

# **Community Health Needs Assessment:**

## **A Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas**

**Prepared by:**

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Angelo State University**

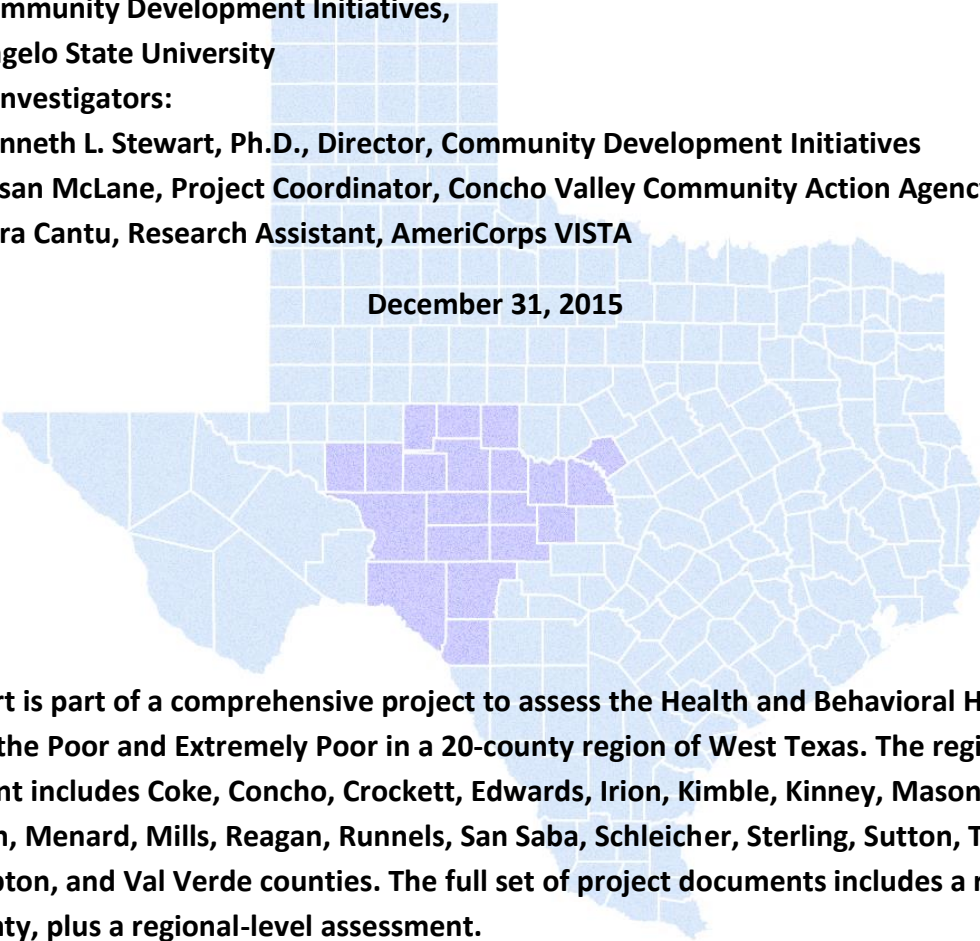
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**This report is part of a comprehensive project to assess the Health and Behavioral Health Needs of the Poor and Extremely Poor in a 20-county region of West Texas. The regional assessment includes Coke, Concho, Crockett, Edwards, Irion, Kimble, Kinney, Mason, McCulloch, Menard, Mills, Reagan, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Upton, and Val Verde counties. The full set of project documents includes a report for each county, plus a regional-level assessment.**

**Methodist Healthcare Ministries of South Texas and the San Angelo Health Foundation provided support for this Community Health Needs Assessment for the people of West Texas.**

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## ACKNOWLEDGMENTS

Community Development Initiatives at Angelo State University led the research effort for the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas. The comprehensive project to study the Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas is the product of collaboration among Community Development Initiatives, the Concho Valley Community Action Agency, and many community champions and stakeholders of the twenty-counties in the study region.

The purpose of the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor is to identify and prioritize health needs of the more than 39,000 people in poverty and 14,000 extremely poor individuals living in a twenty-county area covered by the project. The Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor is a vital part of the comprehensive regional assessment.

In conducting the research, Community Development Initiatives was guided by a six-member community research advisory group including:

- Mark Bethune, Concho Valley Community Action Agency
- Tim Davenport-Herbst, St. Paul Presbyterian Church of San Angelo
- Dusty McCoy, West Texas Counseling & Guidance
- Susan McLane, Concho Valley Community Action Agency
- Sue Mims, West Texas Opportunities & Solutions
- Kenneth L. Stewart, Community Development Initiatives

The generous support of Methodist Healthcare Ministries of South Texas and the San Angelo Health Foundation made the comprehensive regional project and this Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas possible.

In addition, the research team of principal investigators and the members of the community research advisory group appreciate the generosity of HEB and the Concho Valley Transit District for providing us hundreds of gift cards and bus passes worth \$10 each to give to survey respondents to thank them for their participation.

Numerous community-based organizations in West Texas embraced the purpose of conducting the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor. Their level of engagement with the research team was truly inspiring. We are grateful to the following 72 organizations for their collaboration with Community Development Initiatives in conducting the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas.

First United Methodist Church of Bronte	First United Methodist Church of Robert Lee
Concho County Hospital	Ozona United Methodist Church
City of Rocksprings	Irion Food Pantry
First United Methodist Church of Mertzon	Junction First UMC Food Bank
Junction Head Start	Junction Independent School District
City of Brackettville, Mayor	First United Methodist Church of Brackettville
Community Council of South Central Texas	Committee of Senior Citizens, Brackettville
Hope Outreach, Brackettville	Mason First United Methodist Church
Mason Food Pantry	Brady First Baptist Church Food Pantry
Hope House Food Bank, FUMC of Menard	Menard Community Center
Mills Food Bank	Ballinger Housing Authority
Central Texas Opportunities	Samaritan's House, Winters
First Presbyterian Church of Ballinger	San Saba Food Bank
Hill Country Community Action Agency	Eldorado Head Start
Schleicher County Resource Center	Eldorado Housing Authority
Sterling County	Sonora Medical Clinic
Sutton County Food Pantry	West Texas Area Health Education Center
Concho Valley Alcohol & Drug Abuse Council	Angelo State University
Bethel United Methodist Church, San Angelo	Christians in Action, San Angelo
Concho Valley 211	Esperanza Health & Dental Centers, San Angelo
Concho Valley Community Action Agency	Loaves & Fishes Food Pantry, Grape Creek UMC
Lakeview United Methodist Church, San Angelo	Maximus Inc.
Concho Valley MHMR	North Concho Valley Pantry
Our Daily Bread, San Angelo Wesley Trinity UMC	Rust Street Ministries, San Angelo
Morning Glories, First UMC, San Angelo	Shannon Medical Center
Sierra Vista United Methodist Church, San Angelo	St. Luke United Methodist Church, San Angelo
St. Paul Presbyterian Church, San Angelo	West Texas Counseling & Guidance
Concho Valley Workforce Solutions	San Angelo Homeless Coalition
West Texas Opportunities & Solutions	Salvation Army, San Angelo
San Angelo Coalition Against Violence	Kids Eat Free, San Angelo
Concho Valley Council of Governments	San Angelo Public Housing Authority
Rankin Food Pantry	First United Methodist Church of Del Rio
Department of Public Health, Del Rio	Laughlin AFB Family Advocacy Outreach
Val Verde Regional Medical Center	United Medical Centers
Del Rio United Methodist Women's Group	Quad Counties Council on Alcohol & Drug Abuse
Val Verde Health Department	Wesley Nurses

## **EXECUTIVE SUMMARY**

This project is the product of collaboration among Community Development Initiatives, the Concho Valley Community Action Agency, and many community champions and stakeholders in the study region. The purpose of the community-based needs assessment is to identify and prioritize health needs of the more than 39,000 people in poverty and 14,000 extremely poor individuals living in a twenty-county area covered by the project.

Between April and September 2015, Angelo State University's Community Development Initiatives and 72 community-based organizations collaborated to complete detailed interviews with poor and extremely poor residents of the 20 counties in the study region. A total of 597 interviews were completed. Analysis of the data identified 19 community health needs across the counties in the region. Facilitated by a prioritization instrument from November 13 to December 14, 2015, key informants and stakeholders prioritized needs within each category below in the following order:

### **Prioritization of Access Needs**

- Increasing outreach to vulnerable groups to reduce cost and other barriers to treatment.
- Reducing cost and other barriers to behavioral health services.
- Increasing the availability of nutritious foods.
- Increasing access to affordable housing in safe neighborhoods.
- Access to quality dental care.

### **Prioritization of Chronic Disease Needs**

- Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce mortality from complications arising from diabetes.
- Develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including hospital admissions arising from diabetes.
- Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce mortality from heart disease, cerebrovascular disease, and cardiovascular disease.
- Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce mortality from COPD.

- Develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including hospital admissions arising from congestive heart failure.
- Develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including hospital admissions arising from COPD.

### **Prioritization of Behavioral Health Needs**

- Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to reduce obesity.
- Increase capacity and access for the poor and other vulnerable groups by providing quality behavioral health resources for prevention and treatment of alcohol and drug abuse.
- Increase capacity and access for the poor and other vulnerable groups by providing quality behavioral health resources for prevention and treatment for depression.
- Increase capacity and access for the poor and other vulnerable groups by providing quality behavioral health resources for smoking and tobacco cessation.

### **Prioritization of Community Actions to Address Health Needs**

- Increase capacity to address health needs of growing numbers of seniors and children.
- Develop collaborative community efforts to increase investment in community health needs. Consider solutions for expanding quality coverage of the uninsured, coordinated funding and development of proposals or campaigns, coordinated organizational and agency strategic planning, and other collaborative community capacity building approaches.
- Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to provide education to promote healthy living and wellness.
- Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to improve case management and routine preventative screenings.

### **Recommendations**

The research team offers the following recommendations for action toward solutions with immense respect and gratitude toward the communities we studied in West Texas and the organizations that supported the project:

### *Recommendations for Stakeholders*

- Form Community Collaborations.
- Focus on the Health and Behavioral Health Need(s) the Collaboration is Able to Address.
- Identify or Establish Leadership Organizations.
- Consider the Full Potential as well as the Limitations of the Collaboration.

### *Recommendations for Funding Organizations*

- Create a Forum for Policymakers, Funding Organizations, and Regional Stakeholders.
- Incentivize Collaborating Coalitions of Organizations to Address the Health and Behavioral Health Needs of the Poor and Other Vulnerable Groups.
- Adopt and Promote a Long-Term, Socially Responsible Community Investment Perspective and Culture.

The research team developed the following products as a result of the needs assessment:<sup>1</sup>

1. Community Health Asset Maps:  
Maps that inventory the hospitals, clinics, pharmacies, nursing homes, mental health facilities, and other resources of the region. Additional thematic maps depict ratios of population to key health professionals in the region.
2. County Health Profiles:  
A health profile for each of the 20 counties in the study region including publically available secondary data (demographic features, health and mental health care resources, utilization patterns, and morbidity and mortality rates), the results of a sub-regional sample of responses from the Survey of Poor and Extremely Poor, and identification and prioritization of health and behavioral health issues in the profile county.
3. Comprehensive Report:  
A comprehensive regional-level assessment and most detailed analysis of the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas.

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<sup>1</sup> Publically available online on the project website, see Community Health Needs Assessment of the Poor and Extremely Poor in West Texas: <http://www.angelo.edu/faculty/ljones/Community%20Health/>.

## INTRODUCTION

The Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas employed a collaborative community-based approach to evaluate the health status and situation of the vulnerable poor population in the study region. A prior stage of the comprehensive project developed a set of health profiles focused on each county in the region. Each county profile includes:

1. A demographic overview featuring the vulnerable groups in the population. The profile integrates publicly available secondary demographic data.
2. A health status profile of community health and mental health care resources, utilization patterns, and morbidity and mortality rates.
3. Results of a sub-regional sample of responses from the survey of poor and extremely poor residents of the profile county as well as selected nearby counties.
4. Identification and prioritization of health and behavioral health issues in the profile county.

Another product of the prior project stage was development of a set of online community health asset maps. The maps inventory the hospitals, clinics, pharmacies, nursing homes, mental health facilities, and other resources of the region. Additional thematic maps depict ratios of population to key health professionals in the region. The county health profiles and the community health asset maps are publicly available at the project website.<sup>2</sup>

This report complements the products of the prior project stage by providing the comprehensive and most detailed analysis of the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas.

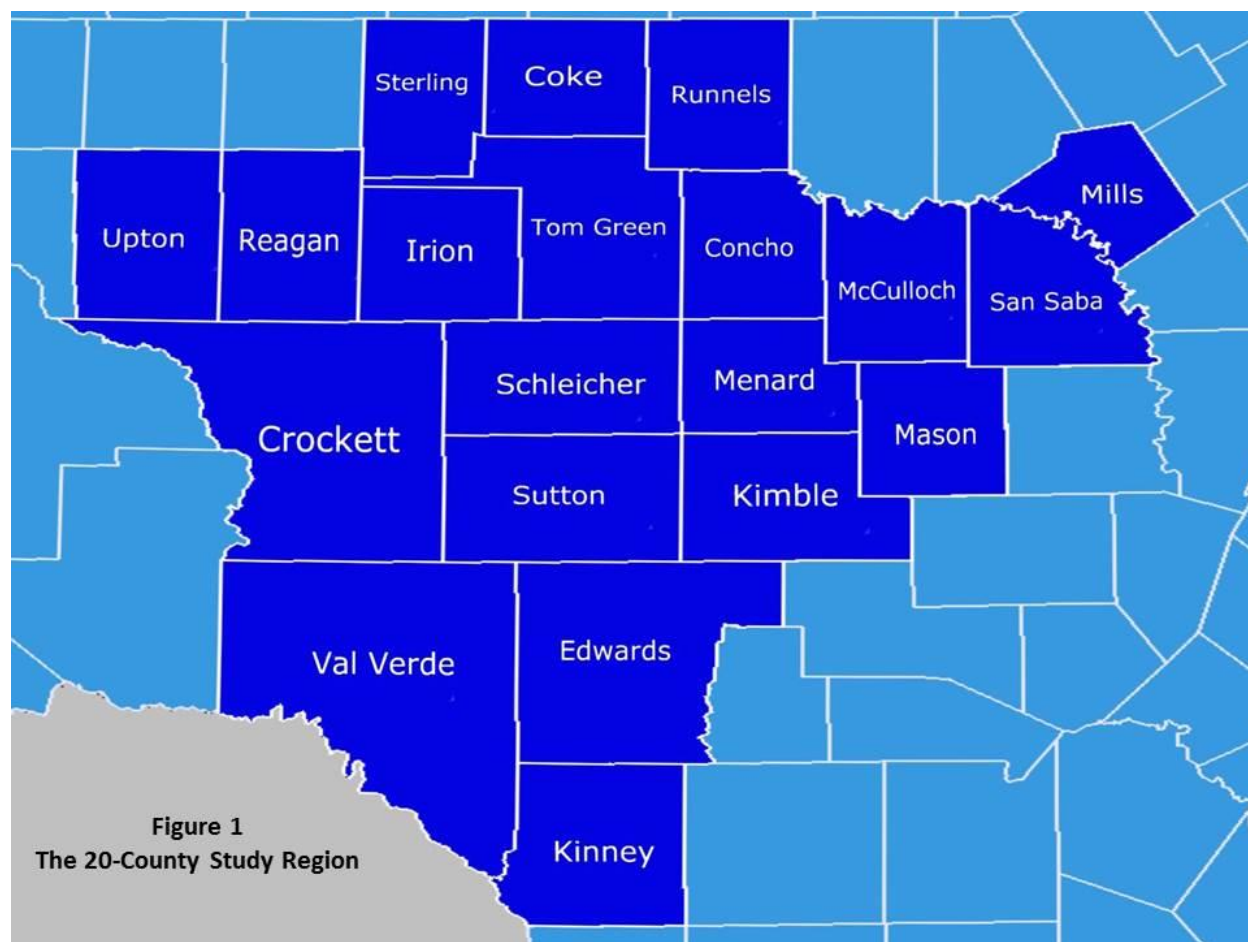
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<sup>2</sup> See Community Health Needs Assessment of the Poor and Extremely Poor in West Texas: <http://www.angelo.edu/faculty/ljones/Community%20Health/>.



## DEMOGRAPHIC DESCRIPTION OF THE 20-COUNTY STUDY REGION

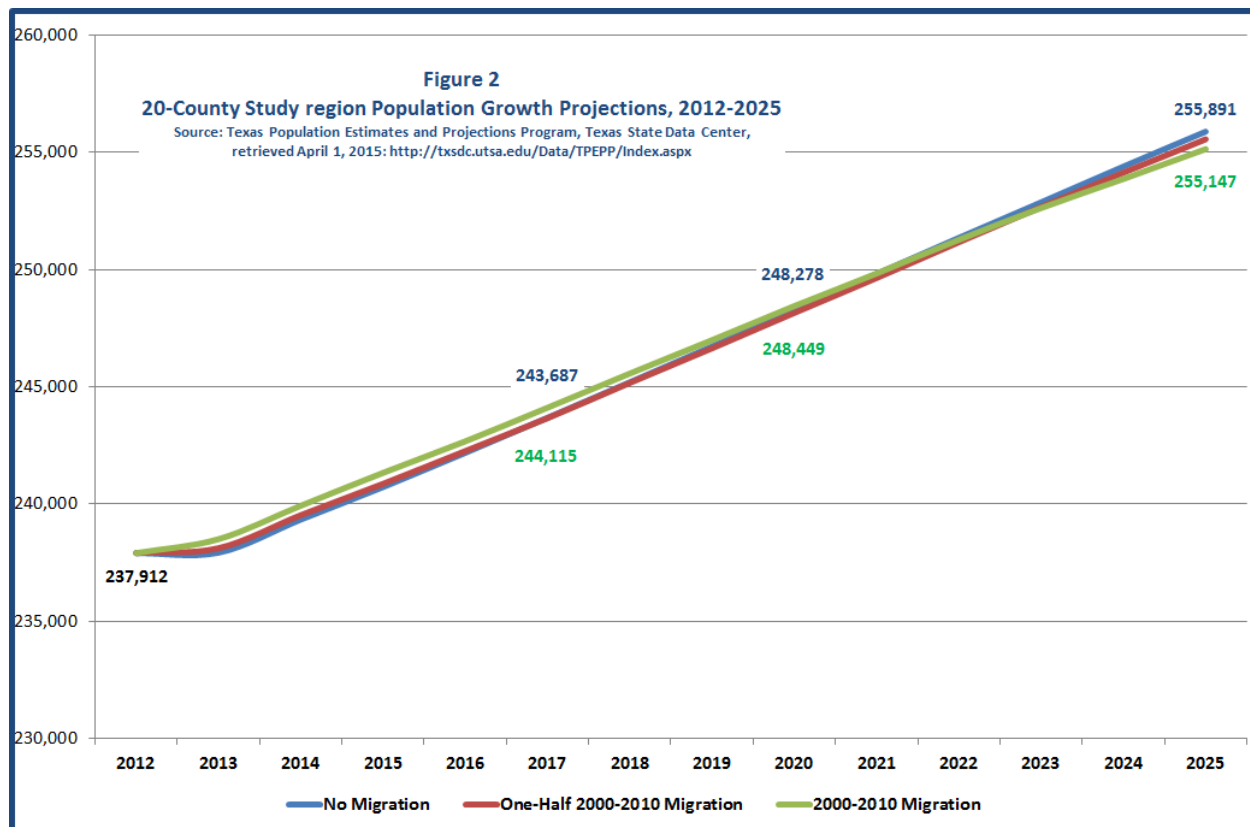
The survey was conducted between April and September of 2015 in communities covering 20 counties in a 27,084 square mile land area encompassing the majority of the Edwards Plateau region of West Texas. The 20 counties of the region include Coke, Concho, Crockett, Edwards, Irion, Kimble, Kinney, Mason, McCulloch, Menard, Mills, Reagan, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Upton, and Val Verde (see Figure 1).



The Texas State Demographer's 2012 Population Estimates fix the region's population at 237,912. In addition, the State Demographer developed three Population Projections based on varying assumptions about migration in years ahead. Figure 2 depicts current projections for the study region through 2025.

The highest growth projection (blue line) anticipates the county will reach 255,891 residents in 2025. The projection foresees little or no net gain of population as a result of migration of people moving into and out of the region. However, it forecasts a significant shift in the composition of the population. The number of White, non-Hispanic residents is expected to

decline by about three percent from between 2012 and 2025. In contrast, the forecast sees a 19 percent increase of Hispanic population. The State Demographer’s projections portend a region that will join other parts of Texas with a majority Hispanic population by 2025.



The Census Bureau’s 2009-2013 5-Year American Community Survey data approximates that 39,528 residents of the 20-county study region are living below the federal poverty level. Moreover, the Census Bureau data indicates that some 14,743 or 37.3 percent of these residents are extremely poor with incomes less than half the poverty level.<sup>3</sup>

<sup>3</sup> Table “C17002: RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS,” 2009-2013 American Community Survey 5-Year Estimates, US Census Bureau, retrieved January 14, 2015: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

## SURVEY METHODOLOGY

Between April and September 2015, Angelo State University's Community Development Initiatives and 72 community-based organizations collaborated to complete detailed interviews with poor and extremely poor residents of the 20 counties in the study region. A total of 597 interviews were completed.

### The Interview Questionnaire

Community Development Initiatives worked with the six-member research advisory group (see p. i) to begin the project by developing the interview questionnaire. The result was a 32 item instrument that functioned to screen prospective respondents for participation in the survey while measuring 178 variables. The questionnaire, included in Appendix A, covered the following general topics:

- Subject's demographic characteristics
- Medical, dental, and mental health services access
- Morbidity experiences
- Obesity and related factors
- Mental health and substance use
- Immunization and preventative health screening

The focus of the survey of poor and extremely poor residents required screening prospective respondents to qualify them for participation. This was achieved at the beginning of interview sessions by asking three key demographic questions: county of residence, household size, and household income. Prospective subjects were qualified for participation in the remainder of the survey if they resided in a study region county and their self-reported monthly household income fell below the 2015 US Department of Health and Human Services Poverty Guideline for a household of the indicated size.<sup>4</sup>

The Behavioral Risk Factor Surveillance System (BRFSS) surveys, conducted with adults age 18 and over by state health departments in partnership with the Centers for Disease Control and Prevention (CDC), served as the model for many questions in the survey.<sup>5</sup> The interview

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<sup>4</sup> See the Annual Update of the HHS Poverty Guidelines, 2015 Poverty Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register: <https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines#t-1>. The project divided the official income values by 12 and then rounded to nearest hundred dollars to apply a monthly income guideline to qualify respondents.

<sup>5</sup> BRFSS interviews are conducted by telephone. This project enlisted trained community-based interviewers in a face-to-face informal format. Information on the Texas BRFSS is at <http://www.dshs.state.tx.us/chs/brfss/default.shtm>.

responses yield 31 indicators in parallel with similar items in the 2013 BRFSS for Texas as depicted in Appendix B. The 31 parallel indicators form a cornerstone for the analysis.

## Sampling

Community Development Initiatives created a proportional sampling procedure for the survey that was designed to oversample the extremely poor population of the region. The extremely poor are defined for purposes of the study as the population comprised of individuals living on income less than 50 percent of the poverty threshold based on household size. The sampling procedure was based on population parameters retrieved from the Census Bureau's 2009-2013 American Community Survey 5-Year Estimates.<sup>6</sup> Table 1 details the procedure and outcomes.

The first step in the sampling procedure was to set a robust total sample target for the study region at 600. This target was selected for three reasons. One objective was to ensure a minimum sample target of five to as many of the twenty counties in the study region as possible. Using a sample size of 600 for the study region, as depicted in Table 1, allotted sample targets of five or more to 16 of the 20 counties when the proportional sampling procedure was applied.

A second objective was to ensure a reasonable margin of error for a descriptive study designed to estimate population parameters such as health and behavioral health risk factors. The selected total sample target of 600 is well above the sample size of 384 required to achieve a margin of error of  $\pm .05$  under the probability assumptions associated with simple random sampling.<sup>7</sup>

Feasibility was the final reason for setting the total sample target at 600. The research team estimated that a sample of 600 face-to-face interviews could be achieved given the project timeline, as well as the budget and other available resources.

Table 1 depicts the application of the "Sampling Procedure" and its "Outcomes." The first column reports the Census estimate of extremely poor residents in each county. The second displays each county's proportion of the total 14,743 extremely poor individuals in the study region. The third column sets the county's sample target by multiplying the total sample target of 600 by the percent of the extremely poor. The sample target of 5 for Coke County, for instance, is 600 multiplied by 0.85 percent.

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<sup>6</sup> Table "C17002: RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS," *op. cit.*

<sup>7</sup> See Johnnie Daniel, *Sampling Essentials: Practical Guidelines for Making Sampling Choices* (Los Angeles: Sage, 2012) Chapter 7, pp. 236-253 for a discussion of the assumptions and complications involved in selecting a sample size.

<b>Table 1</b> <b>Proportional Sampling Procedure and Outcomes</b>							
County	Sampling Procedure			Outcomes			
	Under 50 Percent of Poverty Threshold	Percent of Study Region	Sample Target	Sample Respondents	Percent of Sample	Under 50 Percent of Poverty Threshold	Percent of Respondents
Coke	126	0.85%	5	5	0.84%	1	20.0%
Concho	193	1.31%	8	8	1.34%	1	12.5%
Crockett	367	2.49%	15	16	2.68%	8	50.0%
Edwards	113	0.77%	5	5	0.84%	2	40.0%
Irion	71	0.48%	3	3	0.50%	2	66.7%
Kimble	223	1.51%	9	9	1.51%	1	11.1%
Kinney	474	3.22%	19	19	3.18%	5	26.3%
Mason	112	0.76%	5	5	0.84%	3	60.0%
McCulloch	445	3.02%	18	22	3.69%	9	40.9%
Menard	250	1.70%	10	10	1.68%	3	30.0%
Mills	261	1.77%	11	10	1.68%	1	10.0%
Reagan	11	0.07%	0	0	0.00%	0	0.0%
Runnels	915	6.21%	37	37	6.20%	15	40.5%
San Saba	373	2.53%	15	13	2.18%	6	46.2%
Schleicher	476	3.23%	19	19	3.18%	6	31.6%
Sterling	74	0.50%	3	3	0.50%	0	0.0%
Sutton	40	0.27%	2	2	0.34%	0	0.0%
Tom Green	6,837	46.37%	278	275	46.06%	160	58.2%
Upton	314	2.13%	13	12	2.01%	5	41.7%
Val Verde	3,068	20.81%	125	124	20.77%	52	41.9%
Study Region	14,743	100.00%	600	597	100.00%	280	46.9%

“Sample Respondents” under “Outcomes” in Table 1 represents the actual number of completed interviews, and the “Percent of Sample” column gives the proportion of total interviews completed in the respective county. Thus, the five completed interviews in Coke County comprise 0.84 percent of the 597 total interviews for the region.

Comparison of the relevant columns in Table 1 reveals the success of the proportional sampling process. The “Percent of Sample” ratios under “Outcomes” closely correspond to the “Percent of Study Region” proportions under “Sampling Procedure.” This means that the survey succeeded at collecting data in proportion to the representation of the extremely poor population within the respective counties of the study region.

The “Percent of Respondents” column under “Outcomes” compares the “Sample Respondents” with the number of respondents “Under 50 Percent of Poverty Threshold.” This comparison, however, reveals that not all completed interviews were done with extremely poor respondents. Indeed, the respondents who were extremely poor ranged from 66.7 percent in Irion County to zero percent in Reagan, Sterling, and Sutton counties.

Region-wide, nonetheless, 280 or 46.9 percent of all completed interviews were conducted with extremely poor respondents. This compares to the previously noted Census Bureau

estimate that extremely poor individuals make up 37.3 percent of the region's 39,528 people in poverty. This comparison indicates that the survey succeeded by 9.6 percent in oversampling extremely poor respondents.

## Data Collection

The survey employed a community-based data collection process that collaborated with 72 organizations and 145 community contacts across the 20-county region. The project coordinator guided the process.

Community-based organizations collaborated in the data collection process in two different ways. Some organizations provided both venues and trained interviewers to work with respondents completing the survey questionnaire. Others participated by providing one or more interviewers or a venue, but not both.

Of the 72 collaborating organizations, 29 were Social Service Agencies including Faith-Based Service Ministries (15 of 29); 16 were Food & Commodity Programs; 12 were Governmental Public Outreach Organizations; 8 were Health & Mental Health Service Providers; 4 were Educational Organizations; and 3 were Volunteer Associations. Hospitals, clinics, and health or mental health provider organizations were not targeted as venues for interviewing in order to avoid biasing the survey with respondents who clearly had established some level of access.<sup>8</sup>

Community Development Initiatives, under the leadership of the project coordinator, conducted nine interviewer training sessions during April and May of 2015. Sessions included state and federal health privacy regulations and legal obligations; research ethics and confidentiality standards; and hands-on training of the survey instrument. Sixty-four interviewers were trained to qualify prospective respondents and to conduct face-to-face sessions assisting the respondents in completion of the interview questionnaire. Three additional research assistant staff members at Community Development Initiatives were trained for interviewing. The three assistants joined with the project coordinator to conduct 157 (26.3%) of the interviews in 11 sparsely populated counties where no trained interviewers were available. They also added capacity to aid local interviewers in 2 additional counties. The 64 local community-based interviewers completed 440 interviews (73.7%).

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<sup>8</sup> Concho County Hospital provided a venue to interview community members who were not selected from their patient pool. However, United Medical Centers in Del Rio may have used their facility for conducting some interviews which may have introduced minor indeterminate error into the access risks.

## SURVEY FINDINGS AND ANALYSIS

### Comparison of the Sample to the Poverty Population Parameters

Comparison of sample demographics to population parameters to assess the extent to which the sample represents the targeted population is an essential part of analyzing the survey findings. Table 2 compares the sample to the parameters of the poverty population in the study region as depicted from data retrieved from the Census Bureau's 2009-2013 American Community Survey.

The previous section on sampling demonstrated that the survey succeeded in its objective to collect data from the various counties in proportion to the distribution of extremely poor population across the study region. Table 2 confirms that the process also resulted in a proportional sample mirroring the distribution of the overall poverty population in the region.

In addition, Table 2 again confirms the previously mentioned result that the survey intentionally oversampled the extremely poor subset of the poverty population. Indeed, the application of a Chi-Square test to the "Poverty Status" results in Table 2 confirmed that the difference between the percentages of extremely poor individuals in the sample and the population parameter is statistically significant.

A separate Chi-Square test indicates that the survey oversampled females. The "Gender" section depicted in Table 2 produced a statistically significant Chi-Square result.<sup>9</sup> The other sample demographics compared in Table 2 (county of residence, ethnicity, age, years of schooling, and single person and single parent household compositions) are close representations of the poverty population parameters for the study region.<sup>10</sup>

### Access to Health and Wellness Resources

Table 3 compares the three indicators of access to basic community health and wellness resources. The results confirm significantly higher risk levels of encountering access obstacles within the poverty population as represented by the sample compared to BRFSS indicators for the general adult population of the region and state. The 56.8 percent of regional poor residents reporting a cost obstacle to seeing a doctor, for instance, is nearly three times the rate at which the adult populations in the region and state experience this obstacle according to the 2013 BRFSS.

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<sup>9</sup> Chi-Square for Poverty Status = 3.177,  $p$  (1-tail) = 0.04; Chi-square for Gender = 3.603,  $p$  (1-tail) = 0.03.

<sup>10</sup> Inconsistencies in the coding of household types between the Census Bureau and the survey excluded the possibility of comparing the survey's identification of households occupied by couples with children and without children, as well as "other" households, with American Community Survey population parameters.



<b>Table 2</b> <b>Sample Demographics Compared to</b> <b>2009-2013 American Community Survey (ACS)</b> <b>Poverty Population Parameters*</b>			
County of Residence	Sample n	Sample Percent	ACS Percent
Coke	5	0.80%	0.86%
Concho	8	1.30%	1.18%
Crockett	16	2.70%	1.58%
Edwards	5	0.80%	0.96%
Irion	3	0.50%	0.35%
Kimble	9	1.50%	2.21%
Kinney	19	3.20%	2.18%
Mason	5	0.80%	3.44%
McCulloch	22	3.70%	1.39%
Menard	10	1.70%	1.28%
Mills	10	1.70%	1.56%
Runnels	37	6.20%	5.64%
San Saba	13	2.20%	2.10%
Schleicher	19	3.20%	1.89%
Sterling	3	0.50%	0.50%
Sutton	2	0.30%	0.74%
Tom Green	275	46.10%	43.45%
Upton	12	2.00%	1.40%
Val Verde	124	20.80%	26.48%
Poverty Status	Sample n	Sample Percent	ACS Percent
Severely poor	280	46.9%	37.3%
Poor	278	46.6%	62.7%
Gender	Sample n	Sample Percent	ACS Percent
Male	160	26.8%	39.5%
Female	436	73.0%	60.5%
Ethnicity	Sample n	Sample Percent	ACS Percent
Not Hispanic	254	42.5%	44.1%
Hispanic	342	57.3%	55.9%
Age	Sample n	Sample Percent	ACS Percent
18-29	75	12.6%	83.9%
30-39	108	18.1%	
40-49	111	18.6%	
50-64	212	35.5%	
65 & Over	87	14.6%	16.1%
Years of Schooling	Sample n	Sample Percent	ACS Percent**
Less than 12	267	44.7%	40.9%
12 or More	318	53.3%	59.1%
Household Composition	Sample n	Sample Percent	ACS Percent
Single Person	71	11.9%	9.0%
Single Parent	126	21.1%	24.1%
Couples with Children	142	23.8%	***
Couples without Children	114	19.1%	***
Other****	144	24.1%	***
<p>*The total sample size was 597. Some frequencies and percentages reported do not sum to 597 or 100% because of missing data. Poverty Population Parameters were computed by Community Development Initiatives based on data for adults living in poverty from the 2009-2013 American Community Survey 5-Year Estimates, US Census Bureau, retrieved December 1, 2015: <a href="http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml">http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml</a>.</p> <p>**These percentages were computed from ACS data on educational attainment of the population age 25 and over.</p> <p>***The available ACS data is not comparable with the coding of data in the survey for these household composition types.</p> <p>****Other households includes small numbers of respondents living with parents, grandparents living with grandchildren, persons living with extended relatives, and persons living with roommates.</p>			



Similarly, nearly 40 percent of the adult poverty population of the region has no “medical home” in the sense of having someone they view as their personal doctor. This perception is 20 to 30 percent higher in the poverty population than in the study region or state populations.

<b>Table 3</b> <b>Indicators of Access of the Poor and Extremely Poor in West Texas</b> <b>with BRFSS Comparisons</b>					
Risk Indicators	Survey Results: 20 County Study Region*			BRFSS Risk Comparisons**	
	Sample	Population at Risk	Percent at Risk	Study Region Counties	Texas
Could not see a doctor because of cost during past 12 months	597	339	56.8%	20.2%	19.3%
Does not think of anyone as a personal doctor	597	238	39.9%	30.0%	33.1%
Difficult to access fresh fruits & vegetables	597	146	24.5%	9.9%	7.7%
*These columns report the Survey of the Poor & Extremely Poor in West Texas results for the 20-county study region. **These columns include results from the Texas BRFSS conducted by the Texas Department of State Health Services in 2013. The BRFSS estimates reported for the Study Region Counties are adjusted by Community Development Initiatives at Angelo State University to account for the specific demographic characteristics of the counties.					

Also, adults in the poverty population appear to experience difficulties acquiring quality fruit and vegetable dietary staples at a rate that is 2.5 to 3 times higher than the adult populations region-wide and statewide. This observation is consistent with the CDC’s modified retail food environment index (mRFEI) estimates from 2011 indicating that an average of only 7 percent of food retailers in more than 4,300 Texas census tracts are healthy food resources (e.g. supermarkets, large grocery stores, produce stores, or supercenters) with fresh fruits and vegetables, low-fat dairy items, meat products, and whole grain foods. The CDC mRFEI data indicated an average 12 percent of retailers in the 66 census tracts located in the study region were healthy food sources.<sup>11</sup> A further indication of food insecurity is reflected in the fact that 57.3 percent of the survey respondents reported that someone in their household received food assistance such as SNAP or WIC during the past year.

<sup>11</sup> CDC designed the mRFEI to combine the “food desert” and “food swamp” concepts into a single measure. Scores of zero on the mRFEI generally correspond with food deserts. Twenty-five (38%) of the 66 census tracts in the study region scored zero on the mRFEI. Another seven of the tracts had low scores (less than 10) which correspond with food swamps dominated by convenience stores and fast food retailers. See “Census Tract Level State Maps of the Modified Retail Food Environment Index (mRFEI),” Centers for Disease Control and Prevention: [ftp://ftp.cdc.gov/pub/Publications/dnpao/census-tract-level-state-maps-mrfei\\_TAG508.pdf](ftp://ftp.cdc.gov/pub/Publications/dnpao/census-tract-level-state-maps-mrfei_TAG508.pdf). Modified Retail Food Environment Index (mRFEI) data retrieved December 5, 2015: [http://www.cdc.gov/obesity/downloads/2\\_16\\_mrfei\\_data\\_table.xls](http://www.cdc.gov/obesity/downloads/2_16_mrfei_data_table.xls).

Table 4 reports additional survey results revealing variations in access to health and wellness resources by certain demographic elements within the regional poverty population.

There is a key difference between the findings in Table 4 and the previous discussion comparing survey and BRFSS indicators. The results in Table 4 are based only on responses to particular survey items. For instance, the responses of males and females are depicted in the section on respondents who could not see a doctor because of cost, and again in the section on respondents who do not think of anyone as a personal doctor. Readers may notice that the total numbers of men and women represented in the two sections are not the same. The difference results from responses to the particular items; 593 men and women responded on the personal doctor item, but only 415 answered the cost barrier item.

The results in Table 4 depict the following differences in access:

- The vast majority of individuals in poverty who encounter a cost barrier to seeing a doctor are females. However, males in poverty run a slightly higher risk of experiencing this barrier.
- Poor individuals in their thirties, and those in the pre-retirement ages 50-64, have slightly higher risks than other age groups of encountering cost barriers to seeing a doctor.
- Single persons in poverty and couples with or without children experience slightly higher risks of having a cost barrier to seeing a doctor.
- Among individuals in poverty, the severely poor have a significantly higher risk of not having someone to call their personal doctor.
- The majority of individuals in poverty who do not have a personal doctor are females. However, males in poverty run a higher risk of experiencing this barrier.
- Adults in poverty who are under the age of 50, especially those under the age 30, have higher risk of not having someone to call their personal doctor.
- Individuals in poverty who are single persons, as well as couples with children, show higher risk of not having someone to call their personal doctor.
- Individuals in poverty who are single parents or live in “Other” households (such as living with parents, grandchildren, extended relatives, or roommates) are at somewhat higher risk of having difficulty accessing fresh fruits and vegetables.

**Table 4**  
**Indicators of Access of the Poor and Extremely Poor**  
**by Selected Demographic Factors\***

Could not see a doctor because of cost during past 12 months				
Gender	Sample	Sample Percent	At Risk	Percent of at Risk
Male	108	26.0%	96	28.3%
Female	307	74.0%	243	71.7%
Age	Sample	Sample Percent	At Risk	Percent of at Risk
18-29	54	13.0%	46	13.6%
30-39	80	19.3%	71	20.9%
40-49	85	20.5%	69	20.4%
50-64	159	38.4%	134	39.5%
65 & Over	36	8.7%	19	5.6%
Household Composition	Sample	Sample Percent	At Risk	Percent of at Risk
Single Person	48	11.5%	42	12.4%
Single Parent	93	22.4%	71	20.9%
Couples with Children**	110	26.4%	97	28.6%
Couples without Children**	77	18.5%	65	19.2%
Other***	88	21.2%	64	18.9%
Does not think of anyone as a personal doctor				
Poverty Status	Sample	Sample Percent	At Risk	Percent of at Risk
Severely poor	277	50.0%	135	60.5%
Poor	277	50.0%	88	39.5%
Gender	Sample	Sample Percent	At Risk	Percent of at Risk
Male	159	26.8%	79	33.2%
Female	434	73.2%	159	66.8%
Age	Sample	Sample Percent	At Risk	Percent of at Risk
18-29	74	12.5%	45	18.9%
30-39	108	18.3%	59	24.8%
40-49	111	18.8%	48	20.2%
50-64	211	35.8%	75	31.5%
65 & Over	86	14.6%	11	4.6%
Household Composition	Sample	Sample Percent	At Risk	Percent of at Risk
Single Person	71	12.0%	36	15.1%
Single Parent	126	21.2%	48	20.2%
Couples with Children**	141	23.8%	66	27.7%
Couples without Children**	113	19.1%	32	13.4%
Other***	142	23.9%	56	23.5%
Difficult to access fresh fruits & vegetables				
Household Composition	Sample	Sample Percent	At Risk	Percent of at Risk
Single Person	71	12.0%	27	18.5%
Single Parent	126	21.2%	29	19.9%
Couples with Children**	142	23.9%	24	16.4%
Couples without Children**	113	19.1%	24	16.4%
Other***	141	23.8%	42	28.8%

\*Differences depicted for each demographic factor produced statistically significant Chi-Square results at the 0.05 level or lower (2-tail). The sample size was 597. However, frequencies reported may not sum to 597 because of missing data for the selected variables.

\*\*Couples may be married couples or unmarried partners.

\*\*\*Other households includes small numbers of respondents living with their parents, grandparents living with grandchildren, persons living with extended relatives, and persons living with roommates.

Table 5 expands the findings along two dimensions. First, the table reports barriers arising from obstacles other than monetary cost. Secondly, the table includes barriers to providers and services in addition to doctors.

The first row indicates that 69.7 percent of the total survey respondents answered the items on access barriers to doctors. Of the 416 who responded, 81.5 percent indicated cost barriers.<sup>12</sup> In addition, 37.3 percent reported travel obstacles, 15.9 percent said work hours interfered, 7.5 percent reported barriers due to childcare responsibilities, and 9.4 percent said fear or anxiety blocked the way.

Some notable observations from Table 5 include:

- High percentages of respondents who answered access questions indicated cost barriers for all providers and services. The highest percentages indicated cost barriers to see dentists (91.6%) and to purchase prescriptions (90.6%).
- Twenty-five to 40 percent of responses indicated travel barriers to providers and services. The highest indications of travel barriers were for follow-up appointments (39.4%) and getting in to see doctors (37.3%).
- Six to 16 percent of responses identified work hours as barriers. Most frequent was work hours obstructing access to doctors (15.9%) and follow-up appointments (12.2%).
- Childcare responsibilities were pegged as obstacles in four to eight percent of responses. The most frequent indications were childcare blocking access to doctors (7.5%) and rehabilitation or physical therapy services (6.5%).
- Fear and anxiety were identified as obstacles in two to seventeen percent of responses. These feelings were most frequently identified as obstacles to seeing counselors (16.5%) and medical specialists (10.9%).

The high percentages of respondents indicating cost barriers to access reflect the insurance status of the poor residents of the study region. When queried, 278 (47.2%) of 589 respondents to the survey indicated that they lacked coverage by Medicaid, Medicare, or any other form of health insurance. In addition, the majority of survey respondents lacking health insurance were extremely poor (66%); female (71.9%); and Hispanic (57.9%). The uninsured rate for non-elderly survey respondents between the ages of 18 and 64 was 54.6 percent.<sup>13</sup>

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<sup>12</sup> This percentage differs from the previously reported 56.8% in Table 3 because it is based only on the 416 respondents who answered the item. The percentage in Table 3 was based on the total sample size of 597.

<sup>13</sup> This rate is consistent with the Census Bureau's 2013 Small Area Health Insurance Estimates indicating that 51.1 percent of approximately 32,874 residents of the study region between the ages of 18 and 64 are uninsured; data retrieved December 8, 2015: <http://www.census.gov/did/www/sahie/index.html>.

<b>Table 5</b>							
<b>Risk of Encountering Various Barriers to Access of Needed Resources</b>							
<b>Needed Access in Past Year to:</b>	<b>Item Response Rate</b>	<b>Number of Respondents</b>	<b>Percent at Risk of Access Barrier</b>				
			<b>Cost</b>	<b>Travel</b>	<b>Work</b>	<b>Childcare</b>	<b>Fear/Anxiety</b>
Doctor	69.7%	416	81.5%	37.3%	15.9%	7.5%	9.4%
Dentist	68.0%	406	91.6%	26.4%	10.8%	5.4%	7.4%
Specialist	57.1%	341	85.3%	34.0%	9.7%	6.2%	10.9%
Follow-up	59.1%	353	83.0%	39.4%	12.2%	6.2%	4.5%
Prescriptions	57.3%	342	90.6%	24.9%	6.4%	4.1%	1.5%
Rehabilitation	36.3%	217	85.3%	31.3%	7.8%	6.5%	6.0%
Counselor	41.5%	248	81.5%	28.2%	7.3%	5.6%	16.5%

The previously noted high cost barrier to dental care is also confirmed by the survey query on dental insurance status. Of 583 respondents reporting dental coverage status, 525 (90.1%) were uninsured for dental care. Unlike the pattern health insurance coverage, however, both elderly and non-elderly adults lack dental insurance at high rates. Among elderly survey respondents, 81 (94.2%) reported no dental insurance coverage; 89.3 percent of respondents between 18 and 64 did the same.

Notwithstanding the significance of cost barriers experienced by the poor, it is important to keep sight of the other access obstacles. Evidence suggests that individuals in poverty often experience multiple impediments to care, despite the relatively lower risks of travel, work, childcare, or fear/anxiety obstacles compared to cost barriers as depicted in Table 4. For instance, the 416 survey respondents with access barriers to seeing a doctor actually reported 1.5 obstacles per capita. Indeed, the number of barriers per capita reported by the poor, ranged from 1.3 (for access to prescriptions) to 1.5 (for access to doctors, specialists, and follow-up appointments).

Some of the direct consequences of the high obstacles to access health and dental care are evident in the survey results. For instance, 40 percent of 587 survey respondents had not seen a doctor within the past year, and nearly 10 percent had not seen one in more than five years. A more important illustration of the access obstacles to health care is the finding that 56 percent of respondents of 293 respondents over age 50 have never had a colon/rectal exam.

The barriers for access to dental care, moreover, appear to be higher. Only 23 percent of 581 survey respondents said they had seen a dentist in the past year, and 44 percent said they had not seen one in more than 5 years. A similar percentage (44.6%) reported never having dental cleaning or x-rays.

## Morbidity Patterns among the Poor and Severely Poor

The poor and severely poor of West Texas show elevated risk of seven chronic diseases in comparison to BRFSS indicators of diagnosis. Each of the seven chronic diseases is included in the top ten causes of death for study region.<sup>14</sup>

Table 6 lists the seven diseases in order of their level of elevated risk. For instance, 7.2 percent or 43 of the 597 survey respondents reported being diagnosed with kidney disease. This indicates a level of risk that is 3.3 times the 2.2 percent risk estimate for the study region based on the BRFSS. The same comparisons indicate an elevated risk by a factor of 3.0 for COPD; 1.8 for diabetes; 1.4 for heart disease; and 1.3 for stroke, asthma, and for heart attack.

<b>Table 6</b> <b>Elevated Chronic Disease Diagnostic Risks</b> <b>of the Poor and Extremely Poor in West Texas with BRFSS Comparisons</b>					
Risk Indicators	Survey Results: 20 County Study Region*			BRFSS Risk Comparisons**	
	Sample	Population at Risk	Percent at Risk	Study Region Counties	Texas
Diagnosed kidney disease	597	43	7.2%	2.2%	3.1%
Diagnosed COPD (Emphysema, chronic bronchitis)	597	92	15.4%	5.2%	5.4%
Diagnosed diabetes	597	150	25.1%	14.2%	10.9%
Diagnosed heart disease	597	61	10.2%	7.4%	5.7%
Diagnosed stroke	597	33	5.5%	4.2%	2.5%
Diagnosed asthma	597	123	20.6%	15.8%	12.6%
Diagnosed heart attack (myocardial infarction)	597	45	7.5%	5.8%	3.9%
*These columns report the Survey of the Poor & Extremely Poor in West Texas results for the 20-county study region. **These data include results from the Texas BRFSS conducted by the Texas Department of State Health Services in 2013. The BRFSS estimates reported for the Study Region Counties are adjusted by Community Development Initiatives at Angelo State University to account for the specific demographic characteristics of the counties.					

The findings also show that respondents over age 50 ran higher risks of being diagnosed with each of the conditions in Table 6, with the exception of asthma. Non-Hispanics revealed a higher risk of a COPD or asthma diagnosis. Hispanic survey respondents, on the other hand, had

<sup>14</sup> The top cause of death was cancer (malignant neoplasms) with an age-adjusted death rate of 157 per 100,000 population according to Vital Statistics from the 20-county study region for the 2009-2012 time period. This was followed by heart diseases including heart attack (152.3/100,000), chronic lower respiratory diseases including COPD and asthma (46.2/100,000), accidents (40.4/100,000), cerebrovascular diseases including stroke (37.9/100,000), Alzheimer's (28.1/100,000), diabetes (25.2/100,000), kidney diseases including nephritis, nephrotic syndrome and nephrosis (16.4/100,000), influenza and pneumonia (14.9/100,000), and chronic liver disease and cirrhosis (14.5/100,000). Data from the Texas Department of State Health Services, retrieved December 9, 2015: <http://soupfin.tdh.state.tx.us/death10.htm>.

a much higher risk of a diabetes diagnosis, as did respondents with less than 12 years of schooling.<sup>15</sup>

The respondents reported a total of 547 diagnostic incidents in Table 6 (the sum of the Population at Risk column). However, only 298 survey respondents reported these events. Half of these respondents had only one diagnosis among the seven conditions. The other half, 149 respondents, revealed comorbid conditions, and 62 respondents indicated 3 or more comorbid conditions. Table 7 depicts the distribution of comorbidity for the seven chronic diseases among the survey respondents.

<b>Table 7</b> <b>Comorbidity of the Elevated Chronic Disease Diagnostic Risks</b> <b>among the Poor and Extremely Poor in West Texas with BRFSS Comparisons</b>					
Risk Indicators	Population at Risk	Single Diagnosis	Two Conditions	Three or More Conditions	Average
Diagnosed kidney disease	43	18.6%	41.9%	39.5%	1.5
Diagnosed COPD (Emphysema, chronic bronchitis)	92	18.5%	35.9%	45.7%	1.6
Diagnosed diabetes	150	43.3%	26.7%	30.0%	1.1
Diagnosed heart disease	61	8.2%	37.7%	54.2%	1.9
Diagnosed stroke	33	12.1%	27.3%	60.7%	2.1
Diagnosed asthma	123	39.0%	34.1%	26.8%	1.1
Diagnosed heart attack (myocardial infarction)	45	4.4%	20.0%	75.5%	2.4
Total	298	50.0%	29.2%	20.8%	1.8

Table 8 shows these respondents reported a total 398 dyads of the seven chronic diseases. The most frequent combination was COPD and asthma reported 53 times. However, diabetes was the condition occurring most often in the dyads with the other diseases. Diabetes was included in 159 (40%) of the 398 comorbid combinations. It coupled most frequently with COPD and heart disease (33 dyads each).

COPD was included in 144 (36%) of the dyads, followed by 134 (34%) combinations with asthma, 117 (29%) with heart disease, and 108 (27%) with heart attack. Stroke and kidney disease were the least frequent conditions appearing the dyads with 68 (17%) and 66 (17%) combinations respectively.

<sup>15</sup> Each of elevated risks described in this paragraph was statistically significant at the 0.05 level or lower.

<b>Table 8</b> <b>Matrix of Comorbid Dyads of Seven Elevated Risk Chronic Diseases</b> <b>Reported by the Poor and Extremely Poor in West Texas</b>							
Risk Indicators	Kidney disease	COPD	Diabetes	Heart disease	Stroke	Asthma	Heart attack
Kidney disease		14	23	8	6	9	6
COPD	14		33	15	12	53	17
Diabetes	23	33		33	15	32	23
Heart disease	8	15	33		13	16	32
Stroke	6	12	15	13		8	14
Asthma	9	53	32	16	8		16
Heart attack	6	17	23	32	14	16	
Total	66	144	159	117	68	134	108

Respondents diagnosed with the seven chronic diseases demonstrated further comorbid combinations with the additional conditions depicted in Table 9. For instance, 76.9 percent of the 150 respondents with diabetes also reported being told by health professionals that they have high blood pressure; 57 percent said they were diagnosed with high cholesterol; 21 percent were told they had cardiovascular disease; 57.2 indicated they were diagnosed with arthritis; and half were told by a professional that they had depression.

<b>Table 9</b> <b>Correlates of Elevated Disease Diagnostic Risks</b> <b>of the Poor and Extremely Poor in West Texas with BRFSS Comparisons</b>						
Risk Indicators	Population at Risk	High Blood Press	High Cholesterol	Cardiovascular Disease	Arthritis	Depression
Diagnosed kidney disease	43	74.4%	53.5%	20.5%	65.9%	64.3%
Diagnosed COPD (Emphysema, chronic bronchitis)	92	62.6%	44.9%	19.8%	61.4%	62.6%
Diagnosed diabetes	150	76.9%	57.0%	21.0%	57.2%	50.0%
Diagnosed heart disease	61	86.9%	71.9%	69.0%	61.7%	60.0%
Diagnosed stroke	33	72.7%	59.4%	37.5%	63.6%	60.6%
Diagnosed asthma	123	52.1%	30.3%	15.4%	51.6%	56.9%
Diagnosed heart attack (myocardial infarction)	45	73.3%	65.1%	56.8%	63.6%	55.6%
Population at Risk	298	255	159	56	213	247

In summary, morbidity patterns among the poor and severely poor in West Texas highlight the following important observations:

- The poor and severely poor population demonstrates elevated risk compared to BRFSS indicators of being diagnosed with seven fatal chronic diseases that rank in the top 10 causes of death within the 20-county study area.



- Members of the poor population over the age of 50 are more vulnerable to the elevated risks of the seven fatal chronic diseases than younger members of the population.
- Hispanic members of the poor population are more vulnerable to the elevated risk of being diagnosed with diabetes.
- Half of the poor population diagnosed with one of the seven high-risk fatal chronic diseases indicates one or more comorbidities with the other fatal chronic diseases. About one in five is diagnosed with three or more of the conditions.
- Diabetes is the diagnosed condition that occurs most frequently among the poor as a comorbid combination with one or more of the other six high-risk fatal chronic diseases.
- Members of the poor population diagnosed with one or more of the seven high-risk fatal chronic diseases also demonstrate high frequency comorbidities with conditions such as high blood pressure or arthritis. These high frequency correlates include depression, a behavioral health condition.

### **Behavioral Health Risks among the Poor and Severely Poor**

MHMR Services for the Concho Valley served 973 residents of Coke, Concho, Crockett, Irion, Reagan, Runnels, Sutton, and Tom Green counties during 2013. One in five of these (20.6% or 201) residents were diagnosed with depression.<sup>16</sup> Moreover, the consistently high levels of comorbidity between depression and the fatal chronic diseases depicted previously in Table 9 highlight the significance of behavioral factors in the health status of the poverty population in West Texas.

Table 10 compares BRFSS results for the study region and state with the prevalence of depression and five other behavioral health indicators in the survey. The level of diagnosed depression is nearly three times higher in the poverty population compared to the general population of the study region as indicated in the 2013 BRFSS. The rate of obesity is about 36 percent higher, and morbid obesity (BMI greater than or equal to 35) is about double.

Members of the poverty population are nearly twice as likely to smoke or use tobacco products, and the frequency of binge drinking is about 37 percent higher than among the region's general adult population. Moreover, within the poverty population, both of these behavioral factors are significantly correlated to diagnosed depression.<sup>17</sup>

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<sup>16</sup> Computed by Community Development Initiatives from data provided by MHMR Services for the Concho Valley, September 1, 2015.

<sup>17</sup> The Chi-Square test for the association between smoking or tobacco use and diagnosed depression was 26.4 with 3 degrees of freedom and a p-value of 0.00. The test for the association between binge drinking and

<b>Table 10</b> <b>Behavioral Health Risks of the Poor and Extremely Poor in West Texas</b> <b>with BRFSS Comparisons</b>					
Risk Indicators	Survey Results: 20 County Study Region*			BRFSS Risk Comparisons**	
	Sample	Population at Risk	Percent at Risk	Study Region Counties	Texas
Diagnosed depression (major, chronic, minor)	597	247	41.4%	15.1%	16.0%
Obese BMI $\geq 30$	597	267	44.7%	32.9%	30.9%
Morbidly Obese BMI $\geq 35$	597	134	22.4%	11.5%	12.7%
Current smoker	597	216	36.2%	18.7%	15.9%
Current smokeless tobacco user				8.1%	4.3%
Binge drinking	597	122	20.4%	14.9%	16.7%
*These columns report the Survey of the Poor & Extremely Poor in West Texas results for the 20-county study region. **These columns include results from the Texas BRFSS conducted by the Texas Department of State Health Services in 2013. The BRFSS estimates reported for the Study Region Counties are adjusted by Community Development Initiatives at Angelo State University to account for the specific demographic characteristics of the counties.					

Also, the survey reveals that the elevated behavioral risks depicted in Table 10 are significantly involved with the medical condition of the poor in the following additional ways:

- Sixty-one percent of the 150 respondents who were diagnosed with diabetes were also obese or morbidly obese (Chi-Square = 21.83; 2 df;  $p = 0.00$ ).
- Forty-seven percent of the 123 respondents diagnosed with asthma were also obese or morbidly obese (Chi-Square = 6.13; 2 df;  $p = 0.05$ ).
- Fifty-three percent of the 92 respondents diagnosed with COPD also smoked or used tobacco (Chi-Square = 24.42; 3 df;  $p = 0.00$ ).
- Fifty-two percent of the 123 respondents diagnosed with asthma also smoked or used tobacco (Chi-Square = 20.7; 3 df;  $p = 0.00$ ).

## Access to Health and Wellness Resources

Recent evaluation assessments indicate the effectiveness of behavioral counseling services provided by San Angelo-based West Texas Counseling and Guidance and by MHMR Services for the Concho Valley.<sup>17</sup> Yet, despite their effectiveness, the poverty population of the region faces substantial obstacles to accessing the services.

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diagnosed depression yielded a Chi-Square of 4.5 with 1 degree of freedom and a p-value of 0.04.

<sup>18</sup> Schell, K., A. Chavarria, and W. Russell, "Evaluation of Counseling Outcome Metric Efficiency," presented to West Texas Counseling and Guidance, December 15, 2015, San Angelo, Texas indicates a 48% improvement in the social and behavioral functioning of clients as measured by the Outcome Rating Scale over six brief therapy sessions. Additional analysis by Community Development Initiatives of data provided by MHMR Services for the Concho Valley, October 8, 2015, shows that annual Global Assessment of Functioning scores for 514 clients served over

Data presented previously in Table 5 indicated that 81.5 percent of 248 poor and severely poor respondents to the survey indicated being unable to see a counselor because of cost. Travel to see a counselor was reported as a barrier by 28.2 percent and 16.5 percent reported being averted by fear and anxiety. Additional investigation of these obstacles indicates:

- The severely poor with incomes under half the applicable poverty threshold are most likely (87.9%) to experience a cost barrier (Chi-Square = 10.87; 1 df;  $p = 0.00$ ).
- Non-Hispanics are most likely (37.3%) to experience a travel barrier (Chi-Square = 9.56; 1 df;  $p = 0.00$ )
- Seventy-four percent of poor people diagnosed with depression experience cost barriers to seeing a counselor (Chi-Square = 13.37; 1 df;  $p = 0.00$ ). Thirty-nine percent experience travel barriers (Chi-Square = 16.56; 1 df;  $p = 0.00$ ), and 22 percent are averted by fear and anxiety (Chi-Square = 7.24; 1 df;  $p = 0.01$ ).
- On average, members of the poverty population experience 1.4 obstacles to accessing counseling services. Nine percent of them experience two or more barriers to service.

## IDENTIFICATION AND PRIORITIZATION OF HEALTH NEEDS

### Identification of Community Health Needs

The previous sections of this report summarize the findings of the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas. In combination with these results, the research team previously analyzed the following data for each county in the region to provide a foundation for identification of health needs of the poverty populations in West Texas communities:<sup>19</sup>

- **Demographic Trend Data:** Demographic projections of population growth in West Texas counties were reviewed. Growth trends for vulnerable population groups were included in the review.
- **Hospital Data:** Available data on utilization, revenue, charges, and quality of care at hospitals in West Texas communities were analyzed.
- **Other Health Care Resources:** Data and information on the supply of health care professionals, community clinics, nursing homes, home health agencies, and mental health services were reviewed.
- **Family and Maternal Health:** Secondary data indicators of family composition, domestic abuse data, and maternal health were reviewed.
- **Potentially Preventable Hospitalizations:** Data on hospitalization of West Texas residents that might have been avoidable if individuals accessed and complied with relevant preventative and outpatient healthcare services were reviewed.
- **Leading Causes of Death:** Data on leading causes of death were used to identify specific diseases associated with higher death rates in West Texas communities compared to the state.

It is important to emphasize the community-wide and regional focus of this study of the health needs of poverty populations in the 20-county study region of West Texas. With this perspective at the forefront, the needs assessment has made every effort to use data to identify needs of community-level importance which, in many instances, can only be addressed through cooperative, collective community action. Following is a summary list of identified health needs of the poor and severely poor in West Texas:

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<sup>19</sup> Complete detail on the results of the previous analysis of applicable data for each county is available at the project website. See the Community Health Needs Assessment of the Poor and Extremely Poor in West Texas: <http://www.angelo.edu/faculty/ljones/Community%20Health/>.

1. Access to dental care.

Increase capacity and access to quality dental care, especially by poor and extremely poor residents and households. This was identified as a specific community health need in the following 15 regional counties: Crockett, Edwards, Kimble, Kinney, Mason, McCulloch, Menard, Mills, Reagan, San Saba, Schleicher, Sutton, Tom Green, Upton, and Val Verde.

2. Potentially Preventable Hospitalizations.

Continue to develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including admissions arising from:

- Congestive heart failure, identified as a specific community health need in the following 4 regional counties: Coke, Concho, Runnels, and Tom Green.
- COPD, identified as a specific community health need in the following 3 regional counties: Coke, Runnels, and Tom Green.
- Diabetes, identified as a specific community health need in the following 2 regional counties: Runnels and Tom Green.

3. Capacity and access to behavioral health services for vulnerable groups.

Increase capacity and access for the poor and other vulnerable groups by reducing cost and other barriers to quality behavioral health services. This was identified as a specific community health need in the following 14 regional counties: Crockett, Edwards, Kimble, Kinney, Mason, McCulloch, Menard, Mills, Reagan, San Saba, Schleicher, Sutton, Upton, and Val Verde.

4. Capacity and access to quality behavioral health services to provide:

- Prevention and treatment of depression, identified as a specific community health need in the following 6 regional counties: Coke, Concho, Irion, Runnels, Sterling, and Tom Green.
- Smoking and tobacco cessation, identified as a specific community health need in the following 6 regional counties: Coke, Concho, Irion, Runnels, Sterling, and Tom Green.
- Prevention and treatment of alcohol and drug abuse, identified as a specific community health need in the following 6 regional counties: Coke, Concho, Irion, Runnels, Sterling, and Tom Green.

5. Preventative actions.

Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce morbidity and mortality from:

- Heart and vascular diseases, identified as a specific community health need in all 20 regional counties.
- COPD, identified as a specific community health need in the following 17 regional counties: Coke, Concho, Crockett, Kimble, Kinney, Mason, McCulloch,

Menard, Mills, Reagan, Runnels, San Saba, Schleicher, Sutton, Tom Green, Upton, and Val Verde.

- Diabetes, identified as a specific community health need in the following 12 regional counties: Coke, Concho, Crockett, Kimble, Kinney, McCulloch, Mills, Runnels, Sutton, Tom Green, Upton, and Val Verde.

6. Preventative outreach to the poor and extremely poor.

Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to:

- Reduce obesity, identified as a specific community health need in all 20 regional counties.
- Reduce cost and other barriers to treatment, identified as a specific community health need in all 20 regional counties.
- Improve case management and preventative screenings, identified as a specific community health need in all 20 regional counties.
- Provide education to promote healthy living and wellness, identified as a specific community health need in all 20 regional counties.

7. Food and housing security.

Increase the security of poor and extremely poor individuals and households by:

- Increasing access to nutritious foods, identified as a specific community health need in all 20 regional counties.
- Increasing affordable housing in safe neighborhood environments, identified as a specific community health need in the following 9 regional counties: Coke, Concho, Edwards, Irion, Kinney, Runnels, Sterling, Tom Green, and Val Verde.

8. Investment in community health needs.

Develop collaborative community efforts to increase investment in community health needs. This was identified as a specific community health need in the following 7 regional counties: Coke, Concho, Kinney, Mills, Runnels, Tom Green, and Val Verde.

9. Needs of vulnerable groups such as seniors and children.

Increase capacity to address health needs of growing numbers of seniors and children in the population. This was identified as a specific community health need in all 20 regional counties.

## **Prioritization of Community Health Needs**

A prioritization instrument was used to facilitate a priority ranking by key informants and stakeholders for the identified health needs relevant to the respective counties. The instrument was reviewed with informants and stakeholders at a series of community forums during October 2015. Invitations were sent to county judges and county officials, mayors and city

officials, law enforcement officials, hospital/clinic administrators and key personnel, mental health leaders, dentists, health departments, church leaders, service organization leaders, school administrators and personnel, chambers of commerce, and significant employers. Two events were held in San Angelo, one in Brady, and one in Del Rio.

Preview copies of the county health profiles and associated identified needs were subsequently distributed via e-mail to key informants and stakeholders. Invitations and links to the prioritization instrument were provided to key informants and stakeholders from November 13 to December 14, 2015. Respondents ranked the needs associated with their county of interest based on specified criteria. A total of 131 responses were returned.

Each key informant or stakeholder used the prioritization instrument to assign four different ranks to each of the relevant identified community health needs. A score between 1 and 5 was assigned for each of four criteria. The four ranking criteria were presented to respondents as follows:

- Prevalence: How many people are potentially affected by the issue, considering how it might change in the next 5 to 10 years?
  - 5 - More than 25% of the community (more than 1 in 4 people)
  - 4 - Between 15% and 25% of the community
  - 3 - Between 10% and 15% of the community
  - 2 - Between 5% and 10% of the community
  - 1 - Less than 5% of the community (less than 1 in 20 people)
- Significance: What are the consequences of not addressing this need?
  - 5 - Extremely High
  - 4 - High
  - 3 - Moderate
  - 2 - Low
  - 1 – Minimal Consequences
- Impact: What is the impact of the need on vulnerable populations?
  - 5 - Extremely High
  - 4 - High
  - 3 - Moderate
  - 2 - Low
  - 1 - Minimal Impact

- Feasibility: How likely is it that individuals and organizations in the community would take action to address this need?

5 - Extremely High

4 - High

3 - Moderate

2 - Low

1 - Minimal

## Prioritization of Access Needs

Table 11 reports results of the prioritization of needs related to access barriers that challenge members of the regional poverty population. The needs are listed in the rank order reflected in the adjusted averages on the right side of the table. The adjusted averages emphasize the importance of needs that respondents viewed as the most feasible for the community take action upon.

Table 11 Prioritization of Needs to Reduce Barriers to Access				
Identified Community Health Needs and Ranking Criteria	Responses	Counties	Average	Adjusted Average
<b>Preventative Outreach: Reduce Cost &amp; Other Barriers to Treatment</b>				<b>4.61</b>
Prevalence: percent of people are potentially affected by the issue.	131	20	4.19	4.19
Significance: consequences of not addressing this need.	128		4.08	4.08
Impact: impact of the need on vulnerable populations.	127		4.19	4.19
Feasibility: likelihood the community would take action to address this need.	126		2.98	5.96
<b>Behavioral Health Services: Reduce Cost &amp; Other Barriers</b>				<b>4.52</b>
Prevalence: percent of people are potentially affected by the issue.	93	14	4.05	4.05
Significance: consequences of not addressing this need.	93		4.03	4.03
Impact: impact of the need on vulnerable populations.	90		4.07	4.07
Feasibility: likelihood the community would take action to address this need.	89		2.96	5.92
<b>Food Security: Increase Access to Nutritious Foods</b>				<b>4.45</b>
Prevalence: percent of people are potentially affected by the issue.	131	20	3.93	3.93
Significance: consequences of not addressing this need.	127		3.84	3.84
Impact: impact of the need on vulnerable populations.	128		3.82	3.82
Feasibility: likelihood the community would take action to address this need.	125		3.11	6.22
<b>Housing &amp; Neighborhood Security: Increase Affordable Housing in Safe Neighborhoods</b>				<b>4.33</b>
Prevalence: percent of people are potentially affected by the issue.	93	20	3.75	3.75
Significance: consequences of not addressing this need.	89		3.67	3.67
Impact: impact of the need on vulnerable populations.	92		3.75	3.75
Feasibility: likelihood the community would take action to address this need.	90		3.07	6.14
<b>Access to Dental Care: Increase Capacity and Access to Quality Dental Care</b>				<b>4.25</b>
Prevalence: percent of people are potentially affected by the issue.	108	15	3.98	3.98
Significance: consequences of not addressing this need.	109		3.67	3.67
Impact: impact of the need on vulnerable populations.	107		3.75	3.75
Feasibility: likelihood the community would take action to address this need.	107		2.79	5.58



The adjusted average for each need is based on the separate average scores assigned by respondents for the prevalence, significance, impact, and feasibility criteria. For instance, the prevalence row under the first need listed in the table shows that 131 responses from 20 counties assigned an average score of 4.19 on the five-point scale for the prevalence criterion. Responses on the significance criterion yielded an average score of 4.08, while the impact and feasibility criteria received averages of 4.19 and 2.98 respectively.

Based on these averages, the adjusted average of 4.61 emphasizes the feasibility criterion by giving it double-weight according to the following formula:

$$\text{Adjusted Average} = [\text{prevalence score} + \text{significance average} + \text{impact average} + (\text{feasibility average} \times 2)] \div 4$$

Thus, the computation of the adjusted average for the need to reduce cost and other barriers to treatment is the sum of 4.19, 4.08, 4.19, and 5.96 (i.e.  $2.98 \times 2$ ) divided by 4.

Two reasons led the research team to give the feasibility criterion its double weight in determining the adjusted average. One reason is statistical and the other is practical.

The statistical reason involves the inter-correlation patterns observed between respondent rankings on the four criteria. The research team noted that scores assigned to the prevalence, significance, and impact criteria produced strong statistical inter-correlations ranging from approximately 0.5 to 0.8. The correlations between feasibility ratings and the other three criteria, however, tended to be more modest, falling in an approximate range between 0.2 and 0.45.<sup>20</sup>

Observation of these inter-correlation patterns steered the research team toward consideration of the underlying logic of the four prioritization criteria, as well as a close inspection of the average ratings associated with the items. Logically, it was recognized that each of the first three criteria (prevalence, significance, and impact) gauge the importance of a health need from various perspectives. The feasibility item, in contrast, asks about an entirely different issue, the potential for community action.

With this logical distinction in mind, the research team noticed the propensity of respondents to assign lower average ratings on the feasibility measure compared to the other three criteria. The averages depicted in Table 11 not only illustrate this; they reveal a tendency for the gaps between feasibility and the other three criteria to be larger when respondents assigned higher

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<sup>20</sup> A factor analysis designed to indicate whether patterns in the responses to the four criteria separate into different abstract statistical components revealed that the feasibility criterion loaded on a separate factor from the other three. The pattern was consistent across the responses for all the community health needs included in the prioritization procedure.

averages for prevalence, significance, and impact.<sup>21</sup> The decision to double weight the feasibility averages in the adjusted average was made to balance the feasibility of community action with the importance of community health needs.

With this adjustment in place, the need to increase community capacity and action to reduce cost and other barriers to medical care and treatment is the highest priority access need for the poor and extremely poor in West Texas. The same need applied to behavioral health services is of high importance. These following access needs are also important priorities for the poor and extremely poor populations in the region:

- Increasing the availability of nutritious foods.
- Increasing access to affordable housing in safe neighborhoods.
- Access to quality dental care.

### **Prioritization of Chronic Disease Needs**

A previous section of the report focused on survey findings revealing morbidity patterns of serious chronic diseases included in the top 10 causes of death for the West Texas region. Table 12 details the prioritization of chronic disease categories that overlap with the elevated patterns of morbidity described within the regional poverty population.

Key informants and stakeholders prioritized needs to address the chronic diseases in the following order:

- Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce mortality from complications arising from diabetes.
- Develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including hospital admissions arising from diabetes.
- Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce mortality from heart disease, cerebrovascular disease, and cardiovascular disease.
- Increase emphasis on preventative actions in screening, treatment, case management, and community outreach and education to reduce mortality from COPD.

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<sup>21</sup> A series of T-tests comparing the differences between the feasibility averages and the other criteria confirmed these observations. T-tests generally produced statistically significant differences between the means for feasibility and the other rating standards, and the T-tests tended to depict stronger differences when the prevalence, significance, and impact criteria were rated higher on average by respondents.

- Develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including hospital admissions arising from congestive heart failure.
- Develop and strengthen collaborative community efforts to reduce potentially preventable hospitalizations, including hospital admissions arising from COPD.

<b>Table 12</b>				
<b>Prioritization of Needs to Address Chronic Diseases</b>				
<b>Identified Community Health Needs and Ranking Criteria</b>	<b>Responses</b>	<b>Counties</b>	<b>Average</b>	<b>Adjusted Average</b>
<b>Preventative Actions: Diabetes</b>				<b>4.82</b>
Prevalence: percent of people are potentially affected by the issue.	106	12	4.09	4.09
Significance: consequences of not addressing this need.	114		4.20	4.20
Impact: impact of the need on vulnerable populations.	112		4.24	4.24
Feasibility: likelihood the community would take action to address this need.	110		3.37	6.74
<b>Potentially Preventable Hospitalizations: Diabetes</b>				<b>4.66</b>
Prevalence: percent of people are potentially affected by the issue.	41	2	3.80	3.80
Significance: consequences of not addressing this need.	42		4.02	4.02
Impact: impact of the need on vulnerable populations.	41		4.12	4.12
Feasibility: likelihood the community would take action to address this need.	40		3.35	6.70
<b>Preventative Actions: Heart &amp; Vascular Diseases</b>				<b>4.55</b>
Prevalence: percent of people are potentially affected by the issue.	130	20	3.98	3.98
Significance: consequences of not addressing this need.	130		3.92	3.92
Impact: impact of the need on vulnerable populations.	127		3.98	3.98
Feasibility: likelihood the community would take action to address this need.	126		3.15	6.30
<b>Preventative Actions: COPD</b>				<b>4.26</b>
Prevalence: percent of people are potentially affected by the issue.	126	17	3.74	3.74
Significance: consequences of not addressing this need.	127		3.67	3.67
Impact: impact of the need on vulnerable populations.	124		3.78	3.78
Feasibility: likelihood the community would take action to address this need.	123		2.93	5.86
<b>Potentially Preventable Hospitalizations: Congestive Heart Failure</b>				<b>4.17</b>
Prevalence: percent of people are potentially affected by the issue.	63	4	3.32	3.32
Significance: consequences of not addressing this need.	64		3.72	3.72
Impact: impact of the need on vulnerable populations.	62		3.76	3.76
Feasibility: likelihood the community would take action to address this need.	61		2.93	5.86
<b>Potentially Preventable Hospitalizations: COPD</b>				<b>3.90</b>
Prevalence: percent of people are potentially affected by the issue.	55	3	3.16	3.16
Significance: consequences of not addressing this need.	57		3.39	3.39
Impact: impact of the need on vulnerable populations.	55		3.49	3.49
Feasibility: likelihood the community would take action to address this need.	54		2.78	5.56

## Prioritization of Behavioral Health Needs

The report reviewed survey findings describing several elevated behavioral health risks within the regional poverty population in an earlier section. Table 13 shows the detailed results of the prioritization by key informants and stakeholders of needs to address behavioral health problems.

Key informants and stakeholders prioritized the needs to address behavioral health issues in order as follows:

- Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to reduce obesity.
- Increase capacity and access for the poor and other vulnerable groups by providing quality behavioral health resources for prevention and treatment of alcohol and drug abuse.
- Increase capacity and access for the poor and other vulnerable groups by providing quality behavioral health resources for prevention and treatment for depression.
- Increase capacity and access for the poor and other vulnerable groups by providing quality behavioral health resources for smoking and tobacco cessation.

Table 13 Prioritization of Needs to Address Behavioral Health Risks				
Identified Community Health Needs and Ranking Criteria	Responses	Counties	Average	Adjusted Average
<b>Preventative Outreach: Obesity</b>				<b>4.70</b>
Prevalence: percent of people are potentially affected by the issue.	131	20	4.19	4.19
Significance: consequences of not addressing this need.	128		4.15	4.15
Impact: impact of the need on vulnerable populations.	128		4.14	4.14
Feasibility: likelihood the community would take action to address this need.	126		3.15	6.30
<b>Behavioral Health Services: Alcohol &amp; Drug Abuse</b>				<b>4.57</b>
Prevalence: percent of people are potentially affected by the issue.	59	6	3.90	3.90
Significance: consequences of not addressing this need.	60		4.07	4.07
Impact: impact of the need on vulnerable populations.	58		4.02	4.02
Feasibility: likelihood the community would take action to address this need.	56		3.14	6.28
<b>Behavioral Health Services: Depression</b>				<b>4.52</b>
Prevalence: percent of people are potentially affected by the issue.	67	6	3.84	3.84
Significance: consequences of not addressing this need.	60		4.05	4.05
Impact: impact of the need on vulnerable populations.	57		3.95	3.95
Feasibility: likelihood the community would take action to address this need.	57		3.11	6.22
<b>Behavioral Health Services: Smoking &amp; Tobacco</b>				<b>4.09</b>
Prevalence: percent of people are potentially affected by the issue.	60	6	3.62	3.62
Significance: consequences of not addressing this need.	60		3.62	3.62
Impact: impact of the need on vulnerable populations.	58		3.57	3.57
Feasibility: likelihood the community would take action to address this need.	56		2.77	5.54

## Prioritization of Community Actions to Address Health Needs

Table 14 reports prioritization results from queries concerning comprehensive community actions (not specifically targeted toward specific diseases or health risks) to address health needs.

Key informants and stakeholders prioritized comprehensive community actions in order as follows:

- Increase capacity to address health needs of growing numbers of seniors and children.
- Develop collaborative community efforts to increase investment in community health needs. Consider solutions for expanding quality coverage of the uninsured, coordinated funding and development of proposals or campaigns, coordinated organizational and agency strategic planning, and other collaborative community capacity building approaches.
- Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to provide education to promote healthy living and wellness.
- Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to improve case management and routine preventative screenings.

<b>Table 14</b>				
<b>Prioritization of Needs for Community Actions to Address Health Needs</b>				
<b>Identified Community Health Needs and Ranking Criteria</b>	<b>Responses</b>	<b>Counties</b>	<b>Average</b>	<b>Adjusted Average</b>
<b>Needs of Vulnerable Groups such as Seniors and Children</b>				<b>4.81</b>
Prevalence: percent of people are potentially affected by the issue.	131	20	4.26	4.26
Significance: consequences of not addressing this need.	131		3.99	3.99
Impact: impact of the need on vulnerable populations.	128		4.13	4.13
Feasibility: likelihood the community would take action to address this need.	127		3.43	6.86
<b>Investment in Community Health Needs</b>				<b>4.66</b>
Prevalence: percent of people are potentially affected by the issue.	83	7	4.02	4.02
Significance: consequences of not addressing this need.	80		4.19	4.19
Impact: impact of the need on vulnerable populations.	82		4.11	4.11
Feasibility: likelihood the community would take action to address this need.	81		3.16	6.32
<b>Preventative Outreach: Healthy Living &amp; Wellness</b>				<b>4.48</b>
Prevalence: percent of people are potentially affected by the issue.	130	20	4.12	4.12
Significance: consequences of not addressing this need.	129		3.96	3.96
Impact: impact of the need on vulnerable populations.	127		3.98	3.98
Feasibility: likelihood the community would take action to address this need.	126		2.92	5.84
<b>Preventative Outreach: Case Management &amp; Preventative Screenings</b>				<b>4.45</b>
Prevalence: percent of people are potentially affected by the issue.	131	20	4.08	4.08
Significance: consequences of not addressing this need.	126		3.90	3.90
Impact: impact of the need on vulnerable populations.	127		3.92	3.92
Feasibility: likelihood the community would take action to address this need.	127		2.94	5.88

## RECOMMENDATIONS

The survey of the poor and extremely poor population of West Texas unveils important health needs requiring community action for solutions and progress. The broader project of using community-based methods to assess health and behavioral health needs in a 20-county region entailed establishing contact, cooperation, and collaboration with many of the organizations, agencies, communities, and stakeholders who are also among the subjects of the study.

The research team encourages the counties, communities, and stakeholders in West Texas to utilize the findings, the identified health and behavior health needs, and the prioritization of needs in every appropriate way to advance their interests in making progress to improve the health status of the poor and other vulnerable groups in West Texas.

### Recommendations for Stakeholders

#### **1. Form Community Collaborations.**

Stakeholders and community-based organizations have varying interests in the many health and behavioral health needs of the poor and other vulnerable groups. Solutions to most issues revealed in this study require groups and organizations working together as collaborators. Stakeholders should consider the following qualities in efforts to form collaborating community coalitions to make progress:

- 1.1. Collaborating organizations should share an understanding of the need(s) they want to solve and the community change they must create to solve it.
- 1.2. Coalitions must share commitment to a common approach to solving the need(s) and be willing to agree upon carrying out mutually reinforcing actions necessary for solutions.

#### **2. Focus on the Health and Behavioral Health Need(s) the Collaboration is Able to Address.**

The health and behavioral health needs of the poor and vulnerable groups are overwhelming and extensive. Even a strong coalition should take a focused approach to one or two areas and build upon successes in future endeavors. Collaborating organizations should consider the following in deciding on specific need priorities:

- 2.1. What monetary and non-monetary (staff-time, facilities, equipment, specialized knowledge) resources partners can access for investment into solving the need(s).
- 2.2. What specific activities each partner can best perform in ways that complement and support contributions of others.
- 2.3. How the collaborators can measure and assess outcomes and progress in ways that are acceptable and agreeable to the all partners.

### **3. Identify or Establish Leadership Organizations.**

A collaborating coalition will increase its effectiveness by identifying a leadership organization. There may be a need for more than one leadership organization serving different needs in a county or community. In any case, stakeholders should consider the following in identifying leadership organizations:

- 3.1. A leadership organization must serve as the nerve center of collaboration to achieve a sustainable set of working relationships.
- 3.2. A leadership organization must have the respect and trust of the community and all member organizations of the collaboration.
- 3.3. A leadership organization must commit time of skilled staff members and any other necessary resources for conducting oversight, communications, and other management functions for the collaborating coalition.

### **4. Consider the Full Potential as well as the Limitations of the Collaboration.**

- 4.1. Collaborators with sufficiently strong capacity should consider extending coalition partnerships to other regional counties or communities where capacity to solve health and behavioral health needs are more limited.
- 4.2. Collaborators with limited capacity should consider what they can offer to potential regional partners who augment capabilities to solve health and behavioral health needs of the poor and other vulnerable groups.

## **Recommendations for Funding Organizations**

### **5. Create a Forum for Policymakers, Funding Organizations, and Regional Stakeholders.**

A forum for regional stakeholders is needed for gathering with funding organizations and local, state, and federal policymakers to share knowledge of local and regional health and behavioral health needs of the poor and other vulnerable groups; what is working to address those needs; the challenges faced by local stakeholders; the priorities of funding organizations; and in-depth understanding of existing and potential policy initiatives.

- 5.1. Funding organizations should inaugurate at least one forum of this kind during the 2016 calendar year as part of an effort to encourage building local and regional capacity for addressing the health and behavioral health needs of the poor and other vulnerable populations in West Texas.
- 5.2. Funding organizations should consider organizing an annual, or periodic as appropriate, forum devoted to these purposes.

**6. Incentivize Collaborating Coalitions of Organizations to Address the Health and Behavioral Health Needs of the Poor and Other Vulnerable Groups.**

Funding organizations should use a significant portion of resources to provide incentives to organizations willing to collaborate with community partners to apply evidence-based solutions to health and behavioral health needs.

- 6.1. Funding incentives should be used, in part, to encourage collaborating coalitions that identify and organize around strong leadership organizations willing and able to devote resources to oversight and management of collaborative action. Befitting their missions, the regional medical centers such as those in Tom Green and Val Verde counties, the regional mental health authorities, and the regional FQHCs should be encouraged to utilize some of their capacities to provide leadership to collaborating coalitions. Local hospitals in Sutton, Kimble, McCulloch, Schleicher, Concho, Runnels, Reagan, and Upton counties can also provide leadership in their areas of strength.
- 6.2. Funding incentives should also be used, in part, to encourage collaborating coalitions with strong leadership and capacity to extend into other regional counties or communities where capacity to solve health and behavioral health needs are more limited. Likewise, those with limited capacity should be encouraged to augment capabilities with regional partners to solve health and behavioral health needs of the poor and other vulnerable groups.

**7. Adopt and Promote a Long-Term, Socially Responsible Community Investment Perspective and Culture.**

Funding organizations should adopt and promote a long-term, socially responsible community investment perspective and culture for addressing the health and behavioral health needs of the poor and other vulnerable groups.

- 7.1. Funding organizations should commit a portion of resources to long-term, project-centered as opposed to time-centered, investments into communities that advance the best efforts for potentially solving the health and behavioral health needs of the poor and other vulnerable groups.
- 7.2. Through communications and relationships with local and regional stakeholders, funding organizations should promote a culture of long-term investment in the best initiatives for solving health and behavioral health needs through collaborative community action applying evidence-based solutions.

The research team offers the above recommendations for action toward solutions with immense respect and gratitude toward the communities we studied in West Texas and the organizations that supported the project.



## APPENDIX A: SURVEY PACKET AND FACILITATOR (INTERVIEWER) TRAINING

### Community Health Survey Instruction Guide

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#### Step 1. Determine Eligibility

Please have a friendly and informal conversation to find out where the respondent lives and provide that information:

Where does the respondent live?

City or town name: \_\_\_\_\_ County Name: \_\_\_\_\_  
☐ Lives in Town/City ☐ Lives in the Countryside

Ask if he or she has ever taken this survey before. If so, please thank them for already participating and do not continue. If not, use the following chart to determine if the person is eligible for participation in the survey.

Household Size	1	2	3	4	5	6	7	8+
Level A	\$500	\$650	\$850	\$1,000	\$1,200	\$1,350	\$1,500	\$1,700
Level B	\$1,000	\$1,300	\$1,700	\$2,000	\$2,400	\$2,700	\$3,000	\$3,400

Circle the number of people in their household (household size) and answer the questions below:

1. Was the household income last month lower than

Level A?

☐ Yes. Go to Step 2: Informed Consent.

☐ No. Go to eligibility question 2.

2. Was the household income last month around or

below Level B?

☐ Yes. Go to Step 2: Informed Consent.

☐ No. Thank them for their time. Do not start survey.

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#### Step 2. Detach the last two pages of the packet. Review and sign Informed Consent.

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#### Step 3. Begin Survey

**Respondent Instructions:** Please answer each question to the best of your ability. You may choose to skip any question you do not want to answer. Don't forget your gift card when you have finished the survey!

**Facilitator Instructions:** After the respondent signs the Informed Consent [Step 2], please help him or her complete the survey, working together as a team. Refer to the helpful definitions on the back of this page during the survey if needed. Please write clearly in print.

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#### Step 4. Additional comments

If the respondent would like to make comments or discuss other health concerns that were not addressed in the survey, please make notes below:

## Community Health Survey Definitions

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### Some Helpful Definitions

*What is a household?* A household can be one person or many who live in the same place and usually share expenses like food, clothing, transportation, and other bills. If you have children, family members, a “significant other,” or anyone else who lives with you, they are part of your household. Household size is the number of people in a household.

*Sexually Transmitted Diseases:* STDs are caused by infections that can be passed from one person to another during sexual contact. Examples: Chlamydia, Gonorrhea, Viral Hepatitis, Genital Herpes, HIV/AIDS, Human Papillomavirus (HPV), Syphilis, Trichomoniasis

*Accidental injuries:* Examples include motor vehicle accidents; other transportation accidents; falls; accidental discharge of firearms; accidental drowning and submersion; accidental exposure to smoke, fire, flames; accidental poisoning and exposure to poisonous substances

*A place to call home:* A roof over your head in a dwelling (a house, apartment, mobile home, or temporary lodging for a job), where you reside, or where you stay with someone, without fear of being kicked out or asked to leave without warning.

*Social support:* churches, temples, mosques, or a group of like-minded friends who can serve as a support system

**Sex**

Male..... ☐  
Female..... ☐

**Ethnicity**

White..... ☐  
Hispanic..... ☐  
Black..... ☐  
Asian..... ☐  
Other..... ☐

**What year were you born?**

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**What is your height  
in feet and inches?**

--	--	--	--

**What is your weight?**

--	--	--

 lbs**How many years of school did you complete?  
How many years of work training?**

School		
--------	--	--

Work training		
---------------	--	--

**Are you a veteran?**

Yes..... ☐  
No..... ☐

**Does a physical, mental, or emotional health  
condition limit you in any way?**

Yes..... ☐  
No..... ☐

**Are any of these people in your household? Mark  
all that apply:**

My Spouse /Partner	My Children	My Grand- children	My Parents	My other relatives	Others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Have you or has anyone in your household  
received benefits in the last 12 months, such as:**

	Yes	No
Food assistance, such as SNAP, WIC, or food stamps	<input type="checkbox"/>	<input type="checkbox"/>
TANF or welfare benefits	<input type="checkbox"/>	<input type="checkbox"/>
Housing vouchers or housing assistance	<input type="checkbox"/>	<input type="checkbox"/>

**In the last 12 months, has anyone in your  
household gotten food from a food bank, soup  
kitchen, meals on wheels, or similar program?**

Yes..... ☐  
No..... ☐

**Is it easy for you to get to a store that carries  
fresh fruits and vegetables from your home?**

Yes..... ☐  
No..... ☐

**In your neighborhood, are there places where  
you and other household members can safely  
walk, run, or ride bicycles?**

Yes..... ☐  
No..... ☐

**How often do you feel safe in your  
neighborhood?**

Often or always..... ☐  
Sometimes..... ☐  
Rarely or never..... ☐

**Do you currently have any of the following?**

	Yes	No
Regular doctor or health care provider	<input type="checkbox"/>	<input type="checkbox"/>
Specialist health care provider	<input type="checkbox"/>	<input type="checkbox"/>
Regular dentist	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>
Other health insurance	<input type="checkbox"/>	<input type="checkbox"/>
Dental insurance	<input type="checkbox"/>	<input type="checkbox"/>

What city or town would you usually go to for the following? How long does it take to get there?

Counseling.....	
How long?.....	
Dentist.....	
How long?.....	
Doctor .....	
How long?.....	
Pharmacy.....	
How long?.....	

In the past 12 months, did any of these reasons keep you from getting health services you needed? (Skip the services you did not need.)

	Cost	Travel difficulty	Missing work	Childcare	Fear or anxiety
See a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See a specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See a dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a medical operation or procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go to a follow-up appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get prescription medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get rehab or physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See a counselor or mental health professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About how long has it been since you last had a routine checkup with:

	Within 1 Year	1-2 Years	3-5 Years	More than 5 Years	Never had a checkup
Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have any of these people been told by a doctor, nurse, or other health professional that they had:

	Myself	Household Member	Blood Relative	No one
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD, emphysema, or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's disease or another form of dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[If YES to diabetes] Mark the box if they test their blood sugar daily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you take any medicine regularly?

Yes -- for physical health conditions, such as diabetes, blood pressure, heart problems, asthma, or others ..... ☐

Yes -- for mental health conditions, such as depression, anxiety, ADHD, or others ..... ☐

No ..... ☐

**How many standard vaccines have the people in your household received?**

The vaccines required for school are: Diphtheria / Tetanus / Pertussis (DPT or DTaP), Polio, Measles / Mumps / Rubella (MMR), Hepatitis B, Varicella / Chickenpox, Meningitis, and Hepatitis A.

	All	Some	None
Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (under 18)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Who in your household has had these vaccines:**

	Myself	Children (under 18)	Others	No one
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal flu (in the past 12 months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Have you ever had any of these screenings?**

	Yes	No
[If female] Mammogram or pap smear	<input type="checkbox"/>	<input type="checkbox"/>
Colon/rectal exam	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure check	<input type="checkbox"/>	<input type="checkbox"/>
Blood work	<input type="checkbox"/>	<input type="checkbox"/>
HIV Test	<input type="checkbox"/>	<input type="checkbox"/>
Vision screening	<input type="checkbox"/>	<input type="checkbox"/>
Hearing screening	<input type="checkbox"/>	<input type="checkbox"/>
Dental cleaning or x-rays	<input type="checkbox"/>	<input type="checkbox"/>

**How often do you now smoke cigarettes or use e-cigarettes, chewing tobacco, snuff, or other smokeless tobacco?**

Every day .....	<input type="checkbox"/>
Some days .....	<input type="checkbox"/>
I quit .....	<input type="checkbox"/>
Never .....	<input type="checkbox"/>

**Which option best describes the rules about where smoking is allowed in your environment?**

	ALL areas	SOME areas	Not allowed
Inside your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inside bars & restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer the next few questions with a "Yes" or "No." Remember you may skip questions you do not wish to answer.**

In the past 30 days, have you had more than (men: 5) (women: 4) alcoholic drinks on any one occasion? Yes No  
☐ ☐

Do you or does anyone in your household suffer from substance abuse or addiction, including alcohol, tobacco, or other drugs? Yes No  
☐ ☐

In the past year, has anyone in your household been treated for a sexually transmitted disease (STD)? Yes No  
☐ ☐

Have you had any accidental injuries in the past 12 months? Yes No  
☐ ☐

Has there been a time in the past 5 years when you did not have a place to call home for a week or more? Yes No  
☐ ☐

Is there a group of people you really love or who are important to you that would support you if you needed help? Yes No  
☐ ☐

**How often do you get the feeling that it is impossible to have a fulfilling life?**

Often or always ..... ☐  
 Sometimes ..... ☐  
 Rarely or never ..... ☐

**How often do you avoid situations you think will make you feel nervous, afraid, upset, or anxious, even if you know it would be good for you?**

Often or always ..... ☐  
 Sometimes ..... ☐  
 Rarely or never ..... ☐

**How often do you feel like you don't have much in common with the people around you or you feel alone?**

Often or always ..... ☐  
 Sometimes ..... ☐  
 Rarely or never ..... ☐

## Community Health Survey

### Step 2: Informed Consent

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The purpose of this survey is to research the health needs in your area. The survey should take about 20 minutes to complete. The facilitator is here to help you understand the questions and write down your answers.

There are some costs and risks involved in participating in the survey. The survey requires the cost of volunteering your time. The risks have to do with the type of information we are asking about. We will ask questions about your health and the health of your household members. The facilitator will know the information you share, but he or she has legal obligations to keep that information private. You might be asked questions that make you feel somewhat uncomfortable. You do not have to answer any question you don't want to answer. You can also stop the survey at any time.

Other than the gift card for completing the survey, you will not receive any direct benefits from being a part of this survey. However, your answers and those of others in your area will be used to tell organizations how to best help people like you with their health needs.

Your answers will be confidential. That means that your information will not be shared without your knowledge or permission. The answers you provide will be combined with answers from other people in reports that will help organizations understand what is needed in your community to improve health. We will NOT collect or share your identity (your name and other personal information that says who you are).

You can contact the Project Coordinator if you have any questions about the research and your rights. Alternately, you can contact our local partner organization.

Susan McLane, Project Coordinator  
Community Development Initiatives  
[susan.mclane@angelo.edu](mailto:susan.mclane@angelo.edu)  
325-486-6427

Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
City: \_\_\_\_\_  
Phone: \_\_\_\_\_

Your participation is completely voluntary. If you do not wish to participate, or decide after starting that you do not want to finish, there are no penalties or negative consequences. You can choose not to participate at any time.

***I understand the purpose, costs, and risks of the survey and I agree to participate.***

Sign or make your mark: \_\_\_\_\_ Date: \_\_\_\_\_  
Gift Card # \_\_\_\_\_  
(last 4 or 5): \_\_\_\_\_

**KEEP THIS COPY**

## Guía con Instrucciones para la Encuesta de Salud Comunitaria

### Paso 1. Determinar la elegibilidad

Por favor tenga una conversación amable e informal para averiguar dónde vive el encuestado y ponga la información aquí:

**¿Dónde vive el encuestado/la encuestada?**

Nombre de ciudad o pueblo: \_\_\_\_\_ Nombre de condado: \_\_\_\_\_  
☐ Vive dentro de la ciudad/el pueblo ☐ Vive en el campo

**Pregúntele a él o ella si ha contestado alguna vez esta encuesta.** En caso afirmativo, por favor, dé las gracias por haber participado y no continúe. En caso contrario, utilice la siguiente tabla para determinar si la persona es elegible para participación en la encuesta.

Tamaño del hogar	1	2	3	4	5	6	7	8+
Nivel A	\$500	\$650	\$850	\$1,000	\$1,200	\$1,350	\$1,500	\$1,700
Nivel B	\$1,000	\$1,300	\$1,700	\$2,000	\$2,400	\$2,700	\$3,000	\$3,400

**Circulé alrededor del número de personas en su hogar (tamaño del hogar) y conteste las siguientes preguntas:**

1. ¿Fue el ingreso por hogar del mes pasado más bajo que Nivel A? 2. ¿Fue el ingreso por hogar del mes pasado más bajo que o alrededor de Nivel B?

☐ Sí. Continúe al Paso 2: Consentimiento Informado.

☐ No. Vaya a la 2ª pregunta de elegibilidad.

☐ Sí. Continúe al Paso 2: Consentimiento Informado.

☐ No. Darle las gracias por su tiempo. No empiece la encuesta.

### Paso 2. Separe las 2 últimas páginas del paquete. Revisar y firmar el Consentimiento Informado.

### Paso 3. Empezar la encuesta

**Instrucciones para el encuestado:** Por favor responde a cada pregunta lo mejor de su habilidad. Usted puede optar por omitir cualquiera pregunta que no quiera contestar. ¡No se olvide su tarjeta de regalo cuando haya terminado la encuesta!

**Instrucciones para el facilitador:** Después de que el encuestado firme el Consentimiento Informado [Paso 2], por favor ayúdele a completar la encuesta, trabajando juntos como un equipo. Consulte las definiciones útiles en la parte posterior de esta página durante la encuesta si es necesario. Por favor escribe claramente en letra empresa.

### Paso 4. Comentarios adicionales

Si el encuestado desea hacer comentarios o hablar de otros problemas de salud que no fueron dirigidos en la encuesta, por favor tome notas abajo:

## Guía con Instrucciones para la Encuesta de Salud Comunitaria

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### Algunas Definiciones Útiles

*¿Qué es un hogar?* Un hogar puede ser una persona o muchas personas que viven en el mismo lugar y generalmente comparten gastos como comida, ropa, transporte, y otros recibos. Si usted tiene hijos, familiares, un “otro significativo” o cualquier otra persona que vive con usted, ellos son parte de su hogar. El tamaño del hogar es el número de personas en un hogar.

*Enfermedades de transmisión sexual:* ETS son causadas por infecciones que pueden transmitirse de una persona a otra durante el contacto sexual. Ejemplos: clamidia, gonorrea, hepatitis viral, herpes genital, VIH/SIDA, Virus del Papiloma Humano (VPH), sífilis, tricomoniasis

*Lesiones accidentales:* Ejemplos incluyen los accidentes de vehículos motorizados; otros accidentes de transporte; caídas; descarga accidental de armas de fuego; ahogamiento y sumersión accidental; exposición accidental a humo, fuego, llamas; envenenamiento accidental y la exposición a sustancias venenosas

*Un lugar al que llamar hogar:* Un techo sobre su cabeza en una vivienda (una casa, un apartamento, tráiler/casa móvil o alojamiento temporal para el trabajo) donde usted reside, o donde se queda con alguien, sin miedo de ser echado sin aviso.

*Apoyo social:* Iglesias, templos, mezquitas o un grupo de amigos con ideas iguales que pueden servir como un sistema de apoyo

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**Sexo**Hombre..... ☐Mujer..... ☐**Etnicidad**Blanco..... ☐Hispano..... ☐Negro..... ☐Asiático..... ☐Otro..... ☐**¿En qué año nació?****¿Cuál es su altura en  
pies y pulgadas?****¿Cuánto pesa usted  
en libras?** lbs**¿Cuántos años de escuela ha completado? ¿de  
capacitación?**Escuela Entrenamiento para el trabajo **¿Es veterano?**Sí..... ☐No..... ☐**¿Tiene usted algún problema de salud física,  
mental o emocional que se le limita de alguna  
manera?**Sí..... ☐No..... ☐**¿Está alguna de estas personas en su hogar?  
Marque todo lo que corresponda:**

Mi esposo/a o pareja	Mis hijos	Mis nietos	Mis padres	Mis otros parientes	Otros
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**¿Ha recibido usted o alguien en su hogar  
beneficios en los últimos 12 meses, tales como:**

	Sí	No
Asistencia alimentaria, como SNAP, WIC o cupones de alimentos	<input type="checkbox"/>	<input type="checkbox"/>
TANF o prestaciones sociales	<input type="checkbox"/>	<input type="checkbox"/>
Vales de vivienda o asistencia de vivienda	<input type="checkbox"/>	<input type="checkbox"/>

**En los últimos 12 meses, ¿ha conseguido alguien  
en su hogar comida de un banco de alimentos,  
comedor de beneficencia, comidas a domicilio o  
algún programa similar?**Sí..... ☐No..... ☐**¿Es fácil para usted llegar a una tienda que  
vende frutas y verduras frescas desde su casa?**Sí..... ☐No..... ☐**En su barrio, ¿hay lugares donde usted y otros  
miembros del hogar pueden andar, correr o  
andar en bicicleta con seguridad?**Sí..... ☐No..... ☐**¿Con qué frecuencia se siente seguro en su  
barrio?**A menudo o siempre..... ☐A veces..... ☐Rara vez o nunca..... ☐**¿Tiene actualmente alguno de los siguientes?**

	Sí	No
Médico o proveedor de salud habitual	<input type="checkbox"/>	<input type="checkbox"/>
(Médico) Especialista	<input type="checkbox"/>	<input type="checkbox"/>
Dentista habitual	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid (seguro médico popular)	<input type="checkbox"/>	<input type="checkbox"/>
Medicare (seguro médico para mayores)	<input type="checkbox"/>	<input type="checkbox"/>
Otro tipo de seguro médico	<input type="checkbox"/>	<input type="checkbox"/>
Seguro dental	<input type="checkbox"/>	<input type="checkbox"/>

■ **¿En qué ciudad o pueblo suele ir para los siguientes servicios médicos? ¿Cuánto se tarda en llegar allí?**

Asesoramiento o terapia	
¿Cuánto se tarda?....	
Dentista.....	
¿Cuánto se tarda?....	
Médico .....	
¿Cuánto se tarda?....	
Farmacia.....	
¿Cuánto se tarda?....	

**En los últimos 12 meses, ¿alguna de estas razones le impidieron recibir servicios de salud que necesitaba? (Omita los servicios que no necesitaba.)**

	Costo	Dificultad en viajar	Faltar al trabajo	Cuidado de niños	Miedo o ansiedad
Ver a un médico	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consultar a un especialista	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ver a un dentista	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tener una operación o procedimiento médico	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ir a una cita de seguimiento	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtener medicina recetada	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conseguir rehabilitación o terapia física	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ver a un consejero o profesional de salud mental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**¿Acerca de cuánto tiempo ha pasado desde la última vez que tuvo un examen de rutina con:**

	Dentro de 1 año	1-2 años	3-5 años	Más de 5 años	Nunca lo tuvo
Médico	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentista	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

■ **De estas personas, ¿quiénes han sido informado por un médico, enfermera u otro profesional de salud que tenían**

	Yo mismo	Miembro del hogar	Pariente de sangre	Nadie
Presión arterial alta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colesterol alto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Un ataque al corazón	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedad del corazón	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Un derrame cerebral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedad cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cáncer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPOC, enfisema o bronquitis crónica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artritis, artritis reumatoidea, gota, lupus o fibromialgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedad del riñón	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedad de Alzheimer u otra forma de demencia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depresión o ansiedad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[En caso afirmativo a diabetes] Marque la casilla si haga un chequeo a su nivel de azúcar en sangre diaria.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**¿Toma alguna medicina regularmente?**

Sí -- por condiciones de salud física, como la diabetes, la presión arterial, problemas cardíacos, asma u otras ☐

Sí -- por condiciones de salud mental, como la depresión, la ansiedad, el TDAH u otras..... ☐

No..... ☐

**¿Cuántas vacunas estándar han recibido las personas en su hogar?**

Las vacunas requeridas para la escuela son: difteria / tétanos / tos ferina (DPT o DTaP), polio, sarampión / paperas / rubéola (MMR), la hepatitis B, varicela, la meningitis y la hepatitis A

	Todas	Algunas	Ninguna
<b>Yo mismo</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Niños (menores de 18 años)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otros	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**¿Quién en su hogar ha recibido estas vacunas?**

	Yo mismo	Niños	Otros	Nadie
Pulmonía	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripe estacional (en los últimos 12 meses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**¿Alguna vez ha tenido alguno de estos chequeos?**

	Si	No
[Si mujer] Mamografía o papanicolaou	<input type="checkbox"/>	<input type="checkbox"/>
Examen colorrectal	<input type="checkbox"/>	<input type="checkbox"/>
Tomar la presión	<input type="checkbox"/>	<input type="checkbox"/>
Análisis de sangre	<input type="checkbox"/>	<input type="checkbox"/>
Prueba para VIH	<input type="checkbox"/>	<input type="checkbox"/>
Examen de la vista	<input type="checkbox"/>	<input type="checkbox"/>
Examen de audición	<input type="checkbox"/>	<input type="checkbox"/>
Limpieza dental o rayos X dentales	<input type="checkbox"/>	<input type="checkbox"/>

**¿Con qué frecuencia fuma cigarrillos o usa cigarrillos electrónicos, tabaco de mascar, rapé u otro tabaco sin humo?**

Todos los días.....	<input type="checkbox"/>
Algunos días.....	<input type="checkbox"/>
Lo dejé.....	<input type="checkbox"/>
Nunca .....	<input type="checkbox"/>

**¿Cuál opción mejor describe las reglas sobre dónde se permite fumar en su medioambiente?**

	Todas las áreas	Algunas áreas	No se permite
Dentro de su casa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
En el trabajo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentro de los bares y restaurantes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Por favor responda a las siguientes preguntas con un "Sí" o "No." Recuerde que puede omitir preguntas que no desea responder.**

En los últimos 30 días, ¿ha tomado más de (hombres: 5) (mujeres: 4) bebidas alcohólicas en una sola ocasión? Sí No  
☐ ☐

¿Sufre usted o alguien en su hogar de abuso de sustancias o adicción, incluyendo alcohol, tabaco u otras drogas? Sí No  
☐ ☐

En el año pasado, ¿alguien en su hogar ha recibido tratamiento por una enfermedad de transmisión sexual (ETS)? Sí No  
☐ ☐

¿Ha sufrido alguna lesión accidental en los últimos 12 meses? Sí No  
☐ ☐

¿Ha habido una vez en los últimos 5 años cuando usted no tenía "hogar" por una semana o más? Sí No  
☐ ☐

¿Hay un grupo de gente a quienes los ama mucho y son importantes para usted que lo apoyarían si necesita ayuda? Sí No  
☐ ☐

**¿Con qué frecuencia se siente que es imposible tener una vida realizada?**

A menudo o siempre ..... ☐  
A veces ..... ☐  
Rara vez o nunca ..... ☐

**¿Con qué frecuencia evita situaciones que usted piensa le harán sentir nervioso, ansioso, disgustado o tener miedo, aunque sabe que sería buena para usted?**

A menudo o siempre ..... ☐  
A veces ..... ☐  
Rara vez o nunca ..... ☐

**¿Con qué frecuencia usted se siente como que no tiene mucho en común con todos los que lo rodean o se siente solo?**

A menudo o siempre ..... ☐  
A veces ..... ☐  
Rara vez o nunca ..... ☐

## Encuesta de Salud Comunitaria

### Paso 2: Consentimiento Informado

---

El propósito de este estudio es investigar las necesidades de salud en su área. La encuesta debe durar 20 minutos para completar. El facilitador está aquí para ayudarle a entender las preguntas y anotar sus respuestas.

Hay algunos costos y riesgos relacionados en participar en la encuesta. La encuesta requiere el costo de ofrecer su tiempo. Los riesgos tienen que ver con el tipo de información que estamos pidiendo. Vamos a preguntarle sobre su salud y la salud de los miembros de su hogar. El facilitador va a conocer la información que comparta, pero tiene la obligación legal de mantener privada la información. Es posible que haya preguntas que le hacen sentir un poco incómodo. Usted no tiene que contestar ninguna pregunta que no quiera responder. También puede terminar la encuesta en cualquier momento.

Aparte de la tarjeta de regalo por completar la encuesta, usted no recibirá ningún beneficio directo por ser parte de esta encuesta. Sin embargo, sus respuestas y las de los demás en su área serán utilizadas para decirle a las organizaciones cómo ayudar mejor la gente como usted con sus necesidades de salud.

Sus respuestas serán confidenciales. Eso significa que su información no será compartida sin su conocimiento o permiso. Las respuestas que proporcione se combinarán con las respuestas de otras personas en informes que les ayudarán a las organizaciones a entender lo que se necesita en su comunidad para mejorar la salud. No vamos a recoger o compartir su identidad (su nombre y otra información personal que dice quién es).

Puede ponerse en contacto con el Coordinador del Proyecto si usted tiene alguna pregunta acerca de la investigación y sus derechos. Alternativamente, usted puede ponerse en contacto con la organización local.

Susan McLane, Coordinador del Proyecto  
Community Development Initiatives  
[susan.mclane@angelo.edu](mailto:susan.mclane@angelo.edu)  
325-486-6427

Nombre: \_\_\_\_\_  
Organización: \_\_\_\_\_  
Ciudad: \_\_\_\_\_  
Teléfono: \_\_\_\_\_

Su participación es completamente voluntaria. Si no desea participar, o decide después de comenzar que usted no quiere terminar, no hay sanciones ni consecuencias negativas. Usted puede optar por no participar en cualquier momento.

**Entiendo el propósito, los costos y los riesgos de la encuesta y estoy de acuerdo en participar.**

Firme o haga su marca: \_\_\_\_\_

Fecha: \_\_\_\_\_  
N° de tarjeta de  
regalo (últimos 4 o 5): \_\_\_\_\_

**GUARDE ESTA COPIA**

# West Texas Regional Health Project

## HIPAA, Confidentiality, & Community Health Survey

### Facilitator (Interviewer) Training

Susan McLane, MPA  
Project Coordinator, Community Development Initiatives  
Angelo State University

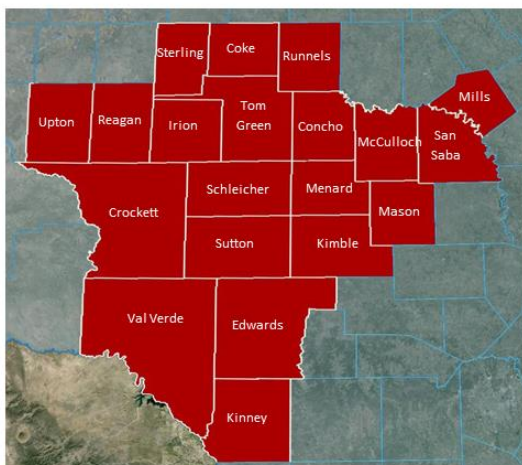


## The Concho Valley Community Action Agency

### 20 County Community Health Needs Assessment

#### 20 County Region

Coke, Concho, Crockett, Edwards, Irion, Kimble, Kinney, Mason, McCulloch, Menard, Mills, Reagan, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Upton, & Val Verde



#### Community Health Needs Assessment

Supported by *Methodist Healthcare Ministries of South Texas*, the *San Angelo Health Foundation*, *HEB*, and the *Concho Valley Transit District*

Goal: to identify and prioritize health and behavioral health needs of the extremely poor individuals living in the 20 county region

#### Regional Health Assessment Survey

- **Community-based participatory needs survey**
  - 20-30 minute survey about health needs with the extremely poor
  - Covering access, chronic conditions, oral health, and behavioral health
- *Participation by community leaders and members is essential*

#### Contact:

Susan McLane  
[susan.mclane@angelo.edu](mailto:susan.mclane@angelo.edu)  
(325) 486-6427



# Training Overview

- Introduction to HIPAA: Understand the Legal Requirements & Your Responsibilities
- Research & Confidentiality
- Survey Training

## Health Insurance Portability & Accountability Act of 1996 (HIPAA)

A federal law which, in part, protects the privacy of individuals' information, and provides for the electronic and physical security of health and medical information.

- Updates in 2009 & 2013
- Protects Private Information
- Privacy Rule & Security Rule



## HIPAA: Privacy Rule

- Privacy Rule defines
  - What information must be protected;
  - Who is authorized to access, use, or disclose information;
  - What processes must be in place to control the access, use, and disclosure of information; and
  - Patient rights
- Based on the principles of “need to know” and “minimum necessary”

## HIPAA: Privacy Rule

The work we are doing does not allow for the disclosure of information for our participants.

All information should be held in  
**STRICT CONFIDENCE.**

# HIPAA: Security Rule

- Security Rule defines
  - Standards for administrative, technical, and **physical** safeguards designed to protect the confidentiality, integrity, and availability of Protected Health Information (PHI)



**KNOW THE RULES!**



## Texas HB300

- Texas Health & Safety Code §181.201
- Equivalent Texas state law to HIPAA
- Provides greater privacy protections



## Consequences for Violations

HIPAA Violation	Civil Monetary Penalties	HIPAA Violation	Criminal Penalties
Individual did not know (and by exercising reasonable diligence would not have known) that he/she violated HIPAA	\$100-\$50,000 for each violation, up to a maximum of \$1.5 million in a calendar year	Unknowingly or with reasonable cause	Up to one year imprisonment, fine up to \$50,000
HIPAA violation due to reasonable cause and not due to willful neglect	\$1,000-\$50,000 for each violation, up to a maximum of \$1.5 million in a calendar year	Under false pretenses	Up to five years imprisonment, fine up to \$100,000
HIPAA violation due to willful neglect but violation is corrected within the required time period	\$10,000-\$50,000 for each violation, up to a maximum of \$1.5 million in a calendar year	For personal gain or malicious reasons	Up to ten years, fine up to \$250,000
HIPAA violation is due to willful neglect and was not corrected	\$50,000 or more for each violation, up to a maximum of \$1.5 million in a calendar year		

HB300 Violation	State Penalties
If negligent	\$5,000 per violation per year
If knowing or intentional	\$25,000 per violation per year
If knowing or intentional and for financial gain	\$250,000 per violation per year
Pattern of abuse	Up to \$1.5 million annually

## Research & Confidentiality

- Information respondents give to participate in the survey has been disclosed in a relationship of **TRUST**.
- Principles of *respect* and *beneficence*
- Confidentiality protects participants against psychological, social, and legal harm.
- Participants must feel secure they are being protected to be willing to give honest answers to private and sensitive questions.

**CONFIDENTIAL**

## Examples

Example: You are visiting with a friend who tells you her organization will be starting a new free program to help people manage diabetes. She asks if there's anyone you can think of who could benefit from the program, and you instantly remember Mr. Smith mentioning in the survey that he had trouble checking his blood sugar and taking his medicine regularly.

- A. Tell her Mr. Smith would be an excellent candidate because he could really use the help.
- B. Tell her you know of someone, and you could take him some information.
- C. Tell her she might find some candidates by talking to the folks at the soup kitchen and food bank, knowing Mr. Smith uses those services.
- D. Tell her you can't help, but hope the program does well.

## Examples

Example: You can't stop thinking about Ms. Sanchez after you found out she was diagnosed with cancer when you were assisting her with the survey. You want to turn to your faith to find help.

- A. Submit a prayer request: Please pray for Ms. Sanchez, who is facing great challenges in her life, the most critical of which is her failing health and inability to pay for care.
- B. Submit a prayer request: Please pray for Ms. Sanchez, who could use some extra prayers right now.
- C. Talk to your minister for guidance; tell him you know someone in the church is suffering from cancer without the ability to pay for medical care.
- D. Submit a prayer request: Please pray for those who are battling cancer. Talk to your minister about putting together resources to help families of those who are battling cancer.

# Examples

Example: You were really surprised about the number of survey respondents who said they had major dental problems in your community. You are fired up and want to do something about it:

- A. Get on Facebook and post that you've learned your community has a severe problem with dental health to start a conversation on how to make a difference.
- B. Discuss what you've learned with your personal dentist, hoping he will want to help with the cause.
- C. Wait for the project's reports to come out; base your future activity on the findings and recommendations from the report.
- D. Include extra items for dental health when you drop off donations at your local organization that offers provisions for low-income families.

## Survey Training

- Instruction Guide
- Helpful Definitions
- Survey
- Informed Consent & Incentive
- Acknowledgement of Support

# Survey Instruction Guide

## Step 1. Determine Eligibility

Please have a friendly and informal conversation to find out where the respondent lives and provide that information:

Where does the respondent live?

City or town name: \_\_\_\_\_ County Name: \_\_\_\_\_  
☐ Lives in Town/City ☐ Lives in the Countryside

Ask if he or she has ever taken this survey before. If so, please thank them for already participating and do not continue. If not, use the following chart to determine if the person is eligible for participation in the survey.

Household Size	1	2	3	4	5	6	7	8+
Level A	\$500	\$650	\$850	\$1,000	\$1,200	\$1,350	\$1,500	\$1,700
Level B	\$1,000	\$1,300	\$1,700	\$2,000	\$2,400	\$2,700	\$3,000	\$3,400

Circle the number of people in their household (household size) and answer the questions below:

1. Was the household income last month lower than Level A?

- ☐ Yes. Go to Step 2: Informed Consent.  
☐ No. Go to eligibility question 2.

2. Was the household income last month around or below Level B?

- ☐ Yes. Go to Step 2: Informed Consent.  
☐ No. Thank them for their time. Do not start survey.

# Survey Instruction Guide

## Step 2. Detach the last two pages of the packet. Review and sign Informed Consent.

Susan McLane, Project Coordinator  
Community Development Initiatives  
[susan.mclane@angelo.edu](mailto:susan.mclane@angelo.edu)  
325-486-6427

Name & Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State ZIP \_\_\_\_\_  
Phone: \_\_\_\_\_

Your participation is completely voluntary. If you do not wish to participate, or decide after starting that you do not want to finish, there are no penalties or negative consequences. You can choose not to participate at any time.

*I understand the purpose, costs, and risks of the survey and I agree to participate.*

Sign or make your mark: \_\_\_\_\_ Date: \_\_\_\_\_

# Survey Instruction Guide

## Step 3. Begin Survey

**Respondent Instructions:** Please answer each question to the best of your ability. You may choose to skip any question you do not want to answer. Don't forget your gift card when you have finished the survey!

**Facilitator Instructions:** After the respondent signs the Informed Consent [Step 2], please help him or her complete the survey, working together as a team. Refer to the helpful definitions on the back of this page during the survey if needed. Please write clearly in print.

## Step 4. Respondent comments

If the respondent would like to make comments or discuss other health concerns that were not addressed in the survey, please make notes below:



# Survey Role Play

Survey Takers: Please make up the answers you give in response to the survey!

The Regional Health Needs Assessment Project  
thanks the following organizations for their support:

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HIPAA Training Content informed by:  
Margaret Benson, Compliance Officer  
Shannon Medical Center

If you are aware of a breach of privacy, contact  
Susan McLane, the survey coordinator, immediately.

Susan McLane, MPA  
Project Coordinator  
Community Development Initiatives  
Angelo State University  
(325) 486-6427

[susan.mclane@angelo.edu](mailto:susan.mclane@angelo.edu)



## APPENDIX B: GAP ANALYSIS OF PARALLEL INDICATORS TO THE TEXAS BRFSS

The following table details the parallel indicator comparisons with the 2013 Texas BRFSS created by data collected from the interview instrument used in the Survey of Health and Behavioral Health Needs of the Poor and Extremely Poor in West Texas.

Parallel Risk Indicators	Survey Results: 20 County Study Region*			BRFSS Risk Comparisons**	
	Sample	Population at Risk	Percent at Risk	Study Region Counties	Texas
Limited by poor physical, mental, or emotional health conditions	597	284	47.6%	13.6%	11.6%
Does not think of anyone as a personal doctor	597	238	39.9%	30.0%	33.1%
Could not see a doctor because of cost during past 12 months	597	339	56.8%	20.2%	19.3%
Five or more years since routine checkup by a doctor	597	57	9.5%	9.6%	10.5%
Diagnosed high blood pressure	597	255	42.7%	36.7%	31.2%
Diagnosed high blood pressure: not taking meds	255	36	14.1%	21.1%	23.2%
Never had cholesterol check	597	83	13.9%	19.4%	22.2%
Diagnosed heart attack (myocardial infarction)	597	45	7.5%	5.8%	3.9%
Diagnosed heart disease	597	61	10.2%	7.4%	5.7%
Diagnosed stroke	597	33	5.5%	4.2%	2.5%
Diagnosed cardiovascular disease	597	56	9.4%	10.5%	7.2%
Diagnosed asthma	597	123	20.6%	15.8%	12.6%
Diagnosed any cancer	597	46	7.7%	8.8%	9.0%
Diagnosed COPD (incl. emphysema, chronic bronchitis)	597	92	15.4%	5.2%	5.4%
Diagnosed arthritis, rheumatoid arthritis, gout, lupus, fibromyalgia	597	213	35.7%	24.5%	20.7%
Diagnosed kidney disease	597	43	7.2%	2.2%	3.1%
Diagnosed depression (major, chronic, minor)	597	247	41.4%	15.1%	16.0%
Diagnosed diabetes	597	150	25.1%	14.2%	10.9%
Diagnosed diabetes, not checking blood glucose or sugar daily	150	21	14.0%	44.3%	39.1%
Obese BMI $\geq 30$	597	267	44.7%	32.9%	30.9%
Morbidly Obese BMI $\geq 35$	597	134	22.4%	11.5%	12.7%

\*These columns report the Survey of the Poor & Extremely Poor in West Texas results for the 20-county study region.

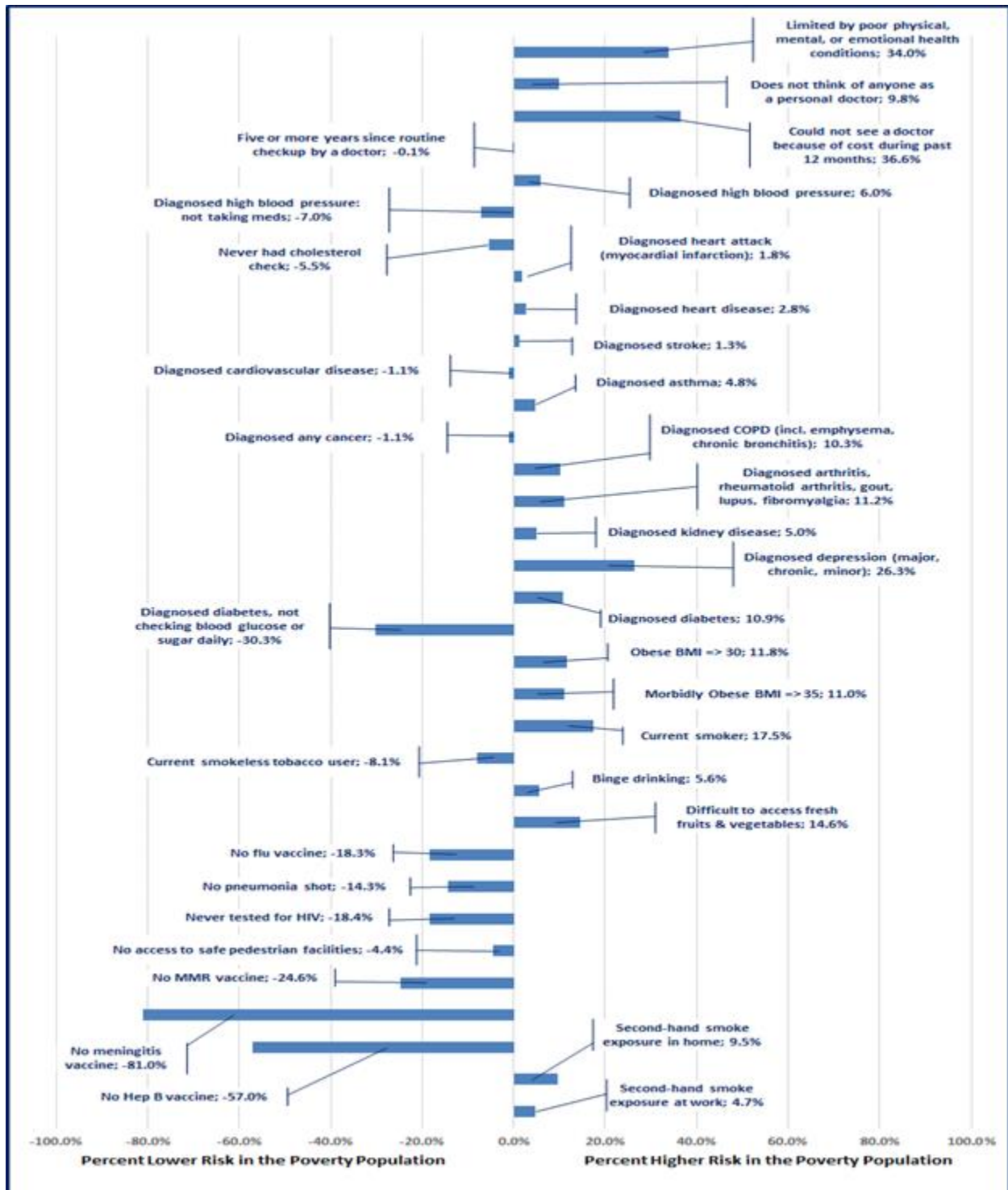
\*\*These columns include results from the Texas BRFSS conducted by the Texas Department of State Health Services in 2013. The BRFSS estimates reported for the Study Region Counties are risk-adjusted by Community Development Initiatives at Angelo State University to account for the specific demographic characteristics of the counties.

†The BRFSS data paralleling these items were derived from two separate items in the BRFSS interview. One item asked whether respondents were "kept from usual activities for 5 or more days by poor physical health." The other asked about mental health in the same manner.

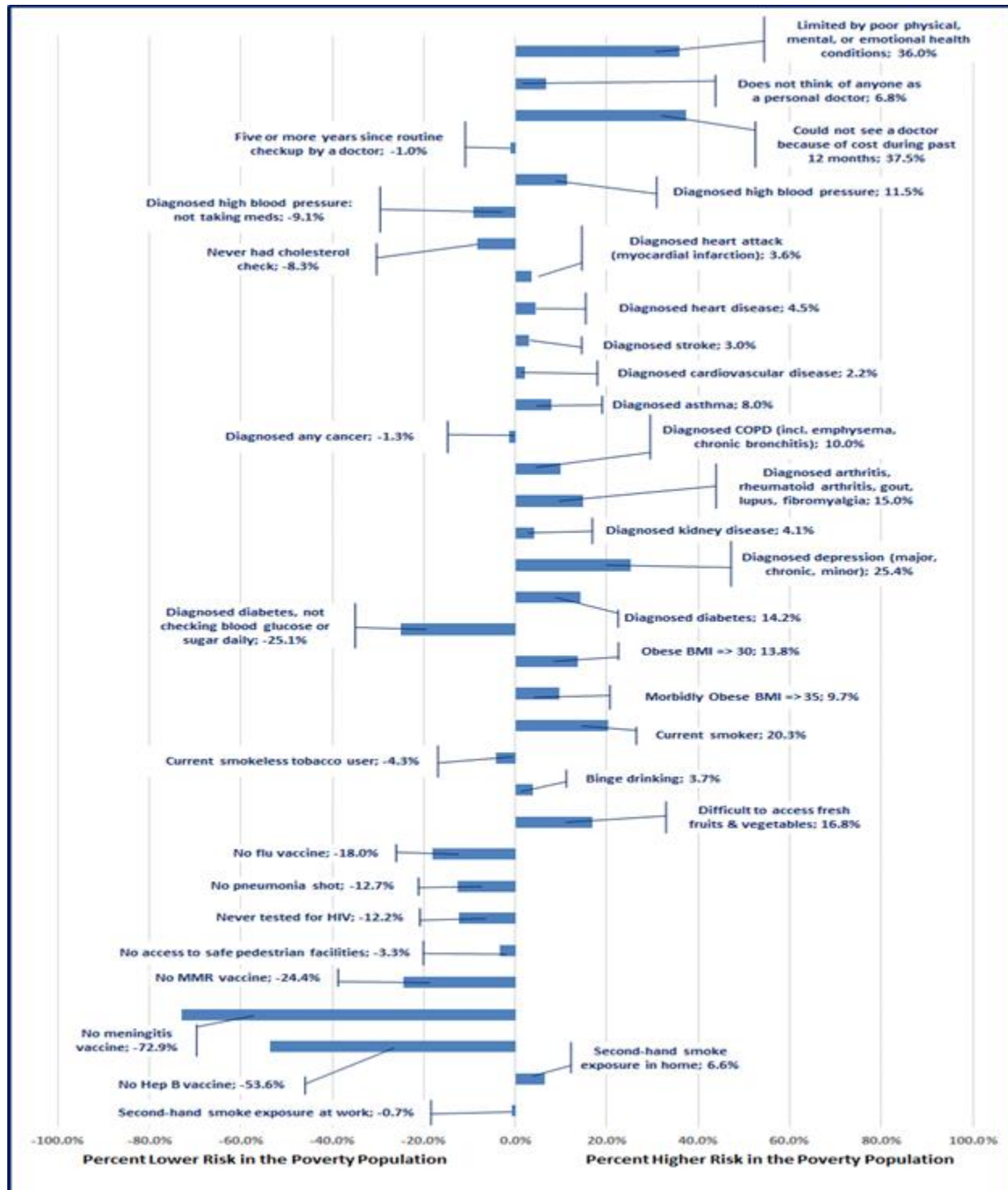
Parallel Risk Indicators (Continued)	Survey Results: 20 County Study Region*			BRFSS Risk Comparisons**	
	Sample	Population at Risk	Percent at Risk	Study Region Counties	Texas
Current smoker	597	216	36.2%	18.7%	15.9%
Current smokeless tobacco user				8.1%	4.3%
Binge drinking	597	122	20.4%	14.9%	16.7%
Difficult to access fresh fruits & vegetables	597	146	24.5%	9.9%	7.7%
No flu vaccine	597	276	46.2%	64.6%	64.2%
No pneumonia shot	597	333	55.8%	70.0%	68.5%
Never tested for HIV	597	295	49.4%	67.8%	61.6%
No access to safe pedestrian facilities	597	127	21.3%	25.7%	24.6%
No MMR vaccine	597	156	26.1%	50.8%	50.5%
No meningitis vaccine				81.0%	72.9%
No Hep B vaccine				57.0%	53.6%
Second-hand smoke exposure in home	597	121	20.3%	10.8%	13.7%
Second-hand smoke exposure at work	417	76	18.2%	13.5%	18.9%
<p>*These columns report the Survey of the Poor &amp; Extremely Poor in West Texas results for the 20-county study region.</p> <p>**These columns include results from the Texas BRFSS conducted by the Texas Department of State Health Services in 2013. The BRFSS estimates reported for the Study Region Counties are risk-adjusted by Community Development Initiatives at Angelo State University to account for the specific demographic characteristics of the counties.</p>					



The figure below provides a gap analysis between the survey indicators of health and behavioral health risks within the West Texas poverty population compared to parallel 2013 Texas BRFSS indicators for the 20-county study region. The percentages of higher or lower risk in the poverty population are derived from the data table above.



The figure below provides a gap analysis between the survey indicators of health and behavioral health risks within the West Texas poverty population compared to parallel 2013 Texas BRFSS indicators for state. The percentages of higher or lower risk in the poverty population are derived from the data table above.



## **APPENDIX C: RISK INDICATORS BY GEOGRAPHY AND DEMOGRAPHY**

The following tables report the survey responses to the health and behavioral health risk indicators by county of residence (geography) and demographic characteristics of respondents. Only individuals who provided demographic information and responded to the particular risk indicator depicted are included in the risk calculations (i.e. cases were deleted on a pairwise basis). Counties with fewer than five respondents on a given risk indicator are also excluded from the tables.

In all the tables, couples may be married couples or unmarried partners. Other households include respondents living with their parents; grandparents living with grandchildren; persons living with extended relatives; and persons living with roommates.

<b>Limited by poor physical, mental, or emotional health</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Crockett	16	10	62.5%
McCulloch	22	16	72.7%
Runnels	37	18	48.6%
San Saba	13	8	61.5%
Tom Green	275	148	53.8%
Val Verde	123	50	40.7%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	279	135	48.4%
Poor	277	128	46.2%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	159	88	55.3%
Female	436	196	45.0%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	254	152	59.8%
Hispanic	341	132	38.7%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	75	14	18.7%
30-39	108	31	28.7%
40-49	111	51	45.9%
50-64	212	141	66.5%
65 & Over	86	45	52.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	267	128	47.9%
12 or More	318	152	47.8%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	71	43	60.6%
Single Parent	126	47	37.3%
Couples with Children	142	41	28.9%
Couples without Children	114	62	54.4%
Other	142	91	64.1%

<b>Does not think of anyone as a personal doctor</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Kinney	18	5	27.8%
Runnels	37	6	16.2%
San Saba	13	5	38.5%
Schleicher	19	5	26.3%
Tom Green	274	155	56.6%
Upton	12	7	58.3%
Val Verde	123	40	32.5%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Severely poor	277	135	60.5%
Poor	277	88	39.5%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Male	159	79	33.2%
Female	434	159	66.8%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Not Hispanic	252	102	42.9%
Hispanic	341	136	57.1%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
18-29	74	45	18.9%
30-39	108	59	24.8%
40-49	111	48	20.2%
50-64	211	75	31.5%
65 & Over	86	11	4.6%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Less than 12	266	111	47.4%
12 or More	317	123	52.6%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Single Person	71	36	15.1%
Single Parent	126	48	20.2%
Couples with Children	141	66	27.7%
Couples without Children	113	32	13.4%
Other	142	56	23.5%

<b>Could not see a doctor because of cost during past 12 months</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Concho	7	7	100.0%
Crockett	14	5	35.7%
Kimble	7	5	71.4%
Kinney	11	7	63.6%
McCulloch	15	12	80.0%
Runnels	18	10	55.6%
San Saba	9	6	66.7%
Schleicher	13	8	61.5%
Tom Green	208	181	87.0%
Upton	8	8	100.0%
Val Verde	83	72	86.7%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Severely poor	220	186	58.3%
Poor	171	133	41.7%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Male	108	96	28.3%
Female	307	243	71.7%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Not Hispanic	175	142	41.9%
Hispanic	240	197	58.1%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
18-29	54	46	13.6%
30-39	80	71	20.9%
40-49	85	69	20.4%
50-64	159	134	39.5%
65 & Over	36	19	5.6%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Less than 12	183	152	45.2%
12 or More	227	184	54.8%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Single Person	48	42	12.4%
Single Parent	93	71	20.9%
Couples with Children	110	97	28.6%
Couples without Children	77	65	19.2%
Other	88	64	18.9%

<b>Five or more years since routine checkup by a doctor</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Tom Green	272	37	13.6%
Val Verde	118	7	5.9%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	272	37	13.6%
Poor	276	18	6.5%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	156	23	14.7%
Female	430	34	7.9%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	253	27	10.7%
Hispanic	333	30	9.0%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	9	12.2%
30-39	107	15	14.0%
40-49	106	7	6.6%
50-64	211	23	10.9%
65 & Over	85	3	3.5%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	261	30	11.5%
12 or More	316	27	8.5%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	68	6	8.8%
Single Parent	125	13	10.4%
Couples with Children	141	13	9.2%
Couples without Children	113	8	7.1%
Other	140	17	12.1%

<b>Diagnosed high blood pressure</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Concho	8	5	62.5%
Crockett	16	12	75.0%
Kinney	19	5	26.3%
McCulloch	22	11	50.0%
Runnels	37	15	40.5%
San Saba	13	9	69.2%
Tom Green	268	103	38.4%
Val Verde	121	70	57.9%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	275	118	42.9%
Poor	274	121	44.2%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	157	70	44.6%
Female	428	185	43.2%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	249	108	43.4%
Hispanic	336	147	43.8%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	10	13.5%
30-39	106	24	22.6%
40-49	110	45	40.9%
50-64	207	113	54.6%
65 & Over	85	61	71.8%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	265	125	47.2%
12 or More	310	127	41.0%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	69	25	36.2%
Single Parent	124	43	34.7%
Couples with Children	140	52	37.1%
Couples without Children	113	60	53.1%
Other	140	75	53.6%



<b>Diagnosed high blood pressure &amp; not taking meds</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Tom Green	103	23	22.3%
Val Verde	70	6	8.6%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	118	21	17.8%
Poor	121	13	10.7%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	70	12	17.1%
Female	185	24	13.0%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	108	14	13.0%
Hispanic	147	22	15.0%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	10	5	50.0%
30-39	24	7	29.2%
40-49	45	9	20.0%
50-64	113	13	11.5%
65 & Over	61	2	3.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	125	20	16.0%
12 or More	127	16	12.6%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	25	3	12.0%
Single Parent	43	9	20.9%
Couples with Children	52	13	25.0%
Couples without Children	60	6	10.0%
Other	75	5	6.7%

Never had cholesterol check			
County of Residence	Sample	At Risk	Percent at Risk
Kinney	19	6	31.6%
Tom Green	275	50	18.2%
Val Verde	119	12	10.1%
Poverty Status	Sample	At Risk	Percent at Risk
Severely poor	279	46	16.5%
Poor	275	31	11.3%
Gender	Sample	At Risk	Percent at Risk
Male	159	36	22.6%
Female	432	47	10.9%
Ethnicity	Sample	At Risk	Percent at Risk
Not Hispanic	252	24	9.5%
Hispanic	339	59	17.4%
Age	Sample	At Risk	Percent at Risk
18-29	75	18	24.0%
30-39	107	15	14.0%
40-49	110	18	16.4%
50-64	212	28	13.2%
65 & Over	85	4	4.7%
Years of Schooling	Sample	At Risk	Percent at Risk
Less than 12	266	48	18.0%
12 or More	314	33	10.5%
Household Composition	Sample	At Risk	Percent at Risk
Single Person	71	13	18.3%
Single Parent	125	14	11.2%
Couples with Children	141	23	16.3%
Couples without Children	114	13	11.4%
Other	141	20	14.2%

<b>Diagnosed heart attack (myocardial infarction)</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Tom Green	266	18	6.8%
Val Verde	110	8	7.3%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	273	18	6.6%
Poor	264	22	8.3%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	151	12	7.9%
Female	421	33	7.8%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	245	24	9.8%
Hispanic	327	21	6.4%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	0	0.0%
30-39	103	1	1.0%
40-49	109	2	1.8%
50-64	204	28	13.7%
65 & Over	81	14	17.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	259	21	8.1%
12 or More	303	22	7.3%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	67	3	4.5%
Single Parent	122	8	6.6%
Couples with Children	137	7	5.1%
Couples without Children	112	13	11.6%
Other	135	14	10.4%

<b>Diagnosed heart disease</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Crockett	16	6	37.5%
Tom Green	266	21	7.9%
Val Verde	116	12	10.3%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	272	28	10.3%
Poor	267	27	10.1%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	153	17	11.1%
Female	421	44	10.5%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	246	29	11.8%
Hispanic	328	32	9.8%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	72	1	1.4%
30-39	105	0	0.0%
40-49	110	6	5.5%
50-64	203	36	17.7%
65 & Over	82	18	22.0%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	258	27	10.5%
12 or More	306	32	10.5%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	67	4	6.0%
Single Parent	122	10	8.2%
Couples with Children	138	8	5.8%
Couples without Children	111	14	12.6%
Other	137	25	18.2%

<b>Diagnosed stroke</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Tom Green	265	13	4.9%
Val Verde	108	8	7.4%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	266	14	5.3%
Poor	264	18	6.8%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	150	10	6.7%
Female	413	23	5.6%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	242	12	5.0%
Hispanic	321	21	6.5%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	71	0	0.0%
30-39	102	2	2.0%
40-49	109	4	3.7%
50-64	200	18	9.0%
65 & Over	79	9	11.4%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	253	13	5.1%
12 or More	301	20	6.6%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	68	3	4.4%
Single Parent	119	7	5.9%
Couples with Children	134	2	1.5%
Couples without Children	111	11	9.9%
Other	132	10	7.6%

<b>Diagnosed cardiovascular disease</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Crockett	16	7	43.8%
Tom Green	263	20	7.6%
Val Verde	110	12	10.9%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	267	23	8.6%
Poor	261	29	11.1%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	151	18	11.9%
Female	411	38	9.2%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	239	31	13.0%
Hispanic	323	25	7.7%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	72	1	1.4%
30-39	102	3	2.9%
40-49	106	5	4.7%
50-64	200	26	13.0%
65 & Over	80	21	26.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	254	24	9.4%
12 or More	300	30	10.0%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	67	4	6.0%
Single Parent	123	9	7.3%
Couples with Children	134	6	4.5%
Couples without Children	111	17	15.3%
Other	128	20	15.6%

<b>Diagnosed asthma</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
McCulloch	22	6	27.3%
Runnels	37	15	40.5%
Tom Green	269	60	22.3%
Val Verde	114	21	18.4%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	274	51	18.6%
Poor	267	60	22.5%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	152	37	24.3%
Female	424	86	20.3%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	244	74	30.3%
Hispanic	332	49	14.8%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	75	13	17.3%
30-39	104	16	15.4%
40-49	110	25	22.7%
50-64	205	55	26.8%
65 & Over	80	13	16.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	258	49	19.0%
12 or More	308	71	23.1%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	69	16	23.2%
Single Parent	122	19	15.6%
Couples with Children	137	22	16.1%
Couples without Children	112	32	28.6%
Other	137	34	24.8%

<b>Diagnosed cancer</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
McCulloch	22	5	22.7%
Tom Green	270	25	9.3%
Val Verde	110	6	5.5%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	273	20	7.3%
Poor	264	23	8.7%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	151	13	8.6%
Female	422	33	7.8%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	244	27	11.1%
Hispanic	329	19	5.8%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	75	2	2.7%
30-39	104	7	6.7%
40-49	110	7	6.4%
50-64	203	20	9.9%
65 & Over	79	9	11.4%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	257	22	8.6%
12 or More	306	21	6.9%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	69	2	2.9%
Single Parent	122	9	7.4%
Couples with Children	136	8	5.9%
Couples without Children	110	11	10.0%
Other	137	16	11.7%



<b>Diagnosed COPD</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Crockett	16	5	31.3%
McCulloch	21	5	23.8%
Runnels	37	7	18.9%
Tom Green	262	38	14.5%
Val Verde	112	19	17.0%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	269	39	14.5%
Poor	262	44	16.8%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	149	18	12.1%
Female	417	74	17.7%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	237	58	24.5%
Hispanic	329	34	10.3%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	73	1	1.4%
30-39	103	2	1.9%
40-49	108	21	19.4%
50-64	201	50	24.9%
65 & Over	79	17	21.5%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	256	47	18.4%
12 or More	301	43	14.3%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	68	16	23.5%
Single Parent	122	15	12.3%
Couples with Children	135	7	5.2%
Couples without Children	110	34	30.9%
Other	132	20	15.2%

<b>Diagnosed arthritis</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Concho	8	8	100.0%
Crockett	16	8	50.0%
Kinney	19	10	52.6%
McCulloch	22	13	59.1%
Mills	8	5	62.5%
Runnels	37	14	37.8%
Schleicher	19	5	26.3%
Tom Green	270	87	32.2%
Val Verde	113	35	31.0%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	275	96	34.9%
Poor	266	105	39.5%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	151	48	31.8%
Female	425	164	38.6%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	244	103	42.2%
Hispanic	332	109	32.8%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	5	6.8%
30-39	104	19	18.3%
40-49	109	31	28.4%
50-64	206	100	48.5%
65 & Over	81	57	70.4%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	261	101	38.7%
12 or More	305	108	35.4%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	70	27	38.6%
Single Parent	123	35	28.5%
Couples with Children	137	28	20.4%
Couples without Children	112	56	50.0%
Other	135	67	49.6%

<b>Diagnosed kidney disease</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Tom Green	266	20	7.5%
Val Verde	112	12	10.7%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	270	26	9.6%
Poor	266	14	5.3%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	151	10	6.6%
Female	419	33	7.9%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	243	18	7.4%
Hispanic	327	25	7.6%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	4	5.4%
30-39	104	1	1.0%
40-49	107	8	7.5%
50-64	202	20	9.9%
65 & Over	81	10	12.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	257	23	8.9%
12 or More	303	19	6.3%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	69	10	14.5%
Single Parent	122	6	4.9%
Couples with Children	136	3	2.2%
Couples without Children	110	11	10.0%
Other	134	13	9.7%

<b>Diagnosed depression</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Concho	8	7	87.5%
Crockett	16	7	43.8%
Kinney	19	6	31.6%
McCulloch	22	8	36.4%
Menard	10	5	50.0%
Runnels	36	12	33.3%
San Saba	13	7	53.8%
Tom Green	271	136	50.2%
Val Verde	116	38	32.8%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	276	121	43.8%
Poor	271	107	39.5%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	154	68	44.2%
Female	428	178	41.6%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	248	133	53.6%
Hispanic	334	113	33.8%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	21	28.4%
30-39	106	39	36.8%
40-49	110	53	48.2%
50-64	209	101	48.3%
65 & Over	81	30	37.0%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	261	112	42.9%
12 or More	311	131	42.1%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	70	35	50.0%
Single Parent	123	44	35.8%
Couples with Children	139	47	33.8%
Couples without Children	112	50	44.6%
Other	139	71	51.1%

<b>Diagnosed diabetes</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
McCulloch	22	7	31.8%
Runnels	37	10	27.0%
Tom Green	267	63	23.6%
Val Verde	119	41	34.5%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	272	75	27.6%
Poor	272	65	23.9%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	155	35	22.6%
Female	426	115	27.0%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	245	44	18.0%
Hispanic	336	106	31.5%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	74	4	5.4%
30-39	104	9	8.7%
40-49	110	26	23.6%
50-64	205	71	34.6%
65 & Over	86	39	45.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	265	85	32.1%
12 or More	306	63	20.6%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	69	22	31.9%
Single Parent	123	24	19.5%
Couples with Children	139	26	18.7%
Couples without Children	114	37	32.5%
Other	137	41	29.9%

<b>Diagnosed diabetes, not checking blood glucose or sugar daily</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Tom Green	63	10	15.9%
Val Verde	41	7	17.1%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	63	14	22.2%
Poor	58	5	8.6%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	32	7	21.9%
Female	97	14	14.4%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	41	5	12.2%
Hispanic	88	16	18.2%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	4	3	75.0%
30-39	7	2	28.6%
40-49	21	3	14.3%
50-64	62	11	17.7%
65 & Over	34	2	5.9%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	76	15	19.7%
12 or More	52	6	11.5%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	18	3	16.7%
Single Parent	20	2	10.0%
Couples with Children	23	7	30.4%
Couples without Children	32	6	18.8%
Other	36	3	8.3%

<b>Obesity: BMI greater than or equal to 30</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Crockett	16	5	31.3%
Kinney	18	7	38.9%
McCulloch	21	11	52.4%
Mills	9	5	55.6%
Runnels	36	14	38.9%
San Saba	11	5	45.5%
Schleicher	17	7	41.2%
Tom Green	271	121	44.6%
Val Verde	120	67	55.8%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	272	131	48.2%
Poor	267	119	44.6%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	157	52	33.1%
Female	421	215	51.1%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	247	97	39.3%
Hispanic	331	170	51.4%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	73	31	42.5%
30-39	106	43	40.6%
40-49	108	64	59.3%
50-64	204	97	47.5%
65 & Over	85	30	35.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	256	128	50.0%
12 or More	313	134	42.8%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	68	27	39.7%
Single Parent	126	67	53.2%
Couples with Children	136	65	47.8%
Couples without Children	110	52	47.3%
Other	138	56	40.6%

<b>Morbid Obesity: BMI greater than or equal to 35</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
McCulloch	21	7	33.3%
Runnels	36	6	16.7%
Tom Green	271	57	21.0%
Val Verde	120	35	29.2%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	272	74	27.2%
Poor	267	51	19.1%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	157	26	16.6%
Female	421	108	25.7%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	247	46	18.6%
Hispanic	331	88	26.6%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	73	15	20.5%
30-39	106	25	23.6%
40-49	108	34	31.5%
50-64	204	47	23.0%
65 & Over	85	12	14.1%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	256	60	23.4%
12 or More	313	74	23.6%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	68	14	20.6%
Single Parent	126	35	27.8%
Couples with Children	136	30	22.1%
Couples without Children	110	26	23.6%
Other	138	29	21.0%



Current smoker or tobacco user			
County of Residence	Sample	At Risk	Percent at Risk
McCulloch	22	9	40.9%
Mills	10	6	60.0%
Runnels	37	17	45.9%
San Saba	13	6	46.2%
Tom Green	274	119	43.4%
Upton	12	5	41.7%
Val Verde	117	31	26.5%
Poverty Status	Sample	At Risk	Percent at Risk
Severely poor	276	108	39.1%
Poor	275	95	34.5%
Gender	Sample	At Risk	Percent at Risk
Male	158	80	50.6%
Female	430	135	31.4%
Ethnicity	Sample	At Risk	Percent at Risk
Not Hispanic	251	139	55.4%
Hispanic	337	76	22.6%
Age	Sample	At Risk	Percent at Risk
18-29	75	25	33.3%
30-39	108	47	43.5%
40-49	111	48	43.2%
50-64	212	77	36.3%
65 & Over	80	16	20.0%
Years of Schooling	Sample	At Risk	Percent at Risk
Less than 12	261	88	33.7%
12 or More	316	123	38.9%
Household Composition	Sample	At Risk	Percent at Risk
Single Person	71	28	39.4%
Single Parent	125	38	30.4%
Couples with Children	142	47	33.1%
Couples without Children	111	42	37.8%
Other	140	61	43.6%

<b>Binge drinking</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Runnels	37	11	29.7%
Tom Green	275	65	23.6%
Val Verde	118	22	18.6%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	277	49	17.7%
Poor	277	65	23.5%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	159	42	26.4%
Female	431	79	18.3%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	251	53	21.1%
Hispanic	339	68	20.1%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	75	16	21.3%
30-39	108	37	34.3%
40-49	110	19	17.3%
50-64	212	42	19.8%
65 & Over	83	7	8.4%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	264	54	20.5%
12 or More	315	66	21.0%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	71	15	21.1%
Single Parent	125	20	16.0%
Couples with Children	142	38	26.8%
Couples without Children	113	22	19.5%
Other	140	27	19.3%

<b>Difficult to access fresh fruits &amp; vegetables</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Runnels	37	5	13.5%
San Saba	13	6	46.2%
Tom Green	273	83	30.4%
Upton	12	5	41.7%
Val Verde	123	25	20.3%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Severely poor	278	77	56.6%
Poor	276	59	43.4%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Male	158	40	27.4%
Female	435	106	72.6%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Not Hispanic	252	72	49.3%
Hispanic	341	74	50.7%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
18-29	75	17	11.8%
30-39	108	18	12.5%
40-49	111	30	20.8%
50-64	210	61	42.4%
65 & Over	86	18	12.5%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Less than 12	267	67	46.9%
12 or More	316	76	53.1%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent of at Risk</b>
Single Person	71	27	18.5%
Single Parent	126	29	19.9%
Couples with Children	142	24	16.4%
Couples without Children	113	24	16.4%
Other	141	42	28.8%

<b>No flu vaccine</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Kimble	9	6	66.7%
Kinney	19	8	42.1%
McCulloch	22	9	40.9%
Menard	10	8	80.0%
Runnels	37	17	45.9%
San Saba	12	9	75.0%
Schleicher	19	8	42.1%
Tom Green	262	131	50.0%
Upton	12	10	83.3%
Val Verde	114	56	49.1%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	268	134	50.0%
Poor	268	125	46.6%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	150	88	58.7%
Female	421	188	44.7%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	243	128	52.7%
Hispanic	328	148	45.1%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	72	40	55.6%
30-39	107	68	63.6%
40-49	107	52	48.6%
50-64	202	91	45.0%
65 & Over	81	24	29.6%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	257	121	47.1%
12 or More	305	152	49.8%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	65	33	50.8%
Single Parent	123	56	45.5%
Couples with Children	141	77	54.6%
Couples without Children	110	47	42.7%
Other	133	63	47.4%

No pneumonia shot			
County of Residence	Sample	At Risk	Percent at Risk
Concho	8	5	62.5%
Edwards	5	5	100.0%
Kimble	7	6	85.7%
Kinney	18	12	66.7%
McCulloch	21	7	33.3%
Menard	10	6	60.0%
Runnels	36	23	63.9%
San Saba	12	10	83.3%
Schleicher	18	14	77.8%
Tom Green	258	159	61.6%
Upton	12	11	91.7%
Val Verde	105	67	63.8%
Poverty Status	Sample	At Risk	Percent at Risk
Severely poor	260	164	63.1%
Poor	249	149	59.8%
Gender	Sample	At Risk	Percent at Risk
Male	145	105	72.4%
Female	398	227	57.0%
Ethnicity	Sample	At Risk	Percent at Risk
Not Hispanic	242	136	56.2%
Hispanic	301	196	65.1%
Age	Sample	At Risk	Percent at Risk
18-29	65	53	81.5%
30-39	96	73	76.0%
40-49	101	62	61.4%
50-64	199	111	55.8%
65 & Over	80	32	40.0%
Years of Schooling	Sample	At Risk	Percent at Risk
Less than 12	245	139	56.7%
12 or More	289	188	65.1%
Household Composition	Sample	At Risk	Percent at Risk
Single Person	65	38	58.5%
Single Parent	112	67	59.8%
Couples with Children	127	95	74.8%
Couples without Children	111	61	55.0%
Other	129	72	55.8%

Never tested for HIV			
County of Residence	Sample	At Risk	Percent at Risk
Concho	8	5	62.5%
Crockett	16	10	62.5%
Kinney	19	16	84.2%
McCulloch	22	12	54.5%
Runnels	37	27	73.0%
San Saba	13	10	76.9%
Schleicher	19	8	42.1%
Tom Green	272	119	43.8%
Val Verde	116	62	53.4%
Poverty Status	Sample	At Risk	Percent at Risk
Severely poor	274	128	46.7%
Poor	273	143	52.4%
Gender	Sample	At Risk	Percent at Risk
Male	158	86	54.4%
Female	426	208	48.8%
Ethnicity	Sample	At Risk	Percent at Risk
Not Hispanic	249	98	39.4%
Hispanic	335	196	58.5%
Age	Sample	At Risk	Percent at Risk
18-29	75	33	44.0%
30-39	105	35	33.3%
40-49	109	54	49.5%
50-64	211	114	54.0%
65 & Over	82	58	70.7%
Years of Schooling	Sample	At Risk	Percent at Risk
Less than 12	261	145	55.6%
12 or More	312	143	45.8%
Household Composition	Sample	At Risk	Percent at Risk
Single Person	71	37	52.1%
Single Parent	123	47	38.2%
Couples with Children	139	68	48.9%
Couples without Children	114	67	58.8%
Other	138	76	55.1%

No access to safe pedestrian facilities			
County of Residence	Sample	At Risk	Percent at Risk
McCulloch	22	8	36.4%
Tom Green	273	87	31.9%
Val Verde	122	15	12.3%
Poverty Status	Sample	At Risk	Percent at Risk
Severely poor	278	60	21.6%
Poor	276	54	19.6%
Gender	Sample	At Risk	Percent at Risk
Male	159	27	17.0%
Female	433	100	23.1%
Ethnicity	Sample	At Risk	Percent at Risk
Not Hispanic	252	66	26.2%
Hispanic	340	61	17.9%
Age	Sample	At Risk	Percent at Risk
18-29	75	16	21.3%
30-39	108	15	13.9%
40-49	111	25	22.5%
50-64	210	57	27.1%
65 & Over	85	12	14.1%
Years of Schooling	Sample	At Risk	Percent at Risk
Less than 12	266	61	22.9%
12 or More	316	63	19.9%
Household Composition	Sample	At Risk	Percent at Risk
Single Person	71	15	21.1%
Single Parent	124	16	12.9%
Couples with Children	142	36	25.4%
Couples without Children	113	23	20.4%
Other	142	37	26.1%

<b>No MMR, meningitis, or Hep B vaccine</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Kinney	18	8	44.4%
McCulloch	22	6	27.3%
Runnels	37	11	29.7%
San Saba	12	7	58.3%
Schleicher	19	5	26.3%
Tom Green	233	50	21.5%
Val Verde	116	56	48.3%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	250	66	26.4%
Poor	254	79	31.1%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	145	45	31.0%
Female	393	110	28.0%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	230	45	19.6%
Hispanic	308	110	35.7%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	70	12	17.1%
30-39	102	25	24.5%
40-49	96	29	30.2%
50-64	187	56	29.9%
65 & Over	81	32	39.5%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	240	82	34.2%
12 or More	291	70	24.1%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	64	16	25.0%
Single Parent	116	17	14.7%
Couples with Children	122	32	26.2%
Couples without Children	107	41	38.3%
Other	130	50	38.5%



Second-hand smoke exposure in home			
County of Residence	Sample	At Risk	Percent at Risk
Concho	8	6	75.0%
McCulloch	22	10	45.5%
Runnels	36	8	22.2%
Tom Green	258	62	24.0%
Upton	12	5	41.7%
Val Verde	98	16	16.3%
Poverty Status	Sample	At Risk	Percent at Risk
Severely poor	259	51	19.7%
Poor	256	59	23.0%
Gender	Sample	At Risk	Percent at Risk
Male	149	40	26.8%
Female	400	80	20.0%
Ethnicity	Sample	At Risk	Percent at Risk
Not Hispanic	240	88	36.7%
Hispanic	309	32	10.4%
Age	Sample	At Risk	Percent at Risk
18-29	71	9	12.7%
30-39	105	16	15.2%
40-49	100	22	22.0%
50-64	200	59	29.5%
65 & Over	71	14	19.7%
Years of Schooling	Sample	At Risk	Percent at Risk
Less than 12	238	53	22.3%
12 or More	301	67	22.3%
Household Composition	Sample	At Risk	Percent at Risk
Single Person	65	17	26.2%
Single Parent	119	11	9.2%
Couples with Children	139	23	16.5%
Couples without Children	105	36	34.3%
Other	122	34	27.9%

<b>Second-hand smoke exposure at work</b>			
<b>County of Residence</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Runnels	31	12	38.7%
Tom Green	197	31	15.7%
Val Verde	79	19	24.1%
<b>Poverty Status</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Severely poor	196	31	15.8%
Poor	193	42	21.8%
<b>Gender</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Male	115	28	24.3%
Female	301	48	15.9%
<b>Ethnicity</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Not Hispanic	161	34	21.1%
Hispanic	255	42	16.5%
<b>Age</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
18-29	66	14	21.2%
30-39	85	24	28.2%
40-49	83	16	19.3%
50-64	134	18	13.4%
65 & Over	48	4	8.3%
<b>Years of Schooling</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Less than 12	185	32	17.3%
12 or More	223	42	18.8%
<b>Household Composition</b>	<b>Sample</b>	<b>At Risk</b>	<b>Percent at Risk</b>
Single Person	48	5	10.4%
Single Parent	99	17	17.2%
Couples with Children	120	28	23.3%
Couples without Children	72	11	15.3%
Other	78	15	19.2%

## APPENDIX D: KEY INFORMANT & STAKEHOLDER OPEN-ENDED COMMENTS

### Coke County

These two hospital districts don't seem to be interested in working together. They are in competition with each other and don't want to give up the nursing homes in their respective towns, to be more efficient.

### Concho County

Nutrition Services are unavailable to Senior Citizens effect 12/31/15. Will have no means of supplementing daily requirements.

Even though our neighbor county Menard has a dentist provided by Frontera, Concho County only has one dentist, and he only works two days per week. I think Concho County is in desperate need of a dentist and that office would be used quite often.

To my knowledge, Concho County does not have a community health worker. Currently we are participating in the Texas 1115 Transformation Waiver, and most of the projects we collaborate with have, and use, CHW's all of the time. For the resources it takes to certify one, and the wages that person would make, the impact on the community, especially the Medicaid, 2-income, and uninsured population is vast and that worker will always prove to be a necessity.

Diabetic patients' needs are tough to meet for any community. Whether it be diet management, supplies, medication, and costs or all of the above, any and all resources available to help them will be used often.

Through our 1115 Waiver Diabetic project, we have realized that one of our biggest challenges is overcoming the cost barriers for our patients. We have found a way to help them, but need more ideas on how to sustain improvements for the future aside from helping them financially because our funding is obviously not going to last forever. Then what happens to our patients when the program is over? Measurements for our project reveal that the MLIU population from last demonstration year (10/01/2014-09/30/2015) is 40% of our patients, which is up 15% from last year.

Case management is needed because it adheres to the patient's needs on a case by case basis and helps to ensure that everybody has their screenings and vaccinations and keeps regular doctor's appointments.

We see this [preventative outreach to vulnerable groups to promote healthy living & wellness] a lot with our Health and Wellness Center, people want to get healthy and exercise, but some

of the people just cannot afford it. But, for people in general to just get healthy, the poor, extremely poor, etc. need more education and resources.

Obesity prevention (especially for children) is something this county really needs. With the opening of our new Health and Wellness Center, we are going to try something for kids, but Concho County needs to pool resources to address this problem. A boys and girls club for after school that provides healthy snacks and education about eating and cooking healthy is something this community needs.

Extremely difficult, if not impossible, to obtain [reducing cost and other barriers for behavioral health]. MHMR refuses to evaluate or accept patients from county hospital.

Depression is hard to treat. Sometimes patients have to try a host of different medications and therapeutic strategies before they find something that really works for them. I just think Concho County needs more resources for those suffering from Depression or any other behavioral condition for that matter.

### **Edwards County**

Senior Citizens need to have a good health clinic to be taken to on a daily basis

Dental is an important phase of the elders' lives. A Facility with this kind of help would make things easier.

Our closest [cancer] treatment facility is 77 miles away. Transportation to and from doctors is always needed.

Edwards County is a small community with very little resources. Most of the Edwards residents are on a fixed income and not enough money. Residents have to drive at least 30 to 40 miles to the closest hospital or nearest physician. Any resources brought to this community will help tremendously.

### **Irion County**

Having a HCP [health care professional] in the community monthly or every two weeks would be beneficial especially for the working poor and seniors.

Offering free screenings.

### **Kimble County**

One dentist in town, and I am told she is very limited on what services she can provide.

The only clinic we have is in Junction, Texas which is accessed Monday-Friday 8-5. We do have an excellent hospital which can stabilize individuals prior to transport to other agencies.

No classes currently being taught on prevention or maintenance [of diabetes].

One major barrier to treatment is transportation; some folks can't even get to our clinic, and some can't get to specialists out of town. Our charity program quickly runs out of funds every month, and our indigent program only covers those at the 21st percentile or below poverty level.

The closing of the State DSHS office affected many people who either don't have access/knowledge of computer use, or can't get a ride to Brady to enroll in programs such as SNAP, Medicaid, TANF, etc. I end up helping several people every month, and to many of them, I am their only resource.

No such [diabetes] programs are provided in Junction that I am aware of.

To my knowledge, the only food bank in town is run through our local Methodist Church, and their supplies do sometimes run low. It would be nice to see them collaborate with and receive items from one of the larger grocery store chains, like some big city food banks do. It would be great to see some 'nutritional counseling' and 'self-sufficiency in gardening' type classes be offered. Or even, "How to stretch your SNAP benefits with healthy choices" rather than blowing through \$120 of benefits on sodas and frozen burritos, etc.

## **Kinney County**

Too often I hear about out senior citizens falling and breaking a hip or ankle. I believe we need a comprehensive program that can come in and senior proof these citizens' homes. I think another issue that needs to be looked at is seniors traveling from Kinney County to Del Rio or Uvalde or San Antonio to special care. Too often I hear requests at my church or from concerned family members that their loved ones need to get to one of these locations to see a specialist and often do not have a reliable way to get to their appointments.

Need for seniors is great in Kinney County. They need the resources to be made aware of what benefits area available to them. They also need transportation to medical appointments.

There is limited health care in the community. At present we do have a clinic but not a doctor. The poverty keeps people from even seeking health care. There is no specialty care like pediatrics or geriatric care.

More screening for adults and children in way of health fairs through the school and senior nutrition center.

There is not a licensed child-care facility, or pre-school in Kinney County. There is a head-start program at the public school for 4 yr. olds, but it is limited in number of children it can take. The problem is two-fold. Many children in our county are not prepared to enter into the education system and succeed. 2nd - Families remain impoverished, because the lack of childcare makes work or job training improbable to manage. Whatever is done in the way of childcare, it needs to be sliding scale with a possibility of full scholarship so that registration fees don't prevent participation.

HOPE outreach, a Methodist Ministry, has been trying to work on programs to engage teens into community programs. Upon talking to teens we find that alcohol and drugs are a problem thus leading to the teen pregnancies.

The teen pregnancy rate of our county is one of the highest in the nation. Education, counseling, for both parents and children are needed.

Most citizens or a large percentage of our citizens have to go to Mexico for their dental care, due to the affordability of that foreign country as opposed to this nation.

The dental care needs of many in the lower income groups are being met in Kinney County. There is a great need for a dentist.

We have many families in the county who need access to trained behavioral health providers. Alcohol and substance abuse is an issue in our county as is domestic violence, which often goes unreported, because there are no good solutions, even when reported.

No nursing home in the area. Closest homes are either 32 or 40 miles away.

Nursing homes are within 30 miles of Brackettville. More effort should be spent in other areas rather than nursing homes.

We have a local church alliance that works toward working together to improve the community.

We have one PA in the clinic and no doctor. The closest doctors are 32 miles away. Most of the poverty level clients have no transportation. There are no public transports either.

Very often I hear about this kid or that kid indicating some need to see a psychiatrist, or having suicide tendencies or crying out for help. Our school does provide some type of help but for its good reasons or legal reasons I believe they fall short of sharing information. I did form a group named SALT (Saving A Life Together), but we are in need of more professional training. It is difficult to get that training because everyone has to work for a living, and it is hard to take time off duty hours. It's like a catch 22.

More training for peace officers, first responders and EMS personnel for mentally challenged patients, criminals, etc.

There is often not enough monthly income to cover the cost of basics, such as housing, food, and utilities, so practice of health screening for early detection is not standard practice for most in the county, nor is seeking treatment until health problems are advance.

Needs are for outdoor walking tracks, recreational park, soccer field and education classes regarding this treatable and preventable disease [obesity].

Again much needed counseling and education [for obesity]. And again, it must be provided at home as well as at school.

We have a church alliance sponsored Commodities distribution for qualifying families monthly and an emergency food pantry that tries to help bridge the gaps throughout the month as needs arise. Much of the groceries supplied are canned or dried foods. Fresh vegetables and fruit are not part of the distribution programs we have in place. Meat distribution is rare.

Very limited on resources. Most have to drive to the nearest community. Transportation plays a big problem in Kinney.

### **Mason County**

Mason's population contains a high amount of individuals 65 and older. I believe the need for more senior services is a must.

Need someone who is bilingual to address the Hispanic segment of our community regarding this topic [preventative outreach to vulnerable groups to promote healthy living and wellness; to reduce obesity; and to reduce diabetes]. Need some incentive for people to attempt to improve their situation.

Mason does not have access to any type of mental health, counseling or depression related services. I feel that it is a must for the service as well.

I would like to see some type of proven program implemented here in Mason that can empower people to seek improved health & financial status, rather than continue watching efforts to just give to needy people.

### **McCulloch County**

Working for the Better Living for Texans program, we work hard to educate the poor and very poor on better eating habits as well as smart shopping and the importance of exercise. While working with this program, I have witnessed first-hand the need in this community. I have

found that many of the residents here do not like to admit that they are in need as well as a helplessness as far as change goes. I have met many that would rather go without than utilize the local food pantry because of the amount of paperwork involved in the process as well as the humiliation of the process. That being said, many people do benefit from the program. I do believe that once a month at the main pantry is not sufficient for those most in need. Many have stated that it is near impossible to make it to the end of the month. While we can educate and give them tools to making their food dollars go farther, living in a food desert, it is hard to find the best prices on staple items. I would like to see a more people friendly system for distribution of food at this location.

### **Schleicher County**

If we could educate the general public, the poor and the extremely poor in our county about the importance of healthy living and wellness, maybe some of the health issues in our county would start to correct themselves.

This area is a food desert. Many of the lifestyle changes that people need to make are next to impossible to carry out due to the lack of fresh nutritionally rich sources of food.

### **Sterling County**

There seem to be a disproportionate number of accidents here. Not sure what can be done about it, except as regards to alcohol.

Alcohol abuse is an issue in the area for a number of folks, which leads to influenced driving, which leads to deaths and injuries due to accidents.

### **Sutton County**

The Food and Resource Center of Sutton County opened its doors in October 2014. After one year of operation, the Center is now providing monthly food boxes to an average of 120 families made up of 325 individuals. Our client base is composed of 185 families made up of more than 450 individuals. In addition to monthly food distribution, the Center provides office and/or meeting space for the following services: MHMR, West Texas Guidance and Counseling Center, Rio Grande Legal Aid, American Cancer Society and other social service providers. Lillian Hudspeth Memorial Hospital has a Community Outreach Nurse who operates out of the center three days a week. The Food and Resource Center of Sutton County is a non-profit organization that seeks to address the health and emotional needs of residents of Sutton County. The Center is located at 704 Glasscock Street in Sonora, Texas. Theresa Ward, Executive Director, may be contacted at 325-387-2458.



## Tom Green County

Since Tom Green County Indigent Health Care doesn't cover dental care, or eyeglasses either, and they serve the poor, I doubt San Angelo will work hard at increasing access to quality dental care. My youngest daughter was on the waiting list for a year at UT San Antonio Dental School until this past August to be seen and I have to drive her there and back to be able to receive advanced dental care that she needs at reasonable prices.

We just need more dentists in San Angelo that service students with Medicaid. A lot of our parents have to travel to outlying towns to take their children to the dentists.

At Rust Street Ministries we see so many people who need dental care and have no resources to pay for dental care. Their health is greatly affected by their poor teeth. If their income allows them to pay for rent, maybe utilities and some food there is nothing left for dental care. There is a great need in Tom Green County for dental care.

Foundation for Better Health - formerly known as Tom Green County Partnership for Better Health has had a huge success - reducing between 10-15% over the past two years' worth of data. <http://tgcpartnershipforbetterhealth.org/> The next two years we are focusing on case management.

Unfortunately, my own late husband passed away from urosepsis, which was caused by a catheter associated UTI contracted in a hospital ER in east Texas, and not due to not receiving a transplant that he was on a list for in Dallas. This was a shock to me after all he went through in the seven years he was on the list. I don't think there is enough done by hospitals to prevent the thousands of death every year that are reflected in reports of mortality data.

San Angelo has already implemented a comprehensive smoking ordinance. We need more education for cancer preventions.

Because of my own personal experience in the difficulty of accessing health care back in 2011, I realized that if I was an educated person and had the difficulty I had, that the uneducated population suffers much, much more than I did in receiving the care it needs. If a person isn't healthy enough to work, they can't become self-sufficient and are forced to rely on and drain the community's resources. In the three years I was ill, I was amazed how many people didn't know there were resources available to them that I ended up accessing mostly by my own efforts. I used my own experience to help advocate for as many people as I could, because I knew what it meant to me to become healthy again. Too many resources in San Angelo are duplicated.

Obesity is at epidemic proportions so we need to educate the community about the importance of healthy eating and physical exercise.

Increasing mental health services is the highest priority in my opinion. Many of the other risks could be minimized with better behavioral treatment.

The rate of suicide completion is double the state average and I recently read that young Hispanic females lead the demographic groups. We must intercede.

Tom Green County has been above the state average for suicide rates every year since 2000.

We need to make sure that every resident of our county has access to 3 nutritious meals each day. We need to eliminate food deserts and make sure, especially, that all children and seniors have sufficient food to eat.

I don't think I am knowledgeable enough to make accurate comments on most of the survey topics. The answers provided are my best guesses. I don't think other employees would be better equipped to answer the questions. It should be noted that I work for [agency redacted], which is really more of a support service, rather than a direct care health provider. We do some things that are directly related to health care, but generally we assist others who are more involved in that type of work. I am not sure what is really being asked by the questions. And it simply would take too much time to try to figure it out. I am grateful for the work and information provided in the reports, but I question the effectiveness of the survey I just completed.

What will it take to get the two main medical centers to work together to help their community's poorest members?

You did question and/or comment specifically of dentists/dentistry in several places. You noted the number of pharmacists but I don't recall any specific questions or comments. And no notation of the number of pharmacies (probably more of a problem in out counties). I believe ready access to pharmacies and the cost of drugs are potentially very significant factors. Another factor with regard to getting health care is transportation to health care professionals, but in larger towns and in out-counties with fewer health care resources. I don't recall comments on transportation.

## **Upton County**

We have an aging population so our needs for things like diabetes education/prevention, COPD education/prevention, stroke/HTN education/prevention would be beneficial to our community.

Dental services are accessed in Crane, Midland, or San Angelo. We are a small population and probably could not support a dentist coming to Rankin.

Obesity is a major issue in this area. Wellness education and support would be beneficial to our community. We have a new, beautiful wellness center and will be focusing on building our wellness program over the next year.

### **Val Verde County**

There is a real need for pediatricians and a doctor specializing in Geriatrics for the growing population of Baby Boomers.

We are a young population in the county. Children are our future and we have to ensure their health needs are met; likewise with seniors. It is a growing population faced with multiple changes. Both populations are very vulnerable and need our support to help maintain quality of life, through outreach, and education

Have school district be more proactive with the community at large and open its doors to assist with this growing situation [teen pregnancy].

Need to have collaboration of all dentists in the Del Rio area. (Findings through 6 years of Dental clinics provided within in the community have found that not only access but cost has and continues to be a barrier for many residents here in Del Rio.) For further information please contact [name redacted].

Behavioral health is often ignored but is just as important as physical health for quality of life. Hill Country does a good job but is limited by their criteria in terms of who they serve. Other resources do exist but are also limited as well in serving those that do not have insurance. Need more resources that can reach out to these populations.

As a pastor, if someone who needed behavioral health services came to me, I would not know who to refer that person to.

Work with business leaders, economic development team to attract more health care professionals (i.e., physicians) to Val Verde County.

We definitely need more physicians and access to more specialists here. Many people have to travel to San Antonio or San Angelo to even see a doctor during high peak times.

We need at least one more psychiatrist.

For a large population, it's a shame we only have one psychiatrist and few psychologists. Those that most need them cannot travel out of town to see someone due to financial limitations and even if they can it may take a long time to schedule an appointment given a shortage of psychiatrists accessibility is also an issue due to economics.

There is a need for qualified counselors, especially to help those that don't have the means to pay.

Dieticians can provide Nutrition Education that can really help these people. Active lifestyles starting at an early age can reduce Heart Disease.

Again, Dieticians can assist or teach people with Diabetes about the nutrition that will help them control their blood sugar.

Although there is a [diabetes] program that assists with some of these issues, it too needs to be brought to the forefront as a community involvement program.

We continue to have many families not eligible for medical and dental insurance for many factors and [ineligibility] is one of if not the main barrier found as in most other communities.

Important to get out into the community. Must get out to help educate, inform them of what's available and help them access those services.

The best way to reach the poor and extremely poor is through education/outreach to promote wellness.

Increased physical activity and eating healthy foods can help in decreasing the rate of Obesity, Heart Disease and Diabetes. We need more sidewalks and parks with areas for adult sports, walking, running, swimming, biking, or playing other sports.

I do feel that there are efforts being made with varying degrees of effectiveness in a number of areas put forth in this survey. Overcoming cultural barriers may take personal individual education with a great amount of patience.