MEMORIAL HERMANN SOUTHEAST HOSPITAL

2019 Community
Health Needs
Assessment

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Southeast

Board Approved June 27, 2019

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Executive Summary

Introduction & Purpose

Memorial Hermann Southeast Hospital (MH Southeast) is pleased to present its 2019 Community Health Needs Assessment (CHNA). This CHNA report provides an overview of the process and methods used to identify and prioritize significant health needs across Memorial Hermann Health System's regional service area (including MH Southeast), as federally required by the Affordable Care Act. Memorial Hermann Health System partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA for 13 facilities:

- Memorial Hermann Katy Hospital
- Memorial Hermann Memorial City Medical Center
- Memorial Hermann Greater Heights Hospital
- Memorial Hermann Northeast Hospital
- Memorial Hermann Southeast Hospital
- Memorial Hermann Sugar Land Hospital
- Memorial Hermann Southwest Hospital
- Memorial Hermann The Woodlands Medical Center
- Memorial Hermann Rehabilitation Hospital – Katy
- Memorial Hermann – Texas Medical Center
- TIRR Memorial Hermann
- Memorial Hermann Surgical Hospital Kingwood
- Memorial Hermann Surgical Hospital First Colony

The purpose of this CHNA is to offer a comprehensive understanding of the health needs in MH Southeast's service area and guide the hospital's planning efforts to address those needs. Special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services, and input from the community. To standardize efforts across the Memorial Hermann Health System and increase the potential for impacting top health needs in the greater Houston region, community health needs were assessed and prioritized at a regional/system level.

Findings from this report will be used to identify and develop efforts to improve the health and quality of life of residents in the community.

Summary of Findings

The CHNA findings in this report result from the analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and primary data collected from community leaders, non-health professionals, and organizations serving the community at large, vulnerable populations, and/or populations with unmet health needs.

Through an examination of the primary and secondary data, the following top health needs were identified:

Memorial Hermann Health System's Significant Health Needs		
• Access to Health Services • Cancers • Children's Health • Diabetes • Economy	• Education • Food Insecurity • Heart Disease/Stroke • Lack of Health Insurance • Low-Income/Underserved	• Mental Health • Obesity • Older Adults/Aging • Substance Abuse • Transportation

Prioritized Areas

In March 2019, stakeholders from the 13 hospital facilities in the Memorial Hermann Health System completed a survey to prioritize the significant health issues, based on criteria including health impact and risk as well as consideration of Memorial Hermann's strategic focus. The following four topics were identified as priorities to address:

Memorial Hermann Health System's CHNA Priorities
• Access to Healthcare • Emotional Well-Being • Food as Health • Exercise Is Medicine

MH Southeast will develop strategies to address these priorities in its 2019 Implementation Strategy.

Introduction

Memorial Hermann Southeast Hospital

Located in the heart of southeast Houston, Memorial Hermann Southeast Hospital has been caring for families in the Bay Area of Houston since 1986 at the current 293-bed facility. The highly trained and experienced staff and affiliated doctors span a diverse range of medical specialties and disciplines to offer area residents exceptional care close to home with services including breast care, children's care, cancer care, esophageal disease treatment, heart and vascular care, neuroscience, orthopedics and sports medicine, sleep disorders, wound care, and women's care. In 2016, Memorial Hermann Pearland, a 64-bed hospital located 14 miles from Memorial Hermann Southeast and operating under the Southeast license opened, providing medical/surgical, intensive and cardiac care, and labor and delivery services.

Vision

Memorial Hermann will be the preeminent health system in the U.S. by advancing the health of those we serve through trusted partnerships with physicians, employees and others to deliver the best possible health solutions while relentlessly pursuing quality and value.

Mission Statement

Memorial Hermann is a not-for-profit, community-owned, health care system with spiritual values, dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas.

Memorial Hermann Health System

One of the largest not-for-profit health systems in the nation, Memorial Hermann Health System is an integrated system with an exceptional affiliated medical staff and more than 26,000 employees. Governed by a Board of community members, the System services Southeast Texas and the Greater Houston community with more than 300 care delivery sites including 19 hospitals; the country's busiest Level 1 trauma center; an academic medical center affiliated with McGovern Medical School at UTHealth; one of the nation's top rehabilitation and research hospitals; and numerous specialty programs and services.

Memorial Hermann has been a trusted healthcare resource for more than 110 years and as Greater Houston's only full-service, clinically integrated health system, we continue to identify and meet our region's healthcare needs. Among our diverse portfolio is Life Flight, the largest and busiest air ambulance service in the United States; the Memorial Hermann Physician Network, MHMD, one of the largest, most advanced, and clinically integrated physician organizations in the country; and, the Memorial Hermann Accountable Care Organization, operating a care delivery model that generates better outcomes at lower costs to consumers, while providing residents of the Greater Houston area broad access to health insurance through the Memorial Hermann Health Insurance Company. Specialties span burn treatment, cancer, children's health, diabetes and endocrinology, digestive health, ear, nose and throat, heart and vascular, lymphedema, neurosurgery, neurology, stroke, nutrition, ophthalmology, orthopedics, physical and occupational therapy, rehabilitation, robotic surgery, sleep studies, transplant, weight loss, women's health, maternity and wound care. Supporting the System in its impact on

overall population health is the Community Benefit Corporation. At a market share of 26.1% in the 'expanded' greater Houston area of 12 counties, our vision is that Memorial Hermann will be a preeminent integrated health system in the U.S. by advancing the health of those we serve.

Memorial Hermann Southeast Hospital Service Area

The service area for MH Southeast includes Brazoria, Fort Bend, Galveston, and Harris counties in Texas. The geographic boundaries of the service area are shown in Figure 1. The zip codes within MH Southeast's primary service area are listed in Table 1 and represent approximately 75% of inpatient discharges (18.7% in Brazoria County, 0.4% in Fort Bend County, 6.2% in Galveston County, and 49.6% in Harris County). Of Memorial Hermann Pearland's discharges, 71% share these boundaries and counties.

Figure 1. MH Southeast Service Area
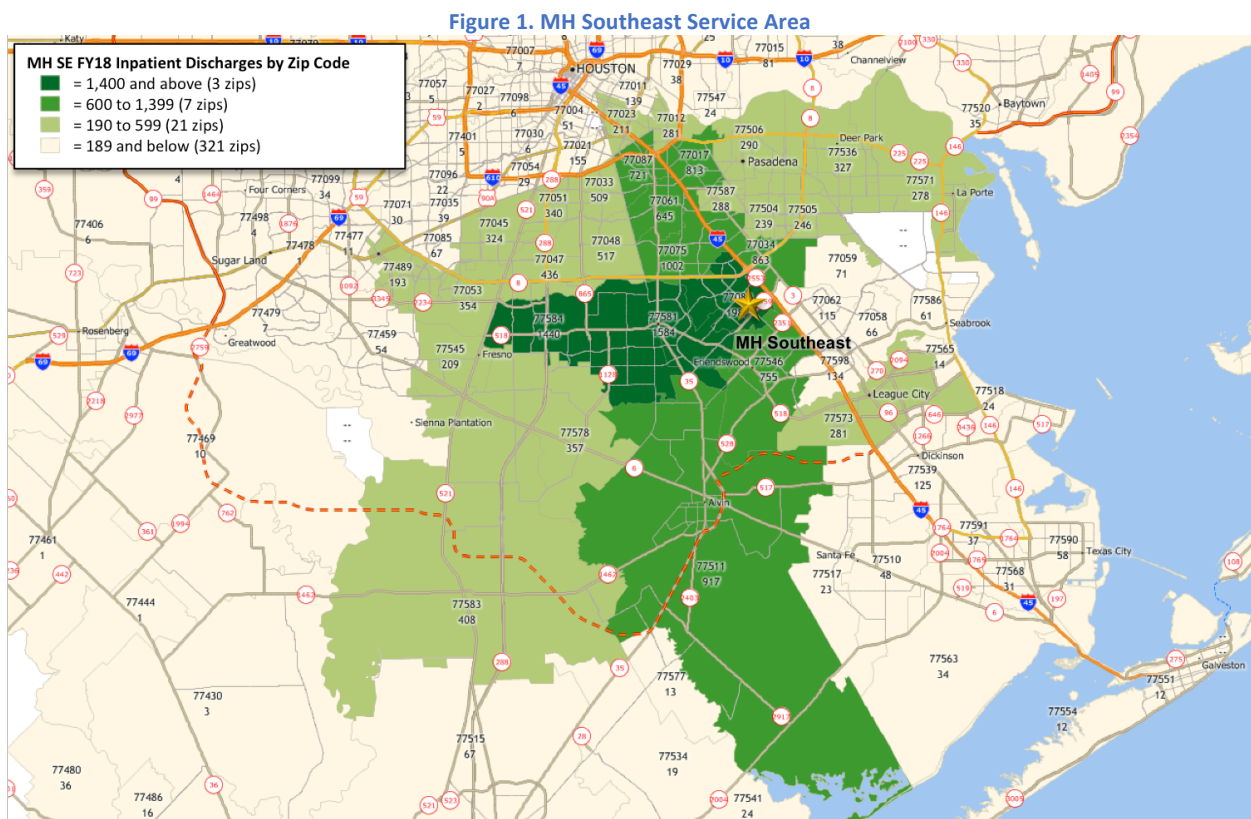
Table 1. Proportion of Patient Population Served by Zip Code

ZIP Code	County	Total Population Estimate
77089	Harris	12.0%
77581	Brazoria	8.5%
77075	Harris	5.9%
77034	Harris	5.2%
77017	Harris	4.9%
77511	Brazoria	4.6%
77546	Galveston	4.5%

ZIP Code	County	Total Population Estimate
77087	Harris	4.2%
77584	Brazoria	4.2%
77061	Harris	3.8%
77502	Harris	2.1%
77536	Harris	1.9%
77033	Harris	1.8%
77506	Harris	1.7%
77573	Galveston	1.7%
77587	Harris	1.7%
77505	Harris	1.5%
77048	Harris	1.3%
77047	Harris	0.7%
77578	Brazoria	0.7%
77583	Brazoria	0.7%
77051	Harris	0.6%
77053	Fort Bend	0.4%
77045	Harris	0.3%

Consultants

Memorial Hermann Health System commissioned Conduent Healthy Communities Institute (HCI) to conduct its 2019 Community Health Needs Assessment. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/community-population-health.

Evaluation of Progress Since Prior CHNA

The CHNA process should be viewed as a three-year cycle. An important part of that cycle is revisiting the progress made on priority topics from previous CHNAs. By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can better focus and target its efforts during the next CHNA cycle.

Figure 2. CHNA Process
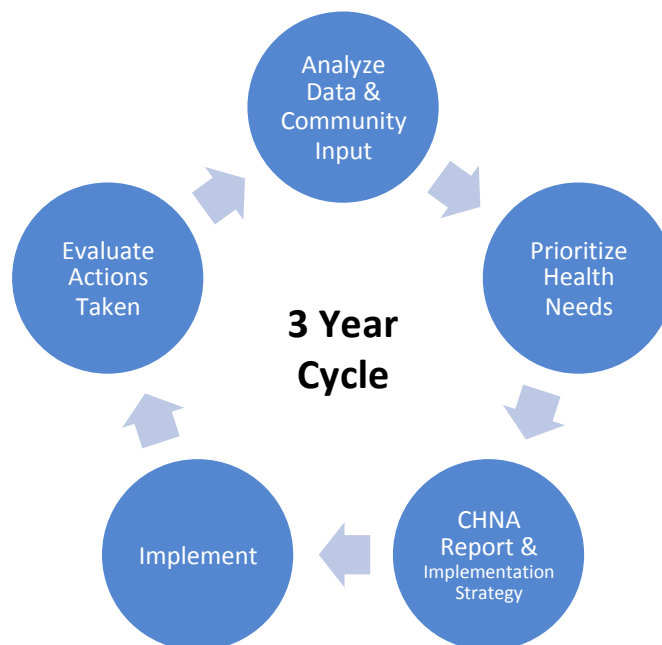
Priority Health Needs and Impact from Prior CHNA

MH Southeast's last CHNA was conducted in 2016. The priority areas in FY16-18 were:

- **Healthy Living**: Encourage and foster healthy lifestyles through education, awareness and early detection to prevent illness.
- **Healthcare Access:** Improve community knowledge about healthcare access points and reduce perceived barriers to care.
- **Behavioral Health:** Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.

Each of the above health topics correlates well with the priorities identified for the current CHNA (detailed below); thus MH Southeast will be building upon efforts of previous years. A

detailed table describing the strategies/action steps and indicators of success for each of the preceding priority health topics can be found in Appendix A. MH Southeast's preceding CHNA was made available to the public via the website and community feedback directed to Memorial Hermann's Community Benefit Department: http://www.memorialhermann.org/locations/southeast/community-health-needs-assessment-southeast/. No comments or feedback were received on the preceding CHNA at the time this report was written.

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Methodology

Overview

Two types of data were used in this assessment: primary and secondary data. Primary data are data that have been collected for the purposes of this community assessment. Primary data were obtained through a community survey and key informant interviews. Secondary data are health indicator data that have already been collected by public sources such as government health departments. Each type of data was analyzed using a unique methodology. Findings were organized by health topics and then synthesized for a comprehensive overview of the health needs in MH Southeast's service area.

Secondary Data Sources & Analysis

Secondary data used for this assessment were collected and analyzed from HCI's community indicator database. This database, maintained by researchers and analysts at HCI, includes over 100 community indicators from at least 15 state and national data sources. HCI carefully evaluates sources based on the following three criteria: the source has a validated methodology for data collection and analysis; the source has scheduled, regular publication of findings; and the source has data values for small geographic areas or populations.

Secondary Data Scoring

HCI's Data Scoring Tool® was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2020, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. Please see Appendix B for further details on the quantitative data scoring methodology as well as secondary data scoring results.

Figure 3. Summary of Topic Scoring Analysis

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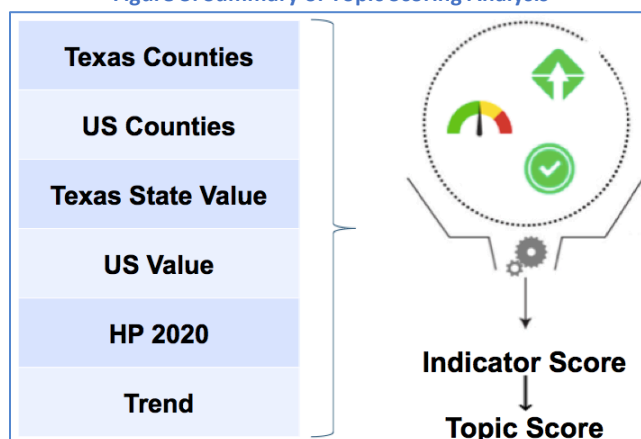
Disparities Analysis

When a given indicator has data available for subgroups like race/ethnicity, age or gender – and values for these subgroups include confidence intervals – significant differences between the subgroups' value and the overall value can be determined. A significant difference is defined as two values with non-overlapping confidence intervals. Only significant differences in which the value for a subgroup is worse than the overall value are identified. Confidence intervals are not available for all indicators. In these cases, there are not enough data to determine if two values are significantly different from each other.

Primary Data Methods & Analysis

Community input for Memorial Hermann Health System was collected to expand upon the information gathered from the secondary data. Primary data used in this assessment consisted of a community survey in English and Spanish as well as key informant interviews. See Appendix C for the survey and interview questions.

Community Survey

Input from community residents was collected through an online survey. This survey consisted of 11 questions related to top health needs in the community, individuals' perception of their overall health, and weekly exercise habits. The community survey was distributed online through SurveyMonkey® from October 23rd through November 27th of 2018. The survey was made available in both English and Spanish. Paper surveys were also made available and answers to the paper survey were entered into the SurveyMonkey tool. A total of 285 responses were collected. Results in this report are based on the service area for Memorial Hermann Health System. This was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable to the population as a whole.

Table 2. Community Survey Outreach

Community Event	Description
Step Health Event – Moody Park, 77009	Community event hosted by Memorial Hermann providing park activation, walking tours, Zumba instruction, and (through a partnership with Houston Food Bank) food distribution to low-income, at-risk, and mostly uninsured residents.
Step Health Event – Castillo Park, 77009	Community event hosted by Memorial Hermann providing park activation, walking tours, Zumba instruction, and (through a partnership with Houston Food Bank) food distribution to low-income, at-risk, and mostly uninsured residents.
Memorial Hermann Health Centers for Schools	10 school-based health clinics in 5 school districts (74 schools) in Harris and Fort Bend Counties, providing medical, mental health, and dental care, along with nutrition, navigation, and summer boot camp programs to uninsured and underinsured children throughout the Greater Houston area.
West Orem YMCA, 77085	A community-centered organization that brings people together to bridge the gaps in community needs (underserved residents), nurtures residents' potential to learn, grow, and thrive, and mobilizes the local community to effect lasting, meaningful change.
Spring Branch Community	A Federally Qualified Health Center (FQHC) providing quality, affordable healthcare services to the underserved and uninsured communities of Spring

HealthCenter, 77080	Branch and West Houston.
Wesley Community Center, 77009	A multi-purpose social service agency providing residents of Houston: short-term rent, utility, and food assistance to prevent homelessness and maintain family financial stability; a career and personal financial service center; and Early Head Start, a child development program serving infants to toddlers to promote school readiness.
Complete Communities, Houston	Program initiated by the Mayor of Houston in five communities - all historically under-resourced, each with a base level of community involvement and support, and with diverse populations. The program is designed to enhance access to quality affordable homes, jobs, well-maintained parks and greenspace, improved streets and sidewalks, grocery stores and other retail, good schools and transit options. Communities: Acres Homes [77018, 77088, 77091], Gulfton [77056, 77057, 77081], Near Northside [77009, 77022, 77026], Second Ward [77003, 77011, 77020], and Third Ward [77003, 77004, 77204].
Healthy Living Matters	A Houston/Harris County Childhood Obesity Collaborative - A collaborative of multi-sector leaders that promote policy aimed at system-level and environmental change to reduce the incidence of childhood obesity. Priority communities were selected due to the lack of access to healthy food options and opportunities to engage in physical activity as well as for their community assets and readiness for change. Priority Communities: City of Pasadena [77058, 77059, 77502, 77503, 77504, 77505, 77506, 77507, 77536, 77571, 77586], Near Northside [77009, 77022, 77026], and Fifth Ward/Kashmere Gardens [77020, 77026, and 77028]
Greater Northside Health Collaborative	Non-profit collaborative whose goal is to expand active living resources and increase access to quality healthcare and healthy food by promoting resident leadership and civic participation.

The race/ethnicity make-up of survey respondents is shown in Figure 4. The largest proportion of respondents identified as Hispanic/Latino (47.2%), 22.4% as White, 20.8% as Black/African American, and the remaining 9.6% of respondents as Asian/Pacific Islander, Other and Native American.

Figure 4. Survey Respondents by Race/Ethnicity

- Hispanic 47.20%
- White 22.40%
- African American 20.80%
- Asian/Pacific Islander 4.80%
- Other 3.60%
- Native American 1.20%
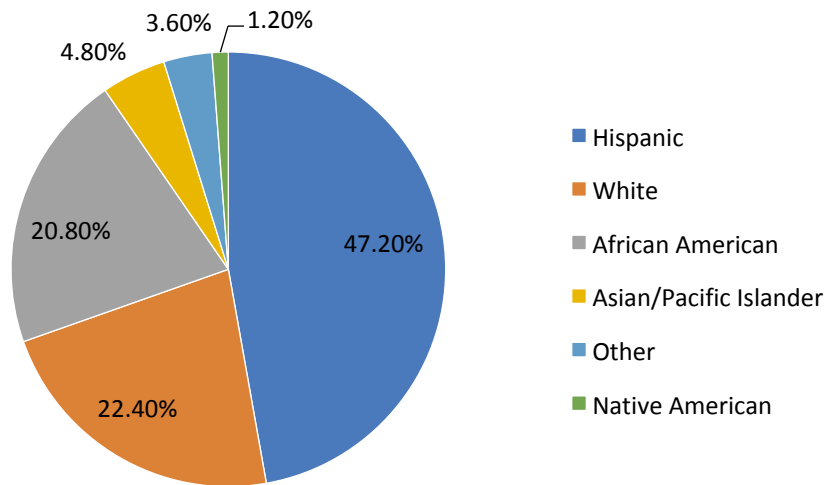
Survey respondents were asked to select top issues most affecting the community's quality of life. As shown in Figure 5, the majority of respondents identified Diabetes, Obesity/Overweight, Substance Abuse, and Mental Health & Mental Disorders as top issues in the community.

Figure 5. Top Issues Affecting Quality of Life (Survey)

Issue	Percent
Diabetes	69%
Obesity/Overweight	64%
Substance Abuse	54%
Mental Health & Mental Disorders	51%
Cancers	35%
Heart Disease & Stroke	26%
Elder Care	26%
Injuries, Violence & Safety	23%
Respiratory/Lung Disease	17%
Other	14%
Reproductive Health	13%
Teenage Pregnancy	13%
Oral health	10%
Sexual Health	10%
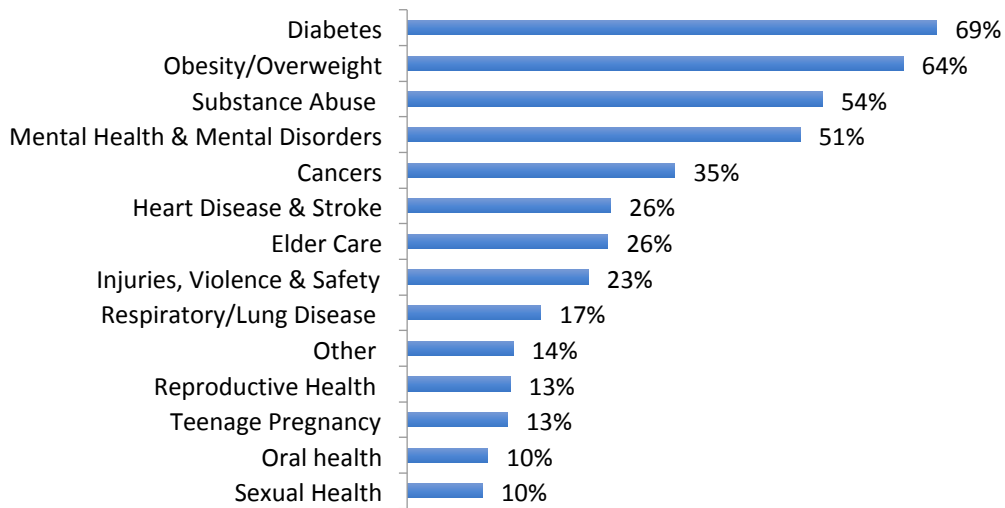
Key Informant Interviews

Community input was also collected through key informant interviews.

Memorial Hermann Health System joined with the Episcopal Health Foundation (EHF) in their key informant interview initiative supporting four Greater Houston area hospital systems in preparing their community health needs assessments. The collaborating hospitals of this initiative include Memorial Hermann, CHI St. Luke's Health, Houston Methodist, and Texas Children's (Table 3). Through this partnership, a total of 53 interviews were conducted with

stakeholders from a range of sectors such as government, healthcare, business, and community service organizations. Community leaders with specific experience working with priority populations, such as women, children, people of color, the disabled, and more, were also interviewed.

Table 3. Memorial Hermann Collaborative Partners

Episcopal Health Foundation's mission is to advance the Kingdom of God with specific focus on human health and well-being through grants, research, and initiatives in support of the work of the Diocese, spanning 57 counties. Through informed action, collaboration, empowerment, stewardship, transparency, and accountability the foundation strives for the transformation of human lives and organizations with compassion for the poor and powerless.

CHI St. Luke's Health, a part of Catholic Health Initiatives (CHI), one of the nation's largest health systems, is dedicated to a mission of enhancing community health through high-quality, cost-effective care. Through partnerships with physicians and community partners, CHI St. Luke's Health serves Greater Houston with its commitment to excellence and compassion in caring for the whole person while creating healthier communities.

Houston Methodist is a nonprofit health care organization serving Greater Houston, dedicated to excellence in research, education, and patient care. Houston Methodist brings compassion and spirituality to all its endeavors to help meet the health needs of the community through the system's I CARE values: integrity, compassion, accountability, respect, and excellence.

Texas Children's Hospital is a not-for-profit organization whose mission is to create a healthier future for children and women throughout Greater Houston and the global community by leading in patient care, education, and research. Texas Children's is committed to creating a healthy community for children by providing the best pediatric care possible, through groundbreaking research and emphasis on education, while also offering a full continuum of family-centered care for women, from obstetrics to well-woman care.

In total, 64 key informant interviews were conducted by phone from August through November 2018; 53 key informant interviews were conducted through the collaborative and 11 interviews were conducted by HCI.

Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs and/or represented the broad interest of the community served by the hospital, and/or could speak to the needs of medically underserved or vulnerable populations. Efforts were made to identify interviewees working in and/or knowledgeable about the counties in Memorial Hermann Health System's service area. As seen in Table 4, some interviewees were identified with knowledge of multiple counties.

Table 4. Key Informants by County

County	Key Informants
Austin	*Included in Multiple Counties*
Brazoria	3
Chambers	2

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County	Key Informants
Fort Bend	10
Galveston	7
Harris	28
Liberty	1
Montgomery	4
San Jacinto	*Included in Multiple Counties*
Walker	*Included in Multiple Counties*
Waller	2
Wharton	2
*Multiple Counties**	*5*
Total	**64**

*Five (5) of the Key Informant Interviews represented 2 or more counties, including: Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, San Jacinto, Walker, Waller, and Wharton counties.

Interviews were transcribed and analyzed using the qualitative analytic tool, Dedoose[1]. Interview excerpts were coded by relevant topic areas and key health themes. Three approaches were used to assess the relative importance of the needs discussed in these interviews. These approaches included: the frequency by which a health topic was discussed across all interviews; the frequency by which a topic was described by the key informant as a barrier/challenge; and the frequency by which a topic was mentioned per interviewee.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators.

Data scores represent the relative community health need according to the secondary data for each topic and should not be considered to be a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole, and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

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[1] Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com

Race/Ethnic Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

Zip Codes and Zip Code Tabulation Areas

This report presents both ZIP Code and ZIP Code Tabulation Area (ZCTA) data. ZIP or Zone Improvement Plan Codes were created by the U.S. Postal Service to improve mail delivery service. They are based on postal routes, which factor in delivery-area, mail volume and geographic location. They are not designed to be used for statistical reporting and may change frequently. Some ZIP Codes may only include P.O. boxes or cover large unpopulated areas. ZCTAs or ZIP Code Tabulation Areas were created by the U.S. Census Bureau and are generalized representations of ZIP Codes that have been assigned to census blocks. Therefore, ZCTAs are representative of geographic locations of populated areas. In most cases, the ZCTA will be the same as its ZIP Code. ZCTAs will not necessarily exist for ZIP Code areas with only businesses, single or multiple addresses, or for large unpopulated areas. Since ZCTAs are based on the most recent Census data, they are more stable than ZIP Codes and do not change as frequently.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference ZIP Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources is representative by ZIP Codes and are labeled as such.

Prioritization

In order to focus efforts on a smaller number of the most significant community issues, sixteen representatives from the Memorial Hermann Health System (one or more representing each facility) participated in an online prioritization process to prioritize the fifteen significant health needs identified through the secondary and primary data analyses. The prioritized health needs will be under consideration for the development of an implementation plan that will address some of the community's most pressing health issues.

Prioritization Process

To prioritize significant health needs, Memorial Hermann stakeholders participated in an online webinar on March 7, 2019 to review data synthesis results followed by completion of a prioritization matrix listing significant health needs and four criteria by which to rate each need. Participants scored each need for each of the criteria on a scale from 1-5, with 1 meaning the respondent strongly disagrees to 5 meaning the respondent strongly agrees that the health need meets the criterion. Respondents were also able to select "Don't Know/Unsure" for each health need.

The criteria for prioritization included to what extent an issue:
- Impacts many people in the community
- Significantly impacts subgroups in the community (gender, race/ethnicity, LGBTQ, etc.)

- Has inadequate existing resources in the community
- Has high risk for disease or death

Completion of the prioritization matrix in Appendix D resulted in numerical scores for each health need that corresponded to how well each health need met the criteria for prioritization. The scores were ranked from highest to lowest (Table 5).

Table 5. Results from Memorial Hermann Prioritization Matrix

Significant Health Need	Impact on Community	Impact on Subgroups	Inadequate Resources	High Risk	Average Score
Obesity (Exercise, Nutrition and Weight)	4.69	4.00	3.19	4.50	4.09
Mental Health	4.44	3.44	4.50	3.75	4.03
Diabetes	4.50	4.00	3.25	4.19	3.98
Lack of Health Insurance	4.31	4.19	3.38	4.00	3.97
Low-Income/Underserved	4.19	4.19	3.44	4.00	3.95
Heart Disease/ Stroke	4.44	3.82	2.81	4.44	3.88
Substance Abuse	3.56	3.88	3.63	4.19	3.81
Access to Health Services	4.00	3.94	3.25	3.88	3.77
Older Adults and Aging	4.38	3.81	3.13	3.75	3.76
Food Insecurity	3.88	4.00	3.44	3.50	3.70
Cancers	4.19	3.19	3.00	4.31	3.67
Education	3.88	3.81	3.00	3.13	3.45
Transportation	4.00	3.88	2.81	3.00	3.42
Children's Health	4.00	3.50	3.00	3.19	3.42
Economy	3.31	3.31	2.69	2.88	3.05

In addition to rating each need in the matrix, prioritization participants were asked to rate the level of importance of Memorial Hermann's 4 strategic pillars.

1. Improving **Access to Healthcare** through programming, education, and social service support;
2. Addressing **Emotional Well-being** (mental and behavioral health) through innovative access points;
3. Promoting the importance of a healthy diet through screening and creating access to nutritious **Food as Health**; and,
4. Fostering improved health through **Exercise Is Medicine** with culturally appropriate activities.

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Each of these intersecting pillars connect to each other through various points in Memorial Hermann programs and initiatives advancing the health of our communities (Figure 6).

Figure 6. Memorial Hermann's Four Pillars for Community Health

Over 93% of participants responded that the 4 pillars were important or very important. The Memorial Hermann Community Benefit team reviewed these findings, and taking into account the alignment of top needs with Memorial Hermann's strategic focus areas, a decision was made to integrate:

- Lack of Health Insurance, Low-Income/Underserved, and Access to Health Services into Pillar 1: **Access to Healthcare**
- Mental Health and Substance Abuse into Pillar 2: **Emotional Well-Being**
- Diabetes, Food Insecurity and Heart Disease/Stroke into Pillar 3: **Food as Health**
- Obesity (Exercise, Nutrition and Weight) into Pillar 4: **Exercise Is Medicine**

Through this system-wide prioritization process, the following four priorities for Memorial Hermann Health System are:

- **Access to Healthcare** (addressing Access to Health Services, Lack of Health Insurance, and Low-Income/Underserved)
- **Emotional Wellbeing** (addressing Mental Health and Substance Abuse)
- **Food as Health** (addressing Diabetes, Food Insecurity, and Heart Disease/Stroke)
- **Exercise Is Medicine** (addressing Obesity)

These four health topics will be explored further in order to understand how findings from the secondary and primary data analyses resulted in each issue being a high priority health need for Memorial Hermann Health System.

Demographics

The following section explores the demographic profile of MH Southeast's service area, including Brazoria, Fort Bend, Galveston, and Harris counties. The demographics of a community significantly impact its health profile. Different race/ethnic, age, and socioeconomic groups have unique needs and require different approaches to health improvement efforts. All demographic estimates are sourced from the U.S. Census Bureau's 2013-2017 American Community Survey unless otherwise indicated. Furthermore, tables in this section list indicator values for the top 75% of zip codes within MH Southeast's service area in descending order of inpatient discharges unless otherwise noted.

Population

According to the U.S. Census Bureau's 2013-2017 American Community Survey, the four counties in MH Southeast's service area had populations of 362,457 (Brazoria County), 764,828 (Fort Bend County), 335,036 (Galveston County), and 4,652,980 (Harris County). Figure 7 illustrates the population size by county and Table 6 by zip code. The most populous zip codes in Memorial Hermann Southeast's service area are 77584 (Brazoria County), 77573 (Galveston County), and 77089 (Harris County).

Figure 7. Population by County
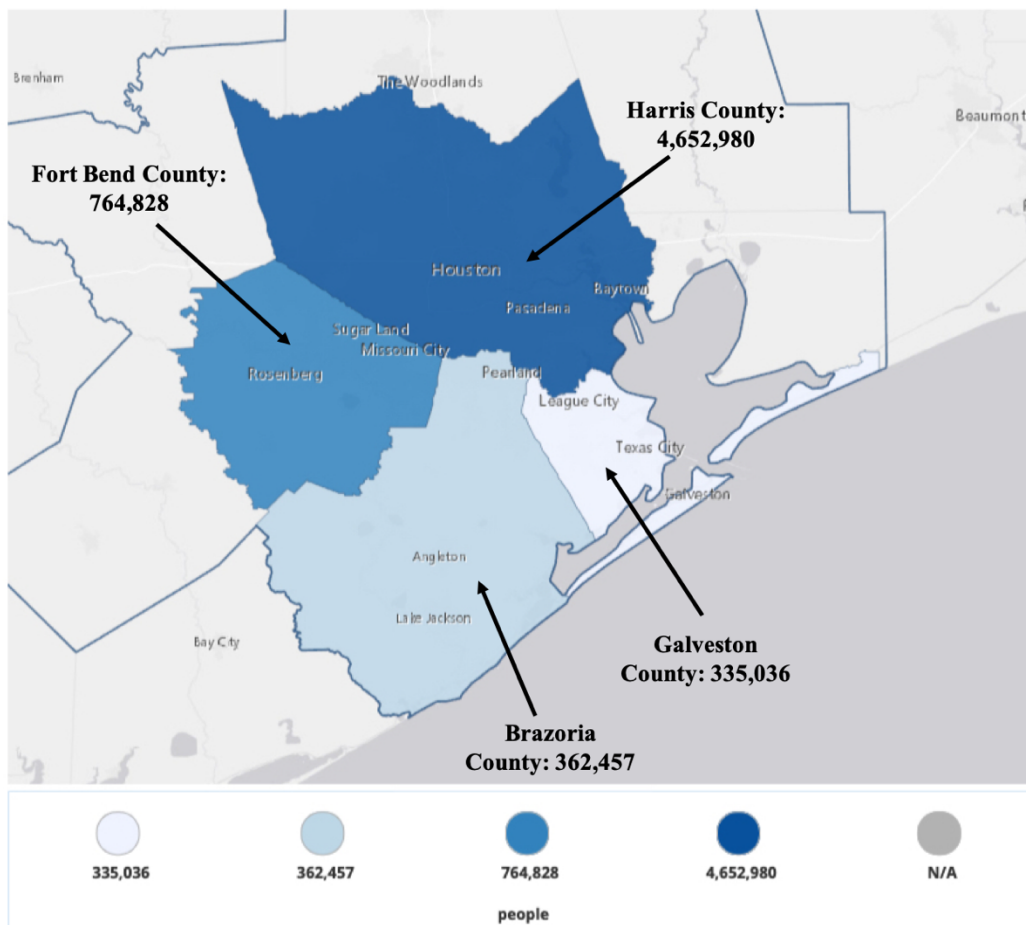
Table 6. Population by Zip Code

ZIP Code	County	Total Population Estimate
77089	Harris	52,699
77581	Brazoria	47,625
77075	Harris	43,586
77034	Harris	40,183
77017	Harris	32,556
77511	Brazoria	46,121
77546	Galveston	52,261
77087	Harris	37,200
77584	Brazoria	87,121
77061	Harris	26,276
77502	Harris	39,040
77536	Harris	32,392
77033	Harris	29,692
77506	Harris	37,736
77573	Galveston	85,108
77587	Harris	16,901
77505	Harris	24,230
77048	Harris	17,143
77047	Harris	29,410
77578	Brazoria	18,636
77583	Brazoria	35,308
77051	Harris	16,661
77053	Fort Bend	31,868
77045	Harris	36,270

American Community Survey, 2013-2017

Age

Figure 8 shows MH Southeast's service area population that is under 18 years old. Brazoria, Fort Bend, and Harris counties all have higher proportions of residents under 18 compared to the state and national values (26% and 22.6%, respectively).

Figure 8. Population Under 18
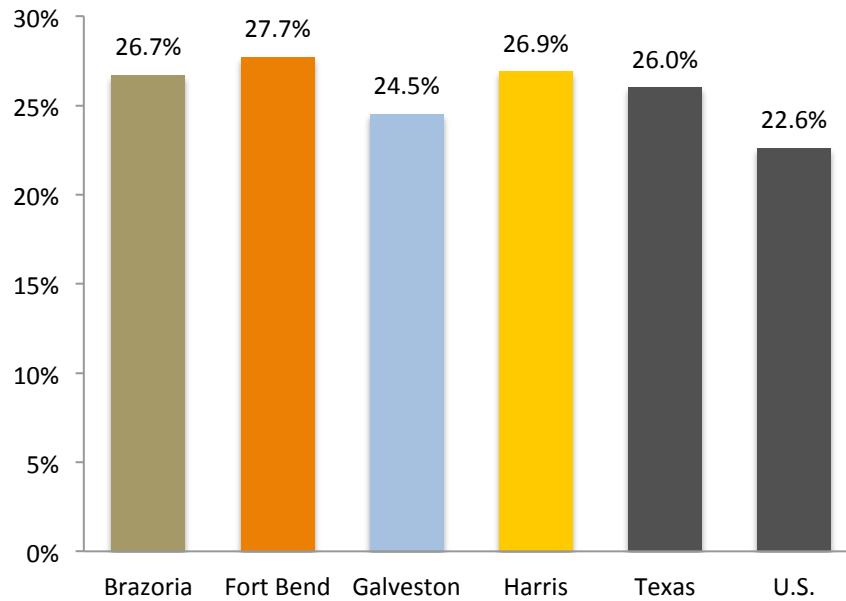
As shown in Figure 9, Brazoria, Fort Bend, and Harris counties all have smaller proportions of older adults compared to Texas and the U.S. Galveston County has the highest proportion of older adults (13.8%) out of the four counties in the service area.

Figure 9. Population Over 65
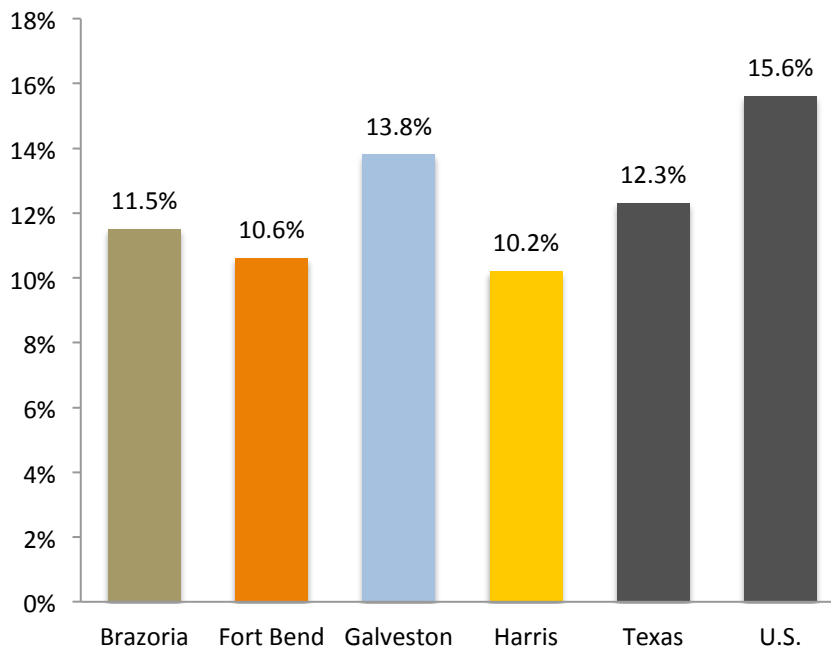
Figure 10 shows that Harris County has a larger proportion of residents under 5 years old (7.7%) compared to both Texas and the U.S. (7.2% and 6.1%, respectively). Galveston County has the smallest proportion of its population under age 5 (6.5%) out of the four counties in the service area.

Figure 10. Population Under 5
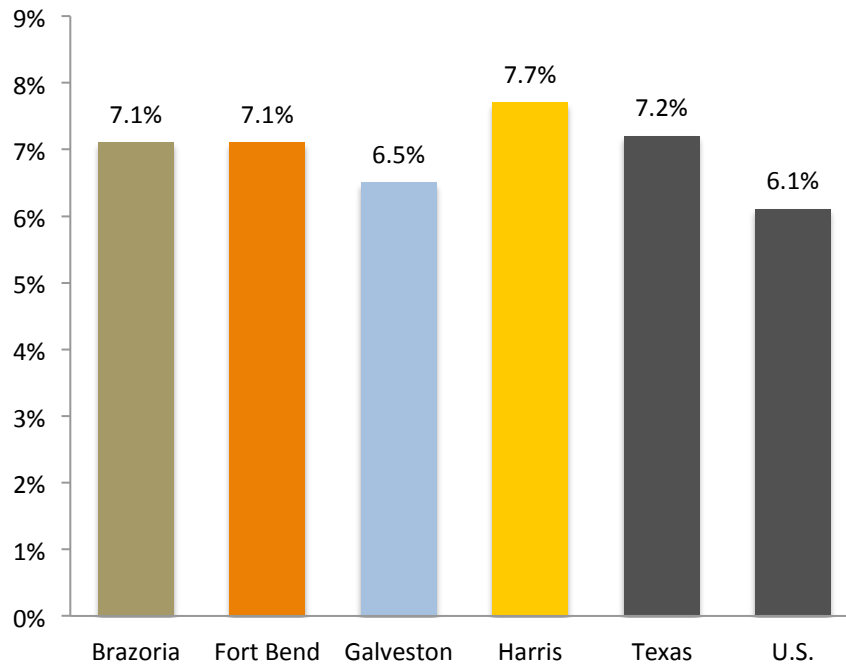
Race/Ethnicity

The race and ethnicity composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care and child care. Race and ethnicity data are also useful for identifying and understanding disparities in housing, employment, income, and poverty.

A larger number of residents in Brazoria, Fort Bend, and Galveston counties identify as White, non-Hispanic, while in Harris County there are a larger number of residents who identify as Hispanic or Latino. Figure 11 shows the racial composition of residents in Brazoria County with 49.1% of residents identifying as White, non-Hispanic; 29.7% as Hispanic or Latino (of any race); 12.9% as Black or African American; 6.2% as Asian; and 2.1% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", and/or "Two or more races".

Figure 11. Race/Ethnicity in Brazoria County

- White, non-Hispanic — 49.1%
- Black or African American — 12.9%
- Asian — 6.2%
- Hispanic or Latino (of any race) — 29.7%
- Other — 2.1%
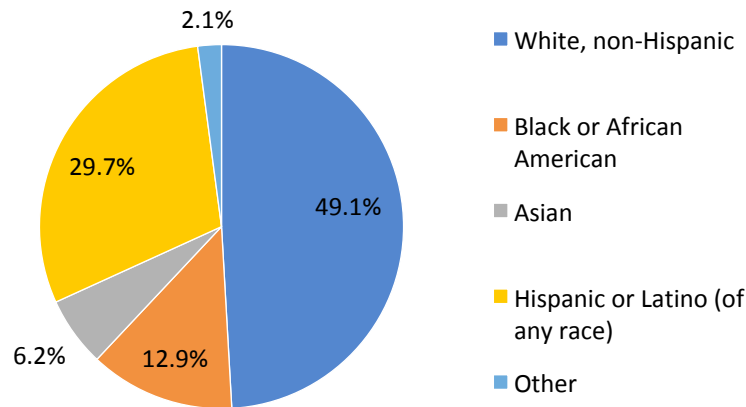
Figure 12 shows the racial composition of residents in Fort Bend County with 34.4% of residents identifying as White, non-Hispanic; 24.2% as Hispanic or Latino (of any race); 20.2% as Black or African American; 19.2% as Asian; and 2% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", and/or "Two or more races".

Figure 12. Race/Ethnicity in Fort Bend County

- White, non-Hispanic — 34.4%
- Black or African American — 20.2%
- Asian — 19.2%
- Hispanic or Latino (of any race) — 24.2%
- Other — 2.0%
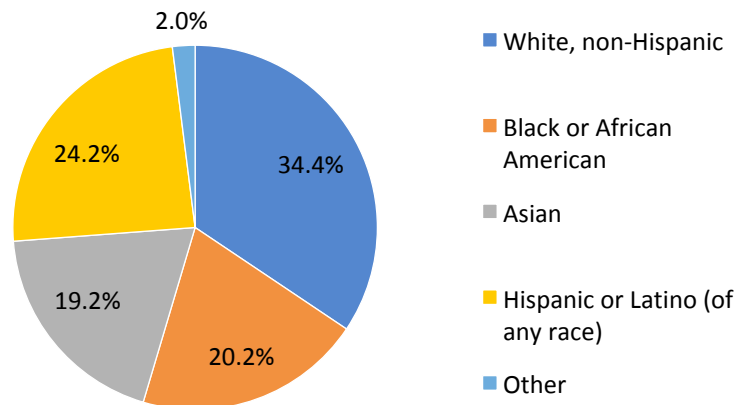
Figure 13 shows the racial composition of residents in Galveston County with 58.0% of residents identifying as White, non-Hispanic; 23.9% as Hispanic or Latino (of any race); 12.5% as Black or African American; 12.5% as Asian; and 2.3% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", and/or "Two or more races".

Figure 13. Race/Ethnicity in Galveston County

- White, non-Hispanic — 58.0%
- Black or African American — 12.5%
- Asian — 3.3%
- Hispanic or Latino (of any race) — 23.9%
- Other — 2.3%
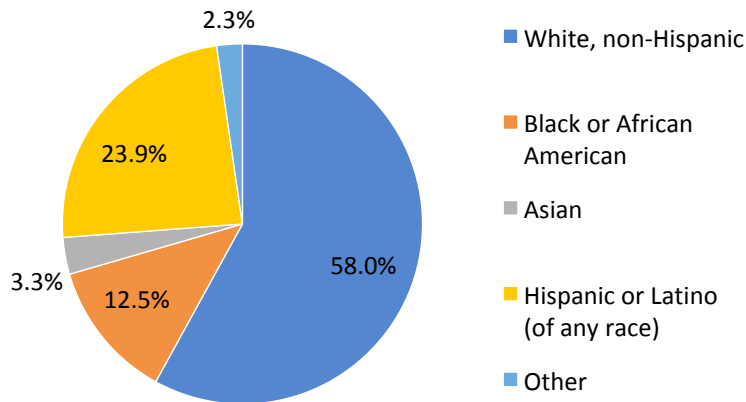
Figure 14 shows the racial composition of residents in Harris County with 42.2% of residents identifying as Hispanic or Latino (of any race); 30.6% as White; 18.5% as Black or African American; 6.8% as Asian; and 1.9% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", and/or "Two or more races".

Figure 14. Race/Ethnicity in Harris County

- White, non-Hispanic — 30.6%
- Black or African American — 18.5%
- Asian — 6.8%
- Hispanic or Latino (of any race) — 42.2%
- Other — 1.9%
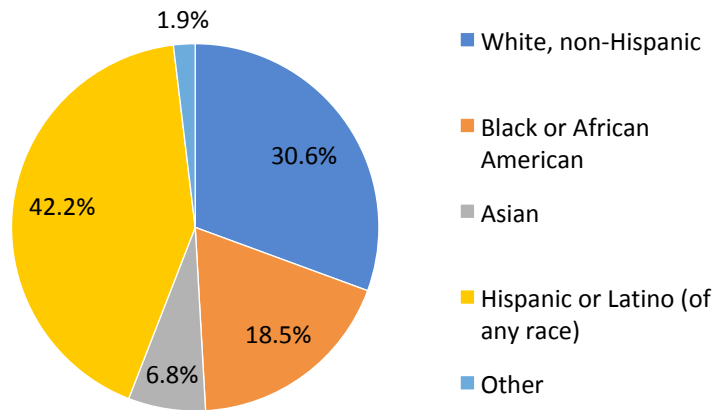
Language

Language is an important factor to consider for outreach efforts in order to ensure that community members are aware of available programs and services.

Figure 15. Language Other than English Spoken at Home
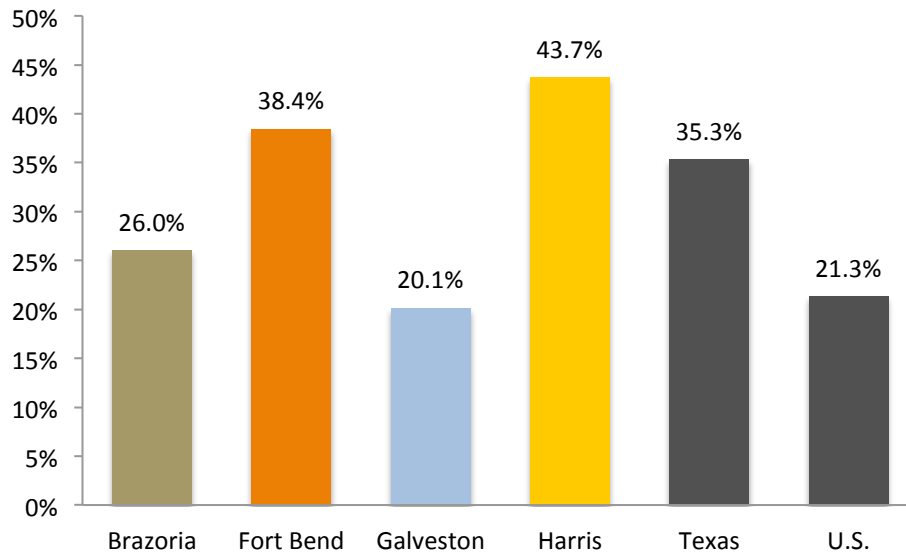
Figure 15 shows the proportion of residents in Brazoria, Fort Bend, Galveston, and Harris counties who speak a language other than English at home. Approximately 38% of residents in Fort Bend County and almost 44% of residents in Harris County speak a language other than English as compared to 35.3% in Texas and 21.3% in the U.S. This is an important consideration for the effectiveness of services and outreach efforts, which may be more effective if conducted in languages other than English alone.

Table 7. Population with Difficulty Speaking English by Zip Code

ZIP Code	County	Difficulty Speaking English
77089	Harris	16.1%
77581	Brazoria	5.1%
77075	Harris	26.1%
77034	Harris	26.9%
77017	Harris	31.2%
77511	Brazoria	7.9%
77546	Galveston	5.2%
77087	Harris	33.6%
77584	Brazoria	8.1%
77061	Harris	30.7%
77502	Harris	31.3%
77536	Harris	5.0%
77033	Harris	11.5%
77506	Harris	36.0%
77573	Galveston	4.9%
77587	Harris	38.4%
77505	Harris	6.8%
77048	Harris	7.9%
77047	Harris	9.1%

ZIP Code	County	Difficulty Speaking English
77578	Brazoria	6.5%
77583	Brazoria	15.5%
77051	Harris	5.3%
77053	Fort Bend	27.0%
77045	Harris	25.2%
Brazoria	--	**7.9%**
Fort Bend	--	**13.0%**
Galveston	--	**6.8%**
Harris	--	**20.4%**
Texas	--	**14.1%**

American Community Survey, 2013-2017

As shown in Table 7, Harris County has a larger proportion of residents with difficulty speaking English (20.4%) compared to the other three counties in the service area, as well as the state of Texas (14.1%). In Harris County, 38.4% of residents in zip code 77587 and 36.0% of residents in zip code 77506 have difficulty speaking English. Within four of MH Southeast's top five zip codes for inpatient discharges (77089, 77075, 77034, and 77017) the proportion of community members with difficulty speaking English is higher than the state value.

Social and Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health in Memorial Hermann Southeast's service area. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Income

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have a greater share of educated residents and lower unemployment rates.

Figure 16 compares the median household income values for all four counties in MH Southeast's service area to the median household income value for Texas and the U.S. As shown, Fort Bend County's median household income of $93,645 is greater than that of the other three counties in the service area. Harris County's median household income is similar to the state and national values.

Figure 16. Median Household Income
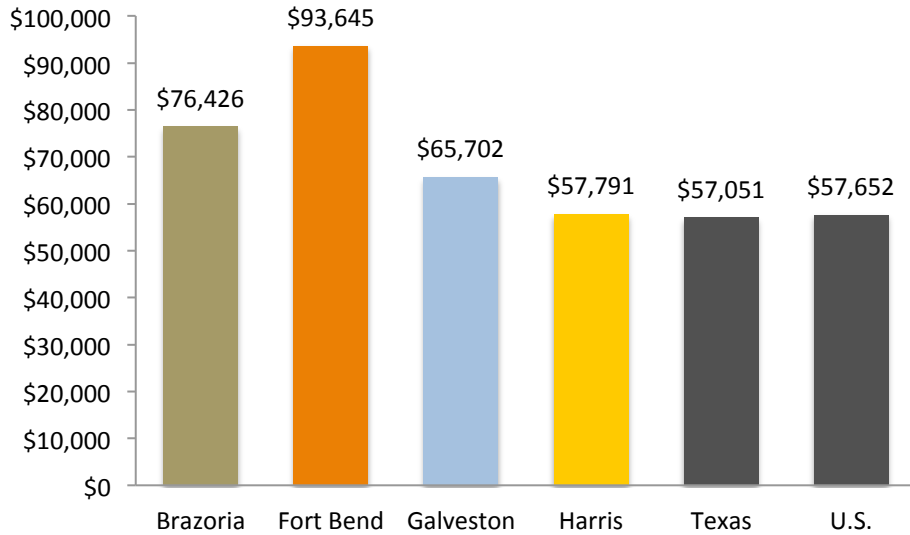
As shown in Table 8, MH Southeast's top zip codes for inpatient discharges reveal a broad range in median household income. At $50,653 and $47,252 respectively, zip codes 77075 and 77034 (both in Harris County) have median household incomes lower than the state of Texas, whereas zip codes 77089 (Harris County) and 77581 (Brazoria County) have median household incomes greater than $65,000.

Table 8. Median Household Income by Zip Code

ZIP Code	County	Median Household Income
77089	Harris	$66,775
77581	Brazoria	$89,931
77075	Harris	$50,653
77034	Harris	$47,252
77017	Harris	$44,286
77511	Brazoria	$57,098
77546	Galveston	$98,621
77087	Harris	$35,302
77584	Brazoria	$106,162
77061	Harris	$39,180
77502	Harris	$46,105
77536	Harris	$82,420
77033	Harris	$33,750
77506	Harris	$34,838
77573	Galveston	$103,922
77587	Harris	$44,371
77505	Harris	$77,490
77048	Harris	$41,220
77047	Harris	$56,706
77578	Brazoria	$99,082

ZIP Code	County	Median Household Income
77583	Brazoria	$67,241
77051	Harris	$27,244
77053	Fort Bend	$45,953
77045	Harris	$51,170
Brazoria	--	**$76,426**
Fort Bend	--	**$93,645**
Galveston	--	**$65,702**
Harris	--	**$57,791**
Texas	--	**$57,051**

American Community Survey, 2013-2017

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions.

Figure 17 shows the proportion of residents living below the poverty level in Brazoria, Fort Bend, Galveston, and Harris counties compared to the state of Texas and the U.S. The percentage of residents living below the poverty level in Harris County is 16.8%, which is higher than the national value (14.6%) and slightly higher than the state value (16.0%). Brazoria, Fort Bend, and Galveston counties (9.9%, 8.1% and 13.9%, respectively) all have lower proportions of people living below the poverty level compared to both Texas and the U.S.

Figure 17. People Living Below Poverty Level
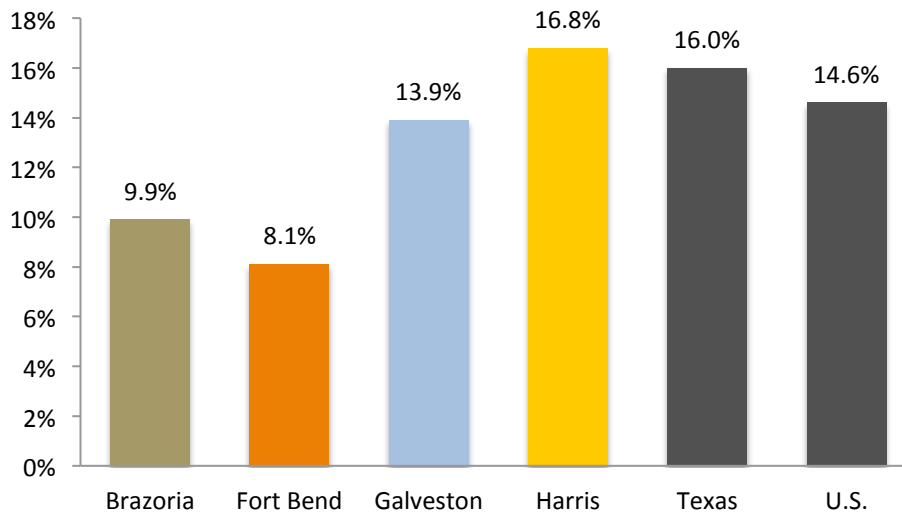
Figure 18 shows the proportion of residents living below the poverty level by race/ethnicity. For all race/ethnicity groups in Brazoria and Fort Bend Counties, the percentage of residents living below the poverty level is lower than the values for Texas and the U.S. In Galveston and Harris Counties, a greater proportion of Hispanic/Latino residents and Black/African American residents live below the poverty level compared to White and Asian residents. The percentages

of Black and Asian residents living below the poverty level in Galveston and Harris counties are higher than the state proportions.

Figure 18. People Living Below Poverty Level by Race/Ethnicity

Legend: Brazoria, Fort Bend, Galveston, Harris, Texas, U.S.

White, non-Hispanic: 7.7%, 3.8%, 8.2%, 7.0%, 8.8%, 10.3%
Black or African American: 10.2%, 9.4%, 23.6%, 21.8%, 21.4%, 25.2%
Asian: 3.3%, 5.9%, 11.4%, 11.4%, 10.6%, 11.9%
Hispanic or Latino: 15.1%, 14.8%, 23.2%, 22.6%, 23.0%, 22.2%

Figure 19. People Living Below Poverty Level by Zip Code

Legend: 4.4% - 6.9% | 6.9% - 14.5% | 14.5% - 19.8% | 19.8% - 22.5% | 22.5% - 35.0% | N/A

Poverty rates are higher in Harris County compared to the other three counties in the service area, as well as the state of Texas. As shown in Figure 19 and Table 9, within MH Southeast's service area, over 22.5% of residents in zip codes 77051, 77033, 77053, and 77087 are living below the poverty level, which is higher than the values for Harris County (16.8%) and Texas (16%), and more than 2.5 times the value for Fort Bend County (8.1%).

Table 9. People Living Below Poverty Level by Zip Code

ZIP Code	County	People Living Below Poverty Level
77089	Harris	11.2%
77581	Brazoria	6.1%
77075	Harris	18.5%
77034	Harris	19.8%
77017	Harris	18.2%
77511	Brazoria	13.9%
77546	Galveston	5.1%
77087	Harris	27.8%
77584	Brazoria	5.3%
77061	Harris	21.8%
77502	Harris	21.1%
77536	Harris	10.2%
77033	Harris	28.7%
77506	Harris	27.2%
77573	Galveston	6.9%
77587	Harris	24.9%
77505	Harris	6.1%
77048	Harris	21.3%
77047	Harris	22.5%
77578	Brazoria	4.4%
77583	Brazoria	14.5%
77051	Harris	35.0%
77053	Fort Bend	24.6%
77045	Harris	21.0%
Brazoria	--	**9.9%**
Fort Bend	--	**8.1%**
Galveston	--	**13.9%**
Harris	--	**16.8%**
Texas	--	**16.0%**

American Community Survey, 2013-2017

Food Insecurity

The Supplemental Nutrition Assistance Program (SNAP) is a federal assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The goal of the program is to increase food security and reduce hunger by increasing access to nutritious food.

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Table 10 shows the percent of households with children that participate in SNAP in the zip codes within MH Southeast's service area. Both Fort Bend and Harris counties have higher proportions of households with children receiving SNAP (73.5% and 67.7%, respectively) compared to the state of Texas (64.3%). Although the average values for Brazoria and Galveston counties are lower overall compared to the other two counties and Texas, certain zip codes have proportions higher than 80%. In particular, zip code 77578 in Brazoria County has 96.1% of households with children receiving SNAP and zip code 77573 in Galveston County has 81.2%. The top zip codes for inpatient discharges at MH Southeast, zip codes 77089 and 77581, have approximately 64% of households with children receiving SNAP.

Table 10. Households with Children Receiving SNAP by Zip Code

ZIP Code	County	Households with Children Receiving SNAP
77089	Harris	64.6%
77581	Brazoria	63.8%
77075	Harris	72.1%
77034	Harris	77.9%
77017	Harris	60.2%
77511	Brazoria	71.1%
77546	Galveston	76.8%
77087	Harris	60.7%
77584	Brazoria	72.0%
77061	Harris	57.6%
77502	Harris	77.3%
77536	Harris	84.0%
77033	Harris	63.7%
77506	Harris	73.5%
77573	Galveston	81.2%
77587	Harris	80.6%
77505	Harris	68.2%
77048	Harris	63.8%
77047	Harris	71.2%
77578	Brazoria	96.1%
77583	Brazoria	65.7%
77051	Harris	46.5%
77053	Fort Bend	77.4%
77045	Harris	75.4%
Brazoria	--	**63.1%**
Fort Bend	--	**73.5%**
Galveston	--	**59.9%**
Harris	--	**67.7%**
Texas	--	**64.3%**

American Community Survey, 2013-2017

Unemployment

The unemployment rate is a key indicator of the local economy. Unemployment occurs when local businesses are not able to supply enough appropriate jobs for local employees and/or when the labor force is not able to supply appropriate skills to employers. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.

Figure 20 displays the rate of unemployment in Brazoria, Fort Bend, Galveston, and Harris counties between May 2017 and November 2018. In all four counties, the unemployment rate has exhibited a decrease. In November 2018, the Fort Bend County unemployment rate (3.5%) was equivalent to the state and national rate. However, the unemployment rate in Brazoria County (3.9%), Galveston County (4.1%), and Harris County (3.8%) all remain higher than Texas and the U.S.

Figure 20. Unemployment Rate per County (U.S. Bureau of Labor Statistics, 2017-2018)
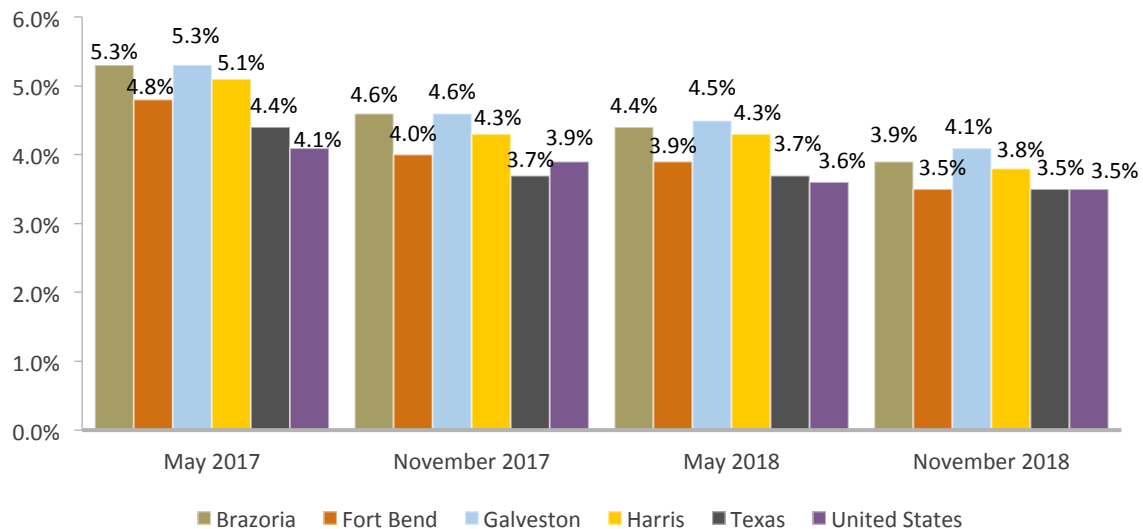
Education

Graduating from high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates can also be an important indicator of the performance of an educational system. Having a bachelor's degree opens up career opportunities in a variety of fields and is often a prerequisite for higher-paying jobs.

Figure 21 displays the proportion of residents in Brazoria, Fort Bend, Galveston, and Harris counties who are 25 years and older with at least a high school degree. Over 87% of residents 25 years and older in Brazoria, Fort Bend, and Galveston counties have at least a high school degree compared to 80.5% in Harris County. Harris County's value is lower than the U.S.

(87.3%) and Texas (82.8%) while the other three counties have higher values than both the U.S. and Texas.

Figure 21. People 25+ with a High School Degree or Higher
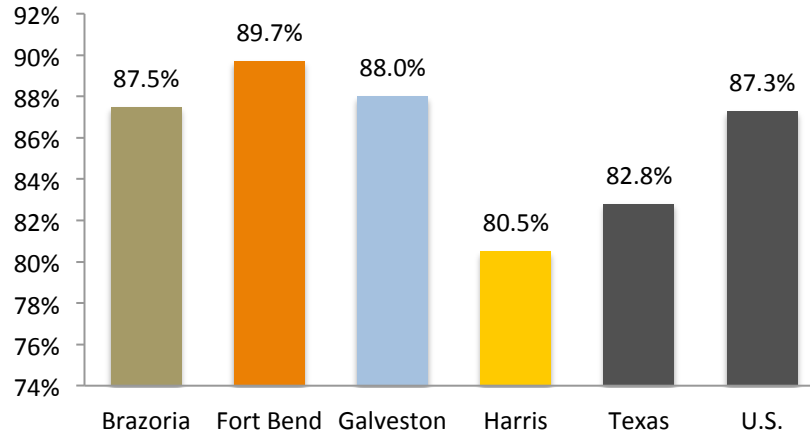
Figure 22 shows the proportion of residents in Brazoria, Fort Bend, Galveston, and Harris counties who are 25 years and older with a bachelor's degree or higher. With nearly 46% of residents 25 and older having a bachelor's degree in Fort Bend, this county has an economic advantage compared to the other three counties in the service area. The proportions of residents 25 and older with a bachelor's degree in Brazoria, Galveston, and Harris counties are somewhat higher than the Texas rate (28.7%), and slightly lower than the U.S. rate (30.9%).

Figure 22. People 25+ with a Bachelor's Degree or Higher
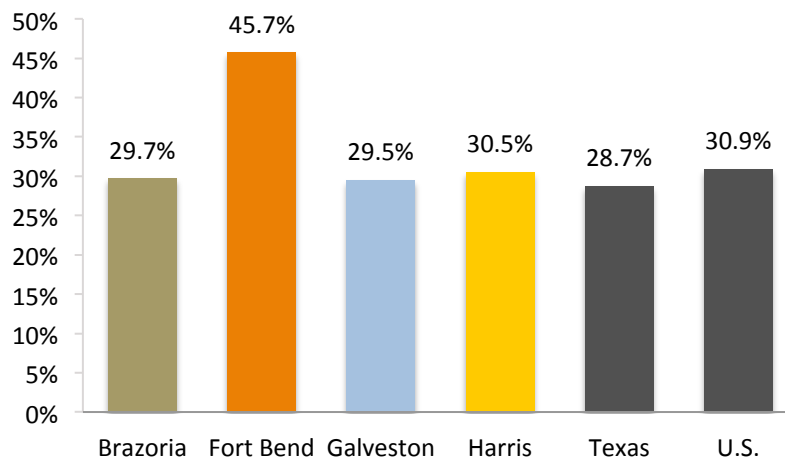
Table 11 displays the educational attainment indicators for residents 25 years and older by zip code in MH Southeast's service area. For high school degree attainment, the zip code with the highest rate is 77573 in Galveston County (96.0%) and the zip code with the lowest rate is 77506 in Harris County (55.0%). For attainment of a bachelor's degree, the zip code with the

highest rate is 77584 in Brazoria County (53.3%) and the zip code with the lowest rate is 77506 in Harris County (3.9%). The zip codes with highest proportions of MH Southeast's inpatient discharges, zip codes 77089 and 77581, have over 80% of people 25 years and older with a high school degree. In zip code 77089, 21.6% of residents 25 years and older have a bachelor's degree or higher; in zip code 77581, over 37% have a bachelor's degree.

Table 11. People 25+ with a High School Degree and People 25+ with a Bachelor's Degree by Zip Code

ZIP Code	County	High School Degree or Higher	Bachelor's Degree or Higher
77089	Harris	81.9%	21.6%
77581	Brazoria	93.1%	37.7%
77075	Harris	69.3%	12.5%
77034	Harris	72.1%	13.3%
77017	Harris	60.1%	8.3%
77511	Brazoria	83.8%	15.0%
77546	Galveston	95.1%	48.0%
77087	Harris	60.8%	8.9%
77584	Brazoria	95.2%	53.3%
77061	Harris	65.9%	13.2%
77502	Harris	61.5%	7.2%
77536	Harris	89.5%	20.4%
77033	Harris	68.6%	7.3%
77506	Harris	55.0%	3.9%
77573	Galveston	96.0%	45.5%
77587	Harris	56.4%	7.7%
77505	Harris	90.8%	25.2%
77048	Harris	80.9%	18.1%
77047	Harris	86.0%	27.2%
77578	Brazoria	94.3%	43.1%
77583	Brazoria	75.3%	19.5%
77051	Harris	78.0%	11.2%
77053	Fort Bend	68.0%	10.8%
77045	Harris	70.1%	15.1%
Brazoria	--	**87.5%**	**29.7%**
Fort Bend	--	**89.7%**	**45.7%**
Galveston	--	**88.0%**	**29.5%**
Harris	--	**80.5%**	**30.5%**
Texas	--	**82.8%**	**28.7%**

American Community Survey, 2013-2017

Transportation

There are numerous ways in which transportation may influence community health. Public transportation offers mobility, particularly to people without cars. Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public

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transportation also reduces fuel consumption, minimizes air pollution, and relieves traffic congestion. Walking to work helps protect the environment, while also providing the benefit of daily exercise.

Figure 23. Households Without a Vehicle by Zip Code
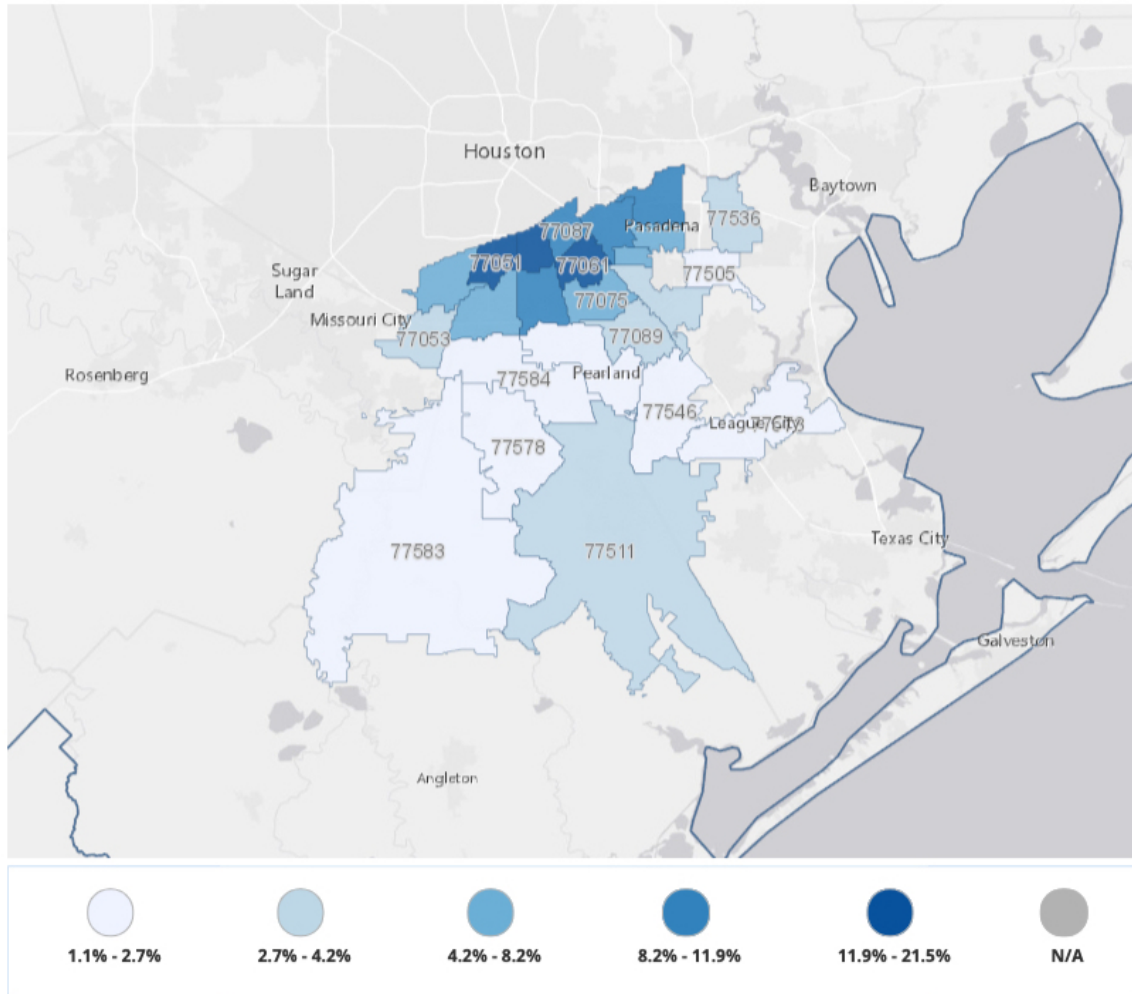
Figure 23 shows the percentage of households without a vehicle. More than 11.9% of households in zip codes 77051 and 77061 do not have a vehicle.

Table 12. Modes of Commuting by Zip Code

ZIP Code	County	Commute by Walking	Commute by Biking	Commute by Driving Alone	Commute by Public Transportation
77089	Harris	0.9%	0.1%	82.0%	2.8%
77581	Brazoria	0.8%	0.0%	90.3%	0.1%
77075	Harris	1.2%	0.4%	83.1%	1.8%
77034	Harris	2.0%	0.0%	75.5%	0.7%
77017	Harris	2.0%	0.0%	77.6%	2.6%
77511	Brazoria	1.4%	0.2%	83.1%	0.0%
77546	Galveston	0.8%	0.0%	85.2%	1.2%

ZIP Code	County	Commute by Walking	Commute by Biking	Commute by Driving Alone	Commute by Public Transportation
77087	Harris	2.7%	0.1%	72.2%	2.9%
77584	Brazoria	0.4%	0.0%	88.8%	0.3%
77061	Harris	1.2%	0.0%	73.2%	5.7%
77502	Harris	1.7%	0.3%	77.3%	0.0%
77536	Harris	1.5%	0.1%	85.6%	0.4%
77033	Harris	0.4%	0.0%	79.3%	6.3%
77506	Harris	2.1%	0.5%	74.7%	0.0%
77573	Galveston	0.5%	0.2%	84.3%	1.3%
77587	Harris	1.9%	1.3%	70.7%	1.4%
77505	Harris	0.5%	0.1%	87.0%	0.3%
77048	Harris	0.0%	0.5%	84.2%	2.9%
77047	Harris	0.0%	0.5%	80.9%	1.8%
77578	Brazoria	0.2%	0.0%	81.6%	0.0%
77583	Brazoria	0.8%	0.1%	83.8%	0.2%
77051	Harris	1.4%	0.2%	79.7%	4.6%
77053	Fort Bend	0.6%	0.0%	74.4%	1.5%
77045	Harris	0.1%	0.2%	75.0%	3.9%
Brazoria	--	**0.8%**	**0.0%**	**86.3%**	**0.2%**
Fort Bend	--	**0.5%**	**0.1%**	**82.0%**	**1.6%**
Galveston	--	**2.0%**	**0.6%**	**80.9%**	**0.9%**
Harris	--	**1.5%**	**0.3%**	**79.3%**	**2.7%**
Texas	--	**1.6%**	**0.3%**	**80.5%**	**1.5%**

American Community Survey, 2013-2017

Table 12 displays the different modes of commuting used by residents of Brazoria, Fort Bend, Galveston, and Harris counties. In Brazoria and Fort Bend counties, less than 1% of the population commutes by walking or biking. In Galveston and Harris counties, slightly more residents commute by walking and biking. In all four counties, the majority of residents commute by driving alone. In Harris County, 6.3% of residents living in zip code 77033 commute by public transportation, which is more than 4 times the state value (1.5%). Considering the top ten zip codes for inpatient discharges within MH Southeast's service area, zip codes 77089, 77017, 77087, and 77061 (all within Harris County) have the highest proportions of residents commuting by public transportation.

SocioNeeds Index®

Conduent Healthy Communities Institute developed the SocioNeeds Index® to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for six different social and economic determinants of health – income, poverty, unemployment, occupation, educational attainment, and linguistic barriers – that are associated with poor health outcomes including preventable hospitalizations and premature death.

Zip codes within each county are assigned an index value from 0 (low need) to 100 (high need), based on how those zip codes compare to others in the U.S. Within each county, the zip codes

are then ranked from 1 (low need) to 5 (high need) to identify the relative level of need. Zip codes with populations under 300 persons are excluded.

Figure 24. SocioNeeds Index by Zip Code
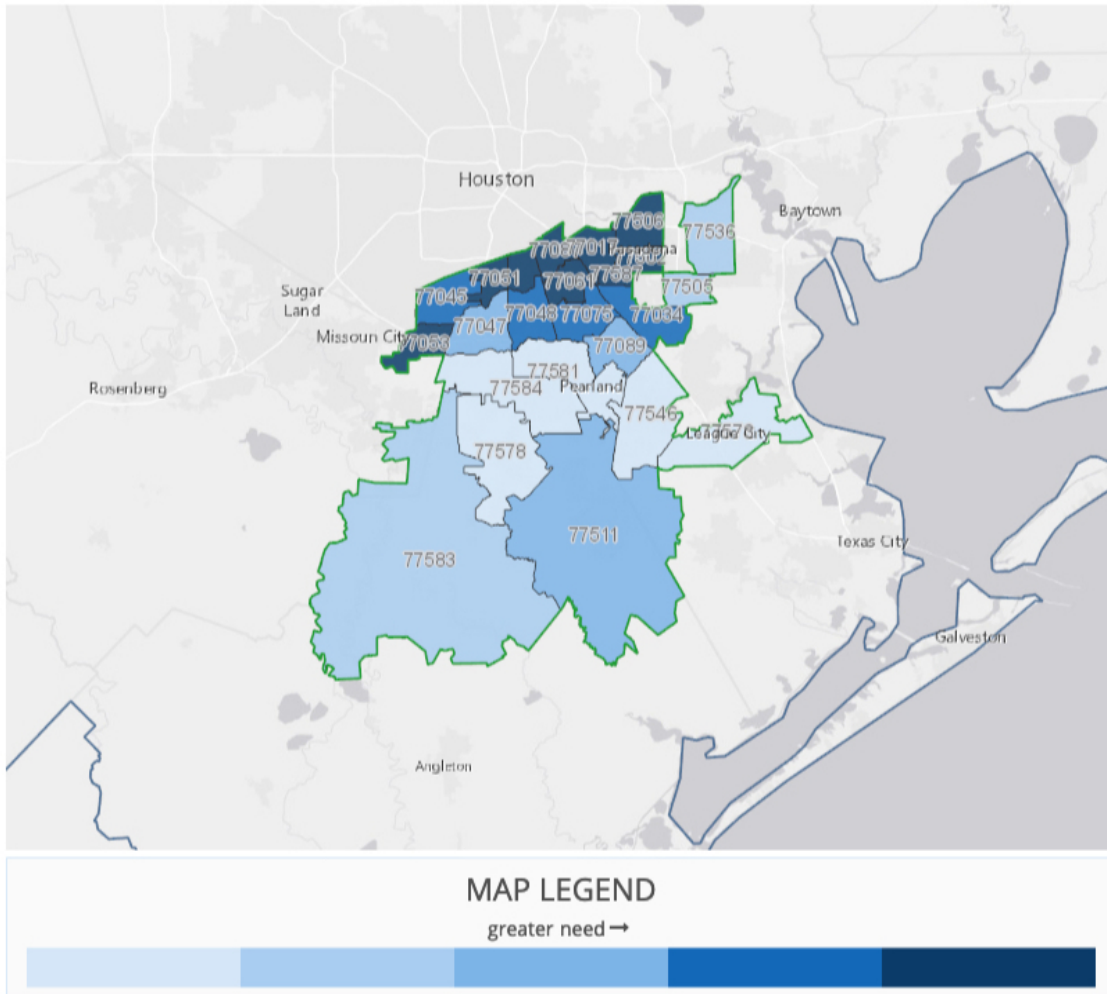
As shown in Figure 24 and Table 13, most of the zip codes within MH Southeast's service area with the highest SocioNeeds Index values are within Harris County. Zip codes 77506, 77051, 77033, 77087, 77587, 77502, 77017, 77061 (all within Harris County), and 77053 (Fort Bend County) all have values greater than 95. The zip codes with the largest proportion of inpatient discharges at MH Southeast, zip codes 77089 and 77581, have SocioNeeds Index values of 59.4 and 15.4, respectively.

Table 13. SocioNeeds Index by Zip Code (In Order of SocioNeeds Index Value)

ZIP Code	County	SocioNeeds Index Value
77506	Harris	98.9
77051	Harris	98
77033	Harris	97.8
77087	Harris	97.8

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ZIP Code	County	SocioNeeds Index Value
77587	Harris	97.2
77502	Harris	96.1
77017	Harris	96
77061	Harris	95.9
77053	Fort Bend	95.7
77048	Harris	92.1
77034	Harris	91.9
77045	Harris	90.9
77075	Harris	89.7
77047	Harris	68.7
77511	Brazoria	63.8
77089	Harris	59.4
77536	Harris	36.8
77583	Brazoria	29.2
77505	Harris	24
77581	Brazoria	15.4
77578	Brazoria	12.7
77584	Brazoria	7.7
77546	Galveston	6.8
77573	Galveston	6.7

Conduent SocioNeeds Index, 2019

Data Synthesis

All forms of data have their own strengths and limitations. To gain a comprehensive understanding of the significant health needs for Memorial Hermann Health System, the findings from both the primary data and the secondary data were compared and studied together.

The secondary data, key informant interviews and community survey were treated as three separate sources of data. The secondary data were analyzed using data scoring, which identified health areas of need based on the values of indicators for each topic area (Appendix B). The following tables display the data scores for Health and Quality of Life Topics for Brazoria, Fort Bend, Galveston, and Harris counties.

Table 14. Brazoria County Topic Scores

Topic	Score
Transportation	2.11
Heart Disease & Stroke	1.80
Older Adults & Aging	1.56
Exercise, Nutrition, & Weight	1.53
Public Safety	1.46
Access to Health Services	1.42
Immunizations & Infectious Diseases	1.41
Mental Health & Mental Disorders	1.37
Environment	1.36
Other Chronic Diseases	1.31
Respiratory Diseases	1.28
Substance Abuse	1.28
Children's Health	1.23
Cancer	1.21
Mortality Data	1.16
Maternal, Fetal & Infant Health	1.12
Prevention & Safety	1.11
Social Environment	1.10
Women's Health	1.10
Wellness & Lifestyle	1.06
Economy	1.04
Men's Health	1.01
Education	0.96

Table 15. Fort Bend County Topic Scores

Topic	Score
Transportation	1.83
Immunizations & Infectious Diseases	1.47
Exercise, Nutrition, & Weight	1.45
Other Chronic Diseases	1.44
Public Safety	1.37

Topic	Score
Heart Disease & Stroke	1.32
Environment	1.27
Substance Abuse	1.24
Maternal, Fetal & Infant Health	1.23
Older Adults & Aging	1.19
Access to Health Services	1.18
Children's Health	1.15
Social Environment	1.03
Mental Health & Mental Disorders	0.95
Economy	0.91
Education	0.83
Prevention & Safety	0.78
Men's Health	0.75
Women's Health	0.71
Wellness & Lifestyle	0.68
Respiratory Diseases	0.63
Mortality Data	0.61
Cancer	0.53

Table 16. Galveston County Topic Scores

Topic	Score
Heart Disease & Stroke	1.86
Other Chronic Diseases	1.72
Men's Health	1.71
Transportation	1.69
Older Adults & Aging	1.62
Wellness & Lifestyle	1.61
Children's Health	1.58
Immunizations & Infectious Diseases	1.58
Substance Abuse	1.55
Exercise, Nutrition, & Weight	1.50
Mental Health & Mental Disorders	1.50
Public Safety	1.48
Cancer	1.45
Mortality Data	1.45
Environment	1.44
Maternal, Fetal & Infant Health	1.44
Respiratory Diseases	1.41
Economy	1.34
Access to Health Services	1.32
Social Environment	1.32
Women's Health	1.28
Prevention & Safety	1.19
Education	1.13

Table 17. Harris County Topic Scores

Topic	Score
Transportation	1.82
Women's Health	1.81
Immunizations & Infectious Diseases	1.78
Other Chronic Diseases	1.78
Public Safety	1.65
Maternal, Fetal & Infant Health	1.64
Prevention & Safety	1.58
Social Environment	1.58
Education	1.56
Economy	1.55
Heart Disease & Stroke	1.54
Children's Health	1.52
Older Adults & Aging	1.50
Access to Health Services	1.48
Exercise, Nutrition, & Weight	1.48
Wellness & Lifestyle	1.42
Men's Health	1.38
Diabetes	1.34
Environment	1.34
Substance Abuse	1.33
Cancer	1.31
Mortality Data	1.29
Mental Health & Mental Disorders	1.26
Respiratory Diseases	0.99

This methodology was applied to each of the 12 counties within Memorial Hermann Health System's primary service area and then data scores calculated for the region in order to determine significant health needs across the system. Table 18 lists the resulting data scores for Health & Quality of Life Topic Areas.

Table 18. Memorial Hermann Region Topic Scores

Topic	Score
Transportation	1.84
Heart Disease & Stroke	1.82
Access to Health Services	1.79
Older Adults & Aging	1.60
Exercise, Nutrition, & Weight	1.56
Other Chronic Diseases	1.52
Mental Health & Mental Disorders	1.50
Children's Health	1.47
Immunizations & Infectious Diseases	1.43
Education	1.43
Women's Health	1.42
Social Environment	1.42

Wellness & Lifestyle	1.41
Maternal, Fetal & Infant Health	1.41
Respiratory Diseases	1.41
Economy	1.41
Environment	1.40
Public Safety	1.36
Cancer	1.31
Prevention & Safety	1.26
Substance Abuse	1.23
Men's Health	1.21

The analysis of key informant interviews occurred using the qualitative software: Dedoose[1]. For the community survey, HCI performed a simple review and analysis to identify top health needs. Overall, each method produced individual results that represent the community input in this report. This consolidated input leads to the prioritized heath needs in this report. This triangulated approach is shown in Figure 25.

Figure 25. Visual of Data Synthesis Approach
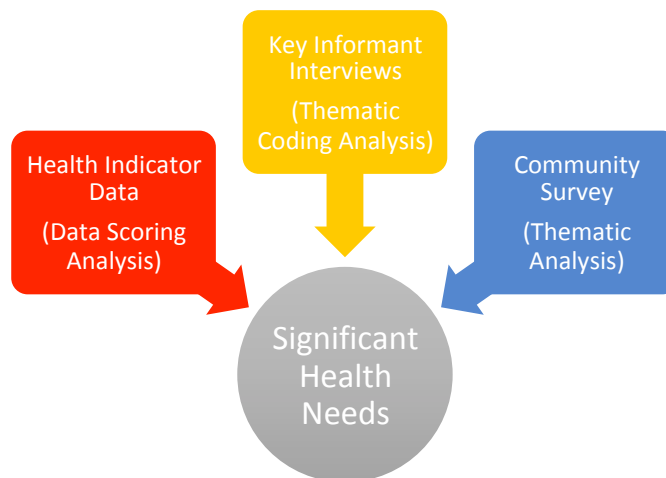
The team used the triangulated approach to identify significant health needs for Memorial Hermann Health System. Figure 26 displays the results of this synthesis. For many of the health topics evidence of need was present across multiple data sources, including Obesity, Mental Health, Access to Health Services, Transportation, and Uninsured. For other health topics the evidence was present in just one source of data, however it should be noted that this may be reflective of the strength and limitations of each type of data that was considered in this process.

Figure 26. Data Synthesis Results

Secondary Data
- Heart disease/stroke
- Older adults/aging

(*) indicates a direct relation to Memorial Hermann's 4 pillars.

- Access to health services*
- Transportation

- Obesity*
- Mental health*

Community Survey
- Diabetes
- Cancers
- Substance abuse*

- Uninsured

Key Informant Interviews
- Education
- Food insecurity*
- Low-income/underserved
- Children's health
- Economy
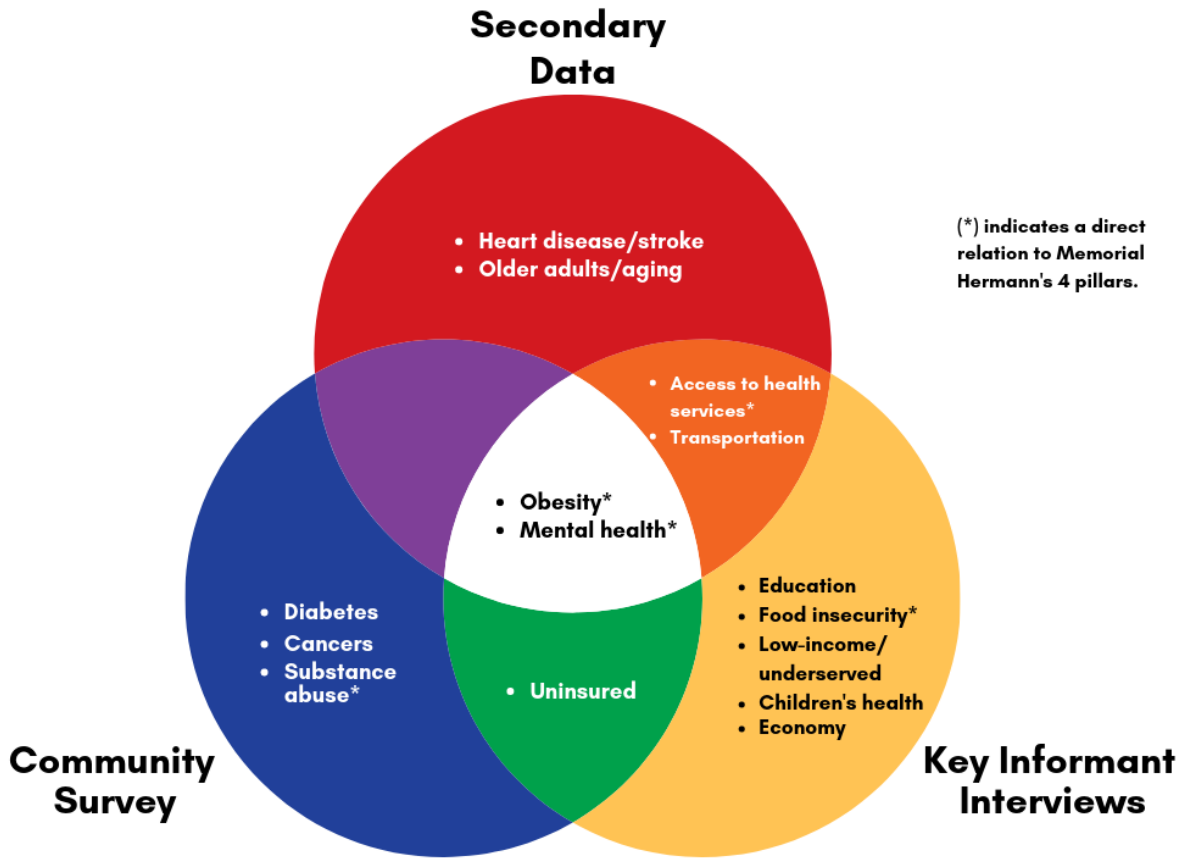
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Prioritized Significant Health Needs

Prioritization Results

Upon completion of the online prioritization survey, four health areas were identified for subsequent implementation planning by Memorial Hermann Health System. These four health priorities are: Access to Care, Emotional Well-Being, Food as Health, and Exercise Is Medicine.

The following section will dive deeper into each of these health topics in order to understand how findings from the secondary and primary data led to each health topic becoming a priority health issue for Memorial Hermann Health System. For each prioritized health need, key issues are summarized; secondary data scores are noted for indicators of concern; and community input is described.

> ***Secondary Data Scoring Methodology***
> *For each indicator, each county in MH Southeast's service area was assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varied by indicator and was dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Please see Appendix B for further information on HCI Data Scoring methodology.*

Access to Healthcare

Key Issues:
- Range of barriers, including transportation, access to specialty care, lack of awareness, and fear or stigma
- Lack of health insurance
- Low income and vulnerable groups

Secondary Data

Access to Health Services, Lack of Insurance and Low-Income/Underserved were identified as significant needs for Memorial Hermann Health System. As shown in Table 19, there are several indicators related to Access to Health Services with data scores equal to or greater than 1.75; Harris County having a greater number of indicators of concern overall compared to Brazoria, Fort Bend and Galveston counties.

Mental Health Provider Rate is an indicator of concern for Brazoria, Fort Bend and Galveston counties, with scores between 1.78 and 2.11. In Harris County, indicators of concern include: Adults Unable to Afford to See a Doctor, Adults with Health Insurance, Children with Health Insurance, and Persons with Health Insurance. Over 22% of Harris County adults are unable to afford to see a doctor, which is higher than the proportion in Texas (18.3%) and the U.S. (12.1%). Moreover, approximately 20% of residents in Harris County do not have health insurance.

Table 19. Secondary Data Scoring Results: Access to Health Services

| Indicator | County | | Data Score | County Value Compared to: | | | | |
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Adults Unable to Afford to See a Doctor [10] (2015)	Brazoria		---	---	---	---	---	---
	Fort Bend		---	---	---	---	---	---
	Harris	22.1 percent	2	1.5	3	3	1.5	1.5
	Galveston		---	---	---	---	---	---
[10] Texas Behavioral Risk Factor Surveillance System								
Adults with Health Insurance: 18-64 [9] (2016)	Brazoria	82.0 percent	1.47	0	1	1.5	3	1
	Fort Bend	85.4 percent	0.92	0	0	1.5	3	0
	Harris	74.7 percent	1.75	2	2	1.5	3	0
	Galveston	81.3 percent	1.47	0	1	1.5	1.5	1
[9] Small Area Health Insurance Estimates								
Children with Health Insurance [9] (2016)	Brazoria	91.30 percent	1.14	0	1	1.5	2	0
	Fort Bend	93.30 percent	0.97	0	1	1.5	2	0
	Harris	89.40 percent	1.81	1	2	1.5	3	1
	Galveston	91.40 percent	1.36	0	1	1.5	1.5	1
[9] Small Area Health Insurance Estimates								
Mental Health Provider Rate [4] (2017)	Brazoria	56.5 providers/ 100,000 population	2	1	3	3	1.5	1.5
	Fort Bend	59.8 providers/ 100,000 population	2.11	1	3	3	1.5	2
	Harris	103.7 providers/ 100,000 population	1.44	0	1	3	1.5	2

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	Galveston	95.9 providers/ 100,000 population	1.78	0	2	3	3	2

[4] County Health Rankings

Non-Physician Primary Care Provider Rate [4] (2017)	Brazoria	44.3 providers/ 100,000 population	1.67	1	3	3	1.5	0
	Fort Bend	52.2 providers/ 100,000 population	1.67	1	3	3	1.5	0
	Harris	72.2 providers/ 100,000 population	1	0	1	3	1.5	0
	Galveston	77.4 providers/ 100,000 population	0.67	0	0	2	2	0

[4] County Health Rankings

Persons with Health Insurance [9] (2016)	Brazoria	85.0 percent	1.25	0	1	1.5	3	0
	Fort Bend	88.0 percent	1.08	0	1	1.5	3	0
	Harris	79.3 percent	1.75	2	2	1.5	3	0
	Galveston	84.3 percent	1.47	0	1	1.5	1.5	1

[9] Small Area Health Insurance Estimates

Primary Care Provider Rate [4] (2015)	Brazoria	65.3 providers/ 100,000 population	1.22	0	1	3	1.5	1
	Fort Bend	80.3 providers/ 100,000 population	0.33	0	0	1	1.5	0
	Harris	57.2 providers/ 100,000 population	1.61	0	2	3	1.5	2
	Galveston	71.7 providers/ 100,000 population	1	0	0	2	2	1.5

[4] County Health Rankings

When considering Access to Health Services, it is important to take into account the economy and how financial barriers impact community residents' ability to access care. As shown in

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Table 20, there are several economic indicators with data scores greater than 2 in Fort Bend and Harris counties.

There are five economic indicators of concern in Brazoria County: Median Household Gross Rent, Median Monthly Owner Costs for Households without a Mortgage, Mortgaged Owners Median Monthly Household Costs, SNAP Certified Stores, and Unemployed Workers in Civilian Labor Force. In Fort Bend County, three indicators of concern include: Median Household Gross Rent, Median Monthly Owner Costs for Households without a Mortgage, and Mortgaged Owners Median Monthly Household Costs. In addition to the same five economic indicators of concern as Brazoria County, Galveston County's Homeownership received a score above 2.

Compared to the other three counties, Harris County has the broadest range of economic indicators of concern, including: Homeownership, Severe Housing Problems, Students Eligible for the Free Lunch Program, Median Monthly Owner Costs for Households without a Mortgage, SNAP Certified Stores, Median Household Gross Rent, Families Living Below Poverty Level, and Food Insecurity Rate. Less than 50% of Harris County residents own a home. Over 20% of residents in Harris County have severe housing problems. And more than 58% of students are eligible for the free lunch program compared to the national value of 42.6%. In Harris County, there are over 14% of families living below the poverty level compared to 13% in Texas and 11% in the U.S.

Table 20. Secondary Data Scoring Results: Economy

| Indicator | County | | Data Score | County Value Compared to: | | | | |
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Child Food Insecurity Rate [5] (2016)	Brazoria	**20.1 percent**	**1**	0	0	3	1.5	0
	Fort Bend	**19.1 percent**	**0.67**	0	0	2	1.5	0
	Harris	**23.5 percent**	**1.67**	1	2	3	1.5	0
	Galveston	**22.4 percent**	**1.33**	1	1	3	3	0
[5] Feeding America								
Children Living Below Poverty Level [1] (2012-2016)	Brazoria	**13.2 percent**	**0.39**	0	0	0	1.5	1
	Fort Bend	**11.2 percent**	**0.39**	0	0	0	1.5	1
	Harris	**26.0 percent**	**1.67**	2	2	3	1.5	0
	Galveston	**19.2**	**1.11**	1	0	1	1	2

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		percent						

[1] American Community Survey

Families Living Below Poverty Level [1] (2012-2016)	Brazoria	7.90 percent	0.56	0	0	0	1.5	1
	Fort Bend	6.40 percent	0.39	0	0	0	1.5	1
	Harris	14.40 percent	2.06	**2**	**3**	**3**	**1.5**	**1**
	Galveston	10.20 percent	1.11	1	0	1	1	2

[1] American Community Survey

Food Insecurity Rate [5] (2016)	Brazoria	14.5 percent	1.33	1	1	3	1.5	0
	Fort Bend	14.8 percent	1.56	1	1	3	1.5	1
	Harris	16.6 percent	2.06	**2**	**2**	**3**	**1.5**	**1**
	Galveston	17.0 percent	2	2	3	3	3	0

[5] Feeding America

Homeowner Vacancy Rate [1] (2012-2016)	Brazoria	1.6 percent	0.89	1	1	0	1.5	1
	Fort Bend	1.1 percent	0.17	0	0	0	1.5	0
	Harris	1.5 percent	0.67	**1**	**1**	**0**	**1.5**	**0**
	Galveston	2.7 percent	2.28	2	3	3	3	2

[1] American Community Survey

Homeownership [1] (2012-2016)	Brazoria	64.3 percent	0.83	0	0	0	1.5	3
	Fort Bend	74.4 percent	0.39	0	0	0	1.5	1
	Harris	49.6 percent	2.44	**3**	**2**	**3**	**1.5**	**2**
	Galveston	54.7 percent	2.17	2	2	2	2	3

[1] American Community Survey

Median Household	Brazoria	951	2.25	3	2	2	1.5	3

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Gross Rent [1] (2012-2016)		**dollars**						
	Fort Bend	**1252 dollars**	**2.58**	3	3	3	1.5	3
	Harris	**937 dollars**	**2.08**	**3**	**2**	**1**	**1.5**	**3**
	Galveston	**941 dollars**	**2.08**	3	2	1	1	3
[1] American Community Survey								
Median Monthly Owner Costs for Households without a Mortgage [1] (2012-2016)	Brazoria	**490 dollars**	**2.03**	3	2	2	1.5	2
	Fort Bend	**712 dollars**	**2.36**	3	3	3	1.5	2
	Harris	**534 dollars**	**2.14**	**3**	**3**	**3**	**1.5**	**1**
	Galveston	**523 dollars**	**2.58**	3	3	3	3	3
[1] American Community Survey								
Mortgaged Owners Median Monthly Household Costs [1] (2012-2016)	Brazoria	**1645 dollars**	**2.14**	3	3	3	1.5	1
	Fort Bend	**1884 dollars**	**2.25**	3	3	3	1.5	1.5
	Harris	**1504 dollars**	**1.81**	**3**	**2**	**2**	**1.5**	**1**
	Galveston	**1648 dollars**	**2.14**	3	3	3	3	1
[1] American Community Survey								
People 65+ Living Below Poverty Level [1] (2012-2016)	Brazoria	**8.7 percent**	**0.89**	1	0	1	1.5	1
	Fort Bend	**6.9 percent**	**0.39**	0	0	0	1.5	1
	Harris	**11.3 percent**	**1.89**	**2**	**2**	**3**	**1.5**	**1**
	Galveston	**8.0 percent**	**0.72**	1	0	0	0	1
[1] American Community Survey								
People Living Below Poverty Level [1] (2012-2016)	Brazoria	**10.5 percent**	**0.39**	0	0	0	1.5	1
	Fort Bend	**8.2 percent**	**0.39**	0	0	0	1.5	1

	Harris	**17.4 percent**	**1.67**	**2**	**2**	**3**	**1.5**	**0**
	Galveston	**13.6 percent**	**1.11**	1	0	1	1	2

[1] American Community Survey

Severe Housing Problems [4] (2010-2014)	Brazoria	**14.6 percent**	**1.5**	2	0	0	1.5	3
	Fort Bend	**14.8 percent**	**1.06**	2	0	0	1.5	1
	Harris	**20.9 percent**	**2.39**	**3**	**3**	**3**	**1.5**	**1**
	Galveston	**16.3 percent**	**1.06**	2	0	0	0	1

[4] County Health Rankings

SNAP Certified Stores [17] (2016)	Brazoria	**0.5 stores/ 1,000 population**	**2**	3	1.5	1.5	1.5	1.5
	Fort Bend	**0.4 stores/ 1,000 population**	**1.89**	3	1.5	1.5	1.5	1
	Harris	**0.6 stores/ 1,000 population**	**2.11**	**3**	**1.5**	**1.5**	**1.5**	**2**
	Galveston	**0.7 stores/ 1,000 population**	**2.11**	3	1.5	1.5	1.5	2

[17] U.S. Department of Agriculture - Food Environment Atlas

Students Eligible for the Free Lunch Program [8] (2015-2016)	Brazoria	**38.5 percent**	**0.5**	0	0	1	1.5	0
	Fort Bend	**26.7 percent**	**0.17**	0	0	0	1.5	0
	Harris	**58.2 percent**	**2.22**	**2**	**3**	**3**	**1.5**	**1**
	Galveston	**40.5 percent**	**0.72**	0	0	1	1	1

[8] National Center for Education Statistics

Total Employment Change [16] (2014-2015)	Brazoria	**3.6 percent**	**0.67**	1	0	0	1.5	1.5
	Fort Bend	**6.2 percent**	**0.5**	0	0	0	1.5	1.5
	Harris	**2.4**	**1.67**	**1**	**3**	**2**	**1.5**	**1.5**

		percent						
	Galveston	3.9 percent	0.5	0	0	0	0	1.5

[16] U.S. Census - County Business Patterns

Unemployed Workers in Civilian Labor Force [15] (July 2018)	Brazoria	4.7 percent	2.44	3	3	3	1.5	2
	Fort Bend	4.1 percent	1.78	2	2	1	1.5	2
	Harris	4.4 percent	1.94	2	2	2	1.5	2
	Galveston	4.7 percent	2.44	3	3	3	3	2

[15] U.S. Bureau of Labor Statistics

Primary Data

During the key informant interview process, Access to Health Services was discussed over 160 times and was raised by participants almost 50 times in relation to barriers or challenges to achieving health in the community. The primary themes related to barriers or challenges were limitations to procuring specialty care services, transportation to services and hours of operation. In addition to the primary themes, two additional barriers or challenges stood out as key factors impacting access to health care services, lack of knowledge and stigma or fear preventing people from seeking care.

The issue that interview participants were most concerned with was patients being able to access follow up care with specialty care providers. Multiple participants raised concerns that even if patients are able to access preventative or primary care services, they may not be able to access the appropriate follow up care with a specialty care provider. Some participants raised this concern in context of patients not living near a specialist and others raised in context of patients not being able to afford the cost of follow up care.

"…specialty care is a huge problem. They have specialists here in the county, but trying to help our Coastal patients get in to see specialists or just people out in the community trying to see specialists, if they're not insured, and they don't have private funds to pay for it, they just don't get that care. And we see that in the public health programs."

A concern brought up by a few participants, that for serious chronic conditions, patients would ultimately end up seeking care from emergency services instead. Another common concern raised by interview participants, was transportation to services and hours of operation of services limiting patients' access to care. Participants described how these factors determine whether patients decide to take off from work and seek services in the first place. A few participants described the many services and resources that are available to the community but that many may not be aware how they can access or benefit from them. One participant described resources being concentrated in certain geographic areas and more remote locations

not being well connected or knowledgeable about how they may also benefit from these resources. Participants described the potential for more collaboration and partnership to connect communities to one another. Several participants described a down-turn in people seeking preventative care service and hypothesized that one of the factors may be related to the immigrant community in the region experiencing fear or stigma related to having to show identification or proof of citizenship.

"Even though we at the Health District do not ask for proof of immigration status, people don't understand that, particularly since we're a government agency, and it's been a real challenge to get some of these folks to come in for services."

There were almost 80 references to the uninsured population in the key informant interviews and lack of health insurance was raised as a barrier or challenge to achieving health in the community 19 times. Lack of health insurance was most often brought up in context of patients having limited financial resources and a factor to not accessing health care services. Participants discussed patients not having the ability to pay fees for multiple appointment co-pays or not seeking care due to competing financial priorities. While health care services may be available in the community, for those who are lacking health insurance, accessing health care services is not necessarily an option. Lack of health insurance creates a particular challenge for those who require specialty care services.

"I think those are the biggest two—access, again, with the majority of our adult population being uninsured, having them try to find a provider that, again, will take sliding fee scale, or reduced rates. Once they're able to access those services, then it becomes a matter of paying for the things that are needed. The patient comes in and we diagnose them with diabetes, then comes the cost of medications, and if that patient is needing specialty care outside of the scope of primary care, access to specialists."

Participants brought up issues related to low income or groups who may be underserved in the community 115 times during the key informant interview process. Particular groups that participants felt may experience added challenges accessing health care services included the immigrant population, individuals with disabilities, families with young children, and the elderly. Several participants raised fees related to co-pays or out of pocket expenses as a barrier to patients seeking initial preventative services or ongoing treatment for chronic conditions. Participants identified several groups they felt were underserved in the community. Multiple participants discussed the unique and specific challenges with providing culturally appropriate care for a diverse and recent immigrant population in the community. Participants felt that families with young children and the elderly population are particularly vulnerable groups in the community that experience barriers and challenges accessing health care services. Specifically, participants discussed these groups experiencing high levels of poverty placing them at higher risk for poor health outcomes.

"Most of them are extremely low income and they fall in those categories where we have a significant number of elderly disabled, single moms and their children, so vulnerable folks here in Houston."

Emotional Well-Being

Key Issues:
- Mental health as part of overall health
- Need for more behavioral health services and providers, and services to support local communities
- Alcohol and substance abuse
- Alzheimer's and dementia

Secondary Data

Mental Health and Substance Abuse were identified as significant needs for Memorial Hermann Health System. As shown in Table 21, there are several indicators related to Mental Health & Mental Disorders with data scores greater than 1.5. Brazoria County has three concerning indicators related to Mental Health and Mental Disorders: Age-Adjusted Death Rate due to Suicide, Alzheimer's Disease or Dementia in the Medicare Population, and Mental Health Provider Rate. In addition to the latter three indicators of concern, Depression in the Medicare Population is another concerning indicator for Galveston County. In Harris County, 11.4% of the Medicare Population has Alzheimer's Disease or Dementia, which is higher than the U.S. value (9.9%). Moreover, 80% of residents in Harris County reported having 5 or more poor mental health days in the past month. In Fort Bend County, an indicator of concern is the Mental Health Provider Rate (with an indicator score above 2). Fort Bend County's rate of 59.8 providers per 100,000 population is approximately forty percent lower than the state's value (98.8) and less than one third of the national value (214.3).

Table 21. Secondary Data Scoring Results: Mental Health & Mental Disorders

Indicator	County			County Value Compared to:				
	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Age-Adjusted Death Rate due to Suicide [12] (2010-2014)	Brazoria	12.4 deaths/ 100,000 population	2	1.5	2	1	3	3
	Fort Bend	7.3 deaths/ 100,000 population	0.94	1.5	0	0	0	2
	Harris	10.3 deaths/ 100,000 population	0.94	1.5	0	0	2	1
	Galveston	12.9 deaths/ 100,000 population	1.67	1.5	3	2	2	0
[12] Texas Department of State Health Services								
Alzheimer's Disease or Dementia: Medicare Population [3] (2015)	Brazoria	10.7 percent	1.67	1	1	2	1.5	1.5
	Fort Bend	10.2	1.33	1	0	2	1.5	1.5

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Indicator	County	Value						
		percent		2 (yellow)	1 (green)	3 (orange)	1.5 (tan)	1 (tan)
	Harris	11.4 percent	1.89	2	1	3	1.5	1
	Galveston	11.1 percent	2.11	2	1	3	3	2

[3] Centers for Medicare & Medicaid Services

Indicator	County	Value						
Depression: Medicare Population [3] (2015)	Brazoria	15.50 percent	1.5	1	1	1	1.5	3
	Fort Bend	12.20 percent	0.61	0	0	0	1.5	2
	Harris	14.80 percent	0.94	1	0	0	1.5	2
	Galveston	18.20 percent	2.33	3	2	2	2	3

[3] Centers for Medicare & Medicaid Services

Indicator	County	Value						
Mental Health Provider Rate [4] (2017)	Brazoria	56.5 providers/ 100,000 population	2	1	3	3	1.5	1.5
	Fort Bend	59.8 providers/ 100,000 population	2.11	1	3	3	1.5	2
	Harris	103.7 providers/ 100,000 population	1.44	0	1	3	1.5	2
	Galveston	95.9 providers/ 100,000 population	1.78	0	2	3	3	2

[4] County Health Rankings

Indicator	County	Value						
Poor Mental Health: 5+ Days [10] (2016)	Brazoria		---	---	---	---	---	---
	Fort Bend		---	---	---	---	---	---
	Harris	80.0 percent	1.53	1.5	1	1.5	1.5	2
	Galveston		---	---	---	---	---	---

[10] Texas Behavioral Risk Factor Surveillance System

Substance Abuse is another topic of concern in Brazoria, Fort Bend and Harris counties. For all three counties, the proportion of alcohol-impaired driving deaths is higher than the state and the U.S. There were 34.3% alcohol-impaired driving deaths in Brazoria County, 36% in Fort Bend

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County and 37.8% in Harris County, compared to 28.3% and 29.3% in Texas and the U.S., respectively (Table 22).

Table 22. Secondary Data Scoring Results: Substance Abuse

| Indicator | County | | | County Value Compared to: | | | | |
	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Alcohol-Impaired Driving Deaths [4] (2012-2016)	Brazoria	**34.3** percent	**2.22**	3	3	3	1.5	1
	Fort Bend	**36.0** percent	**2**	3	3	3	1.5	0
	Harris	**37.8** percent	**2.17**	**3**	**3**	**3**	**1.5**	**0**
	Galveston	**31.8** percent	**1.67**	2	3	2	2	0
[4] County Health Rankings								
Adults who Drink Excessively [4] (2016)	Brazoria	**19.4** percent	**1.67**	3	1	2	0	1.5
	Fort Bend	**18.3** percent	**1.5**	2	1	2	0	1.5
	Harris	**18.1** percent	**1.5**	**2**	**1**	**2**	**0**	**1.5**
	Galveston	**18.8** percent	**1.5**	2	1	2	2	1.5
[4] County Health Rankings								
Death Rate due to Drug Poisoning [4] (2014-2016)	Brazoria	**8.1** deaths/ 100,000 population	**0.64**	1.5	0	0	1.5	1
	Fort Bend	**5.6** deaths/ 100,000 population	**0.86**	1.5	0	0	1.5	2
	Harris	**10.2** deaths/ 100,000 population	**1.19**	**1.5**	**2**	**0**	**1.5**	**2**
	Galveston	**15.6** deaths/ 100,000 population	**1.58**	1.5	3	1	1	1.5
[4] County Health Rankings								

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Primary Data

Approximately 50% of community survey respondents cited Mental Health as one of the top issues most affecting the quality of life in their community and 52% of respondents noted Substance Abuse. In interviews with key informants, Mental Health was discussed 113 times and was raised by participants 33 times as a needs or concern for the health of the community. The primary themes related to Mental Health were treating mental health as part of overall health, address behavioral health in school, need for behavioral health providers and services and older adults with Alzheimer's and dementia.

Some participants discussed a recent shift in care delivery and the continued need to address mental health as part of a person's total health similarly to how chronic disease is managed. One particularly vulnerable population that would benefit from a broader approach to treatment, inclusive of mental health, is the homeless population. Several participants brought up issues regarding a need for more behavioral health providers and services in the community.

"(…) I think there needs to be more work around funding for behavioral health but also funding for recruiting and training therapists and behavioral health specialists to address substance abuse, anxiety, depression and suicidality."

Of particular concern for some participants is the need to have mental health services that will support local communities having experienced traumatic events.

"And I think mental health is another concern. Especially when you're talking about Harvey, the recovery efforts there. This community also had the Sante Fe [school] shooting, so I think that mental health has to be up there as well, from a standpoint of concerns."

One participant observed recent increases and changes within the local population. From the participant's perspective, there should be more programs or services to address the growing need for addressing mental health in the community. Another participant suggested solutions for addressing the need for more behavioral health providers in the community such as expanding residency programs for psychiatrists and developing comprehensive telemedicine programs to provide services more efficiently.

Furthermore, participants recommended addressing behavioral health with younger populations in the schools. Schools that provide behavioral health services through telemedicine have been received well in the community and the perception is that they are effective. Some participants believe that these programs should be expanded and available across the community.

"We're also looking to bring in some non-profit organizations working in the school setting of community schools, Boys and Girls Club, also, looking at working with our mental health task forces and the mental health deputies."

"There [are] the mental health units that have gone out into the schools. They're not school-based but that's the venue they will drive to with their mobile units. They have a big impact. They're seeing

thousands of kids. They've done some telemedicine with mental health, behavioral health, with some of the high schools. From what I've heard, (…) it's been pretty effective and well received."

A challenge that health care providers identified for the medical community is adequately addressing dementia and Alzheimer's within the geriatric population.

"Dementia's a terminal illness. (…) Much more needs to be done with healthcare systems around routine screening and identification of it as an issue. (…) So, that is the first thing that needs to happen. Then there needs to be an understanding that there are things – there are medications that can be helpful to the systems of the dementia. (…) But you can affect it by addressing some of the symptoms."

Substance Abuse was discussed 55 times and was raised by participants 15 times as a need or concern for the health of the community. Multiple unique themes emerged from the key informant interviews related to Substance Abuse: funding for treatment programs, invisibility of alcoholism, overcoming stigma of seeking treatment, and emerging shifts in outreach models. Participants identified funding for programs and availability of services for those who may not be able to afford treatment out-of-pocket as issues the community is facing to address substance abuse. One participant raised alcohol abuse specifically as an issue in the community that does not get the amount of attention of other substance abuse topics but may in fact be impacting a larger proportion of the population and connected to many other health issues. Multiple participants identified cultural stigma as a barrier for those who may benefit from seeking treatment. Stigma or fear may be unique and vary from population to population in the community.

"With substance abuse, it's culture and stigma. Nobody goes to substance abuse treatment on their own. They may not be adjudicated but someone is really, really pushing them, family member, boss. No one goes to treatment if they're not under duress."

A few participants described unique approaches to outreach and substance abuse treatment in the community that would support removing barriers for people having to take the first step on their own.

"For instance, it's pretty new, but there's an initiative that's called the Heroes Project that's looking at overdoses, so when an overdose happens, they're sending a team to the ER. So, it's got a peer support specialist, the EMP is involved – but they actually go in to the ER and they do an intervention there to try to help with linkage to treatment so that we can assist the patients."

Food as Health

Key Issues:
- Food insecurity and limited access to healthy foods
- Diabetes and heart disease linked to socioeconomic factors
- Sedentary lifestyle and driving culture

Secondary Data

The topics of Diabetes and Heart Disease & Stroke emerged as significant health needs. Heart Disease & Stroke rose to the top of the secondary data scoring results for Memorial Hermann Health System. Although Diabetes was not in the top results of the secondary data scoring, an indicator of concern for Brazoria, Fort Bend and Harris counties is the proportion of diabetes in the Medicare population, with values of 29.4%, 30.8% and 28.1% respectively, compared to 26.5% in the U.S. (Table 23).

Table 23. Secondary Data Scoring Results: Diabetes

Indicator	County		Data Score	County Value Compared to:				
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Diabetes: Medicare Population [3] (2015)	Brazoria	29.4 percent	2.5	2	2	3	1.5	3
	Fort Bend	30.8 percent	2.22	3	2	3	1.5	1
	Harris	28.1 percent	1.67	2	1	2	1.5	1.5
	Galveston	27.8 percent	1.78	2	1	2	2	2
[3] Centers for Medicare & Medicaid Services								

As shown in Table 24, another indicator of concern is Stroke in the Medicare Population with proportions of 5.1%, 4.7%, 5.6%, and 5.2% in Brazoria, Fort Bend, Galveston, and Harris counties, respectively, compared to 4% in the U.S. An additional indicator of concern in Brazoria and Galveston counties is Heart Failure in the Medicare Population. In Fort Bend County, the percentage of Hyperlipidemia (46.6%) in the Medicare Population is higher than the national value.

Table 24. Secondary Data Scoring Results: Heart Disease & Stroke

Indicator	County		Data Score	County Value Compared to:				
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) [12] (2010-2014)	Brazoria	38.6 deaths/ 100,000 population	1.25	1	1	2	3	0
	Fort Bend	35.4 deaths/ 100,000 population	0.64	0	0	1	2	0
	Harris	41.5 deaths/ 100,000 population	1.42	1	1	3	3	0
	Galveston	44.4	1.75	2	2	3	3	0

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		deaths/ 100,000 population						

[12] Texas Department of State Health Services

Atrial Fibrillation: Medicare Population [3] (2015)	Brazoria	8.0 percent	1.78	2	2	1	1.5	2
	Fort Bend	6.9 percent	0.94	1	1	0	1.5	2
	Harris	7.3 percent	1.5	1	1	1	1.5	3
	Galveston	8.0 percent	1.78	2	2	1	1	2

[3] Centers for Medicare & Medicaid Services

Heart Failure: Medicare Population [3] (2015)	Brazoria	16.60 percent	2.11	1	2	3	1.5	2
	Fort Bend	13.90 percent	1.06	0	0	2	1.5	1
	Harris	16.00 percent	1.89	1	2	3	1.5	1
	Galveston	17.60 percent	2.44	2	3	3	3	2

[3] Centers for Medicare & Medicaid Services

Hyperlipidemia: Medicare Population [3] (2015)	Brazoria	44.9 percent	1.78	2	1	2	1.5	2
	Fort Bend	46.6 percent	2.17	2	2	2	1.5	3
	Harris	43.2 percent	1.44	1	1	1	1.5	2
	Galveston	42.0 percent	1.5	1	1	1	1	3

[3] Centers for Medicare & Medicaid Services

Hypertension: Medicare Population [3] (2015)	Brazoria	59.3 percent	1.94	2	2	2	1.5	2
	Fort Bend	57.1 percent	1.61	1	1	2	1.5	2
	Harris	55.5 percent	1.22	1	1	2	1.5	1
	Galveston	59.2 percent	1.94	2	2	2	2	2

[3] Centers for Medicare & Medicaid Services

Indicator	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Ischemic Heart Disease: Medicare Population [3] (2015)	Brazoria	**31.0** percent	**1.83**	2	2	3	1.5	0
	Fort Bend	**28.0** percent	**1.22**	0	1	2	1.5	1
	Harris	**28.8** percent	**1.33**	1	2	2	1.5	0
	Galveston	**29.2** percent	**1.72**	1	2	3	3	1
[3] Centers for Medicare & Medicaid Services								
Stroke: Medicare Population [3] (2015)	Brazoria	**5.1** percent	**2.61**	3	3	3	1.5	2
	Fort Bend	**4.7** percent	**2.5**	2	2	3	1.5	3
	Harris	**5.2** percent	**2.61**	3	3	3	1.5	2
	Galveston	**5.6** percent	**2.83**	3	3	3	3	3
[3] Centers for Medicare & Medicaid Services								

Table 25 reveals food-related indicators of concern, including: SNAP Certified Stores in Brazoria, Galveston, and Harris counties (with scores greater than 2); Grocery Store Density in Brazoria County (with score equal to 2); as well as Food Insecurity Rate in Harris County (with score greater than 2).

Table 25. Secondary Data Scoring Results: Nutrition

	County			County Value Compared to:				
Indicator	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Child Food Insecurity Rate [5] (2016)	Brazoria	**20.1** percent	**1**	0	0	3	1.5	0
	Fort Bend	**19.1** percent	**0.67**	0	0	2	1.5	0
	Harris	**23.5** percent	**1.67**	1	2	3	1.5	0
	Galveston	**22.4** percent	**1.33**	1	1	3	3	0
[5] Feeding America								
Children with Low Access to a Grocery Store [17] (2015)	Brazoria	**6.20** percent	**1.67**	2	1.5	1.5	1.5	1.5
	Fort Bend	**7.40**	**1.83**	2	1.5	1.5	1.5	1.5

		percent						
	Harris	**5.40** percent	**1.5**	**1**	**1.5**	**1.5**	**1.5**	**1.5**
	Galveston	**8.10** percent	**1.83**	2	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas								
Fast Food Restaurant Density [17] (2014)	Brazoria	**0.6** restaurants/ 1,000 population	**1.44**	1	1.5	1.5	1.5	2
	Fort Bend	**0.6** restaurants/ 1,000 population	**1.33**	1	1.5	1.5	1.5	1.5
	Harris	**0.7** restaurants/ 1,000 population	**1.67**	**2**	**1.5**	**1.5**	**1.5**	**1.5**
	Galveston	**0.7** restaurants/ 1,000 population	**1.67**	2	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas								
Food Environment Index [4] (2018)	Brazoria	**7.5**	**1.22**	1	0	2	1.5	1
	Fort Bend	**7.4**	**1.22**	1	0	2	1.5	1
	Harris	**7.2**	**1**	**1**	**0**	**2**	**1.5**	**0**
	Galveston	**6.9**	**1.56**	2	0	3	3	1
[4] County Health Rankings								
Food Insecurity Rate [5] (2016)	Brazoria	**14.5** percent	**1.33**	1	1	3	1.5	0
	Fort Bend	**14.8** percent	**1.56**	1	1	3	1.5	1
	Harris	**16.6** percent	**2.06**	**2**	**2**	**3**	**1.5**	**1**
	Galveston	**17** percent	**2**	2	3	3	3	0
[5] Feeding America								
Grocery Store Density [17] (2014)	Brazoria	**0.1** stores/ 1,000 population	**2**	3	1.5	1.5	1.5	1.5
	Fort Bend	**0.1**	**1.83**	2	1.5	1.5	1.5	1.5

		stores/ 1,000 population							
	Harris	0.2 stores/ 1,000 population	1.5	1	1.5	1.5	1.5	1.5
	Galveston	0.2 stores/ 1,000 population	1.39	1	1.5	1.5	1.5	1
[17] U.S. Department of Agriculture - Food Environment Atlas									
People 65+ with Low Access to a Grocery Store [17] (2015)	Brazoria	2.2 percent	1.33	1	1.5	1.5	1.5	1.5
	Fort Bend	1.9 percent	1.17	0	1.5	1.5	1.5	1.5
	Harris	1.4 percent	1	0	1.5	1.5	1.5	1.5
	Galveston	3.5 percent	1.67	2	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas									
SNAP Certified Stores [17] (2016)	Brazoria	0.5 stores/ 1,000 population	2	3	1.5	1.5	1.5	1.5
	Fort Bend	0.4 stores/ 1,000 population	1.89	3	1.5	1.5	1.5	1
	Harris	0.6 stores/ 1,000 population	2.11	3	1.5	1.5	1.5	2
	Galveston	0.7 stores/ 1,000 population	2.11	3	1.5	1.5	1.5	2
[17] U.S. Department of Agriculture - Food Environment Atlas									

Primary Data

Food-related topics emerged in the community input gathered through the survey and key informant interviews. Food Insecurity, Food Programs and Food Knowledge issues were discussed over 170 times during the key informant interviews and were raised by participants 34 times in relation to barriers or challenges to achieving health in the community. The primary themes related to barriers or challenges that emerged in the interviews were access to healthy foods and affordability, knowledge gaps and limited food familiarity and program limitations.

The most common issue raised by key informant participants related to food insecurity was community members not being able to access healthy foods in their community. Multiple participants believed that in many communities, healthy food options were not available to people within a five-mile radius from their home or work. Participants described 'food deserts'

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as a top issue affecting health in the community and how limited access to healthy foods also was closely associated with people also being not being able to afford healthy foods.

"I think the neighborhood conditions can be barriers to healthy living as well. [In] some of the neighborhoods, if they don't have a car, they are on a bus, then there is no market. There might be a dollar store that has some foods available, but there are neighborhoods that do not have healthy food choices, they have a neighborhood little store, and 7-Eleven type of things…"

Participants also discussed the imbalance of healthy food options for those communities with lower housing prices and in general, lower average incomes. One participant described the link between people having to work multiple jobs and having time to shop for and prepare healthy foods.

"We have a grocery store on every corner but not every corner in the poor neighborhoods. It's been my personal experience that eating healthy is expensive. It costs more money to buy healthy fruits and vegetables and more healthy food, in general than it does to buy food that's not so healthy, that's high fat, high carb, high sugar…. It costs more money. It takes longer to prepare. When you have a mom and a dad or either and they're trying to handle two jobs, if not three. They've got kids of varying ages. The mechanics of shopping and preparing meals is probably an activity that gets let go."

Some participants had direct experience with educating the community about healthy foods and eating. These participants shared that some community members have limited knowledge of fresh fruits and vegetables and would benefit from early education for parents and children in schools.

In Memorial Hermann's community survey, 67% of respondents selected Diabetes as one of the top issues most affecting the quality of life in their community. During key informant interviews, Diabetes was discussed 64 times and was raised by participants 32 times as a health need or concern in the community. For those participants who raised Diabetes as a top health issue in the community, unique themes emerged regarding how diabetes is impacting specific groups in the community and the way a sedentary lifestyle impacts diabetes. Multiple participants attributed the surge in obesity and diabetes in general in the U.S. to a shift to a more sedentary lifestyle while others specifically identified the local climate and driving culture as key factors leading to an increase in sedentary lifestyles impacting the region.

Heart Disease & Stroke was discussed 34 times during the key informant interviews and was raised by participants 16 times as a health need or concern in the community. For those participants who raised Heart Disease & Stroke as a top health issue in the community, the unique themes that emerged in the interviews were chronic disease risk related to socioeconomic status and challenges with managing heart-related conditions.

"You have so many communities that are food deserts so, of course, I think we are all at risk for things like diabetes and hypertension, obesity, stroke – but, I think in addition to that, those that are most are already marginalized. People who are low income. Low socioeconomic status. So, education, and all of

those indicators are probably even more at risk for chronic diseases than someone, for example, who has access to care and insurance. So, they probably are doubly at risk."

Exercise Is Medicine

Key Issues:
- Obesity
- Walkability of communities
- Safety of outdoor spaces and places to exercise

Secondary Data

Exercise, Nutrition & Weight was the third highest-ranking topic in the secondary data results for Fort Bend County, fourth for Brazoria County and fifth for Memorial Hermann Health System. Although Exercise, Nutrition & Weight did not rise to the top of the secondary data scoring results for Harris County, there are indicators of concern for all four counties (Table 26). An exercise-related indicator of concern with score above 2 is: Workers Who Walk to Work (Brazoria, Fort Bend and Harris counties).

Table 26. Secondary Data Scoring Results: Exercise, Nutrition & Weight

| Indicator | County | | Data Score | County Value Compared to: | | | | |
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Adults (18+ Years) Who Are Obese [10] (2016)	Brazoria		---	---	---	---	---	---
	Fort Bend		---	---	---	---	---	---
	Harris	**32.0 percent**	**1.67**	**1.5**	**1**	**2**	**2**	**2**
	Galveston		---	---	---	---	---	---

[10] Texas Behavioral Risk Factor Surveillance System

| Indicator | County | | Data Score | County Value Compared to: | | | | |
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Child Food Insecurity Rate [5] (2016)	Brazoria	**20.1 percent**	**1**	0	0	3	1.5	0
	Fort Bend	**19.1 percent**	**0.67**	0	0	2	1.5	0
	Harris	**23.5 percent**	**1.67**	1	2	3	1.5	0
	Galveston	**22.4 percent**	**1.33**	1	1	3	3	0

[5] Feeding America

Indicator	County		Data Score	County Value Compared to:				
Children with Low	Brazoria	**6.20**	**1.67**	2	1.5	1.5	1.5	1.5

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Access to a Grocery Store [17] (2015)		percent		2				
	Fort Bend	7.40 percent	1.83	2	1.5	1.5	1.5	1.5
	Harris	5.40 percent	1.5	1	1.5	1.5	1.5	1.5
	Galveston	8.10 percent	1.83	2	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas								
Fast Food Restaurant Density [17] (2014)	Brazoria	0.6 restaurants/ 1,000 population	1.44	1	1.5	1.5	1.5	2
	Fort Bend	0.6 restaurants/ 1,000 population	1.33	1	1.5	1.5	1.5	1.5
	Harris	0.7 restaurants/ 1,000 population	1.67	2	1.5	1.5	1.5	1.5
	Galveston	0.7 restaurants/ 1,000 population	1.67	2	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas								
Food Environment Index [4] (2018)	Brazoria	7.5	1.22	1	0	2	1.5	1
	Fort Bend	7.4	1.22	1	0	2	1.5	1
	Harris	7.2	1	1	0	2	1.5	0
	Galveston	6.9	1.56	2	0	3	3	1
[4] County Health Rankings								
Food Insecurity Rate [5] (2016)	Brazoria	14.5 percent	1.33	1	1	3	1.5	0
	Fort Bend	14.8 percent	1.56	1	1	3	1.5	1
	Harris	16.6 percent	2.06	2	2	3	1.5	1
	Galveston	17 percent	2	2	3	3	3	0
[5] Feeding America								
Grocery Store Density	Brazoria	0.1	2	3	1.5	1.5	1.5	1.5

[17] (2014)		stores/ 1,000 population		2	1.5	1.5	1.5	1.5
	Fort Bend	0.1 stores/ 1,000 population	1.83	2	1.5	1.5	1.5	1.5
	Harris	0.2 stores/ 1,000 population	1.5	1	1.5	1.5	1.5	1.5
	Galveston	0.2 stores/ 1,000 population	1.39	1	1.5	1.5	1.5	1

[17] U.S. Department of Agriculture - Food Environment Atlas

People 65+ with Low Access to a Grocery Store [17] (2015)	Brazoria	2.2 percent	1.33	1	1.5	1.5	1.5	1.5
	Fort Bend	1.9 percent	1.17	0	1.5	1.5	1.5	1.5
	Harris	1.4 percent	1	0	1.5	1.5	1.5	1.5
	Galveston	3.5 percent	1.67	2	1.5	1.5	1.5	1.5

[17] U.S. Department of Agriculture - Food Environment Atlas

SNAP Certified Stores [17] (2016)	Brazoria	0.5 stores/ 1,000 population	2	3	1.5	1.5	1.5	1.5
	Fort Bend	0.4 stores/ 1,000 population	1.89	3	1.5	1.5	1.5	1
	Harris	0.6 stores/ 1,000 population	2.11	3	1.5	1.5	1.5	2
	Galveston	0.7 stores/ 1,000 population	2.11	3	1.5	1.5	1.5	2

[17] U.S. Department of Agriculture - Food Environment Atlas

Workers who Walk to Work [1] (2012-2016)	Brazoria	0.80 percent	2.78	3	3	3	3	2
	Fort Bend	0.60 percent	2.67	3	3	3	3	1.5
	Harris	1.50 percent	2.17	2	2	3	3	1.5
	Galveston	2.00 percent	1.56	1	0	3	3	1

[1] American Community Survey

Primary Data

Over 60% of Memorial Hermann's community survey respondents noted Obesity as a top issue affecting the quality of life in their community. In key informant interviews, Exercise, Nutrition & Weight was discussed almost 170 times and was raised by participants 42 times as a need or concern for achieving health in the community. The primary barriers related to Exercise, Nutrition & Weight identified by participants were walkability, access to safe outdoor spaces and programming that may not meet the needs of communities facing financial limitations.

Several participants discussed barriers to healthy lifestyle changes and described communities where sidewalks are limited or pedestrian pathways are not available. The ability for community members to make small shifts in their daily lives, such as walking regularly, may be more feasible than undertaking an exercise regimen. The limitations of pedestrian pathways and safer walking spaces prevent those in some sections of the community from making these shifts.

For individuals who may not be able to afford gym memberships nor attend classes due to work schedules, outdoor activities and fitness areas offer a free alternative. Participants felt that in many neighborhoods, these outdoor spaces are not available due to disrepair or unsafe environments.

"And for the activity part of it, it's also an access factor for a lot of people. When we did our survey, one of the responses we had [was that] people couldn't afford gym memberships, and they may not have a safe place to exercise in their communities, if they live in a higher crime area, the kids don't go outside, they stay in the house where their parents feel that they're safe."

"I think the built environment is huge, too. If you live out in a planned community, they usually have walking trails, or they have a pretty fountain area for you to walk around it. They have those little exercise things that you stop on part way around the trail and you do your little push-ups and your sit-ups and your pull-ups (…) You go into these poorer areas and there's no sidewalks. There's no lights at night. There's a park—it's all rusted equipment."

Participants also described programs and facilities that are either limited or lacking. These programs included free exercise programs with child care options, youth sports leagues and recess in the schools and free or low-cost options for air-conditioned facilities during times of the year when the weather does not permit outdoor activities.

"In poor areas of Houston, there's just not a lot of parks. There's no little league, and there's no soccer leagues, and so, there's not a lot of recess in the schools. There's just not—the culture among the kids is just not being created around physical activity."

Non-Prioritized Significant Health Needs

The following additional significant health needs emerged from a review of the primary and secondary data. With the need to focus on the prioritized health needs described above, these topics are not specifically prioritized efforts in the 2019-2022 Implementation Strategy. However, due to the interrelationships of social determinant needs many of these areas fall, tangentially, within the prioritized health needs and will be addressed through the upstream efforts of the prioritized health needs. Additionally, many of them are addressed within ongoing programs and services. Examples of these efforts are provided below by topic area.

Older Adults and Aging

Secondary Data

The secondary data scoring results revealed the topic of Older Adults and Aging as a significant health need for Brazoria, Fort Bend, Galveston, and Harris counties. Older Adults and Aging was in the top 5 highest-ranking topics for Brazoria and Galveston counties' secondary data results and in the top 10 topics for Fort Bend County. Older Adults and Aging received a topic score of 1.5 in the secondary data results for Harris County.

In Brazoria County, indicators with scores greater than 2 included: Stroke, Diabetes, Chronic Kidney Disease, and Heart Failure (all in the Medicare Population). In Fort Bend County, indicators of concern included Stroke, Diabetes, Chronic Kidney Disease, and Hyperlipidemia (all in the Medicare Population). Concerning indicators in Galveston County include: Chronic Kidney Disease, Stroke, Heart Failure, Depression, and Alzheimer's Disease or Dementia (all in the Medicare Population). Indicators of note in Harris County included: Chronic Kidney Disease and Stroke (both in the Medicare Population) as well as Age-Adjusted Death Rate due to Falls.

Primary Data

Key informants and stakeholders discussed Older Adults and Aging. Over 62% of participants in Memorial Hermann Health System's prioritization process cited Older Adults as one of the groups most affected by poor health outcomes. Interviews with key informants noted the growing population of older adults and needs related to specialized care, financial assistance and outreach. Participants also mentioned existing senior programs and services.

"…[W]e are going to watch the literal doubling of the number of Americans over the age of 65 in the next 25 years. Every day, between now and 2030, day after day, 10,000 Americans will turn 65, so we are watching an extraordinary expansion of challenges of aging. (…) [M]ore and more Americans are going to be getting old, so caring for this massive increase in the aging population is going to be one of the great challenges I think."

"UTMB has a senior citizens' center, and they have an institute for life-long learning, where they offer a lot of informational and educational classes for seniors."

Efforts

Memorial Hermann Health System includes two freestanding Rehabilitation Hospitals (TIRR and Katy) as well as a senior living facility (University Place), featuring independent living, personal assistance services, and a separate, but attached, nursing center.

Additional community outreach includes health education on: Alzheimer's disease, Discounted Diabetes Education, Education/outreach for Seniors, Injury Prevention, Fall Prevention, and support groups for various populations, including: Alzheimer's, Amputees, Cardiac patients, Chronic disease, Diabetics, Grief, Parkinson's disease, Stroke, Survivorship, and more.

Cancers

Secondary Data

Although Cancer was not one of the top ten topics in the secondary data scoring results for Brazoria, Fort Bend, Galveston, and Harris counties, there are certain indicators to note. In Brazoria County, the Colorectal Cancer Incidence Rate (42.5 cases per 100,000 population) is higher than the state and U.S. values (38.1 and 39.2, respectively). In Fort Bend County, indicators with indicator scores equal to or above 1.5 are Cancer in the Medicare Population and Prostate Cancer Incidence Rate. In Galveston County, there are indicators with scores greater than 2: Age-Adjusted Death Rate due to Prostate Cancer, Age-Adjusted Death Rate due to Colorectal Cancer, and Age-Adjusted Death Rate due to Cancer. In Harris County, several indicators are of concern including: Cervical Cancer Incidence Rate and Age-Adjusted Death Rate due to Breast Cancer (both with indicator scores above 2), Cancer in the Medicare Population, Colon Cancer Screening, and Age-Adjusted Death Rate due to Prostate Cancer.

Primary Data

In Memorial Hermann's community survey, over one third of respondents noted Cancer as a top issue affecting the quality of life in their community. Interviews with key informants revealed the importance of making cancer screening services and specialty care available and accessible (e.g., telehealth, mobile mammography).

Efforts

As leading providers of cancer treatment in Houston, Memorial Hermann Cancer Centers are committed to cancer treatment, prevention, and research. Their broad geographical coverage makes cancer treatment extremely accessible and convenient to where patients live or work. All eight Memorial Hermann Cancer Centers are approved by the American College of Surgeons Commission on Cancer (ACoS CoC); only 25 percent of hospitals across the country have received this special recognition. With guaranteed access to comprehensive care, collaborative team approach for coordinating the best available treatment options, state-of-the-art equipment and services, education and support, and lifelong patient follow-up through the Cancer Registry, patients are able to access a full menu of therapies and treatment options.

Additional outreach includes education and support groups for cancer patients: Art, Self-guided Art Therapy, Lymphedema, Brest Cancer, Oncology Nutrition Therapy, Stress Relief, Look Good Feel Better, Yoga, Meditation, and Healthy Eating Advices.

Education

Secondary Data

Education received a topic score of 1.56 in the secondary data results for Harris County. There are several education-related indicators to consider: Infants Born to Mothers with Less Than 12 Years of Education (with a value of 27.5% in Harris County, compared to 21.3% in Texas and 15.9% in the U.S.), Student-to-Teacher Ratio, High School Drop Out Rate, and People 25+ with a High School Degree or Higher. Although the topic of Education did not receive a high score in the secondary data results for Galveston County, there is an indicator to note (with score greater than 2): the Student-to-Teacher Ratio, which at 16.7 students per teacher is higher than the Texas value (15.4).

Primary Data

During key informant interviews, the topic of Education came up frequently and in relation to different focus areas and target audiences, including children, general community members as well as providers. The link between individuals' level of education and quality of life was emphasized. Key informants recommended finding opportunities to expand the availability of education (related to health and non-health topics) as well as integrating health education into existing activities in both clinical and non-clinical settings, such as schools and churches. Key informants noted that education (for example, related to healthy eating) must be provided to both children and adults in order for the information to be applied successfully. Opportunities were also pointed out to educate healthcare providers (and provide continuing education) on available community linkages and resources and on how to initiate conversations with patients regarding different health topics.

"We want to go into different groups and educate them on what they should be doing or shouldn't be doing. (…) I think education is a huge component but we've got to figure out how to integrate that. The education, without the integration into somebody's lifestyle, doesn't do them any good."

"The kids do receive education in school, but that doesn't necessarily go back home to their parents, nor do they listen to their children when they do bring it up…"

"…it is the whole family. The mom might be the one who's cooking, and the kids are eating, dad's buying fast food—it involves everybody."

Efforts

Memorial Hermann operates ten Health Centers for Schools, established in 1996, offering access to primary medical, dental and mental health services to underserved children at 82 schools in the Greater Houston Area. Research shows that school-based health centers increase educational success by providing medical and mental health care that allows students to stay in school and learn. The primary goal of the program is to keep children healthy and feeling well so that they stay in school and can perform well academically, creating a foundation for a brighter future. By providing improved access to health care to at-risk children across the region, Memorial Hermann has demonstrated success in creating healthier outcomes for kids,

including improvements in their physical health, their mental wellbeing, and even their attendance rate at school.

Transportation

Secondary Data

For Brazoria, Fort Bend and Harris counties, Transportation rose to the top of the secondary data scoring results, with a topic score of 2.11 in Brazoria County, 1.83 in Fort Bend County and 1.82 in Harris County. In all three counties, indicators of concern include: Solo Drivers with a Long Commute, Mean Travel Time to Work, and Workers who Walk to Work. In addition to these, Brazoria County has additional indicators to note: Workers Who Drive Alone to Work and Workers Commuting by Public Transportation; in Fort Bend County, an additional indicator to note includes Workers who Drive Alone to Work (with an indicator score of 1.94). Furthermore, there exist high disparities for a few of these indicators. Transportation was the fourth highest-ranking topic in Galveston County's secondary data results; indicators scoring above 2 include: Solo Drivers with a Long Commute and Mean Travel Time to Work.

Primary Data

Participants raised the topic of Transportation 59 times in relation to barriers or challenges to achieving health in the community – more than any other topic. Key informants repeatedly noted that the Houston region has significant transportation issues (including availability, accessibility) that impact community members' ability to access health programs and services, and noted the challenges of residents living in rural counties. In addition to limited options for public transportation, travel cost and time were brought up. Moreover, for certain populations, like older adults or people with disabilities, public transportation is not a feasible option.

"This remarkable spread-out city, the size of Massachusetts, is the Greater Houston Metropolitan Area. (…) This is not a city and a suburb anymore, it's a metropolitan region with eight to ten centers of activity that are larger than downtown San Diego, spread out over this massive area, but getting from one place to another is an increasing challenge. Poverty also means inadequate transportation, we have no really good transit system because it's almost impossible to develop a good transit system for a city so lacking in density and so spread out as Houston is. We haven't solved that problem, and a lot of the healthcare issues come because people [are] without a car trying to get to a hospital, or to healthcare…"

"…we live in a rural community and the lack of transportation to get from one place to another is very difficult."

"You and I have cars, but not everybody has a car, and the bus system here is complicated so if you are trying to go from one end of town to the next, it might take you two or three buses. Transportation can be an issue."

Efforts

Memorial Hermann provides bus and taxi tokens as required for discharge and continuity of care needs.

One Memorial Hermann strategic effort to not only provide the right care at the right time in the right place, but also provide the opportunity to access help/care via the telephone is the Memorial Hermann Nurse Health Line. Established in 2014, the Nurse Health Line is a free telephone service for Greater Houston residents who are experiencing a health concern and are unsure of what to do or where to go. Experienced, bilingual nurses use their training and expertise to conduct assessments by phone, and are available to answer calls 24 hours a day, seven day a week for any resident living in Harris or surrounding counties. They help callers decide when and where to go for medical care and assist with social service referrals and transportation needs.

Children's Health

Secondary Data

Children's Health received a topic score of 1.58 in Galveston County and 1.52 in Harris County. In Galveston County, approximately 8% of children have low access to a grocery store. Also, the Substantiated Child Abuse Rate (9.5 cases per 1,000 children) is higher than Texas (8.5). Particular indicators to note in Harris County include: Children with Health Insurance, Child Food Insecurity Rate, and Children with Low Access to a Grocery Store. Close to 10% of children in Harris County do not have health insurance. Although Children's Health did not receive a topic score above 1.5 in Brazoria and Fort Bend counties, for both counties an indicator above 1.5 is: Children with Low Access to a Grocery Store.

Primary Data

When discussing Children's Health, key informants pointed out specific issues such as childhood obesity, access to services, childcare, and being uninsured. Some participants advised efforts to engage children, families and communities more comprehensively.

"Texas ranks very low in dollars spent on health for children. We rank low in our ranking, generally, in children's health. We're not putting enough money and resources into it. I think we need to shift our attention and (…) give more attention to children's health and how important it is for early childhood development and for brain development and ongoing health in the rest of their lives. I would say put that as a priority. Put children's health as a priority. Not just saying the early years, not just saying zero to five but also throughout early adolescence, pre-adolescence, early adolescence and into the teens."

Efforts

Children's Memorial Hermann Hospital, licensed under Memorial Hermann Texas Medical Center, was founded in 1986 and is the primary teaching hospital for the pediatric and obstetrics/gynecology programs at The University of Texas Medical School at Houston. Children's Memorial Hermann offers care in more than thirty pediatric and women's related specialties including the latest advances in maternal-fetal medicine and neonatal critical care services, and renowned programs in pediatric trauma, neurosciences, pulmonology and cardiac care. More than 37,000 children come to Children's Memorial Hermann Hospital each year. In addition to Memorial Hermann's school-based health efforts described above, Memorial Hermann is an on-going financial collaborator with Children at Risk, a 501 non-profit

organization that drives change for children through research, education, and influencing public policy.

Economy

Secondary Data

With a topic score of 1.55, Economy was one of the top ten topics in the secondary data scoring results for Harris County. In particular, eight economic indicators had scores above 2: Homeownership, Severe Housing Problems, Students Eligible for the Free Lunch Program, Median Monthly Owner Costs for Households without a Mortgage, SNAP Certified Stores, Median Household Gross Rent, Families Living Below Poverty Level, and Food Insecurity Rate. Eight additional indicators received scores between 1.5 and 2.

Although Economy was not a main topic for Brazoria, Fort Bend and Galveston counties, there are several economic indicators to note (with scores of 1.5 or above): Median Household Gross Rent (all three counties), Median Monthly Owner Costs for Households without a Mortgage (all three counties), Mortgaged Owners Median Monthly Household Costs (all three counties), SNAP Certified Stores (all three counties), Unemployed Workers in a Civilian Labor Force (all three counties), Food Insecurity Rate (Fort Bend and Galveston counties), and Low-Income and Low Access to a Grocery Store (Brazoria and Fort Bend counties). Additional concerning indicators for Galveston County include: Homeowner Vacancy Rate, Homeownership, and Female Population 16+ in Civilian Labor Force.

Primary Data

Key informants discussed food insecurity and food deserts as factors related to poor health outcomes. They pointed out that, although individuals might understand that eating healthy foods is recommended, they may not have access to grocery stores or be able to afford healthier food options. Key informants noted the importance of addressing socioeconomic barriers to improve health and wellbeing. Existing programs and services for uninsured and poor community members were mentioned along with events such as the Annual Poverty Summit.

" (…) That's a matter of money. You can educate [a] woman all day long, but if she's got a couple of kids to feed and she can feed them all for seven dollars as opposed to 25, she's going to go to McDonald's."

Efforts

It's a daunting task in a region like Greater Houston, which has an estimated 7 million people and one of the highest rates of uninsured and underinsured in the country. But Memorial Hermann believes that we can ONLY impact the health of our community, and the health of individuals, by focusing on the multiple determinants of health that play the greatest role in influencing a person's overall health and wellbeing.

Other Findings

Critical components in assessing the needs of a community are identifying barriers and disparities in health care. The identification of barriers and disparities helps inform and focus strategies for addressing prioritized health needs. The following section outlines barriers across Memorial Hermann Health System and disparities as they pertain to MH Southeast's service area.

Barriers to Care

Community input revealed a wide range of barriers to care and wellbeing. As discussed in the previous section, transportation was the most frequently cited barrier in the community, followed by other barriers such as access to health services, healthy food and exercise options, low income, and food insecurity. Overall, the secondary and primary data confirmed that socioeconomic factors impact community members' ability to achieve good health.

"Many things come back to poverty and lack of disposable income."

Key informants described the influence of social determinants of health (including income, poverty, language, education, employment) on health outcomes. Participants discussed the importance of addressing social and economic factors to get at the root causes of poor health and wellbeing.

"I think you have to understand that a lot of folks work from paycheck to paycheck, so if they actually end up at one of these medical centers and they require a thirty dollar copay or ten dollars or fifteen dollars, then they're not going to have it. So, they're going to walk away until they do have that money and that could be months later. So, if they are sick, they're just going to become sicker. So, that's one of the big barriers."

Disparities

Significant community health disparities are assessed in both the primary and secondary data collection processes. Table 27 identifies the number of secondary data health indicators with a health disparity for MH Southeast's service area. See Appendix B for the specific indicators with significant disparities.

Table 27. Number of Health Disparities Identified in Secondary Data Analysis

Brazoria County	Fort Bend County	Galveston County	Harris County
Hispanic or Latino (6) Other Race (6)	Hispanic or Latino (7) Other Race (7) Black or African American (6) White (4)	Black or African American (12) Other Race (6) Hispanic or Latino (5)	Black or African American (13) White (8) Hispanic or Latino (8) Other Race (7) American Indian or Alaska Native (6)
Male (5)	Male (5)	Male (5)	Male (10) Female (3)
65+ years of age (2)	65+ years of age (2)	60-64 years of age (2)	<6 years of age (2)

Brazoria County	Fort Bend County	Galveston County	Harris County
		65+ years of age (2)	25-44 years of age (2)
			45-64 years of age (2)
			65+ years of age (2)

Geographic disparities were identified using the SocioNeeds Index. As shown earlier in Table 13, zip codes 77506, 77051, 77033, 77087, 77587, 77502, 77017, 77061 (all within Harris County), and 77053 (in Fort Bend County) were identified as zip codes with the highest socioeconomic need, potentially indicating poorer health outcomes for residents in those areas. The zip codes with the largest proportion of inpatient discharges at MH Southeast, zip codes 77089 and 77581, have SocioNeeds Index values of 59.4 and 15.4, respectively.

Conclusion

The Community Health Needs Assessment for MH Southeast utilized a comprehensive set of secondary data indicators to measure the health and quality of life needs for MH Southeast's service area. Furthermore, this assessment was informed by input from knowledgeable and diverse individuals representing the broad interests of the community. Memorial Hermann's system-wide prioritization process resulted in four focus areas or pillars: Access to Healthcare, Emotional Well-Being, Food as Health, and Exercise Is Medicine. MH Southeast will review these priorities more closely during the Implementation Strategy development process and design a plan for addressing these pillars moving forward.

In addition, MH Southeast invites your feedback on this CHNA report to help inform the next Community Health Needs Assessment process. If you have any feedback or remarks, please send them to: Deborah.Ganelin@memorialhermann.org.

Appendix

Appendix A. MH Southeast Impact Report

Evaluation Since Prior CHNA

Priority 1: Healthy Living

Priority 1: Healthy Living				
Goal 1: Serve and be recognized as the community resource for preventative medicine.				
Early Detection & Screening **Objective 1.1: Identify and treat chronic conditions early to prevent inappropriate ER admissions and disease advancement**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of health fairs offered	20	25	11	22/year
• Number of participants in Diabetes Prevention Program	30	0	0	30
• Number of Health and Wellness articles	16	6	38	16
• Number of Health and Wellness webinars	2	3	0	2
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
1.1.1: Conduct quarterly community outreach via health fairs, employer events, speaker bureaus, lunch and learns. Screen for: head and neck, skin cancer, oral cancer, smoking cessation, BP, BMI, bone density, signs of stroke				1, 2, 3
1.1.2: Partner with community partners (YMCA and others) to underwrite Diabetes Prevention Program		Unable to underwrite DPP due to marketing budget reduction	MHSE has not been able to start a diabetes prevention program.	1, 2, 3
1.1.3: Education and Outreach: Provide Health and Wellness articles in biannual newsletter, online webinars with physicians (recorded and archived on website)			This has been discontinued due to a lack of response from the community	1, 2, 3
1.1.4: Explore support for post-partum depression (investigate needs, partners)				2, 3
		Monitoring/Evaluation Approach: • Sign in sheets for health fairs • Participant roster/list for Diabetes Prevention Program • Count of articles and webinars		

		Priority 1: Healthy Living
		Goal 1: Serve and be recognized as the community resource for preventative medicine.
		Potential Partners: • YMCA • Employers • Other CBO's (community based organizations)

Obesity Prevention
Objective 1.2: Prevent and reduce obesity and its related conditions/comorbidities

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of nutrition focused classes offered (bariatric surgery, pediatric nutrition, general nutrition/weight management)	78	4	70	81, 85, 90 (5%/year)
• Number of participants in bariatric and breastfeeding support groups	200	22	16	5%/year
• Number of participants in Pediatric Weight Management Program	Establish baseline Y1	0	12	TBD
• Number of participants in the YMCA health cooking classes	Establish baseline Y2		0	TBD
• Industrial employers engaged in nutrition counseling	1 Industrial employer	1	2	3, 6, 9
• Number of employees participating across all employers	95	138	15	3%/year

Strategies:	Year 1 Notes	Year 2 Notes	Timeline: Year 1,2,3
1.2.1: Host pre and post support group for Bariatric surgery patients			1, 2, 3
1.2.2: Provide nutrition outreach at community events, like Healthy Kids Day			1, 2, 3
1.2.3: Facilitate employer Wellness and Nutrition talks (Lunch and Learns, hosted by physicians and dieticians/nutritionists)			1, 2, 3
1.2.4: Provide support groups for breastfeeding and link to community resources (e.g., Lactation Foundation)			1, 2, 3
1.2.5: Conduct prenatal outreach on the benefits of breastfeeding and maternal health; provide free prenatal guide to all OB providers to standardize education for mothers throughout conception, pregnancy, and post-partum			1, 2, 3
1.2.6: YMCA: currently strategizing to use teaching kitchen to offer healthy cooking classes; intend to pilot and add exercise component		MHSE does not offer this YMCA classs	2, 3
1.2.7: Partner with industrial employers to provide nutrition visits and 1:1 counseling with dietician on-site			1, 2, 3
1.2.8: Offer free Pediatric Weight Management Program to kids and parents in a bilingual format, promoted via schools and pediatricians. Topics include: packing healthy lunch, exercise and conclude with program graduation	Unable to underwrite due to marketing budget reduction		1, 2, 3
1.2.9: Provide classrooms for WIC instructors to teach their patients (Medicaid moms) and Southeast's Spanish-speaking patients about prenatal care and breastfeeding			2, 3

Monitoring/Evaluation Approach:
- Class rosters and sign in sheets
- Classroom utilization calendar
- Scheduling of employer sites/employees for counseling

		Potential Partners: • YMCA • Local Schools • WIC • State Dept of Health

Priority 1:   Healthy Living

Goal 1:   Serve and be recognized as the community resource for preventative medicine.

Access to Healthy Food					
Objective 1.3: Enhance access to healthy food for all patients in the Southeast community					
Outcome Indicators:		**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
•	Money raised to support local food pantries	$25,000	$20,948	0	TBD
•	Pounds of food/families served via food drives	Establish baseline Y1	270 pounds of food	0	TBD
•	Number of ER patients screened for food insecurity via the ER Navigation program	1,823	2,997	2,897	1,823
•	Number of CHW referrals to community food pantries via the ER Navigation program	478	147	993	478
•	Number of supported special events hosted by community partners	2	Included in system area events	30	4
•	Number of participants in YMCA Diabetes Management classes	50	0	0	100
•	Number of YMCA Diabetes Management classes	6/year	0	0	6/year
Strategies:			**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.3.1:	Continue to participate in the MH ER Navigation program in which participants are screened for food insecurity and referred to food pantries if necessary				1, 2, 3
1.3.2:	Collect food to support food pantries or special events hosted by community partners to improve access to healthy foods			Annual Food Drive discontinued	1, 2, 3
1.3.3:	Support system-wide Food Drive/Pantry which provides financial support to local pantries; and provide financial support to ten local pantries			Annual Food Drive discontinued	1, 2, 3
1.3.4:	Underwrite YMCA for Diabetes Management program which includes vouchers for local food pantries to provide access to local fruits and vegetables		Unable to underwrite DPP due to marketing budget reduction	Budet reduction	1, 2, 3

Monitoring/Evaluation Approach:
- YMCA report
- Patient activity documented and reported within the ER Navigation electronic record system

Potential Partners:
- YMCA
- School districts
- Cleveland Ripley Neighborhood Center
- Harbach Ripley Neighborhood Center
- Clearlake Food Pantry
- Pearland Neighborhood Center
- Pasadena Community Ministries
- LINC's Pasadena Pantry
- Memorial Hermann Community Benefit Corporation

Time for/Safety During Physical Activity Objective 1.4: Prevent injuries and promote active lifestyles				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of sports physicals conducted each year	Establish baseline in Year 2		750	150/year
• Number of patients seen at Saturday morning injury clinics	5	32	30	10 per week in football season per year
• Number of concussion education sessions taught	Establish baseline in Year 2		2	3/year
• Number of participants in Concussion Education Program	Establish baseline in Year 2		45	Target TBD
• Number of bicycle helmets provided	Establish baseline in Year 2		0	Target TBD
• Number of classes held for expectant mothers	150	441	75	Increase by 3% each year
• Number of participants in classes for expectant mothers	Establish baseline Year 1	835	627	TBD
• Number of events for Shattered Dreams and Live Your Dream	Establish baseline in Year 2		0	1/year
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
1.4.1: Schools: Provide sports physicals at local schools for student athletes				2, 3
1.4.2: Offer concussion education to promote awareness and prevent injury/reinjury				2, 3
1.4.3: Provide Saturday morning injury clinics where sports medicine doctors are available to prevent/treat school athletes				2, 3
1.4.4: Partner with the MH Trauma Institute to provide bicycle helmets for kids			Program was not implemented as planned	2, 3
1.4.5: Partner with YMCA to provide injury prevention education through Livestrong Program (See 1.5.6)				1, 2, 3
1.4.6: Drowning prevention: conduct outreach at events, provide educational materials from Trauma Institute				2, 3
1.4.7: Offer on-site (low cost) classes for expectant mothers				1, 2, 3
1.4.8: Partner with local schools to deliver drunk driving/distracted driving education (Shattered Dreams and Live Your Dream)			Program was not implemented as planned	2, 3

Priority 1: Healthy Living		
Goal 1: Serve and be recognized as the community resource for preventative medicine.		
		Monitoring/Evaluation Approach: • Class rosters • Class schedules • Sign in sheets • Count of helmets distributed
		Potential Partners: • Schools • MH Trauma Institute

Chronic Disease Management

Objective 1.5: Help patients manage chronic diseases to prevent decline in overall health and well-being

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of new patient consults in Diabetes Clinic	Establish baseline in Year 1	0	62	50/year
• Number of ongoing disease management patients in Diabetes Clinic	Establish baseline in Year 1	0	62	50/year
• Number of participants in post stroke support group/number of offerings	8 attendees per quarter	56	62	15 – 20 per meeting (year 2 bi monthly)
• Number of post discharge patients reached	Establish baseline in Year 1	0	320	35% (increase by 3% in year 2, 3)
• Number of participants in Bariatric Support Group/number of offerings	12 with 381 participants	11	113	Increase 5% year over year
• Number of patients seen in Pharmacy Wellness Clinic	20	56	875	75/year

Strategies:		Year 1 Notes	Year 2 Notes	Timeline: Year 1,2,3
1.5.1:	Host post stroke support group for patients and families			1, 2, 3
1.5.2:	Conduct post-discharge callbacks to ensure compliance with recommended treatment			1, 2, 3
1.5.3:	Provide outpatient consults in Diabetes Education clinic	MHSE did not have a Diabetes Educator in FY17		1, 2, 3
1.5.4:	Host Bariatric Support Group for surgical patients and their families to ensure compliance with weight loss program	Data Collection Underway		1, 2, 3
1.5.5:	Pharmacy Medication and Wellness Therapy clinic for patients: Medical evaluation, education for complex drug therapies, prevention for infectious disease screenings and flu vaccine administration, tobacco cessation counseling. 2 visits free of charge			1, 2, 3
1.5.6:	Partner with community partners (YMCA and others) to underwrite Livestrong Survivor Program (see 1.4.5)	YMCA program was not funded for FY17		1, 2, 3
		Monitoring/Evaluation Approach: • Patient direct portal (electronic) • Class schedules • Rosters/sign in sheets		
		Potential Partners: American Diabetes Association (ADA)		

Priority 2: Access to Health Care

Priority 2:	Health Care Access
Goal 2:	**Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.**

Availability of Primary Care and Specialty Providers
Objective 2.1: Increase the availability of primary care and specialty providers in local settings

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of new specialty recruits/hires MHMG	13.5	6	4	22
• Number of patients referred to lactation consultants	91 participants per year	1,274	120	3% year over year growth
• Number of appointments made with PCP's and specialty preventive care services at outreach fairs	Establish baseline Y1	19	0	TBD
• Number of Telemedicine Consultations	750	1,237	1,323	750

Strategies:		Year 1 Notes	Year 2 Notes	Timeline: Year 1,2,3
2.1.1:	Partner with UT Health and their Physician Group to recruit and align subspecialists with community needs and provide services in the community. (UT provides desired academic affiliation and Southeast provides local clinical practice)			1, 2, 3
2.1.2:	Offer PCP outreach fairs and events where community members can sign up for appointment with PCP, specialty preventive care services (e.g., mammograms, colonoscopies).		PCP appointments were not made at Health Fairs this year due to reduction in force.	1, 2, 3
2.1.3:	Provide dedicated lactation consultants at no charge to evaluate patients for additional care needs and connect them to appropriate resources. (WIC, Lactation Foundation, etc.)			1, 2, 3
2.1.4:	A project of Memorial Hermann-Pearland, the Telemedicine Program provides 24/7 neurological consultations in our network hospitals, through the use of telemedicine technologies such as digital imaging and real-time video conferencing providing patients with continuity in treatment, a fast-tracked process, and the most effective drug therapies.			1, 2, 3
		Monitoring/Evaluation Approach: • Monthly reports for who is onboarded • List of patient referrals to lactation consultants		

Priority 2:	Health Care Access	
Goal 2:	**Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.**	
		Potential Partners: • ACO • WIC • Lactation Foundation • UT Teleneurology

Health Insurance Coverage and Costs Objective 2.2: Facilitate coverage of prescription medication for uninsured children				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of class D prescriptions to two Pasadena school-based health centers	619	630	1,261	619
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
2.2.1: Provide class D Prescriptions to the WAVE and Kruse School-Based Health Centers in support of primary medical care provided to uninsured children and teens at no cost				1, 2, 3
		Monitoring/Evaluation Approach: • SBHC medical records		
		Potential Partners: • WAVE SBHC • Kruse SBHC		

Transportation Objective 2.3: Provide patients in need with just-in-time transportation resources/supports				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of vouchers provided	2	407	500	4
• Number of patients served by transport services provided by Cancer Center	2	0	0	4
• Number of gas cards	2	0	1,440	4
Strategies:		**Year 1 Notes**	**Year 12 Notes**	**Timeline:** **Year 1,2,3**
2.3.1: Conduct needs assessment upon patient discharge, provide vouchers for transportation back home and alignment with other local resources				1, 2, 3
2.3.2: Cancer Center: transport services for ongoing chemotherapy ($25 gas cards)		The cancer center did not have any patients that used transport services in FY 17	No patients were served by transport services for the Cancer Center in FY 18.	1, 2, 3
		Monitoring/Evaluation Approach: • Voucher receipt book		
		Potential Partners: • Community based organizations (CBO's) who provide transportation services (e.g., Uber, Yellow Cab, Metro, etc.)		

Health Care Navigation

Objective 2.4: Provide single source patient advocate to help coordinate treatment and services along the care continuum

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of Southeast hospital's associated counties' calls to Nurse Health Line (Brazoria, Galveston, and Harris)	30, 939 calls	31,567	32,268	30, 939 calls
• Number of nurse navigators in the Center of Excellence services	Establish baseline in Year 1	0	3	.5 (shared with SW)
• Number of patients served by nurse navigators via Center of Excellence services	Establish baseline in Year 1	0	1,418	50
• Number of patients served by Diabetes educator	12		1,030	Increase 3% each year
• Number of patients enrolled in the ER Navigation Program	1,985	2,928	2,861	1,985
• Number of ER Navigation patient encounters	3,441	7,213	7,739	3,441
• Number of ER Navigation referrals to community resources	4,280	6,806	6,839	4,280
• Number of ER Navigation scheduled appointments	210	244	214	210

Strategies:		Year 1 Notes	Year 2 Notes	Timeline: Year 1,2,3
2.4.1	Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the MHHS community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources			1, 2, 3
2.4.2	Continue to participate in the MH ER Navigation program in which patients are referred to a medical home (See 1.3.1)			1, 2, 3
2.4.3:	Provide nurse navigators and care coordinators for all Center of Excellence services (Bariatric Center, Joint, Chest Pain/Stroke, Esophageal Disease, and Cancer Center.) Navigator coordinates appointments, education classes, follow up care, etc. Occupational Medicine liaison works with local employers re: OSHA reportables and work related injuries. Expedites treatment for patient	This was a shared position with other campuses in FY 17. The MHSE nurse navigator position was vacant		1, 2, 3

Priority 2:	Health Care Access			
Goal 2:	**Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.**			
2.4.4:	Diabetes Educator provides care coordination for this patient base	MHSE did not have a Diabetes Educator in FY17		1, 2, 3
2.4.5:	Dedicated Perinatal Educator: provides education, follow up, gestational diabetes pre and post-natal follow up			1, 2, 3
2.4.6:	Occupational Medicine liaison works with local employers re: OSHA reportables and work related injuries to expedite treatment for patient			1, 2, 3
2.4.7:	Athletic Trainer for Sports Medicine: Provide outreach in local schools, help to navigate care for student athletes post injury (ER, imaging, specialty care, etc.). Provide same-day game coverage			1, 2, 3
		Monitoring/Evaluation Approach: • Monthly patient access report • Class Schedule roster /sign in sheets • Patient activity documented and reported within the ER Navigation electronic record system		
		Potential Partners: • Schools • Local employers • Physicians • VCARE Clinic • Pasadena Community Health Center • Stephen F Austin Community Health Center • Central Care Community Health Center • Ibn Sina Foundation Clinic • Memorial Hermann Community Benefit Corporation		

Priority 3: Behavioral Health

The following tables provide strategies and outcome indicators that reflect an MHHS system-wide approach to Behavioral Health. Data is not specific to MH Southeast Hospital but to the community at large with the exception of reduction in ER encounters that result in a psychiatric inpatient stay through linkages wit a network of behavioral partners.

Priority 3:	Behavioral Health			
Goal 3:	Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.			
Objective 3.1:	Create nontraditional access points around the community (crisis/ambulatory, acute care, and community-based chronic care management), and link those who need services to permanent providers and resources in the community			
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Decrease in number of ER encounters that result in psychiatric inpatient stay	1,146	1,213	1,135	1,089 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay -- Southeast	106	109	128	101
• Decrease in number of ER encounters that result in psychiatric inpatient stay -- Pearland	36	39	52	34 5% reduction over baseline
• Number of MHCC Memorial Hermann Crisis Clinic total visits	5,400	5,590	5,154	5% over baseline
• Number of Psychiatric Response Care Management total visits	1,200	1,103	1,259	5% over baseline
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**

Priority 3:	Behavioral Health			
Goal 3:	**Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.**			
3.1.1:	Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7 at Southeast.	An uptick in acute care volume over the past fiscal year has contributed to a higher number of psychiatric transfers overall.	An increase in acute care volume and number of acute care sites over the past fiscal year have contributed to a higher number of psychiatric transfers overall.	1, 2, 3
3.1.2:	Provide mental health assessment, care, and linkage to services at Pearland/SE	See 3.1.1 notes	See 3.1.1 notes	1, 2, 3
3.1.3:	Create nontraditional community access to psychiatric providers for individuals experiencing a mental health crisis. Clinical Social Workers connect the target population to on-going behavioral health care		Recruiting mental health providers willing to commit to a non-traditional schedule remains a challenge. Continuing this urgent care model of treatment remains a priority, due to limited mental health treatment access in the community.	1, 2, 3

Priority 3:	Behavioral Health
Goal 3:	Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.

3.1.4:	Engage individuals with a chronic mental illness and work to maintain engagement with treatment and stability in the community via enrollment in community-based mental health case management program	Staffing issues impeded year one target. Identifying appropriately licensed clinicians willing to consider a career that is community based with the requirement of making home visits and working non-traditional hours is an ongoing challenge.	Case Managers partner with their clients to identify specific recovery goals and utilize evidence-based practices to facilitate client achievement. We continue to partner with community providers to address the mental health needs of the Greater Houston Community	1, 2, 3

		Monitoring/Evaluation Approach: • EMR/registration system (track and trend daily, weekly, monthly)
		Potential Partners: • System acute care campuses • Memorial Hermann Medical Group • Network of public and private providers

Objective 3.2: Reduce stigma in order to promote mental wellness and improve community awareness that mental health is part of physical health and overall well-being					
Outcome Indicators:		**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of presentations/educational sessions for healthcare professionals within MHHS		50 sessions per year	63	71	5% increase over baseline
• Number of presentations/educational sessions for corporations		5	7	8	5% over baseline
• Training on Acute Care Concepts - system nurse resident program		15 trainings (45 hours total/3 hours each)*	18	9	15 trainings (45 hours total/3 hours each)*
• Training on CMO Roundtable - system-wide		1 training (2 hours)*	0	4	1 training (2 hours)*
		*Total time includes training material development and implementation 531.6			
		Strategies:			**Timeline: Year 1,2,3**
		3.2.1: Provide mental health education sessions within the MH health system for nurses and physicians			1, 2, 3
		3.2.2: Work with employer solutions group to provide education and training with corporations on MH topics (stress, PTSD)			1, 2, 3
		Monitoring/Evaluation Approach: • Requests for presentations and sessions tracked via calendar/excel			
		Potential Partners: • System acute care campuses • System Marketing and Communications • Employer solutions group			

Objective 3.3:	Quality of mental health and substance abuse services: access, link, and practice utilizing evidence-based practice to promote overall wellness				
Outcome Indicators:		**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of Memorial Hermann Crisis Clinic follow-ups post discharge with clinic patients		7,716	6,431	5,154	5% over baseline
• Psychiatric Response Case Management reduction in system ER utilization		54.4%	53.0%	50%	5% increase over baseline
Strategies:			**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
3.3.1: Social workers follow-up with discharged patients and their families to assess well-being and connect them to community resources			The goal is to continue to educate the community, including other health systems, about the crisis clinic level of care so that when someone is experiencing a mental health crisis or needs immediate access to a behavioral health provider, the clinic will be the identified referral source.	The System has seen an overall increase in patient acuity with complex physical and behavioral health needs requiring higher levels of care. The Crisis Clinic and Psych Response Case Management Programs continue to meet the needs of patients with behavioral health conditions by providing immediate access to a mental health provider.	1, 2, 3

Priority 3:	Behavioral Health			
Goal 3:	Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.			
3.3.2:	Psychiatric Response Case Management Program utilizes evidence-based practice interventions (motivational interviewing, MH First Aid, CAMS, etc.) to reduce ER utilization for program enrollees		Case Managers continue to partner with community agencies in an effort to connect program enrollees to resources for ongoing wellness. Program clinicians continue to use evidence-based practice interventions to reduce ER utilization and improve quality of life.	1, 2, 3
		Monitoring/Evaluation Approach: • Social work logs (Excel spreadsheet)		
		Potential Partners: • System acute care campuses • Community-based clinical providers • Network of public and private providers		

Appendix B. Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that have been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national sources used in Memorial Hermann Southeast's Community Health Needs Assessment.

Brazoria County

1. American Community Survey
2. American Lung Association
3. Centers for Medicare & Medicaid Services
4. County Health Rankings
5. Feeding America
6. Institute for Health Metrics and Evaluation
7. National Cancer Institute
8. National Center for Education Statistics
9. Small Area Health Insurance Estimates
10. Texas Department of Family and Protective Services
11. Texas Department of State Health Services
12. Texas Education Agency
13. Texas Secretary of State
14. U.S. Bureau of Labor Statistics
15. U.S. Census - County Business Patterns
16. U.S. Department of Agriculture - Food Environment Atlas
17. U.S. Environmental Protection Agency

Fort Bend County

1. American Community Survey
2. Centers for Medicare & Medicaid Services
3. County Health Rankings
4. Feeding America
5. Institute for Health Metrics and Evaluation
6. National Cancer Institute
7. National Center for Education Statistics
8. Small Area Health Insurance Estimates
9. Texas Department of Family and Protective Services
10. Texas Department of State Health Services
11. Texas Education Agency
12. Texas Secretary of State
13. U.S. Bureau of Labor Statistics
14. U.S. Census - County Business Patterns
15. U.S. Department of Agriculture - Food Environment Atlas

16. U.S. Environmental Protection Agency

Galveston County
1. American Community Survey
2. American Lung Association
3. Centers for Medicare & Medicaid Services
4. County Health Rankings
5. Feeding America
6. Institute for Health Metrics and Evaluation
7. National Cancer Institute
8. National Center for Education Statistics
9. Small Area Health Insurance Estimates
10. Texas Department of Family and Protective Services
11. Texas Department of State Health Services
12. Texas Education Agency
13. Texas Secretary of State
14. U.S. Bureau of Labor Statistics
15. U.S. Census - County Business Patterns
16. U.S. Department of Agriculture - Food Environment Atlas
17. U.S. Environmental Protection Agency

Harris County
1. American Community Survey
2. American Lung Association
3. Centers for Medicare & Medicaid Services
4. County Health Rankings
5. Feeding America
6. Institute for Health Metrics and Evaluation
7. National Cancer Institute
8. National Center for Education Statistics
9. Small Area Health Insurance Estimates
10. Texas Behavioral Risk Factor Surveillance System
11. Texas Department of Family and Protective Services
12. Texas Department of State Health Services
13. Texas Education Agency
14. Texas Secretary of State
15. U.S. Bureau of Labor Statistics
16. U.S. Census - County Business Patterns
17. U.S. Department of Agriculture - Food Environment Atlas
18. U.S. Environmental Protection Agency

Secondary Data Scoring

Data scoring is done in three stages:
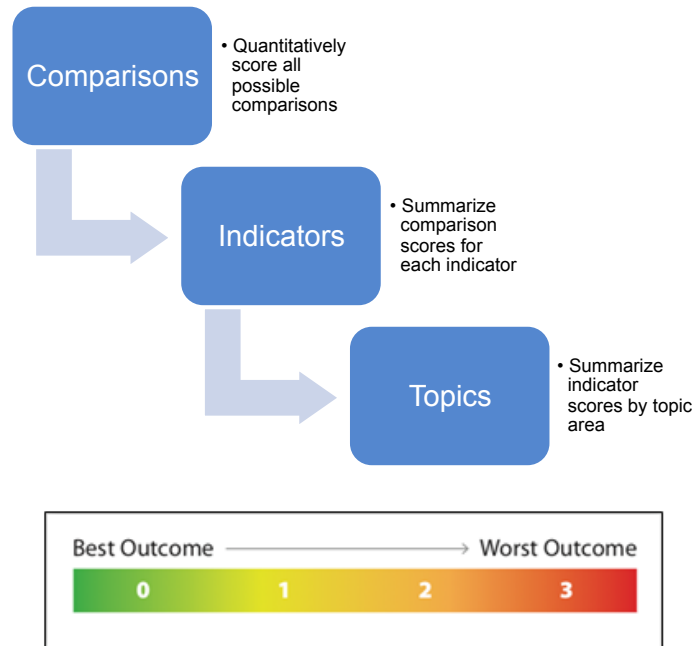
For each indicator, each county in Memorial Hermann Southeast's service area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2020 (HP2020) goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

Data Scoring Results

The following tables list each indicator by topic area for each of the counties in Memorial Hermann Southeast's service area. Secondary data for this report are up to date as of November 2, 2018.

Brazoria County

SCORE	ACCESS TO HEALTH SERVICES	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Mental Health Provider Rate	providers/ 100,000 population	56.5		98.8	214.3	*2017*		4
1.67	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	44.3		66.8	81.2	*2017*		4
1.47	Adults with Health Insurance: 18-64	percent	82	100	77.4		*2016*		9
1.25	Persons with Health Insurance	percent	85	100	81.4		*2016*		9
1.22	Primary Care Provider Rate	providers/ 100,000 population	65.3		59.9	75.5	*2015*		4
1.17	Dentist Rate	dentists/ 100,000 population	52.2		55.9	67.4	*2016*		4
1.14	Children with Health Insurance	percent	91.3	100	90.3		*2016*		9
SCORE	CANCER	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.94	Colorectal Cancer Incidence Rate	cases/ 100,000 population	42.5	39.9	38.1	39.2	*2011-2015*		7
1.67	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	15.3	14.5	14.4	14.5	*2011-2015*		7
1.56	Cancer: Medicare Population	percent	7.4		7.1	7.8	*2015*		3
1.50	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	60.4		53.1	60.2	*2011-2015*		7
1.28	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	44.1	45.5	39	43.4	*2011-2015*		7
1.22	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	167.5	161.4	156.4	163.5	*2011-2015*	Male	7
1.17	All Cancer Incidence Rate	cases/ 100,000 population	410.4		401.3	441.2	*2011-2015*		7
		cases/ 100,000							

SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.08	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.1	20.7	20.2	20.9	2011-2015		7
1.06	Breast Cancer Incidence Rate	cases/ 100,000 females	106.7		111.7	124.7	2011-2015		7
0.94	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	10.7		10.9	11.6	2011-2015		7
0.69	Cervical Cancer Incidence Rate	cases/ 100,000 females	6.9	7.3	9.2	7.5	2011-2015		7
0.42	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	17.2	21.8	18.1	19.5	2011-2015		7
SCORE	CHILDREN'S HEALTH	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Children with Low Access to a Grocery Store	percent	6.2				2015		16
1.14	Children with Health Insurance	percent	91.3	100	90.3		2016		9
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	6.4		8.5		2017		10
1.00	Child Food Insecurity Rate	percent	20.1		23	17.9	2016		5
SCORE	ECONOMY	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.44	Unemployed Workers in Civilian Labor Force	percent	4.7		4	4.1	July 2018		14
2.25	Median Household Gross Rent	dollars	951		911	949	2012-2016		1
2.14	Mortgaged Owners Median Monthly Household Costs	dollars	1645		1444	1491	2012-2016		1
2.03	Median Monthly Owner Costs for Households without a Mortgage	dollars	490		467	462	2012-2016		1
2.00	SNAP Certified Stores	stores/ 1,000	0.5				2016		16

		population							
1.50	Low-Income and Low Access to a Grocery Store	percent	6.9				*2015*		16
1.50	Severe Housing Problems	percent	14.6		18.3	18.8	*2010-2014*		4
1.33	Female Population 16+ in Civilian Labor Force	percent	58.9		57.7	58.3	*2012-2016*		1
1.33	Food Insecurity Rate	percent	14.5		15.4	12.9	*2016*		5
1.17	Population 16+ in Civilian Labor Force	percent	64.6		64.2	63.1	*2012-2016*		1
1.00	Child Food Insecurity Rate	percent	20.1		23	17.9	*2016*		5
0.92	Median Housing Unit Value	dollars	157100		142700	184700	*2012-2016*		1
0.92	Persons with Disability Living in Poverty (5-year)	percent	21.8		25.1	27.6	*2012-2016*		1
0.89	Homeowner Vacancy Rate	percent	1.6		1.6	1.8	*2012-2016*		1
0.89	People 65+ Living Below Poverty Level	percent	8.7		10.8	9.3	*2012-2016*	Hispanic or Latino	1
0.83	Homeownership	percent	64.3		55	55.9	*2012-2016*		1
0.67	Renters Spending 30% or More of Household Income on Rent	percent	36.1		48	47.3	*2012-2016*		1
0.67	Total Employment Change	percent	3.6		3.2	2.5	*2014-2015*		15
0.64	Persons with Disability Living in Poverty	percent	19.4		24.2	26.6	*2016*		1
0.56	Families Living Below Poverty Level	percent	7.9		13	11	*2012-2016*	Hispanic or Latino, Other	1
0.50	Students Eligible for the Free Lunch Program	percent	38.5		52.9	42.6	*2015-2016*		8
0.39	Children Living Below Poverty Level	percent	13.2		23.9	21.2	*2012-2016*	Black or African American, Hispanic or Latino, Other	1
0.39	People Living 200% Above Poverty Level	percent	75		62.8	66.4	*2012-2016*		1

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SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.39	People Living Below Poverty Level	percent	10.5		16.7	15.1	2012-2016	18-24, 6-11 Hispanic or Latino, Other	1
0.33	Per Capita Income	dollars	31180		27828	29829	2012-2016	American Indian or Alaska Native, Hispanic or Latino, Other, Two or More Races	1
0.17	Households with Cash Public Assistance Income	percent	0.8		1.6	2.7	2012-2016		1
0.17	Median Household Income	dollars	72006		54727	55322	2012-2016	Hispanic or Latino, Other	1
SCORE	EDUCATION	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.50	Student-to-Teacher Ratio	students/teacher	16		15.4	17.7	2015-2016		8
1.22	High School Drop Out Rate	percent	0.9		2		2016		12
1.00	People 25+ with a High School Degree or Higher	percent	86.7		82.3	87	2012-2016	65+	1
0.67	People 25+ with a Bachelor's Degree or Higher	percent	28.7		28.1	30.3	2012-2016	65+ American Indian or Alaska Native, Other	1
0.42	Infants Born to Mothers with <12 Years Education	percent	13.5		21.6	15.9	2013		11
SCORE	ENVIRONMENT	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Grocery Store Density	stores/ 1,000 population	0.1				2014		16
2.00	SNAP Certified Stores	stores/ 1,000 population	0.5				2016		16
1.75	Annual Ozone Air Quality	grade	F				2014-2016		2

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SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Children with Low Access to a Grocery Store	percent	6.2				2015		16
1.50	Farmers Market Density	markets/ 1,000 population	0				2016		16
1.50	Low-Income and Low Access to a Grocery Store	percent	6.9				2015		16
1.50	Severe Housing Problems	percent	14.6		18.3	18.8	2010-2014		4
1.44	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2014		16
1.42	Drinking Water Violations	percent	4.4		6.6		FY 2013-14		4
1.33	Access to Exercise Opportunities	percent	79		80.6	83.1	2018		4
1.33	People 65+ with Low Access to a Grocery Store	percent	2.2				2015		16
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		16
1.22	Food Environment Index		7.5		6	7.7	2018		4
1.17	PBT Released	pounds	4237				2017		17
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.5				2015		16
0.61	Liquor Store Density	stores/ 100,000 population	2.3		6.8	10.5	2015		15
0.39	Houses Built Prior to 1950	percent	4.3		7.4	18.2	2012-2016		1
SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Workers who Walk to Work	percent	0.8	3.1	1.6	2.8	2012-2016		1
2.00	Grocery Store Density	stores/ 1,000 population	0.1				2014		16
2.00	SNAP Certified Stores	stores/ 1,000 population	0.5				2016		16
1.67	Children with Low Access to a Grocery Store	percent	6.2				2015		16

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SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.50	Farmers Market Density	markets/ 1,000 population	0				2016		16
1.50	Low-Income and Low Access to a Grocery Store	percent	6.9				2015		16
1.44	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2014		16
1.33	Access to Exercise Opportunities	percent	79		80.6	83.1	2018		4
1.33	Food Insecurity Rate	percent	14.5		15.4	12.9	2016		5
1.33	People 65+ with Low Access to a Grocery Store	percent	2.2				2015		16
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		16
1.22	Food Environment Index		7.5		6	7.7	2018		4
1.00	Child Food Insecurity Rate	percent	20.1		23	17.9	2016		5
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.5				2015		16
SCORE	HEART DISEASE & STROKE	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.61	Stroke: Medicare Population	percent	5.1		4.5	4	2015		3
2.11	Heart Failure: Medicare Population	percent	16.6		15.5	13.5	2015		3
1.94	Hypertension: Medicare Population	percent	59.3		57.5	55	2015		3
1.83	Ischemic Heart Disease: Medicare Population	percent	31		28.8	26.5	2015		3
1.78	Atrial Fibrillation: Medicare Population	percent	8		7.4	8.1	2015		3
1.78	Hyperlipidemia: Medicare Population	percent	44.9		46.1	44.6	2015		3

SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.25	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	38.6	34.8	42	37.3	*2010-2014*		11
1.08	Age-Adjusted Death Rate due to Heart Disease	*deaths/ 100,000 population*	173		173	171.9	*2010-2014*	Male	11
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Syphilis Incidence Rate	*cases/ 100,000 population*	16		40.6		*2017*		11
1.50	HIV Diagnosis Rate	*cases/ 100,000 population*	10.7		16.1		*2016*		11
1.44	Chlamydia Incidence Rate	*cases/ 100,000 population*	392.3		511.6		*2017*		11
1.39	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.7	1	4.5		*2013-2017*		11
1.28	Gonorrhea Incidence Rate	*cases/ 100,000 population*	84.7		160.2		*2017*		11
1.17	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13		14.2	15.2	*2010-2014*		11
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.03	Babies with Low Birth Weight	*percent*	8.8	7.8	8.3	8	*2013*		11
1.86	Mothers who Received Early Prenatal Care	*percent*	60.9	77.9	59.2	74.2	*2013*		11
1.25	Preterm Births	*percent*	11.7	9.4	12	11.4	*2013*		11
1.17	Babies with Very Low Birth Weight	*percent*	1.4	1.4	1.4	1.4	*2013*		11
0.64	Teen Births	*percent*	2.1		2.8	4.3	*2014*		11
0.47	Infant Mortality Rate	*deaths/ 1,000 live births*	3.9	6	5.8	6	*2013*		11

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SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.42	Infants Born to Mothers with <12 Years Education	percent	13.5		21.6	15.9	2013		11
SCORE	MEN'S HEALTH	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.44	Life Expectancy for Males	years	76.1		76.2	76.7	2014		6
1.17	Prostate Cancer Incidence Rate	cases/ 100,000 males	98.5		95.4	109	2011-2015		7
0.42	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	17.2	21.8	18.1	19.5	2011-2015		7
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	12.4	10.2	11.7	12.5	2010-2014	Male White	11
2.00	Mental Health Provider Rate	providers/ 100,000 population	56.5		98.8	214.3	2017		4
1.67	Alzheimer's Disease or Dementia: Medicare Population	percent	10.7		11.7	9.9	2015		3
1.50	Depression: Medicare Population	percent	15.5		17	16.7	2015		3
1.08	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	26		26.6	24.5	2010-2014		11
0.67	Frequent Mental Distress	percent	9.9		10.6	15	2016		4
0.67	Poor Mental Health: Average Number of Days	days	3.2		3.4	3.8	2016		4
SCORE	OLDER ADULTS & AGING	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source

2.61	Stroke: Medicare Population	*percent*	5.1		4.5	4	*2015*		3
2.50	Diabetes: Medicare Population	*percent*	29.4		28.2	26.5	*2015*		3
2.17	Chronic Kidney Disease: Medicare Population	*percent*	19.7		19.9	18.1	*2015*		3
2.11	Heart Failure: Medicare Population	*percent*	16.6		15.5	13.5	*2015*		3
1.94	Hypertension: Medicare Population	*percent*	59.3		57.5	55	*2015*		3
1.83	Ischemic Heart Disease: Medicare Population	*percent*	31		28.8	26.5	*2015*		3
1.78	Atrial Fibrillation: Medicare Population	*percent*	8		7.4	8.1	*2015*		3
1.78	Hyperlipidemia: Medicare Population	*percent*	44.9		46.1	44.6	*2015*		3
1.67	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.7		11.7	9.9	*2015*		3
1.56	Cancer: Medicare Population	*percent*	7.4		7.1	7.8	*2015*		3
1.50	Asthma: Medicare Population	*percent*	7.5		8.2	8.2	*2015*		3
1.50	Depression: Medicare Population	*percent*	15.5		17	16.7	*2015*		3
1.33	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	7.3	7.2	7.4	8.3	*2010-2014*		11
1.33	People 65+ with Low Access to a Grocery Store	*percent*	2.2				*2015*		16
1.11	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	29.4		31.6	30	*2015*		3
1.08	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	26		26.6	24.5	*2010-2014*		11
0.94	People 65+ Living Alone	*percent*	22.5		23.9	26.4	*2012-2016*		1
0.89	People 65+ Living Below Poverty Level	*percent*	8.7		10.8	9.3	*2012-2016*	Hispanic or Latino	1
0.83	COPD: Medicare Population	*percent*	10.8		11.1	11.2	*2015*		3

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SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.67	Osteoporosis: Medicare Population	percent	5.2		6.5	6	2015		3
SCORE	**OTHER CHRONIC DISEASES**	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Chronic Kidney Disease: Medicare Population	percent	19.7		19.9	18.1	2015		3
1.11	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	29.4		31.6	30	2015		3
0.67	Osteoporosis: Medicare Population	percent	5.2		6.5	6	2015		3
SCORE	**PREVENTION & SAFETY**	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.50	Severe Housing Problems	percent	14.6		18.3	18.8	2010-2014		4
1.33	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	7.3	7.2	7.4	8.3	2010-2014		11
0.97	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	38.1	36.4	37.6	39.2	2010-2014	Male White	11
0.64	Death Rate due to Drug Poisoning	deaths/ 100,000 population	8.1		9.8	16.9	2014-2016		4
SCORE	**PUBLIC SAFETY**	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.22	Alcohol-Impaired Driving Deaths	percent	34.3		28.3	29.3	2012-2016		4
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	6.4		8.5		2017		10
1.06	Violent Crime Rate	crimes/ 100,000 population	175		407.6		2012-2014		4

SCORE	RESPIRATORY DISEASES	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.50	Asthma: Medicare Population	*percent*	7.5		8.2	8.2	*2015*		3
1.50	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	60.4		53.1	60.2	*2011-2015*		7
1.39	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.7	1	4.5		*2013-2017*		11
1.28	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.1	45.5	39	43.4	*2011-2015*		7
1.17	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13		14.2	15.2	*2010-2014*		11
0.83	COPD: Medicare Population	*percent*	10.8		11.1	11.2	*2015*		3
SCORE	SOCIAL ENVIRONMENT	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Mean Travel Time to Work	*minutes*	29.4		25.9	26.1	*2012-2016*	Male	1
2.25	Median Household Gross Rent	*dollars*	951		911	949	*2012-2016*		1
2.14	Mortgaged Owners Median Monthly Household Costs	*dollars*	1645		1444	1491	*2012-2016*		1
2.03	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	490		467	462	*2012-2016*		1
1.33	Female Population 16+ in Civilian Labor Force	*percent*	58.9		57.7	58.3	*2012-2016*		1
1.28	Linguistic Isolation	*percent*	4		7.9	4.5	*2012-2016*		1
1.25	Persons with Health Insurance	*percent*	85	100	81.4		*2016*		9
1.22	Voter Turnout: Presidential Election	*percent*	61.5		58.8		*2016*		13
1.17	Population 16+ in Civilian Labor Force	*percent*	64.6		64.2	63.1	*2012-2016*		1
1.11	Substantiated Child Abuse Rate	*cases/ 1,000*	6.4		8.5		*2017*		10

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SCORE		UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
		children							
1.00	People 25+ with a High School Degree or Higher	percent	86.7		82.3	87	2012-2016	65+	1
0.94	People 65+ Living Alone	percent	22.5		23.9	26.4	2012-2016		1
0.92	Median Housing Unit Value	dollars	157100		142700	184700	2012-2016		1
0.83	Homeownership	percent	64.3		55	55.9	2012-2016		1
0.67	People 25+ with a Bachelor's Degree or Higher	percent	28.7		28.1	30.3	2012-2016	65+ American Indian or Alaska Native, Other	1
0.67	Total Employment Change	percent	3.6		3.2	2.5	2014-2015		15
0.39	Children Living Below Poverty Level	percent	13.2		23.9	21.2	2012-2016	Black or African American, Hispanic or Latino, Other	1
0.39	People Living Below Poverty Level	percent	10.5		16.7	15.1	2012-2016	18-24, 6-11 Hispanic or Latino, Other	1
0.33	Per Capita Income	dollars	31180		27828	29829	2012-2016	American Indian or Alaska Native, Hispanic or Latino, Other, Two or More Races	1
0.17	Median Household Income	dollars	72006		54727	55322	2012-2016	Hispanic or Latino, Other	1
0.17	Single-Parent Households	percent	25.3		33.3	33.6	2012-2016		1
SCORE	SUBSTANCE ABUSE	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.22	Alcohol-Impaired Driving Deaths	percent	34.3		28.3	29.3	2012-2016		4
1.67	Adults who Drink Excessively	percent	19.4	25.4	19.4	18	2016		4
0.64	Death Rate due to Drug Poisoning	deaths/ 100,000 population	8.1		9.8	16.9	2014-2016		4
0.61	Liquor Store Density	stores/ 100,000 population	2.3		6.8	10.5	2015		15

SCORE	TRANSPORTATION	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Mean Travel Time to Work	minutes	29.4		25.9	26.1	2012-2016	Male	1
2.78	Workers who Walk to Work	percent	0.8	3.1	1.6	2.8	2012-2016		1
2.67	Workers who Drive Alone to Work	percent	86.9		80.3	76.4	2012-2016	55-59 Black or African American	1
2.61	Solo Drivers with a Long Commute	percent	48.2		36.9	34.7	2012-2016		4
2.28	Workers Commuting by Public Transportation	percent	0.2	5.5	1.5	5.1	2012-2016		1
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.5				2015		16
0.61	Households without a Vehicle	percent	3.4		5.6	9	2012-2016		1
SCORE	WELLNESS & LIFESTYLE	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.56	Life Expectancy for Females	years	80.2		80.8	81.5	2014		6
1.44	Life Expectancy for Males	years	76.1		76.2	76.7	2014		6
1.00	Insufficient Sleep	percent	31.2		32.7	38	2016		4
1.00	Self-Reported General Health Assessment: Poor or Fair	percent	16.1		18.2	16	2016		4
0.67	Frequent Physical Distress	percent	9.9		10.8	15	2016		4
0.67	Poor Physical Health: Average Number of Days	days	3.3		3.5	3.7	2016		4

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SCORE	WOMEN'S HEALTH	UNITS	BRAZORIA COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.56	Life Expectancy for Females	years	80.2		80.8	81.5	2014		6
1.08	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.1	20.7	20.2	20.9	2011-2015		7
1.06	Breast Cancer Incidence Rate	cases/ 100,000 females	106.7		111.7	124.7	2011-2015		7
0.69	Cervical Cancer Incidence Rate	cases/ 100,000 females	6.9	7.3	9.2	7.5	2011-2015		7

Fort Bend County

SCORE	ACCESS TO HEALTH SERVICES	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.11	Mental Health Provider Rate	providers/ 100,000 population	59.8		98.8	214.3	2017		3
1.67	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	52.2		66.8	81.2	2017		3
1.17	Dentist Rate	dentists/ 100,000 population	51.8		55.9	67.4	2016		3
1.08	Persons with Health Insurance	percent	88	100	81.4		2016		8
0.97	Children with Health Insurance	percent	93.3	100	90.3		2016		8
0.92	Adults with Health Insurance: 18-64	percent	85.4	100	77.4		2016		8
0.33	Primary Care Provider Rate	providers/ 100,000 population	80.3		59.9	75.5	2015		3

SCORE	CANCER	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.56	Cancer: Medicare Population	percent	7.3		7.1	7.8	2015		2
1.50	Prostate Cancer Incidence Rate	cases/ 100,000 males	103.8		95.4	109	2011-2015		6
1.17	Breast Cancer Incidence Rate	cases/ 100,000 females	114.7		111.7	124.7	2011-2015		6

SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.56	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	10		10.9	11.6	*2011-2015*		6
0.50	All Cancer Incidence Rate	*cases/ 100,000 population*	367.6		401.3	441.2	*2011-2015*		6
0.47	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.1	20.7	20.2	20.9	*2011-2015*		6
0.47	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4	7.3	9.2	7.5	*2011-2015*		6
0.25	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	14.6	21.8	18.1	19.5	*2011-2015*		6
0.22	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.9	14.5	14.4	14.5	*2011-2015*		6
0.17	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	39.5		53.1	60.2	*2011-2015*		6
0.00	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	126.2	161.4	156.4	163.5	*2011-2015*	Male	6
0.00	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	28.1	45.5	39	43.4	*2011-2015*		6
0.00	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	34	39.9	38.1	39.2	*2011-2015*		6

SCORE	CHILDREN'S HEALTH	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Children with Low Access to a Grocery Store	*percent*	7.4				*2015*		15
1.11	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.5		8.5		*2017*		9
0.97	Children with Health Insurance	*percent*	93.3	100	90.3		*2016*		8
0.67	Child Food Insecurity Rate	*percent*	19.1		23	17.9	*2016*		4

SCORE	ECONOMY	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Median Household Gross Rent	*dollars*	1252		911	949	*2012-2016*		1

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2.36	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	712		467	462	*2012-2016*		1
2.25	Mortgaged Owners Median Monthly Household Costs	*dollars*	1884		1444	1491	*2012-2016*		1
1.89	SNAP Certified Stores	*stores/ 1,000 population*	0.4				*2016*		15
1.78	Unemployed Workers in Civilian Labor Force	*percent*	4.1		4	4.1	*July 2018*		13
1.56	Food Insecurity Rate	*percent*	14.8		15.4	12.9	*2016*		4
1.50	Low-Income and Low Access to a Grocery Store	*percent*	7.1				*2015*		15
1.17	Female Population 16+ in Civilian Labor Force	*percent*	59.3		57.7	58.3	*2012-2016*		1
1.17	Population 16+ in Civilian Labor Force	*percent*	66.9		64.2	63.1	*2012-2016*		1
1.06	Renters Spending 30% or More of Household Income on Rent	*percent*	40.1		48	47.3	*2012-2016*		1
1.06	Severe Housing Problems	*percent*	14.8		18.3	18.8	*2010-2014*		3
0.75	Persons with Disability Living in Poverty (5-year)	*percent*	15.6		25.1	27.6	*2012-2016*		1
0.67	Child Food Insecurity Rate	*percent*	19.1		23	17.9	*2016*		4
0.64	Persons with Disability Living in Poverty	*percent*	16.2		24.2	26.6	*2016*		1
0.56	Households with Cash Public Assistance Income	*percent*	1.1		1.6	2.7	*2012-2016*		1
0.50	Total Employment Change	*percent*	6.2		3.2	2.5	*2014-2015*		14
0.42	Median Housing Unit Value	*dollars*	217600		142700	184700	*2012-2016*		1
0.39	Children Living Below Poverty Level	*percent*	11.2		23.9	21.2	*2012-2016*	Hispanic or Latino, Other	1
0.39	Families Living Below Poverty Level	*percent*	6.4		13	11	*2012-2016*	Hispanic or Latino, Other	1
0.39	Homeownership	*percent*	74.4		55	55.9	*2012-2016*		1
0.39	People 65+ Living Below Poverty Level	*percent*	6.9		10.8	9.3	*2012-2016*	Hispanic or Latino, Other	1

SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.39	People Living Below Poverty Level	percent	8.2		16.7	15.1	2012-2016	Hispanic or Latino, Other, <6, 6-11, 12-17, 18-24	1
0.17	Homeowner Vacancy Rate	percent	1.1		1.6	1.8	2012-2016		1
0.17	Median Household Income	dollars	91152		54727	55322	2012-2016	Black or African American, Hispanic or Latino, Other	1
0.17	People Living 200% Above Poverty Level	percent	79.4		62.8	66.4	2012-2016		1
0.17	Per Capita Income	dollars	37134		27828	29829	2012-2016	Black or African American, Hispanic or Latino, Other, Two or More Races	1
0.17	Students Eligible for the Free Lunch Program	percent	26.7		52.9	42.6	2015-2016		7
SCORE	EDUCATION	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Student-to-Teacher Ratio	students/ teacher	16.5		15.4	17.7	2015-2016		7
1.00	High School Drop Out Rate	percent	1.1		2		2016		11
0.89	People 25+ with a High School Degree or Higher	percent	89.2		82.3	87	2012-2016	65+	1
0.42	Infants Born to Mothers with <12 Years Education	percent	9.2		21.6	15.9	2013		10
0.17	People 25+ with a Bachelor's Degree or Higher	percent	44.6		28.1	30.3	2012-2016	Black or African American, Other, Two or More Races, Female, 65+	1
SCORE	ENVIRONMENT	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.89	SNAP Certified Stores	stores/ 1,000 population	0.4				2016		15
1.83	Children with Low Access to a Grocery Store	percent	7.4				2015		15

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SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Grocery Store Density	stores/ 1,000 population	0.1				2014		15
1.61	Recognized Carcinogens Released into Air	pounds	18132				2017		16
1.50	Farmers Market Density	markets/ 1,000 population	0				2016		15
1.50	Low-Income and Low Access to a Grocery Store	percent	7.1				2015		15
1.39	PBT Released	pounds	18164				2017		16
1.33	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2014		15
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		15
1.22	Food Environment Index		7.4		6	7.7	2018		3
1.17	People 65+ with Low Access to a Grocery Store	percent	1.9				2015		15
1.08	Drinking Water Violations	percent	0.9		6.6		FY 2013-14		3
1.06	Severe Housing Problems	percent	14.8		18.3	18.8	2010-2014		3
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.1				2015		15
0.83	Access to Exercise Opportunities	percent	83.8		80.6	83.1	2018		3
0.61	Liquor Store Density	stores/ 100,000 population	5.2		6.8	10.5	2015		14
0.39	Houses Built Prior to 1950	percent	1.2		7.4	18.2	2012-2016		1
SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.67	Workers who Walk to Work	percent	0.6	3.1	1.6	2.8	2012-2016	25-44	1
1.89	SNAP Certified Stores	stores/ 1,000 population	0.4				2016		15
1.83	Children with Low Access to a Grocery Store	percent	7.4				2015		15
1.83	Grocery Store Density	stores/ 1,000 population	0.1				2014		15

SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.56	Food Insecurity Rate	percent	14.8		15.4	12.9	2016		4
1.50	Farmers Market Density	markets/ 1,000 population	0				2016		15
1.50	Low-Income and Low Access to a Grocery Store	percent	7.1				2015		15
1.33	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2014		15
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		15
1.22	Food Environment Index		7.4		6	7.7	2018		3
1.17	People 65+ with Low Access to a Grocery Store	percent	1.9				2015		15
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.1				2015		15
0.83	Access to Exercise Opportunities	percent	83.8		80.6	83.1	2018		3
0.67	Child Food Insecurity Rate	percent	19.1		23	17.9	2016		4
SCORE	HEART DISEASE & STROKE	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Stroke: Medicare Population	percent	4.7		4.5	4	2015		2
2.17	Hyperlipidemia: Medicare Population	percent	46.6		46.1	44.6	2015		2
1.61	Hypertension: Medicare Population	percent	57.1		57.5	55	2015		2
1.22	Ischemic Heart Disease: Medicare Population	percent	28		28.8	26.5	2015		2
1.06	Heart Failure: Medicare Population	percent	13.9		15.5	13.5	2015		2
0.94	Atrial Fibrillation: Medicare Population	percent	6.9		7.4	8.1	2015		2
0.64	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	35.4	34.8	42	37.3	2010-2014		10
0.42	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	135		173	171.9	2010-2014	Black, White, Male	10

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SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Chlamydia Incidence Rate	cases/ 100,000 population	373.5		511.6		2017		10
1.67	Gonorrhea Incidence Rate	cases/ 100,000 population	93		160.2		2017		10
1.67	Syphilis Incidence Rate	cases/ 100,000 population	19		40.6		2017		10
1.56	Tuberculosis Incidence Rate	cases/ 100,000 population	3.7	1	4.5		2013-2017		10
1.22	HIV Diagnosis Rate	cases/ 100,000 population	9.2		16.1		2016		10
1.06	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	13.6		14.2	15.2	2010-2014		10
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.36	Babies with Low Birth Weight	percent	9.3	7.8	8.3	8	2013		10
1.86	Mothers who Received Early Prenatal Care	percent	62.8	77.9	59.2	74.2	2013		10
1.47	Preterm Births	percent	11.5	9.4	12	11.4	2013		10
1.39	Babies with Very Low Birth Weight	percent	1.4	1.4	1.4	1.4	2013		10
0.69	Infant Mortality Rate	deaths/ 1,000 live births	4.3	6	5.8	6	2013		10
0.42	Infants Born to Mothers with <12 Years Education	percent	9.2		21.6	15.9	2013		10
0.42	Teen Births	percent	1		2.8	4.3	2014		10
SCORE	MEN'S HEALTH	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.50	Prostate Cancer Incidence Rate	cases/ 100,000 males	103.8		95.4	109	2011-2015		6
0.50	Life Expectancy for Males	years	80.1		76.2	76.7	2014		5

SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.25	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	14.6	21.8	18.1	19.5	*2011-2015*		6
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.11	Mental Health Provider Rate	*providers/ 100,000 population*	59.8		98.8	214.3	*2017*		3
1.33	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.2		11.7	9.9	*2015*		2
0.94	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	7.3	10.2	11.7	12.5	*2010-2014*	White, Male	10
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	20.6		26.6	24.5	*2010-2014*	White	10
0.61	Depression: Medicare Population	*percent*	12.2		17	16.7	*2015*		2
0.50	Frequent Mental Distress	*percent*	9		10.6	15	*2016*		3
0.50	Poor Mental Health: Average Number of Days	*days*	3		3.4	3.8	*2016*		3
SCORE	**OLDER ADULTS & AGING**	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Stroke: Medicare Population	*percent*	4.7		4.5	4	*2015*		2
2.22	Diabetes: Medicare Population	*percent*	30.8		28.2	26.5	*2015*		2
2.17	Chronic Kidney Disease: Medicare Population	*percent*	19.2		19.9	18.1	*2015*		2
2.17	Hyperlipidemia: Medicare Population	*percent*	46.6		46.1	44.6	*2015*		2
1.61	Hypertension: Medicare Population	*percent*	57.1		57.5	55	*2015*		2
1.56	Cancer: Medicare Population	*percent*	7.3		7.1	7.8	*2015*		2
1.56	Osteoporosis: Medicare Population	*percent*	6		6.5	6	*2015*		2
1.33	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.2		11.7	9.9	*2015*		2

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SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.22	Ischemic Heart Disease: Medicare Population	percent	28		28.8	26.5	2015		2
1.17	People 65+ with Low Access to a Grocery Store	percent	1.9				2015		15
1.06	Heart Failure: Medicare Population	percent	13.9		15.5	13.5	2015		2
0.94	Atrial Fibrillation: Medicare Population	percent	6.9		7.4	8.1	2015		2
0.72	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	6	7.2	7.4	8.3	2010-2014		10
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	20.6		26.6	24.5	2010-2014	White	10
0.61	Asthma: Medicare Population	percent	6.5		8.2	8.2	2015		2
0.61	Depression: Medicare Population	percent	12.2		17	16.7	2015		2
0.61	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	26.1		31.6	30	2015		2
0.39	COPD: Medicare Population	percent	7.7		11.1	11.2	2015		2
0.39	People 65+ Living Alone	percent	15.2		23.9	26.4	2012-2016		1
0.39	People 65+ Living Below Poverty Level	percent	6.9		10.8	9.3	2012-2016	Hispanic or Latino, Other	1
SCORE	OTHER CHRONIC DISEASES	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Chronic Kidney Disease: Medicare Population	percent	19.2		19.9	18.1	2015		2
1.56	Osteoporosis: Medicare Population	percent	6		6.5	6	2015		2
0.61	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	26.1		31.6	30	2015		2
SCORE	PREVENTION & SAFETY	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.06	Severe Housing Problems	percent	14.8		18.3	18.8	2010-2014		3

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SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.86	Death Rate due to Drug Poisoning	deaths/ 100,000 population	5.6		9.8	16.9	2014-2016		3
0.72	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	6	7.2	7.4	8.3	2010-2014		10
0.47	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	24.9	36.4	37.6	39.2	2010-2014	White, Male	10

SCORE	PUBLIC SAFETY	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Alcohol-Impaired Driving Deaths	percent	36		28.3	29.3	2012-2016		3
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	3.5		8.5		2017		9
1.00	Violent Crime Rate	crimes/ 100,000 population	261.5		407.6		2012-2014		3

SCORE	RESPIRATORY DISEASES	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.56	Tuberculosis Incidence Rate	cases/ 100,000 population	3.7	1	4.5		2013-2017		10
1.06	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	13.6		14.2	15.2	2010-2014		10
0.61	Asthma: Medicare Population	percent	6.5		8.2	8.2	2015		2
0.39	COPD: Medicare Population	percent	7.7		11.1	11.2	2015		2
0.17	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	39.5		53.1	60.2	2011-2015		6
0.00	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	28.1	45.5	39	43.4	2011-2015		6

SCORE	SOCIAL ENVIRONMENT	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Mean Travel Time to Work	minutes	32.6		25.9	26.1	2012-2016	Male	1
2.58	Median Household Gross Rent	dollars	1252		911	949	2012-2016		1

2.36	Median Monthly Owner Costs for Households without a Mortgage	dollars	712		467	462	2012-2016		1
2.25	Mortgaged Owners Median Monthly Household Costs	dollars	1884		1444	1491	2012-2016		1
1.72	Linguistic Isolation	percent	6.2		7.9	4.5	2012-2016		1
1.17	Female Population 16+ in Civilian Labor Force	percent	59.3		57.7	58.3	2012-2016		1
1.17	Population 16+ in Civilian Labor Force	percent	66.9		64.2	63.1	2012-2016		1
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	3.5		8.5		2017		9
1.08	Persons with Health Insurance	percent	88	100	81.4		2016		8
0.89	People 25+ with a High School Degree or Higher	percent	89.2		82.3	87	2012-2016	65+	1
0.89	Voter Turnout: Presidential Election	percent	64.8		58.8		2016		12
0.61	Single-Parent Households	percent	22.4		33.3	33.6	2012-2016		1
0.50	Total Employment Change	percent	6.2		3.2	2.5	2014-2015		14
0.42	Median Housing Unit Value	dollars	217600		142700	184700	2012-2016		1
0.39	Children Living Below Poverty Level	percent	11.2		23.9	21.2	2012-2016	Hispanic or Latino, Other	1
0.39	Homeownership	percent	74.4		55	55.9	2012-2016		1
0.39	People 65+ Living Alone	percent	15.2		23.9	26.4	2012-2016		1
0.39	People Living Below Poverty Level	percent	8.2		16.7	15.1	2012-2016	Hispanic or Latino, Other, <6, 6-11, 12-17, 18-24	1
0.17	Median Household Income	dollars	91152		54727	55322	2012-2016	Black or African American, Hispanic or Latino, Other	1
0.17	People 25+ with a Bachelor's Degree or Higher	percent	44.6		28.1	30.3	2012-2016	Black or African American, Other, Two or More Races, Female, 65+	1
0.17	Per Capita Income	dollars	37134		27828	29829	2012-2016	Black or African American, Hispanic or Latino, Other,	1

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				Two or More Races	

SCORE	SUBSTANCE ABUSE	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Alcohol-Impaired Driving Deaths	percent	36		28.3	29.3	2012-2016		3
1.50	Adults who Drink Excessively	percent	18.3	25.4	19.4	18	2016		3
0.86	Death Rate due to Drug Poisoning	deaths/ 100,000 population	5.6		9.8	16.9	2014-2016		3
0.61	Liquor Store Density	stores/ 100,000 population	5.2		6.8	10.5	2015		14

SCORE	TRANSPORTATION	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Mean Travel Time to Work	minutes	32.6		25.9	26.1	2012-2016	Male	1
2.83	Solo Drivers with a Long Commute	percent	57.5		36.9	34.7	2012-2016		3
2.67	Workers who Walk to Work	percent	0.6	3.1	1.6	2.8	2012-2016	25-44	1
1.94	Workers who Drive Alone to Work	percent	82.3		80.3	76.4	2012-2016	Black or African American, 20-44	1
1.06	Workers Commuting by Public Transportation	percent	1.7	5.5	1.5	5.1	2012-2016	Hispanic or Latino	1
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.1				2015		15
0.50	Households without a Vehicle	percent	2.7		5.6	9	2012-2016		1

SCORE	WELLNESS & LIFESTYLE	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.17	Insufficient Sleep	percent	32.5		32.7	38	2016		3
0.72	Life Expectancy for Females	years	83.5		80.8	81.5	2014		5
0.67	Self-Reported General Health Assessment: Poor or Fair	percent	14.1		18.2	16	2016		3
0.50	Frequent Physical Distress	percent	8.7		10.8	15	2016		3

SCORE		UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.50	Life Expectancy for Males	*years*	80.1		76.2	76.7	*2014*		5
0.50	Poor Physical Health: Average Number of Days	*days*	2.9		3.5	3.7	*2016*		3
SCORE	**WOMEN'S HEALTH**	UNITS	FORT BEND COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.17	Breast Cancer Incidence Rate	*cases/ 100,000 females*	114.7		111.7	124.7	*2011-2015*		6
0.72	Life Expectancy for Females	*years*	83.5		80.8	81.5	*2014*		5
0.47	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.1	20.7	20.2	20.9	*2011-2015*		6
0.47	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4	7.3	9.2	7.5	*2011-2015*		6

Galveston County

SCORE	ACCESS TO HEALTH SERVICES	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.78	Mental Health Provider Rate	providers/ 100,000 population	95.9		98.8	214.3	2017		4
1.50	Dentist Rate	dentists/ 100,000 population	42.8		55.9	67.4	2016		4
1.47	Adults with Health Insurance: 18-64	percent	81.3	100	77.4		2016		9
1.47	Persons with Health Insurance	percent	84.3	100	81.4		2016		9
1.36	Children with Health Insurance	percent	91.4	100	90.3		2016		9
1.00	Primary Care Provider Rate	providers/ 100,000 population	71.7		59.9	75.5	2015		4
0.67	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	77.4		66.8	81.2	2017		4

SCORE	CANCER	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	22.5	21.8	18.1	19.5	2011-2015		7
2.22	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	16.9	14.5	14.4	14.5	2011-2015		7
2.17	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	189	161.4	156.4	163.5	2011-2015	Male Black	7
1.94	Cancer: Medicare Population	percent	7.7		7.1	7.8	2015		3
1.83	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	50.4	45.5	39	43.4	2011-2015		7
1.53	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	21.2	20.7	20.2	20.9	2011-2015		7
1.39	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.8		10.9	11.6	2011-2015		7

SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.17	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	59.2		53.1	60.2	2011-2015		7
1.17	Prostate Cancer Incidence Rate	cases/ 100,000 males	99.8		95.4	109	2011-2015		7
1.00	All Cancer Incidence Rate	cases/ 100,000 population	403		401.3	441.2	2011-2015		7
0.97	Cervical Cancer Incidence Rate	cases/ 100,000 females	7.8	7.3	9.2	7.5	2011-2015		7
0.83	Breast Cancer Incidence Rate	cases/ 100,000 females	110.1		111.7	124.7	2011-2015		7
0.33	Colorectal Cancer Incidence Rate	cases/ 100,000 population	35.4	39.9	38.1	39.2	2011-2015		7
SCORE	CHILDREN'S HEALTH	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Children with Low Access to a Grocery Store	percent	8.1				2015		16
1.78	Substantiated Child Abuse Rate	cases/ 1,000 children	9.5		8.5		2017		10
1.36	Children with Health Insurance	percent	91.4	100	90.3		2016		9
1.33	Child Food Insecurity Rate	percent	22.4		23	17.9	2016		5
SCORE	ECONOMY	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Median Monthly Owner Costs for Households without a Mortgage	dollars	523		467	462	2012-2016		1
2.44	Unemployed Workers in Civilian Labor Force	percent	4.7		4	4.1	July 2018		14
2.28	Homeowner Vacancy Rate	percent	2.7		1.6	1.8	2012-2016		1
2.17	Homeownership	percent	54.7		55	55.9	2012-2016		1
2.14	Mortgaged Owners Median Monthly Household Costs	dollars	1648		1444	1491	2012-2016		1

2.11	SNAP Certified Stores	stores/ 1,000 population	0.7				2016		16
2.08	Median Household Gross Rent	dollars	941		911	949	2012-2016		1
2.00	Food Insecurity Rate	percent	17		15.4	12.9	2016		5
1.50	Female Population 16+ in Civilian Labor Force	percent	58.1		57.7	58.3	2012-2016		1
1.50	Low-Income and Low Access to a Grocery Store	percent	7.8				2015		16
1.50	Renters Spending 30% or More of Household Income on Rent	percent	45.6		48	47.3	2012-2016		1
1.33	Child Food Insecurity Rate	percent	22.4		23	17.9	2016		5
1.33	Population 16+ in Civilian Labor Force	percent	64.2		64.2	63.1	2012-2016		1
1.11	Children Living Below Poverty Level	percent	19.2		23.9	21.2	2012-2016	Black or African American, Hispanic or Latino, Other	1
1.11	Families Living Below Poverty Level	percent	10.2		13	11	2012-2016	Black or African American, Hispanic or Latino, Other	1
1.11	People Living Below Poverty Level	percent	13.6		16.7	15.1	2012-2016	12-17, 18-24, 6-11, <6 Black or African American, Hispanic or Latino, Other	1
1.08	Persons with Disability Living in Poverty (5-year)	percent	23.2		25.1	27.6	2012-2016		1
1.06	Severe Housing Problems	percent	16.3		18.3	18.8	2010-2014		4
0.97	Persons with Disability Living in Poverty	percent	22.7		24.2	26.6	2016		1
0.92	Median Housing Unit Value	dollars	161100		142700	184700	2012-2016		1
0.72	People 65+ Living Below Poverty Level	percent	8		10.8	9.3	2012-2016	Black or African American	1
0.72	Students Eligible for the Free Lunch Program	percent	40.5		52.9	42.6	2015-2016		8

SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.56	Households with Cash Public Assistance Income	percent	1		1.6	2.7	2012-2016		1
0.56	People Living 200% Above Poverty Level	percent	70.7		62.8	66.4	2012-2016		1
0.50	Total Employment Change	percent	3.9		3.2	2.5	2014-2015		15
0.39	Median Household Income	dollars	63064		54727	55322	2012-2016	Black or African American, Hispanic or Latino, Other	1
0.33	Per Capita Income	dollars	32756		27828	29829	2012-2016	Black or African American, Hispanic or Latino, Other, Two or More Races	1
SCORE	EDUCATION	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.11	Student-to-Teacher Ratio	students/teacher	16.7		15.4	17.7	2015-2016		8
1.22	High School Drop Out Rate	percent	1.1		2		2016		12
0.89	People 25+ with a Bachelor's Degree or Higher	percent	28.9		28.1	30.3	2012-2016	65+ Black or African American, Other	1
0.75	Infants Born to Mothers with <12 Years Education	percent	16.2		21.6	15.9	2013		11
0.67	People 25+ with a High School Degree or Higher	percent	87.6		82.3	87	2012-2016	65+ Black or African American	1
SCORE	ENVIRONMENT	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.11	SNAP Certified Stores	stores/1,000 population	0.7				2016		16
1.92	Drinking Water Violations	percent	8.8		6.6		FY 2013-14		4
1.83	Children with Low Access to a Grocery Store	percent	8.1				2015		16

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SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Annual Ozone Air Quality	grade	F				2014-2016		2
1.67	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2014		16
1.67	People 65+ with Low Access to a Grocery Store	percent	3.5				2015		16
1.61	PBT Released	pounds	5336				2017		17
1.56	Food Environment Index		6.9		6	7.7	2018		4
1.50	Low-Income and Low Access to a Grocery Store	percent	7.8				2015		16
1.44	Liquor Store Density	stores/ 100,000 population	8.7		6.8	10.5	2015		15
1.39	Grocery Store Density	stores/ 1,000 population	0.2				2014		16
1.39	Recognized Carcinogens Released into Air	pounds	233970				2017		17
1.33	Farmers Market Density	markets/ 1,000 population	0				2016		16
1.25	Annual Particle Pollution	grade	A				2014-2016		2
1.17	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		16
1.06	Severe Housing Problems	percent	16.3		18.3	18.8	2010-2014		4
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.4				2015		16
0.83	Access to Exercise Opportunities	percent	88.1		80.6	83.1	2018		4
0.83	Houses Built Prior to 1950	percent	8.3		7.4	18.2	2012-2016		1
SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.11	SNAP Certified Stores	stores/ 1,000 population	0.7				2016		16
2.00	Food Insecurity Rate	percent	17		15.4	12.9	2016		5

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SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Children with Low Access to a Grocery Store	percent	8.1				2015		16
1.67	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2014		16
1.67	People 65+ with Low Access to a Grocery Store	percent	3.5				2015		16
1.56	Food Environment Index		6.9		6	7.7	2018		4
1.56	Workers who Walk to Work	percent	2	3.1	1.6	2.8	2012-2016	55-59, 60-64	1
1.50	Low-Income and Low Access to a Grocery Store	percent	7.8				2015		16
1.39	Grocery Store Density	stores/ 1,000 population	0.2				2014		16
1.33	Child Food Insecurity Rate	percent	22.4		23	17.9	2016		5
1.33	Farmers Market Density	markets/ 1,000 population	0				2016		16
1.17	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		16
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.4				2015		16
0.83	Access to Exercise Opportunities	percent	88.1		80.6	83.1	2018		4
SCORE	HEART DISEASE & STROKE	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Stroke: Medicare Population	percent	5.6		4.5	4	2015		3
2.44	Heart Failure: Medicare Population	percent	17.6		15.5	13.5	2015		3
1.94	Hypertension: Medicare Population	percent	59.2		57.5	55	2015		3
1.78	Atrial Fibrillation: Medicare Population	percent	8		7.4	8.1	2015		3
1.75	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	44.4	34.8	42	37.3	2010-2014	Black	11

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SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.72	Ischemic Heart Disease: Medicare Population	percent	29.2		28.8	26.5	2015		3
1.50	Hyperlipidemia: Medicare Population	percent	42		46.1	44.6	2015		3
0.92	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	170.7		173	171.9	2010-2014	Male Black	11
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Chlamydia Incidence Rate	cases/ 100,000 population	491.3		511.6		2017		11
1.67	Gonorrhea Incidence Rate	cases/ 100,000 population	132.8		160.2		2017		11
1.61	HIV Diagnosis Rate	cases/ 100,000 population	13.7		16.1		2016		11
1.44	Syphilis Incidence Rate	cases/ 100,000 population	23.3		40.6		2017		11
1.39	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	14.6		14.2	15.2	2010-2014		11
1.39	Tuberculosis Incidence Rate	cases/ 100,000 population	3.1	1	4.5		2013-2017		11
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.14	Preterm Births	percent	13.5	9.4	12	11.4	2013		11
1.86	Mothers who Received Early Prenatal Care	percent	61.3	77.9	59.2	74.2	2013		11
1.69	Babies with Low Birth Weight	percent	8.4	7.8	8.3	8	2013		11
1.31	Infant Mortality Rate	deaths/ 1,000 live births	5.6	6	5.8	6	2013		11
1.28	Babies with Very Low Birth Weight	percent	1.4	1.4	1.4	1.4	2013		11

SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.03	Teen Births	percent	2.5		2.8	4.3	2014		11
0.75	Infants Born to Mothers with <12 Years Education	percent	16.2		21.6	15.9	2013		11
SCORE	**MEN'S HEALTH**	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	22.5	21.8	18.1	19.5	2011-2015		7
1.72	Life Expectancy for Males	years	74.7		76.2	76.7	2014		6
1.17	Prostate Cancer Incidence Rate	cases/ 100,000 males	99.8		95.4	109	2011-2015		7
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.33	Depression: Medicare Population	percent	18.2		17	16.7	2015		3
2.11	Alzheimer's Disease or Dementia: Medicare Population	percent	11.1		11.7	9.9	2015		3
1.78	Mental Health Provider Rate	providers/ 100,000 population	95.9		98.8	214.3	2017		4
1.67	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	12.9	10.2	11.7	12.5	2010-2014	Male	11
1.33	Poor Mental Health: Average Number of Days	days	3.5		3.4	3.8	2016		4
0.83	Frequent Mental Distress	percent	10.7		10.6	15	2016		4
0.42	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	21.4		26.6	24.5	2010-2014		11

SCORE	OLDER ADULTS & AGING	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Chronic Kidney Disease: Medicare Population	percent	21.9		19.9	18.1	2015		3
2.83	Stroke: Medicare Population	percent	5.6		4.5	4	2015		3
2.44	Heart Failure: Medicare Population	percent	17.6		15.5	13.5	2015		3
2.33	Depression: Medicare Population	percent	18.2		17	16.7	2015		3
2.11	Alzheimer's Disease or Dementia: Medicare Population	percent	11.1		11.7	9.9	2015		3
1.94	Cancer: Medicare Population	percent	7.7		7.1	7.8	2015		3
1.94	Hypertension: Medicare Population	percent	59.2		57.5	55	2015		3
1.78	Atrial Fibrillation: Medicare Population	percent	8		7.4	8.1	2015		3
1.78	Diabetes: Medicare Population	percent	27.8		28.2	26.5	2015		3
1.72	Ischemic Heart Disease: Medicare Population	percent	29.2		28.8	26.5	2015		3
1.67	People 65+ with Low Access to a Grocery Store	percent	3.5				2015		16
1.61	Asthma: Medicare Population	percent	8.1		8.2	8.2	2015		3
1.50	Hyperlipidemia: Medicare Population	percent	42		46.1	44.6	2015		3
1.44	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	30.8		31.6	30	2015		3
1.06	COPD: Medicare Population	percent	10.6		11.1	11.2	2015		3
0.89	Osteoporosis: Medicare Population	percent	5.2		6.5	6	2015		3
0.72	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	6.2	7.2	7.4	8.3	2010-2014		11
0.72	People 65+ Living Alone	percent	23.6		23.9	26.4	2012-2016		1

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SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.72	People 65+ Living Below Poverty Level	percent	8		10.8	9.3	2012-2016	Black or African American	1
0.42	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	21.4		26.6	24.5	2010-2014		11
SCORE	OTHER CHRONIC DISEASES	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Chronic Kidney Disease: Medicare Population	percent	21.9		19.9	18.1	2015		3
1.44	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	30.8		31.6	30	2015		3
0.89	Osteoporosis: Medicare Population	percent	5.2		6.5	6	2015		3
SCORE	PREVENTION & SAFETY	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.58	Death Rate due to Drug Poisoning	deaths/ 100,000 population	15.6		9.8	16.9	2014-2016		4
1.42	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	40.9	36.4	37.6	39.2	2010-2014	Male	11
1.06	Severe Housing Problems	percent	16.3		18.3	18.8	2010-2014		4
0.72	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	6.2	7.2	7.4	8.3	2010-2014		11
SCORE	PUBLIC SAFETY	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.78	Substantiated Child Abuse Rate	cases/ 1,000 children	9.5		8.5		2017		10
1.67	Alcohol-Impaired Driving Deaths	percent	31.8		28.3	29.3	2012-2016		4
1.00	Violent Crime Rate	crimes/ 100,000 population	261.1		407.6		2012-2014		4

SCORE	RESPIRATORY DISEASES	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	50.4	45.5	39	43.4	*2011-2015*		7
1.61	Asthma: Medicare Population	*percent*	8.1		8.2	8.2	*2015*		3
1.39	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.6		14.2	15.2	*2010-2014*		11
1.39	Tuberculosis Incidence Rate	*cases/ 100,000 population*	3.1	1	4.5		*2013-2017*		11
1.17	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	59.2		53.1	60.2	*2011-2015*		7
1.06	COPD: Medicare Population	*percent*	10.6		11.1	11.2	*2015*		3

SCORE	SOCIAL ENVIRONMENT	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	523		467	462	*2012-2016*		1
2.50	Mean Travel Time to Work	*minutes*	27.8		25.9	26.1	*2012-2016*	Male	1
2.17	Homeownership	*percent*	54.7		55	55.9	*2012-2016*		1
2.14	Mortgaged Owners Median Monthly Household Costs	*dollars*	1648		1444	1491	*2012-2016*		1
2.08	Median Household Gross Rent	*dollars*	941		911	949	*2012-2016*		1
1.78	Substantiated Child Abuse Rate	*cases/ 1,000 children*	9.5		8.5		*2017*		10
1.50	Female Population 16+ in Civilian Labor Force	*percent*	58.1		57.7	58.3	*2012-2016*		1
1.47	Persons with Health Insurance	*percent*	84.3	100	81.4		*2016*		9
1.33	Population 16+ in Civilian Labor Force	*percent*	64.2		64.2	63.1	*2012-2016*		1

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SCORE		UNITS							
1.28	Single-Parent Households	percent	30.6		33.3	33.6	2012-2016		1
1.22	Voter Turnout: Presidential Election	percent	59.8		58.8		2016		13
1.11	Children Living Below Poverty Level	percent	19.2		23.9	21.2	2012-2016	Black or African American, Hispanic or Latino, Other	1
1.11	People Living Below Poverty Level	percent	13.6		16.7	15.1	2012-2016	12-17, 18-24, 6-11, <6 Black or African American, Hispanic or Latino, Other	1
1.06	Linguistic Isolation	percent	3.2		7.9	4.5	2012-2016		1
0.92	Median Housing Unit Value	dollars	161100		142700	184700	2012-2016		1
0.89	People 25+ with a Bachelor's Degree or Higher	percent	28.9		28.1	30.3	2012-2016	65+ Black or African American, Other	1
0.72	People 65+ Living Alone	percent	23.6		23.9	26.4	2012-2016		1
0.67	People 25+ with a High School Degree or Higher	percent	87.6		82.3	87	2012-2016	65+ Black or African American	1
0.50	Total Employment Change	percent	3.9		3.2	2.5	2014-2015		15
0.39	Median Household Income	dollars	63064		54727	55322	2012-2016	Black or African American, Hispanic or Latino, Other	1
0.33	Per Capita Income	dollars	32756		27828	29829	2012-2016	Black or African American, Hispanic or Latino, Other, Two or More Races	1
SCORE	SUBSTANCE ABUSE	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Alcohol-Impaired Driving Deaths	percent	31.8		28.3	29.3	2012-2016		4
1.58	Death Rate due to Drug Poisoning	deaths/ 100,000 population	15.6		9.8	16.9	2014-2016		4
1.50	Adults who Drink Excessively	percent	18.8	25.4	19.4	18	2016		4

SCORE		UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.44	Liquor Store Density	stores/ 100,000 population	8.7		6.8	10.5	2015		15
SCORE	**TRANSPORTATION**	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Solo Drivers with a Long Commute	percent	40.7		36.9	34.7	2012-2016		4
2.50	Mean Travel Time to Work	minutes	27.8		25.9	26.1	2012-2016	Male	1
1.56	Workers Commuting by Public Transportation	percent	1.1	5.5	1.5	5.1	2012-2016		1
1.56	Workers who Walk to Work	percent	2	3.1	1.6	2.8	2012-2016	55-59, 60-64	1
1.39	Households without a Vehicle	percent	6		5.6	9	2012-2016		1
1.00	Households with No Car and Low Access to a Grocery Store	percent	1.4				2015		16
1.00	Workers who Drive Alone to Work	percent	80		80.3	76.4	2012-2016	60-64 White, non-Hispanic	1
SCORE	**WELLNESS & LIFESTYLE**	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Insufficient Sleep	percent	34.7		32.7	38	2016		4
1.78	Life Expectancy for Females	years	79.7		80.8	81.5	2014		6
1.72	Life Expectancy for Males	years	74.7		76.2	76.7	2014		6
1.67	Self-Reported General Health Assessment: Poor or Fair	percent	17.7		18.2	16	2016		4
1.50	Poor Physical Health: Average Number of Days	days	3.7		3.5	3.7	2016		4
1.17	Frequent Physical Distress	percent	11.2		10.8	15	2016		4

SCORE	WOMEN'S HEALTH	UNITS	GALVESTON COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.78	Life Expectancy for Females	*years*	79.7		80.8	81.5	*2014*		6
1.53	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.2	20.7	20.2	20.9	*2011-2015*		7
0.97	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.8	7.3	9.2	7.5	*2011-2015*		7
0.83	Breast Cancer Incidence Rate	*cases/ 100,000 females*	110.1		111.7	124.7	*2011-2015*		7

Harris County

SCORE	ACCESS TO HEALTH SERVICES	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Adults Unable to Afford to See a Doctor	*percent*	22.1		18.3	12.1	*2015*		10
1.81	Children with Health Insurance	*percent*	89.4	100	90.3		*2016*		9
1.75	Adults with Health Insurance: 18-64	*percent*	74.7	100	77.4		*2016*		9
1.75	Persons with Health Insurance	*percent*	79.3	100	81.4		*2016*		9
1.61	Primary Care Provider Rate	*providers/ 100,000 population*	57.2		59.9	75.5	*2015*		4
1.44	Mental Health Provider Rate	*providers/ 100,000 population*	103.7		98.8	214.3	*2017*		4
1.00	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	72.2		66.8	81.2	*2017*		4
0.50	Dentist Rate	*dentists/ 100,000 population*	66.3		55.9	67.4	*2016*		4

SCORE	CANCER	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	11	7.3	9.2	7.5	*2011-2015*		7
2.25	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.2	20.7	20.2	20.9	*2011-2015*	Black	7

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Score		Units	Harris County	HP2020	Texas	U.S.	Measurement Period	High Disparity*	Source
1.94	Cancer: Medicare Population	percent	7.6		7.1	7.8	2015		3
1.58	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	percent	57.6		62.3		2016		10
1.53	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	19.8	21.8	18.1	19.5	2011-2015		7
1.39	Breast Cancer Incidence Rate	cases/ 100,000 females	113.2		111.7	124.7	2011-2015		7
1.33	Prostate Cancer Incidence Rate	cases/ 100,000 males	102.5		95.4	109	2011-2015		7
1.22	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.6	14.5	14.4	14.5	2011-2015		7
1.00	All Cancer Incidence Rate	cases/ 100,000 population	402.6		401.3	441.2	2011-2015		7
0.94	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	157.8	161.4	156.4	163.5	2011-2015	Black, Male	7
0.94	Colorectal Cancer Incidence Rate	cases/ 100,000 population	38.8	39.9	38.1	39.2	2011-2015		7
0.89	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	10.9		10.9	11.6	2011-2015		7
0.50	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	50.9		53.1	60.2	2011-2015		7
0.33	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	37.5	45.5	39	43.4	2011-2015		7
SCORE	CHILDREN'S HEALTH	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.81	Children with Health Insurance	percent	89.4	100	90.3		2016		9
1.67	Child Food Insecurity Rate	percent	23.5		23	17.9	2016		5
1.50	Children with Low Access to a Grocery Store	percent	5.4				2015		17
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	5.4		8.5		2017		11

SCORE	DIABETES	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Diabetes: Medicare Population	*percent*	28.1		28.2	26.5	*2015*		3
1.44	Adults with Diabetes	*percent*	10.2		11.2	10.5	*2016*		10
0.92	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	20.2		21.7	21.2	*2010-2014*	Black, Hispanic, Male	12

SCORE	ECONOMY	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.44	Homeownership	*percent*	49.6		55	55.9	*2012-2016*		1
2.39	Severe Housing Problems	*percent*	20.9		18.3	18.8	*2010-2014*		4
2.22	Students Eligible for the Free Lunch Program	*percent*	58.2		52.9	42.6	*2015-2016*		8
2.14	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	534		467	462	*2012-2016*		1
2.11	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2016*		17
2.08	Median Household Gross Rent	*dollars*	937		911	949	*2012-2016*		1
2.06	Families Living Below Poverty Level	*percent*	14.4		13	11	*2012-2016*	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other	1
2.06	Food Insecurity Rate	*percent*	16.6		15.4	12.9	*2016*		5
1.94	Unemployed Workers in Civilian Labor Force	*percent*	4.4		4	4.1	*July 2018*		15
1.89	People 65+ Living Below Poverty Level	*percent*	11.3		10.8	9.3	*2012-2016*	Asian, Black or African American, Hispanic or Latino, Other, Female, 75+	1
1.81	Mortgaged Owners Median Monthly Household Costs	*dollars*	1504		1444	1491	*2012-2016*		1
1.67	Child Food Insecurity Rate	*percent*	23.5		23	17.9	*2016*		5
1.67	Children Living Below Poverty Level	*percent*	26		23.9	21.2	*2012-2016*	American Indian or Alaska Native, Black	1

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							or African American, Hispanic or Latino, Other, <6	
1.67	People Living Below Poverty Level	percent	17.4		16.7	15.1	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Female, <6, 6-11, 12-17, 18-24	1
1.67	Total Employment Change	percent	2.4		3.2	2.5	2014-2015		16
1.50	Renters Spending 30% or More of Household Income on Rent	percent	46.8		48	47.3	2012-2016		1
1.42	Persons with Disability Living in Poverty (5-year)	percent	25.4		25.1	27.6	2012-2016		1
1.33	Low-Income and Low Access to a Grocery Store	percent	6.3				2015		17
1.33	People Living 200% Above Poverty Level	percent	61.6		62.8	66.4	2012-2016		1
1.08	Median Housing Unit Value	dollars	145600		142700	184700	2012-2016		1
0.97	Persons with Disability Living in Poverty	percent	22.9		24.2	26.6	2016		1
0.94	Female Population 16+ in Civilian Labor Force	percent	59.8		57.7	58.3	2012-2016		1
0.94	Population 16+ in Civilian Labor Force	percent	68.3		64.2	63.1	2012-2016		1
0.89	Households with Cash Public Assistance Income	percent	1.5		1.6	2.7	2012-2016		1
0.67	Homeowner Vacancy Rate	percent	1.5		1.6	1.8	2012-2016		1
0.50	Median Household Income	dollars	55584		54727	55322	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other	1
0.50	Per Capita Income	dollars	29850		27828	29829	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino,	1

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SCORE								Native Hawaiian or Other Pacific Islander, Other, Two or More Races	
SCORE	EDUCATION	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.92	Infants Born to Mothers with <12 Years Education	percent	27.5		21.6	15.9	2013		12
1.89	Student-to-Teacher Ratio	students/ teacher	16.4		15.4	17.7	2015-2016		8
1.67	High School Drop Out Rate	percent	2.6		2		2016		13
1.67	People 25+ with a High School Degree or Higher	percent	80.2		82.3	87	2012-2016	Male, 35-44, 45-64, 65+	1
0.67	People 25+ with a Bachelor's Degree or Higher	percent	30.1		28.1	30.3	2012-2016	American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, 45-64, 65+	1
SCORE	ENVIRONMENT	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.39	Severe Housing Problems	percent	20.9		18.3	18.8	2010-2014		4
2.11	SNAP Certified Stores	stores/ 1,000 population	0.6				2016		17
1.75	Annual Ozone Air Quality	grade	F				2014-2016		2
1.69	Annual Particle Pollution	grade	C				2014-2016		2
1.67	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2014		17
1.61	Recognized Carcinogens Released into Air	pounds	1962916				2017		18
1.50	Children with Low Access to a Grocery Store	percent	5.4				2015		17
1.50	Farmers Market Density	markets/ 1,000	0				2016		17

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
		population							
1.50	Grocery Store Density	stores/ 1,000 population	0.2				2014		17
1.33	Low-Income and Low Access to a Grocery Store	percent	6.3				2015		17
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		17
1.25	Drinking Water Violations	percent	1.7		6.6		FY 2013-14		4
1.17	PBT Released	pounds	210516				2017		18
1.00	Food Environment Index		7.2		6	7.7	2018		4
1.00	Households with No Car and Low Access to a Grocery Store	percent	0.9				2015		17
1.00	People 65+ with Low Access to a Grocery Store	percent	1.4				2015		17
0.89	Liquor Store Density	stores/ 100,000 population	6.3		6.8	10.5	2015		16
0.67	Access to Exercise Opportunities	percent	90.4		80.6	83.1	2018		4
0.17	Houses Built Prior to 1950	percent	6.2		7.4	18.2	2012-2016		1
SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Workers who Walk to Work	percent	1.5	3.1	1.6	2.8	2012-2016	White, non-Hispanic	1
2.11	SNAP Certified Stores	stores/ 1,000 population	0.6				2016		17
2.06	Food Insecurity Rate	percent	16.6		15.4	12.9	2016		5
1.67	Adults (18+ Years) Who Are Obese	percent	32	30.5	33.6	29.9	2016		10
1.67	Child Food Insecurity Rate	percent	23.5		23	17.9	2016		5
1.67	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2014		17
1.50	Adults who are Overweight or Obese	percent	66.7		68.4	65.2	2016		10
1.50	Children with Low Access to a Grocery Store	percent	5.4				2015		17

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SCORE		UNITS							
1.50	Farmers Market Density	markets/ 1,000 population	0				2016		17
1.50	Grocery Store Density	stores/ 1,000 population	0.2				2014		17
1.42	Adult Fruit and Vegetable Consumption	percent	18.7		17.2		2015		10
1.33	Low-Income and Low Access to a Grocery Store	percent	6.3				2015		17
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		17
1.00	Food Environment Index		7.2		6	7.7	2018		4
1.00	Households with No Car and Low Access to a Grocery Store	percent	0.9				2015		17
1.00	People 65+ with Low Access to a Grocery Store	percent	1.4				2015		17
0.67	Access to Exercise Opportunities	percent	90.4		80.6	83.1	2018		4
SCORE	HEART DISEASE & STROKE	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.61	Stroke: Medicare Population	percent	5.2		4.5	4	2015		3
1.89	Heart Failure: Medicare Population	percent	16		15.5	13.5	2015		3
1.50	Atrial Fibrillation: Medicare Population	percent	7.3		7.4	8.1	2015		3
1.44	Hyperlipidemia: Medicare Population	percent	43.2		46.1	44.6	2015		3
1.42	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	41.5	34.8	42	37.3	2010-2014	Black	12
1.33	Ischemic Heart Disease: Medicare Population	percent	28.8		28.8	26.5	2015		3
1.22	Hypertension: Medicare Population	percent	55.5		57.5	55	2015		3
0.92	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	167.6		173	171.9	2010-2014	Black, White, Male	12

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.33	Gonorrhea Incidence Rate	*cases/ 100,000 population*	182.1		160.2		*2017*		12
2.33	Syphilis Incidence Rate	*cases/ 100,000 population*	59.3		40.6		*2017*		12
2.11	Chlamydia Incidence Rate	*cases/ 100,000 population*	571.4		511.6		*2017*		12
1.83	Tuberculosis Incidence Rate	*cases/ 100,000 population*	6.6	1	4.5		*2013-2017*		12
1.78	Adults 65+ with Influenza Vaccination	*percent*	57.2		57.3	58.6	*2016*		10
1.67	HIV Diagnosis Rate	*cases/ 100,000 population*	26.3		16.1		*2016*		12
1.17	Adults 65+ with Pneumonia Vaccination	*percent*	73.5	90	71.3	73.4	*2016*		10
1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14		14.2	15.2	*2010-2014*	Black, Male	12
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.36	Infant Mortality Rate	*deaths/ 1,000 live births*	6.8	6	5.8	6	*2013*		12
1.97	Mothers who Received Early Prenatal Care	*percent*	56.1	77.9	59.2	74.2	*2013*		12
1.92	Infants Born to Mothers with <12 Years Education	*percent*	27.5		21.6	15.9	*2013*		12
1.81	Babies with Low Birth Weight	*percent*	8.6	7.8	8.3	8	*2013*		12
1.61	Babies with Very Low Birth Weight	*percent*	1.5	1.4	1.4	1.4	*2013*		12
1.25	Preterm Births	*percent*	11.8	9.4	12	11.4	*2013*		12
0.58	Teen Births	*percent*	2.5		2.8	4.3	*2014*		12
SCORE	MEN'S HEALTH	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source

SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.53	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	19.8	21.8	18.1	19.5	2011-2015		7
1.33	Prostate Cancer Incidence Rate	cases/ 100,000 males	102.5		95.4	109	2011-2015		7
1.28	Life Expectancy for Males	years	76.4		76.2	76.7	2014		6
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.89	Alzheimer's Disease or Dementia: Medicare Population	percent	11.4		11.7	9.9	2015		3
1.53	Poor Mental Health: 5+ Days	percent	80		81.5		2016		10
1.50	Poor Mental Health: Average Number of Days	days	3.7		3.4	3.8	2016		4
1.44	Mental Health Provider Rate	providers/ 100,000 population	103.7		98.8	214.3	2017		4
1.17	Frequent Mental Distress	percent	11.2		10.6	15	2016		4
0.94	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	10.3	10.2	11.7	12.5	2010-2014	White, Male	12
0.94	Depression: Medicare Population	percent	14.8		17	16.7	2015		3
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	17.9		26.6	24.5	2010-2014	White, Female	12
SCORE	OLDER ADULTS & AGING	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.67	Chronic Kidney Disease: Medicare Population	percent	20.9		19.9	18.1	2015		3
2.61	Stroke: Medicare Population	percent	5.2		4.5	4	2015		3
2.06	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	10.4	7.2	7.4	8.3	2010-2014	White, Male	12
1.94	Cancer: Medicare Population	percent	7.6		7.1	7.8	2015		3
1.89	Alzheimer's Disease or Dementia: Medicare Population	percent	11.4		11.7	9.9	2015		3
1.89	Heart Failure: Medicare Population	percent	16		15.5	13.5	2015		3

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.89	People 65+ Living Below Poverty Level	percent	11.3		10.8	9.3	2012-2016	Asian, Black or African American, Hispanic or Latino, Other, Female, 75+	1
1.78	Adults 65+ with Influenza Vaccination	percent	57.2		57.3	58.6	2016		10
1.72	Osteoporosis: Medicare Population	percent	6.3		6.5	6	2015		3
1.67	Diabetes: Medicare Population	percent	28.1		28.2	26.5	2015		3
1.50	Atrial Fibrillation: Medicare Population	percent	7.3		7.4	8.1	2015		3
1.44	Hyperlipidemia: Medicare Population	percent	43.2		46.1	44.6	2015		3
1.44	People 65+ Living Alone	percent	24.4		23.9	26.4	2012-2016		1
1.33	Ischemic Heart Disease: Medicare Population	percent	28.8		28.8	26.5	2015		3
1.22	Hypertension: Medicare Population	percent	55.5		57.5	55	2015		3
1.17	Adults 65+ with Pneumonia Vaccination	percent	73.5	90	71.3	73.4	2016		10
1.00	People 65+ with Low Access to a Grocery Store	percent	1.4				2015		17
0.94	Asthma: Medicare Population	percent	7.3		8.2	8.2	2015		3
0.94	Depression: Medicare Population	percent	14.8		17	16.7	2015		3
0.94	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	27.8		31.6	30	2015		3
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	17.9		26.6	24.5	2010-2014	White, Female	12
0.39	COPD: Medicare Population	percent	9.6		11.1	11.2	2015		3
SCORE	OTHER CHRONIC DISEASES	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.67	Chronic Kidney Disease: Medicare Population	percent	20.9		19.9	18.1	2015		3
1.72	Osteoporosis: Medicare Population	percent	6.3		6.5	6	2015		3

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.94	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	27.8		31.6	30	2015		3
SCORE	**PREVENTION & SAFETY**	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.39	Severe Housing Problems	percent	20.9		18.3	18.8	2010-2014		4
2.06	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	10.4	7.2	7.4	8.3	2010-2014	White, Male	12
1.19	Death Rate due to Drug Poisoning	deaths/ 100,000 population	10.2		9.8	16.9	2014-2016		4
0.69	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	36.1	36.4	37.6	39.2	2010-2014	White, Male	12
SCORE	**PUBLIC SAFETY**	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Alcohol-Impaired Driving Deaths	percent	37.8		28.3	29.3	2012-2016		4
1.67	Violent Crime Rate	crimes/ 100,000 population	713.7		407.6		2012-2014		4
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	5.4		8.5		2017		11
SCORE	**RESPIRATORY DISEASES**	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Tuberculosis Incidence Rate	cases/ 100,000 population	6.6	1	4.5		2013-2017		12
1.78	Adults 65+ with Influenza Vaccination	percent	57.2		57.3	58.6	2016		10
1.17	Adults 65+ with Pneumonia Vaccination	percent	73.5	90	71.3	73.4	2016		10
1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	14		14.2	15.2	2010-2014	Black, Male	12
0.94	Asthma: Medicare Population	percent	7.3		8.2	8.2	2015		3
0.50	Lung and Bronchus Cancer	cases/ 100,000	50.9		53.1	60.2	2011-2015		7

SCORE		UNITS							

SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Incidence Rate	population							
0.39	COPD: Medicare Population	percent	9.6		11.1	11.2	2015		3
0.33	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	37.5	45.5	39	43.4	2011-2015		7
SCORE	SOCIAL ENVIRONMENT	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.67	Mean Travel Time to Work	minutes	28.6		25.9	26.1	2012-2016	Male	1
2.50	Linguistic Isolation	percent	11.8		7.9	4.5	2012-2016		1
2.44	Homeownership	percent	49.6		55	55.9	2012-2016		1
2.17	Single-Parent Households	percent	36.2		33.3	33.6	2012-2016		1
2.14	Median Monthly Owner Costs for Households without a Mortgage	dollars	534		467	462	2012-2016		1
2.08	Median Household Gross Rent	dollars	937		911	949	2012-2016		1
1.81	Mortgaged Owners Median Monthly Household Costs	dollars	1504		1444	1491	2012-2016		1
1.75	Persons with Health Insurance	percent	79.3	100	81.4		2016		9
1.67	Children Living Below Poverty Level	percent	26		23.9	21.2	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, <6	1
1.67	People 25+ with a High School Degree or Higher	percent	80.2		82.3	87	2012-2016	Male, 35-44, 45-64, 65+	1
1.67	People Living Below Poverty Level	percent	17.4		16.7	15.1	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Female, <6, 6-11, 12-17, 18-24	1
1.67	Total Employment Change	percent	2.4		3.2	2.5	2014-2015		16
1.67	Voter Turnout: Presidential Election	percent	58.4		58.8		2016		14

SCORE		UNITS		HP2020		U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.44	People 65+ Living Alone	percent	24.4		23.9	26.4	*2012-2016*		1
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	5.4		8.5		*2017*		11
1.08	Median Housing Unit Value	dollars	145600		142700	184700	*2012-2016*		1
0.94	Female Population 16+ in Civilian Labor Force	percent	59.8		57.7	58.3	*2012-2016*		1
0.94	Population 16+ in Civilian Labor Force	percent	68.3		64.2	63.1	*2012-2016*		1
0.67	People 25+ with a Bachelor's Degree or Higher	percent	30.1		28.1	30.3	*2012-2016*	American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, 45-64, 65+	1
0.50	Median Household Income	dollars	55584		54727	55322	*2012-2016*	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other	1
0.50	Per Capita Income	dollars	29850		27828	29829	*2012-2016*	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, Two or More Races	1
SCORE	**SUBSTANCE ABUSE**	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Alcohol-Impaired Driving Deaths	percent	37.8		28.3	29.3	*2012-2016*		4
1.50	Adults who Drink Excessively	percent	18.1	25.4	19.4	18	*2016*		4
1.28	Adults (18+ Years) Reporting Binge Drinking Within the Last 12 months	percent	16.6	24.2	17.9	16.9	*2016*		10
1.19	Death Rate due to Drug Poisoning	deaths/ 100,000 population	10.2		9.8	16.9	*2014-2016*		4

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.94	Adults who Smoke	percent	12.1	12	14.3	17.1	2016		10
0.89	Liquor Store Density	stores/ 100,000 population	6.3		6.8	10.5	2015		16

SCORE	TRANSPORTATION	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.83	Solo Drivers with a Long Commute	percent	45.8		36.9	34.7	2012-2016		4
2.67	Mean Travel Time to Work	minutes	28.6		25.9	26.1	2012-2016	Male	1
2.17	Workers who Walk to Work	percent	1.5	3.1	1.6	2.8	2012-2016	White, non-Hispanic	1
1.44	Workers who Drive Alone to Work	percent	79.1		80.3	76.4	2012-2016	White, non-Hispanic, 25-44, 55-59	1
1.33	Households without a Vehicle	percent	6.4		5.6	9	2012-2016		1
1.28	Workers Commuting by Public Transportation	percent	2.8	5.5	1.5	5.1	2012-2016	Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Two or More Races, White, non-Hispanic, Male, 25-44	1
1.00	Households with No Car and Low Access to a Grocery Store	percent	0.9				2015		17

SCORE	WELLNESS & LIFESTYLE	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Self-Reported General Health Assessment: Poor or Fair	percent	18.2		18.2	16	2016		4
1.75	Poor Physical Health: 5+ Days	percent	80.6		81.5		2016		10
1.67	Insufficient Sleep	percent	33.9		32.7	38	2016		4
1.28	Life Expectancy for Males	years	76.4		76.2	76.7	2014		6
1.17	Frequent Physical Distress	percent	11.5		10.8	15	2016		4
1.17	Poor Physical Health: Average Number of Days	days	3.6		3.5	3.7	2016		4

SCORE		UNITS		HP2020		U.S.	MEASUREMENT PERIOD		Source
1.06	Life Expectancy for Females	years	81		80.8	81.5	2014		6

SCORE	WOMEN'S HEALTH	UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Cervical Cancer Incidence Rate	cases/ 100,000 females	11	7.3	9.2	7.5	2011-2015		7
2.25	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	23.2	20.7	20.2	20.9	2011-2015	Black	7
1.39	Breast Cancer Incidence Rate	cases/ 100,000 females	113.2		111.7	124.7	2011-2015		7
1.06	Life Expectancy for Females	years	81		80.8	81.5	2014		6

Appendix C. Primary Data Methodology

Community Input Participants

AccessHealth (FQHC) (Fort Bend Family Health Center)

AIDS Foundation of Houston

Association for the Advancement of Mexican Americans

Avenue CDC

Catholic Charities - Archdiocese of Galveston

Catholic Charities - Fort Bend

Child Advocates of Fort Bend

Children at Risk

Christ Clinic

City of Houston, Department of Parks and Recreation

Coastal Area Health Education Centers (AHEC)

Community Health Choice

El Centro de Corazon

Episcopal Health Foundation

Fort Bend County Health and Human Services

Fort Bend County Sheriff's Office

Fort Bend Regional Council On Substance Abuse

Fort Bend Seniors Meals on Wheels

Fort Bend Women's Center

Galveston County Health District

Galveston County Mental Health Deputies

Greater Houston Partnership

Greater Houston Women's Chamber of Commerce

Gulf Coast Medical Foundation

Harris County Public Health

Healthcare for the Homeless - Houston

HOPE Clinic (FQHC)

Houston Food Bank

Houston Health Department

Houston Housing Authority

Houston Independent School District

Interfaith Community Clinic

Kinder Institute

Legacy Community Health

Liberty County Sheriff's Office

Lone Star Family Health Center

Midtown Arts and Theater Center Houston

Montgomery County Women's Center

Baker-Ripley Early Head Start

Patient Care Intervention Center (PCIC)

Prairie View A&M University

Santa Maria Hostel, Inc.

The Arc of Fort Bend County

The Harris Center for Mental Health and IDD (formerly MHMRA)

The Rose

The Women's Home

Tri-County Services Behavioral Healthcare

United Way of Brazoria County

United Way of Greater Houston

United Way of Harris and Montgomery County

West Chambers Medical Center (FQHC)

YMCA of Greater Houston

Key Informant Interview Questionnaire (Episcopal Health Foundation)

- Good morning/afternoon [NAME OF INFORMANT]. My name is [NAME OF INTERVIEWER], and I am with Health Resources in Action, a non-profit public health organization based in Boston. Thank you for speaking with me today.

- As we mentioned in our interview invitation, the Episcopal Health Foundation is coordinating an interview initiative to support four Greater Houston area hospital systems in preparing their community health needs assessments. The collaborating hospitals include CHI St. Luke's, Houston Methodist Hospital, Memorial Hermann Health System, and Texas Children's Hospital.

- The purpose of this interview is to gain a greater understanding of the health status and wellbeing of residents in the Greater Houston area and determine how these health needs are currently being addressed. Interviews like this one are being conducted with about 70 stakeholders from a range of sectors such as government, healthcare, business, and community service organizations. We are also interviewing community leaders with specific experience working with priority populations such as women, children, people of color, and the disabled to name a few.

- We are interested in hearing people's feedback on the needs of the broader Greater Houston community and the populations you work with as a leader in your community. The Foundation and the four hospitals welcome your critical feedback and suggestions for health improvement activities in the future. Your honesty during today's interview is encouraged and appreciated.

- As we mentioned in our interview invitation, the interview will last between 45 minutes to an hour and it will be recorded. After all the interviews are completed, Health Resources in Action will provide a transcript of your interview to the four hospitals for use in preparing their community health needs assessment reports. Each hospital will keep your interview transcript confidential and accessible only to the team that is preparing the community health needs assessment report. Health Resources in Action will also be preparing a report of the general themes that emerge across all the interviews to help the hospitals prepare their reports.

- The Foundation has asked Health Resources in Action to ask all interviewees how they wish any quotes from today's interview to be presented in reports. There are three options. Quotes may be presented anonymously without your name or organization, presented with your name and organization, or presented with only the sector you represent. Which option would you like to choose?
    - RECORD RESPONSE FROM INTERVIEWEE:
      ❐ Anonymous ❐ Name and organization ❐ Sector

- Thank you. We will note your choice in the transcript that we provide to the hospitals.

- IF THE RESPONDENT IS UNSURE AT THE TIME OF THE INTERVIEW: Ok, please feel free to think it over and we will follow up with you for your decision before we send the transcript to the hospitals.

- Do you have any questions before we begin? BEGIN RECORDING THE INTERVIEW

INTERVIEW QUESTIONNAIRE (55 MINUTES)

NOTES TO INTERVIEWER:
- INTERVIEW QUESTIONS MAY BE ADDED OR TAILORED TO MEET THE SPECIFIC POSITION/ROLE OF THE INTERVIEWEE
- THE QUESTIONS IN THE INTERVIEW QUESTIONNAIRE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT

BACKGROUND (5 MINUTES)

- Can you tell me a little bit about your role at your organization/agency?
  - Has your organization/agency ever partnered with any of the four hospitals involved in this shared community health needs assessment before? IF SO, PROBE IN WHAT CAPACITY/PROGRAM

- How would you describe the community you represent/the community your organization serves/the Greater Houston population at large? What are some of its defining characteristics in terms of demographics? INTERVIEWER: ESTABLISH WHAT THE INFORMANT CONSIDERS THE COMMUNITY TO BE FROM THEIR PERSPECTIVE

COMMUNITY ISSUES (20 minutes)
INTERVIEWER: VARY THE LABEL OF 'COMMUNITY' BASED ON THE INFORMANT'S BACKGROUND AND HOW HE OR SHE DESCRIBES THE COMMUNITY; BE SURE TO PROBE ON WOMEN'S AND CHILDREN'S ISSUES TO ENSURE WE ADDRESS THE NEEDS OF THE CHILDREN'S HOSPITALS IN ALL QUESTIONS AS RELEVANT

- Thinking about the status of the community today, how would you rate the overall health status of residents on a scale of 1 to 5 with 1 being poor and 5 being very healthy?

- If you had to pick your top 3 health concerns in the community, what would they be? PROBE IN-DEPTH BASED ON INFORMANT AREA OF EXPERTISE

  - Who do you consider to be the populations in the community most vulnerable or at risk for these conditions/issues?

    - IF NOT YET MENTIONED, PROBE SPECIFICALLY ON PRIORITY POPULATION RELEVANT TO THE INFORMANT'S EXPERTISE: What do you think are the most pressing health concerns in the community for [PRIORITY POPULATION]?

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- FOR INFORMANTS EXPERTISE WITH WOMEN AND CHILDREN: What do you think are the most pressing health concerns in the community for children and their families? How about for women?

- IF NOT YET DISCUSSED: Of the top three issues you mentioned, which would you rank as your top issue? How do you see this issue affecting community members' daily lives and their health? PROBE IN-DEPTH IN SPECIFIC FOCUS AREAS; MAY ASK ABOUT ONE ISSUE AT TIME AND FOCUS ON PERSON'S AREA OF EXPERTISE.

- From your experience, what are residents' biggest barriers to addressing the top 3 health issues you identified?
  - PROBE: Social determinants of health?
  - PROBE: Barriers to accessing medical care?
  - PROBE: Barriers to accessing preventive services or programs?

FOCUS AREA: HEALTHY LIVING (5 MINUTES)

- I'd like to ask you about barriers affecting healthy living and the prevention of obesity.
  - What are some of the barriers to healthy eating and physical activity among the communities you serve?
    - What populations are most affected by barriers to healthy living and physical activity? PROBE ABOUT FOOD INSECURITY AND ACCESS TO SAFE SPACES FOR PHYSICAL ACTIVITY
  - What efforts or programs are you aware of that promote healthy living? PROBE ABOUT HEALTHY LIVING MATTERS COLLABORATIVE

ACCESS TO HEALTH CARE AND PUBLIC HEALTH/PREVENTION SERVICES (15 MINUTES)

- I'd like to ask you about access to health care and social services in your community.
  - What do you see as the strengths of the health care and social services in your community?
  - What do you see as its limitations?

- What challenges/barriers do residents in your community face in accessing health care and social services? [PROBE IN DEPTH FOR BARRIERS TO CARE: INSURANCE ISSUES, LANGUAGE BARRIERS, ACCESS TO HEALTH INFORMATION/HEALTH LITERACY, LACK OF TRANSPORTION, CHILD CARE, ETC.]

  - What do you think needs to happen in the community you serve to help residents overcome or address these challenges?

- What programs, services, or policies are you aware of in the community that address access to health care and social services?

- In your opinion, how effective have these programs, services, or policies been at addressing the health needs of residents?

- What program, services, or policies are currently not available that you think should be?

IMPROVING THE HEALTH OF THE COMMUNITY/RESIDENTS (10 MINUTES)

- What do you think needs to happen in the community you serve to help residents overcome or address the challenges they face in being able to be healthy?

- Earlier in this interview, you mentioned [TOP ISSUE] as being your top health priority for area residents. What do you think needs to be done to address [TOP ISSUE HERE]?

  - What do you think hospitals can do to address this issue that they aren't doing right now? Do you have any suggestions about how hospitals can be creative or work outside their traditional role to address this issue and improve community health?

  - What kinds of opportunities are currently out there that can be seized upon to address these issues? For example, are there some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?

VISION FOR THE COMMUNITY (5 MINUTES)

- The hospitals involved in this initiative will be planning their strategy to improve the health of the communities they serve. What advice do you have for the group developing the plan to address the top health needs you've mentioned?

CLOSING (5 MINUTES)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned, after all of the interviews are completed, we will be sending your interview transcripts to the four hospitals. Each hospital will make their community health needs assessment reports publicly available when they are complete. If you have any questions, please feel free to reach out to Jennifer Mineo at the Episcopal Health Foundation who is coordinating this effort on behalf of the four hospitals. Thank you again. Have a good morning/afternoon.

Key Informant Interview Questionnaire (Conduent Healthy Communities Institute)

Good morning/afternoon [NAME OF INFORMANT]. My name is [NAME OF INTERVIEWER], and I am with Conduent Healthy Communities Institute. My colleague [**name**] is also on the line. We are working with Memorial Hermann Health System to conduct a Community Health Needs Assessment.

- **The purpose of this interview is to gain a greater understanding of the health status and wellbeing of residents in the Greater Houston area and determine how these health needs are currently being addressed.** Interviews like this one are being conducted with about 12 stakeholders from a range of sectors such as government, healthcare, business, and community service organizations. We are also interviewing community leaders with specific experience working with priority populations such as women, children, people of color, and the disabled to name a few.

- We are interested in hearing people's feedback on the needs of the community and the populations you work with as a leader in your community. Memorial Hermann welcome your critical feedback and suggestions for health improvement activities in the future. Your honesty during today's interview is encouraged and appreciated.

- As we mentioned in our interview invitation, the interview will last between 45 minutes to an hour and it will be recorded. After all the interviews are completed, we will analyze and summarize all the interviews to incorporate into the community health needs assessment reports. Each MH hospital will keep your interview transcript confidential and accessible only to the team that is preparing the community health needs assessment report.

- Memorial Hermann has asked HCI to ask all interviewees how they wish any quotes from today's interview to be presented in reports. **There are three options. Quotes may be presented anonymously without your name or organization, presented with your name and organization, or presented with only the sector you represent.**

    - Which option would you like to choose?
        - RECORD RESPONSE FROM INTERVIEWEE:
          ☐ Anonymous ☐ Name and organization ☐ Sector

- Thank you. We will note your choice in the transcript that we provide to the hospitals.
    - IF THE RESPONDENT IS UNSURE AT THE TIME OF THE INTERVIEW: Ok, please feel free to think it over and we will follow up with you for your decision before we send the transcript to the hospitals.

    - Do you have any questions before we begin? BEGIN RECORDING THE INTERVIEW

INTERVIEW QUESTIONNAIRE (55 MINUTES)

NOTES TO INTERVIEWER:
- INTERVIEW QUESTIONS MAY BE ADDED OR TAILORED TO MEET THE SPECIFIC POSITION/ROLE OF THE INTERVIEWEE
- THE QUESTIONS IN THE INTERVIEW QUESTIONNAIRE ARE INTENDED TO SERVE AS A <u>GUIDE</u>, NOT A SCRIPT

BACKGROUND (5 MINUTES)

- **Can you tell me a little bit about your role at your organization?**
  - Has your organization/agency ever partnered with MH's community health needs assessment before? IF SO, PROBE IN WHAT CAPACITY/PROGRAM

- **How would you describe the community you represent/the community your organization serves?** What are some of its defining characteristics in terms of demographics? INTERVIEWER: ESTABLISH WHAT THE INFORMANT CONSIDERS THE COMMUNITY TO BE FROM THEIR PERSPECTIVE

COMMUNITY ISSUES (20 minutes)
INTERVIEWER: VARY THE LABEL OF 'COMMUNITY' BASED ON THE INFORMANT'S BACKGROUND AND HOW HE OR SHE DESCRIBES THE COMMUNITY; BE SURE TO PROBE ON WOMEN'S AND CHILDREN'S ISSUES TO ENSURE WE ADDRESS THE NEEDS OF THE CHILDREN'S HOSPITALS IN ALL QUESTIONS AS RELEVANT

- **Thinking about the status of the community today, how would you rate the overall health status of residents on a scale of 1 to 5 with 1 being poor and 5 being very healthy?**

- **If you had to pick your top 3 <u>health</u> concerns in the community, what would they be? PROBE IN-DEPTH BASED ON INFORMANT AREA OF EXPERTISE**

  - Who do you consider to be the populations in the community most vulnerable or at risk for these conditions/issues?

    - IF NOT YET MENTIONED, PROBE SPECIFICALLY ON PRIORITY POPULATION RELEVANT TO THE INFORMANT'S EXPERTISE: **What do you think are the most pressing <u>health</u> concerns in the community for [PRIORITY POPULATION]?**

    - FOR INFORMANTS EXPERTISE WITH WOMEN AND CHILDREN: **What do you think are the most pressing health concerns in the community for children and their families? How about for women?**

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- IF NOT YET DISCUSSED: **Of the top three issues you mentioned, which would you rank as your top issue? How do you see this issue affecting community members' daily lives and their health?** PROBE IN-DEPTH IN SPECIFIC FOCUS AREAS; MAY ASK ABOUT ONE ISSUE AT TIME AND FOCUS ON PERSON'S AREA OF EXPERTISE.

- **From your experience, what are residents' biggest barriers to addressing the top 3 health issues you identified?**
    o PROBE: Social determinants of health?
    o PROBE: Barriers to accessing medical care?
    o PROBE: Barriers to accessing preventive services or programs?

FOCUS AREA: HEALTHY LIVING (5 MINUTES)

- **I'd like to ask you about barriers affecting healthy living and the prevention of obesity.**
    o **What are some of the barriers to healthy eating and physical activity among the communities you serve?**
        ▪ **What populations are most affected by these barriers to healthy living and physical activity**? PROBE ABOUT FOOD INSECURITY AND ACCESS TO SAFE SPACES FOR PHYSICAL ACTIVITY
    o **What efforts or programs are you aware of that promote healthy living?** PROBE ABOUT HEALTHY LIVING MATTERS COLLABORATIVE

ACCESS TO HEALTH CARE AND PUBLIC HEALTH/PREVENTION SERVICES (15 MINUTES)

- I'd like to ask you about access to health care and social services in your community.
    o **What ARE the strengths of the health care and social services in your community?**

    o **What are some of their limitations?**

- **What challenges/barriers do residents in your community face when accessing health care and social services?** [PROBE IN DEPTH FOR BARRIERS TO CARE: INSURANCE ISSUES, LANGUAGE BARRIERS, ACCESS TO HEALTH INFORMATION/HEALTH LITERACY, LACK OF TRANSPORTION, CHILD CARE, ETC.]

    o **What do you think needs to happen in the community to help residents overcome or address these challenges?**

- **What programs, services, or policies are you aware of that address access to health care and social services?**

    o **In your opinion, how effective have these programs, services, or policies been at addressing the health needs of residents?**

    o **What program, services, or policies not available that you think should be?**

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IMPROVING THE HEALTH OF THE COMMUNITY/RESIDENTS (10 MINUTES)

- **What do you think needs to happen in the community to help residents overcome or address the challenges they face in being able to be healthy?**

- Earlier in this interview, you mentioned [TOP ISSUE] as being your top health priority for area residents. What do you think needs to be done to address [TOP ISSUE HERE]?

  - **What do you think hospitals can do to address this issue that they are not doing right now?**

  - Do you have any suggestions about how hospitals can be creative or work outside their traditional role to address this issue and improve community health?

  - What kinds of opportunities are currently out there that can be seized upon to address these issues? For example, are there some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?

VISION FOR THE COMMUNITY (5 MINUTES)

- The hospitals involved in this initiative will be planning their strategy to improve the health of the communities they serve.

  What advice do you have for the group developing the plan to address the top health needs you've mentioned?

CLOSING (5 MINUTES)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned, after all of the interviews are completed, we will be sending your interview transcripts to Memorial Hermann. The community health needs assessment reports will be **publicly** available when they are complete. If you have any questions, please feel free to reach out to Deborah Ganelin at Memorial Hermann who is coordinating this effort. Thank you again. Have a good morning/afternoon.

Community Survey (English)

Memorial Hermann Health System is conducting a Community Health Needs Assessment for the Greater Houston area. This assessment allows Memorial Hermann to better understand the health status and needs of the community and use the knowledge gained to implement programs that will benefit the community.

We can better understand community needs by gathering voices from the community. This survey allows community members like you to tell us about what you feel are important issues for your community.

We estimate that it will take about 5 minutes to complete this survey.

Thank you very much for your input and your time!

1. Please look at this list of community issues. In your opinion, what are the **top 5 issues** most affecting the quality of life in your community?
   - ☐ Diabetes
   - ☐ Obesity/Overweight
   - ☐ Respiratory/Lung Disease (asthma, COPD, etc.)
   - ☐ Cancers
   - ☐ Mental Health and Mental Disorders
   - ☐ Injuries, Violence and Safety
   - ☐ Substance Abuse (alcohol, tobacco, drugs, etc.)
   - ☐ Oral Health
   - ☐ Heart Disease and Stroke
   - ☐ Sexual Health (HIV/AIDS, STDs, etc.)
   - ☐ Teenage Pregnancy
   - ☐ Elder Care
   - ☐ Reproductive Health (family planning)
   - ☐ Other (please specify): _____

2. How would you rate your own personal health?
   - ☐ Very healthy
   - ☐ Somewhat healthy
   - ☐ Unhealthy
   - ☐ Very unhealthy

3. About how many times a week do you exercise or perform a physical activity like walking, running, bicycling, etc.?
   - ☐ Less than 1 time a week
   - ☐ 2-3 times a week
   - ☐ 5 or more times a week
   - ☐ Never
   - ☐ Other (please specify): _____

4. What are some of the barriers or challenges to exercising on a regular basis for you?
   - ☐ No places to exercise
   - ☐ No time to exercise
   - ☐ I don't like exercising
   - ☐ Feel unsafe exercising in the community
   - ☐ None of my friends or family exercise
   - ☐ No childcare
   - ☐ Lack of funds to pay for gym or classes
   - ☐ No transportation
   - ☐ Other (please specify): _____

5. How much do you agree or disagree with each of the statements below.

	Agree strongly	Agree	Disagree	Disagree strongly
There are good parks for children, adults and people of all abilities to enjoy in my community				
In the past 12 months, I had a problem getting the health care I needed for me or a family member from any type of health care provider, dentist, pharmacy, or other facility				
I don't know where to get services for myself when I am sad, depressed or need someone to talk to				
I am confident I can get an appointment when I need to see my doctor fairly quickly				
I have a place to receive medical care other than the emergency room				
Within the past 12 months, I worried whether my food would run out before I got money to buy more				
Within the past 12 months, the food I bought just didn't last and I didn't have money to get more				
There are many options for healthy and affordable food in my community				

6. Has your doctor ever told you that you have any of the following? (Mark all that apply)
   - ☐ High blood pressure
   - ☐ High cholesterol
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Obesity
   - ☐ Asthma
   - ☐ Heart disease
   - ☐ Other (please specify): _____

Now, a few questions so that we can see how different types of people feel about the questions asked.

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7. Zip code where you live: _____

8. What is your age? _____

9. What is your race/ethnicity?
   ☐ White
   ☐ Black/African American
   ☐ Hispanic/Latino
   ☐ Asian/Pacific Islander
   ☐ Native American
   ☐ Other (please specify): _____

10. What are the ages of children living in your household?
    ☐ 11 and younger
    ☐ 12-18 years old
    ☐ 18 and older
    ☐ None

11. What kind of medical insurance or coverage do you have?
    ☐ Private
    ☐ Employer-sponsored
    ☐ Medicaid
    ☐ Medicare
    ☐ None
    ☐ Other (please specify): _____

Thank you for completing this survey!

Community Survey (Spanish)

Memorial Hermann Health System está realizando una Evaluación de las Necesidades de Salud de la Comunidad en el área metropolitana de Houston. Esta evaluación permite a Memorial Hermann comprender mejor el estado de salud y las necesidades de la comunidad, así como usar la información obtenida para poner en práctica programas que beneficien a la comunidad.

Calculamos que le tomará unos 5 minutos completar esta encuesta.

---

1. Lea la lista de problemas de la comunidad. En su opinión ¿cuáles son los **5 problemas que más afectan** la calidad de vida en su comunidad?

□ Diabetes

□ Obesidad/sobrepeso

□ Enfermedades respiratorias/pulmonares (asma, enfermedad pulmonar obstructiva crónica [EPOC], etc.)

□ Cáncer

□ Salud mental y trastornos mentales

□ Lesiones, violencia y seguridad

□ Drogodependencia (alcohol, tabaco, drogas, etc.)

□ Salud bucal

□ Enfermedades cardíacas y accidentes cerebrovasculares

□ Salud sexual (VIH/sida, enfermedades de transmisión sexual [ETS], etc.)

□ Embarazos de adolescentes

□ Cuidado de ancianos

□ Salud reproductiva (planificación familiar)

□ Otros, (especifique): _____

2. ¿Cómo calificaría su propia salud personal?

□ Muy buena

□ Bastante buena

□ Mala

□ Muy mala

3. ¿Aproximadamente, cuántas veces por semana hace ejercicio o alguna actividad física, como caminar, correr, andar en bicicleta, etc.?

□ Menos de 1 vez por semana

□ De 2 a 3 veces por semana

□ 5 o más veces por semana

□ Nunca

□ Otros, (especifique): _____

4. ¿Cuáles son algunas de las barreras o dificultades que le impiden hacer ejercicio regularmente?

□ No tengo un lugar donde hacer ejercicio.

□ No tengo tiempo para hacer ejercicio.

□ No me gusta hacer ejercicio.

□ No me siento seguro/a haciendo ejercicio en mi comunidad.

□ Ninguno de mis amigos o familiares hacen ejercicio.

□ No tengo con quién dejar a mis hijos mientras hago ejercicio.

□ No tengo dinero para pagar un gimnasio o clases.

□ No tengo acceso a transporte.

□ Otros, (especifique): _____

5. ¿Le ha dicho su médico alguna de las siguientes afecciones? (Marque todas las opciones que correspondan).

□ Presión arterial alta

□ Colesterol alto

□ Cáncer

□ Diabetes

□ Otros, (especifique): _____

□ Obesidad

□ Asma

□ Enfermedad cardíaca

6. ¿En qué medida está de acuerdo o en desacuerdo con cada una de las siguientes afirmaciones?

	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
En mi comunidad, hay buenos parques para niños, adultos y personas con todo tipo de capacidades para nuestro disfrute.				
En los últimos 12 meses, tuve un problema para obtener el cuidado médico que necesitaba para mí o para un familiar por parte de cualquier tipo de proveedor de cuidado de la salud, dentista, farmacia u otro centro sanitario.				
No sé dónde obtener servicios para mí cuando estoy triste, deprimido/a, o necesito hablar con alguien.				
Sé con seguridad que puedo obtener una cita con mi médico con cierta rapidez.				
Tengo a mi disposición un lugar para recibir cuidados médicos que no sea una sala de emergencias.				
En los últimos 12 meses, me preocupé de si la comida se agotaría antes de obtener dinero para comprar más alimentos.				
En los últimos 12 meses, los alimentos que compré simplemente no duraron lo suficiente y no tuve dinero para comprar más.				
En mi comunidad hay muchas opciones para comprar alimentos saludables y asequibles.				

Ahora le haremos algunas preguntas para poder ver cómo se sienten los distintos grupos de personas acerca de las preguntas que le hemos hecho.

7. Código postal de su casa: _____

8. ¿Cuántos años tiene? _____

9. ¿Cuál es su raza/origen étnico?

□ Blanco/a

□ Negro/a o afroamericano/a

□ Hispano/a o latino/a

□ Asiático/a o isleño/a del Pacífico

□ Indígena americano/a

□ Otro/a, (especifique): _____

10. ¿Cuántos años tienen los niños/as que viven en su casa?

□ 11 y menos   □ Más de 18 años

□ Entre 12 y 18 años   □ Ninguno

11. ¿Qué tipo de seguro médico o cobertura tiene?

□ Privado   □ Medicare

□ Patrocinado por un empleador   □ Ninguno

□ Medicaid   □ Otro, (especifique): _____

Appendix D. Prioritization Tool

Prioritization Survey

Thank you for your participation in this prioritization process.

The Community Health Needs Assessment (CHNA) process has multiple steps. After thorough research has been completed to identify the significant health needs in the community, these significant health needs must be prioritized for further strategic planning and implementation. Prioritization is the process of determining the most important or urgent health needs to address in communities.

Below is a diagram that shows the methods that were used to identify key issues across Memorial Hermann's service areas. These three methods included: a secondary data review, a community survey and key informant interviews. As you see, some issues revealed themselves across multiple methods. Reviewing this diagram may help you complete this survey.
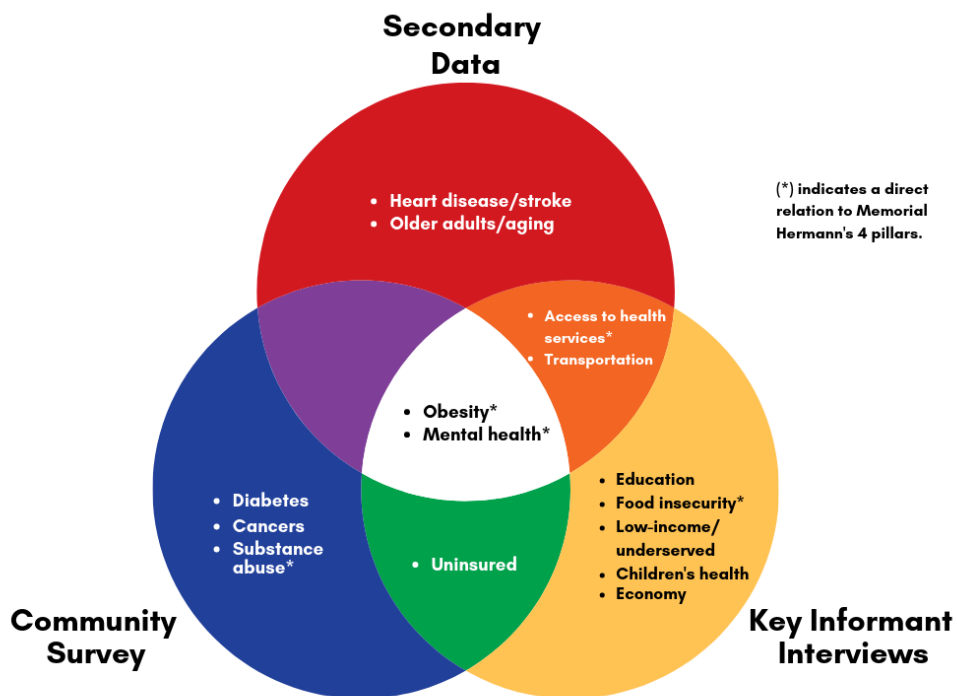
1. The following health needs are not listed by order of importance. For each health need, click on the arrow on the drop down box and select your agreement with each statement. If you are on a tablet or phone, please scroll all the way to the right for each row.

The issue **impacts many people** in my community	This issue **significantly impacts**	There are not enough **existing and adequate**	This issue has **high risk for disease** or death

		subgroups (subgroups by age, gender, race/ethnicity, LGBTQ, etc.)	resources to address this issue in my community	
Access to Health Services				
Heart Disease and Stroke				
Older Adults and Aging				
Obesity (Exercise, Nutrition and Weight)				
Transportation				
Mental Health				
Diabetes				
Substance Abuse				
Cancers				
Lack of Health Insurance				
Education				
Food Insecurity				
Low-Income/Underserved				
Children's Health				
Economy				

2. Indicate the level of importance that should be given towards each of Memorial Hermann's 4 Pillars. Key definitions are listed below.

	Not Important	Somewhat Important	Important	Very Important	Not Sure
Access to care (including healthcare access, healthcare resource awareness, healthcare navigation / literacy)					
Food as health (including food insecurity, food programs, food knowledge)					
Exercise as medicine (including obesity, access to parks, safe places to exercise)					
Emotional well-being (including emotional health, mental health, substance abuse)					

Key definitions:

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Healthcare navigation/literacy: need for education in navigating health systems
Food insecurity: lacking reliable access to healthy food options
Food programs: programs, efforts or services designed to address food issues
Food knowledge: one's understanding of healthy foods

3. Who in your community is most affected by poor health outcomes? (Select up to 5)
    ☐ Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ)
    ☐ Older Adults
    ☐ Persons with Disabilities (cognitive, sensory or physical disability)
    ☐ Racial/Ethnic Minority Populations
    ☐ Veterans
    ☐ Immigrants or other undocumented persons
    ☐ Persons experiencing homelessness or precariously housed
    ☐ Other Populations (please specify): _____

4. Please provide your name: _____

5. Please provide your email address: _____

6. Please select the name(s) of the healthcare facility or facilities you represent. You may choose more than one.
    ☐ Memorial Hermann Katy
    ☐ Memorial Hermann Memorial City
    ☐ Memorial Hermann Greater Heights
    ☐ Memorial Hermann Northeast
    ☐ Memorial Hermann Southeast
    ☐ Memorial Hermann Sugar Land
    ☐ Memorial Hermann Southwest
    ☐ Memorial Hermann The Woodlands
    ☐ Katy Rehab
    ☐ Texas Medical Center
    ☐ TIRR Memorial Hermann
    ☐ Memorial Hermann Surgical Hospital Kingwood
    ☐ Memorial Hermann Surgical Hospital First Colony
    ☐ Memorial Hermann First Colony Hospital (ER)
    ☐ Memorial Hermann Tomball Hospital (ER)
    ☐ Other (please specify): _____

Thank you for your input and participation in the Community Health Needs Assessment process.

Appendix E. Community Resources

The following is a list of community resources mentioned by community input participants.

2-1-1 Texas
A.C. Taylor Health Center
AccessHealth
Acres Home Health Center
AIDS Foundation Houston
Aldine Health Center
American Heart Association
American Red Cross
Amistad Community Health Center
Area Agency on Aging
Association for the Advancement of
Mexican Americans
Avenue 360 Health & Wellness
Avenue CDC
Baker-Ripley
Bastrop Community Health Center
Baylor Teen Health Clinic
Bayside Clinic
Baytown Health Center
Bee Busy Wellness Center
Boat People SOS
Bo's Place
Brighter Bites
Brownsville Community Health Center
Buffalo Bayou Partnership
Burleson Family Medical Center
BVCAA - HealthPoint
Can Do Houston
Casa de Amigos Health Center
Casa El Buen Samaritano
Catholic Charities of the Archdiocese of
Galveston-Houston-Fort Bend
Central Care Community Health
Chambers Community Health Center
CHI St. Luke's Health
Child Advocates of Fort Bend
Children at Risk
Christ Clinic
Christian Community Services Center (CCSC)
CHRISTUS Health System
Cities Changing Diabetes
City of Houston

City of Houston, Department of Parks and
Recreation
City of Pasadena
Coastal Area Health Education Centers
(AHEC)
Community Health Choice
County Indigent Health Care Program
Covenant with Christ Community Service
Center
Cypress Health Center
Danny Jackson Health Center
Dental Hygiene Clinic
E. A. "Squatty" Lyons Health Center
El Centro De Corazon
El Franco Lee Health Center
Episcopal Health Foundation
Family Services (Galveston County)
Fort Bend Connect
Fort Bend County Collaborative Information
System
Fort Bend County Health and Human
Services
Fort Bend County Sheriff's Office
Fort Bend Regional Council On Substance
Abuse
Fort Bend Seniors Meals on Wheels
Fort Bend Women's Center
Galveston County Health District
Galveston County Mental Health Deputies
Go Healthy Houston Task Force
GoodRx
Greater Houston Partnership
Greater Houston Women's Chamber of
Commerce
Gulf Coast Community Services Association
Gulf Coast Medical Foundation
Gulfgate Health Center
Harmony House Respite Center
Harris Center Crisis Line
Harris County Public Health and
Environmental Services (HCPHES)
Harris County Rides
Harris County Social Services

Harris Health System
Harvest Green (Development)
HEAL Initiative
Health Center of Southeast Texas
Healthcare for the Homeless - Houston
Healthy Living Matters (Harris County)
Helping Hands Food Pantry
HOPE Clinic (FQHC)
Houston Food Bank
Houston Health Department
Houston Housing Authority
Houston Independent School District
Houston Ryan White Planning Council
Houston Shifa Synott Clinic
Huntsville Memorial Hospital Clinic
IbnSina Foundation
India House Charity Clinic
Interfaith Community Clinic
Interfaith Ministries Meals on Wheels
Interfaith of The Woodlands
Kinder Institute
La Nueva Casa Health Center
Legacy Health (FQHC)
Leon County Community Health Center
Liberty County Sheriff's Office
Lone Star Family Heath Center (FQHC)
Long Branch Health Center
Long Term Recovery Group
Los Barrios Unidos Community Clinic
Magnolia Health Center
Mamie George Community Center
Martin Luther King Jr. Health Center
Medical Plus Supplies
MEHOP - Matagorda Episcopal Health
Outreach Program
MET Head Start
Methodist Hospital
Metrolift
Midtown Arts and Theater Center Houston
Montgomery County Food Bank
Montgomery County Women's Center
Neighborhood Health Center
Northwest Assistance Ministry's Children's
Clinic
Northwest Health Center
Nuestra Clinica del Valle

Pat McWaters Health Clinic- Second Mile
Mission
Patient Care Intervention Center (PCIC)
Pearland Community Health Center
Pediatric & Adolescent Health Center
Physicians at Sugar Creek
Planned Parenthood
Prairie View A&M University
Quentin Mease Hospital
Regional Association of Grant Makers
Regional Medical Center
Robert Carrasco Health Clinic
RSVP Med Spa
San Jose Clinic
Santa Maria Hostel, Inc.
Settegast Health Center
Seva Clinic Charity Medical Facility
Sheltering Arm Senior Services Division of
Baker Ripley
Shifa Clinic
Smith Clinic
Social Security Administration
Spring Branch Community Health Center
St. Hope Foundation
St. Vincent's House
Stephen F. Austin Community Health
Network
Strawberry Health Center
Texana Behavioral Health
Texas A&M AgriLife Extension Service
Texas Children's Hospital
Texas Medicaid and CHIP Medical
Transportation Program
The Arc of Fort Bend County
The Beacon
The Harris Center for Mental Health and
IDD (formerly MHMRA)
The Rose
The Women's Home
Thomas Street Health Center
TOMAGWA Clinic
Tri-County Services Behavioral Healthcare
Uber Health
United Way of Brazoria County
United Way of Greater Houston
United Way Project Blueprint

University of Houston - College of
Optometry
University of Texas Health - Dental
University of Texas Health Services
University of Texas Physicians
Urban Harvest
UTMB
Valbona Health Center
VCare Clinic
Vecino Health Center
West Chambers Medical Center (FQHC)
West Houston Assistance Ministries
(WHAM)
Whole Life Service Center
Women's Care Center
Workforce Solutions
YMCA of Greater Houston