FRIO REGIONAL HOSPITAL

In Partnership with Methodist HEALTHCARE | SAN ANTONIO

COMMUNITY HEALTH NEEDS ASSESSMENT

2023

TABLE OF CONTENTS

Questions and/or comments regarding Frio Regional Hospital's Community Health Needs Assessment may be directed to:

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EXECUTIVE SUMMARY

Internal Revenue Code (IRC) Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the Affordable Care Act, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- Conduct a community health needs assessment (CHNA) every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA as well as a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The CHNA must consider input from persons including those with special knowledge of or expertise in public health, those who serve or interact with vulnerable populations and those who represent the broad interest of the community served by the hospital facility. The hospital facility must make the CHNA widely available to the public.

This CHNA, which describes both a process and a document, is intended to document Frio Regional Hospital's ("Hospital") compliance with IRC Section 501(r)(3). Health needs of the community have been identified and prioritized so that the Hospital may adopt an implementation strategy to address specific needs of the community.

This document is a summary of all the available evidence collected during the CHNA conducted in tax year 2023. It will serve as a compliance document, as well as a resource, until the next assessment cycle. Both the process and document serve as the basis for prioritizing the community's health needs and will aid in planning to meet those needs.

Frio Regional Hospital is an acute care hospital located in Pearsall, Texas. For the purposes of this CHNA, the Hospital has defined its "community" as a two-county region located in southern Texas accounting for 89.03% of the Hospital's patients. While the Hospital serves patients across a broader region, defining its community will allow it to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

Identified health needs were prioritized with input from members of the Hospital's management team utilizing a weighting method that weighs 1) the size of the problem, 2) the seriousness of the problem, 3) the impact of the issues on vulnerable populations, 4) how important the issue is to the community and 5) the prevalence of common themes. Significant needs were further reviewed and analyzed regarding how closely the need aligns with the Hospital's mission, current and key service lines, and/or strategic priorities.

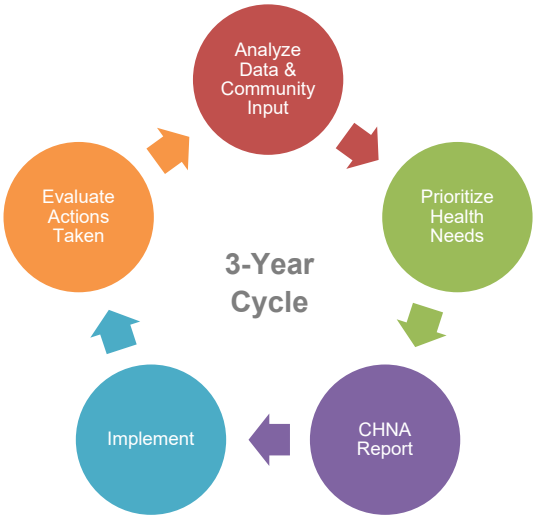
Based on the information gathered through this CHNA and the prioritization process described later in this report, the following priorities were identified. Opportunities for health improvement exist in each area. The Hospital will work to identify areas where it can most effectively focus its resources to have significant impact and develop an Implementation Strategy for 2024-2026 for the priority areas identified below.

- Health education
- Access to primary care physicians
- Access to medical specialists
- Access to care
- Obesity
- Shortage of healthcare workers
- Healthy behaviors and healthy lifestyle choices
- Access to mental health services - adults and children
- Treatment of & management of chronic diseases and conditions
- Access to and use of preventative care treatments
- Access to services for the aging

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

EVALUATION OF PROGRESS SINCE PRIOR CHNA

The CHNA process should be viewed as a 3-year cycle. An important piece of that cycle is revisiting the progress made on priority health topics set forth in the preceding CHNA. By reviewing the actions taken to address a priority health issue and evaluating the impact those actions have made in the CHNA Community, it is possible to better target resources and efforts during the next round of the CHNA cycle.



PRIORITY AREAS FROM PRECEDING CHNA

The implementation strategy for years ending December 31, 2020 through December 31, 2023, focused on three priorities to address identified health needs. Based on the Hospital's most recent evaluation, the Hospital has made significant progress in meeting its goals and strategies outlined in the prior implementation strategy as reported below.

The 2020 implementation strategy focused on five priorities for action between 2020 and 2023:

1. Lack of health knowledge and education
2. Adult obesity
3. Lack of mental health providers and mental health conditions
4. Lack of access to primary care physicians
5. Poverty and children in poverty

HOW THE ASSESSMENT WAS CONDUCTED

Frio Regional Hospital partnered with FORVIS, LLP ("FORVIS") to conduct this community health needs assessment. Ranked among the top 10 public accounting firms in the country, FORVIS has 5,700 dedicated professionals who serve clients in all 50 states as well as across the globe. FORVIS serves hospitals and health care systems across the country. The CHNA was conducted during 2023.

The CHNA was conducted to support its mission responding to the needs in the community it serves and to comply with Internal Revenue Code Section 501(r) and federal tax-exemption requirements. Identified health needs were prioritized in order to facilitate the effective allocation of hospital resources to respond to the identified health needs. Based on guidance from the United States Treasury and the Internal Revenue Service, the following steps were conducted as part of the CHNA:

- Community benefit initiatives, which were implemented over the course of the last three years, were evaluated.
- The "community" served by the Hospital was defined by utilizing inpatient and outpatient data regarding patient origin and is inclusive of medically underserved, low-income, minority populations and people with limited English proficiency. This process is further described in Community Served by the Hospital.
- Population demographics and socioeconomic characteristics of the community were gathered and assessed utilizing various third parties.
- The health status of the community was assessed by reviewing community health status indicators from multiple sources, including those with specialized knowledge of public health and members of the underserved, low-income and minority population or organizations serving their interests.
- Community input was also obtained through key informant surveys of thirty community leaders. See Appendix B for a listing of key stakeholders that provided input.
- Identified health needs were then prioritized considering the community's perception of the significance of each identified need as well as the ability for the Hospital to impact overall health based on alignment with the Hospital's mission and the services it provides. The Hospital's leadership participated in identifying and prioritizing significant health needs.
- An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared.

LIMITATIONS AND INFORMATION GAPS

This assessment was designed to provide a comprehensive and broad picture of the health in the overall community served by the Hospital; however, there may be a few of medical conditions that

are not specifically addressed in this report due to various factors, including but not limited to, publicly available information or limited community input.

In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English or Spanish. Efforts were made to obtain input from these specific populations through key stakeholder surveys.

As with all data collection efforts, there are limitations related to the CHNA's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2023 may be the most current year available for data, while 2021 or 2020 may be the most current year for other sources.

GENERAL DESCRIPTION OF FRIO REGIONAL HOSPITAL

Frio Regional Hospital is located in Pearsall, Texas.

Frio Regional Hospital is dedicated to providing quality health care services to the families in the Pearsall community. In partnership with Methodist Healthcare, the largest health care provider in South Texas, the hospital offers a wide range of services from childbirth, home health and emergency services to laboratory, radiology, and speech therapy.

DESCRIPTION OF SERVICES PROVIDED BY FRIO REGIONAL HOSPITAL

Frio Regional Hospital operates an acute care hospital. The following services are provided:

- Birthing center
- Emergency services
- Eye surgery
- Gastroenterology
- Home health care
- Laboratory services
- Physical and occupational therapy
- Ready care
- Radiology
- Rehabilitation
- Speech therapy
- Swing bed

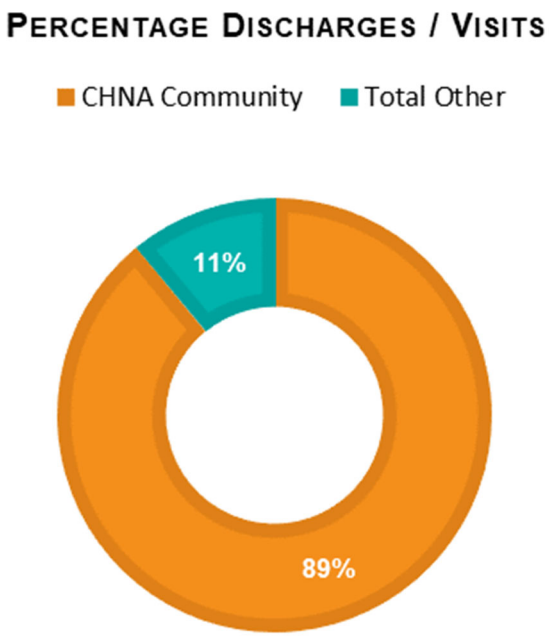
COMMUNITY SERVED BY FRIO REGIONAL HOSPITAL

Frio Regional Hospital is located in Pearsall, Texas. Pearsall is approximately an hour drive southwest from San Antonio, Texas.

DEFINED COMMUNITY

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community.

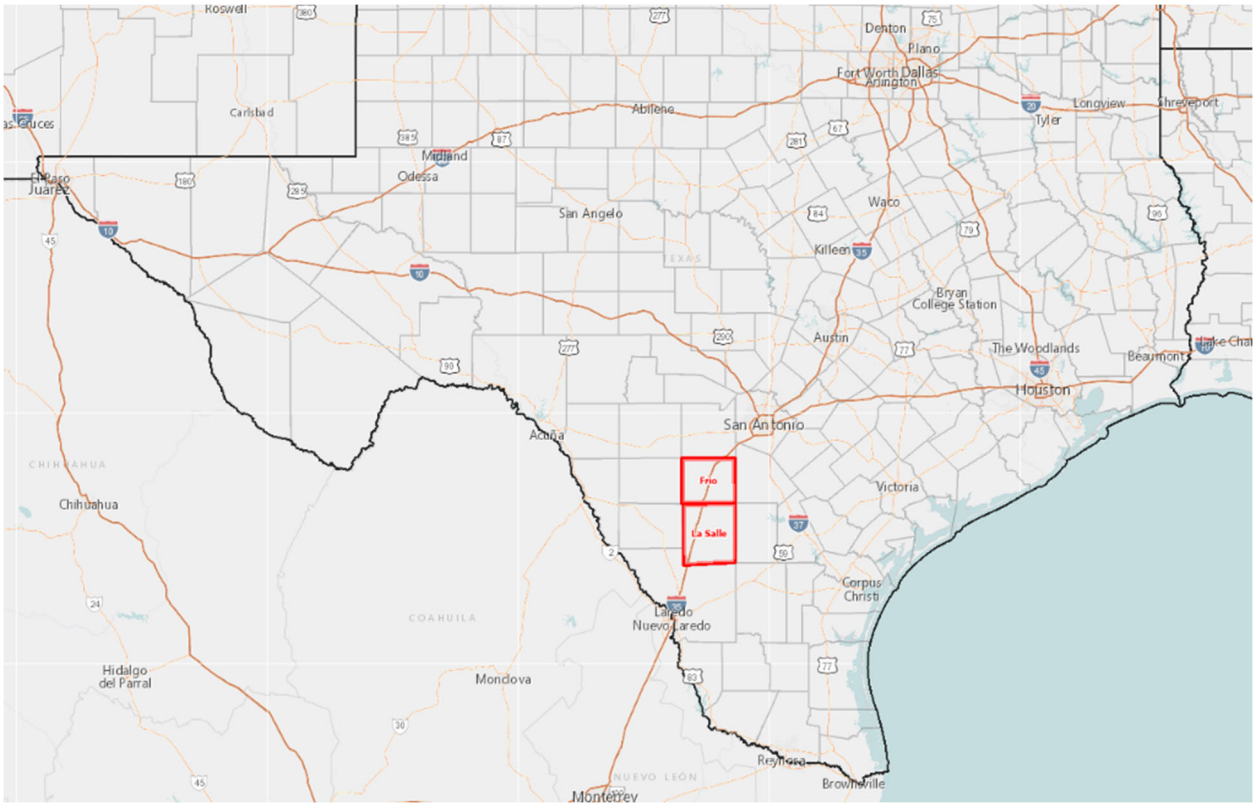
Based on the patient origin of acute care inpatient discharges and outpatient visits management has identified the CHNA community to include Frio and La Salle counties for Frio Regional Hospital as these counties represent approximately 89% of total discharges and visits and are a contiguous area surrounding the Frio Regional Hospital.



COMMUNITY DETAILS

IDENTIFICATION AND DESCRIPTION OF GEOGRAPHICAL COMMUNITY

The following map geographically illustrates the Hospital's community. The map below displays the Hospital's geographic relationship to the community, as well as significant roads and highways.



COMMUNITY POPULATION AND DEMOGRAPHICS

The U.S. Bureau of Census has compiled population and demographic data. The data below shows the total population of the CHNA community. It also provides the breakout of the CHNA community between the male and female population, age distribution, race/ethnicity and the Hispanic population.

Demographic Characteristics

Gender	Frio County	La Salle County	TX	US
Total Population	18,428	6,956	28,862,581	329,725,481
Total Male Population	11,141	4,286	14,398,171	163,206,615
Total Female Population	7,287	2,670	14,464,410	166,518,866
Percent Male	60.46%	61.62%	49.89%	49.50%
Percent Female	39.54%	38.38%	50.11%	50.50%

Population Age Distribution

Age Group	Percent of Frio County	Percent of La Salle County	Percent of TX	Percent of US
0 - 4	6.67%	4.95%	6.24%	5.55%
5 - 17	18.13%	16.00%	18.73%	16.51%
18 - 24	11.65%	8.31%	10.00%	9.43%
25 - 34	16.38%	14.38%	14.15%	13.53%
35 - 44	12.82%	13.49%	13.52%	12.73%
45 - 54	10.61%	13.04%	12.29%	12.33%
55 - 64	10.54%	12.42%	11.61%	13.10%
65+	13.20%	17.41%	13.46%	16.82%
Total	100.00%	100.00%	100.00%	100.00%

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. The population of the CHNA community by race illustrates different categories of race such as, white, black, Asian, other and multiple races.

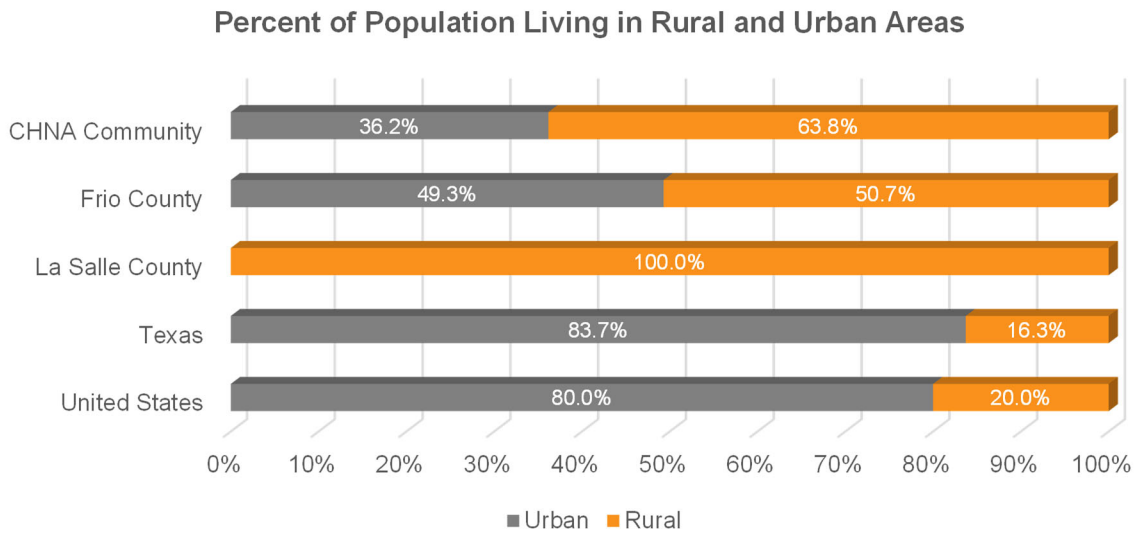
Total Population by Race Alone

Race	Percent of Frio County	Percent of La Salle County	Percent of TX	Percent of US
White	46.33%	47.85%	50.13%	61.63%
Black	3.91%	3.53%	12.19%	12.40%
Asian	1.08%	0.08%	5.44%	6.00%
Native American / Alaska Native	0.71%	0.26%	0.96%	1.12%
Native Hawaiian / Pacific Islander	0.05%	0.00%	0.12%	0.21%
Some Other Race	27.30%	13.99%	13.56%	8.42%
Multiple Race	20.62%	34.29%	17.60%	10.22%
Total	100.00%	100.00%	100.00%	100.00%

Total Population by Ethnicity Alone

Ethnicity	Percent of Frio County	Percent of La Salle County	Percent of TX	Percent of US
Hispanic or Latino	77.08%	73.65%	39.26%	18.73%
Non-Hispanic or Latino	22.92%	26.35%	60.74%	81.27%
Total	100.00%	100.00%	100.00%	100.00%

The graphic below shows the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban. This graphic could help to understand why transportation is considered a need within the community, especially within the rural and outlying populations. Per the graphic below, the population of the CHNA Community lives primarily in rural areas.

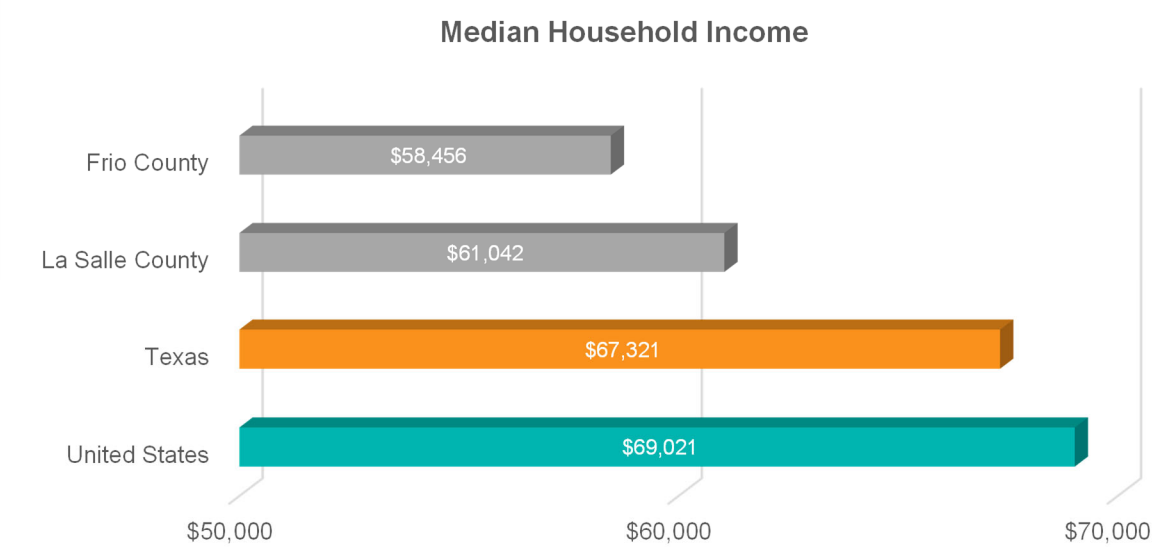

Percent of Population Living in Rural and Urban Areas
CHNA Community
Frio County
La Salle County
Texas
United States
36.2%
63.8%
49.3%
50.7%
100.0%
83.7%
16.3%
80.0%
20.0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Urban
Rural

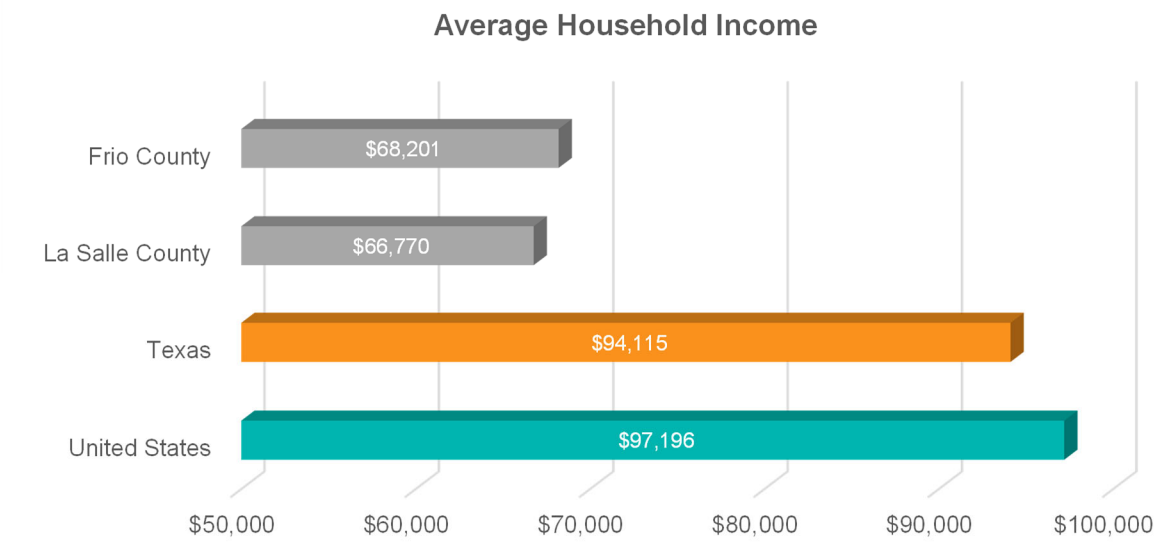
SOCIOECONOMIC CHARACTERISTICS OF THE COMMUNITY

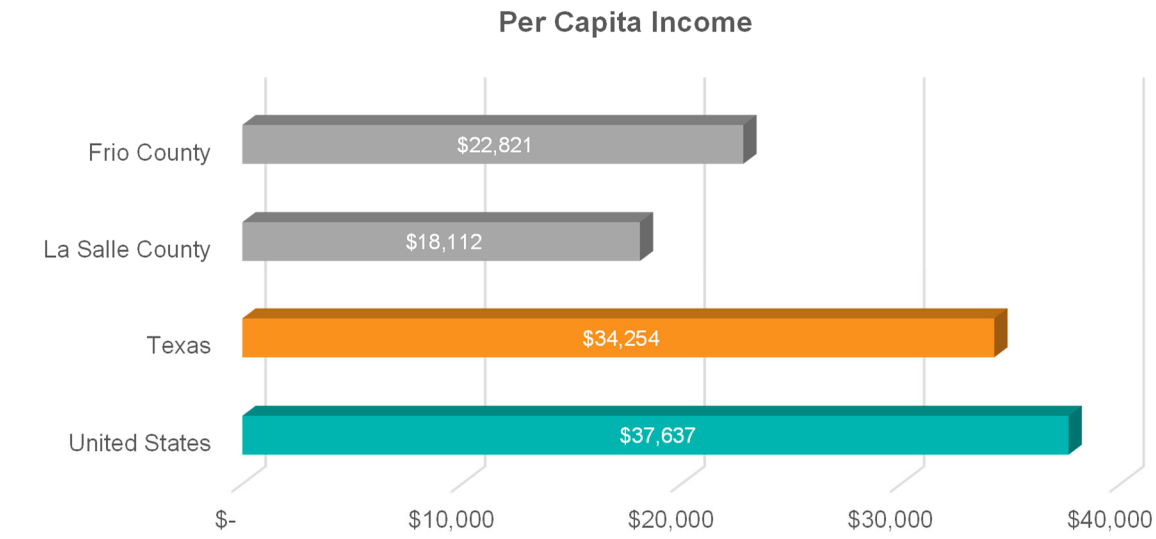
The socioeconomic characteristics of a geographic area influence the way residents access health care services and perceive the need for health care services within society. The economic status of an area may be assessed by examining multiple variables within the CHNA community. The following exhibits are a compilation of data that includes median household income, unemployment rates, poverty, uninsured population and educational attainment for the CHNA community. These standard measures will be used to compare the socioeconomic status of the community to Texas and the United States.

INCOME AND EMPLOYMENT

The median household income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one-person, median household income is usually less than average family income. All counties located within the CHNA Community have a median household income below Texas and the United States.



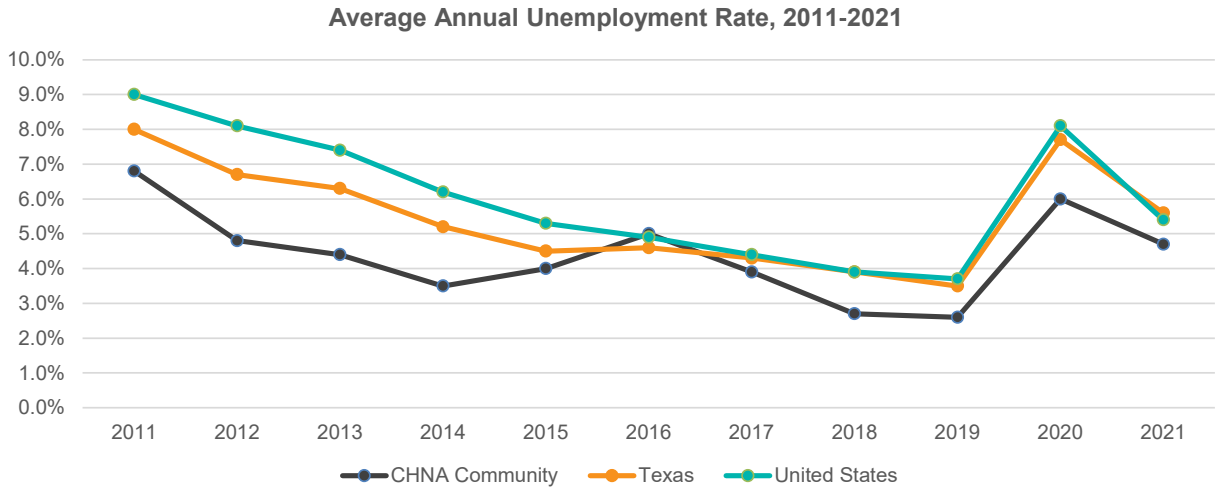




The per capita income is $22,821 and $18,112 for Frio County and La Salle County, respectively. These amounts include all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income for Frio and La Salle Counties are below the per capita income for both Texas and the United States.

UNEMPLOYMENT RATE

The graph below presents the average annual unemployment rate from 2011 through 2021 for the CHNA Community, as well as the trend for Texas and the United States. On average, the unemployment rates for the community are lower than both Texas and the United States.

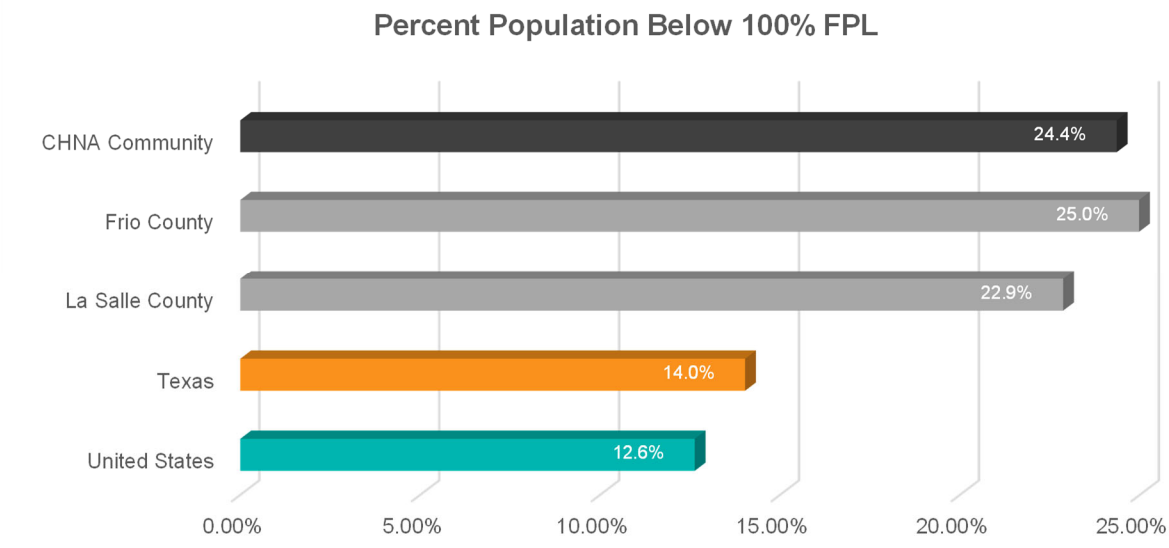


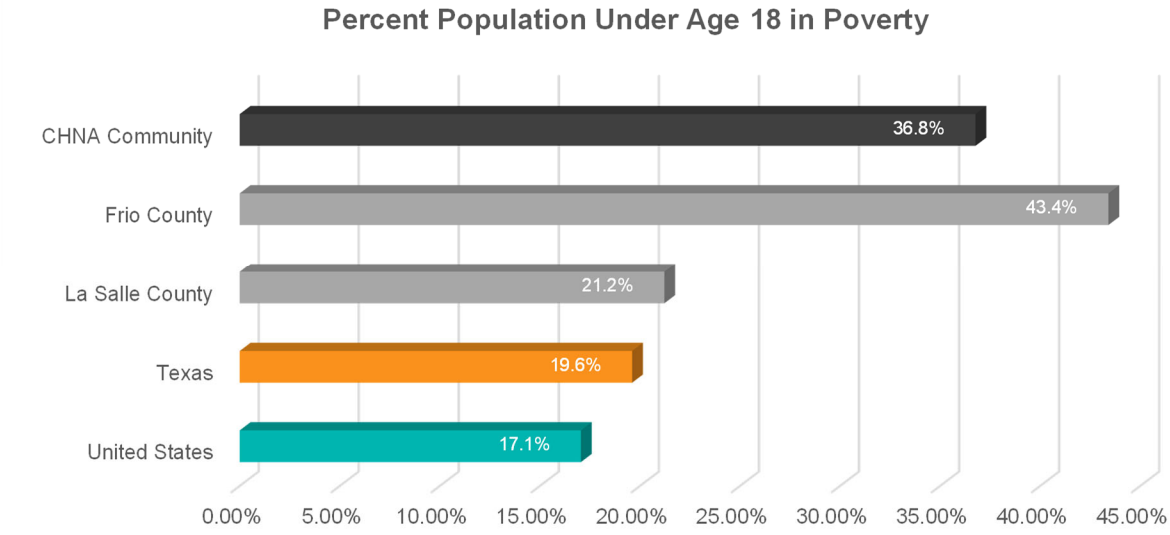
POVERTY

Poverty is a key driver of health status and is relevant because poverty creates barriers to access, including health services, healthy food choices and other factors that contribute to poor health.

The CHNA Community's 24.36% rate of individuals living below 100% of the Federal Poverty Level ("FPL") is greater than the 14.03% Texas rate and the 12.63% national rate. Counties within the CHNA Community with the highest rates of unemployment are Frio (24.98%) and La Salle (22.87%).

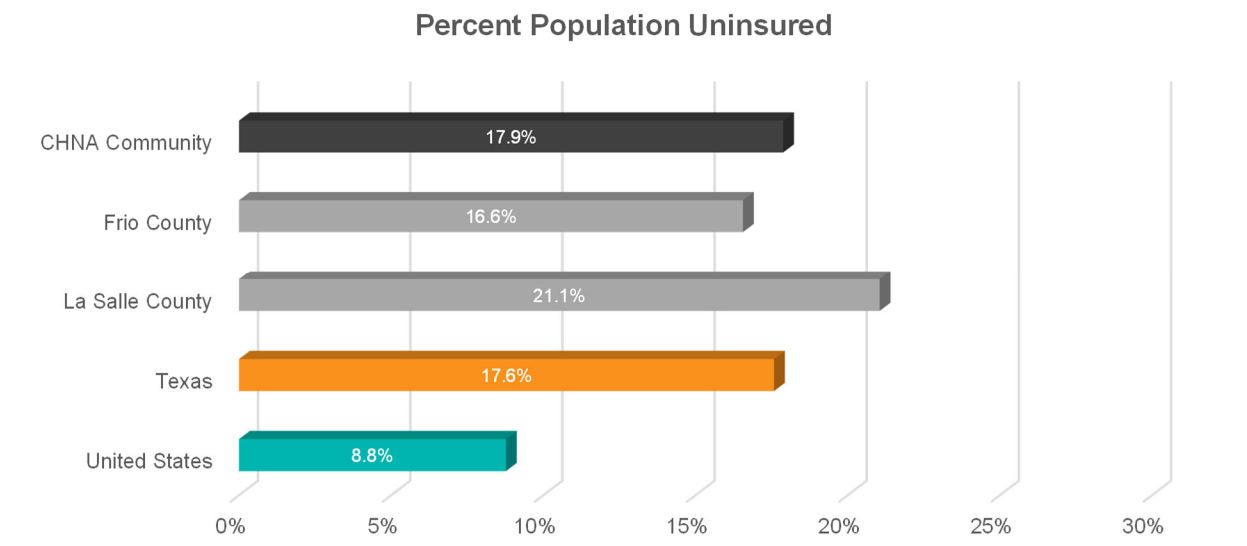
In the CHNA Community, 36.77% or 20,587 children aged 0-17 are living in households with income below the FPL. Like the percentages for total poverty, the CHNA Community, compares unfavorably to both Texas and United States percentages of individuals under age 18 living in households below 100% of FPL.





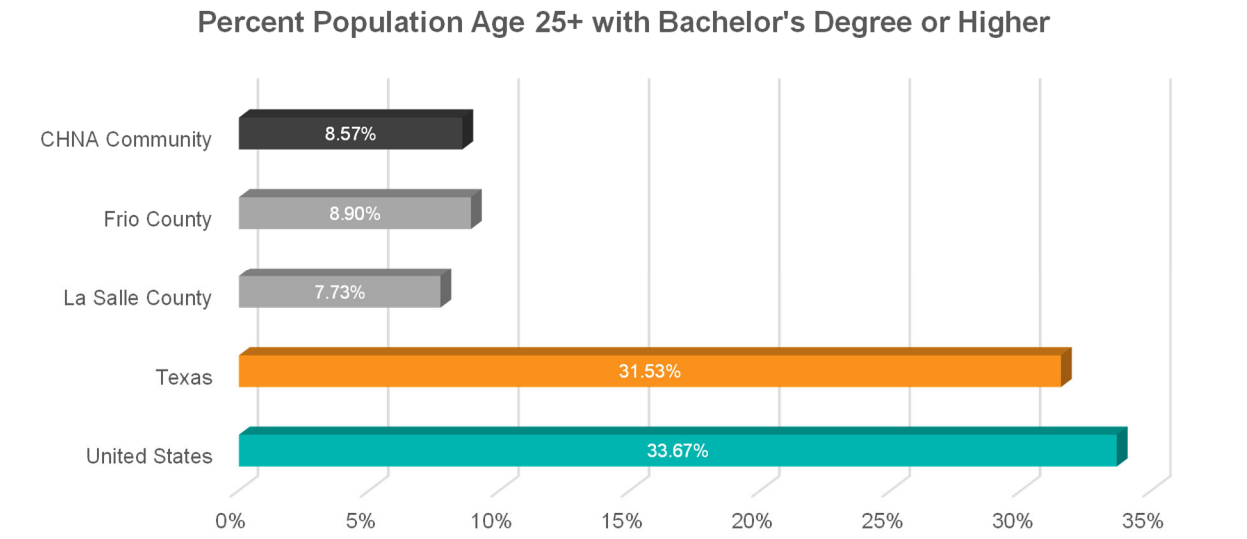
UNINSURED

The percentage of the total civilian non-institutionalized population without health insurance coverage is represented in this graphic. This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Within the CHNA community, 3,686 persons are uninsured based on 5-year estimates produced by the U.S. Census Bureau, 2017 - 2021 American Community Survey. The 2021 uninsured rate is estimated to be 17.88% for the CHNA Community compared to 17.58% for Texas and 8.77% for the United States.



EDUCATION

Nearly 9% of the population of the CHNA Community age twenty-five and older have obtained a bachelor's degree or higher compared to 32% in Texas and 34% in the United States. Education levels obtained by community residents may impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors may indirectly influence community health. The percent of residents within the CHNA Community is below the state and national percentages.

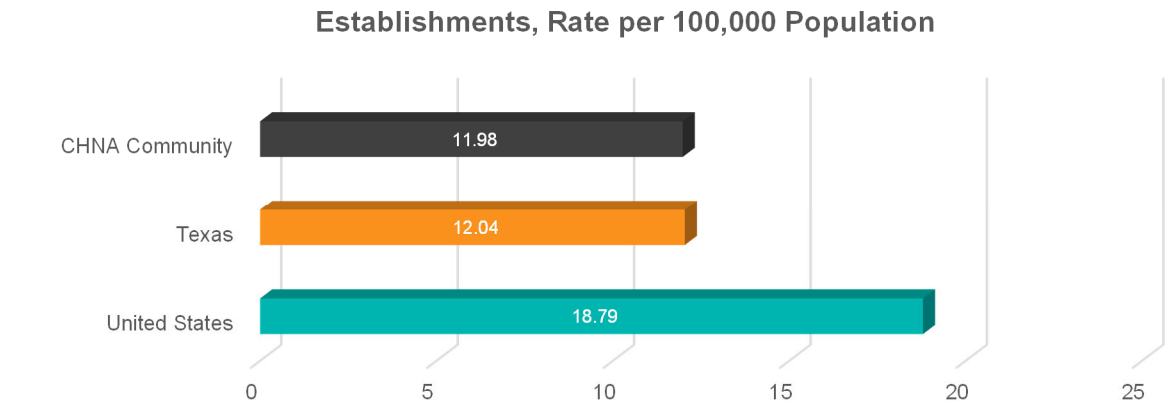


PHYSICAL ENVIROMENT OF THE COMMUNITY

A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned throughout the report.

GROCERY STORE ACCESS

Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables and fresh and prepared meats, such as fish and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors. The CHNA Community compares unfavorably compared to Texas and the United States.



FOOD ACCESS/FOOD DESERTS

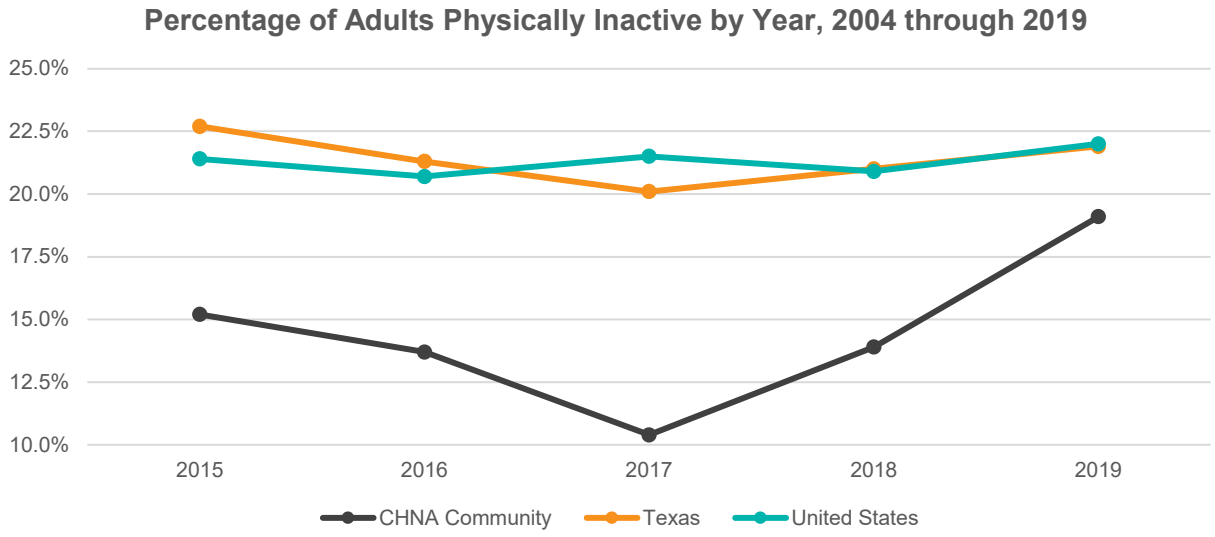
This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery stores. The information in is relevant because it highlights populations and geographies facing food insecurity. The CHNA Community has a population of 24,103 or 74.3% living in food deserts compared to 19.6% for Texas and 12.7% for the United States.

RECREATION AND FITNESS FACILITY ACCESS

This indicator reports the number per 100,000-population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. It is relevant because access to recreation and fitness facilities encourages physical activity and other healthy

behaviors. There are no fitness establishments available to the residents of the CHNA Community. This compares unfavorably to the rates for Texas and the United States.

The trend graph below shows the percentage of adults who are physically inactive by year (2015 through 2019) for the CHNA Community and compared to Texas and the United States. For 2019, the rate for the CHNA Community was 19.1% compared to 21.9% for Texas and 22.0% for the United States. During the period 2015 through 2019, the CHNA Community's highest rate of inactivity was 19.1% in 2019.



TOBACCO USAGE - CURRENT SMOKERS

This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Within the CHNA Community there are 18.2% adults age 18+ who have smoked and currently smoke of the total population age 18+ compared to 15.0% for Texas and 13.8% for the United States.

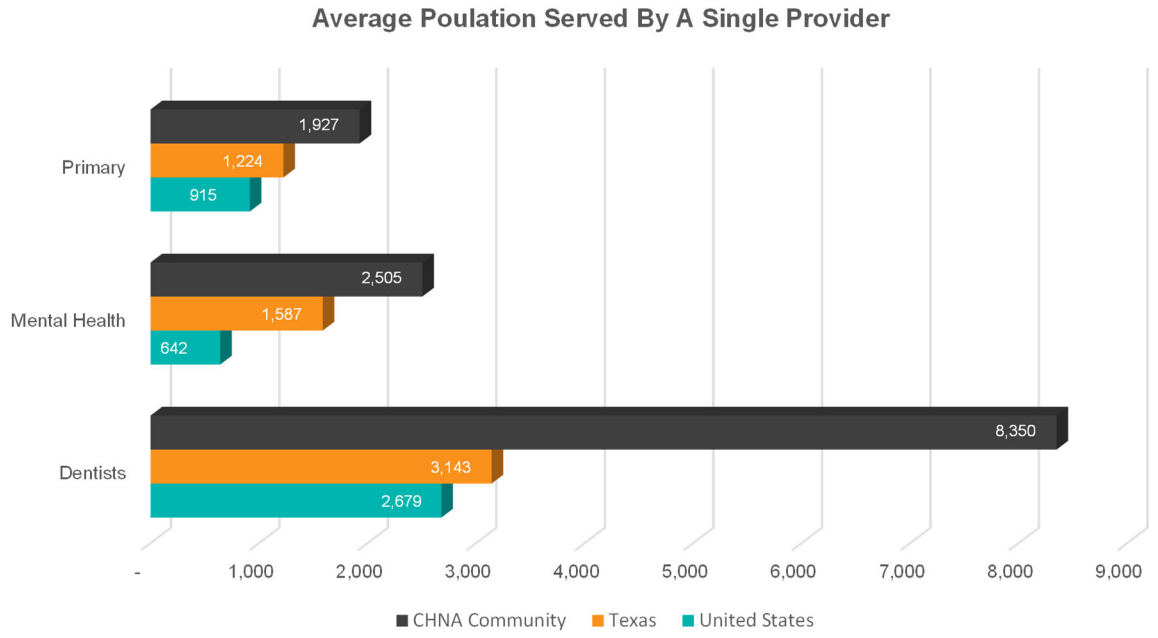
CLINICAL CARE OF THE COMMUNITY

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

Rates of morbidity, mortality and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

ACCESS TO PRIMARY CARE

Doctors classified as "primary care physicians" by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. The primary care physician ratio for the CHNA Community compares unfavorably to the ratio for Texas and the United States. The number of mental health providers practicing in the CHNA Community compares unfavorably to the ratio for Texas and the United States. In addition, the number of dentists practicing in the CHNA Community compares unfavorably to the ratios for both Texas and the United States.



HEALTH STATUS OF THE COMMUNITY

This section of the assessment reviews the health status of the CHNA community and its residents. As in the previous section, comparisons are provided with the state of Texas and the United States. This in-depth assessment of the mortality and morbidity data, health outcomes, health factors and mental health indicators of the county residents that make up the CHNA community will enable the Hospital to identify priority health issues related to the health status of its residents.

Good health can be defined as a state of physical, mental and social well-being, rather than the absence of disease or infirmity. National health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community

health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services.

Studies by the American Society of Internal Medicine conclude that up to 70% of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities and premature death.

The interrelationship among lifestyle/behavior, personal health attitude and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury, and mortality is defined as the incidence of death. Such information provides useful indicators of health status trends and permits an assessment of

the impact of changes in health services on a resident population during an established period. Community attention and health care resources may then be directed to those areas of greatest impact and concern.

LEADING CAUSES OF DEATH

The data below reflects the leading causes of death for the CHNA Community and compares the age-adjusted rates to the state of Texas and the United States.

Location	Cancer	Coronary Heart Disease	Heart Disease
CHNA Community	**160.9**	**130.5**	**200.6**
Frio County	**162.3**	**137.0**	**208.2**
La Salle County	**157.4**	**113.6**	**180.4**
Texas	143.7	94.1	168.9
United States	149.4	91.5	164.8

Location	Lung Disease	Stroke	Unintentional Injury
CHNA Community	**22.3**	**44.1**	39.8
Frio County	**22.3**	**44.1**	39.8
La Salle County	No Data	No Data	No Data
Texas	38.9	40.7	39.9
United States	39.1	37.6	50.4

Location	Poisoning (Including Drug Overdose)	Life Expectancy	Suicide
CHNA Community	No Data	**76.4**	No Data
Frio County	No Data	**76.2**	No Data
La Salle County	No Data	**77.0**	No Data
Texas	12.3	78.4	13.3
United States	24.0	78.6	13.8

The tables above show leading causes of death within the CHNA Community as compared to the state of Texas and the United States. The age-adjusted rate is shown per 100,000 residents. The rates in red represent the CHNA Community and corresponding leading causes of death that are higher than the state and national rates.

HEALTH OUTCOMES AND FACTORS

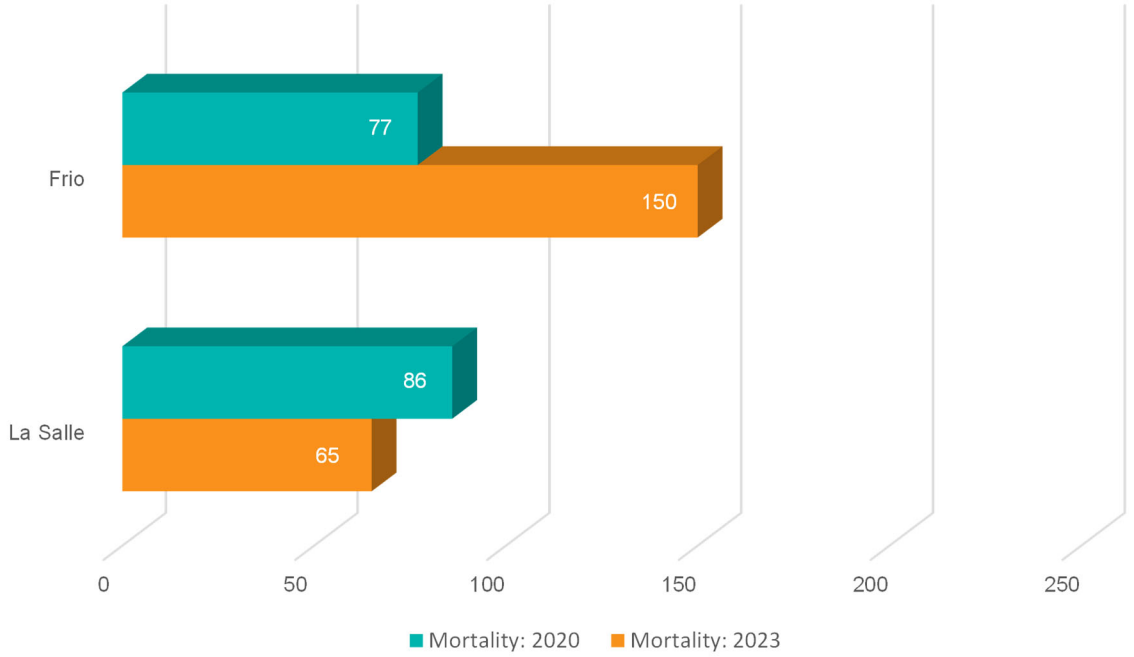
An analysis of various health outcomes and factors for a community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment. This portion of the community health needs assessment utilizes information from County Health Rankings.

The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks all 50 states and the counties within each state, based on the measurement of two types of health outcomes for each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by programs and policies at the local, state and federal levels.

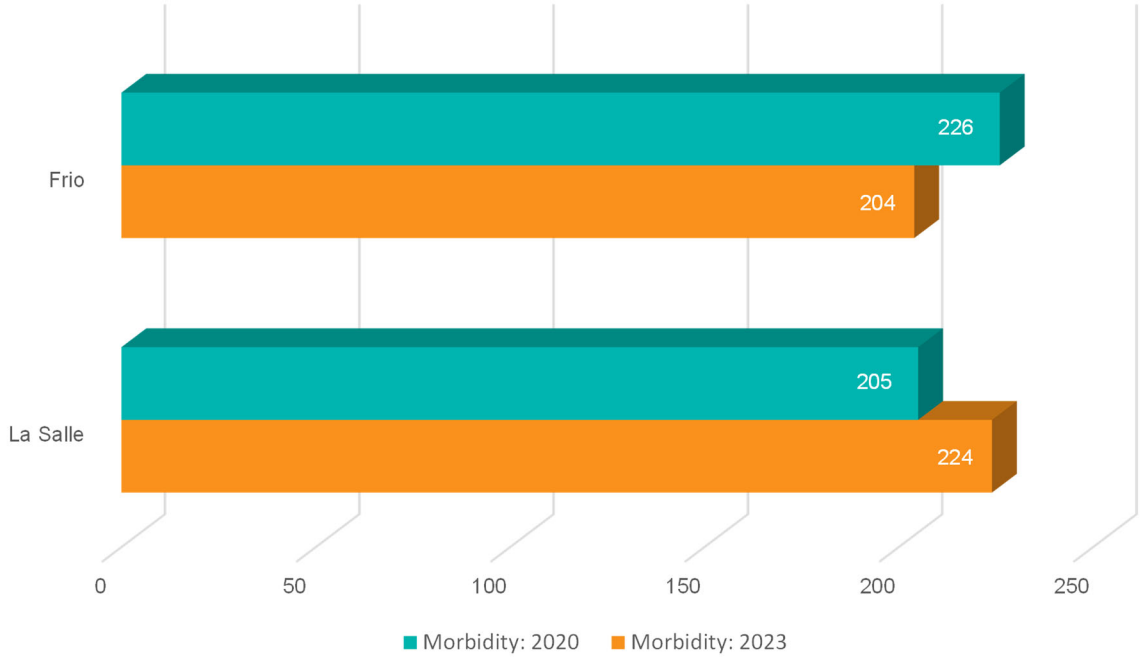
Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g. 1 or 2, are the "healthiest". Counties are ranked relative to the health of other counties in the same state based on health outcomes and factors, clinical care, economic status and the physical environment.

A number of different health factors shape a community's health outcomes. The County Health Rankings (www.countyhealthrankings.org) model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following graphs include the 2020 and 2023 indicators reported by County Health Rankings. A complete table of all community health rankings is provided at Appendix C.

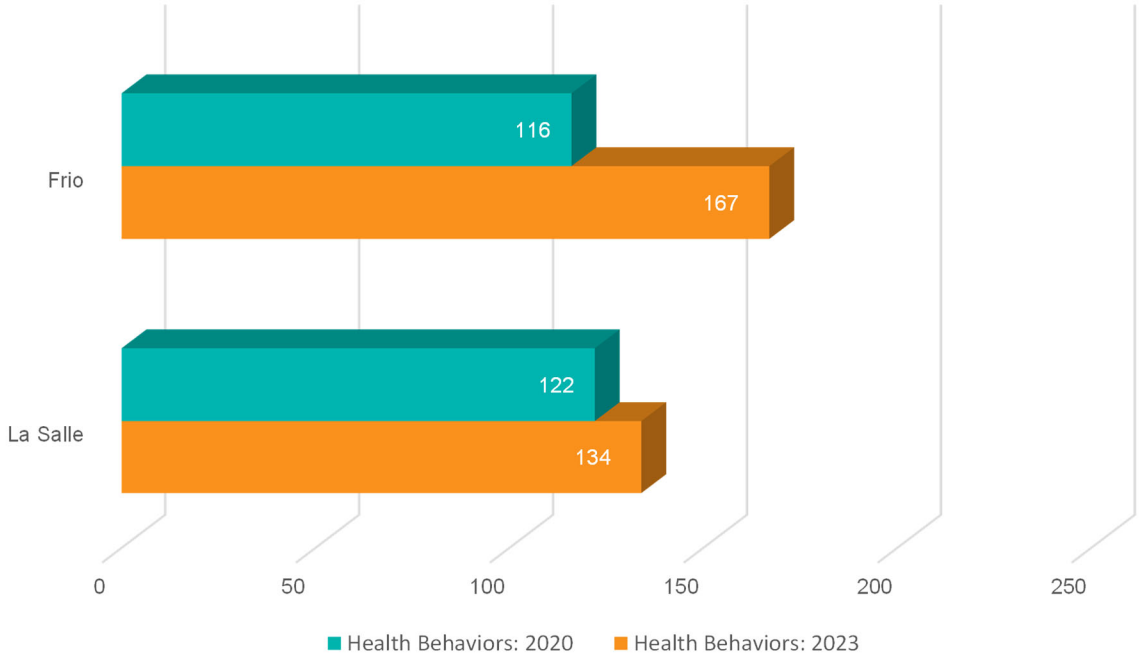
Mortality: Texas County Ranking (1 (Best) to 254 (Worst)): 2020 vs 2023



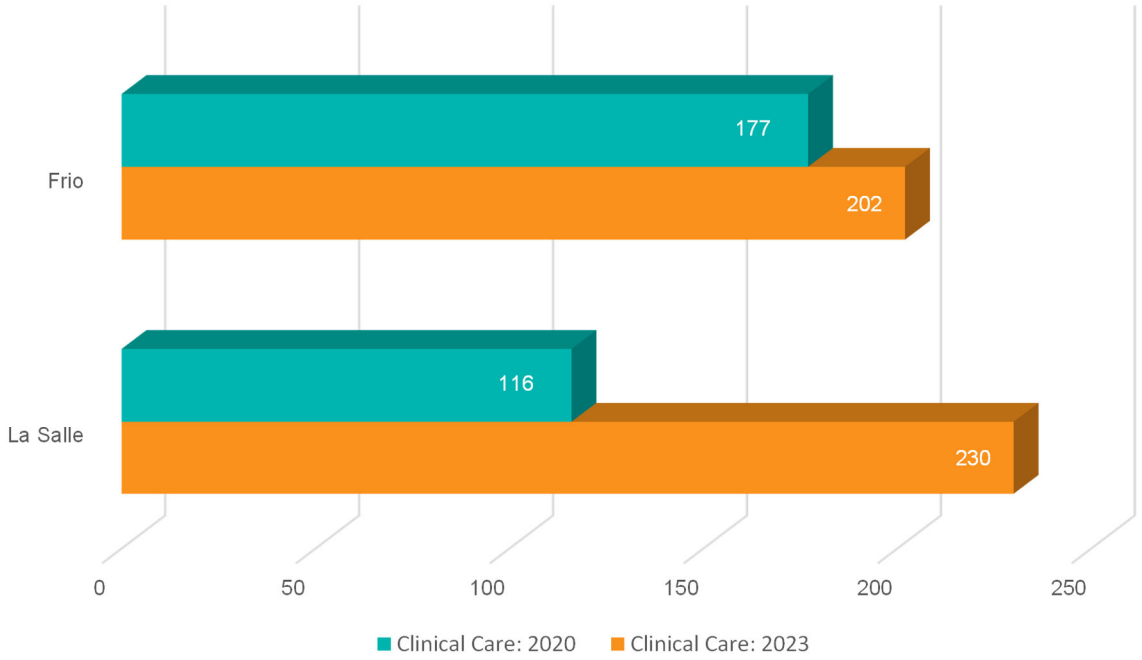
Morbidity: Texas County Ranking (1 (Best) to 254 (Worst)): 2020 vs 2023



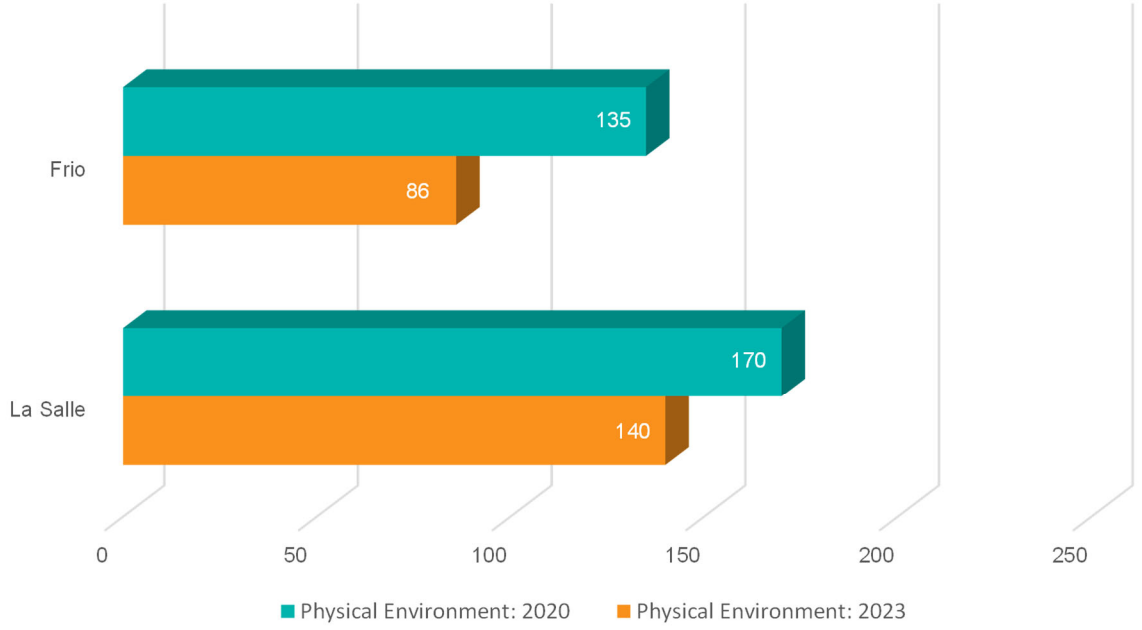
Health Behaviors: Texas County Ranking (1 (Best) to 254 (Worst)): 2020 vs 2023



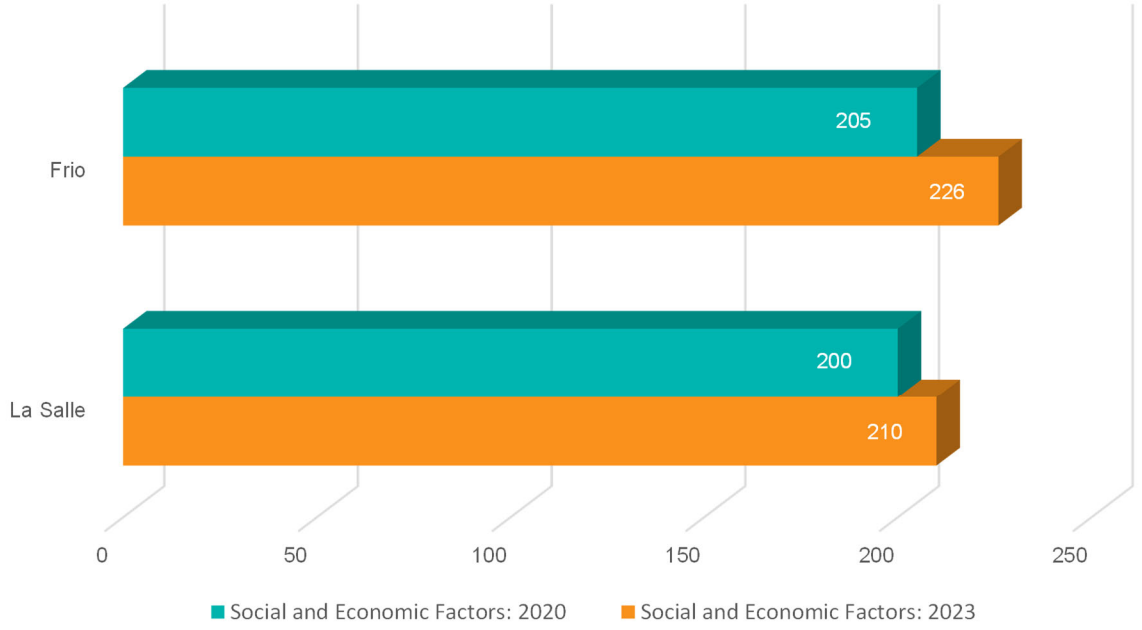
Clinical Care: Texas County Ranking (1 (Best) to 254 (Worst)): 2020 vs 2023



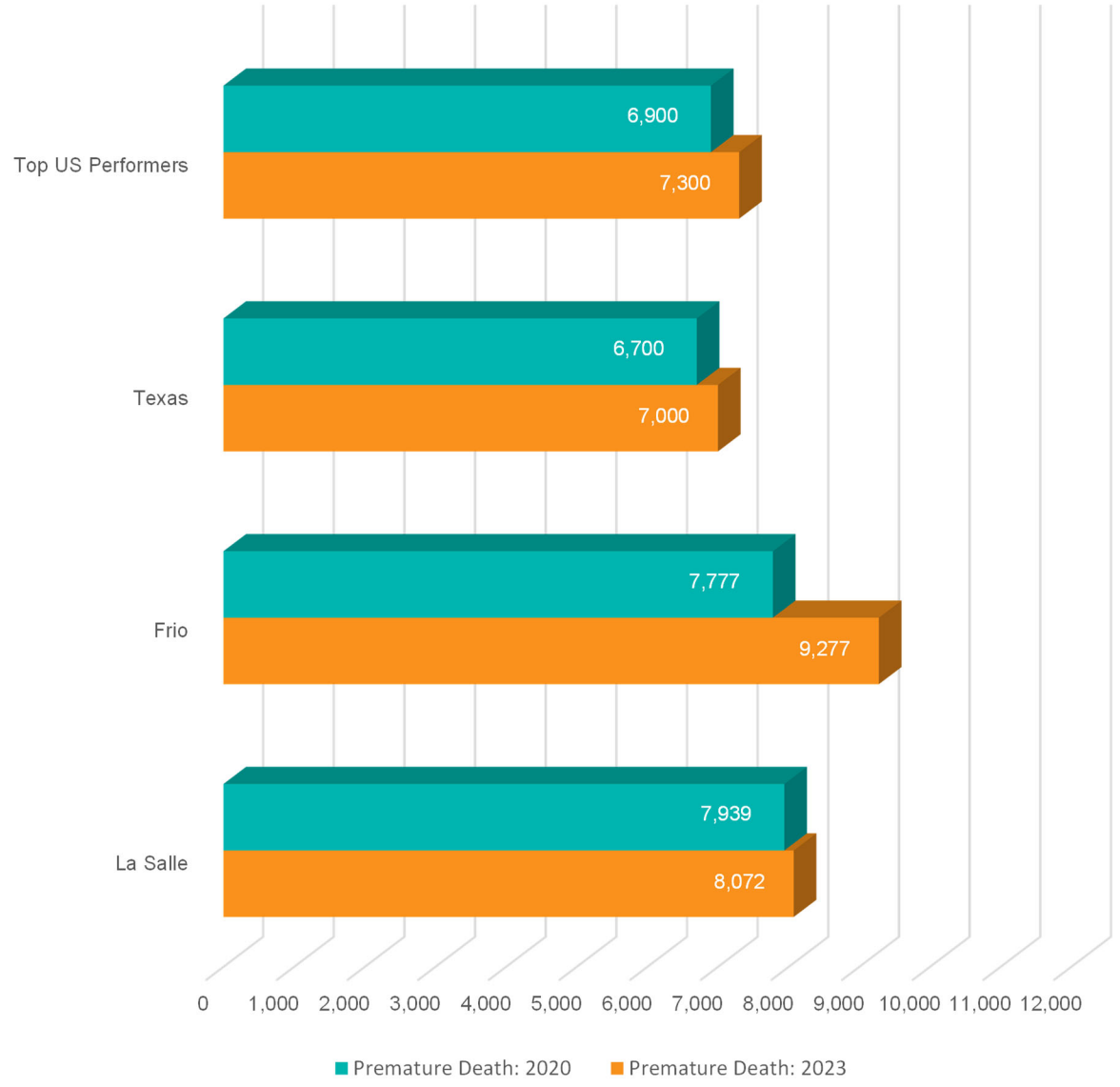
Physical Environment: Texas County Ranking (1 (Best) to 254 (Worst)): 2020 vs 2023



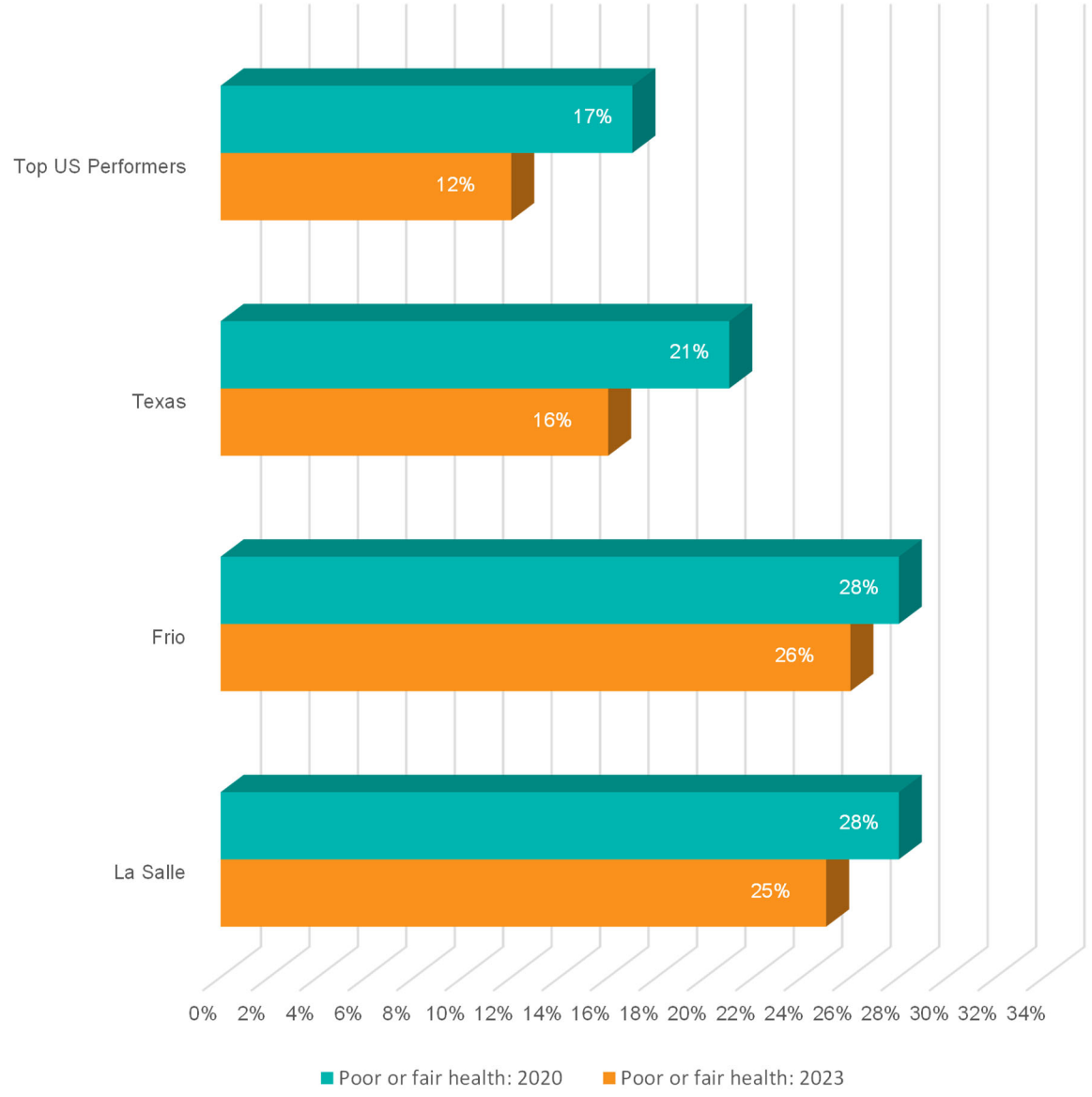
Social and Economic Factors: Texas County Ranking (1 (Best) to 254 (Worst)): 2020 vs 2023



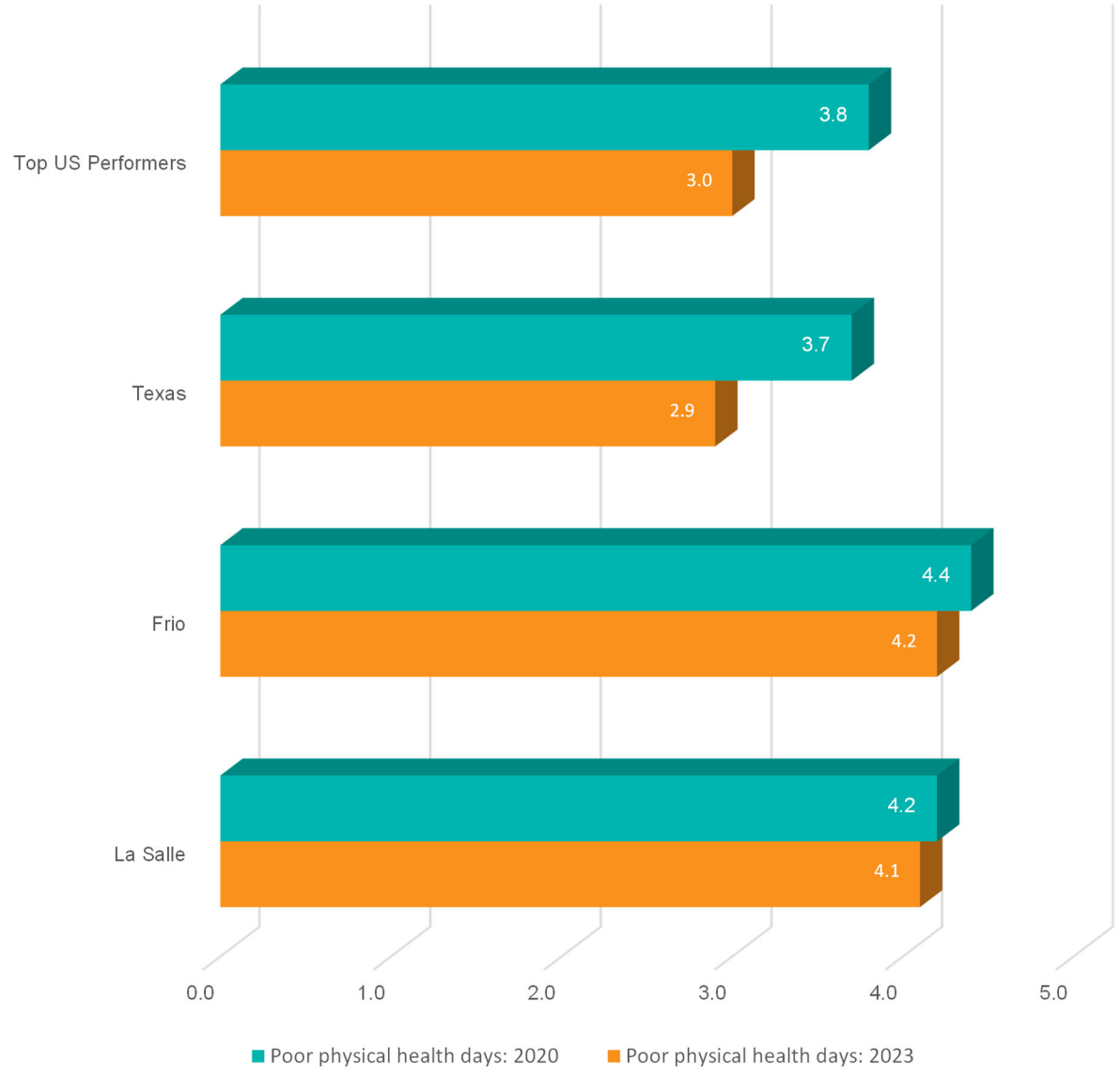
Premature Death – Years of potential life lost before age 75 per 100,000 population (age-adjusted): 2020 vs 2023



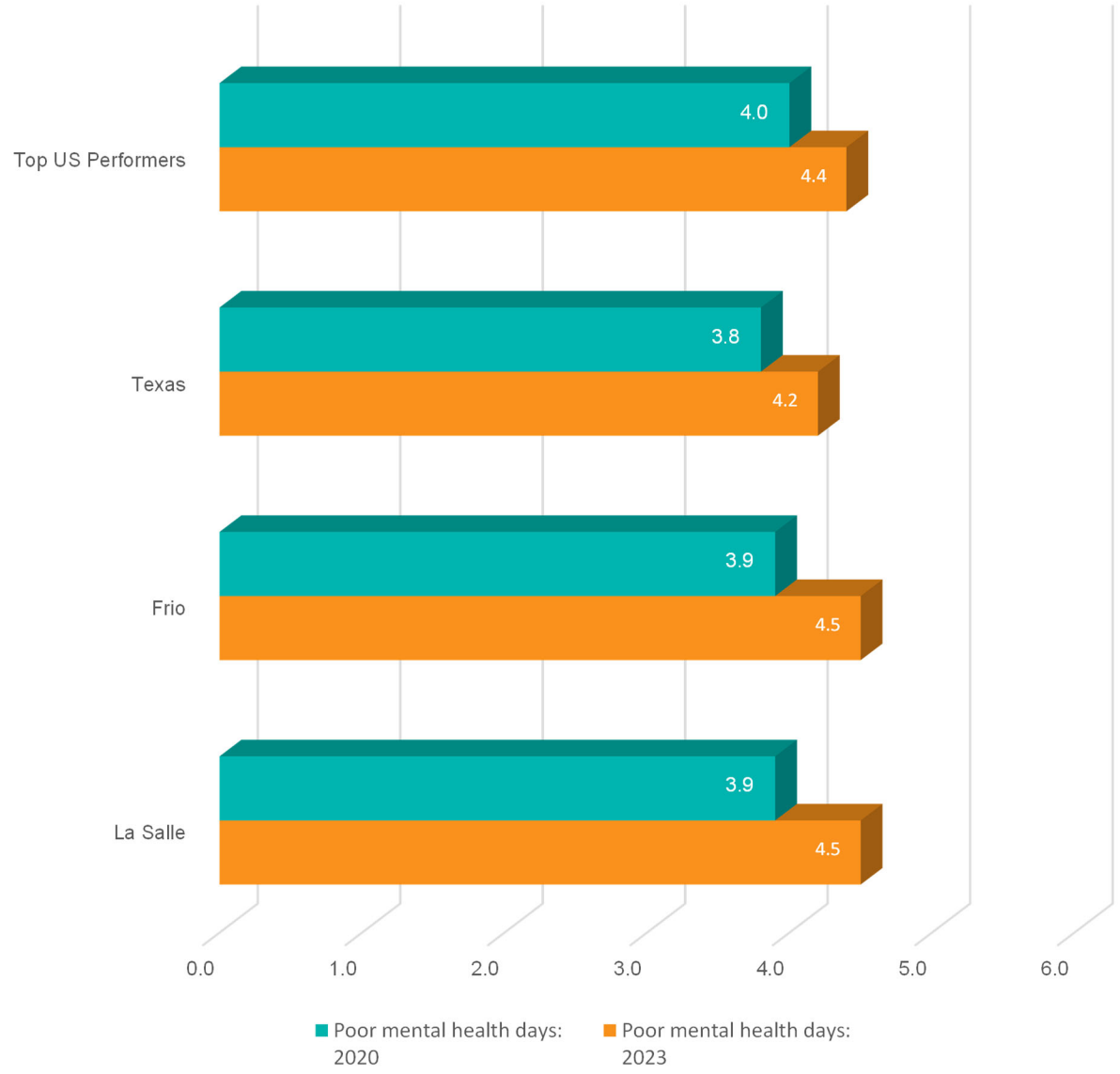
Poor or Fair Health – Percent of adults reporting fair or poor health (age-adjusted)



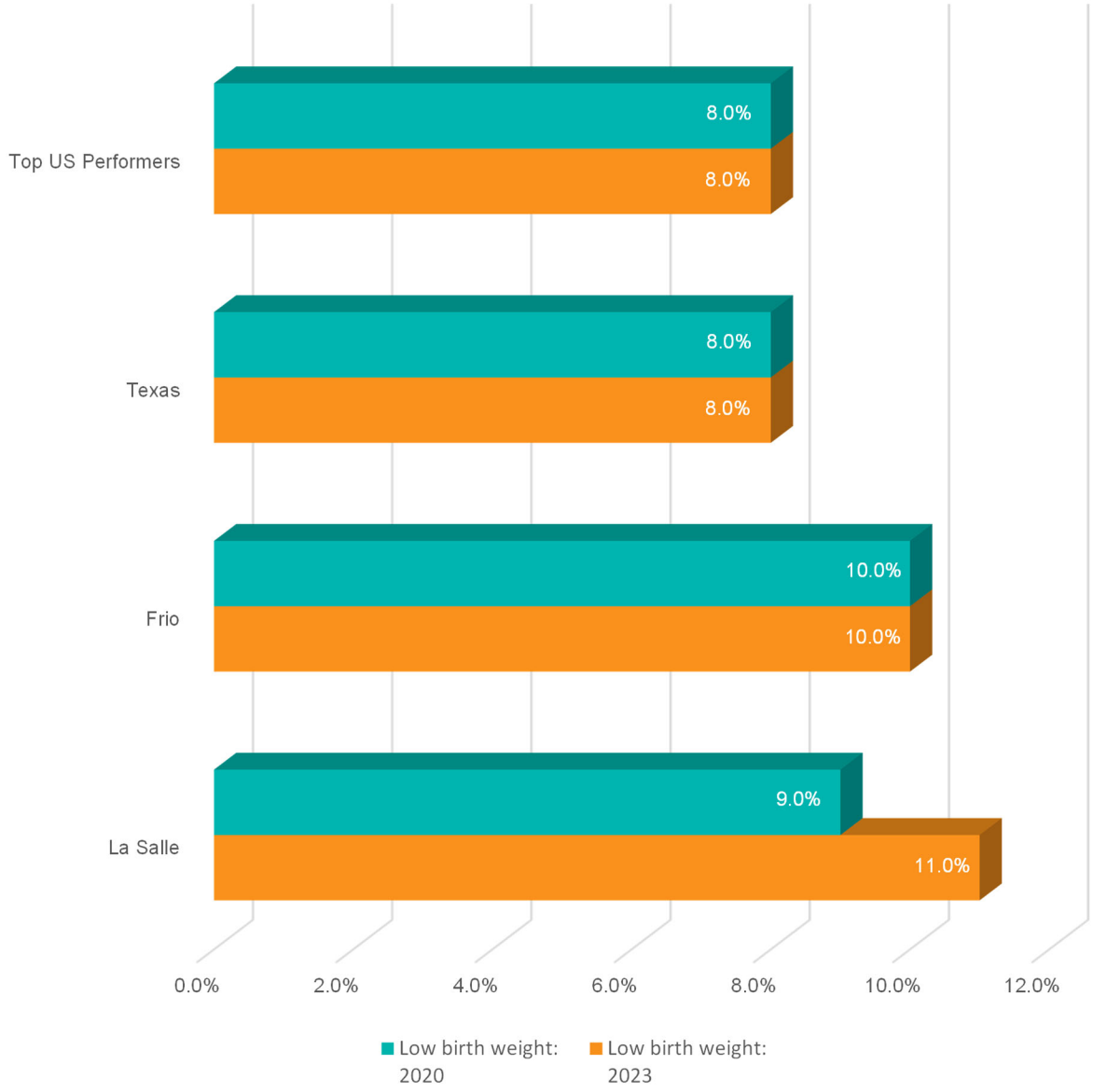
Poor Physical Health Days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)



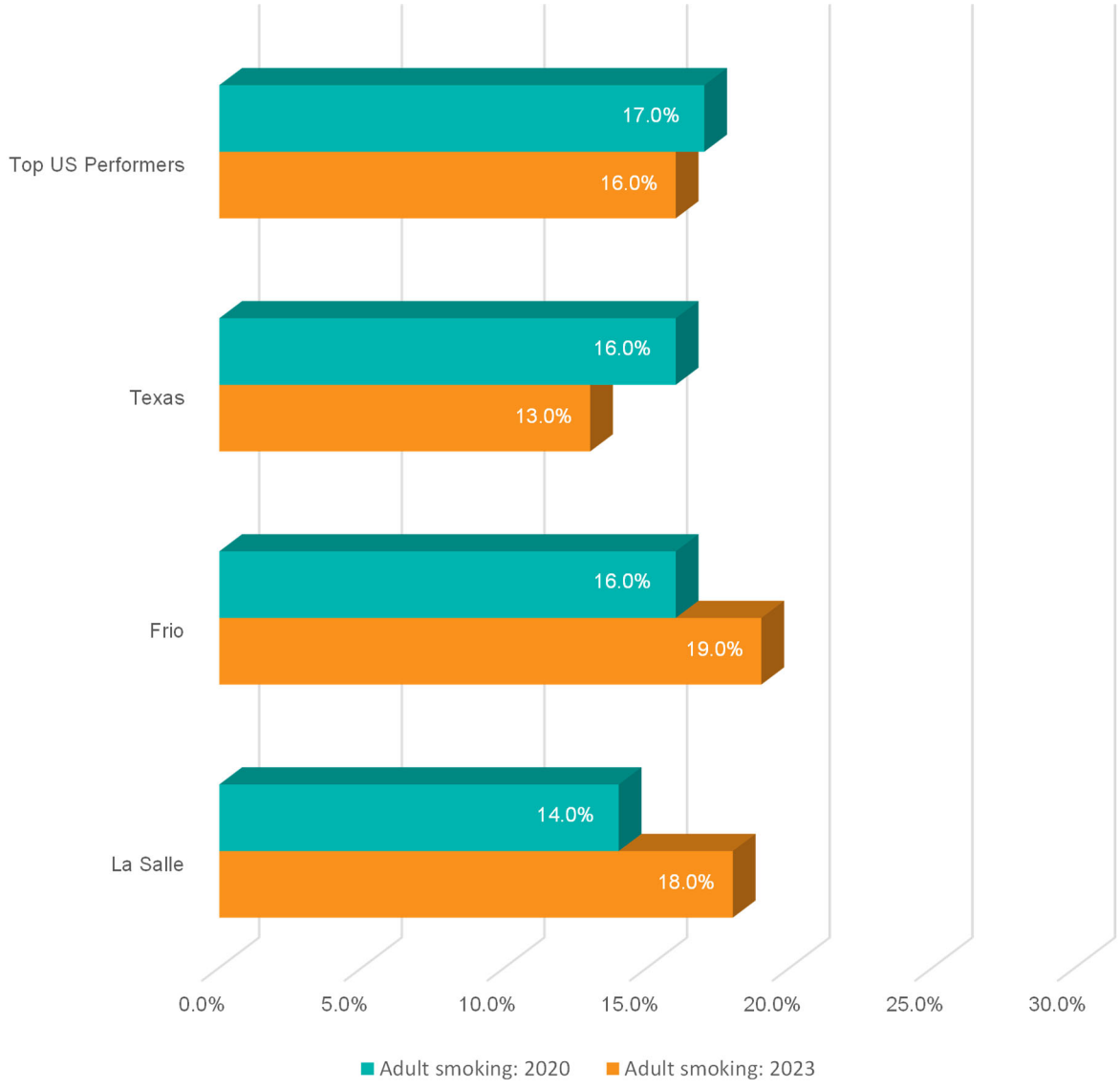
Poor Mental Health Days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

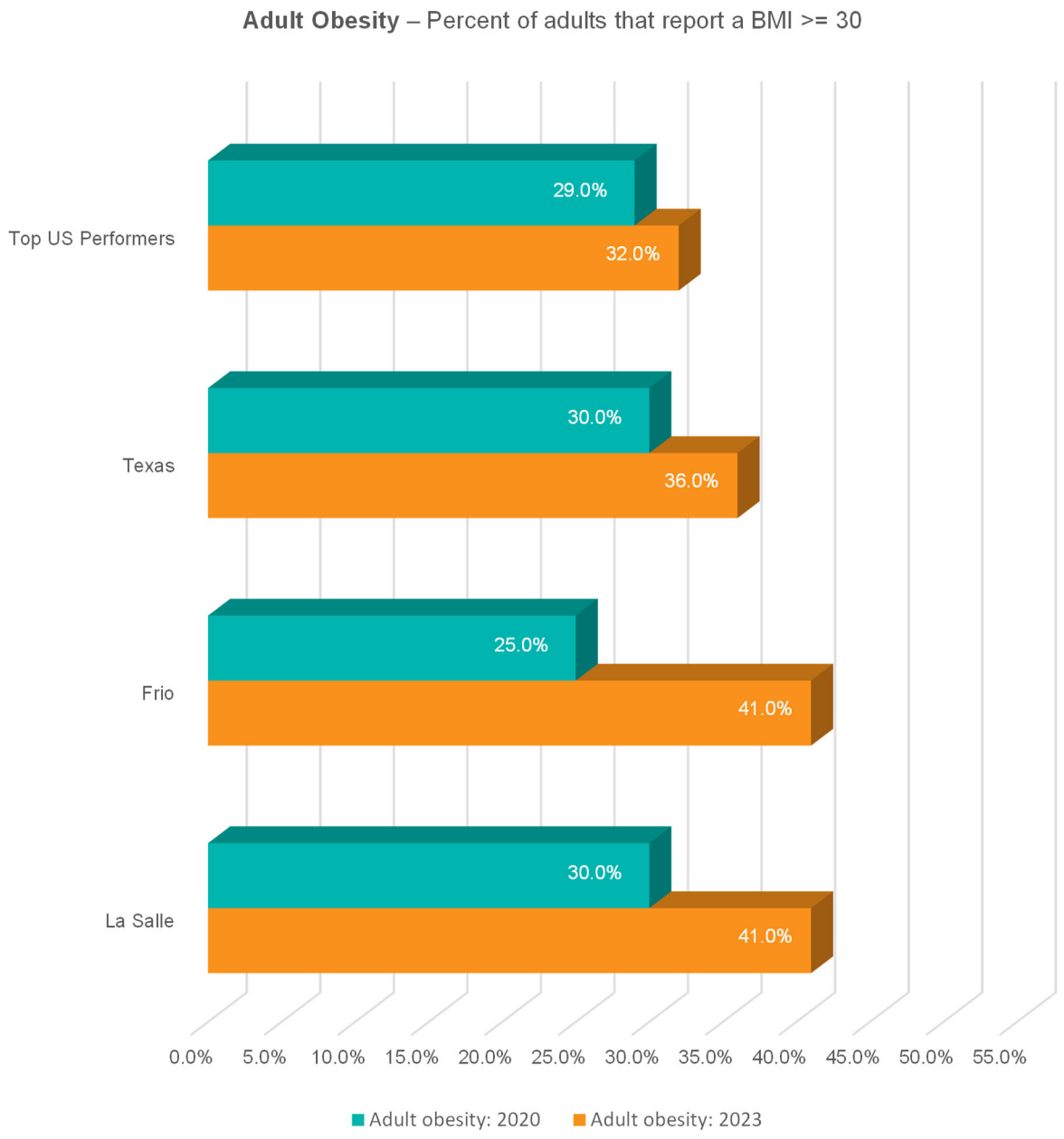


Low Birth Weight – Percent of live births with low birth weight (<2500 grams)

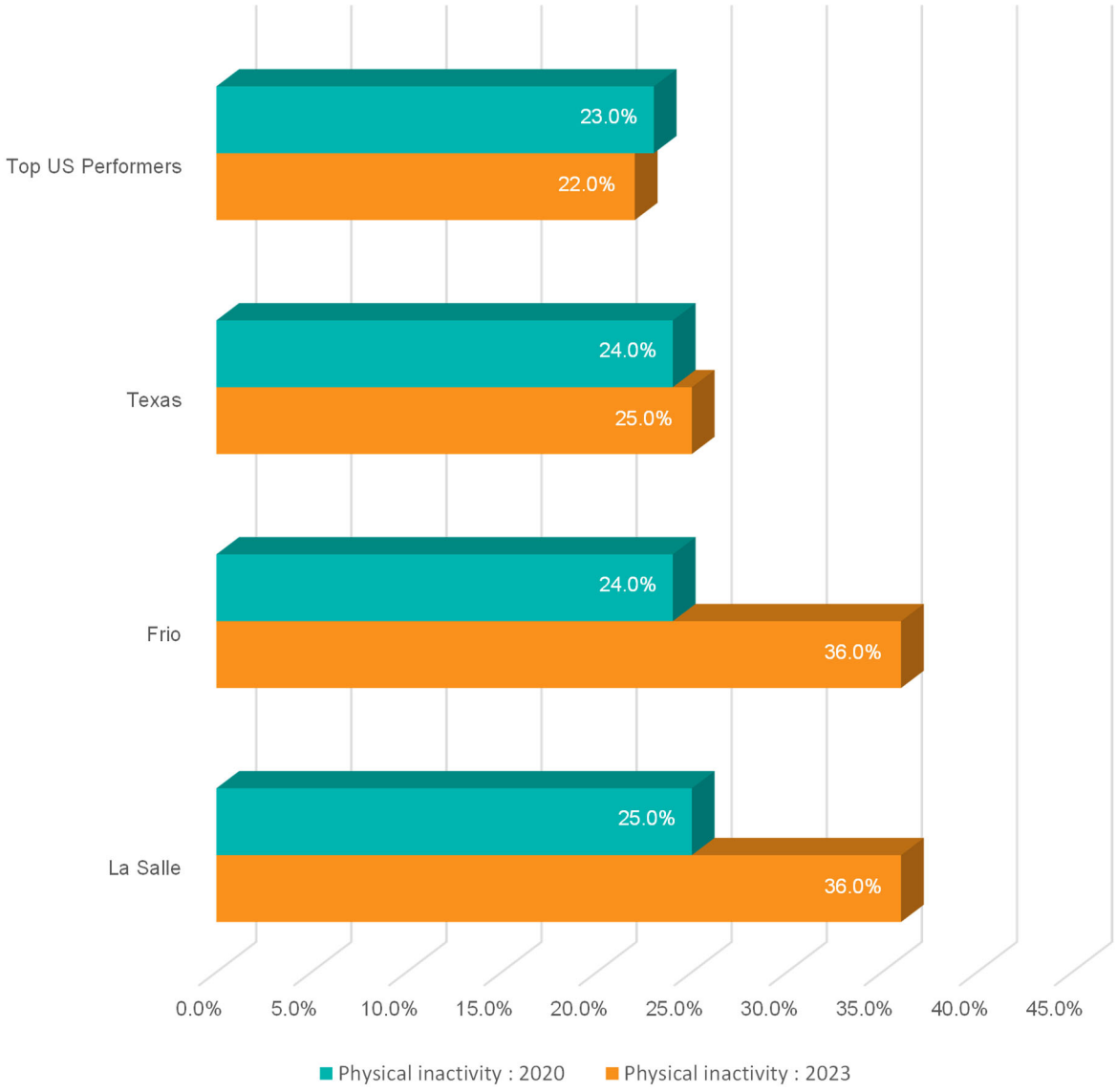


Adult Smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke)

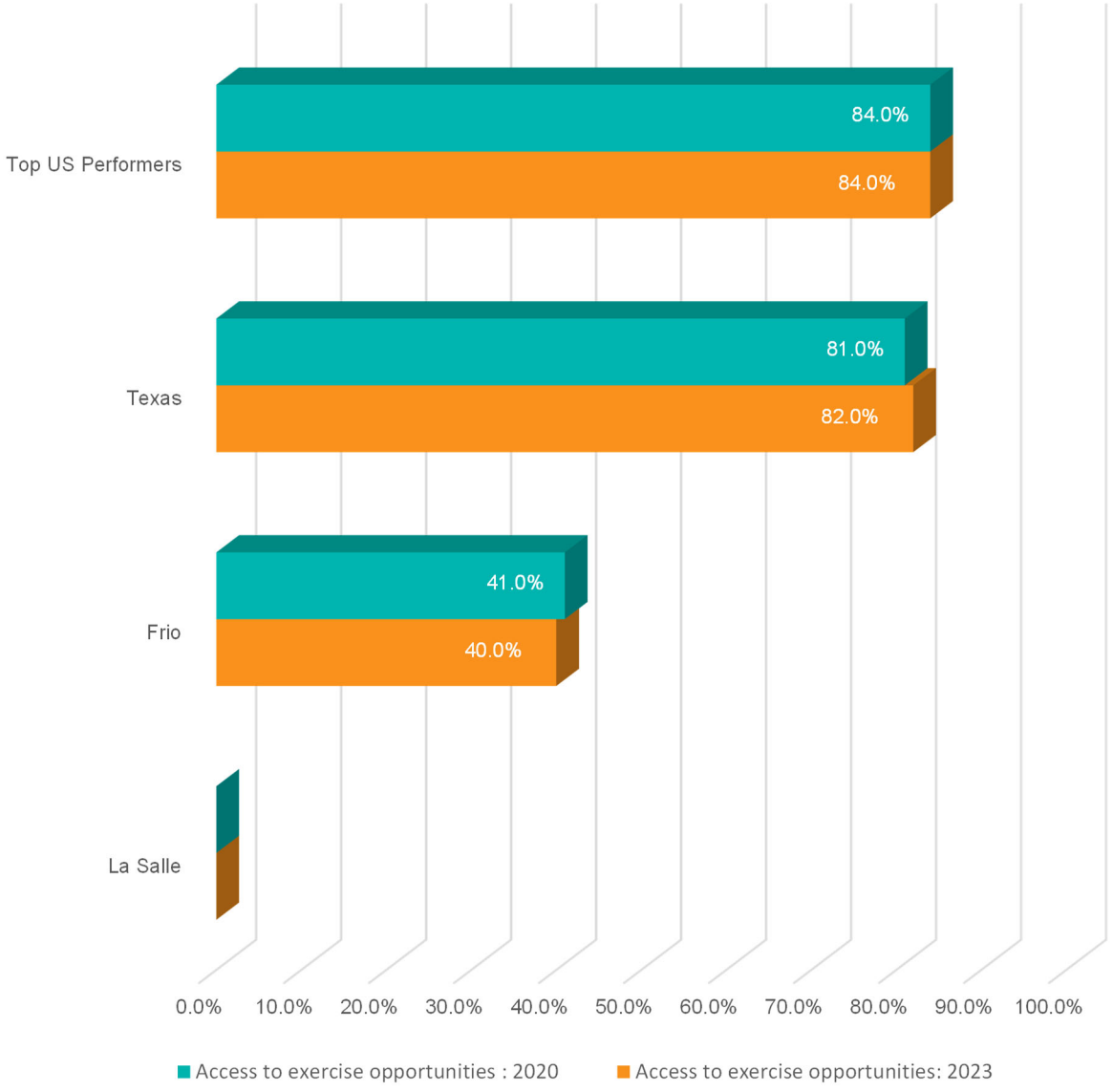



Adult Obesity – Percent of adults that report a BMI >= 30
Top US Performers
29.0%
32.0%
Texas
30.0%
36.0%
Frio
25.0%
41.0%
La Salle
30.0%
41.0%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0% 35.0% 40.0% 45.0% 50.0% 55.0%
Adult obesity: 2020
Adult obesity: 2023

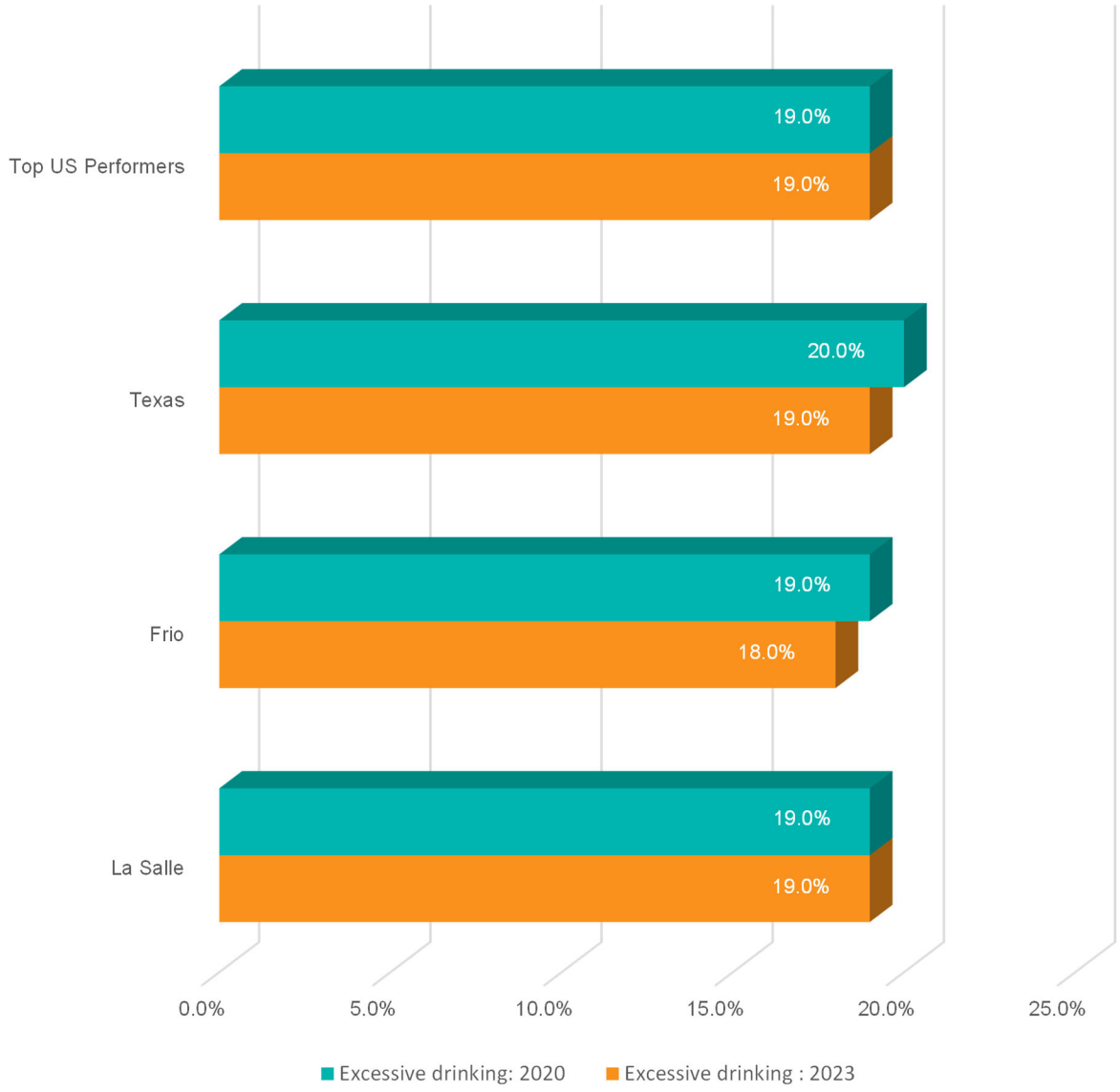
Physical Inactivity – Percent of adults age 20 and over reporting no leisure time physical activity



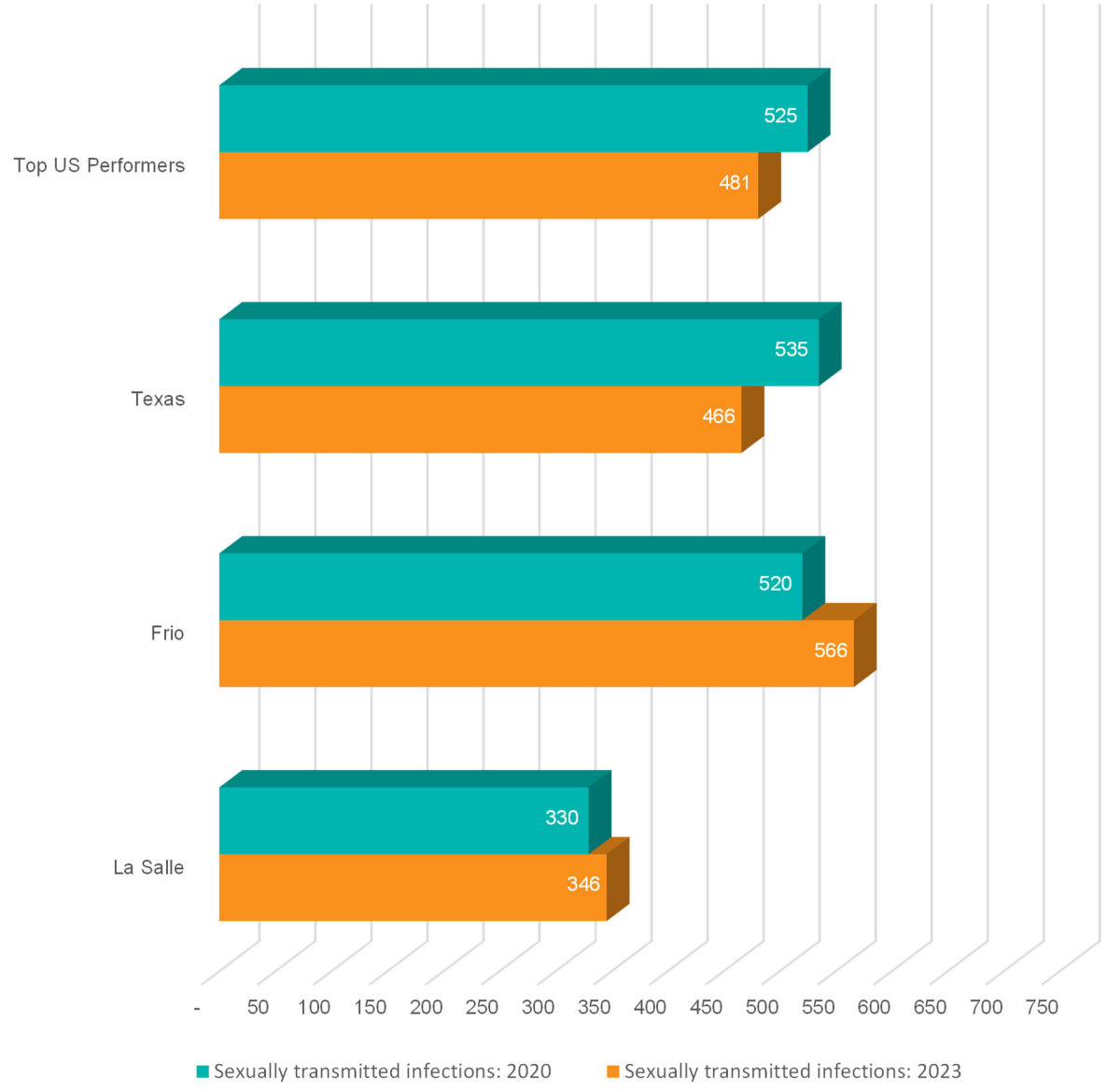
Access to Exercise Opportunities – Percentage of population with adequate access to locations for physical activity



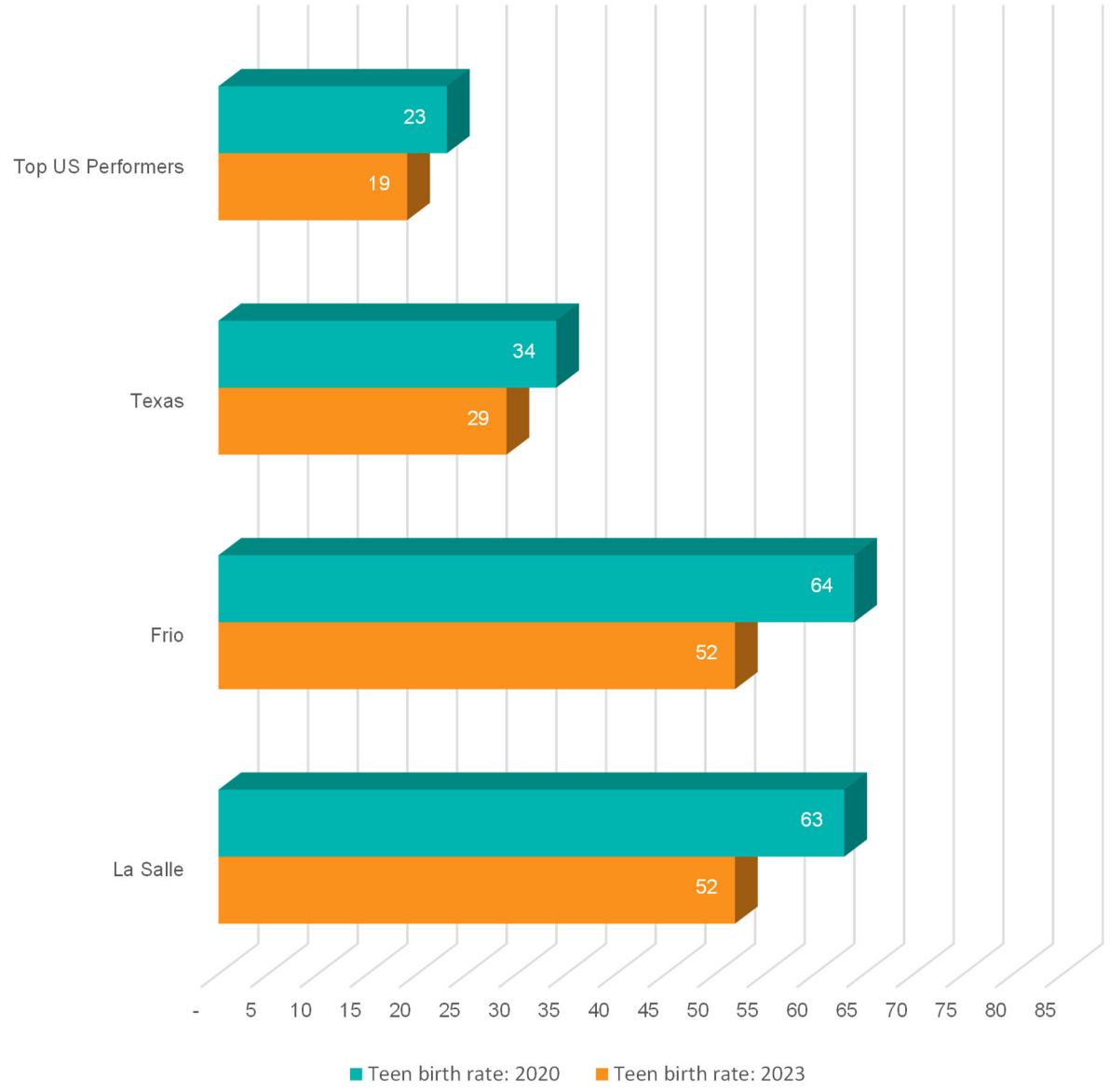
Excessive Drinking – Percent of adults that report excessive drinking in the past 30 days



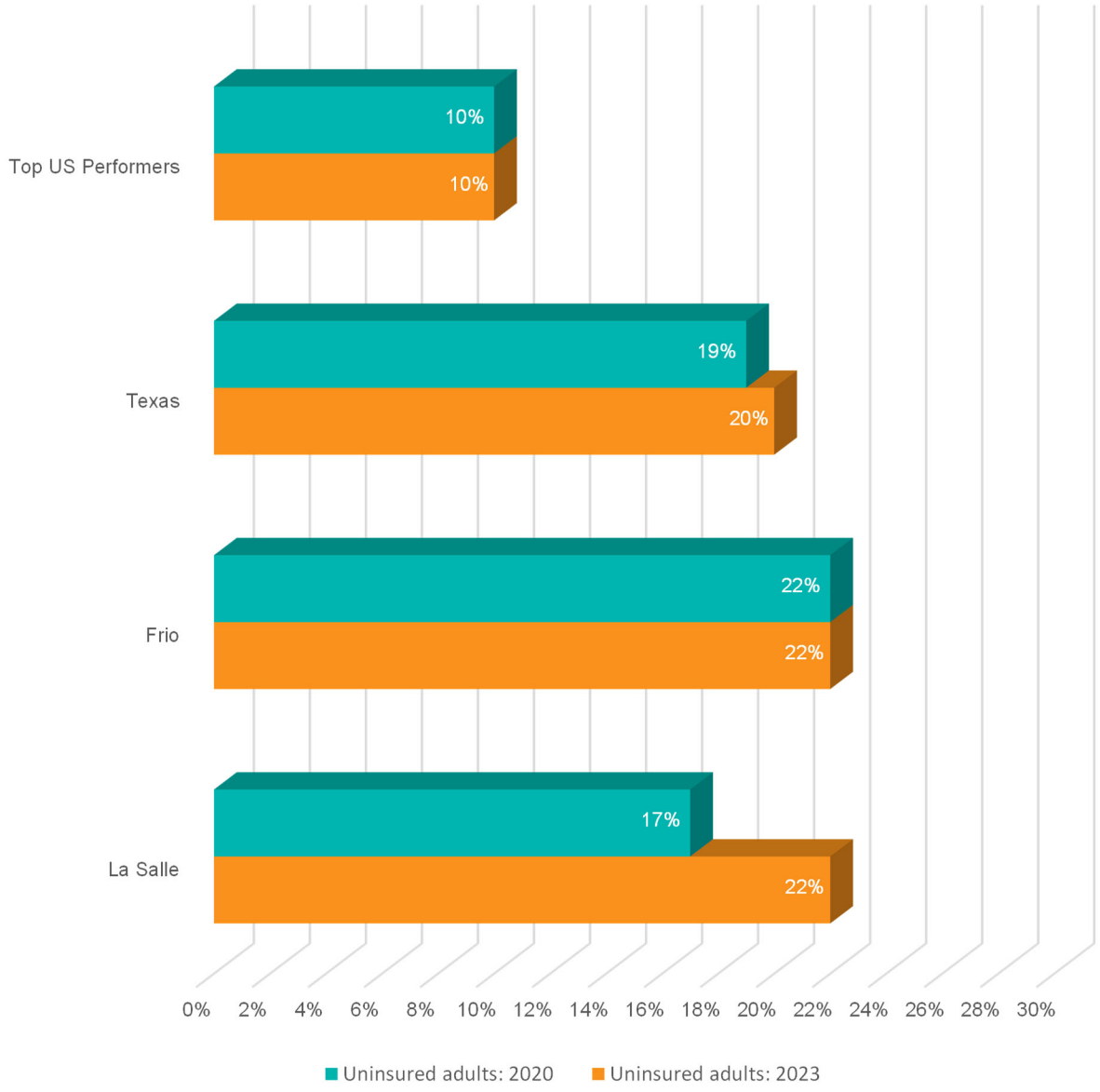
Sexually Transmitted Infections – Chlamydia rate per 100K population



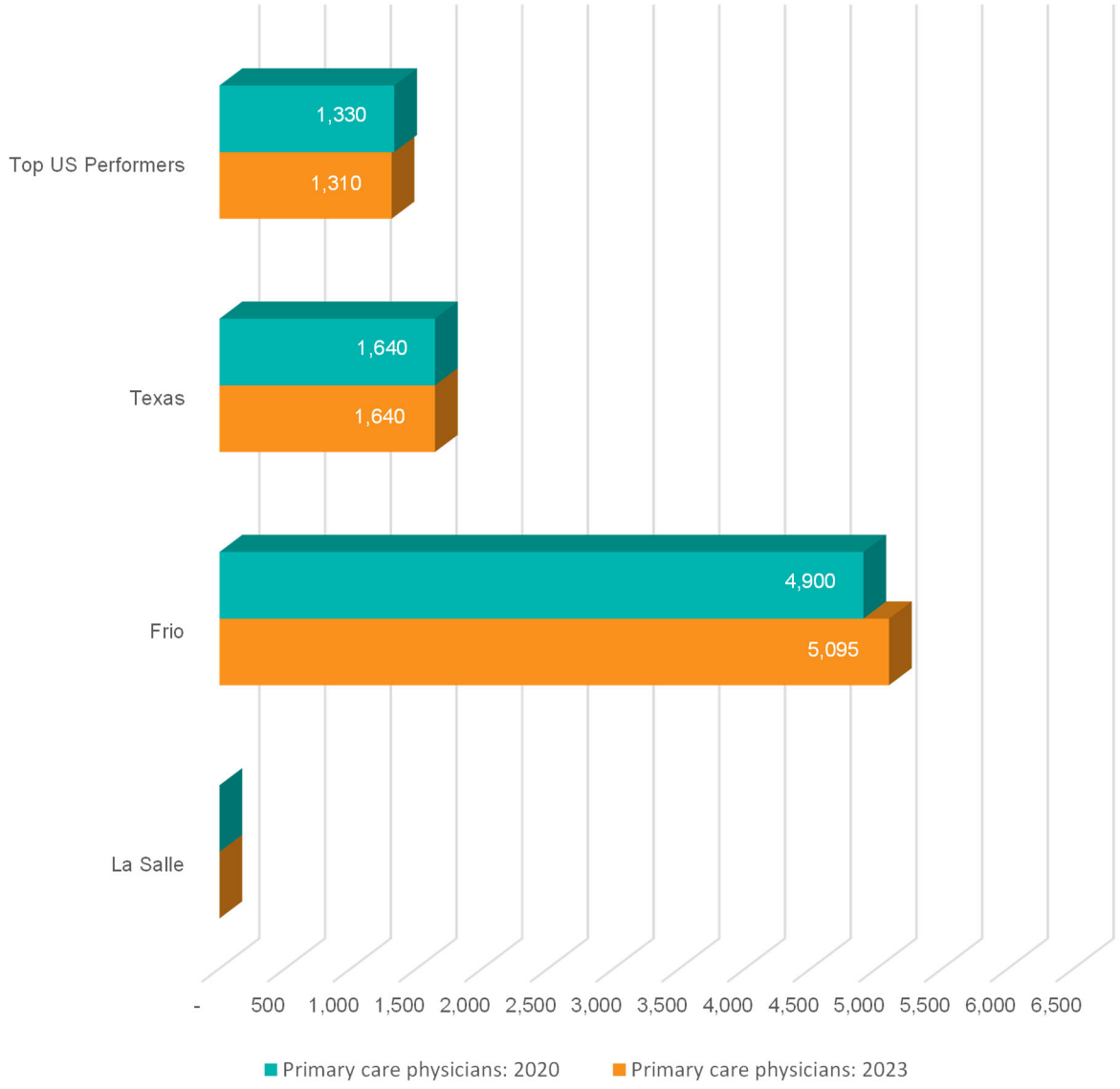
Teen Birth Rate – Per 1,000 female population, ages 15-19



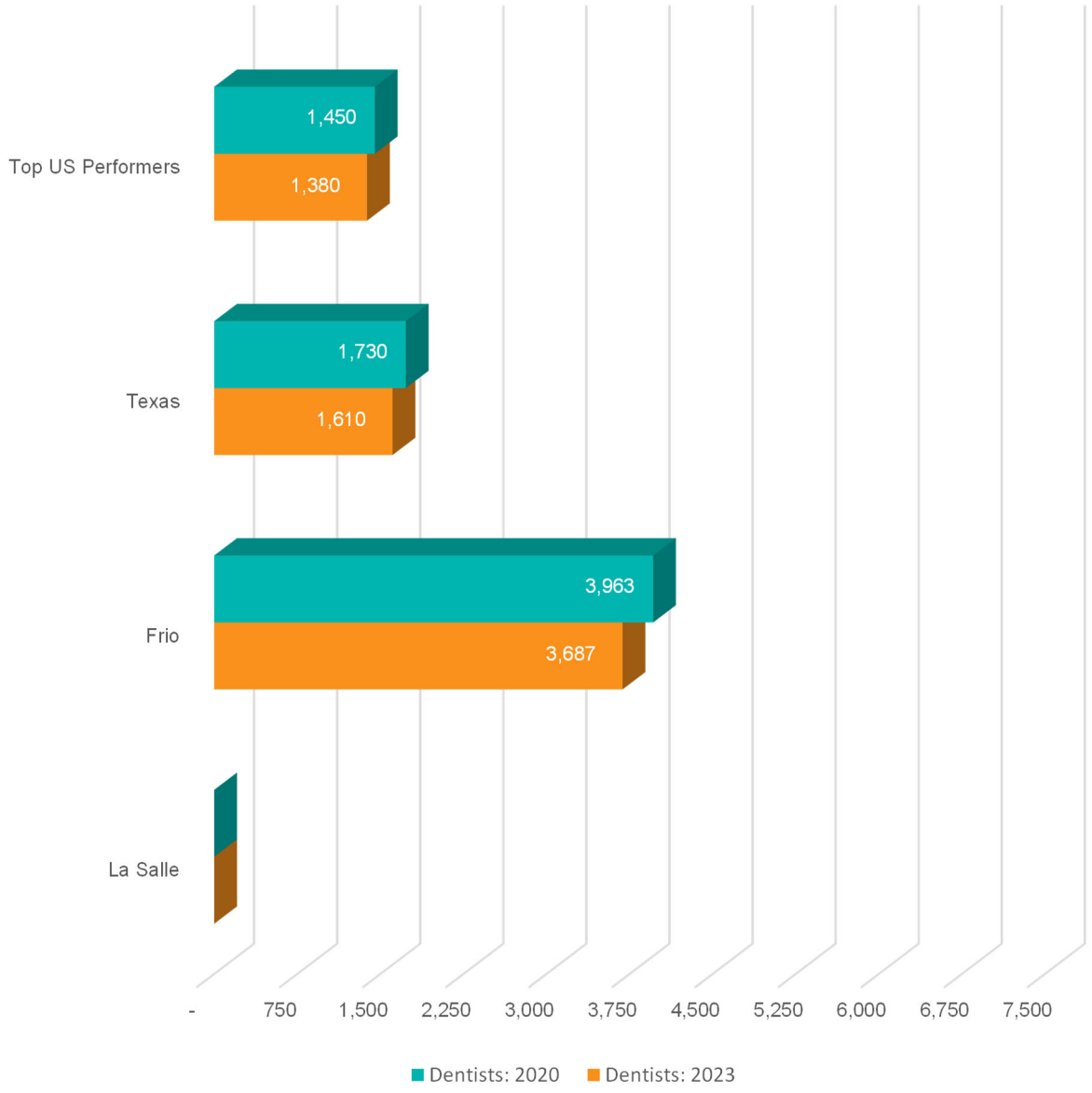
Uninsured Adults – Percent of population under age 65 without health insurance



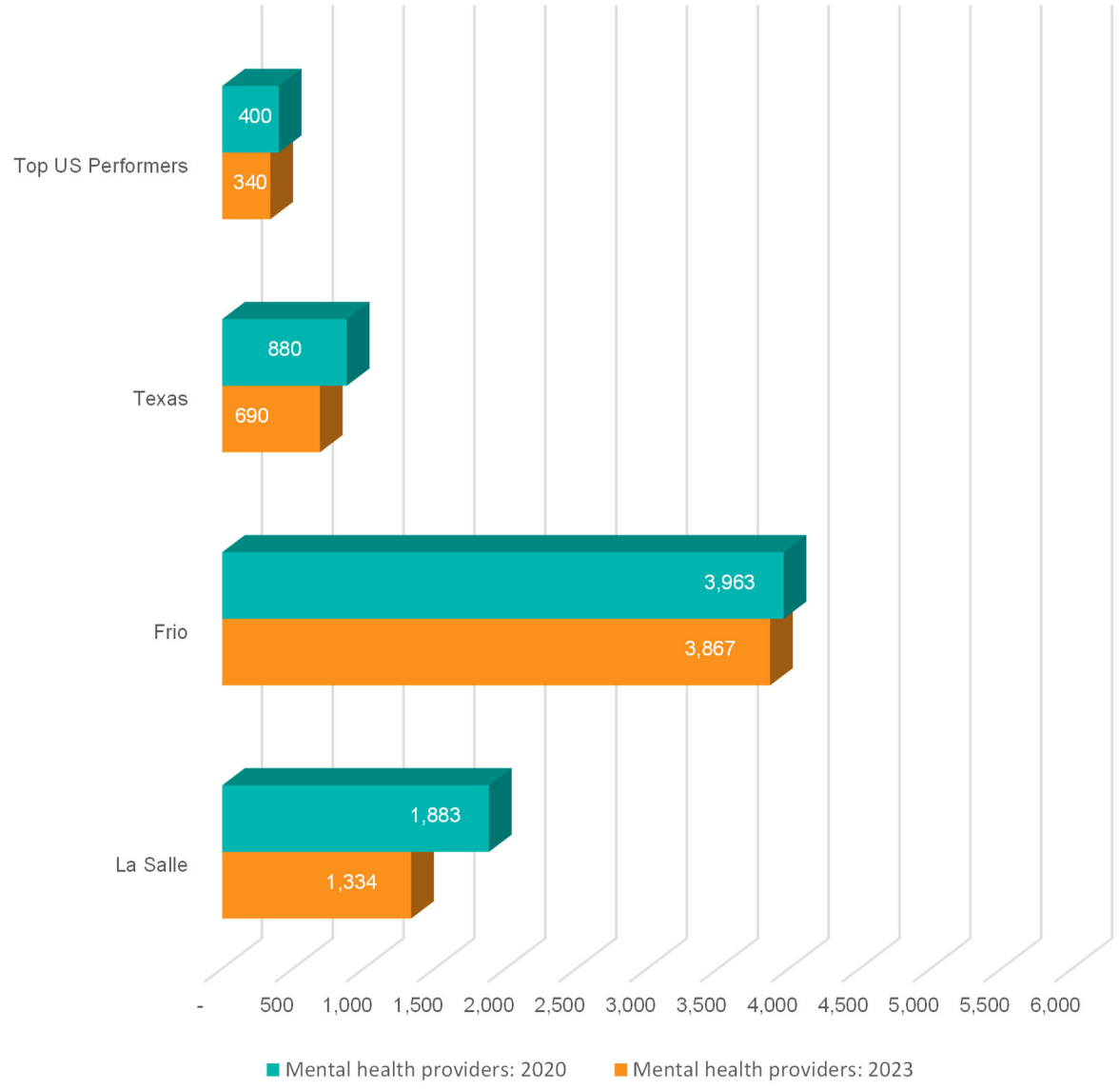
Primary Care Physicians – Ratio of population to primary care physicians (# of physicians: 1)



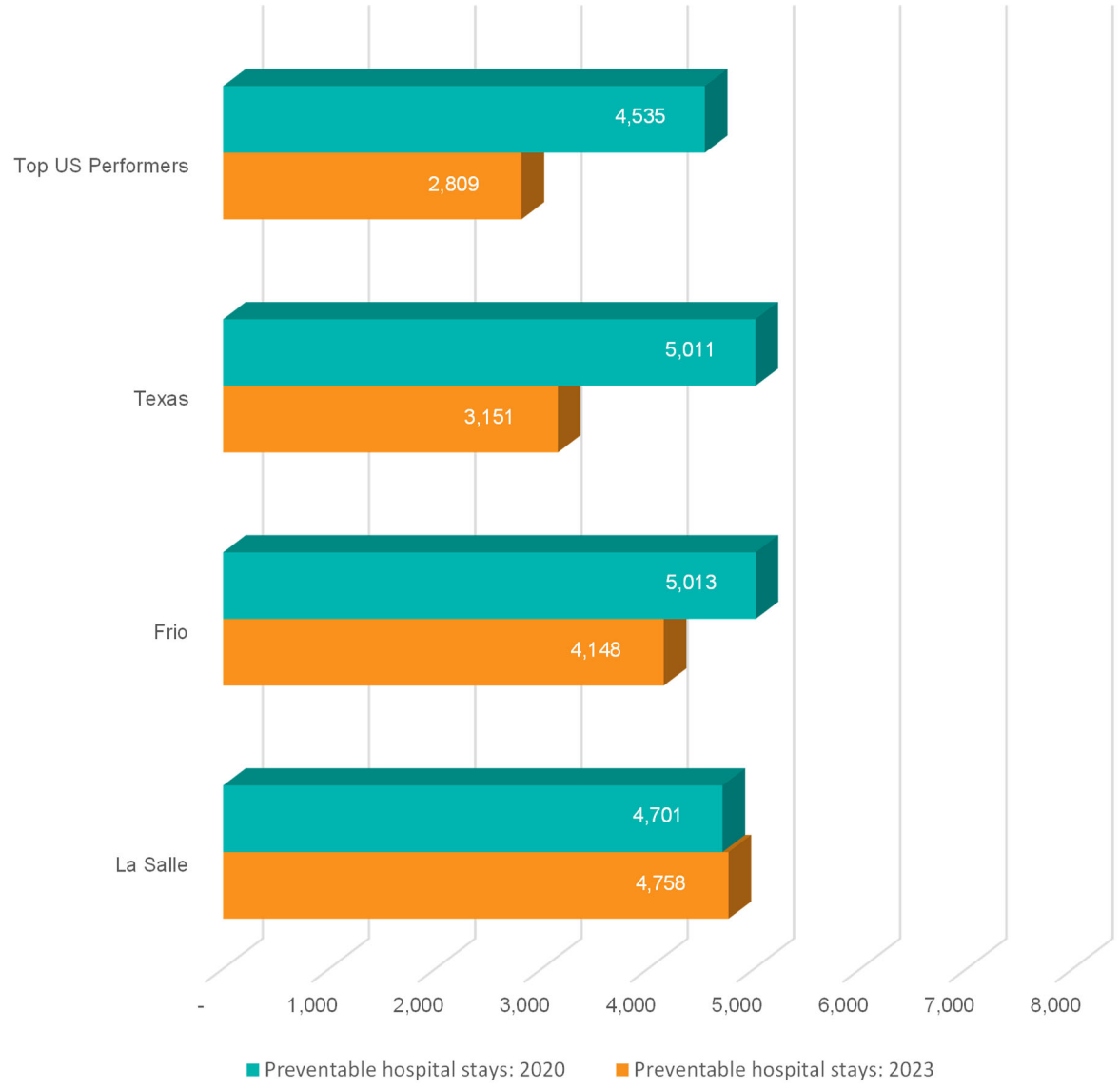
Dentists – Ratio of population to dentists (# of dentists: 1)



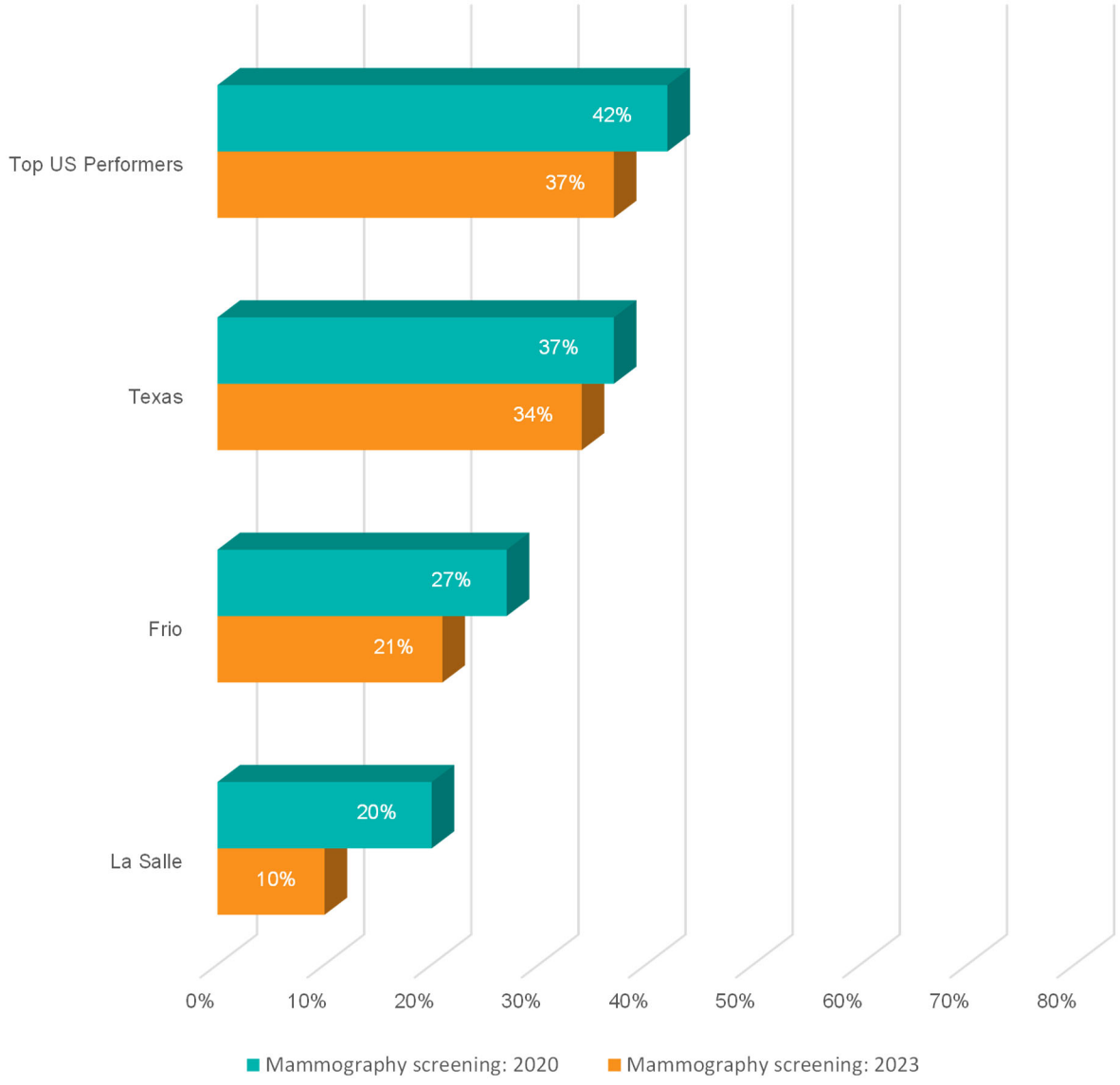
Mental Health Providers – Ratio of population to mental health providers (# of mental health providers: 1)



Preventable Hospital Stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees



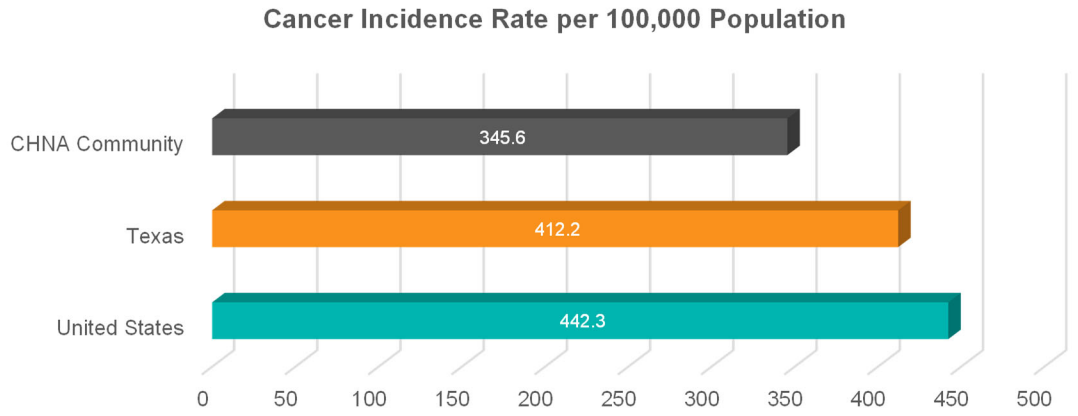
Mammography Screening – Percent of female Medicare enrollees that receive mammography screening



The following data shows a more detailed view of certain health outcomes and factors. The percentages for the CHNA Community are compared to the state of Texas and the United States.

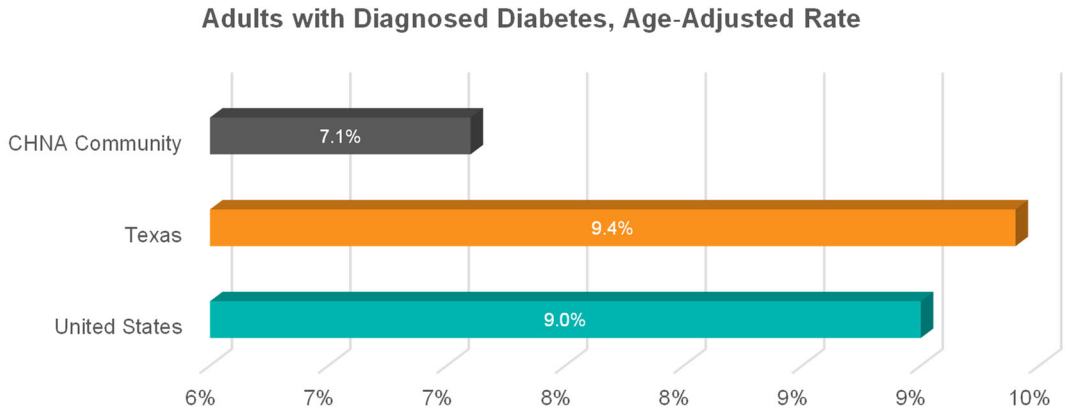
CANCER INCIDENCE

The CHNA Community's cancer incidence rate is 345.6 for every 100,000 of total population. This rate is lower than the state and national rate. Within the CHNA Community, there were 90 new cases of cancer reported. This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).



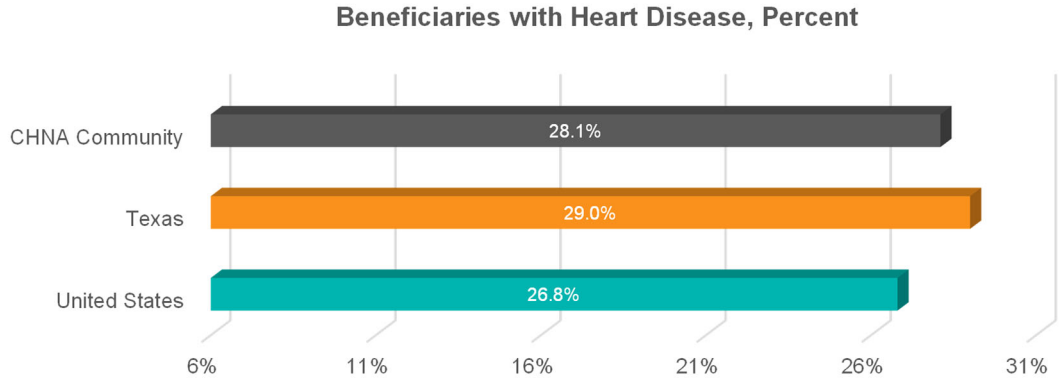
DIABETES (ADULT)

The CHNA Community's percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes is lower than the state and national rate. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.



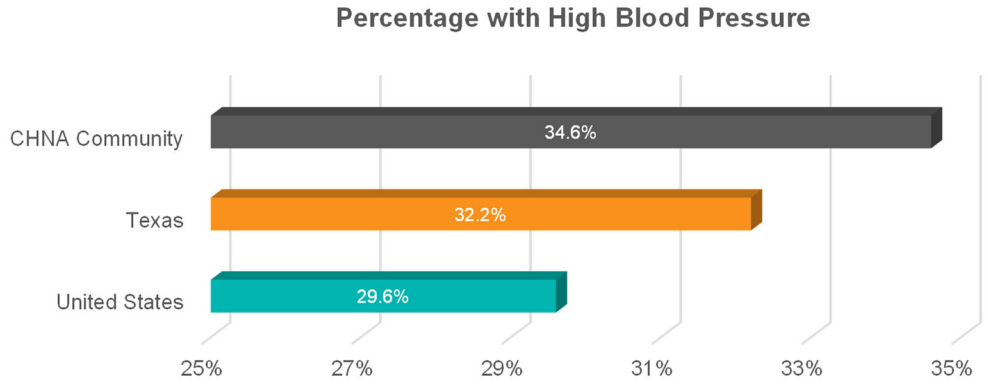
HEART DISEASE (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with Heart Disease is lower than the state rate but higher than the national rate. This indicator reports the number and percentage of the Medicare fee-for-service population with ischemic heart disease.



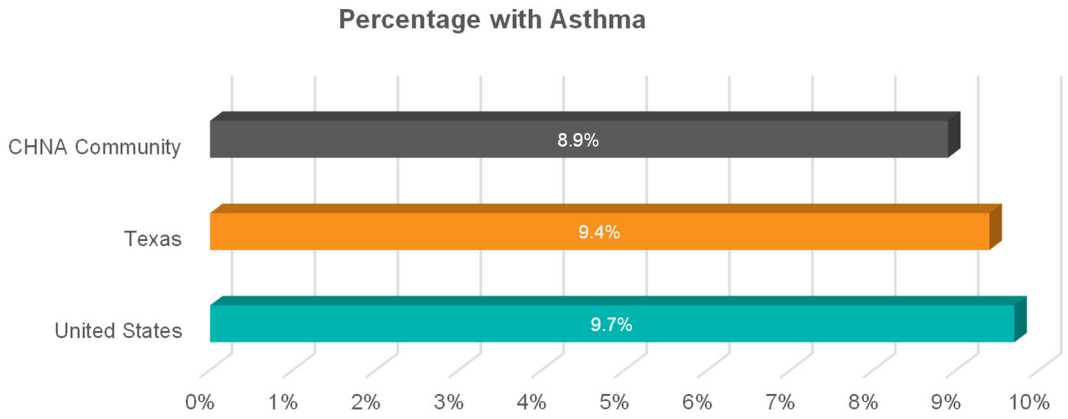
HIGH BLOOD PRESSURE (ADULT)

The CHNA Community's percentage adults aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension is higher than the state and national rates.



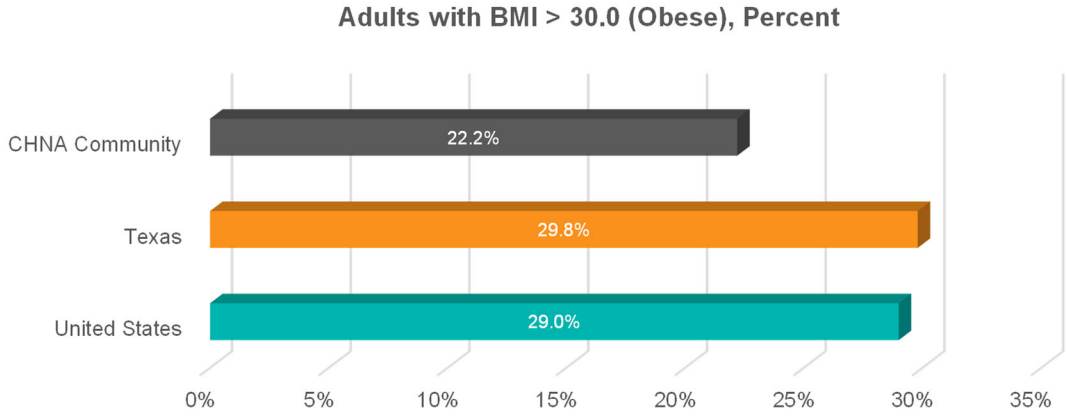
ASTHMA (ADULT)

The CHNA Community's percentage adults age 18+ with Asthma population with asthma is lower than the state rate and national rates. This indicator reports the number and percentage of the Medicare fee-for service population with asthma.



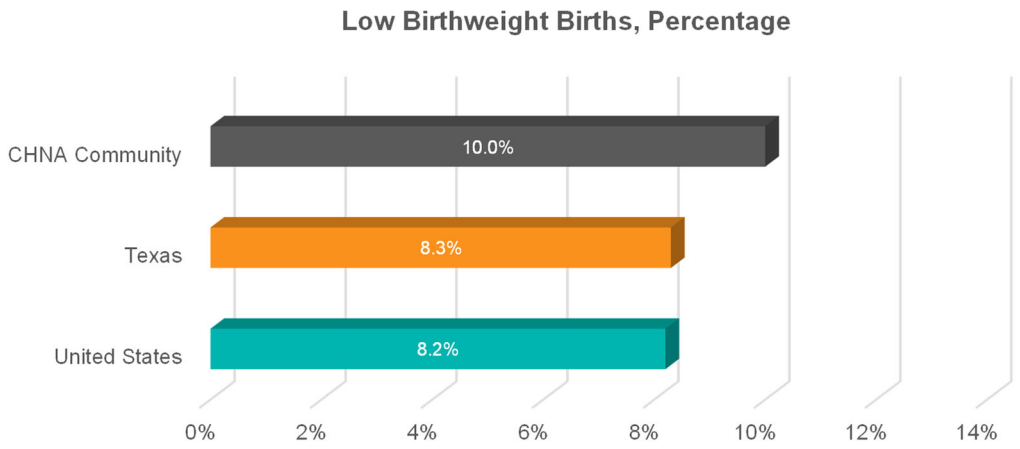
OBESITY

The CHNA Community's percentage of adults aged 20 and older that self-reported that they have a Body Mass Index (BMI) greater than 30.0 (obese) is lower than the state and national rates. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.



LOW BIRTH WEIGHT

The CHNA Community's percentage of total births that are low birth weight (under 2500g) is higher than the state and national rates. This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.



PRIMARY DATA ASSESSMENT

Obtaining input from key stakeholders (persons with knowledge of or expertise in public health, persons representing vulnerable populations, or community members who represent the broad interest of the community, or) is a technique employed to assess public perceptions of the CHNA Community's health status and unmet needs. Key stakeholder input is intended to ascertain opinions among individuals likely to be knowledgeable about the community and influential over the opinions of others about health concerns in the community.

METHODOLOGY

Surveys of nine key informants were conducted in 2023. The survey participants were determined based on their a) specialized knowledge or expertise in public health, b) their affiliation with local government, schools, or c) their involvement with underserved and minority populations and represent a broad aspect of the community.

All surveys utilized a standard format. Survey participant's opinions were collected without judging the truthfulness or accuracy of their remarks. Survey participants provided comments on the following issues:

- Health and quality of life for residents of the community
- Barriers to improving health and quality of life for residents of the community
- Opinions regarding the important health issues that affect the residents of the CHNA Community and the types of services that are important for addressing these issues
- Delineation of the most important health care issues or services discussed and actions necessary for addressing those issues.

Survey data was collected and analyzed. Themes in the data were identified. Survey participants were assured that personal identifiers such as name or organizational affiliations would not be connected in any way to the information presented in this report. This technique does not provide

a quantitative analysis of the leaders' opinions but reveals some of the factors affecting the views and sentiments about overall health and quality of life within the community.

KEY INFORMANT PROFILES

Key informants from the community worked for the following types of organizations and agencies:

- Local, county, and state government
- Public health agencies
- Medical providers
- Community and business leaders

Input from these health care and non-health care professionals was obtained utilizing a standard 10 question interview format.

KEY INFORMANT SURVEY QUESTIONS

Input from these health care and non-health care professionals was obtained utilizing a standard 10-question interview format. The questions included were as follows:

1. Name, organization/title, and county of residence?
2. In general, how would you rate the health and quality of life in the community served by Frio Regional Hospital?
3. In your opinion, in the past three years has the health and quality of life in the community served by Frio Regional Hospital improved, declined, or stayed the same?
4. Please provide what factors influenced your answer in the previous question and describe why you feel the health and quality of life has improved, declined or stayed the same?
5. What barriers, if any, exist to improving health and quality of life of patients served by Frio Regional Hospital?
6. In your opinion, what needs to be done to address the barriers identified in the previous question?
7. How could the services provided by Frio Regional Hospital be improved to better meet the needs of its patients and patient's families?
8. In your opinion, what groups of people in the community served by Frio Regional Hospital have the most serious unmet health care needs? Describe the causes? What should be done to address the needs of these groups of people?
9. In your opinion, what are the three most critical health needs in the community served by Frio Regional Hospital?
10. What needs to be done to address the critical health needs issues identified in the previous question?

RESULTS FROM COMMUNITY INPUT

Key stakeholder interview responses were grouped into four major categories. A summary of the stakeholders' responses by each of the categories follows. This section of the report summarizes what the key stakeholders provided without assessing the credibility of their responses.

GENERAL OPINIONS REGARDING HEALTH AND QUALITY OF LIFE IN THE COMMUNITY

The key stakeholders were asked to rate the health and quality of life in the community. They were also asked to provide their opinion whether the health and quality of life had improved, declined or stayed the same over the past few years. Lastly, key stakeholders were asked to provide support for their answers.

Key stakeholders were asked to rate the health and quality of life in CHNA Community. The survey respondents vary greatly in their responses: 33% rated the health and quality of life in CHNA Community as "very good"; 16.7% rated the health and quality of life in CHNA Community as "average"; 33.3% rated the health and quality of life in CHNA Community as "below average", and 16.7% rated the health and quality of life in CHNA Community as "poor". When asked whether the health and quality of life had improved, declined or stayed the same, 50% of survey respondents indicated the health and quality of life had "improved" over the last three years. Whereas 50% indicated the health and quality of life had "stayed the same" over the last three years.

UNDERSERVED POPULATIONS AND COMMUNITIES OF NEED

Through the key stakeholder surveys, specific populations and groups of people whose health or quality of life may not be as good as others were identified. Survey respondents identified persons living with low-incomes or unemployed are most likely to be underserved due to lack of access to services. Respondents also identified individual suffering from diabetes and mental health disorders as underserved. In addition, other identified groups are the uninsured and under-insured, children, and the elderly.

BARRIERS

The key stakeholders were asked what barriers or problems keep community residents from obtaining necessary health services and improving health in their community. Key stakeholders noted the following barriers in the CHNA Community:

- Lack of community member engagement in their overall health
- Community members face difficulties getting access to primary care, specialists, and mental health providers
- Community members that are uninsured or under-insured
- Community members that lack the financial resources to access care
- Community members that do not have transportation
- Available housing in the community when recruiting healthcare providers
- Lack of education regarding the available healthcare resources in the community

MOST IMPORTANT HEALTH AND QUALITY OF LIFE ISSUES

Key stakeholders were asked to provide their opinion as to the most critical health and quality of life issues facing the county and the most critical issues the Hospital should address over the next three to five years. Responses included:

- Access to health care
- Lack of insurance (and under-insured)
- Chronic diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Obesity
- Lack of health knowledge and education
- Poverty and lack of financial resources
- Access to mental health services - adults and children
- Access to primary care and specialists
- Access to preventative care
- Services for the aging
- Services for children
- Transportation
- Shortage of healthcare workers
- Healthy behaviors / lifestyle choices

HEALTH ISSUES OF VULNERABLE POPULATIONS

Based on information obtained through key informant surveys, the following populations are vulnerable or underserved in the community:

- Elderly
- Uninsured / underinsured / low income
- Residents of rural communities
- Individuals with mental health conditions

PRIORITIZATION OF IDENTIFIED HEALTH NEEDS

Priority setting is a required step in the community benefit planning process. The IRS regulations indicate that the CHNA must provide a prioritized description of the community health needs identified through the CHNA and include a description of the process and criteria used in prioritizing the health needs.

Using findings obtained through the collection of primary and secondary data, the Hospital completed an analysis of these inputs (see Appendices) to identify community health needs. The following data was analyzed to identify health needs for the community:

LEADING CAUSES OF DEATH

Leading causes of death for the community and the death rates for the leading causes of death for the county within the Hospital's CHNA Community were compared to U.S. adjusted death rates.

Causes of death in which the county rate compared unfavorably to the U.S. adjusted death rate resulted in a health need for the Hospital's CHNA Community.

HEALTH OUTCOMES AND FACTORS

An analysis of the County Health Rankings health outcomes and factors data was prepared for the counties within Frio Regional Hospital's CHNA Community. County rates and measurements for health behaviors, clinical care, social and economic factors and the physical environment were compared to state benchmarks.

County rankings in which the county rate compared unfavorably (by greater than 30% of the national benchmark) resulted in an identified health need.

PRIMARY DATA

Health needs identified through key informant interviews were included as health needs. Needs for vulnerable populations were separately reported on the analysis in order to facilitate the prioritization process.

HEALTH NEEDS OF VULNERABLE POPULATIONS

Health needs of vulnerable populations were included for ranking purposes.

PRIORITIZATION METHODOLOGY

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following factors (each factor received a score):

1. **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.
2. **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.
3. **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.
4. **How important the problem is to the community?** Needs identified through community interviews and/or focus groups were rated for this factor.

5. **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, health outcomes and factors and primary data) identified the need.

Each need was ranked based on the prioritization metrics. As a result, the following summary list of needs was identified:

Identified Health Needs	How Many People Are Affected by the Issue? (1 Low - 5 High)	What Are the Consequences of Not Addressing This Problem? (1 Low - 5 High)	What is the Impact on Vulnerable Populations? (1 Low - 5 High)	Prevalence of Common Themes (1 Low - 2 High)
Health education	5	3	5	2
Access to primary care physicians	3	4	4	2
Access to medical specialists	3	4	4	2
Access to care	5	4	5	2
Obesity	5	4	3	2
Shortage of healthcare workers	5	4	3	2
Healthy behaviors and healthy lifestyle choices	3	4	5	2
Access to mental health services - adults and children	3	3	4	2
Treatment of & mgmt of chronic diseases & conditions	4	5	3	2
Access to and use of preventative care treatments	5	3	3	2
Access to services for the aging	4	3	4	1
Stroke	1	3	2	2
Poverty and lack of financial resources	3	3	5	2
Uninsured adults	3	3	4	1
Heart Disease / Coronary Heart Disease	3	3	3	2
Access to services for children	3	3	3	1
Children in poverty	3	3	5	1
Access to exercise opportunities	4	3	3	1
Physical inactivity	4	3	3	1
Preventable hospital stays	2	2	2	1
Access to dental health services	3	2	3	2
Transportation	2	2	2	2
Teen birth rate	1	3	2	1

	Alignment with Mission (1 Low - 5 High)	Alignment with Programs & Strategic Priorities (1 Low - 5 High)	Total Score
Health education	5	5	25
Access to primary care physicians	5	5	23
Access to medical specialists	5	5	23
Access to care	3	3	22
Obesity	5	3	22
Shortage of healthcare workers	3	3	20
Healthy behaviors and healthy lifestyle choices	3	3	20
Access to mental health services - adults and children	4	4	20
Treatment of & mgmt of chronic diseases & conditions	3	2	19
Access to and use of preventative care treatments	3	3	19
Access to services for the aging	3	3	18
Stroke	5	5	18
Poverty and lack of financial resources	2	2	17
Uninsured adults	3	3	17
Heart Disease / Coronary Heart Disease	3	3	17
Access to services for children	3	3	16
Children in poverty	2	2	16
Access to exercise opportunities	2	2	15
Physical inactivity	2	2	15
Preventable hospital stays	4	4	15
Access to dental health services	2	2	14
Transportation	1	1	10
Teen birth rate	2	2	11

MANAGEMENT'S PRIORITIZATION PROCESS

For the health needs prioritization process, the Hospital engaged the leadership team to review the most significant health needs reported in the prior CHNA, as well needs identified in the current process, using the following criteria:

- Current area of Hospital focus
- Established relationships with community partners to address the health need
- Organizational capacity and existing infrastructure to address the health need

This data was reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community. As a result of the analysis described above, the following health needs were identified as the most significant health needs for the community:

- Health education
- Access to primary care physicians
- Access to medical specialists
- Access to care
- Obesity
- Shortage of healthcare workers
- Healthy behaviors and healthy lifestyle choices
- Access to mental health services - adults and children
- Treatment of & management of chronic diseases and conditions
- Access to and use of preventative care treatments
- Access to services for the aging

The Hospital's next steps include developing an implementation strategy to address these priority areas.

COMMUNITY RESOURCES

The availability of health care resources is a critical component to the health of a county's residents and a measure of the soundness of the area's health care delivery system. An adequate number of health care facilities and health care providers are vital for sustaining a community's health status. Fewer health care facilities and health care providers can impact the timely delivery of services. A limited supply of health resources, especially providers, results in the limited capacity of the health care delivery system to absorb charity and indigent care as there are fewer providers upon which to distribute the burden of indigent care.

HOSPITALS

The Hospital is the only hospital facility located within the CHNA community. There are no hospitals within a 30-mile radius available to the residents of CHNA community. Residents of the community take advantage of services provided by hospitals in neighboring counties, as well as services offered by other facilities and providers.

OTHER HEALTH CARE FACILITIES

Short-term acute care hospital services are not the only health services available to members of the Hospital's CHNA Community. The table below provides a listing of other health care facilities within the Hospital's CHNA Community.

Facility Name	County	City, State Zip
Frio Hospital Home Health	Frio	Pearsall, TX 78061
Frio Rehab Center	Frio	Pearsall, TX 78061
Frio Regional Primary Care & Urgent Care Clinic	Frio	Dilley, TX 78017
South Texas Rural Health Services	Frio	Pearsall, Texas 78061
South Texas Rural Health Services	La Salle	Cotulla, TX 7801
South Texas Rural Health Services	Frio	Dilley, TX 78017
Hometown Healthcare	Frio	Dilley, TX 78017
Hometown Healthcare	Frio	Pearsall, TX 78061
Hometown Healthcare	La Salle	Cotulla, TX 78014

APPENDICES

APPENDIX A – ANALYSIS OF DATA

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH

CHNA COMMUNITY

Area	United States	(A) 10% of United States Crude Rate	La Salle County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	149.40	14.94	160.90	11.50	
Coronary Heart Disease	91.50	9.15	130.50	39.00	Health Need
Heart Disease	164.80	16.48	200.60	35.80	Health Need
Lung Disease	39.10	3.91	22.30	-16.80	
Stroke	37.60	3.76	44.10	6.50	Health Need
Unintentional Injury	50.40	5.04	39.80	-10.60	
Poisoning (Including Drug Over	24.00	2.40	No Data		
Life Expectancy	78.60	7.86	76.40	-2.20	
Suicide	13.80	1.38	No Data		

Note: Crude Death Rate (Per 100,000 Pop.)

FRIO COUNTY

Area	United States	(A) 10% of United States Crude Rate	Frio County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	149.40	14.94	162.30	12.90	
Coronary Heart Disease	91.50	9.15	137.00	45.50	Health Need
Heart Disease	164.80	16.48	208.20	43.40	Health Need
Lung Disease	39.10	3.91	22.30	-16.80	
Stroke	37.60	3.76	44.10	6.50	Health Need
Unintentional Injury	50.40	5.04	39.80	-10.60	
Poisoning (Including Drug Over	24.00	2.40	No Data		
Life Expectancy	78.60	7.86	76.20	-2.40	
Suicide	13.80	1.38	No Data		

Note: Crude Death Rate (Per 100,000 Pop.)

LA SALLE COUNTY

Area	United States	(A) 10% of United States Crude Rate	La Salle County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	149.40	14.94	162.30	12.90	
Coronary Heart Disease	91.50	9.15	113.60	22.10	Health Need
Heart Disease	164.80	16.48	180.40	15.60	
Lung Disease	39.10	3.91	No Data		
Stroke	37.60	3.76	No Data		
Unintentional Injury	50.40	5.04	No Data		
Poisoning (Including Drug Over	24.00	2.40	No Data		
Life Expectancy	78.60	7.86	77.00	-1.60	
Suicide	13.80	1.38	No Data		

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH OUTCOMES

FRIO COUNTY

Health Outcomes	Top US Performers: 2023	(A) 30% of National Benchmark	Frio County: 2023	(B) County Rate Less National Benchmark 2023	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	19.0%	3.0%	
Adult obesity	32.0%	9.6%	41.0%	9.0%	
Food environment index	7.0	2.1	6.7	(0.3)	
Physical inactivity	22.0%	6.6%	36.0%	14.0%	Health Need
Access to exercise opportunities	84.0%	25.2%	40.0%	-44.0%	Health Need
Excessive drinking	19.0%	5.7%	18.0%	-1.0%	
Alcohol-impaired driving deaths	27.0%	8.1%	11.0%	-16.0%	
Sexually transmitted infections	481.3	144.4	566.3	85.0	
Teen birth rate	19.0	5.7	52.0	33.0	Health Need
Uninsured adults	10.0%	3.0%	22.0%	12.0%	Health Need
Primary care physicians	1,310	393	5,095	3,785	Health Need
Dentists	1,380	414	3,867	2,487	Health Need
Mental health providers	340	102	3,867	3,527	Health Need
Preventable hospital stays	2,809.0	842.7	4,148.0	1,339.0	Health Need
Mammography screening	37.0%	11.1%	21.0%	-16.0%	
Children in poverty	17.0%	34.0%	34.0%	17.0%	

LA SALLE COUNTY

Health Outcomes	Top US Performers: 2023	(A) 30% of National Benchmark	La Salle County: 2023	(B) County Rate Less National Benchmark 2023	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	18.0%	2.0%	
Adult obesity	32.0%	9.6%	41.0%	9.0%	
Food environment index	7.0	2.1	6.8	(0.2)	
Physical inactivity	22.0%	6.6%	36.0%	14.0%	Health Need
Access to exercise opportunities	84.0%	25.2%	0.0%	-84.0%	Health Need
Excessive drinking	19.0%	5.7%	19.0%	0.0%	
Alcohol-impaired driving deaths	27.0%	8.1%	20.0%	-7.0%	
Sexually transmitted infections	481.3	144.4	345.7	(135.6)	
Teen birth rate	19.0	5.7	52.0	33.0	Health Need
Uninsured adults	10.0%	3.0%	22.0%	12.0%	Health Need
Primary care physicians	1,310	393	No Data		Health Need
Dentists	1,380	414	No Data		Health Need
Mental health providers	340	102	1,334	994	Health Need
Preventable hospital stays	2,809.0	842.7	4,758.0	1,949.0	Health Need
Mammography screening	37.0%	11.1%	10.0%	-27.0%	
Children in poverty	17.0%	5.1%	32.0%	15.0%	Health Need

ANALYSIS OF PRIMARY DATA – KEY INFORMANT SURVEYS

Identified Needs
Access to care
Uninsured / Underinsured
Shortage of healthcare workers
Access to and use of preventative care treatments
Treatment of & mgmt of chronic diseases & conditions
Access to primary care physicians
Access to medical specialists
Access to mental health services - adults and children
Access to services for the aging
Obesity
Access to services for children
Healthy behaviors and healthy lifestyle choices
Lack of health knowledge and education
Transportation
Poverty and lack of financial resources

ISSUES VULNERABLE POPULATIONS

Population	Issues
Uninsured and under-insured population	Transportation
Elderly	Transportation Cost of prescriptions and medical care Lack of health knowledge regarding how to access services Access to services for the aging Shortage of physicians (limit on patients who are on Medicare)
Individuals with mental health conditions	Access to services Lack of health knowledge regarding how to access services
Residents of rural communities	Transportation Access to services

APPENDIX B – ACKNOWLEDGEMENT OF KEY INFORMANTS

KEY INFORMANTS

Thank you to the following individuals who participated in our key informant survey process:

Name	Organization
Delma Aguirrd	Frio County
Juanita Rendon	FHA
Sara Nicholson	Texas A&M AgriLife Extension
Margie Villanueva	Community Volunteer
Ben Briscoe	City Mayor
Mitzy Rodriguez	Pearsall High School Counselor
Tamy Sanchez	Frio County WIC
Paula Winkler	Board Member, South Central Area Health Education Center
Belia Valenzuela	SJRC Belong/Community Liaison

APPENDIX C – COUNTY HEALTH RANKINGS

FRIO COUNTY

Health Outcomes	Frio County: 2020	Frio County: 2023	Change	Texas: 2023	Top US Performers: 2023
Mortality: Texas County Ranking	**77**	**150**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,777	9,277	-	7,000	7,300
Morbidity: Texas County Ranking	**226**	**204**	+		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	28%	26%	+	16%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.4	4.2	+	2.9	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.9	4.5	-	4.2	4.4
Low birth weight – Percent of live births with low birth weight (<2500 grams)	10.0%	10.0%	NC	8.0%	8.0%

Health Outcomes	Frio County: 2020	Frio County: 2023	Change	Texas: 2023	Top US Performers: 2023
Health Behaviors: Texas County Ranking	**116**	**167**	-		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	16.0%	19.0%	-	13.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	25.0%	41.0%	-	36.0%	32.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	8.6	6.7	-	5.9	7.0
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	24.0%	36.0%	-	25.0%	22.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	41.0%	40.0%	+	82.0%	84.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	19.0%	18.0%	+	19.0%	19.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	21.0%	11.0%	+	25.0%	27.0%
Sexually transmitted infections – Chlamydia rate per 100K population	520.4	566.3	-	466.0	481.3
Teen birth rate – Per 1,000 female population, ages 15-19	64.0	52.0	+	29.0	19.0
Clinical Care: Texas County Ranking	**177**	**202**	-		
Uninsured adults – Percent of population under age 65 without health insurance	22.0%	22.0%	NC	20.0%	10.0%
Primary care physicians – Ratio of population to primary care physicians	4900:1	5095:1	-	1640:1	1310:1
Dentists – Ratio of population to dentists	3963:1	3687:1	+	1610:1	1380:1
Mental health providers – Ratio of population to mental health providers	3963:1	3867:1	+	690:1	340:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	5,013	4,148	+	3,151	2,809
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	27.0%	21.0%	+	34.0%	37.0%

Health Outcomes	Frio County: 2020	Frio County: 2023	Change	Texas: 2023	Top US Performers: 2023
Social and Economic Factors: Texas County Ranking	**205**	**226**	-		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	87.0%	66.0%	-	85.0%	89.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	36.0%	25.0%	-	64.0%	67.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	2.9%	4.8%	-	5.7%	5.4%
Children in poverty – Percent of children under age 18 in poverty	34.0%	34.0%	**NC**	20.0%	17.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	5.4	7.1	-	4.8	4.9
Children in single-parent households – Percent of children that live in household headed by single parent	45.0%	36.0%	+	26.0%	25.0%
Social associations – Number of membership associations per 10,000 population	6.6	5.4	-	7.4	9.1
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	237.0	No Data	**NC**	No Data	No Data
Injury deaths – Number of deaths due to injury per 100,000 population	50.0	51.0	-	60.0	76.0
Physical Environment: Texas County Ranking	**135**	**86**	+		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	8.7	9.1	-	8.6	7.4
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	20.0%	14.0%	+	17.0%	17.0%
Driving alone to work – Percentage of the workforce that drives alone to work	87.0%	81.0%	+	77.0%	73.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	19.0%	19.0%	**NC**	39.0%	37.0%

Data Source: Countyhealthrankings.org

LA SALLE COUNTY

Health Outcomes	La Salle County: 2020	La Salle County: 2023	Change	Texas: 2023	Top US Performers: 2023
Mortality: Texas County Ranking	**86**	**65**	+		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,939	8,072	-	7,000	7,300
Morbidity: Texas County Ranking	**205**	**224**	-		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	28%	25%	+	16%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.2	4.1	+	2.9	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.9	4.5	-	4.2	4.4
Low birth weight – Percent of live births with low birth weight (<2500 grams)	9%	11%	-	8.0%	8.0%

Health Outcomes	La Salle County: 2020	La Salle County: 2023	Change	Texas: 2023	Top US Performers: 2023
Health Behaviors: Texas County Ranking	**122**	**134**	-		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	14.0%	18.0%	-	13.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	30.0%	41.0%	-	36.0%	32.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.3	6.8	+	5.9	7.0
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	25.0%	36.0%	-	25.0%	22.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	0.0%	0.0%	NC	82.0%	84.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	19.0%	19.0%	NC	19.0%	19.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	14.0%	20.0%	-	25.0%	27.0%
Sexually transmitted infections – Chlamydia rate per 100K population	329.6	345.7	-	466.0	481.3
Teen birth rate – Per 1,000 female population, ages 15-19	63.0	52.0	+	29.0	19.0
Clinical Care: Texas County Ranking	**116**	**230**	-		
Uninsured adults – Percent of population under age 65 without health insurance	17.0%	22.0%	-	20.0%	10.0%
Primary care physicians – Ratio of population to primary care physicians	No Data	No Data	NC	1640:1	1310:1
Dentists – Ratio of population to dentists	No Data	No Data	NC	1610:1	1380:1
Mental health providers – Ratio of population to mental health providers	1883:1	1334:1	+	690:1	340:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	4,701	4,758	-	3,151	2,809
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	20.0%	10.0%	-	34.0%	37.0%

Health Outcomes	La Salle County: 2020	La Salle County: 2023	Change	Texas: 2023	Top US Performers: 2023
Social and Economic Factors: Texas County Ranking	**200**	**210**	-		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	88.0%	69.0%	-	85.0%	89.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	18.0%	12.0%	-	64.0%	67.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	2.4%	4.3%	-	5.7%	5.4%
Children in poverty – Percent of children under age 18 in poverty	36.0%	32.0%	+	20.0%	17.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	4.4	5.3	-	4.8	4.9
Children in single-parent households – Percent of children that live in household headed by single parent	29.0%	21.0%	+	26.0%	25.0%
Social associations – Number of membership associations per 10,000 population	5.3	5.3	NC	7.4	9.1
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	85.0	No Data	NC	No Data	No Data
Injury deaths – Number of deaths due to injury per 100,000 population	61.0	56.0	+	60.0	76.0
Physical Environment: Texas County Ranking	**170**	**140**	+		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	8.2	9.2	-	8.6	7.4
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	25.0%	16.0%	+	17.0%	17.0%
Driving alone to work – Percentage of the workforce that drives alone to work	87.0%	84.0%	+	77.0%	73.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	32.0%	32.0%	NC	39.0%	37.0%

Data Source: Countyhealthrankings.org

APPENDIX D – SOURCES

Data Indicator	Data Source
Total Population	US Census Bureau, American Community Survey, 2017-21.
Total Population (Census 2020)	US Census Bureau, Decennial Census, 2020.
Total Population Change, 2010 - 2020	US Census Bureau, Decennial Census, 2020.
Total Population Change, 2000 - 2010	US Census Bureau, Decennial Census, 2000 - 2010.
Urban and Rural Population (2020) - Rural	US Census Bureau, Decennial Census, 2020.
Urban and Rural Population (2020) - Urban	US Census Bureau, Decennial Census, 2020.
Group Quarters Population	US Census Bureau, Decennial Census, 2020.
Urban and Rural Population (Incorporated) (Census 2020)	US Census Bureau, Decennial Census, 2020.
Median Age	US Census Bureau, American Community Survey, 2017-21.
Female Population	US Census Bureau, American Community Survey, 2017-21.
Male Population	US Census Bureau, American Community Survey, 2017-21.
Population Under Age 18	US Census Bureau, American Community Survey, 2017-21.
Population Age 0-4	US Census Bureau, American Community Survey, 2017-21.
Population Age 5-17	US Census Bureau, American Community Survey, 2017-21.
Population Age 18-64	US Census Bureau, American Community Survey, 2017-21.
Population Age 18-24	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Population Age 25-34	US Census Bureau, American Community Survey, 2017-21.
Population Age 35-44	US Census Bureau, American Community Survey, 2017-21.
Population Age 45-54	US Census Bureau, American Community Survey, 2017-21.
Population Age 55-64	US Census Bureau, American Community Survey, 2017-21.
Population Age 65+	US Census Bureau, American Community Survey, 2017-21.
Population with Any Disability	US Census Bureau, American Community Survey, 2017-21.
Population in Limited English Households	US Census Bureau, American Community Survey, 2017-21.
Population with Limited English Proficiency	US Census Bureau, American Community Survey, 2017-21.
Population Geographic Mobility	US Census Bureau, American Community Survey, 2017-21.
Foreign-Born Population	US Census Bureau, American Community Survey, 2017-21.
Hispanic Population	US Census Bureau, American Community Survey, 2017-21.
Non-Hispanic White Population	US Census Bureau, American Community Survey, 2017-21.
Black or African American Population	US Census Bureau, American Community Survey, 2017-21.
Citizenship Status	US Census Bureau, American Community Survey, 2017-21.
Veteran Population	US Census Bureau, American Community Survey, 2017-21.
Migration Patterns - Total Population (2010-2020)	IRS - Statistics of Income, 2010-2020.

Data Indicator	Data Source
Migration Patterns - Total Population (2000-2010)	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Migration Patterns - Young Adult (2000-2010)	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Commuter Travel Patterns - Driving Alone to Work	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Long Commute	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Overview	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Overview 2	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Public Transportation	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Walking or Biking	US Census Bureau, American Community Survey, 2017-21.
Employment - Business Creation	US Census Bureau, Business Dynamics Statistics, 2010-2020.
Employment - Employment Change	US Census Bureau, Business Dynamics Statistics, 2019-2020.
Employment - Job Sectors, Largest	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Jobs and Earnings by Sector	US Department of Commerce, US Bureau of Economic Analysis, 2021.
Employment - Jobs Sectors, Highest Earnings	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Labor Force Participation Rate	US Census Bureau, American Community Survey, 2017-21.
Employment - Unemployment Rate	US Department of Labor, Bureau of Labor Statistics, 2023 - September.
Gross Domestic Product (GDP)	US Department of Commerce, US Bureau of Economic Analysis, 2021.

Data Indicator	Data Source
Income - Earned Income Tax Credit	IRS - Statistics of Income, 2018.
Income - Families Earning Over $75,000	US Census Bureau, American Community Survey, 2017-21.
Income - Income and AMI	US Census Bureau, American Community Survey, 2017-21.
Income - Inequality (Atkinson Index)	US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11.
Income - Inequality (GINI Index)	US Census Bureau, American Community Survey, 2017-21.
Income - Median Family Income	US Census Bureau, American Community Survey, 2017-21.
Income - Median Household Income	US Census Bureau, American Community Survey, 2017-21.
Income - Net Income of Farming Operations	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Income - Per Capita Income	US Census Bureau, American Community Survey, 2017-21.
Income - Proprietor Employment and Income	US Department of Commerce, US Bureau of Economic Analysis, 2021.
Income - Public Assistance Income	US Census Bureau, American Community Survey, 2017-21.
Income - Transfer Payments	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Poverty - Children Below 100% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Children Below 200% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data, 2020-2021.
Poverty - Households in Poverty by Family Type	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Poverty - Population Below 100% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Population Below 100% FPL (Annual)	US Census Bureau, Small Area Income and Poverty Estimates, 2021.
Poverty - Population Below 185% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Population Below 200% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Population Below 50% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Poverty Profile	US Census Bureau, American Community Survey, 2021.
Debt - Student Loan Debt	Debt in America, The Urban Institute, 2017-21.
Debt - Any Debt in Collections	Debt in America, The Urban Institute, 2017-21.
Access - Childcare Centers	Department of Homeland Security, Homeland Infrastructure Foundation-Level Data, 2010-2022.
Access - Head Start	US Department of Health & Human Services, HRSA - Administration for Children and Families, 2022.
Access - Childcare Cost Burden	The Living Wage Calculator, Small Area Income and Poverty Estimates, 2022&2021.
Access - Preschool Enrollment (Age 3-4)	US Census Bureau, American Community Survey, 2017-21.
Access - Public Schools	National Center for Education Statistics, NCES - Common Core of Data, 2021-2022.
Attainment - Overview	US Census Bureau, American Community Survey, 2017-21.
Attainment - Associate's Level Degree or Higher	US Census Bureau, American Community Survey, 2017-21.
Attainment - Bachelor's Degree or Higher	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Attainment - No High School Diploma	US Census Bureau, American Community Survey, 2017-21.
Attainment - Some Post-secondary Education	US Census Bureau, American Community Survey, 2017-21.
Attainment - High School Graduation Rate	US Department of Education, EDFacts, 2019-20.
Chronic Absence Rate	U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18.
Proficiency - Student Math Proficiency (4th Grade)	US Department of Education, EDFacts, 2020-21.
Proficiency - Student Reading Proficiency (4th Grade)	US Department of Education, EDFacts, 2020-21.
Public School Revenue	National Center for Education Statistics, NCES - Common Core of Data, 2019-20.
Public School Expenditures	National Center for Education Statistics, NCES - Common Core of Data, 2019-20.
School Funding Adequacy	School Finance Indicators Database, SFID - School Finance Indicators Database, 2020.
School Segregation Index	National Center for Education Statistics, NCES - School Segregation Index, 2021-2022.
Housing Units - Overview (2020)	US Census Bureau, Decennial Census, 2020.
Housing Units - Annual Trends	US Census Bureau, US Census Population Estimates.
Households and Families - Overview	US Census Bureau, American Community Survey, 2017-21.
Families - Overview	US Census Bureau, American Community Survey, 2017-21.
Affordable Housing	US Census Bureau, American Community Survey, 2017-21.
Affordable Housing - Low Income Tax Credits	US Department of Housing and Urban Development, 2019.

Data Indicator	Data Source
Affordable Housing - Assisted Housing Units	US Department of Housing and Urban Development, 2017-21.
Household Structure - Families with Children	US Census Bureau, American Community Survey, 2017-21.
Household Structure - Single-Parent Households	US Census Bureau, American Community Survey, 2017-21.
Household Structure - Older Adults Living Alone	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Cost Burden (30%)	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Cost Burden, Severe (50%)	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Owner Costs	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Owner Costs by Mortgage Status	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Renter Costs	US Census Bureau, American Community Survey, 2017-21.
Housing Quality - Overcrowding	US Census Bureau, American Community Survey, 2017-21.
Housing Quality - Substandard Housing	US Census Bureau, American Community Survey, 2017-21.
Housing Quality - Substandard Housing, Severe	US Census Bureau, American Community Survey, 2011-2015.
Housing Stock - Age	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Housing Unit Value	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Modern Housing	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Mortgage Lending	Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014.

Data Indicator	Data Source
Housing Stock - Net Change	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Residential Construction	US Department of Housing and Urban Development, 2021.
Housing Units - Single-Unit Housing	US Census Bureau, American Community Survey, 2017-21.
Tenure - Mortgage Status	US Census Bureau, American Community Survey, 2017-21.
Tenure - Owner-Occupied Housing	US Census Bureau, American Community Survey, 2017-21.
Tenure - Renter-Occupied Housing	US Census Bureau, American Community Survey, 2017-21.
Vacancy (ACS)	US Census Bureau, American Community Survey, 2017-21.
Vacancy (HUD)	US Department of Housing and Urban Development, 2021-Q4.
Evictions	Eviction Lab, 2016.
Area Deprivation Index	University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2020.
Food Insecurity Rate	Feeding America, 2021.
Homeless Children & Youth	US Department of Education, EDFacts, 2019-2020.
Households with No Motor Vehicle	US Census Bureau, American Community Survey, 2017-21.
Incarceration Rate	Opportunity Insights, 2018.
Insurance - Insured Population and Provider Type	US Census Bureau, American Community Survey, 2017-21.
Insurance - Medicare Enrollment Demographics	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.

Data Indicator	Data Source
Insurance - Population Receiving Medicaid	US Census Bureau, American Community Survey, 2017-21.
Insurance - Uninsured Adults	US Census Bureau, Small Area Health Insurance Estimates, 2021.
Insurance - Uninsured Children	US Census Bureau, Small Area Health Insurance Estimates, 2021.
Insurance - Uninsured Population (ACS)	US Census Bureau, American Community Survey, 2017-21.
Insurance - Uninsured Population (SAHIE)	US Census Bureau, Small Area Health Insurance Estimates, 2021.
Racial Diversity (Theil Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2020.
Racial Segregation (Interaction Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2010.
SNAP Benefits - Households Receiving SNAP (ACS)	US Census Bureau, American Community Survey, 2017-21.
SNAP Benefits - Population Receiving SNAP (SAIPE)	US Census Bureau, Small Area Income and Poverty Estimates, 2020.
Social Capital - Social Capital Index	Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014.
Social Capital - 501c3 organizations	IRS - Exempt Organizations Business Master File, 2020.
Social Capital - ACS Self-response Rate	US Census Planning Database; ACS 2015-19; CARES, 2022.
Social Capital - Voter Participation Rate	Townhall.com Election Results, 2020.
Social Vulnerability Index (SoVI)	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2020.
Teen Births	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2014-2020.
Teen Births (ACS)	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Arrests - Juvenile Arrest Rate	Office of Juvenile Justice and Delinquency Department, Easy Access to State and County Juvenile Court Case Counts (EZACO), 2019.
Property Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014&2016.
Violent Crime - Assault	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Rape	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Robbery	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Housing + Transportation Affordability Index (H+T Index)	Center for Neighborhood Technology, 2022.
Young People Not in School and Not Working	US Census Bureau, American Community Survey, 2017-21.
Gender Pay Gap	US Census Bureau, American Community Survey, 2017-2021.
Opportunity Index	Opportunity Nation, 2018.
Air & Water Quality - Drinking Water Safety	US Environmental Protection Agency, 2018-19.
Air & Water Quality - Ozone	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2019.
Air & Water Quality - Particulate Matter 2.5	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2019.
Air & Water Quality - Respiratory Hazard Index	EPA - National Air Toxics Assessment, 2018.
Air & Water Quality - RSEI Score	US Environmental Protection Agency, 2019.
Built Environment - Banking Institutions	US Census Bureau, County Business Patterns, 2020.

Data Indicator	Data Source
Built Environment - Broadband Access	FCC FABRIC Data, June, 2023.
Built Environment - Households with No Computer	US Census Bureau, American Community Survey, 2017-21.
Built Environment - Households with No or Slow Internet	US Census Bureau, American Community Survey, 2017-21.
Built Environment - Liquor Stores	US Census Bureau, County Business Patterns, 2020.
Built Environment - Recreation and Fitness Facility Access	US Census Bureau, County Business Patterns, 2020.
Built Environment - Social Associations	US Census Bureau, County Business Patterns, 2020.
Built Environment - Tobacco Product Compliance Check Violations	US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-2020.
Population Directly Affected by Wildfire	University of Missouri, Center for Applied Research and Engagement Systems, 2010-2020.
Climate & Health - Climate-Related Mortality Impacts	Climate Impact Lab.
Climate & Health - Dominant Land Cover	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2021.
Climate & Health - Drought Severity	US Drought Monitor, 2017-2019.
Climate & Health - Flood Vulnerability	Federal Emergency Management Agency, National Flood Hazard Layer, 2011.
Climate & Health - High Heat Index Days (Absolute)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking, 2019-21.
Climate & Health - High Heat Index Days (Relative)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking, 2019-21.
Climate & Health - National Risk Index	Federal Emergency Management Agency, National Risk Index, 2021.
Climate & Health - Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2021.

Data Indicator	Data Source
Community Design - Distance to Public Transit	Environmental Protection Agency, EPA - Smart Location Database, 2021.
Community Design - Park Access (CDC)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Community Design - Park Access (ESRI)	US Census Bureau, Decennial Census, ESRI Map Gallery, 2013.
Community Design - Road Network Density	Environmental Protection Agency, EPA - Smart Location Database, 2021.
Community Design - Walkability Index Score	Environmental Protection Agency, EPA - Smart Location Database, 2021.
Community Design - Community Diversity (Emp. + Housing)	Environmental Protection Agency, EPA - Smart Location Database, 2021.
Food Environment - Fast Food Restaurants	US Census Bureau, County Business Patterns, 2020.
Food Environment - Food Desert Census Tracts	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Grocery Stores	US Census Bureau, County Business Patterns, 2020.
Food Environment - Leading Agricultural Products (1)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Leading Agricultural Products (2)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Low Income & Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Modified Retail Food Environment Index	Centers for Disease Control and Prevention, CDC - Division of Nutrition, Physical Activity, and Obesity, 2011.
Food Environment - SNAP-Authorized Food Stores	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2023.
Orchards	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012.

Data Indicator	Data Source
Threatened and Endangered Species	US Fish and Wildlife Service, Environmental Conservation Online System, 2019.
Access to Exercise Opportunities	ArcGIS Business Analyst and Living Atlas of the World, YMCA & US Census Tigerline Files, 2022&2020.
Cancer Screening - Mammogram (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
Cancer Screening - Mammogram (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Cancer Screening - Cervical Cancer Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Cancer Screening - Sigmoidoscopy or Colonoscopy	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Dental Care Utilization	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Diabetes Management - Hemoglobin A1c Test	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Hospitalizations - Preventable Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
Hospitalizations - Emergency Room Visits	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Inpatient Stays	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Heart Disease	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2017-2019.
Hospitalizations - Stroke	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2017-2019.
Late or No Prenatal Care	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2019.
Opioid Drug Claims	Centers for Medicare & Medicaid Services, CMS - Part D Opioid Drug Mapping Tool, 2019.
Prevention - Annual Wellness Exam (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.

Data Indicator	Data Source
Prevention - Seasonal Influenza Vaccine	Centers for Disease Control and Prevention, CDC - FluVaxView, 2021.
Prevention - Cholesterol Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Prevention - High Blood Pressure Management (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Prevention - High Blood Pressure Management (Medicare)	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2018.
Prevention - Recent Primary Care Visit (Medicare)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Prevention - Core Preventative Services for Men	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Prevention - Recent Primary Care Visit (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Prevention - Core Preventative Services for Women	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Readmissions - All Cause (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Readmissions - Chronic Obstructive Pulmonary Disease	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Heart Failure	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Pneumonia	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Elective Delivery	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Stroke	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.

Data Indicator	Data Source
Alcohol - Heavy Alcohol Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Alcohol - Binge Drinking	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Alcohol - Expenditures	Nielsen, Nielsen SiteReports, 2014.
Breastfeeding - Ever	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Any)	U.S. Census Bureau, National Survey of Children's Health, 2018.
Breastfeeding (Exclusive)	U.S. Census Bureau, National Survey of Children's Health, 2018.
Fruit/Vegetable Expenditures	Nielsen, Nielsen SiteReports, 2014.
Physical Inactivity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Soda Expenditures	Nielsen, Nielsen SiteReports, 2014.
STI - Chlamydia Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - Gonorrhea Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - HIV Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - HIV Prevalence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
Tobacco Expenditures	Nielsen, Nielsen SiteReports, 2014.
Insufficient Sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Tobacco Usage - Current Smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.

Data Indicator	Data Source
Walking or Biking to Work	US Census Bureau, American Community Survey, 2017-21.
Birth Outcomes - Infant Mortality (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2014-2020.
Birth Outcomes - Low Birth Weight (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2014-2020.
Cancer Incidence - All Sites	State Cancer Profiles, 2016-20.
Cancer Incidence - Breast	State Cancer Profiles, 2016-20.
Cancer Incidence - Cervical	State Cancer Profiles, 2016-20.
Cancer Incidence - Colon and Rectum	State Cancer Profiles, 2016-20.
Cancer Incidence - Lung	State Cancer Profiles, 2016-20.
Cancer Incidence - Prostate	State Cancer Profiles, 2016-20.
Chronic Conditions - Alcohol Use Disorder (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Alzheimer's Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Asthma (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Asthma Prevalence (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - Cancer (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions – Chronic Obstructive Pulmonary Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Chronic Obstructive Pulmonary Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.

Data Indicator	Data Source
Chronic Conditions - Depression (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Diabetes Incidence (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018.
Chronic Conditions - Diabetes Prevalence (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Chronic Conditions - Diabetes Prevalence (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Heart Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - Heart Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - High Blood Pressure (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - High Blood Pressure (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - High Cholesterol (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - High Cholesterol (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Kidney Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - Kidney Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Mental Health and Substance Use Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020.
Chronic Conditions - Opioid Use Disorder	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
Chronic Conditions - Substance Use Disorder (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Multiple Chronic Conditions (Medicare Population)	Centers for Medicare and Medicaid Services, 2018.

Data Indicator	Data Source
Deaths of Despair (Suicide + Drug/Alcohol Poisoning)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Cancer	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Coronary Heart Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Firearm	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Heart Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Homicide	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Influenza & Pneumonia	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Life Expectancy	University of Wisconsin Population Health Institute, County Health Rankings, 2018-2020.
Mortality - Life Expectancy	Institute for Health Metrics and Evaluation, 2019.
Mortality - Life Expectancy (Census Tract)	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project, 2010-15.
Mortality - Liver Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Lung Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash (NVSS)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash (NHTSA)	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2018-2020.
Mortality - Motor Vehicle Crash, Alcohol-Involved	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2016-2020.
Mortality - Motor Vehicle Crash, Pedestrian	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2016-2020.

Data Indicator	Data Source
Mortality - Drug Overdose (All Substances)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Opioid Overdose	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Poisoning	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Premature Death	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2018-2020.
Mortality - Stroke	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Suicide	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Unintentional Injury (Accident)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Obesity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Poor Dental Health - Teeth Loss	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Poor or Fair Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Poor Mental Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Poor Mental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Poor Physical Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Poor Physical Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Stroke (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Stroke (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.

Data Indicator	Data Source
Access to Care - Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Buprenorphine Providers	US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Oct. 2023.
Access to Care - Dental Health	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2021.
Access to Care - Dental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Mental Health	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2022.
Access to Care - Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Nurse Practitioners	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Primary Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2020.
Access to Care - Primary Care Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Federally Qualified Health Centers	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, September 2020.
Hospitals with Cardiac Rehabilitation Units	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2019.
Health Professional Shortage Areas - All	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
Health Professional Shortage Areas - Dental Care	US Census Bureau, American Community Survey, 2017-21.
Population Living in a Health Professional Shortage Area	US Census Bureau, American Community Survey, 2017-21.
COVID-19 - Confirmed Cases	Johns Hopkins University, 2022.
COVID-19 - Mortality	Johns Hopkins University, 2022.

Data Indicator	Data Source
COVID-19 Fully Vaccinated Adults	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2022.
Social Distancing - Mobility Reports (Google)	Google Mobility Reports, Feb 01, 2022.
Discharges by Zip Code	Frio Regional Hopsital
County Health Rankings	County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/explore-health-rankings
Sparkmap Data Analysis	https://sparkmap.org/report/