ACCESS TO HEALTH CARE

IN BEXAR COUNTY DURING COVID-19

CITY OF SAN ANTONIO — TEXAS —
METROPOLITAN HEALTH DISTRICT

Health Collaborative
Bexar County's Community Health Leadership

Message from the Metro Health Director

For better and for worse, COVID disrupted how we use health care. Telehealth became more routine, and the federal government subsidized free tests, vaccines and treatments in unprecedented ways. At the same time, many people suffered from delayed or canceled checkups and surgeries, and staff burnout and workforce shortages continue to this day.

How did these national trends play out in San Antonio, where life expectancy can differ by more than 20 years in zip codes on opposite sides of town? As part of Metro Health's SA Forward plan, our Access to Care Office partnered with the Bexar County Health Collaborative to find out. The Health Collaborative, in turn, partnered with CI:Now, the University of Texas San Antonio, the University of Texas School of Public Health, and C3HIE in a prodigious joint effort.

This report is the culmination of eight months of data exploration, key informant interviews, focus groups and communitywide surveys. With an eye toward equity, the survey team oversampled marginalized populations—out of 1,821 responses, 910 were in Spanish, and 65 in Chinese, Vietnamese, Arabic, or Pashto. For people without internet, UTSA created a "bubble sheet" version of the survey on paper. The Health Collaborative administered hundreds of paper surveys. We are grateful for the labors of our innovative and hardworking colleagues and look forward to further joint efforts among academia, non-profits and public health.

Some findings were expected, others were surprising. In keeping with national trends, fear of acquiring COVID was a major barrier to care, as was difficulty scheduling appointments, especially for people with disabilities. Additionally:

- Oral health care was the most commonly postponed type of service among survey respondents, and the need was particularly acute among Afghan refugees.
- Strikingly, almost half of people in our convenience sample had experienced discrimination or rude treatment at medical offices even pre-COVID.
- Although pregnant individuals were far more likely to have Medicaid coverage during the Public Health Emergency, the percentage of pregnancies with early prenatal care did not change, staying near 80% every year from 2019 to 2021. This points to the presence of other barriers besides insurance, which corroborates what we know from other sources such as maternal mortality and morbidity reviews.
- Rates of drug-related deaths and suicides rose, especially in men, and the unmet demand for mental health care providers was greater than ever.
- Immunization rates fell in kindergarteners.

As you read this report consider: What resonates, what's surprising, what's urgent, what do you want to know more about? Then join us for a series of conversations about how to collectively create a community where all of us have access to welcoming, respectful health care services. Look for information about Opening Doors: Improving Access to Care at sanantonio.gov/health and on social media by following @SAMetroHealth. Let's roll up our sleeves and work together for the health of all of San Antonio and Bexar County.

Claude A. Jacob

Health Director

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Executive Summary

The San Antonio Metropolitan Health District (Metro Health) is vested in identifying obstacles Bexar County residents encountered when accessing care during the COVID-19 pandemic. In this effort, a collaborative effort was put forth in partnership with the Institute for Demographic and Socioeconomic Research (IDSER) at The University of Texas at San Antonio (IDSER – UTSA), CI:Now, and the Bexar County Health Collaborative. A commitment was made to collect insights and perspectives from various community leaders, stakeholders, and residents. From each unique population and lens a better understanding is gained as to who lacked access to health care, what barrier to care are located, and where the gaps in health care services reside.

This report focused on how social determinants of health (SDoH) affected participants' access to and use of health services. This report is based on 1,821 resident completed surveys, 11 key informant interviews with San Antonio City Councilmembers and health care executives, and six focus groups with representation from community health workers, nurses, domestic workers, families, and senior citizens.

Many recognized health insurance, financial assistance with health care costs, and disparate geographic barriers as barriers to care that originated prior to the pandemic and persisted throughout. The relationship between public health and health care became more apparent during the pandemic. Getting appointments became more difficult and the availability of providers decreased; yet the need for training and support for health care professionals increased. The increase in the demand for mental health care services became more notable with the limited supply of mental health providers.

Telehealth became a theme toward effective improvement in access to health care but was not without difficulties. The multitude of platforms added to confusion in provider and population groups already unfamiliar with the virtual medium. However, when the obstacles were overcome with the assistance of family members or with tablets delivered to the home by clinical staff, provider availability and the continuity of care improved while reducing the need for hospital visits. Economic disparities increased during the pandemic and highlighted transportation as a barrier to access to care for many. Increased competency with telehealth mitigated such barrier.

This report examines on some of the barriers to access to care Bexar County residents experienced during COVID-19 pandemic, but is not exhaustive. It serves to highlight some gaps and offer direction toward improvement opportunities—a conversation to be continued.

Introduction

The City of San Antonio Metropolitan Health District (Metro Health) commissioned this report via a public Request for Proposals. Metro Health described the purpose as follows:

> *The City of San Antonio Metropolitan Health District (Metro Health) seeks to assess the availability of health care services during the COVID-19 pandemic through a collaborative process, using data for the identification of populations who lack access to health care and identifying gaps in health care services and barriers to care. It is important for Metro Health and community providers to understand populations who experience barriers to health care services, the gaps in access to health care, and the barriers to the receipt of care so that effective strategies can be put in place to address the lack of access to health care in the community.*

This report was developed by a group of five organizations guided by a broader group of community stakeholders. Led by The Health Collaborative (THC), other project partners included C3HIE, Community Information Now (CI:Now), the Institute for Demographic and Socioeconomic Research (IDSER) at The University of Texas at San Antonio (UTSA), and San Antonio-based researchers at the UT Health Science Center at Houston (UTHealth) School of Public Health (UTHealth SPH). Particularly in terms of data collection via survey, focus groups, and interviews, the project was also guided by community members external to the project. THC has worked with and for community since 1997, and throughout this time THC has established relationships with various partners that have taken a focus on distinct population groups within the community. Using these established relationships and contacts, THC sent out a request to partners to lend a voice on behalf of the people they serve and represent to provide us insights about individual group experiences in accessing health care during the height of COVID-19 pandemic. The **Acknowledgements and Project Team** section of this report includes more information about each project partner and that partner's role and contribution. The content and conclusions of this report are a compilation of the work and contributions of many different individuals and organizations and do not necessarily reflect the views of either Metro Health or any project partner or research participant.

Both the extant and primary data used for this report draw from a wide variety of sources that covered very different issues, populations, and time frames. While that variety makes for rich source material, it greatly complicates presentation of the information in the standardized and coherent way one would normally expect from a community assessment. The main report content is generally organized in three categories of what is known: (1) national and local background and context; (2) access to and utilization of care; and (3) local policy and health care system responses to pandemic and its effects on health and health care. Information from all data sources – extant, survey, focus groups, and interviews – is interwoven within the appropriate category.

Beyond the main body of data-focused content, the report includes an **Executive Summary**; a **Technical Notes** section describing sources, methods, and cautions; **Reference Maps** to orient the reader to geography; **Acknowledgements and Project Team; Additional Resources** the

reader may find valuable, and **Appendices** that describe the survey, focus group, and interview methods and results in greater detail.

Neither Metro Health nor the contributors to this report intends any retrospective look at COVID-19's effects on access to care to imply that this pandemic is fully over. Metro Health did not prescribe any specific definition of the pandemic timeframes, and those timeframes tend to vary by data source. Wherever available, extant data – both purpose-collected (e.g., surveys) and administrative, gathered as part of an organization's usual operations – is analyzed for one to three years pre-pandemic through to the present. The community survey, focus groups, and key informant interviews seek to understand changes that occurred during the pandemic but do not impose specific date ranges. Again, more information about all methods used in this report is available in the **Technical Notes** section.

Both the data and gaps in the data, noted throughout the report, raise as many questions as they answer. The project team hopes that this report will spur further local efforts to understand and address the effects of the pandemic on access to care, care utilization, and health behaviors and outcomes. Over the next months, Metro Health will solicit community insights and feedback, in person and virtually, to hear the stories behind the data and community priorities for collective action. Meanwhile, we hope the initial information contained here will be useful to advocates, policymakers, consumers, medical providers and everyone else who is passionate about making health care more accessible in San Antonio and Bexar County.

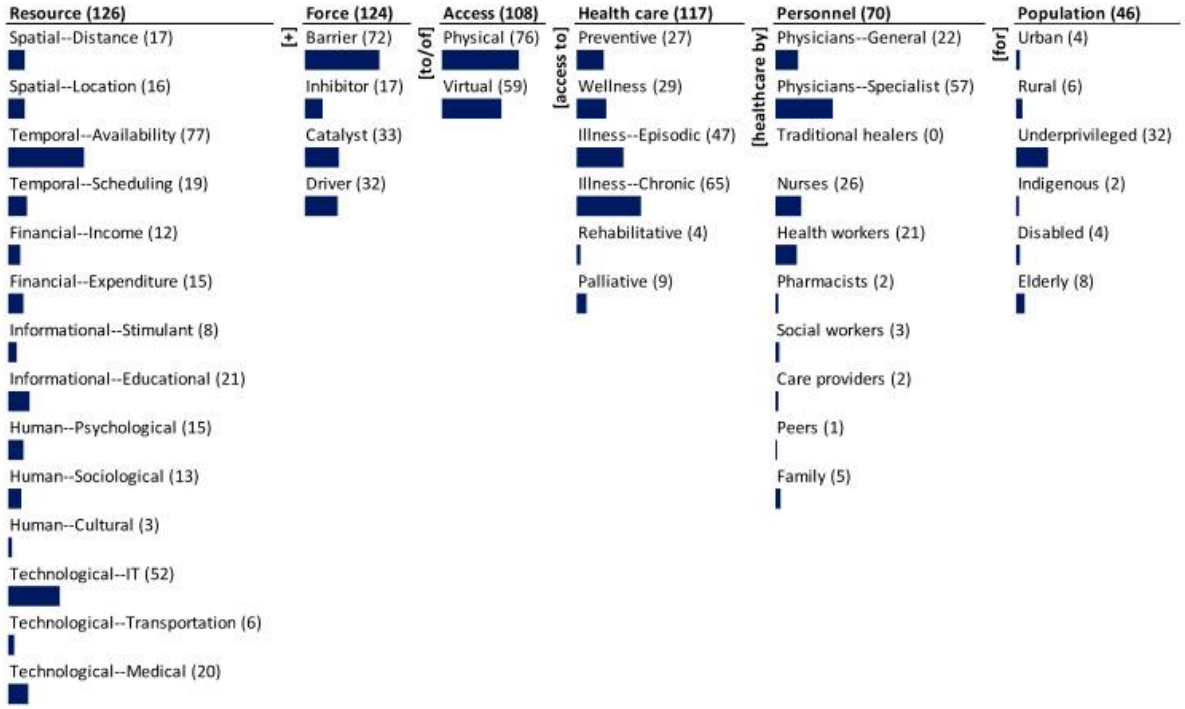
This report was funded by Centers for Disease Control & Prevention (CDC) grant OT21-2103, National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities.

Emerging Issues in Access to Care in the U.S.

The Scope of COVID-19 Impact on Access to Care

Early in the COVID-19 pandemic, a group of researchers developed a framework for understanding access to health care since pandemic onset and mapped the existing literature onto that framework.[1] The results appear in the figure below. Research on access has exploded since publication of the map in March 2021, but the figure still serves to show just how many factors and issues are worth consideration in an assessment of access to care. Although dates are not well-defined, care access and utilization varied dramatically across major milestones like the local stay-at-home order, the widespread introduction of COVID-19 vaccines, and nationally inconsistent but increasing school and workplace re-openings. The picture is even further complicated by disjointed systems and a changing patchwork of policies and practices at the national, state, local, and organizational (e.g., insurance company, employer, health care practice) levels.

Monad Map of Research on Access to Health Care During Covid-19



Source: Núñez, A.; Sreeganga, S.D.; Ramaprasad, A. (2021, March 14). Access to health care during COVID-19. *International Journal of Environmental Research and Public Health*.18(6):2980.

Neither the brief review of emerging issues in access to care in the United States below, nor the local data that follow are intended to cover every factor and dynamic well – or in some cases, at all. Both sections are framed primarily in response to the combination of Metro Health's stated priorities and the availability of relevant information.

Telehealth and the Digital Divide

Prior to the COVID-19 pandemic, telehealth and the delivery of health services using telecommunication technology was fairly novel. The United States had implemented some of these services in underserved rural settings but not on a wide scale.[2] The sudden March 2020 declaration of a pandemic with social distancing restrictions forced a significant shift in health care that included rapid expansion and adoption of telehealth services. By April of 2020, Medicare telehealth visits nationwide had increased 350% from pre-pandemic visits, and almost half of all Medicare primary care visits were conducted using telehealth technology.[3] (Relevant reimbursement policies are discussed in the next section.) A virtual modality allowed health care providers to treat patients without increasing the risk of infection, increased access to services on a large scale, and reduced care costs for patients and payers.[3]

Telehealth adoption and practice integration and effectiveness varied by medical specialty. Specifically, telehealth interactions increased for psychiatry (60%) and gastroenterology (49%), but were lower for OB/GYN (12%) and hematology/ oncology (8%).[2] These differences in telehealth use by specialty are due to multiple policy and organizational level factors but largely due to some types of care and services (e.g., pelvic exams or cancer imaging tests) requiring in-person visits.[4] Services using smartphone applications gained popularity as they allowed patients and physicians to consult regarding health, helped reduce the spread of COVID-19 through data collection, and disseminated health information to raise awareness of pandemic-related issues.[5]

Particularly among disadvantaged populations, the utilization of telehealth also facilitated access to health care by reducing geographic barriers, medical costs, and the risk of SARS-CoV-2 transmission; improving engagement and adherence through patient portals (e.g., direct messaging, prescription refills); and increasing provider availability, continuity of care, and hospital capacity to treat patients.[6] Many of these vulnerable groups, such as low-income or chronic disease patients, have worse health outcomes and significant barriers to accessing primary care services.[7] The availability of telehealth eliminates common access barriers for these patients, such as mobility limitations or transportation costs. Further, recent survey trends show patients and physicians were highly satisfied with telehealth during the pandemic and are optimistic about its permanent integration into the health care system.[8,9]

While telehealth may improve health care access for some and is becoming progressively implemented, access to and adoption of these services has not been equitable across population subgroups. The rapid transition to telehealth during the pandemic presented challenges and highlighted the existing digital divide and disparities in access to technology between socioeconomic groups.[4] Though telehealth relies primarily on internet and video connection, many Americans have reduced internet access (poor internet speeds or connections) or a lack of access to the internet, webcams and computers altogether. Nearly 25% of adults lack home broadband connectivity[10] and 23% of lower-income adults do not own a computer or a smartphone.[11] Individuals who are more likely to lack digital access include older adults, people of color, those living in low-income households, and those with less than a high school education.[12] Telehealth use is also lower in Southern states, federally qualified health centers, rural health centers, and understaffed centers.[13] Further, there are advantages to using telehealth services with video over telephone calls alone, including better diagnostic

accuracy and less medication errors.[14] Unfortunately, these differences in telehealth device use can widen inequalities among underserved groups. Older adults (>60 years) are less likely to be internet proficient or use video conferencing than younger, educated and wealthier adults[10] and adults with disabilities, especially those with vision or hearing impairments, report additional functionality barriers to using telehealth services.[15] Finally, health care system barriers to telehealth use also decrease access to care among underserved groups. These barriers include limited payment systems for virtual care; outdated telecommunication infrastructure; and provider or patient discomfort with the virtual format, lack of knowledge, and inadequate training.[4]

Some public health organizations have implemented interventions to help bridge the digital divide and provide vulnerable patients with access to telehealth. These programs have shown success in improving access to telehealth among certain disenfranchised groups and include efforts such as tablet and device loans, financial support for internet use, and technology training.[16] While there is potential for telehealth and related interventions to extend health care access to disadvantaged groups, there is still limited infrastructure and remaining inequities in access to care among marginalized groups.[5] As telehealth services have been efficient and cost-effective for general delivery of health care,[4] they will likely be continually adopted and implemented in the future and it will be important to consider how this affects access for vulnerable groups. Policymakers and health care organizations need to evaluate underserved community needs and resources to suitably address telehealth access disparities exposed during the pandemic and prevent them from becoming part of the digital divide.

Reimbursement and Payment

This section will focus on changes to reimbursement structure and rates and payment mechanisms rather than sources of relief funds for health care providers like the Provider Relief Fund, Paycheck Protection Program, and other CARES Act loan programs. Even so, the scope, number, and rapid rate of changes during the pandemic to an already very complex array of policies and systems make it impossible to cover this topic adequately in this report. Relevant state-level policy and practice changes are covered in the **System Level Drivers of Access** section later in this report.

The COVID-19 pandemic caused several changes in health care that raised new issues about health payment systems and insurance coverage and forced rapid policy changes, including restructuring of hospital services, expansion of intensive care units (ICU) and capacity, and swift transition to telehealth services.[17] The federal public health emergency implemented "continuous Medicaid coverage," eliminating required re-enrollment and the income checks built into that re-enrollment process. The Centers for Medicare & Medicaid Services (CMS) updated reimbursement practices and expanded coverage of telehealth services nearly immediately[18] and state and national organizations relaxed regulations and inflated temporary coverage.[19] The Department of Health and Human Services also waived penalties for HIPAA violations as providing telehealth services became crucial for treating patients.[20]

One major high-level change is the accelerated shift from fee-for-service to value-based care triggered by COVID-19-related disparities. The traditional fee-for-service model simply reimburses providers for (covered) services provided, while the value-based care is intended to

reimburse based on quality of care and patient outcomes. The idea is to pay for the *right* services rather than simply *more* services, and to make a start to addressing social determinants of health like housing, nutrition, and transportation.[21]

The Texas Medical Association relayed the powerful way that CMS framed the issue:

> *"The disparities in the data reflect long-standing challenges facing minority communities and low income older adults, many of whom face structural challenges to their health that go far beyond what is traditionally considered 'medical,'" CMS Administrator Seema Verma said in an agency release. "Now more than ever, it is clear that our fee-for-service system is insufficient for the most vulnerable Americans because it limits payment to what goes on inside a doctor's office. The transition to a value-based system has never been so urgent. When implemented effectively, it encourages clinicians to care for the whole person and address the social risk factors that are so critical for our beneficiaries' quality of life."*[22]

This transition to value-based care started in 2011, but implementation has been slow and complex, as it requires renovation of most system processes (e.g., patient treatment, insurance billing) so health systems, providers and insurers continue to work within the two payment models. Supporters of value-based care say the model has many benefits for patients, can encourage telehealth service adoption, and may increase access to health care among disadvantaged groups. These models, such as Medicare Advantage, pay physicians and hospitals based on quality of care and quality improvement, and reward patients for preventive care which can reduce costs and avert further health interventions (e.g., hospital-acquired infections or readmissions).[23] Some studies show that organizations who operated under value-based care have been more successful during the pandemic than those that continue to use fee-for-service care, performing better on widely-accepted quality indicators known as Health care Effectiveness Data and Information Set (HEDIS®) measures.[24] Insurance companies have also started to adopt value-based health care reimbursement models and implement these models for chronic disease management.[25] Value-based care has been cited as influential in encouraging hospitals and other providers to develop innovative solutions (e.g., mobile technology, AI and machine learning) to health care access and quality.[26]

While the health system payment changes expanded coverage for certain services during the pandemic, there were still gaps in health coverage for vulnerable groups. Underserved patients faced numerous barriers to accessing value-based care and telehealth services, including limited or complete lack of digital access, training and skills.[6] Telehealth dentistry has not received the same support and reimbursement improvements that telehealth medical and behavioral health have.[27] While changes in reimbursement and regulation were initially temporary and only in effect during the public health emergency, many payment system changes continue to be adopted and implemented, and implications for access to care need to be considered.[28] In addition, health care and insurance costs continue to increase, with rising premiums, copays, deductibles, and out-of-pocket costs for patients.[29] Employers that provide insurance benefits also continue to see increases in premiums.[28] As a result, patients, particularly vulnerable groups, are less likely use or afford doctor visits, prescription drugs, and medical procedures.[28] The government has tried to combat this issue by releasing the Federal Hospital Price Transparency rule in 2021, which specifies that hospitals must provide a list of

services and costs to patient so they can estimate potential cost of care,[30] but progress has been incremental.

Another indirect effect of the pandemic that greatly reduced Americans' access to the health care system was the economic downturn in the United States.[31] The nationwide shut-downs caused a large increase in unemployment and debt burden among Americans, and as business began to recover, inflation began to grow as well. These changes amplified existing inequalities in access, such as loss of health care coverage, difficulty in making copayments, and obtaining transportation to services.[30] Unfortunately, patient costs continue to rise even with current health care payment systems. There are barriers to affording care for not only uninsured patients, but even insured patients. A recent study by the Kaiser Family Foundation found that 46% of insured adults had difficulty paying out-of-pocket health care costs and went without certain types of health care if they could not afford it.[28]

Health Care Professional Availability and Training

Different areas of the health care industry were affected by COVID-19 in different ways and to different degrees. Utilization and spending dropped off markedly early in the pandemic for some services and resources (e.g., dental, physician, and non-COVID hospital visits) and increased for others, such as prescription drugs and – obviously – COVID-related hospitalizations.[32] Those decreases drove reductions in staffing, or in some cases redeployment of staff to other high-demand areas such as intensive care units. Recovery of overall staffing totals likely masks churn, as burnout pushed overburdened hospital and nursing staff out of the health care sector.[33] National data indicates that as of December 2022, employment levels rebounded to and slightly exceeded March 2020 baseline in physician offices (6% higher than baseline), outpatient care centers (4% higher), home health care (4% higher), and hospitals (1% higher), but remain well below baseline in nursing care facilities (14% lower) and community care facilities for the elderly (7% lower).[34]

Mental health provider availability is an interesting case. Even before the COVID-19 pandemic, the Health Resources and Services Administration (HRSA) reported expected shortages of behavioral health providers by 2025.[35] Additionally, in late 2020, HRSA stated that there were more than 5,700 mental health provider shortage areas where only 27% of mental health needs were being met, and 33% of American lived in these areas and lacked access to care.[19] At the same time, demand for mental health care increased during the pandemic: surveys conducted by the Centers for Disease Control and Prevention in 2021 found that 41% of adults reported having symptoms of anxiety or depression, and 26% of adults reported having trauma and stress symptoms related to COVID-19.[36] Traditionally office-based behavioral health services are an area where telehealth expanded, at least theoretically improving access by reducing geographic and transportation-related barriers. However, increased demand has further strained an already-scarce provider resource, meaning a greater absolute number of people are experiencing barriers to access.[37]

Interest in the health professions appears to have grown during the pandemic, which raised awareness of the lack of adequate healthcare infrastructure. Medical schools and other health profession education and training programs have seen enrollment boosts.[38] Beyond COVID-19 itself, the increased emphasis on racial equity since the murder of George Floyd in 2020 has also been cited as a factor attracting young people to health professions.[39]

Other Changes Affecting the Health Care System

This last section touches on just a few other key issues and developments during the pandemic that directly affect access to health care. Again, change is rapid and ongoing, so much is left undiscussed in this section.

Health care settings, internal policies and practices, and workflows had to be entirely and rapidly redesigned during the pandemic – and in most cases, that initial redesign has likely been modified many times since March 2020 in response to changing pandemic conditions and evolving public health and industry recommendations. As cases of COVID-19 increased, hygiene standards only became more strict, and implementation of physical distancing requirements, greater use of personal protective equipment (PPE), and widespread testing made it more expensive and time consuming to treat patients, including those without COVID-19 symptoms. [40]

Many of the decisions to address increasing COVID-19 infection rates negatively affected health service access to care for more disadvantaged populations with other non-emergency conditions.[22] For example, early on in the pandemic, health care services were assigned varying levels of priority to make the best use of limited capacity. However, this meant that other elective and non-urgent procedures and services were canceled or delayed, though some services categorized as “elective” likely did not feel non-urgent to the patient.[41] While hospitals tried to implement strategies to address non-emergency cases, such as telehealth visits, there were still barriers to care in underserved groups, such as limited technology access.[22]

The pandemic affected access to and utilization of dental care in specific ways, as some issues are more common or unique to the dental care setting, perhaps the most obvious being that treatment requires the patient to be unmasked with an open mouth. Compounding that, though, are the very close physical proximity of the patient to the dental care provider and the frequency of aerosol-generating procedures for dental cleaning and scaling. In response to the latter problem, dental practices are focusing increasing attention on prevention and on non-aerosolizing procedures.[42] However, various surveys of U.S. dental care practices during the pandemic have generally indicated that those practices adapted well and continued providing care. [43] For example, a January 2023 panel survey by the American Dentist Association asked dentists whether or not their previous week’s schedule was full. Among general practice dentists in private practice, 86% had a full schedule the week prior; 83% for pediatric dentists in private practice; 98% for dentists in public health settings.[44]

The impact on pharmacy practice varies significantly by setting. For example, community pharmacies became a major hub for COVID-19 testing and vaccinations for the general public, while hospital- and clinic-based pharmacy operations did not. Similarly, many community pharmacies redesigned both facilities and workflows to establish or expand drive-through services to improve access while minimizing contact between pharmacy staff and clients.[45] As hospitals worked to quickly expand access to intensive care services by adapting other spaces to serve as additional intensive care units, hospital pharmacy services emphasized thoughtful use and placement of automated dispensing cabinets (ADCs), as well as medication “bundling”,

or consolidating medication schedules so that nurses do not have to enter and exit the patient room as often.[46]

Public health has not been widely considered to be part of the "health care system" as the general public understands it, but the relationship between public health and health care arguably became more apparent as the entire U.S. population faced a highly infectious disease that took a much higher toll on older people in long-term care facilities, people with serious underlying medical conditions, and people who had long faced higher barriers to preventive and primary care – and that strained hospital systems and personnel to near the breaking point. During the pandemic, the U.S. has seen efforts at federal, state, and local levels to strengthen public health infrastructure after a history of chronic underinvestment.[47] The pandemic was a primary catalyst, but climate disasters and other scenarios requiring emergency preparedness played a role as well. Unfortunately, that positive trend plays out alongside a sharply increasing politicization of public health, with rising hostility not just against public health measures like stay-at-home orders and masks, but also against public health workers and policymakers in both community and health care settings.[48]

Although these are by no means new concepts, health equity and social determinants of health are receiving increased attention and discussion in the U.S. health care system and larger health field. Initiatives and conversations have been started or notably expanded by entities ranging from the CDC to CMS, the Institute for Healthcare Improvement, and the American Hospital Association, bringing attention to more widely accepted drivers of disparities in health outcomes like poverty and education, but also racism and discrimination, workforce diversity, and failure to build and maintain data capacity to identify and quantify inequities.[49]

For both the health workforce and the public, the pandemic brought into sharp relief the nation's inadequate infrastructure and capacity for capturing, protecting, sharing, and using health-related data.[50] While most of the concerns appear to have centered on effectiveness of those processes and platforms, others have focused on their equitability.[51]

Finally, policy substantially affecting access to care continues to evolve at federal, state, and local levels. Although resembling very little the original framework proposed as the Build Back Better Act, the federal Inflation Reduction Act of 2022 included provisions allowing the federal government to negotiate lower Medicare drug costs, which may facilitate state price-reduction efforts as well. The legislation also extended by three years the enhanced premium tax credits that reduce the cost of purchasing coverage through the Affordable Care Act marketplace.[52]

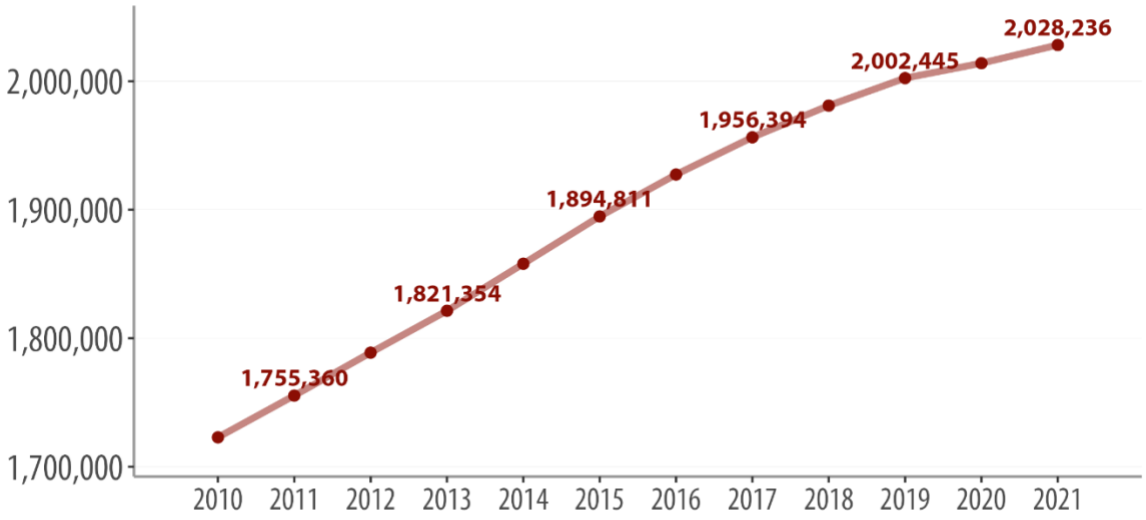
The Local Context

Bexar County Population

Bexar County's population grew by about 18% between 2010 and 2021 (Figure 1.1), the most recent year for which population estimates are available. About 25% of county residents are children and youth under the age of 18, and 13% are 65 or older (Figure 1.2).

Fig. 1.1 Total population

Bexar County, Texas

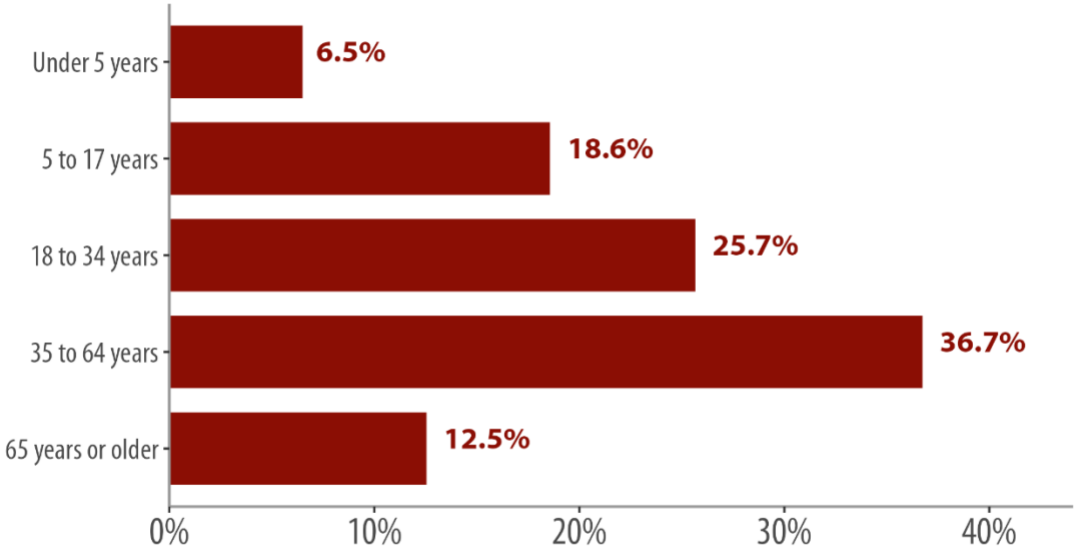


Source: U.S. Census Bureau
Prepared by CI:Now for The Health Collaborative

About 61% of county residents (Figure 1.3) identify as Hispanic or Latino (regardless of race). The next largest race/ethnicity groups are white (26%) and Black or African American (7%); together these three groups make up 94% of the county population.

Fig. 1.2 Percent of total population by age, 2021

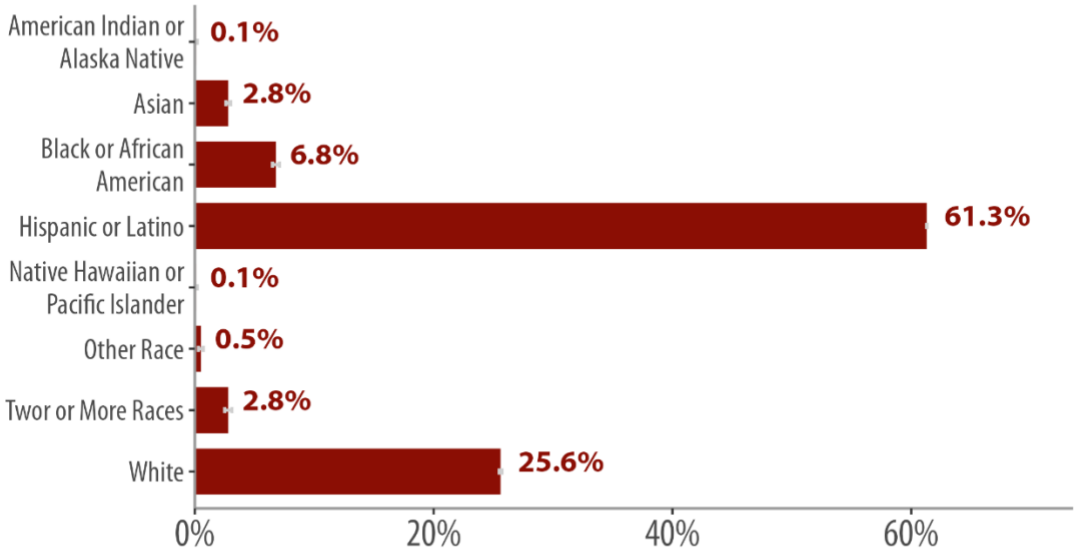
Bexar County, Texas



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

Fig. 1.3 Percent of total population by race/ethnicity, 2021

Bexar County, Texas



Source: ACS 1-Year Estimates. Table: DP05
Prepared by CI:Now for The Health Collaborative

Although Bexar County is not nearly as segregated by race/ethnicity as it is by income, Figure 1.4 shows that different race/ethnicity groups are not evenly distributed across the county. As is evident in Figure 1.5, population density varies tremendously across the county, ranging from nearly 8,000 people per square mile in some areas inside Loop 1604 to 500 or fewer people per square mile in outlying areas, particularly those in the southern half of the county. It should be noted here that while high for the county overall, population growth varies geographically, and in five to 10 years this map may look quite different.

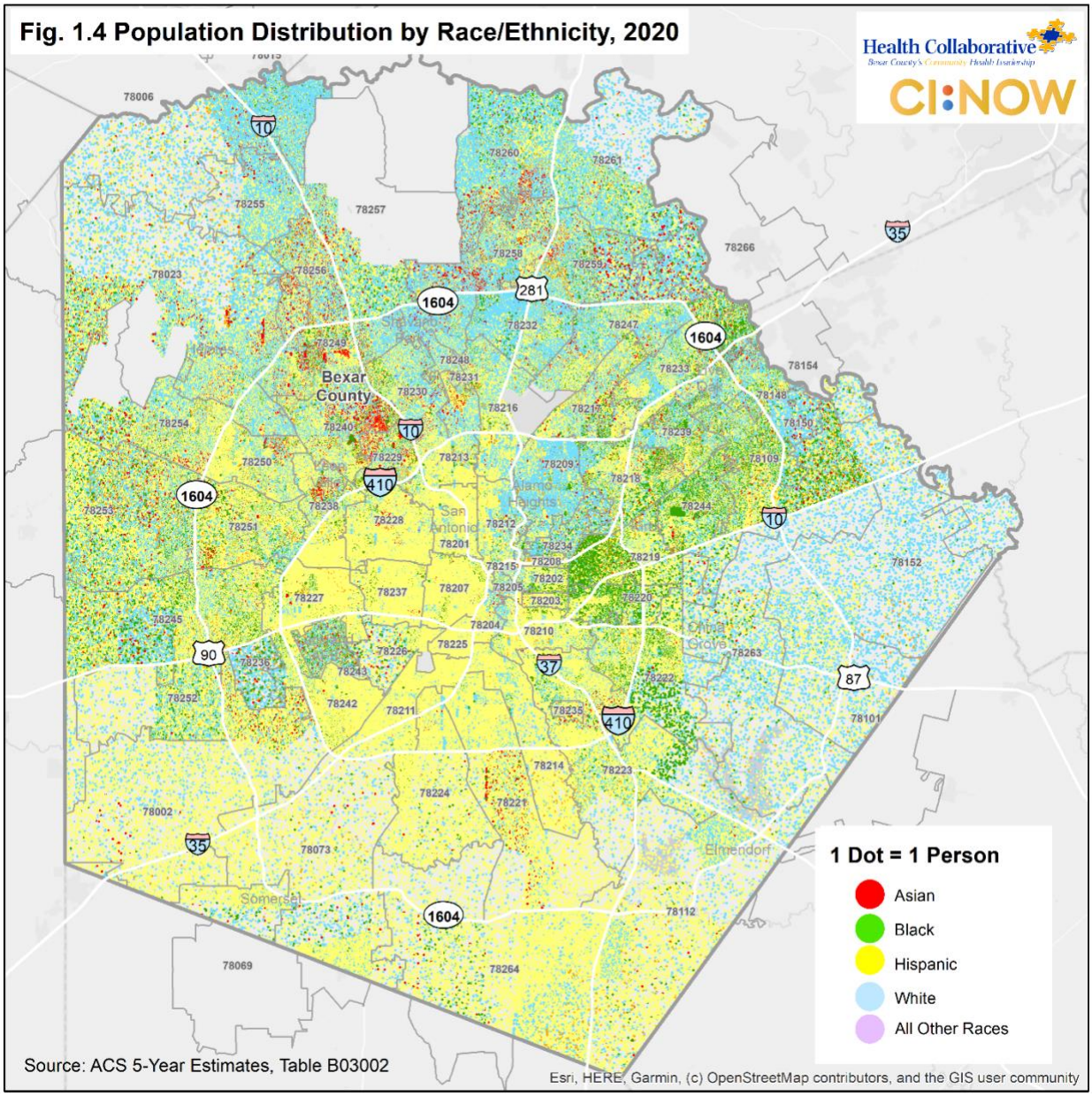
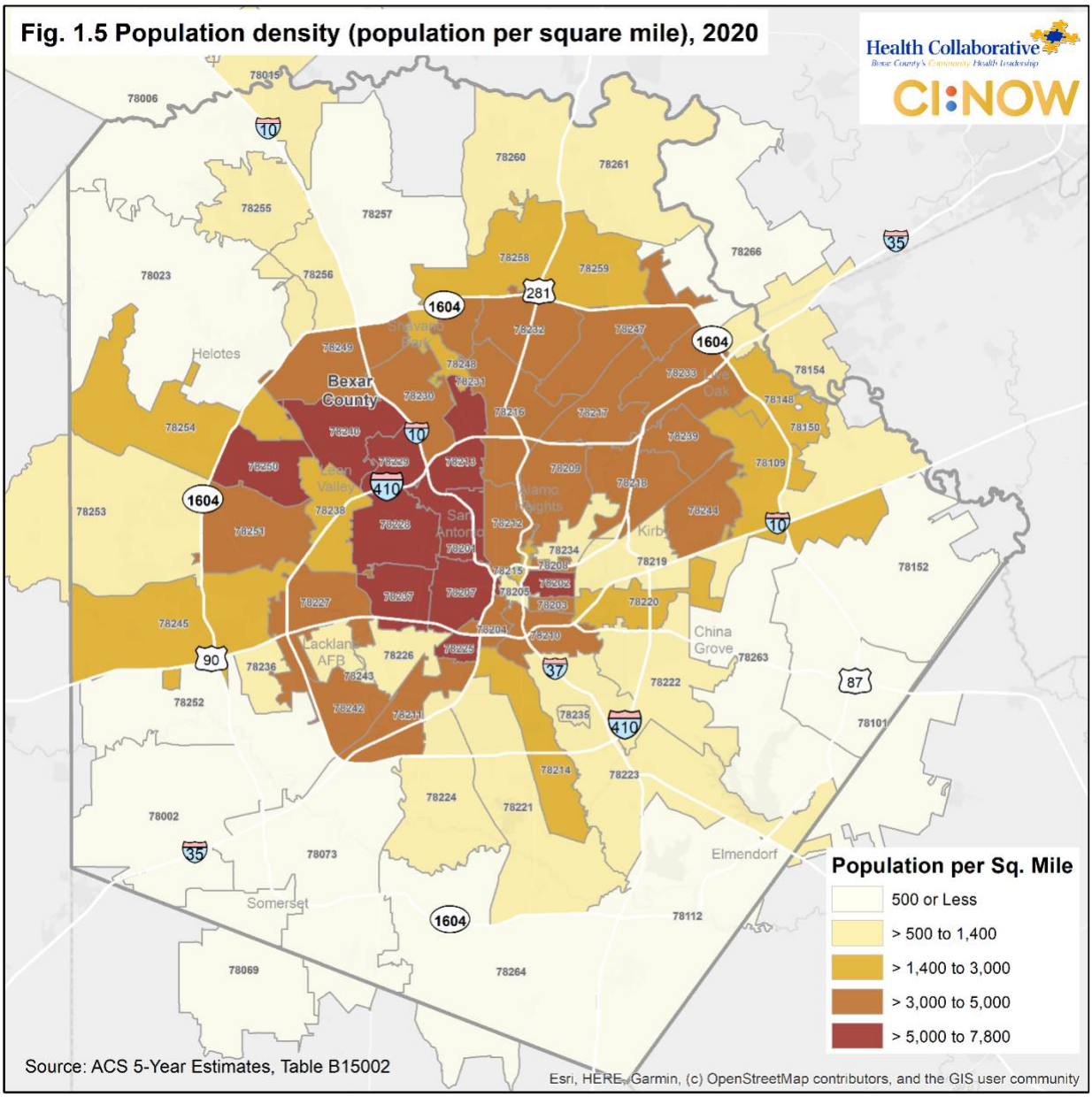


Fig. 1.5 Population density (population per square mile), 2020



Overview of Pre-Pandemic Access to Care

Residents of San Antonio and Bexar County had uneven access to health care pre-pandemic. Financial barriers included lack of insurance, particularly among adults but also among moderate-income children and teens, and high out-of-pocket costs even for people with insurance. Moreover, although the availability of ACA Marketplace coverage and aggressive local enrollment efforts made a substantial dent in the uninsured rate, the majority of insurance for adults has been employer-sponsored and thus vulnerable to job loss, part-time status, and employer policy.

Geographic barriers can be substantial for those without a car, as health care facilities may be far from a person's home or work and require multiple bus transfers. Geographic barriers interact with temporal barriers. For example, many employers do not offer paid sick leave, and workers cannot afford to miss work for either sick or preventive care. Although video- and telephone-based telehealth was already available, the pandemic forced widespread adoption among both health care providers and users.

Although much better than in surrounding rural areas, San Antonio and Bexar County already experienced a shortage of some types of health care providers, particularly mental health providers. Provider shortages translate into long appointment waits or an inability to find a provider accepting new patients and/or patients using a given insurance plan. Low wages, challenging work, and a growing and aging population already strained the supply of home health workers.

Health care staff may not be proficient in the language preferred by the client or patient, most commonly Spanish but also other languages. Low health literacy complicates care decisions and self-management, particularly coupled with basic literacy issues. Discrimination in health care and low trust in the health care establishment also presented barriers pre-pandemic, particularly for historically marginalized and currently marginalized populations like people of color, people with disabilities, women and girls, and members of the LGBTQ community. The pandemic appears to have further eroded overall trust in healthcare providers, according to annual Gallup polls.

An in-depth look at or exhaustive inventory of pre-pandemic barriers to care is beyond the scope of this report. However, a number of these pre-pandemic barriers are discussed throughout this report and quantified through trend lines starting in 2019 or earlier.[1]

[1] Another resource is the *2022 Bexar County Community Health Needs Assessment*, https://www.healthcollaborativechna.com/2022chnabexar.

Although the question was intended to learn about how COVID-19 affected access to care locally, the community survey administered as part of this project offers insight into pre-pandemic barriers to care for that population of respondents (Figure 2.1 in the next section). Excluding from the calculation entirely those who responded “not applicable” to an issue, those people who indicated that an issue was “never a problem” before or after pandemic onset are the proportion who did *not* experience the issue as a barrier to care pre-pandemic. The most common pre-pandemic issue among these respondents was language barriers (58%), which could be expected given the high proportion of respondents who completed the survey in a language other than English. All other issues were reported as a barrier for somewhere between one in five and one in two respondents: discrimination or rude treatment by health care staff (48%), lack of transportation (50%), not having access to a computer and internet for telehealth (48%), not knowing how to find needed health care (42%), the cost of health care or finding a provider who takes their insurance (28%), difficulty getting an appointment when care is needed (25%), the cost of prescription medicines (24%), and fear of catching an illness while visiting the doctor’s office (20%).

Access and Utilization During the Pandemic

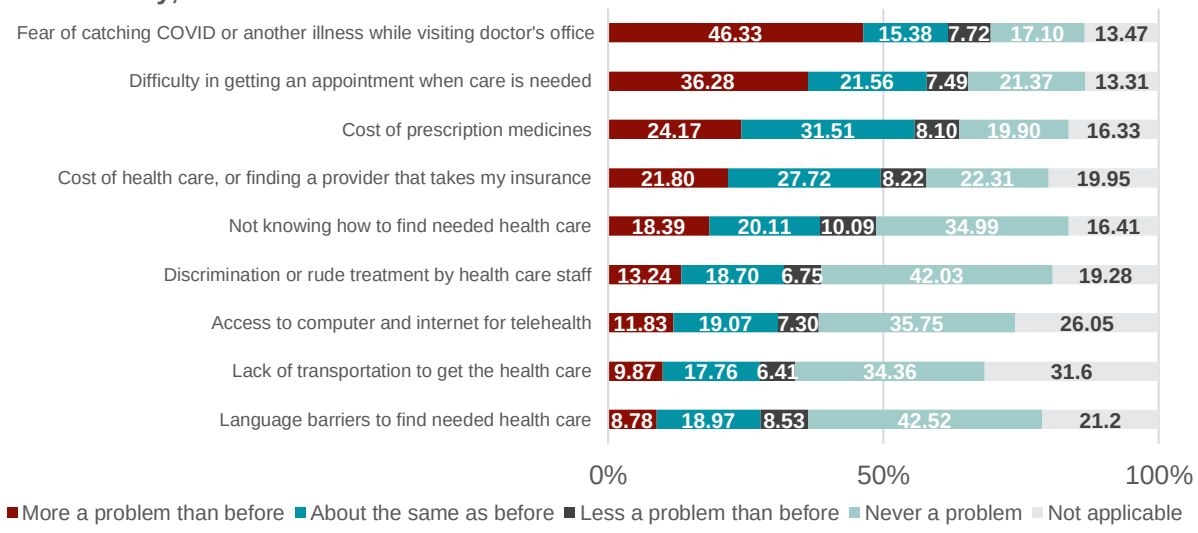
Key Affected Populations and Issues

Some available data sources on access to care during COVID-19 focused on particular populations, typically through digital or paper surveys. These datasets are important sources of information not available elsewhere. Because these surveys used a convenience sample rather than a random sample, however, the results represent only the people who responded to the survey and should not be generalized to the larger population. For that reason, these datasets are presented here separate from larger administrative datasets (e.g., hospital data) and surveys targeting a random sample of respondents.

Access to Care survey respondents

Each horizontal bar in Figure 2.1 represents a potential barrier to getting needed health care, such as fear of catching illness while seeking care, difficulty in getting medical appointments, and cost of prescription medicines. The segments of each bar represent different levels of hindrance regarding each barrier during the COVID-19 pandemic, including more a problem than before (the pandemic), about the same as before, less a problem than before, never a problem, and not applicable. “Fear of catching COVID or another illness while visiting doctor’s office” was reported by 46% of respondents as being a bigger problem during the pandemic than before the pandemic, followed by “Difficulty in getting an appointment when care is needed” (36%). Interestingly, for each barrier, 6% to 10% of respondents reporting the barrier being *less* a problem than pre-pandemic. It is important to note, however, that a response of “not applicable” may represent people who do not see a value in getting preventive or primary care when they and their household members are well.

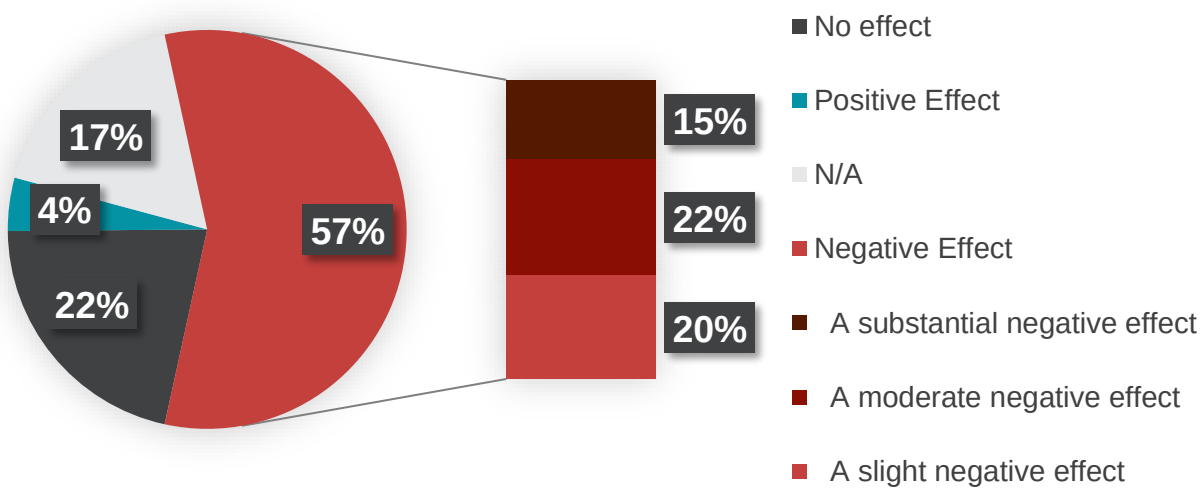
Fig. 2.1 Barriers to health care services during COVID-19 among survey respondents
Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Figure 2.2 summarizes respondents' perception of how the COVID-19 pandemic impacted their access to needed health care in six categories: a substantial negative effect, a moderate negative effect, a slight negative effect, positive effect, no effect, and not applicable. The majority of respondents (57%) claimed the COVID-19 pandemic had negative effects on their access to needed health care. Specifically, 22% of the respondents claimed the pandemic had moderate negative effects; 20% of the respondents claimed the pandemic had slight negative effects; 15% of the respondents claimed the pandemic had substantial negative effects. On the other hand, 22% of the respondents believed the COVID-19 pandemic had no effect on their access to needed health care, 4% of the respondents mentioned the COVID-19 pandemic had positive effects on their access to needed health care, and the reminder 17% of the respondents said the pandemic effect is not applicable regarding their access to needed health care.

Fig. 2.2 Pandemic impact on access to care among survey respondents
Bexar County, Texas

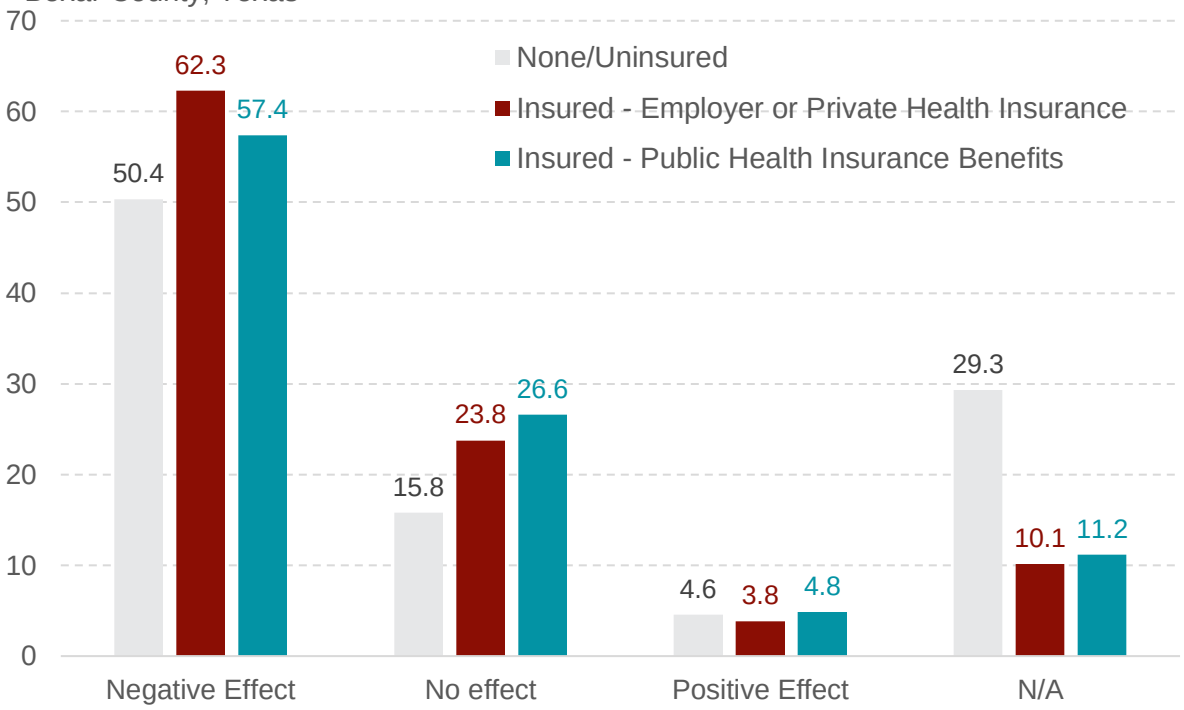


Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Responses to that question were broken out by respondent insurance status (Figure 2.3). Respondents with health insurance were more likely to answer “No Effect” on their health care access during the pandemic, whereas respondents without health insurance were more likely to select “Not Applicable”. Insurance status was assessed at the time of survey response, so the insured group reporting a positive effect may have been uninsured pre-pandemic and then secured insurance, or may have experienced positive effects due to public health emergency declaration-related expansions in access to care without regard to insurance status.

Fig 2.3 Pandemic impact on access to care by insurance status

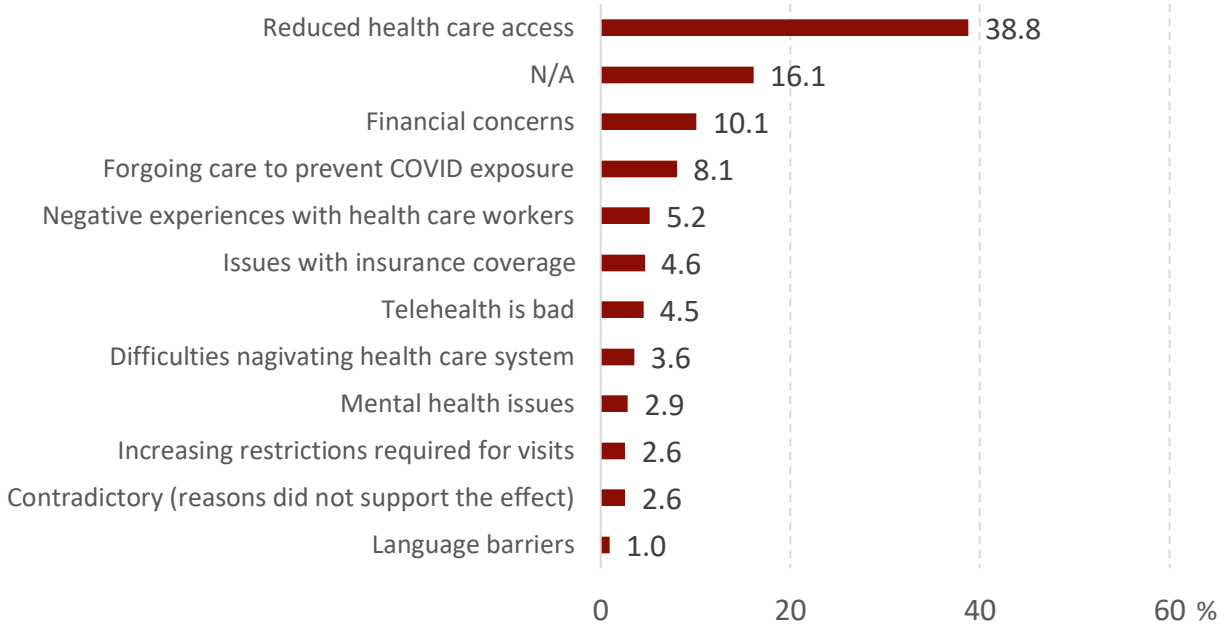
Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

The survey instrument includes a follow-up question, allowing respondents to explain in their own words why they answered that COVID-19 had negative, positive, or no effects on their access to care. The next three charts show several common reasons as to why respondents claimed the COVID-19 pandemic had negative effects, positive effects, or no effects (or not applicable) on their access to needed health care services, respectively. As shown in Figure 2.4, 39% stated “reduced health care access” or similar phrase, essentially just restating that COVID-19 had negatively affected their access to care. Specific reasons cited included limited staff capacity, shortened hours, and fewer available appointments. Financial concerns (10%) and avoiding care to prevent COVID-19 exposure (8%) were also commonly cited.

Fig. 2.4 Reasons for negative effect of COVID-19 on health care access
Bexar County, Texas

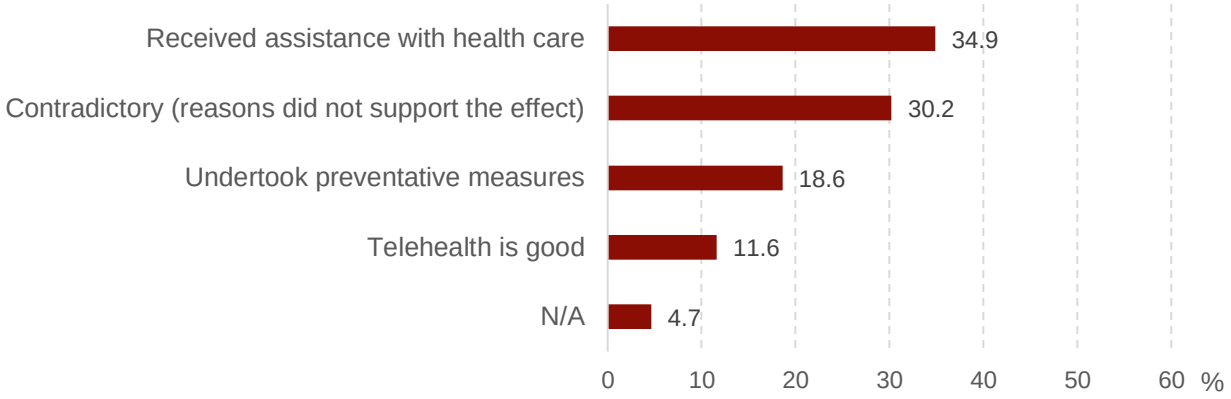


Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

As illustrated in Figure 2.5, the receipt of assistance with health care was mentioned as the most common reason as to why the respondents claimed the pandemic had positive effects on their health care access. As evidenced in Figure 2.6, “No effect on care” was cited as the most common reason as to why the pandemic had no effect (or N/A) on respondents’ health care access. This may imply that those respondents did not need medical services during the pandemic or could not access health care due to a lack of health insurance coverage.

Fig. 2.5 Reasons for positive effect of COVID-19 on health care access

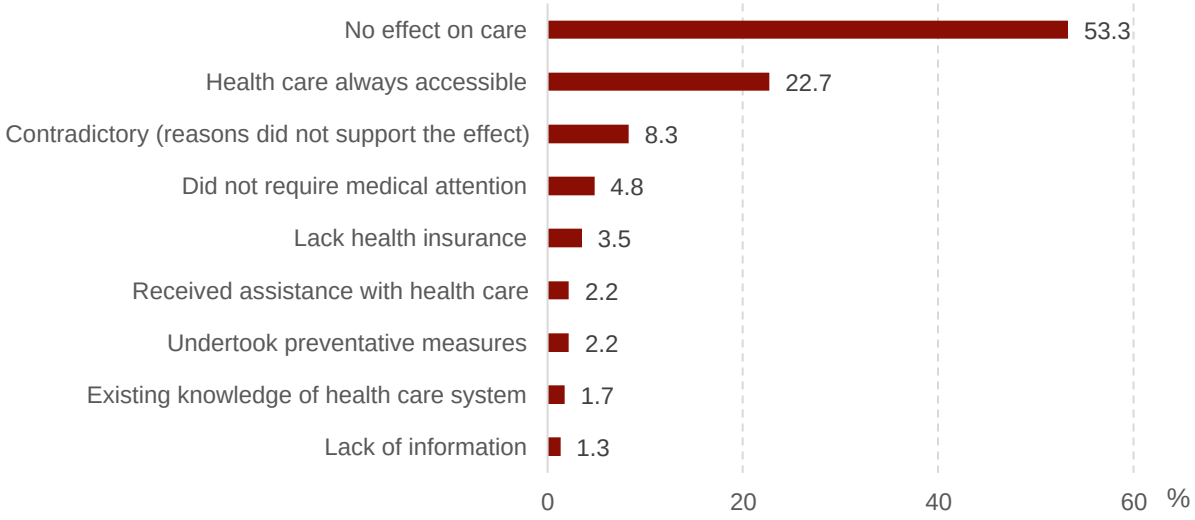
Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Fig. 2.6. Reasons for no effect (or not applicable) of COVID-19 on health care access

Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

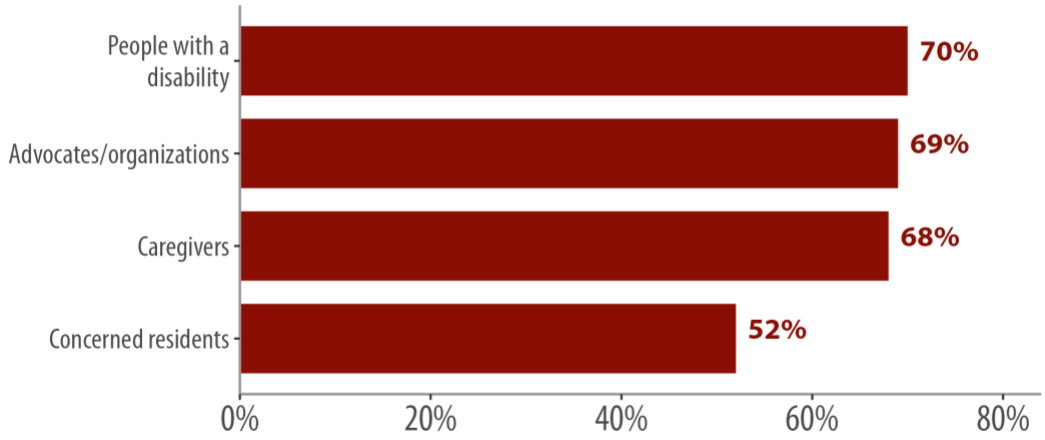
"What happened with my doctor...she was exposed. One of her patients was exposed. So then she cut us off. You know, and her attitude changed with patients. With that information, you know, we were like, what's going on? You know, she's still our doctor, and she is not the same person anymore. So I changed doctors." – Older focus group participant

People with Disabilities

A local survey administered online in 2020[53] sought to understand the impact of COVID-19 on individuals with disabilities, their family members and caregivers, and organizations serving the community. As shown in Figure 2.7 below, 70% of respondents reporting having a disability indicated that their health care and medical supplies had been impacted by the pandemic. Thirty-one percent of respondents with a disability reported that COVID-19 impacted their digital technology, while 28% reported an impact on transportation. Digital technology and transportation play a critical role in access to virtual and in-person health care visits.

Fig. 2.7 Percent of disability survey respondents reporting that COVID-19 impacted their health care and medical supplies, 2020

San Antonio, Texas



Source: Scharven, D.; Cawthon, M.; Paccione, J.; & Denny, K. (2020). Gathering the Experiences of People with Disabilities During COVID-19 Summary Report. San Antonio, TX: City of San Antonio, Disability Access Office; disABILITYsa; and Successfully Aging and Living in San Antonio. Prepared by CI:Now for The Health Collaborative

People Identifying as LGBTQ+

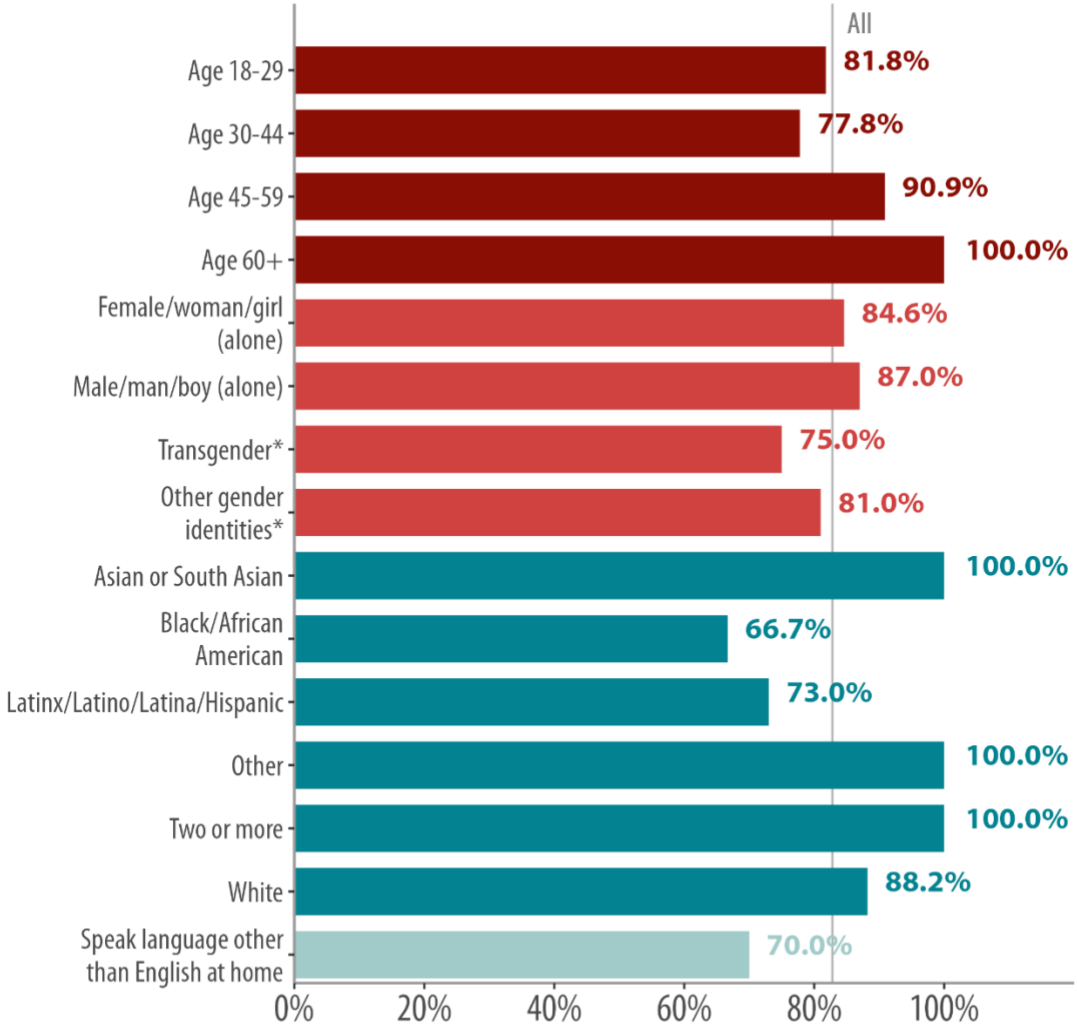
Bexar County's lesbian, gay, bisexual, transgender, queer, & other gender & sexual minority (LGBTQ+) residents experienced serious barriers to care even prior to the COVID-19 pandemic. The 2019 Strengthening Colors of Pride online survey gathered a wide range of information from 1,819 LGBTQ+ residents of Bexar and seven surrounding counties, with 85% of respondents (n=1,545) living in Bexar County.[54] Survey results shined a light on many barriers to care beyond financial considerations. Although only 15% reported not having health insurance, 46% of respondents reported that they had avoided visiting a health care professional that year. Forty-one percent reported having problems finding LGBTQ+ competent health care, and 31% reported having been refused treatment by a health care provider. One in five reported having been assaulted in a health care setting. Higher percentages across the board were reported by transgender respondents.

The summer 2020 "COVID and You" online survey,[55] which included several questions related to access to health care, gathered responses from 129 sexual- and gender-diverse adults living in Bexar County. Overall, about 83% of survey respondents reported being "covered by any health insurance or health coverage plan" (Figure 2.8). That figure was lower for people identifying as transgender (75%) or as being of two or more gender identities (not including transgender), non-binary, gender non-conforming, agender, or genderqueer (81%); Black/African American (67%); or Latinx/Latino/Latina/Hispanic (73%); as well as for people reporting speaking a language other than English at home (70%).

The survey asked seven questions about whether people had tried to access prescriptions, health care, and social services, and if so, what degree of difficulty they encountered. Each question is discussed individually below, excluding those people who had not tried to access the particular service. While substantial percentages of many different groups reported that it was "very difficult" or "extremely difficult" to access a particular service, the percentage was consistently higher among people reporting identifying as transgender or speaking a language other than English at home.

Fig. 2.8 Percent of COVID-19 and You LGBTQ+ survey respondents reporting being covered by health insurance or health coverage plan, 2020

Bexar County, Texas



*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.

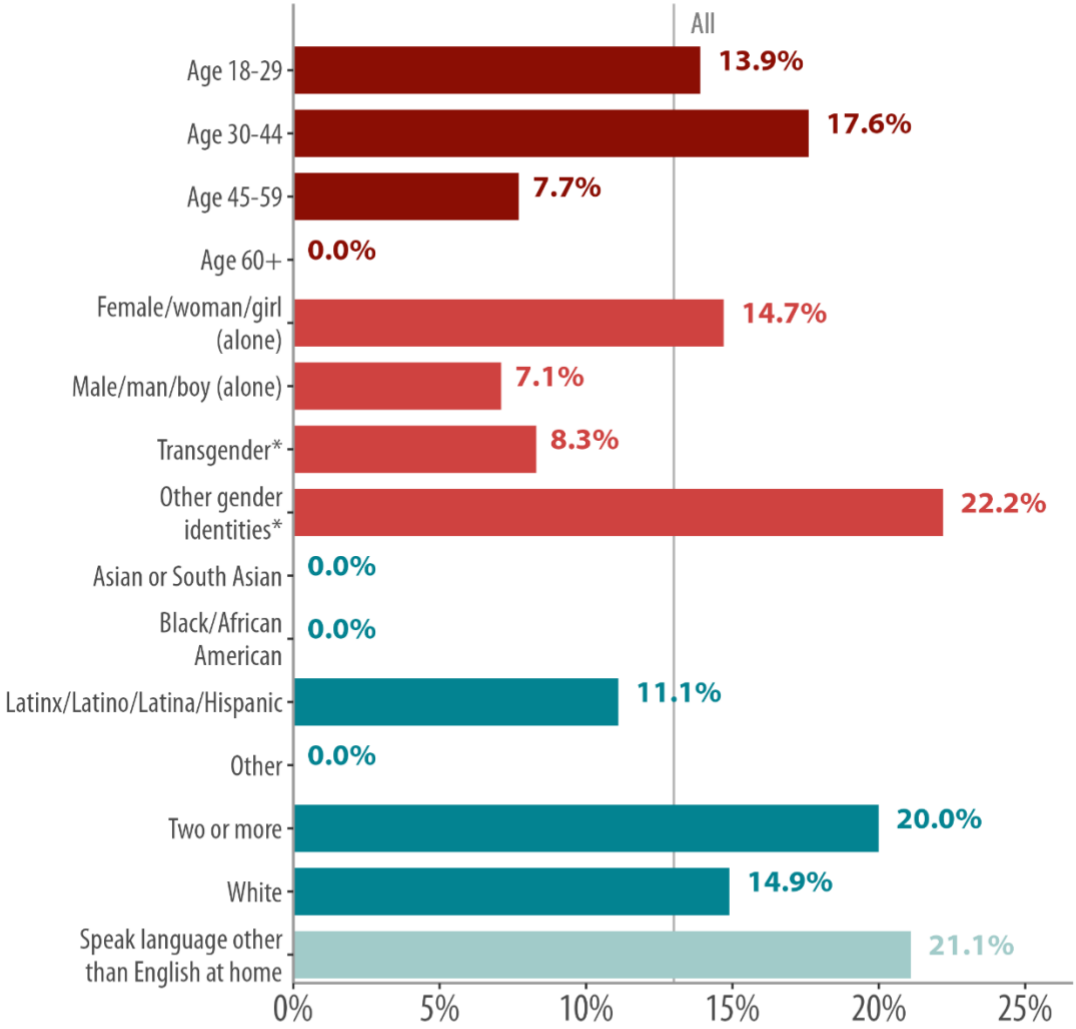
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.

Prepared by CI:Now for The Health Collaborative

Thirteen percent of respondents (12 of 92) reported that it was “very difficult” or “extremely difficult” to access health care services (Figure 2.9). That proportion was quite a bit higher for people age 30 to 44 (18%); people identifying as being of two or more gender identities (not including transgender), non-binary, gender non-conforming, agender, or genderqueer (22%); people identifying as being of two or more races/ethnicities (20%); and people reporting speaking a language other than English at home.

Fig. 2.9 Percent of COVID-19 and You LGBTQ+ survey respondents reporting “Very Difficult” or “Extremely Difficult”: Accessing health care services, 2020

Bexar County, Texas



*Respondents could choose more than one gender identity. “Transgender” includes all respondents identifying as transgender, whether alone or in combination with another gender identity. “Other gender identities” includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.

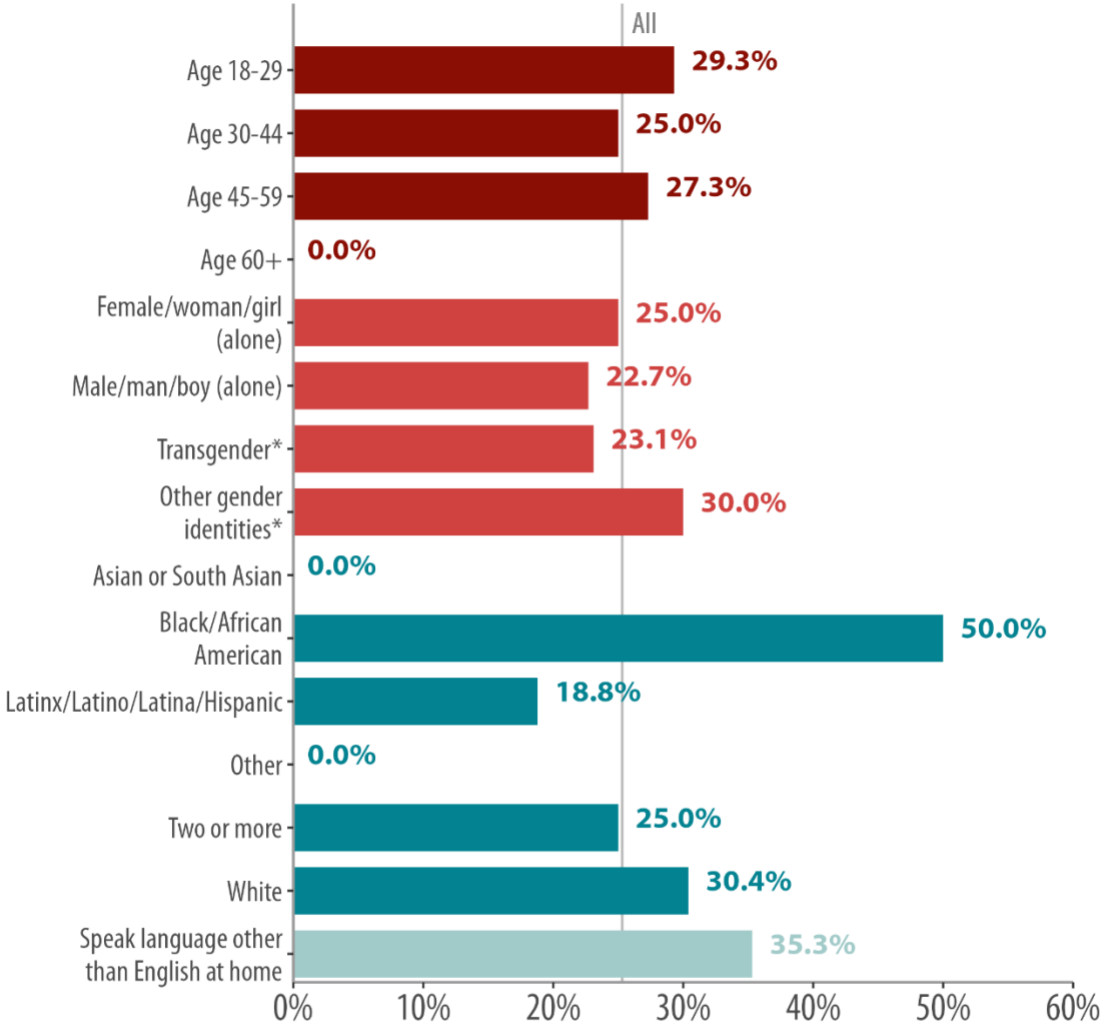
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.

Prepared by CI:Now for The Health Collaborative

A quarter of respondents (22 of 87) reported substantial difficulty accessing mental health services (Figure 2.10). Those percentages did not differ much among age groups. A higher percentage was found for people identifying as transgender (30%); people identifying as Black/African American (50%) or white (30%); and people reporting speaking a language other than English at home (35%).

Fig. 2.10 Percent of COVID-19 and You LGBTQ+ survey respondents reporting "Very Difficult" or "Extremely Difficult": Accessing mental health services, 2020

Bexar County, Texas



*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.

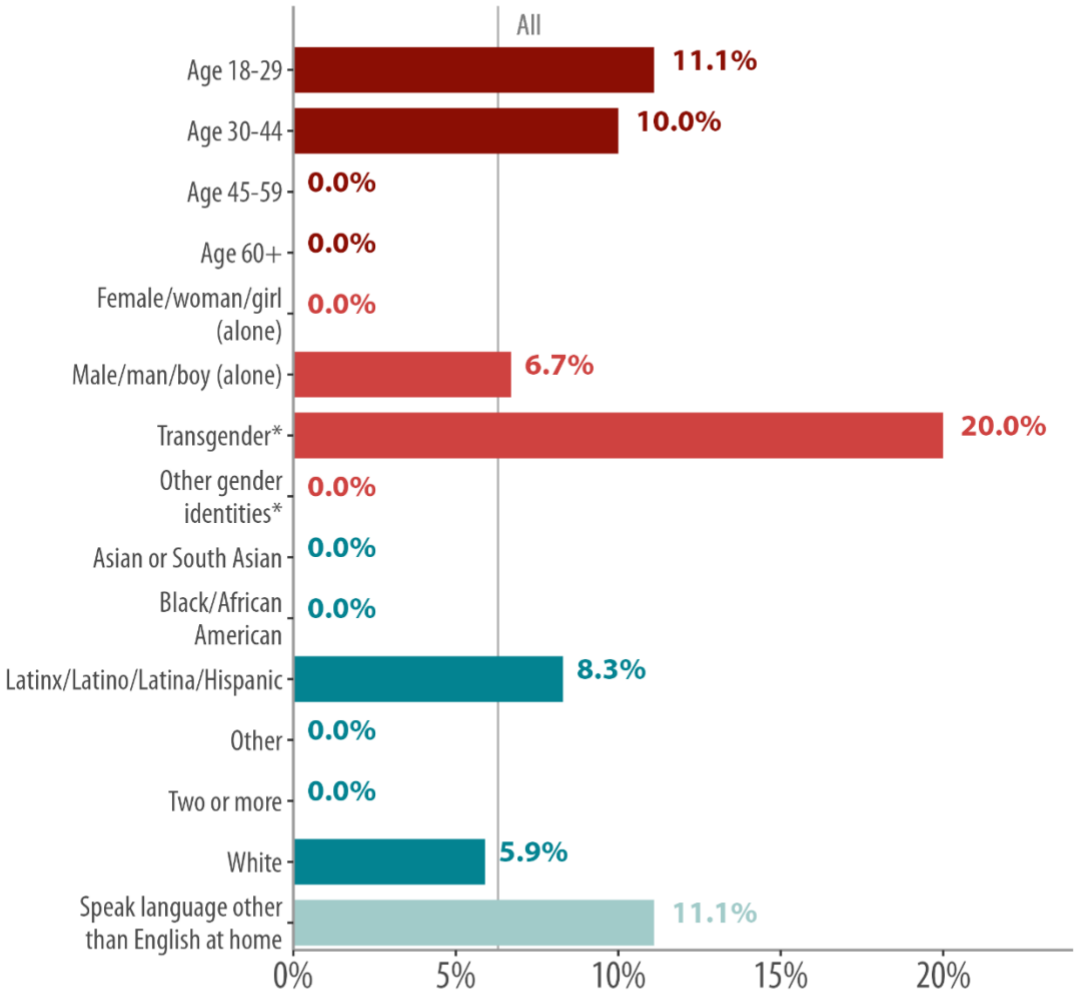
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.

Prepared by CI:Now for The Health Collaborative

Six percent of respondents (2 of 32) reported substantial difficulty accessing addiction and recovery services (Figure 2.11). Those numbers are extremely small, and small numbers expressed as percentages can make differences among groups seem much greater than they truly are. Having said that, the percentage was higher among people age 18 to 29 (11%) or 30 to 44 (10%), people identifying as transgender (20%); Latinx/Latino/Latina/Hispanic people (8%); and people reporting speaking a language other than English at home (11%).

Fig. 2.11 Percent of COVID-19 and You LGBTQ+ survey respondents reporting "Very Difficult" or "Extremely Difficult": Accessing addiction and recovery services, 2020

Bexar County, Texas

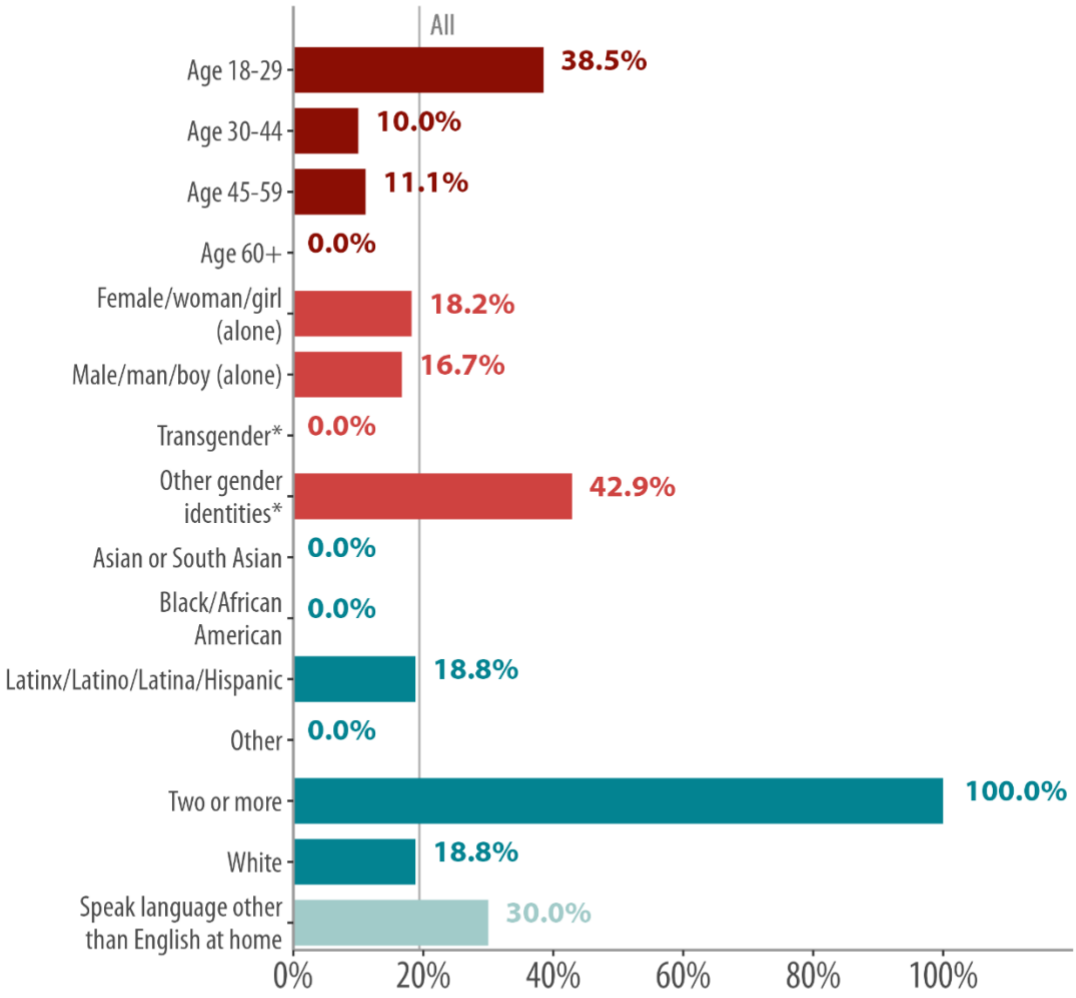


*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.
Prepared by CI:Now for The Health Collaborative

Overall, 19% (7 of 36 respondents) reported substantial difficulty accessing assistance programs such as food stamps (Figure 2.12). That percentage was quite a bit higher for people age 18 to 29 (39%); people identifying as being of two or more gender identities (not including transgender), non-binary, gender non-conforming, agender, or genderqueer (43%); people identifying as being of two or more races/ethnicities (100%); and people reporting speaking a language other than English at home (30%).

Fig. 2.12 Percent of COVID-19 and You LGBTQ+ survey respondents reporting "Very Difficult" or "Extremely Difficult": Accessing assistance programs such as food stamps, 2020

Bexar County, Texas

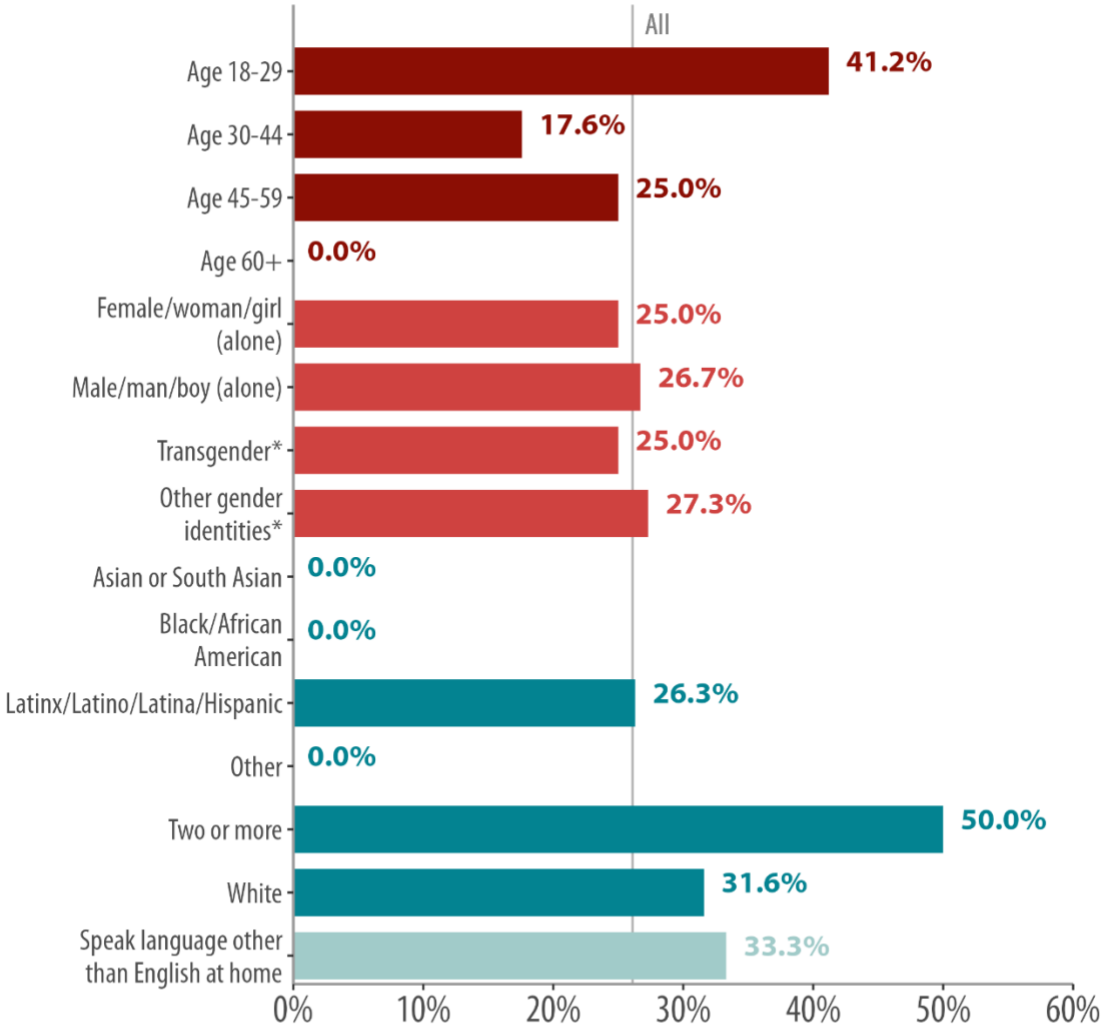


*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.
Prepared by CI:Now for The Health Collaborative

Twenty-six percent of respondents (12 of 46) reported substantial difficulty accessing other social services (Figure 2.13). That percentage was higher for people age 18 to 29 (41%); people identifying as being of two or more races/ethnicities (50%) or white (32%); and people reporting speaking a language other than English at home (33%).

Fig. 2.13 Percent of COVID-19 and You LGBTQ+ survey respondents reporting "Very Difficult" or "Extremely Difficult": Accessing other social services, 2020

Bexar County, Texas

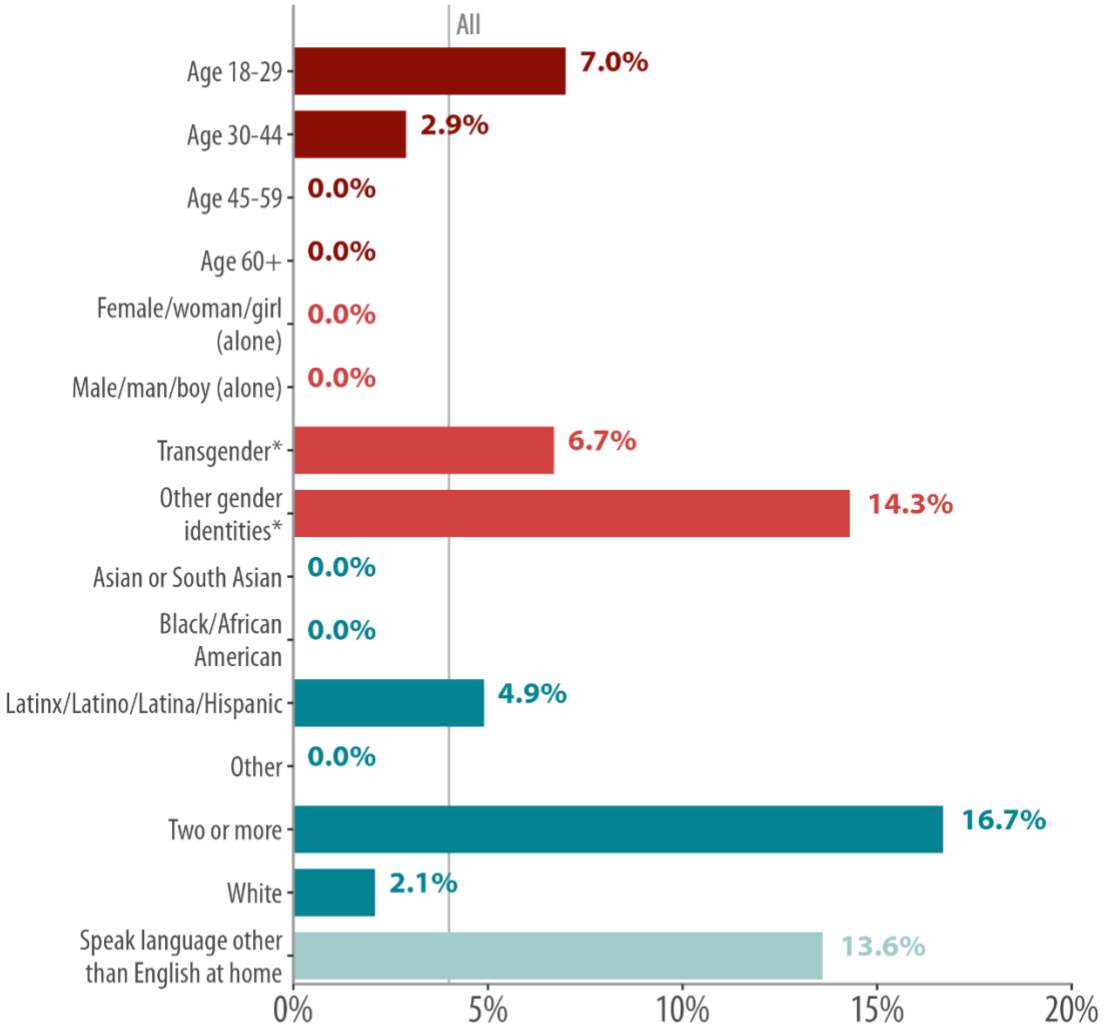


*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.
Prepared by CI:Now for The Health Collaborative

Four percent of respondents overall (4 of 101) reported substantial difficulty getting their prescriptions (Figure 2.14). The respondent numbers are very small, so these rates should be interpreted with caution, but the percentage was higher for people age 18 to 29 (7%); people identifying as transgender (7%); people identifying as being of two or more gender identities (not including transgender), non-binary, gender non-conforming, agender, or genderqueer (14%); people identifying as being of two or more races/ethnicities (17%); and people reporting speaking a language other than English at home (14%).

Fig. 2.14 Percent of COVID-19 and You LGBTQ+ survey respondents reporting "Very Difficult" or "Extremely Difficult": Getting your prescriptions, 2020

Bexar County, Texas



*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.

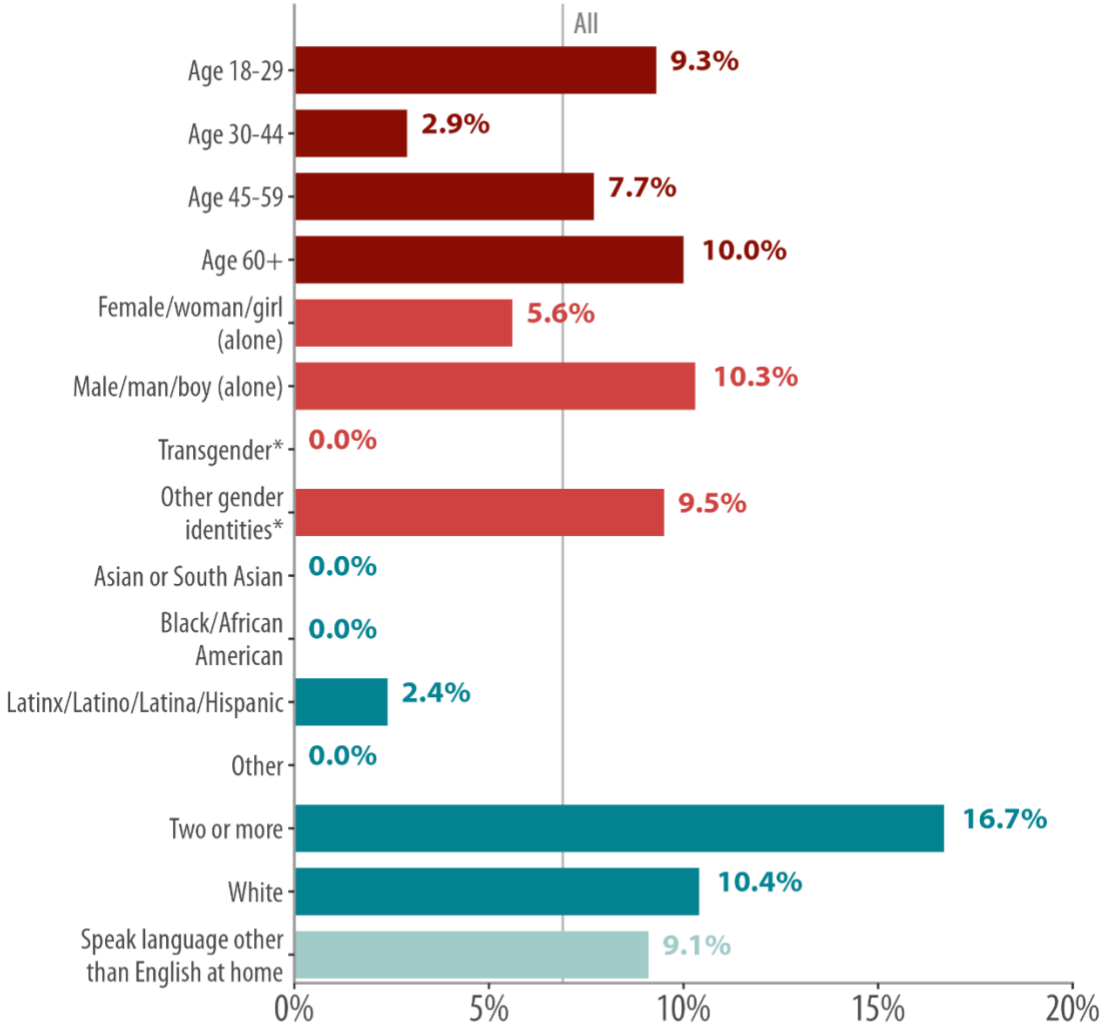
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.

Prepared by CI:Now for The Health Collaborative

Overall, 7% of respondents (7 of 101) reported substantial difficulty paying for their prescriptions (Figure 2.15). Again, the numbers are very small, which will overstate differences in percentage among groups, but the percentage was substantially higher for people age 18 to 29 (9%) or 60 and older (10%); people identifying as male (10%) or transgender (10%); people identifying as being of two or more races/ethnicities (17%) or white (10%); and people reporting speaking a language other than English at home (9%).

Fig. 2.15 Percent of COVID-19 and You LGBTQ+ survey respondents reporting "Very Difficult" or "Extremely Difficult": Paying for your prescriptions, 2020

Bexar County, Texas



*Respondents could choose more than one gender identity. "Transgender" includes all respondents identifying as transgender, whether alone or in combination with another gender identity. "Other gender identities" includes all other gender identities, alone or in combination, including non-binary, gender non-conforming, agender, and genderqueer.
Source: Schnarrs, P.W., Loza, O., Ciszek, E., et al. (2021, April). COVID-19 & you: Experiences of sexual and gender-diverse Texans during COVID-19 pandemic. The University of Texas at Austin.
Prepared by CI:Now for The Health Collaborative

Afghan Refugees

Either self-administered or with the help of an on-site interpreter, 77 surveys were completed during the pandemic by Afghan refugees served by the Center for Refugee Services in San Antonio.[56] Language barriers were reported as a top health concern by 44% of respondents. Lack of health insurance was cited by about 48% total, whether they had applied for insurance and were waiting (22%) or had not applied (26%). Health care for kids or for family was cited by 20% and 9%, respectively. Although the survey did not ask about barriers, access to dental care appears critical, as the most often-cited health concern (65%) was teeth problems.

Other Community Members

Paper questionnaires were completed by 176 adult attendees at four different health fairs[2] across the county during the pandemic. The questionnaires asked about barriers to health participants encountered, rather than barriers to health care specifically, but over 10% of respondents each reported "no insurance" and "health care team" as barriers to care.[57]

"In older communities, sometimes they're not physically able to drive or they just don't rely on their own personal vehicle. And so taking the bus or walking is often how they're able to go about and perform their do activities. And so doctor's offices, if they're not within walking distance or they have to travel on the bus, that can make it more difficult, you know, having to schedule extra time to get to the bus station. And then depending on public transportation, that sometimes isn't as reliable as we would like it to be"- Office of a San Antonio City Council member

"In terms of getting the vaccine, it was transportation and access… it was folks who were disabled requesting them...and really it was hard to hear because they were begging for people to come to their homes. They had folks who were homebound and couldn't leave… it was almost always, it was somebody who either had a wheelchair or was bedbound. Or was just afraid to come out because they had all of the indicators that said that you were at high risk. And they were just afraid to leave their home. And it was, it was almost always older people. I believe it was, like, older people over the age of 60."- Office of a San Antonio City Council member

[2] Grace Pavilion Community Outreach in Windcrest (San Antonio City Council District 2), Association of Pakistani Physicians of North America South Texas Chapter at Muslim Children Education and Civic Center (District 8), Big Mama's Safe House at Phillis Wheatley Park (District 2), and Asian American Health Fair at New World Church (District 7).

System-Level Drivers of Access

Health Care Provider Capacity and Distribution

One key determinant of health care access is the availability of health care providers. As a large urban area, Bexar County overall generally fares pretty well on this measure. However, the presence of a health care provider in the county does not necessarily translate to access. Providers may be geographically far from residents and may not be accessible to the general population if working in, for example, the mental health authority or the military health care system.

Total employment in health care occupations dropped markedly in 2020 in both hospital and ambulatory health care services settings (Figure 3.1). Ambulatory health care employment recovered in 2021 and markedly surpassed pre-pandemic levels in 2022, while hospital employment was lower in 2022 than even in 2020.

While data on the shifts are not available, anecdotally it is clear that many health care employees transitioned to different care settings when the pandemic hit. Given the growth in ambulatory care staffing, it may be that many formerly hospital-based employees moved to ambulatory care settings early in the pandemic and stayed there. Given the disproportionate stress on and shortage of staff in hard-hit hospital units like the intensive care unit and emergency room, however, it seems likely that a meaningful number left the health care field entirely and have not returned.

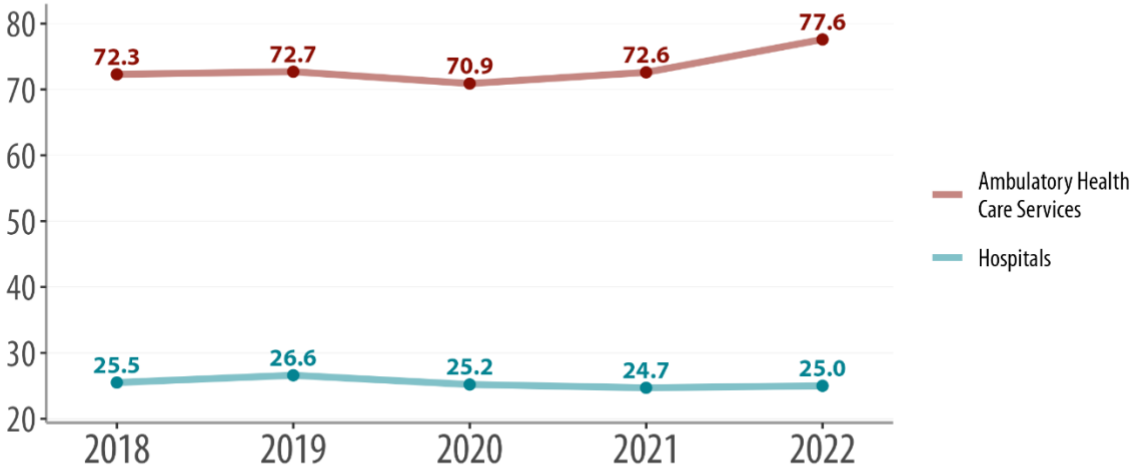
Not quantified in this report are trends in the nursing care workforce, a critical component of the health care system. Analysis of Registered Nurse and Vocational Nurse workforce data by the Center for Health Care Statistics at the Texas Department of State Health Services is underway but was not yet final at the time of writing of this report.

"We had to surge into units that we normally wouldn't have surged into. And with the volume, it created the need for extra adult ER nurses to other adult units. So we had to cross-train our pediatric nurses to become adult nurses." – Hospital leader

"We had to cross-train physical therapists, respiratory therapists, other people, and other disciplines to kind of assist nurses with the care of those types of patients, the COVID-19 patients." – Hospital chief executive

Fig. 3.1 Annual average health services employees, in thousands

San Antonio-New Braunfels Metro Area

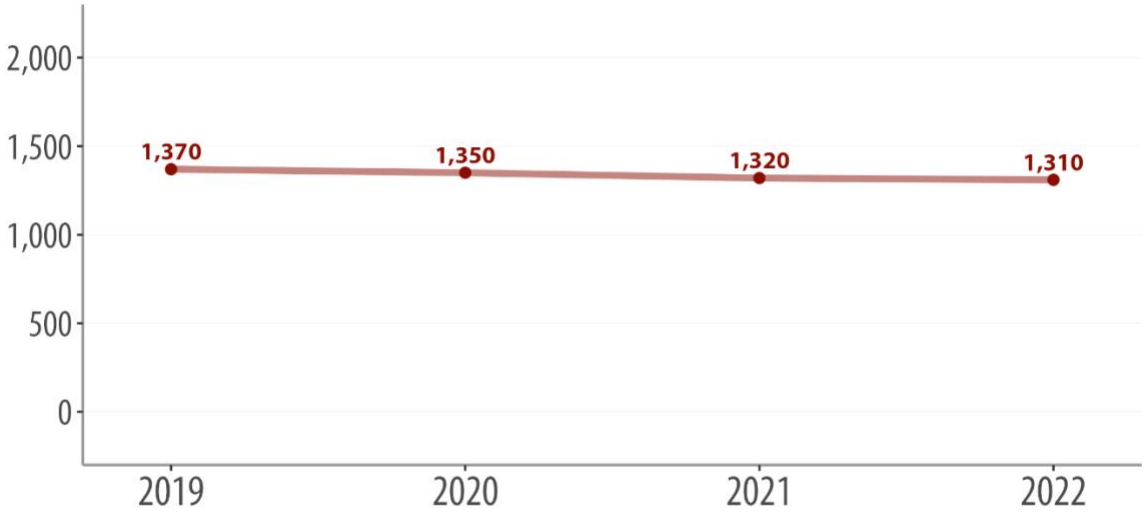


The December figure in the 2022 average is preliminary
Source: US Bureau of Labor Statistics State and Area Employment, Hours, and Earnings
Prepared by CI:Now for The Health Collaborative

Despite ongoing population growth, Figure 3.2 shows a slight but steady decline in the ratio of Bexar County population per primary care physician (excluding OB/GYNs) – less than 5% over five years. This would point to an *increase* in primary care provider availability over the past several years, consistent with the data presented above. The ratio of population per dentist declined about 8% over five years (Figure 3.3); that data source does not include dental hygienists in its calculation.

Fig. 3.2 Ratio of population to primary care physicians*

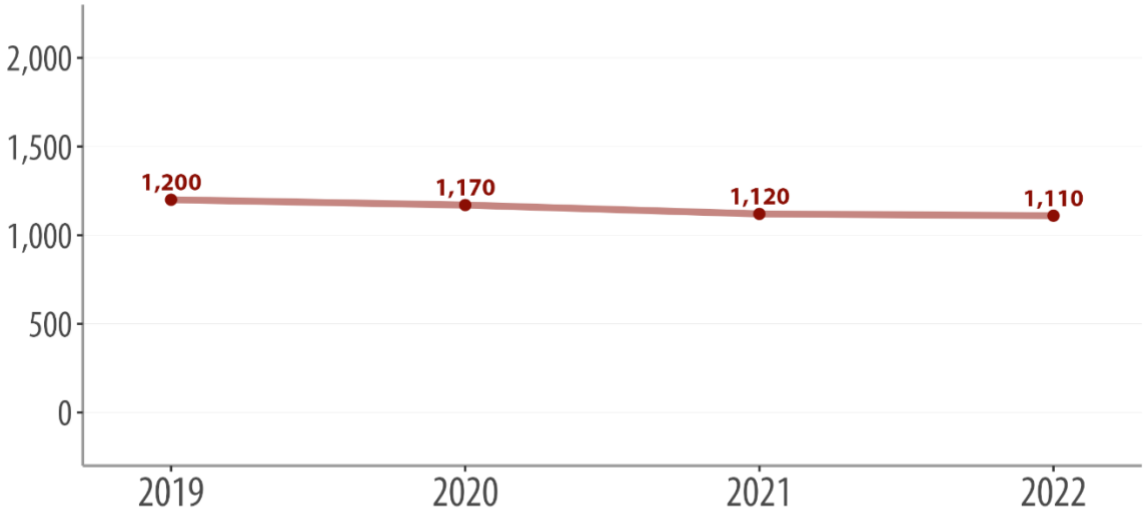
Bexar County, Texas



*MDs and DOs but excluding OB/GYNs
Source: County Health Rankings
Prepared by CI:Now for The Health Collaborative

Fig. 3.3 Ratio of population to dentists

Bexar County, Texas



Source: County Health Rankings
Prepared by CI:Now for The Health Collaborative

"We had a mass exodus of our staff, especially ICU staff, nursing staff, ED, respiratory therapists…STRAC nurses started coming in once we hit the height of the pandemic...that brings challenges…they also brought things like how much they were getting paid and all of the benefits that they were getting as travel nurses, which then prompted my staff … to decide to go travel nurse for the dollars." – Hospital chief executive

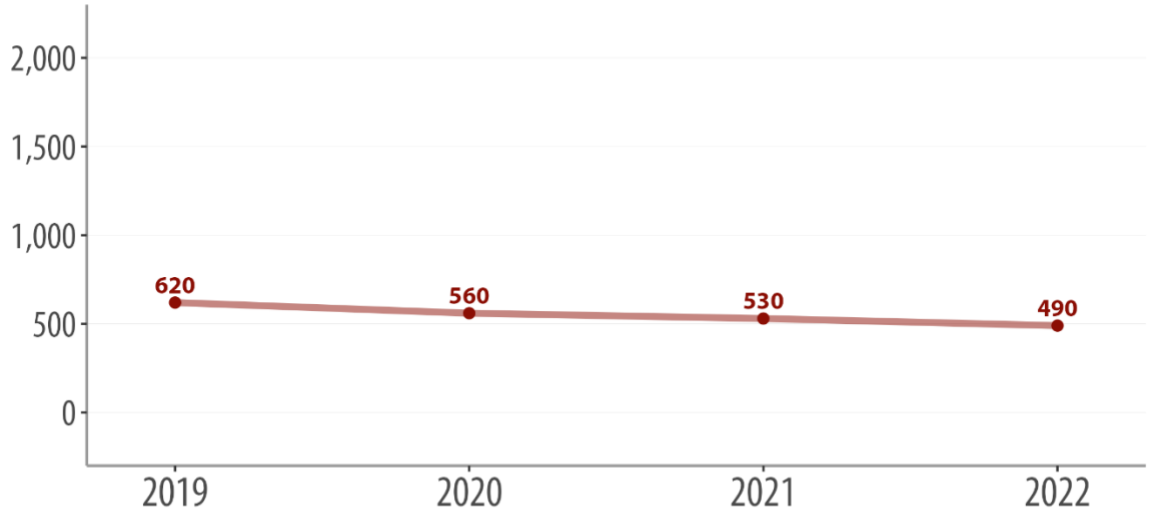
"If I'm a nurse and I'm working in a hospital for 10 years and I'm happy here, but then somebody comes in doing the same work and they're getting paid three times as much, I'm probably not as happy, right? And it doesn't take long to figure that out. And so that's not unique to our hospital. That happened all over the country. So you can see how that really disrupted things for hospitals during those big surges." - Hospital chief medical officer

"When I was working [there], I was doing the job of three people, because we could not get people to stay in the job… I ended up leaving that job after a year. Just literally working the job of three people." – Urgent care nurse

The same steady decline in population-to-provider ratio – that is, a steady *increase* in availability – is seen for mental health providers (Figure 3.4) and for dentists.[3] However, the dynamics of mental health provider availability are different from those for physicians and dentists. The demand for mental health services has increased markedly since the start of the pandemic, which does not appear to be the case for either primary medical care or dental care. Not specific to COVID-19, schools and the State of Texas have expanded school-based mental health services, particularly in the wake of mass school shootings in Santa Fe and Uvalde.[58] The schools' increase in demand occurs in the context of a pre-existing shortage of mental health services for people of any age needing care at any point along a continuum, from preventive or wellness services to mental health counseling to long-term residential psychiatric care. As noted in the **Emerging Issues** section of this report, the shortage of mental health providers prevents realization of the full promise of telehealth in that area. For example, although state leaders have directed close to $6M to the Texas Child Health Access Through Telemedicine (TCHATT) program for public school students, program leadership cites the provider shortage as a major barrier to expansion of telehealth services.[59]

Fig. 3.4 Ratio of population to mental health providers

Bexar County, Texas



Source: County Health Rankings
Prepared by CI:Now for The Health Collaborative

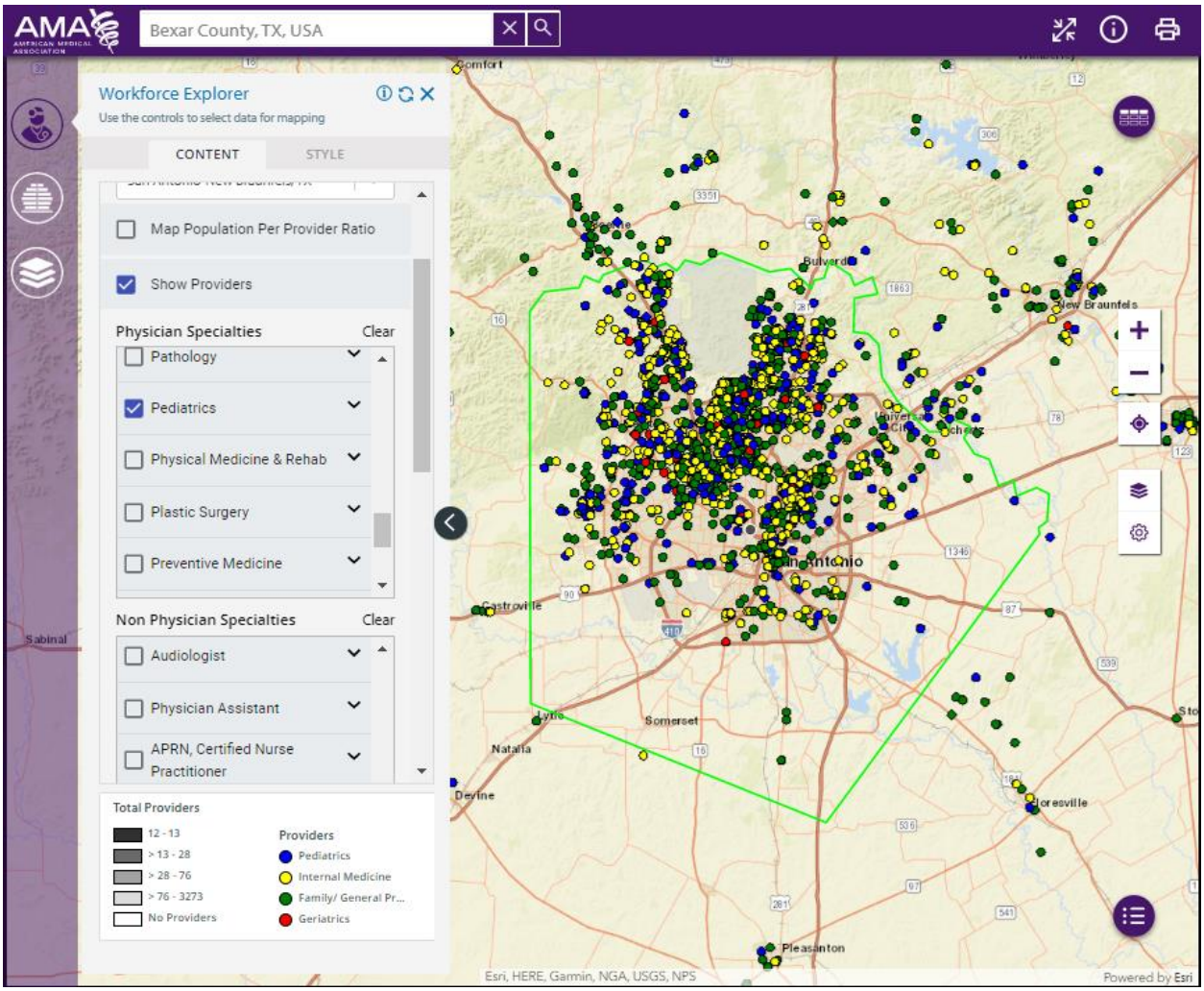
[3] The data source, County Health Rankings, defines mental health providers as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.

Health care of all kinds tends to be concentrated in the northern half of the county. The American Medical Association's interactive online Workforce Explorer[60] shows the geographic distribution of different kinds of health care providers, although the data does not include all provider types (e.g., dental care providers, licensed clinical social workers), and the map cannot be filtered to show only providers engaged in direct patient care. As shown in the four images below, the urban north side[4] has a much higher density of providers than the rest of the county for primary medical care (family practice, internal medicine, pediatrics, and geriatrics, Figure 3.5), midlevel medical providers (physician assistants and nurse practitioners, Figure 3.6), obstetrics and gynecology providers (OB/GYN physicians and midwives, Figure 3.7), and mental health providers (psychiatrists and clinical psychologists, Figure 3.8).

[4] Unfortunately the AMA Workforce Explorer does not allow the user to query only those health professionals engaged in direct patient care, which may overstate the true density of providers in geographic areas such as the Medical Center where a substantial number of professionals are working in research, teaching, or administration rather than direct care.

Fig. 3.5 Geographic distribution of primary medical care providers

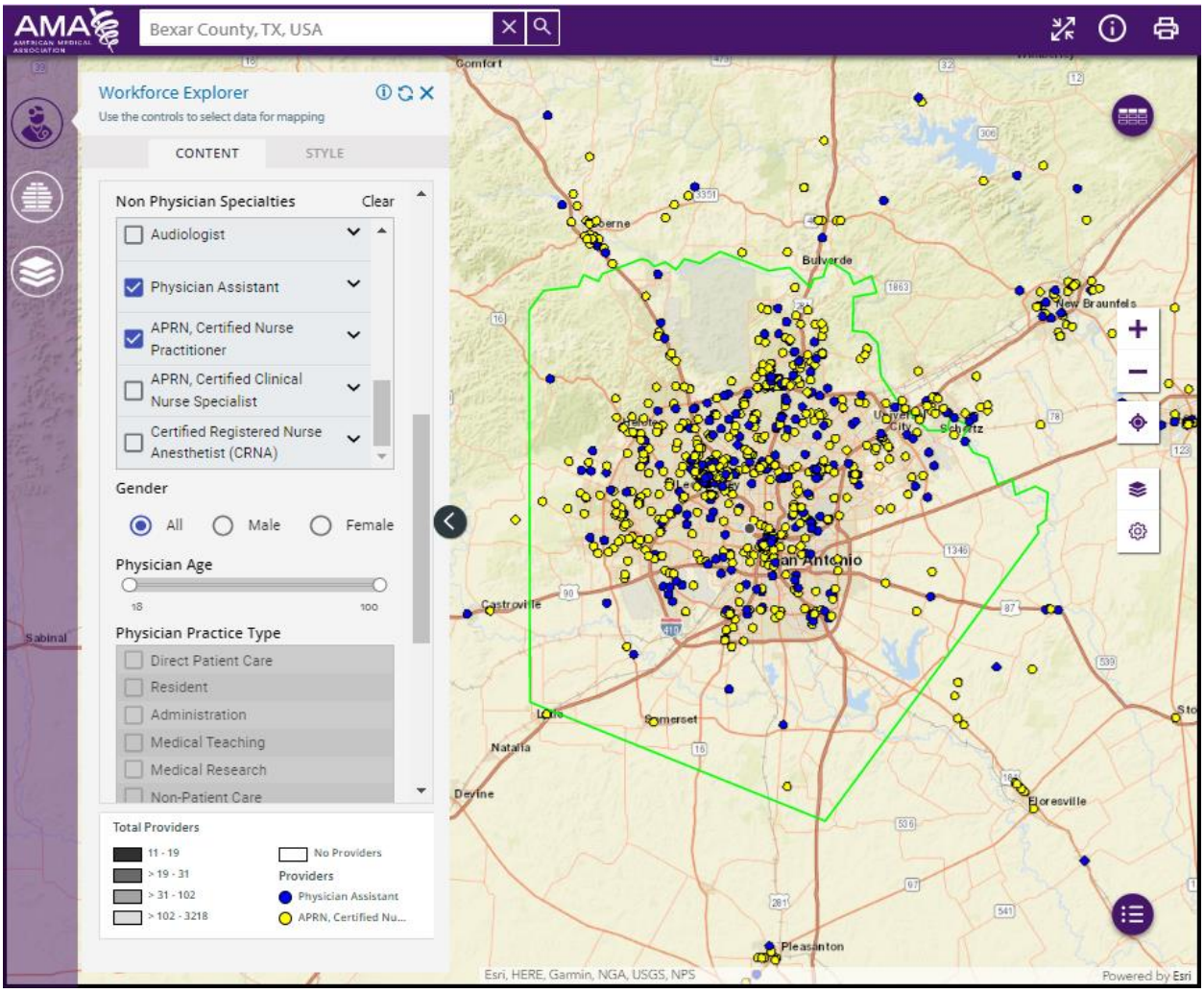
Bexar County, Texas



Source: American Medical Association Workforce Explorer, 2023
Prepared by CI:Now for The Health Collaborative

Fig. 3.6 Geographic distribution of midlevel medical providers

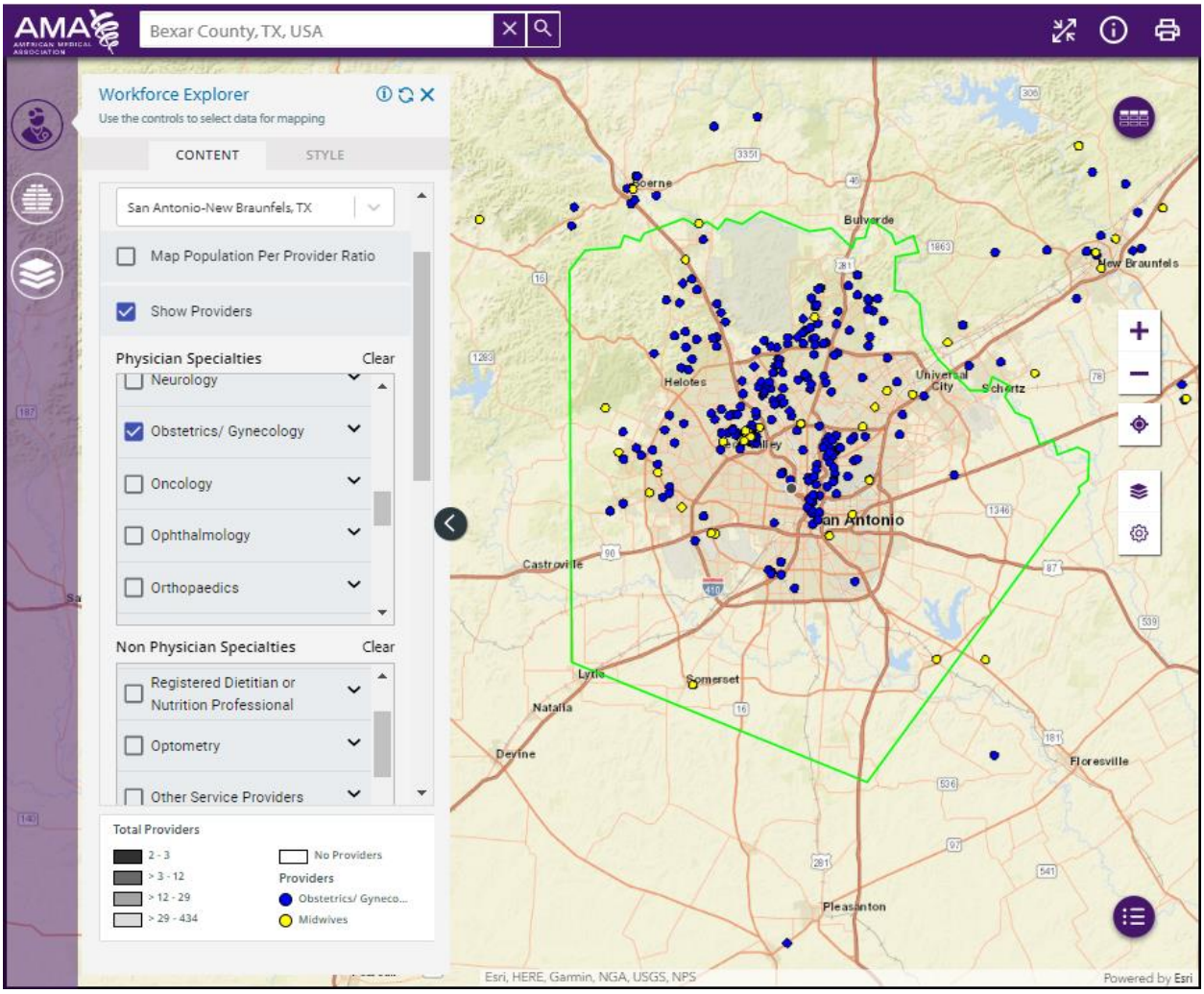
Bexar County, Texas



Source: American Medical Association Workforce Explorer, 2023
Prepared by CI:Now for The Health Collaborative

Fig. 3.7 Geographic distribution of obstetrics and gynecology providers

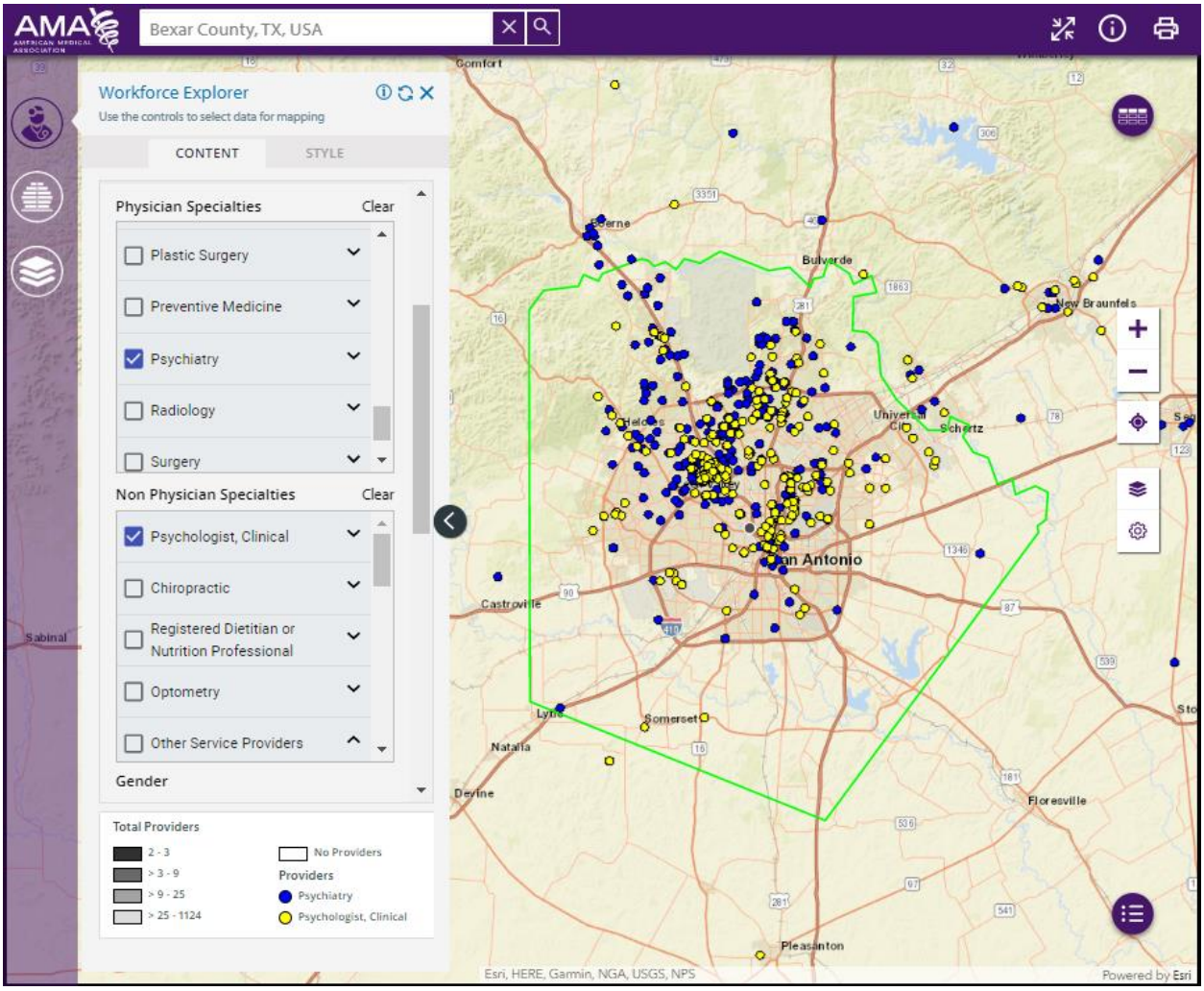
Bexar County, Texas



Source: American Medical Association Workforce Explorer, 2023
Prepared by CI:Now for The Health Collaborative

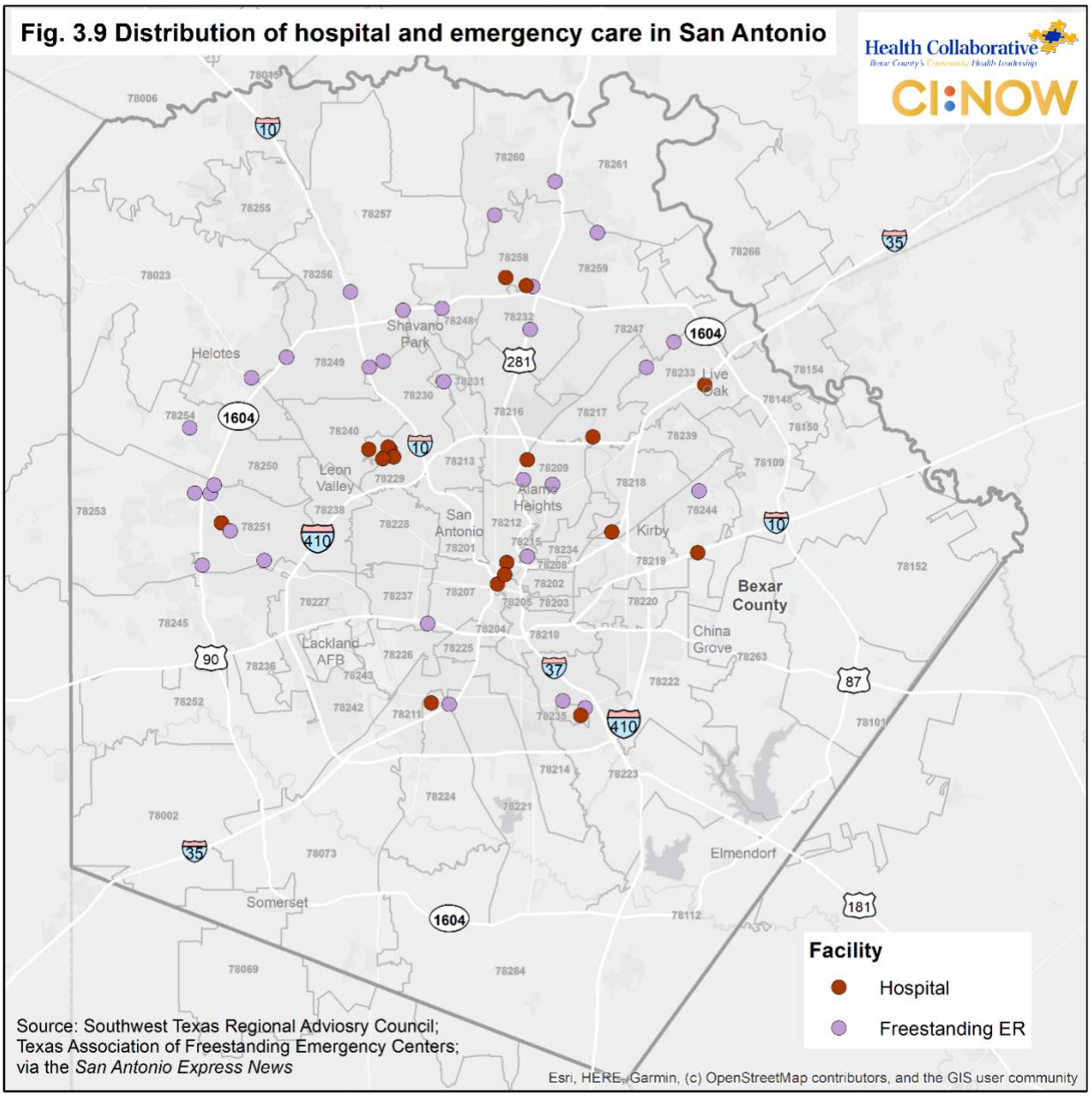
Fig. 3.8 Geographic distribution of mental health care providers

Bexar County, Texas



Source: American Medical Association Workforce Explorer, 2023
Prepared by CI:Now for The Health Collaborative

As shown in Figure 3.9, hospitals and free-standing emergency rooms are also concentrated in the northern half of the county, with most hospitals clustered in the Texas Medical Center and downtown. An ongoing development at the time of writing of this report is the impending closure of the privately owned Texas Vista Medical Center, one of two hospitals serving the southern portion of the county. This will leave the Southside with just 110 hospital beds, compared to more than 5,100 on the North side. As of this writing, county hospital district University Health is working with other local health system players to relocate Texas Vista patients and medical residents.[61]



The Texas Health and Human Services Commission (THHSC) maintains current directories of several types of licensed long-term care providers and closures, allowing snapshots of number of facilities and total licensed capacity for intermediate care (ICF/IID, or Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions) and nursing facilities.[62] It is important to note, however, that total licensed capacity does not necessarily translate to beds filled. One can expect that the actual number of residents at any given time could fall well short of licensed capacity, particularly if the facility faces COVID-19 infection control challenges and staffing shortages.

Several facilities closed entirely during the pandemic. Among nursing facilities, that closure rate does not appear to markedly exceed pre-pandemic closures, but ICF/IID closures appear to have spiked during the pandemic. Among nursing facilities, none closed in 2019, one closed in 2020, one in 2021, one in 2022, and none in January or February of 2023. Among ICF/IID facilities, one closed in 2019, none in 2020, four in 2021, two in 2022, and none in January or February of 2023.

Again, capacity does not necessarily translate to people served, but capacity appears to be stable recently. Between mid-November 2022 and mid-March 2023, the overall number of assisted living facilities increased by two, and total licensed capacity increased to 5,689. That slight uptick consisted of an increase in ICD/IID capacity, rising from 85 facilities and 898 capacity to 87 and 904, respectively. It is important to note that 339 of the capacity mentioned – more than a third – in each year is in the San Antonio State Supported Living Center. Nursing facility capacity stayed level, with 64 facilities and total capacity of 7,999 at both measurement points.

Although quantitative data on the issue is lacking, ongoing staff training needs are a clearly a challenge for health care providers. The text box on this page paints a vivid picture of training challenges in local health care.

“I will say that we've hired a lot of nurses that are the first year of school nurses, so that's a whole other problem, because they really spent their residency in a lab and not hands-on at the bedside. And so they can't handle a workload of five or six patients to one nurse. And so we've had to augment with CNA's or other staff to try to help them until they can get used to having the workload and then what they need to do every day for the patients.” – Hospital chief executive

"*Because there was so much challenge and chaos and need for acute care, you wonder whether we had the ability to maintain that same level of training. Even if they [new hires] are competent clinically and we educate them, It is still not quite the same as having one of your own staff members in many ways, and so I think that was an adverse challenge for us in a lot of cases.*" – Hospital chief medical officer

"At times, there were frustrations, because if you've got to do this and you got to do it this way, and you roll it out to your 10,000 employees--and then two days later, you're changing what you had to do….I don't know that is all on the health department as much as they were getting their directives from top down too. And there was so much change in the pandemic as we learned more about it, that drove some of the changes from Metro Health." – Hospital leader

Health Insurance Coverage

> *"Health care shouldn't be tied to employment, for the reason that larger businesses tend to reduce your hours so they don't have to provide you benefits, particularly health care benefits, and then seeing how people are losing their jobs just dependent on their boss's values and vision and profit"* - Office of a San Antonio City Council District

Health insurance coverage is arguably the most important factor in financial access to health care in the U.S. However, as with provider availability, coverage does not ensure access. A provider may not accept a resident's insurance plan, or may not be accepting new patients at all, and families may not be able to afford out-of-pocket expenses. Further, many health insurance plans offer limited or no benefits at all for mental health, dental, or vision care.

Health insurance coverage rates vary dramatically by age group. Coverage is highest by far in the 65 and older age group, the overwhelming majority of whom are eligible for Medicare.[5] The lowest rates are seen among adults ages 19 to 64, as Medicaid in Texas extends only very limited eligibility to low-income pregnant women and people with serious disabilities.

Coverage rates also vary by race and ethnicity. Figures 3.10 and 3.11 show the percent of each race/ethnicity group who are uninsured by age. These estimates should be interpreted with caution for any group except total population, Hispanics, and whites. American Community Survey 1-year estimates rather than 5-year estimates were needed to see a recent trend, so all other population groups have small sample sizes. As a result, the estimates for smaller groups show considerable "bounce" in the trend line and have wide margins of error, though those margins of error are omitted from these charts for readability. Unfortunately, the pandemic and the Decennial Census workload prevented the U.S. Census Bureau from releasing 2020 estimates that could be trended "apples to apples" with prior and subsequent years,[63] so although each trend line is continuous, the 2020 data points are missing from both charts.

Beyond the very coarse measure of whether people have any kind of health insurance coverage at all, the quality and extent of that coverage matters greatly. While it is known that higher-quality and more comprehensive coverage is less accessible to people with less to spend on health insurance premiums and out-of-pocket costs, we do not have good local data to understand coverage trends and gaps. Coverage parity for dental care and behavioral health care – not just medical care – has always been an issue, and though many plans help with catastrophic health events, there is much less help with preventive and primary care services. As discussed elsewhere in this report, expanded telehealth in both public (e.g., Medicare and Medicaid) and private insurance may help meaningfully increase access to behavioral health, but not dental care.

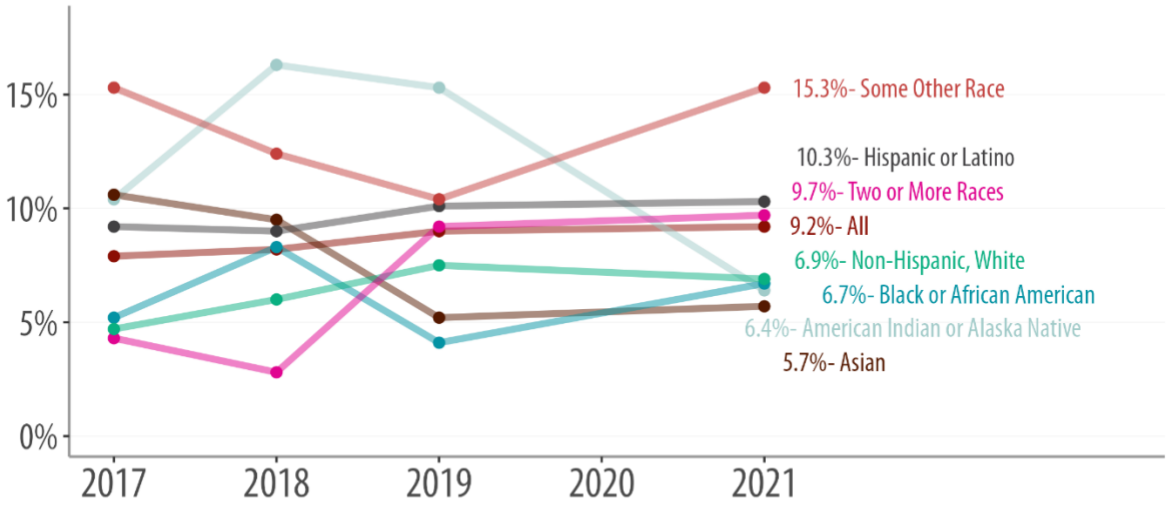
Federal subsidies and changes in state-level policy in Texas have made Affordable Care Act marketplace gold-level plans, with higher quality coverage than silver-level plans, more affordable to Texas individuals and families, with insurance plans picking up about 80% of

[5] Medicare eligibility does not extend to undocumented immigrants or all legal residents.

costs. Further, an estimated three-quarters of those who do buy health insurance on the marketplace are able to secure gold-level coverage for a $0 premium.[64]

Fig. 3.10 Percent population under 19 uninsured by race/ethnicity

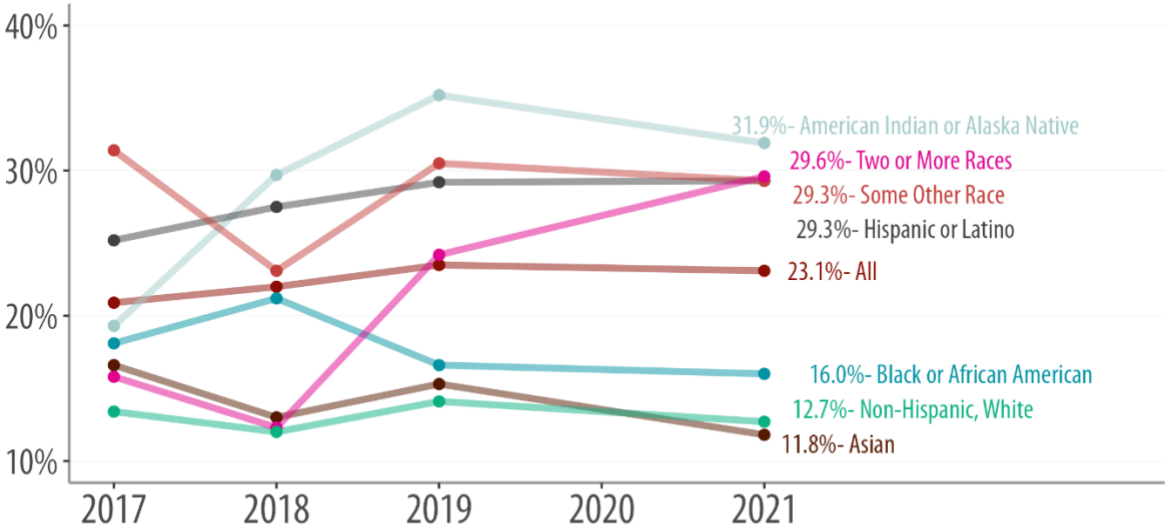
Bexar County, Texas



Some estimates are unreliable
2020 ACS 1-Year Estimates not available
Source: American Community Survey 1-Year Estimates. Table: C27001 B-I
Prepared by CI:Now for The Health Collaborative

Fig. 3.11 Percent population 19 to 64 uninsured by race/ethnicity

Bexar County, Texas



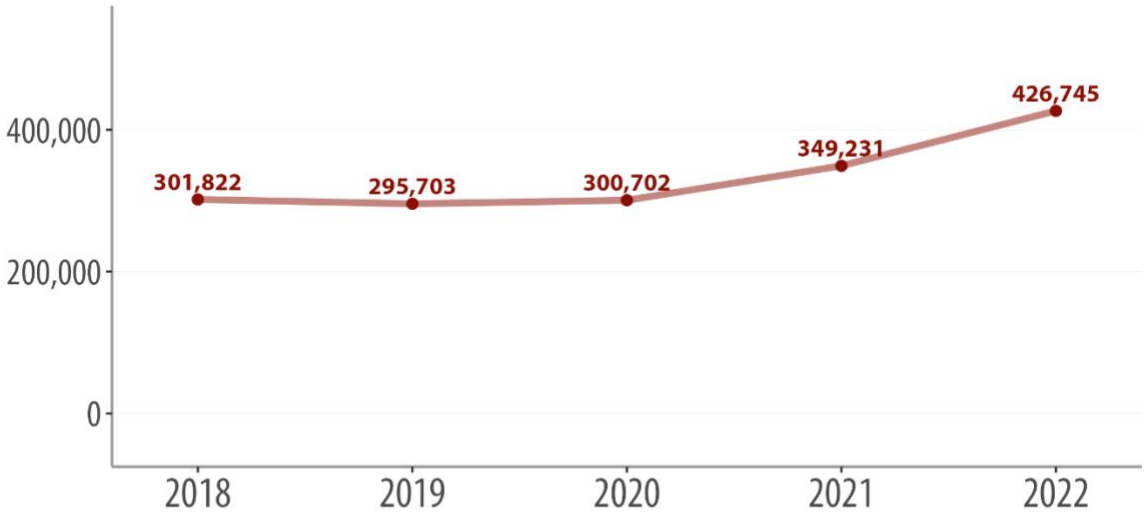
2020 ACS 1-Year Estimates not available
Source: American Community Survey 1-Year Estimates. Table: C27001 B-I
Prepared by CI:Now for The Health Collaborative

> *"It was hard for the insurance to figure out that even though they [patients] had been at the hospital for 15 days or 30 days, they still weren't well enough to go home, and they needed additional care, and they needed to authorize that additional care. And that's if the patient had insurance."* - Hospital chief executive

The total annual Medicaid caseload, which can generally be considered to be the number of people in Bexar County with Medicaid coverage, increased markedly in state fiscal years[6] (SFY) 2021 and 2022 after fairly level numbers between SFY 2018 and 2020 (Figure 3.12.). Looking at the trend for each Medicaid-eligible group (Figures 3.13 through 3.16), it becomes clear that the increase was driven primarily by retaining pregnant women and children on the Medicaid rolls; disability- and Medicare-related cases changed very little.

Fig. 3.12 Total Medicaid caseload*

Bexar County, Texas

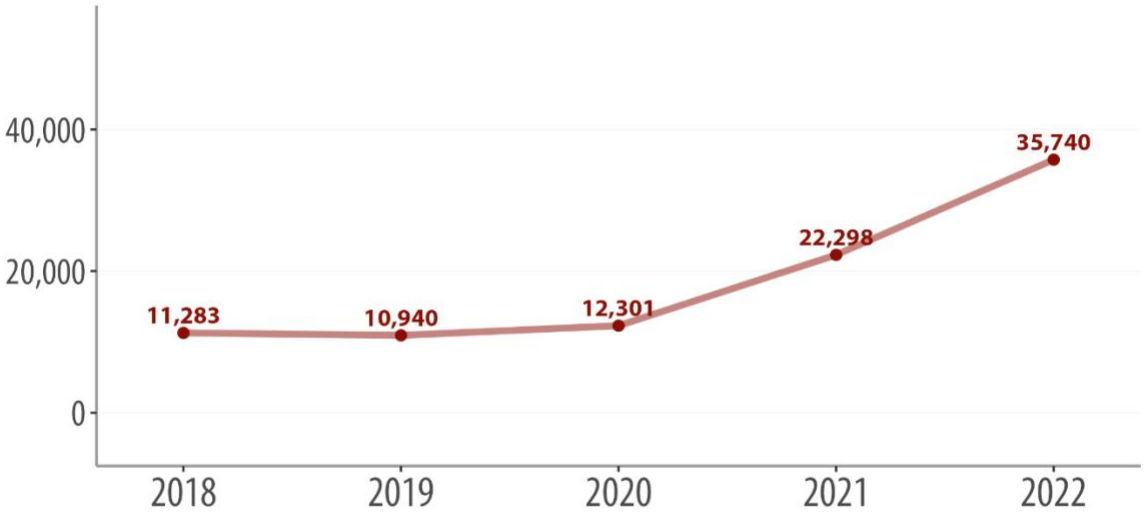


*Preliminary (November 2022)
Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

[6] The state fiscal year runs from September 1 to August 31 and is expressed in terms of the year it ends, meaning that, for example, the period labelled "2020" in this data is for the 12-month period ending August 31, 2020. SFY 2022 numbers were considered preliminary rather than final at the time this data was collected.

Fig. 3.13 Medicaid enrollment: Pregnant women*

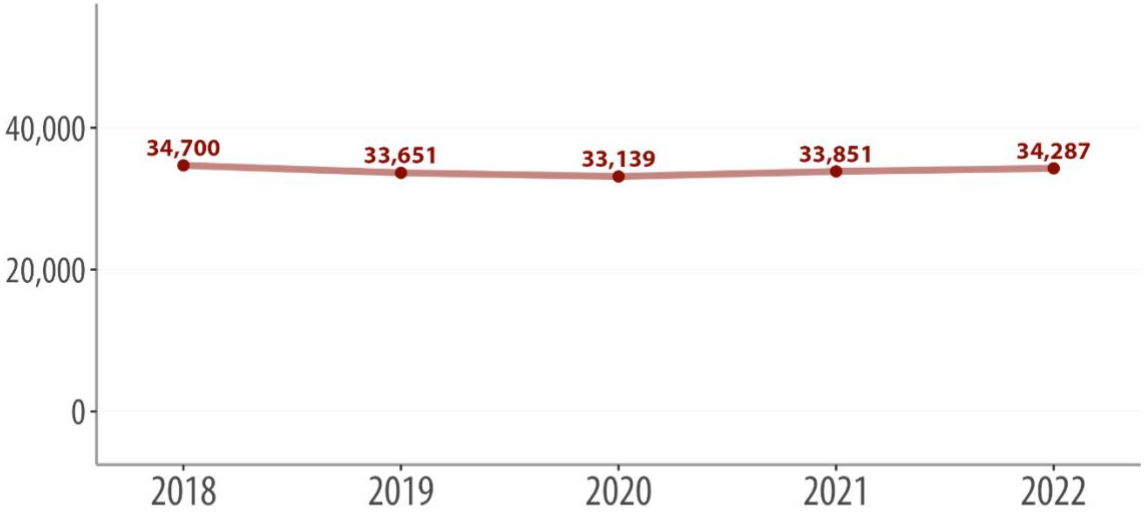
Bexar County, Texas



*Preliminary (November 2022)
Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.14 Medicaid enrollment: Disability-related cases*

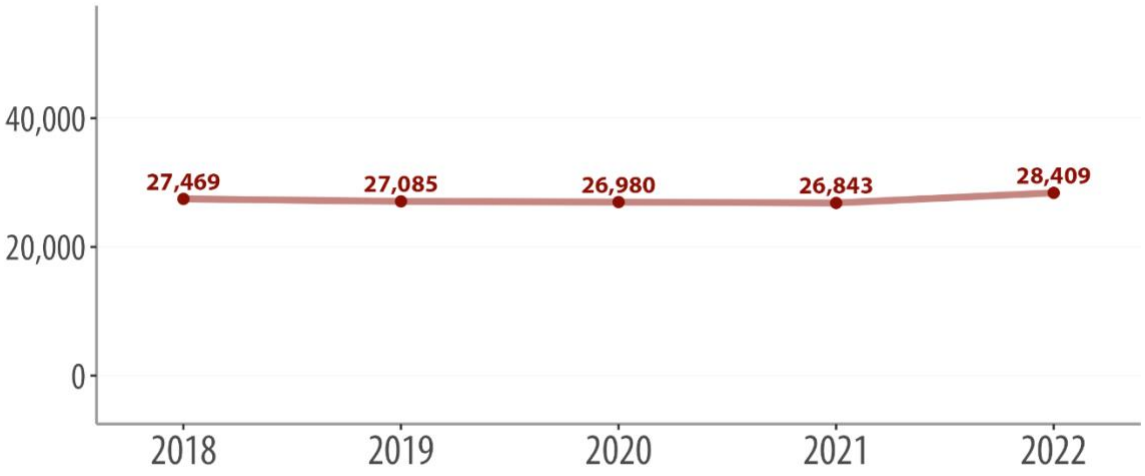
Bexar County, Texas



*Preliminary (November 2022)
Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.15 Medicaid enrollment: Aged and Medicare related cases*

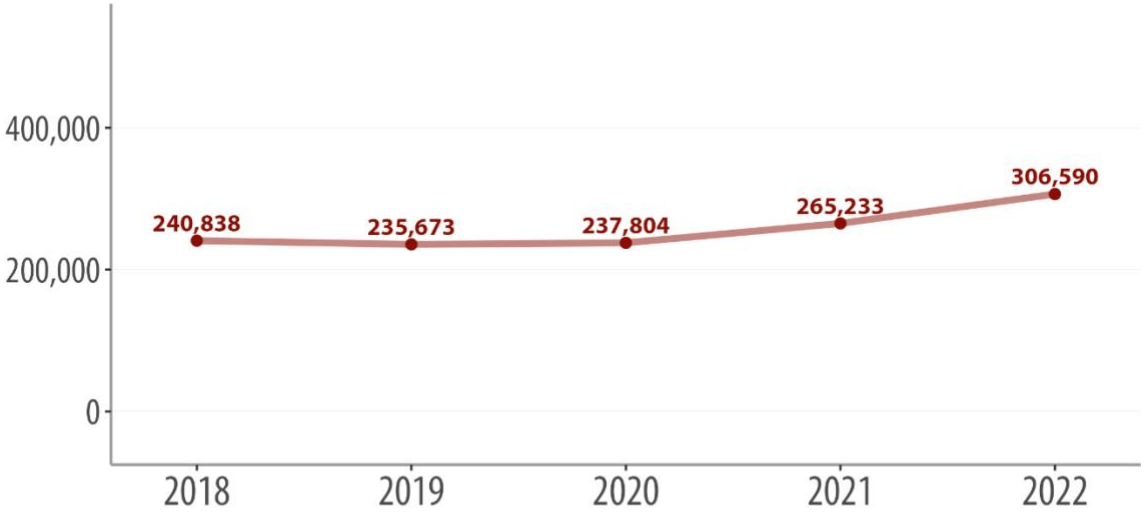
Bexar County, Texas



*Preliminary (November 2022)
Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

Fig. 3.16 Childrens Medicaid & CHIP enrollment*

Bexar County, Texas



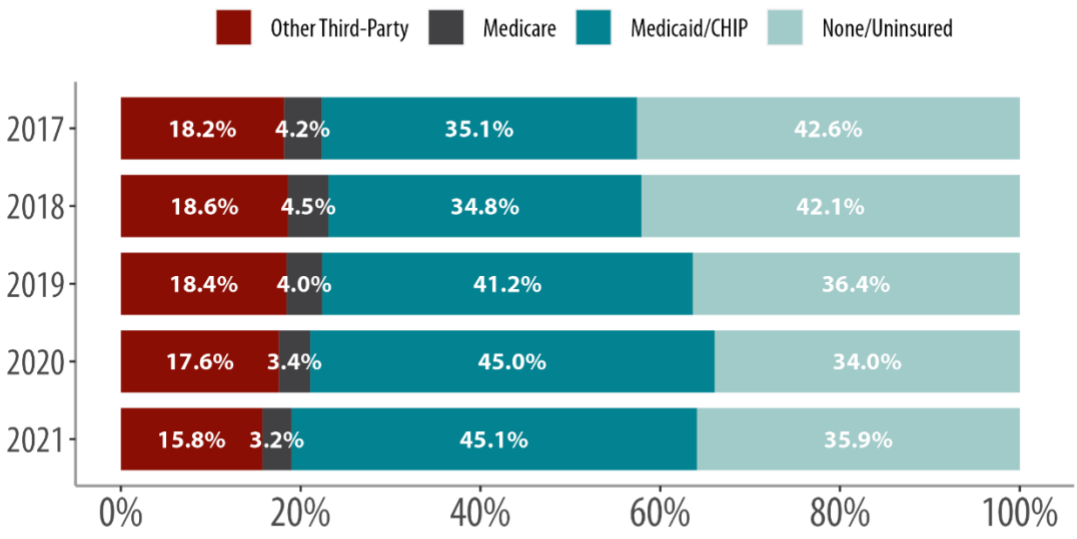
*Preliminary (November 2022)
Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

Another way to see changes in the uninsured rate is to look at payor mix for patients receiving care from health care organizations designed to increase access for low- and moderate-income people, including those without insurance. Figures 3.17 and 3.18 below show the relative percentages of patients by primary payor category for two local Federally Qualified Health Centers, commonly called FQHCs. Among patients of both FQHCs, the "None/Uninsured" proportion of patients was already declining, and the "Medicaid/CHIP" (Children's Health Insurance Plan) proportion of patients was already growing, prior to the start of the pandemic.

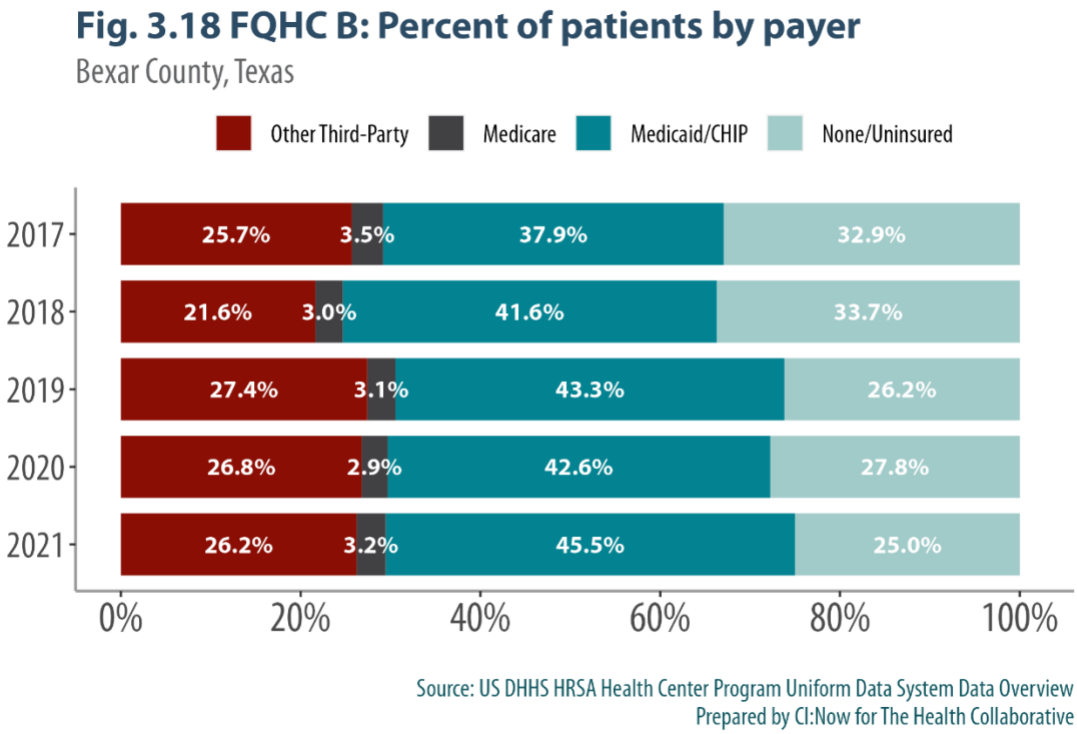
The decline in the percent of FQHC A patients with "Other/Third-Party" coverage may speak to job losses and transitions causing termination of employer-sponsored health insurance, but it could also mean the pandemic hindered efforts to enroll people in ACA Marketplace coverage, which has been a major driver of recent decreases in the county's uninsured rate. That same pattern was not seen for patients of FQHC B.

Fig. 3.17 FQHC A: Percent of patients by payer

Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative



Continuous Medicaid Coverage

Many of the changes to reimbursement and benefits to both insured and uninsured people derived from the national emergency and public health emergency declarations, which were put in place in early 2020 and expired May 11, 2023.[65] One of the most significant implications for Bexar County's health care system and residents was *continuous Medicaid coverage*, which allowed Medicaid enrollees to remained automatically covered.

That automatic coverage expired at the end of March, prior to expiration of the emergency declarations. As of this writing, the Texas Health and Human Services Commission (HHSC) is directing eligible enrollees to resubmit renewal applications.[7] It is difficult to overstate the negative impact this loss will have on the health and well-being of pregnant women, children, and new mothers and their families, as well as on the health care providers serving those community members.[66]

Other Financial and Policy Factors

Increasing costs and loss of COVID-era protections mean that shelter, food, and other goods and services directly compete against health care for every household dollar. The U.S. Bureau of Labor Statistics Consumer Price Index (CPI) inflation calculator indicates that what cost $100 in January 2020 cost $116 in January 2023. Just a few key competing expenses are highlighted

[7] A useful *End of Continuous Medicaid Coverage Ambassador Toolkit* with information for providers, Medicaid enrollees, and SNAP recipients is available on the THHSC website at https://www.hhs.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-provider-information/end-continuous-medicaid-coverage-ambassador-toolkit.

here: housing, utility/energy, and food costs. At 10.1% and 8.7% as compared to 6.4% overall, food and energy have seen the highest 12-month percentage change in the Consumer Price Index.[67]

Many Bexar County residents, particularly renters, were already housing cost-burdened prior to the pandemic. During the pandemic, housing prices have risen, eviction moratoriums have long ended, even for residents of public housing,[68] and rental assistance has been limited and is not required to be accepted by the landlord.[69] Local utility companies suspended disconnections for some time, as a substantial proportion of customers fell behind on their bills. San Antonio Water System (SAWS)[70] and CPS Energy resumed normal billing and disconnections late in 2021, and CPS Energy reinstated late fees in January 2022.[71]

Similarly, food access was inequitable prior to the pandemic, but in April 2020, San Antonio made national headlines for its long lines of cars at the San Antonio Food Bank.[72] The same federal COVID emergency declaration “continuous coverage provision” that protected people from being dropped from the Medicaid rolls also applied to the Supplemental Nutrition Assistance Program (SNAP), but this year, families saw a decrease in or complete elimination of benefits.[73] “Emergency allotment” benefits were established in April 2020 for SNAP recipients, so recipients had been receiving the maximum allowable benefit based on family size – a minimum of an additional $95 per month. Those additional benefits ended in March 2023.[74]

"I've had conversations with constituents who, you know, they had a car at the start of the pandemic, and they don't anymore because they had to make choices, right, on what to pay. And they've had to sell their car and rely on public transportation. So getting access to doctor's appointments is another challenge." - Office of a San Antonio City Council member

Telehealth and Digital Access

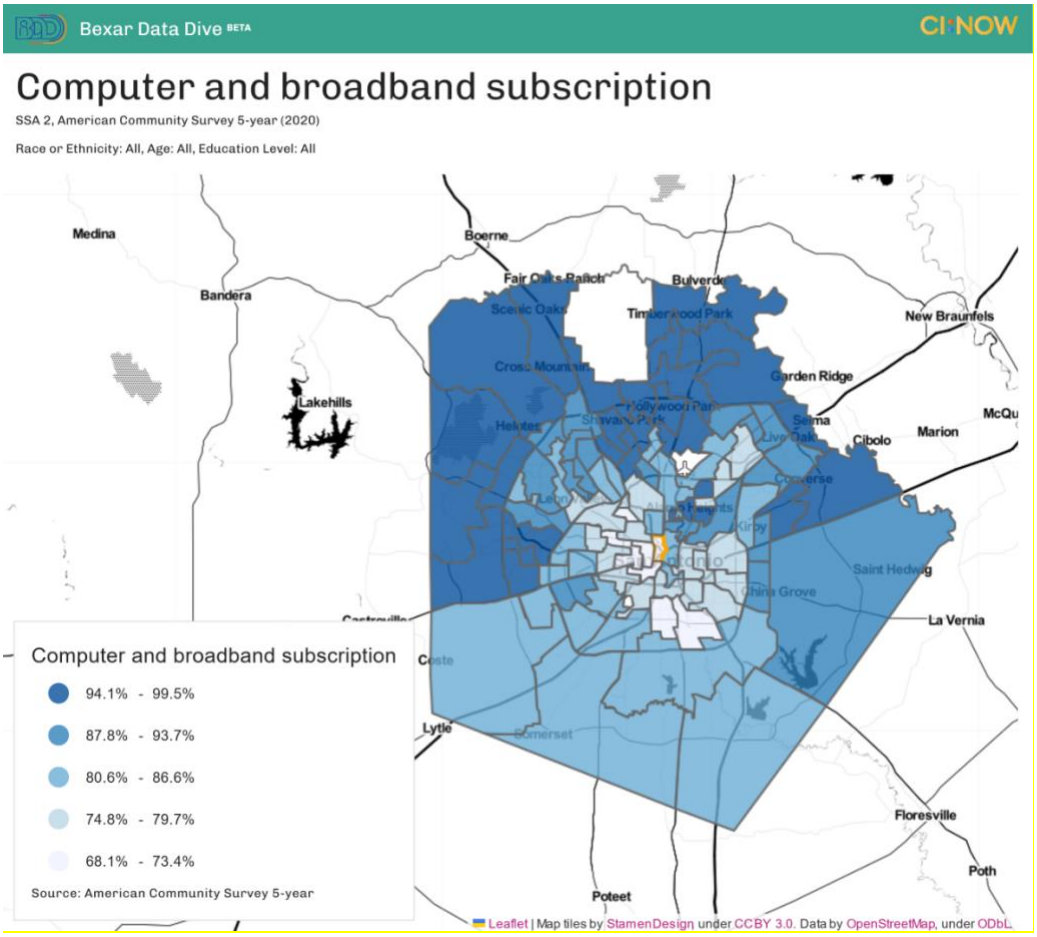
Telehealth can expand access by removing transportation barriers, and to a lesser extent language barriers, as the interpreter does not need to be at the same site as the health care provider. Telehealth can also mitigate provider shortages if people are able to work entirely virtually with a provider anywhere in the state or country, but in practical terms, that scenario is greatly constrained by payor and provider policies. Finally, the technology can be used to improve access for populations experiencing specific barriers that the general population may not experience, including families with children in schools and children with autism spectrum disorder.[75]

Although telehealth can be solely over the phone, video is commonly used, meaning a device and an internet connection are required. A smartphone may meet that need, but digital access via home computer and broadband subscription remains uneven across geography and demographic groups. A computer and broadband connection may also make it easier to use a patient portal to communicate with a provider, set an appointment, and receive lab results.

"In some cases, you've really got to lay hands on the patient, but for many, a lot of these visits could be managed through telehealth. And sometimes that's a benefit… You can reach individuals who may not have easy access or that live in remote areas or that are in rural areas. You know, we have a hospital at home program that we developed under a waiver. Through this, the federal government and approved by the state, where if you're a certain type of patient, you're still an inpatient. But we can actually care for you at home. And we do that through iPad connections that we have, and you don't even have to have Wi-Fi. We have a hot spot that we provide. We have a nurse that visits twice a day. We have a virtual visits from physicians." – Hospital chief medical officer

An estimated 87% of Bexar County households have a computer and broadband subscription. However, that percentage is only about 75% among households headed by a person 65 and older, 71% for households headed by a person with less than a high school diploma or GED, and far lower in neighborhoods on the near southside and near westside than in the outlying areas in the northern half of the county (Figure 3.19).

Fig. 3.19 Percent of households with computer and broadband subscription
Bexar County, Texas



Source: U.S. Census ACS 2020 5-Year Estimates, via Bexar Data Dive (dive.cinow.info)
Prepared by CI:Now for The Health Collaborative

"The digital literacy component is huge in my district. So now, not only the digital divide but also digital literacy. And by the way, health literacy is already difficult for a lot of residents in my area because a lot of them speak Spanish, or a lot of them read at a certain grade level." - Office of a San Antonio City Council member

"The community that I represent has a large population of seniors, so I think of my seniors who have landlines and don't have Internet. And who may have Internet but don't know how to use the computer; who may have a computer but may not have access to the Internet. And then if they do have Internet, phone and access to your computer, just navigating, filling out the documentation to get into the meeting is very difficult. And you know, we've seen it with our city meetings with Zoom and WebEx."- Office of a San Antonio City Council member

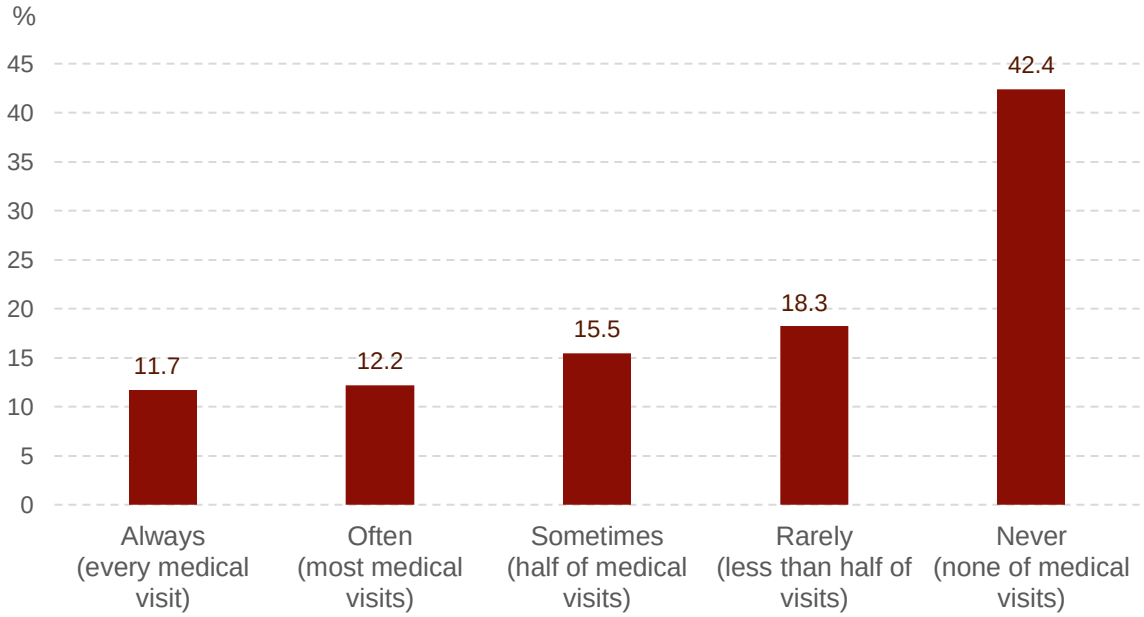
Unfortunately, no data source offers comprehensive information about the extent of telehealth capacity or utilization locally. It is almost certain, however, that telehealth use has expanded to one degree or another in virtually every local health care setting. As with any workflow or policy, providers' usage of telehealth can change over time. Some providers may have adopted it heavily early in the pandemic and then backed off in favor of more in-person visits once local vaccination rates increased. Others may have been slow to adopt telehealth early on but have become more comfortable with its use over time.

As shown in Figure 3.20, 39% of survey respondents used telehealth during the COVID-19 pandemic for at least half of their medical visits, while 42% never used telehealth. When further analyzing the utilization of telehealth by respondents' health insurance status (Figure 3.21), 59% of uninsured respondents never used telehealth, as compared to 37% and 31% of publicly and privately insured respondents, respectively.

Figure 3.22 breaks the same data out by race/ethnicity group. Respondents identifying as Hispanic were most likely (43%) of all race/ethnicity groups to have never utilized telehealth during the COVID-19 pandemic. The data for Asian and other-race/ethnicity respondents should be interpreted with caution due to the relatively small sample size.

Fig. 3.20 Use of telehealth by Access to Care Survey respondents

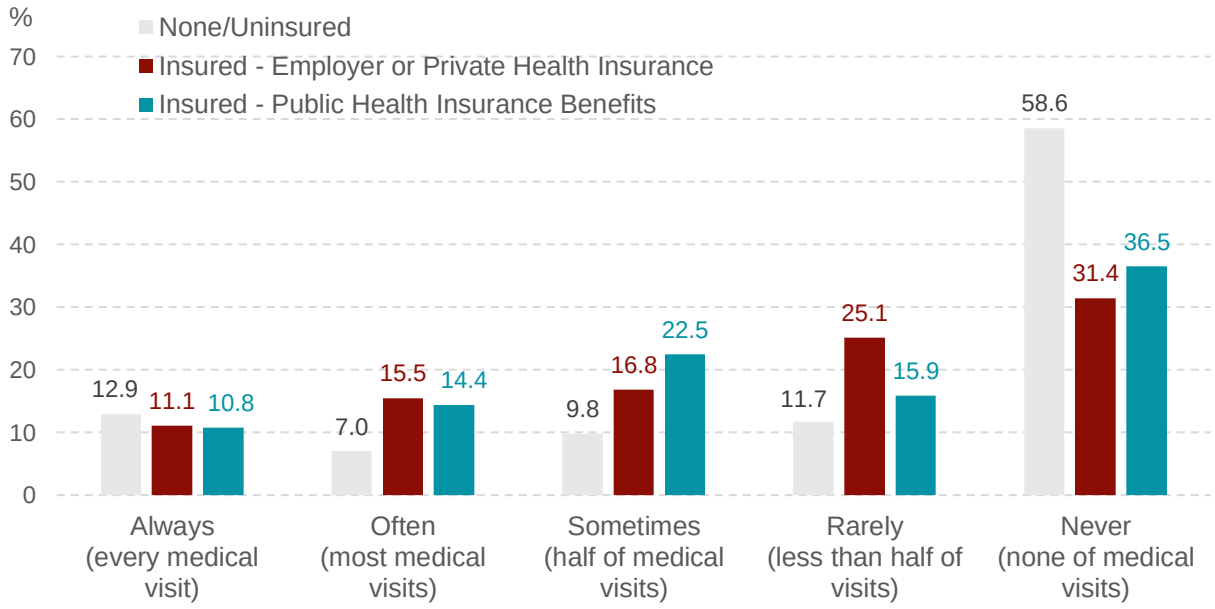
Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Fig. 3.21 Use of telehealth by survey respondent insurance status

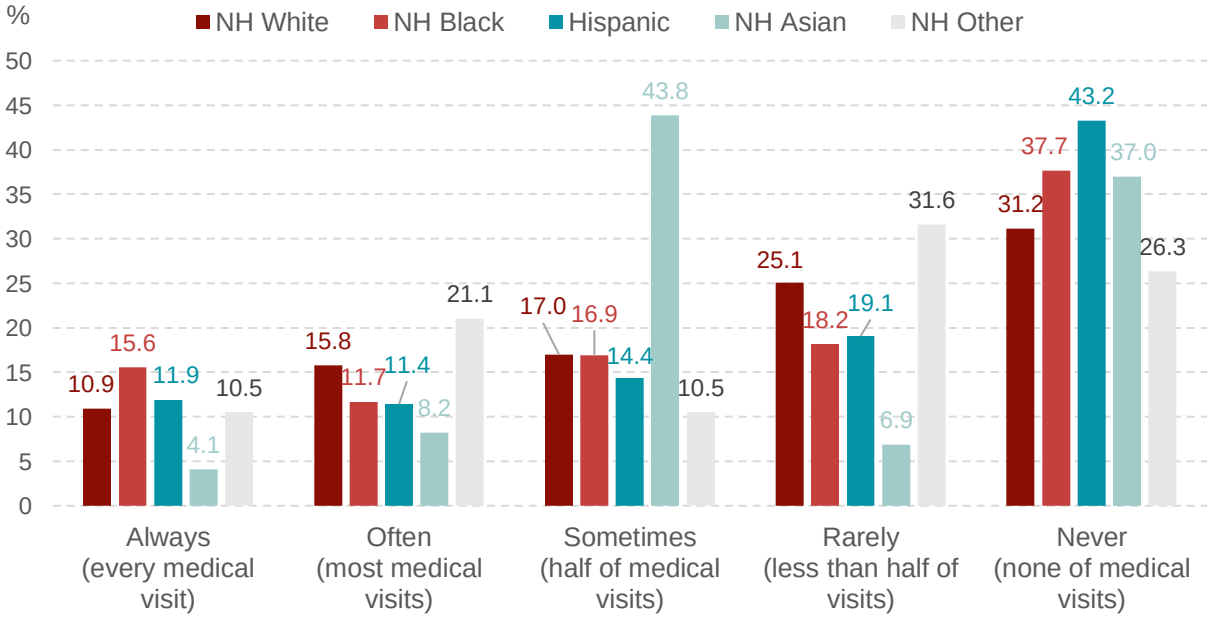
Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Fig. 3.22 Use of telehealth by survey respondent race/ethnicity

Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Another important group not representative of the general population is people living with moderate to severe mental illness. The Center for Health Care Services, the local mental health authority, administered a survey to its consumers to learn their preferences about telehealth visits. Seventy-one percent of consumers reported having attended a telemedicine appointment with their prescriber or care manager in the past year. When asked “Did your telemedicine appointment meet your health care needs?” 81% responded “yes.” When asked “Would you welcome future telemedicine appointments should they be available?” 90% responded “yes” (B. Santos, personal communication, September 8, 2022).

Telehealth reimbursement policies and rates have varied by payor and over time through the pandemic. Coverage by private health insurance varies by carrier and plan. Recent legislation detaches an expansion of Medicare telehealth from the public health emergency and extends those benefits through December 2024. However, states largely retain the power to determine Medicaid benefits, including telehealth coverage.[76]

Texas has been developing Medicaid rules on medical, behavioral, case management, and other supportive teleservices since related legislation (HB 4; SB 670) was passed in the Texas legislature’s 2021 session to enable and guide telehealth coverage after the end of the public health emergency declarations. The rules allow and disallow (e.g., dentistry) various services by type, provider type (e.g., Federally Qualified Health Centers and Rural Health Clinics), and modality (telemedicine, telehealth, and audio-only).[77] Notably, although CHIP office visit co-payments waived under the public health emergency will be reinstated in May, co-payments are not required for services delivered to CHIP recipients via telemedicine[8] or telehealth.[78]

"Some of the reimbursements improved, particularly around telehealth. That was probably one of the big barriers to most systems sort of jumping in because even though I think there was good intention and recognition that this could be a benefit, if you're not paying for it, it's a zero-sum game. Well, when that became paid for, at least it was like, I can do both. I can do face-to-face. I can do virtual and actually reach larger numbers of patients. My no show rate goes down with virtual visits because people tend to show up when you connect to them virtually rather than if they have barriers to transportation to come into your clinics. So I think that was probably the most significant reimbursement improvement. - Hospital chief medical officer

[8] Texas Medicaid rules make a distinction between the terms “telemedicine” and “telehealth”, but “telehealth” is used in this report to describe delivery of any health-related service using telecommunication technology.

Access and Utilization

Access to health care does not necessarily translate to appropriate utilization of care, and conversely, utilization does not necessarily mean that access was easy. However, both types of indicators are important in understanding whether Bexar County residents got the care they needed during the pandemic. Because they are interrelated, and to some degree utilization can serve as proxy measure of access, the two types of indicators are covered together in this section of the report.

211 Information and Referral Requests

The Texas Health and Human Service Commission's 2-1-1 Texas information & referral (I&R) service provides information on a wide variety of health and social services via phone, online query, and online chat. I&R requests to this service reasonably indicate care-seeking and/or a scarcity of services and resources.

The total number of requests for two broad service categories[9] – *Healthcare and COVID-19* and *Mental Health & Addictions* – in Bexar County are trended in Figure 4.1 below. To better align the data with pandemic timing, instead of calendar years, each time period in the chart is a 12-month period beginning March 1 of the year indicated. Thus, the period labelled "2020" is March 1, 2020, to February 28, 2021.[10] After a 55% increase in that year over prior year, total *Healthcare & COVID-19* requests returned to pre-pandemic levels, then dropped sharply in 2022. *Mental Health & Addictions* requests rose only about 8% in 2020 and then fell by more than 40% for 2021 and 2022.

Figure 4.2 trends specific request totals within the *Mental Health & Addictions* category, and Figures 4.3 and 4.4 trend requests for the subgroup of non-COVID services and resources within the larger *Healthcare & COVID-19* category. The striking pattern is that requests dropped for virtually every service/resource in both categories. The primary exception was mental health services requests, which spiked in 2020 before dropping below pre-pandemic levels.

These trends are best interpreted in the context of other indicators of access. For example, Medicaid continuous coverage may have contributed to the decline in health insurance requests, but decreased care-seeking for non-crisis services like preventive and primary medical and dental care likely played a role as well. It is probable that when the pandemic arrived, a substantial proportion of people put routine care on the "back burner" in favor of seeking help for acute issues like COVID-19 itself and COVID-driven mental and behavioral health needs.

Some requests have seen an uptick in the March 2022 to February 2023 period, including requests for substance abuse and addictions, mental health facilities, medical providers, and

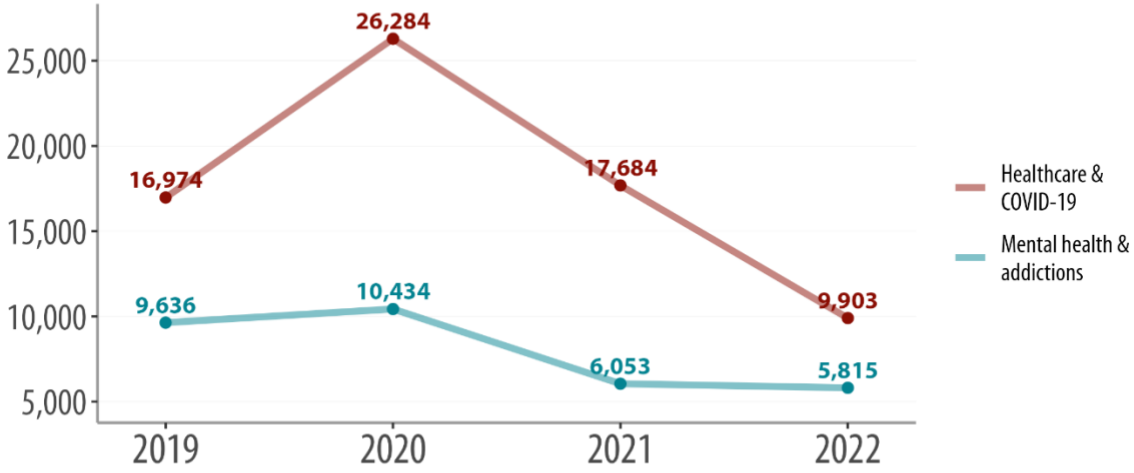
[9] All categories are defined by 2-1-1

[10] Unfortunately the dataset starts January 1, 2020, so the 2019 figure is annualized from the January and February 2020 total. As the dataset was queried in February 2023, the 11-month request totals for March 2022 to January 2023 were annualized to estimate a 12-month total.

nursing homes and adult care. These trends may represent emerging pandemic consequences, the beginning of a return to pre-pandemic levels, or both.

Fig. 4.1 Count of total 211 requests by health-related category

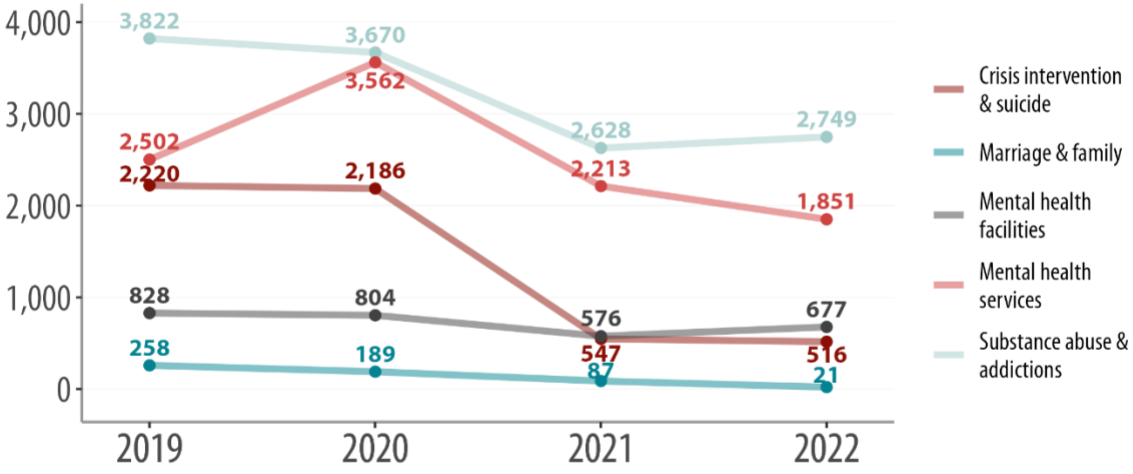
Bexar County, Texas



Each year is from March of that year to February of the next
Source: Texas 2-1-1 Counts
Prepared by CI:Now for The Health Collaborative

Fig. 4.2 Count of 211 requests for mental health & addictions

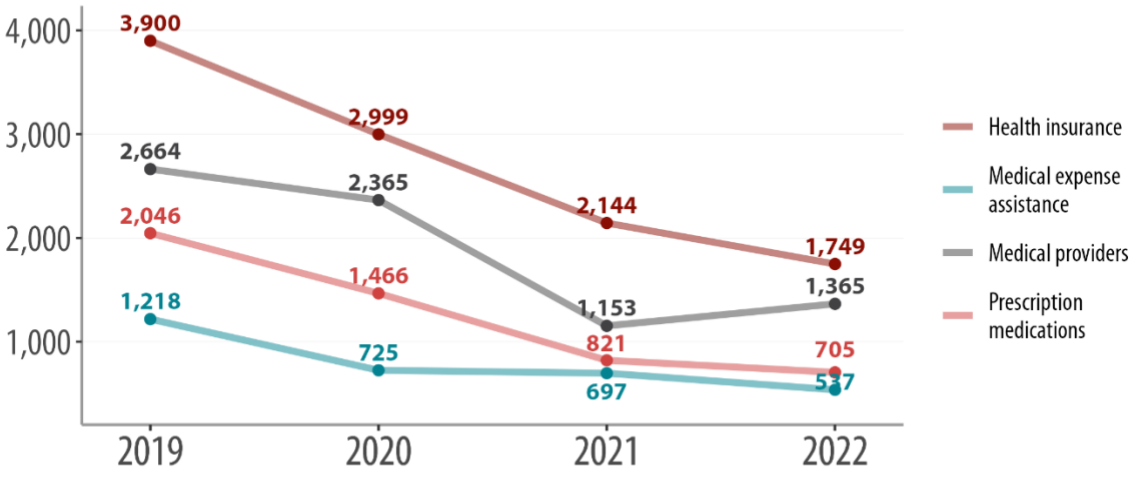
Bexar County, Texas



Each year is from March of that year to February of the next
Source: Texas 2-1-1 Counts
Prepared by CI:Now for The Health Collaborative

Fig. 4.3 Count of 211 requests for medical care and prescriptions

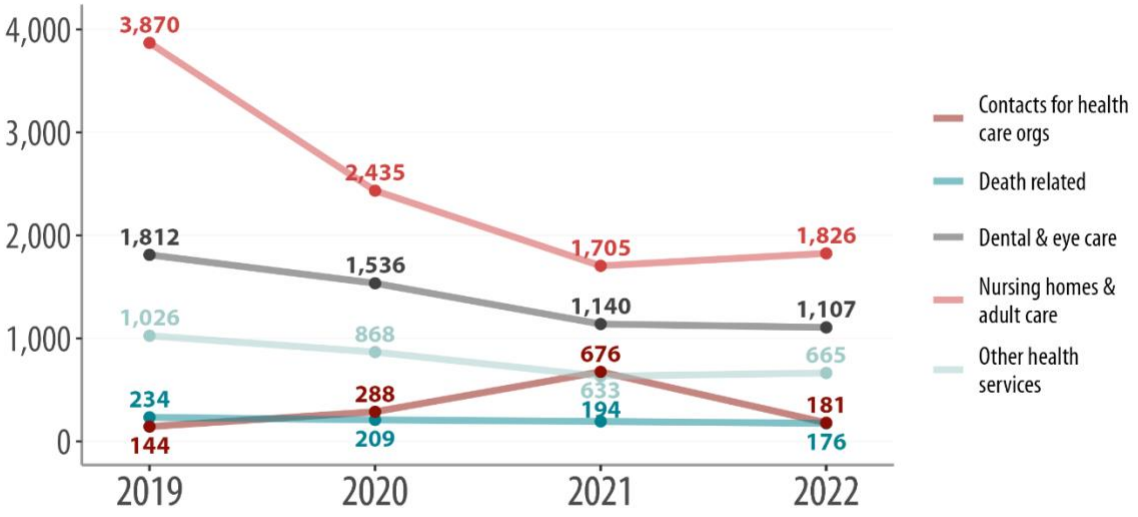
Bexar County, Texas



Each year is from March of that year to February of the next
Source: Texas 2-1-1 Counts
Prepared by CI:Now for The Health Collaborative

Fig. 4.4 Count of 211 requests for other healthcare services

Bexar County, Texas



Each year is from March of that year to February of the next
Source: Texas 2-1-1 Counts
Prepared by CI:Now for The Health Collaborative

Preventive and Primary Care

"What became more difficult to access were preventative health care services, checkups. And I'll tell you why. The price on them went up astronomically, so…. that price is not really low cost or affordable anymore for our clients. – Local community health leader

Unfortunately, the data on preventive and primary care utilization among the general population is greatly lacking. One of the key sources usually relied on is the Behavioral Risk Factor Surveillance System (BRFSS) telephone survey of adults. The sample size is small, even at the county level, which results in uncertain estimates with a wide margin of error. Moreover, although it is administered annually, many question modules are included in alternating years as a way to reduce survey length while still gathering important data. For example, questions related to cancer screening and oral heath are asked only during even years (e.g., 2018, 2020, 2022). The margins of error are wide enough that no clear differences emerge between 2018 and 2020 figures, and data for 2022 is not yet available.[11] A year from now this dataset will be of more use in understanding health care access and utilization, but the small sample size will not ever support a good understanding of differences by sex, age group, race/ethnicity, education, or other factors.

One question that is included in the BRFSS survey every year is whether there was a time in the past 12 months when the respondent needed to see a doctor but could not because of the cost. Figure 5.1 trends that data for all, female, and male respondents. The year-to-year differences from 2018 to 2021 are not great, particularly given the wide confidence intervals for this dataset, but the difference in estimates for females and males seems consistent.

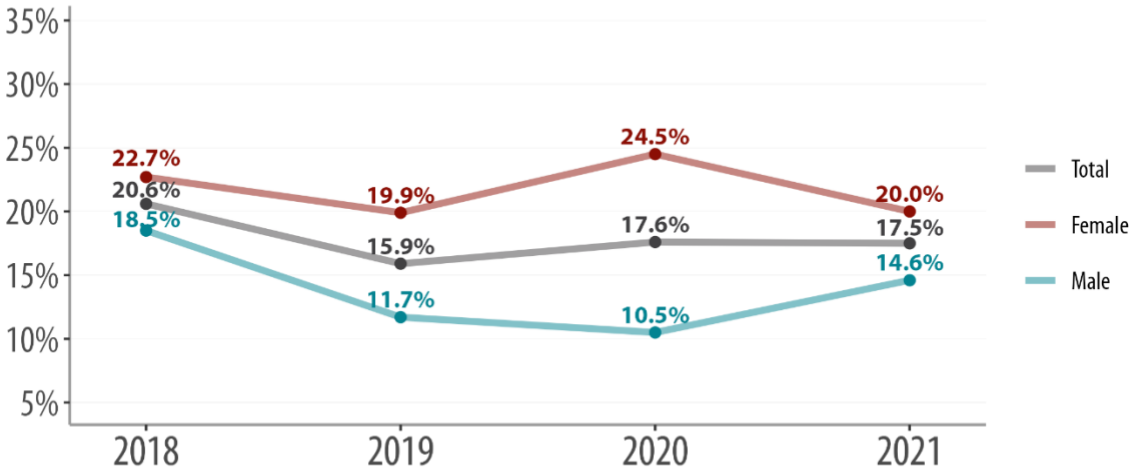
Although data is not consistently available for every age group, another BRFSS question asked annually is whether the respondent had a routine checkup in the past year. That proportion generally rises with age, and two key age groups for which data is available are shown in Figure 5.2. Although the change from 2018 to 2021 is not dramatic, particularly given the relatively wide confidence intervals, the gap between the two age groups remains.

"Some of my clients are like, 'I'm not gonna go because I'm gonna be slapped with a big bill that I can't afford.' So a lot of them I've talked to say that they're just, like, toughing it out, you know. Even right now, I have a client that has all these medical issues, and she was still, like, trying not to go. And then when she finally went, because I convinced her to go, you know, it came to find out that she has all these things and needs surgery." - Community health worker

[11] Any available Bexar County data not included in this report can be explored via the Texas Department of State Health Services' Texas Health Data portal. Navigate to "Data Tables, 2011-2021" at https://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/behavioral-risk-factor-surveillance-system

Fig. 5.1 Percentage of adults who needed to see a doctor in the past year but could not because of cost

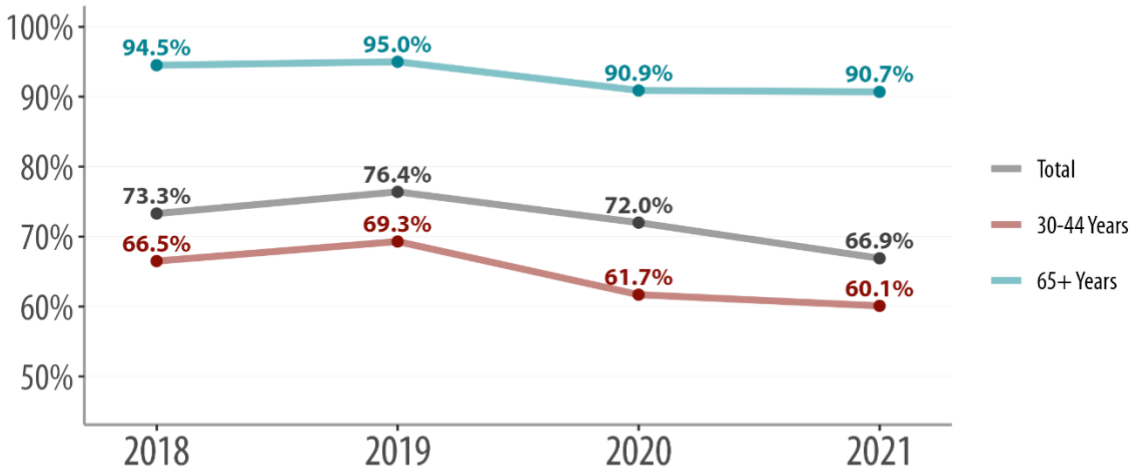
Bexar County, Texas



Source: Texas Behavioral Risk Factor Surveillance System
Prepared by CI:Now for The Health Collaborative

Fig. 5.2 Percentage of adults in key age groups who had a routine checkup in the past year

Bexar County, Texas

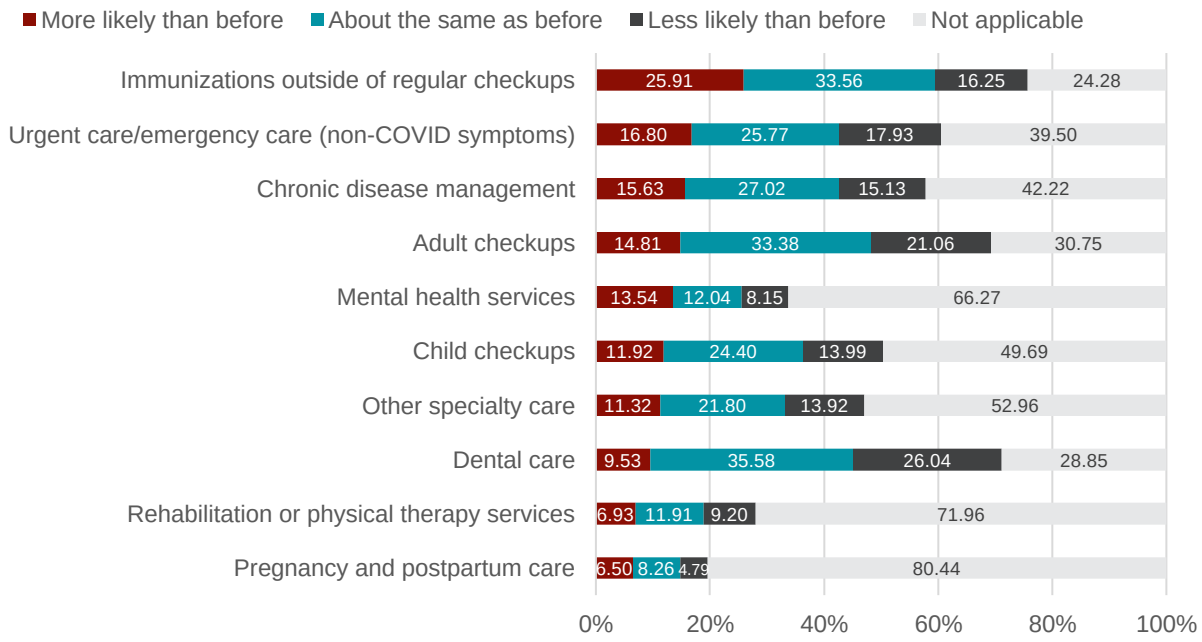


Source: Texas Behavioral Risk Factor Surveillance System
Prepared by CI:Now for The Health Collaborative

Again, although respondents are not representative of the general population of San Antonio or Bexar County, the Access to Care community survey administered for this project in spring 2023 includes information on the frequency of use of different types of health services before and after pandemic onset. In Figure 5.3 below, each horizontal bar represents one type of health care service, such as adult checkups, mental health services, and urgent/emergency care (non-COVID symptoms). The segments of each bar represent various levels of utilization for each health care service during the COVID-19 pandemic, including more likely (to utilize) than before (the pandemic), about the same as before, less likely than before, and not applicable.

Fig. 5.3. Service utilization during the pandemic by Access to Care Survey respondents

Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

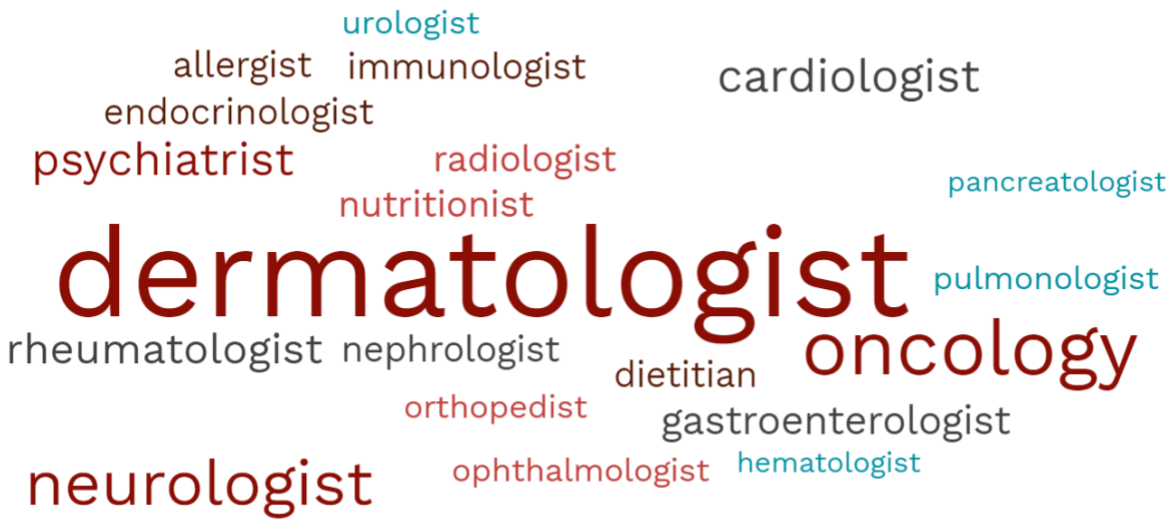
About a quarter of respondents reported that their household members were more likely than pre-pandemic to use immunizations outside of regular checkups. The “more likely” percentages drop off markedly after that, ranging from 17% for urgent/emergency care (other than for COVID-19 symptoms) to 7% for rehabilitation or physical therapy services and for pregnancy and postpartum care. Looking at which services respondents’ household members were *less* likely to use than they were pre-pandemic, dental care topped the list at 26%, with the lowest being for pregnancy and postpartum care. Unfortunately, the “not applicable” response, which ranged from 24% to 80%, is a bit difficult to interpret. It is understandable why respondents might select “not applicable” for pregnancy and postpartum care, mental health services, or

urgent/emergency care. However, selecting “not applicable” for routine adult or child checkups or dental care likely means that household members did not see a value in preventive medical or dental care.

Figure 5.4 is a graphic representation of the frequency with which survey respondents mentioned other types of specialty care used by household members. The larger the font size, the more frequently that specialty was mentioned. The most frequently mentioned specialty care used during the COVID-19 pandemic was dermatology, followed by oncology and neurology.

Fig. 5.4. Other health services used by Access to Care Survey respondents during the pandemic

Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

"San Antonio's growing. And if we're going to continue to care for the patients, then we need, you know, there's gonna have to be some capital expansions. Where we have enough beds to care for our community, I would think maybe where you could say health departments could help is if there were more preventative programs, education around heart disease, stroke, diabetes, that type of thing, to keep patients well enough not to have to come to the hospital. But when I think of how fast San Antonio is growing, I think we're just gonna continue to see the increased demand over the next four or five years." – Hospital leadership

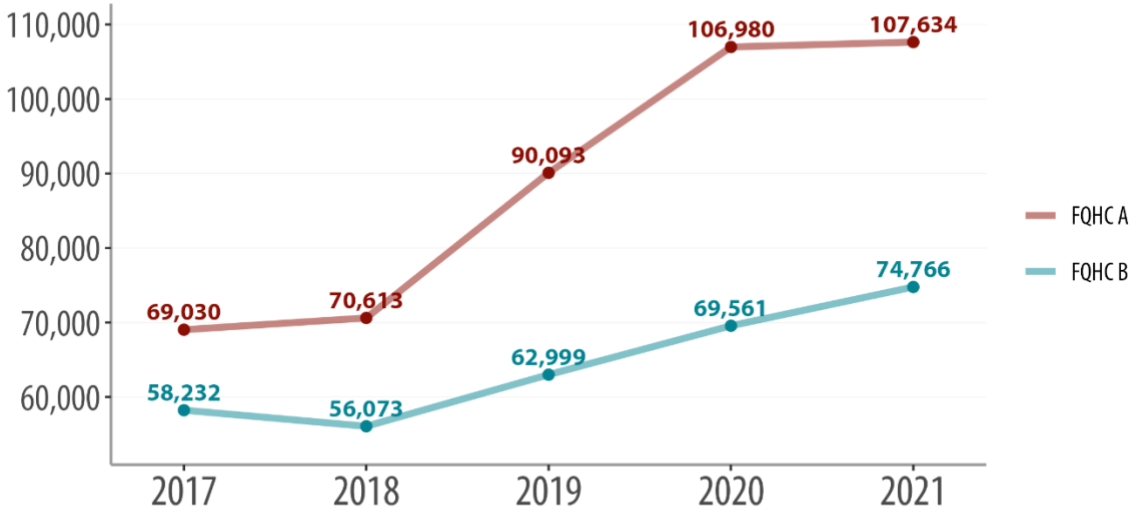
A publicly available source of data that is much more complete but only for a subset of the county population is the extensive Uniform Data System (UDS) reporting required of Federally Qualified Health Centers (FQHCs). Again, FQHC patients are different from the county population as a whole, with a significant proportion being best served in a language other than English, for example, and virtually all having household incomes below 200% of the Federal Poverty Level. FQHC patients under the age of 65 are more likely than the general population to be either uninsured or covered to some degree by Medicaid. Thus, UDS data cannot be safely generalized to the total population or even to the lower-income population, as a substantial proportion of that lower-income population is likely getting different care or no care at all. The dataset is still very useful, though, because of the breadth and consistency of the data FQHCs must track and report each year, and because of the sheer number of people included in it: although the two patient totals cannot be added together as some people get care at both, one FQHC served 112,950 patients in 2021, and the other served 84,123.

One measure of interest is the total number of patients by service type, charted below, with medical patients shown separately (Figure 5.5) because of the much greater patient volume compared to other services. Both FQHCs provided medical care to a much greater number of people in 2020 and 2021 than in 2017 and 2018, but the growth was already underway before the pandemic began.

The trend lines appear much flatter for other service types (Figures 5.6 and 5.7) because the absolute numbers of medical care patients are so much higher, but increases are still evident 2021 after varying decreases in 2020. For example, from 2020 to 2021 the number of dental patients increased 44% for one FQHC and 13% for the other.

Fig. 5.5 Number of medical patients

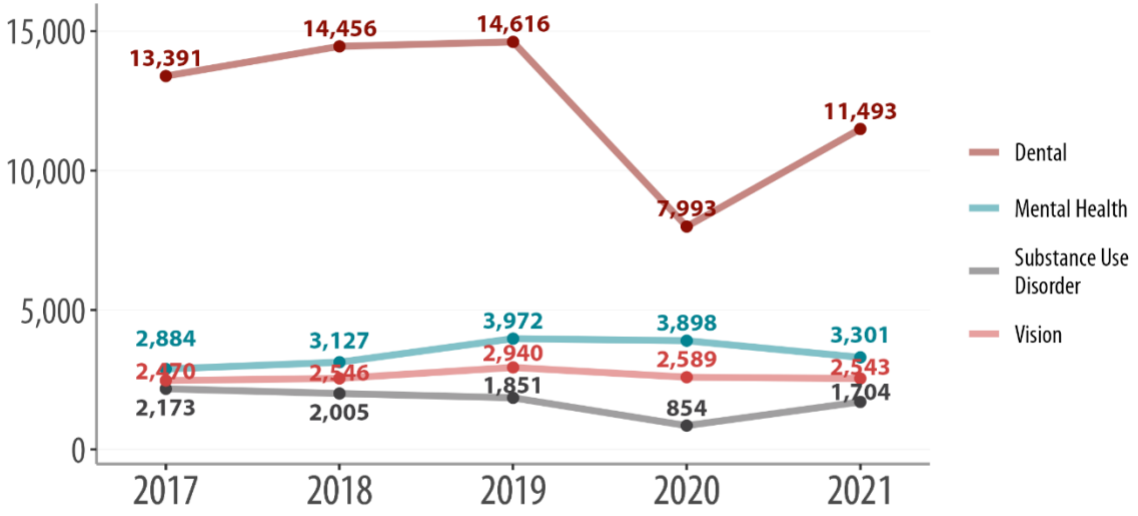
Two FQHCs in Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Fig. 5.6 FQHC A: Patients by service type

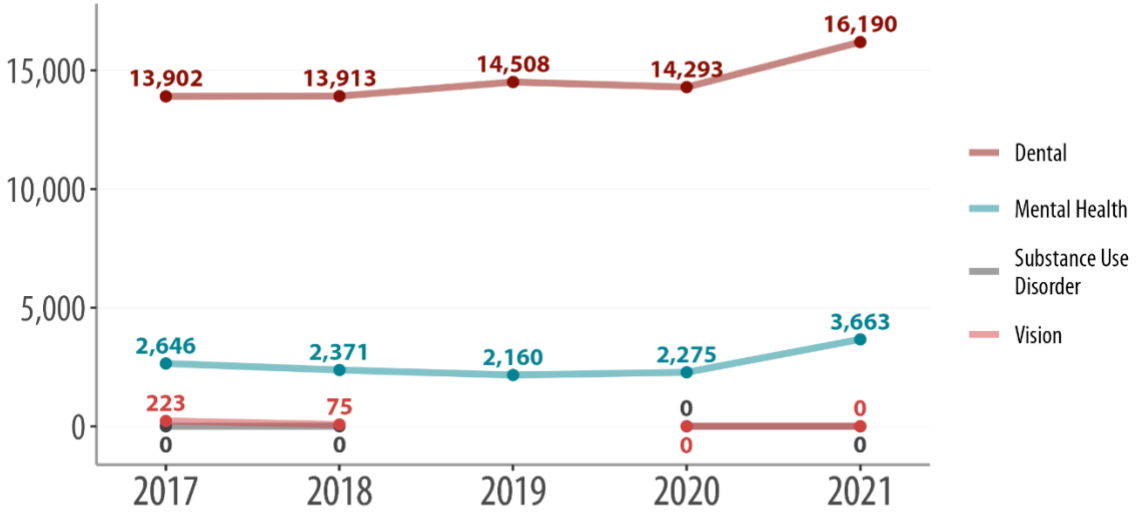
Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Fig. 5.7 FQHC B: Patients by service type

Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

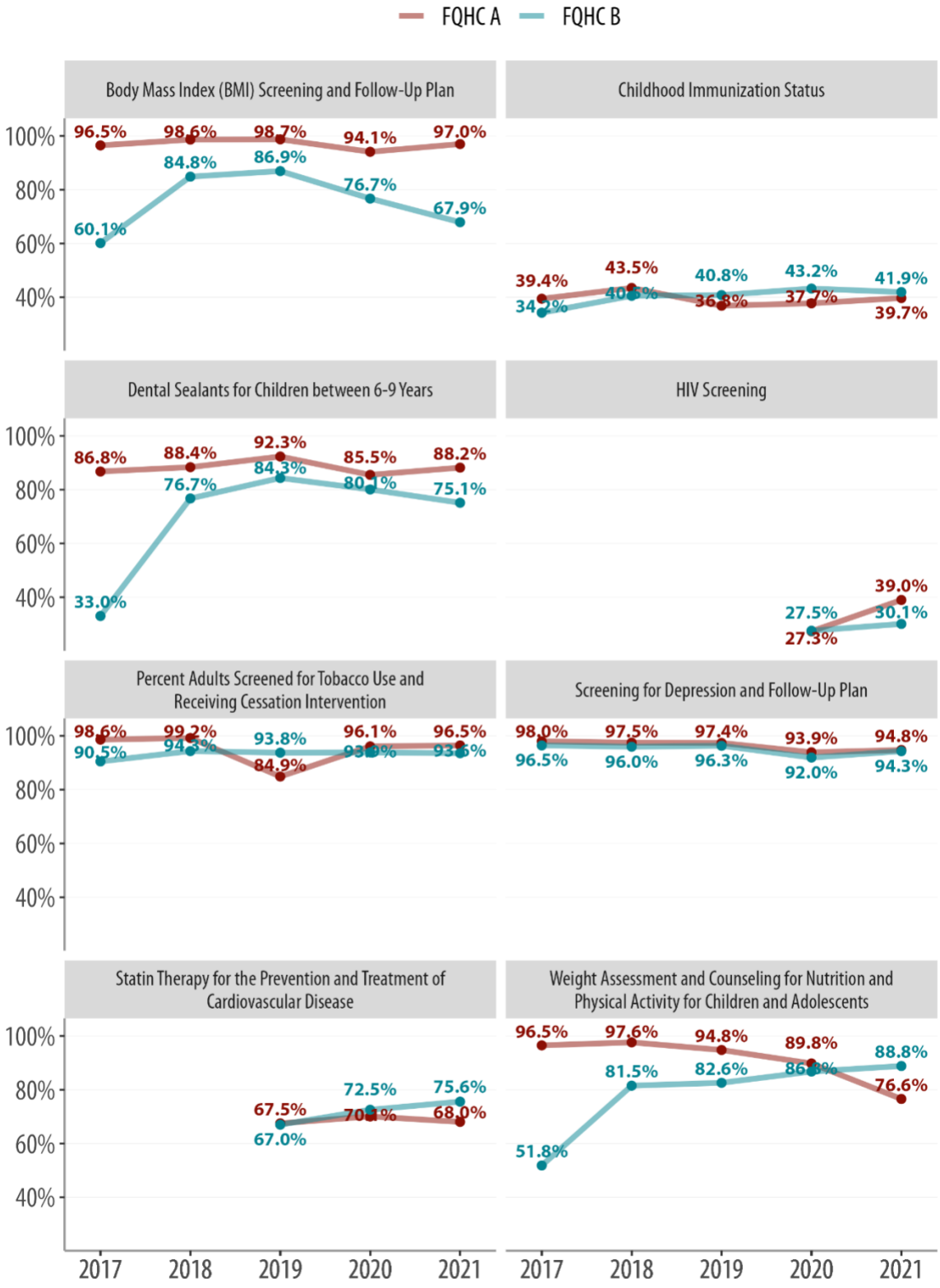
Figure 5.8 trends the percentage of patients at each FQHC who met a variety of key preventive care standards.[12] Because of the emphasis within the FQHC program nationwide on tracking and improving key quality of care measures, these patients are likely faring better on these indicators than are people engaged in care outside the FQHC system – and certainly better than those people not engaged in care at all.

Despite the pandemic, the trend lines held remarkably steady across the board for childhood immunization status, adult tobacco use screening and cessation intervention, and depression screening and follow-up planning. Rates increased for HIV screening, for which data was not available prior to 2020. The experience was mixed for BMI/weight screening, counseling, and follow-up planning at all ages; statin therapy for the prevention and treatment of cardiovascular disease; and for dental sealants in children.

[12] The UDS Manual for each year contains detailed specifications for all UDS measures in this report and is available at https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance.

Fig. 5.8 Percent of eligible patients who received appropriate preventative care services

Two FQHCs in Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

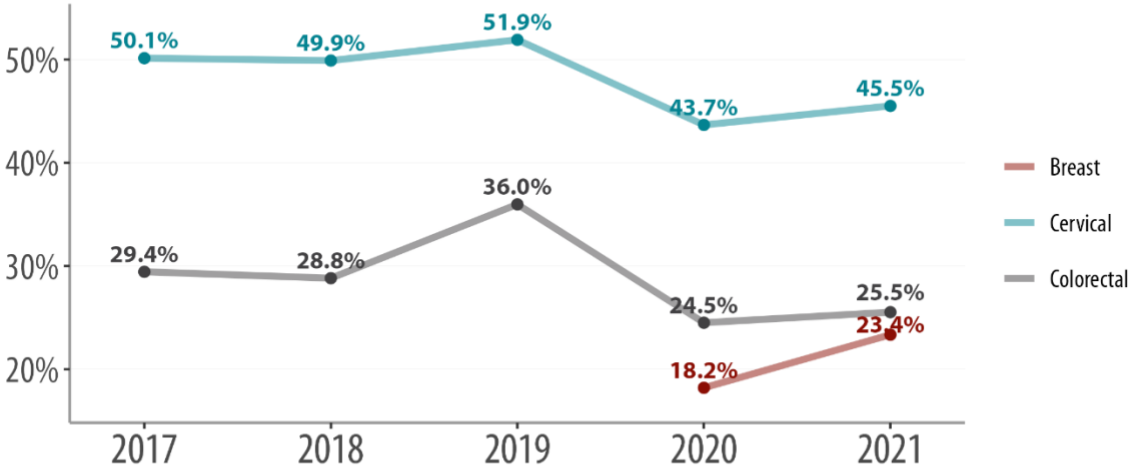
Cancer Screening

As noted above, BRFSS data for breast, cervical, colorectal, and prostate cancer screening was only available for 2018 and 2020. The confidence intervals were too wide to determine differences between those two years.

Looking just at FQHC patients (Figures 5.9 and 5.10), screening rates improved through 2019, dipped in 2020, and began recovering in 2021. The extent of that dip and recovery varies quite a bit both by screening type and by FQHC.

Fig. 5.9 FQHC A: Percent of eligible patients who received appropriate cancer screening

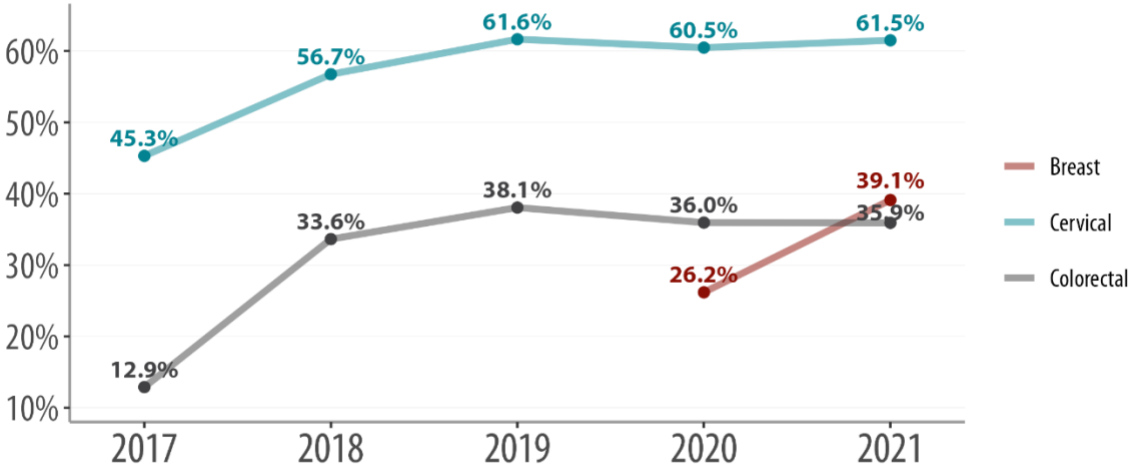
Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Fig. 5.10 FQHC B: Percent of eligible patients who received appropriate cancer screening

Bexar County, Texas



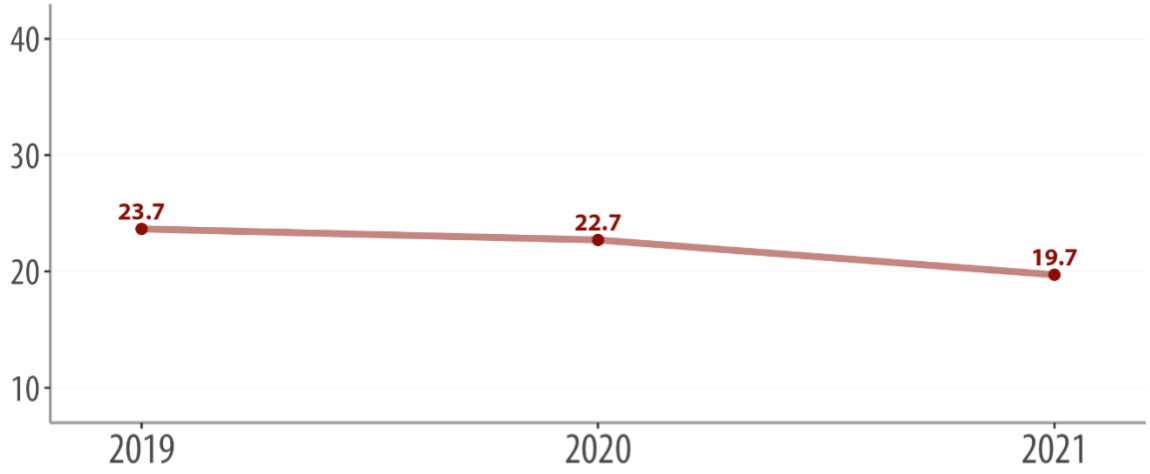
Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Perinatal Care

Already falling prior to the pandemic, the rate of births to females aged 15 to 19 continued to drop during the pandemic (Figure 5.11). The trend for the county total birthrate, however, was different, ticking slightly downward from 13.0 per 1,000 females in 2019 to 12.5 in 2020, and back up to 12.6 in 2021.[79] The percent of mothers receiving prenatal care in the first trimester remained level between 2019 and 2021 (Figure 5.12), while the percent receiving no prenatal care increased slightly (Figure 5.13).

Fig. 5.11 Number of births to mothers aged 15-19 per 1K females

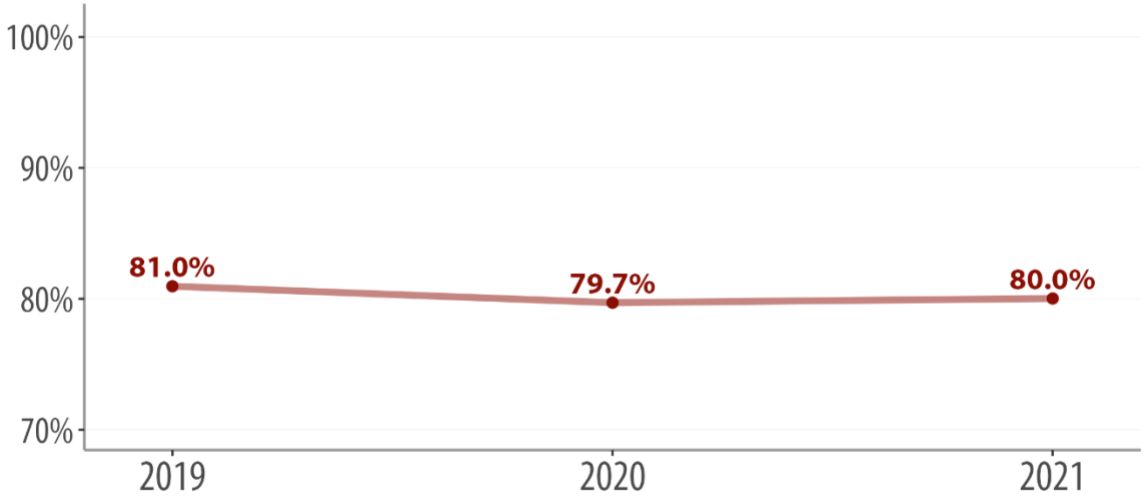
Bexar County, Texas



Source: CDC WONDER-Natality, ACS 5-Year Estimates, Table: B01001
Prepared by CI:Now for The Health Collaborative

Fig. 5.12 Percent of births to mothers who received prenatal care in 1st trimester

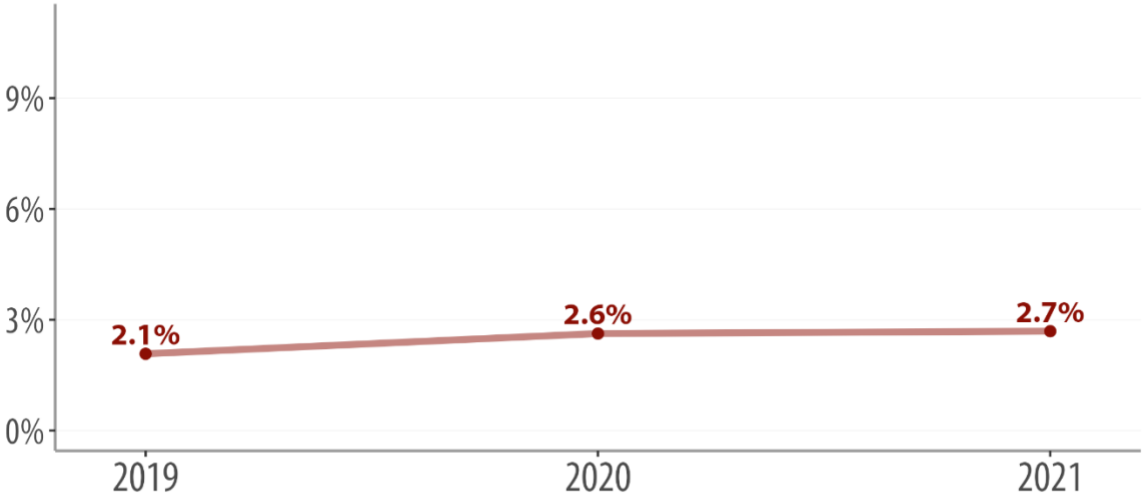
Bexar County, Texas



Source: CDC WONDER-Natality
Prepared by CI:Now for The Health Collaborative

Fig. 5.13 Percent of births to mothers who received no prenatal care

Bexar County, Texas

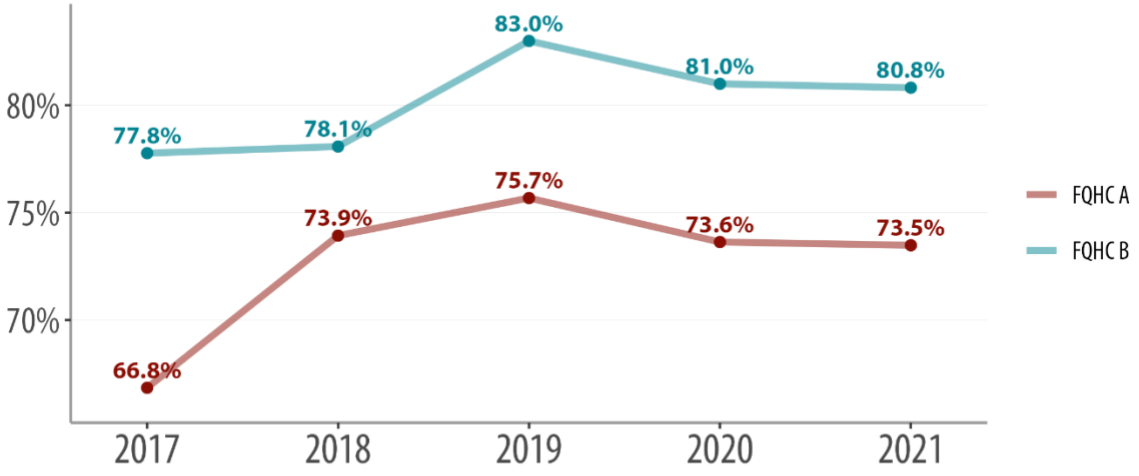


Source: CDC WONDER-Natality
Prepared by CI:Now for The Health Collaborative

Looking just at patients engaged in prenatal care at a local FQHC – *not* the full population of FQHC patients who became pregnant that year – the percentage who entered that care in the first trimester rose steadily between 2017 and 2019 and then declined slightly (Figure 5.14).

Fig. 5.14 Percent of prenatal care patients who entered prenatal care during their first trimester

Two FQHCs in Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Maternal morbidity and mortality could be a powerful indicator of impaired access to many kinds of care, and particularly of racial/ethnic disparities in outcomes, but local data is hard to come by. Nationally, the maternal mortality rate rose dramatically after the start of the pandemic, from 20.1 deaths per 100,000 live births in 2019 to 23.8 in 2020 and 32.9 in 2021. Preliminary numbers indicate that the 2022 rate may be lower than 2021, but that figure is not yet available.[80]

Released in December 2022 after delays, a long-awaited report from the Texas Maternal Mortality and Morbidity Review Committee and DSHS examined maternal deaths only through 2019, before the pandemic, and it does not include county-level data. It does report a Public Health Region 8 (Bexar and 13 other counties) rate of delivery hospitalizations involving severe maternal morbidity (SMM) of 54.4 per 10,000 delivery hospitalizations, but the time period for that data is 2016 through 2020, mostly prior to the pandemic, and no statewide comparison figure is provided for that period. Statewide rates are provided by race/ethnicity and year, with the overall rate dropping slightly from 61.1 in 2016 and rising from 2018 to a high of 72.7 in 2020 (provisional data). The trend for Hispanic mothers followed the same curve and rose from

57.9 in 2019 to 72.1 in 2020. Both the baseline disparity and the increase were much more severe for Black mothers, rising from 91.6 in 2016 to 117.3 in 2020 – 1.6 times as high as the overall state rate in 2020.[81]

The same report explored co-morbidity of COVID-19 infection with severe maternal morbidity (SMM) in delivery hospitalizations between April and December 2020. Statewide, Black and Hispanic mothers were much more likely than white mothers to experience SMM and/or COVID-19, but the patterns differ. While 48.3% of all delivery hospitalizations in that period were to Hispanic mothers, 70.1% of delivery hospitalizations involving SMM alone, and 48.9% involving both SMM and COVID-19, were to Hispanic mothers. As compared to 12.4% of all delivery hospitalizations to Black mothers, 20% of delivery hospitalizations involving SMM alone, and 11.6% involving both SMM and COVID-19 were to Black mothers. White mothers made up 31.5% of total delivery hospitalizations but only 23.8% of those involving SMM alone and 10.4% of those involving both SMM and COVID-19.

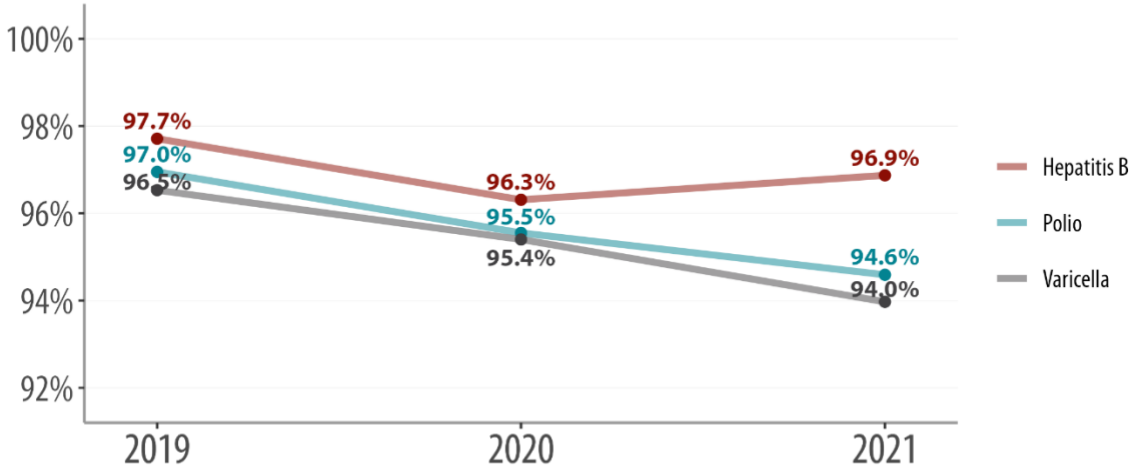
Vaccinations

The following charts on child vaccination trends include students in both public and private schools, but not those being homeschooled. The data is collected from school districts via an online survey that can be completed anytime between the last Friday in October and the second Friday in December.[82]

Among kindergarten students (Figures 5.15 and 5.16), Hepatitis A and B vaccination rates held fairly steady. All other vaccination rates – varicella, polio, DTP/DTaP/Dt/Td (diphtheria, tetanus, and pertussis), and MMR (measles, mumps, and rubella) – declined slightly. Among seventh graders (Figures 5.17 and 5.18), all rates remained fairly level except for Tdap/Td and meningococcal, which dropped markedly in 2020 before rising in 2021 to 2019 levels.

Fig. 5.15 Vaccine coverage rates among kindergartners by school year: Hepatitis B, Polio & Varicella

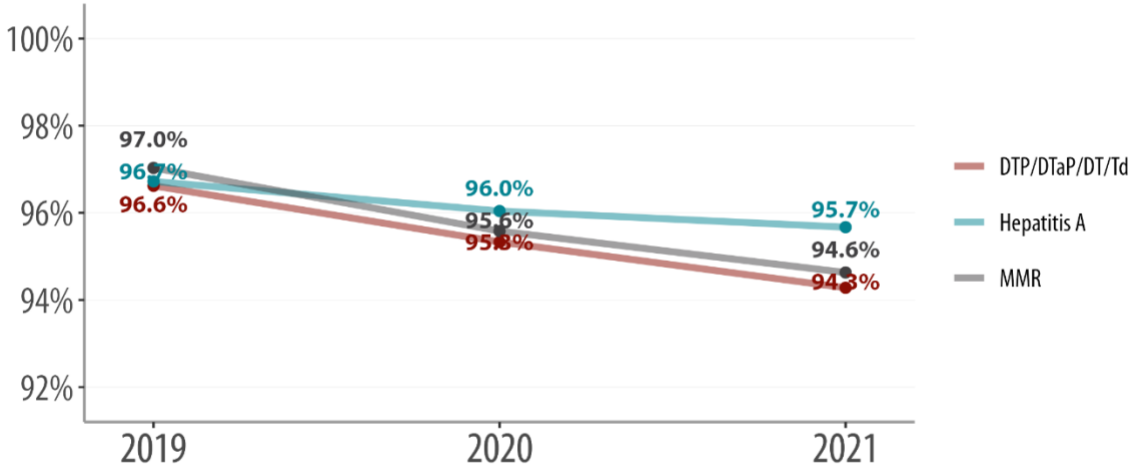
Bexar County, Texas



Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

Fig. 5.16 Vaccine coverage rates among kindergartners by school year: DTP/DTaP/DT/Td, Hepatitis A, MMR

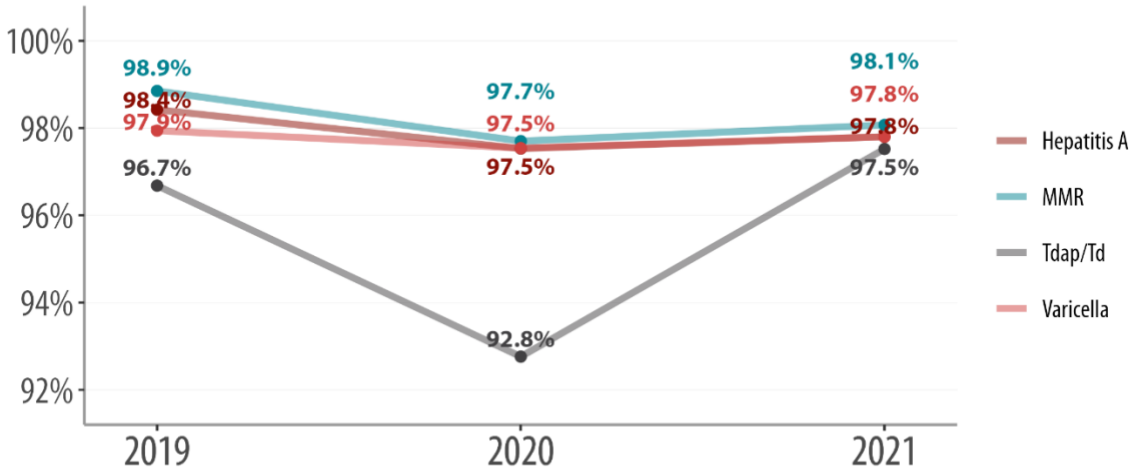
Bexar County, Texas



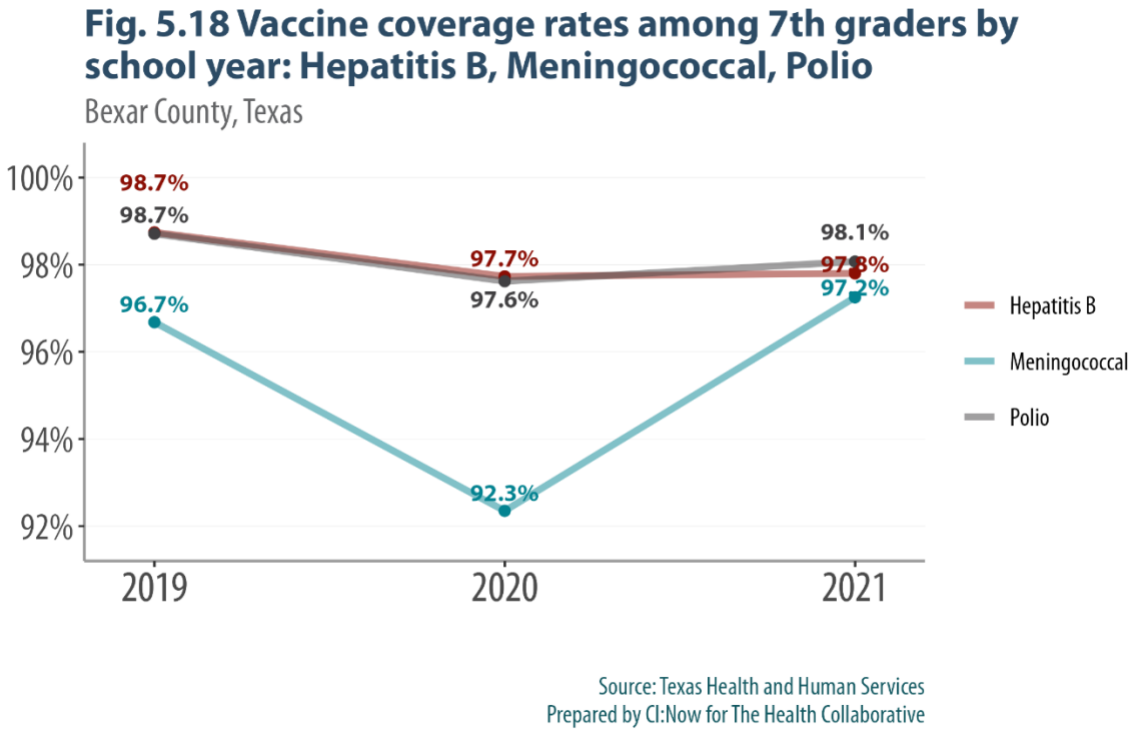
Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative

Fig. 5.17 Vaccine coverage rates among 7th graders by school year: Hepatitis A, MMR, Tdap/Td, Varicella

Bexar County, Texas

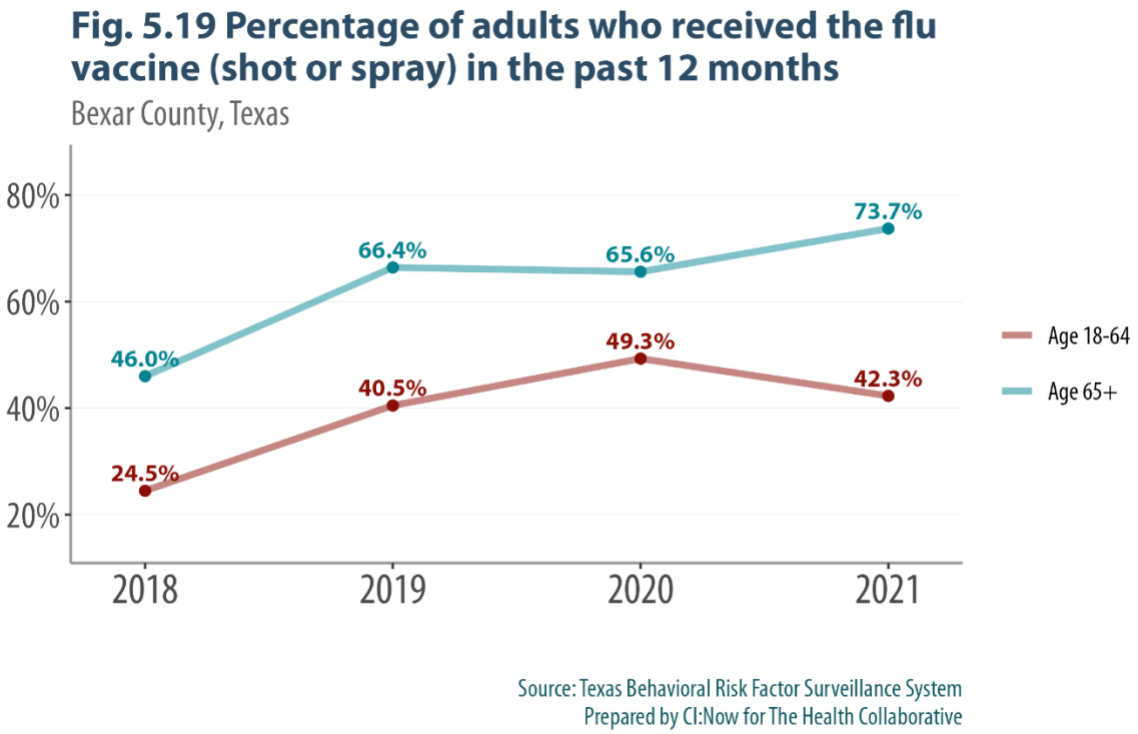


Source: Texas Health and Human Services
Prepared by CI:Now for The Health Collaborative



The patterns were different for percentage of adults receiving the flu vaccine the past year (Figure 5.19). Both the 18 to 64 and 65 and older age groups saw a sharp increase between 2018 and 2019. Among adults 18 to 64, the percentage increased again in 2020 before dropping off in 2021. Among older adults, the percentage remained largely unchanged in 2020 before increasing quite a bit in 2021, perhaps largely due to ongoing efforts starting early in 2021 to reach older people with initial and booster doses of the COVID-19 vaccine.

"In Texas, you have to opt into the [statewide vaccine] registry. So everyone who received the COVID vaccine and they did not sign up for ImmTrac, they'll be deleted in five years, it'll be gone. They need to change the law." – Vaccine outreach leadership



Current and historical information on trends and disparities in COVID-19 vaccination rates is available on the Metro Health and Texas Department of State Health Services websites and is not included in this report. One of several Kaiser Family Foundation reviews of the implications of the public health emergency declaration and its termination notes that COVID-19 vaccines will remain free to all people so long as the federally purchased vaccine supply lasts, without regard to the end of the public health emergency. The same is true of COVID-19 pharmaceutical treatments, such as Paxlovid, purchased by the federal government. COVID-19 tests, on the other hand, may become costlier for insured people, whether self-administered or by a health care professional. The availability of free at-home tests via traditional Medicare and Medicaid ends in May 2023 and September 2024, respectively. For people without health insurance who have COVID-19 symptoms or were exposed, free testing is available through approximately November 2023 at sites listed at https://testinglocator.cdc.gov/. At-home tests were never free for uninsured people in Texas, other than the limited quantities that could be ordered from the federal government or that were distributed by nonprofits and local governments.[83]

Chronic Disease Management

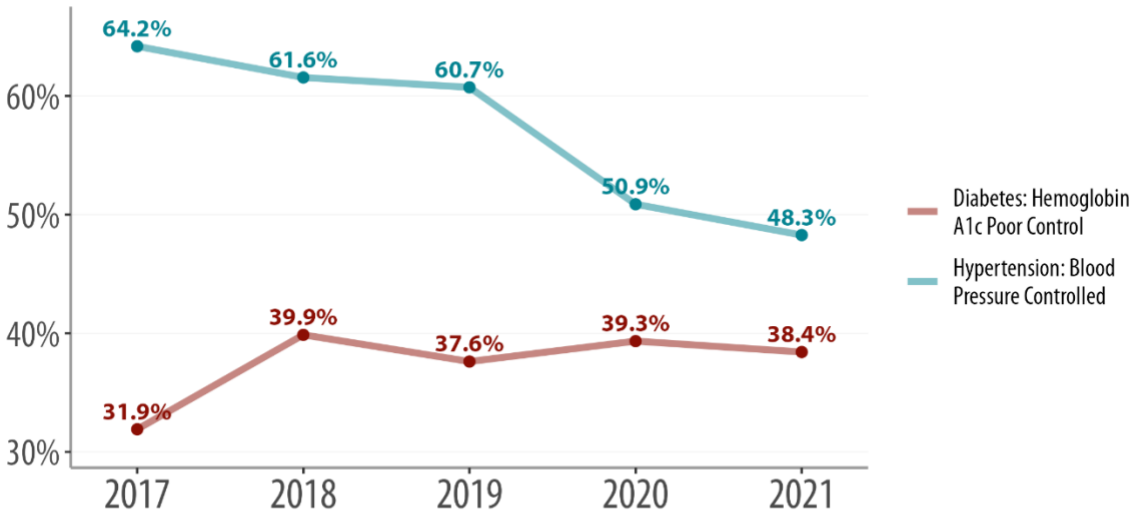
The BRFSS survey is once again unable to help understand access or utilization of chronic disease management services among the county's general adult population. For example, the survey often asks questions related to diabetes management, such as whether in the past year respondents saw a doctor for diabetes, had a hemoglobin A1c (HbA1c) test, had a doctor check their feet, or had an eye exam. County-level data is available for several of these questions for 2019, but not for any year since. Another lens on chronic disease management is preventable hospitalizations for chronic conditions, presented in the next section.

Local FQHC measures can offer some insight into chronic disease management care for that patient population (Figure 5.20 and 5.21). The percent of diabetic patients with poor hemoglobin A1c control – a measure of blood sugar control – was relatively unchanged for both FQHCs over recent years. While the diabetes indicator measures *poor* control, defined as over 9% or no test during the year, the hypertension indicator measures *good* control, defined as less than 140/90. That measure of hypertension control trended downward for both FQHCs between 2019 and 2021.

Of interest here is 2021 BRFSS data (not available for prior years) on two measures of chronic disease *self*-management, or care that is done at home without a health care visit. Only 32% (confidence interval 26%-39%) of respondents regularly check their blood pressure outside of their health care professional's office or at home, and only 64% (47%-78%) had their blood checked daily for glucose or sugar.

Fig. 5.20 FQHC A: Chronic disease management

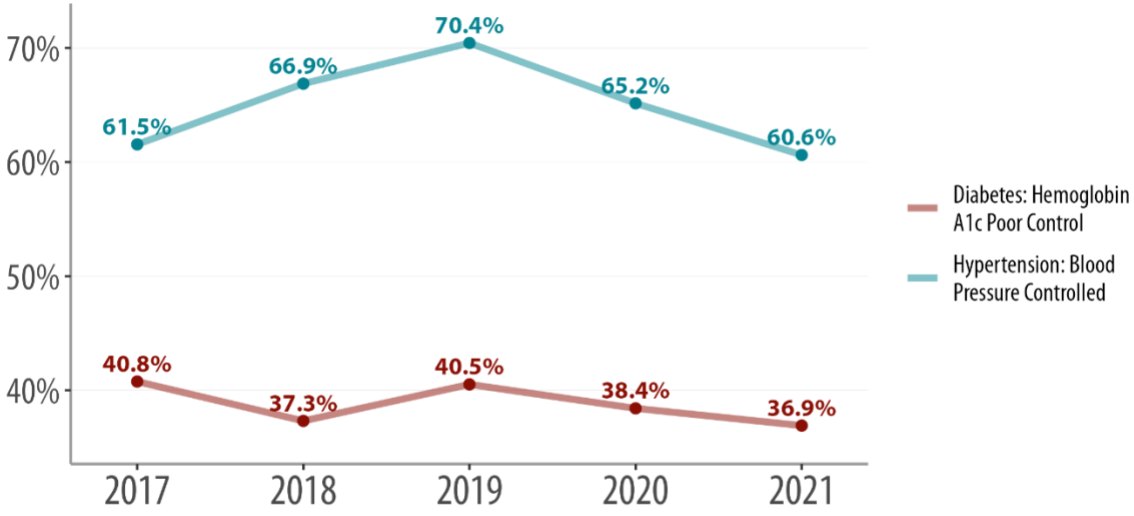
Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Fig. 5.21 FQHC B: Chronic disease management

Bexar County, Texas



Source: US DHHS HRSA Health Center Program Uniform Data System Data Overview
Prepared by CI:Now for The Health Collaborative

Preventable Hospitalizations

Preventable hospitalizations can be used as a measure of "upstream" care utilization that treats or manages illness and thus prevents hospitalizations, but there is a lag effect, as lack of preventive, primary, and chronic disease management care may not result in immediate hospitalization. The pandemic further complicates the picture, as a decrease in preventable hospitalizations could also be expected to be impacted by reduced hospital capacity or other system-level factors while the COVID-19 transmission and hospitalization rates were high.[84] Preventable hospitalizations resulting from reduced access to and utilization of "upstream" care during the pandemic might not occur until 2022 or 2023, too recent to appear in the data currently available.

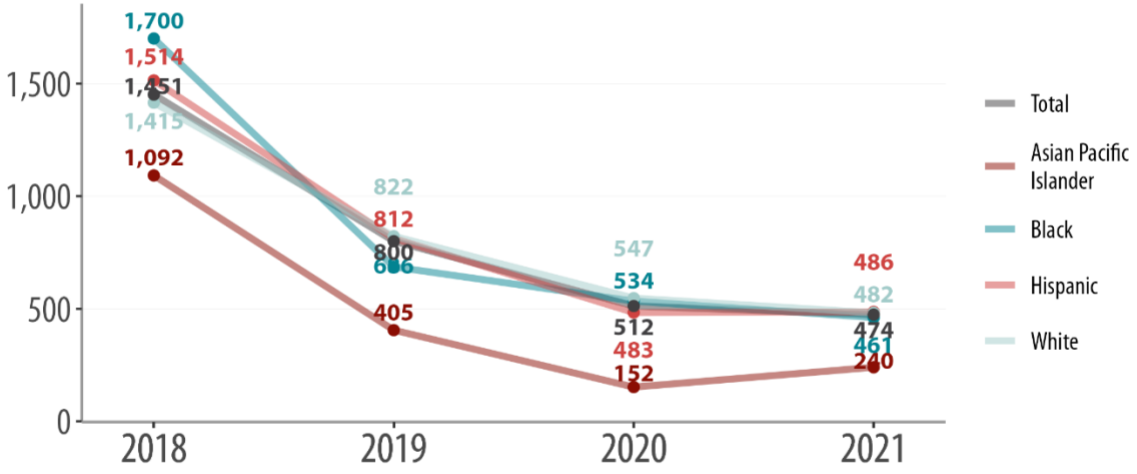
U.S. Centers for Medicare & Medicaid Services (CMS) report annual rates of preventable hospitalizations among Medicare beneficiaries for both acute conditions and chronic conditions. The charts that follow trend rates for the Prevention Quality Acute Composite (PQI #91), which includes community-acquired pneumonia and urinary tract infection, and Prevention Quality Chronic Composite (PQI #92), which includes diabetes, asthma, hypertension, and heart failure.

Medicare preventable hospitalizations for acute conditions decreased overall between 2018 and 2021 (Figure 6.1), although the curve flattened out considerably between 2020 and 2021. The same was true for most race/ethnicity groups except the Asian/Pacific Islander group, which had the lowest rate in every year but saw the rate increase by 58% between 2020 and 2021. Looking at the data by sex (Figure 6.2), the rate among females decreased until 2020 and remained about level 2021. The rate among males, on the other hand, continued to decline through the entire period.

The trend lines for Medicare preventable hospitalizations for chronic conditions are remarkably similar across demographic groups. For Medicare beneficiaries overall (Figure 6.3), females and males (Figure 6.4), and every race/ethnicity group except Black, the line is flat from 2018 to 2019, drops markedly between 2019 and 2020, and largely flattens again from 2020 to 2021.

Fig. 6.1 Medicare preventable hospitalizations for acute conditions by race/ethnicity, per 100K beneficiaries

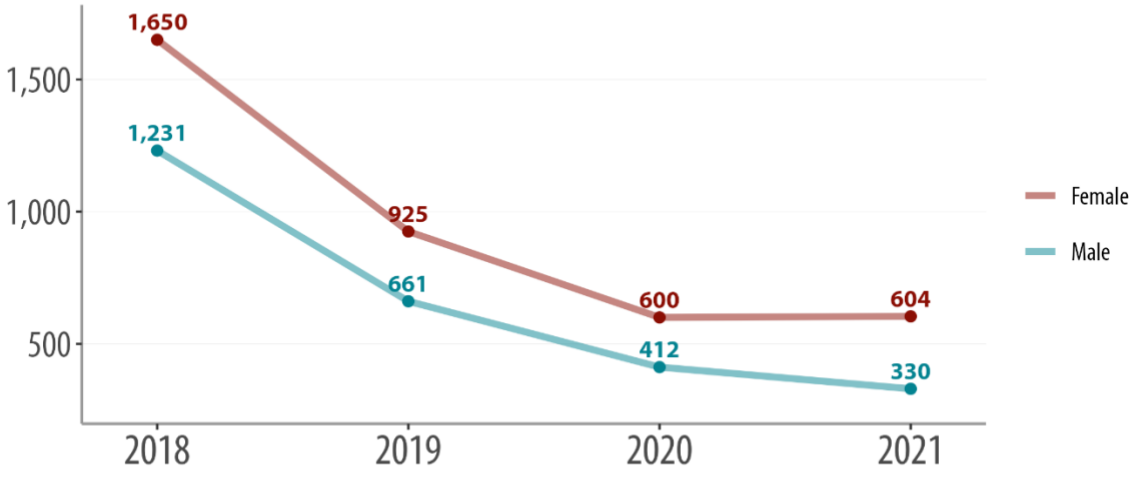
Bexar County, Texas



Unsmoothed age-adjusted
Source: US Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool
Prepared by CI:Now for The Health Collaborative

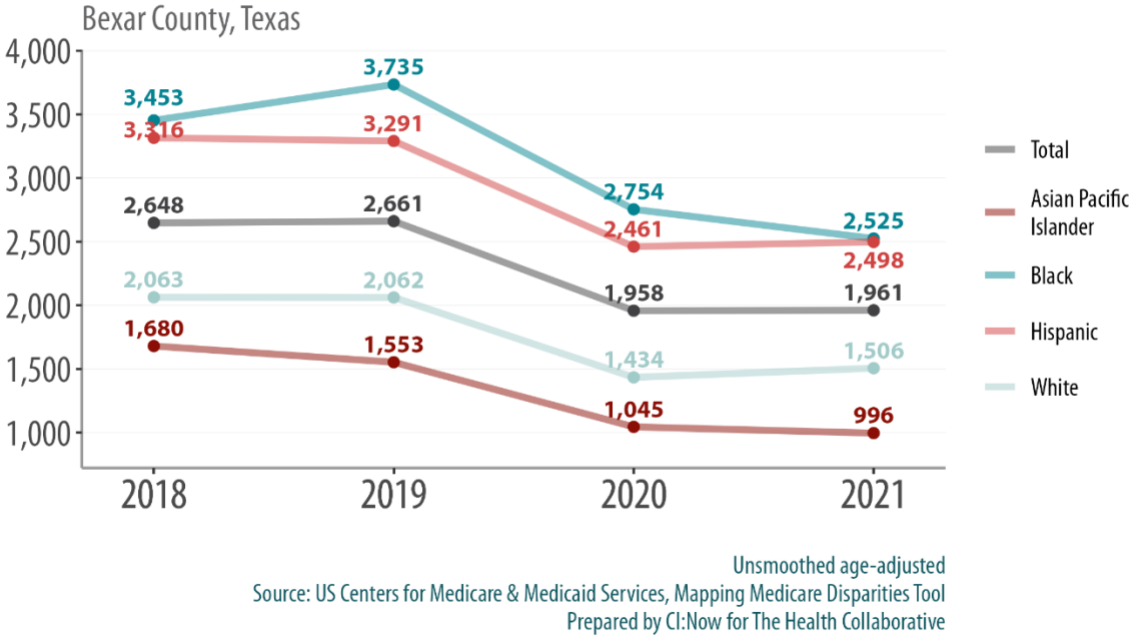
Fig. 6.2 Medicare preventable hospitalizations for acute conditions by sex, per 100K beneficiaries

Bexar County, Texas



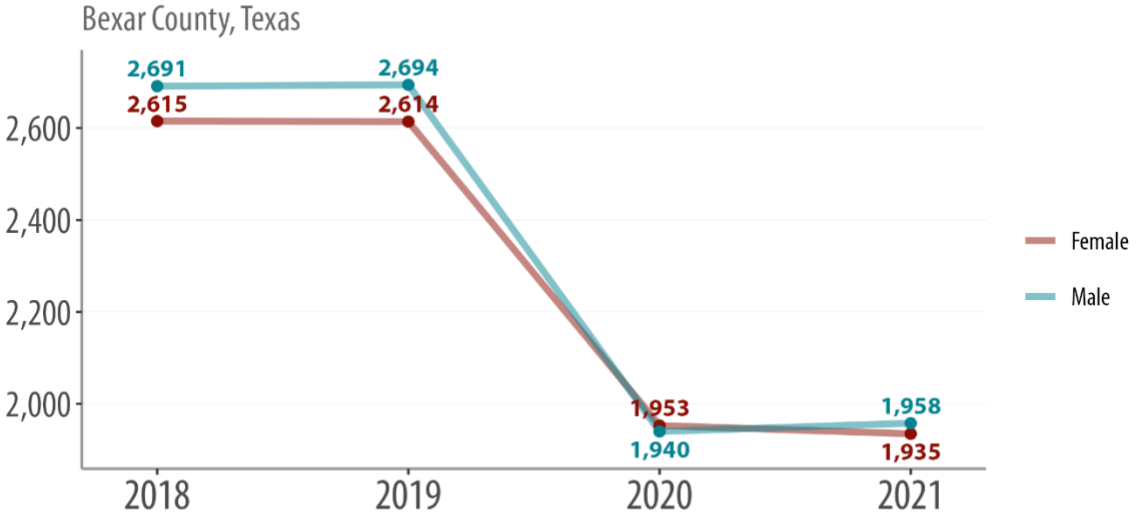
Unsmoothed age-adjusted
Source: US Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool
Prepared by CI:Now for The Health Collaborative

Fig. 6.3 Medicare preventable hospitalizations for chronic conditions by race/ethnicity, per 100K beneficiaries



Unsmoothed age-adjusted
Source: US Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool
Prepared by CI:Now for The Health Collaborative

Fig. 6.4 Medicare preventable hospitalizations for chronic conditions by sex, per 100K beneficiaries



Unsmoothed age-adjusted
Source: US Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool
Prepared by CI:Now for The Health Collaborative

Emergency Department Visits

C3HIE, the local health information exchange, provided de-identified data on hospital emergency department (ED) visits. To better align with the dates of both pandemic start and widespread vaccination efforts a year later, the data was queried and analyzed in 12-month periods running from March of one year through February of the next. An ED visit may or may not result in a hospitalization, and hospitalizations are not addressed in the charts in this section.

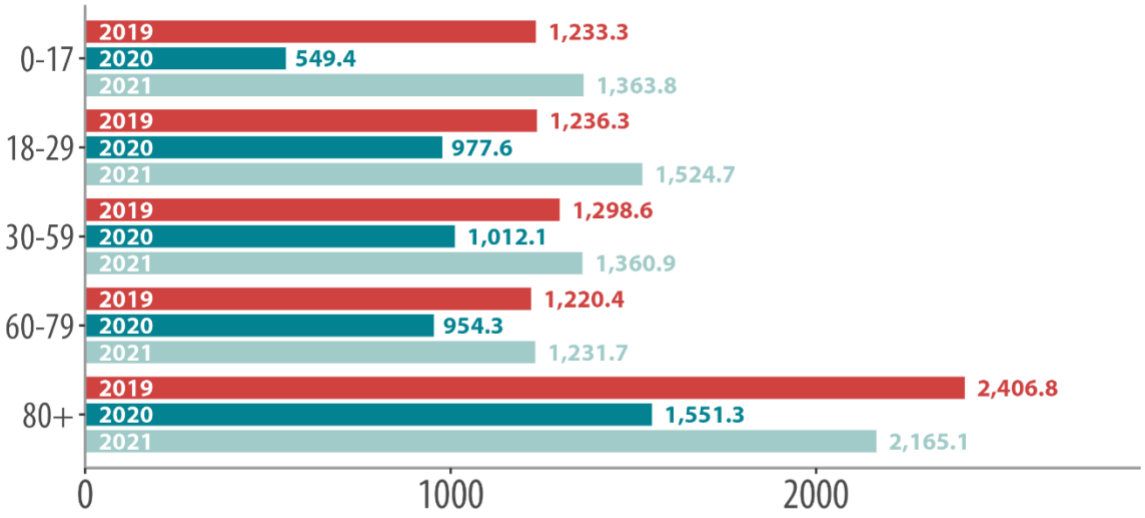
"I got COVID when it first started as well, and I was at home in bed by myself—they didn't have some medicine. They didn't have nothing. By the word of God, I didn't have any symptoms. I only had, you know, mild symptoms. I would call my doctor and they'd just tell me, There's nothing we can do, and don't go to the emergency room…that's worse. And so I said, OK, I'll just ride it out here." Older focus group participant

The percent change varied, but across the board, ED visits were markedly lower in the March 2020 to February 2021 period than in the prior or subsequent period. Figure 7.1. summarizes ED visit rates by age group. The percentage change from pre-pandemic to the first year of the pandemic is not shown in these charts, but the rate dropped most (55%) in the 0-17 age group, followed by the 80 and older age group (35%), and the least (21% to 22%) in the other age groups. The drop in the first year did not differ by sex (Figure 7.2), dropping 30% to 31% for both females and males.

The degree to which ED visit rates returned to pre-pandemic levels in the March 2021 to February 2022 period also varied by age group, falling short of pre-pandemic level among people 80 and older, about the same as pre-pandemic level among people 60 to 79, and exceeding pre-pandemic level in all younger age groups. The 2021-2022 rate slightly exceeded pre-pandemic level for both females and males.

Fig. 7.1 Emergency department visits by age per 10K population

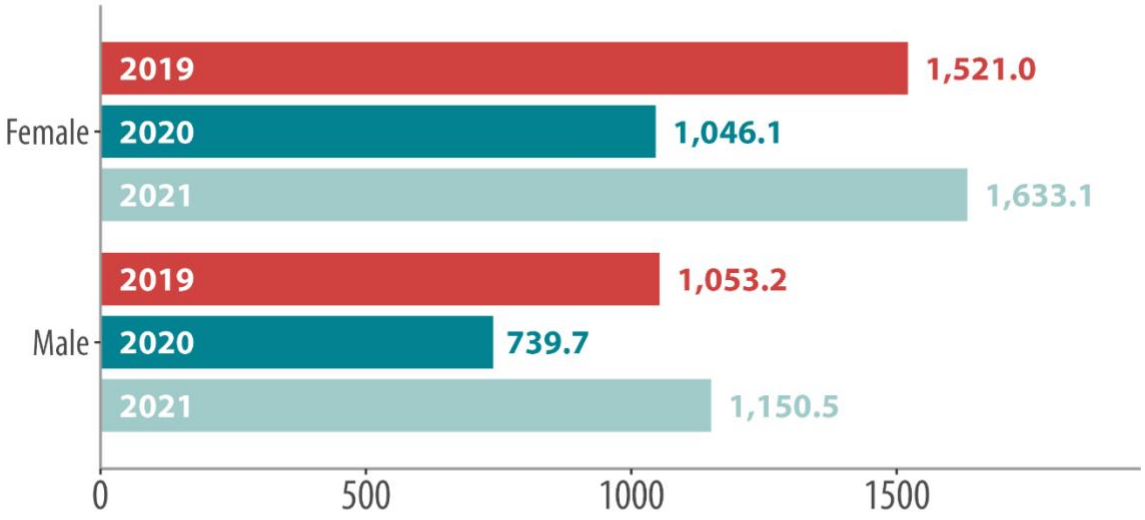
Bexar County, Texas



Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

Fig. 7.2 Emergency department visits by sex per 10K population

Bexar County, Texas



Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

The next serious of charts examines ED visit rates by age group for the most common ICD-10 principal diagnoses during the three-year period. Pregnancy-related conditions were the most common principal diagnosis in the 18 to 29 age group in all three years (Figure 7.3). As was the case for overall ED visit rates, the 2020-2021 rate for this age group dropped markedly for every principal diagnosis except COVID-19, which of course was not a common diagnosis prior to March 2020. Notably, the 2021-2022 ED visit rate for acute pharyngitis and acute upper respiratory infection far exceeds the 2019-2020 rate in this age group.

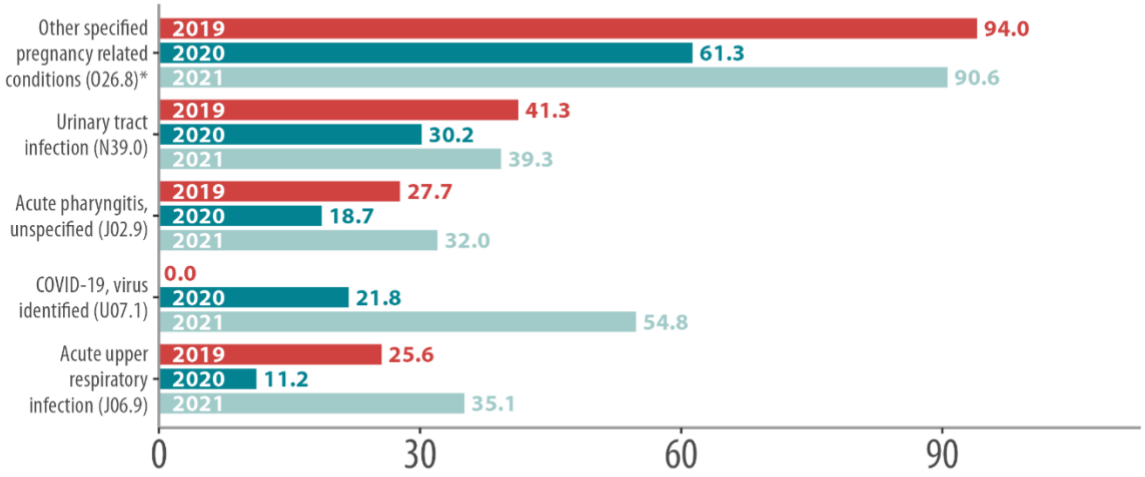
The trend varies quite a bit by diagnosis among the 30 to 59 age group (Figure 7.4), with the ED visit rate for chest pain on breathing, the most common principal diagnosis, falling only slightly in 2020-2021 and then substantially exceeding the pre-pandemic rate in 2021-2022. The trend for acute upper respiratory infection mirrors that among the 18 to 29 age group.

The year-to-year change was relatively small among the 60 to 79 age group for ED visits with a principal diagnosis of chest pain on breathing (Figure 7.5). The 2021-2022 rate is similar to the 2019-2020 rate for all principal diagnoses except COVID-19 in this age group. Notably, acute upper respiratory infection did not appear in the top five principal diagnoses for this group.

Among the 80 and older age group (Figure 7.6), the greatest decreases in ED visit rate from 2019-2020 to 2020-2021 were for dizziness and giddiness (43%) and essential hypertension (42%), followed by urinary tract infection (39%). Other than COVID-19, 2021-2022 rates in this age group did not differ dramatically from 2019-2020 rates for any of the top five principal diagnoses in the three-year period.

Fig. 7.3 Emergency department visits per 10K population for top primary diagnoses by age group: 18-29

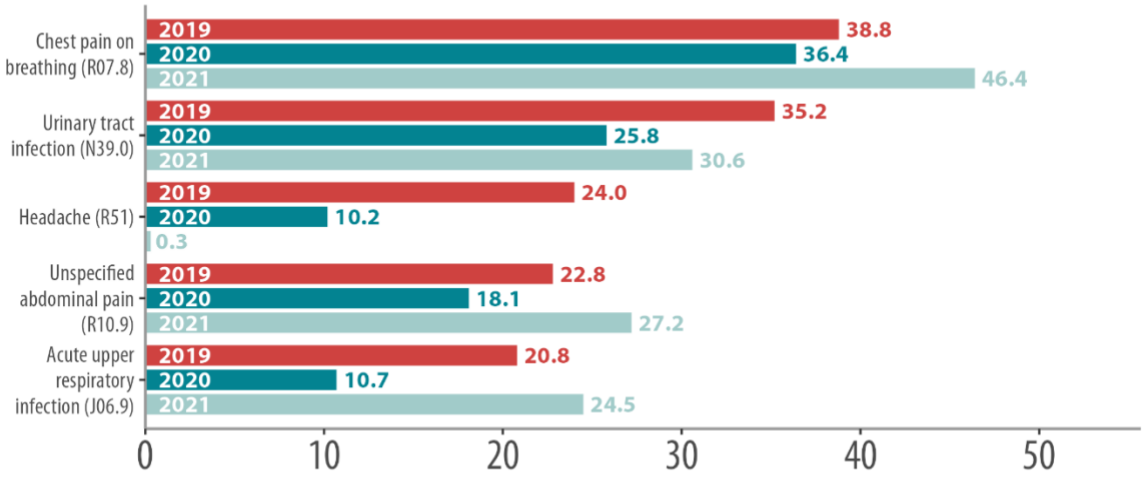
Bexar County, Texas



*Rate is for females only. Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

Fig. 7.4 Emergency department visits per 10K population for top primary diagnoses by age group: 30-59

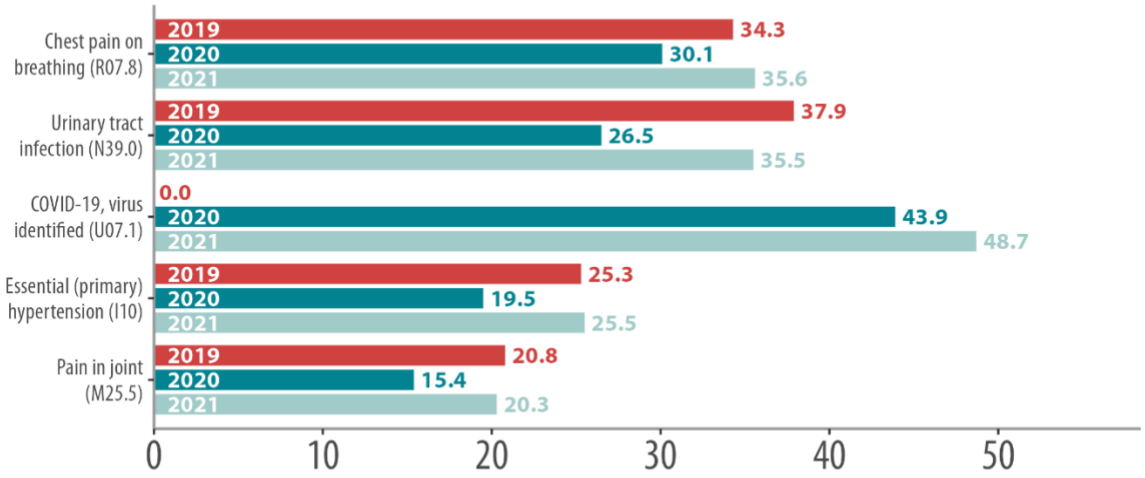
Bexar County, Texas



Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

Fig. 7.5 Emergency department visits per 10K population for top primary diagnoses by age group: 60-79

Bexar County, Texas

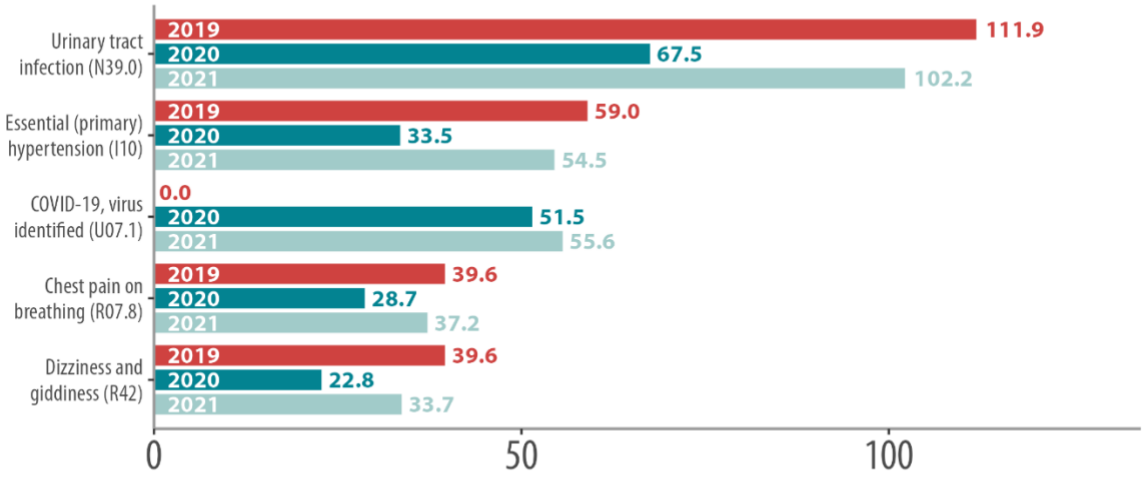


Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

The next two charts summarize the trend in ED visit rate for the 10 most common principal diagnoses in the three-year period for males (Figure 7.7) and for females (Figure 7.8). As was the case among younger adults, for both sexes the 2021-2022 ED visit rate for principal diagnosis of acute upper respiratory infection far exceeds the pre-pandemic rate. To a lesser extent, the same is true for viral infection (unspecified), acute pharyngitis, and chest pain on breathing.

Fig. 7.6 Emergency department visits per 10K population for top primary diagnoses by age group: 80+

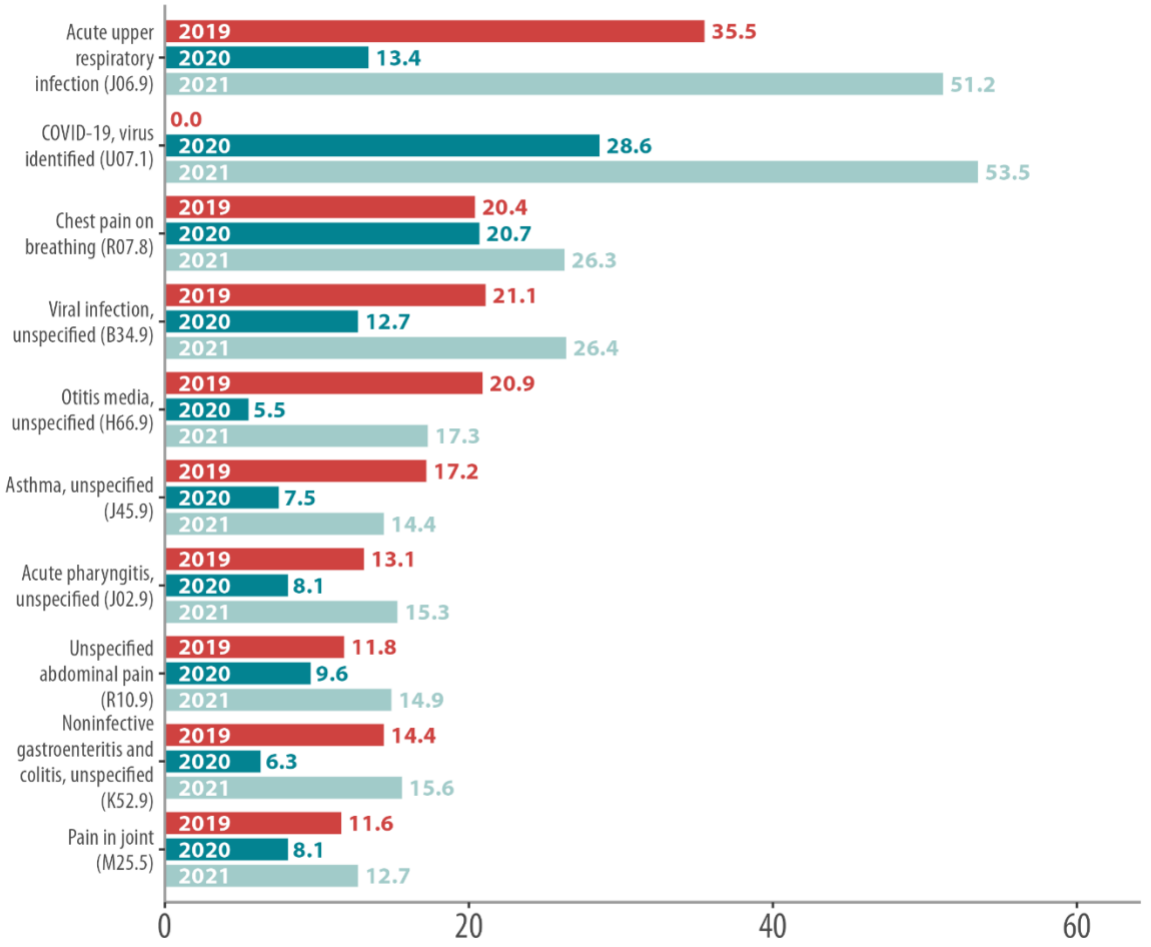
Bexar County, Texas



Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

Fig. 7.7 Emergency department visits per 10K population for top primary diagnoses by sex: Males

Bexar County, Texas

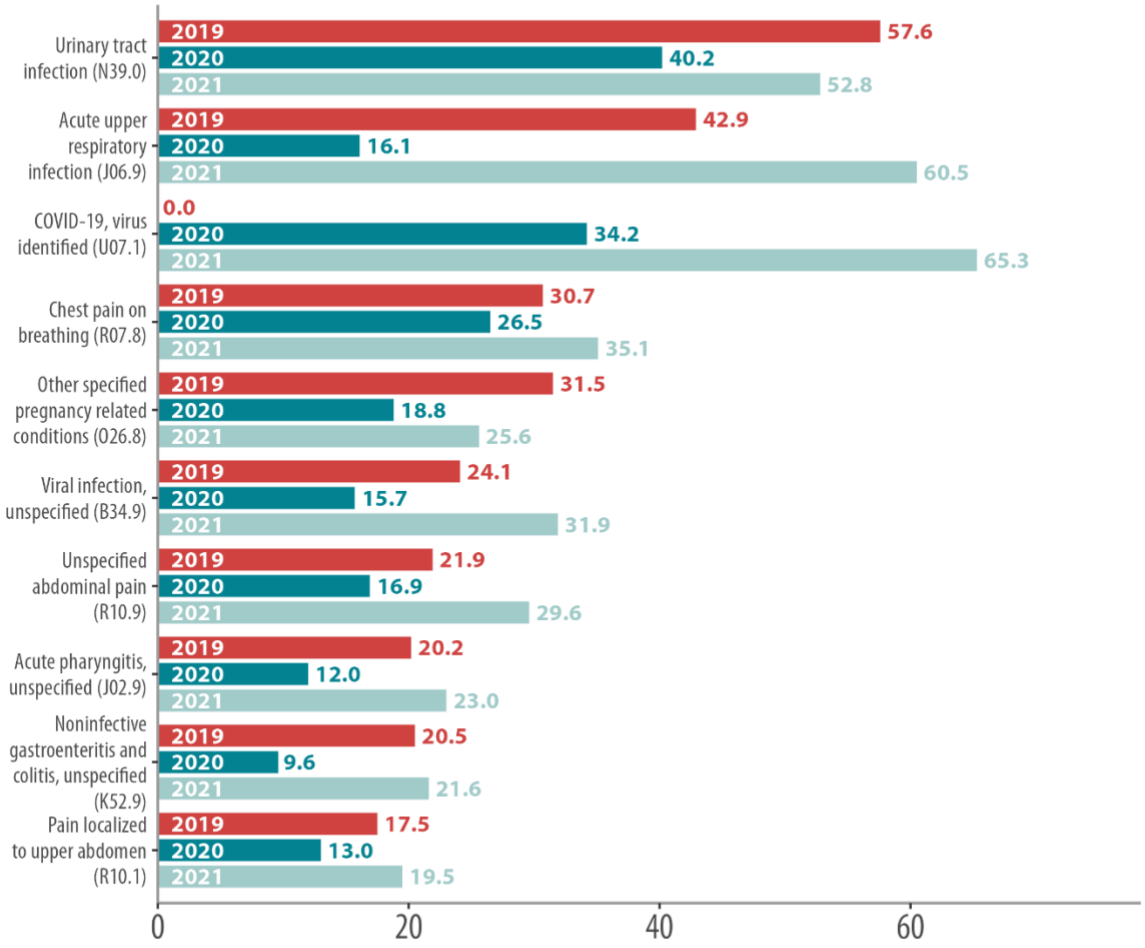


Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

Among females (Figure 7.8), the 2020-21 ED visit rate for a principal diagnosis of pregnancy-related complications fell 40% from pre-pandemic level and has not recovered. That trend is difficult to interpret; it could point to fewer pregnancies than pre-pandemic, fewer complications, presentation to a provider/facility other than an ED, fewer visits to any provider, or a combination of factors.

Fig. 7.8 Emergency department visits per 10K population for top primary diagnoses by sex: Females

Bexar County, Texas



Each year is from March of that year to February of the next
Source: C3HIE
Prepared by CI:Now for The Health Collaborative

Mental Illness and Substance Abuse

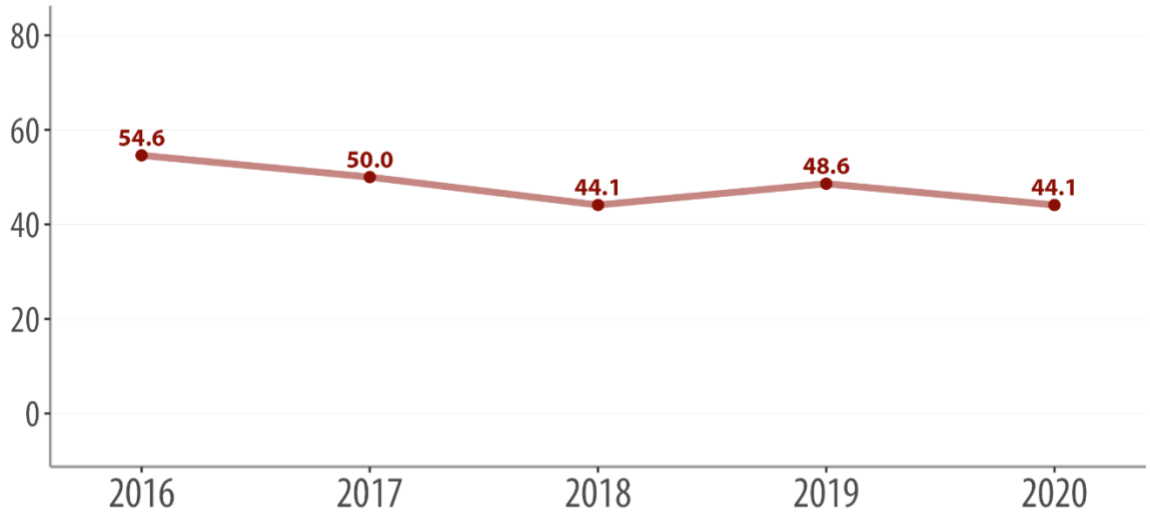
> *"Mental health issues were spiked. We had older adults who were struggling with just being alone constantly. And not even having their family able to come and visit because they were older family members. Didn't wanna put them at risk. So you know, there were calls, people would check on their folks, but the truth of the matter is, is that that was really, really hard. It was a very, very - it was a tragic time for District 4."* - Office of San Antonio City Council District 4

As noted earlier in this report, harms to mental and behavioral health during the pandemic were many and varied. Unfortunately, data to describe and quantify those harms, including in terms of access to care, is terribly inadequate. The available data largely describes "downstream" consequences of poor mental health and access to mental health care, rather than preferable "upstream" indicators like increased demand for care, wait time to get an appointment, or percent of insured people whose plan includes any meaningful mental health benefit.

Opioid prescribing trends, while affected by state and national policies, may serve as a measure of access to one type of care. Unfortunately more recent data is not available, but the 2020 opioid dispensing rate in 2020 was 44.1 per 100 persons (Figure 8.1), not out of line with the pre-pandemic rate. One notable implication of the end of the federal public health emergency declarations is that prescriptions for controlled substances, temporarily allowed via telehealth, once again require in-person visits after May 11, 2023.[85]

Fig. 8.1 Opioid dispensing rate per 100 persons

Bexar County, Texas

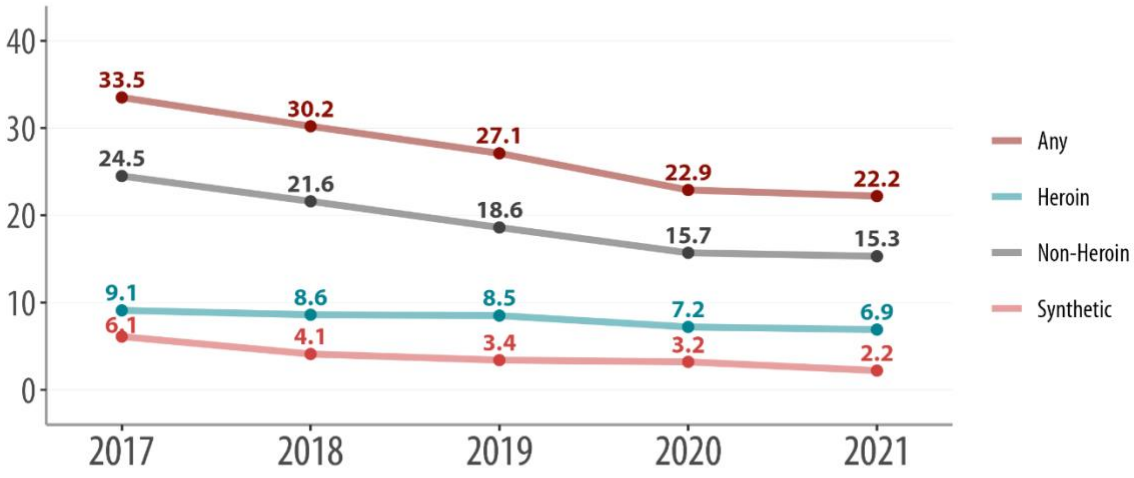


Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control
Prepared by CI:Now for The Health Collaborative

The rate of opioid-related emergency department visits declined steadily between 2017 and 2021 for all opioid drugs tracked (Figure 8.2), which on its face might seem like a purely positive trend. The decline may be understood differently, however, in light of drug-related death rates that have steadily increased for both females and males (Figure 8.3) and for Hispanics and whites (Figure 8.4), the only two race/ethnicity groups for whom small numbers did not result in data suppression. The lowest rate of increase between 2018 and 2021 was 40% for Hispanics, as compared to nearly 60% for whites and just over 50% for both females and males. These deaths may have been accidental or intentional.

Fig. 8.2 Opioid related emergency department visits per 100K population

Bexar County, Texas



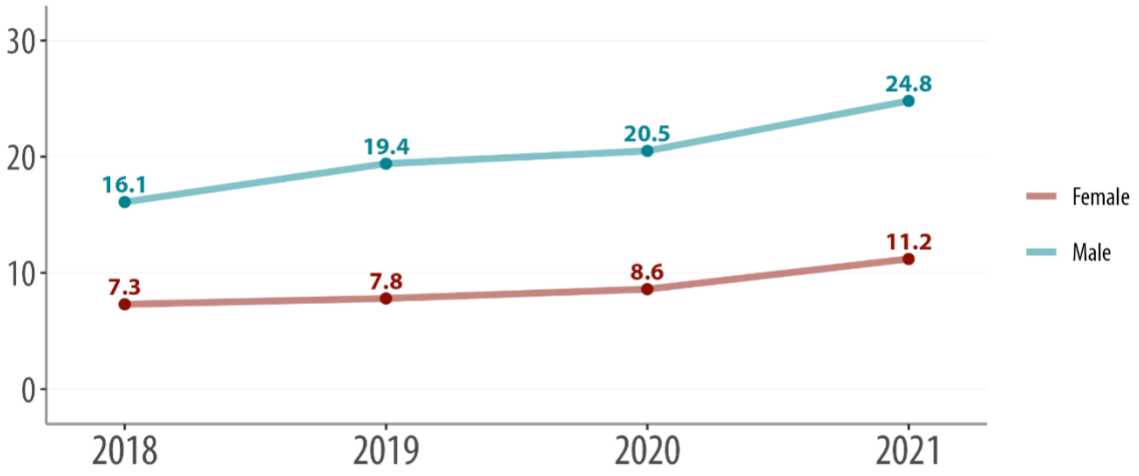
Source: Texas Health Care Information Collection
Prepared by CI:Now for The Health Collaborative

"There's many of us that are dedicated to our community, tremendously. It's a way of life. So when we were isolated, it started affecting the CHWs, because we weren't able to communicate or, you know, to see our clients, our families. So we already had a lot of issues with the families because we work with families that have needs. So with the pandemic, they multiplied and more of them were added. So and us not being able to either go there or provide the resources, it started causing us to get depressed." - CHW instructor and advocate

"We started seeing anywhere from 80 to 100 patients daily from all the influx. It was just basically like herding cattle, it wasn't even good health care anymore. The staff was overworked. Long hours. We didn't have enough providers. We were just getting everybody that the hospitals were turning away, that the doctors were turning away, that everybody was turning away and it was, it was just difficult." - Urgent care nurse

Fig. 8.3 Drug-related deaths (any intent) per 100K population by sex

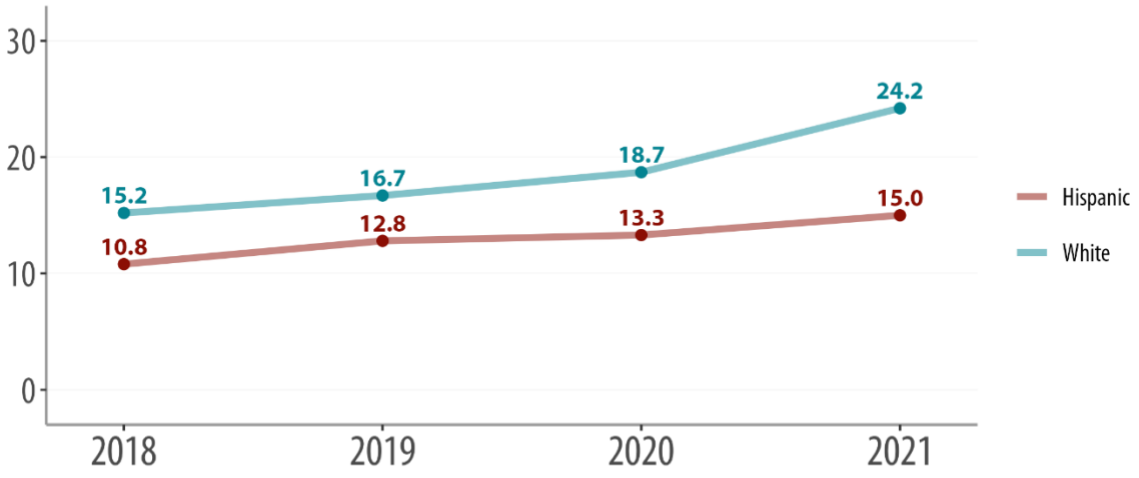
Bexar County, Texas



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

Fig. 8.4 Drug-related deaths (any intent) per 100K population by race and ethnicity

Bexar County, Texas

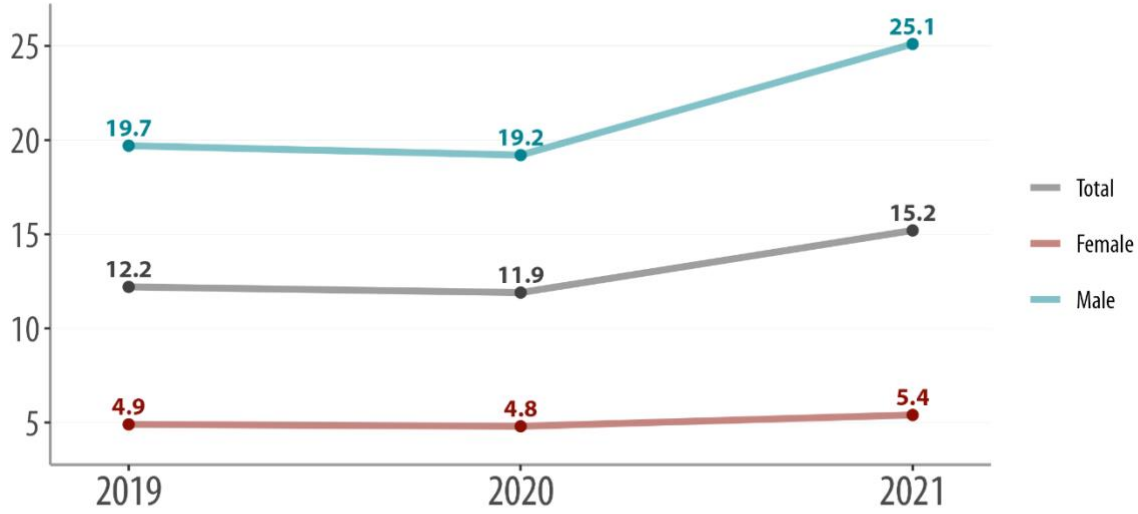


Data available only for two largest race/ethnicity groups
Source: Texas Department of State Health Services
Prepared by CI:Now for The Health Collaborative

Suicide rates reflect multiple factors including access to lethal means, as well as lack of access to and utilization of crisis mental health services. The suicide rate in Bexar County rose 25% between 2019 and 2021 (Figure 8.5). At 27%, the increase in suicide deaths among males (versus a 10% increase among females) drove the overall increase. The disparity by sex also widened over that period: the ratio of male to female suicide death rates was 4.0 in 2019, increasing to 4.6 in 2021. Suicide is preventable through multi-pronged strategies at individual, family and community levels.

Fig. 8.5 Suicide deaths per 100K population

Bexar County, Texas



Source: CDC WONDER-Underlying Cause of Death
Prepared by CI:Now for The Health Collaborative

The Local Response

Changes to Local Policy, Practice, and Funding

Participants in project focus groups and key informant interviews offered tremendous insight into how the pandemic has affected local health care systems; how providers, systems, and policy makers responded; and what next steps for policy and practice might be. Key themes emerging from that qualitative data are summarized below.

Difficulties with Training Staff and Students

Health care leaders reported that the pandemic had a significant impact on the training of health workers and students. Virtual orientation became the new norm for healthcare workers, while virtual education became the standard for students. The shift to online learning led to some students missing out on crucial in-person interactions with patients and hospital-based learning, which were vital components of practical training, especially for first-year students learning to become doctors, nurses, pharmacists, and physical therapists. Furthermore, the lack of hands-on experience during the pandemic had an adverse effect on the ability of many health professional students to perform effectively as new hires.

> *"I will say that we've hired a lot of nurses that are the first year of school nurses, so that's a whole other problem, because they really spent their residency in a lab and not hands-on at the bedside. And so they can't handle a workload of five or six patients to one nurse. And so we've had to augment with CNA's or other staff to try to help them until they can get used to having the workload and then what they need to do every day for the patients."* – Hospital chief executive

> *".. As the pandemic progressed, we started having issues with our own staff getting COVID, so we had that challenge of having to replace our staff, our workforce with nurses of the pandemic."* – Hospital leadership

The emergence of the pandemic led to nurses taking certain shortcuts to administer patient care, which may have been necessary in the moment but could be less effective in the long run. This new standard of practice resulted in the original default training being disregarded by both seasoned and new nurses.

> *" The nurses got used to doing a lot of shortcuts because of having to deal with pandemic patients, and now that we're back to normal, it's almost like having to reteach everyone what we did every day and the processes and the steps that we took every day with patients. And so that's kind of, this has been our transition year that we've been spending a lot of time with education." – Hospital leadership*

Other hospital systems faced the challenge of maintaining training standards, particularly for new hires, due to the influx of patients during the pandemic.

> "*Because there was so much challenge and chaos and need for acute care, you wonder whether we had the ability to maintain that same level of training. Even if they [new*

hires] are competent clinically and we educate them, it is still not quite the same as having one of your own staff members in many ways, and so I think that was an adverse challenge for us in a lot of cases." – Hospital chief medical officer

Amplified Marginalization During the Pandemic: Exploring Social Determinants of Health

The pandemic-induced increase in unemployment rates led to a rise in uninsured patients seeking care at hospitals. Those who had previously relied on employer-provided health insurance lost their coverage, making it difficult for them to afford routine doctor visits and maintain continuous care. This trend was particularly noticeable in economically challenged areas, such as City Council Districts 4, 5, and 7 in San Antonio, as noted by local government officials and staff, one of whom said:

> *"Health care shouldn't be tied to employment, for the reason that larger businesses tend to reduce your hours so they don't have to provide you benefits, particularly health care benefits, and then seeing how people are losing their jobs just dependent on their boss's values and vision and profit."*

The situation with uninsured patients during the pandemic was a significant concern for hospitals, especially when it came to discharging COVID-19 patients who needed further treatment. Without insurance, many patients could not afford to continue their care, and next-level-of-care institutions were hesitant to take them without payment. At least one hospital system (Christus Santa Rosa) covered patient fees to transfer uninsured patients safely to their next level of care.

In contrast, the pandemic brought about a significant improvement in coverage for those with public insurance. The Public Health Emergency provided funding that allowed individuals to maintain Medicaid and CHIP continuous coverage even after their enrollment period had ended. Health care executives expressed their appreciation for this positive change, which lasted until "Medicaid Unwinding" began in April 2023.

The pandemic also impacted access to transportation and the affordability of health care services. Local government officials and staff agreed that these barriers increased for specific demographics, such as older people, low-income earners, and people with disabilities, unstable housing, or living in low-income neighborhoods.

> *"In older communities, sometimes they're not physically able to drive or they just don't rely on their own personal vehicle. And so taking the bus or walking is often how they're able to go about and perform their activities. And so doctor's offices, if they're not within walking distance or they have to travel on the bus, that can make it more difficult, you know, having to schedule extra time to get to the bus station. And then depending on public transportation, that sometimes isn't as reliable as we would like it to be."* - Office of a San Antonio City Council member

> *"In terms of getting the vaccine, it was transportation and access… it was folks who were disabled requesting them...and really it was hard to hear, because they were begging for*

> *people to come to their homes. They had folks who were homebound and couldn't leave… it was almost always somebody who either had a wheelchair or was bedbound. Or was just afraid to come out because they had all of the indicators that said that you were at high risk, and they were just afraid to leave their home. And it was almost always older people. I believe it was, like, older people over the age of 60."*- Office of a San Antonio City Council member

> *"I've had conversations with constituents who, you know, they had a car at the start of the pandemic, and they don't anymore because they had to make choices, right, on what to pay. And they've had to sell their car and rely on public transportation. So getting access to doctor's appointments is another challenge."* - Office of a San Antonio City Council member

> *"It was a tragic time for District 4, especially when this is in 78242. It's one of our areas that's most in need. … So are 78248, 78245"* - Office of San Antonio City Council District 4

Additionally, the inflated costs of health care services affected access for low-income people.

> *"Some of my clients are like, 'I'm not gonna go because I'm gonna be slapped with a big bill that I can't afford.' So a lot of them I've talked to say that they're just, like, toughing it out, you know? Even right now, I have a client that has all these medical issues and she was still, like, trying not to go. And then when she finally went, because I convinced her to go, you know, it came to find out that she has all these things and needs surgery."* - Community health worker

A local community health leader spoke about inflated pricing of preventative health care services, which affected their ability to keep providing those low-cost services to their clients.

> *"What became more difficult to access where preventative health care services, checkups. And I'll tell you why. The price on them went up astronomically so…. that price is not really low cost or affordable anymore for our clients. So that's where we're at with that."*

Being homeless or not having a phone also were significant barriers to receiving health care services such as COVID-19 testing.

> *"There was a lot of barriers for testing because the COVID testing that we were doing required something like an e-mail address or a phone number. So that was a challenge in itself. Some people were homeless, too."* - Community health worker.

Older participants notably mentioned a lack of social support during the pandemic. Some mentioned that they lived alone without anyone to assist them when they needed help. An older woman spoke about the living condition of her older friend during the pandemic:

> *"He had caught COVID twice. He never got help. He needs someone to come help him still."* - Older focus group participant.

Local government officials and staff reported an upsurge in evictions, overdue bills, and demand for housing and utility support, attributed to pandemic-induced inflation. To address the issue, the officials planned to partner with the Mexican American Unity Council to provide mortgage and utility assistance to constituents. However, the need for financial aid in various areas, such as medication costs and copays, still remains unaddressed.

The pandemic also affected social support and mental health. The pandemic's impact on social support and mental health was observed by a government official working with city constituents to facilitate healthcare access. This official noted a surge in mental health issues among older adults during the pandemic.

> *"Mental health issues were spiked. We had older adults who were struggling with just being alone constantly. And not even having their family able to come and visit because they were older family members. Didn't want to put them at risk. So you know, there were calls, people would check on their folks, but the truth of the matter is, is that that was really, really hard. It was a tragic time for District 4"* - Office of San Antonio City Council District 4

Telehealth Barriers to Care

Amid the pandemic, healthcare systems broadened their telehealth services. Health executives and non-profit organizations acknowledged the advantages of such changes, such as eliminating transportation costs and decreasing no-show rates. However, certain barriers to accessing telehealth services disproportionately affected specific demographics, including older individuals, low-income families, and those with low literacy.

Telehealth challenges included inadequate technology and technology literacy, unstable Wi-Fi connectivity, and limited language access. Some older participants also found it difficult to learn new telehealth platforms for each virtual appointment with different providers. To alleviate these issues, older individuals suggested the provision of assistance with appointment scheduling and implementation of a standard telehealth platform across providers. Participants who did not experience difficulties with telehealth often reported receiving aid from family members or being given pre-configured tablet computers by nurses.

A community leader emphasized that functional literacy, not just technological literacy or the lack of technology, posed a challenge for some people in accessing telehealth services. The leader cited North African immigrant communities as an example. Local government officials and staff also acknowledged digital literacy difficulties in areas with high numbers of elderly and non-English-speaking residents.

> *"The community that I represent has a large population of seniors. So I think of my seniors who have landlines and don't have Internet. And who may have Internet but don't know how to use the computer; who may have a computer but may not have access to the Internet. And then if they do have Internet, phone and access to your computer, just navigating, filling out the documentation to get into the meeting is very difficult. And you know, we've seen it with our city meetings with Zoom and WebEx."*- Office of a San Antonio City Council member

> *"The population and the demographics of our residents are largely older adults. And so there are a lot of retired folks, and so there is the digital divide in terms of knowledge of how do you access the Internet, and perhaps you don't have Internet at home, and we have to travel elsewhere"* - Office of a San Antonio City Council member

> *"The digital literacy component is huge in my district. So now not only the digital divide but also digital literacy. And by the way, health literacy is already difficult for a lot of residents in my area because a lot of them speak Spanish or a lot of them read at a certain grade level."* - Office of a San Antonio City Council member

The impact of low digital literacy extended to healthcare providers as well. Leadership at one nonprofit highlighted that clinicians frequently had to devote a significant portion of their appointments to teach clients how to submit documentation using technology, undermining the purpose of health consultations and reducing their efficacy.

Moreover, the ability to maintain confidentiality during virtual therapy sessions was significantly compromised, particularly when clients shared bedrooms with family members or lived in small spaces without privacy. This led to the loss of existing clients during the pandemic, according to a nonprofit executive.

Limited Capacity and Distribution of Staff

Healthcare leaders reported that hospitals experienced an unprecedented staff shortage during the pandemic. Some staff members were hesitant to risk exposing their loved ones to the virus and resigned. Some staff contracted COVID-19 and were unable to work, while many nurses were lured away by contracting agencies offering more competitive salaries. The shortage of nurses resulting from recruitment by travel nurse agencies affected all the hospital systems interviewed.

> *"We had a mass exodus of our staff, especially ICU staff, nursing staff, ED, respiratory therapists…STRAC nurses started coming in once we hit the height of the pandemic...that brings challenges…they also brought things like how much they were getting paid and all of the benefits that they were getting as travel nurses, which then prompted my staff on the 2nd day to decide to go travel nurse for the dollars."* – Hospital chief executive

> *"If I'm a nurse and I'm working in a hospital for 10 years and I'm happy here, but then somebody comes in doing the same work and they're getting paid three times as much, I'm probably not as happy, right? And it doesn't take long to figure that out. And so that's not unique to our hospital. That happened all over the country. So you can see how that really disrupted things for hospitals during those big surges."* - Hospital chief medical officer

Hospital executives additionally shared that collaborating with travel nurses often presented challenges due to their unfamiliarity with existing systems or lack of investment in their jobs as compared to non-travel nurses.

> *"Having travel nurses is not a good thing for your environment. Basically, because they're only here for a little while and they're gonna leave. And they don't really want to adapt to your culture. There's 80% of them that are good nurses, and then you have the 20% that are on their phone the whole time and you're trying to teach him how to do things in your facility, and they don't really care because they're only here for 13 weeks or 15 weeks, and so they don't really want to adapt to anything that you're doing. So that doesn't help in trying to do patient experience, making sure that they know what our policies are."* – Hospital chief executive

> *"It's also a challenge when you have somebody that's really not a part of your system by taking a nurse who's been here 10 years, who knows our system, our culture and is very familiar, and you bring in somebody brand new. They're just not going to operate at the same level, even though they're clinically competent."* - Hospital chief medical officer

Nurse attrition during the pandemic led to remaining nurses taking on additional responsibilities. The resulting imbalance in nurse-to-patient ratios was exacerbated by the influx of adult COVID-19 patients. As a result, pediatric nurses and staff from other departments had to be cross-trained to work in adult units.

> *"We had to surge into units that we normally wouldn't have surged into. And with the volume, it created the need for extra adult ER nurses to other adult units. So we had to cross-train our pediatric nurses to become adult nurses. We cross-trained our PACU nurses to become adult nurses. And so we did a lot of cross-training of our nursing to ensure that we could continue to have our beds open and to care for those patients during that pandemic."* – Hospital leadership

> *"We had to cross-train physical therapists, respiratory therapists, other people, and other disciplines to kind of assist nurses with the care of those types of patients, the COVID-19 patients."* – Hospital chief executive

Nurses who worked in urgent care facilities confirmed dealing with an unusual volume of patients and often having to bring in providers from other clinics to help. Nurses also mentioned feeling burnout from working hours when hospitals were understaffed.

> *"We started seeing anywhere from 80 to 100 patients daily from all the influx. It was just basically like herding cattle, it wasn't even good health care anymore. The staff was overworked. Long hours. We didn't have enough providers. We were just getting everybody that the hospitals were turning away, that the doctors were turning away, that everybody was turning away and it was, it was just difficult." - Urgent care nurse*.

> *"The volume of patients was at some point pretty unsafe just because it was just so, so many and then they would have to get staff from other clinics, or PAs or NPs, and doctors from other clinics." - Urgent care nurse*.

> *"When I was working at Family Medicine, I was doing the job of three people because we could not get people to stay in the job…towards the I ended up leaving that job after a year. Just literally working the job of three people." - Urgent care nurse*.

The issue of burnout among nurses was found to be more prevalent in urgent care clinics compared to larger hospitals during the pandemic. Hospital executives reported implementing wellness programs that offered mental health counseling, yoga, salsa classes, and other stress-reducing activities for their employees. However, nurses working in urgent care settings from various health care systems did not mention similar workplace wellness support.

Another group of health care workers that uniquely felt the impact of the pandemic were Community Health Workers (CHWs). During the pandemic, some CHWs initially were not approved to work remotely. A community health worker described their experience with depression during that time:

> *"There's many of us that are dedicated to our community, tremendously. It's a way of life. So when we were isolated, it started affecting the CHWs because we weren't able to communicate or, you know, to see our clients, our families. So we already had a lot of issues with the families because we work with families that have needs. So with the pandemic, they multiplied, and more of them were added. So and us not being able to either go there or provide the resources, it started causing us to get depressed."* - CHW instructor and advocate

Negative Operational Impacts

Like all businesses, hospitals experienced supply chain shortages over the pandemic. These were national and not unique to any hospital. However, hospitals that had fully stocked warehouses were less impacted. Materials in short supply included Personal Protective Equipment (PPE), medications, drugs, CT contrast media and construction materials. Many supplies are still on back order.

> *"We were fortunate because we had a warehouse, we never had any PPE shortages, but we had shortages of certain medications and drugs, and that was a national thing. We couldn't do anything about it. There was a national shortage of contrast material for doing CT imaging, and that was because Shanghai shut down and 70% of the national supply came out of Shanghai. And so all of us were having to readjust protocols to make sure that we could still do the images even in the absence of some of that contrast, and so those are probably more frequent now than they used to be."* - Hospital chief medical officer

> *"We've been able to get patient care, but we've had issues where maybe, cardiac leads are on back order, or you have an issue with blood products or blood tubes or CT contrast. So it's a lot of that supplying chain trying to catch up now."* – Hospital leadership

> *"It's still affecting our supply chain. We were doing some construction during COVID and so, everything from a door taking a year to get here, HVAC – we ordered an HVAC in January of last year, we just got it in January of this year. So equipment took a long time, and then we're still, we still have some back orders occasionally with supplies, and we're having to use alternative supplies to kind of do the same thing." – Hospital chief executive*

Supply-demand dynamics during the pandemic led to a significant increase in the costs of equipment and labor. Hospitals faced high demand for agency nurses, who were expensive to recruit due to the unusual staff losses. One hospital faced financial risk after hiring travel nurses:

> *"And so they kept recruiting my staff away. So then that led us into having to backfill a lot of positions with agency staff at a very, very high rate of pay. And so that impacted our financials. It was devastating for our financials, actually. So every month, it was super trying to figure out, How do we recruit staff to stabilize our staff?"*

Local hospitals remained strained due to bed availability constraints well into 2023. As patients returned for routine care and new patients joined, bed space quickly filled up, leading to challenges in accommodating patients in a timely manner. "*We need to add physical beds quicker…there is increasing demand on the system*," said one hospital leader.

During the pandemic, some health providers' ability to discharge patients worsened, while others' improved. One executive mentioned barriers created by insurance companies and by admissions limitations at next-level-of-care institutions:

> *"It was hard for the insurance to figure out that even though they [patients] had been at the hospital for 15 days or 30 days, they still weren't well enough to go home, and they needed additional care, and they needed to authorize that additional care. And that's if the patient had insurance… Insurances run Monday through Friday and close at noon. So if you didn't get authorization from an insurance company within that time, then the patient is going to stay over the weekend, because the insurance company doesn't open again until Monday at 8.*
>
> *"And then the next-level-of-care institutions like a rehab—if they are a COVID-positive patient, then you have to show that there have been three negatives before you can transfer, and during the height of the pandemic, they don't have enough beds. So then we have to hold on to some patients until they could have enough beds in the city to support those patients."* – Hospital chief executive

In contrast, at another hospital, the ability to get insurance approvals improved as their institution utilized CMS waivers that shortened the discharge process. As these blanket waivers and flexibilities ended, insurance approvals once again became harder to access:

> *"During the pandemic, when we had some oversight by the government agencies and we had the waivers, it did make it easier to discharge patients, get them placed and then they would kind of approve on the back end….We have seen over the last year that we're starting to flip, to go back to the other way, now that the waivers are gone, where it takes, you know, sometimes 2,3,4 days to get an approval "* – Hospital leadership

Furthermore, delays in accessing primary care services were commonplace as health care providers prioritized COVID-19 patients. Nationally and locally, there is now backlogged demand for primary care services, as patients return to care sicker than before, to medical offices that remain short-staffed. A local community health leader who coordinates mobile mammogram screenings and mental health services noted that their services were suspended at the beginning of the pandemic and only resumed within the last year, contributing to the

backlog.

Lack of access to primary care services disproportionately affected older residents in San Antonio. A local government official mentioned that older residents experienced difficulty getting routine doctor's appointments due to more limited appointment times or converting primary care services to virtual. Older residents also mentioned having their appointments canceled, and they expressed a desire for more help.

> *"You know, that's the hardest part. They kept putting us off too, you know, they wouldn't see us."* - Older focus group participant

> *"At the beginning, they didn't know what they were dealing with. So they didn't know what to do, because I got COVID when it first started as well. And I was at home in bed by myself; they didn't have some medicine. They didn't have nothing. By the word of God, I didn't have any symptoms. I only had mild symptoms. I would call my doctor, and they'd just tell me. There's nothing we can do, and don't go to the emergency room. ... And so I said, OK, I'll just ride it out here"* - Older focus group participant

Negative Impacts on Quality of Care

Health care executives mentioned that hospital-acquired infections (HAI) rates increased during the peak of the pandemic in 2020, but recently, those rates have fallen. One hospital leader shared that the national increase in central line catheter and urinary tract infections also impacted their hospital. Another hospital executive mentioned having more ventilator-associated infections due to a high volume of COVID-19 patients and an unusual number of ventilator lines used by each patient.

> *"… we have problems with lung collapses because of the number of lines that the patients, especially the COVID-19 patients, had, so we had to learn how to deal with taking care of those lines differently. And now we're back to all of our bundle compliance and the things that we've always done. But we have the manpower to take care of it. When you had two or three COVID patients that you were taking care of in the ICU and they all had 20 lines or 30 lines to manage, we had infections, and they were on ventilators and their lines for such a long time—that was really, really hard to manage*." – Hospital chief executive

Additionally, according to a leader at Methodist Health, there was fear and panic among health providers when the characteristics of the virus were unknown. Older people mentioned that they felt this panic from health providers. They mentioned not being cared for or being told to go home when seeing a doctor. One person said they had to change their primary care providers because their doctor changed their attitude toward them after being exposed to COVID-19 from another patient.

> *"What happened with my doctor...she was exposed. One of her patients was exposed. So then she cut us off. You know, and her attitude changed with patients. With that information, you know, we were like, What's going on? You know, she's still our doctor, and she is not the same person anymore. So I changed doctors."* - Older focus group participant.

> *"I think the doctors also had that fear for themselves as well because they have families. They have children. So they're trying to protect themselves as well. And I think it just caused a big chaos."* - Senior Population Events Coordinator

> *"You know, that's the hardest part. You know, they kept putting us off too, you know, they wouldn't see us.*" - Older focus group participant.

There were also frustrations in coordinating care with the health department during panic or uncertainty about the virus. One hospital leader described their experience:

> *"At times, there were frustrations, because if you've got to do this, and you got to do it this way, and you roll it out to your 10,000 employees—and then two days later, you're changing what you had to do....Umm, I don't know that it is all on the health department as much as they were getting their directives from top down, too. And there was so much change in the pandemic as we learned more about it, that drove some of the changes from Metro Health."*

Pandemic Silver Linings

Despite the challenges in accessing health care during the pandemic, there were some positive developments in the health care sector. Health care executives observed greater levels of collaboration between health care systems and the government. When hospitals faced difficulty discharging patients due to inflexible health policies, the federal government provided discharge waivers that reduced bureaucracy and facilitated a faster process.

Hospitals also praised continuous Medicaid coverage policies and expanded reimbursement for telehealth visits, both discussed earlier in this report.

> *"When [telehealth] became paid for, at least it was like, I can do both. I can do face-to-face. I can do virtual and actually reach larger numbers of patients. My no-show rate goes down with virtual visits, because people tend to show up when you connect to them virtually rather than if they have barriers to transportation to come into your clinics. So I think that was probably the most significant reimbursement improvement."* – Hospital chief medical officer

During the pandemic, healthcare systems and local government offices implemented innovative strategies to provide healthcare services to individuals in underserved areas. One such approach was the organization of pop-up vaccination events, which aimed to improve health equity by reaching those who may have limited access to healthcare services. For instance, Metro Health, in collaboration with partners, identified pop-up vaccine locations based on an equity map. Additionally, partnerships such as the one between Wellmed and the City of San Antonio helped bring vaccines to the Southside. Several facilities also opened up their spaces to host pop-up clinics, highlighting the importance of community engagement in promoting public health.

> *"When we became a provider of the vaccine, we put more emphasis on vaccines and people in the community and social determinants of health and how we were going to*

meet them where they are... we went to places that really needed us…We were out of the back of the cars, in the rain. We were there." – Vaccine clinic leader

"On the South side, initially there were not any [vaccines]…we had to go downtown if we wanted to get a vaccine. And if you had to go up north, it would be really far away, and people were struggling; gas is expensive. And she [the Councilwoman] started making calls all over, and by the end of that week, there was a partnership in place." – Office of a San Antonio City Council member

Practice-Based Recommendations

When asked about recommendations to improve health care access in San Antonio, participant suggestions included the following. Some of these recommendations were already being executed, and participants felt they needed to be encouraged and sustained.

Participants mentioned the need to increase marketing around health care resources in the city. Local government officials expressed interest in collaborating with Metro Health to promote diabetes and heart disease events and to raise awareness of Metro Health's resource fairs. They suggested using various marketing channels, such as television ads, news channels, or mail, to reach a wider audience.

Participants in the senior focus group underscored the importance of marketing efforts geared toward older adults who rely heavily on community organizations for information. This highlights the need for health care providers to partner with community organizations, such as churches, to disseminate health care information and resources to vulnerable populations.

In addition, older focus group participants provided practical suggestions for improving transportation access during the pandemic. Some participants mentioned using senior transportation services to reach long-distance healthcare appointments and suggested that more of these services should be promoted better. For example, some medical offices offer transportation for people with Medicare:

“I use Comfort Care all the time. They take you over there and then you call them when you're ready. They pick you up and bring you back” - Older focus group participant

Several hospital executives, local government officials and staff, and nonprofit leaders also suggested improving telehealth for many different reasons, including for people in rural communities and to address the backlog of primary care services.

"In some cases, you're really got to lay hands on the patient, but for many, a lot of these visits could be managed through telehealth. And sometimes that's a benefit… You can reach individuals who may not have easy access or that live in remote areas or that are in rural areas. We have a hospital at home program that we developed under a waiver. Through this, the federal government and approved by the state, where if you're a certain type of patient, you're still an inpatient, but we can actually care for you at home. And we do that through iPad connections that we have, and you don't even have to have Wi-Fi. We have a hotspot that we provide. We have a nurse that visits twice a day. We have a virtual visit from physicians." – Hospital chief medical officer

Other health care leaders highlighted the need to conduct needs assessments on telehealth barriers in San Antonio. One nonprofit leader emphasized the need to identify technology deficits before transitioning to telehealth, given San Antonio's the digital divide. Additionally, one Council office noted that people living in affordable housing units often face unstable connections and emphasized the importance of installing proper equipment during the development of those units to ensure stable connections for telehealth.

Also brought up was the need to provide guided help for older people for telehealth appointments. This could mean allowing patients to fill out their health history details with their doctor instead of doing so online before their appointments. A community health leader suggested that using a simpler, more interactive platform may be helpful. Some focus group participants had tablet computers sent to them fully set up by their nurses, which elevated their telehealth experience.

A local nonprofit leader stressed the importance of prioritizing common languages like Arabic and Pashto due to the large population of Middle Eastern, North African, and South Asian immigrants in San Antonio. They said Metro Health is in the process of adopting a tiered approach to language access, as recommended by the City of San Antonio's Language Access Office. Arabic and Pashto languages are among the languages that will be prioritized for interpretation and translation services because they are widely spoken in San Antonio:

> "In addition to Tier 1 language access, which is Spanish and ASL, Tier 2 would include Arabic, Pashto, and Vietnamese, and then Tier 3 is four other languages. The City's goal is that Metro Health and other city departments will provide information in the languages that are spoken. I believe it will be beneficial to San Antonio's immigrant community when Metro Health adopts that tiered approach for language access."

A faculty member at a healthcare education institution suggested the need for more investment in telehealth programs at teaching facilities, which would also allow students to gain experience when they cannot be on-site. While some efforts are underway, such as follow up calls made by students to obstetrics patients at an FQHC, more investment is needed, this faculty member said.

Both this faculty member and another community health leader recommended that health care systems be more collaborative in coordinating care. The community health leader noted that in Utah, community health workers are integrated into the hospital system to connect patients to resources from the hospital:

> *"You can pretty much be flat broke, don't have a dollar in your pocket, and get phenomenal care in Utah and the Intermountain Healthcare system. They utilize Community Health Workers inside the hospital system to help dole out resources, and why can't we do that here too?"*

Finally, a hospital leader said San Antonio needs to add hospital beds:

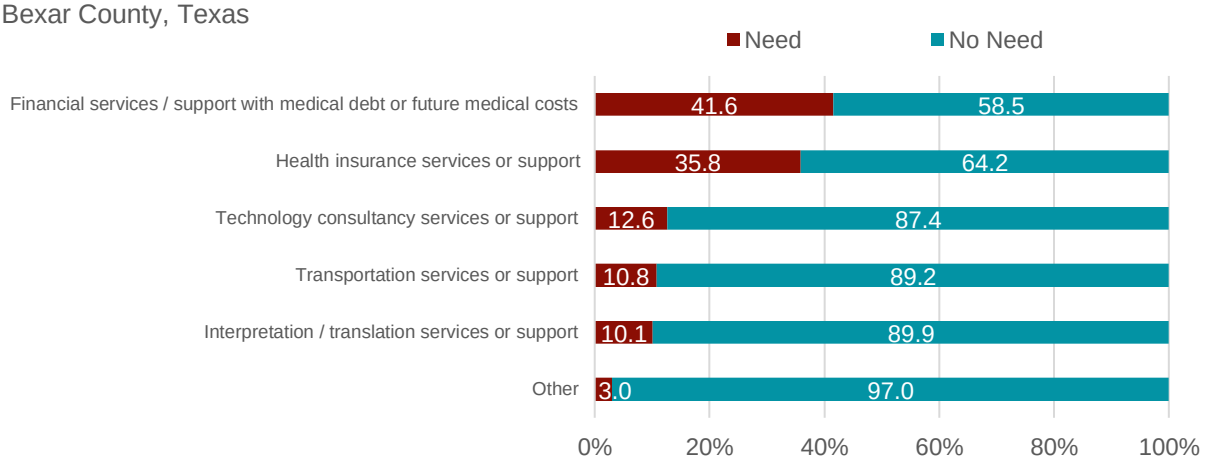
> *"San Antonio's growing. And if we're going to continue to care for the patients that we need, you know, there's gonna have to be some capital expansions. Where we have enough beds to care for our community, I would think maybe where you could say health*

departments could help is if there were more preventative programs, education around heart disease, stroke, diabetes, that type of thing to keep patients well enough not to have to come to the hospital. But when I think of how fast San Antonio is growing, I think we're just gonna continue to see the increased demand over the next four or five years."

Needed Supports Cited by Survey Respondents

Access to Care survey respondents were asked, ”What services or support would help you get the Healthcare you need now? (select all that apply.)” As shown in Figure 9.1, “Financial services or support with medical debt or future medical costs” was the most frequently mentioned type of support, cited by 42% of respondents. Thirty-six percent cited “Health insurance services or support.” Only 10% to 13% of respondents cited technology consultancy, transportation, or interpretation/translation services or support as being helpful, a result that is surprising given that a fair percentage of respondents reported each of those as being a barrier to care before pandemic onset, since pandemic onset, or both. For the 3% of respondents who left comments on the “Other” needs (Figure 9.2), “Expanded insurance coverage (including universal health care coverage)” and “Expanded medical service capacity (including more providers or longer hours)” were the most frequently-mentioned needs.

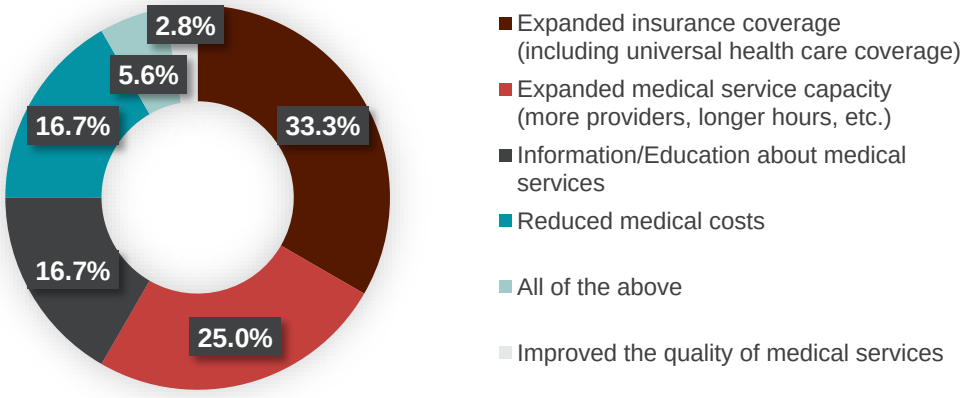
Fig. 9.1. Support Needed to Obtain Health Care Services Now
Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

Fig. 9.2. Other Supports Needed by Survey Respondents to Obtain Services Now

Bexar County, Texas



Source: Access to Care During COVID-19 Survey, 2023
Prepared by UTSA IDSER for The Health Collaborative

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Technical Notes

Unless otherwise indicated, data in this report were pulled in fall 2022. Surveys and focus groups took place in spring 2023. This research was supported by CDC grant OT21-2103, National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities.

Community Stakeholder Involvement

Community members and health care stakeholders guided this project, with input particularly in the survey, focus group, and interview components. Working with its extensive network of community partners, the Health Collaborative (THC) sent an initial invitation to a virtual meeting to brief interested participants about the project. Community participants were invited to review focus group and key informant interview instruments and provided input both during a virtual meeting and via email. Once interview materials were finalized, the community was invited to participate in the interviews. Given a short project window for the interview portion of the assessment, the number of interviews that could be scheduled was limited.

Data Sources and Methods

This report analyzes data from three primary sources: extant quantitative data, a purpose-built community survey, and focus groups and key informant interviews. The methodology and other technical notes for each main data source are described separately below.

Extant Data

The report includes multiple types of extant data from about 25 original sources, including common publicly available datasets, ad-hoc surveys administered during the COVID-19 pandemic, and administrative data collected or generated in the course of an organization doing usual business. Guided by the information provided in the original Request for Proposals and subsequent contract, as well as suggestions from Metro Health, several other potential data sources were investigated but were unable to provide data both specific to Bexar County/San Antonio and covering at least one year during the pandemic. To manage the project to budget and timeline, CI:Now excluded from this report some indicators (e.g., BRFSS and hospital discharges) that were reported in the *2022 Bexar County Community Health Needs Assessment* published by The Health Collaborative in fall 2022.

The degree to which the available data could be disaggregated depended on both the source data itself and this project's scope and budget. Most indicators are reported at the county level and disaggregated by race/ethnicity, sex, or both. Every attempt was made to compile and analyze at least one year pre-pandemic, or prior to March 2020, in order to identify changes that occurred at the time of – if not necessarily because of – the pandemic. Except as noted below, analysis of the extant data consisted of calculating proportions and rates, with margins of error or confidence intervals where appropriate; no statistical testing was required.

A subset of variables and (anonymous) Bexar County resident response records from the *COVID-19 & You* survey were provided for custom analysis. The analysis approach and aggregation choices, such as combining multiple gender identity response options to manage the problems of small numbers, were determined by CI:Now and do not necessarily reflect the views of the *COVID-19 & You* research team, Metro Health, The Health Collaborative, or any other project partner.

The C3HIE health information exchange provided de-identified hospital records for Bexar County residents according to query specifications developed by CI:Now and project partners. To better align with both the start of the pandemic locally and the widespread availability of vaccines a year later, each 12-month period queried is March 1 to the last day of February of the following calendar year. The analysis focuses on primary diagnosis, and it should be noted both that coding practices vary among hospitals, and that any secondary or tertiary diagnosis that might have been recorded was not utilized for the analysis. Variations in race/ethnicity coding by facility and a large proportion of missing values precluded disaggregation of the data by race/ethnicity. The 2021-2022 data included 12,001 records with ICD-9 rather than ICD-10 codes, as compared to four records in 2019-2020 and 162 records in 2020-201. Using the General Equivalence Mapping approach, all valid ICD-9 codes were converted to ICD-10 codes at the four-digit level (e.g., AXX.X) using STATA code developed by the National Bureau of Economic Research (NBER)[13] to streamline conversion with the Centers for Medicare & Medicaid Services (CMS) General Equivalence Mappings. In all three 12-month periods, records with no valid ICD-9 or ICD-10 code were excluded from analysis; virtually all were FT modifiers or brief text notes (e.g., “chest hurts”, “Medstar”). The final count of visit records with a valid ICD-9 or ICD-10 code in the primary diagnosis field totaled 251,926 (99.9% of the original 252,257) for 2019-2020, 177,059 (99.8% of 177,453) for 2020-2021, and 277,438 (99.8% of 277,977) for 2021-2022. The analysis approach and methods were determined by CI:Now and do not necessarily reflect the views of C3HIE or its participating hospital systems, Metro Health, The Health Collaborative, or any other project partner.

Apart from some images drawn directly from the data source as noted in the report, extant data was visualized in line and bar charts using the R programming language. Maps were generated using ArcGIS Pro. The source, time period, and geography of the data are included for every chart and map. As with analysis, the visualization approach and methods were determined by CI:Now and do not necessarily reflect the views of Metro Health, The Health Collaborative, or any other project partner.

The extant data was compiled with the assistance of staff or many different local and state organizations. Those organizations are recognized in the **Acknowledgements and Project Team** section of the report.

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Focus Groups and Key Informant Interviews

To obtain community input for this report, focus groups and individual qualitative interviews were held with various local groups and key informants in San Antonio to gather opinions on community health needs. Staff at the UTHealth School of Public Health and The Health Collaborative (THC) moderated the focus groups and conducted individual interviews. The UTHealth School of Public Health conducted the qualitative analysis with assistance from Community Information Now (CI: Now). A general grounded theory approach[14] was taken in conducting the focus groups/qualitative interviews and the qualitative data analysis. With this approach, codes and themes were derived inductively through the responses of participants. There was a strong focus on how social determinants of health (SDoH) impacted participants' access to and use of health services. The primary social determinants include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[15] Where applicable, qualitative analysis was approached through a lens of social determinants and how they affected San Antonio. It was important for the report to reflect the thoughts and opinions of people within the community and those who serve it.

Qualitative analysis was based on key informant interviews with San Antonio City Councilmembers and staff (Districts 4, 5 and 7), health care leadership (Methodist Healthcare System, Christus Santa Rosa Health System, University Health, University of the Incarnate Word, Metro Health), nonprofits (YWCA, ChildSafe, Culturingua), and on five focus groups with representation from community health workers, nurses, domestic workers, families, and senior citizens. Focus groups ranged from three to 15 participants, for a total of about 75 people represented in the thematic analysis. The main topics for the interviews and focus groups included the impact of the pandemic on the delivery of care and training, telehealth access, health insurance, and reimbursement, and patient barriers to care/social determinants of health. As part of the needs assessment core, interviewees were also asked to provide recommendations for bridging the gaps to care. Questions for the interview and focus group guides were drafted by the UTHealth School of Public Health to complement the survey questions and goals of the assessment. All materials were subsequently revised based on feedback from the group of community stakeholders.

All interviews were recorded and transcribed by the UTHealth School of Public Health and THC. Thematic analysis was performed in Atlas.ti and Microsoft Word to identify common themes using rapid assessment procedures (RAP).[16].

[14] Strauss, A., & Corbin, J. M. (1997). *Grounded theory in practice.* Sage.

[15] Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services; https://health.gov/healthypeople/priority-areas/social-determinants-health

[16] Manderson, L., & Aaby, P. (1992). An epidemic in the field? Rapid assessment procedures and health research. Social science & medicine, 35(7), 839-850.

Community Survey

Overview

In collaboration with CI: Now and The Health Collaborative, the Institute for Demographic and Socioeconomic Research (IDSER) at The University of Texas at San Antonio (IDSER - UTSA, thereafter) has developed a survey about health care seeking and health care experiences before and during the COVID-19 pandemic. The survey was based on community partner inputs and included demographic information, self-report measures assessing physical health, mental health, education, employment, finances, insurance, and self-efficacy as well as open-ended questions regarding health priorities, concerns, and resource/service needs. Respondents were recruited through social media, physical and electronic recruitment materials, and community partner word-of-mouth collaboration.

Surveys were collected via an online survey platform (Qualtrics), printed survey sheets (manually entered to the Qualtrics platform by The Health Collaborative team), and scannable survey sheets. Surveys were available in English, Spanish, Vietnamese, Chinese (Traditional and Simplified), Arabic, Pashto, and Farsi. Survey promotional flyers with the survey URL link and QR code were broadly distributed by all the project team members, including Metro Health, CI:Now, UTHealth Houston School of Public Health, The Health Collaborative, and IDSER-UTSA. Throughout the survey collection period from Jan. 23rd to Mar. 3rd, 2023, the team successfully collected a total of 1,821 surveys.

THC leveraged relationships with diverse community partners to attempt to bridge the digital divide for data collection efforts and adequately capture the voices of residents that lack digital access. Community partners (Araceli with Domesticas Unidas, Pastora Liliana with Impacto Community Center, Saul with Radio La Nuestra, and Sher with THC's COVID Response Team) assisted in collecting surveys via tablet or paper copies from people otherwise likely to be under-represented in the survey response because English is not the primary language spoken at home and digital access is limited. THC manually entered data from completed paper surveys into UTSA's Qualtrics digital survey platform. Some surveys were completed on paper survey forms structured and formatted by UTSA for optical character recognition (OCR) so that the survey responses could be digitized via scan.

After the survey was officially closed on Mar. 3rd, 2023, the IDSER-UTSA team exported all the survey data and combined them into a single master spreadsheet. The data file then underwent the team's data cleaning processes, including removing duplicated records, recoding items, and assessing data quality. The IDSER-UTSA team also supplemented the data with the most current 2021 American Community Survey (ACS) 1-Year estimates data for assessing the representativeness (in Bexar County) of the survey data. Standard descriptive statistics were provided in the following sections to summarize demographic and survey items. Results were summarized and illustrated in charts and figures. In addition, the IDSER-UTSA team has coded qualitative responses to identify themes, patterns, and overlaps, and developed word cloud images or histograms to summarize the key takeaway points from the qualitative data. Findings from both quantitative and qualitative survey responses will help the project team to identify: (1)

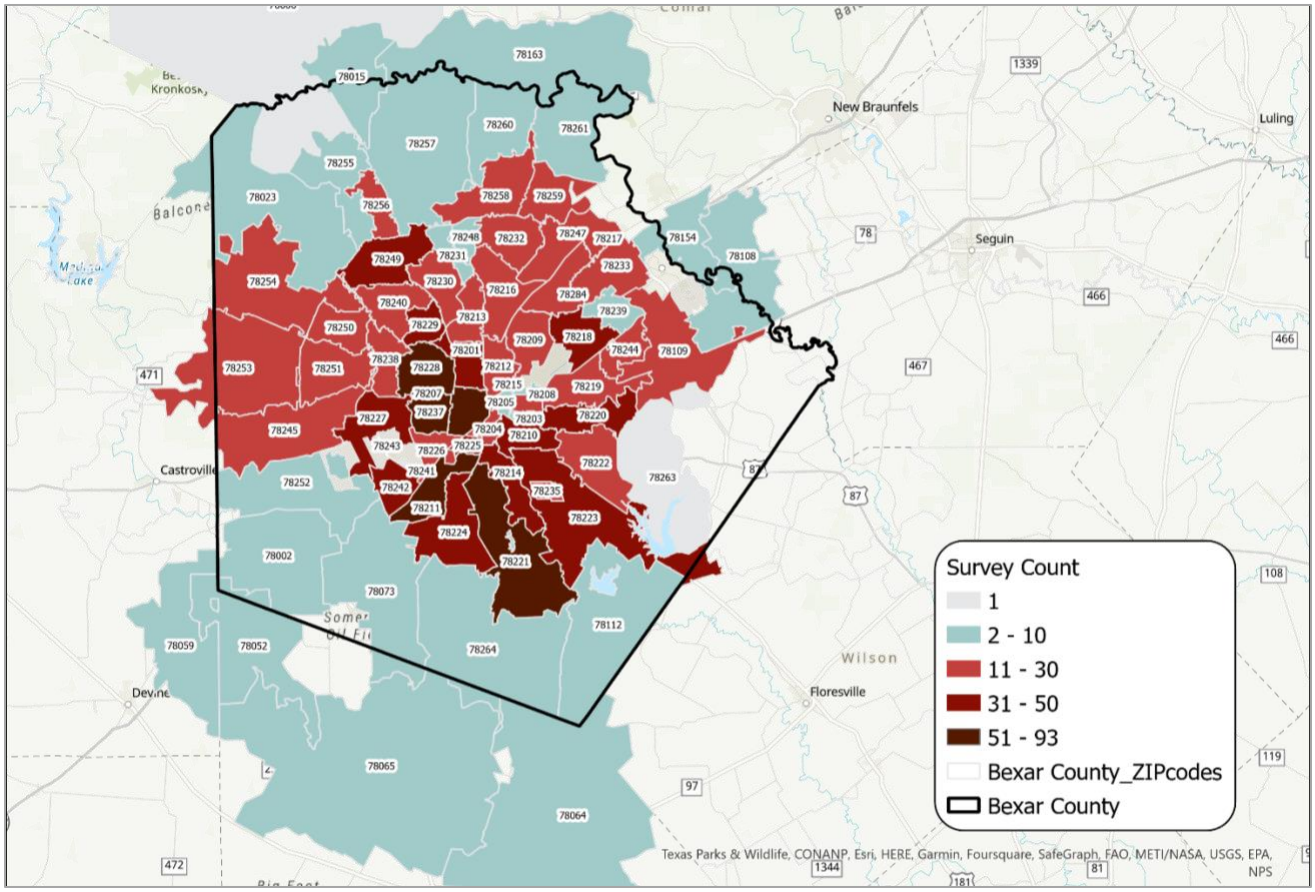
unserved or underserved populations who lack access to health care and (2) service gaps and barriers to accessing health care services (3) attitudes and perceptions relating to one's health care.

Please see **Appendix A: Technical Memorandum for Access to Care During COVID-19 Survey** for much more detailed documentation of survey approach, methods, and results.

Respondent Characteristics

A much more in-depth analysis of survey respondent characteristics is provided in **Appendix A: Technical Memorandum for Access to Care During COVID-19 Survey**. In brief, respondents were more likely than Bexar County residents overall to be female (69% vs. 50%). People aged 35 to 54 were over-represented in the survey sample as compared to the county's adult population, while younger and older people were under-represented. Survey respondents were more likely than county residents to live in low- and moderate-income households: 70% of respondents reported an annual household income of less than $50,000, as compared to 40% of county households overall. Thirty-seven percent of survey respondents were uninsured, about double the percent of adults in Bexar County overall. Of all survey responses, 51.1% were completed in Spanish, 45.6% in English, 2.2% in Pushto, 0.7% in Chinese, 0.3% in Arabic, and 0.2% in Vietnamese. As shown in the map below, the final survey sample draws from nearly every ZIP code in Bexar County, particularly those with higher population counts.

Valid Survey Response Counts by ZIP Code



Acknowledgments and Project Team

This report was developed for the City of San Antonio Metropolitan Health District (Metro Health) by a group of five organizations guided by a broader set of community stakeholders. Led by The Health Collaborative, other project partners included C3HIE, Community Information Now (CI:Now), the Institute for Demographic and Socioeconomic Research (IDSER) at The University of Texas at San Antonio (UTSA), and San Antonio-based researchers at the UT Health Science Center at Houston (UTHealth) School of Public Health. Each project partner's primary roles and team are described below, but all project partners contributed in some way to every aspect of the project.

Before describing each partner's role, the collaborative project team as a whole extends its gratitude to the community members who made this report possible by guiding the research, assisting with outreach, responding to the survey, or participating in a focus group or interview. The project team hopes that this report is of service in supporting the health and well-being of these and other community residents.

The Health Collaborative. The Health Collaborative's primary roles were to lead and inform all aspects of the project, manage project finances and reporting, convene community stakeholders to guide the assessment, recruit focus group and interview participants and provide logistical

support for that work, facilitate two Spanish-language focus groups and one in both English and Spanish, assist with focus group transcription, ensure that diverse voices were represented in the community survey response (including by interviewing community members face-to-face), translate project instruments and communication materials, and develop the Executive Summary. Special thanks to the board leadership of The Health Collaborative and the entire staff for their support and contributions to this community report.

C3HIE. Under the leadership of Phil Beckett, the C3HIE health information exchange queried and provided a de-identified dataset to support understanding of emergency room utilization.

Community Information Now. Community Information Now (CI:Now), a nonprofit local data intermediary based in San Antonio, handled extant data research, compilation/query, analysis, and visualization, and assisted in overall project management. CI:Now compiled and organized report content from each partner and wrote the bulk of the report narrative. CI:Now also assisted with qualitative data processing and analysis. The CI:Now project team included Cristina Martinez, Dr. Danequa Forrest, Jeremy Pyne, Dr. Laura McKieran, and Natalia Rodriguez.

Institute for Demographic and Socioeconomic Research (IDSER). IDSER at UTSA led the community survey portion of the project, including background research, survey development and digitization, development of OCR-compatible paper surveys for Health Collaborative use in the field, survey data processing and analysis, translation of project instruments and communication materials, narrative description of survey results, and description of survey methods and other technical notes. The IDSER team consisted of Dr. Po-Chun Huang, Dr. Jeff Jordan, Dr. Lloyd Potter, Alfredo Zavala, Julie Gonzalez, Valeria Alvarez, and Janine Geppert.

UTHealth Houston School of Public Health. The San Antonio team at UTHealth Science Center at Houston (UTHealth) School of Public Health led the focus group and key informant interview portion of the project, including background research, developing focus group and interview guides, conducting focus groups and interviews, transcribing all qualitative content, thematic coding and analysis, and description of focus group and interview methods and other technical notes. The UTHealth Houston School of Public Health team, with faculty and staff based in San Antonio, included Sandra Ovuegbe, Dr. Jack Tsai, and Asha Collier.

City of San Antonio Metropolitan Health District. The report was commissioned by the City of San Antonio Metropolitan Health District (Metro Health), and staff of Metro Health and other City departments were strong collaborators in the work. Those staff helped conceptualize and guide the work, pointed partners to background research and potential data sources, framed and facilitated project communications both within and external to COSA, translated project instruments and communication materials, promoted the community survey via SASpeakUp, informed recruitment of focus group and interview participants, and guided report design and layout. Special thanks go to Dr. Junda Woo, Sian Elmore, David Alegria, Cleo Garcia, and Dr. Golareh Agha for their insight and support as the work unfolded.

Whether or not they actually provided data, staff of many other local and state organizations spent considerable time and effort helping CI:Now and other project partners identify available data and understand the strengths and limitations of that data, and in some cases query/extract it and analyze or aggregate it as needed. The Health Collaborative and CI:Now are indebted to these individuals and the agencies who allowed them to share their time and expertise. In order by agency name, particular thanks go to Burt Santos at the Center for Health Care Services; Jose Ibarra and Joseph Contreras at CentroMed; Debbie Scharven in the COSA Department of Diversity, Equity, Inclusion, and Accessibility; Danielle Johnson, formerly of the San Antonio Council on Alcohol and Drug Awareness (SACADA); Cassie Fox and Pamela Lauer in the Texas Department of State Health Services (TDSHS); and Phillip Schnarrs in the University of Texas at Austin’s Dell Medical School Department of Population Health.

Appendix A: Technical Memorandum for Access to Care During COVID-19 Survey

www.sanantonio.gov/Portals/0/Files/health/News/Reports/Access-to-Care-During-COVID-19-Survey.pdf

CITY OF SAN ANTONIO — TEXAS —

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