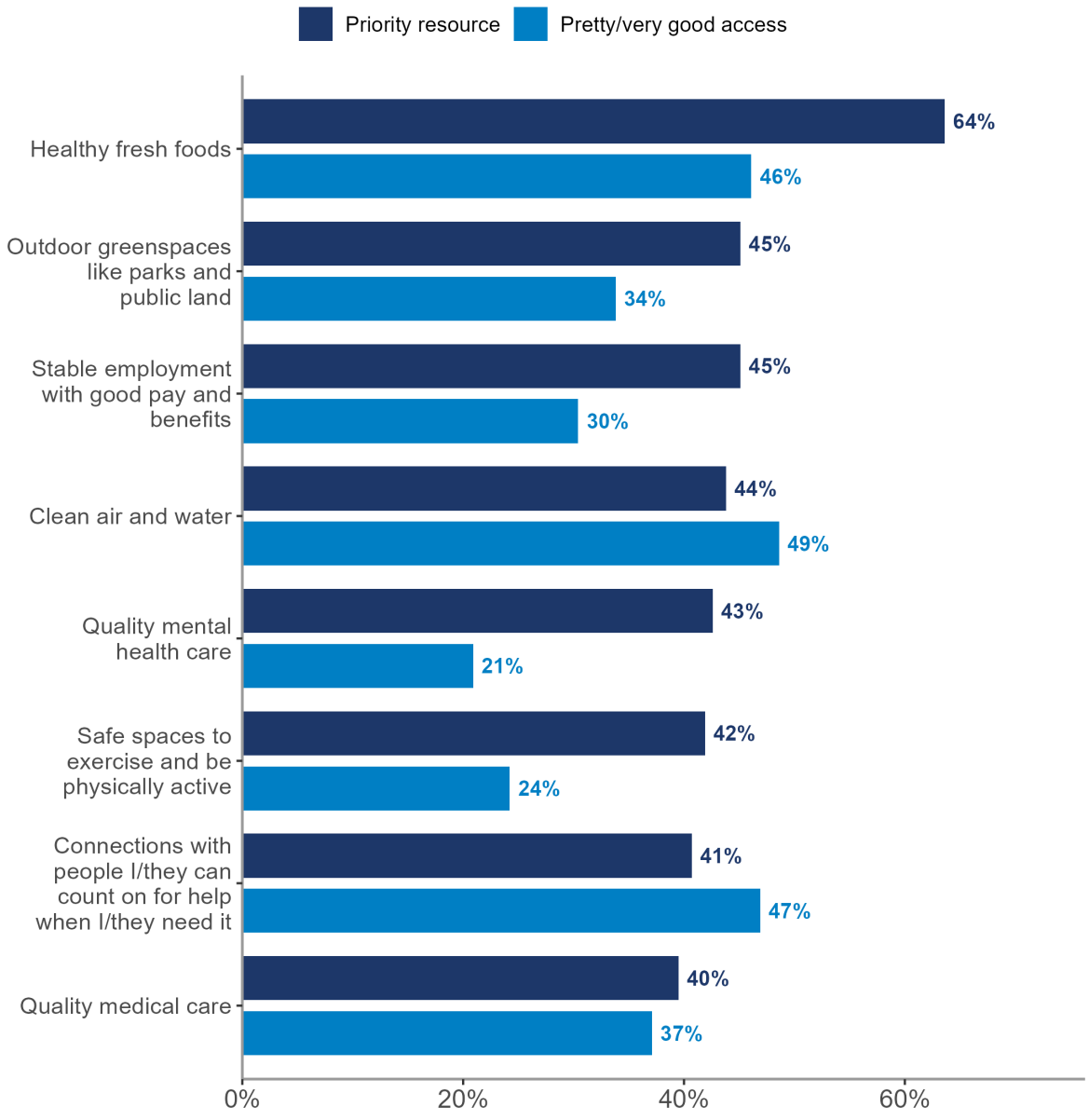
– Adrian Lopez (CEO, Workforce Solutions Alamo)



CINow also asked CHNA Community Survey respondents to rate their own access to the resources they indicated do or would make the most positive difference in their own health and that of their loved ones (**Fig. 2A.4**). What emerged is, for the most part, a mismatch between what respondents rated highly and what they have good access to, perhaps indicating that resources were selected because they would, rather than currently do, make a positive difference. Sixty-four percent of respondents prioritized healthy fresh foods, but only 46% reported having good ("pretty good" or "very good") access to them.

Fig. 2A.4 Top 8 priority resources CHNA survey respondents rated as having "pretty good" or "very good" access to, 2025

Bexar County, Texas



Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Community voices stressed that resources supporting health and well-being are deeply interconnected, where access to one often depends on another. For example, participants wanted more assistance and training to find " ood" jobs, so that they could increase their earning potential and afford other basic necessities, like stable housing, food, and transportation to doctors' appointments and activities. As one participant explained, resources need to be more encompassing.

"As someone who's been on both sides of being homeless, the resources are accessible [...] [but] Say you get housing, they give you an apartment. That's $900. Your job gives you $500, maybe, every month. That's not enough to even cover it once your housing is up, so it's almost like they set you up for failure because they give you housing, but then you don't even have a job that could pay for it after you're done, so a lot of people end up back in shelters because they don't have enough to make it."

– CHNA Focus Group #2 Participant

The gaps were widest for quality mental health care and safe spaces to exercise and be physically active. Quality mental health care was selected as a priority resource by 43% of survey respondents, but fewer than half (21%) of respondents said they have good access to it. The percent of respondents reporting good access to clean air and water (49%) and connections with people who can be counted on for help when needed (47%) were both very slightly higher than the percent of respondents rating those resources as making the most positive difference in their own health and that of their loved ones.

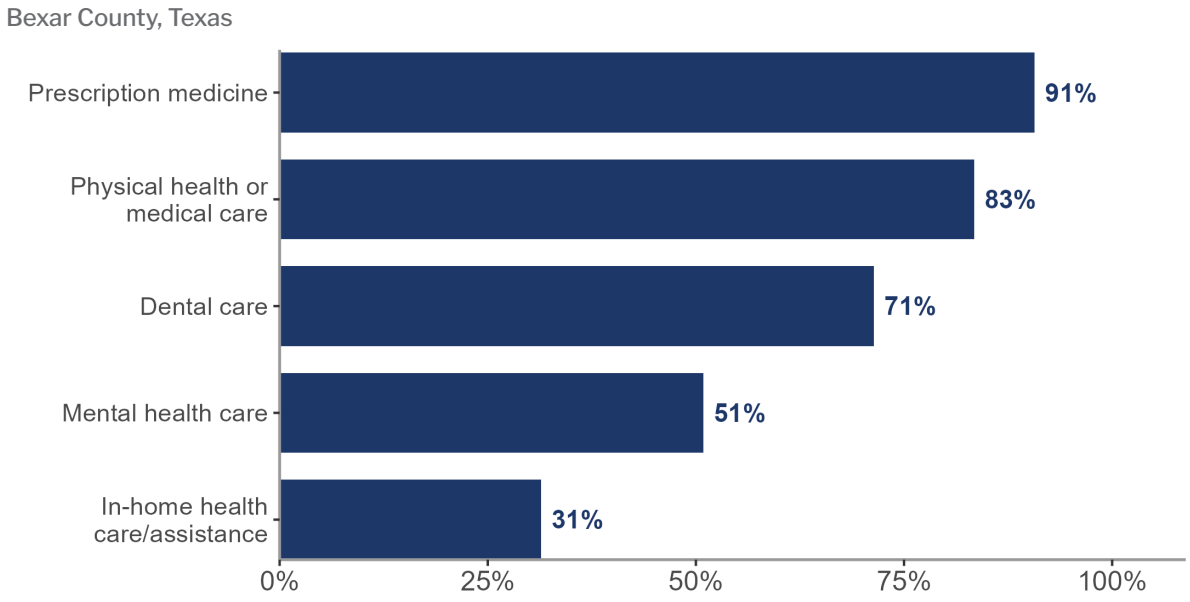
Stepping back from comparisons, though, it is worth noting that fewer than half of respondents who selected these resources as a priority reported having good access to any of the eight. Looking beyond the top eight, a few bright spots do emerge. Most notably (not shown in chart), only about a quarter of respondents selected "interesting and fun things for teenagers and young adults to do," but about nine in 10 of those respondents reported good access. Good access was also reported by over half of those respondents who chose "computer/laptop with high speed internet" or "religious or spiritual home or community" as priorities for their own health and that of their loved ones.

Looking specifically at other major themes that emerge in this assessment, fewer than 20% of survey respondents rated "help with short-term crisis needs" and "quality and uncrowded housing" as a top priority for health, but only a quarter to a third said they had good access to those resources. Although no questions about income were asked in the survey, these response patterns are likely reflective of a secure financial situation among most respondents. Please note that the full survey descriptive statistics are available online; the link can be found in **Appendix B Technical Notes.**

Healthcare Access and Use

When asked about their ability to get the health care they needed in the past 12 months, just 31% of those who needed in-home health care/assistance reported often or always being able to get it (**Fig. 2A.5**). About half of those needing mental health care reported often or always being able to get it. For context, 35% of respondents indicated they needed in-home care, and 75% reported needing mental health care.

Fig. 2A.5 Percent of CHNA survey respondents reporting often or always getting the care they need, by type of care, 2025



Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Mental health was also identified y other community voice sources (focus group participants and key informants) as an area where the community still feels underserved, especially in the context of COVID-19.

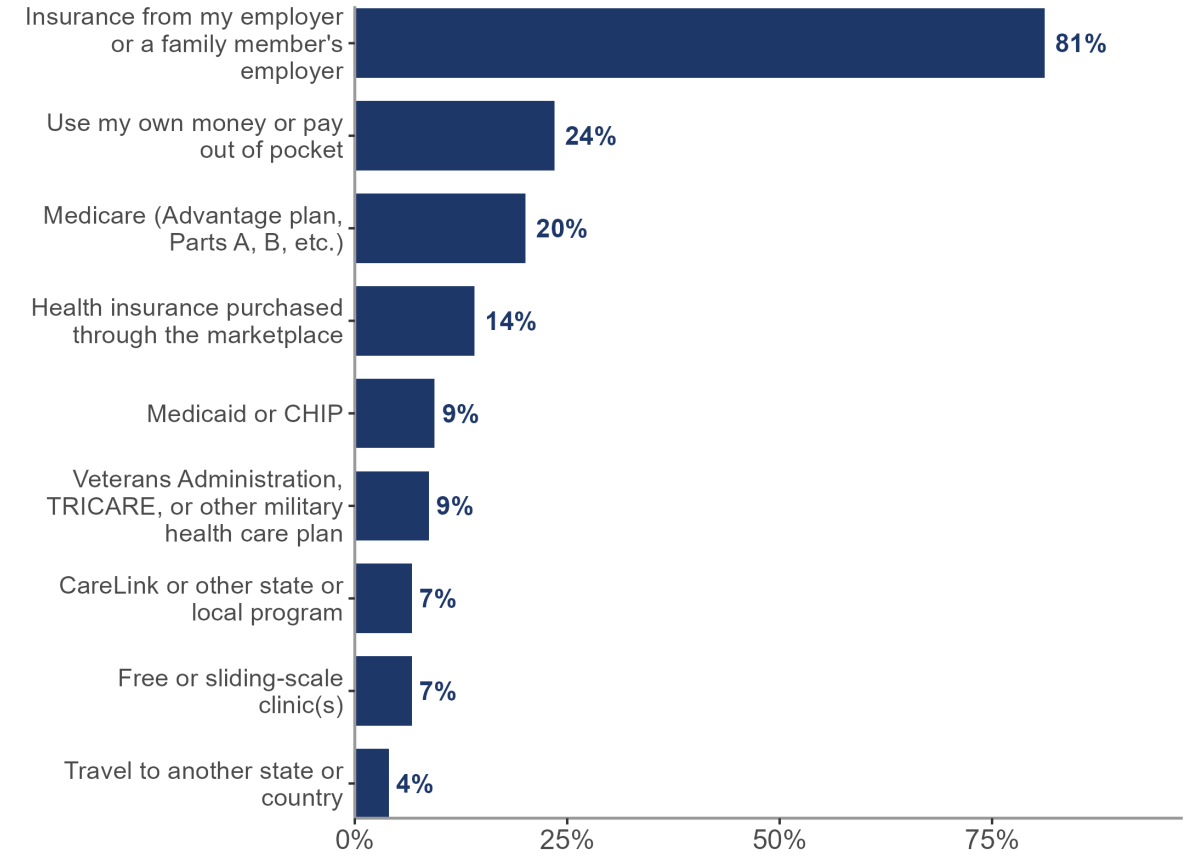
"I think that COVID really affected a lot of people's mental wellness, and especially younger, younger folks. I just don't think a lot of people have healed, because we're still behind on various types of mental health services. When I say younger generation, probably 17 to 27, because these kids were in school... and it's still that level of isolation that has not been dealt with... We still need health care, mental health care services, especially from the trauma that probably got brought."

– CHNA Focus Group #2 Participant

CHNA Community Survey respondents reported that they and members of their household use a variety of payment sources and strategies to get health care (**Fig. 2A.6**). Of note, respondents could make multiple selections, so the percentages add to well over 100%. Eight in 10 (81%) use employer-sponsored insurance, and 14% use insurance purchased through the marketplace. Nearly a quarter reported paying out of pocket. Four percent reported traveling to another state or country for care.

Fig. 2A.6 Percent of CHNA survey respondents reporting use of healthcare, by how they and/or their household members access it, 2025

Bexar County, Texas



N= 149 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

The remainder of this section of the report summarizes trends and differences among groups on indicators of known drivers of health and well-being in Bexar County. While the survey was fielded after this section was planned, all the resources prioritized highly by survey respondents are addressed here to the extent that data is available.

"Basic needs are more fragile than ever due to the economy."

– Anonymous respondent to prioritization survey

EARNING AND BUILDING WEALTH

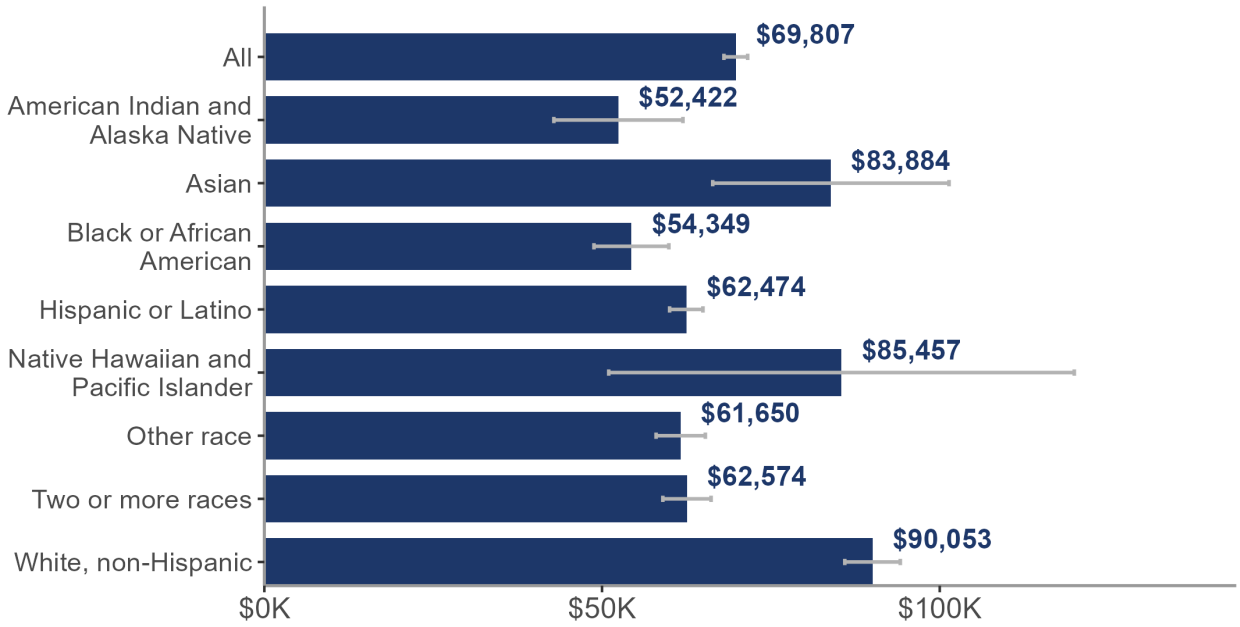
Income and asset measures are key insights into both the financial hardship and economic opportunities within a community. They help identify where support is most needed and where there is potential to build financial stability and long-term wealth.

Household Income

In 2023, Bexar County's median household income was $69,807 (**Fig. 2B.1**). When broken down by race/ethnicity, the three groups with the highest median household incomes were white (non-Hispanic), Asian, and Native Hawaiian and Other Pacific Islander. Because their margins of error overlapped, the differences among these three groups were not statistically significant, making it unclear which group had the highest income. Still, of the three, the white (non-Hispanic) group had the smallest margin of error, making it the most likely to be close to the estimate of $90,053. It was also the only one of the three highest that was statistically higher than the county's average. Among the remaining groups, Black and American Indian or Alaska Native households had the lowest median household incomes, at $54,349 and $52,422, respectively. Because of overlapping margins of error, the difference between the incomes is not statistically meaningful.

Fig. 2B.1 Median household income, by race/ethnicity, 2023

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: S1903
Prepared by CINow for The Health Collaborative

Financial Insecurity

With many measures of financial insecurity, the "poverty line" may differ across agencies. For instance, the Census Bureau's poverty thresholds differ somewhat from the U.S. Department of Health and Human Services' thresholds used to determine eligibility for programs and services.[12]

The Federal Poverty Level (FPL) is a measure used by the government based solely on income and family size to determine eligibility for benefit programs. For context, 100% FPL in this report would equate to a 2023 income of $15,480 for one person and $30,900 for a family of two adults and two children.[13]

Building on that, ALICE (an acronym for Asset Limited, Income Constrained, Employed) includes families who make enough to be above the poverty level but are ineligible for many types of public assistance and do not make enough to get by.[14] It helps fill a gap by identifying households that struggle to meet basic needs despite earning too much to qualify for assistance.

ALICE HOUSEHOLD SURVIVAL BUDGET, BEXAR COUNTY TEXAS, 2023

Monthly Costs	Single Adult	One Adult One Child	One Adult, One In Child Care	Two Adults	Two Adults Two Children	Two Adults, Two In Child Care	Single Adult 65+	Two Adults 65+
Housing	$1,023	$1,177	$1,177	$1,177	$1,430	$1,430	$1,023	$1,177
Child Care	$0	$268	$715	$0	$536	$1,478	$0	$0
Food	$409	$692	$621	$750	$1,257	$1,110	$376	$690
Transportation	$431	$565	$565	$670	$958	$958	$361	$530
Health Care	$178	$488	$488	$488	$780	$780	$563	$1,126
Technology	$86	$86	$86	$116	$116	$116	$86	$116
Miscellaneous	$213	$328	$365	$320	$508	$587	$241	$364
Taxes	$303	$257	$338	$391	$351	$523	$364	$630
Monthly Total	$2,643	$3,861	$4,355	$3,912	$5,936	$6,982	$3,014	$4,633
ANNUAL TOTAL	$31,716	$46,332	$52,260	$46,944	$71,232	$83,784	$36,168	$55,596
Hourly Wage	$15.86	$23.17	$26.13	$23.47	$35.62	$41.89	$18.08	$27.80

Source: United for ALICE

Focus group participants shared how even small increases in income can affect their qualific tion for social services without actually improving their quality of life, creating a frustrating cycle of economic instability.

"And then with housing, if you make too much money, 'Now, we can't give you housing assistance'. You're kind of stuck in between. If I go out and make $5 over, I don't qualify for this. But then, if I make more money, now I have to spend the $200 you were giving me in food. Now I got to spend that. So really, I'm not really getting ahead. It's a big cycle of poverty."

– CHNA Focus Group #2 Participant

*"**Participant 1:** I pay a little over $1,000 for the apartment I just got. I have nothing left over for the month.*

***Participant 2:** I'm in the same situation.*

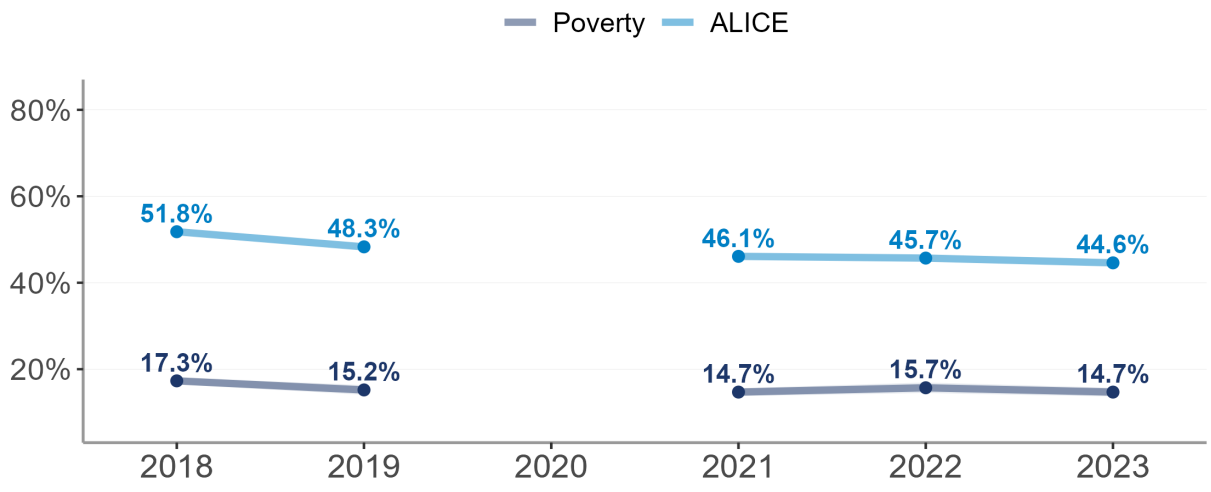
***Participant 1:** And for people like [Participant], they don't even help you with like food stamps, or they help the wrong people, people that are not even working."*

– CHNA Focus Group #1 Participants

Figure 2B.2 shows financial insecurity among Bexar County families, measured using both the ALICE threshold and the Federal Poverty Level (FPL). The most recent numbers show that as of 2023, 15% of Bexar families had incomes below the poverty line. However, as of 2022, an additional 46% still could not afford basic needs and did not qualify for many forms of assistance, even though many of those families were employed. Both measures followed similar trends, showing only slight declines over time, with the share of ALICE households hovering around 50%. Further, ALICE households are common in virtually every area of the county, with ALICE households representing 25% or fewer of total households in only a handful of ZIP codes (**Fig. 2B.3**). Taken together, financial insecurity affects more than half of Bexar County families, highlighting the limitations of relying on the FPL alone to understand economic hardship and financial need.

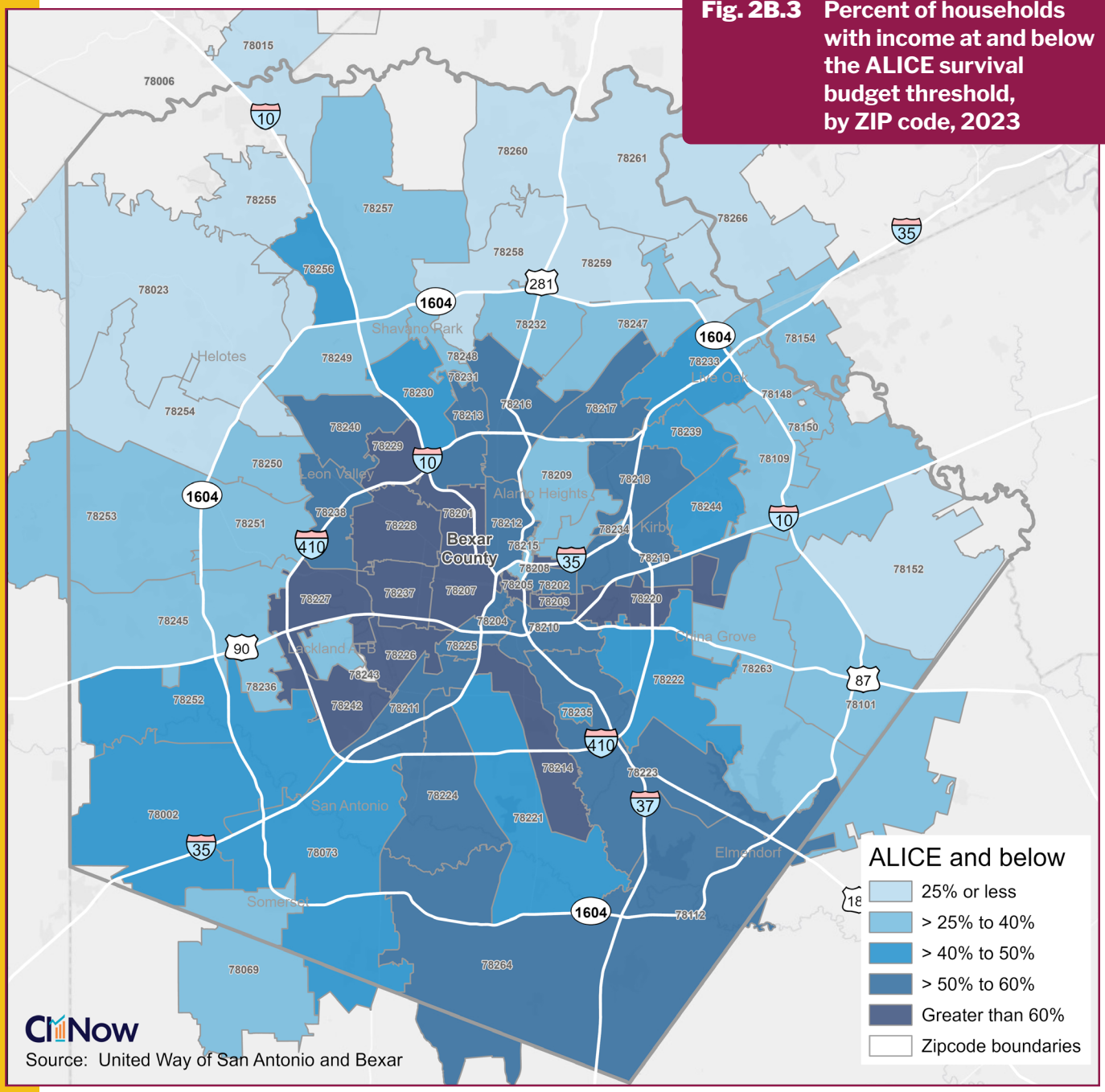
Fig. 2B.2 Percent of population with income below the FPL and of households with income below the ALICE survival budget threshold

Bexar County, Texas



FPL= Federal Poverty Level, ALICE= Asset Limited, Income Constrained, Employed; Data for 2020 is unavailable due to data collection restrictions during the COVID-19 pandemic.
Source: ACS 1-Year Estimates, Table: B17001; ALICE United Way of Texas
Prepared by CINow for The Health Collaborative

Fig. 2B.3 **Percent of households with income at and below the ALICE survival budget threshold, by ZIP code, 2023**



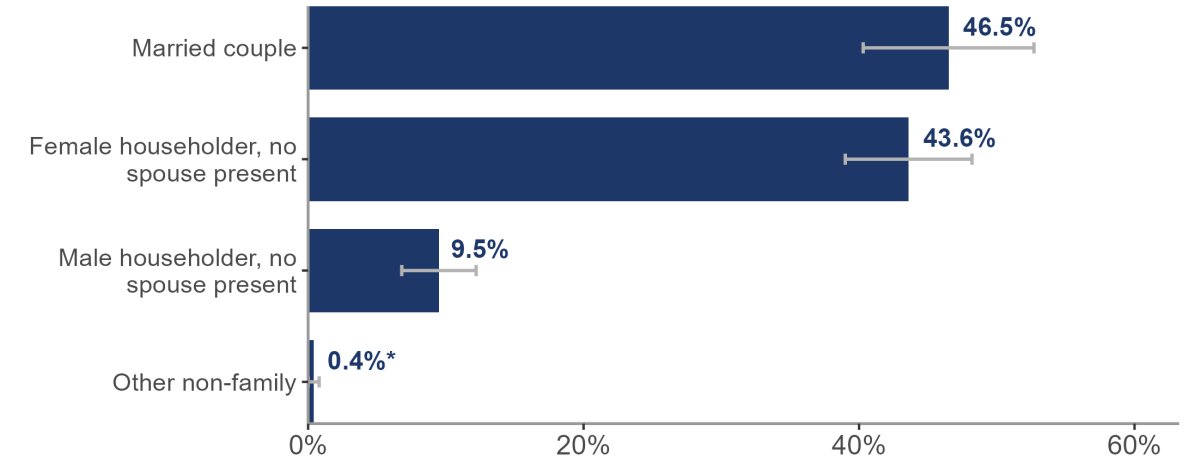
Source: United Way of San Antonio and Bexar

Figure 2B.4 shows the percentage of children living in households that received income support through public assistance programs, broken down by household type. Specifically, it includes households that received assistance in the past 12 months from Supplemental Security Income (SSI), cash public assistance income, like Temporary Assistance for Needy Families (TANF), and food stamps or Supplemental Nutrition Assistance Program (SNAP).

In 2023, children receiving such support most commonly lived in married couple households (46.5%) and "female householder, no husband present" households (43.6%). Because of overlapping margins of error, it is unclear which of the two was the most common. Smaller percentages of children receiving this support lived in a "male householder, no wife present" household (9.5%), and very few lived in non-family households (0.4%).

Fig. 2B.4 Percent of children in households receiving SSI, cash public assistance income, or food stamps/SNAP in the past 12 months, by household type, 2023

Bexar County, Texas



SSI= Supplemental Security Income, SNAP= Supplemental Nutrition Assistance Program
*Unreliable: Error is too large relative to estimate.
Source: ACS 1-Year Estimates. Table: B09010
Prepared by CINow for The Health Collaborative

GETTING ONLINE AND STAYING CONNECTED

Digital inclusion refers to reliable and affordable access to the internet with adequate infrastructure, capable devices, and necessary digital skills to navigate today's digital world. It is foundational to reducing social and economic disparities while driving economic development and mobility.[15] As of December 2023, 98% of Bexar County households had access to high-speed broadband (defined as speeds greater than or equal to 100/20 Mbps).[16]

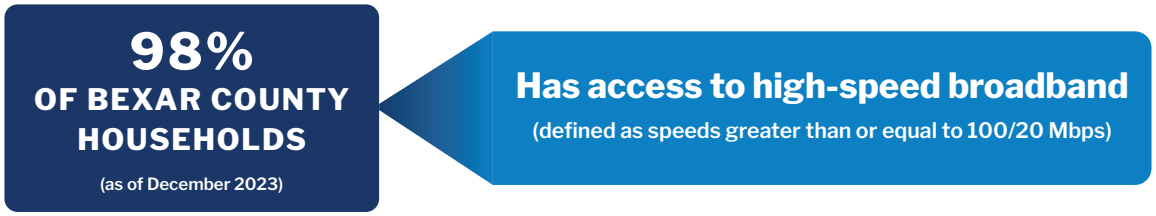
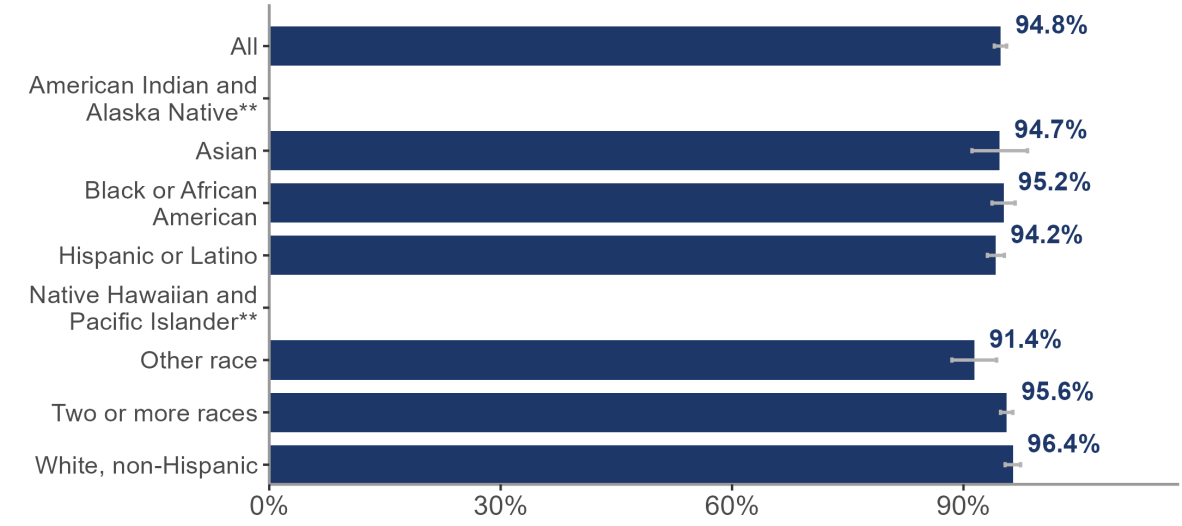


Figure 2C.1 shows that 95% of Bexar County households have both a computer and a broadband internet subscription and breaks it down by race/ethnicity. The percentage for every race/ethnicity group for which a stable rate is available was lower than the 98% of county households with high-speed broadband noted above, which speaks to a lack of computing devices, such as a desktop, laptop, or tablet, rather than just a smartphone. While overlapping margins of error and suppression limit the ability to determine statistically significant differences for all groups, most reported access above 90%.* White (96.4%) and "Two or more races" (95.6%) households had the highest proportions of households with a computer and broadband internet subscription, and were statistically higher than the lowest groups, "Other race" (92%) and Hispanic households (94%).

* Differences among groups may not be statistically significant due to limited data or overlapping margins of error.

Fig. 2C.1 Percent of households with a computer and broadband internet subscription, by race/ethnicity, 2023

Bexar County, Texas



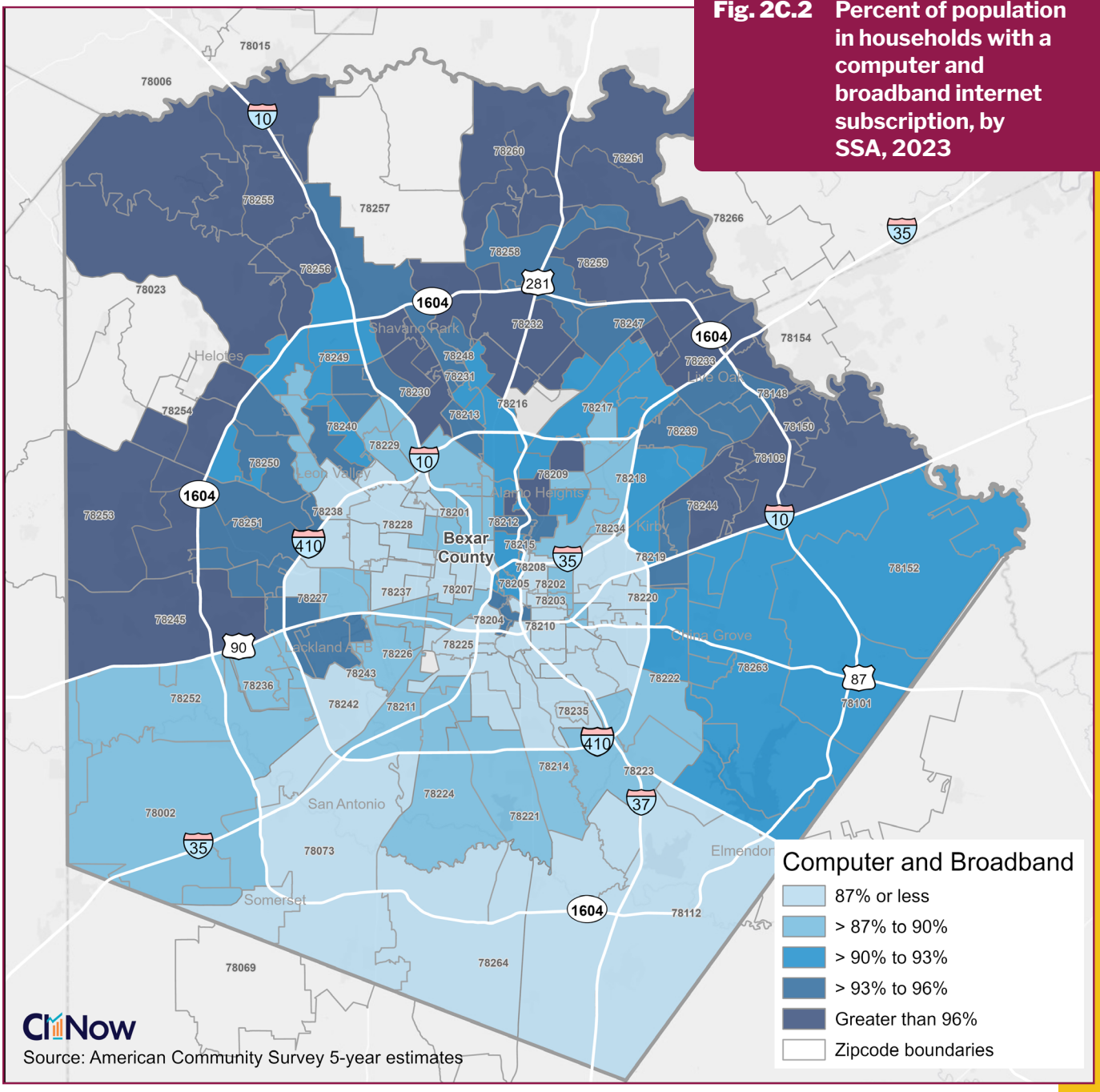
**Suppressed by data source.
Source: ACS 1-Year Estimates. Tables: B28008, B28009 B-I
Prepared by CINow for The Health Collaborative

Highlighting digital equity and access, especially in rural areas, CHNA community voices emphasized how a lack of technological infrastructure affects community members' access to healthcare, work, education, and other resources.

"One other common theme, especially in rural areas, is digital equity. Some important considerations in this regard are whether first, and foremost, are these communities connected? What tools do they need to leverage the connection and what training do they need to use those tools, or do they require Navigators to help? Another important issue regardless of whether you are in a rural area or not, is how important digital connection is to one's ability to find work and education at every level. You need digital connection to compete in this world."

– Jaime Wesolowski (President/CEO, Methodist Healthcare Ministries)

Fig. 2C.2 **Percent of population in households with a computer and broadband internet subscription, by SSA, 2023**



CINow
Source: American Community Survey 5-year estimates

Although the differences were not dramatic among the race/ethnicity groups for which data is available, geographic disparities by SSAs were stark (**Fig. 2C.2**). In far north SSAs, virtually all of the population lived in a household with a computer and broadband internet subscription, compared to between 74% and 87% in far-south SSAs and about half of the SSAs inside Loop 410.

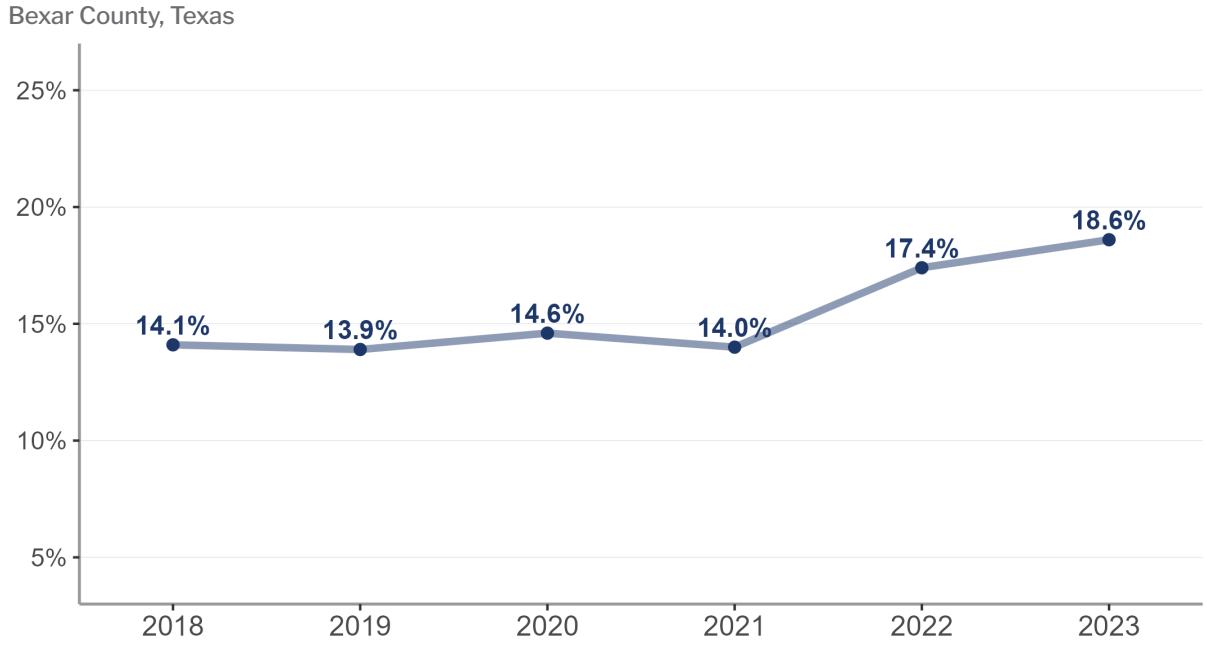
PUTTING HEALTHY FOOD ON THE TABLE

Food insecurity refers to a lack of consistent access to sufficient, safe, and nutritious food that meets dietary needs and food preferences for an active, healthy life. It is also a household-level economic, social, and environmental condition of limited or uncertain access to adequate food that meets cultural or personal needs. Food insecurity may mean being unable to find or afford healthy, fresh food, or worrying about where the next meal will come from at all. It can lead to missed meals, higher health risks, reduced ability to work productively or learn in school, and poor health outcomes like anxiety and depression, chronic physical disease, and premature death Addressing food insecurity goes beyond increasing physical access to food, but also improving food quality and variety, ensuring economic access to food, and understanding patterns of nutrition and consumption of food.

Food Insecurity

From 2018 to 2021, the percentage of people who are food insecure in Bexar County hovered around 14%, with a slight increase in 2020 (**Fig. 2D.1**). However, in 2022, the number rose nearly a quarter to 17.4%. This increase may be attributed to the end of emergency support introduced during the COVID-19 pandemic, like extended SNAP and stimulus benefits,[17] and ongoing financial strains.

Fig. 2D.1 Percent of population that is food insecure

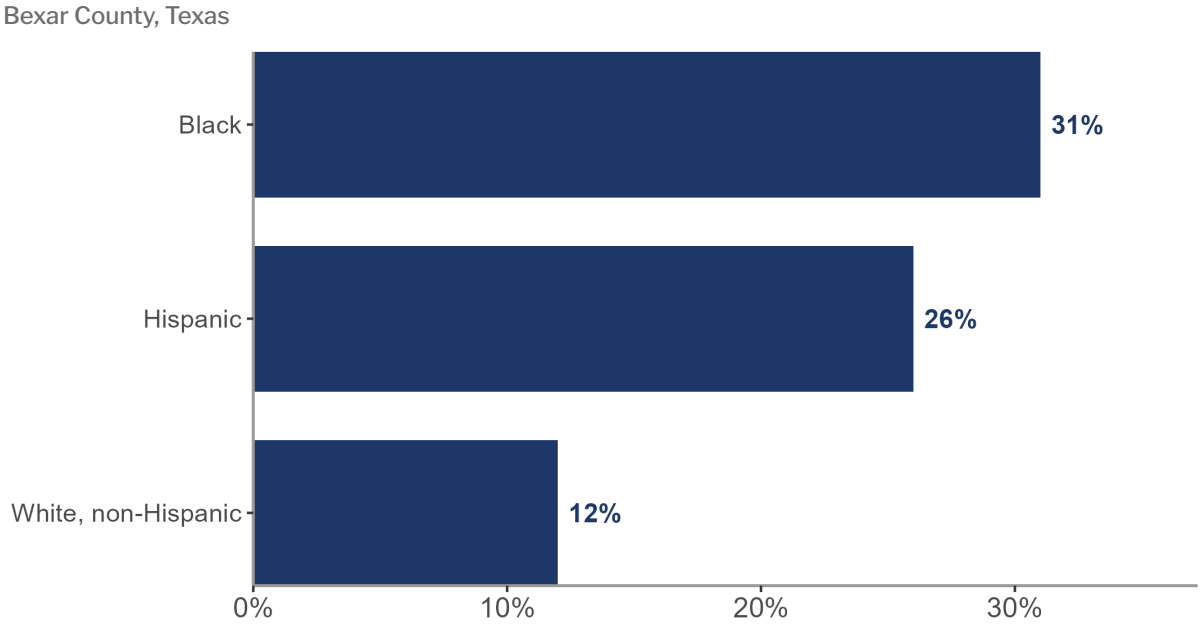


Source: Feeding America
Prepared by CINow for The Health Collaborative

Although data is only available for the three largest race/ethnicity groups, **Figure 2D.2** shows disparities in food insecurity by race/ethnicity. White (non-Hispanic) residents had the lowest proportion of people experiencing food insecurity at 11%, which is lower than the overall percentage for that year (17.4%). In contrast, Black and Hispanic populations experienced food insecurity at 28% and 24%, respectively, more than twice the rate among white residents. Because these categories are not mutually exclusive, that is, Black includes those of all ethnicities and

Hispanic includes those of all races, there may be overlap and therefore cannot be directly compared to one another. In 2022, ZIP codes with a higher percentage of food insecurity were found inside Loop 410 and more broadly across the southside of the county, including areas beyond both Loop 410 and 1604 (**Fig. 2D.3**).

Fig. 2D.2 Percent of population that is food insecure, by race/ethnicity, 2023



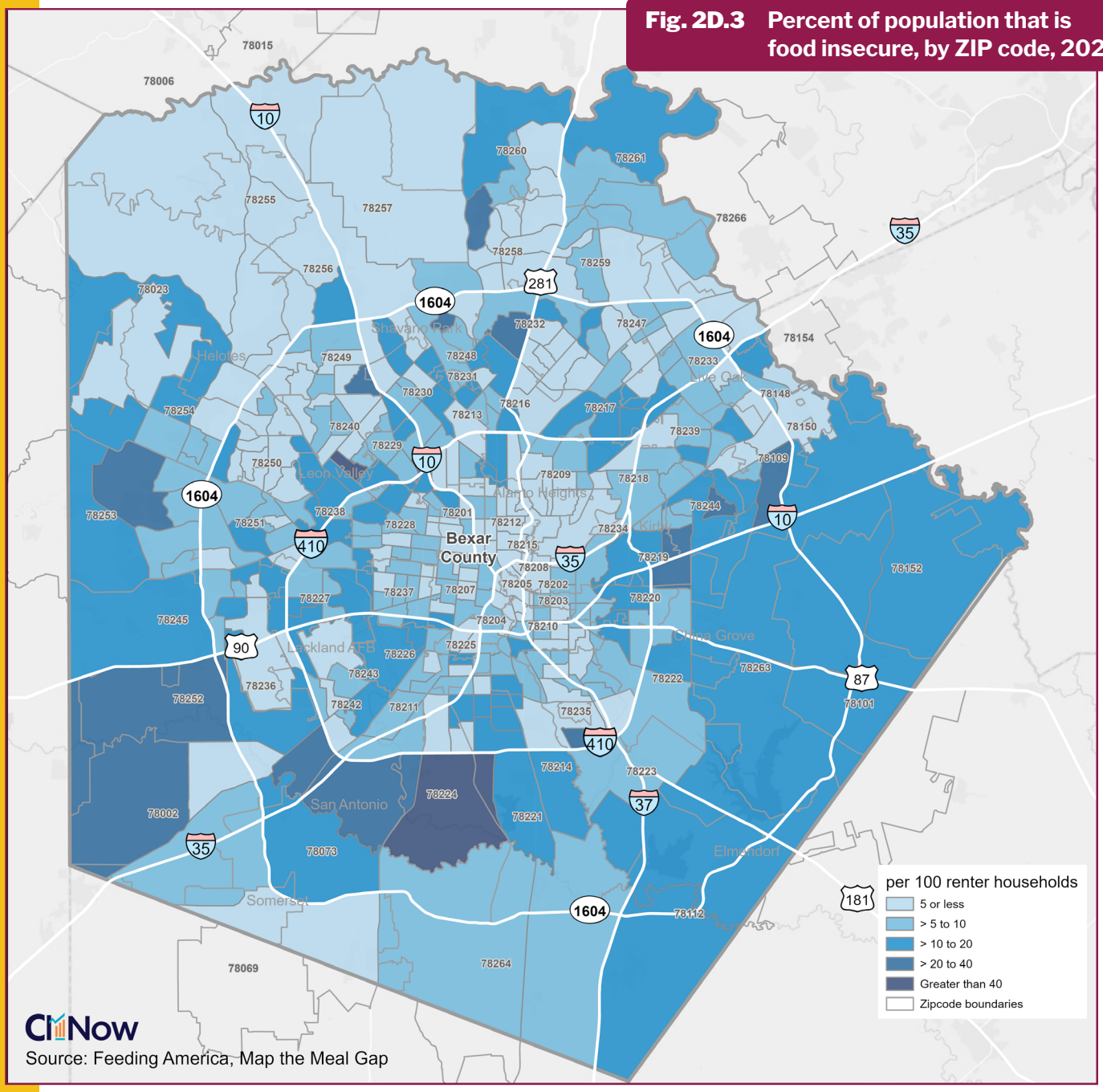
"Black persons" includes those of all ethnicites and "Hispanic persons" includes those of all races.
Source: Feeding America
Prepared by CINow for The Health Collaborative

Limited access to healthy food is a persistent issue that is compounded by transportation barriers, which also affect access to doctors and jobs, as one participant explained.

"I live in Von Ormy. [...] I don't have a car, [and] we have to go all the way to San Antonio for doctors, for HEB, and all of that, because we don't have a big store here. So, to go get groceries, I have to go to this HEB, but we don't have buses that run [come] out here. [...] it's really hard if you don't have a car. If you live here in Von Ormy, or in Somerset, and you don't have a car, there's no way to get around or to get to work, it's really hard."

– CHNA Focus Group #4 Participant, translated from a mix of Spanish and English

Fig. 2D.3 Percent of population that is food insecure, by ZIP code, 2022



CINow
Source: Feeding America, Map the Meal Gap

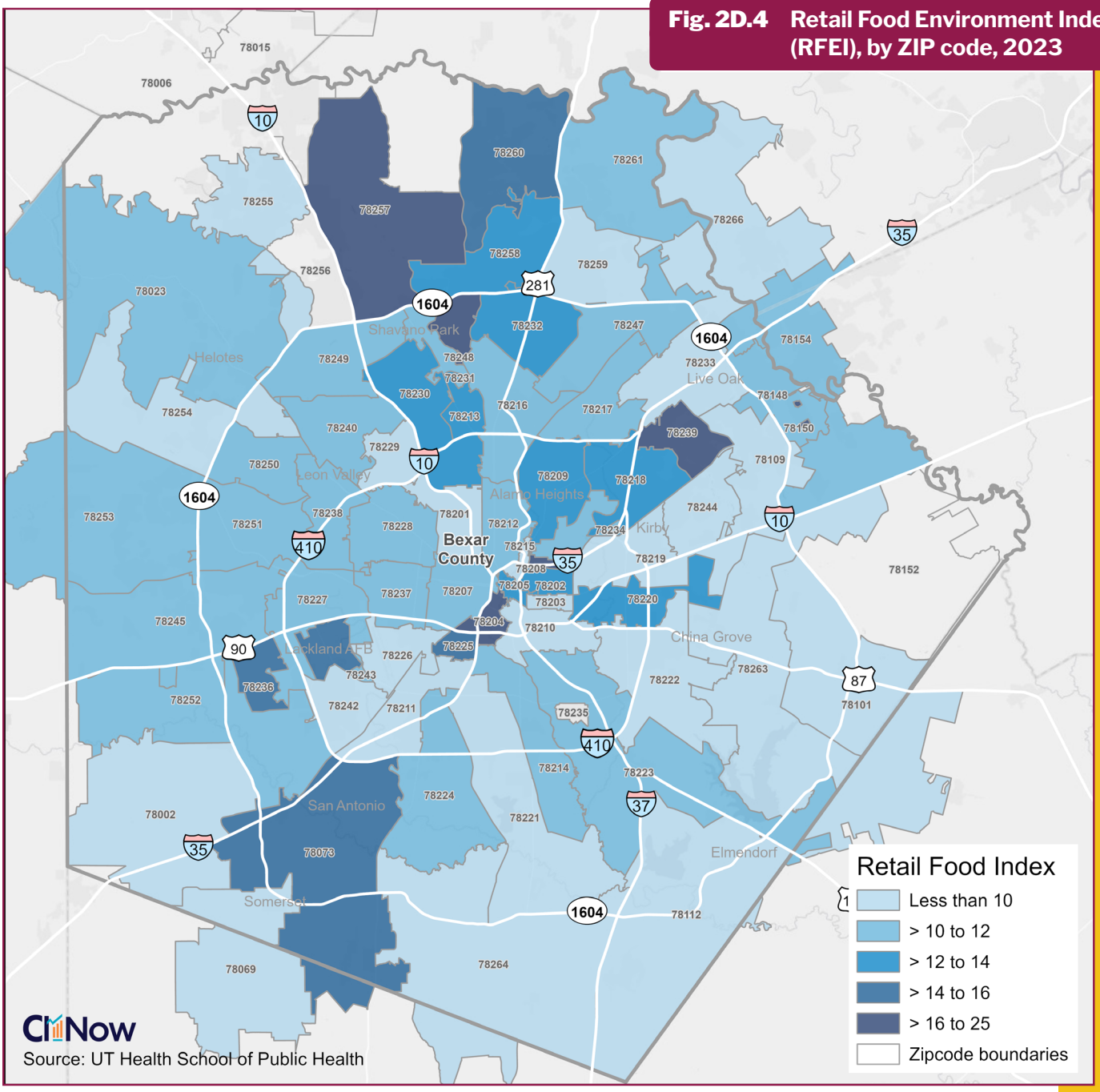
Access to Healthy Food

The Retail Food Environment Index (RFEI) measures healthy foods available from certain retailers in a given geographic area, with higher scores indicating more stores offering healthier, more nutritious foods. In Bexar County, areas with higher RFEI scores were mostly concentrated on the northside, especially outside Loops 410 and 1604 (**Fig. 2D.4**). Additional concentrations appeared around Lackland Air Force Base and Alamo Heights, as well as farther south, near Somerset.

Food Assistance

The Supplemental Nutrition Assistance Program (SNAP) is a critical source of support for low- and moderate-income people. **Figure 2D.5** shows two metrics drawn from a snapshot of SNAP payments in May of each year: the number

Fig. 2D.4 Retail Food Environment Index (RFEI), by ZIP code, 2023



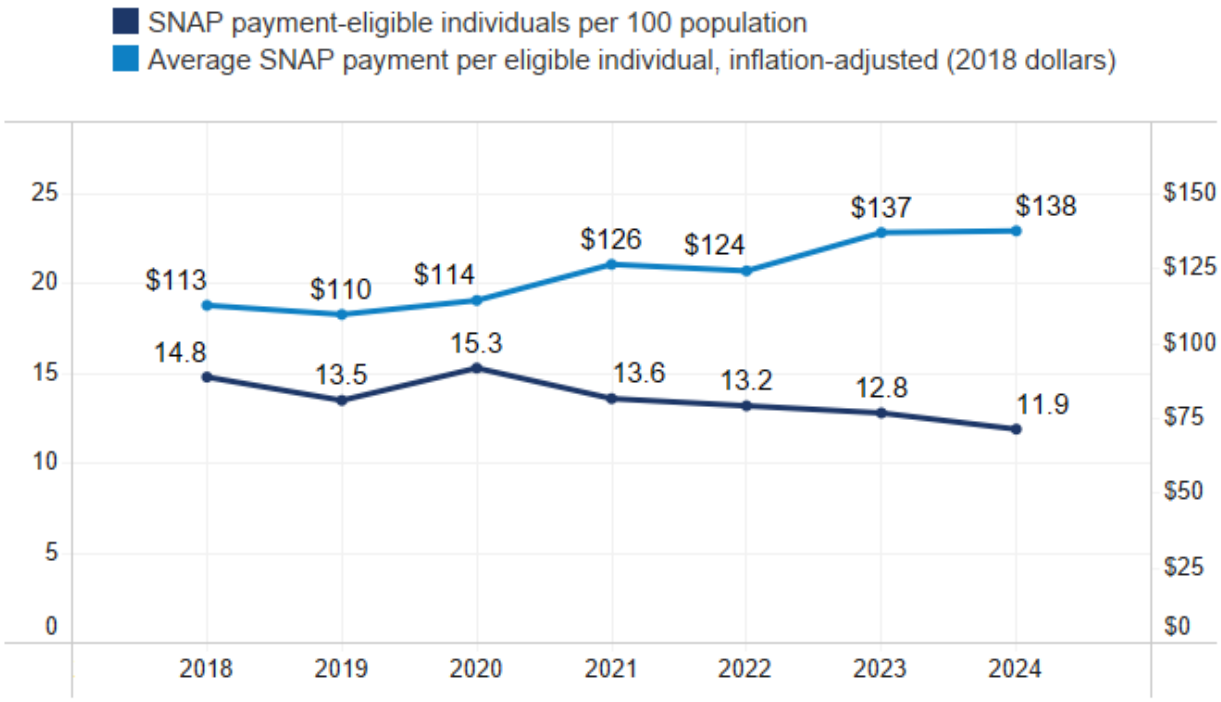
of payment-eligible individuals per 100 population, and the inflation-adjusted trend in average SNAP payment per eligible individual. An "eligible individual" is a member of a "case", a group (e.g., family household) certified as eligible for SNAP benefits. It is important to note that these are people for whom eligibility has been formally determined, and they represent only a fraction of those who would meet eligibility requirements if they were assessed. Further, not every eligible individual in a case necessarily receives the SNAP benefit; for example, parents may use the benefit solely for their children.

Except for a sharp spike in May 2020, early in the COVID-19 pandemic, the number of individuals determined to be eligible per 100 people dropped from 14.8 to 11.9 per 100 population. Not shown in the chart, the average number of eligible individuals per case decreased only slightly between 2018 and 2024, from 2.4 to 2.2. The average payment

per eligible individual increased from $113 to $174 (an increase of 54%, not shown in the chart) over the period, but after adjusting for inflation, the increase was only 22%. Again, that average is greatly affected by how many cases and individuals are certified SNAP-eligible and almost certainly does not reflect actual need.

Fig. 2D.5 SNAP certified-eligible ate per 100 population and infl tion-adjusted average payment per person, May annual snapshot

Bexar County, Texas



Source: Texas Health and Human Services Commission
Prepared by CINow for The Health Collaborative

In addition to eligibility challenges, community voices expressed concerns about federal funding cuts and the future stability of food assistance programs like SNAP and WIC. Eric Cooper explained how this would strain nonprofits and the families who rely on them, hindering the Food Bank's ability to help people with food and resources.

"The biggest threat at the moment is where the Federal Government, under budget reconciliation, is deciding to cut back on direct opportunities that nonprofits have used to support themselves and indirect programs that support those neighbors, those residents, that we care about.

Specifically for the Food Bank, we've lost about $12 million in support, which means less food in our, in our warehouse and displaced federal workers that just recently lost their job. Now, they're looking for basic needs, coming to the Food Bank for food. So, my line is getting longer.

And those traditional support programs like SNAP and WIC that help put food on the table, the federal government's looking to cut those programs now. Those cuts haven't gone into place yet, but as they make decisions in the next few weeks to reduce the support that those families get, again, resources and policy. We've got to have good, effective public policy that supports us."

– Eric Cooper (President/CEO, San Antonio Food Bank)

FINDING AND KEEPING A HOME

Affordable housing and housing stability refer to access to safe, quality, and reasonably priced housing while still having enough income for other basic needs. Certain populations, including renters and foster youth, are especially vulnerable to displacement and housing instability. At the same time, already financially strained households are left with even less money for other essentials like food, childcare, and transportation.

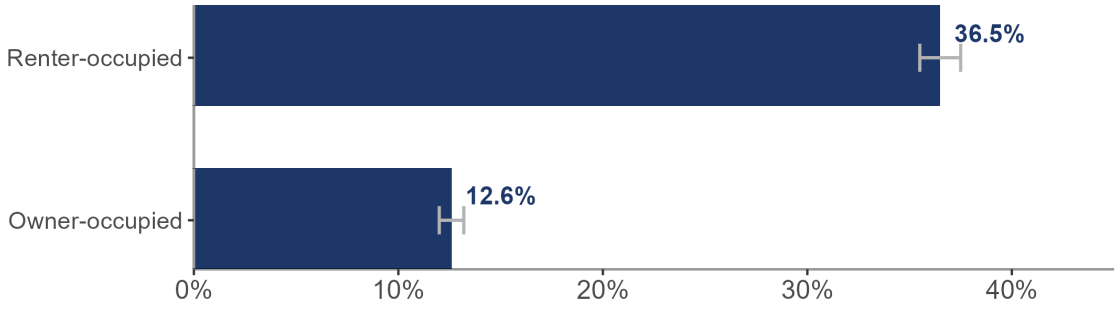
Housing Cost Burden

Households are considered housing-cost burdened when they spend over 30% of their income on housing, including rent or mortgage payments plus utilities. This burden alone signals financial strain but also underscores persistent financial vulnerability when coupled with a broader measure of economic hardship, like being below 200% of the Federal Poverty Level (FPL). The 200% FPL threshold includes households that are below the poverty level as well as households with low-incomes but not officially poor (earning between 100-199% FPL).

Figure 2E.1 shows the proportions of renter-occupied and owner-occupied households under 200% FPL that were housing-cost burdened as of 2023. Renters in this income group were nearly three times as likely to be burdened by housing costs compared to homeowners (37% versus 13%).

Fig. 2E.1 Percent of households under 200% FPL that are housing cost-burdened, by tenure type, 2023

Bexar County, Texas



Source: ACS 5-Year Estimates, Public Use Microdata Samples (PUMS)
Prepared by CINow for The Health Collaborative

Elaborating on housing affordability, a key informant explained how housing also needs to be diverse. Building more apartments alone will not solve housing difficulties, as people need di erse, affordable options for their families and multi-generational needs.

"Access to a variety and a diverse level of housing is key as well, people tend to focus on affordable housing versus market-rate housing. Well, when you look at housing, there's a lot more diversity associated with that. And what you want to have is a healthy community, where maybe you started in a small, affordable unit. But over time, you graduated to what the American dream would be, which is a single-family detached home. Not to say that that journey is not a good journey. You could still have good quality housing in each of those aspects, whether it's affordable or somewhere in between that and [a] mid-market rate. Having a diverse level and supply of housing is extremely critical to a healthy community. The integration of things like how the city grows."

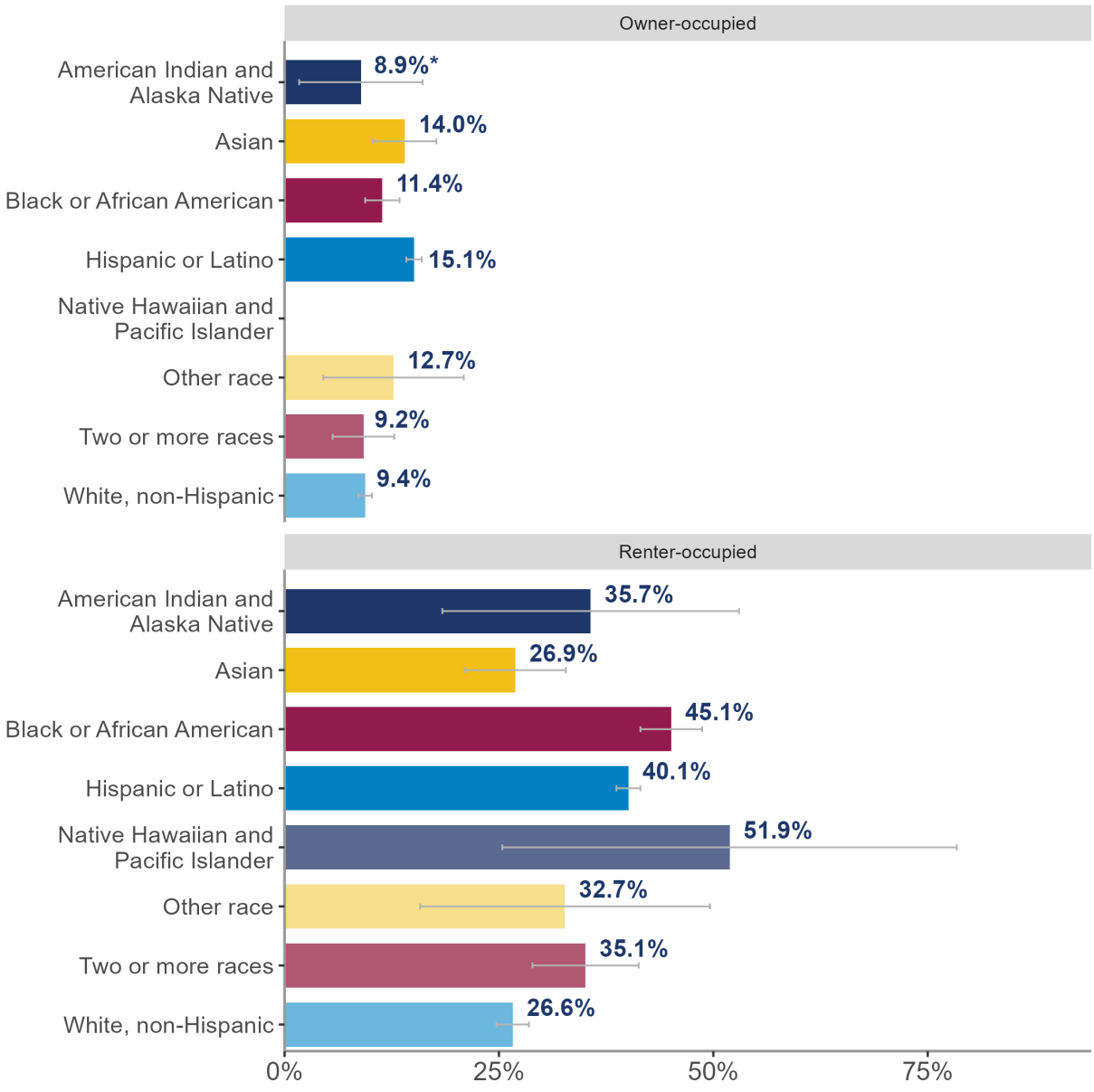
– Adrian Lopez (CEO, Workforce Solutions Alamo)

Even greater disparities become apparent when that data by tenure (renter versus owner) is further disaggregated by race/ethnicity (**Fig. 2E.2**). Renter households under 200% FPL with an Asian or non-Hispanic white householder were far less likely to be housing cost-burdened than those with a householder who is Black or Hispanic. Among owner-occupied households under 200% FPL, those with a Black, non-Hispanic white, or multiracial householder

were less likely to be housing cost-burdened than those with a Hispanic householder. Worth noting are great intra-group disparities between renters and owners. Among households under 200% FPL with a Black or African American householder, renters are four times as likely to be housing cost-burdened as owners. Among households under 200% FPL with a Black or African American householder, renters are four times as likely to be housing cost-burdened as owners. Among those with a non-Hispanic white householder, that ratio is about three; among those with a Hispanic householder, the ratio is 2.7.

Fig. 2E.2 Percent of households under 200% FPL that are housing cost-burdened, by race/ethnicity and tenure type, 2023

Bexar County, Texas



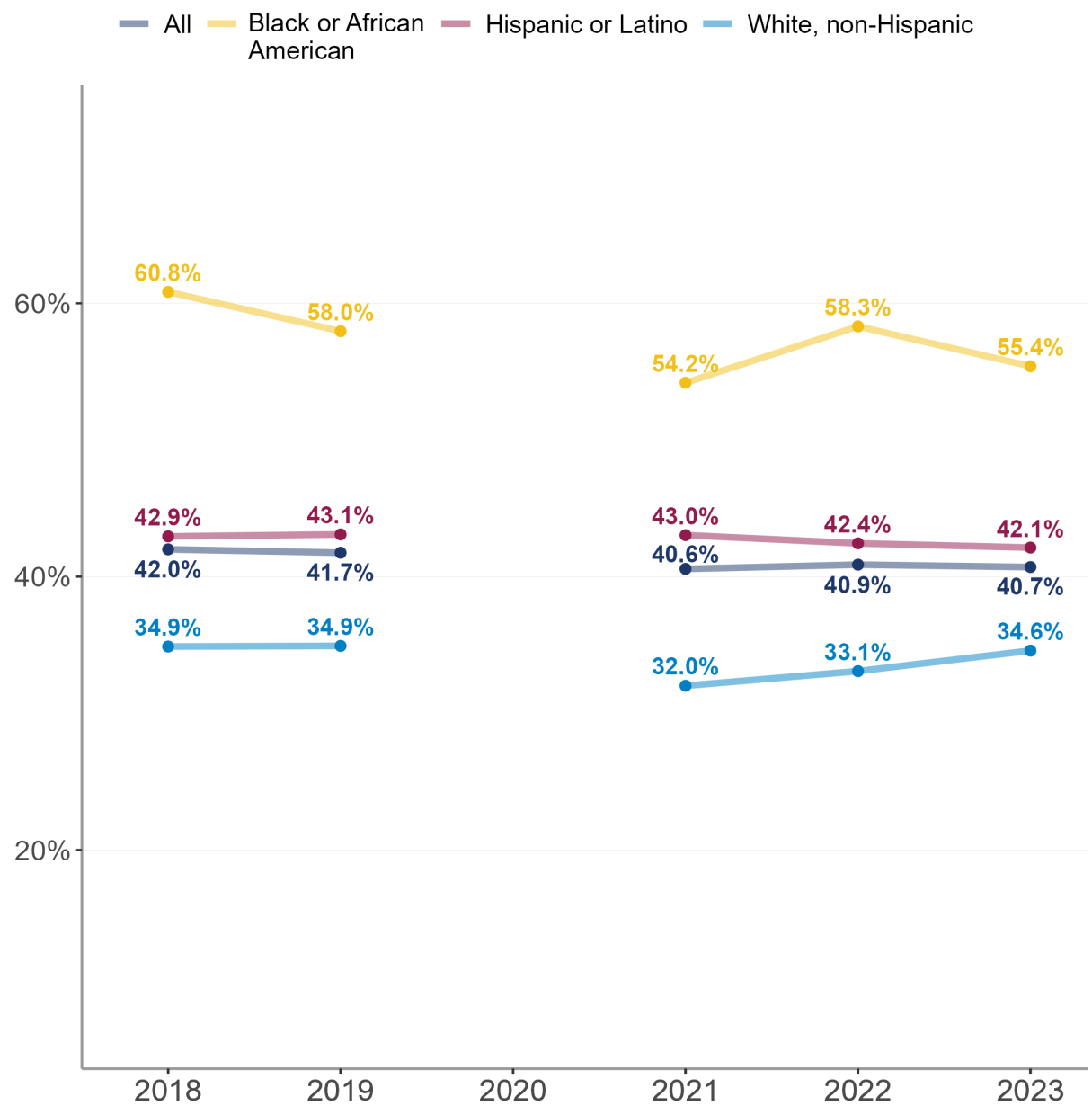
"Owner-occupied" percent for Native Hawaiian and Pacific Islander is suppressed by data source.
*Unreliable: Error is too large relative to estimate.
Source: ACS 5-Year Estimates, Public Use Microdata Samples (PUMS)
Prepared by CINow for The Health Collaborative

Renters

In Bexar County, the share of occupied housing units that are renter-occupied has remained steady at about 40% since 2019 (**Fig. 2E.3**). Of the race/ethnicity groups with available data, Black-headed households are 1.7 times as likely as white-headed households to be renting, and Hispanic-headed household populations consistently showed a higher reliance on renting compared to white households and the county overall.

Fig. 2E.3 Percent of housing units that are renter-occupied, by race/ethnicity

Bexar County, Texas



Data for 2020 is unavailable due to data collection restrictions during the COVID-19 pandem
Source: ACS 1-Year Estimates. Tables: B25003, B25003B, B25003H, B250
Prepared by CINow for The Health Collaborat

Addressing housing affordability, a key informant explained why he believes that, "rent is the new redlining." He described how redlining, the act of banks maintaining racial segregation through geographically biased lending practices, affected generational wealth by keeping families of color from owning homes and passing down assets to their children.

"...[Redlining] tended to fall on race lines. You know more Hispanics over there. And if you, and if you look at their homes, because there wasn't anyone giving oversight, sometimes the houses weren't built [to] quality. They weren't built to code, and those assets didn't appreciate or go up in value... But then the assets outside of the red line, man, they just grew in equity, and those tended to be more white people.

... And for generations, those communities failed to thrive based on this policy, like the fact that they couldn't get good lending for home ownership, ... people might say, 'I'll never be able to afford a house, so I'm going to rent for the rest of my life.'

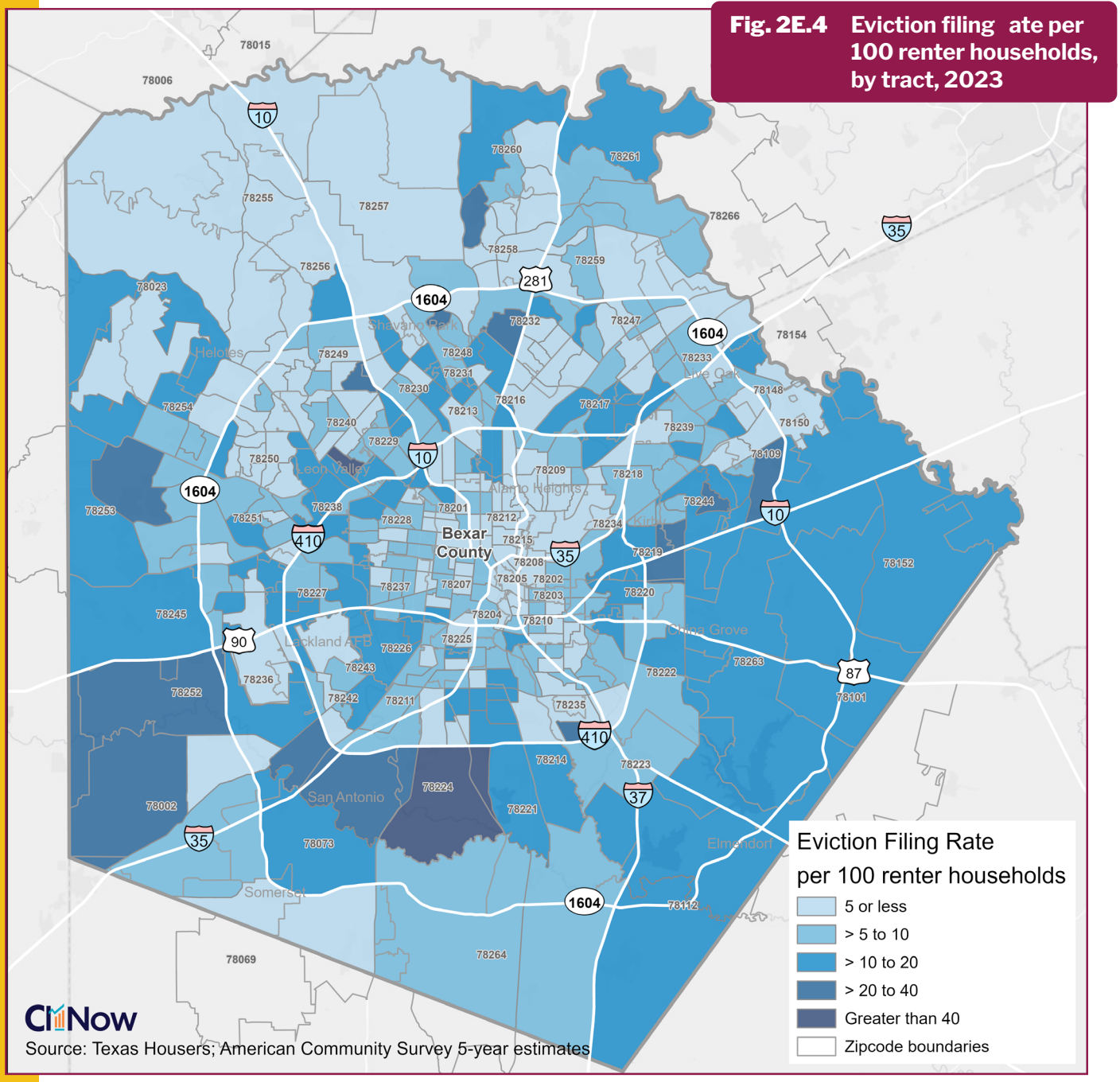
... And therefore, when [...] someone that owns a home is getting ready for retirement, that $400,000 home potentially could be paid off, and maybe is worth now $800,000, and they have a nest egg and equity that moves them into wealth and financial independence. But that person that rented, they've got nothing, and they've got no equity. So, that's why, I say, rent is the new redlining."

– Eric Cooper (President/CEO, San Antonio Food Bank)

Formal eviction filings are one of the few sources of eviction data available, but substantially underestimate the actual rate of eviction, as many or most evictions occur before a court filing becomes necessary. Informal evictions are common, as tenants "see the writing on the wall" and self-evict, or leave after lockout or landlord threats, because they do not know their rights under the law.

Figure 2E.4 maps eviction filing rates by census tract, with ZIP code boundaries and names overlaid to help the reader identify neighborhoods. Filing rates were generally lower on the northside and in the Alamo Heights-281-Broadway corridor, but pockets of high eviction rates are visible throughout the county. In very small ZIP codes like the one in Leon Valley and less-populous ZIP codes like 78224 on the south side, a single large apartment complex can drive up the eviction filing rate for the entire ZIP code.

Fig. 2E.4 Eviction filing ate per 100 renter households, by tract, 2023



CINow

Source: Texas Housers; American Community Survey 5-year estimates

Unhoused

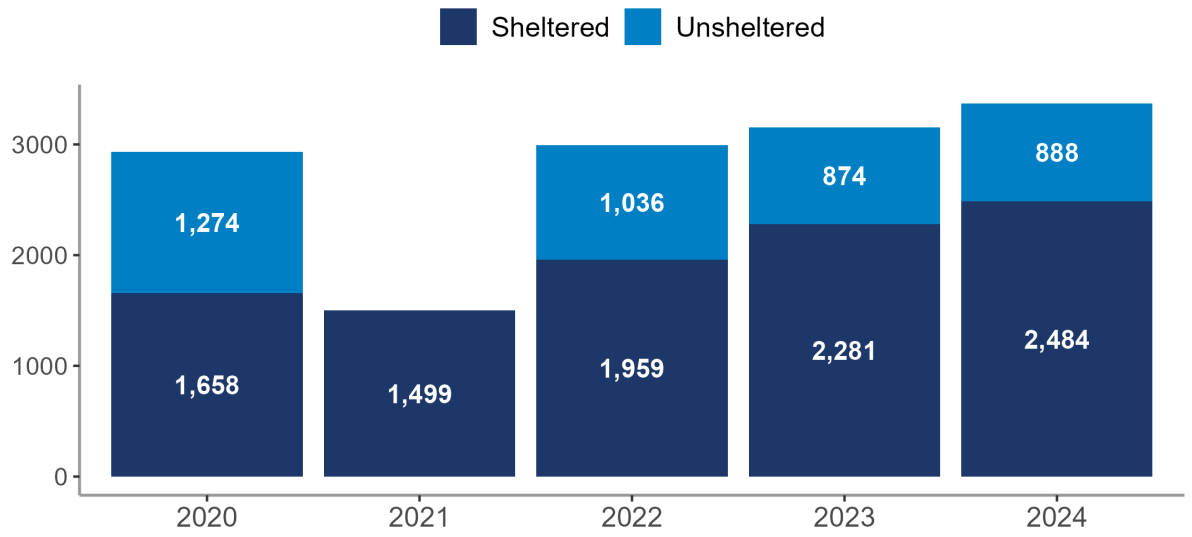
The South Alamo Regional Alliance for the Homeless (SARAH) Point-in-Time (PIT) count provides a one-night snapshot of people experiencing homelessness in the region. It counts both those who, at the time of the count, are sheltered (e.g., staying in emergency shelters or transitional housing programs) and unsheltered (e.g., sleeping outdoors, in abandoned buildings, or vehicles). Because the PIT count measures only a single night, it provides a valuable but incomplete picture that captures trends over time but does not account for all people who may experience homelessness over the course of a year.

Recently, the combined total count of people experiencing homelessness has increased each year, mirroring population growth in the region, and possibly also reflecting improved identification and engagement of people in

need (**Fig. 2E.5**). At the same time, the proportion of unsheltered individuals in the total count has declined (from about 40% in 2020 to just under 30% in 2024). Contributing factors include expanded street outreach teams, better-coordinated intake processes, greater access to shelter beds after COVID-19 distancing restrictions eased, and a boost in resources from CARES Act funding and emergency housing vouchers.[18]

Fig. 2E.5 Number of sheltered and unsheltered unhoused persons

Bexar County, Texas



"Unsheltered" count for 2021 is unavailable due to data collection restrictions during the COVID-19 pandemic.
Source: South Alamo Regional Alliance for the Homeless Point in Time Report
Prepared by CINow for The Health Collaborative

Foster Youth

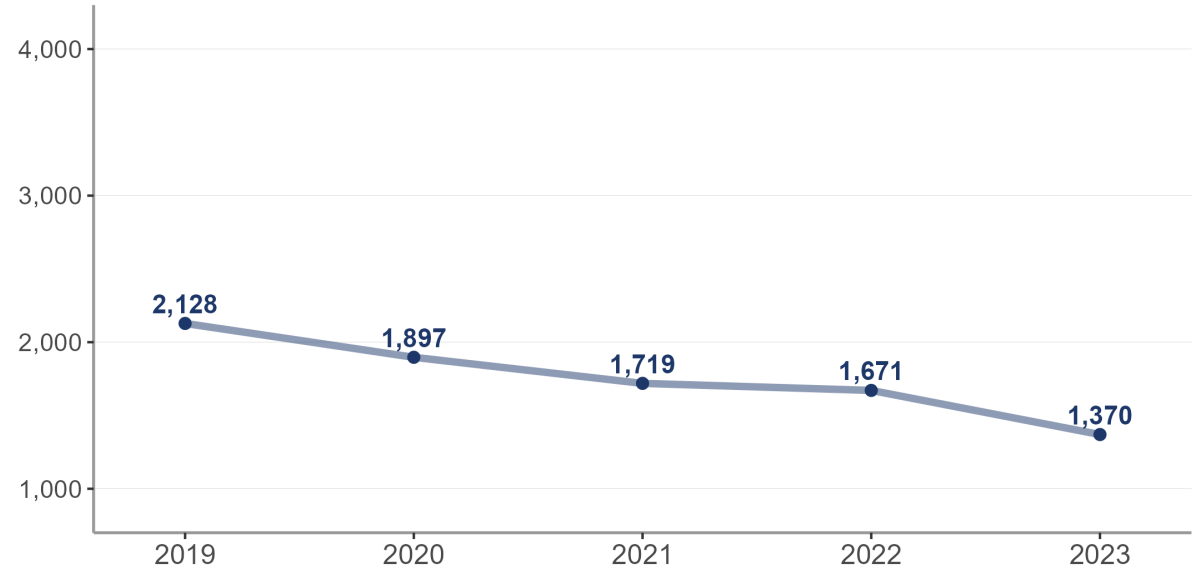
Foster youth are a vulnerable population that faces a heightened risk of homelessness and housing instability as they transition out of the system. **Figures 2E.6** and **2E.7** show the number of foster youth who exited the legal custody of the Texas Department of Family and Protective Services (TDFPS). There are different types of exits, including aging out, adoption, and reunification with family.

Figure 2E.6 shows a gradual decline in youth exiting TDFPS legal custody since 2019, with the most significant drop between 2022 and 2023, during which time 301 fewer youth exited the system. While fewer exits could indicate reduced entries into foster care, it does not necessarily reflect an improvement. It may instead point to longer stays in legal custody without stable placements, delays in reunification or adoption, or other system- or policy-level challenges like post-COVID-19 pandemic backlogs.

Figure 2E.7 shows race/ethnicity differences in the number of foster youth exiting the legal custody of Texas DFPS. The number for Hispanic foster youth stands out as the highest among all groups, with 1,017 exits in 2023. However, it does not necessarily indicate a higher rate of exit. Instead, it could just reflect a larger Hispanic population in care. As noted above, a higher number of exits from legal custody is not always positive since it does not imply stable placement—for example, more youth may be aging out of care rather than being reunited with their families or adopted.

Fig. 2E.6 Number of foster youth who exited Texas DFPS legal custody

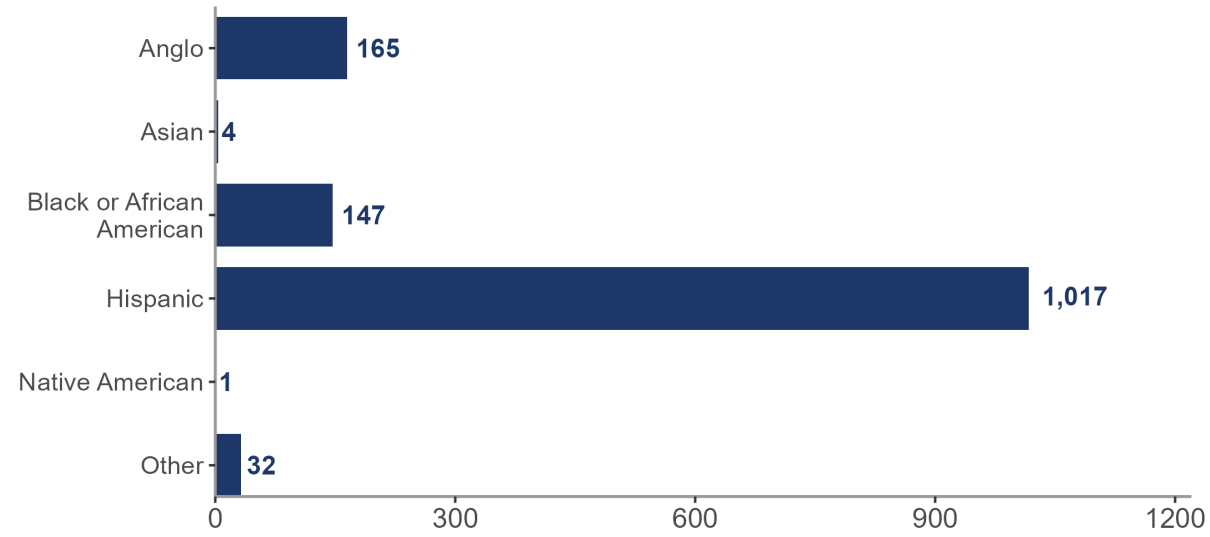
Bexar County, Texas



DFPS= Department of Family and Protective Services
Source: Texas Department of Family and Protective Services
Prepared by CINow for The Health Collaborative

Fig. 2E.7 Number of foster youth who exited Texas DFPS legal custody, by race/ethnicity, 2023

Bexar County, Texas



DFPS= Department of Family and Protective Services
Source: Texas Department of Family and Protective Services
Prepared by CINow for The Health Collaborative

A CHNA Community Survey respondent emphasized the urgent need to address the inequities that youth aging out of foster care continue to face, especially around housing, education, health care, and general long-term well-being.

"I wish health care and local government staff knew the extreme inequity for youth aging out of foster care. At times, they exit the system into homelessness (1 in 4) which can lead to systemic distrust, inability or lack of knowledge of benefits that are owed them, abysmal college degree attainment rates (~3%), and higher rates of unplanned or early parenthood (1 in 10 - aged 17 to 19 years & 1 in 4 - aged 19 to 21), increased incarceration rates (1 in 5).

This, in conjunction with academic gaps, mental and physical health, engagement in safety and risky behaviors, and subpar wellbeing--prevalent poverty, lack of community/family relationships, education, and healthcare collide to change the trajectory of youth with experiences of foster care.

There is a need for additional youth-specific programming for emergency housing and transitional housing in Bexar County. Also, this information needs to be clearly communicated widely via bus wraps, roadside signs, training healthcare and other professionals on the resources available. I do hope we will make an intentional effort to support youth with experiences of foster care in an excellent way."

– CHNA Community Survey Respondent

STAYING SAFE AT HOME AND IN OUR COMMUNITIES

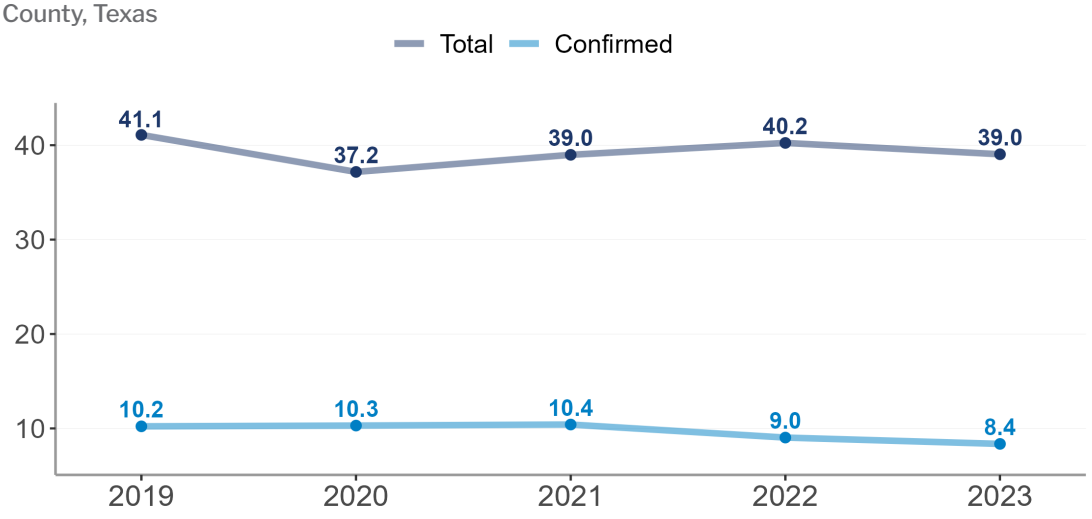
Staying safe at home and in our communities means being protected from abuse, neglect, and community violence across all stages of life. Understanding how safe residents feel in their homes, on the roads, and in their daily lives helps identify risk factors and highlight communities that may need additional support or intervention.

Child Abuse

Figure 2F.1 shows the report rate and confirmed victim rate of child abuse or neglect in Bexar County. Between state fiscal years 2019 and 2023, Bexar County's rate of child abuse and neglect reports averaged between 39 and 41 per 1,000 children, with a notable dip in 2020, when COVID-19 pandemic-driven school closures greatly impacted the rate. School personnel are very often the people who see and report signs of abuse or neglect when school is held in person, so opportunities to identify and report concerns decrease significantly if schools are closed or operating remotely. The rate of confirmed victims per 1,000 children, however, actually ticked up slightly in 2020, and both rates increased the next several years. The 2023 report rate is 5% lower than the 2019 report rate, while the 2023 confirmed victim rate is 18% lower – a notable gap.

Fig. 2F.1 Child abuse or neglect report rate and confirmed vi tim rate per 1K children aged 0-17

Bexar County, Texas



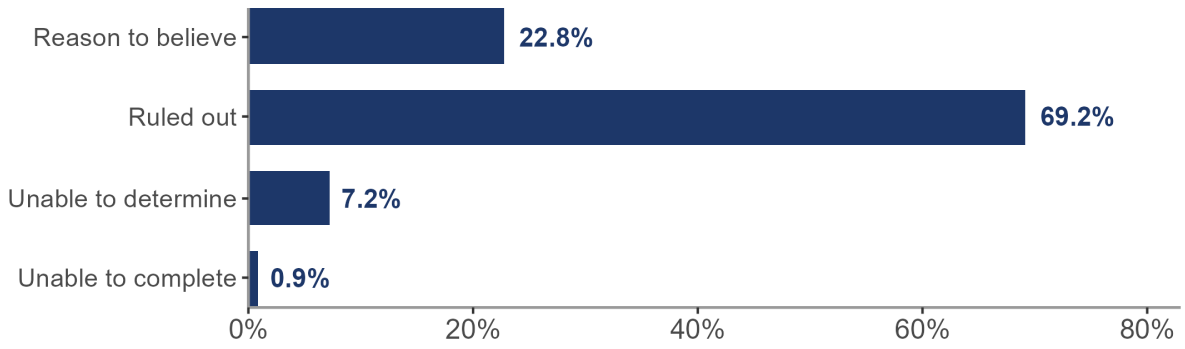
Source: Texas Department of Family and Protective Services
Prepared by CINow for The Health Collaborative

Because staffing shortages and high caseloads may hinder investigations and victims being either confirmed or ruled out, tracking the rate at which reports are investigated and investigations completed helps reveal not just potential underreporting but also gaps in system capacity. **Figure 2F.2** shows the disposition of investigations for 2023. In 23% of investigations, TDFPS staff found reason to believe child abuse or neglect had occurred, and in 69% abuse and neglect were ruled out. Notably, 8% of all cases remained inconclusive, classified as "unable to complete" or "unable to determine"; the same was true in 2019.

What happens between the report and the investigation is not shown in this chart. In 2023, 70% of reports were assigned for investigation; 14% were handled through "alternative response", engaging with the family without opening an investigation; and 16% received neither alternative response nor investigation. In 2019, those figures were 61%, 13%, and 26%, respectively.

Fig. 2F.2 Percent of child abuse or neglect reports for children aged 0-17, by disposition, 2023

Bexar County, Texas



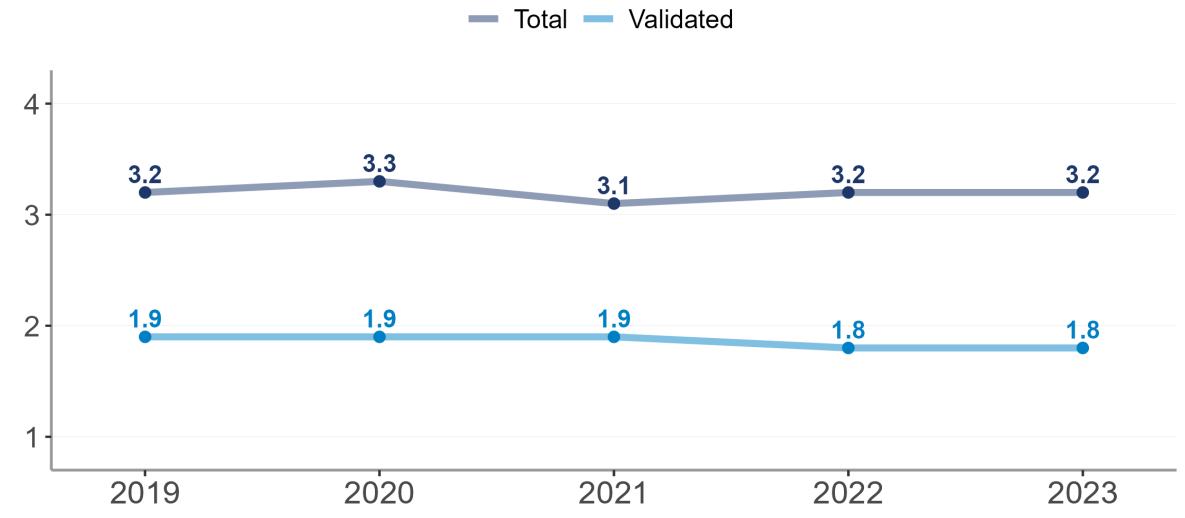
Source: Texas Department of Family and Protective Services
Prepared by CINow for The Health Collaborative

Older Adult Abuse

Adults aged 65 and older are another vulnerable population. Like child abuse or neglect, the rates for total reports and validated reports per 1,000 adults remained relatively steady between 2019 and 2023 (**Fig. 2F.3**). The pandemic-era drop in reports was much smaller than that seen for child abuse or neglect reports – 3% compared to 9% – and occurred a year later. Further, the older adult abuse or neglect report rate has ticked back up to pre-pandemic levels, and the validated report rate has declined just 5% from 2019. Medical personnel are the most common source of reports of older adult abuse or neglect.

Fig. 2F.3 Older adult abuse or neglect report rate and validated rate per 1K adults aged 65 and older

Bexar County, Texas

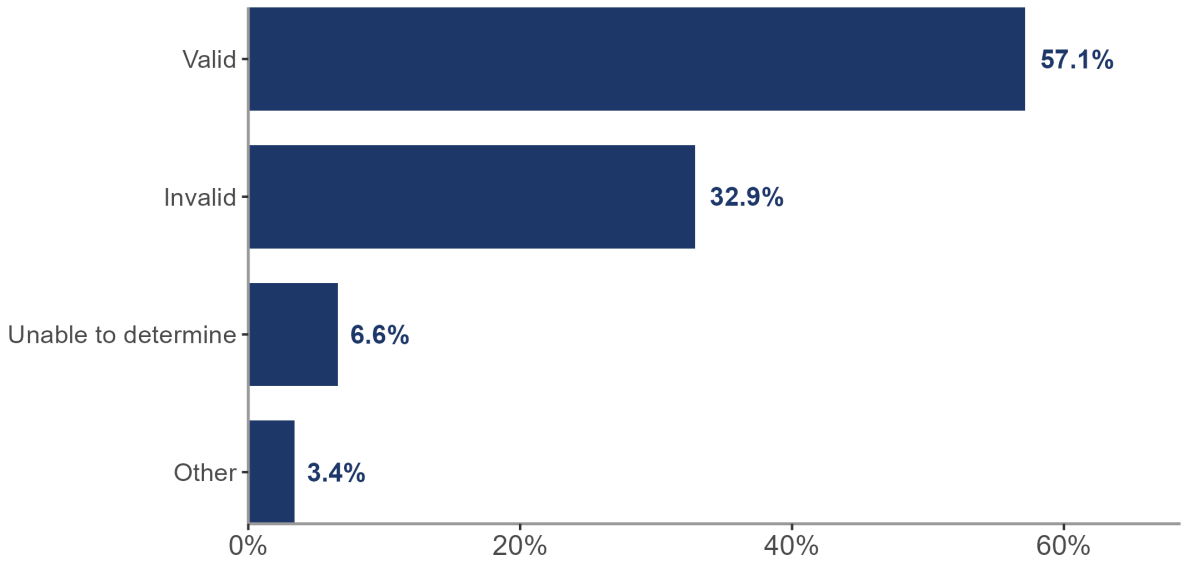


Source: Texas Department of Family and Protective Services
Prepared by CINow for The Health Collaborative

In 2023, just 33% of older adult abuse or neglect reports were determined to be invalid, compared to 69% for child abuse or neglect, while 10% were categorized as "other" or "unable to determine" (**Fig. 2F.4**). Data on the proportion of reports not assigned for investigation is not readily available.

Fig. 2F.4 Percent of older adult abuse or neglect reports for adults aged 65 and older, by disposition, 2023

Bexar County, Texas



Source: Texas Department of Family and Protective Services
Prepared by CINow for The Health Collaborative

In focus groups, participants highlighted how staying safe at home and in the community goes beyond preventing abuse, expressing a need for better education and safe spaces for kids.

"We need to bring back the DARE program into schools... if they were to shut down all the smoke shops around here and put in like a resource center for our community, or learning centers. You know, where they have computers. They need safe places where they can explore, like sports activities, where they can go to a safe place to play sports. Because I know there's some kids that want to go to the gym, but they can't even afford it, because you have to be a member. You have to pay for it. We need some affordable gyms, and in general, like safe places for children and families."

– CHNA Focus Group #1 Participant

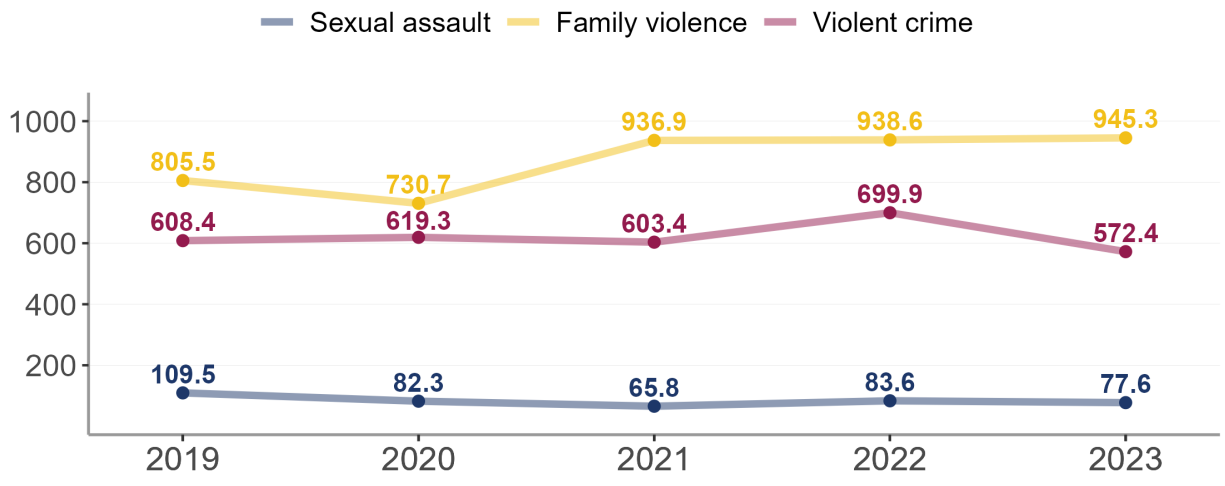
Violence

Figure 2F.5 illustrates trends for sexual assault, family violence, and violent crime rates per 100,000 people in Bexar County. Although these indicators help assess community safety and freedom from violence, they do not capture the full spectrum of harm or all forms of violence. Between 2019 and 2023, all three indicators reflected the impact of the COVID-19 pandemic, though not always in the same years. Contributing pandemic factors include limited access to safe reporting outlets like schools and workplaces, social isolation, service disruptions during lockdowns, and post-pandemic instability and stressors, like financial strain.

- Family violence rates were consistently the highest among the three indicators, with a noticeable decline in 2020, followed by a sharp spike in 2021 that has continued to worsen through 2023, reaching 945.3 crimes per 100,000 people. Increasing rates reflect heightened risk factors of family violence, like financial insecurity, behavioral health challenges, and access to resources.
- Violent crime rates, which include murder, reported rape, robbery, and aggravated assault, fluctuated over the five years.[19] The most significant increase happened in 2022, followed by a notable drop in 2023 to 572.4 per 100,000 people. While decreasing rates could suggest improvements in public safety or enforcement, it should be interpreted with caution. Changes in how crimes are reported and classified can influence rates and may not always reflect real decreases in violence.
- Sexual assault, which includes rape as well as other non-consensual sexual acts, continued to affect community safety and well-being. While rates dropped between 2019 and 2021, they increased again in 2022 before slightly declining in 2023 to 77.6 per 100,000 people. Decreases here should also be interpreted with caution, as sexual assault is widely underreported and subject to changes in the proportion of sexual assaults that are reported.

Fig. 2F.5 Sexual assault, family violence, and violent crime rate per 100K population

Bexar County, Texas



Violent crime includes murder, rape, robbery, and aggravated asault, as defined by the Department of Public Safety's Texas Crime Analysis.
Source: Texas Department of Public Safety; ACS 1-Year Estimates, Table: B01001; 2020 Decennial Census Estimate, Table: DP1
Prepared by CINow for The Health Collaborative

During Focus Group #1, there was much conversation about domestic violence and the need for safety courses to help break cycles of violence and harm within families and communities, pointing out how these issues are deeply interconnected with stigma, addiction, and other challenges.

"And domestic violence awareness classes... They should make it mandatory for you to take them every year... make it mandatory for everyone who lives in the household to be able to take these classes in order to live here [in public housing] that way everybody goes through the program and won't be afraid 'if I take the class, they're gonna know.' And I think that would help a lot with the violence. A lot of parents don't know, because they're just getting high... I've personally been on both sides. And I would have wanted help."

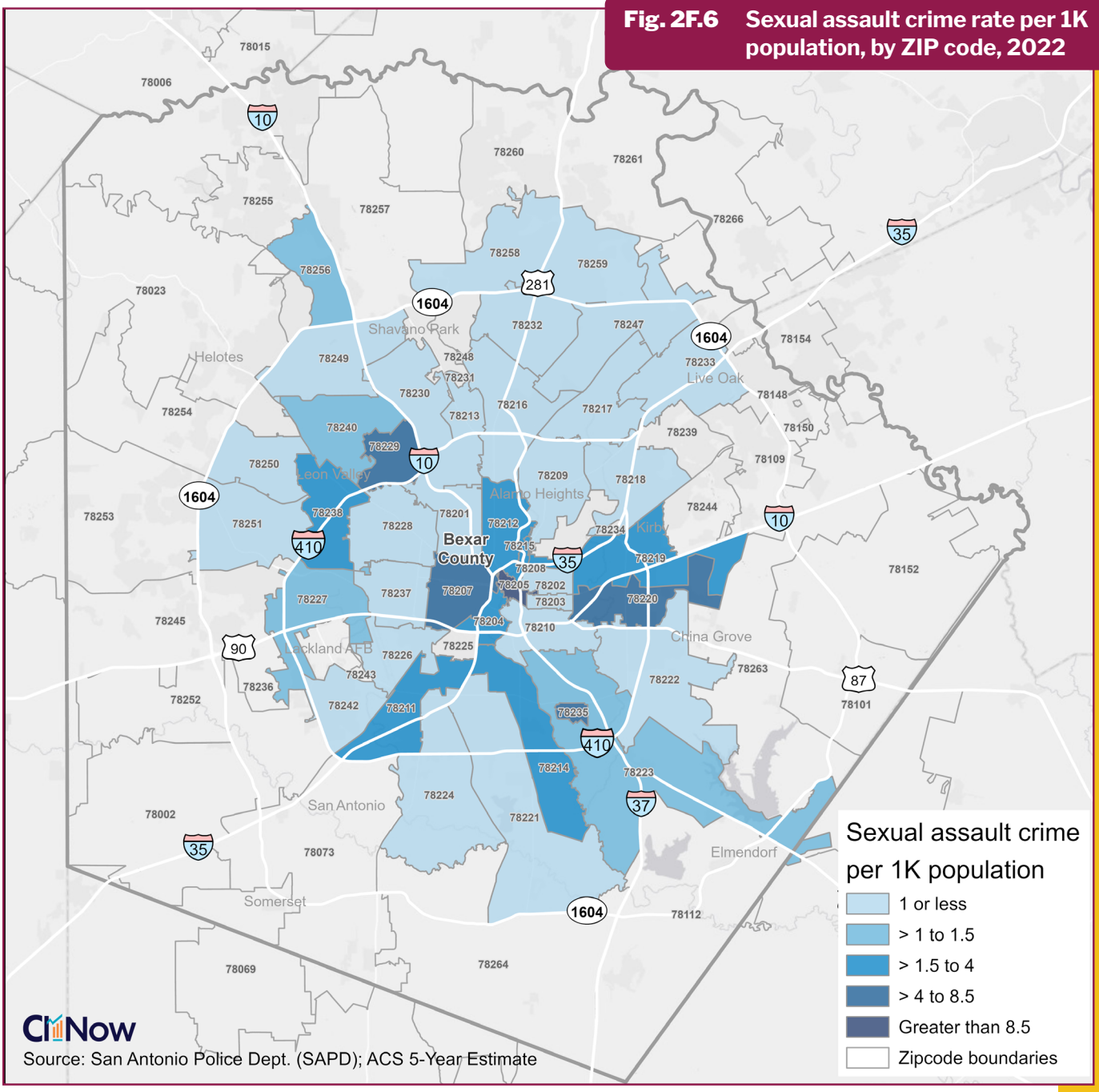
– CHNA Focus Group #1 Participant

In the same session, another participant noted how community safety efforts often overlook people with disabilities, particularly the deaf community, emphasizing the need for more inclusive and accessible services. They witnessed deaf teenagers engaging in harmful relationship dynamics.

"[When they had to intervene] he didn't fully understand why it was happening, because nobody fully tells the deaf community. He wasn't aware of the harm he was causing... With these resources, I would say about 80% of these resources wouldn't be accessible to the deaf, because a lot of places don't want to have to pay for the interpreters, because they are very expensive. Or they give the deaf person the runaround on. You have to pay for it, or they just take forever."

– CHNA Focus Group #1 Participant

Fig. 2F.6 Sexual assault crime rate per 1K population, by ZIP code, 2022

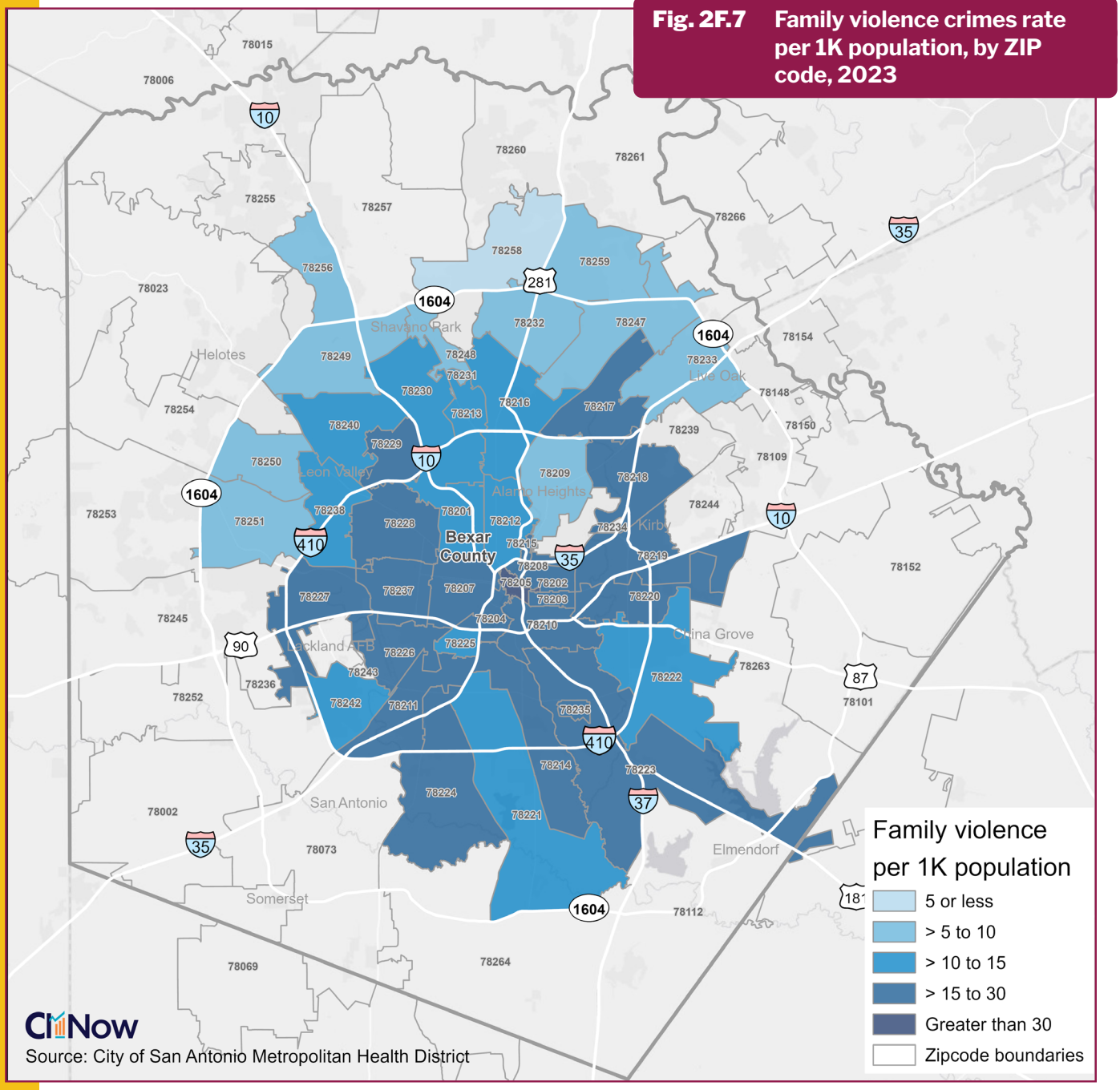


CINow

Source: San Antonio Police Dept. (SAPD); ACS 5-Year Estimate

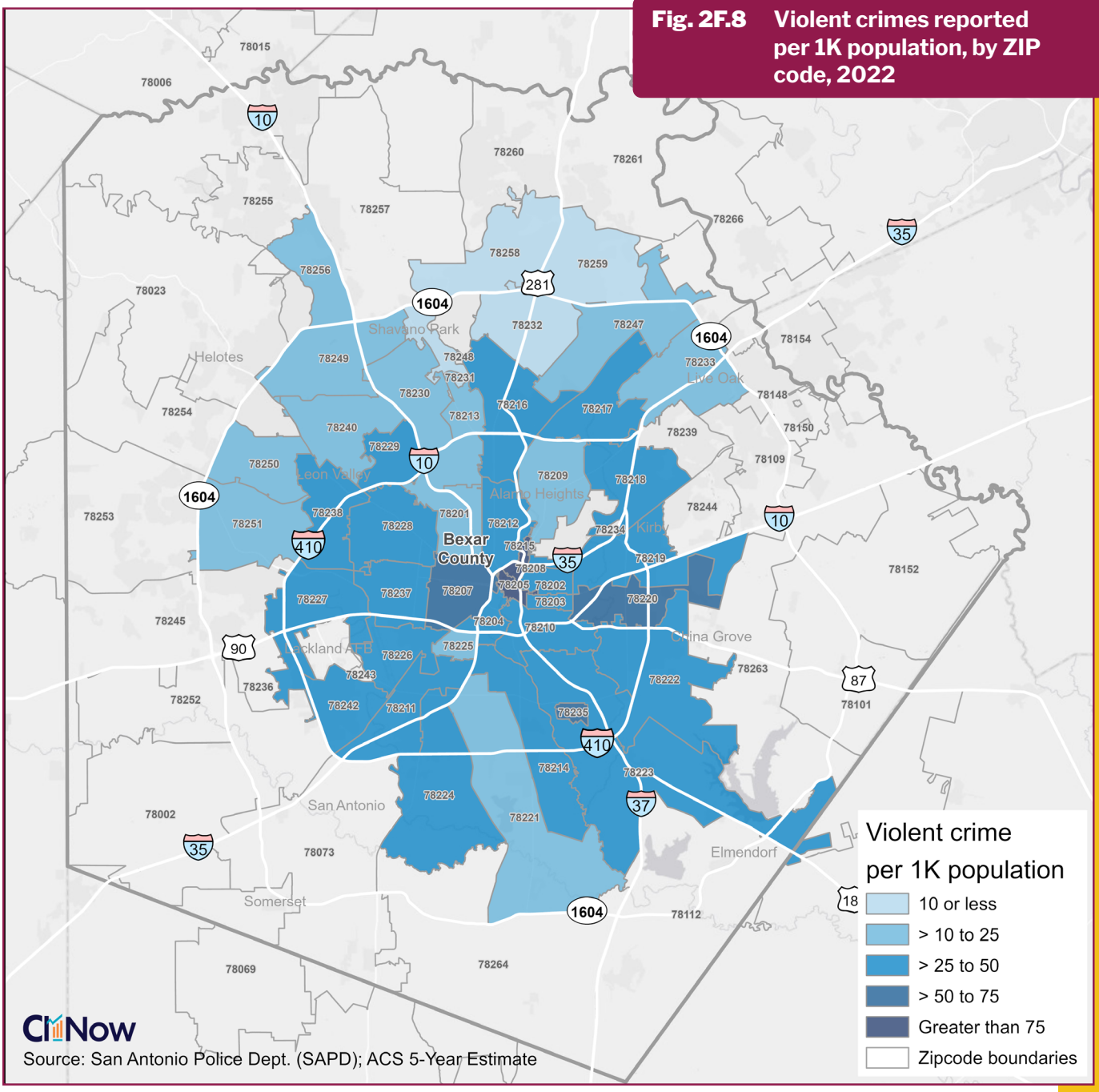
The ZIP code with the highest sexual assault rate was downtown (78205), with a rate of 19.7 crimes per 1,000 people. However, that rate should be interpreted with caution because when the resident count is so small, even a few cases can appear as a high rate (**Fig. 2F.6**). Other high rates were seen in ZIP codes 78229 in the Medical Center area and 78207 on the near west side, both of which are densely populated and so much less vulnerable to misleading rates. Notably, areas with the highest rates shift when looking at different location types; for instance, by SSAs, SSA #1, which is also downtown near ZIP code 78212, had the highest rate in the county, at 29.3 crimes per 1,000 people. It is important to note that a large proportion of sexual assaults go unreported, and the reporting rate is likely uneven across the county.

Fig. 2F.7 **Family violence crimes rate per 1K population, by ZIP code, 2023**



Family violence incidents also may be reported at different rates across neighborhoods, but the ZIP codes with the highest reported rates were downtown and generally inside Loop 410 (**Fig. 2F.7**). By ZIP code, the highest rate was found in ZIP 78205, with a rate of 99.8 per 1,000 people. Again, the downtown rate should be interpreted with caution because the population denominator is small. Unfortunately, family violence data is available only for the City of San Antonio; the gray shade indicates that data is not available for that ZIP code, not that there were no family violence incidents there in 2023.

Fig. 2F.8 **Violent crimes reported per 1K population, by ZIP code, 2022**



CiNow

Source: San Antonio Police Dept. (SAPD); ACS 5-Year Estimate

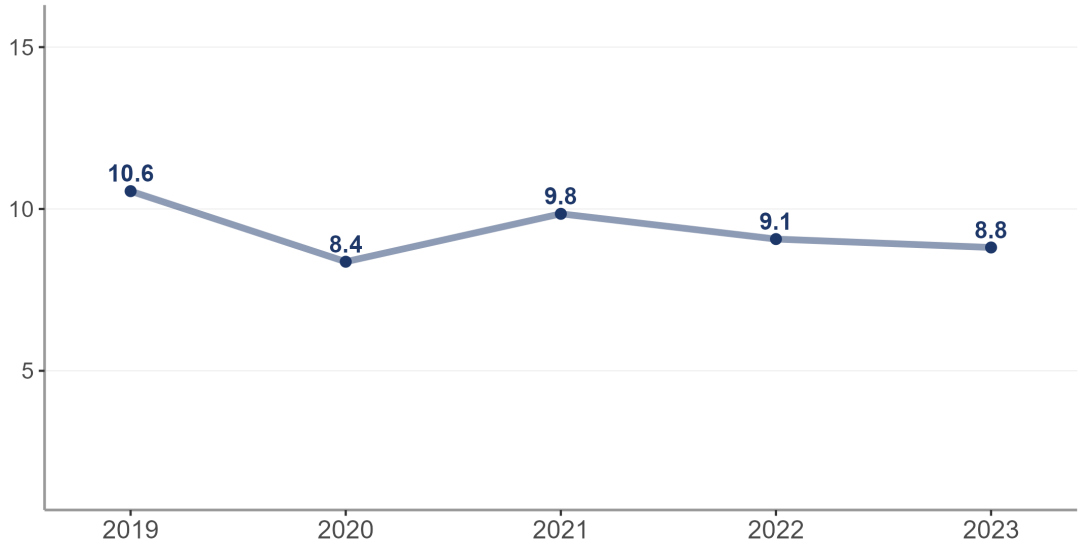
The highest overall violent crime rates per 100,000 population by ZIP code were near the center of the county (**Fig. 2F.8**). Again, the downtown rate should be interpreted with caution because the population denominator is small. The ZIP codes with the next-highest rates were 78207 just west of downtown and 78220, which straddles Loop 410 between I-10 East and Hwy. 87.

Alcohol-Related Crashes

Another community safety indicator is the alcohol-involved motor crash rate, shown per 10,000 residents in **Fig. 2F.9**. In 2019, the rate peaked at a five-year high of 10.6 crashes per 10,000 people. A notable drop occurred in 2020, reaching a five-year low of 8.4, likely due to COVID-19 pandemic-related decreases in travel. The rate rose again in 2021 but has steadily declined since, reaching a 2023 level (8.8) that is, remarkably, approaching the 2020 low. Though this does not account for all types of vehicle crashes, it might reflect changes in driving behavior, enforcement efforts, or prevention strategies.

Fig. 2F.9 Alcohol-involved motor vehicle crash rate per 10K population

Bexar County, Texas



Source: Texas Department of Transportation; ACS 1-Year Estimates, Table B01001; Decennial Census Estimate
Prepared by CINow for The Health Collaborative

Community voice underscored the many facets of what community safety means for them. Focus group participants felt that if they had access to more safe spaces for families and youth, then there would be fewer safety concerns in the neighborhood. Along with general community safety, CHNA Community Survey respondents also brought up concerns around gun violence. As one focus group participant expressed, sometimes residents have no choice but to live in areas where they do not feel safe.

"There's a lot of people who don't really have too much of a choice. They just kind of take what they can get. And the areas are drug and gang infested. And people just don't want to raise their family. They literally don't even want to go outside."

– CHNA Focus Group #2 Participant

A CLEAN AND HEALTHY ENVIRONMENT

Prolonged exposure to poor air quality and high temperatures poses serious health risks, especially for more vulnerable groups, like children, older adults, people with chronic illnesses, and those experiencing homelessness or lacking access to adequate cooling. Furthermore, extreme heat also stresses the power grid, heightening the risk of power outages during peak demand periods.

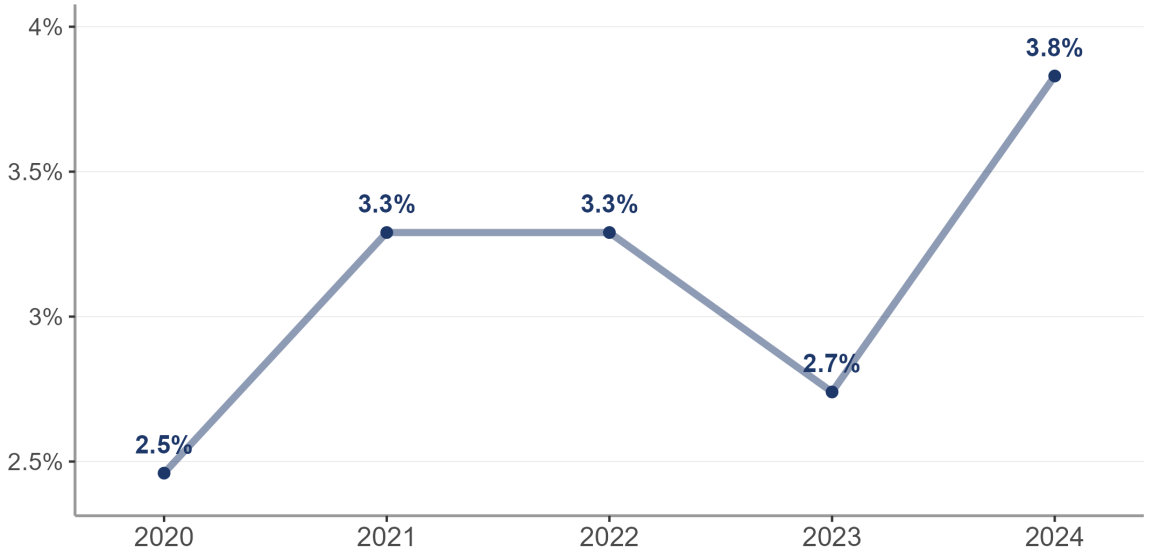
Air Quality

The Environmental Protection Agency (EPA) monitors and reports air quality levels, including the number of days with unhealthy air quality levels deemed unhealthy for sensitive groups, as shown in **Fig. 2G.1**. Sensitive groups include individuals who are more vulnerable to air pollution even at moderate levels, such as children, older adults, and people with respiratory conditions.[20] The Air Quality Index (AQI) also identifies certain minority groups as sensitive populations, such as people with lower incomes and outdoor workers, as they may face higher exposure.

In 2024, nearly two weeks of the year (3.8%) were considered unhealthy for sensitive groups—the highest count in recent years and four days more than the five-year low in 2020. On these days, sensitive groups are advised to limit outdoor activity to reduce health risks and avoid worsening underlying health conditions.

Fig. 2G.1 Percent of days with AQI unhealthy for sensitive groups

Bexar County, Texas



AQI= Air Quality Index
Source: Environmental Protection Agency
Prepared by CINow for The Health Collaborative

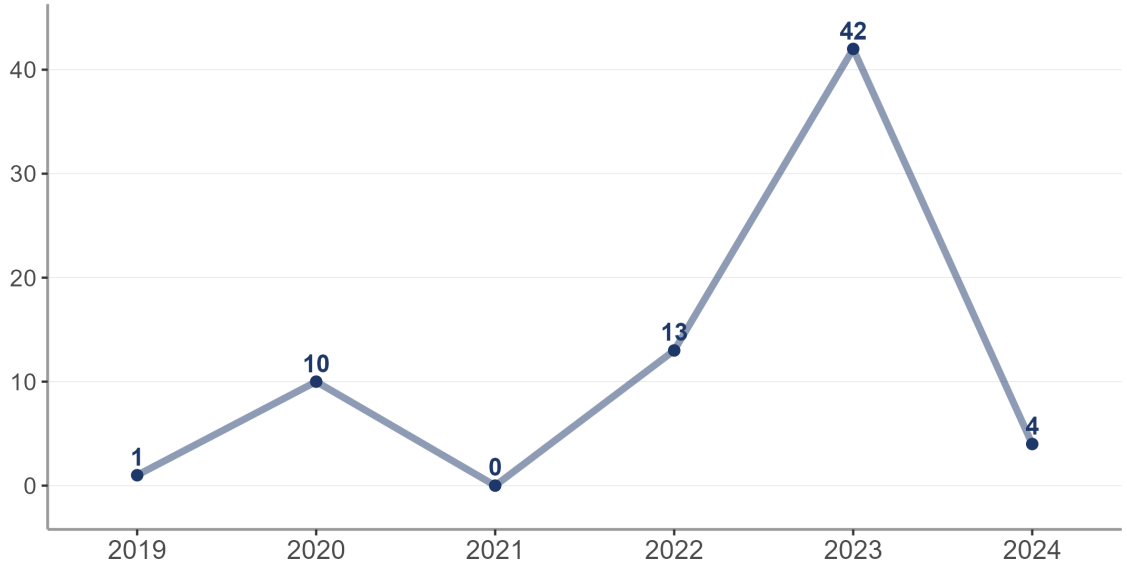
Extreme Heat

Another measure of environmental quality is the number of days with a maximum temperature of 103°F or higher, which is considered "dangerous heat" as prolonged exposure can lead to heat disorders (**Fig. 2G.2**).[21] While this data is shown specifically for San Antonio and not directly comparable to the Bexar County air quality data in the previous chart, both indicators reflect the broader impacts of climate and environmental conditions on public health.

Between 2019 and 2024, the numbers fluctuated widely, ranging from zero days in 2021 to a high of forty-two days in 2023. Notably, this 2021 drop to zero days occurred across other cities and areas and has been linked by NASA to La Niña temperature patterns.[22] The most recent year, 2024, only had four days with a maximum temperature of 103°F or higher. This fluctuation reflects how days with extreme heat are unpredictable and highlights a need for community preparedness.

Fig. 2G.2 Number of days with a maximum temperature of 103° F or greater

Bexar County, Texas



Source: National Weather Service
Prepared by CINow for The Health Collaborative

One focus group participant talked about the struggle to afford cooling and how financial barrie s can make even basic relief, like air conditioning or a fan, out of reach, particularly for vulnerable populations.

"You know what they should do is help people during the summer with their electric bill, because it is so hot. Some people cannot afford to turn on their air condition, or to buy an air condition, or to buy a fan - a good fan, not the box fan, because the box fans really don't throw air, and you can't put them in your window if you live in an apartment, because they don't allow that, and you can't sleep with your windows open. They need to learn to help people with a, with their air condition, give them out, or help them pay their bill, especially elderly people."

– CHNA Focus Group #3 Participant

Dealing with extreme weather conditions was a common concern among focus group participants, CHNA Community Survey respondents, and key informants, especially how it disproportionately impacts vulnerable populations, such as the elderly and those without stable housing.

"I think it's more on the side of those who don't have anywhere to go, like those who are unhoused probably experience it (extreme weather) more than we do, and there are some shelters who don't understand the necessity of 'it's hot, and we need air,' or 'it's cold, and we need heat.' The community isn't very compassionate about making sure that they're taken care of. If it's cold outside, they need a place and also something warm to put on, and the places they do go where they know they might find warmth or something, the community is very adamant about calling the police, because they don't have nowhere to go. And so, there's only so much they can and can't do when it comes to when it's cold and when it's hot outside."

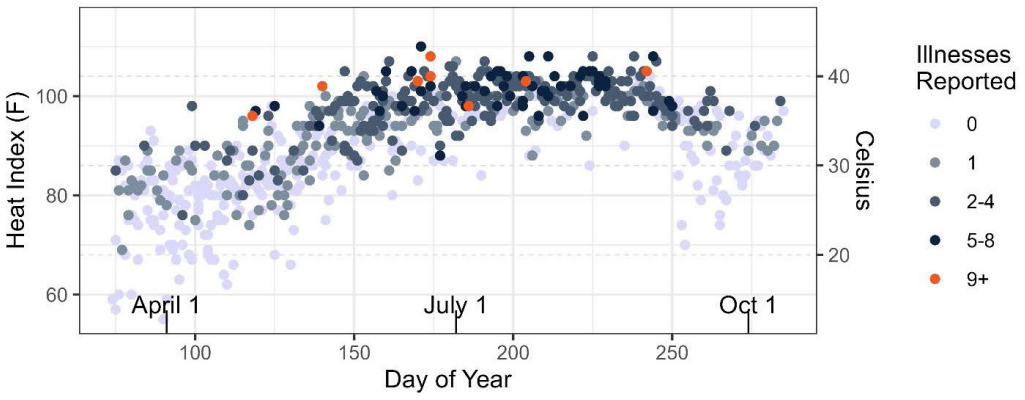
– CHNA Focus Group #2 Participant

The City of San Antonio Metropolitan Health District recorded 781 cases of heat illness, primarily heat exhaustion, from March to October 2023. That total was 50% higher than in 2022, when 522 cases were recorded during the same period.[23] National Weather Service data show that 2023 logged a total of 75 days with temperatures hitting 100°F or higher, as compared to 58 in 2022.[24]

A report from the Sustainable, Pervasive Urban Resilience (SPUR) Center at the University of Texas at San Antonio, commissioned by the City of San Antonio Office of Sustainability, relates the historical count of heat-related illness cases reported per day between 2017 and 2020 to the heat index for that day of the year (**Fig. 2G.3**).[25] Particularly in March and April, the heat index need not be extremely high to see sizable numbers of heat-related illness cases.

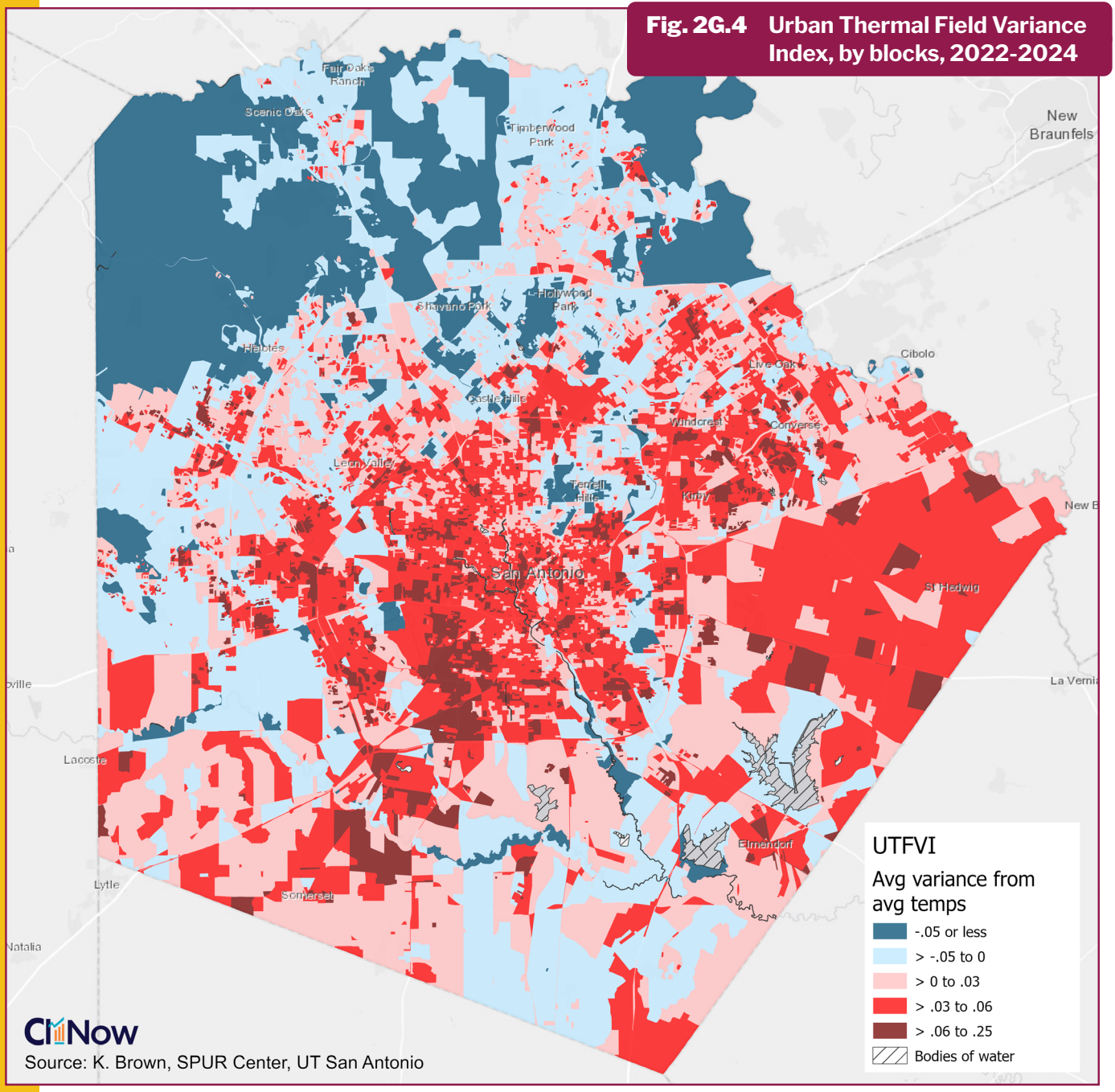
Fig. 2G.3 Count of cases of heat illness by day and day's heat index, 2017-2020

San Antonio, Texas



Source: The SPUR Center at UTSA. (n.d.). An Assessment of Urban Heat Vulnerability in San Antonio, Texas. Used with permission.

Fig. 2G.4 Urban Thermal Field Variance Index, by blocks, 2022-2024



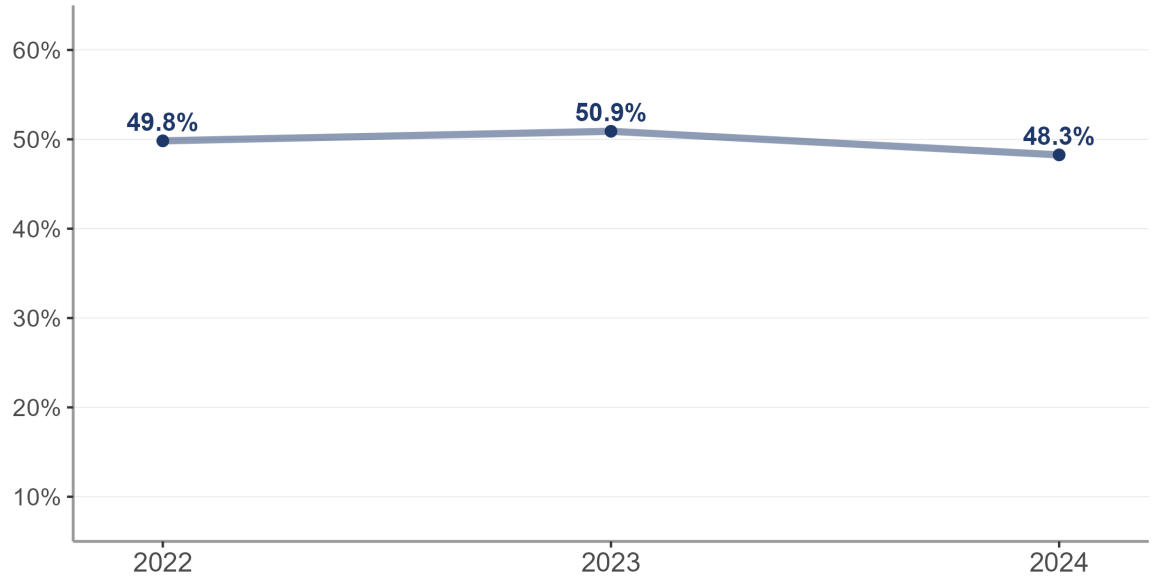
Whole-county data cannot tell the entire story, however, as heat varies considerably across the county and is exacerbated in "urban heat islands" by water-impervious surface cover like concrete, buildings that restrict air flow, human activity like running household appliances, and sparse tree canopy.[26] SPUR Center researchers calculated the urban thermal field variance index (UTFVI) to normalize temperature data across multiple measurement dates. That data is mapped by Census block in **Figure 2G.4**. To simplify somewhat, the higher the UTFVI, the hotter that area is relative to the countywide average; the lower the UTFVI, the cooler that area is relative to the countywide average. Although there are blocks warmer than the county average in most areas of the county, higher-income areas like Alamo Heights, Terrell Hills, Castle Hills, Shavano Park, and Hollywood Park are far cooler than neighboring areas that are equally urban but lower-income.

Walkable Park Access

As part of their ParkScore® Index, the Trust for Public Land measures the percentage of residents living within a 10-minute walk (about half a mile) of a public space.[27] **Figure 2G.5** shows that between 2022 and 2024, around half of Bexar County's residents had walkable park access (on average, about 49.7%), with a slight drop in 2024. This means that the other half of the population did not have access. Ensuring equitable access to public outdoor spaces is important for promoting community health and well-being, helping with climate resilience, and building stronger, more connected communities.

Fig. 2G.5 Percent of population with walkable park access

Bexar County, Texas



Source: Trust for Public Land
Prepared by CINow for The Health Collaborative

As a focus group participant mentioned, providing safe spaces for families and children is not as simple as placing a park or patio in a neighborhood. It also means providing solutions for other environmental hazards, like the loose dogs and animals that make families feel unsafe to walk in their neighborhoods.

"It would be nice to have like a patio, or like a backyard, but in this neighborhood, I personally wouldn't recommend it, because there are a lot of stray dogs."

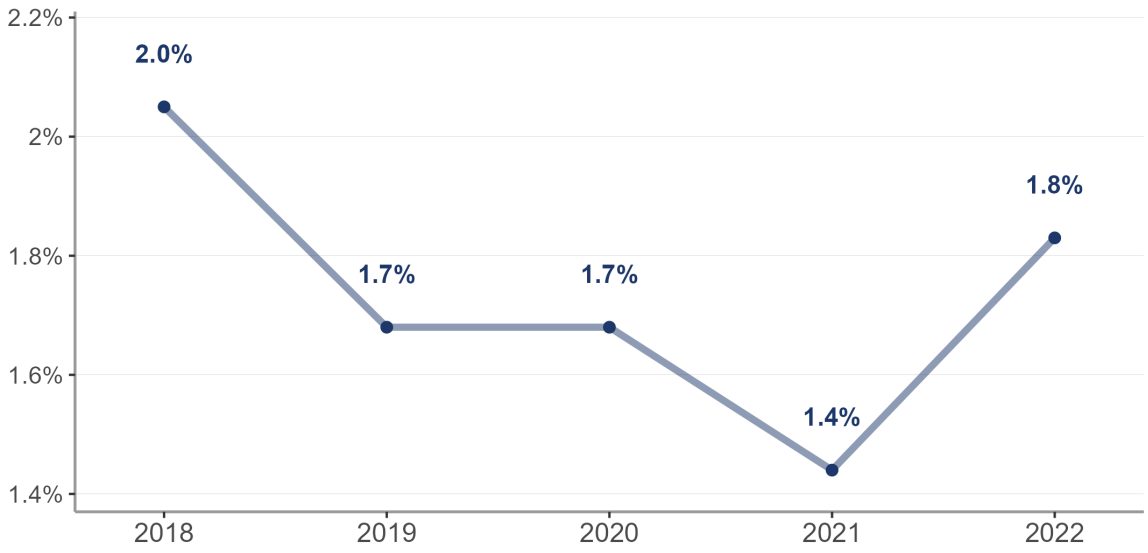
– CHNA Focus Group #2 Participant

Lead Exposure

Lead is a toxic metal that can still be found in many living environments, like peeling paint in older homes, contaminated soil, aging water pipes, and imported toys. Even low levels of exposure can cause serious health problems, especially in young children, harming a child's brain and nervous system, potentially causing developmental delays, learning difficulties, and other permanent effects.[28] The only way to confirm exposure is through a blood test, and early detection is critical for identifying the source and initiating treatment. **Figure 2G.6** shows the percentage of children ages zero to five who tested positive for elevated blood lead levels, which remained relatively flat from 2018 to 2022, between 1.4% and 2.0%.

Fig. 2G.6 Percent of children aged 0-5 who were tested for lead poisoning that have elevated blood lead levels

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

GETTING THE CARE WE NEED

Access to healthcare is more than just having insurance coverage; it means getting the care one needs, when needed, without barriers. In addition to insurance, key factors include affordability, transportation, and health literacy. Importantly, these factors are further exacerbated by disparities experienced by certain populations, such as rural or marginalized groups.

Healthcare Provider Availability

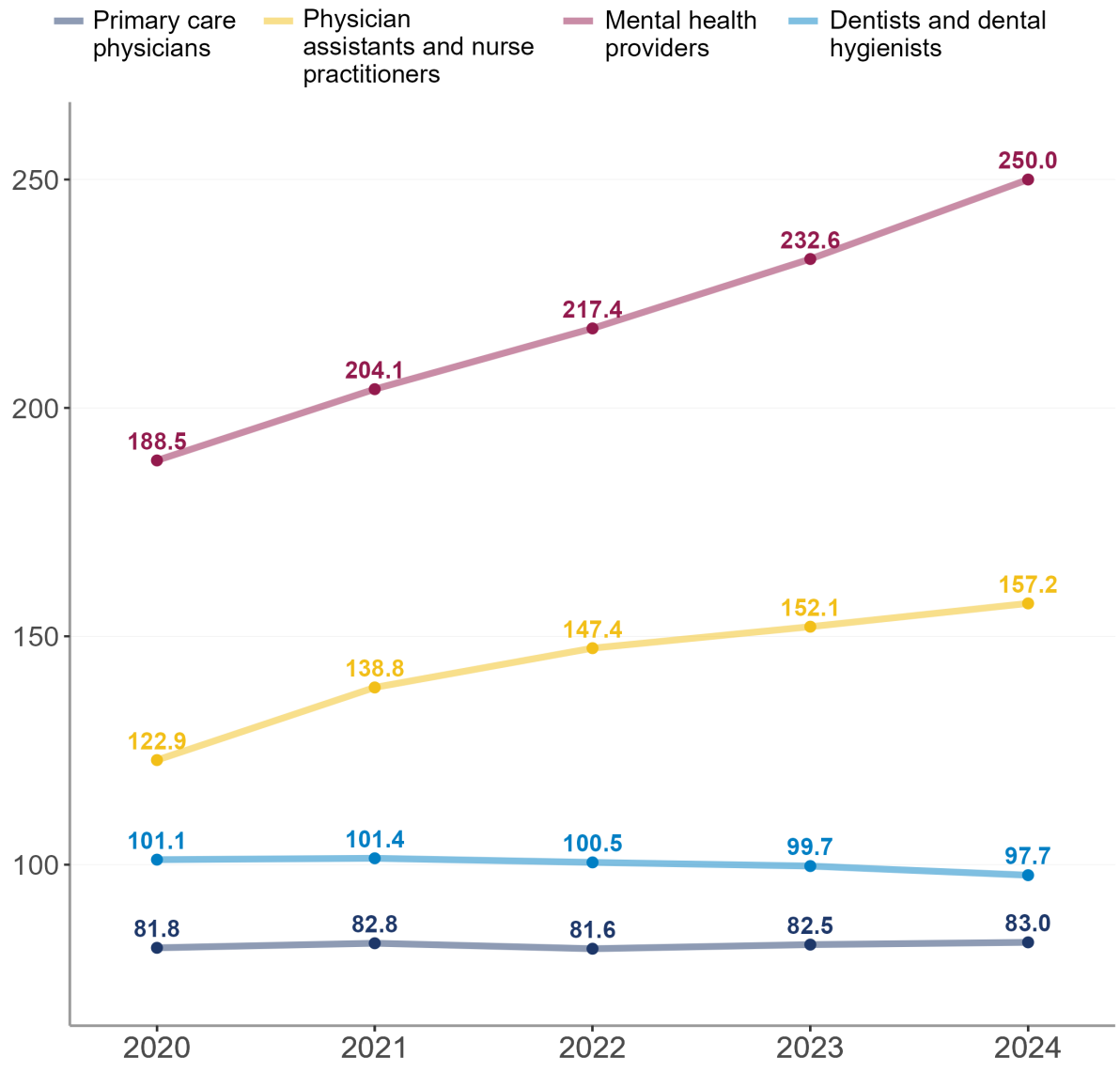
Another key factor is the availability of providers, especially for specialized services like reproductive care or in-home support. As one of the largest counties in the region, Bexar offers more healthcare access to providers and specialized services than many other areas, attracting individuals from surrounding regions. Still, significant gaps remain when looking at the number of providers available to residents.

Figure 2H.1 shows the number of select healthcare providers per 100,000 residents from 2020 to 2024. While the number of primary care professionals remained stable over this period, other provider types saw changes. These numbers point to shifting dynamics in health care access as well as the workforce distribution in the region.

- At the bottom, with the least availability, were primary care professionals, which includes family medicine physicians and pediatricians. They have maintained a low, steady presence, averaging about 82 per 100,000 residents throughout the five years.

Fig. 2H.1 Number of primary care physicians, mental health providers, and dentists and dental hygienists per 100K population

Bexar County, Texas



Source: Texas Department of State Health Services, Health Professions Resource Center; University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps
Prepared by CINow for The Health Collaborative

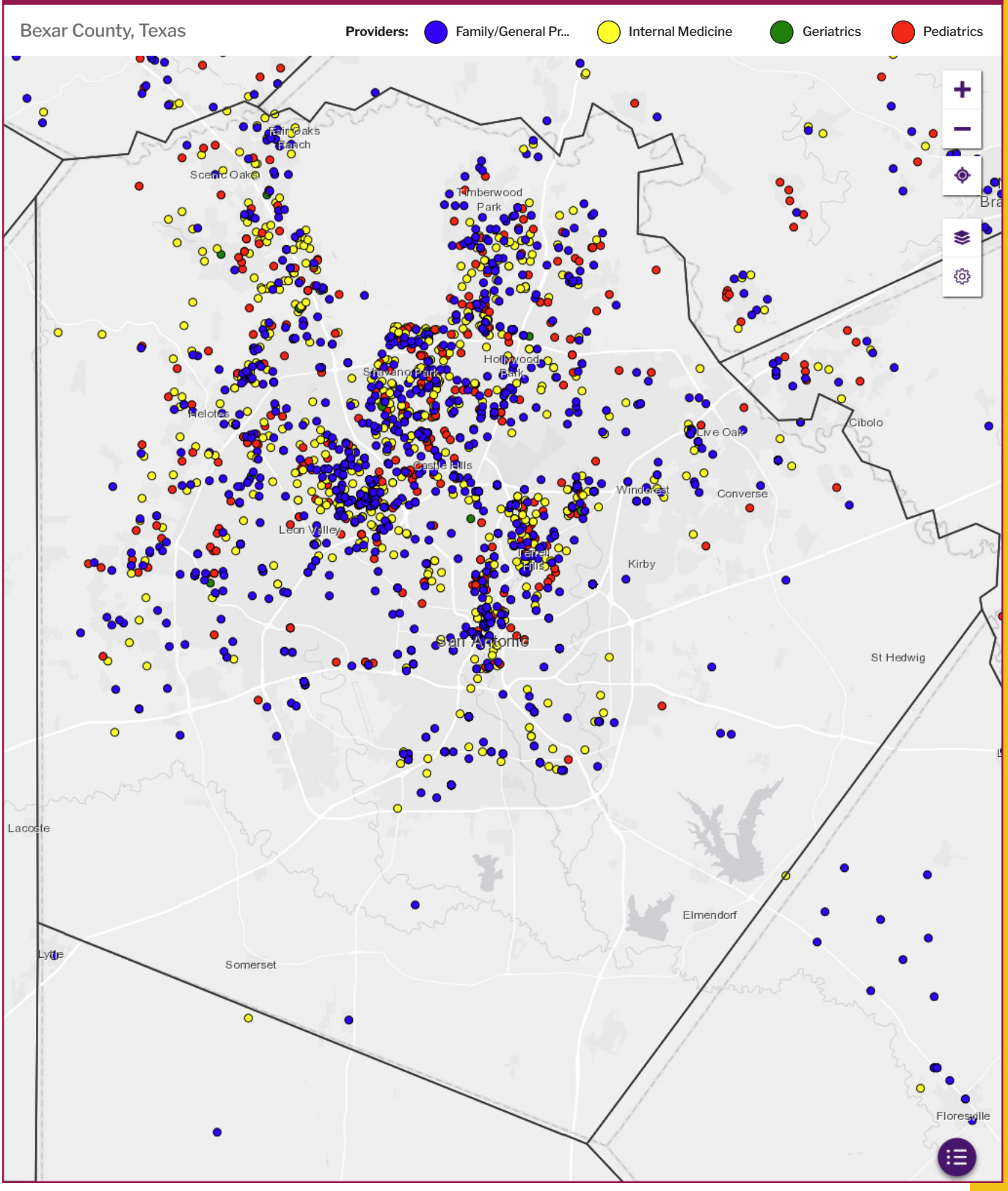
- Notably, mental health provider numbers had the highest availability throughout, with numbers rising more sharply than other provider types. As of 2024, there were 250 mental health providers per 100,000 residents, a 33% increase from 2020. This trend might highlight growing mental health needs and/or increased investment in behavioral health services.
- Similarly, the number of physician assistants (PAs) and nurse practitioners (NPs) increased over time, surpassing the number of dentists and dental hygienists in 2022 and reaching 157.2 per 100,000 residents by 2024. This shift may signal changing roles in healthcare delivery and efforts to fill provider gaps.
- In contrast, the number of dentists and dental hygienists slightly decreased over time, with 142.7 per 100,000 residents in 2024.

Not shown in the chart are the even lower numbers for specialized care including obstetrician/gynecologist (Ob/Gyn) providers (36.2 per 100,000 female residents in 2023) and home health providers (which remain scarce at just 0.3 per 100,000 residents).

Health care of all kinds tends to be concentrated in the northern half of the county. The American Medical Association's interactive online Workforce Explorer[29] shows the geographic distribution of different kinds of health care providers. However, the data does not include all provider types (e.g., dental care providers, licensed clinical social workers), and the map cannot be filtered to show only providers engaged in direct patient care.

The following four figures (**Fig. 2H.2 to 2H.5**) show different provider distributions across the county. As shown in across the maps, the urban north side has a much higher density of providers than the rest of the county for primary medical care (family practice, internal medicine, pediatrics, and geriatrics, **Fig. 2H.2**), midlevel providers (physician assistants and nurse practitioners, **Fig. 2H.3**), obstetrics and gynecology providers (OB/GYN physicians and midwives, **Fig. 2H.4**), and mental health providers (psychiatrics and clinical psychologists, **Fig. 2H.5**).

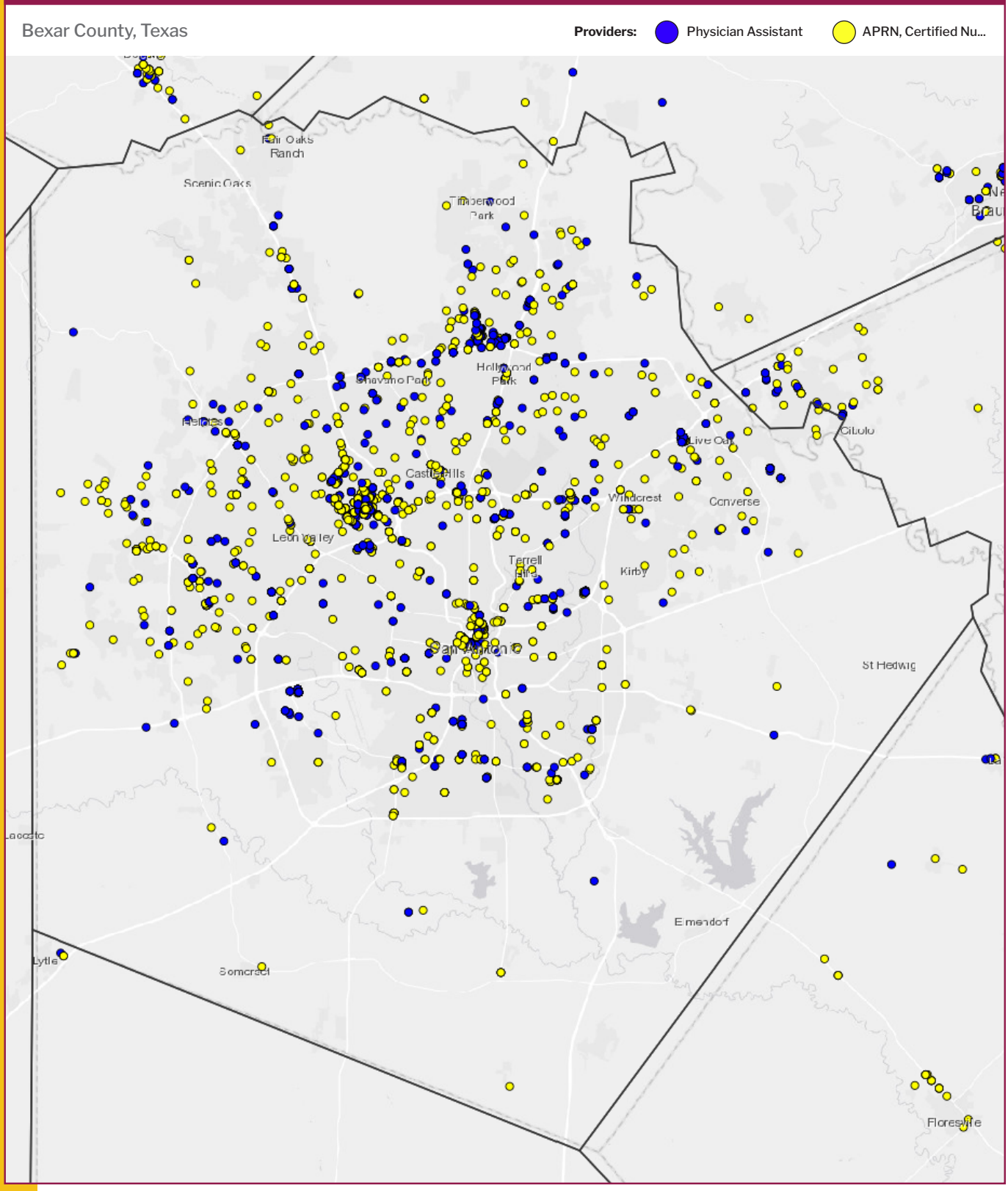
Fig. 2H.2 Distribution of primary medical care providers, 2025



Source: American Medical Association (AMA) Workforce Explorer

Fig. 2H.3 Distribution of mid-level medical care providers, 2025

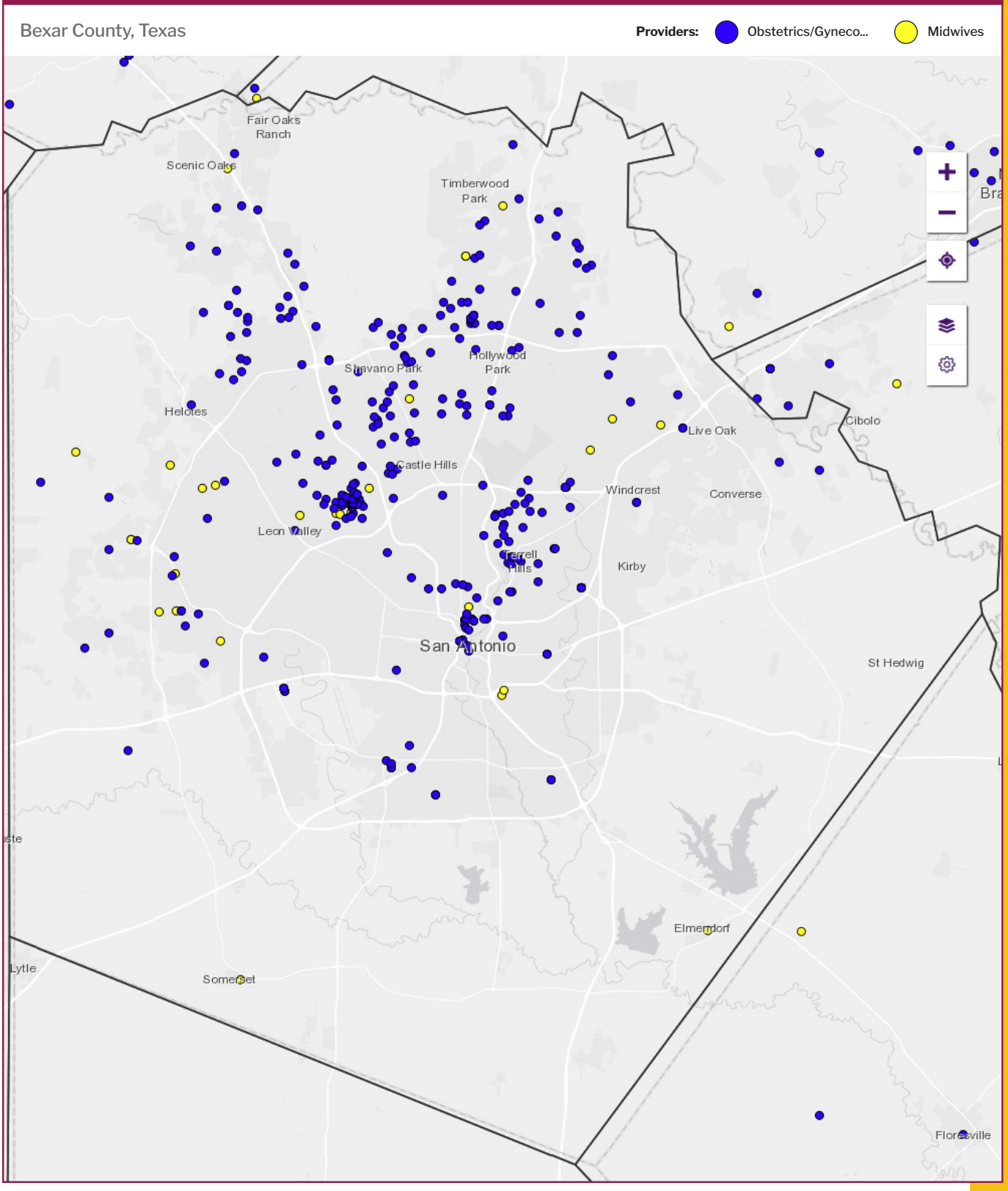
Bexar County, Texas



Source: American Medical Association (AMA) Workforce Explorer

Fig. 2H.4 Distribution of obstetrics and gynecology providers, 2025

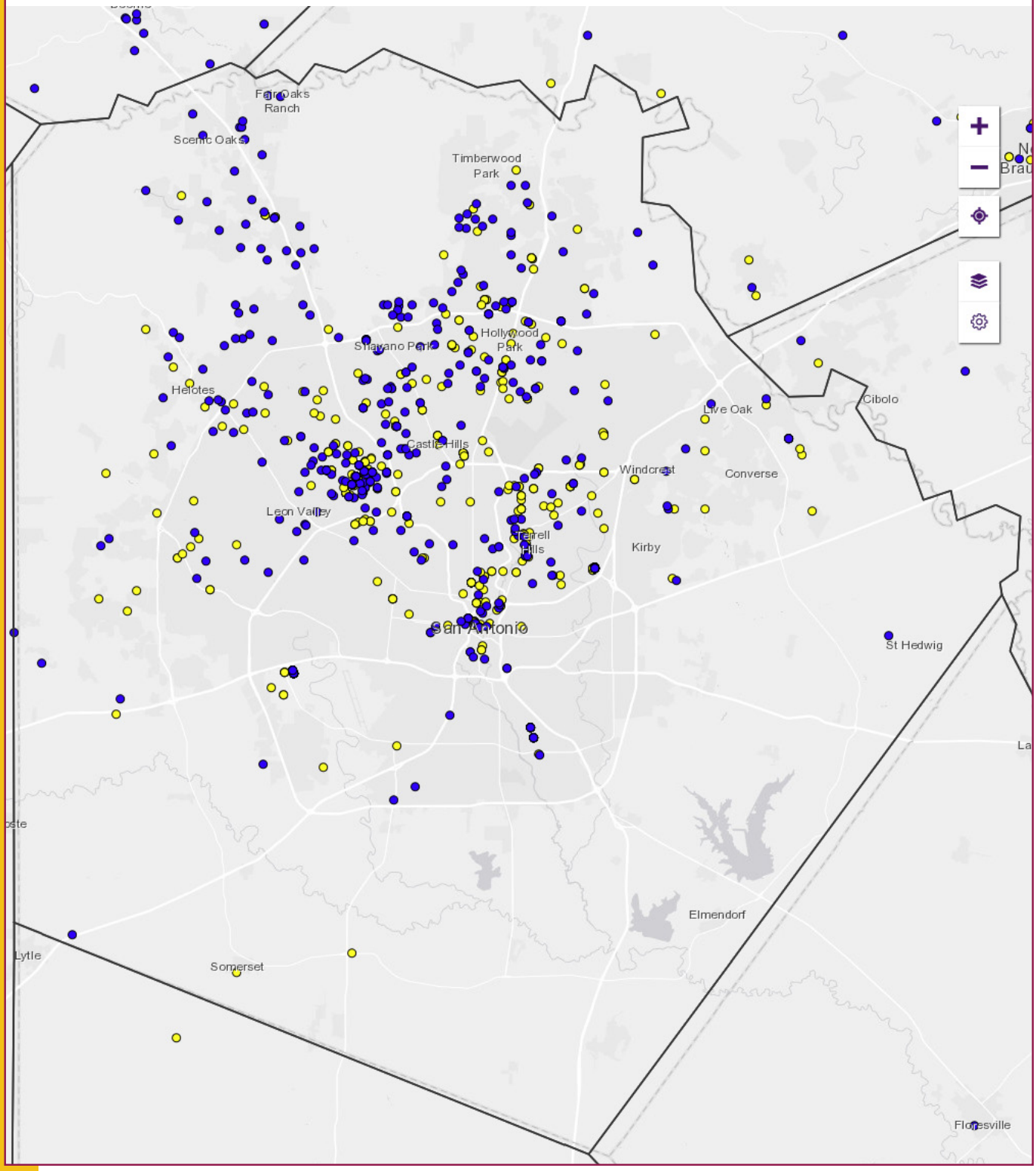
Bexar County, Texas



Source: American Medical Association (AMA) Workforce Explorer

Fig. 2H.5 Distribution of mental health care providers, 2025

Bexar County, Texas



Source: American Medical Association (AMA) Workforce Explorer

Community voices emphasized the lack of medical resources and infrastructure on the South Side compared to the North Side. Residents often have to seek their medical care, particularly specialty care, through a commute to another side of the county, which is more difficult or those without reliable transportation.

> *"Having one emergency room for the entire southside of San Antonio is the reason residents have a 20-year difference in life expectancy and other negative health outcomes. Quality healthcare is needed South of Highway 90. There needs to be an influx of medical facilities, not the opposite."*
>
> **– CHNA Community Survey Respondent**

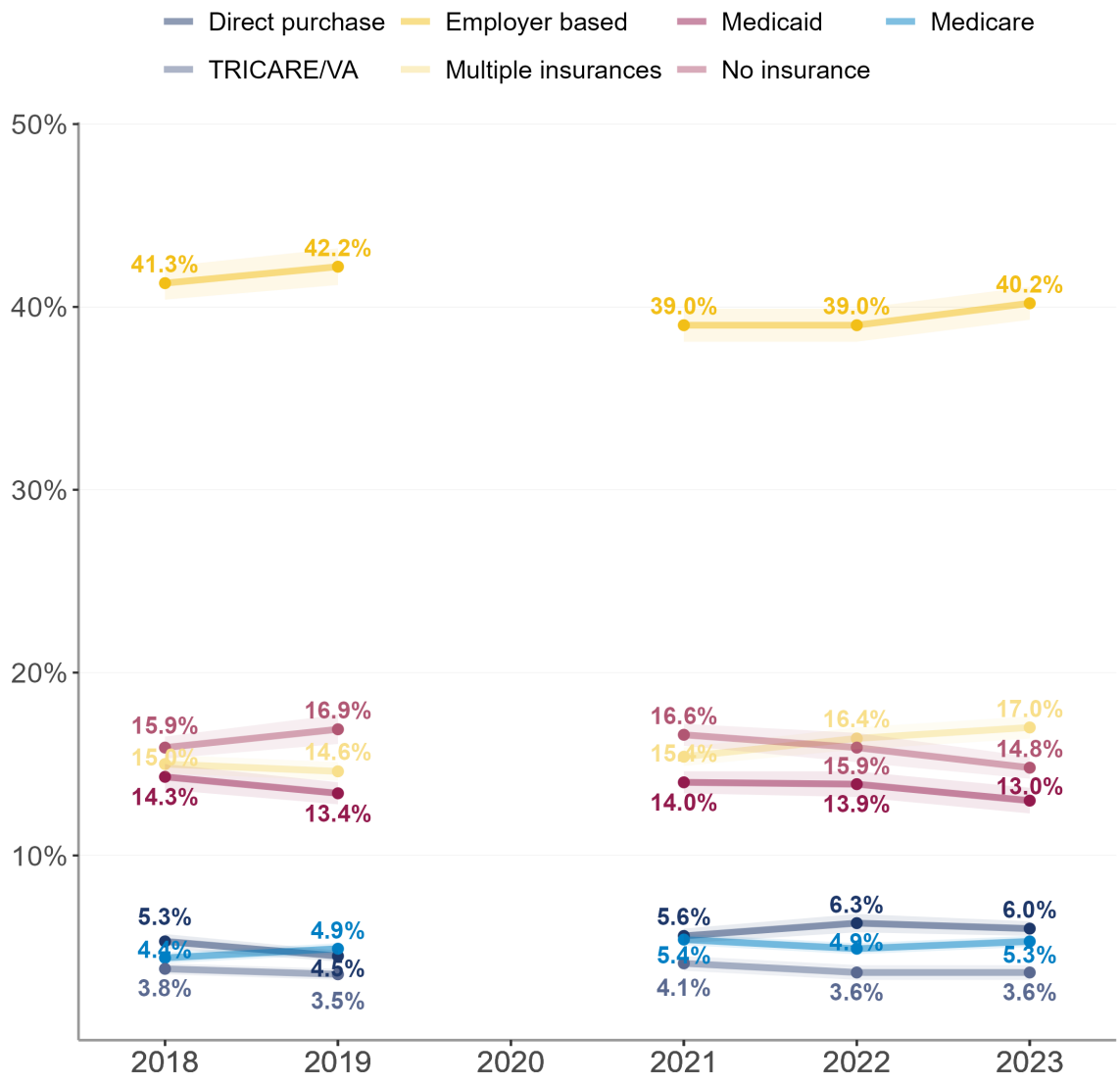
Health Insurance Coverage

Perhaps one of the most important factors influencing access to healthcare is having affordable and reliable insurance coverage. It plays a critical role in connecting people to preventive services, like immunizations, routine check-ups, and screenings. However, not all insurance offers the same level of access to timely and high-quality care. Not everyone in Bexar County has insurance coverage, and of the civilian, non-institutionalized population who do, the type of coverage varies significantly (**Fig. 2H.6**).

- Employer-based coverage was the most common form of insurance between 2018 and 2023. A slight drop in the rate in 2021 (to 39%) remained the same in 2022, likely reflecting job loss during the COVID-19 pandemic. In 2023, the rate appeared to increase slightly (to 40.2%); however, because the margins of error slightly overlap, the increase is not statistically significant. Still, as the dominant form of insurance, about 60% more individuals were covered through employer-based insurance than by the next most common type: multiple insurance plans.
- Until recently, there were more uninsured individuals than individuals with any insurance type other than employer-based. But in 2023, this shifted; 17% had multiple insurance coverage, and 15% were uninsured. This could reflect a growing number of individuals with multi-coverage. While the uninsured rate did decrease, the overlap in margins of error suggests that the decline is promising, but not statistically conclusive.
- Medicaid, which provides coverage to low-income populations including adults, children, and pregnant women, has remained relatively stable over the years, averaging around 14%. Together with Medicaid, no insurance, and multiple insurance forms form a middle tier on the chart.
- The least common insurance coverage types form a lower tier on the chart. It includes Medicare, which typically provides coverage for people aged 65 and over or individuals with disabilities, and direct purchase insurance, which refers to insurance bought privately or through the Affordable Care Act (ACA) marketplace. These two have remained consistently low, averaging about 5.0% and 5.5%, respectively. Because of overlapping margins of error, the difference between the two was not meaningful, except in 2018 and 2022, where direct purchase was slightly higher.
- TRICARE/VA insurance, which includes military and veteran health benefits, has been the least common type of insurance, remaining stable over the years and covering about 3.6% of the population in 2023.

Fig. 2H.6 Percent of civilian, non-institutionalized population, by health insurance status and type

Bexar County, Texas



Data for 2020 is unavailable due to data collection restrictions during the COVID-19 pandemic.
Source: ACS 1-Year Estimates. Table: B27010
Prepared by CINow for The Health Collaborative

Fig. 2H.7 shows the proportion of insured Bexar County residents within different age and race/ethnicity groups in 2023.* Overall, 85% of the population was insured, shown as a vertical gray line on the chart, but this rate varied across demographic groups.

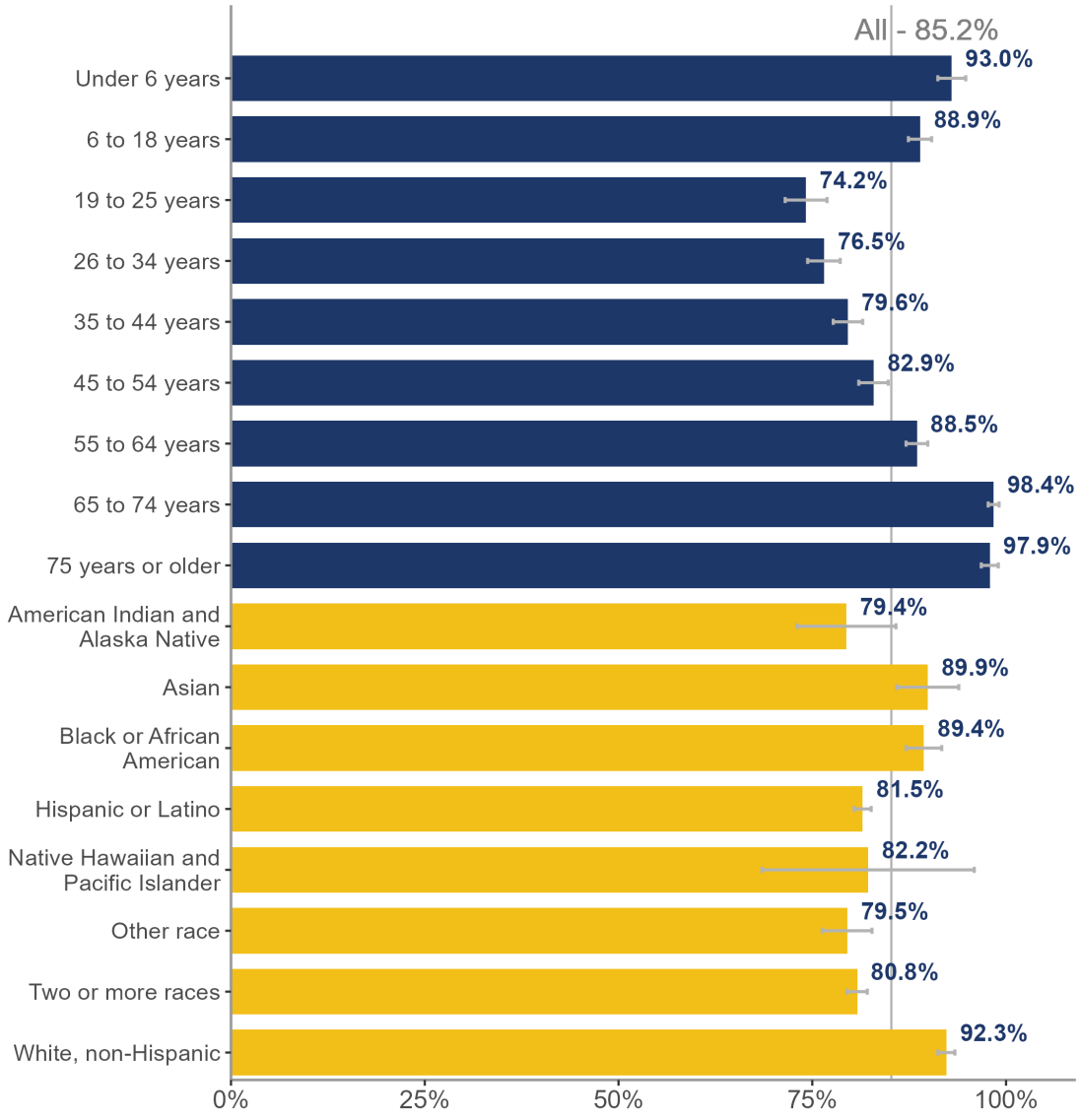
By age,

- Residents in the age groups between 19 and 54 had lower insurance coverage than the population overall. This is notable given that they represented most of the working-age population, and employer-based insurance was the most common coverage type, as shown in the previous chart.

* Differences among groups may not be statistically significant due to limited data or overlapping margins of error.

Fig. 2H.7 Percent of insured civilian, non-institutionalized population, by age and race/ethnicity, 2023

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: S2701
Prepared by CINow for The Health Collaborative

- Among adults, insurance coverage generally increased with age despite some overlapping margins of error between groups.
- In fact, the highest rates of coverage by age were among those aged sixty-five to seventy-four (98.4%) and seventy-five and older (97.9%).
- Notably, the more vulnerable age groups, children and older adults, were more likely to be insured than the general population. Children are typically eligible for public programs like Medicaid or CHIP, and older adults are generally eligible for Medicare, which may contribute to their higher coverage rates.

By race/ethnicity,

- White (non-Hispanic), Asian, and Black or African American residents had higher proportions of insured persons than the overall population. However, there was no meaningful difference between these groups because of overlapping margins of error.
- On the other hand, the Hispanic, "Other race", and "Two or more races" groups had lower coverage rates than the population overall.

Healthcare Affordability

The BRFSS survey asks adults if, at any point in the 12 months prior, they had gone without care even though they needed to see a doctor because of costs.[30] Between 2017 and 2023, 16% of Bexar County adult respondents self-reported foregoing care because of financial restraints (**Fig. 2H.8**). Notably, there were some statistically significant differences by sub-county sector (**Fig. 2H.9**). Specifically, the Near Westside had the highest estimated percentage of adults who needed to see a doctor but could not because of cost (28%), statistically higher than the Northeast (13%), Far Northside (10%), and Far Northwest (9%).*

Broken down by sex and race/ethnicity, there were some statistically significant differences.

- By sex, women were more likely than men to report cost-related barriers to care (20% vs. 12%).
- By race/ethnicity, 21% of Hispanic respondents reported not receiving medical attention because of cost, nearly three times the rate of white (non-Hispanic) respondents (8%). Moreover, white respondents were less likely to report cost as a barrier than the Bexar County respondent average of about 16%.

Focus group participants shared frustrations about navigating health insurance, describing challenges with understanding coverage, selecting plans, and finding doctors who accept their insurance.

"**Participant 1:** *A lot of times when you're sick, your health insurance doesn't cover [treatment], but you gotta pay a copay, and sometimes you don't have sufficient funds. The thing I don't like about it [is] that they send you from Medicaid to Medicare. And Medicare has different plans that you gotta choose, and they only go for like 6 or 12 months, and then you gotta renew again if you want to keep going with that plan or get a new plan. And that's a hassle for me, you know, finding a medical insurance, you know, changing, and which doctor, you want more accessible.*

Participant 2: *You're right, 'cause I was trying to get it for my mom. And Medicare doesn't provide a lot of stuff. And you gotta find a specific doctor that would accept your insurance."*

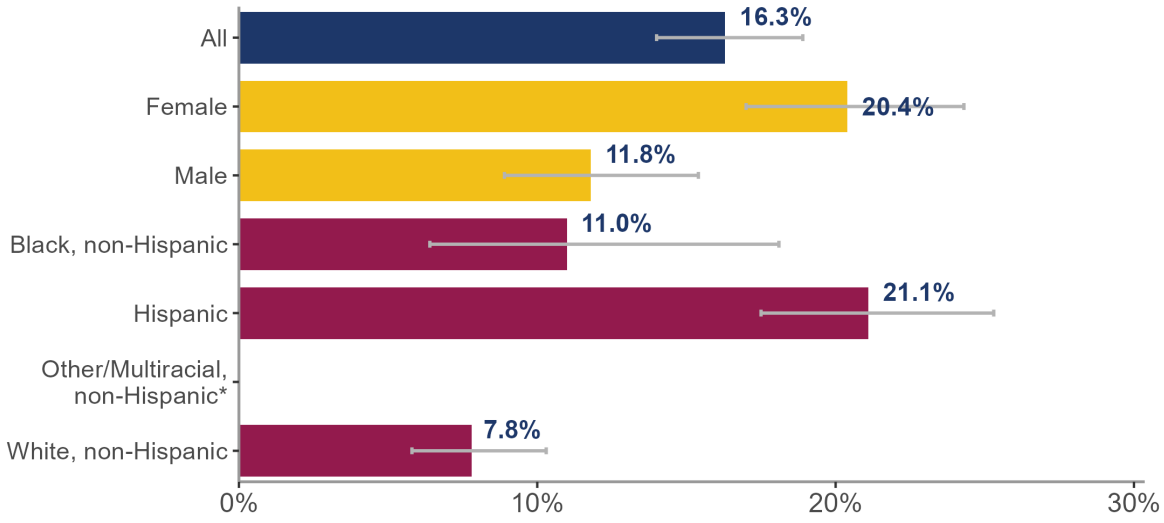
– CHNA Focus Group #1 Participants

* Differences among groups may not be statistically significant due to limited data or overlapping margins of error.

Although subgroup comparisons are not available, we know that disparities are compounded when multiple factors intersect. That being said, the overall trends suggest that white males appear to be the least likely group to report cost as a barrier to care, while Hispanic females are among the most likely.

Fig. 2H.8 Percent of adults who needed to see a doctor but could not due to cost in the past 12 months, by sex and race/ethnicity, 2017-2023

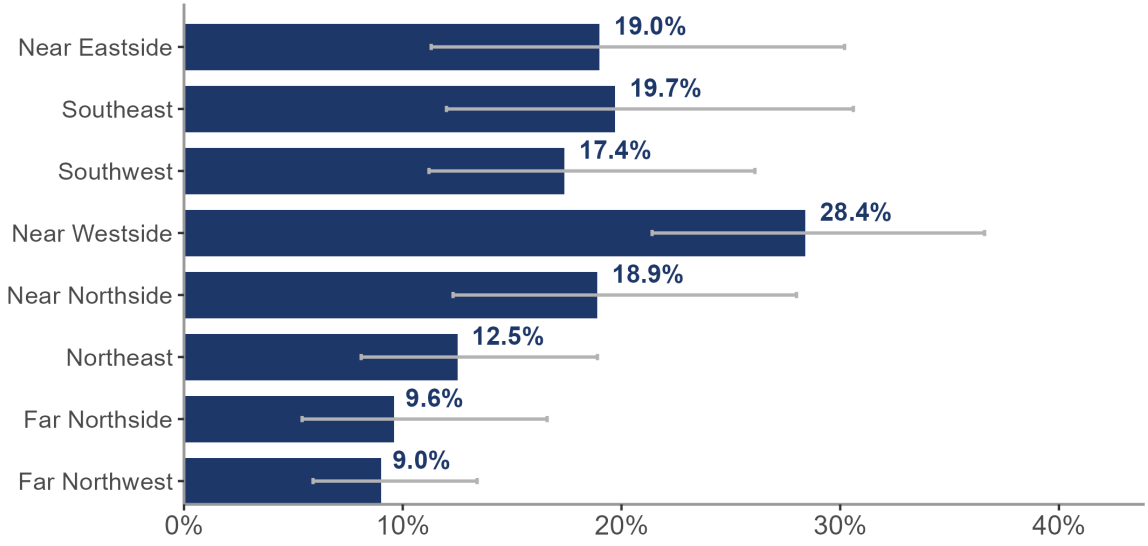
Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 2H.9 Percent of adults who needed to see a doctor but could not due to cost in the past 12 months, by sector, 2017-2023

Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

HOW WE'RE TAKING CARE OF OURSELVES

WHAT WE HEARD FROM THE COMMUNITY

Staying current with preventive and primary care, like checkups, screenings, and vaccinations, is critical for health and well-being. Without insurance, though, that care can be costly, and those appointments must compete with work, school, child and elder care, and housework for one's time and energy.

Help with Accessing Care

Survey respondents were asked, "Which of the following would make it easier for you or others you live with to get the care you need?" and could select any number of response options or write in their own. The most frequently selected options were evening or weekend appointments (58% overall; 62% women, 54% men), lower out-of-pocket costs (52% overall; 53% women, 51% men), and more appointments, or appointments available sooner (50% overall; 47% women, 56% men). Evening or weekend appointments were the top choice regardless of gender or race/ethnicity, with between 50% and 100% of every group selecting it.

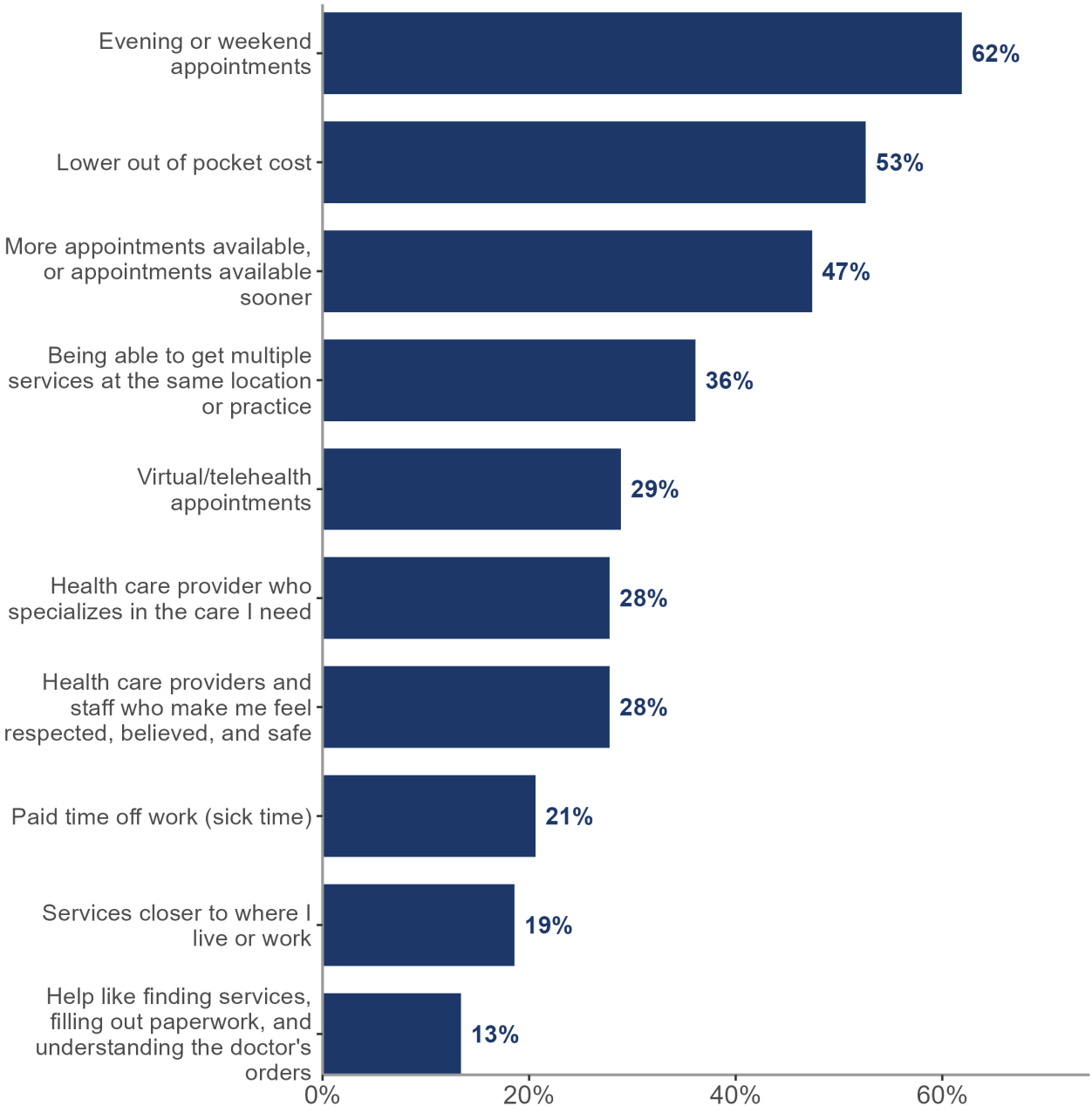
While **Figure 3A.1** and **Figure 3A.2** only show the top 10 choices for female and male residents there were additional noteworthy differences by race/ethnicity.* These difference highlight variation in what people value or need based on their lived experiences:

- Female respondents (36%) were more likely than male respondents (28%) to choose "being able to get multiple services at the same location or practice."
- On the other hand, male respondents (40%) were more likely than females (29%) to choose "virtual/telehealth appointments."
- Respondents who were female (28%), Black or African American (20%), or Hispanic or Latino/a/x (26%) were more likely to select "health care provider who specializes in the care I need" than those who were male (12%) or white (13%).
- Similarly, respondents identifying as female (28%), Black or African American (20%), or Hispanic or Latino/a/x (27%) were more likely to choose "health care providers and staff who make me feel respected, believed, and safe," than those who were male (9%, not among their top 10) or white (9%).

* Due to small respondent counts, data for respondents identifying as non-binary is suppressed for privacy in these two charts.

Fig. 3A.1 Top 10 resources female CHNA survey respondents rated as helpful for getting the care they and/or their household members need, 2025

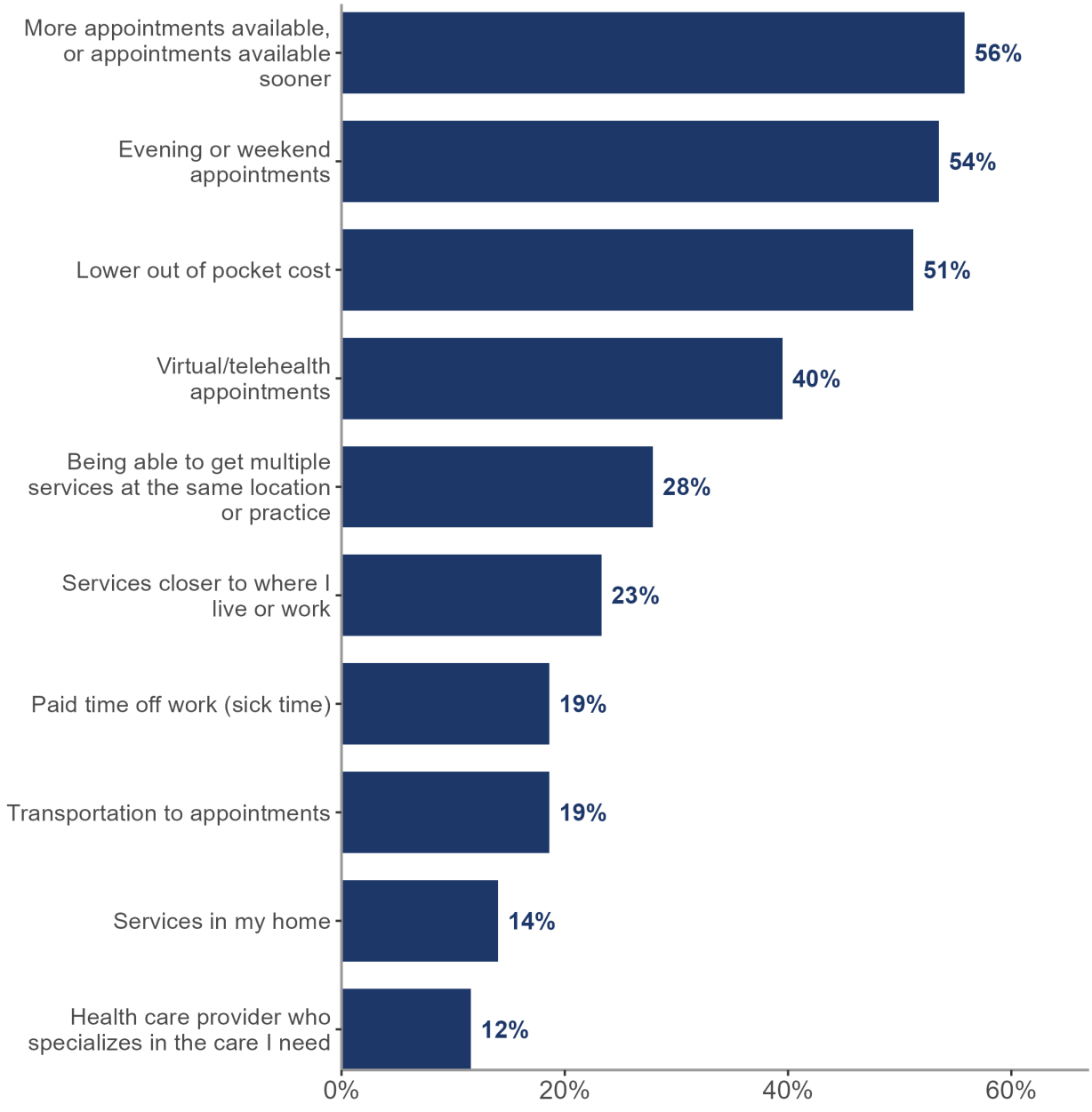
Bexar County, Texas



N= 97 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Fig. 3A.2 Top 10 resources male CHNA survey respondents rated as helpful for getting the care they and/or their household members need, 2025

Bexar County, Texas



N= 43 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

"We can definitely improve our communication between organizations. Figure out a way to not duplicate services."

– Anonymous respondent to prioritization survey

Even when preventive care is available, high out-of-pocket costs can make it inaccessible, especially for those without insurance or with limited coverage. As one key informant explained, high medical costs often lead to a cycle of poor health and financial in tability where people get sick again from not affording their medicines.

"Preventive care can cost about $50. Emergency room is a minimum cost [of] over $500. But then, what do you do? Once you leave, you can't afford any of those medicines because you don't have insurance or your insurance has a $100 copay for your medicines, and you can't afford that. Either way, you don't have enough access. So, what's going to happen? You're not going to get those medicines. You're going to be sick again. But also remember, the time you're sick, you're not being a productive member of society because you can't work. So, it's one of those things where it becomes a vicious cycle."

– CHNA Key Informant representing an organization that serves vulnerable people in crisis

MANAGING WHAT HELPS OR HARMS OUR HEALTH

Our behaviors and choices directly impact our well-being, and our circumstances can limit or expand what our choices are and how easy or hard it is to adopt healthy behaviors. Following recommended dietary and physical activity guidelines, like recommended fruit and vegetable consumption, offers significant benefits, including lowering the risk of chronic diseases and improving mental health. On the other hand, behaviors like heavy alcohol use, smoking, and substance abuse contribute to a range of health issues. Understanding how residents engage in habits that help or harm their health underscores the need for targeted efforts to promote healthier lifestyles across the community.

Despite the documented and widely-understood importance of healthy behaviors, related local data is scarce, particularly for children and youth. The Behavioral Risk Factor Surveillance System (BRFSS), overseen by the U.S. Centers for Disease Control and Prevention but administered by each state, is the primary source available for the general population of adults, and because of small sample sizes, uncertainty in the estimate is a problem. Disaggregating or "breaking out" the data by sex, race/ethnicity, or sub-county geography yields wide margins of error that make it difficult to determine whether true differences exist among groups. However, BRFSS remains the best source of data we have for most health-related behaviors.

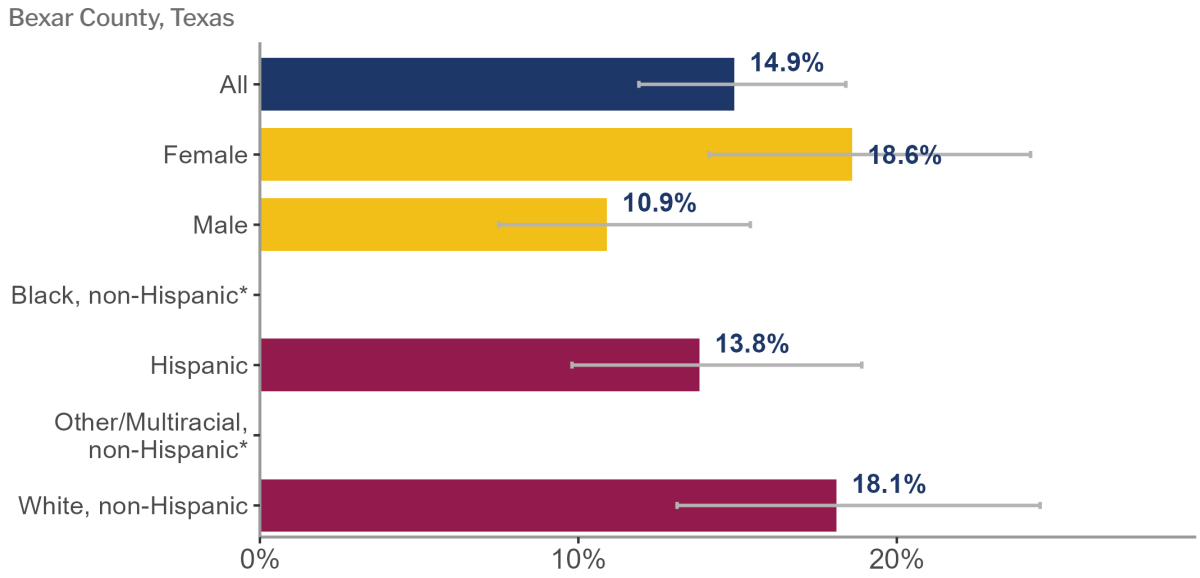
ABOUT SUB-COUNTY SECTORS

The Behavioral Risk Factor Surveillance System (BRFSS) sample size isn't large enough to allow us to break the data out at ZIP code level. CINow created sectors in 2013 to deal with this problem, grouping ZIP codes into eight clusters by geography, population size, and median household income. Because population and income change over time, we periodically revisit the sector groupings to ensure they still make sense. Check Appendix B Technical Notes for a map of the sectors and a list of ZIP codes included in each sector.

Nutrition and Physical Activity

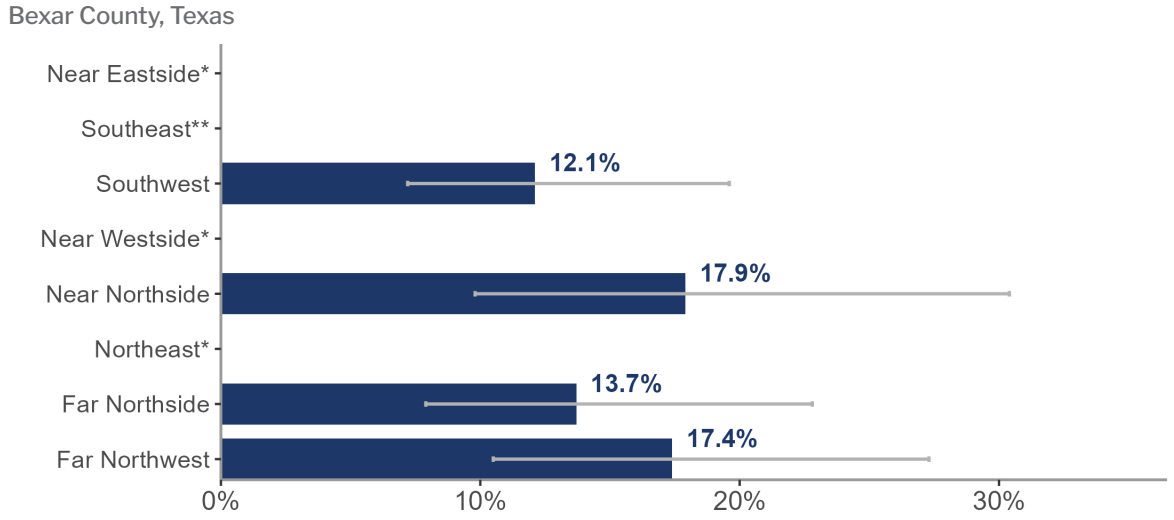
Eating fruits and vegetables five or more times per day has long been recommended as part of a healthy diet because it is linked with reduced risk of chronic diseases like heart disease, stroke, certain cancers, and type 2 diabetes.[31,32] Moreover, populations that do not meet this dietary recommendation may be at increased risk for poor nutrition and related health outcomes. Overall, only 15% of Bexar County BRFSS survey respondents reported eating fruits or vegetables five or more times a day (**Fig. 3B.1**). **Figures 3B.1** and **3B.2** show percentages for demographic groups and county sectors, but differences across groups and sectors should be interpreted with caution.

Fig. 3B.1 Percent of adults who consumed fruits and vegetables 5 or more times per day, by sex and race/ethnicity, 2017-2023



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3B.2 Percent of adults who consumed fruits and vegetables 5 or more times per day, by sector, 2017-2023



*Unreliable: Error is too large relative to estimate.
**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Not having enough income to thrive means not affording survival necessities, like food, housing, and healthcare, as well as the basic needs to provide a healthy, happy life. Money is a barrier to medical care, nutritious food, education, and more, which all affect one's ability to care for their own and their loved ones' health while pursuing long-term well-being.

"The challenge is the income. Not that money solves everything, but I think of hunger, not as a food issue, but [as] an income issue. If people have access to thriving wages, then they can sustain themselves, and they don't need these supplements and these supports, and they can experience independence and the social status that goes along with self-reliance. I think our communities struggle in the areas of not enough opportunity to obtain wages that allow for a household to thrive in the community, or to sustain themselves, or to be secure in the community. So, they might be grappling with some of those basic needs, like food and shelter. They might not have the education, and then that employment, that 'right' job, is just not obtainable, or there's just a bounty of jobs that don't provide a secure status. That's the way it's framed - there's 'low wage employees.' No, there are employers that don't pay a living wage or a thriving wage... And I think we have to get our employers to provide security to their workforce."

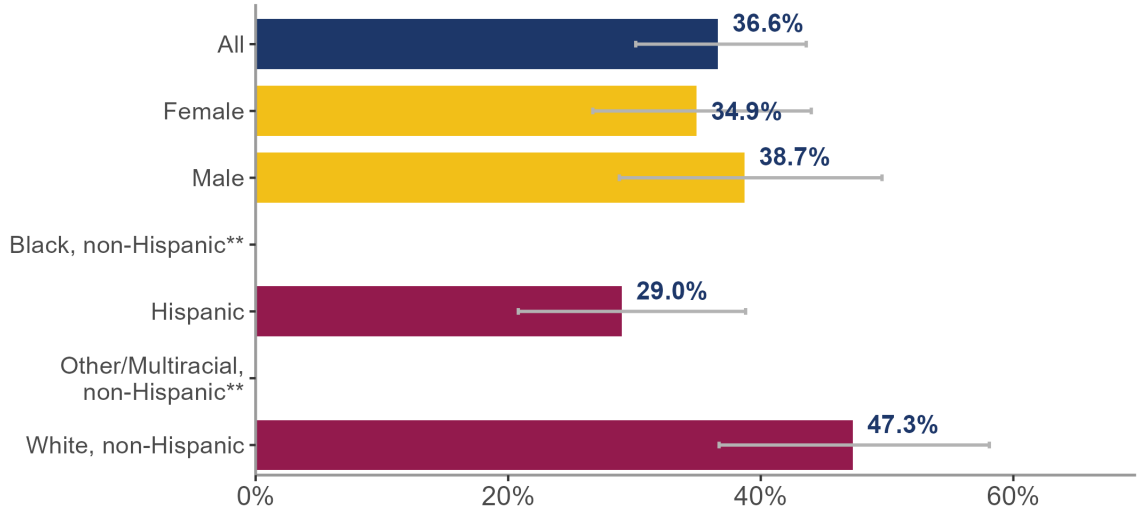
– Eric Cooper (President/CEO, San Antonio Food Bank)

> *"I wish there were more healthy restaurants in the area and safe places for teens to hang out."*
>
> **– CHNA Community Survey Respondent**

Current physical activity guidelines from the U.S. Department of Health and Human Services recommend that adults do at least 150 to 300 minutes a week of moderate-intensity aerobic or physical activity for substantial health and well-being benefits.[33] Overall, only 37% of Bexar County survey respondents reported meeting this physical activity guideline (**Fig. 3B.3**). **Figures 3B.3** and **3B.4** show percentages for demographic groups and county sectors, but again, differences across groups and sectors should be interpreted with caution.

Fig. 3B.3 Percent of adults who participated in 150 minutes or more of aerobic physical activity per week, by sex and race/ethnicity, 2017-2023

Bexar County, Texas

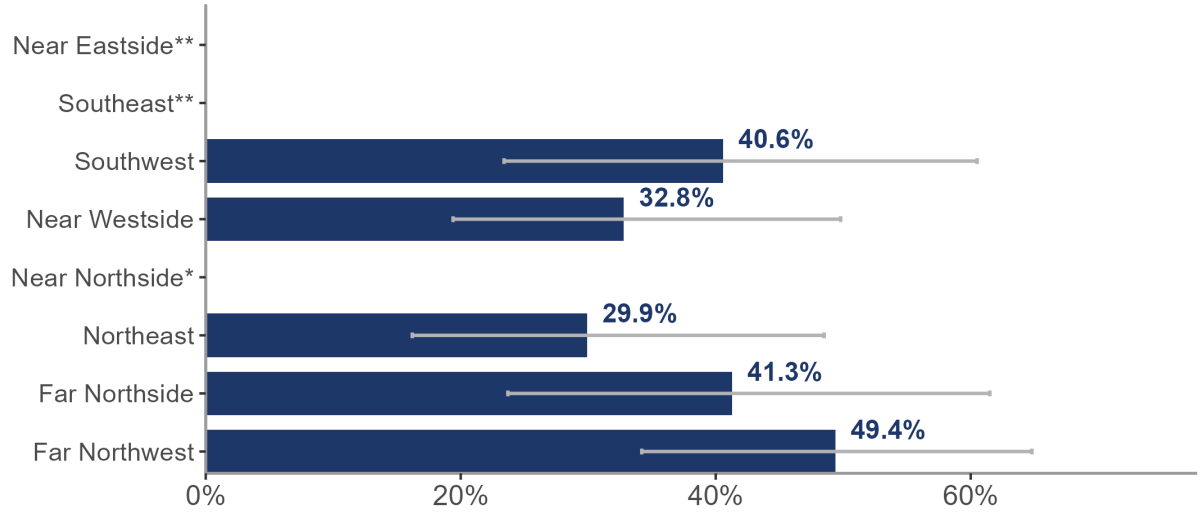


**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

The BRFSS survey asks for survey respondents' height and weight so that Body Mass Index (BMI) can be calculated as a measure of weight-related health risks across populations. A BMI between 18.5 and 24.9 is classified as "healthy," neither overweight nor obese. Disparities in BMI can reflect broader inequities in access to nutrition, physical activity, and preventive care. Overall, 28% of Bexar County survey respondents have a BMI within the healthy range (**Fig. 3B.5**). While data on differences by sex and race/ethnicity are available, the only statistically significant difference is between white (non-Hispanic) and Hispanic respondents. At 24%, Hispanic adults were less likely than white adults (35%) to fall within the healthy BMI range. Other differences across groups in **Figure 3B.5** and sectors in **Figure 3B.6** should be interpreted with caution.

Fig. 3B.4 Percent of adults who participated in 150 minutes or more of aerobic physical activity per week, by sector, 2017-2023

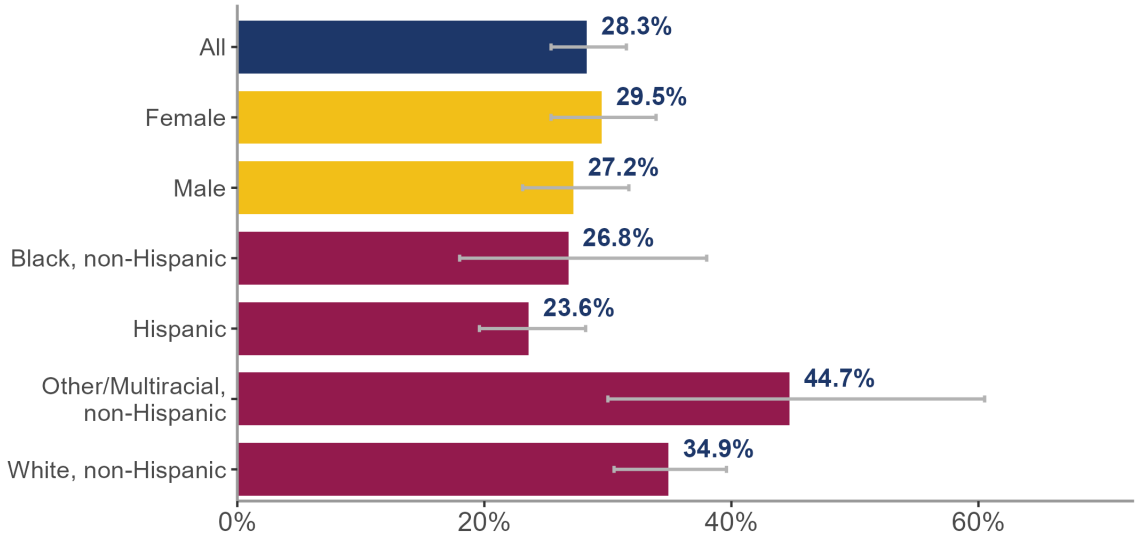
Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3B.5 Percent of adults with Body Mass Index (BMI) within healthy range, by sex and race/ethnicity, 2017-2023

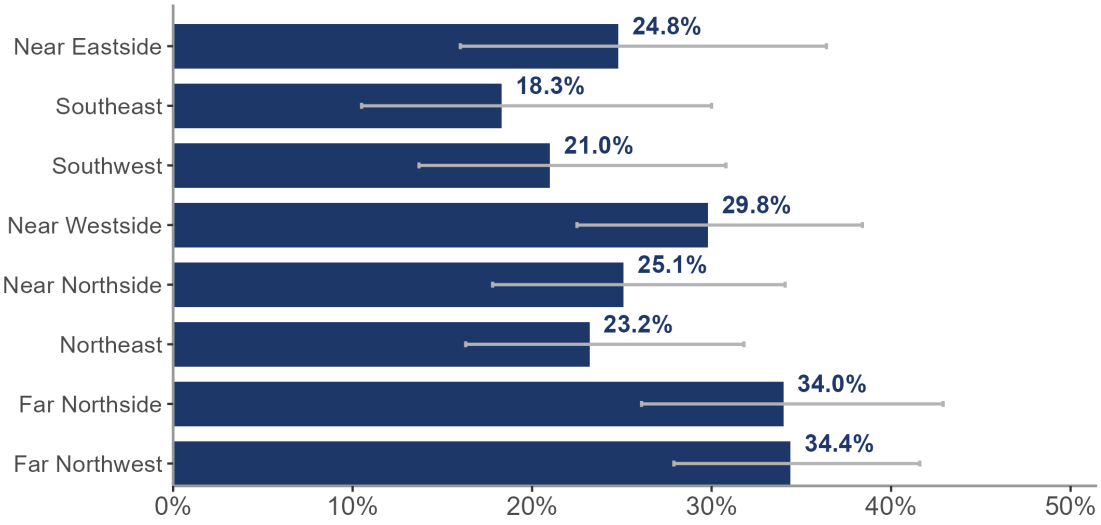
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3B.6 Percent of adults with Body Mass Index (BMI) within healthy range, by sector, 2017-2023

Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

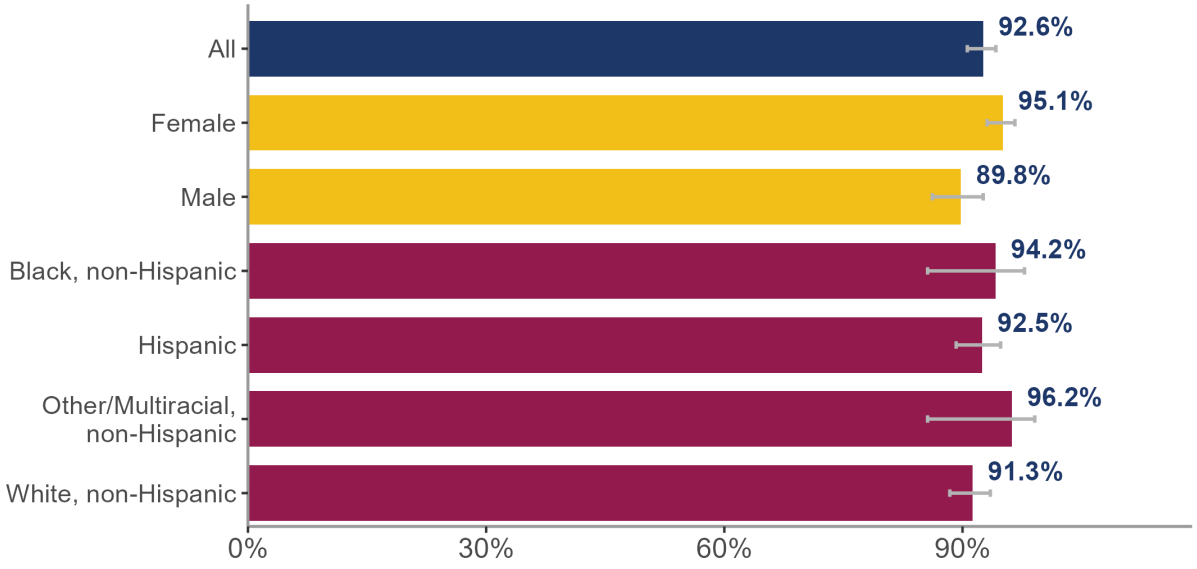
Substance Use and Tobacco Use

Heavy alcohol use, defined as heavy or binge drinking, is categorized differently for men and women over the age of 21.[34] For men, heavy drinking means 15 or more drinks per week, while for women it means eight or more drinks per week. Binge drinking is defined as consuming five or more drinks on a single occasion for men, and four or more for women. Any alcohol use by pregnant individuals or by those under 21 is considered excessive.

Overall, more than nine in 10 Bexar County survey respondents reported not engaging in heavy alcohol use in the past month (**Fig. 3B.7**). A slightly higher percentage of women (95%) than men (90%) reported not having heavy alcohol use for the 2017-2023 average. That said, differences across race/ethnicity groups in **Figure 3B.7** and sectors in **Figure 3B.8** should be interpreted with caution.

Fig. 3B.7 Percent of adults without heavy alcohol use in the past month, by sex and race/ethnicity, 2017-2023

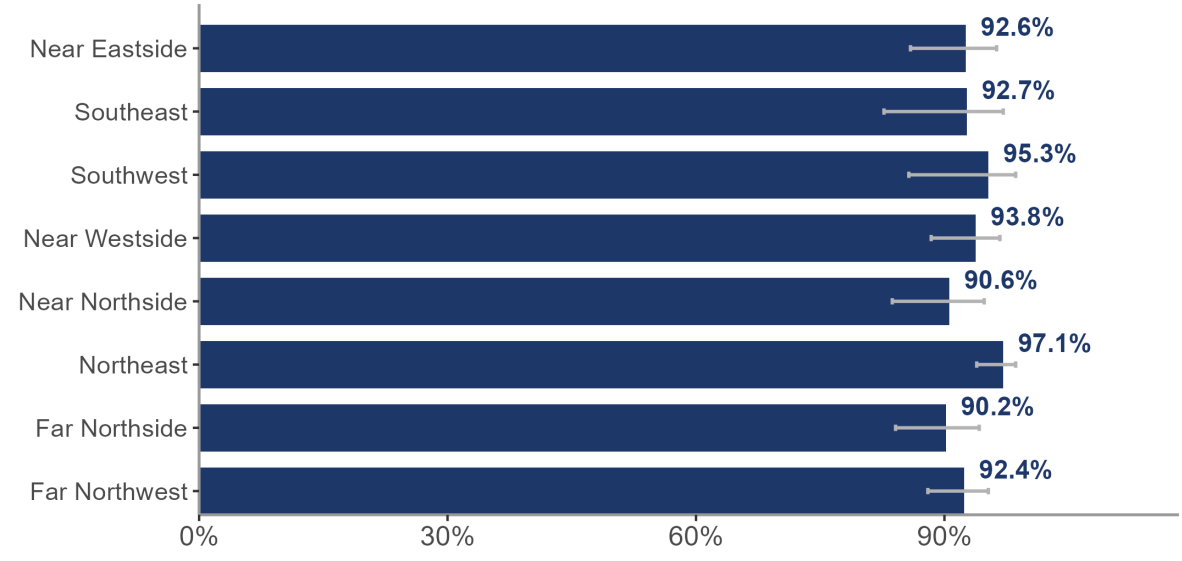
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3B.8 Percent of adults without heavy alcohol use in the past month, by sector, 2017-2023

Bexar County, Texas

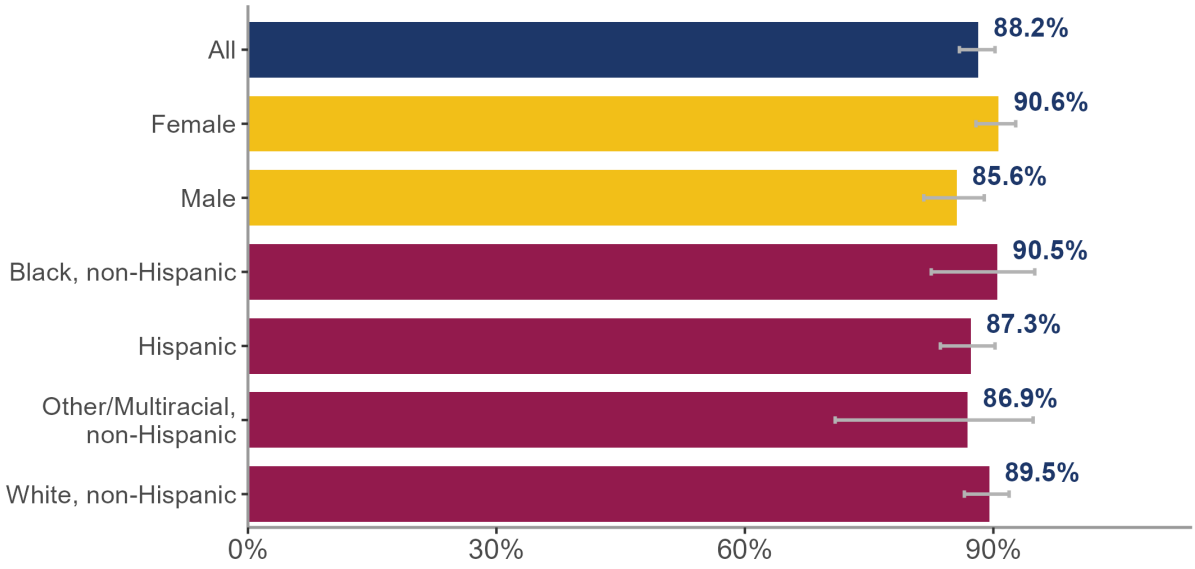


Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

According to the BRFSS questionnaire, current smokers are defined as adults who have smoked at least 100 cigarettes in their lifetime and now smoke them every day or some days. Overall, 88% Bexar County respondents reported not currently smoking (**Fig. 3B.9**). Although the proportion of adults who smoke (12%) was relatively low, it remains critical to monitor tobacco use because smoking is still the leading cause of preventable disease and death in the United States.[35] Moreover, understanding which subgroups are more likely to currently smoke and better surveillance on other forms of smoking, like vaping, are critical to public health. While data on differences by sex and race/ethnicity were available, overlapping margins of error limit the ability to draw conclusions about differences among groups.

Fig. 3B.9 Percent of adults who do not currently smoke, by sex and race/ethnicity, 2017-2023

Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

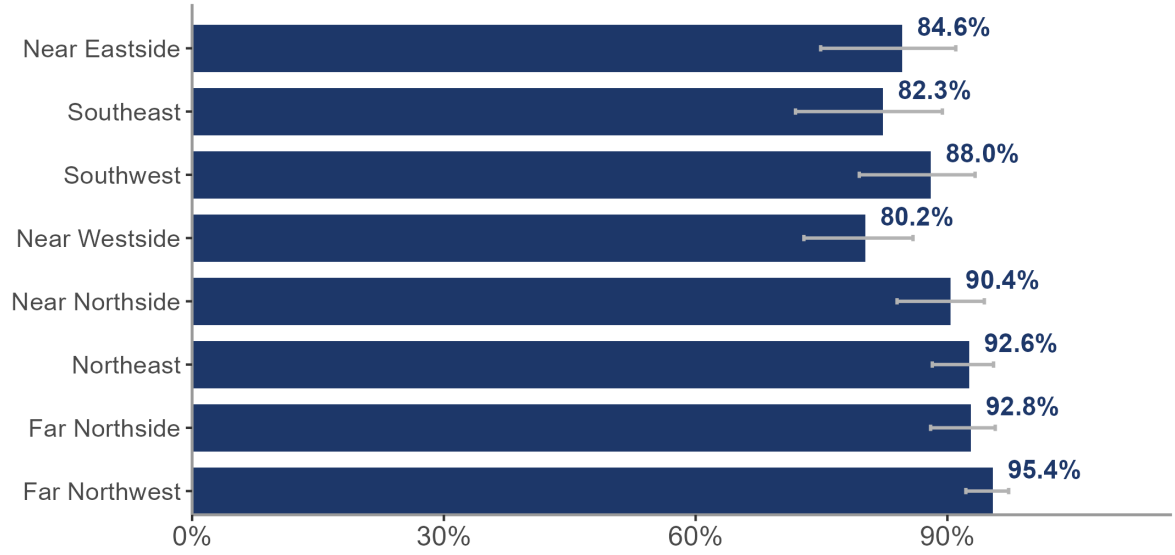
Notably, there were some statistically significant differences by sub-county sector (**Fig. 3B.10**). Specifically, the Near Westside had a lower percentage of non-smoking adults (80%) than the Northeast, Far Northside, and Far Northwest (92% to 95%). Though the margins of error for the three highest sectors overlapped, the Far Northwest sector had the smallest range and was likely the closest to its reported value (95%). Further, it was the only sector that was statistically higher than the countywide average.

Of particular note, this indicator does not include other forms of smoking, like e-cigarettes or vaping, or smokeless tobacco use (snuff, dip). Bexar County adult e-cigarette usage rates have grown from 5% in 2017 to 7% in 2022, while smokeless tobacco use remains steady at 4%. In both cases, users are more likely to be male.[36]

Monitoring the prevalence of prescription opioid use can help identify opioid over-prescription and dependence. Differences among groups should be interpreted carefully, though, and in the context of varying rates of acute and chronic pain, procedures requiring pain medication, and pain-causing conditions like fibromyalgia, diabetic neuropathy, and tooth decay. Overall, 88% of Bexar County survey respondents reported not using prescription opioids in the past year (**Fig. 3B.11**).

Fig. 3B.10 Percent of adults who do not currently smoke, by sector, 2017-2023

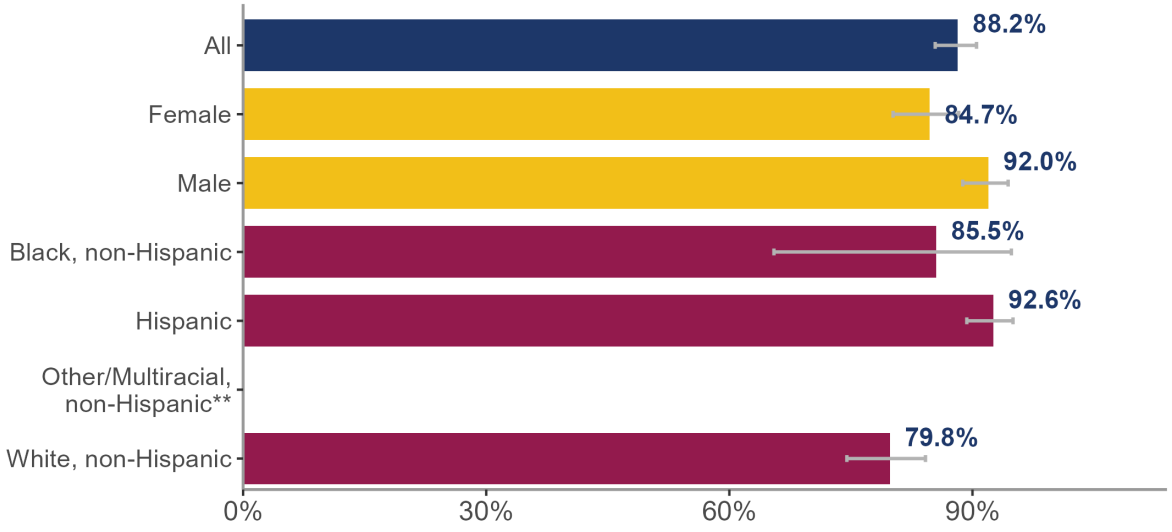
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3B.11 Percent of adults who did not take prescription opioids in the past year, by sex and race/ethnicity, 2017-2023

Bexar County, Texas



**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

The 2017-2023 average shows that a slightly higher percentage of men (92%) than women (85%) reported not taking prescription opioids. While data on differences by race/ethnicity are available, the only statistically significant difference is between white (non-Hispanic) and Hispanic respondents. At 93%, Hispanic adults were more likely than

Health behaviors like physical activity, smoking, drinking, and opioid use are more than just personal choices. Community voices emphasized that knowledge, the environment, and access all play critical roles. As one key informant explained, improving health outcomes requires understanding how to navigate health, illness, and the care system.

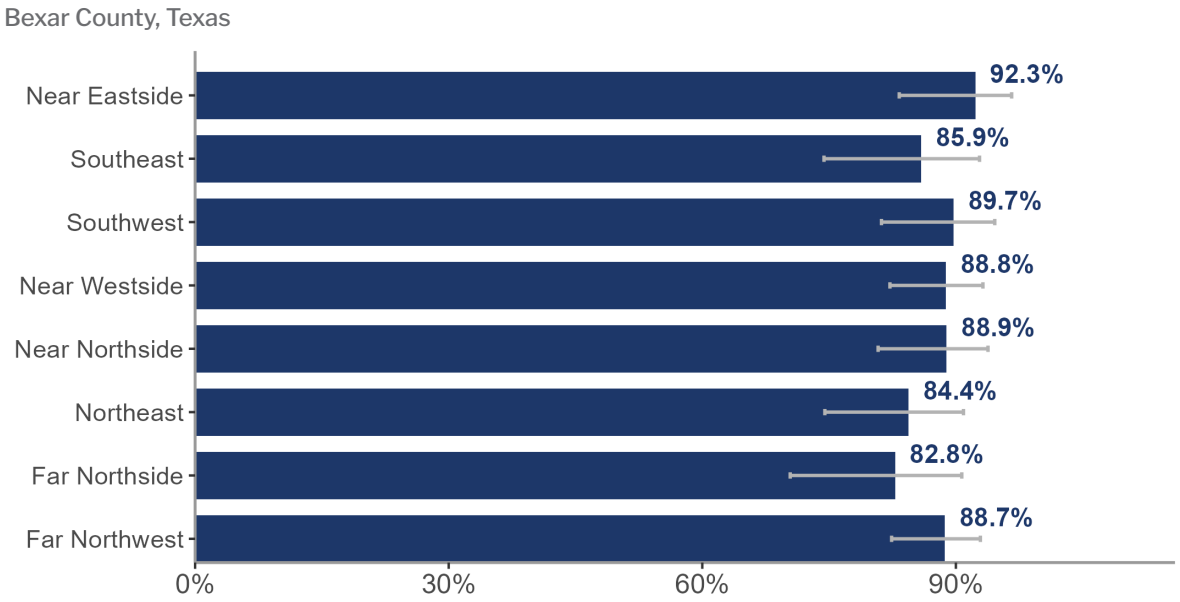
The way I view health literacy is as the ability to understand the healthcare process and how it affects us as human beings. When I was in school, we had a healthcare class that taught the basics—how to burn calories, stay active, and understand common medical conditions. Health literacy means understanding how health impacts you personally, how the lack of appropriate care can affect your family, and how it influences the well-being of your community. It involves recognizing disease processes, how they affect the body, and what can be done to manage them.

For example, someone with asthma may not be able to run easily, but with the right knowledge and care, they can manage their condition effectively. Advanced health literacy takes this understanding further—it's about knowing how to reduce the impact of a diagnosed condition, slow or prevent its progression, or possibly even eliminate it altogether. It also includes recognizing how environmental factors contribute to health, and understanding the cause-and-effect relationship between our choices, our surroundings, and our overall well-being.

– Edward Banos (President/CEO, University Health)

white adults (80%) to report not using prescription opioids. These differences may reflect variations in prescribing practices, access to healthcare, or individual choices related to pain management. Differences across sectors in **Figure 3B.12** should be interpreted with caution.

Fig. 3B.12 Percent of adults who did not take prescription opioids in the past year, by sector, 2017-2023



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

KEEPING CURRENT WITH ROUTINE AND PREVENTIVE CARE

Routine preventive and primary care are essential for maintaining long-term health, preventing issues from getting worse, and managing chronic conditions. Moreover, regular visits to healthcare providers help identify problems early, and early intervention is typically simpler, less invasive, and less costly than treating conditions once they have worsened. Access and use of preventive healthcare services serve as key indicators of a community's health and well-being as well as its progress toward improving health outcomes.

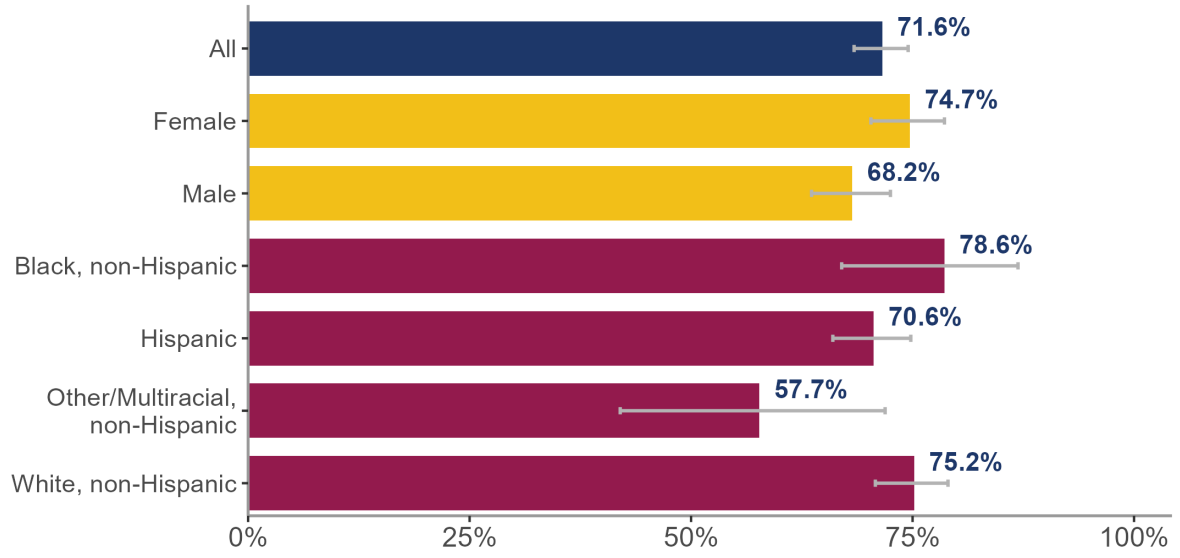
Routine Medical and Dental Care

Annual checkups are an opportunity for early detection, prevention, and management of chronic conditions. Overall, about five in seven (72%) of Bexar County survey respondents reported having had a routine checkup in the past year (**Fig. 3C.1**). While data on differences by sex and race/ethnicity are available, overlapping margins of error and data suppression limit the ability to draw statistically significant conclusions. However, there are some statistically significant differences by geographic sector. Specifically, the Southwest sector had a significantly lower percentage of adults who had a routine checkup in the past year (38%) compared to all other sectors and the county overall (**Fig. 3C.2**). Other differences should be interpreted with caution.*

* The small BRFSS sample size results in estimates with a wide margin of error, i.e., a lot of uncertainty

Fig. 3C.1 Percent of adults who had a routine checkup in the past year, by sex and race/ethnicity, 2017-2023

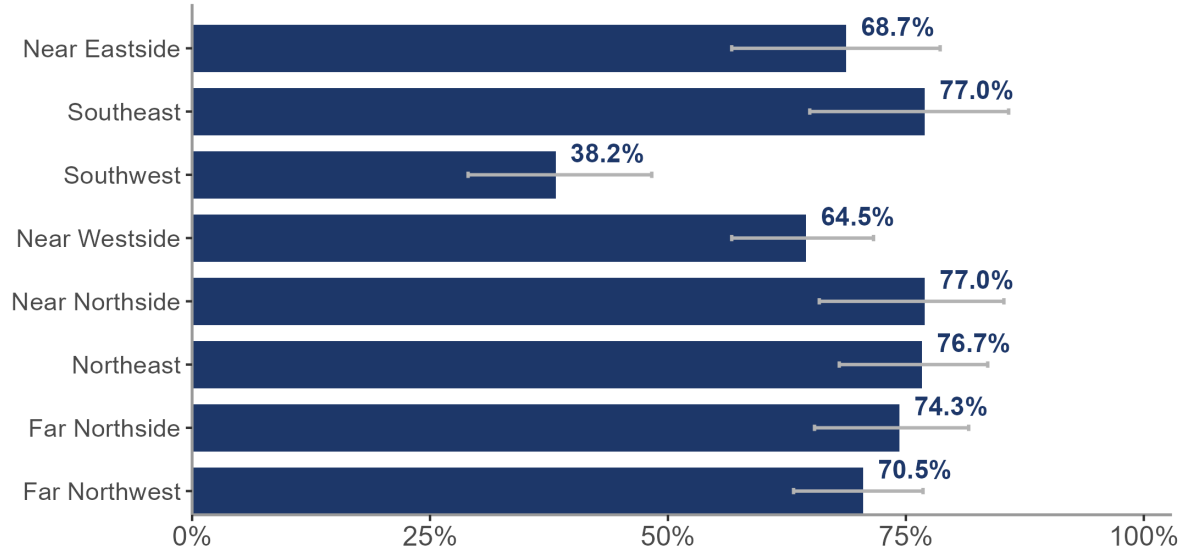
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3C.2 Percent of adults who had a routine checkup in the past year, by sector, 2017-2023

Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

> *"Dental care especially, it's expensive, access is a challenge (especially for low income)"*
>
> **– Anonymous respondent to prioritization survey**

Annual dental checkups are an opportunity for early detection, prevention, and management of dental issues. They also serve as an indicator of both access and use of preventive dental care. Importantly, identifying problems early is typically simpler, less invasive, and less costly.

Overall, just over half of the Bexar County survey respondents, or about five in eight adults (62%), reported having been to the dentist or dental clinic in the past year (**Fig. 3C.3**). Notably, there were some statistically significant differences by geographic sector (**Fig. 3C.4**). The Far Northwest sector had a significantly higher proportion (74%) of adults who had regular dental checkups versus most sectors, including the near Eastside, Southeast, Southwest, and the near Westside. Similarly, the Far Northside reported the highest percentage (81%), exceeding the rates of not only those sectors but also the Northeast. Other differences across gender and race/ethnicity groups in **Figure 3C.3** should be interpreted with caution.*

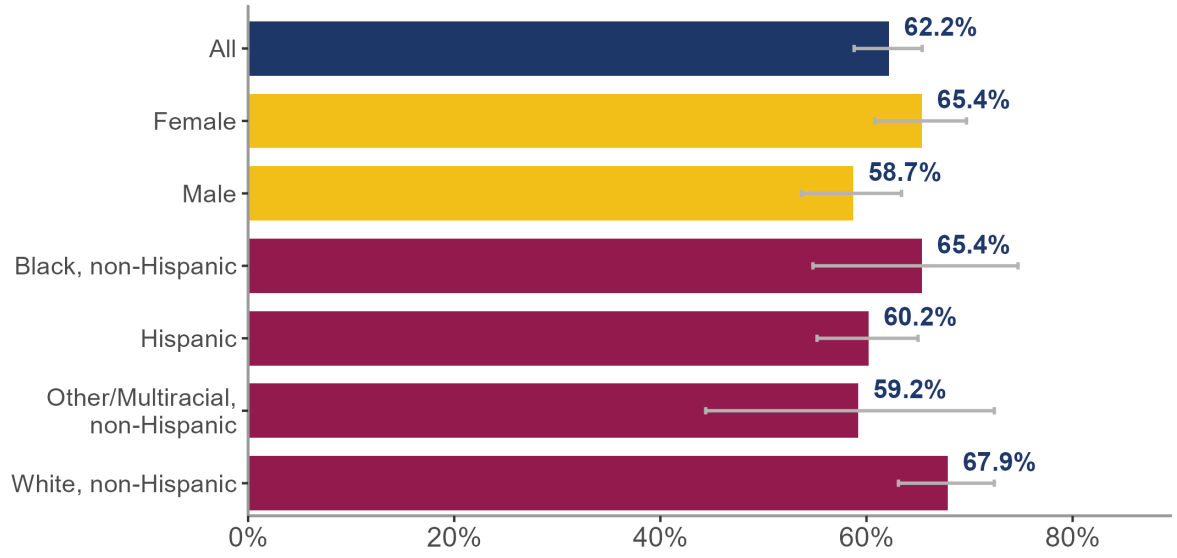
Community leaders interviewed as key informants for this assessment consistently emphasized that it takes more than one thing to help people. They illustrated that it is not just a single issue, but rather a conglomeration of interconnected factors. This is refle ted in their roles, as they and their organizations frequently assist communities with more than just one aspect of their lives, providing basic health services like dental care while also addressing the deeper social conditions that shape people's health.

> *"We seek out those most in need, those that are the least served, and we try to prioritize ways to help them. We provide downstream healthcare, including oral and behavioral health services, but we have shifted to a nice balance of focusing on social determinants of health too looking for why people aren't healthy in the first place. We often say, we are broadening the definition of health care at MHM because we know so many things like poverty, food, instability, unclean water, education or digital equity, influence our health and wellness. Our mission is serving humanity to honor God. And what could be more noble than that? So that's what keeps me pretty pumped up about doing the work that we do."*
>
> **– Jaime Wesolowski (President/CEO, Methodist Healthcare Ministries)**

* The small BRFSS sample size results in estimates with a wide margin of error, i.e., a lot of uncertainty

Fig. 3C.3 Percent of adults who had a dentist or dental clinic visit in the past year, by sex and race/ethnicity, 2017-2023

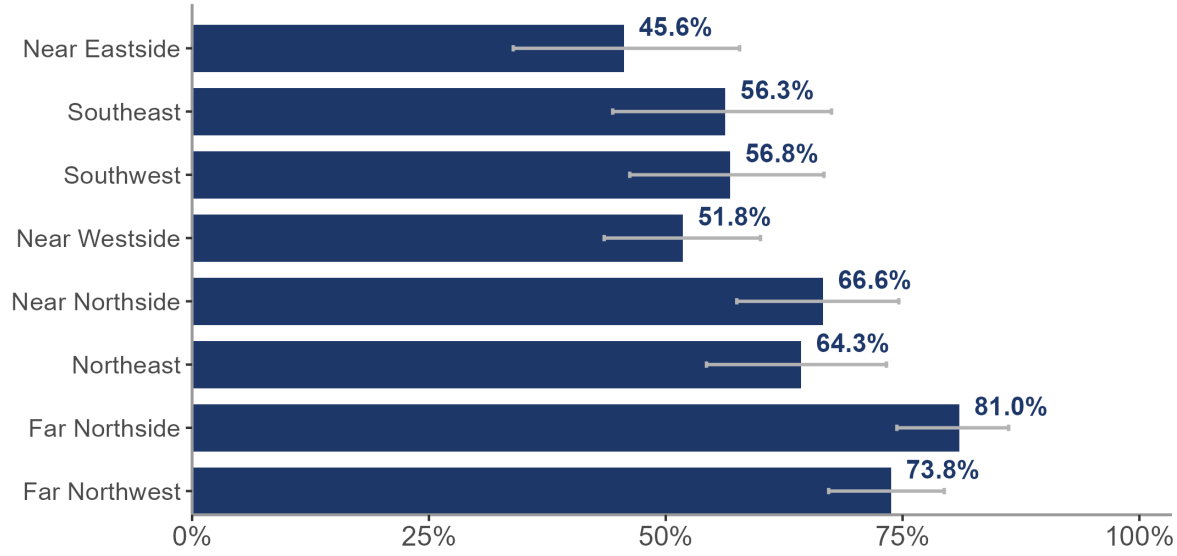
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3C.4 Percent of adults who had a dentist or dental clinic visit in the past year, by sector, 2017-2023

Bexar County, Texas



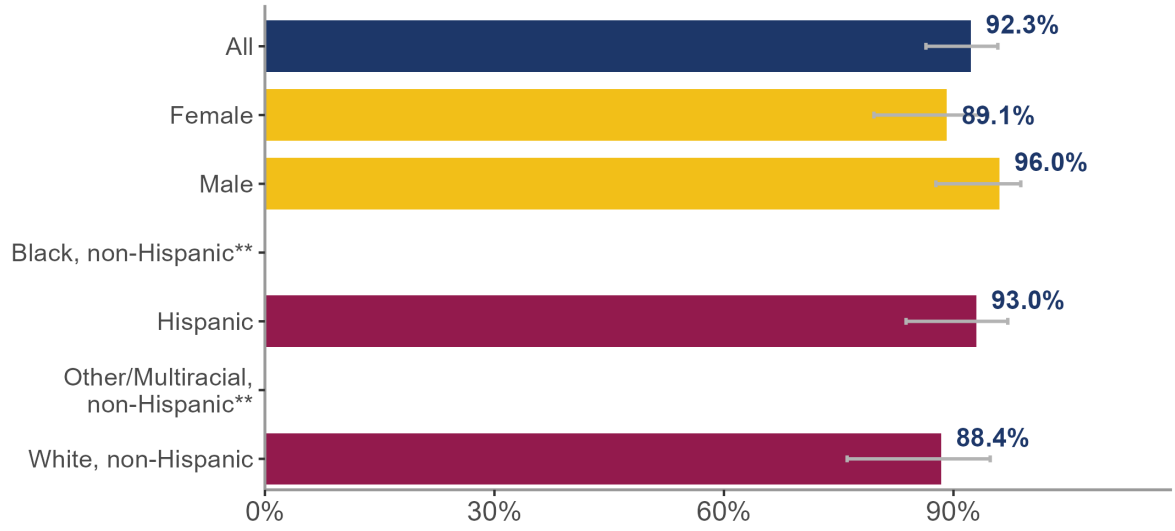
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Diabetic Care

Routine check-ups and doctor's visits are especially important for the treatment and management of chronic conditions like diabetes. Healthcare providers can monitor blood sugar control, adjust medications, detect complications early, and more, through regular visits. In Bexar County, about twelve in thirteen (92%) respondents with diabetes reported seeing a doctor in the past year (**Fig. 3C.5**). That said, differences across groups should be interpreted with caution.

Fig. 3C.5 Percent of adult diabetics who saw a doctor in the past year, by sex and race/ethnicity, 2017-2023

Bexar County, Texas



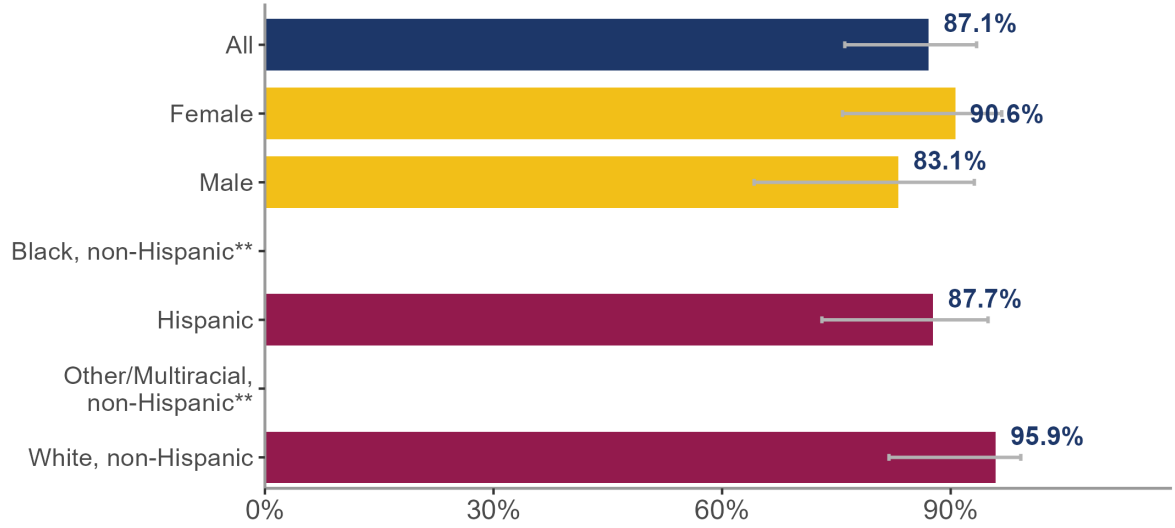
**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Hemoglobin A1c screening averages blood sugar levels over the prior two or three months, giving a broader view of blood control than daily glucose monitoring. Regular checks are especially important for people with diabetes to manage their condition and prevent complications. Averaged across the 2017-2023 period, 87% of Bexar County respondents with diabetes reported having had their hemoglobin A1c checked in the past year (**Fig. 3C.6**). That said, differences across groups should be interpreted with caution.

> *"Diabetes screening, education—but then offer healthy and affordable food options, and offer those foods on all grocery stores, not just in wealthy neighborhoods."*
>
> **– Anonymous respondent to prioritization survey**

Fig. 3C.6 Percent of adult diabetics who have had Hemoglobin A1c checked in the past year, by sex and race/ethnicity, 2017-2023

Bexar County, Texas

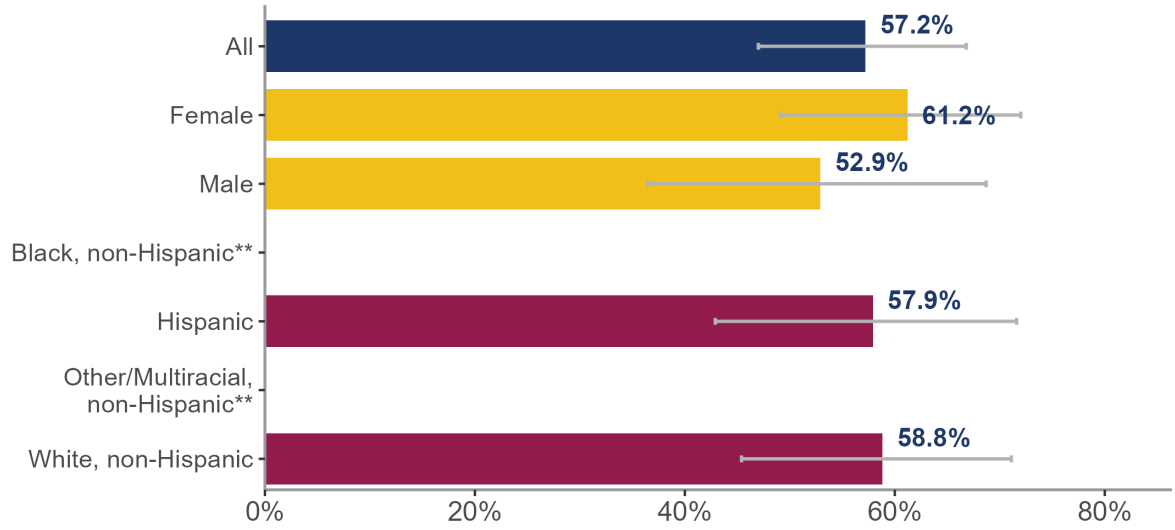


**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Diabetes-related nerve damage most often affects feet and legs, reducing sensation and increasing the risk of unnoticed injuries. Daily foot checks are encouraged so that individuals can catch problems early, before they become serious.[37] In Bexar County overall, 57% reported checking their feet daily (**Fig. 3C.7**). No clear differences among demographic groups emerge.

Fig. 3C.7 Percent of adult diabetics who check feet daily, by sex and race/ethnicity, 2017-2023

Bexar County, Texas



**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Community voices were especially concerned about vulnerable populations in the community, such as people experiencing homelessness, often highlighting how barriers to routine and preventive care are compounded by unstable living conditions and a lack of accessible services.

> *"I personally would like to see more mobile units that can provide at least very routine health services, especially a unit that could go into homeless encampments. They could treat minor wounds or do wound cleaning before they become septic and need to be treated in a hospital. This, I believe, would limit many ER visits. Not everything requires an office visit."*
>
> **– CHNA Community Survey Respondent**

Prenatal Care

Timely prenatal care is critical for protecting both the mother and the developing baby, especially in the first trimester.[38] Lack of early care can lead to increased risks of low birth weight, pregnancy complications, and infant mortality. Regular check-ups during this period allow for essential screenings, early interventions, and important guidance on a healthy pregnancy. Monitoring the percentage of births that receive prenatal care in the first trimester provides insight into access to and utilization of reproductive care and resources.

The percentage of births where prenatal care began in the first trimester decreased from 81% in 2019 to 66% in 2022 (**Fig. 3C.8**) and recovered somewhat to 71% in 2023, with all maternal age groups following the same pattern over the period. This chart is a bit misleading, however, because early prenatal care rates were unusually high from 2019 to 2021. The percentages for 2016, 2017, and 2018 were 67%, 71%, and 77%, respectively.* The reasons for the improvements in the 2019-2021 period and subsequent drop are not clear.

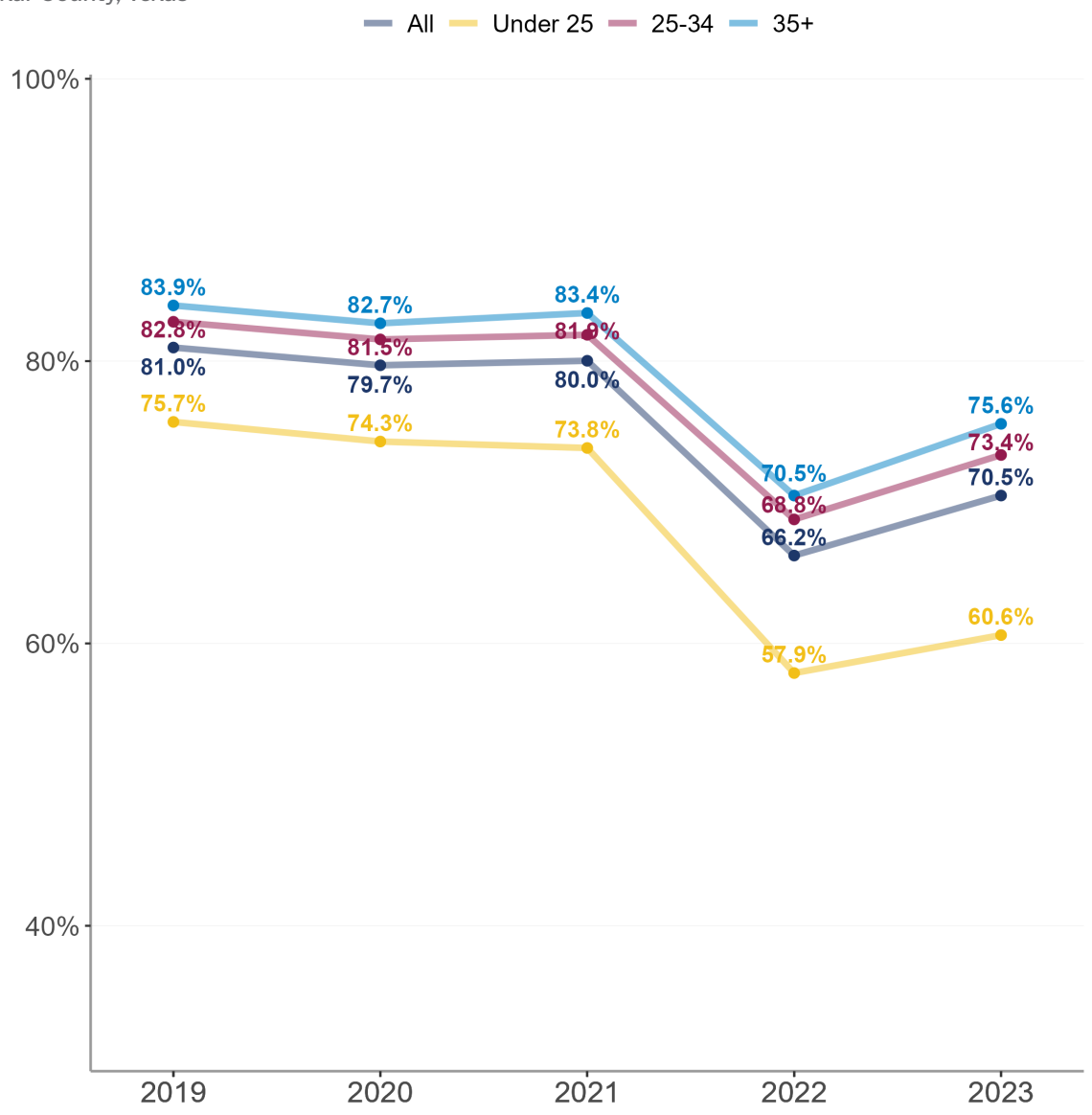
Mothers aged 25 and younger consistently had the lowest proportions of births with first-trimester prenatal care, lower than the overall rate for all mothers (61% in 2023). They were also the age group with the smallest recovery from the 2022 decline. In contrast, mothers over 35 consistently reported the highest proportions of early prenatal care throughout the five-year period (76% in 2023).

Figure 3C.9 shows the trend in first-trimester prenatal care by race/ethnicity, but because the numbers are small, the trend should be interpreted with caution for all groups except Black or African American, Hispanic or Latino, and white. Two concerning stories are clear in this chart. First, the percent decrease from 2021 to 2022 was considerably greater for births to Hispanic (20%) and Black mothers (16%) than for births to white mothers (10%). Second, while the 2023 percentage recovered completely from 2022 for births to white mothers, it remained nearly flat for births to Black and Hispanic mothers.

* Historical figures should not be compared with the 2022 Bexar County CHNA, as different sources were used.

Fig. 3C.8 Percent of births with prenatal care in the fi st trimester, by age

Bexar County, Texas



Source: CDC WONDER
Prepared by CINow for The Health Collaborative

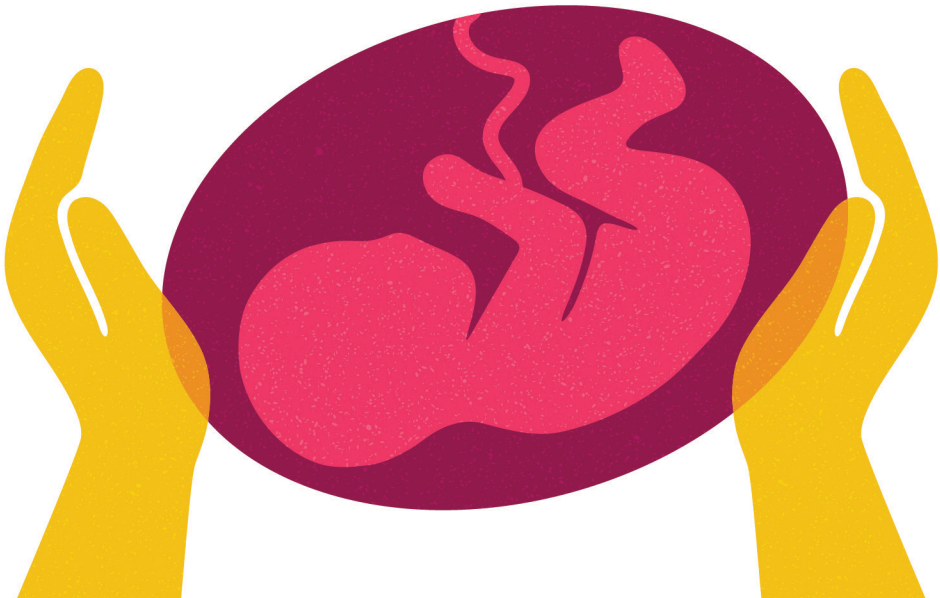
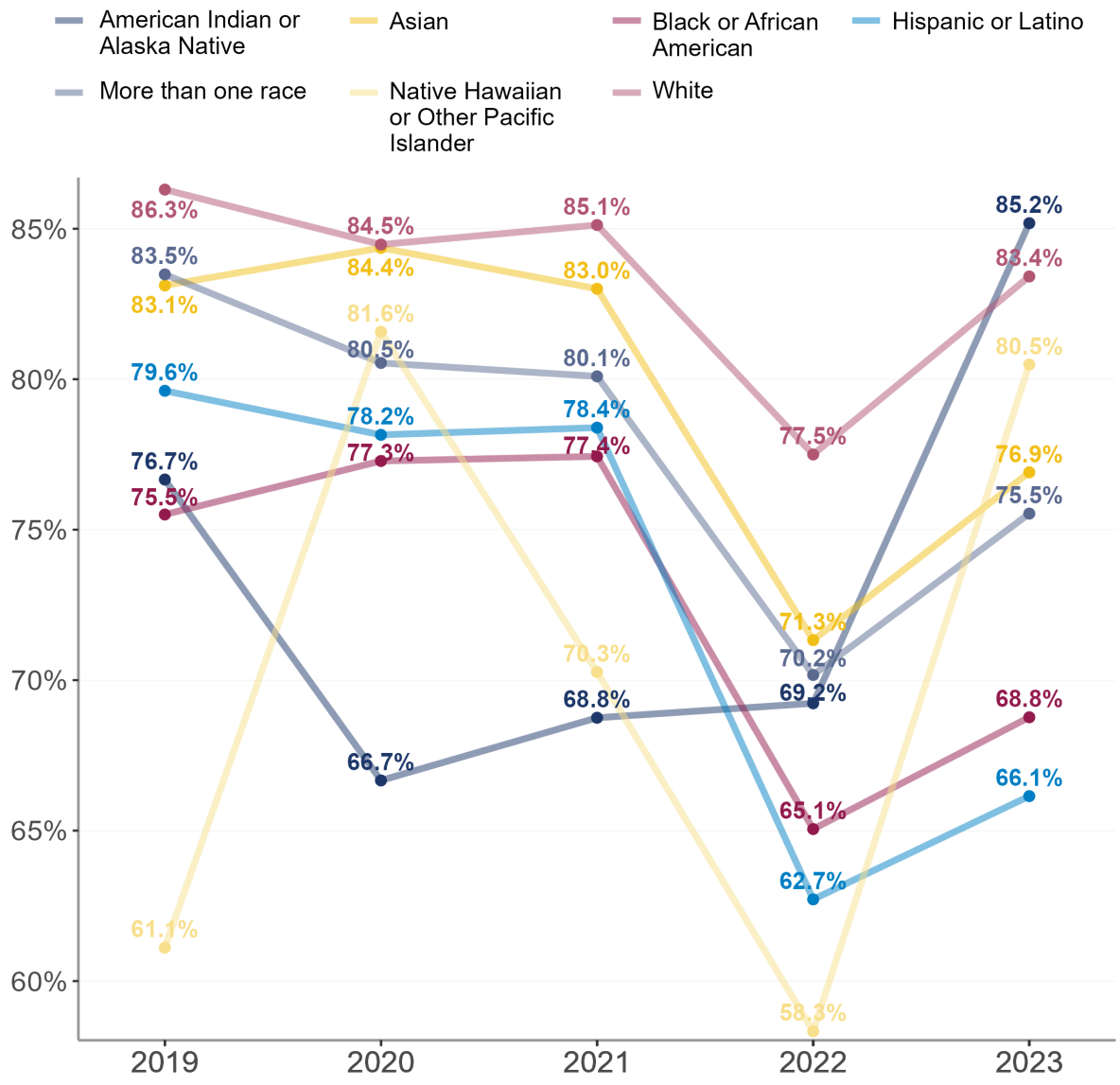


Fig. 3C.9 Percent of births with prenatal care in the fi st trimester, by race/ethnicity

Bexar County, Texas

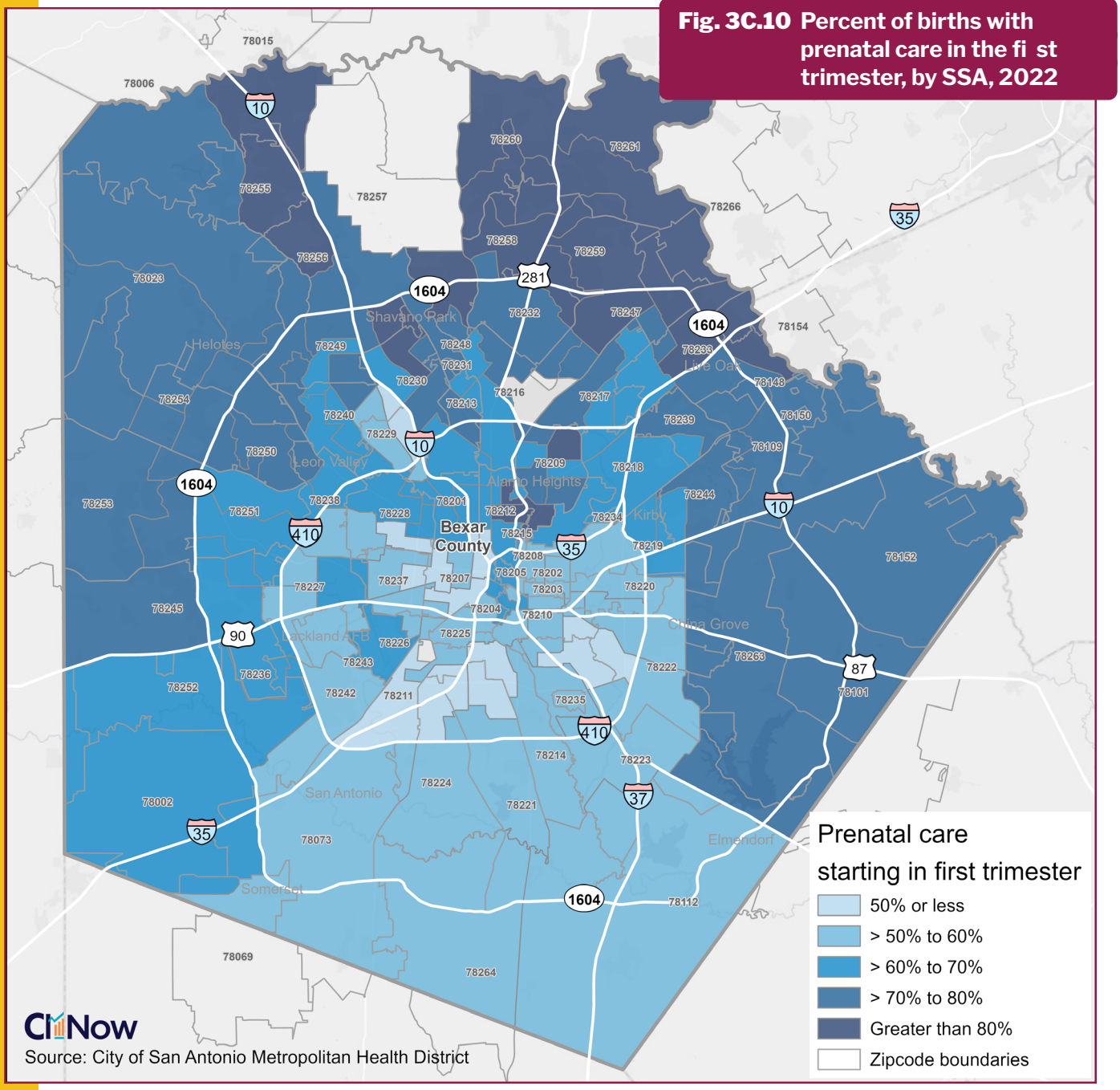


The single race categories are non-Hispanic.
Source: CDC WONDER
Prepared by CINow for The Health Collaborative

"Given the current and anticipated funding cuts to public health at both the federal and state levels, it may be important to explicitly highlight the need for sustained and increased investment in public health infrastructure. This includes funding for data collection, community-based services, preventive care, and health equity initiatives. So all are or should be a high priority."

– Anonymous respondent to prioritization survey

Fig. 3C.10 Percent of births with prenatal care in the fi st trimester, by SSA, 2022



Source: City of San Antonio Metropolitan Health District

In 2022, the percentage of births with prenatal care in the first trimester was highest, at 80% or more, around Alamo Heights, the lower Broadway area, and on the far north side of the county along and outside Loop 1604 (**Fig. 3C.10**). In contrast, SSAs with the lowest rates, 50% or less, were mostly concentrated inside Loop 410 on the westside, eastside, and southside. The other area with low rates is along I-10 West and Fredericksburg Road, an area with a large refugee population and a number of lower-cost, lower-quality apartment complexes.

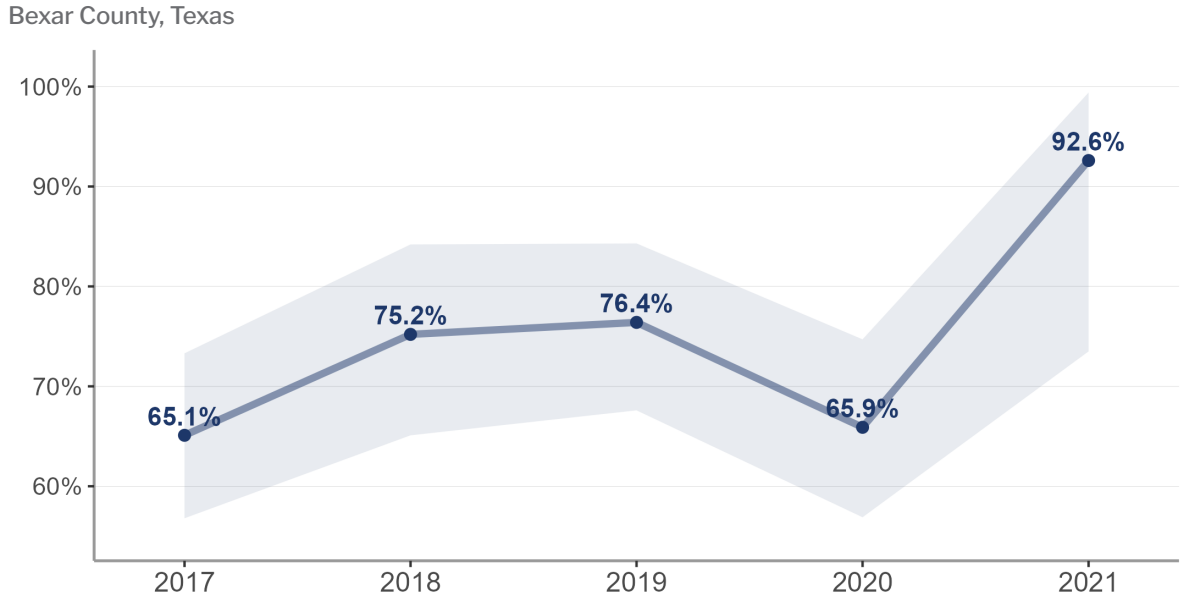
PROTECTING OURSELVES AND EACH OTHER FROM PREVENTABLE DISEASE

Immunization plays a crucial role in preventing the spread of disease and protecting individuals, especially those at higher risk of severe complications. Further, focusing on vulnerable populations who are more susceptible to infections or adverse outcomes is key to ensuring broader community protection.

Child and Teen Vaccination

The "4:3:1:3*:3:1:4 series" refers to a combination of seven key vaccines recommended for children aged 19-35 months, and it serves as a benchmark for understanding compliance with recommended childhood vaccination schedules.[39] In the most recent year available, 2021, Bexar County reached a five-year high of 93% compliance (**Fig. 3D.1**). However, because of a wide margin of error, this percentage was only statistically different from 2017, when compliance decreased to 65%. While the rates fluctuated over the five-year period, many of the year-to-year differences were not statistically significant, because of overlapping margins of error shown here as a lighter blue band behind the trendline.

Fig. 3D.1 Percent of children aged 35 months and younger up to date on 4:3:1:3*:3:1:4 immunization series



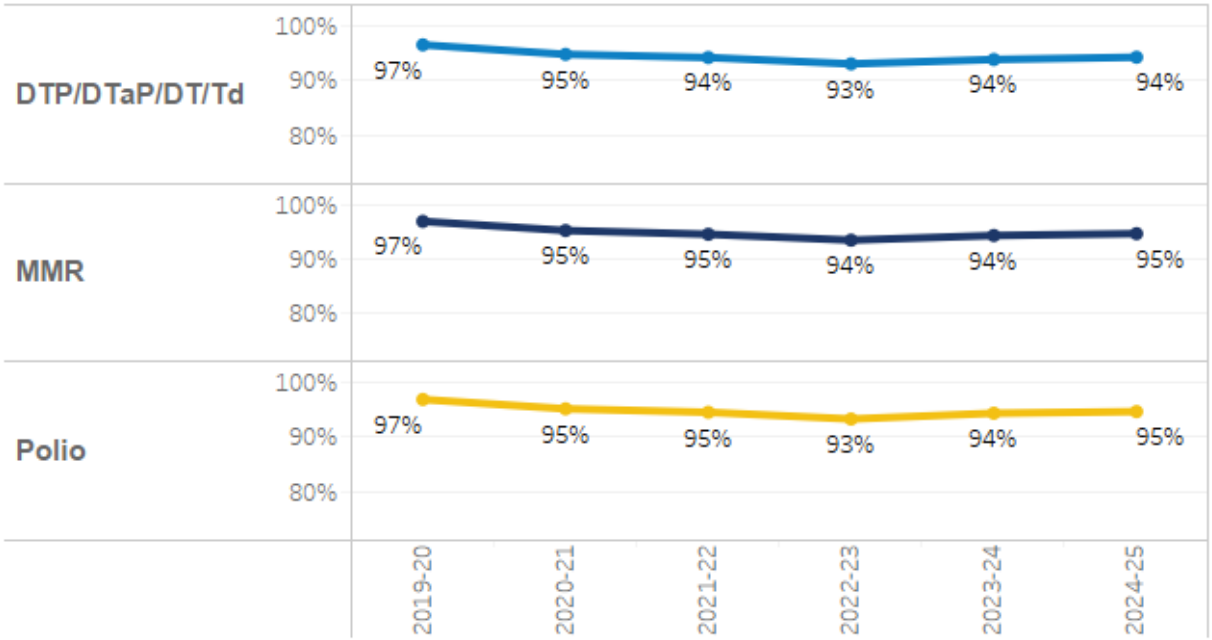
Source: Centers for Disease Control and Prevention
Prepared by CINow for The Health Collaborative

Although no more recent data than 2021 is available for the 4:3:1:3*:3:1:4 series as a whole, single-vaccine data is available for kindergarten students enrolled in schools (**Fig. 3D.2**). It should be noted that this data does not represent all kindergarten-age children in Bexar County, as school is not compulsory in Texas until the first grade. The percentage of kindergarteners receiving each of the three vaccines shown – DTP/DTaP/DT/Td (diphtheria, tetanus, pertussis or whooping cough), MMR (measles, mumps, rubella or 'German measles'), and polio – decreased from the

2019-20 school year through 2022-23 before ticking back up slightly. It is difficult to know what effect the COVID-era shift away from in-person schooling had on collection of this data. Statewide, over 94% of the public school districts and accredited private schools surveyed digitally responded in fall 2019 and fall 2020, as compared to 92% in fall 2021 and fall 2022, 88% in fall 2023, and 91% in fall 2024.[40]

Fig. 3D.2 Percent of kindergarten students with DTP/DTaP/DT/Td, MMR and polio vaccination

Bexar County, Texas



Source: Texas Department of State Health Services Immunization Section
Prepared by CINow for The Health Collaborative

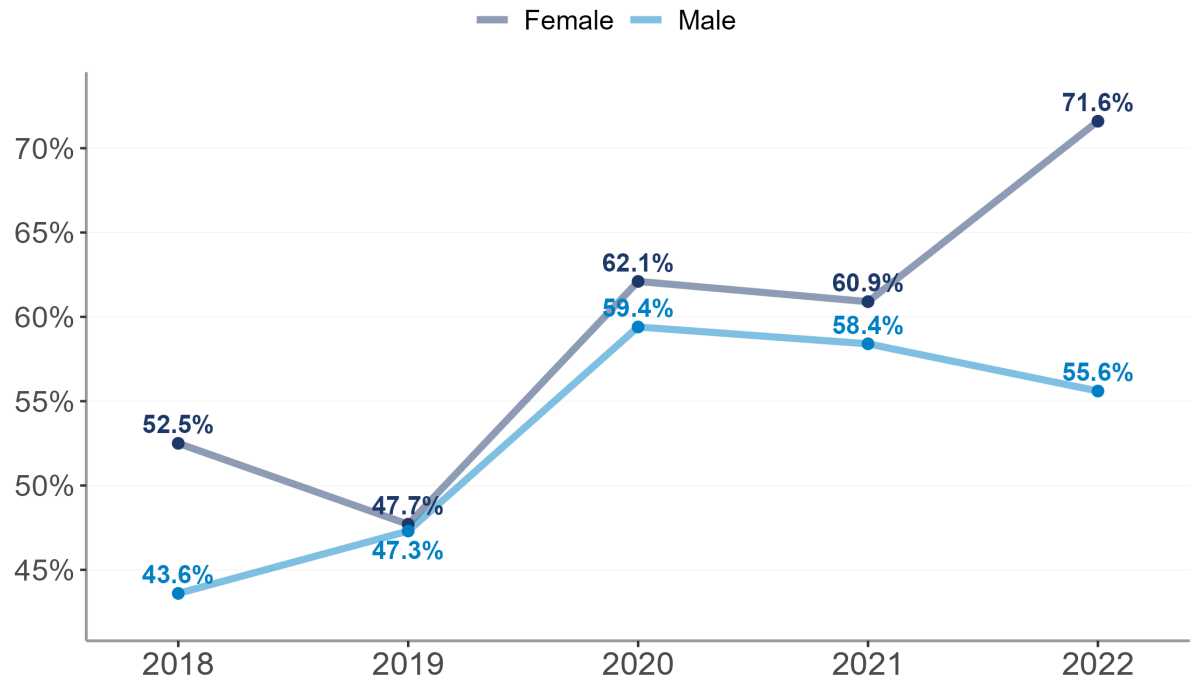
Immunization against Human Papillomavirus (HPV), which can lead to several types of cancer, offers lasting protection and is most effective when administered before exposure, which is why it is recommended at an early age.[41] Between 2018 and 2022, the percentage of teens aged 13 to 17 years who were appropriately vaccinated against HPV varied significantly by sex, with female teens showing higher vaccination rates in most years (**Fig. 3D.3**).

While female teens had higher vaccination rates in 2018, rates for male teens caught up in 2019, with both groups showing nearly identical rates at 47% and 48%. After, both groups steadily followed the same path through 2021. However, in 2022, the gap widened again, with female teens showing much higher vaccination coverage (72% versus 56%).

Notably, the disparities in sex reflect the vaccine's rollout history.[42] When the HPV vaccine was first introduced in 2006, it was only recommended for girls. It was not until 2011 that the recommendation was expanded to include boys. This lag likely continues to influence awareness, provider recommendations, access, and community acceptance.

Fig. 3D.3 Percent of teens aged 13-17 appropriately vaccinated against HPV [two- or three-dose regimen depending on age]

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

COVID-19 Vaccination

Five years after its initial appearance in the U.S., COVID-19 remains a serious threat, though for the general population, the risk is likely less for severe illness and death than for 'long COVID' – disabling symptoms that continue for months or years after infection. People who are immunocompromised, have serious chronic physical health conditions, or have long COVID are more vulnerable to severe illness, hospitalization, and death. Vaccination guidelines for the new 2024-25 COVID-19 have shifted somewhat since their release in fall 2024, but current guidelines generally recommend the new vaccine for anyone aged six months or older.[43]

Figure 3D.4 below shows the percent of National Immunization Survey Adult COVID Module respondents who reported having received the new 2024-25 vaccine, as well as the intent to vaccinate reported by those who has not yet received it at time of survey. No disaggregated data by race, sex, or age group is available for this indicator. The survey is administered weekly, but for the sake of chart readability, only the results from the fourth week of each month are shown.

After a more rapid rise in September and October 2024, the percent of respondents reporting being vaccinated coverage rate then rose quite slowly, topping out at 20% by the fourth week in March 2025. For context, the Bexar County rate is higher than Texas (16%) but lower than the U.S. as a whole (23%).[44]

Among unvaccinated residents, few consistently reported that they "definitely will" get the vaccine, and the "received" and "definitely will" groups together never rose beyond a combined 33%. In contrast, the proportion responding that they definitely or probably would not get the vaccine never fell below 35%.

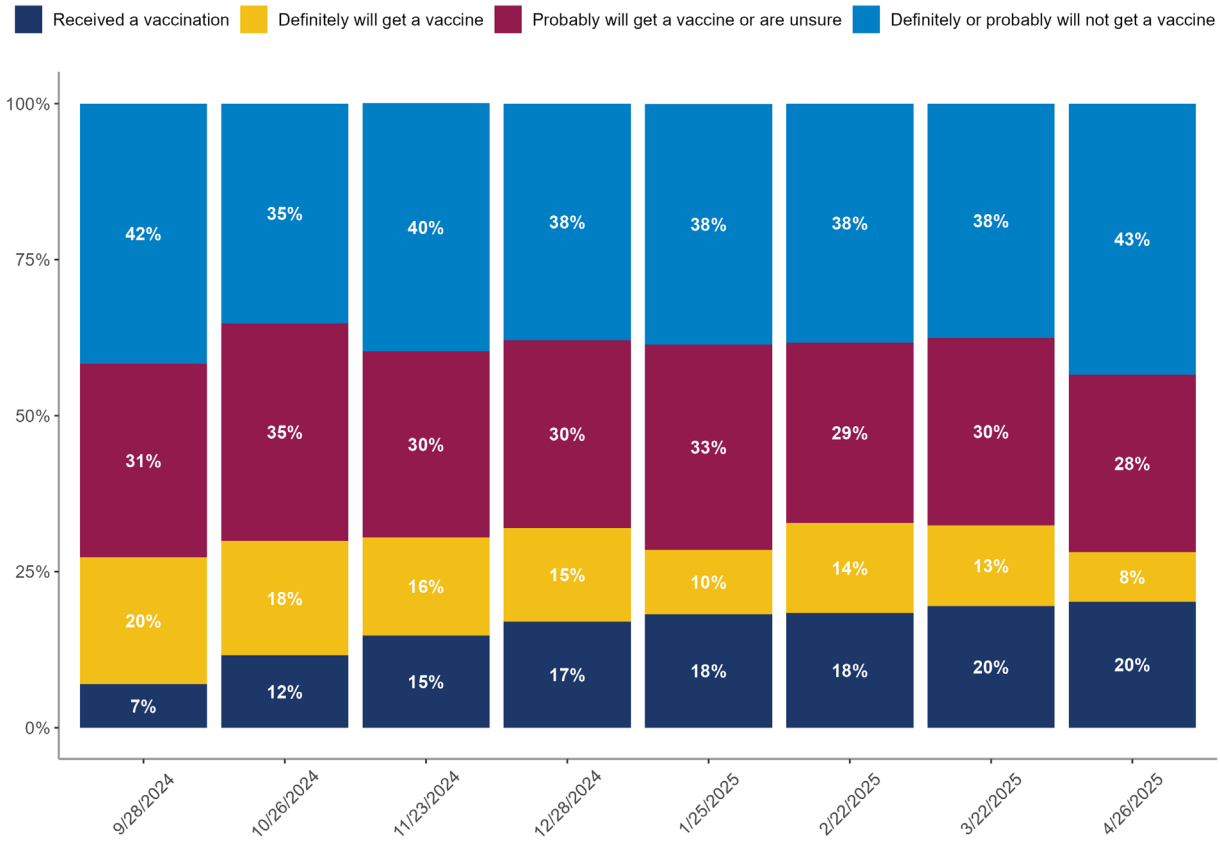
Key informants emphasized the importance of community relationships in encouraging public health recommendations. One key informant explained how building trust with the community was key in encouraging informed decisions about the COVID-19 vaccine.

"I do believe we made a tremendous effort to educate, not just our own patients, but the larger community, about vaccines. That would have never happened without trust. We tried to make sure people understood the pros and cons of getting the COVID vaccines. Ultimately, we had a high level of people choosing to get vaccinated."

– Jaime Wesolowski (President/CEO, Methodist Healthcare Ministries)

Fig. 3D.4 Percent of weekly NIS Adult COVID Module respondents, by 2024-25 COVID-19 vaccine status and intent to vaccinate

Bexar County, Texas



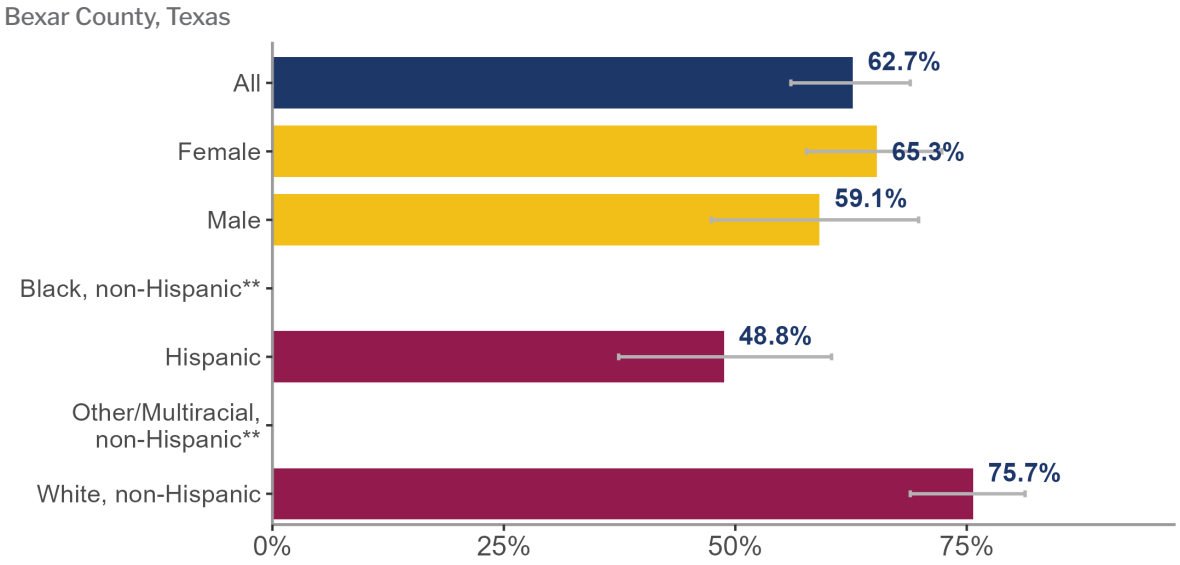
Date for each bar represents end date of measurement week.
Source: Centers for Disease Control and Prevention National Immunization Survey (NIS)
Prepared by CINow for The Health Collaborative

Older Adult Vaccination

Flu vaccination among adults aged 65 and older within the past year is important because older people face the highest risk of severe complications from the flu.[45] Overall, roughly five in eight (63%) Bexar County respondents 65 and older reported having the flu shot within the past year (**Fig. 3D.5**).

While data on differences by sex and race/ethnicity are available, the only statistically significant difference is between Hispanic respondents and white (non-Hispanic) respondents. At 49%, older Hispanic respondents were less likely than older white respondents (76%) to be vaccinated against the flu. Other differences across groups in **Figure 3D.5** and sectors in **Figure 3D.6** should be interpreted with caution.

Fig. 3D.5 Percent of adults aged 65 and older who had a flu sh t within the past year, by sex and race/ethnicity, 2017-2023



**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

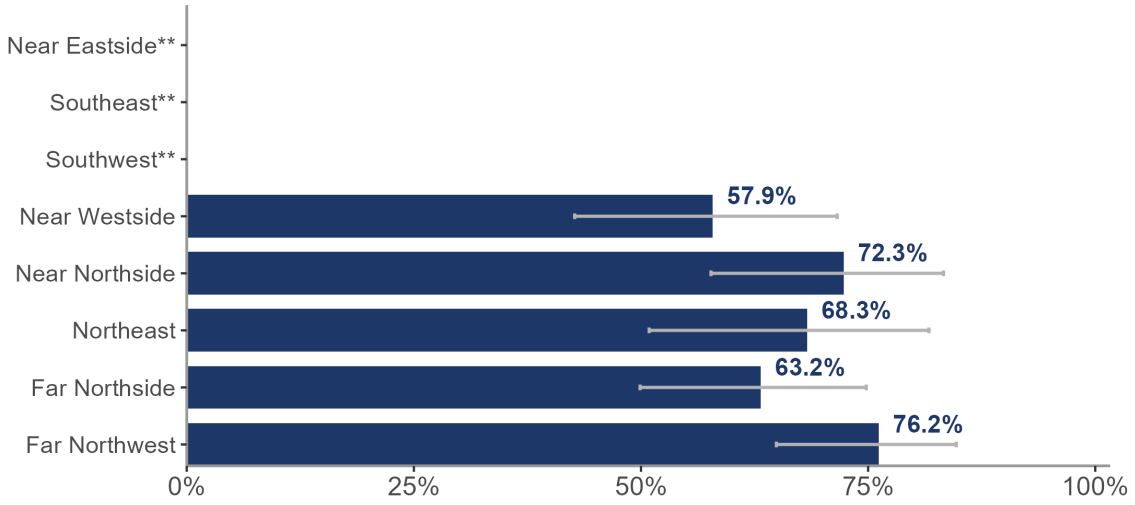
Preventive care like vaccinations is key to protecting individuals and communities from disease, but accessing that care is not always straightforward or easy.

"There are many different barriers to health care, and having health insurance is just the beginning. Then it's having health care literacy- how to make appointments, what appointments to make, what insurance will cover, and what it won't (like having to go to a different location for labs even though there is a lab in your PCP's building because insurance won't cover it)."

– CHNA Community Survey Respondent

Fig. 3D.6 Percent of adults aged 65 and older who had a flu sh t within the past year, by sector, 2017-2023

Bexar County, Texas

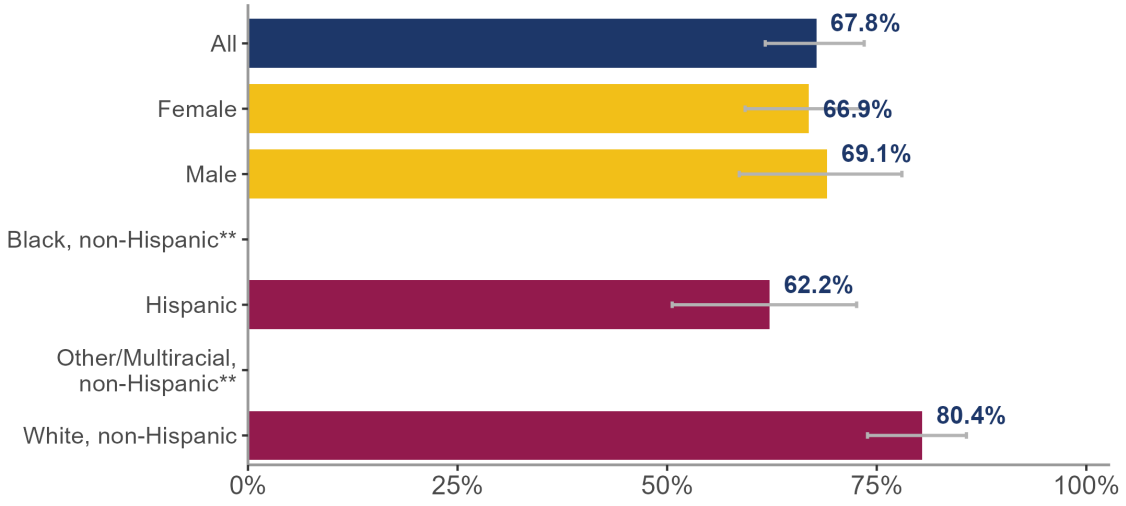


**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Not only are older adults at an increased risk of getting pneumonia and having severe complications, but the risk continues to increase with advancing age.[46] Overall, about two in three Bexar County respondents 65 and older reported having ever received a pneumonia vaccination (**Fig. 3D.7**), which is administered only once rather than annually. As was the case for the flu vaccine, older white respondents (80%) were more likely to be vaccinated against pneumonia than older Hispanic respondents (62%). Differences across sectors in **Fig. 3D.8** should be interpreted with caution.

Fig. 3D.7 Percent of adults aged 65 and older who have ever had a pneumonia vaccination, by sex and race/ethnicity, 2017-2023

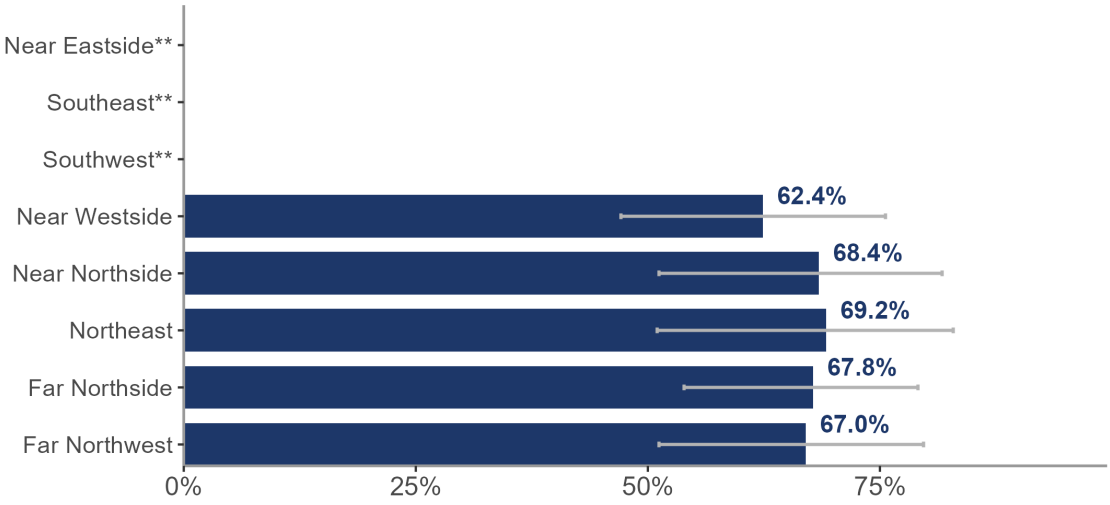
Bexar County, Texas



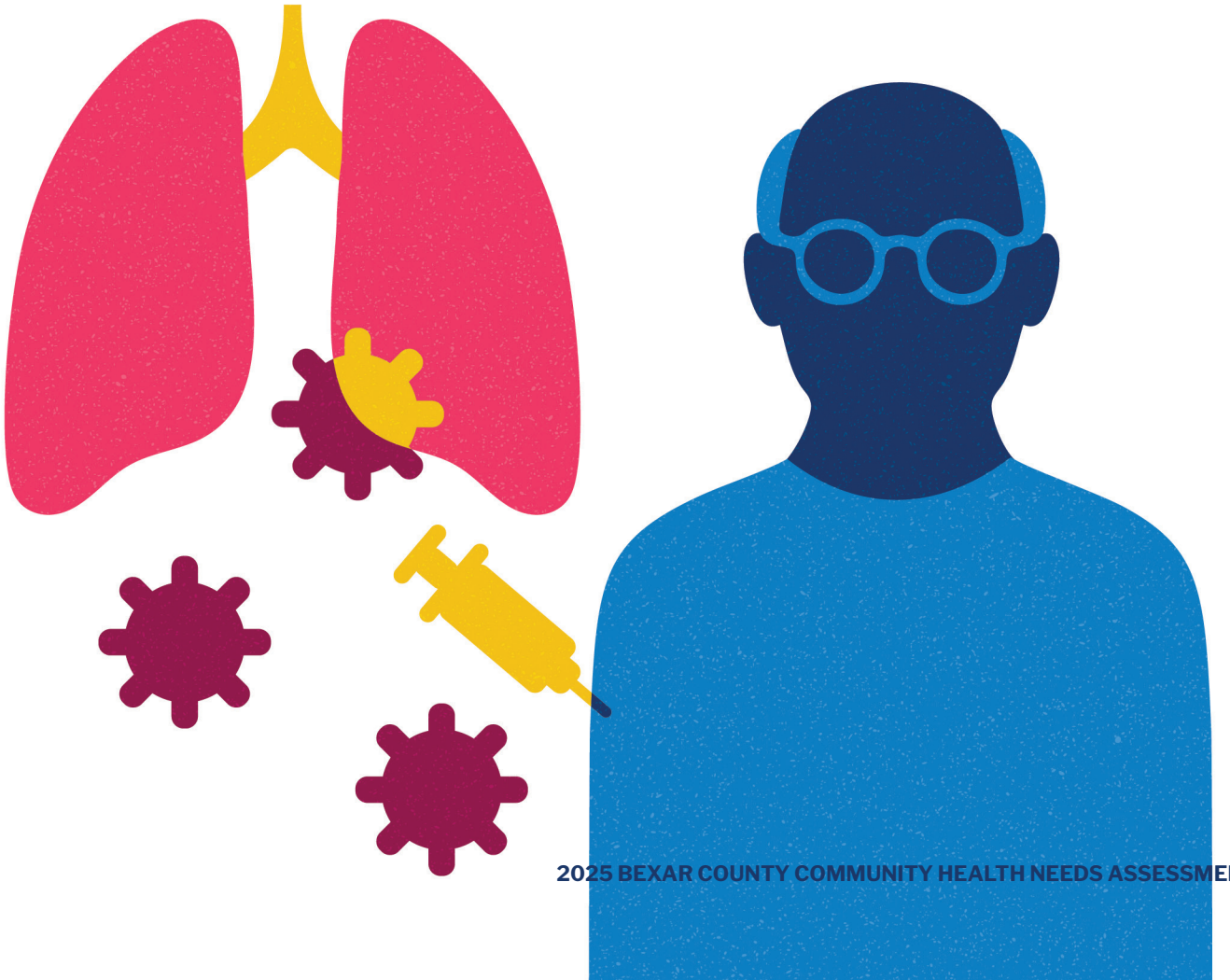
**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3D.8 Percent of adults aged 65 and older who have ever had a pneumonia vaccination, by sector, 2017-2023

Bexar County, Texas



**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative



FINDING DISEASE EARLY

Routine screening and testing are essential tools for early detection, helping to catch conditions before they become more serious, costly, or difficult to treat. Early detection is especially important for monitoring chronic conditions, detecting cancer early when they are more treatable, and preventing the spread of infectious diseases. Certain populations may require more frequent or specialized screenings based on age, sex, or other risk factors, highlighting the importance of equitable access to timely testing.

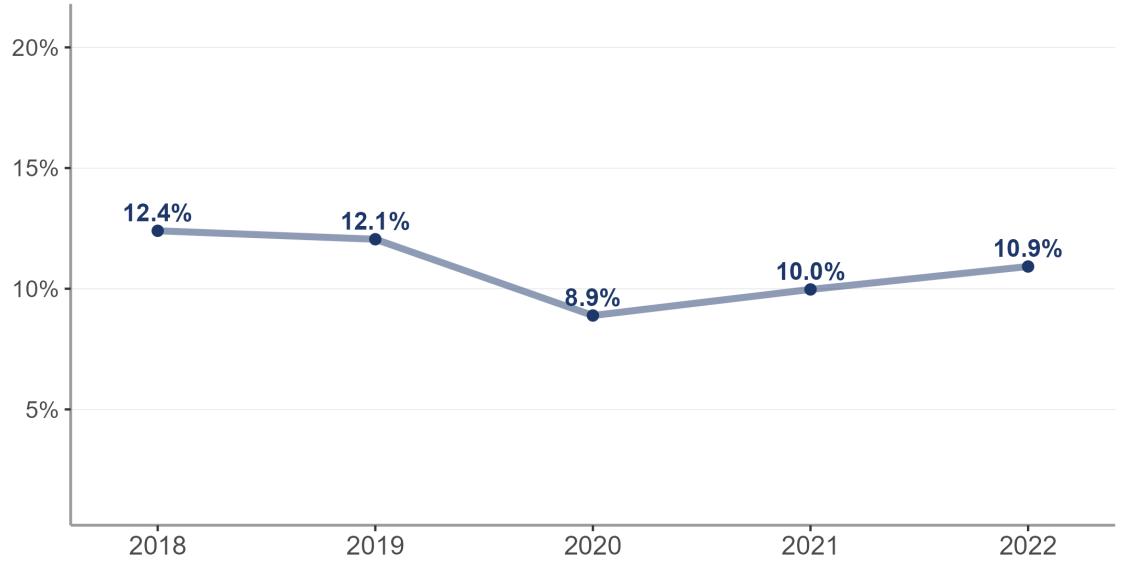
Lead Testing

Among children, one cause of cognitive problems is lead poisoning. Even low levels of exposure to lead can cause serious health problems, especially in young children, harming a child's brain and nervous system, potentially causing developmental delays, learning difficulties, and other permanent effects. The only way to confirm exposure is through a blood test, and early detection is critical for identifying the source and initiating treatment.

In Bexar County, the percentage of children aged zero to five years who were tested for lead poisoning (**Fig. 3E.1**) dropped from 12% to 9% in 2020, likely due to the COVID-19 pandemic. Although testing increased since then, reaching 11% in the most recent year (2022), it still remained below the five-year high in 2018.

Fig. 3E.1 Percent of children aged 0-5 who were tested for lead poisoning

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

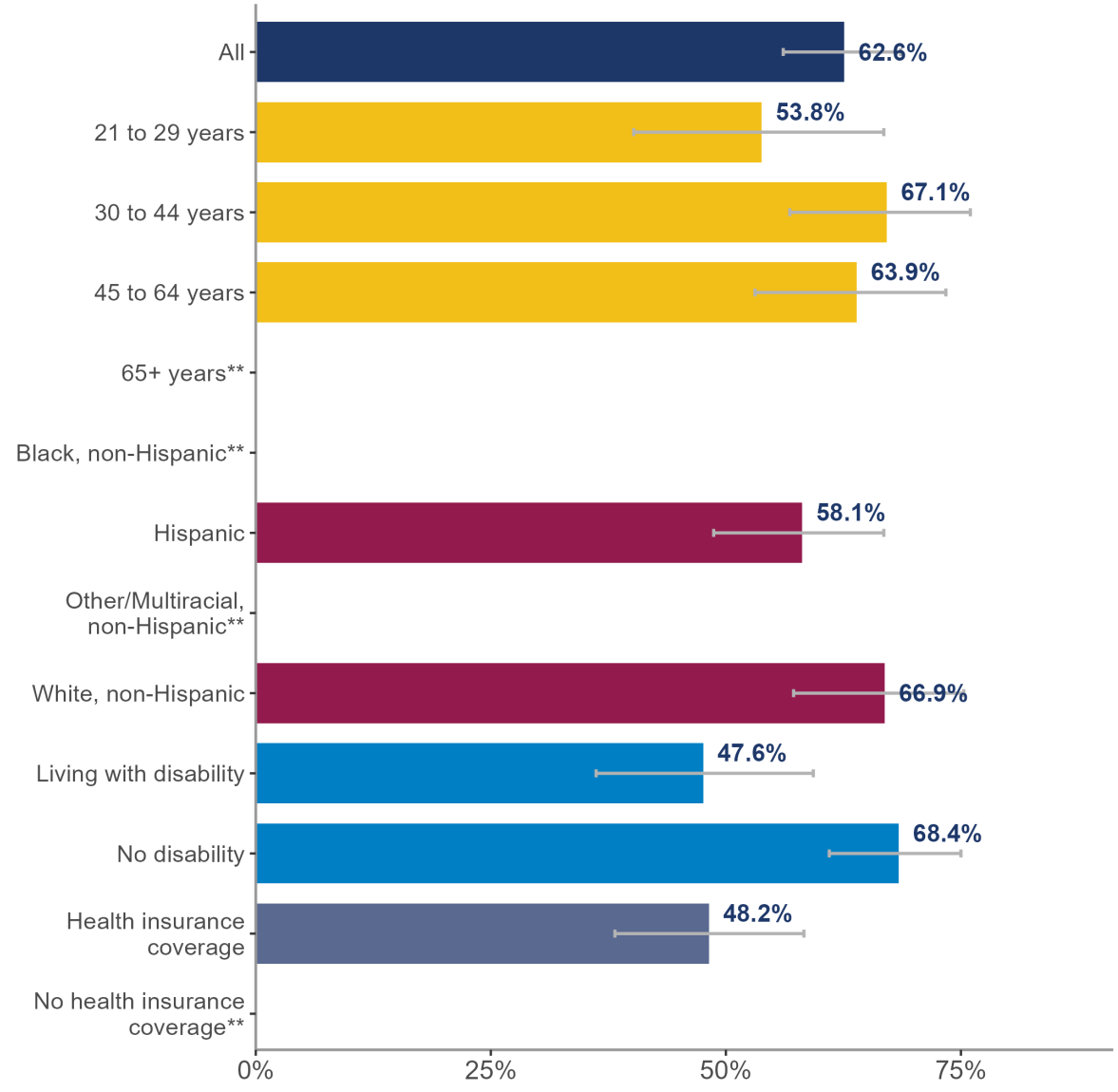
> *"It is more important than ever for organizations to communicate and collaborate to address health issues due to funding reductions and cut backs at the local, state and federal level."*
>
> **– Anonymous respondent to prioritization survey**

Cancer Screening

Pap tests are recommended starting at age 21 and every three years thereafter to detect cervical cancer and dysplasia (pre-cancerous cell changes).[47] Averaged across the 2017-2023 period, 63% of Bexar County women aged 21 to 65 reported having had a Pap cervical cancer screening in the past three years (**Fig. 3E.2**). Notably, there is a significant difference based on disability status; women aged 21 to 65 with a disability were much less likely to report receiving a Pap test in the past three years (48%) compared to those without a disability (68%). Differences across other groups in **Figure 3E.2** and sectors in **Figure 3E.3** should be interpreted with caution.

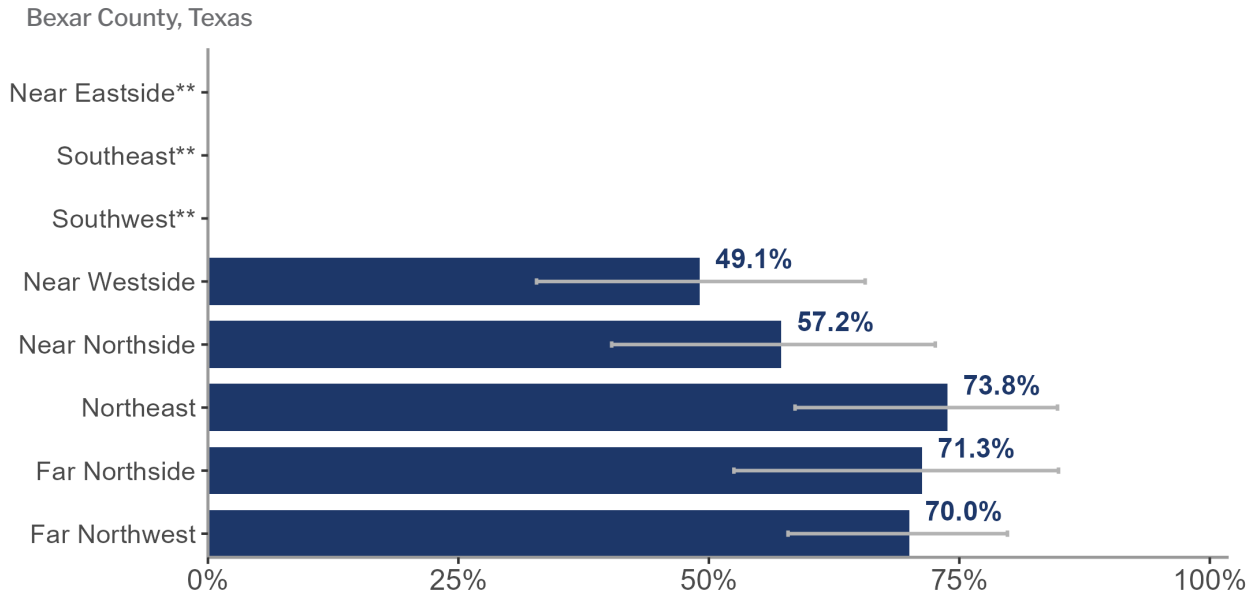
Fig. 3E.2 Percent of women aged 21-65 years with Pap cervical cancer screening in the past 3 years, by age, race/ethnicity, disability status, and insurance status, 2017-2023

Bexar County, Texas

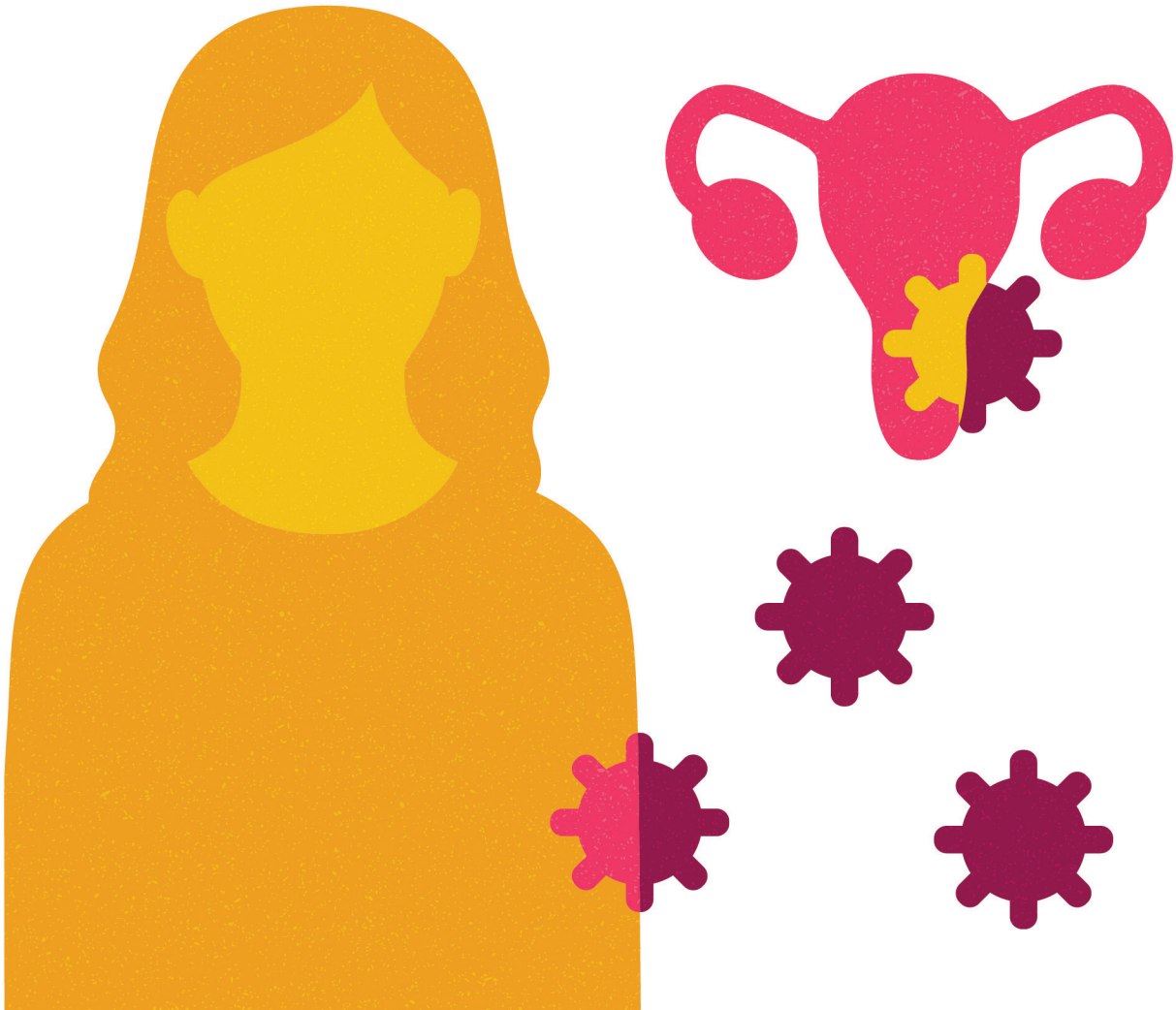


**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3E.3 Percent of women aged 21-65 years with Pap cervical cancer screening in the past 3 years, by sector, 2017-2023



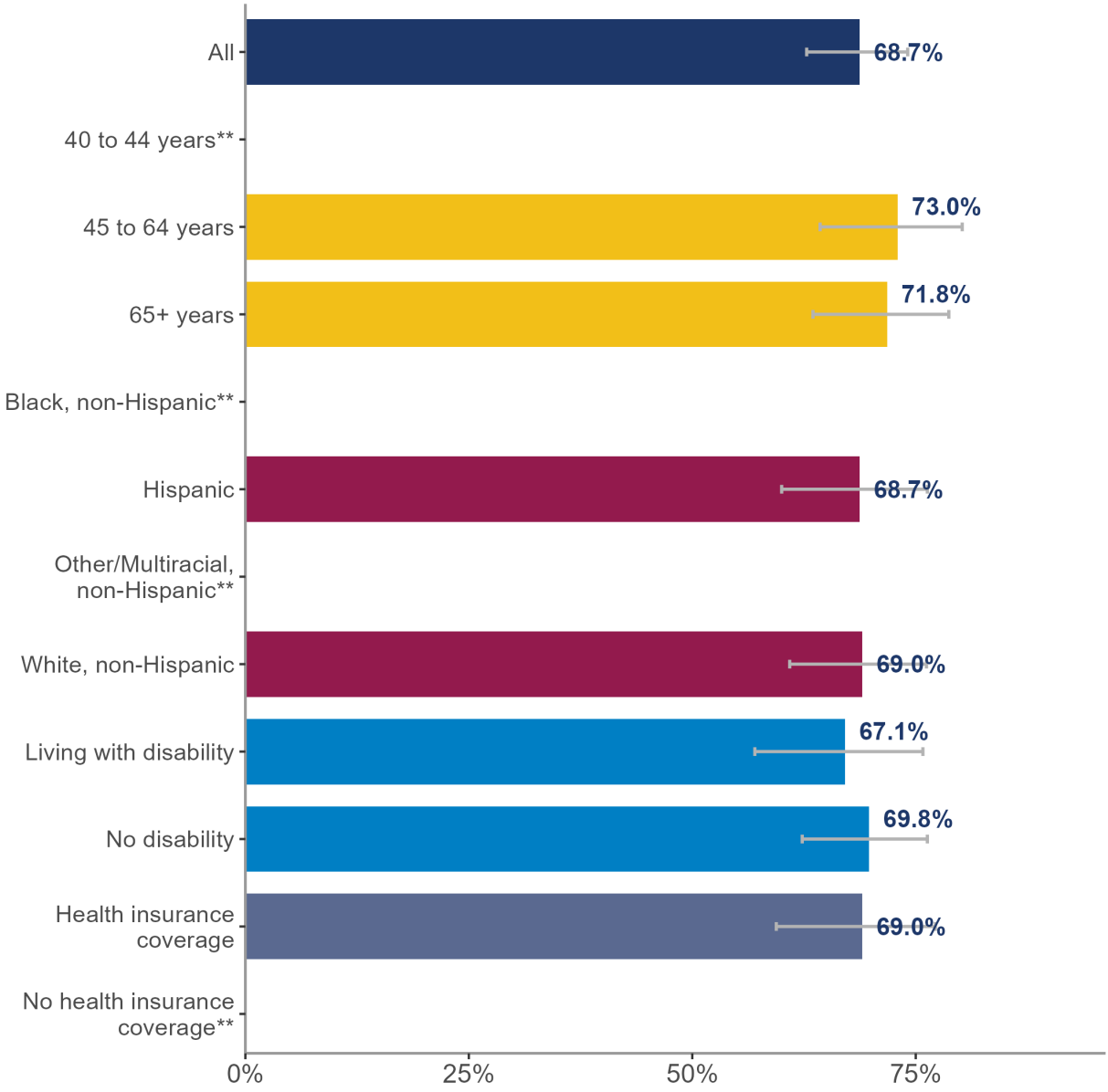
**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative



Regular mammograms can help find breast cancer early, when treatment is more effective and sometimes before any physical symptoms appear.[48] Averaged across the 2017-2023 period, nearly seven in 10 Bexar County women aged 40 and older reported having had a mammogram within the past two years (**Fig. 3E.4**). Because of the small sample size and wide margins of error, differences across groups in **Figure 3E.4** and sectors in **Figure 3E.5** should be interpreted with caution.

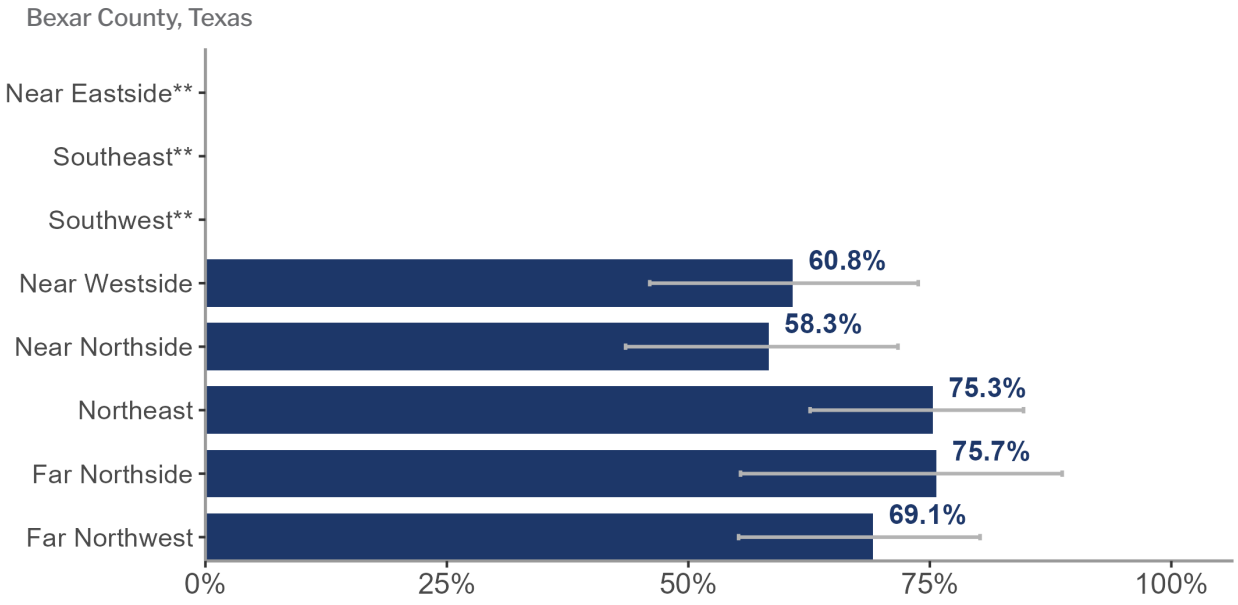
Fig. 3E.4 Percent of women aged 40 and older who have had a mammogram within the past 2 years, by age, race/ethnicity, disability status, and insurance status, 2017-2023

Bexar County, Texas

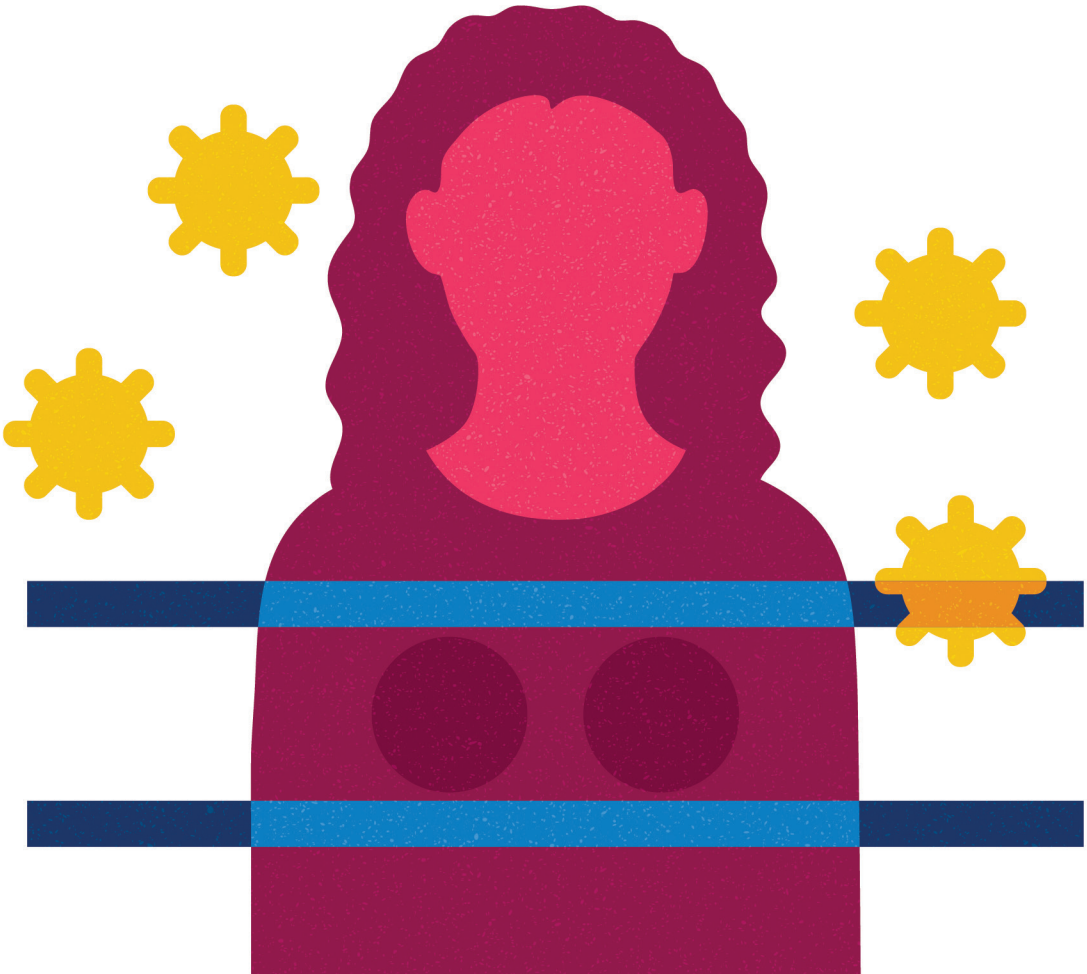


**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3E.5 Percent of women aged 40 and older who have had a mammogram within the past 2 years, by sector, 2017-2023

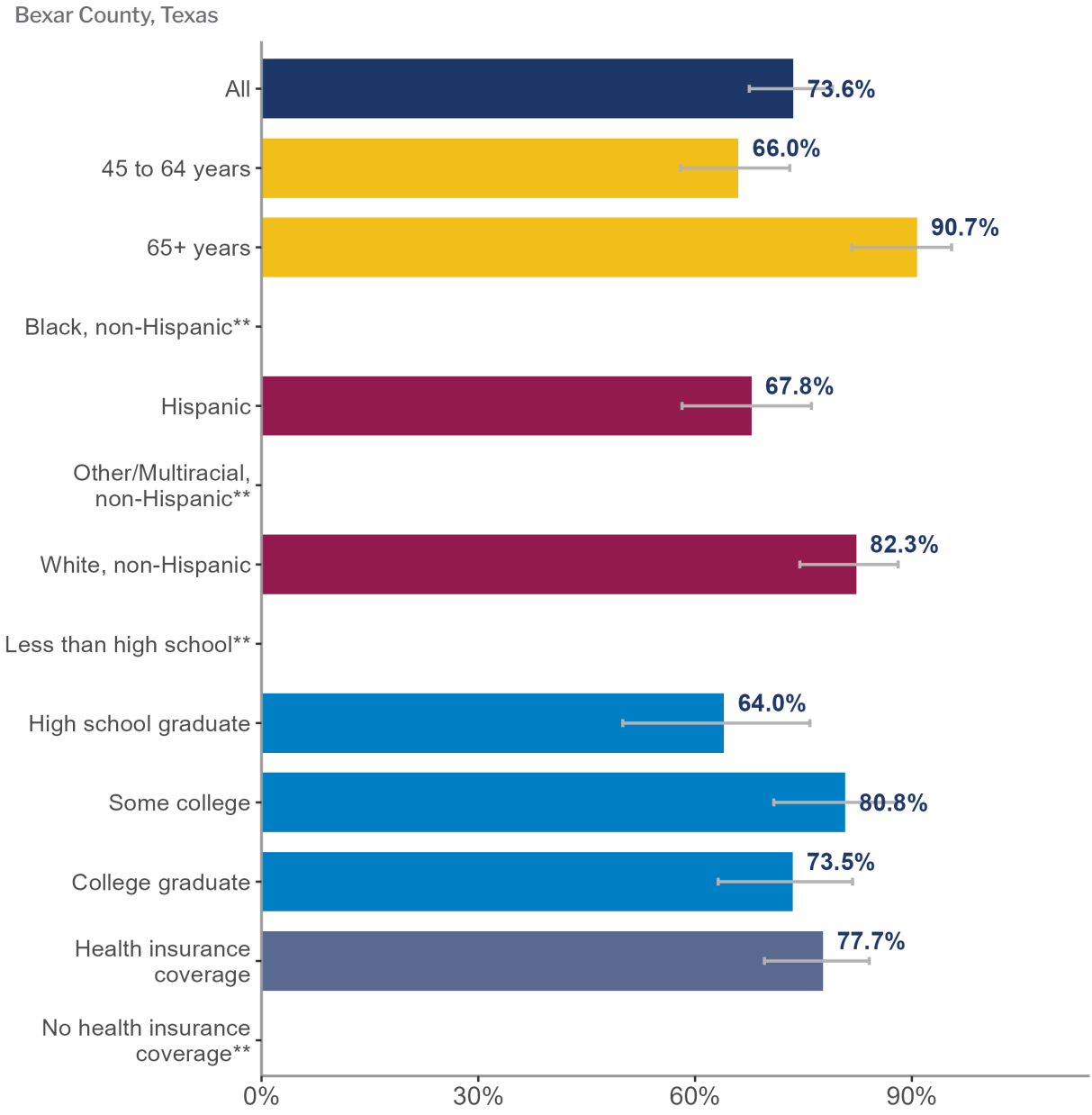


**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative



Colorectal cancer, one of the more common and preventable cancers in the United States, can be prevented or detected early through screening, which is recommended after the age of 45.[49] Overall, 73% of Bexar County survey respondents reported being up to date on recommended screening for colon cancer (**Fig. 3E.6**). Again, differences across groups in **Figure 3E.6** and sectors in **Figure 3E.7** should be interpreted with caution.

Fig. 3E.6 Percent of adults aged 45 and older who are up to date on recommended colon cancer screening, by age, race/ethnicity, highest level of education, and insurance status, 2017-2023



**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

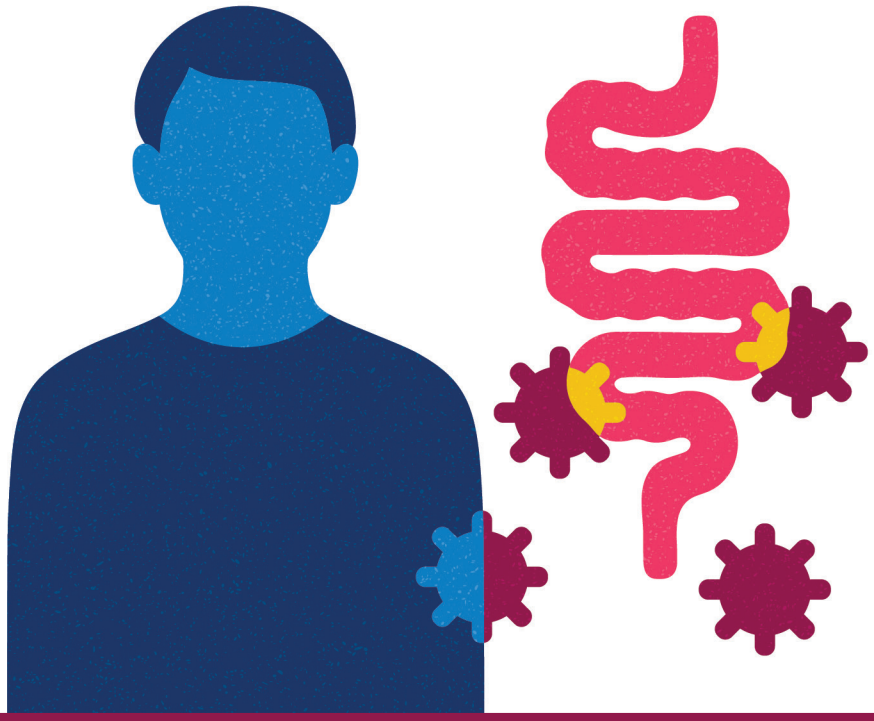
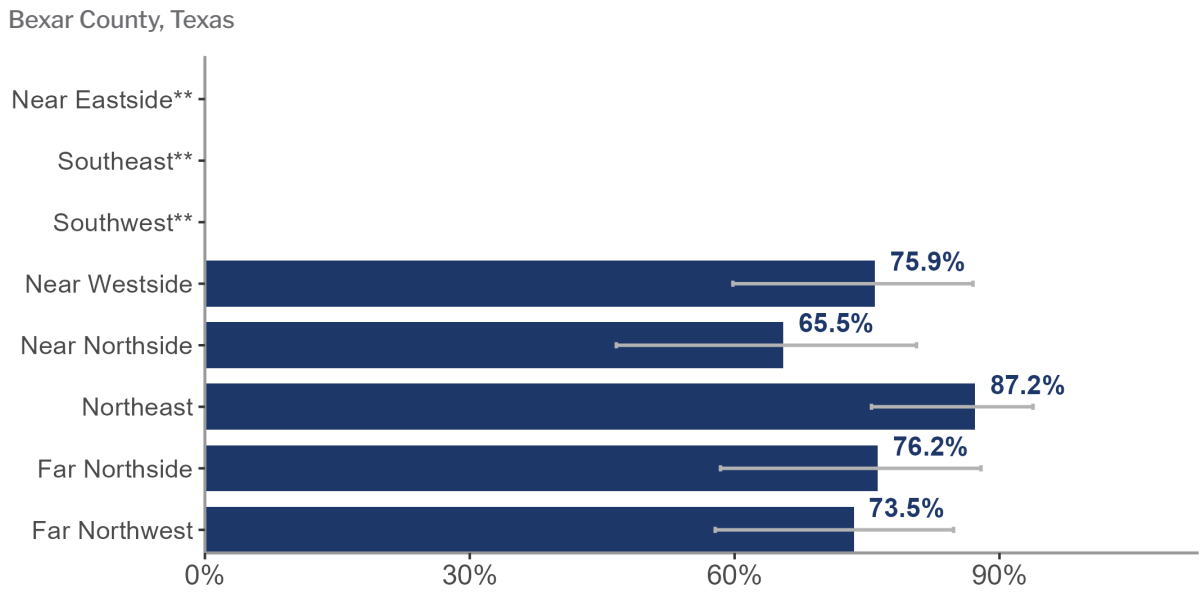


Fig. 3E.7 Percent of adults aged 45 and older who are up to date on recommended colon cancer screening, by sector, 2017-2023



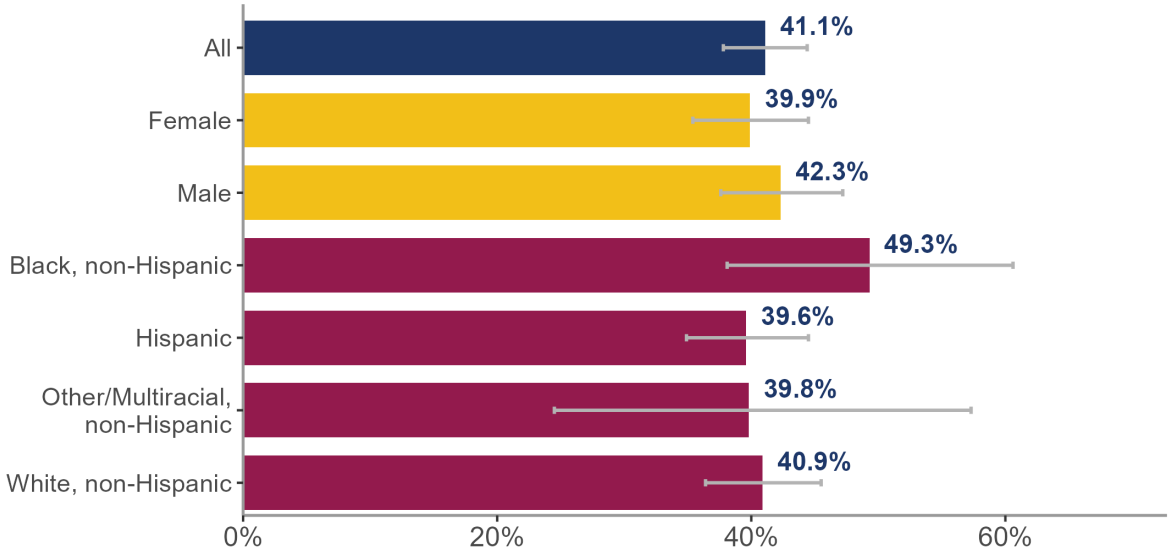
**Suppressed by data source.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

HIV Testing

Early detection of HIV is critical for both individual and public health—an early diagnosis allows individuals to begin treatment sooner, make informed decisions about sexual and reproductive health, and significantly reduce the risk of transmitting the virus to others. Overall, just over two in five (41%) Bexar County respondents reported ever getting tested for HIV based on an average over the seven-year period from 2017-2023 (**Fig. 3E.8**). That said, differences across groups in **Figure 3E.8** and sectors in **Figure 3E.9** should be interpreted with caution.

Fig. 3E.8 Percent of adults who have ever been tested for HIV, by sex and race/ethnicity, 2017-2023

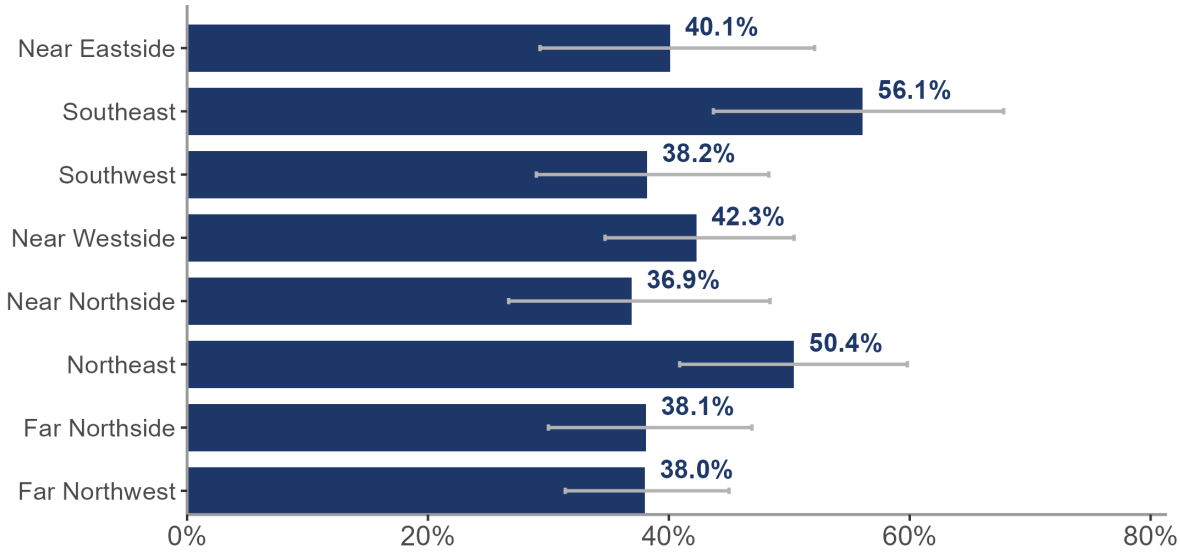
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 3E.9 Percent of adults who have ever been tested for HIV, by sector, 2017-2023

Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Key informants discussed how a common barrier to accessing timely and preventive care is a persistent shortage of providers, especially in rural areas like the South Side or the West Side of Bexar County. This lack of access to specialists can delay diagnoses and worsen health outcomes for already underserved communities.

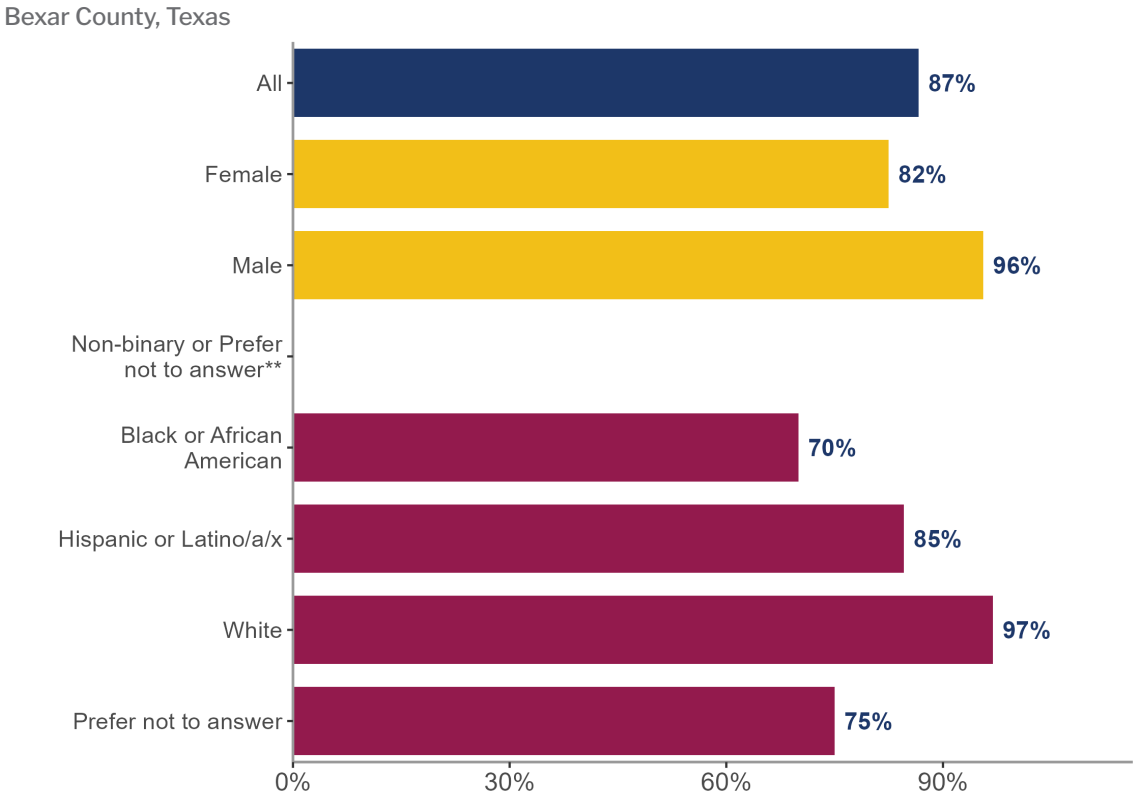
"Hospitals and rural healthcare systems in the region are struggling due to a critical shortage of doctors and nurses. This shortage not only limits specialty care but also access to early detection and preventive care—both essential for maintaining community health. In rural areas, where facilities are often far apart and providers are scarce, many residents miss out on important screenings such as colonoscopies and mammograms and the appropriate follow-up. In contrast, people in urban areas benefit from multiple healthcare facilities nearby, making it easier to receive timely preventative testing and treatment."

– Edward Banos (President/CEO, University Health)

WHAT WE HEARD FROM THE COMMUNITY

When asked to rate their physical health over the past three months as "very poor", "poor", "good", or "very good", 87% of Bexar County Community Health Needs Assessment (CHNA) Community Survey respondents chose "good" or "very good" (**Fig. 4A.1**). The percentage was higher for male respondents (96%) than female respondents (82%). Among the larger race/ethnicity groups, 97% of white respondents chose "good" or "very good". That percentage was lower for Hispanic or Latino/a/x respondents (85%) and Black respondents (70%), highlighting a significant gap. Data is suppressed for privacy for those groups with fewer than five respondents.

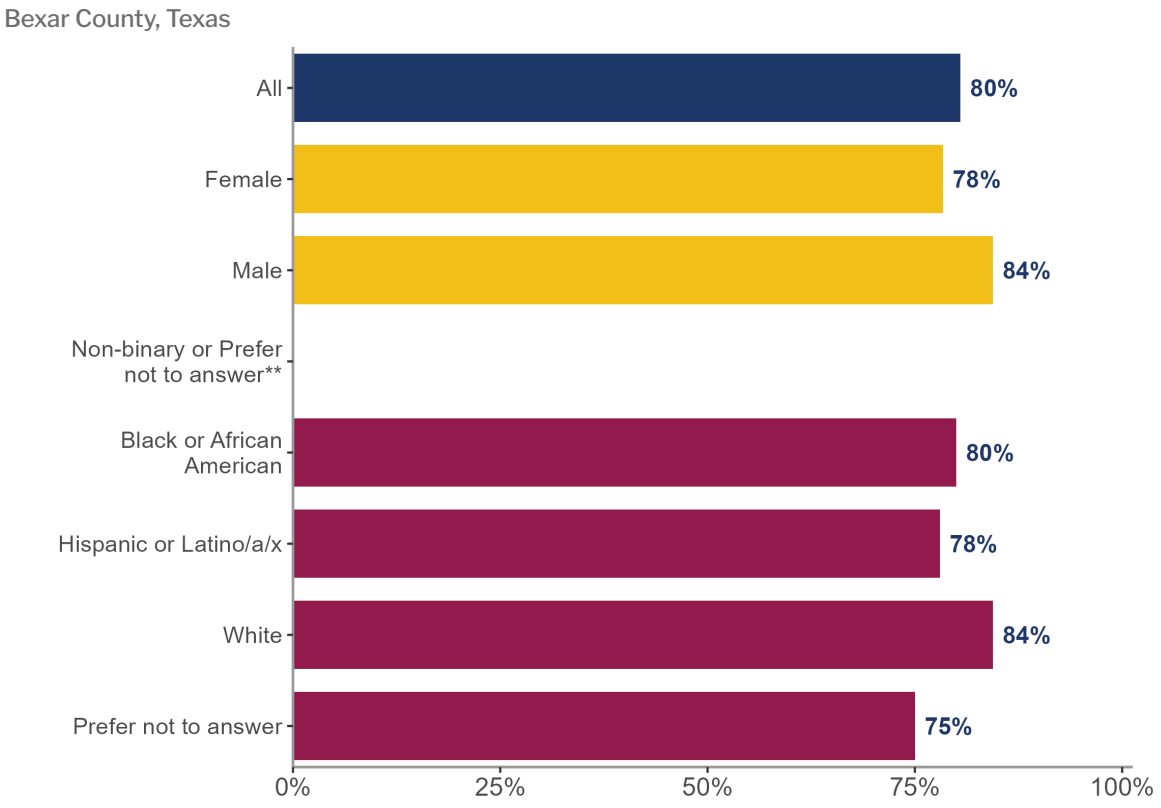
Fig. 4A.1 Percent of CHNA survey respondents rating their physical health in the past 3 months as "good" or "very good", by gender and race/ethnicity, 2025



**Data suppressed for privacy for race/ethnicity groups not shown.
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

For the most part, mental health challenges are shared by all groups, and while disparities among groups remain, the differences are considerably smaller. When asked to rate their **mental health** over the past three months as "very poor", "poor", "good", or "very good", 80% of Bexar County CHNA Community Survey respondents chose "good" or "very good" (**Fig. 4A.2**). At 84%, the percentage was highest for male respondents and white respondents, and lowest for female respondents (78%), Hispanic respondents, and respondents who chose not to share their race/ethnicity (75%).

Fig. 4A.2 Percent of CHNA survey respondents rating their mental health in the past 3 months as "good" or "very good", by gender and race/ethnicity, 2025



**Data suppressed for privacy for race/ethnicity groups not shown.
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Respondents from the survey, focus groups, and interviews highlighted how health issues are multiplied for vulnerable populations like older adults. For older adults, specificall , what often made the difference in their access to care was the strength of their social networks, including family and friends.

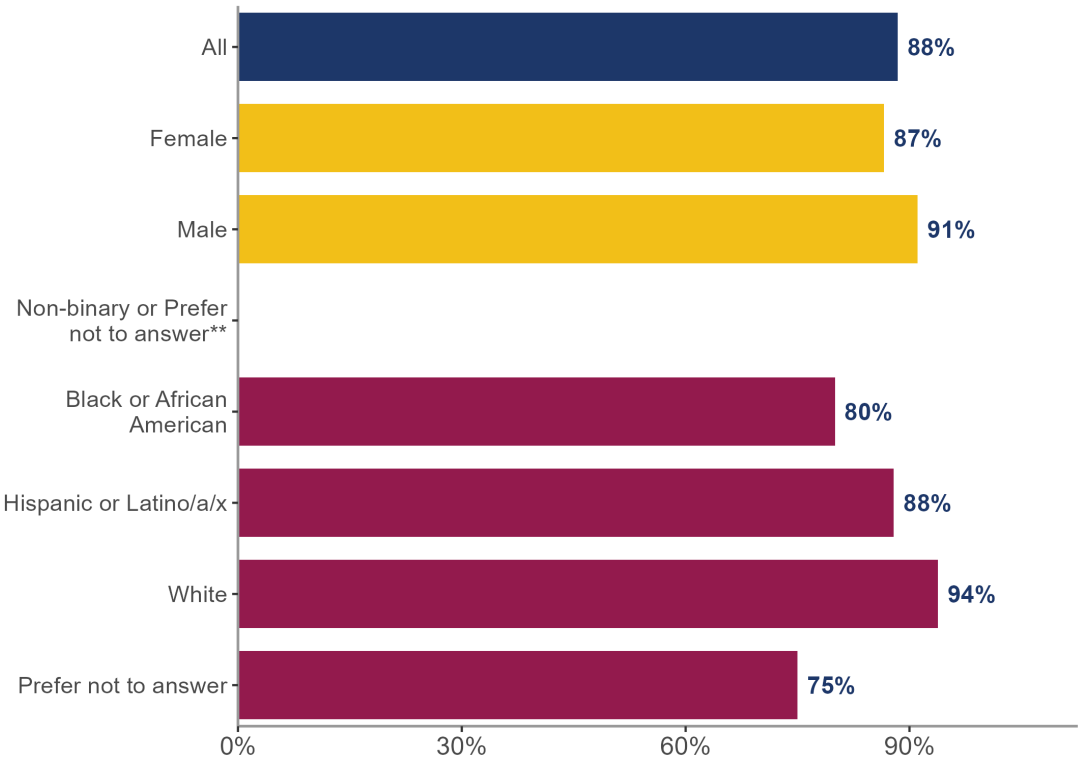
(From a self-identifying older participant): *"When COVID hit, I literally was my own prisoner in my house. I would not go nowhere. My youngest daughter, she let sometimes have my groceries sent to my house, so I wouldn't have to go to the store. Yeah, because I have a lot of problems. And they were afraid that if I go out I'm going to get COVID, because my immune system is so bad, I will get it like that. [...] You know they don't talk about it that much, but COVID's still out there, and I rarely go anywhere unless I got to go to H-E-B. Pick up my medicine or buy some groceries at Sam's. The only place I ever go is those 2 stores."*

– CHNA Focus Group #3 Participant

Social connections and support networks are vital to health and well-being, but not necessarily easy to create, nurture, or call upon when help is needed. Bexar County CHNA Community Survey respondents were asked to rate their **connections with others** over the past three months, such as community, friendships, family, or faith groups (**Fig. 4A.3**). Overall, 88% of respondents rated their social connections with others as “good” or “very good.” The gap between female (87%) and male (91%) narrowed considerably. The highest percentage was among white respondents, and the lowest was among Black or African American respondents (80%) and those who chose not to share their race/ethnicity (75%).

Fig. 4A.3 Percent of CHNA survey respondents rating their connections with others in the past 3 months as "good" or "very good", by gender and race/ethnicity, 2025

Bexar County, Texas



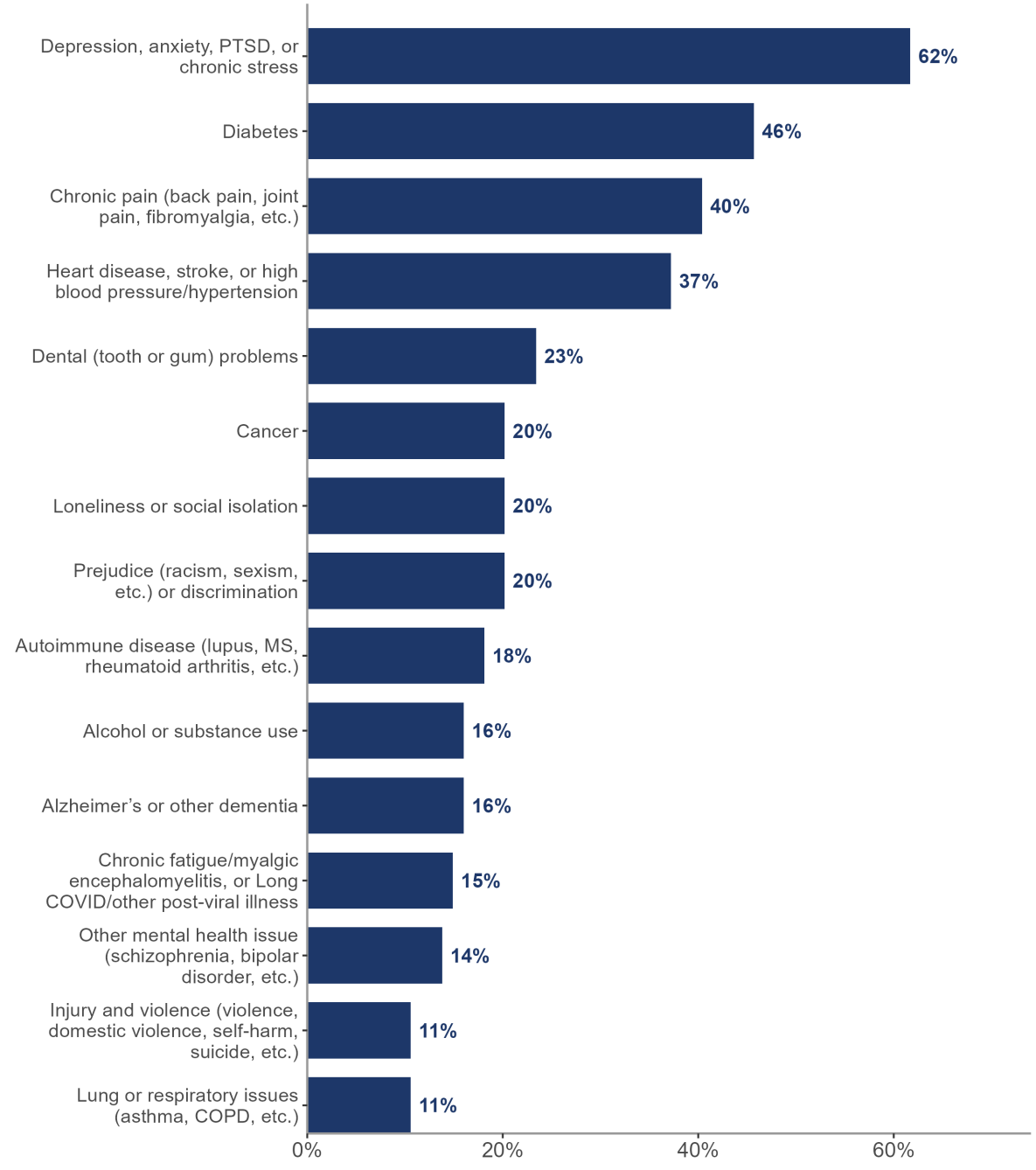
**Data suppressed for privacy for race/ethnicity groups not shown.
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

Bexar County CHNA Community Survey respondents were asked, “Which health issues have the biggest impact on you and/or your loved ones?” and were allowed to select any number of options or write in their own response. These percentages should not be taken as a population prevalence estimate, as the survey asked more about family and friend groups than solely the individual’s experience. Further, the sample was small – 145 respondents – and non-random and should not be assumed to reflect the county's adult population as a whole.

Both similarities and differences emerged between female (**Fig. 4A.4**) and male (**Fig. 4A.5**) respondents. The percentages were similar between females and males for diabetes, cancer, loneliness or social isolation, Alzheimer's or other dementia, and injury and violence.

Fig. 4A.4 Top 15 health issues female CHNA survey respondents rated as having the biggest impact on themselves and/or their loved ones, 2025

Bexar County, Texas

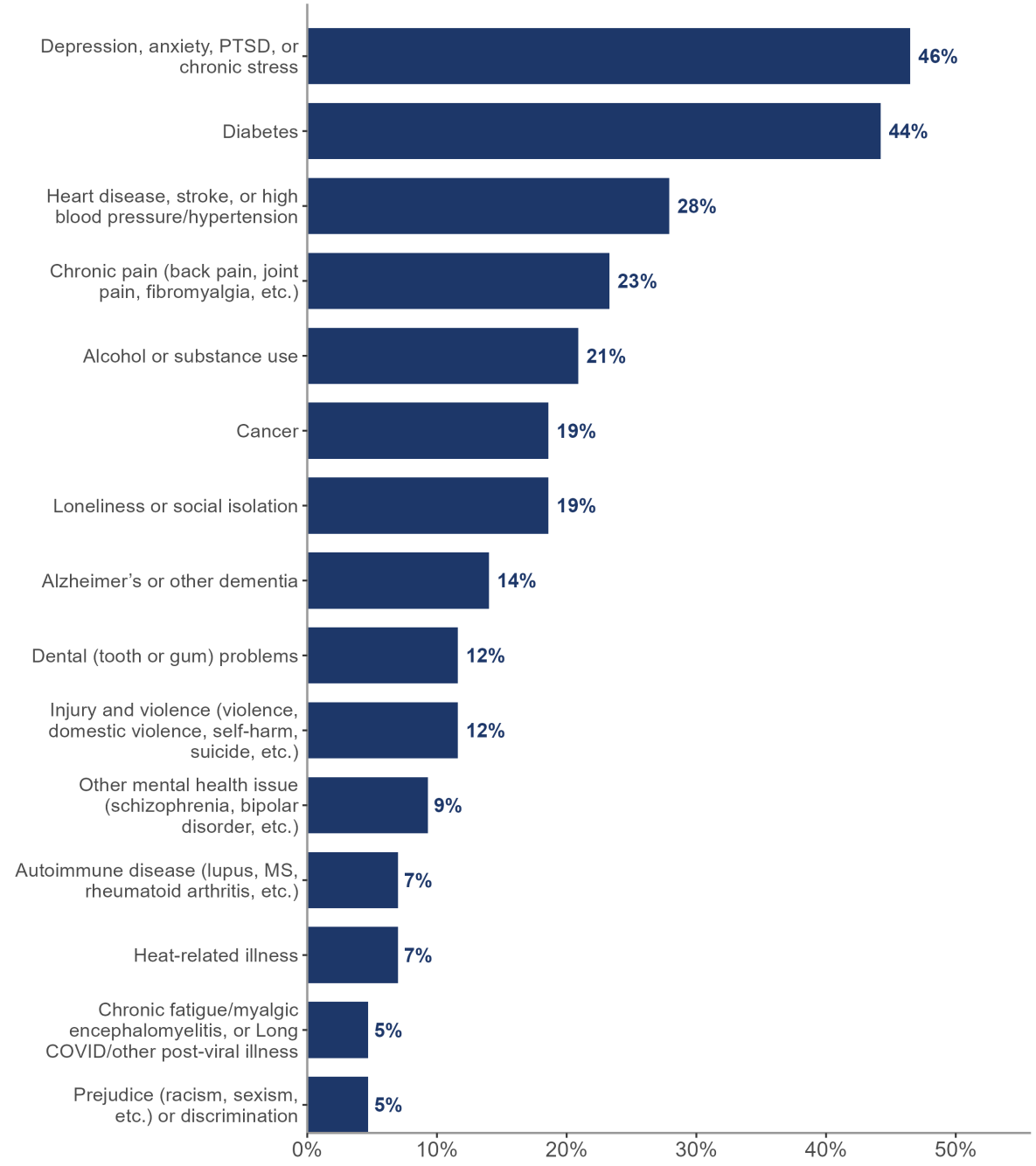


N= 94 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

"Depression, anxiety, PTSD [post-traumatic stress disorder], or chronic stress" was the most frequent response from both groups. However, it was reported by far more females (62%) than males (46%), a ratio of 1.3 females for every one male selecting that response option. In order of increasing degree of disparity, females were also far more likely

Fig. 4A.5 Top 15 health issues male CHNA survey respondents rated as having the biggest impact on themselves and/or their loved ones, 2025

Bexar County, Texas



N= 43 respondents
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

than males to select heart disease, stroke, or hypertension (ratio 1.3); other mental health issues (ratio 1.6); chronic pain (ratio 1.7); dental problems (ratio 1.9); autoimmune disease (ratio 2.6), myalgic encephalomyelitis/chronic fatigue syndrome, Long COVID, or other post-viral illness (ratio 3.0); and prejudice or discrimination (ratio 4.0). Males were much more likely than females to select alcohol or substance use (ratio 1.3) as a health issue having a great impact on them or their loved ones.

It should be said here that these responses might reflect differences in the rates at which each group accesses preventive and primary care and is diagnosed as a result; differences in willingness to disclose health issues may also play a role. However, sex-based disparities are well-documented for many of these issues, such as depression and anxiety, chronic pain, autoimmune disease, myalgic encephalomyelitis/chronic fatigue syndrome and Long COVID, and alcohol and substance use.

Focus group participants echoed CHNA Community Survey findin s that health concerns are deeply tied to basic needs, emphasizing that maintaining health is difficult without onsistent access to food, housing, or medication, and income. Further, worrying about affording basic needs can contribute to stress, which community voices noted can further impact their well-being.

"In order to have a healthy person when it comes to their home, they need to not stress out on where their next meal is going to come from, how they're going to pay their bills, how they're going to get their medication. Because, like for her, for example, if she doesn't get her insulin, that's going to affect her even more."

– CHNA Focus Group #1 Participant

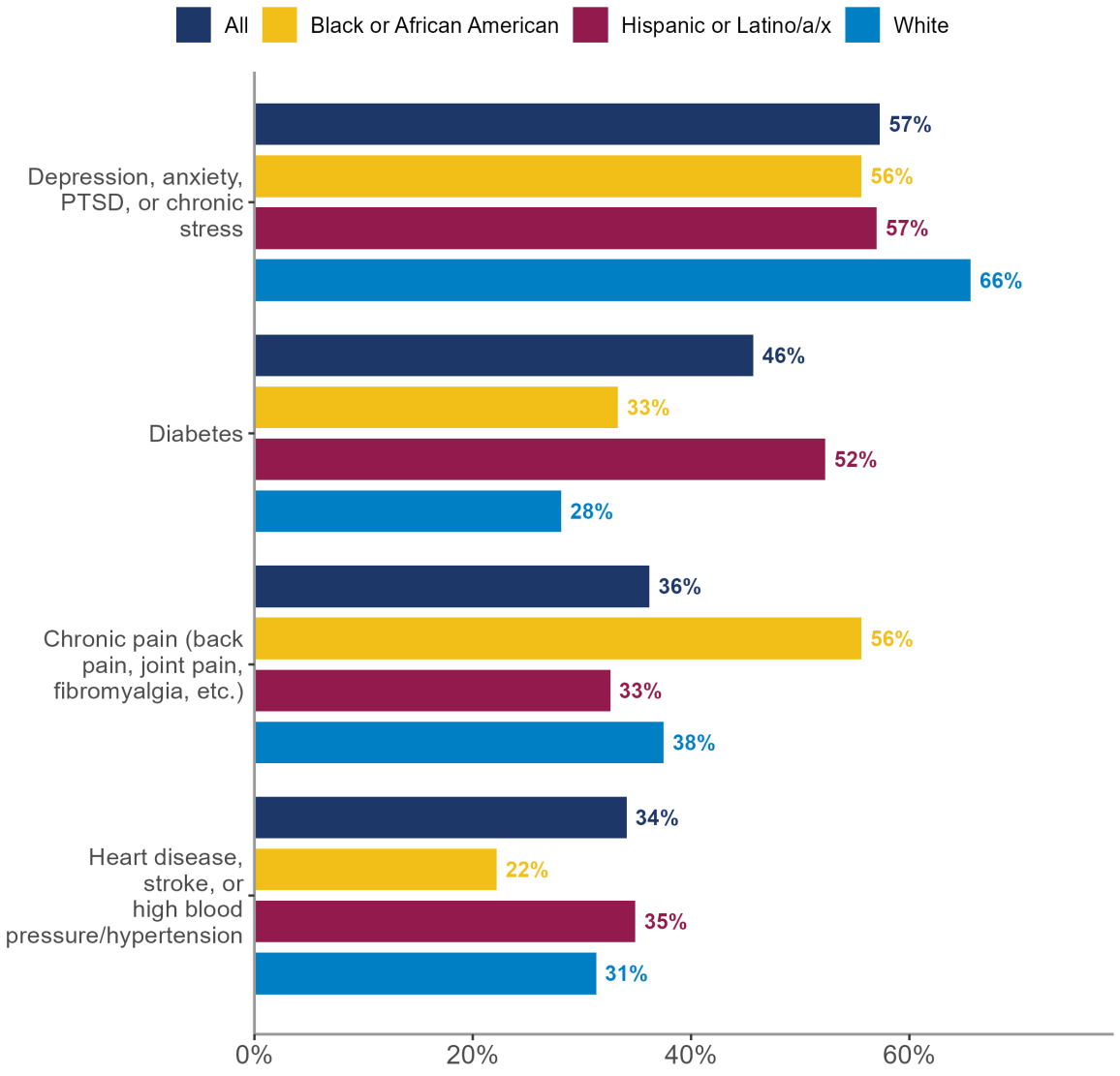
"In Bexar County, while many health conditions are prevalent and disparities persist, economic stability remains a foundational issue. Raising wages and ensuring access to affordable healthcare and insurance are critical steps toward improving health outcomes and reducing inequities. Without economic security, residents face persistent barriers to preventive care, chronic disease management, and mental health support. Addressing income and affordability must be a central part of any strategy to improve community health and well-being."

– Anonymous respondent to prioritization survey

Small numbers make it less useful to examine similarities and differences by race/ethnicity for a long list of health issues, but **Figure 4A.6** covers the top four. White respondents were somewhat more likely than other race/ethnicity groups to select "Depression, anxiety, PTSD [post-traumatic stress disorder], or chronic stress (66%), but less likely to select diabetes (28%). In fact, Hispanic respondents were almost twice as likely as white respondents to select the diabetes response option. Black or African American respondents were about 50% more likely than Hispanic or white respondents to report chronic pain as having a big impact on their own health or that of their loved ones. As is the case for females[50], mounting evidence shows that Black or African American patients are both more likely to report chronic pain and less likely to have that pain recognized and appropriately addressed.[51] Black respondents were less likely than other race/ethnicity groups, however, to select the "heart disease, stroke, or high blood pressure" option.

Fig. 4A.6 Top 4 health issues CHNA survey respondents rated as having the biggest impact on themselves and/or their loved ones, by race/ethnicity, 2025

Bexar County, Texas



**Data suppressed for privacy for race/ethnicity groups not shown.
Source: CHNA Bexar County Survey
Prepared by CINow for The Health Collaborative

OUR OVERALL HEALTH & RESILIENCE

Measures like self-rated health and the impact of illness on daily life help reveal not only individual health status, but also community resilience. Together, they offer insight into how well a population manages physical and mental health challenges and its broader capacity to thrive.

General Health Status

The Behavioral Risk Factor Surveillance System (BRFSS) survey asks adults to rate their health as "excellent", "very good", "good", "fair", or "poor" to monitor perceived general health status in the population. Though a subjective measure, it is a reliable predictor of important health outcomes and is considered a "good global assessment of a person's well-being".[52]

Overall, 79% of Bexar County survey respondents reported having "good", "very good", or "excellent health", based on a seven-year average from 2017 to 2023 (**Fig. 4B.1**).White adults (86%) were more likely than Hispanic adults (74%) and the county overall (79%) to report good or better health. There were also some statistically significant differences by geographic sector. The Far Northwest (85%) and Far Northside (91%) sectors had the highest proportions of adults self-reporting good or better health (**Fig. 4B.2**). Specifically, the Far Northwest reported higher proportions compared to the Southeast and Near Westside sectors, while the Far Northside had a higher proportion than all sectors except for the Northeast and Far Northwest. With most margins of error overlapping, other differences should be interpreted with caution.

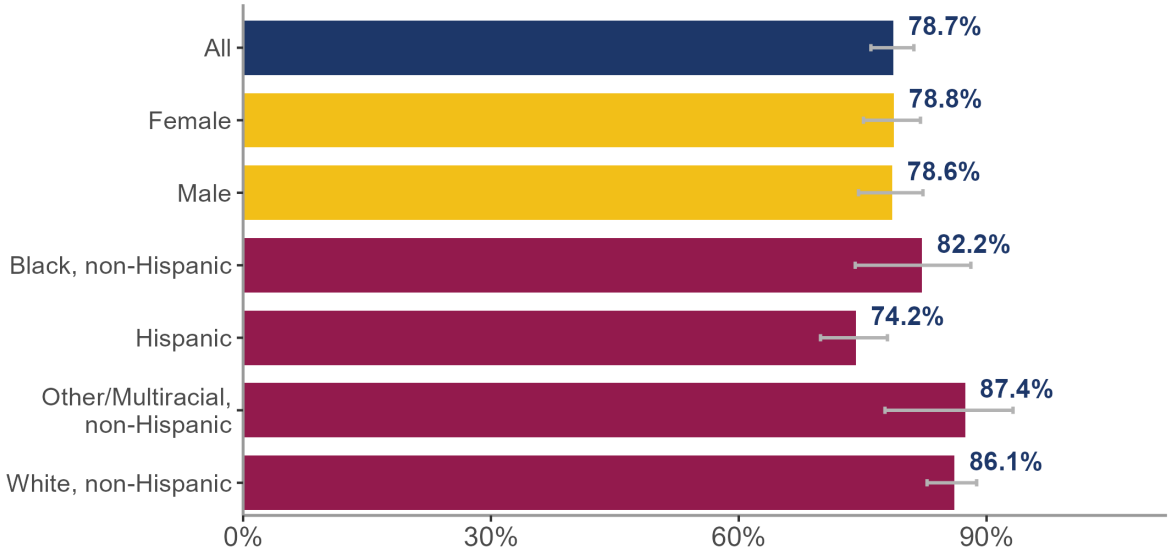
Geographic disparities were highlighted by focus group participants, key informants, and CHNA Community Survey respondents, often discussing differences in medical resources, providers, and infrastructure, especially for rural communities, including the South Side and the West Side.

"There is a dividing line for quality Healthcare, like there is for life expectancy in Bexar County. The treatment and care received at medical facilities South of US 90/I-10 is significantly poorer than the care received in facilities in the north. It is as if the expectation is to only prolong life with treatment for those in the south vs finding a cure for those with access to providers in the north. Also displayed by the level of access to specialists south of US 90."

– CHNA Community Survey Respondent

Fig. 4B.1 Percent of adults with self-reported good or better health, by sex and race/ethnicity, 2017-2023

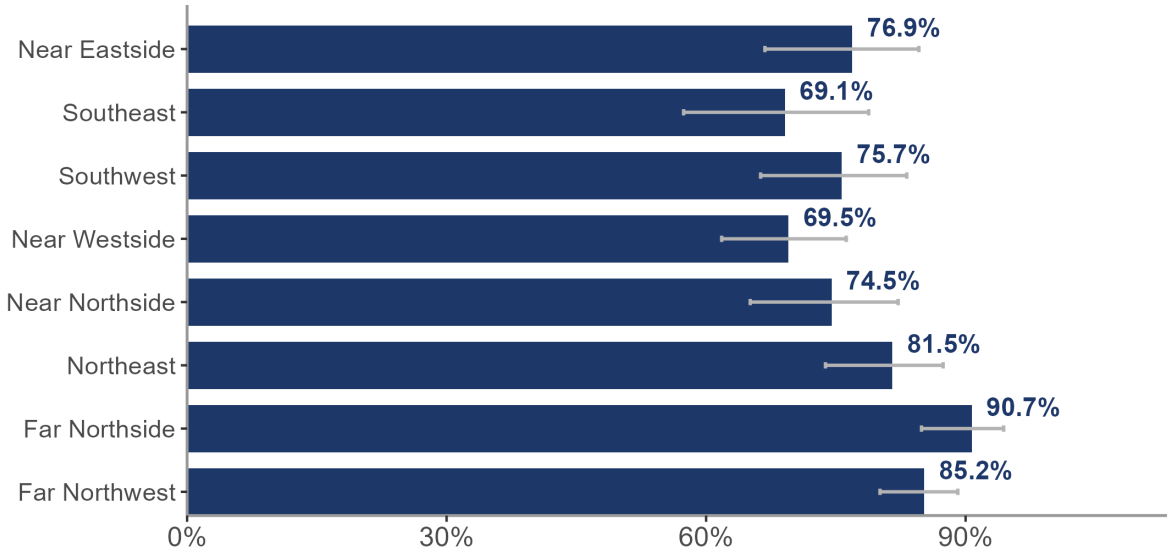
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 4B.2 Percent of adults with self-reported good or better health, by sector, 2017-2023

Bexar County, Texas



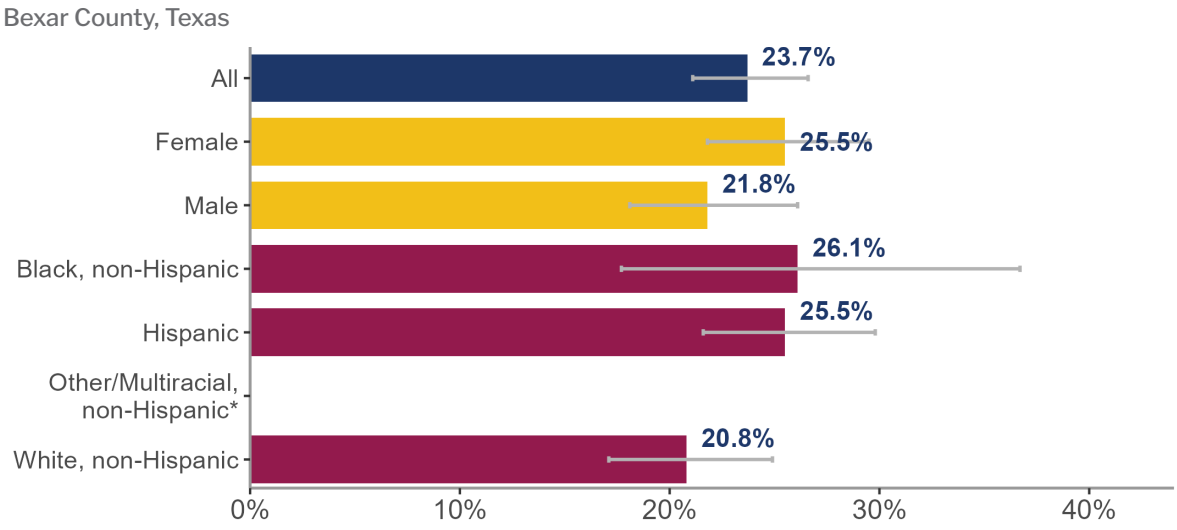
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Daily Life Limitations

The BRFSS survey asks respondents about how many days in the past 30 days poor physical or mental health kept them from usual activities like self-care, work, or recreation. While the CDC standard threshold to indicate frequent mental or physical distress is over 14 days, shorter periods like over five days of disruption can still meaningfully impact functioning and overall health and well-being.

Overall, about one in four respondents reported being kept from usual activities for more than five days in the past month due to poor physical or mental health based on a seven-year average between 2017 and 2023. With overlapping margins of error, differences among groups in **Figure 4B.3** and among sectors in **Figure 4B.4** should be interpreted with caution.

Fig. 4B.3 Percent of adults kept from usual activities for 5 or more days a month due to poor physical or mental health, by sex and race/ethnicity, 2017-2023



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

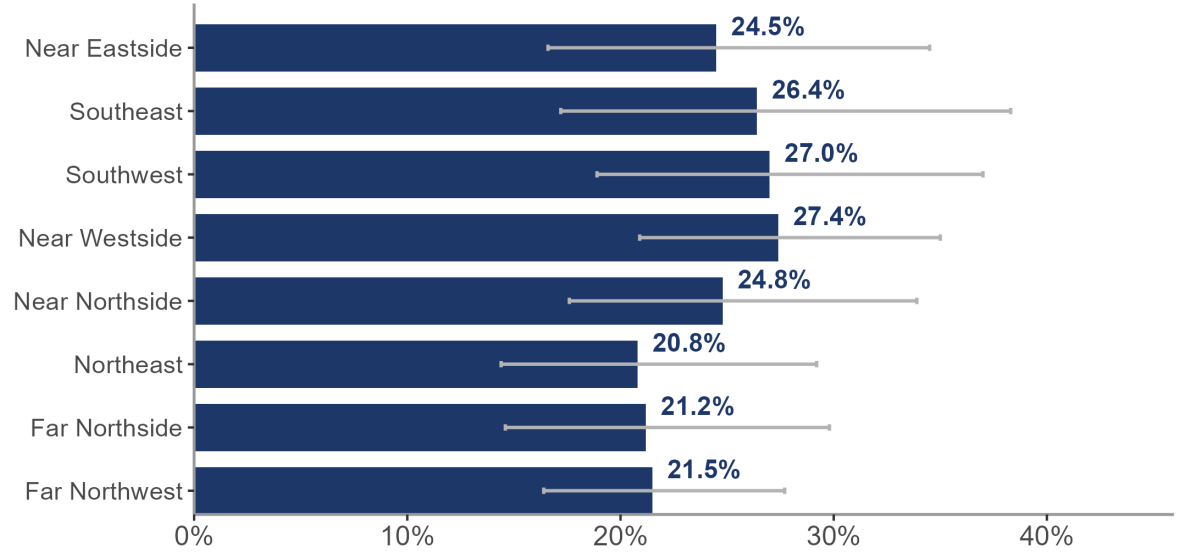
As a focus group participant explains, many continue to face the lasting impacts of COVID-19 on their mental health and well-being, expressing a need for additional resources and services.

"I think that COVID really affected a lot of people's mental wellness... I just don't think a lot of people have healed, because we're still behind on various types of mental health services... and it's still that level of isolation that has not been dealt with... We still need health care, mental health care services, especially from the trauma that probably got brought."

– CHNA Focus Group #2 Participant

Fig. 4B.4 Percent of adults kept from usual activities for 5 or more days a month due to poor physical or mental health, by sector, 2017-2023

Bexar County, Texas

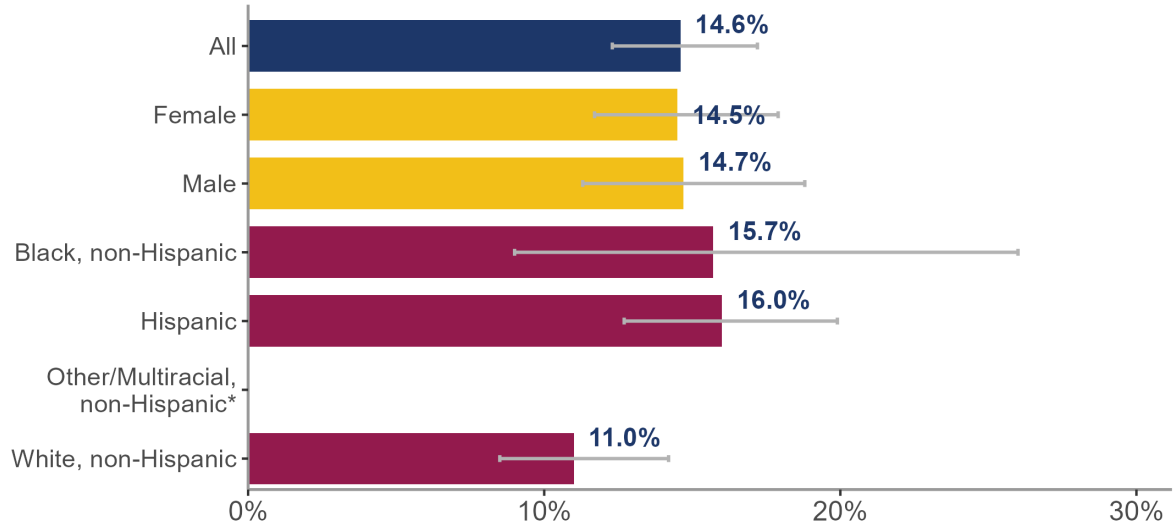


Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

The BRFSS survey asks adult respondents to rate whether they have difficulty concentrating, remembering, or making decisions to better understand the prevalence of cognitive impairments. These challenges could be linked to dementia, mental health conditions, or other underlying factors. Cognitive difficulties can significantly impact daily functioning and overall quality of life. Averaged across the 2017-2023 period, nearly one in seven (15%) Bexar County residents reported having serious difficulty concentrating or making decisions (**Fig. 4B.5**). With wide margins of error, differences across groups in **Figure 4B.5** and sectors in **Figure 4B.6** should be interpreted with caution.

Fig. 4B.5 Percent of adults with serious difficulty oncentrating, remembering, or making decisions, by sex and race/ethnicity, 2017-2023

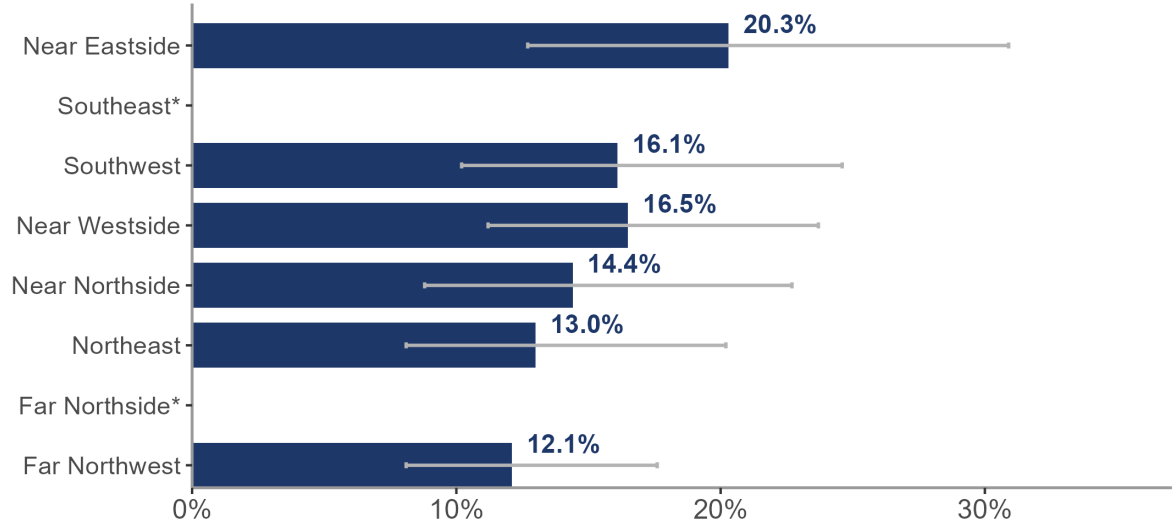
Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 4B.6 Percent of adults with serious difficulty oncentrating, remembering, or making decisions, by sector, 2017-2023

Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

STARTING LIFE STRONG: MOTHERS AND INFANTS

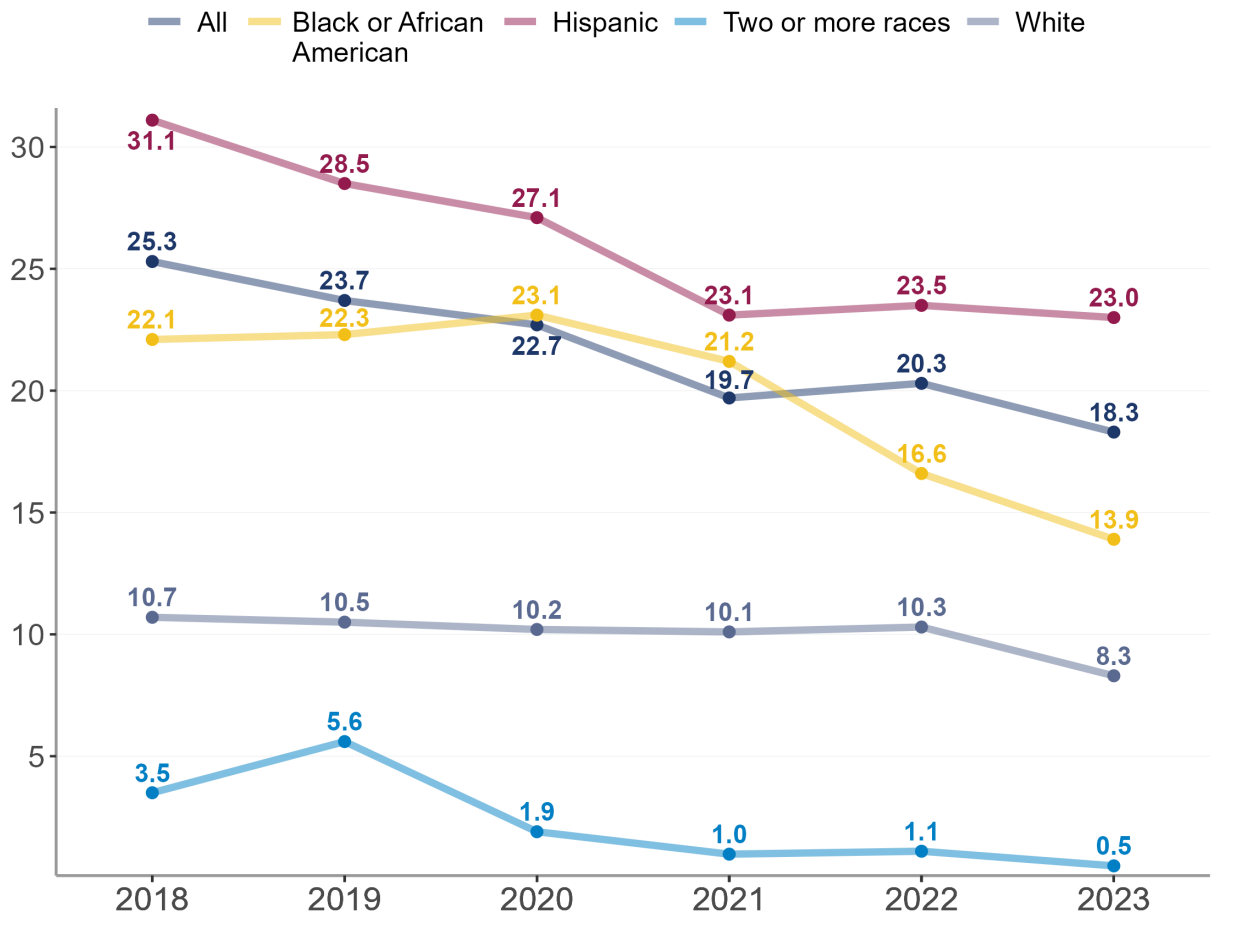
Maternal and infant well-being indicators reflect both medical care as well as broader social and economic conditions that affect prenatal care access. Understanding these patterns not only highlights persistent disparities, but also informs efforts to support healthier beginnings for mothers and infants across Bexar County.

Maternal Well-Being

The birth rate to girls and women aged 15 to 19 continues to decline in every race/ethnicity group, with an overall drop of 28% (**Fig. 4C.1**). The greatest decline – an 86% drop from 3.5 to 0.5 per 1,000 – is among females in the "two or more races" group, but with small numbers and a spike in 2019, that trend should be interpreted with some caution.* The second-greatest decline (37%) was among Black or African American females, from 22.1 in 2018 to 13.9 in 2023. Hispanic teens continue to have the highest rate (23.0 per 1,000), but that rate is 26% lower than the 2018 rate of 31.1.

Fig. 4C.1 Teen birth rate per 1K females aged 15-19, by race/ethnicity

Bexar County, Texas



Source: COSA Metropolitan Health District
Prepared by CINow for The Health Collaborative

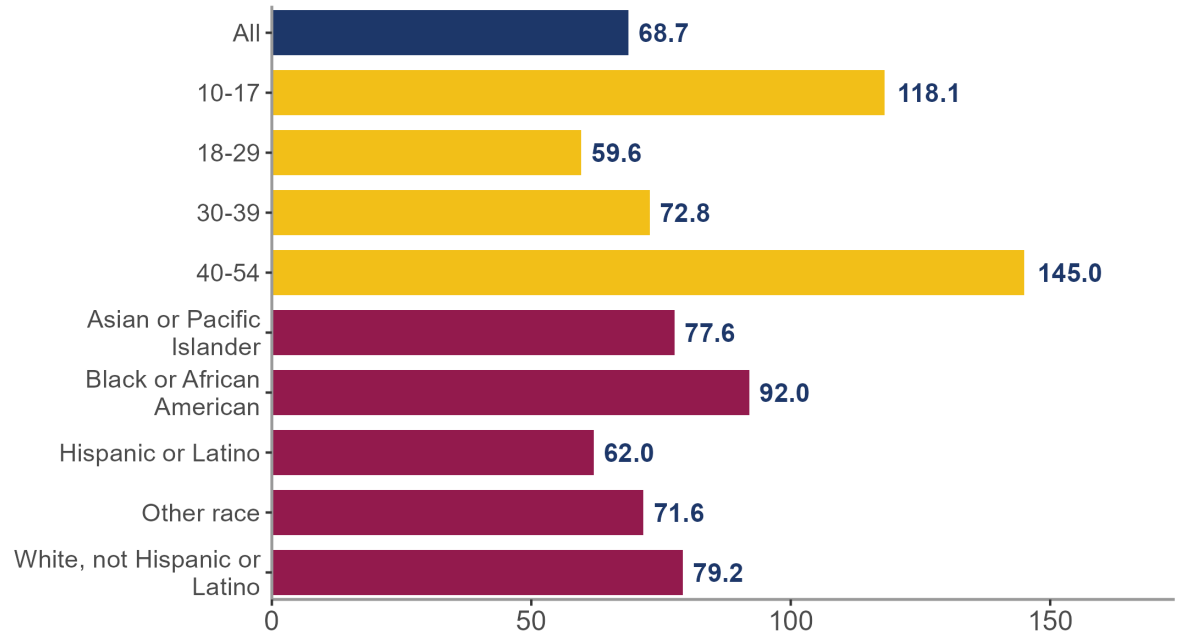
* Low counts for smaller race/ethnicity groups can create rate "bounce", or fluctuation, that exaggerates year-to-year changes.

Severe maternal morbidity (SMM), which the U.S. Centers for Disease Control and Prevention defines as "unexpected outcomes of labor and delivery that can result in significant short- or long-term health consequences," is increasing nationally and in Texas,[53] but to date no data has been available for geographic areas smaller than the multi-county Texas Public Health Region. CINow recently worked with the national Alliance on Innovation in Maternal Health (AIM) to replicate AIM's methodology,[54] calculating SMM for Bexar County. The calculation uses the state hospital discharge dataset, which unfortunately does mean that deliveries at military hospitals are not included. SMM rather than maternal mortality was chosen as the focus because the SMM counts are much larger than maternal death counts, allowing us to look at differences by maternal age and race/ethnicity without risking patient privacy or generating rates that are too unreliable to use.

Figure 4C.2 shows Bexar County's two-year (2022 and 2023 combined) average SMM rate by maternal race/ethnicity and age. Consistent with state and national patterns, by far the highest rate of SMM – 92.0 delivery hospitalizations with SMM per 10,000 deliveries – is among Black or African American females. That rate is 48% higher than the rate among Bexar County Hispanic females and 16%-18% higher than the rate among Asian or Pacific Islander females and non-Hispanic white females. By age, the highest rates were among females 40 and older (145.0 per 10,000 deliveries) and females younger than 18 (118.1 per 10,000 deliveries). Even with two years of data combined, however, the two-year counts for several of the groups in this chart are small,* so rates should be interpreted with that in mind.

Fig. 4C.2 Severe maternal morbidity hospital discharge 2-year average rate per 10K deliveries, by age and race/ethnicity, 2023

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

* Two-year counts for deliveries with severe maternal morbidity (SMM): all n=334; by maternal age: 10-17 years n=9, 18-29 years n=157, 30-39 years n=145, 40-54 years n=23; by maternal race/ethnicity: American Indian or Alaska Native n=0, Asian or Pacific Islander n=11, Black or African American n=27, Hispanic n=182, other race n=32, white n=82, unknown n=0.

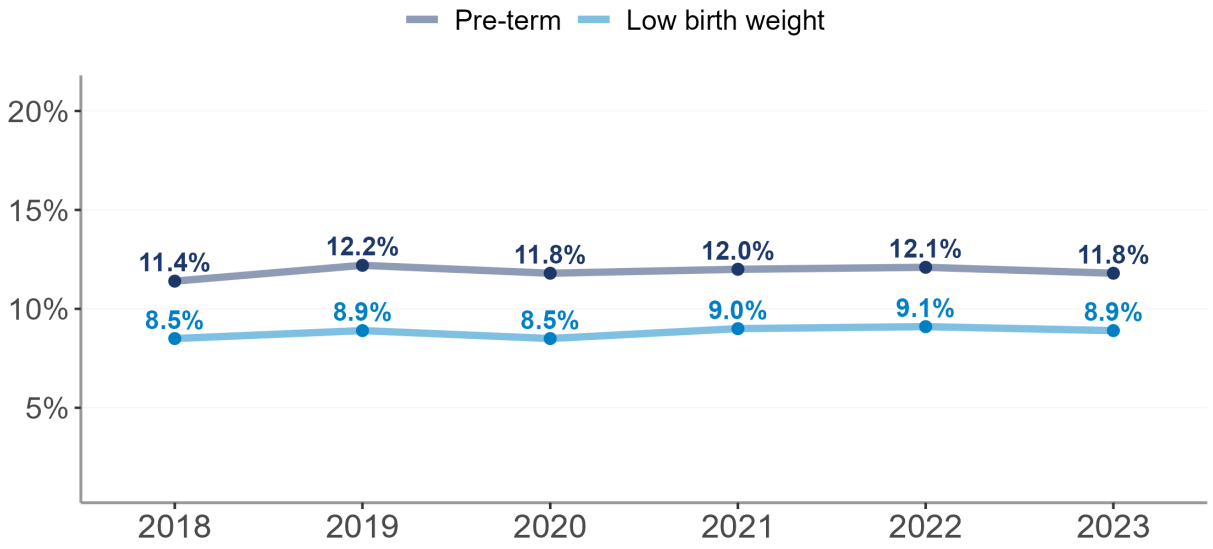
Infant Well-Being

Babies born too early (before 37 weeks of pregnancy) are at an increased risk for challenges and complications, including long-term intellectual and developmental disabilities and higher rates of mortality.[55,56] Low birth weight (under 2,500 grams) is one of the complications associated with pre-term births, though it can also occur in full-term births due to other factors.[57] Both often require extended hospital stays, specialized medical treatment, and long-term follow-up care, putting a strain on the mother, families, and healthcare systems.

The percentage of births that are pre-term or low birthweight both remained relatively flat between 2018 and 2023, which is somewhat unexpected given the decline in prenatal care noted earlier in this report (**Fig. 4C.3**). Race/ethnicity disparities persist, with births to Black mothers more likely than births to mothers of other race/ethnicity groups to be low birthweight or pre-term (**Fig. 4C.4**).

Fig. 4C.3 Percent of pre-term and low-birth weight births

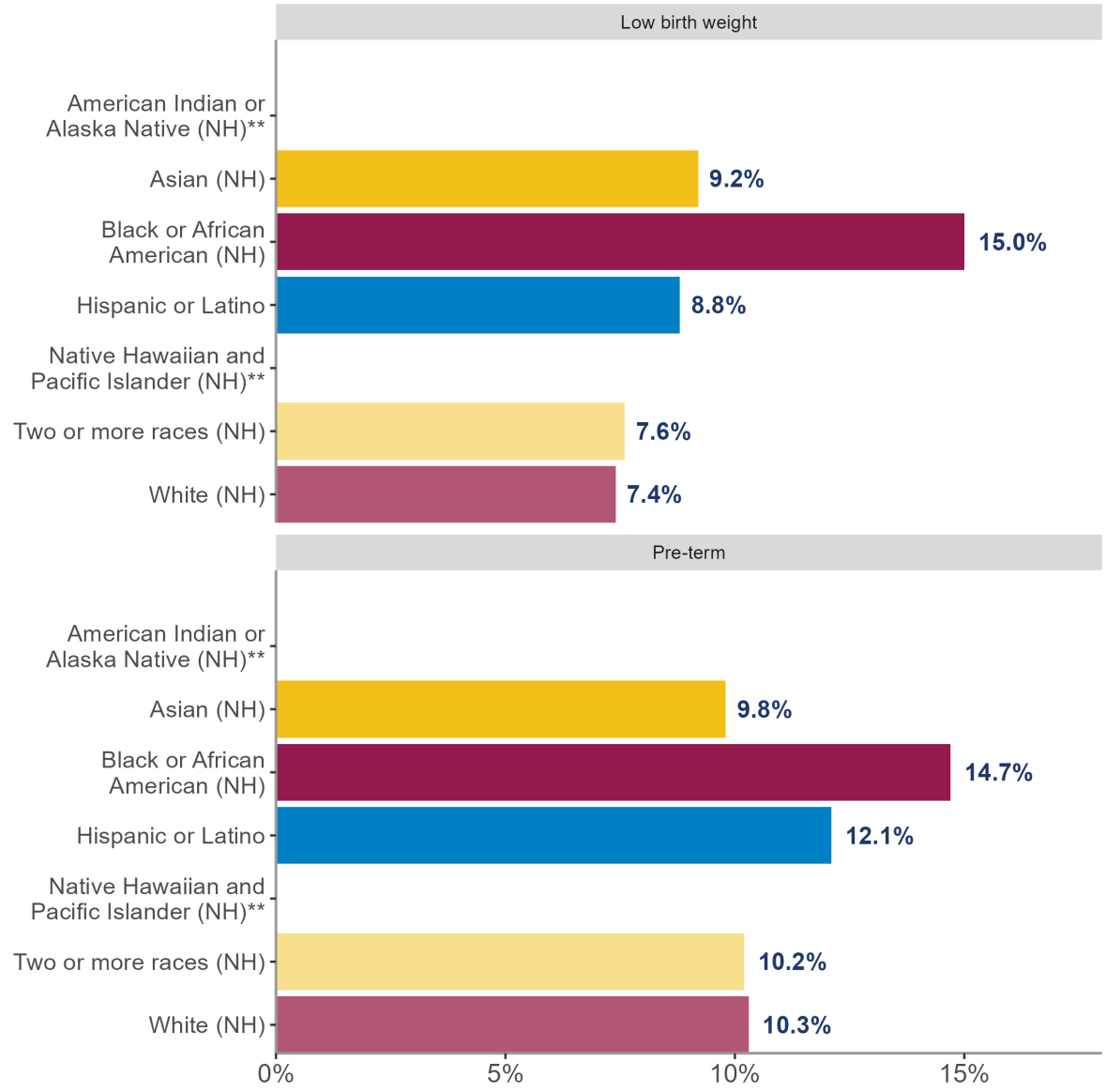
Bexar County, Texas



Low birth weight= under 2,500 grams
Source: COSA Metropolitan Health District
Prepared by CINow for The Health Collaborative

Fig. 4C.4 Percent of pre-term and low-birth weight (LBW) births, by race/ethnicity, 2023

Bexar County, Texas



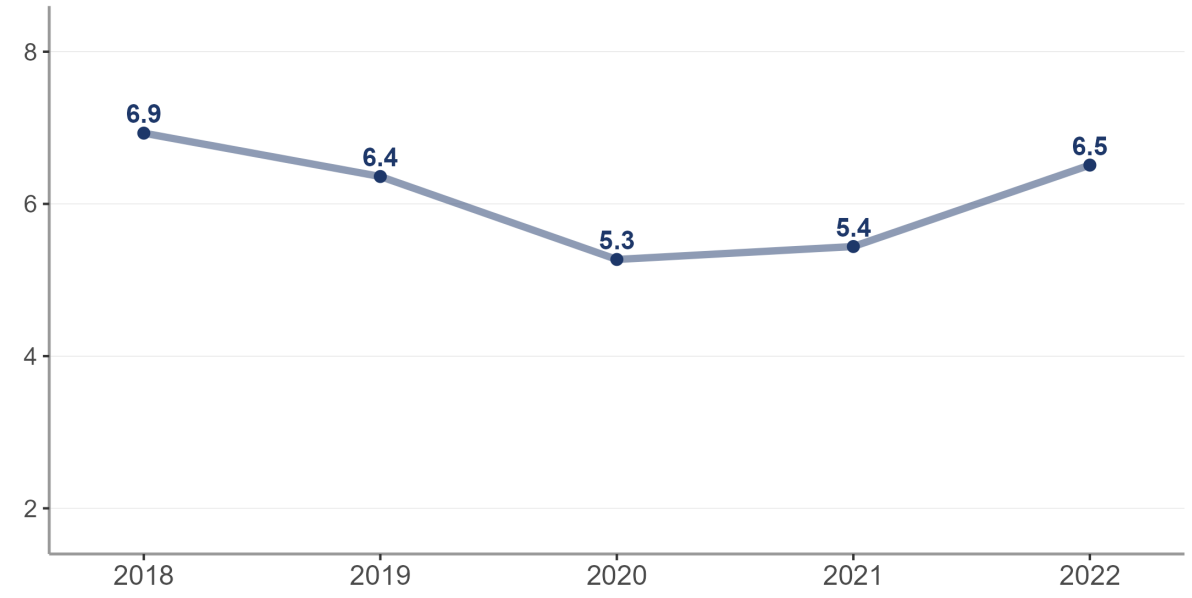
LBW= under 2,500 grams, NH= Not Hispanic or Latino
**Suppressed by data source.
Source: COSA Metropolitan Health District
Prepared by CINow for The Health Collaborative

The infant mortality rate, also called the infant death rate, is a widely recognized and sensitive marker of a population's overall health and well-being. It reflects broader social, economic, and healthcare conditions that affect both maternal and infant outcomes, particularly access to quality care. Infant death rates include both neonatal deaths (within the first 28 days after birth) and post-neonatal deaths (from 28 days to one year). The most common causes include pregnancy or birthing complications, premature birth, sudden infant death syndrome (SIDS), and unintentional injuries.[58]

Figure 4C.5 shows the infant death rate per 1,000 live births in Bexar County over a five-year period (from 2018 to 2020). There was a steady decline from 2018 to 2020, followed by an upward trend in the most recent years. While the 2022 rate (6.5 deaths per 1,000 births) reflects an increase, it remains slightly lower than the five-year high in 2018 of 6.9.

Fig. 4C.5 Infant death rate per 1K births

Bexar County, Texas



Source: CDC WONDER Linked Birth/Infant Death Records dataset
Prepared by CINow for The Health Collaborative

The following three figures (**Fig. 4C.6 to 4C.8**) show different breakdowns of infant death (mortality) rates for Bexar County in 2022 by when prenatal care began, the number of prenatal care visits, by parents' race/ethnicity, and by parents' education level. These charts show U.S. Centers for Disease Control and Prevention linked birth and death data, and it should be noted that the quality and completeness of birth certificate data is quite uneven. Further, some data points are suppressed or considered unreliable because of small death counts and population numbers.*

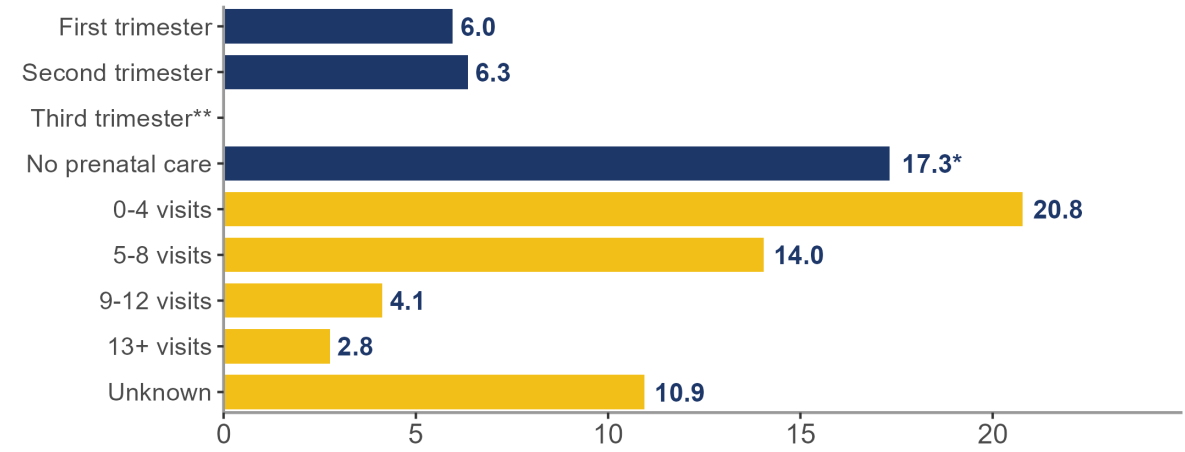
That said, a clear relationship emerges between infant death rate and prenatal care that begins early and continues with frequent visits (**Fig. 4C.6**). Bexar County infant mortality rates were highest for births following fewer than five prenatal care visits (20.8 deaths per 1,000 live births), five to eight visits (14.0), or an unknown number of visits (10.9). The infant mortality rate among infants born after fewer than five prenatal care visits was 7.4 times the rate among infants born after 13 or more prenatal care visits.

At 10.5 deaths per 1,000 live births, the death rate among infants born to Black or African American mothers was roughly twice that of any other maternal race/ethnicity groups (**Fig. 4C.7**). The death rate was also disproportionately high among infants born to fathers who are Black or African American, but the highest rate was among infants born to fathers whose race/ethnicity was unknown or not stated.

* For more information, see the CDC WONDER document at https://wonder.cdc.gov/wonder/help/lbd-expanded.html#.

Fig. 4C.6 Infant death rate per 1K births, by trimester that prenatal care began and number of prenatal visits, 2017-2022

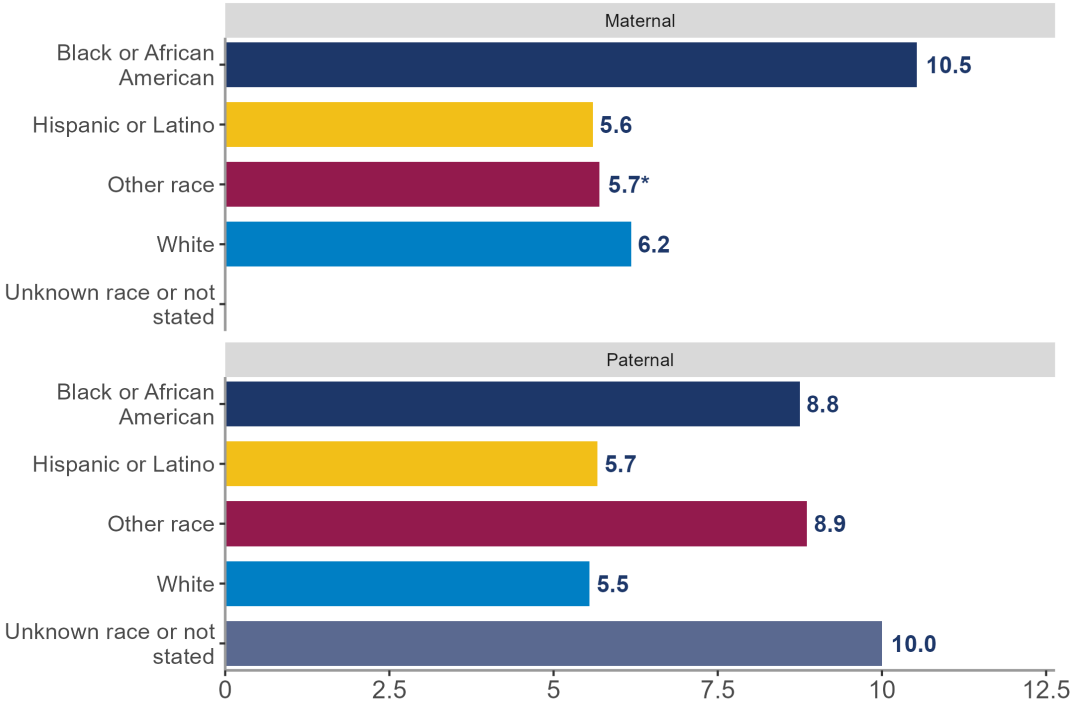
Bexar County, Texas



Rates are marked as "unreliable" when the death counts are less than 20. Rates are marked "suppressed" when the death counts are between 1-9.
*Unreliable: Error is too large relative to estimate.
**Suppressed by data source.
Source: CDC WONDER Linked Birth/Infant Death Records dataset
Prepared by CINow for The Health Collaborative

Fig. 4C.7 Infant death rate per 1K births, by maternal and paternal race/ethnicity, 2017-2022

Bexar County, Texas

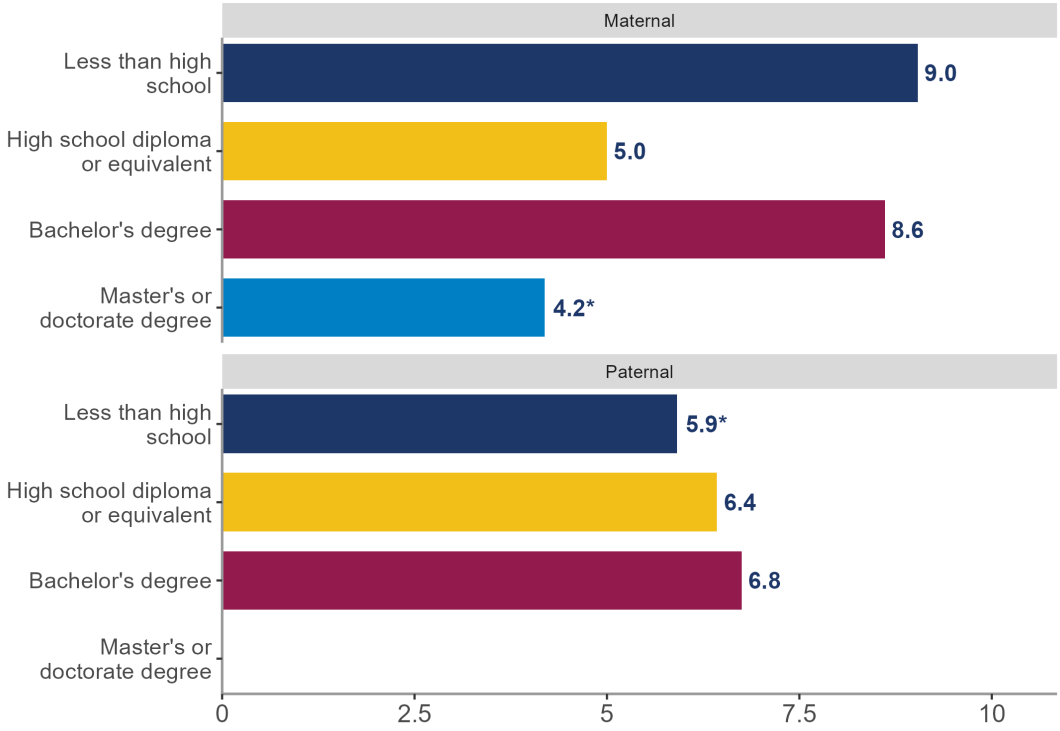


"Other race" includes American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, more than one race, and unknown or not stated. Rates are marked as "unreliable" when the death counts are less than 20.
*Unreliable: Error is too large relative to estimate.
Source: CDC WONDER Linked Birth/Infant Death Records dataset
Prepared by CINow for The Health Collaborative

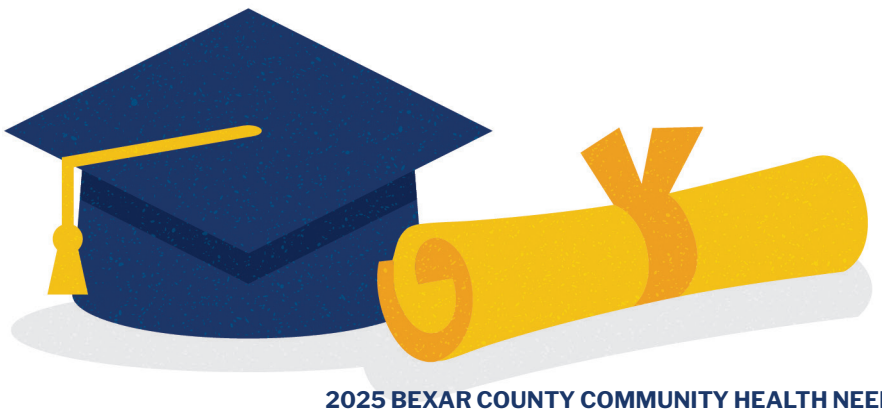
Higher educational attainment is typically associated with better health outcomes, but as was the case for severe maternal morbidity above, the picture is more complicated for infant mortality. The death rates among infants born to mothers without a high school diploma or GED (9.0 per 1,000 live births) and mothers with a bachelor's degree (8.6) were nearly twice as high as the rate among infants born to mothers who completed a high school diploma or GED but not a bachelor's degree (5.0, **Fig. 4C.8**). The association between infant mortality and parental educational attainment is likely confounded or "muddied" by differences in educational attainment by race/ethnicity. Infants born to Black or African American parents tend to experience higher infant mortality rates, and Black or African American residents of Bexar County are more likely (33%) than Hispanic residents (23%) to have a Bachelor's degree or higher.

Fig. 4C.8 Infant death rate per 1K births, by maternal and paternal highest education, 2017-2022

Bexar County, Texas



Rates are marked as "unreliable" when the death counts are less than 20. Rates are marked "suppressed" when the death counts are between 1-9.
*Unreliable: Error is too large relative to estimate.
Source: CDC WONDER Linked Birth/Infant Death Records dataset
Prepared by CINow for The Health Collaborative



Starting life strong is deeply influen ed by broader social and economic conditions. As key informants and focus group participants emphasized, these elements are not isolated issues but part of a larger, interconnected system that affects a family's ability to thrive. Community leaders are especially aware of this connection, recognizing how holistic supports and investments, like childcare, can create positive ripple effects.

"Things like transportation, affordable housing, childcare, all of these types of things. They're all interconnected, and they all are part of the overall fabric that creates an environment where people thrive.

...My budget this year is a $180 million budget. So, we invest about $120 million into childcare. What that means is, you have about 14,000 kids in childcare seats every single day. And it affects about 8,000 families that have the ability to go back to school, get trained, or go back to work.

The results of that are... the child has hopefully better development opportunities because of the curriculum at an early age. So that's a longer-term workforce outcome. The parent has the ability to go back to school, get trained or work. Those who are working are probably earning about... upwards of $27 million every single month. Because childcare allows them the access to go back to work. So that gives you kind of a snapshot of like the importance of childcare."

– Adrian Lopez (CEO, Workforce Solutions Alamo)

SUPPORTING BEHAVIORAL HEALTH

Mental health influences every aspect of a person's life, from managing stress and maintaining healthy relationships to broader areas like economic stability. It also has a reciprocal relationship with physical health; for instance, mental health can potentially worsen physical conditions and contribute to unhealthy behaviors such as substance use, including drug poisoning. Left unaddressed, mental health issues have long-term consequences, placing a burden on families, schools, hospitals, and social services.

Certain populations are not only more vulnerable to poor mental health due to social and economic factors, but also face more barriers to accessing timely and appropriate care. Ensuring early, equitable, and effective support is essential to crisis prevention, long-term recovery, and building a healthier and more resilient community.

Mental Health

The BRFSS survey asks adults if a doctor, nurse, or other healthcare professional has ever told them that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression.[59] While this indicator is based on self-reported diagnosis history, it still offers insight into an individual's interaction with the healthcare system and their recognition of mental health needs. All prevalence rates drawn from BRFSS data should be understood to be an undercount, as for the respondent to answer "yes" to that question, they must have visited a health care professional, been assessed for that condition, been told and understood the diagnosis, and remembered it weeks to decades later.

Mental health and stress were also prevalent themes in the CHNA Community Survey open-ended responses, particularly the need for more accessible mental health resources. Mental health was also a concern for focus group participants and key informants. As one focus group participant put it, the COVID-19 pandemic shined a light on mental health, along with other health issues.

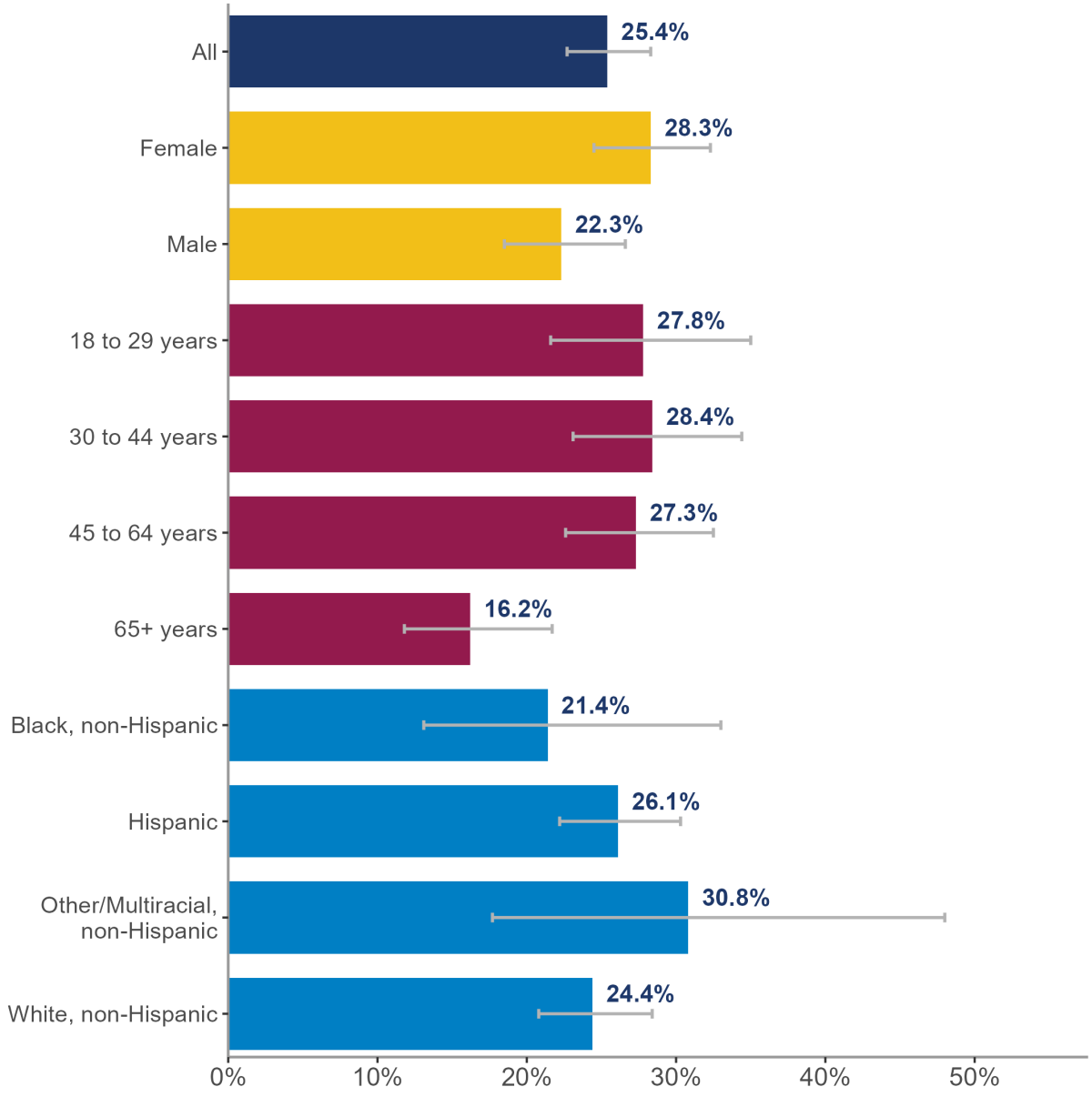
"That COVID situation revealed it. There's a mental problem here. There's a hunger problem here. There's a housing problem here. This, we're struggling. It made you really focus on that stuff now."

– CHNA Focus Group #2 Participant

Overall, about one in four (25%) Bexar County survey respondents reported ever having been diagnosed with a depressive disorder (**Fig. 4D.1**). Notably, adults 65 and older are significantly less likely to report a depressive disorder diagnosis compared to all other age groups and the county average, with only a slight overlap with the 18-29 age group. Other differences across groups in **Figure 4D.1** and sectors in **Figure 4D.2** should be interpreted with caution.

Fig. 4D.1 Percent of adults who have ever been told by a healthcare provider they had a depressive disorder, by sex, age, and race/ethnicity, 2017-2023

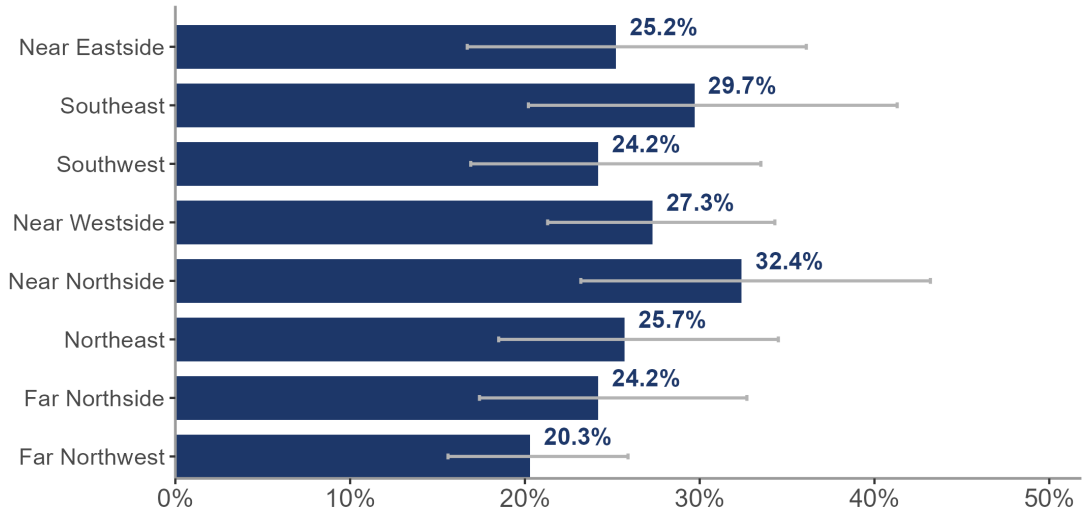
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 4D.2 Percent of adults who have ever been told by a healthcare provider they had a depressive disorder, by sector, 2017-2023

Bexar County, Texas

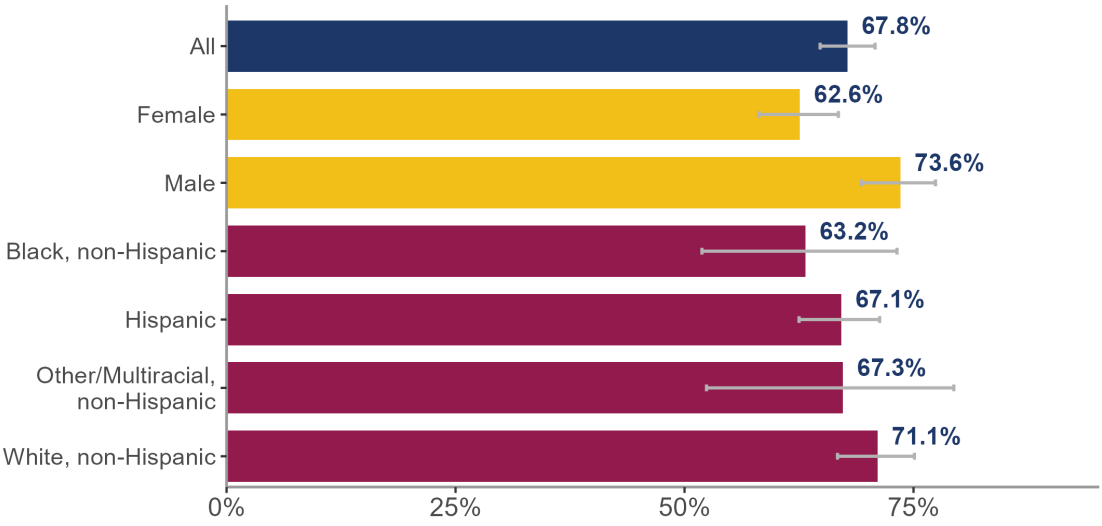


Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

The BRFSS survey asks respondents about how many days in the past 30 days their mental health was "not good", including stress, depression, and problems with emotions. Disruptions over five days can meaningfully impact functioning, overall health, and well-being. Overall, about two-thirds of respondents reported fewer than five days of poor mental health based on a seven-year average between 2017-2023 (**Fig. 4D.3**). While positive, it also means that

Fig. 4D.3 Percent of adults reporting fewer than 5 days of poor mental health in the past 30 days, by sex and race/ethnicity, 2017-2023

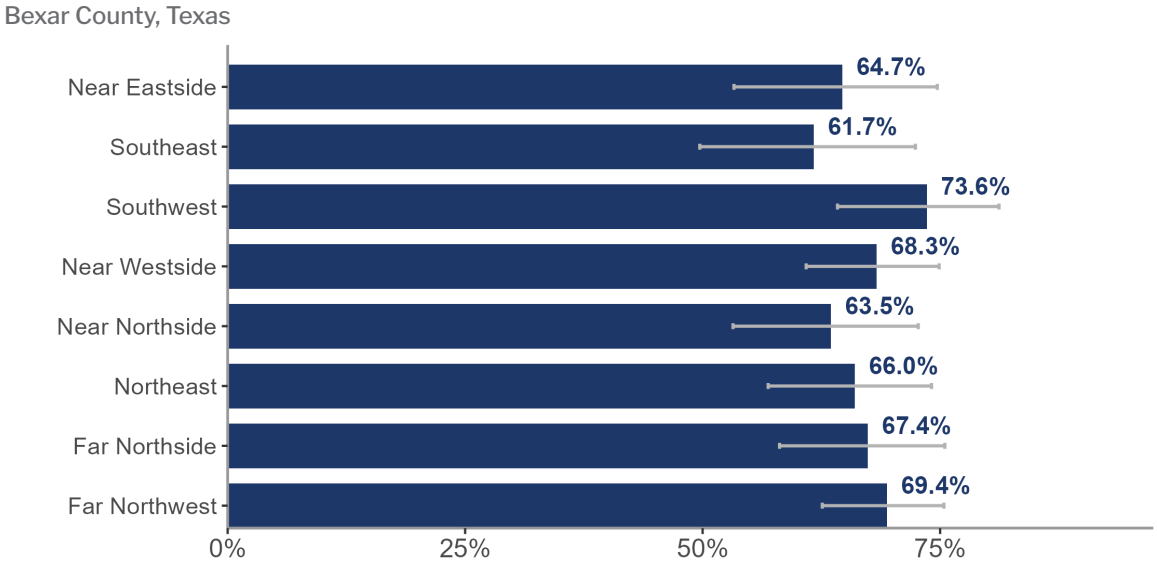
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

a substantial portion of residents experienced more than five days of poor mental health. When broken down by sex, a greater proportion of male respondents (74%) than female respondents (63%) reported experiencing fewer than five days of poor mental health. Other differences across groups in **Figure 4D.3** and sectors in **Figure 4D.4** should be interpreted with caution.*

Fig. 4D.4 Percent of adults reporting fewer than 5 days of poor mental health in the past 30 days, by sector, 2017-2023



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

ABOUT HOSPITAL DISCHARGE AND EMERGENCY DEPARTMENT VISIT RATES

The hospital discharge and emergency department (ED) visit rates shown in this report are three-year averages, which helps minimize "bounce" in the trend line, particularly when the counts are relatively small. The rates represent hospital discharges or ED visits, not the number of people with a hospital discharge or ED visit, and are an undercount because military hospitals are not included in the dataset.

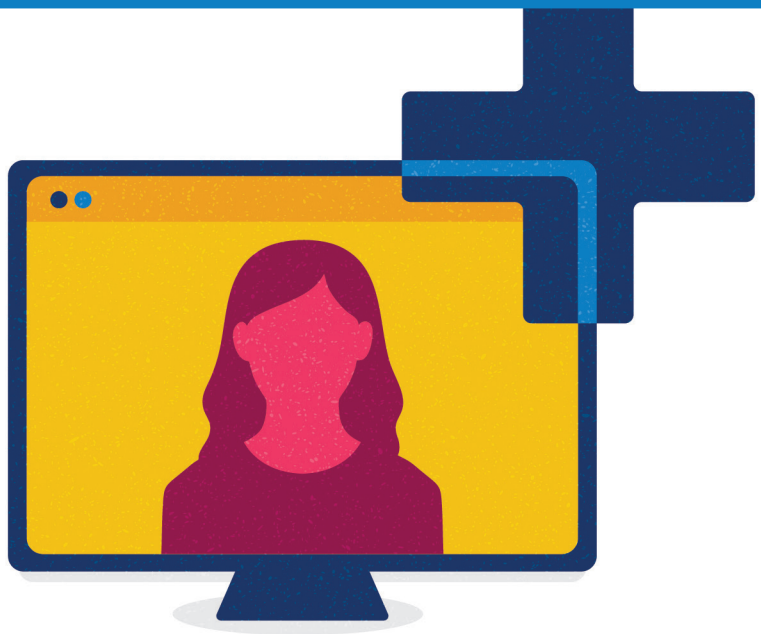
* Differences among groups may not be statistically significant due to limited data or overlapping margins of error.

Hospital discharge with a primary diagnosis of mental illness, shown as a three-year average per 10,000 Bexar County residents, varies greatly by age and race/ethnicity (**Fig. 4D.5** and **Fig. 4D.6**). Despite an overall downward trend from 2017-19 to 2021-23 across most groups, nearly all age and race/ethnicity groups experienced a low point in 2019-21, followed by a rise in 2020-22 and a slight decline again in 2021-23. This trend is reflected in the countywide rate, which declined 39% between 2017-19 and 2019-21, jumped to 34% in 2020-22, and settled to 66.2 in 2021-23 – an overall 29% decrease from the 2017-19 rate. Interpretation of the trend line must take into account pandemic-driven changes in inpatient and ED use for conditions other than COVID. We know that mental health overall did not improve during the pandemic, so the pandemic-era drop in mental illness-related hospital stays almost certainly reflects the loss of a source of care rather than a reduction in mental illness.

Telemedicine during the pandemic made, and continues to make, behavioral health easier,

"We did a lot of telemedicine, especially in behavioral health, and that is something that has continued. People like having their sessions virtually, instead of having to drive all the way to one of our clinics, and they have proven to be equally effective to in-person appointments. But as we have learned through our work to advance digital equity, there are still a lot of places where connectivity is an issue—even in a large city like San Antonio. So, while virtual counseling may be a remnant of the pandemic that has continued, it has underscored the need to ensure that more people are connected, especially in rural areas where access to care may be more limited."

– Jaime Wesolowski (President/CEO, Methodist Healthcare Ministries)

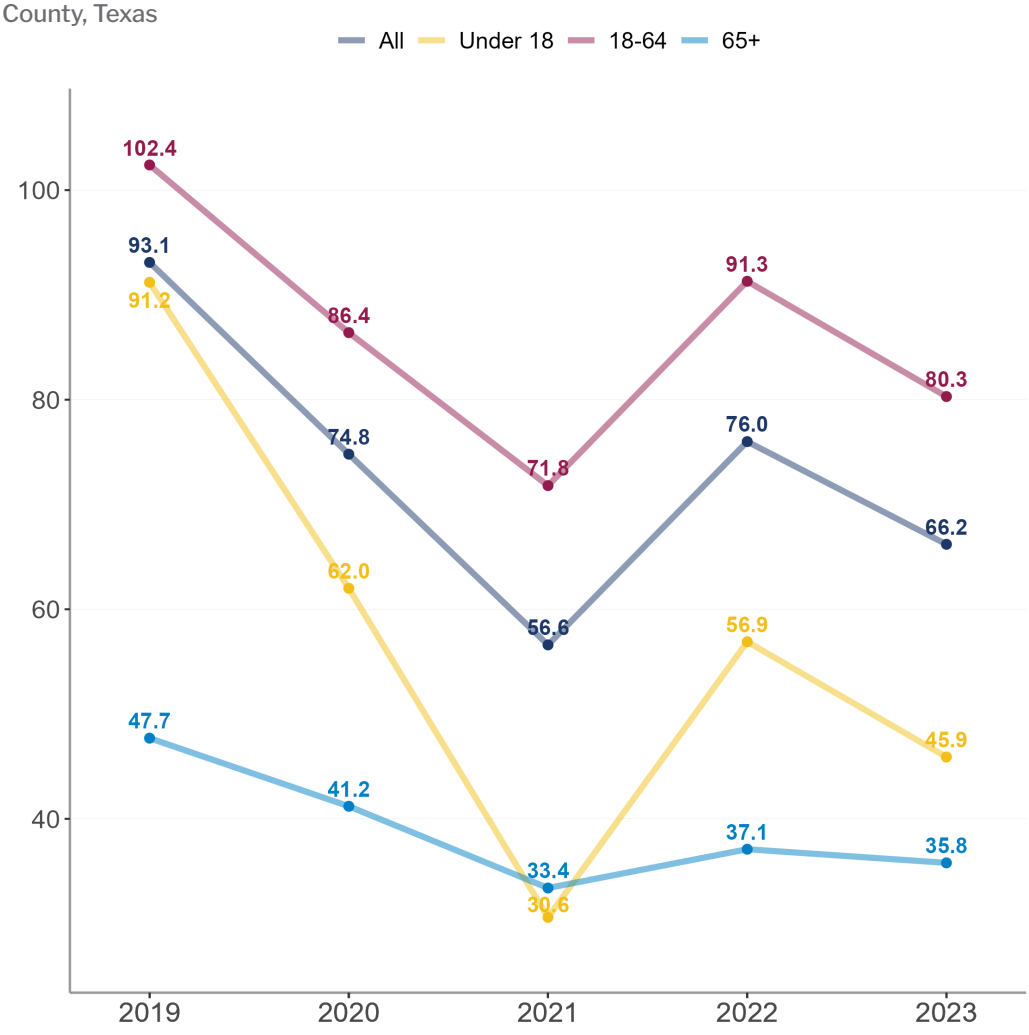


By age (**Fig. 4D.5**),

- Adults aged 18 to 64 consistently experienced the highest rates throughout the period, reaching a three-year average rate of 80.3 per 10,000 in 2021-23.
- Children and adolescents (aged 18 and under) also had relatively high rates early on, beginning at 91.2 in 2017-19, before plummeting by two-thirds to 30.6 in 2019-21 – the sharpest decrease of all age groups – and then rebounding slightly to 45.9 in 2021-23.
- Older adults (ages 65 and older) consistently had the lowest hospitalization rates, ranging from 47.7 in 2017-19 to 35.8 in 2021-23. Although the changes over time were not as marked for the 65-and-older group, the 2021-23 rate is 25% lower than the 2017-19 rate, not dissimilar from the 29% reduction in the population overall.

Fig. 4D.5 Mental illness hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



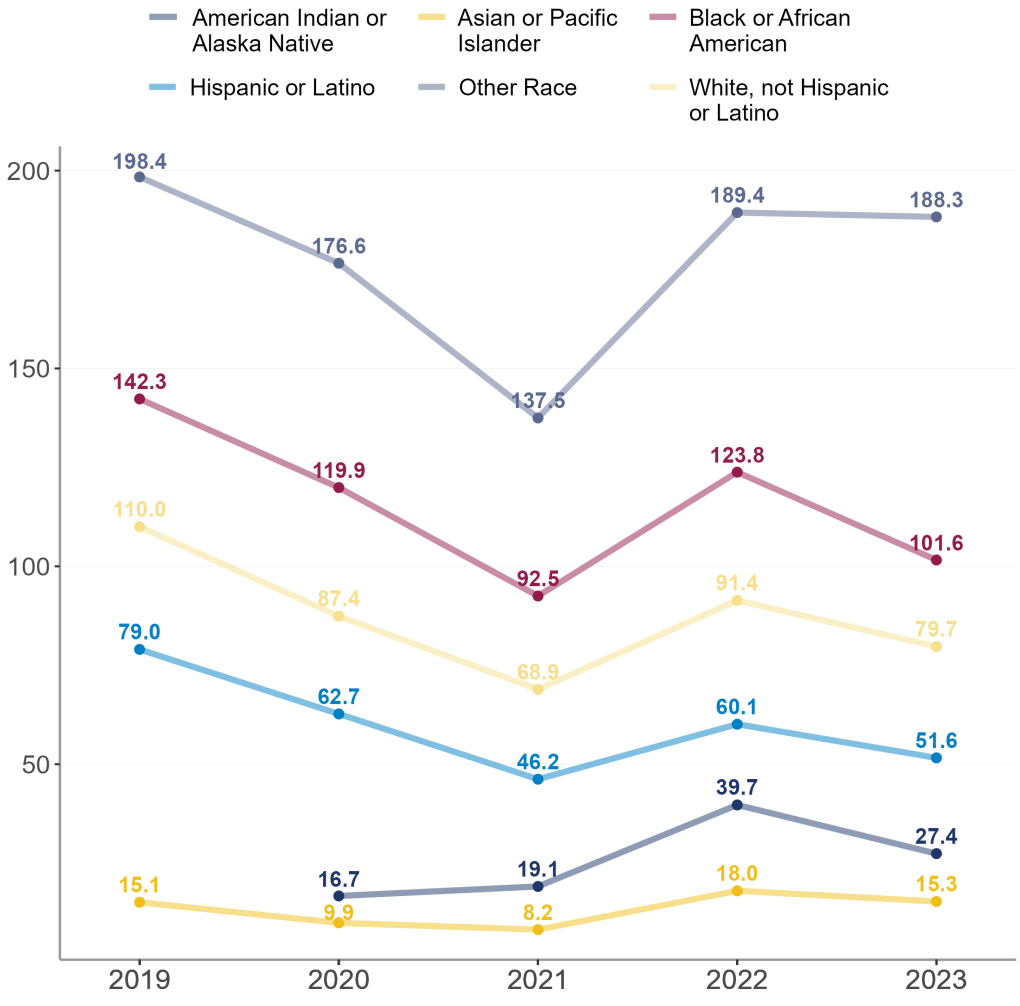
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

By race/ethnicity (**Fig. 4D.6**),

- The "Other race" category had the highest rates throughout the five-year period, ending with 188.3 per 10,000 in 2023. However, this should be interpreted with caution.*
- Black or African American and white (non-Hispanic) residents also experienced relatively high rates in most years, exceeding the countywide average every year.
- Meanwhile, Hispanic or Latino and Asian or Pacific Islander populations consistently had the lowest hospitalization rates with 2023 values of 51.6 and 15.3 per 10,000, respectively.
- Notably, American Indian or Alaska Native residents had limited available data, with no reportable rate in 2019 due to low counts. However, their rates more than doubled from 16.7 in 2020 to 39.7 in 2022, before declining to 27.4 in 2023. This variation may reflect small population sizes rather than a definitive trend.

Fig. 4D.6 Mental illness hospital discharge 3-year average rate per 10K population, by race/ethnicity

Bexar County, Texas



Some values are suppressed due to low counts.
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

* Low counts for some race/ethnicity or other groups may create "bounce" in rates that exaggerates change over time.

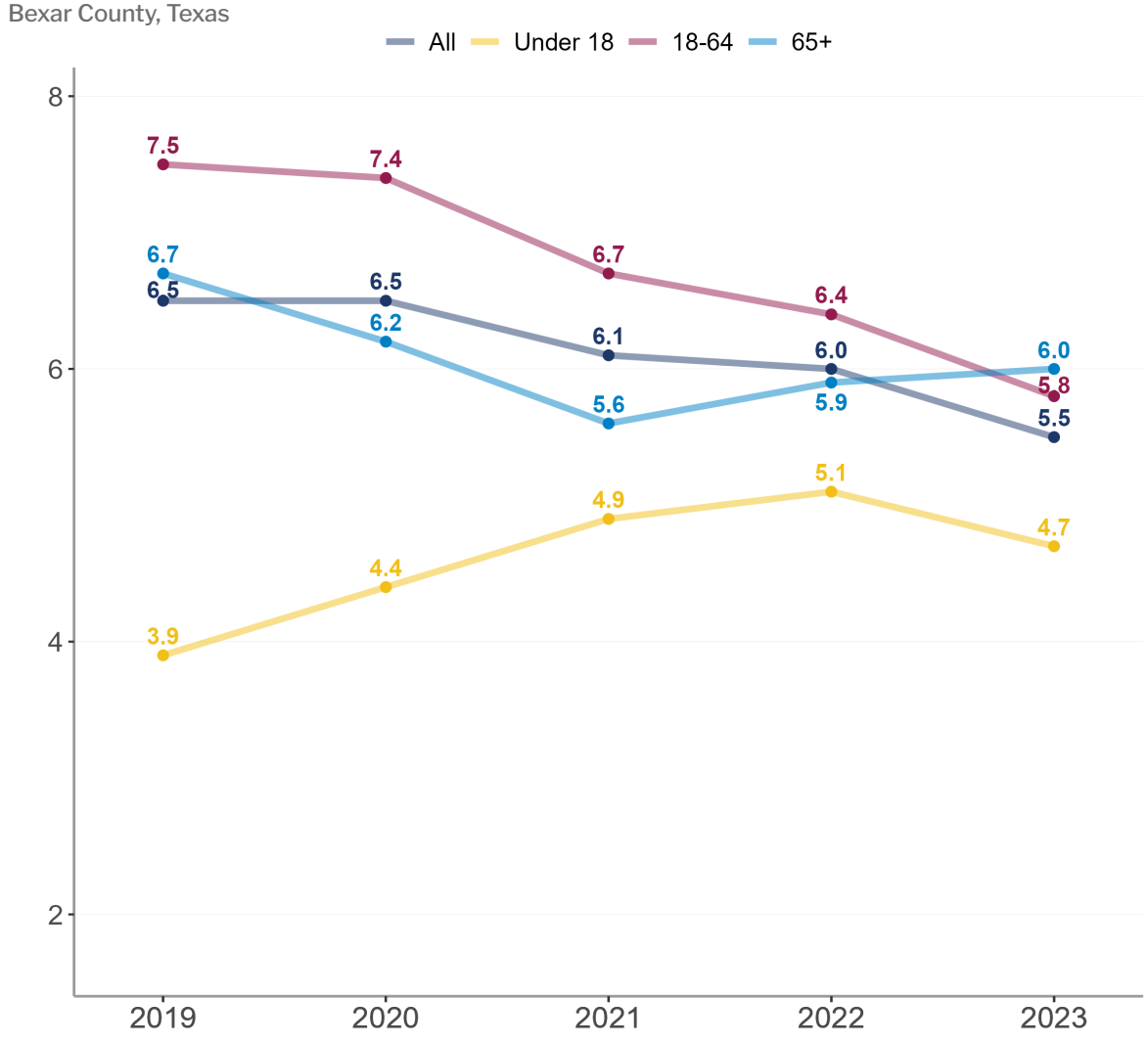
Poisoning by Drugs and Other Substances

The drug poisoning hospital discharge rate measures the number of individuals hospitalized with a primary diagnosis of drug poisoning, whether intentional or unintentional, for every 10,000 people. In Bexar County, the overall rate had a downward trend from 2019 to 2023, reaching a low of 5.5 per 10,000 residents (**Fig. 4D.7**). By age,

- Working-age adults (aged 18 to 64) were the only group that reflected the same pattern as the countywide average. They consistently had the highest hospitalization rates until 2023, when older adults (65 and older) surpassed them.
- The older adult rates dropped from 2019 to 2021, but then steadily increased through 2023, ending with the highest rate of any group at 6.0 per 10,000.
- Although children and adolescents (under 18) had the lowest hospitalization rates across all years, their trend stands out. Unlike the other age groups, their rates increased overall during the five-year period, rising steadily from 3.9 per 10,000 in 2019 to 5.1 in 2022, before declining slightly in 2023.

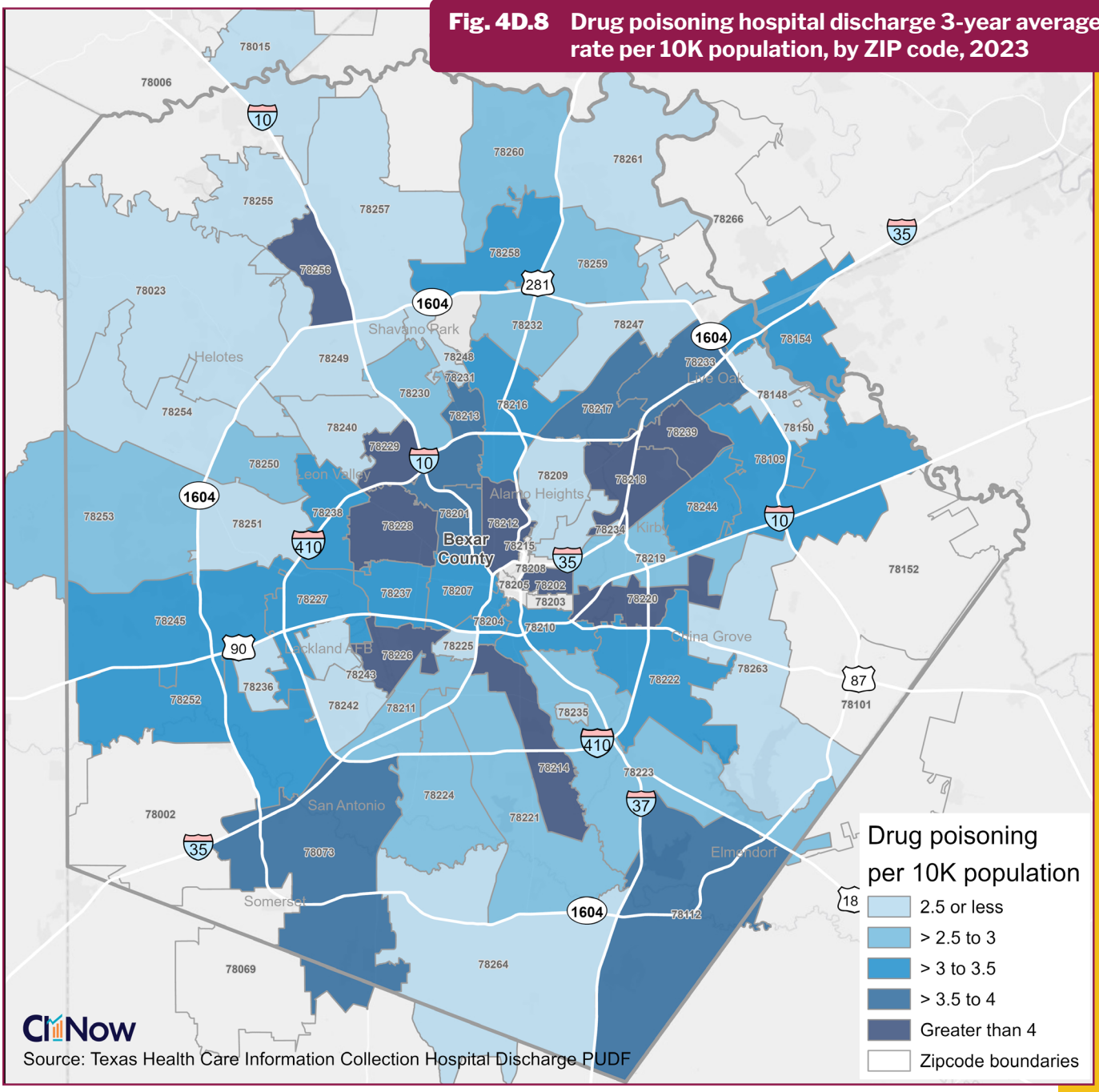
Fig. 4D.7 Drug poisoning hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

Fig. 4D.8 Drug poisoning hospital discharge 3-year average rate per 10K population, by ZIP code, 2023



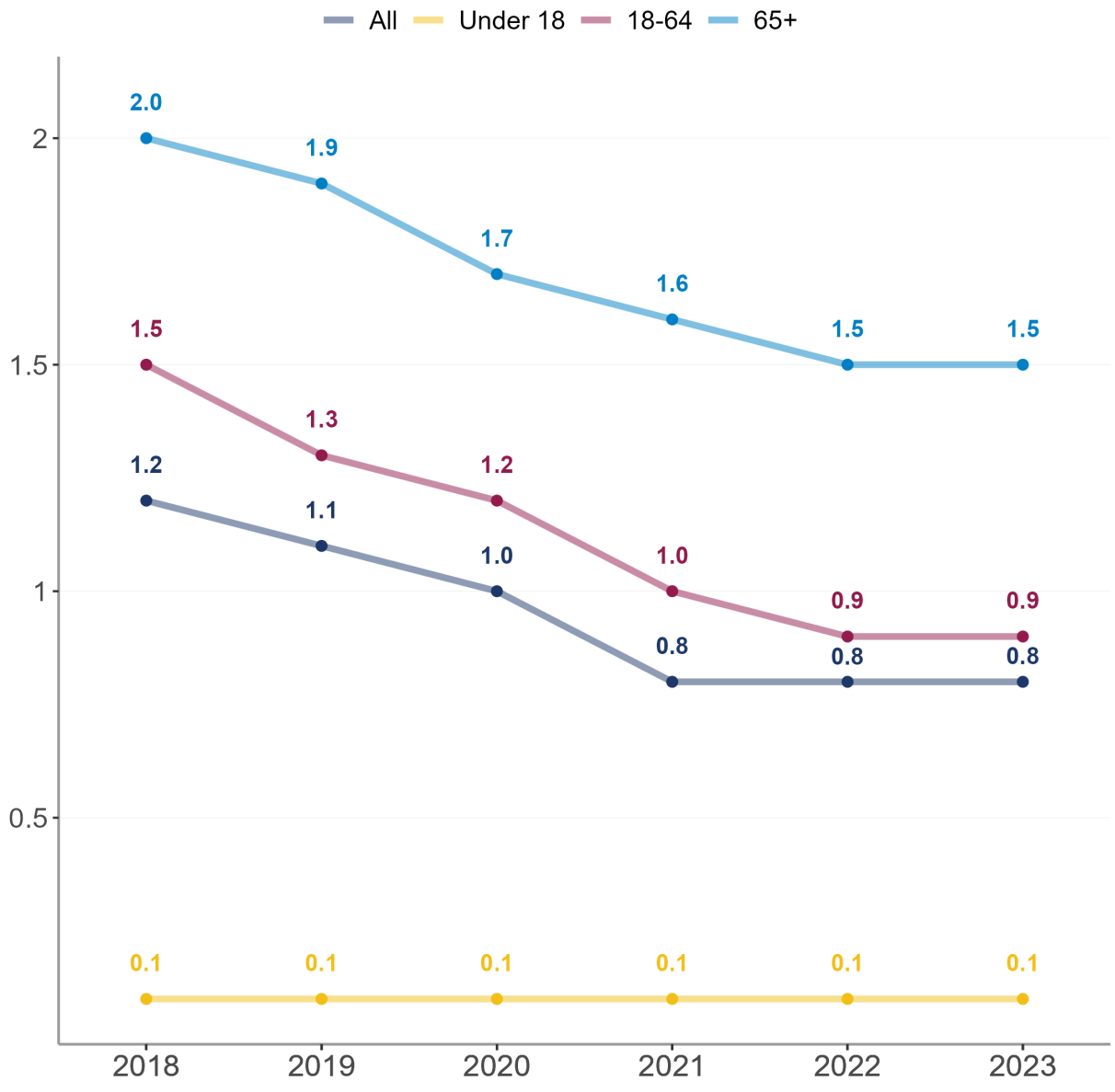
CINow
Source: Texas Health Care Information Collection Hospital Discharge PUDF

Figure 4D.8 maps the rate of hospital discharges with a primary diagnosis of drug poisoning by patient residence ZIP code. No geographic pattern is clearly apparent, but ZIP codes north of the Highway 90 – IH-10 line are overall more likely to have low rates of 2.5 or fewer discharges per 10,000 population.

Figure 4D.9 shows the three-year average rate of hospital discharges with a primary diagnosis of opioid poisoning in Bexar County between 2018 and 2023. Overall, the rates slowly declined over the period, dropping from 1.2 per 10,000 people in 2018 to 0.8 in 2021 and holding steady through 2023. The adult age group followed a similar pattern, with older adults (aged 65 and over) experiencing the highest rates. Children, aged 18 and under, maintained a low but consistent rate of 0.1.

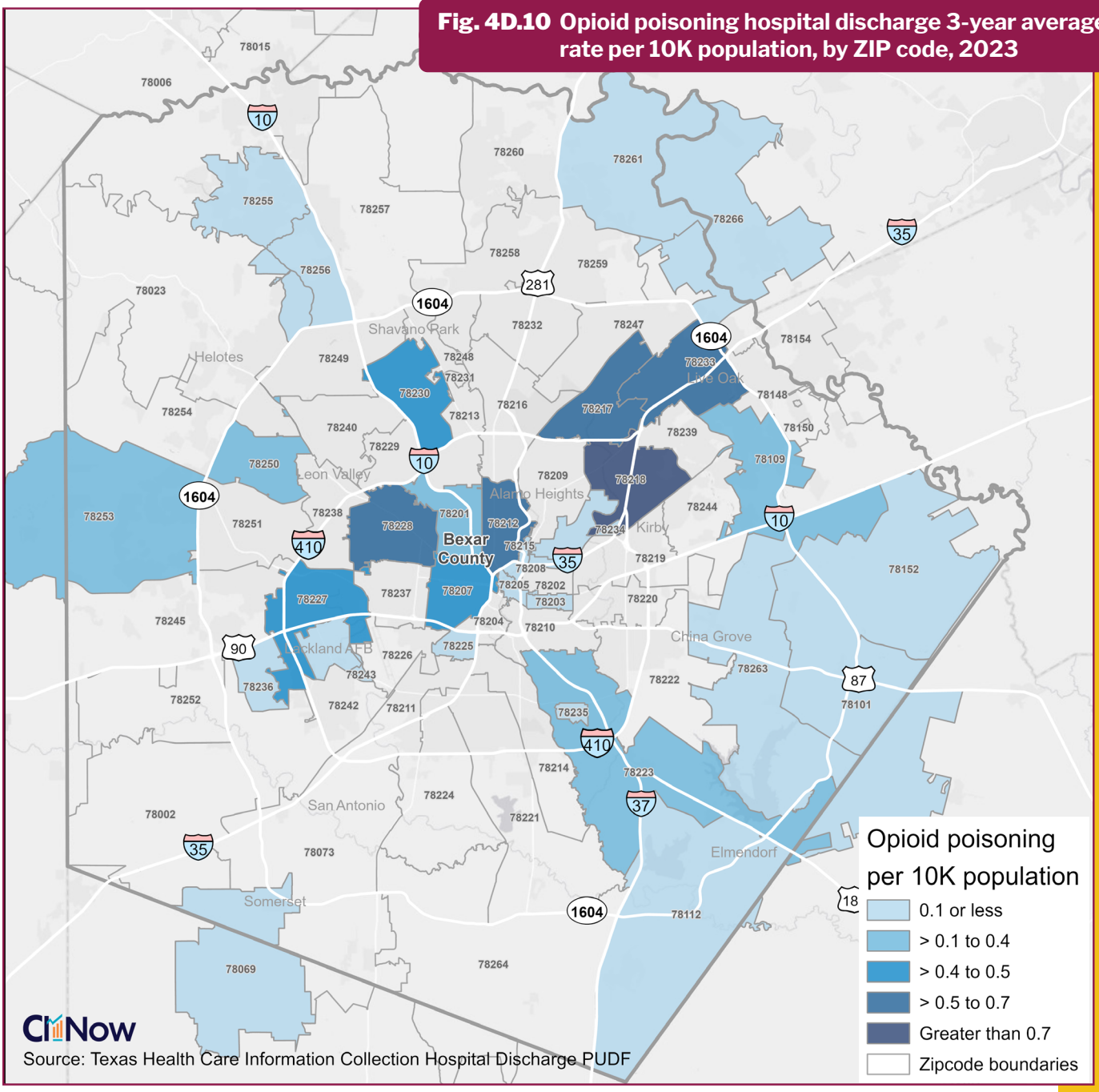
Fig. 4D.9 Opioid poisoning hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

Fig. 4D.10 Opioid poisoning hospital discharge 3-year average rate per 10K population, by ZIP code, 2023

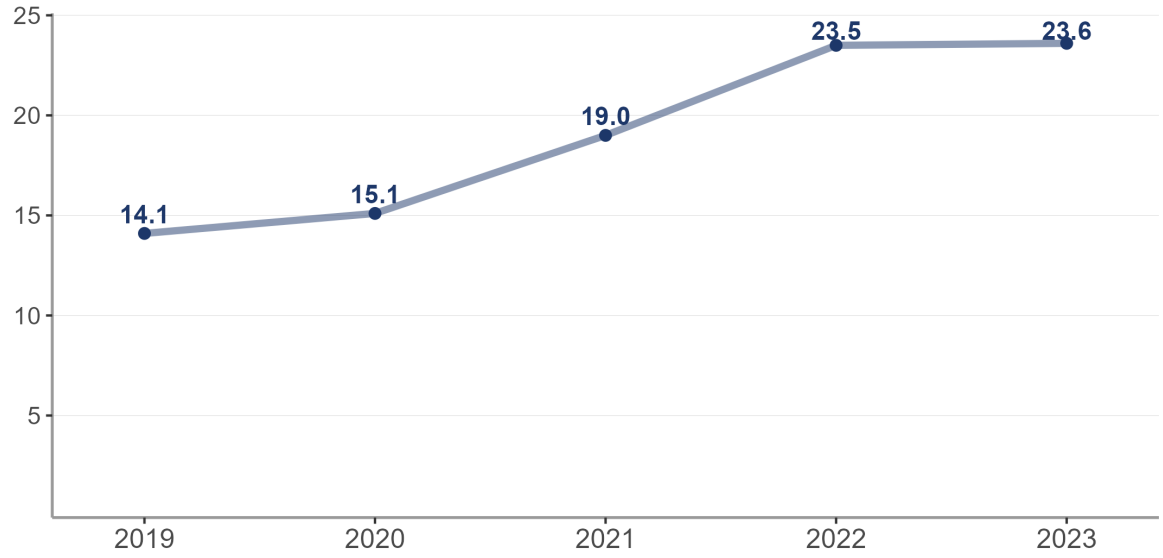


The three-year average opioid poisoning hospital discharge rates per 10,000 residents were highest inside Loop 1604, around the north side of the county (**Fig. 4D.10**). Of the available data, ZIP code 78218 had the highest rate at 1.0 discharge per 10,000 people.

Though it is not possible to separate drug overdose deaths from other types of chemical poisonings in the available data set, the overall rate increased from 2019 to 2023, reaching a five-year high of 23.6 deaths per 100,000 people (**Fig. 4D.11**). The most significant increases occurred between 2020 and 2021, and again between 2021 and 2022, resulting in an overall increase of roughly two-thirds over the five-year period.

Fig. 4D.11 Poisoning by chemical substance (including drugs) death rate per 100K population

Bexar County, Texas



Source: CDC WONDER Underlying Cause of Death dataset
Prepared by CINow for The Health Collaborative

As one focus group participant shared, formerly incarcerated individuals face stigma, particularly around drug abuse, along with other barriers to recovery, like lack of support and limited access to affordable treatment. Other community voices echoed the complex challenges faced by this vulnerable population, including individuals on probation.

"I'm speaking of a background of imprisonment. They've been in jail. They got a lot of drug abuse in their background, you know, which is what society doesn't accept. It just keeps pushing them down. How can I do better when there's no opportunities out there for me? You don't want to help me. You don't want to assist me. You want to send me to a place that costs all this money, and I don't have that, can't even get a job to get it. But if you teach me a trade that I can take care of myself and my family, I could do better with some more accessible trade work."

– CHNA Focus Group #2 Participant

TRACKING INJURIES

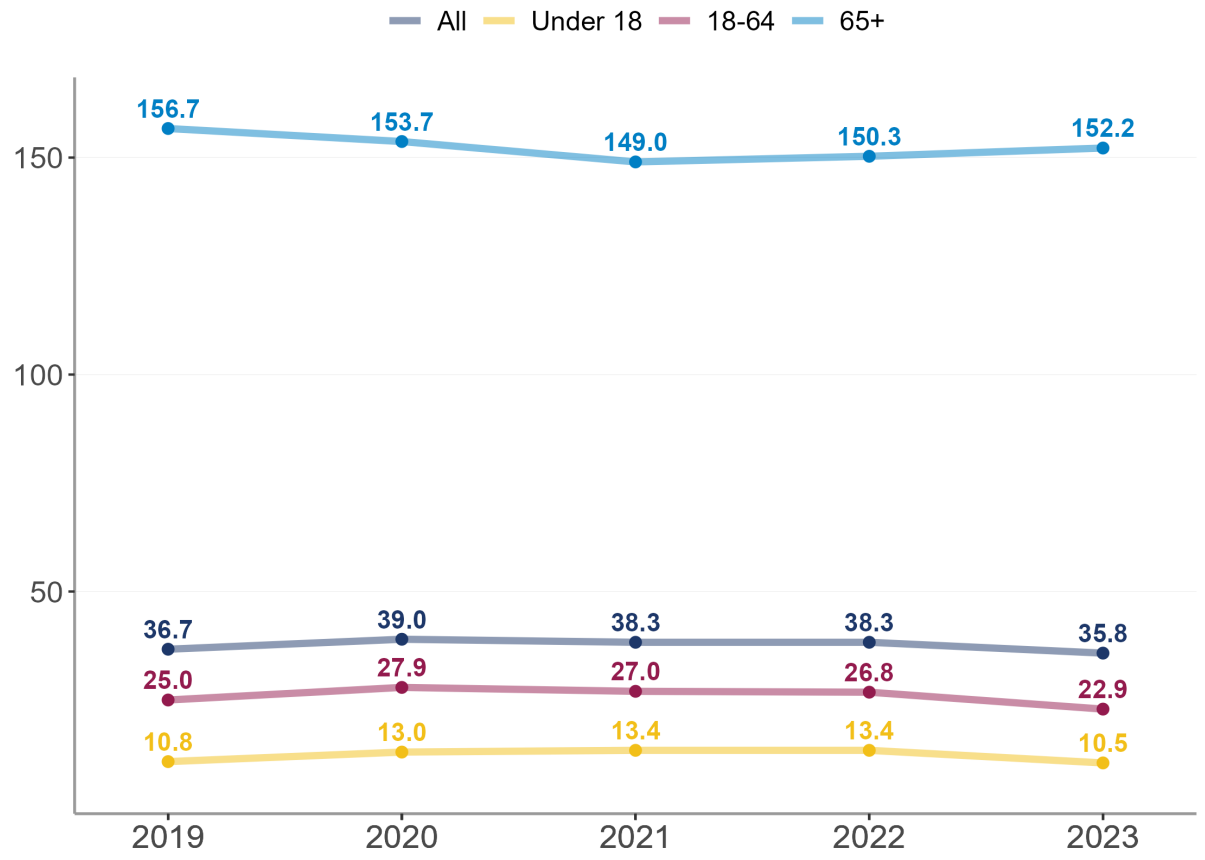
Hospital discharge and emergency department (ED) visit rates are key indicators of moderate to severe injury, including but not limited to injury due to traffic accidents, occupational accidents, assaults, burns, falls, and intentional or unintentional poisoning or overdose. High rates indicate increased demand for emergency care, hospital staffing, rehabilitation services, and rehabilitation programs. For individuals, injury-related hospitalizations often result in significant personal and financial costs, especially for older adults who may face longer recovery periods and greater complications. In the most recent three-year period available (2021-2023), Bexar County's overall hospitalization rate with a primary diagnosis of injury was 35.8 per 10,000 residents (**Fig. 4E.1**).

By age (**Fig. 4E.1**),

- Residents aged 65 and older consistently experienced significantly higher rates of over 150 per 10,000 people each year, more than six times the rate of working-age adults (aged 18-64) and over ten times the rate for children and adolescents under 18.
- The rate increased in the under-18 and 18 to 64 age groups during the 2018-2020 through 2020-2022 periods, the height of the COVID-19 pandemic, but decreased in the 65-and-older group.

Fig. 4E.1 Injury hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



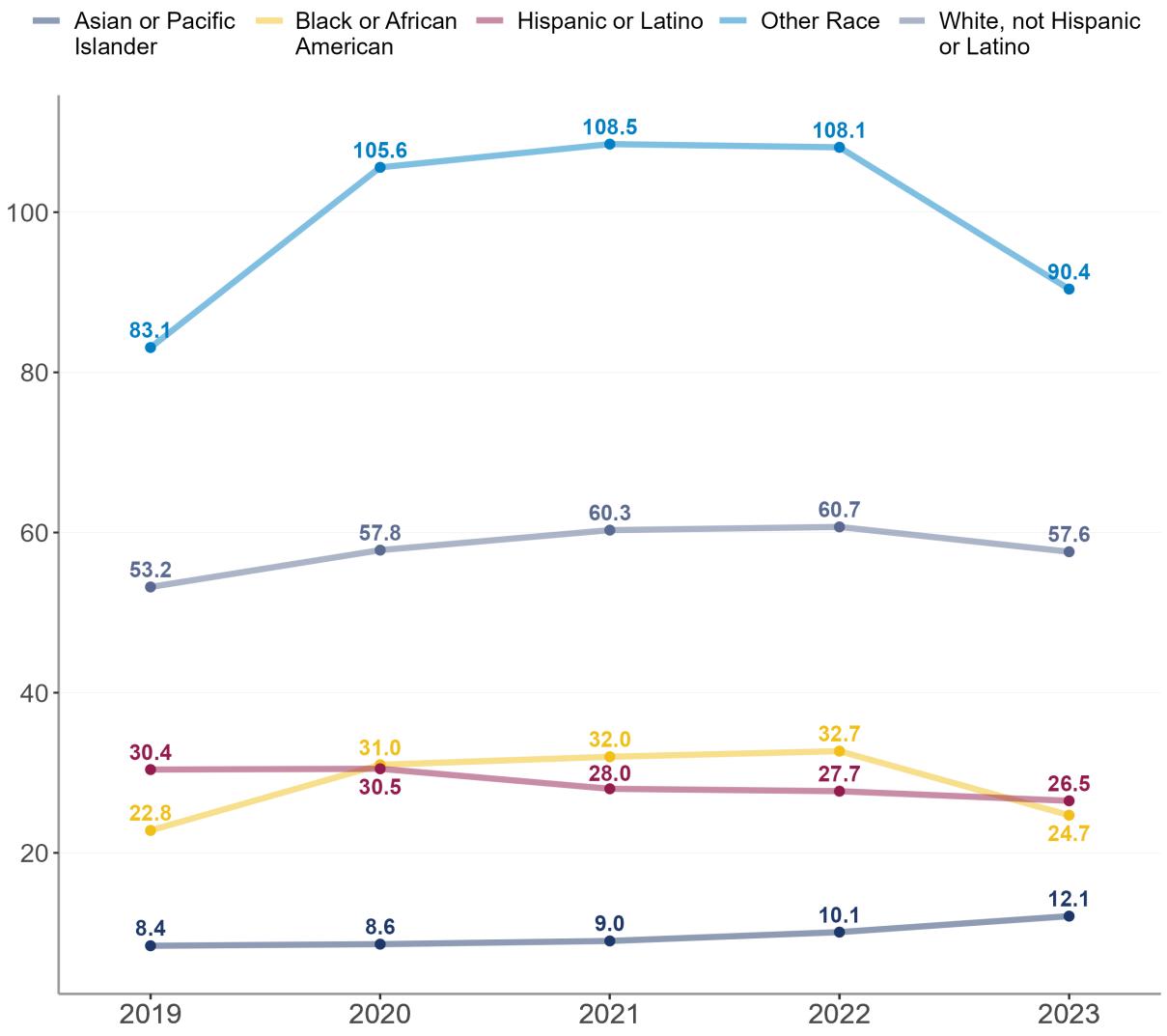
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

By race/ethnicity (**Fig. 4E.2**),

- Across all five years, white (non-Hispanic) residents and those classified as "Other Race" consistently had the highest injury hospitalization rates, reaching as high as 108.5 per 10,000 for "Other Race" in 2021.* Asian or Pacific Islander residents consistently had the lowest rates, but they were the only group for whom the rate did not fall in the 2021-2023 period.
- The rate rose during the height of the COVID-19 pandemic for all race/ethnicity groups except Hispanic; that rate declined in every measurement period from 2018-2020 forward.

Fig. 4E.2 Injury hospital discharge 3-year average rate per 10K population, by race/ethnicity

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

* Low counts for some race/ethnicity or other groups may create "bounce" in rates that exaggerates change over time.

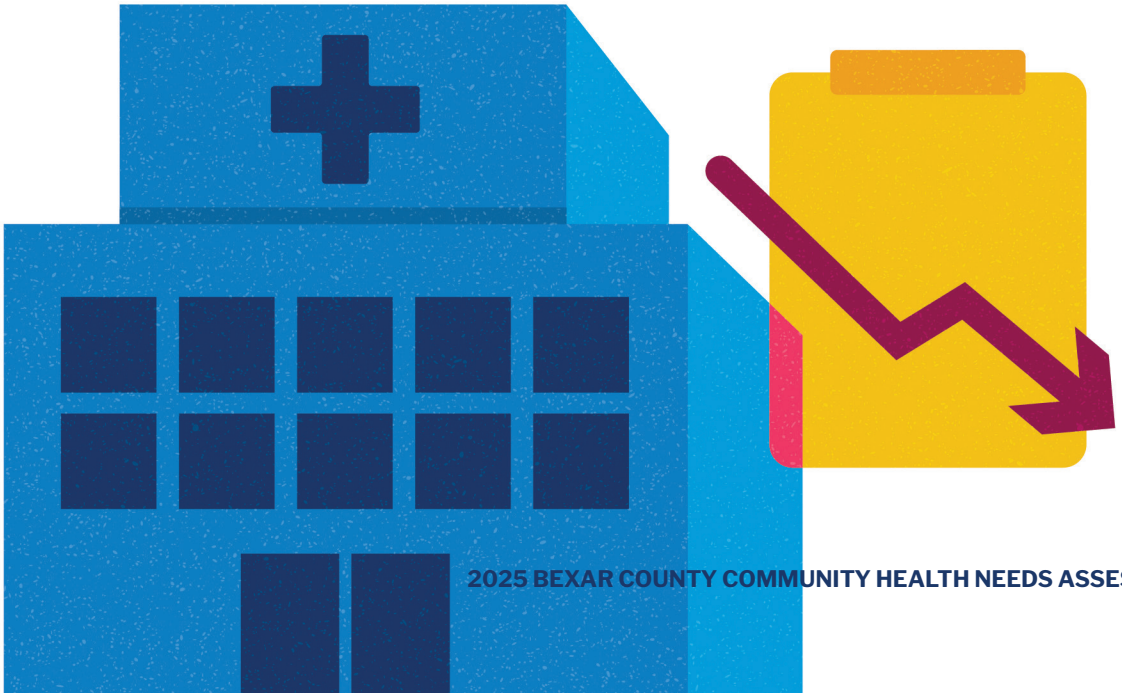
HOW THE COVID-19 PANDEMIC AFFECTED HOSPITALIZATION AND ED VISITS

When the COVID-19 pandemic began, both hospital discharge and ED visit rates decreased for most conditions other than COVID-19 and other conditions with COVID-like symptoms such as fever, cough, and shortness of breath. Those declines are due to a combination of factors that differ by condition.

For example, some people with concerning symptoms likely stayed out of the ED for fear of exposure to COVID-19. Additionally, due to overcrowding and understaffing, both inpatient and ED facilities likely advised people they might otherwise have admitted to instead monitor themselves at home. In these examples, a decrease in the hospital discharge or ED visit rate likely does not refle t a true decrease in the burden of illness or injury.

In other cases, though, such as traffic a cidents or workplace injury, COVID-driven reductions in driving and the employment rate may have caused a real decrease in injuries requiring medical attention. Similarly, reduced exposure to common non-COVID respiratory illnesses while people isolated at home drove a real reduction in flu, respiratory syncytial virus (RSV), bronchitis, and pneumonia that would normally result in an ED visit or hospitalization.

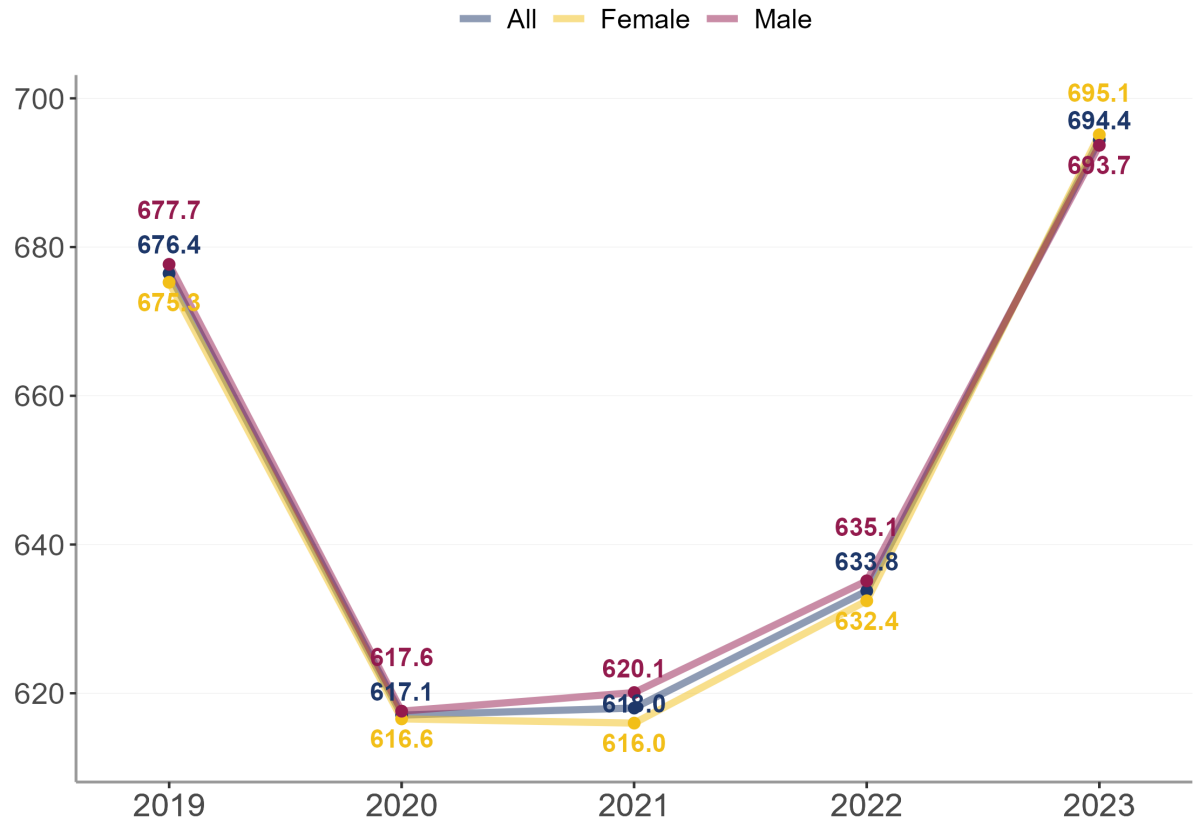
Hospital discharge and ED visit rates have largely rebounded to pre-COVID levels for most conditions. The degree and speed of the rebound differ by condition and demographic group, however. As with the initial decrease, the rebound is influen ed by a complex combination of factors.



ED visits with a primary diagnosis of injury are nearly 20 times as common as hospital discharges in every measurement period and show a somewhat different pattern of disparities among demographic groups. The injury ED visit rate declined when COVID-19 hit, resulting in a 2018-20 three-year average about 9% lower than the prior period (**Fig. 4E.3**). This chart is a bit difficult to read, but an interesting story here is that injury ED visit rates by sex are so similar. For both males and females, the rate began to rise again in the 2019-21 period, rebounding to the baseline rate by the 2021-23 period. The rate was similar for males and females in every three-year period.

Fig. 4E.3 Injury emergency department visit 3-year average rate per 10K population, by sex

Bexar County, Texas

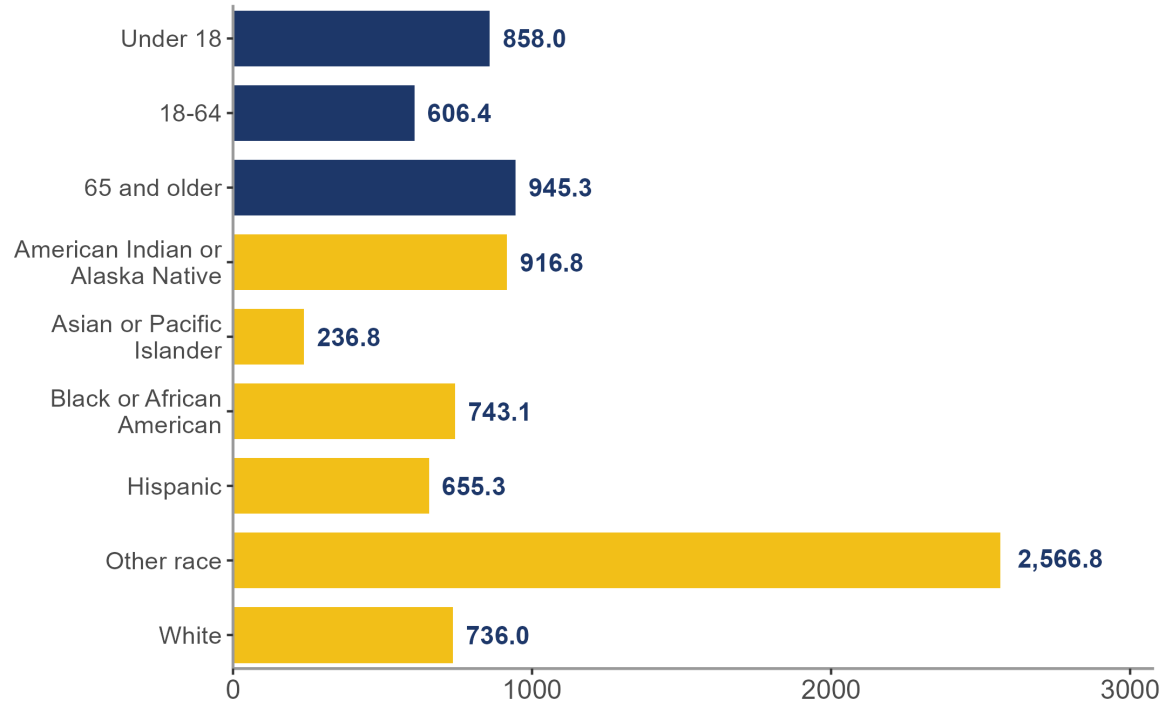


For the "All" and sex categories, the cases with missing sex information were removed from analyses.
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

As with hospital discharges for injury, the highest rate is among people 65 and older, but the disparity between older and younger people is far less dramatic (**Fig. 4E.4**). In the 2021-23 period, the ratio of injury hospital discharges is 14.5 to 1 in the 65-and-older group versus the under-18 group, but the ratio for ED visits was only 1.1 to 1. Looking at the data by race/ethnicity, the highest rates are in the “other race” and American Indian or Alaska Native groups. Rates for “other race” and American Indian or Alaska Native groups should be interpreted with caution because both population and ED visit counts are relatively much smaller for those two groups.

Fig. 4E.4 Injury emergency department visit 3-year average rate per 10K population, by age and race/ethnicity, 2023

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

Injury-related hospitalizations and emergency room visits highlight opportunities for funding and collaboration between organizations and health systems to keep patients out of the ER.

"I think there's opportunities where we can work together to keep those patients out of their emergency room. We do have the skill-set to provide the housing, food, and case management. I think there are opportunities that exist where we could work better. What we need is the funding. So, I think there is potential for these health systems and us to partner together. And it still would be a win-win, because the services we're talking about would cost less than that emergency room visit."

– CHNA Key Informant representing an organization that serves vulnerable people in crisis

FIGHTING INFECTIONS & PREVENTING OUTBREAKS

Communicable and vaccine-preventable diseases can spread quickly, especially in group settings like schools and shelters, and can lead to serious health complications if left untreated. While anyone can be affected, these conditions often disproportionately impact vulnerable populations due to factors like poverty, limited access to healthcare, and stigma. Barriers to timely testing and treatment can contribute to delayed diagnoses and ongoing transmission. Notably, trends in infection rates likely reflect shifts in healthcare access, public health outreach, and social behaviors, particularly during and after the COVID-19 pandemic.

COVID-19

Hospitalization is a valuable indicator of severe COVID-19 illness and risk of death. Overall, the 2021-23 three-year average for COVID-19 hospital discharges in Bexar County was 24.7 per 10,000 people (**Fig. 4F.1**). Adults aged 65 and over experienced much higher rates (88.3), more than three times higher than the county average. The rate was highest among the "Other race" group, but that figure should be interpreted with caution given the smaller size of that group (**Fig. 4F.2**). The rate for white Bexar County residents is about 50% higher than for Hispanic and Black or African American residents, likely at least in part because the white population is older on the whole. It should be noted that the COVID-19 vaccine was introduced in spring 2021, so these hospital discharge rates are far lower than those earlier in the pandemic.

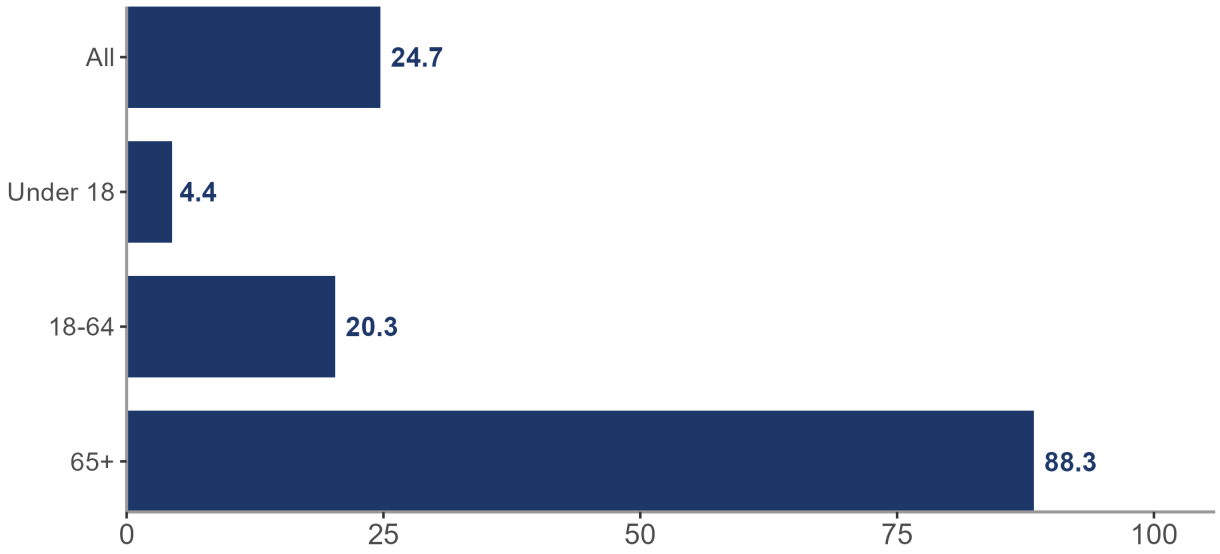
CHNA Key Informants felt that the COVID-19 pandemic shined a light on the disparities that need to be addressed, opened the availability of telemedicine, and taught them how to act quickly and react in moments of crisis—a sort of silver lining.

"I think we definitely learned [during COVID-19] that we could operate in a moment of crisis… organizations, they understood they could adjust if they needed to. Now, it didn't mean that it was an ideal situation, by all means. It didn't mean that at all. But that we could adjust, and we could still sort of function. I think, it did demonstrate that, and that's probably one of the bigger lessons learned."

– Adrian Lopez (CEO, Workforce Solutions Alamo)

Fig. 4F.1 COVID-19 hospital discharge 3-year average rate per 10K population by age, 2023

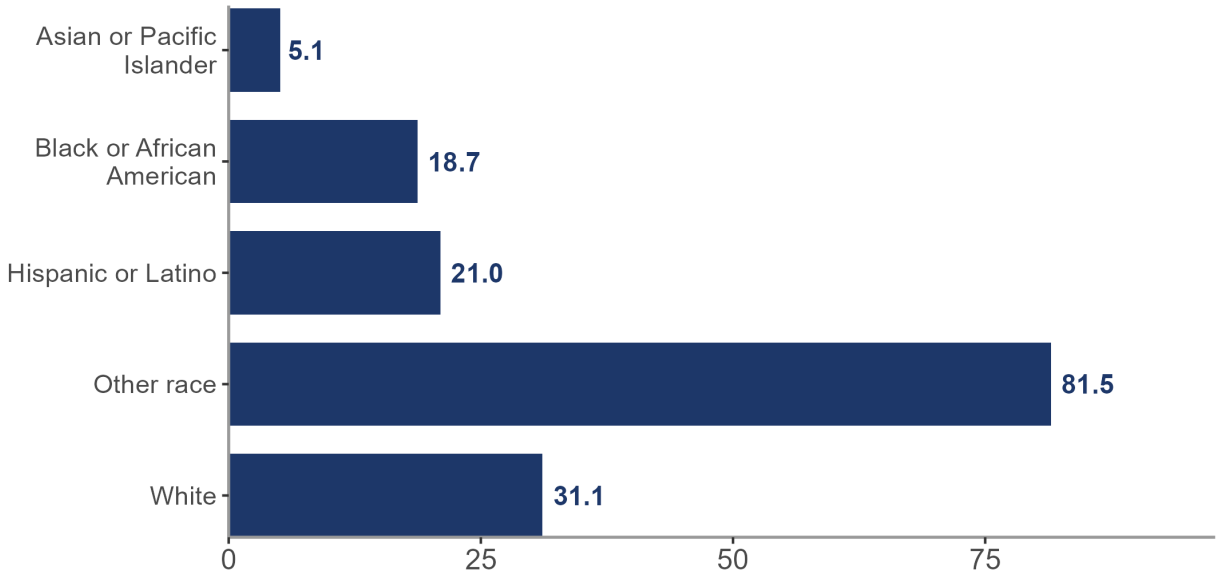
Bexar County, Texas



Some values are suppressed due to low counts.
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

Fig. 4F.2 COVID-19 hospital discharge 3-year average rate per 10K population by race/ethnicity, 2023

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

Fig. 4F.3 COVID-19 hospital discharge 3-year average rate per 10K population, by ZIP code, 2023

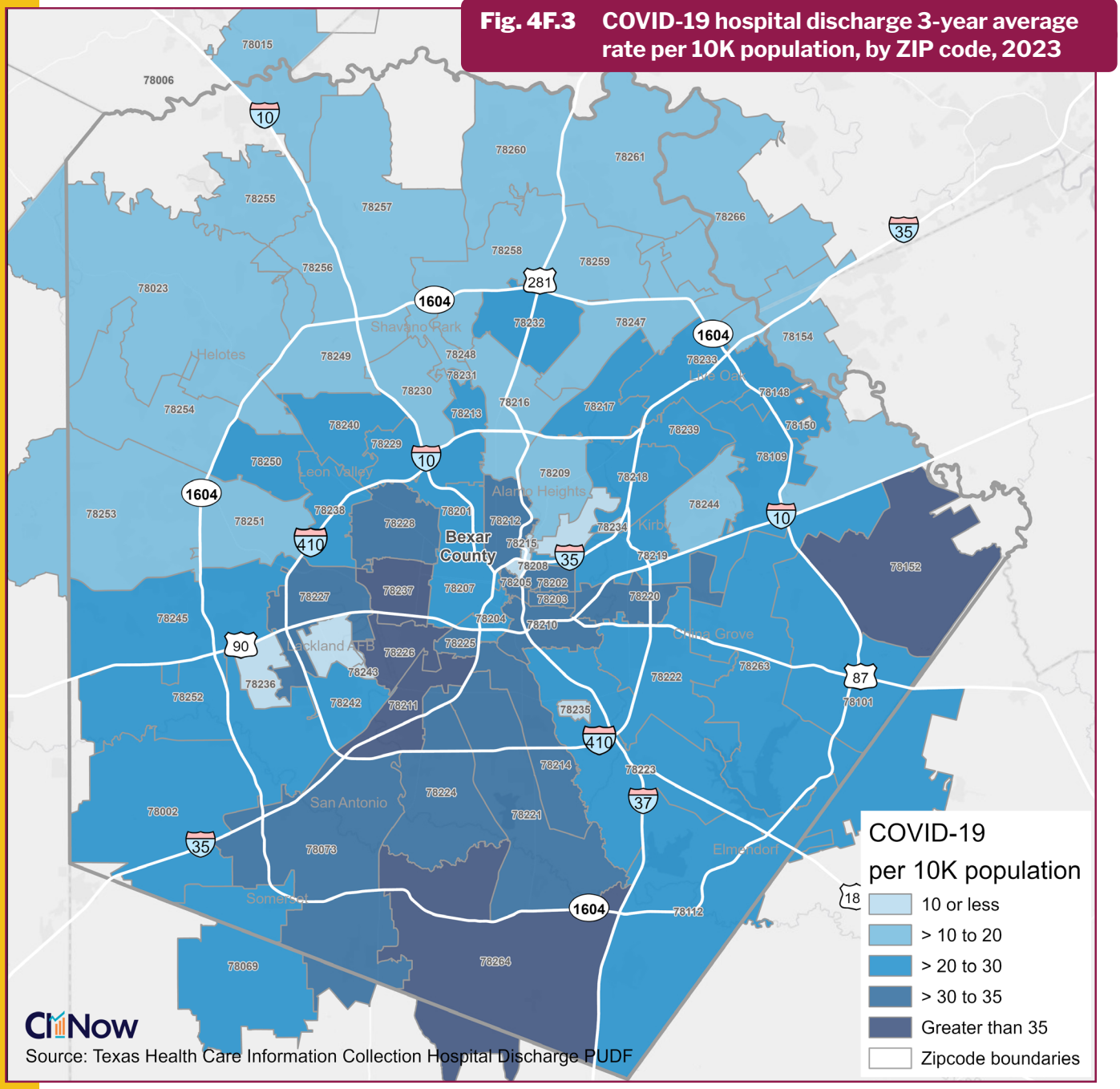


Figure 4F.3 shows the distribution of Bexar County hospital discharges with a primary diagnosis of COVID-19 in 2023. The ZIP codes with rates greater than 35 per 10,000 residents are in the southwest of inside Loop 410 and at the far east and far south around Loop 1604. The ZIP codes with the lowest rates are all north of the Highway 90 - Interstate 10 line.

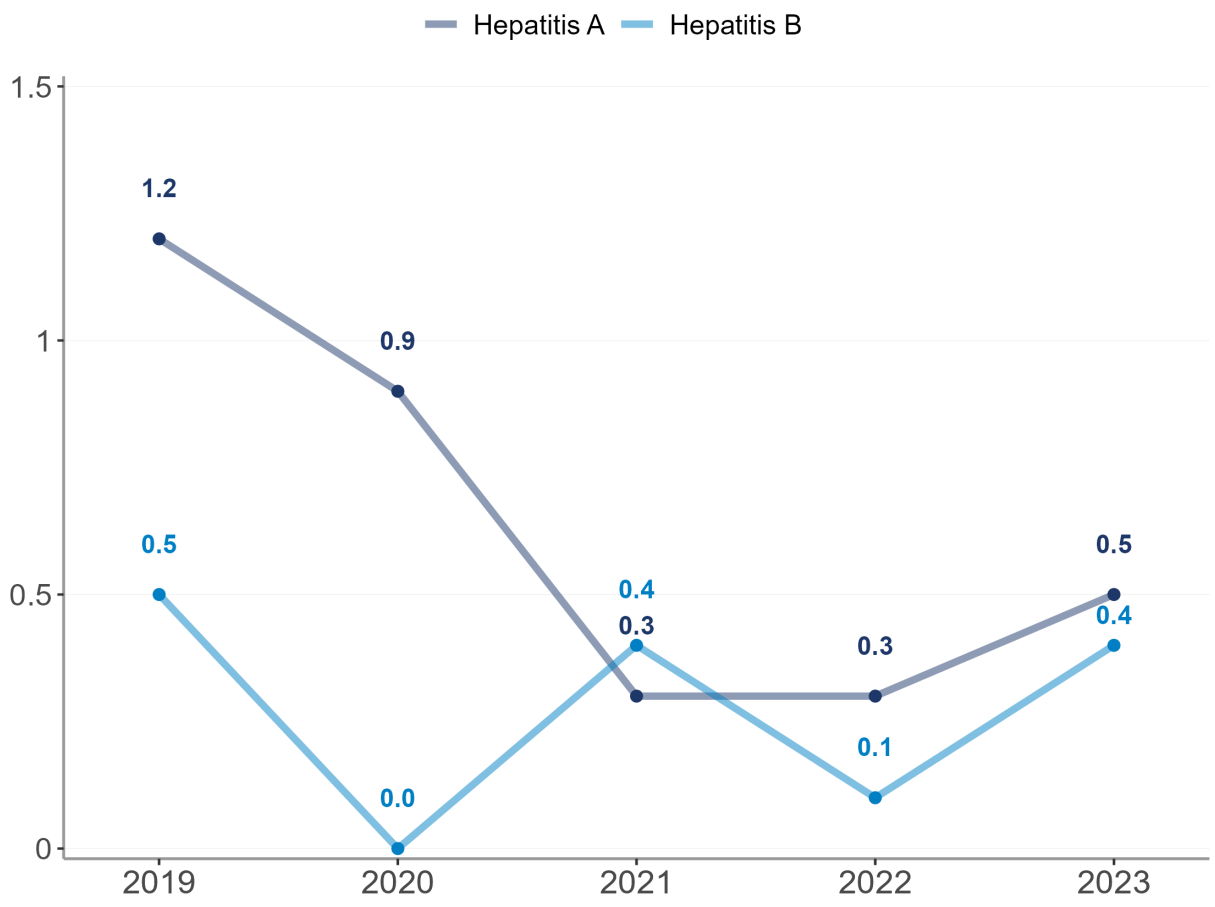
Hepatitis A and Hepatitis B

Hepatitis A is transmitted through the fecal-oral route, while hepatitis B is transmitted through blood or sexual contact, but both are vaccine-preventable and affect vulnerable populations. People who use or inject drugs have an increased risk of contracting viral hepatitis, including both A and B, and individuals experiencing homelessness are especially vulnerable to hepatitis A due to challenges in sanitation and hygiene.[60,61]

Figure 4F.4 shows incidence rates – number of new cases diagnosed per year – for hepatitis A and hepatitis B per 100,000 Bexar County residents over the five-year period from 2019 to 2023. Hepatitis A incidence dropped 75% from 2019 to 2021. The onset of COVID-19 likely played a large role in that decrease, but the data does not allow us to know what proportion of the effect was preventing cases from being identified versus actually preventing infection from occurring. Hepatitis B incidence, on the other hand, showed a "w"-shaped trend line, with rates varying between 0.0 and 0.5 per 100,000 during the five-year period.

Fig. 4F.4 Hepatitis A and hepatitis B incidence rate per 100K population

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

Measles, Mumps, Whooping Cough, and Chickenpox

Chickenpox (varicella), measles, mumps, and whooping cough (pertussis) are highly contagious infections that can lead to serious complications and spread easily in group settings like schools and shelters. Recent Bexar County health needs assessments have not included a measles indicator at all because cases were so rare in Texas. That changed when an unvaccinated child from Gaines County in west Texas died of measles in January 2025. As of this writing in August 2025, a total of 762 cases have been confirmed in Texas, including one Bexar County case identified in mid-June as linked to the west Texas outbreak. That case is Bexar County's first since two cases were identified in 2019.[62]

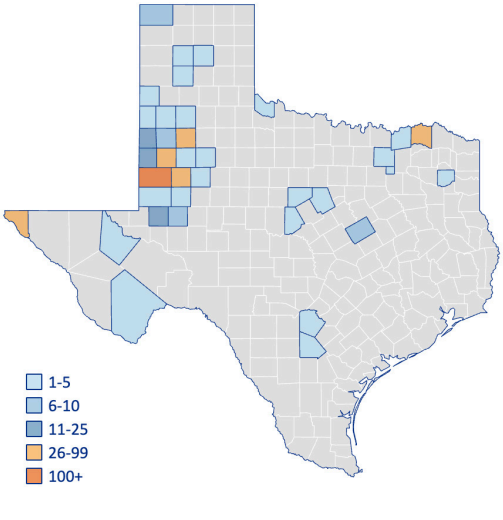
2025 TEXAS MEASLES OUTBREAK

08/12/2025
All data provisional and subject to change

OUTBREAK CASES BY COUNTY

HOME COUNTY	CONFIRMED	% OF TOTAL
Andrews	3	0.40%
Atascosa	1	0.10%
Bailey	2	0.30%
Bexar	1	0.10%
Borden	1	0.10%
Brewster	1	0.10%
Brown	1	0.10%
Carson	1	0.10%
Cochran	14	1.80%
Collin	1	0.10%
Dallam	7	0.90%
Dawson	26	3.40%
Eastland	2	0.30%
Ector	12	1.60%
El Paso	59	7.70%
Erath	1	0.10%
Fannin	4	0.50%
Gaines	414	54.30%
Garza	2	0.30%
Hale	5	0.70%
Hardeman	1	0.10%
Hockley	7	0.90%
Lamar	28	3.70%
Lamb	1	0.10%
Lubbock	52	6.80%
Lynn	2	0.30%
Martin	3	0.40%
McLennan	9	1.20%
Midland	6	0.80%
Parmer	5	0.70%
Potter	1	0.10%
Randall	1	0.10%
Reeves	2	0.30%
Rockwall	1	0.10%
Terry	60	7.90%
Upshur	5	0.70%
Yoakum	20	2.60%
Total	**762**	**100.00%**

OUTBREAK CASES BY COUNTY



OUTBREAK CASES BY AGE

AGE GROUP	CONFIRMED
0-4 Yrs	225
5-17 Yrs	286
18+ Yrs	247
Pending	4

OUTBREAK CASES BY VACCINATION STATUS

VACCINATION STATUS	CONFIRMED
Unknown/Unvaccinated*	718
Vaccinated: 1 dose	23
Vaccinated: 2+ doses	21

*The unvaccinated/unknown category includes people with no documented doses of measles vaccine more than 14 days before symptom onset.

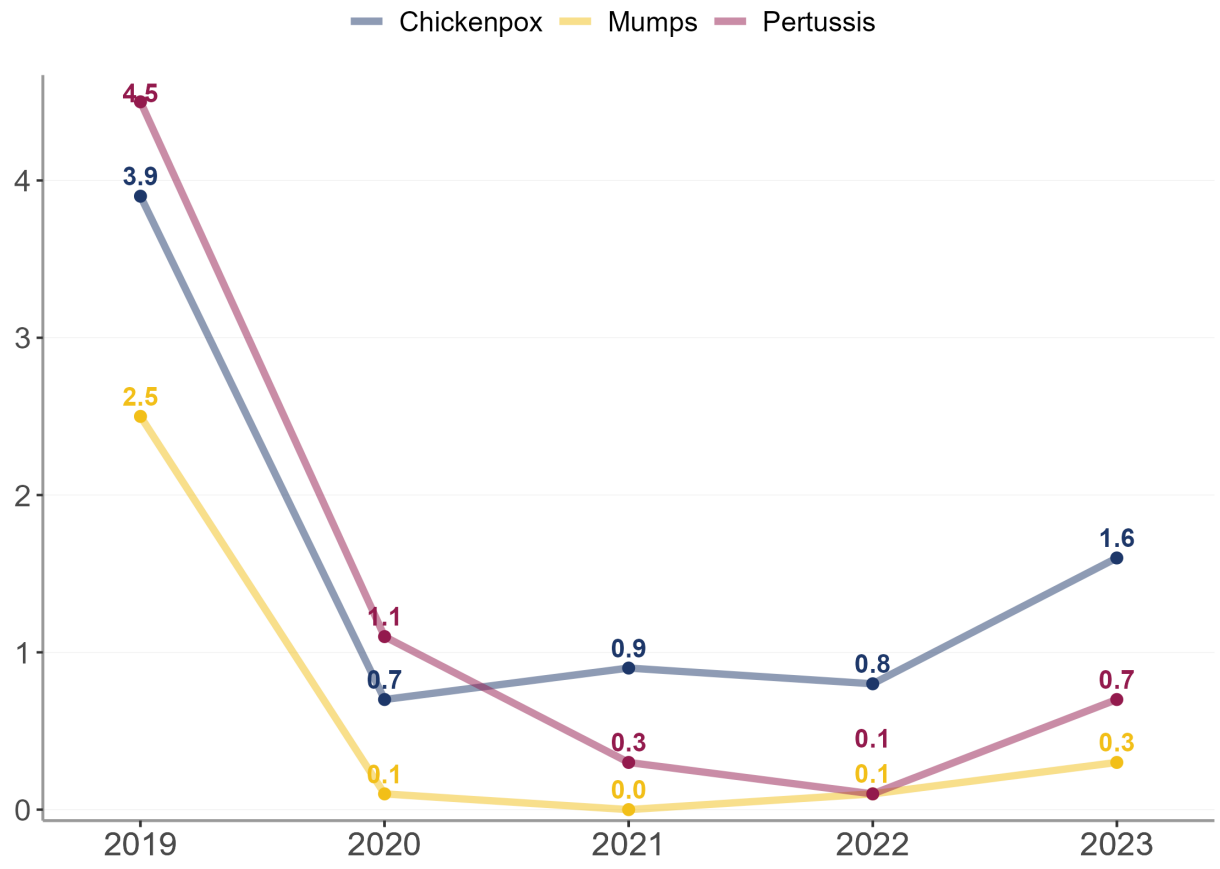
Source: Image of Texas Department of State Health Services 2025 Texas Measles Outbreak dashboard 8/12/25[63]

Pertussis, or whooping cough, incidence fell 76% from 2019 (4.5 per 100,000) to 2020 (1.1 per 100,000) and reached a five-year low of 0.1 per 100,000 in 2022. Although the 2023 rate rebounded, it was still just 16% of the 2019 incidence. The dramatic decrease in incidence in 2020 was almost certainly due to the closure of in-person school, day care, and other settings where respiratory illnesses can spread easily. Infants under the age of one are at greatest risk of getting whooping cough and having severe complications from it. [64]

Throughout the five-year period from 2019 to 2023, varicella (chickenpox) and mumps incidence rates per 100,000 trended similarly to pertussis (**Fig. 4F.5**). Both rates dropped sharply in 2020, likely influenced by COVID-19 mitigation measures like remote rather than in-person school and work, and temporary child care closures. From 2019 to 2020, varicella incidence and mumps incidence fell by 82% and 96%, respectively. Rates then fluctuated slightly but remained low through 2022 before rebounding in 2023. Again, although the 2023 rates were roughly double the 2022 rates, both remained far lower than 2019.

Fig. 4F.5 Chickenpox (varicella), mumps, and whooping cough (pertussis) incidence rate per 100K population

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

Chlamydia and Gonorrhea

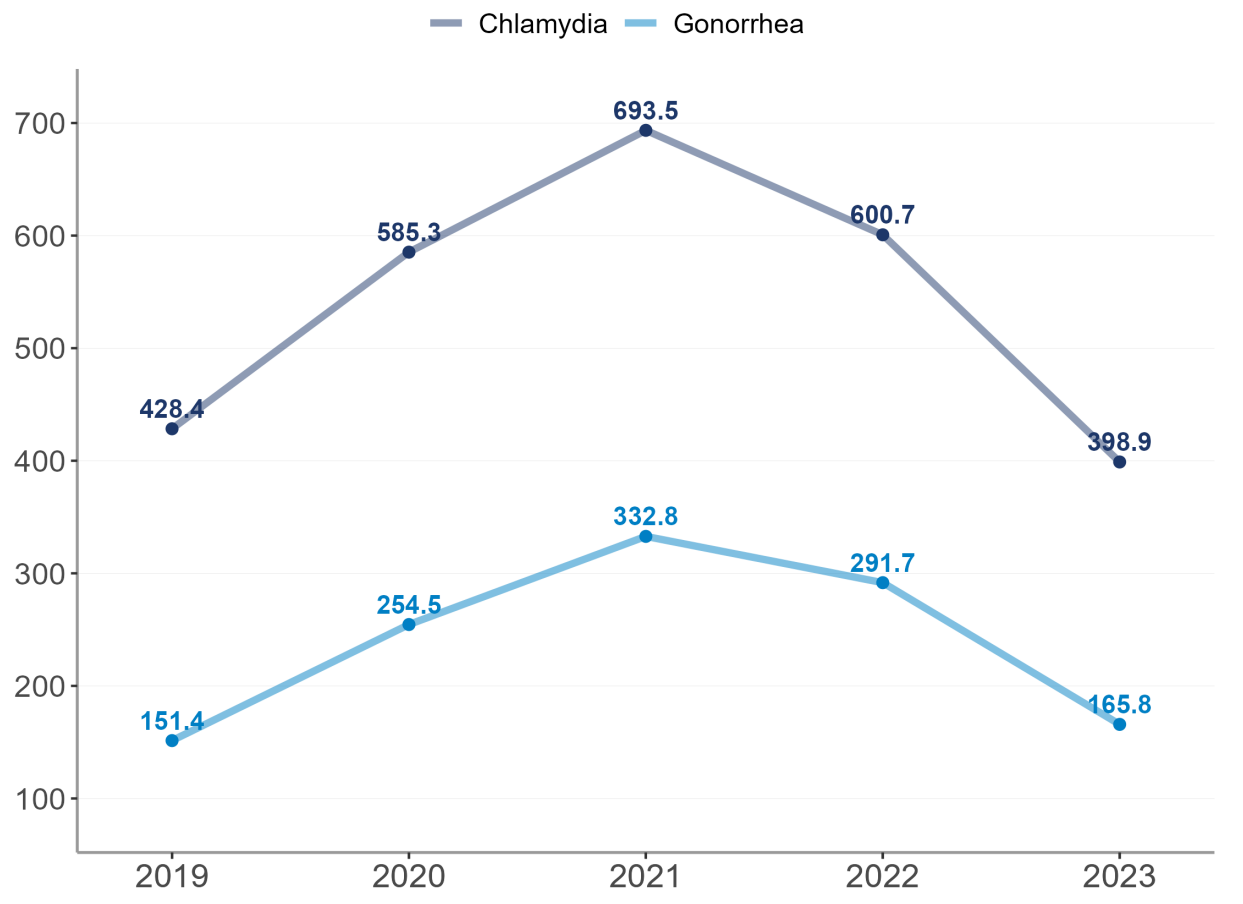
Chlamydia and gonorrhea are common sexually transmitted infections (STIs). While many people with these infections do not experience symptoms, if left untreated, they can lead to serious health problems and can continue to spread unknowingly.[65] Throughout the five-year period from 2019 to 2023, incidence rates per 100,000 Bexar County residents followed a similar pattern for both infections, with chlamydia cases consistently outnumbering gonorrhea cases (**Fig. 4F.6**). Both rates increased through 2021, reaching five-year highs, before steadily decreasing through 2023.

More specifically,

- Chlamydia had its lowest rate in 2023 at 398.9 diagnosed cases per 100,000 residents, a drop of about 42% from its peak in 2021 of 693.5. Notably, the 2023 rate was 7% lower than the 2019 rate (428.4), showing a return to pre-COVID-19 pandemic levels.
- Similarly, gonorrhea rates increased to a five-year high in 2021 of 332.8 before dropping significantly (by about 50%) through 2023. However, the 2023 rate (165.8) remained about 10% higher than the five-year low in 2019 of 151.4

Fig. 4F.6 Chlamydia and gonorrhea incidence rate per 100K population

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

HIV and Early Latent Syphilis

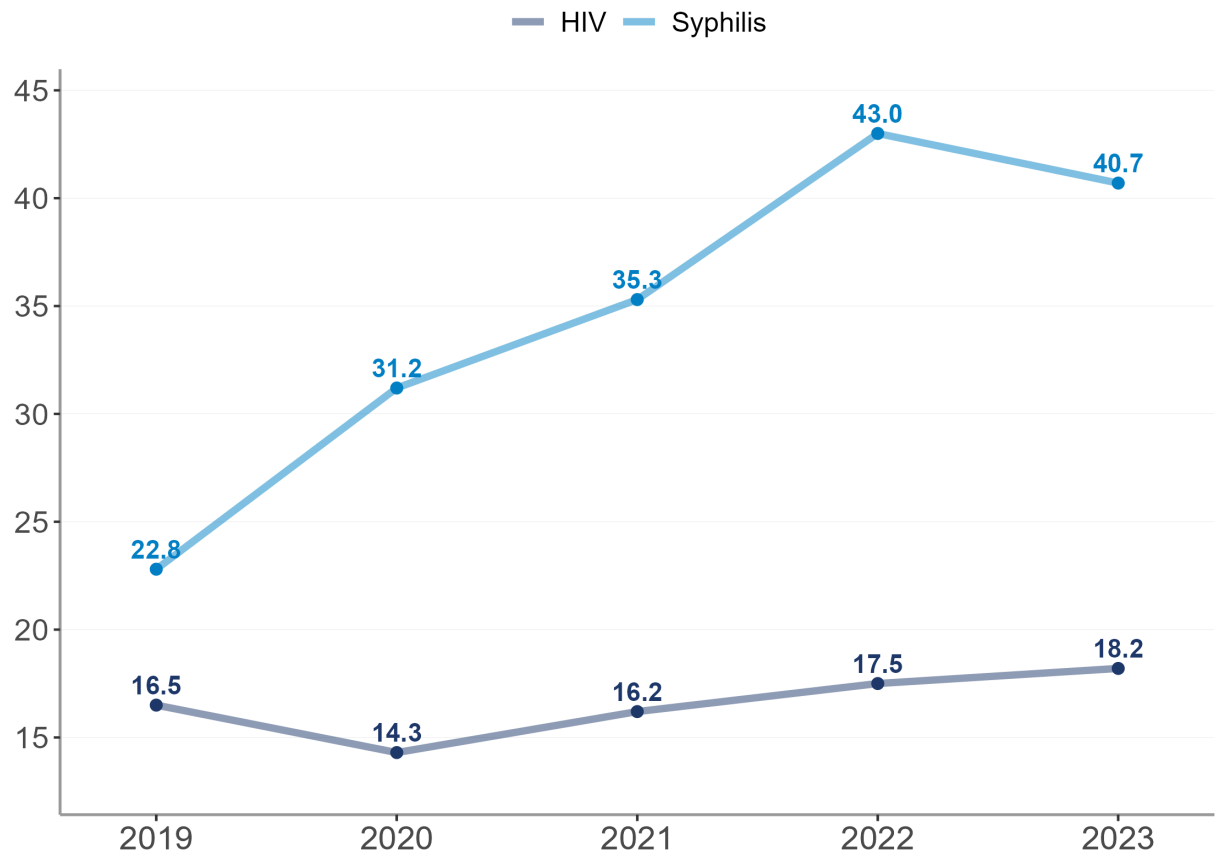
Both HIV and early latent syphilis are STIs that can also be transmitted from mother to child during pregnancy or childbirth. These infections disproportionately affect certain populations due to sexual behaviors, barriers to healthcare access, and broader social factors like poverty, stigma, and discrimination.[66] From 2019 to 2023, incidence rates per 100,000 Bexar County residents showed a similar overall upward trend for both infections, with syphilis cases consistently outnumbering HIV cases (**Fig. 4F.7**).

More specifically,

- Syphilis rates started at a five-year low in 2019 (22.8 per 100,000 residents), which steadily increased through 2022, peaking at 43.0, and then slightly declining to 40.7 in 2023. Despite this slight drop, the 2023 rate remains nearly 80% higher than in 2019.
- HIV diagnosis rates were lower overall but followed a similar upward trend in recent years. After decreasing to a five-year low of 14.3 in 2020, rates increased each year, reaching a five-year high of 18.2 in 2023, reflecting an increase of about 27% from 2020.

Fig. 4F.7 HIV new diagnoses and early latent syphilis incidence rate per 100K population

Bexar County, Texas



Source: Texas Department of State Health Services
Prepared by CINow for The Health Collaborative

CHRONIC ILLNESS AND CANCER

Heart disease and cancer are the leading causes of death nationally and locally.[67] These conditions often share common risk factors, like poor nutrition and chronic stress. Early detection plays a critical role, not only in reducing the risk of severe complications but in timely intervention and effective, long-term management. Understanding their prevalence helps highlight the burden of chronic disease in the community.

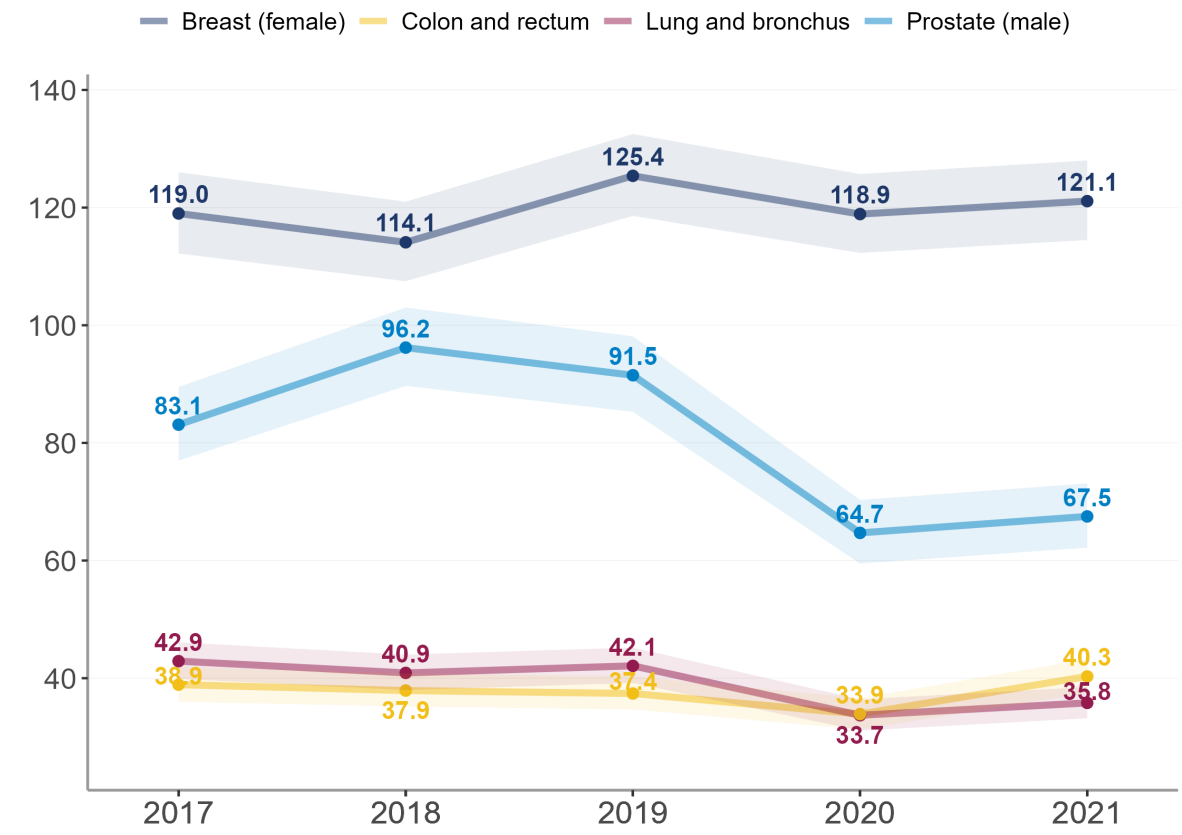
Cancer

Figure 4G.1 shows incidence rates per 100,000 Bexar County residents for the most common invasive cancers, listed by cancer site, from 2017 to 2021. More specifically,

- Breast cancer (in females) was by far the most common among those, with an incidence rate of 121.1 per 100,000 residents in 2021. Despite some minor fluctuations, the rates remained relatively stable across the five-year period, averaging around 119.7 cases per 100,000 residents.
- Prostate cancer (in males) was the second most common and showed a notable decline from 2018 to 2020, dropping from 96.2 to 64.7, a decrease of about 33%, before slightly rebounding to 67.5 in 2021.

Fig. 4G.1 Age-adjusted invasive cancer incidence rate per 100K population, by cancer site

Bexar County, Texas



Source: Texas Cancer Registry
Prepared by CINow for The Health Collaborative

- Among the cancer sites, the colon and rectum and the lung and bronchus showed the lowest rates. Because of overlapping margins of error, shown as shaded areas in the chart, distinctions between the two cannot be confidently made in any given year. Following similar trends over the five-year period, both remained relatively stable from 2017 to 2019, decreased in 2020, and increased slightly again in 2021. In the most recent year, 2021, the incidence of cancer affecting the colon and rectum was 40.3 per 100,000 residents, and lung and bronchus cancer had a rate of 35.8.

Poverty and health insurance are huge barriers to accessing consistent healthcare and catching diagnoses early, as one CHNA Key Informant explained,

"Poverty is a serious influencing factor to health. People have a very difficult time focusing on wellness if they can barely afford the food, products and services they need to maintain their own health. That's where so many families are—even if they are employed, many are living paycheck- to paycheck for just the bare necessities. Being able to afford health insurance, paying for prescriptions or hospital services is difficult when buying food or paying the rent is a challenge. Poverty is a significant determinant of one's health."

– Jaime Wesolowski (President/CEO, Methodist Healthcare Ministries)

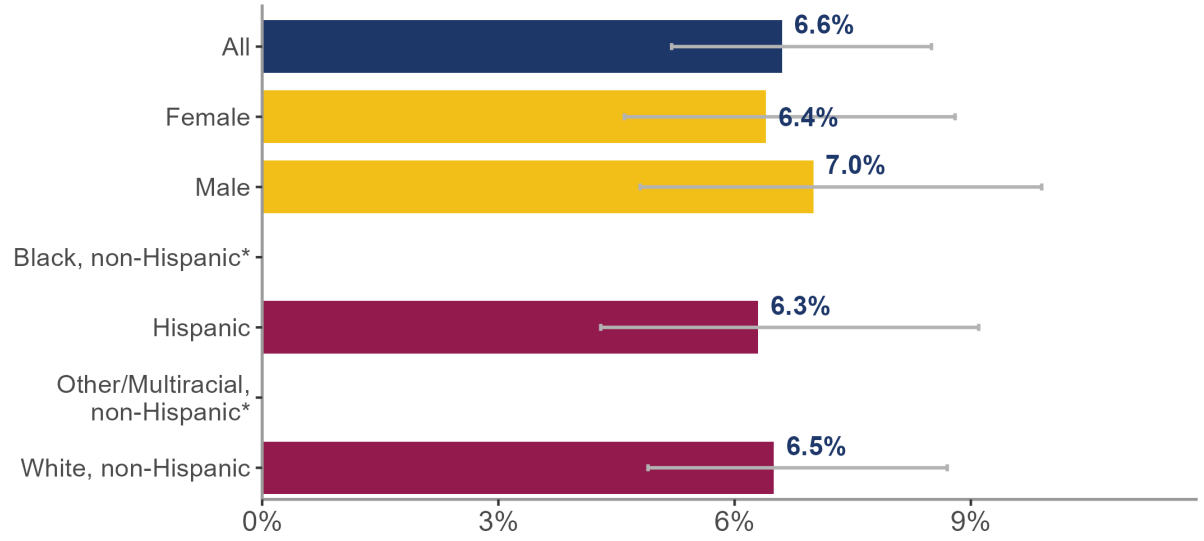
Heart Disease

The BRFSS survey asks respondents if a doctor, nurse, or other health professional ever told them they have angina or coronary heart disease.[68] Overall, only about one in 15 (7%) Bexar County respondents reported being diagnosed with heart disease (**Fig. 4G.2**). That said, differences across groups in **Figure 4G.2** and sectors in **Figure 4G.3** should be interpreted with caution.*

* Differences among groups may not be statistically significant due to limited data or overlapping margins of error.

Fig. 4G.2 Percent of adults ever told by a healthcare provider that they have heart disease, by sex and race/ethnicity, 2017-2023

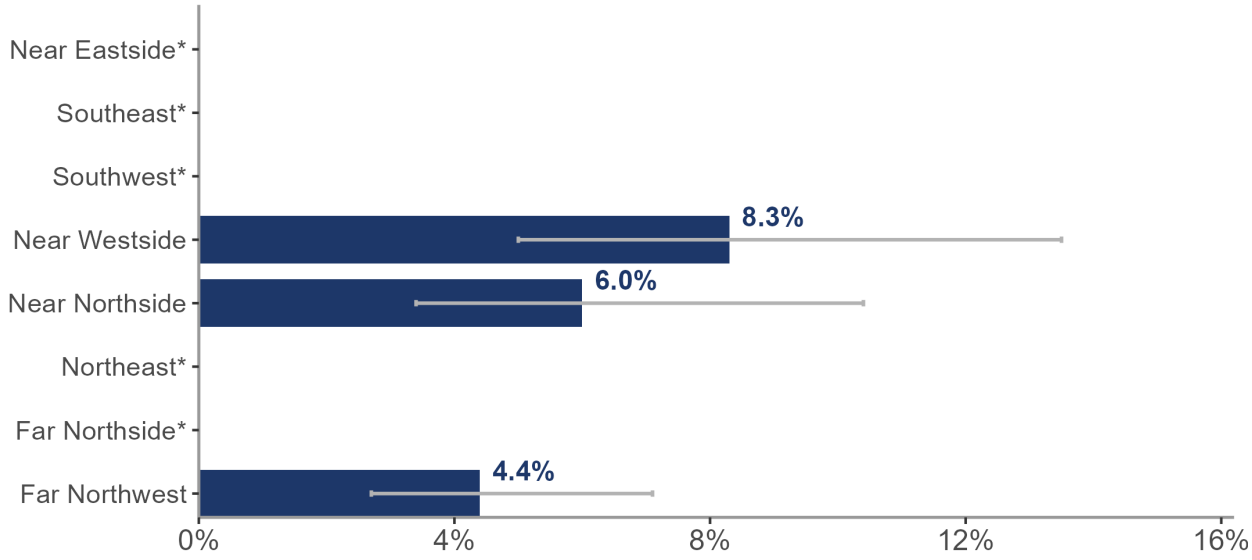
Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 4G.3 Percent of adults ever told by a healthcare provider that they have heart disease, by sector, 2017-2023

Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Hypertension

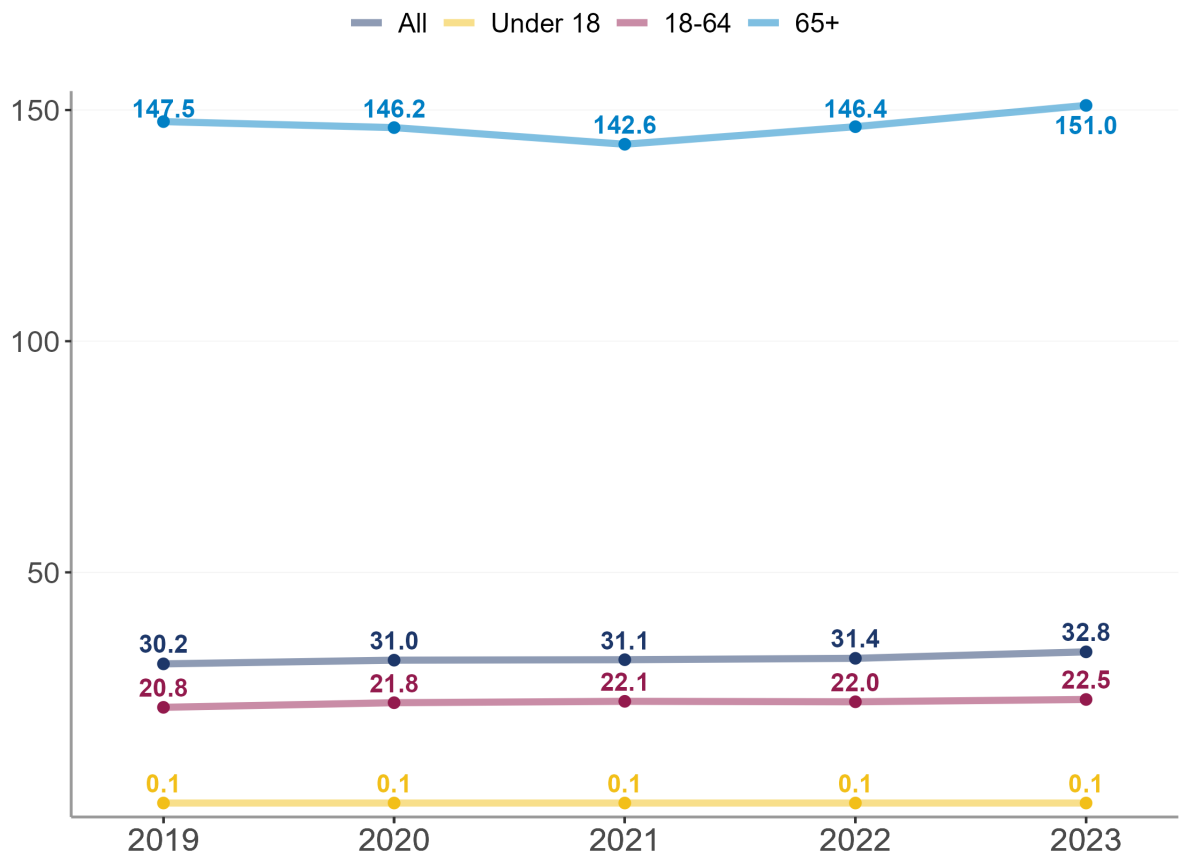
Hypertension hospital discharge rates, shown as three-year averages per 10,000 Bexar County residents, varied significantly by age and race/ethnicity (**Fig. 4G.4** and **Fig. 4G.5**). Most group rates remained relatively steady over the five-year period from 2019-2023, with no overlap in trend lines. Overall, the countywide rate increased gradually each year, ranging from 30.2 in 2019 to 32.8 in 2023, and averaging about 31.3 over the five-year period.

By age (**Fig. 4G.4**),

- Rates increased with age, with older adults (aged 65 and over) consistently experiencing significantly higher hospitalization rates, reaching a five-year high in 2023 of 151 hospitalizations per 10,000 residents.
- Working-age adults (aged 18-64) had the second-highest rates, though much lower than older adults, about 85% lower in 2023. Their rates increased modestly over time, from 20.8 in 2019 to 22.5 in 2023.
- In contrast, children and adolescents, aged 18 and under, had the lowest rates, consistently remaining at 0.1 throughout the entire period.

Fig. 4G.4 Hypertension hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



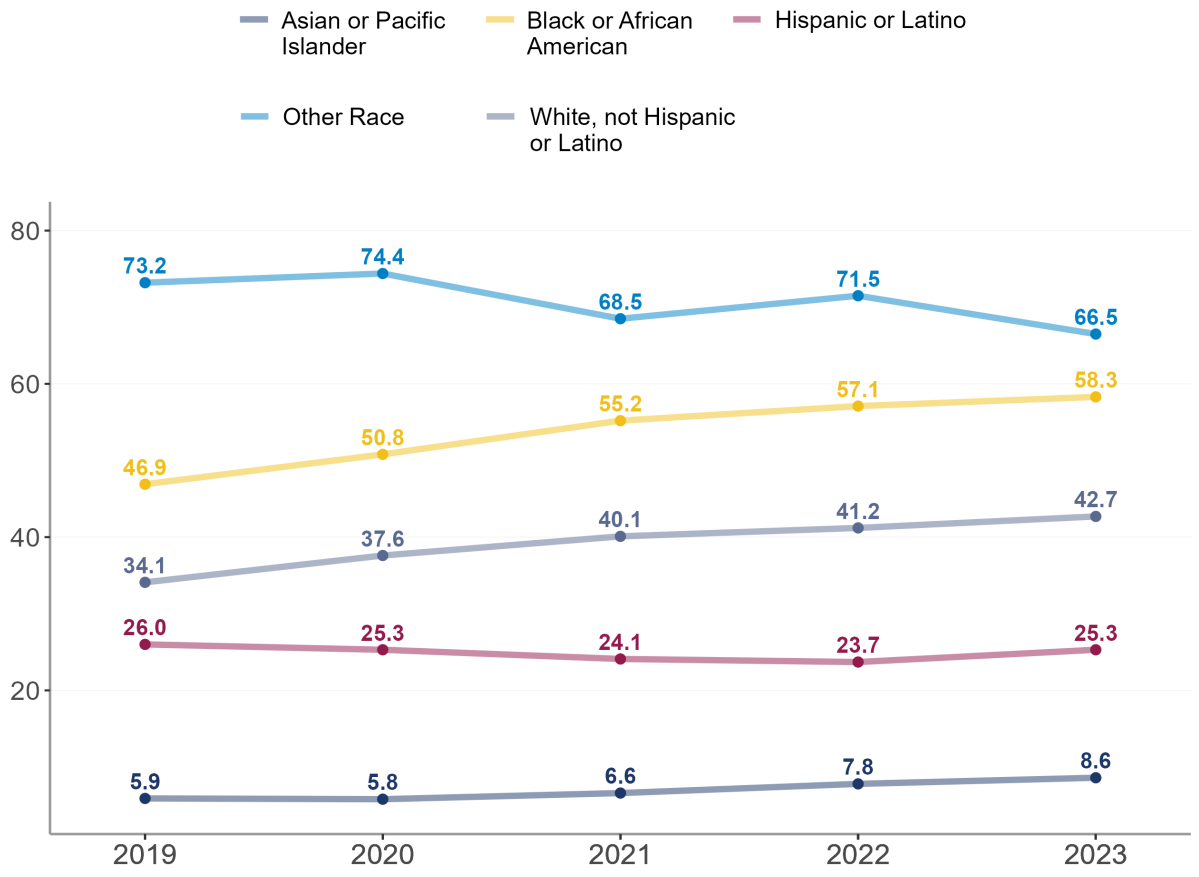
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

By race/ethnicity (**Fig. 4G.5**),

- The "Other race" category had the highest hospitalization rates, averaging 70.8 per 100,000 residents over the five years, though its rate declined from 73.2 in 2019 to 66.5 in 2023. However, this should be interpreted with caution.
- Black or African American residents were the second-highest, with rates increasing steadily from 46.9 in 2019 to 58.3 in 2023.
- Non-Hispanic white residents also experienced increasing rates, from 34.1 in 2019 to 42.7 in 2023.
- Hispanic residents, on the other hand, had relatively low and stable rates, averaging 24.9.
- While Asian or Pacific Islander residents had the lowest rates, these gradually increased significantly from 5.9 in 2019 to 8.6 in 2023.

Fig. 4G.5 Hypertension hospital discharge 3-year average rate per 10K population, by race/ethnicity

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

Community voices gave many examples of how transportation, taking time off work, and childcare are some of the barriers to regular and preventive care, which has a critical impact on early interventions for and diagnoses of diseases, like hypertension.

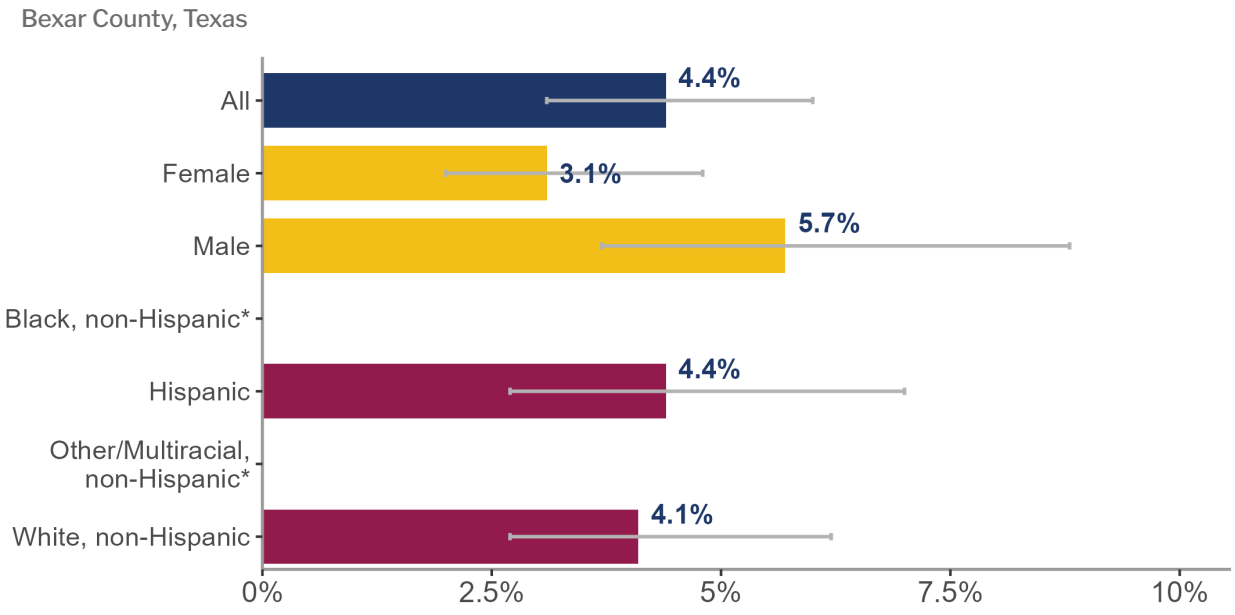
"Then there's getting to the appointment, which can be difficult to take time off of work, or find reliable transportation, or find childcare if children are not allowed at an appointment. It's all difficult, and I can understand why people are unable to adhere to treatment plans or follow preventive health guidance."

– CHNA Community Survey Respondent

Cerebrovascular disease

The BRFSS survey asks respondents if a doctor, nurse, or other health professional ever told them they had a stroke.[69] Overall, only about 4% of Bexar County respondents reported being diagnosed with a stroke (**Fig. 4G.6**). Differences across groups in should be interpreted with caution.

Fig. 4G.6 Percent of adults ever told by a healthcare provider that they had a stroke, by sex and race/ethnicity, 2017-2023



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

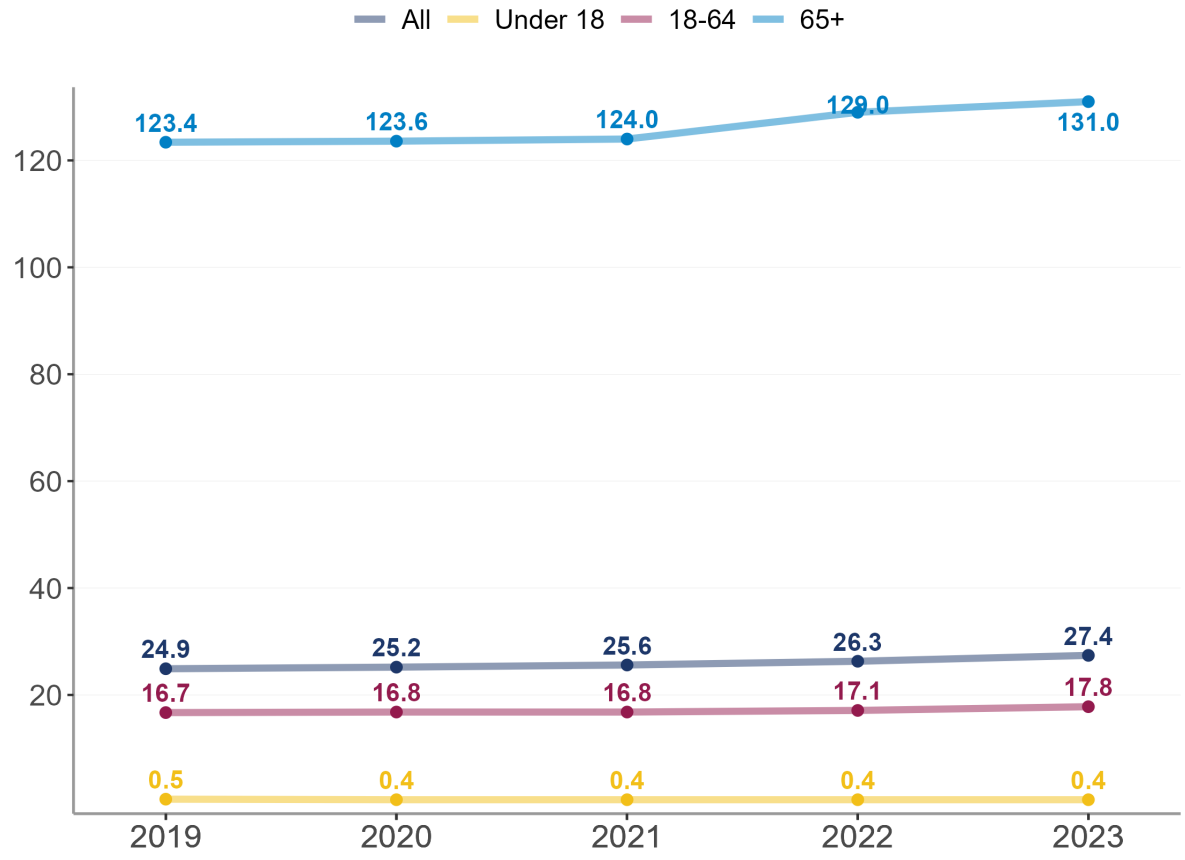
Cerebrovascular disease, or stroke, hospital discharge rates, shown as three-year averages per 10,000 Bexar County's residents, varied significantly by age and race/ethnicity (**Fig. 4G.7** and **Fig. 4G.8**). Most rates increased from 2019 to 2023 with varying fluctuation patterns across groups. The countywide rate increased gradually each year, from 24.9 in 2019 to 27.4 in 2023, averaging about 25.9 over the five-year period.

By age (**Fig. 4G.7**),

- Rates increased with age, with older adults (aged 65 and over) consistently experiencing significantly higher hospitalization rates, reaching a five-year high of 131 hospitalizations per 10,000 residents in 2023.
- Working-age adults (aged 18-64) had the second-highest rates, though still much lower than the rates for older adults (about 86% lower in 2023). Still, their rates increased modestly over time, from 16.7 in 2019 to 17.8 in 2023.
- In contrast, children and adolescents, aged 18 and under, had the lowest rates, starting at 0.5 in 2019 and holding steady at 0.4 from 2020 to 2023.

Fig. 4G.7 Cerebrovascular disease (stroke) hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



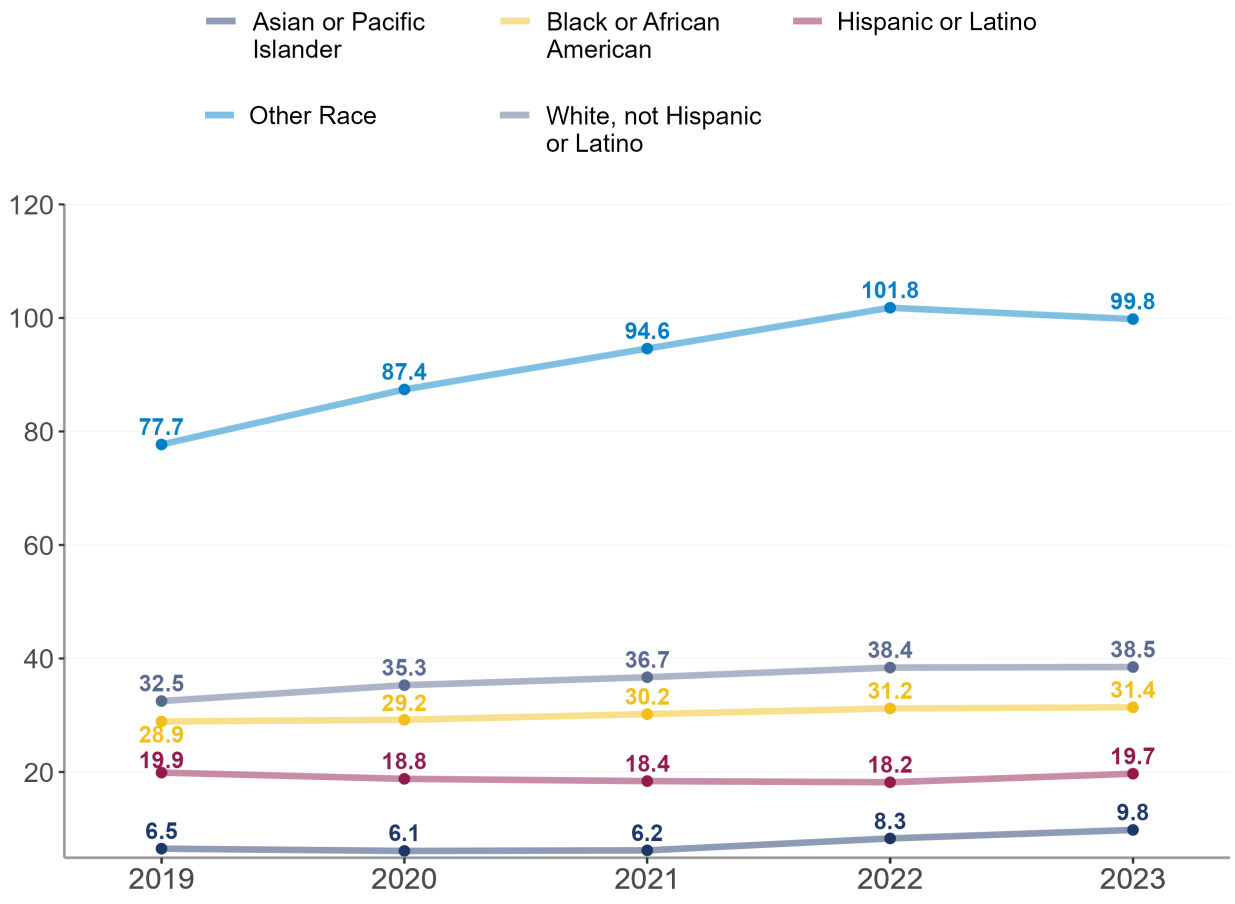
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

By race/ethnicity (**Fig. 4G.8**),

- The "Other race" category consistently had significantly higher hospitalization rates, steadily increasing from 77.7 in 2019 to 101.8 in 2022, before slightly declining to 99.8 in 2023. However, this should be interpreted with caution.
- Non-Hispanic white residents had the second-highest rates, with rates increasing steadily from 32.5 in 2019 to 38.5 in 2023.
- Black or African American residents also experienced increasing rates, from 28.9 in 2019 to 31.4 in 2023.
- In contrast, Hispanic residents experienced mostly declining rates through 2022 (18.2), followed by a slight uptick to 19.7 in 2023.
- The Asian or Pacific Islander group had the lowest rates overall, but their rates steadily increased from 6.1 in 2020 to 9.8 in 2023.

Fig. 4G.8 Cerebrovascular disease (stroke) hospital discharge 3-year average rate per 10K population, by race/ethnicity

Bexar County, Texas



Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

OTHER LONG-TERM HEALTH CONDITIONS

In addition to chronic illnesses like cancer, many individuals live with other long-term health conditions that require consistent management and care. Conditions like oral disease, asthma, and diabetes affect quality of life and place an ongoing demand on healthcare systems, ultimately affecting the community's overall health and well-being. These conditions often require ongoing management and can exacerbate other health challenges, underscoring the need for comprehensive care support and prevention efforts.

Oral Disease

Tooth loss from decay or disease reflects the burden of largely preventable conditions like cavities, as well as broader health disparities. Moreover, poor oral health is linked to chronic conditions like diabetes, heart disease, and stroke. Overall, about five out of eight (62%) Bexar County respondents reported not having had any teeth removed due to decay or disease (**Fig. 4H.1**).

Notably, the Far Northside (75%) and Far Northwest (67%) reported the highest proportions of individuals without tooth loss due to decay or disease. More specifically, the Far Northside figure was significantly higher than in both the Southeast and near Westside sectors, while the Far Northwest figure was significantly higher than the near Westside alone. Other differences across groups in **Figure 4H.1** and sectors in **Figure 4H.2** should be interpreted with caution.*

One CHNA Focus Group participant brought up how health insurance and dental care are two of many other costs to living a healthy life,

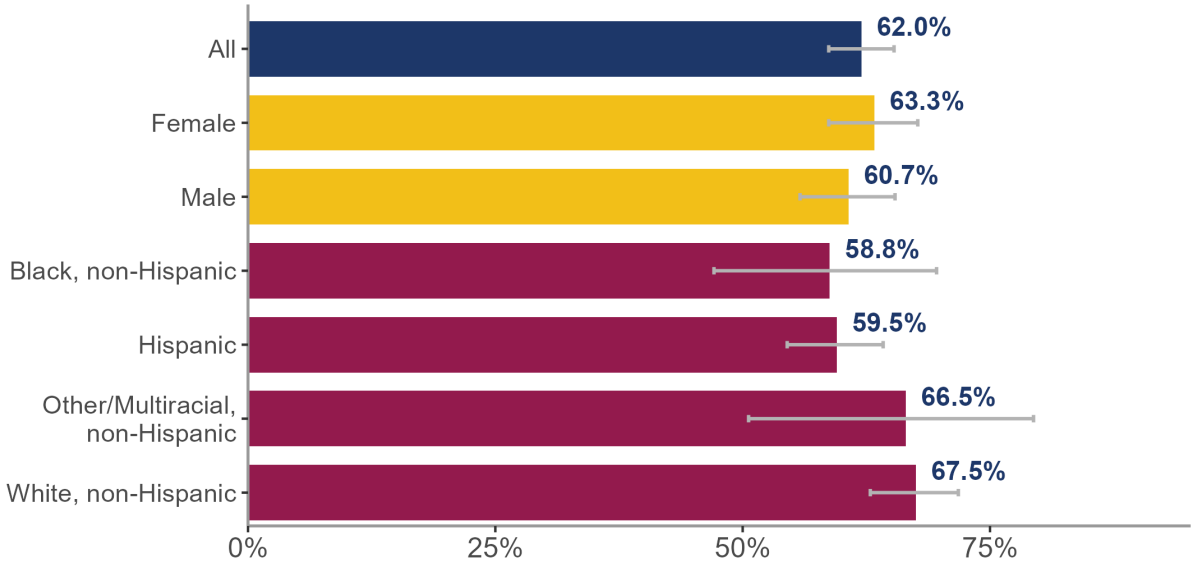
"Not a lot of people have the qualities that you need for food stamps you like literally have to be homeless, making $100 to even qualify for food stamps. You get food depending on how many heads you have in the house, and then, you need insurance, you need dental. If something happened, you need a car. You need gas. Gas isn't cheap, the way prices are going up. I mean, food isn't cheap, either, and then getting to and from work, and then having to pay your rent, and they give you an apartment that's one bedroom for a thousand dollars, and they send you to fail. And then you'd be stressed out. And it affects your mental health. When you apply for housing for the city, the waiting list is at least 5 years."

– CHNA Focus Group #2 Participant

* Differences among groups may not be statistically significant due to limited data or overlapping margins of error.

Fig. 4H.1 Percent of adults who have not had any teeth removed due to decay or disease, by sex and race/ethnicity, 2017-2023

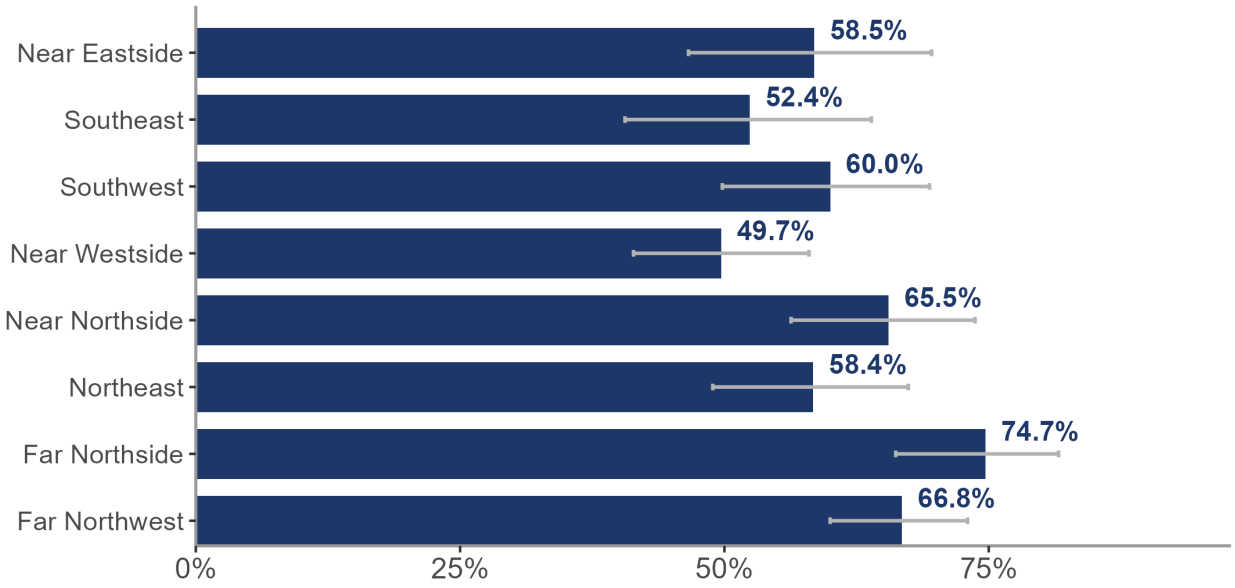
Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 4H.2 Percent of adults who have not had any teeth removed due to decay or disease, by sector, 2017-2023

Bexar County, Texas



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Asthma

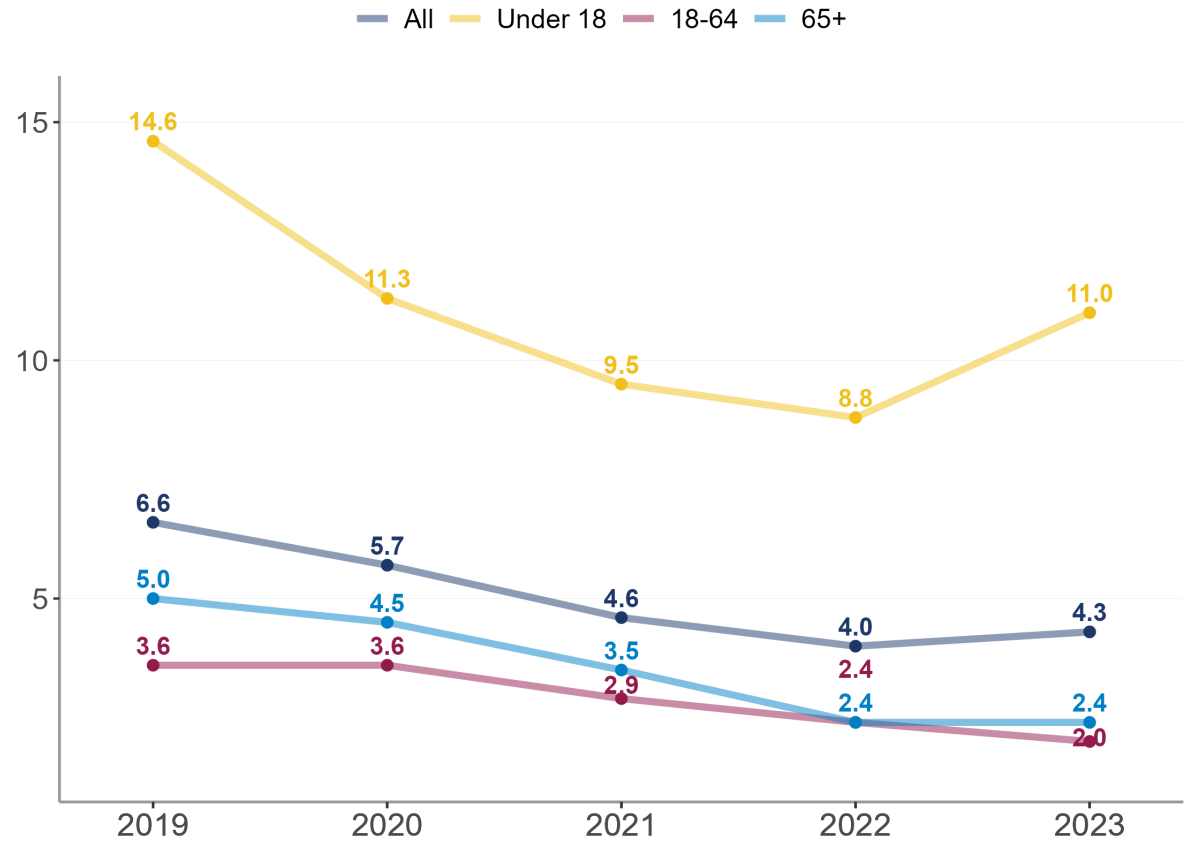
Asthma hospital discharge rates, shown as three-year averages per 10,000 Bexar County residents, varied significantly by age and race/ethnicity (**Fig. 4H.3** and **Fig. 4H.4**). Overall, the rates declined from 2019 to 2023 across most groups. The countywide rate dropped from 6.6 asthma hospitalizations per 10,000 residents in 2019 to a low of 4.0 in 2022, followed by a slight uptick to 4.3 in 2023.

By age (**Fig. 4H.3**),

- Children and adolescents (under 18) consistently experienced the highest rates across all age groups, with a five-year high of 14.6 hospitalizations per 10,000 residents in 2019. While rates steadily declined through 2022, they rose again in 2023 to 11.0, making this the only age group to experience a rebound.
- Adults aged 18-64 consistently had the lowest rates, declining from 3.6 in 2019 to 2.0 in 2023.
- Older adults, aged 65 and older, also showed a steady decline overall, leveling off at 2.4 per 10,000 from 2022 to 2023.

Fig. 4H.3 Asthma hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



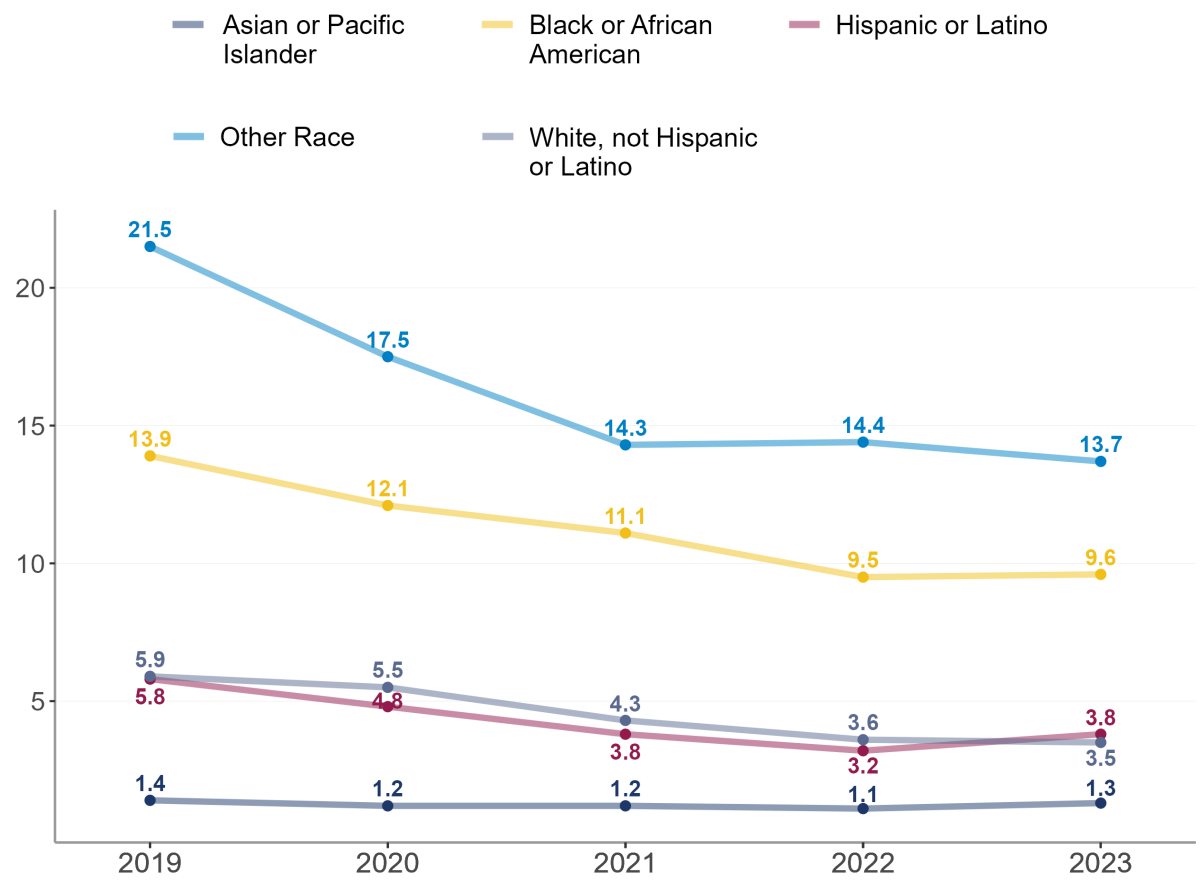
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

By race/ethnicity (**Fig. 4H.4**),

- The "Other race" category had the highest rates throughout the five-year period, starting at 21.5 in 2019 and gradually declining to 13.7 in 2023. Unlike other race/ethnicity groups, this group did not show an increase in 2023. However, this should be interpreted with caution.*
- Black or African American residents had the second highest rates, which decreased from 13.9 in 2019 to 9.5 in 2022, followed by a small increase to 9.6 in 2023.
- Both Hispanic and non-Hispanic white residents had lower and similar rates, ending at 3.8 and 3.5 in 2023, respectively.
- Rates among Asian or Pacific Islander residents remained the lowest and relatively stable, averaging around 1.2 hospitalizations per 10,000 residents across the five-year period.

Fig. 4H.4 Asthma hospital discharge 3-year average rate per 10K population, by race/ethnicity

Bexar County, Texas



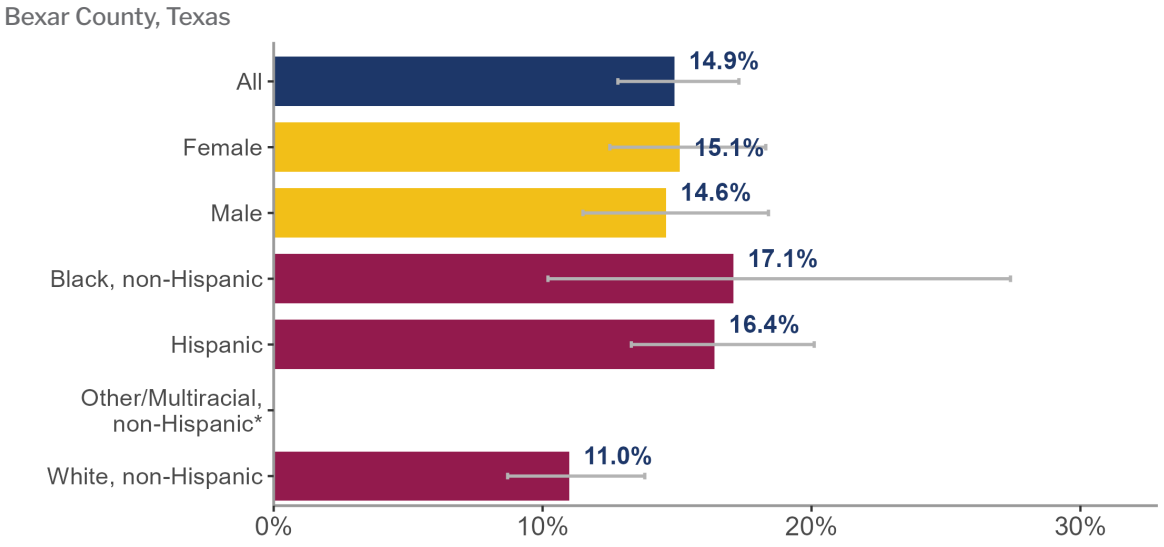
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

* Low counts for some race/ethnicity or other groups may create "bounce" in rates that exaggerates change over time.

Diabetes

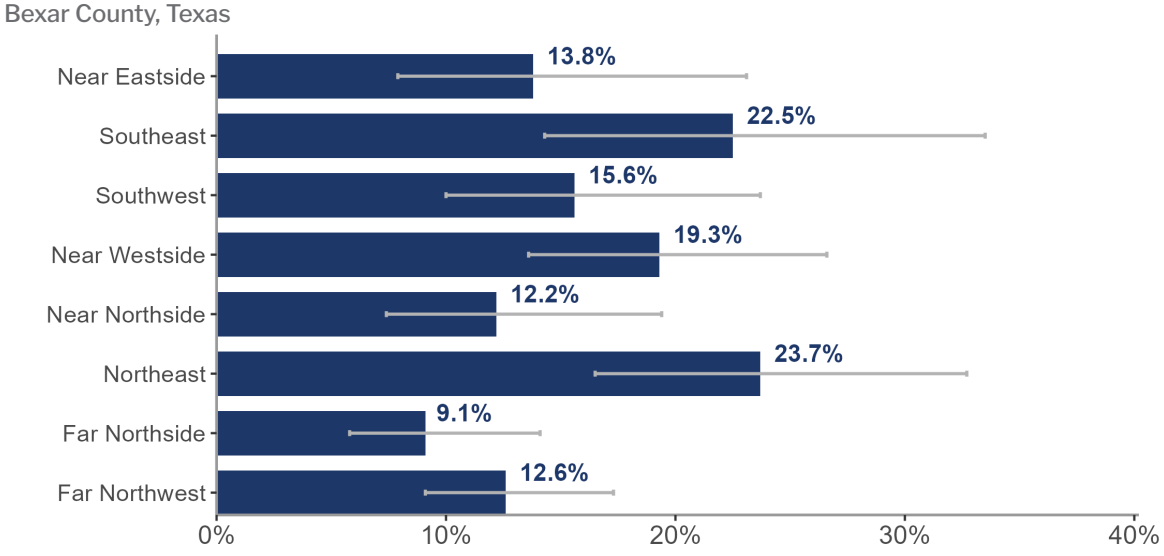
The BRFSS survey asks respondents if a doctor, nurse, or other health professional ever told them they have diabetes.[70] Overall, just over one in seven (15%) Bexar County respondents reported being diagnosed with diabetes (**Fig. 4H.5**). Notably, the Far Northside reported the lowest proportion of individuals with a diabetes diagnosis (9%), significantly lower than the Northeast (24%) and Southeast (23%) sectors (**Fig. 4H.6**).

Fig. 4H.5 Percent of adults ever told by a healthcare provider that they have diabetes, by sex and race/ethnicity, 2017-2023



*Unreliable: Error is too large relative to estimate.
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

Fig. 4H.6 Percent of adults ever told by a healthcare provider that they have diabetes, by sector, 2017-2023



Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CINow for The Health Collaborative

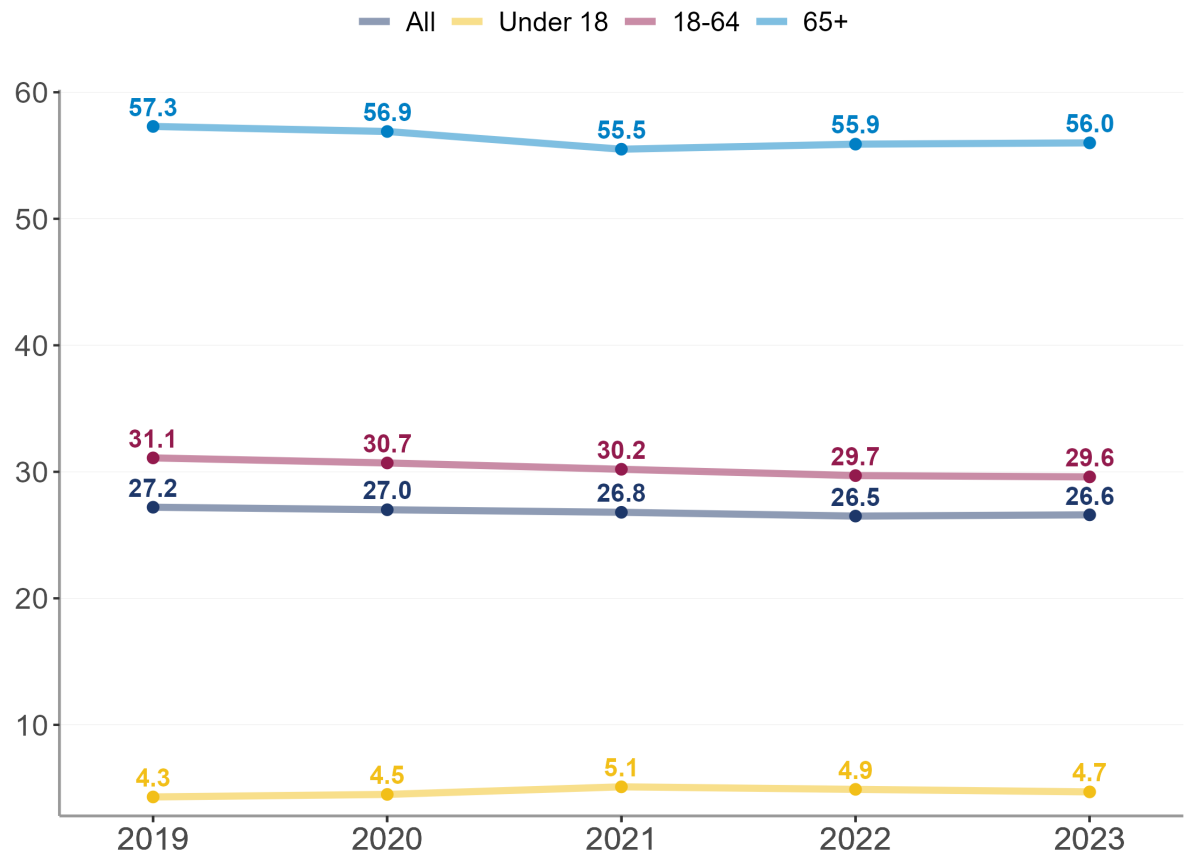
Diabetes hospital discharge rates, shown as three-year averages per 10,000 Bexar County residents, varied significantly by age and race/ethnicity (**Fig. 4H.7** and **Fig. 4H.8**). Most group rates remained relatively steady over the five-year period from 2019 to 2023, with varying fluctuation patterns between groups. The countywide rate ranged from 26.5 hospitalizations per 10,000 residents in 2022 to 27.2 in 2019, averaging about 26.8 over the five-year period.

By age (**Fig. 4H.7**),

- Rates increased with age, with older adults (aged 65 and over) consistently experiencing the highest hospitalization rates, reaching 56.0 in 2023, roughly in line with the five-year average for this group.
- Working-age adults (aged 18-64) had the second-highest rates and were the only age group to experience consistent year-to-year declining rates, falling from 31.1 in 2019 to 29.6 in 2023.
- Children and adolescents, aged 18 and under, had the lowest rates, averaging about 4.7 across the five years, the same as the rate reported in 2023.

Fig. 4H.7 Diabetes hospital discharge 3-year average rate per 10K population, by age

Bexar County, Texas



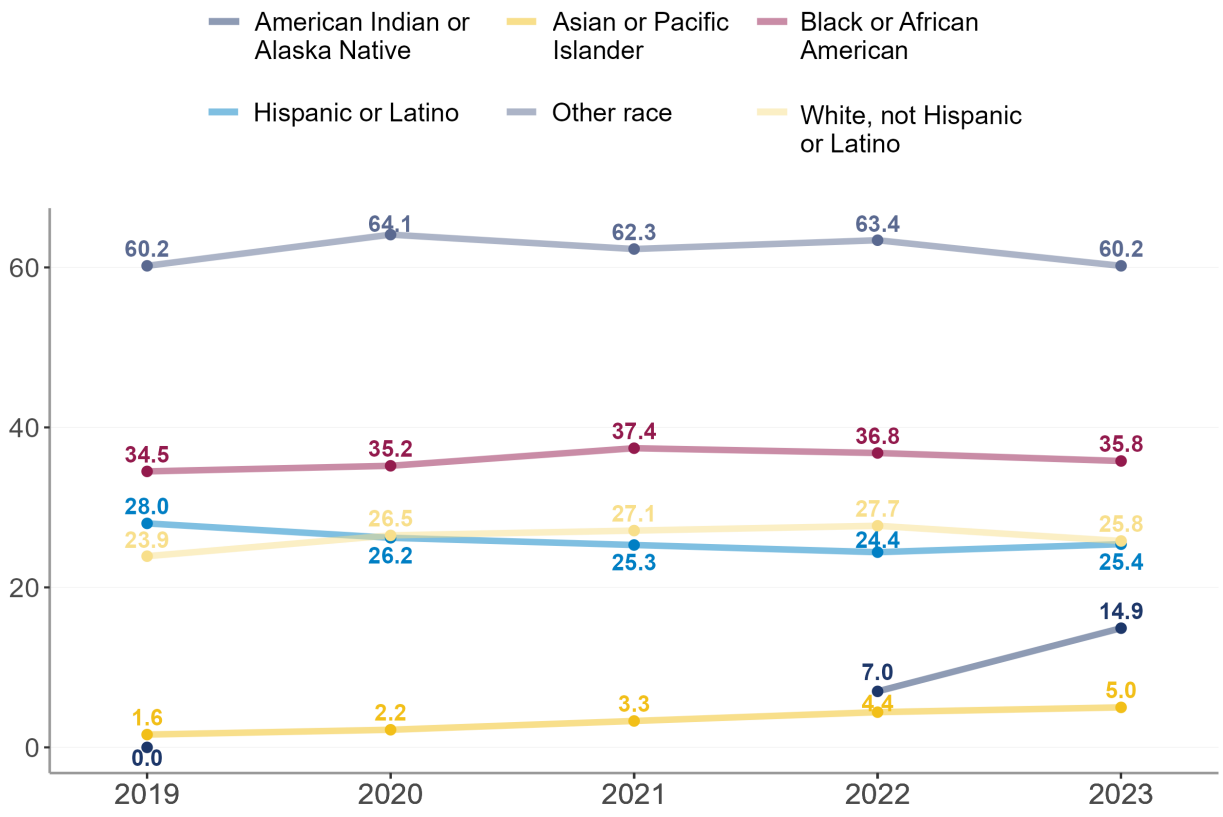
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

By race/ethnicity (**Fig. 4H.8**),

- The "Other race" category had significantly higher rates throughout the five-year period, ending at 60.2 in 2023. However, this should be interpreted with caution.*
- Black or African Americans had the second-highest rates, averaging about 35.9 per 10,000 residents.
- Both the Hispanic and non-Hispanic white populations had similar rates that closely mirrored the countywide averages.
- While the Asian or Pacific Islander residents had the lowest rates overall, they were the only group to show consistent annual increases, from 1.6 in 2019 to 5.0 in 2023, an over three-fold increase.
- Notably, data for the American Indian or Alaska Native group was limited due to low counts, with a rate of zero in 2019 and no reportable rates until 2022. However, the available data show the rate more than doubled from 7.0 in 2022 to 14.9 in 2023, though this variation may reflect small population sizes rather than a definitive trend.

Fig. 4H.8 Diabetes hospital discharge 3-year average rate per 10K population, by race/ethnicity

Bexar County, Texas



Some values are suppressed due to low counts.
Source: Texas Health Care Information Collection Hospital Discharge PUDF
Prepared by CINow for The Health Collaborative

* Low counts for some race/ethnicity or other groups may create "bounce" in rates that exaggerates change over time.

As the community confronts the ongoing challenges of chronic diseases such as diabetes, asthma, and heart disease, local leaders are increasingly recognizing the powerful role of nutrition and preventive care. Eric Cooper (San Antonio Food Bank) highlights the impact of innovative programs addressing these issues:

"We're doing some work around food as medicine and working with healthcare on getting people access to good nutrition, and some of that is showing some bright spots. Our cities struggled with high rates of obesity and chronic diseases like diabetes, hypertension, and heart disease. When we can leverage our ProduceRX! or our Farmacy, that kind of approach can really curb some of those chronic diseases, and get back to good nutrition and physical activity. It's really what it's all about."

– Eric Cooper (President/CEO, San Antonio Food Bank)

LEADING CAUSES OF DEATH

The following eight figures (**Fig. 4I.1 to 4I.8**) show the 10 or 15 leading underlying causes of death in the six-year period from 2017 to 2022 for females and for males of four race/ethnicity groups: Asian, Black or African American, Hispanic (of any race), and white. Heart disease and cancer are by far the most common causes of death among both females and males of every race/ethnicity group shown in these charts. The fact that those confidence intervals do not overlap at all with those of less-common causes of death in the charts presented here means there is a true and statistically significant difference among those death rates and death rates from less-common conditions in every one of the eight sex-race/ethnicity groups.

Although the leading death rates are suppressed for American Indian or Alaska Native males, heart disease and cancer are also the most common causes of death among American Indian or Alaska Native females. They are also most common among Bexar County residents of both sexes who identify as Native Hawaiian or other Pacific Islander or as of more than one race. COVID-19 ranked between third and fifth among the leading causes of death in every one of the eight sex-race/ethnicity groups charted, except white females, among whom it ranked seventh.

UNDERSTANDING THE DATA ON LEADING CAUSES OF DEATH

This section focuses on the leading causes of death for several sex-race/ethnicity groups. In these figu es, the gray line is the "95% confiden e interval", meaning there is a 95% chance that the true crude (i.e., not age-adjusted) death rate for that condition falls somewhere within the range indicated by the gray line. Thus, a shorter gray line indicates greater certainty about the true death rate.

The letters and numbers in parentheses after the name of the cause of death are the corresponding codes from the International Classific tion of Diseases, version 10 (ICD-10). Because these are crude rates rather than age-adjusted, these death rates should be made only within a single sex-race/ethnicity group (e.g., Hispanic females) rather than between sex-race/ethnicity groups.

Cancer deaths in both Asian females and Asian males were most commonly due to cancer of the lung, trachea, or bronchus (**Fig. 4I.1** and **4I.2**). Cerebrovascular disease like stroke and brain aneurism is the third leading cause of death among Asian females, but it appears that COVID-19 may be a more common cause among Asian males.

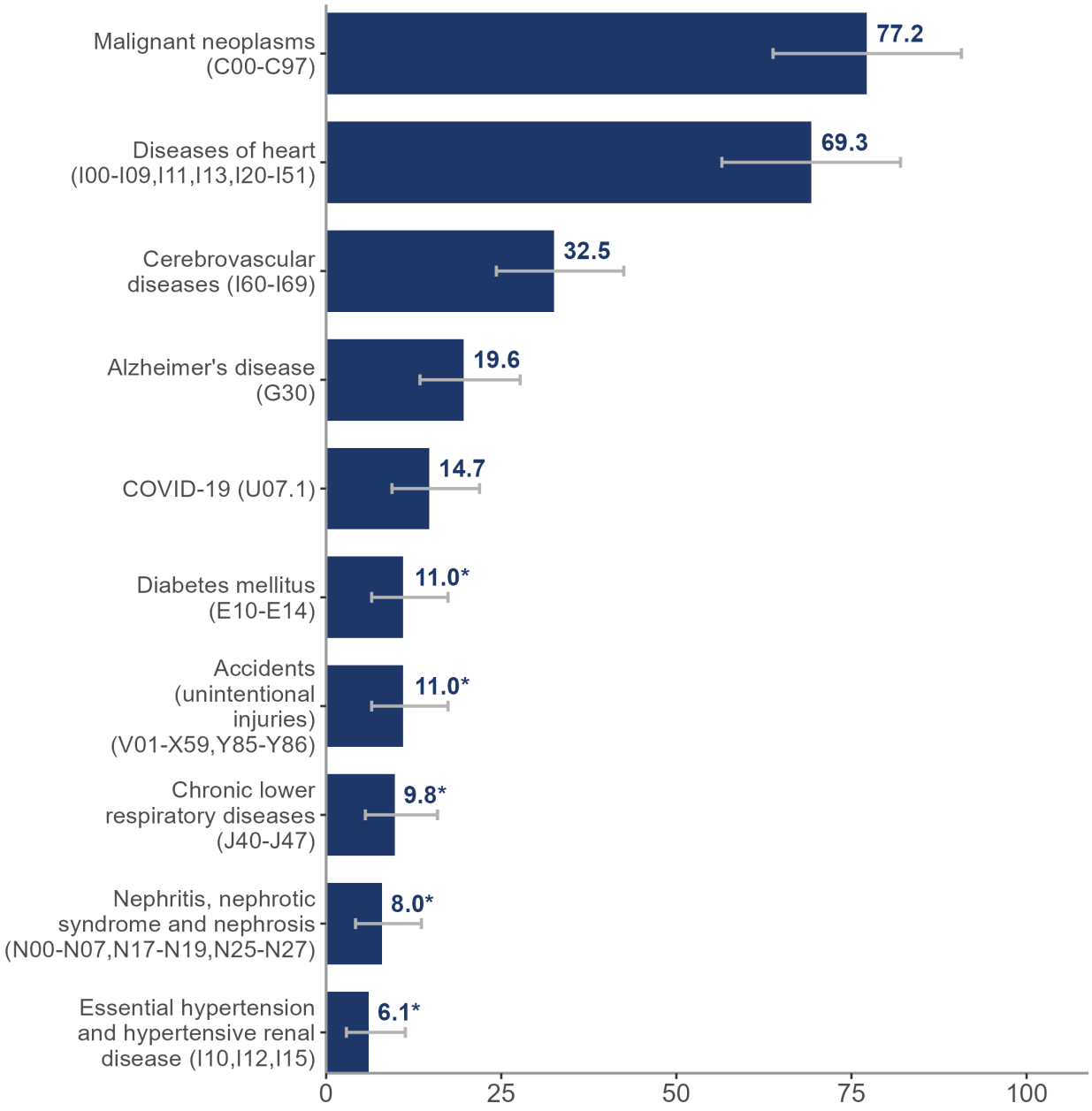
Cancer deaths among Black or African American females were most commonly due to breast cancer (29.3 deaths per 100,000 population); cancer of the lung, trachea, or bronchus (24.8); or pancreatic cancer (13.6) (**Fig. 4I.3**). Cancer of the lung, trachea, or bronchus (27.7) and liver cancer (10.7) were the most common fatal cancers among Black or African American males (**Fig. 4I.4**). Cerebrovascular disease (53.1) and accidents or unintentional injury (62.4) were the third-leading causes of death among Black or African American females and males, respectively.

Among Hispanic females, the most common fatal cancers were cancer of the breast (15.3 deaths per 100,000 population); cancer of the colon, rectum, and anus (10.0); and cancer of lymphoid, hematopoietic, and related tissue (9.7) (**Fig. 4I.5**). Liver cancer (15.9), cancer of the lung, trachea, or bronchus (15.8), and cancer of the colon, rectum, and anus (14.6) were the most common fatal cancers among Hispanic males (**Fig. 4I.6**). Beyond heart disease and cancer, COVID-19 was the third-leading cause of death for both Hispanic females (63.6) and Hispanic males (86.6).

The most common fatal cancer among both white females (44.1) and white males (52.8) was cancer of the lung, trachea, or bronchus (**Fig. 4I.7** and **4I.8**). The next-most common cancers among white females were cancer of the breast (33.7) and cancer of the colon, rectum, and anus (20.1). Among white males, it was cancer of lymphoid, hematopoietic, and related tissue (26.7) and prostate cancer (24.2). The third-leading causes of death among white females and white males were, respectively, Alzheimer's disease (87.2) and accidents/unintentional injury (80.0).

Fig. 4I.1 Death rate per 100K female Asian population, by top 10 leading causes of death, 2017-2022

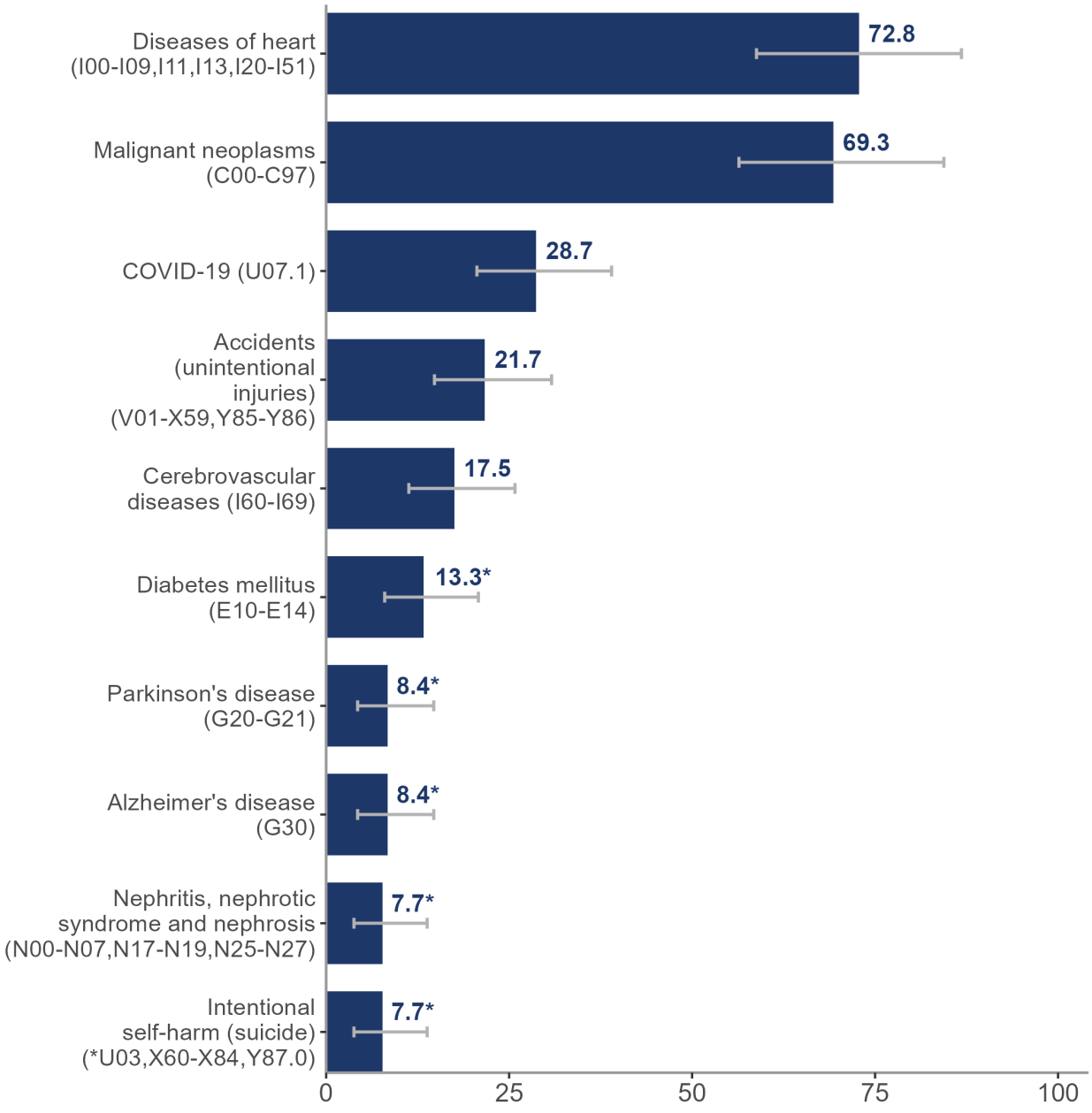
Bexar County, Texas



*Unreliable: Error is too large relative to estimate.
Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

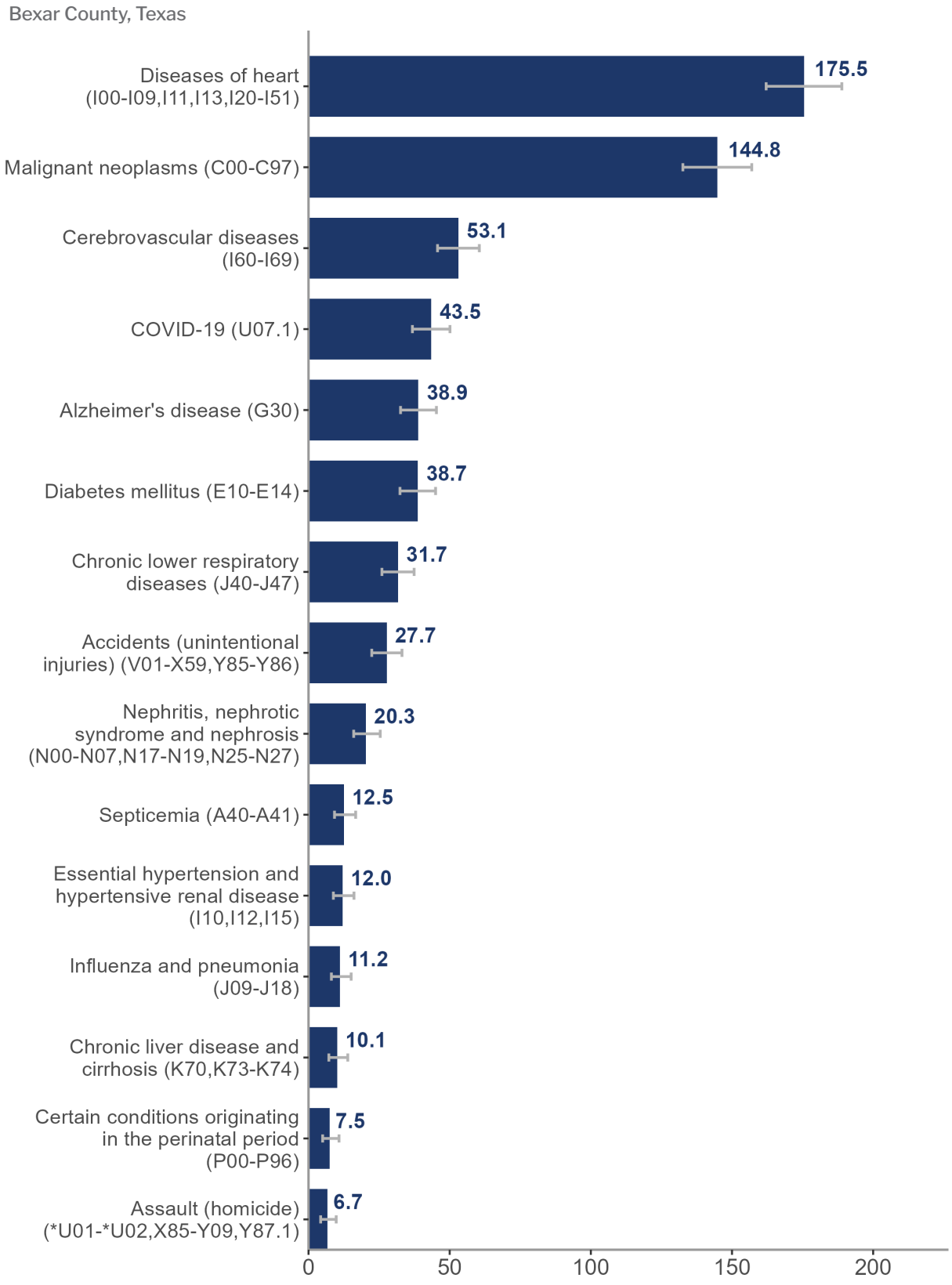
Fig. 4I.2 Death rate per 100K male Asian population, by top 10 leading causes of death, 2017-2022

Bexar County, Texas



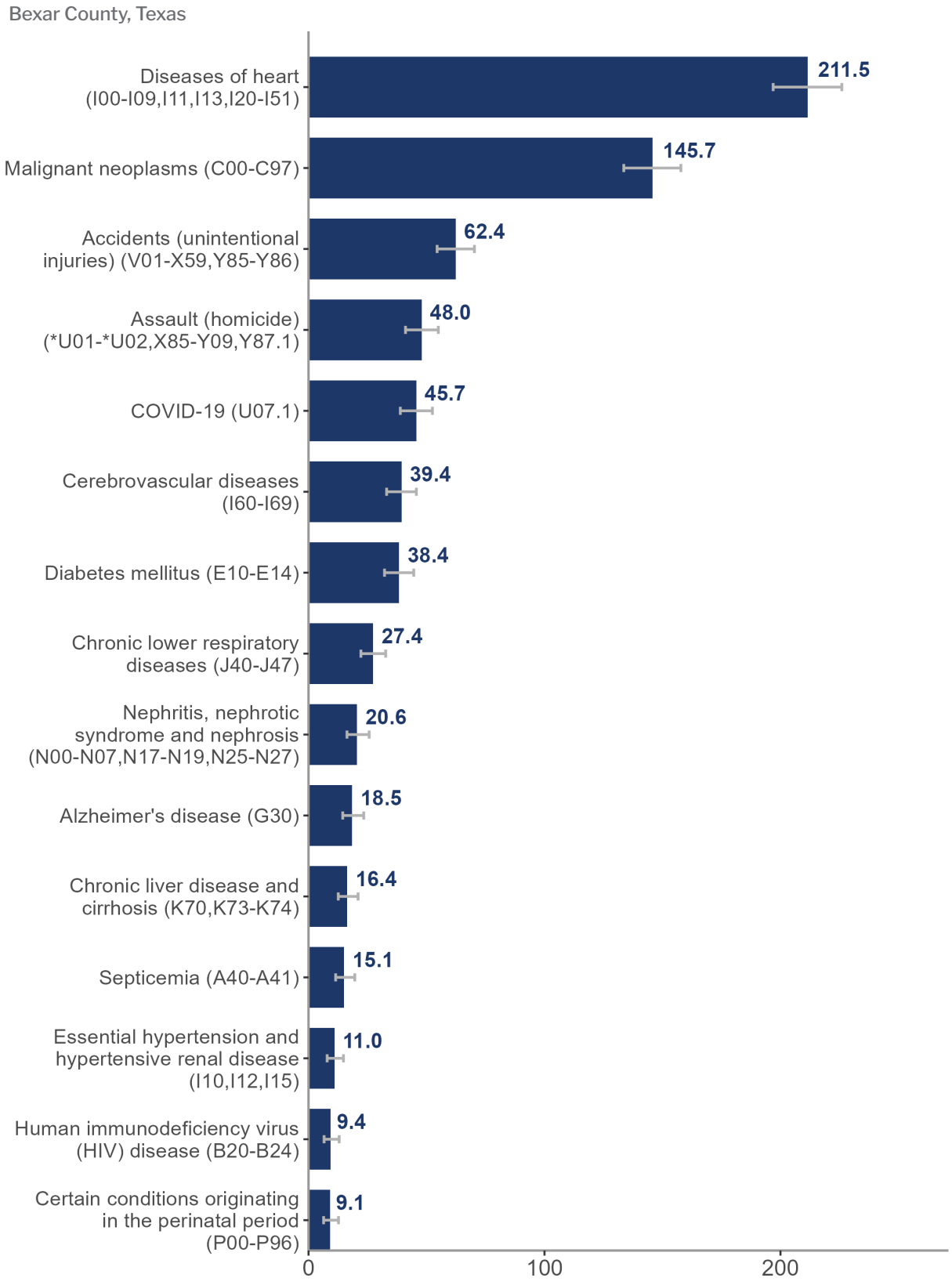
*Unreliable: Error is too large relative to estimate.
Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

Fig. 4I.3 Death rate per 100K female Black or African American population, by top 15 leading causes of death, 2017-2022



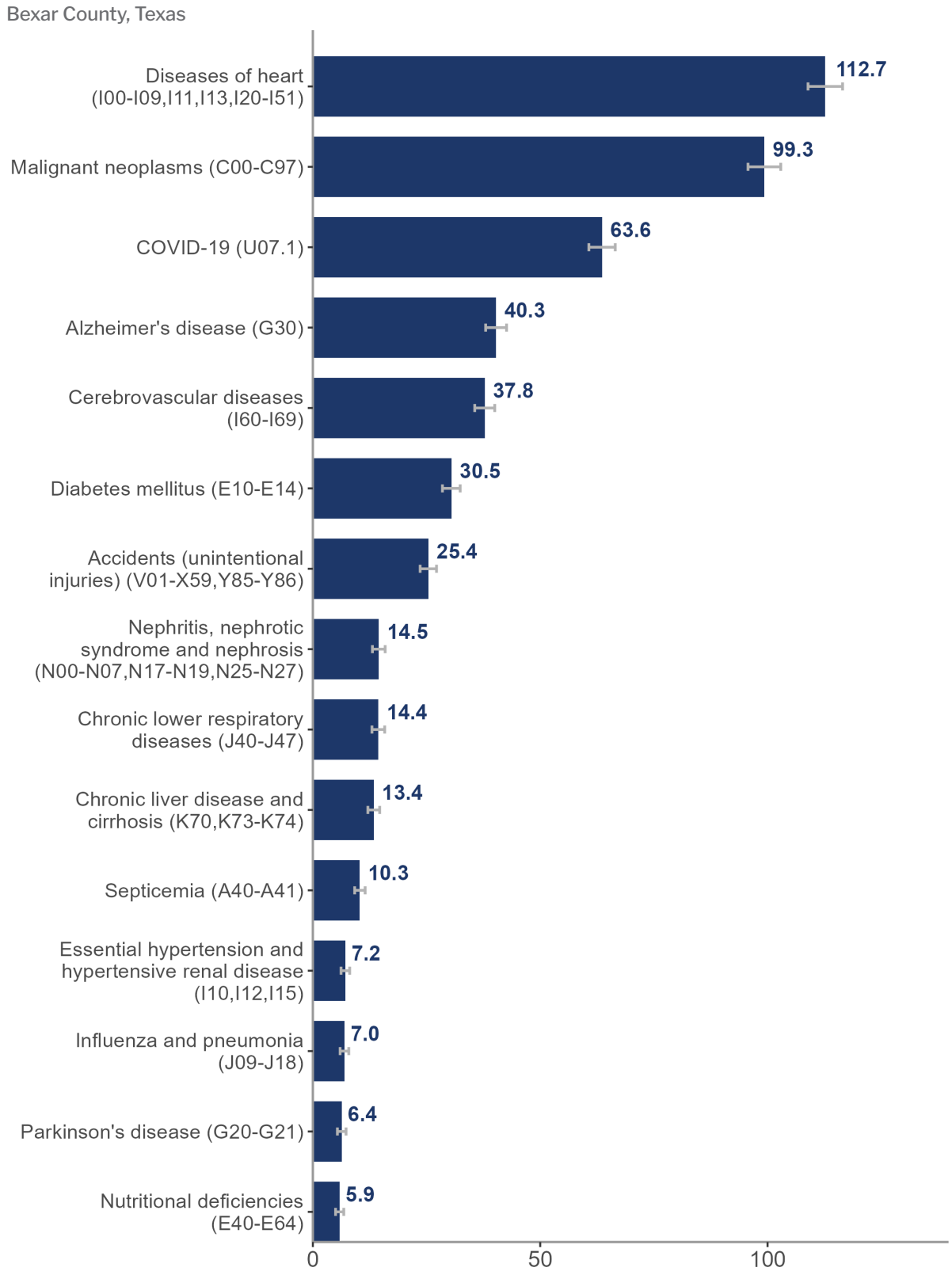
Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

Fig. 4I.4 Death rate per 100K male Black or African American population, by top 15 leading causes of death, 2017-2022



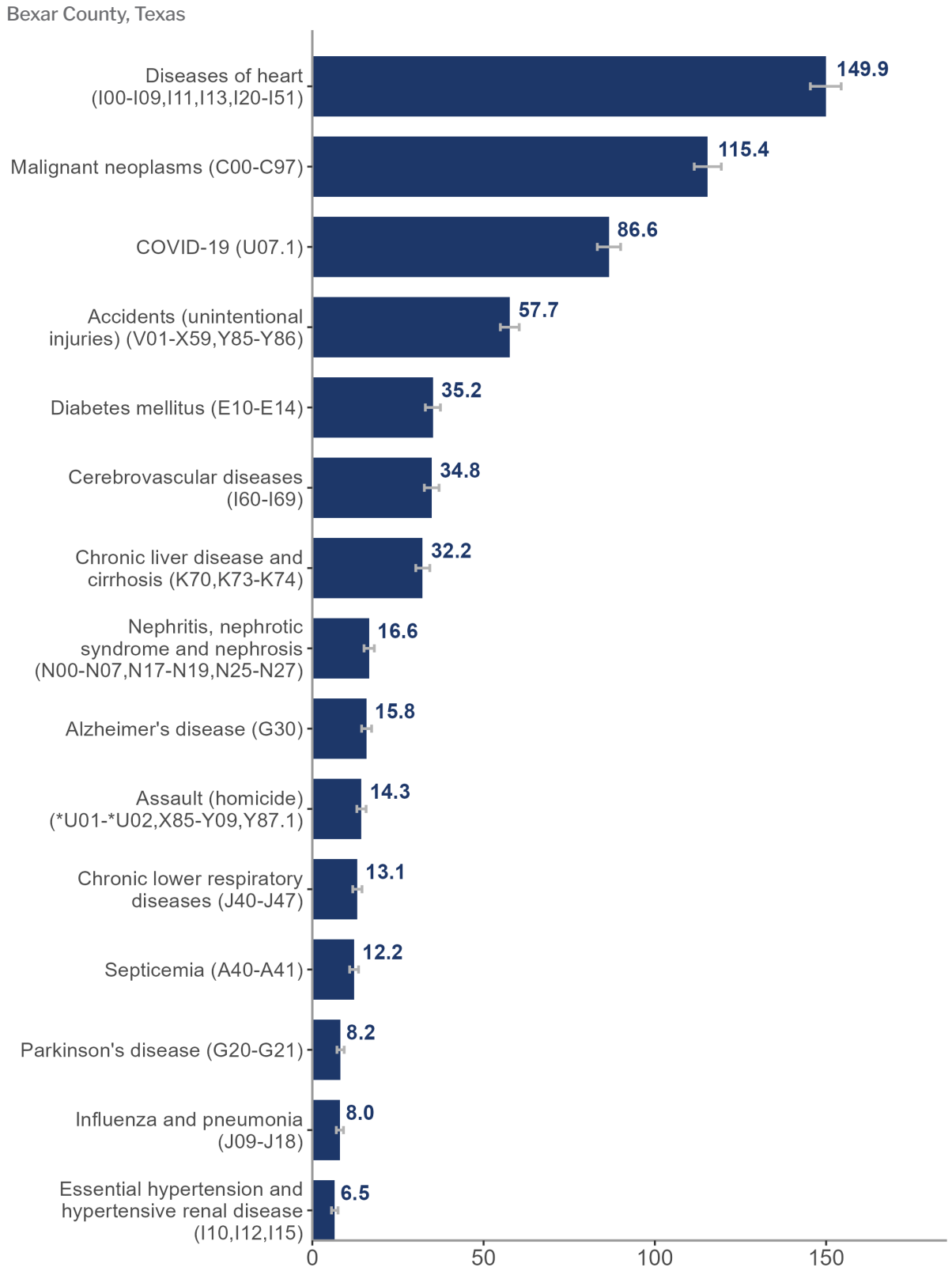
Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

Fig. 4I.5 Death rate per 100K female Hispanic or Latino population, by top 15 leading causes of death, 2017-2022



Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

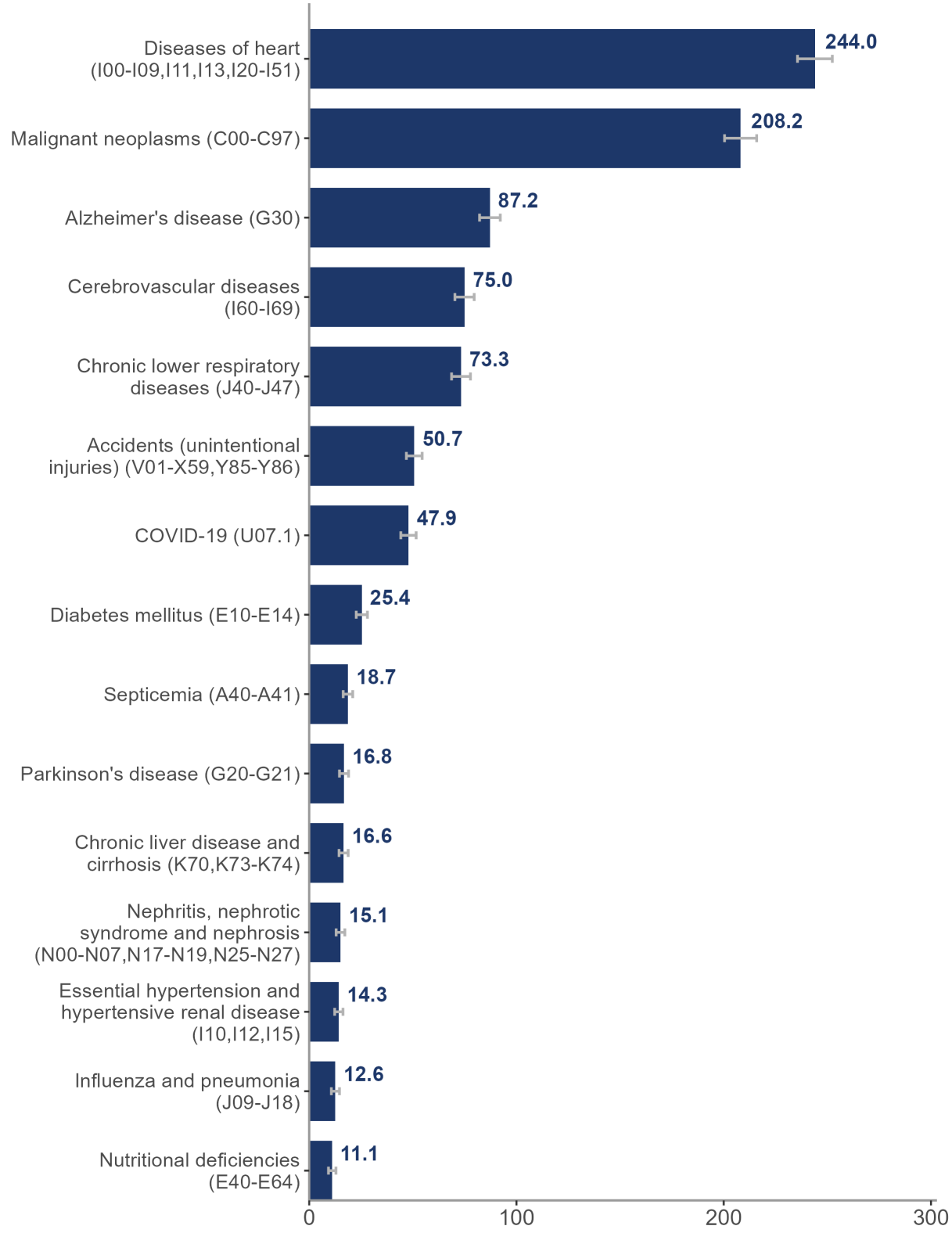
Fig. 4I.6 Death rate per 100K male Hispanic or Latino population, by top 15 leading causes of death, 2017-2022



Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

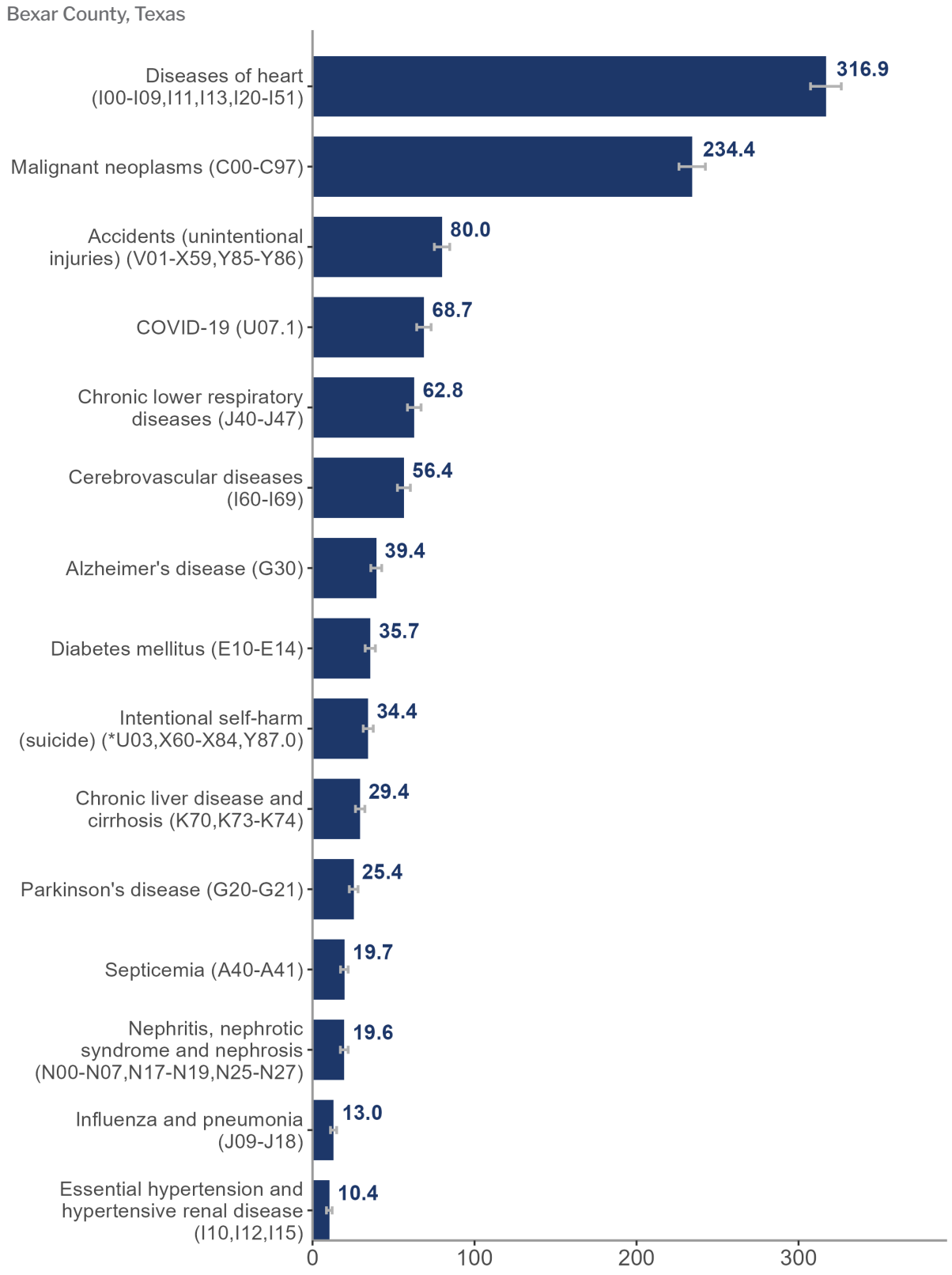
Fig. 4I.7 Death rate per 100K female white (non-Hispanic) population, by top 15 leading causes of death, 2017-2022

Bexar County, Texas



Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

Fig. 4I.8 Death rate per 100K male white (non-Hispanic) population, by top 15 leading causes of death, 2017-2022



Source: CDC WONDER Underlying Cause of Death File
Prepared by CINow for The Health Collaborative

IN CLOSING

The 2025 Bexar County Community Health Needs Assessment compiles about 100 indicators from extant (existing) data plus primary data collected through three methods: a community survey, resident focus groups, and system leader key informant interviews. This section of the report is intended to summarize and triangulate the issues and themes that rose to the top across all data sources.

SHARED AND DIFFERING PRIORITIES

This assessment does not try to rate or rank extant data indicators, but it was possible to qualitatively or quantitatively identify key themes and priorities from participants in the community survey, resident focus groups, and leader key informant interviews. The Health Collaborative's Board of Directors was also invited to review the draft report and identify the 10 or so issues they felt were relatively higher-priority for Bexar County's health and well-being, drawing on both their own experience and expertise and the data they had just reviewed. More information about that process is included in **Appendix B Technical Notes**. When priorities were ranked quantitatively, as in a survey question or a section of the prioritization tool, the top half are included here. Those emerging from qualitative data were identified during the thematic analysis using ATLAS.ti.

The following four tables synthesize and organize the priorities that were identified. Priorities that relate directly to the current Healthy Bexar County Community Health Improvement Plan priorities are shown in **magenta highlight**. This list is not intended to be either all-inclusive or prescriptive, but simply to help organize an enormous and diverse collection of data into information that can inform discussion and action.

> *"I want to emphasize the importance of closely examining population growth and shifts—particularly by age, race/ethnicity, and geography—and how these changes impact health outcomes and well-being. Given the rapid growth and diversification of Bexar County, this should be a high priority for public health planning and resource allocation. Also the importance of income and wages (inequities) and the need to address this."*
>
> **– Anonymous respondent to prioritization survey**

CROSS-CUTTING ISSUES

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Disenfranchised and Vulnerable People				
Disabled people	+	+		
Elderly	+	+	+	
Formerly incarcerated or on probation	+	+	+	
Immigrants/refugees		+	+	
People with language barriers		+	+	
People with substance use disorders	+	+	+	
Racial/ethnic minorities	+	+	+	
Rural areas, South Side, West Side, other geographic disparities	+	+	+	
Those in foster care	+			
Unhoused people	+	+	+	
Veterans			+	
Youth	+	+	+	
Disparities & Inequities				
COVID-19 raised awareness of systemic disparities		+	+	
Disparities, inequities				+
Funding and Policy Changes				
COVID-19: Organizational changes and funding/ resources			+	
Federal or state policy and funding environment				+
Local policy and funding environment				+
Organizational funding, and how it's affected by politics and government	+	+	+	
Philanthropy and volunteerism		+	+	
Local Communication & Coordination				
Collaboration between organizations	+	+	+	
Community outreach and participation		+	+	
Good communication with local leadership and knowing my voice is heard	+			
Lack of knowledge of community resources		+	+	
Respect and Discrimination				
Feeling accepted and respected by the people around me	+			
Prejudice (racism, sexism, etc.) or discrimination	+			

* **Priorities that relate directly to the current Healthy Bexar County Community Health Improvement Plan priorities are shown in magenta highlight .**

WHAT WE NEED FOR HEALTH

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Access to Care				
Health care provider shortages		+	+	+
Health insurance and medical costs	+	+	+	+
Quality medical care	+			
Quality mental health care	+			
Climate				
Extreme and hazardous weather	+			
Education, Training				
Education or training after high school	+			
Public libraries and educational programs and events	+			
Quality schools for children	+			
COVID-19 affected educational quality		+	+	
Educational attainment				+
Employment, Income, Financial Literacy				
Stable employment with good pay and benefits	+			
Childcare		+	+	
COVID-19 caused job loss		+	+	
Financial literacy			+	
Income and assets				+
Food				
Healthy fresh foods	+			
Food security	+	+	+	+
Green Spaces and Recreation				
Outdoor greenspaces like parks and public land	+			
Safe spaces to exercise and be physically active	+			
Housing				
Housing availability, affordability, and diversity	+	+	+	
Stable and quality housing				+
Safety				
Safety	+	+		
Feeling and being safe while driving	+			
Social Environment				
Social Determinants and interconnected social issues (including education, employment, economic mobility, healthcare, built environment and infrastructure, transportation, walkable areas, and potable water access)	+	+	+	
Transportation that's easy, safe, reliable	+			

HOW WE'RE TAKING CARE OF OURSELVES

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Access to Care				
Applying for services, meeting service criteria, long waitlists, and lack of knowledge of resource availability		+		
COVID-19 drove telemedicine, remote work, and technology	+	+	+	
Healthy Eating and Weight				
Healthy eating				+
Healthy weight				+
Preventive Care and Self-Management				
Childhood vaccinations				+
Diabetic self-management (e.g., foot & HbA1c checks)				+
Health literacy, preventive care, and coordination of care				
Physical activity				+
Routine checkups / wellness visits				+
Routine dental care				+
Screening for breast cancer				+
Screening for cervical cancer				+
Social Support				
Connections with people I/they can count on for help when I/they need it	+			

> *"All should be a high priority. How can you have one without the other? It's all connected."*
>
> **– Anonymous respondent to prioritization survey**

HOW WE'RE FARING

ISSUE OR THEME	EMERGED AS HIGH PRIORITY FOR			
	Survey Respondents	Focus Group Participants	Key Informants	THC Board
Activity Limitations and Disability				+
Alcohol or Substance Use	+			
Substance abuse				+
Alzheimer's or Other Dementia	+			
Autoimmune Disease (Lupus, MS, Rheumatoid Arthritis, etc.)	+			
Cancer	+			
Breast cancer				+
Colon and rectum cancer				+
Liver cancer				+
Prostate cancer				+
Chronic Pain (Back Pain, Joint Pain, Fibromyalgia)	+			
Dental (Tooth or Gum) Problems	+			
Diabetes	+			+
Heart Disease, Stroke, or High Blood Pressure/ Hypertension	+			+
Maternal & Infant Health				
Early and ongoing prenatal care				+
Infant mortality				+
Severe maternal morbidity, maternal mortality				+
Mental Health				
COVID-19 harmed mental health, stress, social interaction	+	+	+	
Depression, anxiety, PTSD, or chronic stress	+			+
Loneliness or social isolation	+			
Other mental illness				+
Sexually Transmitted Infections				
HIV/AIDS				+
Syphilis, congenital syphilis				+

> *"Disparities? That's a conversation"*
>
> **– Anonymous respondent to prioritization survey**

CONCLUSION

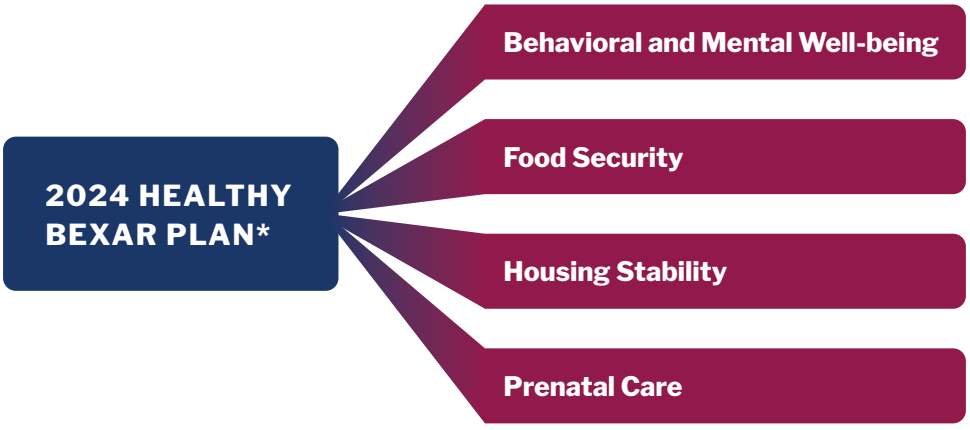
The reader of this community health needs assessment will draw their own conclusions about what most stands out in the wealth of Bexar County information presented here, and what challenges and opportunities present themselves. For the authors of this report, however, a handful of big-picture conclusions emerge.

We are far from recovered from the COVID-19 pandemic. Our community continues to suffer the social, economic, and health harms caused directly and indirectly by the pandemic. While it has stopped climbing, the inflation rate remains stubbornly high, contributing to the high cost of basic goods and services. The housing and job markets remain unbalanced and unstable, and data that paints anything less than a rosy picture is under attack in some quarters. After improving rates of many health-related behaviors in the years leading up to the pandemic – for example, preventive care utilization like prenatal care and school-age vaccinations – those gains have slipped away. Some public health problems are markedly worse than before the pandemic; two ready examples are vaccine hesitancy and pervasive distrust of science and government.

A large proportion of our community is suffering mentally and emotionally. Concern about mental health was a steady drumbeat in survey responses, focus group discussions, and key informant interviews. Mental health challenges are widespread across demographic groups and neighborhoods, and appropriate care is not easy to access even for those with insurance and the means to afford out-of-pocket expenses. And of course, as with chronic physical illness, chronic depression, anxiety, and other mental illness turn the things we most need to do for ourselves – physical movement, for example, and healthy eating and preventive care – the very hardest things to do.

Basic needs and root causes demand our attention. Whether we call them social determinants of health or non-medical drivers of health, we have to talk about them. Issues like food security, decent housing, jobs with a livable wage, and literacy/education are all non-negotiable foundations of health and well-being – not sufficient, but certainly necessary. Like poor mental health, food insecurity and housing instability cropped up again and again in conversations with community members. The same was true for extreme weather, whether unrelenting and concentrated heat, extreme cold as in 2021, or deadly flooding as in recent months. All of these factors intersect, and as a rule, whether a pandemic or a flood or a freeze, it is already-vulnerable people who are hit hardest by disasters and who face the greatest barriers to recovery.

To end on a more positive note, work is already well underway on many of the priorities identified here. Multiple coalitions are tackling mental illness and food insecurity, for example, and several initiatives are addressing varied aspects of the housing shortage. Starting this fall, workgroups will convene around the four priority areas in the **2024 Healthy Bexar Plan**:[71] behavioral and mental well-being, food security, housing stability, and prenatal care.



ABOUT THE HEALTH COLLABORATIVE AND CINOW

Health Collaborative
Bexar County's Community Health Leadership

As it has been for 28 years, this Bexar County Community Health Needs Assessment was organized 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, Bexar County Public Health, CHRISTUS Santa Rosa Health System, the City of San Antonio Metropolitan Health District, Community First Health Plans, Methodist Healthcare Ministries of South Texas Inc., Methodist Healthcare System, Texas A&M University - San Antonio, University Health, the UT Health Science Center at San Antonio (UT Health San Antonio) Department of Family & Community Medicine, 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 provide those services instead represent the general community; the faith-based community; and small, veteran-, and minority-owned business.

CINow
COMMUNITY INFORMATION NOW

Community Information Now (CINow) is a San Antonio-based nonprofit local data intermediary dedicated to ensuring that Bexar County and other Texas communities can access, understand, and use local data to improve community conditions. CINow discovers, collects, links, analyzes, and communicates trustworthy local data on dozens of issues that matter to communities, and we provide training and other supports to help people access and use the data. Via a unique community-academic partnership formed in 2008, our core data staff are contracted through the University of Texas Health Science Center at Houston (UTHealth Houston) and housed at its 46-year-old School of Public Health in San Antonio. The CINow staff who contributed to this assessment are, in order of length of service, Laura McKieran, DrPH; Jeremy Pyne, MPA; Danequa Forrest, PhD; Jeanette Parra; and Natalia Rodriguez, MPH. Learn more about CINow and find a wealth of Bexar County data at CINow.info.

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APPENDIX A: SUMMARY OF THEMES

FROM FOCUS GROUPS, INTERVIEWS, AND THE COMMUNITY SURVEY

INTRODUCTION

The 2025 Community Health Needs Assessment (CHNA) is a mixed-methods overview of health-related indicators in Bexar County, sponsored by The Health Collaborative with data collected, analyzed, and summarized by Community Information Now (CINow). To complement the quantitative measures, CINow collected qualitative data to offer a broader perspective on health and wellbeing in Bexar County. The qualitative summary consists of a thematic analysis of four focus groups (with a total of 46 participants), an open-ended survey question (with 62 responses), and six key informant interviews with community leaders who serve Bexar County. The full qualitative narrative is divided into two main parts: 1) What is the Community Saying?: Focus Groups and Survey Results, and 2) What are Community Leaders Saying?: Key Informant Interview Results. While there is much overlap in the themes discussed in both sections, the first section takes a more micro-perspective on day-to-day behaviors and experiences that community members experience, and the second section takes a more macro-perspective on the systems that created the conditions for these themes. Themes for both are outlined in the Conclusion.

METHODS

CINow held four focus groups, with one being in both Spanish and English. Three of the focus groups were held at churches, and one was online through Zoom. All, except the online focus group, included an interactive activity where

themes were mapped on a large white board throughout the focus groups session, which helped encourage more conversation and kept discussion focused on how multiple themes influence one another. All focus groups were about 1.5 hours long, and participants were compensated by The Health Collaborative for their participation. Zoom was used to transcribe all the focus groups for thematic analysis. There were a total of 46 participants across all the focus groups, and the focus group guide is in Appendix B.

Between February and May, 2025, The Health Collaborative and CINow launched a survey asking community members in Bexar County various health and health-related questions. Of the 142 total responses, 62 of them responded to the open-ended question "What other thoughts do you have about health and well-being in our community? What do you wish health departments, hospitals, health care providers, nonprofits, and/or local governments knew and understood?", which was analyzed thematically and folded into the focus group results due to overlap in themes. The similarities and differences between the focus groups and the open-ended survey responses are outlined in the first section of the qualitative analysis.

CINow interviewed six key informants to get the perspective of community leaders across Bexar County. They included Adrian Lopez with Workforce Solutions Alamo, Edward Banos with University Health, Eric Cooper with the Food Bank, Antonio Fernandez with Catholic Charities, James Wesolowski with Methodist Healthcare Ministries of South Texas, and a confidential Key Informant with an organization that serves vulnerable people in crisis.

For the focus groups, open-ended survey responses, and key informant interviews, CINow performed a qualitative thematic analysis in Atlas.ti using open coding to identify all themes, axial coding to iteratively categorize themes into major vs sub-themes, and selective coding to extract the final themes for write-up. The Key Informant Interviews (KIIs) were analyzed separately from the focus groups and open-ended survey responses because 1) They are different types of participants, with the focus groups and survey aiming for an audience of community members, and the KIIs being community leaders, and 2) The Key Informants were asked different questions based on their positions in the community, which would lend to their qualitative data having specific differences from the community members. While section one of the qualitative narrative focuses on community members, you will notice similarities with section two because community leaders identified similar themes, but from a broader, more organizational perspective. For this reason, themes are presented in different orders between sections one and two, as the topics emerged from distinct contexts.

WHAT IS THE COMMUNITY SAYING?

Focus Groups vs. Survey Respondents

Of the 145 survey responses for Bexar County, 62 of them included open-ended answers to the question "What other thoughts do you have about health and well-being in our community? What do you wish health departments, hospitals, health care providers, nonprofits, and/or local governments knew and understood?" While the recruitment, questions, and data collection methods were very different for the focus groups versus the survey, it is notable that some of the qualitative responses mirror each other. This bolsters and validates the significance of each, particularly because these were completely different groups of people. The focus group participants were intentionally recruited by The Health Collaborative to be representatives of their communities. Due to the location, length, and time of the focus groups, many of the participants were older and retired. For the survey, any community member could have potentially participated, as the survey didn't have the same time constraint as the focus groups due to it being asynchronous. Yet, despite these being different people who were asked different questions, there were some similarities in their health priorities, concerns, and barriers. Where relevant, these similarities (and some of the differences) are expanded upon in the overall qualitative themes that emerged from the focus groups and survey open-ended results.

Disenfranchised Communities and Vulnerable Populations

Woven throughout all of the other themes that emerged during the focus groups and survey open-ended responses was the sentiment that health disparities are multiplied for the most vulnerable members of the community. Anytime participants spoke about difficulties surrounding COVID-19, medical barriers, community support and resources, safety, mental health, housing, extreme weather conditions, transportation, food security, or almost any other topic – they also discussed how all of these are exacerbated for disenfranchised, excluded, or "forgotten about" populations. This included youth, the elderly or those living in assisted living, unhoused people, disabled populations, and those who were formerly incarcerated and/or on probation. The open-ended survey responses echoed the same vulnerable communities discussed in the focus groups, with the addition of LGBTQ+ people as well.

YOUTH

Many of the concerns for youth and younger adults were around quality education, having safe spaces to engage with each other, and their mental health, particularly during and after the height of the COVID-19 pandemic. During Focus Group #1, a participant explained how they were concerned about how youth would be affected by education cuts. ***They were worried that "education for children is not the way it used to be" because "they went from having classrooms of 18 to having classes of 32 kids,"*** thus overwhelming teachers and decreasing the individual quality of each student's education.

Better education and safe spaces for kids

> *"We need to bring back the DARE program into schools... if they were to shut down all the smoke shops around here and put in like a resource center for our community, or learning centers. You know, where they have computers. They need safe places where they can explore, like sports activities where they can go to a safe place to play sports. Because I know there's some kids that want to go to the gym, but they can't even afford it, because you have to be a member. You have to pay for it. We need some affordable gyms, and in general, like safe places for children and families."*
>
> **– FG #1 Participant**

Foster care youth and their outcomes related to homelessness, education, unplanned parenthood, incarceration, mental and physical health, safety, poverty, social relationships, and healthcare

> *"I wish health care and local government staff knew the extreme inequity for youth aging out of foster care. At times, they exit the system into homelessness (1 in 4) which can lead to systemic distrust, inability or lack of knowledge of benefits that are owed them, abysmal college degree attainment rates (~3%), and higher rates of unplanned or early parenthood (1 in 10 - aged 17 to 19 yrs & 1 in 4 - aged 19 to 21), increased incarceration rates (1 in 5). This, in conjunction with academic gaps, mental and physical health, engagement in safety and risky behaviors, and subpar wellbeing--prevalent poverty,*

lack of community/family relationships, education, and healthcare collide to change the trajectory of youth with experiences of foster care. There is a need for additional youth-specific programming for emergency housing and transitional housing in Bexar County. Also, this information needs to be clearly communicated widely via bus wraps, roadside signs, training healthcare and other professionals on the resources available. I do hope we will make an intentional effort to support youth with experiences of foster care in an excellent way."

– Survey Respondent

Covid, isolation, and mental health services for young adults

"I think that Covid, for everybody really affected a lot of people's mental wellness, especially younger folks... When I say younger generation, probably 17 to 27... that isolation and that trauma has not been dealt with. We still need mental healthcare services, especially from the trauma that probably brought."

– FG #2 Participant

Education, social media, and attention spans of youth

"I was a substitute teacher a year ago for middle school, and there are 6th graders that couldn't even read at a 6th grade level. And it was because those couple years when they were in those very vital learning stages of reading, they were online [during COVID-19 remote school]. And not even just that, but social media and stuff with their attention span, like they're so used to watching 30 second, 1-minute videos. And then like endless scrolling. Being able to pay attention for long periods of times, it also affected them that way."

– FG #3 Participant

Safe spaces for teens

"I wish there were more healthy restaurants in the area and safe places for teens to hang out."

– Survey Respondent

Job opportunities for teens

"[We need] opportunities for teens to keep them off the streets, like maybe interning or job opportunities for teens."

– FG #3 Participant

OLDER ADULTS

Elderly people and those in assisted living were discussed as being particularly vulnerable to extreme weather conditions, the effects of COVID-19, and having difficulties with medical services. What often made the difference in their access to care was the strength of their social networks, including family and friends

Extreme weather assistance for elderly people

"You know what they should do is help people during the summer with their electric bill, because it is so hot. Some people cannot afford to turn on their air condition, or to buy an air condition, or to buy a fan - a good fan, not the box fan, because the box fans really don't throw air, and you can't put them in your window if you live in an apartment, because they don't allow that, and you can't sleep with your windows open. They need to learn to help people with a with their air condition, give them out or help them pay their bill, especially elderly people."

– FG #3 Participant

Covid-19, isolation, and social support or elderly people and those who are immunocompromised

(From a self-identifying older participant): *"When Covid hit, I literally was my own prisoner in my house. I would not go nowhere. My youngest daughter, she let sometimes have my groceries sent to my house, so I wouldn't have to go to the store. Yeah, because I have a lot of problems. And they were afraid that if I go out I'm going to get Covid, because my immune system is so bad, I will get it like that. Nobody can pass by me without me getting sick. So, she would tell me, 'if you need groceries, let me know. I will have it sent to your house.' and she would. You know they don't talk about it that much, but Covid's still out there, and I rarely go anywhere unless I got to go to H-E-B. Pick up my medicine or buy some groceries at Sam's. The only place I ever go is those 2 stores."*

– FG #3 Participant

PEOPLE WITHOUT STABLE HOUSING

Participants felt very strongly about helping unhoused people. This topic overlapped with many others, often branching into general conversations about housing costs and availability, which are outlined later, as well as food access, perceptions of safety, mental health, and outreach efforts. Churches sometimes target their efforts towards helping unhoused people, and 2/3 of the Bexar County English focus groups were held at churches, which contributed to how attuned participants were with the needs of unhoused people in their communities. They discussed how some of the unhoused populations are veterans with low resources, disabled, or have mental health needs, which compounds their difficulties.

Mobile healthcare for unhoused people

"I personally would like to see more mobile units that can provide at least very routine health services, especially a unit that could go into homeless encampments. They could treat minor wounds or do wound cleaning before they become septic and need to be treated in a hospital. This, I believe, would limit many ER visits. Not everything requires an office visit."

– Survey Respondent

Need more shelters and community health workers for unhoused people

"I wanted to speak on the shelters. I understand that Haven for Hope is like the main shelter in San Antonio, and they provide a lot of resources. and but I feel like we need to have more satellite shelters because there's homelessness everywhere. Not everybody can get to Haven for Hope. It's way overcrowded, anyway, and it's overcrowded to the point where it is deemed ineffective. And a lot of people who I talk to, who are chronically homeless, absolutely will not go back for various reasons. We need a different model here in the County and in the City. We have a ton of CHWs. How come we can't use our CHWs, with satellite community resource centers, community health partners? But that that all boils down to the same thing. Finances."

– FG #2 Participant

PEOPLE WITH DISABILITIES

Participants provided many examples of how the disabled community is left behind when it comes to community resources and initiatives. For example, during Focus Group #1, there was much conversation about domestic violence and the need for safety courses. However, a participant noted how these efforts also need to be focused towards the deaf community. They witnessed deaf teenagers engaging in harmful relationship dynamics, and when they had to intervene ***"he didn't fully understand why it was happening, because nobody fully tells the deaf community. He wasn't aware of the harm he was causing... With these resources, I would say about 80% of these resources wouldn't be accessible to the deaf, because a lot of places don't want to have to pay for the interpreters, because they are very expensive. Or they give the deaf person the runaround on. You have to pay for it, or they just take forever."*** Additionally, being disabled often overlapped with other vulnerable populations, like the elderly, which served to multiply their barriers to medical services and care.

Health insurance and high medical costs for older and disabled people

"There's people that have worse things than me. I'm older people, so I can imagine how they feel that I'm pretty sure they're not feeling 100% good, because they can't take all their medication, or they can't afford it. They're on Medicaid or Medicare. But still, if you're on Medicare, they take a $185 from your disability check. What they give us for disability ain't nothing, and then we got to pay for Medicare, and then we gotta pay for our medications, you know."

– FG #3 Participant

PEOPLE FORMERLY INCARCERATED OR ON PROBATION

The last vulnerable population that was discussed prominently was those who were formerly incarcerated or on probation. Having a history of incarceration can affect employment prospects, social integration, mental health, and access to resources. Participants spoke on behalf of themselves and others when discussing how difficult it is for people who were formerly incarcerated to live healthy, fulfilling lives due to being outcast from society and the main avenues of support.

Job opportunities, financial assistance, and reducing stigma for those with a background of imprisonment

"I'm speaking of a background of imprisonment. They've been in jail. They got a lot of drug abuse in their background, you know, which is what society doesn't accept. It just keeps pushing them down. How can I do better when there's no opportunities out there for me? You don't want to help me. You don't want to assist me. You want to send me to a place that costs all this money, and I don't have that, can't even get a job to get it. But if you teach me a trade that I can take care of myself and my family, I could do better with some more accessible trade work."

– FG #2 Participant

Housing and jobs for justice-involved individuals

"An easier way to find housing, jobs, and basic life needs for justice-involved individuals, no matter the charges."

– Survey Respondent

Medical, financial, and legal barriers for justice-involved individuals

"Justice Involved individuals face barriers that are medically, financially, and legally complex."

– Survey Respondent

THE SOUTH SIDE

Some participants discussed how they felt the south side of Bexar County has fewer medical resources and infrastructure compared to the North Side. This often leads to residents having to seek their medical care, particularly specialty care, through a commute to another side of the County. However, participants also discussed how they noticed the South Side has received more improvements recently, which they are pleased with.

South Side of Bexar County has less resources, but is improving

> *"I lived all my life here in San Antonio. And I've seen a lot of improvement on the South Side. Before, we never had like more fire stations, clinics, stores like the mall, and stuff like that. But we had to drive to the North Side to go to Best Buy or some other stuff like that. But now it's in the South Side, it's improving a little bit better. We see the environment... I've been living all my life here and it's improving a lot."*
>
> **– FG #4 Participants, translated from a mix of Spanish and English**

VULNERABLE POPULATIONS OVERALL

While reviewing the rest of the prominent themes and topics below, bear in mind participants identified these as being exacerbated for the vulnerable populations discussed. When thinking of initiatives, programs, and strategies to address barriers, it's important to consider what populations are not in the room and how their specific needs can be incorporated.

Key Issues the Community is Facing

COVID-19, MENTAL HEALTH, AND STRESS

COVID-19 had a profound effect on many aspects of people's lives, including work, housing, school, social institutions, recreational activities, and mental health. This was mentioned during the focus groups as participants lamented about missing 24-hour Walmart, how difficult it was to find employment during and after the height of the pandemic, how the quality of their children's education dropped during remote-schooling, missing being around their friends and family more, and how depressing it was to deal with social isolation. Mental health and stress were also prevalent themes in the survey open-ended responses, particularly the need for more accessible mental health resources.

Young people, isolation, mental health, and the lasting effects of Covid-19

> *"I think that Covid really affected a lot of people's mental wellness, and especially younger- younger folks. I just don't think a lot of people have healed, because we're still behind on various types of mental health services. When I say younger generation, probably 17 to 27, because these kids were in school... and it's still that level of isolation that has not been dealt with... We still need health care, mental health care services, especially from the trauma that probably got brought."*
>
> **– FG #2 Participant**

Young people, education, socialization, and Covid-19

"I have a 15-year-old, and she's in high school. I've noticed when Covid happened, she was great with school. She didn't have any real issues. But after Covid, it really took a toll on her, since she was just at home. It's a little bit harder for her to be social or to interact."

– FG #3 Participant

Disability, transportation, and the difficulties of older people going back to the office after Covid-19

"Like during the height of Covid, when there was that push to remote work. But then, now it's kind of getting away from that. The remote jobs were a lot of people that were older and were working in the offices and stuff. So, I think now that they're taking that back, and you gotta go back to the office there. A lot of them are disabled. They can't. I think that's the hardest part for them that they have to find 2 or 3 jobs to make it, and it's harder, because, of course, they don't have transportation or the cost of the fuel is expensive. Car repairs are expensive, so I think our elderly and our disabled are the ones that are going through it."

– FG #1 Participant

Covid-19 revealing mental health, food security, and housing problems

"That Covid situation revealed it. There's a mental problem here. There's a hunger problem here. There's a housing problem here. We're struggling. It made you really focus on that stuff now."

– FG #2 Participant

Housing/rent support being ended after Covid-19

"During Covid, housing was a problem, because I think they had put like a stop on evictions. And then, like after Covid. They lifted it. Then everybody was just getting evicted."

– FG #3 Participant

Affordable access to mental health resources

"We need more, better, and more affordable access to mental health resources."

– Survey Respondent

HEALTHCARE

Most of the conversation about healthcare revolved around inaccessible health insurance, high medical costs, and difficulty finding doctors and specialists. Some of the barriers to accessing health insurance included confusion about Medicaid and Medicare, as they had different coverage criteria, and some participants recently had to switch from one to the other. They would think their doctor or specialist was covered by their insurance plan, only to find out weeks later that they weren't. There were also long wait times between when they started paying into their insurance plan to when they were able to attend an appointment with their doctor. This also indicated some difficulties with health literacy, as participants did not always feel confident in their abilities to find insurance-covered doctors or understand their next steps to addressing health concerns. Not being able to navigate health insurance problems also resulted in complaints about high medical costs, with some participants having to pay more than they thought they would need to for medical services. Making the process even more burdensome was the geographical disparity of specialists. Many participants had to travel to North Bexar County to access their specialists, which was more difficult for those who didn't drive or have access to vehicles.

Survey respondents echoed the same barriers, with an emphasis on needing more affordable healthcare, having more education to increase health literacy, having more diverse appointment time/day options to accommodate people who can only meet after 5pm or on weekends, longer appointments with more empathetic doctors, and geographic disparities causing a need for more hospitals and doctors on the South side of the County.

Medicare having less coverage than Medicaid, high copays, and inaccessible doctors

*"**P1:** A lot of times when you're sick, your health insurance doesn't cover, but you gotta pay a copay, and sometimes you don't have sufficient funds. The thing I don't like about it that they send you from Medicaid to Medicare. And Medicare has different plans that you gotta choose, and they only go for like 6 or 12 months, and then you gotta renew again if you want to keep going with that plan or get a new plan. And that's a hassle for me. You know, finding a medical insurance, you know, changing, and which doctor, you want more accessible.*

***P2:** You're right, 'cause I was trying to get it for my mom. And Medicare doesn't provide a lot of stuff. And you gotta find a specific doctor that would accept your insurance."*

– FG #1 Participants

Need quality healthcare on the South Side

"Having one emergency room for the entire southside of San Antonio is the reason residents have a 20-year difference in life expectancy and other negative health outcomes. Quality healthcare is needed South of Highway 90. There needs to be an influx of medical facilities not the opposite."

– Survey Respondent

"There is a dividing line for quality Healthcare like there is for life expectancy in Bexar County. The treatment and care received at medical facilities South of US 90/I-10

is significantly poorer than the care received in facilities in the north. It is as if the expectation is to only prolong life with treatment for those in the south vs finding a cure for those with access to providers in the north. Also displayed by the level of access to specialists south of US 90."

– Survey Respondent

Affordable healthcare, especially for those with disabilities

"Access to healthcare that is more affordable for the same reason. A person with a disability who is not eligible for ssi or ssdi should not feel they can not take care of basic needs such as medical care, food and housing due to not having a way to pay."

– Survey Respondent

Health insurance, health care literacy, and barriers to healthcare: transportation, childcare, and taking time off work

"There are many different barriers to health care, and having health insurance is just the beginning. Then it's having health care literacy- how to make appointments, what appointments to make, what insurance will cover and what it won't (like having to go to a different location for labs even though there is a lab in your PCP's building because insurance won't cover it). Then there's getting to the appointment, which can be difficult to take time off of work, or find reliable transportation, or find childcare if children are not allowed at an appointment. It's all difficult and I can understand why people are unable to adhere to treatment plans or follow preventive health guidance."

– Survey Respondent

SAFETY

Participants had concerns about safety impacting their ability to live a healthy life with their families. This included wanting more services that offered education about addiction and substance abuse, addressing domestic violence and gun violence, having less loose animals in their neighborhoods, and dealing with theft. Participants noted how helping vulnerable populations, like unhoused people and those with mental health issues, would also help with general community safety. Providing more community resources was often seen as an upstream solution that helped address disparities before they worsened, which was better than downstream solutions which addressed problems after their damaging effects. One such community resource was a community center. Participants felt if they had access to more safe spaces for families and youth, then there would be less safety concerns in the neighborhood. Survey respondents also brought up concerns around gun violence and general community safety.

Substance use, gangs, and not wanting to go outside

> *"There's a lot of people who don't really have too much of a choice. They just kind of take what they can get. And the areas are drug and gang infested. And people just don't want to raise their family. They literally don't even want to go outside."*
>
> **– FG #2 Participant**

Domestic violence awareness classes and substance use

> *"And domestic violence awareness classes... They should make it mandatory for you to take them every year... make it mandatory for everyone who lives in the household to be able to take these classes in order to live here that way everybody goes through the program and won't be afraid 'if I take the class, they're gonna know.' And I think that would help a lot with the violence. A lot of parents don't know, because they're just getting high... I've personally been on both sides. And I would have wanted help."*
>
> **– FG #1 Participant**

Gun violence and de-escalation

> *"Gun Violence -need more violence interrupters in the hospital and credible messengers in the community."*
>
> **– Survey Respondent**

MONEY, THE ROOT OF ALL: EMPLOYMENT, HOUSING, FOOD SECURITY, TRANSPORTATION, AND FUNDING FOR SMALL ORGANIZATIONS

When participants spoke about difficulties with employment, housing, food security, transportation, and the economy, it all boiled down to three things: Financing, funding, and capital – or in other words, money. Participants wanted more assistance and training to find "good" jobs, so that they could increase their earning potential and afford other basic necessities – like stable housing, food, and transportation to doctors' appointments and activities. Every one of these issues could either be solved by money, or they could be used to earn more money, which would in turn help with other problems. Employment was difficult to maintain for some participants because their benefits didn't allow them to work more than a certain number of hours. But without working more, they couldn't afford other needs. Housing was difficult to access for some participants due to availability and cost. While there were many resources for food security, such as churches and food pantries, there were also barriers to accessing these – like transportation and hours of operation. Then, for the small organizations that could offer services that alleviated financial burdens, there was a need for more funding so that their programs could remain sustainable. Participants in FG #2, which took place at a church, mentioned how larger churches and organizations received more funding than them, despite the fact that larger organizations often referred their members to the smaller churches for assistance.

Food security, paying bills, medical costs

> *"In order to have a healthy person when it comes to their home, they need to not stress out on where their next meal is going to come from, how they're going to pay their bills, how they're going to get their medication. Because, like for her, for example, if she doesn't get her insulin, that's going to affect her even more."*
>
> **– FG #1 Participant**

Gas prices and transportation costs

> *"I need them to bring gas back down. Yes, I don't have a car, so I'm always bumming rides, and everything's expensive nowadays, the prices of transportation."*
>
> **– FG #1 Participant**

Housing prices and food stamps

> *"***P1:** *I pay a little over $1,000 for the apartment I just got. I have nothing left over for the month.*
>
> **P2:** *I'm in the same situation.*
>
> **P1:** *And for people like [Participant], they don't even help you with like food stamps, or they help the wrong people, people that are not even working."*
>
> **– FG #1 Participants**

Grocery prices and food stamps

"The price on the groceries is so expensive, they can't even give us enough food stamps so we could buy enough food for the month."

– FG #3 Participant

Grocery, rent, and parking prices

"Everything's going up, like groceries. Like here at our apartments. They make us pay for parking… We're already paying rent. Why do we have to pay for parking? Nobody wants to come visit us, because they got to pay for parking - a daily pass is $20 a day."

– FG #3 Participant

Funding and grants for small churches to provide food, clothing, housing, and outreach to the community

"I'd like to add another category, and that would be finances. Outreach is not free. It takes the heart of the people, but it takes money also… your churches that are out there in the community doing outreach, trying to feed the hungry, clothe the naked, provide housing for them, and whatever else we do - Thanksgiving dinners or Christmas dinners, or what have. It's not free. It all costs money, and then we have a city that has access to grants and fundings. But the smaller churches don't seem to get much of it. It goes to your bigger, well-populated mega churches and those that are already established. But they're not the ones in the street doing the work, so I would like to see some of those grants, and finances, and support in the hands of the churches that are out there really doing the work."

– FG #2 Participant

Need transportation for people to get to doctors, stores, and other essentials

"I live in Von Ormy. And since I don't have a car, we have to go all the way to San Antonio for doctors, for HEB, and all of that, because we don't have a big store here. So, to go get groceries, I have to go to this HEB, but we don't have buses that run [come] out here. So, my question is, 'Where can we get or how can we get someone to listen to us and maybe set up transportation for those of us who don't have a car, so we can get to San Antonio?' Because it's really hard, if you don't have a car. If you live here in Von Ormy, or in Somerset, and you don't have a car, there's no way to get around or to get to work, it's really hard."

– FG #4 Participants, translated from a mix of Spanish and English

EXTREME OR HAZARDOUS WEATHER

During the Great Texas Freeze in February, 2021, many were left without power for days. This was during the height of COVID-19, and it opened many people's eyes to the structural problems their communities had, and still have, in dealing with extreme weather conditions. As mentioned earlier, these problems were exacerbated for vulnerable populations, such as the elderly and those lacking housing. Participants felt there should be more social services dedicated to paying people's electric bills, providing "good" fans, and offering more accessible warming centers. Survey respondents also mirrored sentiments about needing more awareness about extreme weather conditions, particularly heat and the safety of those who work outside, like construction workers.

Extreme weather and homelessness

> *"I think it's more on the side of those who don't have anywhere to go, like those who are unhoused probably experience it (extreme weather) more than we do, and there are some shelters who don't understand the necessity of 'it's hot, and we need air,' or 'it's cold, and we need heat.' The community isn't very compassionate about making sure that they're taken care of. If it's cold outside, they need a place and also something warm to put on, and the places they do go where they know they might find warmth or something, the community is very adamant about calling the police, because they don't have nowhere to go. And so, there's only so much they can and can't do when it comes to when it's cold and when it's hot outside."*
>
> **– FG #2 Participant**

Heat, construction workers, and recognizing signs of sun stroke

> *"I'm concerned about the health and well-being of workers who have to work out in the hot sun during summer months. Specifically, I am speaking of construction workers and landscapers. I would like to see some community awareness on how to recognize sun stroke and keep workers safe."*
>
> **– Survey Respondent**

Community Resources and Barriers to Accessing Them

While there were quite a few key issues participants identified in the community, they also abundantly spoke about community resources that are used to address them. Participants demonstrated in real time how most people gain knowledge and access to these resources, through word of mouth. During FG #1, which was held at a church, a participant mentioned how they needed assistance with doing their laundry. Another participant immediately offered her a washing machine and dryer, which were located at their pastor's home for community use. During FG #2, which was also held at a church, there was a slight interruption when someone knocked on the doors. The pastor

and a congregation member went to the door and spoke with the individual for a few minutes while the rest of us continued the discussion. They later let us know that it was a community member speaking about how they didn't know what to do; they needed help with housing, food, employment, and they were simply fed up with the difficulties it took to access these. All they knew was that they could come to this church and seek help. They were not a current member of the church, but they knew it was a place they could access resources and help. Similar moments happened throughout all three focus groups. Participants would discuss community resources – like churches, organizations that provide educational and employment opportunities, food pantries, housing programs, and more – and they would also exchange information with each other in real time as they identified needs of other participants.

This is one way the open-ended survey responses differed from the focus groups, because the survey responses did not include many mentions of community resources, but they did mention barriers. This could be due to many factors, including the different questions asked in each.

While discussing community resources, focus group participants spoke in tandem about the barriers to accessing those resources. They recognized that some of the services are available, but not necessarily accessible for various reasons, and some services were neither available nor accessible. There was much discussion back and forth about whether it was a lack of individual motivation that keeps people from accessing resources, or whether it was environmental factors, like transportation, job skills training, or outreach efforts. Their insight showed a great communal resilience to adversity along with discernment to recognize the community's strengths and weaknesses.

COMMUNITY RESOURCES

There were many key issues discussed in the focus groups, but resources to address these issues were talked about just as often. There was a sense of pride and strength as participants explained programs and services that offered assistance with employment, housing, education, computer classes, food pantries, and safe environments for children.

Job training classes and education resources

> *"On the good jobs, there's a consistent - I know housing, which is Opportunity Homes. They're consistently having training classes. Either they'll have them at the main office downtown, or they'll have them at your community office, or wherever. They're very consistent with that. They're usually on Facebook. It's usually on Instagram, actually, part of that program where we actually got a high school diploma from there. So, they also offer education there as well. Trainings."*
>
> **– FG #1 Participant**

Individualism, it's up to the person to use resources

> *"It comes down more to the person. I used to live in the projects. But I did what I can do to get out. There are also classes, right, to educate yourself. I took computer classes, you know, so it comes down to the person. If they really, if they really want it, they'll find a way to get out."*
>
> **– FG #1 Participant**

An abundance of community resources for families and children

"Everywhere, like in this area that we're in. We have a food pantry here. We have church activities. We have outreaches here, the offices here for Opportunity Home, they have Fiesta week, and they have all kinds of things where you can take your kids and some healthy, safe environment to have your kids run around have fun and stuff like that. They have that here. in other areas I wouldn't know, because you know. But here in this area. But all of that is here."

– FG #1 Participant

Another source of support, resources, and service information was the church. As mentioned earlier, there was a moment during FG #2, which was held at a church, when an individual came knocking on the door for assistance. They didn't know what to do, they weren't a member of the church, but they knew this was a place they could seek and obtain help. Other participants echoed this sentiment that the church was a community resource.

The church is a community resource for activities, children, and outreach

"I was just gonna admit that this church has been a resource for the community. We have outreach, and we have unity in the community activities. And so, the community comes to us. We have bounces on the ground for the children, and balloons, and clothing, and stuff like that. So, the community does come here. But I understand something more concrete needs to be developed in this particular community."

– FG #2 Participant

The church provides shoes for children

"We did an event, might have been 2 weeks ago or 3 weeks ago. We [the church] went door to door and we got all the kids shoe sizes, and we had a big event here for the youth, and I was just so overwhelmed and moved. How many kids that we had that needed help, and also that a lot of them were single parents in the home. They had 3 or 4 kids, so they're doing the best they can as a mom. And one was a dad that was a single parent. But he's trying to work 2 jobs. So, the kids are basically kind of raising themselves. So, how can we get in as a community and support them?"

– FG #2 Participant

BARRIERS TO ACCESS

If there are so many resources within these communities, then why aren't the key issues being addressed? Well, participants also explained how even though there's an abundance of resources, there are complex, related barriers to accessing these resources. Solving issues with housing, food insecurity, or community safety is not as simple as providing the resource. There were often layered barriers that prevented people from accessing services, care, and other resources, which made participants feel they were 'setup for failure.' A Participant in FG #2 mentioned how providing safe spaces for families and children wasn't as simple as placing a park or patio in a neighborhood. You also had to provide solutions for the loose dogs and animals that made families feel unsafe to walk in their neighborhoods. They said ***"it would be nice to have like a patio, or like a backyard, but in this neighborhood, I personally wouldn't recommend it, because there are a lot of stray dogs."***

Similarly, another participant in FG #2, shown below, provided a detailed explanation of what makes accessing services difficult. They explained how housing services have long wait lists, and then once you obtain housing, the rent is unreasonable for the income you make, and some people don't feel safe in the housing they're placed in. Furthermore, accessing food stamps can be difficult for some families who don't meet the requirements, but even for those who do, you still have to pay for insurance, dental care, transportation, and gas.

Money is a barrier to living a healthy life, but making more money is a barrier to qualifying for food stamps, housing, and health insurance.

Many people make too much to receive social services, but don't make enough to sustain a healthy life.

"There's a lot of people who make a certain income and want to work, want to raise a family, want to better their education, but they can't, because of their financial situation compared to what employers are offering. You know, compared to what everything costs. It's just unattainable. But the flip side of that, if you do get a job and you make more money, then you're gonna no longer qualify for food stamps.

And then with housing, if you make too much money now, we can't give you housing assistance. You're kind of stuck in between. If I go out and make $5 over, I don't qualify for this. But then if I make more money, now I have to spend the $200 you were giving me in food. Now I got to spend that. So really, I'm not really getting ahead. It's a big cycle of poverty.

I work with some young ladies, and they say 'you know what, it's better for me to stay right here. At least I'm getting food stamps.' But you're stuck, you can't go forward.

So if they go out and get something (a good job), they won't take it, because then you don't qualify for the health insurance because they're gonna take that. So it's like, if I do get a job, then I won't be making enough for my food, my health, my new office here. It's best that I don't even work. This is the system, it's not set up right."

– FG #2 Participant

Resources need to be more encompassing. Receiving housing is great, but if you don't also have employment that pays a livable wage, then you will need more than immediate assistance, need long-term education and solutions to develop skills for survival

*"**Facilitator:** Are there any community resources that help alleviate those difficulties?*

***Participant:** I don't think so. As someone who's been on both sides of being homeless, the resources are accessible, but they give them to people who take advantage of them. And then when you get them - say you get housing, they give you an apartment. That's $900. Your job gives you $500, maybe, every month. That's not enough to even cover it once your housing is up, so it's almost like they set you up for failure because they give you housing, but then you don't even have a job that could pay for it after you're done, so a lot of people end up back in shelters because they don't have enough to make it. I think, as far as like affordable housing, something within decent prices you have to think about.*

You need groceries. Not a lot of people have the qualities that you need for food stamps – you like literally have to be homeless, making $100 to even qualify for food stamps. You get food depending on how many heads you have in the house, and then, you need insurance, you need dental. If something happened, you need a car. You need gas. Gas isn't cheap the way prices are going up. I mean, food isn't cheap, either, and then getting to and from work, and then having to pay your rent, and they give you an apartment that's 1 bedroom for a thousand dollars, and they send you to fail. And then you'd be stressed out. And it affects your mental health. When you apply for housing for the city, the waiting list is at least 5 years."

– FG #2 Participant

"But that's the problem with the city, that they're taking away the opportunity from many families, from getting assistance instead of educating us on how we can survive the things that we're going through. A lot of times it's easier that, to give people food or diapers, instead of educating them to go work to support their family. And that's the problem with the city, that there's so many problems they're helping with, yes, of course, but they are, at the same time as helping them, they're pushing them lower because they're not educating them on how to survive, or how to pick themselves up. And that's not teaching us [or giving us] he opportunity to grow."

– FG #4 Participant, translated from a mix of Spanish and English

These sentiments were echoed across many participants and survey respondents. Most of the barriers included:

- Applying for services. For example, you might need a physical address to apply for some services, including housing.
- Meeting the criteria to apply for resources. ALICE (Asset Limited, Income Constrained, Employed) households make income above the federal poverty level, so they often can't apply for some resources, but they don't make enough to afford all their basic needs, like housing, healthcare, and food.
- Long waitlists
- After a service is accessed, you need other assistance to maintain it. For example, people might need employment to maintain housing, and transportation to maintain employment.
- Lack of knowledge of what resources and services are available. Many participants discussed how organizations, programs, and services need to be better advertised to them through various methods of outreach in the communities and collaboration with other known organizations.
- Technology problems. Participants noted how you often need a cellphone, knowledge of using websites, and access to the internet to find and use services, which not everyone has.
- Language barriers. A survey respondent explained how ***"It's difficult for my mom to go to her appointments without my help. She has low literacy and language barriers; also, she is not tech savvy. It can be daunting for folks to check-in on iPad and even park in parking garage. I think that CHWs could help in some of these instances."***

WHAT ARE COMMUNITY LEADERS SAYING?

Role in Community and Motivation

The key informants for the 2025 Community Health Needs Assessment were carefully and intentionally chosen for their experiences, expertise, and impactful roles in the community. CINow interviewed six key informants to get the perspective of community leaders across Bexar County. They included Adrian Lopez with Workforce Solutions Alamo, Edward Banos with University Health, Eric Cooper with the San Antonio Food Bank, Antonio Fernandez with Catholic Charities of the Archdiocese of San Antonio, James Wesolowski with Methodist Healthcare Ministries of South Texas, and a confidential Key Informant with an organization that serves vulnerable people in crisis. Something they all have in common is a deep understanding that it takes more than one thing to help people, but rather a conglomeration of interconnected factors, such as economic development, job training, supporting small businesses, food security, transportation, sustainable infrastructure during population growth, accessible health care, and more. This is reflected in their roles, as they and their organizations frequently assist communities with more than just one aspect of their lives. When asked about what motivates them to fulfill their roles, it usually related to wanting to help vulnerable people and provide vibrant lives for communities.

> *"I've had the pleasure of working for everything, from nonprofits to city county government, to a housing authority, to a council government. What motivates me serving people… I understand how community development is extremely important to people's lives and livelihood. I've also done economic development, which is either at a larger scale with hundreds, if not thousands, of jobs, but also economic development with small businesses. I've done some economic revitalization like in inner city corridors, and I understand how access to a vibrant commercial corridor is key to ensuring that a neighborhood continues to become or remain vibrant."*
>
> **– Adrian Lopez, Workforce Solutions Alamo**

"It's my mission here to help those who are vulnerable. That's what I like. So, that's why I'm here." – "Rapid response and disaster relief. Oh, we're very good at that, and we have contracts with different states and entities to do that. We mobilize all the time. When there's a hurricane, we put up shelters, bring in case managers talk to people to take care of those who unfortunately were affected by that, and try to connect them to the resources that are available to them. We do that all the time."

– Key Informant, organization that serves vulnerable people in crisis

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"I'm motivated, inspired to try to meet that right, that mom who has a child asking, you know you know what's for dinner and you know, strengthening her as a mother and giving her the resources to be successful... I get - not depressed - but just humbled, overwhelmed, with a heavy heart, for those that are in such a state. But I am motivated to try to solve that problem and ease the suffering."

– Eric Cooper, San Antonio Food Bank

"It's the people who are being helped by Catholic Church. Just to see the smile, to see a family getting some money, or some food, or some clothes, some love of respect and dignity, and just seeing them go. It brings satisfaction to me."

– Antonio Fernandez, Catholic Charities of the Archdiocese of San Antonio

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"We are the public health system for Bexar County and the major academic healthcare system for Bexar County and the region. We are the health system that is here everyone – insured or not – to make sure everyone has the ability to get the highest quality of care from our health care team."

– Edward Banos, University Health

"We seek out those most in need, those that are the least served, and we try to prioritize ways to help them. We provide downstream healthcare, including oral and behavioral health services, but we have shifted to a nice balance of focusing on social determinants of health too looking for why people aren't healthy in the first place. We often say, we are broadening the definition of health care at MHM because we know so many things like poverty, food, instability, unclean water, education or digital equity, influence our health and wellness. Our mission is serving humanity to honor God. And what could be more noble than that? So that's what keeps me pretty pumped up about doing the work that we do."

– Jaime Wesolowski, Methodist Healthcare Ministries

Disenfranchised Communities and Vulnerable Populations

Due to the nature of their roles in the community, the key informants were particularly aware of how disenfranchised communities and vulnerable populations in Bexar County were especially in need of services and resources. They identified geographic disparities in healthcare access for communities in rural areas, the South Side, and the West Side of the County. Additionally, the most vulnerable populations mentioned were racial/ethnic minorities, immigrants/refugees, people with language barriers, unhoused people, youth, the elderly, those who were incarcerated or on probation, people who struggle with substance use, and veterans.

RURAL AREAS, SOUTH SIDE, WEST SIDE, AND OTHER GEOGRAPHIC DISPARITIES

When discussing communities that needed more services, resources, and investment in Bexar County, the most common ones included rural areas, the South Side, and the West Side. There was general discussion about how the County has geographic disparities in ratio of providers to residents, as well as infrastructure like parks, potable water, and social services. However, these specific communities were discussed as being particularly in need of assistance. For rural areas, in particular, there was discussion about digital equity and access and how a lack of technological infrastructure affects their access to healthcare, work, education, and other resources.

Rural communities and South Bexar County need better access to fi efig ting equipment and clean water

"What's happening with the County is a combination of how things were built out. Also, the need for expansion of services for what were largely rural areas. About a month or so ago, there was a huge grass fire that took place in Southern Bexar County. Before the grass fire happened that ultimately burned people's cars and homes, you come to realize that some folks are still living in those same types of conditions. What that requires in some instances is, for example, if you want potable water, you have to go haul it. You go buy the big old plastic things, and go to HEB, fill them up. That's your drinking water. You may have access to water for like showering and toilets, but having to haul water back and forth is a real issue in some parts of the of the community.

Access to firefighting equipment and infrastructure like fire hydrants does affect some parts of the community that may not have access to that those types of utilities, which affects insurance rates, and it affects somebody's livelihood. Because if your home cannot get insured because those utilities don't exist and it burns down, guess what? You're out of luck, you just lost everything, and you're now having to figure it out. How do I recover from that? That's a really good example, is to think about what happened recently with the grass fires in Southern Bexar County."

– Adrian Lopez, Workforce Solutions Alamo

Rural communities need digital connection and equity to access jobs and education

"One other common theme, especially in rural areas, is digital equity. Some important considerations in this regard are whether first, and foremost, are these communities connected? What tools do they need to leverage the connection and what training do they need to use those tools, or do they require Navigators to help? Another important issue regardless of whether you are in a rural area or not, is how important digital connection is to one's ability to find work and education at every level. You need digital connection to compete in this world."

– Jaime Wesolowski, Methodist Healthcare Ministries

RACIAL/ETHNIC MINORITIES, IMMIGRANTS/REFUGEES, AND PEOPLE WITH LANGUAGE BARRIERS

Key informants discussed how there needed to be more services for immigrants and refugees, accessible resources for people with language barriers, and how racism was built into the systems of society and kept racial and ethnic minorities from attaining generational wealth. For example, Eric Cooper at the Food Bank provided a detailed example of how redlining, the act of banks maintaining racial segregation through geographically biased lending practices, affected generational wealth of Hispanic people in Bexar County by keeping them from obtaining housing and passing down assets to their children. Additionally, he explains how "rent is the new redlining."

"Rent is the new redlining." – Eric Cooper, San Antonio Food Bank

"Back in the day when people bought a house, they had to borrow money… When it comes to lending practices there's liability. And to help with that liability, the Federal Government would offer insurances. They would say to Banks, we'll ensure these loans if the banks lend to these communities… In San Antonio, there are certain communities where the risk, in their mind, was too great. So where they decided not to lend. And they took the map of the city, and they basically drew a red line, and if you were borrowing money for a house in this side of town, the government would back it… But if you were wanting to build in this side of the town across the red line, then the government was saying, 'Look, we're not going to back that, we're not going to lend. We're not going to have anything to do with that side of town.'

Well, that tended to fall on race lines. You know more Hispanics over there, and if you and if you look at their homes, because there wasn't anyone giving oversight, sometimes the houses weren't built quality. They weren't built to code, and those assets didn't appreciate or go up in value… But then the assets outside of the red line man, they just grew in equity, and those tended to be more white people

... And for generations those communities failed to thrive based on this policy, like the fact that they couldn't get good lending for home ownership, ... people might say 'I'll never be able to afford a house, so I'm going to rent for the rest of my life.'

... And therefore, when they retire and someone that owns a home is getting ready for retirement, that $400,000 home potentially could be paid off and maybe is worth now $800,000, and they have a nest egg and equity that moves them into wealth and financial independence. But that person that rented, they've got nothing, and they've got no equity. So, that's why, I say, rent is the new redlining."

– Eric Cooper, San Antonio Food Bank

UNHOUSED PEOPLE, YOUTH, ELDERLY, FORMERLY INCARCERATED OR ON PROBATION, PEOPLE WITH SUBSTANCE USE DISORDER, AND VETERANS

Consistent with the focus groups and open-ended survey responses, the key informants identified unhoused people, youth, elderly people, those who experienced incarceration or probation, and people who struggle with substance use as being particularly vulnerable to barriers to health care and healthy living, which are discussed further below. Unlike the focus groups and open-ended survey responses, the key informants also recognized how veterans need better access to health services and housing. Additionally, when people are part of more than one of these populations, it multiplies their disparities and lack of access to resources and services. The Key informants discussed how they need more funding, volunteers, and collaboration to be able to further their reach to these vulnerable populations.

Unhoused, substance use disorder, veterans, and children are most vulnerable

"We serve the most vulnerable populations... We serve homeless, we serve those with substance use disorder, veterans, children. Any people in distress and tend to have challenges getting access to services. We serve them."

– Key Informant, Organization that serves vulnerable people in crisis

Adopt A Senior program to help elderly people with basic necessities

"We just opened a program called Adopt A Senior. There are many seniors in San Antonio who don't have access to transportation... We have 400 volunteers that will go to senior houses to check on them, just providing them with companionship, sometimes just going to the pharmacy with them, or going to the doctor, or going to whatever it is for basic necessities... We're working with our County and with Senior Services at the City as well. But, how do we become creative enough to ensure that we actually can provide for these people? We're gonna have to have everything - the money, the volunteers, the creativity - to do more with less."

– Antonio Fernandez, Catholic Charities

Barriers to Healthcare and Healthy Living

The most diverse topics discussed with key informants were the barriers to healthcare and healthy living. Since they and their organizations view their mission work as encompassing many aspects of people's lives, the key informants often tied multiple factors and barriers together, due to how interconnected many social issues are. This included Social Determinants of Health (SDoH), which are non-medical factors that affect people's health and well-being, such as economic stability, healthcare access, education, employment, built environment and infrastructure (including city services, public transportation, walkable areas, potable water, and economic development to handle population growth), and more. The other prevalent barriers to healthcare and healthy living were affordability, including medical costs and health insurance, housing, health provider shortages, food security, health literacy, lack of preventive care, lack of coordination of care, financial literacy, childcare, and extreme/hazardous weather.

SOCIAL DETERMINANTS OF HEALTH AND INTERCONNECTED SOCIAL ISSUES

The Social Determinants of Health, or non-medical drivers of health, are interconnected social factors that affect each other, as well as people's well-being and healthcare access. These include education, employment, economic stability, healthcare resources, built environment, and more. All of these were heavily discussed by key informants, particularly from the perspective of their organizations, their missions, and the populations they serve. All of the key informants help people in Bexar County with more than one factor of living healthy, but rather they also assist with other factors of healthy living as well. This might mean providing both employment resources AND education resources, or offering financial literacy classes as well as information on the closest food pantry. Key informants recognized that people's primary needs are often influenced by other secondary needs as well, and they take a well-rounded approach to people's health and well-being.

There was a considerable amount of conversation specifically about built environment, basic needs, and infrastructure. They noticed that some areas of Bexar County, like the rural parts, were not fully equipped to deal with population growth, and this has led to a deficit in city infrastructure and services in those areas. This includes public transportation not servicing enough areas, not enough parks, sidewalks, streetlights, and walkable areas, as well as a lack of access to potable and clean water. All of these factors are interconnected and also influence people's abilities to get to work, maintain employment, have access to educational resources, be able to have clean water for them and their families, and more.

Childcare, housing, transportation, and healthcare need to be taken into consideration during economic and business development

"Having deliberate strategies with economic development, business development, childcare, housing, and transportation, having all of that happen at the same time is critical to ensuring that we have a healthy community." - "The ability to reduce as many barriers and stresses for individuals that they have the opportunity to actually concentrate on well-being, health, and healthy eating. What we tend to see is populations don't have time to do that because they're focused on 'I've got 2 jobs, and I'm working, and I've got 2 kids who are not school-aged. I'm having to pay for a significant amount for childcare that's reducing my ability to be able to go back to school and get trained to get access to a really good job, let's say, in manufacturing or aerospace or health care, or whatever it may be.' In terms of the built environment, how cities grow and how

they're packaged together does affect individuals' well-being and the privilege to say 'Yeah, I have time now to make sure that I concentrate on my own well-being,' because what happens with people is they're sacrificing their own well-being for the sake of something else."

– Adrian Lopez, Workforce Solutions Alamo

HEALTHCARE PROVIDER SHORTAGES

Key informants discussed how a common barrier to healthcare, particularly for those in rural areas, the South Side, or the West Side of Bexar County, was a shortage of healthcare providers. Often, residents would need to arrange transportation to get to another part of the County to see their doctors and specialists, or they would miss out on healthcare altogether due to a shortage of health providers in their area. This would lead to a lack of preventive care, healthcare access, and general wellbeing. This is one way that the South Side, West Side, and more rural areas of Bexar County are similar to other rural Counties in the surrounding area.

The struggle to access healthcare services in rural communities

"Rural hospitals and health systems in the region are struggling due to a critical shortage of doctors and nurses. This shortage limits access to specialty care as well as early detection and preventive care—both essential for maintaining the good health of a community. In rural areas, where facilities are often far apart and providers are scarce, many residents miss important screenings such as colonoscopies and mammograms and the appropriate follow-up care. In contrast, people in urban areas have access to many healthcare facilities close to their homes or workplaces, making it easier to receive timely preventive health services, diagnostic testing and treatments."

– Edward Banos, University Health

HEALTH LITERACY, LACK OF PREVENTIVE CARE, AND COORDINATION OF CARE

Similar to how a shortage of healthcare providers can lead to a lack of preventive care, a lack of health literacy can also lead to a lack of preventive care. Key informants discussed how health literacy and more widespread education about health, the healthcare system, preventive care, and health-related behaviors could prevent many diseases and illnesses, like diabetes and tobacco-related cancers. Edward Banos at University Health provided a great description of health literacy. Key informants also discussed how health literacy is not just the responsibility of schools, but there should also be knowledge passed around inter-generationally. Grandchildren who learn about health-related behaviors at school could share these insights with their grandparents and other family members. Sharing health-related information could help the healthcare world seem less complex. As another key informant at an organization that serves vulnerable people in crisis noted, with ***"health literacy, people can have an MBA, but still may not know how to navigate the healthcare world because it is so complex. Unfortunately, that's the current way. Everything's structured, and it's difficult to navigate."***

Health literacy is knowing how to reduce the impact of a diagnosed condition, slow or prevent its progression, or even eliminate it altogether – Edward Banos, University Health

"I view health literacy as the ability to find, understand and use health-related information in ways that can positively impact our health. When I was in school, we had a healthcare class that taught the basics—how to burn calories, stay active, and understand common medical conditions. Health literacy means understanding how health impacts you personally, how the lack of appropriate care can affect your family, and how it influences the well-being of your community. It involves recognizing disease processes, how they affect the body, and what can be done to manage them.

For example, a person with asthma may not be able to run easily, but with the right knowledge and care, is able to manage their condition effectively. Advanced health literacy takes this understanding further—it's about knowing how to reduce the impact of a diagnosed condition, slow or prevent its progression, or even eliminate it altogether. It also includes recognizing how environmental factors contribute to health and understanding the cause-and-effect relationship between our choices, our surroundings, and our overall well-being."

– Edward Banos, University Health

AFFORDABILITY: MEDICAL COSTS AND HEALTH INSURANCE

A substantial barrier to healthcare in Bexar County is affordability. Key informants explained how many of the community members they work with have difficulties with medical costs and obtaining adequate health insurance. This is also related to health literacy, as some community members struggle with understanding their medical bills and navigating the ins-and-outs of health insurance. While there are community health workers to help people understand their resources and coverage, many residents are not aware of what to do or where to begin. The key informants explained how getting behind on preventive care or medical costs is cyclical and causes other parts of people's lives and wellbeing to suffer as well.

Medical costs are high and people get sick again from being unable to afford their medicines

"Preventive care can cost about $50. Emergency room is a minimum cost over $500. But then, what do you do? Once you leave, you can't afford any of those medicines because you don't have insurance or your insurance has a $100 copay for your medicines, and you can't afford that. Either way, you don't have enough access. So, what's going to happen? You're not going to get those medicines. You're going to be sick again. But also remember, the time you're sick, you're not being a productive member of society because you can't work. So, it's one of those things where it becomes a vicious cycle."

– Key Informant, Organization that serves vulnerable people in crisis

POVERTY, ECONOMIC MOBILITY, EMPLOYMENT AND LIVABLE WAGE, AND FINANCIAL LITERACY

Related to medical costs are difficulties with poverty, economic mobility, maintaining employment with a livable wage, and financial literacy. Key informants discussed how one way or another, residents need better access to a steady, sustainable, thriving income, as well as the knowledge of how to maintain it. Not having enough income to thrive causes people not be able to afford their survival necessities – like food, housing, and healthcare – as well as the basic needs to provide a healthy, happy life. Money is a barrier to medical care, nutritious food, education, and more – which all affect people's ability to care for their health.

Need higher income to sustain a healthy life

"The challenge is the income. Not that money solves everything, but I think of hunger, not as a food issue, but an income issue. If people have access to thriving wages, then they can sustain themselves, and they don't need these supplements and these supports, and they can experience independence and the social status that goes along with self-reliance. I think our communities struggle in the areas of not enough opportunity to obtain wages that allow for a household to thrive in the community, or to sustain themselves, or to be secure in the community. So, they might be grappling with some of those basic needs, like food and shelter. They might not have the education, and then that employment, that 'right' job is just not obtainable, or there's just a bounty of jobs that don't provide a secure status. That's the way it's framed - there's 'low wage employees.' No, there are employers that don't pay a living wage or a thriving wage... And I think we have to get our employers to provide security to their workforce."

– Eric Cooper, San Antonio Food Bank

"Poverty is a signifacant determinant of one's health." – Jaime Wesolowski, Methodist Healthcare Ministries

"Poverty is a serious influencing factor to health. People have a very difficult time focusing on wellness if they can barely afford the food, products and services they need to maintain their own health. That's where so many families are—even if they are employed, many are living paycheck- to paycheck for just the bare necessities. Being able to afford health insurance, paying for prescriptions or hospital services is difficult when buying food or paying the rent is a challenge. Poverty is a significant determinant of one's health."

– Jaime Wesolowski, Methodist Healthcare Ministries

HOUSING

A very common topic in the focus groups and key informant interviews was the necessity for accessible, affordable, and diverse housing in Bexar County. Especially as the population grows in parts of the County, the economic development and housing needs to also grow. Housing is a barrier to healthcare and wellbeing in that people can't focus on their health if they're worried about shelter, which is often a more immediate need. However, the key

informant interviews elaborated on this topic by explaining how housing also needs to be diverse. Building more apartments alone will not solve housing difficulties, as people need diverse options for their families and multi-generational needs.

Need a variety of diverse types of housing for different types of families

"Access to a variety and a diverse level of housing is key as well, people tend to focus on affordable housing versus market rate housing. Well, when you look at housing, there's a lot more diversity associated with that. And what you want to have is a healthy community, where maybe you started in a small, affordable unit. But over time, you graduated to what the American dream would be, which is a single family detached home. Not to say that that journey is not a good journey. You could still have good quality housing in each of those aspects, whether it's affordable or somewhere in between that and mid-market rate. Having a diverse level and supply of housing is extremely critical to a healthy community. The integration of things like how the city grows."

– Adrian Lopez, Workforce Solutions Alamo

FOOD SECURITY

For both the focus groups and key informant interviews, food security was a theme that focused on having access to healthy, diverse, affordable, and close food options, which in turn affects people's health and can be a barrier to wellness. While "healthy" was defined differently based on people's health needs, often it was described as being able to access an HEB with fresh vegetables and quality products. Not all areas of Bexar County have equal access to HEB. It's why Antonio Fernandez at Catholic Charities said what they do most is ***"counseling and food security."*** Additionally, food security, particularly access to good nutrition, has effects on people's health and wellbeing throughout their lives, as discussed by Eric Cooper at the Food Bank.

Using ProduceRX! and Farmacy programs to promote food as medicine

"We're doing some work around food as medicine and working with healthcare on getting people access to good nutrition, and some of that is showing some bright spots. Our cities struggled with high rates of obesity and chronic diseases like diabetes, hypertension, and heart disease. When we can leverage our ProduceRX! or our Farmacy, that kind of approach can really curb some of those chronic diseases, and get back to good nutrition and physical activity. It's really what it's all about."

– Eric Cooper, San Antonio Food Bank

EXTREME OR HAZARDOUS WEATHER

An increasingly more popular topic is how extreme or hazardous weather, particularly in Bexar County, is causing barriers to health and safety. From critical freezes in the winter that cause people to lose electricity, to flash floods, to dangerous heat in the summers that cause dehydration, heat stroke, and other health hazards – residents in Bexar County require more resources, such as accessible fire hydrants, more equipment for firefighters, free and affordable fans and a/c, better infrastructure to handle electric use in the winter, utility assistance, and hazardous weather preparedness.

Rural and Southside need better access to fi e equipment and clean water

> *"[Pertaining to fires that broke out in Southern Bexar County]: You may have access to water for like showering and toilets and those things, but having to haul water back and forth is a real issue in some parts of the of the community. Access to firefighting equipment and infrastructure like fire hydrants does affect some parts of the community that may not have access to those types of utilities, which affects insurance rates, and it affects somebody's livelihood."*
>
> **– Adrian Lopez, Workforce Solutions Alamo**

CHILDCARE

The last prominent barrier to healthcare and wellbeing discussed in the key informant interviews, and by coincidence the focus groups as well, was child care. This was framed in an overall conversation about how parents and guardians, including grandparents raising grandchildren, need more assistance with childcare, especially when the parent or guardian has to work. Not having adequate childcare was often a distraction and a barrier to other health-related behaviors, like providing nutritious meals and having time for wellness. As mentioned earlier, many of these topics are interconnected and do not exist in a bubble outside of one another. Adrian Lopez at Workforce Solutions Alamo explained how he looks at all these factors, including childcare, as a whole of a greater fabric that makes up a healthy, thriving life. This is why his organization dedicates a majority portion of their budget into childcare services. Childcare provides development opportunities for children, as well as allows parents and guardians to go to school or work and improve the health and wellbeing of themselves and their families.

Childcare affects people's ability to participate in work and education

> *"Things like transportation, affordable housing, childcare, all of these types of things. They're all interconnected, and they all are part of the overall fabric that creates an environment where people thrive." – " My budget this year is a $180 million budget. So, we invest about $120 million into childcare. What that means is, you have about 14,000 kids in childcare seats every single day. And it affects about 8,000 families that have the ability to go back to school, get trained, or go back to work. The results of that are… the child has hopefully better development opportunities because of the curriculum at an early age. So that's a longer-term workforce outcome. The parent has the ability to*

go back to school, get trained or work. Those who are working are probably earning about… upwards of $27 million every single month. Because childcare allows them the access to go back to work. So that gives you kind of a snapshot of like the importance of childcare."

– Adrian Lopez, Workforce Solutions Alamo

The COVID-19 Pandemic

The COVID-19 pandemic affected people's lives on the individual micro-level of day-to-day living, as well as macro-level operational changes to organizations and systems. Because of this, there was a lot of discussion between the focus groups and key informant interviews about how the pandemic altered their lives in various ways. While the focus group participants identified changes to homelife, the key informants noted changes to organizational funding and how COVID-19 highlighted and exacerbated systemic disparities. Both the focus group participants and key informants discussed how the pandemic had an effect on mental health, remote work, telemedicine, education, and social interaction. Something unique to the key informant interviews was the inside perspective from within organizations and how they managed to maintain or pivot operations during and after the height of the COVID-19 pandemic. Some organizations were thankful for the American Rescue Plan Act (ARPA), which provided them with essential funds to continue operating and helping people. However, now that those funds have declined or ceased, organizations have to figure out how to maintain services, with a different workforce than they had pre-pandemic. Additionally, health-based organizations, such as Methodist Healthcare Ministries (MHM) felt they had to establish "a trust level" with the community to get them to trust public health recommendations. As Jaime Wesolowski with MHM described, they ***"made a tremendous effort to educate, not just our own patients, but the larger community, about vaccines. That would have never happened without trust. We tried to make sure people understood the pros and cons of getting the COVID vaccines. Ultimately, we had a high level of people choosing to get vaccinated."*** A silver lining is that key informants feel the COVID-19 pandemic shined a light on the disparities that need to be addressed, opened availability of telemedicine, and it taught them how to act quickly and react in moments of crisis.

Now that pandemic funding has run out, it's difficult for organizations to operate at normal levels

"The reality is, the pandemic was a huge effort for many people, and I have to be honest with you. It was led by the Government. The government dedicated billions of dollars, ARPA money that gave millions of dollars to many cities, counties, and states, so entities like Catholic Charities, the Food Bank, and so on. We got money to provide for families for services. We didn't pay rent because they lost their job because the job was closed. For people, whatever they needed, we were able to do, and all the money ended in February of 2025. Some people are still not back aboard, and now we are dealing with those situations. How do we have these people get back to work again?"

– Antonio Fernandez, Catholic Charities of the Archdiocese of San Antonio

Organizations learned to adapt and adjust during the pandemic

"I think we definitely learned [during COVID-19] that we could operate in a moment of crisis... organizations, they understood they could adjust if they needed to. Now, it didn't mean that it was an ideal situation, by all means. It didn't mean that at all. But that we could adjust, and we could still sort of function. I think, it did demonstrate that, and that's probably one of the bigger lessons learned."

– Adrian Lopez, Workforce Solutions Alamo

Telemedicine during the pandemic made, and continues to make, behavioral health easier

"We did a lot of telemedicine, especially in behavioral health, and that is something that has continued. People like having their sessions virtually, instead of having to drive all the way to one of our clinics, and they have proven to be equally effective to in-person appointments. But as we have learned through our work to advance digital equity, there are still a lot of places where connectivity is an issue—even in a large city like San Antonio. So, while virtual counseling may be a remnant of the pandemic that has continued, it has underscored the need to ensure that more people are connected, especially in rural areas where access to care may be more limited."

– Key Informant

Organizations and Their Functioning

From their unique perspectives as community leaders and change-makers, the key informants were able to offer insight into how organizations could better support Bexar County residents, as well as themselves to optimize their longevity and impact. Overall, the key informants felt organizations need better ways to coordinate collaboration, perform outreach to gain participation from community members, and gain more funding to fulfill their goals and mission. Funding was a topic that often intertwined with politics and government, because the ebb and flow of resources and funding is heavily influenced by government funding availability and decisions made by the current Administration that affect how organizations have to pivot their priorities and structure.

Need funding and collaboration between organizations and health systems to keep patients out of the ER

"I think there's opportunities where we can work together to keep those patients out of their emergency room. We do have the skill-set to provide the housing, food, and case management. I think there are opportunities that exist where we could work better. What we need is the funding. So I think there is potential for these health systems and us to partner together. And it still would be a win-win, because the services we're talking about would cost less than that emergency room visit. So from that perspective definitely."

– Key Informant, Organization that serves vulnerable people in crisis

Federal government funding cuts hinder the Food Bank from helping people with food and resources

"The biggest threat at the moment is where the Federal Government, under budget reconciliation, is deciding to cut back on direct opportunities that nonprofits have used to support themselves and indirect programs that support those neighbors, those residents that we care about. Specifically for the Food Bank, we've lost about $12 million in support, which means less food in our in our warehouse and displaced federal workers that just recently lost their job. Now, they're looking for basic needs coming to the Food Bank for food. So my line is getting longer. And those traditional support programs like SNAP and WIC that help put food on the table, the federal government's looking to cut those programs now. Those cuts haven't gone into place yet, but as they make decisions in the next few weeks to reduce the support that those families get, again, resources and policy. We've got to have good, effective public policy that supports us."

– Eric Cooper, San Antonio Food Bank

Uncertainty about federal government funding cuts and how it will affect services

"What is happening to us with new legislation, I have no clue. What's coming next?... We know that September 30th is going to be a very critical day. So that is another day that is going to be major in the United States, in San Antonio, because that's when this fiscal year, which started that with President Biden, will end. So, a lot of the funding that President Biden put out there is finished. So on October 1st everything is coming from the new Administration, so we are getting ready to see. How do we save pennies here or dollars there. So October 1st, we can't provide more services to people, because we know that there's going to be services that will stop on that day."

– Antonio Fernandez, Catholic Charities of the Archdiocese of San Antonio

Federal government funding cuts to Medicaid and SNAP might have less effect on Texas than other states

"Well, the biggest thing right now is what was just passed by the House of Representatives that will be coming up to the Senate, which if passed would result in more cuts to Medicaid and cuts to the SNAP program. And that would just be a shame. I think the cuts would be deeper in other States, because Texas is one of 10 States that didn't expand Medicaid. But the 40 States that did, if that's enacted, their cuts will go back to where we are in Texas, which would be a shame. and then the SNAP benefits would be a shame, also."

– Key Informant

Philanthropy and Volunteerism

Lastly, key informants were pleased to discuss the prevalent spirit of philanthropy in Bexar County. Whether through religion, social norms, culture, or other avenues, the act of giving and volunteering is something significant and beneficial about Bexar County residents. Some of the key informants' organizations rely on volunteerism and philanthropy to maintain their operations and services.

What you see in San Antonio is a caring, faith-based community, with people who give back to their community. And that's how I see philanthropy." – Edward Banos, University Health

"There are so many people in our community who are committed to making San Antonio and Bexar County the best they can be – in every sense of that word. This commitment spurs the philanthropy that is making a real difference for so many of our community programs and nonprofits. Philanthropy is what comes from your heart. There are people who can write large checks, and that's philanthropy. But when you see hundreds of volunteers come to this hospital because they want to help take care of a patient, not in a medical sense, but just to be there for people who are sick, scared and anxious. Seeing a friendly face and someone who just wants to sit with them can make a huge difference – that is another way people give from their hearts. People sometimes think philanthropy is about a wealthy person getting a building named after them, but what you see in San Antonio are people who genuinely care - a very caring culture, a very faith-based culture that wants to commit to giving back to this community. That is philanthropy in action."

– Edward Banos, University Health

CONCLUSION

In total, this qualitative summary synthesizes a thematic analysis of four focus groups (46 participants total), an open-ended survey question (62 responses), and seven key informant interviews with community leaders who serve Bexar County. There were many overlapping themes, including mental health, housing, infrastructure, economic mobility, education, and employment. However, there was nuance in how these themes were discussed by participants. The focus group participants and survey respondents generally discussed the topics in a more micro-perspective that detailed day-to-day experiences of community members and how their individual health has been impacted. The key informants mostly discussed these same themes in a more macro/organizational perspective where they detailed the systems which allow barriers to exist and worsen. Overall, all the qualitative data points to a need for systems and organizations to shelter vulnerable communities and populations, dismantle barriers to healthcare and healthy living, assist with the negative outcomes from the COVID-19 pandemic, have more efficient avenues and resources for organization to operate successfully, and have accessible ways for communities to engage in philanthropy and find community resources. The most prominent themes and sub-themes from all the qualitative data can be found in the table at the end of this appendix. While these themes are not the only things that matter, they were discussed at length multiple times by different people. The table also shows whether the theme or sub-theme was present in the focus groups, open-ended survey responses, and/or key informant interviews.

We thank all participants for sharing their perspective and experience, as we would not have been able to gather such thoughtful insights without them.

Fig. A1 Summary of topics/themes prevalent in qualitative portions of 2025 Bexar County CHNA

Topic/Theme	Focus Group	Key Informant Interview	Open Ended Survey Response
Role in the community and motivation		+	
Disenfranchised communities and vulnerable populations			
Rural areas, South Side, West Side, other geographic disparities	+	+	+
Racial/ethnic minorities	+	+	+
Immigrants/refugees	+	+	
People with language barriers	+	+	
Unhoused people	+	+	+
Those in foster care			+
Youth	+	+	+
Elderly	+	+	+
Formerly incarcerated or on probation	+	+	+
Disabled people	+		+
People with substance use disorders	+	+	+
Veterans		+	
Barriers to healthcare and healthy living			
Social determinants of health and interconnected social issues (including education, employment, economic mobility, healthcare, built environment and infrastructure, transportation, walkable areas, and potable water access)	+	+	+
Health insurance and medical costs	+	+	+
Housing availability, affordability, and diversity	+	+	+
Health provider shortages	+	+	
Food security	+	+	+
Health literacy, preventive care, and coordination of care	+	+	+
Financial literacy		+	
Safety	+		+
Childcare	+	+	
Extreme/hazardous weather	+	+	+
Applying for services, meeting service criteria, long waitlists, and lack of knowledge of resource availability	+		
COVID-19			
Mental health, stress, and lack of social interaction	+	+	+
Telemedicine, remote work, and technology	+	+	+
Organizational changes and funding/resources		+	
More awareness of systemic disparities	+	+	
Educational quality	+	+	
Job loss	+	+	
Organizations and their functioning			
Collaboration between organizations	+	+	+
Community outreach and participation	+	+	
Organizational funding; how it's affected by politics/government	+	+	+
Philanthropy and volunteerism	+	+	
Community resources	+	+	

APPENDIX B: TECHNICAL NOTES

ASSESSMENT DEVELOPMENT PROCESS AND PARTICIPANTS

The 2025 Bexar County Community Health Needs Assessment (CHNA) was developed through a collaborative, equity-centered process that prioritized the voices of those most impacted by poor health and social outcomes. The approach intentionally engaged both organizational stakeholders and community residents to ensure that the final report reflects lived experiences, frontline insights, and actionable guidance.

Elements of **stakeholder analysis** were applied to guide stakeholder selection. These tools helped identify individuals and organizations with deep ties to high-need populations, including those facing homelessness, poverty, chronic illness, housing instability, and systemic barriers to care.

Key Stakeholder Involvement

ORGANIZATIONAL ENGAGEMENT

A total of **seven Key Informant (KI) interviews** were conducted with leaders from a diverse cross-section of community-based, public, and private organizations. These individuals were nominated by **CHNA Board Members, CHIP Workgroup partners**, and **Data Committee members**, based on their leadership roles in serving populations

with the highest needs. Recommendations included hospital and public health leadership, food insecurity advocates, workforce development agencies, and trusted lay leaders. These Key Informants:

- participated in one-on-one interviews to share insights on root causes, barriers, and service gaps;
- supported the design of culturally and linguistically appropriate outreach strategies; and
- informed data interpretation through a real-world lens grounded in community needs.

Several of these organizations also served on standing advisory or CHIP working groups and contributed to the review and refinement of CHNA survey tools and data indicators. Please see the **Key Informant Interviews** section of this appendix to learn more about that methodology.

COMMUNITY-BASED COLLABORATION

The Health Collaborative and CINow team worked closely with grassroots, community-based, and faith-based **organizations** to ensure outreach and engagement efforts were inclusive and trusted. These partners helped connect the process to neighborhoods and populations often underrepresented in traditional needs assessments. Through this collaboration:

- trusted messengers helped recruit residents with lived experience to participate in focus groups;
- outreach materials and settings were adapted to be welcoming, accessible, and culturally relevant; and
- community organizations hosted sessions and helped create safe spaces for honest dialogue.

RESIDENT PARTICIPATION & CHW-SUPPORTED FACILITATION

To center lived experience, **four focus groups** were conducted in high-need ZIP codes. Populations included:

- individuals with experience of homelessness;
- low-income families and caregivers;
- individuals managing mental health and chronic conditions; and
- immigrants and other residents with limited access to care.

Community Health Workers (CHWs) served a central role in engaging residents, brokering trust, and facilitating participation. CHWs helped host while CINow facilitated these focus groups, ensuring participants had the opportunity to share their needs, priorities, and areas of greatest concern. Their involvement deepened trust, enhanced cultural responsiveness, and aligned with a community-based model of engagement. Please see the Resident Focus Groups section of this appendix to learn more about the methodology.

EQUITY-CENTERED ENGAGEMENT

Organizations and community members involved in the CHNA process represented populations disproportionately affected by the conditions contributing to poor health outcomes. Their engagement extended beyond consultation and included:

- recommending trusted Key Informants and co-developing outreach strategies;
- hosting and facilitating focus groups for hard-to-reach communities;
- informing culturally responsive approaches to data collection; and
- co-interpreting findings and naming priority areas for action.

This participatory approach strengthens the CHNA's validity and accountability, ensuring that resulting priorities are truly grounded in the voices and needs of the community. **Fig. B1** summarizes the primary ways that various organizations and stakeholder groups participated in the CHNA, and through which organizations/groups and roles nine different communities and populations were represented. Individuals' names are not listed for privacy.

Planning and Scoping the Assessment

The Health Collaborative contracted with Community Information Now (CINow), a nonprofit local data intermediary serving Bexar County and Texas, for quantitative and qualitative data collection, data analysis, and report development. The two organizations worked closely throughout the roughly 10-month assessment period.

The Health Collaborative's board, staff leadership, and Community Information Now (CINow) drafted a CHNA approach, structure and flow, data collection methods and instruments, list of extant data indicators, and timeline for review by a Steering Committee in January 2025. CINow set up a shared drive in UTH-Share, UTHealth Houston's implementation of Google's G Suite for Education, to facilitate collaboration and review and edit of CHNA plans and draft materials.

The CHNA approach was developed based on about 50 collective years of conducting community health needs assessments in Bexar and a number of other Texas counties, as well as teaching community health assessment to graduate public health students. It did not adhere strictly to any prescribed national model, but closely resembles the Catholic Health Association of the United States' approach as outlined in its *Assessing and Addressing Community Health Needs* guide. Each component of the approach is intended to serve a specific purpose.

COMPONENT	COMPONENT PURPOSE
Extant Quantitative Data	Use the best available extant administrative and survey data to identify trends, patterns, and disparities in area demographics, social determinants or non-medical drivers of health, health-related behaviors and other risk and protective factors including preventive care utilization, and health outcomes including overall health status, morbidity, and mortality..
Community Resident Survey	Learn how residents rate their health and social connections, what challenges they're living with, what assets they feel are most important to their health and how easily they can access those assets, and how well they're able to access several specific types of health care.
Focus Groups	Learn how people from several vulnerable groups (**Fig. B1**) view "healthy", what they need to be healthy, what challenges and barriers they experience, how the COVID-19 pandemic changed their lives, and any other issues they choose to raise.
Key Informant Interviews	Learn from leaders or organizations serving populations with the highest needs what they view as root causes, barriers, and service gaps; learn about any specific challenges or windows of opportunity for the community.

Fig. B1 Summary of participant roles and representation in 2025 Bexar County CHNA

KEY TO CHNA ROLES:

P - planning, oversight, input on issue prioritization for report Conclusion, report review and feedback

V - provided data via survey response or participation in focus group or key informant interview

D - Data collection (incl. participant recruitment), analysis & visualization, interpretation, report development

Organization (participant count)	Role(s) in CHNA	Population Represented								
		Communities of color	Residents of lower-income neighborhoods	People managing mental illness or other chronic conditions	People living with one Or more disabilities	Immigrants, refugees, and/or their immediate family	LGBTQIA+	Military and veterans	People without stable housing	People with poor access to health & human services*
Local governmental public health & hospitals										
Bexar Co. Prev. Health & Environmental Svcs. (2)	P	+								
City of SA Metropolitan Health District (6)	P V	+								
University Health (3)	P V	+								
Hospital systems, other providers, health plans										
CHRISTUS Health (1)	P V	+								
Community First Health Plans (2)	P	+								
Methodist Healthcare Ministries (2)	P V									
Methodist Healthcare System (1)	P	+								
Universities										
Texas A&M University San Antonio (1)	P									
UT Health San Antonio (2)	P	+								
UTHealth Houston School of Public Health in SA (3)	D	+								
Other key categories										
Community residents on THC Board (3)	P V	+	+							+
Community residents in focus groups (46)	V	+	+	+	+	+	+	+	+	+
Community resident survey respondents (145)	V	+	+	+	+	+	+	+		+
Faith community (2)	V	+								
Human services providers** via interview (3)	V	+								
Philanthropy and funders via interview (4)	V	+								
Private business, for-profit and nonprofit (2)	P V	+						+		
Workforce development (1)	V	+								
CHNA staffin										
The Health Collaborative (8)	P D	+	+	+	+	+	+	+	+	+
Community Information Now (5)	P D	+	+	+	+	+	+			

* Includes people with low/moderate income, without health insurance, with limited English speaking ability

** Food, housing, refugee assistance, veterans' assistance

Extant data indicators for trending and disaggregation were selected from CINow's inventory of 177 indicators for which relevant data is available for Bexar County. The categories in the adjacent table are based on the Bay Area Regional Health Inequities Initiative model used for several prior Bexar County CHNAs. After some discussion by CINow and The Health Collaborative, 90 extant data indicators were selected, with several related to current Community Health Improvement Plan (CHIP) objectives. A total of 153 individual charts (bar and five-year trend) and maps (typically ZIP code/ZCTA) were designed to visualize those 90 indicators.

CATEGORY	CANDIDATE INDICATORS
1 Population/demographics	5
2 Physical environment	16
3 Social environment	35
4 Economic environment	23
5 Service environment	9
6 Health behaviors and risks	26
7 Health outcomes	63
Total	**177**

Timeline

As The Health Collaborative and CINow were simultaneously conducting CHNAs in five counties (Atascosa, Bexar, Comal, Gillespie, and Guadalupe), much of the work was done once (e.g., key informant interview guide development) for all counties. Similarly, it was more efficient to gather and analyze extant data for all five counties at the same time. Primary data collection, data analysis, and report development was specific to each county. **Fig B.2** lays out the timeline for both cross-county and Bexar-specific task areas.

Fig. B2 2025 Bexar County CHNA timeline

Cross-county task areas*	2024			2025								
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Planning and scoping	■	■	■									
Community survey development & translation		■	■	■	■							
Focus group guide development & translation			■				■					
Key informant interview guide development			■									
Extant quant. data collection & processing (all counties)	■	■	■	■	■	■	■	■	■	■	■	
Data visualization (extant & survey data charts+maps)	■	■	■	■	■	■	■	■	■	■	■	
Bexar County-specific task a eas	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Community survey deployment and results analysis					■	■	■	■	■			
Focus groups and analysis							■	■				
Key informant interviews and analysis								■	■			
Report development, review, revision									■	■	■	
Further issue prioritization for report Conclusion section										■	■	
Report design and layout											■	■
Release/launch												■

* Most of the CHNA planning, scoping, and instrument development was done simultaneously for five counties: Atascosa, Bexar, Comal, Gillespie, and Guadalupe. Four additional counties were added in June 2025, but as the work did not affect Bexar County, that timeline is not shown here.

The overall CHNA approach, timeline, workplan of extant data indicators and charts/maps, focus group guide, key informant interview guide, and proposed report flow were presented to the Bexar County CHNA Steering Committee in January 2025. Members were invited to provide feedback on any component; no concerns were voiced in or outside of the meeting to drive changes in the plans or materials.

Issue Prioritization

The report conclusion is intended to summarize and triangulate the issues and themes that rose to the top in the community survey, focus groups, key informant data, and extant data. The Health Collaborative's Board of Directors (see **Fig. B1** earlier in this appendix) was invited to review the draft report and identify the 10 or so issues they felt were relatively higher-priority for Bexar County's health and well-being, drawing on both their own experience and expertise and the data they had just reviewed. Prioritization participants were not required to apply any specific criteria to determine which issues they felt were higher-priority. Prioritization was conducted in late July and early August 2025 using a digital tool developed by CINow for this purpose, similar to that used in prior CHNAs, and 13 people participated.

The digital prioritization tool listed the issues and factors covered in the CHNA, organized in the same sections as the report itself, with the exception of an additional "cross-cutting issues" category. Each issue had side-by-side radio buttons labeled "Lower priority" and "Higher priority," and the default rating was set to "lower priority." Several write-in spaces were offered should the participant want to add any issues or factors not listed. An optional comment box was provided at the end of each section should the participant want to provide their reasoning or any other thoughts they feel would be helpful. Participants were allowed to choose a few issues from each section or concentrate their choices in just one or two sections.

PRIMARY DATA AND COMMUNITY VOICE

Community Resident Survey

The goal of the community survey was to learn how residents rate their health and social connections, what challenges they're living with, what assets they feel are most important to their health and how easily they can access those assets, and how well they're able to access several specific types of health care. CINow researched and reviewed a number of surveys in use in the United States. The survey instrument ultimately developed was based largely on an instrument used for the 2023 Maricopa County (Arizona) coordinated community health needs assessment, and that questionnaire was in turn adapted from an instrument created by the National Association of County and City Health Officials (NACCHO).* The survey instrument and full descriptive statistics are in Appendix C at https://cinow.info/2025-bexar-chna-appendix-c/.

The community survey was digital (QuestionPro) with a convenience sample. The English-language survey was auto-translated to seven other languages, but because of budget limitations, only the Spanish-language version was human-reviewed and revised to better reflect Spanish commonly spoken in the San Antonio area. No responses were received in any language except English and Spanish. Closed-ended survey questions were analyzed in R. Open-ended responses were analyzed in ATLAS.ti using open coding to identify all themes, axial coding to iteratively categorize themes into major vs. sub-themes, and selective coding to extract the final themes.

* Maricopa County Department of Public Health. (2024, July). *Coordinated Community Health Needs Assessment: 2023 Community Survey Report*. Retrieved November 25, 2024 from https://www.maricopa.gov/DocumentCenter/View/96382/Maricopa-County-CHNA-Survey-Report

Although the survey was open for nine weeks (February 10 to April 15, 2025) and advertised in multiple ways, only 145 responses were received from Bexar County residents. Respondents were disproportionately female (67%), with fewer than five respondents identifying as non-binary. Of the respondents who provided a race/ethnicity (n=141), those percentages reflected the Bexar County population surprisingly well (**Fig. B3**).

Fig. B3 Race/ethnicity of 2025 Bexar CHNA survey respondents and Bexar County residents

RACE/ETHNICITY GROUP	RESPONDENTS	BEXAR COUNTY
Asian	3%	3%
Black or African American	7%	8%
Hispanic or Latino/a/x	60%	60%
Native Hawaiian or Pacific Islander	1%	<1%
Some other race	0%	<1%
Two or more races	6%	3%
White*	23%	26%

Source: 2025 Bexar CHNA survey data and U.S. Census ACS 2023 1-Year Estimates, Table DP05

* Although Middle Eastern or North African (MENA) was a response option offered, no respondents identified as MENA

Bexar CHNA survey respondents were asked whether they identified with any of several listed characteristics or groups, all of which can be considered vulnerable populations (**Fig. B4**). They were able to select more than one option and write in additional options. People living with a disability were slightly under-represented compared to Bexar County residents overall (14% vs. 16%), as were veterans and active-duty military (9% vs. 11%). The under-representation was much more pronounced for immigrants (5% vs. 14%), the only other respondent group for which Bexar County data is available.

Fig. B4 Other characteristics of Bexar CHNA survey respondents and Bexar County residents

RACE/ETHNICITY GROUP	RESPONDENTS	BEXAR COUNTY
Living with a disability	14%	16%
LBGTQIA+	12%	*
Veteran or active-duty military	9%	11%
Immigrant	5%	14%
Homebound	2%	*
Senior living in group setting with or w/o living assistance or medical care	1%	*
Daughter of immigrants¥	1%	*
Foster youth or former foster youth	0%	*
Homeless/houseless (including "couch surfing")	0%	*
Refugee	0%	*

¥ Write-in response

Source: 2025 Bexar County CHNA survey data and U.S. Census ACS 2023 1-Year Estimates, Tables DP02, DP03

* Data is not available for this Bexar County population

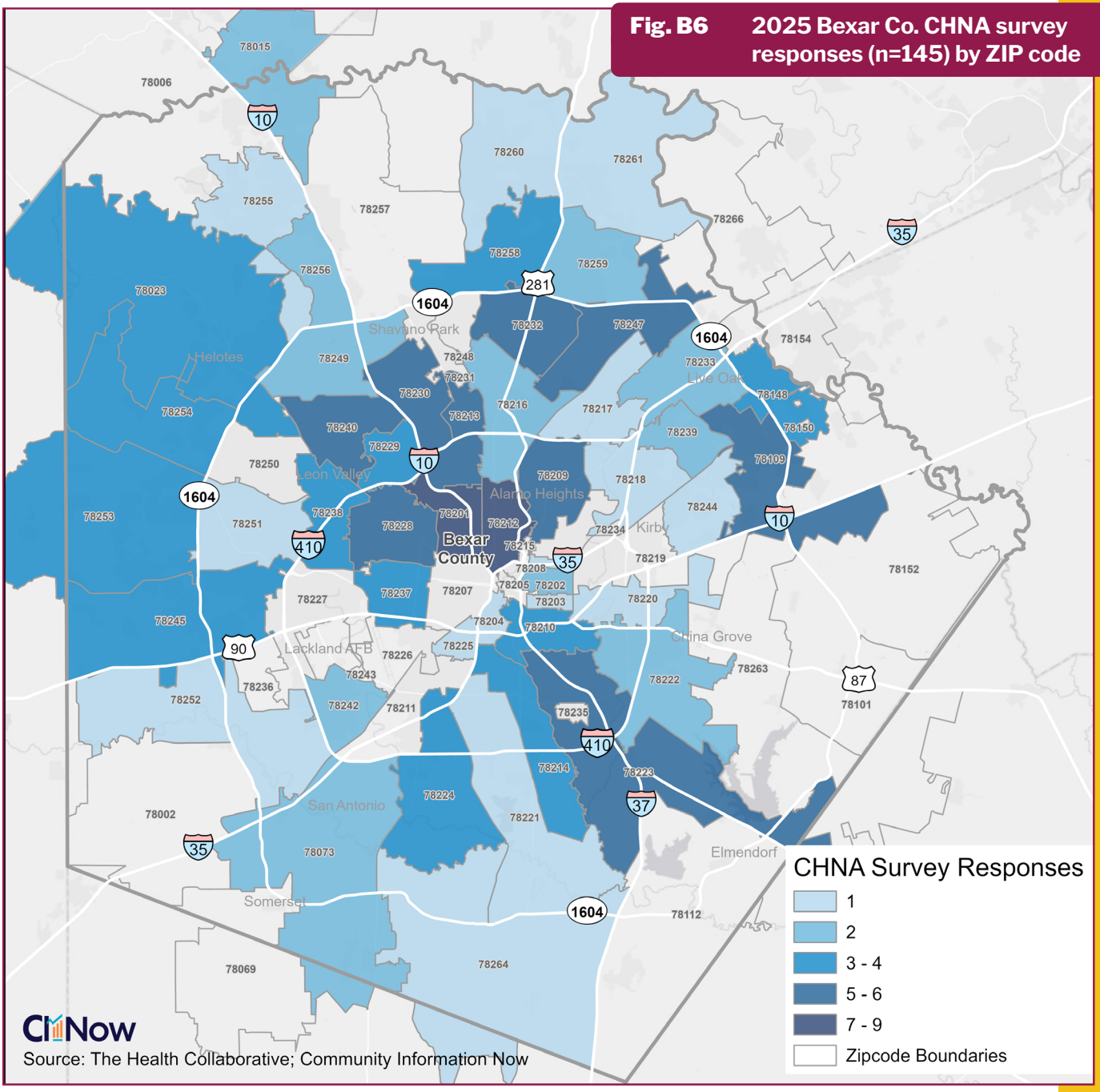
The median household size was two people, and the average size was 2.8. Households were fairly diverse in terms of age composition, as shown in **Fig. B5**, but nearly half only had members between the ages of 18 and 64. Unfortunately, respondents were not at all geographically representative of the county population, with respondents from only 49 ZIP codes (**Fig. B6**). The survey had no respondents at all from some of the county's most populous ZIP codes.

Fig. B5 Household age composition and size reported by 2025 Bexar CHNA survey respondents

HOUSEHOLD AGE COMPOSITION	PERCENT OF HOUSEHOLDS (N=144)	AVERAGE HOUSEHOLD SIZE
0-17 only	1%	2.0
18-64 and 0-17	27%	4.1
18-64 only	49%	2.1
18-64 and 65+	10%	2.9
0-17, 18-64, and 65+	6%	4.9
65+ and 0-17	0%	-
65+ only	8%	1.8
Total	**100%**	**2.8**

Source: 2025 Bexar County CHNA survey data

Fig. B6 **2025 Bexar Co. CHNA survey responses (n=145) by ZIP code**



Resident Focus Groups

With substantial input as to focus group goals and potential participants from the CHNA Steering Committee, volunteer focus group participants were selected with an eye toward engaging meaningful and substantive input from people who worked and lived in Bexar County. The focus group questions were developed by CINow with guidance and input from The Health Collaborative. The English- and Spanish-language focus group guides are available in Appendix C at https://cinow.info/2025-bexar-chna-appendix-c/.

The Health Collaborative, with the help of community health workers, scheduled four focus groups for Community Information Now to facilitate, with one being in both Spanish and English and the others in English alone. Three of the focus groups were held at churches, and one was online through Zoom. All, except the online focus group, included an interactive activity where themes were mapped on a large white board throughout the focus groups, which helped encourage more conversation and kept discussion focused on how multiple themes influence one another. All focus groups were about 1.5 hours long, and participants were compensated by The Health Collaborative for their participation. A total of 46 community residents participated across all the focus groups.

Although all but one focus group was conducted in person, Zoom was used to "listen in" to those in-person groups so that transcripts would be auto-generated. Those transcripts were then human-reviewed and cleaned with the audio recording for backup. Because Zoom transcription works well only for English speech, "Spanglish"-language sessions had to be human-transcribed and reviewed by a second native Spanish speaker prior to thematic analysis.

For the focus groups, open-ended survey responses, and key informant interviews, CINow performed a qualitative thematic analysis in ATLAS.ti using open coding to identify all themes, axial coding to iteratively categorize themes into major vs sub-themes, and selective coding to extract the final themes for write-up. Even though they're included in the same qualitative narrative summary, the Key Informant Interviews (KIIs) were analyzed separately from the focus groups and open-ended survey responses because 1) They are different types of participants, with the focus groups and survey aiming for an audience of community members, and the KIIs being community leaders, and 2) The Key Informants were asked different questions based on their positions in the community, which would lend to their qualitative data having specific differences from the community members. While section one of the qualitative narrative focuses on community members, you will notice similarities with section two because community leaders identified similar themes, but from a broader, more organizational perspective. For this reason, themes are presented in different orders between sections one and two, as the topics emerged from distinct contexts.

Key Informant Interviews

Seven semi-structured key informant interviews were conducted to gather the perspectives of Bexar County community leaders. Key informants were carefully and intentionally chosen by The Health Collaborative for their experiences, expertise, and impactful roles in the community. The goal was to capture a diverse range of voices from different sectors, including those representing healthcare, economic development, faith-based organizations, crisis response, and food security. A set of questions was provided to participants in advance. This was used to begin and guide the conversation, but the interviewer used a flexible, responsive approach, allowing participants to elaborate on topics most relevant to their work and communities. The interview guide is available in Appendix C at https://cinow.info/2025-bexar-chna-appendix-c/.

The interviews were conducted in May 2025, all via Zoom, typically lasting 60-90 minutes. The transcripts auto-generated by Zoom were human-reviewed and cleaned with the audio recording for backup. CINow then performed a qualitative thematic analysis in ATLAS.ti using open coding to identify all themes, axial coding to iteratively categorize themes into major vs sub-themes, and selective coding to extract the final themes.

EXTANT QUANTITATIVE SOURCES AND ANALYSIS

Overview of Sources

This assessment contains quantitative data on approximately 100 indicators, each disaggregated by race/ethnicity group and sub-county geography (ZIP Code Tabulation Area [ZCTA], sector, Census tract, or block group) wherever possible. Indicators were also disaggregated by age group and sex where those variables were thought to add critical

information. Each indicator source is cited throughout the assessment. The 2025 Assessment draws from too many data sources to list here, but the following local, state, and federal sources were used heavily.

- Population and housing data from the U.S. Census Bureau 2020 Census and American Community Survey
- Physical, social, and economic conditions data from the U.S. Census Bureau American Community Survey One-Year Estimates, Five-Year Estimates, and Supplemental Estimates
- Crime data from the U.S. Department of Justice National Incident-Based Reporting System (NIBRS) and the San Antonio Police Department
- Behavioral Risk Factor Surveillance System (BRFSS), vital statistics, injury, blood lead, hospital discharge, emergency department, and communicable disease data from the Texas Department of State Health Services Texas Health Data query system, Texas Health Care Information Collection (THCIC), and by special request
- Supplemental Nutrition Assistance Program (SNAP) data from the Texas Health and Human Services Commission
- Data on people who are unhoused from the Close to Home Point in Time Count Report
- Teen birthrate and low birthweight data from the City of San Antonio Metropolitan Health District
- Vital statistics and prenatal care data from the CDC WONDER query system
- Immunization and vaccination data from the Centers for Disease Control and Prevention
- Child and older adult abuse/neglect data from the Texas Department of Family and Protective Services
- Motor vehicle crash data from the Texas Department of Transportation

Staff from these and many other local and state organizations spent considerable time and effort pulling data for the 2025 Assessment and sharing important context and cautions for that data. The Health Collaborative and CINow are indebted to these individuals and the agencies who allowed them to share their time and expertise.

Analysis of the data typically consisted of calculating proportions and rates, with margins of error or confidence intervals where appropriate; no statistical testing was required. Margins of error and confidence intervals are displayed throughout the assessment. Margins of error were minimized where feasible by combining multiple years of data or, in the case of BRFSS data, by combining ZIP codes into eight sectors as described above.

Sub-county Sectors

Some indicators are broken out geographically by eight sub-county sectors (**Fig. B1**) based on ZIP Code Tabulation Areas (ZCTAs), as ZIP code is a common variable across many local and state datasets. These sectors were developed for the 2013 report in response to the problem of small sample sizes, particularly with regard to the BRFSS dataset. CINow 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 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. As population distribution and income change over time, we periodically revisit the sector groupings to ensure they still make sense.

Hospital Discharge Technical Notes

We call them hospitalization rates for short, but these indicators reflect hospital discharges rather than admissions. The hospital discharge data was downloaded from the Texas Department of State Health Services and the ICD codes that were used for the analysis are listed below.

There are some important limitations to understand with hospital discharge data. The rates are determined by hospitalizations for the disease as the primary diagnosis, not all hospital discharges with that diagnosis. In the case of

the asthma hospitalization rate, for example, the intent is to reflect the rate of hospitalizations for an asthma attack, not hospitalizations for heart attacks or car accidents among people who also happen to have diagnosed asthma unrelated to the reason for the hospitalization. Therefore, the rates are not prevalence or incidence of the disease. These hospitalization counts are also not unique visits or people. If the same person in 78205 goes to the hospital three times for asthma in 2014 then all three visits are included if asthma was the primary diagnosis for the admission during that year.

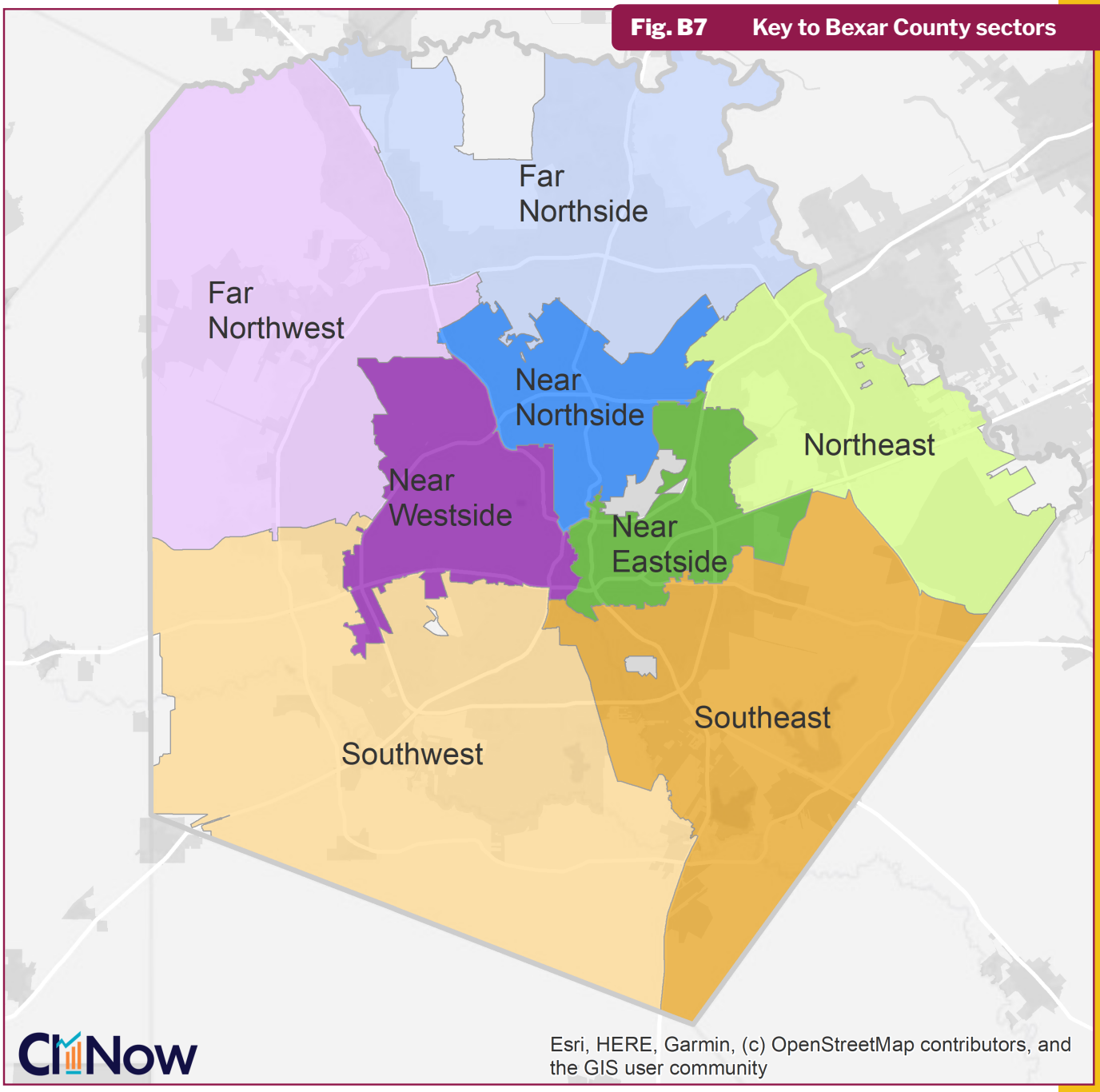
Because the San Antonio Military Health System does not report their hospitalizations to DSHS, the public data files exclude any federal hospital discharges. Because the military hospital systems account for a large portion of our population, the Bexar County hospitalization data should not be compared to other major cities who do not have large federal hospital exclusions in their datasets.

The hospitalization discharge rates were calculated following the Prevention Quality Indicators (PQIs) methodology provided by the Agency for Healthcare Research and Quality (AHQR) for diabetes, hypertension, and heart failure. The PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality outpatient care. The PQIs are population based and adjusted for covariates. Asthma hospitalizations followed the San Antonio Metropolitan Health District's methodology for diagnosis codes and cerebrovascular disease followed the CDC's definition for ICD-10 diagnosis codes. All population estimates for the rates were calculated from the American Community Survey 1-Year estimates available in Table B01001.

Fig. B7 Key to Bexar County sectors

NEAR WESTSIDE	NEAR NORTHSIDE	NEAR EASTSIDE	FAR NORTHWEST	FAR NORTHSIDE	NORTHEAST	SOUTHEAST	SOUTHWEST
78201	78209	78202	78006	78015	78109	78101	78002
78204	78212	78203	78023	78231	78148	78112	78069
78207	78213	78205	78249	78232	78152	78214	78073
78227	78216	78208	78250	78247	78154	78222	78211
78228	78217	78210	78251	78248	78233	78223	78221
78229	78230	78215	78253	78257	78239	78263	78224
78237		78218	78254	78258	78244		78225
78238		78219	78255	78259			78226
78240		78220	78256	78260			78236
				78261			78242
				78266			78245
							78252
							78264

Fig. B7 Key to Bexar County sectors



Behavioral Risk Factor Surveillance System Technical Notes

From the CDC User Guide: The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project between all the states in the United States and the Centers for Disease Control and Prevention (CDC). The BRFSS is a system of ongoing health-related telephone surveys designed to collect data on health-related risk behaviors, chronic health conditions, and use of preventive services from the noninstitutionalized adult population (≥18 years) residing in the United States. Since 2011, the BRFSS has been conducting both landline telephone and cellular telephone surveys. All the responses were self-reported; proxy interviews are not conducted by the BRFSS. The data are transmitted to CDC

for editing, processing, weighting, and analysis. An edited and weighted data file is provided to each participating state health department for each year of data collection, and summary reports of state-specific data are prepared by CDC.

The BRFSS sample sizes were too small to trend annually so three years of data were combined for analysis with a new weight applied. The Texas State Health Department provided three different datasets for Bexar County. The BRFSS core survey had all years 2021-2023 and the supplemental questions were either asked in odd years (2019, 2021, 2023) or in even years (2018, 2020, 2022). In some cases, questions were asked randomly in the 2017 to 2023 timeframe. We pulled the latest three years when possible. In some rare cases where 3 years were not available, we pulled the latest two years. The tables are all labeled as 2017-2023 and in almost all cases include three years within that range.

BRFSS observations marked with an asterisk (*) represent cases in which the Relative Standard Error (RSE) is 30 percent or higher, considered statistically unreliable. The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying the result by 100 to express it as a percentage. The asterisk (*) may also denote cases with a small sample where we are unable to calculate a RSE.

The 2025 Bexar County 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

application STUDIO

CHRISTUS Health

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Methodist HEALTHCARE

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.

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