Community Health Needs Assessment and Implementation Strategy

St. Luke's Lakeside Hospital

October 29, 2013

The Community Health Needs Assessment and Implementation Strategy for the St. Luke's Lakeside Hospital were conducted and developed between April 22 and October 29, 2013, in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. It was approved by the St. Luke's Lakeside Hospital Board of Directors on November 5, 2013.

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Introduction

A Community Health Needs Assessment (CHNA) for the St. Luke's Lakeside Hospital (SLLH) was conducted by SLLH and Episcopal Health Charities (the Charities) between April 22 and October 5, 2013, in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. The CHNA process involved the review of secondary data sources describing the health needs of the community served by SLLH and a series of focus groups with hospital, public health and community stakeholders to identify the priority community health needs. This CHNA document was developed with the SLLH hospital advisory team and includes a description of the community served by SLLH; the process and methods used to conduct the assessment; a description of how SLLH included input from persons who represent the broad interests of the community served by SLLH; a prioritized description of all of the community health needs identified through the CHNA; and, a description of the existing healthcare facilities and other resources within the community available to meet the community health needs identified through the CHNA. The accompanying Implementation Strategy provides an overview of SLLH's plan to address the identified priority community health needs.

Description of Community Served by the Hospital

The community served by St. Luke's Lakeside Hospital is described by the geographic area of SLLH and the contiguous zip codes determined by 2012 SLLH hospital discharge data. Located in Montgomery County, the SLLH service area contains both a large urban complex, as well as smaller rural communities, and is home to nearly 700,000 residents across seven Texas counties. The Primary Service Area (PSA) is based on 75% of discharges, and the Secondary Service Area (SSA) reflects an additional 5%. Because the majority of primary service area zip codes are found in both Montgomery and Walker Counties, this report has relied upon recent data available for Montgomery and Walker Counties to draw inferences about the SLLH community.

The 2012 Behavioral Risk Surveillance System (BRFSS) data provides in-depth information for the SLLH primary and secondary service area zip codes. From here forward, the

SLLH community refers to PSA and SSA data that was matched to the available zip codes in the BRFSS, and the data was compared to BRFSS Harris County data as a reference. The SLLH primary and secondary service area map and zip codes are included in Appendix 1.

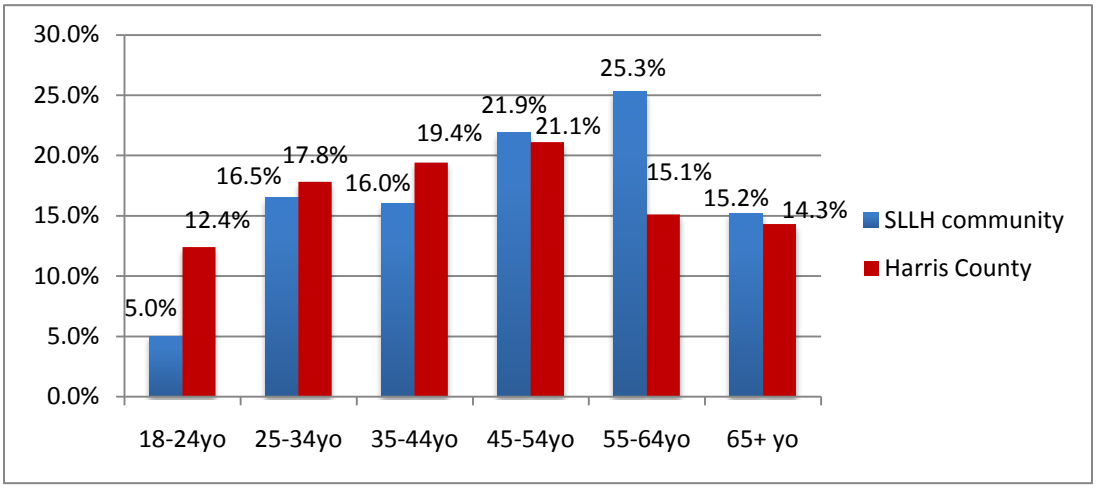
Community Demographics

Demographic data were collected and analyzed using comparisons within the area designated as the SLLH community (Montgomery and Walker county data) and with the aggregated county data representing Harris County. Overall, the community served by SLLH compared with Harris County has a higher number of community residents aged 55-64 years, is majority White non-Hispanic, and has a larger population of high school graduates with some college education. A full description of the data from the SLLH's PSA and SSA and the 2012 Behavioral Risk Surveillance System can be found in Appendix 2.

Below are additional details related to the demographics of Montgomery and Walker counties compared with Harris County:

- ***Age:*** One-fourth (25.3%) of those living in the SLLH community are between 55-64 years old, one-fifth (21.9%) are between 45-54 years old, one-sixth (16.5%) are between 25-34 years old, and one-sixth (16.0%) are between 35-44 years old. Those older than 65 years were the fifth-largest category (15.2%), and those between 18-24 years old were the smallest category (5.0%). Compared with Harris County, the SLLH community has fewer 18-24-year-olds (5.0% SLLH vs. 12.4% Harris County) (Figure 1).

Figure 1. Age distribution for the SLLH community and Harris County



- ***Race/Ethnicity:*** Respondents from the BRFSS survey of Montgomery and Walker Counties self-identify as White non-Hispanic (68.4%), Hispanic (24.0%), Multiracial/non-Hispanic (2.9%), Asian/non-Hispanic (1.7%), and Black non-Hispanic (1.4%). (Appendix 2). In a more comprehensive analysis of the SLLH hospital discharge data, the race and ethnicity of the community served by SLLH are White/non-Hispanic (65.1%), Hispanic (24.1%), Black non-Hispanic (7.9%), Asian/non-Hispanic (3.6%), and Multiracial/non-Hispanic (2.0%). This differs from the racial/ethnic distribution of Harris County, where 34.1% are White non-Hispanic and 39.7% are Hispanic. (Table 1).

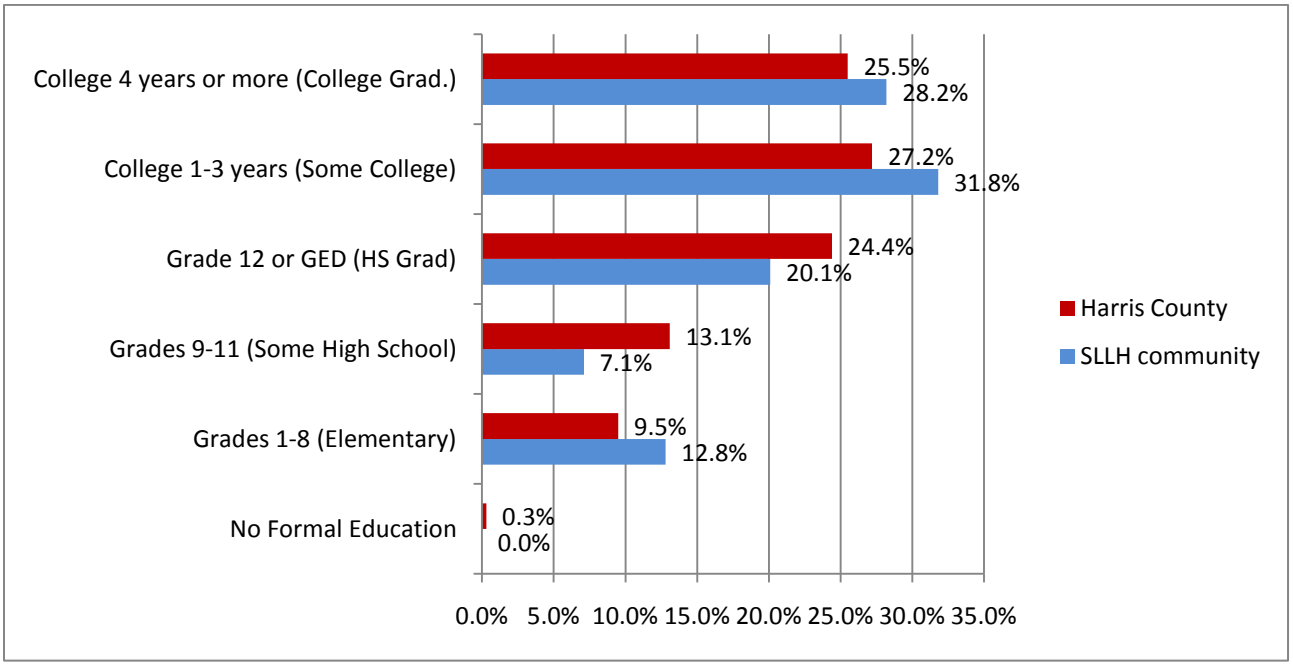
Table 1. Racial/ethnic distribution for SLLH community and Harris County

Race/Ethnicity	SLLH community	Harris County
White/non-Hispanic	65.1%	34.1%
Black/non-Hispanic	7.9%	16.7%
Hispanic	24.1%	39.7%
Asian/non-Hispanic	3.6%	4.3%
Multiracial/non-Hispanic	2.0%	2.6%

- ***Gender:*** Compared with Harris County, the SLLH community reported a higher population of males (55.3% SLLH vs. 49.2% Harris County).

- ***Education:*** In both the SLLH community and Harris County, most residents have more than or equal to a high school education / GED; however, the SLLH community has a higher percentage of residents with more than or equal to a high school education / GED (80.1% SLLH vs. 77.1% Harris County) (Figure 2).

Figure 2. Educational attainment rates for the SLLH community and Harris County



Description of the Process and Methods Used to Conduct the CHNA

Episcopal Health Charities was contracted to manage the Community Health Needs Assessment for St. Luke's Health System, which includes St. Luke's Lakeside Hospital. The Charities, affiliated with the Episcopal Diocese of Texas, is a research-informed grant-maker dedicated to funding programs that improve the health of underserved people throughout 57 counties in Texas. Founded in 1997, the Charities is a unique funder committed to taking healthcare beyond the walls of conventional healthcare and out into the community. A one-of-a-kind entity in Texas, the Charities utilizes research practices built on community partnerships that support more effective interventions and improved health outcomes. To date, the Charities has touched 17 million lives with $90 million distributed through 1,851 research-informed grants to nonprofit community health service programs throughout Southeast Texas. The Charities developed a nationally recognized Center for Community-Based Research through partnering with area institutions, universities, and national and local funders to help reduce health disparities. Using a mixed method approach, which includes epidemiological data and community-based participatory research, the Charities has written twelve technical reports

and conducted nine community needs assessments with the goal of creating systemic change and measurable improvement in overall community health status and individual well-being.

The Charities collaborated with the SLLH hospital advisory team, subject matter experts from The University of Texas School of Public Health and Clarus Consulting Group, public health experts, community organizations, and community stakeholders to conduct the SLLH CHNA. The SLLH hospital advisory team met regularly with the Charities team in-person and communicated via email and conference calls to offer input and provide guidance on the CHNA. The SLLH hospital advisory team consisted of executive leadership staff including the Assistant Vice President and Chief Finance Officer, the Chief Nursing Officer, the Community Relations and Business Development Manager and the Project Manager and Board Coordinator. The Charities collaborated with The University of Texas School of Public Health to research secondary data sources to obtain quantitative information on existing needs assessments, community demographics, county resources, and hospital service data. Clarus Consulting Group facilitated focus groups and analyzed qualitative data obtained from community input focus groups. The names, titles, organizations, and roles of those involved in the CHNA, including the data analysis and community input portions, can be found in Appendix 3.

Public Health Data

Public health data collection, review, and analysis efforts were guided by two main questions: "What are the health needs of the community served by the hospital facility?" and "What are the characteristics of the populations experiencing these health needs?" Quantitative data were obtained and analyzed between April and September 2013 from various data sources, including the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey and the 2012 St. Luke's Health System hospital discharge data.

The 2012 BRFSS database is maintained by the Centers for Disease Control and Prevention (CDC). Data for this report were analyzed for Montgomery and Walker Counties, as being representative of the SLLH's service area, and for Harris County to serve as a point of comparison. BRFSS items used in this report capture respondent characteristics and behaviors related to demographics, health status, healthcare access, preventive services, and risk factors. Analyses were conducted using responses from adults, that is, those 18 years of age or older.

Cases were weighted using the general BRFSS weighting variable for adult cases. Weighting corrects for the fact that potential respondents may have unequal probabilities of being contacted, and different segments of the population may have different response rates when contacted to participate. The weighted interview variables for Montgomery and Walker Counties were a total of 372,050 and for Harris County were 2,568,229. For Montgomery and Walker Counties, the weighted variable for insurance status was 365,211 and poverty status was 330,865. For Harris County, the weighted variable for insurance status was 2,550,977 and for poverty status was 2,229,784. Differences between total responses for insurance status and poverty status within each county can be accounted for by differential patterns of response to the relevant items. Thus, totals for insurance status do not equal totals for poverty status. Given the high response rates for insurance status, when overall percentages are reported insurance totals have been referenced.

Hospital Discharge Data

Data on all hospital discharges for 2012 were provided by the St. Luke's Health System. Data were aggregated by the 5-digit ICD-9 diagnosis code and divided into inpatient and outpatient discharges. ICD-9 codes were further aggregated into more relevant and less clinically specific categories. Discharge data were summarized for SLLH, and the categories reflecting the most frequently occurring diagnoses were highlighted (Appendix 4).

For those diagnoses with high prevalence, the categories were disaggregated to a level that aided understanding if the main description was extremely broad. Classifications are presented for inpatient (n = 76), outpatient (n = 2,265), and total patient load (N = 2,341). Overall, the leading discharge categories were *Injury and Poisoning* (28.2%); *Symptoms, Signs, and Ill-Defined Conditions* (20.9%); *Diseases of the Musculoskeletal System and Connective Tissue* (12.3%); and *Diseases of the Respiratory System* (9.3%).

Of the 2012 SLLH inpatient discharges, 27.6% were for *Diseases of the Circulatory System*. Within this category, the most common conditions were *ischemic heart disease* (28.6%), *diseases of pulmonary circulation* (23.8%), and *other forms of heart disease* (19.0%). *Injury and Poisoning* accounted for 23.7% of inpatient discharges. Within this category, the

most common conditions were *fracture of lower limb* (55.6%) and *complications of surgical and medical care, not elsewhere classified* (38.9%). *Diseases of the Respiratory System* accounted for 18.4% of inpatient discharges. Within this category, p*neumonia and influenza* (71.4%) was the most common condition, followed by *chronic obstructive pulmonary disease and allied conditions* (21.4%).

Of the 2012 SLLH outpatient discharges, 28.3% were for *Injury and Poisoning*. Within this category, the most common conditions were *sprains and strains of joints and adjacent muscles* (24.8%), *fracture of upper limb* (15.0%), and *contusion with intact skin surface* (12.2%). *Symptoms, Signs, and Ill-Defined Conditions* accounted for 21.6% of outpatient charges, with 99.4% of these discharges being for *symptoms*. *Diseases of the Musculoskeletal System and Connective Tissue* accounted for 12.3% of outpatient discharges. Within this category, *dorsopathies* (47.1%) and *arthopathies and related disorders* (32.7%) were the most common conditions.

Key Indicators and Health Disparities

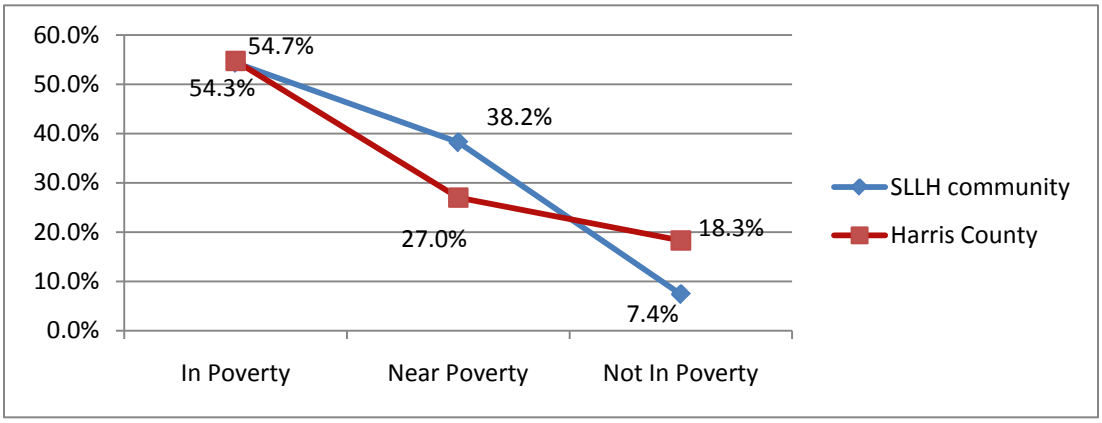
The SLLH community key indicators and health disparities were established by comparing the 2012 BRFSS data for Montgomery and Walker Counties with the 2012 BRFSS data for Harris County (Appendices 2, 5-8). Data reviewed indicate that sufficient health information is already available from local public health sources to allow for the identification of the most important health needs of the SLLH community.

The SLLH community, as represented by the Montgomery and Walker Counties 2012 BRFSS data, has lower uninsured and poverty rates, higher skin cancer rates, higher rates of high blood pressure, and high cardiovascular disease rates compared with Harris County. The below indicators reflect analyses from the 2012 BRFSS data for both the SLLH community and Harris County.

- ***Health insurance and access to care:*** Approximately 22.3% of adults in the SLLH community are uninsured (Appendix 2 and 6). This uninsured rate is lower than the Harris County rate (32.1%) but higher than the national rate (18.5%). Compared with Harris County, fewer residents in the SLLH community reported no personal doctor or healthcare provider (28.9%

SLLH vs. 39.1% Harris County) (Appendix 6, Table 1). Only 16.1% of those in the SLLH community reported they could not see a doctor in the previous year because of cost, compared with 24.7% in Harris County (Appendix 6, Table 1). In the SLLH community, those living in poverty were more likely to report being uninsured (54.3%) than those living in near poverty (38.2%) or not in poverty (7.4%) (Figure 3; Appendix 6, Table 1). Approximately 19.3% of adults in the SLLH community are below the federal poverty level, which is lower than the rate for Harris County (25.0%) (Appendix 6, Table 1).

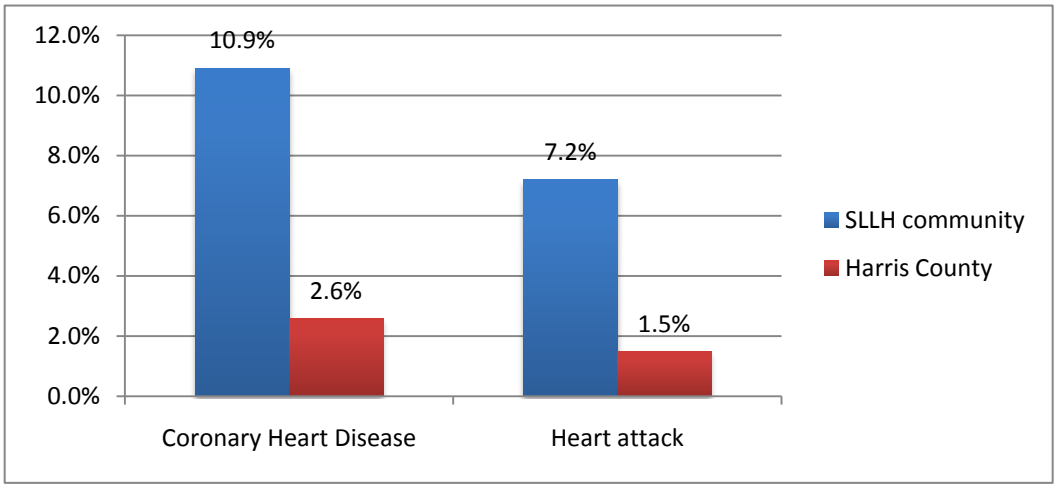
Figure 3. Percentage of uninsured and in poverty in the SLLH community and Harris County



- ***Cancer:*** The rates for skin cancer are three times higher in the SLLH community than in Harris County (10.9% SLLH vs. 3.3% Harris County) (Appendix 5, Table 1). Cancer diagnoses other than skin can are lower in the SLLH community than in Harris County (2.7% SLLH vs. 5.7% Harris County).
- ***Asthma:*** Compared with Harris County, the SLLH community reported lower rates of asthma (4.5% SLLH vs. 8.7% Harris County) (Appendix 5, Table 1).
- ***Diabetes:*** In the SLLH community, there is a lower rate of those diagnosed with diabetes (9.9% SLLH vs. 12.5% Harris County) (Appendix 5, Table 1).
- ***High blood pressure:*** Compared with Harris County, the SLLH community reported higher rates of high blood pressure (38.7% SLLH community vs. 32.0% Harris County) (Appendix 5, Table 1). In the SLLH community, 57.2% of those in poverty reported high blood pressure (Appendix 5, Table 2).

- ***Mental health:*** In the SLLH community, 27% reported one or more days of poor mental health compared to Harris County where approximately 35% reported one or more days of poor mental health (Appendix 5, Table 1).
- ***Cardiovascular disease:*** Compared with Harris County, the SLLH community has higher rates of coronary heart disease (8.3% SLLH vs. 3.1% Harris County), heart attack (3.1% SLLH vs. 2.2% Harris County), and stroke (5.0% SLLH vs. 2.8% Harris County) (Appendix 5, Table 1). The SLLH near poverty population has higher rates of coronary heart disease (10.9%) and heart attack (7.2%) than the Harris County near poverty population (2.6% coronary heart disease, 1.5% heart attack) (Figure 4; Appendix 5, Table 2).

Figure 4. Cardiovascular disease diagnosis for those living near poverty in the SLLH community and Harris County



- ***Use of preventive services:*** Overall, the SLLH community reported higher lifetime rates of preventive services including mammography, Pap test, blood stool test, and sigmoidoscopy/colonoscopy than those in Harris County (Appendix 7, Table 1). Testing for HIV was at a lower rate in the SLLH community than in Harris County (30.5% SLLH vs. 45.7% Harris County) (Appendix 7, Table 1).
- ***Smoking:*** The percentage of lifetime smokers in the SLLH community is higher than in Harris County (40.3% SLLH vs. 38.0% Harris County) (Appendix 8, Table 1). In the SLLH community, 34.6% of residents smoke cigarettes every day; in Harris County, 23.8% smoke every day.

- ***Exercise or physical activity:*** More individuals reported physical activity in the SLLH community (79.7%) than in Harris County (72.7%) (Appendix 8, Table 1).

Description of Community Input

A broad representation of the community was engaged through multiple meetings, focus groups, interviews, and written correspondence. Stakeholders were identified based on those with special knowledge of or expertise in public health; state, regional, or local health departments, with current data or other information relevant to the health needs of the community served by SLLH; and leaders, representatives, or members of medically underserved, low-income, and minority populations, as well as populations with chronic disease needs, in the community served by SLLH. Community input was obtained from the SLLH hospital advisory team, SLLH community stakeholders, and the public health community. Appendix 3 lists the participants involved in the CHNA including names, titles, and roles.

<u>SLLH Hospital Advisory Team Input</u>

A CHNA kickoff meeting was held on April 24, 2013, to inform leadership of St. Luke's Health System hospitals of the new Internal Revenue Service requirement to conduct a CHNA. The hospital leadership discussed their community's health needs, as well as identified existing resources, programs, and community stakeholders. Individual hospital meeting notes were developed and distributed approximately one week after the meeting. Hospital advisory teams were identified, and meetings were held from June to October 2013 to discuss the CHNA requirements and the process of conducting a CHNA. The hospital advisory team received updates of the progress being made on the CHNA, information regarding the community meeting specific to their community, and deadlines for submitting the Implementation Strategy.

On July 10, 2013, the SLLH hospital advisory team met to provide input on the most significant health needs of their community, existing gaps in available healthcare, and strategies to address the community needs, while keeping in mind the underserved, minority, uninsured, and elderly communities. There was also a discussion on key stakeholders and resources that

currently exist within the community. The SLLH hospital advisory team summary report can be found in Appendix 9. The SLLH hospital advisory team identified the following areas of need:

- ***Childhood obesity:*** Obesity was identified as a major need, specifically in youth.
- ***Continuity of care:*** A need for more Primary Care Physicians and their role in the continuity of care were expressed.
- ***Homeless population:*** Montgomery County is very large and has many pockets of homeless communities; Conroe also has a large homeless community.
- ***Overutilization of emergency department:*** The surrounding community uses the St. Luke's The Woodlands (SLWH) Emergency Department because it lacks the resources to access preventive care. SLWH is the only Emergency Department in Montgomery and North Harris County that offers 24/7 pediatric services. The hospital sees a significant number of self-pay patients.
- ***Psychiatric or chemical dependency services:*** There are few resources in the area for these patients; this impacts the number of inpatient admissions, as well as visits to the ED.
- ***Transportation:*** Most patients seen at SLLH live in the rural areas of the county and do not have access to transportation.

SLLH Community Stakeholder Input

Through active outreach to key community stakeholders, a broad representation from the communities served by SLLH was identified to participate in the community input portion of the CHNA. A focus group was held on Thursday, August 22, 2013, from 9:00 am to 10:30 am at the Montgomery County United Way in The Woodlands, TX. The event brought people from different roles and organizations together to discuss matters that are important to the health needs of the community served by the hospital. There were sixteen stakeholders and organizations, which represented a range of community-based organizations, health clinics, and business organizations. The SLLH community stakeholder summary report can be found in Appendix 10. Stakeholders identified the following areas of need:

- ***Access to care:*** Many stakeholders expressed concern surrounding access to care as an important health problem in the community. Two key factors surfaced that affect access to care: lack of health insurance and lack of transportation.
  - Health insurance – Stakeholders identified having health insurance as a key component to accessing healthcare, specifically within the indigent population. There is a gap to accessing medications and primary care within the lower income community because of lack of health insurance.
  - Transportation – Stakeholders noted that lack of transportation for seniors and rural-area residents limits access to healthcare and healthy activities. Some neighborhoods within the community served by SLLH are implementing plans for public transportation, but this remains an important need for patients to access care.
- ***Behavioral health including mental health and substance abuse:*** Stakeholders identified both mental health and substance abuse as important health problems in the community served by SLLH. Furthermore, stakeholders noted the increasing complexity of these overlapping and interrelated health needs. For example, they expressed the need for a healthcare model that integrates treatment for both mental health and substance abuse issues, as well one that integrates both mental health and physical health services. One stakeholder noted the important link between chronic illness and mental health. Stakeholders also noted the specific need for mental health, residential mental health, and detox care and treatment facilities.
- ***Chronic disease:*** Stakeholders noted that obesity-related chronic disease is a health problem in the community. Specifically, stakeholders noted the connection between obesity and other chronic diseases such as diabetes, heart attack, and stroke. They acknowledged that, generally, the community lacks understanding about the severity of chronic disease, and suggested education surrounding prevention and disease management.
- ***Primary care:*** Stakeholders noted primary care as an important unmet healthcare need, specifically for low-income and rural-area residents. The uneven distribution (mainly in

the southern part of the Montgomery county) of primary care clinics makes it difficult for residents outside the area to access care. One stakeholder also mentioned that the limited locations of primary care facilities makes it difficult for healthcare providers to implement preventive care, treat chronic diseases, and have continuity in meeting rural-area patients' needs.

Public Health Experts Input

Another focus group was held for Public Health Experts on Thursday, August 8, 2013, from 2:30 pm to 4:00 pm at the Episcopal Health Charities in Houston, TX. This discussion included twelve representatives from local, county, regional, and state governmental public health organizations. In general, participants noted the correlation between a healthy community and fewer admissions to the hospital, and suggested that elevating the idea of a healthy community is a health need in the community. Participants also noted specific unmet healthcare needs in the community, which include access to care, communication, chronic disease, maternal and child health, behavioral health, environmental health, and health disparities. The Public Health Experts summary report can be found in Appendix 11. The Public Health Experts identified the following areas of need:

- ***Access to care:*** Public Health Experts expressed that access to care was the most important health problem in the community. They acknowledged that there is a sufficient number of health clinics in the area, but that access to care remains an issue for a significant portion of the population. Several factors that contribute to the access to care issue include transportation, knowledge, and insurance and finances.

- ***Chronic disease:*** Public Health Experts expressed that the rate of chronic disease, such as diabetes, obesity, high cholesterol, hypertension, heart disease, and asthma (especially in children), is an important health problem in the community. They noted that the rate of adults with diabetes or pre-diabetes is 60%, which illustrates the significance and alarming nature of the chronic disease problem. They felt that more individuals need to be screened

for chronic diseases, and that more information about how to access help for chronic diseases needs to be disseminated.

- ***Communication:*** Public Health Experts indicated that more effective communication around healthcare is an unmet health need. Specifically, they expressed that better communication is needed from healthcare providers to inform the community about services and resources that are available. In addition, better communication is needed between healthcare providers and health departments/public health agencies.

- ***Environmental health:*** Public Health Experts suggested that poor environmental health causes both acute and chronic health issues in the community. The importance of the relationship between environmental health and chronic disease was highlighted, and it was suggested that the community should be offered more educational initiatives around this relationship. Specifically, the experts noted that environmental problems such as air quality or road construction can be obstacles to healthy communities in that they discourage individuals from going outside to exercise, and can also lead to chronic health problems such as respiratory problems, heart attack, stroke, and asthma.

- ***Health disparities:*** Public Health Experts suggested that health disparities are a major healthcare concern in the community. It was noted that there are correlations between race/ethnicity and individuals who do not get regular or necessary healthcare screenings.

- ***Maternal and child health:*** Public Health Experts focused on maternal, infant, and prenatal care as being an important health issue in the community. They cited high rates of maternal and infant mortality and high rates of preterm birth and fetal mortality as evidence of this problem. It was further noted that high rates of poor birth outcomes lead to higher numbers of children with special needs. Overall, the experts suggested that women are aware of the importance of maternal, infant, and prenatal care, but they encounter many barriers to obtaining these services such as transportation, funding, access, finding a doctor, and making an appointment.

- ***Mental health services:*** Public Health Experts suggested that mental health and chronic mental illness are important health issues. While it was specifically noted that individuals with schizophrenia, bipolar disorder, and depression rarely get the care that they need, there has also been progress in addressing this need, such as the police department helping to place individuals with mental health issues in treatment centers instead of placing them in the law enforcement system.

Description of Identifying and Prioritizing Community Health Needs

Community health needs were identified through an analysis of five major data sources: SLLH Hospital Advisory Team Input, SLLH Community Stakeholders Input, Public Health Experts Input, 2012 BRFSS data, and hospital discharge data for the SLLH community. This process involved a detailed review of the priorities identified in each separate data source and the determination of the most important health priorities.

Identifying Community Health Needs

Key criteria for identifying community health needs were: 1) importance of the problem for the community, 2) impact of the problem on vulnerable populations, and 3) lack of existing resources to address the problem. Health status and social determinants of health were incorporated into the analysis of areas of need, challenges, and barriers. The community health needs were designated by source, and the data were compared and cross-validated with the analysis of secondary data. Table 2 displays the areas of need, challenges, and barriers from the various data sources.

Table 2. Identified areas of need, challenges, and barriers

Data Source	Areas of Need	Challenges and Barriers
SLLH Hospital Advisory Team Input	Access to care Childhood obesity Continuity of care Psychiatric or chemical dependency services Transportation	Few primary care physicians Overstrained emergency department Difficult to reach homeless population
SLLH Community Stakeholders Input	Access to care Behavioral health (includes mental health and substance abuse) Chronic disease Health insurance Primary care and preventive services Integrated services (mental health, physical health, substance abuse, and chronic disease) Transportation	Lack of transportation Limited education and health literacy Limited access to care for low-income individuals Lack of continuity of care Limited care for patients with Medicare
Public Health Experts Input	Access to care Chronic disease Communication Environmental health Health disparities Maternal and child health Mental health services	Lack of public transportation Lack of health service navigation knowledge Lack of health and orientation services for immigrants Lack of health insurance, financial resources Environmental issues (pollution, crime, recreation facilities, food deserts) Lack of funding for programs
BRFSS Survey Data for the SLLH community	Access to care Health disparities Preventive and diagnostic services Mental and behavioral health	Poverty Delay to care

Prioritizing Community Health Needs

The identified community health needs were then prioritized through a triangulation process that looked at the priorities identified in each of the three sources of data separately, compared and contrasted across sources, and identified specific commonalities (Figure 5).

Figure 5. Community health needs triangulation process

Priority Community Health Needs Identified for SLLH

The highest priority health needs for the community served by SLLH are:

1. **Access to Care.** The lack of health insurance particularly in low income and minority communities affects access to care. There is a need to link community members into primary care, especially those with low income and in rural areas. The uneven distribution of primary care clinics in the county makes it difficult for residents outside of the main areas to access care. Lack of transportation for seniors and rural-area residents also limits access to healthcare and healthy activities.

2. **Cardiovascular Disease.** There are high rates of cardiovascular disease and a lack of education about the prevention, severity, and disease management of coronary heart disease, heart attack, and stroke.

3. **Communication.** There is a lack of communication among organizations on strategies for effectively meeting the health needs of lower income residents. There is also a need to address healthcare issues for the Hispanic population, including preventive care, dental care, and limited education about available resources due to language barriers.

4. **Injury prevention.** There a lack of education and outreach programs that focus on strategies to prevent injuries. There is a need for injury prevention programs that target both youth and seniors within the community. This need was specifically identified from the high rate of SLLH discharges related to injuries.

Description of Community Resources

Within the community engagement meetings and focus groups, existing resources and programs that address health in the community were discussed. Identifying these resources began to build bridges, foster understanding, and increase awareness of existing services. The available resources identified in the SLLH community are listed below:

- ***1115 Waiver Project***: This program provides mobile psychiatric screenings.
- ***Area Agency on Aging***: The Area Agency on Aging implements preventive programs for seniors that promote health for this important sector of the population.
- ***Asthma-related Support Services***: Although funding is no longer available for this initiative, participants noted a program that provided healthy alternatives for the home for families with children that suffer from asthma. The program was a relatively small resource to address a large problem, but it made a difference for children and families who struggle with asthma.

- ***Civic Clubs and Social Clubs***: Civic and social clubs are an important part of the community and could be a great avenue to reach communities to address health priorities.
- ***Emergency Medical Services (county) and Community Para-medicine Program***: This program provides responses to patients who call with primary care inquiries.
- ***Faith-based Organizations***: Ministries and churches throughout the community reach important (often underserved) demographic groups.
- ***Lone Star Family Clinic***: This clinic provides primary care to families and patients of all ages.
- ***Partnership for Prescription Assistance***: This program offers discounts on medication from pharmaceutical companies but doctors in the area are reluctant to use this resource.
- ***TOMAGWA Health Ministries***: This organization provides healthcare to low-income families in the Tri-County area.
- ***United Way***: The United Way is a great resource that addresses a myriad of health-related issues in the community. This organization links businesses and other sectors in the community to bridge resources and foster communication.

Community Health Needs Assessment Summary

The Community Health Needs Assessment (CHNA) for St. Luke's Lakeside Hospital (SLLH) spanned from April through October, 2013. A CHNA kickoff meeting was held on April 24 to inform hospital leadership of the new Internal Revenue Service requirement to conduct a CHNA and develop a 3-year Implementation Strategy for each hospital. Hospital advisory teams were identified and met with the Charities team from June to July to discuss the CHNA requirement. An overview of the CHNA process was provided, and the hospitals were given an opportunity to discuss their community's health needs, as well as identify any existing resources, programs, and community stakeholders. Individual hospital meeting notes were developed and distributed to the hospital advisory teams approximately one week after each meeting.

For the community input portion of the CHNA, the Charities team solidified meeting locations, scheduled community meetings for each hospital, and invited community organizations and stakeholders. Through active outreach to key community stakeholders, the Charities team obtained a broad representation from the communities served by the hospitals to participate in the community input portion of the CHNA. Focus groups were held to identify and prioritize community health needs with three stakeholder groups: hospital advisory team, community stakeholders, and public health experts. These events brought key stakeholders together to discuss community health needs, challenges, and priorities for the communities served by SLLH.

The Charities team analyzed secondary data and gathered background information on community health needs. The data include national, state, local, and hospital-specific sources. Additional public health data include community demographics, health indicators, health risk factors, access to healthcare, and social determinants of health. The identified community health needs were then prioritized through a triangulation process that looked at the priorities identified in each of the sources of data, compared and contrasted across sources, and identified specific commonalities. The highest priority health needs for the community served by SLLH are:

1. **Access to Care.** The lack of health insurance particularly in low income and minority communities affects access to care. There is a need to link community members into primary care, especially those with low income and in rural areas. The uneven distribution of primary care clinics in the county makes it difficult for residents outside of the main areas to access care. Lack of transportation for seniors and rural-area residents also limits access to healthcare and healthy activities.

2. **Cardiovascular Disease.** There are high rates of cardiovascular disease and a lack of education about the prevention, severity, and disease management of coronary heart disease, heart attack, and stroke.

3. **Communication.** There is a lack of communication among organizations on strategies for effectively meeting the health needs of lower income residents. There is also a need to address healthcare issues for the Hispanic population, including preventive care, dental care, and limited education about available resources due to language barriers.

4. **Injury prevention.** There a lack of education and outreach programs that focus on strategies to prevent injuries. There is a need for injury prevention programs that target both youth and seniors within the community. This need was specifically identified from the high rate of SLLH discharges related to injuries.

From October 5 to October 29, 2013, the hospital advisory team reviewed the CHNA and developed the SLLH Implementation Strategy. The timeframe included in the Implementation Strategy is 2013-2015 (Years 1-3). The CHNA and Implementation Strategy were submitted for approval by the SLLH Board of Directors at the November 5, 2013 board meeting. The CHNA and Implementation Strategy will be made widely available to the public on the St. Luke's Health System and St. Luke's Lakeside Hospital websites.

Implementation Strategy

Introduction

As an integral part of St. Luke's Health System, St. Luke's Lakeside Hospital's (SLLH) mission is to contribute to enhancing community health by delivering superior value in high-quality, cost-effective care since 2009. SLLH, a 30-bed specialized medical facility located in The Woodlands, Texas, offers specialized medical facility in cardiology, orthopedics, and sports medicine including orthopedic/spine care, diagnostic imaging services, nuclear medicine, wellness and prevention, and joint replacement "prehab" camp. In collaboration with the medical staff, we are dedicated to excellence and compassion in caring for the whole person—body, mind and spirit. We also are committed to the growth and development of our care providers and employees, and to securing the health of future generations by creating, applying and disseminating health knowledge through education and research.

Through our commitment to deliver faith-based, compassionate, quality and cost-effective care, SLLH shall be the provider of choice for cardiology, sports and orthopedic medical care. SLLH adopts the five core values of the St. Luke's Health System, which are central to everything we do:

- *Integrity*—being honest is the basis for our actions
- *Valuing People*—taking care of people, including patients, employees and medical staff—is the reason we exist
- *Goal Orientation*—focusing on what we want to achieve helps us design the best way to realize our vision
- *Excellence*—striving to enhance high quality is our constant pursuit
- *Stewardship*—enhancing our stewardship through transparency, fiscal discipline, accountability, efficient management and maximization of resources throughout our Health System to best meet the needs of the community.

In fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code, a Community Health Needs Assessment (CHNA) was conducted collaboratively with the SLLH hospital advisory team, Episcopal Health Charities, and other partners between April 22

and October 5, 2013; the Implementation Strategy was developed by the SLLH hospital advisory team from October 5 to October 29, 2013. The CHNA and Implementation Strategy were submitted for approval to the SLLH Board of Directors and approved at the board meeting on November 5, 2013. The timeframe included in the Implementation Strategy are 2013-2015 (Years 1-3).

SLLH is a hospital facility that conducted a CHNA and adopted an Implementation Strategy in 2013 (Year 1). From 2014-2015 (Years 2-3), SLLH will implement at strategies to meet the health needs identified through that CHNA. SLLH will address each of the priority health needs by the last day of 2015 (Year 3). The CHNA and Implementation Strategy will be made widely available to the public on the St. Luke's Health System and St. Luke's Lakeside Hospital websites.

Overview of the Community Served by SLLH

The community served by SLLH is described by the geographic area of SLLH and the contiguous zip codes determined by 2012 SLLH hospital discharge data. SLLH is located in Montgomery County, and the SLLH service area spans seven Texas counties and contains both a large urban complex, as well as smaller rural communities. The Primary Service Area (PSA) is based on 75% of discharges and the Secondary Service Area (SSA) reflects an additional 5%; therefore, the overall service area used for this report is defined by the residential location for 80% of the hospital discharges in 2012. The remaining 20% are outside of the areas considered for this report. SLLH service area zip codes and service area map are included in Appendix 1.

SLLH serves an area that is home to a population of over 700,000 residents that represent diverse ethnicities, backgrounds, and needs. Key descriptors of the community served by SLLH include:

- ***Age-*** One-fourth (25.3%) of those living in the SLLH community are between 55-64 years old, one-fifth (21.9%) are between 45-54 years old, one-sixth (16.5%) are between 25-34 years old, and one-sixth (16.0%) are between 35-44 years old. Those older than 65 years

were the fifth-largest category (15.2%), and those between 18-24 years old were the smallest category (5.0%)

- ***Race/Ethnicity*** - In an analysis of the SLLH hospital discharge data, the race and ethnicity of the community served by SLLH are White/non-Hispanic (65.1%), Hispanic (24.1%), Black non-Hispanic (7.9%), Asian/non-Hispanic (3.6%), and Multiracial/non-Hispanic (2.0%).
- ***Education***- The majority of residents have some college and are college graduates.

Development of the Implementation Strategy

The CHNA was conducted collaboratively with the SLLH hospital advisory team, Episcopal Health Charities, and other partners between April 22 and October 5, 2013; the Implementation Strategy was developed by the SLLH hospital advisory team from October 5 to October 29, 2013. The SLLH hospital advisory team consisted of executive leadership staff including the Assistant Vice President and Chief Finance Officer, the Chief Nursing Officer, the Community Relations and Business Development Manager and the Project Manager and Board Coordinator. Appendix 3 lists the names, titles, and roles of all involved in the CHNA and Implementation Strategy.

Overview of the Identification and Prioritization of Community Health Needs

As a component of the CHNA, community health needs were identified through an analysis of four major data sources: SLLH Hospital Advisory Team, SLLH Community Focus Group Discussion, Public Health Experts Focus Group Discussion and 2012 BRFSS data for the SLLH community. This process involved a detailed review of the key priorities identified in each separate data source and the determination of the most important health priorities. Key criteria for identifying priorities were: 1) importance of the problem for the community, 2) impact of the problem on vulnerable populations and 3) lack of existing resources to address the problem. Health status and social determinants of health were incorporated into the analysis of the areas of needs, challenges, and barriers. The community health needs were designated by source and the data was compared and cross-validated with the analysis of secondary data (See Table 2). The identified community health needs were then prioritized

through a triangulation process that looked at the priorities identified in each of the three sources of data separately, compared and contrasted across sources, and identified specific commonalities (See Figure 5).

The highest priority health needs for the community served by SLLH are:

1. **Access to Care.** The lack of health insurance particularly in low income and minority communities affects access to care. There is a need to link community members into primary care, especially those with low income and in rural areas. The uneven distribution of primary care clinics in the county makes it difficult for residents outside of the main areas to access care. Lack of transportation for seniors and rural-area residents also limits access to healthcare and healthy activities.

2. **Cardiovascular Disease.** There are high rates of cardiovascular disease and a lack of education about the prevention, severity, and disease management of coronary heart disease, heart attack, and stroke.

3. **Communication.** There is a lack of communication among organizations on strategies for effectively meeting the health needs of lower income residents. There is also a need to address healthcare issues for the Hispanic population, including preventive care, dental care, and limited education about available resources due to language barriers.

4. **Injury prevention.** There a lack of education and outreach programs that focus on strategies to prevent injuries. There is a need for injury prevention programs that target both youth and seniors within the community. This need was specifically identified from the high rate of SLLH discharges related to injuries.

Action Plan to Address Priority Community Health Needs

From October 5 to October 29, the SLLH hospital advisory team discussed the health needs as prioritized by the community in the CHNA and identified strategies to address those needs. The hospital advisory team carefully reviewed the CHNA and made recommendations

based on data from the SLLH hospital advisory team notes, SLLH community stakeholder summary report, public health experts summary report, and the local public health data. The hospital advisory team also discussed the activities and the programs that SLLH is already doing to address the priority community health needs.

As a result of extensive analysis and discussion of both quantitative and qualitative data, the priority health needs identified in St. Luke's Lakeside Hospital Community Health Needs Assessment will be addressed through the following strategies for FY 2013-2015:

Access to Care. SLLH will implement the following strategies to address access to care:

1. SLLH will be active in educating surgeons on the quality and operational benefits provided by SLLH. As a specialty hospital, the staff at SLLH is highly specialized in cardiovascular, neurological and orthopedic surgery. SLLH will increase opportunities for local physicians to obtain educational information on the impact on quality and patient satisfaction.
2. In addition, through a strong partnership with St. Luke's The Woodlands Hospital, SLLH will improve access to care through the recruitment of physicians into the 501(a) organization. These physicians, ranging from primary care to orthopedic surgeons, will be located in the community and primarily serve Montgomery County. In addition to increasing access to specialty care, these physicians will be active in treating the uninsured and underinsured population.

Cardiovascular Disease. SLLH will implement the following strategies to address cardiovascular disease:

1. SLLH seeks to implement a chronic disease management registry which will allow for patients to be stratified based on disease, self-management, and risk status. The registry aims to increase patient adherence to cardiovascular disease management programs and recommendations, improve processes for identifying and providing specialized treatments to high need patients and reduce readmission rates and potentially preventable readmissions by high risk populations.
2. Through the hospital's strong relationship with St. Luke's The Woodlands Hospital, located on the same campus, SLLH will refer patients to St. Luke's Performance

Medicine. This clinic offers a cardiac rehab program for patients recovering from heart attack, heart disease or surgery. This comprehensive program is customized to provide exercise and education to reduce the risk of future heart problems.

Communication. SLLH will implement the following strategies to address communication:

1. SLLH will be more active in the community as a healthcare provider as well as a health resource. Through health fairs and community health screenings, SLLH will provide current health information to members of our community. In addition, community members will be invited to join our hospital and medical staff in regular round table activities to discuss cardiovascular health.
2. SLLH will continue its presence on social media outlets, such as Facebook and Twitter, and allow for continued dissemination of health information. Articles, quick tips and information about the hospital's community events will be regularly shared with the public.

Injury Prevention. SLLH will implement the following strategy to address injury prevention:

1. Through the hospital's strong relationship with St. Luke's The Woodlands Hospital, located on the same campus, the Hospital will refer patients to St. Luke's Performance Medicine. This clinic offers information sessions and courses on injury prevention for athletes. This partnership also allows for physical therapy and athletic development referrals to improve form and prevent and/or recover from injuries.

Community Health Needs Not Being Addressed

All four of the priority health needs identified in the CHNA are being addressed. There is no limit to the number of issues to which a healthcare institution could devote resources. Time, people, and money often are limiting factors for why we cannot do more. However, prevailing wisdom suggests an organization like SLLH must focus on a high priority projects as identified in the CHNA. SLLH will also make every effort to avoid duplication and encourage collaboration and coordination with other organizations and community groups. As SLLH assessed unmet health needs and determined its priorities, we also evaluated those issues that are being addressed by others.

Approval

The St. Luke's Lakeside Hospital Board of Managers approves the Community Health Needs Assessment and Implementation Strategy for the priorities identified in the Community Health Needs Assessment. This report was prepared for the November 5, 2013 Board of Managers meeting.

Board of Managers Approval:

By Name

Stephen Pickett, Manager
Title

November 5, 2013
Date

References

Centers for Disease Control and Prevention (CDC). *2011 Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

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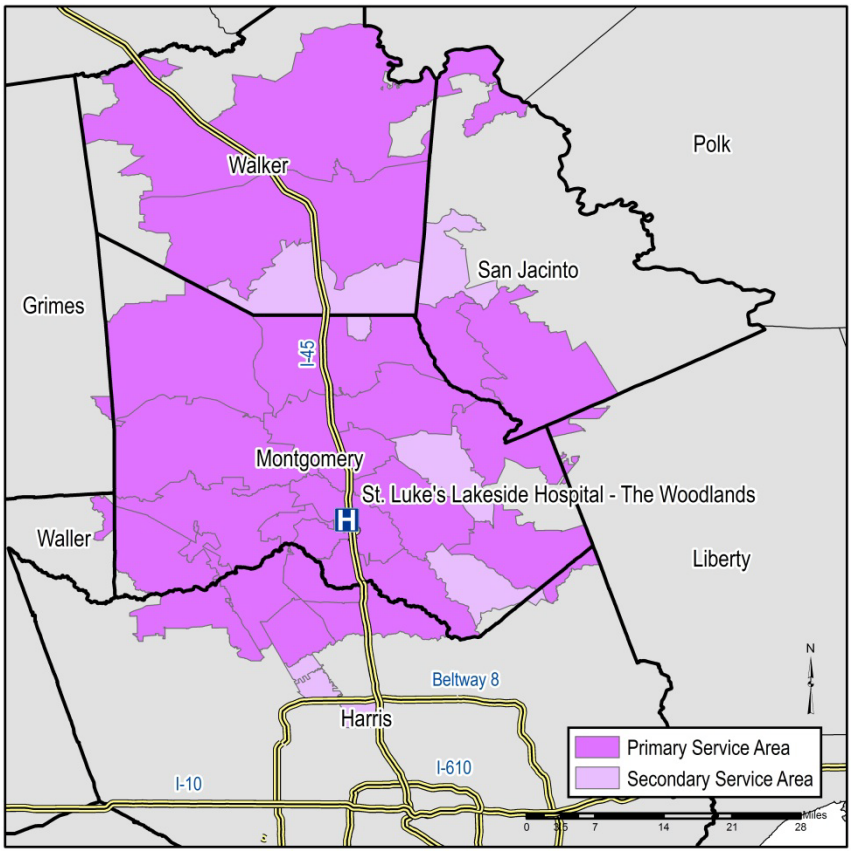
U.S. Department of Health & Human Services (HHS). *2011 HHS Poverty Guidelines; One version of the [U.S.] federal poverty measure*. Washington, DC: 2011.

U.S. Department of Health & Human Services (HHS). *2012 HHS Poverty Guidelines; One version of the [U.S.] federal poverty measure*. Washington, DC: 2012.

Appendix 1. Primary and Secondary Service Area Map and Zip Codes

The community served by SLLH consists of adjacent zip codes determined by 2012 hospital discharge data provided by the St. Luke's Health System. The Primary Service Area (PSA) is based on 75% of discharges and the Secondary Service Area (SSA) reflects an additional 5% of discharges. The PSA for SLLH includes the following zip codes: 77381, 77356, 77382, 77304, 77384, 77386, 77354, 77373, 77385, 77303, 77379, 77318, 77316, 77380, 77302, 77389, 77388, 77301, 77320, 77340, 77378, 77377, 77362, 77375, 77357, 77355, and 77328. The SSA for SLLH includes the following zip codes: 77066, 77365, 77069, 77358, 77038, and 77306. Because the majority of primary service area zip codes are found in both Montgomery and Walker Counties, this report has relied upon recent data available for Montgomery and Walker Counties to draw inferences about the SLLH community. The map below displays the SLLH community.



Appendix 2. Demographics of Community Served by SLLH

Table 1. Demographics of Adults[1] in the SLLH Community and Harris County[2] by Poverty Status[3,4]

	SLLH Community (Montgomery and Walker Counties)							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	n	%	n	%	n	%	%	n	%	n	%	n	%	%
Gender														
Male	49,064	70.7%	33,513	56.8%	114,119	56.4%	59.4%	233,359	41.4%	242,572	49.6%	633,151	53.7%	49.7%
Female	20,298	29.3%	25,482	43.2%	88,390	43.6%	40.6%	329,768	58.6%	246,102	50.4%	544,832	46.3%	50.3%
Race/Ethnicity														
White	3,722	5.4%	44,322	75.1%	171,639	84.8%	66.4%	62,552	11.1%	132,719	27.2%	601,577	51.1%	35.7%
Black	3,107	4.5%	0	0.0%	1,345	0.7%	1.3%	108,560	19.3%	81,227	16.6%	185,041	15.7%	16.8%
Hispanic	56,538	81.5%	6,073	10.3%	21,110	10.4%	25.3%	346,246	61.5%	233,462	47.8%	270,397	23.0%	38.1%
Asian	0	0.0%	0	0.0%	6,195	3.1%	1.9%	3,822	0.7%	27,059	5.5%	45,111	3.8%	3.4%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0.0%	0	0.0%	4,407	0.9%	8,346	0.7%	0.6%
American Indian or Alaskan Native	0	0.0%	0	0.0%	0	0.0%	0.0%	13,613	2.4%	0	0.0%	0	0.0%	0.6%
Multiracial	5,995	8.6%	4,643	7.9%	0	0.0%	3.2%	21,655	3.8%	4,671	1.0%	36,722	3.1%	2.8%
Don't Know/Not Sure/Refused	0	0.0%	3,956	6.7%	2,219	1.1%	1.9%	6,680	1.2%	5,129	1.0%	30,789	2.6%	1.9%
Age (Years)														
18-24	0	0.0%	4,158	7.0%	7,094	3.5%	3.4%	67,475	12.0%	49,120	10.1%	114,628	9.7%	10.4%
25-34	24,757	35.7%	14,955	25.4%	16,145	8.0%	16.9%	163,111	29.0%	53,619	11.0%	152,546	12.9%	16.6%
35-44	14,609	21.1%	5,118	8.7%	39,829	19.7%	18.0%	141,218	25.1%	105,467	21.6%	216,142	18.3%	20.8%
45-54	0	0.0%	9,513	16.1%	54,511	26.9%	19.4%	98,229	17.4%	120,680	24.7%	292,605	24.8%	22.9%
55-64	28,327	40.8%	7,381	12.5%	55,135	27.2%	27.5%	53,624	9.5%	74,411	15.2%	216,371	18.4%	15.4%
65 or older	1,669	2.4%	17,869	30.3%	29,793	14.7%	14.9%	39,470	7.0%	85,376	17.5%	185,691	15.8%	13.9%
Own or Rent														
Own	36,835	53.1%	37,259	63.2%	191,621	94.6%	80.3%	213,111	37.8%	266,670	54.6%	1,044,762	88.7	68.4%
Rent	28,355	40.9%	13,605	23.1%	10,887	5.4%	16.0%	309,393	54.9%	203,783	41.7%	117,355	10.0%	28.3%
Other arrangements	4,172	6.0%	8,131	13.8%	0	0.0%	3.7%	40,622	7.2%	18,222	3.7%	14,825	1.3%	3.3%
Refused	0	0.0%	0	0.0%	0	0.0%	0.0%	0	0.0%	0	0.0%	1,041	0.1%	< 0.01%

	SLLH Community (Montgomery and Walker Counties)							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	n	%	n	%	n	%	%	n	%	n	%	n	%	%
Marital Status														
Married	46,765	67.4%	24,298	41.2%	155,575	76.8%	68.5%	218,122	38.7%	219,901	45.0%	688,609	58.5%	50.5%
A Member of an Unmarried Couple	1,908	2.8%	0	0.0%	6,207	3.1%	2.5%	67,099	11.9%	35,694	7.3%	55,910	4.7%	7.1%
Divorced	0	0.0%	16,564	28.1%	17,630	8.7%	10.3%	70,647	12.5%	71,728	14.7%	134,927	11.5%	12.4%
Widowed	0	0.0%	4,958	8.4%	4,963	2.5%	3.0%	8,796	1.6%	29,147	6.0	48,142	4.1%	3.9%
Separated	6,447	9.3%	3,488	5.9%	0	0.0%	3.0%	26,201	4.7%	45,873	9.4%	20,060	1.7%	4.1%
Never Married	12,827	18.5%	9,687	16.4%	18,133	9.0%	12.3%	172,263	30.6%	86,331	17.7%	230,336	19.6%	21.9%
Refused	1,416	2.0%	0	0.0%	0	0.0%	0.4%	0	0.0%	0	0.0%	0	0.0%	0.0%
Education														
Never Attended School or Only Kindergarten	0	0.0%	0	0.0%	0	0.0%	0.0%	4,361	0.8%	0	0.0%	0	0.0%	0.2%
Grades 1-8 (Elementary)	42,636	61.5%	1,850	3.1%	0	0.0%	13.4%	118,310	21.0%	63,788	13.1%	15,103	1.3%	8.8%
Grades 9-11 (Some High School)	11,563	16.7%	7,715	13.1%	7,094	3.5%	8.0%	180,499	32.1%	78,271	16.0%	50,770	4.3%	13.9%
Grade 12 or GED (High School Graduate)	5,139	7.4%	14,150	24.0%	48,260	23.8%	20.4%	149,361	26.5%	147,423	30.2%	197,946	16.8%	22.2%
College 1-3 Years (Some College or Technical School)	8,116	11.7%	28,199	47.8%	66,358	32.8%	31.0%	95,896	17.0%	132,042	27.0%	401,648	34.1%	28.2%
College 4 Years or More (College Graduate)	1,908	2.8%	7,081	12.0%	80,796	39.9%	27.1%	14,700	2.6%	67,150	13.7%	512,516	43.5%	26.7%

[1] Adults aged 18 and over.

[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).

[3] Poverty Status was computed from items in the 2012 BRFSS measuring household income and family size. Family size and household income were then compared to the 2012 Poverty Guidelines published by the U.S. Department of Health and Human Services. Respondents below the poverty line for their reported household income and family size were classified as "In Poverty." Those not in poverty but within 200% of the poverty line were classified as "Near Poverty." Those above 200% of the poverty line were classified as "Not in Poverty."

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who are Male in Montgomery and Walker Counties, first look at the column "In Poverty" under Montgomery and Walker Counties and then go down to the row "Male" under Gender. Here, the percentage of males in Montgomery and Walker Counties living in poverty is shown (70.7%).

Table 2. Demographics of Adults[1] in the SLLH Community and Harris County[2] by Insurance Status[3,4]

	SLLH Community (Montgomery and Walker Counties)					Harris County				
	Insured		Not Insured		Total	Insured		Not Insured		Total
	n	%	n	%	%	n	%	n	%	%
Gender										
Male	148,261	50.6%	50,745	70.2%	54.5%	770,754	45.3%	485,799	57.1%	49.3%
Female	144,629	49.4%	21,576	29.8%	45.5%	928,980	54.7%	365,443	42.9%	50.7%
Race/Ethnicity										
White	228,079	77.9%	26,524	36.7%	69.7%	772,412	45.4%	101,819	12.0%	34.3%
Black	1,976	0.7%	3,107	4.3%	1.4%	289,035	17.0%	135,723	15.9%	16.7%
Hispanic	48,795	16.7%	33,722	46.6%	22.6%	466,549	27.4%	544,395	64.0%	39.6%
Asian	6,195	2.1%	0	0.0%	1.7%	94,024	5.5%	12,391	1.5%	4.2%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0.0%	7,307	0.4%	5,446	0.6%	0.5%
American Indian or Alaskan Native	0	0.0%	0	0.0%	0.0%	2,637	0.2%	10,975	1.3%	0.5%
Multiracial	1,669	0.6%	8,968	12.4%	2.9%	35,309	2.1%	30,356	3.6%	2.6%
Don't Know/Not Sure/Refused	6,175	2.1%	0	0.0%	1.7%	32,460	1.9%	10,137	1.2%	1.7%
Age (Years)										
18-24	14,476	4.9%	4,158	5.7%	5.1%	163,472	9.6%	151,308	17.8%	12.3%
25-34	29,019	9.9%	32,473	44.9%	16.8%	212,362	12.5%	241,361	28.4%	17.8%
35-44	44,948	15.3%	7,771	10.7%	14.4%	292,083	17.2%	202,809	23.8%	19.4%
45-54	68,857	23.5%	12,786	17.7%	22.4%	355,975	20.9%	185,608	21.8%	21.2%
55-64	79,152	27.0%	15,134	20.9%	25.8%	316,084	18.6%	64,891	7.6%	14.9%
65 or older	56,440	19.3%	0	0.0%	15.5%	359,759	21.2%	5,265	0.6%	14.3%
Own or Rent Home										
Own	247,556	84.5%	30,648	42.4%	76.2%	1,364,739	80.3%	329,966	38.8%	66.4%
Rent	35,363	12.1%	29,370	40.6%	17.7%	301,148	17.7%	416,083	48.6%	28.1%
Other Arrangements	6,389	2.2%	12,303	17.0%	5.1%	23,705	1.4%	69,558	8.2%	3.7%
Don't Know/Not Sure	0	0.0%	0	0.0%	0.0%	4,568	0.3%	22,012	2.6%	1.0%
Refused	3,583	1.2%	0	0.0%	1.0%	5,575	0.3%	13,623	1.6%	0.8%

	SLLH Community (Montgomery and Walker Counties)					Harris County				
	Insured		Not Insured		Total	Insured		Not Insured		Total
	n	%	n	%	%	n	%	n	%	%
Marital Status										
Married	223,695	76.4%	24,648	34.1%	68.0%	921,818	54.2%	329,411	38.7%	49.0%
A Member of an Unmarried Couple	6,207	2.1%	1,908	2.6%	2.2%	100,059	5.9%	89,375	10.5%	7.4%
Divorced	25,767	8.8%	12,786	17.7%	10.6%	196,829	11.6%	99,688	11.7%	11.6%
Widowed	10,821	3.7%	0	0.0%	3.0%	106,307	6.3%	0	0.0%	4.2%
Separated	0	0.0%%	9,935	13.7%	2.7%	52,760	3.1%	44,492	5.2%	3.8%
Never Married	26,400	9.0%	21,628	29.9%	13.2%	321,962	18.9%	288,276	33.9%	23.9%
Refused	0	0.0%	1,416	2.0%	0.4%	0	0.0%	0	0.0%	0.0%
Education										
Never Attended School or Only Kindergarten	0	0.0%	0	0.0%	0.0%	0	0.0%	7,114	0.8%	0.3%
Grades 1-8 (Elementary)	18,524	6.3%	22,196	30.7%	11.1%	84,460	5.0%	160,674	18.9%	9.6%
Grades 9-11 (Some High School)	11,034	3.8%	15,338	21.2%	7.2%	108,172	6.4%	224,360	26.4%	13.0%
Grade 12 or GED (High School Graduate)	63,218	21.6%	11,643	16.1%	20.5%	369,207	21.7%	251,655	29.6%	24.3%
College 1-3 Years (Some College or Technical School)	103,561	35.4%	14,601	20.2%	32.4%	530,456	31.2%	164,335	19.3%	27.2%
College 4 Years or More (College Graduate)	96,554	33.0%	8,542	11.8%	28.8%	607,440	35.7%	43,105	5.1%	25.5%

[1] Adults aged 18 and over.

[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).

[3] Insurance Status was taken from the 2012 BRFSS. Respondents were asked if they had a source of healthcare coverage such as an HMO or Medicare.

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Insured" who are Male in Montgomery and Walker Counties, first look at the column "Insured" under Montgomery and Walker Counties and then go down to the row "Male" under Gender. Here, the percentage of insured males in Montgomery and Walker Counties is shown (50.6%).

Appendix 3 Participants involved in the CHNA

Name	Title	Organization	Role
SLLH Hospital Advisory Team			
Mary Sue Lipham, RN	Assistant Vice President and Chief Finance Officer	St. Luke's Lakeside Hospital	Hospital Advisory Team
Diane Freeman	Chief Nursing Officer	St. Luke's Lakeside Hospital	Hospital Advisory Team
Debra Staley	Community Relations and Business Development Manager	St. Luke's Lakeside Hospital	Hospital Advisory Team
Prathiba Pandian, MPH	Project Manager and Board Coordinator	St. Luke's The Woodlands Hospital	Hospital Advisory Team
St. Luke's Health System Team			
Melinda Grady	Tax Director	St. Luke's Health System	General Oversight
David Gruener	Senior Vice President and Chief Finance Officer	St. Luke's Health System	General Oversight
Kenneth Zieren	Administrative Director of Compliance	St. Luke's Health System	General Oversight
Episcopal Health Charities Team			
Tamara Brickham Bourda, MPH	Manager, Special Programs	Episcopal Health Charities	Overall CHNA Project Management
Patricia Gail Bray, PhD	Executive Director	Episcopal Health Charities	Technical Assistance
Jeanne Hanks, DrPh	Assistant Director of Operations	Episcopal Health Charities	Technical Assistance
Maria Fernandez-Esquer, PhD	Associate Professor	The University of Texas School of Public Health	CHNA Project Management
Pamela M. Diamond, PhD	Associate Professor	The University of Texas School of Public Health	CHNA Project Management
John Atkinson, DrPH	Faculty Associate	The University of Texas School of Public Health	Quantitative Data Analysis
Andria Rusk, MScGH	Graduate Assistant	The University of Texas School of Public Health	Qualitative Data Analysis
Erica Cantu, MPH	Graduate Assistant	The University of Texas School of Public Health	Quantitative Data Analysis
Mariana Arevalo, MSPH	Graduate Assistant	The University of Texas School of Public Health	Quantitative Data Analysis
Lynn Elgin	Community Engagement Manager	Clarus Consulting Group	Community Engagement Coordination

Taylor Cooper	Community Engagement Associate	Clarus Consulting Group	Community Engagement Coordination
Community Stakeholders and Public Health Experts			
Tanya Bryant	Director of Quality Management and Support	Tri-County Services	Community Stakeholder
LaToya J. Carter	Assistant Director	Family Promise of Montgomery County	Community Stakeholder
Nancy Heintz	President and Director of Community Outreach	Montgomery County Homeless Coalition, First United Methodist Church Conroe	Community Stakeholder
Michelle Hill	Healthy Living Director	South Montgomery County YMCA	Community Stakeholder
Randy Johnson	Chief Executive Officer	Montgomery County Hospital District	Community Stakeholder
Julie Martineau	President and Director of Community Outreach	Montgomery County United Way	Community Stakeholder
Carrie Morrison	Associate Community Executive Director	South Montgomery County YMCA at Creekside	Community Stakeholder
Anita Phillips	Clinic Manager	Interfaith Community Clinic	Community Stakeholder
Jeanette Plowman	Board Member	Society of St. Vincent de Paul	Community Stakeholder
Evan Roberson	Executive Director	Tri-County Services	Community Stakeholder
Heather Robison	Director of Crisis Services	Tri-County Services	Community Stakeholder
Marlen Tejeda	Director	The Conroe Hispanic Task Force	Community Stakeholder
Landrum Turner	Executive Director	South Montgomery County YMCA at Shadow Bend	Community Stakeholder
Susan Welbes	Director of Human Resources	The Woodlands Township	Community Stakeholder
Penny Wilson	Director of Healthcare Services	Montgomery County Hospital District/Montgomery County Public Health District	Community Stakeholder
Sheila M. Zea	Vice President of Sales	The Woodlands Area Chamber of Commerce	Community Stakeholder
Latrice Babin, PhD	Environmental Toxicologist	Harris County Pollution Control Services Department	Public Health Expert
June Hanke	Strategic Analyst/Planner	Harris Health System	Public Health Expert
Dr. Nicole Hare-Everline, CHES	City of Houston Wellness/EAP Director	City of Houston	Public Health Expert

Robert Hines	Epidemiologist	Houston Department of Health and Human Services	Public Health Expert
Haley Jackson	Team Lead	Texas Department of State Health Services	Public Health Expert
Lisa Mayes	Executive Director	Harris County Healthcare Alliance	Public Health Expert
Bakeyah Nelson	Public Health Analyst	Harris County Public Health and Environmental Services	Public Health Expert
Beverly Nichols, PsyD, MS, RN	Senior Staff Analyst	Houston Department of Health and Human Services	Public Health Expert
Kimberly Nicholson	Program Specialist II	Texas Department of State Health Services	Public Health Expert
Ebun Odeneye	Senior Health Educator	City of Houston	Public Health Expert
Yan Shi	Management Analyst III	Houston Department of Health and Human Services	Public Health Expert
Lindsey Wiginton	Epidemiologist	Houston Department of Health and Human Services	Public Health Expert

Appendix 4. 2012 SLLH Discharges by ICD-9 Code

Data on all hospital discharges for 2012 were provided by the St. Luke's Health System. Data were available for SLLH and was aggregated by the 5-digit ICD-9 diagnosis code and divided into inpatient and outpatient discharges. No demographic or personally identifiable information was provided; therefore, the information below represents the types of health problems experienced by people who made use of SLLH during 2012. In order to summarize the data more effectively, the ICD-9 codes were further aggregated into more relevant and less clinically specific categories.

Table 1. St. Luke's Lakeside Hospital, 2012 Hospital Discharges by ICD-9 Code[1]

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	n	%	n	%	N	%
1. Infectious and Parasitic Diseases (001–139)	**2**	**2.6%**	**46**	**2.0%**	**48**	**2.1%**
2. Neoplasms (140–239)	**0**	**0.0%**	**1**	**< 0.1%**	**1**	**< 0.1%**
3. Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240–279)	**4**	**5.3%**	**40**	**1.8%**	**44**	**1.9%**
4. Diseases of the Blood and Blood-Forming Organs (280–289)	**0**	**0.0%**	**7**	**0.3%**	**7**	**0.3%**
5. Mental Disorders (290–319)	**0**	**0.0%**	**22**	**1.0%**	**22**	**0.9%**
• ***290-294 organic psychotic conditions***	0	0.0%	5	22.7%	5	22.7%
• ***295-299 other psychoses***	0	0.0%	1	4.5%	1	4.5%
• ***300-316 neurotic disorders, personality disorders, and other nonpsychotic mental disorders***	0	0.0%	16	72.7%	16	72.7%
• ***317-319 intellectual disabilities***	0	0.0%	0	0.0%	0	0.0%
6. Diseases of the Nervous System and Sense Organs (320–389)	**0**	**0.0%**	**89**	**3.9%**	**89**	**3.8%**
7. Diseases of the Circulatory System (390–459)	**21**	**27.6%**	**121**	**5.3%**	**142**	**6.1%**
• ***390-392 acute rheumatic fever***	0	0.0%	0	0.0%	0	0.0%
• ***393-398 chronic rheumatic heart disease***	0	0.0%	0	0.0%	0	0.0%
• ***401-405 hypertensive disease***	3	14.3%	32	26.4%	35	24.6%
• ***410-414 ischemic heart disease***	6	28.6%	23	19.9%	29	20.4%
• ***415-417 diseases of pulmonary circulation***	5	23.8%	2	1.7%	7	4.9%
• ***420-429 other forms of heart disease***	4	19.0%	39	32.2%	43	30.3%
• ***430-438 cerebrovascular disease***	0	0.0%	11	9.1%	11	7.7%
• ***440-449 diseases of arteries, arterioles, and capillaries***	0	0.0%	1	0.8%	1	0.7%
• ***451-459 diseases of veins and lymphatics, and other diseases of circulatory system***	3	14.3%	13	10.7%	16	11.3%
8. Diseases of the Respiratory System (460–519)	**14**	**18.4%**	**204**	**9.0%**	**218**	**9.3%**

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	n	%	n	%	N	%
• *460-466 acute respiratory infections*	0	0.0%	139	68.1%	139	63.8%
• *470-478 other diseases of upper respiratory tract*	0	0.0%	1	0.5%	1	0.5%
• *480-488 pneumonia and influenza*	10	71.4%	31	15.2%	41	18.8%
• *490-496 chronic obstructive pulmonary disease and allied conditions*	3	21.4%	30	14.7%	33	15.1%
• *500-508 pneumoconioses and other lung diseases due to external agents*	0	0.0%	3	1.5%	0	0.0%
• *510-519 other diseases of respiratory system*	1	7.1%	0	0.0%	4	1.8%
9. Diseases of the Digestive System (520–579)	**1**	**1.3%**	**104**	**4.6%**	**105**	**4.5%**
• *520-529 diseases of oral cavity, salivary glands, and jaws*	0	0.0%	25	24.0%	25	23.8%
• *530-539 diseases of esophagus, stomach, and duodenum*	0	0.0%	9	8.7%	9	8.6%
• *540-543 appendicitis*	0	0.0%	7	6.7%	7	6.7%
• *550-553 hernia of abdominal cavity*	0	0.0%	4	3.8%	4	3.8%
• *555-558 noninfective enteritis and colitis*	1	100.0%	14	13.5%	15	14.3%
• *560-569 other diseases of intestines and peritoneum*	0	0.0%	29	27.9%	29	27.6%
• *570-579 other diseases of digestive system*	0	0.0%	16	15.4%	16	15.2%
10. Diseases of the Genitourinary System (580–629)	**2**	**2.6%**	**88**	**3.9%**	**90**	**3.8%**
• *580-589 nephritis, nephrotic syndrome, and nephrosis*	0	0.0%	3	3.4%	3	3.3%
• *590-599 other diseases of urinary system*	2	100.0%	68	77.3%	70	77.8%
• *600-608 diseases of male genital organs*	0	0.0%	5	5.7%	5	5.6%
• *610-612 disorders of breast*	0	0.0%	3	3.4%	3	3.3%
• *614-616 inflammatory disease of female pelvic organs*	0	0.0%	3	3.4%	3	3.3%
• *617-629 other disorders of female genital tract*	0	0.0%	6	6.8%	6	6.7%
11. Complications of Pregnancy, Childbirth, and the Puerperium (630–677)	**0**	**0.0%**	**4**	**0.2%**	**4**	**0.2%**
12. Diseases of the Skin and Subcutaneous Tissue (680–709)	**3**	**3.9%**	**114**	**5.0%**	**117**	**5.0%**
13. Diseases of the Musculoskeletal System and Connective Tissue(710–739)	**10**	**13.2%**	**278**	**12.3%**	**288**	**12.3%**
• *710-719 arthopathies and related disorders*	2	20.0%	91	32.7%	93	32.3%
• *720-724 dorsopathies*	7	70.0%	131	47.1%	138	47.9%
• *725-729 rheumatism, excluding the back*	1	10.0%	51	18.3%	52	18.1%
• *730-739 osteopathies, chondropathies, and acquired musculoskeletal deformities*	0	0.0%	5	1.8%	5	1.7%
14. Congenital Anomalies (740–759)	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
15. Certain Conditions Originating in the Perinatal Period (760–779)	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	n	%	n	%	N	%
16. Symptoms, Signs, and Ill-Defined Conditions (780–799)	**1**	**1.3%**	**488**	**21.6%**	**489**	**20.9%**
• ***780-789 symptoms***	1	100.0%	485	99.4%	486	99.4%
• ***790-796 nonspecific abnormal findings***	0	0.0%	2	0.4%	2	0.4%
• ***797-799 ill-defined and unknown causes of morbidity and mortality***	0	0.0%	1	0.2%	1	0.2%
17. Injury and Poisoning (800–899)	**18**	**23.7%**	**641**	**28.3%**	**659**	**28.2%**
• ***800-804 fracture of skull***	0	0.0%	3	0.5%	3	0.5%
• ***805-809 fracture of spine and trunk***	1	5.6%	20	3.1%	21	3.2%
• ***810-819 fracture of upper limb***	0	0.0%	96	15.0%	96	14.6%
• ***820-829 fracture of lower limb***	10	55.6%	45	7.0%	55	8.3%
• ***830-839 dislocation***	0	0.0%	17	2.7%	17	2.6%
• ***840-848 sprains and strains of joints and adjacent muscles***	0	0.0%	159	24.8%	159	24.1%
• ***850-854 intracranial injury, excluding those with skull fracture***	0	0.0%	16	2.5%	16	2.4%
• ***860-869 internal injury of chest, abdomen, and pelvis***	0	0.0%	1	0.2%	1	0.2%
• ***870-879 open wound of head, neck, and trunk***	0	0.0%	36	5.6%	36	5.5%
• ***880-887 open wound of upper limb***	0	0.0%	53	8.3%	53	8.0%
• ***890-897 open wound of lower limb***	0	0.0%	21	3.4%	21	3.2%
• ***900-904 injury to blood vessels***	0	0.0%	0	0.0%	0	0.0%
• ***905-909 late effects of injuries, poisonings, toxic effects, and other external causes***	0	0.0%	0	0.0%	0	0.0%
• ***910-919 superficial injury***	0	0.0%	22	3.4%	22	3.3%
• ***920-924 contusion with intact skin surface***	0	0.0%	78	12.2%	78	11.8%
• ***925-929 crushing injury***	0	0.0%	5	0.8%	5	0.8%
• ***930-939 effects of foreign body entering through orifice***	0	0.0%	4	0.6%	4	0.6%
• ***940-949 burns***	0	0.0%	5	0.8%	5	0.8%
• ***950-957 injury to nerves and spinal cord***	0	0.0%	1	0.2%	1	0.2%
• ***958-959 certain traumatic complications and unspecified injuries***	0	0.0%	21	3.3%	21	3.2%
• ***960-979 poisoning by drugs, medicinals, and biological substances***	0	0.0%	4	0.6%	4	0.6%
• ***980-989 toxic effects of substances chiefly nonmedical as to source***	0	0.0%	7	1.1%	7	1.1%
• ***990-995 other and unspecified effects of external causes***	0	0.0%	16	2.5%	16	2.4%
• ***996-999 complications of surgical and medical care, not elsewhere classified***	7	38.9%	11	1.7%	18	2.7%
18. Sickle-cell Disease (282.60–282.69)	**0**	**0.0%**	**2**	**0.1%**	**2**	**0.1%**
• ***282.60 sickle-cell disease unspecified***	0	0.0%	0	0.0%	0	0.0%
• ***282.61 Hb-SS disease without crisis***	0	0.0%	0	0.0%	0	0.0%
• ***282.62 Hb-SS disease with crisis***	0	0.0%	2	100.0%	2	100.0%
• ***282.63 Sickle-cell/Hb-C disease without crisis***	0	0.0%	0	0.0%	0	0.0%
• ***282.64 Sickle-cell/Hb-C disease with crisis***	0	0.0%	0	0.0%	0	0.0%

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	n	%	n	%	N	%
• ***282.68 other sickle-cell disease without crisis***	0	0.0%	0	0.0%	0	0.0%
• ***282.69 other sickle-cell disease with crisis***	0	0.0%	0	0.0%	0	0.0%
V Codes Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01–V83)	**0**	**0.0%**	**16**	**0.7%**	**16**	**0.7%**
E Codes Supplementary Classification of External Causes of Injury and Poisoning (e800–e999)	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**

[1] Data are presented for inpatient, outpatient, and total discharged patients. For some categories such as #1, *Infectious and Parasitic Diseases*, the bolded numbers indicate the number of discharges for that diagnosis. For example, there were 2 inpatient discharges in this category, which accounted for 2.6% of all inpatient discharges. Similarly, there were 46 outpatient discharges, which accounted for2.0% of all outpatient discharges. In total, there were 48 discharges for this category, which accounted for 2.1% of total discharges. For categories such as #7, *Diseases of the Circulatory System*, the bolded numbers are to be interpreted similarly. For example, 21 inpatients were diagnosed with a circulatory disease, and these represented 27.6% of all inpatient discharges. The additional rows under this heading represent sub-diagnostic categories. For example, 3 of the 21 inpatient discharges were for "hypertensive disease." As indicated, these cases accounted for 14.3% of all inpatient discharges for a circulatory disease.

Appendix 5. Health Status Indicators

Table 1. Health Status of Adults[1] in the SLLH Community and Harris County[2] by Insurance Status[3,4]

	SLLH Community (Montgomery and Walker Counties)					Harris County				
	Insured		Not Insured		Total	Insured		Not Insured		Total
	n	%	n	%	%	n	%	n	%	%
Reported health status										
Excellent	54,056	18.5%	7,431	10.3%	16.8%	336,026	19.8%	90,336	10.6%	16.7%
Very Good	99,317	33.9%	17,556	24.3%	32.0%	533,259	31.4%	146,631	17.2%	26.7%
Good	78,058	26.7%	32,293	44.7%	30.2%	484,050	28.5%	386,660	45.4%	34.1%
Fair	31,367	10.7%	8,744	12.1%	11.0%	233,156	13.7%	180,503	21.2%	16.2%
Poor	28,965	9.9%	6,297	8.7%	9.7%	105,382	6.2%	41,792	4.9%	5.8%
Refused	1,128	0.4%	0	0.0%	0.3%	7,862	0.5%	5,320	0.6%	0.5%
Ever told have diabetes										
Yes	26,290	9.0%	9,974	13.8%	9.9%	251,519	14.8%	66,079	7.8%	12.5%
Yes, during pregnancy	1,326	0.5%	0	0.0%	0.4%	6,959	0.4%	11,301	1.3%	0.7%
No, pre-diabetes or borderline diabetes	0	0.0%	0	0.0%	0.0%	20,071	1.2%	5,818	0.7%	1.0%
Ever told had skin cancer	39,727	13.6%	0	0.0%	10.9%	72,682	4.3%	12,558	1.5%	3.3%
Ever told had any other type of cancer	9,777	3.3%	0	0.0%	2.7%	131,922	7.8%	12,953	1.5%	5.7%
Ever diagnosed with angina or coronary heart disease	30,283	10.3%	0	0.0%	8.3%	69,707	4.1%	10,317	1.2%	3.1%
Ever told have high blood pressure[5]										
Yes	104,969	46.2%	17,030	19.3%	38.7%	627,249	35.3%	202,660	24.8%	32.0%
Yes, during pregnancy	892	0.4%	0	0.0%	0.3%	34,670	2.0%	11,117	1.4%	1.8%
Borderline high/pre-hypertensive	1,231	0.5%	0	0.0%	0.4%	25,861	1.5%	0	0.0%	1.0
Ever told had a heart attack	11,259	3.8%	0	0.0%	3.1%	50,939	3.0%	4,361	0.5%	2.2%
Ever diagnosed with a stroke	16,720	5.7%	1,416	2.0%	5.0%	41,173	2.4%	30,647	3.6%	2.8%
Ever told have asthma	14,421	4.9%	1,850	2.6%	4.5%	169,479	10.0%	53,712	6.3%	8.7%
Number of days in last 30 days mental health not good										
None	218,693	74.7%	47,739	66.0%	73.0%	1,147,098	67.5%	554,533	65.1%	66.7%
1-5 days	42,379	14.5%	0	0.0%	11.6%	233,740	13.8%	129,928	15.3%	14.3%
6-10 days	4,491	1.5%	4,904	6.8%	2.6%	75,864	4.5%	58,642	6.9%	5.3%
11-30 days	26,189	8.9%	19,677	27.2%	12.6%	219,201	12.9%	105,216	12.4%	12.7%
Don't Know/Not Sure	1,139	0.4%	0	0.0%	0.3%	12,944	0.8	0	0.0	0.5%
Refused	0	0.0%	0	0.0%	0.0%	10,887	0.6%	2,924	0.3%	0.5%

[1] Adults aged 18 and over.

[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).

[3] Insurance Status was taken from the 2012 BRFSS. Respondents were asked if they had a source of healthcare coverage such as an HMO or Medicare.

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Insured" in Montgomery and Walker Counties who reported their health as "Excellent," first look at the column "Insured" under Montgomery and Walker Counties and then go down to the row "Excellent" under Reported Health Status. Here, the percentage of those insured in Montgomery and Walker Counties who reported having excellent health is shown (18.5%).

[5] The 2012 BRFSS did not contain the high blood pressure item. Data from the 2011 BRFSS were used to assess high blood pressure.

Table 2. Health Status of Adults[1] in the SLLH Community and Harris County[2] by Poverty Status[3,4]

	SLLH Community (Montgomery and Walker Counties)							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	n	%	n	%	n	%	%	n	%	n	%	n	%	%
Reported health status														
Excellent	0	0.0%	4,580	7.8%	48,147	23.8%	15.9%	29,456	5.2%	39,518	8.1%	288,281	24.5%	16.0%
Very Good	15,461	22.3%	6,055	10.3%	80,383	39.7%	30.8%	61,222	10.9%	85,913	17.6%	441,864	37.5%	26.4%
Good	25,684	37.0%	37,576	63.7%	48,139	23.8%	33.7%	205,041	36.4%	197,936	40.5%	320,160	27.2%	32.4%
Fair	6,649	9.6%	2,703	4.6%	19,729	9.7%	8.8%	194,376	34.5%	106,536	21.8%	100,659	8.5%	18.0%
Poor	21,568	31.1%	6,953	11.8%	6,109	3.0%	10.5%	67,712	12.0%	50,910	10.4%	27,019	2.3%	6.5%
Refused	0	0.0%	1,128	1.9%	0	0.0	0.3%	5,320	0.9%	7,862	1.6%	0	0.0%	0.6%
Ever told have diabetes														
Yes	2,756	4.0%	7,201	12.2%	19,997	9.9%	9.1%	102,533	18.2%	94,836	19.4%	113,915	9.7%	14.0%
Yes, during pregnancy	0	0.0%	0	0.0%	1,326	0.7%	0.4%	5,726	1.0%	0	0.0%	3,478	0.3%	0.4%
No, pre-diabetes or borderline diabetes	0	0.0%	0	0.0%	0	0.0%	0.0%	14,296	2.5%	10,052	2.1%	1,541	0.1%	1.2%
Ever told had skin cancer	0	0.0%	6,242	10.6%	30,247	14.9%	11.0%	13,161	2.3%	13,810	2.8%	47,947	4.1%	3.4%
Ever told had any other type of cancer	0	0.0%	2,266	3.8%	7,511	3.7%	3.0%	22,898	4.1%	32,899	6.7%	75,673	6.4%	5.9%
Ever diagnosed with angina or coronary	0	0.0%	6,426	10.9%	23,857	11.8%	9.2%	30,890	5.5%	12,858	2.6%	40,639	3.4%	3.8%
Ever told have high blood pressure[5]														
Yes	24,574	57.2%	26,135	32.9%	51,732	37.0%	39.1%	163,128	33.8%	206,182	39.0%	351,048	29.5%	32.7%
Yes, during pregnancy	0	0.0%	0	0.0%	892	0.6%	0.3%	7,267	1.5%	21,918	4.1%	14,465	1.2%	2.0%
Borderline high/pre-hypertensive	0	0.0%	0	0.0%	1,231	0.9%	0.5%	2,451	0.5%	0	0.0%	22,052	1.9%	1.1%
Ever told had a heart attack	0	0.0%	4,223	7.2%	6,380	3.2%	3.2%	17,959	3.2%	7,165	1.5%	26,953	2.3%	2.3%
Ever diagnosed with a stroke	3,085	4.4%	1,128	1.9%	10,684	5.3%	4.5%	20,003	3.6%	24,853	5.1%	19,171	1.6%	2.9%
Ever told have asthma	2,376	3.4%	6,414	10.9%	6,195	3.1%	4.5%	49,712	8.8%	32,786	6.7%	131,311	11.1%	9.6%
Number of days in last 30 days mental														
None	17,122	24.7%	8,364	14.2%	16,238	8.0%	12.6%	296,112	52.6%	340,014	69.6%	825,909	70.1%	65.6%
1-5 days	1,416	2.0%	3,488	5.9%	3,859	1.9%	2.6%	111,635	19.8%	42,392	8.7%	166,057	14.1%	14.4%
6-10 days	11,563	16.7%	15,927	27.0%	11,239	5.5%	11.7%	54,977	9.8%	19,323	4.0%	53,554	4.5%	5.7%
11-30 days	39,261	56.6%	30,077	51.0%	171,171	84.5%	72.7%	94,143	16.7%	72,956	14.9%	124,187	10.5%	13.1%
Don't Know/Not Sure	0	0.0%	1,139	1.9%	0	0.0%	0.3%	0	0.0%	7,921	1.6%	2,407	0.2%	0.5%
Refused	0	0.0%	0	0.0%	0	0.0%	0.0%	6,261	1.1%	6,067	1.2%	5,869	0.5%	0.8%

[1] Adults aged 18 and over.

[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).

[3] Poverty Status was computed from items in the 2012 BRFSS measuring household income and family size. Family size and household income were then compared to the 2012 Poverty Guidelines published by the U.S. Department of Health and Human Services. Respondents below the poverty line for their reported household income and family size were classified as "In Poverty." Those not in poverty but within 200% of the poverty line were classified as "Near Poverty." Those above 200% of the poverty line were classified as "Not in Poverty."

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Insured" in Montgomery and Walker Counties who reported their health as "Excellent," first look at the column "In Poverty" under Montgomery and Walker Counties and then go down to the row "Excellent" under Reported Health Status. Here, the percentage of those in Montgomery and Walker Counties living in poverty who reported having excellent health is shown (0.0%).

[5] The 2012 BRFSS did not contain the high blood pressure item. Data from the 2011 BRFSS were used to assess high blood pressure.

Appendix 6. Health Access Indicators

Table 1. Health Access of Adults[1] in the SLLH Community and Harris County[2] by Insurance Status[3,4]

	SLLH Community (Montgomery and Walker Counties)					Harris County				
	Insured		Not Insured		Total	Insured		Not Insured		Total
	n	%	n	%	%	n	%	n	%	%
Poverty Status[5]										
In Poverty	23,220	9.2%	39,304	54.3%	19.3%	165,191	11.0%	390,065	54.7%	25.0%
Near Poverty	31,346	12.5%	27,649	38.2%	18.2%	296,128	19.6%	192,546	27.0%	22.0%
Not in Poverty	197,140	78.3%	5,368	7.4%	62.5%	1,046,167	69.4%	130,768	18.3%	53.0%
Personal Doctor or Healthcare Provider										
Yes, only one	224,200	76.5%	12,420	17.2%	64.8%	1,259,845	74.1%	162,751	19.1%	55.8%
More than one	21,824	7.5%	1,268	1.8%	6.3%	102,208	6.0%	9,195	1.1%	4.4%
No	46,866	16.0%	58,633	81.1%	28.9%	332,298	19.6%	664,852	78.1%	39.1%
Don't Know/Not Sure	0	0.0%	0	0.0%	0.0%	5,383	0.3%	9,267	1.1%	0.6%
Refused	0	0.0%	0	0.0%	0.0%	0	0.0%	5,177	0.6%	0.2%
Could not see doctor in past 12 months because of cost	34,399	11.7%	24,437	33.8%	16.1%	236,602	13.9	393,244	46.2%	24.7%

[1] Adults aged 18 and over.
[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).
[3] Insurance Status was taken from the 2012 BRFSS. Respondents were asked if they had a source of healthcare coverage such as an HMO or Medicare.
[4] The percentages in this table are column percentages. For example, to find the percentage of those "Insured" in Montgomery and Walker Counties who were "In Poverty," first look at the column "Insured" under Montgomery and Walker Counties and then go down to the row "In Poverty" under Poverty Status. Here, the percentage of those insured in Montgomery and Walker Counties who are living in poverty is shown (9.2%).
[5] Poverty Status was computed from items in the 2012 BRFSS measuring household income and family size. Family size and household income were then compared to the 2012 Poverty Guidelines published by the U.S. Department of Health and Human Services. Respondents below the poverty line for their reported household income and family size were classified as "In Poverty." Those not in poverty but within 200% of the poverty line were classified as "Near Poverty." Those above 200% of the poverty line were classified as "Not in Poverty."

Table 2. Health Access of Adults[1] in the SLLH Community and Harris County[2] by Poverty Status[3,4]

	SLLH Community (Montgomery and Walker Counties)							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	n	%	n	%	n	%	%	n	%	n	%	n	%	%
Health Insurance[5]	23,220	37.1%	31,346	53.1%	197,140	97.3%	77.7%	165,191	29.8%	296,128	60.6%	1,046,167	88.9%	67.9%
Personal Doctor or Healthcare Provider														
Yes, only one	20,229	29.2%	22,797	38.6%	165,214	81.6%	62.9%	176,676	31.4%	255,182	52.2%	846,569	71.9%	57.3%
More than one	2,376	3.4%	7,509	12.7%	9,764	4.8%	5.9%	16,332	2.9%	13,333	2.7%	61,754	5.2%	4.1%
No	46,758	67.4%	28,688	48.6%	27,530	13.6%	31.1%	359,558	63.9%	213,262	43.6%	269,661	22.9%	37.8%
Don't Know/Not Sure	0	0.0%	0	0.0%	0	0.0%	0.0%	5,383	1.0%	6,897	1.4%	0	0.0%	0.6%
Refused	0	0.0%	0	0.0%	0	0.0%	0.0%	5,177	0.9%	0	0.0%	0	0.0%	0.2%
Could not see doctor in past 12 months because of cost	16,721	24.1%	21,710	36.8%	17,333	8.6%	16.9%	289,963	51.5%	117,712	24.1%	165,763	14.1%	25.7%

[1] Adults aged 18 and over.
[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).
[3] Poverty Status was computed from items in the 2012 BRFSS measuring household income and family size. Family size and household income were then compared to the 2012 Poverty Guidelines published by the U.S. Department of Health and Human Services. Respondents below the poverty line for their reported household income and family size were classified as "In Poverty." Those not in poverty but within 200% of the poverty line were classified as "Near Poverty." Those above 200% of the poverty line were classified as "Not in Poverty."
[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" in Montgomery and Walker Counties who had health insurance, we first look at the column "In Poverty" under Montgomery and Walker Counties and then go down to the row "Health Insurance." Here, the percentage of those living in poverty in Montgomery and Walker Counties who are uninsured is shown (37.1%).
[5] Insurance Status was taken from the 2012 BRFSS. Respondents were asked if they had a source of healthcare coverage such as an HMO or Medicare.

Appendix 7. Preventive Services Indicators

Table 1. Preventive Services obtained by Adults[1] in the SLLH Community and Harris County[2] by Insurance Status[3,4]

	SLLH Community (Montgomery and Walker Counties)					Harris County				
	Insured		Not Insured		Total	Insured		Not Insured		Total
	n	%	n	%	%	n	%	n	%	%
Ever had a mammogram[5]	113,445	78.4%	13,133	66.0%	76.9%	620,435	71.5%	142,886	39.1%	61.9%
Ever had a Pap test[5]	128,424	94.7%	19,885	100.0%	95.4%	796,596	91.9%	306,490	83.9%	89.5%
Ever had blood stool test using a home kit	61,585	38.4%	2,094	9.0%	34.6%	284,653	37.1%	19,128	13.5%	33.5%
Ever had a sigmoidoscopy/colonoscopy[6]	118,133	73.6%	6,835	29.2%	67.9%	557,525	72.7%	15,473	10.9%	63.1%
Ever tested for HIV	77,298	28.0%	28,668	40.6%	30.5%	664,734	42.0%	439,424	52.8%	45.7%

[1] Adults aged 18 and over.
[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).
[3] Insurance Status was taken from the 2012 BRFSS. Respondents were asked if they had a source of healthcare coverage such as an HMO or Medicare.
[4] The percentages in this table are column percentages. For example, to find the percentage of women "Insured" in Montgomery and Walker Counties who had ever had a mammogram, first look at the column "Insured" under Montgomery and Walker Counties and then go down to the row "Ever had a mammogram." Here, the percentage of insured women in Montgomery and Walker Counties who had ever had a mammogram is shown (78.4%).
[5] Asked of women only.
[6] Asked of respondents 50 years of age or older.

Table 2. Preventive Services obtained by Adults[1] in the SLLH Community and Harris County[2] by Poverty Status[3,4]

	SLLH Community (Montgomery and Walker Counties)							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	n	%	n	%	n	%	%	n	%	n	%	n	%	%
Ever had a mammogram[5]	11,440	61.5%	21,486	84.3%	74,387	84.2%	81.0%	129,337	39.7%	167,214	72.1%	354,671	70.4%	61.3%
Ever had a Pap test[5]	18,607	100.0%	23,918	93.9%	79,383	100.0%	98.7%	268,919	82.5%	220,780	95.2%	474,503	94.2%	90.8%
Ever had blood stool test using a home kit	1,669	5.6%	17,260	51.5%	35,755	32.5%	31.5%	42,193	29.9%	68,124	36.1%	144,865	30.3%	31.6%
Ever had a sigmoidoscopy/colonoscopy[6]	21,862	72.9%	18,157	54.2%	79,192	72.1%	68.7%	50,197	35.6%	100,296	53.1%	352,949	73.8%	62.3%
Ever tested for HIV	18,557	27.4%	24,877	46.2%	53,315	27.9%	30.9%	310,983	56.4%	202,317	43.2%	461,623	41.6%	45.8%

[1] Adults aged 18 and over.
[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).
[3] Poverty Status was computed from items in the 2012 BRFSS measuring household income and family size. Family size and household income were then compared to the 2012 Poverty Guidelines published by the U.S. Department of Health and Human Services. Respondents below the poverty line for their reported household income and family size were classified as "In Poverty." Those not in poverty but within 200% of the poverty line were classified as "Near Poverty." Those above 200% of the poverty line were classified as "Not in Poverty."
[4] The percentages in this table are column percentages. For example, to find the percentage of women "In Poverty" in Montgomery and Walker Counties who had ever had a mammogram, first look at the column "In Poverty" under Montgomery and Walker Counties and then go down to the row "Ever had a mammogram." Here, the percentage of women in Montgomery and Walker Counties living in poverty who had ever had a mammogram is shown (61.5%).
[5] Asked of women only.
[6] Asked of respondents 50 years of age or older.

Appendix. 8 Risk Factors

Table 1. Risk Factors of Adults[1] in the SLLH Community and Harris County[2] by Insurance Status[3,4]

	SLLH Community (Montgomery and Walker Counties)					Harris County				
	Insured		Not Insured		Total	Insured		Not Insured		Total
	n	%	n	%	%	n	%	n	%	%
Smoked at least 100 Cigarettes in Lifetime	113,372	38.7%	33,906	46.9%	40.3%	594,158	36.1%	350,896	41.7%	38.0%
Frequency of Days Now Smoking[5]										
Every day	28,303	25.0%	22,678	66.9%	34.6%	131,230	22.1%	93,292	26.6%	23.8%
Some days	5,634	5.0%	3,785	11.2%	6.4%	60,728	10.2%	139,709	39.8%	21.2%
Not at all	79,435	70.1%	7,443	22.0%	59.0%	399,933	67.3%	107,932	30.8%	53.7%
Refused	0	0.0%	0	0.0%	0.0%	2,266	0.4%	9,964	2.8%	1.3%
Exercise or Physical Activity (non-work) in Past 30 Days	230,385	78.7%	60,533	83.7%	79.7%	1,337,972	78.7%	517,669	60.8%	72.7%

[1] Adults aged 18 and over.
[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).
[3] Insurance Status was taken from the 2012 BRFSS. Respondents were asked if they had a source of healthcare coverage such as an HMO or Medicare.
[4] The percentages in this table are column percentages. For example, to find the percentage of those "Insured" in Montgomery and Walker Counties who had smoked at least 100 cigarettes in their lifetime, first look at the column "Insured" under Montgomery and Walker Counties and then go down to the row "Smoked 100 Cigarettes in Lifetime." Here, the percentage of those insured in Montgomery and Walker Counties who had smoked at least 100 cigarettes in their lifetime is shown (38.7%).
[5] Of those who had smoked at least 100 cigarettes in lifetime.

Table 2. Risk Factors of Adults[1] in the SLLH Community and Harris County[2] by Poverty Status[3,4]

	SLLH Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	n	%	n	%	n	%	%	n	%	n	%	n	%	%
Smoked at least 100 Cigarettes in Lifetime	13,986	20.2%	37,599	63.7%	79,266	39.1%	39.5%	237,207	42.5%	217,502	45.0%	412,009	35.9%	39.6%
Frequency of Days Now Smoking[5]														
Every day	7,970	57.0%	19,720	52.4%	20,220	25.5%	36.6%	70,550	29.7%	70,499	32.4%	69,754	16.9%	24.3%
Some days	1,691	12.1%	2,094	5.6%	0	0.0%	2.9%	86,517	36.5%	35,744	16.4%	55,898	13.6%	20.6%
Not at all	4,325	30.9%	15,785	42.0%	59,046	74.5%	60.5%	80,140	33.8%	101,296	46.6%	284,092	69.0%	53.7%
Refused	0	0.0%	0	0.0%	0	0.0%	0.0%	0	0.0%	9,964	4.6%	2,266	0.5%	1.4%
Exercise or Physical Activity (non-work) in Past 30 Days	42,024	60.6%	40,691	69.0%	173,690	85.8%	77.5%	311,461	55.3%	337,337	69.0%	995,019	84.5%	73.7%

[1] Adults aged 18 and over.

[2] Montgomery and Walker Counties and Harris County data were obtained from analyses of the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control and Prevention (CDC).

[3] Poverty Status was computed from items in the 2012 BRFSS measuring household income and family size. Family size and household income were then compared to the 2012 Poverty Guidelines published by the U.S. Department of Health and Human Services. Respondents below the poverty line for their reported household income and family size were classified as "In Poverty." Those not in poverty but within 200% of the poverty line were classified as "Near Poverty." Those above 200% of the poverty line were classified as "Not in Poverty."

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" in Montgomery and Walker Counties who had smoked at least 100 cigarettes in their lifetime, first look at the column "In Poverty" under Montgomery and Walker Counties and then go down to the row "Smoked at least 100 cigarettes in Lifetime." Here, the percentage of those in Montgomery and Walker Counties living in poverty who had smoked at least 100 cigarettes in their lifetime is shown (20.2%).

[5] Of those who had smoked at least 100 cigarettes in lifetime.

Appendix 9. SLLH Hospital Advisory Team Summary Report

St. Luke's The Woodlands & St. Luke's Lakeside Hospital Team Meeting Notes
July 10, 2013 at St. Luke's The Woodlands Hospital

Attendees: Mary Sue Lipham (SLWH & SLLH), Diane Freeman (SLLH), John Nguyen (SLWH), Prathiba Pandian (SLWH), Kathryne Pruitt (SLWH), Zachary Martinez (SLWH,)Tamara Bourda (EHC), Maria Fernandez-Esquer (UT), Pamela Diamond (UT), John Cooks (EHC)

Introduction and review of CHNA kickoff meeting

The assessment and hospital teams were introduced and an overview of the needs assessment process was provided. The CHNA process includes reaching out to the community to identify needs, leveraging existing data sets, assessing health needs by county, holding focus group discussions, and possibly conducting a community survey.

Although the SLWH and SLLH will have unique needs assessments and implementation plans, the hospital team meeting was combined due to close proximity of the hospitals, as well as overlap in some administrative roles.

Hospital's perspective on community needs

There was a discussion of the hospital's view on the needs of the community, the focus of the assessment and what may not show up in the reports, and ways to discover new data rather than repeat old efforts.

- Define the community
    - The community definition for the CHNA will be based on the data, and the community and stakeholders will prioritize the identified needs
    - The primary service area for both SLWH and SLLH is Montgomery County; patients mainly come from The Woodlands, Conroe and surrounding rural areas
    - Additions made to the one-pagers include: Wound care for SLWH services, and Montgomery County facts and Factor Rankings

- Community unmet needs
    - Childhood Obesity
        - Obesity specifically in the youth population is a major need expressed by the hospital team
    - Continuity of Care
        - There is a need for more Primary Care Physicians and there is a role for the PCP in the continuity of care
    - Overutilization of Emergency Department
        - The community uses the ED because they lack resources to access preventive care
        - SLWH is the only ED in Montgomery and North Harris Co that offers Pediatric ED 24/7
        - ED sees a significant number of self-pay patients

- Psychiatric or Chemical Dependency Services
    - There are little resources in the area for these patients; this impacts inpatient and the ED
- Homeless population
    - Montgomery County is very large with many pockets of homeless communities; Conroe has a large homeless community
- Transportation
    - Most of the patients seen live in the rural areas of the county

- Existing services and relationships
    - Montgomery County United Way – collaborated with SLWH and conducted a community health assessment in 2011; this organization may be a possible host for input related to community needs
    - Montgomery County YMCA
    - Interfaith Ministries – long standing community presence and excellent reputation of community work; also an EHC grantee
    - Community clinic in South Montgomery County- offers medical and dental care; serves working poor and those that do not qualify for Medicaid
    - Komen Foundation- conducted a survey on Fort Bend and said that Montgomery County would be the next survey area
    - Memorial Hermann The Woodlands- addresses need in mammogram screening, transportation, prosthetics, wigs, etc
    - Texas Children's Hospital- assists with pediatric care for SLWH; Emergency care, NICU, and inpatient
    - Women's Shelter and Youth Services for abused children
    - Junior League of North Harris and Montgomery County

- New ideas and strategies to address needs
    - Continue to provide education and training opportunities to the community and providers
        - Safety and Education Training –to prevent injury and accidents
        - Women's health services and programs
        - Physicals provided for student athletes
    - Continue strong relationships with organizations including United Way and YMCA
    - Focus on some DSRIP projects identified by the hospital
    - Implement measurement strategies to evaluate impact of current services provided

Review of IRS requirements

The assessment and implementation plan must be submitted together at the end of the tax year, Dec 2013. The implementation plan should demonstrate how the hospital is addressing the needs for the next 3 years.

Next steps and proposed timeline

- Assessment team will give the hospital a preliminary report for review
- Final assessment and implementation plan will submitted to be included in board packet 2 weeks before the November 5, 2013 board meeting
- Board approved report will be submitted to the System for filing with taxes

Action items

- Kathryne- send contact information to follow-up with Junior League; send hospital services list to Tamara
- Tamara- update one pager with Montgomery County information; send 2013 Montgomery County Community Assessment to team when it becomes available from United Way

Special thanks to the SLWH and SLLH hospital team for submitting many useful documents (United Way assessment, DSRIP project summary, Community Relations summary of activities, etc) prior to this meeting. This greatly assists in identifying stakeholders and addressing community need.

For additional information regarding the community health needs assessment, contact Tamara Bourda at tbourda@sleh.com, 832-355-4983.

Appendix 10. Community Stakeholder Summary Report

Introduction

In accordance with Federal law, a Community Health Needs Assessment (CHNA) must take into account "input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health." Gathering this community input for St. Luke's Woodlands Hospital (SLWH) and St. Luke's Lakeside Hospital (SLLH) took place through a carefully designed process of community engagement that included a Group Conversation. The sections that follow describe how this community engagement met and exceeded Federal requirements to engage:

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

Overview of Group Conversation

A Group Conversation was held in support of the St. Luke's Woodlands Hospital and St. Luke's Lakeside Hospital Community Health Needs Assessment on Thursday, August 22, 2013, from 9:00 am to 10:30 am at the Montgomery County United Way in The Woodlands, TX. It included sixteen participants from a range of community organizations and health-related groups. The Group Conversation was an organized event that brought people from different roles and organizations together to discuss matters that are important to the health needs of the community served by SLLH. It was a dynamic process intended to allow all participants to share their thoughts and views, listen to other perspectives, and build on one another's ideas. The Group Conversation did not seek specific answers or responses—all input was welcomed. The exchange that occurred in the Group Conversation allowed participants to share ideas and thoughts with one another in a structured way.

Format of Group Conversation

In the Group Conversation, participants were seated at tables that formed a "U" shape facing the front of the room so that participants could see one another when speaking and listening. The Group Conversation was led by a facilitator that guided the discussion by introducing the topic of discussion and posing four questions to the group. Before the Group Conversation began, the facilitator informed participants of several guidelines and protocols for the discussion, including:

- Comments made in the meeting will not be associated with a participant's name or organization. Feedback will be analyzed and reported in a summary format so that participants' comments remain anonymous.
- Because speaking and listening are key components of the Group Conversations, participants should not engage in side conversations and participants should speak one at a time.
- The questions asked in the Group Conversation are designed to be non-directive and open-ended in order to allow for dynamic and open conversation.

Participants spent approximately 15 minutes discussing each question. At the end of discussion for the fourth question, the facilitator shared a brief report of what she heard from the group and offered an opportunity to ask questions and contribute additional comments. The following four questions were asked during the Group Conversation:

1. What are the most important health problems or unmet healthcare needs in the community?
2. What are the challenges and/or barriers to addressing unmet healthcare needs in the community?
3. What healthcare needs do you see as priorities that should be addressed first? Second? Third?
4. What resources may be already available in the community that can help address the unmet health priorities?

Community Stakeholder Recruitment

Thirty-two individuals and organizations were identified as key stakeholders in the community and invited via email and follow-up telephone calls to attend the Group Conversation for St. Luke's Lakeside Hospital. Collectively, these stakeholders not only represent the broad interests of the community, but also represent significant knowledge and expertise in public health. Below is a list of the types of organizations that were invited to attend the Group Conversation, and the unique perspective that each group has on health needs of the community.

- *Health Clinics and Federally Qualified Health Centers (FQHC)* – Health clinics and FQHCs serve a medically underserved area or population and have firsthand knowledge of the health needs of these communities, as well as general knowledge of public health.
- *Regional and Local Health Departments* – Regional, county, and local public health departments are responsible for the general health of citizens in a certain area. Health departments often provide health-related services and maintain current statistics and data on the health of a given population.
- *Health-related Support Groups* – National associations that support research and prevention of diseases, illnesses, and health risk factors often sponsor local support groups. These health-related support groups address health needs of local communities.
- *School Districts* – School Districts have health services departments and staff in each school within a district. These professionals support general student health, access to health services, and appropriate intervention for students with high-risk or chronic medical needs.
- *Community Organizations* – Community organizations range in scope and mission from serving minority and low-income populations, to promoting healthy communities, to advocating for a range of community needs. Community organizations effectively serve as representatives of the individuals and communities they serve.
- *Business Organizations* – Business organizations, such as chambers of commerce, often work to promote economic development and quality of life in communities. They have unique perspectives on quality of life issues including education and health.
- *Services for the Disabled* – Agencies and organizations that provide services for the disabled have a unique perspective on community health needs and priorities. Individuals with mental and/or physical disabilities are often underrepresented in communities.
- *Services for Seniors* – Agencies and organizations that provide services for seniors have a unique perspective on community health needs. Elderly and aging populations often have chronic health needs but encounter significant obstacles to obtaining access to services to meet those needs.

Community Stakeholder Attendance

Below is a list of participants who contributed to the Group Conversation held in support of the St. Luke's Woodlands Hospital and St. Luke's Lakeside Hospital Group Conversation on August 22, 2013. As described above, the group included persons with special knowledge of or expertise in public health; state and local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and leaders, representatives, or members of medically underserved, low-income, and minority populations, as well as populations with chronic disease needs, in the community served by the hospital facility.

	Name	Title	Organization
1	Tanya Bryant	Director of Quality Management and Support	Tri-County Services
2	LaToya J. Carter	Assistant Director	Family Promise of Montgomery County
3	Nancy Heintz	President and Director of Community Outreach	Montgomery County Homeless Coalition, First United Methodist Church Conroe
4	Michelle Hill	Healthy Living Director	South Montgomery County YMCA
5	Randy Johnson	Chief Executive Officer	Montgomery County Hospital District
6	Julie Martineau	President and Director of Community Outreach	Montgomery County United Way
7	Carrie Morrison	Associate Community Executive Director	South Montgomery County YMCA at Creekside
8	Anita Phillips	Clinic Manager	Interfaith Community Clinic
9	Jeanette Plowman	Board Member	Society of St. Vincent de Paul
10	Evan Roberson	Executive Director	Tri-County Services
11	Heather Robison	Director of Crisis Services	Tri-County Services
12	Marlen Tejeda	Director	The Conroe Hispanic Task Force
13	Landrum Turner	Executive Director	South Montgomery County YMCA at Shadow Bend
14	Susan Welbes	Director of Human Resources	The Woodlands Township
15	Penny Wilson	Director of Healthcare Services	Montgomery County Hospital District/Montgomery County Public Health District
16	Sheila M. Zea	Vice President of Sales	The Woodlands Area Chamber of Commerce

Community Stakeholder Feedback

Below is a description of participant feedback from the Group Conversation held for the SLLH community. Data are organized according to the four questions posed to participants.

1. What are the most important health problems or unmet healthcare needs in the community?

- **Behavioral Health including Mental Health and Substance Abuse.** Participants identified both mental health and substance abuse as important health problems in the community served by the hospitals. Furthermore, participants noted the increasing complexity of these overlapping and interrelated health needs. For example, they expressed the need for a healthcare model that integrates treatment for both mental health and substance abuse issues, as well one that integrates both mental health and physical health services. One participant noted the important link between chronic illness and mental health. Participants also noted the specific need for mental health, residential mental health, and detox care and treatment facilities.

- **Chronic Disease.** Participants noted that obesity-related chronic disease is a health problem in the community. Specifically, participants noted the connection between obesity and other chronic diseases such as diabetes, heart attack, and stroke. They acknowledged that, generally, the community lacks understanding about the severity of chronic disease and suggested education surrounding prevention and disease management.

- **Access to Care.** Many participants expressed concern surrounding access to care as an important health problem in the community. Two key factors surfaced that affect access to care: lack of health insurance and lack of transportation.
  - Health Insurance – Participants identified having health insurance as a key component to accessing healthcare, specifically within the indigent population. There is a gap to accessing medications and primary care within the lower income community because of lack of health insurance.
  - Transportation – Participants noted that lack of transportation for seniors and rural-area residents limits access to healthcare and healthy activities. Some neighborhoods within the community served by the hospitals are implementing plans for public transportation, but this remains an important need for patients to access care.

- **Primary Care.** Participants noted primary care as an important unmet healthcare need, specifically for low-income and rural-area residents. The uneven distribution (mainly in the southern part of the county) of primary care clinics makes it difficult for residents outside of the area to access care. One participant also mentioned that the limited locations of primary care facilities also makes it difficult for providers to implement preventive care, treat chronic diseases, and have continuity in meeting rural-area patients' needs.

2. What are the challenges and/or barriers to addressing unmet healthcare needs in the community?

- **Transportation.** Several participants acknowledged that lack of transportation is a barrier to addressing healthcare needs in the community. Participants identified this as a barrier specifically for seniors and those in rural areas. Lack of public transportation prevents elderly, low-income and rural area populations from keeping doctor's appointments and maintaining necessary medications and care.

- **Education and Health Literacy.** Many participants noted that lack of education surrounding healthcare is both a challenge and a barrier to meeting healthcare needs in the community. While participants acknowledged that this need cuts across all socioeconomic sectors, this need emerged as a challenge for two unique sectors: patients and businesses.
  - Patients – Participants noted a lack of understanding concerning the use of Medicare and Medicaid and use of the Emergency Department for primary care purposes. Participants also identified a need for patient education about the severity of chronic disease and how to prevent chronic disease through lifestyle choices.
  - Businesses – One participant expressed concern about small businesses navigating the new healthcare and health insurance policies. Participants also noted the need for educating businesses and their employees about available resources in the community.

- **Healthcare for Low-Income Individuals.** Participants noted that serving low-income patients creates a healthcare challenge. Participants emphasized that there are pockets of extreme poverty in parts of the community further away from the hospitals. Participants identified two main challenges: continuity of care and Medicaid-managed care.
  - Continuity of Care – Participants acknowledged that many low-income patients utilize the Emergency Department for primary care purposes. This is a problem because treatment is given on an episodic basis and patients are not able to receive continuous and/or preventive care.
  - Care for Patients with Medicaid – Participants also noted that for providers, accepting patients with Medicaid makes it difficult for practices to have long-term economic sustainability. The services provided and the increasing overhead costs associated with the services exceed the federal funding provided by Medicaid. While participants acknowledge the importance of serving—and their willingness to serve—low-income individuals, they highlighted the need to explore new business and management models to meet the changing healthcare policy landscape.

3. What healthcare needs do you see as priorities that should be addressed first? Second? Third?

Participants identified three main areas for addressing healthcare needs and priorities in their community:

- Obtain funding to make helpful healthcare resources available in the community.
- Communicate among different parties in the community to generate ideas about how to effectively meet health needs in the community.
- Address healthcare needs in the Hispanic population including language barriers, dental care, preventive care, and education about available resources.

Other healthcare needs identified by participants as priorities included approaching healthcare holistically, addressing capacity issues within primary care, and maintaining quality healthcare.

4. What resources may be already available in the community that can help address the unmet health priorities?

Participants noted the following resources that are available in the community:

- United Way – This organization links businesses and other sectors in the community to bridge resources and foster communication.
- 1115 Project – This program provides mobile psychiatric screenings.
- Emergency Medical Services (county) and Community Para-medicine Program – This program provides responses to patients who call with primary care inquiries.
- Lone Star Family Clinic – This clinic provides primary care to families and patients of all ages.
- TOMAGWA Health Ministries – This organization provides healthcare to low-income families in the Tri-County area.
- Faith-based Organizations – Ministries and churches throughout the community reach important (often underserved) demographic groups.
- Partnership for Prescription Assistance – This program offers discounts on medication from pharmaceutical companies, but doctors in the area are reluctant to use this resource.

Group Conversation Evaluation

All participants were asked to evaluate their knowledge and expertise of public health; knowledge of or involvement with medically underserved, low-income, and minority populations, as well as populations with chronic disease needs; and knowledge of the SLLH community. The participants identified their primary area of knowledge/expertise and the community they serve as including the following areas in general: preventive health, wellness, and social/educational programs; healthy living and prevention; chronic disease; mental healthcare for those who are uninsured or have public insurance; mental illness, intellectual disability, and substance abuse; low-income, medically underserved, and indigent populations; homeless families with children; homeless and underserved populations; social and community services; community development and services; SLLH community and employee families' health needs; business community; Montgomery County residents voices through community listening program; and local and national healthcare changes and needs. More specifically, participants answered the following questions about their knowledge/expertise:

Question	Yes	No
In your opinion, do you feel that you or your organization represent the broad interests of the community served by the St. Luke's Lakeside Hospital?	14	1
Are you a person with knowledge or expertise in public health?	10	5
Are you a representative of a federal, tribal, regional, state, or local health department or agency?	5	10
Does the organization you represent have current data or other information relevant to the health needs of the community served by the St. Luke's Lakeside Hospital?	11	1
Are you a leader, representative, or member of a population served by the St. Luke's Lakeside Hospital that could be characterized as medically underserved, low income, minority, or having chronic disease needs?	14	1

Recommendations Made by Community Stakeholders

The Group Conversation produced several recommendations for how St. Luke's Lakeside Hospital can engage with the community and meet overall health needs. The following recommendations were suggested for the hospitals to consider:

- Increasing education and prevention resources for chronic disease in the community
- Approaching healthcare more holistically, including integration of mental health, physical health, and substance abuse services
- For low-income healthcare
    - Offer providers more educational opportunities around navigating healthcare laws and policies
    - Expand case management to assist with disease management to reduce the Emergency Department load
- Providing mobile/satellite clinics to reach populations in rural areas that lack transportation services
- Linking community programs and resources and centralizing the list for providers and the general population to access
- Hosting additional conversations between different community organizations to promote dialogue about area health needs and how to meet them.

Although participants acknowledged that health problems and needs in the community, such as access to healthcare and prevention, are complex and multilayered, the ideas listed above were put forward by the community for the hospitals' consideration.

Appendix 11. Public Health Experts Summary Report

Introduction

In accordance with Federal law, a Community Health Needs Assessment (CHNA) must take into account "input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health." In collaboration with Episcopal Health Charities, Clarus Consulting Group identified and invited Public Health Experts, facilitated focus groups, and developed the Public Health Experts summary report. Gathering the community input for the hospitals in the St. Luke's Health System took place through a carefully designed process of community engagement that included a "Group Conversation," or targeted focus group. The sections that follow describe how this community engagement met and exceeded Federal requirements to engage federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility.

Overview of Group Conversation

A Group Conversation was held in support of the CHNAs for all six hospitals in the St. Luke's Health System (St. Luke's Medical Center, St. Luke's Lakeside Hospital, St. Luke's Sugar Land Hospital, St. Luke's The Woodlands Hospital, St. Luke's Patient's Medical Center, St. Luke's Hospital at The Vintage) on Thursday, August 8, 2013, from 2:30 pm to 4:00 pm at the Episcopal Health Charities in Houston, TX. It included twelve participants from city, county, regional, and state public health organizations. The Group Conversation was an organized event that brought public health experts together to discuss matters that are important to the health needs of the community served by the hospital system. It involved a dynamic process that allowed all participants to share their thoughts and views, listen to other perspectives, and build on one another's ideas. The Group Conversation did not seek specific answers or responses—all input was welcomed. The exchange that occurred in the Group Conversation allowed participants to share ideas and thoughts with one another in a structured way.

Format of Group Conversation

In the Group Conversation, participants and a facilitator were seated around a conference table, so that participants could see one another when speaking and listening. The Group Conversation was led by a facilitator that guided the discussion by introducing the topic of discussion and posing four questions to the group. Before the Group Conversation began, the facilitator informed participants of several guidelines and protocols for the discussion, including:

- Comments made in the meeting will not be associated with a participant's name or organization. Feedback will be analyzed and reported in a summary format so that participants' comments remain anonymous.
- Because speaking and listening are key components of the Group Conversations, participants should not engage in side conversations, and participants should speak one at a time.
- The questions asked in the Group Conversation are designed to be non-directive and open-ended in order to allow for dynamic and open conversation.

Participants spent approximately 15 minutes discussing each question. At the end of discussion for the fourth question, the facilitator shared a brief report of what she heard from the group and offered an opportunity to ask questions and contribute additional comments. The following four questions were asked during the Group Conversation:

1. What are the most important health problems or unmet healthcare needs in the community?

2. What are the challenges and/or barriers to addressing unmet healthcare needs in the community?
3. What healthcare needs do you see as priorities that should be addressed first? Second? Third?
4. What resources may be already available in the community that can help address the unmet health priorities?

Public Health Experts Recruitment

Twenty-four public health organizations and individuals were identified as key stakeholders in the field of public health and invited via email to attend the Group Conversation for St. Luke's Health System. Collectively, these groups represent significant knowledge and expertise in public health. Regional, county, and local public health departments are responsible for the general health of citizens in a certain area. Health departments often provide health-related services and maintain current statistics and data on the health of a given population.

Public Health Experts Attendance

Below is a list of participants who contributed to the Group Conversation held in support of the St. Luke's Health System Group Conversation on August 8, 2013. As described above, the group included persons with special knowledge of or expertise in public health as it relates to the communities served by the St. Luke's Health System.

	Name	**Title**	**Organization**
1	Latrice Babin, PhD	Environmental Toxicologist	Harris County Pollution Control Services Department
2	June Hanke	Strategic Analyst/Planner	Harris Health System
3	Dr. Nicole Hare-Everline, CHES	City of Houston Wellness/EAP Director	City of Houston
4	Robert Hines	Epidemiologist	Houston Department of Health and Human Services
5	Haley Jackson	Team Lead	Texas Department of State Health Services
6	Lisa Mayes	Executive Director	Harris County Healthcare Alliance
7	Bakeyah Nelson	Public Health Analyst	Harris County Public Health and Environmental Services
8	Beverly Nichols, PsyD, MS, RN	Senior Staff Analyst	Houston Department of Health and Human Services
9	Kimberly Nicholson	Program Specialist II	Texas Department of State Health Services
10	Ebun Odeneye	Senior Health Educator	City of Houston
11	Yan Shi	Management Analyst III	Houston Department of Health and Human Services
12	Lindsey Wiginton	Epidemiologist	Houston Department of Health and Human Services

Public Health Experts Feedback

Below is a description of participant feedback from the Group Conversation held for Public Health Experts. Data are organized according to the four questions posed to participants.

1. What are the most important health problems or unmet healthcare needs in the community?

In general, participants noted the correlation between a healthy community and fewer admissions to the hospital, and suggested that elevating the idea of a healthy community is a healthcare need in the Greater Houston community. Participants also noted specific unmet healthcare needs in the community, including access, communication, chronic disease, mother/infant/prenatal care, behavioral health, environmental health, and health disparity issues:

- **Access.** Collectively, participants felt that access to care was the most important health problem in the community. Participants acknowledged that there is sufficient number of health clinics in the area but that access to care remains an issue for a significant portion of the population. Several factors contribute to the access to care issue.
- **Transportation.** Houston is a very spread out city, and transportation to and from healthcare settings is a problem for many people in Houston.
- **Knowledge.** Some participants felt that many people simply do not understand how to obtain healthcare resources and services. This problem is especially evident as it relates to prenatal and behavioral healthcare needs.
- **Insurance and Finances**. Many people do not have access to care because they do not have the financial resources to pay for care. Many people do not have insurance and do not know how to pay for care. This often leads to a deferral of care and higher admittance to the emergency department.
- **Communication.** Participants indicated that more effective communication around healthcare in the Greater Houston community is an unmet healthcare need. Specifically, participants felt that better communication is needed from healthcare providers to inform the community about services and resources that are available. In addition, better communication is needed between healthcare providers and health departments/public health agencies.
- **Chronic Disease.** Participants suggested that the rate of chronic diseases, such as diabetes, obesity, high cholesterol, hypertension, heart disease, and asthma (especially in children), is an important health problem in the community. One participant noted that the rate of adults with diabetes or pre-diabetes is 60%, which illustrates the significance and alarming nature of the chronic disease problem in the Greater Houston community. Participants felt that more individuals need to be screened for chronic diseases, and that more information about how to access help for chronic diseases needs to be disseminated.
- **Mother/Infant/Prenatal Care.** Several participants focused on maternal, infant, and prenatal care as being an important health problem in the Greater Houston community. Participants cited high rates of maternal and infant mortality and high rates of preterm birth and fetal mortality as evidence of this problem. Participants further noted that high rates of poor birth outcomes lead to higher numbers of children with special needs. Participants suggested that, overall, women are aware of the importance of maternal, infant, and prenatal care, but they encounter many barriers to obtaining these services such as transportation, funding, access, finding a doctor, and making an appointment.
- **Behavioral Health.** Several participants suggested that mental health and chronic mental illness are important healthcare issues in the Greater Houston community. While participants specifically noted that individuals with schizophrenia, bipolar disorder, and depression rarely get care they need, they also cited some progress in addressing this need, such as the police department helping

to place individuals with mental health issues in treatment centers instead of placing them in the law enforcement system.

- **Environmental Health.** Participants suggested that poor environmental health causes both acute and chronic health issues in the community. Participants noted the importance of the relationship between environmental health and chronic disease, and suggested that the Greater Houston community needs more educational initiatives around this relationship. Participants noted that environmental problems such as air quality or road construction can be obstacles to healthy communities in that they discourage individuals from going outside to exercise, but they can also lead to chronic health problems such as respiratory problems, heart attack, stroke, and asthma.
- **Health Disparities.** Participants suggested that disparity issues are a major healthcare concern in the Greater Houston community. One participant provided the example that there are correlations between ethnicity and individuals that do not get regular or necessary healthcare screenings.

2. What are the challenges and/or barriers to addressing unmet healthcare needs in the community?

Participants discussed the challenges and barriers to addressing unmet healthcare needs in the community at the individual, organizational, and the community levels.

- **Barriers for Individuals.** Barriers to addressing unmet healthcare needs for individuals in the Greater Houston community relate to access to care issues. Transportation, insurance and financial resources, and scarcity of time are all barriers to addressing unmet healthcare needs for individuals in the Greater Houston community.
    - Transportation – Transportation to and from healthcare settings is a significant barrier to obtaining healthcare services for many individuals in the Greater Houston community.
    - Insurance and Financial Resources – Many individuals in Houston lack insurance and/or do not know how to access Medicaid funds. Participants indicated that while most individuals are educated about the benefits of healthcare, they do not have the financial resources to access healthcare services.
    - Time – Participants acknowledged that time is a precious resource for individuals in Houston and that scarcity of time is often a barrier to accessing healthcare services. In particular, participants noted a need for individuals to understand the difference between after-hours and emergency care facilities in terms of accessing care.
- **Barriers for Organizations.**
    - Political Climate and Acceptance of Available Funds – Participants voiced that the political climate is a barrier for some health-related organizations in the Greater Houston community. Specifically, participants noted that governing bodies that serve as a funding source for health-related organizations often do not want to accept funds that may be politically controversial, such as funds associated with Medicaid expansion. Participants noted that some organizations are seeking assistance with this challenge at the state level but have not seen much progress made in terms of this unique funding barrier.
- **Barriers for Communities.** At the community level, participants observed that poverty, resources for individuals, and access to healthy foods are barriers to addressing unmet healthcare needs.
    - Poverty – Several participants stated that from a community perspective, the high rate of poverty is a barrier to addressing unmet healthcare needs. Poverty is a growing issue in Houston, and communities with high rates of poverty often are not able to place exercise and accessing healthcare as priorities.

- Empowering the Individual – Participants suggested that communities do a good job of educating the public, but that education needs to be followed up on the community level by empowering individuals to act on the information they receive related to healthcare.
- Access to Healthy Foods – Participants noted that many communities in Houston are considered "Food Deserts" because they lack access to fresh, healthy foods. Access to healthy foods is a basic principle in creating healthy communities and many communities in Houston lack such access.

3. What healthcare needs do you see as priorities that should be addressed first? Second? Third?

- **Infant and Maternal Health.** Participants identified maternal, infant, and prenatal health as an important unmet healthcare need in the community. Participants agreed that this is a priority healthcare need in the community.
- **Access and Awareness.** Participants suggested that a range of issues related to access and awareness should be a priority in the community. Access to transportation, healthy foods, information about chronic diseases such as diabetes and asthma, cancer screenings, and preventive care were access/awareness issues named specifically by participants. Participants also emphasized that a focus on outreach to communities dealing with high rates of poverty should be a priority for providing access to healthcare.
- **Referrals between Hospitals and Federally Qualified Health Centers (FQHCs).** Participants identified developing a working relationship between hospitals and FQHCs to efficiently and effectively refer patients to the appropriate healthcare provider as a priority for the community. Participants acknowledged that it is not only best for the patient to be seen in the right healthcare setting, but it also helps relieve overuse of emergency care facilities for primary care purposes. Participants also noted that part of this referral system should be the provision of transportation and appropriate follow up to ensure that patients received care through the appropriate healthcare setting.
- **Health Services (and Orientation to Services) for Immigrants.** Participants noted that Houston is a "city of immigrants" and that working to establish a holistic approach to providing social services and healthcare for immigrants should be a priority for the Greater Houston community. A partnership with the Office of Immigration to provide education around navigating the health system and introducing health as a way of life could be a part of this priority.
- **Promoting Availability of Services.** Participants suggested that promoting awareness about availability of services should be a priority in the Greater Houston community. Promoting availability of services should occur through broad communication efforts.
- **Promote Healthy Communities.** Participants felt that promoting healthy communities overall should be a priority. From a policy standpoint, communities should look at policies that form the behavior of hospitals and the incentive to participate in community level work.

4. What resources may be already available in the community that can help address the unmet health priorities?

In answer to this specific question, as well as throughout the Group Conversation, participants noted several existing resources and programs that address health in the community.

- Active and Engaged Civic Clubs and Social Clubs – Civic and social clubs are an important part of communities in Houston and could be a great avenue to reach communities to address health priorities.
- Active Church and Faith-based Community – The active church and faith-based communities throughout Houston are often involved in all aspects of life, including health and wellness.
- United Way – The United Way is a great resource in Houston that addresses a myriad of health-related issues in the community. Participants specifically noted programs of the United Way related to cancer screenings and transportation to health-related services.
- Area Agency on Aging – The Area Agency on Aging implements preventive programs for seniors that promote health for this important sector of the population.
- Asthma-related Support Services – Although funding is no longer available for this initiative, participants noted a program that provided healthy alternatives for the home for families with children that suffer from asthma. The program was a relatively small resource to address a large problem, but it made a difference for children and families who struggle with asthma.

Group Conversation Evaluation

All participants were asked to evaluate whether his or her organization represents the broad interests of the communities served by the St. Luke's Health System, and whether the organization he or she represents has current data or other information relevant to the health needs of the communities served by the St. Luke's Health System. Participants were also asked which of the six hospital communities in the St. Luke's Health System he or she is most closely familiar with. Participants answered these questions according to the chart below.

Question	Yes	No
In your opinion, do you feel that you or your organization represent the broad interests of the communities served by the St. Luke's Health System hospitals?	10	0
Does the organization you represent have current data or other information relevant to the health needs of the communities served by the St. Luke's Health System hospitals?	10	0
Which of the following hospital service area health needs do you feel that you are most closely familiar with? (Mark all that apply.)		
St. Luke's Medical Center	6	-----
St. Luke's Hospital at The Vintage	3	-----
St. Luke's The Woodlands Hospital	4	-----
St. Luke's Sugar Land Hospital	1	-----
St. Luke's Patient's Medical Center	3	-----
St. Luke's Lakeside Hospital	1	-----

Recommendations made by Public Health Experts

Several specific ideas for how St. Luke's Health System could engage with the community to meet overall health needs of the community emerged from the Group Conversation. Although health problems and needs in the community, such as access to healthcare and prevention, are complex and multi-layered, there were a number of ideas and recommendations put forward by public health experts for the hospitals' consideration, including the following:

- Development of a resource center for chronic diseases, similar to a diabetes resource center
- Promotion of available resources in the community—and healthy communities in general—by engaging with the local community to become aware of and promote available resources instead of waiting for community members and organizations to come to the hospital
- Development of partnerships and collaboration between hospitals and public health departments and agencies based on similarities in accreditation processes and health needs assessments for both entities
- Support policies that promote health in rural communities, such as complete streets policies
- Develop a partnership with METRO to help publish transportation system maps that include hospital and clinic locations
- Partner with external facilities that can help with services that the hospital would like to address, such as emergency care facilities