2021

COMMUNITY HEALTH NEEDS ASSESSMENT

Covenant Hospital Plainview

Plainview, TX

This CHNA was completed in collaboration with Covenant Health Plainview and Covenant Health Levelland. To provide feedback about this CHNA or obtain a printed copy free of charge, please email Veronica Soto at vsoto@covhs.org.

CovenantHealth

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EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2021 CHNA was adopted by the Covenant Plainview Hospital Board of Directors on December 8, 2021.

Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across the Lubbock, Hockley and Hale counties, information was collected from a variety of public data sources. Community Surveys were conducted with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. Stakeholder listening sessions were conducted with representatives from organizations that serve these populations.

The CHNA was updated to include information about the disproportionate impact of COVID-19 on certain populations in Texas and the South Plains. Due to systemic inequities, Black and Hispanic communities were disproportionately affected by COVID-19 deaths. The pandemic also affected student learning and outcomes based on the State of Texas Assessment of Academic Readiness (STAAR). Housing was highlighted as a great need in the South Plains in the first year of the pandemic, with almost a quarter of 2-1-1 requests related to housing and shelter.

Identifying Top Health Priorities

Priorities were determined through a collaborative process engaging the Texas/New Mexico Community Health Investment team, community stakeholders, hospital representatives and hospital board members. This was accomplished by conducting a workshop engaging internal and external stakeholders from Lubbock, Levelland and Plainview to review the primary and secondary data and complete prioritization of identified needs. The Covenant Health Lubbock Community Benefit Committee, Covenant Levelland Board of Directors and Covenant Plainview Board of Directors completed a final review and approval of the selected priorities. The following priority areas were agreed upon for all Covenant Health hospitals:

PRIORITY 1: MENTAL AND BEHAVIORAL HEALTH

Mental and behavioral health treatment, intervention, and prevention services for the community, including related issues such as substance use

PRIORITY 2: ACCESS TO HEALTH SERVICES

Access to health services including but not limited to prevention, mental health, oral health, prescription assistance, health/community navigation, transportation, and health education/prevention services

PRIORITY 3: HOMELESSNESS AND HOUSING INSTABILITY

Safe, affordable, stable housing and permanent supportive housing solutions for people experiencing chronic homelessness

PRIORITY 4: FOOD INSECURITY AND NUTRITION

Access to healthy food, nutrition education, and healthy lifestyle support

Community Health Improvement Plan

Covenant Health will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources, community capacity, and core competencies. The 2021-2023 CHIP will be approved and made publicly available.

INTRODUCTION

Who We Are

Our Mission As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Covenant Health is network including multiple acute-care hospitals founded in 1998 through a merger of two faith-based hospitals in Lubbock, TX. Covenant's network includes Covenant Medical Center, Covenant Children's, Grace Medical Center, and Covenant Specialty Hospital (joint venture) all located in Lubbock, TX. Additionally, Covenant operates two regional hospitals, Covenant Health Plainview, and Covenant Health Levelland, as well as various Covenant Medical Group clinics throughout West Texas and Eastern New Mexico. Covenant Medical Group (CMG) is an employed physician group comprised of approximately 150 primary care and specialist physicians across West Texas and Eastern New Mexico. CMG offers a wide array of primary care and specialists throughout Lubbock, West Texas, and New Mexico. Our total service area spans roughly 35,000 square miles and includes approximately 750,000 people. The Community Health Needs Assessment focuses on the three counties where we provide direct services: Lubbock, Hockley, and Hale.

Our hospital facilities include more than 1,000 available licensed beds, and four acute-care hospitals in Texas located in the cities of Lubbock, Levelland and Plainview. Covenant Health has a staff of more than 5,200, including more than 600 physicians. Major programs and services include but are not limited to cardiac care, cancer treatment, pediatrics, women's services, surgical services, orthopedics, critical care, neuroscience, endoscopy, diagnostic imaging, emergency medicine and obstetrics.

Our Commitment to Community

Covenant Health dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2021, our six-hospital region provided $91 million in community benefit in response to unmet needs and improve the health and well-being of those we serve in the West Texas and Eastern New Mexico region. Due to the expansive geographic nature of the region and limited access to health care, the region served by Covenant Health includes 21 counties. For the purposes of the Community Health Needs Assessment,we focus on the counties where we provide direct service: Lubbock, Hockley, and Hale.

Covenant Medical Center further demonstrates organizational commitment to the community health needs assessment (CHNA) through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The Texas/New Mexico Regional Director of Community Health Investment is responsible for ensuring the compliance Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital leadership, physicians,

and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[1]).

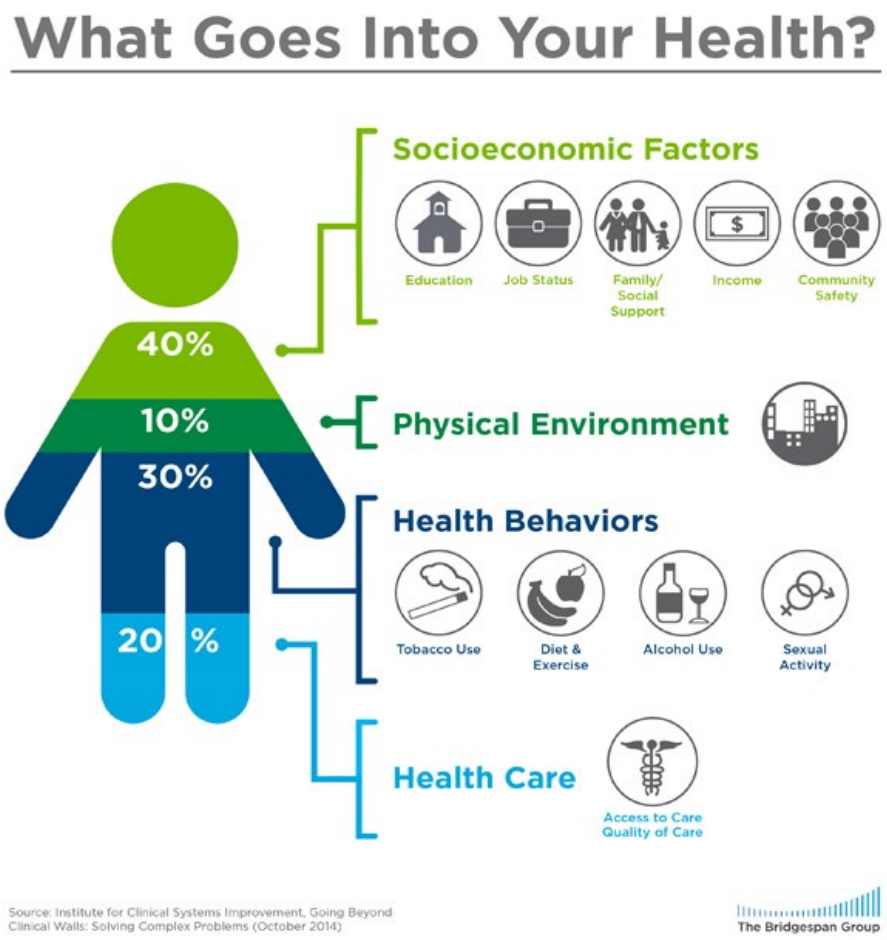


Figure 1. Factors contributing to overall health and well-being

[1] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms[2]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:

Health Equity

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

Figure 2. Definitions of key terms

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

Report data at the block group level to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

[2] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

OUR COMMUNITY

Description of Community Served

Covenant Health provides West Texas and Eastern New Mexico communities with access to advanced care and advanced caring. The CHNA service area, including Lubbock, Hockley, and Hale Counties, is home to approximately 379,000 people.

Hospital Service Area

The service area for Covenant Medical Center, Covenant Children's Hospital, Covenant Specialty Hospital, and Grace Hospital is the entirety of Lubbock County. Covenant Levelland serves Hockley County, and Covenant Plainview serves Hale County. Due to the level of care provided at these six hospitals, Covenant hospitals see patients from surrounding counties, although for the purposes of this CHNA, the total service areas will include Lubbock, Hockley, and Hale Counties. Data collected in this CHNA focus on these three counties, which are within a geographic area that is directly served by the Covenant community health outreach programs.

Surrounding counties outside of the CHNA service area where patients may live include the following: Castro, Swisher, Baily, Cochran, Yoakum, Gaines, Dawson, Scurry, Lamb, Terry, Lynn, Garza, Crosby, and Floyd Counties in Texas, as well as Curry, Roosevelt, Lea, and Eddy in New Mexico.

Table 1. Cities and ZIP Codes in the Covenant Health Service Area

Cities	ZIP Code(s)
Lubbock County	
Idalou	79329
New Deal	79350
Shallowater	79363
Slaton	79364
Ransom Canyon	79366
Wolfforth	79382
Lubbock	79401, 79402, 79403, 79404, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, 79499
Hockley County	
Anton	79313
Levelland	79336, 79338
Pep	79353
Ropesville	79358
Smyer	79367
Sundown	79372

The red portions of the map below are considered “high need” census tracts, and the green portions arethe broader service area. Together, these areas make up the hospitals’ service areas.

Figure 3. Covenant Health Service Area

CHNA Service Area Definition

The service area for Covenant Health was defined using census tracts inside Lubbock, Hale and Hockley counties. In total there are 84 census tracts within the service area of Covenant Health. These are the primary areas directly served by Covenant Outreach Services at the time of this report. Due to the large geographic service area of Covenant Health, outreach services are concentrated within Lubbock, Hale and Hockley Counties however services are available to all. All census tracts in the service area were enriched with social determinants of health in order to analyze the differences in the overall health of those populations.

HIGH NEED SERVICE AREA

Within a medical center's service area is a high need service area and is based on social determinants of health related to the inhabitants of that census tract. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool the following variables were used in the calculation of a high need census tract:

- Population Below 200% the Federal Poverty Level (FPL) (2019, American Community Survey)
- Percent of Population with at least a high school education (2019, American Community Survey)
- Percent of population who are unemployed (2019, American Community Survey)
- Life Expectancy at Birth (Estimates based on 2010 – 2015 data, CDC)

For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people who are unemployed, and a lower life expectancy at birth were identified as "high need". All variables were weighted equally, and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth.

Ultimately, a census tract was given a score between 0 and 1 where 0 represents the best performing census tract. The mean score for census tracts in the Lubbock County is **0.31** with a standard deviationof **0.15**. In Hale County the mean value is **0.47** with a standard deviation of **0.29** and in Hockley Countythe average **0.41** with a standard deviation of **0.29**. Census tracts that scored over the mean of their county were categorized as a high need area. High need areas from all three counties were aggregatedas one high need service area for Covenant Health and those areas that did not fall into the high need area were categorized as the broader service area.

Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the Covenant Health service areas and how the high need area compares to the broader service area. Additional detail is available in **Appendix 2**, or online.

POPULATION AND AGE DEMOGRAPHICS

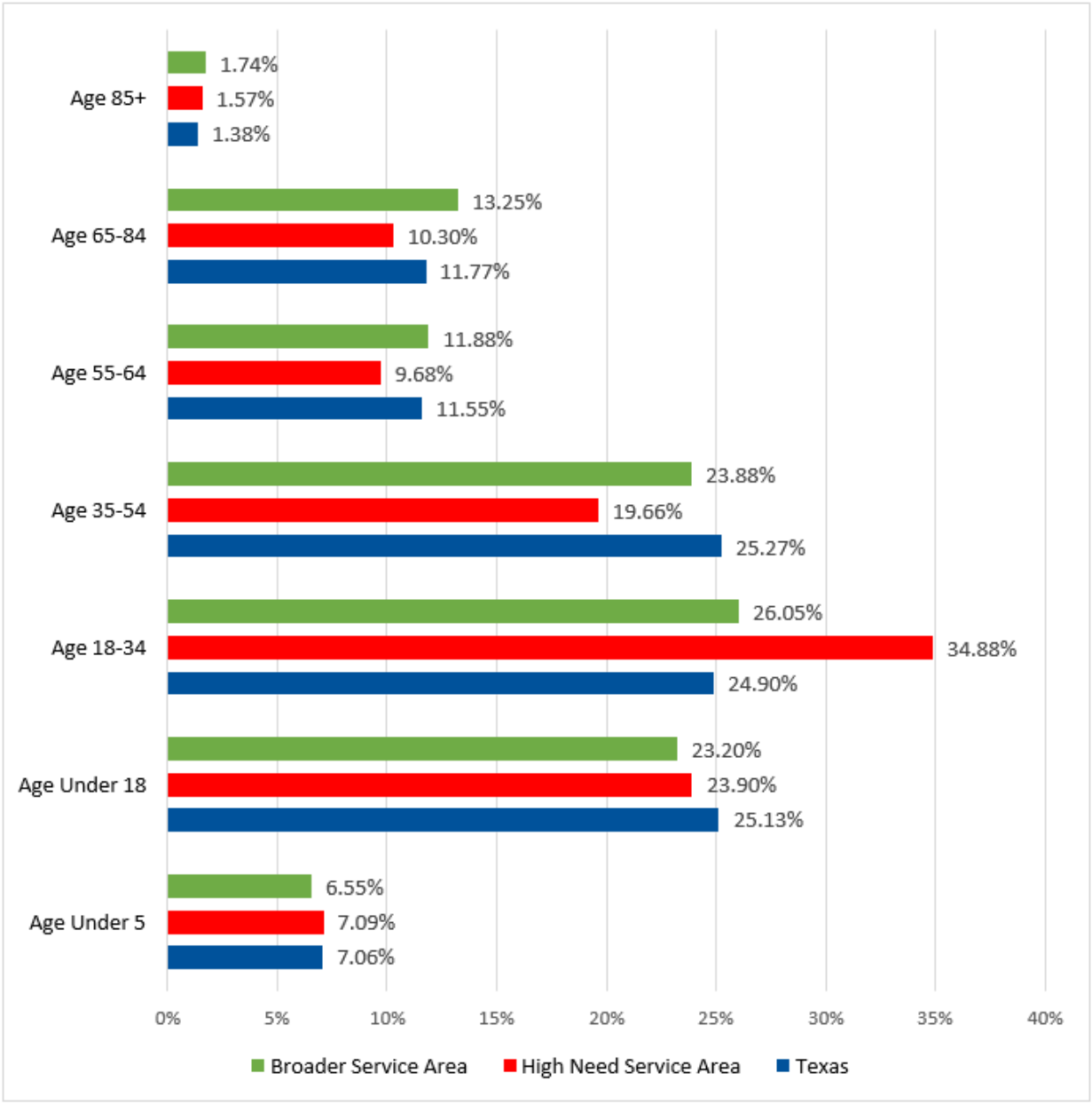
Table 2. Population Demographics for Covenant Health Service Areas

Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
2019 Total Population	207,773	171,503	319,837	35,735	23,704	29,443,411
Female Population	50.75%	49.78%	50.52%	48.26%	50.60%	50.39%
Male Population	49.25%	50.22%	49.48%	51.74%	49.40%	49.61%

For the most part, the age distribution for age groups 85+ and under 5 years are roughly proportional across the broader service area, high need service area, and three counties. While the broader and high need service areas are roughly proportional, Hale County has a slightly greater proportion of people under 18 years. People between 18 and 34 are substantially more likely to live in a high need area, likely

young families, and those in and around college towns. Those ages 35 to 84 are less likely to live in a high need area. The population of Lubbock County is approximately 5 times that of Hale and Hockley counties combined.

Figure 4. Age Group by Geography



Additional detail of age group by county is available in **Appendix 2.** Individuals aged 18-34 are more likelyto live in a high needs service area compared to the broader service area. This is likely due, at least in part, to a large student population.

RACE AND ETHNICITY

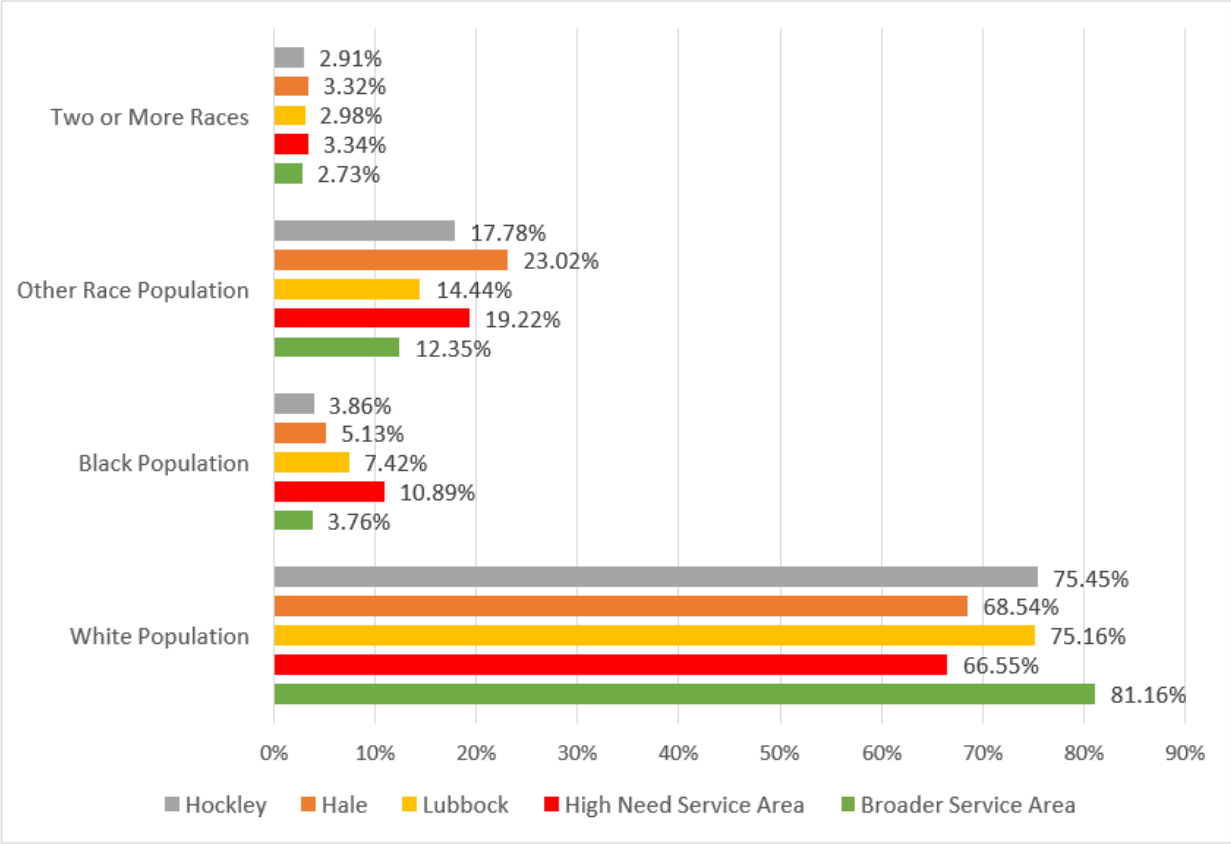
Table 3. Ethnicity by Service Area

Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Hispanic Population	30.90%	49.64%	36.34%	60.00%	49.20%	39.98%

The Hispanic population is over-represented in the high need communities, representing nearly 50% of the population in those areas compared to 31% in the broader service area. Those who identify as white are less likely to live in high need communities, while those who identify as "other" race population and as Black are more likely to live in the high need communities. While the Black population makes up nearly 4% of the broader service area, they make up almost 11% of the high need service area.

Approximately 60% of the population in Hale County identifies as Hispanic, as do nearly 50% of the population of Hockley County.

Figure 5. Race by Geography



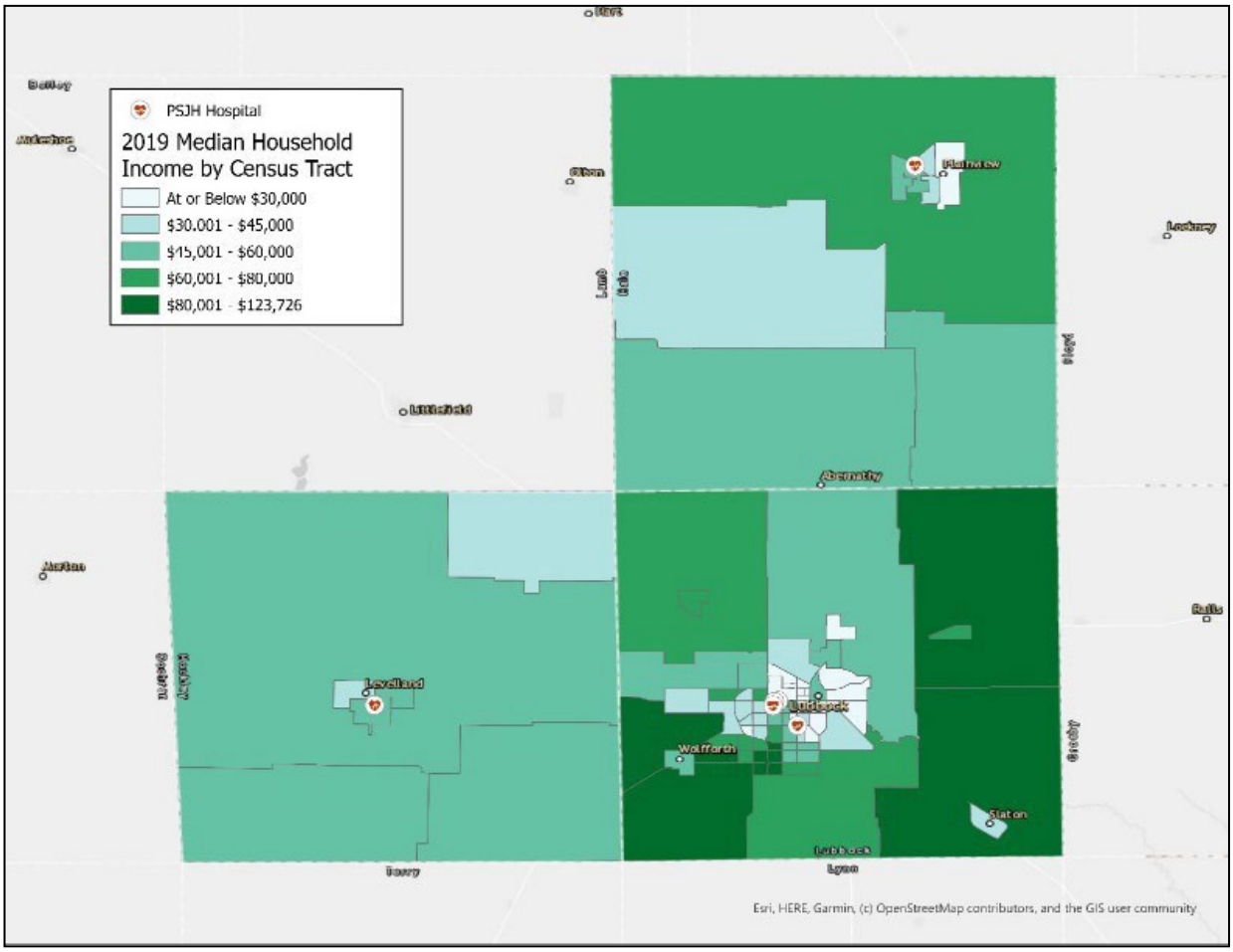
*Pacific Islander, Asian and American Indian were consolidated with Other Race population

MEDIAN INCOME

Table 4. Median Income for Service Areas

Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Median Income Data Source: American Community Survey Year: 2019	$61,442	$33,173	$48,826	$44,794	$49,265	$59,676

Figure 6. Median Household Income by Census Tract



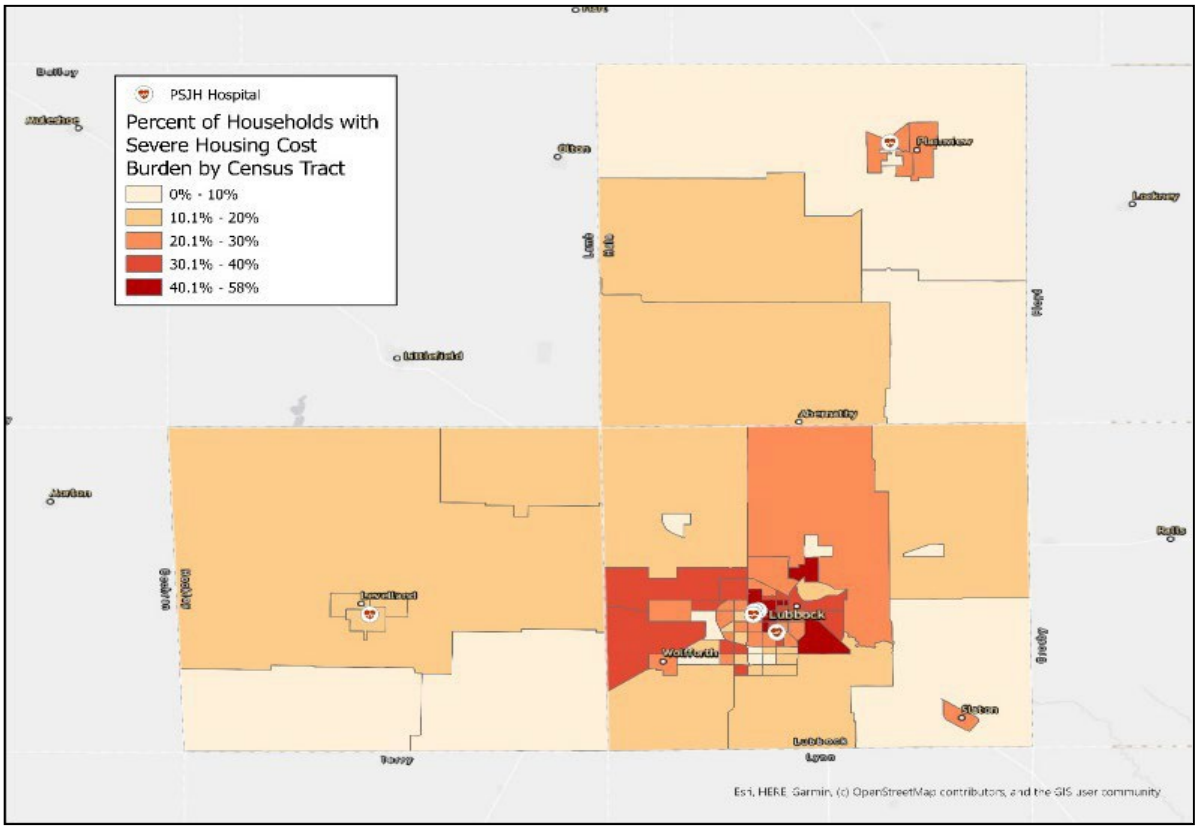
The median income for the high need service area is lower than that of all three counties and the state of Texas. It is also about half the median income of the broader service area. Census tracts with the lowest median households' incomes are found near Covenant Medical Center, Grace Medical Center andCovenant Health Plainview.

HOUSING INDICATORS

Table 5. Percent of Households with Severe Housing Cost Burden for Service Areas

Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	21.5%	30.0%	27.2%	17.7%	11.9%	21.1%

Figure 7. Percent of Households with Severe Housing Cost Burden by Census Tract



Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. The high need service area has a higher percentage of renter households with severe housing cost burden than each of the counties in the total service area and the state of Texas.

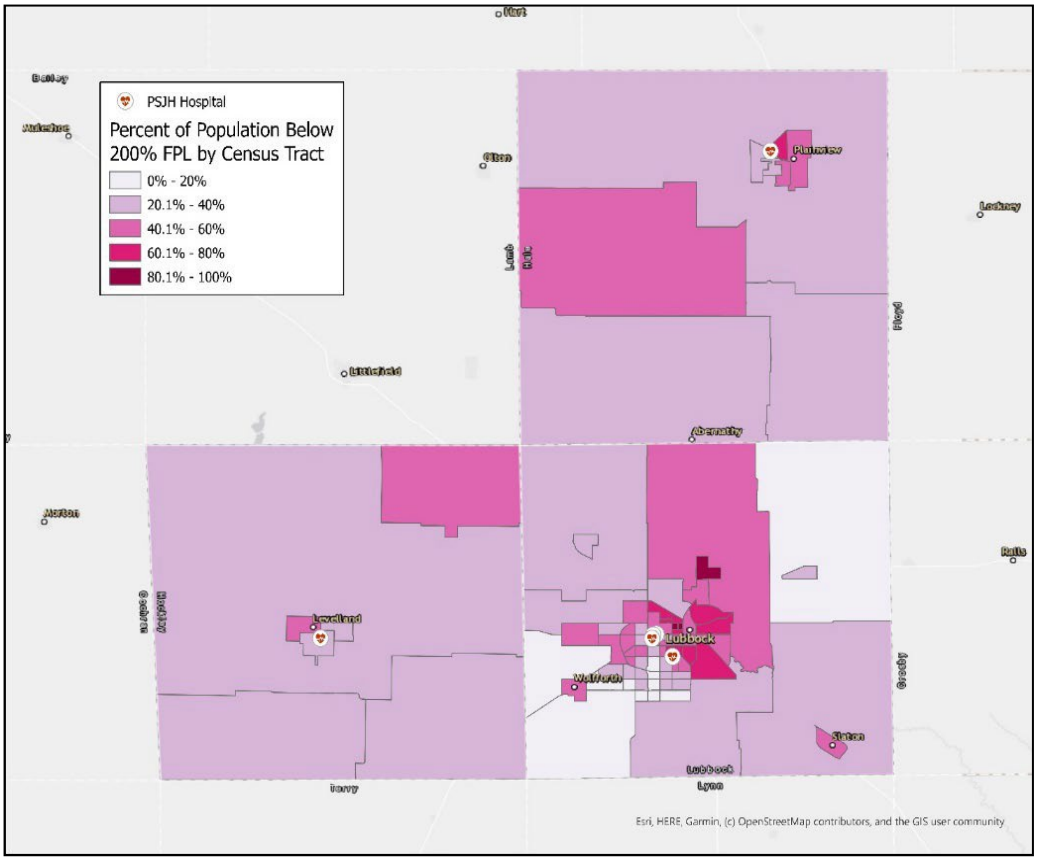
Lubbock County has the highest percentage of households that are severely housing cost burden when compared to Hale and Hockley Counties. Census tracts around Covenant Medical Center and Grace Medical Center have the highest percentage of households that are severely housing cost burdened in the service area.

Table 6. Population Below 200% FPL by Service Area and County

Indicator	Broader ServiceArea	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Percent of Population Below 200% Federal Poverty Level Data Source: American Community Survey Year: 2019	28.3%	55.1%	39.4%	44.3%	40.2%	36.2%

In 2019, 200% of the Federal Poverty Guideline represents an annual household income of $51,500 or less for a family of four.

Figure 8. Population Below 200% FPL by Census Tract



The high need service area has a substantially larger proportion of population living below 200% FPL, 55%, compared to Lubbock County (40%), Hale County (44%), and Hockley County (40%). The gap is even wider between the high need service area, 55%, and the broader service area, 28%, when comparing percent of population living below 200% FPL. Census tracts with the highest percent of population below 200% FPL are found in the area surrounding Covenant Hospitals.

COVID-19: Disproportionate Impact on Communities

In Texas, COVID-19 affected all populations, but according to Impact of COVID-19 on Vulnerable Populations in Texas, certain demographics were disproportionately affected by COVID-19 deaths:

- People 80 years or older were most affected by COVID-19 deaths, comprising 33% of all deaths from March through October 2020. The second highest age group were people ages 70-79, which made up 25% of COVID-19 deaths.
- Hispanics were disproportionately affected by COVID-19 deaths. While they make up approximately 40% of the Texas population, they accounted for almost 58% of COVID-19 deaths March through October 2020.
- Hispanics and Black/African Americans had the two highest crude and age-adjusted death rates per 100,000 for COVID-19 in March through October 2020. For Hispanics, the crude rate was 89.6 and age adjusted was 133.9. For Black/African Americans, the crude rate was 58.9 and age-adjusted was 72.9.[3]

According to the Economic Impacts of Health Disparities in Texas 2020: An Update in the Time of COVID-19, the Texas Department of State Health Services reported 70% of the confirmed COVID-19 fatalities at the end of September 2020 were people of color. Systemic factors may contribute to Black and Hispanic communities being disproportionately affected by COVID-19 in Texas:

- Black and Hispanic community members are more likely to work in occupations with public contact and be less likely to work from home. These roles may also not provide paid time off.
- Black and Hispanic populations in Texas are less likely to have health insurance and a regular health care provider. This may prevent these populations from receiving early and timely care for symptoms.
- Black and Hispanic populations are more likely to have underlying health conditions, which is a risk factor for severe COVID-19 disease.[4]

The COVID-19 pandemic also affected student learning and outcomes based on the State of Texas Assessments of Academic Readiness (STAAR). According to Impacts of COVID-19 and Accountability Updates for 2022 and Beyond and Overview of 2021 STAAR Results, the pandemic negatively affected academic performance as measured by STAAR:

- Between 2019 and 2021, the percentage of students that met grade level or above in reading declined by 4%.
- Between 2019 and 2021, the percentage of students that met grade level or above in math declined by 15%.

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[3] Impact of COVID-19 on Vulnerable Populations in Texas.; 2021. Accessed September 18, 2022. https://www.hhs.texas.gov/sites/default/files/documents/services/health/coronavirus-covid-19/impact-covid-19-vulnerable-populations-texas.pdf

[4] Turner A, LaVeist TA, Richard P, Gaskin DJ. *Economic Impact of Health Disparities in Texas 2020: An Update in the Time of COVID-19*.; 2021. Accessed September 18, 2022. https://www.episcopalhealth.org/wp-content/uploads/2021/01/Econ-Impacts-of-Health-Disparities-Texas-2020-FINAL-002.pdf

- Reports of learning loss in reading and math were greater for students considered economically disadvantaged. In math, students considered economically disadvantaged who met or mastered grade level in math decreased by 5 percentage points more than students considered non-economically disadvantaged (18% decline compared to 13% decline, respectively).[5]
- Limited English Proficiency (LEP) students experienced greater learning loss than non-LEP students based on summative STAAR outcomes.[6]

The Lubbock Area United Way's 2021 Community Status Report highlighted some of the effects of COVID-19 on the South Plains Community:

- In the first year of the pandemic, of all 2-1-1 requests, 22.1% were related to housing and shelter, and 53.8% of those were specifically for rent assistance (March 1, 2020, through June 30, 2021).
- Almost one in four (22.5%) children in Texas were considered food insecure before the start of the COVID-19 pandemic, with Black and Hispanic families disproportionately affected by financial challenges contributing to food insecurity. Families may experience barriers to accessing food pantries and services in parts of Lubbock County.
- Child abuse rates in Lubbock County were at a record low of 12.8 per 1,000 children in 2020, however this could be the result of underreporting and should be interpreted with caution.
- As of July 25, 2021, the cumulative COVID-19 cases in Lubbock County were 50,218, with a rate of 16,658.6 per 100,000 people and 1.59% of cases resulting in death.[7]

[5] Texas Education Agency. *Overview of 2021 STAAR Results*. Accessed September 18, 2022. https://tea.texas.gov/sites/default/files/covid/Overview-of-2021-STAAR-Results.pdf

[6] Texas Education Agency. *Impacts of COVID-19 and Accountability Updates for 2022 and Beyond*. Accessed September 18, 2022. https://tea.texas.gov/sites/default/files/2021-tac-accountability-presentation-final.pdf

[7] 2021 Community Status Report.; 2021. Accessed September 18, 2022. https://www.liveunitedlubbock.org/sites/liveunitedlubbock/files/2021%20CSR%20-%20final.pdf

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospitals we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders to provide additional context to the quantitative data through qualitative data in the form of listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code, census tract, or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities. Census designated geographies also ensure similar total population size, improving comparability.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. A glossary of terms from the CHNA can be found in **Appendix 1****.**

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance abuse.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Information gathered during stakeholder interviews and caregiver listening sessions is dependent on who was invited and who participated. Efforts were made to include people who

could represent the broad interests of the community and/or were representative of communities of greatest need.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2017 CHNA and 2018-2020 CHIP reports, which were made widely available to the public via posting on the internet in December 2017 (CHNA) and May 2018 (CHIP), as well as through various channels with our community-based organization partners.

No written comments were received.

HEALTH INDICATORS

Quantitative data were collected from several sources. Data collected and reviewed in relation to effects on community health include the following: demographics, economic indicators, education, language, health outcomes, disease prevalence, hospital data, and information on social determinantsof health.

See Appendix 2: Quantitative Data

Hospital Utilization Data

In addition to this public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Lubbock, Hockley, and Hale Counties. We were particularly interested in studying potentially avoidable Emergency Department visits and Prevention Quality Indicators. Avoidable Emergency Department (AED) is reported as a percentage of all Emergency Department visits over a given time period and are identified based on an algorithm developed by PSJH's Population Health Care Management team based on NYU and Medi-Cal's definitions.

The Prevention Quality Indicators (PQIs) are similar, although they are based on in-patient admissions. Both PQIs and AED serve as proxies for inadequate access to, or engagement in, primary care. As possible, we look at the data for total utilization, frequency of diagnoses, demographics, and payer to identify disparities.

Table 7. Covenant Avoidable ED Visits

Facility	Non-AED	AED Visit	Grand Total	AED %
Covenant Children's Hospital	13,045	7,842	20,887	37.5%
Covenant Levelland	3,832	2,013	5,845	34.4%
Covenant Medical Center	23,512	12,060	35,572	33.9%
Covenant Plainview	8,592	4,638	13,230	35.1%
Grand Total	**48,981**	**26,553**	**75,534**	**35.2%**

When comparing the Covenant Health hospitals, Covenant Children's Hospital had the highest percentage of potentially avoidable ED utilization in 2019 and Covenant Medical Center had the lowest, though all are approximately 35%.

At **Covenant Children's Hospital**, individuals identifying as Native American/Eskimo/Aleutian had the highest percentages of avoidable ED visits at 71%, although there were only 7 visits for this race group, meaning these data should be interpreted with caution. Individuals identifying as "other" had the second highest percentage of avoidable ED visits at 40%. Individuals under the age of 18 had the highest percentage of avoidable ED visits, which is not surprising given this is a children's hospital. ZIP Codes 79403, 79412, and 79415 produced the greatest number of potentially avoidable ED visits, accounting for approximately 33% (2,301) of all potentially avoidable visits in 2019.

At **Covenant Levelland**, individuals with the race identifier left blank had the highest percentages of avoidable ED visits at 67%, although there were only 9 visits for this group, meaning these data should be interpreted with caution. Individuals identifying as Black/African American and with an "unknown" race category had the second and third highest percentages, both around 40%. Avoidable ED visits were fairly consistent across age groups under 65 years, with individuals 65 years and older having the lowest percentages of avoidable visits. ZIP Code 79336 produced the greatest number of potentially avoidable ED visits, accounting for approximately 76% (1,642) of all potentially avoidable visits in 2019.

At **Covenant Medical Center**, individuals identifying as Pacific Islander/ Native Hawaiian had the highest percentages of avoidable ED visits at 100%, although there were only 5 visits for this race group, meaning these data should be interpreted with caution. Individuals identifying as Black/African American had the second highest percentage of avoidable ED visits at 38%. Avoidable ED visits were fairly consistent across age groups under 45 years (around 36%), with individuals 65 years and older having the lowest percentages of avoidable visits. ZIP Codes 79424 and 79423 produced the greatest number of potentially avoidable ED visits, accounting for approximately 26% (2,576) of all potentially avoidable visits in 2019.

At **Covenant Plainview**, individuals identifying as Black/African American or Native American/Eskimo/Aleutian had the highest percentages of avoidable ED visits, both around 36%. Following closely, individuals identifying as white and with an "unknown" race category had the third and fourth highest percentages, both around 34%. Individuals aged 18 to 44 had the highest percentage of avoidable ED visits, while individuals 65 years and older had the lowest percentages of avoidable visits. ZIP Code 79072 produced the greatest number of potentially avoidable ED visits, accounting for approximately 74% (3,105) of all potentially avoidable visits in 2019.

See Appendix 2: Quantitative Data for additional detail.

County Health Rankings Data

In addition to the demographic and hospital utilization data referenced above, we reviewed data from University of Wisconsin's County Health Rankings & Roadmaps for broader surveillance data. Additional information can be found here: https://www.countyhealthrankings.org/app/texas/2021/overview.

Hale and Hockley counties both have more children enrolled in free or reduced lunch and children living in poverty than the Texas state average, and slightly higher percentage of people reporting being in fair or poor health. All counties in the Covenant service area have higher than average "mentally unhealthy days" (4.4 for Hale and Lubbock, 4.5 for Hockley, compared to 3.8 as the Texas state average). The three counties are similar to state averages for percentage of adults who are smokers and excessive drinking. Hale County has a much high teen birth rate (47 per 10,000 compared to 31 across Texas), and Lubbock County has a greater prevalence of children in poverty.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Covenant Health Lubbock Hospitals in partnership with Covenant Health Levelland and Covenant Health Plainview, held ten Stakeholder focus groups in which nonprofit and government stakeholders, as well as public health experts, discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Additionally, community members who utilize outreach services completed just under one hundred community surveys. Below is a high-level summary of the findings from these sessions; full details on the protocols and methodology are available in **Appendix 3**.

FINDINGS FROM LUBBOCK STAKEHOLDER LISTENING SESSIONS (LUBBOCK COUNTY)

Stakeholders were asked to speak to the unmet health-related needs in the Lubbock community. Full details on the participants and findings from the Lubbock listening sessions are available in **Appendix 3A**.

Unmet Health-Related Needs

Stakeholders were most concerned about the following health-related needs:

1. Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care
2. Access to health care services
3. Homelessness/ lack of safe, affordable housing
4. Economic insecurity
5. Access to community resources
6. Food insecurity, including obesity and nutrition

Because of the substantial number of stakeholders, 27, that participated in the Lubbock listening sessions, the health-related needs were divided into “high priority” and “medium priority” categories based on the stakeholders’ input. Therefore, the top three needs, behavioral health, access to health care services, and homelessness were considered high priority needs, while the remaining three, economic insecurity, access to community resources, and food insecurity, were considered medium priority needs.

FINDINGS FROM PLAINVIEW STAKEHOLDER LISTENING SESSIONS (HALE COUNTY)

Stakeholders were asked to speak to the unmet health-related needs in the Plainview community. Full details on the participants and findings from the Plainview listening sessions are available in **Appendix 3B**.

Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs:

1. Access to health care services
2. Food insecurity, including obesity and nutrition
3. Economic insecurity and workforce
4. Homelessness/ lack of safe, affordable housing
5. Mental health challenges and access to mental health care

FINDINGS FROM LEVELLAND STAKEHOLDER LISTENING SESSIONS (HOCKLEY COUNTY)

Stakeholders were asked to speak to the unmet health-related needs in the Levelland community. Full details on the participants and findings from the Levelland listening sessions are available in **Appendix 3C**.

Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs:

1. Homelessness/ lack of safe, affordable housing
2. Access to health care services
3. Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care
4. Food insecurity, including obesity and nutrition
5. Economic insecurity

SUMMARY OF FINDINGS FROM COMMUNITY SURVEY

In order to better capture community perspective and input, and due to restrictions on gathering due to COVID-19, we administered a survey to community members across the three counties during the summer of 2020. Just under one hundred people completed and returned surveys, representing those who utilize community outreach services through Covenant Health or through community partner non-profits. See **Appendix 2** for a copy of the survey administered. A few key findings are noted below, which fed directly into the prioritization process. Other results from the survey will support our community health improvement planning process and community health service delivery.

Of the 92 respondents, 28 (30%) reported that someone in their household had hours or pay reduced due to the COVID-19 pandemic.

Top Five Reasons Persons Did Not Obtain Needed Healthcare

1. Cost
2. Not having a Primary Care Physician
3. No knowledge of where to obtain services
4. Unable to get to appointments/office hours
5. Transportation

Top Five Community Health Service Needs

1. Cost
2. Not having a Primary Care Physician
3. No knowledge of where to obtain services
4. Transportation
5. Unable to get to appointments when needed/office hours

Have Gone Without in The Past 12 Months Due to Financial Burdens

1. Dental Care 36.9% of respondents
2. Food 22.8% of respondents
3. Transportation 22.8% of respondents
4. Medical Care 21.7% of respondents
5. Stable Housing/Shelter 20.6% of respondents

Challenges in Obtaining Community Input

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. All sessions were conducted virtually which has its limitations in fostering group conversation. The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

To prioritize the list of significant health needs and select priorities to be addressed by Covenant Health, a prioritization process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry. Input was included from persons representing broad interests of the community to assist with identifying and prioritizing significant health needs. All data were reviewed by the Community Health Investment team and Outreach Program Managers.

Priorities were ranked utilizing the following criteria:

- Worsening trend over time
- Disproportionate impact on low-incomeand/or communities of color
- PSJH service area/high need area ratesworse than state average
- and/or national benchmarks
- Organizational commitment, partnership, severity and/or scale of need
- Alignment with existing Systempriorities and Mission
- Opportunity to Impact

Following this internal assessment, a workshop was held to engage internal and external stakeholders from the Lubbock, Levelland and Plainview service areas to review the primary and secondary data and complete a final prioritization of identified needs. The CHNA priority setting workgroup included Board Members, Community Benefit Committee Members, nursing representatives, the Covenant Health Chief Mission Officer, and hospital leaders. The recommendations of the workgroup were presented to the Covenant Health Lubbock Community Benefit Committee (Covenant Lubbock Board Committee), Covenant Levelland Board of Directors and the Covenant Plainview Board of Directors. Feedback was solicited for final review and approval of the selected rank priorities.

See Appendix 4: Prioritization Protocol and Criteria

2021 Priority Needs

Ranked significant health needs identified through the Community Health Needs Assessment process:

PRIORITY 1: MENTAL AND BEHAVIORAL HEALTH

Mental and behavioral health treatment, intervention, and prevention services for the community, including related issues such as substance use

PRIORITY 2: ACCESS TO HEALTH SERVICES

Access to health services including but not limited to prevention, mental health, oral health, prescription assistance, health/community navigation, transportation, and health education/prevention services

PRIORITY 3: HOUSING INSECURITY/HOMELESSNESS

Safe, affordable, stable housing and permanent supportive housing solutions for people experiencing chronic homelessness

PRIORITY 4: FOOD INSECURITY AND NUTRITION

Access to healthy food, nutrition education, and healthy lifestyle support

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Local Health Departments, several Federally Qualified Health Centers, Covenant Health hospitals and clinics, Texas Tech Health Sciences Center, STARCARE, and University Medical Center. Within Covenant Health, direct outreach programs are designated to address community needs. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see **Appendix 5****.**

EVALUATION OF 2019-2021 CHIP IMPACT

This report evaluates the impact of the 2019-2021 Community Health Improvement Plan (CHIP). Covenant Health responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 8. Outcomes from 2019-2021 CHIP

Priority Need	Program or Service Name	Results/Outcomes	Type of Support
Mental/Behavioral Health	Covenant Community Counseling Center	Free and reduced cost counseling services available through an outreach counseling center for vulnerable populations within the service area. Service sites were expanded during CHIP timeframe to include on-site counseling for various community partners. In response to COVID-19 tele-counseling was added during 2020. Case Management support was added for clients through the patient navigation program. Wrap around counseling services were made available to Lubbock ISD students enrolled in the Community Advocacy Program. Annual Mental Health First Aid courses offered free of charge for the community in 2019. An on-site LPCI was housed at Covenant Levelland to provide services to the Levelland community which was later transitioned to tele-counseling. Mental health voucher program was funded in 2021 through Catholic Charities.	Direct Outreach Program
Access to Care/Dental	Covenant Dental Outreach (fixed site Lubbock and Plainview)	Covenant Health operates a full-service Dental Outreach clinic for low-income and un-insured community members in Plainview and Lubbock. The dental outreach team provided dental sealants and oral health screenings to third graders in 3 area school districts including Levelland, Sundown and Lubbock. The dental team participated in multiple health education events and	Direct Outreach Program

		educated over 700 children on oral hygiene annually. A new fixed site community dental clinic for low-income/uninsured was opened Plainview, Tx and an expansion of the dental sealant program was completed. During 2021, Covenant Health also partnered with the Lubbock YWCA expand children's dental screenings and sealants on-site at a new YWCA location in central Lubbock.	
Food Insecurity, Nutrition and Education	Covenant Health Education Program	Expanded health outreach to include more innovative approaches to prevention with emphasis on early interventions with children and families, collaborate with internal and external partners to implement evidence-based practices, and increase access to medication. Including focus on preventive lifestyle issues such as obesity reduction, unhealthy lifestyles, food choices and exercise. Diabetes health education classes and individual appointments offered at Catholic Charities, Lubbock Children's Health Clinic, The Lubbock Dream Center, and Salvation Army. Additional classes and individual interventions were added through collaboration with the Low-Income Patient Navigation Team. Provided on-site screening and interventions for food insecurity at Catholic Charities. Provided funding to local food pantries, to The Dream Center Action Family Food Outreach, and to Double Up Food Bucks North TX program	Direct Outreach Program & Community Grants
Mental/Behavioral Health	Covenant Community Advocacy Project for Students (CAPS) & Lubbock ISD KEY Grant	Intervention programing for youth-at-risk utilizing a comprehensive wellness approach was expanded during CHIP timeframe to all Lubbock ISD schools. CAPS improves the school climate for youth by offering individual and group life skills development and advocate-to-student intervention for youth-at-risk. Counseling services added as additional intervention. Provided funding and in-kind support to Lubbock ISD Keep Empowering Youth program which provides both prevention and intervention	Community Grant Funding and In-kind Staff Support

		mental/behavioral health on-site services within schools	
Diabetes Prevention and Intervention	Go Noodle	Engage elementary school students by increasing movement during the day through the use of Go Noodle. During CHIP period Go Noodle Plus was expanded to include all schools within the following counties: Lubbock, Lea, Hale, and Hockley	Direct Funding
Mental/Behavioral Health	Work to Be Well	Expanded Anti-Stigma Multi-Media Work to Be Well Campaign in 2020 & 2021 focused content on youth and teens in Lubbock, Hale and Hockley Counties	Anti-stigma campaign
Housing/Homelessness	Built for Zero and Grant Support to Open Door	Provided funding and land feasibility study to Open Door for Housing First permanent supportive housing expansion in 2020 and 2021; provided in-kind dental and navigation services; funded Community Solutions Built for Zero program 2021	Community Grant, Financial and In-kind Support
Access to Care	Community Navigation Services	Utilized navigation and health education programs to provide education to persons with chronic diseases and connect them to community resources, establishing a primary care provider and assisting them with resource applications.	Direct Program

Addressing Identified Needs

The Community Health Improvement Plan developed for the Plainview, TX service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how Covenant Health plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Covenant Health intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Covenant Health and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than September 30, 2022.

2021 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Covenant Plainview Hospital Board of Directors of the hospital on December 8th, 2021. The final report was made widely available by September 30, 2022.

12/8/2021

Walter Cathey — Date
CEO Covenant Health
Providence Regional Chief Executive Texas/ New Mexico

12/8/2021

Cassie D. Mogg — Date
CEO Covenant Hospital Plainview

9/19/2022

Justin Crowe — Date
Senior Vice President, Community Partnerships
Providence

CHNA/CHIP Contact:
Tavia Hatfield
Regional Director, Community Health Investment
4122 22nd Place, Lubbock, TX 79410
tlhatfield@covhs.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

APPENDICES

Appendix 1: Definition of Terms Related to Community Input

Access to health care services: The timely use of personal health services to achieve the best health outcomes (excluding oral health and behavioral health care services, which are included in other categories). Health care services include primary care providers, pediatricians, OB/GYN, and specialists. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Access to oral health care services: The timely use of oral health care services to achieve the best health outcomes related to dental care, tooth loss, oral cancer, and gum disease. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system. Access to safe, nearby transportation

Accessibility for people with disabilities: The ease with which a person with a disability can utilize or navigate a product, device, service, or environment.

Affordable daycare and preschools: All families, regardless of income, can find high-quality, reasonably priced, convenient childcare options for their children birth to five. This includes free or reduced cost daycare and preschools for families that meet certain income requirements.

Aging problems: The challenges faced by adults as they age, specifically those over the age of 65, who may experience memory, hearing, vision, and mobility challenges. Adults over the age of 65 make up a larger percentage of the U.S. population than ever before and require specific supportive services related to health care, housing, mobility, etc.

Air quality: The degree to which the air is pollution and smoke-free.

Avoidable Emergency Department Utilization (AED): Based on algorithms by MediCal and NYU, PSJH Healthcare Intelligence developed an "AED" flag. This is a list of conditions by diagnostic code that should not require Emergency Department care and are better treated at a more appropriate level of care. Reported at the hospital level and by payor group.

Behavioral health challenges and access to care: Includes challenges related to both mental health and substance use disorders, as well as difficulties getting the support services and care to address related challenges. Covers all areas of emotional and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Bullying and verbal abuse: Put downs and personal attacks that cause a person emotional harm. Examples include name calling, shaming, jokes at the expense of someone else, excessive criticism, yelling and swearing, and threats. Specifically referring to instances taking place outside of the home, in places in the community such as school and the workplace.

Child abuse and neglect: "Injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child by any person under circumstances which indicate that the child's health, welfare, and safety is harmed."[8]

Discrimination: Treating a person unfairly because of who they are or because they possess certain characteristics or identities. Examples of characteristics or identities that are discriminated against include the following: age, gender, race, sexual orientation, disability, religion, pregnancy and maternity, gender reassignment, and marriage and civil partnership.[9]

Domestic violence: Also called intimate partner violence, "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain control over another intimate partner."[10]

Economic Insecurity: Lacking stable income or other resources to support a standard of living now andin the foreseeable future.

Few arts and cultural events: A lack of representation of different cultures and groups in the community demonstrated through music, dance, painting, crafts, etc.

Firearm-related injuries: Gun-related deaths and injuries.

Food insecurity: A lack of consistent access to enough good-quality, healthy food for an active, healthy life.

Gang activity/ violence: Encompasses the incidence of crime and violence in the community as well as the fear of it, which prevents people from using open space or enjoying their community.

Health Equity: A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity

[8] https://www.dcyf.wa.gov/safety/what-is-abuse

[9] https://www.eoc.org.uk/what-is-discrimination/

[10] https://www.thehotline.org/is-this-abuse/abuse-defined/

means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups."[11]

HIV/AIDS: Acquired immunodeficiency syndrome (AIDS), a chronic potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Refers to challenges addressing the spread of HIV in the community and challenges providing treatment, support, and health education related to HIV and AIDS.

Homelessness/ lack of safe, affordable housing: Affordability, availability, overcrowding, and quality of housing available in the community. Includes the state of having no shelter or inadequate shelter.

Job skills training: Occupational training with an emphasis on developing the necessary skills to support and guide individuals in finding jobs that meet their interests and pay a livable wage.

Lack of community involvement: Individuals in a defined geographic area do not actively engage in the identification of their needs, nor do they participate in addressing those needs.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

Poor quality of schools: Schools that do not provide a quality education to all students regardless of race, ethnicity, gender, socioeconomic status, or geographic location. A quality education is defined as one that "provides the outcomes needed for individuals, communities, and societies to prosper. It allows schools to align and integrate fully with their communities and access a range of services across sectors designed to support the educational development of their students."[12]

Racism: "Prejudice against someone based on race, when those prejudices are reinforced by systems of power."[13]

Safe and accessible parks/recreation: Issues around a shortage of parks or green spaces, or existing parks/green spaces being poorly maintained, inaccessible, or unsafe.

Safe streets for all users: People walking, biking, driving, and using public transportation can generally trust that they are safe on the road. Includes safety features such as crosswalks, bike lanes, lighting, and speed limits.

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[11] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does aDefinition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

[12] http://www.ascd.org/ASCD/pdf/siteASCD/policy/ASCD-EI-Quality-Education-Statement.pdf

[13] Oluo, Ijeoma. *So You Want to Talk About Race.*

Social Determinants of Health: Conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Unemployment/ lack of living wage jobs: Not having employment or lacking a job that pays the minimum income necessary for a worker to meet their basic needs.

Appendix 2: Quantitative Data

POPULATION LEVEL DATA

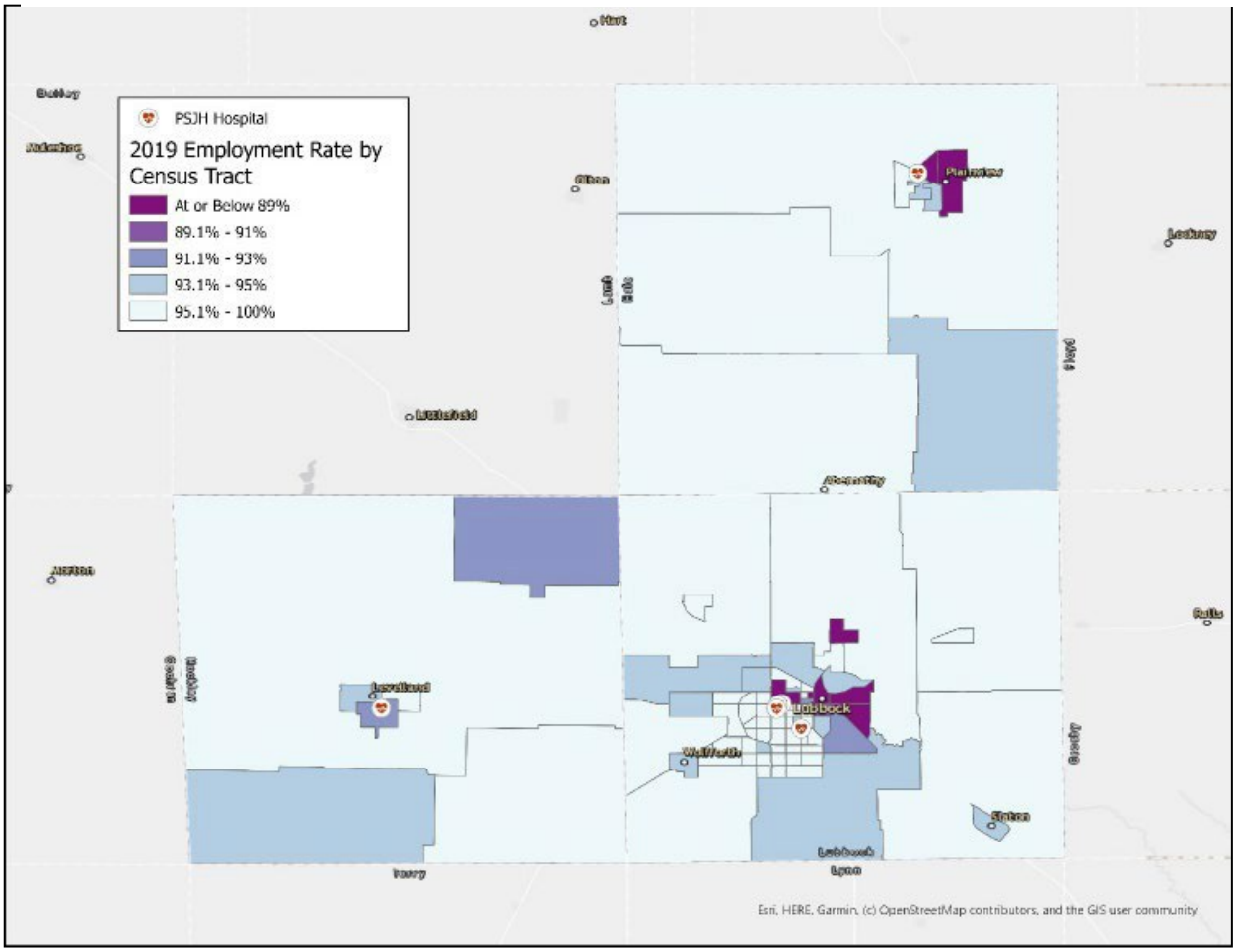
To explore these tools independently, please visit
https://psjh.maps.arcgis.com/apps/opsdashboard/index.html#/3213ef87f2dd420a9d0f78aaab2f5984

Table_Apx 1. Percent of Population Age 25+ with a High School Diploma by Service Area and County

Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Percent of Population Age 25+ With A High School Diploma Data Source: American Community Survey Year: 2019	90.5%	77.6%	86.6%	77.0%	82.6%	84.1%

- The Percent of population with a high school diploma is substantially lower in the high needservice area (78%) compared to the broader service area (91%).
- The high need service area has a lower percentage of population with a high school diplomathan Lubbock County, Hockley County and the state of Texas.
- The census tracts with the lowest percent of people with high school diplomas are in the areassurrounding Covenant Health Plainview, Covenant Health Lubbock, and Grace Medical Center.

Figure_Apx 1. Percent of Population Age 16+ Who Are Employed by Census Tract

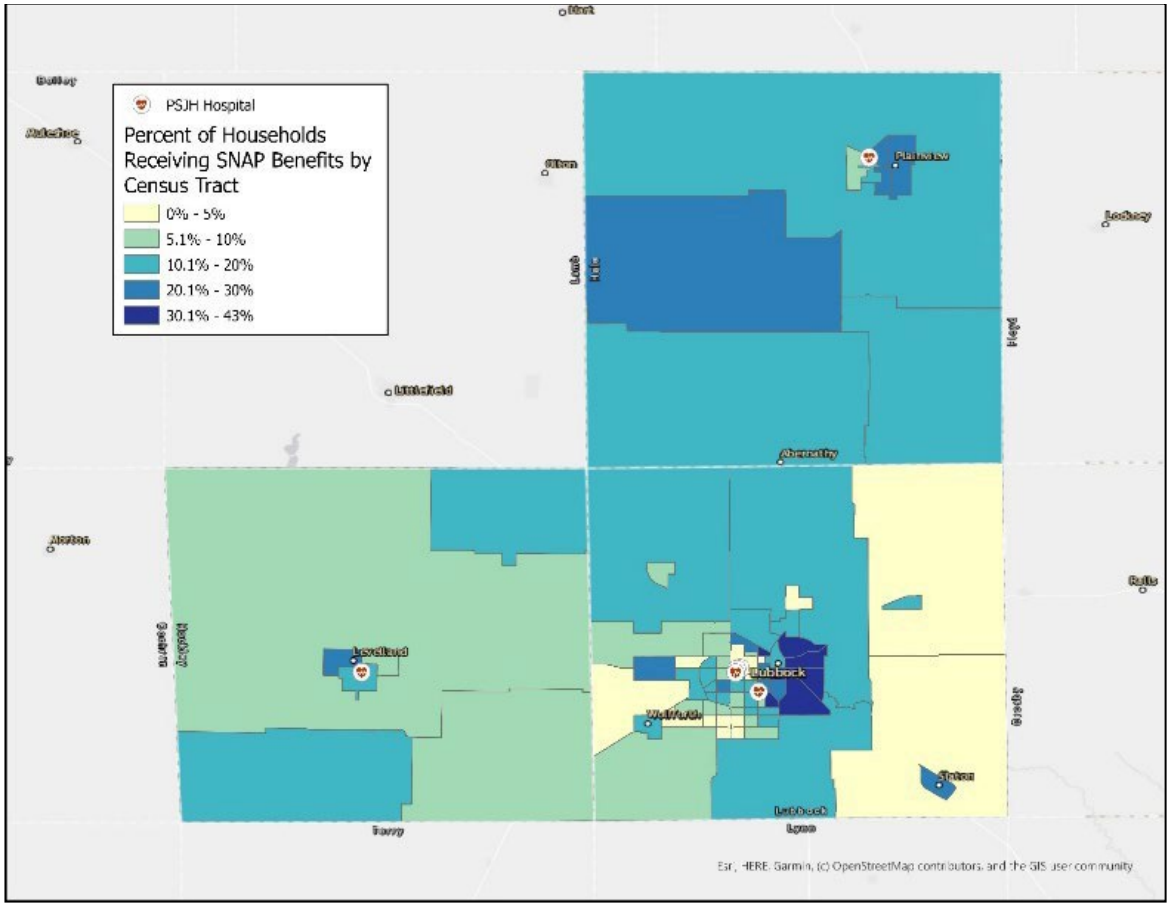


There are seven census tracts with a lower percentage of people employed, ranging from 89% to71%. Those census tracts are found near Covenant Medical Center, Grace Medical Center, and Covenant Health Plainview.

Table_Apx 2. Percent of Households Receiving SNAP Benefits by Service Area and County

Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Percent of Households Receiving SNAP Benefits Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	8.1%	20.1%	12.6%	17.6%	13.6%	12.7%

Figure_Apx 2. Percent of Households Receiving SNAP Benefits by Census Tract



- The percent of households receiving SNAP benefits in the high need service area is more than twice that in the broader service area and higher than all three counties in the total service area.
- The census tracts with the highest percentage of households with SNAP benefits are located in Lubbock with seven census tracts above 30%.

Table_Apx 3. Percent of Population Age 5+ Who Do Not Speak English Very Well by Service Area and County

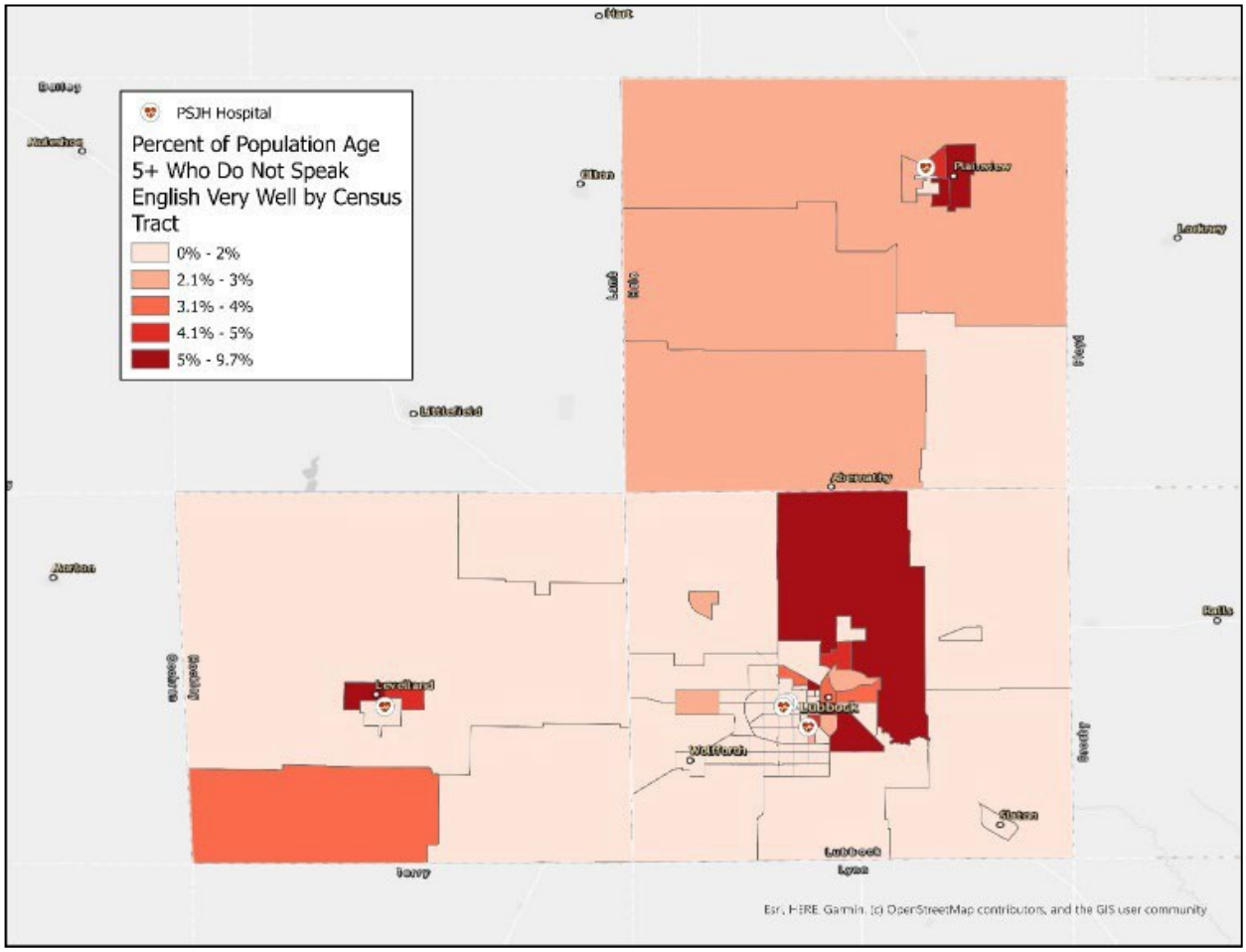
Indicator	Broader Service Area	High Need Service Area	Lubbock County	Hale County	Hockley County	Texas
Percent of Population Age 5+ Who Do Not Speak English Very Well Data Source: American Community Survey Year: 2019	1.2%	2.7%	1.5%	3.9%	3.7%	4.8%

- The percent of population that does not speak English very well in the high need service area ismore than twice that of the broader service area.
- Of the three counties in the Covenant Health Lubbock service area, Lubbock County has the lowest percent of population who do not speak English very well. Both Hale and Hockley Countyhave over twice the value of Lubbock County. All three counties have values lower than the state of Texas.
- here are census tracts in Lubbock, Hockley and Hale County with values that are above theTexas average. The highest value census tract is 9.7% and is in Plainview.

HOSPITAL LEVEL DATA

Avoidable Emergency Department (AED) Visits

Figure_Apx 3. Percent of Population Age 5+ Who Do Not Speak English Very Well by Census Tract



Emergency department discharges for the year 2019 were coded as "avoidable" per the Providence St. Joseph Health definition for Covenant Children's Hospital, Covenant Levelland, Covenant Medical Center and Covenant Plainview. Avoidable emergency department (AED) are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Table_Apx 4. Avoidable Emergency Department Visits by Covenant Health Hospital

Facility	Non-AED	AED Visit	Grand Total	AED %
Covenant Children's Hospital	13,045	7,842	20,887	37.5%
Covenant Levelland	3,832	2,013	5,845	34.4%
Covenant Medical Center	23,512	12,060	35,572	33.9%
Covenant Plainview	8,592	4,638	13,230	35.1%
Grand Total	**48,981**	**26,553**	**75,534**	**35.2%**

Prevention Quality Indicators

Prevention Quality Indicators were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCsare conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications.
More info on PQIs can be found on the following links:
https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx
PQIs were calculated for Covenant Children's Hospital, Covenant Levelland, Covenant Medical Centerand Covenant Plainview using inpatient admission data for the year 2019.

Covenant Levelland had the highest rate of potentially avoidable hospitalizations when compared to Covenant Children's Hospital, Covenant Medical Center, and Covenant Plainview. Covenant Children'sHospital only had 2 potentially avoidable hospitals out of 3,569. The PQI with the highest rate for Covenant Children's Hospital was the following:

1. Perforated Appendix: 9.25 per 1,000 visits

The top three PQIs for Covenant Levelland were the following:

1. Heart Failure: 67.75 per 1,000 visits
2. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults: 62.19 per 1,000 visits
3. Dehydration: 48.60 per 1,000 visits

The top three PQIs for Covenant Medical Center were the following:

1. Dehydration: 50.04 per 1,000 visits
2. Heart Failure: 49.98 per 1,000 visits
3. Diabetes Composite (includes uncontrolled diabetes, diabetes short-term complications, anddiabetes long-term complications): 30.58 per 1,000 visits

The top three PQIs for Covenant Plainview were the following:

1. Heart Failure: 68.58 per 1,000 visits
2. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults: 39.42 per 1,000 visits
3. Dehydration: 30.70 per 1,000 visits

PRIMARY DATA COLLECTION: 2020 CHNA SURVEY

This survey was fielded in July 2020 and had 92 respondents. Detailed results are available uponrequest.

CHNA Survey

Demographics

1. Zip Code: _____
2. Year of birth: _____
3. Gender identity:
   - ❑ Female
   - ❑ Male
   - ❑ Transgender
   - ❑ Other, self-identify: _____
4. Are you of Hispanic, Latino, or Spanish origin?
   - ❑ Yes
   - ❑ No
5. Which one or more of the following would you say is your race? *Mark all that apply*.
   - ❑ White
   - ❑ Black or African American
   - ❑ Asian
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ American Indian or Alaska Native
   - ❑ Don't know/ Not sure

Household Finances

6. Altogether, how many people currently live in your home? *Count adults and children under 18*.Me, plus_____other adults and_____children

7. What is your gross household income (before taxes and deductions are taken out) for last year(2019)? *Your best estimate is fine.*
   - ❑ $0
   - ❑ $1 to $10,000
   - ❑ $10,001 to $20,000
   - ❑ $20,001 to $30,000
   - ❑ $30,001 to $40,000
   - ❑ $40,001 to $50,000
   - ❑ $50,001 to $60,000
   - ❑ $60,001 to $70,000
   - ❑ $70,001 to $80,000

- ❑ $80,001 to $90,000
- ❑ $90,001 to $100,000
- ❑ $100,001 or more

8. What is your current employment status?
   - ❑ Employed full time
   - ❑ Employed part time
   - ❑ Self-employed
   - ❑ Retired
   - ❑ Unable to work due to illness, injury, or disability
   - ❑ Homemaker or stay at home parent
   - ❑ Student
   - ❑ Unemployed

9. Have you or someone in your household lost a job or taken a pay cut due to the COVID-19(coronavirus) outbreak?
   - ❑ Yes
   - ❑ No

10. Which of the following best describes your housing situation today? *Mark all that apply.*
    - ❑ I have housing of my own and I'm NOT worried about losing it
    - ❑ I have housing of my own, but I AM worried about losing it
    - ❑ I'm staying in a hotel
    - ❑ I'm staying with friends or family
    - ❑ I'm staying in a shelter, in a car, or on the street
    - ❑ Other (tell us): _____

11. In the past 12 months, have you or someone in your household had to go without any of thefollowing when it was really needed because you were having trouble making ends meet?

	Yes	No
Food		
Utilities		
Transportation		
Clothing		
Stable housing or shelter		
Medical care		

Childcare		
Dental care		

12. The most recent time you or a member of your household delayed or went without neededhealth care, what were the main reasons? *Mark all that apply.*

- ❑ Cost
- ❑ Not having a regular health care provider
- ❑ Not knowing where to go
- ❑ Couldn't get appointments quickly enough
- ❑ Offices aren't open when I can go
- ❑ Needed childcare
- ❑ Needed transportation
- ❑ Not having a provider that understands my culture or speaks my language
- ❑ Other reasons (tell us): _____

Short Answers

1. What health-related services are needed, but are not currently being provided in ourcommunity?
2. What one thing could be done to improve the overall health and quality of life in our county?

Quality of Life Issues

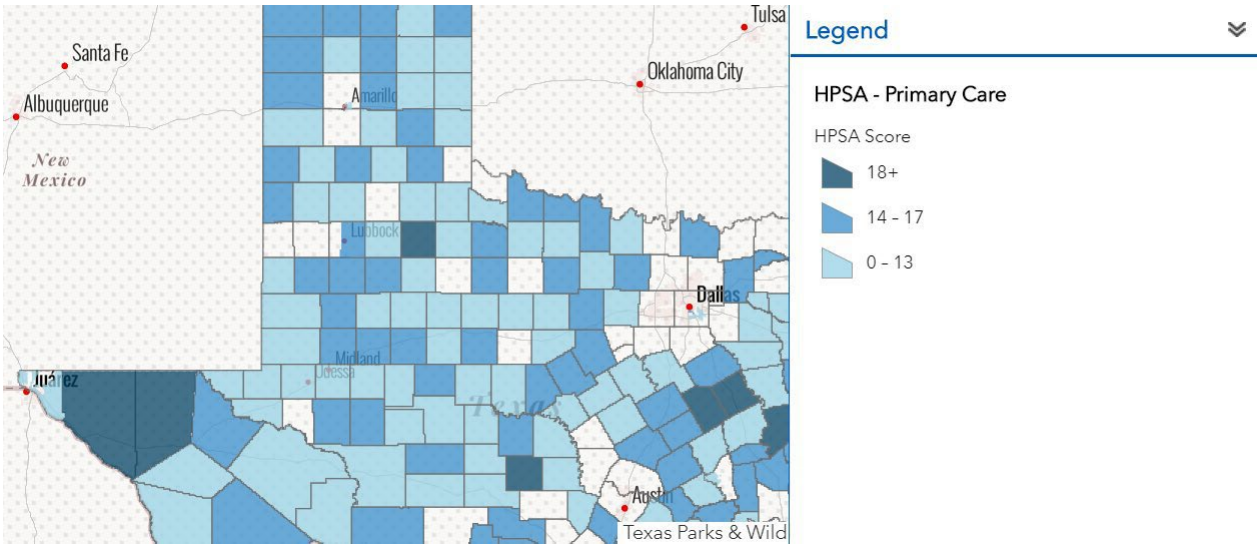
Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Aging problems (e.g. memory/ hearing/vision loss)		Access to oral health care
	Air quality (e.g. pollution, smoke)		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation
	Gang activity/violence		Behavioral health challenges and access to care (includes both mental health and substance use disorder)
	HIV/AIDS		Poor quality of schools

	Homelessness/lack of safe, affordablehousing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to health care services		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
			Other:

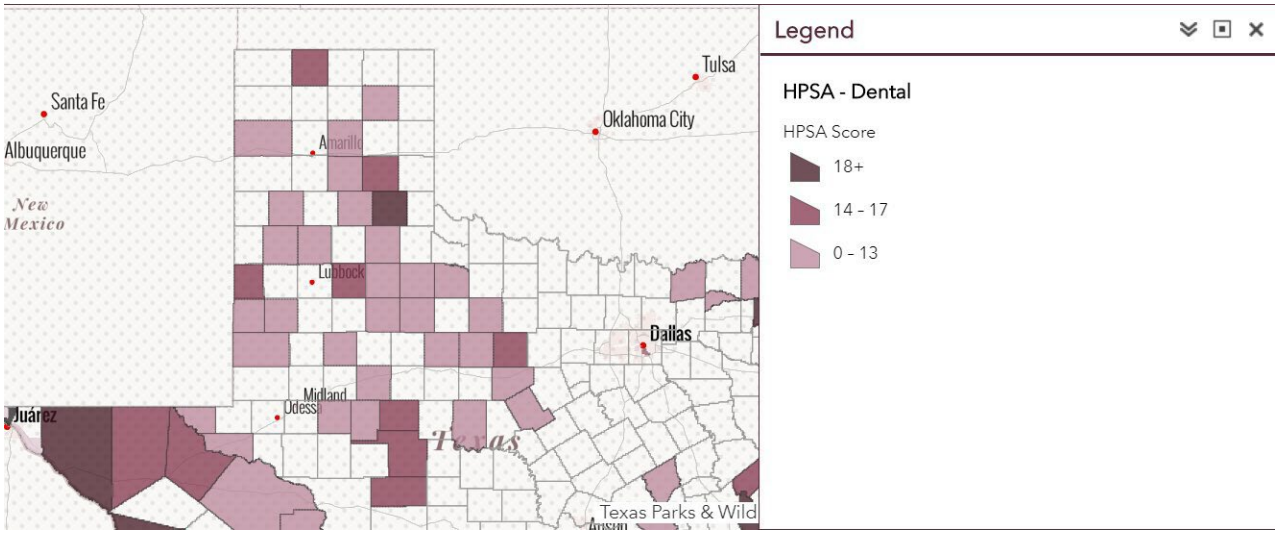
HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low- income population), or institutions (i.e., comprehensive health centers). Large portions of the Covenant Health service area are designated as shortage areas.

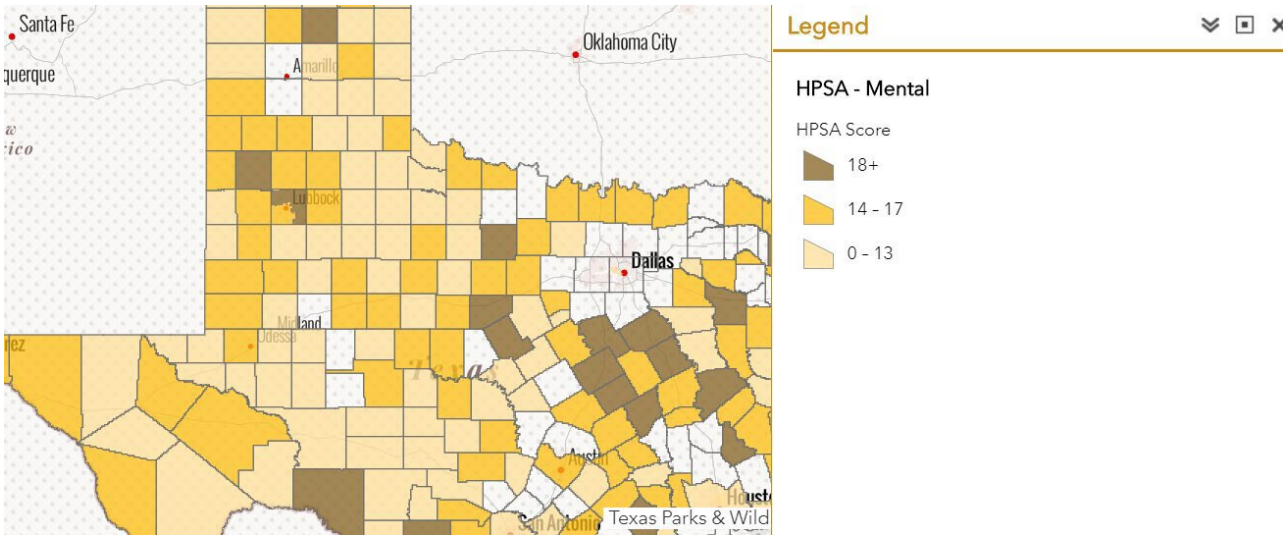
Figure_Apx 4. Primary Care HPSA



Figure_Apx 6. Dental Health HPSA



Figure_Apx 5. Mental Health HPSA



Source: https://www.dshs.texas.gov/chpr/Health-Professional-Shortage-Area-Designation.aspx

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts the MUAs and MUPs within a 30 mile radius from Covenant Health

Source: https://data.hrsa.gov/maps/map-tool/

Appendix 3: Community Input

METHODOLOGY

Facilitation Guide

Providence St. Joseph Health developed a facilitation guide that was used across all hospitals completingtheir CHNAs (see "Stakeholder Listening Session Questions" in this appendix):

- The role of the stakeholder's organization and community served
- Prioritization of unmet health related needs in the community, including social determinants ofhealth
- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

Training

The facilitation guide provided instructions on how to conduct a stakeholder listening session, includingbasic language on framing the purpose of the interview. Each facilitator was provided a list of questionsto ask the stakeholder.

Data Collection

The facilitator conducted all the interviews using the Microsoft Teams platforms and recorded theinterviews with participants' permission.

Analysis

Qualitative data analysis of stakeholder listening sessions was conducted by Providence St. JosephHealth using Atlas.ti, a qualitative data analysis software. The data were coded into themes, whichallows the grouping of similar ideas across the sessions, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smallerpieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) role of organization, 2) population served by organization, 3) unmet health-related needs, 4) disproportionately affected populations, 5) gaps in services, 6) barriers to services, 7) community assets, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent theinformation included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "mental health" can occur often with the code "stigma." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related needand the barriers to addressing those needs. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

LIMITATIONS

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. All sessions were conducted virtually whichhas its limitations in fostering group conversation.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst'sunique identities and experiences.

STAKEHOLDER LISTENING SESSION QUESTIONS

1. How would you describe your organization's role within the community? How would youdescribe the community your organization serves? Please include the geographic area.
2. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, andaccess to care, just to name a few.
    a. How would you prioritize these issues? What are your top 3 concerns?
3. Please identify and discuss specific gaps in community services for the persons you serve thatcontribute to the unmet health-related needs you identified earlier.
4. Please identify and discuss specific barriers for the persons you serve that contribute to theunmet health-related needs you identified earlier.
5. Are there specific populations or groups in your community who are disproportionately affectedby these unmet health-related needs?
6. What existing community health initiatives or programs in your community are helpful inaddressing the health-related needs of the persons you serve, especially

in relation to the health-related needs you identified earlier?

7. What suggestions do you have for organizations to work together to provide better services andimprove the overall health of your community?
8. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in yourcommunity? If yes, in what ways?

Appendix 3A: Participants and Findings from Lubbock Stakeholder Listening Sessions (Lubbock County)

Covenant Health Lubbock conducted stakeholder listening sessions, recognizing the importance of including the voices of community leaders who help make Lubbock County healthier. Listening to andengaging with the people who live and work in the community is a crucial component of the CHNA, asthese individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder listening sessions are particularly important this CHNA cycle as the COVID-19 pandemic prevented the hospital from facilitating listening sessions with community members. They relied on community stakeholders to represent the broad needs of the communities they serve.

Representatives from Covenant Health Lubbock conducted 6 listening sessions including 27 total stakeholders, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. The goal of the sessions was to identify what needs arecurrently not being met in the community and what assets could be leveraged to address these needs.

STAKEHOLDER PARTICIPANTS

A total of 6 stakeholder listening sessions including 27 participants were completed by representatives from Covenant Health Lubbock. Stakeholders were selected based on their knowledge of the communityand engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Covenant Health Lubbock aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was a representative from the City of Lubbock Health Department.

Table_Apx 5. Community Stakeholder Listening Session Participants in Lubbock

Session	Organization	Name	Title	Sector
7/6/2020	Lubbock Children's Health Clinic	Nedra Hotchkins	Executive Director	Community Health
	Family Promise of Lubbock	Doug Morris	Executive Director	Non-profit / Housing/ Homelessness
	Texas Tech University - Centerfor Adolescent Resiliency	Linn Walker	Director, Community Advocacy Project for Students	Public Education

	CASA (Court Appointed Special Advocates)	Lauren Westerberg	Chief Program Officer	Non-profit / Childwelfare
7/8/2020	One Heart Orphan Care Lubbock	Aaron Dawson	Care Coordinator	Non-profit / Adoption / Foster Care
	Lubbock OpenDoor	Andrea Omojola	Chief Operating Officer	Non-profit / Housing / Homelessness
	Habitat for Humanity Lubbock	Christy Reeves	Executive Director	Non-profit / Housing / Homelessness
	Lubbock Impact	Rori Thomas	Executive Director	Non-profit
	Catholic Charities of Lubbock	Cynthia Quintanilla	Executive Director	Non-profit / Religious
7/9/2020	Texas Boys Ranch	Traci Cheek	Development Officer	Non-profit / Adoption / Foster Care
	Lubbock Independent School District	Kami Finger	Executive Director ofSpecial Education	Public Education
	StarCare Lubbock	Kris Galvan	Mental Health First Aid Outreach Coordinator	State Mental Health Provider
	StarCare Lubbock	Brandi Ivey	Community Relations Coordinator	State Mental Health Provider
	YWCA of Lubbock	Glenda Mathis	Executive Director	Non-profit
	Family Guidanceand Outreach Center	Abby Reed	Executive Director	Non-profit
7/14/2020	Texas Tech University HealthScience Center SON - Larry Combest Health and Wellness Center	Linda McMurray	Executive Director	FQHC
	Family Counseling Services	Bryan Moffitt	Executive Director	Non-profit / Mental Health
	Kingdom Come Ministries	Kristin Montgomery	Co-Director	Non-profit

	Kingdom Come Ministries	Leslie Roach	Co-Director	Non-profit
	Lubbock OpenDoor	Chad Wheeler	Executive Director	Non-profit / Housing / Homelessness
7/14/2020	Lubbock Police Department - Homeless Outreach Team	Steven Bergen	Sergeant	Justice System
	South Plains Food Bank	Savannah Forsyth	Healthy Partnerships Organizer	Non-profit
	Texas Tech University Health Science Center SON - Larry Combest Health and Wellness Center	Michelle Hunter	Senior Director - Marketing & Community Outreach	FQHC
	South Plains Food Bank	Jaime Roe		Non-profit
8/19/2020	City of Lubbock Health Department	Madeline Geeslin	Health Education Facilitator	Public Health
	Grace Campus	Jerri Anne Moore		Homelessness
	Lubbock Independent School District - O.L. Slaton Middle School	Jorge Sanchez	Principal	Public Education

FINDINGS FROM STAKEHOLDER LISTENING SESSIONS LUBBOCK

Stakeholders were asked to speak to the unmet health-related needs in the community. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

High Priority Unmet Health-Related Needs

Stakeholders were most concerned about the following health-related needs:

1. Behavioral health challenges (includes both mental health and substance use disorder) andaccess to behavioral health care
2. Access to health care services

3. Homelessness/ lack of safe, affordable housing

Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care

Stakeholders overwhelmingly spoke to a lack of mental health and substance use disorder (SUD)treatment services in Lubbock, contributing to long wait times and challenges accessing care.

"We all know that there is just not enough mental health, behavior health professionals, orfacilities for people to go. I think we have an overwhelming number of behavior health services, but we have a gap in being able to provide enough to accommodate for the overwhelming number of people that we have."—Community Stakeholder

They shared the following gaps related to behavioral health services:

- **A lack of inpatient SUD treatment centers**: This was the primary gap named by stakeholders. They shared there are no quality options for people on Medicaid or lacking insurance. This lack of services affects parents who are part of the child welfare system who are trying to reunify with children but need to participate in a SUD treatment program. They noted that without these services people with SUD end up going to jail or a psychiatric hospital, neither of which areappropriate outcomes for meeting their needs.

"There are just no treatment centers available that are not really expensive private pay centers here. For people who don't have insurance or who are on Medicaid, there's just really no quality options, and that is really affecting the family unit in Lubbock in terms ofability for parents to reunify with children. When they can't conquer their addiction, they can't safely provide for their children. When they don't have any local resources to help them with that, it really does present a problem."—Community Stakeholder

- **No inpatient youth mental health services**
- **A lack of Hepatitis C outreach programs** for intravenous drug users
- **A lack of trauma informed care providers**: Stakeholders spoke to the importance of not onlytraining case workers to take a trauma-informed approach, but also teachers, health care workers, and others providing direct services.

"That the lack of trauma-informed care providers is a big deal for us, because you might getthem there but if you give somebody who doesn't really understand the concept of dealing with somebody who's had trauma in their life, that make any difference."—Community Stakeholder

Stakeholders shared the following barriers to addressing behavioral health needs:

- **Strict requirements for behavior in health care settings**: Rigid health care systems do not always meet the needs of individuals and are often intolerant of certain behaviors. For example,individuals may miss appointments or have difficulty engaging in consistent care due to their mental health or substance use challenge, which may lead to them being barred from services.

"For example, for a lot of the people that we serve without stability, they have trouble meeting appointments and showing up for repeat visits where they have to show up at StarrCare or wherever multiple times in order to maintain access to medication and they miss an appointment, and then they get dropped, or they miss meeting with somebody and then they get dropped or they don't show up at the right time and they get dropped. Those highlyunstable individuals who really severely need that kind of care, tend to fall through the gaps. I don't know, I think our system just needs to become a little more flexible and accessible to people who are not that stable in their lives."—Community Stakeholder

- **Stigma**: Talking about mental health can often be hard for people. Youth Mental Health First Aidis a tool for helping teachers and people who work with youth learn how to recognize and respond to young people experiencing mental health concerns.
- **Lack of community understanding about the spectrum of mental health needs**: People oftenthink of the extreme example of mental health challenges and lack understanding of the different ways mental health needs can present.

Stakeholders named a variety of populations that may have additional challenges accessing appropriatemental health services or who may be disproportionately affected by behavioral health needs:

- **People experiencing homelessness**: Stakeholders discussed the need for people experiencing homelessness to first be stably housed before being able to address mental health and/or SUDtreatment needs. People living unhoused with behavioral health challenges may end up in jail due to a lack of other support services.

"We are firm believers in the Housing First approach, which prioritizes housing stability forpeople as one of the first things that people need before they can gain stability through other kinds of supports. Trying to resolve mental health and substance use and unemployment and all these other things without housing is impossible, uphill battle for people. I feel like that's one of the priority things to start with, but like others have said, mental health services for us seem to be one of the very big challenges."—Community Stakeholder

- **Rural communities**: People in rural communities may not have trust developed

with mentalhealth services outside of their community. With increasing access to mental health servicesthrough telehealth, stakeholders recognize that some health care providers may need to prioritize trust building to engage rural communities.

"People have to pretty much adjust to the fact that mental health counseling and substanceabuse counseling is a thing, because in the rural communities, sometimes it doesn't happen as fast. People have to trust the counseling and the people that are performing it. Once youhave somebody in that community realize that it's basically just people sitting down talking and that it's not a foreign thing from West Texas, then it usually goes really well, and then they tell their friends and it goes from there."—Community Stakeholder

- **People engaged in the child welfare system**: Families engaged with Child Protective Services (CPS) often have some elements of substance use involved. They may not know where to accessSUD treatment services until they engage with CPS. Stakeholders noted that there is a need for SUD treatment facilities for the parents engaged with CPS and mental health services for foster children and their families.

"I think [mental health services are] a need of the community in general, but it's specifically a need for the child welfare system. Because the way that it works is that CPS contracts withmental health providers to provide services to families who are involved in the child welfare system, and there's just not very many providers that will contract with CPS. The ones who do are incredibly overwhelmed and either have a waiting list or cannot see clients as frequently as they really need to be seen. That's certainly a need."—Community Stakeholder

"Then, this is quite obvious, but substance abuse treatment facilities that are lacking the parents' side of that so the first was treatment and re-integration for kiddos, and then on the parents' side, treatment and coaching. I love those together for parents. Not just accessto treatment but how to be a parent. Training that actually makes a different back to their family pathways. I think that's a really good model for that, they're being successful, but it needs to be scaled pretty greatly. I'll stop there for now."—Community Stakeholder

- **Children**: Stakeholders spoke to the importance of addressing early mental health needs, especially for children that may have experienced trauma. They shared the importance of equipping parents and community members with the tools to respond to children's mental health challenges with empathy and compassion and supporting children in developing healthycoping skills.

"I would wholeheartedly agree that the mental health of our children, especially at early ages, is one of our most significant issues, especially in the school system. Not just those students coming in with the severity of need, but also the community

around them and theirresponse. Understanding how to be empathetic to their needs and then equipping them with the necessary tools to support that child in the way that they need to be supported."— Community Stakeholder

The **COVID-19 pandemic** has only exacerbated behavioral health challenges. Stakeholders spoke toincreased acute and long-term needs, including increased anxiety, depression, and loneliness.

Stakeholders shared the following challenges accessing mental health and SUD treatment services:

- **Cancellation of substance use support groups or move to virtual groups**: People participating inAlcoholics Anonymous or Narcotics Anonymous may be lacking their support groups during this time or not feel as connected through virtual sessions.

"On the substance abuse side, my fear is that, particularly the Alcoholics Anonymous and Narcotics Anonymous meetings have become canceled during this, and that is primarily where the folks are being served. That's going to be a pretty big backslide that's going to need attention, just because the main crux of where people were going for that, has been shut down. We're seeing a great amount of folks for substance abuse group coming in a lotmore than we've had."—Community Stakeholder

- **Reduced mental health appointments**: Some mental health sites reduced appointment hours orclosed altogether.
- **Telehealth visits**: Not everyone is able to successfully engage in virtual visits, particularly peopleexperiencing homelessness who may not have a cell phone or access to technology.
- **Lack of insurance**: With job loss, some people have lost their health insurance, making accessingservices more challenging.

Stakeholders were particularly concerned about the following populations:

- **Families with children**: Stakeholders shared that families are adjusting to new norms and havingto cope with distance learning. They shared concerns that families are experiencing more anxiety, stress, and tension related to schooling and financial instability.

"One of the biggest concerns we have right now, and you are very aware, is going to besocial and emotional state of our students, but I'm also concerned about the parents. Especially, since we've been basically closed down since March. Part of the concern is going to be, "How are students, how are parents coping if they have to stay home?" The anxiety ofnot being able to work maybe not to be able to produce. Those are the ones that might have missed out on work."—Community Stakeholder

- **Older adults**: Increased, persistent isolation of older adults, along with fear related to theirhealth and COVID-19, has led to an increase in depression.

"A lot of Zoom calls that we've been having lately has to do with mental health. Just peoplewho are impacted by COVID-19, they are isolated mainly the elderly and those who have a compromised immune system. We hear a lot of stories around the need for mental health and to address some of those needs is really important right now. I think it's an unmet needbecause a lot of people don't have the resources to be able to access that kind of care."— Community Stakeholder

Stakeholders noted a need for **more case management** during the pandemic, noting that individuals arenot getting adequate follow up after receiving inpatient mental health services.

Access to health care services

Stakeholders described a variety of barriers that prevent people from accessing needed health care.Three barriers were frequently noted by stakeholders:

- **Transportation**: Stakeholders shared this as a persistent barrier for a variety of populations, especially people **experiencing homelessness**, **children in the foster care system**, and **peopleliving in rural areas.**

"I really think that we see a lot of transportation issues with the people that we serve. City bus has helped that a little bit during COVID and that they're offering free rides and comingto your house and stuff like that. That's been nice, but prior to that, but that would be a huge issue for the people that we serve."—Community Stakeholder

- **Cost of care, particularly for people lacking insurance**: Stakeholders spoke to challenges affording necessary medical equipment (such as diabetic strips) and prescriptions. They sharedthat many people are forced to make spending tradeoffs, deciding whether to pay for food or other basics or health care.

"In addition to that, people at our clinic, and this has been going on for years, have to makea decision, do I pay for my prescriptions or do I buy food for my family? Those are huge, huge obstacles that our families deal with."—Community Stakeholder

- **Lack of health literacy and comfort with or trust in health care systems**: Stakeholders discussedthat people often need a health advocate to help explain information with the provider, but alsobecause they expect they will be treated with more respect with an advocate present. People may be uncomfortable in a health care setting or lack trust in certain agencies, meaning that building trust and ensuring that people receive culturally responsive services is important. Thismay especially be a barrier for **immigrant communities**.

"The biggest barrier that we see is exactly what he was just speaking to, was the need for an advocate when they're seeking help specifically for health-related needs or anything else,they don't feel confident in going in and being able to access those needs. They may know where they can go but they don't always feel comfortable going or what to say or the right questions to ask or even when they're being told maybe what's going on, they don't understand at all what's being said to them kind of thing and so having an advocate there to help walk them through I think is something that's definitely needed."—Community Stakeholder

"Something else that's more probably subliminal, is trust. Folks need to be able to have trustin the people that are providing them with the healthcare information that they're receiving. That also means that the person providing the healthcare needs to understand the different needs of people. A homeless person may have a different need than somebody else, and relating their treatment to the environment of the people that they're serving."— Community Stakeholder

Other barriers include **appointments during working hours**, a **lack of providers who accept Medicaid**, and **confusion over where to access health care services**. Stakeholders noted patients may choose to goto the Emergency Department because they do not know where else they can receive affordable care.

Stakeholders shared the following gaps in health-related services:

- Health education messaging
- Access to birth control
- Tobacco cessation education and programs
- Nutrition classes with dieticians

While the above barriers note different populations that may be particularly prone to transportation orhealth literacy challenges, stakeholders also noted two populations that may experience additional challenges accessing high-quality, responsive care:

- **Latino/a and African American communities**: Stakeholders shared that they see Latino/a and African American communities disproportionately seeking low income health care services and amedical home. These groups, as well as **mixed status families** (families with a combination of documentation statuses), may experience a lack of opportunities and racism, contributing to economic insecurity.
- **People with incomes slightly above the Medicaid threshold**, but who are unable to afford private health insurance: Stakeholders spoke to a gap in services for people whose income is toohigh to qualify for Medicaid, but too low to afford to buy health insurance. They shared that thisgroup often "falls through the cracks."

"There just aren't services available for those people who they're not poor enough to be considered poor, but they're not making enough money to be able to do everything

that they need and want to be able to do for their families and for their health. That's not specific, but we do see that a lot and for people who don't, with our immunizations, we have kiddos who are 19, they just fall through the cracks because there's so much red tape around when and how you can receive services if you are 'poor,' if you don't check every boxexactly correctly or whatever it is. We see that and that's real frustrating too. It's like, 'Sorry, I know you can't afford your groceries, but the government said you can, so we can't help you.'"—Community Stakeholder

Stakeholders spoke to increased access to care challenges during the **COVID-19 pandemic**, sharing thefollowing:

- **Families losing their health insurance**: Stakeholders shared the FQHCs are seeing new patientswho have recently lost their health insurance.

  "One of the other things that we're seeing is we're having a large number of patients whoare coming from other practitioners. They say that their PCP is not able to get them in, so they're showing up here [at an FQHC]."—Community Stakeholder

- **Families delaying care**: Stakeholders noted many kids are not receiving their well child visits,meaning they are behind on their vaccines.

  "Right now, I know an immediate issue that we're going to be seeing is that everyone's behind on vaccines. There is a chance to see some of these and maybe try to get a foothold or that people are going to be like, 'Well, I didn't get my vaccines, I didn't die.' Therefore wesee an uptake in the passive anti-vaccine movement. That's a pretty novel immediate concern I think."—Community Stakeholder

- **Reduced or changed clinic hours and/or procedures**: Some services have been reduced or temporarily closed. For examples, the Health Department and State Health Department areclosed meaning people cannot access free HIV and STD testing and screening. FQHCs have limited evening hours and some clinics are trying to have certain hours for healthy kids andother hours for sick kids. This is creating some confusion for families.
- **Reduced case management and social services**: People are having more challenges navigatingservices and need more support on how to access care.
- **Difficulty using telehealth services**: Some patients are uncomfortable using telehealth technology and others lack the Wi-Fi of technology to successfully engage in these services. Thismay be especially true for people experiencing homelessness.

Homelessness/ lack of safe, affordable housing

Stakeholders described housing as **foundational** to health and well-being. They stressed the importanceof addressing homelessness through a Housing First approach, stating that people cannot begin their journey to stability without first being stably housed.

"We go with the slogan that 'housing ends homelessness' and that's the start to all of thebeginning of healing in all areas."—Community Stakeholder

The primary barrier to housing stability in Lubbock is the **high cost of housing** in comparison to typicalwages. Families end up spending a majority of their income on rent and utilities, sometimes for substandard housing, which makes it challenging for them to afford other basics, such as healthy foodand health care.

"We have a lot of single parents that we serve with multiple kids. Even the two-parent households with kids, all of their money goes to their vehicle to keep their transportation, their housing to keep housing, and then utilities to keep the lights on. It makes it very hardto afford food and other things that they need."—Community Stakeholder

"How can folks afford things? The cost of a two-bedroom apartment in Lubbock is something like $800 a month. For a family that is the main wage earner is making $8 or $9 an hour, they just can't afford it, and so that's definitely an issue."—Community Stakeholder

They noted the following gaps in addressing homelessness and housing instability:

- **Rental assistance resources:** Stakeholders spoke to the need for more rent, utility, and mortgage assistance programs, as well as more education to help people know of and accessthese services.

"Just access to community resources. We are trying to put together some information where we're able to provide that resource such as the City of Lubbock Community Development where they're able to assist families that are affected by COVID with rentutility, mortgage assistance."—Community Stakeholder

- **Homelessness prevention**: Stakeholders spoke to the importance of preventing people frombecoming homelessness, instead of only addressing people's needs once they are living unhoused. They spoke to a need for more people in decision-making roles related to fundingand programs to be entrenched in direct services to understand where the needs are.
- **Respite care for people experiencing homelessness**: When people are discharged from the hospital, they need time to recover and shelters are not equipped to manage health conditions. *''I really think a gap in Lubbock is medical respite care for people who are in homelessness…*

They'll get discharged, and they're sleeping on the streets with a wound that's trying to

heal. A lot of times, they'll just end up right back in the ER. I feel like that's a gap that wecould potentially be preventing people from longer recovery times and potentially, worsening conditions if they were able to heal in an environment where that was supported."—Community Stakeholder

Stakeholders identified **East Lubbock** as a geographic area with more housing instability and named thefollowing populations as disproportionately affected by housing instability and homelessness:

- **People with mental health challenges and/or physical disabilities**: They shared a need for moresupportive housing for groups with social-emotional or physical challenges who may not qualify for the State Supported Living Center, but still need support.

"Then also 18 years and older adults with disabilities, with social-emotional challenges whoneed job support and additional residential living with group homes. Sometimes they're notable to get in the State Supported Living Center because their intellectual disability, IQ quotient isn't low enough. There's definitely a gap there."—Community Stakeholder

- **Transitional Age Youth**: As young people age out of the foster care system, they may lack support networks and resources, meaning they are more at risk of living unsheltered or beingincarcerated.
- **Latino/a and Black communities**: Due to a lack of opportunities, racism and discrimination,these communities are more likely to experience economic insecurity.

"In particular, the African American community, there has been so much discrimination in their lives and they just haven't had the opportunities for upward mobility, for education, tothink they can have a better life."—Community Stakeholder

Stakeholders shared they expected to see an increase in homelessness and housing instability as a resultof the **COVID-19 pandemic**, particularly as people face longer stretches of unemployment than expected. They noted concern for "mass evictions" as the evictions that were filed during the moratorium are processed.

"I think that one of the big things that we have on our horizon right now is the increase in homelessness because of COVID. Everything I'm hearing and reading says that we're going to see a lot of people, especially, let's hope situationally homeless people, those numbers will rise because of people losing jobs and because of not having income and being able to pay rent. There's talk of an eviction tsunami in the United States right now, because evictions were put on hold during the early months of COVID. What that meant was that they could not be processed in the courts, but they could be filed. Thousands of evictions have been filed everywhere, and they've been sitting in the courts waiting for that moratorium to end, which it has now. The word is that we're going to be seeing

lots of massevictions in Texas as well as around the country. That could really stress the system as a whole in the coming months."—Community Stakeholder

Medium Priority Unmet Health-Related Needs

Three additional needs were often prioritized by stakeholders, although with less frequency andimportance than the high-priority needs:

1. Economic insecurity
2. Access to community resources
3. Food insecurity/ obesity and nutrition

Additionally, note the theme of **child welfare** was woven throughout the other needs, particularly housing and behavioral health. The theme of **transportation** was woven throughout the other needs,particularly access to health care services, behavioral health, and access to community resources.

Economic insecurity

Stakeholders emphasized the **lack of livable wages** in Lubbock, particularly in connection to the **cost of housing**. They noted that people working in the retail or food industries do not make enough income toafford childcare, quality house, transportation, and other basics.

''Just because when we go in and we qualify clients either for our food or the social service team is helping them get their SNAP application together, they might be working 40 hours aweek but every cent they make goes to their rent, and then it goes towards their utilities. I don't think that the living wage is very good for this area and also household size to take anaccount for that."—Community Stakeholder

Stakeholders noted that many of the people their organizations serve, particularly single parents, areseeking **education and job training opportunities** with the goal of having a better paying job.

Unfortunately, they also discussed a **lack of job resources** and support finding job opportunities, notinglocal agencies engaged in this work are currently overwhelmed.

"The other thing too that we try to do a little bit of work with are those who are trying to get an education or trying to get some kind of job training in order to support themselves and their families. We see a lot of single parents who are trying to raise their families and trying to get an education. We try to support them in that respect and try to help them along the way and provide mentors for them so that they can continue with their educationand can get a better paying job."—Community Stakeholder

They also shared that lack of living wages and poverty are tied to **trauma, abuse, and neglect**.

They noted that addressing families' basic needs will start to address some of these connected communitychallenges.

"I'm very concerned about the livable wage issue, and I would put that pretty high up. Of course, that impacts then housing and transportation and all the other ancillary pieces. It then feeds also into the whole idea of abuse and neglect. It's a real problem."—CommunityStakeholder

Stakeholders named **racism** as a contributor to economic insecurity, preventing the Black communityfrom accessing the same opportunities for education and upward mobility.

''In particular, the African American community, there has been so much discrimination in their lives and they just haven't had the opportunities for upward mobility, for education, tothink they can have a better life."—Community Stakeholder

The **COVID-19 pandemic** has exacerbated economic insecurity in the community. Stakeholders notedthe pandemic is affecting employment longer than originally expected, which may mean people are lacking income for longer than planned.

"Another being poverty. It's a real hard time to live in poverty right now with COVID goingaround because COVID's pretty much back slid everybody that does not have money back further."—Community Stakeholder

''I think we were planning on the COVID situation being over in the summer and then a bounce back. Now that it's continuing on into the fall, I think that's a long period of unemployment for folks is going to become bad. I think you'll see a lot of housing loss andthat kind of thing."—Community Stakeholder

Access to community resources

Many of the barriers and challenges to accessing health care services also pertain to accessing other community resources, such as those provided by 211. Notably, stakeholders spoke to the **complexity ofnavigating the many resources** available to people in Lubbock and a lack of coordination. They shared that services, such as those related to health care, food vouchers, rent/utility assistance, diaper assistance, are not co-located, therefore people spend a lot of time bouncing between services. They also may not always know which programs or services are available and if they qualify.

''I think just a coordinated effort of some type would be helpful for those who are seeking any kind of assistance. I know 211 does a pretty good job about keeping some of that information, but there's so many resources, especially here in the

Lubbock community that alot of people are unaware of. If we had one, I think if we had one place where people could go to, they would be able to find out exactly how they could access the resources that wouldprobably be helpful."—Community Stakeholder

People noted that while there are a lot of services in the community, including classes to help people gain health education or navigate services, **transportation** and **childcare** can be barriers. To make classes and opportunities accessible for families, free transportation and childcare should be provided.

Stakeholders noted that **immigrant communities** may experience challenges accessing services, especially public benefit programs due to mistrust of government agencies and stigma around needingthese services. These families may not always receive services in their native language, adding an additional barrier.

Food insecurity/ obesity and nutrition

Stakeholders described food insecurity as being connected **to economic insecurity**, noting that even forfamilies with two adults working, they may spend all their money on rent and other basics and not haveenough to afford sufficient food.

"In addition to that, people at our clinic, and this has been going on for years, have to makea decision, do I pay for my prescriptions or do I buy food for my family? Those are huge, huge obstacles that our families deal with."—Community Stakeholder

Stakeholders noted **single parent households**, **older adults**, and the **Latino/a population** may be disproportionately affected by food insecurity. They also noted **people with incomes slightly above the threshold to qualify for SNAP** benefits do not receive food assistance, but also cannot afford healthyfood.

"There just aren't services available for those people who they're not poor enough to be considered poor, but they're not making enough money to be able to do everything that they need and want to be able to do for their families and for their health… There's so muchred tape around when and how you can receive services if you are 'poor,' if you don't check every box exactly correctly or whatever it is. We see that and that's real frustrating too. It's like, 'Sorry, I know you can't afford your groceries, but the government said you can, so we can't help you.'"—Community Stakeholder

They shared that food insecurity is connected to **obesity** and **poor nutrition**, noting a need for more nutrition education, particularly for young people. They shared that families rely on fast and convenient foods instead of healthy, nutritious foods, particularly if they are **busy working**. These families may be in**"survival" mode** and not have the capacity to consider the long-term effects of their food choices on their health.

"Of course, diabetes and all of those [chronic conditions]. I guess it doesn't even enter into their realm of thinking because they're so busy working and they're so tired and they're justtrying to get through each day, it's like survival… [Programs on nutrition,] just like that's a luxury they can't afford, even thinking about those things, because they're just trying to getthrough day to day."—Community Stakeholder

The **COVID-19 pandemic** drastically increased the need for food assistance for many people. Stakeholders noted they quadrupled their mobile food pantry delivery every month just to meet theneeds. Some organizations that provided food assistance shut down at the start of the pandemic or paused their food distribution, putting pressure on those organizations that have remained open.

"The people that we serve, they're having a hard time catching up for that loss income, ifthey did have jobs. It's going to be many months into the future that I think this need for food assistance is going to continue."—Community Stakeholder

Schools have stepped up to provide meals to families participating in remote learning, but not everyfamily has the transportation to pick up the food.

People have still been able to apply for SNAP benefits online, however for clients lacking internet accessthey have resorted to completing the application over the phone on paper and mailing or faxing the applications.

Effects of COVID-19

Stakeholders shared the COVID-19 pandemic has highlighted **racial inequities** in the community, withBlack, Brown, Indigenous, and People of Color more likely to be working in essential roles without the option to work from home.

Stakeholders shared an increase in **mental health challenges** with increased depression, anxiety, andisolation. They noted particular concern for older adults who may be isolated and parents of childrenwho may be adjusting to new norms of remote working and learning. They also noted **substance use**

challenges may be exacerbated as people experience more barriers to care and have less access tosupport networks.

Stakeholders noted people are **delaying care** and not everyone can engage successfully in **telehealth**

services. They were also concerned about people losing their **health insurance** with their employment.

Economic insecurity has been increasing as families lose wages and jobs. This exacerbates **housing instability** and **food insecurity**. With this insecurity, stakeholders expect more children to enter into thefoster care system, as well as more **child abuse** and **domestic violence**.

"One of the things that has not yet changed for us but that we are anticipating, is an increase in the number of children who are coming into foster care. We know

historicallythat times when families are economically stressed, not a lot of outside support or resources, can lead to an increase in domestic violence and an increase in child abuse."—Community Stakeholder

Stakeholders also noted **disparities in remote learning**, with students who need the most support having challenges with remote learning. They also noted challenges communicating with some studentsand saw an increase in crime when the school closed.

"The schools did everything that they could to meet with the student virtually, the counselors if they were working with the kiddos. It was a really, really hard blow for us, personally, to not be able to have that connection, and we saw some of our kids slip away.

Even as hard as the school tried to keep up with them and send out teams to try to locatehim, a lot of our kids sort of fell through the cracks. Not by anybody's fault but just the situation, because the school district did everything that they could possibly do to try to locate them, and some of our kids just we lost."—Community Stakeholder

Community-based organizations have seen a decrease in **funding** as donations and special fundraising events slow down, despite the increased need for their services.

"Our funding has decreased just because of donations, special events, and things like that. The funding is not coming in the way it was, and yet, we're anticipating an increase in the need for our services, so it's kind of a perfect storm for something that we really don't wantto see happen."—Community Stakeholder

Assets

Stakeholders shared the following community programs, organizations, or initiatives that are helpful foraddressing community health-related needs:

Table_Apx 6. Community Assets to Addressing Health-Related Needs in Lubbock

Health-related need	Community program, organization, or services (number of sessions mentioned if more than 1)
Behavioral health	Grace Manor StarCare Specialty Health System: Includes the Mobile Crisis Outreach Team (2) Youth Mental Health First Aid program
Economic security	Lubbock National Bank

Education	Lubbock Independent School District (full continuum of services in the general education and special education setting) REACH Program (a Special Education program in the Lubbock Independent School District) Texas Tech University
Family and Child Support	Community-Base Care approach to foster care Family Guidance and Outreach Center (emotional wellness programs) The Parenting Cottage
Food Security	South Plains Food Bank (2)
Health Care	Larry Combest Community Health & Wellness Center (2) Lubbock Impact The Community Health Center of Lubbock
Housing and Homelessness	Coordinated Entry System Family Promise of Lubbock Grace Campus Salvation Army (2)
Religion and Spirituality	Alliance Church Community churches
Resources and Social Services	211 (3) Catholic Charities of Lubbock Lubbock Area United Way Lubbock Impact Neighborhood House Open Doors (2) The Dream Center Volunteer Center of Lubbock
Services for Veterans	VetStar

Opportunities to Work Together

Stakeholders agreed that there are a lot of organizations doing great work in the community. Their primary concern was around fostering more communication between agencies, breaking down silos,and better sharing the resources available to communities.

Stakeholders talked about creating a communication "hub" to **centralize communication**. This wouldensure organizations are not "reinventing the wheel" or duplicating services, but brining people together to learn about resources. They noted the importance of **relationship-building**

across organizations.

"Not reinventing the wheel, but just all being able to communicate, have open lines of communication. I really love the idea of a partner agency or an agency conference like what we do every year with agencies that help us hand out food vouchers. Just definitely maybe having this big conference every year where we get as many players to the table as we can, and we just make it to where everyone gets to meet each other and understand each other's agencies."—Community Stakeholder

They noted the need for more **cross-sector collaboration** and communication. This could include government agencies, nonprofits, for-profits, and other community organizations that are invested inmeeting community needs.

"I also feel like it's not just agencies, and nonprofits, and government groups that can help.Like for example, Lubbock National Bank, one of their lenders is a volunteer. He joined our One Lubbock virtual meeting last night. They're putting the bank into the United on Parkway and they really want to hire people from the community. They want to offer jobs.

They want to offer different opportunities… It's connecting not only agencies and services, but for-profit companies that really want to diversify and they want to solve some of theseproblems. I think we need to plug in like the whole community together."—Community Stakeholder

By bringing together a group of multi-sector representative they could **leverage the varying expertise** ofthose represented in the room. This would ensure that content experts and those working directly with community could provide insight into how to best address needs.

Additionally, they noted a need to **set aside ego** and feeling "territorial" of one's work, recognizing thecommunity benefits when organizations collaborate.

"We operate a lot as silos in this area…I think that really just us getting past sort of-- I don'tknow if it's an old school mentality or if it's just a traditional mentality, what to call it, but this idea that we are going to take something from you if we work together, or feeling veryterritorial, I think is the word, it's not necessary… Just really be being able to move past ourown organizational egos, ours included. I'm not just pointing the finger outwards, I know that we all contribute to that. I feel like that's really where you begin to see some of the progress towards overall health of the community."—Community Stakeholder

To better meet the needs of community members, stakeholders noted the following suggestions:

- **Co-locate services** when possible

"I know one thing that's been really great for us is that right before the pandemic hit, [a community organization] moved in and so they are co-located with us at this point. It has been a huge boom to us just being able to work with them and walk down the hall and helpfigure out housing situations and what are people's rights. For our families who are out of work or who need assistance, it's literally as easy as walking three doors down and saying, 'Hey, this family needs help. Can you talk to them?' That's been really helpful. They've beena huge asset to us. We knew they would be, but I think it has been unexpectedly impactful to have them around."—Community Stakeholder

- **Have one location where community members can go to get information** and learn aboutresources (something like 211)

"I think just a coordinated effort of some type would be helpful for those who are seeking any kind of assistance. I know 211 does a pretty good job about keeping some of that information, but there's so many resources, especially here in the Lubbock community that alot of people are unaware of. If we had one, I think if we had one place where people could go to, they would be able to find out exactly how they could access the resources that wouldprobably be helpful."—Community Stakeholder

Appendix 3B: Participants and Findings from Plainview Stakeholder Listening Sessions (Hale County)

Covenant Health Plainview conducted stakeholder listening sessions, recognizing the importance of including the voices of community leaders who help make Hale County healthier. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, asthese individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder listening sessions are particularly important this CHNA cycle as the COVID-19 pandemic prevented the hospital from facilitating listening sessions with community members. They relied on community stakeholders to represent the broad needs of the communities they serve.

Representatives from Covenant Health Plainview conducted 2 listening sessions including 6 total stakeholders, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. The goal of the sessions was to identify what needs arecurrently not being met in the community and what assets could be leveraged to address these needs.

STAKEHOLDER PARTICIPANTS

A total of 2 stakeholder listening sessions including 6 participants were completed by representatives from Covenant Health Plainview. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Covenant Health Plainview aimed to engage stakeholdersfrom social service agencies, health care, education, housing, and government, among others, to ensurea wide range of perspectives. Included in the interviews was a representative from Hockley County Indigent Healthcare.

Table_Apx 7. Community Stakeholder Listening Session Participants in Plainview

Session	Organization	Name	Title	Sector
8/4/2020	Chamber of Commerce	Tonya Keesee	Executive Director	Non-profit
	City of Plainview	Jeffrey Snyder	City Manager	City Government
	Legacy Farms	Brent Bouma	Owner	Agriculture/Economy
	Plainview Christian Academy		Board President	Education
8/5/2020	Wee Care Child Center - Plainview, TX	Angel Morren	Director	Childcare

	Wayland Baptist University, Plainview, TX	Charles Starnes	Professor of Economics / Plainview City Councilman / Mayoral candidate	Higher Education
	Plainview Independent School District, Plainview, TX	Ryan Rhoades	Athletic Director	Public Education

FINDINGS FROM HALE COUNTY STAKEHOLDER LISTENING SESSIONS

Stakeholders were asked to speak to the unmet health-related needs in the community. The effects ofthe COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs:

1. Access to health care services
2. Food insecurity, including obesity and nutrition
3. Economic insecurity and workforce
4. Homelessness/ lack of safe, affordable housing
5. Mental health challenges and access to mental health care

Access to health care services

Stakeholders shared that Plainview has made a lot of efforts recently to expand its health care servicesand to "transform" the reputation that Plainview has quality medical services to offer, although peoplemay still travel to Lubbock to receive care. They noted growth in orthopedics and outpatient surgery, although said that there have still been some challenges **retaining specialists**.

"I think I used to say that we were lacking in specialty doctors, but I feel like Plainview is getting those. I want to set it in a positive note. I also believe our hospital's renovation andremodeling has put us very much into specialty and having all the best equipment and so forth."—Community Stakeholder

Stakeholders shared a need for **more information available for people with limited English proficiency**as to what **health care resources are available** to them, such as Medicaid. They noted they work with people who may not realize support services are available that can help them afford care.

They noted the following barriers to people accessing high-quality care:

- **Lack of health insurance**: Stakeholders shared that many people in low-income jobs,

such as those working in childcare, may not receive benefits through their employer. These adults havedifficulty accessing affordable care.

- **Cost of care**: Stakeholders noted people may avoid seeking care for fear of bills, particularlythose lacking insurance or with low incomes.
- **Not being able to afford missing work due to lost wages**: People, especially single parents, maydelay care for themselves or their children because they cannot afford to miss work and lose those wages.

"The majority of our kids then have Medicaid. Parents do well taking their kids to the doctor. If you have a single-mom family and the child is sick, the mom doesn't want to miss work. Sometimes, it's a struggle in those areas putting the medical needs of the child aheadof needing to be at work to make a paycheck, to pay the bills."—Community Stakeholder

- **Lack of trust in health care services**: This may be particularly relevant for people with limitedEnglish proficiency.
- **Transportation**: While people can and often do use the South Plains Area Regional Transportation Assistance Network (SPARTAN) public transportation, the $2 roundtrip cost canbe a barrier for some.

"If a person needs to go to the, say the doctor, for example, it costs them $1 each way to get picked up. If they need to go to Lubbock, the cost used to be $8, I don't know what it is anymore. For the poverty of poverty folks, the people who cannot afford their own transportation or are unable to take themselves places due to physical or other kind of things that prohibit their driving, that's a big gap that could use some assistance in helpingthose folks out."—Community Stakeholder

Stakeholders shared that some of their workers must be cleared by a doctor before returning to work ifthey have **COVID-19 symptoms**. Because these workers often receive low incomes and no health benefits, they have difficulty affording this visit. Cost of care can be a barrier to workers seeing a provider and returning to work, leading to more lost wages.

"The adults that will neglect their health because of the cost of just simple services with the doctor. There are some providers that do provide based on income and such. One thing rightnow is hard, if I have somebody that's out sick and I have to send them to the doctor before they can come back, and they don't have money to go to the doctor."—Community Stakeholder

Food insecurity, including obesity and nutrition

Stakeholders described food insecurity as a significant challenge in the community related to **economicinsecurity**. Plainview Independent School District (PISD) provides free breakfast and

lunch to students based on income level of the community. A community program Snack Pak 4 Kids, works to provide nutritious food to kids. Despite these meal programs, stakeholders noted that middle and high school students do not receive **weekend meals** and school breaks, such as **Summer**, are times when allstudents may not receive sufficient and nutritious food.

Stakeholders that work with organizations that provide **childcare** services noted seeing kids coming inMonday morning very hungry.

> *"We have had parents that will wait until they know their child has had supper before theywill pick them up. We have kids that come in on Monday mornings really hungry. We're pleased to let them eat and to feed them well, but you do worry that are they getting whatthey need at home." – Community Stakeholder*

Stakeholders identified **older adults** as another population experiencing food insecurity, particularlybecause of transportation and mobility challenges.

They shared the concern is not only related to quantity of food, but also quality, noting kids are not receiving **nutritious foods**. Addressing food insecurity is important because hunger and poor nutritionaffect ability to pay attention in school and be active.

> *"I would go and buy every kind of a nutritious snack I could think of because we have somany kids that aren't fed or certainly aren't fed nutritiously."—Community Stakeholder*

Stakeholders described families experiencing food insecurity as also experiencing economic insecurity,leading to a lack of access to nutritious food and **obesity**. They noted obesity is a problem for both children and adults in the community. The police even changed to larger cars because people were having difficulty fitting in their smaller cars.

> *"Over the past few years, we've started buying Chevy Tahoes as our city patrol vehicles. Oneof the reasons that the chief of police gave was that many people that they were having to take into custody were too big, too obese to fit into a Chevy Caprice sedan. Obesity is an issue. If you look around, we're about the same as any other place in America, but it's a significant issue. With obesity comes poor diet choices which are often driven by income."—Community Stakeholder*

More people have been seeking food assistance from food banks due to layoffs and furloughs as a resultof **COVID-19.**

Economic Insecurity and workforce

Stakeholders described a lack of a living wage in Plainview, leading to low incomes. Stakeholders notedthe connection between economic insecurity and **food insecurity**, **housing instability**, and **access to care challenges**. Workers in low wage roles often do not receive health benefits and therefore, may experience challenges paying medical bills or neglect seeking out needed services

for fear of cost.

Stakeholders noted a need for more **skill-based training** and **workforce development**, which willultimately benefit people's ability to afford nutritious food and good-quality housing.

"I think the labor's important… and workforce training and development, those really tie into-- almost domino effect into the other things like food and quality housing available forfolks. I think we've discussed a lot of that."—Community Stakeholder

Stakeholders identified **older adults** as experiencing economic insecurity, many of whom requirefinancial assistance with bills.

Stakeholders described a **labor shortage** in Plainview, noting it is challenging for employers to findenough labor in the area.

"I would just mention the labor shortage in general as an employer. It's been getting tighter and tighter. Over the last few years, it's been really tight trying to find enough labor in general in the area. I don't know how that plays into your discovery that you're doing here, but just know that we do have a labor shortage."—Community Stakeholder

They connected this labor shortage to the **loss of the largest employer**, Cargill Meatpacking Plant, aboutseven years ago. This meant losing about 2,200 direct jobs and another 500 indirect jobs. Since then, theworkforce and number of jobs have shrunk. Related, there has not been an increase in **personal wealth** in Plainview in the last decade.

"Of course, you know seven years ago, we lost our largest employer, the Cargill meatpacking plant, with about 2,200 direct jobs and about another 500 indirect jobs. Thatshowed that our labor force has over the last seven years has shrunk substantially."— Community Stakeholder

Besides wages, stakeholders noted another barrier for the workforce is **transportation**. Some workers without personal cars use the SPARTAN to get to work ($1 each way). If they have to drop their child offat childcare on the way, then they pay $2 each way, totaling $4 per day on transportation. Stakeholderssaid, "$4, that's like a half an hour's wage."

"We've had some parents and some staff, and it is the dollar both ways. If you have a parent that has to bring their children here first, and then leave from here to go to work, then that's $2 to get to work and $2 to get back from work. It is somewhat challenging because they do stay busy. I've had staff that have taken it before, and they get to work 45 minutes early because that's where it fits in the schedule. It's not always as convenient as-- Ihad a parent who had two special needs kids and that's how she brought them. It can be challenging. They are quick and it adds up if

you're paying $4 every day and you don't have much income at all."—Community Stakeholder

The **COVID-19 pandemic** has exacerbated economic insecurity, with more people being laid off orfurloughed. Stakeholders have seen more people seeking assistance paying their bills.

They noted a lot of uncertainty around job situations and when/if jobs will resume, as well as the long-term impacts of COVID-19 on the economy.

''The food banks are getting hit real hard because there's a lot of jobs that just aren't happening. There's definitely the uncertainty about when things get rolling again. With thatuncertainty, it creates anxieties. It can create depression; it can create just the desire to get out of town and go someplace else where there might be opportunity. All these factors come into play."—Community Stakeholder

"I think there's still a lot of unknowns wrapped around COVID-19 and the impact it's havingon our local economy, and what the domino effect is what jobs are going to be here and available, and what resources are going to be available."—Community Stakeholder

Homelessness/ lack of safe, affordable housing

Stakeholders noted the importance of both **affordable** and **good-quality housing**. They were particularlyconcerned about the **poor housing conditions** many people live in, such as lacking hot water or heat in the winter.

"I was continuously amazed with some of the situations that we run into, people with rotting floors, and no hot water, and no heat in the winter, and you just take so much for granted when you don't realize you're blinded to the reality that some people live in right inour own backyard."—Community Stakeholder

They noted the connection between housing and **health**, stressing that quality housing is important for hygiene and sanitation, as well as protection from the weather. Stakeholders identified the **Seth Ward** area as having more housing instability due to lower incomes.

Stakeholders were particularly concerned about **overcrowded housing conditions**, leading to the spreadof **COVID-19**. They noted that **migrant labor families** may be living 3 or 4 families in a home, contributing to the easy spread of the virus and challenges self-isolating.

Mental health challenges and access to mental health care

Stakeholders shared a need for more mental health services for **children**, noting that children engagedwith Child Protective services may experience **trauma** and need support coping.

"A lot of children go through things that we as adults cannot imagine. We have one counselor that comes and sees a few of our children. That's something that is very important because some kids have it rough and they need that support to help them copewith some of the things that they've been through."—Community Stakeholder

They also noted there may be a need for more mental health services to respond to the "fallout" fromthe **COVID-19 pandemic**. The pandemic has created more **anxiety** and **depression** as people are uncertain about what is happening with their jobs and having to rely on financial and food assistance programs.

Effects of COVID-19

The COVID-19 pandemic has highlighted **communication challenges** within the community. Stakeholders described difficulties sharing up-to-date and accurate **resources** and **health education information** with community members. They noted the main method of communication is through Facebook (which requires people to actively engae), although other less utilized options are newspaperand radio.

"The city and county health authorities are trying to do a good job keeping people informed,but then the only way that they get informed is either through Facebook or the newspaper,

and our newspaper is getting weaker and weaker. It's a reach just like all newspapers are.Local radio stations, they don't have a very big audience. Facebook, you have to actively engage Facebook to find out the information. Information is another tough thing that thecommunity faces."—Community Stakeholder

They also shared not all school-age children have access to Wi-Fi or technology to successfully engage in**remote learning**. Families may also experience challenges keeping their children home from childcare orschool to quarantine for 14 days after exposure because they need to go to work. Missing two weeks of work to quarantine is a **financial hardship** on many families. Paying for **health care services** related to COVID-19 can also be a barrier for families with low incomes or those lacking insurance.

Stakeholders shared they are seeing more **economic insecurity** related to increased layoffs and furloughs. More people are seeking **food assistance** as a result. This uncertainty has created **anxiety** and**depression** for people. Migrant labor families often live in **overcrowded housing**, contributing to easier spread of COVID-19 among household members and workers.

Assets

Stakeholders named the following community initiatives, programs, or organizations as assets foraddressing community needs:

Table_Apx 8. Community Assets to Addressing Health-Related Needs in Plainview

Health-related need	Community program, organization, or services (number of sessions mentioned if more than 1)
Education and Job Skills	Plainview Independent School District South Plains College (skill-based training and certificate programs) Texas Workforce Commission
Food Security	Meals on Wheels Snack Pak 4 Kids
Health Education	Plainview Health Department (health education seminars)
Resources and Social Services	Plainview Area United Way Plainview Cares
Transportation	SPARTAN Public Transportation (2)

Appendix 3C: Participants and Findings from Levelland StakeholderListening Sessions (Hockley County)

Covenant Health Levelland conducted stakeholder listening sessions, recognizing the importance of including the voices of community leaders who help make Hockley County healthier. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, asthese individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder listening sessions are particularly important this CHNA cycle as the COVID-19 pandemic prevented the hospital from facilitating listening sessions with community members. They relied on community stakeholders to represent the broad needs of the communities they serve.

Representatives from Covenant Health Levelland conducted 2 listening sessions including 7 total stakeholders, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. The goal of the sessions was to identify what needs arecurrently not being met in the community and what assets could be leveraged to address these needs.

STAKEHOLDER PARTICIPANTS

A total of 2 stakeholder listening sessions including 7 participants were completed by representatives from Covenant Health Levelland. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Covenant Health Levelland aimed to engage stakeholdersfrom social service agencies, health care, education, housing, and government, among others, to ensurea wide range of perspectives. Included in the interviews was a representative from Hockley County Indigent Health Care.

Table_Apx 9. Community Stakeholder Listening Session Participants in Levelland

Session	Organization	Name	Title	Sector
7/29/2020	Hockley County Extension Service	Marcia Blair	County Extension Agent—Family & Community Health	Social Services
	Levelland Independent School District	Carrie Ellis	Board Member	Public Education
	City of Levelland, Texas	Beth Walls	City Secretary	City Government
	City of Levelland, Texas	Melissa Fields-Allgeyer	Director, Human Resources	City Government

8/5/2020	Hockley County Public Assistance	Rebecca Currington	Public Assistance / Indigent Health Care Administrator	Social Services
	South Plains Rural Health	Jeff Malpiede	Outreach Coordinator	FQHC
	Hockley County	Derek Lawless	Justice of the Peace	Justice System

FINDINGS FROM HOCKLEY COUNTY STAKEHOLDER LISTENING SESSIONS

Stakeholders were asked to speak to the unmet health-related needs in the community. The effects ofthe COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs:

1. Homelessness/ lack of safe, affordable housing
2. Access to health care services
3. Behavioral health challenges (includes both mental health and substance use disorder) andaccess to behavioral health care
4. Food insecurity, including obesity and nutrition
5. Economic insecurity

Homelessness/ lack of safe, affordable housing

Stakeholders discussed a need for more housing for all income levels, although especially for peoplewith **mid-level incomes.** They shared that housing is not affordable for people even with jobs.

> *"Housing for all income level in Levelland is difficult to find. That's why that's one of the strategic plans that the city has. That's a pillar of the strategic plan is housing. We've made some really great strides, but we need more housing for middle-income professional people.We've got good housing on the higher end, there's a lot of housing on the lower end."— Community Stakeholder*

Stakeholders discussed **poverty** and **lack of living wage jobs** as the main contributors to housinginstability, poor living conditions, and overcrowding.

> *"We heard some stories of just kids living on top of kids and multi-generation families in onehouse and some really sad situations. I think the poverty was not good before all of this and we expect our numbers to rise significantly [due to COVID]."— Community Stakeholder*

For **people with low incomes** and **older adults**, they noted challenges maintaining and fixing homes andidentified a need for **financial assistance to help people address housing issues**, such as plumbing and gas problems. For older adults or people with limited mobility, they may also need help making modifications to their home, such as adding a ramp, to make it **more accessible.**

> *"I have people come to my office or call me. Is there any way we can find somebody to helpthem? They've got plumbing problems, gas problems, things that they can't afford to fix, and there's not really anybody out there who will do that at a reduced rate or free. I understand that because once a plumber does a really cheap job for somebody to be nice, then everybody's calling. I understand their situation there. With us doing public assistanceand rent assistance, through that, we've become really familiar with what some of the rental housing and unfortunately, even some people on their own homes. Like your senior citizens that are very low income. They can't afford to maintain that like they need to."—Community Stakeholder*

Geographically, they identified the **West and Northwest areas** of Levelland as having poorer qualityhousing and increased housing instability.

> *"The majority of our folks that are most at risk live on the west and the northwest side oftown mostly low income… Where we have much more housing that is just a lot of its uninhabitable and yet it's got people in it."—Community Stakeholder*

While stakeholders noted there are support resources available in the area, **accessing and navigating** them can be challenging and stressful, and stringent qualification standards make it difficult for peopleto qualify.

> *"I have to say, we do have systems in place to help some folks, but it's challenging to get to work through the tape that you have to go through. When you already don't have resourcesand you go into try to get help with resources… just the pushback that there is for folks in those positions. The agencies are there and are wonderful and do really great things, but it involves just an enormous amount of effort for someone who already feels beaten down to stay upright and try to walk through that."—Community Stakeholder*

The **COVID-19 pandemic** has created increased housing instability due to people losing wages or jobs.While eviction moratoriums at the start of the pandemic protected people, many of those protectionshave ended. Stakeholders noted oil field workers in particular have lost their jobs or wages.

> *"COVID put a lot of people who were already at risk at deeper risk, and they live in places that they couldn't afford beforehand and now they really can't afford, they can't pay theirrent. There was some protection for them in the beginning of COVID because they had putholds on evictions and stuff like that. That's all gone away."—Community Stakeholder*

Access to health care services

Stakeholders described a variety of barriers that prevent people from accessing the health care servicesthey need:

- **Cost of care:** They shared that a lack of income or resources, even with insurance may prevent people from seeking health care services or prescriptions they need. They noted **older adults** inparticular may have challenges affording prescriptions and durable medical equipment.

  "Two of the biggest things I say are people who need durable medical equipment. The whole range that that includes. Nobody covers it. Medicaid doesn't cover it. We don't coverit. Sometimes that's a big necessity. A lot of times that they're needing something that fallsunder that category of DMEs. Then the other thing, of course, would be prescriptions. I know that now with things like good RX and I know our pharmacies here are good about looking for coupons and those cheaper prices when they can... That's a good thing that helps there but getting prescriptions, especially the really expensive ones, that's a really bigproblem."—Community Stakeholder

- **Transportation**: They shared there is no major public transportation system in Levelland, andpeople may have to travel outside of Levelland to access the care they need.

  "Sometimes it'll go out into transportation especially as rural as some of these communitiesare, when people have to drive 50 or 60 miles to get to a clinic or a hospital, that's a barrierright there."—Community Stakeholder

- **Lack of knowledge about where or how to access services**: People may not know what resources are available to them, especially if they have not needed support in the past. They may rely on first responders to provide insight into where they can receive medical and socialservices.

  "But getting that education to our stakeholders, our law enforcement, our other first respondents to be able to, again, point people in the right direction so that they can help them through those processes… We saw it all the time where people, whether it's first resort or last resort, people come to law enforcement and other first respondents for thattype of help, just no knowing where else to go."—Community Stakeholder

Stakeholders identified two populations that may have challenges accessing services:

- **People with low incomes**: Stakeholders shared people with low incomes are more likely to havechronic conditions and poor health outcomes. Affording care may be a challenge and

other social factors may be a contributor to these health outcomes. Stakeholders noted that this population may need more health education and awareness about conditions and the importance of regular medical care.

- **People with incomes slightly above the threshold to qualify for Medicaid or Indigent HealthCare:** Stakeholders discussed that some people may make too much money to qualify for freehealth care, but not enough to be able to afford their own insurance. This may compound challenges affording care.

"They don't make enough where they can buy insurance. They're stuck right there because they're over income from programs like [County Indigent Health Care], and they don't makeenough to where they can afford even bad insurance. That's a real group that they have I think as many medical problems as anybody else because they just can't get covered and they let it go."—Community Stakeholder

The **COVID-19 pandemic** has exacerbated access to care challenges for the following reasons:

- **Fear accessing care**: People, especially those who are older or with underlying health conditions,may be choosing to delay care for fear of contracting COVID-19.
- **Confusion and a lack of information**: With job loss and changing financial situations, some people may have lost their insurance or find that they need to access support services for the first time. For some, they may not know where to get the medical and social supports theyneed.
- **Lack of internet access and technology literacy**: While a lot of medical care has moved to telehealth, not everyone is able to engage successfully in these services due to a lack of internetor technology, or challenges navigating the online services.

"During these months when we've gone to Telehealth, there are some people who just theyeither can't or incapable of using that option. Many are, but I think there's a subset of people we serve that just do not have that capacity and so they may not seek health care.

They certainly can come into the clinic, they can come to our food bank, they can come forany of our services but it's definitely a barrier when they don't have that kind of access or that kind of literacy. We have so many resources for them as you all do. Patient portals, there's a lot of information they can get and there's a subset of our population that just can't access that."—Community Stakeholder

Behavioral health challenges and access to care (includes both mental health and substance use disorder)

Stakeholders described a variety of barriers that prevent people from accessing the behavioral healthcare services they need:

- **Stigma and lack of prioritization**: Stakeholders spoke to mental health services not always beingprioritized by people who may not see the value in those services. They also noted that people may consider physical health to be more important than mental health and have preconceived ideas about what mental health services entail.

  "The adults don't see the value of behavioral and mental health support for them or their children but because of the preconceived notion of, 'I don't need that, or that's not important, or if I seek that out, I'm going to be somehow labeled.' Again, it's a multi-leveledfacet situation, it's the stigma and how do we get past the stigma? Are there resources andare they readily available and confidential and safe and protected for community members,for the adults, but also, do we have those resources available in the schools that we can provide to kids to say, 'Hey, this is available, why don't you go talk to this person maybe they can help you?' Without again, labeling or stigmatizing and providing full access."— Community Stakeholder

- **Transportation**: Some behavioral health services may exist outside of the community, contributing to transportation challenges for people who have to travel to Lubbock or otherareas, necessitating a need to take off additional time from work to account for travel.

Stakeholders noted the following populations may be less likely to receive the mental health servicesthey need:

- **Older adults**: Stigma and not seeing the value in mental health services may prevent peoplefrom seeking out the care they need.
- **Children**: Schools may not have the capacity to meet the mental health needs of students. Additionally, young people may be reliant on their guardians to access these services for them.

Stakeholders discussed the potential for the **COVID-19 pandemic** to exacerbate mental health needs inschool-age children and insufficient capacity and resources for schools to meet the need.

"If you talk to our counselors, they would say that our school counselors, in general, just donot have the resources to deal with, particularly the mental health right now.

There's just not enough time, money, and resources to take that on, but a serious need for it."— Community Stakeholder

Food insecurity, including obesity and nutrition

Stakeholders described food insecurity as connected to **poverty** and **unemployment**.

"Our driver's mostly poverty and then occasionally like she said that whether it be COVID or oil field or whatever on recently laid off and it's some of our students are on there all the time once they get on, once they're identified until they graduate in our numbers. There arethose that mom or dad has recently been laid off and are new to our numbers until they canget back on their feet or we've had some that mom's got cancer and so there is a wage earner. They'll be on there until they can get back on their feet. I would say that poverty is aleading indicator of ours."—Community Stakeholder

They shared the following barriers to people eating nutritious, healthy foods:

- **Cost of healthy, fresh foods**: Stakeholders shared that for families with limited resources,buying fresh foods does not always seem feasible.
- **Limited time**: Families are busy, and people often want quick and easy meal options. *"In the long run, most of us know if you can cook from scratch and make those healthymeals and all, it is cheaper in the long run and it's better on your health but that's not*

something-- We've become such an instant society. They're grabbing that fast stuff. They'renot looking at their diet."—Community Stakeholder

- **Short sightedness**: People may not consider or fully understand how their diet affects theiroverall health, choosing unhealthy options.

"The other things I just made a note were people's diet. That's something that people don'ttake into consideration a lot. The people that we serve, most of them, they live in the moment. They don't look down the road about health which that comes into diet and education and exercise, of course. They're stuck right where they're at. They don't look anyfurther into the future."—Community Stakeholder

Stakeholders shared that food insecurity is connected to obesity and other chronic conditions, noting the need for more **health education**. They shared that giving people in-depth understanding of chronicconditions and the importance of engaging in regular primary care is important.

"We try to meet the immediate need. We try to follow up with new patients, but I think widespread, wide-based health education on a number of these chronic

conditions is to me a high priority. It's not that people are lacking in any knowledge, but I think lacking sufficient knowledge to know what to do. We have a big problem with people following upon their appointments, the plans that their providers make with them and it's very hard toprevent the progression of any kind of disease if you aren't regular with your medical providers."—Community Stakeholders

Stakeholders shared concern for the following populations:

- **School-age children**: Students receive food during the school year, but food distributions do notoperate during summer break, which is a time when families may experience more food insecurity.

  "We've taken a hybrid approach and we'll really serve kids for all the meals they're missing during the school year. As the community has expressed concern and we're concerned, we just don't know how to fill that gap of what happens in the summer, all summer long. They can really get served through June through summer school, but it's really right now, July anduntil school starts in August."—Community Stakeholder

- **People with low incomes**: This population may experience more challenges affording andaccessing nutritious, fresh foods, contributing to increased risk of chronic diseases.

Economic insecurity

Stakeholders discussed the connection between lack of living wage jobs and **food insecurity** and **housinginstability**. People with limited or no income may live in poor quality or overcrowded housing. They noted the north and northwest areas of Levelland may be disproportionately affected by economic insecurity.

Stakeholders noted the COVID-19 pandemic has **exacerbated economic insecurity** and made housinginstability worse for many.

"COVID put a lot of people who were already at risk at deeper risk, and they live in places that they couldn't afford beforehand and now they really can't afford, they can't pay theirrent. There was some protection for them in the beginning of COVID because they had putholds on evictions and stuff like that."—Community Stakeholder

People who may not have experienced economic insecurity before may have **lost their job or wages**, inaddition to their **health insurance**. They noted the full economic effects of the pandemic are still to be determined.

"The people who are needing assistance are oftentimes people who didn't just a few months ago. With people losing jobs and obviously that stems to losing healthcare,

insurance, and things like that. I think we haven't even begun to see the true fallout quite yet. I think it's still a few months down the road. I think just from my perspective that's what it is, is that that whole demographic has changed. I think it's continuing to."—EconomicInsecurity

Families may also be experiencing increased economic insecurity if one parent needs to leave their jobto **care for children** due to closed childcare and at home learning. This may put additional stress and strain on families.

"It's effecting people that beginning of the year never would have thought it would beeffecting. We've had a couple of employees that have left because of childcare issues.

Childcare is going to be a huge thing with the uncertainty of in-class school. I know we haveparents here that are scrambling to figure out how they're going to do it… It's creating an impact for families that weren't having issues before. One of the parents has to leave their job to do childcare because there's no other possibility."—Community Stakeholder

Effects of COVID-19

Stakeholders primarily discussed the increased **financial insecurity** many people are experiencing due tothe pandemic. For some, this insecurity may be new, for others it may have only exacerbated their challenges. With increased economic insecurity, stakeholders noted increased **housing instability** and **food insecurity**. This may only increase as eviction moratoriums are lifted and people lose their apartments.

People may be seeking support services related to health care and social services that they have neverhad to use in the past. For example, people who have **lost their insurance** may need support applying for Medicaid. Providing support navigating these systems is important.

Parents may experience particular strain as a result of losing their **childcare** or needing to stay homewith children who are doing remote learning, meaning a loss of income.

Stakeholders shared people are **delaying needed care** due to fear of contracting COVID-19 and noted that **telehealth** is not a successful solution for everyone, especially those who lack internet or comfortwith technology. They expressed there may be more mental health needs in young people and insufficient resources and capacity to provide all of the support needed.

Assets

Stakeholders shared the **Community Resource Coordination Groups** are especially helpful in supportingcollaboration between public and private agencies.

Opportunities to Work Together

Stakeholders agreed there are opportunities for more communication regarding community

resources.They expressed interest in having more **cross-sector conversations** to share information and build relationships.

> *"We do try to have good communication among agencies and there's different forums for that, but it just seems like there's always that, "Oh I didn't know we had that available in Hockley County or Levelland."—Community Stakeholder*

They also noted they see an opportunity for health care and social services to **engage with first responders, teachers, and counselors** to share resources as people may seek out support from these groups first. They shared providing a resource guide or handout could ensure they have a quick way toshare helpful community information.

> *"I guess the only thing I would add is like I was talking about earlier, being able to get this information into the hands of our first responders. A lot of times they're going to be trying to help people through this. They also a lot of times they're not going to be able to make that meeting like that. I don't know exactly what it looks like, but the ability when we do start having a coordinated meeting like this with resources. To easily take it back and shareit with whether it's on some sort of a document that we can hand out, or something like that. Where we have an easy access to that information for the people that are going to betrying to answer those questions."—Community Stakeholder*

Appendix 4: Prioritization Protocol and Criteria

The selection process began with the development of a general list of potential health needs, derived from a broad review of the indicator data, focus group findings, and literature around health concerns and social determinants of health. The goal of the selection process was to analyze the wide variety andlarge quantity of information obtained through the quantitative and qualitative processes in a consistentmanner.

Using criteria standard to Providence St. Joseph Health, the Community Health Investment team rankedeach health need on the following criteria.

- Worsening trend over time
- Disproportionate impact on low-income and/or communities of color
- PSJH service area/high need area rates worse than state average and/or national benchmarks
- Organizational commitment, partnership, severity and/or scale of need
- Alignment with existing System priorities and Mission
- Opportunity to Impact

PRIORITY COMMUNITY NEEDS WORKSHOP

Following this internal assessment, a workshop was held to engage internal and external stakeholders from the Lubbock, Levelland and Plainview service areas to review the primary and secondary data and

complete a final prioritization of identified needs. The CHNA priority setting workgroup included Board Members, Community Benefit Committee Members, nursing representatives, the Covenant Health ChiefMission Officer and hospital leaders.

COMMUNITY BENEFIT COMMITTEE AND REGIONAL BOARD ENGAGEMENT

A charter approved in 2007 established the formulation of the Covenant Health Community Benefit Committee for Covenant Health Medical Center and Covenant Health Children's Hospital. The role of theCommunity Benefit Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Benefit Committee is charged with developing policies and programs that address identified needs in the servicearea particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities. The Local Board of Directors has direct oversight of Community Benefit for Covenant Health Plainview and Covenant Health Levelland.

The recommendations of the workgroup were presented to the Covenant Health Lubbock Community Benefit Committee (Covenant Lubbock Board Committee), Covenant Levelland Board of Directors and the Covenant Plainview Board of Directors. Feedback was solicited for final review and approval of theselected rank priorities.

Appendix 5: Community Resources Available to Address Significant Health Needs

Covenant Health cannot address all the significant community health needs by working alone. Improvingcommunity health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 10. Community Resources Available to Address Significant Health Needs

Organization Type	Organizationor Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
Hospital	UniversityMedical Center	Primary medical care services, Lubbock County Indigent Program Funding	602 Indiana Avenue | Lubbock, TX 79415	Access to Care
Health Sciences Center/University	Texas TechHealth Sciences Center and Medical School	Primary medical care services, Specialty Care, Mental Health Services Lubbock County Indigent Program Funding	3601 4th St, Lubbock, TX 79430	Access to Care
Federally Qualified Health Center	Larry Combest Community Health & Wellness Center	Primary medical care services, Specialty Care, Mental Health Services Lubbock County IndigentProgram Funding	301 40th St, Lubbock, TX 79404	Access to Care, prescription assistance, transportation Assistance
Non-Profit Clinic	Lubbock Children's Health Clinic	Pediatric and Women's health services	Address: 302 N University Ave, Lubbock, TX 79415	Access to Care, mental health services, prescription Assistance
Non-Profit	Open Door	Housing Program including permanent supportive housing	1916 13th St, Lubbock, TX 79401	Housing and Homelessness
Non-Profit	YMCA Plainview	Healthy living, youth development, Salsa, Sabor y Salud Program builds on the rich traditions and values of Hispanic and Latino cultures to help families adopt and maintain healthy lifestyles.	313 Ennis Plainview, TX79072	Nutrition and Exercise

Non-Profit	YWCA Lubbock	The YWCA has been designated as an EnVision Center by Housing and Urban Development (HUD). These are centralized hubs that provide people with resources and support needed to become successful and navigate life. The YWCA is focusing on economic empowerment, educational advancement, health/wellness, and leadership development.	6501 University Ave, Lubbock, TX 79413	Food Insecurity, Nutrition, Healthy Lifestyle, MentalHealth, Access to Health Care Services
Non-Profit	South Plains Community Action Association	Head Start Program, Children's Dental and Medical Access, Children's Mental Health Services, Food and Nutrition, Transportation Services, Utility Assistance	411 Austin Street Levelland, Texas 79336	Access to Care, Mental Health, Food and Nutrition, Education, Economic Assistance
FQHC	South PlainsRural Health	South Plains Rural Health Services is committed to providing comprehensive health care to patients of all ages. Located in Levelland, Lamesa, and Big Spring, Texas	1000 FM300, Levelland, TX79336	Access to Care, prescription assistance, transportation assistance
FQHC	Regence Health Network, Inc	Primary healthcare that services including: Medical, Dental, Behavioral Health, Laboratory Services, WIC Services; RHN accepts most insurance plans to include Medicaid and Medicare and offers sliding fee scale	2801 W. 8th St Plainview, TX79072	
Non-Profit	Catholic Charities	Counseling for youth, legal assistance, direct client services, nutrition education, parent education, prescription and utility assistance for 30 counties in the South Plains	102 Ave. J, Lubbock, Texas 79401	Financial Assistance, Access to Prescriptions, Transportation, Mental Health, Food Insecurity and Nutrition

Appendix 6: Covenant Health Community Health Needs Assessment Committee

Table_Apx 11. Community Health Needs Assessment Workgroup and Community Benefit Committee Members

Name	Title	Organization	Sector
Karen Worley	Retired	Covenant Health Board Member	Community
Eddie McBride	President and CEO	Lubbock Chamber of Commerce/ Covenant Health Board Member	Business
Val Cochran	Owner	RedMark Marketing/ Covenant Health Board Member	Business
Regan Manning	Financial Advisor	Edward Jones Financial/Covenant Health Plainview Board Member	Business
Lee Turner	Chief Mission Officer Region & Behavioral Health	Covenant Health/Providence St. Joseph Health	Healthcare
Jessica Maples	Director of Nursing	Covenant Health Levelland	Healthcare
Chris Allen	*Director of Workforce Development and FTZ-260*	Lubbock Economic Development Alliance (LEDA)/Community Benefit Committee Member	Workforce Development
Tammy Franklin	Project Coordinator	Covenant Health Levelland	Healthcare
Alan King	CEO Covenant Plainview	Covenant Health Plainview	Healthcare
David Bayouth	President	Jarvis Metals Recycling/ Covenant Health Board Member	Business
Sr. Christine Ray	Sister of St. Joesph of Orange	Covenant Health Board Member	Healthcare
Kim Turner	Chief Audit Executive	Texas Tech University System/ Covenant Health Board Member	Higher Education

Michelle Hunter	Senior Director-Marketing & Community Outreach	TTUHSC Larry Combest Health and Wellness Center/ Community Benefit Committee MEmber	Healthcare
Aaron Dawson	Missional Life Minister	Monterey Church of Christ/Community Benefit Committee Member	Religious
Jorge Sanchez	Principal	Lubbock ISD/ Community Benefit Committee Member	Public Education
Christopher Moore	Pastor	Victory In Praise Church/Community Benefit Committee Member	Religious