

2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Covenant Health Plainview

Plainview, Texas



To provide feedback on this CHNA or obtain a printed copy free of charge, please email Veronica Soto at vsoto@covhs.org

CovenantHealth  SM

CONTENTS

Message to the Community and Acknowledgements	4
Executive Summary.....	5
Understanding and Responding to Community Needs	5
Gathering Community Health Data and Community Input	5
Measuring Our Success: Results from the 2021 CHNA and 2021-2023 CHIP	6
Introduction	8
Who We Are.....	8
Overview of CHNA Framework and Process.....	9
Equity Framework.....	9
CHNA Framework.....	10
Data Sources	10
Data Limitations and Information Gaps.....	11
Process for Gathering Comments on Previous CHNA and Summary of Comments Received	11
Our Community.....	12
CHNA Service Area and Community Served	12
Providence Need Index	12
Community Demographics	13
Economic Indicators.....	17
Health Professional Shortage Area	18
Health Indicators.....	19
County Health Rankings.....	19
Indicators	19
Hospital Utilization Data	20
Community Input	24
Summary of Community Input Hale County.....	24
Community Strengths Hale County.....	24
Community Needs Hale County.....	24
Significant Health Needs	27
Review of Primary and Secondary Data.....	27

Identification and Prioritization of Significant Health Needs	27
2023 Priority Needs	28
Alignment with Other Community Health Needs Assessments	28
Potential Resources Available to Address Significant Health Needs	29
Evaluation of 2021-2023 CHIP	30
Addressing Identified Needs	31
2023 CHNA Governance Approval	32
Appendices.....	33
Appendix 1: Quantitative Data	33
Appendix 2: Community Input	37
Appendix 3: Community Resources Available to Address Significant Health Needs.....	47
Appendix 4: Covenant Health Plainview Board of Directors	49

MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

Health for a Better World starts with our commitment to understanding and serving the needs of the community, especially the poor and vulnerable. The Community Health Needs Assessment process assists us in identifying and addressing areas of focus to transform health and well-being within the communities we serve.

We work to increase comprehensive access to health and social services by addressing the foundational gaps in care for the most poor and vulnerable members of our communities. With each investment we make and partnership we develop, we find ways to best address and prioritize our region's most challenging needs as identified through our community health needs assessment. The process includes a review of public health data, interviews with key stakeholders, and community focus groups with an intentional effort to include potentially under-represented populations.

The goals of our community health outreach efforts include increasing the number of people who have access to health care, connecting individuals with resources, and addressing core issues such as food insecurity, housing instability, education, resource availability, and other social factors that contribute to improved well-being. Additionally, we craft outreach programs to address health issues that disproportionately affect our most vulnerable community members. Such direct outreach programs include dental services, mental health counseling, health education, diabetes outreach and community health navigation.

We are grateful for the opportunity to serve communities in Texas and New Mexico and look forward to continuing local partnerships as we seek to collectively achieve Health for a Better World.

Walter L. Cathey FACHE
CEO Covenant Health
Providence Regional Chief Executive Texas/New Mexico

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Covenant Health Plainview to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

The 2023 CHNA was approved by the Covenant Health Plainview Board of Directors on October 19, 2023 and made publicly available by December 28, 2023.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, and hospital-level data. To actively engage the community, we conducted listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. We also conducted key informant interviews and focus group listening sessions with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Community members and key informants identified community commitment and involvement as a top community asset.
- Mental health and substance abuse related issues were high priorities for community members and key informants.
- The high need services area reflects disproportionate percentage of persons identifying as Hispanic.
- Access to healthcare and resources was a theme noted with an emphasis on social determinates of health as root causes of disparities.

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

Identifying Top Health Priorities

Through a collaborative and engaging process, the Covenant Health CHNA Advisory Council, Covenant Community Benefit Board Committee, and Covenant Hospital Boards identified the following priority focus areas (listed in no particular).

MENTAL/RELATIONAL HEALTH

Mental and behavioral health treatment, intervention, and prevention services for the community; including social and relational health, stigma reduction, and community education.

SUBSTANCE MISUSE

Substance misuse including the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco; community education and awareness through partnerships with non-profits, law enforcement, and schools; support for accessibility and availability of addiction treatment options.

ACCESS TO CARE AND HEALTH RESOURCES

Issues related to accessing health services and resources including social determinants of health with an emphasis on vulnerable populations and health equity; includes but is not limited to the following areas of focus: Dental Care for the Uninsured, Mental Health and Counseling Services, Health Education (preventative care and chronic diseases), Women's Health, and social determinants of health.

FOOD INSECURITY

Access to healthy food, nutrition education, and healthy lifestyle support with an emphasis on health equity; supporting current food solution partners and options to meet growing needs and to address root causes.

Covenant Health Plainview will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2024-2026 CHIP will be approved and made publicly available no later than May 15, 2024.

Measuring Our Success: Results from the 2021 CHNA and 2021-2023 CHIP

This report evaluates the impact of the 2021-2023 CHIP. Covenant Health Plainview responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2021 CHNA and 2021-2023 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the 2021 CHNA and 2021-2023 CHIP. The 2021 CHNA and 2021-2023 CHIP priorities were the following:

- Priority 1: Mental and Behavioral Health
- Priority 2: Access to Health Services

- Priority 3: Homelessness and Housing Instability
- Priority 4: Food Insecurity and Nutrition

A few of the key outcomes from the previous CHIP are listed below:

- Expanded our Community Counseling Center which provides counseling services for low-income and uninsured persons by adding tele-counseling (which provided access to Plainview), creating an internship program through partnership with local universities, and by adding on-site counseling services at the Lubbock YWCA
- Added a rapid response mental health team within Covenant Health Partners
- Provided low-cost dental services to dentally un-insured through dental outreach clinics in Lubbock and Plainview, partnering with Lubbock Impact to hold full-day dental clinics, and performing free dental sealants to children in need in Lubbock and Hockley counties
- Provided Built for Zero support to local homeless providers along with direct grants to expand permanent supportive housing
- Collaborated with local organizations and schools to provide community-based health education; provided free diabetes education with a focus on health equity
- Supported local food bank with both in-kind and financial support

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Covenant Health Plainview is a part of Covenant Health, a network of acute-care hospitals founded in 1998 through a merger of two faith-based hospitals in Lubbock, TX. Covenant Health’s network includes Covenant Medical Center, Covenant Children’s Hospital, Grace Surgical Hospital, and Covenant Specialty Hospital (joint venture) all located in Lubbock, TX. Additionally, Covenant operates three regional hospitals in Texas and Eastern New Mexico, Covenant Health Plainview, and Covenant Health Levelland, and Covenant Health Hobbs Hospital. Covenant Health also operates Covenant Medical Group clinics throughout West Texas and Eastern New Mexico. Covenant Medical Group (CMG) is an employed physician group comprised of approximately 150 primary care and specialist physicians throughout Lubbock, West Texas, and Eastern New Mexico. The total service area spans roughly 35,000 square miles and includes approximately 750,000 people.

The Community Health Needs Assessment (CHNA) focuses on Hale County, TX where Covenant Plainview provides direct community outreach services and/or support. Covenant Health facilities include more than 1,000 available licensed beds and five acute-care hospitals located in the cities of Lubbock, Levelland, Plainview and Hobbs. Covenant Health has a staff of more than 5,000, including more than 600 physicians. Major programs and services include, but are not limited to, cardiac care, cancer treatment, pediatrics, women’s services, surgical services, orthopedics, critical care, neuroscience, endoscopy, diagnostic imaging, emergency medicine and obstetrics.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities:

<https://www.providence.org/about/annual-report/reports/texas>

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

Equity Framework

Our vision, Health for a Better World, is driven by a belief that health is a human right. Every person deserves the chance to live their healthiest life. At Providence, we recognize that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion, or socioeconomic status. Our health equity statement can be found online: <https://www.providence.org/about/health-equity>.

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

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



Approach

- Explicitly name our commitment to equity
- Take an asset-based approach, highlighting community strengths
- Use people first and non-stigmatizing language



Community Engagement

- Actively seek input from the communities we serve using multiple methods
- Implement equitable practices for community participation
- Report findings back to communities



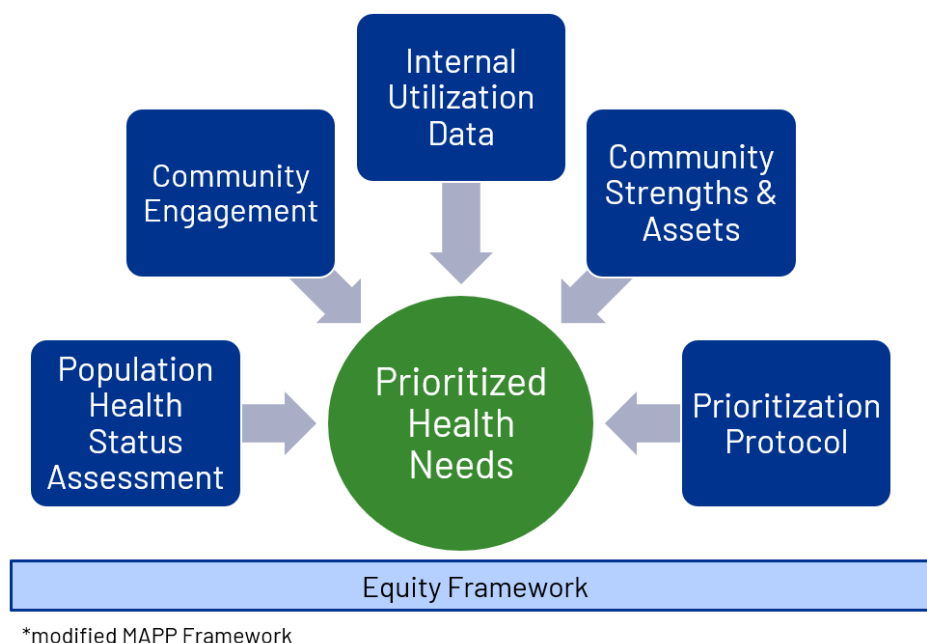
Quantitative Data

- Report data at the census tract level to address masking of needs at county level
- Disaggregate data when responsible and appropriate
- Acknowledge inherent bias in data and screening tools

Intentional effort was made to capture issues and concerns related to health equity. Key informants were included who represent and serve medically underserved, low-income, and/or minority populations. Specific feedback was solicited concerning health equity.

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed-methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



Data Sources

In gathering information on the communities served by Covenant Health Plainview, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the following sources:

Primary Data Sources	Secondary Data Sources
<ul style="list-style-type: none"> • Key informant interviews • Focused listening sessions • Internal hospital utilization data 	<ul style="list-style-type: none"> • American Community Survey • Behavioral Risk Factor Surveillance System (BRFSS) • U.S. Census Bureau • County Health Rankings

Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

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

Written comments were solicited on the 2021 CHNA and 2021-2023 CHIP reports, which were made widely available to the public via posting on the internet in 2021, as well as through various channels with our community-based organization partners.

No comments were received.

OUR COMMUNITY

CHNA Service Area and Community Served

The CHNA service area for Covenant Health Plainview is Hale County. This service area is based on the availability of data, geographic access to Covenant Health facilities, location of local resources, accessibility of Covenant Health outreach programming, and population density. Many outreach programs are based in Lubbock County with extension services in Hale County.

Due to the proximity to Lubbock County, community members often seek services there. Surrounding counties outside of the CHNA service area where patients may live include the following: Castro, Swisher, Baily, Cochran, Yoakum, Gaines, Dawson, Scurry, Lamb, Terry, Lynn, Garza, Crosby, and Floyd Counties in Texas, as well as Curry, Roosevelt, and Eddy in New Mexico.

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a “high need” service area and a “broader” service area, which together make up the Hale County Service Area. Based on work done by the Public Health Alliance of Southern California and their [Healthy Places Index \(HPI\)](#) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.¹

For this analysis, census tracts with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as “high need.” The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average were classified as a high need service area and are depicted in green.

¹ The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in [Limited English Households](#) (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

**Figure 1. Hale County
Service Area**



Community Demographics

The graphs below provide demographic information about the service areas in comparison to the high need service areas. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboards can be found here:

Texas Data: <https://experience.arcgis.com/experience/6dc400dbac0149c3ab9f8abe42fbe887/>

HALE COUNTY DEMOGRAPHICS

Table 1. Hale County Total Population by Geography

Indicator	Hale County	Broader Service Area	High Need Service Area
Total Population	32,879	16,931	15,948

Source: American Community Survey, 2021 5-year estimates

Hale county has a relatively young population. The largest age group in Hale County is under 18, constituting 27.2% of the population. The high-need service area has an even higher percentage (31.6%). There is a slightly higher percentage of males in Hale County at 52.5%, however males and females are almost equally represented within the high need service area. The Black/African American population is higher in Hale County (4.3%) compared to the high need service area (2.7%). The Hispanic population is a significant demographic within Hale County, constituting 60.6% of Hale County's population and 76.0% in the high-need service area. The category of two or more races is notable, representing 14.2% of the total population in Hale County, and a higher 19.4% in the high-need service area. Detailed demographics are found in [Appendix 1](#). The following graphic representations detail percentage demographics by service area.

Figure 2. Hale County Population Age Groups by Geography

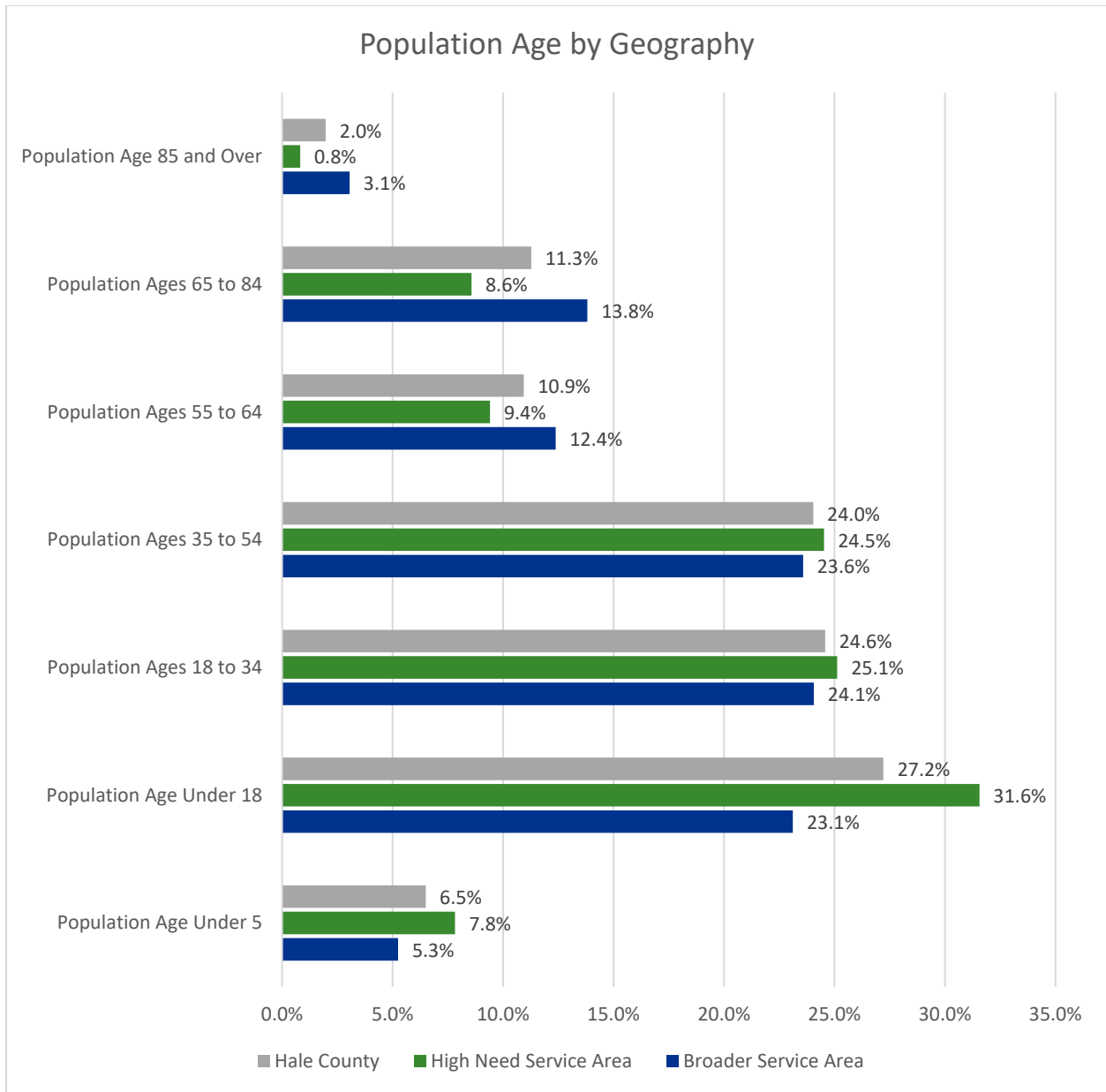
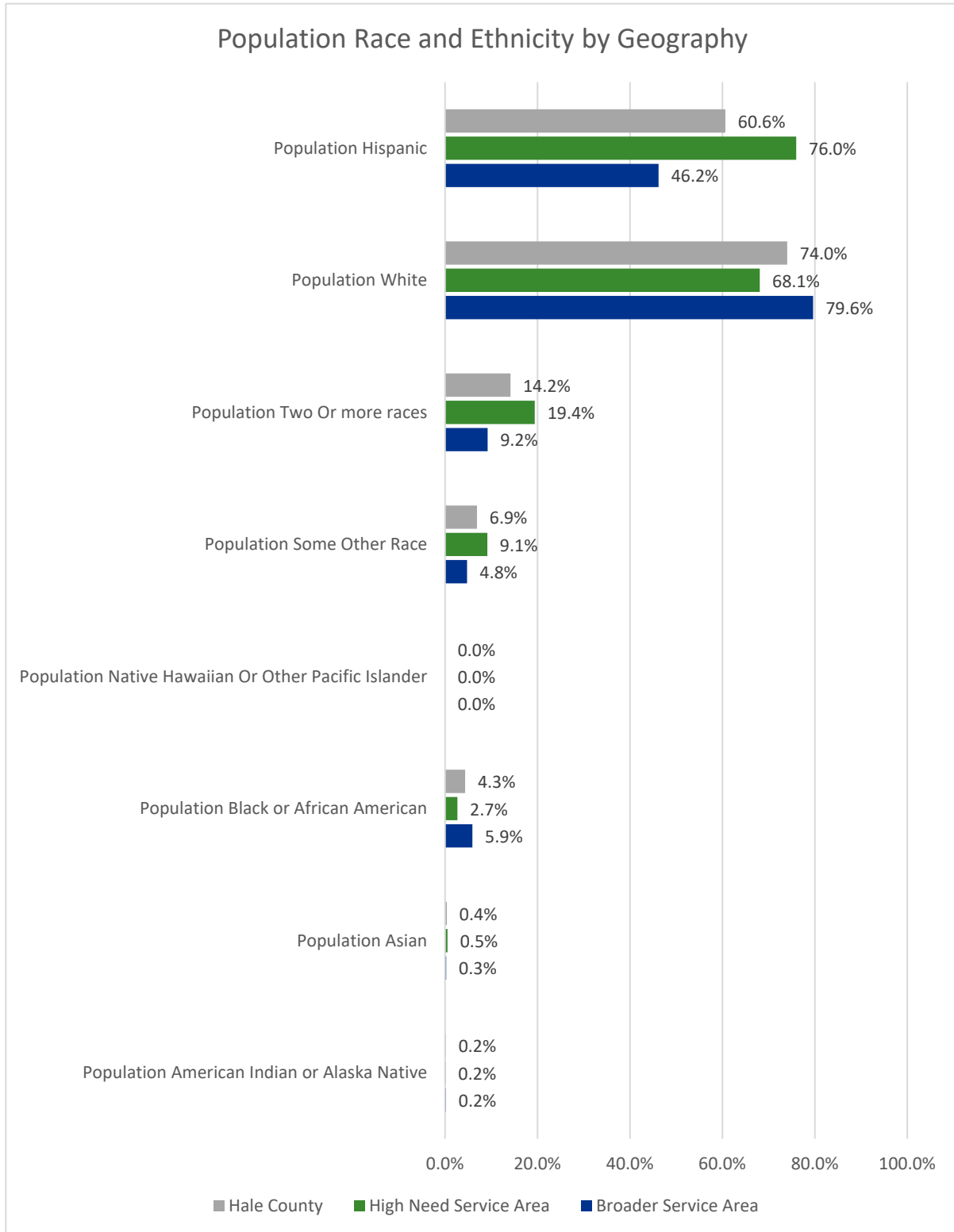


Figure 3. Hale County Population Race and Ethnicity by Geography



Economic Indicators

Household median incomes includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one-person, average household income is usually less than average family income.

Renter households experiencing severe housing cost burden are households spending 50% or more of the income on housing costs. County Health Rankings and Roadmaps explain the link between health and housing in the following way: "There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs. When the majority of a paycheck goes toward the rent or mortgage, it makes it hard to afford doctor visits, healthy foods, utility bills, and reliable transportation to work or school. This can, in turn, lead to increased stress levels and emotional strain."

Table 2. Hale County Economic Indicators

Indicator	Hale County	Broader Service Area	High Need Service Area	Texas
Median Household Income	\$48,439	\$50,492	\$42,562	\$67,062
Severe Housing Cost Burden	18.1% (756 renter households)	11.8% (318 persons)	22.7% (438 persons)	21.7% (1,177,536 renter households)
Households Receiving SNAP Benefits	16.7% (1,853 households)	11.1% (770 persons)	21.5% (1,083 persons)	11.5% (1,177,536 households)
Population Uninsured	23.0% (7,187 persons)	20.1% (3,021 persons)	26.0% (4,166 persons)	17.6% (4,995,381 persons)

Source: 2021 American Community Survey, 5-Year Estimate

Hale County data indicates a lower median income in all categories when compared to the state. The high need service area median income is almost \$25,000 lower than the state and approximately \$6,000 less than Hale County overall. The high need service area has a slightly higher severe housing cost burden than the state, although Hale County and the broader service area are lower. A substantially higher percentage of households are receiving SNAP benefits, and a higher percentage of the population is uninsured in the high need service area compared to the state.

Health Professional Shortage Area

Health Professional Shortage Areas (HPSAs) are geographic areas, populations, or facilities, and which have a shortage in primary, dental, or mental health care providers. All Covenant Health service areas have portions that are designated as HPSA.

Hale County is designated as a primary care, dental health, and mental health HPSA. Regence Health Network, Inc. is a designated HPSA facility for primary care, dental health, and mental health.

Hockley County is designated as a dental and mental health HPSA. South Plains Rural Health Services, Inc. is a designated HPSA facility for primary care, dental health, and mental health.

Lubbock County has a large portion, north and central, designated as a primary care HPSA. Southeast, southwest, and central Lubbock County are designated as mental health HPSAs. The entirety of the county is designated as a dental health HPSA. The following facilities are all designated HPSA for primary care, dental health, and mental health: The Community Health Center of Lubbock, Inc. and Texas Tech University School of Nursing, Larry Combest Health and Wellness Center

Lea County is designated as a primary care and dental health HPSA. The southeastern catchment area is designated as a mental health HPSA. The following facilities are all designated HPSA for primary care, dental health, and mental health: Presbyterian Medical Services, Family Health Center of Lea County, Hobbs Medical Clinic, Lovington Clinic, and Tatum Clinic.

See [Appendix 1](#) for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

HEALTH INDICATORS

Please refer to the Texas Data Hub 2023 to review each of the following health indicators mapped at the census tract level:

Texas Data: <https://experience.arcgis.com/experience/6dc400dbac0149c3ab9f8abe42fbe887/>

The hub provides data on each indicator in the counties of Lubbock, Hockley, and Hale. Data is shown for the high need service area, broader need service area, and the State of Texas, as well as information about the importance of each indicator.

To review all studied health indicators and to see the high need service area data, refer to the data hub link above. Review of health indicators indicates a disproportionate need in most geographically high need serve areas. Additionally, service areas are generally trending worse than the state. All 26 health indicators were reviewed, analyzed, and compared with the community input to guide priority setting.

County Health Rankings

The County Health Rankings were also reviewed. County Health Rankings are based on a model of population health that emphasizes the many social, economic, physical, clinical, and other factors that influence how long and how well we live. Countyhealthrankings.org helps counties understand what influences how healthy their residents are and the factors that could determine how long they will live. The Rankings measure the current health of each county and show the differences in health and opportunity by place. They then assess the future health of communities with measures that look at factors such as children living in poverty, access to nutritious foods, smoking rates, obesity rates, and teen births. Finally, selected measures and strategies highlight the intersection of racism, discrimination, and disinvestment to support actions toward equity.

For more information and to review all CHR measures:

<https://www.countyhealthrankings.org/explore-health-rankings/texas/hale?year=2023>

See [Appendix 1](#) for additional Population Health Data

Indicators

The following table represents selected health indicators from The Behavioral Risk Factor Surveillance System which is administered by the CDC's Division of Population Health. All primary Texas Counties counties served by Covenant Health are represented in the data below for comparison.

Lubbock, Hale, and Hockley counties all have similar percentages of Binge Drinking Prevalence (around 18.0%), while the state Texas has a slightly lower prevalence at 16.8%. The data demonstrates higher depression prevalence and mental health distress in the three TX counties than the state in TX counties. The prevalence of coronary heart disease in Lubbock, Hale, and Hockley counties (around 6.3-6.8%) is

approximately double that observed in the overall state of Texas (3.2%). Hale has the highest percentage of individuals reporting fair or poor self-rated health status (22.4%), followed by Hockley (21.0%), Lubbock (18.0%), and the state of Texas (15.9%). Obesity rates are elevated in Hale (38.2%) and Hockley (39.4%) compared to Lubbock (34.6%) and the state of Texas (35.5%). The prevalence of diabetes among the three counties is like the state of Texas (12.0%), with Hale having the highest prevalence of diagnosed diabetes (14.0%), followed by Hockley (12.9%), and Lubbock (12.0%). Dental visit prevalence is lower overall in the three counties when compared to the state of Texas (57.5%), with Lubbock County having the highest prevalence of dental visits (53.7%), followed by Hockley County (48.6%), and Hale County (46.0%).

Table 3. Selected Health Indicators for Lubbock, Hale, and Hockley Counties and Texas

Selected Indicator	Lubbock County	Hale County	Hockley County	Texas
Binge Drinking Prevalence	18.1%	17.9%	18.1%	16.8%
Depression Prevalence	21.4%	20.8%	22.2%	17.7%
Self-Reported Mental Health “Not Good” for More than 14 of Past 30 Days Prevalence	15.7%	15.8%	16.4%	13.3%
Obesity Prevalence	34.6%	38.2%	39.4%	35.5%
Coronary Heart Disease Prevalence	6.3%	6.8%	6.7%	3.2%
Fair or Poor Self-Rated Health Status Prevalence	18.0%	22.4%	21.0%	15.9%
Diagnosed Diabetes Prevalence	12.0%	14.0%	12.9%	12.0%
Dental Visit Prevalence	53.7%	46.0%	48.6%	57.5%

Source: Behavioral Risk Factor Surveillance System Survey (BRFSS), 2020
 All indicators are age adjusted and specific to adults aged 18 years or older.

See [Appendix 1](#) for additional Population Health Data

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence’s Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve

our outreach and partnerships. From April 1, 2022, through March 31, 2023, 33.4% of all Emergency Department visits to the Medical Centers listed were potentially avoidable. Data is included for all Covenant facilities for comparison.

AVOIDABLE EMERGENCY DEPARTMENT CASES

Between 4/1/2022 – 3/31/2023, our data showed the following key insights:

Table 4. Percent of Avoidable Emergency Department Visits at Covenant Hospitals

Covenant Hospitals	% of Avoidable ED Visits
Covenant Childrens Hospital	35.2%
Covenant Health Hobbs Hospital	30.8%
Covenant Health Levelland	34.4%
Covenant Medical Center	34.3%
Covenant Health Plainview	30.1%
Grace Surgical Hospital*	25.5%
Average of All Hospitals	33.4%

Covenant Health Childrens

- At Covenant Children’s Hospital, 35.2% of all emergency department cases were classified as avoidable. Among these avoidable ED cases, most patients self-identified their race as White/Caucasian (60.3%), Black/African American (18.0%), or Other (20.2%), and a large portion self-identified their ethnicity as Hispanic or Latino (33.8%).
- As expected, patients aged 0-17 made up the largest percentage (96.2%) of total avoidable ED cases.
- Among these avoidable ED cases, most patients indicated they lived in the ZIP Codes 79403 (43.7%) and 79404 (41.4%).
- The three largest payors for avoidable ED visits include Self-pay, Medicaid, and Other Government Payors.
- The top diagnoses for avoidable ED cases at Covenant Childrens Hospital were bronchitis and other upper respiratory disease, tonsillitis, and acute otitis media and sinusitis.

Covenant Medical Center

- At Covenant Medical Center, 34.3% of all emergency department cases were classified as avoidable. Among these avoidable ED cases, most patients self-identified their race as

White/Caucasian (59.1%), Black/African American (12.6%), or Other (22.1%), the majority of patients indicated they were not Hispanic or Latino (57.9%)

- Among total AED cases, a large portion of patients were between the ages of 18-39 (41.6%).
- Among total AED cases at Covenant Medical, the largest percentage of cases came from 79242 and 79423. However, cases were fairly uniform throughout all ZIP Codes, roughly about one third in all ZIP Codes.
- The three largest payors for avoidable ED visits include Commercial, Medicaid, and Self-Pay.
- The top diagnosis for avoidable ED cases at Covenant Medical Center were unclassified, urinary tract infections, and bronchitis and other upper respiratory disease.

Covenant Health Hobbs Hospital

- At Covenant Health Hobbs Hospital, 30.8% of all emergency department cases were classified as avoidable. Among these avoidable ED cases, most patients self-identified their race as White/Caucasian (50.9%), or Other (37.2%), and the majority of patients indicated they were Hispanic or Latino (55.9%)
- Among total AED cases, a large portion of patients were between the ages of 18-39 (38%).
- Among total AED cases at Covenant Hobbs, the largest percentage of cases came from ZIP Codes 88240, 88242.
- The three largest payors for avoidable ED visits include Commercial, Medicaid, and Self-Pay.
- The top diagnoses for avoidable ED cases at Covenant Hobbs Hospital were bronchitis and other upper respiratory disease, tonsillitis, and urinary tract infections.

Covenant Health Levelland

- At Covenant Health Levelland, 34.4% of all emergency department cases were classified as avoidable. Among these avoidable ED cases, most patients self-identified their race as White/Caucasian (74.9%), or Other (17.5%), and the majority of patients indicated they were Hispanic or Latino (54.9%)
- Among total AED cases, a large portion of patients were between the ages of 18-39 (30.5%).
- Among total AED cases at Covenant Levelland, the largest percentage of cases came from ZIP Codes 88240, 88242, 88260.
- The three largest payors for avoidable ED visits include Medicaid, Medicare, and Self-Pay.
- The top diagnoses for avoidable ED cases at Covenant Levelland Hospital were Bronchitis and Other Upper Respiratory Disease, Urinary Tract Infection, and Acute Otitis Media and Sinusitis.

Covenant Health Plainview

- 30.1% of all emergency department cases were classified as avoidable. Among these avoidable ED cases, most patients self-identified their race as White/Caucasian (50.0%), or Other (38.9%), and most patients indicated they were Hispanic or Latino (64.9%)
- Among total AED cases, a large portion of patients were between the ages of 18-39 (33.1%).

- Among total AED cases at Covenant Plainview, the largest percentage of cases came from ZIP Codes 79072, 79041, 79064.
- The three largest payors for avoidable ED visits include Medicaid, Medicare, and Self-Pay, and Commercial.
- The top diagnoses for avoidable ED cases at Covenant Plainview Hospital were Bronchitis and Other Upper Respiratory Disease, Urinary Tract Infection, and Tonsillitis.

Grace Surgical Hospital*

- 25.5% of all emergency department cases were classified as avoidable. Among these avoidable ED cases, most patients self-identified their race as White/Caucasian (72.6%), or Other (15.3%), and most patients indicated they were not Hispanic or Latino (67.4%)
- Among total AED cases, a large portion of patients were between the ages of 18-39 (34.2%) and 40-64 (33.2%).
- Among total AED cases at Grace Medical Center, the largest percentage of cases came from ZIP Codes 79424, 79382, and 79407.
- The three largest payors for avoidable ED visits include Commercial, Medicare and Self-Pay.
- The top diagnoses for avoidable ED cases at Grace Medical Center were Urinary Tract Infection, Skin Infection, and Tonsillitis.

*Grace Surgical Hospital's ED was discontinued in July 2023

For additional information regarding the above findings, please contact Veronica Soto vsoto@covhs.org

COMMUNITY INPUT

Summary of Community Input Hale County

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Covenant Health conducted key informant interviews and focus groups with representatives from community-based organizations. Community input for Hockley, Lubbock, and Lea counties is available at the following link: [Community Benefit Annual Report: CHNA and CHIPs | Providence](#) All community input was collected between June and August 2023.

See [Appendix 2](#) for methodology, participant details, and in-depth findings.

Community Strengths Hale County

Key informants were asked to highlight community strengths. These questions are important for understanding what matters to community members and leveraging what is already going well:

Community Strengths

- Strong Sense of Community
- Quality community resources and organizations
- Effective collaboration between organizations, agencies and resources
- Organizations, agencies and resources are engaged and involved
- Generosity and Resource Sharing

Community Needs Hale County

HIGH PRIORITY UNMET HEALTH-RELATED NEEDS

Housing Instability/ Homelessness

Key informants and participants in listening sessions have identified housing insecurity and homelessness as a growing issue within the community, with a particular focus on its complexity and the need for more resources. They noted that the COVID-19 pandemic exacerbated this problem, with many individuals experiencing homelessness not being local residents but coming from neighboring areas due to barriers to accessing help in their own communities. The lack of resources to address housing insecurity and homelessness is a significant concern, including a shortage of funding, long waitlists for housing programs, and an increasing number of people resorting to temporary accommodations like hotels. Moreover, children and teenagers are increasingly affected by housing insecurity and homelessness, underscoring the need for additional support, education, and housing assistance for this demographic.

Behavioral Health challenges and access to care

Key informants and participants in listening sessions identified several critical behavioral health needs within the community, including a lack of mental health facilities and resources, difficulties in accessing essential medications, and a need for community collaboration and resource promotion. Barriers to accessing mental health and substance use services, such as transportation limitations, language barriers, and stigma, were also discussed. Youth, in particular, face challenges related to mental health and substance use/misuse, with concerns about an increase in suicidal thoughts and depression among younger kids and vaping among teenagers. To address these needs, a coordinated effort involving community leaders, healthcare providers, schools, advocacy groups, and local government is necessary, focusing on raising awareness, reducing stigma, improving access to care, and providing education to create a more supportive and mentally healthy community.

Access to health care services

Key informants and listening session participants highlighted multiple challenges in accessing healthcare services within their community. These challenges encompass gaps in women's healthcare, sexually transmitted diseases (STD) testing, and prescription access, compounded by systemic issues like language barriers, discrimination, and health literacy. The absence of a health clinic within the Health Department leads to referrals for medical services. Emergency Medical Services (EMS) struggles with reduced funding and medication shortages. Expanding STD testing and treatment services, improving access to medication, enhancing health education, and addressing language barriers and health literacy are essential steps to improve healthcare access and equity. Additionally, the impact of the COVID-19 pandemic on healthcare services, including vaccine access and hesitancy, further complicates the healthcare in the community. Listening session participants described caregivers and healthcare providers in the community as overwhelmed and in need of support to recharge to continue contributing to the community through volunteering and caregiving. Certain populations, such as the people without uninsurance, women, and Black, Brown, Indigenous, and People of Color (BBIPOC), face unique and exacerbated challenges in accessing healthcare, underscoring the need for focused interventions to address disparities and discrimination.

MEDIUM PRIORITY UNMET HEALTH-RELATED NEEDS

Food Insecurity

Key informants and listening session participants discussed the pressing issue of food insecurity in their area, which has been exacerbated by increasing living and food costs, shortages of essential items like baby formula, and the lingering economic impact of COVID-19. The end of COVID-19 relief funds, combined with the

	<p>continued rise in living expenses, has created financial hardship for many. Certain populations, including the elderly, young families, and the lower middle class, face disproportionate challenges in accessing affordable, nutritious food. This situation underscores the need for focused assistance programs to help bridge the income-expense gap for those who are experiencing food insecurity in the community.</p>
Transportation	<p>Key informants and listening session participants in the community discussed transportation challenges, including the absence of a comprehensive public transportation system, no evening transportation options after 5 PM, and the resulting difficulties in accessing behavioral health and healthcare services. This lack of transportation has forced healthcare agencies to rely on other organizations for patient transportation. The community's limited, inconvenient, and costly public transportation options create significant barriers to accessing essential services, particularly in the realm of behavioral healthcare, putting a strain on local resources and responsibilities.</p>
Support for Schools	<p>Support for schools, including funding, grants, and the creation of after-school programs, is essential. Many schools face budget constraints, making it challenging to sustain existing after-school initiatives; adequate financial backing ensures these programs can flourish, benefiting students. Moreover, there's a pressing lack of after-school options, leaving children and teenagers with limited educational and structured activities outside of regular school hours. Supporting the establishment of new programs can address this gap. These after-school initiatives are critical for youth development, providing a secure and enriching environment for various activities that foster academic success, personal growth, and the acquisition of vital life skills. Overall, this support is integral not only for educational and developmental needs but also for the safety and well-being of the community's young population.</p>

See [Appendix 2](#) for methodology and participant details

SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by key informants through a ranking process and by community members through discussion and theming of the data. Additionally, needs were identified after reviewing the quantitative data.

The Covenant CHNA Advisory and Community Benefit Committee reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

- Mental Health
- Substance Abuse
- Access to Care and Health Resources
- Housing
- Food Insecurity
- Economic Insecurity
- Crime/Safety/Safe Public Spaces
- Homelessness
- Chronic Conditions/Obesity
- Civic Issues
- Transportation
- Racial and Health Equity Issues
- Support to Schools
- Support to Aging Populations
- Teen and Youth Support Programs

Identification and Prioritization of Significant Health Needs

The Covenant CHNA Advisory and Community Benefit Committee reviewed the medium and high need issues identified within the community input. Additionally, primary data was examined with an emphasis on the high need service areas. The committee also considered Covenant Community Outreach staff input.

The following criteria were used in the prioritization process:

						
Alignment with Mission, Vision and Values	Importance to Community: extent community engagement recognized and identified as a problem	Disproportionate impact: low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities	High need service area rates compared to state average and/or national benchmarks	Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need	Alignment with existing strategies and priorities	Risk of creating or increasing a gap by not addressing or stopping a current service

2023 Priority Needs

The list below summarizes the significant health needs identified through the 2023 Community Health Needs Assessment process (listed in no order):

MENTAL/RELATIONAL HEALTH

Mental and behavioral health treatment, intervention, and prevention services for the community; including social and relational health, stigma reduction, and community education.

SUBSTANCE MISUSE

Substance misuse including the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco; community education and awareness through partnerships with non-profits, law enforcement, and schools; support for accessibility and availability of addiction treatment options.

ACCESS TO CARE AND HEALTH RESOURCES

Issues related to accessing health services and resources including social determinants of health with an emphasis on vulnerable populations and health equity; includes but is not limited to the following areas of focus: Dental Care for the Uninsured, Mental Health and Counseling Services, Health Education (preventative care and chronic diseases), Women’s Health, and social determinants of health.

FOOD INSECURITY

Access to healthy food, nutrition education, and healthy lifestyle support with an emphasis on health equity; supporting current food solution partners and options to meet growing needs and to address root causes.

Alignment with Other Community Health Needs Assessments

To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including City of Lubbock Community Needs Assessment 2021 and University Medical Center CHNA 2022. We also reviewed the South Plains Community Action Association Annual Report, Lubbock Health Department 2023 Statical Reports, and The Lubbock Area United Way Status Report 2022. The Covenant CHNA Advisory Committee and Covenant Community Outreach staff reviewed these CHNA reports to confirm alignment with government and non-profit organizations serving Lubbock and the surrounding counties.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include South Plains Rural Health Levelland, University Medical Center Lubbock, Larry Combest Health and Wellness Center, Plainview Health Department, RHN Medical & Dental Group Plainview, and Community Health Centers of Lubbock. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see [Appendix 3](#).

EVALUATION OF 2021-2023 CHIP

The 2021 CHNA and 2021-2023 CHIP priorities were the following: Mental and Behavioral Health, Access to Health Services, Homelessness and Housing Instability, and Food Insecurity and Nutrition. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). Covenant Health responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 51. Outcomes from 2021-2023 CHIP

Priority Need	Program	Program Description	Results/Outcomes
Mental and Behavioral Health	Covenant Community Counseling Center	Outreach counseling center for vulnerable populations within the service area.	Service sites were expanded to include on-site counseling for various community partners. Wrap around counseling services were made available to Lubbock ISD students enrolled in the Community Advocacy Program. Tele-health counseling was added to support Levelland, Plainview and surrounding communities. Counseling internship program created through partnerships with area universities to expand counseling access.
Access to Health Services	Covenant Dental Outreach	Outreach clinic located in Plainview and Lubbock for low-income and uninsured community members.	The dental outreach team provided dental sealants and oral health screenings to elementary schools in Levelland, Sundown, Littlefield, and Lubbock; Sealants were also provided at the Lubbock YWCA; educated and provided oral hygiene items to over 700 children annually; Provided free dental services to homeless and low-income adults through a partnership with the Lubbock Health Department and Lubbock Impact.
Food Insecurity and Nutrition	Covenant Health Education Program	Community health education program which partners with Covenant Health Partners and Health Equity to provide free	Expanded health outreach to include more diabetes health education classes and individual appointments at Catholic Charities, Lubbock Children’s Health Clinic, The Lubbock Dream Center, Our Lady of Grace church, and Salvation Army and the Lubbock YWCA; collaboration with Health Equity to include

		community health education and community case social services support	diabetes program in 2022, provided on-site screening and interventions for food insecurity at Catholic Charities. Provided funding to local food pantries and to The Dream Center Action Family Food Outreach
Homelessness and Housing Instability	Community Grant, Financial and In-kind Support	Built for Zero and Grant Support and In-Kind Support	Provided funding to Open Door for Housing First and permanent supportive provided in-kind and grant support to Habitat for Humanity; provided dental and navigation services to Open Door; Funded Community Solutions Built for Zero program for community housing providers

Addressing Identified Needs

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

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Covenant Health and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Covenant Health Plainview Board of Directors² of the hospital on October 19th, 2023. The final report was made widely available by December 28, 2023.



12/01/23

Walter L. Cathey FACHE
CEO Covenant Health
Providence Regional Chief Executive Texas/New Mexico

Date



12/01/23

Barbara Kiser
Chair, Covenant Health Plainview Board

Date



12/8/23

Joel Gilbertson
Divisional Chief Executive
Providence Central Division

Date

CHNA/CHIP Contact:

Veronica Soto
Community Programs Manager
4421 21st, Lubbock Texas 79410
vsoto@covhs.org

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

² See [Appendix 4: Covenant Health Plainview Board of Directors](#)

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Hale County Demographics

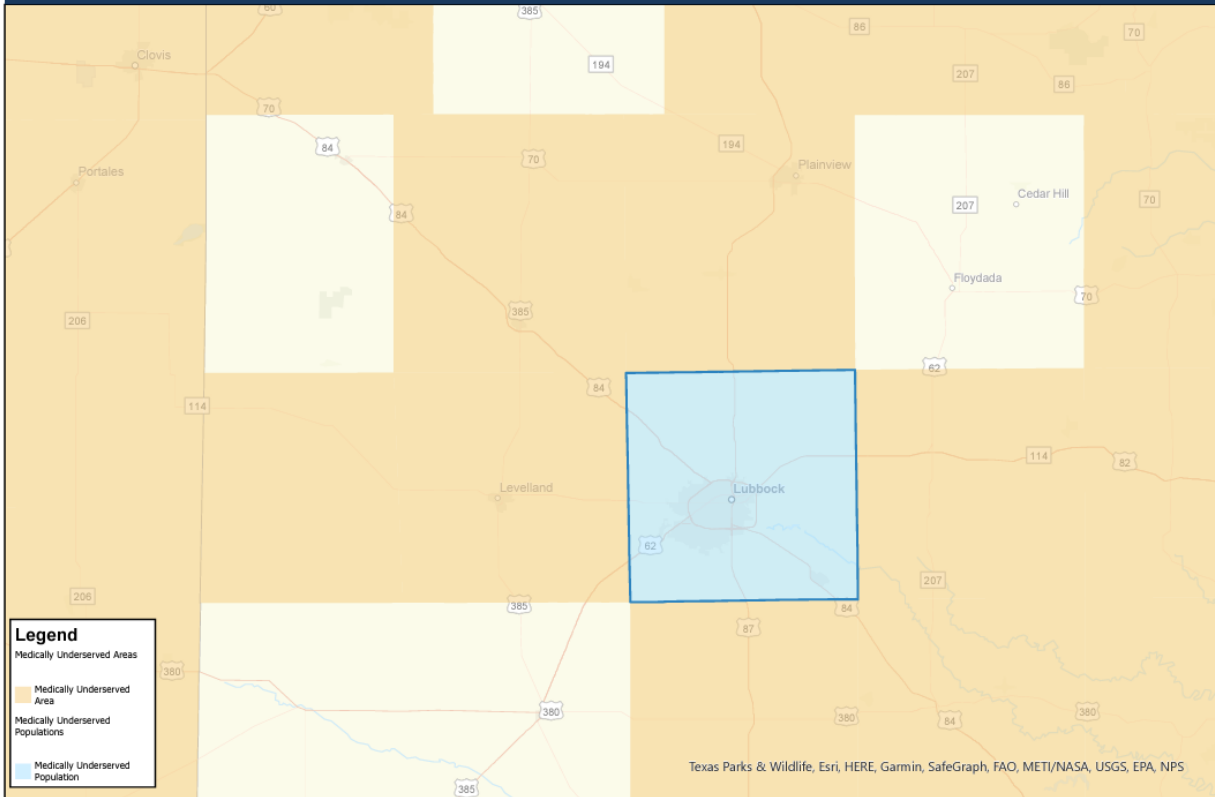
Indicator	Hale County	Broader Service Area	High Need Service Area
Population by Age Groups			
Total Population	32,879	16,931	15,948
Population Age Under 5	6.5% (2,137)	5.3% (889)	7.8% (1,248)
Population Age Under 18	27.2% (8,946)	23.1% (3,913)	31.6% (5,033)
Population Ages 18 to 34	24.6% (8,080)	24.1% (4,074)	25.1% (4,006)
Population Ages 35 to 54	24.0% (7,903)	23.6% (3,992)	24.5% (3,911)
Population Ages 55 to 64	10.9% (3,596)	12.4% (2,096)	9.4% (1,500)
Population Ages 65 to 84	11.3% (3,706)	13.8% (2,339)	8.6% (1,367)
Population Age 85 and Over	2.0% (648)	3.1% (517)	0.8% (131)
Population by Gender			
Female	47.5% (15,608)	44.8% (7,592)	50.3% (8,016)
Male	52.5% (17,271)	55.2% (9,339)	49.7% (7,932)
Population by Race			
American Indian and Alaska Native	0.2% (59)	0.2% (34)	0.2% (25)
Asian Population	0.4% (128)	0.3% (45)	0.5% (83)
Black or African American Population	4.3% (1,430)	5.9% (1,003)	2.7% (427)
Native Hawaiian and Other Pacific Islander Population	0.0% ()	0.0% ()	0.0% ()
Other Race Population	6.9% (2,267)	4.8% (808)	9.1% (1,459)
Two or more Races Population	14.2% (4,654)	9.2% (1,559)	19.4% (3,095)
White Population	74.0% (24,341)	79.6% (13,482)	68.1% (10,859)
Population by Ethnicity			
Hispanic Population	60.6% (19,936)	46.2% (7,819)	76.0% (12,117)

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). More information on HPSAs in Texas can be found here: <https://www.dshs.texas.gov/texas-primary-care-office-tpco/health-professional-shortage-area-designations>

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary. The following maps depict the MUAs and MUPs in the area. Lubbock County is designated as an MUP for low-income populations. Hale, Hockley, and Lea are designated as MUAs.



Appendix 2: Community Input

METHODOLOGY

The hospital completed two key informants focus group sessions that included a total of thirteen participants and one key informant interview. The sessions occurred between July and August 2023.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Organizations were included who represent medically underserved, low-income, and/or minority populations. The hospital interviewed the Nurse Manager from the Plainview Health Department as a key informant to ensure the input from a state, local, tribal, or regional governmental public health department.

Table_Apx 1. Community Key informant Participants

Organization	Name	Title	Sector
Plainview Health Department	Odilia Alvarado	Nurse Manager	Public Health
Wee Care Center	Michelle Rivera	Teacher	Childcare
Plainview Ahead	Damone Davis	Public Relations	Equality Advocacy
Wee Care Center and United Baptist Church	LeQuitta Davis	Assistant Director	Childcare Faith Community
Temple Sinai	Soley Soto	Volunteer	Faith Community
Crisis Center of the South Plains	Stephanie Godino	Executive Director	Community Based Non-Profit
Plainview Fire Department	Bobby Gibson	Fire Chief	First Responders
Plainview Independent School District	Sara Marquez	Elementary Advanced Academics Coordinator	Public Education
Salvation Army Plainview	Grace Velasquez	Social Worker	Community Based Non-Profit

Central Plains	Sylvia De La Garza	Supervisor	Community Based Non-Profit
Covenant Health Plainview	Sherrie Wall	Mission Integration Manager	Non-Profit Healthcare
Covenant Health Plainview	Homer Marquez	Director of Operations	Non-Profit Healthcare
Covenant Health Plainview	Brandy Mangan	Nurse Manager, ICU	Non-Profit Healthcare
Covenant Health Plainview	Susan Wilhoite	Nursing Manager ED	Non-Profit Healthcare

Facilitation Guides

For the key informant interview and focus groups, Providence developed a facilitation guide that was used across all hospitals completing their 2023 CHNAs:

- The community served by the key informant’s organization
- The community strengths
- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

Training

The facilitation guides provided instructions on how to conduct a key informant interview and listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a key informant interview and listening session and were provided question guides.

Data Collection

Key informant sessions were conducted primarily in-person with a virtual option, and information was collected in one of two ways: 1) recorded with the participant’s permission or 2) a note taker documented the conversation. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

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

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the sessions using a merged set of notes. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

Limitations

While key informants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Some sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

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

FINDINGS FROM KEY INFORMANT FOCUS GROUPS AND INTERVIEWS

Community Needs

Participants in the key informant focus group and interview sessions highlighted several pressing community needs observed in the hospital setting in Plainview:

- **Chronic Disease:** Listening session participants identified chronic disease as a significant concern within the community. Diabetes is a significant health concern in the community and participants expressed the need to address health equity issues in diabetes care. The hospital is working on expanding and re-engaging their diabetes program to address this need. Additionally, there are plans for expanded diabetes outreach that will work on addressing a crucial need for the community.
- **Homelessness and Housing Instability:** Participants discussed observing an increase in homelessness within the community. Listening session participants suggested some of the increase in homelessness can be attributed to an increasing number of individuals experiencing homelessness coming to Plainview from nearby areas like Lubbock and Amarillo.
- **Transportation:** Transportation is a major issue within the community, especially after 5 PM and on weekends. There is a need for alternative transportation to cars within the community, as the lack of transportation options directly affects access to healthcare. The hospital struggles with providing transportation to its patients. In the past, employees would try to meet this need by using their personal cars to provide transportation to patients, however this is no longer a viable option due to liability concerns.
- **Food Insecurity:** Participants emphasized that food insecurity is a growing issue within the community. This can be attributed to high food costs, which is particularly affecting the elderly and youth. Affordability and accessibility to nutritious food are challenges impacting community health, leading many individuals to face difficulties when it comes to making nutritious choices. Consequently, there is a pressing need for education that promotes affordable and nutritious alternatives. During the listening session, participants underscored the importance of enhancing health and wellness education, with a specific emphasis on making it relatable to a broader audience.
- **Racial Inequities in Healthcare:** Racial inequities in healthcare are still observed in the community. Listening session participants emphasized the need for addressing these disparities.
- **Access to Medications:** Some individuals face challenges accessing medications. Lack of access to necessary medications can lead to emergency room visits when they cannot take prescribed medications.
- **Healthcare Provider and Caregiver Support:** Caregivers in the community are in need of more support. Listening session participants described caregivers in the community as overwhelmed and in need of support to recharge in order to continue contributing to the community through volunteering and caregiving.
- **Behavioral health and substance use/misuse:** Substance use/misuse and mental health issues persist in the community, with insufficient resources to meet the demand for support.

Community Strengths

The interviewer asked participants to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Strong sense of community: The community in Plainview has a strong sense of togetherness and mutual support. People are engaged and involved within the Plainview community, volunteering their time, helping each other out and, and being willing to collaborate for the greater good of their neighborhood. The community actively supports cultural events such as Juneteenth, demonstrating a commitment to celebrating and preserving their cultural heritage.

Quality community resources and organizations present: There are many community resources and organizations that demonstrate the diversity of support and services available within Plainview. They cover areas such as emergency response, healthcare, family support, cultural enrichment, and education, contributing to the overall quality of life in the community.

Effective collaboration between organizations, agencies, and resources: Organizations in Plainview collaborate through resource sharing, healthcare partnerships, community outreach, support for cultural events, and emergency response coordination. These collaborative efforts reflect a commitment to improving the community's well-being, addressing its needs, and celebrating its culture. There is a willingness to support and work together to address community needs, even when faced with bureaucratic challenges. Collaboration enhances the effectiveness of individual organizations and strengthens the overall resilience and cohesion of the community.

Organizations, agencies, and resources are engaged and involved with the community: Organizations in the Plainview community actively engage and involve themselves in various aspects of community life, including outreach, partnership, cultural support, resource distribution, education, advocacy, and employment opportunities. Their active participation contributes to the well-being, unity, and overall development of the community. By striving to increase their outreach efforts to provide the community with information about available resources, they are actively fostering a culture of awareness and support.

Generosity and Resource Sharing: The community is known for its generosity, with a willingness to donate items such as diapers and hygiene products. Donations are substantial and benefit various organizations, not just the receiving ones. There is a culture of sharing resources across different organizations within the community. This collaborative approach helps in efficiently meeting the needs of the community.

The strengths of the Plainview community lie in their strong sense of unity, generosity, effective collaboration among emergency services and agencies, resource sharing, and a commitment to community well-being through various outreach initiatives and healthcare partnerships. Key informants valued the collaboration among organizations and agencies and suggested leveraging this strength by

fostering even stronger partnerships between different entities, and creating formal collaborative initiatives to address specific community needs more effectively.

HIGH PRIORITY UNMET HEALTH-RELATED NEEDS

Key informants were asked to identify their top five health-related needs in the community. Three needs were prioritized by most key informants and with high priority. Three additional needs were categorized as medium priority. Key informants were most concerned about the following health-related needs:

- Homelessness
- Behavioral health challenges and access to care (mental health and substance use/misuse)
- Access to healthcare

Homelessness

Key informants identified homelessness as a rising issue within the community. They emphasized the complexity of homelessness and housing issues within the community, the need for more resources, support for individuals experiencing homelessness from outside the area, and specific attention to the education and well-being of teens and students who are experiencing homelessness.

- **Homelessness has been within the community:** Key informants and listening session participants said homelessness has been on the rise in the community, suggesting a growing issue that needs attention. The COVID-19 pandemic exacerbated existing homelessness within the community due to economic and social factors. However, a significant portion of the current homeless population is not local to the area, indicating that the problem extends beyond just local residents. Many homeless individuals in the community come from Lubbock or Amarillo because they often face barriers to accessing help within their local community due to a lack of identification.
- **Lack of resources addressing homelessness:** Key informants discussed a lack of resources present in the community to meet the growing need. There is a shortage of funding to adequately address the homelessness problem, which may be contributing to the issue. There are long waitlists for HUD housing programs, prompting some people to seek assistance from Floydada's public housing programs because the wait in Plainview is too lengthy. More people are resorting to living in hotels. Key informants urged for increased investment in shelters, mental health services, substance use/misuse treatment programs, and affordable housing options.
- Key informants identified that youth especially seem to be impacted by homelessness.
 - **Youth:** There is an observable increase in the number of children and teenagers who are experiencing homelessness, highlighting the need for additional support for this vulnerable demographic. Homelessness affects teenagers in the community, and there is a need to provide education and support to these youth who need housing and other assistance.

Behavioral health challenges and access to care (mental health and substance use/misuse)

Participants highlighted several significant behavioral health needs within the community. These needs encompass a range of issues, from substance use/misuse to mental health stigma and access to care, detailed below:

Key informants discussed several barriers that prevent people from accessing mental health and substance use services, including:

- **Transportation:** Lack of transportation hinders access to behavioral health services, and agencies lack transportation assistance for individuals in need.
- **Language barrier:** Language barriers prevent some individuals from seeking behavioral health resources. There is a need for multilingual resources and culturally sensitive mental health services to ensure access for diverse populations.
- **Stigma:** Stigma prevents families from seeking mental health help for themselves and their children, and they are hesitant to involve schools. Public awareness campaigns and community discussions can help reduce the stigma and encourage more people to seek support when needed.

Key informants discussed how youth in particular face challenges regarding mental health and substance use/misuse:

- **Increase in Suicidal Thoughts and Depression Among Younger Kids:** Younger kids are experiencing an increase in suicidal thoughts and depression. The rise in suicidal thoughts and depression among younger children underscores the need for increased awareness and education about mental health among youth. Schools can play a vital role in providing mental health education and resources for parents, teachers, and students.
- **Vaping:** Vaping has become a concerning issue among teenagers, which can lead to addiction and other health problems. Key informants suggested community education programs for both teenagers and parents can be helpful in addressing this issue.
- **Open Communication and Education:** Key informants discussed how the community should prioritize open communication about mental health and provide resources for education. Schools, community centers, and local organizations can collaborate to provide workshops, seminars, and information to raise awareness.
- **Addressing these behavioral health needs will require a coordinated effort involving community leaders, healthcare providers, schools, advocacy groups, and local government. Raising awareness, reducing stigma, improving access to care, and providing education are essential steps in creating a more supportive and mentally healthy community.**

There is a Lack of Mental Health Facilities and Resources: The absence of mental health facilities and resources in the community is a significant challenge. First responders will often take people who are experiencing mental health crises to the ER, but emergency rooms are not the ideal setting to treat mental health crises. Developing crisis intervention teams and crisis centers can provide more appropriate care for individuals experiencing mental health emergencies.

Difficulty Accessing Medications: Participants discussed how difficult it can be for patients to access essential medications they need to treat their mental health. Advocacy for improved prescription access and support programs can be beneficial.

Community Collaboration: There is a need for community agencies to collaborate, advertise available resources, and educate the community about what is accessible. Collaborative efforts between community agencies can help consolidate resources and create a more comprehensive network of mental health support. Promoting available resources through various channels can increase public awareness about what help is available to them.

Access to Healthcare

Key informants discussed how the community faces multiple challenges in accessing healthcare services, including gaps in women's healthcare, STD testing, and prescription access, as well as systemic issues related to language barriers, discrimination, and health literacy. Addressing these issues will require a comprehensive approach to improve healthcare access and equity in the community.

Lack of sufficient services: The local health department lacks a clinic, leading to the need for referrals for those seeking medical services. Emergency Medical Services (EMS) is struggling with reduced funding and increased demand. Medication shortages exacerbate the demand, as people without access to necessary medications find themselves in medical crises.

STD Testing and Treatment: There is a pressing need for expanded STD testing and treatment services, especially for young adults.

Access to Medication: Many individuals in the community face difficulties in accessing necessary medications, leading to health crises. Many residents are unable to afford life-saving medications, such as diabetes medication. Access to prescriptions needs to be increased, and education on medication adherence should be provided to prevent health crises.

Health Education: There is a need to improve overall access to healthcare services and health education, particularly for Black and Spanish-speaking residents.

Support for healthcare providers and caregivers: Healthcare providers and caregivers in the community are in need of more support. Listening session participants described caregivers in the community as overwhelmed and in need of support to recharge in order to continue contributing to the community through volunteering and caregiving.

COVID-19 Impact: The COVID-19 pandemic has disrupted healthcare services, including vaccine access and vaccine hesitancy. Many people fell behind in receiving vaccines during this time period. However, vaccine resistance is gradually decreasing.

Key informants and listening session participants discussed several barriers that prevent people from accessing healthcare services, including:

- **Language Barriers:** Language barriers hinder individuals from seeking healthcare services. The absence of Spanish-speaking healthcare providers makes it challenging for Spanish-speaking residents to access care. Health education and focused programs should be developed in Spanish to better reach this population.
- **Health Literacy:** Many people struggle to receive adequate care due to difficulties in understanding medical terminology.
- **Transportation:** Lack of alternative transportation options to cars makes it difficult for people to travel to access healthcare services.

Certain populations face unique challenges in accessing healthcare:

- **People who are uninsured:** Uninsured individuals in the community cannot access primary care and regular screenings.

- **Women:** There is a significant gap in women's healthcare services, with women struggling to access gynecological and reproductive health services.
- **BBIPOC:** Racial disparities and discrimination within the healthcare system are evident, particularly in the treatment of women of color. Women of color in particular, report feeling unheard.

MEDIUM PRIORITY UNMET HEALTH RELATED NEEDS

Three additional needs were often prioritized by key informants:

- Food Insecurity
- Transportation
- Support for schools

Food Insecurity

Key informants discussed how the community is grappling with the complex issue of food insecurity, exacerbated by economic challenges and a lack of sufficient support programs, detailed below:

Rising Costs: The cost of living and the cost of food have been on the rise, making it increasingly difficult to afford healthy food.

Shortages of Essential Items: Community members have reported shortages of crucial items such as baby formula, highlighting the strain on the availability of necessities.

COVID-19 Impact: Food insecurity and housing insecurity have seen a notable increase in the aftermath of the COVID-19 pandemic, suggesting lingering economic challenges. Many in the community relied on COVID-19 relief funding, which has now run out. However, the cost of living continues to increase, exacerbating financial hardships.

Some populations experience disproportionate impact related to food insecurity:

- **Elderly Population:** Older adults in the community are facing challenges in accessing healthy food due to affordability issues, putting their nutritional well-being at risk.
- **Young Families:** Young families are also struggling to afford nutritious food, with many being forced to compromise on the quality of the food they can afford.
- **Lower Middle Class:** The lower middle class is in a precarious situation, as they earn too much to qualify for most assistance programs yet struggle to meet all their needs, especially as the cost of living continues to rise. The lower middle class is particularly affected by economic insecurity, highlighting the need for targeted assistance to bridge the gap between income and expenses.

Transportation

Key informants discussed transportation challenges within their community, highlighting the following issues:

Limited Public Transportation: The community lacks a comprehensive public transportation system. This deficiency places additional burdens on agencies providing healthcare and behavioral health services, forcing them to seek assistance from other organizations to arrange transportation for their patients.

No Evening Transportation Options: After 5 pm, there are no viable transportation options available to residents. The existing public transportation system presents challenges as it requires appointments made 24 hours in advance, making spontaneous or urgent travel difficult. Moreover, the cost of using this service is prohibitive for many people.

Direct Impact on Access to Behavioral Healthcare and Healthcare services: The absence of adequate transportation severely impacts individuals' ability to access behavioral health services. Notably, agencies lack access to transportation assistance to support individuals in need. This results in situations where people may be sent to rehabilitation facilities but are left without transportation when they are discharged. In the absence of alternative transportation options, the burden of providing rides to patients falls on the Hale County Sheriff's Office, further stretching their resources and responsibilities. The lack of transportation in the community has far-reaching consequences, particularly in accessing vital behavioral health services. Public transportation is limited, and even when available, it is not user-friendly or affordable. These challenges place significant pressure on healthcare agencies and the local sheriff's office to address transportation needs within the community.

Support for Schools

Support for schools, especially in terms of funding, grants, and the establishment of after-school programs, is essential. It not only addresses the educational and developmental needs of students but also contributes to the overall safety and well-being of the community's young population.

Funding and Grants for Existing After School Programs: Many schools are struggling to maintain their after-school programs due to budget constraints. Adequate funding and grants can ensure that these programs continue to thrive, providing valuable opportunities for students.

Lack of After School Programs: There is a significant shortage of after-school programs. This gap leaves children and adolescents with limited options for structured and educational activities outside of regular school hours. Support can help establish new programs to bridge this gap.

Importance of After School Programs for Youth: After-school programs play a vital role in the development of young minds. They offer a safe and enriching environment where students can engage in various activities. These programs contribute to academic success, personal growth, and the development of crucial life skills.

Appendix 3: Community Resources Available to Address Significant Health Needs

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

Table_Apx 2. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
Hospital	University Medical Center	Primary Medical and Acute Care, Lubbock County Indigent Program	602 Indiana Ave, Lubbock, TX 79415	Access to Care
Health Sciences Center	Texas Tech University Health Sciences Center	Primary Medical Care, Specialty Care, Mental Health, Lubbock County Indigent Program	3601 4th St., Lubbock, TX 79430	Access to Care and Mental Health Services
Federally Qualified Health Center	Larry Combest Health and Wellness Center	Primary Medical Care, Limited Specialty Care, Mental Health, Health Education, Prescription Assistance, Lubbock County Indigent Program	301 40 th , Lubbock, TX, 79404	Access to Care
Non-Profit Clinic	Lubbock Children's Health Clinic	Pediatric and Women's health services	302 N University Ave, Lubbock, TX 79415	Access to Care
Federally Qualified Health Center	Community Health Centers of Lubbock	Primary Care, Dental, Prescription Assistance	1610 5 th St., Lubbock, TX 79401	Access to Care

Non-Profit	YMCA Plainview	Healthy Living and Youth Programs	313 Ennis, Plainview, TX 79072	Access to Health Resources
Non-Profit	South Plains Community Action Association	Head Start Program, Children’s Dental, Children’s Mental Health Services, Food and Nutrition, Transportation Services, Utility Assistance	411 Austin Street Levelland, Texas 79336	Access to Care, Mental Health, Food Insecurity, Education, Economic Assistance
Federally Qualified Health Clinic	South Plains Rural Health	Healthcare Services for Levelland, Lamesa, and Big Spring, Texas	1000 FM300, Levelland, TX 79336	Access to Care, Social Services
Federally Qualified Health Clinic	Regence Health Network, Inc	Medical, Dental, Behavioral Health, Laboratory Services, WIC Services	2801 W. 8th St., Plainview, TX 79072	Access to Care, Mental Health
Community Action Agency	Housing and Utility Assistance	Low Rent Housing	208 North Turner, Hobbs, NM 88240	Housing Assistance
Non-Profit	Guidance Center of Lea County	Substance Misuse Counseling, Health Promotion, Supportive Housing	920 West Broadway, Hobbs, NM 88241	Mental Health, Substance Misuse, Housing
Public Health	Hobbs Department of Health	Immunizations, Nutrition, Health Education, Women, Infants and Children	1923 North Dal Paso St B, Hobbs, NM 88240	Access to Care, Food Insecurity
Non-Profit	Open Door	Permanent Supportive Housing	1916 13 th , Lubbock, TX 79401	Housing

Appendix 4: Covenant Health Plainview Board of Directors

Table_Apx 3. Board of Directors Members

Name	Title	Organization	Sector
Laura Brandenburg	Christian Author and Speaker	Self-Employed	Independent
Sheron Collins	Justice of the Peace	Hale County	Government
Tyke Dipprey	Managing Director	Higginbotham Insurance	Local Business
Randy Kaufman	Certified Public Accountant	Lewis, Kaufman, Reid, Stukey, Gattis & Co., P.C.	Local Business
Barbara Kiser	Owner	Kiser Auto Parts	Local Business
Regan Manning	Financial Advisor	Edward Jones	Finance
Cassie Mogg	Administrator	Covenant Health Plainview	Non-profit Healthcare
Joshua Rollins, DO	Physician	Covenant Health Plainview	Non-profit Healthcare
H.T. Sanchez	Superintendent	Plainview Independent School District	Public Education
Mark True	Commercial Sales	Allstar Fuel	Energy
John Tye	Chairman	Learwood Capital Inc.	Finance
Chris Williams	Executive Director	West Texas Area Health Education Center	Workforce Development