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ATASCOSA COUNTY 2022

2022

ATASCOSA COUNTY

COMMUNITY HEALTH NEEDS
ASSESSMENT REPORT

Health Collaborative
Bexar County's Community Health Leadership

GrowHealthyTogether
PATHWAYS COMMUNITY HUB

TABLE OF
CONTENTS

THE ASSESSMENT

Every three years the Health Collaborative commissions a comprehensive community health needs assessment for Atascosa County.

Over 100 indicators were researched for this 2022 Atascosa County Community Health Needs Assessment, with data available for about 90 indicators visualized through about 125 charts and maps. Beyond conforming with federal requirements, the 2022 assessment is intended to help stakeholders understand local trends and demographic and geographic disparities in a broad range of social, economic, and environmental determinants of health; health-related behaviors; well-being, illness, and injury; and death. The 2022 Atascosa County Community Health Needs Assessment was guided by a volunteer Steering Committee representing diverse perspectives, and conducted primarily by Community Information Now with substantial community voice data-gathering by The Health Collaborative.

WHAT'S NEW FOR THIS ASSESSMENT?

The most obvious departure from the *2019 Bexar County and Atascosa County Community Health Needs Assessment* is that the Bexar County and Atascosa County assessments have been split into two separate documents. This document focuses solely on Atascosa County.

For better content flow, this assessment is also organized somewhat differently from the 2016 assessment. Some sections that may have stood alone in the 2016 are now folded together under major headers.

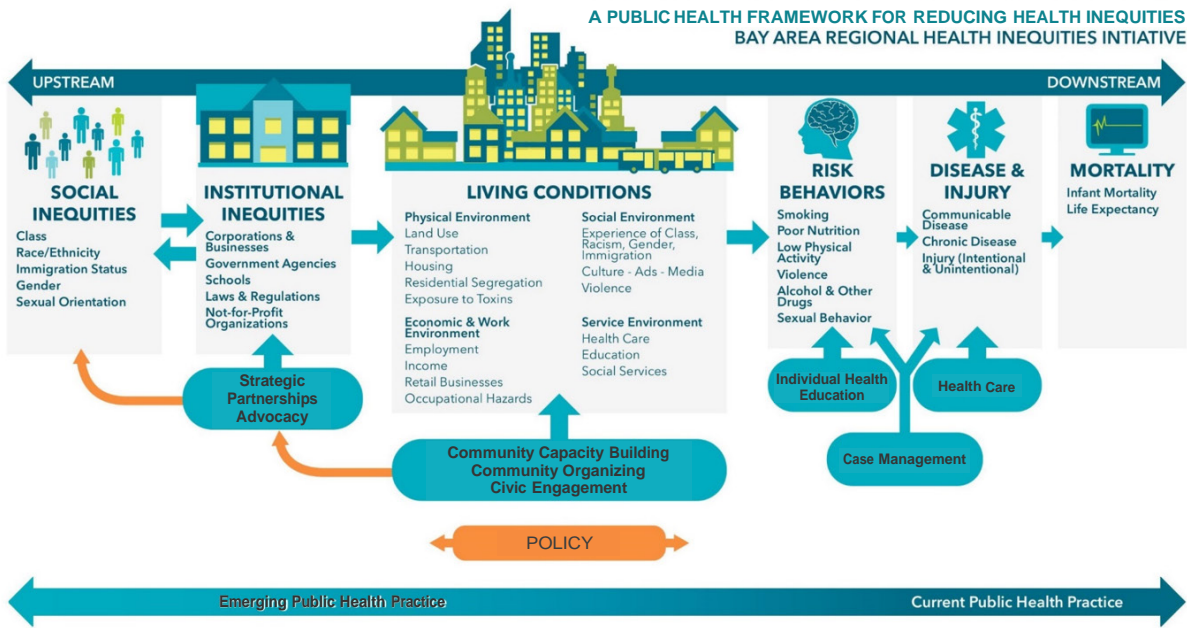# WHAT CONTINUES WITH THIS ASSESSMENT?

As with the 2016 and 2019 assessments, this report follows the Bay Area Regional Health Inequities Initiative's (BARHII) health equity framework. That framework explicitly situates social, economic, environmental, and structural factors as upstream drivers of health-related behaviors; well-being, illness and injury, and death.

The relative contribution of medical care to health and well-being is only 10% to 20%. As in past reports, this assessment devotes significant attention to the determinants of the other 90% of health and well-being.

This assessment continues extensive disaggregation of the data, breaking it out wherever possible by race/ethnicity group, age group, sex, and smaller-than-county geography. Disaggregation helps uncover disparities and inequities that are hidden in measures like averages and medians. As with prior reports, unfortunately, breaking the data down into many categories sacrifices certainty and precision due to smaller samples and suppression. Administrative data (e.g. deaths, abuse and neglect) may be suppressed for privacy reasons or because small numbers result in unstable rates. Small sample sizes in survey data mean wide margins of error or confidence intervals, particularly for the Behavioral Risk Factor Surveillance System (BRFSS) survey.

[1]Internal Revenue Service. (2021). Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3). Available online at **https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3**

[2]See for example McGovern, L.et al. (2014). Health policy brief: The relative contribution of multiple determinants to health outcomes. Available online at **http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf**

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INTIATIVE

UPSTREAM → DOWNSTREAM

SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

INSTITUTIONAL INEQUITIES
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations

LIVING CONDITIONS
Physical Environment
Land Use
Transportation
Housing
Residential Segregation
Exposure to Toxins

Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards

Social Environment
Experience of Class, Racism, Gender, Immigration
Culture - Ads - Media
Violence

Service Environment
Health Care
Education
Social Services

RISK BEHAVIORS
Smoking
Poor Nutrition
Low Physical Activity
Violence
Alcohol & Other Drugs
Sexual Behavior

DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)

MORTALITY
Infant Mortality
Life Expectancy

Strategic Partnerships Advocacy

Community Capacity Building
Community Organizing
Civic Engagement

Individual Health Education

Health Care

Case Management

POLICY

Emerging Public Health Practice ← → Current Public Health Practice

Pop-up COVID-19 Vaccine & Flu Clinics, KN95 mask & COVID rapid home test distribution to community

Health Collaborative
Bexar County's Community Health Leadership
With UIW School of Nursing, Lela Pharmacy & YWCA at Empower House and Northside Activity Center

The Health Collaborative conducted community focus groups and key informant interviews, the transcripts of which CI:Now qualitatively analyzed. Relevant content is embedded in appropriate sections throughout the report, and the full analysis is provided as an appendix. Ellipses ("…") show where quotes were edited for clarity, and some identifiers have been removed. Any quotes utilized in this assessment reflect the opinion of one or more community members and not necessarily that of The Health Collaborative. Participant characteristics and narrative summaries of all qualitative information provided through the interviews and discussion groups are included in Appendix A, **Community Voice,** and Appendix E, **Technical Notes.**

As in 2019, the 2022 findings highlighted in the Conclusion section were chosen by respondents in a survey of the Steering Committee and the Health Collaborative board of directors and then grouped into coherent themes. Those findings are presented by section – for example, social determinants separate from illness, injury, and death – to preserve and illustrate priority issues at three separate points in the "upstream-downstream" continuum of health determinants and health outcomes.

ABOUT RACE AND ETHNICITY IN THIS ASSESSMENT

Whenever the data is available, this report breaks data out by race/ethnicity, sex, and age group. One of the challenges of doing so is that different data sources categorize these groups differently. Individual ages are grouped differently (e.g., age 0 to 17 vs age 0 to 19), and some data values (e.g., transgender and non-binary) may not be recognized by the data source at all. The same is true for race (e.g., African American, Asian) and ethnicity (Hispanic or non-Hispanic). Some data sources report race and ethnicity separately, while others combine them, and some data sources report eight race/ethnicity categories while others use just three or four.

Where the data is available, CI:Now employs the U.S. Census Bureau's race categories and combines those race categories with ethnicity. Wherever possible, Hispanic or Latino people are reported as one race/ethnicity group, with ethnically non-Hispanic people reported in racial categories. Preliminary 2020 Census data showed an increasing number of Hispanics are identifying (and being coded) as of other race or two or more races, Thus, in reviewing the data it should be remembered that a Hispanic person may identify as any race or as multiracial.

Finally, CI:Now uses Associated Press style (AP) to guide capitalization of group names. The names of all race/ethnicity groups except white are capitalized. CI:Now also uses AP style for general audiences in treating the word data as singular rather than plural.

DEMOGRAPHICS
POPULATION COMPOSITION

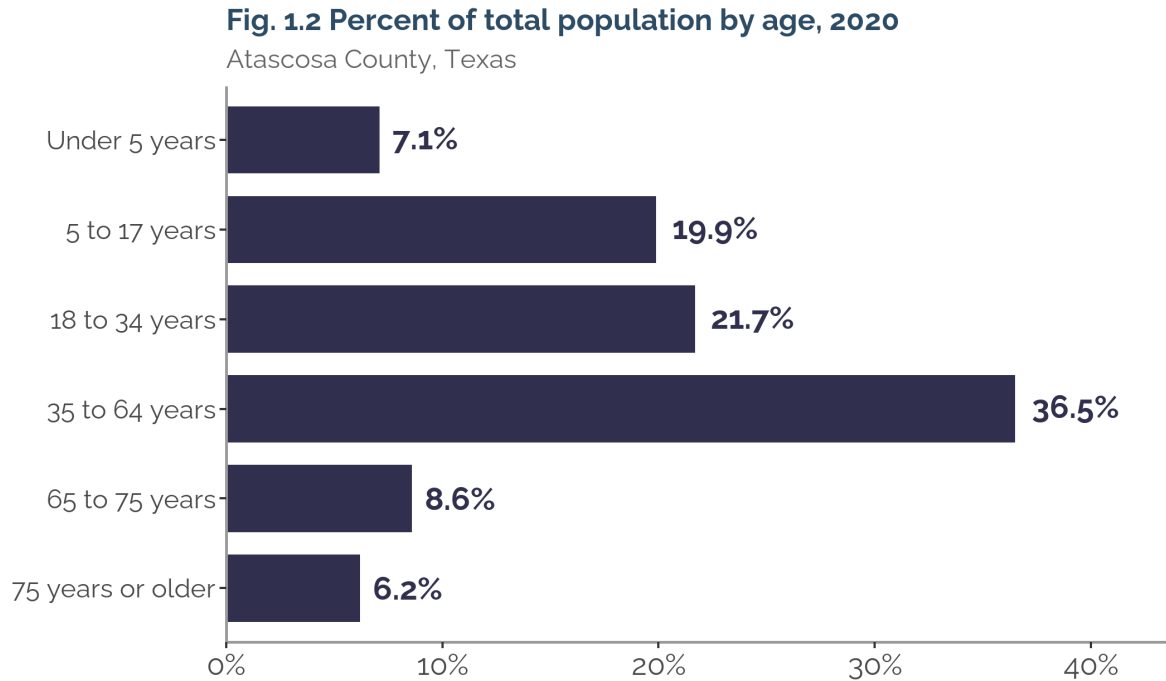**Fig. 1.1 Total Population**
Atascosa County, Texas
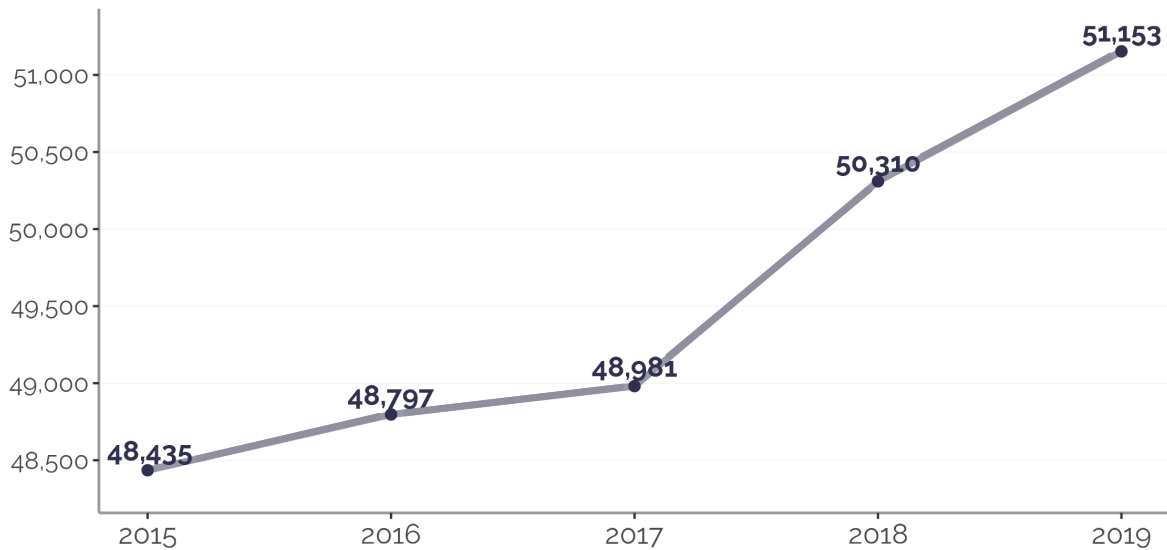
Source: ACS 1-Year Supplemental Estimates. Table: K200101
Prepared by CI:Now for The Health Collaborative

Atascosa County's total population is estimated by the U.S. Census American Community Survey to have grown nearly 6% between 2015 and 2019 (Figure 1.1), although the 2020 Census put total population at 48,981.[1] The Texas Demographic Center projects the county's population will grow to 60,000 by 2030 and to more than 73,000 by 2050,[2] placing further demands on local infrastructure and services.

[1]U.S. Census Bureau. 2020 Decennial Census, Table P-1. Available online at **https://data.census.gov/cedsci/table?q=2020%20 population&g=0500000US48029&d=DEC%20Redistricting%20Data%20%28PL%2094-171%29&tid=DECENNIALPL2020.P1**

[2]Texas Demographic Center. (n.d.) Texas Population Projections Program: 2018 Sex and Race/Ethnicity Total Population. Available online at **https:// demographics.texas.gov/Data/TPEPP/Projections/**.

Fig. 1.2 Percent of total population by age, 2020
Atascosa County, Texas

Age	Percent
Under 5 years	7.1%
5 to 17 years	19.9%
18 to 34 years	21.7%
35 to 64 years	36.5%
65 to 75 years	8.6%
75 years or older	6.2%

Source: ACS 5-Year Estimates. Table: B01001
Prepared by CI:Now for The Health Collaborative

Atascosa County has a relatively young population, with people 65 and older comprising 14.8% of total population (Figure 1.2). In comparison, people 65 and older make up 16.5% of the U.S. population. [3]

ZIP CODES AND ZCTAS

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

ESTIMATES AND ERROR BARS

No data is ever perfect, but some things can be counted one by one – housing units, deaths, hospitalizations. For others the effort and expense of a count is often very high, so instead we look only at a sample, or subset of the total. Wherever there's a sample, there's always an open question about the estimates that came from it. The smaller the sample relative to the total, the less confident we can be that the estimate holds true for the total. In this report we usually call that uncertainty the margin of error (MOE) or confidence interval, and we show it with gray "error bars". Error bars (or lighter color bands in time trend charts) will be present in virtually every chart where the figures are estimates rather than counts. In general, the wider the error bar or the color band for an estimate, the more we need to take that estimate with a grain of salt.

[3]U.S. Census Bureau. (n.d.) Census QuickFacts. Available online at **https://www.census.gov/quickfacts/fact/table/US/PST045221.**

Atascosa County is overwhelmingly Hispanic (65%) and white (33%), with American Community Survey estimates indicating that only 2.5% of the population is of any other race/ethnicity group (Figure 1.3). The Hispanic category in the chart includes Hispanics of any race or combination of races.
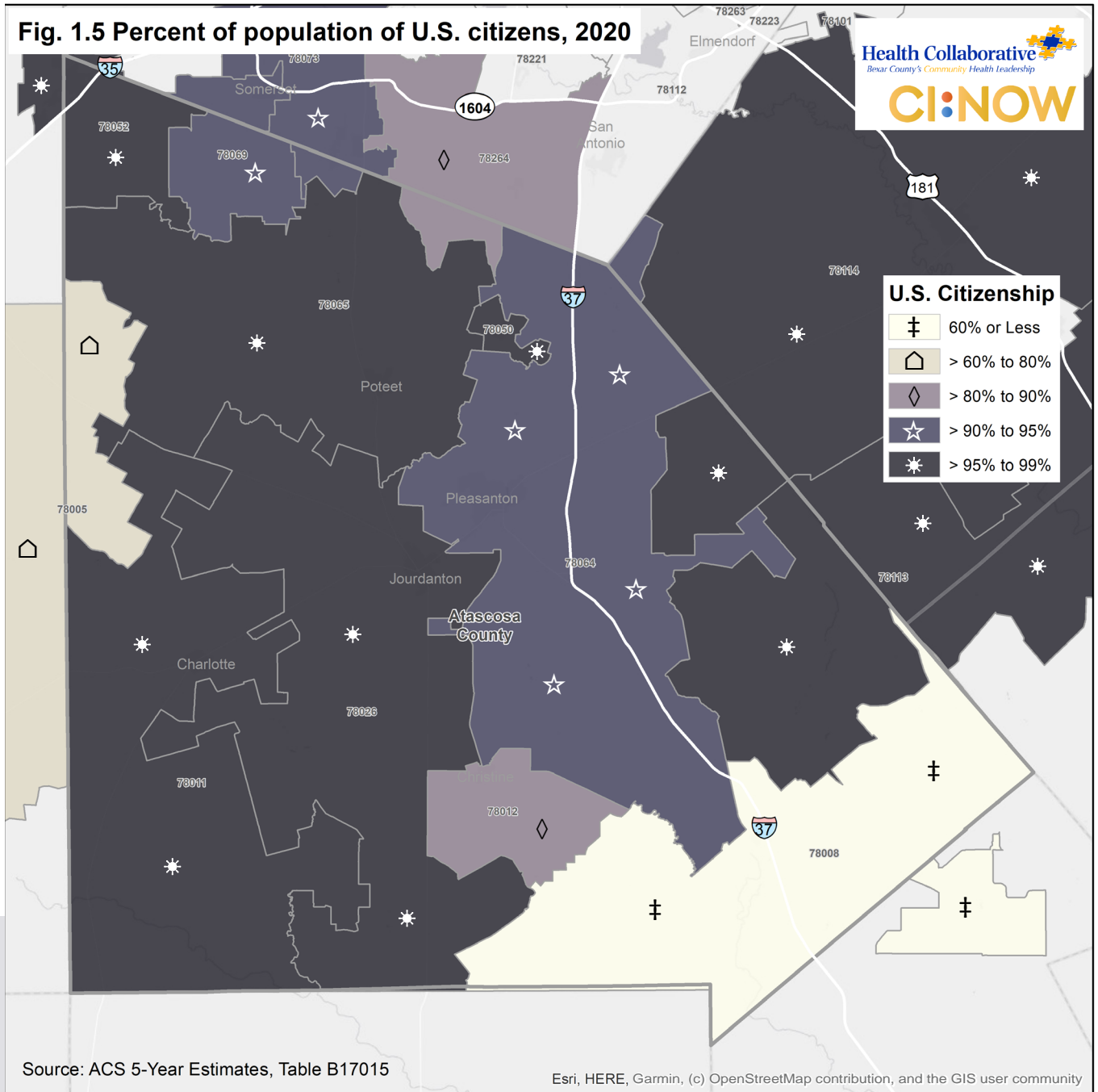
Fig. 1.3 Percent of total population by race, 2020

Atascosa County, Texas

Race	Percent
American Indian or Alaska Native	0.0%*
Asian	0.5%
Black or African American	1.0%
Hispanic	64.7%
Native Hawaiian or Pacific Islander	0.0%*
Other Race	0.0%*
Two or More Races	0.9%
White (Non-Hispanic)	32.8%

*Unreliable: Error is too large relative to estimate
Source: ACS 5-Year Estimates. Table: DP05
Prepared by CI:Now for The Health Collaborative

Fig. 1.4 Percent of total population of U.S. citizens by birth or naturalization

Atascosa County, Texas

Year	Percent
2015	94.4%
2016	96.6%
2017	93.7%
2018	96.7%
2019	93.8%

Source: ACS 1-Year Supplemental Estimates. Table: K200501
Prepared by CI:Now for The Health Collaborative
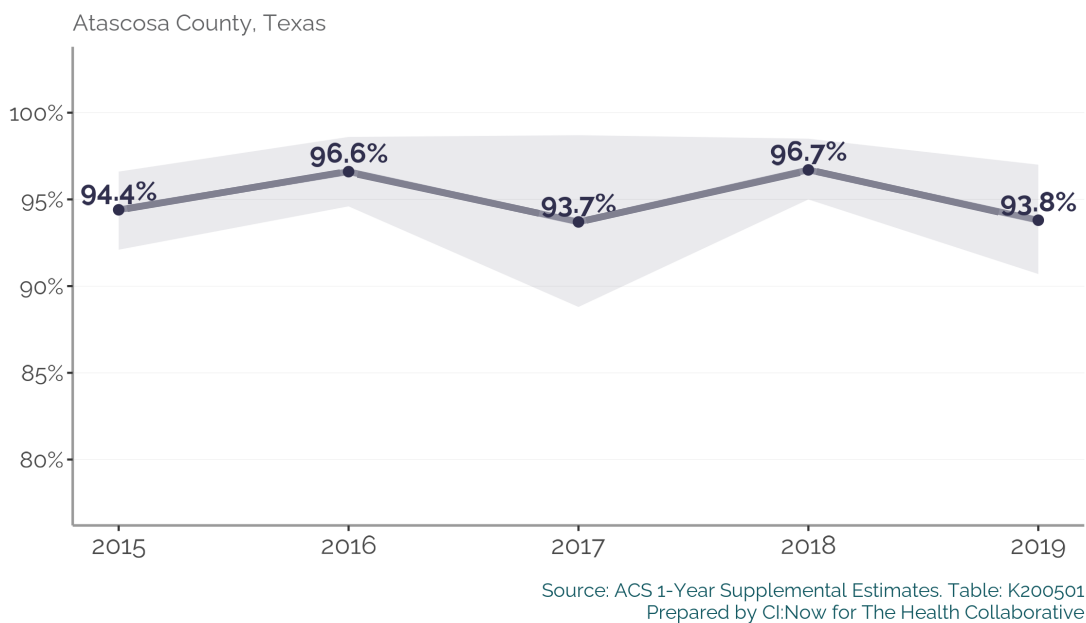
Citizenship and documented status have implications for availability of and willingness to seek services and assistance. The percent of residents who are U.S. citizens has remained flat over the past five years, estimated at more than nine in 10 county residents (Figure 1.4).

Fig. 1.5 Percent of population of U.S. citizens, 2020
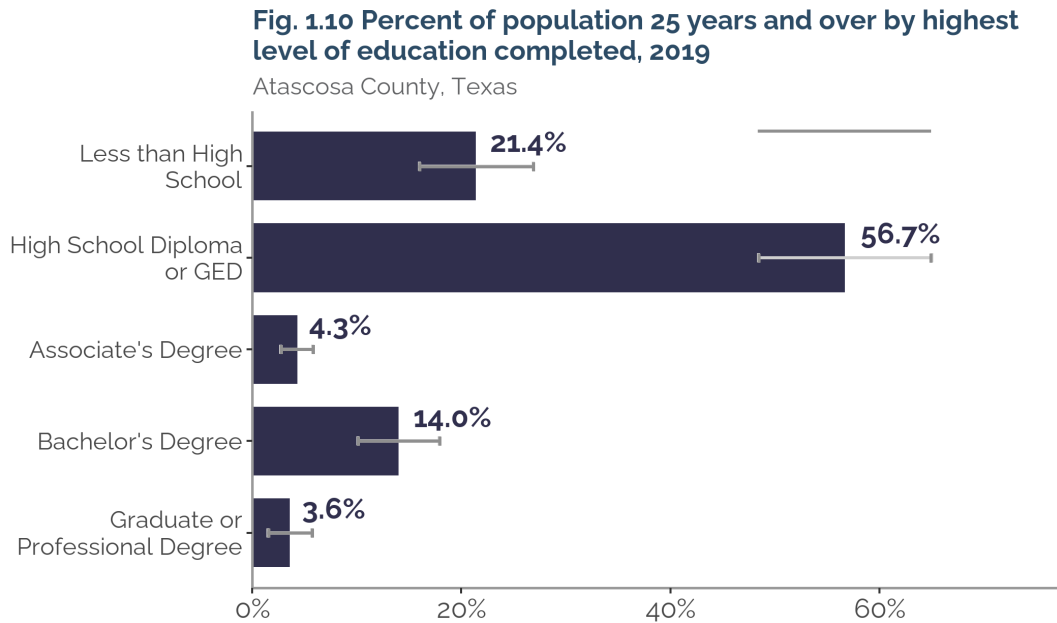
Source: ACS 5-Year Estimates, Table B17015

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

Although high in all ZIP codes, the U.S. citizen population is not evenly distributed throughout the county (Figure 1.5). The proportion of population who are U.S. citizens is lowest in 78008 and 78012 in the southeastern part of the county.

Over half of households are a married-couple household (Figure 1.6), with nearly three in 10 being a person living alone. Single female householders are about twice as common as single male householders, and together these two groups make up more than two in 10 households, the same proportion as those living alone. Although this is by no means a homogenous population, living alone or being a single householder, particularly where children are present, may have implications for social support needs and isolation.

Fig. 1.6 Percent of total households by type of household, 2020
Atascosa County, Texas

Household Type	Percent
Married Couple	53.8%
Male Householder, no wife present	7.4%
Female Householder, no husband present	15.3%
Living Alone	20.5%
Other Non-Family	3.1%
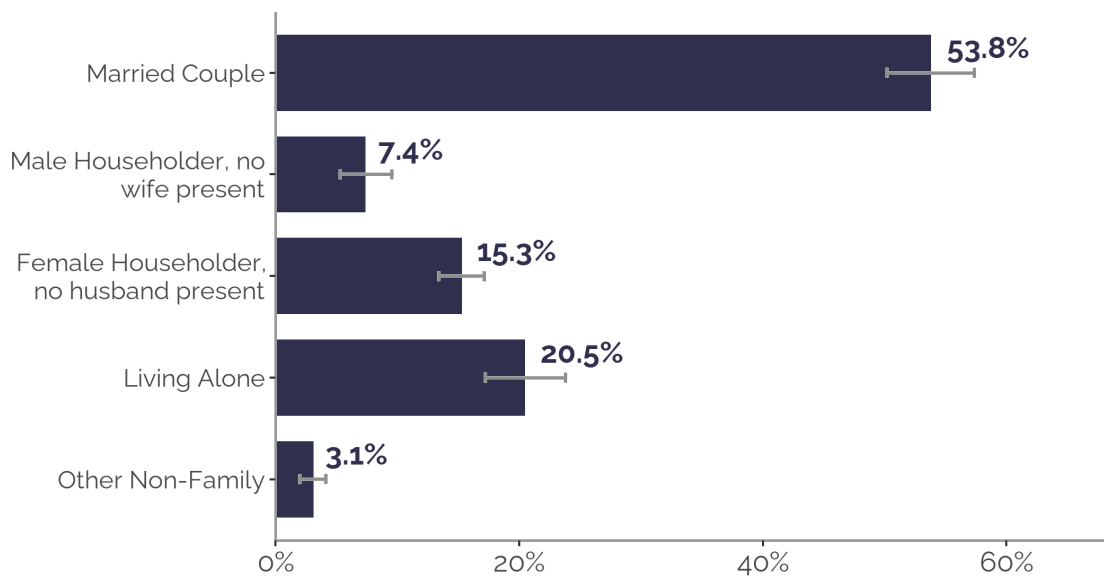
Source: ACS 5-Year Estimates. Table: B11001
Prepared by CI:Now for The Health Collaborative

Fig. 1.7 Total Population, 2020

Total Population
- ‡ 1,500 or Less
- ⌂ > 1,500 to 3,000
- ◇ > 3,000 to 7,000
- ☆ > 7,000 to 11,000
- ✳ > 11,000 to 25,000

Source: ACS 5-Year Estimates, Table B03002
Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
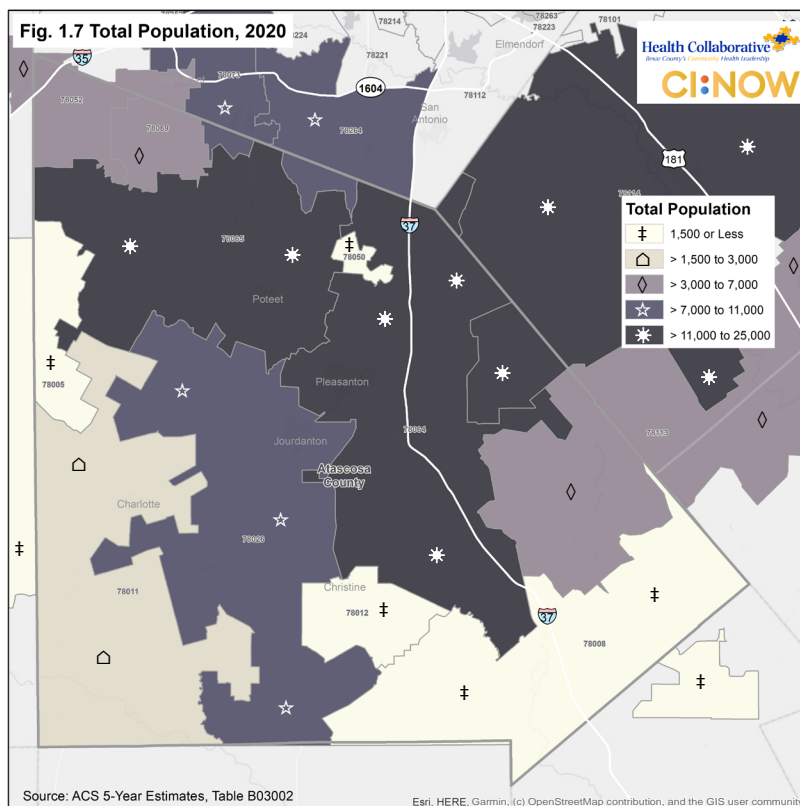
When mapped by ZIP code, the most populous ZIP codes are 78064 and 78065, which include Pleasanton and Poteet (Figure 1.7). ZIP codes are of different geographic sizes, though, so this map must be interpreted with that in mind.

Fig. 1.8 Population density (population per square mile), 2020

Source: ACS 5-Year Estimates, Table B15002

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

Population per Sq. Mile

‡	10 or Less
⌂	> 10 to 30
◇	> 30 to 70
☆	> 70 to 120
✳	> 120 to 190
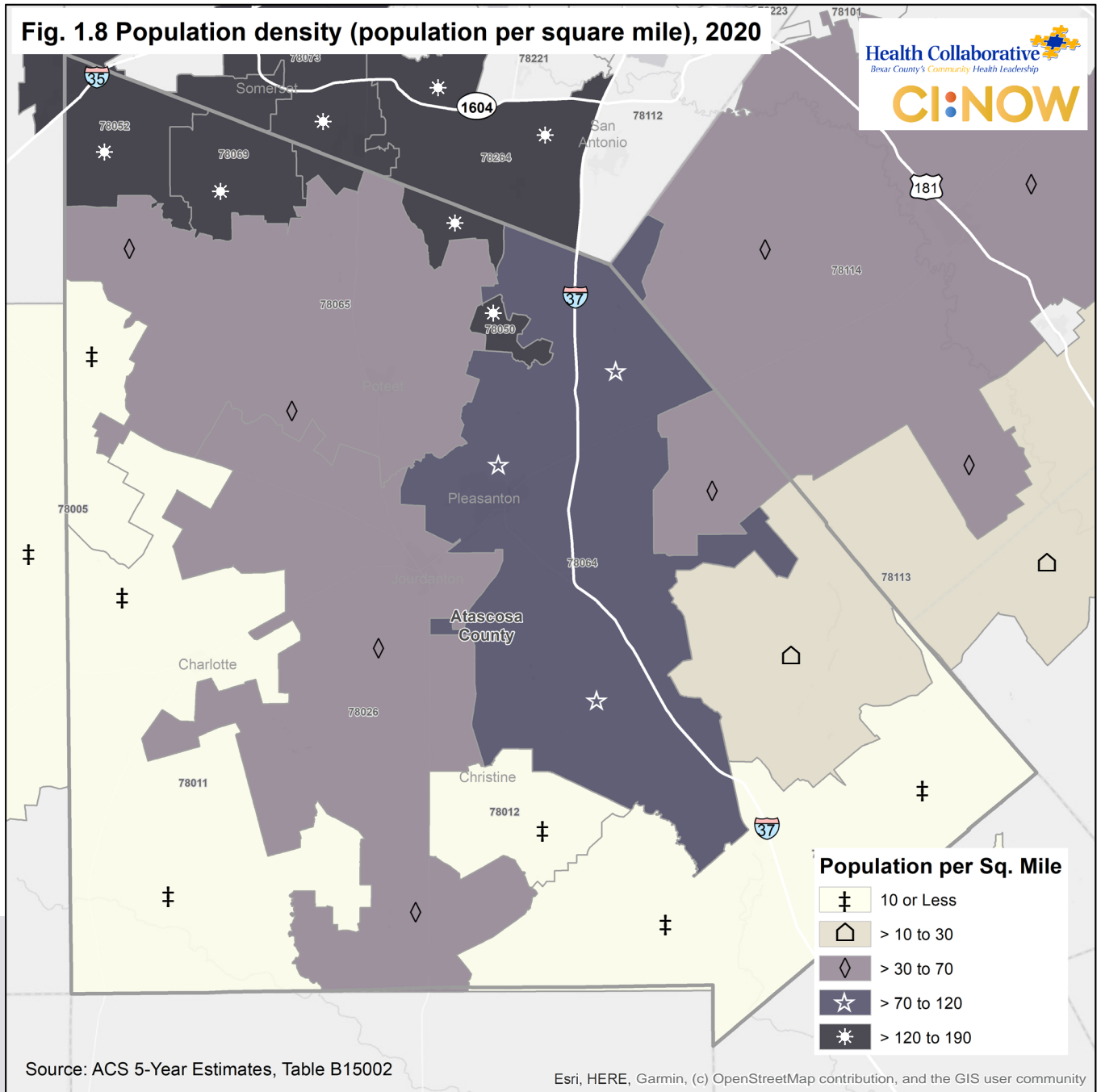
While total population by ZIP code is highest in 78064 and 78065, population density – population per square mile – by ZIP code is highest along the Bexar County border (Figure 1.8). The population in the ZIP codes in the west and southeast of the county is much less dense and more rural.
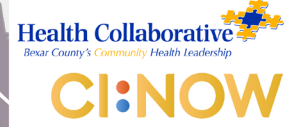
Fig. 1.9 Population Distribution by Race/Ethnicity, 2020
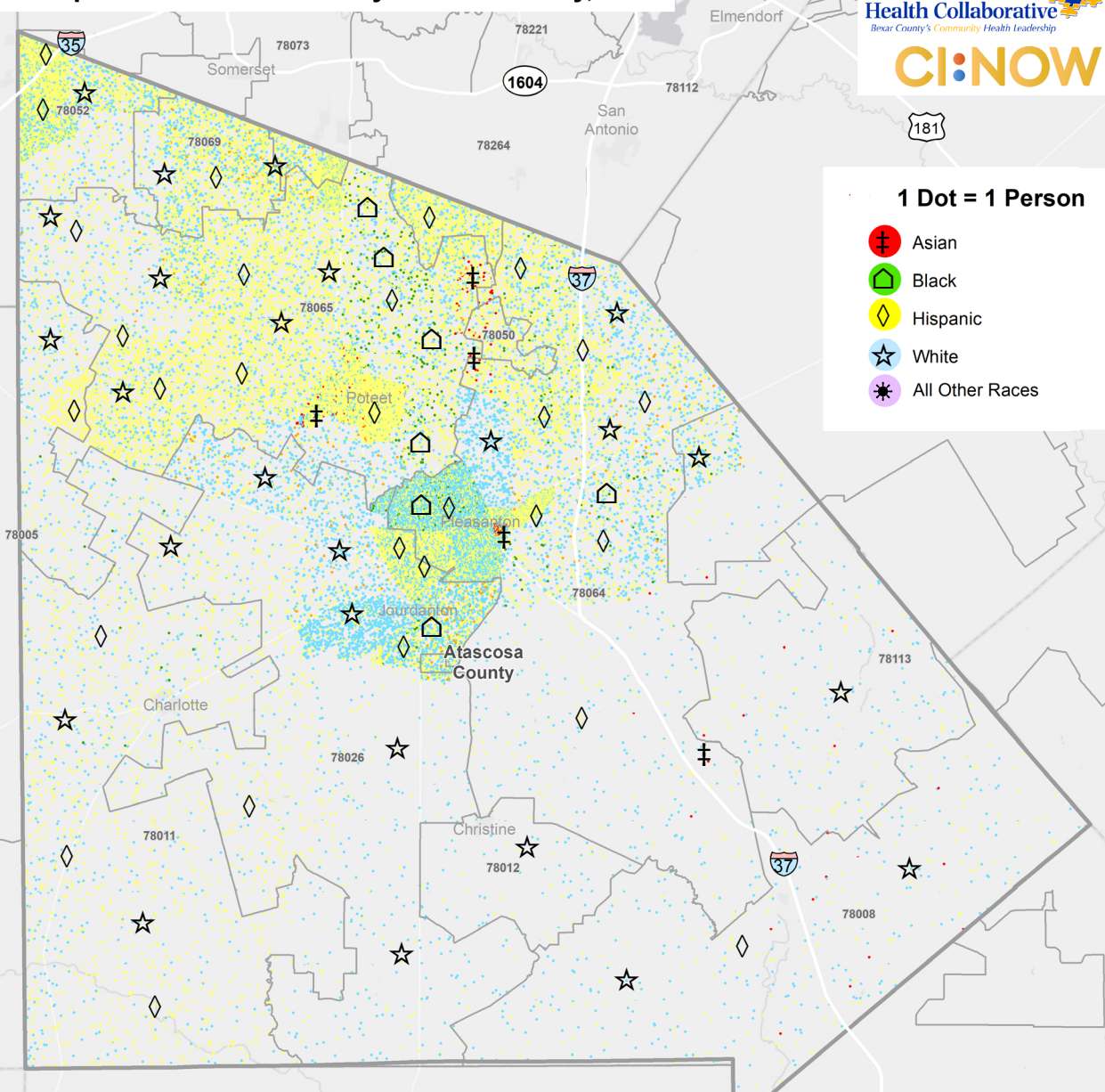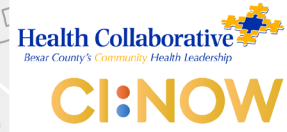
1 Dot = 1 Person

- ✛ Asian
- ⬠ Black
- ◇ Hispanic
- ✰ White
- ✳ All Other Races

Source: ACS 5-Year Estimates, Table B03002

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

(Figure 1.9) roughly plots population by race/ethnicity. While Hispanics and whites live throughout Atascosa County, Asians and Black or African Americans tend to be concentrated in the northern half of the county.

SOCIAL ENVIRONMENT
EDUCATION

Fig. 1.10 Percent of population 25 years and over by highest level of education completed, 2019

Atascosa County, Texas

Source: ACS 1-Year Suppplemental Estimates. Table: K201501
Prepared by CI:Now for The Health Collaborative

Atascosa County continues to have low educational attainment overall (Figure 1.10). With the link between health and education well-documented,[4] low educational attainment has strong negative implications for residents' health status.

One in five residents 25 and older did not finish high school, and another half have no college education. This American Community Survey data does not capture other certificate or certification credentials, however, so almost certainly underestimates the proportion of population with some kind of postsecondary education and training.

[4]See for example Zajacova A. and Lawrence E.M. (2018). The relationship between education and health: Reducing disparities through a contextual approach. Annual Review of Public Health 39:1, 273-289. Available online at **https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-031816-044628**

The estimated percent of population with an associate's degree or higher remained flat between 2015 and 2019 (Figure 1.11), with overlapping confidence intervals and estimates hovering between 16% and 22%. Again, this figure does not include non-degree certificates or credentials.

Fig. 1.11 Percent of population 25 years and over who earned associates degree or higher

Atascosa County, Texas

Fig. 1.12 Percent of population 25 years and over who earned associates degree or higher, 2020

Associates Degree or Higher

‡	Less than 7%
⌂	> 7% to 12%
◊	> 12% to 18%
☆	> 18% to 25%
✳	> 25% to 35%

Source: ACS 5-Year Estimates, Table B15002

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
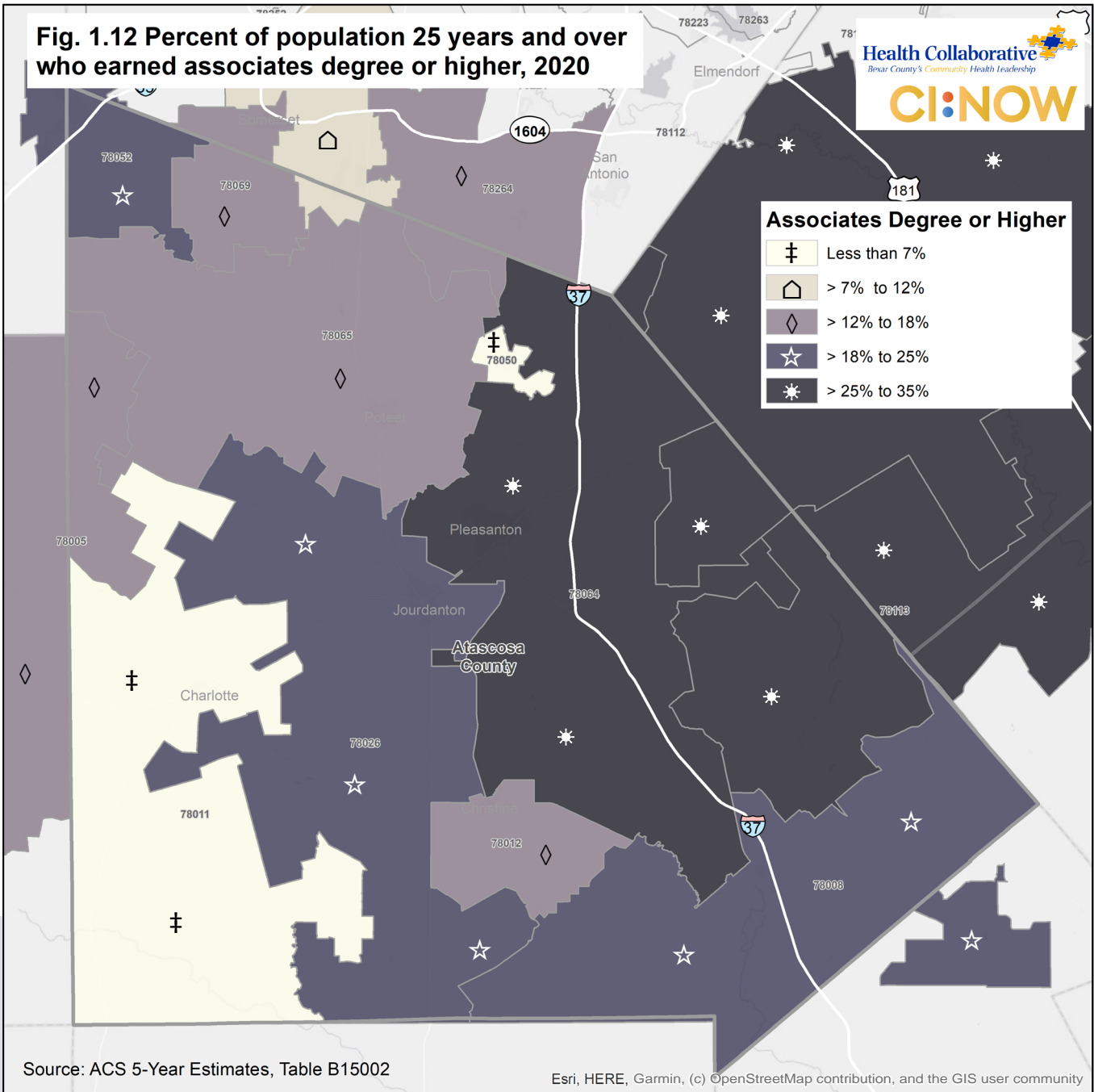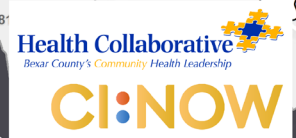
College degrees are most common in the eastern portion of the county, with the lowest percentages in ZIP codes 78011 (southwest) and 78050 (Leming area) (Figure 1.12).

LANGUAGE AND DIGITAL INCLUSION

Fig. 1.13 Percent of population 5 years and over who speak only English or speak English "very well"
Atascosa County, Texas
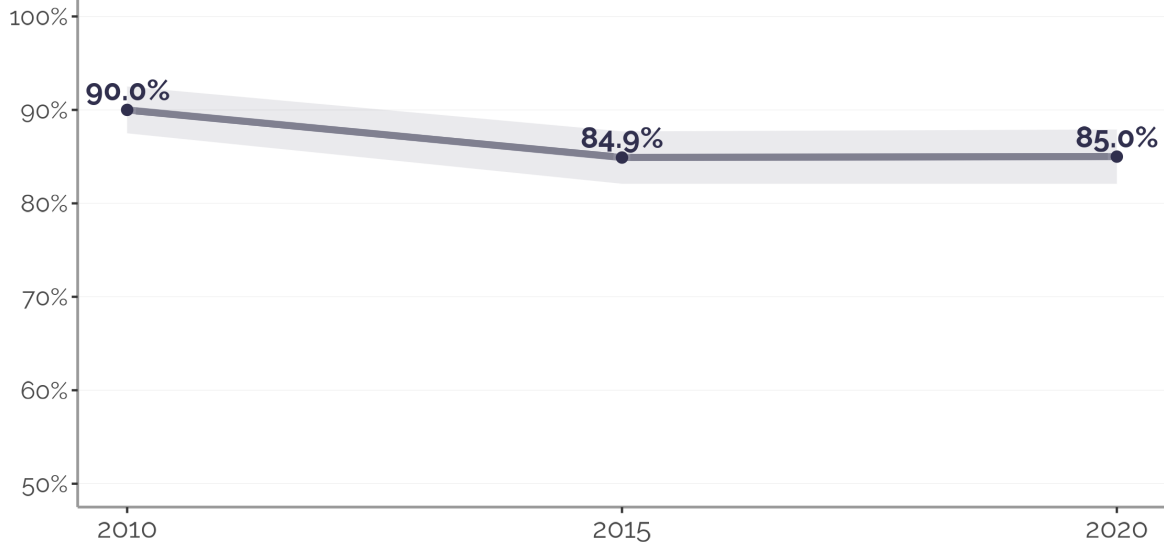
Source: ACS 5-Year Estimates. Table: B16004
Prepared by CI:Now for The Health Collaborative

The proportion of population speaking English only or "very well" (as self-reported) appears to have dropped slightly between 2010 and 2020 (Figure 1.13). Language barriers to accessing services and resources are likely an issue for about 15% of the population.

Fig. 1.14 Percent of population 5 years and over who speak only English or speak English "very well", 2020

Ability to Speak English
Speak Enlish Only or Very Well

‡ 65% or Less
⌂ > 65% to 75%
◊ > 75% to 83%
☆ > 83% to 90%
✳ > 90% to 96%

Source: ACS 5-Year Estimates, Table B16004

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
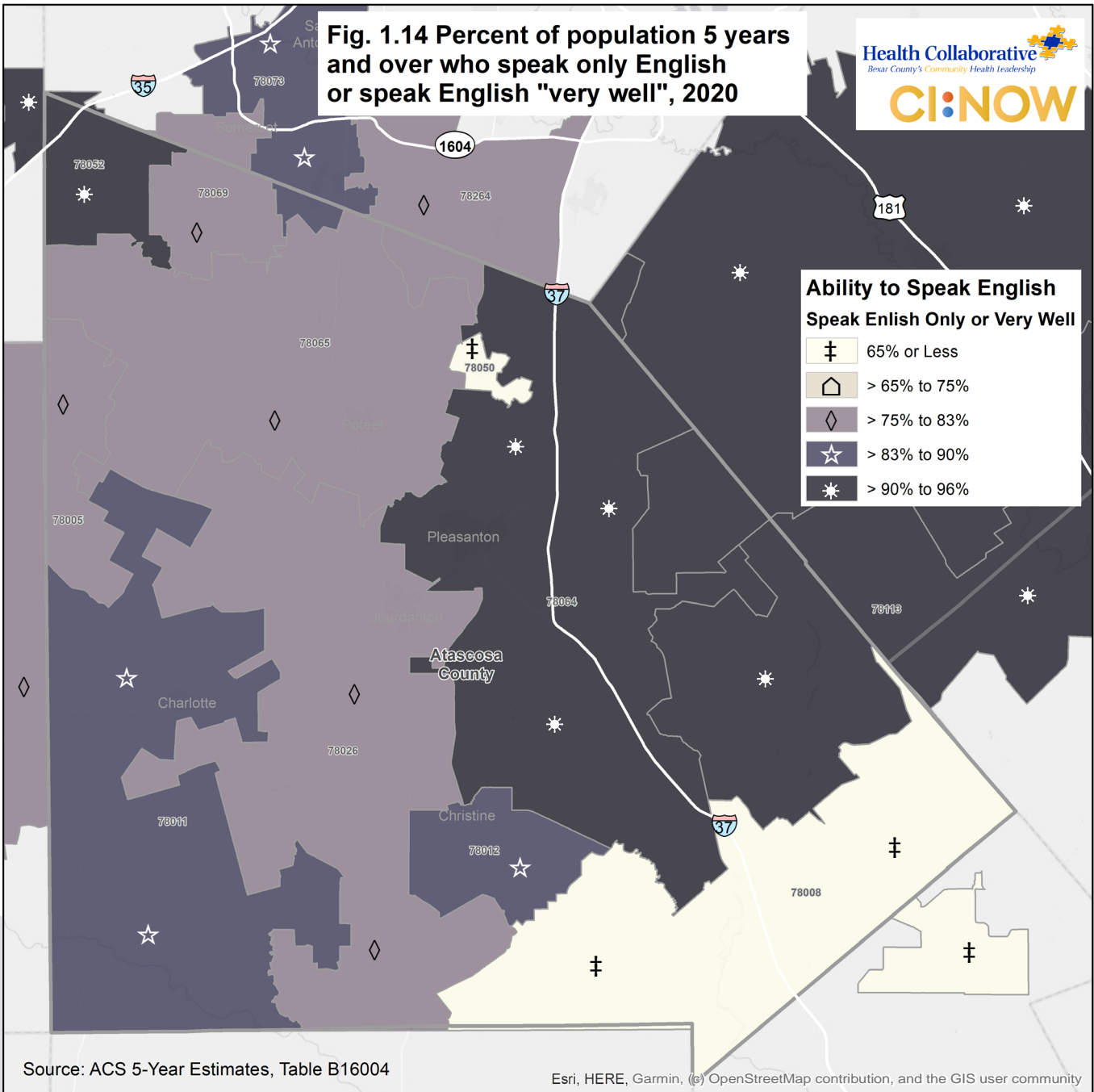
The highest proportions of pop speaking English only or "very well" are in ZIP codes in the eastern half of the county and in 78052 on the Bexar County line (Figure 1.14). The ZIP codes with the lowest proportions – 65% or fewer – are 78050 (Leming area) and 78008 (Campbellton and Whitsett area).

Fig. 1.15 Percent of households with a computer and broadband internet subscription

Atascosa County, Texas
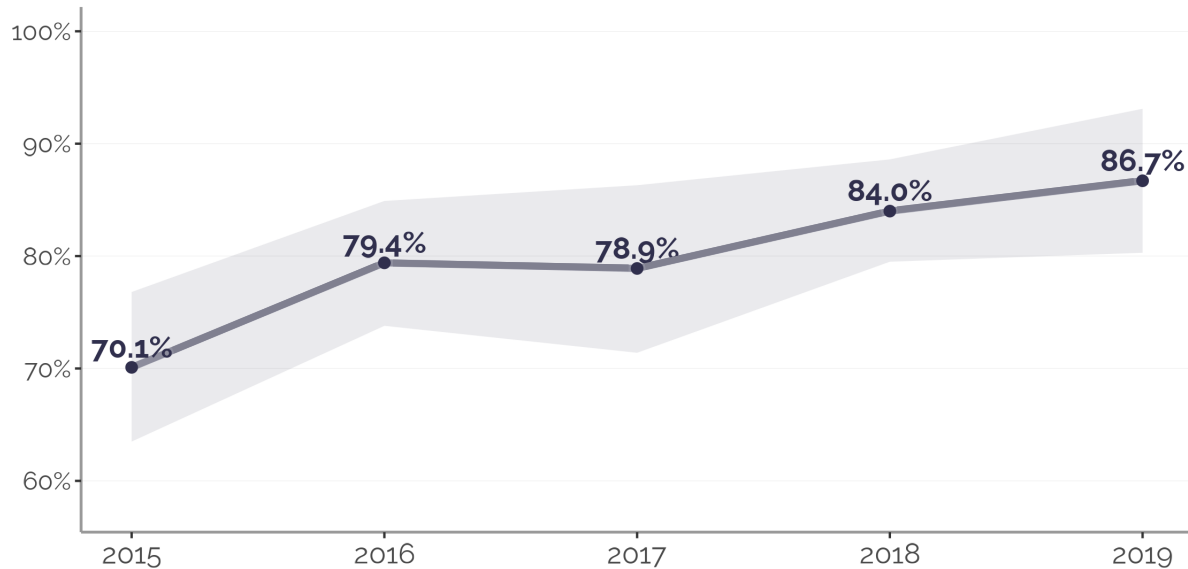
70.1%
79.4%
78.9%
84.0%
86.7%

While the percent of households with a computer and broadband internet subscription was at a low of 70% in 2015, it has increased every year, reaching an estimated 87% in 2019 (Figure 1.15), a statistically significant difference from 2015. Good internet access is only growing more critical to education, full participation in the economy, and social connection.

Fig. 1.16 Percent of households with a computer and broadband internet subscription, 2020

Computer and Broadband
percent of households
‡ 45% or Less
⌂ > 45% to 70%
◇ > 70% to 80%
☆ > 80% to 85%
✳ > 85% to 90%

Source: ACS 5-Year Estimates, Table B17026

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
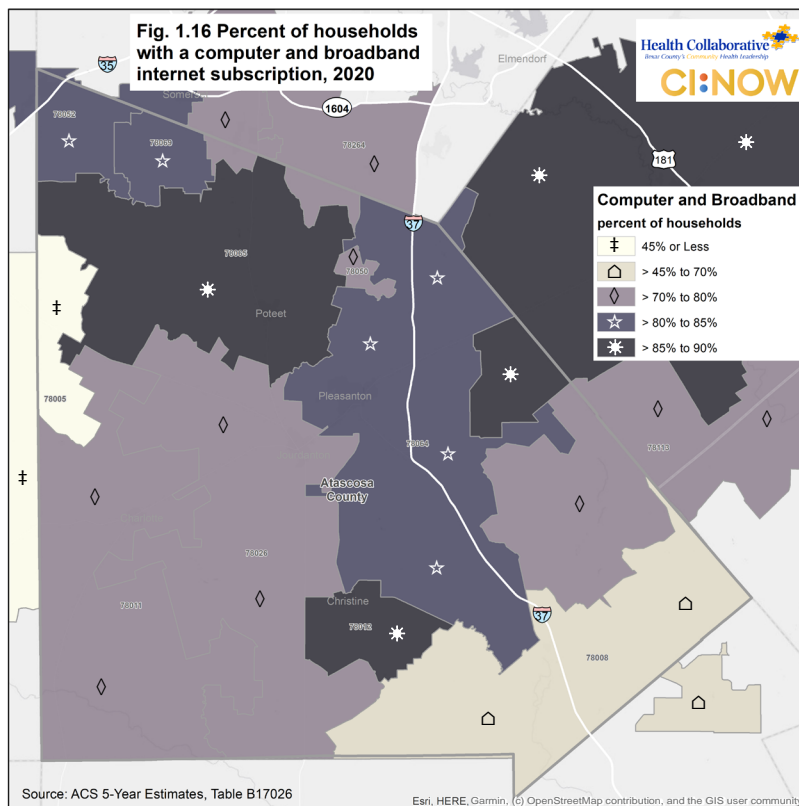
Households are most likely to have a computer and broadband internet in ZIP codes 78065 (Poteet area) and 78012 (Christine area) (Figure 1.16). The lowest rate is in 78005 (Bigfoot area) on the western edge of the county, where 45% or fewer of households have a computer and broadband.

Fig. 1.17 Percent of population food insecure
Atascosa County, Texas

Food insecurity rose in 2018 and 2019 (Figure 1.17). The cause for this increase is not known, as this period falls between the Great Recession and the COVID-19 pandemic. Food insecurity almost certainly further increased during the pandemic.

Conversely, Feeding America's Map the Meal Gap data indicates a small but continuing decrease in food insecurity among children (Figure 1.18). Again, this data predates the COVID-19 pandemic, so 2020 and 2021 are likely to show a higher percentage when that data becomes available.

Fig. 1.18 Percent of children food insecure
Atascosa County, Texas
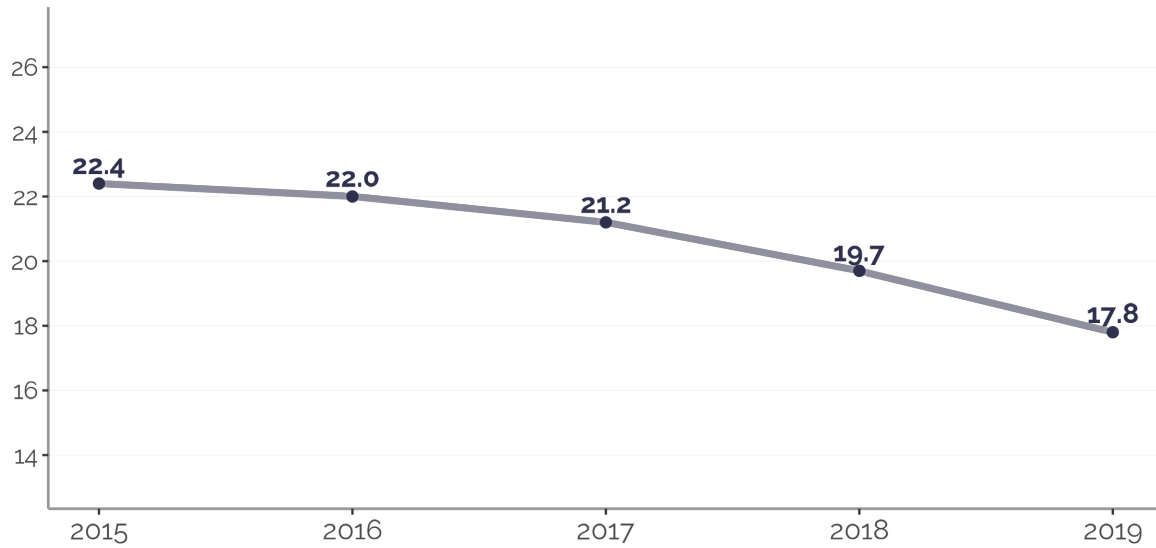
Source: Map the Meal Gap
Prepared by CI:Now for The Health Collaborative
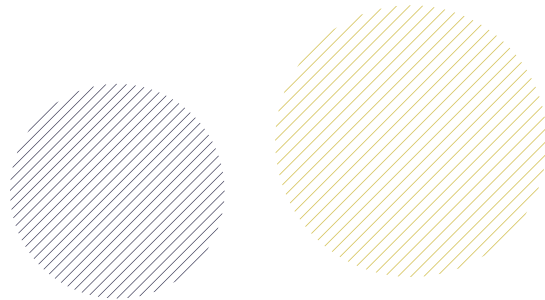
Fig. 1.19 Areas with low income and low food access, 2019

Low Income and Low Food Access Areas

1 mile for urban areas and 10 miles for rural areas

Low Income and Low Food Access Areas

Source: USDA Food Access Research Atlas

Esri, HERE, Garmin, (c)
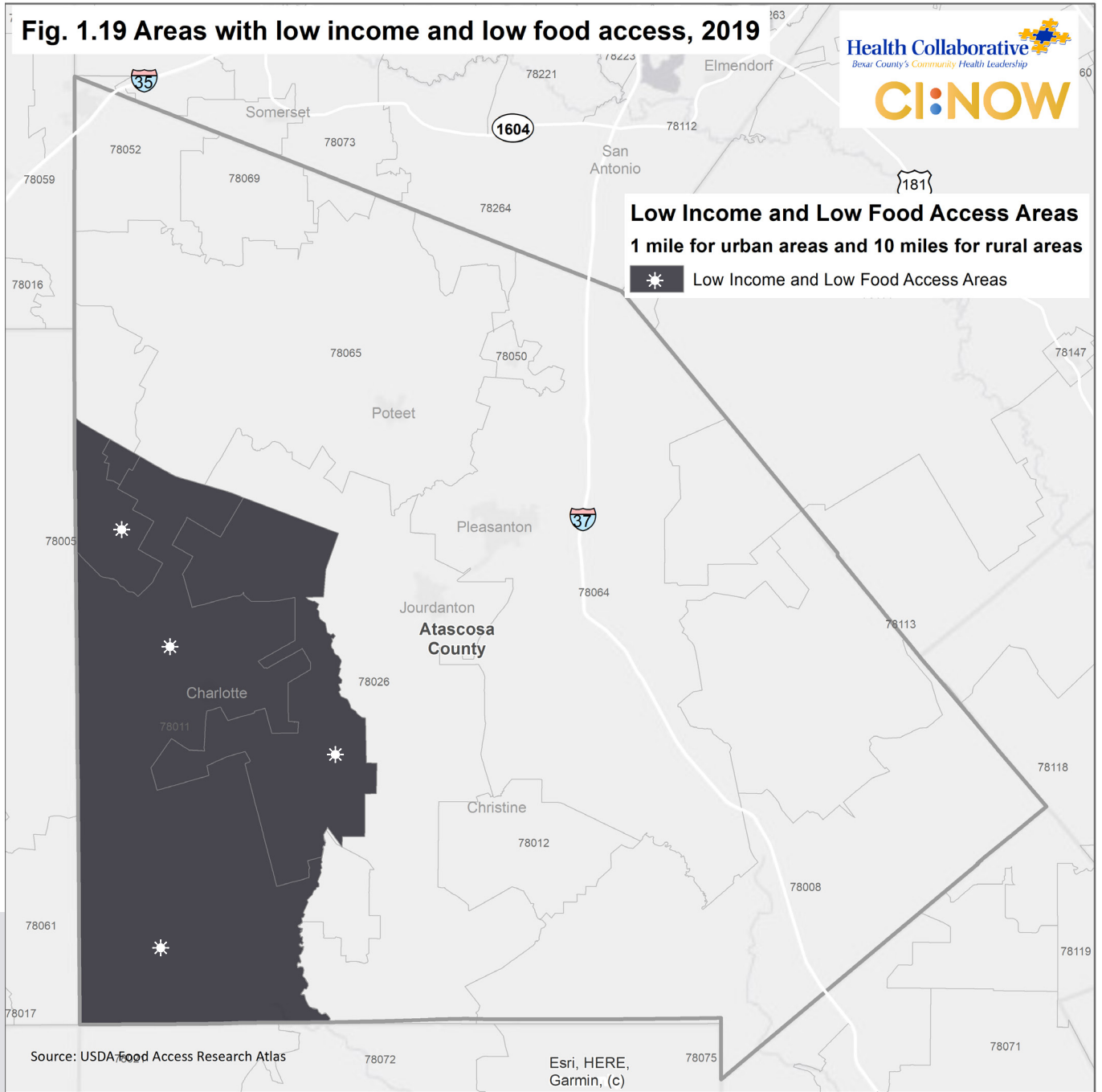
Census tracts in ZIP codes 78011, 78005, and the western portion of 78026 are considered both low-income with low food access (Figure 1.19).

ALCOHOL LICENSES

Fig. 1.20 Alcohol Licenses per 100,000 population, 2022

Alcohol Licenses
per 100,000 population

‡	1 to 9
⌂	> 9 to 10
◇	> 10 to 14
☆	> 14 to 16
☀	> 16 to 18

Source: Texas Alcohol Beverage Commission

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
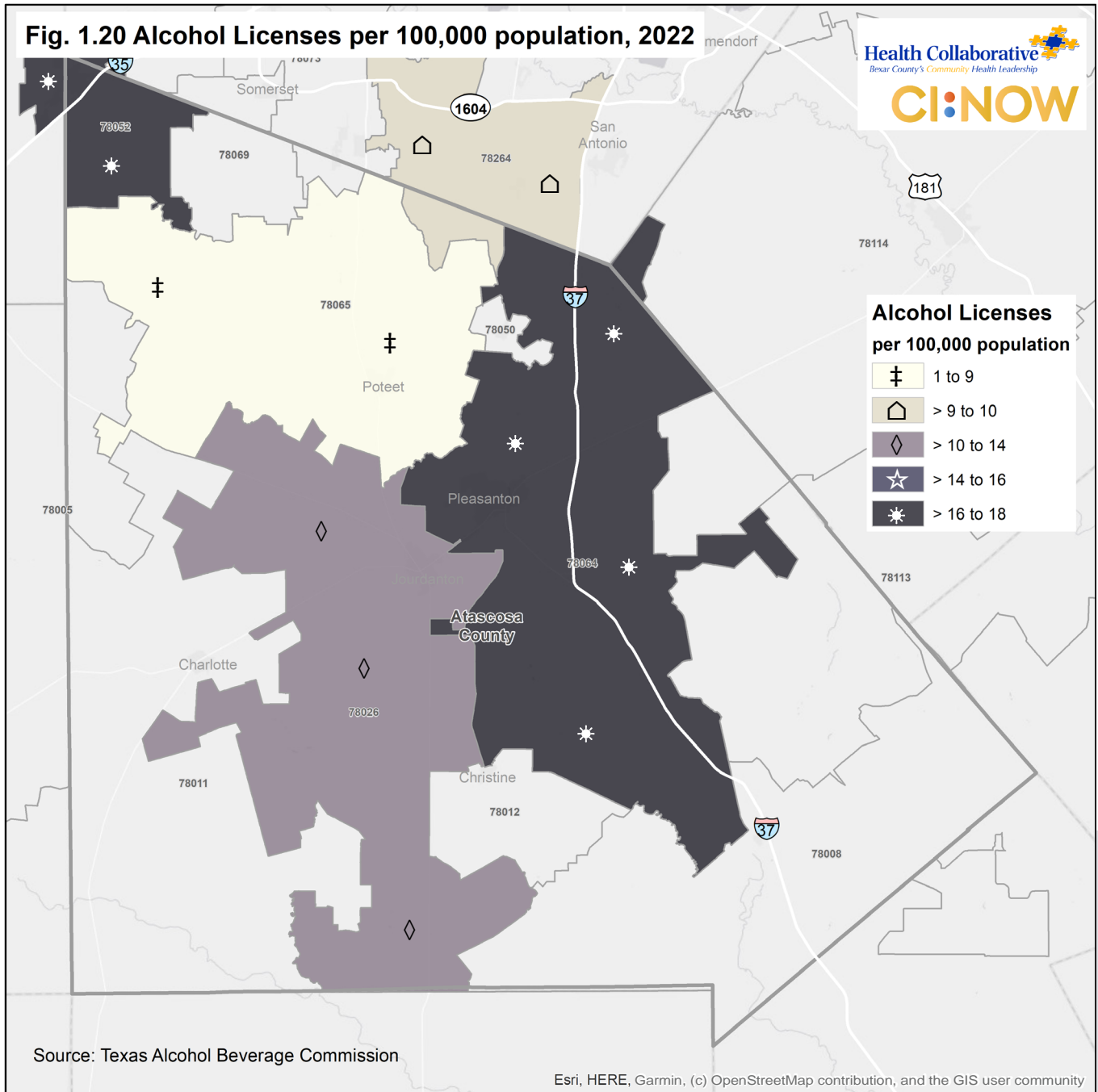
The ZIP codes with the highest density of establishments with alcohol licenses (package store permits) per 100,000 population are 78052 on the Bexar County line and 78064 along the I-37 corridor (Figure 1.20). Several ZIP codes have no establishments with package store permits.

CRIME AND SAFETY

Fig. 1.21 Number of violent crimes reported per 100,000 population
Atascosa County, Texas
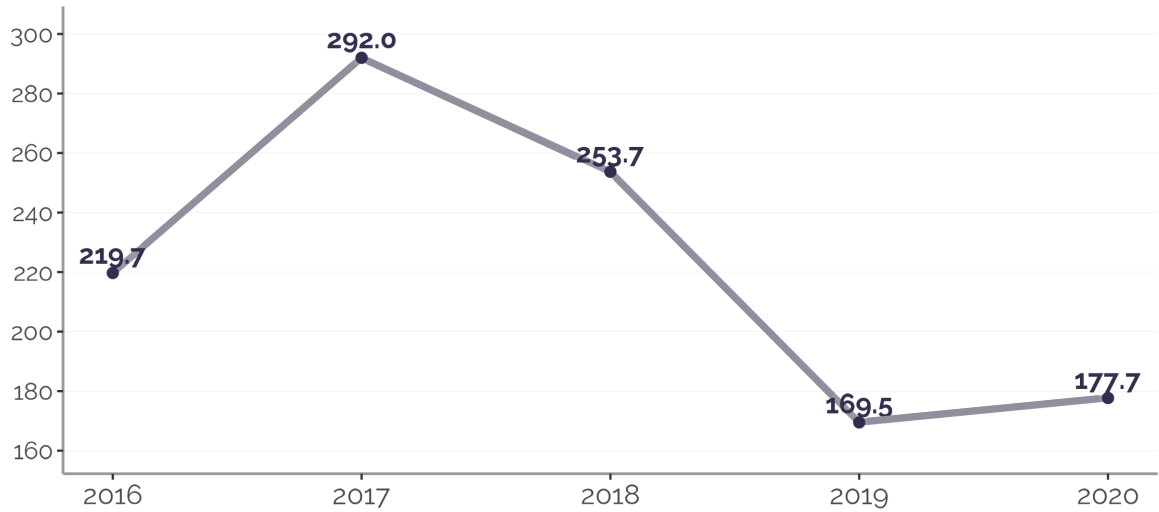
Source: Texas Department of Public Safety
Prepared by CI:Now for The Health Collaborative

The reasons for the steep drop in reported overall violent crime in 2018 and 2019 are not known (Figure 1.21). The violent crime rate did increase slightly in 2020, the most recent year of data available, but is still well below the 2016 level. Violent crime includes murder, rape, robbery, and aggravated assault.[5]

[5]Texas Department of Public Safety. (2021.) The Texas crime report for 2020. Available online at **https://www.dps.texas.gov/sites/default/files/documents/ crimereports/20/2020cit.pdf.**

The homicide trend line shows a lot of "bounce" or instability because of very low numbers, but hovers between 0 and 9.5 per 100,000 population – or about 0 to five – in the 2016-2020 five-year period (Figure 1.22).

Fig. 1.22 Number of homicides per 100,000 population
Atascosa County, Texas

Fig. 1.23 Family violence crimes committed per 1,000 population
Atascosa County, Texas

Although violent crime overall has generally decreased over the past five years, the rate of reported family violence incidents has increased (Figure 1.23). A single family violence incident may involve one or several victims in the family.

ECONOMIC ENVIRONMENT
LABOR FORCE PARTICIPATION AND EMPLOYMENT

Fig. 1.24 Family Type: Atascosa County, 2019

	Married-Couple		Single Male		Single Female	
Experiencing Instability	**282**	**8%**	**25**	**6.7%**	**269**	**23.8%**
	(±137)	**(±3.8%)**	**(±29)**	**(±7.2%)**	**(±152)**	**(±12.1%)**
Unemployment	261	7.4%	18	4.9%	0	0.0%
	(±134)	(±3.7%)	(±26)	(±6.7%)	(±33)	(±2.9%)
No Labor Force Participation	21	0.6%	7	1.9%	269	23.8%
	(±27)	(±0.8%)	(±13)	(±3.4%)	(±148)	(±11.8%)
Families with Own Children	3,523		371		1,131	
	(±409)		(±169)		(±270)	

Source: US Census Bureau; ACS 5-Year Estimates, Table B23007, 2019.

This measure of economic instability (Figure 1.24) has the advantages of including both unemployment and not being in the labor force. The unemployment rate is based only on people who are either employed or on record as looking for work, so it does not capture people not working or looking for work due to child care challenges, criminal background, disability, or because they do not need to work. At a very high one in four, single females are least likely to be in the labor force. Single females are about three times as likely as single males or married couples to experience financial instability.

The unemployment rate more than doubled from 2019 to 2020 (Figure 1.25), the first year of the COVID-19 pandemic, after several years of slight by steady decline. Again, unemployment rates do not capture the population that has left the labor force entirely, neither working nor seeking work.

Fig. 1.25 Percent of population 16 and older in labor force who are unemployed

Atascosa County, Texas
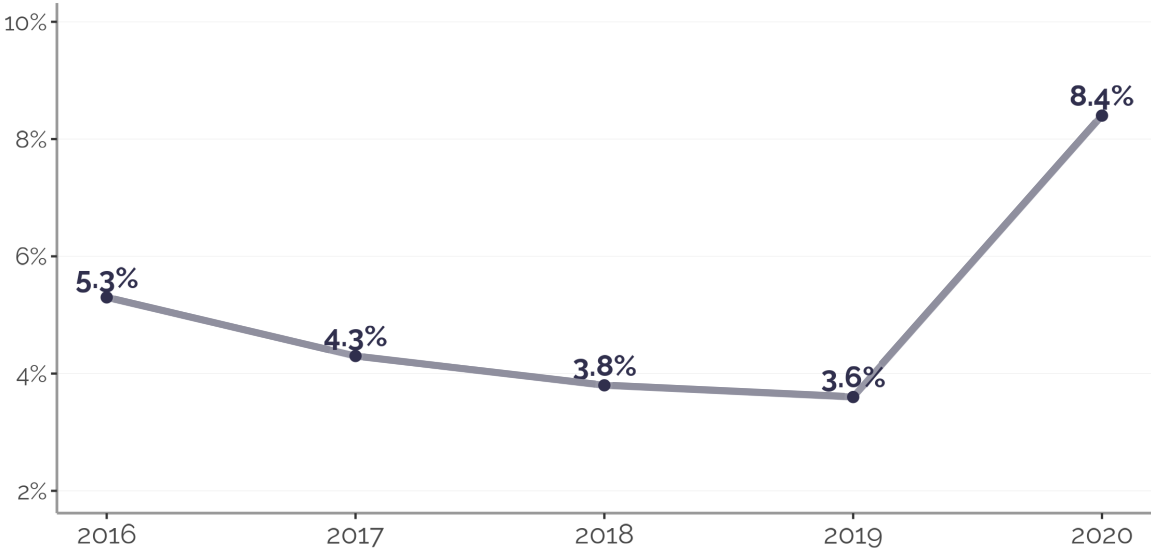
Source: Bureau of Labor Statistics
Prepared by CI:Now for The Health Collaborative
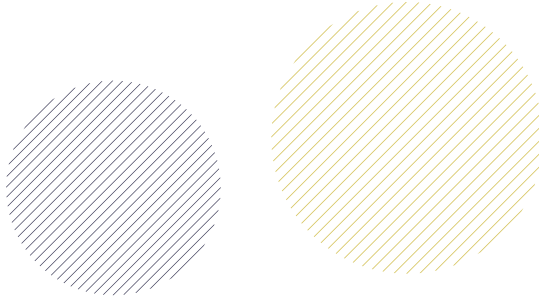
INCOME AND POVERTY

Fig. 1.26 Median household income
Atascosa County, Texas
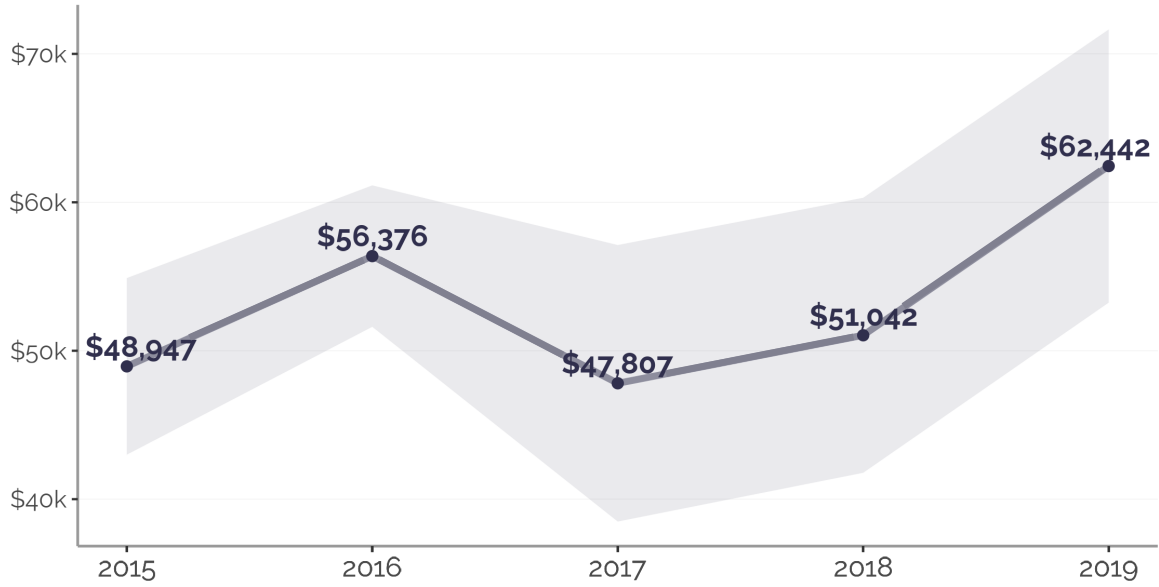
Source: ACS 1-Year Supplemental Estimates. Table: K201902
Prepared by CI:Now for The Health Collaborative

The wide margins of error make the trend hard to interpret, but median household income appears to have risen between 2015 and 2019 (Figure 1.26). This data predates the COVID-19 pandemic, so the trend may not have continued.
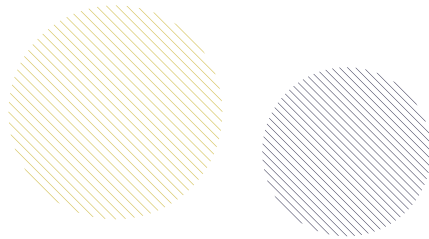
Fig. 1.27 Median Household Income, 2020

Median Household Income

‡	$32,000 to $35,000
⌂	> $35,000 to $50,000
◇	> $50,000 to $60,000
☆	> $60,000 to $65,000
✹	> $65,000 to $72,000

Source: ACS 5-Year Estimates, Table B19013

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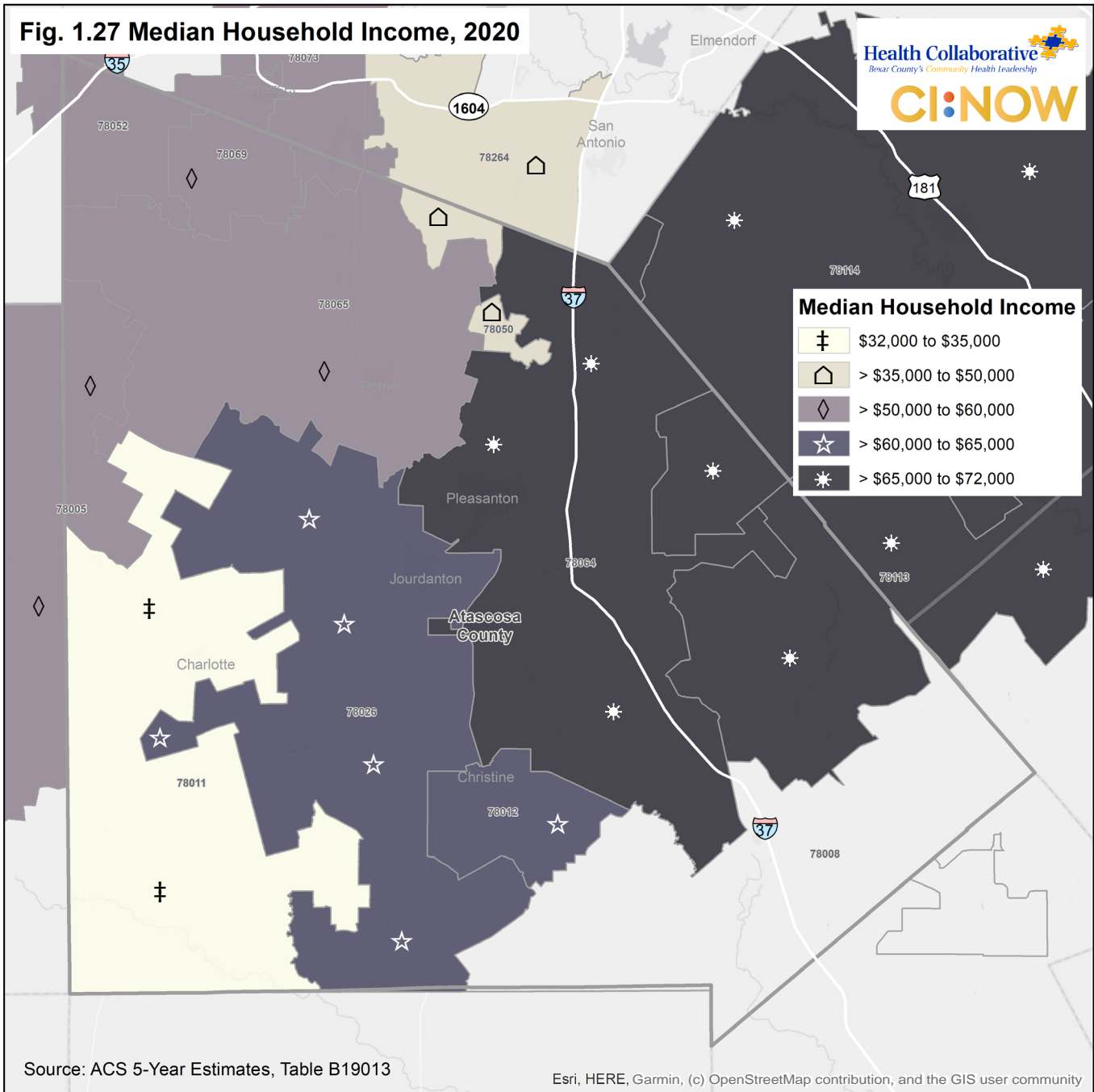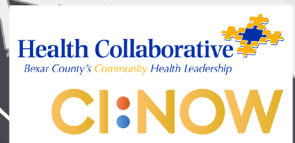
Median household income is highest in ZIP codes in the eastern half of the county (Figure 1.27) and lowest in 78011 to the southwest. The median is the cutpoint at which half of household incomes are higher and half lower.

Married-couple households have by far the highest median household income (Figure 1.28). Among single-parent households, median household income among single male householders is about 30% higher than that among single female householders.
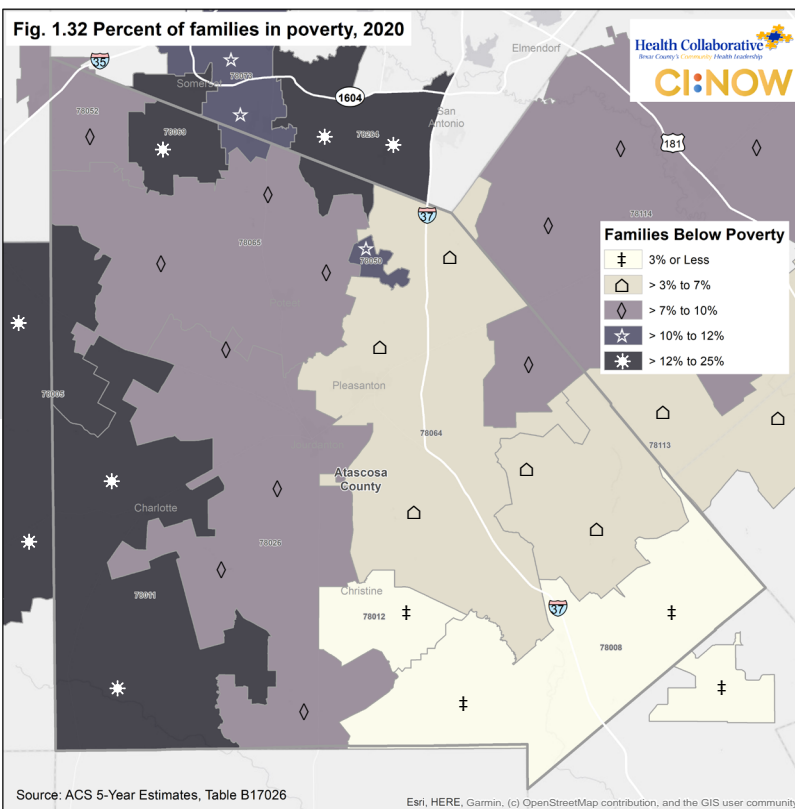
Fig. 1.28 Median household income by family type, 2020
Atascosa County, Texas
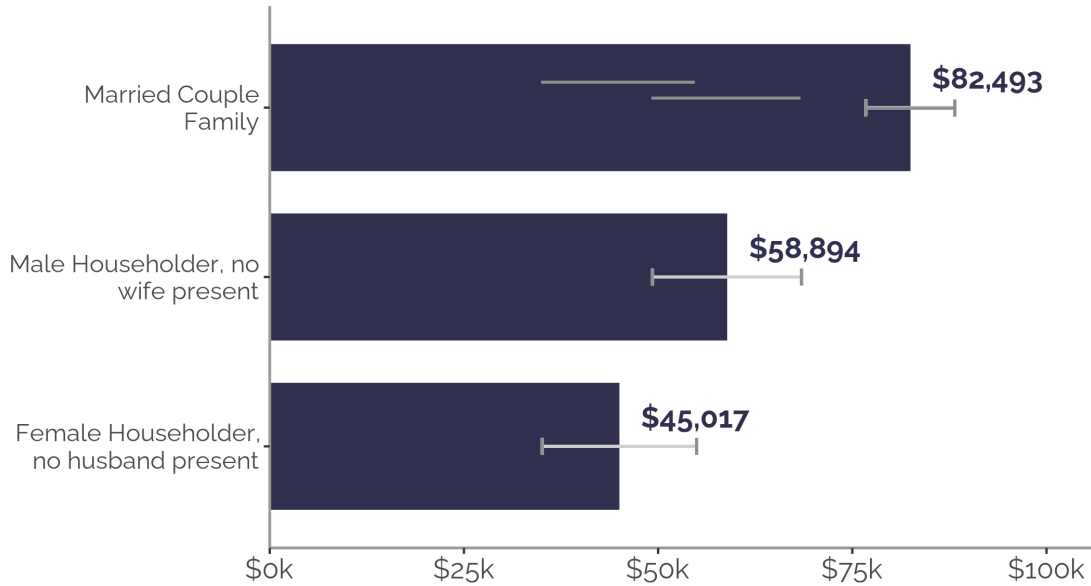
Source: ACS 5-Year Estimates. Table: B19126
Prepared by CI:Now for The Health Collaborative

Fig. 1.29 Median family income
Atascosa County, Texas
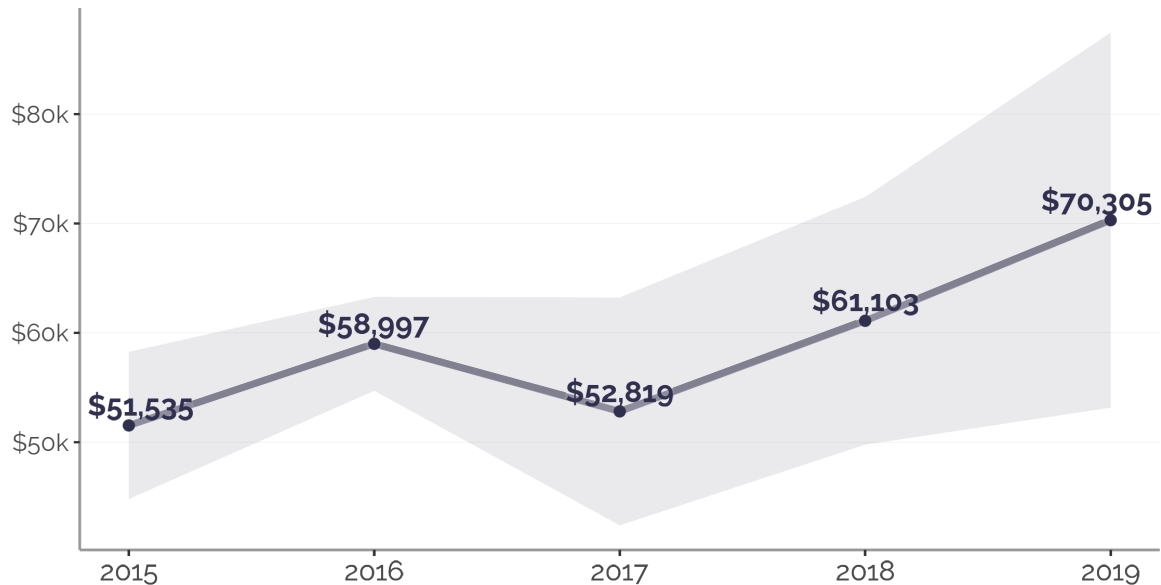
Source: ACS 1-Year Supplemental Estimates. Table: K201904
Prepared by CI:Now for The Health Collaborative

Median appears to have risen between 2015 and 2019, but the wide margins of error mean uncertainty in the trend (Figure 1.29). Again, this data predates the COVID-19 pandemic.

Fig. 1.30 Median Family Income, 2020

Median Family Income

‡	$34,000 to $45,000
⌂	> $45,000 to $60,000
◇	> $60,000 to $65,000
☆	> $65,000 to $75,000
✴	> $75,000 to $83,000
⠿	Suppressed

Source: ACS 5-Year Estimates, Table B19126

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
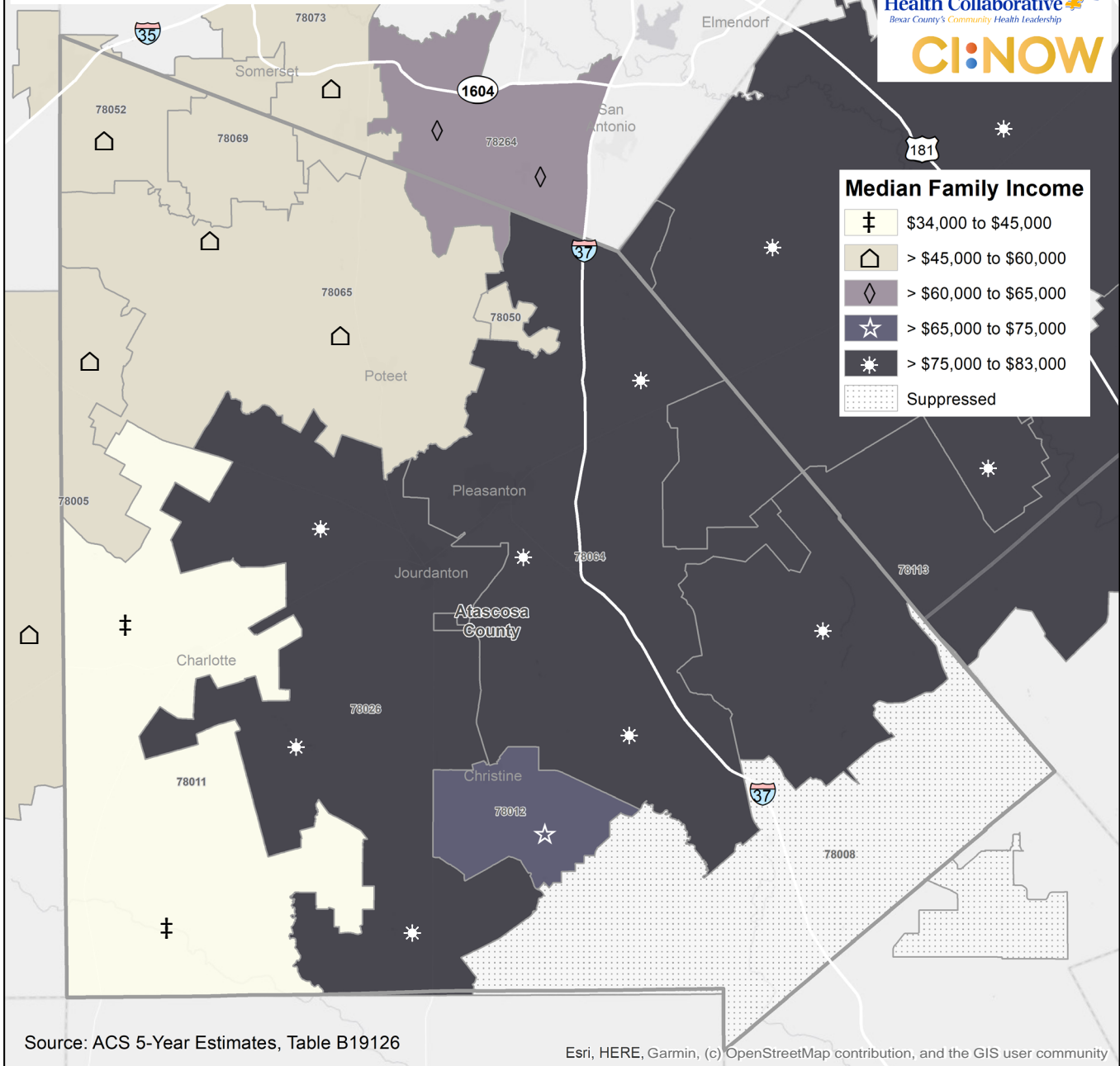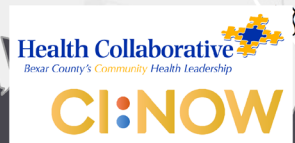
Figure 1.30 shows that median family income is nearly twice as high in 78026 (including Jourdanton) as in neighboring 78011 (including Charlotte). No data is available for 78008 in the southeastern part of the county.

Fig. 1.31 Percent of families for whom poverty status is determined by level of poverty, 2020

Atascosa County, Texas
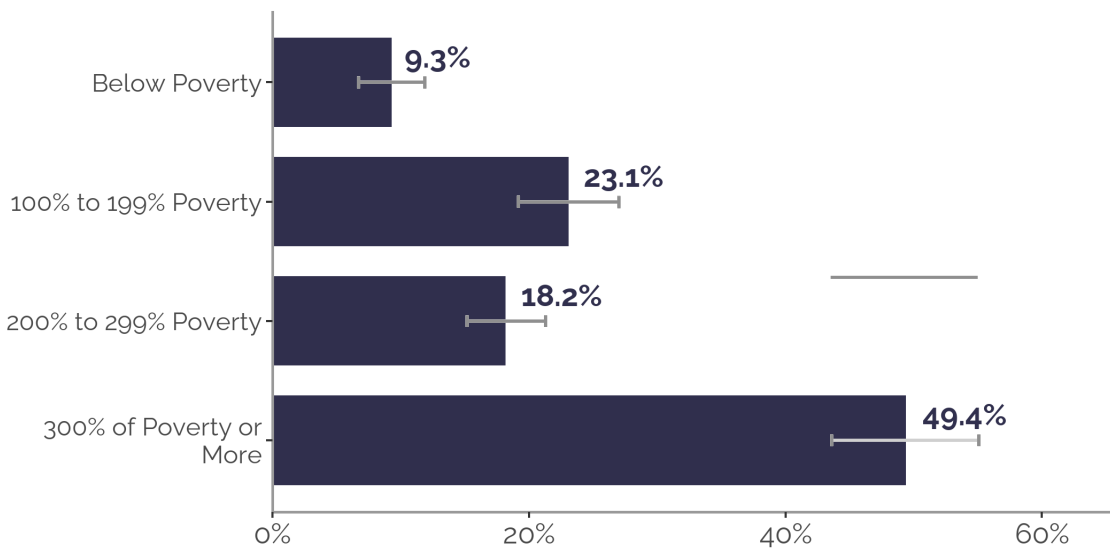
Source: ACS 5-Year Estimates. Table: B17026
Prepared by CI:Now for The Health Collaborative

One in 10 families lives below the poverty level (Figure 1.31), which the Census defines for 2021 as $27,479 for a family of four with two children and $21,811 for a single parent with two children.[6] Three in 10 live below 200% of the poverty level.

Families in poverty are most likely to live near Somerset or in the far west of the county (Figure 1.32). Families in 78008 (Campbellton and Whitsett area) are least likely to live in poverty.

Fig. 1.32 Percent of families in poverty, 2020

Families Below Poverty

‡ 3% or Less
⌂ > 3% to 7%
◇ > 7% to 10%
☆ > 10% to 12%
✳ > 12% to 25%

Source: ACS 5-Year Estimates, Table B17026

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

[6] U.S. Census Bureau. (2022). Poverty thresholds by size of family and number of children: 2021. Available online at https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html

Fig. 1.33 Additional Household Sizes, Atascosa County, Texas, 2018

The ALICE Household Survival Budget can also be customized for different household sizes using the numbers below:

Add 1 Adult	Add 1 Senior (65+)	Add 1 Infant	Add 1 Preschooler	Add 1 School-Age Child
$14,386	$15,355	$16,936	$16,012	$10,439

ALICE Household Stability Budget, Atascosa County, Texas, 2018

	Single Adult	Two Adults	Two Adults Two Children	Two Adults, Two in Child Care
Housing	$768	$1,020	$1,047	$1,047
Child Care	$0	$0	$618	$1,647
Food	$513	$1,041	$1,857	$1,628
Transportation	$845	$1,043	$1,364	$1,364
Health Care	$166	$452	$688	$688
Technology	$125	$145	$145	$145
Miscellaneous	$294	$442	$711	$792
Savings	$294	$442	$711	$792
Taxes	$519	$719	$1,387	$1,404
Monthly Total	$3,524	$5,304	$8,528	$9,507
Annual Total	$42,288	$63,648	$102,336	$114,084
Hourly Wage	$21.14	$31.82	$51.17	$57.04

ALICE is an acronym for Asset Limited, Income Constrained, Employed. It is intended to capture families who make enough to be above the poverty level and are ineligible for many types of public assistance, but do not make enough to get by.[7] Figure 1.33 shows the ALICE "Stability Budget" for different Atascosa County household compositions in 2018. More information about the Survival Budget and Stability Budget expenses and methodology can be found on the *United for Alice* website.[8]

[7]United Way of Northern New Jersey. (2022). United for ALICE: Who is ALICE? Available online at **https://www.unitedforalice.org/**

[8]United Way of Northern New Jersey. (2022). United for ALICE: Research center - methodology. Available online at **https://www.unitedforalice.org/methodology**

The proportion of households that are ALICE rose steadily between 2010 and 2018 (Figure 1.34),[9] while the proportion of households in poverty remained fairly flat. Taken together, however, the proportion of households that are ALICE or below rose from 41% in 2010 to 49% in 2018. These estimates pre-date the COVID-19 pandemic. Once available, the 2020 and 2022 estimates are likely to be higher than prior years.
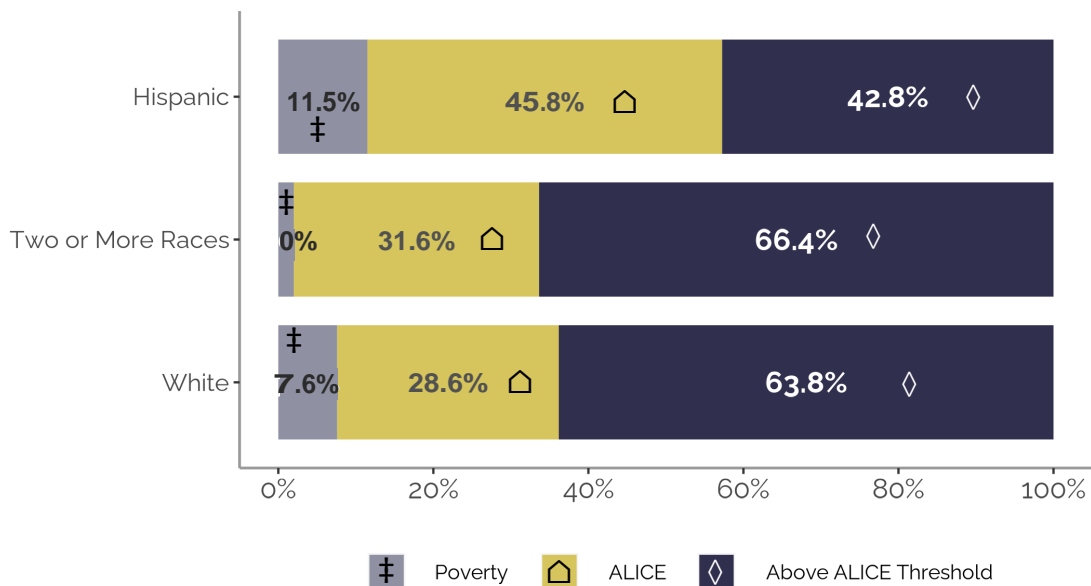
Fig. 1.34 Percent of ALICE households
Atascosa County, Texas

34.0%

30%

24.7%   22.8%   25.4%   26.6%

25%

16.5%   17.0%   15.6%   14.7%   14.6%

20%

15%

2010   2012   2014   2016   2018

‡ —— Poverty   ⌂ —— ALICE

Fig. 1.35 Percent of ALICE households by race, 2018
Atascosa County, Texas

Hispanic   11.5% ‡   45.8% ⌂   42.8% ◊

Two or More Races   0% ‡   31.6% ⌂   66.4% ◊

White   7.6% ‡   28.6% ⌂   63.8% ◊

0%   20%   40%   60%   80%   100%

‡ Poverty   ⌂ ALICE   ◊ Above ALICE Threshold

At nearly six in 10, the proportion of households that are ALICE or below is highest for Hispanics (Figure 1.35). In every race/ethnicity group, the proportion of households that are ALICE is four to 16 times the proportion of households in poverty.

[9] Data on ALICE households is calculated biannually rather than each year.

Fig. 1.36 Percent of ALICE households by type, 2018

Atascosa County, Texas

	Poverty	ALICE	Above ALICE Threshold
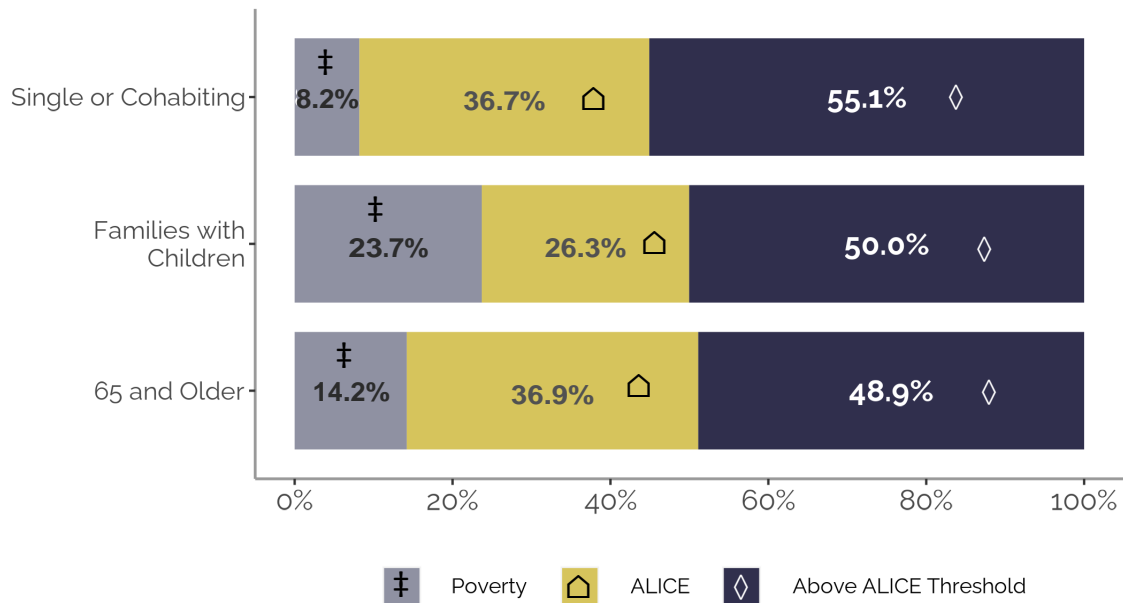
Source: ALICE United Way of Texas
Prepared by CI:Now for The Health Collaborative

Half of family households with children are either in poverty or ALICE; the same is true of households where the householder is 65 or older (Figure 1.36). The proportion is slightly lower (44%) for households where the householder is single or cohabiting.

Fig. 1.37 Percent of households ALICE and below, 2018

Households Below ALICE

‡	30% and Less
⌂	> 30% to 40%
◇	> 40% to 55%
☆	> 55% to 70%
✴	> 70% to 82%

Source: www.unitedforalice.org, 2018

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
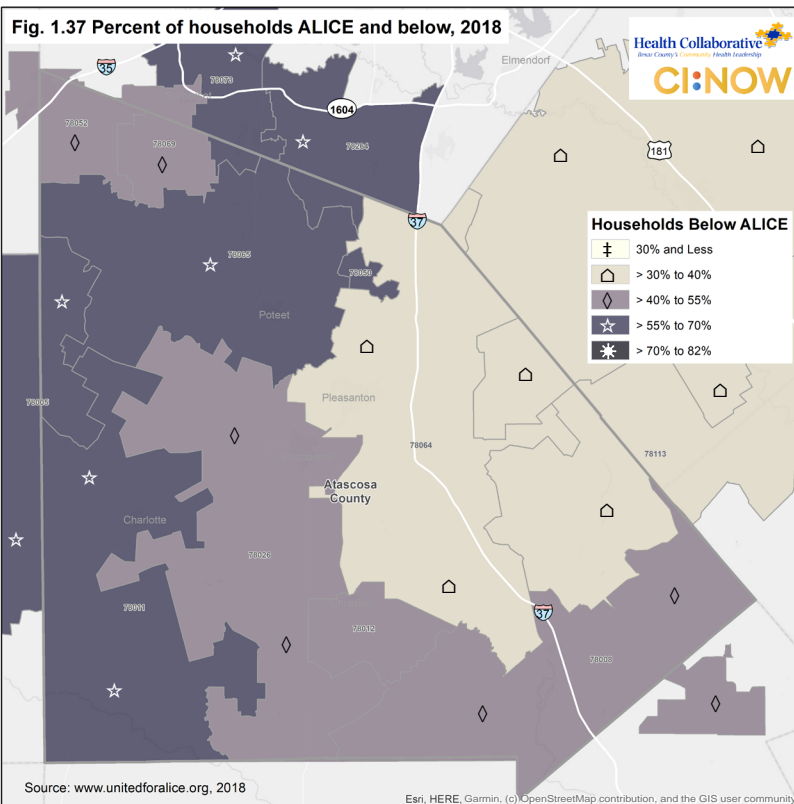
Households that are ALICE or below, including households in poverty, are most common in ZIP codes in the western half of the county (Figure 1.37).

BUILT & NATURAL ENVIRONMENT
HOUSING

Fig. 1.38 Percent of occupied housing units by housing tenure
Atascosa County, Texas
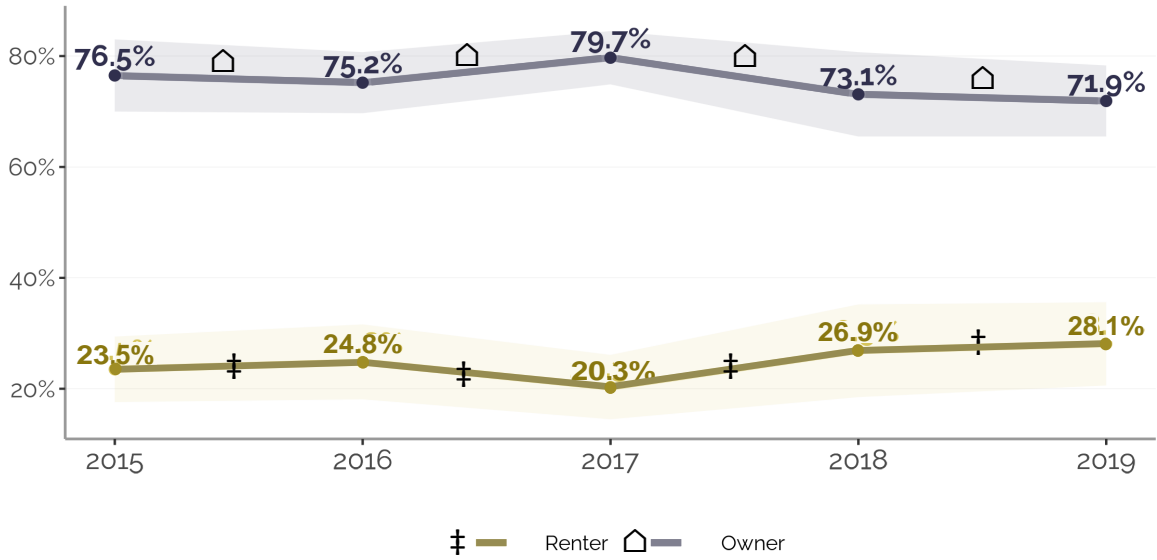
Source: ACS 1-Year Supplemental Estimates. Table: K202502
Prepared by CI:Now for The Health Collaborative

The proportion of owner-occupied vs. renter-occupied housing units stayed fairly flat between 2015 and 2019 (Figure 1.38), with about three in 10 households renting. This data is pre-pandemic and preceded the current housing shortage.

Fig. 1.39 Percent of occupied housing units that are renter-occupied, 2020

Renter Occupied Units

‡	12% or Less
⌂	> 12% to 18%
◊	> 18% to 20%
☆	> 20% to 25%
✳	> 25% to 33%

Source: ACS 5-Year Estimates, Table B25003

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
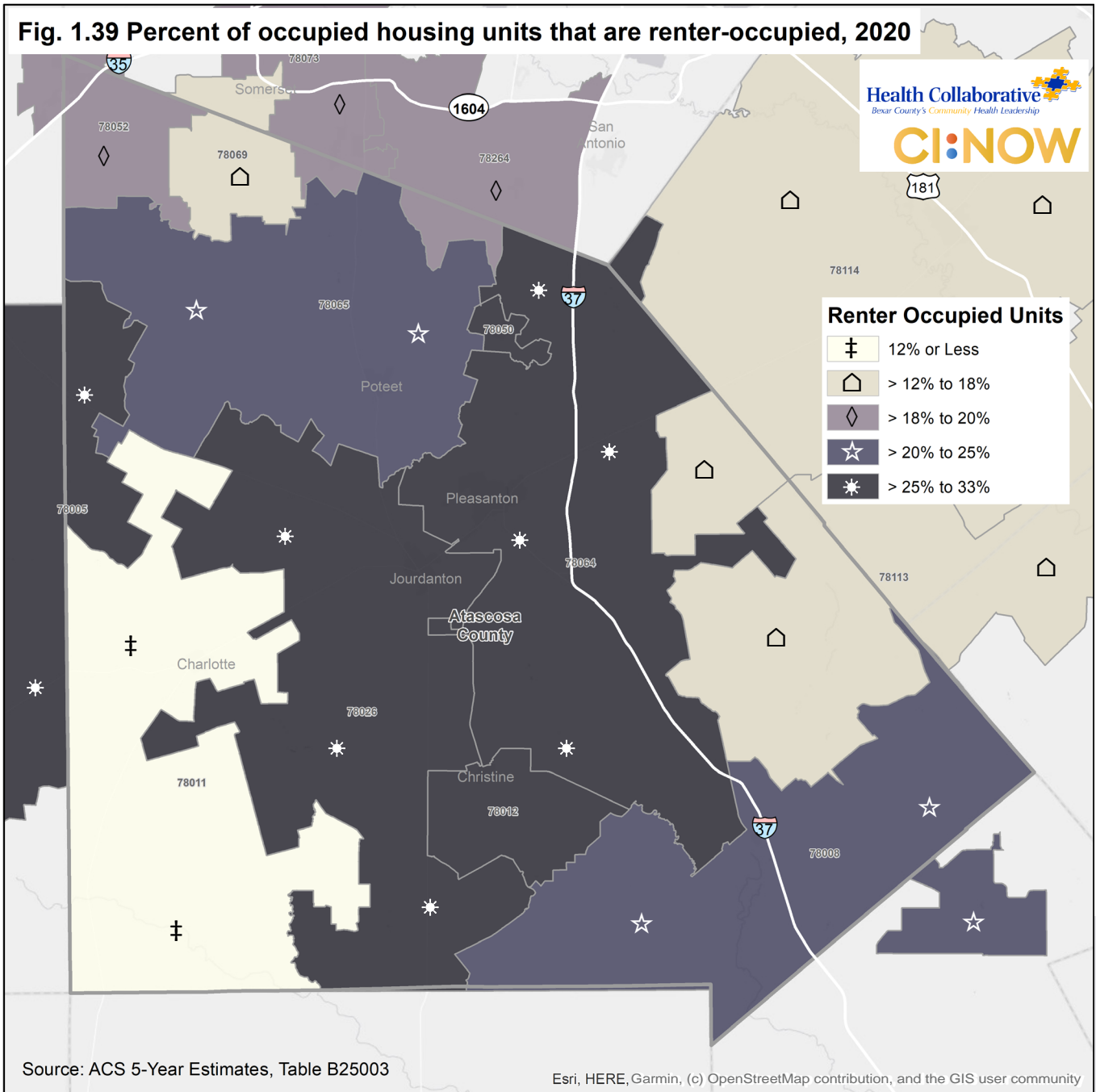
Renter-occupied units are most common in the central ZIP codes of the county (Figure 1.39), likely because those ZIP codes include the larger towns. The ZIP code with the lowest proportion of renters is 78011 to the southwest.

A household is considered housing cost-burdened if housing costs account for 30% or more of household income. Housing cost burden decreased markedly between 2010 and 2020 (Figure 1.40), but this data predates the pandemic. With the loss of income due to COVID-19 in 2020 and 2021, housing cost burden may have increased in 2021.

Fig. 1.40 Percent of occupied housing units where housing costs or rent is 30% or more of household income

Atascosa County, Texas
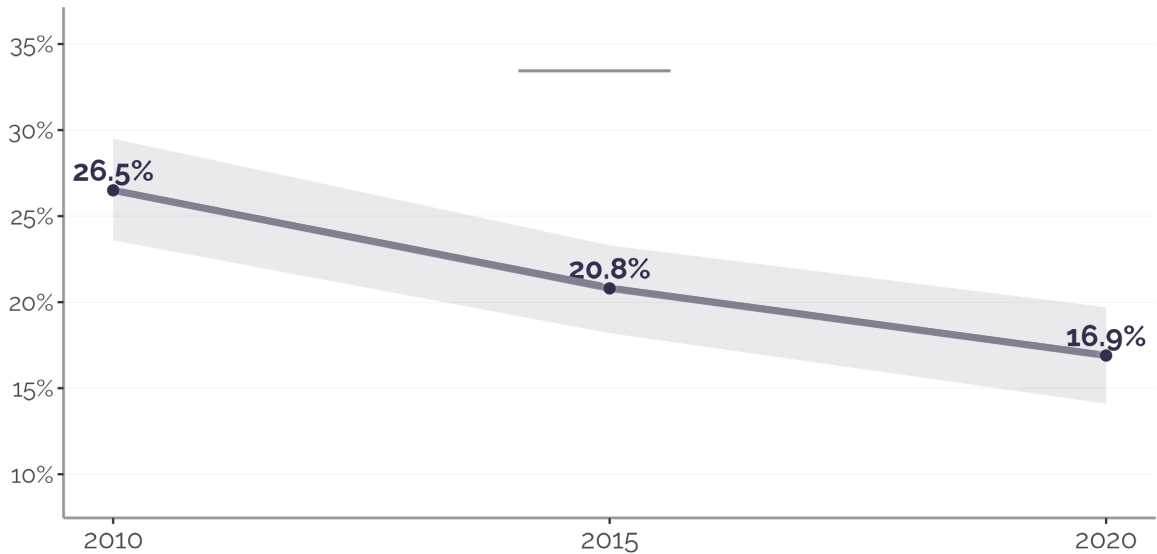
Source: ACS 5-Year Estimates. Table: B25106
Prepared by CI:Now for The Health Collaborative

Fig. 1.41 Percent of occupied housing units where housing costs or rent is 30% or more of household income by household type, 2020

Atascosa County, Texas
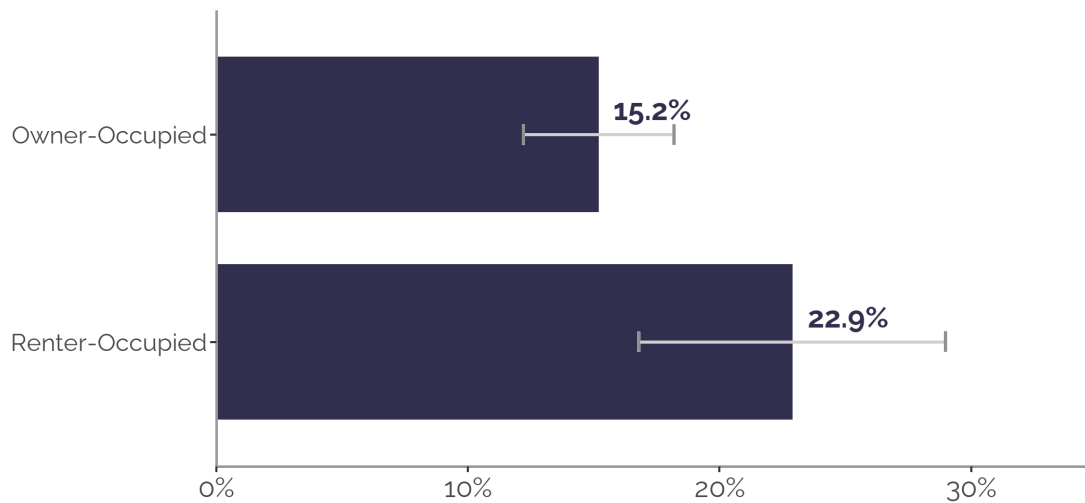
Source: ACS 5-Year Estimates. Table: B25106
Prepared by CI:Now for The Health Collaborative

An estimated 23% of renter-occupied households and 15% of owner-occupied households were considered housing cost-burdened in 2020 (Figure 1.41).

Fig. 1.42 Percent of households housing cost-burdened, 2020

Housing Cost Burden
paying 30% or more in housing costs

‡	3% or Less
⌂	> 3% to 12%
◇	> 12% to 18%
☆	> 18% to 24%
✷	> 24% to 28%

Source: ACS 5-Year Estimates, Table B25106

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
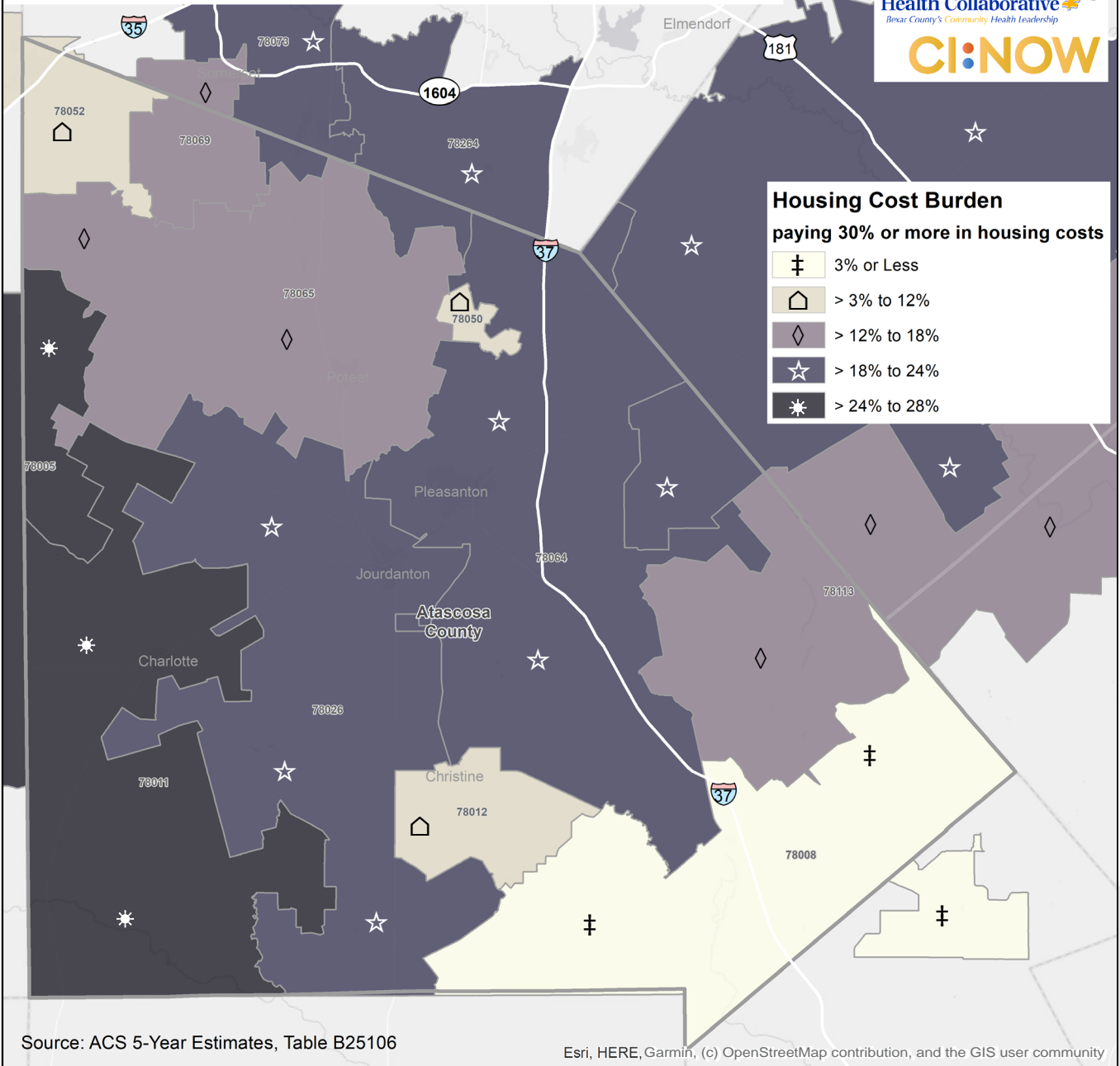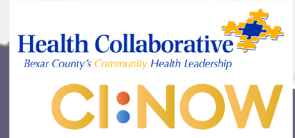
Housing cost-burdened households are most common at the western edge of the county (Figure 1.42). ZIP code 78008 in the southwest of the county has an extremely low rate of housing cost burden.

AIR QUALITY

Only two years of air quality data are available (Figure 1.43), but the percent of days when air quality was unhealthy rose 35% from 2020 to 2021. The low percent in 2020 may be partly attributable to reduced driving early in the COVID-19 pandemic. The determination of "unhealthy" air quality by day – the Air Quality Index – incorporates measurements of carbon monoxide, ozone, nitrogen dioxide, PM10 & PM2.5 particulate matter, and sulfur dioxide.[10]

Fig. 1.43 Percent of days air quality levels were unhealthy - above moderate
Atascosa County, Texas
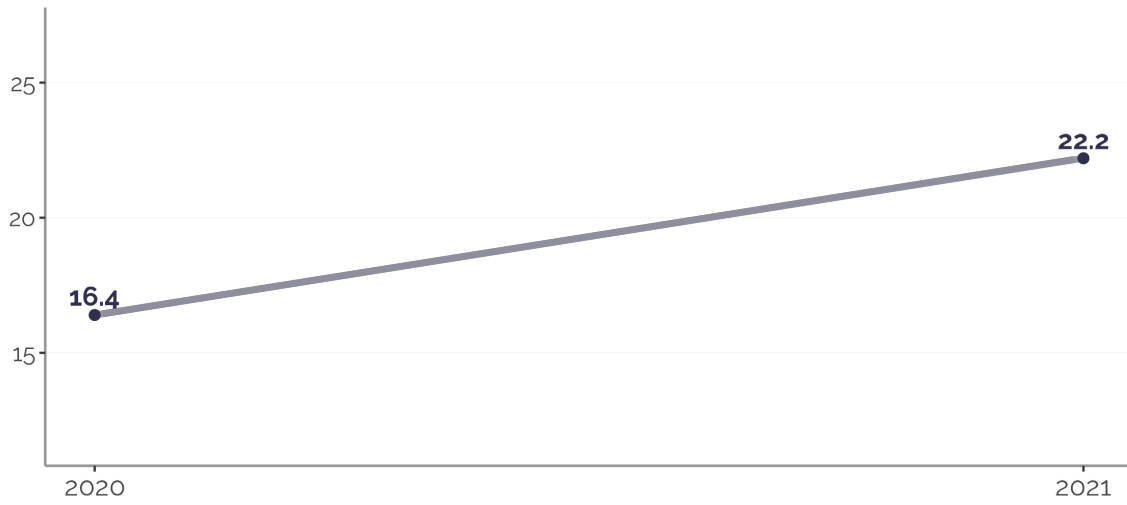
Source: Environmental Protection Agency
Prepared by CI:Now for The Health Collaborative
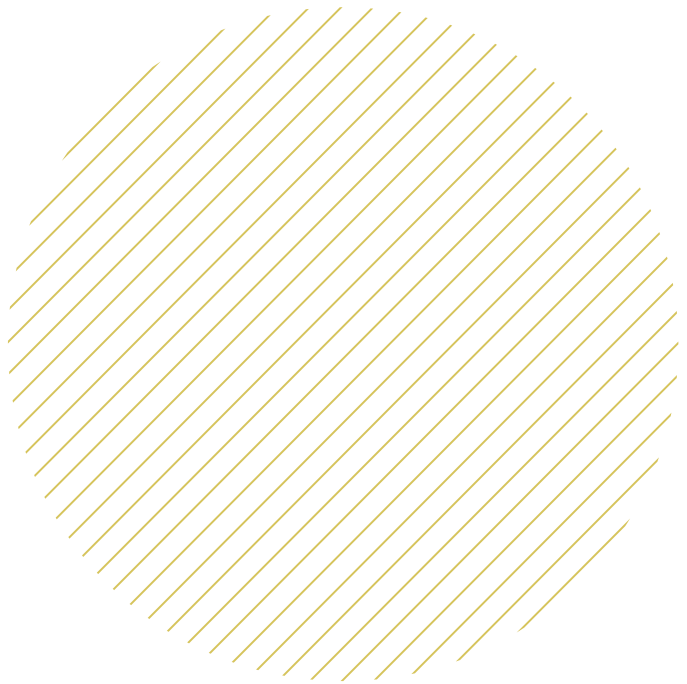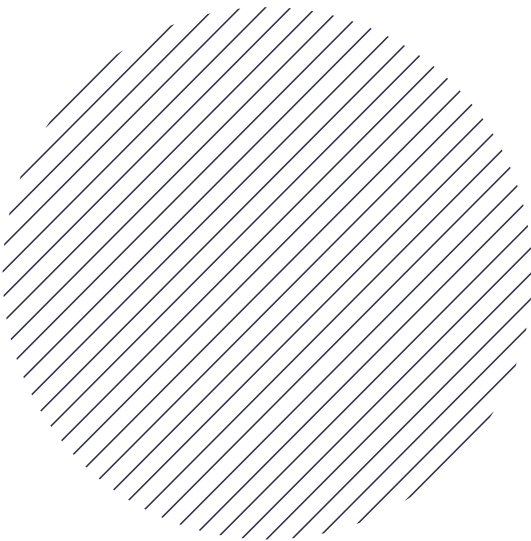
SECTION 2: ACCESS TO CARE, PREVENTIVE CARE AND HEALTHY BEHAVIORS

ACCESS TO CARE
HEALTH INSURANCE

Despite the Affordable Care Act making coverage generally more accessible, the percent of the civilian non-institutionalized population that has health insurance remained fairly flat between 2015 and 2019 at an estimated 77% to 84% (Figure 2.1). Because the confidence intervals overlap for every year, there may not truly have been an increase or decrease in any year.

Fig. 2.1 Percent of insured civilian non institutionalized population

Atascosa County, Texas
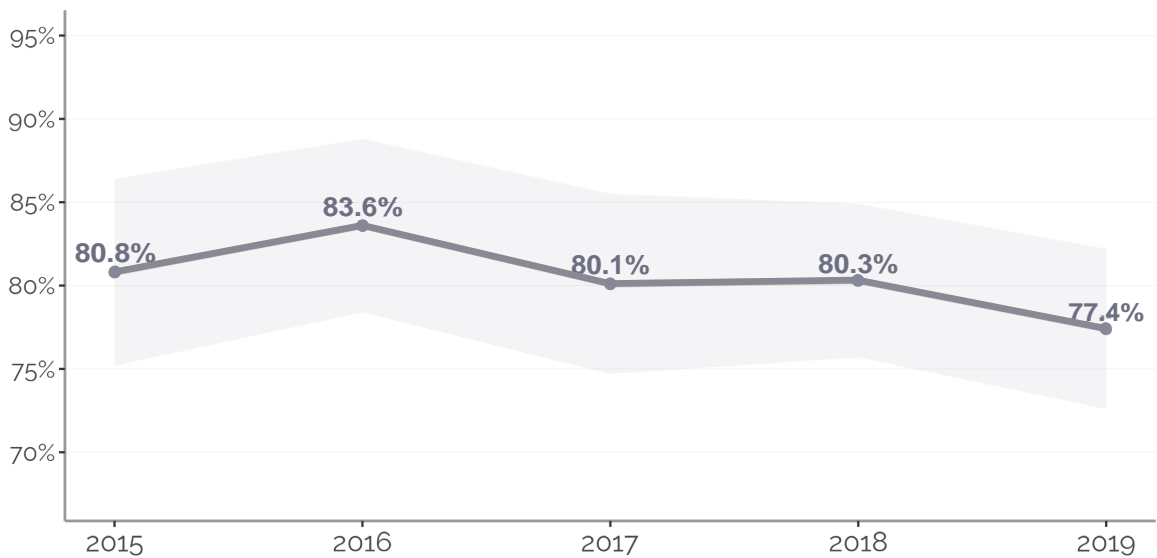
Source: ACS 1-Year Supplemental Estimates. Table: K202701
Prepared by CI:Now for The Health Collaborative

Health insurance coverage is highest in the Medicare-eligible older population, and next highest among young children eligible for Medicaid (Figure 2.2). Coverage rates are lowest among working-age adults, particularly younger adults aged 19 to 25.

Fig. 2.2 Percent of insured civilian, non-institutionalized population by age group, 2020

Atascosa County, Texas

Age group	Percent insured
Age Under 6	89.9%
Age 6-18	89.6%
Age 19-25	59.4%
Age 26-34	66.9%
Age 35-44	74.6%
Age 45-54	77.5%
Age 55-65	81.8%
Age 65-74	98.0%
Age 75 and Over	100.0%
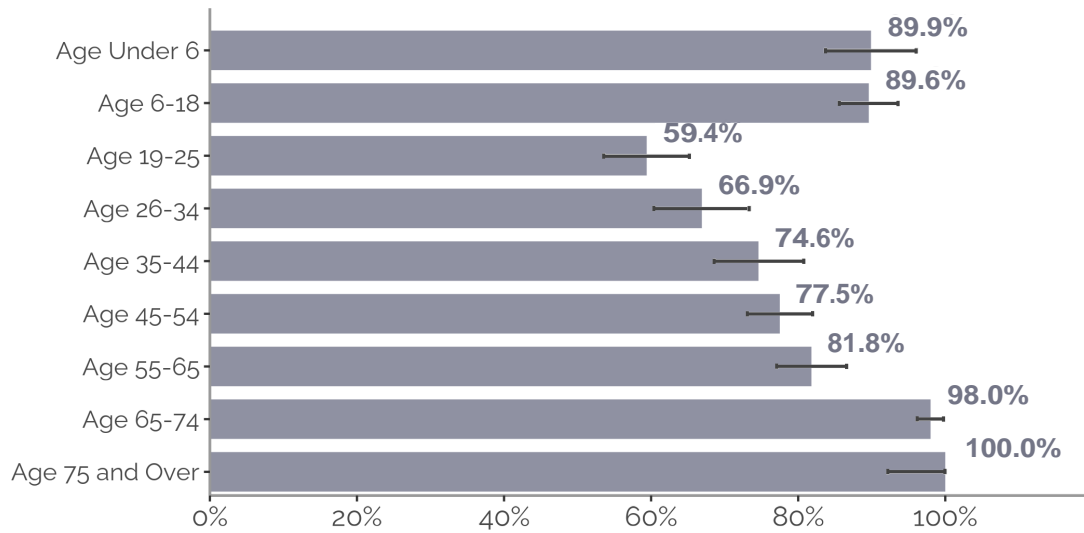
Source: ACS 5-Year Estimates. Table: B27001
Prepared by CI:Now for The Health Collaborative

Even though insurance coverage is least common among working-age adults, employer-based coverage is still the dominant form of insurance among the approximately 77% of people who are insured, serving as the sole form of coverage for four in 10 insured Atascosa County residents (Figure 2.3). Medicaid is the next-most common. Those with solely direct-purchase insurance constitute less than five percent of people with insurance coverage.

Fig. 2.3 Percent of insured civilian, non-institutionalized population by type of insurance, 2020

Atascosa County, Texas

Type	Percent
Employer Based	43.3%
Direct Purchase	4.1%
Medicare	5.0%
Medicaid	12.6%
Tricare Military	0.8%
VA Healthcare	0.3%*
Multiple Insurances	9.3%
Other Type of Insurance	6.0%
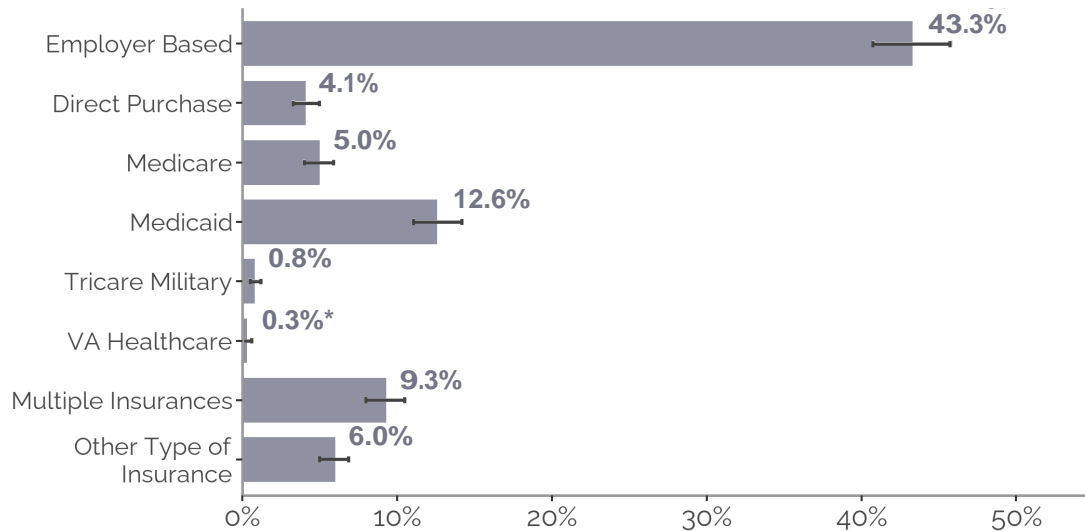
*Unreliable: Error is too large relative to estimate
Source: ACS 5-Year Estimates. Table: B27010
Prepared by CI:Now for The Health Collaborative

Fig. 2.4 Percent civilian, non-institutionalized population insured by race/ethnicity, 2020

Atascosa County, Texas

Race/Ethnicity	Percent
American Indian or Alaska Native	46.3%*
Asian	86.1%
Black or African American	98.3%
Hispanic	77.6%
Native Hawaiian or Pacific Islander**	
Other Race	83.8%
Two or More Races	67.7%
White (Non-Hispanic)	88.1%
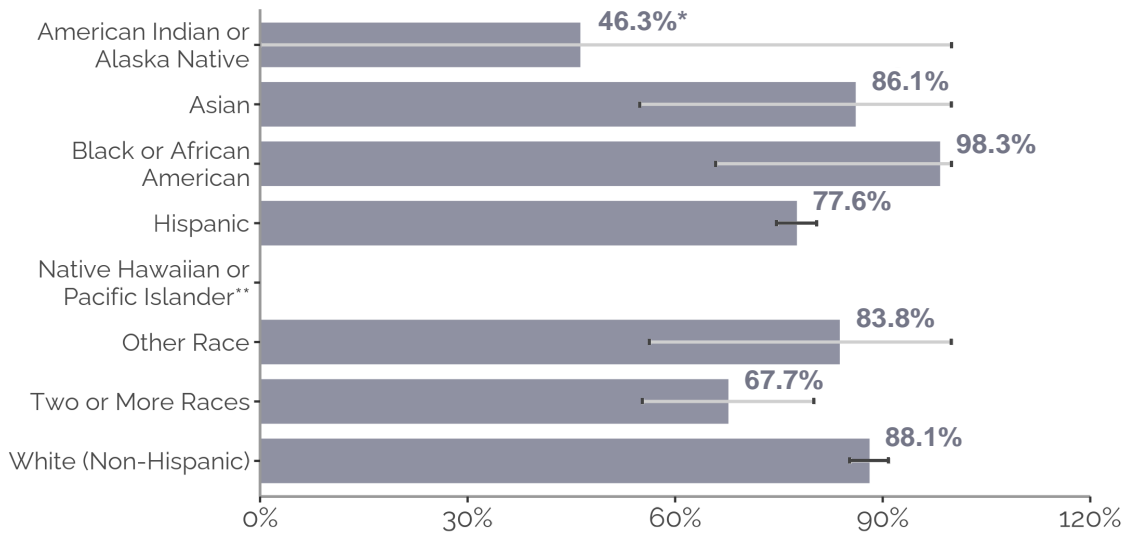
*Unreliable: Error is too large relative to estimate, **Suppressed
Source: ACS 5-Year Estimates. Table: C27001 B-I
Prepared by CI:Now for The Health Collaborative

Although American Indian or Alaska Natives appear to have the lowest rate of health insurance coverage, that difference is uncertain because the confidence interval is so wide (Figure 2.4). Hispanics and people of more than one race are less likely than whites to have health insurance. The rate among Native Hawaiian or Pacific Islanders is unstable and is suppressed by the data source.

Fig. 2.5 Percent of insured civilian, non-institutionalized population, 2020

Population with Health Insurance

Symbol	Range
‡	70% or Less
⌂	> 70% to 75%
◇	> 75% to 85%
☆	> 85% to 90%
✳	> 90% to 100%

Source: ACS 5-Year Estimates, Table B27001

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
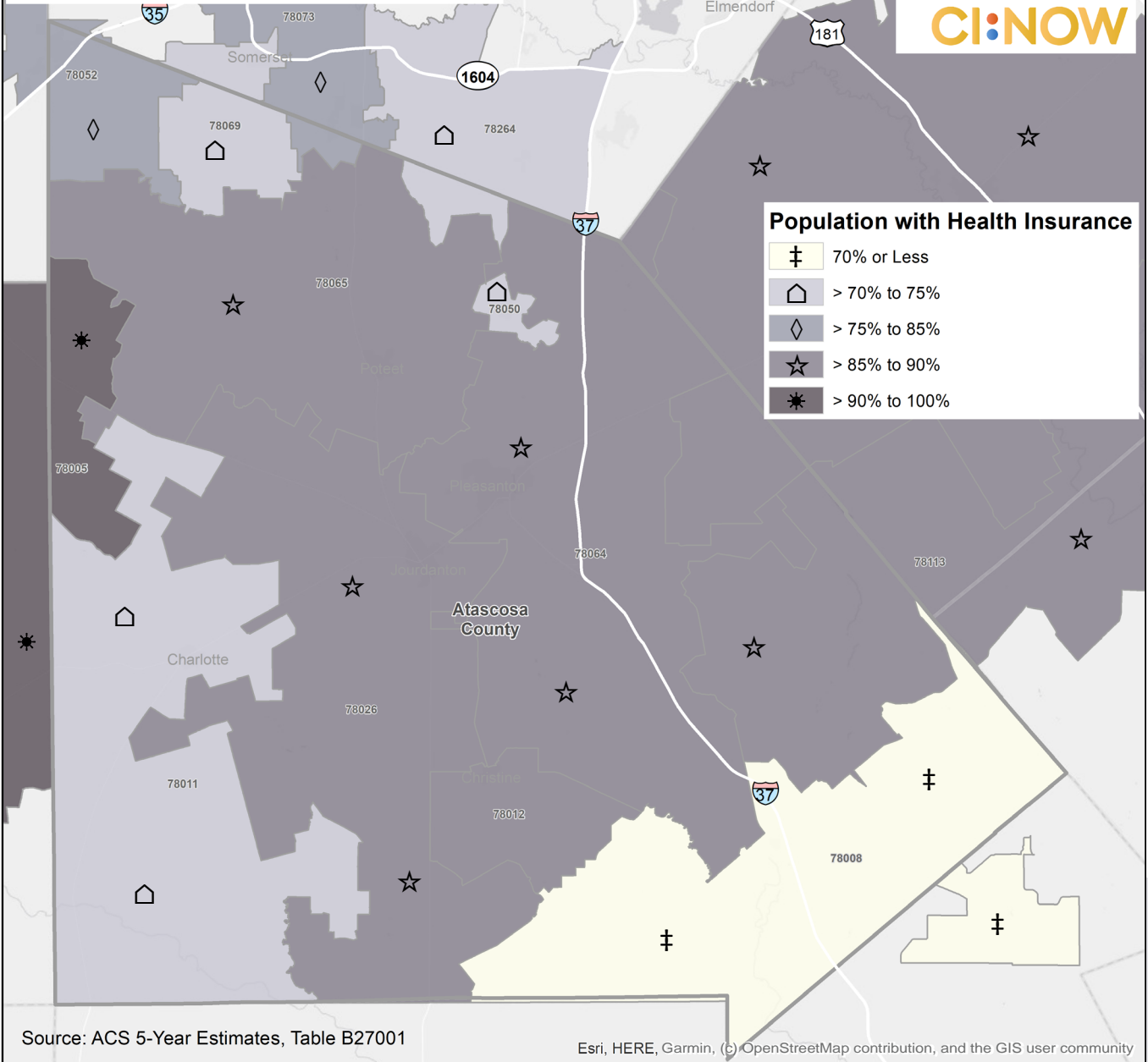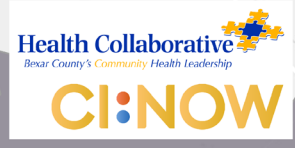
Health insurance coverage is lowest in ZIP code 78008 in the far southeast part of the county (Figure 2.5). Low rates are also seen in ZIP code 78269 (Somerset area), 78050 in the northern part of the county, and 78011 in the southwest part of the county.
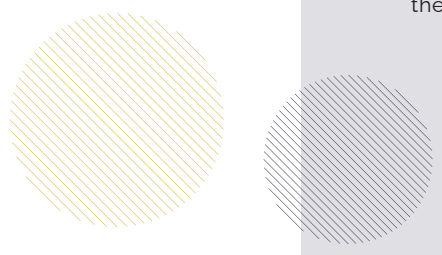
PROVIDER AVAILABILITY

Figure 2.6 quantifies the number of healthcare professionals per 100,000 population in Atascosa County. Unfortunately, the County Health Rankings data from which this chart is drawn does not include midlevel providers – physician assistants or nurse practitioners – in its count of primary care providers. County Health Rankings defines mental health providers as "psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care." It is important to note that for any provider type, a provider may practice only part-time or in some other setting that limits their availability to the general population.

Fig. 2.6 Number of healthcare professionals by type per 100,000 population, 2021

Atascosa County, Texas

Provider Type	Value per 100,000
Primary Care Physicians	21.9
Dentists	41.0
Mental Health Providers	39.1
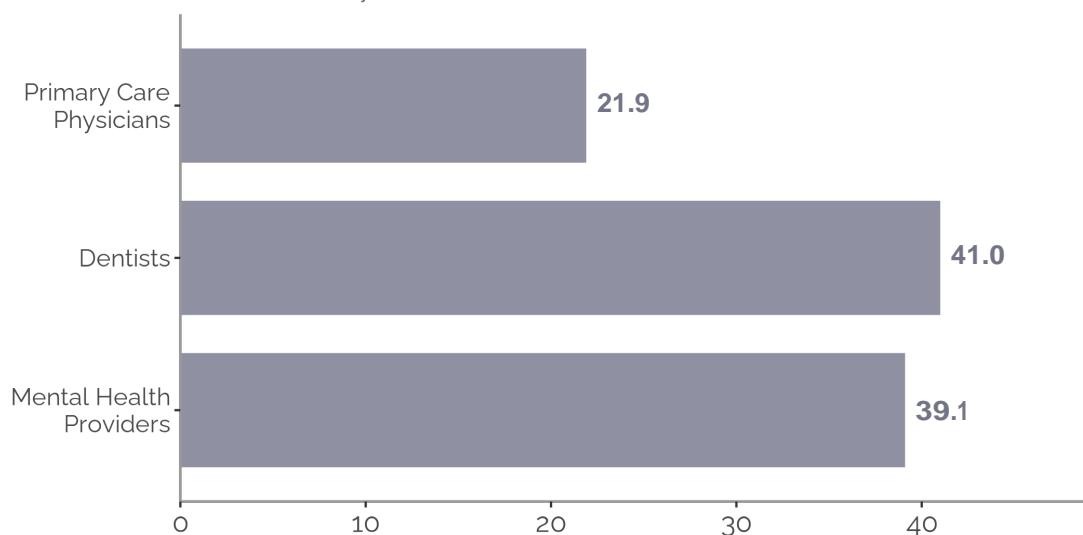
Source: County Health Rankings
Prepared by CI:Now for The Health Collaborative

PREVENTIVE CARE
MEDICAL VISITS

Many of the charts that follow in this section represent data from the Behavioral Risk Factor Surveillance System (BRFSS), a household telephone survey of adults with an extremely small sample size for Atascosa County. Because the sample size is so small relative to the size of the adult population, even with multiple years of data combined, each BRFSS estimate has a good bit of uncertainty. The true value may lie anywhere in the range of the estimate's confidence interval, which is represented as a horizontal gray line in each bar of the chart. When the confidence intervals (gray lines) for two estimates overlap, one cannot be sure that there is truly any difference between the two estimates. That issue will arise over and over again in the narrative describing these charts.

As in the 2019 Bexar County and Atascosa County Community Health Needs Assessment, at the recommendation of the Texas Department of State Health Services, all Atascosa County BRFSS data has been combined with similar Wilson and Medina Counties so that the confidence intervals are not so wide as to make the data useless. Several recent survey years have also been combined for the same reason.

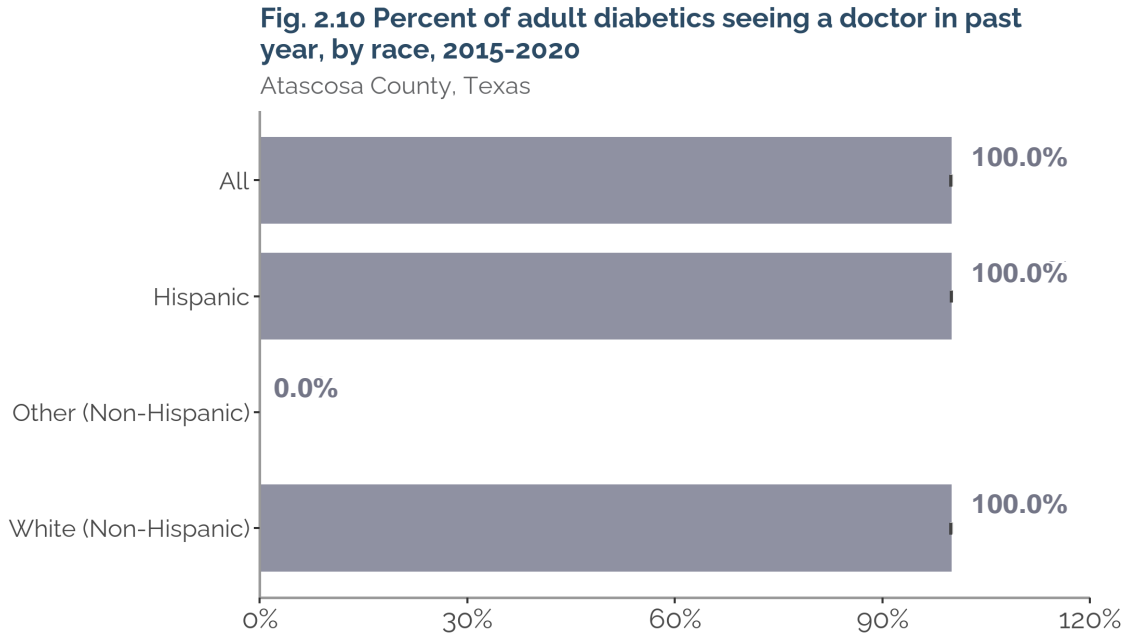**Fig. 2.7 Percent of adults who visited a doctor last year, by race, 2015-2020**
Atascosa County, Texas
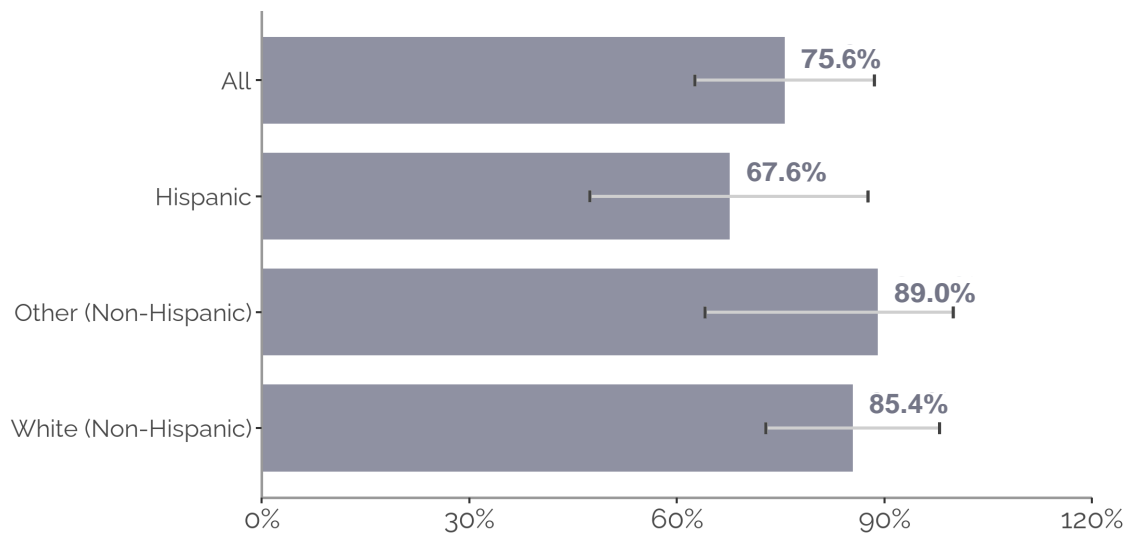
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CI:Now for The Health Collaborative

An estimated 75% of BRFSS respondents reported having seen a doctor in the past year (Figure 2.7), although the data is mostly pre-pandemic and the survey does not ask whether the visit was for preventive or sick care.

No data is available for percent of respondents visiting a dentist or dental clinic in the past year.

DIABETES MANAGEMENT

For Atascosa County as a whole, an estimated seven in 10 adult diabetics report that they check their feet daily (Figure 2.8). Even after combining multiple years of data, differences among race/ethnicity groups are hard to interpret because of wide margins of error, but the rates appear similar for whites and Hispanics.

Fig. 2.8 Percent of adult diabetics who check feet daily, by race, 2015-2020
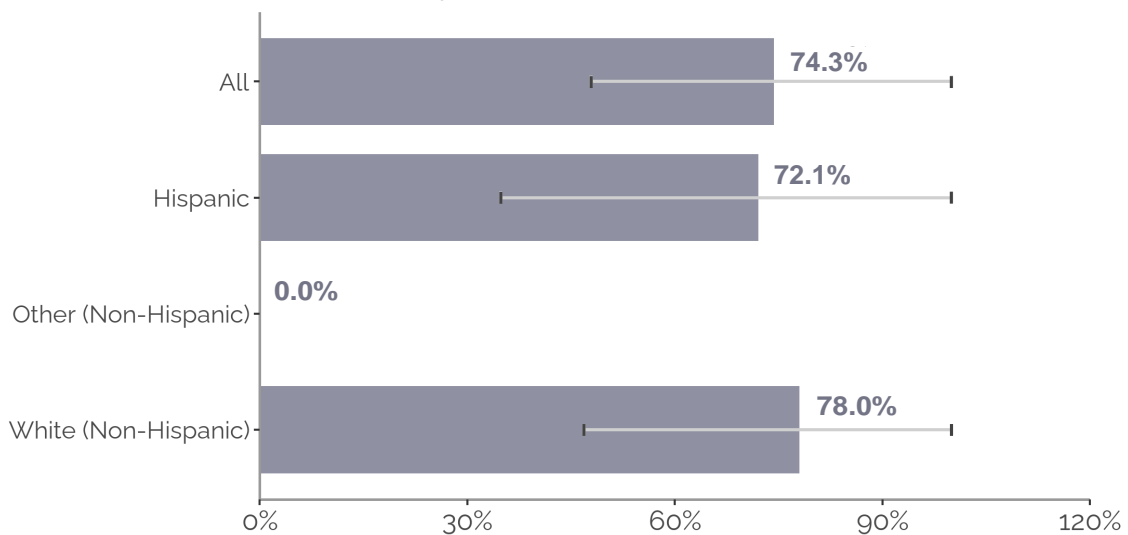
Atascosa County, Texas

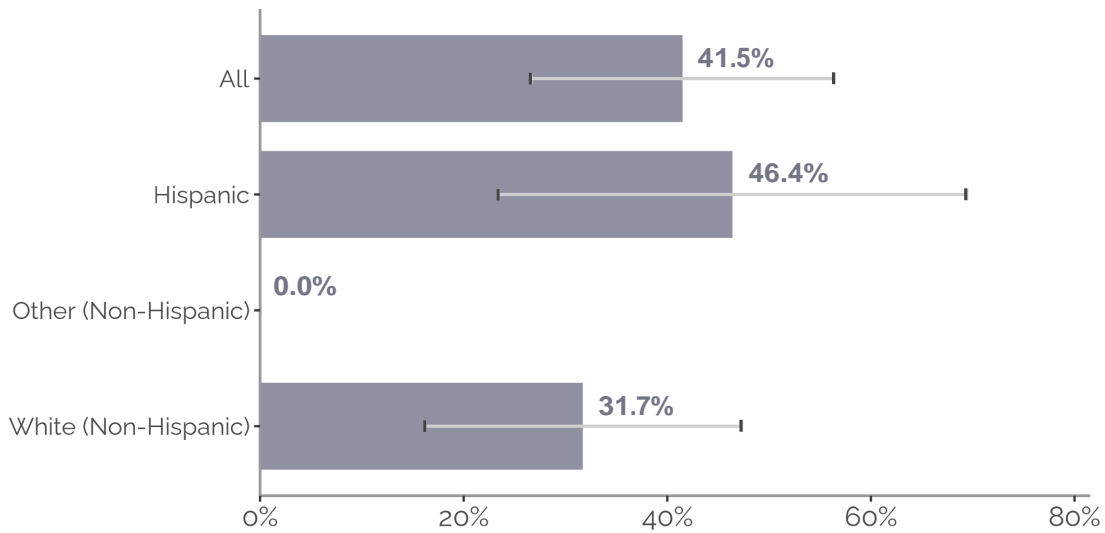|	
All	74.3%
Hispanic	72.1%
Other (Non-Hispanic)	0.0%
White (Non-Hispanic)	78.0%

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

Overall, about nine in 10 adult diabetics report having their hemoglobin A1c, a measure of blood sugar level, checked in the past year (Figure 2.9). Although the estimates for Hispanics and whites appear quite different, the overlapping confidence intervals mean that difference is not certain.

Fig. 2.9 Percent of adult diabetics who have had Hemoglobin A1c checked in past year, by race, 2015-2020
Atascosa County, Texas
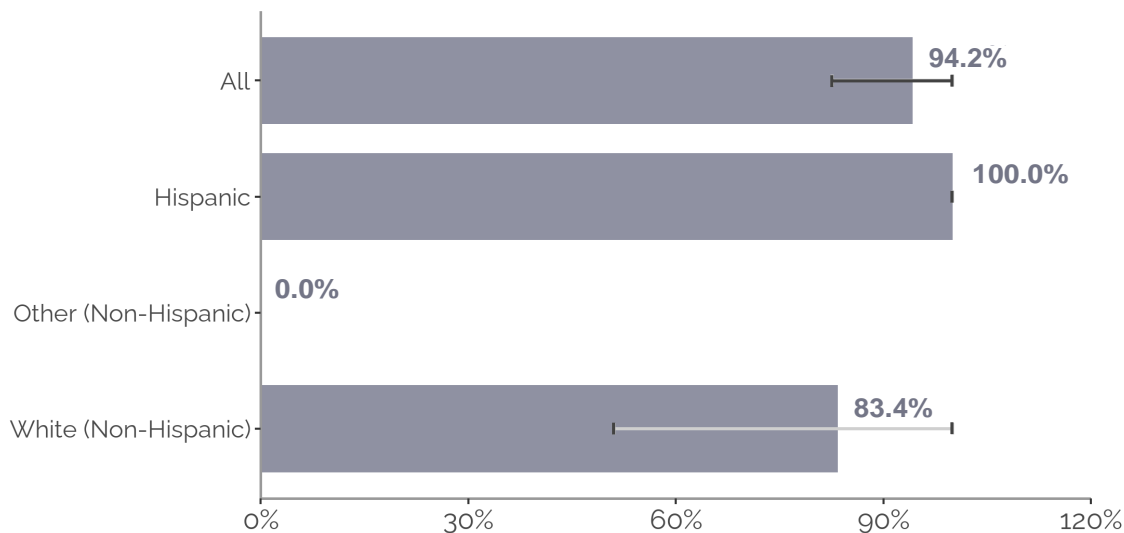
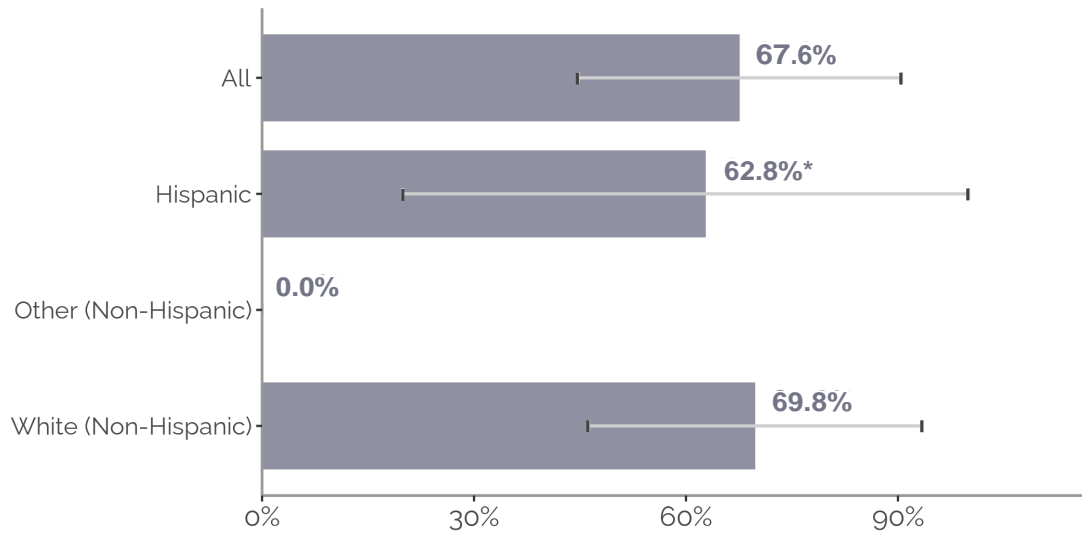| Race	Percent
All	94.2%
Hispanic	100.0%
Other (Non-Hispanic)	0.0%
White (Non-Hispanic)	83.4%

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

Surprisingly, all adult diabetic respondents report having seen a doctor in the past year (Figure 2.10). There were no other-race respondents.

Fig. 2.10 Percent of adult diabetics seeing a doctor in past year, by race, 2015-2020

Atascosa County, Texas

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

The production of Atascosa ~~County adult diabetics reporting having had a course~~ in self-management is estimated at about four in 10 (Figure 2.11). Differences among groups are hard to interpret because of wide margins of error.

Fig. 2.11 Percent of adult diabetics who have had a course in self-management, by race, 2015-2020
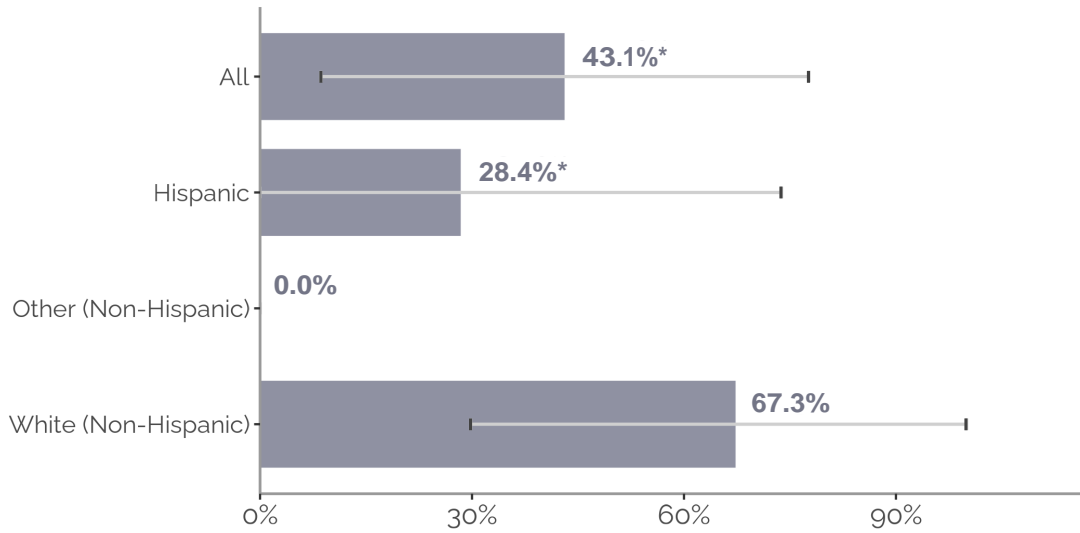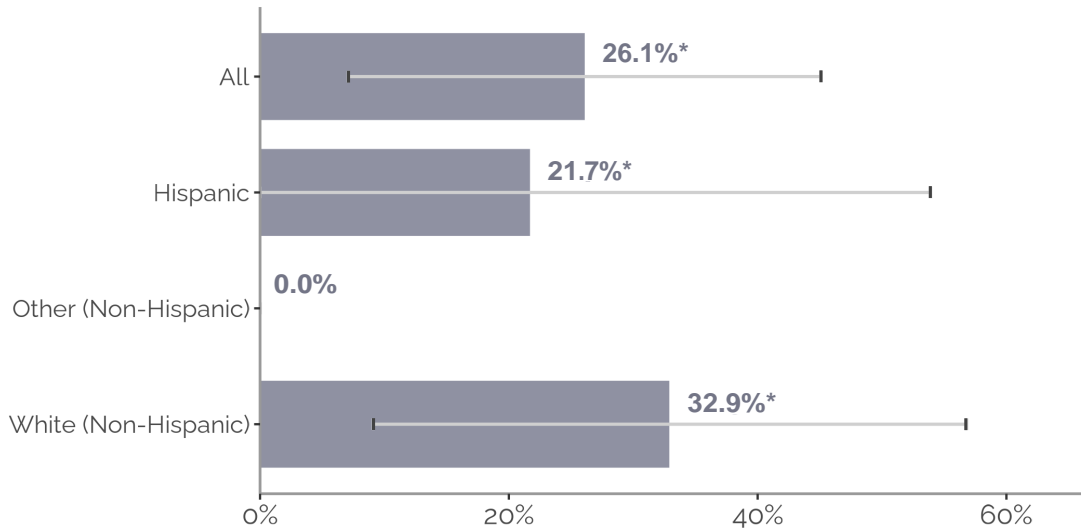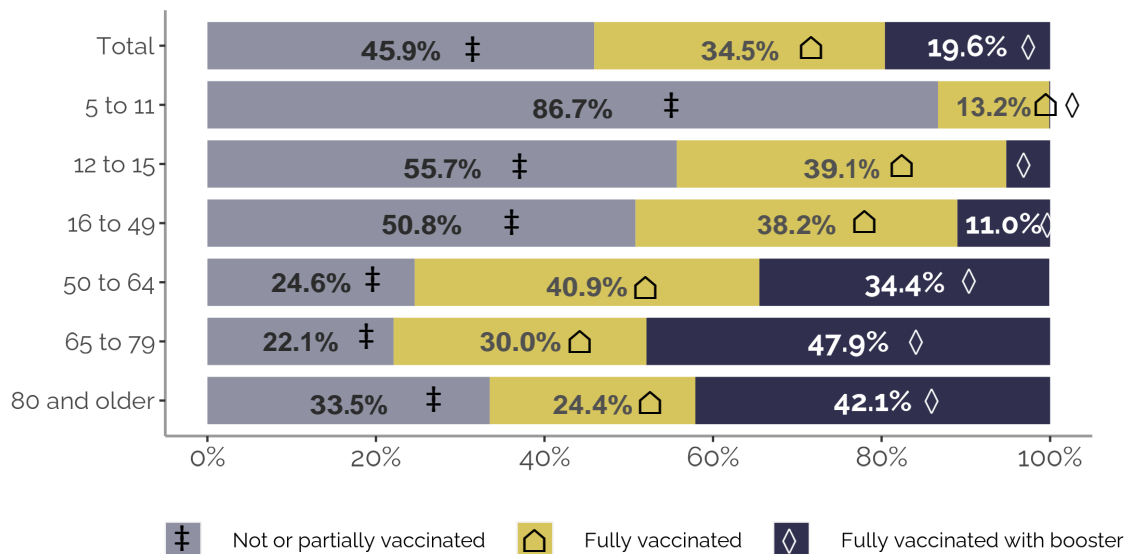
Atascosa County, Texas

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

CANCER SCREENING

Mammography compliance is low, with only an estimated one in six female respondents 50 and older reporting having had a mammogram screening for breast cancer in the past two years (Figure 2.12). The difference in the rates among Hispanics as compared to whites appears statistically significant.

Fig. 2.12 Percent of women 50+ who have had a mammogram within the past two years, by race, 2015-2020
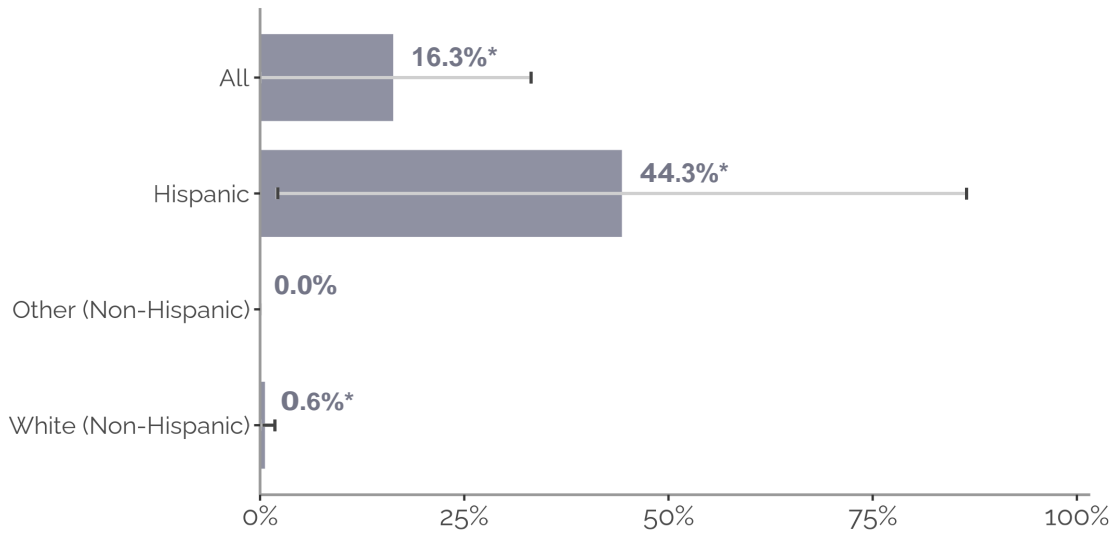
Atascosa County, Texas

All — **16.3%***

Hispanic — **44.3%***

Other (Non-Hispanic) — **0.0%**

White (Non-Hispanic) — **0.6%***

0%   25%   50%   75%   100%

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

In Atascosa County overall about three in four women 21 and older have ever had a Pap test screening for cervical cancer (Figure 2.13). No differences can be determined among race/ethnicity groups because the confidence intervals all overlap almost entirely.

Fig. 2.13 Percent of women 21+ who have ever had a Pap test, by race, 2015-2020
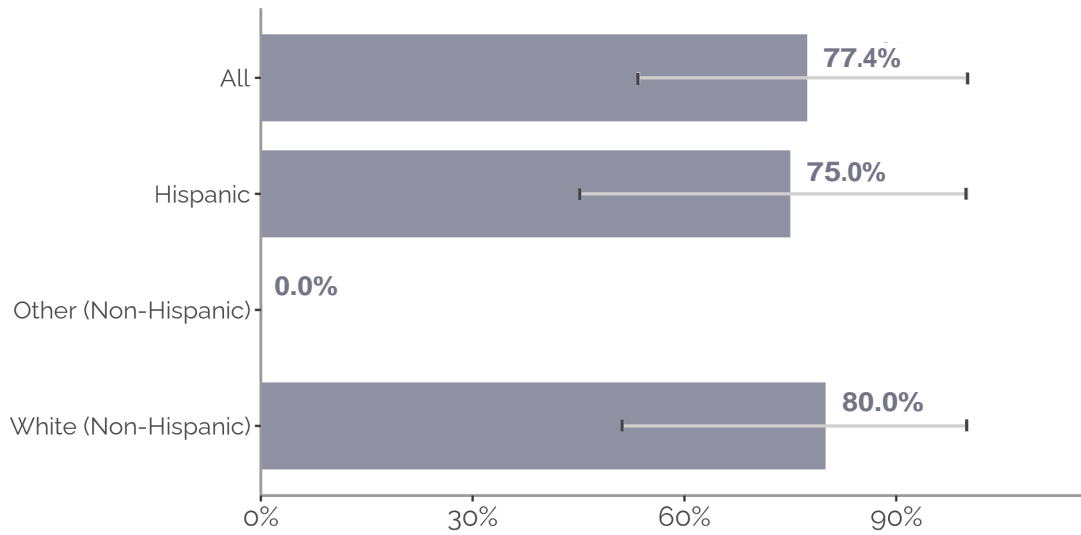
Atascosa County, Texas

Category	Percent
All	77.4%
Hispanic	75.0%
Other (Non-Hispanic)	0.0%
White (Non-Hispanic)	80.0%

HIV TESTING

About four in 10 Atascosa County respondents report ever having been tested for HIV (Figure 2.14). There were no other-race respondents. With overlapping confidence intervals, no difference among groups is certain.

Fig. 2.14 Percent of adults ever tested for HIV, by race, 2015-2020

Atascosa County, Texas

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

VACCINATIONS

Seven in 10 county respondents 65 and older report ever having had a pneumonia vaccination (Figure 2.15), which need only be given once. The data shows no clear differences between whites and Hispanics.

Fig. 2.15 Percent of adults 65 and older who have ever had a pneumonia vaccination, by race, 2015-2020

Atascosa County, Texas

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

Only an estimated quarter of Atascosa County respondents 65 and older report having had a flu shot in the past year (Figure 2.16). It is difficult to determine differences among groups because the confidence intervals overlap.

Fig. 2.16 Percent of adults 65 and older who had a flu shot within the past year, by race, 2015-2020

Atascosa County, Texas

All — **26.1%***

Hispanic — **21.7%***

Other (Non-Hispanic) — **0.0%**

White (Non-Hispanic) — **32.9%***

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

Fig. 2.17 Percent of COVID-19 vaccine-eligible population by vaccination status and age group, June 6, 2022

Atascosa County, Texas

| Age group	Not or partially vaccinated	Fully vaccinated	Fully vaccinated with booster
Total	45.9% ‡	34.5% ⌂	19.6% ◊
5 to 11	86.7% ‡	13.2% ⌂	◊
12 to 15	55.7% ‡	39.1% ⌂	◊
16 to 49	50.8% ‡	38.2% ⌂	11.0% ◊
50 to 64	24.6% ‡	40.9% ⌂	34.4% ◊
65 to 79	22.1% ‡	30.0% ⌂	47.9% ◊
80 and older	33.5% ‡	24.4% ⌂	42.1% ◊

‡ Not or partially vaccinated   ⌂ Fully vaccinated   ◊ Fully vaccinated with booster

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

As of early June 2022, just 54% of Atascosa County residents five and older are fully vaccinated against COVID-19, as compared to 66% of the Texas population overall. Twenty percent have received at least one booster dose.   As shown in Figure 2.17, vaccination and booster rates are highest among people 50 and older, with a steep drop in younger age groups.

Figure 2.18 presents COVID-19 vaccination data in a different way, comparing the race/ethnicity breakdown of the fully vaccinated population to the race/ethnicity breakdown of the county's vaccine-eligible population. Each light bar represents that race/ethnicity group's share of the vaccine-eligible population. Where the dark bar extends farther than the light bar, then, that group is over-represented among the fully-vaccinated population. Where the dark bar falls short of the light bar, that group is under-represented among the fully-vaccinated population. Either case represents a disparity in vaccination rate.

This chart should be interpreted with caution because of the very high percent of the fully vaccinated population coded as "other" race/ethnicity. If each fully vaccinated person's race/ethnicity were recorded and coded in the same way that the Census Bureau records and codes race/ethnicity for the population, most of that fully vaccinated "other" group would be distributed across the Asian, Black, Hispanic, and white groups. It is impossible to know, though, how uneven that distribution would be.

No vaccination rate data is available for the 4:3:1:3*:3:1:4 series for Atascosa County children. However, the rate likely declined in 2020 as was the case nationally[2] and for Bexar County.[2] The immunization series includes at least 4 DTaP, 3 polio, 1 MMR, 3 Hib (3 or 4 doses depending on vaccine type),[3] Hep B, 1 varicella, and 4 PCV13 doses. Likewise, HPV vaccination data is not available for Atascosa County.
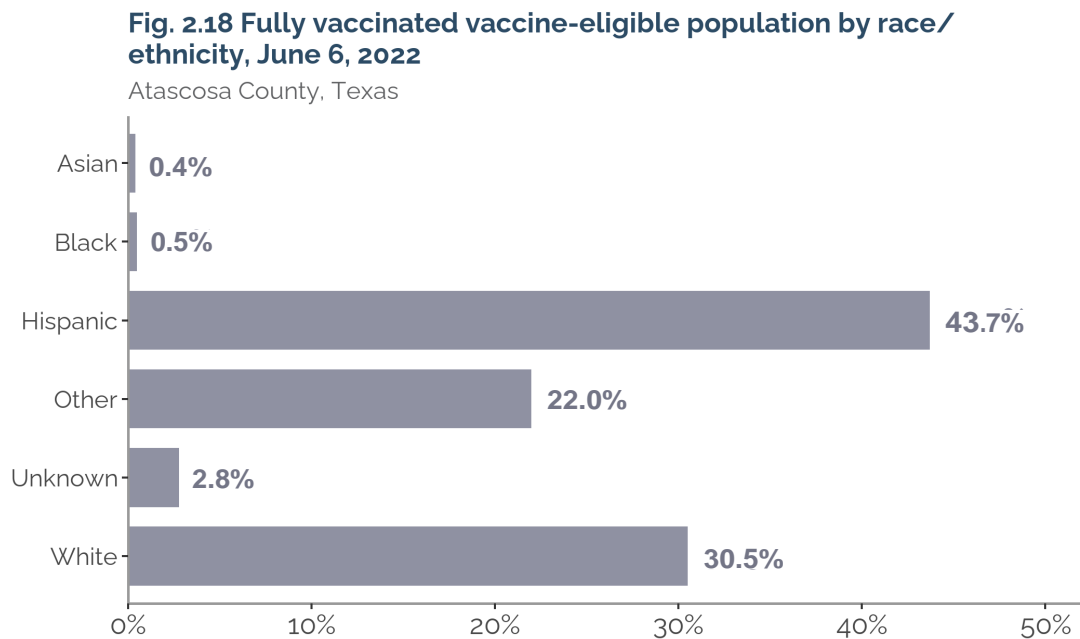
Fig. 2.18 Fully vaccinated vaccine-eligible population by race/ethnicity, June 6, 2022

Atascosa County, Texas

Race/Ethnicity	Percent
Asian	0.4%
Black	0.5%
Hispanic	43.7%
Other	22.0%
Unknown	2.8%
White	30.5%

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

[2] See for example DeSilva, M.B., Haapala, J., Vazquez-Benitez, G., et al. (2022). Association of the COVID-19 pandemic with routine childhood vaccination rates and proportion up to date with vaccinations across 8 US health systems in the Vaccine Safety Datalink. JAMA Pediatrics, 176(1):68–77. Available online at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2784888

[3] The Health Collaborative. 2022 Bexar County Community Health Needs Assessment. [forthcoming, to be available online at http://healthcollaborative.net/]

HEALTH-RELATED BEHAVIORS
HEALTHY EATING

Fig. 2.19 Percent of adults who consumed fruits and vegetables 5+ times per day, by race, 2015-2020
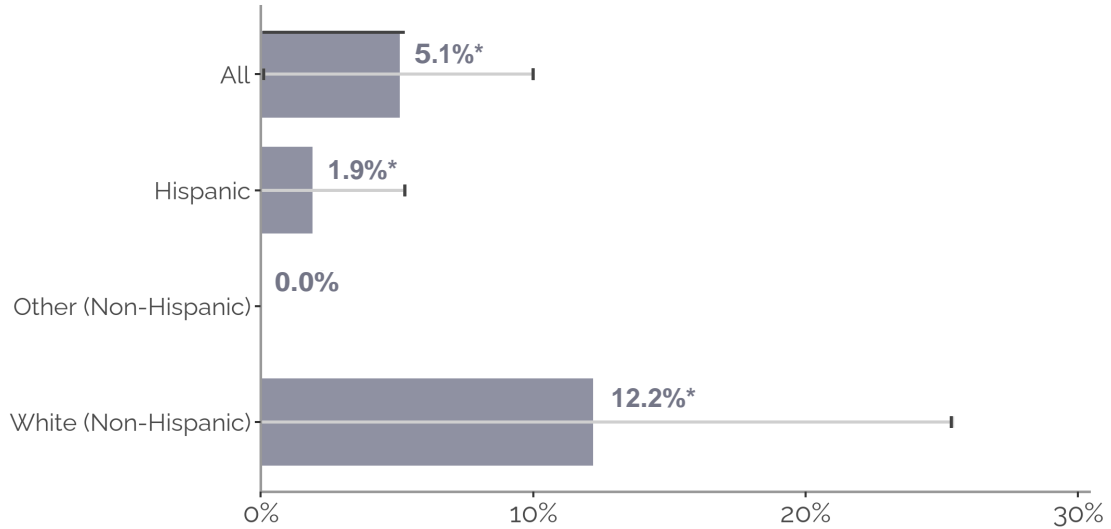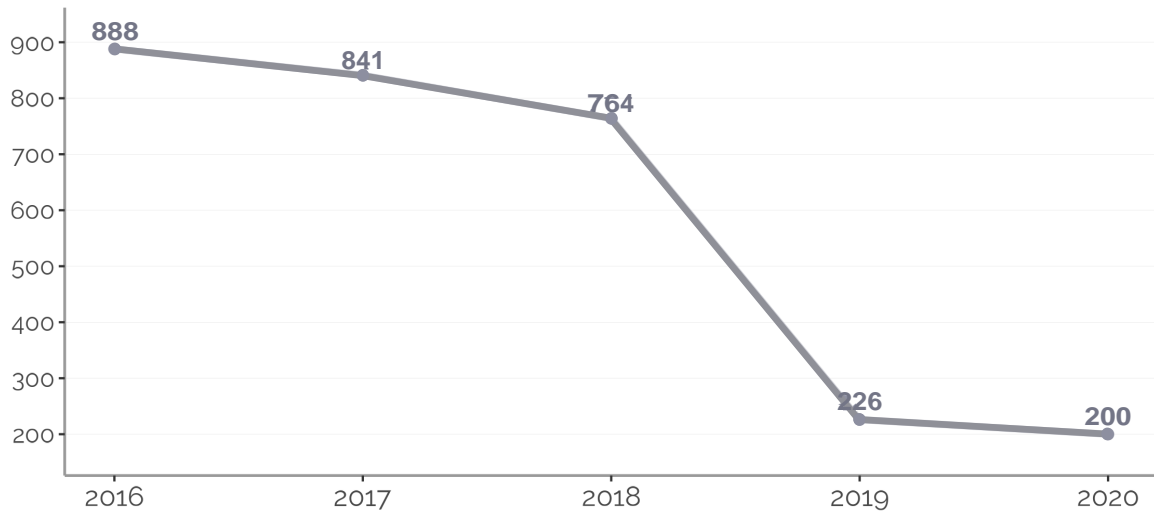
Atascosa County, Texas

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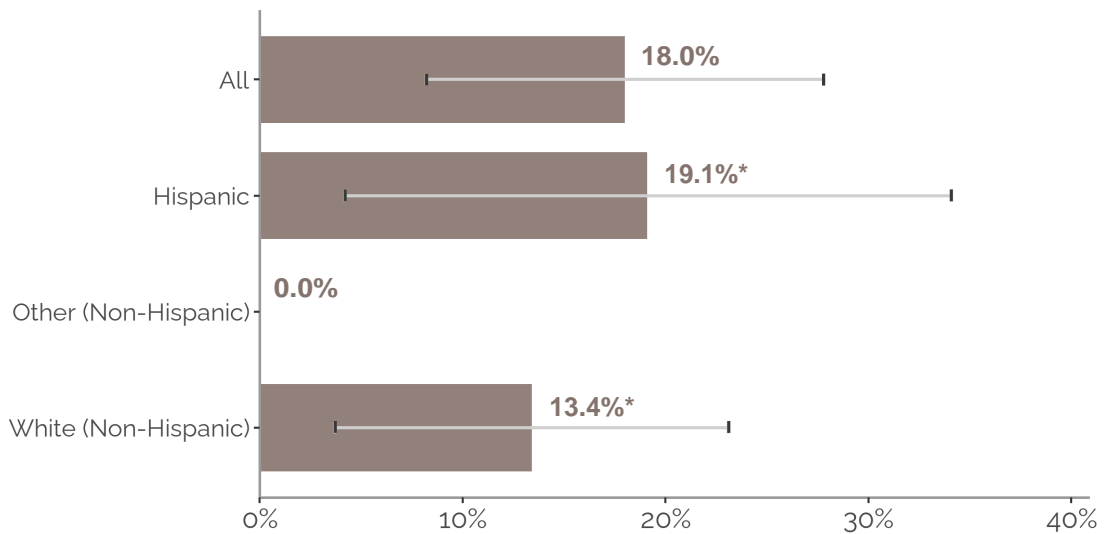Prepared by CI:Now for The Health Collaborative

Just five percent of Atascosa County adult BRFSS respondents reported consuming fruits and vegetables five or more times per day (Figure 2.19). Overlapping confidence intervals mean uncertainty about differences among race/ethnicity groups.

PHYSICAL ACTIVITY

Fig. 2.20 Percent of adults participating in 150 minutes or more of aerobic physical activity per week, by race, 2015-2020
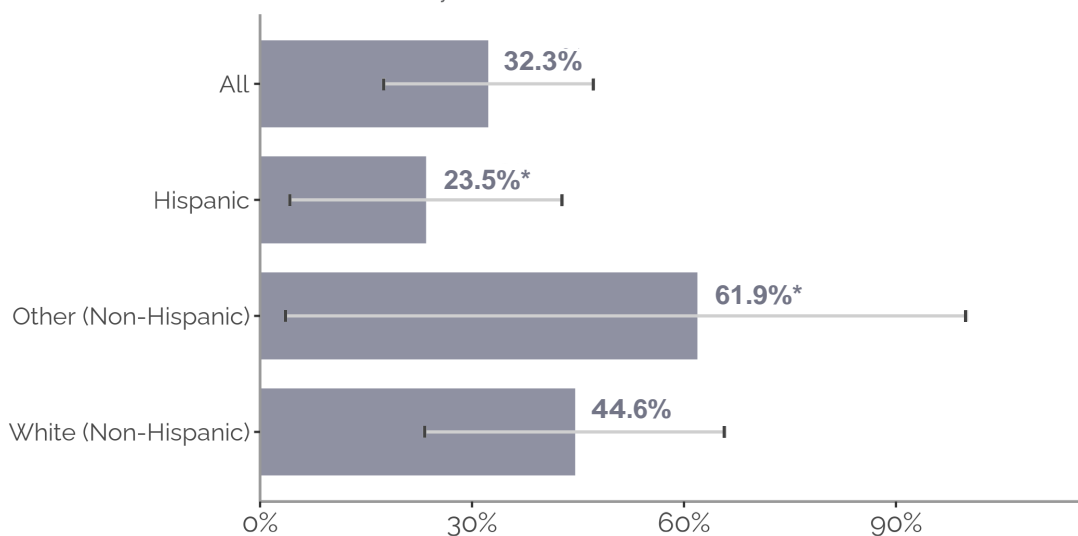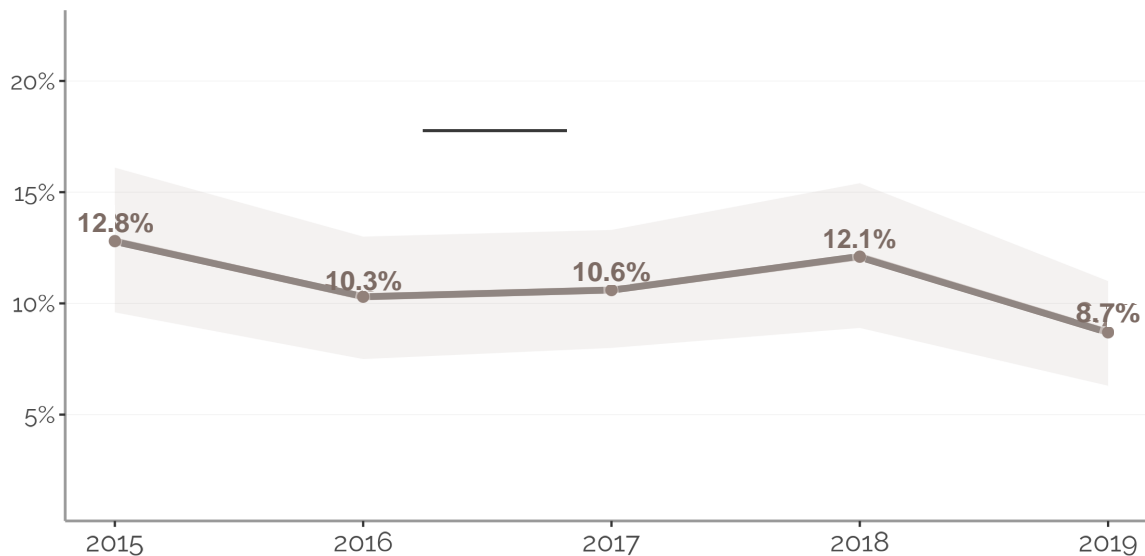
Atascosa County, Texas

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

Just one-third of respondents reported participating in at least 150 minutes of aerobic physical activity per week (Figure 2.20). With overlapping confidence intervals, the data shows no clear differences among race/ethnicity groups.

OPIOID PRESCRIPTIONS

Fig. 2.21 Rate of opioid prescriptions per 1,000 adults in the past 12 months
Atascosa County, Texas

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

The opioid prescription rate per 1,000 adults saw a steep decrease in 2019. The 2020 rate is a 77% drop from 2016 (Figure 2.21), decreasing from about 89 opioid prescriptions for every 100 adults in Atascosa County to 20 per 100 adults.

ALCOHOL USE

Fig. 2.22 Percent of adults who reported heavy alcohol use in last month, by race, 2015-2020
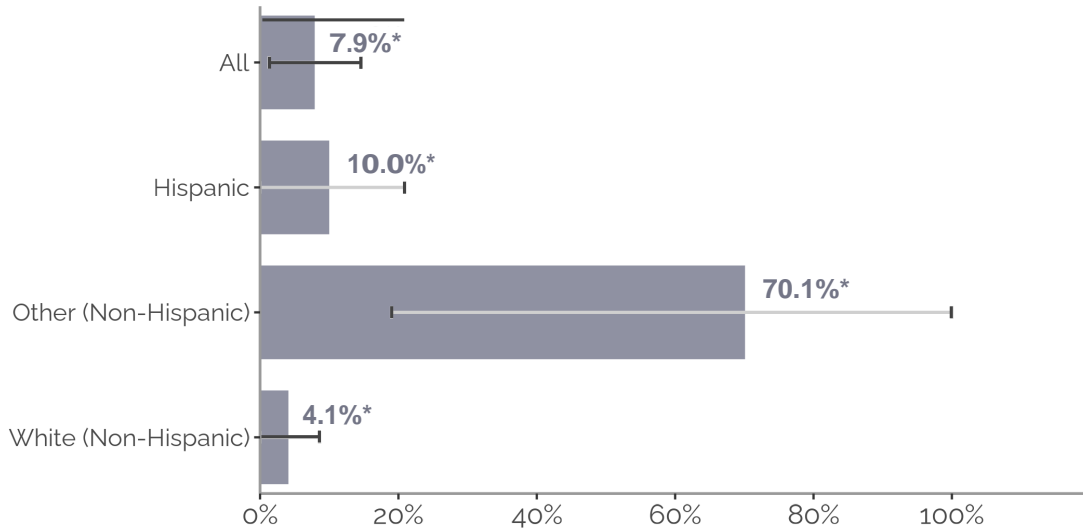
Atascosa County, Texas

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

The BRFSS survey defines heavy drinking as consuming 15 or more drinks per week for men or eight or more drinks per week for women.[4] Just 68% of respondents report drinking that meets that definition in the past month (Figure 2.22). The difference in the other-race rate as compared to the white rate, and likely the Hispanic rate as well, is statistically significant.

---

[4] Centers for Disease Control and Prevention. (2022). Data on excessive drinking. Available online at https://www.cdc.gov/alcohol/data-stats.htm

SMOKING

About 20% of respondents report current smoking (Figure 2.23). There are no clear differences among race/ethnicity groups.

Fig. 2.23 Percent of adults who currently smoke, by race, 2015-2020
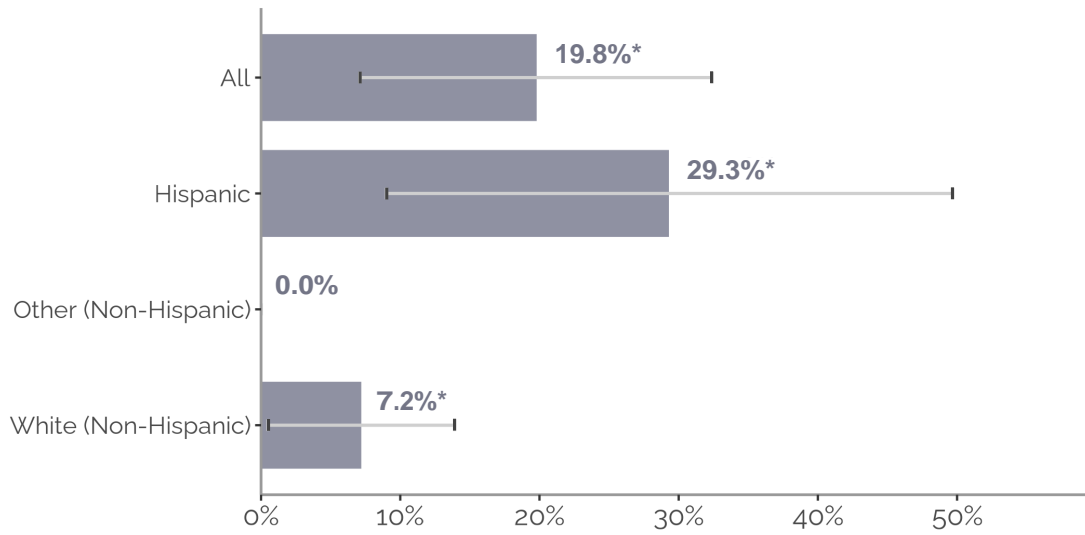
Atascosa County, Texas

All — 19.8%*

Hispanic — 29.3%*

Other (Non-Hispanic) — 0.0%

White (Non-Hispanic) — 7.2%*

*Unreliable: Error is too large relative to estimate
Source: Behavioral Risk Factor Surveillance System (BRFSS)
Prepared by CI:Now for The Health Collaborative
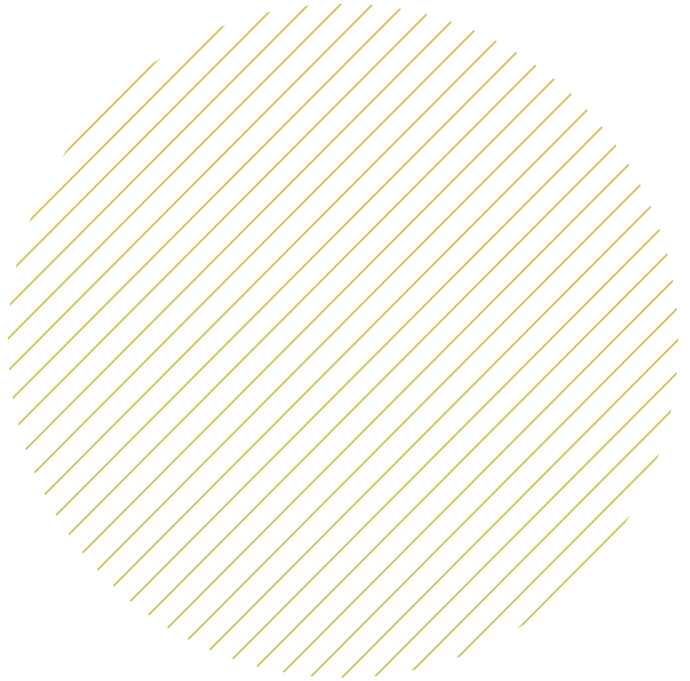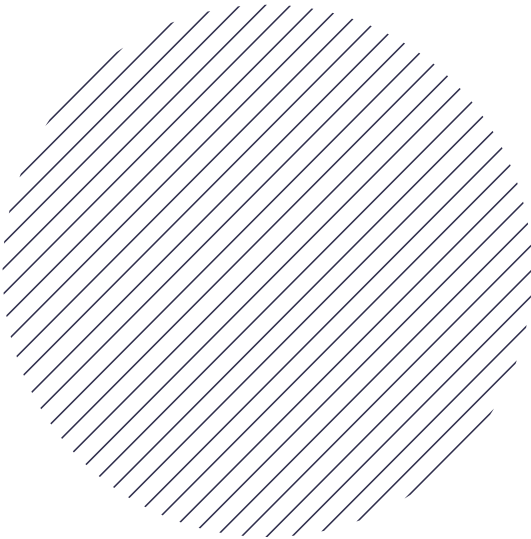
HEALTH STATUS AND DISABILITY

Differences among race/ethnicity groups are hard to interpret because of wide margins of error in the best available data (Figure 3.1), but it appears that about one in five Atascosa County respondents reports being kept from usual activities for five or more days a month due to poor mental or physical health.

Fig. 3.1 Percent of adults kept from usual activities for 5+ days a month due to poor physical or mental health, by race, 2015-2020

Atascosa County, Texas

- All: **18.0%**
- Hispanic: **19.1%***
- Other (Non-Hispanic): **0.0%**
- White (Non-Hispanic): **13.4%***

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

The percent of non-institutionalized civilians with a self-reported disability of some kind appears to have decreased somewhat between 2015 and 2019 (Figure 3.2), but the trend is uncertain because of overlapping margins of error.

Fig. 3.2 Percent of civilian non-institutionalized population with a disability

Atascosa County, Texas

Source: ACS 1-Year Supplemental Estimates. Table: K201801
Prepared by CI:Now for The Health Collaborative

Fig. 3.3 Percent of civilian noninstitutionalized population with a disability by age, 2019

Atascosa County, Texas
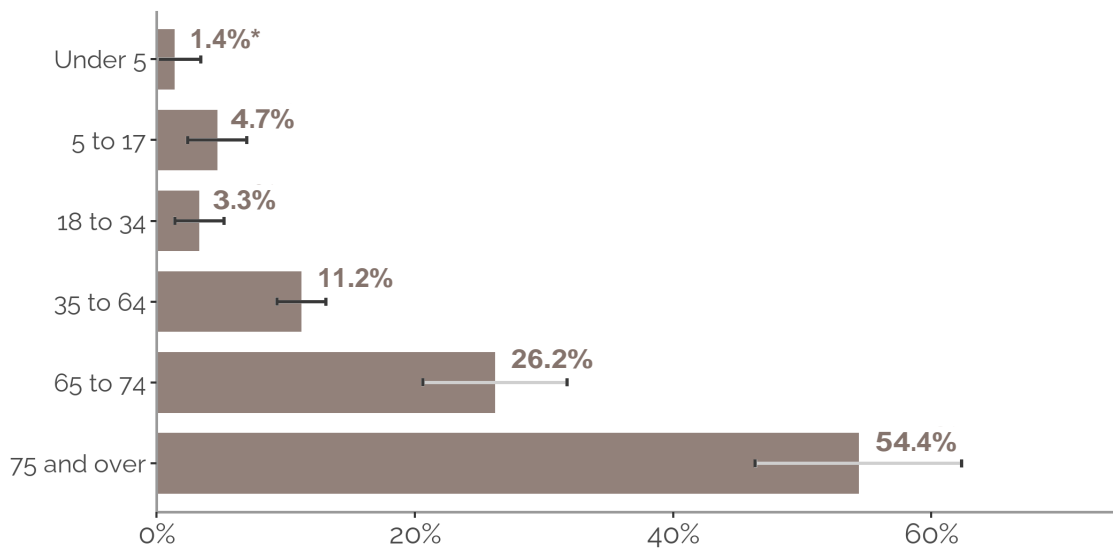
*Unreliable: Error is too large relative to estimate
Source: ACS 5-Year Estimates. Table: B18101
Prepared by CI:Now for The Health Collaborative

As one might expect, self-reported disability is highest in the populations aged 65 to 74 and 75 and older (Figure 3.3). An estimated half of people 75 and older report a disability. The proportion is just one in 10 in the 35 to 64 age group.

Fig. 3.4 Percent of civilian non-institutionalized population with a disability, 2020

Population with a Disability

‡	4% or Less
⌂	> 4% to 8%
◇	> 8% to 12%
★	> 12% to 15%
✴	> 15% to 18%

Source: ACS 5-Year Estimates, Table B18101

Esri, HERE, Garmin, (c) OpenStreetMap contribution, and the GIS user community
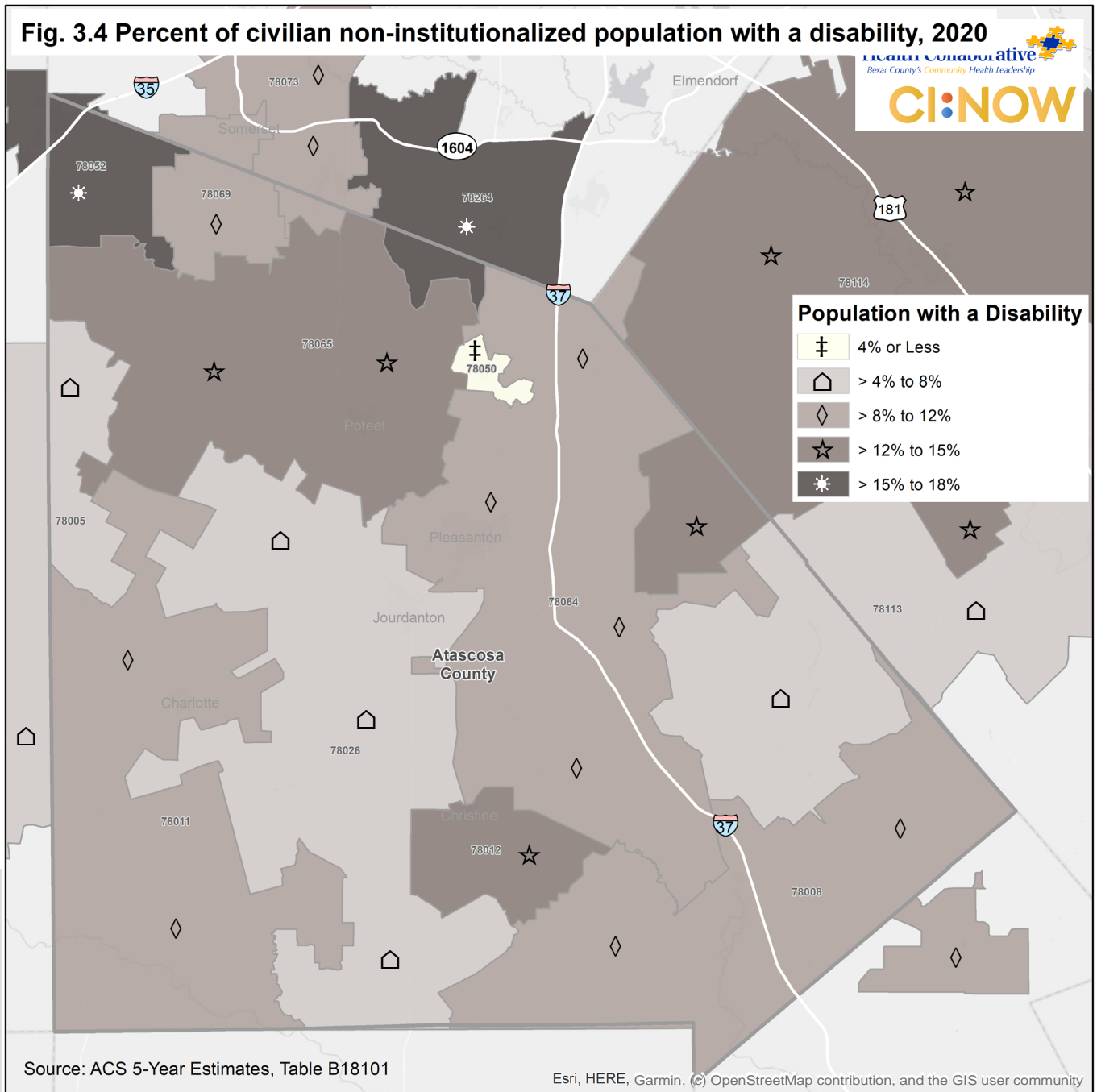
The ZIP codes with the highest disability rates are those bordering Bexar County (Figure 3.4). The lowest rate was in ZIP code 78050 (Leming area).

Differences among race/ethnicity groups are hard to interpret because of wide margins of error in the best available data (Figure 3.5). Overall it appears that about one in four adults reports being in fair or poor (as opposed to "better") health. The proportion appears higher for people of "other" race than among whites.

Fig. 3.5 Percent of adults with self-reported fair or poor health versus better health, by race, 2015-2020
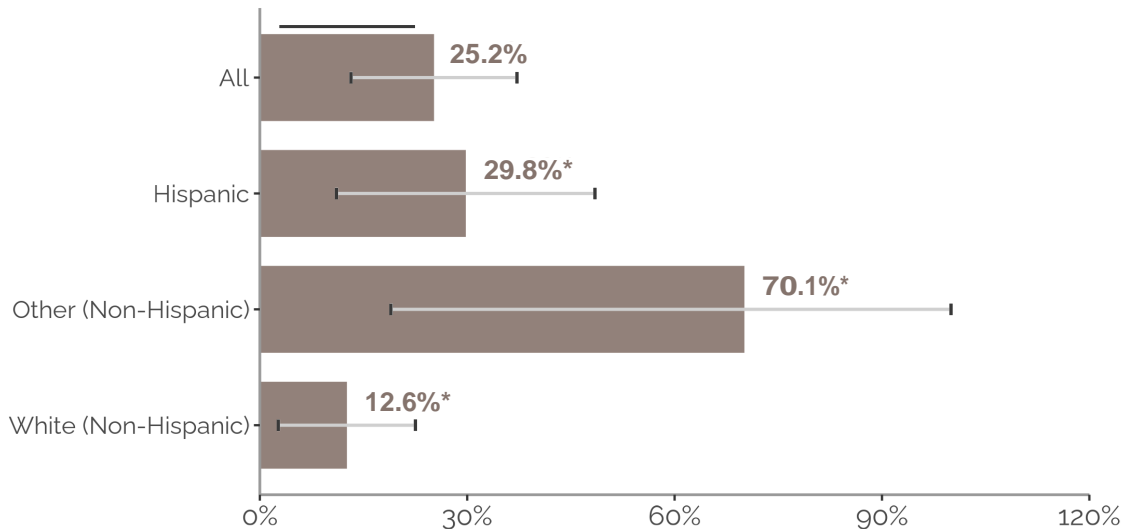
Atascosa County, Texas

Race	Percent
All	25.2%
Hispanic	29.8%*
Other (Non-Hispanic)	70.1%*
White (Non-Hispanic)	12.6%*

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

OVERWEIGHT AND OBESITY

Rates of overweight and obesity are startlingly high in every race/ethnicity group, estimated at about nine in 10 people for the county adult population overall (Figure 3.6). Although the rates are about a third higher than those calculated for the 2019 assessment, no errors are found in the data or calculation code. Differences among race/ethnicity groups are difficult to discern because of wide confidence intervals.

Fig. 3.6 Percent of adults by BMI category (overweight and obese), by race, 2015-2020
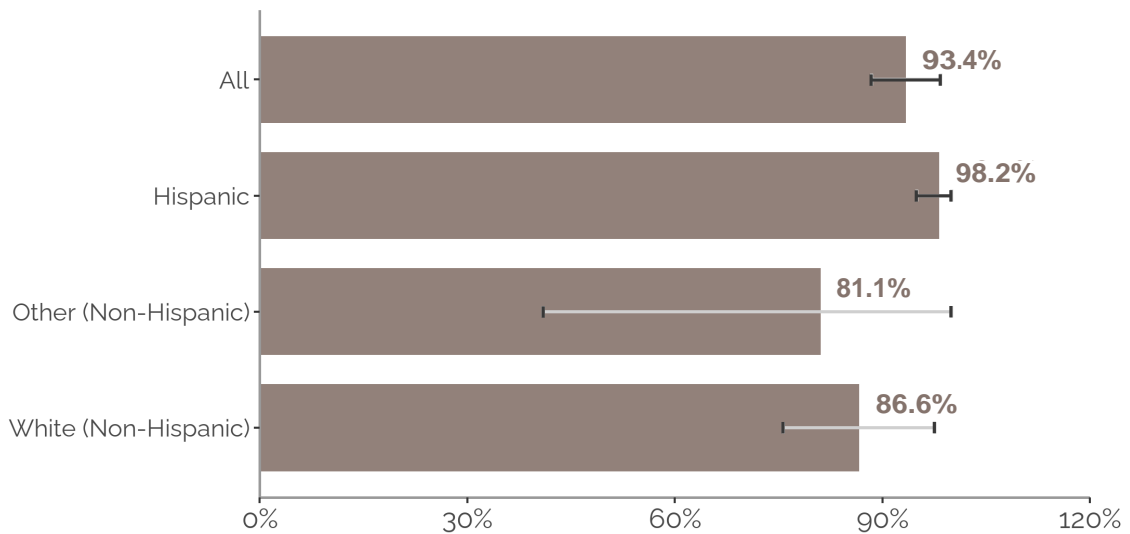
Atascosa County, Texas

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

REPRODUCTIVE AND SEXUAL HEALTH
MATERNAL CHARACTERISTICS

The teen birth rate changes substantially in several years, but the trend line can exaggerate the change when actual numbers are low (Figure 3.7). Overall no steady decline is seen, bucking the national trend, [3] but again, the trend is difficult to pin down.

Fig. 3.7 Number of births to mothers aged 15-19 per 1,000 females
Atascosa County, Texas
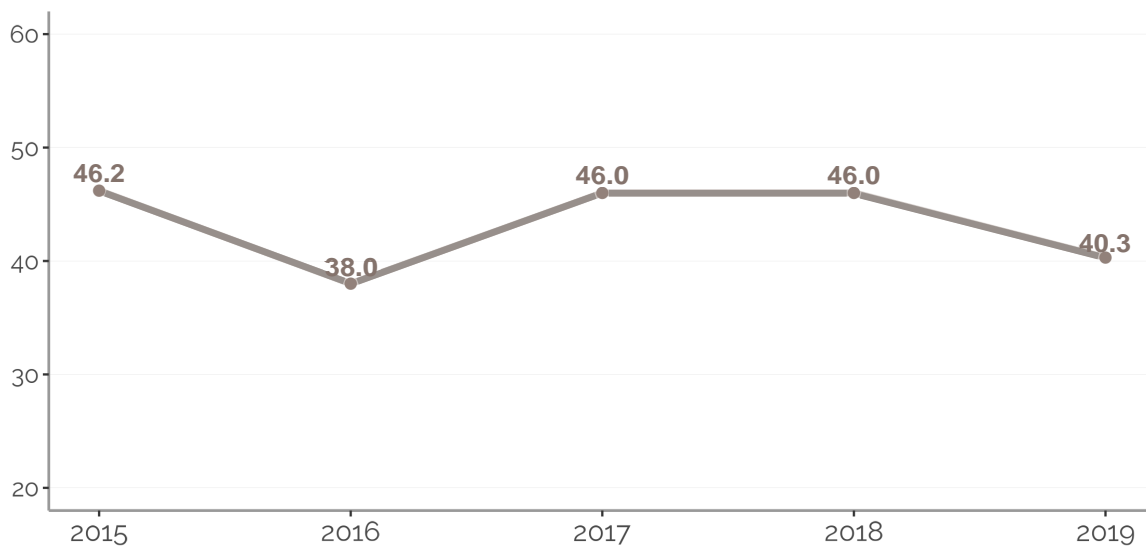
Source: Texas Vital Statistics & NCHS Bridged Race Population Estimates
Prepared by CI:Now for The Health Collaborative

[1]US DHHS OSH Office of Population Affairs. (n.d.) Trends in teen pregnancy and childbearing. Available online at **https://opa.hhs.gov/adolescent-health/ reproductive-health-and-teen-pregnancy/trends-teen-pregnancy-and-childbearing**

PRENATAL CARE

The percent of births for which prenatal care began in the first trimester increased markedly between 2016 and 2019 (Figure 3.8), from about half to 63%. Once more recent data becomes available, 2020 and 2021 will likely show adverse effects from the COVID-19 pandemic.

Fig. 3.8 Percent of births to mothers who received prenatal care in the first trimester

Atascosa County, Texas
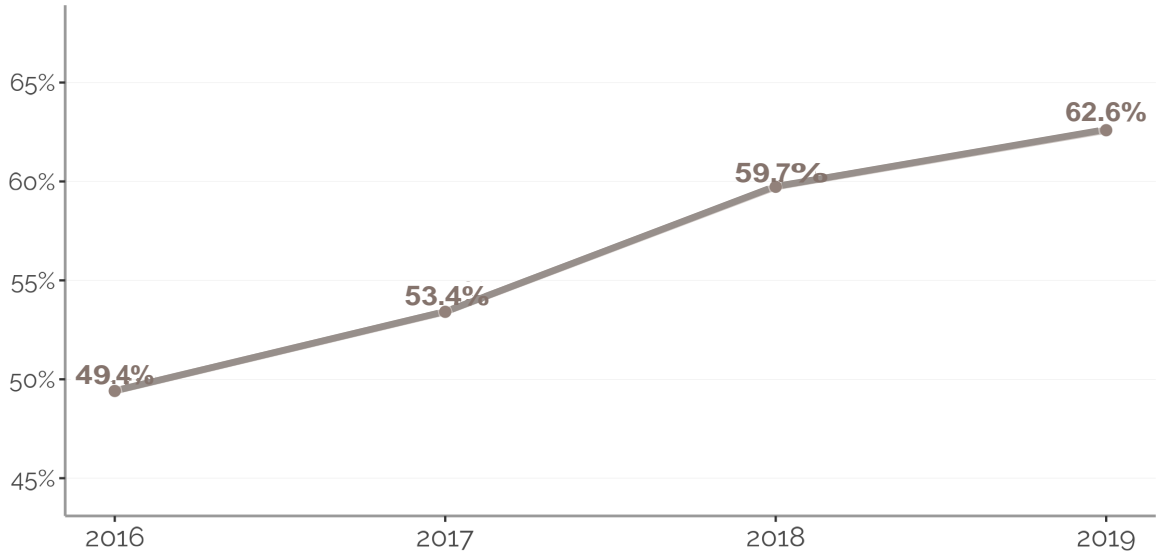
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.9 Percent of births to mothers who received no prenatal care

Atascosa County, Texas
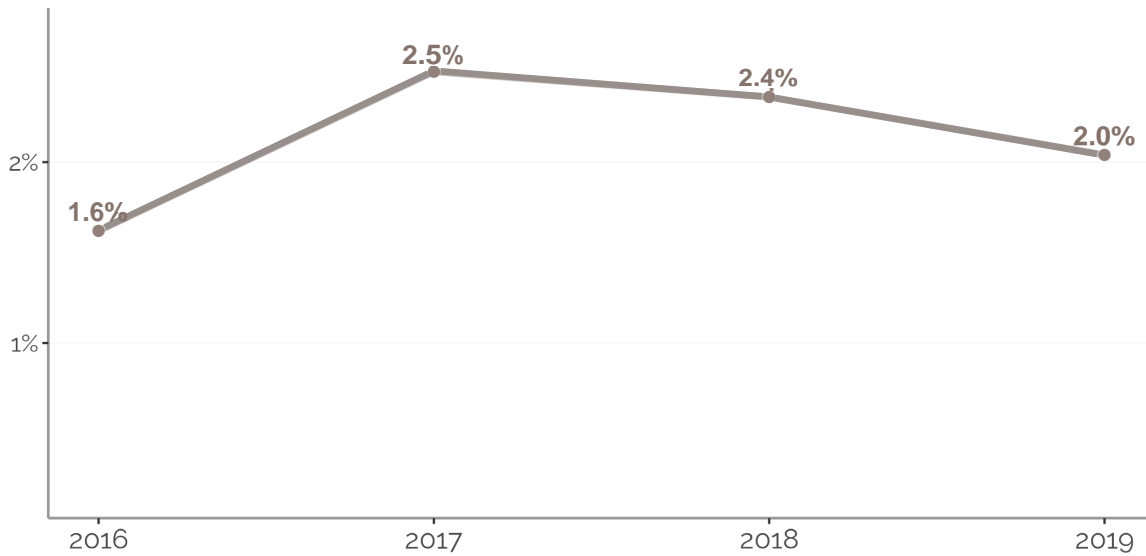
2.5%

2.4%

2.0%

1.6%

2%

1%

2016   2017   2018   2019

Again, the most recent data available predates the COVID-19 pandemic, but the proportion of births with no prenatal care at all has held fairly steady since 2016, ranging between 1.6% and 2.5% (Figure 3.9).

Fig. 3.10 Percent of births to mothers receiving no prenatal care by age (3-year average), 2017-2019
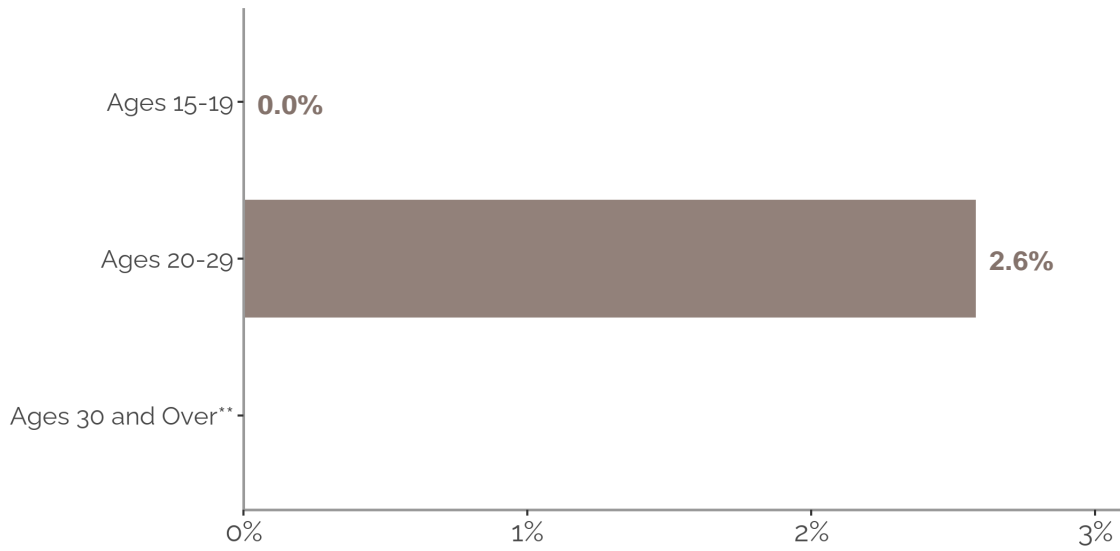
Atascosa County, Texas

Ages 15-19 — **0.0%**

Ages 20-29 — **2.6%**

Ages 30 and Over**

0%   1%   2%   3%

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

No teen mothers, and fewer than three percent of mothers aged 20 to 29, received no prenatal care (Figure 3.10).
The percent for mothers aged 30 and older is suppressed by the data source

BIRTH OUTCOMES

The prevalence of low birth weight was steady at about 9% between 2015 and 2017, then declined somewhat in 2018 and 2019 (Figure 3.11). This data predates the COVID-19 pandemic, however, and the trend may see an uptick in 2020 or 2021. Data on low birthweight by age is not available.

Fig. 3.11 Percent of low birth weight births
Atascosa County, Texas
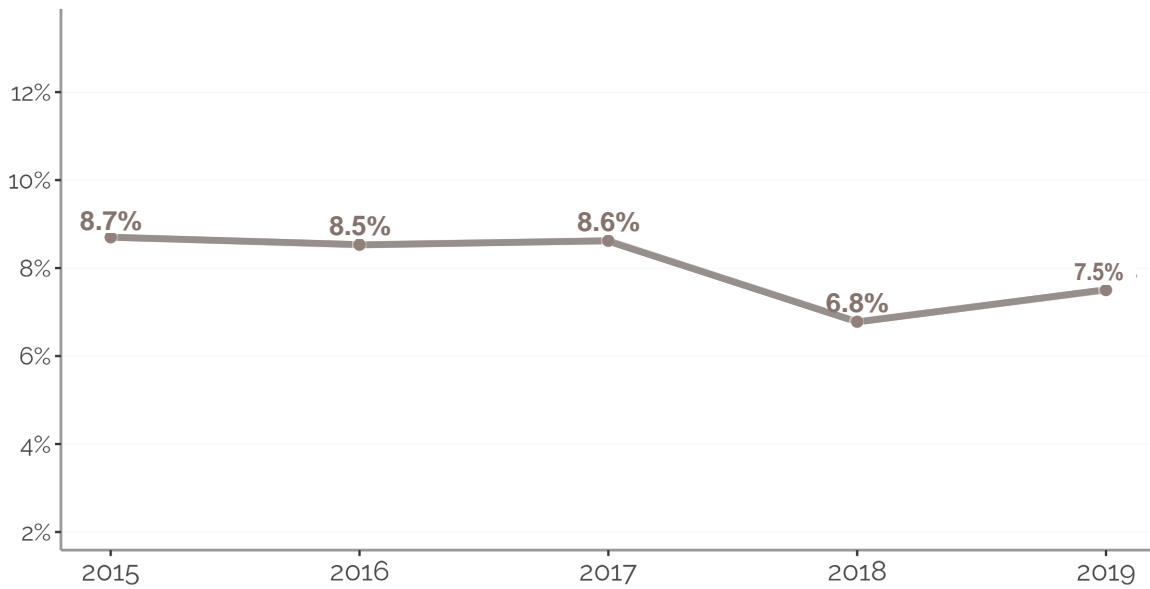
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

The percent of births that are pre-term hovered at 12% to 14% between 2015 and 2019 (Figure 3.12). As with low birthweight, however, 2020 or 2021 may see an increase in premature births once more recent data are available.
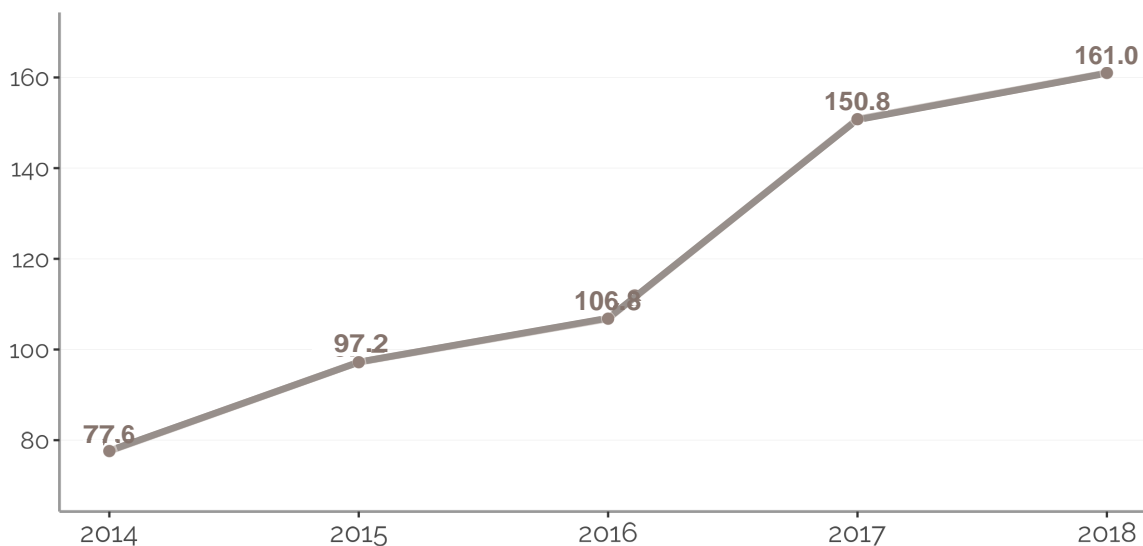
Fig. 3.12 Percent of pre-term births

Atascosa County, Texas
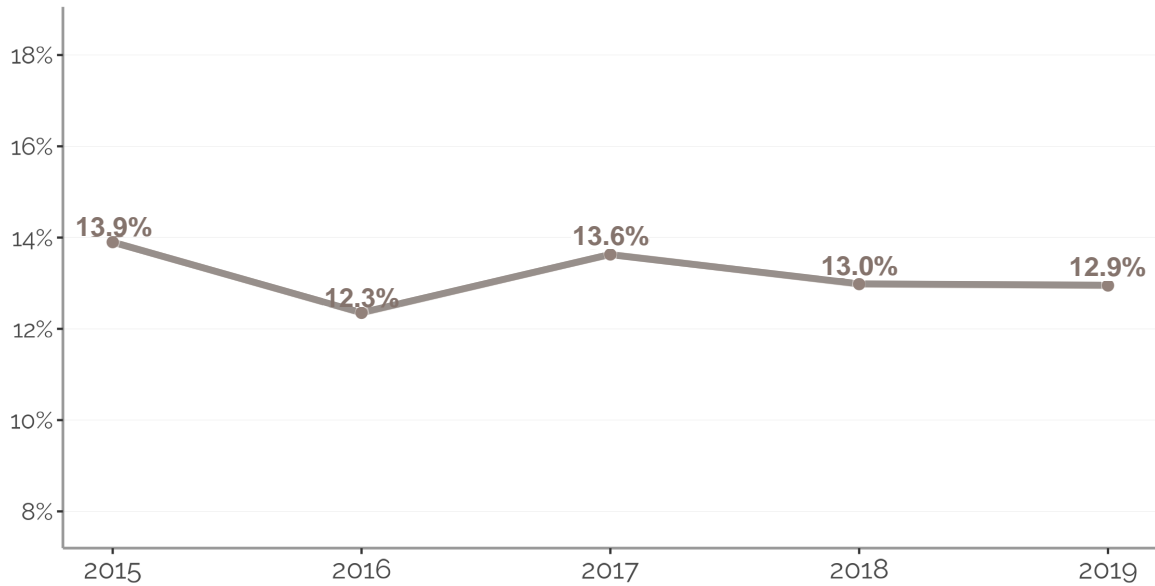
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.13 Percent of pre-term births by age (3-year average), 2017-2019
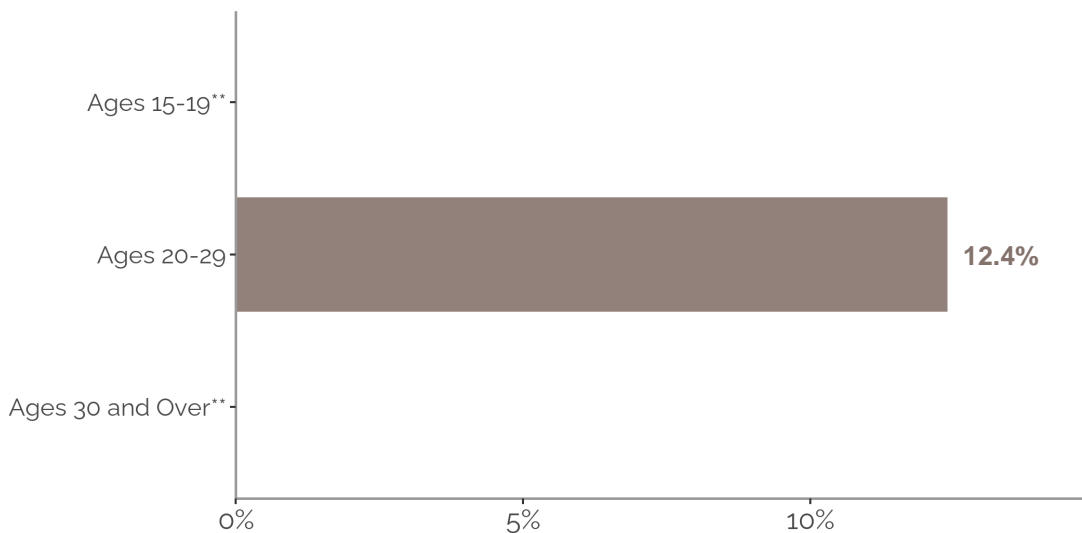
Atascosa County, Texas

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Data on pre-term births is only available for mothers aged 20 to 29, among whom about 12% of births are pre-term (Figure 3.13). Data for the other two maternal age groups is suppressed by the data source.

SEXUALLY TRANSMITTED INFECTIONS

The most recent data available in this section is generally for 2018, predating the COVID-19 pandemic. The effects of the pandemic on transmission, screening, detection, and case investigation are not yet known. However, as testing is conducted in primary care settings, mobile settings, as part of the blood donation process, and even in emergency departments, any decrease in care utilization will decrease testing and detection rates. The effect is likely to be an incidence rate that significantly underestimates the true burden of illness.

Fig. 3.14 Number of new cases of Chlamydia per 100,000 population
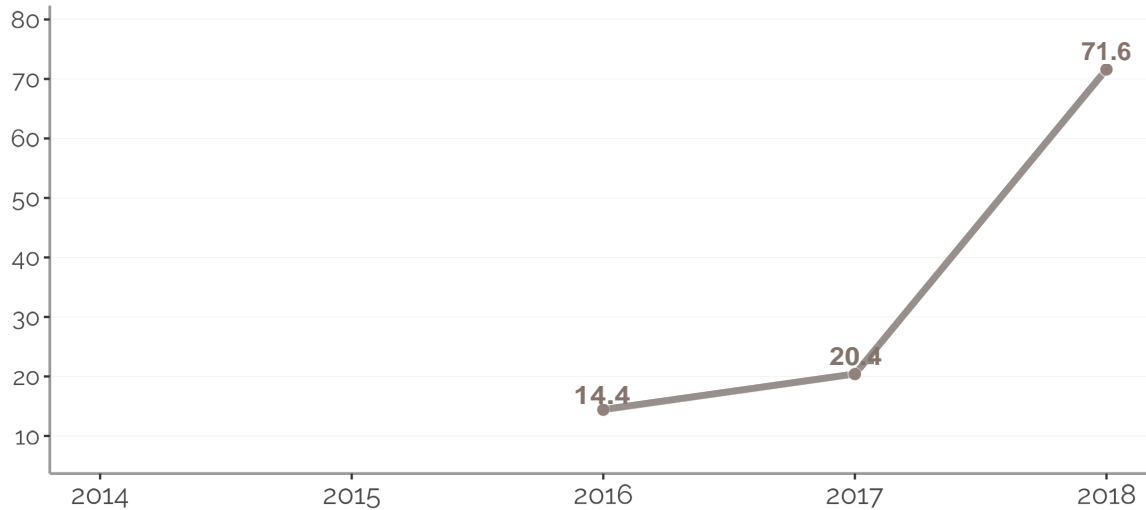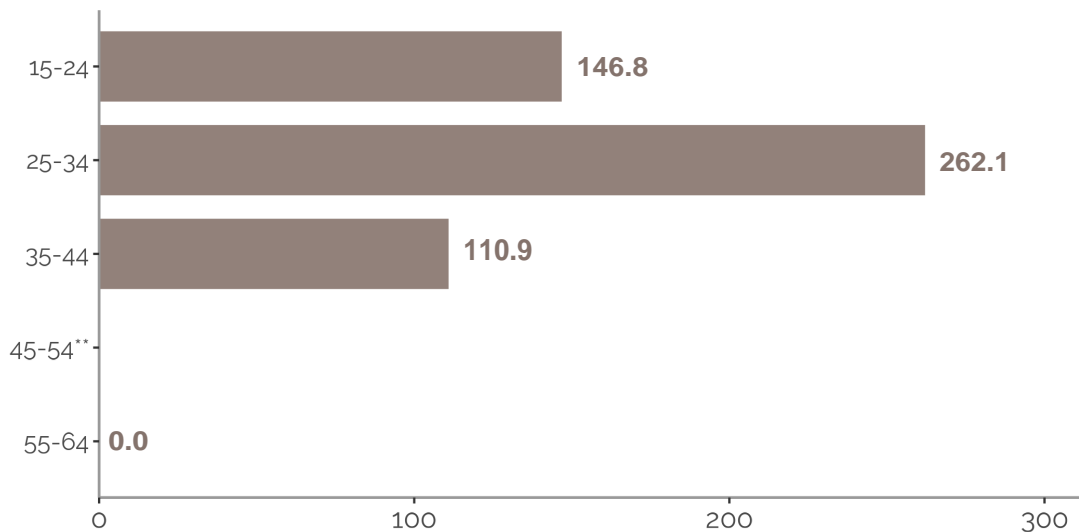Atascosa County, Texas
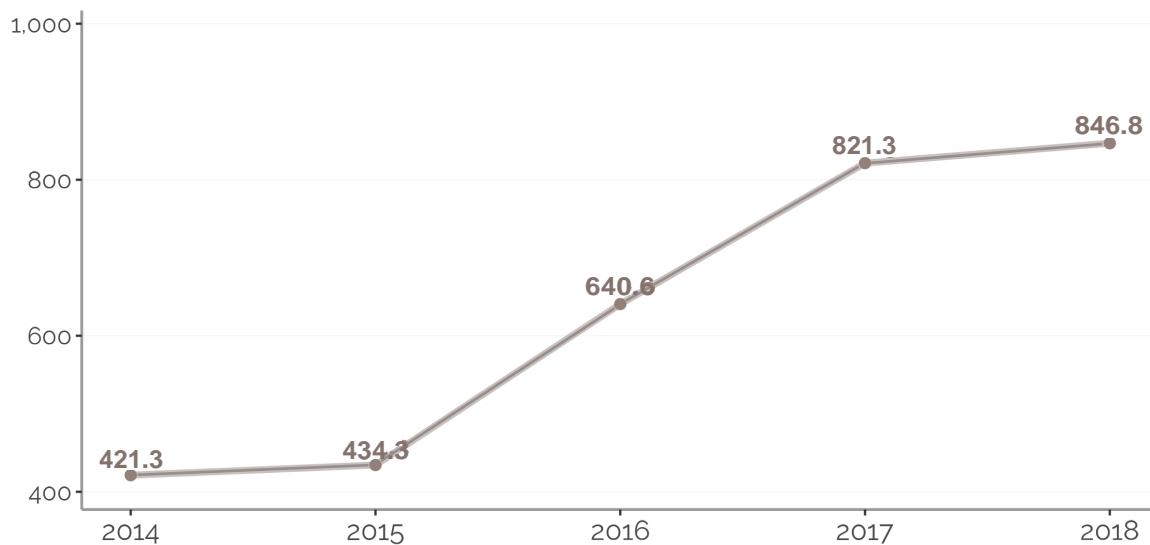
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Chlamydia incidence climbed markedly between 2015 and 2018 (Figure 3.14). No specific drivers of the trend are known, though the trend for chlamydia is influenced by changes from year to year in who accesses care and is tested. This most recent available data predates the COVID-19 pandemic, and risk behavior and screening were both likely affected for 2020 and possibly 2021.

The newly-diagnosed chlamydia case rate is highest by far in the 15 to 24 age group. That incidence of 3,992 per 100,000 population is more than twice as high as the 25 to 34 age group and more than 10 time as high as the 35 to 44 age group (Figure 3.15).

Fig. 3.15 Number of new cases of Chlamydia by age per 100,000 population, 2018
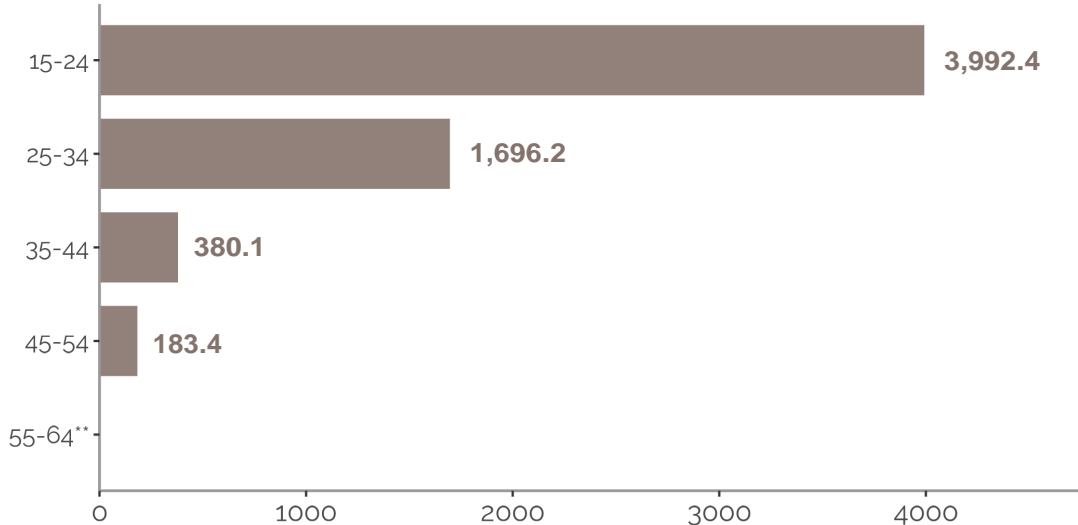
Atascosa County, Texas

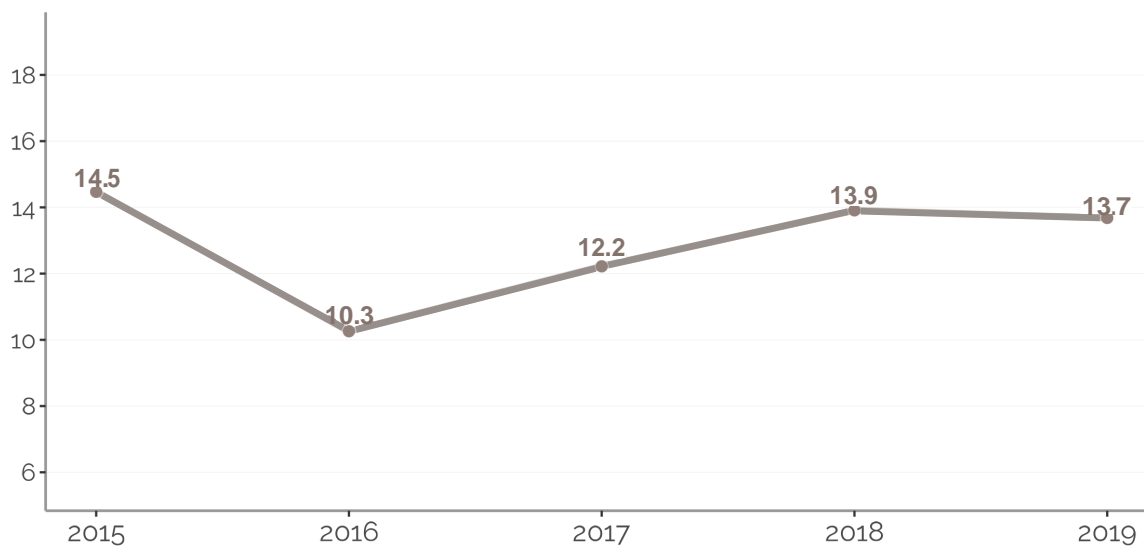| Age	Rate
15-24	3,992.4
25-34	1,696.2
35-44	380.1
45-54	183.4
55-64**	

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.16 Number of new cases of Gonorrhea per 100,000 population
Atascosa County, Texas

Year	Rate
2014	77.6
2015	97.2
2016	106.8
2017	150.8
2018	161.0

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

Gonorrhea incidence also increased through 2018, prior to the pandemic (Figure 3.16). The 2018 rate of 161.0 per 100,000 is more than double the 2014 rate.

At 528.4 and 416.3 per 100,000, respectively, gonorrhea incidence is highest in the 15 to 24 and 25 to 34 age groups (Figure 3.17). The disparity by age is not nearly as pronounced as with chlamydia, however.

Fig. 3.17 Number of new cases of Gonorrhea by age per 100,000 population, 2018
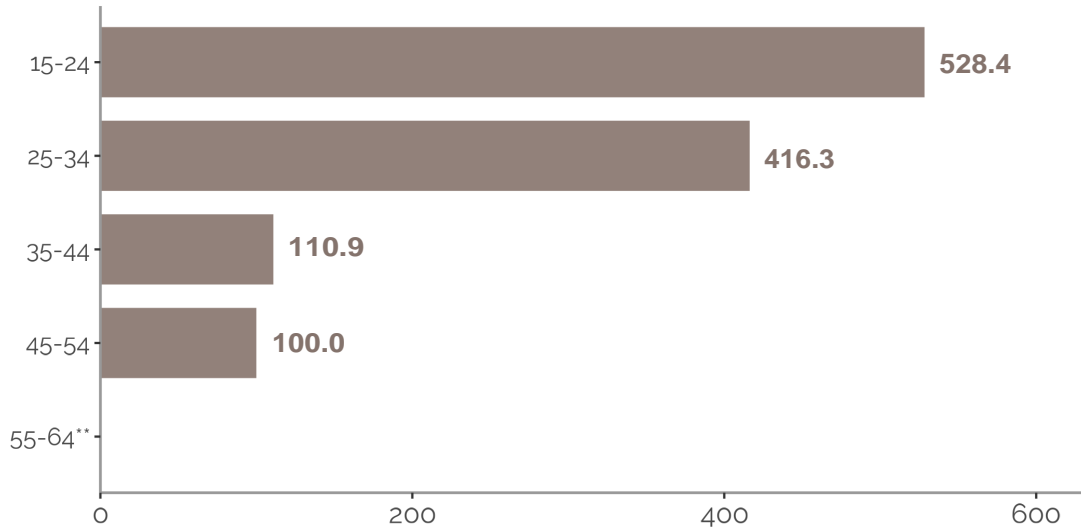
Atascosa County, Texas

Age	Rate
15-24	528.4
25-34	416.3
35-44	110.9
45-54	100.0
55-64**	

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.18 Number of new cases of early latent Syphilis per 100,000 population

Atascosa County, Texas

Year	Rate
2016	14.4
2017	20.4
2018	71.6

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

The data for primary and secondary syphilis is suppressed by the data source, and latent syphilis data is only available for 2016 through 2018. Latent syphilis is the stage of syphilis disease following primary and secondary syphilis, in which no visible symptoms are present, and "early" means the infection is determined to have occurred within the past 12 months. After an increase between 2016 and 2017, early latent syphilis incidence more than tripled to 71.6 per 100,000 (Figure 3.18). The drivers of this trend are unclear, but the trend should be interpreted with caution given that the actual numbers are small.

At 262.1 new cases per 100,000 population, early latent syphilis incidence is quite high in the 25 to 34 age group (Figure 3.19), a later age than for the other sexually transmitted infections discussed earlier in this report.

Fig. 3.19 Number of new cases of early latent Syphilis by age per 100,000 population, 2018

Atascosa County, Texas

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.20 Number of new cases of HIV per 100,000 population
Atascosa County, Texas

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

With the exception of 2016. HIV incidence generally hovered at 12% to 15% between 2015 and 2019 (Figure 3.20). Again, trend lines can exaggerate the year-to-year change in actual number of new cases diagnosed. No data for HIV incidence by age is available as it has been suppressed by the data source.

ILLNESS AND INJURY
COVID-19

The Johns Hopkins University COVID-19 Status Report puts Atascosa County's total cumulative COVID-19 case number (including probable cases) at 13,738 as of early June 2022.[3] Unfortunately, the race/ethnicity, age, sex, and ZIP code breakdown of Atascosa County COVID-19 cases are not available.

OTHER COMMUNICABLE DISEASE

Fig. 3.21 Rate of Varicella, Pertussis and Hepatitis A per 100,000 population
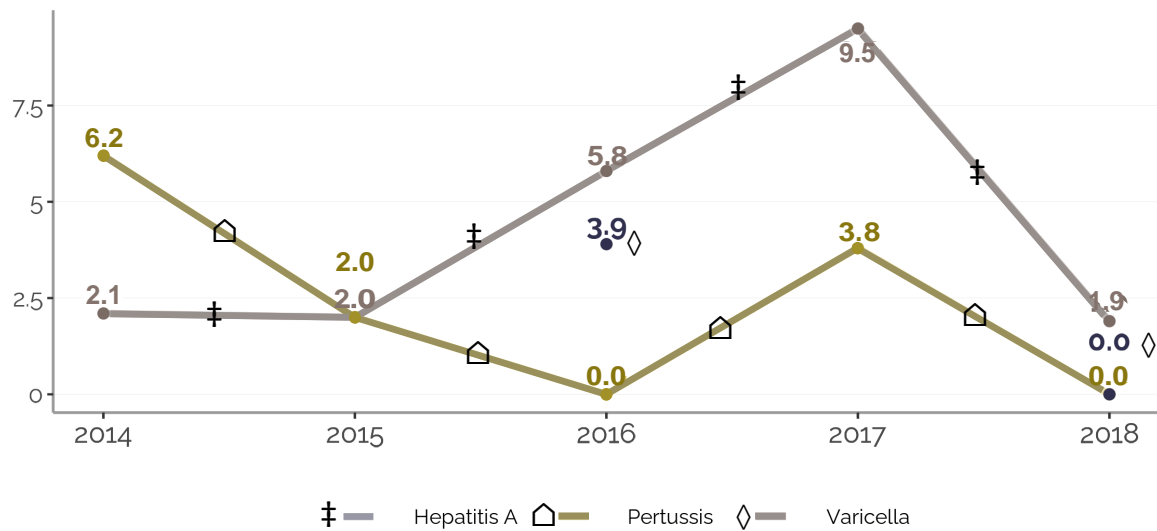
Atascosa County, Texas

Hepatitis A   **Pertussis**   **Varicella**

**Suppressed
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Low numbers for all (e.g., one case of varicella or chickenpox in 2018) and suppressed data for Hepatitis A mean the trends in incidence of all three communicable diseases are difficult to interpret (Figure 3.21). No data is available for Hepatitis B, mumps, or Haemophilus influenzae b (Hib).

[3] Johns Hopkins University, Coronavirus Resource Center. (2022, June 8). COVID-19 status report: Atascosa, Texas. Available online at https://bao.arcgis.com/covid-19/jhu/county/48013.html

TOOTH LOSS

Many of the charts that follow in this section represent data from the Behavioral Risk Factor Surveillance System (BRFSS), a household telephone survey of adults with a very small sample size for Atascosa County. Because the sample size is so small relative to the size of the adult population, even with multiple years of data combined, each BRFSS estimate has a good bit of uncertainty. The true value may lie anywhere in the range of the estimate's confidence interval, which is represented as a horizontal gray line in each bar of the chart. When the confidence intervals (gray lines) for two estimates overlap, one cannot be sure that there is truly any difference between the two estimates. That issue will arise over and over again in the narrative describing these charts.

Fig. 3.22 Percent of adults having one or more teeth removed because of decay or disease, by race, 2015-2020
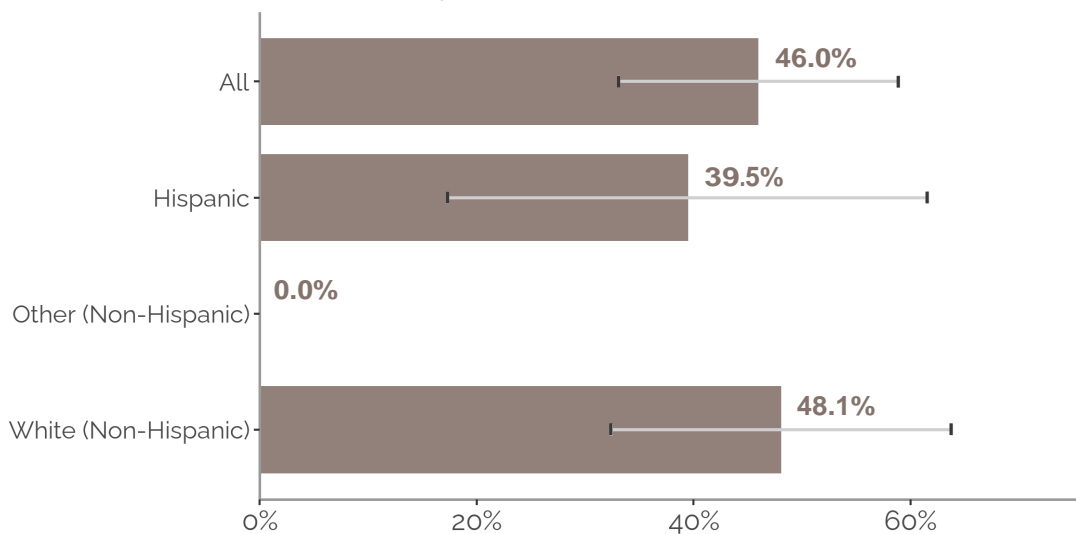
Atascosa County, Texas

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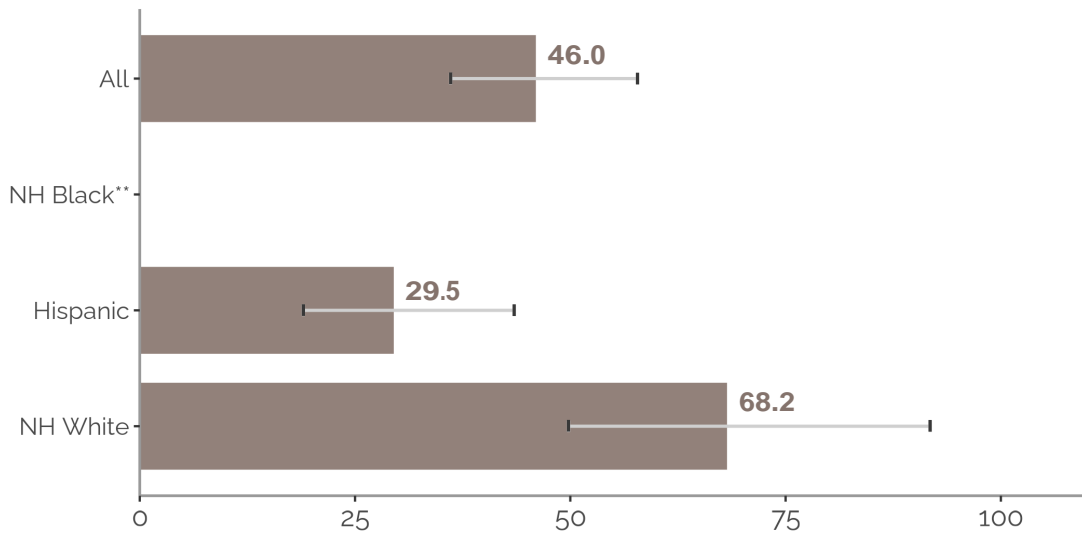Prepared by CI:Now for The Health Collaborative

Overall, an estimated 46% of Atascosa County adults has had at least one tooth removed (Figure 3.22). Even combining multiple years of data, differences among groups are hard to interpret because of wide margins of error, but the differences do not appear substantive.

CHILD BLOOD LEAD POISONING

The rate of testing for lead poisoning in children 14 and younger rose between 2015 and 2019 (Figure 3.23), with the 2019 rate of 778.8 being a 27% increase over 2015. The drivers of the increase are not clear, but local short-term grants or special lead testing initiatives could play a role. This data predates the COVID-19 pandemic, so once available, the rates for 2020 and 2021 will likely be lower.

Fig. 3.23 Rate of children 0-14 tested for lead poisoning per 10,000 population
Atascosa County, Texas
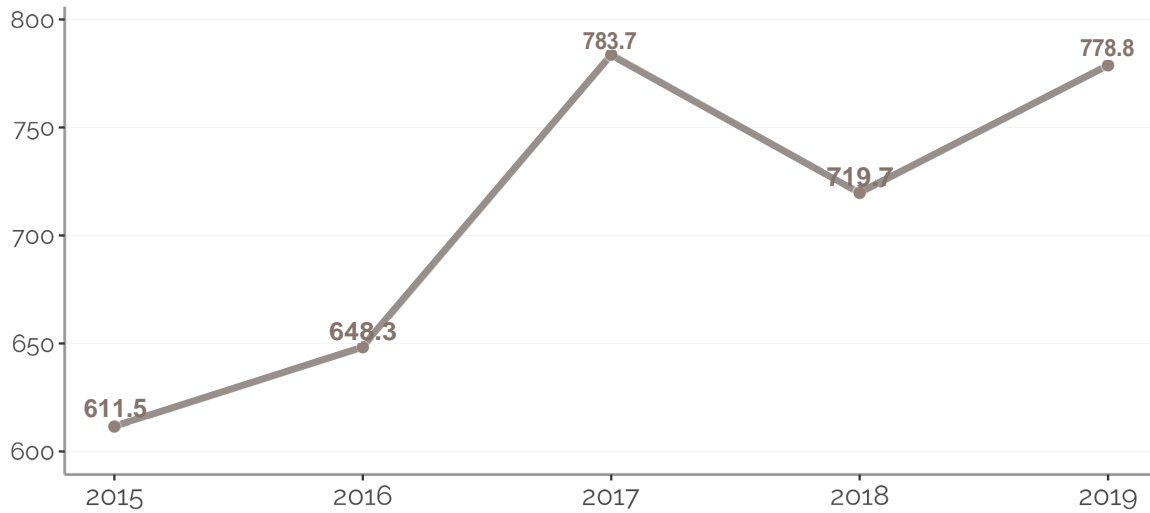
Fig. 3.24 Percent of tested children aged 0-5 with elevated blood lead levels
Atascosa County, Texas
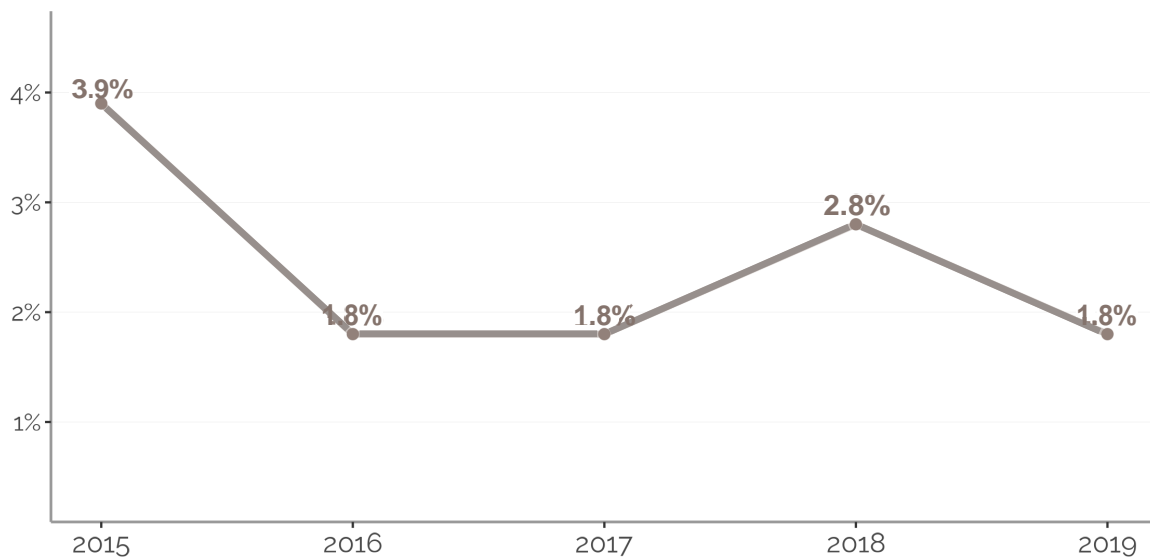
Of those children tested, the percent identified as having elevated blood lead levels decreased in 2016 and then hovered between 1.8% and 2.8% in subsequent years (Figure 3.24).

ASTHMA

Another issue with the BRFSS dataset is that the survey is by self-report, and people may or may not report accurately. Many questions are phrased as "Have you ever been told by a doctor, nurse, or other health professional that you have…?" a disease. Answering yes to that question requires that the person had access to care, utilized care, was formally diagnosed with the disease (regardless of the reason for the visit), understood the diagnosis, and remembered the diagnosis months or years later. For that reason, the estimates in these next several BRFSS charts should likely be considered underestimates.

Fig. 3.25 Percent of adults who reported being told they have asthma by a doctor, nurse, or other health professional, by race, 2015-2020
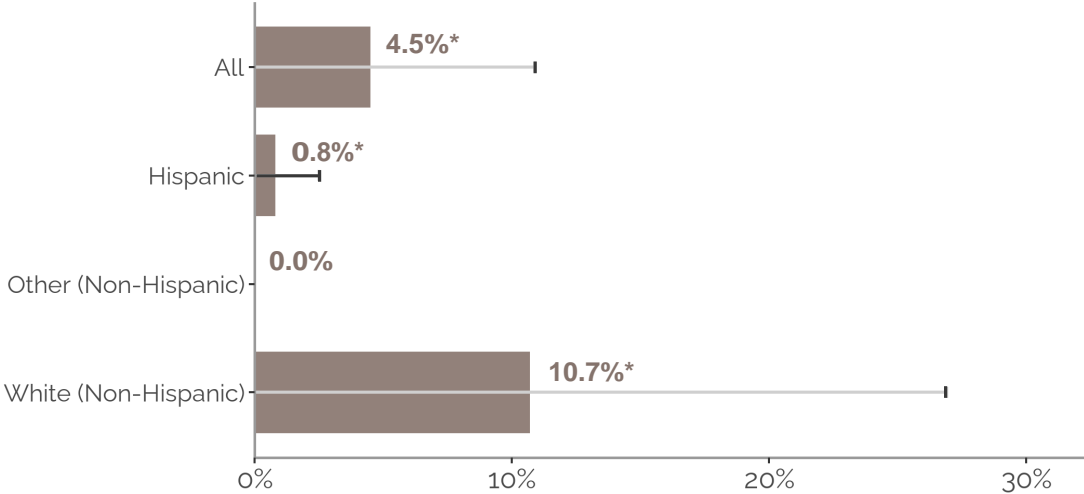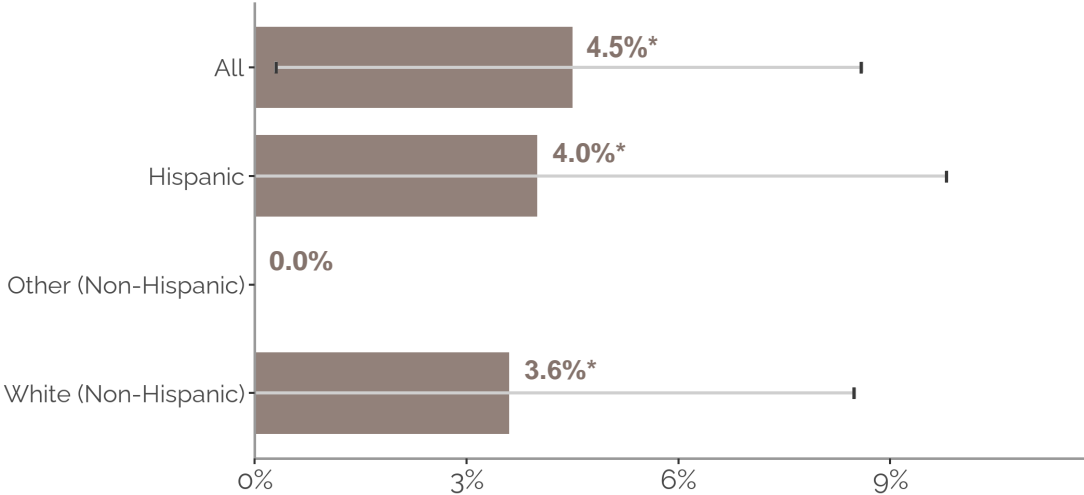
Atascosa County, Texas
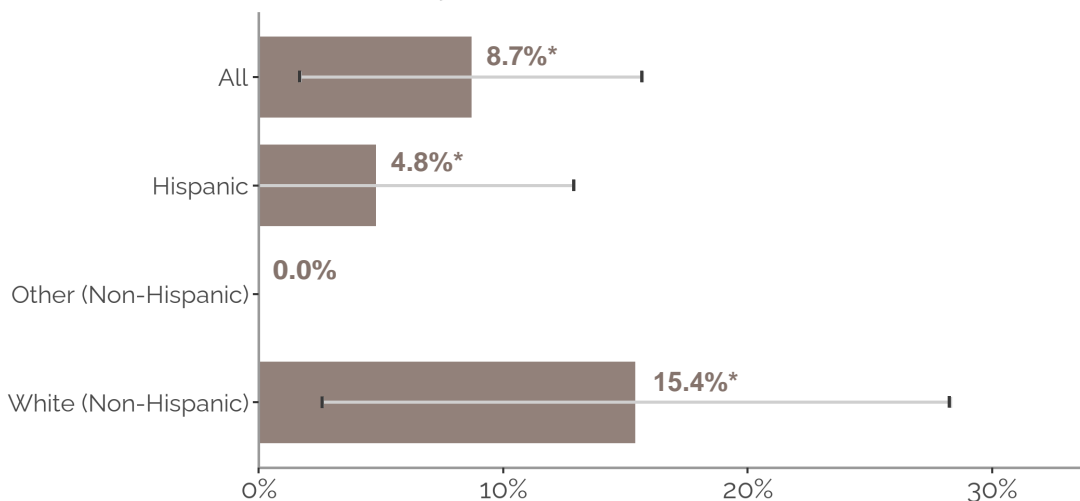
*Unreliable: Error is too large relative to estimate
Source: Behavioral Risk Factor Surveillance System (BRFSS)
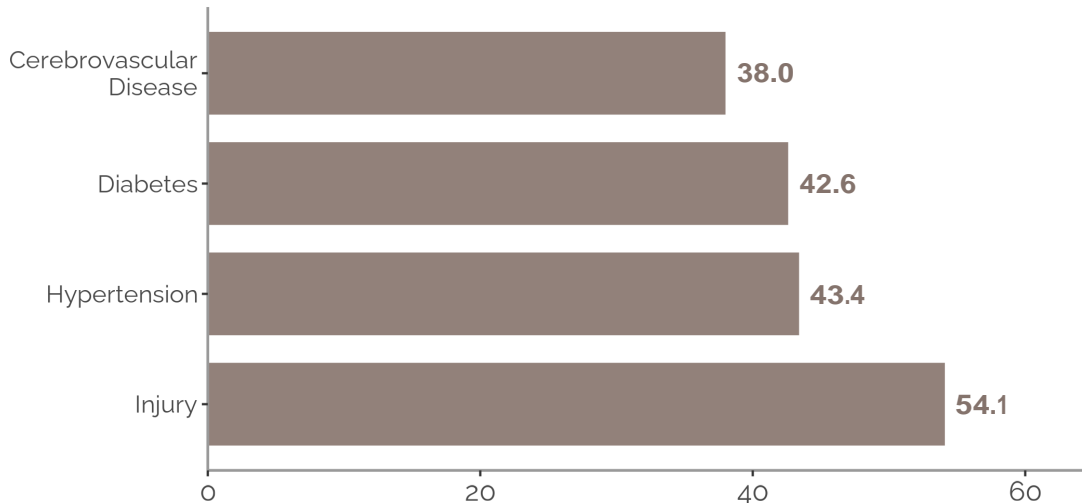Prepared by CI:Now for The Health Collaborative

Overall, an estimated 9% of Atascosa County residents report ever having been told by a health professional that they have asthma (Figure 3.25). That figure appears lower for other-race respondents.

LUNG CANCER

Lung and bronchus cancer incidence (newly-diagnosed cases in a year) is estimated at 46 per 100,000 population in Atascosa County (Figure 3.26). Non-overlapping confidence intervals mean a statistically significant difference exists in the lower rate among Hispanics as compared to whites. Data by sex is not available.

Fig. 3.26 Age-adjusted lung and bronchus cancer incidence rate by race per 100,000 population, 2016-2018

Atascosa County, Texas

All — 46.0
NH Black** —
Hispanic — 29.5
NH White — 68.2

**Suppressed
Source: Texas Cancer Registry
Prepared by CI:Now for The Health Collaborative

DIABETES ~~AND PRE-DIABETES~~

BRFSS data on diabetes prevalence in Atascosa County is not available, but overall about 16% of Atascosa County adults report ever having been told by a health professional that they have pre-diabetes (Figure 3.27). ~~Wide and overlapp~~ing confidence intervals prevent determination of any difference among race/ethnicity groups.

Fig. 3.27 Percent of adults who have ever been told by a doctor or other health professional that they ave with pre-diabetes or borderline diabetes, by race, 2015-2020
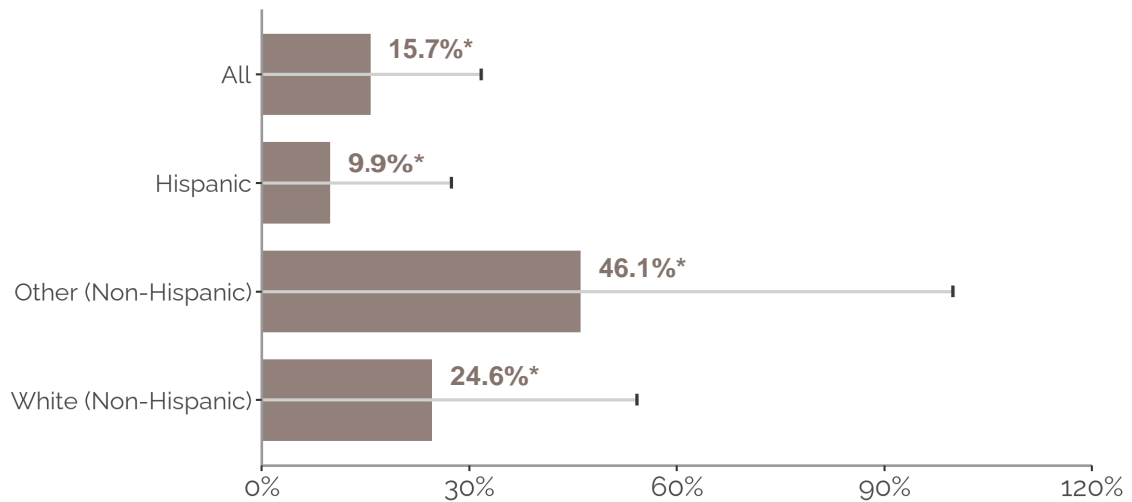
Atascosa County, Texas

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

HEART DISEASE AND STROKE

An estimated five percent of Atascosa County respondents report having ever been told by a health professional that they have had a heart attack (Figure 3.28). As with earlier measures, wide and overlapping confidence intervals prevent determination of any difference among race/ethnicity groups.

Fig. 3.28 Percent of adults who have been told by a doctor, nurse, or other health professional that they have had a heart attack, by race, 2015-2020

Atascosa County, Texas

All — 4.5%*
Hispanic — 0.8%*
Other (Non-Hispanic) — 0.0%
White (Non-Hispanic) — 10.7%*

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

Fig. 3.29 Percent of adults who have ever been told by a doctor, nurse, or other health professional that they had a stroke, by race, 2015-2020

Atascosa County, Texas

All — 4.5%*
Hispanic — 4.0%*
Other (Non-Hispanic) — 0.0%
White (Non-Hispanic) — 3.6%*

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

Overall about 5% of adult BRFSS survey respondents report ever having been told they had a stroke at some point (Figure 3.29). Wide confidence intervals make it impossible to tell whether there are real differences among race/ethnicity groups.

COMMON CAUSES OF HOSPITALIZATION

At 54.1 hospital discharges per 10,000 adults per year, injury is a more common cause of hospitalization among adults than cardiovascular disease, hypertension, or diabetes (Figure 3.30). This data draws from hospital records, not a survey, and thus has no margin of error or confidence interval.

Fig. 3.30 Number of hospital discharges by type per 10,000 adults 18+, 2020
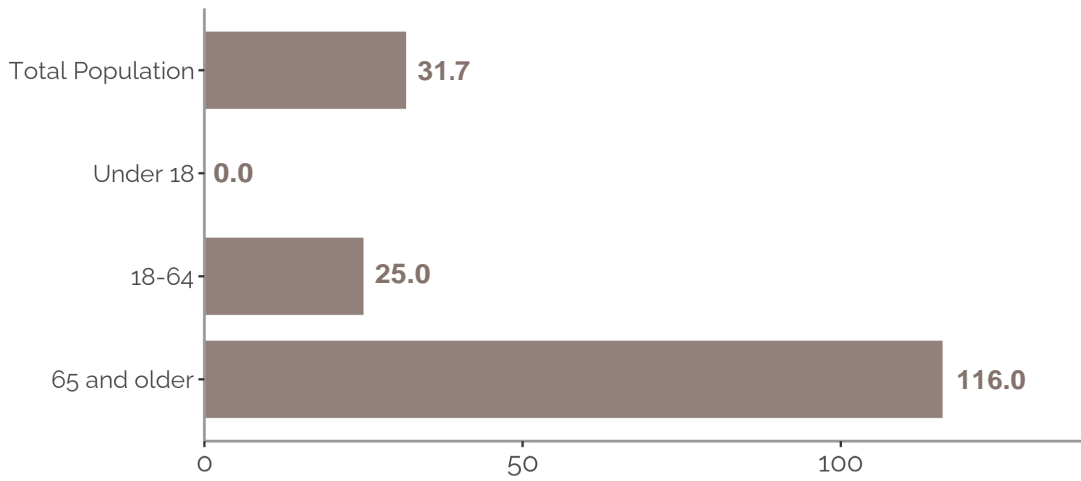
Atascosa County, Texas

Source: Texas Hospital Inpatient Discharge Public Use Data File, 2020, Texas Department of State Health Services Center for Health Statistics, Austin, Texas
Prepared by CI:Now for The Health Collaborative

Fig. 3.31 Number of hospital discharges with a primary discharge diagnosis of diabetes per 10,000 population, 2020

Atascosa County, Texas
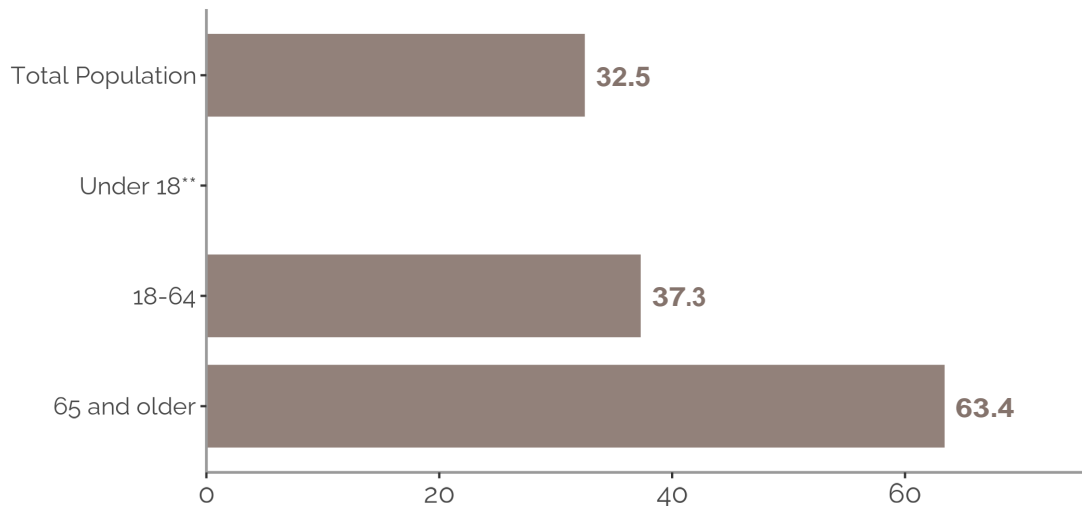
**Suppressed
Source: Texas Hospital Inpatient Discharge Public Use Data File, 2020, Texas Department of State Health Services Center for Health Statistics, Austin, Texas
Prepared by CI:Now for The Health Collaborative

As noted above, diabetes is a common cause of hospitalization, particularly among older adults (Figure 3.31). That group is hospitalized at a rate of 63.4 hospital discharges per 10,000 population 65 and older.

Injury hospitalizations are by far most common among older adults (Figure 3.32). That rate of 143.0 per 10,000 is 4.5 times as high as the rate among people aged 18 to 64. Because of low numbers, the injury hospitalization rate among children and teens was suppressed by the data source.

Fig. 3.32 Number of hospital discharges with a primary discharge diagnosis of injury per 10,000 population, 2020
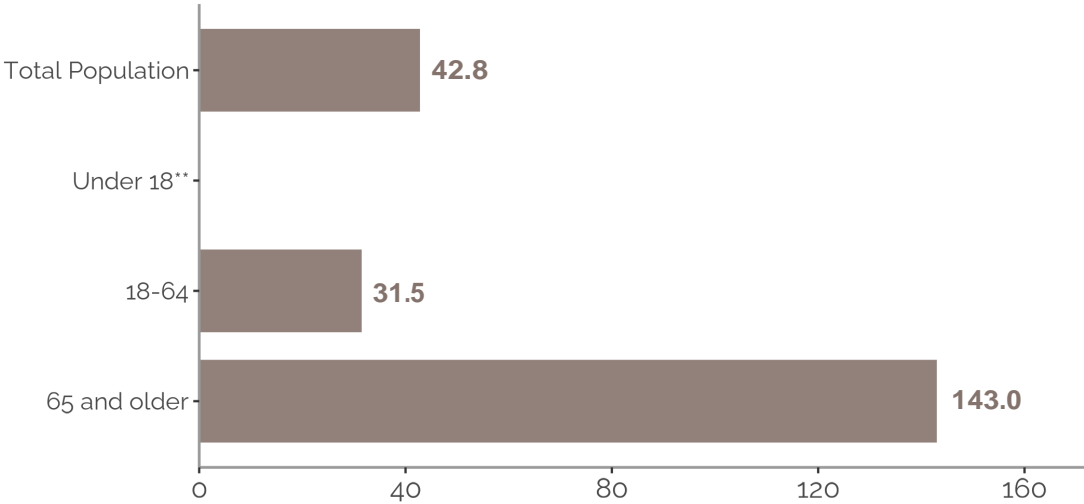
Atascosa County, Texas

Fig. 3.33 Number of hospital discharges with a primary discharge diagnosis of cerebrovascular disease per 10,000 population, 2020
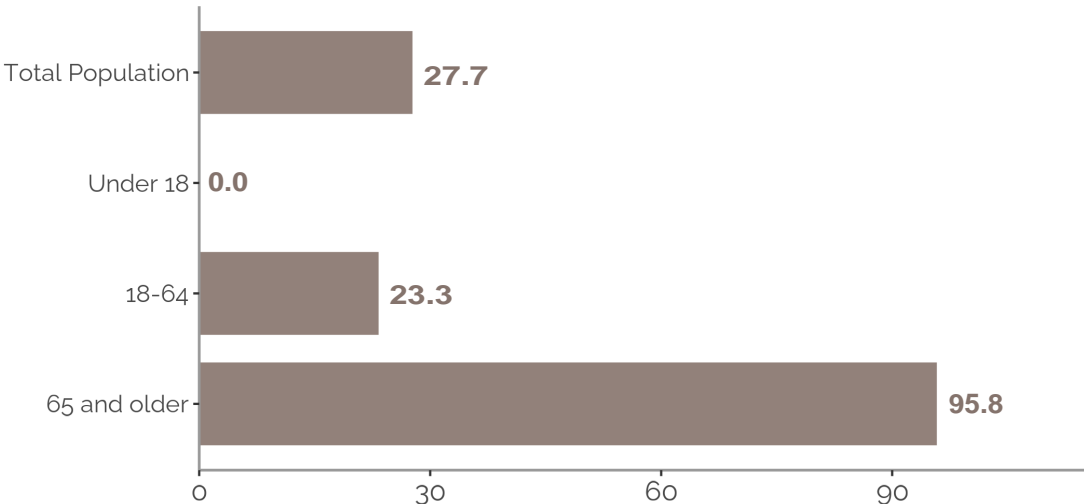
Atascosa County, Texas

The rate of cerebrovascular disease hospitalization is 27.7 discharges per 10,000 population, a rate that would be much higher were children and teenagers excluded from the calculation (Figure 3.33). These hospitalizations are most common in the older population, with a rate four times as high as the rate among people aged 18 to 64.

The same pattern as cerebrovascular hospitalization is seen for hospitalizations for hypertension and ischemic heart disease (Figure 3.34). These hospitalizations are most common in the older population, at 116.0 discharges per 10,000 population 65 and older.

Fig. 3.34 Number of hospital discharges with a primary discharge diagnosis of hypertension or ischemic heart disease per 10,000 population, 2020
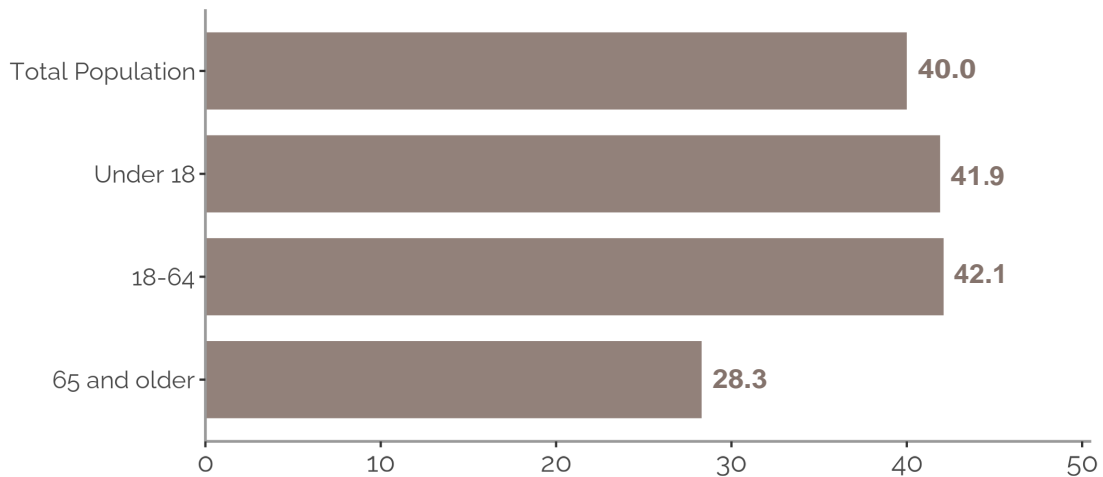
Atascosa County, Texas

Source: Texas Hospital Inpatient Discharge Public Use Data File, 2020, Texas Department of State Health Services Center for Health Statistics, Austin, Texas
Prepared by CI:Now for The Health Collaborative

MENTAL ILLNESS

Fig. 3.35 Number of hospital discharges with a primary discharge diagnosis of mental health/behavioral disorder per 10,000 population, 2020

Atascosa County, Texas

Source: Texas Hospital Inpatient Discharge Public Use Data File, 2020, Texas Department of State Health Services Center for Health Statistics, Austin, Texas
Prepared by CI:Now for The Health Collaborative

The rate of hospital discharges with a primary discharge diagnosis of a mental health or behavioral disorder is 40.0 per 10,000 (Figure 3.35). Surprisingly, at 41.9 and 42.1, the rates are virtually the same in the under-18 and 18 to 64 age groups.

Based on data from the National Survey on Drug Use and Health (NSDUH), the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 15.0% (17.6%-20.5%) of people 18 and older had any mental illness in the past year, and that 12.5% (10.5% - 15.1%) of people 18 and older received mental health services in the past year.[4]   Unfortunately, region – which includes Atascosa, Bexar, and 26 other counties – is the smallest geography available. Because of geographic barriers to care, the treatment rate within Region 8 is likely lower in rural areas with fewer mental health services available.

[4] Available online at https://www.samhsa.gov/data/nsduh/2018-2020-substate-reports
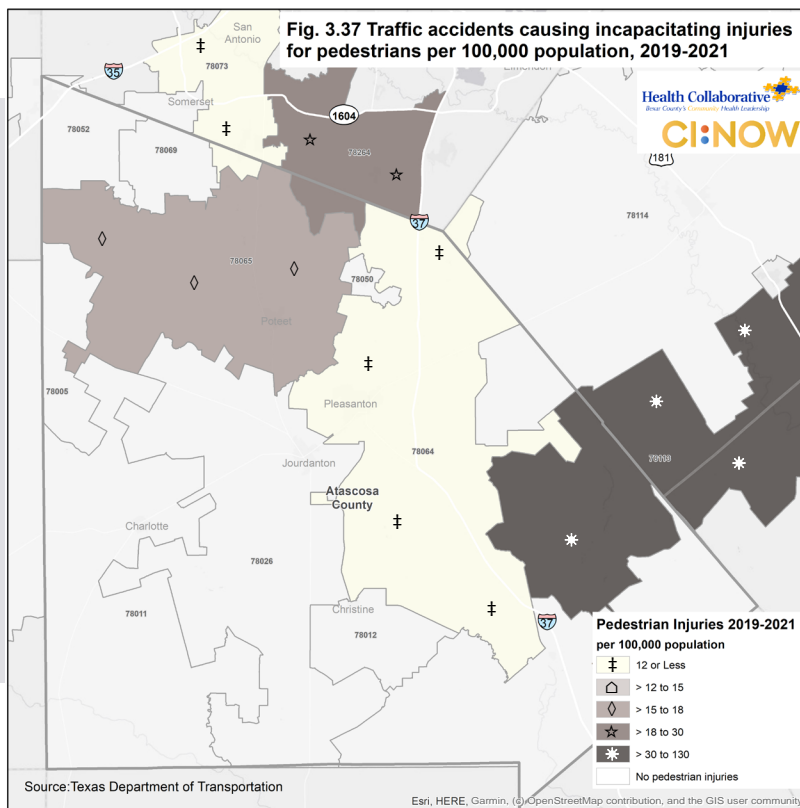
TRAFFIC ACCIDENT INJURIES

Fig. 3.36 Traffic accidents causing incapacitating injuries for pedestrians per 100,000 population
Atascosa County, Texas
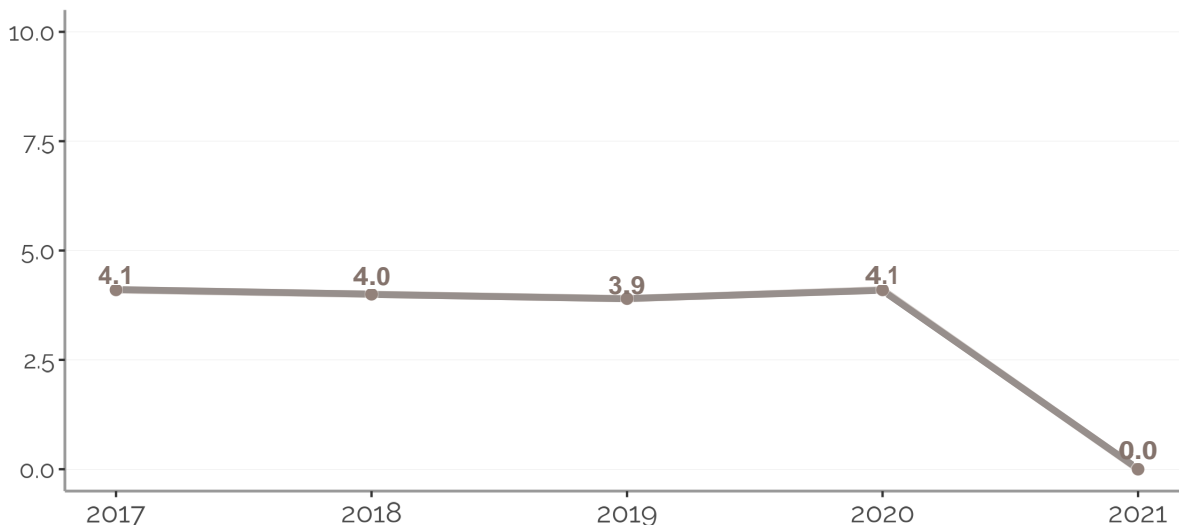
Source: Texas Department of Transportation
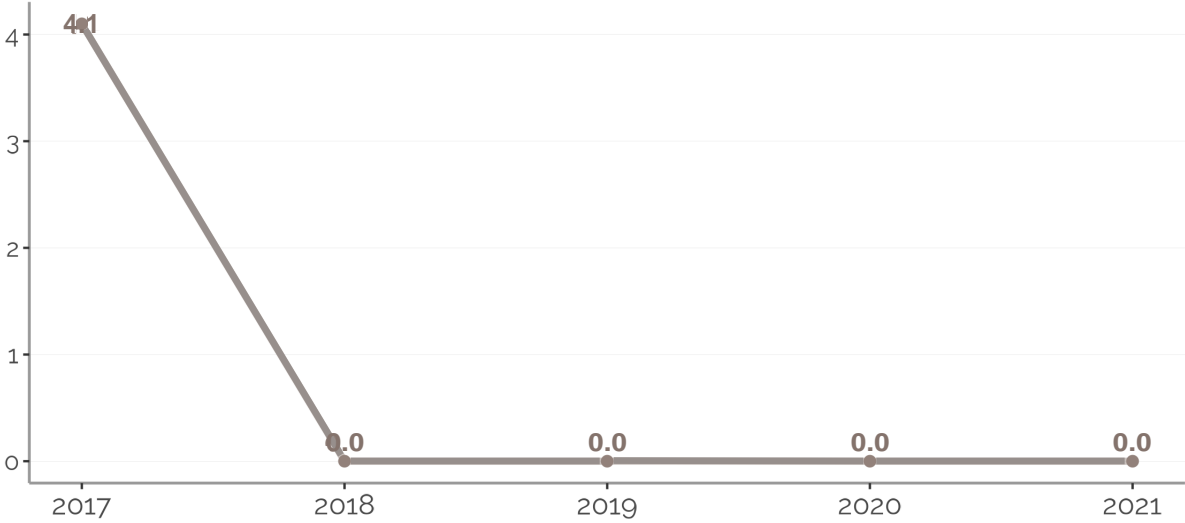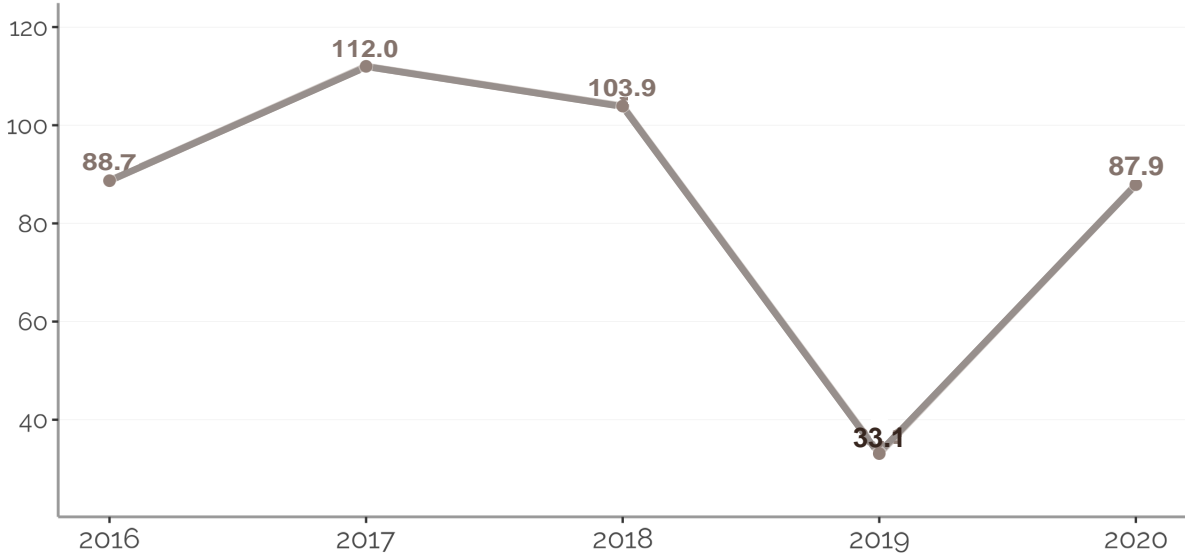Prepared by CI:Now for The Health Collaborative

At about 4.0 accidents per 100,000 population, the rate of traffic accidents causing incapacitating injuries for pedestrians was flat between 2017 and 2020, dropping in 2021 (Figure 3.36). In actual numbers, the drop from 2020 to 2021 was from two accidents to no accidents.

The traffic accident pedestrian injury rate is highest in ZIP codes straddling the east and north county lines (Figure 3.37). No accidents causing pedestrian injury occurred in most ZIP codes in the county.

Fig. 3.37 Traffic accidents causing incapacitating injuries for pedestrians per 100,000 population, 2019-2021

Source:Texas Department of Transportation

Fig. 3.38 Traffic accidents causing incapacitating injuries for cyclists per 100,000 population
Atascosa County, Texas

After a rate of 4.1 per 100,000 in 2017, the rate of traffic accidents causing incapacitating injuries to cyclists dropped to zero for 2018 through 2021 (Figure 3.38).

SEXUAL ASSAULT

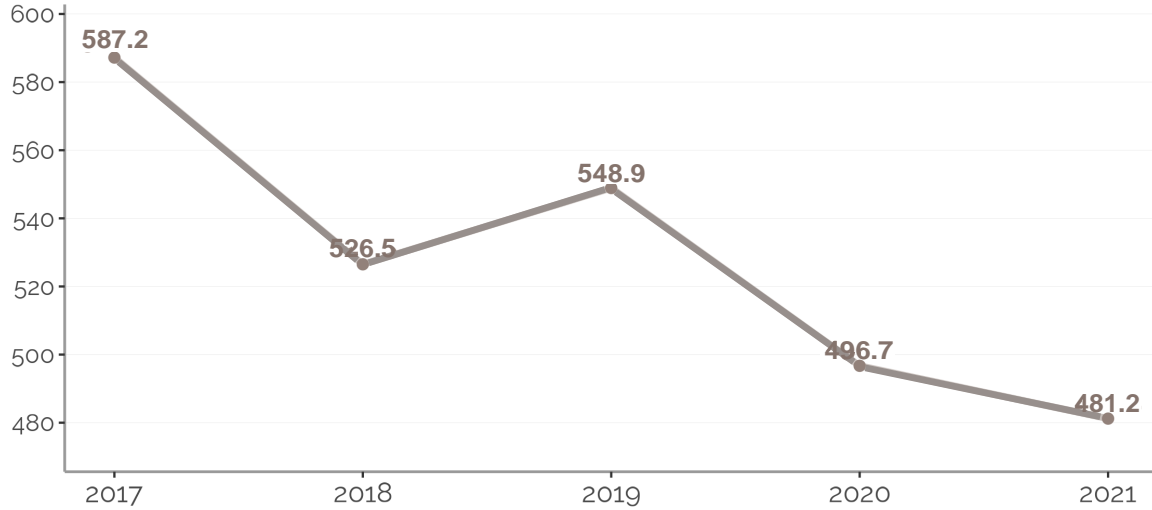**Fig. 3.39 Sexual assault crimes committed per 100,000 population**
Atascosa County, Texas

The trend must be interpreted with caution because of small numbers, but the rate of reported sexual assault dropped significantly in 2019, in a trend that otherwise hovered between 88 and 112 per 100,000 between 2016 and 2020 (Figure 3.39). As with any reported crime, this measure is vulnerable to changes in proportion of sexual assaults that are reported.

CHILD AND ADULT ABUSE AND NEGLECT

Child Protective Services staffing and caseloads may hinder investigation and victims being either confirmed or ruled out, so it is important to track initial reports of child abuse and neglect, not just confirmed victims. The report rate declined sharply during COVID (Figure 3.40), likely because school personnel are often the people who see and report signs of abuse and neglect when school is held in person.

Fig. 3.40 Number of child abuse or neglect reports per 10,000 children aged 0-17
Atascosa County, Texas

Fig. 3.41 Number of confirmed child abuse or neglect victims per 1000 children aged 0-17
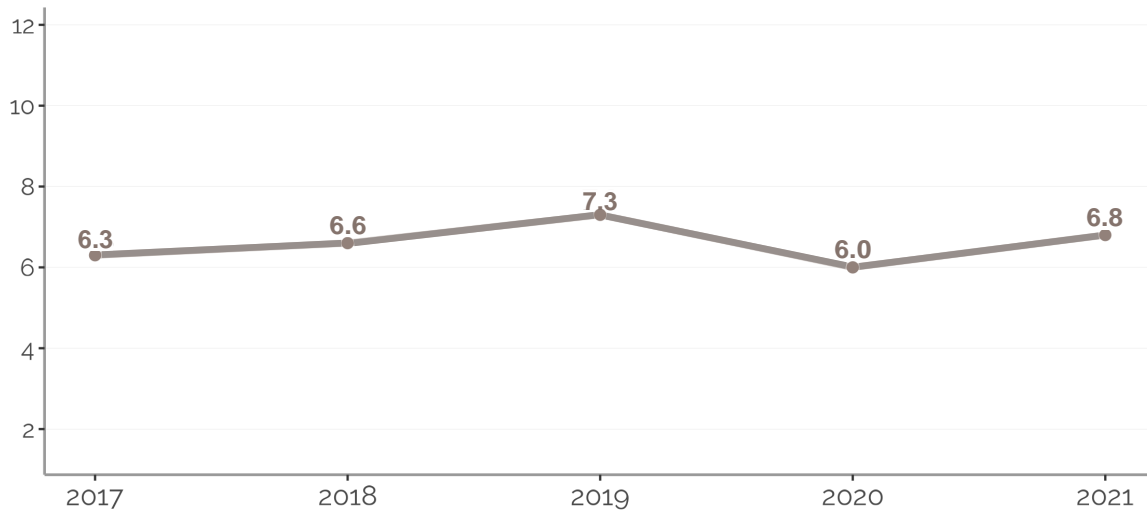Atascosa County, Texas

The rate of confirmed victims decreased about 25% between 2017 and 2021 (Figure 3.41). Again, a victim can only be either confirmed or ruled out if the report is assigned for investigation and the investigation is timely completed.

Fig. 3.42 Number of confirmed child abuse or neglect victims per 1000 children aged 0-17, 2020

Child Abuse and Neglect
per 1k population age 0-17

Symbol	Range
‡	1 or Less
⌂	> 1 to 3
◇	> 3 to 4
☆	> 4 to 7
✳	> 7 to 18
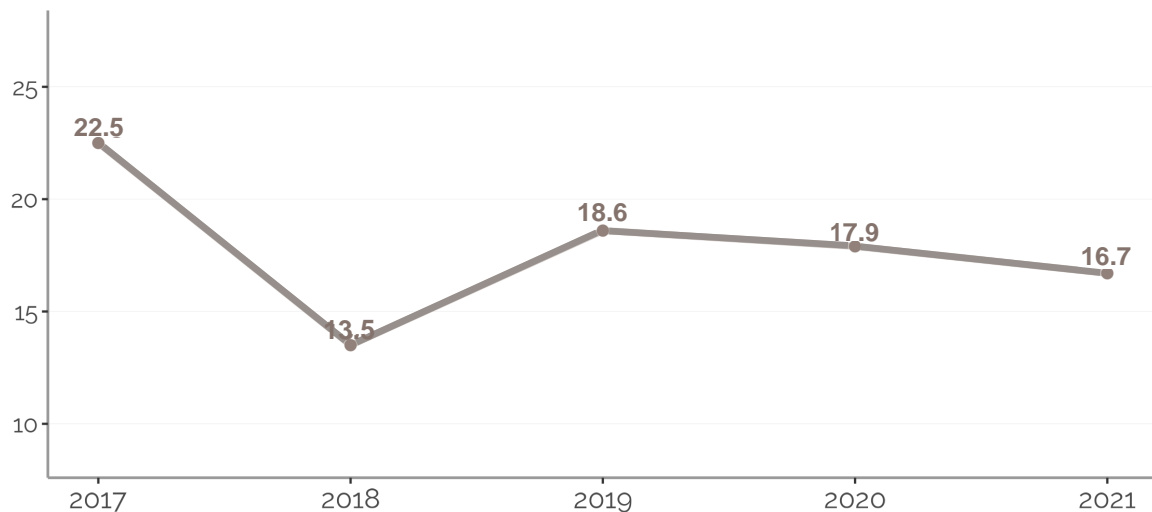
Source: Texas Department of Family and Protective Services, 2021
Note: Some zipcodes have been suppressed for confidentiality purposes

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

Confirmed child abuse/neglect by ZIP code is highest in 78065, including the Poteet area (Figure 3.42). It is not known to what degree it happens in Atascosa County, but both reports and investigations can be influenced by class and race/ethnicity bias.

As with child abuse and neglect, it is important to track reports of adult abuse or neglect, not just confirmed victims, because Adult Protective Services staffing and caseloads may hinder investigation and victims being either confirmed or ruled out. The rate of adult abuse or neglect reports remained flat between 2016 and 2020 (Figure 3.43).

Fig. 3.43 Number of adult abuse or neglect reports per 1,000 adults
Atascosa County, Texas

Fig. 3.44 Number of confirmed adult abuse or neglect per 1,000 adults
Atascosa County, Texas

After a small but steady increase in the rate of confirmed victims of adult abuse or neglect between 2017 and 2020, the rate fell slightly in 2021 (Figure 3.44).

All death rates for children and teens are so low as to be suppressed for Atascosa County. COVID-19 was the third-leading cause of death among adults aged 18 to 64 in 2020 (Figure 4.1), trailing heart disease and cancer but outpacing accidents.

Fig. 4.1 Leading causes of death for ages 18-64, crude rate per 100,000, 2020
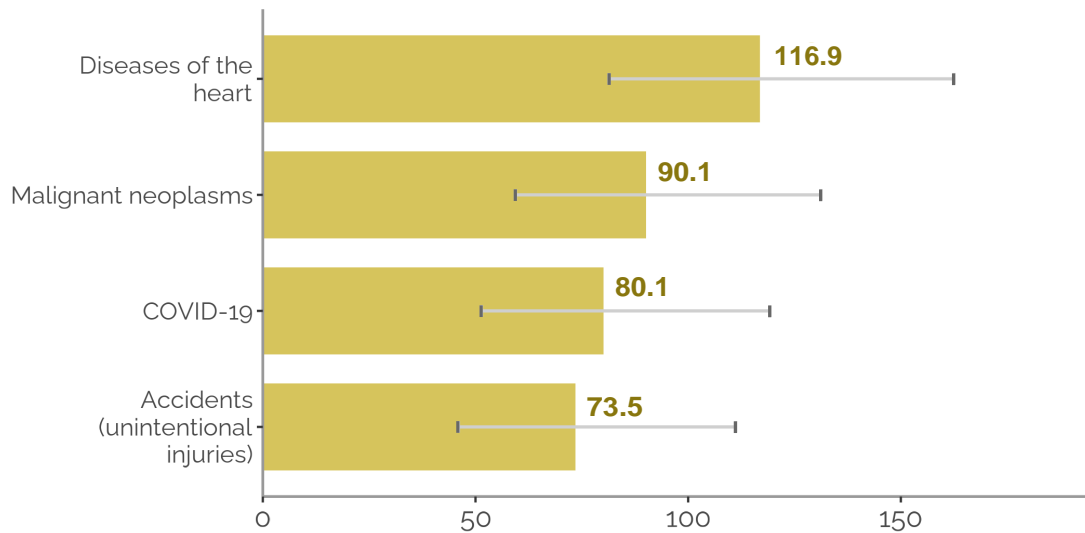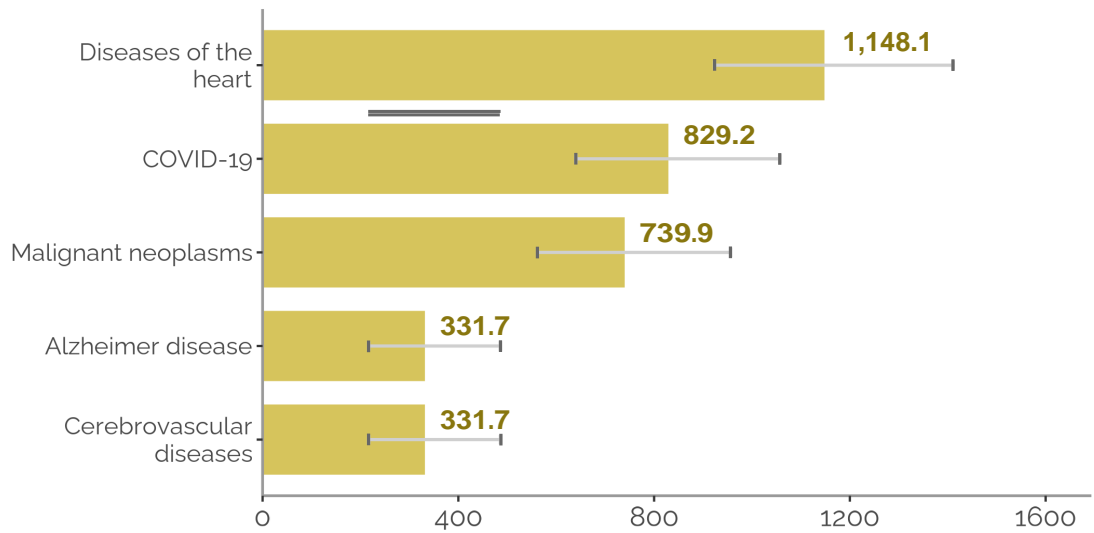
Atascosa County, Texas

Diseases of the heart	116.9
Malignant neoplasms	90.1
COVID-19	80.1
Accidents (unintentional injuries)	73.5

Source: CDC Wonder Online Data, Underlying Cause of Death
Prepared by CI:Now for The Health Collaborative

COVID-19 was the second-leading cause of death among adults 65 and older (Figure 4.2), trailing heart disease but outpacing cancer. The other leading causes of death in that age group were cancer, Alzheimer disease, and cerebrovascular disease.

Fig. 4.2 Leading causes of death for ages 65 or older, crude rate per 100,000, 2020

Atascosa County, Texas

Source: CDC Wonder Online Data, Underlying Cause of Death
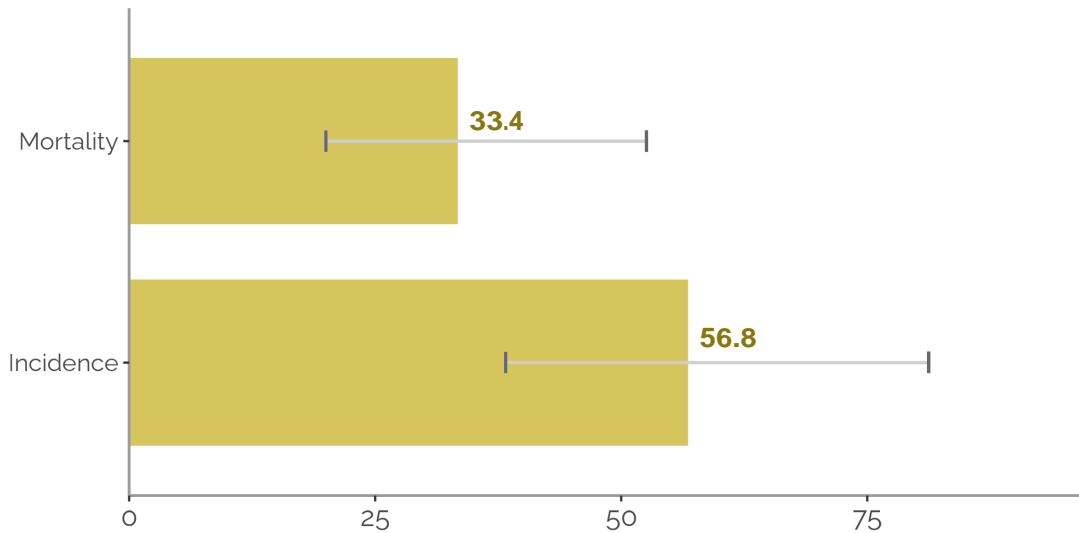Prepared by CI:Now for The Health Collaborative

COVID-19

The Johns Hopkins University COVID-19 Status Report puts total COVID-19 deaths at 231 for Atascosa County as of early June 2022, with a 1.68% fatality rate, calculated as deaths among confirmed cases as a percentage of confirmed cases. That rate is 33% higher than the Texas fatality rate of 1.26%.[1] Unfortunately, the race/ethnicity, age, sex, and ZIP code breakdown of Atascosa County COVID-19 deaths are not available.

CANCER

Atascosa County's age-adjusted lung and bronchus cancer mortality rate was 29.3 per 100,000 for the 2016-2018 period, the most recent data available (Figure 4.3). Wide error bars and suppressed data make it difficult to determine difference among race/ethnicity groups.

Fig. 4.3 Age-adjusted lung and bronchus cancer rate - Incidence and mortality per 100,000 population, 2018

Atascosa County, Texas

Source: Texas Cancer Registry
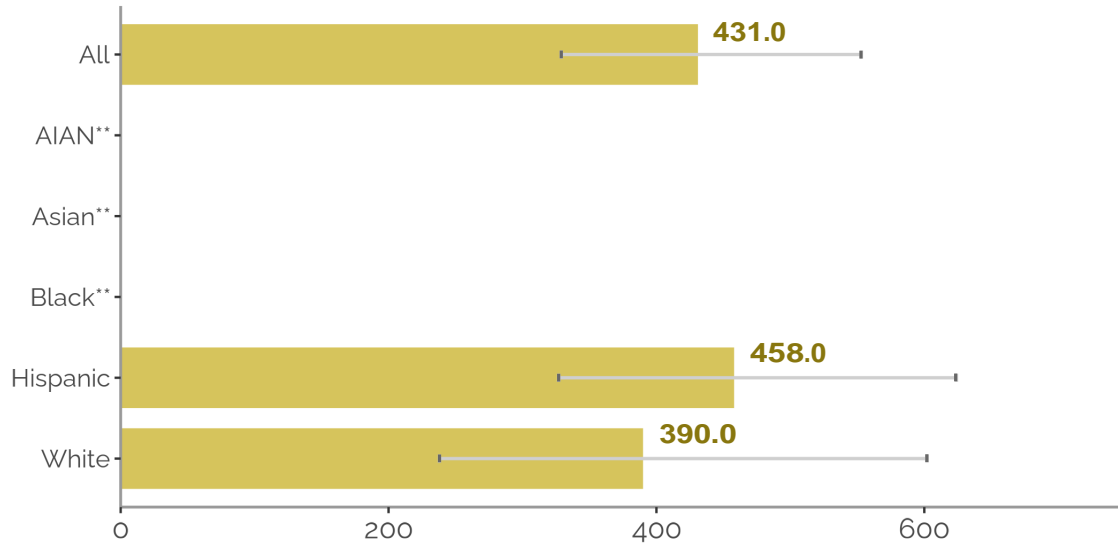Prepared by CI:Now for The Health Collaborative

[1] Johns Hopkins University, Coronavirus Resource Center. (2022, June 8). COVID-19 status report: Atascosa, Texas. Available online at https://bao.arcgis.com/covid-19/jhu/county/48013.html

INFANT MORTALITY

The number of infant deaths in Atascosa County is small enough that the rate would be suppressed, so Figure 4.4 above combines Atascosa, Medina, and Wilson County data for the period of 2009 to 2020. That combined infant mortality rate is 431 per 100,000 population under one year of age.[2] Unfortunately infant mortality rates by race/ethnicity are not available for Atascosa County.

Fig. 4.4 Number of infant deaths per 100,000 population <1 year, 2009-2020

Atascosa & Wilson Counties, Texas

All — 431.0
AIAN** —
Asian** —
Black** —
Hispanic — 458.0
White — 390.0

**Suppressed
Source: CDC Wonder Underlying Cause of Death, 1999-2020
Prepared by CI:Now for The Health Collaborative

OVERDOSE AND POISONING

It is not possible to separate drug overdose deaths from other chemical poisonings in the available dataset, but the overall crude rate due to poisoning has remained relatively flat since 2016 (Figure 4.5). Although the estimates vary, the overlapping confidence intervals mean no change may have occurred year to year.

Fig. 4.5 Deaths due to poisoning by chemical substance including drugs (crude death rate)
Atascosa County, Texas
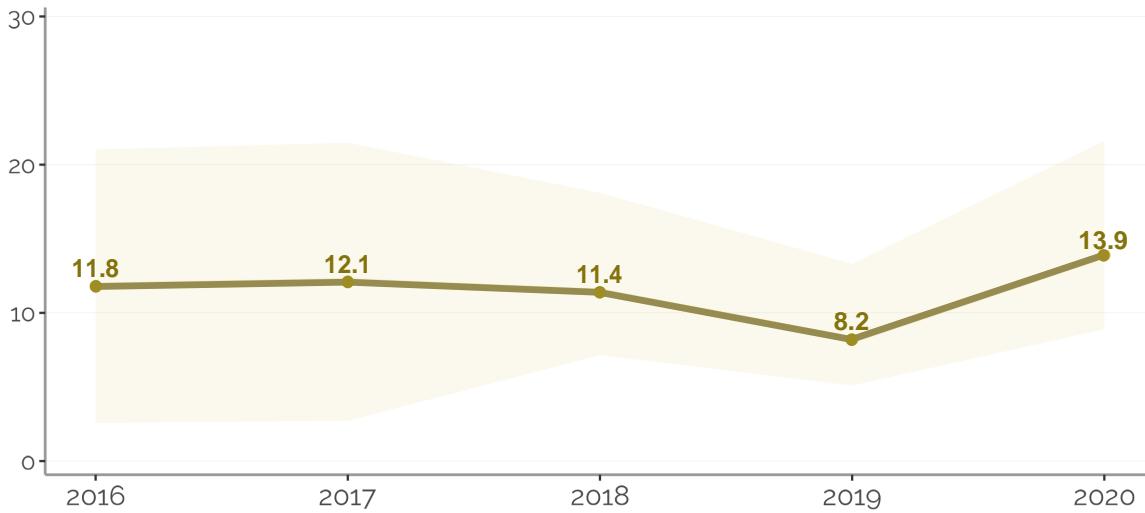
Source: Centers for Disease Control and Prevention
Prepared by CI:Now for The Health Collaborative

SUICIDE

Atascosa County's suicide rate is estimated at 17.2 per 100,000 population. Although the rate of suicide among females is suppressed, suppression means low numbers, so the rate among males likely far exceeds that of females (Figure 4.6). Unfortunately rates by age group and race/ethnicity are either suppressed or considered unreliable by the data source. It does appear, though, that the rate is higher in the 15 to 34 age group than in the 35 to 64 age group.

Fig. 4.6 Suicide rate by age , sex and race, 2020

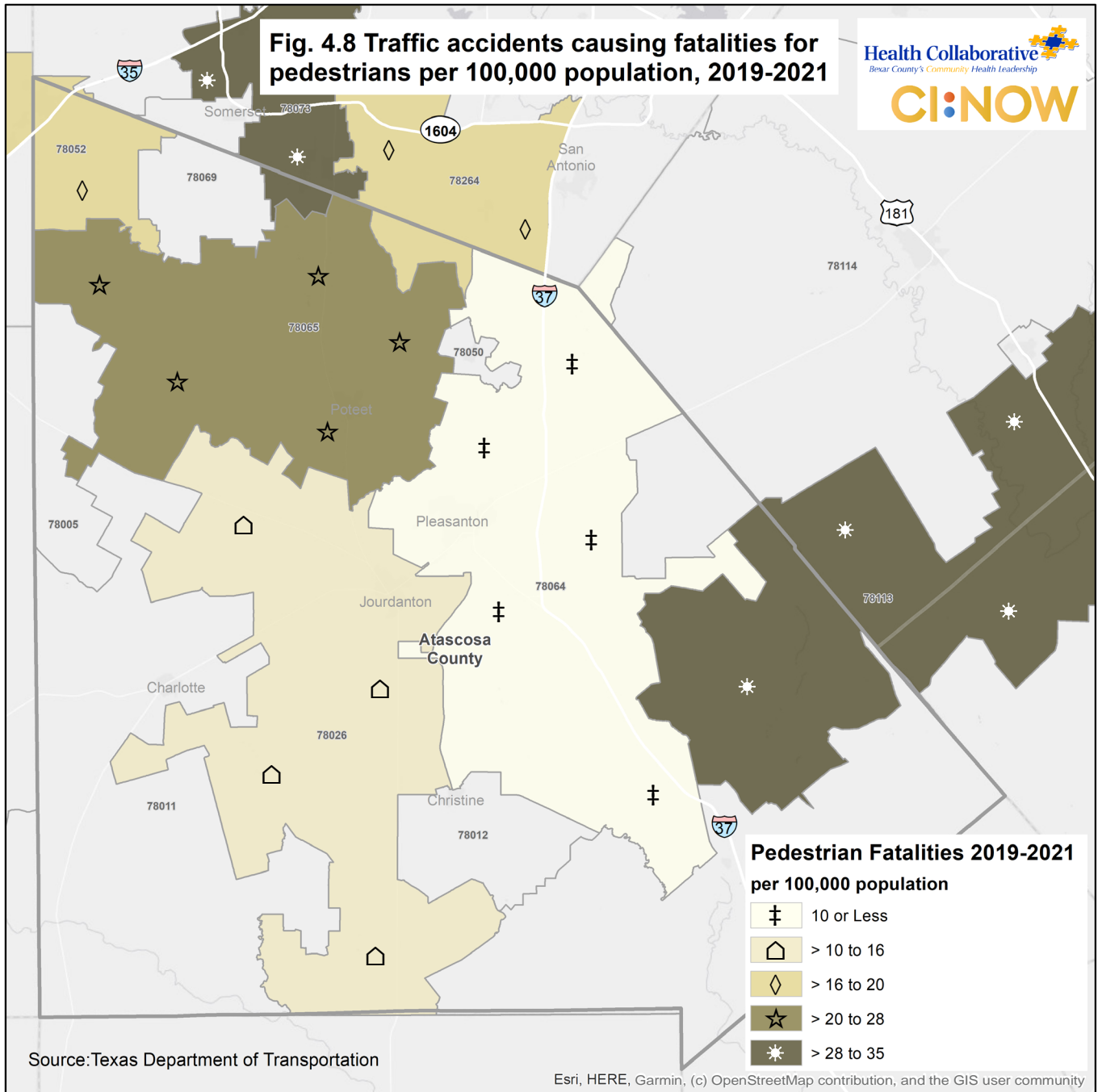| Atascosa County 2018-2020	
Total, 2020	17.2 (11.1 - 25.3)
Sex and age group, 2018-2020	
Female	Suppressed
Male	33 (21.2 - 49.2)
15 to 34 years (crude)	Unreliable (11.9 - 45.7)
35 to 64 (crude)	Unreliable (8.7 - 33.3)
Race/Ethnicity, 2018-2020	
Black or African-American	Suppressed
Hispanic	Unreliable (9.2 - 26.5)
White non-Hispanic	Unreliable (9.1 - 38)

TRAFFIC ACCIDENT FATALITIES

The rate of traffic accidents causing pedestrian death remained flat from 2017 through 2021 except for a spike in 2020 (Figure 4.7). The trend should be interpreted with caution given the low numbers. The rate of traffic accidents causing cyclist death has remained at 0.0 for 2019 through 2021, the only years for which data is available.

Fig. 4.7 Traffic accidents causing fatalities for pedestrians per 100,000 population
Atascosa County, Texas
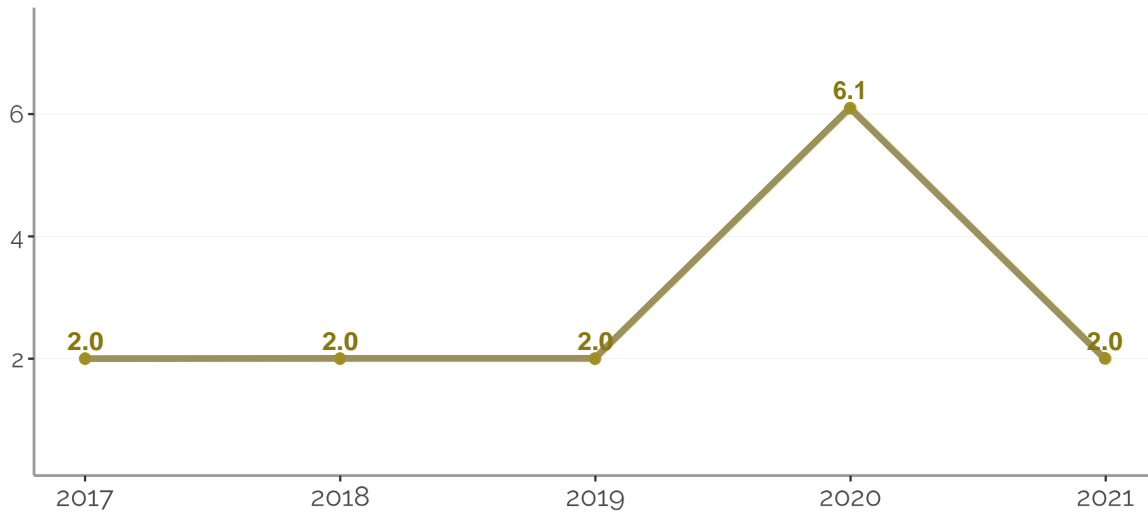
Source: Texas Department of Transportation
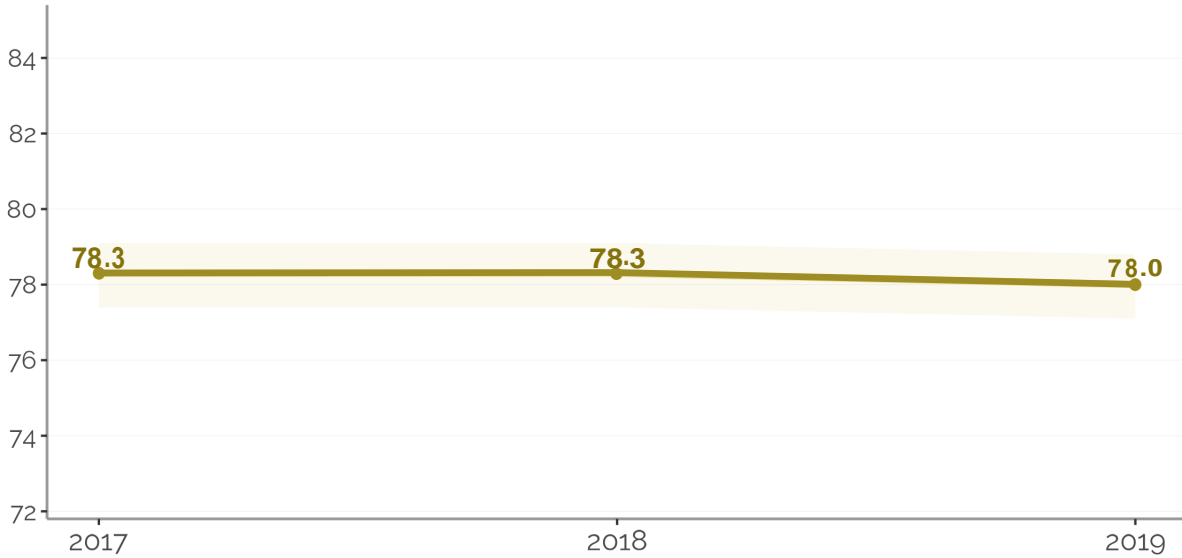Prepared by CI:Now for The Health Collaborative

Fig. 4.8 Traffic accidents causing fatalities for pedestrians per 100,000 population, 2019-2021

Pedestrian Fatalities 2019-2021

per 100,000 population

‡ 10 or Less

⌂ > 10 to 16

◇ > 16 to 20

☆ > 20 to 28

✳ > 28 to 35

Source: Texas Department of Transportation

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

The rate of traffic accidents causing pedestrian death was highest in ZIP codes 78073 (Somerset area) and 78113, both of which fall primarily in a different county (Figure 4.8). The lowest rate was in ZIP code 78064, which includes Pleasanton and the I-37 corridor.
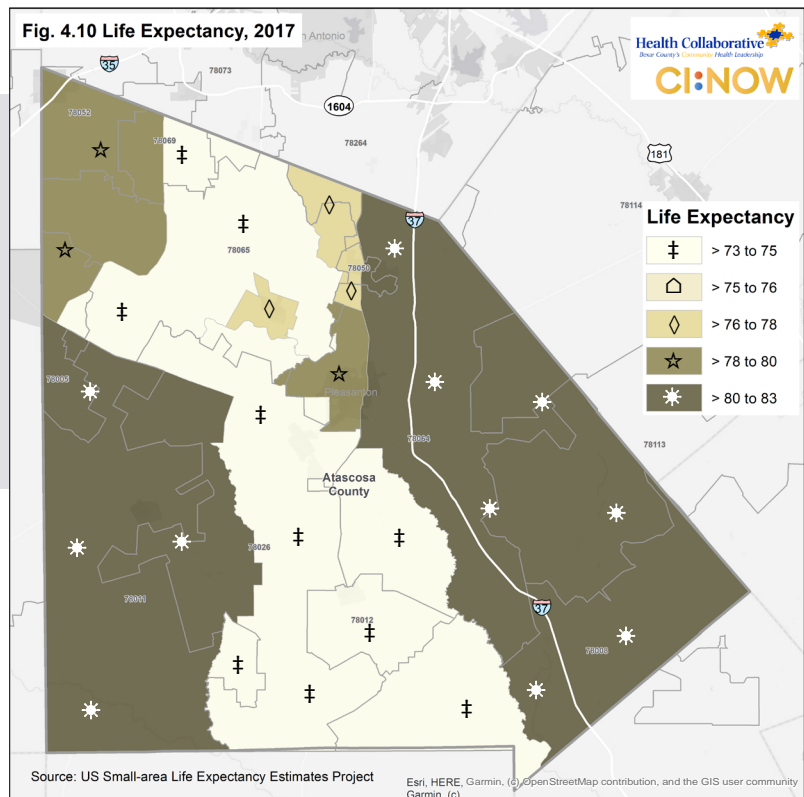
LIFE EXPECTANCY

Fig. 4.9 Life Expectancy (3-year average)
Atascosa County, Texas

Calculated as a three-year average, overall life expectancy was relatively flat from 2015-2017 to 2017-2019 (Figure 4.9). Unfortunately, the most recent available data pre-dates the COVID-19 pandemic. Local life expectancy likely dropped significantly during the pandemic, and racial disparities likely widened, if Atascosa County followed the national trend. [3]

Prior to COVID-19 life expectancy was shortest in ZIP codes in a north-south belt in the center of the county, and highest in the eastern and western portion of the county (Figure 4.10). That geographic disparity may have grown during the pandemic.

Fig. 4.10 Life Expectancy, 2017

Life Expectancy

‡ > 73 to 75
⬠ > 75 to 76
◇ > 76 to 78
☆ > 78 to 80
✳ > 80 to 83

Source: US Small-area Life Expectancy Estimates Project

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

3 See for example Andrasfay, T. and Goldman, N. (2021). Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. PNAS, 118 (5). Available online at https://www.pnas.org/doi/10.1073/pnas.2014746118

WHAT ISSUES STAND OUT?

A handful of issues stand out in each of the latter four sections, as shown in the diagram on the following page. Highlighted issues were selected by the Community Health Needs Assessment Steering Committee through an indicator rating survey. Respondents' decisions were informed both by the full array of quantitative assessment data and by each member's own understanding of health and well-being in Atascosa County.

Although COVID-19 deaths specifically are addressed below, it bears noting that no issue addressed in this assessment was unaffected by the pandemic. Most existing social and economic problems deepened, existing inequities grew starker, and years of recent progress were partly or entirely erased. Much of the available data predates the pandemic, and its effects will not be fully understood for years or perhaps decades.

HEALTH CARE

Find data in report Section 2: Access to Care, Preventive Care, and Health Behavior

The importance of health insurance was highlighted in this section, as about two in 10 Atascosa County residents has no health insurance at all. That figure rises to four in 10 among 19- to 25-year-olds. Because most health insurance for adults younger than 65 is employer-sponsored, this issue is also closely related to stable employment.

Chronic disease management emerged as a priority, and access to health care is of course closely related to the health insurance priority noted above. Most of these services show racial/ethnic disparities in access and utilization, as well as in the health outcomes (e.g., diabetes) that preventive and primary care are intended to prevent or manage. Although the full impact of the pandemic on preventive and primary care utilization and subsequent health outcomes is not yet known, it is certain that utilization declined.
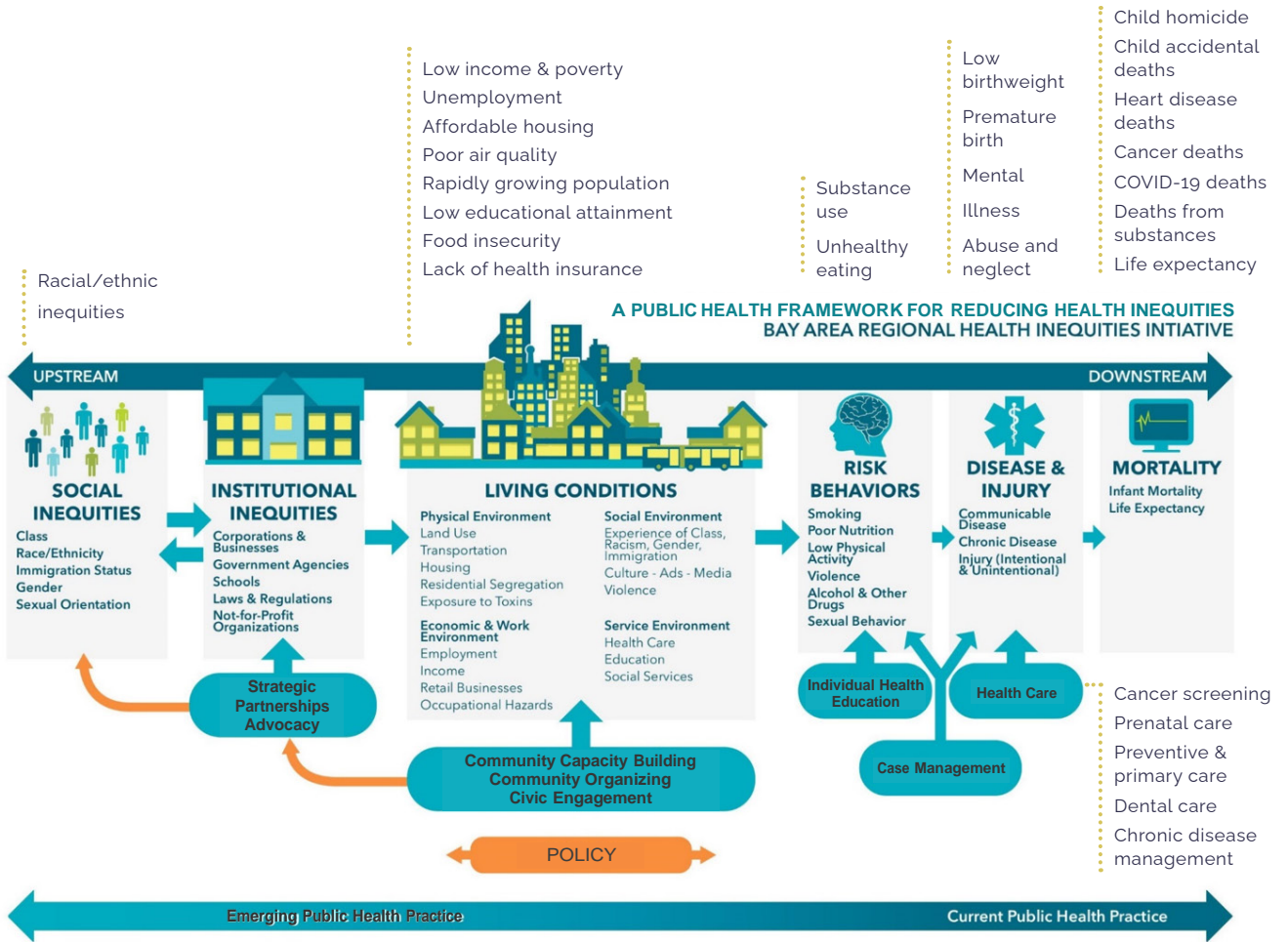
COMMUNITY VOICE

"We do have a lot of diabetes and hypertension, those are probably the two top ones that I hear about, the practitioners talk about within that." – Monty Small, Chief Executive Officer of Atascosa Health Center

COMMUNITY VOICE

"I don't know that the access to virtual, like through the internet or digital, I don't know that that is this readily available in this community as it is in a more, you know urban area like in Bexar county. We have a lot of lot of individuals who are very rural, and so that access is just … not there all the time or it's not reliable. And so, and I don't know that all the population is even willing to do it." – Amber Champagne, Vice President, Human Resources at Methodist Hospital South

Racial/ethnic inequities

Low income & poverty
Unemployment
Affordable housing
Poor air quality
Rapidly growing population
Low educational attainment
Food insecurity
Lack of health insurance

Substance use
Unhealthy eating

Low birthweight
Premature birth
Mental Illness
Abuse and neglect

Child homicide
Child accidental deaths
Heart disease deaths
Cancer deaths
COVID-19 deaths
Deaths from substances
Life expectancy

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INTIATIVE

UPSTREAM — DOWNSTREAM

SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

INSTITUTIONAL INEQUITIES
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations

LIVING CONDITIONS
Physical Environment
Land Use
Transportation
Housing
Residential Segregation
Exposure to Toxins

Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards

Social Environment
Experience of Class, Racism, Gender, Immigration
Culture - Ads - Media
Violence

Service Environment
Health Care
Education
Social Services

RISK BEHAVIORS
Smoking
Poor Nutrition
Low Physical Activity
Violence
Alcohol & Other Drugs
Sexual Behavior

DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)

MORTALITY
Infant Mortality
Life Expectancy

Strategic Partnerships Advocacy

Community Capacity Building
Community Organizing
Civic Engagement

Individual Health Education

Health Care

Case Management

Cancer screening
Prenatal care
Preventive & primary care
Dental care
Chronic disease management

POLICY

Emerging Public Health Practice — Current Public Health Practice

COMMUNITY VOICE

"There is a great need for in-patient psych facility and services. Most patients with mental health issues are brought in by the police and they have to wait in the Emergency Room until there are open beds at a San Antonio facility. Hospital staff and/or security have to stay with the patient in the ER until they are able to be transported." – Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1

DISEASE AND INJURY

Find data in report Section 3: Well-Being, Illness, and Injury

Mental illness emerged as a priority as well. Both qualitative and quantitative data point to mental health concerns in both young people and adults, and a lack of services and resources in-county.

Child and adult abuse and neglect stood out as well. Children in particular are vulnerable to ongoing abuse and neglect when the usual people who notice and report it, like school personnel, do not see and spend time with children, as was the case during the pandemic when learning was conducted virtually. The danger of abuse and neglect in both age groups may have been exacerbated during the pandemic when family members who normally go to work or school outside the home cannot, particularly in the context of extreme economic and health stressors.

COMMUNITY VOICE

"Whether it's for children or adults. I don't think that there's enough acceptance of mental health, behavioral health needs, and so I think that there's still a stigma around that. And then there's not the resources available either, there's not the counselors, there's not the facilities. There's not the emphasis on it. I just don't think that there are those resources." – Amber Champagne, Vice President, Human Resources at Methodist Hospital South

COMMUNITY VOICE

"Most of the reporting to the Child Protective System (CPS), is done by school staff and in many cases, the determination that "all is good" returns the child(ren) to the home and the case is closed. Perhaps, the reason is the lack of caseworkers and/or the high caseloads." - Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1

MORTALITY

Infant mortality is the last issue highlighted by community reviewers. Both lack of adequate perinatal care and environmental factors can contribute to infant death.

COMMUNITY VOICE

Sidebar: Community Voice

"There are currently no OB/GYN physicians, clinics, or services in Atascosa County. Pregnant women have to travel to San Antonio to deliver their babies and to access preventive services and care. … Many women go without preventive care and/or other women's health services because they don't want to travel to San Antonio." – Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1

APPENDIX A: COMMUNITY VOICE

The qualitative analysis for the 2022 Atascosa County Community Health Needs Assessment was based on two focus groups and three key informant interviews from community members. The focus groups and interviews were moderated by staff at The Health Collaborative and analyzed by Community Information Now (CI:Now). Using a grounded theory framework and the software Dedoose, CI:Now performed open coding as an initial way of identifying general themes, axial coding as a way of connecting the themes into categories and subcategories, and selective coding to identify final themes.

Healthy Child and Family Development, and Mental and Emotional Health, and Safe Communities were the priority topics of the focus groups and interviews. There were many themes that emerged from each of these, as shown below. It should be noted, even if the pandemic was not specifically mentioned in each theme, every experience the participants had was influenced by the pandemic in some way.

HEALTHY CHILD AND FAMILY DEVELOPMENT HEALTHCARE, HEALTH SERVICES, AND PROVIDERS

Access to healthcare, health services, and providers is limited in Atascosa County. "The lack of health care coverage is very prevalent in the Atascosa community. The participants reported that it is very likely due to high premium rates and high deductibles. They reported that when Obamacare first started, there were people helping patients to sign up for affordable health coverage, but they have not seen that type of help since then. There is currently no program that helps residents learn more about and apply for affordable health coverage" (CHNA Healthcare Workers Focus Group 1, Notes taken by staff at The Health Collaborative, 2022).

Additionally, for those Atascosa County residents who do have health insurance, many of them still choose to travel to San Antonio, or another city outside of Atascosa County, for health services because they have difficulty finding the providers they need.

> *"I came from west Texas and I have two sons, so I was [inaudible 00:18:08] and then it was so difficult for me to find a pediatrician. Our pediatrician is in San Angelo, and even though I was working here already, we go to San Angelo... I tried to find another pediatrician over here, but I think there's not a lot of data that I can get or information like, okay, we have a pediatrician here or here and there." –* Participant in CHNA Healthcare Workers Focus Group 2

> *"I don't think that [provider] ... went out and tried to do a lot of education, and let's talk about you know teen pregnancy and things like that... So I do think that that is an area of opportunity, and we do not have the resources in the community to address that." –* Amber Champagne, Vice President, Human Resources at Methodist Hospital South

> **"There are currently no OB/GYN physicians, clinics, or services in Atascosa County. Pregnant women have to travel to San Antonio to deliver their babies and to access preventive services and care. The local hospital system has state of the art mammography equipment that is underutilized due to the lack of marketing, knowledge by community. Many women go without preventive care and/or other women's health services because they don't want to travel to San Antonio."** – *Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1*

As quoted above, OB/GYN services in particular are in high demand, and Atascosa County residents do not have easy access to the providers they need. While some residents are willing to make the drive to another county, others opt to not have the service at all.

HEALTH PROGRAMS AND RESOURCES

Participants were very grateful for all of the organizations promoting health initiatives to help make Atascosa County healthier. They really appreciated "the support down here of the San Antonio Food Bank. And I know that some of the food pantries down here have been very active" (Participant in CHNA Healthcare Workers Focus Group 2, Moderated by The Health Collaborative, 2022). However, participants also noticed a gap in knowledge of the health programs and resources available to them.

> **"I'm not aware of any sort of collaboration that's focusing on healthy eating, active living that is beyond just like individual organizations. You know here and there. I'm not aware of that on a grander scale. I think there would be a lot of opportunity to educate, and perhaps create some momentum around that."** – *Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

> **"But then just food and health literacy and just knowing what to buy and how to prepare it, I feel like there's a big lack of knowledge on... You can have all of this available at H-E-B for cheap, but if somebody doesn't know how to make it, or make it taste good, then they might as well get something out of a package."** – *Participant in CHNA Healthcare Workers Focus Group 2*

There also appears to be a disconnect between available health resources and resident knowledge of those resources, speaking to a need for health initiatives to outreach and market themselves to the community. Once residents are aware of a health program, it can help with health outcomes, as Monty Small, Chief Executive Officer of Atascosa Health Center, explained: "We do have a lot of diabetes and hypertension, those are probably the two top ones that I hear about, the practitioners talk about within that. There has been a big challenge within that. We participate in the [inaudible] program over the years, seeing if we can help make an impact within there" (Monty Small, CHNA Interview with The Health Collaborative, 2022).

POVERTY AND JOB LOSS

Poverty and job loss were the most common themes under Healthy Child and Family Development. Participants had much to say about how income and employment affect Atascosa County residents' abilities to live healthy lives with their families.

> *"We've got a lot of families that are maybe lower income on state aid. Don't have the resources and support systems themselves to foster that healthy family environment which I think can contributes to healthy child development." – Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

> *"Just opportunities for employment, we grew a lot during the oil and gas boom, and now that market is so much more volatile so people will have a job one day and not the next. And then access to stable services." – Participant in Healthcare Workers Focus Group 2*

> *"It'd be interesting to take a look at the correlation between COVID cases and COVID deaths, and employment and unemployment because I don't think we've done an overlay of that. Recently you read an article about sort of the tragic effects of COVID in some parts of our city and counties right that were largely minority, and understanding sort of like how does that look like with the employment and unemployment, and economic recovery." – Adrian Lopez, Chief Executive Officer, Workforce Solutions Alamo*

> *"I'd say that our community has always had issues with just low-income individuals. I know Jourdanton's a Title I school. I'm sure Charlotte is. I'm not sure about Pleasanton, Poteet probably. But there's just high needs in the community." - Participant in Healthcare Workers Focus Group 2*

Many participants felt income and stable employment were the main predictors of healthy living. Access to more monetary resources would allow Atascosa County residents to have consistent access to services for themselves and family members.

TECHNOLOGY AND TRANSPORTATION

The final common themes under Healthy Child and Family Development were the role of technology and transportation in connecting people to resources and services. Participants had concerns about lack of digital inclusion affecting people's ability to live health lives.

> *"We also saw, a lot associated with the disparities with things like lack of digital devices and access to the Internet, which is one of the reasons why early on, yes, we were closed 100% and providing virtual services but very quickly we pivoted back to opening up our centers." – Adrian Lopez, Chief Executive Officer, Workforce Solutions Alamo*

> *"I don't know that the access to virtual, like through the Internet or digital, I don't know that that is readily available in this community as it is in a more, you know urban area like in Bexar county. We have a lot of lot of individuals who are very rural, and so that access is just not there all the time or it's not reliable. And so, I don't know that all the population is even willing to do it." – Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

Additionally, transportation is a large hindrance to some parts of the Atascosa community receiving consistent healthcare.

> *"The only transit system in the tri-city area (Pleasanton, Poteet, and Jourdanton) is the Alamo Regional Transit's (ART) Atascosa Cowboy Connect. The 2 loops, one-hour long each, connects residents of Jourdanton and Poteet to Pleasanton and started on July 1, 2020.*
>
> *The participants of the first healthcare workers focus group mentioned this system very vaguely, placing more emphasis on the lack of public transportation, especially as it relates to patient transport. Patients must rely on family, friends, or neighbors for a ride if they do not have a personal vehicle. Lots of times, surgeries have to be cancelled because the patient was unable to secure a ride home afterwards.*
>
> *There is no Uber nor taxi cab service in this area either, however, Door Dash does operate in the area, for the delivery of prepared food." - Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1*

While the pandemic has caused many health providers to lean more heavily on digital scheduling and telehealth appointments, it has also exacerbated the digital divide for those who do not have easy access to the internet nor the knowledge of how to navigate it. Lack of transportation is also a barrier in people reaching their appointments or getting home from them. Some procedures require you prove that you have someone who can drive you home afterwards, which is difficult for those without support.

MENTAL AND EMOTIONAL HEALTH
FAMILY AND SOCIAL SUPPORT

Participants felt the best way to address mental and emotional health was with the family and through social support.

> *"So in terms of the mental benefits associated with that, they are tremendous because mom or dad having to work less and get paid more offers a real opportunity for them to focus on family issues and family problems that we all have in our families, whether it's relationships between spouses, or whether it's sort of taking care of a child as they're growing up in terms of their development needs or early on, or you know helping them out through their homework, you know, as they're going through elementary, middle, and high school, and offering a real sort of opportunity to provide some real guidance and some real support there."* – Adrian Lopez, Chief Executive Officer, Workforce Solutions Alamo

Having a network of people to rely on can help alleviate some of the barriers mentioned thus far. Having family who can help take you to appointments and peers who can explain how to apply for jobs online can help provide a way to access services that were previously difficult. Having a healthy relationship with your family and peers is an important factor in fostering mental and emotional health. Participants also felt it was important that parents are mindful of the environment they create for their children because "their parents may have behavioral or mental health that trickles down into the children" (Amber Champagne, CHNA Interview with The Health Collaborative, 2022). Family and peers have a large influence over one another's emotional well-being, and Atascosa County participants think resources should be aimed at strengthening familial and peer relationships.

AWARENESS AND RESOURCES

Many participants felt awareness and resources around mental health services were lacking in Atascosa County.

> *"There is a great need for in-patient psych facility and services. Most patients with mental health issues are brought in by the police and they have to wait in the Emergency Room until there are open beds at a San Antonio facility. Hospital staff and/or security have to stay with the patient in the ER until they are able to be transported."* – Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1

> *"Whether it's for children or adults. I don't think that there's enough acceptance of mental health, behavioral health needs, and so I think that there's still a stigma around that. And then there's not the resources available either, there's not the counselors, there's not the facilities. There's not the emphasis on it. I just don't think that there are those resources."* – Amber Champagne, Vice President, Human Resources at Methodist Hospital South

They would like to see more emphasis placed on providing mental health resources in their communities as well as more awareness to help de-stigmatize the subject and provide a general understanding of what's available.

SUBSTANCE ABUSE

The last prevalent theme under Mental and Emotional Health was substance abuse. Participants felt many residents struggle with substance abuse and that the situation would be improved if there were more employment opportunities available.

> *"Substance abuse is a big one… Substance abuse is a major challenge within there. I mean, we get the you know, we see the abusers and seekers [inaudible]… But we do have patients that need our help so we are able to meet that need too now." – Monty Small, Chief Executive Officer, Atascosa Health Center*

> *"And then just the issues with the drug abuse in our area. We get patients that are meth abusers, or opiate or heroin abusers that get infections in the injection site or bloodstream infections, et cetera. I mean, we've had people with heart failure in their 30s or 40s because of drug abuse. And I don't know if that's something that's grown over time? Was it always this way and we didn't know? But I'd say that's also kind of a possible growing issue in our community, and I'm sure that's linked to the lack of employment and opportunities." – Participant in CHNA Healthcare Workers Focus Group 2*

SAFE COMMUNITIES
CRIME AND VIOLENCE

Participants, particularly the healthcare workers, had concerns about crime and violence in their communities.

> *"Crime has started to rise within the last five years, especially home break-ins and vandalism. The participants also reported that many individuals possess concealed weapons license, however, security and staff at the local hospital are unarmed… Most of the reporting to the Child Protective System (CPS), is done by school staff and in many cases, the determination that "all is good" returns the child(ren) to the home and the case is closed. Perhaps, the reason is the lack of caseworkers and/or the high caseloads." - Notes taken by staff at The Health Collaborative, CHNA Healthcare Workers Focus Group 1*

When asked about how the community is responding to safety concerns, one participant responded:

> *"We do have some great organizations here in the community. We have Safer Path, which is a family violence, domestic violence [organization]. They recently became a shelter as well.*
>
> *We've got other child advocacy groups like CASA [Court Appointed Special Advocates]. There's another one that I just heard about called Family Matters and so these are all organizations that are geared towards you know, making sure children's environments are safe. Things like that." – Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

It is encouraging that participants were aware of organizations which are geared toward safety in communities. However, health workers felt they needed more support in feeling safe while working in local hospitals.

INFRASTRUCTURE AND POLICE PRESENCE

Quality built environments, family-friendly programming, and a positive police presence made participants feel safer about their communities. These were building blocks to feeling secure and welcome in Atascosa County, and like it was a place they wanted to invest in.

> ❝ *"I've seen a much stronger presence in our local law enforcement, and really you know not that they're doing something… so I've seen much more of a social presence with them over the last couple of years to help build that relationship with the community, so that they do feel safer."*
> *– Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

> ❝ *"When we moved here from West Texas, it was really difficult for us to find a place to stay or find a property to purchase because there's not a lot of advertisement… It's hard for those people coming here, looking for a place to stay. So, I think that could also be one of the things that can be improved."– Participant in CHNA Healthcare Workers Focus Group 2*

> ❝ *"Pleasanton over the last few years, has done a lot of investment into their community park. They've redone the entire thing and they've really done a lot of work at trying to host different events, family events, throughout the year. I actually live in Pleasanton, and so that's been a big thing for my family, is that Pleasanton, almost on a monthly basis, has something going on that's family driven.*
>
> *Jourdanton is close to following suit. They've done a lot of revamping on their park, their pool, and Jourdanton being the other major town here in the community. And that's also where the hospital is.*
>
> *And then the third major town is Poteet. Poteet is trying to do much of the same thing." – Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

Participants had mixed feelings about infrastructure development in Atascosa County. Some were pleased with the projects that have happened thus far to facilitate family outings, while others have had difficulty providing basic needs for their family – like housing. Additionally, the satisfaction with police presence and community investment may vary depending on the income of the town.

CROSS-CUTTING THEMES
EQUITY, COLLABORATION, AND FUNDING

As many of the participants were community health workers, there was much talk about equity work, collaboration between organizations, and funding their efforts throughout all the themes. Participants understood that services and resources needed to do more than just exist. They have to reach the community on a personal level and assess their need adequately, "because now we understood that families needed a lot more support than what they traditionally needed in the past. I think part of that the alignment with our community-based organizations, and being able to make sure that folks understood what services were out there" (Adrian Lopez, CHNA Interview with The Health Collaborative, 2022). As Mr. Lopez said, alignment and collaboration are important to doing the equity work of reaching the communities who need more support. However, to do this work, they need more funding.

> *"I think what has to happen also is we do need focus on that and give more funding to your community colleges. To focus on programs that would focus on MA's and LVN's, even RN's." –* Monty Small, Chief Executive Officer, Atascosa Health Center

Their organizations receive grants, of which they are very appreciative, but there are some aspects of public health work that need more support.

RURAL VS. URBAN

Lastly, a common cross-cutting theme throughout most of the participants' answers was how living in a rural area influenced their health needs. Atascosa County participants frequently explained how their resources were different from residents in Bexar County.

> *"So for right now, if I was your neighbor and I had a lump on my leg or something, I was concerned, what is the first thought? What is the first thing that comes to mind? I would just be thinking, 'I need to head to San Antonio'? Yeah."* – *Participant in Healthcare Workers Focus Group 2*

> *"Moderator: And, you said, they have to have someone pick them up, right? What if they don't have anyone to pick them up?*
>
> *Participant: Well, normally, San Antonio has the Yellow Cab and you have Uber and all kinds of other resources. Here, we really don't so we have to use our ambulance services, any wheelchair vans usually to give them a ride home."* – *Participant in Healthcare Workers Focus Group 1*

> *"I don't know that the access to virtual, like through the internet or digital, I don't know that that is this readily available in this community as it is in a more, you know urban area like in Bexar county. We have a lot of lot of individuals who are very rural, and so that access is just … not there all the time or it's not reliable. And so, and I don't know that all the population is even willing to do it."* – *Amber Champagne, Vice President, Human Resources at Methodist Hospital South*

In fact, this theme was coded the most often and was mentioned in all but one of the Atascosa County focus groups and interviews. Living in a rural area affected participants' experiences with transportation, access to health services, digital literacy, and employment and housing opportunities. Many participants desire the resources of an urban environment be brought to their rural community so that residents don't have to drive out of the county for services.

APPENDIX B: GLOSSARY OF DATA TERMS

TABLE OF CONTENTS

NOTE ON USE AND ORIGIN

This Glossary of Common Data Terms was developed by Community Information Now as a non-technical resource for those interested in expanding their functional data vocabulary. This glossary contains commonly used data terms defined in easy-to-understand language. Although the definitions are informal and non-academic, the following academic texts heavily informed their development:

Shryock, H.S., and Siegel, J.S. The Methods and Materials of Demography. San Diego, CA: Academic Press, 1976.

Haupt, A. and Kane, T.T. Population Handbook. Washington, DC: Population Reference Bureau, Inc., 1978.

ADDITIONAL INFORMATION

Below are a few of the free resources available online for those who would like to learn more about data from the basics to advanced concepts and skills.

1. School of Data. **https://schoolofdata.org/handbook/courses/what-is-data/**

2. Data-Pop Alliance. **http://datapopalliance.org/item/what-is-data-literacy/**

3. Oceans of Data Institute. **http://oceansofdata.org/our-work/big-data-big-promise**

A

Administrative data: data generated in the everyday course of business, like sales data in a grocery store, attendance data in a school, or diagnosis data in a doctor's office. Administrative data is a type of secondary data. See Secondary data.

Age distribution: the frequency of different ages or age groups in a population.

Age-adjusted rate: a rate with a calculation applied to allow an "apples to apples" comparison between populations with different age distributions. For example, an older population may have a higher crude death rate than a younger population, even if the younger population is shouldering a greater burden of lethal issues like drug overdose, severe asthma, breast cancer, or homicide. Age-adjusted rates artificially standardize the two populations' crude rates against a single "reference population" so that the confusing influence of age distribution is removed. These rates are useful for comparison purposes only and should not be used to describe a measure for a single population. See Age distribution, Crude rate, Age-specific rate, and Rate.

Age-specific rate: the number of cases or events in a given age group divided by the total population of that age group. See Rate, Age-adjusted rate, and Crude rate.

Aggregate data: individual data records that have been "rolled up" to a summary level. Data can be aggregated in many different ways. Data are often aggregated by geography like zip code or by some characteristic like race/ethnicity or age group.

AISP: acronym for "Actionable Intelligence for Social Policy." AISP is an initiative housed at the University of Pennsylvania that focuses specifically "on the development, use, and innovation of integrated data systems (IDS) for policy analysis and program reform" and not community data in general. See Integrated Data Systems.

Average: the average describes the typical value in a set of values and is calculated as the sum of the values divided by the number of values. It is important to look at the individual values when interpreting because an average can be influenced (skewed) by extreme high or low values in the dataset. The average and Mean are the same thing.

B

Big data: the term is generally intended to mean datasets that are so large or complex that they can't be handled – managed, analyzed, stored, transferred – using traditional data tools. Big data typically means petabytes of data (1,024 terabytes, where a terabyte is 1,024 gigabytes [GB]) or exabytes (1,024 petabytes) of data. By definition, any data that can be worked with using Excel, Filemaker, Access, or a similar tool is not big data. "Big data" is often misused as a buzzword synonymous to data or analytics.

C

(Student) chronic absenteeism: specific measure of how much school a student misses for any reason. A student is considered chronically absent if they have missed more than 10% of enrolled school days.

CIC: acronym for "Community Indicators Consortium." CIC is an organization that offers resources and tools to help communities and practitioners advance the practice and effective use of community indicators to improve quality of life. CIC focuses specifically on community indicators rather than on community data and information systems in general.

Cohort: group that shares a defining characteristic.

Comorbidity: two or more disorders or illnesses occurring in the same person.

Crude rate: total number of cases or events in a specific time period and geography divided by the total population in that time period and geography. See Rate, Age-adjusted rate, and Age-specific rate.

D

Dashboard: a high-level graphic report that provides a summary of related data. "Dashboard" is often misused as a buzzword synonymous with all data visualizations.

Data: broad concept that generally means a collection of values or pieces of information. Among other characteristics, data may be quantitative (numerical) or qualitative (non-numerical, like words or images), raw or processed, record-level or aggregated (grouped), and primary (collected/created for the purpose of answering a question) or secondary (created for some other purpose). "Data" and "indicators" are not the same thing; indicators are calculated from data.

Demography: the study of population dynamics including size, structure, distribution, and how populations change over time due to births, deaths, migration, and aging.

Denominator: number below the line in a common fraction.

E

Ethnicity: classification of a population based on cultural characteristics such as religion, traditions, language, or national origin. Ethnicity is a different concept from Race and is not determined by biology.

Extant data: see Secondary data.

F

Fertility rate: specific rate measuring total number of live births per 1,000 women of reproductive age defined as 15-44 years. See Rate.

H

Health information exchange (HIE): in general, refers to the electronic transfer of health-related information among organizations. The term is commonly used to describe the central database of health-related information as well as the organization that assembles and manages that data.

High school graduation rate: specific rate measuring number of students from a cohort of 9th graders having graduated from high school by their anticipated graduation date per 100 students in the same 9th grade cohort. The cohort includes students who enroll during the second, third, and fourth years. See Cohort and Rate.

I

ICD-10: acronym for "International Classification of Diseases, 10th edition". A system for classifying diseases and injuries developed by the World Health Organization (WHO) and used worldwide to improve comparability of cause of death statistics reported from different countries.

Indicator: general term for a thing that tells us the state or level of something. "Four-year graduation rate" tells us something about how well kids in a high school do and "temperature" tells us something about how hot or cold it is. An indicator isn't necessarily a good indicator. Often used interchangeably with measure. "Indicator" is not synonymous with "data;" indicators are calculated from data.

Integrated data system (IDS): links records across datasets, usually from schools and other human service agencies, using a common identifier to assemble a more complete data "picture" of individual people and/or groups of people like families. Can vary widely in purpose, topic, size, and functionality.

L

Life expectancy (at birth): the average number of years a newborn is expected to live based upon the mortality patterns for the geographic area at the time of birth.

M

Margin of error: when we can't measure all of something, like people in a city, we sample them – measure only some to get an idea (estimate) of what's true for everyone. Sampling introduces error and uncertainty, and the margin of error – for example, "plus or minus three percentage points" – is a measure of how much uncertainty there is. The smaller the sample in relation to the total population, generally, the larger the margin of error.

Mean: see Average.

Median: value in an ordered set of values above and below which there are an equal number of values. This can also be referred to as the 50th percentile.

Mode: most common or most frequent value in a set of values.

Morbidity: can refer to having a disease or a symptom of disease. See Comorbidity. Or, to the amount of disease within a population often expressed as a morbidity rate. See Rate.

Mortality: refers to deaths.

N

Natality: refers to births.

NNIP: acronym for "National Neighborhood Indicators Partnership." NNIP is "a collaborative effort by the Urban Institute and local partners to further the development and use of neighborhood information systems in local policymaking and community building."

Numerator: number above the line in a common fraction.

O

Open data: defined by the Open Knowledge International as data that anyone is "free to use, reuse, and redistribute – subject only, at most, to the requirement to attribute and/or share-alike."

P

p-value: calculated probability that what is being observed in the data has happened by chance. Generally, if the p-value associated with an observation is less than .05 the observation is accepted as statistically significant. A p-value less than .05 indicates a less than 5% chance that what is being observed happened by chance or a more than 95% certainty that chance alone cannot explain the observation. See Statistical significance.

Percent increase/decrease: one way of describing the difference between your current measurement and a past measurement, relating it to the past measurement. The percent change is the difference between the two values, divided by the past value, and it's usually phrased like "percent decrease from prior year" or "percent increase over prior year." For example, if the percent of the population that smokes cigarettes decreased from 19% in 2014 to 17% in 2015, you'd have a 10.5% (percent) decrease, because the difference between 19 and 17 is two, and two divided by 19 is 10.5%.

Percentage point increase/decrease: one way of describing the difference between your current measurement and a past measurement, without relating the change to the past measurement. It's just the difference between the two values, and it's usually phrased as "decrease of X percentage points." If the percent of the population that smokes cigarettes decreased from 19% in 2014 to 17% in 2015, you'd have a two percentage point decrease, because the difference between 19 and 17 is two.

Population: people in a given area.

Proportion: specific type of ratio in which the denominator always includes the numerator. See Ratio.

R

Race: a classification of a population based on biological characteristics.

Range: the difference between the lowest and highest values in a set of values calculated by subtracting the lowest value from the highest.

Rate: the number of cases or events in a specified period of time and geography divided by the population who could have experienced – were "at risk" for – the case or event within that same period of time and geography. Rates are often multiplied by a factor of 1,000, 10,000, or 100,000 just to make the numbers easier to read. (A percentage is just a rate multiplied by a factor of 100.) As an example, the male juvenile arrest [case/event] rate in the US [geography] in 2015 [time] was 3,806.2 [frequency] per 100,000 [multiplier] males age 10-17 [population "at risk" of the case/event].

Ratio: relation of one population subgroup to another subgroup, or to the whole population.

Residence data: data attributed geographically to the usual place of residence without regard to the location the event occurred. For example, births are attributed to the mother's usual residence even if the birth occurred in a different geographic location.

S

Secondary data: existing data that has already been collected by someone else, likely for some purpose different from yours. Two common kinds of secondary data are survey data and administrative data. Also called extant data.

Statistical cut-off: date by which records of vital events for a specific year must be received in order to be included in the statistical analyses for that year.

Statistical significance: likelihood that what is being observed in the data has happened by chance. The more statistically significant an observation is, the less likely it occurred by chance. See p-value.

V

Vital statistics: data on important life events, such as births, deaths, marriages, and migrations.

Y

Years of potential life lost (YPLL75): measure of premature death for a population. YPLL75 is the sum of all the years of life "lost" by individuals in that population who died before age 75. A person who died at age 60 would contribute 15 years to the population's YPLL, a person who died at age 48 would contribute 27 years, and a person who died at 75 or older would contribute zero. The YPLL75 is often reported as a rate. See Rate.

QUANTITATIVE CONTENT AND SOURCES

This assessment contains quantitative data on approximately 150 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. The list of indicators was finalized in February 2022.

The 2019 Bexar County and Atascosa County Community Health Needs Assessment included an extensive list of indicators selected through a consensus process by the broad-based Community Health Needs Assessment Steering Committee. Those indicators covered health outcomes, health behaviors, and "upstream" social, economic, and environmental conditions that affect health.

To make the best use of budget and a shortened timeline, that list was narrowed somewhat for 2022 to prioritize health outcome indicators, and social determinant indicators that were not already better-addressed in some other very recent local report. (References to those other reports are embedded throughout the 2022 assessment.) Indicators for which no new data is available since the 2019 report were eliminated. Some 2019 healthcare access and utilization indicators were cut because they will be covered in much greater detail in a separate report expected to be released in early 2023.

Each indicator source is cited throughout the assessment. The 2019 Assessment draws from too many data sources to list here, but the following sources were used heavily.

- Population and housing data from the U.S. Census Bureau Census 2010 Summary File 1

- Population estimates and projections from the Texas State Demographic Center at the University of Texas at San Antonio

- Physical, social, and economic conditions data from the U.S. Census Bureau American Community Survey One-Year Estimates, Five-Year Estimates, and Supplemental Estimates

- Crime data from the U.S. Department of Justice Uniform Crime Report

- Behavioral Risk Factor Surveillance System (BRFSS), vital statistics, injury, blood lead, hospital discharge, hospital bed, and health professions data from the Texas Department of State Health Services Texas Health Data query system and by special request

- Medicaid and public benefits data from the Texas Health and Human Services Commission

- Mortality data from the CDC WONDER query system

- Motor vehicle crash data from the Texas Department of Transportation

- Communicable disease and vital statistics data from the Texas Department of State Health Services

Staff from these and many other local and state organizations spent considerable time and effort pulling data for the 2022 Assessment and sharing important context and cautions for that data. The Health Collaborative and CI:Now are indebted to these individuals and the agencies who allowed them to share their time and expertise.

QUANTITATIVE ANALYSIS AND LIMITATIONS

Analysis of the data typically consisted of calculating proportions and rates, with margins of error or confidence intervals where appropriate; no statistical testing was required. Margins of error and confidence intervals are displayed throughout the assessment. Margins of error were minimized where feasible by combining multiple years of data. Some indicators are examined geographically by eight sub-county sectors based on Zip Code Tract Areas (ZCTAs), as zip code is a common variable across many local and state datasets. A sector map and ZCTA crosswalk appears in Appendix D. These sectors were developed for the 2013 assessment in response to the problem of small sample sizes, particularly regarding the BRFSS dataset. CI:Now used a non-statistical process to group adjacent ZCTAs with median household incomes (from Census American Community Survey five-year estimates) more similar than not, and with the aim of having a sufficiently large and similar total population size for each sector. The final groupings also considered our own local understanding of our "parts of town" as reflected in the commonly used divisions of north-, south-, east-, and westside. This process was performed again in 2018 and did not indicate any need for changes. Thus, while not ideal, the sector groupings were retained for this assessment.

HOSPITALIZATION TECHNICAL NOTES

We call them hospitalization rates for short, but these indicators reflect hospital discharges, not admissions. The hospital discharge data was downloaded from the Texas Department of State Health Services and the ICD codes that were used for the analysis are listed below.

There are some important limitations to understand with hospital discharge data. The rates are determined by hospitalizations for the disease as the primary diagnosis, not all hospital discharges with that diagnosis. In the case of the asthma hospitalization rate, for example, the intent is to reflect the rate of hospitalizations for an asthma attack, not hospitalizations for heart attacks or car accidents among people who also happen to have diagnosed asthma unrelated to the reason for the hospitalization. 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.

International classification of diseases (ICD-10 codes) used in analysis were selected based on the following methodologies and sources.

Disease	Source
Asthma	J45 per San Antonio Metropolitan Health District
Diabetes long term	https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/ V2018/TechSpecs/PQI_03_Diabetes_Long-term_Complications_ Admission_Rate.pdf
Uncontrolled diabetes	https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/ V2018/TechSpecs/PQI_14_Uncontrolled_Diabetes_Admission_ Rate. pdf
Hypertension	https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/ V2018/TechSpecs/PQI_07_Hypertension_Admission_Rate.pdf
Cerebrovascular diseases	https://wonder.cdc.gov/ucd-icd10.html
Heart failure admission rate	https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/ V2018/TechSpecs/PQI_08_Heart_Failure_Admission_Rate.pdf

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM TECHNICAL NOTES

From the CDC User Guide: The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project between all 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. In 2017, an optional module was included to provide a measure for several childhood health and wellness indicators, including asthma prevalence for people aged 17 years or younger.

The BRFSS sample 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 2018-2020 and the supplemental questions were either asked in odd years (2015, 2017, 2019) or in even years (2016, 2018, 2020). The tables are all labeled as 2015-2020 and 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 and are statistically unreliable. The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying the result by 100 in order to express it as a percentage. The asterisk (*) may also denote cases with a small sample where we are unable to calculate a RSE.

QUALITATIVE CONTENT AND SOURCES

With substantial input as to focus group goals and potential participants from the CHNA Steering Committee, volunteer focus group participants were selected with an eye toward engaging meaningful and substantive input from medically underserved, low-income, and minority populations. The focus group questions were developed by the Health Collaborative, the CHNA Steering Committee, and the UT Health Houston School of Public Health in San Antonio. The Health Collaborative scheduled five focus groups and six key informant interviews with the help of its partnering agencies: The Mexican American Unity Council; The Razakaar Foundation with interpreter support from Shukriya Hotakay; The House of Neighborly Service; Harper's Chapel Ministries; Meadows Mental Health Policy; San Antonio Area Foundation; Alamo Workforce Solutions; San Antonio Metropolitan Health District; The City of San Antonio; and Southside Independent School District. UTHealth facilitated and recorded the interviews. The interview questions were developed by UTHealth School of Public Health, the Health Collaborative, and the CHNA Steering Committee.

QUALITATIVE ANALYSIS AND LIMITATIONS

The Health Collaborative led and recorded the focus groups. CI:Now then took the audio and transcript files from the focus groups and interviews to perform a thematic analysis using a grounded theory approach2. The qualitative analysis program Dedoose was used for open coding of the data, axial coding to identify categories between and across the data, and selective coding to identify the final themes.

As with the quantitative information, this qualitative information has limitations. The focus groups and interviews conducted for this assessment provide valuable insight into the realities of our community members but do not serve to represent the opinions of the entire population. Because the goal was to explore the priority issues in depth rather than cast a broad but shallow net, likely not all issues important to residents or key informants were mentioned. Finally, the data were collected at one point in time and therefore findings, while directional and descriptive, should not be interpreted as definitive.

ASSESSMENT STAFFING AND PARTICIPANTS

The 2022 Atascosa County Community Health Needs Assessment was conducted by The Health Collaborative, a nonprofit network of citizens, community organizations and businesses working together to solve critical community health problems. The Health Collaborative's membership is composed of a wide array of organizations including Appdiction Studios, the Baptist Health System, Bexar County Department of Community Resources, CHRISTUS Santa Rosa Health System, the City of San Antonio Metropolitan Health District, Community First Health Plans, Interlex Communications, Methodist Healthcare Ministries of South Texas Inc., Methodist Healthcare System, Our Lady of the Lake University, San Antonio Clubhouse, University Health System, the University of the Incarnate Word, the UT Health Science Center at San Antonio Dept. of

Family & Community Medicine, the YMCA, and community members at large. Nearly all these organizations provide health care, human services, education, or peer support to those medically underserved, low-income, and minority populations. Of those that do not, all represent the general community; the faith-based community; and small, veteran-, or minority-owned business.

The Health Collaborative's volunteer Community Health Needs Assessment (CHNA) Steering Committee provided direction on general approach, scope, potential data sources, data interpretation and highlights, and media messaging. A list of CHNA Steering Committee members with organizational affiliation appears on the inside back cover of this assessment.

The Health Collaborative contracted with Community Information Now (CI:Now), a nonprofit local data intermediary serving south central Texas, for quantitative data collection and analysis, qualitative data analysis, and development of the assessment narrative. The Health Collaborative staff handled all recruitment, scheduling, and moderating of the focus groups and key information interviews. Qualitative analysis was conducted by CI:Now using a grounded theory thematic analysis in the program Dedoose.

APPENDIX D: REFERENCE MAP OF ZIP CODES

APPENDIX E: TABLE OF FIGURES

SECTION 2: ACCESS TO CARE, PREVENTIVE CARE AND HEALTHY BEHAVIORS

SECTION 4: DEATH

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THE 2022 BEXAR COUNTY AND ATASCOSA COMMUNITY HEALTH NEEDS ASSESSMENT IS PRESENTED AS A GIFT TO THE COMMUNITY BY THE BOARD OF DIRECTORS OF THE:

Health Collaborative
Bexar County's Community Health Leadership

Community Members

Stephen K. Blanchard

Charles L. Kight

Pilar Oates

The Health Collaborative began informally in 1997 when "an Antonio's major healthcare organizations agreed to put aside their competitive business practices to conduct a comprehensive health needs assessment. The evolution in 2000 to an incorporated entity with a long-range strategic plan was in response to the founding members' interest in improving the health status of the community by working together.

The Health Collaborative has developed into a powerful network of citizens, community organizations and businesses. The result is a more robust, less duplicative, more synergistic approach to solving critical community health needs, while efficiently utilizing resources.

For more information about The Health Collaborative, its programs and initiatives, please contact Elizabeth Lutz, Executive Director :

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