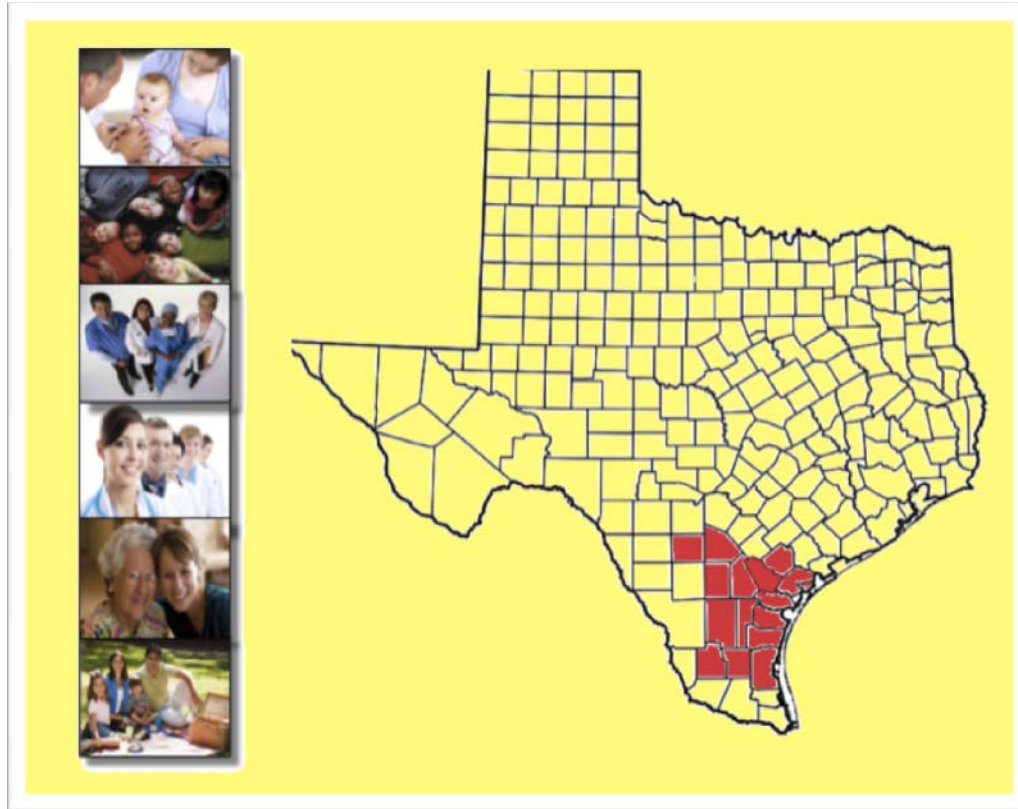


THE COASTAL BEND'S 2010 COMMUNITY HEALTH NEEDS ASSESSMENT



SOCIAL SCIENCES RESEARCH CENTER

COLLEGE OF LIBERAL ARTS

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Authorization

On March 6, 2010, the Social Science Research Center, College of Liberal Arts, Texas A&M University (SSRC) was contracted by the Coastal Bend Health Needs Assessment Steering Committee to conduct a health needs assessment of 15 Coastal Bend counties for 2010. Pursuant to a memorandum between Brian P. Smith, Vice President Mission Integration for CHRISTUS Spohn Health System, Dr. Harvey Knull, Vice President for Research and Scholarly Activity, Dr. Kelly Quintanilla, Dean, College of Liberal Arts, Dr. Philip Rhoades, Director of the SSRC, and Dr. Pamela S. Meyer, Principal Investigator, the following deliverable is in fulfillment of said memorandum and contract.

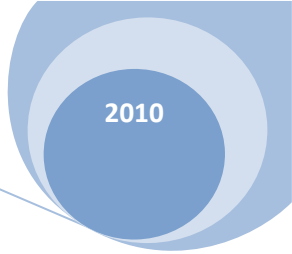
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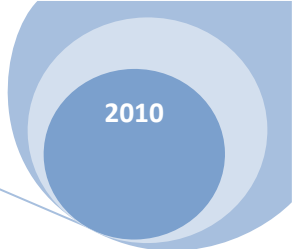
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Table of Contents

I) Executive Summary.....	9
II) Framing the Issues	13
Why Health Needs Assessment?	13
Methodology	14
Community Telephone Survey	14
Coastal Bend Health Systems Data	17
Health Care and Social Service Provider Survey	18
Community Focus Group Interviews	19
III) Coastal Bend Hospital Utilization	24
Basic Description of Patients	24
Most Common DRG Codes	25
Demographic Information about Patients	26
Patients' Employment Status and Financial Status	28
Principal and Secondary Diagnoses by Year	31
2007	31
2008	37
2009	44
Summary of Trends from 2007 to 2009	51
Trends by Diagnosis	51
Pneumonia	51
Cesarean Delivery	53
Heart Failure	54
Urinary Tract Infection	55
Hypertension	57
Diabetes Mellitus	58
IV) Perceived Health Status	61
Perceived Health Status	61
Days Physical Health "Not Good"	63
Days Mental Health "Not Good"	63
Body Mass Index	64
V) Access to Health Care	65
Health Insurance Coverage	65
Prescription Drug Coverage	71
Interaction with Health Care Providers	71
Personal Doctor	72
Routine Check-Ups and Procedures	75
Reported Conditions	77
Services Utilized	83
Health Information	85



VI) Children's Health Care Access and Status	88
Health Care Access	88
Children's Health Status	89
Asthma	89
Obesity	90
Premature Births	91
Mental Health Status	91
VII) Assessment of Issues in Coastal Bend	93
Children and Youth	93
Families	93
Seniors	93
Education/Preparation/Job Skills	94
Self-Sufficiency Basic Needs	94
Neighborhood and Community	94
Health and Well Being	95
VIII) References	104
IX) Appendices	107
A. Coastal Bend Counties' Report Cards	107
B. Urban and Rural County Criteria	122
C. Summary of Community Telephone Survey Results	125
D. Summary of Health Care /Social Service Provider Results	154
E. Focus Group Questions	163



List of Table and Figures

Table 1. 2010 Coastal Bend Health Needs Assessment Community Proportionate Sampling Strategy	16
Figure 1. Coastal Bend Counties Included In Health Needs Assessment By Rural/Urban.....	17
Table 2. Focus Group Description	21
Table 3. Focus Group Interviewees’ Demographic Description.....	23
Table 4. Frequency Distribution Of Patient’s Visits By Coastal Bend Hospitals.....	24
Table 5. Most Common Principal Diagnoses (Sept. 1, 2007 – August 31, 2009).	25
Table 6. Most Common Secondary Diagnoses (Sept. 1, 2007 – August 31, 2009).....	26
Figure 2. Race/Ethnicity Of Patients	27
Figure 3. Patient’s Race/Ethnicity By Age Groupings	28
Table 7. Cross-Tabulation Of Financial Class By Age Groupings	29
Table 8. Cross-Tabulations Of Financial Class By Race/Ethnic Groupings	30
Table 9. 2007 Most Common Principal Diagnoses (September 1 – December 31).	32
Table 10. 2007 Most Common Secondary Diagnoses (September 1 – December 31).	32
Table 11. Patients Less Than 1 Year Old 2007 Principal Diagnoses By Sex (September 1 – December 31).	33
Table 12. Patients 1 To 17 Years Old 2007 Principal Diagnoses By Sex (September 1 – December 31).	34
Table 13. Patients 18 To 49 Years Old 2007 Principal Diagnoses By Sex (September 1 – December 31).	35
Table 14. Patients 50 To 65 Years Old 2007 Principal Diagnoses By Sex (September 1 – December 31).	36
Table 15. Patients 66 Years And Older 2007 Principal Diagnoses By Sex (September 1 – December 31).	37
Table 16. 2008 Most Common Principal Diagnoses.....	38
Table 17. 2008 Most Common Secondary Diagnoses	38
Table 18. Patients Less Than 1 Year Old 2008 Principal Diagnoses By Sex.....	39
Table 19. Patients Aged 1 To 17 Years 2008 Principal Diagnoses Code By Sex.....	40
Table 20. Patients Aged 18 To 49 Years 2008 Principal Diagnoses By Sex.	41
Table 21. Patients Aged 50 To 65 Years 2008 Principal Diagnoses By Sex	42
Table 22. Patients Aged 66 Years And Older 2008 Principal Diagnoses By Sex.	43
Table 23. 2009 Most Common Principal Diagnoses (January 1 – August 31).	44
Table 24. 2009 Most Common Secondary Diagnoses (January 1 – August 31).....	45
Table 25. Patients Less Than 1 Year Old 2009 Principal Diagnoses For By Sex (January 1 – August 31).	46
Table 26. Patients 1 To 17 Years Old 2009 Principal Diagnoses By Sex (January 1– August 31).	47

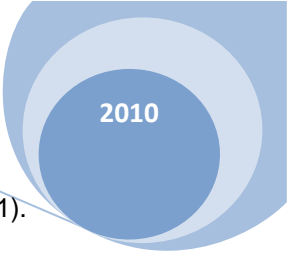


Table 27. Patients 18 To 49 Years Old 2009 Principal Diagnoses By Sex (January 1 – August 31).
 48

Table 28. Patients 50 To 65 Years Old 2009 Principal Diagnoses By Sex (January 1 – August 31).
 49

Table 29. Patients 66 Years And Older 2009 Principal Diagnoses By Sex (January 1 – August 31).
 50

Figure 4. Female Patients With Pneumonia By Age And Race/Ethnicity: 2007 - 2009 52

Figure 5. Male Patients With Pneumonia By Age And Race/Ethnicity: 2007 - 2009 53

Table 30. Cesarean Deliveries By Age And Race/Ethnicity Of Mother: 2007-2009..... 54

Figure 6. Female Patients With Heart Failure By Age And Race/Ethnicity: 2007 - 2009..... 54

Figure 7. Male Patients With Heart Failure By Age And Race/Ethnicity: 2007 - 2009 55

Figure 8. Female Patients With UTI As Secondary Diagnosis By Age And Race/Ethnicity: 2007 - 2009
 56

Figure 9. Male Patients With UTI As Secondary Diagnosis By Age And Race/Ethnicity: 2007 - 2009
 56

Figure 10. Female Patients With Hypertension As A Secondary Diagnosis By Age And Race/Ethnicity:
 2007 - 2009..... 57

Figure 11. Male Patients With Hypertension As A Secondary Diagnosis By Age And Race/Ethnicity: 2007
 - 2009 58

Figure 12.. 2007 Age-Adjusted Estimates Of The Percentages Of Adults With Diagnosed Diabetes In
 Texas 59

Figure 13. Female Patients With Diabetes As A Secondary Diagnosis By Age And Sex: 2007- 2009
 60

Figure 14. Male Patients With Diabetes As A Secondary Diagnosis By Age And Sex: 2007 - 2009
 60

Figure 15. Reported General Health Status Of Telephone Survey Participants 61

Table 31. Cross-Tabulation Of Health Status By Respondent’s Sex 62

Table 32. Cross-Tabulation Of Health Status By Respondent’s Urban/Rural County Residency. 62

Table 33. Cross-Tabulation Of Reported Health Status By Respondent’s Age Group..... 63

Table 34. Frequency Distribution Of Body Mass Index. 64

Figure16. Insurance Coverage Of Telephone Survey Participants..... 65

Figure 17. U.S. Census Bureau Health Insurance Coverage Estimates, 2006..... 66

Figure 18. Reasons For No Health Insurance Coverage Of Telephone Survey Participants 67

Figure 19. Type Of Health Insurance Coverage Of Telephone Survey Participants..... 69

Figure 20. Health Care And Social Service Provider Survey Responses To “In Your Professional
 Experience, Please Indicate The Degree To Which The Following Are Barriers To Health For Your
 Patients/Clients?” 70

Figure 21. Reasons Given For Medication Non-Compliance..... 71

Figure 22. Responses To “Is There More Than One Or No Person Who You Think Of As You Personal
 Doctor Or Health Care Provider?” 72

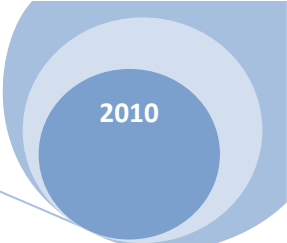


Figure 23. Responses To “Where Do You Usually Go For Routine Health Care?” 74

Figure 24. Responses To “About How Long Has It Been Since You Last Visited A Doctor For A Routine Check-Up?” 76

Figure 25. Responses To “Have You Had Any Of The Following Procedures In The Past 12 Months?” 77

Figure 26. Responses To “Do You Or Anyone In Your Household Presently Have Any Of The Following Conditions?” 78

Table 35. Conditions Reported By Telephone Survey Respondents By Urban/Rural County Status 79

Figure 27. Health Care And Social Service Provider Survey Responses To “In The Past 12 Months, What Was The Most Frequent Disease Or Condition You Saw?” 81

Figure 28. Chart Of “Other” Diseases Commonly Found In The Past 12 Months By Health Care Providers 82

Figure 29. Responses To “Have You Used Any Of The Following Services” 83

Table 36. Cross-Tabulation Of Services Needed By Age Group 84

Figure 30. Responses To “Where Do You Get Most Of Your Health Related Information?” 86

Table 37. Cross-Tabulation Of Source Of Health Information By Respondent’s Age Group. 86

Figure 31. Do Children Have Health Care Coverage? 88

Table 38. Frequency Distribution Of Respondent’s Type Of Insurance For Children..... 89

Table 39. Responses To “Has A Doctor, Nurse Or Other Health Care Professional Ever Said That Your Child (Or One Of Your Children) Has Asthma?..... 90

Table 40. Responses To “Has A Doctor, Nurse Or Other Health Care Provider Ever Said That Your Child (Or One Of Your Children) Needed Mental Health Services?” 92

Figure 32. Types Of Mental Health Services Needed For Children (Telephone Survey) 93

Table 41. Assessment Of Issues In The Coastal Bend 97

Executive Summary

The Coastal Bend 15 County Health Needs Assessment Steering Committee commissioned a health needs assessment study. The resulting report is based on information garnered from a community telephone survey, focus group interviews, a survey of health care and social service providers, and local health systems data.

This report documents the status in the Coastal Bend area regarding access and utilization of health care services since the first health needs assessment was conducted in 2004. Because the focus of the report is a “needs assessment,” the executive summary will highlight the “needs” of the community as supported by the data. This approach helps to delineate the issues and allows for more effective action planning.

Data indicate that some segments of the Coastal Bend population have limited access to health care services

In the 2004 needs assessment, 18.4% of area residents lacked health care coverage. The 2010 community telephone survey revealed that 18.2% did not have any kind of health care coverage, including health insurance, prepaid plans, or governmental plans such as Medicare and Medicaid. There were 5.2% who reported “self pay” as the method of payment for medical services. Focus group participants maintain that residents often do not have health coverage due to the high cost of private insurance, employers not offering this benefit, and/or for not meeting the qualifications for governmental plans. The overall picture of accessibility to health care indicates that for some segments of the Coast Bend population, accessibility has not improved since 2004. In addition, the data indicate that some Coastal Bend residents did not comply with their medication regime due to cost. It is important to address these discrepancies to ensure that everyone, regardless of his or her circumstances, has equal access to health care, especially given the current economic climate. It is recommended to:

- Increase community awareness about health related resources.
- Increase number of Coastal Bend residents with health insurance coverage.

Data indicate that some hospitalizations are preventable

Analysis of the hospital utilization data revealed that many patients end up in the hospital for conditions that are preventable such as dehydration, pneumonia, and urinary tract infections. Focus group participants state that the high occurrences of many preventable diseases may be due to a lack of health coverage, which prevents individuals from getting annual check-ups, preventative measures, and other basic health needs. It is recommended to:

- Decrease prevalence of pneumonia through a campaign for immunizations of the very young and the older residents of the Coastal Bend.
- Increase awareness of how to prevent dehydration.
- Decrease prevalence of urinary tract infections through education of hospital staff, nursing home staff, and patients.

Data indicate mental health admissions are increasing

Compared with data from the 2004 Community Needs Assessment, mental health issues seem to have increased in 2010. This may be due to increases in bed capacity over the past several years. Hospital, community survey, health care, and social service provider survey data reveal a variety of mental disorders afflict some members of the Coastal Bend community. Additional research is needed to determine if the actual incidence of mental health issues has increased. It is recommended to:

- Determine the prevalence of people who suffer from mental disorders.
- Increase awareness about resources available to those who suffer from mental disorders.
- Explore ways of increasing resources to treat mental health issues.

Data indicate that obesity is a major problem in our community

The Body Mass Index scores indicated that 65% of the telephone survey respondents were overweight or obese with only 24.2% at "normal" weight. Focus group participants observed the increased prevalence of obesity across the life course, citing inactive lifestyles and the ease of consuming unhealthy food options as primary causes. In addition, the health care and social service providers reported that the most frequent condition they saw in the past 12 months was obesity and overweight patients. Being overweight or obese is associated with a variety of health issues including Type 2 diabetes, hypertension, coronary heart disease, and stroke among other diseases. It is recommended to:

- Increase community awareness about the health risks associated with being overweight and obese.
- Increase community awareness about resources available to maintain a healthy weight.

Data reveal urban/rural differences in perceptions of health care access and conditions

Data from the community telephone survey and focus group interviews suggest that those who live in rural areas are more likely to perceive more barriers to health care

access than those who live in urban areas. Some of the issues raised were transportation to and from health care facilities, time waiting for services, quality of services, and the availability of certain kinds of specialists. In addition, rural residents were more likely to report medical disabilities, obesity, and orthopedic impairment than were urban residents. It is recommended to:

- Increase awareness of health care resources available to rural residents.
- Consider ways to increase health care access for rural residents.

Data indicate that chronic conditions are prevalent in the Coastal Bend

As in any community with a large proportion over the age of 65 years, chronic conditions such as cancer, hypertension, diabetes, and cardiovascular disease become more prevalent. To reduce the incidence of degenerative diseases such as these would require more preventive measures. For those who suffer with these chronic conditions, discovering ways to increase the quality of life seems prudent. It is recommended to:

- Increase awareness on how to prevent and/or delay the onset of chronic conditions such as hypertension, diabetes, and cardiovascular diseases.
- Increase the number of screenings for prostate, skin, colon, lung, and breast cancer to increase early detection of disease.
- Consider ways to improve the quality of life for those who suffer with chronic conditions.

Data indicate that additional medical specialists are needed in the Coastal Bend

The survey data indicate that most residents are able to successfully find needed medical specialists for their health conditions. However, there is a need for additional specialists, particularly cardiologists, neurologists, orthopedists, hepatologists, and pulmonologists. Focus group participants expressed a strong need for additional dental care and dental specialists in particular. Rural residents had increased difficulty in locating specialists in comparison to those in urban areas. It is recommended to:

- Increase awareness of medical specialists available to residents.
- Increase number of Coastal Bend residents' access to dental care.
- Consider ways to increase access to medical specialists for rural residents.

Data indicate disparate perceptions of issues among health care and social service providers and community members

The survey and focus group interview data indicate that in some areas, the community residents and health care and social service providers have different perceptions of the

issues in the Coastal Bend. The survey data, for example, shows that residents view illegal drug use and neighborhood conditions as more serious problems than do health care and social service providers. Health care and social service providers are more likely to view obesity, homelessness, affordable housing, mental health, and access to health care and education as serious problems than are survey respondents. Focus group participants cited particular community health issues that were not captured by survey data, particularly environmental hazards, the lack of city services for basic community health needs, and the impact of local industry on community/environmental health. It is recommended to:

- Increase dialogue between Coastal Bend residents and social service and health care providers to set priorities and solutions to community issues.
- Increase awareness of health care resources in the Coastal Bend community for more residents to utilize.

Continued cooperation among the health care providers is important

The level of cooperation among 2010 Coastal Bend Steering Committee members is highly commendable and should be applauded. To address the needs of the community requires a holistic approach to avoid duplication of efforts. The fact that the committee shared institutional data for the needs assessment is a step in the right direction. Improving the health of the community will require the collaboration of the region's hospitals, physicians, social and health agencies, and government and business leaders. It is recommended that the Coastal Bend hospital systems:

- Continue to work together to meet the needs of the community.
- Standardize the way hospital data is entered for future analyses.
- Set up community health needs task force comprised of hospitals, agencies, health departments, and local business leaders to develop priorities and action plans to address the needs raised by this report.

Framing the Issues

WHY HEALTH NEEDS ASSESSMENT?

Needs assessment is a systematic appraisal of type, depth, and scope of problems as perceived by study targets and/or their advocates (Neuman, 2000; Rossi and Freeman, 1982). The purpose of needs assessment in health care is to gather information required to produce change beneficial to the population's overall health. For this project, multiple perspectives on health needs may lead to re-conceptualizing a problem or a prospective intervention, or may indicate the advisability of continuing or abandoning current measures.

Recently, the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute presented the *2010 County Health Rankings*. The rankings are based on a collection of 50 reports that reflect the overall health of counties in every state across the United States. The rankings allow comparison of one county to another in terms of overall health and factors that influence health. The indicators included health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social, economic factors and physical environment). The purpose of the project was to get a standard way to measure how healthy a county is and see where it can improve. Those counties having high ranks (e.g. 1 or 2) are estimated to be the "healthiest."

Coastal Bend counties are not ranked highly. On most indicators, the Coastal Bend counties are ranked in the middle to bottom range. For comparison purposes, each county in the Coastal Bend was given a "report card" based on the *2010 County Health Rankings* as detailed in the Appendix A. On the Health Outcomes indicator, Coastal Bend counties' ranks ranged from 33 (Goliad) to 193 (Jim Wells) out of 221 with a mean rank of 108.23. On the Health Factors indicator, Coastal Bend counties' ranks ranged from 49 (Goliad) to 203 (Brooks) out of 221 with a mean rank of 127.46. These lower ranks suggest that the Coastal Bend counties need to improve health outcomes by addressing all health factors with evidence-based practices and policies.

The 2010 Coastal Bend Health Needs Assessment involved hospitalized patients' information, the health care and social service providers' views, and the views of the community at large. That is, this project used a mixed methods design approach to assess the community's health needs.

As detailed below, the purpose of the community telephone survey, health care and social service provider survey, and focus group interviews is to provide residents of the Coastal Bend an opportunity to report their health care utilization and needs. Although the health system data supplies information about those residents who are hospitalized,

it is limited in imparting the extent of the problems residents face or the prevalence of unreported disease conditions.

METHODOLOGY

The data for the project came from the following sources:

- Telephone survey of residents in the 15 counties of the Coastal Bend
- Data from CHRISTUS Spohn Health System, Corpus Christi Medical Center, and Driscoll Health System
- On-line survey of health care and social service providers
- Focus group interviews of residents representing the 15 counties of the Coastal Bend

Community Telephone Survey

For the purposes of this project, a community survey of residents in the 15 county area was necessary to establish what residents considered were the health care utilization and needs. Not all individuals will be able to seek help from local hospitals or agencies. As a result, they may not all be counted as patients or clients. As noted by Neuman (2000), sample surveys are the most direct and usually the most accurate data on target populations.

For the telephone survey that targeted a randomly selected sample of residents in the Coastal Bend, a survey instrument of 58 mostly closed-ended questions was developed (see Appendix C). The instrument was comprised of six sections.

- **Introduction.** To ensure that the respondent was a resident of one of the targeted Coastal Bend counties, the introductory section asked the respondents about where their residence was located.
- **Health Status.** Comprised of three questions, this section asked respondents about their general health status, including mental health.
- **Health Care Access.** The third section consisted of 24 questions inquiring about the respondent's ability to seek health care when needed and types of health care needed. It also included questions about the ability to pay for drug prescriptions and how long it had been since the last check-up.
- **Assessment of Issues in the Coastal Bend.** This section mimics questions from the 2004 Coastal Bend 12 County Needs Assessment. It asked respondents to indicate whether an issue was a major problem, moderate problem, or not a problem at all. The issues included health care issues, safety, traffic, schools, crime, domestic violence, transportation, and affordable housing among others.

- **Children's Health Status.** The fifth section of the survey was designed for those who had children under the age of 18 living with them. Questions in this section asked about whether children had health insurance and physical and/or mental health issues.
- **Background Information.** The last section of the survey instrument asked respondents basic demographic information such as sex, age, race/ethnicity, education, marital status, employment status, height, weight, and annual income.

After training, interviewers began the telephone survey on April 12, 2010 and completed the targeted number of completed surveys on May 20, 2010. The interviewers called from 3:00 until 9:00 p.m., Monday through Thursday, for the six week period. Interviews were both in English and Spanish. Over 7% of the respondents were interviewed in Spanish rather than English at the request of the respondent.

Each interviewer was assigned a list of phone numbers to call for a particular county to represent a random sample. A maximum of three attempts were made to reach each number in the sample. Using notebook computers, responses were recorded into the questionnaire posted at surveymonkey.com and later entered into the Statistical Package for the Social Sciences analysis program. Since many of the counties required long distance phoning, Skype was used to dial the numbers from the phone number lists.

To ensure that the study had representation from all 15 counties in the Coastal Bend area, a proportionate sampling strategy was used. Table 1 indicates the target number for each county and the actual number of surveys completed from each county. Nueces County contributed the majority (51.8%) of the respondents. There were 496 totally completed surveys and 41 partially completed surveys. The interviewers dialed 8,423 numbers. Of these, 7.3% were disconnected numbers and 10.8% refused to participate in the survey. The margin of error for this analysis is +/-4.5 with a 95% confidence interval.

TABLE 1. 2010 Coastal Bend Health Needs Assessment Community Proportionate Sampling Strategy.

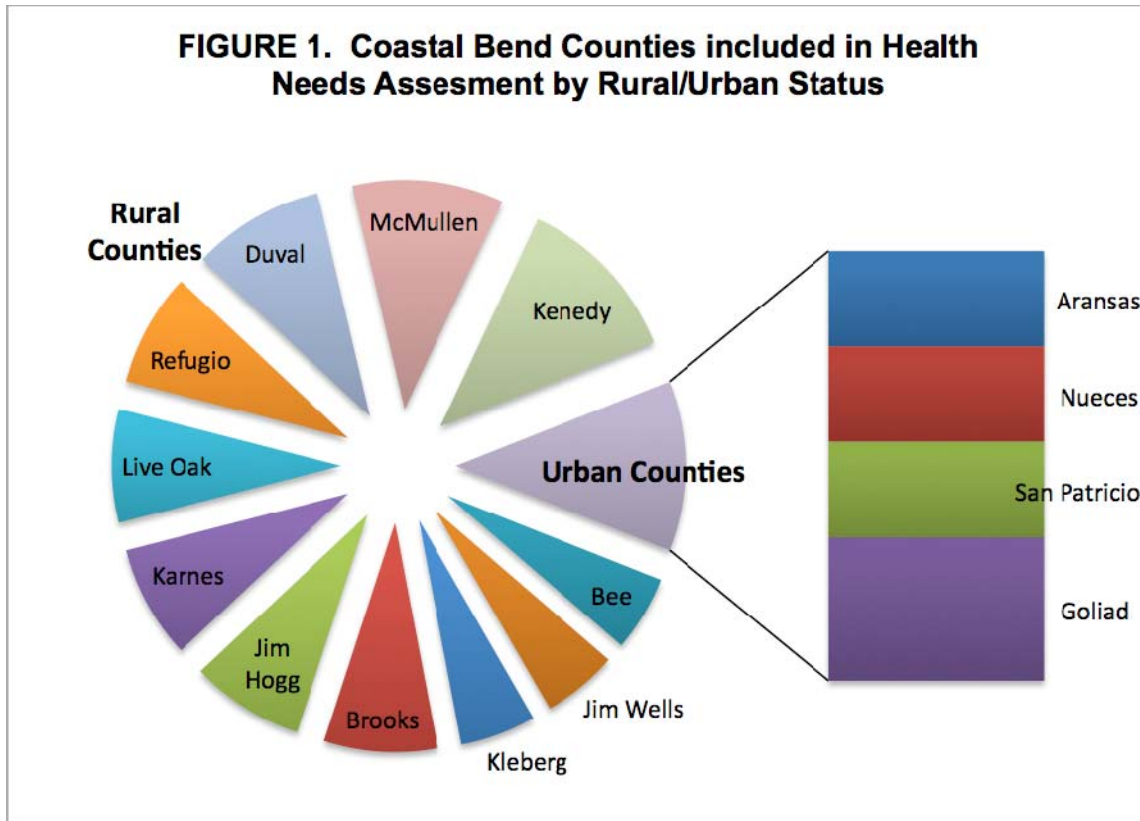
County	Population*	% of 15 County Total	Proposed Number in Sample by County	Actual Number in Community Survey
Aransas	24,900	4.246	21	25
Bee	32,661	5.569	27	31
Brooks	7,549	1.287	6	2
Duval	12,033	2.052	10	12
Goliad	7,152	1.219	6	10
Jim Hogg	5,016	0.855	4	5
Jim Wells	41,069	7.000	35	39
Karnes	15,051	2.566	12	4
Kenedy	388	0.066	3	2
Kleberg	30,739	5.241	26	27
Live Oak	11,247	1.918	9	22
McMullen	837	0.143	7	3
Nueces	322,077	54.918	274	271
Refugio	7,350	1.253	6	4
San Patricio	68,399	11.663	58	66
TOTAL	586,486	99.997%	504	523

*Source: U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates. Available at: <http://quickfacts.census.gov/qfd/states/48/48355.html>

Respondents to the telephone survey included 65.4% females and 34.4% males with an average age of 55.25 years. Over 58% were Hispanic. Half of the respondents were married. Respondents were more likely to be retired (34.4%) although 29.4% were employed for wages and 5.5% self employed. The majority (31.8%) reported incomes of less than \$25,000, but 21.2% of the respondents reported incomes between \$35,000 and \$74,999. Most (32.3%) completed high school and 27.9% had some college (1 to 3 years), but they did not receive a degree. The vast majority (68.8%) owned their own home and 18.3% rented or leased their homes. According to the U.S. Census, in 2000 (the most recent date for which there is county-level data), the homeownership rate for the state of Texas was 63.8%; the median homeownership rate for the fifteen counties assessed for this report was 74.2%, with the lowest home ownership rate being 34.8% in Kenedy County and the highest home ownership rate being 81.4% in Live Oak County. Some (12.8%), however, lived with family or friends. The average household included 2.20 adults. There were 176 (37%) respondents who had children under the age of 18 in the household. Although most respondents (81.9%) indicated that they spoke English as the primary language in their households, 18.1% replied that Spanish was the primary language in their household.

For some analyses, the county data was dichotomized into urban and rural categories using criteria established by United States Department of Agriculture Economic Services (see Appendix B). In general, the urban and rural counties were similar in age

structure and income level. Rural county residents (64.2%) were slightly more likely to be Hispanic than were residents of the urban counties (56.1%).



Coastal Bend Health Systems Data

Data from CHRISTUS Spohn Health System, Corpus Christi Medical Center, and Driscoll Health System were combined to determine the patterns of usage and prevalence of disease among the three hospital systems' patients. The data did not have any information identifying patients, so some of the cases may be repeat patients.

The three Excel files contained the following data: home zip code, patient's home county, discharge date, patient's age, patient's sex, patient's race, discharge disposition, Diagnosis Related Group (DRG) codes, DRG description, principal diagnosis code, principal diagnosis description, secondary diagnosis code, secondary diagnosis description, financial class, primary insurance, and patient's employment status.

The three Excel files were combined and analyzed using the Statistical Package for the Social Sciences. Some variables were transformed to increase the comparability of the data. To simplify the analysis, the response categories for age, race, financial class, primary insurance, and employment status were reorganized into a smaller number of categories.

In order to ensure that the Diagnosis Related Groups (DRG) codes were comparable across years, the researcher analyzed the principal and secondary diagnostic codes by year to detect any changes in the coding. Variables indicating the most common principal and secondary diagnoses were created for each year. This approach helped to identify any shifts in prevalence of diagnoses from year to year. In addition, certain diseases were examined by age, race/ethnicity, and gender to determine if certain subgroups are more likely to have particular diseases/conditions than were others.

Health Care and Social Service Provider Survey

To complement the Coastal Bend hospital data and community telephone survey, area health care and social service providers were asked to complete a brief on line survey. The questionnaire was posted at a Survey Monkey website and consisted of 11 mostly closed ended questions developed by members of the Steering Committee (see Appendix D).

- **Introduction.** The introductory section explained the purpose of the survey and that the responses would be kept confidential.
- **Location.** In addition to asking respondents to identify the county in which they worked, they were also asked to describe their work setting (urban/rural; for-profit/not for profit) and role in the organization.
- **Health Care Access.** The third section consisted of 5 questions inquiring about the respondent's accomplishments and challenges as a health care or social service provider. It also asked about what they saw as barriers to health and most frequent diseases or conditions for their patients/clients.
- **Assessment of Issues in the Coastal Bend.** This section mimics questions from the 2004 Coastal Bend 12 County Needs Assessment. It asked respondents to indicate whether an issue was a major problem, moderate problem, or not a problem at all. The issues included health care issues, safety, traffic, schools, crime, domestic violence, transportation, and affordable housing among others.

On May 17, 2010, a flyer with information about the 2010 Coastal Bend Health Needs Assessment and website link to the survey were sent to members of the Nueces County Medical Association and social services agencies. On May 24, a reminder was sent to those who had not responded. The survey concluded on May 31, 2010. Despite all efforts, the response rate was very weak. Because of the small number of responses, the data presented from the Health Care and Social Service Provider Survey should be interpreted cautiously.

In all, 44 social service agency representatives, 421 physicians affiliated with Spohn and 625 Nueces County Medical Society members (some physician names were on

both lists) received the request to complete the survey. Only 39 responded. The sample consists of 19 physicians (48.7%) and 10 social service agencies representatives (25.6%) with 10 other types of health care providers. The vast majority (84.6%) were from Nueces County and mostly in urban settings (74.4%). Most (56.4%) reported working in private practices while 30.8% worked in the public sector. Similarly, most (46.2%) reported working as part of a physician practice while 28.2% indicated working in a nonprofit social service or health agency.

Community Focus Group Interviews

In addition to the hospital data, the community telephone survey, and the online survey of health care and social service providers, nine focus groups were conducted within the fifteen-county area. The committee determined the locations within the fifteen counties.

Focus groups are often used by public health researchers for a number of reasons (Esterberg, 2002; Morgan, 1996). Focus group interviews are essentially semi-formal group conversations focused on a key set of issues (Kamberelis and Dimitriadis, 2008). The primary purpose of focus groups is to draw out detailed information from participants and to allow them to speak candidly about topics (Berg, 2004). Moreover, by gathering people “informally” to discuss topics such as the quality of health and health care in the community, focus groups offer researchers insight into how people talk about and how they make sense of particular issues (Neuman, 2007).

In general, focus groups allow for the building of understanding from the lived experiences of those participating in the research project (Peräkylä, 2008). Focus groups guide participants to collectively discover the social contexts that may have led to particular real world outcomes in their communities. This method is most useful when researchers want to know about people's attitudes and opinions, for topics such as community health (Esterberg, 2002). Unlike other research designs, focus groups can put participants on more equal ground, thus allowing more comprehensive data (Berg, 2004; Kamberelis and Dimitriadis, 2008; Madriz 1998, 2000; Montell, 1999). Focus groups are frequently used in conjunction with other research methods, particularly surveys (Esterberg, 2002). They are also ideal when a “one-shot collection” of data is needed in a relatively short period of time (Berg, 2004:123; Esterberg, 2002).

Sample

Focus group members should be homogenous and should not include close friends or relatives. In a typical study, a researcher uses four to six separate groups. The size of the group should range between six and ten participants, with each interview lasting between 60 to 90 minutes (Berg, 2004; Esterberg, 2002). The moderator should be

non-directive and facilitate free, open discussion by all group members (Berg, 2004; Neuman, 2007).

Because the life cycle encompasses “biological processes which take the individual from infancy into adult maturity and old age: growth and physical decline, and eventual death” (Hunt, 2005:10) and because stages of life and age categories have shaped behaviors, norms, and access to various health care resources that would interact with that biological process, the decision was made to organize the nine focus groups around three age categories. Three focus groups targeted populations of adults between the ages of 18 and 40. Three focus groups targeted adults between the ages of 41 and 61, and three focus groups targeted adults aged 62 and older.

The researcher team attempted to recruit participants for focus groups using a number of strategies. First, they posted flyers announcing the focus group's date, time, and targeted population at various governmental agencies such as Nueces County's Women Infant and Children (WIC) office, the Horn Road Clinic, Texas Department of State Health Services in Sinton, TX, at public libraries in the various communities, neighborhood clinics and hospitals, laundromats, restaurants, community action agencies, grocery stores, restaurants, and community centers. Directors of various agencies participated in disseminating information regarding the focus groups to eligible participants. Additionally, flyers were placed on vehicles in parking lots, at grocery stores, clinics, and libraries. Table 2 provides information regarding the nine focus groups.

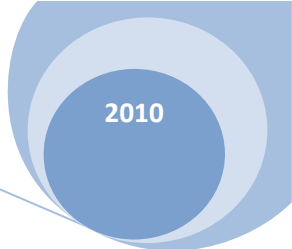


TABLE 2. Focus Group Description.

Focus Group	Location	Date Conducted	Number of Participants	Duration of Session
1: Ages 18-40	Greenwood Branch Library Conference Room Corpus Christi	June 5	6	1 hour 15 min
2: Ages 18-40	Christus Spohn – Kleberg HEB Educational Center Kingsville ¹	June 12	4	39 min
3: Ages 18-40	La Retama Central Library Conference Room Corpus Christi	July 6	10	1 hour 13 min
4: Ages 41-61	HEB Conference Room Corpus Christi	June 10	1	25 min
5: Ages 41-61	Christus Spohn – Kleberg HEB Educational Center Kingsville	June 12	5	1 hour 11 min
6: Ages 41-61	San Patricio County Department of Public Health Conference Room Sinton	June 14	6	1 hour 39 min
7: Ages 62 and Older	Oveal Williams Senior Center Corpus Christi	June 7	13	1 hour 12 min
8: Ages 62 and Older	Mullen Building Conference Room Alice	June 8	14	1 hour 19 min
9: Ages 62 and Older	Senior Citizens Community Center Aransas Pass	June 11	6	1 hour 16 min

¹ Qualitative interview studies—both one-on-one and focus group formats—often have unanticipated challenges (Ely et al., 1999; Esterberg, 2002; Morgan, 1995). Despite the researchers' efforts to recruit for this focus group through widespread advertising and by offering incentives for participation, recruitment for the Kleberg focus group proved to be problematic. Though a few community members initially signed up for this group, no participants had arrived by the scheduled start of the focus group. Esterberg (2002: 110) emphasizes that "unless the [research] topic is of great intrinsic interest to potential participants, they may not be motivated to participate." What is more, the researchers believe that particular community members in the earlier part of the life course may simply not have the flexibility in their work and family schedules to participate in focus groups, even if they are motivated to do so. As other researchers have suggested, flexibility in data collection is paramount (Ely et al., 1999; Esterberg, 2002). A back-up plan was created in which one researcher approached people in public places who fit the focus group selection criteria and asked for a series of "on-the-spot" one-on-one interviews. The duration of the session reflects the total number of minutes spent interviewing community members.

Staging of Focus Groups

The moderators have two primary tasks in facilitating focus groups (Esterberg, 2002). First, they take on the “directive role” in posing questions to participants. In the focus groups conducted for this study, the direction taken was general and open-ended. This allowed the most pressing issues to emerge in the focus group discussions. Second, moderators have the task of attempting to structure group dynamics in the focus groups. They should encourage all to participate and attempt to engage conflicting views on issues raised. Last, though moderators are the central figures in the focus groups, they should simultaneously attempt to background her/his self as much as possible. A majority—upwards of 90%—of the conversation should be from the participants themselves (Berg, 2004). The ideal moderator is one who is restrained, simply asking questions, fielding responses, and drawing out details with probes and follow-up questions (Berg, 2004).

The researchers used a standardized approach in organizing the focus group interviews. They began with introductions of the moderators and research assistants, followed by a short overview of the Coastal Bend Health Assessment Study. They then described the format of the focus groups, stressing that the design of the interview format was flexible with the intention of going in the direction the participants themselves saw as most relevant (Berg, 2004).

Prior to beginning the focus group, the moderators distributed consent forms to participants that were then read aloud. Participants were informed that their participation was completely voluntary and that they did not have to answer any questions with which they were uncomfortable. They were also assured that their identities would remain confidential and that at the end of the focus group they were to be compensated with a \$15 HEB gift card for their participation.

After completing the consent forms, a short survey was also distributed to participants. This “extended focus group” tactic asked primarily open-ended questions about participants’ perceptions about the health and needs of the community as well as basic demographic information (Berg, 2004) (See Appendix E). Most, but not all, participants completed the short survey. The intention of the survey was two-fold. First, the questionnaire was to spark the participants’ thinking on the issues focused on in the focus group. Second, it was to assist the data generated for the project. Such “pre-thinking” responses often allow for a broader range of responses to the interview itself, as individuals have a short list of ideas to which they can refer throughout the focus group session.

Table 3 provides the demographic characteristics of the participants of the focus groups who chose to complete the short survey with which they were provided.

TABLE 3. Focus Group Interviewees Demographic Description (n=63).

Sex	
Female	18
Male	45
Race/Ethnicity	
Non-Hispanic White	3
Hispanic	34
African American	17
Native America	1
Age	
18-24	2
25-34	3
35-44	8
45-54	10
55-64	10
65 and older	25
Education	
<High School	14
High School	18
Some College or A.A.	15
4-year degree or more	5

Research assistants had a particular role during the focus group interviews as well. In addition to their assisting the organization of the interviews, they observed interactions in the focus groups and took field notes during the sessions themselves. When possible, they created a working list of topics raised by participants on a dry-erase board (Berg, 2004). Doing so allowed participants and researchers to attempt to more fully discuss and examine issues before moving on to the next, thus allowing a more comprehensive data collection.

Interviews were recorded using digital voice recorders. The research assistants transcribed the interviews in their entirety. Participants were given pseudonyms to preserve confidentiality.

Data were analyzed using a grounded theory approach developed by Strauss and Corbin (1990 and 1998). While particular attention was given to issues tied to the quantitative data collections, the researchers also uncovered a number of issues that were not captured by the survey portion of the study.

Initial transcriptions were reviewed in three stages by each focus group moderator and her/his research assistant. The first phase—open coding—was where the researchers identified themes and assigned initial codes/labels in an attempt to condense the mass

of data into categories. Axial coding took place during the second phase of the coding. Here, the researchers began with the initial set of codes from the first phase with the primary task being to review and examine the initial codes. Causes, consequences, conditions, interactions, processes that clustered together were identified and collapsed into more inclusive categories/themes when possible. The final phase of the coding, selective coding, involved the scanning of previous codes, looking for cases that illustrated the themes and to make comparisons and contrasts between the different participants’ responses.

After each moderator and his/her research assistants coded the transcripts independently, the moderators and the research assistants met to review the themes they identified independently. The categorization of the themes was reviewed and consensus regarding the dominant theme categories was achieved. These findings are presented in the report.

Coastal Bend Hospital Utilization

For the 15 counties in the Coastal Bend area, data from the three area hospital systems, Spohn Health System, Corpus Christi Medical Center, and Driscoll Health System, are combined and form the basis of this analysis. Overall, the data represent 153,781 patient visits from September 1, 2007 through August 31, 2009. The following section serves as an introduction to the background of Coastal Bend patients and the conditions that brought them to the hospitals.

BASIC DESCRIPTION OF PATIENTS

Overall, the majority of cases were from the CHRISTUS Spohn Hospital System (67.9%) followed by the Corpus Christi Medical Center as shown in Table 4. With its targeted population, Driscoll Health System comprised 12.3% of the total. About 94% of the patients were from the 15 counties of the Coastal Bend. Patients from Nueces County comprised 54% of the group.

TABLE 4. Frequency Distribution of Patient’s Visits by Coastal Bend Hospitals.

	Frequency	Percent
Driscoll Health System	18,868	12.3
Corpus Christi Medical Center	30,489	19.8
CHRISTUS Spohn Health System	104,424	67.9
Total	153,781	100.0

Most Common DRG Codes

The Diagnosis Related Groups (DRG) were developed for the Health Care Financing Administration as a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. While all patients are unique, groups of patients have common demographic, diagnostic and therapeutic attributes that determine their resource needs. The DRGs form a manageable, clinically coherent set of patient classes that relate a hospital's case mix to the resource demands and associated costs experienced by the hospital. For the analysis, the hospital data is combined without reference to its specific source. Table 5 illustrates the most common principal diagnoses (based on DRG codes) for two years of hospital data (September 1, 2007 through August 31, 2009). The list includes both chronic and acute conditions with pneumonia as the most common infectious disease and heart failure as the most common chronic condition.

TABLE 5. Most Common Principal Diagnoses (Sept. 1, 2007 – August 31, 2009).

Diagnostic Code	Diagnostic Description	Percentage of Total (138,941)	Number
486.00	Pneumonia	3.3	4,612
428.00	Heart Failure	2.3	3,221
654.21	Previous Cesarean Delivery ²	2.1	2,910
414.01	Coronary Atherosclerosis, of Native Coronary Artery	1.5	2,059
650.00	Normal Delivery	1.5	2,053
599.00	Urinary Tract Infection	1.4	1,947
491.21	Obstructive Chronic Bronchitis with Acute Exacerbation	1.3	1,828
276.51	Dehydration	1.2	1,675
682.60	Cellulitis and Abscess, Leg, Except Foot	1.1	1,513
584.90	Acute Renal Failure	1.0	1,419
410.71	Subendocardial Infarction	1.0	1,416
493.02	Extrinsic Asthma	0.9	1,249
434.91	Cerebral Artery Occlusion, Unspecified	0.8	1,062

Table 6 presents the most common secondary diagnoses for two years. Many of the secondary diagnoses represent chronic conditions such as hypertension, diabetes, renal disease and failure. Pneumonia, however, persists as the most frequent secondary diagnoses.

² The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.

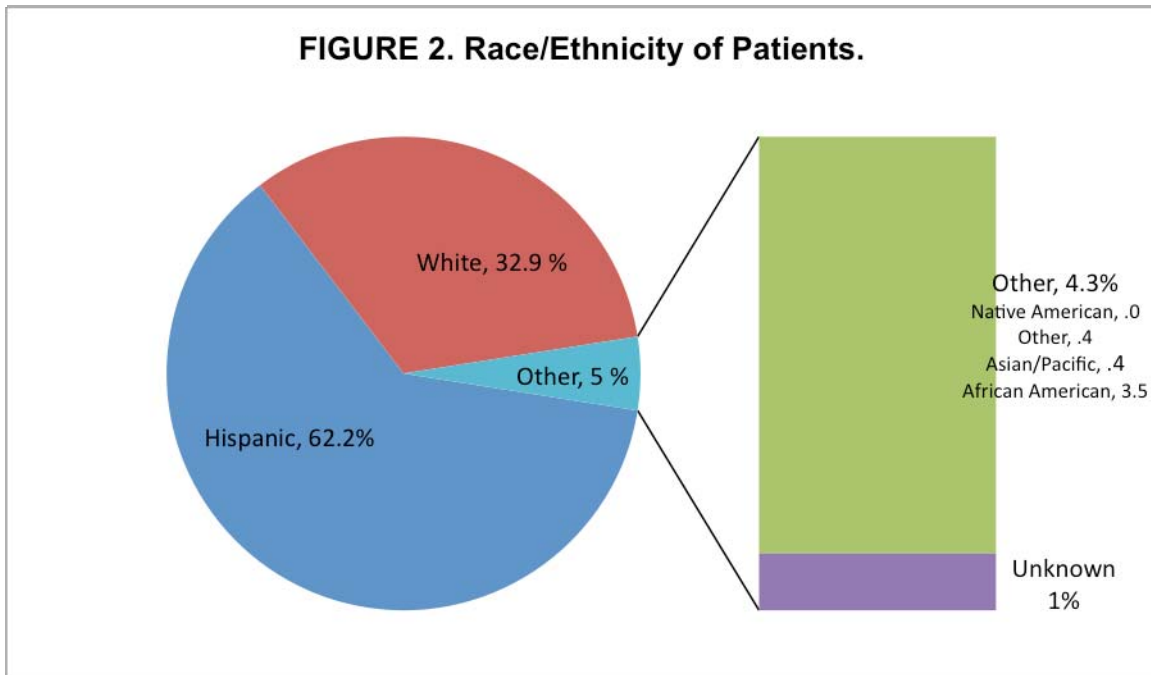
TABLE 6. Most Common Secondary Diagnoses (Sept. 1, 2007 – August 31, 2009).

Diagnostic Code	Diagnostic Description	Percentage of Total (130,494)	Number
599.00	Urinary Tract Infection	4.0	5,194
401.90	Essential Hypertension, Unspecified	3.5	4,595
584.90	Acute Renal Failure	3.1	4,036
486.00	Pneumonia	3.0	3,971
585.60	End Stage Renal Disease	2.9	3,822
250.00	Diabetes without Mention of Complications	1.6	2,091
518.81	Interstitial Emphysema	1.4	1,714
276.10	Hyposmolality and/or Hyponatremia	1.3	1,752
276.51	Dehydration	1.1	1,615
414.01	Coronary atherosclerosis	0.9	1,228
491.21	Obstructive chronic bronchitis with acute exacerbation	0.9	1,095
411.10	Intermediate Coronary Syndrome	0.9	2,445

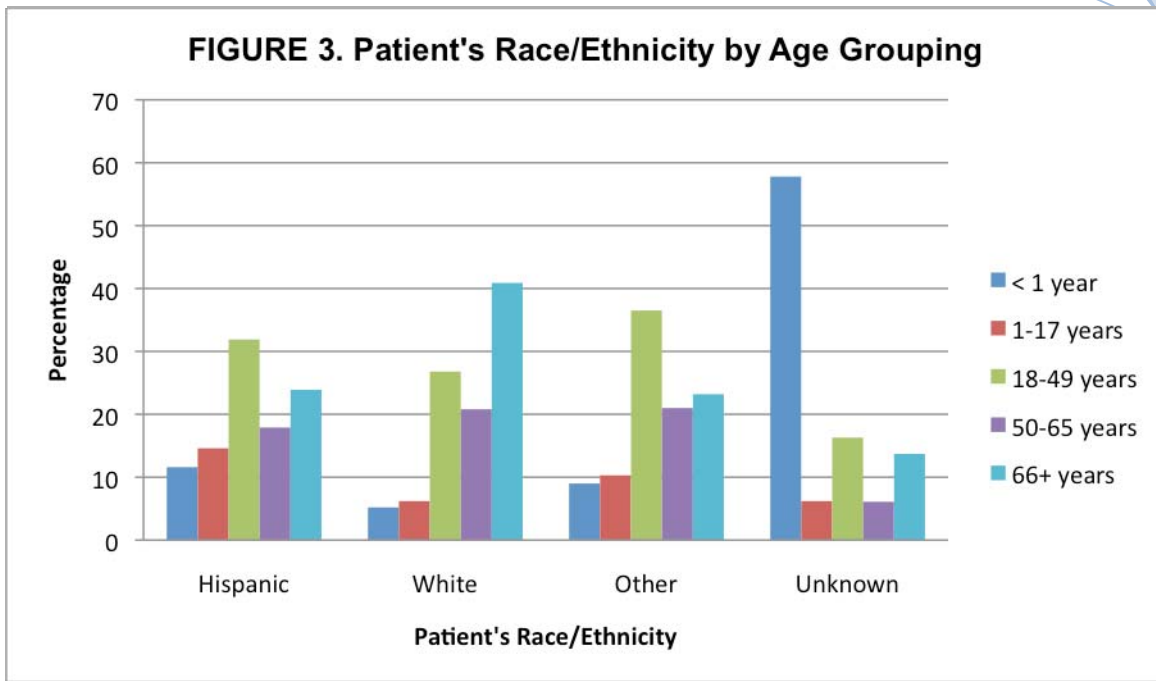
Demographic Information about Patients.

The majority of patient visits were female (56.9%). Patients' ages ranged from 0 to 107 with a mean patient age of 52.19 years. For Driscoll Children's Hospital, patients' ages ranged from 0 to 27 years with a mean age of 6.32 years. For Corpus Christi Hospital, patients' ages ranged from 0 to 107 years with a mean age of 52.19 years. Similarly, CHRISTUS Spohn Health System patients' ages ranged from 0 to 107 years with a mean age of 48.77 years.

As shown in Figure 2, the majority of patients were Hispanic (62.2%) and White (32.9%). The "Other" category includes 5,376 African Americans (3.5%), 682 Asian/Pacific Islanders (0.4%), 51 Native Americans (0.0%), 608 members of other racial/ethnic groups (0.4%), and 608 Unknown (0.6%).



As shown in Figure 3, it should be noted, however, that the age structure within each racial/ethnic category did vary. For example, White patients were more likely to be over the age of 66 years (40.9%) than were Hispanics (23.4%) or Other minorities (23.2%). Also, Hispanic and Other minority patients were more likely to be younger than were Whites. This may reflect a national pattern that shows minorities typically have a younger age structure than do Whites indicating slightly higher fertility rates (Ventura, et al, 2009).



Patient's Employment Status and Financial Status.

One concern of any organization such as a hospital is the economic status of its clients. Overall, the majority of patients were most likely to be unemployed (including homemakers and retirees). For patients in the 18 to 49 age category, for example, over half (59.5%) were unemployed. It is unclear whether the unemployment is due to the current economic circumstances, the patient's health status, or age that prevented employment. Not surprisingly, over 80 % of those who were aged 66 and older were retired. The disabled comprise 11.9% of all patients and were most likely to be in the 50 to 65 years age category.

Examining patients' employment status by race and/or ethnicity showed that a larger percentage of Whites were more likely to be retired (39%) than were Hispanics (19.9%) or Blacks (20.7%). Twenty percent of Blacks and 21.6% of Native Americans were disabled compared to 13.5% of Hispanic and 7.9% of White patients.

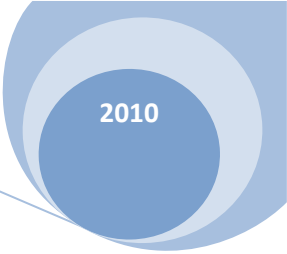
Financial class refers to how a patient paid for the hospital services received. Table 7 shows the relationship between financial class and patient's age. Most (28.1%) patients used Medicare to pay for services. Private insurance (including PPOs and HMOs) accounted for 22.9% of the payment methods used by patients, while Medicaid Managed Care comprised 17.7%.

Those patients who are in the "productive years" associated with employment (18 to 65 years age category) were more likely to use private health insurance, self pay, and/or federal/state health coverage (such as CHAMPUS) than were other age groups. For those patients less than 1 year of age, payments were most likely to be from Medicaid

Managed Care, (49.6%), Medicaid (22.1%), or private insurance (22.6%). Patients 66 years or older overwhelmingly paid for hospital services through the Medicare program (72.1%). Most (24.8%) of the remaining older patients used a Medicare Managed Care program for payment.

TABLE 7. Cross-tabulation of Financial Class by Age Groupings.

	Age Groupings					Total
	Less than 1 year	1-17 years	18-49 years	50-65 years	66 years and older	
MEDICARE	.0%	.8%	7.2%	24.5%	72.1%	28.1% (42,656)
PRIVATE INSURANCE	22.6%	29.6%	32.8%	34.7%	2.5%	22.9% (34,696)
MEDICAID MANAGED CARE	49.6%	28.6%	25.4%	9.6%	.1%	17.7% (26,770)
MEDICAID	22.1%	32.4%	12.5%	6.9%	.1%	11.0% (16,734)
MEDICARE MANAGED CARE	.0%	.0%	1.4%	9.2%	24.8%	9.5% (14,338)
SELF PAY	2.9%	4.0%	10.5%	6.4%	.2%	5.2% (7,865)
OTHER/ NCHD	.0%	.0%	4.8%	4.0%	.2%	2.3% (3,425)
FEDERAL/ STATE PROGRAM	2.4%	.6%	3.7%	2.7%	.0%	2.0% (2,958)
CHARITY	.0%	.0%	1.0%	1.4%	.0%	.6% (852)
CHIP	.5%	4.0%	.1%	.0%	.0%	.5% (815)
WORKER'S COMPENSA- TION	.0%	.0%	.5%	.6%	.1%	.3% (452)
UNKNOWN	.0%	.0%	.0%	.0%	.0%	.0% (24)
Total	14,660	17,591	46,025	28,689	44,620	151,585
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



As depicted in Table 8, when examining financial class by the patient's race/ethnic group, one does not find much variation by race or ethnicity, with a few exceptions. Asian/Pacific Islanders, for example, were more likely to pay through private insurance (38%) than any other method. Whites representing an overall older group, moreover, were more likely to use the Medicare program than any other payment methods.

TABLE 8. Cross-tabulations of Financial Class by Race/Ethnic Groupings.

	Asian/ Pacific	Black	Hispanic	Native American	Other	Unknown	White	Total
MEDICARE	20.5%	25.9%	22.8%	9.8%	19.2%	12.4%	37.7%	27.7% (42,658)
PRIVATE	38.0%	17.4%	20.7%	27.5%	31.1%	27.4%	27.2%	22.9% (31,152)
MEDICAID MANAGED CARE	7.5%	22.5%	22.3%	29.4%	9.2%	30.7%	9.9%	18.1% (27,889)
MEDICAID	8.9%	12.2%	14.6%	7.8%	11.7%	16.0%	4.7%	11.2% (17,282)
MEDICARE MANAGED CARE	2.3%	10.3%	9.2%	7.8%	5.1%	2.8%	9.7%	9.3% (14,338)
SELF PAY	9.7%	4.8%	5.4%	2.0%	14.8%	4.2%	4.6%	5.1% (7,851)
OTHER/ NCHD	1.3%	3.0%	2.3%	2.0%	2.8%	.3%	2.0%	2.2% (3,425)
FEDERAL/ STATE PROGRAM	10.9%	3.3%	1.0%	13.7%	5.6%	5.6%	3.3%	1.9% (2,973)
CHARITY	.3%	.4%	.6%	.0%	.0%	.3%	.4%	(852)
CHIPS	.4%	.1%	.7%	.0%	.0%	.0%	.3%	.5% (845)
WORKER'S COMPENS ATION	.1%	.2%	.3%	.0%	.3%	.2%	.3%	.3% (452)
UNKNOWN	.0%	.0%	.0%	.0%	.2%	.0%	.0%	.0% (24)
Total	682	5,376	95,660	51	608	862	50,525	153,764
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

PRINCIPAL AND SECONDARY DIAGNOSES BY YEAR

In order to establish some sense of the prevalence of certain diseases in the Coastal Bend area, the principal and secondary diagnostic codes for each year were examined. For the sake of simplicity, the analysis included only the top diagnoses for each year. In addition, using cross-tabulations, the relationships between demographic characteristics of the patients and principal diagnoses were explored. Overall, the top diagnosis for both males and females was pneumonia. For females, the next top two diagnoses were normal delivery and cesarean delivery. For males, the next top two diagnoses were congestive heart failure and coronary atherosclerosis.

As many diseases are related to the patient's age, the relationship between the patient's age and principal diagnoses was explored. As the data displayed in the tables illustrate, young people were more likely to have pneumonia or dehydration than were those age 18-64 years. Congestive heart failure and other chronic conditions, however, were more likely to occur in the over 65 age category. Urinary tract infections were more prevalent among those who are less than 1 year old or over the age of 65.

2007

For 2007, the data from September 1 to December 31 are included. As a result, the 2007 data represent only a part of the calendar year, and hence, has fewer patients (N=28,784) than 2008.

Tables 9 and 10 depict the most common diagnoses for patients in 2007. In general both acute and chronic conditions are represented. Preventable conditions, such as urinary tract infections, dehydration and pneumonia, appear as both primary and secondary diagnoses.

For the most common principal diagnoses, pneumonia and heart failure lead the list as shown in Table 9. Surprisingly, previous Cesarean deliveries emerge in the third position of the most common principal diagnoses while normal deliveries rank fifth in the list.

TABLE 9. 2007 Most Common Principal Diagnoses (September 1 – December 31).

Diagnostic Code	Diagnostic Description	Percentage of Total (28,784)	Number
486.00	Pneumonia	2.9	843
428.00	Heart Failure	1.8	526
654.21	Previous Cesarean Delivery ³	1.8	518
493.02	Extrinsic Asthma	1.6	458
650.00	Normal Delivery	1.4	414
276.51	Dehydration	1.3	366
414.01	Plaque Deposits in Native Heart Valve	1.3	360
682.60	Cellulitis, Leg, Except Foot	1.2	349
599.00	Urinary Tract Infection	1.1	326
466.11	Acute Bronchitis Due to Respiratory Virus	0.8	243
38.90	Unspecified Septicemia	0.8	229

As Table 10 illustrates, urinary tract infection, renal disease (end stage and acute), hypertension, and pneumonia were the most common secondary diagnoses for 2007.

TABLE 10. 2007 Most Common Secondary Diagnoses (September 1 – December 31).

Diagnostic Code	Diagnostic Description	Percentage of Total (23,553)	Number
599.00	Urinary Tract Infection	2.9	841
401.90	Essential Hypertension Unspecified	2.3	735
585.60	End Stage Renal Disease	1.9	544
486.00	Pneumonia	1.8	507
584.90	Acute Renal Failure, Unspecified	1.6	472
276.51	Dehydration	1.6	464
41.11	Staphylococcus	1.2	341
250.00	Diabetes Mellitus Without Mention of Complication	1.1	322
276.10	Hyposmolality and/or Hyponatremia	1.0	300
518.81	Interstitial Emphysema	0.9	264
496.00	Chronic Airway Obstruction	0.8	239
428.00	Heart Failure	0.7	202

³ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.

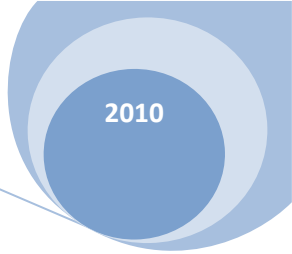
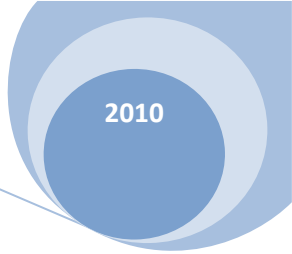


Table 11 demonstrates that the principal diagnoses for patients less than 1 year old significantly vary by sex. Females, for example, are more likely to suffer from urinary tract infections and cellulitis, while males are more likely to be dehydrated. Dehydration is related to a variety of causes including heat, intestinal problems, or virus. The percentage with bronchitis, pneumonia, and asthma, however, do not vary by sex.

TABLE 11. Patients less than 1 year old 2007 Principal Diagnoses by Sex (September 1 – December 31).

	Patient's gender		
	Female	Male	Total
Acute Bronchitis Due to Respiratory Virus	36.8%	34.5%	35.5% (459)
Pneumonia	21.8%	27.7%	25.1% (324)
Dehydration	10.8%	16.1%	13.8% (178)
Urinary Tract Infection	15.2%	7.8%	11.1% (143)
Extrinsic Asthma	7.5%	8.9%	8.3% (107)
Unspecified Septicemia	4.2%	3.2%	3.6% (47)
Cellulitis, Leg, Except Foot	3.5%	1.8%	2.6% (33)
Heart Failure	.2%	.0%	.1% (1)
Total	573	719	1292
	100.0%	100.0%	100.0%

Chi square = 33.54; d.f. = 7; p = .0001



As Table 12 shows, females have urinary tract infections more often than males. Infectious diseases, dehydration, pneumonia, and cellulitis persist as problems for younger patients. Asthma is most prevalent (32%) among patients age 1 to 17 years.

TABLE 12. Patients 1 to 17 Years Old 2007 Principal Diagnoses by Sex (September 1 – December 31).

	Patient's gender		
	Female	Male	Total
Extrinsic Asthma	24.2%	38.6%	32.3% (1082)
Pneumonia	22.5%	27.4%	25.2% (845)
Dehydration	16.9%	17.6%	17.3% (580)
Cellulitis, Leg, Except Foot	10.6%	9.9%	10.2% (343)
Urinary Tract Infection	9.6%	1.7%	5.2% (174)
Acute Bronchitis Due to Respiratory Virus	4.3%	4.1%	4.2% (140)
Normal Delivery	8.6%	.0%	3.8%(127)
Previous Cesarean Delivery	2.6%	.0%	1.1% (38)
Unspecified Septicemia	.5%	.6%	.6% (20)
Heart Failure	.3%	.0%	.1% (4)
Total	1482	1871	3353
	100.0%	100.0%	100.0%

Chi square = 3.74; d.f. = 9; p = .0001

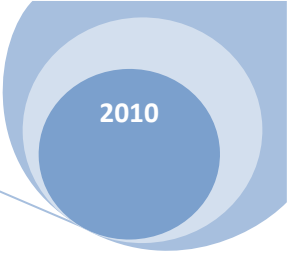


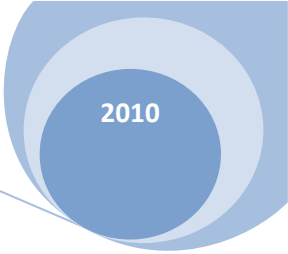
Table 13 displays the 2007 most common diagnoses for patients aged 18 to 49 years. Normal and cesarean deliveries appear on the most common diagnoses for females in this age group. Males were more likely to have infectious diseases such as pneumonia, septicemia, urinary tract infections, and cellulitis than were females of the same age. In addition, men were more likely to suffer from dehydration, heart failure, and plaque deposits in heart valves than were women. For the most part, women were hospital patients most often for childbirth.

TABLE 13. Patients 18 to 49 Years Old 2007 Principal Diagnoses by Sex (September 1 – December 31).

	Patient's gender		
	Female	Male	Total
Previous Cesarean Delivery ⁴	49.5%	.0%	40.8% (2872)
Normal Delivery	33.2%	.0%	27.4% (1926)
Pneumonia	5.1%	23.8%	8.4% (591)
Cellulitis, Leg, Except Foot	3.0%	29.1%	7.6% (534)
Heart Failure	1.6%	12.5%	3.5% (249)
Plaque Deposits in Native Valve	1.1%	12.9%	3.2% (225)
Dehydration	2.4%	6.7%	3.2% (222)
Unspecified Septicemia	1.7%	9.3%	3.1% (216)
Urinary Tract Infection	2.2%	5.3%	2.8% (194)
Extrinsic Asthma	.1%	.5%	.2% (13)
Total	5801	1241	7042
	100.0%	100.0%	100.0%

Chi square = 3.45; d.f.= 9; p = .0001

⁴ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.

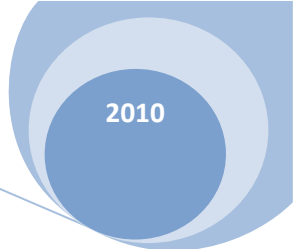


In the 50 to 65 years of age, women are starting to catch up with men in the principal diagnoses, except for urinary tract infection and dehydration, as shown in Table 14. Men are still slightly more likely to be in the hospital for cellulitis than are women. Normal and cesarean deliveries no longer appear as the most common diagnoses for women reflecting changes in the life cycle that come with this age group. Cesarean sections were not as common when these women were in their child-bearing years.

TABLE 14. Patients 50 to 65 Years Old 2007 Principal Diagnoses by Sex (September 1 – December 31).

	Patient's gender		
	Female	Male	Total
Plaque Deposits in Native Valve	19.1%	27.3%	23.5% (899)
Heart Failure	21.5%	23.6%	22.6% (865)
Pneumonia	24.3%	18.6%	21.2% (810)
Cellulitis, Leg, Except Foot	9.8%	12.5%	11.2% (429)
Unspecified Septicemia	9.3%	8.6%	8.9% (339)
Urinary Tract Infection	9.0%	5.0%	6.8% (260)
Dehydration	7.0%	4.6%	5.7% (218)
Total	1751	2069	3820
	100.0%	100.0%	100.0%

Chi square = 81.97; d.f. = 6; p = .0001.



With the patients 66 years and older, differences in diagnosis almost completely disappear by sex, as illustrated in Table 15. The only exception to this pattern is that women are still more likely than men to suffer from urinary tract infections. As noted earlier, several infectious diseases such as septicemia and pneumonia are prevalent among patients aged 66 years and older. The chronic condition, heart failure, however, is the most frequent diagnosis among this age group.

TABLE 15. Patients 66 Years and Older 2007 Principal Diagnoses by Sex (September 1 – December 31).

	Patient's gender		
	Female	Male	Total
Heart Failure	25.3%	27.9%	26.5% (2101)
Pneumonia	24.7%	25.8%	25.2% (1998)
Urinary Tract Infection	17.2%	10.3%	14.2% (1123)
Plaque Deposits in Native Valve	10.2%	13.8%	11.8% (935)
Unspecified Septicemia	10.8%	11.6%	11.1% (882)
Dehydration	6.6%	5.1%	5.9% (470)
Cellulitis, Leg, Except Foot	5.2%	5.5%	5.3% (423)
Extrinsic Asthma	.0%	.0%	.0%(1)
Total	4411	3522	7933
	100.0%	100.0%	100.0%

Chi square = 1.03; d.f. = 7; p = .0001.

2008

In the entire 2008 year, there were 63,384 patients with principal diagnostic codes. Tables 16 and 17 depict the most common diagnoses for 2008. The patterns observed are similar to those found for 2007. Osteoarthritis and subendocardial infarction (or heart attacks), however, are new additions to the most common principal diagnoses as illustrated in Table 16.

TABLE 16. 2008 Most Common Principal Diagnoses.

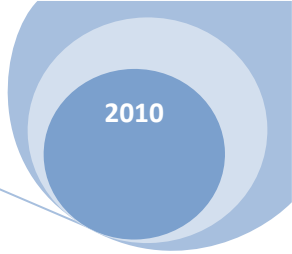
Diagnostic Code	Diagnostic Description	Percentage of Total (63,384)	Number
486.00	Pneumonia	3.0	2,291
428.00	Congestive Heart Failure	2.2	1,679
654.21	Previous Cesarean ⁵ Delivery	1.9	1,464
650.00	Normal Delivery	1.3	1,026
599.00	Urinary Tract Infection, Site Not Specified	1.3	983
491.21	Obstructive Chronic Bronchitis With (Acute) Exacerbation	1.2	909
782.60	Cellulitis and Abscess of Leg, Except Foot	1.1	859
276.51	Dehydration	1.1	844
410.71	Subendocardial Infarction	1.0	744
38.90	Unspecified Septicemia	1.0	737
414.01	Coronary Atherosclerosis of Native Coronary Artery	0.9	717
715.36	Osteoarthritis, Localized, Not Specified	0.8	600

As in 2007, urinary tract infection, hypertension, end stage renal disease, pneumonia and acute renal failure continue are the most frequent secondary diagnoses in 2008 (see Table 17).

TABLE 17. 2008 Most Common Secondary Diagnoses.

Diagnostic Code	Diagnostic Description	Percentage of Total (63,384)	Number
599.00	Urinary Tract Infection	3.5	2,689
401.90	Essential Hypertension Unspecified	3.1	2,334
486.00	Pneumonia	2.6	1,984
585.60	End Stage Renal Disease	2.6	1,951
584.90	Acute Renal Failure, Unspecified	2.6	1,950
250.00	Diabetes Mellitus Without Mention of Complication	1.4	1,091
518.81	Acute Respiratory Failure	1.2	890
276.10	Hyposmolality and/or Hyponatremia	1.1	854
276.51	Dehydration	1.0	758
285.10	Acute Post hemorrhagic Anemia	0.8	574

⁵ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.



For those patients who were less than one year of age, there were statistically significant differences by sex in the 2008 principal diagnoses. As Table 18 shows, males were more likely to suffer from dehydration and pneumonia than were females, while females were more likely to be admitted to the hospital for urinary tract infections and cellulitis.

TABLE 18. Patients less than 1 year old. 2008 Principal Diagnoses by Sex.

	Patient's gender		
	Female	Male	Total
Pneumonia	39.2%	48.8%	44.6% (324)
Dehydration	19.4%	28.4%	24.5% (17)
Urinary Tract Infection, Site not Specified	27.3%	13.7%	19.7% (143)
Unspecified Septicemia	7.5%	5.6%	6.5% (47)
Cellulitis and Abscess of Leg, Except Foot	6.3%	3.2%	4.5%(33)
Congestive Heart Failure	.3%	0%	1% (1)
Obstructive Chronic Bronchitis With (Acute) Exacerbation	0%	.2%	.1% (1)
Total	319	408	727
	100.0%	100.0%	100.0%

Chi-square = 33.11; d.f.=6; p=.0001

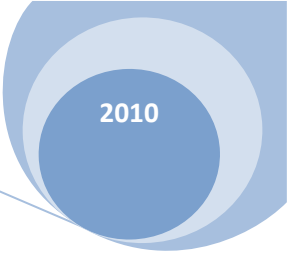


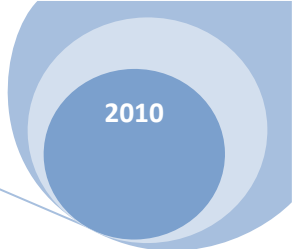
Table 19 shows the patterns for patients aged 1 to 17 years. The pattern is similar as for those patients age less than 1 year of age, with the exception of normal and cesarean deliveries for females.

TABLE 19. Patients aged 1 to 17 years 2008 Principal Diagnoses Code by Sex.

	Patient's gender		
	Female	Male	Total
Pneumonia	30.8%	47.1%	39.0% (845)
Dehydration	23.2%	30.3%	26.8% (580)
Cellulitis and Abscess of Leg, Except Foot	14.5%	17.1%	15.8% (343)
Urinary Tract Infection, Site not Specified	13.1%	2.9%	8.0% (174)
Normal Delivery	11.8%	.0%	5.9% (127)
Previous Cesarean ⁶ Delivery	3.5%	.0%	1.8% (38)
Obstructive Chronic Bronchitis With (Acute) Exacerbation	1.9%	1.5%	1.7% (36)
Unspecified Septicemia	.7%	1.1%	.9% (20)
Congestive Heart Failure	.4%	.0%	.2% (4)
Total	1080	1087	2167
	100.0%	100.0%	100.0%

Chi square = 2.90; d.f. = 8; p=.0001

⁶ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.



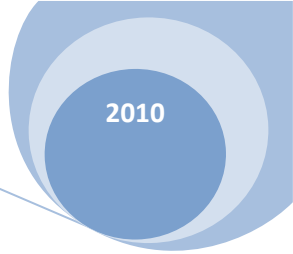
In the 18 to 49 age group, women were more likely to be in the hospital for deliveries, while men were more likely admitted for infectious diseases such as septicemia, pneumonia, and cellulitis than were women, as shown in Table 20. Men were also more likely to suffer from chronic conditions such as congestive heart failure, subendocardial infarction, and atherosclerosis than were women in this age group.

TABLE 20. Patients aged 18 to 49 years 2008 Principal Diagnoses by Sex.

	Patient's gender		
	Female	Male	Total
Previous Cesarean Delivery ⁷	48.6%	.0%	39.6% (2872)
Normal Delivery	32.6%	.0%	26.6% (1926)
Pneumonia	5.0%	22.0%	8.2% (591)
Cellulitis and Abscess of Leg, Except Foot	2.9%	26.9%	7.4% (534)
Congestive Heart Failure	1.6%	11.6%	3.4% (249)
Dehydration	2.4%	6.2%	3.1% (222)
Unspecified Septicemia	1.7%	8.6%	3.0% (216)
Urinary Tract Infection, Site not Specified	2.2%	4.9%	2.7% (194)
Coronary Atherosclerosis of Native Coronary Artery	.8%	8.9%	2.3% (168)
Subendocardial Infarction	.6%	6.2%	1.6% (118)
Obstructive Chronic Bronchitis With (Acute) Exacerbation	1.2%	3.4%	1.6% (115)
Osteoarthritis, Localized, Not Specified	.4%	1.3%	.6% (42)
Total	5907	1340	7247
	100.0%	100.0%	100.0%

Chi square = 3.468; d.f. = 11; p = .0001

⁷ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.

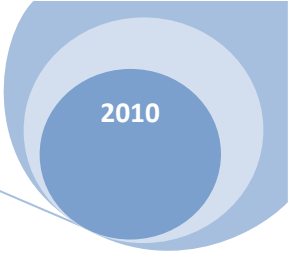


As shown in Table 21, diagnoses for more chronic conditions such as heart failure, subendocardial infarction and atherosclerosis became more frequent for patients aged 50 to 65 years. In addition, pneumonia continued to persist as a principal diagnosis for this age group.

TABLE 21. Patients aged 50 to 65 years 2008 Principal Diagnoses by Sex.

	Patient's gender		
	Female	Male	Total
Congestive Heart Failure	16.4%	18.1%	17.3% (865)
Pneumonia	18.5%	14.3%	16.2% (810)
Coronary Atherosclerosis of Native Coronary Artery	10.4%	15.1%	12.9% (645)
Obstructive Chronic Bronchitis With (Acute) Exacerbation	10.5%	10.0%	10.2% (510)
Subendocardial Infarction	6.0%	12.8%	9.7% (483)
Osteoathrosis, Localized, Not Specified	11.5%	6.3%	8.7% (433)
Cellulitis and Abscess of Leg, Except Foot	7.4%	9.6%	8.6% (429)
Unspecified Septicemia	7.0%	6.6%	6.8% (339)
Urinary Tract Infection, Site not Specified	6.8%	3.8%	5.2% (260)
Dehydration	5.4%	3.5%	4.4% (218)
Total	2299	2693	4992
	100.0%	100.0%	100.0%

Chi square = 1.73; d.f. = 9; p = .001



In the 66 and older group of patients, differences between males and females in principal diagnoses start to diminish, as shown in Table 22. Older women were slightly more likely to suffer from urinary tract infections and osteoathrosis than were men. Men, on the other hand, were slightly more likely to suffer from subendocardial infarction and atherosclerosis than were women.

TABLE 22. Patients aged 66 years and older 2008 Principal Diagnoses by Sex.

	Patient's gender		
	Female	Male	Total
Congestive Heart Failure	19.5%	21.8%	20.5% (2101)
Pneumonia	19.0%	20.1%	19.5% (1998)
Obstructive Chronic Bronchitis With (Acute) Exacerbation	11.0%	11.8%	11.4% (1165)
Urinary Tract Infection, Site not Specified	13.2%	8.0%	10.9% (1123)
Unspecified Septicemia	8.3%	9.0%	8.6% (882)
Subendocardial Infarction	7.0%	9.1%	7.9% (815)
Osteoathrosis, Localized, Not Specified	7.6%	4.8%	6.4% (653)
Coronary Atherosclerosis of Native Coronary Artery	5.4%	7.1%	6.1% (630)
Dehydration	5.1%	3.9%	4.6% (470)
Cellulitis and Abscess of Leg, Except Foot	4.0%	4.3%	4.1% (423)
Total	5737	4523	10260
	100.0%	100.0%	100.0%

Chi square = 1.361; d.f. = 9; p= .001

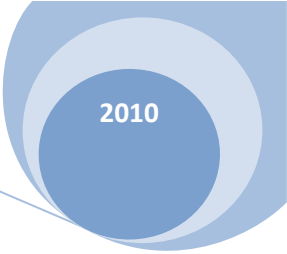
2009

The examination of 2009 hospital data represents a partial year; data are only available for hospital admissions from January 1 through August 31, 2009. Tables 22 and 23 display the most common diagnostic codes for the principal and secondary diagnosis, respectively. This is the first year that codes for mental disorders (schizoaffective and manic depressive disorder) emerge in the most common principal diagnoses, as depicted in Table 22. During this time period, new mental health facilities, such as the Northwest Behavior, were built in the Coastal Bend, factors that may inadvertently skew the mental health numbers for 2009.

TABLE 23. 2009 Most Common Principal Diagnoses (January 1 – August 31).

Diagnostic Code	Diagnostic Description	Percentage of Total (29,529)	Number
486.00	Pneumonia	3.0	1,478
428.00	Heart Failure	2.1	1,016
654.21	Previous Cesarean Delivery ⁸	1.9	928
491.21	Obstructive Chronic Bronchitis with Acute Exacerbation	1.4	674
414.01	Coronary Atherosclerosis, of Native Coronary Artery	1.4	671
296.34	Manic Depressive Disorder	1.3	654
599.00	Urinary Tract Infection	1.3	638
650.00	Normal Delivery	1.3	613
682.60	Cellulitis and Abscess, Leg, Except Foot	1.2	569
38.90	Unspecified Septicemia	1.1	553
295.70	Schizoaffective Disorder	1.0	475
434.91	Cerebral Artery Occlusion, Unspecified	0.9	462
715.36	Osteoarthritis, Localized, Not Specified	0.8	402

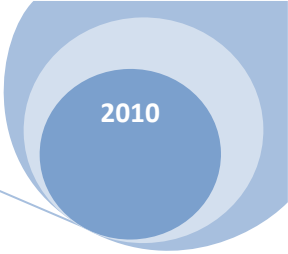
⁸ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.



In Table 24, the list of the most common secondary diagnoses for 2009 is very similar to those for 2007 and 2009. The most frequently occurring diagnoses are pneumonia and urinary tract infections. The remainder of the list consists of more chronic and/or degenerative diseases/conditions such as renal failure, hypertension, and diabetes mellitus.

TABLE 24. 2009 Most Common Secondary Diagnoses (January 1 – August 31).

Diagnostic Code	Diagnostic Description	Percentage of Total (38507)	Number
599.00	Urinary Tract Infection	3.4	1,664
584.90	Acute Renal Failure, Unspecified	3.3	1,614
401.90	Essential Hypertension, Unspecified	3.1	1,526
486.00	Pneumonia	3.0	1,480
585.60	End Stage Renal Disease	2.7	1,327
250.00	Diabetes Mellitus Without Mention of Complications	1.4	678
276.10	Hyposmolality and/or Hypernatremia	1.2	598
518.81	Acute Respiratory Failure	1.1	560
285.10	Acute Post Hemorrhagic Anemia	0.9	427
491.21	Obstructive Chronic Bronchitis	0.8	379

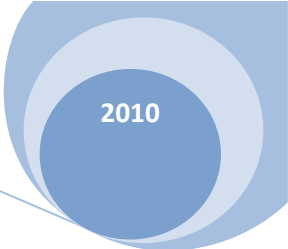


To explore the relationships between demographic characteristics of the patients and principal diagnoses for 2009, cross-tabulations were conducted. Table 25 demonstrates that the principal diagnoses for patients less than 1 year old did significantly vary by sex. Urinary tract infections (33.9%) and pneumonia (48.6%) accounted for most of the infant females diagnoses. Infant males, however, were more likely to be diagnosed with pneumonia (68.2%) than for any other principal diagnosis.

TABLE 25. Patients less than 1 Year Old 2009 Principal Diagnoses for by Sex (January 1 – August 31).

	Patient's gender		
	Female	Male	Total
Pneumonia	48.6%	68.2%	59.0% (324)
Urinary Tract Infection	33.9%	19.2%	26.0% (143)
Unspecified Septicemia	9.3%	7.9%	8.6% (47)
Cellulitis and Abscess, Leg, Except Foot	7.8%	4.5%	6.0% (33)
Heart Failure	.4%	.0%	.2% (1)
Obstructive Chronic Bronchitis	.0%	.3%	.2% (1)
Total	257	292	549
	100.0%	100.0%	100.0%

Chi square = 24.998; d.f. = 5; p = .0001



As Table 26 illustrates, males and females aged 1 to 17 years were more likely to be diagnosed with pneumonia (50.1%) or cellulitis (20.3%) than any other condition. Males were more likely to be diagnosed with schizoaffective disorders, while females were more likely to be diagnosed with manic depressive disorder. Females continue to suffer from urinary tract infections more than males.

TABLE 26. Patients 1 to 17 Years Old 2009 Principal Diagnoses by Sex (January 1– August 31).

	Patient's gender		
	Female	Male	Total
Pneumonia	37.5%	64.0%	50.1% (845)
Cellulitis and Abscess, Leg,	17.7%	23.2%	20.3% (343)
Urinary Tract Infection	16.0%	4.0%	10.3% (174)
Normal Delivery	14.3%	.0%	7.5% (127)
Manic Depressive Disorder	5.3%	2.6%	4.0% (68)
Previous Cesarean Delivery ⁹	4.3%	.0%	2.3% (38)
Obstructive Chronic Bronchitis	2.3%	2.0%	2.1% (36)
Schizoaffective Disorder	1.1%	2.4%	1.7% (29)
Unspecified Septicemia	.9%	1.5%	1.2% (20)
Heart Failure	.5%	.0%	.2% (4)
Cerebral Artery Occlusion,	.2%	.2%	.2% (4)
Total	888	800	1688
	100.0%	100.0%	100.0%

Chi square = 2.89; d.f. = 10; p = .001

⁹ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.

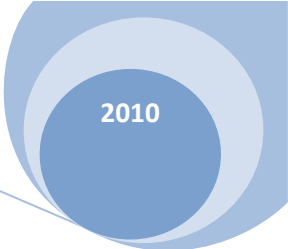
For those aged 18 to 49 years old, normal (22.2%) and cesarean deliveries (33.1%) accounted for the majority of the hospital visits (see Table 27). As females comprised all births, males accounted for the majority of the mental disorders (10% of 2009 total) in this age group. Almost 41% of the males were hospitalized for schizoaffective disorder (25%) and manic depressive disorder (16.3%).

TABLE 27. Patients 18 to 49 Years Old 2009 Principal Diagnoses by Sex (January 1 – August 31).

	Patient's gender		
	Female	Male	Total
Previous Cesarean Delivery ¹⁰	44.2%	.0%	33.1% (2872)
Normal Delivery	29.6%	.0%	22.2% (1926)
Schizoaffective Disorder	5.2%	24.6%	10.0% (871)
Manic Depressive Disorder	5.6%	16.3%	8.3% (718)
Pneumonia	4.6%	13.6%	6.8% (591)
Cellulitis and Abscess, Leg, Except Foot	2.7%	16.7%	6.2% (534)
Heart Failure	1.4%	7.2%	2.9% (249)
Coronary Artherosclerosis, of Native Coronary Artery	1.0%	7.4%	2.6% (225)
Unspecified Septicemia	1.6%	5.3%	2.5% (216)
Urinary Tract Infection	2.0%	3.0%	2.2% (194)
Obstructive Chronic Bronchitis with Acute Exacerbation	1.1%	2.1%	1.3% (115)
Cerebral Artery Occlusion, Unspecified	.8%	2.9%	1.3% (112)
Osteoathrosis, Localized, Not Specified	.4%	.9%	.5% (45)
Total	6501	2167	8668
	100.0%	100.0%	100.0%

Chi square = 3.764; d.f. = 12; p = .0001

¹⁰ The 654.21 code does not necessarily indicate a procedure; it can also indicate a pre-existing condition.

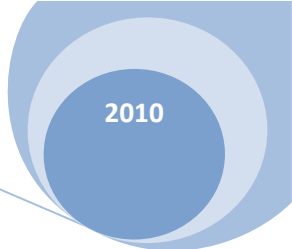


As Table 28 illustrates, atherosclerosis (16.1%) and heart failure (15.5%) lead the list of principal diagnoses for patients aged 50 to 65 years in 2009. These chronic conditions were slightly more common among men than women. Infections such as pneumonia (14.5%) and urinary tract infections, however, were major contributors to hospitalization for this age group.

TABLE 28. Patients 50 to 65 Years Old 2009 Principal Diagnoses by Sex (January 1 – August 31).

	Patient's gender		
	Female	Male	Total
Coronary Artherosclerosis, of Native Coronary Artery	12.7%	19.1%	16.1% (899)
Heart Failure	14.3%	16.5%	15.5% (865)
Pneumonia	16.2%	13.0%	14.5% (810)
Obstructive Chronic Bronchitis	9.2%	9.1%	9.1% (510)
Osteoathrosis, Localized,	11.4%	6.3%	8.7% (486)
Cellulitis and Abscess, Leg	6.5%	8.7%	7.7% (429)
Cerebral Artery Occlusion,	6.0%	7.7%	6.9% (385)
Unspecified Septicemia	6.2%	6.0%	6.1% (339)
Schizoaffective Disorder	6.0%	5.3%	5.6% (315)
Manic Depressive Disorder	5.6%	4.8%	5.2% (288)
Urinary Tract Infection	6.0%	3.5%	4.7% (260)
Total	2634	2952	5586
	100.0%	100.0%	100.0%

Chi square = 1.281; d.f. = 10; p = .0001



As Table 29 shows, the differences between male and female patients diminish in the 66 years and over age group. Heart failure (19.6%) and pneumonia (18.6%) comprise the major diagnoses for this age group. Males, however, are more likely to be diagnosed with heart failure and atherosclerosis than are women. Women continue to be more likely than men to have urinary tract infections.

TABLE 29. Patients 66 Years and Older 2009 Principal Diagnoses by Sex (January 1 – August 31).

	Patient's gender		
	Female	Male	Total
Heart Failure	18.5%	21.0%	19.6% (2101)
Pneumonia	18.0%	19.4%	18.6% (1998)
Obstructive Chronic Bronchitis	10.4%	11.4%	10.8% (1165)
Urinary Tract Infection	12.6%	7.8%	10.5% (1123)
Coronary Artherosclerosis, of Native Coronary Artery	7.4%	10.3%	8.7% (935)
Unspecified Septicemia	7.9%	8.7%	8.2% (882)
Manic Depressive Disorder	5.1%	5.0%	5.0% (540)
Cerebral Artery Occlusion,	8.3%	6.9%	7.7% (828)
Osteoathrosis, Localized,	7.6%	5.1%	6.5% (697)
Cellulitis and Abscess, Leg, Except Foot	3.8%	4.1%	3.9% (423)
Schizoaffective Disorder	.5%	.4%	.5% (49)
Total	6045	4696	10741
	100.0%	100.0%	100.0%

Chi square = 1.322; d.f. = 10; p = .0001

SUMMARY OF TRENDS FROM SEPTEMBER 1, 2007 TO AUGUST 31, 2009

The hospital data from 2007 to 2009 show several trends. One trend concerns the top three most common principal diagnoses: pneumonia, previous cesarean delivery, and heart failure. Pneumonia is a preventable disease often associated with the most vulnerable members of the population, the very young and elderly. Are people failing to receive inoculations against such infectious diseases? Or, are people waiting until their immune systems are so compromised to seek help that pneumonia is inevitable?

Although distinctions between primary diagnosis and chronic condition were undetermined in the previous cesarean delivery code, the number of previous cesarean delivery designations is quite surprising. The national trend for cesarean deliveries is 32%. This fact raises questions about the previous cesarean delivery designation in contrast to the normal delivery designation. Does the Coastal Bend really have a high rate of high-risk pregnancies?

Another trend for principal diagnoses involves the shift in the most common principal diagnoses from 2007 to 2009. Respiratory virus and dehydration lead the list and were replaced with mental disorders such as schizoaffective disorder and manic depression.

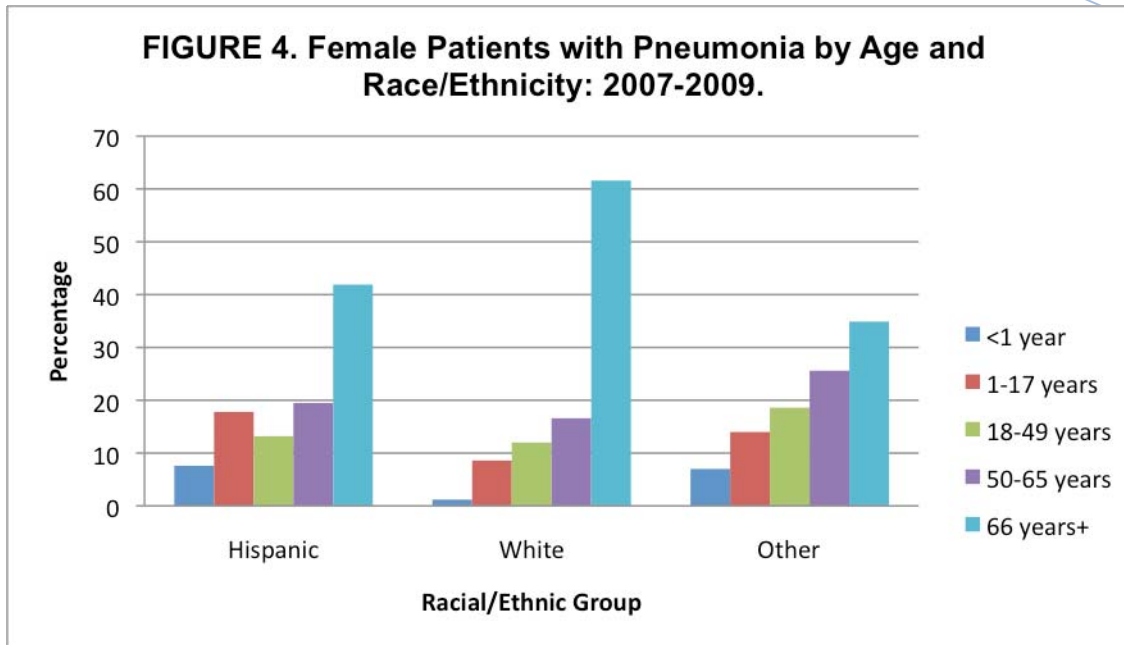
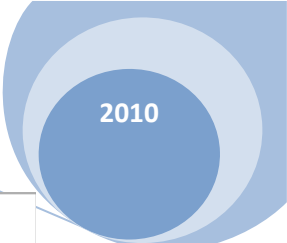
From 2007 to 2009, renal failure and end-stage renal disease almost doubled as a secondary diagnosis. In 2007, renal related conditions accounted for 3.2% of patients' secondary diagnoses. In 2009, however, renal-related conditions accounted for 6% of patients' secondary diagnoses. This trend may be related to an aging population, but other causes may be relevant. Renal disease is often associated with hypertension and diabetes. Diabetes and hypertension consistently remain on the secondary diagnoses list for all years.

TRENDS BY DIAGNOSIS.

To understand the shift in principal diagnoses, further examination of the most common conditions may provide some insights. Some of the more common principal and secondary diagnoses are explored by the patient's age, sex, racial/ethnic group.

Pneumonia

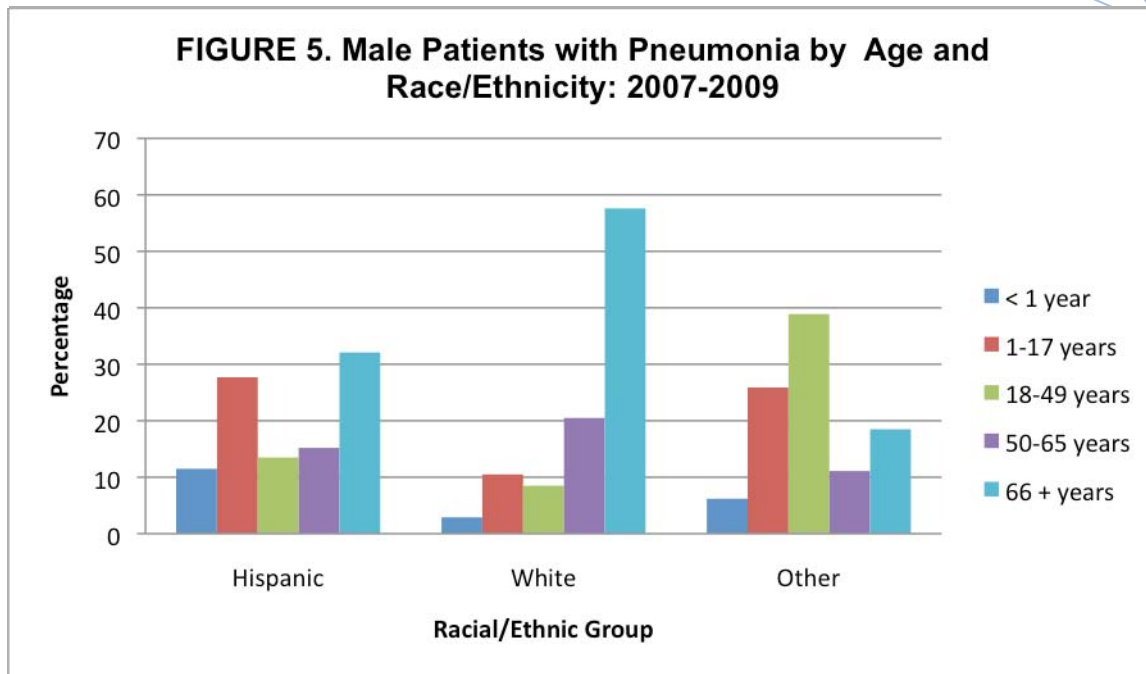
It was found that there are statistically significant differences among groups who were diagnosed with pneumonia as a principal diagnosis. In focusing just on female patients, Figure 4 displays that minority female children (Hispanic (25.4%) and Other minority female children (21%)) under the age of 18 years are more likely to have pneumonia than are White female children (9.8%). Female White patients over the age of 66 years (61.6%), however, are more likely to be in the hospital for pneumonia than are Hispanics (41.9%) or other groups (34.9%).



Chi-square = 1.132; d.f. = 8; p = .0001

Figure 5 depicts the percentage of male patients with pneumonia by their age and racial/ethnic classification. Older (66 + years) White males (57.6%) were more likely to be admitted to the hospital for pneumonia than were Hispanic (32.1%) or Other minority males (18.5%). Hispanic (39.2%) and Other minority (32.1%) male children were more likely to have pneumonia than were White male children (13.4%).

Overall when comparing pneumonia patients by sex, male children were slightly more likely to have pneumonia than were female children of all racial/ethnic groups. Children under the age of 18 years who were diagnosed with pneumonia were more likely to be Hispanic (39.2%) or Other minority group (32.1%). Overall, males aged 66 years and older were slightly less likely to have pneumonia than were their female counterparts. White males in this age category (57.6%) were more likely to have pneumonia than Other minority groups. According to the National Health Interview Survey (Heyman et al, 2010) women aged 65 to 74 years were more likely to have ever received a pneumococcal vaccination than men. Overall, Heyman (et al, 2010) determined that 60% of adults aged 65 years and over received the vaccination.



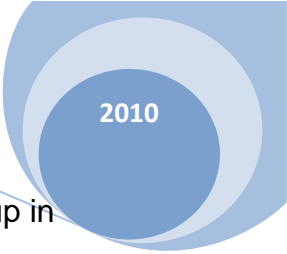
Chi square = 1.132; d.f. = 8; p = .0001

Cesarean Delivery

According to the hospital data, previous cesarean deliveries exceeded normal deliveries as the most common principal diagnosis from 2007 to 2009. Of the 4,963 deliveries from September 1, 2007 to August 31, 2009, 58.63% were previous cesarean deliveries compared to the 41.36% normal deliveries. In this report, the differences between primary diagnosis and chronic condition in this code category were not able to be determined. (There were an additional 72 deliveries coded as 669.71, another code for cesarean delivery). Examining previous cesarean deliveries by age and race/ethnicity of the mother showed no statistically significant differences among the groups (see Table 30).

A recent brief from the National Center for Health Statistics indicates that nearly one-third (32%) of all births were cesarean deliveries in 2007, the highest rate ever reported (Menacker et al, 2010). The rate for Texas (33.7%) is higher than the national average. The rate for the Coastal Bend was found to be 39.8%.

Menacker (et al, 2010) reported that cesarean delivery was the most frequently performed surgical procedure in United States hospitals and occurs at higher rates than most other industrialized nations. Clinical reasons for the increase may be related to the rate of multiple births. Non-clinical explanations may include maternal demographic characteristics (e.g., older maternal age), maternal choice, physician practice patterns, and/or legal pressures. The report also noted that the increase in cesarean deliveries did not vary by race/ethnicity or gestational age. As Table 30 shows, similar to



Menacker's findings, that Cesarean delivery rates did not vary by race/ethnic group in the Coastal Bend.

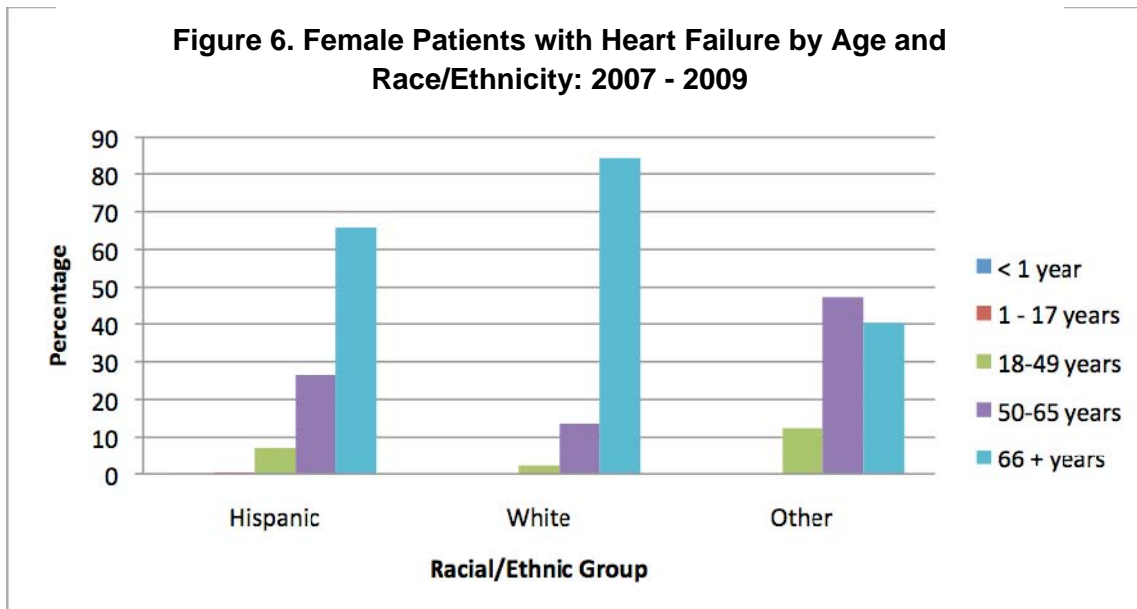
TABLE 30. Cesarean Deliveries by Age and Race/Ethnicity of Mother: 2007-2009.

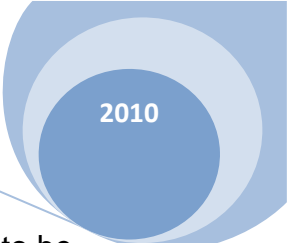
	Race/Ethnic Group			
	Hispanic	Other	White	Total
1-17 years	1.6%	.0%	.3%	1.3% (21)
18-49 years	98.4%	100.0%	99.7%	98.7%(1614)
Total	1260	75	300	1635
	100.0%	100.0%	100.0%	100.0%

Heart Failure

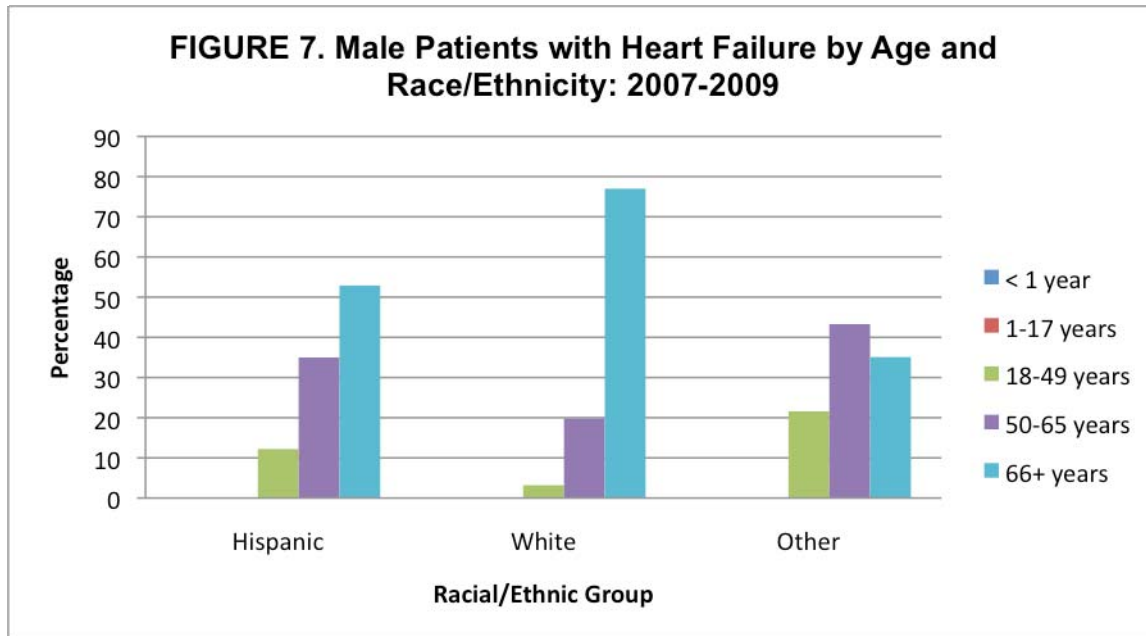
According to the Centers for Disease Control, heart failure is a serious condition, but it does not mean that the heart has stopped beating. When the heart cannot pump enough blood and oxygen to support other organs, then heart failure occurs. The most common causes of heart failure are coronary artery disease, high blood pressure, and diabetes. All of which are often reported as secondary diagnoses.

From 2007 to 2009, 3,221 patients were in the hospital for heart failure listed as the principal diagnosis. White men and women aged 66 years and over were more likely to be hospitalized for heart failure than were men and women in other racial/ethnic groups. As Figure 6 shows, Hispanic and Other minority group women aged 50 to 65 years and over were more likely to have heart failure than were White women in the same age group. White women tend to have heart failure at later ages.





Illustrated in Figure 7, White males aged 66 years and over also were more likely to be hospitalized for heart failure than Hispanic or other male groups. Overall, males from minority groups tend to have heart failure at younger ages than White males.

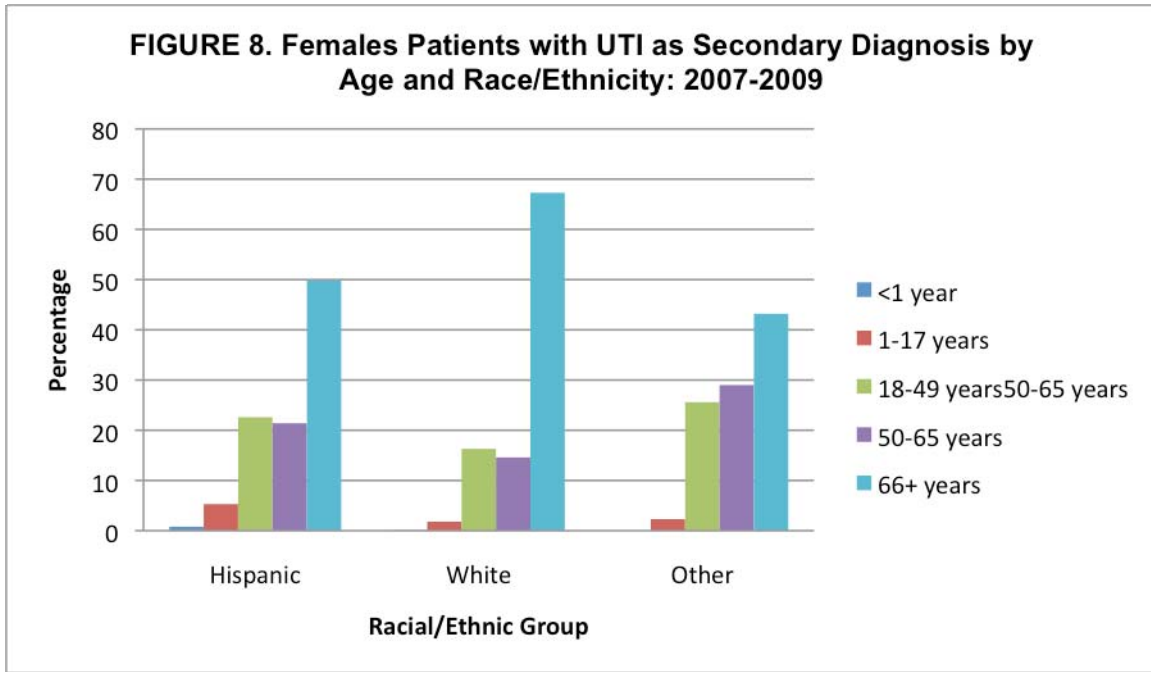
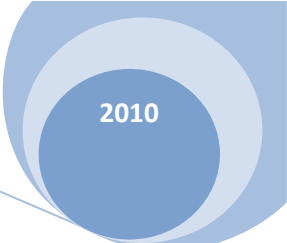


According to the Centers for Disease Control Heart Failure Fact Sheet (2010), early diagnosis and treatment can improve quality of life and life expectancy for people who have heart failure, but many people may not be aware that they are candidates for heart failure. To increase longevity, people at risk for heart failure are encouraged by their health care providers to take appropriate medicines, reduce salt in the diet, and get daily physical activity. For those without a primary care physician and/or lack health insurance, early diagnosis may not occur.

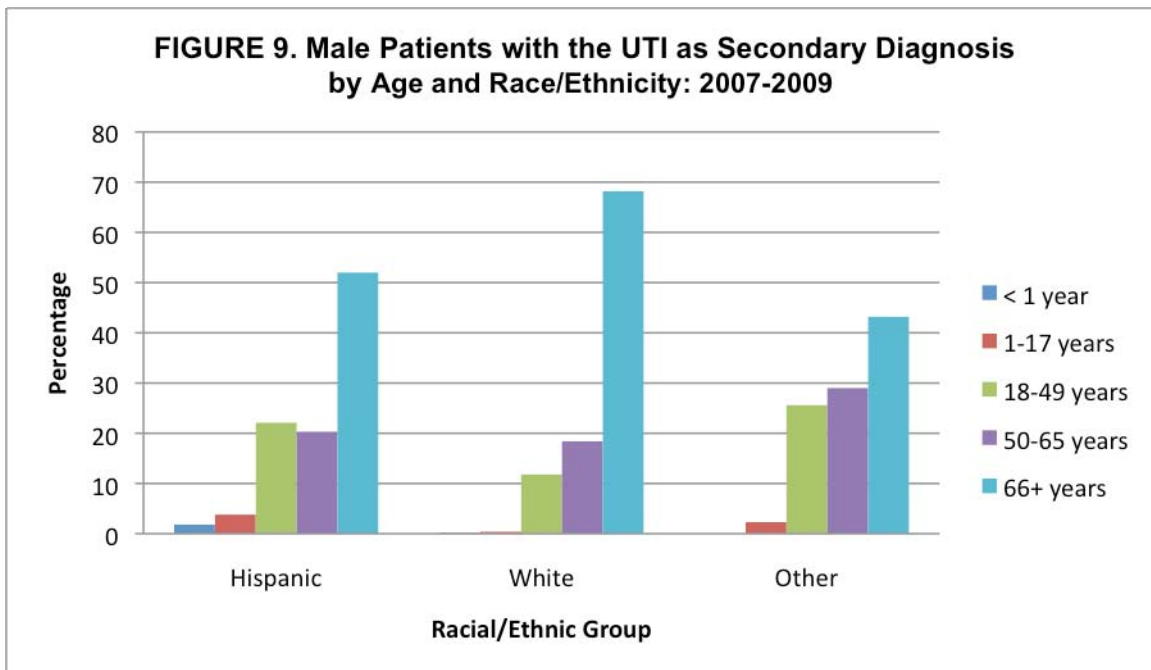
Urinary Tract Infections

According to the Centers for Disease Control, urinary tract infections are the most common type of infection, accounting for more than 30% of infections reported by acute care hospitals. Instrumentation of the urinary tract is the leading cause of almost all healthcare-associated UTIs. Catheter-associated urinary tract infection (CAUTI) has been associated with increased morbidity, mortality, hospital cost, and length of stay. Transmission of infection to other patients is also a concern.

In addition, the 2007-2009 hospital data had 5,194 patients who were given the secondary diagnosis of UTI, the most common secondary diagnosis in all years. Figures 8 and 9 show the results are statistically significant. The vast majority of both male and female patients with UTI were aged 66 and over.



Chi square = 139.184; d.f. = 8; p = .0001



Chi square = 139.184; d.f. = 8; p = .0001

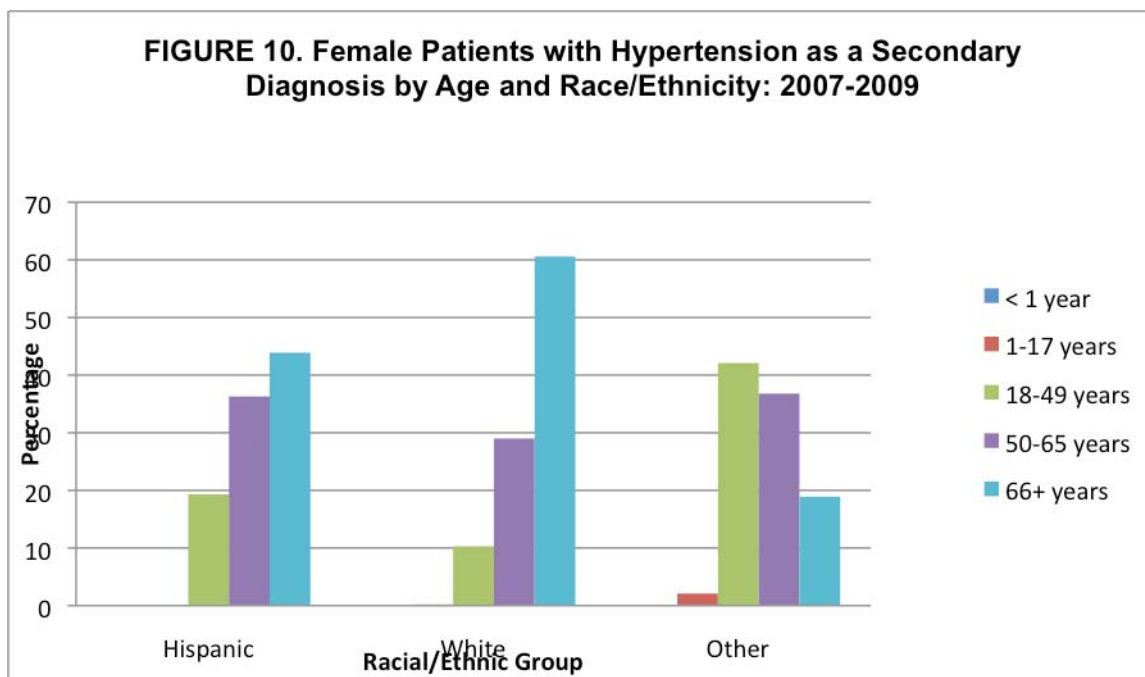
The age of the patients with UTIs suggests that many are requiring urinary catheters which may contribute to the infection. Urinary drainage systems are often reservoirs for multidrug-resistant bacteria. The CDC Division of Healthcare Quality Promotion estimates that between 15% and 25% of hospitalized patients may receive short-term

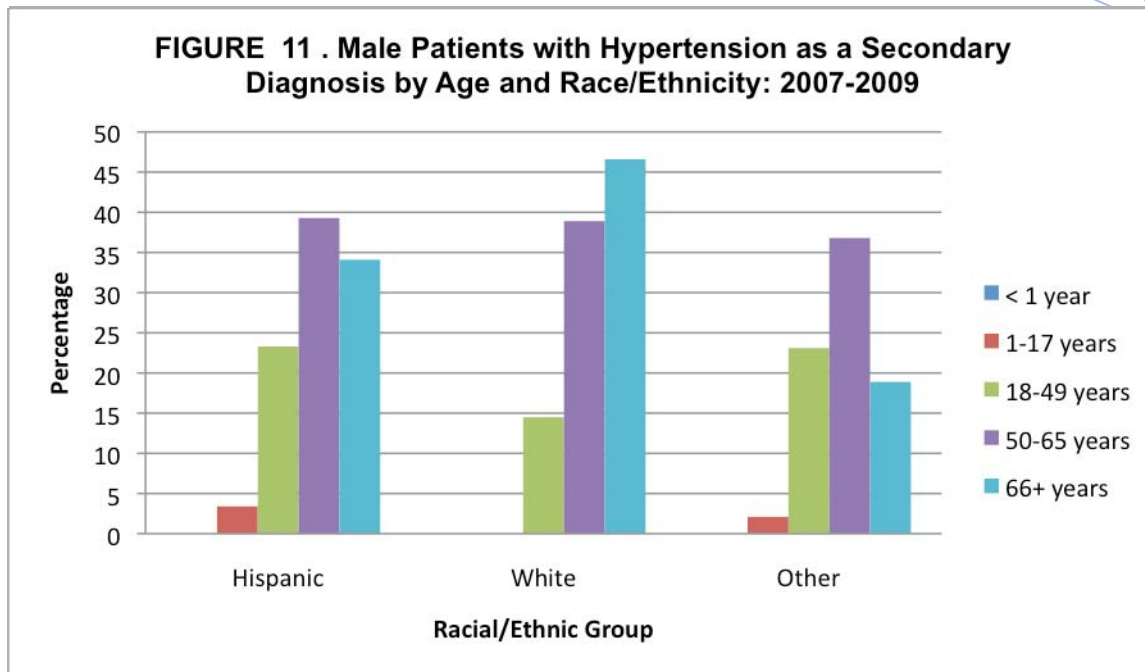
indwelling urinary catheters during their hospital stay. Although the overall prevalence of long-term indwelling urethral catheterization use is unknown, the prevalence of urinary catheter use in residents in long-term care facilities in the United States is on the order of 5%, representing approximately 50,000 residents with catheters at any given time. The CDC notes there is a high prevalence of urinary catheters in patients transferred from acute care hospitals to skilled nursing facilities.

Hypertension

In the United States, 32% of non-institutionalized adults ages 20 and over are hypertensive, according to data from a National Center for Health Statistics (2003-2006) report. Hypertension can affect men and women of all ages and racial/ethnic groups. The majority of people who have this condition, however, are older women.

Examination of the hospital secondary diagnosis data from 2007-2009 indicates that the national trend mirrors the patterns found in the Coastal Bend. There were 4,595 who were diagnosed with hypertension. As Figures 10 and 11 illustrate, a higher proportion of older Hispanic and White women received the secondary diagnosis of hypertension than did Hispanic and White men. Over 60% of the White women who were deemed hypertensive were aged 66 years and over, compared to 46.6% of the White men in the same age group. Similarly, 43.9% of Hispanic women with hypertension were aged 66 years and over, while only 34.1% of Hispanic men with hypertension were over the age of 65 years.





Hypertension, hypercholesterolemia, and diabetes are all chronic conditions associated with the leading cause of death, cardiovascular disease, in the United States. Uncontrolled hypertension is a serious condition also related to renal disease and stroke. Many people may not be aware that they have hypertension. Using data from the Health and Nutrition Examination Survey (HANES), Fryar (et al, 2010) determined that approximately 8% of U.S. adults have undiagnosed hypertension, and the proportion with undiagnosed hypertension is similar across racial/ethnic groups.

Diabetes Mellitus

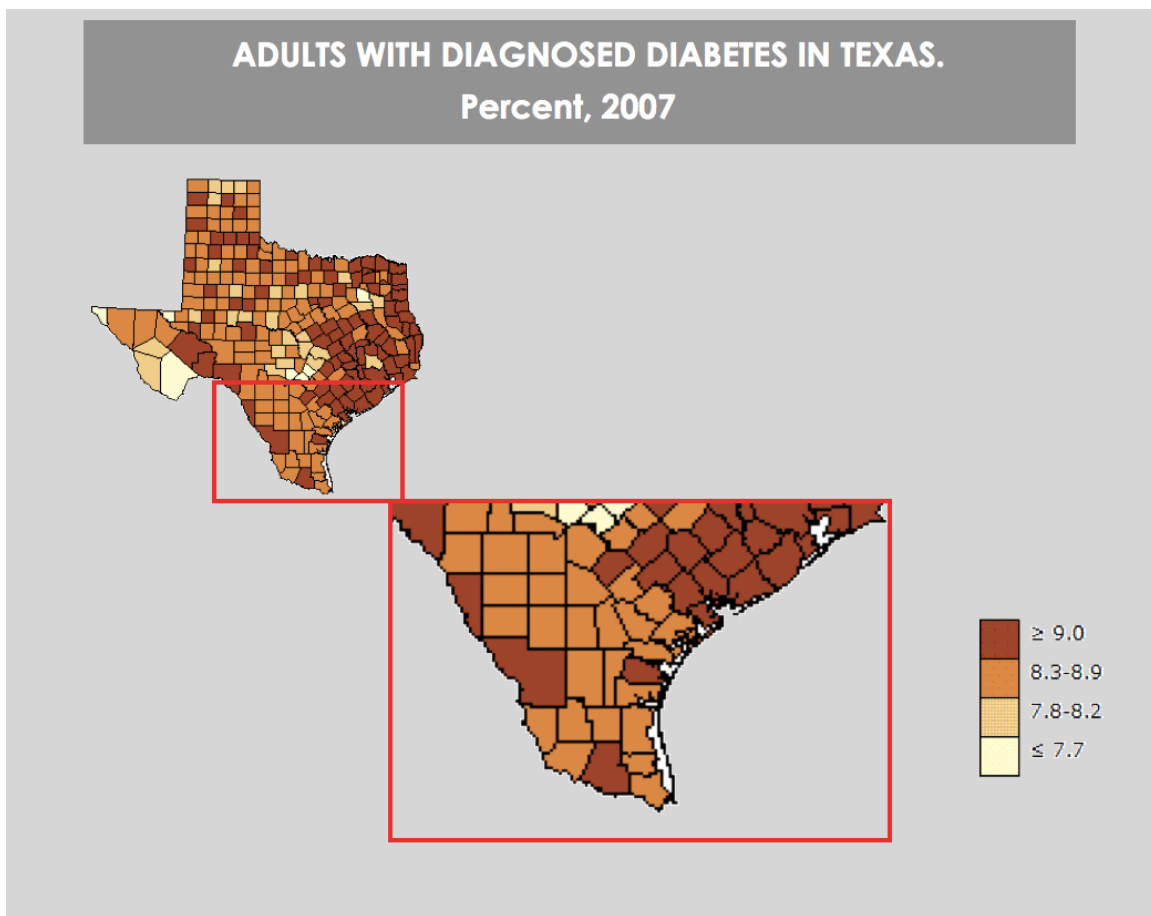
Diabetes is a disease characterized by levels of blood glucose resulting from defects in insulin production that causes sugar to build up in the body. In the United States, diabetes is the seventh leading cause of death. It can cause serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations. People with diabetes, however, can control the disease and lower the risk of complications with behavioral changes.

According to the Centers for Disease Control, a total of 23.6 million people or 7.8% of the population have diabetes. Figure 12 illustrates the prevalence of diagnosed diabetes in Texas counties based on data from the CDC's National Diabetes Surveillance System. Nueces County has more than 9% of the population diagnosed with diabetes and other Coastal Bend counties have 8.3% to 8.9% of their populations diagnosed with diabetes. Nationally, about 18 million have diagnosed diabetes, while an estimated 5.7 million have undiagnosed diabetes. After adjusting for population age and sex

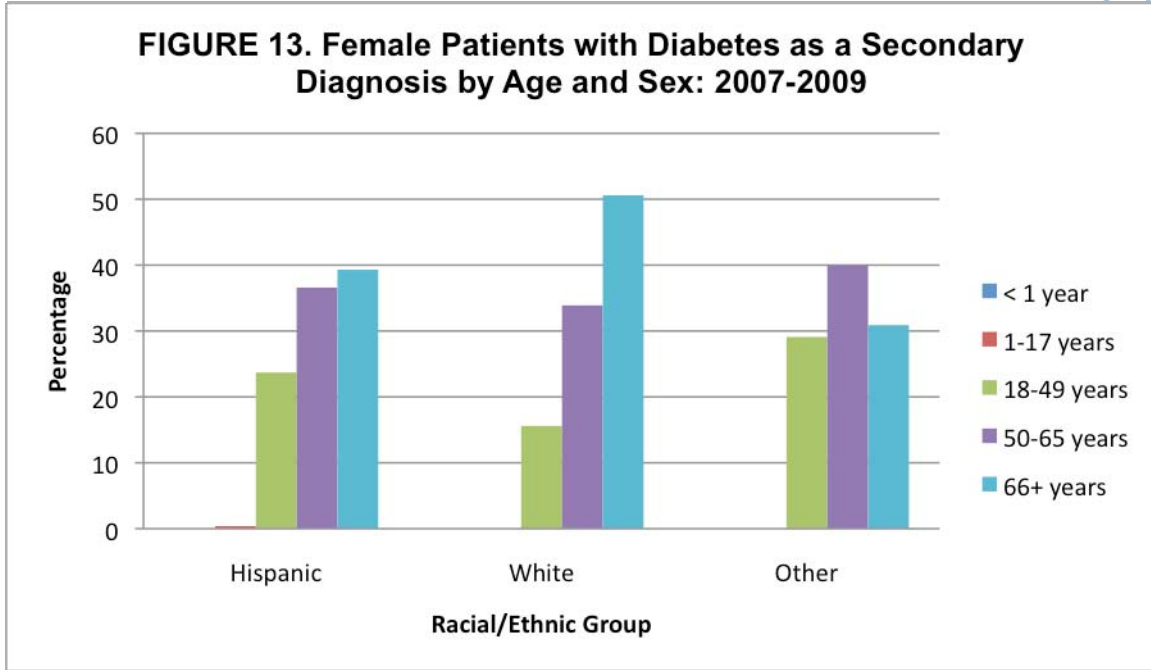
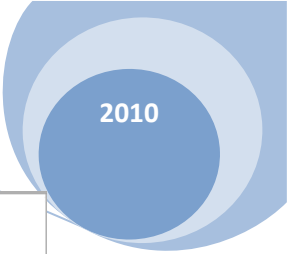
differences, impaired fasting glucose prevalence of diagnosed and undiagnosed diabetes among U.S. adults aged 20 years or older in 2003–2006 was 21.1% for non-Hispanic blacks, 25.1% for non-Hispanic whites, and 26.1% for Mexican Americans.

Counties in the Coastal Bend area have a high percentage of adults (older than 20 years) with diagnosed diabetes as shown in Figure 12. What is not known, however, is the number of people with undiagnosed diabetes in the Coastal Bend area. Nueces County's diabetes death rates have been double that of the state of Texas from 2004 through 2006. In 2006, Nueces County's diabetes death rate was 4.48 per 10,000 people, while the State's was only 2.20.

FIGURE 12. 2007 Age-Adjusted Estimates of the Percentage of Adults with Diagnosed Diabetes in Texas

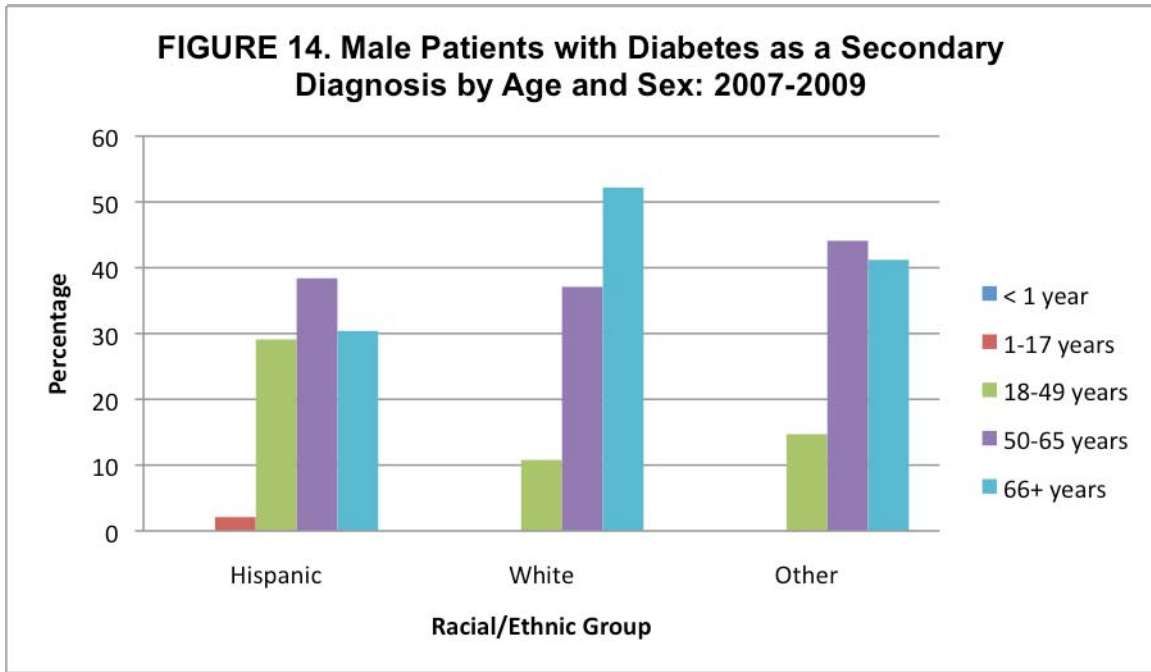


As Figures 13 and 14 illustrate, there were 1,513 Hispanics with diabetes as the secondary diagnosis compared to 489 Whites, and 89 Other minorities. Hispanic females (23.7%) and Other females with diabetes (29.1%) were more likely to younger (aged 18-49 years) than were White females (15.9%). White females (50.6%), however, were more likely to be older (66+ years) compared to Hispanics (39.3%) and Other minority females (30.9%) with diabetes (see Figure 13).

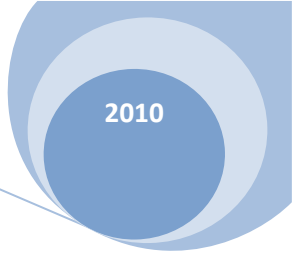


Chi square = 16.443; d.f. = 6; p = .012

As Figure 14 shows, Hispanic (29.1%) and Other males (14.7%) with diabetes were more likely to be younger (18-49 years) than were Whites (10.8%). White males with diabetes (52.2%) were more likely to 66 years and older than Hispanics (30.4%) or Other males (41.2%).



Chi square = 53.903; d.f. = 6; p = .0001



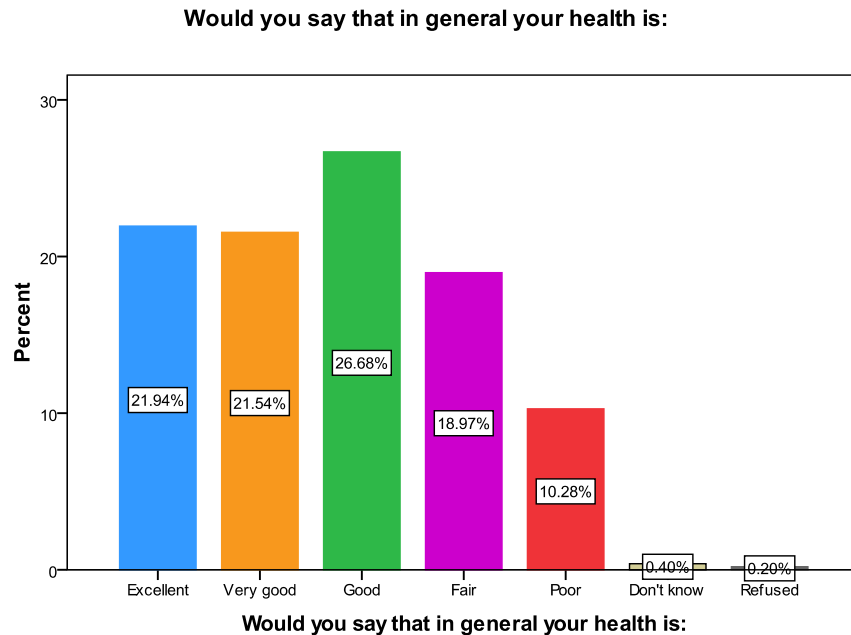
Perceived Health Status

In this section, residents’ views of their own and children’s physical and mental health status are reviewed. In addition, respondents are asked to report the number of days of poor physical and mental health in the last 30 days.

PERCEIVED HEALTH STATUS

In general, the community telephone participants reported that their health status was good. As Figure 15 illustrates, the majority (66.1%) indicated that their health was “excellent,” “very good,” or “good” while 18.97% said it was “fair” and 10.28% said it was “poor.”

FIGURE 15. Reported General Health Status (Telephone Survey).



Men and women did not differ in their reported health status. As Table 31 shows, women were only slightly more likely to report that their health was “fair” or “poor” than were men.

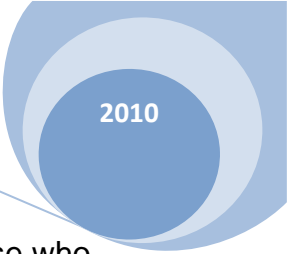
Table 32 illustrates that the reported health status did not vary by whether the respondent lived in an urban or rural county.

TABLE 31. Cross-tabulation of Health Status by Respondent's Sex (Telephone Survey).

	Respondent's Sex		Total
	Male	Female	
Excellent	48 30.0%	51 16.6%	99 21.2%
Very Good	34 21.3%	69 22.5%	103 22.1%
Good	39 24.4%	86 28.0%	125 26.8%
Fair	24 15.0%	63 20.5%	87 18.6%
Poor	15 9.4%	35 11.4%	50 10.7%
Don't Know	0 0.0%	2 0.7%	2 0.4%
Refused	0 0.0%	1 0.3%	1 0.2%
Total	160	307	467

TABLE 32. Cross-tabulation of Health Status by Respondent's Urban/Rural County Residency (Telephone Survey).

		County by Urban/Rural		Total
		Urban	Rural	
Would you say that in general your health is:	Excellent	73 21.0%	35 24.1%	108 21.9%
	Very good	75 21.6%	30 20.7%	105 21.3%
	Good	97 27.9%	36 24.8%	133 27.0%
	Fair	63 18.1%	30 20.7%	93 18.9%
	Poor	37 10.6%	14 9.7%	51 10.3%
	Don't know	2 .6%	0 .0%	2 .4%
	Refused	1 .3%	0 .0%	1 .2%
Total		348	145	493



Examining the reported health status, however, shows that there are statistically significant differences by the respondent’s age group, as shown in Table 33. Those who are older are less likely to report excellent or good health status than are those who are younger. Almost 40% of those who are 66 years and older reported fair or poor health compared to only 18.6% of the 18-49 year old group and 31% of the 50-65 year old group. There were no statistically significant differences by ethnicity.

TABLE 33. Cross-tabulation of Health Status by Respondent’s Age Group (Telephone Survey).

	18-49 years	50-65 years	66+ years	Total
Excellent	55 33.1%	30 19.0%	20 13.7%	106 22.5%
Very good	34 20.5%	37 23.4%	30 20.5%	102 21.6%
Good	44 26.5%	42 26.6%	38 26.0%	124 26.3%
Fair	20 12.0%	30 19.0%	39 26.7%	89 18.9%
Poor	11 6.6%	19 12.0%	19 13.0%	49 10.4%
Total	166 100.0%	158 100.0%	146 100.0%	472 100.0%

Chi-square = 37.94; d.f. = 20; p = .009

Days Physical Health “Not Good”

When asked, “Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?,” the majority of respondents (56.6%) replied that on no days during the past 30 days was their physical health “not good.” There were 12.3% of the telephone survey respondents who indicated that they did not have good health during the whole month (30 days). Overall, however, the mean number of days of a “not good health” status was 5.85 days (s.d. = 10.31).

Days Mental Health “Not Good”

Similarly, when asked, “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?,” the majority of respondents (68.5%) said that on no days during the last 30 days was their mental health “not good.” Almost ten percent

(9.7%), however, indicated that their mental health was “not good” for the past 30 days. Interestingly, 4.1% replied that their mental health was “not good” for 2 of the past 30 days and 3.3% replied their mental health was “not good” for 15 of the past 30 days. Overall, the mean number of days of “not good” mental health was 4.73 days in the past 30 (s.d. = 9.52).

BODY MASS INDEX

Another measure of a person’s health status is the Body Mass Index (BMI). It is calculated by taking an individual’s body weight and dividing it by the square of his/her height. The BMI is not a direct measure of body fat, but it helps establish whether someone is obese or not. The telephone survey asked participants to self-report their height and weight and 84% complied. From this information, a BMI was calculated. A BMI of 30 or greater is considered “obese.”

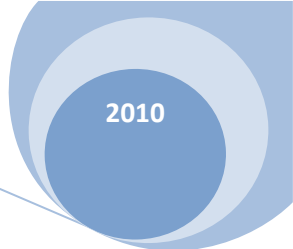
According to the Texas Behavioral Risk Factor Surveillance System (2008), in the Public Health Administrative Region 11 (that includes Nueces County and other Coastal Bend counties), the percent at risk for obesity among adults 18 and over was 41.0%. This percentage exceeds that for Texas (29.5%) and the total U.S. (28.3%).

For this sample, the average BMI was 27.70 (s.d. = 8.376), indicating that the average person in the Coastal Bend area is “overweight”. As Table 34 shows, 65% of the survey respondents were “overweight” or “obese” with only 24.2% at “normal” weight.

TABLE 34. Frequency Distribution of Body Mass Index.

		Frequency	Percent	Valid Percent
Valid	Underweight	24	4.5	5.3
	Normal	130	24.2	28.8
	Overweight	149	27.7	33.0
	Obese	148	27.6	32.8
	Total	451	84.0	100.0
Missing	System	86	16.0	
Total		537	100.0	

There is a consensus that many of the people in the Coastal Bend area are overweight or obese (Colletti and Masters, 2010; Texas Behavioral Risk Factor Surveillance System, 2008). As Figure 27 notes (see below), 60.6% of the health care and social service providers indicated that the condition they saw most frequently in the past 12 months were patients who were overweight and obese.



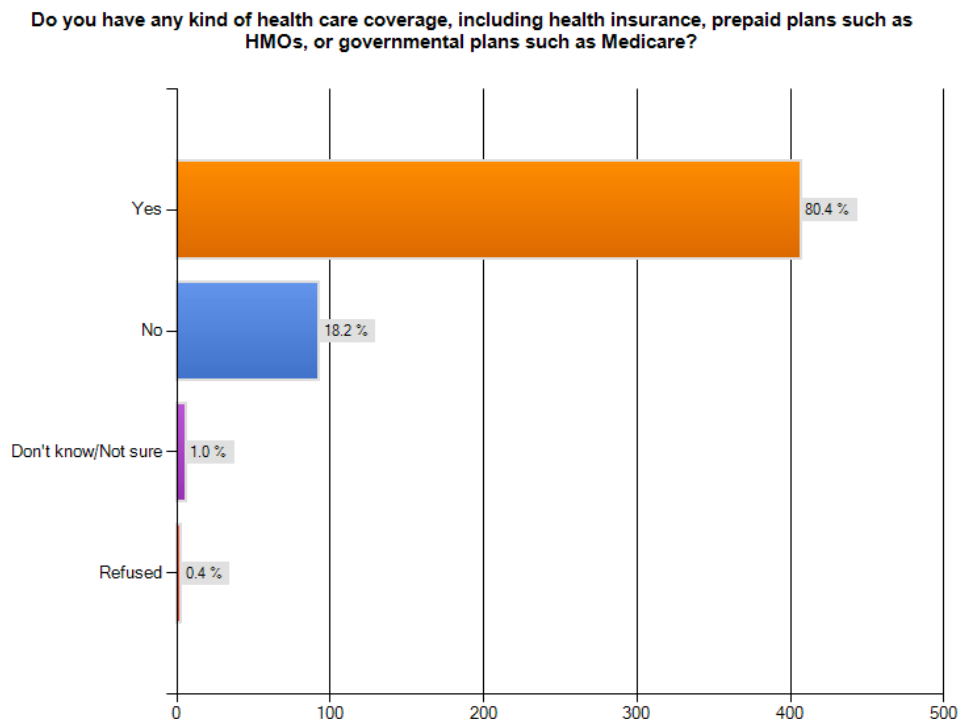
Access to Health Care

One of the major concerns in a health needs assessment is whether those who need health care are able to obtain it. In this section, the analysis focused on whether the residents of the Coastal Bend are receiving the health care they need or not. Potential barriers to health care are explored.

HEALTH INSURANCE COVERAGE

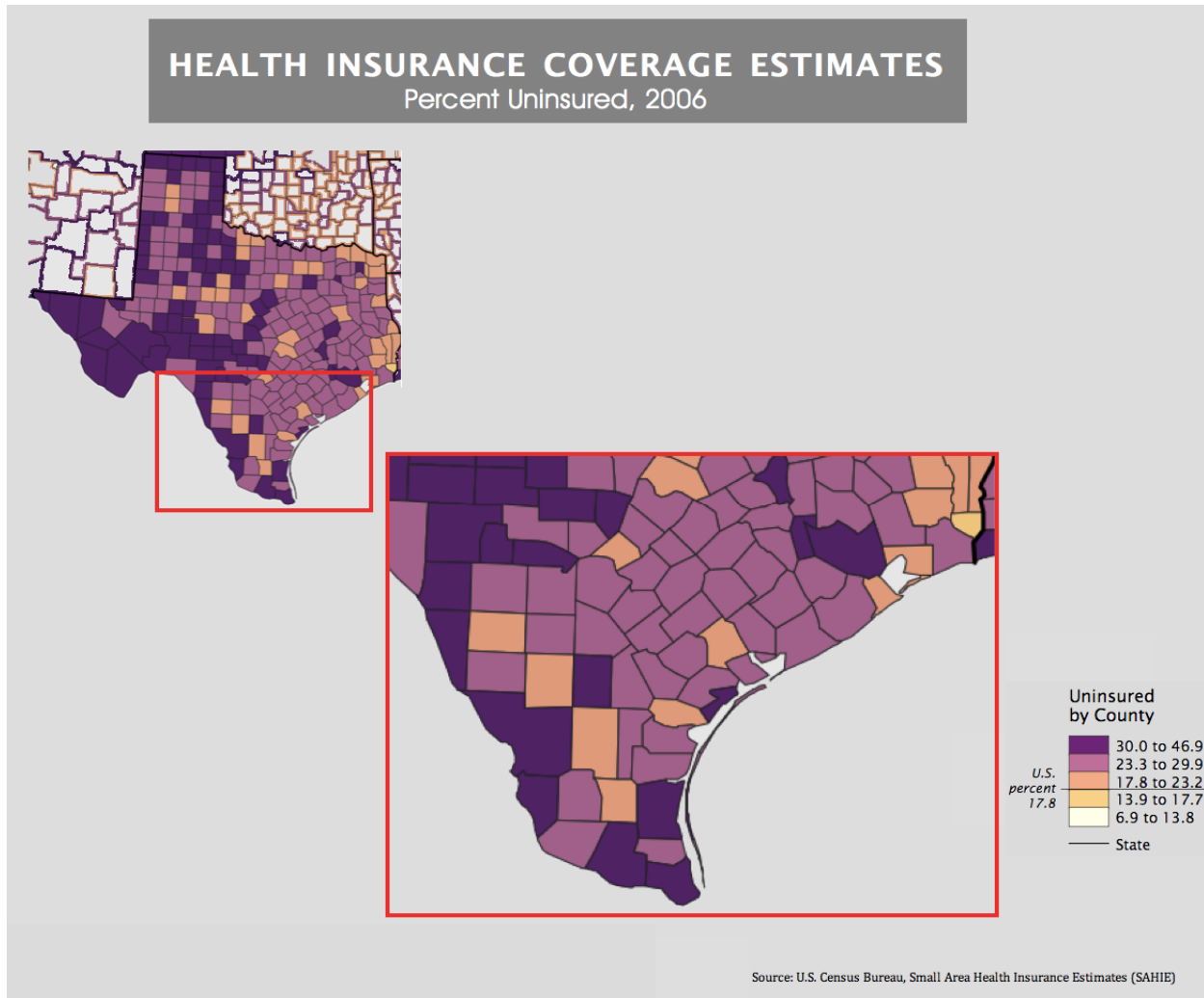
As Figure 16 shows, the vast majority (80.4%) of telephone survey participants reported having some type of health insurance coverage. As the 2004 needs assessment also found, over 18% of the community is still without any type of health insurance. In other words, despite local and national efforts over the past 6 years, a substantial segment of the population continues to lack any health coverage. This problem, however, is not unique to the Coastal Bend area. The National Health Survey (Cohen et al, 2009) estimated that 16.7% of U.S. residents do not have health insurance coverage. The report also contains estimates of health insurance coverage for the 20 largest states, and shows Massachusetts had the lowest percentage of uninsured individuals under age 65 (3.4 percent) in 2008. In contrast, approximately 1 in 4 persons under age 65 lacked coverage in Florida and Texas, and 1 in 5 lacked coverage in Arizona, California and Georgia.

FIGURE 16. Insurance Coverage of Participants (Telephone Survey).



The U.S. Census Bureau (2006) estimates that there is an even larger percentage uninsured than the telephone survey results indicate. As Figure 17 shows, most of the Coastal Bend counties have somewhere between 17 to 46.9 percent of their populations uninsured. The U.S. Census Bureau estimates also place Texas as one of the states with most uninsured. In the Coastal Bend, Aransas, Kenedy, and McMullen counties have over 30% uninsured adults under the age of 65 years.

FIGURE 17. U.S. Census Bureau Health Insurance Coverage Estimates, 2006.



The reasons for lack of coverage given by the telephone survey respondents all relate to insurance costs for the individual (63.9%) or employer (9.5%) and/or job loss (15.7%) as shown in Figure 18.

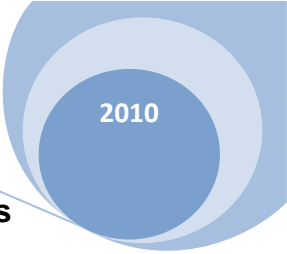
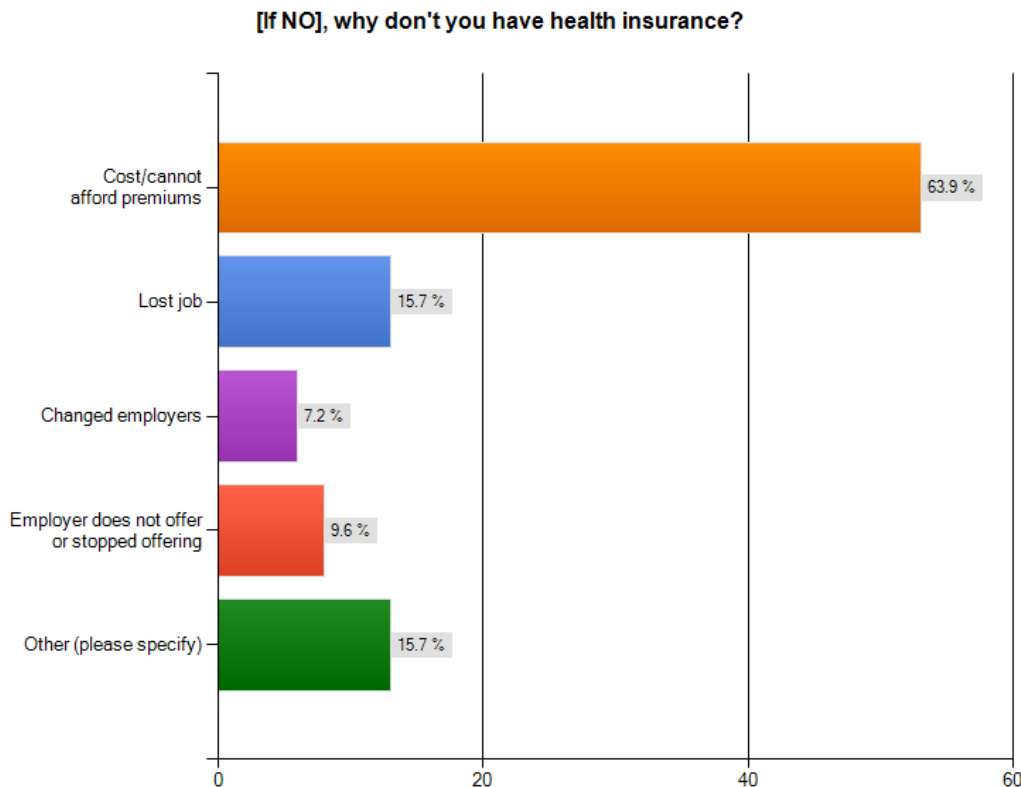


FIGURE 18. Reasons for No Health Insurance Coverage of Participants (Telephone Survey).



A number of focus group participants spoke about the challenges related to maintaining health insurance. These individuals did not meet the qualifications for receiving benefits. Although they are employed and may have children, they are below the threshold for obtaining insurance. One man from a rural county said, " There's a lot of [people] out there that work and try to do what they can. And they don't have enough money to carry insurance... They don't qualify for it."

Participant 9-4 also has a similar experience. She shares, "Like me, where I was working, I also ran into that gap...I had to change jobs. Go where I could have insurance... COBRA... the COBRA raised the insurance to \$500 a month. And I paid it a couple of months. Working and working, thinking I was going to lose everything soon if I don't quit paying this COBRA" (lines 1092-1096).

Others felt the challenges of obtaining insurance after the downturn in the economy. Participant 9-5 states, "When I got laid off, I lost my insurance. I don't have insurance... I can't afford it. I still can't afford it... I am considered to be making a little bit too much— \$35 too much [to be eligible to receive care from a clinic]. And I don't get insurance

because I'm part-time... I have to wait two years before I can get Medicare" (lines 1089-1091).

Others who are fortunate to have insurance coverage still face limitations. For instance, one man shares his frustration with the limited coverage of his worker's compensation. He said, "Like me, right now I am having problems because I got hurt at work about two months ago. And I'm having problems with that worker's comp. Nobody around here takes worker's comp." He continued by saying he had to seek treatment from a physician he described as substandard because he did not have any other choice.

These participants' comments support the findings from the survey, but they also underscore the structural challenges workers face. Part-timers at their place of employment are either not eligible for insurance or the cost of insurance is so expensive as to render it prohibitive. In the mean time, those without insurance are compelled to live with their conditions untreated. Participant 9-5 reveals, "I have a cataract growing on this eye, and I don't have the money to pay for it. Working part-time and a little Social Security, by the time I pay rent and utilities, I have very little left for food, and gas for the car, and car insurance" (line 1099). Finally, those with insurance coverage do not necessarily have their health needs met due to limitations in choice and health care availability in their counties.

Figure 19 illustrates the types of health insurance that the telephone participants reported having. Over one third (36.8%) have Medicare, but this is not surprising given that 30% of the survey participants were over the age of 65 years, therefore qualifying for this federal program. Over 36% reported having traditional private insurance, and 20% reported that they participated in a Managed Care program. Almost 12% of the respondents have Medicaid coverage.

When specifically asked "Was there a time in the past 12 months when you needed to see a health care provider but could not because of cost?" the majority (85.3%) said "no" while 13.7% replied "yes."

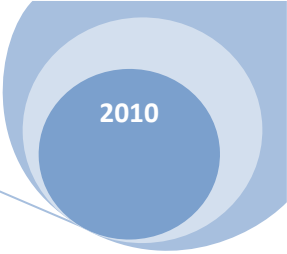
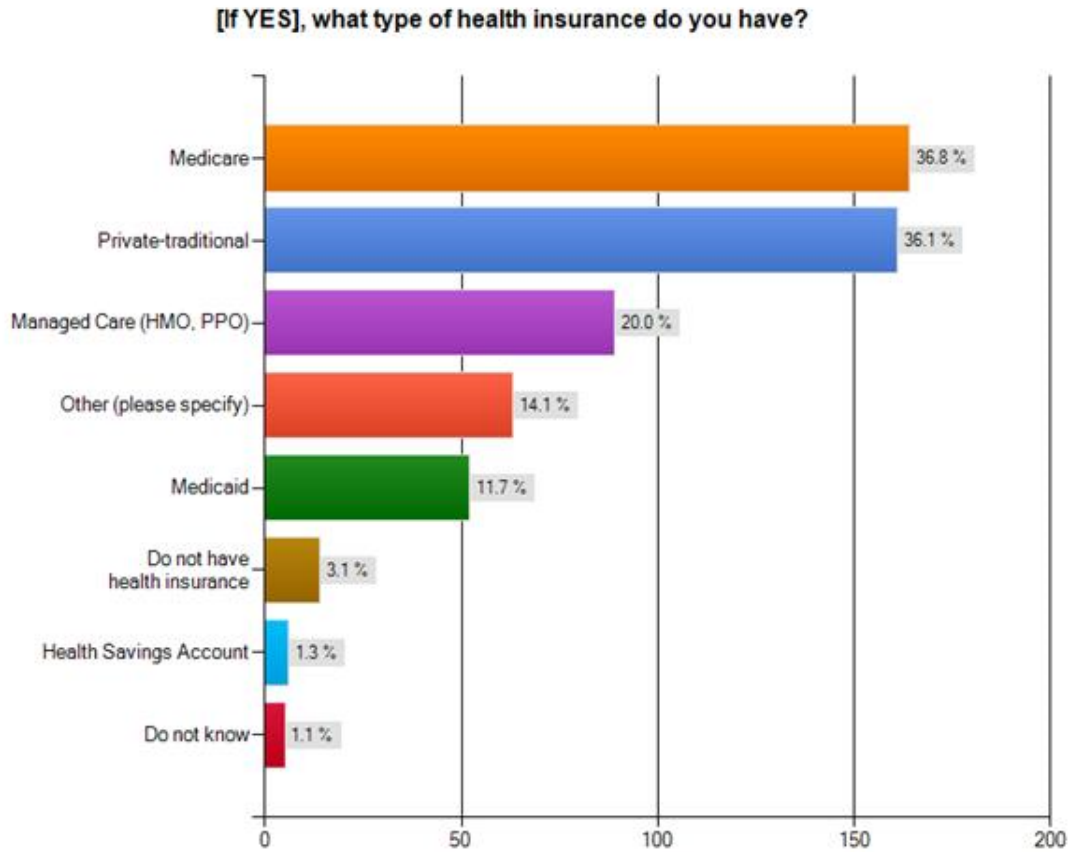


FIGURE 19. Type of Health Insurance Coverage for Participants (Telephone Survey).



Health care and social service providers were asked in the on-line survey to identify what they saw as barriers to health care for their patients/clients. As Figure 20 depicts, 48.5% responded that lack of insurance coverage was a major problem for their patients/clients.

Many participants in focus group seven discussed the challenges associated with not having dental insurance. Six participants wanted to have teeth pulled because of the pain the teeth were causing them, but the cost was so expensive for nearly all of them. Participant 7-3 resigned herself to just “suffer. You have pain” (line 366). Another, Participant 7-12, noted that eventually, “You had to borrow from Peter to pay Paul” (line 374).

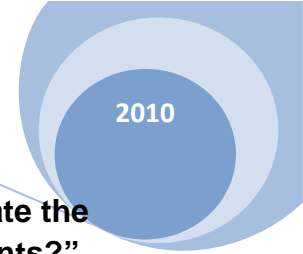
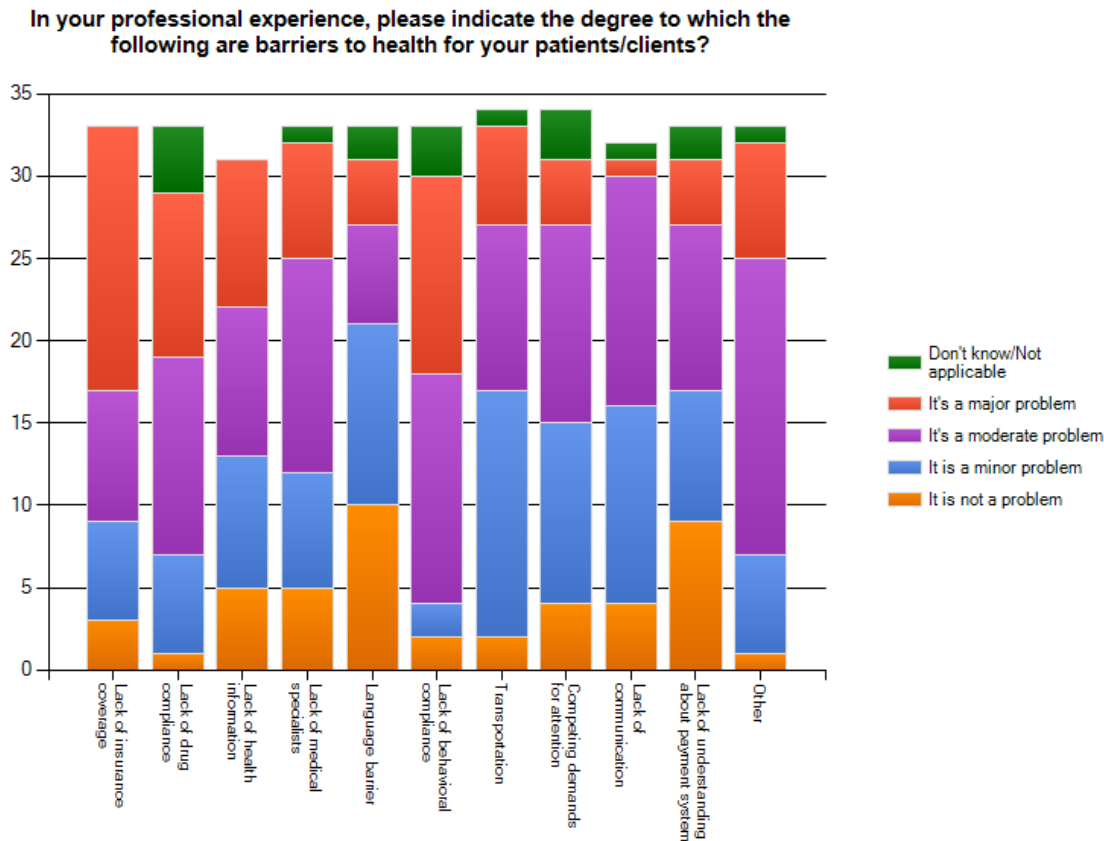


FIGURE 20. Responses to “In your professional experience, please indicate the degree to which the following are barriers to health for your patients/clients?” (Health Care and Social Service Provider Survey).



Participant 7-1, was finally able to get her teeth fixed because it cost her daughter “fifteen hundred dollars. I didn’t have no money” (line 379); she continues, “I cried so hard on the phone, and she hurried up and sent the doctor the money.” (line 381). The absence of health care. As those in Focus Group 7 demonstrate, it leads to a diminished quality of life and fiscal challenges for those close to and/or related to the uninsured.

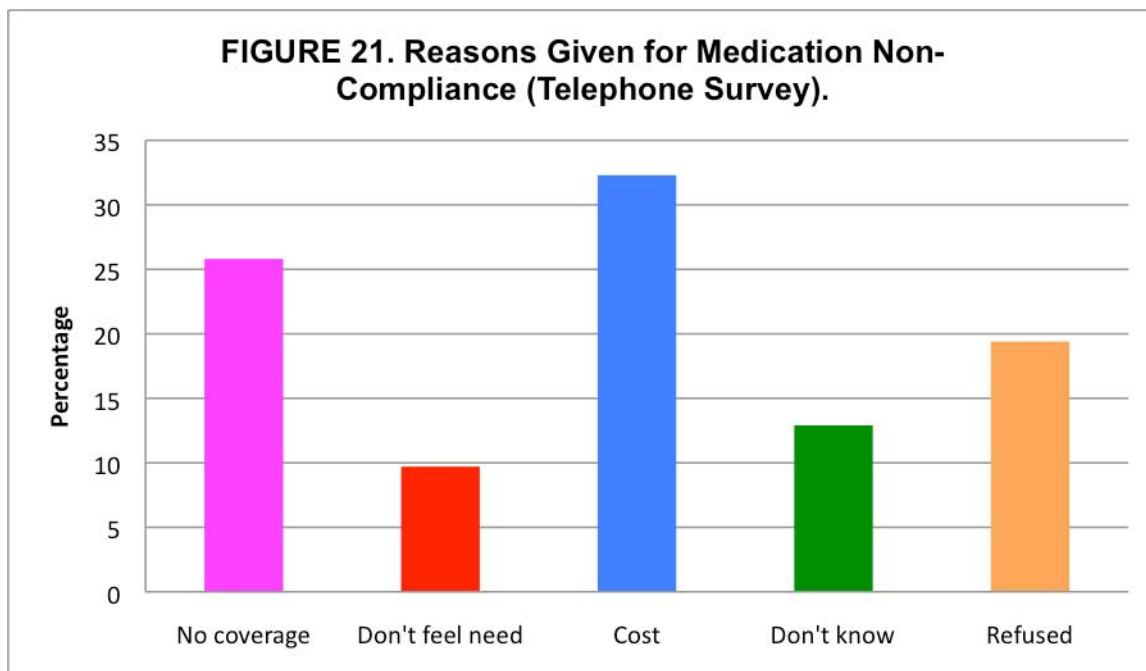
The second most frequent barrier noted as a major problem by the health care and social service providers is the lack of prescription compliance (30.3%) and behavioral compliance (36.4%) by patients/clients. The next section on drug insurance coverage provides some insight into this finding.

PRESCRIPTION DRUG COVERAGE

Sixty-five percent of the telephone survey respondents reported that they are prescribed medications. Of those who are prescribed medication, 86.9% report that they are taking their prescribed medications.

There were 40 respondents who indicated that they are not taking their prescribed medications. Their reasons for non-compliance are depicted in Figure 21. Respondents reported that the major reason for medication non-compliance is related to cost (32.3%) and/or no drug insurance coverage (25.8%).

When specifically asked “Was there a time in the past 12 months when you needed to fill a prescription but could not because of cost?” the vast majority (83.7%) answered “no,” but 15.9% did say “yes.”



A number of focus group participants highlighted the high cost of prescriptions as a major factor influencing community health. In addition to the constraints in obtaining insurance coverage as mentioned above, others suggested that a typical strategy to obtain more affordable prescriptions was to travel elsewhere. Specifically, some participants mentioned knowing of individuals in their communities and families having traveled to Mexico for cheaper medication.

INTERACTION WITH HEALTH CARE PROVIDERS

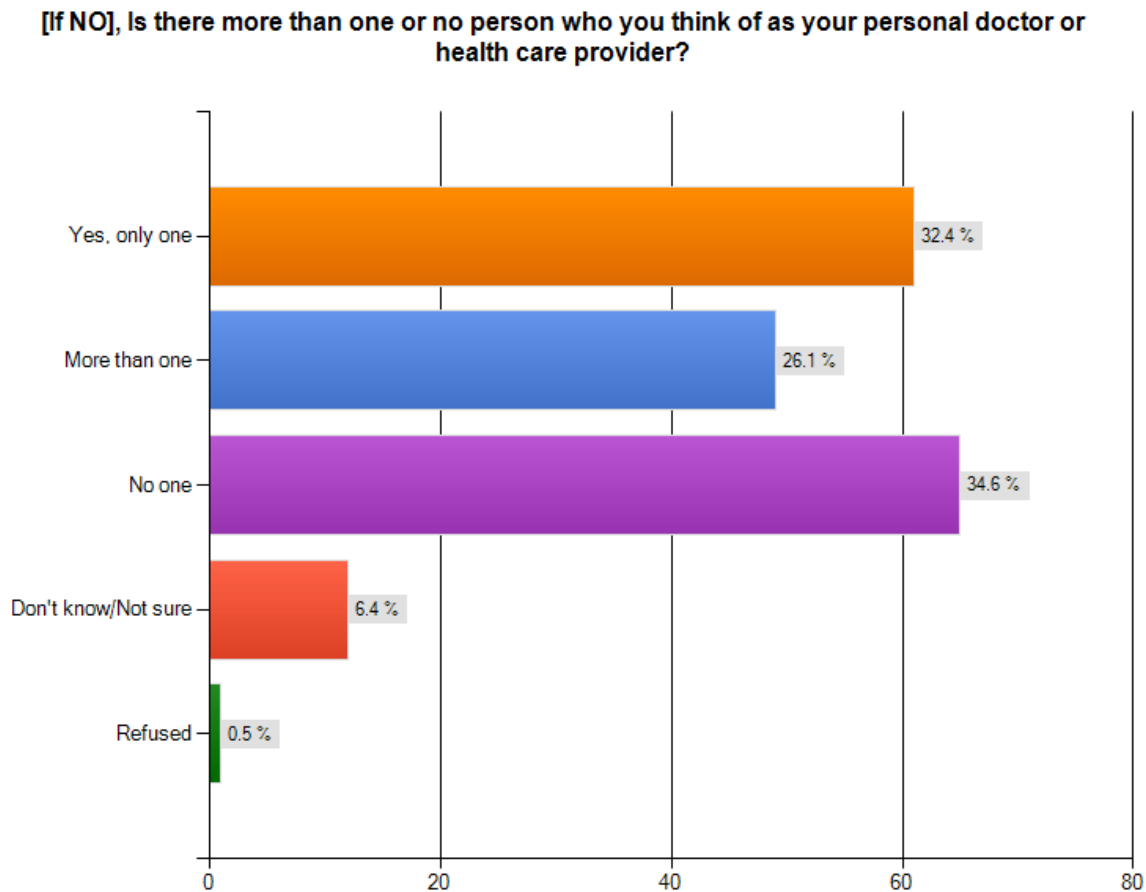
The survey had a series of questions asking respondents about how they interacted with the health care providers and organizations in the community. The majority

(78.1%) reported that they had one person who they considered their personal doctor or health care provider. A follow-up question concerned whether they had more than one or no person who they think of as their personal doctor or health care provider.

Personal Doctor

As Figure 22 shows, 34.6% responded that there was no one person they considered their personal doctor or health care provider. Over 30% of the respondents indicated that there was at least one person they considered their personal doctor/health care provider and 26.1% had more than one person.

FIGURE 22. Responses to “Is there more than one or no person who you think of as your personal doctor or health care provider?” (Telephone Survey).



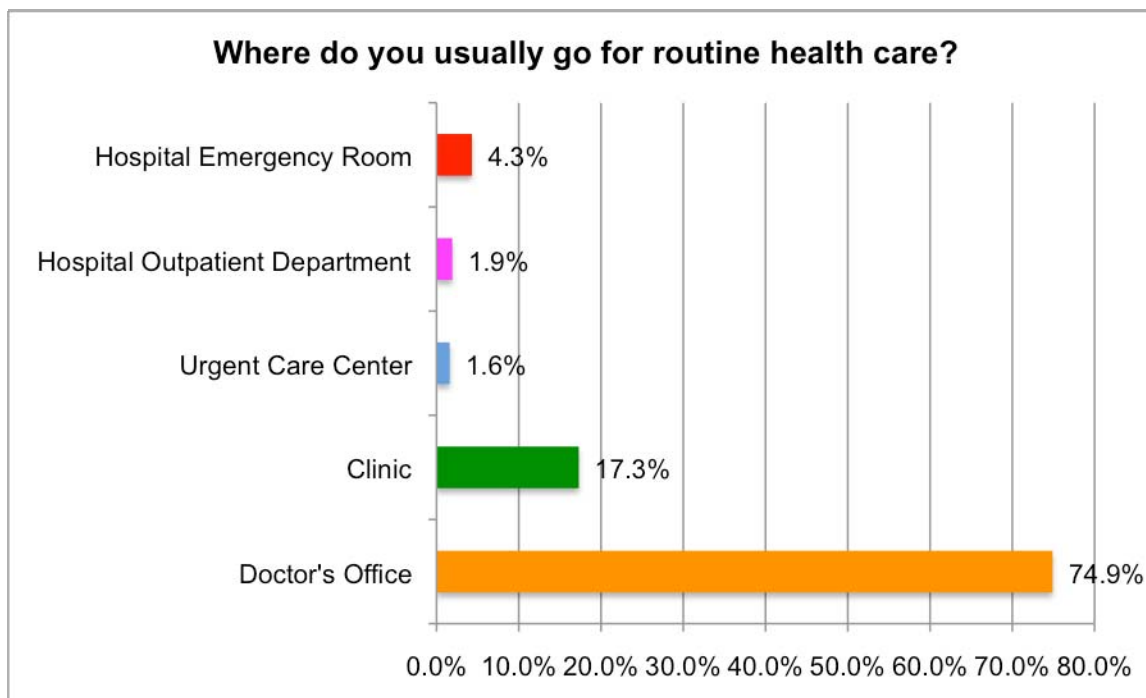
A partial explanation for the lack of a personal relationship with a doctor or health care provider may be related to where respondents usually went for routine health care. As Figure 23 shows, there was a segment of the survey sample who use clinics (17.3%),

hospital ERs (4.3%), or hospital outpatient departments (1.9%), rather than a doctor’s office for routine care.

In terms of specialists, 11% of the respondents indicated that they could not find a specialist in the area when they needed one in the past 12 months. The type of specialists needed included cardiologists, neurologists, orthopedists, hepatologists, and pulmonologists.

One of most recurring predicaments suggested by individuals from rural areas was the lack of physicians in their communities. There is often only one main hospital, a few clinics, and very few physicians serving these areas. Many rural residents were exasperated that there are few, if any, specialists in their communities for particular (and pressing) health needs. These individuals face the predicament of hoping to get the care that they need or alternatively driving to more urban areas in hopes of having more health care options. Many choose the latter, as one woman from a rural community says, "When it comes to the children, the grandkids, I would rather take them to Driscoll [Children's Hospital] than [to a hospital] here. Now, when my mom was ill, I'd rather take her to Corpus because there were heart specialists and heart hospitals more than what they have here. So it's pretty limited of what's here." Many other rural residents suggested that health care in their areas was "not dependable."

FIGURE 23. Responses to “Where do you usually go for routine health care?” (Telephone Survey).



Micro-Level Interactions with Health Care Providers

Focus group participants emphasized a number of one-on-one interactional issues in the health care system that influenced their access, treatment, and evaluation of health care at large. As discussed above, many individuals suggested a structural lack of adequate resources in terms of health care facilities and providers in rural areas. A related dissatisfaction among focus group participants was with scheduling appointments. When booking appointments, some focus group participants (in both rural and urban areas) anticipated they would not see their physician for a quite some time. In discussing this issue, one woman said, "You're not going to get in to see the doctor within the same month. It's going to be at least a month out that they schedule you."

Even attempts to schedule appointments due to episodes of chronic or immediate pain must be deferred. As one male focus group participant from an urban area said, "you need assistance right then. You are aching then and they make you an appointment two weeks later."

To add to this frustration, some question the scheduling process itself. Often times, despite having a scheduled appointment, patients undergo long (often day long) waits to see their physicians. Many voiced similar ideas similar to what one young man in an urban area said, "People shouldn't have to wait at the doctor's office all day just to be seen and miss a full day's work."

Some focus group participants did not feel particularly welcomed when they arrived at some clinics and hospitals. One summative reaction by one woman in a rural area was the feeling that the health care staff doesn't care, and that "they've taken the care out it." For some, it starts with the reception desk and may carry on into their one-on-one interactions with nurses and physicians.

At the same time, a number of residents (specifically those from urban areas) discussed a range of interactional episodes in the health care system with which they were extremely satisfied. First, many urban residents expressed positive interactions with their physicians. They felt their physicians were not only qualified, but that they also had an empathic disposition towards their patients.

A number of patients compared experiences with previous doctors to their current health care experiences. Urban residents in particular suggested that recent interactions with health care providers have been "the first time I've been to a doctor that I haven't felt like just a number being pushed out the door. They actually took the time to listen and gave compassion by concerns instead of just blowing off. That needs to be said...."

They took the time to listen to the symptoms. They didn't try to rush me through the process and push me out the door."

Many focus group participants also felt empowered through interactions with their physicians. While a good deal of the information relayed from their physicians was elaborate, patients felt that many doctors regularly take the time to explain their diagnoses and procedures to patients and their families. One woman said, "[my husband's doctors] explain everything to him. You know 'This is what's going on, this is what's not going on. You need to do a little bit more of this and a little less than that.' They just sort things out for him. And that gives me an understanding because I am his caregiver, and I have to know what medications to take and what not to take. It's a big responsibility." Again, receiving thorough information and explanation of the treatment set the family's mind at ease.

The overall level of satisfaction seemed to be particularly tied to patients' geographic location. Those in rural areas were less satisfied, while urban residents had more satisfactions. Some, if not a majority, of these satisfactions seemed to be tied to the numbers of resources, options, and overall agency/autonomy patients felt they had in more urban areas with a greater range of medical agencies, providers, and physicians.

Routine Check-ups and Procedures

The results, however, do indicate that the majority (78.2%) of the telephone survey respondents are getting routine check-ups within the past year and 11.5% had one within the past 2 years. Only 4.0% indicated not having a check-up in the past 5 years. Figure 24 depicts the frequency of respondents' check-ups.

In contrast to the survey data, focus group participants suggested that routine check-ups were not the norm among the larger population. Their understanding was that while many residents would ideally like to regularly visit their physicians for annual check-ups, few actually do so. The underlying reason, according to the focus group participants, was due to health insurance coverage. While those with adequate coverage had the opportunities to obtain annual exams, those without insurance "wish they could do the routine [check-ups]," but often cannot make this a priority on their limited budgets. One main consequence is that early detection and preventative measures are often overlooked, until it is "too late."

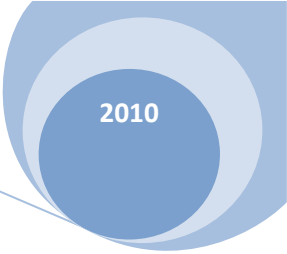
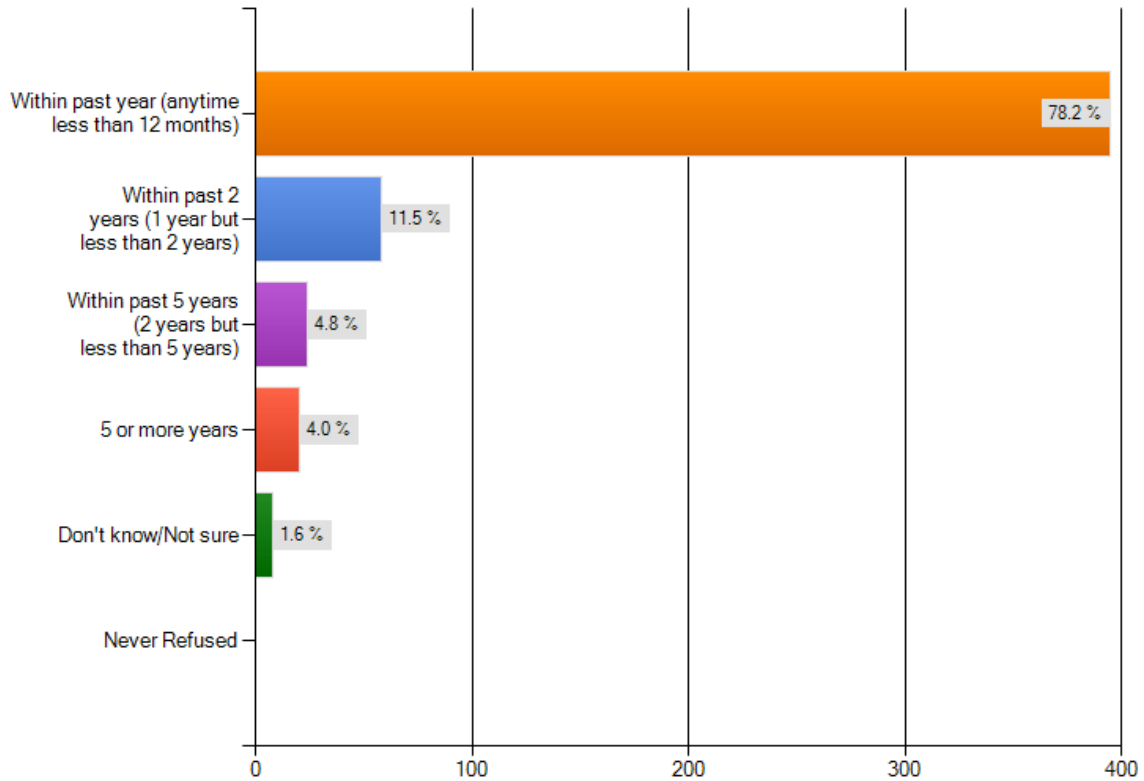


FIGURE 24. Responses to “About how long has it been since you last visited a doctor for a routine check-up?” (Telephone Survey).

About how long has it been since you last visited a doctor for a routine check-up? A routine check-up is a general physical exam, not an exam for a specific injury, illness, or condition.



It also seems that many of the respondents to the telephone survey have access to certain kinds of screening and monitoring procedures (see Figure 25). For example, 75.3% have had their blood pressure checked and 63.9% have had their blood sugar checked. Over half received a flu shot and had their cholesterol screened. Other procedures, however, are less likely to occur. Only a third of the women indicated that they have had a mammogram or Pap smear in the past 12 months. Very few of the men indicated getting prostate cancer screening.

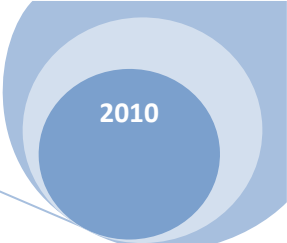
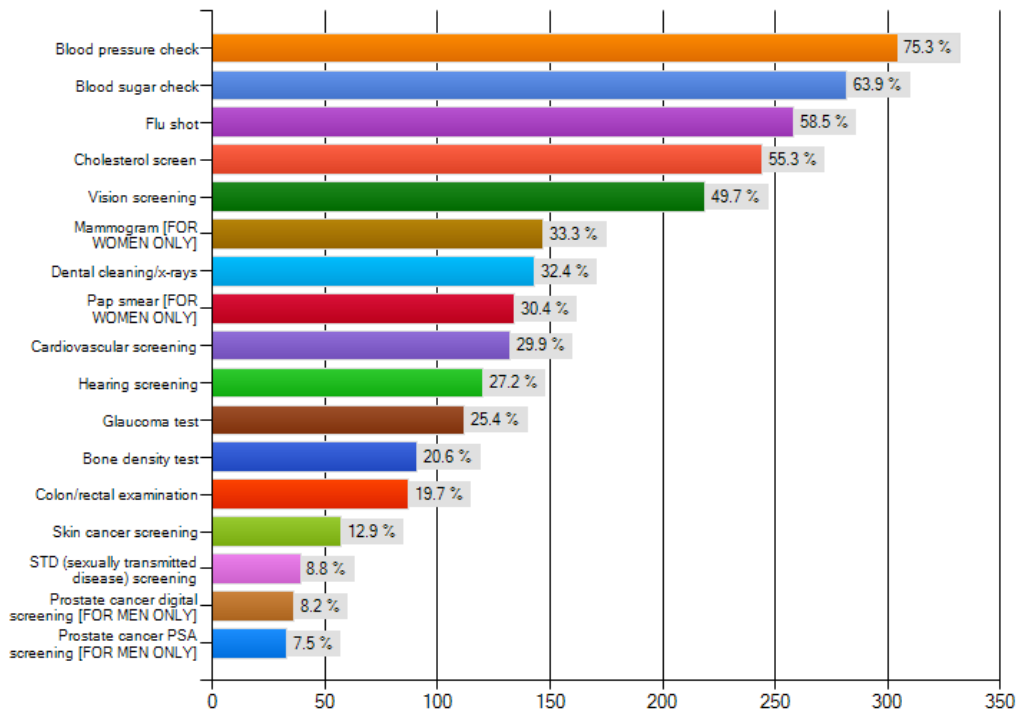


FIGURE 25. Responses to “Have you had any of the following procedures in the past 12 months?” (Telephone Survey).

Have you had any of the following procedures in the past 12 months? (Select all that apply)



Reported Conditions

The survey also asked respondents to indicate whether anyone in their household had certain conditions. As illustrated in Figure 26, allergies and arthritis were the most commonly reported conditions. Diabetes, hypertension, and back pain afflicted over a third of the respondents’ households, respectively. The majority (81.9%) indicated that they were able to seek treatment for their own or their household member’s conditions.

In comparison to the hospital data, the telephone survey data suggests that mental problems may be more prevalent than documented by the hospital data. Also, the telephone survey respondents indicated that they and members of their household are dealing with many chronic conditions.

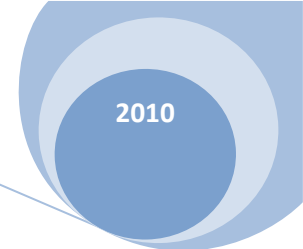
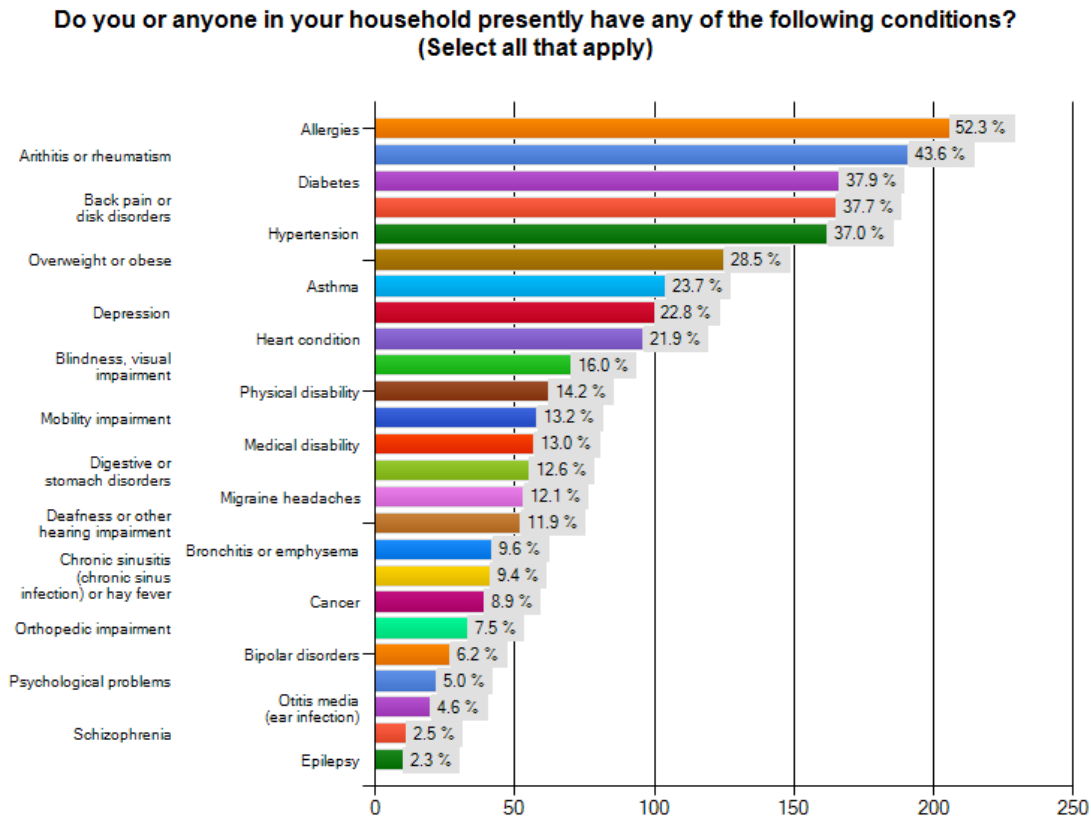


FIGURE 26. Responses to “Do you or anyone in your household presently have any of the following conditions?” (Telephone Survey).



As a follow-up question, telephone survey respondents were asked to indicate whether they were able to seek treatment for the identified conditions. The majority (81.9%) replied that they were able to seek treatment, but 14.4% said they could not seek treatment. The major reason given for their inability to get help was “cost.”

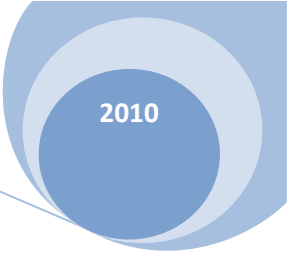
In the community telephone survey, over twelve percent indicated that transportation was ever a barrier to seeking health care while 85.6% said transportation was not a barrier. The focus groups, especially those with participants aged 62 and older and those in rural communities, however, indicated that transportation was a major barrier to access to care. Some were unaware that transportation services were available. One participant from Focus Group Six commented, “[For] the ones that do know... sometimes don’t like it because they get picked up at seven in the morning and don’t get home until five. Or, they may want to take a family member, if they are a certain age or disability. But they are not allowed to take a family member” (line 1269).

Health care and social service providers were asked to indicate the most frequent disease or condition they saw last year. As Figure 27 shows, “overweight or obese” patients were the most frequent response. Participants responded that Asthma (30.3%), diabetes (24.2%) and ear infections (27.3%) were the second most frequent disease or condition seen. Taken collectively, however, mental health issues (psychological problems (33.3%), depression (30.3%), bipolar disorders (18.2%), and schizophrenia 9.1%) comprise a surprisingly large proportion of the conditions seen by the physician and social survey providers.

Telephone survey responses to reported diseases or conditions were also examined by whether the telephone survey respondent lived in an urban or rural county (see Table 35). Overall, there were slight differences in conditions indicated by rural and urban respondents with a few exceptions. Allergies, physical disabilities, back pain, heart conditions, orthopedic impairment, and obesity were more likely in rural counties. Urban county residents were more likely to report psychological problems, depression, and schizophrenia than were rural residents.

TABLE 35. Conditions Reported Respondents by Urban/Rural County Status (Telephone Survey).

	County by Urban/Rural		Total
	Urban Counties	Rural Counties	
Arthritis or rheumatism	123 42.4%	63 46.3%	186
Allergies	142 49.0%	77 56.6%	219
Asthma	71 24.5%	30 22.1%	101
Back pain or disk disorders	105 36.2%	57 41.9%	162
Bipolar disorders	21 7.2%	6 4.4%	27
Blindness, visual impairment	48 16.6%	21 15.4%	69
Bronchitis or emphysema	35 12.1%	6 4.4%	41
Cancer	26 9.0%	12 8.8%	38
Chronic sinusitis (chronic sinus infection)	29 10.0%	11 8.1%	40



or hay fever			
Deafness or other hearing impairment	33 11.4%	19 14.0%	52
Diabetes	109 37.6%	51 37.5%	160
Digestive or stomach disorders	36 12.4%	18 13.2%	54
Depression	70 24.1%	27 19.9%	97
Epilepsy	6 2.1%	4 2.9%	10
Heart condition	59 20.3%	36 26.5%	95
Hypertension	108 37.2%	49 36.0%	157
Medical disability	32 11.0%	25 18.4%	57
Migraine headaches	34 11.7%	18 13.2%	52
Mobility impairment	39 13.4%	18 13.2%	57
Orthopedic impairment	17 5.9%	16 11.8%	33
Otitis media (ear infection)	12 4.1%	8 5.9%	20
Overweight or obese	71 24.5%	50 36.8%	121
Physical disability	37 12.8%	24 17.6%	61
Psychological problems	21 7.2%	1 .7%	22
Schizophrenia	10 3.4%	1 .7%	11
Total	290	136	426

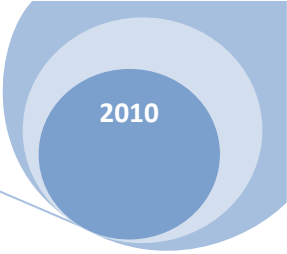
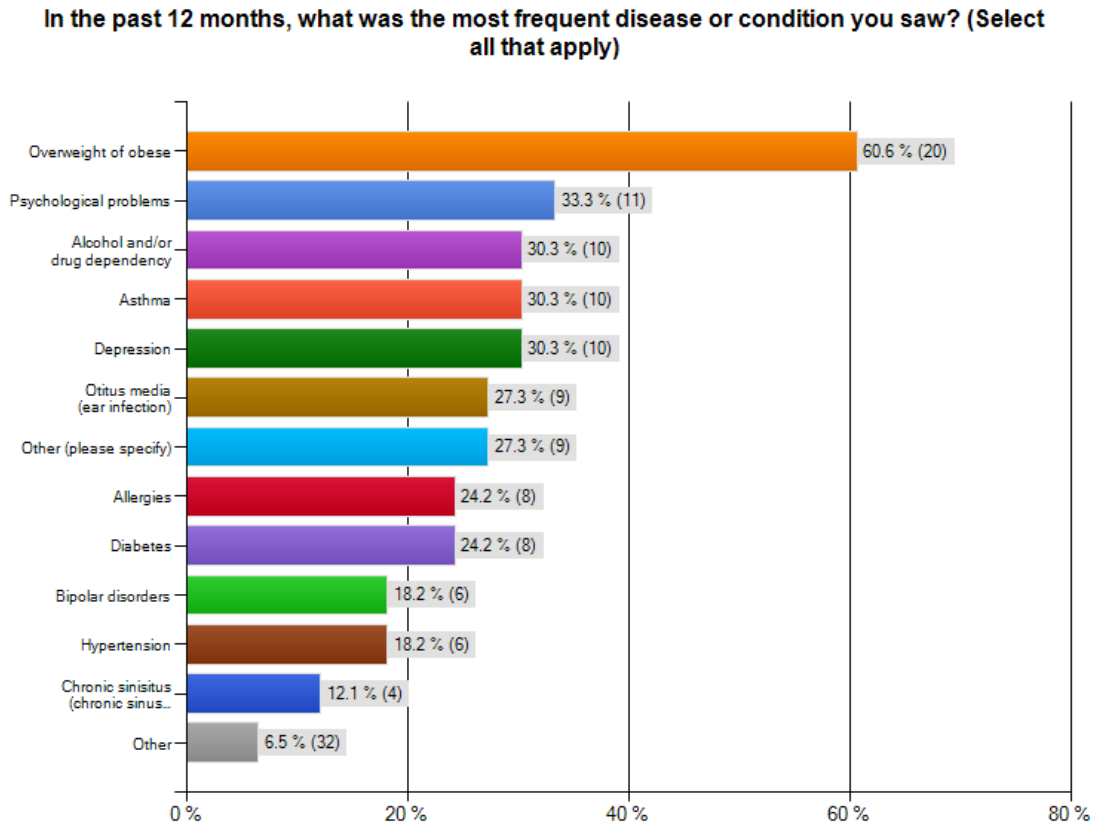
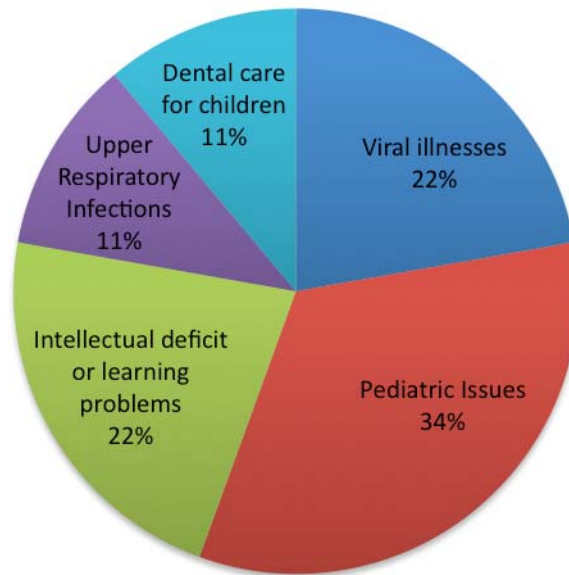


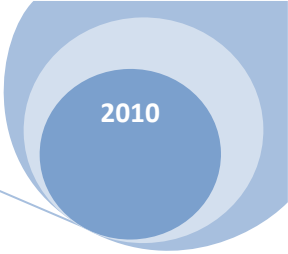
FIGURE 27. Responses to “In the past 12 months, what was the most frequent disease or condition you saw?” (Health Care and Social Service Provider Survey).



As Figure 28 shows, 27.3% responded "Other" to the question. To investigate this category further, subsequent analysis of written responses was conducted. Figure 30 shows that the "Other" category includes a variety of issues. Pediatric issues comprise over a third of the responses followed by 22% viral illnesses and 22% intellectual deficits or learning problems.

FIGURE 28. Chart of "Other" Diseases Commonly Found in the Past 12 Months (Health Care and Social Service Provider Survey).

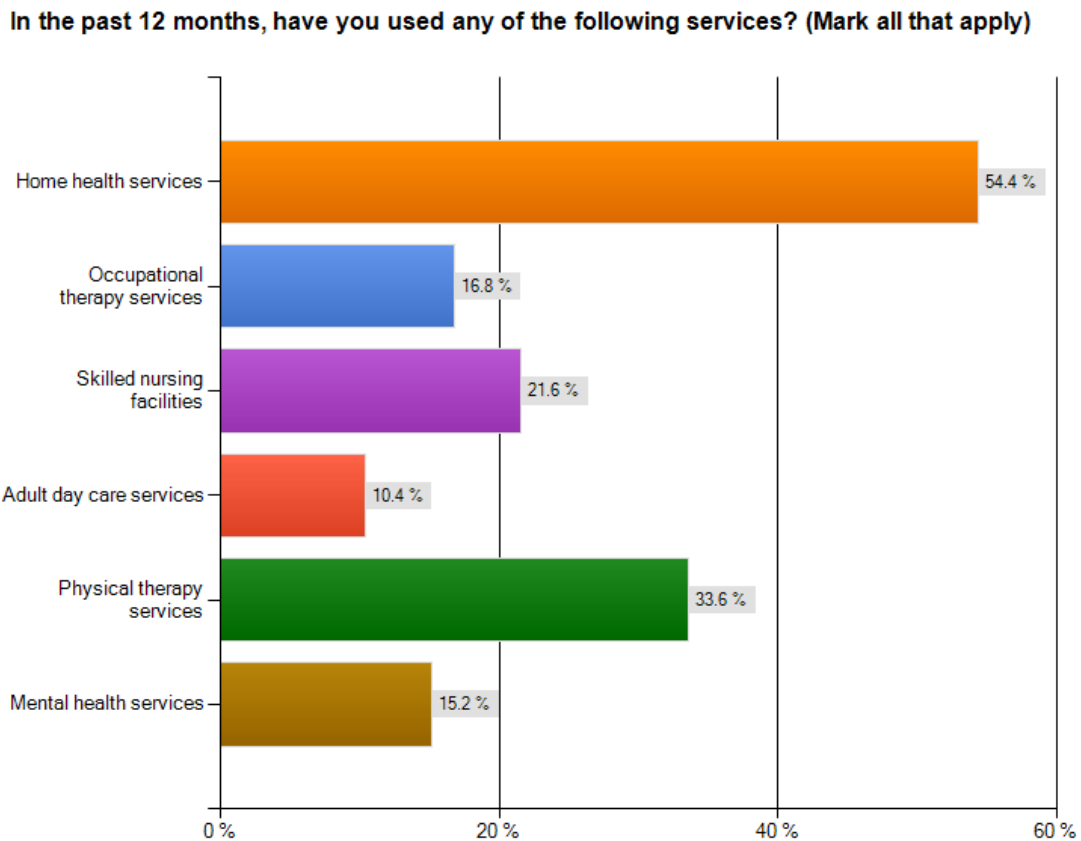


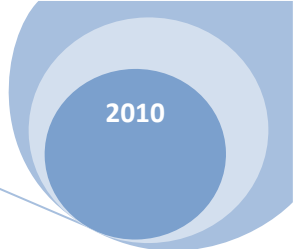


Services Utilized

Telephone survey respondents were asked to indicate whether they used particular services in the past 12 months. Only 125 of the respondents answered this question representing an older age group. As Figure 29 depicts, the majority (54.4%) used home health services followed by 33.6% who used physical therapy services.

FIGURE 29. Responses to “Have you used any of the following services?” (Telephone Survey).





Examining the responses to this question by age group (Table 36) revealed that younger groups were more likely to use occupational therapy, mental health services, and adult day care services than older groups. The older groups were more likely to need home health services than were the younger aged groups.

TABLE 36. Cross-tabulation of Respondents’ Services Needed by Age Group (Telephone Survey).

	Age Group			Total
	1-17 years	50-65 years	66+ years	
Home health services	16 31.4%	18 27.3%	29 43.3%	63
Physical therapy services	11 21.6%	15 22.7%	16 23.9%	42
Skilled nursing facilities	5 9.8%	11 16.7%	11 16.4%	27
Occupational therapy services	7 13.7%	7 10.6%	6 9.0%	20
Mental health services	7 13.7%	12 18.2%	0 .0%	19
Adult day care services	5 9.8%	3 4.5%	5 7.5%	13
Total	51	66	67	184

Very few focus group respondents suggested their regular use of services and seems to be due to their not being aware of their existence in the first place. When asked what services they believe improve community health, a number of focus group participants responded, "I don't think that there's any." Sometimes (though not regularly), another participant would counter by informing the group what services and agencies were available to the community. In retort, others stated that "finding those resources is not always easy, though." In general, focus group participants were more familiar with available educational services in the community than they were with health care services.

The few participants who were aware of services did suggest that better advertising of such services would serve the population well. If residents do not know particular services or agencies are available to begin with, they will not be able to take advantage of them, thereby negatively impacting community health.

In general, the limited use of services in the community may be due in large part of residents' lack of knowledge of their existence. While many services could no doubt improve the lives of residents and the community at large, there may need to be a stronger campaign to advertise services and thereby help the community put these resources to their full use.

Health Information

Figure 30 shows how telephone survey respondents get most of their health information. The majority (68.7) relied on receiving information from their doctors, nurses, or pharmacists. Eleven percent relied on getting information from the internet and 11.3% used the media (television and newspapers) as their source of information.

To further investigate, the responses to the question, "Where do you get MOST of your health related information?" were examined by age group. As Table 37 illustrates, sources of information do tend to vary by age group in a statistically significant way. Those who were over the age of 66 were most likely to rely on health care professionals than were other age groups. Those younger than 66 years were more likely to rely upon the newspaper, TV, and the internet than were older respondents. These results suggest that health education efforts will need targeted programs aimed at reaching age groups at risk.

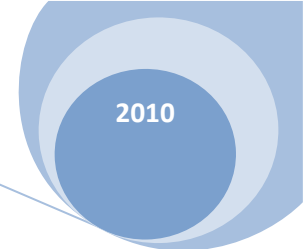


FIGURE 30. Responses to “Where do you get MOST of your health related information?” (Telephone Survey).

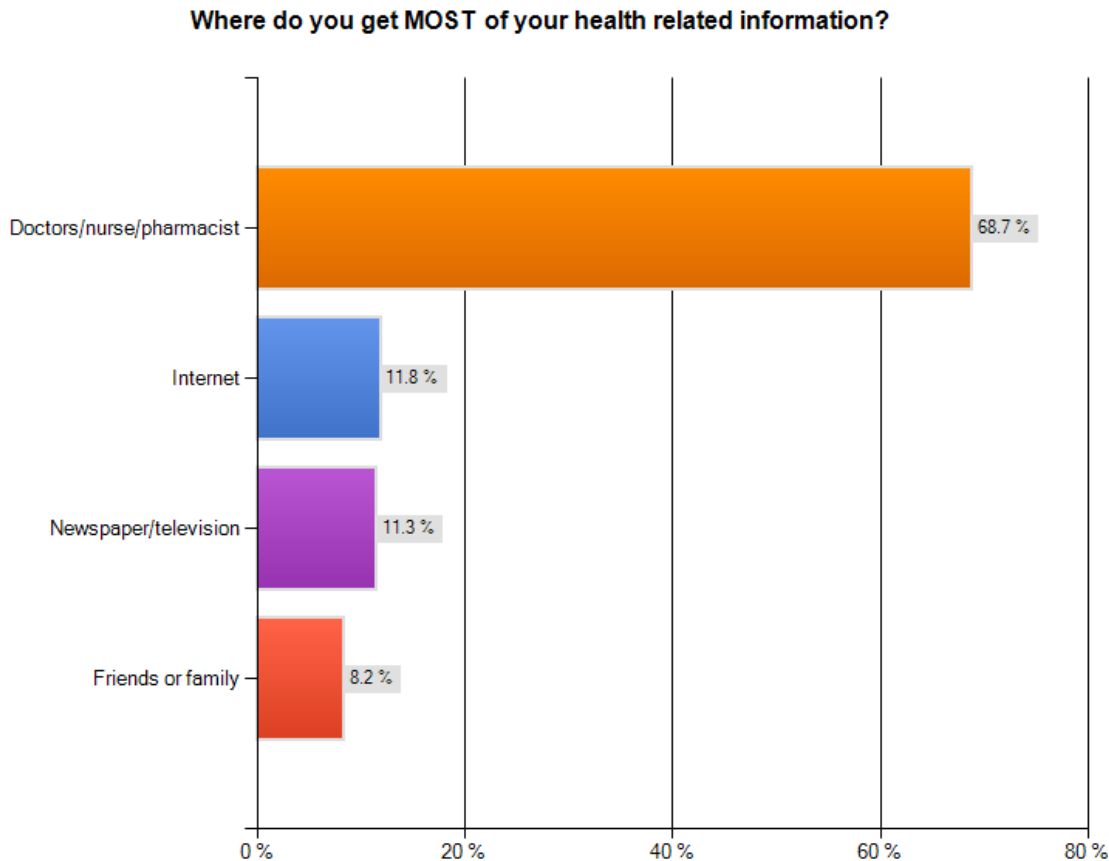


TABLE 37. Cross-tabulation of Source of Health Information by Respondent’s Age Group (Telephone Survey).

	1-17 years	50-65 years	66+ years	Total
Doctors/Nurses/Pharmacists	92	100	123	316
	56.8%	62.9%	86.0%	68.0%
Internet	29	24	3	56
	17.9%	15.1%	2.1%	12.0%
Newspaper/TV	20	19	15	54
	12.3%	11.9%	10.5%	11.6%
Friends or family	21	16	2	39
	13.0%	10.1%	1.4%	8.4%
Total	162	159	143	465
	100.0%	100.0%	100.0%	100.0%

Chi-square = 41.645; d.f.=9; p=.0001.

Information from the focus groups both support and challenge the findings from the telephone survey. Participants of the focus groups did say their doctors' offices helped them get access to services. But, they also indicated that friends, family, and staff from various agencies were critical to participants learning about the type of services and assistance programs that are available to patients. Sometimes, a social worker at a hospital would inform participants about the services/programs available. For some, an enthusiastic worker from a community action agency informed seniors about programs for which seniors were eligible. But, often times, participants revealed that learning about the types of programs in existence takes work. One participant commented, "I have heard a lot of people say, a lack of knowing is what is going on... Yes, somebody told me. In a way that's the way life is, you ain't gonna hear about it unless someone tells you... I got into the habit of finding resources..." This respondent was in his seventies. Thus, taking time to seek out services may be something that is much more easily done by senior citizens who are no longer working and no longer parenting.

People with limited means, multiple roles, and non-standard, shifting work schedules may be at a disadvantage to accessing resources because they may not have as much time to devote to learning about services as compared to their senior counterparts. At several of the focus groups, as participants were discussing the challenges they faced accessing health care or the types of programs available to people with limited resources, others would share information, alternative programs, while others respond with surprise and enthusiasm that such services did exist. Even these focus groups served as unanticipated opportunities for participants to learn about services/programs available.

Several participants who actually worked for health care agencies indicated that they "do a lot of outreach." They disseminated pamphlets at health fairs and to as many public events as possible. One participant who worked for a health care agency indicated she even visited her area's courthouse to distribute information. One participant who was a health care professional suggested that agencies could "try and constantly keep OB-GYN offices knowing [about programs that are available for patients, especially when they lose their Medicaid], to which a respondent who worked for a health care agency responded, "They [doctors' offices] don't give out information. I know I have been to plenty of doctors' offices... They won't give [the pamphlets we leave] out; they're really busy. They ARE very busy, but I wish that somebody would just take the time to give [patients] information."

Recognizing that younger people get their information through the internet, focus group members who were staff at some agencies indicated that they have spoken with their agencies' directors about establishing Facebook pages for their specific agencies. Though it is important to note, those pages have not yet been created; they are simply introducing those ideas to those in charge of their agencies.

Children's Health Care Access and Health Status

In this section, results about the community's children as ascertained from the telephone survey are presented. About a quarter of the telephone survey respondents had children under the age of 18 living in their households. There was an average of 1.79 children per household.

HEALTH CARE ACCESS

Of those who had children in their households, 82.4% reported that their children had health insurance coverage (see Figure 31). Table 38 shows that most children had traditional/private health insurance coverage. Over 27% relied upon Medicaid for health care coverage for their children. Others received coverage through the state CHIP or local STAR Medicaid programs.

For the few who did not have health insurance for their children, the lack of insurance was due to cost or employers who did not provide this kind of insurance. Two respondents indicated that they did not think health care insurance for their children was necessary.

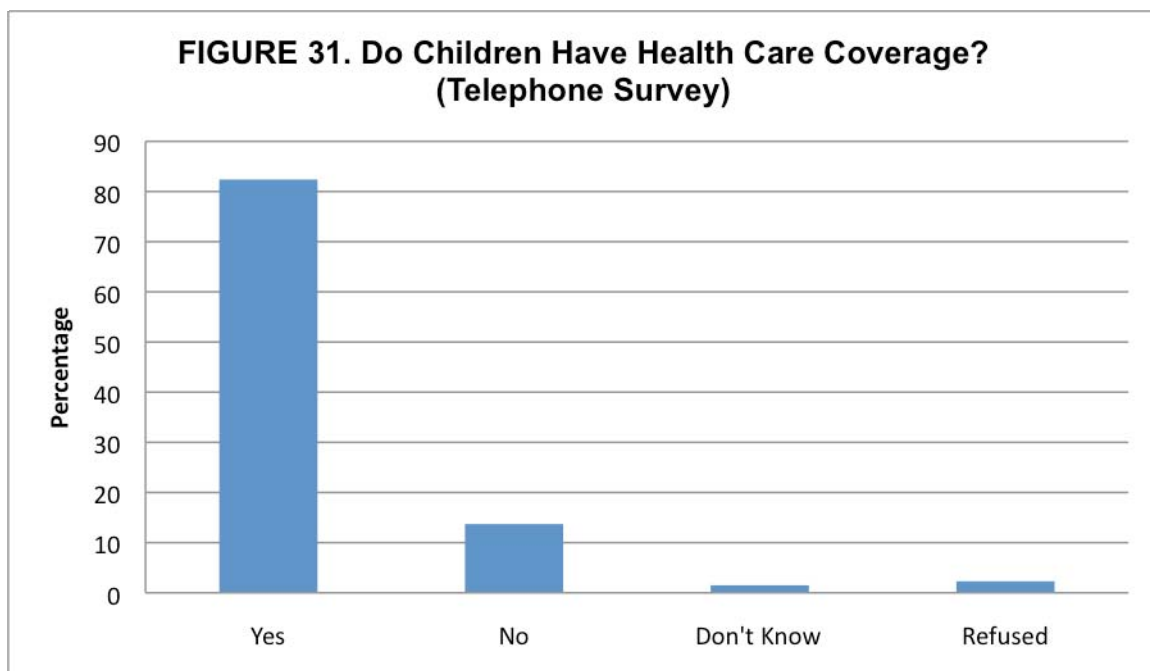


TABLE 38. Frequency Distribution of Respondents' Type of Insurance for Children (Telephone Survey).

		Frequency	Percent	Valid Percent
Valid	Private/Traditional	51	9.5	46.8
	CHIP	9	1.7	8.3
	STAR Medicaid	8	1.5	7.3
	Medicaid	30	5.6	27.5
	Don't know/Not sure	9	1.7	8.3
	Do not have health insurance	2	.4	1.8
	Total	109	20.3	100.0
Missing	System	428	79.7	
Total		537	100.0	

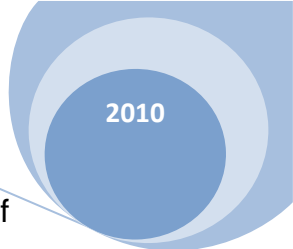
CHILDREN'S HEALTH STATUS

In the Coastal Bend community, there were several particular concerns for children identified by the Steering Committee: asthma, obesity, premature births, and mental health issues. The telephone community survey provided an opportunity to determine the extent of these problems.

Asthma

In terms of asthma, 35.2% of the telephone survey respondents indicated that their health care provider indicated that their child had asthma (see Table 39). For those whose children were identified as having asthma, 36.7% of those children still had asthma while 58.3% did not (5% "don't know").

Recent data from the 2008 Behavioral Risk Factor Survey indicates that the U.S adult asthma prevalence rate is 8.5% and 9.0% for all children. For U.S. children aged 5 to 17 over 10% currently have asthma. For Texas, the 2008 Behavioral Risk Factor Survey reports that 7.3% of adults and 9.2% of children currently have asthma. For Texas children aged 5 to 17 over 10% currently have asthma. For Texas Health Service



Region 11 which includes several counties of the Coastal Bend, the prevalence of current asthma among children (11.2%) was higher than the state and U.S. rates.

TABLE 39. Responses to “Has a doctor, nurse or other health care professional EVER said that your child (or one of your children) has asthma?” (Telephone Survey).

		Frequency	Percent	Valid Percent
Valid	Yes	44	8.2	35.2
	No	75	14.0	60.0
	Don't know	2	.4	1.6
	Refused	4	.7	3.2
	Total	125	23.3	100.0
Missing	System	412	76.7	
Total		537	100.0	

Obesity

The majority (80.5%) indicated that they did not think that their children were obese. Obesity can be perceived differently by individuals. Lacking any objective measures (such as BMIs) of children’s obesity in this health needs assessment study, conclusions about childhood obesity cannot definitively be ascertained. Other sources (see below), however, indicate that childhood obesity is an issue in the Coastal Bend community and state, as a whole.

Nationally, Texas is ranked 12th in adult obesity and 4th in overweight high school students (Trust for American’s Health, 2005). When overweight Texans are included in the data, the percentages are even more striking: 60.1% of white, 75.7% of black, and 71.0 % of Hispanics over the age of 18 are either overweight or obese. Considering eighth grade girls, 34.5% of whites, 39.2% of blacks, and 40.7% of Hispanics were overweight or obese in Texas. For eighth grade boys 30.9% of whites, 23.9 % of blacks and 49.2% of Hispanics were overweight or obese (Texas Department of State Health Services, 2005). A variety of health issues have been associated with increased rates of

obesity, including Type 2 diabetes, hypertension, coronary heart disease, stroke among other diseases (CDC, 2006).

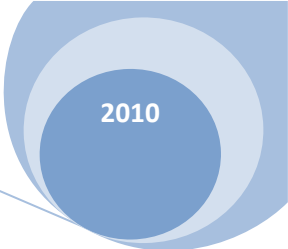
In addition, the Health Care and Social Service Provider Survey respondents were asked what they saw as the most frequent disease or condition they saw last year. Sixty percent said that the patients' being overweight or obese was the most common condition they saw (see Figure 27).

In nearly every focus group with young adults (aged 18 – 40), a number of respondents cited *Men's Health* ranking of Corpus Christi as "American's fattest city" (<http://www.menshealth.com/fattestcities2010/>). Young adults referenced obesity as a problem in children, adolescents, and adults alike. In their reflecting on childhood obesity, most focus group participants believed contemporary children's immobile and inactive lifestyles the primary cause. Others cited fast-paced lifestyles as contributing to obesity as well. Today's time demands make it difficult for families (often the responsibility of mothers in particular) to prepare home-cooked, healthy meals. As such, it is "easier" to buy pre-cooked, processed foods for family meals. Time demands also influence activity levels among children. One woman said, "They don't make time [for physical activity]. You can do at least 5 minutes out of the day, maybe 10 minutes out of the day to make that effort. That's why, nowadays, you don't even see children playing outside. They are either too busy playing [video] games, and they've never exercised in their life. They just eat and don't exercise. If you do 5 minutes a day or 10 minutes a day, it would help. At least a little bit, especially for the cardio, for your heart. I think if they would exercise more, they would be a lot healthier." While a large part of the burden rests on cultural changes in the family, school, and work worlds, participants believe individuals in each of these institutions (particularly parents and educators) are responsible for "allowing" today's children too become inactive and, hence, obese.

There seems to be a disconnect between how health care professionals (health care and social service providers, Texas Department of Health, the Centers for Disease Control) and community survey respondents define obesity. More community awareness about how to assess obesity and its related health problems is imperative.

Premature Births

Preterm births (less than 37 weeks of gestation) were reported by only 18 of the survey respondents. Preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. According to data from the Centers for Disease Control (Martin et al, 2010), preterm births have declined for the first time in three decades. For the U.S. in 2008, 12.3% of all births were preterm. Preterm births declined from 2006 to 2008 for mothers of all age groups under age 40, for the largest



race and Hispanic origin groups and for most U.S. states including Texas. The preterm birth rate for Texas, however, is 13.3%, slightly above the national rate.

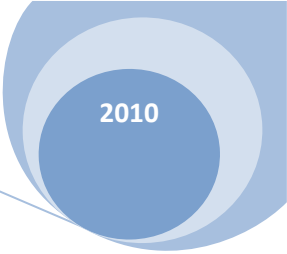
The manner of birth did not seem to explain the decline. For the U.S., Martin (et al, 2010) found that the overall preterm rate from 2006 to 2008 was related to declines in all types of delivery, in preterm cesarean and induced and non-induced vaginal births.

MENTAL HEALTH STATUS

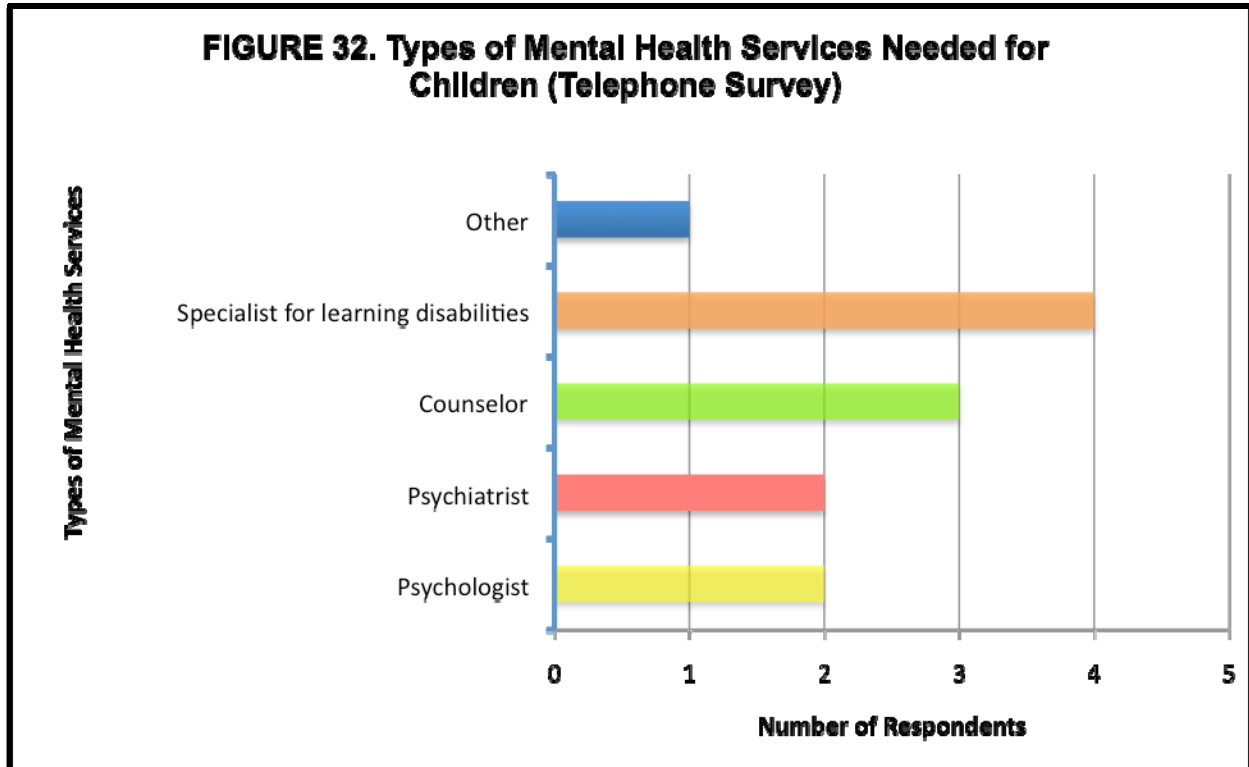
Respondents also asked if any health care provider said that their child needed mental health services. As Table 40, shows the majority reported that their children did not need mental health services.

TABLE 40. Responses to “Has a doctor, nurse or other health care provider EVER said that your child (or one of your children) needed mental health services?” (Telephone Survey).

		Frequency	Percent	Valid Percent
Valid	Yes	15	2.8	12.5
	No	100	18.6	83.3
	Don't know	2	.4	1.7
	Refused	3	.6	2.5
	Total	120	22.3	100.0
Missing	System	417	77.7	
Total		537	100.0	



As Figure 32 shows, for the 15 who indicated that their child needed mental health services, the majority needed a specialist for learning disabilities. “Counselor” was indicated as the second most frequent type of help needed. Only 50% received the mental health services recommended.



Assessment of Issues in the Coastal Bend

In order to assess how people viewed health issues compared to other issues in the Coastal Bend, respondents from the community telephone survey, health care and social service providers were asked to rate various issues and indicate whether they viewed it as “not a problem,” “a minor problem,” “a moderate problem,” or “a major problem.” Table 41 illustrates the summary of responses about issues in the Coastal Bend from the 2010 data sources as compared to the findings of the 2004 Coastal Bend Needs Assessment.

As the Table 41 shows there were some areas of agreement (shown in blue) and disagreement (shown in yellow) among the various respondent groups.

CHILDREN AND YOUTH

In general for 2010, a higher percentage of the community and health care and social service providers consider alcohol use among children and youth to be a major problem in the Coastal Bend than in 2004. There is disagreement about illegal drug use as the community survey respondents were more likely to view it as a major problem while the health care and social service providers saw it as a minor problem. Social services for children and youth were not considered areas of concern.

FAMILIES

The majority viewed child care as a minor problem. This is an improvement from the 2004 Coastal Bend Needs Assessment where 29% saw this issue as an area of concern.

The majority in both 2004 and 2010 viewed domestic violence as a major problem for the community. Similarly, child abuse was viewed as an area of concern, but community members rate this issue slightly less serious than the health care and social service providers.

Poverty continues to be viewed by most as a major problem in the Coastal Bend. With the recent economic upheavals resulting in job loss or underemployment, many are adapting to new economic realities.

SENIORS

The majority do view elder abuse as a minor problem for the Coastal Bend. There is a difference in perceptions between the community members and health care and social

service providers; however, when it comes to affordable housing for the elderly, the community is more likely to view it as not a problem.

EDUCATION/PREPARATION/JOB SKILLS

Unemployment and lack of job skills are viewed as problem areas by the Coastal Bend community and continues trends noted in 2004. Surprisingly, the majority of the community does not view access to higher education as a problem while health care and social service providers do view educational access a moderate to major issue.

Although 18% of the community telephone survey participants indicated that they only speak Spanish in their homes, most of the community does not see that language barriers exist in the Coastal Bend.

When asking focus group participants if they felt language barriers existed in the Coastal Bend, most felt that there did not exist such challenges. Participants indicated that offices and hospitals usually had translators available. They also noted that many people at the offices already spoke Spanish or "Tex-Mex." So, language was not a barrier. It may be worth noting that focus group participants who were racial/ethnic minorities were Hispanic, African American, or American Indian, and they indicated they did not see language barriers in access to services. It is worth noting those who speak neither English nor Spanish may not share the same perceptions as those who participated in the focus groups.

SELF-SUFFICIENCY BASIC NEEDS

Transportation was seen as a minor problem by the majority of the Telephone Survey and Physician and Social Service Provider Survey participants, perhaps an improvement from the 2004 results. The rural living seniors in the focus group interviews, however, indicated that transportation was a major issue for them. The community respondents and health care and social service providers, however, varied in their views regarding homelessness and affordable housing. The community telephone survey respondents were more likely to rate these minor problems compared to the health care and social service survey respondents who viewed them as moderate to major problems.

NEIGHBORHOOD AND COMMUNITY

Comparing the 2004 to 2010 needs assessment results showed that many have not seen improvements in their neighborhoods or community conditions. Streets in disrepair continue to be rated as a problem by a majority of the community. In addition, a higher proportion of people in 2010 saw crime and gangs as major problems than in 2004.

Nearly every focus group felt the need for more city and/or county services regarding a range of community issues and concerns. Many saw that the quality of their health was compromised by the government's inability to meet the basic needs of the community whether it was to pick up stray animals in residential areas, to spray for mosquitoes, fleas, and other pests, and to pick up garbage in public areas. A number of other focus group participants in nearly every age range cited environmental pollution as detrimental to community health. They cited local oil refineries as the primary culprits in the degradation of air quality. Though focus group participants were aware of the debate regarding the extent to which the refineries alone are responsible for declining health in the area, they do cite a number of conditions that may be linked to the refineries' waste. One woman said, "It is bad, because a lot of people in [my] area have developed blood cancer throughout the years. And they're fighting right now. They're fighting the refineries. You know, there's a lot of people that have emphysema, they've got lung cancer, liver cancer. Some people that have never smoked – a lot of them have this disease, you know? And it's like a lot of the people got tested and they said that they had stuff wrong in their blood." Other participants mention problems concerning water contamination due perhaps to waste from local industries. In sum, participants feel that while some health conditions are due to individuals' health habits, other conditions may have amplified due to local industries.

HEALTH/WELL BEING

The consensus was that affordable and/or adequate health insurance was a moderate to major issue in the Coastal Bend. In fact, the 2010 health needs assessment determined that the same proportion of residents are without health insurance as were in 2004 (18%).

There is disagreement, however, about the degree to which access to health care is a concern. In 2004, the majority of citizens reported that they did not know a place to get health care. In contrast, the community telephone survey respondents indicated that did not think that access to health care was a problem. Health care and social service providers, however, were more likely to indicate that access was a moderate problem.

Similarly, mental health was viewed by the health care and social service providers as a major problem while the community survey respondents did not. Both groups agreed, however, that access for services for people with disabilities was not a serious problem.

Transportation to and from health care facilities was not viewed as a major problem by the survey participants. For focus group participants, transportation was more often cited as a moderate problem.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
Children & Youth	Illegal Drug Use	45% think it is a major problem	47% think it's a minor problem	Not cited as a major problem	Up to 16.2% of citizens surveyed reported children involved with drugs and alcohol.
	Alcohol Use	43% think it is a major issue	56% think it's a major problem	Not cited as a major problem	
	Social Services for Youth	About 40% think it is not a problem	43% think it's a moderate problem, but not serious	Cited as a moderate problem	Emotional stability of children is considered an important concern. Teens in the 12 counties are 1.5 times more likely to commit suicide than teens at the state level.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
Families	Childcare	About 46% think it is not a problem.	39% think it's a moderate problem, to not serious problem.	Cited as a moderate problem	Up to 29% are dissatisfied with childcare arrangements and describe affordability of high quality childcare as a significant barrier.
	Domestic Violence	About 40% think it is a moderate to serious problem	56% think it's a moderate problem	Not cited as a major problem	Family Violence in the 12 counties varies greatly by county. Nueces (4.4 per 1000), Brooks (3.3 per 1000) and Refugio (3.5 per 1000) shelter children at a greater rate than the state average of 2.8 per 1000.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
		Poverty	About 52% think it is a moderate to serious problem	40% think it's a moderate problem, while other 40% believe it is a major problem	Cited as a moderate problem
Child Abuse	About 50% think it is a moderate to not serious problem	About 70% think it is a moderate to serious problem	Not cited as a major problem		
Seniors	Affordable Housing for Seniors	41% think it is not a problem	About 50% think it is a moderate to major problem	Not cited as a problem	Up to 41% of those elderly needing personal nurse did not receive help.
	Elder Abuse	About 47% think it is not a problem	About 40% believe it is not a major problem	Not cited as a problem	1614 (1.85%) confirmed cases of elder abuse in the 12 counties.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
		Dental Care	Not addressed	Not addressed	Major problem for Seniors as Medicare does not provide such insurance
Education/ Preparation/ Job Skills	Access to Higher Education	About 54% think it is not a problem	60% think it is a moderate to major problem	Cited as a moderate problem	Up to 31.2% of responding households reported attaining a college education.
	Unemployment	About 50% think it is a moderate to serious problem	About 60% of people believe it is a moderate problem	Cited as a moderate problem	Up to 9.4% of citizens reported a household member who has at least been temporarily unemployed in the past 12 months.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
	Lack of Job Skills	About 43% think it is a moderate to serious problem	50% of people believe it is a major problem	Cited as a moderate problem	94% agree that people need more information about job training opportunities available to them.
	Language barriers	About 50% think it is not a problem	More than 50% of the people believe it is not a major problem	Not cited as a major problem	Up to 3.3% of households reported Spanish being primary language spoken at home.
Self-sufficiency Basic Needs	Homelessness	About 42% think it is not a problem	Around 50% believe it is a moderate to major problem	Cited as a moderate problem	Up to 5.9% of respondents described experience of homelessness in the past 12 months.
	Transportation	More than 50% think it is a minor problem	47% think it is a minor problem	Cited as a major problem by seniors in rural communities	Up to 16.2% described lack of transportation as a barrier in their lives.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
	Affordable Housing	About 48% think it is not a problem	50% believe it is a moderate to serious issue	Cited as a moderate problem	Up to 21.6% of citizens report having had difficulty paying rent.
Neighborhood & Community	Streets in Disrepair	About 56% think it is a moderate to serious problem	About 60% think it is a moderate to serious problem	Cited as a moderate problem, including poor drainage	Up to 41.6% of citizens are concerned about the poor state of street repair.
	City/County Services			Seniors: cited as a major problem. Need sidewalks, animal and vector control, trash collection, etc.	
	Crime	44% think it is a serious problem	Around 50% think it is a major problem	Cited as a moderate problem	Up to 30.2% of citizens report crime being a problem in their community.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
	Gangs	43% think it is a major problem	47% think it is a major problem	Not cited as a major problem	Up to 19.5% of respondents describe gang activity as a detractor for their community.
Health/ Well-being	Access to Health Services	About 52% think it is not a major problem	44% think it is a moderate problem	Cited as a major problem	Up to 64.6% of citizens reported that they did not know a place to get help from.
	Affordable/ adequate Health Insurance	50% think it is a moderate to major issue	50% think it is a major issue	Cited as a major problem	Up to 18.4% of households reported not having any insurance coverage.
	Mental Health	About 45% think it is not a major issue	46% think it is a major problem	Cited as a minor problem	Up to 4.6% of households reported the occurrence of a mental health crisis within the past 12 months.

TABLE 41. ASSESSMENT OF ISSUES IN THE COASTAL BEND

Target Needs Area	Issue	2010			2004
		Telephone community	Health Care and Social Service Providers	Focus Groups	Citizens
	Transportation to and from Health Care Facilities	About 51% think it is not a major problem	60% think it is not a major problem	Cited as a major problem	
Disabilities	Access for Services for People with disabilities	49% think it is not a serious problem	About 60% think it moderate to not serious problem	Cited as a minor problem	Up to 33.3% of the persons with disabilities feel like they need help with daily activities. Up to 42.6% say they never get help they need with basic daily activities: eating, toileting, etc.

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