

**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 Southeast Texas Health System is a non-profit, Catholic integrated health care delivery system that includes acute care hospitals and inpatient facilities in three counties in southeastern Texas. CHRISTUS Southeast Texas 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 Southeast Texas Health System works closely with the local community to ensure that regional health needs are identified and incorporated into system-wide planning and strategy. To this end, CHRISTUS Southeast Texas 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. This report fulfills the legal requirements for all hospitals in the CHRISTUS Southeast Texas Health System. CHRISTUS Dubuis Hospital of Beaumont, a long-term acute care hospital operated by LHC Group of Lafayette, participated in the CHNA to better understand and address the unique needs of its patient population.

In this CHNA, THI staff and CHRISTUS Southeast Texas 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. All combined, these data 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 six prioritized health concerns were developed. These are summarized in the table below. A subsequent community health improvement plan (CHIP) will specify actions that CHRISTUS Southeast Texas Health System will take to address the first five health concerns. The CHIP will also specify actions CHRISTUS Dubuis of Beaumont will take to address the sixth health concern.

Rank	Health Concern
1	Access to Mental and Behavioral Health
2	Access to Primary Care
3	Transportation
4	Healthcare Disparities
5	Food Insecurity
6	Improved End-of-Life Resources and Supports

### ***CHRISTUS Southeast Texas Health System Prioritized Health Needs, 2020-2022***

## INTRODUCTION

The CHRISTUS Southeast Texas Health System (CSETHS) service area centers on the Beaumont-Port Arthur metropolitan statistical area, located approximately 85 miles east of Houston and 25 miles west of the Texas-Louisiana state line. CSETHS is currently comprised of two non-profit hospitals primarily serving a six-county region in southeast Texas. CHRISTUS Southeast Texas St. Elizabeth Hospital is located in downtown Beaumont. CHRISTUS Southeast Texas Jasper Memorial Hospital, located 70 miles north of Beaumont-Port Arthur, serves the northern portion of the CSETHS service area. CSETHS also encompasses clinics and outpatient centers across the five counties in the report area; a number of physician partnerships, PHOs, and MSOs; and the CHRISTUS Southeast Texas Foundation.<sup>1</sup> Also participating in this Community Health Needs Assessment (CHNA) is CHRISTUS Dubuis Hospital of Beaumont, a long-term acute care hospital (LTACH) located on the 4<sup>th</sup> floor of CHRISTUS Southeast Texas St. Elizabeth Hospital, and operated by the LHC Group of Lafayette, Louisiana. Currently the hospital has 33 beds.

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. 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," CHRISTUS Southeast Texas Health System 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."<sup>2</sup>

Federal law requires all non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years to maintain their tax-exempt status. CHRISTUS Health contracted with Texas Health Institute (THI) to develop the CHNA report for CSETHS, a document that will fulfill the requirements set forth in IRS Notice 2011-52, 990 requirements for non-profit hospitals' community health needs assessments, and will be made available to the public. This report fulfills the IRS requirement for all three CSETHS hospitals, including the LTACH located within St. Elizabeth Hospital.

To complete its CHNA, the THI team and CSETHS 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 and priorities, challenges, resources and potential solutions.

A CHNA ensures that CSETHS 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

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<sup>1</sup> In June 2019 CSETHS closed CHRISTUS Southeast Texas St. Mary Hospital in Port Arthur. CHRISTUS St Mary Hospital was included in the analysis of hospital admissions and emergency department visits as it provides insight about the health needs in the community.

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

planning, ensuring that CSETHS 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 the the Southeast Texas region, such as the Regional Needs Assessment released in 2018 by the Prevention Resource Center 4.<sup>3</sup> Findings from previous CHNAs and 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 CSETHS 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 service 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 these sourcee 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 CSETHS internal data and conducted descriptive analysis for three acute care hospitals (including one that was recently closed) and the long-term acute care hospital. 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.

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<sup>3</sup> Regional Needs Assessment. (2018). Region 4 Prevention Resource Center. Available at: <https://www.etcada.com/rna>.



### ***Sample and Recruitment***

Representatives from CSETHS contributed contact information for 19 people who represent the broad interests of the report area 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 19 key informants by email and telephone, and 11 individuals responded to the request. THI conducted 10 interviews between September and December 2018, each lasting between 30 to 60 minutes. One interview was conducted in May 2019 to provide additional information related specifically to the CHRISTUS Dubuis Hospital patient population.

### ***Transcription***

THI used the notes and recordings to develop transcripts of 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 CSETHS staff.

### ***Recruitment and Sample***

Potential participants were identified by CSETHS leadership. 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). A total of 16 people participated in the focus group.

### ***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 develop transcripts for later coding and analysis.

## 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 those from Texas and the US to determine evidence of “health needs.”<sup>4</sup> 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 CSETHS 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.

THI utilized a hybrid approach to qualitative analysis based on both thematic and content analysis as well as grounded theory-based methods.<sup>5,6,7</sup> Whereas thematic analysis identifies and *qualifies* narratives, content analysis identifies and *quantifies* recurring narratives.<sup>8</sup> 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 readings of key informant and focus group transcripts, the THI team methodologically analyzed transcripts to uncover 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)

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<sup>4</sup> Rates were age-adjusted for comparisons.

<sup>5</sup> Smith, J., & Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse researcher*, 18(2), 52-62.

<sup>6</sup> Joffe, H., & Yardley, L. (2004). Content and thematic analysis. *Research methods for clinical and health psychology*, 56, 68.

<sup>7</sup> Corbin, J. & Strauss, A. (1990). Grounded theory method: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13, 3-21.

<sup>8</sup> 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.

barriers to care and (4) assets and solutions to address population health and health system needs. Next, the THI team tagged transcript passages, open-coded key concepts within passages, compared patterns of codes within and across transcripts, and collapsed these codes into thematic categories.

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 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.<sup>9</sup> 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

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<sup>9</sup> Lipmanowicz, H., & McCandless, K. (2010). Liberating structures: innovating by including and unleashing everyone. *E&Y Performance*, 2(4), 6-19.

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 January 2019. THI staff informed the CSETHS 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 28 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 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.

Finally, in recognition of the unique needs of the patient population in CHRISTUS Dubuis Hospital, one additional prioritized need was developed. Identifying this need was supplemented by reports from informants rooted in the community and with broad knowledge about the needs of the LTACH patients and families. The result was a list of six prioritized health needs.

## **SUMMARY OF ACTIVITY SINCE 2017-2019 CHNA**

In 2016 THI conducted a CHNA and companion Community Health Improvement Plan (CHIP for CSETHS for the 2017-2019 triennium.<sup>10,11</sup> In collaboration with a wide variety of stakeholders CSETHS prioritized a list of top health needs. CSETHS pursued actions to address the top five of these health needs. In order of ranking starting with the top priority, these included (1) access to primary care, (2) unhealthy behaviors, (3) preventable hospital stays, (4) access to mental health providers and services, and (5) food insecurity. The information below summarizes the expanded actions CHRISTUS Southeast Texas Health System has pursued since that time for each of the targeted health needs.

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<sup>10</sup> CHRISTUS Health. *Community Health Needs Assessment, 2017-2019*. Available at: <https://www.christushealth.org/-/media/files/homepage/giving-back/chna/2017--2019-chna-christus-st-michael-approved.ashx?la=en>

<sup>11</sup> CHRISTUS Health. *Community Health Improvement Plan, 2017-2019*. Available at: <https://www.christushealth.org/-/media/files/chip/2017--2019-chip-christus-setx-rev.ashx?la=en>



## **SIGNIFICANT NEEDS WITH HOSPITAL IMPLEMENTATION RESPONSIBILITY**

### ***Access to Primary Care***

Strong collaboration with local Federally Qualified Health Centers (FQHCs) was the core strategy for addressing access to primary care. Legacy Community Health Services (Legacy), an FQHC operating in the report area, offers primary care services to uninsured individuals with chronic conditions lacking a medical home. CSETHS refers uninsured patients or other individuals lacking a medical home to Legacy to ensure compliance with discharge planning and appropriate ambulatory follow-up. Designed to reduce hospital admissions, the partnership was developed as a project supported by the Texas' Delivery System Reform Incentive Payment (DSRIP) program.

As with all DSRIP projects, the Texas Health and Human Services Commission requires each project to report metrics on program impact. The latest metrics indicates that over 15,000 patients a year had been treated as a result of CSETHS's referrals to Legacy. Most of these referrals are Medicaid or Low Income qualified. The referrals to the Legacy clinic were primarily from the Beaumont area, close to the CHRISTUS Southeast Texas St. Elizabeth Hospital.

Another referring relationship to increase primary care access was established in the location of the (now closed) CHRISTUS Southeast Texas St. Mary Hospital, in Port Arthur. The Port Arthur FQHC is Gulf Coast Clinic. Both of these FQHCs participated in the CHNA done in 2016 and again in the current CHNA. The FQHC staff in both Beaumont and Port Arthur have been collaborators in the annual enrollment efforts for the Affordable Care Act, chaired by CHRISTUS Health in the Enroll Southeast Texas Coalition designed to increase medical insurance coverage among the uninsured.

### ***Unhealthy Behaviors***

COPD, smoking, diabetes, hypertension, obesity, and lack of exercise, all highly prevalent health issues in the report area, can be addressed through behavioral interventions. CHRISTUS Southeast Texas Health System Center for Health Management Clinic specializes in addressing unhealthy behaviors among Medicaid and Low Income patients. The clinic addressed unhealthy behaviors by treating over 500 patients per year, with each of them having multiple visits essential to the type of follow-up required for lifestyle changes leading to better health and reduced hospital admissions.

### ***Preventable Hospital Stays***

CSETHS's partnership with the two FQHCs discussed above included an initiative to reduce rates of unnecessary hospital re-admissions through outreach to patients discharged from the hospital's Emergency Department. Diseases such as hypertension were targeted with a software program employed to flag patients upon admission so that they did not get "lost in the system" when follow-up would clearly benefit their health. A focus was made on preferred post-acute providers with high quality ratings and preventable readmission programs. A CSETHS community health worker followed up on the flagged patients.

In addition, CHRISTUS collaborates with companies, such as Encompass, that have readmission follow-up programs. Multi-disciplinary hospital rounds with physicians increased discussions of post-acute care needs so that the proper home health, needed equipment or perhaps even the safety of the patient was more deliberate in discharge planning. Similarly, Emergency Room (ER) case management identified social needs and referred patients to social service providers such as the Salvation Army and the Food Bank.

### ***Access to Mental Health Providers and Services***

The state-wide shortage of providers and inpatient facilities to treat mental and behavioral health conditions makes addressing this need a challenge. CSETHS addressed this challenge by educating its providers about how to better work with patients with mental health conditions. Many patients presenting with acute physical conditions in the ER also have psychiatric conditions or substance abuse issues with associated behaviors often not recognized among clinical and other staff. To begin addressing this need, CHRISTUS Associates provided de-escalation training throughout the organization. In addition, CHRISTUS Southeast Texas Health System is implementing a workplace violence program to provide support for staff injured by patients that are violent. This is part of a comprehensive program that ultimately is meant to benefit the patients. Education is now provided to all clinical staff for risk suicide identification and prevention. Finally, CHRISTUS Southeast Texas Health System participates in a semimonthly meeting among local providers to discuss emergency care services for these patients. Participants at these meetings include include representatives from the MHMR agency, other mental health providers, local law enforcement, and ambulance services.

### ***Food Insecurity***

To address food insecurity, CSETHS partnered with The Food Bank of Southeast Texas. The Executive Director of The Food Bank of Southeast Texas addressed staff at a CSETHS hospital management meeting about the nature and extent of food insecurity and how the health system can help. In response, CHRISTUS Southeast Texas Health System has supported the Food Bank through monetary and in-kind donations. The CHRISTUS Foundation awarded the Food Bank a large grant to provide diabetic appropriate groceries and meals to discharged patients in need. Meal vouchers to the hospital cafeteria are provided to qualified patients and their family members when they are staying at the local medical house of hospitality. CHRISTUS Health Associates have donated canned items to the Food Bank after several collection campaigns, and the Food Bank also benefits from the annual hospital-wide United Way campaign.

## **KEY FINDINGS**

### **POPULATION DEMOGRAPHICS**

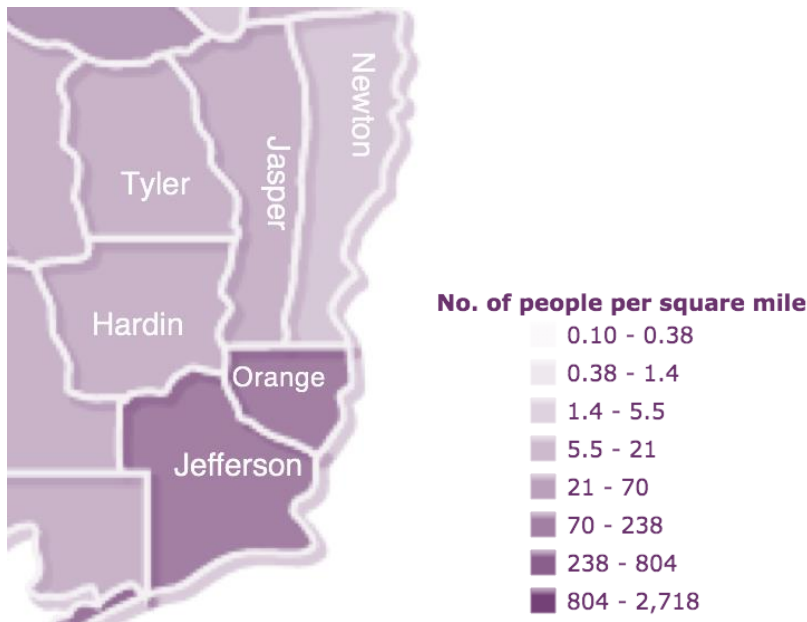
CSETHS serves Hardin, Jasper, Jefferson, Newton, Orange, and Tyler Counties in Texas, henceforth referred to as the “report area”, consisting of a total population of 469,537 residents (see Figure 1). Nearly 75% of the region’s population resides in Jefferson County and Orange County. Eighty-eight percent of residents in the report area live in Hardin, Jefferson, Newton, Orange Counties which are urban counties, while the remaining 12% live Jasper and Tyler Counties which are rural (see Table 1).<sup>12</sup> The population increased for the report area by 1.6% from years 2010 to 2017. The highest population growth was in Hardin County at 4.6%.

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<sup>12</sup> Health Services and Resources Administration. (2016). List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties. Available at <https://www.hrsa.gov/sites/default/files/ruralhealth/resources/forhpeligibleareas.pdf>

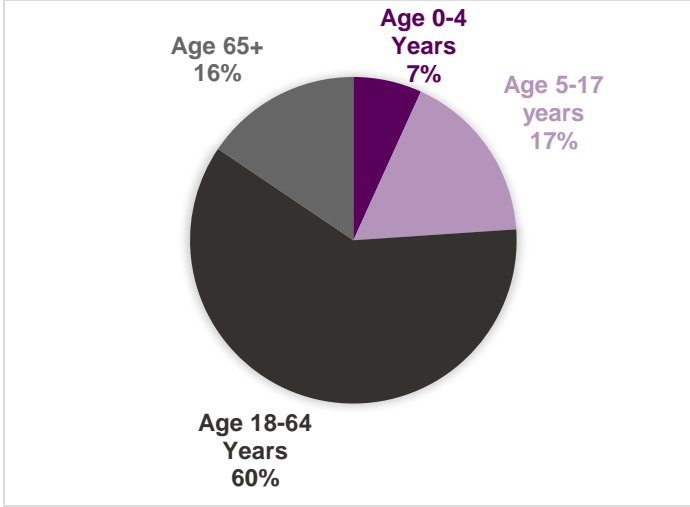
County Name	Population (%)
Hardin County, TX	57139 (12.2)
Jasper County, TX	35561 (7.6)
Jefferson County, TX	256299 (54.6)
Newton County, TX	13952 (3.0)
Orange County, TX	85047 (18.1)
Tyler County, TX	21539 (4.6)
Report Area	469537

**Table 1. Report Area Population, by County**



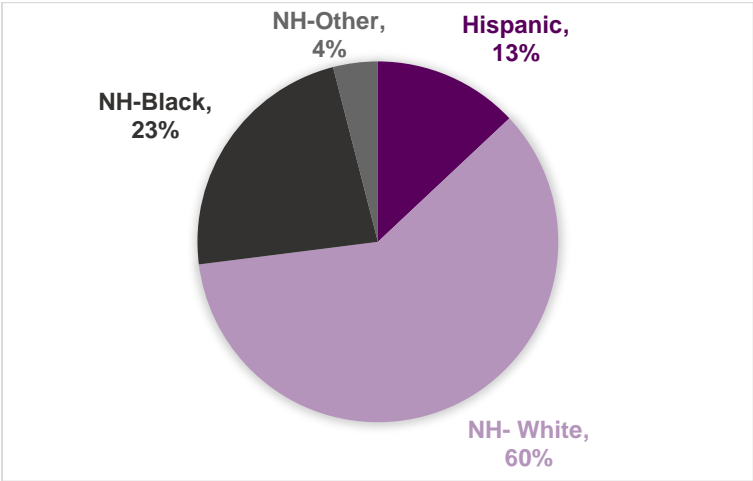
**Figure 1. Population Density (Persons per Square Mile)**

Individuals between ages 18 and 64 (working-aged adults) constitute 60% of total population. Of the remaining population, 16% are ages 65 and older, 17% 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%). Newton (20%) and Tyler (22%) Counties have an even higher population 65 and older.



**Figure 2. Report Area Population by Age Groups**

Compared to Texas, the population in the report area have a lower proportion of Hispanic residents (Table 2). The Hispanic/Latino population in the report area more closely resembles that of the US than that of Texas — just over 13% of the report area is Hispanic/Latino, compared to 39% of Texans. The NH-African American population in the report area have a higher proportion of residents at 23% compared to Texas at 12%. The NH-Asian, NH-Native Hawaiian/Pacific Islander and NH-Native American/Alaska Native categories each comprise less than 4% of the report area population. The report area population is virtually evenly distributed by gender (51% male, 49% female), mirroring the gender distribution of Texas and the US.



**Figure 3- Report Area Population by Race and Ethnicity**



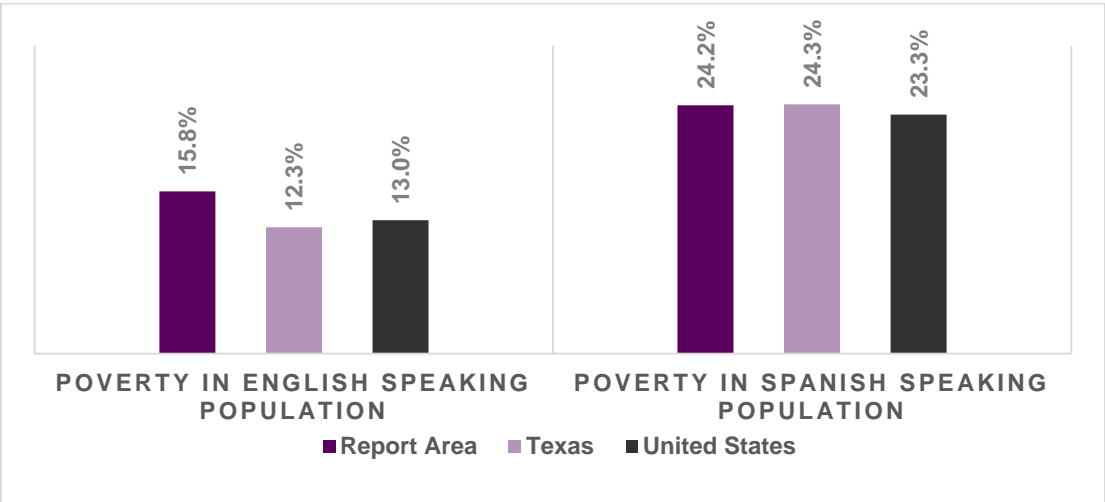
Race and Ethnicity	Report Area	Texas	United States
Hispanic %	13.1	38.6	17.3
NH- White alone%	60.0	43.4	62.0
NH- - Black or African American alone %	22.9	11.6	12.3
NH- American Indian and Alaska Native alone %	0.2	0.2	0.7
NH- Asian alone %	2.3	4.3	5.2
NH- Native Hawaiian and Other Pacific Islander alone %	0.0	0.1	0.2
NH- Some other race alone %	0.1	0.1	0.2
NH- - Two or more races %	1.4	1.6	2.3

**Table 2. Report Area Population by Race and Ethnic Breakdown**

**SOCIAL AND ECONOMIC ENVIRONMENT**

Consolidated median income data for the report area is not available, but county-level data show that Hardin County has a median annual family income nearly \$19,000 higher than Newton County (\$68,750 compared to \$49,806). For all counties besides Hardin County, the income level is lower than Texas’ median family income (\$64,585).

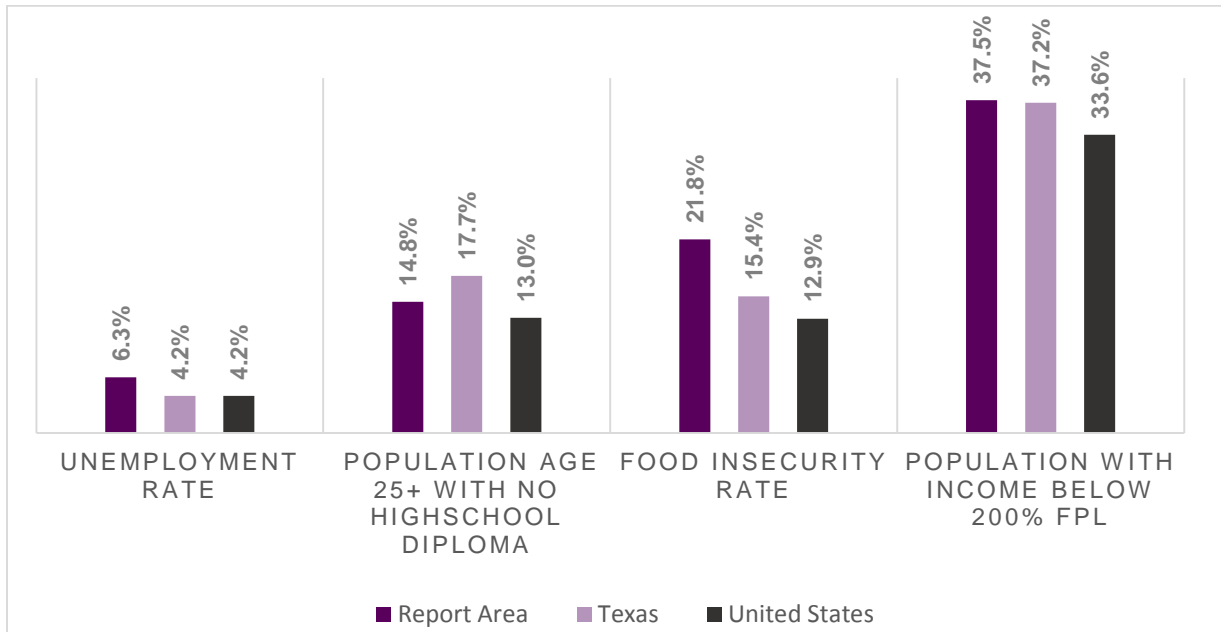
Poverty is fairly widespread in the report area, with 38% of report area residents earning annual incomes at or below 200% FPL. This is on par with the poverty for the state of Texas at 37%. Newton County has the highest poverty at 42%. According to 2019 federal guidelines, 200% FPL corresponds to an income of \$51,500 per year for a family of four.<sup>13</sup>



**Figure 4. Poverty Distribution by Language**

<sup>13</sup> 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>

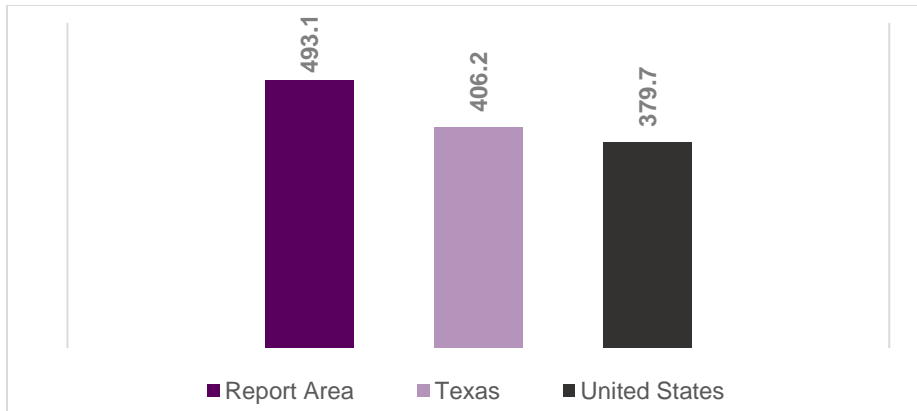
Spanish-speaking populations have higher poverty rates than English-speaking populations for each county (Figure 4; Appendix A). Poverty within both populations mirrors the Texas and US poverty levels.



**Figure 5. Socioeconomic Characteristics of Report Area**

Figure 5 provides a comparative summary chart of socioeconomic indicators for the report area, Texas and the US. High school graduation rates are slightly lower than Texas graduation rates. Also, college graduation in the report area is significantly lower than Texas, 24% versus 35%, and varies widely by county with the lowest graduation rates in Jasper County at 18% and Tyler County at 17%.

Obesity and chronic disease 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. For example, Feeding America defines food insecurity and defines it as a lack of consistent access to enough food for an active, healthy life. Compared to Texas, the report area's unemployment and food insecurity is significantly higher (Figure 5). Twenty-two percent of report area residents experience food insecurity compared to about 15% of Texas residents.



**Figure 6. Violent Crime Rate per 100,000 Population**

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 493.1 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 60.4 in violent crimes per 100,000 in Newton to 686.9 violent crimes per 100,000 in Jefferson County.

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“The lack of transportation is probably our number one barrier to people being compliant with care.”  
--Key Informant

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“There is a two year wait list for housing. If you do not have proper housing, how are supposed to have proper health care?”  
--Key Informant

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A common theme among the focus groups and key informant interviews was that many regions within the report area suffered from chronic poverty, limited affordable housing, limited transportation, drug abuse and food insecurity. Prevalent types of drug abuse were synthetic marijuana, meth, and opioids. Another prevalent issue noted in both focus group and key informant interviews was the increase in violent crime within the report area. Informants noted that this risk creates barriers to engaging in activities outside of the home and takes a toll on one’s mental health.

Several informants stated the need for increased community representation for the growing Hispanic community within the government, school board, and non-profits sectors. Others noted the importance of health partnerships to help address healthcare disparities. For example,

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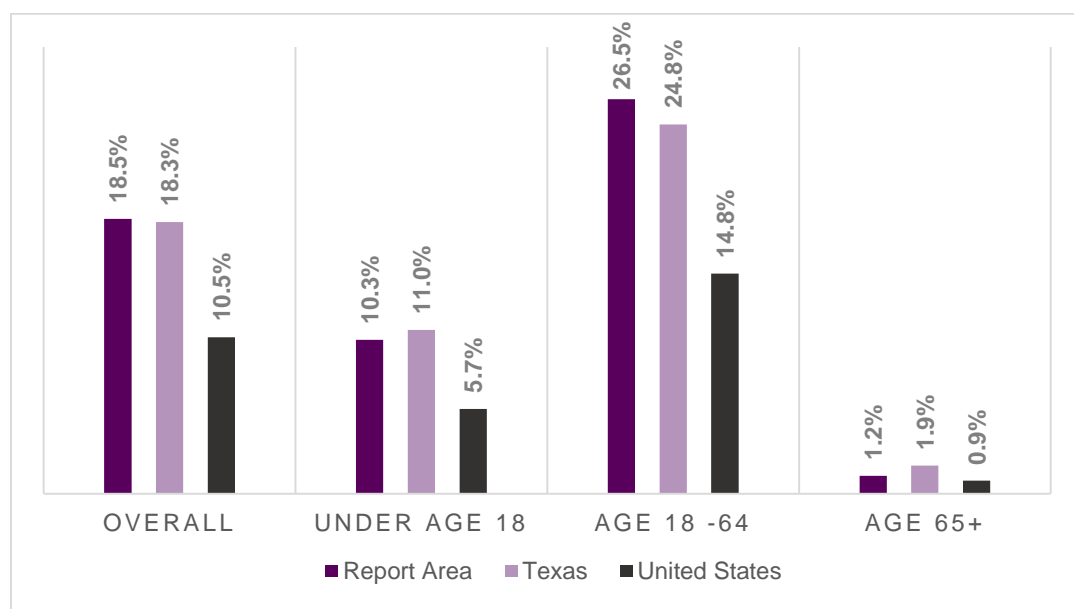
“It is expensive for people to eat healthy and those foods are just not available throughout the city?”  
--Focus group participant

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CHRISTUS has partnered in the past to create health fairs within Hispanic communities and provides multilingual services within the emergency department.

## ACCESS TO HEALTH CARE

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.<sup>14</sup> 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.



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

In the report area the overall uninsured percentage of 19% is on par with Texas' uninsured percentage of 18%. Less than 2% of elderly adults in the area are uninsured due to the availability of Medicare coverage for this age group. In contrast, around 1 in 4 working-age adults in the report area are uninsured and 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.<sup>15</sup>

<sup>14</sup> Institute of Medicine. (1993). Access to health care in America. Committee on Monitoring Access to Personal Health Care Services. Washington, DC: National Academy Press.

<sup>15</sup> 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%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

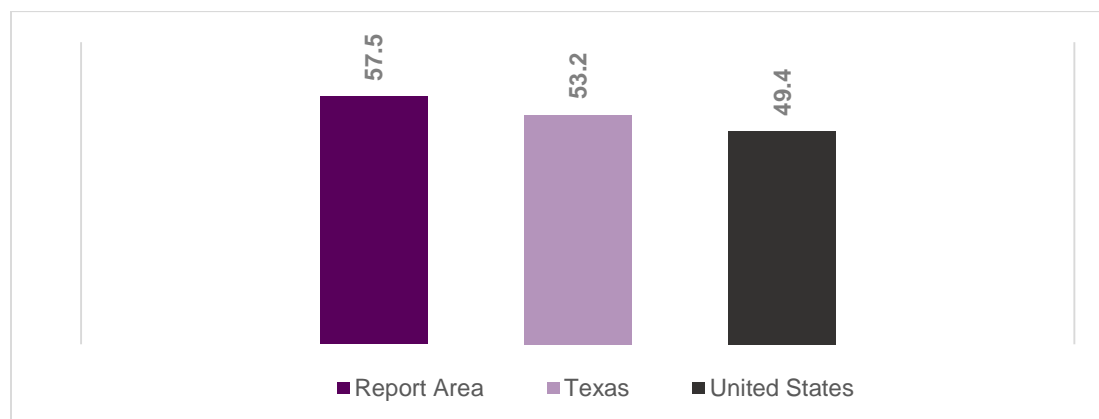


Health insurance is just one component of access to care and does not guarantee access even to those who have it. Without an adequate supply of local health care providers, the health system will not have the capacity to accommodate all patients who need care, regardless of insurance status. Higher numbers 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 the report area. County variation in access to various providers reveal significant disparities. For example, while all report area counties have higher population to primary care practitioners (e.g., primary care physicians), Hardin and Tyler Counties have significantly higher ratios compared to Jefferson County, which is close to the Texas ratio (Table 3). The report area ratio for psychiatrists at 23,133:1 is significantly higher than the Texas ratio of 13,145:1. Note, however, that these ratios say nothing about the level of need for the services and many rural counties rely on close by urban areas.

Geography	Primary Care Practitioners	Registered Nurse	General Dentists	Psychiatrist
Hardin County, TX	5518:1	407:1	5058:1	---
Jasper County, TX	2173:1	181:1	3694:1	---
Jefferson County, TX	1437:1	84:1	2875:1	12594:1
Newton County, TX	3594:1	846:1	---	---
Orange County, TX	3776:1	354:1	4570:1	---
Tyler County, TX	4496:1	326:1	11241:1	---
Report Area	1991:1	127:1	3599:1	23133:1
Texas	1350:1	121:1	2753:1	13145:1

**Table 3. Population to Healthcare Provider Ratio**



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

Among residents in the report area, an overwhelming 83% were classified as having a shortage of primary medical care, dental or mental health professionals. This percentage is significantly higher than that of Texas at 17%. Health professional shortages and high population to provider ratios tell half the story, however. Excess needs for the services of a provider (e.g., high rates of dental canaries) alongside the lack of access to the provider (e.g., dentists) provide greater certainty of health needs.

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. These preventable visits numbered 57.5 per 1,000 Medicare enrollees in the report area, similar to the 53.2 preventable hospital events per 1,000 Medicare enrollees in Texas (Figure 8).

Stakeholders identified access to care issues with primary and specialty care. Specifically, long appointment waittimes, limited physicians within the area, and an application process to be accepted by a doctor. These factors were noted as immediate causes of the high emergency department use. Another challenge of note is that a large percentage of physicians are over 60 and holding off retirement since there are no available physicians to replace their vital role in the community. Many health care providers interviewed also stated being overburdened with treating mental and physical health needs due to limited mental health professionals within the report area.

Many informants stated that many residents lack the awareness, knowledge, or skills to navigate the system and use available resources to their maximum benefit. Both focus group and key informant interview participants noted the need to increase patient awareness about private free-standing emergency rooms. Many residents are unaware that these private services do not accept Medicaid, Medicare, or Tricare (military insurance) and are shocked by the high fees until after the bill arrives.

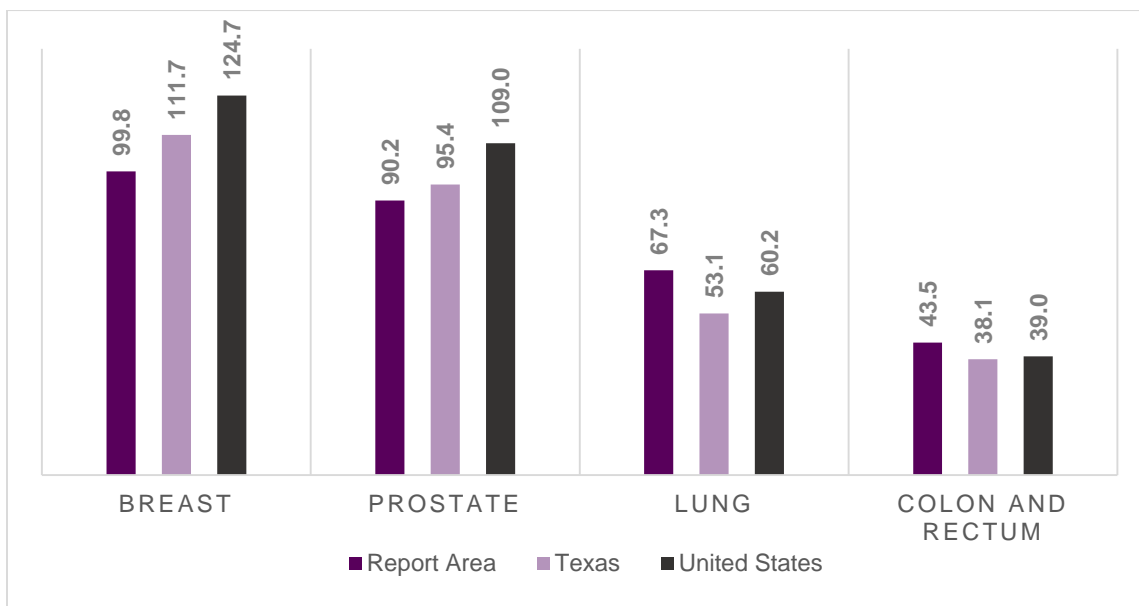
## HEALTH OUTCOMES

### Physical Health

Geography	Diabetes Prevalence (%)	Poor Physical Health Days
Hardin County, Texas	10.2%	3.3
Jasper County, Texas	12.8%	3.7
Jefferson County, Texas	12.4%	3.7
Newton County, Texas	11.4%	3.8
Orange County, Texas	11.4%	3.6
Tyler County, Texas	12.2%	3.6
Texas	10%	3.5

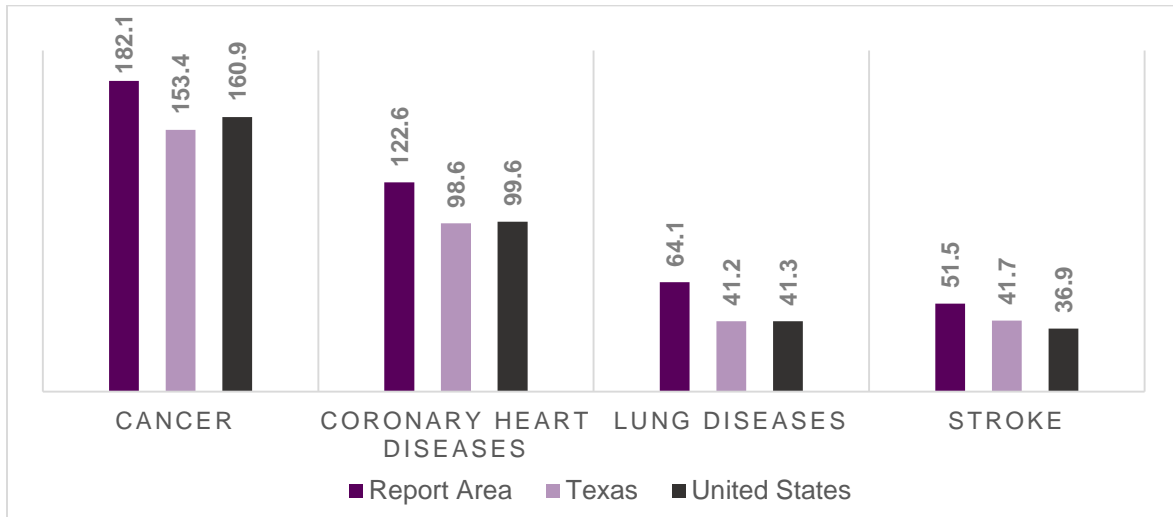
**Table 4. Diabetes Prevalence and Poor Physical Health in Report Area**

Diabetes, heart disease, hypertension, stroke, and cancer were raised numerous times throughout the key informant interviews and focus groups. Specifically, cancer was stated as a very prevalent illness throughout the community and often thought to be exacerbated by exposure to the chemical and refinery plants within the report area. These observations paint a portrait of a community with health needs greater than Texas. Quantitative data support these observations. All report area counties have higher diabetes prevalence than Texas, and only Hardin County has a lower number of poor physical health days that Texas.

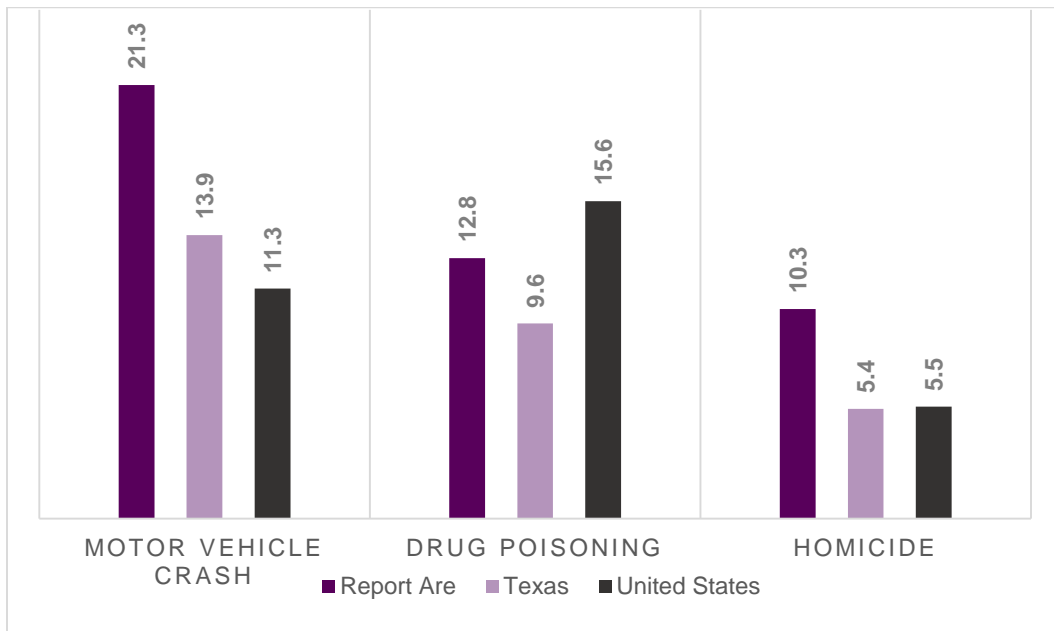


**Figure 9. Age-adjusted Cancer Incidence per 100,000 Population, by Type**

Among all types of cancer, breast cancer has the highest incidence in the report area at 99.8 per 100,000. The incidence of breast and prostate cancers in the report area are lower than the Texas and US rates (Figure 9). The largest differences observed is in the incidence of lung cancer. The lung cancer incidence rate at 67.3 per 100,000 is higher than both the Texas and US rate at 53.1 per 100,000 and 60.2 per 100,000, respectively. Of note, compared to Texas and the US, cancer mortality is higher among residents in the report area. There are 28 more cancer deaths per 100,000 population in the report area than in Texas (Figure 10).



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



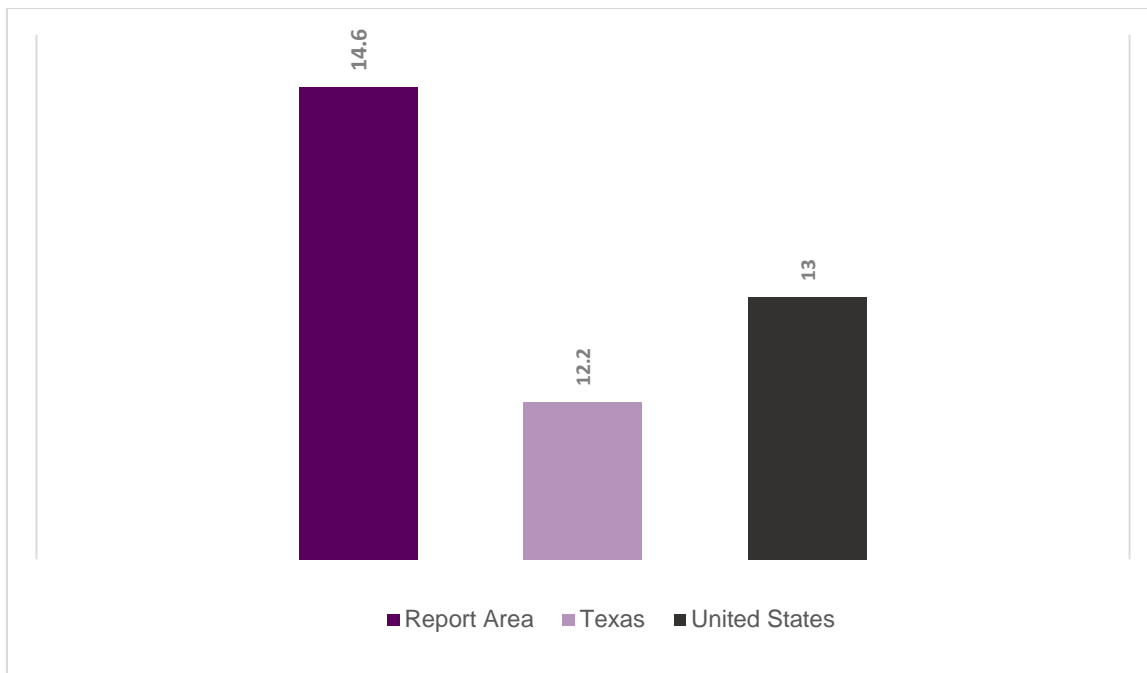
**Figure 11. Age-adjusted Mortality Rate per 100,000 Population, by External Cause**

Age-adjusted mortality from heart disease, lung disease and stroke are all significantly higher in the report area as well (Figure 10). For example, there are 24 more deaths per 100,000 from heart disease in the report area compared to Texas. Prevention, early detection, and improved disease management can help reduce mortality rates from these and other chronic conditions.

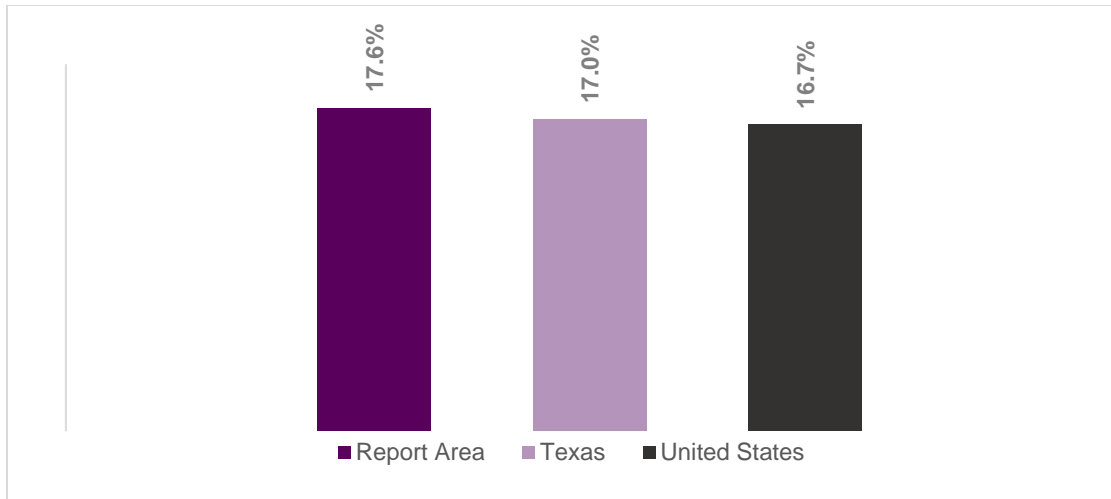
Community members stressed the importance of educating the patients to managing chronic illnesses and navigate the health care system to to ensure early detection and treatment of these diseases. They also cited the importance of increasing community collaboration and outreach in order to provide members of the community with this education and support community prevention.

In regards to external mortality causes, 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 21.3 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 Tyler County at 37.7 per 100,000 and Jasper County at 29.7 per 100,000. Homicide and drug poisoning are also higher in the report area compared to Texas. Homicide in particular is two times higher than Texas rate. (10.3 per 100,000 vs 5.4 per 100,000)

### ***Mental and Behavioral Health***



**Figure 12. Age-adjusted Suicide Mortality Rate per 100,000 Population**



**Figure 13. Prevalence of Depression among Medicare Beneficiaries**

The burden of morbidity and mortality resulting from mental illness represents a significant and growing concern among the report area. After age adjustment, approximately 14.6 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 (25.3 per 100,000) is significantly higher than the suicide rate overall, suggesting strong variation by gender. In the report area, males die by suicide at a rate approximately three times higher than that of females. Suicide risk is particularly elevated among older adults, which comprise a large and growing proportion of the report area population. Depression, a major risk factor for suicide, affects 17.6% 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

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People are desperate and in some cases hopeless. A lot of folks lost everything. They lost their homes and all of their belongings and most of them in the area did not have insurance coverage to be able to rebuild. And so we have a lot of people that are in dire circumstances.  
--Focus Group Participant

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options and long wait times. It was stated as well that the few resources that are available are geared towards helping those in crisis and leaves a gap in serving those with mild cases and providing preventative education. These access issues are even more common for Hispanic communities since there are only two certified licensed counselors in the area who speaks Spanish.



All of these needs have been significantly and negatively impacted since Hurricane Harvey. Many people were and still are displaced from the hurricane and in turn this has taken a significant toll on the community.

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I'm not saying we did not have mental health problems before Harvey, but I do think that for those people who may have been managing before, that they are having more struggles now.  
 --Key Informant

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## 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 low birth weight, disability, and infant mortality.<sup>16</sup> 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.<sup>17</sup>

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)
Hardin County, TX	4	46	8.4%
Jasper County, TX	NA	52	9.0%
Jefferson County, TX	8	47	10.3%
Newton County, TX	NA	47	9.4%
Orange County, TX	9	51	9.5%
Tyler County, TX	NA	56	9.5%
Texas	6	41	8.0%

**Table 5. Maternal and Child Health**

Teen births by each county in the report area, defined as births to mothers age 15-19, are all higher than the Texas rate of teenage pregnancy (Table 5). This ranges from 46 teen births per 1,000 in Hardin County to 56 teen births per 1,000 in Tyler County.

<sup>16</sup> Healthy People 2020. (2014). Maternal, infant, and child health. Available at: <http://www.healthypeople.gov/2020/topicsobjectives/topic/maternal-infant-and-child-health>

<sup>17</sup> Youth.gov. (2016). Adverse effects of teen pregnancy. Available at: <http://youth.gov/youth-topics/teen-pregnancy/prevention/adverse-effects-teen-pregnancy>

The infant mortality rate is only available for the larger counties in the report area ranges depending on the county. Low birth weight is elevated in all counties compared to Texas at 8% with the highest in Jefferson County at 10.3%.

**HEALTH BEHAVIORS**

<b>Geography</b>	<b>Adult Obesity</b>	<b>Physical Inactivity</b>	<b>Insufficient Sleep</b>	<b>Excessive Drinking</b>	<b>Adult Smoking</b>
Hardin County, TX	30.5%	31.4%	30.2%	20.2%	15.1%
Jasper County, TX	29.7%	26.0%	32.0%	18.5%	17.2%
Jefferson County, TX	34.3%	32.5%	35.2%	16.8%	17.1%
Newton County, TX	30.2%	28.0%	33.3%	18.4%	17.1%
Orange County, TX	32.6%	31.5%	33.5%	21.1%	18.1%
Tyler County, TX	30.5%	27.2%	30.3%	19.1%	15.9%
Texas	28.0%	24.0%	33.0%	19.0%	14.0%

**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, physical inactivity, and tobacco use in the report area all slightly exceed 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) or insufficient sleep was on par with Texas.

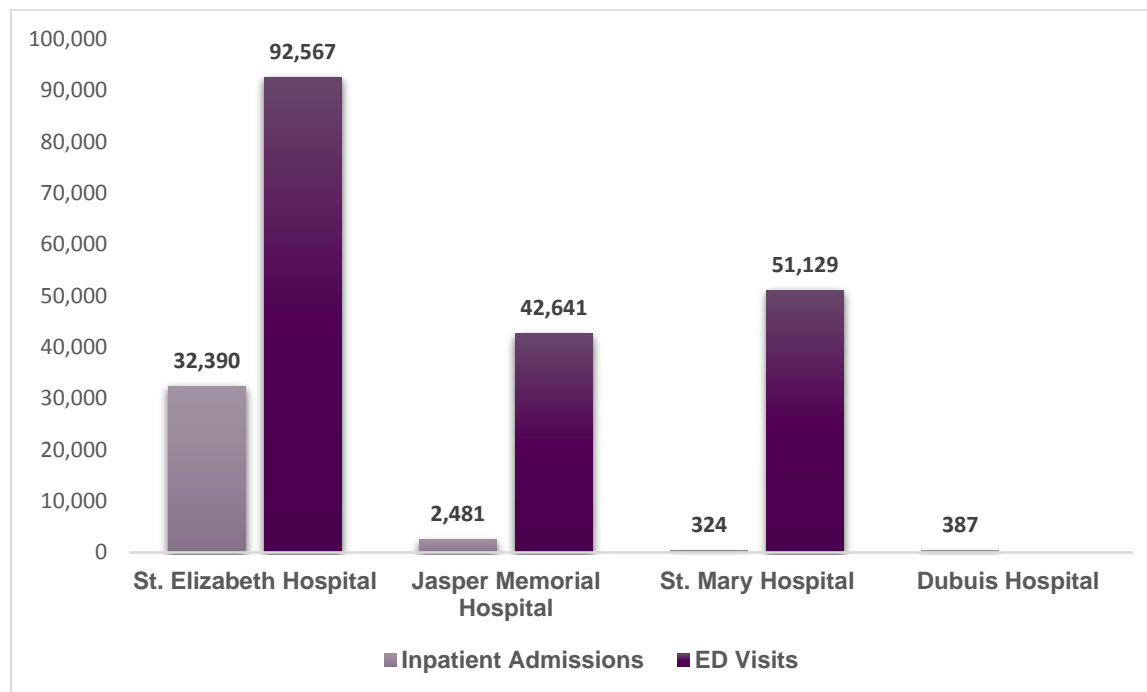
Of note, Jefferson County has the highest percentage of obesity and physical inactivity (34% and 33%) compared to the other report areas and Texas (28% and 24%).

**HOSPITAL DATA**

The CHRISTUS Southeast Texas Health System supplied internal data from its main hospital and satellite hospitals. for presentation and descriptive analysis in this section. Two years of hospital admission and emergency department utilization data are provided (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 in this report, as opposed to the full tabulation. 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 2.8 to 1 for the main CHRISTUS Southeast Texas hospital to as high as 157.8 to 1 for the CHRISTUS St. Mary branch.<sup>18</sup>

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 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, be managing multiple chronic conditions, and report poorer health status — all important factors to consider when planning interventions for populations who may need assistance managing their health in settings other than the emergency department.<sup>19</sup>



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

<sup>18</sup> CHRISTUS Dubuis Hospital does not have its own emergency department and is located within St. Elizabeth Hospital.

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

CHRISTUS St. Elizabeth		Jasper Memorial Hospital		CHRISTUS St. Mary	
ZIP Codes	Number	ZIP Codes	Number	ZIP Codes	Number
77662	8621	75932	1216	77619	5008
77701	5836	75951	20499	77627	4475
77703	8913	75956	6678	77640	10564
77705	8182	75966	4488	77642	21533
77706	7409	75979	1756	77651	2444

**Table 7. Top Five ZIP Codes for Emergency Department Visits**

Table 7 highlights emergency department utilization by ZIP code. For the one year period, the top 5 zipcodes for the CHRISTUS St. Elizabeth emergency department represent the surrounding Beaumont area and Vidor (77662) and account for one-third of the emergency room visits. For Jasper Memorial Hospital nearly 50% of the emergency department visits came from central Jasper (75951). Over 62% of Emergency department visits for CHRISTUS St. Mary come from the Port Arthur regions (77640 and 77642).

Rank	Inpatient Admissions		Emergency Department Visits	
	Service Line	Proportion (%)	Service Line	Proportion (%)
1	Obstetrics	12.8%	General Medicine	23.6%
2	Cardiology	11.8%	Otolaryngology	12.5%
3	General Medicine	10.1%	Orthopedics	11.1%
4	General Surgery	9.8%	Gastroenterology	10.5%
5	Pulmonary	9.3%	Cardiology	9.3%

**Table 8. Services Provided During Inpatient Admissions and Emergency Department Visit<sup>20</sup>**

General medicine represents the most frequent type of clinical service for those seeking care in the emergency department while obstetrics is the most common inpatient admission (Table 9). Cardiovascular disease ranks as the second most common type of clinical service for admitted patients and fifth most common in the emergency department, an observation that may be closely linked to the relatively high rates of obesity, physical inactivity, and smoking identified in the report area and presented in Table 6.

<sup>20</sup>Data includes combined admission from Main and satellite branches.

Insurance Type	Inpatient Admissions	Emergency Department Visits
Private	27%	16%
Medicaid	19%	28%
Medicare	42%	25%
Self Pay	8%	25%
Other	4%	6%

**Table 9. Payment Source for Inpatient Admissions and Emergency Department Visits<sup>21</sup>**

Table 9 presents the proportion of patients paying with select payment types, includes Medicare, Medicaid, Self-pay and Private. Not presented are data on patients enrolled in certain types of public insurance (e.g., CHIP, TRICARE). Differences in the payer mix between the admitted patient population and users of emergency care are clearly evident. Medicare pays for 42% of hospital admissions, but only 25% of emergency department visits. Conversely, the payer mix in the emergency department is comprised of far more uninsured patients, who comprise 25% of the emergency department mix but just 8% of inpatient admissions. Also, the proportion of patients covered under Medicaid is slightly higher in ED visits compared to inpatient admissions (28% vs 19%).

CHRISTUS Dubuis Hospital, a LTACH located on the 4<sup>th</sup> floor of CHRISTUS St. Elizabeth Hospital, had only 387 admissions for calendar years 2016 (186 admissions) and 2017 (201 admissions). Seventy-five percent of these patients were on Medicare, 22% had private insurance of some kind, and about 3 percent lacked insurance.

Reason of Admittance	Percentage
Acute and Chronic Respiratory Failure with Hypoxia	26%
Acute Respiratory Failure, Unspecified	21%
Sepsis	19%
Infection Following Procedure	19%
Acute and Chronic Respiratory Failure, Unspecified	15%

**Table 10. Top Five Inpatient Diagnoses for CHRISTUS Dubuis Hospital, 2016-2017**

Nearly 50% of CHRISTUS Dubuis Hospital patients had a primary diagnosis of respiratory failure (see Table 10), a life-limiting condition associated with physical, psychosocial, and spiritual suffering. A large percentage of these patients admitted are elderly and require end-of-life care.

<sup>21</sup> Data includes combined admission from Main and satellite branches excepting Dubuis Hospital.

## OTHER QUALITATIVE FINDINGS

Those patients at Dubuis Hospital with nonmalignant respiratory illness could be discharged to a nursing home or a home environment with adequate ventilator capabilities for continued treatment and supportive palliative care. For example, patients with nonmalignant respiratory diseases typically suffer from dyspnea, pain, cough, depression, and anxiety, conditions that could be addressed with palliative care.<sup>22</sup> According to key informants, however, families are often unprepared or lack the resources for home care, and the nearest nursing facility with ventilator capabilities is in Katy, Texas (over 111 miles from Beaumont!). As a result, families are reluctant to discharge their relatives from the hospital and hospital costs continue to accrue.

THI key informant interviews uncovered other community health needs specific to the kinds of long-term care patients seen at CHRISTUS Dubuis Hospital. They identify the need to (1) increase the use of telemedicine, (2) improve access to neurology specialists, (3) increase the number of Psych beds, and (4) improve resources and supports for end-of-life care. The latter was selected as a top priority to be addressed in the CHIP.

## 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 CSETHS service area. This 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 Southeast Texas 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 Southeast Texas Health System in taking action to improve the health of the community it serves. A forthcoming report presenting the CHIP in detail will closely 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.

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<sup>22</sup> McVeigh, C. (2015). Palliative Care for patients with non-malignant respiratory disease. *Nursing Standard* (2014+), 29(36), 44.



## APPENDIX A: COUNTY LEVEL DATA

<i>Indicator Name</i>	Hardin	Jasper	Jefferson	Newton	Orange	Tyler
County Population by Age Groups (%)						
Ages 0- 4	6.7	6.2	7.1	4.8	7.0	5.2
Ages 5-17	18.1	17.8	16.9	15.4	17.9	14.1
Ages 18 -64	59.1	56.7	61.9	59.6	59.4	58.7
Ages 65 +	16.2	19.3	14.1	20.1	15.6	22.1
Race and Ethnicity (%)						
Hispanic	5.2	6.5	19.0	3.4	6.8	7.2
NH- White alone	87.2	74.6	42.3	73.5	81.8	79.7
NH - Black alone	5.6	16.6	33.6	21.1	8.1	10.7
NH - Other	2.1	2.4	5.2	2.0	3.3	2.3
NH- American Indian and Alaska Native alone	0.1	0.3	0.2	0.3	0.4	0.3
NH - Asian alone	0.6	0.6	3.5	0.4	1.1	0.4
NH - Native Hawaiian and Other Pacific Islander alone	0.0	0.0	0.0	0.0	0.0	0.0
NH - Some other race alone	0.1	0.2	0.0	0.0	0.1	0.2
NH - Two or more races	1.2	1.3	1.3	1.3	1.8	1.5
Poverty (%)						
English Speaking Population	11.4	15.4	17.8	15.2	14.7	15.2
Spanish Speaking Population	27	26	24.7	24.3	17.2	19
Socioeconomic Characteristics						
Unemployment Rate	5.7	6.8	6.7	6.9	5.9	6.9
Population Age 25+ with no Highschool Diploma	13.1	13.2	16.7	13.3	10.8	15.6
Food Insecurity Rate	18.0	21.8	23.5	22.9	19.8	19.8
Population with Income below 200% FPL	27.8	38.6	40.7	42.0	34.2	35.3
Uninsured Population						
Overall	15.13	18.23	20.8	14.66	15.34	15.42
Under Ages 18	9.36	12.53	11.33	3.56	8.72	7.44
Ages 18-64	21.26	26.5	29.44	24.01	22.01	25.41
Ages 65 +	1.19	1.04	1.8	0	0.25	0.14
Cancer Incidence Rate (Age Adjusted Incidences per 100000 Population per Year)						
Breast	108.5	98.0	100.9	84.9	102.4	70.7
Prostate	86.3	94.1	97.1	81.6	78.2	76.4
Lung	69.2	67.2	63.0	71.6	75.3	73.0
Colon and Rectum	42.3	54.6	40.7	56.4	46.0	38.0
Mortality rates						

<b>Indicator Name</b>	<b>Hardin</b>	<b>Jasper</b>	<b>Jefferson</b>	<b>Newton</b>	<b>Orange</b>	<b>Tyler</b>
(Age Adjusted Deaths per 100000 Population per Year)						
Cancer	175.3	183	180	187.8	194.5	170.5
Coronary Heart Disease	108.1	132.7	109.3	200	140.9	178.1
Lung Disease	73.2	79.3	53.9	58.3	83	66.1
Stroke	50.8	55.5	51.6	54.5	55	30.7
Motor Vehicle Crash	24.7	29.7	16.1	-	27	37.7
Drug Poisoning	14.4	-	11.3	-	16.2	-
Homicide	-	-	10.8	-	8.9	-
Suicide	15.7	12.7	12.5	-	17.7	26.7
Other Conditions and Risk Factors						
Violent Crimes (Per 100000 Population)	154.5	338.2	686.9	60.4	333.6	252.4
Depression In Medicare Population (%)	17.8	19.5	17.0	21.0	16.9	18.9
Preventable Hospital Admissions (Per 1000 Medicare Enrollees)	58.9	57.8	56.1	64.8	53.7	72.3

## 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: **[Beaumont-Port Arthur interviewee]**—Jefferson, Orange, Hardin, Jasper, Tyler, and Newton 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]***

## 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 the CHRISTUS Southeast Texas Health System service area. 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
CHRISTUS Southeast Texas Health System	Three acute care facilities, long term care facility, several outpatient facilities, trauma center, and rural health clinics.
Baptist Hospitals of Southeast Texas	Two hospitals, cancer center, and family medicine clinic.
United Way	Two operating: Beaumont and North Jefferson County and Mid-South Jefferson County. Partner with local nonprofits, business, and government to address community needs, including health needs.
Legacy Community Health	Federally qualified health center providing primary care, pediatrics, dental, vision, behavioral health, OB/GYN, vaccinations, health promotion, community outreach, and more.
Gulf Coast Health Center, Inc.	Federally qualified health center providing comprehensive primary care, medical, dental, pharmacy, enrollment assistance, health fairs, and more.
Beaumont Bone and Joint Institute	A CHRISTUS Orthopedic Specialty Center partner. Full range of orthopedic services, including diagnostic services, imaging, surgery, and physical therapy/rehabilitation.
YMCA of Southeast Texas	Two locations in Port Arthur. Healthy living programs and community education focused on chronic disease prevention and offering opportunities for physical activity for all ages.
Gift of Life	Offers free cancer screenings to medically underserved persons, including mammograms for women and prostate exams for men.

Name	Description
	Conducts community outreach and education, and hosts events to raise cancer awareness.
Beaumont Healthy Living Foundation/Healthy Southeast Texas	Connects southeast Texas residents with resources to promote physical activity and healthy eating habits.
Texas A&M AgriLife Extension County Offices	Provide citizens with education and access to resources on health topics such as diabetes prevention, healthy eating and nutrition, food safety, and more.
Spindletop Center	Local mental health authority. Psychiatric care, crisis assessment, and community support services for people with serious mental illness, substance use disorders, people experiencing emotional crisis, and people with functional difficulties related to mental health problems.
Beaumont Public Health Department	Health promotion services including presentations to community groups on chronic and infectious disease, emergency preparedness, safety, and prevention. Hosts community health fairs. Operates immunization clinics, STD clinics, and tuberculosis clinics.
Smart Health Clinic at Baptist Hospitals of Southeast Texas	Follows up with high-risk, medically complex emergency department users to help them manage health outside hospitals and prevent readmissions.
Jefferson County Public Health Department	Provides excellence in individual and community health care while promoting healthy lifestyles and preserving a healthy environment for the citizens of Jefferson County. This includes but is not limited to a prescription assistance program, basic needs program, transportation services and pharmacy services.
Salvation Army	Provides the following services: Worship Services, Emergency Shelter, Emergency Financial Assistance, Casework Services, Transitional Housing, Men's Ministries, Women's Ministries, Boys' & Girls' Club.

Name	Description
Port Arthur Health Department	<p>The mission of the Port Arthur City Health Department is to:</p> <ul style="list-style-type: none"> <li>• Prevent communicable and vaccine-preventable diseases</li> <li>• Promote health and wellness through health promotion, education, nutritional food and counseling</li> <li>• Educate and prepare the community for natural or bioterrorism disasters</li> <li>• Maintain an overall maximum well status</li> <li>• To link clients with appropriate health and social services.</li> </ul>
Burke Mental Health Services	<p>Burke provides complete mental health services to adults and children in East Texas. From our 24 Hour Crisis Line and innovative counseling and treatment interventions to our state-of-the-art mental health emergency center in Lufkin, we have the facilities, resources, and staff to help East Texans in need.</p>
Southeast Texas Food Bank	<p>At the Southeast Texas Food Bank, our staff is passionate about our mission. Our management team, program staff, transportation crew, and warehouse workers are committed to finding innovative ways to increase the quantity and improve the quality of food available to our partner agencies. We also strive to raise public awareness of issues related to hunger in our area.</p>
Communities in Schools	<p>The mission of Communities In Schools of Southeast Texas is to surround students with a community of support empowering them to stay in school and achieve in life.</p>
Southeast Texas Council on Alcohol and Drug Abuse (SETCADA)	<p>To advocate and provide necessary substance abuse prevention, intervention, and treatment services for the community at large.</p>
Golden Triangle Minority Business Council (GTMBC)	<p>GTMBC is proud to be the leading small business advocate helping build a stronger, more equitable society by supporting and promoting diversity and inclusion.</p>
Help! I'M Hurting! INC.	<p>Non-profit aimed at assisting those affected by Hurricane Harvey.</p>

Name	Description
The Medical Center of Southeast Texas	The Medical Center of Southeast Texas Beaumont Campus is dedicated to providing leading-edge, exceptional surgical and diagnostic services to the Southeast Texas community.
UT Physicians	Through UT Physicians Multispecialty – Beaumont, you will have access to our full practice of more than 1,000 physicians certified in 80 medical specialties and subspecialties. UT Physicians Multispecialty – Beaumont will offer primary and specialty care for children, adolescents, and adults. Specialties include: behavioral health, family medicine, obstetrics & gynecology and pediatrics.
Mental Health America of Southeast Texas	Our mission is to promote the mental wellness of our region and enhance the lives of all individuals impacted by mental illness through community collaboration, education, and advocacy.

CHRISTUS Southeast Texas Health System would like to thank residents and stakeholders from the community who contributed to this Community Health Needs Assessment.

