CHRISTUS Spohn Health System

Community Health Needs Assessment 2020-2022

About Texas Health Institute:

Texas Health Institute (THI) is a non-profit, non-partisan public health institute. Since 1964, THI has served as a trusted, leading voice on public health and healthcare issues in Texas and the nation. THI's expertise, strategies, and nimble approach makes it an integral and essential partner in driving systems change efforts. THI works across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life.

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EXECUTIVE SUMMARY

CHRISTUS Spohn Health System is a non-profit, Catholic integrated health care delivery system that includes five acute care hospitals in four counties in the coastal bend region. CHRISTUS Spohn Health System's dedicated staff provides specialty care tailored to the individual needs of every patient, aiming to deliver high-quality services with excellent clinical outcomes. CHRISTUS Spohn Health System works closely with the local community to ensure regional health needs are identified and incorporated into system-wide planning and strategy. To this end, CHRISTUS Spohn Health System commissioned Texas Health Institute to conduct and produce its 2020-2022 Community Health Needs Assessment (CHNA), as required by law to be performed once every three years as a condition of 501(c)(3) tax-exempt status.

In this community health needs assessment, THI staff and CHRISTUS Spohn Health System community stakeholders analyzed over 40 different indicators of health needs based on demographics and socioeconomic trends; measures of physical, behavioral, social, and emotional health; and risk factors and behaviors that promote health or produce sickness. The latter provided insight into social determinants of health operating in the report area, such as transportation, and food insecurity. Report findings combine secondary analysis from publicly available data sources, hospital utilization data and input from those with close knowledge of the local public health and health care systems to present a comprehensive overview of unmet health needs in the region.

The voice of the community guided the needs assessment process throughout the life of the project, ensuring the data and analyses remained grounded in local context. Focus group and needs prioritization meetings ensured input from low income and minority communities and stakeholders representing those communities. Through an iterative process of community debriefing and refinement of findings, a final list of five prioritized health concerns were developed. These are summarized in the table below. This priority list of health needs and the data compiled in support of their selection lays the foundation for CHRISTUS Spohn Health System to remain an active, informed partner in population health in the region for years to come.

Rank	Health Concern
1	Mental Health/ Drug Abuse/ Suicide
2	Affordable Housing
3	Community and Family Violence
4	Vulnerable Populations and Trust
5	High Emergency Room Use

CHRISTUS Spohn Health System Prioritized Health Needs, 2020-2022

INTRODUCTION

CHRISTUS Spohn Health System (CSHS) is a non-profit hospital system serving the Coastal Bend region. CSHS responds to the region's health care needs through services provided at three hospital campuses composing the CHRISTUS Spohn Hospital Corpus Christi -- the 557-bed Shoreline campus, the 341 bed Memorial campus, and the 158-bed South campus. Additionally, CSHS serves more rural communities through the CHRISTUS Spohn Hospital Kleberg with 100 beds in Kingsville, CHRISTUS Spohn Hospital Alice with 135 beds in Alice, and CHRISTUS Spohn Hospital Beeville in Beeville with 69 beds. All CSHS facilities share one objective - to lead the way to a healthier community. The CHRISTUS Spohn region offers comprehensive health care ranging from its primary care family health clinics, to its six acute care hospitals, the only Level II Trauma Center in the region, and the only inpatient behavioral medicine program that accepts the uninsured. In addition, a comprehensive Cancer Center, Palliative Care program, CHRISTUS Home Health, and CHRISTUS Hospice provide care for families and patients at the end of life.

While CSHS serves a wide swath of the coastal bend region, CSHS defines the report area for this Community Health Needs Assessment (CHNA) to include the following four Texas counties: Nueces, Bee, Jim Wells and Kleberg. The demography and socioeconomic conditions of these counties are broadly representative of the CSHS service area. As such, they offer insight into the health needs of the patients of and communities surrounding the six hospitals for which this CHNA is conducted. [1]

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico and Chile. As part of CHRISTUS Health's mission "to extend the healing ministry of Jesus Christ," CSHS strives to be, "a leader, a partner, and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love."[2]

Federal law requires all non-profit hospitals to conduct a CHNA every three years to maintain their tax-exempt status. CHRISTUS Health contracted with Texas Health Institute (THI) to develop the CHNA report for CSHS, a document that will fulfill the requirements set forth in IRS Notice 2011-52, 990 requirements for non-profit hospitals' community health needs

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[1] The following six facilities are included in the CHNA for CSHS: CHRISTUS Spohn Hospital Corpus Christi- Shoreline, CHRISTUS Spohn Hospital- Alice, CHRISTUS Spohn Hospital- Beeville, CHRISTUS Spohn Hospital- Kleberg, CHRISTUS Spohn Hospital Corpus Christi- Memorial and CHRISTUS Spohn Hospital Corpus Christi- South.

[2] CHRISTUS Health. (2019). Our mission, values, and vision. Available at: http://www.christushealth.org/OurMission.

assessments and will be made available to the public. To complete its CHNA, the THI team and CSHS leadership drew upon a wide range of primary and secondary data sources and engaged a group of community residents and stakeholders with special knowledge of vulnerable population groups and the local public health landscape. All together, these data and diverse perspectives provide insight into community health needs, priorities, challenges, resources, and potential solutions.

A CHNA ensures that CSHS has made efforts to identify the unmet health needs of residents in its service region, examine barriers residents face in achieving and maintaining good health status and inventory health opportunities and assets available within the report area that can be leveraged toward the improvement of population health. The CHNA lays the foundation for future planning, ensuring that CSHS is prepared to undertake efforts that will help residents of the local community attain the highest possible standard of health.

METHODOLOGY

REVIEW OF LITERATURE AND QUANTITATIVE DATA

THI staff conducted a literature review using previously published community health needs assessments and other reports focused on health in report region. These included regional assessments such as the *Community Needs Assessment* released in 2018 by the Regional Healthcare Partnership 4 and the Community Health Implementation Strategy 2015-2017 released by Driscoll Children's Hospital.[3,4] Findings from the literature review, CSHS's prior CHNA, and CSHS progress reporting on initiatives launched in response were incorporated into project design, interviews, focus groups, and this report as applicable.

THI used a mixed-methods approach to data collection and analysis. Both qualitative and quantitative measures are drawn from primary and secondary data sources to ensure a comprehensive understanding of health needs and the potential for CSHS to address those needs in collaboration with community partners. This mixed-methods approach is standard in all THI needs assessments and was used in concurrent needs assessments in four other CHRISTUS services areas in 2019.

CHNA development began with collection and examination of quantitative data from secondary sources. Unless otherwise specified, all data were accessed from Community Commons, a repository of community-level data compiled from archival sources including, but not limited to, the American Community Survey, U.S. Census Bureau, the CDC Behavioral Risk Factor Surveillance System, and the National Vital Statistics System. The most recent data available from this source were examined for the report area in aggregate and by county across several dimensions, including sociodemographics, health risk behaviors, access to care and clinical outcomes. THI subsequently obtained internal data from CSHS's main and satellite hospitals

[3] Community Needs Assessment. (2018). *Regional Healthcare Partnership 4*. Available at: https://www.nchdcc.org/pdf/RHP-4-Final-CNA-April-2018.pdf.
[4] Community Health Implementation Strategy 2015-2017. *Driscoll Children's Hospital*. available at: https://issuu.com/texashealthimprovementnetwork/docs/implement2016_driscoll_children_s_h

and conducted a descriptive analysis. Together, THI staff reviewed over 40 measures and categorized them for higher-level examination.

KEY INFORMANT INTERVIEWS

Purpose

The purpose of in-depth interviews was to gather a broad sample of perspectives on significant health needs in the community. Findings from interviews informed the design of the focus group and were incorporated into the results to lend context to quantitative patterns and trends. Semi-structured interviews followed a pre-designed questionnaire covering the identification of health needs, community resources, and possible opportunities for action. The interviewer asked about barriers and reasons for unmet health needs, existing capacity, needed resources, and potential solutions that could enhance well-being in the community, either for specific subgroups or the population at-large. The full-length Key Informant Interview Protocol can be found in Appendix B of this report.

Sample and Recruitment

Representatives from CSHS contributed contact information for 36 people who represent the broad interests of Corpus Christi and who possess knowledge about the region's health-related challenges. For example, key stakeholders included nonprofit leaders, health department authorities, university and college leaders, healthcare providers or leaders, human services providers, local and state agencies, people representing distinct geographic areas and people representing diverse racial/ethnic groups.

To recruit interviewees, the THI team contacted these 36 key informants by email and telephone, and 13 individuals responded to the request. THI conducted 13 interviews between April and May 2019, each lasting between 30 to 60 minutes.

Recordings

THI used the notes and recordings for each key informant interview for later coding and analysis. The identities of key informants and transcribed content of their statements will remain confidential.

FOCUS GROUP

Purpose and Questions to Address

The purpose of the focus group was to obtain clarity around needs and concepts proposed for inclusion in the CHNA report, and to approximate a group response to the collection of ideas put forth. The group followed a semi-structured protocol intended to elicit responses aligned with the following objectives:

1. Identify significant health needs
2. Identify community resources to meet its health needs
3. Identify barriers and reasons for unmet health needs
4. Identify supports, programs, and services that would help to improve the needs or issues

THI staff finalized the design of the focus group guide after a review of quantitative data and discussions with CSHS staff.

Recruitment and Sample

Potential participants were identified by CSHS leadership. A total of 15 people participated in the focus group. To assist with recruitment, the local CHRISTUS liaison recruited these stakeholders who represented diverse population groups, occupations, and healthcare or related service providers (e.g., clinics, community organizations and social service agencies).

Administering Focus Group and Collecting Data

The focus group lasted two hours. The facilitator opened with a general assessment of the participants' views of the community's overall health profile, inviting general comments using open-ended questions about health needs. Next, the facilitator followed with probes regarding any health needs that arose in the quantitative and qualitative analyses but did not appear in the group members' initial responses. An assistant moderator took notes and recorded the group responses. THI used the notes and recordings to code and analyze the findings.

ANALYSIS

Quantitative Analysis

The first stage of the analysis involved comparing rates of mortality, morbidity, health utilization, and various measures of social determinants of health using publicly available secondary data sources. The THI team compared the rates in the report area with Texas and the US to determine evidence of "health needs."[5] These comparisons represented quantitative indicators of need. For example, if the lung cancer rate in the report area were greater than the rate in Texas, that would be indicative of the need for more oncological services or primary prevention (e.g., reducing cigarette smoking). In addition to these comparisons, THI compared rates across counties within the report area to uncover potential regional disparities.

Primary data from CSHS provided additional information to supplement the analysis of health needs. THI calculated rates of hospital and emergency room admissions. Indicators from these data were based on comparisons across facility, service line, payment type, and zip code. For example, if ER visits for an ambulatory care sensitive condition were concentrated in one zip code, along with increasing trends across adjacent years, this might be indicative of the need to improve access to primary care in that region.

Qualitative Analysis

Whereas quantitative data analysis provides evidence of the magnitude of various health needs in the report area population (relative to a standard), qualitative data analysis facilitates exploration of *why* those health needs were arising in the report area and *how* the community could potentially respond.

[5] Rates were age-adjusted for comparisons.

THI utilized a hybrid approach to qualitative analysis based on both thematic and content analysis as well as grounded theory-based methods.[6,7,8] Whereas thematic analysis identifies and *qualifies* narratives, content analysis identifies and *quantifies* recurring narratives.[9] These two approaches are used to develop a comprehensive understanding of the report area while identifying priority health needs based on the weight of the evidence.

Grounded theory is an inductive approach to forming an understanding of a phenomenon that best fits *all* the data. The approach is an iterative process that involves collecting the data, coding similar concepts, forming concepts into categories, generating theory, and then going back to the data to verify the theory. THI used this iterative process to identify recurring themes that evidenced community health needs and health system needs—instead of generating theory per se. The iterative nature of collecting, analyzing, and reviewing data with stakeholders was built into THI's CHNA process from start to finish.

From successive listening to key informant and focus group recordings and reading notes, the THI team methodologically analyzed interviews to understand interviewee narratives. The analysis focused on understanding stakeholders and focus group participant views with respect to (1) health needs (including physical, behavioral, and social/emotional) (2) the social determinants of health (3) barriers to care and (4) assets and solutions to address population health and health system needs. Next, the THI team categorized topics and summarized the most commonly mentioned needs along with pertinent information.

The key informant interviews and focus group interviews varied in the themes that arose. In addition, some of the themes were supported by quantitative findings. The THI team therefore triangulated the results across all the data—key informant interviews, the focus group interview, and quantitative measures—to identify themes that emerged most frequently. These themes essentially offer a "theory" about the health needs in the community and the ways in which (health and non-health sector) systems could improve to support greater health outcomes in the report area. The last stage of the analysis involved verifying whether these themes were an accurate reflection of health and systems needs in the service area. This last step was incorporated as part of the needs prioritization.

NEEDS PRIORITIZATION

Phase 1: Initial Prioritization

The needs prioritization occurred in two phases. The first phase included a data-based prioritization from the THI team in advance of convening a needs prioritization committee comprised of local stakeholders. In this phase, THI identified the top indicators of need based

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[6] Smith, J., & Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse researcher*, *18*(2), 52-62.
[7] Joffe, H., & Yardley, L. (2004). Content and thematic analysis. *Research methods for clinical and health psychology*, *56*, 68.
[8] Corbin, J. & Strauss, A. (1990). Grounded theory method: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13, 3-21.
[9] Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, *15*(3), 398-405.

on both the qualitative and quantitative analysis. The top indicators based on the qualitative analysis included the most recurring themes for which there was the greatest evidence base on all available data. These emerged in the process of triangulation described above.

For quantitative analysis, THI determined whether:

- Rates for the report area exceeded those for Texas or the US.
- Health measures were deemed to impact a large percentage of residents in the report area.
- Evidence of significant variation in rates across counties in the report area, indicating potential regional disparities.

This process enabled THI to sort quantitative indicators across three tiers—those with (I) clear, (II) middling, or (III) no evidence of health needs. All of Tier I and some of Tier II indicators were assembled for presentation at a needs prioritization workshop.

Phase 2: Workshop for Validation and Prioritization

The second phase involved facilitating a community-driven process to validate phase 1 findings and further refine and prioritize health needs. More specifically, the key objectives of this process were to determine the validity of THI's findings about community health needs (i.e., phase 1 results), identify a core set of community health issue areas for more focused discussion, and implement a fair process that enabled the group to prioritize needs through generative dialogue and group consensus.

To do this, THI designed a needs prioritization workshop that combined focused discussion with liberating structures.[10] The workshop design (1) facilitated a fair and inclusive process so that all the stakeholders could review and comment on preliminary results on an equal footing, (2) enabled all stakeholders to feel free to present their views about the core health needs in the community, and (3) utilized a cumulative voting method to prioritize needs after uncovering the diverse perspectives of the group.

The needs prioritization workshop took place in June 2019. THI staff informed the CSHS liaison about the purpose of this meeting and appropriate logistics were arranged. The local liaison recruited individuals from the community to serve on the needs prioritization committee, and 12 people ultimately attended the meeting. A key component of recruitment was to ensure that the focused discussion included residents from or stakeholders representing the interests of low income, minority, vulnerable, or medically underserved communities.

THI staff facilitated the needs prioritization workshop and successfully identified a prioritized list of health needs. THI staff presented the initial analysis of all data, facilitated discussion about the validity of the results, and identified approximately 10 issue areas for focused discussion based on the indicators presented. The facilitation ensured open discussion among all participants and used group consensus before moving to the next stage of the workshop. After discussion of the issue areas, participants voted on their top priorities based on a three-vote cumulative voting method. Facilitators from THI consolidated individual participants' scores to generate an overall ranking and a ranking based on community votes only to identify any

[10] Lipmanowicz, H., & McCandless, K. (2010). Liberating structures: innovating by including and unleashing everyone. *E&Y Performance*, *2*(4), 6-19.

differences in prioritization between community stakeholders and those from CHRISTUS. No differences were found, and the prioritization committee reached consensus on the composite ranking before finalizing the priority health needs list.

SUMMARY OF ACTIVITY SINCE THE 2016 CHNA

In 2016 CSHS completed its most recent CHNA and developed a companion Implementation Plan for CSHS-led community health improvement for the 2017-2019 triennium.[11] The CSHS pursued actions to address four top health needs identified in the CHNA. The information below summarizes the expanded actions CSHS has pursued since that time for each of the targeted prioritized health needs.

SIGNIFICANT NEEDS WITH HOSPITAL IMPLEMENTATION RESPONSIBILITY

Improve Access to Healthcare and Reduce ER Use for Primary Care
CSHS's principal strategy to meet the primary healthcare needs of low income, uninsured, and Medicaid populations was to provide support and expand current services at CHRISTUS Spohn Family Health Centers operating in the report area. This was achieved by providing extended hours for walk-in clinics, creating centralized automatic scheduling for clinics, increasing access to specialty care and the placement of a coordinator in the ED to assist in the triage process.

Another objective was to achieve a 10% reduction in ED visits for the economically disadvantaged by improving access to appropriate care alternatives. This included care coordination and collaboration with community providers to promote alternative access points.

Reduce Preventable Hospitalizations
The 2016-2019 CHNA identified the need for a reduction in preventable hospitalizations. CSHS has been addressing this by expanding access to medical care/ family practice for the financially challenged. This was achieved by increasing primary care visits through appropriate and timely referrals, and expanded clinic hours.

Improve Understanding and Management of Chronic Conditions
CSHS addressed this need by increasing pneumonia vaccinations among the homeless, poor and underserved via CareVan outreach, increased collaboration with skilled nursing facilities and home care, hiring additional FTEs to the Care transitions team, and provide free flu vaccines to the underserved.

Improve Health Literacy
To address the need for improved health literacy, CSHS created a health resource guide that is disseminated region-wide and updated as needed.

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[11] CHRISTUS Health. *Community Health and Needs Assessment and Implementation Plan*. June 2016. Available at: https://www.christushealth.org/-/media/files/homepage/giving-back/chna/2017--2019-chna-christus-spohn.ashx?la=en

Improve Women's Health in Community
To address the need for improved women's health in the community, CSHS continued support and expanded services for the CHRISTUS Spohn CareVan Women Services.

KEY FINDINGS

POPULATION DEMOGRAPHICS

County Name	Population (%)
Bee County, TX	32,563 (7.0%)
Jim Wells County, TX	40,871 (8.8%)
Kleberg County, TX	31,088 (6.7%)
Nueces County, TX	361,221 (77.6%)
Report Area	465,734

Table 1. Report Area Population, by County

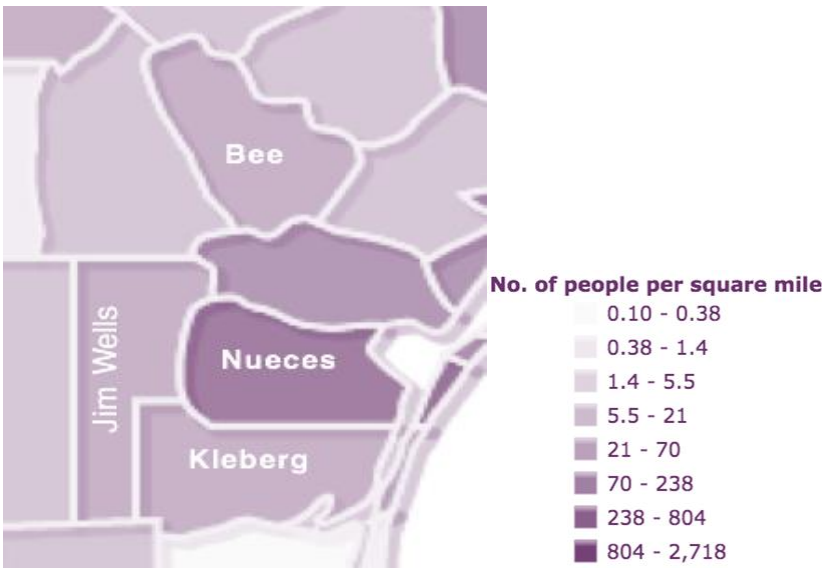

Figure 1. Report Area Population Density (Persons per Square Mile)[12]

[12] Source:https://www.indexmundi.com/facts/united-states/quick-facts/texas/population-density#map%E2%80%8B

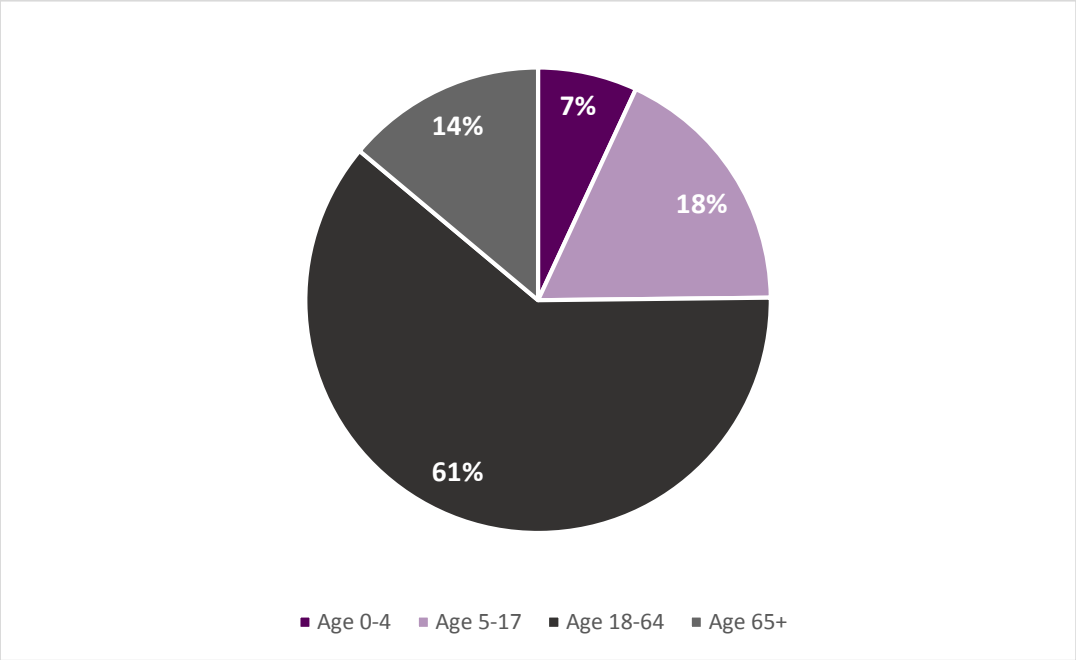

Figure 2. Report Area Population by Age Groups

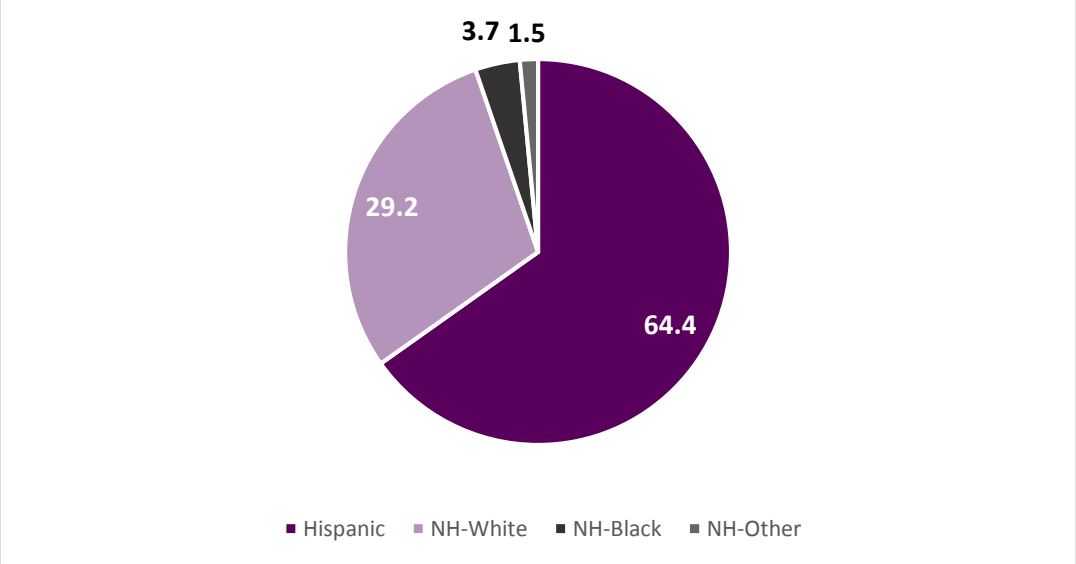

Figure 3- Report Area Population by Race and Ethnicity

Race and Ethnicity	Report Area	Texas	United States
Hispanic %	64.4	38.6	17.3
NH- White alone (%)	29.2	43.4	62.0
NH - Black alone (%)	3.7	11.6	12.3
NH- American Indian and Alaska Native alone (%)	0.2	0.2	0.7
NH - Asian alone (%)	1.6	4.3	5.2
NH - Native Hawaiian and Other Pacific Islander alone (%)	0.1	0.1	0.2
NH - Some other race alone (%)	0.1	0.1	0.2
NH - Two or more races (%)	0.8	1.6	2.3
NH -Other %	2.7	6.3	8.4

Table 2. Report Area Population by Race and Ethnicity

To gauge the health needs of the very broad region CSHS serves, the report area includes the following four counties: Bee County, Jim Wells County, Kleberg County and Nueces County. Consisting of a total population of 465,734 residents (Table 1), the report area (Figure 1) reflects the diverse communities in the coastal bend region from which CSHS patients could live while representing the bulk of individuals using CSHS services. Just over 75% of the report area's population resides in Nueces County. Seventy-eight percent of residents in the report area live in Nueces County which is the only urban county, while the remaining 22% live in the remaining report area rural counties.[13] This also mirrors the urban-rural breakdown of Texas population statewide. The population within the report area had a population change of 4.7% from years 2010 to 2017.

Individuals between ages 18 and 64 (working-aged adults) constitute 61% of total population. Of the remaining population, 14% are ages 65 and older, 18% are school age children, and 7% are in infancy or early childhood (Figure 2). Overall, the population ages 65 and older are slightly higher than that of the population of Texas (12%). Compared to Texas, the population in the report area have a higher proportion of Hispanic residents (Table 2). The Hispanic/Latino proportion in the report area is 64%, compared to 39% of Texans and 17% of US Citizens. The NH-Asian, NH-Native Hawaiian/Pacific Islander and NH-Native American/Alaska Native categories each comprise less than 2% of the report area population. The report area population is almost evenly distributed by gender (50% male, 50% female), mirroring the gender distribution of Texas and the US.

[13] Health Services and Resources Administration. (2016). List of Rural Counties and Designated Eligible Census Tracks in Metropolitan Counties. Available at https://www.hrsa.gov/sites/default/files/ruralhealth/resources/forhpeligibleareas.pdf

SOCIAL AND ECONOMIC ENVIRONMENT

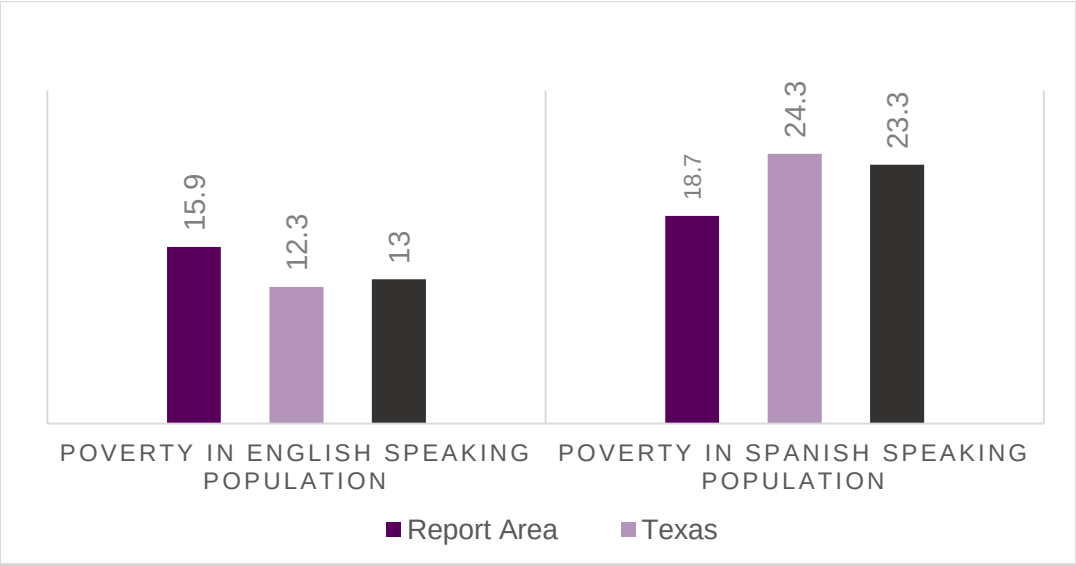

Figure 4. Poverty Distribution by Language

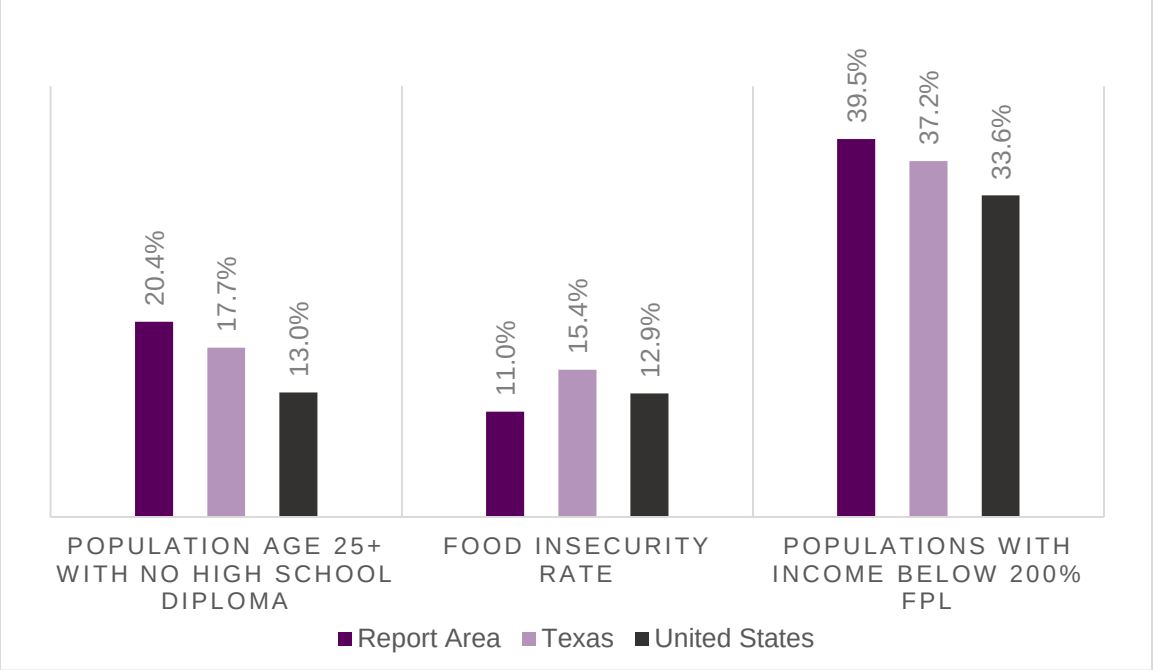

Figure 5. Socioeconomic Characteristics of Report Area

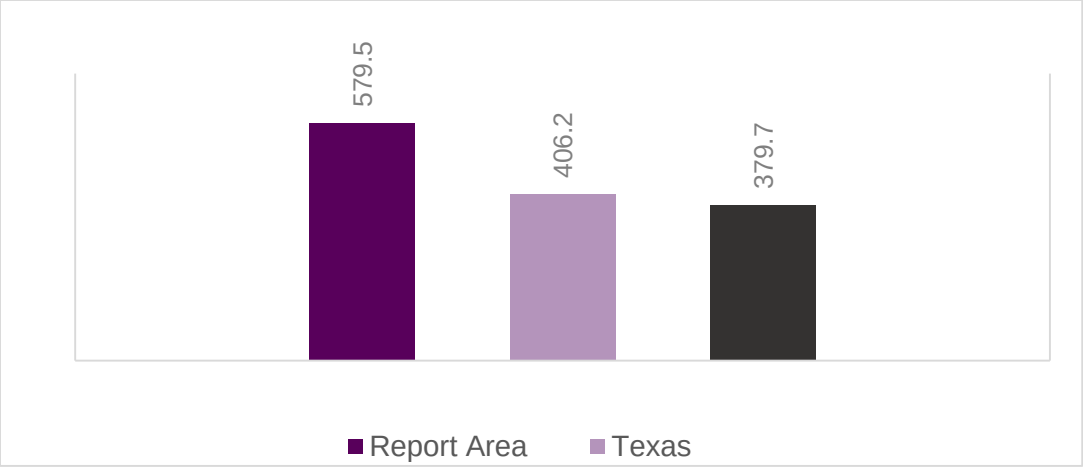

Figure 6. Violent Crime Rate per 100,000 Population

Consolidated median income data for the report area is not available, but county-level data show that Nueces County has a median annual family income just over $14,000 higher than Bee County ($61,273 compared to $47,234). For all counties, the income level is lower than Texas' median family income ($64,585).

Poverty is widespread in the report area, with 40% of report area residents earning annual incomes at or below 200% FPL. Bee County and Jim Wells County have even higher poverty at 47% and 48%, respectively. According to 2019 federal guidelines, 200% FPL corresponds to an income of $51,500 per year for a family of four.[14] Spanish-speaking populations have higher poverty rates than English-speaking populations for the report area (16% versus 19%; Figure 4). The poverty within the English-speaking population mirrors the Texas and US poverty levels. Whereas, the poverty within the Spanish-speaking population is lower than the Texas and US poverty levels (19%, 24%, 23%).

Figure 5 provides a comparative summary chart of socioeconomic indicators for the report area, Texas, and the US. High school graduation are on par with Texas. However, when broken down by county, Bee County and Jim Wells County have a higher percentage of the population that have not completed high school at 29% and 27%, respectively. Also, college graduation is significantly lower than Texas at 26% versus 35%, respectively.

Compared to Texas, the report area's unemployment is similar while food insecurity is slightly lower (Figure 5). Eleven percent of report area residents experience food insecurity (i.e., uncertainty about whether they will be able to get enough nutritious food at some point during the year) compared to about 15% of Texas residents. Overweight, obesity and chronic disease

[14] Office of the Assistant Secretary for Planning and Evaluation. (2019). US Poverty Guidelines Used to Determine Financial Eligibility for Certain Government Programs. Available at https://aspe.hhs.gov/poverty-guidelines

have remained consistent areas of need within the report area, and food insecurity can create barriers for individuals who need to manage their weight and nutrition. Feeding America measures food insecurity and defines it as a lack of consistent access to enough food for an active, healthy life.

The cost of living is the biggest thing within the community. Whether you're renting or paying mortgage, having a roof over your head is going to be your biggest concern

--Key Informant

Community safety represents an environmental indicator with implications for population health, including mental health. Violent crime (defined as homicide, rape, robbery, and aggravated assault) occurred in the report area at a rate of 579.5 violent crimes per 100,000 population, which is substantially higher than the overall violent crime rates in Texas (406.2 per 100,000 population; Figure 6). Within the report area, substantial disparities in violent crime appear by county. Violent crime ranges from 181.3 violent crimes per 100,000 in Bee County to 617.7 violent crimes per 100,000 in Nueces County.

A common theme among the focus groups and key informant interviews was that many regions within the report area need increased access to affordable housing and improvements in walkability and transportation within the community. Also, it was mentioned that there is a significant need to address community and family violence within the region. This was discussed in tandem with need to support and help vulnerable populations within the community. This includes veterans, homeless, undocumented immigrants, elderly, children, individuals with disabilities and residents of *colonias*.

ACCESS TO HEALTH CARE

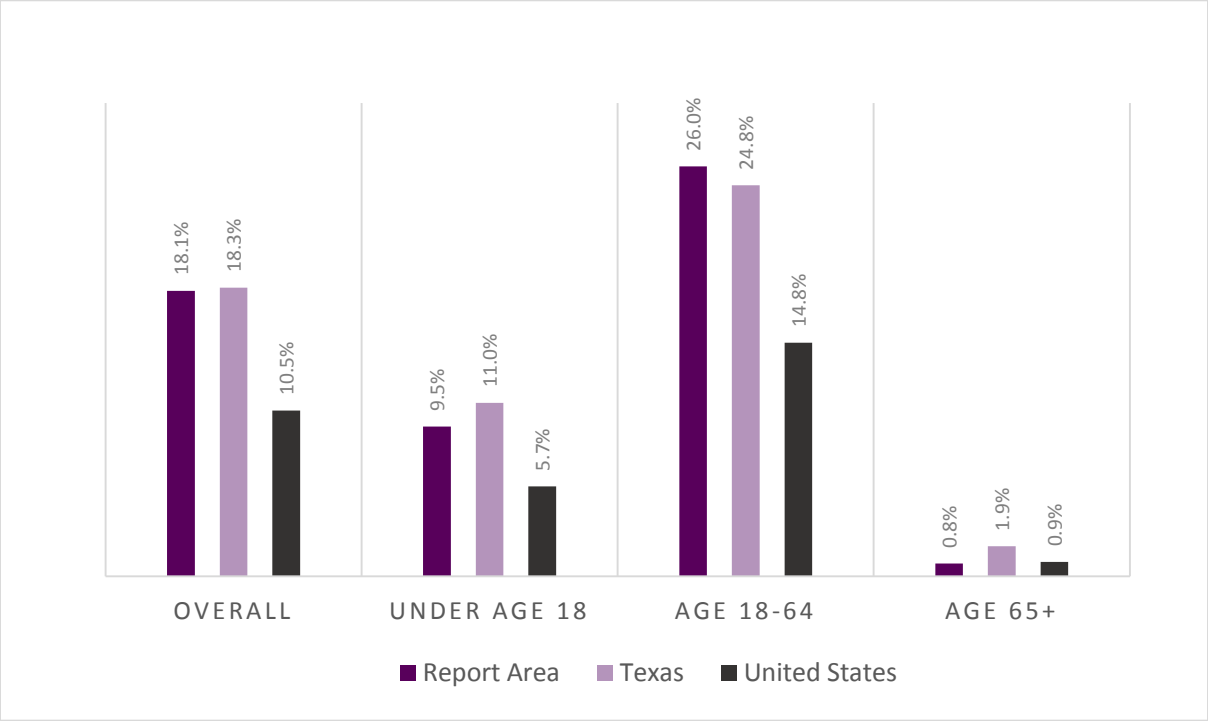

Figure 7. Uninsured Rate in Report Area, Overall and by Age Group

Geography	Primary Care Practitioners	Registered Nurse	General Dentists	Psychiatrist
Bee County, Texas	2,209.00	280.8	8,283.8	-
Jim Wells, Texas	1,905.60	203.9	4,869.9	-
Kleberg, Texas	2,318.50	253.9	3,864.2	-
Nueces, Texas	1,003.10	90.2	2,953.1	16,779.2
Report Area	1,142.2	105.4	3,271.3	21,858.36
Texas	1,350.4	120.7	2,752.8	13,145.2

Table 3. Population to Healthcare Provider Ratio

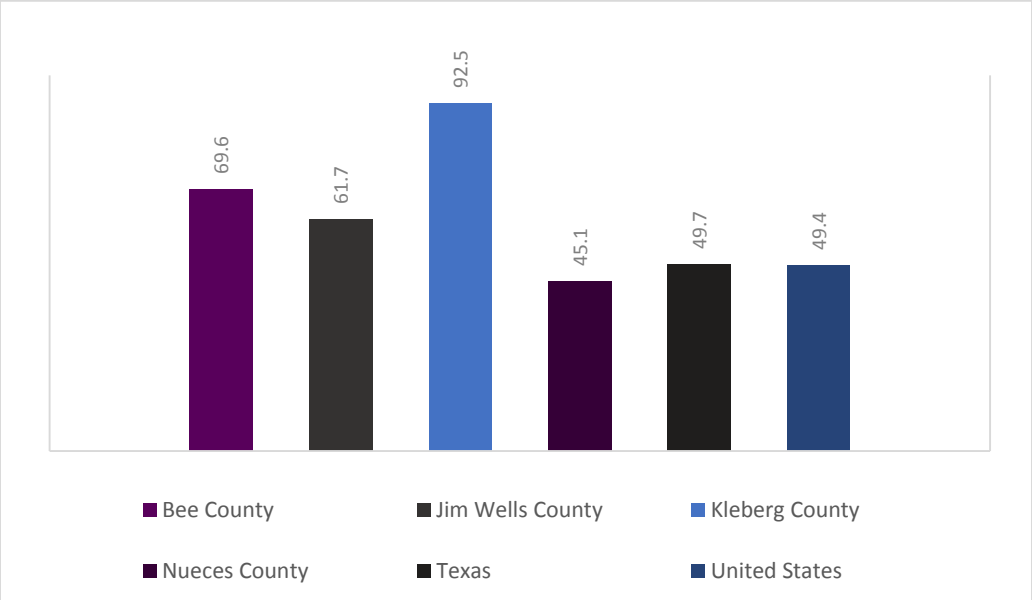

Figure 8. Preventable Hospital Admissions (per 1,000 Medicare Enrollees)

Access to health care is a key component of maintaining and improving overall health. The Institute of Medicine identifies three essential steps in attaining access to care: gaining entry into the health care system, finding access to appropriate sites and types of care, and developing relationships with providers who meet patients' needs and whom patients can trust.[15] For many, health insurance represents not only a ticket into the health care system, but an assurance that the cost of most health services will remain affordable to them.

At 18% the rate of uninsured in the report area (18%) is the same as Texas' rate of uninsured. Less than 1% of elderly adults in the area are uninsured due to the availability of Medicare coverage for this age group (Figure 7). In contrast, 1 in 4 working-age adults in the report area are uninsured and approximately 1 in 10 children living in the report area are uninsured. At the time of this writing, Texas remains among the 14 states that have declined to expand Medicaid.[16]

Health insurance is just one component of access to care and does not guarantee access even to those who have it. Without an adequate supply of local health care providers, the health system will not have the capacity to accommodate all patients who need care, regardless of

[15] Institute of Medicine. (1993). Access to health care in America. Committee on Monitoring Access to Personal Health Care Services. Washington, DC: National Academy Press.
[16] Kaiser Family Foundation. (2019). Stat of state action on the Medicaid expansion decision. Available at: https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

insurance status. Higher numbers of residents per provider in an area, the population to provider ratio, is an indicator of fewer providers available for the population in a region. Differences in access to providers can be seen when comparing population to provider ratios across report area rural and urban counties. The only urban county, Nueces, has provider ratios on par to those observed for Texas (Table 3). All the available county data from the rural counties show that most provider ratios are much higher than the report area and Texas. This discrepancy can be seen especially when looking at population to psychiatrist ratio, which shows none practicing in the rural counties. Note, however, that these ratios say nothing about the level of need for the services and many rural counties rely on nearby urban areas.

Primary care access barriers are a concern due to the potential for minor, treatable health conditions to worsen in severity, leading to avoidable hospital visits and potential overuse of costly emergency department services. Preventable hospital stays are defined as hospital visits for conditions that could have been prevented if adequate primary care resources were available and accessed by those patients. In Nueces County, preventable hospital admissions for Medicare enrollees are on par with Texas Medicare enrollees (45.1 vs. 49.7; Figure 8)**.** However, the rural counties all have significantly higher rates of preventable Medicare hospital admissions, with the highest in Kleberg County at 92.5 preventable hospital admissions per 1,000 Medicare enrollees.

In key informant and focus group interviews, stakeholders reported a lack of accessible care to mental health treatment. Physician retention and recruitment was noted as one of the top reasons for lack of specialty and mental health care within the area.

Also, a wide range of informants hypothesized that consumers often lack the awareness, knowledge, or skills to navigate the system and use resources to their maximum benefit. This lack of patient navigation was seen as one of the most leading causes of high emergency room use along with a large homeless population. An important aspect of patient navigation that was addressed was the need for building trust within the community. It was stated as crucial for the use of community health workers and peer support to forge this trust in order to increase patient compliance and support.

HEALTH OUTCOMES

Geography	Diabetes Prevalence (%)	Poor Physical Health Days in 30 Days
Bee County, TX	9.0%	3.9
Jim Wells County, TX	10.0%	4.2
Kleberg County, TX	9.0%	4.4
Nueces County, TX	11.0%	4.3
Texas	10.0%	3.5

Table 4. Diabetes Prevalence and Poor Physical Health in Report Area

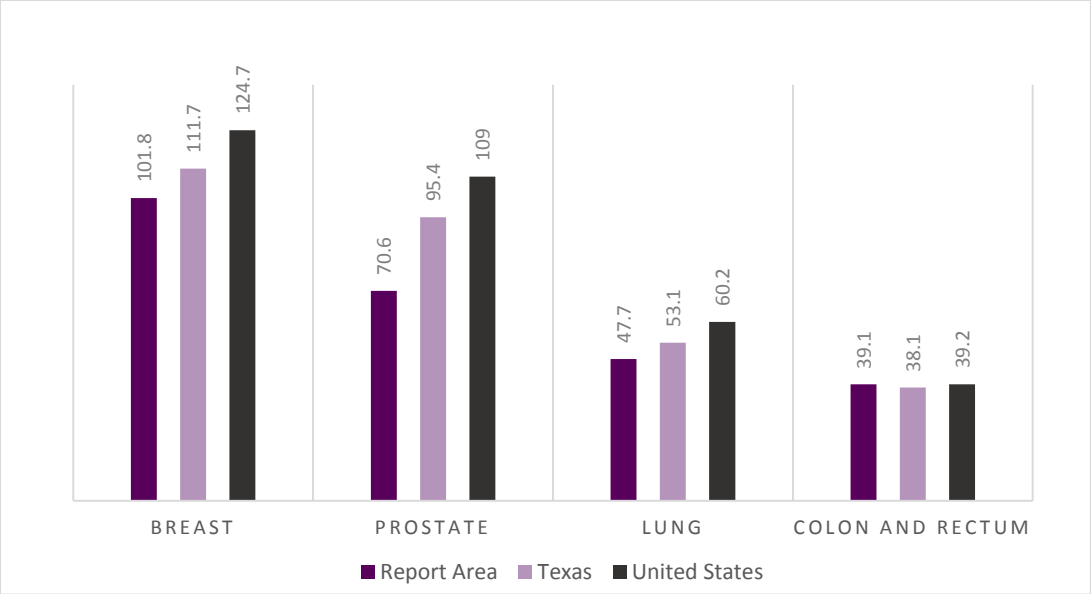

Figure 9. Age-adjusted Cancer Incidence per 100,000 Population, by Type

We've always struggled in Nueces County with—and I don't think it's gotten any better—has been domestic and family violence. We're still not there yet when it comes to prevention and education, and this is not acceptable in our community [to] have high rates.

--Key Informant

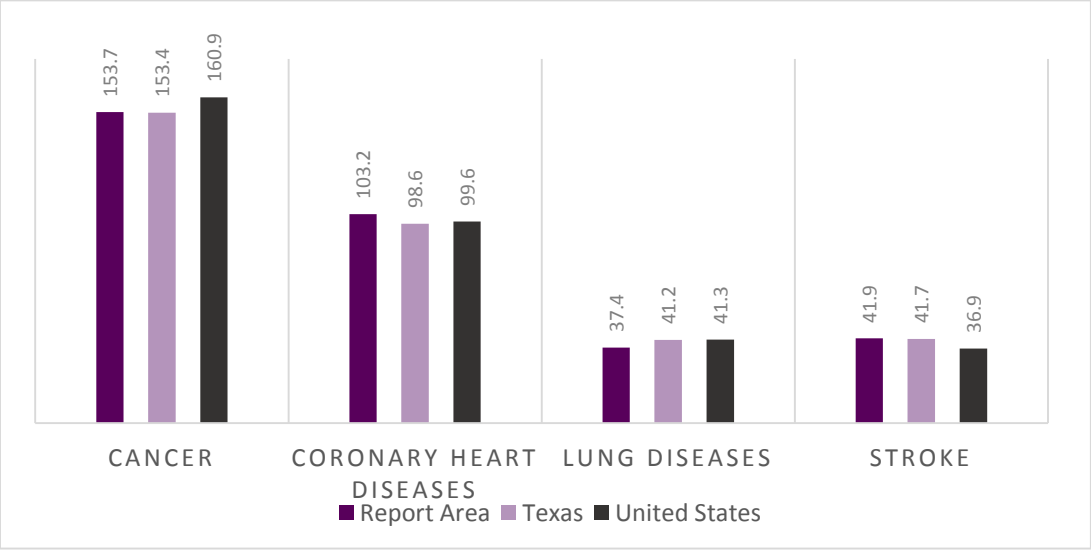

Figure 10. Age-adjusted Mortality Rate for Selective Diseases per 100,000 Population

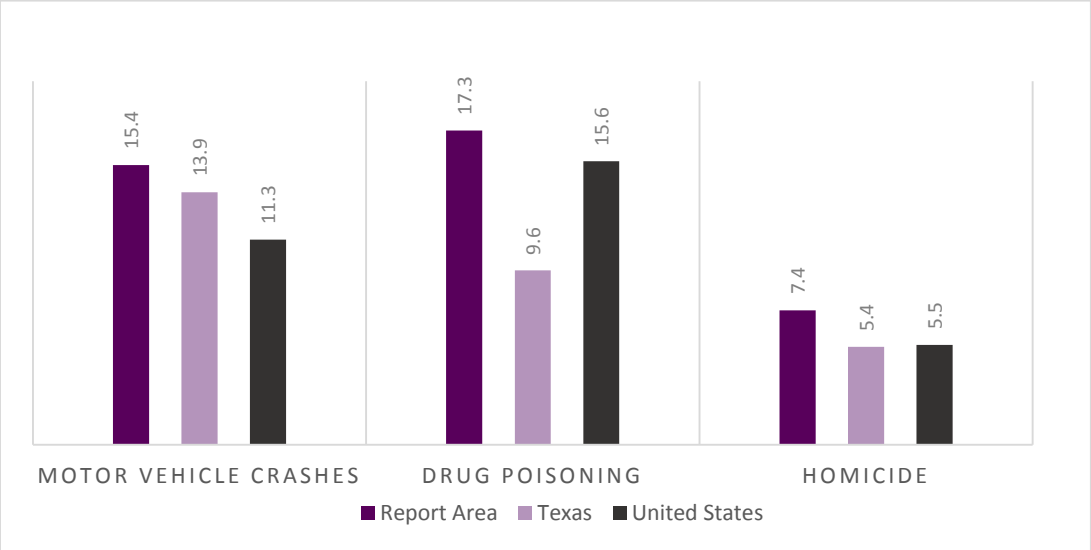

Figure 11. Age-adjusted Mortality Rate per 100,000 Population, by External Cause

Physical Health

The number of days reported in poor health over the past 30 days ranges from 3.9 to 4.4 across counties in the report area compared to only 3.5 for Texas as a whole. In regards to type II diabetes, the only county higher than the state prevalence is Nueces County at 11% compared to 10% for Texas.

Among all types of cancer, the incidence of cancer for all counties is either lower or on par with Texas (Figure 9; Appendix A). However, even though the rates of incidence are significantly lower, the cancer mortality rate is on par with Texas at 153.7 deaths per 100,000 versus 153.4 deaths per 100,000, respectively (Figure 10).

In regards mortality due to other chronic illness, stroke and lung disease are on par with Texas. However, heart disease mortality for the report area is on par with Texas (98.6 per 100,000), but when broken down by county significant disparities are present. Specifically, Jim Wells County and Kleberg County at 188.2 per 100,000 and 144.9 per 100,000, respectively (Appendix A).

Several mortality differences by external cause are notable. Motor vehicle crashes are significantly higher in the report area compared to Texas and the US. (Figure 11). The report area has a motor vehicle mortality rate of 15.4 per 100,000 compared to 13.9 for Texas and 11.3 for the US. This is even higher when broken down by county for Bee County at 23 per 100,000 and Jim Wells County at 30 per 100,000. Drug poisoning and homicide rates were also higher in the report area compared to Texas.

Stakeholders consistently noted the challenges associated with chronic disease. Diabetes, heart disease, hypertension and obesity were raised numerous times throughout the key informant interviews and focus groups. Community members stressed the importance of educating the

patient about managing chronic illnesses and how to navigate the health care system. As well as increasing community collaboration and outreach in order to provide members of the community with this education.

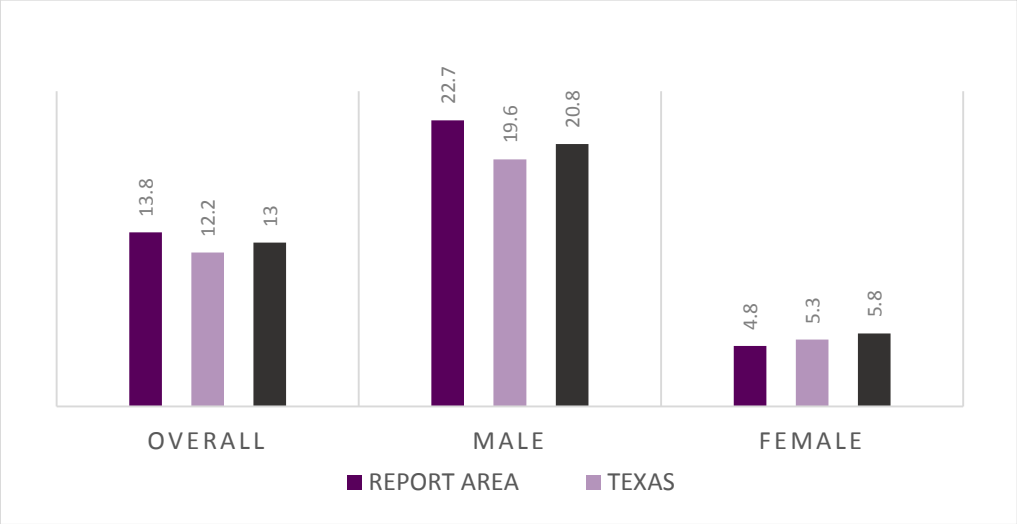

Figure 12. Age-adjusted Suicide Mortality Rate per 100,000 Population, Overall and by Gender

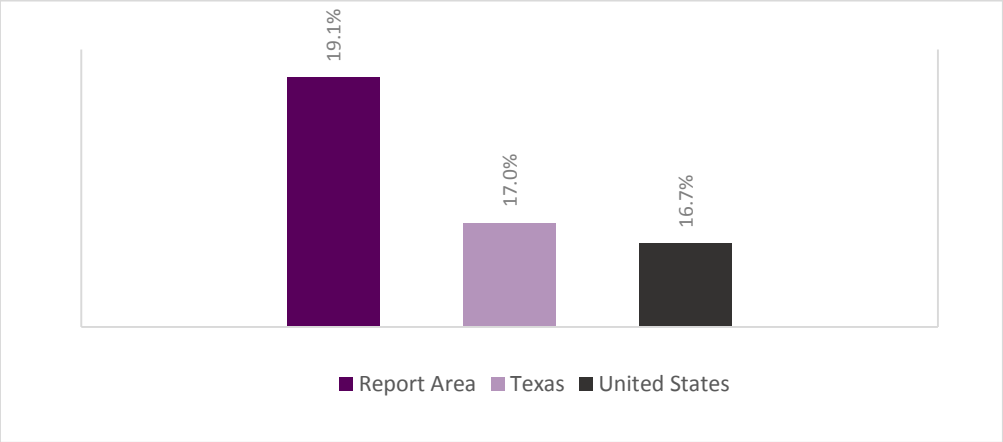

Figure 13. Prevalence of Depression among Medicare Beneficiaries

People being impacted by substance abuse and mental health: it's going to continue to persist simply because they lack health care coverage.

--Key Informant

Mental and Behavioral Health

The burden of morbidity and mortality resulting from mental illness represents a significant and growing concern in the report area. After age adjustment, approximately 13.8 people per 100,000 population in the report area die of suicide, compared to 12.2 deaths by suicide per 100,000 population in Texas and 13.0 in the US (Figure 12). The suicide rate among report-area males (22.7 per 100,000) is significantly higher than the suicide rate overall, showing strong variation by gender. In the report area, males die by suicide at a rate approximately four times higher than that of females.

Depression, a major risk factor for suicide, affects 19.1% of Medicare beneficiaries in the report area, which is slightly higher than the rates of depression among Medicare beneficiaries in Texas and the US (Figure 13).

Mental and behavioral health is considered the number one community health need. Stakeholders discussed at great length the lack of available inpatient and outpatient treatment options, long wait times and access to care for low income populations. This was discussed in tandem with drug abuse, mental health stigma, and violence among homeless individuals who have untreated and severe mental illness.

MATERNAL AND CHILD HEALTH

Geography	Infant Mortality per 1,000 Live Births	Teen Birth per 1,000 Female Population Ages 15-19 Years	Low Birth Weight Percentage (< 2500 grams)
Bee County, TX	NA	64	9.4%
Jim Wells County, TX	5	68	8.8%
Kleberg County, TX	NA	41	9.1%
Nueces County, TX	5	48	6.6%
Texas	6	41	8.0%

Table 5. Maternal and Child Health

Healthy People 2020 stresses the role of maternal, infant, and child health as a key driver of overall population health and wellness. Delaying childbearing into adulthood decreases the likelihood of perinatal and postnatal complications, including infant mortality, low birth weight, and disability.[17] Over the long term, children born to teen parents are less likely to be prepared for kindergarten, have lower educational attainment and high school completion rates, and exhibit higher rates of social, emotional, and behavioral problems.[18]

Teen births by each county in the report area, defined as births to mothers age 15-19, vary greatly depending on the county and all are either the same or higher than the Texas rate (Table 5). For example, Jim Wells County has 68 teen births per 1,000 compared to Texas at 41 teen births per 1,000. Infant mortality rates are only available for the larger counties, but they are slightly lower compared to Texas' infant mortality rate. There is a rural/urban divide when looking at low birth weight. Nueces County is lower than Texas, while all of the other three rural counties are slightly higher than Texas.

HEALTH BEHAVIORS

Geography	Adult Obesity	Physical Inactivity	Excessive Drinking	Adult Smoking	Insufficient Sleep
Bee County, TX	30%	27.7%	19.5%	16.6%	34.1%
Jim Wells County, TX	29%	25.8%	19.5%	15.5%	36.3%
Kleberg County, TX	28%	21.8%	19.0%	15.8%	33.8%
Nueces County, TX	33%	28.5%	18.1%	14.5%	28.9%
Texas	28.0%	24.0%	19.0%	14.0%	33.0%

Table 6. Health Behavior Indicators

Residents in the report area describe a wide variety of unhealthy behaviors as highly prevalent. Table 6 displays comparative prevalence rates of select health behaviors within the report area and Texas. Rates of obesity and physical inactivity are all highest within Nueces County in comparison to the other counties and Texas. The proportion of residents reporting heavy alcohol consumption (more than two drinks per day on average for men and more than one drink per day on average for women), adult smoking and insufficient sleep was on par with Texas.

[17] Healthy People 2020. (2014). Maternal, infant, and child health. Available at: http://www.healthypeople.gov/2020/topicsobjectives/topic/maternal-infant-and-child-health
[18] Youth.gov. (2016). Adverse effects of teen pregnancy. Available at: http://youth.gov/youth-topics/teen-pregnancyprevention/adverse-effects-teen-pregnancy

So that peer support, whether it's in a mental or behavioral health setting, in the community, or whether it's with disabilities, that peer support can actually get people on the road to doing things better.

--Key Informant

HOSPITAL DATA

The CHRISTUS Spohn Health System supplied internal data from its main hospital and satellite hospitals to offer additional insight about community needs. These included two years of hospital admission and emergency department utilization data (2017- 2018) disaggregated by facility, ZIP code, service line, and source of payment. For ZIP code, service line, and payment type, selected options reported at the greatest frequency and/or determined to be of interest are displayed to supplement understandings based on the primary and secondary community data.

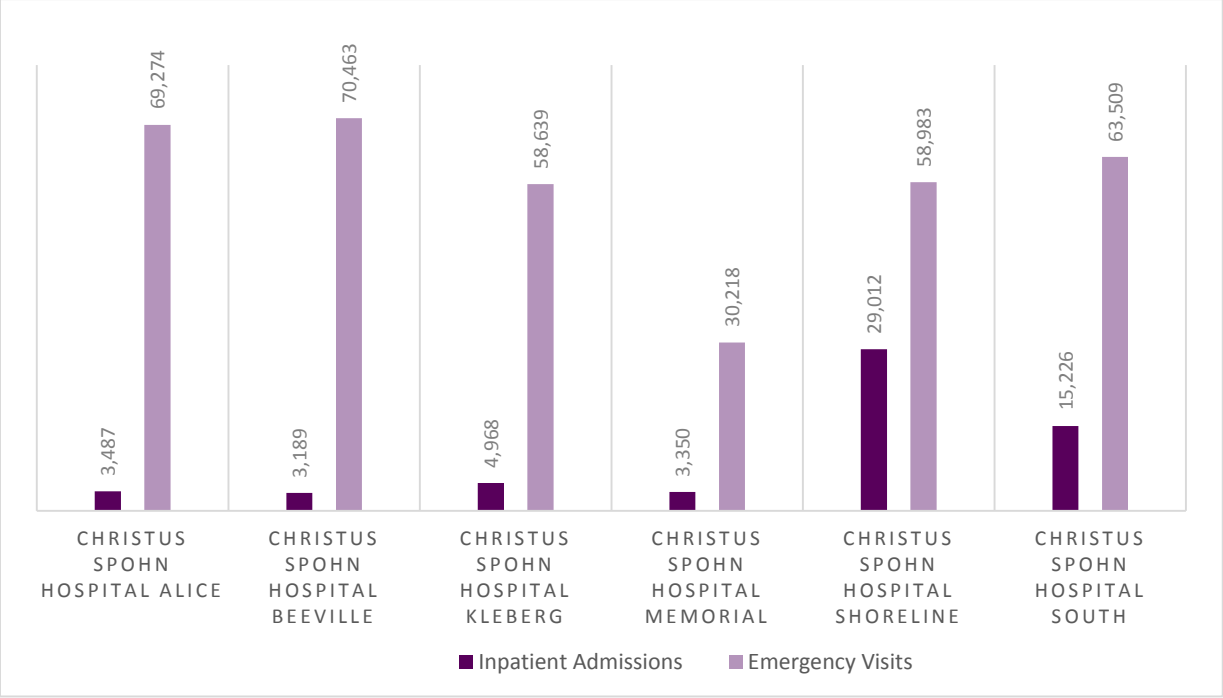

Figure 14. Total Inpatient Admissions and Emergency Department Visits by Facility (2017-2018)

Overall, the hospital data reveal a clear disproportionality in emergency department use compared to hospital admissions (Table 7; Figure 14). While some inherent differences may be expected, the frequency of emergency department visits overwhelmingly exceeded the frequency of hospital admissions over the data collection period. Emergency department visits exceeded hospital admissions and ranged from a ratio of 2.0 to 1 for the CHRISTUS Spohn Hospital- Shoreline to as high as 22.1 to 1 for the more rural Beeville branch.

While further analysis is needed to determine what may be driving utilization trends in the report area, disproportionate emergency department use can indicate a high number of patients cycling in and out of the emergency department. Such patterns may highlight concerns

Facility	Inpatient Admission	Emergency Visits
Christus Spohn Hospital Alice	3,487	69,274
Christus Spohn Hospital Beeville	3,189	70,463
Christus Spohn Hospital Kleberg	4,968	58,639
Christus Spohn Hospital Memorial	3,350	30,218
Christus Spohn Hospital Shoreline	29,012	58, 983
Christus Spohn Hospital South	15,226	63,509

Table 7. Inpatient Admissions and Emergency Department Visits by Facility

Regarding overuse and/or misuse of emergency services within the report area. Data presented in Figure 8 show a relatively high rate of avoidable hospital events in the report area, further supporting the notion that use of the emergency department for non-emergent or preventable needs may be a system-wide concern. Individuals who make frequent visits to the emergency department are likely to have lower incomes, manage multiple chronic conditions, and report poorer health status — all important factors to consider when planning interventions for populations needing assistance managing their health in community settings.[19]

Table 8 highlights some variation in emergency department utilization by ZIP code. For the two-year period, Memorial, Shoreline and South branches have fairly equal distribution among the top five zip codes and have patients from various location. Whereas, for the more rural hospital locations, Beeville, Alice and Kleberg, have 75% or more of their patients coming from one zip code. These are 78332 for Alice, 78102 for Beeville and 78363 for Kleberg.

Table 8. Top Five ZIP Codes for Emergency Department Visits

[19] Peppe, E. Mays, JW, and Chang, HC (2007). Characteristics of frequent emergency department users. Kaiser Family Foundation, Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7696.pdf.

Christus Spohn Hospital Alice		Christus Spohn Hospital Beeville		Christus Spohn Hospital Kleberg		Christus Spohn Hospital Memorial		Christus Spohn Hospital Shoreline		Christus Spohn Hospital South	
Zip Codes	Visits	Zip Codes	Visits	Zip Codes	Visits	Zip Codes	Visits	Zip Codes	Visits	Zip Codes	Visits
78332	51,912	78102	56,026	78363	45,834	78405	5,349	78415	7,392	78413	10,038
78333	4,716	78104	6,078	78375	3,034	78415	4,166	78405	6,042	78415	9,097
78372	4,498	78389	4,064	78364	2,486	78408	3,329	78404	5,830	78414	8,108
78375	2,962	78146	1,048	78379	2,330	78416	2,732	78408	4,878	78412	6,795
78383	1,434	78391	718	78343	2,116	78404	2,592	78416	4,213	78411	4,826

General medicine represents the most frequent type of clinical service delivered for patients seeking care in the emergency department. However, infectious disease is the most common reason for a patient to be admitted into the hospital. Cardiology is a service line unique to hospital inpatient admissions in these data as well as normal newborn delivery and obstetrics care (Table 9). For emergency department visits, orthopedics, ENT and pulmonology was unique in comparison with inpatient admissions.

Inpatient Admissions			Emergency Department Visits	
Rank	Service Line	Proportion (%)	Service Line	Proportion (%)
1	Infectious Disease	13%	General Medicine/Surgery	26%
2	Cardiology	11%	Infectious Disease	10%
3	General Medicine/Surgery	10%	Orthopedics	8%
4	Normal Newborn	9%	ENT	7%
5	Obstetrics	7%	Pulmonology	7%

Table 9. Services Provided During Inpatient Admissions and Emergency Department Visit[20]

[20]Hospital data combine main and satellite branches.

Insurance Type	Inpatient Admissions	Emergency Department Visits
Private	20%	19%
Medicaid	22%	25%
Medicare	49%	28%
Self-Pay	9%	28%

Table 10. Payment Source for Inpatient Admissions and Emergency Department Visits[21]

Table 10 presents the proportion of patients paying with select payment types, including Private, Medicaid, Medicare, and Self-pay. Not presented are data on patients enrolled in certain types of public insurance (e.g., CHIP, TRICARE). Clear differences in the payer mix between the admitted patient population and emergency care users are evident. Medicare pays for 49% of hospital admissions, but only 28% of emergency department visits. Conversely, the payer mix in the emergency department includes far more uninsured patients. The uninsured comprise 28% of the emergency department visits but just 9% of inpatient admissions.

MOVING FORWARD

Findings from the qualitative and quantitative data and the final prioritization of needs highlight numerous gaps, issues, and threats to population health and quality of life in the communities comprising the report area. This CHNA report has also emphasized key resources, assets, capacity, and potential opportunities that exist in the region to address the identified problems. In particular, the voice of stakeholders in the community has been core and central to the needs assessment process, contextualizing data in community realities while shaping the process and product.

The content of this report is intended to inform planning and strategy for the CHRISTUS Spohn Health System in coming years. The findings from this CHNA report lay the groundwork for a companion Community Health Improvement Plan (CHIP) to aid the CHRISTUS Spohn Health System improve the health of the community it serves. The forthcoming CHIP will follow the release of this CHNA report and will describe opportunities, solutions, and innovations with the potential to address critical areas of unmet need in the region.

[21] Data includes combined admission from main and satellite branches.

APPENDIX A: COUNTY LEVEL DATA

Indicator	Bee	Jim Wells	Kleberg	Nueces
Age (%)				
Ages 0- 4	6.1	7.9	6.9	6.9
Ages 5-17	15.4	20.3	17.5	17.9
Ages 18 -64	66.4	56.7	62.6	61.1
Ages 65 +	12.1	15.0	12.9	14.1
Race and Ethnicity (%)				
Hispanic	57.9	79.9	71.9	62.6
NH- White alone	32.7	18.6	21.5	30.8
NH - Black alone	8.0	0.6	3.6	3.6
NH - Other	1.4	0.8	3.0	3.0
NH- American Indian and Alaska Native alone	0.6	0.1	0.1	0.2
NH - Asian alone	0.5	0.4	2.0	1.8
NH - Native Hawaiian and Other Pacific Islander alone	0.0	0.1	0.0	0.1
NH - Some other race alone	0.1	0.0	0.1	0.1
NH - Two or more races	0.2	0.2	0.7	0.9
Poverty (%)				
English Speaking Population	19.5	19.3	22.4	14.8
Spanish Speaking Population	19.4	20.1	24.3	17.9
Socioeconomic Characteristics (%)				
Unemployment Rate	4.7	4.9	4.7	4.3
Population Age 25+ with no Highschool Diploma	28.6	26.6	22.6	18.7
Food Insecurity Rate	14.1	10.1	12.2	11.0
Population with Income below 200% FPL	46.9	42.3	47.8	37.9
Violent Crimes (Per 100000 Population)				
	181.3	616.2	520.8	617.7
Uninsured Population (%)				
Overall	21.8	19.1	18.3	17.7
Under Ages 18	14.0	9.4	7.4	9.3
Ages 18-64	30.8	28.8	26.7	25.3
Ages 65 +	2.3	0.6	1.6	0.7
Preventable Hospital Admissions (Per 1000 Medicare Enrollees)				
	69.6	61.7	92.5	45.1
Cancer Incidence Rate (Age Adjusted Incidences per 100000 Population per Year)				
Breast	89.1	106.7	116.6	101.0
Prostate	61.6	54.6	82.3	72.4
Lung	43.7	39.7	46.6	49.1
Colon and Rectum	38.4	44.2	39.5	38.5

Indicator	Bee	Jim Wells	Kleberg	Nueces
Mortality rates (Age Adjusted Deaths per 100000 Population per Year)				
Cancer	147.2	157.1	166.5	152.7
Coronary Heart Disease	81.4	188.2	144.9	91.5
Lung Disease	33.3	40.8	29.0	38.2
Stroke	47.3	48.2	43.1	40.6
Motor Vehicle Crash	23	30	-	13
Drug Poisoning	-	-	-	17.3
Homicide	-	13.7	-	6.6
Suicide	17.1	16.5	-	13.1
Depression in Medicare Population (%)				
Depression	19.6	17.4	24.9	17.3

APPENDIX B: KEY INFORMANT INTERVIEW PROTOCOL

[Notes to interviewer: All instructions to the interviewer are in square brackets. Do not read the statements aloud. Suggested script for interviewer appears in italics. The main questions are numbered. Interviewer should read and understand questions prior to starting the interview. Interviewer should cover all questions in protocol.

Questions phrasing is *suggested*. This is a discussion. Interviewer should phrase questions in a way that s/he is comfortable speaking.

Follow-up questions may be employed to more fully explore the topic area when applicable. If interviewer believes the concept has been covered s/he may skip follow-up questions. Probes are optional. If interviewer believes the participant has not fully engaged or answered the main or follow-up question s/he may use one or more of the "probes" to further investigate and engage the participant. These optional questions are listed below the main question stem.]

Hello, may I please speak with **[NAME]?**
My name is **[INTERVIEWER'S NAME]** and I am calling from the **[Texas Health Institute]. [INSERT CHRISTUS HEALTH CONTACT PERSON'S NAME]** from CHRISTUS Health gave me your information in order to participate in CHRISTUS Health's Community Health Needs Assessment. Thank you so much for offering to speak with me.

As you may know, all non-profit hospitals are required to conduct a community health needs assessment every three years. The purpose of this assessment is for the hospital to gain an understanding of the current health status of their target area, learn about the top health needs and priorities, and to develop an action plan to address some of those health needs when possible. Part of the assessment is gathering quantitative data on health indicators from secondary analysis and the other part of the assessment process includes getting input from community residents and key stakeholders, which is why I am conducting this interview with you. Your input will be used to inform the health needs assessment and potential future action by CHRISTUS Health in your community. The interview will take a maximum of one hour.

In order to capture all of the information we talk about, I will be taking notes throughout the conversation. I will not record your name on the call; I will only start taking notes with the beginning of the questions. After the interview is completed, we will transcribe and code the interviews so that we can see if any themes arise across the multiple interviews conducted. All transcripts will be destroyed at the end of the project, and your responses will not be tied back to you in any way; the results of the interviews will only be reported in aggregate. Are you comfortable with having the conversation recorded in this way?

[IF YES]: Great, thank you. I will call you at **[DATE AND TIME].** I look forward to speaking with you then.
[IF NO, THANK THE PARTICIPANT FOR THEIR TIME AND END CALL]

[START HERE FOR ACTUAL INTERVIEW]

Hello, may I please speak with **[NAME]?**

Thank you so much for taking this time to speak with me. Do you have any questions about the assessment that we discussed during our last call? **[ALLOW TIME FOR QUESTIONS]**

[IF PREVIOUSLY AGREED TO RECORDING]: In order to capture all of the information we talk about, I am going to take detailed notes throughout our conversation. After the interview is completed, we will review and code the interviews so that we can see if any themes arise across the multiple interviews conducted. All of your responses will not be tied back to you in any way; the results of the interviews will only be reported in aggregate. Do you agree to participate in this way?

[IF YES, PROCEED WITH INTERVIEW]
[IF NO, THANK THE PARTICIPANT FOR THEIR TIME AND END CALL]

[BEGIN INTERVIEW]: Thank you! I appreciate your time. Again, please remember that your responses will not be tied back to you directly so feel free to be as honest as possible. We are truly interested in hearing your opinions and ideas. You may refuse to answer any question or topic during the interview. Do you have any questions? Let's get started. I am going to begin the recording now. **[BEGIN RECORDING]**

This is key informant interview **[#]** on **[day, date, time]**
As we go through these questions, please answer based on your perception for the following geographies: **[Insert Counties] —** counties

1. Can you please tell me a little bit about your background and how you are connected to CHRISTUS Health, if at all?
Probe: Are you a public health expert, local/county/state official; community resident; representative of CBO, faith-based organization, schools, other health setting, etc.?

Follow-up: Do you meet any of these criteria? [Note: Participant does not necessarily have to meet any of these to participate]
[CIRCLE ALL THAT APPLY]

1. Persons with special knowledge of or expertise in public health
2. Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
3. Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

COMMUNITY HEALTH AND WELLNESS
2. What are some of your community's assets and strengths as related to the health and well-being of community residents?
Probe: primary and preventive health care; mental/behavioral health; social environment; any other community assets

3. What do you think are the physical health needs or concerns of your community? [free list]
Probe: heart disease, diabetes, cancer, asthma, STIs, HIV, etc.
Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?
Follow up: These are the top 3 health needs we have identified: [Refer to data sheet and read the corresponding top 3 health needs for the region from which the interviewee is representing]. Do you think these are primary concerns for your community?

Follow up: Are there any other needs that should be addressed?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones?

4. What do you think are the behavioral/mental health needs or concerns of your community? [free list]

Probe: suicide, depression, anxiety, ADHD, etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

5. What do you think are the environmental, including built environment, concerns facing your community? Not just limited to factors like air quality, these concerns can include things like access to green space, safe sidewalks or playgrounds, and reliable transportation. [free list]
Probe: Air quality, water quality, workplace related dangers, toxin/chemical exposures, transportation, green space, etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations, assets or infrastructure (i.e. green space, parks, bike lanes, etc.) already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

6. Now I want you to think a little about a broader range of factors that could affect health. What do you think are the economic concerns facing your community? [free list]
Probe: Housing, employment, access to quality daycare, chronic poverty, etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

7. Again, thinking about other issues that could impact a person's health and well-being, what do you think are the social concerns facing your community? These could be concerns that impact a person's ability to interact with others and thrive or concerns that influence how the members of that society are treated and behave toward each other.
Probe: Neighborhood safety, violence, dropout rates, teen and unplanned pregnancy etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations, assets or initiatives in place already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

BEHAVIORAL RISK FACTORS
8. What are behaviors that promote health and wellness in your community?
Probe: Exercise, healthy nutrition, etc.

Follow up: Who engages in these positive behaviors and who is impacted (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?
Follow up: Based on your experience/ knowledge/ expertise, what could be done to facilitate that more individuals can engage in these behaviors?

9. What are behaviors that cause sickness and death in your community?
Probe: Smoking, drinking, drug use, poor diet/nutrition, lack of physical activity, lack of screening (breast cancer, diabetes, etc.), etc.

Follow up: Who engages in these risk factors and who is impacted (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?
HEALTH CARE UTILIZATION
10. Where do members of your community go to access existing primary health care?
Probe: Can you identify the facilities and what types they are (free clinic, private doctors office)?

Follow up: Who accesses these services?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (preventive, chronic care, etc.)?

11. Where do members of your community go to access existing specialty care?
Probe: Can you identify the facilities and what types they are (free clinic, private doctors office)?

Probe: What types of specialty care are people in your community seeking (ie gynecology, heart specialist, dialysis, etc.?

Follow up: Who accesses these services?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (preventive, chronic care, etc.)?

12. Where do members of your community go to access emergency rooms or urgent care centers?

Probe: Please identify these facilities:

Follow up: Who accesses these services?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (emergencies, preventive, chronic care, etc.)?

Follow up: Why do they go to emergency care facilities rather than primary care?

13. Where do members of your community go to access existing mental and behavioral health care?

Probe: Can you identify the facilities and what types they are (free clinic, private doctors office)?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (preventive, chronic care, etc.)?

ACCESS TO CARE

14. Are you satisfied with the current capacity of the health care system in your community?

Probe: Access, cost, availability, quality, options in health care, etc.

Follow up: Why or why not?

15. What are some barriers to accessing primary health care in your community? [free list]

Probe: inadequate transportation, long wait times, don't know where to go, lack of insurance, etc.

16. What are some barriers to accessing mental and behavioral care in your community [free list]

Probe: inadequate transportation, long wait times, don't know where to go, lack of insurance, stigma, etc.

17. Who are impacted by these barriers?

18. Reflecting on these barriers, what are one or two things CHRISTUS, its partners, or other organizations in the community could do to try to address these?

Those are all of the questions I have for you today. Is there anything else you would like to add before I turn of the recorder? **[ALLOW TIME FOR COMMENTS]**

Thank you very much for your time today; we really appreciate you sharing your thoughts on the current status and health needs of your community. If you have any questions about the interviews we are conducting, you can contact **[INSERT CONTACT NAME AND INFORMATION]**

Note: This interview was initially developed as a partnership between the Texas Health Institute and the Louisiana Public Health Institute. All prompts and probes are tailored to the informant.

APPENDIX C: COMMUNITY RESOURCES

An inventory of community resources was compiled based on key informant interviews, focus group discussions, and an internet-based review of health services in Tyler. The list below is not meant to be exhaustive but represents a broad sampling of feedback received from the stakeholder engagement process. The list of community resources is restricted to only those that are physically located within the report area. Several additional organizations located outside the report area may provide services to report area residents but fall outside the scope of inclusion in this needs assessment. Similarly, many of the organizations identified in this resource compilation serve a population broader than the report area but are included here in the context of the services they offer to report area residents.

Name	Description
Amistad Community Health Center (FQHC)	Amistad Community Health Center strives to provide the underserved healthcare population in the Corpus Christi community with the highest quality medical care available in the spirit and strength of Jesus Christ.
Catholic Charities of Corpus Christi	Enables individuals to reach their full potential towards self-sufficiency and financial independence by developing and implementing supportive services such as job coach and placement, educational components, help develop the capacity to manage their own affairs, make own decisions, and provide for own self.
Charlie's Place Recovery Center	Charlie's Place Recovery Center is committed to working with, encouraging, and developing those who have a passion to create a community where addiction is accepted as a treatable disease, services are readily accessible, lives are rebuilt, families are reunited and society is enriched by each individual achieving recovery. From direct care staff to licensed professionals, our team treats patients with the dignity and respect they deserve because we know the power of compassion in reaching success.

Name	Description
Coastal Bend Center for Independent Living	The Coastal Bend Center for Independent Living (CBCIL) is a 501(c)(3) organization. We are consumer-controlled, non-residential, non-profit and cross-disability oriented, providing core services of information and referral, advocacy, peer counseling, and independent living skills training. We are a service organization designed specifically to assist people with cross disabilities who themselves have been successful in establishing independent lives. These people have both training and the personal experience to know exactly what is needed to live independently. In addition, they have deep commitment to assisting other people with disabilities in becoming more independent.
Coastal Bend Health Education Center	The Texas A&M Coastal Bend Health Education Center, in Corpus Christi, Texas, is committed to improving the quality of health care in the Coastal Bend by advancing the knowledge and skills of health care professionals, students and the community through partnerships in education, research and technology. As a proud partner of Texas A&M Healthy South Texas, our services have expanded beyond the Coastal Bend to improve health outcomes throughout a 27-county area. By engaging families, promoting healthy behavior change and enhancing education, everyone in South Texas can enjoy the benefits of better health now, and for generations to come.
Coastal Bend Neighborhood Empowerment	Coastal Bend Neighborhood Empowerment utilizes a process called Asset-Based Community Development to empower neighborhoods and create lasting change.

Name	Description
Coastal Bend Wellness Foundation	The Coastal Bend Wellness Foundation (CBWF) is a grass-roots, community based non-profit organization, with a long standing history of providing services to those in our community that are often disenfranchised, taking on causes to fill gaps in services that no other agency provides. Current services include primary health care, mental health and substance abuse programs, infectious disease testing, education and linkage to treatment, and youth education to provide information on the dangers of drug use.
Community Action Corporation of South Texas	CACOST is a private non-profit organization established in 1971 and funded through federal, state and local grants. CACOST currently serves 16 counties via a wide variety of community programs and services. CACOST lives its mission each day, which is to continuously improve the lives of South Texans by providing high quality health care, education, housing and economic opportunities to reduce poverty through services and partnerships.
Corpus Christi Nueces County Public Health District	The mission of the Health District is to prevent disease, disability, & premature death; promote healthy lifestyles; and protect the health & quality of the environment for all residents of Nueces County.
Driscoll Health	Driscoll Health Plan is a non-profit, community-based health insurance plan offering health care coverage to the communities of South Texas. Our insurance products include STAR Medicaid, STAR Kids, CHIP and CHIP Perinatal.
Methodist Healthcare Ministries	This mission also includes Methodist Healthcare Ministries' one-half ownership of the Methodist Healthcare System – the largest healthcare system in South Texas.

Name	Description
	This creates a unique avenue to ensure the Methodist Healthcare System continues to be a benefit to the community by providing quality care to all and charitable care when needed, and it provides revenue to Methodist Healthcare Ministries for its programs.
Metro Ministries - Gabbard Health Clinic	The Dr. James Gabbard Memorial Health Clinic is a free primary care medical clinic staffed by generous volunteer doctors and nurses from the community. The clinic provides medical exams and vision exams. In addition to performing these exams, the clinic provides help with medications and other services to help as many clients as possible. The clinic also focuses on referring clients to more permanent medical homes and enrolling them in public assistance programs.
Mission of Mercy Clinic	Our mission is to restore dignity, “Healing Through Love,” by providing free healthcare. Mission of Mercy’s success will be measured by our ability to provide health care to uninsured working families at no cost to those who seek help at our Medical Center and Sandia clinic site.
Rural Economic Assistance League (REAL)	The Rural Economic Assistance League, Inc. (REAL) is a non-profit organization established in 1972 with the mission to provide safe, caring and quality community-centered services for the elderly, persons with disabilities and the general public by assisting them and their families in maintaining an independent and fulfilling life.
South Coastal Area Health Education Center	The mission of South Coastal AHEC is to improve access to quality health care in South Texas through the facilitation of health professions training and education.

Name	Description
STCH Ministries	STCH Ministries (originally South Texas Children's Home) is a faith-based, nonprofit organization that has been caring for children and families since 1952. We provide: • **Homes for Children**, caring for children of all ages • **Homes for Families** for single moms and their children • **Family Counseling** services for individuals, couples, and families sorting through the challenges of life • **International**, reaching children and families through international missions • **Faith & Work** to enhance job skills and spiritual growth • **Faith & Finances** to teach biblical principles of money management • **Pastor Care** to serve those who are always serving others • **Family Support** to connect needs of families with resources • **Ministry Consulting** to share expertise and resources with other ministries
Texas A&M AgriLife Extension	The Texas A&M AgriLife Extension Service educates Texans in the areas of agriculture, environmental stewardship, youth and adult life skills, human capital and leadership, and community economic development. Extension offers the knowledge resources of the land-grant university system to educate Texans for self-improvement, individual action and community problem solving. Texas A&M AgriLife Extension Service professionals associated with the Texas A&M AgriLife Research and Extension Center at Corpus Christi proudly serve their community.

Name	Description
The Recovery Collective	The Recovery Collective unites people in the Coastal Bend community in all stages of recovery. We believe that by building collective agency among those whose lives have been impacted by substance abuse, together we can empower each other to make positive changes in our lives and in our communities through education, advocacy, and volunteerism.

Note: Some services may be available in multiple counties.

CHRISTUS Spohn Health System would like to thank residents and stakeholders from the community who contributed to this community health needs assessment.