MEMORIAL HERMANN THE WOODLANDS MEDICAL CENTER

2019 Community
Health Needs
Assessment

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Medical Center

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Introduction & Purpose

Memorial Hermann The Woodlands Medical Center (MH The Woodlands) 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 The Woodlands), 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 The Woodlands' 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	• Education	• Mental Health
• Cancers	• Food Insecurity	• Obesity
• Children's Health	• Heart Disease/Stroke	• Older Adults/Aging
• Diabetes	• Lack of Health Insurance	• Substance Abuse
• Economy	• Low-Income/Underserved	• 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 The Woodlands will develop strategies to address these priorities in its 2019 Implementation Strategy.

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Introduction

Memorial Hermann The Woodlands Medical Center

Since 1985, Memorial Hermann The Woodlands Medical Center has been continually recognized for delivering a higher level of care. It is a trauma center and is still the first and only hospital in Montgomery County to be granted Magnet status for nursing excellence by the American Nurses Credentialing Center. Memorial Hermann The Woodlands is a 351-private bed, full-service, comprehensive, acute care facility that brings together the ultimate in healthcare technology, expertise and healing for families in south Montgomery County, north Harris County and surrounding communities.

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 The Woodlands Service Area

The service area for MH The Woodlands includes Harris and Montgomery counties in Texas. The geographic boundaries of the service area are shown in Figure 1. The zip codes within MH The Woodlands' primary service area are listed in Table 1 and represent approximately 75% of inpatient discharges (21.7% in Harris County and 53.7% in Montgomery County).

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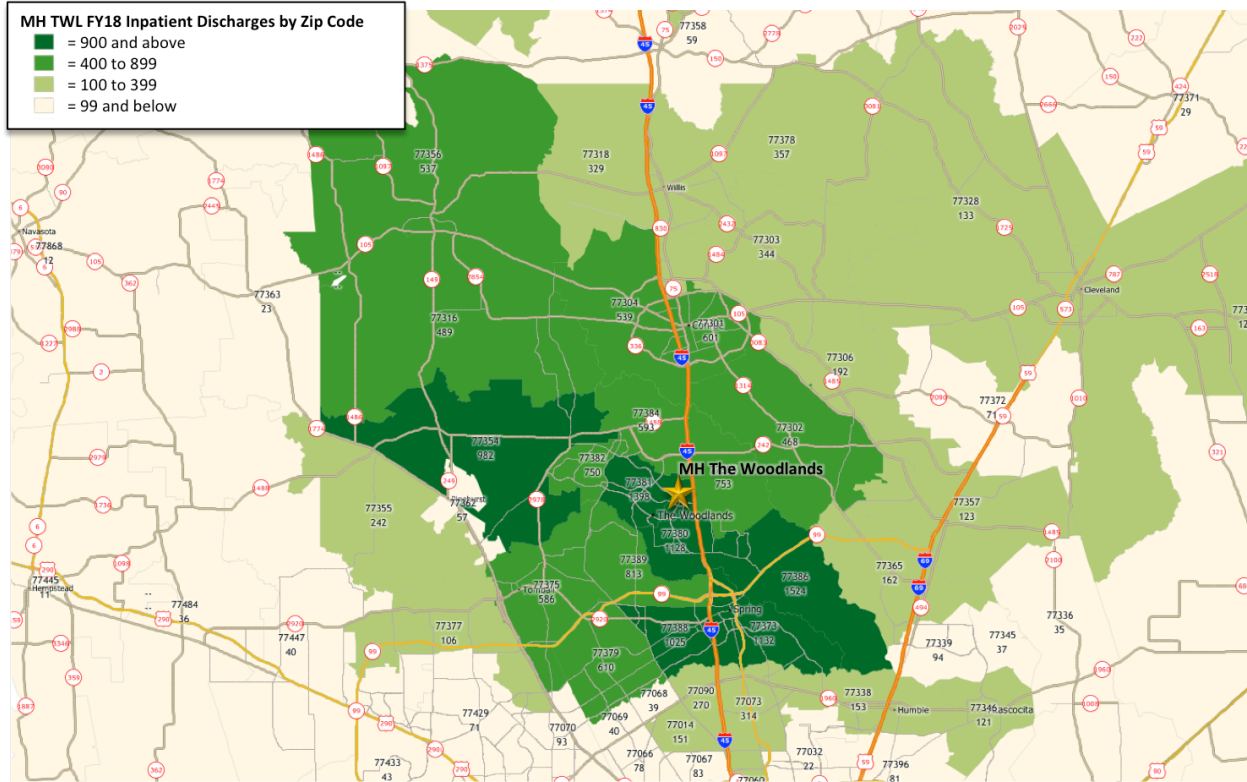
Table 1. Proportion of Patient Population Served by Zip Code

ZIP Code	County	Percent of Patient Population
77386	Montgomery	7.4%
77381	Montgomery	6.8%
77373	Harris	5.5%
77380	Montgomery	5.5%
77388	Harris	5.0%
77354	Montgomery	4.8%
77389	Harris	3.9%
77385	Montgomery	3.7%
77382	Montgomery	3.6%
77379	Harris	3.0%
77301	Montgomery	2.9%

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ZIP Code	County	Percent of Patient Population
77384	Montgomery	2.9%
77375	Harris	2.8%
77304	Montgomery	2.6%
77356	Montgomery	2.6%
77316	Montgomery	2.4%
77302	Montgomery	2.3%
77303	Montgomery	1.7%
77378	Montgomery	1.7%
77318	Montgomery	1.6%
77073	Harris	1.5%
77355	Montgomery	1.2%

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
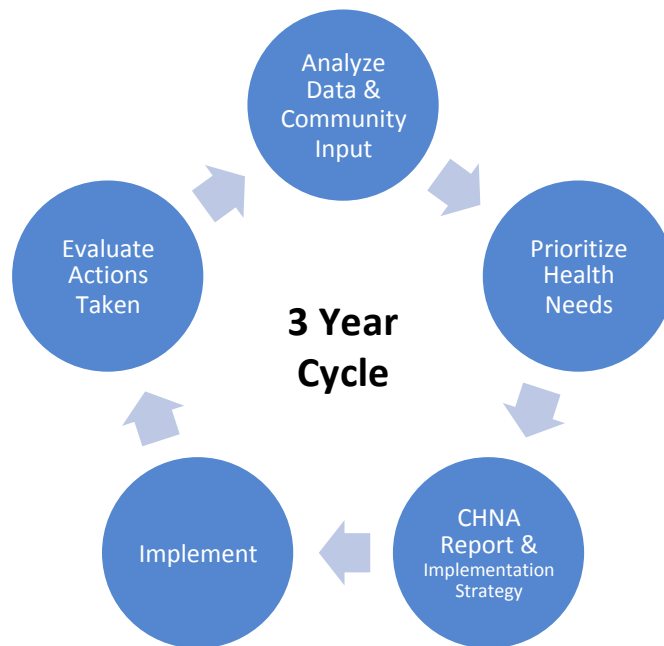
Priority Health Needs and Impact from Prior CHNA

MH The Woodlands' 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 The Woodlands 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 The Woodlands' 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/the-woodlands/community-health-needs-assessment-the-woodlands/. No comments or feedback were received on the preceding CHNA at the time this report was written.

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 The Woodlands' 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
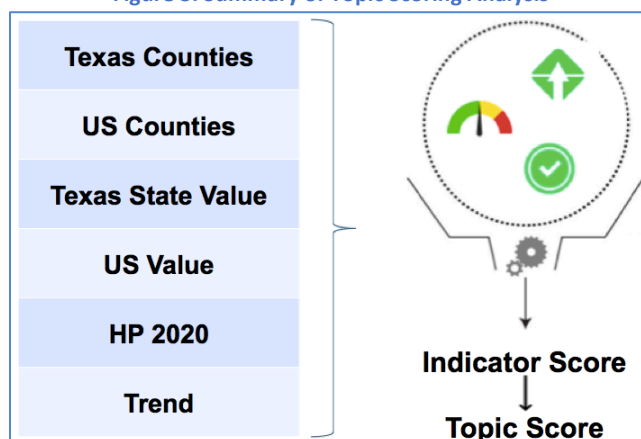
Disparities Analysis

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.

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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%
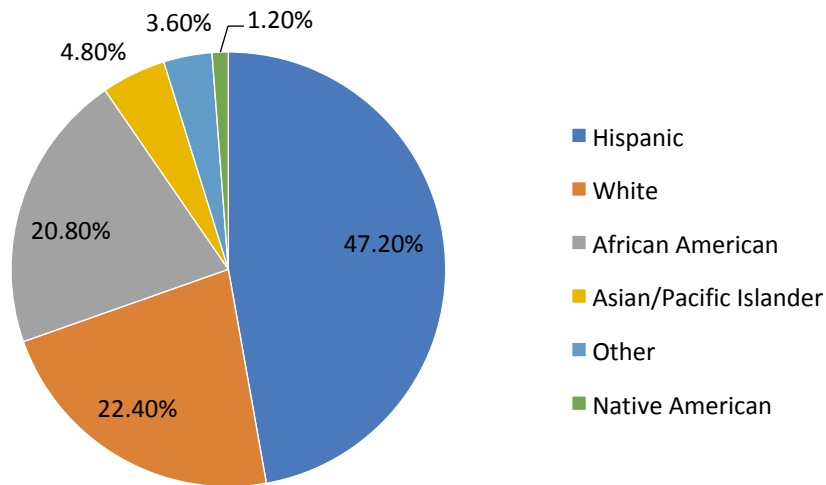
Survey respondents were asked to select top issues most affecting the community's quality of life. As shown in Figure 5, the majority of respondents identified Diabetes, Obesity/Overweight, Substance Abuse, and Mental Health & Mental Disorders as top issues in the community.

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

- 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%
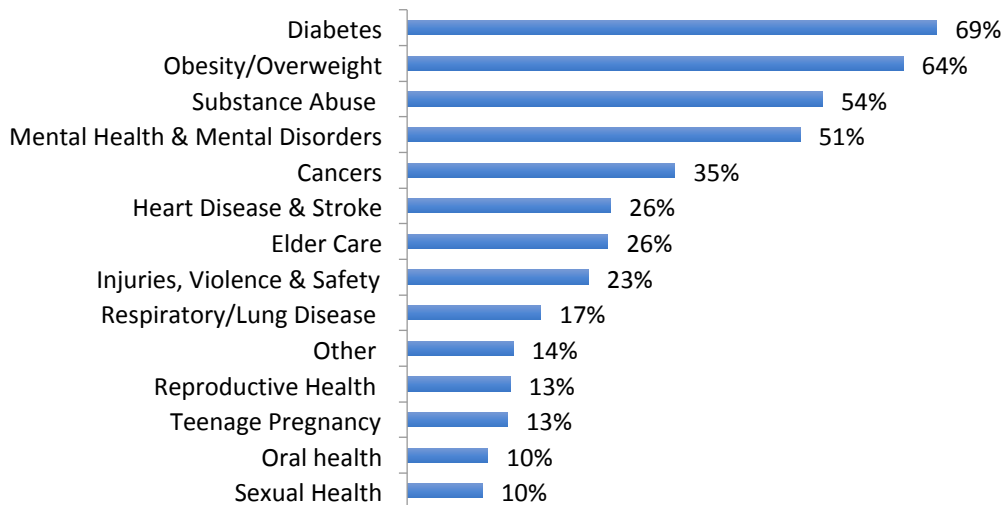
Key Informant Interviews

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.

<div align="center">Table 3. Memorial Hermann Collaborative Partners</div>

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.

<div align="center">Table 4. Key Informants by County</div>

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.)

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- 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.

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 The Woodlands' service area, including Harris and Montgomery 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 The Woodlands' 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 two counties in MH The Woodlands' service area had populations of 4,652,980 (Harris County) and 570,934 (Montgomery County). Figure 7 illustrates the population size by county and Table 6 by zip code. The most populous zip codes in MH The Woodlands' service area are 77379 (Harris County), 77373 (Harris County), and 77386 (Montgomery County).

Figure 7. Population by County

Table 6. Population by Zip Code

ZIP Code	County	Total Population Estimate
77386	Montgomery	53,042
77381	Montgomery	36,919
77373	Harris	58,255
77380	Montgomery	26,691
77388	Harris	45,841
77354	Montgomery	35,904
77389	Harris	31,883
77385	Montgomery	23,578
77382	Montgomery	40,546
77379	Harris	78,226
77301	Montgomery	31,801
77384	Montgomery	16,472
77375	Harris	50,525
77304	Montgomery	28,692
77356	Montgomery	25,888
77316	Montgomery	21,272
77302	Montgomery	19,311
77303	Montgomery	19,695
77378	Montgomery	16,150
77318	Montgomery	15,437
77073	Harris	42,780
77355	Montgomery	27,271

American Community Survey, 2013-2017

Age

Figure 8 shows MH The Woodlands' service area population that is under 18 years old. 26.9% of Harris County's population and 26.5% of Montgomery County's population is under 18. Both Harris and Montgomery counties have higher proportions of residents under 18 compared to the state and national values.

Figure 8. Population Under 18

26.9%	26.5%	26.0%	22.6%
Harris	Montgomery	Texas	U.S.
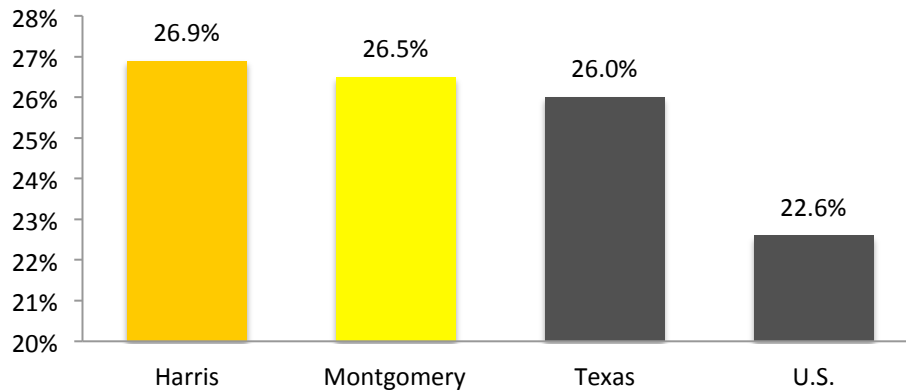
As shown in Figure 9, Harris County has a smaller proportion of older adults (10.2%) compared to Texas and the U.S. (12.3% and 15.6%, respectively). In Montgomery County, 12.9% of residents are over 65.

Figure 9. Population Over 65

10.2%	12.9%	12.3%	15.6%
Harris	Montgomery	Texas	U.S.
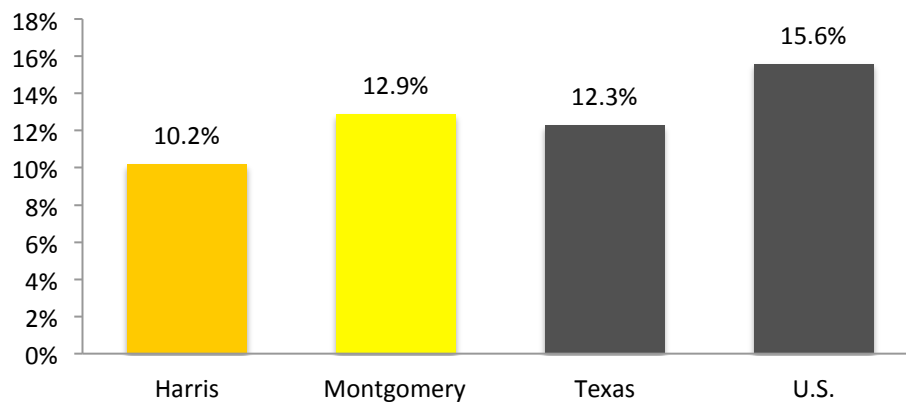
Figure 10 shows that Harris County has a larger proportion of residents under 5 years old (7.7%) compared to both Texas and the U.S. (7.2% and 6.1%, respectively). Approximately 7% of Montgomery County's population is under 5.

Figure 10. Population Under 5

Figure 10. Population Under 5
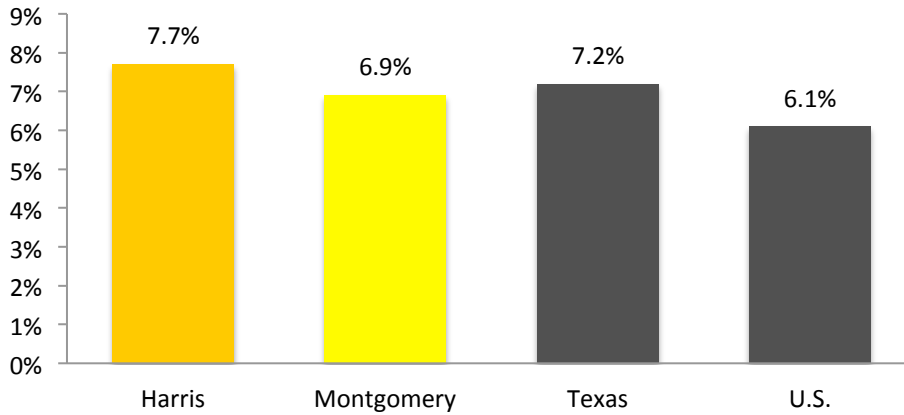
Race/Ethnicity

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 Montgomery County 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 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 11. Race/Ethnicity in Harris County
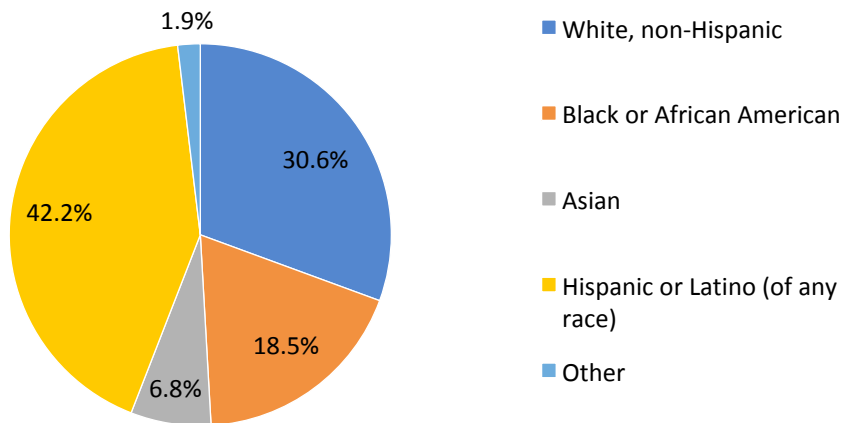
Figure 12 shows the racial composition of residents in Montgomery County with 67.9% of residents identifying as White, non-Hispanic; 23.0% as Hispanic or Latino (of any race); 4.5% as Black or African American; 2.8% as Asian; and 1.8% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", and/or "Two or more races".

Figure 12. Race/Ethnicity in Montgomery County

- White, non-Hispanic
- Black or African American
- Asian
- Hispanic or Latino (of any race)
- Other
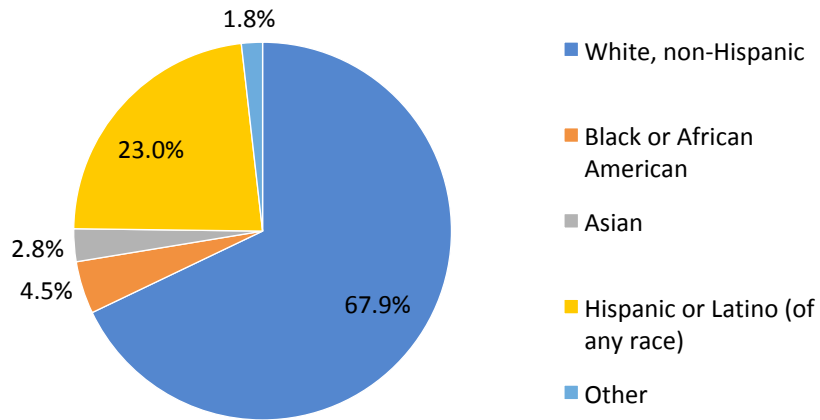
Language

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 13. Language Other than English Spoken at Home
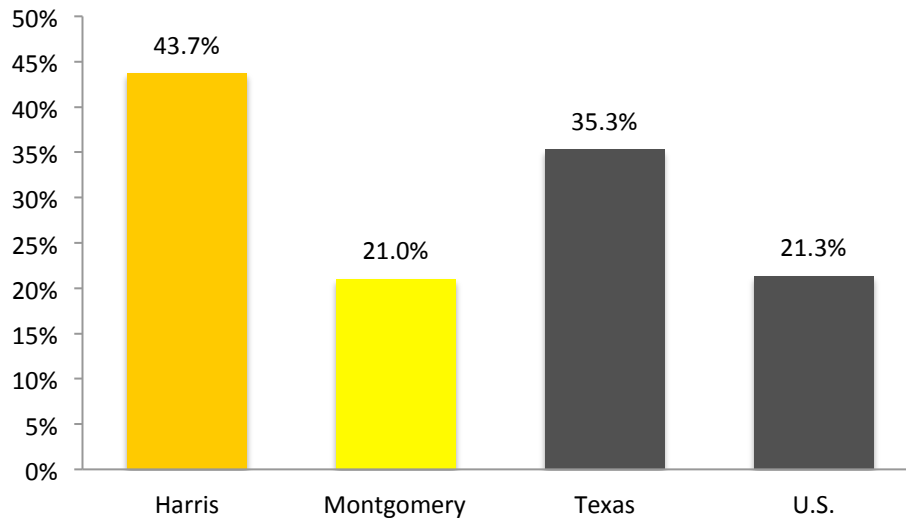
Figure 13 shows the proportion of residents in Harris and Montgomery counties who speak a language other than English at home. Montgomery County has 21% of residents who speak a language other than English at home (similar to the state value). Harris County's proportion is more than twice Montgomery County's value, with 44% of residents speaking a language other than English at home. 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
77386	Montgomery	4.7%
77381	Montgomery	3.3%
77373	Harris	8.1%
77380	Montgomery	7.4%
77388	Harris	9.0%
77354	Montgomery	7.1%
77389	Harris	9.0%
77385	Montgomery	9.4%
77382	Montgomery	6.2%
77379	Harris	8.8%
77301	Montgomery	25.6%
77384	Montgomery	3.1%
77375	Harris	12.5%
77304	Montgomery	5.1%
77356	Montgomery	1.1%
77316	Montgomery	4.4%
77302	Montgomery	8.5%
77303	Montgomery	9.8%
77378	Montgomery	15.2%
77318	Montgomery	5.1%
77073	Harris	20.8%
77355	Montgomery	5.1%
Harris	--	**20.4%**
Montgomery	--	**7.8%**
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 Montgomery County (7.8%) and the state of Texas (14.1%). Although Montgomery County has a relatively lower value overall, over 25% of residents in zip code 77301 have difficulty speaking English.

Social and Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health in MH The Woodland' 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.

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Figure 14 compares the median household income values for the two counties in MH The Woodlands' service area to the median household income value for Texas and the U.S. Montgomery's median household income of $74,323 is greater than that of Harris County ($57,791). Harris County's median household income is similar to the state and national values.

Figure 14. Median Household Income
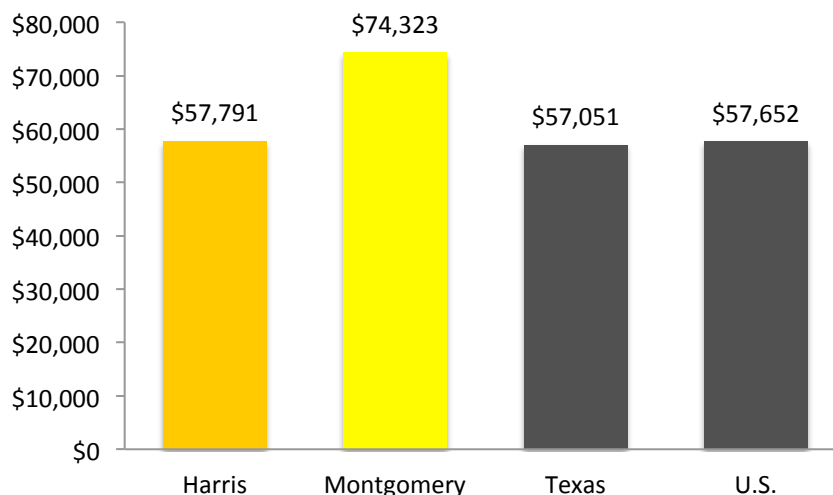
As shown in Table 8, MH The Woodlands' top zip codes for inpatient discharges reveal a relatively high range in median household income. At $99,076 and $103,439 respectively, zip codes 77386 and 77381 have median household incomes noticeably higher than the state of Texas ($57,051).

Table 8. Median Household Income by Zip Code

ZIP Code	County	Median Household Income
77386	Montgomery	$99,076
77381	Montgomery	$103,439
77373	Harris	$67,924
77380	Montgomery	$68,839
77388	Harris	$87,574
77354	Montgomery	$79,440
77389	Harris	$115,725
77385	Montgomery	$88,220
77382	Montgomery	$139,902
77379	Harris	$99,693
77301	Montgomery	$40,795
77384	Montgomery	$85,371
77375	Harris	$69,446
77304	Montgomery	$60,568
77356	Montgomery	$77,444
77316	Montgomery	$86,719
77302	Montgomery	$63,328
77303	Montgomery	$52,283

ZIP Code	County	Median Household Income
77378	Montgomery	$55,114
77318	Montgomery	$61,722
77073	Harris	$54,079
77355	Montgomery	$83,713
Harris	--	**$57,791**
Montgomery	--	**$74,323**
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 15 shows the proportion of residents living below the poverty level in Harris and Montgomery counties compared to Texas and the U.S. The percentage of residents living below the poverty level in Harris County (16.8%) is higher than the national value (14.6%) and slightly higher than the state value (16.0%). Approximately 10% of residents in Montgomery County live below the poverty value, which is lower than both the state and national values.

Figure 15. People Living Below Poverty Level
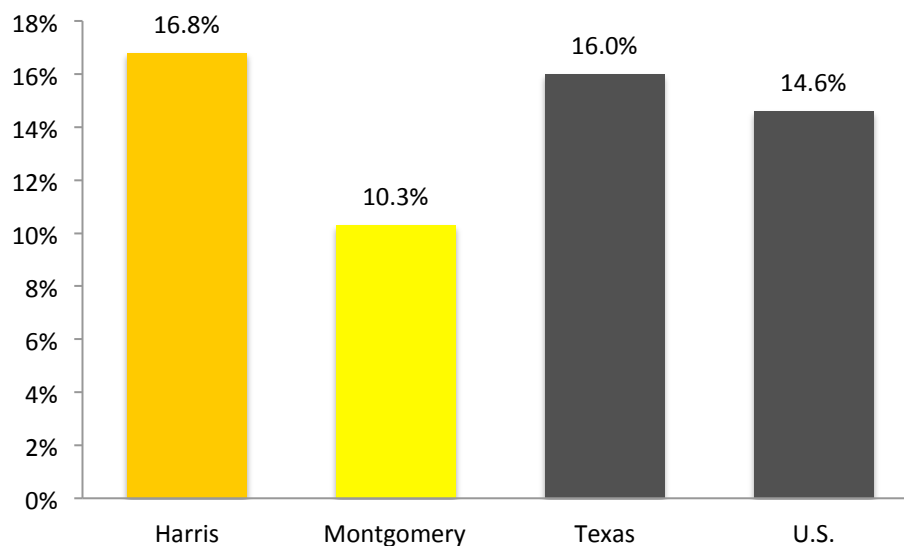
Figure 16 shows the proportion of residents living below the poverty level by race/ethnicity. In Harris County, 22.6% of Hispanic or Latino residents and 21.8% of Black or African American residents live below the poverty level, compared to 7.0% White and 11.4% Asian residents. The percentage of Black and Asian residents living below the poverty level in Harris County (21.8% and 11.4%, respectively) is higher than the state values for Black and Asian residents. For all race/ethnicity groups in Montgomery County, the percentage of residents living below the poverty level is lower than the values for Texas and the U.S.

Figure 16. People Living Below Poverty Level by Race/Ethnicity

Figure 16. People Living Below Poverty Level by Race/Ethnicity

	White, non-Hispanic	Black or African American	Asian	Hispanic or Latino
Harris	7.0%	21.8%	11.4%	22.6%
Montgomery	6.7%	13.1%	5.6%	21.5%
Texas	8.8%	21.4%	10.6%	23.0%
U.S.	10.3%	25.2%	11.9%	22.2%

Figure 17. People Living Below Poverty Level by Zip Code

Figure 17. People Living Below Poverty Level by Zip Code

Legend: 2.4% - 5.3% | 5.3% - 8.0% | 8.0% - 12.7% | 12.7% - 14.9% | 14.9% - 20.1% | N/A
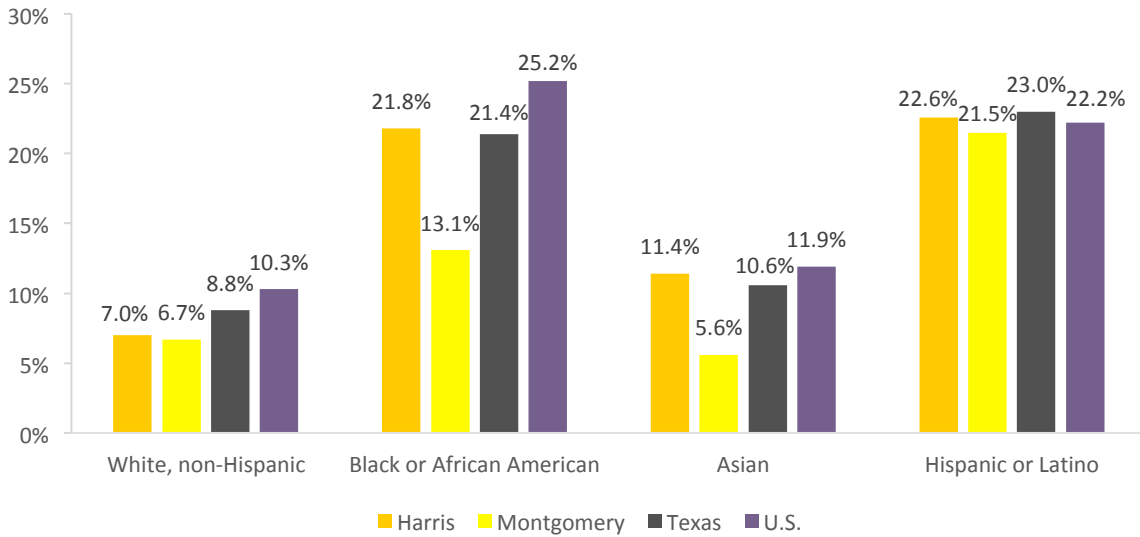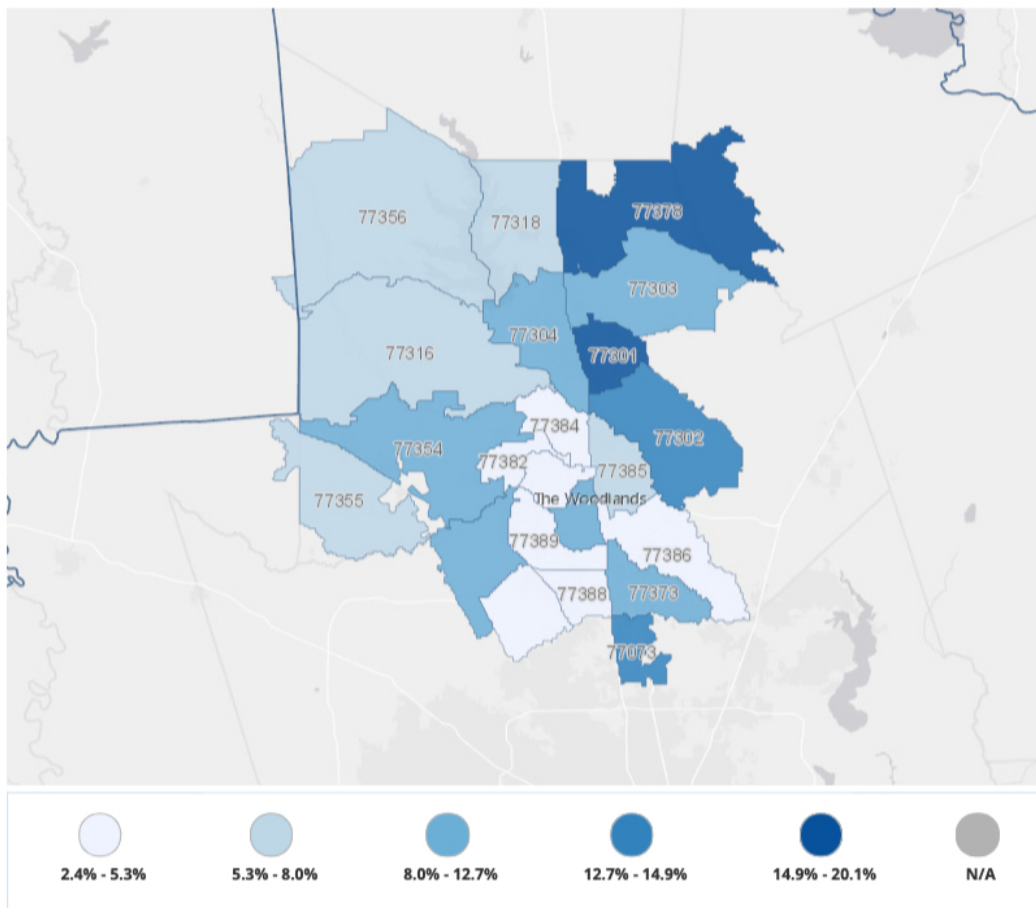
Poverty rates are higher in Harris County (16.8%) compared to Montgomery County (10.3%). As shown in Figure 17**Error! Reference source not found.** and Table 9, within MH The Woodlands'

service area, 18.8% of residents in zip code 77301 and 20.1% of residents in zip code 77378 are living below the poverty level, both higher than the value for Texas (16%).

Table 9. People Living Below Poverty Level by Zip Code

ZIP Code	County	People Living Below Poverty Level
77386	Montgomery	3.6%
77381	Montgomery	4.1%
77373	Harris	12.2%
77380	Montgomery	11.4%
77388	Harris	5.3%
77354	Montgomery	12.7%
77389	Harris	4.9%
77385	Montgomery	8.0%
77382	Montgomery	2.4%
77379	Harris	4.0%
77301	Montgomery	18.8%
77384	Montgomery	4.2%
77375	Harris	10.1%
77304	Montgomery	10.5%
77356	Montgomery	7.3%
77316	Montgomery	7.8%
77302	Montgomery	14.7%
77303	Montgomery	12.0%
77378	Montgomery	20.1%
77318	Montgomery	6.9%
77073	Harris	14.9%
77355	Montgomery	7.6%
Harris	--	**16.8%**
Montgomery	--	**10.3%**
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.

Table 10 shows the percent of households with children that participate in SNAP in the zip codes within MH The Woodlands' service area. Harris County has a higher proportion of households with children receiving SNAP compared to Texas, while Montgomery County has a lower proportion compared to the state value. In particular, zip codes 77386 and 77373 stand out, as they represent MH The Woodlands' top zip codes for inpatient discharges and also have more than 75% of households with children receiving SNAP. MH The Woodlands' top zip codes

for inpatient discharges reveal a broad range of economic circumstances in the service area. Zip code 77381 has 20.5% of households with children receiving SNAP, whereas the proportion in zip code 77386 is four times higher (81.8%).

Table 10. Households with Children Receiving SNAP by Zip Code

ZIP Code	County	Households with Children Receiving SNAP
77386	Montgomery	81.8%
77381	Montgomery	20.5%
77373	Harris	75.3%
77380	Montgomery	60.0%
77388	Harris	68.3%
77354	Montgomery	67.8%
77389	Harris	77.6%
77385	Montgomery	52.8%
77382	Montgomery	0.0%
77379	Harris	68.2%
77301	Montgomery	55.7%
77384	Montgomery	--
77375	Harris	67.4%
77304	Montgomery	39.6%
77356	Montgomery	30.2%
77316	Montgomery	69.8%
77302	Montgomery	89.4%
77303	Montgomery	58.9%
77378	Montgomery	65.8%
77318	Montgomery	60.5%
77073	Harris	86.0%
77355	Montgomery	86.1%
Harris	--	**67.7%**
Montgomery	--	**61.7%**
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.

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Figure 18 displays the rate of unemployment in Harris and Montgomery counties between May 2017 and November 2018. In both counties, the unemployment rate has exhibited a decrease. In November 2018, the Montgomery County rate (3.4%) was almost equivalent to the state and national rate. However, the unemployment rate in Harris County (3.8%) remains higher than Texas and the U.S.

Figure 18. Unemployment Rate per County (U.S. Bureau of Labor Statistics, 2017-2018)
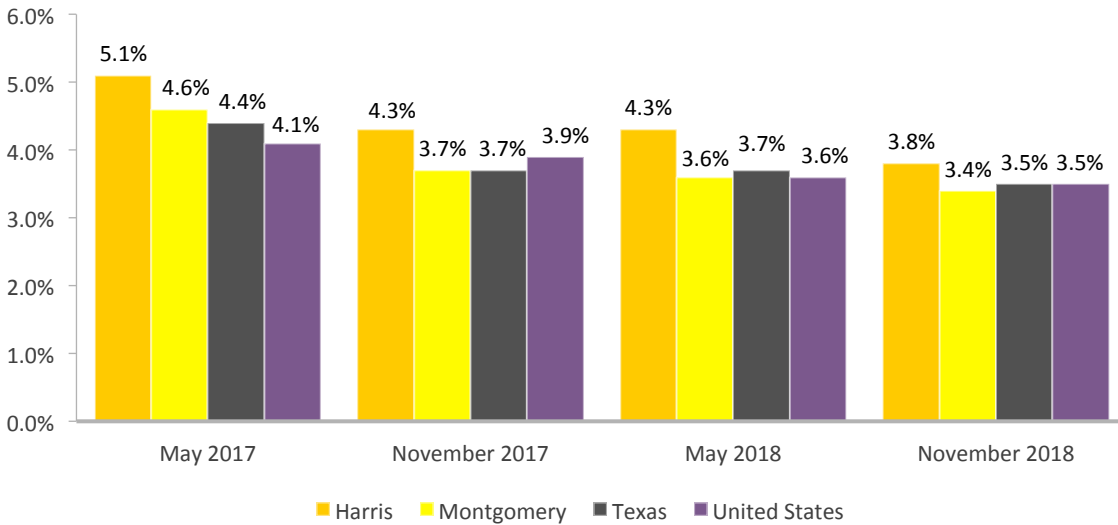
Education

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 19 displays the proportion of residents in Harris and Montgomery counties who are 25 years and older with at least a high school degree. Nearly 90% of residents 25 years and older in Montgomery County have at least a high school degree compared to 80.5% in Harris County. Montgomery County's value is higher than the U.S. (87.3%) and Texas (82.8%) while Harris County's value (80.5%) is lower.

Figure 19. People 25+ with a High School Degree or Higher

Figure 19. People 25+ with a High School Degree or Higher
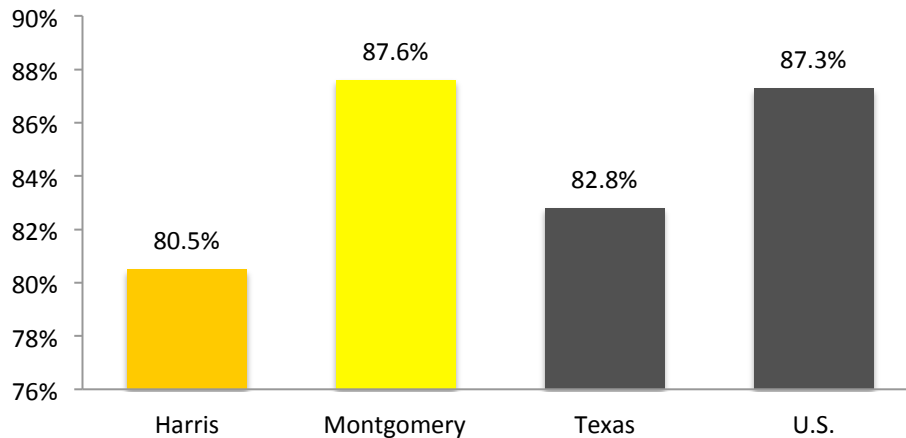
Figure 20 shows the proportion of residents in Harris and Montgomery counties who are 25 years and older with a bachelor's degree or higher. With over 30% of residents 25 and older having a bachelor's degree in Harris and Montgomery counties, both have an economic advantage compared to some other counties in the state. The proportion of residents 25 and older with a bachelor's degree in Montgomery County (33.7%) is higher than the state value (28.7%) and the U.S. (30.9%).

Figure 20. People 25+ with a Bachelor's Degree or Higher
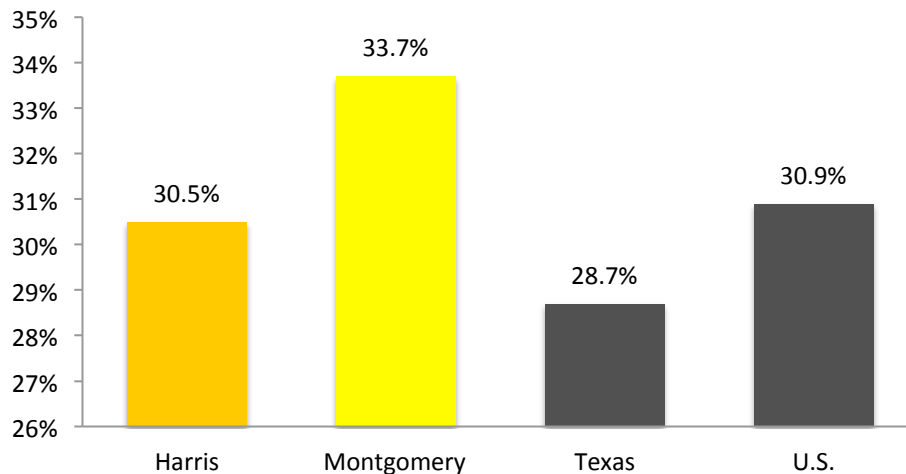
Table 10 displays the educational attainment indicators for residents 25 years and older by zip code in MH The Woodlands' service area. For high school degree attainment, the zip code with the highest rate is 77381 (98%) and the zip code with the lowest rate is 77301 (63.2%). For attainment of a bachelor's degree, the zip code with the highest rate is 77382 (64.9%) and the zip code with the lowest rate is 77303 (12.3%). The zip codes with highest proportions of MH The Woodlands' inpatient discharges, zip codes 77386 and 77381, have more than 90% of people 25 years and older with a high school degree. Furthermore, in both zip codes, over 40% residents 25 years and older have a bachelor's degree or higher, compared to the state value of 28.7%.

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
77386	Montgomery	94.8%	42.3%
77381	Montgomery	98.0%	61.9%
77373	Harris	91.6%	23.5%
77380	Montgomery	93.6%	47.9%
77388	Harris	91.2%	35.7%
77354	Montgomery	89.1%	31.2%
77389	Harris	95.1%	54.2%
77385	Montgomery	89.7%	33.9%
77382	Montgomery	97.1%	64.9%
77379	Harris	94.7%	47.8%
77301	Montgomery	63.2%	12.7%
77384	Montgomery	94.6%	47.1%
77375	Harris	89.7%	30.8%
77304	Montgomery	90.2%	35.0%
77356	Montgomery	96.6%	39.2%
77316	Montgomery	90.4%	31.7%
77302	Montgomery	84.1%	19.2%
77303	Montgomery	76.0%	12.3%
77378	Montgomery	78.1%	14.2%
77318	Montgomery	92.3%	26.1%
77073	Harris	82.7%	16.4%
77355	Montgomery	88.4%	28.5%
Harris	--	**80.5%**	**30.5%**
Montgomery	--	**87.6%**	**33.7%**
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 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.

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Figure 21. Households Without a Vehicle by Zip Code

Figure 21. Households Without a Vehicle by Zip Code
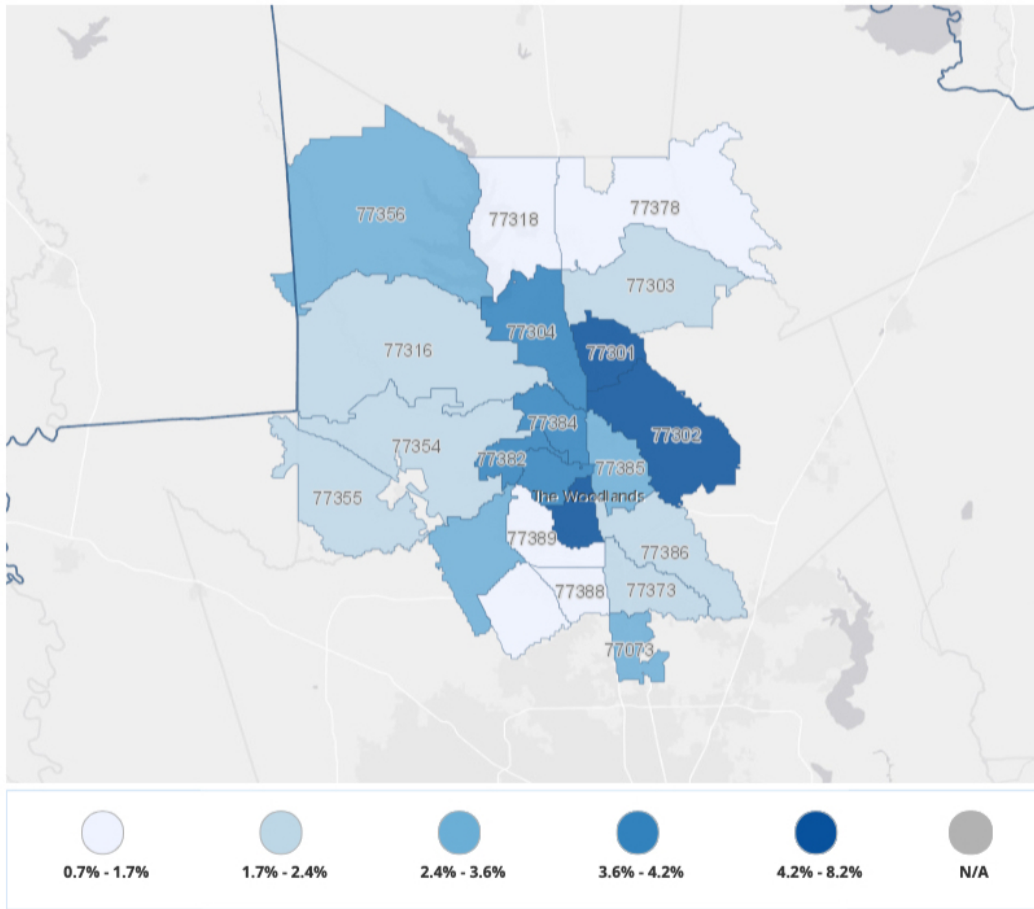
Figure 21 shows the percentage of households without a vehicle. As shown, zip codes 77301 and 77302 have the highest percentages of households that do not have a vehicle.

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
77386	Montgomery	1.2%	0.0%	82.0%	1.3%
77381	Montgomery	1.5%	0.2%	81.1%	2.7%
77373	Harris	1.0%	0.3%	80.7%	1.3%
77380	Montgomery	1.6%	0.9%	81.3%	2.0%
77388	Harris	0.9%	0.1%	83.8%	1.6%
77354	Montgomery	1.2%	0.0%	80.2%	0.3%
77389	Harris	0.9%	0.0%	85.4%	0.9%
77385	Montgomery	0.2%	0.1%	79.2%	1.2%
77382	Montgomery	1.3%	0.0%	81.6%	3.7%
77379	Harris	0.6%	0.1%	84.3%	1.8%
77301	Montgomery	0.5%	1.2%	75.0%	0.6%
77384	Montgomery	0.0%	0.0%	81.6%	1.1%
77375	Harris	1.2%	0.3%	79.0%	0.7%

ZIP Code	County	Commute by Walking	Commute by Biking	Commute by Driving Alone	Commute by Public Transportation
77304	Montgomery	1.7%	0.6%	83.5%	1.0%
77356	Montgomery	1.1%	0.0%	79.3%	0.7%
77316	Montgomery	0.4%	0.0%	83.6%	0.9%
77302	Montgomery	0.6%	0.0%	84.9%	1.5%
77303	Montgomery	0.6%	0.0%	84.6%	0.4%
77378	Montgomery	0.0%	0.0%	88.3%	0.1%
77318	Montgomery	1.1%	0.0%	79.7%	1.0%
77073	Harris	0.5%	0.0%	80.8%	2.3%
77355	Montgomery	0.5%	0.0%	86.9%	0.7%
Harris	--	**1.5%**	**0.3%**	**79.3%**	**2.7%**
Montgomery	--	**0.9%**	**0.2%**	**82.1%**	**1.2%**
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 Harris and Montgomery counties. In Montgomery County, less than 1% of the population commutes by walking. In Harris County, slightly more residents commute by walking (1.5%). In both counties, the majority of residents commute by driving alone (79.3% in Harris County and 82.1% in Montgomery County), which is similar to the state value (80.5%).

Public transportation is used by Harris County residents (2.7%) more so than Montgomery residents (1.2%), perhaps indicative of differences in public transportation infrastructure. Although public transportation is not as common in Montgomery County compared to Harris County, 3.7% of residents living in zip code 77382 commute by public transportation. Considering the top ten zip codes for inpatient discharges within MH The Woodlands' service area, zip codes 77380, 77381, and 77382 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 22. SocioNeeds Index by Zip Code
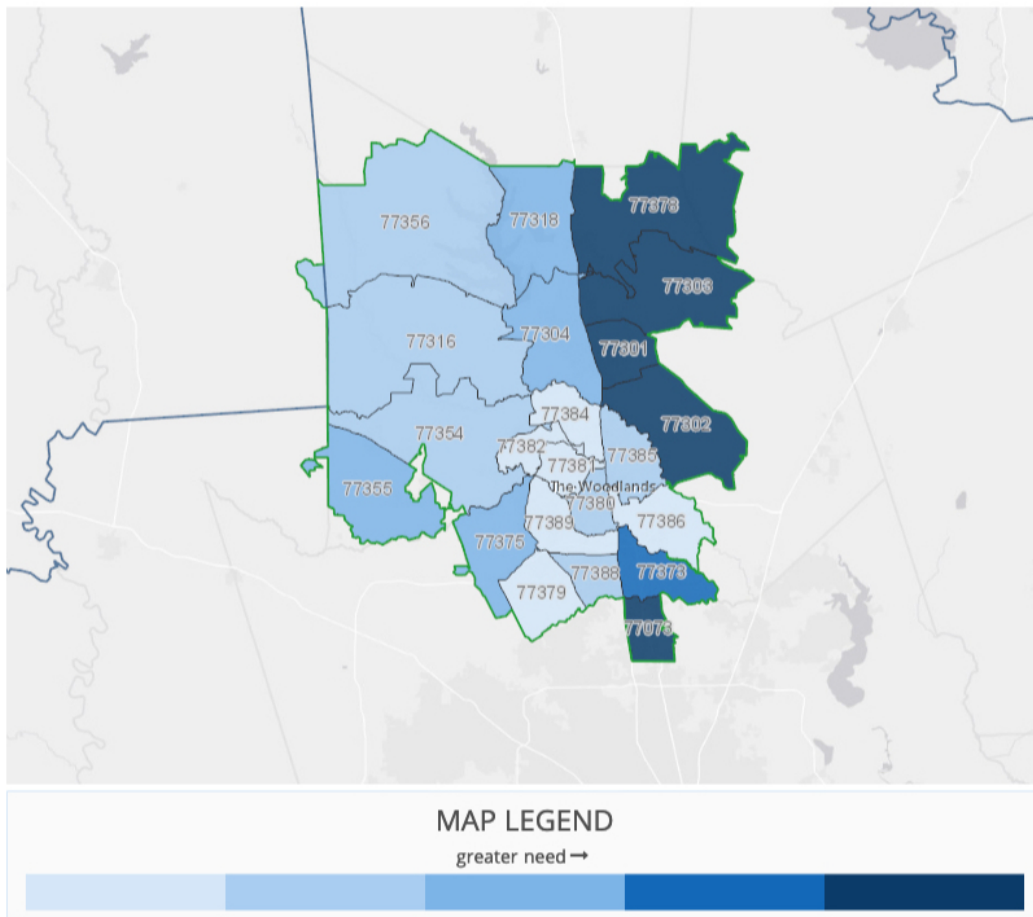
As shown in Figure 22 and Table 13, most of the zip codes within MH The Woodlands' service area with the highest SocioNeeds Index values are within Montgomery County; zip codes 77301 and 77303 both have values greater than 80. The zip codes with largest proportion of inpatient discharges at MH The Woodlands, zip codes 77386 and 77381, have low SocioNeeds Index values (6.2 and 2.4, respectively).

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

ZIP Code	County	SocioNeeds Index Value
77301	Montgomery	91.6
77303	Montgomery	81.3
77073	Harris	77.1
77378	Montgomery	69.9
77302	Montgomery	67.0
77373	Harris	42.0
77355	Montgomery	34.0
77318	Montgomery	32.3
77304	Montgomery	30.4
77375	Harris	24.6
77385	Montgomery	17.3

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ZIP Code	County	SocioNeeds Index Value
77354	Montgomery	14.1
77356	Montgomery	13.2
77388	Harris	13.1
77380	Montgomery	11.5
77316	Montgomery	11.4
77379	Harris	8.1
77389	Harris	7.2
77386	Montgomery	6.2
77384	Montgomery	5.8
77381	Montgomery	2.4
77382	Montgomery	2.2

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). Table 14 and Table 15 display the data scores for Health and Quality of Life Topics for Harris and Montgomery counties.

Table 14. 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

Table 15. Montgomery County Topic Scores

Topic	Score
Transportation	1.93
Heart Disease & Stroke	1.65
Access to Health Services	1.56
Other Chronic Diseases	1.52

Topic	Score
Exercise, Nutrition, & Weight	1.50
Substance Abuse	1.49
Children's Health	1.37
Older Adults & Aging	1.36
Women's Health	1.35
Public Safety	1.33
Environment	1.32
Immunizations & Infectious Diseases	1.32
Mental Health & Mental Disorders	1.31
Education	1.11
Social Environment	1.10
Respiratory Diseases	1.08
Cancer	1.06
Economy	1.04
Mortality Data	1.00
Men's Health	0.95
Wellness & Lifestyle	0.93
Prevention & Safety	0.85
Maternal, Fetal & Infant Health	0.83

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 16 lists the resulting data scores for Health & Quality of Life Topic Areas.

Table 16. 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

Topic	Score
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 23.

Figure 23. Visual of Data Synthesis Approach
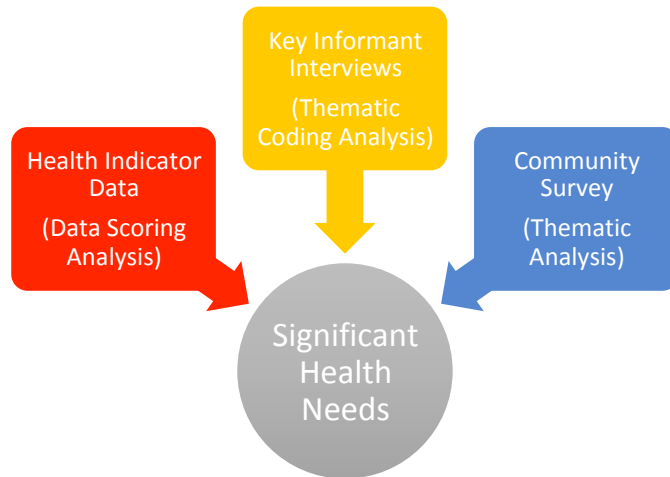
The team used the triangulated approach to identify significant health needs for Memorial Hermann Health System. Figure 24 displays the results of this synthesis. For many of the health topics evidence of need was present across multiple data sources, including Obesity, Mental Health, Access to Health 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 24. 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
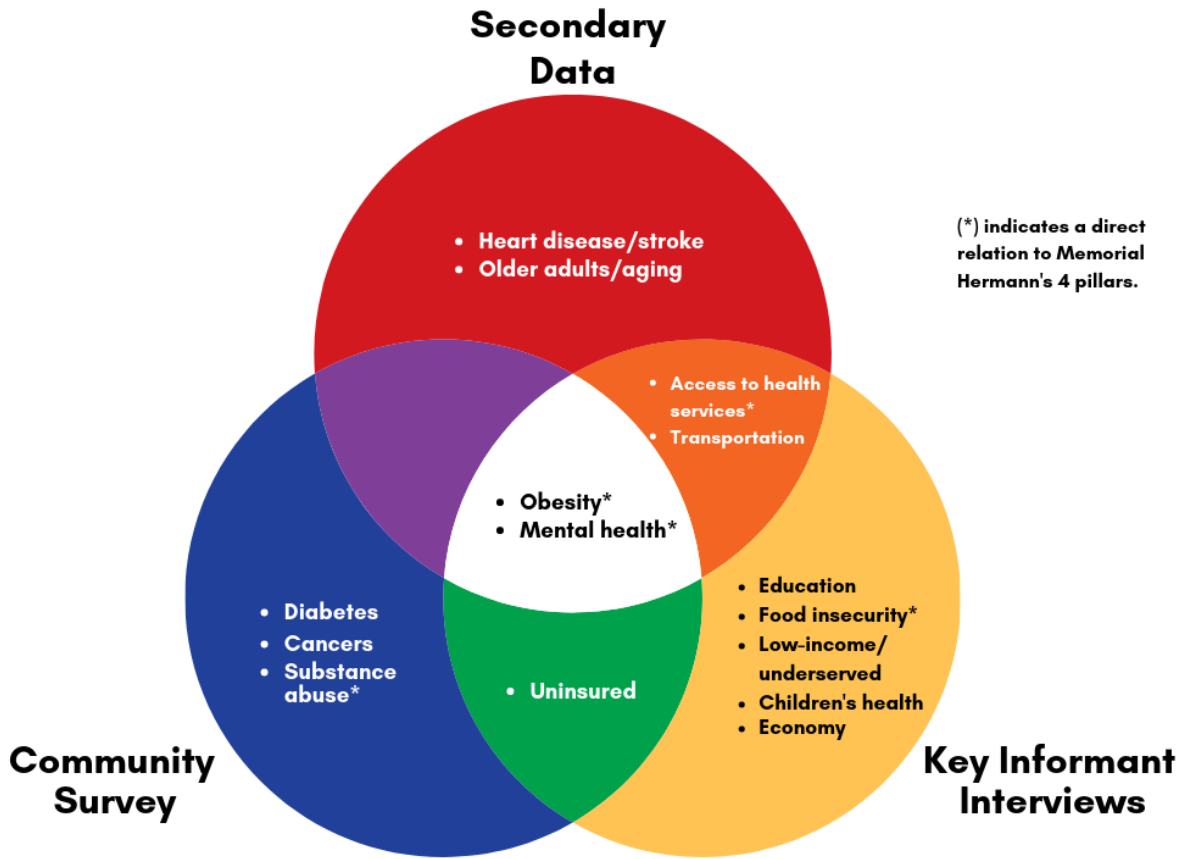
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Prioritized Significant Health Needs

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 The Woodlands' 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 17, several indicators received scores of 1.75 or above through the secondary data scoring process: Adults Unable to See a Doctor (Harris County); Adults with Health Insurance (Harris County); Children with Health Insurance (Harris County); Mental Health Provider Rate (Montgomery County); and Persons with Health Insurance (Harris County).

Table 17. Secondary Data Scoring Results: Access to Health Services

	County			County Value Compared to:				
Indicator	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Adults Unable to Afford to See a Doctor [10] (2015)	Montgomery		---	---	---	---	---	---

	County	Value						
	Harris	22.1 percent	2	1.5	3	3	1.5	1.5

[10] Texas Behavioral Risk Factor Surveillance System

	County	Value						
Adults with Health Insurance: 18-64 [9] (2016)	Montgomery	79.7 percent	1.47	0	1	1.5	3	1
	Harris	74.7 percent	1.75	2	2	1.5	3	0

[9] Small Area Health Insurance Estimates

	County	Value						
Children with Health Insurance [9] (2016)	Montgomery	90.2 percent	1.53	0	2	1.5	2	1
	Harris	89.4 percent	1.81	1	2	1.5	3	1

[9] Small Area Health Insurance Estimates

	County	Value						
Dentist Rate [4] (2016)	Montgomery	45.5 dentists/ 100,000 population	1.56	0	3	3	1.5	1
	Harris	66.3 dentists/ 100,000 population	0.5	0	0	2	1.5	0

[4] County Health Rankings

	County	Value						
Mental Health Provider Rate [4] (2017)	Montgomery	69.4 providers/ 100,000 population	2	1	3	3	1.5	1.5
	Harris	103.7 providers/ 100,000 population	1.44	0	1	3	1.5	2

[4] County Health Rankings

	County	Value						
Non-Physician Primary Care Provider Rate [4] (2017)	Montgomery	55 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

[4] County Health Rankings

	County	Value						
Persons with Health Insurance [9] (2016)	Montgomery	83.1 percent	1.47	0	1	1.5	3	1
	Harris	79.3 percent	1.75	2	2	1.5	3	0

[9] Small Area Health Insurance Estimates

	County	Value						
Primary Care	Montgomery	61.8	1.22	0	1	3	1.5	1

Provider Rate [4] (2015)		providers/ 100,000 population						
	Harris	**57.2** providers/ 100,000 population	**1.61**	**0**	**2**	**3**	**1.5**	**2**
[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 Table 18, both counties have indicators of concern, including: Families Living Below Poverty Level (Harris County); Female Population 16+ in Civilian Labor Force (Montgomery County); Food Insecurity Rate (Harris County); Homeownership (Harris County); Median Household Gross Rent (Harris and Montgomery counties); Median Monthly Owner Costs for Households without a Mortgage (Harris and Montgomery counties); Mortgaged Owners Median Monthly Household Costs (Montgomery County); People 65+ Living Below Poverty Level (Harris County); Severe Housing Problems (Harris County); SNAP Certified Stores (Harris and Montgomery counties); Students Eligible for the Free Lunch Program (Harris County); and Unemployed Workers in Civilian Labor Force (Harris County). Out of this list, Harris County had eight economic indicators with secondary data scores above 2 compared to Montgomery County with four indicators equal to or above 2, indicating potentially greater economic need in Harris County.

Table 18. Secondary Data Scoring Results: Economy

Indicator	County			County Value Compared to:				
	Name	**Value**	**Data Score**	**TX Counties**	**TX Value**	**US Value**	**HP 2020 Target**	**Trend Over Time**
Child Food Insecurity Rate [5] (2016)	Montgomery	**21.2** percent	**1.17**	0	1	3	1.5	0
	Harris	**23.5** percent	**1.67**	1	2	3	1.5	0
[5] Feeding America								
Children Living Below Poverty Level [1] (2012-2016)	Montgomery	**14.8** percent	**0.17**	0	0	0	1.5	0
	Harris	**26.0** percent	**1.67**	2	2	3	1.5	0
[1] American Community Survey								
Families Living Below Poverty Level [1] (2012-2016)	Montgomery	**8.3** percent	**0.56**	0	0	0	1.5	1
	Harris	**14.4** percent	**2.06**	2	3	3	1.5	1

[1] American Community Survey								
Female Population 16+ in Civilian Labor Force [1] (2012-2016)	Montgomery	**53.6** percent	**2**	1	2	2	1.5	3
	Harris	**59.8** percent	**0.94**	**0**	**1**	**1**	**1.5**	**2**
[1] American Community Survey								
Food Insecurity Rate [5] (2016)	Montgomery	**14.6** percent	**1.33**	1	1	3	1.5	0
	Harris	**16.6** percent	**2.06**	**2**	**2**	**3**	**1.5**	**1**
[5] Feeding America								
Homeownership [1] (2012-2016)	Montgomery	**65.6** percent	**0.61**	0	0	0	1.5	2
	Harris	**49.6** percent	**2.44**	**3**	**2**	**3**	**1.5**	**2**
[1] American Community Survey								
Median Household Gross Rent [1] (2012-2016)	Montgomery	**1077** dollars	**2.58**	3	3	3	1.5	3
	Harris	**937** dollars	**2.08**	**3**	**2**	**1**	**1.5**	**3**
[1] American Community Survey								
Median Monthly Owner Costs for Households without a Mortgage [1] (2012-2016)	Montgomery	**531** dollars	**2.58**	3	3	3	1.5	3
	Harris	**534** dollars	**2.14**	**3**	**3**	**3**	**1.5**	**1**
[1] American Community Survey								
Mortgaged Owners Median Monthly Household Costs [1] (2012-2016)	Montgomery	**1635** dollars	**2.19**	3	3	2	1.5	2
	Harris	**1504** dollars	**1.81**	**3**	**2**	**2**	**1.5**	**1**
[1] American Community Survey								
People 65+ Living Below Poverty Level [1] (2012-2016)	Montgomery	**7.7** percent	**0.78**	0	0	0	1.5	2
	Harris	**11.3** percent	**1.89**	**2**	**2**	**3**	**1.5**	**1**
[1] American Community Survey								
People Living Below Poverty Level [1] (2012-2016)	Montgomery	**11.0** percent	**0.17**	0	0	0	1.5	0
	Harris	**17.4**	**1.67**	**2**	**2**	**3**	**1.5**	**0**

		percent		🟧	🟧	🟥	🟨	🟩

[1] American Community Survey

Severe Housing Problems [4] (2010-2014)	Montgomery	16.0 percent	1.28	2	0	0	1.5	2
	Harris	20.9 percent	2.39	3	3	3	1.5	1

[4] County Health Rankings

SNAP Certified Stores [17] (2016)	Montgomery	0.5 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

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

Students Eligible for the Free Lunch Program [8] (2015-2016)	Montgomery	35.1 percent	0.56	0	0	0	1.5	1
	Harris	58.2 percent	2.22	2	3	3	1.5	1

[8] National Center for Education Statistics

Total Employment Change [16] (2014-2015)	Montgomery	3.5 percent	1	1	1	0	1.5	1.5
	Harris	2.4 percent	1.67	1	3	2	1.5	1.5

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

Unemployed Workers in Civilian Labor Force [15] (July 2018)	Montgomery	3.8 percent	1.28	1	1	1	1.5	2
	Harris	4.4 percent	1.94	2	2	2	1.5	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.

"We have a year-long waiting list for our dental services (…) having more clinics or places for patients to go is a huge need."

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.

"We can take care of helping them control their diabetes, and keep their blood pressure in check, and we can treat them for that common cold, we can provide that annual pap smear for the woman and provide that mammogram, but it's when the person experiences something of a more significant issue—say they have a gallbladder attack, or they have a hernia—that is just a resource that we simply don't have. Or someone needs to see an orthopedic surgeon. We try to take care of them the best that we can in the setting that we have, but that is a huge barrier that we face with our patients, or that our patients face. So, what happens is it becomes an urgent situation, and they end up in the emergency room, and they're given surgery on an emergency basis."

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.

"I would love to see somebody from the public assistance, and I'll just call it Medicaid, or the public benefits, maybe have an office inside the hospital. That would be phenomenal. I've worked in a different state as a hospital social worker previously, and there was someone from a public assistance, from the Department of Human Health and Welfare Services in the hospital, and that person was able to connect the people there with emergency Medicaid, with Medicaid, which also helps the hospital. Have their bills paid and whatnot, and maybe it would cut down on outsourcing and some of the collections and whatnot. I think that that would be wonderful, would be to have someone from the state public benefits program housed inside the hospital."

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.

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.

Emotional Well-Being

Key Issues:
- Mental health as part of overall health
- Need for more behavioral health services and providers
- 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. Substance Abuse ranked sixth in the top topics for Montgomery County's secondary data results.

As shown in Table 19, in Montgomery County, mental health indicators of note include: Mental Health Provider Rate and Age-Adjusted Death Rate due to Suicide. While Mental Health & Mental Disorders did not rank as high for Harris County, an indicator to note is Alzheimer's Disease or Dementia in the Medicare Population.

Table 19. Secondary Data Scoring Results: Mental Health & Mental Disorders

| 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 Suicide [12] (2010-2014)	Montgomery	**14.6** deaths/ 100,000 population	**2.28**	1.5	3	3	3	2
	Harris	**10.3** deaths/ 100,000 population	**0.94**	1.5	0	0	2	1
[12] Texas Department of State Health Services								
Alzheimer's Disease or Dementia: Medicare Population [3] (2015)	Montgomery	**10.7** percent	**1.67**	1	1	2	1.5	1.5
	Harris	**11.4** percent	**1.89**	2	1	3	1.5	1
[3] Centers for Medicare & Medicaid Services								
Mental Health Provider Rate [4] (2017)	Montgomery	**69.4** providers/ 100,000 population	**2**	1	3	3	1.5	1.5
	Harris	**103.7** providers/ 100,000 population	**1.44**	0	1	3	1.5	2
[4] County Health Rankings								
Poor Mental Health: 5+ Days [10] (2016)	Montgomery		---	---	---	---	---	---
	Harris	**80.0** percent	**1.53**	1.5	1	1.5	1.5	2
[10] Texas Behavioral Risk Factor Surveillance System								

Substance Abuse is another topic of concern for Memorial Hermann Health System. Both Harris and Montgomery counties have indicators with scores above 2. There were over 37% alcohol-impaired driving deaths in Harris County and almost 33% in Montgomery County, compared to 29.3% in the U.S. Moreover, 21% of adults drink excessively in Montgomery County as compared to the national value of 18%.

Table 20. Secondary Data Scoring Results: Substance Abuse

| Indicator | County | | Data Score | County Value Compared to: | | | | |
	Name	Value		TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Adults who Drink	Montgomery	**21.0**	**2.17**	3	2	3	0	1.5

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Excessively [4] (2016)		**percent**						
	Harris	**18.1 percent**	1.5	2	1	2	0	1.5
[4] County Health Rankings								
Alcohol-Impaired Driving Deaths [4] (2012-2016)	Montgomery	**32.9 percent**	2.06	2	3	3	1.5	1
	Harris	**37.8 percent**	2.17	3	3	3	1.5	0
[4] County Health Rankings								

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.

"We here see a huge gap in mental health, there's just not a lot of supportive services for mental health, and we're seeing that to really hit our young adults, our adults who are in their 20s. We see a lot of people having a lot of PTSD or even having a psychotic break, and we only have one agency that would support somebody maybe without insurance that's having mental health issues, which is causing so much trauma for them from that point forward. I would say one of the huge indicators for us would be mental health, it's huge for us."

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.

"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 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.

"(…) we're seeing a lot of addiction and (…) if you don't have the funds to go into a treatment program, your options are limited and there's a wait time."

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."

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Food as Health

Key Issues:
- Food insecurity and limited access to healthy foods
- Diabetes and heart disease linked to socioeconomic factors
- Food deserts

Secondary Data

The topics of Diabetes and Heart Disease & Stroke emerged as significant health needs for Memorial Hermann Health System. Heart Disease & Stroke ranked as the second most important topic for Montgomery County. Although the topic of Diabetes did not receive a high secondary data score overall, 28.1% of the Medicare Population has diabetes in Harris County, compared to the U.S. value of 26.5%. (Table 21)

Table 21. Secondary Data Scoring Results: Diabetes

Indicator	County			County Value Compared to:				
	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Diabetes: Medicare Population [3] (2015)	Montgomery	24.8 percent	0.94	0	0	1	1.5	2
	Harris	28.1 percent	1.67	2	1	2	1.5	1.5
[3] Centers for Medicare & Medicaid Services								

As shown in Table 22 Heart Disease & Stroke is also a concerning topic in Montgomery and Harris counties. Indicators to note include Atrial Fibrillation, Hyperlipidemia and Stroke (all in the Medicare Population). In Harris County, indicators to observe are Heart Failure and Stroke (both in the Medicare Population).

Table 22. Secondary Data Scoring Results: Heart Disease & Stroke

Indicator	County			County Value Compared to:				
	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Atrial Fibrillation: Medicare Population [3] (2015)	Montgomery	8.8 percent	2.44	3	3	2	1.5	2
	Harris	7.3 percent	1.5	1	1	1	1.5	3
Heart Failure: Medicare Population [3] (2015)	Montgomery	14.6 percent	1.22	0	1	2	1.5	1

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Indicator	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
	Harris	16.0 percent	1.89	1	2	3	1.5	1
Hyperlipidemia: Medicare Population [3] (2015)	Montgomery	46.3 percent	1.94	2	2	2	1.5	2
	Harris	43.2 percent	1.44	1	1	1	1.5	2
Hypertension: Medicare Population [3] (2015)	Montgomery	56.0 percent	1.61	1	1	2	1.5	2
	Harris	55.5 percent	1.22	1	1	2	1.5	1
Stroke: Medicare Population [3] (2015)	Montgomery	4.6 percent	2.28	2	2	3	1.5	2
	Harris	5.2 percent	2.61	3	3	3	1.5	2
[3] Centers for Medicare & Medicaid Services								

Table 23 displays nutrition-related indicators. In both Harris and Montgomery counties, SNAP Certified Stores are of concern; additional indicators of note include Food Insecurity Rate in Harris County and Grocery Store Density in Montgomery County.

Table 23. 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)	Montgomery	21.2 percent	1.17	0	1	3	1.5	0
	Harris	23.5 percent	1.67	1	2	3	1.5	0
[5] Feeding America								
Children with Low Access to a Grocery Store [17] (2015)	Montgomery	5.6 percent	1.67	2	1.5	1.5	1.5	1.5
	Harris	5.4 percent	1.5	1	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas								
Fast Food Restaurant Density [17] (2014)	Montgomery	0.6 restaurants/ 1,000 population	1.5	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

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[17] U.S. Department of Agriculture - Food Environment Atlas								
Food Insecurity Rate [5] (2016)	Montgomery	**14.6 percent**	**1.33**	1	1	3	1.5	0
	Harris	**16.6 percent**	**2.06**	**2**	**2**	**3**	**1.5**	**1**
[5] Feeding America								
Grocery Store Density [17] (2014)	Montgomery	**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**
[17] U.S. Department of Agriculture - Food Environment Atlas								
SNAP Certified Stores [17] (2016)	Montgomery	**0.5 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**
[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' 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.

"We have a really large county. (…) The west doesn't cater to the east very easily and vice versa. (…) Once you get off of that interstate, you start getting into the east county and west county you'll go miles and miles and miles without grocery stores, so there are food deserts in our community."

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.

"And there are places which we are really concerned about, (…) east of I45 where there's this food insecurity, food desert, and all other problems that are happening, and we're seeing increasing incidence of child obesity in those areas, and those zip codes. So definitely education is the key. It starts from probably prenatal care of mom, and it goes on to school."

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 and convenience of fast food
- Walkability of communities
- Safety of outdoor spaces and places to exercise

Secondary Data

Exercise, Nutrition & Weight was the fifth highest-ranking topic in the secondary data scoring results for Memorial Hermann Health System. It received the same topic ranking in Montgomery County and, although it did not rank as high in the secondary data scoring results for Harris County, there are indicators to note.

Table 24 displays indicators of concern, with several scores equal to or above 1.75. An exercise-related indicator of concern is: Workers Who Walk to Work (with an indicator score of 2.78 in Montgomery County and 2.17 in Harris County).

Table 24. Secondary Data Scoring Results: Exercise, Nutrition & Weight

Indicator	County			County Value Compared to:				
	Name	Value	Data Score	TX Counties	TX Value	US Value	HP 2020 Target	Trend Over Time
Adults (18+ Years) Who Are Obese [10] (2016)	Montgomery		---	---	---	---	---	---
	Harris	**32.0 percent**	**1.67**	1.5	1	2	2	2
[10] Texas Behavioral Risk Factor Surveillance System								
Child Food Insecurity Rate [5] (2016)	Montgomery	**21.2 percent**	**1.17**	0	1	3	1.5	0
	Harris	**23.5 percent**	**1.67**	1	2	3	1.5	0
[5] Feeding America								
Children with Low Access to a Grocery Store [17] (2015)	Montgomery	**5.6 percent**	**1.67**	2	1.5	1.5	1.5	1.5
	Harris	**5.4 percent**	**1.5**	1	1.5	1.5	1.5	1.5
[17] U.S. Department of Agriculture - Food Environment Atlas								
Fast Food Restaurant Density [17] (2014)	Montgomery	**0.6 restaurants/ 1,000 population**	**1.5**	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

[17] U.S. Department of Agriculture - Food Environment Atlas								
Food Insecurity Rate [5] (2016)	Montgomery	**14.6 percent**	**1.33**	1	1	3	1.5	0
	Harris	**16.6 percent**	**2.06**	**2**	**2**	**3**	**1.5**	**1**
[5] Feeding America								
Grocery Store Density [17] (2014)	Montgomery	**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**
[17] U.S. Department of Agriculture - Food Environment Atlas								
SNAP Certified Stores [17] (2016)	Montgomery	**0.5 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**
[17] U.S. Department of Agriculture - Food Environment Atlas								
Workers who Walk to Work [1] (2012-2016)	Montgomery	**1.0 percent**	**2.78**	3	3	3	3	2
	Harris	**1.5 percent**	**2.17**	**2**	**2**	**3**	**3**	**1.5**
[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, programming that may not meet the needs of communities facing financial limitations, and the convenience of unhealthy foods.

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.

"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.

Another challenge that several participants raised is the convenience and low cost of unhealthy foods. For families that may have financial or time limitations, the convenience of inexpensive, less healthy foods is difficult to contend against.

"We have the big chain grocery stores here in the community, but a lot of times, because our population is limited with funds, the bad foods are the ones that are the cheapest and most accessible, so they go in and buy the cheapest/fastest thing they can get."

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

Older Adults and Aging was a topic of concern for Harris and Montgomery counties, with a topic score of 1.5 for Harris County's secondary data results and as the eighth highest-ranking topic in Montgomery County. In both counties, Stroke in the Medicare Population is an indicator to be aware of. In Harris County, additional indicators scoring above 2 include Chronic Kidney Disease in the Medicare Population as well the Age-Adjusted Death Rate due to Falls. In Montgomery County, Atrial Fibrillation in the Medicare Population is an indicator with score above 2.

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.

"…[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."

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

Cancer was not a top topic for Harris and Montgomery counties' secondary data results. However, there are a couple of indicators to note in Harris County (with scores above 2): Cervical Cancer Incidence Rate and Age-Adjusted Death Rate due to Breast 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 scoring for Harris County. There are several education-related indicators to consider in Harris County: 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.

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. 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.

"I think it comes down to education because probably 75% of our diagnosed diabetes are type 2 diabetes, and that is something that with proper diet, proper exercise, and education that many patients can overcome, and so we have worked, and we continue to provide (…) the proper education."

"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."

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 Harris and Montgomery counties, Transportation rose to the top of the secondary data scoring results, with a topic score of 1.82 in Harris County and 1.93 in Montgomery County. In both 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, another indicator to note for Montgomery County is Workers who Drive Alone to Work. Furthermore, there exist high disparities for a few of these indicators.

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. 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…"

" Houston is really spread out (…) and it can go from city to rural very quickly. The families in the rural communities that really are within a 20-mile radius of the city, so really still within the Houston address, I think that transportation for them is a huge barrier. That's a tough one, because Houston is so big, and it can go quickly to rural, very quickly, and your zip code is still reflecting Houston."

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

In the secondary data results, Children's Health received a topic score of 1.52 in Harris County. Harris County has several indicators to note including: Child Food Insecurity Rate, Children with Health Insurance and Children with Low Access to a Grocery Store. Close to 10% of children in Harris County do not have health insurance.

Primary Data

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

"A lot of people wont go to a FQHC to get their kid immunized because it's a huge doctor visit that requires a lot of paperwork and time/effort."

"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

In the secondary data scoring results, Economy received a topic score of 1.55 in Harris County. Harris County has eight economic indicators with 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.

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.

"I think in some of the lower income neighborhoods, the options for buying food are limited and do not offer a lot of healthy choices, and that a lot of time healthier food costs more. And so the ability to easily get and afford healthy food, whether you're eating at home or eating out, are just more limited for some people and in some neighborhoods…"

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 The Woodlands' 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 25 identifies the number of secondary data health indicators with a health disparity for MH The Woodlands' service area. See Appendix B for the specific indicators with significant disparities.

Table 25. Number of Health Disparities Identified in Secondary Data Analysis

Harris County	Montgomery County
Black or African American (13)	Other Race (8)
White (8)	Black or African American (6)
Hispanic or Latino (8)	Hispanic or Latino (6)
Other Race (7)	American Indian or Alaska
American Indian or Alaska Native (6)	Native (3)
	Two or More Races (3)
Male (10)	Male (5)
Female (3)	
65+ years of age (2)	<6 years of age (1)
	65+ years of age (1)

Geographic disparities were identified using the SocioNeeds Index. As shown previously in Table 13, most of the zip codes within MH The Woodlands' service area with the highest SocioNeeds Index values are within Montgomery County; zip codes 77301 and 77303 both have values greater than 80.

Conclusion

The Community Health Needs Assessment for MH The Woodlands utilized a comprehensive set of secondary data indicators to measure the health and quality of life needs for MH The Woodlands' 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 The Woodlands 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 The Woodlands 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: Evaluation Since Prior CHNA

Appendix B. Secondary Data Methodology

Secondary Data Sources

Secondary Data Scoring

Data Scoring Results

Appendix C. Primary Data Methodology

Community Input Participants

Key Informant Interview Questionnaire (Episcopal Health Foundation)

Key Informant Interview Questionnaire (Conduent Healthy Communities Institute)

Community Survey (English)

Community Survey (Spanish)

Appendix D. Prioritization Tool

Prioritization Survey

Appendix E. Community Resources

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Appendix A. MH The Woodlands Impact Report

Evaluation Since Prior CHNA

Priority 1: Healthy Living

Priority 1: HEALTHY LIVING				
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.				
Early Detection and Screening **Objective 1.1:** Increase screening to promote early detection and reduce advanced stages of diseases				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of participants in screenings (e.g. skin cancer and mammograms.)	Skin 40 Mammogram 300	Skin Cancer 53 Mammograms 314	Skin Cancer 25 Mammograms 311	Skin 45 Mammogram 315
• Number of low dose CT scans at a reduced cost to catch lung cancer earlier	0 (new program) Establish baseline in Y1	63 Lung CT Scans	84 Lung CT Scans	Low Dose Lung CTs 70
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 29 Attendees: 1,635	Events: 25 (6 health fairs, 19 talks) Attendees: 3,339	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See also 1.2, 1.3, 1.4)	14 Groups 220 Attendees	Events: 16 Attendees: 3,920	Groups: 26 Attendees: 2,785	14 Groups 254 Attendees (5% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
1.1.1: Provide education/awareness health talks at area schools and/or local businesses (See 1.2.3, 1.3.5, 1.4.5, 1.5.1)				1, 2, 3

Priority 1:	HEALTHY LIVING			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.				
1.1.2:	Provide free screening mammograms and breast ultrasounds as needed for Interfaith Community Clinic patients and under/uninsured patients of private physicians	47 breast ultrasounds performed for underserved women	67 breast ultrasounds performed for underserved women	1, 2, 3
1.1.3:	Provide free annual screenings for skin cancer during an annual event	53 screened for skin cancer; 26 referred for a biopsy and 12 Basal Cell Carinomas and 3 Melanomas diagnosed	25 screened for skin cancer; 6 referred for a biopsy and 1 Squamous Cell Carinoma diagnosed.	1, 2, 3
1.1.4:	Conduct low dose CT scans for older adults to diagnose lung cancer at earlier stages to prevent Stage 3 & 4 cancer at a reduced cost (communicate to PCPs via their support paperwork for these patients to make them aware of this service)	63 screened; 65% had another significant finding leading to follow-up with specialist (e.g. emphasema)	84 people screened	1, 2, 3
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager, Oncology Nurse Navigator, and Imaging Directors. • Mammogram screenings tracked by Outpatient Imaging		
		Potential Partners: • Community companies/employers (health fairs, talks, screenings) • Area schools (health fairs, talks, screenings) • Community organizations that work with low income patients (e.g. The Rose, Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs, like In the Pink and Lung Cancer CT scans to their patients)		

Obesity Prevention

Objective 1.2 Increase educational offerings that promote healthy eating and exercise

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	28 annually Attendees 4,000	Events: 25 (6 health fairs, 19 talks) Attendees: 3,339	Events: 32 (annually) Attendees: 4,200 (5% annually)
• Number of Support Groups, number of attendees (See 1.1)	See 1.1	4 groups Attendees: 700	3 groups Attendees: 740	5 groups Attendees: 800
• Number of exercise classes, food demonstrations and healthy food education for cancer survivors and family	Establish baseline in Y1	8 Events Attendees: 1,000	10 events Attendees: 1,389	10 Events Attendees: 1,200
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
1.2.1: Conduct no cost support groups for weight loss and for conditions where obesity plays a role - diabetes, heart disease, and stroke		4 groups	3 groups	1, 2, 3
1.2.2: Provide facilities on-campus for Canopy program to conduct exercise classes to cancer survivors and their caregivers (e.g., yoga, ballroom dancing, line dancing, guided meditation, tai chi) (See 1.4.2) and free food demonstrations and education about healthy food options for cancer survivors and families via nutritionists and dietary staff (See 1.3.1)		Demo kitchen, flexible space for fitness activities or events	Demo kitchen, flexible space for fitness activities or events; have expanded these to include children of a cancer survivor too.	1, 2, 3

Priority 1: HEALTHY LIVING			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.			
1.2.3: Provide education/awareness health talks at area schools and/or local businesses	Health fair screenings: BMI, nutritionist, diabetes info, heart info, blood pressure and/or stroke risk assessments	Health fair screenings: BMI, nutritionist, diabetes info, heart info, blood pressure and/or stroke risk assessments – trauma is also educating the public on balance and strength.	1, 2, 3

		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager & Occupational Medicine Liaison • Canopy programs maintained by Canopy Coordinator
		Potential Partners: • Community companies/employers (health fairs, talks, screenings) • Area schools (health fairs, talks, screenings) • Community organizations that work with low income patients (e.g. Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)

Access to Healthy Food				
Objective 1.3: Increase education about healthy foods to improve access and awareness				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Pounds of food donated to local food pantries	14,000 lbs.	Donated 2,471lbs and $4,531 in cash donated; this translates to 25, 126lbs of food	Memorial Hermann food drive discontinued	16,300 lbs. total (5% annually)
• Number of Farmer's Markets held (number of participant transactions)	5 sessions $1,750 in sales on avg /session	5 events, $1,750 avg/session – 8/16 $1,400 in sales; 9/16 $2,100; 10/16 $1,700; 3/17 $1,900; and 4/17 $1,800	5 sessions May 31, April 5, Nov. 17, Oct. 26, Sept. 27	Sessions: 3 total Sales of $2,000/session
• Number of food demonstrations and healthy food education for cancer survivors and family	8 evemts Attendees: 637	8 events, 637 attendees – cooking demos 70 attendess; Oncology nutrition 117, Cooking together (kids) 60; Special Functions with healthy foods (end of year survivor events 120, Breast Friends Christmas party 130, Valentine's Tea 42, Cinco de Mayo Fiesta 98	41 total events 489 attendees • Eating Well Thru Cancer • Cooking Demos • Oncology Nutrition • Cooking Together • Val Tea • Cinco de Mayo Christmas	10 events Attendees 800
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500		X reference to 1.2.1.	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See 1.1)	See 1.1		X reference to 1.1.1	See 1.1
• Number of attendees at weekly breastfeeding support group	26 weekly		34	26 weekly

Priority 1:	**HEALTHY LIVING**			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.				
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline** **Year 1,2,3**
1.3.1:	Nutritionists and dietary staff provide free food demonstrations and education about healthy food options for cancer survivors and families via the program at Canopy (See strategy 1.2.2)	Canopy cancer survivorship center has a demo kitchen, flexible space for fitness activities or events. At Canopy, supplies and food are paid for using Foundation monies; this is why there are no charges in those areas	Canopy cancer survivorship center has a demo kitchen, flexible space for fitness activities or events. At Canopy, supplies and food are paid for using Foundation monies; this is why there are no charges in those areas	1, 2, 3
1.3.2:	Collect food to support food pantries or special events hosted by community partners such as the Montgomery County Food Bank and/or Interfaith Food Pantry	Donated to the Interfaith Food Bank – we broke a 6-yr record in FY17!	No food drive in FY18.	1, 2, 3
1.3.3:	Offer Farmer's Markets on-campus for staff, patients, patient families, and community members	Held in the Healing Garden at the Campus and once in the Cafeteria due to rain.	Held in the Healing Garden at the Campus and once in the Cafeteria due to rain. There was an attempt to extend the farmer's market in part by setting up produce bins in the Cafeteria. This was not overly successful, and also our cafeteria is very small and crowded and lines can be long. *No financial sales data received for FY18 by deadline*	2, 3

Priority 1: HEALTHY LIVING			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.			
1.3.4 Provide education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)	**TOTALS FY17:** **943 people served / 15 events** **TOTALS: 604 attendees / 13 events** -Halliburton Series: Navigating Nutrition Labels (9/1/16, **46**, 2 s hr) -Huntsman Corp. Talks (2-3 locations rotating): Diabetes Preventions (Plant Site, 7/26, **32**, 2 v hr, 1 s hr); Diabetes Prevention(9/2, **81**, 2 v hr, 1 s hr); Stress Mgt. (Plant Site, 11/1, **29**, 2 s hr); Stress Mgt. (2/24/17, **84**, 2 s hr); Diabetes (3/15, **45**, 2 v hr, 1 s hr); Cholesterol Mgt (Plant Site, 3/28, **38**, 2 v hr, 1 s hr); Colorectal Cancer (6/14, **35**, 2 v hr, 1 s hr). -Strike Corp. Talks: Diabetes (8/2/16, **37**, 2 v hr, 1 s hr); Men's Health (9/6, **48**, 6 v hr, 2 s hr); Women's Health (10/4, **35**, 6 v hr, 2 s hr); Heart Health & Cholesterol Baby Fair: 200 attendees (free event and included in Priority 1); MHTW has 9 lactation consultants and one is present for support groups Donation to Meals on Wheels, plus staff working on distribution and sharing into on preventing slips, trips and falls (major cause of trauma). (11/1, **54**, 2 v hr, 1 s hr); Nutrition Trends & Fads (12/6, **40**, 3 s hr) **Meals on Wheels:** Bronze Sponsor of Miles for Meals $1,000 contribution *Helps feed 139 seniors a meal.* **10th Annual Baby Fair for Expectant, New & Experienced Parents** (8/6/16, **200**) breastfeeding promotion, WIC, La Leche League, Mother's Milk Bank of Austin	**TOT FY18: 961 ppl / 8 events** • Huntsman Talks • Senior Woodlands Township Talks • Lone Star College Adult Lifelong Learning: Doc Talks • Canopy Doc Talks • Pelvic Floor Community Talk • Heart Healthy Talk • Trauma Symposium National Night Out at Auburn Lakes (first aid and health info given out	1, 2, 3

Priority 1: HEALTHY LIVING			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.			
1.3.5	Provide education/awareness on breastfeeding benefits for mother and baby (nutrition, bonding, low cost alternative to formula, immunity boosting, etc.) via Baby Fair and breastfeeding support group	Support groups meet in perinatal classroom behind lactation center and support groups are facilitated by a lactation consultant nurse	Support groups meet in perinatal classroom behind lactation center and support groups are facilitated by a lactation consultant nurse *No Baby Fair in FY18.*
			1, 2, 3

	31 weekly attendees All About Moms Support Group: 15 moms weekly on avg. Adventures in Breastfeeding Support Group: 16 moms weekly on avg.	**Monitoring/Evaluation Approach:** • Patient/participant experience surveys (Patient Satisfaction survey on hospital food) • Events log maintained by Marketing Manager, Occupation Medicine Liaison, and Oncology Nurse Navigator • Food Bank report

		Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**
		Potential Partners: • Interfaith Food Pantry; Montgomery County Food Bank • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Community organizations that work with low income patients (e.g. Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • Local growers of fresh produce/farmers

	Time for/Safety During Physical Activity			
	Objective 1.4: Increase the avenues for the community to participate in activities that promote safe physical activity			
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of events where we provide medical support/athletic trainers	350 Events	**FY 17: 414 events** 395 athletic events at schools where MHTW provided Athletic Trainer coverage; 19 community events where ATs, first aid and a physician were provided for medical coverage 52 free injury screenings at ISMI for school age athletes 3,900 student physicals where a nominal fee was charged and all funds were donated back to the schools in the form of a donation from MHTW…in FY17 this totaled $82,365		350 Events
• Number of educational talks/events like health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500			Events: 40 (annually Attendee s: 580 (5% annually)
• Number of exercise classes to cancer survivors and their caregivers	Events: 8 Attendees 1,000	**12 events,** **1,665 attendees** Cooking and Nutrition related offerings at Canopy in FY17: cooking demos **70** attendees, oncology nutrition **117**; Cooking Together (kids) **60**; special functions with healthy foods (end of yr survivor event **120**, Breast Friends Christmas party **130**, Valentine's Tea **42**, Cinco de Mayo Fiesta **98**) Fitness related classes at Canopy Cancer Survivorship Center in FY17: dancing **35** attendees, Pilates **40**, Yoga **754**, Tai Chi **199**	**10 events** **Attendees: 1,389** • Yoga • Tai Chi • Pilates • Guided Meditation • Eating Well Thru Cancer • Cooking Demos • Oncology Nutrition • Cooking Together • Active After Cancer • Cancer Rehab	Events: 10 Attendee s: 1,200

Priority 1: HEALTHY LIVING				
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.				
• Financial support of walk/runs	4 Events	**FY17: 15 events** **American Heart Assoc. Heart Walk:** Nov. 2016, $5,000 contribution, our MHTW staff teams raised another $21,000! **Conroe ISD Kids Running for Kids:** $500 contribution **Leukemia & Lymphoma Society's Light the Night:** Oct. 2016, $5,000 contribution **Multiple Sclerosis Society's Walk MS:** Oct. 2016, $1,000 contribution **Woodlands United Methodist School's Walk/Run:** $500 contribution **Resolve Walk of Hope (Infertility):** $500 contribution **March of Dimes' March for Babies:** $3,500 contribution, plus our MHTW staff team raised another $8,700 **YMCA's Dragon Boat Races:** First Aid coverage for 4 days and two teams came to a $4,800 contribution (funds raised benefit YMCA memberships for low income families) **YMCA Run Thru The Woods:** $6,500 contribution and included First Aid coverage at Thanksgiving morning 5K (funds raised also benefit YMCA memberships for low income families) **CB&I Tri:** $9,168 contribution **10 for Texas:** Oct. 2016, $9,166 contribution **Muddy Trails:** $9,166 contribution **American Cancer Society's Relay for Life:** $1,000 contribution **Woodforest Charity Run:** $750 contribution **Birdies for Parkinsons Golf Tournament:** $2,000 contribution	**15 Events** FY18 Events and Contributions: • AHA Heart Walk $5K • CISD Kids Running for Kids $500 • L&LS Light the Night $5K • Walk MS $1K • WUM Walk Run $500 • Walk of Hope $500 • MoD March for Babies $3.5K • YMCA Dragon Boat Races $4.8K • YMCA Run Thru The Woods $9,166 • CB&I Tri $9,166 • Muddy Trails $9,166 • 10 for Texas $9,166 • Relay for Life $1K • Woodforest Charity Run $750 Birdies for Parkinson's $2K **Total: $61,214.00**	4 Events

Priority 1: HEALTHY LIVING			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.			
Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.4.1: Provide financial support to four (4) runs; 10 for Texas, CBI Tri, Muddy Trails and Run Thru The Woods in the community	These four are part of The Woodlands Township sponsored runs, but we contribute and/or participate in far more (listed above).	These four are part of The Woodlands Township sponsored runs, but we contribute and/or participate in far more (listed above).	1, 2, 3
1.4.2: Provide facilities on-campus for Canopy program to conduct exercise classes to cancer survivors and their caregivers (e.g., yoga, ballroom dancing, line dancing, guided meditation, tai chi) (See 1.2.2)	In FY17, also performed 52 free injury screenings for student athletes in our ISMI Clinic.	10 events Attendees: 1,389	1, 2, 3
1.4.3: Provide medical support/trainer presence and first aid supplies at community sporting events and other annual events (runs, walks, and clubs)	We performed 3,900 student physicals at a nominal fee, which we in turn donated BACK to the schools. Area schools received a total of $82,365 from Memorial Hermann from these physicals. We performed cardiac screenings for students in grades 7-12 at a nominal cost. 63 students took advantage at The Woodlands High School and 2 of those were referred to affiliated pedi cardiologist Faustino Ramos, MD	We did continue to perform school physicals for a nominal fee and donated back to individual schools. We also continued to perform cardiac heart screenings for students at a nominal charge.	1, 2, 3

Priority 1:   HEALTHY LIVING
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.

1.4.4: Conduct education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)		**TOT FY18: 961 ppl / 8 events** • Huntsman Talks • Senior Woodlands Township Talks • Lone Star College Adult Lifelong Learning: Doc Talks • Canopy Doc Talks • Pelvic Floor Community Talk • Heart Healthy Talk • Trauma Symposium National Night Out at Auburn Lakes (first aid and health info given out)	1, 2, 3
		Monitoring/Evaluation Approach: • Participant experience surveys • Events log maintained by Marketing Manager , Occupational Medicine Liaison and Oncology Nurse Navigator	
		Potential Partners: • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)	

Chronic Disease Management:				
Objective 1.5: Provide support to those impacted with a chronic disease to help them effectively control and monitor their progress.				
Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 6 annually Attendees: 300	**FY 17: 309 attendees / 6 events** -Woodlands Township Senior Community Talks: Arthritis (9/30, **79**, 2 v hr, 1 s hr) -Huntsman Corp. Talks (2-3 locations rotating): Diabetes Prevention (Plant Site, 7/26, **32**, 2 v hr, 1 s hr); Diabetes Prevention (9/2, **81**, 2 v hr, 1 s hr); Diabetes (3/15/17, **45**, 2 v hr, 1 s hr); and Colorectal Cancer (6/14, **35**, 2 v hr, 1 s hr). -Strike Corp. Talks: Diabetes (8/2/16, **37**, 2 v hr, 1 s hr)		Events: 8 Attendees: 350

Priority 1: HEALTHY LIVING				
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.				
• Number of Support Groups, number of attendees. (See 1.1)	8 groups Attendees: 1000	**FY 17: 12 groups / 2,310 attendees** -Mended Hearts: 9/15/16 **41** attendees; 11/7 **40**; 1/19/17 **18**; 3/16 **18**; and 5/18 **18** (10 s hr total); $1,080 catering -Diabetes Support Group: 7/13 **8**; 8/18 **10**; 9/14 **13**; 10/20 **8**; 11/9 **17**; 12/15 **12**; 1/11/17 **16**; 2/8 **9**; 4/20 **22**; 5/3 **11**; 6/14 **7** (22 staff hrs) -Weight Loss Support Group: Meets 2x mo, about 18-20 attendees /session **456** attendees (12 v hr) -Parkinson's Support Group: Meets mo, 7-15 attendees /session…**144** attendees (14 s hr) -Multiple Sclerosis (MS) Support Group: Meets mo, 10-15 attendees /session…**144** attendees (14 s hr) -Dysautonomia Support Group: Meets mo, 2-4 attendees /session…**36** attendees (14 s hr) -Cancer Education & -Cancer Widows Support Group: **42** attendees for FY17 (14 s hr) -Look Good, Feel Better (Cancer): **57** attendees for FY17 (14 s hr) -Art Therapy Support Group (Cancer): **644** attendees for FY17 (14 s hr, 18 v hr)Support Group: **222** attendees for FY17 (14 s hr) -Cancer Coffee & Chatting: **252** attendees for FY17 (14 s hr) -Teal Tales Ovarian Cancer Support Group: **45** attendees for FY17 (14 s hr)		10 groups Attendees: 1,250
• Number of patients receiving free prosthetics, wigs and scarves	126	**FY17: 88 items** 64 wigs, 24 breast prosthesis, and 22 scarves provided free of charge	**FY18: 92 items** Wigs and prosthesis, plus 26 scarves	168 (10% annually)

Priority 1: HEALTHY LIVING			
Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.			
Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
1.5.1: Conduct education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)			1, 2, 3
1.5.2: Conduct no cost support groups for weight loss and for conditions where obesity plays a role - diabetes, heart disease, and stroke (See strategy 1.2.1)			1, 2, 3
1.5.3 Provide Nurse Oncology Navigator support and/or Canopy coordinator support to fit patients with free prosthesis, wigs and scarves provided by Canopy	Canopy cancer survivorship center has a salon like room for shaving parties, wig fittings, scarves and prosthesis fittings	Canopy cancer survivorship center has a salon like room for shaving parties, wig fittings, scarves and prosthesis fittings	1, 2, 3
	Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager & Occupational Medicine Liaison • Oncology Nurse Navigator to maintain log of prosthetics, wigs and scarves		
	Potential Partners: • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)		

Priority 2: Access to Health Care

Priority 2: HEALTH CARE ACCESS				
Goal 2: Improve access points to primary care and specialty providers by reducing barriers.				
Availability of Primary Care and Specialty Providers **Objective 2.1: Increase the number of primary care and specialty care providers in local settings**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Montgomery, Walker and Harris) (See 2.4.1)	30,089	30,130 Top 3 adult concerns: abdominal pain, vaginal symptoms and chest pain. Top 3 pediatric concerns: fever, vomiting and coughing.	31,407	30,089
• People served through Interfaith Community Clinic	2,107 patients 8,681 visits	$682,275 in charity care 2,190 patients Number of Visits: 9,686	$685,059.25 in charity care 2,184 patients Number of Visits: 9,846	2,212 patients 9,115 visits
• Number of telemedicine consultations	275/year (in 2015)	**FY17 Total: 324** Stroke: **284** Pediatric Surgery: **40**	**FY18 Total: 282** Stroke: **266** Pediatric Surgery: **16**	275/year
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**

Priority 2: HEALTH CARE ACCESS			
Goal 2: Improve access points to primary care and specialty providers by reducing barriers.			
2.1.1: 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. (see 2.4.1)	More than 46% of all patients seen in the Emergency Room are there for Primary Care related conditions. Open 24/7, 365 days a year with English and Spanish-speaking RNs According to the Nurse Health Line, 78% who would have gone to the ER for care…were redirected to primary care Also according to the Nurse Health Line, of those that were triaged by the RN on the phone, 49% were directed to PCP, 33% to the ER, and 18% to self-care at home		1, 2, 3
2.1.2: Provide funding support for the Interfaith Community Clinic which provides free care to underserved populations.	The Clinic is located across I45 from MHTW.	The Clinic is located across I45 from MHTW.	1, 2, 3

Priority 2:	HEALTH CARE ACCESS			
Goal 2:	Improve access points to primary care and specialty providers by reducing barriers.			
2.1.3: Provide telemedicine consults free of charge for stroke and pediatric surgery patients, to determin		Pedi telemedicine consults in the ER and in the NICU; of the 40, only 9 had to be transferred to CMHH in the TMC; 21 were admitted or stayed admitted at MHTW; and 10 were treated and d/c to home		1, 2, 3
		Stroke Consults in the ER with the TMC; of those consults, 27 were given tPA and 13 were transferred to the TMC		
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Interfaith Community Clinic feedback • ER visits and Interfaith Community Clinic funding tracked through finance • Telemedicine consults maintained in the ER • Nurse Health Line calls		
		Potential Partners: • Government relations office • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • Memorial Hermann Community Benefit Corporation		

Health Insurance Coverage and Costs Objective 2.2 Increase health insurance coverage for uninsured and underinsured populations				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
Number of people successfully insured through RCA	1,400 patients screened	**1,842** patients screened. A total of 678 of these patients were able to be placed into a program to assist them with medical costs.	**1,230** patients screened. A total of **584** of these patients were able to be placed into a program to assist them with medical costs	1,621 (5% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Time line: Year 1,2,3**
2.2.1: Contract with Resource Corporation of America (RCA) to provide services to increase insurance coverage for community RCA is a third-party eligibility vendor (paid by MHTW) to assist patients with the application process for Medicaid, County Indigent, Affordable Care Act Insurance Exchange, and other third-party payors.		Of those screened: 55 placed into Medicaid for Aged & Disabled; 240 into County programs; 273 into traditional Medicaid; 96 into Social Sec Disability; 14 into VVC (Crime Victims' Assistance)	Placed among: Medicaid for Aged & Disabled; County programs; traditional Medicaid; Social Sec Disability; VVC (Crime Victims' Assistance	1, 2, 3
	Monitoring/Evaluation Approach: • Log of insured through RCA			
	Potential Partners: • Case Workers			

Transportation Objective 2.3: Reduce the barrier of transportation to more efficiently access health care services				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of patients who did not need to be transferred due to telemedicine consults	Stroke 200 Pediatric – Establish baseline in Y1 40	Pedi telemedicine consults in the ER and in the NICU; of the **40**, only 9 had to be transferred to CMHH in the TMC; 21 were admitted or stayed admitted at MHTW; and 10 were treated and d/c to home --- **284** Stroke Consults in the ER with the TMC; of those consults, 27 were given tPA and 13 were transferred to the TMC		Stroke 231 (5% annually) Pediatric (once baseline established) 50
• Number of vouchers used	182	211	240	211 (5% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
2.3.1: Provide transportation vouchers for patients to return home following care		Average of **18** taxi vouchers per month per OA Richard Smedley, RN	Average of **20** taxi vouchers per month per OA Richard Smedley, RN	1, 2, 3
2.3.2: Provide telemedicine consults free of charge for stroke and pediatric surgery patients, to determine if additional transfer and associated expense is necessary or could be avoided (See 2.1.3)		231	262	1, 2, 3
		Monitoring/Evaluation Approach: • Patient experience surveys • Telemedicine consults maintained in the ER • Voucher count maintained by case management		
		Potential Partners: • Area physicians (to promote free or low cost programs to their patients) • Community organizations that work with low income patients (e.g. The Rose, Interfaith Community Clinic)		

Health Care Navigation				
Objective 2.4: Connect patients to resources to help them better navigate the health care system				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Montgomery, Walker, and Harris) (See 2.1.1)	30,089	**30,130** Top 3 adult concerns: abdominal pain, vaginal symptoms and chest pain. Top 3 pediatric concerns: fever, vomiting and coughing.	31326	30,089
• Number of patient navigators	1	1	2	1-2
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 (See 2.1.1)				1, 2, 3
2.4.2: Increase number of patient navigators to provide services to our cancer patients		Still just the one – Carolyn Allsen, RN who is now officed in Canopy (Cancer Survivorship Center)		1, 2, 3
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Nurse Health Line call log		
		Potential Partners: • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • 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 The Woodlands but to the community at large with the exception of reduction in ER encounters that result in a psychiatric inpatient stay through linkages with 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 – The Woodlands	157	166	179	149
• Number of Memorial Hermann Crisis Clinic total visits	5,400	5,590	5,590	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
3.1.1: Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7 at The Woodlands		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

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.			
3.1.2:	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
3.1.3:	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)		

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.	
		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
• TW Stress management (total time includes training material development and implementation)		1 training (6.5 hours)*	0	1	1 training (6.5 hours)*
• 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:			**Year 1 Notes**	**Year 2 Notes**	**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 The Woodlands' Community Health Needs Assessment.

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

Montgomery 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

Secondary Data Scoring

Data scoring is done in three stages:
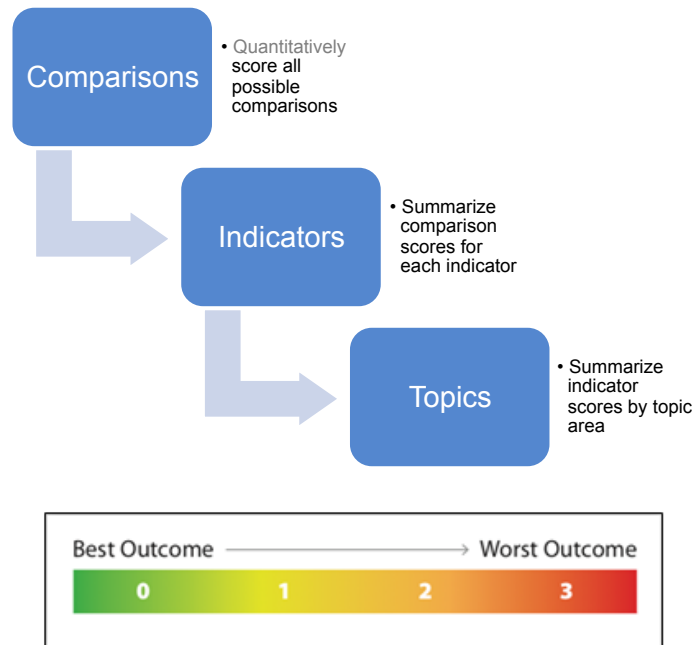
For each indicator, each county in Memorial Hermann The Woodlands' service area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome 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 The Woodlands' service area. Secondary data for this report are up to date as of November 2, 2018.

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
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

SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
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 or African American, Hispanic or Latino, Other, <6	1
1.67	People Living Below Poverty Level	percent	17.4		16.7	15.1	2012-2016	American Indian or Alaska Native, Black	1

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								or African American, Hispanic or Latino, Other, Female, <6, 6-11, 12-17, 18-24	
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, Native Hawaiian or Other Pacific	1

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SCORE									Islander, Other, Two or More Races	
(green)										
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	

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
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
1.33	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	percent	66.7		68.4	65.2	2016		10

SCORE		UNITS		HP2020			MEASUREMENT PERIOD		Source
	Obese								
1.50	Children with Low Access to a Grocery Store	percent	5.4				2015		17
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	percent	28.8		28.8	26.5	2015		3

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Population								
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

SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
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
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
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

SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
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
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

SCORE		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 Incidence Rate	*cases/ 100,000 population*	50.9		53.1	60.2	*2011-2015*		7
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
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

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
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
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-	1

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SCORE		UNITS	HARRIS COUNTY	HP2020	TEXAS	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
								59	
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
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

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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

Montgomery County

SCORE	ACCESS TO HEALTH SERVICES	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Mental Health Provider Rate	providers/ 100,000 population	69		99	214	2017		4
1.67	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	55		67	81	2017		4
1.56	Dentist Rate	dentists/ 100,000 population	46		56	67	2016		4
1.53	Children with Health Insurance	percent	90.2	100.0	90.3		2016		9
1.47	Adults with Health Insurance: 18-64	percent	79.7	100.0	77.4		2016		9
1.47	Persons with Health Insurance	percent	83.1	100.0	81.4		2016		9
1.22	Primary Care Provider Rate	providers/ 100,000 population	62		60	76	2015		4

SCORE	CANCER	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.72	Cancer: Medicare Population	percent	7.8		7.1	7.8	2015		3
1.58	Cervical Cancer Incidence Rate	cases/ 100,000 females	8.0	7.3	9.2	7.5	2011-2015		7
1.56	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.2		10.9	11.6	2011-2015		7
1.33	Breast Cancer Incidence Rate	cases/ 100,000 females	117.6		111.7	124.7	2011-2015		7
1.19	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	17.8	21.8	18.1	19.5	2011-2015		7
1.08	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	19.6	20.7	20.2	20.9	2011-2015		7
0.94	Age-Adjusted Death Rate due to	deaths/ 100,000	42.4	45.5	39.0	43.4	2011-2015		7

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Lung Cancer	population							
0.83	All Cancer Incidence Rate	cases/ 100,000 population	398.9		401.3	441.2	2011-2015		7
0.83	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	56.4		53.1	60.2	2011-2015		7
0.78	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.4	14.5	14.4	14.5	2011-2015		7
0.67	Colorectal Cancer Incidence Rate	cases/ 100,000 population	36.6	39.9	38.1	39.2	2011-2015		7
0.67	Prostate Cancer Incidence Rate	cases/ 100,000 males	88.7		95.4	109.0	2011-2015		7
0.61	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	156.0	161.4	156.4	163.5	2011-2015	Male	7
SCORE	CHILDREN'S HEALTH	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Children with Low Access to a Grocery Store	percent	5.6				2015		16
1.53	Children with Health Insurance	percent	90.2	100.0	90.3		2016		9
1.17	Child Food Insecurity Rate	percent	21.2		23.0	17.9	2016		5
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	5.5		8.5		2017		10
SCORE	ECONOMY	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Median Household Gross Rent	dollars	1077		911	949	2012-2016		1
2.58	Median Monthly Owner Costs for Households without a Mortgage	dollars	531		467	462	2012-2016		1

2.19	Mortgaged Owners Median Monthly Household Costs	*dollars*	1635		1444	1491	*2012-2016*		1
2.00	Female Population 16+ in Civilian Labor Force	*percent*	53.6		57.7	58.3	*2012-2016*		1
1.89	SNAP Certified Stores	*stores/ 1,000 population*	0.5				*2016*		16
1.50	Population 16+ in Civilian Labor Force	*percent*	63.7		64.2	63.1	*2012-2016*		1
1.33	Food Insecurity Rate	*percent*	14.6		15.4	12.9	*2016*		5
1.33	Low-Income and Low Access to a Grocery Store	*percent*	5.9				*2015*		16
1.28	Severe Housing Problems	*percent*	16.0		18.3	18.8	*2010-2014*		4
1.28	Unemployed Workers in Civilian Labor Force	*percent*	3.8		4.0	4.1	*July 2018*		14
1.17	Child Food Insecurity Rate	*percent*	21.2		23.0	17.9	*2016*		5
1.06	Renters Spending 30% or More of Household Income on Rent	*percent*	39.4		48.0	47.3	*2012-2016*		1
1.00	Total Employment Change	*percent*	3.5		3.2	2.5	*2014-2015*		15
0.86	Persons with Disability Living in Poverty	*percent*	17.9		24.2	26.6	*2016*		1
0.78	People 65+ Living Below Poverty Level	*percent*	7.7		10.8	9.3	*2012-2016*	Black or African American, Hispanic or Latino, Other	1
0.75	Persons with Disability Living in Poverty (5-year)	*percent*	19.1		25.1	27.6	*2012-2016*		1
0.61	Homeownership	*percent*	65.6		55.0	55.9	*2012-2016*		1
0.58	Median Housing Unit Value	*dollars*	190000		142700	184700	*2012-2016*		1
0.56	Families Living Below Poverty Level	*percent*	8.3		13.0	11.0	*2012-2016*	Black or African American, Hispanic	1

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
								or Latino, Other	
0.56	Households with Cash Public Assistance Income	percent	1.1		1.6	2.7	2012-2016		1
0.56	People Living 200% Above Poverty Level	percent	73.0		62.8	66.4	2012-2016		1
0.56	Students Eligible for the Free Lunch Program	percent	35.1		52.9	42.6	2015-2016		8
0.39	Median Household Income	dollars	70805		54727	55322	2012-2016	Black or African American, Hispanic or Latino, Other, Two or More Races	1
0.17	Children Living Below Poverty Level	percent	14.8		23.9	21.2	2012-2016	Hispanic or Latino, Other	1
0.17	Homeowner Vacancy Rate	percent	1.2		1.6	1.8	2012-2016		1
0.17	People Living Below Poverty Level	percent	11.0		16.7	15.1	2012-2016	12-17, 18-24, 6-11, <6 Black or African American, Hispanic or Latino, Other	1
0.17	Per Capita Income	dollars	35912		27828	29829	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races	1
SCORE	**EDUCATION**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.89	Student-to-Teacher Ratio	students/ teacher	16.2		15.4	17.7	2015-2016		8
1.22	People 25+ with a High School Degree or Higher	percent	86.8		82.3	87.0	2012-2016	American Indian or Alaska Native	1
1.08	Infants Born to Mothers with <12 Years Education	percent	17.6		21.6	15.9	2013		11

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SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.00	High School Drop Out Rate	percent	0.9		2.0		2016		12
0.33	People 25+ with a Bachelor's Degree or Higher	percent	33.0		28.1	30.3	2012-2016	25-34, 65+ American Indian or Alaska Native, Other, Two or More Races	1

SCORE	ENVIRONMENT	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.89	SNAP Certified Stores	stores/ 1,000 population	0.5				2016		16
1.83	Grocery Store Density	stores/ 1,000 population	0.1				2014		16
1.75	Annual Ozone Air Quality	grade	F				2014-2016		2
1.67	Children with Low Access to a Grocery Store	percent	5.6				2015		16
1.50	Farmers Market Density	markets/ 1,000 population	0.0				2016		16
1.50	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2014		16
1.39	Recognized Carcinogens Released into Air	pounds	16762				2017		17
1.33	Low-Income and Low Access to a Grocery Store	percent	5.9				2015		16
1.33	People 65+ with Low Access to a Grocery Store	percent	2.5				2015		16
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		16
1.28	Severe Housing Problems	percent	16.0		18.3	18.8	2010-2014		4
1.25	Drinking Water Violations	percent	1.7		6.6		FY 2013-14		4
1.22	Food Environment Index		7.5		6.0	7.7	2018		4

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.17	Households with No Car and Low Access to a Grocery Store	percent	1.5				2015		16
1.00	Access to Exercise Opportunities	percent	82.7		80.6	83.1	2018		4
0.67	Liquor Store Density	stores/ 100,000 population	6.3		6.8	10.5	2015		15
0.39	Houses Built Prior to 1950	percent	1.2		7.4	18.2	2012-2016		1
SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Workers who Walk to Work	percent	1.0	3.1	1.6	2.8	2012-2016		1
1.89	SNAP Certified Stores	stores/ 1,000 population	0.5				2016		16
1.83	Grocery Store Density	stores/ 1,000 population	0.1				2014		16
1.67	Children with Low Access to a Grocery Store	percent	5.6				2015		16
1.50	Farmers Market Density	markets/ 1,000 population	0.0				2016		16
1.50	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2014		16
1.33	Food Insecurity Rate	percent	14.6		15.4	12.9	2016		5
1.33	Low-Income and Low Access to a Grocery Store	percent	5.9				2015		16
1.33	People 65+ with Low Access to a Grocery Store	percent	2.5				2015		16
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014		16
1.22	Food Environment Index		7.5		6.0	7.7	2018		4
1.17	Child Food Insecurity Rate	percent	21.2		23.0	17.9	2016		5

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.17	Households with No Car and Low Access to a Grocery Store	percent	1.5				2015		16
1.00	Access to Exercise Opportunities	percent	82.7		80.6	83.1	2018		4
SCORE	HEART DISEASE & STROKE	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.44	Atrial Fibrillation: Medicare Population	percent	8.8		7.4	8.1	2015		3
2.28	Stroke: Medicare Population	percent	4.6		4.5	4.0	2015		3
1.94	Hyperlipidemia: Medicare Population	percent	46.3		46.1	44.6	2015		3
1.61	Hypertension: Medicare Population	percent	56.0		57.5	55.0	2015		3
1.25	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	38.5	34.8	42.0	37.3	2010-2014		11
1.25	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	173.2		173.0	171.9	2010-2014	Male Black	11
1.22	Heart Failure: Medicare Population	percent	14.6		15.5	13.5	2015		3
1.17	Ischemic Heart Disease: Medicare Population	percent	28.6		28.8	26.5	2015		3
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Syphilis Incidence Rate	cases/ 100,000 population	13.1		40.6		2017		11
1.50	Chlamydia Incidence Rate	cases/ 100,000 population	265.4		511.6		2017		11
1.44	HIV Diagnosis Rate	cases/ 100,000	7.7		16.1		2016		11

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SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
		population							
1.39	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.8	1.0	4.5		*2013-2017*		11
1.28	Gonorrhea Incidence Rate	*cases/ 100,000 population*	52.4		160.2		*2017*		11
0.67	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.8		14.2	15.2	*2010-2014*		11
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Mothers who Received Early Prenatal Care	*percent*	60.7	77.9	59.2	74.2	*2013*		11
1.08	Infants Born to Mothers with <12 Years Education	*percent*	17.6		21.6	15.9	*2013*		11
0.83	Babies with Very Low Birth Weight	*percent*	1.1	1.4	1.4	1.4	*2013*		11
0.75	Preterm Births	*percent*	10.4	9.4	12.0	11.4	*2013*		11
0.47	Babies with Low Birth Weight	*percent*	6.6	7.8	8.3	8.0	*2013*		11
0.47	Infant Mortality Rate	*deaths/ 1,000 live births*	4.5	6.0	5.8	6.0	*2013*		11
0.42	Teen Births	*percent*	2.0		2.8	4.3	*2014*		11
SCORE	**MEN'S HEALTH**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.19	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	17.8	21.8	18.1	19.5	*2011-2015*		7
1.00	Life Expectancy for Males	*years*	76.7		76.2	76.7	*2014*		6
0.67	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	88.7		95.4	109.0	*2011-2015*		7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.28	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	14.6	10.2	11.7	12.5	2010-2014	Male	11
2.00	Mental Health Provider Rate	providers/ 100,000 population	69		99	214	2017		4
1.67	Alzheimer's Disease or Dementia: Medicare Population	percent	10.7		11.7	9.9	2015		3
1.28	Depression: Medicare Population	percent	15.9		17.0	16.7	2015		3
0.67	Frequent Mental Distress	percent	10.2		10.6	15.0	2016		4
0.67	Poor Mental Health: Average Number of Days	days	3.3		3.4	3.8	2016		4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	18.8		26.6	24.5	2010-2014		11

SCORE	OLDER ADULTS & AGING	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.44	Atrial Fibrillation: Medicare Population	percent	8.8		7.4	8.1	2015		3
2.28	Stroke: Medicare Population	percent	4.6		4.5	4.0	2015		3
2.00	Chronic Kidney Disease: Medicare Population	percent	18.3		19.9	18.1	2015		3
1.94	Hyperlipidemia: Medicare Population	percent	46.3		46.1	44.6	2015		3
1.72	Cancer: Medicare Population	percent	7.8		7.1	7.8	2015		3
1.67	Alzheimer's Disease or Dementia: Medicare Population	percent	10.7		11.7	9.9	2015		3

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.61	Hypertension: Medicare Population	percent	56.0		57.5	55.0	2015		3
1.39	COPD: Medicare Population	percent	11.7		11.1	11.2	2015		3
1.33	People 65+ with Low Access to a Grocery Store	percent	2.5				2015		16
1.33	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	28.5		31.6	30.0	2015		3
1.28	Asthma: Medicare Population	percent	7.7		8.2	8.2	2015		3
1.28	Depression: Medicare Population	percent	15.9		17.0	16.7	2015		3
1.22	Heart Failure: Medicare Population	percent	14.6		15.5	13.5	2015		3
1.22	Osteoporosis: Medicare Population	percent	5.8		6.5	6.0	2015		3
1.17	Ischemic Heart Disease: Medicare Population	percent	28.6		28.8	26.5	2015		3
0.94	Diabetes: Medicare Population	percent	24.8		28.2	26.5	2015		3
0.78	People 65+ Living Below Poverty Level	percent	7.7		10.8	9.3	2012-2016	Black or African American, Hispanic or Latino, Other	1
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	18.8		26.6	24.5	2010-2014		11
0.50	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	5.1	7.2	7.4	8.3	2010-2014		11
0.50	People 65+ Living Alone	percent	21.5		23.9	26.4	2012-2016		1
SCORE	OTHER CHRONIC DISEASES	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Chronic Kidney Disease: Medicare Population	percent	18.3		19.9	18.1	2015		3

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.33	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	28.5		31.6	30.0	*2015*		3
1.22	Osteoporosis: Medicare Population	*percent*	5.8		6.5	6.0	*2015*		3
SCORE	**PREVENTION & SAFETY**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.28	Severe Housing Problems	*percent*	16.0		18.3	18.8	*2010-2014*		4
1.08	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	10.6		9.8	16.9	*2014-2016*		4
0.53	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	34.1	36.4	37.6	39.2	*2010-2014*	Male	11
0.50	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	5.1	7.2	7.4	8.3	*2010-2014*		11
SCORE	**PUBLIC SAFETY**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.06	Alcohol-Impaired Driving Deaths	*percent*	32.9		28.3	29.3	*2012-2016*		4
1.11	Substantiated Child Abuse Rate	*cases/ 1,000 children*	5.5		8.5		*2017*		10
0.83	Violent Crime Rate	*crimes/ 100,000 population*	171.2		407.6		*2012-2014*		4
SCORE	**RESPIRATORY DISEASES**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.39	COPD: Medicare Population	*percent*	11.7		11.1	11.2	*2015*		3
1.39	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.8	1.0	4.5		*2013-2017*		11
1.28	Asthma: Medicare Population	*percent*	7.7		8.2	8.2	*2015*		3

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SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.94	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	42.4	45.5	39.0	43.4	2011-2015		7
0.83	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	56.4		53.1	60.2	2011-2015		7
0.67	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	10.8		14.2	15.2	2010-2014		11
SCORE	SOCIAL ENVIRONMENT	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.61	Mean Travel Time to Work	minutes	32.5		25.9	26.1	2012-2016	Male	1
2.58	Median Household Gross Rent	dollars	1077		911	949	2012-2016		1
2.58	Median Monthly Owner Costs for Households without a Mortgage	dollars	531		467	462	2012-2016		1
2.19	Mortgaged Owners Median Monthly Household Costs	dollars	1635		1444	1491	2012-2016		1
2.00	Female Population 16+ in Civilian Labor Force	percent	53.6		57.7	58.3	2012-2016		1
1.50	Population 16+ in Civilian Labor Force	percent	63.7		64.2	63.1	2012-2016		1
1.47	Persons with Health Insurance	percent	83.1	100.0	81.4		2016		9
1.22	People 25+ with a High School Degree or Higher	percent	86.8		82.3	87.0	2012-2016	American Indian or Alaska Native	1
1.11	Substantiated Child Abuse Rate	cases/ 1,000 children	5.5		8.5		2017		10
1.00	Total Employment Change	percent	3.5		3.2	2.5	2014-2015		15
0.83	Linguistic Isolation	percent	3.7		7.9	4.5	2012-2016		1
0.67	Voter Turnout: Presidential Election	percent	65.5		58.8		2016		13

SCORE		UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.61	Homeownership	percent	65.6		55.0	55.9	2012-2016		1
0.58	Median Housing Unit Value	dollars	190000		142700	184700	2012-2016		1
0.50	People 65+ Living Alone	percent	21.5		23.9	26.4	2012-2016		1
0.39	Median Household Income	dollars	70805		54727	55322	2012-2016	Black or African American, Hispanic or Latino, Other, Two or More Races	1
0.39	Single-Parent Households	percent	23.8		33.3	33.6	2012-2016		1
0.33	People 25+ with a Bachelor's Degree or Higher	percent	33.0		28.1	30.3	2012-2016	25-34, 65+ American Indian or Alaska Native, Other, Two or More Races	1
0.17	Children Living Below Poverty Level	percent	14.8		23.9	21.2	2012-2016	Hispanic or Latino, Other	1
0.17	People Living Below Poverty Level	percent	11.0		16.7	15.1	2012-2016	12-17, 18-24, 6-11, <6 Black or African American, Hispanic or Latino, Other	1
0.17	Per Capita Income	dollars	35912		27828	29829	2012-2016	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races	1
SCORE	**SUBSTANCE ABUSE**	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Adults who Drink Excessively	percent	21.0	25.4	19.4	18.0	2016		4
2.06	Alcohol-Impaired Driving Deaths	percent	32.9		28.3	29.3	2012-2016		4
1.08	Death Rate due to Drug Poisoning	deaths/ 100,000 population	10.6		9.8	16.9	2014-2016		4
0.67	Liquor Store Density	stores/ 100,000	6.3		6.8	10.5	2015		15

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SCORE	TRANSPORTATION	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
			population						
2.78	Workers who Walk to Work	percent	1.0	3.1	1.6	2.8	2012-2016		1
2.61	Mean Travel Time to Work	minutes	32.5		25.9	26.1	2012-2016	Male	1
2.61	Solo Drivers with a Long Commute	percent	49.9		36.9	34.7	2012-2016		4
2.17	Workers who Drive Alone to Work	percent	81.5		80.3	76.4	2012-2016		1
1.67	Workers Commuting by Public Transportation	percent	1.3	5.5	1.5	5.1	2012-2016	16-19, 20-24 Other	1
1.17	Households with No Car and Low Access to a Grocery Store	percent	1.5				2015		16
0.50	Households without a Vehicle	percent	3.6		5.6	9.0	2012-2016		1

SCORE	WELLNESS & LIFESTYLE	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.39	Life Expectancy for Females	years	80.7		80.8	81.5	2014		6
1.17	Insufficient Sleep	percent	31.8		32.7	38.0	2016		4
1.00	Life Expectancy for Males	years	76.7		76.2	76.7	2014		6
0.67	Frequent Physical Distress	percent	9.9		10.8	15.0	2016		4
0.67	Poor Physical Health: Average Number of Days	days	3.3		3.5	3.7	2016		4
0.67	Self-Reported General Health Assessment: Poor or Fair	percent	14.1		18.2	16.0	2016		4

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SCORE	WOMEN'S HEALTH	UNITS	MONTGOMERY COUNTY	HP2020	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.58	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.0	7.3	9.2	7.5	*2011-2015*		7
1.39	Life Expectancy for Females	*years*	80.7		80.8	81.5	*2014*		6
1.33	Breast Cancer Incidence Rate	*cases/ 100,000 females*	117.6		111.7	124.7	*2011-2015*		7
1.08	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.6	20.7	20.2	20.9	*2011-2015*		7

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.

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- 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?
  - o 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

  - o 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?
  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 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 do you see as the strengths of the health care and social services in your community?
  o 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.]

  o 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?

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 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]?

o   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?

o   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

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?**

- 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 these 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 ARE the strengths of the health care and social services in your community?**

  - **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.]

  - **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?**

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

  - **What program, services, or policies 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 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.

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   □ Obesidad

□ Colesterol alto   □ Asma

□ Cáncer   □ Enfermedad cardíaca

□ Diabetes

□ Otros, (especifique): _____

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   □ Asiático/a o isleño/a del Pacífico

□ Negro/a o afroamericano/a   □ Indígena americano/a

□ Hispano/a o latino/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.
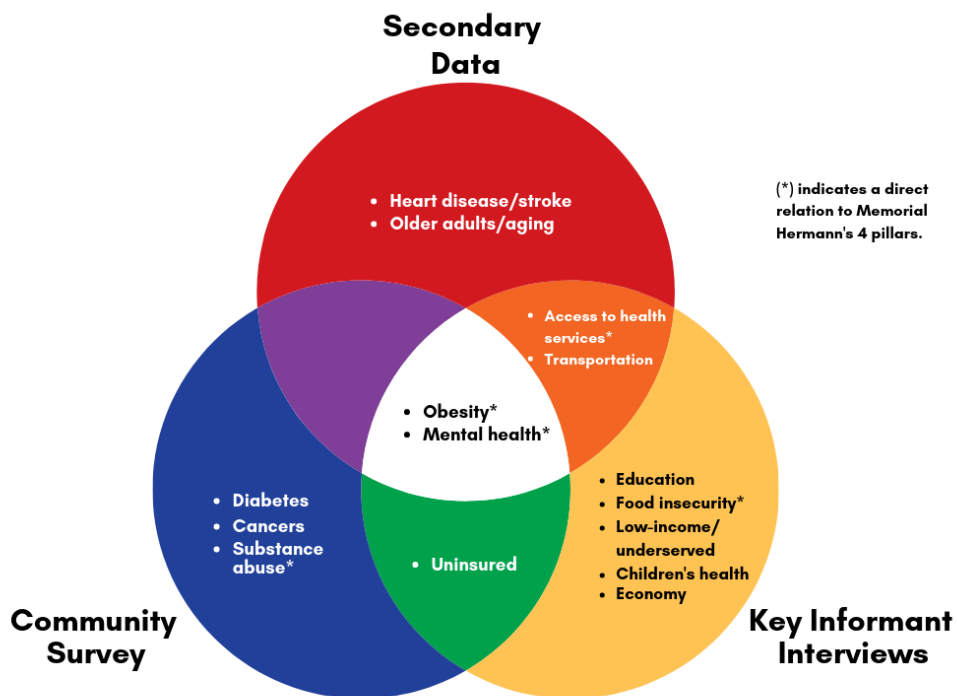
1. The following health needs are not listed by order of importance. For each health need, click on the arrow on the drop down box and select your agreement with each statement. If you are on a tablet or phone, please scroll all the way to the right for each row.

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