



**COVENANT MEDICAL CENTER
LUBBOCK, TEXAS
Community Needs and Assets Assessment***



Prepared by the Community Health Outreach Department
June 1st, 2011

* Updated to align with The Patient Protection and Affordable Care Act (Pub. L. 111-148) which added section 501(r) to the Internal Revenue Code. Section 501(r) imposes new requirements on non-profit hospitals. Section 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through such assessment. The CHNA must (1) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health and (2) be made widely available to the public. Section 501(r)(3)(B). Covenant Health, Covenant Medical Center relied on Notice 2011-52: *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals* to meet the requirements.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

MISSION, VISION AND VALUES

INTRODUCTION

Who We Are and Why We Exist

COMMUNITY

Description of Community Served
Community Benefit Service Area Description
Zip Code Data
Insurance and Health Risk Data

Community Profile
Intercity Hardship Index
Community Need Index

METHODOLOGY

Analytic Methods
Priority Setting Criteria
Information Gaps
Collaborating Organizations

SECONDARY DATA

Overview of Secondary Data and Community Asset Mapping Report

Health Behaviors:

Obesity
Tobacco Use
Binge Drinking

Access to Care

Clinical Conditions:

Oral Health
Mental Illness
Diabetes
Maternal and Child Healthcare
Substance Abuse
Cardiovascular Disease
Respiratory Diseases
Sexually Transmitted Diseases

ATTACHMENTS:

1. Covenant Leadership Focus Group Comments
2. Covenant Medical Group Physician Survey Results
3. Community Providers Providing Services to the Economically Disadvantaged
4. Local Agency Interviews
5. Community Leaders and Health Experts Consulted
6. Community Benefit Committee Roster
7. Priority Setting Template

EXECUTIVE SUMMARY

Completed June 1, 2011

Updated to include new IRS required elements on April 1, 2012

Report developed by Covenant Health's Community Health Outreach Department

Covenant Health's Community Health Outreach Department (CHO) conducts a community needs and assets assessment every three years. This needs assessment is conducted as a system which consists of a collaborative effort between the following facilities (ministries): Covenant Medical Center, Covenant Children's Hospital and Covenant Specialty Hospital (Joint Venture) all located in Lubbock, TX. The assessment process includes demographics data review, secondary data analysis, review of community assets (asset mapping), focus groups, and a physician survey. The information is used by the CHO department and the Covenant Community Benefit Committee to select FY 12- FY 14 community health outreach priorities for Covenant Health.

The demographic data sets included in this report were provided by Lubbock Economic Development Alliance, St. Joseph Health and Covenant Health System. The secondary data analysis was provided by public health expert, Catherine F. Kinney PhD, of Kinney Associates. Asset mapping and focus groups were conducted by the Covenant Community Health Outreach department.

MISSION, VISION AND VALUES

Our Mission

To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

Our Vision

We bring people together to provide compassionate care, promote health improvement and create healthy communities.

Our Values

The four core values of St. Joseph Health -- Service, Excellence, Dignity and Justice -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

INTRODUCTION

Who We Are and What We Do

Covenant Health-Medical Center, located in Lubbock, Texas is a member of the St. Joseph Health, sponsored by the St. Joseph Health Ministry, and is a part of Covenant Health which is the largest health care institution in the West Texas and Eastern New Mexico region, with 4,500 employees and more than 600 admitting physicians. Covenant Health was created in 1998, through the merger of Lubbock Methodist Hospital System and St. Mary Hospital. Cornerstone facilities in Lubbock include Covenant Medical Center, Covenant Children's Hospital, Covenant Specialty Hospital and Hospice of Lubbock. Covenant Medical Group offers a wide array of primary care and specialists throughout Lubbock, West Texas and New Mexico.

Covenant is committed to offering accessible, affordable care to Lubbock's surrounding areas through 2 leased and 12 affiliated regional hospitals, including Covenant Hospital Levelland and Covenant Hospital Plainview, and Covenant Medical Group, a large employed physician group comprised of approximately 150 primary care and specialist physicians across West Texas and Eastern New Mexico. Additionally, a fleet of four mobile coaches and two ECHO/PV vans travel to take needed services to the medically underserved.

ORGANIZATIONAL COMMITMENT

Community Benefit Governance and Management Structure

Our Community Benefit Committee, a subcommittee of CH's Board of Trustees, is made up of hospital leadership and local community professionals. Our Executive Management Team (EMT) is involved in community benefit planning, prioritization of programs and reporting through the participation of the Vice President of Mission Integration, the CEO, COO and the Board Liaison at the monthly Community Benefit Committee meetings. In addition, the Chair of the Community Benefit committee reports monthly at Board of Director's meetings, keeping them

informed about program progress. Both the CB Committee and Board of Directors approved the FY12- FY14 CB Plan/Implementation Strategy Report.

The Community Benefit Committee consists of five CH Board of Director's members and seven at-large community members. Each has a unique insight to the communities we serve. The committee consists of a Sister of St. Joseph, physicians, a banking officer, an investment broker, an administrator with Texas Tech University – College of Education Outreach Department, a director of Texas Tech University Health Science Center, Vice President of United Way, Vice President Chamber of Commerce – Administration, a Lubbock Independent School District Trustee who is a retired Elementary School Principal, and a Community Volunteer with the Boys & Girls Club who is retired from the Lubbock Police Department.

The role of the Community Benefit Committee of Covenant Health (CH) Board of Directors is to support the Board of Directors in providing oversight of achievement of the Healthiest Communities goals and initiatives, community outreach activities, and assuring the accuracy of information included in the community benefit reports approved by the Board and submitted as required to state and federal agencies. The Community Benefit Committee achieves this role through fulfilling the following functions as outlined in the committee charter:

- Monitor Healthiest Communities (Childhood Obesity) initiatives.
- Develop policies and programs that address the identified needs in the CH service area with particular attention to vulnerable populations with disproportionate unmet needs.
- Oversee the development and implementation of the Community Needs Assessment and Community Benefit Plan every three (3) years.
- Monitor annual progress against Community Benefit Plan goals.
- Review all Community Benefit expenditures annually.
- Review and approve annual Care for the Poor budget and recommend approval to CH Board of Directors.
- Review and approve program design to assure that it best meets the needs of the population served.
- Ensure that Community Benefit programs target the populations with the greatest disproportionate unmet health related needs in the CH service area.
- Review and recommend programs for continuation/discontinuation annually.
- Review community benefit reports to assure accuracy of information before being approved by the Board and submitted to state and federal agencies.
- Identify potential sources and partnerships for Community Benefit programs. Provide letters of support or introduction, as appropriate.
- Assure effective communication and engagement of diverse stakeholders in Community Benefit planning and implementation.

Covenant Health (CH) is a member of the St. Joseph Health, sponsored by the St. Joseph Health Ministry, and is one of the largest non-profit healthcare organizations in the West Texas/Eastern New Mexico region, serving a 62 county area. We consist of 986 licensed beds, approximately 5,000 employees, and over 500 admitting physicians. Covenant Health has an

average daily census of 409, over 28,000 annual patient discharges, and more than 85,000 annual Emergency Room visits.

Community Description

Covenant Health – Covenant Medical Center, Covenant Children’s Hospital and Covenant Specialty Hospital (Joint Venture) are all located in Lubbock, TX.

Lubbock is the county seat of Lubbock County. The city is located in the northwestern part of the state at the base of the Panhandle in a region known as the Llano Estacado. Lubbock is home to Texas Tech University, Lubbock Christian University and has satellite campuses of South Plains Jr. College and Wayland Baptist University. The Lubbock Metropolitan Statistical Area is comprised of Lubbock and Crosby Counties. Lubbock serves as an economic center with an economy based in agriculture, healthcare, education, and manufacturing.

Community Benefit Service Area

Our FY 12 – FY 14 Community Benefit Service Area (CBSA) addresses populations within both Covenant Medical Center’s primary and secondary service areas.

Primary CBSA: Lubbock County with an emphasis on residents who live within the following zip codes: 79401, 79403, 79404, 79411, 79412 and 79415.

Secondary CBSA includes the Texas counties of Crosby, Dawson, Lamb, Gains, and Lynn.

The following additional geographic analysis was conducted to get an understanding of the geographic needs in the Lubbock County area.

Intercity Hardship Index (IHI)

Intercity Hardship Index (IHI) was developed by the Urban & Metropolitan Studies Program at the Nelson A. Rockefeller Institute of Government.

IHI aggregates six socioeconomic indicators that contribute to health disparity Indicators

Income level

- Per capita Income

Crowded Housing

- % of Households with 7+ people

Unemployment

- % of those 16 and over without employment

Education

- % of those 25 and over without a High School diploma

Poverty

- % of people living below the Federal Poverty Level

Dependency

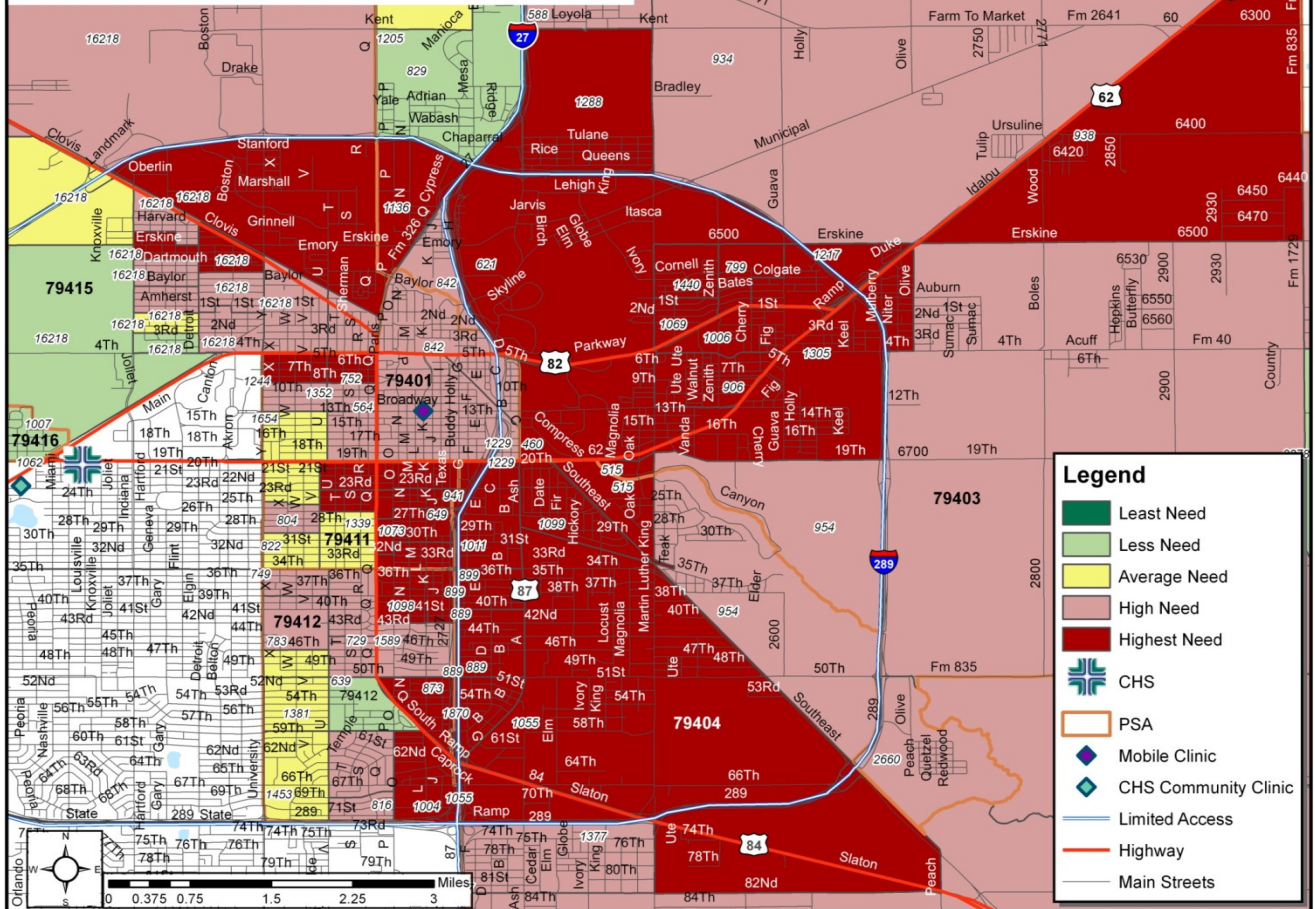
- % of the population under 18 years and over 64 years

IHI demonstrates need at the block group level where each block group is assigned a score from 1 (least need) to 5 (highest need) for all indicators. The indicators were standardized then averaged to create a composite score and using zoom maps, key block group areas of need were identified

Color-Coded Map

- **Red- Highest Need (HI Score: 5)**
- **Pink- High Need (HI Score: 4)**
- **Yellow- Average Need (HI Score: 3)**
- **Light Green- Less Need (HI Score: 2)**
- **Dark Green- Least Need (HI Score: 1)**

Lubbock Need by Block Group



Source: Intercity Hardship Index, The Nelson A. Rockefeller Institute of Government, 2007

Prepared by the St. Joseph Health System Community Health Department

When applying the methodology outlined above portions of the targeted zip codes in our primary Community Benefit Service Area fall into the highest need categories. Many of these communities are Medically Underserved Areas (MUA's) or Persistent Poverty Areas (PPA's) or both. The statistics provided in the demographics section of this report highlight unmet need in both the PCBSA and SCBSA.

The Needs and Assets in a community need to be understood to get a full scope of the circumstances shaping community health.

The following chart describes the community, by zip code or city that, by community need and assets.

Disproportionate Unmet Health Need Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
<p><i>Lubbock city Zip Codes: 79401, 79403, 79404, 79411, 79412, 79415</i></p>	<p><i>Per capita income significantly lower than county, state and U.S. averages</i></p> <p><i>% of children below the poverty level significantly higher than county, state and U.S. averages</i></p> <p><i>% of aged 65+ below the poverty level significantly higher than county, state and U.S. averages</i></p> <p><i>% of individuals below the poverty level below the poverty level significantly higher than county, state and U.S. averages</i></p>	<p><i>Some neighborhood clinics available, community centers, hospital services through both Covenant Health System and University Medical center, mobile units provided by Covenant Health System</i></p>
<p><i>Crosbyton, Lamesa, Littlefield, Seminole, Tahoka</i></p>	<p><i>Per capita income significantly lower than county, state and U.S. averages</i></p> <p><i>% Spanish as primary language higher than state and U.S. average (excluding Tahoka which is lower than the state average but higher than the U.S. average)</i></p> <p><i>% of children below poverty level significantly higher than the state and U.S. (excluding Tahoka which is lower than the state average but higher than the U.S. average)</i></p> <p><i>% of aged 65+ below the poverty level significantly higher in Crosbyton and Tahoka than Lubbock county, state and U.S. averages</i></p>	<p><i>Rural Hospitals and some clinics; Texas Agri-life extension agent services; some outreach and mobile services are provided locally by agencies, hospitals (including Covenant Health System) and non-profit organizations based out of Lubbock</i></p>

Community Benefit Service Area Data

	Cities						County	State	National
	Crosbyton	Lamesa	Littlefield	Lubbock	Seminole	Tahoka	Lubbock County	TX	U.S.
Population	1,737	8,961	6,000	219,801	6,009	2,545	262,985	23,819,042	301,461,533
Average HH Size	2.68	2.47	2.77	2.41	2.78	2.59	2.46	2.81	2.6
% of age 0-17	29.1%	28.5%	27.0%	23.8%	30.9%	29.8%	24.7%	27.8%	24.6%
% of age 65+	13.5%	17.6%	15.7%	11.0%	11.3%	14.0%	11.2%	10.1%	12.6%
% White	76.2%	79.0%	82.8%	78.4%	82.5%	80.7%	79.7%	71.8%	74.5%
% African American	7.4%	3.6%	7.0%	7.9%	2.4%	2.4%	7.2%	11.5%	12.4%
% Asian	0.0%	0.1%	0.1%	1.7%	0.2%	2.2%	1.5%	3.4%	4.4%
% Other*	16.4%	17.3%	10.1%	12.0%	14.9%	14.7%	11.6%	13.3%	8.7%
% Latino origin**(of any race)	58.6%	58.5%	51.2%	30.8%	40.6%	47.4%	30.6%	35.9%	15.1%
% Spanish-Primary Language at Home	37.4%	41.2%	37.2%	18.9%	29.9%	26.6%	18.9%	28.9%	12.1%
% 25+ with no HS diploma	29.4%	33.4%	26.7%	17.2%	34.2%	24.5%	18.0%	36.6%	15.5%
% of HH with Gross Rent ≥ 35% Income	31.0%	26.7%	19.1%	49.7%	20.4%	35.3%	48.6%	39.5%	41.0%
Per Capita Income	\$16,900	\$17,474	\$16,952	\$21,672	\$20,940	\$21,892	\$21,939	\$24,318	\$27,041
% Children Below Poverty	35.0%	37.6%	22.7%	22.5%	21.5%	19.8%	21.4%	23.7%	18.6%
% 65+ Below Poverty	25.5%	10.5%	8.7%	7.8%	10.2%	20.5%	7.9%	12.2%	9.8%
% Individuals Below Poverty	13.5%	23.5%	19.3%	20.4%	18.2%	17.5%	19.1%	16.8%	13.5%

Census: 2005-2009 American Community Survey <http://factfinder.census.gov>, *other includes American Indian, Pacific Islander, two or more races and other race, ** Latino is not listed as a race by the US Census Bureau but as an origin

Community Profile – Focused Zip Code Data

	Zip Codes						County	State	National
	79401	79403	79404	79411	79412	79415	Lubbock County*	TX*	U.S.*
Population	10,936	15,265	10,230	5,307	15,034	16,241	262,985	23,819,042	301,461,533
% of age 0-17	24.0%	33.2%	31.1%	26.4%	25.7%	28.8%	24.7	27.8%	24.6%
% of age 65+	6.0%	11.6%	9.5%	8.5%	12.4%	8.2%	11.2	10.1%	12.6%
% White	54.0%	37.3%	39.9%	65.6%	61.2%	54.7%	79.7%	71.8%	74.5%
% African American	13.9%	36.7%	27.0%	7.3%	10.2%	4.6%	7.2%	11.5%	12.4%
% Asian	5.4%	0.1%	0.2%	0.9%	0.5%	1.1%	1.5%	3.4%	4.4%
% Other*	26.7%	25.9%	32.9%	26.2%	28.1%	39.6%	11.6%	13.3%	8.7%
% Latino origin** (of any race)	45.2%	38.4%	52.3%	40.8%	42.9%	62.3%	30.6%	35.9%	15.1%
% 25+ with no HS diploma	35.5%	42.9%	39.8%	30.3%	28.7%	43.0%	18.9%	28.9%	12.1%
Per Capita Income	\$11,168	\$10,514	\$9,712	\$12,315	\$13,132	\$11,116	\$21,939	\$24,318	\$27,041
% Children Below Poverty	40.5%	34.8%	40.6%	38.1%	27.4%	31.1%	21.4%	23.7%	18.6%
% 65+ Below Poverty	23.6%	19.0%	25.2%	29.4%	8.4%	19.0%	7.9%	12.2%	9.8%
% Individuals Below Poverty	35.6%	27.3%	30.1%	26.3%	18.6%	27.9%	19.1%	16.8%	13.5%

Source: U.S. Census: 2005-2009 American Community Survey <http://factfinder.census.gov>, *other includes American Indian, Pacific Islander, two or more races and other race, ** Latino is not listed as a race by the US Census Bureau but as an origin

Community Profile- County Insurance and Health Risk Data

	Lubbock County	Crosby County	Dawson County	Lamb County	Gaines County	Lynn County	TX	U.S.
% Uninsured under age 65	31%	36%	29%	33%	40%	34%	30%	17.5%
% Medicare	12.24%	18.45%	16.34%	19.32%	10.80%	18.59%	12%	15%
% Medicaid	13.27%	18.46%	17.08%	19.80%	15.14%	14.89%	17%	19%
# of Primary Care physicians per County/Rate per 100K population	165	31	56	35	60	64	n/a	n/a
% Adult Obesity Rate per County	26%	28%	28%	27.5%	28.3%	27.9%	29.5%	33%
Childhood Obesity Rate per County (Low Income Preschool Age)	13.3%	12.9%	18.1%	12%	11.9%	13.7%	15.7%	14%

Sources: Kaiser Family Foundation, Centers for Disease Control and Prevention, U.S. Census: 2005-2009 American Community Survey 5-Year, Texas Department of State Health Services: BRFSS 2009

METHODOLOGY

ANALYTIC METHODS USED

The following section outlines the methodology followed to conduct the community health needs and assets assessment. This assessment process was conducted in the spring of 2011. The methodology is outlined below.

Community needs and assets assessment process

- Identify priority health issues for the economically poor in primary service area (PSA), focusing on the selected zip codes, for use of Care for the Poor funds, including grants. Primary Service Area is identical for Medical Center, Children’s Hospital and Specialty Hospital
- Identify of issues/needs for which there are not adequate resources (assets) in place by other community providers to address those unmet needs
- Selection of priority health issues/initiatives for CHO/Care for the Poor investments for FY 12-14 plan

Secondary Data Collection and Analysis

- Summarize demographic data for service area
- Contracted with Cathy Kinney, PhD Kinney Associates to collect available secondary data, gather, summarize, and document key health issues, based on criteria and prepare a summary report for use in primary data collection, describing key health issues
- Some information is not available at the city or zip code level for Lubbock and the surrounding areas. This is detailed within the secondary data report. All data sources and relevant dates of the data sourced are also listed in the secondary data report.

Primary data collection:

- Analyze existing community assets and programs by key health issue
 - Develop questions based on secondary data and asset mapping, to probe for additional perspectives and information during focus groups with local community health experts and community service providers

PRIORITIZATION PROCESS AND CRITERIA

Select priorities for FY 12- FY 14 Community Benefit Plan/Implementation Strategy Report

- Engage leadership in considering options, identifying additional questions, and developing recommendations
- Recommend priorities to Community Benefit Committee with criteria based rationale and implications/next steps

Develop plan for each priority

- Engage groups of consumers/residents through focus groups, surveys, interviews to gather their perspective on needed approaches, strengths/weaknesses of current approaches, etc.
- Establish measurable outcome for priority, for local and SJHS reporting
- Review evidence about effective approaches to impacting outcome
- Identify key strategies and activities

All identified health needs were presented to focus groups comprised of community health leaders from the Lubbock area, internal Covenant department leaders and the CB Committee. Covenant Medical Group physicians were asked to complete an on-line survey related the identified needs. The feedback received from these groups combined with the secondary data analysis helped shape the final priorities. Priorities were then ranked by the CHO program leadership team according to how well they met the following required elements and additional considerations listed below. The CHO program leadership team included the CHO Director, Community Services Manager, Manager of the Counseling Center and Health Education, Community Benefit Supervisor, Financial Analyst, Community Benefit Analyst, Health Education Dietitian, and department administrative intern.

Required Elements:

- All priorities will be focused on the economically poor within the primary service area for CH
- Local secondary and primary data have identified this problem as affecting a substantial number of persons in Covenant's service area
- Local secondary and primary data and national evidence have identified this problem as an important one in affecting residents' health status
- Available local resources to address the problem are not adequate
- Issue can be effectively addressed within the CH mission, vision, and values

Additional Considerations:

Internal alignment within Covenant Health:

- Focus on this area will help CH Emergency Department and inpatient services provide the services needed to address needs at appropriate intensity of care and thus reduce charity care costs
- Focus on this area will help CMG provide the services needed for the economically poor in its practice and thus reduce charity care costs
- Focus on this area will help CH insure that the economically poor receive services in areas of CH clinical excellence
- Focus on this area will help CH address other strategic priorities

Community perception:

- Other community service providers agree that there is a need for additional services and providers
- Other community service providers support CH being a provider in this arena

Continuity of current priorities:

- There would be a negative impact on community if CHO discontinued a current program or service

Service design/delivery capacity

- CH can provide this service as efficiently as other providers of this service in the community
- CH has or will develop the competencies/expertise needed to address this need effectively
- CH will focus on primary and/or secondary prevention approaches to this problem, rather than tertiary prevention
- CH will address this problem through an integrated/coordinated approach working with other providers to meet consumers' needs and "best practice" standards

To further develop the final priorities a template for selecting priority topics (3-W Template) was applied to each priority selected. Each priority was evaluated in the following areas:

- Detailed definition of the problem including the scope and seriousness of the issue
- Evaluation of community resources that currently address the issue
- Overall Alignment with internal strategic plans

INFORMATION GAPS

Demographic and health data is not available at the city or zip code level for Lubbock and the surrounding areas. However, this did not impact Covenant Health, Covenant Medical Center's ability to reach reasonable conclusions regarding community health needs.

COLLABORATING ORGANIZATIONS

Covenant Health's Community Health Outreach Department (CHO) conducts a community needs and assets assessment every three years. This needs assessment is conducted as a system which includes Covenant Medical Center, Covenant Children's Hospital and Covenant Specialty Hospital (Joint Venture) all located in Lubbock, TX.

SECONDARY DATA

Overview of Secondary Data and Community Asset Mapping Report

The following section provides data on the three main topics: health behaviors, access to care and clinical conditions that Covenant Health leadership and other key stakeholders identified as key areas to examine for unmet need. There were no significant information gaps identified in the secondary data analysis. The secondary data report is organized in the following manner:

- Summary
- Key Types of Data sources
- National, State and Local Data pertaining to topic
- Summary of Community Assets pertaining to topic
- Implications

A Community Status Report from the United Way in 2011, found that the percentage of children living in poverty in Lubbock County is 22.9% and percentage of adults living in poverty is 19.8%. This reflects a higher percentage of children and adults in Lubbock County live in poverty than the national averages of 20% for children and 12.5% for adults.

Lubbock, the largest city within our primary and secondary service areas, is located on the South Plains of Texas and has a population of 219,801 and a county (Lubbock County) population of 262,985 according to the 2009 US Census Estimate. Lubbock serves as a major medical center for the entire South Plains of Texas and Eastern New Mexico region, caring for people within a 62-county, 80,000 square mile radius of the city.

Health Behavior: Obesity

Summary: Obesity and its causes, low physical activity and poor eating habits, are major risk factors for negative health outcomes. At national, state, and local levels, rates are growing among both adults and children. In the Covenant Health System (CHS) service area, well over 50% of the adult population is overweight or obese. For children, available local data suggest that rates are consistent with state data, which describe over 30% of children ages 10-17 as overweight or obese.

Background: Obesity and physical inactivity are risk factors in more than twenty chronic diseases, including type 2 diabetes, heart disease, and some forms of cancer. Obesity-related medical costs are nearly 10% of all annual medical spending. Obesity is also associated with lower productivity at work. Among children, obesity negatively impacts mental health and school performance.¹ Lifestyle has been shown to be a more powerful factor than genetics in obesity.²

Key types of data:

- Obesity is commonly measured through Body Mass Index, the ratio of height to weight. Persons with BMIs between 25 and 29.9 are considered overweight; those with BMIs over 30 are considered obese.
- Self-report by adults (Behavioral Risk Factor Surveillance Survey, BRFSS)
- Self-report by youth (Youth Risk Behavioral Survey, YRBS)
- Weight and height measurement of children (Pediatric Nutrition Surveillance System)

National data: More than two-thirds of Americans are obese or overweight. Over 23% of American adults report that they do not engage in any physical activity, and only 33% of high school students have daily physical education.³ Approximately 25 million US children are obese or overweight, at a rate that has more than tripled since 1980.⁴

State data: In 2010, 29.5% of Texas adults were overweight or obese. This rate has increased considerably since 1995, and has consistently been higher than the national average.⁵ In 2007, 20.4% of Texas children ages 10-17 were obese, and 32.2% were overweight or obese.⁶ In 2009, 13.6% of high school children were obese.⁷ The large majority of high school students engage in unhealthy dietary behaviors, and patterns of physical inactivity are also high.

Local data: In the area of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties, the 2009 BRFSS oversample study of adults found that 25.7% of men and 29.5% of women were obese.

¹ Trust for America's Health. *Combating the Obesity Epidemic*, September 2010.

² Eagle, K. et al., *American Heart Journal*, 2011.

³ Centers for Disease Control and Prevention, 2009.

⁴ National Center for Health Statistics, Centers for Disease Control and Prevention, 2006.

⁵ United Health Foundation. *America's Health Rankings*, 2010. Texas Department of State Health Services. *Texas Chronic Disease Burden Report*, 2010.

⁶ Commonwealth Fund. *State Score Card on Child Health System Performance*, 2011.

⁷ Trust for America's Health, 2010.

If overweight and obesity are considered together, 65.8% of men and 58.5% of women were overweight or obese.

There does not appear to be a large distinction by income group: for those with incomes under \$25,000, the rate of overweight/obesity was 56.6%; with incomes between \$25,000 and \$49,999, the rate was 69.5%; with incomes above \$50,000, the rate was 60.6%. With regard to the recommendations for moderate or vigorous physical activity, 50.6% of males and 55.4 % of females do not meet these recommendations. The demographic segment that performs most favorably is the group between 18 and 29 years, where only 37.6% do not meet the recommendations for physical activity.

Data from 2006-2008 provide some comparisons by county. Obesity rates by county were as follows: 26% for Lubbock County; 20% for Hale County; 28% for Crosby and Lynn Counties, and 27% for Hockley County, compared to a statewide rate of 29%.⁸

Local data about the prevalence of child obesity are very limited. A 2004-5 research project provides some information regarding obesity for Public Health Region 1 (in which CHS' service area is located). At 4th grade, 15% of children were overweight and another 23% were obese. By 8th grade, 23% were overweight and 19% were obese. By 11th grade, 14% were overweight and 17% were obese.⁹

Obesity data are also available about Lubbock County low income children ages 2-4 for the period 2007-2009. In this group, the obesity rate was 13.3%, compared to a Texas rate of 15.7%.¹⁰

Obesity Community Assets Summary

The following services are offered to the underserved population in the CHS service area.

Area Services Provided Include:

- Chronic Disease Management
- Nutritional Education
- Food Preparation Classes
- Screenings and Consultations for Obesity
- Meal Planning
- Nutrition Counseling

The asset mapping found five community organizations that provide medical services targeted at the obese population; however, of those five, only three accept Medicaid. There is a concern among agencies that budget cuts will further reduce their ability to fund and create programs geared towards reducing obesity.

Covenant Community Health Outreach (CHO) has a Health Education Program. The Health Educator provides individual consultations and education related to obesity. The Lutheran Social Services offers screening and consultation for obesity and provides dietary education. Their patients are referred to Covenant's (CHO) Health Educator for meal plans and educational support. Community Health Center of Lubbock provides clinical services to adults and children. Their adult patients are also referred to Covenant's CHO Health Educator for meal plans and educational support. The Children's Health Clinic

⁸ University of Wisconsin. *County Health Rankings*, 2011.

⁹ Span III Research Project, cited by Texas Department of Health and Human Services.

¹⁰ Centers for Disease Control. *Pediatric Nutrition Surveillance System*.

of Lubbock and CHO collaborate to education the parents of at-risk children. The nurses refer children to the CHO Health Educator for consultations and education. The Combest Wellness Center also offers obesity education and nutritional guidance to their patients.

AgriLIFE Extension has formed a Building Fit Communities Committee composed of a cross section of agencies and organizations to raise awareness about the negative effects of obesity specifically related to community health and health care costs. Covenant Health System also has formed a Community Obesity Awareness committee to raise community awareness about health issues related to obesity.

Implications

Local health care providers, agencies and organizations recognize the negative impact of obesity on the health of both children and adults. There is also a negative financial impact of obesity within our communities. There is an identified gap in obesity related services, education and support for the community as a whole. The most economically underserved seem to be particularly vulnerable to chronic diseases related to or caused by becoming over-weight or obese.

Health Behavior: Tobacco Use

Summary: Tobacco use has a demonstrated negative impact on health and is responsible for significant healthcare costs. Approximately 25% of the adults in the CHS service area smoke, a rate higher than state and national rates. Noteworthy variations occur by income, sex, and ethnic group. About 20% of Lubbock area high school students smoke.

Background: Tobacco use is a cause in multiple diseases, including cancers, cardiovascular diseases, and adverse reproductive effects. Tobacco is the leading preventable cause of death in the US, accounting for approximately 19% of all deaths related to these conditions.¹¹ Tobacco use costs the US almost \$100 billion annually in healthcare bills and an additional \$97 billion in lost productivity. In addition, exposure to second hand smoke costs \$10 billion in healthcare costs.

Key types of data:

- Self-report of cigarette smoking by adults (Behavioral Risk Factor Surveillance System, BRFSS). A smoker is defined as a person who smoked 100 cigarettes in his/her lifetime and now smokes every day or some days.
- Self-report of cigarette smoking by high school students (Youth Risk Behavior Survey, YRBS). A smoker is defined as a person who has smoked at least one day during the 30 days before the survey.
- Self-report of behaviors by Lubbock ISD students grades 8-12 (Developmental Assets Survey), in 2009. A smoker is defined as a person who has smoked at least one day during the 30 days before the survey.

National data: In 2008, 20.6% of adults smoked cigarettes. Approximately 31.5% of adults who live below the poverty level smoked, compared to 19.6% of those who live at or above the poverty level. Smoking prevalence is higher among men (22%) than women (17%). Additionally, there are differences in smoking prevalence by race: 36% of American Indians, 21% of whites, 20% of African Americans, 13% of Hispanics, and 10% of Asians smoke.¹²

The rate of smoking among high school students has remained around 20% for many years.¹³

Texas data: Currently 17.9% of adult Texans smoke, a significant decrease from 23.7% in 1995.¹⁴ Males have a significantly higher smoking rate than females. African Americans and whites have slightly higher prevalence rates than Hispanics. Cigarette smoking prevalence decreases with increasing age. The rate of Texas high school students who report current cigarette use decreased significantly from 28.4% in 2001 to 21.2% in 2009. African American students are less likely to report current cigarette

¹¹ McGinnis JM and Foege WH. Actual causes of death in the United States, *Journal of the American Medical Association*, 270(18), 2207-2212.

¹² University of Wisconsin, *County Health Rankings*, 2011.

¹³ Trust for America's Health. *Preventing Tobacco Use and Exposure*, 2010.

¹⁴ United Health Foundation. *America's Health Rankings*, 2010.

use than were Hispanic or white students. Of those high school students who smoke, only 47% have tried to quit smoking.¹⁵

Local data: In the area of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties, the 2009 BRFSS study found that 24.9% of adults were smokers, a rate significantly higher than state or national rates. Noteworthy variations exist by sex, income, and ethnic group. Among males, 29.1% smoke, in contrast to 20.9% of females. Among Hispanics, 36.9% smoked, a much higher rate than that of whites, 21.4%. Income and education were also significant factors: 36.7% of those making less than \$25,000 smoke, while only 22.6% of those making \$50,000 or more smoke.¹⁶

Within Lubbock County, an average of adult smoking rates from 2002 through 2008 yields a 23% smoking rate. Within Hale County, the same time period shows a 28% rate. Both are higher than the state rate of 20% for that period. Data specific to other counties in the CHS service area are not available, due to small sample sizes.¹⁷

The 2009 Developmental Assets survey of Lubbock ISD students found that the smoking rate grew significantly by year: 7% of 8th graders, 13% of 9th graders, 16% of 10th graders, 22% of 11th and 32% of 12th graders smoked. The same pattern was evident with the use of smokeless tobacco over the last year: 3% of 8th graders, 4% of 9th graders, 13% of 10th graders, 11% of 11th graders, and 17% of 12th graders.¹⁸

Tobacco Use Community Assets Summary

There is very few community smoking cessation programs available within the region. The following programs are offered.

- American Cancer Society, Quitline
- American Cancer Society, Fresh Start Program (part of a wellness program offered by employers)
- Court Ordered Tobacco Education for Teens

The Methodist Children's Home Lubbock conducts education for teens ticketed for tobacco use. This is a court ordered program. The American Cancer Society's operates Quitline for smoking cessation. This is a phone number that anyone can call to receive help for quitting smoking. The Quitline is staffed with a group of clinically-trained counselors and is supervised by licensed psychologist. Callers are assessed for their readiness to quit and given phone counseling options. The American Cancer Society also offers a Fresh Start program to local business. Participating businesses incorporate this into their wellness program to assist employees who wish to stop smoking.

Implications

There are very few support services or educational programs available to community members related to tobacco abuse. There are high rates of tobacco usage in the counties served by Covenant Community Health Outreach. More education and targeted interventions related to tobacco cessation could be beneficial to our community.

¹⁵ Texas Department of State Health Services. *Texas Chronic Disease Burden Report*, 2010.

¹⁶ Texas Department of State Health Services. *Behavioral Risk Factor Surveillance Study Special Report*, 2009.

¹⁷ University of Wisconsin. *County Health Rankings*, 2011.

¹⁸ Search Institute, *Lubbock ISD Developmental Assets Survey*, 2009.

Health Behavior: Binge Drinking

Summary: Binge drinking, a significant risk factor for health outcomes, is a growing concern for adults and adolescents. This behavior occurs more frequently with men and is more prevalent in Lubbock than other CHS service area counties, perhaps related to the presence of colleges and universities.

Background: Binge drinking, defined as five or more drinks for men and four or more drinks for women on one occasion, is a risk factor for several health outcomes: alcohol poisoning, heart attacks, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, suicide, interpersonal violence, and motor vehicle crashes.¹⁹ It is estimated that alcohol use is the cause of 5% of the deaths from heart disease, cancers, injuries, and motor vehicle injuries.²⁰

Key types of data:

- Self-report by adults (Behavioral Risk Factor Surveillance Survey, BRFSS)
- Self-report by youth ages 12-17 (Youth Risk Behavioral Survey, YRBS)
- Self-report by high school youth (Developmental Assets survey, Lubbock Intermediate School District, 2009)

National data: The demographic categories most likely to participate in binge drinking are men ages 18-34, Caucasians, and persons in households with incomes greater than \$50,000. However, the highest average number of binge drinking episodes occurs in households with an annual income under \$25,000.²¹ Among youth ages 12-17, binge drinking accounts for 90% of alcohol consumption.

State data: Alcohol is the primary drug of abuse in Texas, with binge drinking a particular concern. In 2010, 14.8% of the adult state population were binge drinkers, ranking Texas as 21st among the states. In 2008, 13% of all secondary students reported binge drinking, a relatively stable rate since 1992. Almost 30% of Texas college students reported binge drinking.²²

Local data: In the area of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties, the 2009 BRFSS study found that 16% of the adult population were binge drinkers. Consistent with national trends, there is significant variation by sex, income, and ethnic group. The rate for males was 20.8%, compared to the female rate of 11.4%. Those with incomes under \$25,000 had a rate of 19.2%, while those with higher incomes had a 15% rate. The rate for the Hispanic population was 32.6%, compared to a rate of 11% for the white population.

¹⁹ Centers for Disease Control and Prevention. Sociodemographic differences in binge drinking among adults-14 states, 2004. *Morbidity and Mortality Weekly Report*. 2009; 58: 301-304.

²⁰ McGinnis, JM and Foege, WH. *op cit*.

²¹ Miller JW, Naimi TS, Brewer RD, Jones SE. Binge drinking and associated health risk behaviors among high school students. *Pediatrics*. 2007; 119: 76-85.

²² Addiction Research Institute. *Substance Abuse Trends in Texas: June 2010*.

Some data about adult binge drinking are available by counties, demonstrating significant differences. When averaged over the years 2002-2008, Lubbock County's rate is 18%; Crosby County 7%; Lamb County 10%. County-specific data are not available for the other local counties.²³

The 2009 Developmental Assets survey in the Lubbock Intermediate School District provides some additional information. Among students in grades 8-12, an average of 25% had gotten drunk once or more in the last two weeks. The rates increased significantly across ages, from 16% in grade eight through 49% in grade twelve. Twenty-eight percent of the boys and 22% of the girls had gotten drunk in this time period. Consequences in risk-taking behaviors also are documented in the survey: 15% of the respondents had driven after drinking, and 45% had ridden with a driver who had been drinking in the last 12 months.²⁴

Binge Drinking Community Assets Summary

The Binge Drinking Asset mapping grid reflects the following services specifically addressing binge drinking in our community.

Services include:

- Celebration of Recovery Meetings
- Families Anonymous Meetings
- Alcoholics Anonymous Meetings

Alcoholic's Anonymous meetings are open to the public. The Center for Study of Addiction and Recovery at Texas Tech University also conducts Families Anonymous meetings and Celebration of Recovery Meetings. Persons who are binge drinkers are welcome to attend these meetings to get the support of trained facilitators, as well as support from others struggling with similar alcohol abuse issues. Binge drinking is often addressed through other substance abuse programs in the community. It is rarely singled out and addressed as a separate issue.

Implications

Binge drinking is an important social issue within our community. It affects crime, violence and family dynamics. There is not an organized campaign to educate the community on the effects and dangers of binge drinking.

²³ University of Wisconsin, *County Health Rankings*, 2010.

²⁴ Search Institute, *Lubbock ISD Developmental Assets Survey*, 2009.

Access to Care

Summary: Timely and appropriate access to healthcare is a significant factor in health and in health costs. Texas ranks very poorly in key aspects of access, including insurance coverage and use of primary care physicians for both adults and children. Local and Covenant-specific data suggest access problems in primary and outpatient care for the economically poor, negatively affecting health status and leading to the use of more costly and less appropriate alternatives, including inpatient and Emergency Department services.

Background: National definitions of “access to care” encompass factors of insurance coverage, availability of appropriate services (particularly primary care), timeliness of care, and necessary workforce. Access to care has been demonstrated to have measurable impact on health status, prevention of disease and disability, quality of life, and life expectancy for individuals, as well as health equity across populations. Lack of access to preventive and primary care often yields later detection of disease and more costly interventions.

Key types of data:

- Insurance: Self-reports on health insurance coverage (BRFSS)
- Lack of access to appropriate level of care: Inpatient admissions for conditions defined as “ambulatory care sensitive conditions” (ACSC) by national quality standards; use of Emergency Department for diagnoses that could have been addressed in primary care settings (Covenant Health System data); self-reported visits to primary care physician for routine checkup and delays in seeking care (BRFSS)
- Healthcare workforce: Ratio of primary care physicians to population (Internal Covenant Health data)

National data:

Insurance: In 2009, there were over 50 million persons without health coverage, due to declines in employer-sponsored coverage, a high unemployment rate, and cost of coverage. About 60% of the uninsured have at least one full-time worker in their family and have no education beyond high school. These persons have no regular source of healthcare, and are more than twice as likely to delay or forgo needed care. Medical bills forced 27% of uninsured adults to use up all or most of their savings in 2009.²⁵

Lack of access to primary/outpatient care: Approximately 12% of all 1990 hospitalizations were potentially preventable, with higher rates among middle and lower income groups.²⁶ National admission rates for the sixteen defined adult ambulatory care sensitive conditions indicate that the highest admission rates are for congestive heart failure, bacterial pneumonia, chronic obstructive pulmonary disease, and urinary tract infections.²⁷

²⁵ Kaiser Foundation. *Key Facts*, September 2010.

²⁶ University of Wisconsin. *County Health Rankings*, 2011.

²⁷ Agency for Healthcare Research and Quality, 2010.

In 2008, 27% of adults went to the Emergency Room for a condition that could have been treated by a regular doctor, if available.²⁸ Chronically ill individuals without insurance are four to six times more likely to have problems accessing care, and therefore rely on Emergency Departments for primary care.²⁹

Access to preventive care: Vulnerable populations obtain less information about their health. In 2005, the percentage of obese adults who received advice from physicians about changing their diet was significantly lower for poor and near-poor adults.³⁰

Workforce supply: Adequate primary care physician supply is associated with improved health outcomes, a lower prevalence of low birth weight, greater life expectancy, improved self-rated health, and lower probability of hospitalization for ambulatory-care sensitive conditions.³¹ However, charity care is being offered by less than half of medical practices, and at less than 2% of gross charges.³²

State data:

Insurance: In 2008, the state of Texas had the highest rate of uninsured adults under 65: 25.1%, compared to the national rate of 15.4%. Texas also had the second highest rate of uninsured children: 17.9% of Texas children were uninsured, compared to the national rate of 9.9%.³³

Lack of access to primary/outpatient care: Based on 2006-7 data, Texas had 78.7 preventable hospitalizations per 1000 Medicare enrollees, yielding a state ranking of 40th.

Workforce: In 2008, Texas had 95.4 primary care physicians per 100,000 population, ranking Texas 42nd in the country.³⁴ Texas ranks first in the country in the number of Health Professional Shortage Areas for primary care.³⁵

When four overall access factors (rate of nonelderly adults insured, rate of children insured, rate of at-risk adults visiting a doctor for routine checkup in last two years, rate of adults not seeing a doctor when needed due to cost) are compared across states, Texas has ranked 51st in both 2007 and 2009. Texas also has ranked 50th or 51st in terms of equity of care for the most vulnerable populations. With regard to avoidable hospital use and costs (including hospitalization for ambulatory care sensitive conditions), Texas ranked 42nd in 2009.³⁶

²⁸ Commonwealth Fund. *National Scorecard on US Health System Performance*, 2008.

²⁹ *Annals of Internal Medicine*, August 2008.

³⁰ Trust for America's Health, 2010.

³¹ University of Wisconsin, *County Health Rankings*, 2010.

³² Metzger, LM et al. Measuring physician contribution to the healthcare safety net, *Harvard Business Review*, 2010.

³³ Trust for America's Health, 2010.

³⁴ University of Wisconsin, *County Health Rankings*, 2011.

³⁵ Trust for America's Health, 2010.

³⁶ Commonwealth Fund. *State Scorecard on Health System Performance*, 2011.

When four child access and affordability factors (rate of children insured, rate of parents insured, rate of insured children for whom coverage is adequate, and cost of coverage premium as percentage of family household income) are compared across states, Texas ranked 50th in 2009.³⁷

Local data:

Insurance: In 2007, the percentage of adults under 65 without insurance in local counties was as follows: Lubbock 31%; Hale 30%; Crosby 36%; Lynn 34%, Hockley 27%; Dawson 29%; Gaines 40%; Lamb 33%; Terry 31%. The Texas rate for this period was 30%.

The 2009 Behavioral Risk Factor Surveillance Survey of an oversample of Crosby, Dickens, Gaines, Hale, Hockley, Lubbock, Lynn, and Terry Counties found that 22.1% of the adults did not have health insurance. The rate of women without insurance was twice as high as that of men. Among those with incomes under \$25,000, 39.9% did not have insurance; between \$25,000 and \$49,999 income, the rate was 21.7%; for those with incomes above \$50,000, the rate was 10.5%.

Lack of access to primary care:

Covenant Health System provides significant amounts of care in the Emergency Departments and in inpatient settings for the economically vulnerable. In FY 2010, the Emergency Department had 24,815 visits from Medicaid patients and 19,124 visits from self-pay patients.³⁸

Inpatient admissions also included a significant proportion for persons who are economically poor:

FY 2010 Covenant Health System Inpatient Admissions of Economically Poor Patients, by Payer Type and Age³⁹

	Self-pay	Medicaid	Medicare under 65*	Total Admissions of the Economically Poor under 65
Age				
0-21	264	3014	15	
22-64	1,344	2,019	2,197	
65 and over	12	17	NA	
SUMMARY				8,882

*Medicare patients under 65 are assumed for this analysis to be receiving Medicare due to disability and therefore likely to be economically poor. Delineation of Medicare/Medicaid coverage (to identify economically poor elderly) among Medicare patients over 65 was not available for this analysis.

However, the provision of Emergency Department and inpatient care for the economically poor may not be clinically (or financially) the most appropriate approach to access for these patients. In 2010, the Texas Dept of State Health Services calculated that the number of Lubbock County inpatient

³⁷ Commonwealth Fund. *State Scorecard on Child Health System Performance*, 2011.

³⁸ Covenant Health System Finance estimates that 90% of self-pay patients are economically poor.

³⁹ Covenant Health System Business Intelligence Department.

admissions for “potentially preventable hospitalizations” (a subset of Ambulatory Care Sensitive Conditions) over the years 2005 through 2008 was 14,727, with charges totaling over \$300 million.⁴⁰

When using 2006-7 Medicare data, the local county rates of preventable admissions (using ACSC criteria) per 1000 Medicare enrollees were these: Lubbock 89; Hale 73; Lynn 98; Hockley 145; Crosby 179; Dawson 112; Gaines 95; Lamb 128; Terry 140.⁴¹

Information about FY 2010 Covenant ACSC admissions among self pay and Medicaid patients suggest that the economically poor are experiencing some challenges with access to care. (Information about economic status or age of Medicare patients could not be determined for this analysis, and therefore Medicare patients are not included.)

FY 2010 Covenant Health System Inpatient Admissions for Ambulatory Care Sensitive Conditions for Self-Pay or Medicaid patients

Ambulatory care sensitive conditions (ACSC)	Self Pay ACSC Admissions	Medicaid ACSC Admissions	Total ACSC Admissions for Economically Poor under 65
Diabetes	46	41	87
--Short term complications	24	11	35
--Long term complications	13	23	36
--Uncontrolled	7	5	12
--Lower Extremity Amputation-Patient with Diabetes	2	2	4
Cardiovascular Disease	32	43	75
--Congestive heart failure	17	37	54
--Hypertension	12	6	18
--Angina without procedure	3	0	3
Pulmonary Disease	53	48	101
--Bacterial pneumonia	29	25	54
--COPD	4	11	15
--Adult asthma	20	12	32
Urinary Infections	16	25	41
Dehydration	8	6	14
Perforated appendix	8	0	8
TOTAL	163	153	316

⁴⁰ Texas Department of Health and Human Services, 2009.

⁴¹ University of Wisconsin, *County Health Rankings*, 2011.

In addition, information about utilization of the CH pediatric ED department by self-pay patients may suggest a lack of access to primary care resources for economically poor children. In 2010, the top ten diagnoses comprised 836 cases. Of these, over 50% were for acute upper respiratory infections and otitis media, potentially conditions that would have been more appropriately addressed in a primary care setting.⁴²

The BRFSS oversample study of Crosby, Dickens, Gaines, Hale, Hockley, Lubbock, Lynn, and Terry Counties gathered information on cost as a barrier to use of healthcare. In 2009, 16.7% of the adult population could not see a doctor because of costs. Among those with incomes of under \$25,000, the rate was 35.4%. Among Hispanics, the rate was 33.4%. In addition, income levels were highly related to the receipt of one standard preventive practice, a cholesterol check. Among those with incomes of less than \$25,000, only 58.2% had had a cholesterol check within the last 5 years, in comparison to 83.4% of those with incomes of \$50,000 or more.⁴³

The Covenant Medical Group clinics are Covenant’s sponsored source of primary care. For the period from December 2010 through January 2011, the percentage of self pay and Medicaid volume at these CMG clinics is as follows:⁴⁴

Percentage of Covenant Medical Group ambulatory clinic patients and visits that are self pay or Medicaid, December 2010 through January 2011

	Self pay patients (% of all)	Self pay visits (% of all)	Medicaid patients (% of all patients)	Medicaid visits (% of all visits)
Health Plus Clinic	11%	7.28%	7.8%	7.5%
Memphis Place Mall Clinic	26.8%	16.14%	0	0
Southwest Medical Park	5.67%	Under 1%	10.23%	12.31%
West Clinic	9.85%	5.59%	5.49%	5.88%

Workforce: The availability of primary care providers is significantly better in Lubbock County than in other local counties. The number of persons per primary care provider in each local county follows: Lubbock 650; Crosby 2070; Hockley 1238; Dawson 1962; Gaines 2512; Lamb 1933; Lynn 1425; Terry 1726; Hale 1954.⁴⁵ Crosby and Lynn Counties are designated as Health Professional Shortage Areas.

⁴² Covenant Health System Business Intelligence Department.

⁴³ Texas Department of State Health Services. *Behavioral Risk Factor Surveillance Study Special Report, 2009.*

⁴⁴ Covenant Medical Group.

⁴⁵ University of Wisconsin, *County Health Rankings, 2011.*

Access to Care Community Assets Summary

The following clinics and organizations provide out-patient care and/or prescription assistance services for Medicaid patients, Lubbock County Indigent patients and/or un-insured patients.

- **Covenant Medical Group (CMG)** accepts Medicaid, CHIP and self-pay. Self-pay patients are required to pay a \$100.00 deposit prior to receiving services. The Covenant Health Plus clinic is open M-F from 8:00am - 7:00pm, on Saturday 9:00am – 5:00pm and on Sunday from 12:00 – 5:00pm.
- **Texas Tech Medical School and Lubbock Impact** operate free clinic for children and adults. It is open on Wednesday evenings 6:00pm – 9:30pm only. This clinic is able to provide some prescriptions free of charge.
- **Community Health Center of Lubbock** is a Federally Qualified Health Center and accepts Medicaid, CHIP and self-pay. There is a sliding scale for self-pay patients who financially qualify. There are four clinic locations and all are open M-F from 8:00am – 5:00pm. The Parkway Clinic is open from 9:00am – 5:00pm on Saturdays for the treatment of general illnesses.
- **Larry Combest Community Health & Wellness Center** is a Federally Qualified Health Center serving Lubbock and surrounding areas. Medicaid and self-pay patients are accepted. There is a sliding fee scale for eligible un-insured clients and payment arrangements are available. Clinic hours are M-F from 8:00am – 5:00pm.
- **Lubbock Children’s Health Clinic*** has two locations and accepts Medicaid, CHIP and self-pay. There is a sliding scale for self-pay patients who financially qualify and no patient is turned away due to inability to pay. The clinics are open M-F from 8:00am – 5:00pm.
- **The Sick Children's Clinic*** is a free, all-volunteer clinic that treats sick children up to age 15. Prescriptions at the on-site pharmacy are free. The days and hours of operation depend upon doctors' schedules. The clinic does not do well baby checks, school physicals or immunizations. It is a ministry of Second Baptist Church.
- **Texas Tech Physician’s of Lubbock** accepts Medicaid, CHIP, Lubbock County Indigent (LCI) and self-pay patients. Self-pay patients are expected to pay at the time of service. The payment amount required depends on the type of service provided. Financial screeners are available to assist un-insured patients with applications for LCI and Medicaid. Clinics operate M-F from 8:00am – 5:00pm.
- **Catholic Family Services*** provides prescription assistance to those who financially qualify.
- **The Lutheran Social Services Health for Friends Clinic** is a nurse-managed clinic that provides free health screening, one-on-one support, and lifestyle education to low-income adults diagnosed as having, or being at risk for, chronic health issues such as diabetes, hypertension, high cholesterol, and morbid obesity. Most patients served are without medical insurance although a few have Medicaid benefits. The clinic operates M-F 8:00am – 4:30pm.
- **Several local private providers accept Medicaid**

*Received Covenant Community Health Outreach Grant in FY11.

Implications

Adults must be at or below 100% of the Federal Poverty Guideline to qualify for the Lubbock County Indigent (LCI) program. Many un-insured adults do not qualify for LCI or for any other government sponsored program. These patients are considered self-pay and generally cannot afford the required deposits and up-front payments to be treated in a clinic. These patients often have no medical home and go without treatment until their conditions are severe. Their diseases are not managed in the out-patient setting. When they become extremely ill they turn to emergency rooms for care. Once they seek treatment the low-income patients frequently have difficulty paying for their prescriptions and very few prescription assistance programs are available.

Clinical Condition: Oral Health

Summary: Oral health has a noteworthy impact on overall health. Rates of tooth decay are particularly high among low income persons, and the early occurrence of problems among very young children is a growing concern. Rates of dental disease and lack of access to preventive and restorative treatments for adults and children in Texas are significantly higher than national averages. Dental disorder was the most frequent diagnosis for self-pay adult patients in Covenant's Emergency Department in 2010.

Background: The health of the mouth and surrounding structures is central to a person's overall health, and can contribute to or indicate other diseases. Major improvements have occurred in the nation's oral health, but an emerging oral health issue is the increase of tooth decay in preschool children. Tooth decay among children is five times more common than asthma and seven times more common than hay fever. Periodontal disease among mothers is correlated with low birth weight infants.⁴⁶ Lack of access to dental care for all ages is a continuing public health challenge. Children receiving dental sealants in school-based programs have 60% fewer new decays.⁴⁷

Key types of data:

- Self-reported untreated decayed tooth
- Receipt of preventive dental services by Medicaid children
- Rate of community water fluoridation
- Death rate from oral/pharyngeal cancer
- Use of Covenant ED for dental disorders among self-pay patients

National data: The probability of tooth decay is highest and the probability of receiving treatment is lowest for adults living below the poverty level. As a result, over 40% of poor adults have at least one untreated decayed tooth, compared to 16% of non-poor adults. More people living below the poverty level in America have lost all of their teeth, compared to those living above the poverty level.

Dental caries remains the most common chronic disease of children aged 6-11 years (25%) and adolescents aged 12-19 years (59%). For children 2-9 years of age living below the poverty level, 37% have one or more decayed primary teeth, compared to 17% of children living above the poverty level. Fewer than 35% of children enrolled in Medicaid received at least one preventive dental service in a recent year.⁴⁸

State data: For two national Healthy People 2020 oral health measures, Texas exceeds national performance: community water fluoridation and death rate from oral/pharyngeal cancer. Seventy-eight percent of Texas' water has appropriate fluoride levels, compared to 62% nationwide. Data are not available for the rate of untreated caries among adults in Texas. Only 33% of the total population over two years of age has had a dental visit in the past year, compared to 43% nationwide.⁴⁹

⁴⁶ Davenport E. S., et al. *Annals of Periodontal Disease*, 1998; 3: 213-323.

⁴⁷ Centers for Disease Control and Prevention. *Oral Health Fact Sheets*, 2011.

⁴⁸ Centers for Disease Control, 2000.

⁴⁹ Texas Department of State Health Services, *Oral Health in Texas*, 2008.

For Texas children, the rates for untreated caries are worse than the national average. Among young children ages 2-4, 29% of Texan children have untreated caries, compared to 20% nationally. Among Texas children ages 6-8, the rate of untreated caries is 44%, compared to the national average of 26%. With regard to preventive treatment, 20% of children at age 8 have received dental sealants, compared to 28% nationally.⁵⁰ Only 74% of children ages 1-17 had a preventive dental care visit in the past year, placing Texas at the 49th ranking among states.⁵¹

Local data: Local data regarding the prevalence of dental disease among children or adults were not found.

Information about local oral health service utilization may be useful in estimating level of unmet need:

- Dental disorders were the diagnosis of highest frequency of visits for self-pay patients in the Covenant adult Emergency Department during 2010, representing almost 17% of the visits.
- Dental disorders did not appear as a category among the self-pay patients seen at the Covenant pediatric Emergency Department during 2010.⁵²
- Texas Dept of State Health Services has identified a standard that all Medicaid children should receive two dental checkups per year. In 2009, 7.4% of Medicaid children met that standard in Lubbock County; in Hockley County, 6.2%; in Lamb County, 4.8%; in Hale County, 3.9%.⁵³

Oral Health Services Community Assets Summary

Services provided for the underserved by local providers include:

- General dentistry
- Sealants
- Denture services and vouchers
- Limited root canal services
- Referral for treatment
- Vouchers

The Oral Health Asset mapping grid reflects an increasing need and a wait list for those persons without dental insurance. Covenant Community Health Outreach and Community Health Center of Lubbock are the only two community providers in Lubbock county serving un-insured dental patients. There are a few agencies that have funding to provide vouchers for dental services; however, there is some uncertainty about how state budget cuts will affect these dental voucher programs. Some private dental offices currently accept Medicaid patients; however, if Medicaid reimbursements are decreased there is concern that fewer private dentists will accept Medicaid patients.

Community Health Center of Lubbock has a dentistry program for adults and children. CHCL provides a wide range of services, but does not perform posterior root canals. There is a denture program for established patients who comply with the treatment plan. CHCL has a mobile unit and also has extended service hours on Tuesday and Wednesday and is open every other Saturday. An adult

⁵⁰ Ibid.

⁵¹ Commonwealth Fund. *State Scorecard on Child Health System Performance*, 2011.

⁵² Covenant Health System, Business Intelligence Department.

⁵³ Texas Department of State Health Services, 2010.

hygiene program is also available. The dental program at CHCL is open to both insured and un-insured patients. Due to overwhelming demand, they are not accepting new adult patients unless referred from UMC ER or from another CHCL provider. Covenant Community Health Outreach (CHO) has a dentistry program for adults and children. Three dentists serve Lubbock and the surrounding region. One dentist is currently dedicated to children and two are dedicated to adults. Comprehensive dental treatment plans are offered to every patient in the program. There is also a denture program. CHO is not currently accepting new adult patients in Lubbock and has closed the wait list due to a demand greater than resources. CHO does see adult patients referred from Covenant's ED every Thursday.

Implications

There is an identified need for dental services in the Lubbock and surrounding region. The greatest need at this time is services for adults. Both Covenant CHO and CHCL have closed their Lubbock wait lists for adult patients. Many adults in the Covenant CHO service area do not have access to dental insurance and many children who are on Medicaid are not meeting the recommendations for two dental visits per year. Covenant Community Health Outreach currently provides a valued and needed service at this time that could potentially be expanded and/or restructured to meet the growing need.

Clinical Condition: Mental Illness

Summary: Mental illness has a substantial negative impact on quality of life and health. Approximately 6% of the adult population has a serious mental illness. Access to services is a particularly difficult problem in Texas for adults and children, due at least in part to low funding levels. Local data are very limited.

Background: Mental disorders are among the most common causes of disability, accounting for 25% of all years of life lost to disability and premature mortality. Mental health and physical health are closely connected, as problems in one domain often impact the other domain. The main burden of illness is concentrated in the 6% who suffer from a serious mental illness. About 20% of children, either currently or at some point in their life, have had a seriously debilitating mental disorder.⁵⁴

Key types of data:

- Admission data from facilities
- Prescription records
- Self-report data for adults (BRFSS)
- Self-report data for youth (Developmental Assets Survey)

National data: In 2008, 13.4% of adults received treatment for a serious mental health problem. Of these, 7.5% received inpatient treatment; 40.5% outpatient treatment; 52.5% received prescription medications. Among adults with any type of serious mental health problem, 58.7% received care, while 71% of those with major depression received care.⁵⁵

The use of Emergency Departments (ED) for mental health/substance abuse care has also risen over the last decade. In 2007, 12.5% of all ED visits in the US were for a diagnosis related to a mental health or substance abuse condition. These visits were two and a half times more likely to result in a hospital admission than other conditions. Of these, 20.6% were uninsured and 19.8% were covered by Medicaid. Mood disorder was the most common reason for an ED visit (42%). A national survey of ED physician directors noted that the resource-intensive care required for these patients has an impact on the quality of care for all patients in the ED.⁵⁶

State data: Fewer than half of the eligible mental health population received services in 2002, with per capita spending of \$39.01 (nationally ranked at 47th). Of children ages 2-17 needing mental health treatment, 41.7% received that care in 2007, compared to a national average of 63%. Texas is nationally ranked at 51st for access to mental health care for children.⁵⁷

Local data: In the area of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties, a 2009 BRFSS study of adults found that 18.8% of the adult population had experienced five or more

⁵⁴ National Institute of Mental Health. Statistics, 2011.

⁵⁵ ibid.

⁵⁶ Owens, PL, Mutter, R, and Stocks, C. "Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007," Agency for Healthcare Research and Quality.

⁵⁷ Voices Transforming Texas, *Texas Assessment of Mental Health Needs and Resources*, 2006.

days of poor mental health. These rates varied significantly among subpopulations, with these particularly high rates: 32.3% of those 18-29 years of age; 27.3% for persons with income under \$25,000, and 27.6% for Hispanic persons.⁵⁸

The 2009 Developmental Assets survey of 8-12th graders in Lubbock Independent School District found that the students reported more developmental assets than national averages. However, 19% said that they had felt sad or depressed most or all of the time in the last month, and 18% reported that they had attempted suicide at least once. Fifteen percent also indicated that they had engaged in bulimic or anorexic behavior. For all of these conditions, the rates among females were significantly higher than for males.⁵⁹

Lubbock County's rate for family violence was 90% higher than the Texas average, and the rate of child abuse was 120% higher than the Texas average.⁶⁰

Mental Health Services Community Assets Summary

The Mental Health asset mapping reveals that counseling services are offered on a limited basis to Medicaid patients and the un-insured with mental disorders. The following are identified services for the vulnerable populations in the community.

- Counseling services
- Diagnoses of ADHD, ADD, Mood and Behavior Disorders
- Medication management (very limited)
- Psychosocial and Rehabilitation services
- Substance abuse education

Funding for many of these services is dependent on State or Federal support.

The Covenant Community Health Outreach Counseling Center provides individual, couples and family counseling services for those who are financially disadvantaged. To qualify for the program one must be at 200% or below the federal poverty guidelines. The Larry Combest Center provides medication management by primary care physicians and nurse practitioners for depression, anxiety and behavioral problems. The Combest Center also provides limited counseling services by a licensed clinical social worker. These services are provided to un-insured patients on a sliding fee scale basis. Lubbock Impact operates a free clinic on Wednesday evenings from 6:00 – 9:30. The clinic is quite limited on the number of patients that can be seen in one evening. People arrive early and stand in line to be treated. This clinic does provide free mental health prescriptions for persons with major depressive disorder and bipolar disorder. The Community Health Center of Lubbock (CHCL) provides counseling services to low income patients, but is only able to offer services to patients who are currently being treated by a CHCL primary care physician. Due to overwhelming demand they are unable to accept patients who are not established with CHCL. The Texas Tech Family Therapy Clinic offers individual, couples, and family counseling services. These services are offered to insured and un-insured patients. There is a sliding scale fee for those who financially qualify. Lubbock Mental Health and Mental Retardation (MHMR) provides medication management and case management services to Medicaid

⁵⁸ Texas Department of State Health Services. *Behavioral Risk Factor Surveillance Study Special Report*, 2009.

⁵⁹ Search Institute. *Lubbock ISD Developmental Assets survey*, 2009.

⁶⁰ Lubbock Area United Way. *Community Status Report*, 2010.

patients but is not accepting new patients. Lubbock MHRM has experienced significant budget reductions and is anticipating additional budget cuts.

Implications

There is an identified gap in medical interventions, prescription assistance, prescription management and access to psychiatrists for un-insured and Medicaid mental health patients. Unfortunately the need for mental health services is growing but the services available are shrinking. Budget reductions at the state and federal level have negatively impacted the ability for organizations to meet the growing mental health needs in the communities we serve. Covenant CHO currently provides counseling services and is working towards creating more stable collaborations with area physicians for prescription maintenance.

Clinical Conditions: Diabetes

Summary: Diabetes is a serious chronic disease, which often leads to serious health complications. The prevalence of diabetes and its associated risk factors of high blood pressure, high blood cholesterol levels, and obesity are high and increasing in the CHS service area. It is estimated that an additional 30% of diabetics have not been diagnosed.

Background: Type 1 diabetes occurs in 5-10% of cases of diabetes, with autoimmune, genetic, and environmental risk factors. For Type 2 diabetes, high blood pressure, high blood cholesterol levels, and obesity are the top three risk factors. The rate of diabetes continues to increase, and Type 2 diabetes is occurring at earlier ages. Diabetes is a major cause of cardiovascular disease and is the leading cause of kidney failure, nontraumatic lower limb amputations, and new cases of blindness. Medical expenses for people with diabetes are more than two times higher than for people without diabetes. Gestational diabetes, which occurs in 2-10% of pregnancies, increases risks to mother and fetus and increases the probability of later diabetes in mothers.⁶¹

Key types of data:

- Self report (Behavioral Risk Factor Surveillance Survey)
- Hospital admission data
- Death data

National data: Diabetes affects 8.3% of the US, population, but approximately 30% of those who have diabetes have not yet been diagnosed. Prevalence by age varies significantly, with rates of less than .5% of those under 20, 3.7% of those 20-44, 13.7% of those 45-64, and 26.9% of those 65 or over. Differences in prevalence by race/ethnicity are partially attributable to age differences. After age adjustments, 7.1% of non Hispanic whites, 8.4% of Asian Americans, 11.8% of Hispanics, and 12.6% of non-Hispanic blacks have diagnosed diabetes. Diabetes is the seventh leading cause of death in the US.⁶²

State data: Approximately 1.8 million adult Texans have adult diabetes, and it is estimated that another 460,000 are undiagnosed diabetics. There has been a steady increase in the rate of diabetes from 2000 to 2007, rising from 6.2% to 10.3% of the adult population. Rates by ethnic group and by age parallel national trends. It is the sixth leading cause of death in Texas, and the fourth leading cost of death for African Americans and Hispanics/Latinos. Approximately 21.9% of adults with diagnosed diabetes do not have health insurance.⁶³

⁶¹ Center for Chronic Disease Prevention and Health Promotion. *National Diabetes Fact Sheet*, 2011.

⁶² Ibid.

⁶³ Texas Diabetes Council. *The Burden of Diabetes in Texas*, 2008.

Local data: Calculations of the prevalence of diagnosed diabetes are all drawn from the BRFSS self-report data, but vary depending on survey sample and year. The 2007 standard BRFSS study found that 10.7% of Lubbock County residents had been diagnosed with diabetes but did not have adequate data to estimate other local counties.⁶⁴ In another analysis of 2007 data, Lubbock Metropolitan Service Area had a diabetes rate of 11.6%. The 2009 BRFSS study (with a larger sample) encompassing Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties found that 6.8% of the adults had been diagnosed with diabetes, with no significant variations by income.⁶⁵ The rate of deaths from diabetes in Lubbock County, 38.6/100,000, is higher than the Texas rate of 26.5/100,000.⁶⁶

Information about use of Covenant inpatient services for diabetes by the economically poor may provide some useful information as well. In 2010, over 27% of the ambulatory care sensitive condition admissions for self-pay and Medicaid admissions were for diabetes-related issues.⁶⁷

Diabetes Community Assets Summary

The following are services offered to diabetics in the community.

- Disease self-management classes
- Family centered diabetes education
- Screenings and One on One Consultations
- Senior house calls
- Two providers provide information in English and Spanish
- There are a few agencies providing funding for Diabetic supplies. A few local agencies help provide test strips to those who financially qualify although they report there are more people in need than they have the funds to help.

Community Health Center of Lubbock (CHCL) has a limited program. They offer free diabetic education classes taught by Promotoras but they do not have a full time diabetic educator for their clinics. CHCL does offer classes in the evenings. The AgriLIFE Extension Services collaborate with CHCL to offer community diabetes classes and education to the Promotoras. The Combest Center Diabetes Education Program is comprised of an interdisciplinary team of professionals, including a Certified Diabetes Educator. Diabetes classes are offered during the daytime and evening. The Combest Center bases fees for services on a sliding scale fee and also accepts Medicaid, Medicare, and private insurance. The Covenant Community Health Outreach (CHO) program offers free nutrition and diabetic classes, test strips, and individual consultations. The program is limited because there is only one educator. Services offered are monthly classes, school outreach and one-on-one consultations. The Children's Health Clinic of Lubbock and CHCL both refer patients to the Covenant CHO health educator for diabetes/nutrition consultations and education.

The American Diabetes Association noted that persons still call looking for the type of service Covenant Diabetes Center used to provide.

Implications

⁶⁴ Texas Department of State Health Services, 2007.

⁶⁵ Texas Department of State Health Services, *Behavioral Risk Factor Surveillance Study Special Report*, 2009.

⁶⁶ Texas Department of State Health Services.

⁶⁷ Covenant Health System Business Intelligence Department.

There is an identified gap between clinical services and educational/preventative services. There is also a deficit in assets related to early intervention, health education, physical fitness programs and preventative education within the schools due to program and budget cuts. There are limited funds available for community providers to assist with diabetic supplies such as test strips and medications. Medications and supplies can be very costly and many patients do not regularly test their blood sugar levels because they cannot afford the strips. Covenant CHO's current Health Education program could be redesigned to better meet the needs of diabetics in our community. Community partnerships and collaborations to address diabetes could also be better developed.

Clinical Condition: Maternal and Child Healthcare

Summary: Maternal and child health are key determinants in long term health status. In the CHS service area, the rate of access to pregnancy care is extremely low, and the rate of low birth weight babies is higher than the state average. A large proportion of local births occur to unmarried mothers, and the local rate of teen mothers is slightly higher than the state average. The provision of prevention and treatment services for children is also very low in Texas. In addition, Texas ranks 50th among the states in equity of services and access for the most vulnerable children.

Background: Pregnancy, childbirth, and the first few years of a child's life are extremely important in the child's long term cognitive, physical, social, and emotional development. Eighty percent of a child's brain develops before the age of four, and research on a number of adult medical conditions points to the importance of early childhood. Factors affecting pregnancy and childbirth outcomes include preconception health status, access to appropriate healthcare, age, use of tobacco, substance abuse, and poverty. Low birth weight reflects maternal exposure to health risks and the infant's current and future health status.⁶⁸ Factors affecting child health include health, nutrition, and behavior of mothers and families. Significant disparities across racial/ethnic and economic groups continue to exist in maternal, infant, and child health.

Key types of data:

- Receipt of early prenatal care: birth certificates
- Low birth weight (low birth weight: less than 2500 grams; very low birth weight less than 1500 grams); unmarried and teen age pregnancy rates: birth certificates
- Prevention and treatment in childhood: medical home, vaccinations, preventive medical care visits: medical records

National data: Fewer than half of all pregnancies are planned.⁶⁹ In 2007, 70.5% of mothers had early and adequate prenatal care. Rates of low birth weight and very low birth babies have increased in recent years. In 2007, 8.2% of births were low birth weight, and an additional 1.5% were very low birth babies. Of children between 0-17 years, 57.5% had access to a medical home to supervise their medical care.⁷⁰

State data: Texas' 2010 rate of prenatal care within the first trimester is 59.1%, the lowest in the country.⁷¹ In 2007, almost 41% of Texas births occurred to unmarried mothers and 4.9% to adolescent mothers (under 18 years of age). The 2007 rate of low birth weight babies was 8.4%, only slightly higher than national average.⁷²

For children's health (ages 0-17) , Texas is ranked 48th nationally in prevention and treatment, as only 50.3% of children have a medical home, 66.7% have received all required vaccinations by 36 months, and 85.6% of children have had a preventive medical care visit in the past year. When several variables related to preventive and treatment services and access and affordability of care are utilized to

⁶⁸ Centers for Disease Control, Healthy People 2020.

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ United Health Foundation. *America's Health Rankings*, 2010.

⁷² Trust for American's Health, 2010.

compare Texas performance for the most vulnerable to the US national average, Texas ranks 50th in equity of its child health system.⁷³

Local data: In Lubbock County in 2007, 41.7% of mothers were unmarried, and 6.3% were adolescents, both higher than the statewide rates. The rate of adolescent motherhood is 10.9% for Hispanic women, 6.6% for African American women, and 1.9% for white women.⁷⁴

The rate of early prenatal care in Lubbock County has paralleled the state rate closely over the last 10 years, with a gradual decline. In 2005, 65% of mothers received prenatal care in the first trimester; in 2006, 60.3% of mothers; in 2007, 58.1%. In 2007, only 50.4% of African American mothers and 51.8% of Hispanic mothers received early prenatal care, compared to 71.2% of white mothers.

The county's rate for low birth weight babies was 11.1%, notably higher than the state level of 8.4% in 2007.

Local data regarding post-delivery child health outcomes was not found.

⁷³ The Commonwealth Fund, *Child Health System Performance*, 2011.

⁷⁴ Texas Department of State Health Services, *Selected Health Facts*, 2007.

Maternal / Child Health Community Assets Summary

The Maternal and Child Health asset mapping found a variety of services offered to under-served expectant mothers, infants, and children in the CHS service area.

- Car Safety Seat Classes
- Education on Community Resources
- Childhood Immunizations
- Parenting Tips
- Women's Health Screening
- STD Screening
- Prenatal Classes
- Referral to Medicaid Doctors
- Incentives for Receiving Prenatal Care
- Home Nurse Visits
- Pediatric Clinical Care for Medicaid and Uninsured Children
- Assistance with Medicaid and CHIP applications
- WIC Nutritional Education
- Prenatal counselors
- Hearing and Vision Screening for Children

In addition to several private providers in Lubbock; TTUHSC, CMG, UMC, CHCL, The Lubbock Children's Health Clinic and Larry Combest Center all accept Medicaid women and children in their clinics. There are also several specialized services available to vulnerable women and children in our area. Larry Combest Wellness Center offers a Nurse Family Partnership Program. This is an evidence-based community health program that helps vulnerable mothers pregnant with their first child. The nurse-client relationship is focused on improving pregnancy outcomes, child health and development and economic self sufficiency of first-time families. Each family served has a registered nurse home visit twice a month and this continues until child is two years old. The Nurse-Family Partnership program is free to eligible low-income participants. Services are provided to the following counties: Lamb, Hale, Floyd, Hockley, Lubbock, Crosby, Terry, Lynn and Garza. The Storks Nest is specialty service for at-risk pregnant women which provides incentive points for pre-natal visits, prenatal classes, and provides referral to Medicaid doctors. Women participating in the program earn these points for the purchase of baby items. The Grand Expectations program provides a counselor to assist at risk women with choosing a doctor and applying for Medicaid. The YWCA also assists women in completing Medicaid and CHIP applications. The Parenting Cottage, the March of Dimes, and AgriLIFE Extension all offer education and support to at-risk pregnant women.

Implications:

There does not seem to be a lack of services offered related to Maternal and Child health in our area. Based on secondary data, it is clear many pregnant women and new parents are either not connected to these services, encounter barriers accessing these services, or choose not to take advantage of the services offered.

Clinical Condition: Substance Abuse

Summary: Alcohol abuse comprises the major component of substance abuse, with substantial impacts on health and safety for the individual, family, and community. Data about the prevalence of diagnosed substance abuse within the Covenant service area are not available. Binge drinking data (included in Health Behaviors section) describe a behavior that may indicate or lead to alcohol abuse.

Background: Substance abuse has significant impact on physical and mental health, including liver damage, hypertension, heart attacks, fetal alcohol and sudden infant death syndromes, sexually transmitted diseases, and suicide. Other societal consequences may include domestic and child abuse, motor vehicle crashes, and crimes. Social attitudes and legal responses make substance abuse a very complex public health issue to address. Emerging issues in substance abuse include the rise in adolescent abuse of prescription drugs and substance abuse among veterans.

Key types of data:

- Self-report of substance abuse (National Epidemiological Survey on Alcohol and Related Conditions and Behavioral Risk Factor Surveillance Survey)
- Admission rates for substance abuse treatment programs (State of Texas)

National data: In 2005, an estimated 17.6 million Americans met standard criteria for an alcohol use disorder, and an additional 4.2 million met criteria for a drug use disorder. About 20% of those with a substance abuse disorder also experience a mood or anxiety mental disorder.⁷⁵ Almost 95% of people with substance use problems are considered to be unaware of their problem.

State data: Alcohol is the primary drug of abuse in Texas. It is estimated that 2.71% of Texas were dependent on or had used an illicit drug in the last year, slightly below the national average.⁷⁶ Comparable information about population rate was not available for alcohol abuse. Clients of public treatment programs include both alcohol and other drugs. In 2009, 28% of clients admitted to publicly funded treatment programs had a primary problem with alcohol. Of these clients, 70% were male, 30% were Hispanic, average age was 39 years, and 46% were polydrug users.⁷⁷

Local data: Local data about the prevalence of diagnosed substance abuse disorders are not available. In addition to binge drinking, another behavior which might indicate or lead to an alcohol abuse disorder is heavy drinking, defined by the BRFSS as more than one drink/day for women and more than two drinks/day for men. The 2009 BRFSS study of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties found that 4% of the population was at risk for heavy drinking. This rate was five times higher for those between 18 and 29 years than for any other age group. Rates varied significantly by income: below \$25,000, the rate of

⁷⁵ National Institute on Alcohol Abuse and Alcoholism, March 2011.

⁷⁶ Addiction Research Institute. *Substance Abuse Trends in Texas*, June 2010.

⁷⁷ ibid.

heavy drinking was 6.1%; between \$25,000 and \$49,999, the rate was 1.2%; above \$50,000, the rate was 5.2%.

A recent national method of estimating potential substance abuse is the percentage of adults who report either binge drinking or heavy drinking. The Lubbock County rate is 18%, compared to a Texas rate of 16%. Data for the other counties in the CHS service area are not available.⁷⁸

Substance Abuse Community Assets Summary

The Substance Abuse asset mapping reflects the following are services available to community members in need of assistance for addictions.

- Individual and Group Counseling
- In-patient Detox
- Halfway House
- Support Groups
- Recovery meetings
- Substance abuse treatment
- Methadone Maintenance

Funding for agencies and organizations addressing substance abuse is provided by Medicaid, Medicare, the U.S. military, military insurance, private health insurance, grants, and private pay. Most of the services are either offered free of charge or on a sliding scale for unfunded persons. The Lubbock Faith Center Inc., offers a halfway house for recovering addicts. There is some state funding available to assist persons without the ability to pay but the funding is limited and in danger of being cut. The cost per person for self-pay is \$370.00 per month. Managed Care offers both in-patient and out-patient treatment programs. Financially qualified individuals can receive some help through state funding. This program is facing potential cuts do to federal and state budget reductions. Lubbock Mental Health and Mental Retardation (MHMR) offers a Methadone Clinic treatment program. There is also some state funding to help those who financially qualify. The Family Counseling Center offers counseling and education on substance abuse. Low income families are offered services at a reduced cost through a sliding fee scale, Medicaid is also accepted. There are active Alcohol Anonymous and Al-Anon groups in Lubbock to provide support to recovering alcoholics and their families. The Lubbock Justice System has several programs in place to assist with substance abuse recovery and rehabilitation of convicted offenders. The Department of Veteran's Affairs offers an out-patient program for veterans with combined mental health and substance abuse problems.

Implications

There is a gap in substance abuse services for the economically vulnerable within our community. It is well known that there is often a link between substance abuse and mental health issues so comprehensive programs are needed to support detox and to sustain recovery. While there are several recovery programs available, there is very little funding to support those without insurance or without financial resources. Private recovery centers require self-pay or insurance payments.

⁷⁸ University of Wisconsin, *County Health Rankings*, 2011.

Clinical Condition: Cardiovascular Disease

Summary: Cardiovascular disease (CVD) is a significant problem in the country and in the CHS service area, reflected both in its prevalence and its costs. Over half of the poorest group of adults in the CHS service area has at least one risk factor for cardiovascular disease.

Background: Together, heart disease and stroke are among the most widespread and costly health problems in the US, causing serious illness and disability, decreased quality of life, and huge economic losses. Both are also preventable, through focus on high blood pressure, high cholesterol, smoking, diabetes, poor diet and physical inactivity, and overweight and obesity.

Key data points:

- Self-report about disease (Behavioral Risk Factor Surveillance Study, BRFSS)
- Death data by condition

National data: In the US, 81.1 million adults live with one or more types of cardiovascular disease. There are significant disparities based on gender, age, race/ethnicity, geographic area, and socioeconomic status. High blood pressure affects approximately 30% of adults, and more than half do not have it under control.⁷⁹ Heart disease is the first and stroke the third leading cause of death.

State data: Cardiovascular disease was the leading cause of death in Texas in 2005, responsible for 49% of deaths. Of these, 81.1% were due to heart disease and 18.9% due to stroke.⁸⁰

Local data: In the area of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties, a 2009 BRFSS study of adults found that the risk factors for CVD were high: 38.9% had high blood cholesterol, with the rate for those with incomes under \$25,000 at 51.6%. The prevalence of high blood pressure was also higher among those with incomes less than \$25,000, at 30.9%.

The rates of CVD are consistently significantly higher for poorer populations. In the CHS area, 7.8% of the population have diagnoses of heart disease, while the rate for those with incomes less than \$25,000 is 11.5%. Similarly, 3.6% of the adult population had had a heart attack, while the rate for those with incomes under \$25,000 is 6.7%. Overall, 2.2% of the adults had experienced a stroke, while the rate for adults with incomes under \$50,000 was 2.4%, in contrast to .7% for those with incomes over \$50,000.⁸¹

Information about use of Covenant services for CVD diagnoses by the economically poor may provide some useful information as well. In 2010, approximately 24% of the ACSC admissions for self-pay and Medicaid patients were due to CVD.

⁷⁹ Centers for Disease Control and Prevention. *Healthy People 2020*, 2011.

⁸⁰ Texas Department of State Health Services. *Texas Chronic Disease Burden Report*, 2010.

⁸¹ Texas Department of State Health Services, *Behavioral Risk Factor Surveillance Study Special Report*, 2009.

Cardiovascular Disease Community Assets Summary

The Cardiology Services Asset mapping reflects the following services are offered to the underserved in the CHS service area.

- Health Screenings
- Health Fairs
- Blood Pressure Checks
- Basic Examinations by Primary Care Physicians

Funding for these community services is at risk of being cut due to budget cuts at the state and federal level.

The most vulnerable populations are adults with no insurance. University Medical Center and Texas Tech Health Sciences Center accept patients who are on the Lubbock County Indigent (LCI) program. Lubbock County residents who are at or below 100% of the Federal Poverty Level may qualify for the LCI program. These patients do have access to both primary and specialty care, but the financial guidelines are so stringent that many un-insured adults do not qualify for the LCI program. Patients who qualify for the Lubbock County Indigent (LCI) program can access cardiology services at the Texas Tech Health Sciences Center; however, many fall in-between 100% and 200% of the federal poverty guidelines and therefore are not qualified for the LCI program.

Lubbock Impact and Community Health Center of Lubbock (CHCL) both provide Primary Care services to low income individuals. CHCL also provides a medical home to individuals; however neither CHCL nor Lubbock Impact provides Cardiologists or specialty care for those in need of advanced services. The Larry Combest Center has a Chronic Disease Management Program for individuals with Hypertension. Sliding fee scales are offered to those who financially qualify.

Implications

Based on secondary data analysis, it is clear that cardiovascular disease affects the most vulnerable and economically disadvantaged at a higher rate than other populations. There is an identified need for access to Cardiologists and specialists related to cardiovascular disease. The clinics providing primary care to un-insured patients face real barriers when attempting to refer patients to specialists due to a lack of specialists in the region who will accept un-insured patients.

Clinical Condition: Respiratory Diseases

Summary: Available data suggests that respiratory diseases affect a modest proportion of the CHS service area population, with an asthma rate higher than in other areas of Texas.

Background: Chronic obstructive pulmonary disease (COPD) is a preventable and treatable disease characterized by airflow limitation. It is the fourth leading cause of death, with a strong genetic component. The prevalence of asthma, a chronic inflammatory disorder of the airways, has increased since 1980. Other respiratory diseases include tuberculosis, lung cancer, and pneumonia.⁸²

Key types of data:

- Self-report of diseases (Behavioral Risk Factor Surveillance System)
- Hospital admission data
- State death records

National data: Approximately 13.6 million persons have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. More than 23 million people have asthma.

State data: The prevalence of asthma in Texas remained relatively unchanged at approximately 7% between 2002 and 2008, consistent with national rates. The overall Age Adjusted Mortality Rate for asthma was generally stable between 2002 and 2006, at 1 case per 100,000 in 2006. There is significant geographic disparity in Texas hospitalization rates for COPD, with the highest rates of hospitalization by whites and those over 65 years of age.⁸³ For lung cancer, the Age Adjusted Mortality Rate was 4.5 per 100,000 in 2006.⁸⁴

Local data: In the area of Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn, and Terry Counties, a 2009 BRFSS study of adults found that 11.6% had asthma. Rates for lower income persons were slightly lower than the overall average, and the rate among Hispanics was 12.8%, higher than the 9.2% rate among whites.⁸⁵

In Lubbock County, 131 persons died from chronic lower respiratory disease in 2007, at a rate higher than the state average. Respiratory/lung cancer claimed 125 lives, at a rate slightly higher than the state rate. Forty persons died from influenza and pneumonia, at a rate slightly lower than the state rate.⁸⁶

Information about use of Covenant services for CVD diagnoses by the economically poor may provide some useful information as well. In 2010, 32% of the ACSC admissions of economically poor adults were for pulmonary diseases, including bacterial pneumonia, adult asthma, and COPD.

Respiratory Diseases Community Assets Summary

⁸² Centers for Disease Control and Prevention. *Healthy People 2020*, 2011.

⁸³ Jackson, BE et al., Geographic disparity in COPD hospitalization rates among the Texas population. *Respiratory Medicine*, 2011.

⁸⁴ Texas Department of State Health Services. *Texas Chronic Disease Burden Report*, 2010.

⁸⁵ Texas Department of State Health Services, *Behavioral Risk Factor Surveillance Study Special Report*, 2009

⁸⁶ Texas Department of State Health Services, *Health Currents Lubbock County*, 2011.

The asset mapping found that many local providers do offer treatment for pulmonary diseases with the primary focus on asthma.

Areas services include:

- Pediatric pulmonary services (pulmonary function, peak flow, nebulizer testing)
- Chronic disease management
- Disease education
- Clinical Services for Children and Adults
- Navigator Services Including Home Visits
- Health Education

Community Health Center of Lubbock provides pulmonary services in their clinics for adults and children. They accept commercial insurance, CHIP, Medicaid, Medicare and have a sliding fee scale for qualified un-insured patients. Texas Tech HSC also provides pulmonary services in their pediatric, internal medicine and family medicine clinics. They accept commercial insurance, CHIP, Medicaid, Medicare, and Lubbock County Indigent patients. TTUHSC also has a Pediatric Pulmonary clinic. Covenant Medical Group physicians treat patients for pulmonary/respiratory disease and accept commercial insurance, CHIP, Medicaid and Medicare. The Larry Combest Center Patient Navigator program helps adults address the management asthma through their Navigator program. The largest portions of patients participating in the Navigator Program are indigent. The Navigators make home visits and help the patients with finding prescription assistance, transportation, food vouchers and other basic needs. The Lubbock Children's Health Clinic provides clinical care to patients with asthma. They accept commercial insurance, CHIP, Medicaid, and the un-insured. Covenant Life-Styles Center offers a Pulmonary Rehab program. Patients who qualify for financial assistance through the hospital are accepted into the program however the majority of patients participating in the program are either commercially insured or on Medicare. The program consists of meeting with an instructor twice a week for pulmonary education, exercise and nutrition.

Implications

While secondary data reflects an increase in the prevalence of asthma, a chronic inflammatory disorder of the airways, since 1980, there is not a significant identified gap in specific pulmonary services for the under-served in our community. There is a gap in access to medications to treat many chronic diseases including pulmonary diseases which is addressed in the access to care section of this report.

Clinical Condition: Sexually Transmitted Diseases

Summary: The consequences of untreated sexually transmitted diseases can be serious for adults and infants. The prevalence of these diseases is low, when compared with other conditions.

Background: Chlamydia is the most frequently reported bacterial sexually transmitted disease. If untreated, Chlamydia infections can progress to serious reproductive and other health problems. Untreated gonorrhea can cause infertility in men or women or ectopic pregnancies and, if transmitted to a child, can cause blindness or blood infections. Untreated syphilis can affect infant mortality and illness and over time can severely damage internal organs.⁸⁷

Key types of data:

- Prevalence of reported Chlamydia
- Prevalence of reported gonorrhea
- Prevalence of reported syphilis

National data: Underreporting of Chlamydia is substantial, as many persons do not know they are infected. It is estimated that over 2 million adults in the country between the ages of 14-39 are infected with the Chlamydia bacteria. In 2006, the rate of reported gonorrheal infections was 120.9 per 100,000 persons. In 2006, over 36,000 cases of syphilis were reported.

State data: In 2009, the Texas rate for primary and secondary syphilis was 7th in the nation; for congenital syphilis, 2nd among 34 areas reporting. The Texas rate for men is 9.5/100,000 persons; for women, 4.0. The syphilis rate among blacks is 14 times that of whites. Texas ranks 14th in the nation for reported cases of gonorrhea. Reported rate for Chlamydia in Texas is also higher than the national average.⁸⁸

Local data: Although the numbers of cases are small, the rates of reported sexually transmitted disease cases in Lubbock County are higher than the state rate. In 2009, there were 1697 reported cases of Chlamydia, 488 of gonorrhea, and 20 of primary and secondary syphilis.⁸⁹

⁸⁷ Centers for Disease Control and Prevention. *Healthy People 2020*, 2010.

⁸⁸ Centers for Disease Control and Prevention. *Sexually Transmitted Diseases Surveillance*, 2009.

⁸⁹ Texas Department of Health Services. *Health Currents*, 2009.

Sexually Transmitted Diseases Community Assets Summary

The STD asset mapping reflects the following services and classes offered to persons in the CHS service area.

- STD Testing and Treatment
- Limited HIV Education
- HIV Specialty Clinic
- Assistance with Basic Needs for HIV Positive Individuals
- Counseling
- A 4-hour Comprehensive Teen and Parent Sex Education Program

There are a few agencies and programs in the community focused on these diseases. Much of the funding for the STD related services is dependent on grants or state funding. The services provided are more focused on providing assistance once a person has an STD or is HIV positive. There is not a significant focus on prevention or education.

The Lubbock Health Department has an STD Clinic which provides STD testing and treatment of HIV, Syphilis, Chlamydia and Gonorrhea. There is no cost of the treatment of the diseases. This clinic is open to the public and there are no financial requirements to receive treatment. The Department of State Health Services (DSHS) has STD Intervention Specialists. They help interview persons who test positive and locate past partners to inform them of the need to be tested. This service offers testing and some treatment for those partners who test positive. There is no cost to the patient. DSHS also provides some HIV education. Teen Straight Talk is a four hour comprehensive sex education program where parents and children (ages 10 & up) attend together. Information is offered about local STD and pregnancy stats, the mental aspects of sexual health, self-esteem, peer pressure, bullying, body image problems, and depression/suicide. This is a comprehensive sexual education program which also covers the topics of abstinence, birth control, and STD prevention. This program is free and open to the public. They are funded by state, national and local grants and in-kind donations. Everyone who participates with the organization is a volunteer. Project Chance is a program for HIV positive individuals in our community. They offer an HIV specialty clinic at the TTUHSC Internal Medicine clinic twice a week. They also help HIV positive patients with obtaining medications and insurance. They offer health education, limited dental and vision assistance, a housing program, emergency assistance and counseling. This program is funded by various grants.

Implications

There is an identified gap in prevention and education related to STDs and HIV within our communities. As a member of a Catholic health system, Covenant Community Health Outreach (CHO) faces some limitations in regards to promoting preventative interventions other than abstinence. However, there is potential for CHO to participate in community partnerships and collaborations related to this issue.

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Benefit Planning Process

All identified health needs were presented to focus groups comprised of community health leaders from the Lubbock area, internal Covenant department leaders and the CB Committee. Community health leaders, experts and representatives consulted are listed in Attachment 1. Covenant Medical Group physicians were asked to complete an on-line survey related the identified needs (Attachment 2). The feedback received from these groups combined with the secondary data analysis helped shape the final priorities. Priorities were then ranked by the CHO program leadership team according to how well they met the following required elements and additional considerations listed below. The CHO program leadership team included the CHO Director, Community Services Manager, Manager of the Counseling Center and Health Education, Community Benefit Supervisor, Financial Analyst, Community Benefit Analyst, Health Education Dietitian, and department administrative intern.

Required Elements:

- All priorities will be focused on the economically poor within the primary service area for CHS
- Local secondary and primary data have identified this problem as affecting a substantial number of persons in Covenant's service area
- Local secondary and primary data and national evidence have identified this problem as an important one in affecting residents' health status
- Available local resources to address the problem are not adequate
- Issue can be effectively addressed within the CHS mission, vision, and values

Additional Considerations:

Internal alignment within CHS:

- Focus on this area will help CHS Emergency Department and inpatient services provide the services needed to address needs at appropriate intensity of care and thus reduce charity care costs
- Focus on this area will help CMG provide the services needed for the economically poor in its practice and thus reduce charity care costs
- Focus on this area will help CHS insure that the economically poor receive services in areas of CHS clinical excellence
- Focus on this area will help CHS address other strategic priorities

Community perception:

- Other community service providers agree that there is a need for additional services and providers
- Other community service providers support CHS being a provider in this arena

Continuity of current priorities:

- There would be a negative impact on community if CHO discontinued a current program or service

Service design/delivery capacity

- CHS can provide this service as efficiently as other providers of this service in the community
- CHS has or will develop the competencies/expertise needed to address this need effectively
- CHS will focus on primary and/or secondary prevention approaches to this problem, rather than tertiary prevention
- CHS will address this problem through an integrated/coordinated approach working with other providers to meet consumers' needs and "best practice" standards

To further develop the final priorities a template for selecting priority topics (3-W Template) was applied to each priority selected. Each priority was evaluated in the following areas:

- Detailed definition of the problem including the scope and seriousness of the issue
- Evaluation of community resources that currently address the issue
- Overall Alignment with internal strategic plans

Attachment 1: Covenant Leadership Focus Groups

Comments from Covenant Leadership Focus Groups conducted in spring 2011

Obesity

Include Healthy Lubbock

Healthy eating & exercise in schools (Michelle Obama's program)

Dr. Kenneth Cooper – Cooper Clinic

Focus needs to be on family not just on the child

Healthy choice of food is more expensive

Education

Fast food restaurants are more convenient to the working and active family. It's easier to stop at McDonalds to grab a hamburger and fries on the way to the child's activity

More children are interested in playing video games than playing outside

PE being cut in schools

Tobacco Use

Education on all types of tobacco not just cigarettes

Binge Drinking/Substance Abuse

Lubbock County Court Division – Judge Rusty Ladd

Lubbock Rape Crisis Center

Victim's Impact – Lubbock County (a monthly panel that is made up of individuals who have been affected by drunk driving)

Education in High School – Early as Middle School

Family Approach

Who & How do you break the cycle

Coordinate with DPS & LPD

MADD (closely tied with Victim's Impact)

Parenting outreach – "Healthy Families" How do they function as a family?

Spiritual outreach to families

Access to Care

Need for nurse on call – avoid the ED

Telephonic triage Service

True after hours clinic (after 7:00 PM)

Patients mistrust the health care system – (illegal immigrants)

Transportation from rural towns to Lubbock

Attachment 1: Covenant Leadership Focus Groups (continued)

Comments from Covenant Leadership Focus Groups conducted in spring 2011

Oral Health

Dr. John Johnson & Dr. Kennel take Medicaid pts. – They see up to 45 cases at the SurgiCenter
JACC patients are educated on oral health

Hospital in-patient's oral health issues go unresolved while in hospital. If the patient starts to show symptoms while in the hospital they have to wait until they are discharged to see a dentist

Access to dental insurance

One dentist that comes to the hospital to see unfunded patients, no dentist will come to the hospital to see funded patients.

Mental Health

Treatment Court – Judge Drew Farmer

Mental Health training for all law enforcement, specific mental health officer will be identified within LPD. Andy Young Psychologist with LCU to train the law enforcement officers

Lack of in-patient services for adolescents

Lack of services for unfunded post partum patients

Homeless Consortium & Carpenters Church possible agencies to contact

Access to medications

It takes 3 or 4 days for a psychologist or psychiatrist to come to the hospital for a consult. A

Judge has to be contacted for a psychologist or psychiatrist to see a patient in the hospital

Children are sent to Midland, Odessa or Amarillo to seek inpatient mental health services

Diabetes

No programs to refer patients to other than CHO's Health Education program, no programs to refer funded patients to

No support for uninsured and insured

Telephonic Service – follow up or to ask questions

Cost of medications – physician will prescribed a high dollar medication when there is a cheaper alternative

Glucose strips are very expensive so the patient will not test their blood sugars as often

Education

Pre Metabolic

More of a partnership with American Diabetes Association

Attachment 1: Covenant Leadership Focus Groups (continued)

Comments from Covenant Leadership Focus Groups conducted in spring 2011

Maternal/Child Health

High rate of teenage pregnancy

Cultural issue

High volume of CPS call for mother who are abusing drugs and/or alcohol

Family education & start young

Immigration status

The patient's education level and lack of education

The patient didn't want anyone to know they were pregnant

Lack of access to prenatal care

Cardiovascular

Noncompliant taking their medications due to cost or they started feeling better

High rate of heart failure since we closed the Heart Failure Clinic

Respiratory

Education for medications especially for children

Ability to pay for the medications

Sexually Transmitted Disease

Lack of education in the community

People are not sharing info with partners

Community denial

Need to talk more openly about it

Comments from Community Service Providers Focus Groups

Obesity

Elevated blood pressure with children

Mental Health Issues due to body image/self esteem

Behavioral issues stemming from low self-esteem

LISD –general health education not required course

Difficulty obtaining food stamps will affect ability to purchase healthier foods

“Electronic world” – kids play video/computer games and don't go outside (also dangerous in some neighborhoods); we all SIT at the computer

Fast Food! Cheaper, easier, underserved don't have money to eat healthier

Both parents working

Not adequate referral resources in Lubbock

Lack of convenient/cheap/safe exercise facilities; community centers are very limited

Nutritionist needed

Transportation barriers

Childhood obesity is a sensitive cultural issue difficult to approach

Attachment 1: Covenant Leadership Focus Groups (continued)

Comments from Covenant Leadership Focus Groups conducted in spring 2011

Obesity (continued)

Location: climate, weather, southern states affect obesity rates
More grandparents raising children: less energy to cook/be active with the children
Community collaboration needed
Family nutritional intake is not as good as it should be
Higher prices are also a misconception: Cheetos & soda vs. banana & milk
Kids can't go grocery shopping – education has to be brought into the home
Schools should have a role in providing healthier eating. (healthy vending machines, etc)
Educate parents - on what BMI is, difficult to capture the adult population (parents of school kids) to educate on adequate physical activities
Ronald McDonald partnership – bus that goes to schools with nutritional education
Entire country epidemic however lower socioeconomic groups just have more barriers to the resources needed to change.
Adults: look at work environment: create an employee-friendly work environment/wellness program. Exercise breaks, education, etc. Benefits the employer too (less time off, cheaper insurance, etc)
Family oriented activities (exercise together, etc) that creates a family connection
Patients larger & sicker
Future healthcare costs expensive
Guidelines on Nutrition Facts Confusing
Preventative measures
Educate parents – especially young parents

Diabetes

Prescription assistance needed
Access to strips
Patients don't understand disease
Many people don't even know they are diabetic (late diagnoses) and those who do still don't understand how to stay healthy
Underlying factors of noncompliance: mental issues, denial, unwilling to make a lifestyle change or diet modifications
Prescription Roulette: won't take insulin as instructed, instead just take it when they feel bad
Related to Obesity (lifestyle issue)
Need for earlier detection
Need for more adult and pediatric diabetes educators
Beneficial to expand community diabetic services

Attachment 1: Covenant Leadership Focus Groups (continued)

Cardiovascular/Respiratory

Underlying factors of noncompliance mental health, denial, unwilling to make a lifestyle change
Society's belief that "A pill will fix everything"

On the rise due to obesity (diabetes and smoking also contribute)

Important issue due to high costs associated with medication and procedures

Patients are often non-compliant about taking medications (cholesterol and blood pressure)

Primarily a lifestyle issue

Focus should be on healthy living

Cardiac conditions are the leading cause of death

Often an allergy related issue in asthma cases (cotton ginning, dust, pollen, wind)

Patients fail to obtain PCP care and preventative/control meds until they are very ill

Binge Drinking/Tobacco Use/Substance Abuse

Prescription Medication Abuse is on the rise (primarily pain medications)

Pregnant women using tobacco may not fully understand the side effects associated with their actions

Lubbock ISD had a Safe & Drug Free Schools Educator (started with preschoolers): funding was cut nationwide last year and this program is no longer in existence

TX Agilife has smoking cessation classes in schools around region.

Communities in Schools would be a good partner

College town

Use social media/ networking to create awareness

Zero tolerance

Socially acceptable

Binge drinking leads to risk behavior, increased accidents, criminal behavior, sexual assault, domestic abuse, child abuse

High number of teenage population smoke

Education is needed at an earlier age

More public awareness / restrictions (smoke-free restaurants)

Smoking is a public health risk (contributes to cancer)

Other forms of tobacco abuse should be included

Easily available (especially alcohol)

Parents sometimes abuse substances too

Drug abuse is tied to alcohol abuse

85% of jail population in for a drug related incident

Attachment 1: Covenant Leadership Focus Groups (continued)

Access to Care

Prescription assistance (adults AND children)

New women's Medicaid

Many patients have coverage but don't utilize visits/don't have a primary care home; patients are sicker; lots of unmanaged disease

Simple prevention education: get care earlier instead of waiting; there is only a limited amount of prevention education

Waiting: cultural, medication ads don't focus on overall prevention, harder for older people to find a physician that will see them, less physicians accept Medicare, long waiting lists

Transportation for all populations is a barrier

Medicaid taxi service: you can only take one child to your appointment with you which creates a babysitting dilemma

Elderly transportation and difficulty finding physicians who accept Medicare

Health insurance: three kids still means three co-pays

Uninsured population is high

Look at ED stats for times that patient inflow peaks

Child might not be sick but needs a physician note to go back to school

Parents can't take off work to take themselves or children to clinic (jobs not flexible)

Companies dropping employee health insurance, more uninsured

Using ED as primary care facility

Might have to wait a long time even if you have a primary care home

Use of Health Fairs put on around town as their primary care, no follow up, not building a detailed medical record

Mobile Medical Care idea: much like Mobile Mammography/Dental units

Access issues are bigger in the surrounding towns

Population of those 60 years old who not old enough to get Medicare yet don't have insurance... fall in the cracks when it comes to specialty care

Lack of knowledge (where to go)

Access will get worse with Medicaid cuts

Need more mobile clinics

More screenings with an emphasis on funneling people to resources

Attachment 1: Covenant Leadership Focus Groups (continued)

Oral Health

ED's don't have dentist

Cosmetic issues if you've been abused, also affects self-esteem

Difficulty getting a job if you have bad teeth

Children: wait too long to start dental hygiene; stay on the bottle too long, more sugar in their diets; lack of resources/services

New research says oral health is related to heart health and premature births

Elderly can't pay for procedures

Bad teeth/tooth aches affect nutrition/food consumption

Dentists don't take payments, they want all at once

Dental insurance has limited availability

Brownfield: once a month offers services for uninsured

Dental care is very low priority in peoples' lives

Few places will take pregnant women without insurance but oral health can affect pregnancy outcomes

Expensive

Long wait lists

People do not know charity care is available

Dental care is often put off if no money is available

Even those who work can't afford dental insurance – working poor

Dental care is a great need in the community

More help (providers/staff) is needed to keep waiting list down

Linked to other health issues and nutrition deficiencies

Mental Health

Prescription assistance

Lack of access to care across the board (paperwork is complicated)

LISD: each campus has a support team, tied with MHMR, paperwork (Medicaid, MHMR, etc) can be very complicated; school helps facilitate paperwork, transportation, etc

State budget for higher-level diseases (schizophrenia, etc) has been gradually decreasing, difficult to treat

Substance abuse attached to mental illness

Juvenile system also addresses issues

Cultural stigma issues to admitting/treating mental illnesses

Medical management of and access to medications is needed

Rural areas have no way to get services, and once these populations get into a more urban area, there is still a lack of services

Insurance doesn't cover well

Labels and negative family associations with mental illnesses prevent families from seeking help

Children born to addicted parents may have mental health from birth; leads to lifelong struggle due to developmental issues

Lack of mental health care in hospitals

Attachment 1: Covenant Leadership Focus Groups (continued)

Mental Health (continued)

Counseling and prescription combo; are difficult to get together
TTU Psychology/Sociology
Earlier intervention is key, but lack of resources
Kids in foster care lose access to any previous treatments after they turn 18
High number of homeless with mental health issues
Increased diagnosis (more likely in the next 5-10 years)
ED is an indicator that there is a need
Need for earlier detection
Education for supporters
More services are needed for teenagers
Very few service providers
MHMR is difficult to get into
Covenant needs more mental health resources

Maternal/Prenatal Care

Decrease in prenatal care
Chronic diseases while pregnant
Some young women are in denial that they are pregnant and put off seeking prenatal care
Teens may try to hide pregnancy
Many physicians refuse to do well check for pregnant teen. In turn patient could lose their Medicaid
Loopholes to qualify for childcare
Young girls don't understand how their body works/what to do when they get pregnant
Teach kids how to protect themselves from sexual abuse and how their body works.
Girls hitting puberty earlier (7,8,9) at risk for being abused and becoming pregnant
Teach parents how to talk with their children
Lack of parental education
Some pregnant teens smoke during pregnancy to keep their babies smaller for easier delivery/to hide it longer/have a small baby
High incidence of teenage pregnancy, impacts community and families
Need for more education – junior high /high school
Need to partner with churches

Attachment 1: Covenant Leadership Focus Groups (continued)

Sexual Transmitted Disease

High incidence in ages 17-35

Huge increase in syphilis

Not always able to find all past partners

Results get reported to the county of residence (College students)

65 and older – generation that never used condoms, too old to get pregnant, have increasing rates of HIV/STDs

Kids have a lot of questions but think they can't talk to parents so they talk to peers and receive false information

High rates of sexual abuse in Lubbock

Teach parents how to talk with their children

HIV tripled in Lubbock in 2010

Teen Street Talk is a resource

Highest rate in the surrounding area, state and nation (Lubbock's #s are high)

Health department main community resource

More education is needed (earlier – to both parents & children)

Schools resistant to sex education

Parents resistant to educating their own children

"Abstinence Only" policy in Texas

Leads to other health issues

Risky behavior (teens don't care about consequences)

Attachment 2: Covenant Medical Group Physician Surveys Results

Covenant Medical Group physicians were asked to complete an on-line survey during the spring of 2011.

1. In the last 5 years, have you seen an increase in patients who are overweight or obese?
Yes: 100
No: 0%
2. Do you think there are adequate community resources to refer your patients to for obesity related education?
Yes: 12%
No: 88%
3. Do you think there is adequate education available within our community concerning the risks of binge drinking, substance abuse and/or tobacco use?
Yes: 38%
No: 62%
4. Do believe there are adequate resources for the poor and vulnerable in our community providing support reducing binge drinking, substance abuse and/or tobacco use?
Yes: 19%
No: 81%
5. Why do you think patients have issues filling their medications?
Patient is noncompliant: 69%
Cannot afford medications: 81%
Lack of education for maintenance medications: 75%
Other, please specify: 19%
6. Why do you think mental health patients have issues filling their medications?
Patient is noncompliant: 69%
Cannot afford medications: 62%
Lack of education related to the need for maintenance medications: 75%
Other, please specify: 38%
7. Do you think there are adequate community resources to refer your Medicaid or un-funded patients to for cardiovascular and/or respiratory services?
Yes: 56%
No: 44%
8. Do you think there are adequate community resources to refer your Medicaid or un-funded patients to for diabetes related services?
Yes: 44%
No: 56%

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

1. What health issues are you treating in your practice related to obesity?

- Diabetes, joint problems, hypertension
- OSA, HTN, High cholesterol, diabetes
- With the help of endocrinology, treating several young children, 11 years of age even, with Type II DM cad
- Diabetes, hypertension, hyperlipidemia
- Multiple. Statistics tell us there are 11 disease states caused or directly related to Obesity.
- Cad, pvd, renal failure
- Gestational diabetes
- Diabetes, hypertension
- Metabolic syndrome, pre-diabetes ,diabetes, dyslipidemia, hypertension, early onset osteoarthritis, depression, sedentary life, malnutrition, etc.
- DM, htn, back pain, knee, ankle pain
- PCOS, Gestational DM
- Arthritic complications
- DM, HTN, Hyperlipidemia, CAD, OSA
- Hypertension, diabetes, knee replacements, high cholesterol, atherosclerosis, depression...
- DM, HTN, CAD

2. The Covenant Community Health Outreach department is focused on care for the poor and the under-served in our community. How can this department work with community partners to reduce obesity in the communities we serve?

- Help provide accountability
- Extremely difficult mission. I don't think it is really possible to make a change unless that availability of copious amounts of fatty (better testing) foods become less.
- Education
- We need diabetes education and dieticians available to treat patients
- Education Dieticians Exercise physiologist Caring supportive physicians and staff not sure
- Dietary instruction; exercise programs
- Need to start at early edge and educated children
- This service can be a resource for that patient who need education related to need for dietary opportunities, and especially for encouragement to make exercise a lifestyle
- Post bill boards of the obese people in hot pants! or I guess you could try a Shape up Lubbock campaign
- Dietary education.
- Education
- Education on diet

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

2. The Covenant Community Health Outreach department is focused on care for the poor and the under-served in our community. How can this department work with community partners to reduce obesity in the communities we serve? (continued)

- Education for families and through the school system... starting yesterday... Quit using scientific studies not published as a reason to stay inactive...
- Diet education, exercise education

3. What would help to reduce the use of the Emergency Department for non-emergent needs?

- Increased availability of primary care services having Medicaid pay a co-pay
- More access to after hours and weekend clinics. This has been largely accomplished in my opinion at CMG pediatrics due to weekend clinics and nurse triage afterhours who direct them to the most appropriate place.
- Out pt clinics
- Patient education
- Chronic universal problem. Urgent care, triage, co pays, federal / state/legal changes in policy, improved community health centers, education.
- Charge more to the patient for ed visits
- I wish I knew.
- Education patients about outpatient clinics and hours. Educate about emergency room use.
- Require some form of payment for services, and add increased emphasis on expanding community based outpatient services for the poor and/or the uninsured
- A clinic need the ER as an alternative, Change the EMTAL Laws
- A fast track clinic. Later hours at the community outreach level for people to come after work
- Education
- Patient education about appropriate use of the ER.
- Free walk in clinics for indigents located near the ER. Free access to regular care with a clinic located IN the indigents' living areas.
- Access to PCP, education of what services are and can be provided at pcp offices

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

4. Why do you think patients have issues filling their medications?

- Pharmaceutical barriers./ side effects/dosing schedules/ cognitive issues
- Lack of follow-up opportunities
- Their buddies/families and their opinions emanating from their own culture and view of health and illness.

5. The Covenant Community Health Outreach department is focused on care for the poor and the under-served in our community. How can this department work with the Covenant Emergency Department, CMG and other community partners to reduce the number of patients using the Emergency Department for primary care issues?

- Increased availability of primary care services
- Education
- According to finance, most of the bad debt/charitable care come from the ED. Until universal health care is available or better employer benefits occur or the ability to refuse care at ED triage, you won't change that population of people from searching for 'free' care.
- Be committed to the under served
- Refer them to the County hospital that receives federal monies for indigent care.
- See 7. Education, tracking pt compliance, availability of referral sources esp specialty care. Cooperation between all providers to take their fair share. Communication. Combined efforts by the major provider systems to address the issue.
- Being available to fill the gaps
- Affordable healthcare venues for the under-served. Not free necessarily but affordable
- Education
- It needs to be advertized more, perhaps by giving every treat- and- release patient information on proper utilization of the benefit of Community Outreach dept.
- Provide after hour alternative to the ER
- Later hours at outreach clinics.
- Work with community organization and foundations
- Patient education
- I don't really know how to answer that because I don't really know what the CCHO does in reality. Give money? Grants? Develop programs? Join with other existing community resources? When Melinda Clark was CEO, I went to her office with my team (N.P. + R.N. + M.A.) and we proposed a joint project with education in the schools. I was told to take my "gimmick" and that I could not say I represented CMG or the CHS for that matter... If anyone at CCHO would like to sit down with me and my team, I would love the opportunity to present a comprehensive approach to educate children and food and exercise choices. I don't think the results of in utero studies are necessary, per what Melinda Clark had suggested...
- Matching patients with pcps in CMG

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

6. There are a large number of adults in our community without access to dental insurance or dental care. What can Covenant Community Outreach do to better serve un-insured adult dental patients?

- Encourage community dentists to see a small number of
- Unfunded patients, then coordinate referrals
- Dental fairs
- Need more dentists in the community to step up and provide some charitable care like almost all docs do in the primary care fields.
- Dental clinics
- Unknown
- Provide adequate access to dentist and hygiene through free/co pay/ or other unique answers. Maybe even the dentist would accept their fair share as we as physicians attempt to do.
- Unclear
- Continue mobile dental services
- Easier referral process and access
- There needs to be easier access to patients in acute need to provide reduction of burden to the ED
- More dental vans.
- Recruit dentists who will donate their time
- More free dental clinics
- Get together with the dental society if there is one or with the dentists in the community and establish an organized program. Abbeville Dentistry recently help a program and served 150 clients free of charge. Surely, with all the other dentists, there could be an organized program that could be held regularly. You've got to involve the dentists...
- Unsure- dentists are on their own and often do not take mcaid and no one likes to work for free for unfunded patients with no money.

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

7. Many adults are presenting in the Emergency Department for dental related problems. How can Covenant better address this problem and potentially reduce the number of adults coming to the Emergency Department for dental care?

- Encourage community dentists to see a small number of unfunded patients, then coordinate referrals
- Have to have preventative care. Dental pain is relatively uncomfortable and not something that can wait weeks before getting into a dentist even if the patient already has a dental home---unbelievable in my opinion.
- Dental clinics
- Put a dentist in the ER to pull teeth
- Availability of care is an issue for emergent or acute care see 10
- Not sure
- See above. and increase the dissemination of the information to those who need it
- Dental protocols for referral
- Same answer as above. Promoting dental hygiene throughout the LISD area of influence. Question the DDS population on these same issues.
- Fast track clinic. Staff dentist for extractions (24 hours).
- Have dentists on call who will accept referrals
- These are usually unfunded patient in medical and dental care so this is where they go for their abscesses.
- See answer to number 10. Also, at those events, you would have folks talk to adults about proper dental care and give toothbrushes!
- Unsure

8. Do you think there are adequate resources to refer your patients to for mental health services?

- No!
- No
- Just like nationally, Lubbock is underserved in this arena.
- No
- Unknown
- No
- Don't know
- No
- No
- Doubtful, some patients report a waiting period as much as a year for a new patient to MHMR.
- Yes MHMR
- No
- No

- No
- Pretty much!!! The big problem is that MHMR waiting list is too long...
- No

9. Why do you think mental health patients have issues filling their medications?

- Obviously they lack something since this population has trouble paying their bills, keeping a budget, and keeping a job.
- The nature of mental illness
- Mental condition
- Cultural hang-ups about mental illness.

10. Do you see any gaps finding Mental Health services for Medicaid or un-funded patients? If so, what would improve access to Mental Health services for these vulnerable patients?

- There are definite gaps (chasms). I have no idea how to solve them.
- More practitioners (psych, etc) willing to service them.
- All the answers are the same---if you have an undersupply of practitioners willing take these patients, then there will always be poor access.
- yes
- The county hospital should be seeing more patients
- More providers/ acceptance of fair share/ better reimbursement/ allied health care.
- Don't know
- I don't know how to improve this
- Yes have difficulty finding psychiatry/psychology follow-up
- Yes. Government is very likely not going to be able to continue to fund these projects since it is also Bankrupt. Local community help is going to be the only resource available in the near future.
- No
- Bigger MHMR department.
- Organize charity based care
- Yes, someone willing to see them for free
- Yes. Find more willing providers...
- Yes, little to no psychiatrists take MCAID and it falls on PCPs to diagnose and treat complicated psychiatric pathologies

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

11. Have you seen an increase in newly diagnosed diabetics within the last 5 years? If so what do you believe is the main factor contributing to the increase?

- Small increase, most likely due to rise in obesity
- No
- Poor metabolism, diet from early in life--- maybe even the womb.
- No
- People are overweight
- Society, obesity, genetic pool, diet, ignorance, lack of
- Exercise, drugs/alcohol, longer life,
- Obesity, lack of exercise
- Yes
- Yes, diet and lack of exercise
- Poor exercise habits and poor eating habits
- No
- No
- No
- Yes, due to increasing obesity.
- Yes, dramatically. Obesity... Obesity... Eating out all the time... only exercise is texting...

- Yes- diet, exercise and lack of education

12. With all of the services available for prenatal care why do you think there is an increase in the number of new mothers who had no prenatal care prior to delivery?

- Still way too many deliver each week. Unsure though of increase.
- yes
- They are teenagers
- Society, ignorance, family, lack of support, poor education, funding, lack of access, don't care, drugs, alcohol.
- Social deterioration/ cost
- They don't 'like' the clinics that are set up to care for them
- Education
- No comment
- No
- Lazy
- Unknown
- Poor education about the benefits of prenatal care.
- Unsure.
- Lack of education and lack of caring

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

13. Do you think there are adequate health resources available for low-income pregnant women in Lubbock and the surrounding region? If not, what resources would you suggest?

- Yes
- Yes.
- No
- Sexual education classes
- No - community outreach, clinics, referral sources, allied health, cooperation between all service providers
- Don't know
- Yes, if they would use them
- Yes
- No comment
- Yes
- Yes
- Unknown
- No
- Don't' know
- Yes

14. Why do you think Lubbock has such a high STD rate?

- Poor parental model for care and self-control
- Poor education
- Poor education. Resistance to education.
- Lack of education
- No sexual education classes in schools
- Promiscuity, lack of adequate education, alcohol/drugs, TV/Movie exposure, moral fabric decay, poor support/family disintegration, bias. College town. Universal poor self esteem resulting in inappropriate search for belonging and meaning.
- Young people like unprotected sex-- sex education lacking
- I have no clue
- Unwillingness of the community to address the social issues
- Because of the absence of moral absolutes, as well as poor modeling at home.
- College town youth feels immortal
- Abstinence only sex ed in school.
- Risky behavior
- Not enough abstinence based teaching
- Lots of unprotected sex and good Christians putting their heads in the sand and playing ostrich and adhering to the just say no point of view and therefore, ... more STD's!
- Lack of education and lack of caring

Attachment 2: Covenant Medical Group Physician Surveys Results (continued)

15. What do you think can be done to lower the STD rate?

- Teach the parents to parent
- Provide more education
- Better proponents of condom use in the schools and at home
- Encourage condom use
- Teach kids to be safe
- Education. Family involvement. Community support for openness and acceptance of reality. RX availability. Screening of all sexually active teens, young adults, and those having multiple exposures. Must alter the perception that sexuality is a recreational sport.
- Educate
- Education
- Education, parent involvement
- Get rid of Planned Parenthood. Have parents pay for the children's sex risk. As long as sex is as casual as it is STD's will remain quite prevalent.
- Nothing
- Put contraception in the water, and make the patient come to the doctor to get off of it, instead of the other way around.
- Education
- Education about the disease
- Educate in the schools, educate in the community, educate in nightclub's bathrooms...
Attempt more education

Attachment 3: Community Providers and Local Agency Findings

Community Providers

The following community service providers have programs available to the economically disadvantaged. Several listed providers only offer limited services for the un-insured and are experiencing budget cuts. Many are not taking new patients.

Obesity

- Covenant Community Health Outreach
- Community Health Center of Lubbock
- Larry Combest Center
- Boys and Girls Club
- Junior League of Lubbock
- AgriLIFE Extension
- Lutheran Social Services
- Lubbock Children's Health Clinic *

Tobacco Use

- TTU Center for Addiction & Recovery
- Methodist Children's Home Lubbock
- American Cancer Society
- Texas AgiLife

Binge Drinking

- TTU Center for Addiction & Recovery
- Alcoholics Anonymous

Access to Care

- Covenant Health System
- Community Health Center of Lubbock
- Larry Combest Wellness Center
- Lubbock Children's Health Clinic *
- Lutheran Social Services
- Lubbock Impact
- City Health Department
- TTU Health Sciences Center
- Catholic Family Services *
- University Medical Center
- Sick Children's Clinic *

Oral Health (Dental)

- Covenant Community Health Outreach
- Catholic Family Services (vouchers for dentures) *
- Community Health Center of Lubbock
- Adult Protective Services (vouchers for dental services)

Attachment 3: Community Providers and Local Agency Findings (continued)

Mental Health

Combest Wellness Center
Department of Veterans Affairs
Mental Health Mental Retardation
Managed Care
Catholic Family Services *
Lubbock Faith Center
Texas Tech Family Therapy Clinic
Lubbock Impact
Community Health Center of Lubbock
Family Counseling Center

Diabetes

Covenant Community Health Outreach
Community Health Center of Lubbock
Larry Combest Community Health & Wellness Center
Lubbock Children's Health Clinic *
United Way of Lubbock
AgriLIFE Extension
Juvenile Diabetes Research Foundation
American Diabetes Association
Lutheran Social Services

Maternal/Child Health

Covenant Health System
University Medical Center
March of Dimes
Larry Combest Center
Parenting Cottage
Lubbock Children's Health Clinic *
YWCA
City Health Department
Texas Tech Health Science Center
Family Outreach
WIC
AgriLIFE Extension
Grand Expectations
The Stork's Nest

Attachment 3: Community Providers and Local Agency Findings (continued)

Substance Abuse

Veterans Affairs
Lubbock Faith Center, Inc
Managed Care
Mental Health Mental Retardation Methadone Clinic

Cardiovascular

Community Health Center of Lubbock
Texas Tech University Health Sciences
Lubbock Impact

Respiratory

Community Health Center of Lubbock
Texas Tech Health Sciences Center
Larry Combest Center
Lubbock Children's Health Clinic *
Sick Children's Clinic *
Lubbock Impact

STD's

Project Chance
Lubbock Health Department- STD Clinic
Department State Health Services STD Intervention Specialists

*** Received grant funding from Covenant Community Health Outreach in FY11**

Attachment 4: Local Agency Interviews

Interviews were conducted in January and February of 2010 by Mission Integration staff to begin the process of planning a full CHNA

<u>Agency/Organization</u>	<u>Interviewee</u>	<u>Comments</u>
Community Health Center of Lubbock (CHCL)	Michael Sullivan, CEO	Mike expressed need to have an "after hours" clinic to help take pressure off ED's
Combest Center	Linda McMurray, Director	Lots of discussions with CHS re: how we can help; MOU with CHS Children's Dental; discussions about referrals from EDs
Lubbock Children's Health Clinic	Sue Hill, Director	CHO Diabetes education beginning to go there Need – ADHD evaluations
West Texas Organizing Strategy (WTOS)	Beatrice Vega, Director	WTOS sees a need for prescription assistance, preventative care and transportation assistance; Feel there is a need for more assistance with CHIP sign up's; Concerned with the cost of insurance and the number of ex-military who cannot afford insurance
United Way of Lubbock	Janis Poteet and Carolyn Simpson	Interested in our diabetes program; forming a diabetes forum (throughout United Way of Texas) grant from Eli Lilly Need – Education for mothers who are on state assistance re: establishing paternity
YWCA	Glenda Mathis	Concerned about childhood obesity and fitness as well as adult fitness; Have aquatics facility that can help when patients cannot afford water therapy and would like to work with Covenant to educate doctors on what the YWCA can offer to their patients; Received CHIP grant in Oct. 09 and looking for ways to follow up with eligible patients who do not complete the CHIP paperwork; Will be performing a needs assessment this spring related to the Texas Healthy Adolescent Initiative
Communities in Schools	Anita Blakey, Program Director	Pre-natal care for teenage mothers who are outside Lubbock; Teenage pregnancy and STD; Dental; Nutrition
City Health Department	Kae Hentges, Board Chair	Dept. reduced to records and immunizations Sees great need for adult dental care & eye screening & care; Mental health screening and follow up, but not need for general health screenings

Attachment 4: Local Agency Interviews (continued)

TTU Health Sciences Center	Dennis Lamb, Director of Patient Services	Believes the greatest unmet needs are related to Diabetic Care, Childhood Obesity, prescription assistance, transportation assistance, preventative care and education especially related to nutrition
Family Outreach and Guidance	Lynette Wilson Robbie Crux	Lack of funding at schools to address drug/alcohol education, teen pregnancy. Would like to see a “one stop shopping” that houses a group of agencies that can support families.
Food Bank	David Weaver, Exec. Director Lyn Garcia, Director of Development Trine Solis – Jackson, Director of External Relations	Need – Seniors in need of medications and healthcare services in rural areas.
Catholic Family Services (CFS)	Jeff Malpiede, Director Virginia Alamanza, Emergency Assistance	Major need in community for prescription assistance; Adult dental needs, even with CHS and CHCL programs; Uninsured – unable to see doctors because of cost and limited providers at CHCL
Foster Care/Child Protective Services	Camille Gilliam, Regional Director	More community resources needed in East Lubbock and in the rural towns and counties. Suggested partnering with Jeff Wherry, Ph.D., Director for the Institute for Child & Family Studies, Human Sciences at TTU. They are getting a lot of grants for their research and studies. Also suggested using United Way as a central place for building community collaboration. Suggested partnering as a Star Health Provider. This is a state operated system that contracts services for parents, especially Mental Health. There is a great need for mental health services in the rural areas (LPC, LMFT, LCSW).

Attachment 5: Community Health Leaders, Experts and Community Representatives Consulted

Focus Groups Conducted on April 26th, 2011 and May 9th, 2011
Strategy Planning Workshop on October 28th, 2011

- Covenant Health System Leadership Groups (included Directors of Nursing, Department Directors, ED Leaders)
- Joy Lopez, Lutheran Social Services
- Arnessa Dotson, Women's Protective Services
- Pat Johnston, Lubbock ISD
- Linda McMurry, RN, DNP, Executive Director, Larry Combest Community Health and Wellness Center
 - **Professional Expertise** Community Health and Wellness, Hospice, home health, nursing administration
 - Extensively involved with a Community Health Worker Program
- Liz Lopez, Chief Development Officer, Community Health Center of Lubbock
- Treasa Arnold, Ronald McDonald House Charities
- Kristin Carpenter, Ronald McDonald House Charities
- Micki Oats, Lubbock ISD
- Linda Brice, Ph.D., Assistant Professor, TTUHSC School of Nursing
 - **Professional Expertise** Obstetrics Community/Population Health Teen Straight Talk Program Stork's Nest Baby Shower Comprehensive Sex Education Program Teen Pregnancy STDs Child Abuse Preterm Birth Low Birth Weight Babies
- Aida Martinez, South Plains Association of Governments
 - 211 – Specialization Community Resources
- Janis Putteet, VP Community Impact, United Way
- Sam Ortegon, former Family Life Services Coordinator Catholic Charities
- Liz Castro, South Plains Association of Governments
 - Department of Aging
- Lyn Garcia, South Plains Food Bank
- Joan Chandler, Executive Director TexAgri-Life Extension
 - Chair of Building Fit Communities Steering Committee which is focusing on the impact of obesity on healthcare and the community
- Beatris Vega, West Texas Organizing Society
 - Special interest in Medicaid coverage for uninsured children in Texas
- Lynnette Wilson, Family Guidance
- Irma Guerra, South Plains Head Start
- Beckie Brawley, Public Health Coordinator, City of Lubbock Health Department
- Michael Sullivan, CEO, Community Health Center of Lubbock

Attachment 5: Community Health Leaders, Experts and Community Representatives Consulted (continued)

Focus Groups Conducted on April 26th, 2011 and May 9th, 2011
Strategy Planning Workshop on October 28th, 2011

- Yolanda Sanchez, Catholic Charities
 - Experienced in prescription assistance for the un-insured
- Debra Flores, PhD, TTU School of Nursing
 - **Professional Expertise** Homeless Healthcare, Community Health Workers, Health Literacy, Childhood Obesity, Chronic Disease Management
 - Experienced in public health issues among Hispanic population (CV Next Page)
- Yolonda Moore, Adult Education Regional Specialist, Region 17 Service Center
- Gayla Dirks, Adult Education Lubbock Specialist, Region 17 Service Center
- Sara Wilson, YWCA
- Kris Altman, YWCA
- Annette Boles, Assistant Director TTU Garrison Institute
 - **Professional Expertise** Community outreach and Health Professional Education Programs
 - Coordinator of Get Fit Lubbock Program and Healthy Lubbock Initiative
- Todd Klein, Lubbock City Council Member
- Beth Zarate, Executive Director, Catholic Charities
- Marsha Blair, TexAgri-Life Extension
- Mara Kenmom, South Plains Workforce

Attachment 5 continued

Public Health Experts Consulted

Catherine F. Kinney, MSW, PhD

cfkinney@comcast.net

505-780-1131

An organizational/community psychologist, Dr. Kinney has supported community and clinical health improvement work as a consultant and organizational leader for over 25 years. Her approach draws upon extensive knowledge and experience in quality/ performance improvement, systems thinking, change management, measurement and evaluation, and operational leadership. She has particular expertise and experience in working with public-private and other inter-organizational coalitions.

She has conducted assessments, facilitated strategic plans, coached operational and governance leaders, designed organizational structures and processes, and guided implementation of new initiatives. Her clients have included hospital systems, community health and social service organizations and coalitions, foundations, and government agencies across diverse communities and at local, state, national, and international levels. As an internal leader, she designed and led the successful startup of performance improvement structures and processes at two large healthcare systems. As an executive in a large community hospital, she led the successful initiation of major clinical and community programs. Her experience also includes clinical and leadership experience in behavioral health. She has served in governance roles on foundation, health, and social services boards, as well as national advisory groups.

Dr. Kinney holds a master's degree in social work and a doctorate in psychology from the University of Michigan. She has served as faculty for several Institute for Healthcare Improvement courses. She is a senior examiner for Quality New Mexico and a member of the Community Advisory Council for the University of New Mexico's Prevention Research Center.

Attachment 5: Public Health Experts Consulted (continued)

Debra Flores, M.A.

(806) 543-0767

debra.flores@ttuhsc.edu

Texas Tech University, PhD(C)	Curriculum & Practice/ Science & Math
Wayland Baptist University, MAM	Management/ Human Resources
Lubbock Christian University, BS	Organizational Management

TTUHSC Certified Community Health Worker (Developed 160 hour curriculum certified by the Texas Department of State Health Services. Teach nine month certification class which prepares adult learners for navigation of chronic diseases, community outreach, and delivery of reliable health information.) Serves as Project Director for Patient Navigator Program (Federal program funded through HRSA), Nurse Family Partnership (State funded program)

Licenses & Certificates

Licensed	Texas, Licensed Vocational Nurse	1983-present
Certified	Texas, Community Health Worker Instructor	2004-present
Certified	Mental Health First Aide Instructor	2010-present
Certified	Collaborative Institutional Training Initiative	2006-present

Certified Curricula

2006 Author of Certified Community Health Worker Program for Texas Tech Health Sciences Center School of Nursing (Certified by Department of State and Health Services #00009)

Completed Research Support

Health & Human Services Administration 09/01/2008-08/31/2010
Transformation for Health Model Program to improve health care outcomes for vulnerable individuals in Lubbock County through the utilization of patient navigators.

USDA National Research Initiative CFDA #10.206 01/01/2006-03/31/2008
"Community Based Approaches to Overweight and Obesity Among Young Children in West Texas" A community-based approach to the prevention and control of overweight and obesity among young children in West Texas through nutrition, exercise and gardening.

Publications:

D. Reed, M. Chyu, D. Feng, M.Boylan, J. Borrego, L. Thompson, C. Esperat, D. Flores, O. Ochoa, L. Billings, O. Norriega. (2007) DEVELOPMENT OF A CHILDHOOD OVERWEIGHT PREVENTION PROGRAM USING COMMUNITY BASED PARTICIPATORY RESEARCH IN WEST TEXAS, Texas Public Health Association.

Attachment 6: Community Benefit Committee Roster

Janis Putteet
VP Community Impact, Lubbock Area United Way

Tom Vermillion
Executive Director Boys and Girls Club

Sharon Bass
Executive Director Volunteer Center of Lubbock

Sheri Nugent
Vice President-Administration Lubbock Chamber of Commerce

Jessie Mendoza
VP- Multicultural Marketing American State Bank

Cari Crooks
Associate Managing Director, Electronic Health Records, TTUHSC

COMMUNITY BENEFIT BOARD COMMITTEE MEMBERS

Sr. Sharon Becker
Suzanne Blake, Vice Chair
Todd Brodbeck, DO
Michael Danchak, MD
Kitty Harris, PhD
Richard Parks Ex-Officio
Janie Ramirez, Chair

Attachment 7

**FY12-FY14 CB PRIORITY INITIATIVES TEMPLATE
SELECTING PRIORITY TOPICS- 3W'S**

STEP 1: DEFINE THE PROBLEM- <i>Define the problem/need that the initiative will address.</i>
COMMUNITY NEED BEING ADDRESSED:
HOW NEED WAS DETERMINED: <i>(Do community members recognize this as a problem? Is the problem seen as important to the affected group?)</i>
SCOPE OF THE PROBLEM: <i>(Prevalence, trends, etc. Is the problem in this community greater than in other areas of the state or region?)</i>
PROBLEM IS RELATED TO: A. Emphasis on Disproportionate Unmet Health-Related Needs (DUHN) B. Prevention (Specify) a. Primary b. Secondary c. Tertiary C. Building a Continuum of Care D. Building Community Capacity E. Collaborative Governance
SERIOUSNESS OF THE PROBLEM: <i>(What are the consequences of not offering services? Is the problem getting worse?)</i>

Attachment 7 (continued)

**FY12-FY14 CB PRIORITY INITIATIVES TEMPLATE
SELECTING PRIORITY TOPICS- 3W'S**

STEP 2: AVAILABLE RESOURCES- *What community resources already exist?*

LIST COMMUNITY RESOURCES CURRENTLY AVAILABLE:

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

STEP 3: OVERALL ALIGNMENT

HOW INITIATIVE ALIGNS WITH SJHS MISSION OUTCOMES:
(Sacred Encounters/Perfect Care/Healthiest Communities)

HOW INITIATIVE ALIGNS WITH LOCAL MINISTRY STRATEGIC PRIORITIES: *(Recommended)*

HOW INITIATIVE ALIGNS WITH MANAGING CHARITY CARE COSTS: *(Recommended)*

CovenantHealth 

St. Joseph Health 

Covenant Health is a member of St. Joseph Health, an integrated Catholic health care delivery system sponsored by the St. Joseph Health Ministry. We provide a full range of care facilities including: acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics and physician organizations throughout California, Texas and New Mexico. Our 24,000 dedicated employees strive daily to provide perfect care while building the healthiest communities and ensuring every encounter is sacred. St. Joseph Health is committed to maintaining a continuum of care that matches the diverse needs of the communities we serve. For more information about St. Joseph Health, log onto www.stjoe.org.