Community Health Needs Assessment and Implementation Strategy

St. Luke's Patients Medical Center

September 26, 2013

The Community Health Needs Assessment and Implementation Strategy for the St. Luke's Patients Medical Center were conducted and developed between April 22 and September 20, 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 Patients Medical Center Board of Managers on September 26, 2013.

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Introduction

A Community Health Needs Assessment (CHNA) for the St. Luke's Patients Medical Center (SLPMC) was conducted by SLPMC and Episcopal Health Charities (the Charities) between April 22 and September 20, 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 SLPMC 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 SLPMC hospital advisory team and includes a description of the community served by the SLPMC; the process and methods used to conduct the assessment; a description of how SLPMC included input from persons who represent the broad interests of the community served by SLPMC; a prioritized description of all of the community health needs identified through the CHNA; and, a description of the existing health care 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 SLPMC's plan to address the identified priority community health needs.

Description of Community Served by the Hospital

The community served by St. Luke's Patients Medical Center is described by the geographic area of SLPMC and the contiguous zip codes determined by 2012 SLPMC hospital discharge data. Located in Harris County, the hospital service area contains both a large urban complex, as well as smaller rural communities, and is home to over 200,000 working class residents representing many diverse ethnicities and backgrounds. This area is primarily industrial, and petrochemical companies are large employers and influence the local community. 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% of discharges are outside of the areas considered for this report. SLPMC primary and secondary service area map and zip codes are included in Appendix 1.

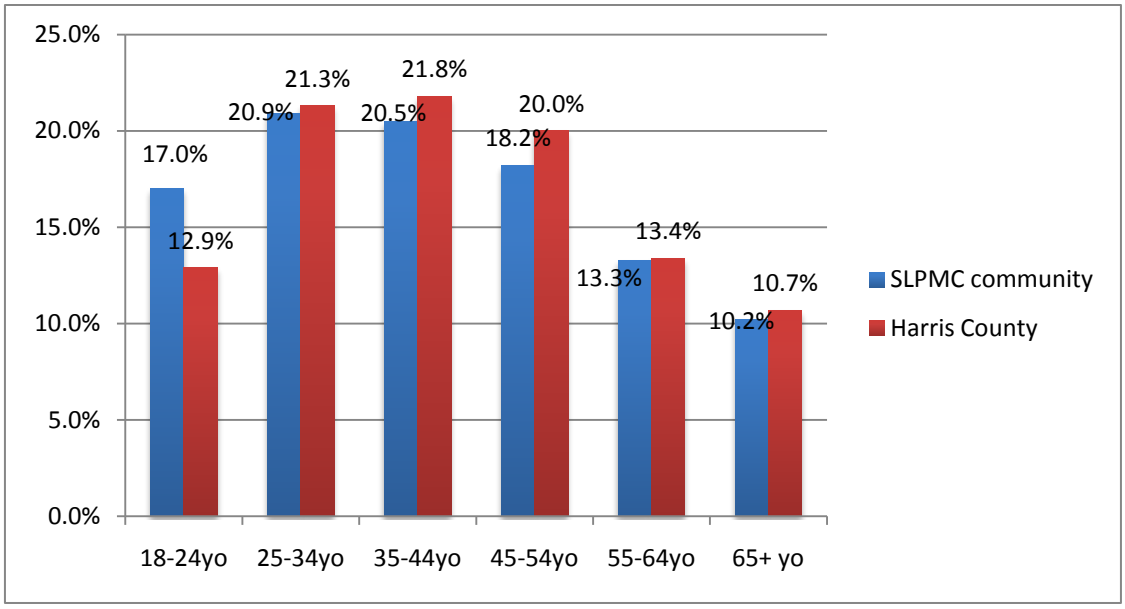
Community Demographics

Demographic data was collected and analyzed using comparisons within the SLPMC community and with the aggregated zip code data representing Harris County. Overall, the community served by SLPMC compared to Harris County is slightly younger, majority Hispanic, and has a large population on high school graduates with some college education. A full description of the data from the SLPMC's PSA and SSA, the 2010 Health of Houston Survey (HHS), and the 2011 Behavioral Risk Surveillance System (BRFSS) can be found in Appendix 2.

Below are additional details related to the demographics of the SLPMC community compared to Harris County:

- ***Age***- One-fifth (20.9%) of those living in the SLPMC community are between 25-34 years old, one-fifth (20.5%) between 35-44 years old, and another fifth between 45-54 years old. The 18-24 year old category was the fourth largest group, followed by 55-64 year olds (13.3%) and those aged 65 and over (10.2%). The age distribution of Harris County resembles those in the SLPMC community (Figure 1).

Figure 1. Age distribution for SLPMC community and Harris County



- ***Race/Ethnicity*** - The majority of the SLPMC community identify as Hispanic (48%) or White non-Hispanics (40%). This differs somewhat from the distribution by race/ ethnicity for all of Harris County, where 37% are Hispanic and 38% are White non-Hispanic (Table 1).

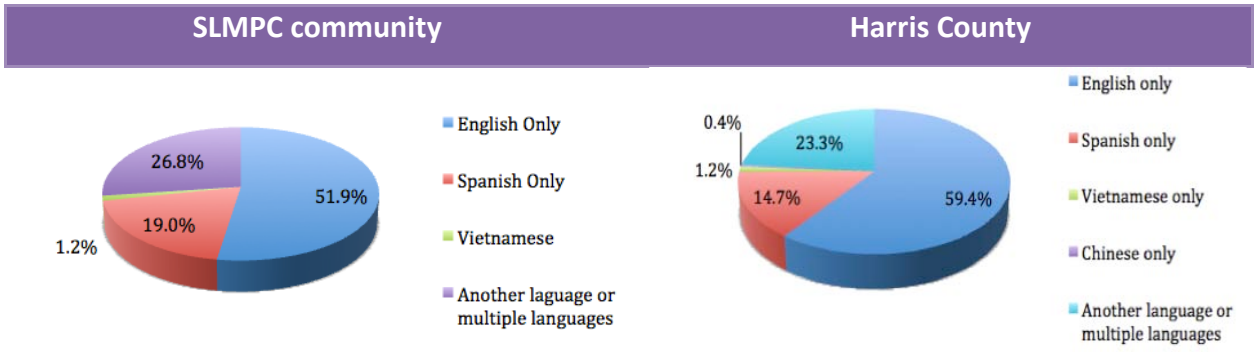
Table 1. Race/ethnicity distribution for SLPMC community and Harris County

Race / Ethnicity	SLPMC community	Harris County
White/ non-Hispanic	40.1%	37.7%
Black/ non-Hispanic	6.2%	17.4%
Hispanic	47.5%	36.8%
Asian/ non-Hispanic	3.2%	4.9%
Other/ non-Hispanic	3.0%	3.2%

- ***Nationality***- Roughly 66% of the SLPMC community were born in the United States, and 25% were born in Mexico. Of the one-third of those that were not born in the United States, 60% as compared to 53% in Harris County are not United States citizens.

- ***Language***- A little over 50% of the households in the SLPMC community speak English only, 19% speak Spanish only, 1.2% speak Vietnamese and 26.8% speak another language or multiple languages. In Harris County, 59.4% speak English only, 14.7% speak Spanish only, 1.2% speak Vietnamese only, 0.4% speak Chinese only and 23.3% speak another language or multiple languages (Figure 2).

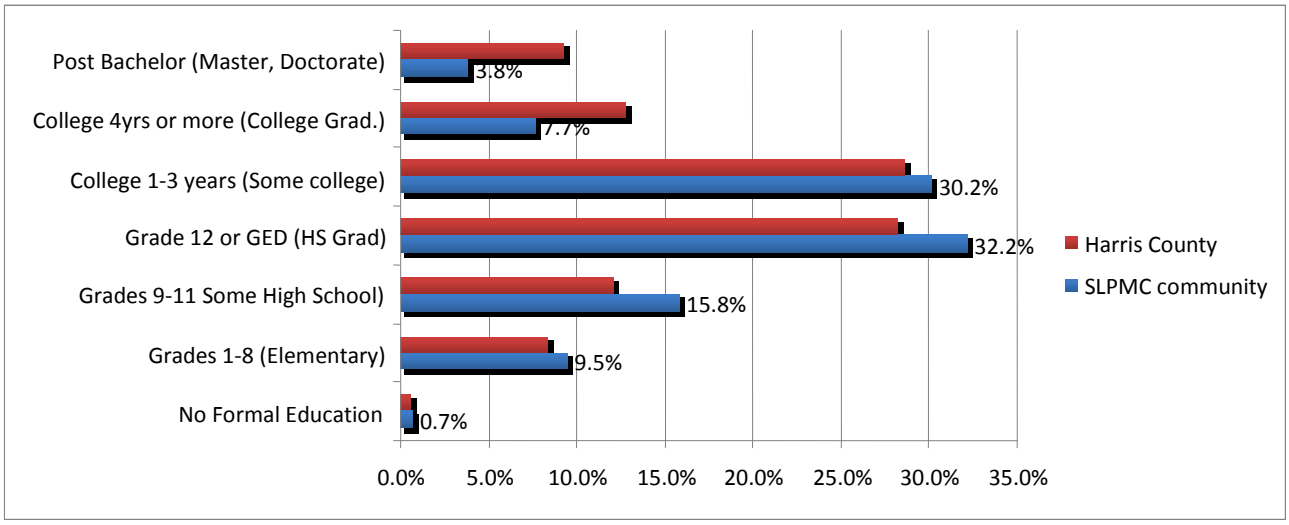
Figure 2. Languages spoken in households of the SLPMC community and Harris County



- ***Gender***- The gender of those in the SLPMC community is evenly distributed between males and females (48.7% and 51.3%, respectively). This breakdown closely resembles the Harris County gender rates of 49.5% males and 50.5% females.

- ***Education***- Fifty-eight percent of the SLPMC community have less than or equal to a high school education / GED. This is higher than the Harris County rate of 49.3%. In the SLPMC community, nearly one third have completed between one to three years in college, less than one tenth have completed four years in college, and less than 4% have completed a Post Baccalaureate degree (Figure 3).

Figure 3. Educational attainment rates for SLPMC 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 Patient Medical Center. 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 SLPMC hospital 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 SLPMC CHNA. The SLPMC 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 SLPMC hospital team consisted of executive leadership staff including the Assistant Vice President, Chief Finance Officer, Chief Nursing Officer and Director of Marketing. 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. Appendix 3 lists the names, titles, and roles of those involved in the CHNA, including the data analysis and community input portions.

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 during April to August, 2013 from various data sources including the 2010 Health of Houston Survey (HHS), 2012 St. Luke's Health System hospital discharge data, and 2011 Behavioral Risk Surveillance System (BRFSS).

The HHS was conducted by the University of Texas, School of Public Health, Institute for Health Policy and consisted of a comprehensive examination of Houston and Harris County residents with regard to their health conditions and health behaviors. Surveys were conducted via telephone, mail, and the internet with 5,116 individuals. Data was weighted to correct for differential probabilities in sampling and to reduce bias resulting from differences in response rates and coverage. In order to assess the relative health profile of the SLPMC, the SLPMC HHS community level data was compared to the HHS data from all residential zip codes in Harris County. Poverty status and insurance status were analyzed to identify the health profile of the underserved and/or vulnerable populations within the SLPMC community. Poverty status was computed in the HHS based on household size and income. Insurance status was obtained by determining insurance coverage through a current or former employer or union, insurance purchased directly from an insurance company, Medicare, Medicaid /CHIP, Tricare /Champus, Champ-VA / VA, or other.

Hospital Discharge Data

Data on all hospital discharges for 2012 was provided by the St. Luke's Health System. Data was aggregated by the 5 digit ICD-9 diagnosis code and divided by inpatient and outpatient discharges. ICD-9 codes were further aggregated into more relevant and less clinically specific categories. Discharge data was summarized for SLPMC 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 = 2,759), outpatient (N = 11,101), and total patient load (N = 13,860). Overall, the leading discharge categories were *Symptoms, Signs, and Ill-Defined Conditions* (34.7%); *Injury and Poisoning* (19.9%); *Diseases of the Musculoskeletal System and Connective Tissue* (7.1%); and *Diseases of the Digestive System* (7.0%).

Among the 2012 SLPMC inpatient discharges, one-fifth (21.6%) were for *Diseases of the Digestive System*. Within this classification, the most commonly occurring conditions were

other diseases of intestines and peritoneum (28.6%) and *other diseases of digestive system* (34.8%). *Diseases of the Circulatory System* accounted for one-fifth (20.3%) of inpatient discharges. Within this category, 18.1% of discharges were for *ischemic heart disease*, and 15.2% were for *cerebrovascular disease.* Two-fifths (40.8%) of discharges fell under the classification, *other forms of heart disease*. The third most common inpatient discharge classification was for *Diseases of the Respiratory System* (16.0%). Two-fifths (39.2%) of inpatient respiratory system discharges were for *chronic obstructive pulmonary disease and allied conditions*, and another two-fifths (36.7%) were for *pneumonia and influenza*.

Among the 2012 SLPMC outpatient discharges, 42.5% were for *Symptoms, Signs, and Ill-Defined Conditions*. Almost all (99.8%) discharges within this grouping were classified as *Symptoms*. The category *Injury and Poisoning* accounted for 23.2% of outpatient discharges. One-quarter (25.2%) of these discharges were for *certain traumatic complications and unspecified injuries*, and one-fifth (19.6%) were for *contusion with intact skin surface*. An additional 14.3% were for *sprains and strains of joints and adjacent muscles*. The third most common outpatient discharge classification (8.5%) was for *Diseases of the Musculoskeletal System and Connective Tissue*. Within this classification, 47.6% of discharges were for *dorsopathies*, 27.4% were for *arthropathies and related disorders*, and 24.6% were for *rheumatism, excluding the back*.

Key Indicators and Health Disparities

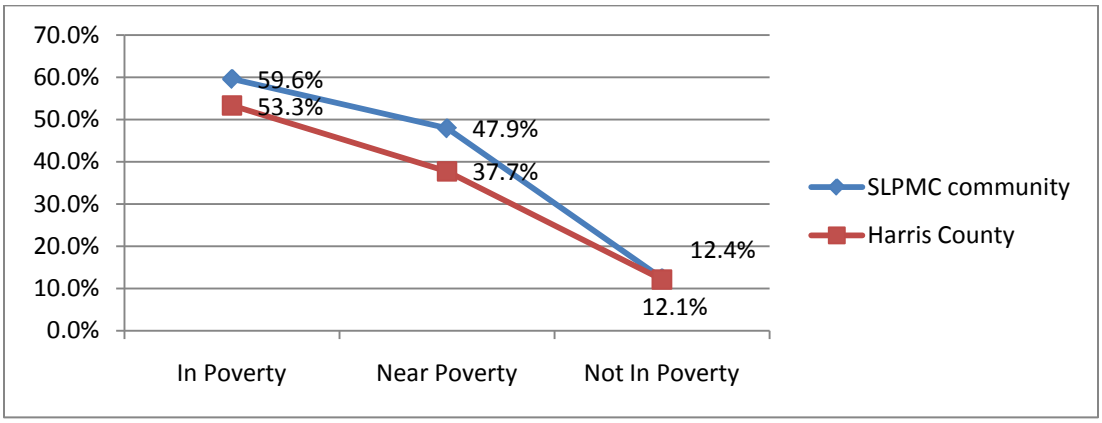
The SLPMC community key indicators and health disparities were identified and compared to the Harris County population (Appendices 2, 4- 11). Data reviewed indicate that sufficient health information is already available from local public health sources to allow for the identification of some of the most important health needs of the SLPMC community. There were no identified information gaps in the gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. The data were analyzed in relation to poverty to identify potential disparities that may exist between socioeconomic groups. Poverty was divided into three categories: in poverty (<100% of the

Federal Poverty Level), near poverty (100-199.9% of the FPL), and not in poverty (200% or more above the FPL).

The SLPMC community as compared to Harris County has less crime and violence, lower rates of cardiovascular disease, higher uninsured population, lower rates of cancer, and higher concerns with fumes from traffic and industry. The below indicators reflect analyses from the 2010 Health of Houston Survey and the 2011 Behavioral Risk Surveillance System for the SLPMC community.

- ***Health Insurance and Access to Care***- Approximately 37% of adults in the SLPMC community are uninsured. This is higher than the Harris County rate of 30.7% uninsured from the HHS data, and the 2011 BRFSS national rate of 18.2% uninsured. Of those insured, the majority (50.3%) of Harris County had private insurance compared to 44.6% of the SLPMC community. Over one-third (35.7%) of those in the SLPMC community reported no personal doctor or health care provider compared to 30.9% in Harris County. Twenty-nine percent of those in the SLPMC community reported delaying seeing a doctor in the previous year due to cost or lack of insurance compared to 24.2% of Harris County. Those in poverty were more likely to report being uninsured; approximately 33% of adults in the SLPMC community are below the federal poverty level (Figure 5). (Appendix 2 and 6).

Figure 5. Percentage of uninsured and in poverty for SLPMC community and Harris County

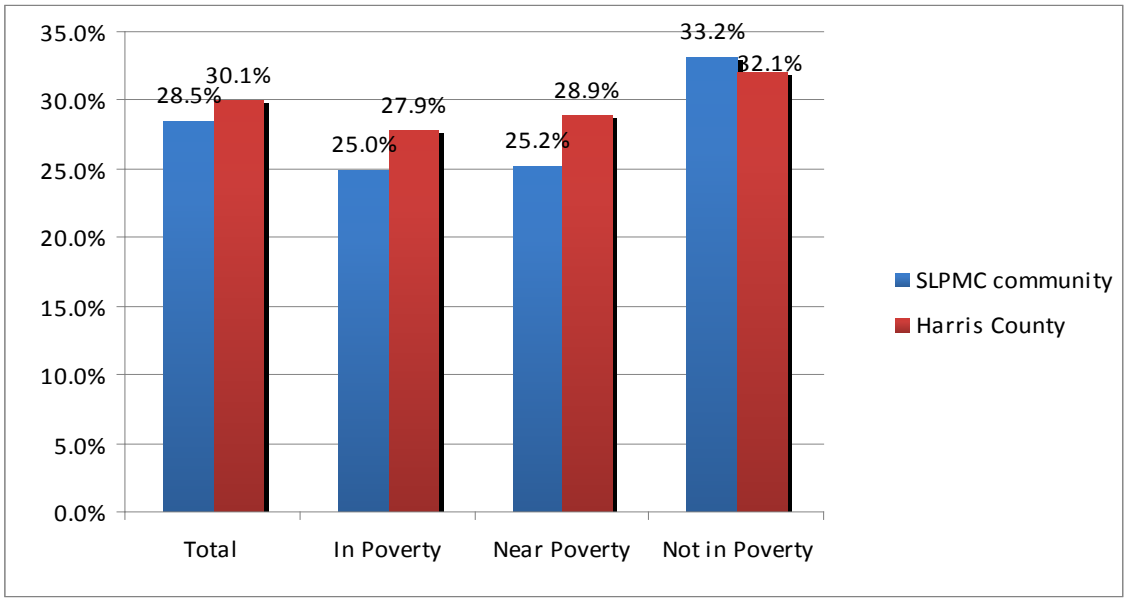


- ***Cancer***- Overall cancer diagnoses rates are similar in SLPMC community and Harris County (4.6% for SLPMC, 6.1% for Harris County). In 2012, neoplasm accounted for 1.9% of SLPMC inpatient discharges and 0.1% of SLPMC outpatient discharges. (Appendices 4 and 5).

- ***Diabetes***- About 10% of those in the SLPMC community from all three poverty groups (11.4% in poverty, 9.9% near poverty, 9.1% not in poverty) have been diagnosed with diabetes. Those rates are consistent with the Harris County rates with 12% in poverty, 10.7% near poverty, and 10.6% not in poverty indicate having been diagnosed with diabetes (Appendix 5).

- ***High Blood Pressure***- High blood pressure diagnosis was more frequently reported amongst those in the SLPMC community not in poverty (33.2%) versus in poverty (25%) and near poverty (25.2%) (Figure 4). A similar trend is present in Harris County (Appendix 5).

Figure 4. High blood pressure diagnosis by poverty for SLPMC community and Harris County



- ***Mental Health***- Thirteen percent of the SLPMC community reported they had felt like talking to a health professional in the previous year for a mental health, emotional, or substance use problem compared to 16.4% in Harris County. The near poverty population has lower rates of reported mental health need in the last 12 months (6.9% SLPMC, 11.7% Harris County). (Appendix 5).

- ***Cardiovascular Disease***-Compared to Harris County, the SLPMC community in poverty has lower rates of coronary heart disease (2.8% SLPMC, 4.1% Harris County) and stroke (2.6% SLPMC, 4.0%). The near poverty population has higher rates of heart attacks than those in Harris County (4.4% SLPMC, 3.1% Harris County). The SLPMC community not in poverty reports higher rates of coronary heart disease (5.4% SLPMC 4.4% Harris County) than in Harris County (Table 2). (Appendix 5).

Table 2. Cardiovascular disease diagnosis for SLPMC community and Harris County

	SLPMC community				Harris County			
	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)
Ever diagnosed with coronary heart disease	2.8	3.1	5.4	4	4.1	2.8	4.4	4
Ever diagnosed with heart attack	3.6	4.4	2.7	3.4	3.7	3.1	2.9	3.2
Ever diagnosed with stroke	2.6	3.2	2.4	2.6	4	2.7	1.9	2.7

- ***Use of Preventive Services***- In the SLPMC community, mammography and pap test rates are 76.3% amongst all three groups; however, for all three groups poverty groups in both the SLPMC community and Harris County are more likely to get a pap test than a mammography. These rates are similar to the Harris County rates where over 82% (aged 35-74) have had a mammography and are more likely to get a pap test. Blood stool test and sigmoidoscopy / colonoscopy screening rates in the SLPMC community were near 40% for those in poverty and near poverty, and 60% for those not in poverty. (Appendix 7).

- ***Prenatal Care***- Among the prenatal care, the rates of prenatal care and breastfeeding behavior were comparable between the SLPMC community and Harris County. Eleven percent (11.2%) of those in the SLPMC community reported cost or no insurance as a reason for not obtaining prenatal care compared to 32.4% of Harris County. Over one-third (36.2%) reported not knowing they were pregnant as the reason compared to 25.7% of those in Harris County. Twenty-two percent (22.5%) of those in the SLPMC community

reported late care with their last pregnancy compared to 16.0% of those in Harris County (Appendix 8).

- ***Smoking***- The current smoking pattern of those in the SLPMC community is higher than in Harris County. Thirty-four percent of those in SLPMC community smoke cigarettes everyday and 17% smoke most days; in Harris County, 29% smoke everyday and 16% smoke most days (Appendix 9).

- ***Environmental and Neighborhood Factors***- One-quarter (23.7%) of those in the SLPMC community stated fumes from traffic were a problem compared to 17.2% in Harris County; and, 42.8% of those in the SLPMC community stated fumes from industry were a problem compared to 14.8% of Harris County. Problems with fumes from industry were reported at nearly three times the rate in the SLPMC community over the Harris County population. Rates of problems with water pollution and drinking water were comparable in the SLPMC community and Harris County (Table 3). (Appendix 10).

Table 3. Environmental and neighborhood factors by poverty for SLPMC community and Harris County

	SLPMC community				Harris County			
	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)
Fumes from Traffic	32.9	16.5	20.6	23.7	20.8	16.4	15.2	17.2
Fumes from Industry	44.3	43.4	41.3	42.8	16.6	16.8	12.6	14.8
Water Pollution	20	12	8.7	13.3	14.4	10.5	7.2	10.2
Drinking Water	26.2	24.3	14.7	20.9	22.5	21	15.2	18.8

- ***Violence***-With respect to crime and violence, 17.3% of those in the SLPMC community reported this was a problem compared to 26.1% of Harris County (Appendix 10).

- ***Social Support***- Of those in the SLPMC community, 20.5% of those in poverty, 23.1% near poverty, and 37.6% of those not in poverty reported having someone to relax with "all of the time". While the majority of respondents in all three poverty groups indicated they

had someone to help with daily chores “all of the time” and someone to understand their problems “all of the time”, rates varied between groups but were similar with rates in Harris County. (Appendix 11).

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 SLPMC; and leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by SLPMC. Community input was obtained from the SLPMC hospital advisory team, SLPMC community stakeholders, and the public health community. Appendix 3 lists the participants involved in the CHNA including names, titles, and roles.

SLPMC Hospital Advisory Team Input

A CHNA kickoff meeting was held on April 24 to inform leadership of St. Luke’s Health System hospitals of the new IRS 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 August 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 June 27, the SLPMC hospital advisory team met to provide input on the most significant health needs of their community, existing gaps in available health care, 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 SLPMC hospital advisory team summary report can be found in Appendix 12. The hospital advisory team identified the following areas of need:

- ***Access to Care***- There is a shortage of primary care physicians. It seems that patients prefer not go to the clinic and wait to go to the ER.
- ***Cancer***- Stakeholders noted that there seems to be high cancer rates in the area; in the past couple years an increase in cancer diagnoses – lung, brain, breast, and leukemia. The hospital borders an industrial environment, and many cancers may be a result of prior exposure to chemicals or industrial work. There are no radiation treatments available in Pasadena; the closest facility is Southeast Memorial and patients have to travel far for treatment. When patients have cancer diagnoses, they have to go to other cancer centers for diagnosis before they begin inpatient treatment; this is an additional burden for those without transportation.
- ***Child Health***- The hospital does not have a pediatric unit or pediatric physicians on staff; there are many children in the area with diverse health needs. Many families are lower income and do not have resources to positively influence their children's health behaviors.
- ***Obesity and related Chronic Disease, specifically for the Hispanic Community***- There is a lack of information on nutrition, obesity and diabetes to help support the large Hispanic community in the area. The community is lower income and there is an overall high cost of healthcare, prescription drugs and lab costs.
- ***Services for Seniors***- There is a large aging population and a lack of primary care physicians to serve them.
- ***Transportation***- There is no public transportation available in Pasadena. Many patients, even those eligible for Harris Health System services, prefer to come to SLPMC rather than the Texas Medical Center or Galveston. The Southmore Hospital, which was in the area, closed in early 2000s. It served a large Medicaid population that now goes to Bayshore Hospital because many do not have transportation to get to SLPMC.

SLPMC Community Stakeholder Input

Through active outreach to key community stakeholders, a broad representation from the communities served by SLPMC was identified to participate in the community input portion of the CHNA. A focus group was held on Thursday, August 8, 2013, from 9:00 am – 10:30 am at The Bridge Over Troubled Waters, Inc. in Pasadena, Texas. 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 twelve stakeholders and organizations represented a range of community based organizations, health clinics and Federally Qualified Health Centers, school districts, and business organizations. The SLPMC community stakeholder summary report can be found in Appendix 13. Stakeholders identified the following areas of need:

- ***Access to Care*****-** Many stakeholders focused on access to care as an important health problem in the SLPMC community. Several factors that affect access to care were highlighted including lack of transportation, lack of adequate health insurance, and access to specialty services and screenings.
- ***Communication, Education, and Prevention*** **-** Stakeholders identified the interrelated issues of communication, education, and prevention as community health needs. Stakeholders also acknowledged the broader benefits of education and prevention in terms of lowering rates of chronic disease, improving health of the overall community, and reducing demand for hospital/emergency services. Communication among health care providers, community service organizations, and the general public emerged several times in the conversation about unmet health needs in the community.
- ***Mental Health Services*****-** Stakeholders identified mental health services for adults and children as a significant unmet healthcare need. For adults with mental health needs, cost and cultural understanding/awareness can be barriers to getting mental health services. Stakeholders noted that obtaining mental health services for children is especially difficult, sometimes taking up to seven days to place a child.

- ***Obesity-*** Stakeholders identified obesity as a major health problem in the community. While many acknowledged that obesity is an issue for people of all ages in the community, there was a particular focus on addressing childhood obesity and nutrition.
- ***Services for Seniors-*** Stakeholders identified adequate and effective care for seniors as an unmet health care need in the community. Factors contributing to this need include lack of transportation, financial resources for transportation and prescription medications, appropriate follow-up from health care professionals, nutrition, and social interaction.
- ***Substance Abuse-*** There are major concerns with substance abuse in the community. There are not enough treatment centers in the area and existing centers are not affordable. There is a need for support services related to substance abuse treatment, such as a place for children to go while their parents are receiving treatment.

Public Health Experts Input

Another focus group was held for Public Health Experts on Thursday, August 8, 2013, from 2:30 pm – 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. Stakeholders also noted specific unmet healthcare needs in the community include access to care, communication, chronic disease, maternal and child health, behavioral health care, environmental health, and health disparities. The Public Health Experts summary report can be found in Appendix 14. 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. The group 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 that contribute to the access to care issue include transportation, knowledge, and insurance and finances.

- ***Chronic Disease*-** Public Health Experts suggested 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. It was 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. Individuals felt that more individuals need to be screened for chronic diseases, and more information about how to access help for chronic diseases needs to be disseminated.
- ***Communication*-** Public Health Experts indicated that more effective communication around health care is an unmet health need. Specifically, individuals expressed that better communication is needed from health care providers to inform the community about services and resources that are available. In addition, better communication is needed between health care 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. Individuals noted that environmental problems such as air quality or road construction can be obstacles to healthy communities in that it discourages individuals from going outside to exercise but can also lead to long-term chronic health problems such as respiratory problems, heart attack, stroke, and asthma.
- ***Health Disparities*-** Public Health Experts suggested that health disparities are a major health care concern in the community. It was noted that there are correlations between ethnicity and individuals that do not get regular or necessary health care screenings.
- ***Maternal and Child Health*-** Public Health Experts focused on maternal, infant, and prenatal care as being an important health issue in the community. Individuals cited high rates of maternal and infant mortality and high rates of pre-term birth and fetal mortality as evidence of this problem. It was further noted that high rates of poor birth outcomes leads 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 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 people 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 four major data sources: SLPMC Hospital Advisory Team Input, SLPMC Community Stakeholders Input, Public Health Experts Input, and Health of Houston Survey Data for the SLPMC 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 was compared and cross-validated with the analysis of secondary data. Table 4 displays the areas of need, challenges, and barriers from the data sources.

Table 4. Identified areas of need, challenges, and barriers

Data Source	Areas of Need	Challenges and Barriers
SLPMC Hospital Advisory Team Input	Access to Care Cancer Child Health Obesity and related chronic disease (specifically for the Hispanic Community) Services for Seniors Transportation	Few community health centers Capacity limits at SLPMC Lack of available cancer diagnostic and treatment services Lack of public transportation
SLPMC Community Stakeholders Input	Access to Care Communication, Education, and Prevention Mental Health Services Obesity Services for Seniors Substance Abuse	Lack of health insurance Inadequate access to nutrition, prevention education Lack of public transportation Limitations on cardiac care for the uninsured Lack of OB-Gyn services No sexual assault exams available in Pasadena
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
HHS Survey Data for the SLPMC community	Access to care Cancer Chronic disease (CVD, Stroke, COPD, Diabetes) Environmental Health	Lack of transportation options Lack of health insurance Low income limitations

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 6. Community health needs triangulation process

Priority Community Health Needs Identified for SLPMC

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

1. **Access to Care**—there is a shortage of primary care physicians, lack of public transportation, and high rates of uninsured. This category was identified in the data and in all stakeholder discussion groups.

2. **Obesity and Related Chronic Disease**—this category was selected given the prevalence of diabetes, CVD and the importance placed on this topic by all stakeholders groups. Important issues to consider are obesity prevention, nutrition, food choices and educating the entire family.

3. **Mental Health**—there are limited services for diagnosis, treatment, care and long-term care of mental health and substance abuse. The need to address the mental health for children was particularly emphasized.

4. **Communication of Community Resources**—there is limited communication among stakeholder groups. Individuals and groups working on behalf of the community appear to work independently and not benefit from existing resources and information.

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 SLPMC community are below:

- ***Active and Engaged Civic Clubs and Social Clubs*** – Civic and social clubs are an important part of communities and could be a great avenue to reach communities to address health priorities.
- ***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 that struggle with asthma.
- ***Churches and the Faith Community*** – Pasadena is known as a "City of Churches" and has an active faith community. The faith-based communities are often involved in all aspects of life, including health and wellness and could be a resource for reaching the community to promote health. The active church and
- ***Community Health Workers*** – Community Health Workers are certified to help bridge the gap between members of a community and healthcare and social service providers. Many Community Health Workers are available in the SLPMC community but are an underutilized

resource. While participants had a high level of interest around Community Health Workers and returned to this topic several times during the discussion, there was a general lack of understanding about how to access Community Health Workers.

- ***Health Fairs*** – Several community organizations such as schools, senior centers, and YMCAs sponsor health fairs that provide great opportunities for community members to meet local healthcare providers.
- ***Healthy Choices Classes*** – The Bridge sponsors classes for family units on making healthy and informed choices.
- ***Healthy Eating Courses for Youth*** – A local community organization sponsors a free summer program for youth that promotes healthy lifestyles through nutrition and exercise.
- ***Pasadena Parks Department*** – Pasadena has an impressive Parks Department that is willing to hold classes on obesity prevention.
- ***Pasadena Independent School District, School Health Advisory Council*** – The School Health Advisory Council for the Pasadena ISD is responsible for 54,000 children and provides a framework for collaboration among community health and social service organizations.
- ***Meals on Wheels*** – The Salvation Army sponsors a Meal on Wheels program that provides nutritional meals to seniors in the community.
- ***Recreational Opportunities*** – The YMCA and Madison Jobe Senior Center provide much-needed recreational and social opportunities for the community and for seniors.
- ***Television*** – Participants noted that television is an excellent way to reach the Hispanic population and the community at large with health-related public service announcements.
- ***United Way*** – The United Way is a great resource 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.

Community Health Needs Assessment Summary

The Community Health Needs Assessment for St. Luke's Patients Medical Center spanned from April through September, 2013. A CHNA kickoff meeting was held on April 24 to inform hospital leadership of the new IRS 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 SLPMC.

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 health care 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 SLPMC are:

1. **Access to Care**—there is a shortage of primary care physicians, lack of public transportation, and high rates of uninsured.

2. **Obesity and Related Chronic Disease** —this category was selected given the prevalence of diabetes, CVD and the importance placed on this topic by both hospital and community stakeholders. Important issues to consider are obesity prevention, nutrition, food choices and educating the entire family.
3. **Mental Health** —there are limited services for diagnosis, treatment, care and long-term care of mental health and substance abuse. The need to address the mental health for children was particularly emphasized.
4. **Communication of Community Resources** —there is limited communication among stakeholder groups. Individuals and groups working on behalf of the community appear to work independently and not benefit from existing resources and information.

From August 29- September 20, the hospital advisory team reviewed the CHNA and developed the SLPMC Implementation Strategy. The timeframe included in the Implementation Strategy are 2013-2015 (Years 1-3). The CHNA and Implementation Strategy was approved by the SLPMC Board of Managers at the September 26, 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 Patients Medical Center websites.

Implementation Strategy

Introduction

As an integral part of St. Luke's Health System, St. Luke's Patients Medical Center's (SLPMC) mission is to contribute to enhancing community health by delivering superior value in high-quality, cost-effective acute care since 2007. SLPMC, a 61-bed facility located in Pasadena, Texas, offers clinical and diagnostic services, including cardiopulmonary and radiology services, surgical services, occupational health, imaging and laboratory services, sleep services, and an expanded emergency services, with outpatient rehabilitation, wound care and ICU. 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, SLPMC shall be the provider of choice in the Southeast Harris County area. SLPMC 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 SLPMC hospital advisory team, Episcopal Health Charities, and other partners between April 22

and August 29, 2013; the Implementation Strategy was developed by the SLPMC hospital advisory team from August 29- September 20, 2013. The CHNA and Implementation Strategy was submitted for approval to the SLPMC Board of Managers and approved at the board meeting on September 26, 2013. The timeframe included in the Implementation Strategy are 2013-2015 (Years 1-3).

SLPMC is a hospital facility that conducted a CHNA and adopted an Implementation Strategy in 2013 (Year 1). From 2014-2015 (Years 2-3), SLPMC will implement at strategies to meet the health needs identified through that CHNA. SLPMC 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 Patients Medical Center websites.

Overview of the Community Served by SLPMC

The community served by SLPMC is described by the geographic area of SLPMC and the contiguous zip codes determined by 2012 SLPMC hospital discharge data. Located in Harris County, the hospital service area contains both a large urban complex, as well as smaller rural communities. This area is primarily industrial, and petrochemical companies are large employers and influence the local community. 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. SLPMC service area zip codes and service area map are included in Appendix 1.

SLPMC serves an area that is home to a population of over 200,000 working class residents that represent many diverse ethnicities, backgrounds, and needs. Key descriptors of the community served by SLPMC include:

- ***Age***- One-fifth (20.9%) of those living in the SLPMC community are between 25-34 years old, one-fifth (20.5%) between 35-44 years old, and another fifth between 45-54 years old. The 18-24 year old category was the fourth largest group, followed by 55-64 year olds (13.3%) and those aged 65 and over (10.2%).

- ***Race/Ethnicity*** - The majority of the SLPMC community identify as Hispanic (48%) or White non-Hispanics (40%).
- ***Nationality***- Roughly 66% of the SLPMC community was born in the United States, and 25% were born in Mexico.
- ***Poverty***- Approximately 33% of the adults in the SLPMC community live below the federal poverty level.
- ***Health Insurance and Access to Care***- Approximately 37% of adults in the SLPMC community are uninsured.

Development of the Implementation Strategy

The CHNA was conducted collaboratively with the SLPMC hospital advisory team, Episcopal Health Charities, and other partners between April 22 and August 29, 2013; the Implementation Strategy was developed by the SLPMC hospital advisory team from August 29-September 20, 2013. The SLPMC hospital team consists of executive leadership staff including the Assistant Vice President, Chief Finance Officer, Chief Nursing Officer and Director of Marketing. 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: SLPMC Hospital Advisory Team, SLPMC Community Focus Group Discussion, Public Health Professionals Focus Group Discussion and Health of Houston Survey Data for the SLPMC 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 4). 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 6).

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

1. **Access to Care**—there is a shortage of primary care physicians, lack of public transportation, and high rates of uninsured. This category was identified in the data and in all stakeholder discussion groups.
2. **Obesity and Related Chronic Disease**—this category was selected given the prevalence of diabetes, CVD and the importance placed on this topic by all stakeholders groups. Important issues to consider are obesity prevention, nutrition, food choices and educating the entire family.
3. **Mental Health**—there are limited services for diagnosis, treatment, care and long-term care of mental health and substance abuse. The need to address the mental health for children was particularly emphasized.
4. **Communication of Community Resources**—there is limited communication among stakeholder groups. Individuals and groups working on behalf of the community appear to work independently and not benefit from existing resources and information.

Action Plan to Address Priority Community Health Needs

From August 29 to September 20, the SLPMC hospital advisory team discussed the health needs as prioritized by the community in the CHNA and identifed strategies to address those needs. The hospital advisory team carefully reviewed the CHNA and made recommendations based on data from the SLPMC hospital advisory team notes, SLPMC 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 SLPMC 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 Patients Medical Center's Community Health Needs Assessment will be addressed through the following strategies for FY 2013-2015:

***Access to Care*.** Underlying factors identified by secondary data and primary input from the focus groups resulted in the need to improve access to health care. SLPMC will implement the following strategies:

1. Provide safety net care for the low-income, uninsured individuals. SLPMC will continually evaluate financial assistance and self-pay discounts policies and practices to ensure optimal access.
2. Provide resources for available health care services. SLPMC will work in conjunction with community health partners to develop a resource guide for referrals of available health services and resources for the community.
3. Research and build relationships. SLPMC will also research and build relationships with quality long term care facilities throughout the community for patients needing additional care after discharge from SLPMC.

***Obesity and Related Chronic Disease*.** Obesity is a growing concern in not only the community served by SLPMC, but also in Texas and in the United States. SLPMC will implement the following strategies:

1. Improve nutrition and physical activities in schools, faith-based institutions, work sites, and childcare settings. In conjunction with the community based program "Healthy Living Series" at SLPMC, classes will be offered to teach the treatment and prevention of diabetes and how to lower cholesterol and blood pressure to better manage weight.
2. Provide nutrition classes to teach the basic concepts of nutrition including label reading, meal planning, and portion control.
3. Explore opportunities to partner with local grocery stores, convenience stores and restaurants to highlight healthy food options.

4. Provide support to churches to enhance wellness program participation and implementation.
5. Provide education to companies on wellness policies and programs related to physical activity, nutrition, chronic disease and tobacco use.
6. SLPMC will partner with other community organizations already active in the service area community to promote and educate a healthy lifestyle focusing on nutrition, physical activity and weight management.
7. Provide meeting room space at no cost to health and community related groups as measured by collaboration with community groups.

***Mental Health*.** Mental health illnesses and substance abuse are an increasing concern in Texas and in the community served by SLPMC. SLPMC will implement the following strategies:

1. In partnership with other community organizations already active in the service area community, SLPMC will collaborate with existing agencies to promote, expand and develop community awareness programs aimed at identifying the dangers and risk of alcohol and other drug use.
2. SLPMC will continue the relationship with MAT Psych Services. MAT Psych Services is a team of mental health professionals, responding to calls from SLPMC's emergency room when patients present with symptoms of mental illness, such as depression, psychosis, or chemical dependency. They stabilize, evaluate, arrange referrals, and follow-up to maintain patient compliance.
3. SLPMC will continue to access Cenikor, HCA Behavioral Health, Memorial Hermann PARC, and Depelchin for psychiatric resources for our patients.
4. Identify and collaborate with local Behavioral Health Service organizations to promote awareness of mental health issues and treatment, reduce the stigma associated with mental illness and recognition of mental health needs.
5. SLPMC will participate in community-based collaborative efforts to improve access to mental health and substance abuse services as opportunities arise.

Communication of Community Resources. In an effort to inform and support the work of the priority health areas and to respond to recommendations from stakeholder interviews, community engagement has been included as part of our Implementation Strategy. SLPMC will implement the following strategies:

1. Increase awareness of hospital and community programs, services and health education through local media and social media.
2. Continue to offer community education programs that include classes in Heart Saver and Safe Sitter.
3. Provide links on SLPMC's website to local healthy living resources and activities.
4. Increase advertisement for the Healthy Living Series which is a program sponsored by SLPMC and held each month to address community health needs and promote wellness and prevention. Topics have included Breast Cancer Awareness, Diabetic Feet, Heart Health, Men's Health and Memory Loss.
5. Bridge relationships with existing community resources to promote awareness of existing services and increase involvement in healthier communities.
6. Reach out to community stakeholders with our Community Health Needs Assessment and Implementation Strategy.

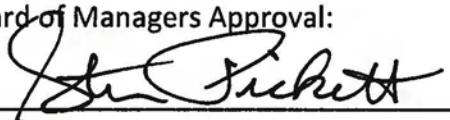
Community Health Needs Not Being Addressed

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 SLPMC must focus on a high priority projects as identified in the CHNA. SLPMC will also make every effort to avoid duplication and encourage collaboration and coordination with other organizations and community groups. As SLPMC assessed unmet health needs and determined its priorities, we also evaluated those issues that are being addressed by others.

Approval

The St. Luke's Patients Medical Center 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 September 26, 2013 Board of Managers meeting.

Board of Managers Approval:



By Name

Chairman

Title

9-26-13

Date

References

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

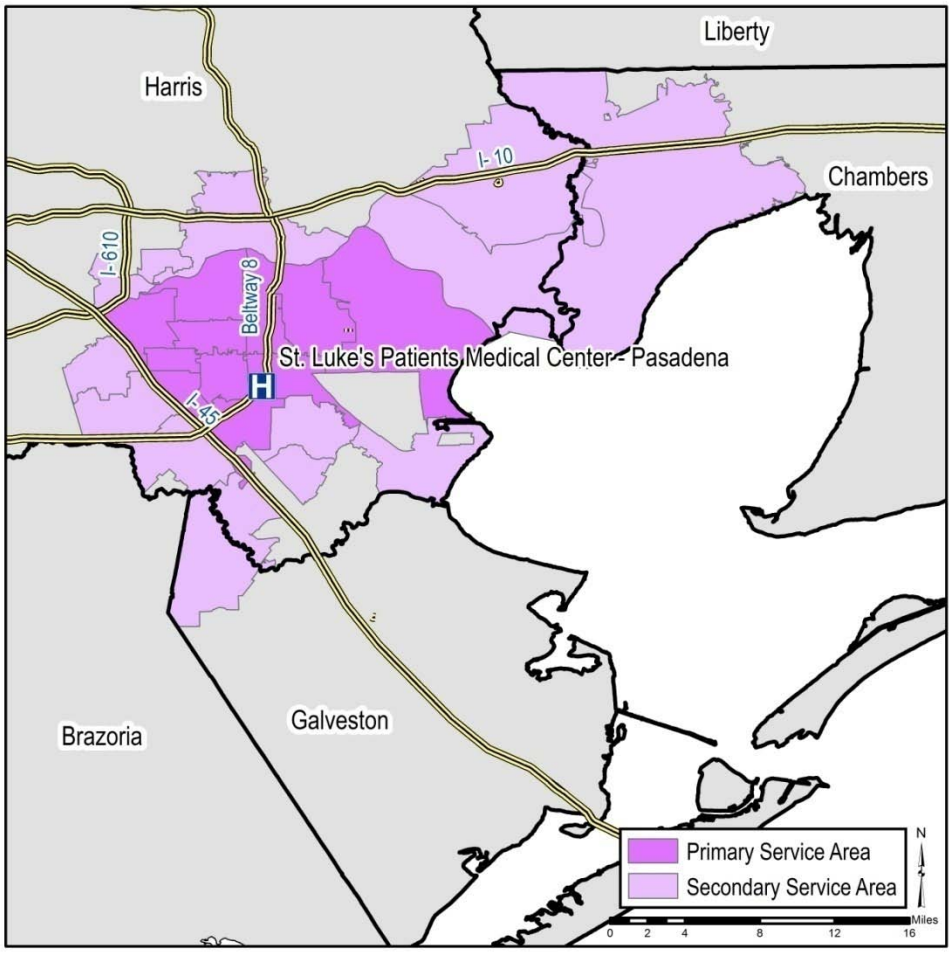
Institute for Health Policy, University of Texas School of Public Health (2011). Health of Houston Survey 2010. Methodology Report. Retrieved online at: https://sph.uth.edu/content/uploads/2011/12/Methodology-Report-HHS-092011_FINAL.pdf

Institute for Health Policy, University of Texas School of Public Health (2012). The Health of Houston Survey 2010. Retrieved online at: https://sph.uth.edu/research/centers/ihp/health-of-houston-survey-2010/

St. Luke's Patients Medical Center 2012 Hospital Discharge Data. Obtained by request from St. Luke's Health System.

Appendix 1 Primary and Secondary Service Area Map and Zip Codes

The community served by the St. Luke's Patients Medical Center consists of adjacent zip codes determined by 2012 hospital discharge data provided by the St. Luke Health System. The Primary Service Area is based on 75% of discharges and the Secondary Service Area reflects an additional 5% of discharges. The service area used for this report is defined by the location for 80% of the hospital discharges in 2012. The Primary Service Area for SLPMC includes the following zip codes: 77017, 77034, 77502, 77503, 77504, 77505, 77506, 77536, 77571, and 77587. The Secondary Service Area for SLPMC includes the following zip codes: 77012, 77015, 77059, 77061, 77062, 77075, 77089, 77520, 77521, 77523, 77546, 77547, and 77586. The below map displays the SLPMC community.



Appendix 2 Demographics of Community served by SLPMC

Table 1 Demographics of Adults[1] in the SLPMC Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Gender														
Male	84,513	45.4%	115,561	51.3%	46,227	49.1%	48.7%	409,704	46.1%	755,123	51.9%	269,266	48.8%	49.5%
Female	101,560	54.6%	109,686	48.7%	47,886	50.9%	51.3%	479,238	53.9%	700,678	48.1%	282,885	51.2%	50.5%
Race/Ethnicity														
White non-Hispanic	27,163	14.6%	127,756	56.7%	47,773	50.8%	40.1%	125,792	14.2%	734,715	50.5%	230,220	41.7%	37.7%
Black non-Hispanic	9,989	5.4%	14,492	6.4%	6,634	7.0%	6.2%	124,923	14.1%	235,326	16.2%	143,253	25.9%	17.4%
Hispanic	137,553	73.9%	67,094	29.8%	35,562	37.8%	47.5%	576,396	64.8%	346,417	23.8%	143,001	25.9%	36.8%
Asian non-Hispanic	5,559	3.0%	8,622	3.8%	1,865	2.0%	3.2%	36,265	4.1%	87,120	6.0%	19,343	3.5%	4.9%
Other non-Hispanic	5,810	3.1%	7,283	3.2%	2,279	2.4%	3.0%	25,566	2.9%	52,224	3.6%	16,334	3.0%	3.2%
Age														
18-24	38,183	20.5%	27,469	12.2%	20,574	21.9%	17.1%	148,069	16.7%	146,425	10.1%	79,280	14.4%	12.9%
25-34	55,516	29.8%	43,502	19.3%	6,378	6.8%	20.9%	251,659	28.3%	331,842	22.8%	33,940	6.1%	21.3%
35-44	44,363	23.8%	53,252	23.6%	5,987	6.4%	20.5%	247,050	27.8%	334,849	23.0%	48,563	8.8%	21.8%
45-54	29,687	16.0%	57,927	25.7%	4,269	4.5%	18.2%	154,334	17.4%	378,158	26.0%	47,001	8.5%	20.0%
55-64	17,998	9.7%	40,899	18.2%	7,958	8.5%	13.2%	84,014	9.5%	243,424	16.7%	60,894	11.0%	13.4%
65 or older	326	0.2%	2,197	1.0%	48,947	52.0%	10.2%	3,817	0.4%	21,103	1.4%	282,474	51.2%	10.6%
Marital Status														
Married	99,481	53.5%	153,969	68.4%	38,930	41.4%	57.8%	446,703	50.3%	938,312	64.5%	219,338	39.7%	55.4%
Living with Partner	18,863	10.1%	9,310	4.1%	7,744	8.2%	7.1%	112,534	12.7%	76,100	5.2%	26,514	4.8%	7.4%

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Divorced	13,607	7.3%	13,362	5.9%	7,439	7.9%	6.8%	63,063	7.1%	116,231	8.0%	63,653	11.5%	8.4%
Widowed	2,027	1.1%	4,886	2.2%	12,142	12.9%	3.8%	15,098	1.7%	22,345	1.5%	93,304	16.9%	4.5%
Separated	6,437	3.5%	2,199	1.0%	3,370	3.6%	2.4%	40,013	4.5%	37,078	2.5%	21,245	3.8%	3.4%
Never Married	45,659	24.5%	41,521	18.4%	24,488	26.0%	22.1%	211,533	23.8%	265,735	18.3%	128,096	23.2%	20.9%
Education														
No Formal Education	808	0.4%	2,523	1.1%	435	0.5%	0.7%	9,391	1.1%	2,523	0.2%	5,283	1.0%	0.6%
Grades- 1-8 (Elementary)	36,064	19.4%	7,711	3.4%	4,323	4.6%	9.5%	155,324	17.5%	47,446	3.3%	41,977	7.6%	8.4%
Grades 9-11 (Some high School)	43,008	23.1%	14,874	6.6%	31,917	23.3%	15.8%	180,904	20.4%	73,671	5.1%	95,927	17.4%	12.1%
Grades 12 or GED (HS Grad)	68,031	36.6%	68,577	30.4%	26,198	27.8%	32.2%	305,668	34.4%	339,485	23.3%	171,893	31.1%	28.2%
College 1-3 years (Some College)	31,227	16.8%	89,621	39.8%	31,813	33.8%	30.2%	182,240	20.5%	485,123	33.3%	159,859	29.0%	28.6%
College ≥4 years (College Grad.)	5,657	3.0%	27,974	12.4%	5,261	5.6%	7.7%	40,655	4.6%	285,940	19.6%	44,213	8.0%	12.8%
Post Bachelor (Master, Doctorate)	1,278	0.7%	13,968	6.2%	4,165	4.4%	3.8	14,762	1.7%	221,614	15.2%	33,001	6.0%	9.3%
Country of Birth														
US or Territories	67,244	36.1%	177,949	79.0%	76,644	81.4%	63.7%	367,838	41.4%	1,106,428	76.0%	451,524	81.8%	66.5%
Mexico	92,502	49.7%	22,885	10.2%	13,028	13.8%	25.4%	357,880	40.3%	114,845	7.9%	43,291	7.8%	17.8%
Vietnam	2,134	1.1%	4,287	1.9%	1,455	1.5%	1.6%	17,543	2.0%	27,700	1.9%	7,615	1.4%	1.8%
China / Taiwan / Hong Kong	0	0.0%	803	0.4%	71	0.1%	0.2%	2,690	0.3%	12,511	0.9%	1,164	0.2%	0.6%
El Salvador	8,030	4.3%	1,284	0.6%	435	0.5%	1.9%	45,529	5.1%	25,592	1.8%	4,726	0.9%	2.6%

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Other	13,431	7.2%	12,537	5.6%	2,160	2.3%	5.6%	90,252	10.2%	149,421	10.3%	34,289	6.2%	9.5%
Dk/Ref	2,732	1.5%	5,502	2.4%	320	0.3%	1.7%	7,211	0.8%	19,303	1.3%	9,542	1.7%	1.2%
Language Spoken at Home														
English only	49,385	26.5%	153,593	68.2%	59,382	63.1%	51.9%	308,040	34.7%	1,019,842	70.1%	392,912	71.2%	59.4%
Spanish only	75,946	40.8%	17,224	7.6%	2,799	3.0%	19.0%	289,688	32.6%	90,693	6.2%	46,541	8.4%	14.7%
Vietnamese only	1,818	1.0%	2,989	1.3%	1,081	1.1%	1.2%	14,359	1.6%	14,340	1.0%	5,255	1.0%	1.2%
Chinese only	0	0.0%	0	0.0%	35	<0.1%	<0.1%	2,582	0.3%	9,546	0.7%	597	0.1%	0.4%
Other or multiple languages	55,361	29.8%	49,368	21.9%	30,496	32.4%	26.8%	265,898	29.9%	312,548	21.5%	97,259	17.6%	23.3%
DK/Refused	3,564	1.9%	2,074	0.9%	320	0.3%	1.2%	8,375	0.9%	8,831	0.6%	9,587	1.7%	0.9%
US Citizen[5]														
Yes	31,487	27.1%	20,944	50.1%	12,509	72.9%	37.1%	125,932	24.5%	167,396	50.7%	58,705	64.5%	37.6%
No	80,161	69.0%	20,775	49.7%	4,478	26.1%	60.2%	345,474	67.2%	119,912	36.3%	25,625	28.1%	52.5%
Application Pending	0	0.0%	23	0.1%	0	0.0%	<.01%	7,246	1.4%	7,785	36.3%	0	0.0%	1.6%
Don't Know	208	0.2%	0	0.0%	0	0.0%	0.1%	4,197	0.8%	582	0.2%	617	0.7%	0.6%
Refused	4,242	3.7%	54	0.1%	163	1.0%	2.5%	31,044	6.0%	34,395	10.4%	6,139	6.7%	7.7%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Not Insured" who are Male in the SLPMC community, we first look at the column "Not Insured" under SLPMC community and then go down to the row "Male" under Gender. Here we find that of those "Not Insured" in the SLPMC community, 45.4% are Male.

[5] This question was asked to people who were not born in the United States.

Table 2 Demographics of Adults[1] in the St. Luke's Patient Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Gender														
Male	63,829	38.0%	56,981	45.6%	125,491	59.0%	48.7%	367,659	40.3%	305,793	48.1%	760,732	56.4%	49.5%
Female	104,022	62.0%	67,870	54.4%	87,240	41.0%	51.3%	544,693	59.7%	330,188	51.9%	587,921	43.6%	50.5%
Race/Ethnicity														
White non-Hispanic	31,938	19.0%	40,619	32.5%	130,136	61.2%	40.1%	137,238	15.0%	189,524	29.8%	763,965	56.6%	37.7%
Black non-Hispanic	13,245	7.9%	3,394	2.7%	14,476	6.8%	6.2%	194,338	21.3%	106,240	16.7%	202,923	15.0%	17.4%
Hispanic	113,452	67.6%	69,656	55.8%	57,101	26.8%	47.5%	530,282	58.1%	270,681	42.6%	264,850	19.6%	36.8%
Asian non-Hispanic	5,891	3.5%	5,417	4.3%	4,738	2.2%	3.2%	31,031	3.4%	34,147	5.4%	77,551	5.8%	4.9%
Other non-Hispanic	3,327	2.0%	5,765	4.6%	6,281	3.0%	3.0%	19,371	2.1%	35,389	5.6%	39,364	2.9%	3.2%
Age														
18-24	31,774	18.9%	15,452	12.4%	39,001	18.3%	17.1%	157,140	17.2%	98,544	15.5%	118,090	8.8%	12.9%
25-34	37,458	22.3%	33,773	27.1%	34,166	16.1%	20.9%	195,353	21.4%	123,300	19.4%	298,788	22.2%	21.3%
35-44	43,124	25.7%	24,950	20.0%	35,527	16.7%	20.5%	219,757	24.1%	139,050	21.9%	271,655	20.1%	21.8%
45-54	22,245	13.3%	23,626	18.9%	46,012	21.6%	18.2%	148,245	16.3%	128,637	20.2%	302,610	22.4%	20.0%
55-64	21,574	12.9%	13,277	10.6%	32,004	15.0%	13.2%	105,652	11.6%	78,490	12.3%	204,189	15.1%	13.4%
65 or older	11,676	7.0%	13,774	11.0%	26,021	12.2%	10.2%	86,114	9.4%	67,960	10.7%	153,321	11.4%	10.6%
Marital Status														
Married	89,642	53.4%	71,289	57.1%	131,449	61.8%	57.8%	408,851	44.8%	344,985	54.2%	850,517	63.1%	55.4%
Living with Partner	18,353	10.9%	4,752	3.8%	12,812	6.0%	7.1%	95,139	10.4%	35,490	5.6%	84,519	6.3%	7.4%
Divorced	8,297	4.9%	13,681	11.0%	12,430	5.8%	6.8%	65,712	7.2%	57,653	9.1%	119,582	8.9%	8.4%

	SLPMC 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	%	%
Widowed	6,854	4.1%	6,585	5.3%	5,616	2.6%	3.8%	47,409	5.2%	41,866	6.6%	41,472	3.1%	4.5%
Separated	6,493	3.9%	2,657	2.1%	2,856	1.3%	2.4%	58,492	6.4%	18,203	2.9%	21,641	1.6%	3.4%
Never Married	38,213	22.8%	25,888	20.7%	47,568	22.4%	22.1%	236,658	25.9%	137,784	21.7%	230,922	17.1%	20.9%
Education														
No Formal Education	2,523	1.5%	1,243	1.0%	0	0.0%	0.7%	13,474	1.5%	3,324	0.5%	398	<0.1%	0.6%
Grades- 1-8 (Elementary)	31,144	18.6%	15,255	12.2%	1,700	0.8%	9.5%	173,163	19.0%	48,352	7.6%	23,232	1.7%	8.4%
Grades 9-11 (Some high School)	43,919	26.2%	23,816	19.1%	12,064	5.7%	15.8%	204,256	22.4%	90,864	14.3%	55,382	4.1%	12.1%
Grades 12 or GED (HS Grad)	54,783	32.6%	44,037	35.3%	63,986	30.1%	32.2%	296,520	32.5%	204,941	32.2%	315,585	23.4%	28.2%
College 1-3 years (Some College)	30,394	18.1%	31,632	25.3%	90,635	42.6%	30.2%	168,179	18.4%	186,031	29.3%	473,011	35.1%	28.6%
College ≥4 years (College Grad.)	4,530	2.7%	7,805	6.3%	26,558	12.5%	7.7%	38,026	4.2%	68,687	10.8%	264,095	19.6%	12.8%
Post Bachelor (Master, Doctorate)	558	0.3%	1,065	0.9%	17,788	8.4%	3.8%	18,643	2.0%	33,782	5.3%	216,951	16.1%	9.3%
Country of Birth														
US or Territories	75,385	44.9%	63,590	50.9%	182,862	86.0%	63.7%	451,546	49.5%	391,809	61.6%	1,082,435	80.3%	66.5%
Mexico	68,713	40.9%	46,495	37.2%	13,207	6.2%	25.4%	302,882	33.2%	142,338	22.4%	70,796	5.2%	17.8%
Vietnam	2,945	1.8%	3,408	2.7%	1,523	0.7%	1.6%	12,125	1.3%	15,585	2.5%	25,148	1.9%	1.8%
China / Taiwan / Hong Kong	0	0.0%	61	<0.1%	813	0.4%	0.2%	4,078	0.4%	3,122	0.5%	9,166	0.7%	0.6%
El Salvador	7,964	4.7%	1,719	1.4%	66	<0.1%	1.9%	47,461	5.2%	14,281	2.2%	14,106	1.0%	2.6%
Other	9,959	5.9%	5,983	4.8%	12,186	5.7%	5.6%	85,196	9.3%	58,178	9.1%	130,586	9.7%	9.5%
Dk/Ref	2,886	1.7%	3,594	2.9%	2,073	1.0%	1.7%	8,973	1.0%	10,668	1.7%	16,416	1.2%	1.2%

	SLPMC 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	%	%
Language Spoken at Home														
English only	60,962	36.3%	54,196	43.4%	147,201	69.2%	51.9%	401,709	44.0%	331,837	52.2%	987,248	73.2%	59.4%
Spanish only	55,997	33.4%	34,477	27.6%	5,495	2.6%	19.0%	274,454	30.1%	99,634	15.7%	52,835	3.9%	14.7%
Vietnamese only	2,810	1.7%	2,068	1.7%	1,010	0.5%	1.2%	9,900	1.1%	7,868	1.2%	16,186	1.2%	1.2%
Chinese only	0	0.0%	0	0.0%	35	<0.1%	0.0%	2,964	0.3%	4,355	0.7%	5,406	0.4%	0.4%
Other or multiple languages	45,538	27.1%	33,304	26.7%	56,383	26.5%	26.8%	212,241	23.3%	185,894	29.2%	277,570	20.6%	23.3%
DK/Refused	2,544	1.5%	807	0.6%	2,607	1.2%	1.2%	10,993	1.2%	6,393	1.0%	9,407	0.7%	0.9%
US Citizen[5]														
Yes	21,103	23.6%	28,573	49.5%	15,263	54.9%	37.1%	117,318	26.0%	94,271	40.4%	140,444	56.2%	37.6%
No	67,048	74.8%	27,052	46.9%	11,313	40.7%	60.2%	299,029	66.2%	120,806	51.7%	71,176	28.5%	52.5%
Application Pending	0	0.0%	0	0.0%	23	1.0%	<0.1%	8,045	1.8%	1,127	0.5%	5,859	2.3%	1.6%
Don't Know	0	0.0%	208	0.4%	0	0.0%	0.1%	1,281	0.3%	3,464	1.5%	651	0.3%	0.6%
Refused	1,429	1.6%	1,833	3.2%	1,196	4.3%	2.5%	26,070	5.8%	13,836	5.9%	31,671	12.7%	7.7%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] "In Poverty" is defined as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who are Male in the SLPMC community, we first look at the column "In Poverty" under SLPMC community and then go down to the row "Male" under Gender. Here we find that of those "In Poverty" in the SLPMC community, 38% are Male.

[5] This question was asked to people who were not born in the United States.

Appendix 3 Participants Involved in the CHNA

Name	Title	Organization	Role
SLPMC Hospital Advisory Team			
Paul Hanson	Assistant Vice President, Chief Finance Officer	St. Luke's Patients Medical Center	Hospital Advisory Team
Dori Upton	Assistant Vice President, Chief Nursing Officer	St. Luke's Patients Medical Center	Hospital Advisory Team
Cheryl Willis	Director of Marketing	St. Luke's Patients Medical Center	Hospital Advisory Team
Danielle L. Dees	Executive Assistant	St. Luke's Patients Medical Center	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, 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	University of Texas School of Public Health	CHNA Project Management
Pamela M. Diamond, PhD	Associate Professor	University of Texas School of Public Health	CHNA Project Management
John Atkinson, DrPH	Faculty Associate	University of Texas School of Public Health	Quantitative Data Analysis
Andria Rusk, MScGH	Graduate Assistant	University of Texas School of Public Health	Qualitative Data Analysis
Erica Cantu, MPH	Graduate Assistant	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			
Latrice Babin, PhD	Environmental Toxicologist	Harris County Pollution Control Services Department	Provided Community Input
June Hanke	Strategic Analyst/Planner	Harris Health System	Provided Community Input
Dr. Nicole Hare-Everline, CHES	City of Houston Wellness/EAP Director	City of Houston	Provided Community Input
Robert Hines	Epidemiologist	Houston Department of Health and Human Services	Provided Community Input
Haley Jackson, MPH	Public Health Team Lead	Texas Department of State Health Services	Provided Community Input

Lisa Mayes	Executive Director	Harris County Healthcare Alliance	Provided Community Input
Bakeyah Nelson, PhD	Public Health Analyst	Harris County Public Health and Environmental Services	Provided Community Input
Beverly Nichols PsyD, MS, RN	Senior Staff Analyst	Houston Department of Health and Human Services	Provided Community Input
Kimberly Nicholson	Program Specialist II	Texas Department of State Health Services	Provided Community Input
Ebun Odeneye	Senior Health Educator	City of Houston	Provided Community Input
Yan Shi	Management Analyst III	Houston Department of Health and Human Services	Provided Community Input
Lindsey Wiginton	Epidemiologist	Houston Department of Health and Human Services	Provided Community Input
Angela Balch	Coordinated School Health Specialist	Pasadena Independent School District	Provided Community Input
Tammy De Los Santos	Recreation Manager	Madison Jobe Senior Center	Provided Community Input
Anna Duron	Membership/Healthy Living Director	San Jacinto YMCA	Provided Community Input
Rick Guerrero	Councilperson	Pasadena Hispanic Business Council	Provided Community Input
Becky Kyles	Grants Compliance Manager	The Bridge Over Troubled Waters	Provided Community Input
Deborah Moseley	Executive Director	The Bridge Over Troubled Waters	Provided Community Input
Ana Perez	Social Worker	Pasadena Independent School District	Provided Community Input
Donaji Stelzig	Clinic Health Educator	Harris Health System	Provided Community Input
John Sweitzer	Chief Executive Officer	Pasadena Health Center	Provided Community Input
Pam Tevis	Instructional Specialist Health/PE	Pasadena Independent School District	Provided Community Input
Diane Thompson	Chief Information Officer	Pasadena Health Center	Provided Community Input
Sherry Trainer	President/CEO	Pasadena Chamber of Commerce	Provided Community Input

Appendix 4 2012 SLPMC 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 SLPMC and was aggregated by the 5 digit ICD-9 diagnosis code and broken down by inpatient and outpatient discharges. No demographic or personally identifying information was provided; therefore, the below information represents the types of health problems experienced by people who made use of the SLPMC 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 Patients Medical Center, 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	**205**	**7.4%**	**85**	**0.8%**	**290**	**2.1%**
2. Neoplasms 140–239	**52**	**1.9%**	**10**	**0.1%**	**62**	**0.4%**
3. Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders 240–279	**172**	**6.6%**	**149**	**1.3%**	**321**	**2.3%**
4. Diseases of the Blood and Blood-Forming Organs 280–289	**54**	**2.0%**	**25**	**0.2%**	**79**	**0.6%**
5. Mental Disorders 290–319	**13**	**0.5%**	**102**	**0.9%**	**115**	**0.8%**
• *290-294 organic psychotic conditions*	6	46.2%	5	4.9%	11	9.6%
• *295-299 other psychoses*	1	7.7%	10	9.8%	11	9.6%
• *300-316 neurotic disorders, personality disorders, and other nonpsychotic mental disorders*	6	46.2%	87	85.3%	93	80.9%
• *317-319 intellectual disabilities*	0	0%	0.0	0.0%	0	0.0%
6. Diseases of the Nervous System and Sense Organs 320–389	**34**	**1.2%**	**449**	**4.0%**	**483**	**3.5%**
7. Diseases of the Circulatory System 390–459	**559**	**20.3%**	**336**	**3.0%**	**895**	**6.5%**
• *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*	48	8.6%	165	49.1%	213	23.8%

[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 205 inpatient discharges in this category which represented 7.4% of all inpatient discharges. Similarly, there were 85 outpatient discharges which accounted for 0.8% of all outpatient discharges. In total, there were 290 discharges for this category, and these cases accounted for 2.1% of total discharges. For categories such as #5, Mental Disorders, the bolded numbers are to be interpreted similarly. For example, 13 inpatients were diagnosed with a mental disorder, and these represented 0.5% of inpatient discharges. The additional rows under this heading represent sub-diagnostic categories. For example, six of the 13 inpatient discharges were for "organic psychotic conditions." As indicated, these cases accounted for 46.2% of the inpatient discharges for a mental disorder.

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
• *410-414 ischemic heart disease*	101	18.1%	34	10.1%	135	15.1%
• *415-417 diseases of pulmonary circulation*	25	4.5%	0	0.0%	25	2.8%
• *420-429 other forms of heart disease*	228	40.8%	57	17%	285	31.8%
• *430-438 cerebrovascular disease*	85	15.2%	34	10.1%	119	13.3%
• *440-449 diseases of arteries, arterioles, and capillaries*	18	3.2%	5	1.5%	23	2.6%
• *451-459 diseases of veins and lymphatics, and other diseases of circulatory system*	54	9.7%	41	12.2%	95%	10.6%
8. Diseases of the Respiratory System 460-519	**441**	**16.0%**	**398**	**3.6%**	**839**	**6.1%**
• *460-466 acute respiratory infections*	7	1.6%	179	45.0%	186	22.2%
• *470-478 other diseases of upper respiratory tract*	1	0.2%	28	7.0%	29	3.5%
• *480-488 pneumonia and influenza*	162	36.7%	43	10.8%	205	24.4%
• *490-496 chronic obstructive pulmonary disease and allied conditions*	173	39.2%	136	34.2%	309	36.8%
• *500-508 pneumoconioses and other lung diseases due to external agents*	53	12.0%	2	0.2%	55	6.6%
• *510-519 other diseases of respiratory system*	45	10.2%	10	2.5%	55	6.6%
9. Diseases of the Digestive System 520-579	**595**	**21.6%**	**369**	**3.3%**	**964**	**7.0%**
• *520-529 diseases of oral cavity, salivary glands, and jaws*	1	0.2%	69	18.7%	70	7.3%
• *530-539 diseases of esophagus, stomach, and duodenum*	71	11.9%	52	14.1%	123	12.8%
• *540-543 appendicitis*	51	8.6%	31	8.4%	82	8.5%
• *550-553 hernia of abdominal cavity*	21	3.5%	8	2.2%	29	3.0%
• *555-558 noninfective enteritis and colitis*	74	12.4%	54	14.6%	128	13.3%
• *560-569 other diseases of intestines and peritoneum*	170	28.6%	95	25.7%	265	27.5%
• *570-579 other diseases of digestive system*	207	34.8%	60	16.3%	267	27.7%
10. Diseases of the Genitourinary System 580-629	**184**	**6.7%**	**354**	**3.2%**	**538**	**3.9%**
• *995*	0	0.0%	0	0.0%	0	0.0%
• *580-589 nephritis, nephrotic syndrome, and nephrosis*	44	23.9%	4	1.1%	48	8.9%
• *590-599 other diseases of urinary system*	110	59.8%	204	57.6%	314	58.4%
• *600-608 diseases of male genital organs*	17	9.2%	39	11.0%	56	10.4%
• *610-612 disorders of breast*	0	0.0%	8	2.3%	8	1.5%
• *614-616 inflammatory disease of female pelvic organs*	2	1.1%	11	3.1%	13	2.4%
• *617-629 other disorders of female genital tract*	11	6.0%	88	24.9%	99	18.4%
11. Complications of Pregnancy, Childbirth, and the Puerperium 630–677	**2**	**0.1%**	**130**	**1.2%**	**132**	**1.0%**
12. Diseases of the Skin and Subcutaneous Tissue 680–709	**119**	**4.3%**	**349**	**3.1%**	**458**	**3.3%**

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
13. Diseases of the Musculoskeletal System and Connective Tissue 710-739	**50**	**1.8%**	**940**	**8.5%**	**990**	**7.1%**
• *710-719 arthopathies and related disorders*	2	4.0%	258	27.4%	260	26.3%
• *720-724 dorsopathies*	22	44.0%	447	47.6%	469	47.4%
• *725-729 rheumatism, excluding the back*	19	38.0%	231	24.6%	250	25.3%
• *730-739 osteopahies, chondropathies, and acquired musculoskeletal deformities*	7	14.0%	4	0.4%	11	1.1%
14. Congenital Anomalies 740-759	**0**	**0.0%**	**1**	**< 0.1%**	**1**	**< 0.1%**
15. Certain Conditions Originating in the Perinatal Period 760–779	**0**	**0.0%**	**2**	**< 0.1%**	**2**	**< 0.1%**
16. Symptoms, Signs, and Ill-Defined Conditions 780-799	**95**	**3.4%**	**4721**	**42.5%**	**4816**	**34.7%**
• *780-789 symptoms*	90	94.7%	4710	99.8%	4800	99.7%
• *790-796 nonspecific abnormal findings*	5	5.3%	8	0.2%	13	0.3%
• *797-799 ill-defined and unknown causes of morbidity and mortality*	0	0.0%	3	0.1%	3	0.1%
17. Injury and Poisoning 800-899	**182**	**6.6%**	**2570**	**23.2%**	**2752**	**19.9%**
• *800-804 fracture of skull*	0	0.0%	6	2.0%	6	0.2%
• *805-809 fracture of spine and trunk*	17	9.3%	18	0.7%	35	1.3%
• *810-819 fracture of upper limb*	3	1.6%	132	5.1%	135	4.9%
• *820-829 fracture of lower limb*	64	35.2%	57	2.2%	121	4.4%
• *830-839 dislocation*	0	0.0%	26	1.0%	26	0.9%
• *840-848 sprains and strains of joints and adjacent muscles*	1	0.5%	368	14.3%	369	13.4%
• *850-854 intracranial injury, excluding those with skull fracture*	5	2.7%	47	1.8%	52	1.9%
• *860-869 internal injury of chest, abdomen, and pelvis*	3	1.6%	1	0.0%	4	0.1%
• *870-879 open wound of head, neck, and trunk*	1	0.5%	152	5.9%	153	5.6%
• *880-887 open wound of upper limb*	2	1.1%	178	6.9%	180	6.5%
• *890-897 open wound of lower limb*	2	1.1%	74	2.9%	76	2.8%
• *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*	1	0.5%	81	3.2%	82	3.0%
• *920-924 contusion with intact skin surface*	4	2.2%	504	19.6%	508	18.5%
• *925-929 crushing injury*	0	0.0%	4	0.2%	4	0.1%
• *930-939 effects of foreign body entering through orifice*	1	0.5%	37	1.4%	38	1.4%
• *940-949 burns*	0	0.0%	36	1.4%	36	1.3%
• *950-957 injury to nerves and spinal cord*	0	0.0%	0	0.0%	0	0.0%
• *958-959 certain traumatic complications and unspecified injuries*	0	0.0%	648	25.2%	648	23.5%

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
• *960-979 poisoning by drugs, medicinals and biological substances*	10	5.5%	28	1.1%	38	1.4%
• *980-989 toxic effects of substances chiefly nonmedical as to source*	1	0.5%	27	1.1%	28	1.0%
• *990-995 other and unspecified effects of external causes*	9	4.9%	75	2.9%	84	3.1%
• *996-999 complications of surgical and medical care, not elsewhere classified*	58	31.9%	71	2.8%	129	4.7%
18. Sickle-cell Disease 282.60-282.69	**2**	**0.7%**	**1**	**.01%**	**3**	**0.2%**
• *282.60 sickle-cell disease unspecified*	0	0.0%	0	0.0%	0	0.0%
• *282.61 Hb-SS disease without crisis*	2	100%	1	100%	3	100%
• *282.62 Hb-SS disease with crisis*	0	0.0%	0	0.0%	0	0.0%
• *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%
• *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)	**2**	**0.7%**	**111**	**1.0%**	**113**	**0.8%**
E Codes Supplementary Classification of External Causes of Injury and Poisoning (e800-e999)	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**

Appendix 5 Health Status Indicators

Table 1 Health Status of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Reported Health Status														
Excellent	23,330	12.5%	22,606	10.0%	6,526	6.9%	10.4%	92,828	10.4%	232,222	16.0%	54,749	9.9%	13.1%
Very Good	41,094	22.1%	91,521	40.6%	24,503	26.0%	31.1%	227,111	25.5%	538,929	37.0%	127,486	23.1%	30.8%
Good	73,809	39.7%	83,113	36.9%	28,676	30.5%	36.7%	332,533	37.4%	510,794	35.1%	188,846	34.2%	35.6%
Fair	34,048	18.3%	24,162	10.7%	28,945	30.8%	17.2%	187,845	21.1%	150,016	10.3%	126,619	22.9%	16.0%
Poor	13,793	7.4%	3,846	1.7%	5,463	5.8%	4.6%	48,627	5.5%	23,839	1.6%	54,452	9.9%	4.4%
Ever diagnosed with diabetes														
Yes	15,565	8.4%	18,770	8.3%	16,485	17.5%	10.1%	74,642	8.4%	133,888	9.2%	112,693	20.4%	11.1%
Borderline pre-diabetes	0	0.0%	6,234	2.8%	2,229	2.4%	1.7%	7,556	0.8%	43,812	3.0%	22,782	4.1%	2.6%
Yes, during pregnancy	557	0.3%	357	0.2%	0	0.0%	0.2%	11,162	1.3%	4,057	0.3%	2,377	0.4%	0.6%
Ever diagnosed with cancer	5,139	2.8%	6,513	2.9%	11,668	12.4%	4.6%	29,345	3.3%	53,535	3.7%	93,764	17.0%	6.1%
Ever diagnosed with high blood pressure														
Yes	30,222	16.2%	64,063	28.4%	49,632	52.7%	28.5%	179,512	20.2%	408,945	28.1%	282,139	51.1%	30.1%
Yes, but only during pregnancy	7,874	4.2%	3,154	1.4%	3,066	3.3%	2.8%	19,611	2.2%	21,278	1.5%	12,404	2.2%	1.8%
Ever diagnosed with coronary heart disease	2,036	1.1%	9,359	4.2%	8,741	9.3%	4.0%	14,482	1.6%	39,677	2.7%	60,742	11.0%	4.0%
Ever diagnosed with a heart attack	1,625	0.9%	5,185	2.3%	10,423	11.1%	3.4%	9,859	1.1%	31,926	2.2%	51,498	9.3%	3.2%
Ever diagnosed with a stroke	1,047	0.6%	3,199	1.4%	9,099	9.7%	2.6%	9,727	1.1%	23,109	1.6%	46,676	8.5%	2.7%
Ever diagnosed with asthma	7,445	4.0%	31,109	13,8%	14,703	15.6%	10.5%	48,570	5.5%	139,747	9.6%	72,353	13.1%	9.0%
Mental Health Need Last 12 Months	25,947	17.1%	18,804	11.7%	6,623	9.6%	13.5%	122,194	16.7%	182,732	15.9%	69,022	17.4%	16.4%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA [4] The percentages in this table are column percentages. For example, to find the percentage of those "Not Insured" who reported "Excellent" health status in the SLPMC community, we first look at the column "Not Insured" under SLPMC community and then go down to the row "Excellent" under Reported Health Status. Here we find that of those "Not Insured" in the SLPMC community, 12.5% reported having "Excellent" Health Status.

Table 2 Health Status of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Reported Health Status														
Excellent	19,687	11.7%	13,069	10.5%	19,707	9.3%	10.4%	96,356	10.6%	98,156	15.4%	185,287	13.7%	13.1%
Very Good	25,338	15.1%	36,458	29.2%	95,321	44.8%	31.1%	175,844	19.3%	201,995	31.8%	515,687	38.2%	30.8%
Good	73,049	43.5%	42,298	33.9%	70,251	33.0%	36.7%	365,662	40.1%	208,968	32.9%	457,542	33.9%	35.6%
Fair	34,693	20.7%	28,748	23.0%	23,714	11.1%	17.2%	206,363	22.6%	103,442	16.3%	154,676	11.5%	16.0%
Poor	15,086	9.0%	4,227	3.4%	3,739	1.8%	4.6%	68,036	7.5%	23,420	3.7%	35,462	2.6%	4.4%
Ever diagnosed with diabetes														
Yes	19,195	11.4%	12,347	9.9%	19,277	9.1%	10.1%	109,639	12.0%	68,081	10.7%	143,503	106.0%	11.1%
Borderline pre-diabetes	1,901	1.1%	1,371	1.1%	5,192	2.4%	1.7%	19,061	2.1%	11,669	1.8%	43,421	3.2%	2.6%
Yes, during pregnancy	0	0.0%	602	0.5%	312	0.1%	0.2%	10,410	1.1%	3,856	0.6%	3,330	0.2%	0.6%
Ever diagnosed with cancer	9,658	5.8%	3,309	2.7%	10,353	4.9%	4.6%	62,141	6.8%	26,103	4.1%	88,401	6.6%	6.1%
Ever diagnosed with high blood pressure														
Yes	41,940	25.0%	31,424	25.2%	70,553	33.2%	28.5%	254,095	27.9%	183,761	28.9%	432,740	32.1%	30.1%
Yes, but only during pregnancy	10,681	6.4%	2,687	2.2%	726	0.3%	2.8%	23,578	2.6%	12,494	2.0%	17,221	1.3%	1.8%
Ever diagnosed with coronary heart disease	4,706	2.8%	3,930	3.1%	11,501	5.4%	4.0%	37,702	4.1%	17,927	2.8%	59,272	4.4%	4.0%
Ever diagnosed with a heart attack	6,036	3.6%	5,498	4.4%	5,699	2.7%	3.4%	34,116	3.7%	19,470	3.1%	39,698	2.9%	3.2%
Ever diagnosed with a stroke	4,328	2.6%	3,950	3.2%	5,067	2.4%	2.6%	36,504	4.0%	17,047	2.7%	25,961	1.9%	2.7%
Ever diagnosed with asthma	10,818	6.4%	12,440	10.0%	29,998	14.1%	10.5%	67,281	7.4%	60,641	9.5%	132,748	9.8%	9.0%
Mental Health Need Last 12 Months	19,983	15.4%	6,124	6.9%	25,267	15.5%	13.5%	135,271	18.9%	58,195	11.7%	180,482	16.9%	16.4%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who reported "Excellent" health status in the SLPMC community, we first look at the column "In Poverty" under SLPMC community and then go down to the row "Excellent" under Reported Health Status. Here we find that of those "In Poverty" in the SLPMC community, 11.7% reported having "Excellent" Health Status.

Appendix 6 Health Access Indicators

Table 1 Health Access of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Poverty Status[5]														
In poverty	99,982	53.7%	30,820	13.7%	37,050	39.4%	33.2%	486,272	54.7%	185,428	12.7%	240,561	43.6%	31.5%
Near poverty	59,742	32.1%	39,756	17.6%	25,354	26.9%	24.7%	239,668	27.0%	275,779	18.9%	120,534	21.8%	22.0%
Not in poverty	26,350	14.2%	154,672	68.7%	31,709	33.7%	42.1%	163,003	18.3%	994,594	68.3%	191,056	34.6%	46.6%
Personal Doctor or Health Care Provider														
Yes, only one	65,912	35.4%	142,406	63.2%	56,099	59.6%	52.3%	302,385	34.0%	939,954	64.5%	344,226	62.3%	54.7%
More than one	18,956	10.2%	28,836	12.8%	12,862	13.7%	12.0%	72,347	8.1%	252,398	17.3%	92,395	16.7%	14.4%
No, not anyone	101,206	54.4%	54,006	24.0%	25,152	26.7%	35.7%	514,211	57.8%	264,350	18.2%	115,530	20.9%	30.9%
Type of Health Care Place														
Doctor's office	60,858	32.7%	167,609	74.4%	60,057	63.8%	57.1%	210,334	23.7%	1,021,207	70.1%	276,096	50.0%	52.0%
Clinic/health center	67,655	36.4%	32,152	14.3%	22,956	24.4%	24.3%	353,806	39.8%	274,791	18.9%	188,568	34.2%	28.2%
Emergency room	6,943	3.7%	1,652	0.7%	447	0.5%	1.8%	56,923	6.4%	16,183	1.1%	18,408	3.3%	3.2%
More than one place	20	<0.1%	465	0.2%	866	0.9%	0.3%	1,919	0.2%	10,542	0.7%	11,939	2.2%	0.8%
No one place	43,372	23.3%	17,631	7.8%	9,742	10.4%	14.0%	220,961	24.9%	117,960	8.1%	47,117	8.5%	13.3%
Some other place	0	0.0%	1,816	0.8%	0	0.0%	0.4%	8,107	0.9%	7,996	0.5%	4,055	0.7%	0.7%
DK/Ref	7,225	3.9%	3,921	1.7%	44	<0.1%	2.2%	36,893	4.2%	7,122	0.5%	5,968	1.1%	1.7%
Delayed Seeing Doctor	90,788	48.8%	38,908	17.3%	16,898	18.0	29.0%	413,934	46.6%	205,442	14.1%	82,586	15.0%	24.2%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Not Insured" who are in poverty in the SLPMC community, we first look at the column "Not Insured" under SLPMC community and then go down to the row "In Poverty" under Poverty Status. Here we find that of those "Not Insured" in the SLPMC community, 53.7% are "In Poverty".

[5] We define "In poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

Table 2 Health Access of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Health Insurance[5]														
Not Insured	99,982	59.6%	59,742	47.9%	26,350	12.4%	36.8%	486,272	53.3%	239,668	37.7%	163,003	12.1%	30.7%
Private Insurance	30,820	18.4%	39,756	31.8%	154,672	72.7%	44.6%	185,428	20.3%	275,779	43.4%	994,564	73.7%	50.3%
Medicare/Other Public	37,050	22.1%	25,354	20.3%	31,709	14.9%	18.6%	240,561	26.4%	120,534	19.0%	191,056	14.2%	19.1%
Personal Doctor or Health Care Provider														
Yes, only one	73,920	44.0%	64,094	51.3%	126,402	59.4%	52.3%	428,716	47.0%	347,992	54.7%	808,956	60.0%	54.7%
More than one	16,493	9.8%	11,616	9.3%	32,545	15.3%	12.0%	80,876	8.9%	87,492	13.8%	248,772	18.4%	14.4%
No, not anyone	77,439	46.1%	49,141	39.4%	53,784	25.3%	35.7%	402,669	44.1%	200,497	31.5%	290,925	21.6%	30.9%
Type of Health Care Place														
Doctor's office	69,398	41.3%	66,610	53.4%	152,517	71.7%	57.1%	298,425	32.7%	304,317	47.9%	904,895	67.1%	52.0%
Clinic/health center	47,455	28.3%	41,571	33.3%	33,737	15.9%	24.3%	353,312	38.7%	202,979	31.9%	260,874	19.3%	28.2%
Emergency room	5,140	3.1%	2,253	1.8%	1,650	0.8%	1.8%	60,147	6.6%	14,945	2.3%	16,422	1.2%	3.2%
More than one place	866	0.5%	465	0.4%	20	<0.1%	0.3%	12,446	1.4%	6,831	1.1%	5,123	0.4%	0.8%
No one place	40,888	24.4%	11,068	8.9%	18,788	8.8%	14.0%	158,597	17.4%	87,875	13.8%	139,565	10.3%	13.3%
Some other place	0	0.0%	0	0.0%	1,816	0.9%	0.4%	7,148	0.8%	7,162	1.1%	5,848	0.4%	0.7%
DK/Ref	4,160	2.4%	2,883	2.3%	4,202	2.0%	2.2%	22,187	2.4%	11,871	1.9%	15,925	1.2%	1.7%
Delayed Seeing Doctor	67,600	40.3%	37,702	30.2%	41,291	19.4%	29.0%	321,980	35.3%	183,042	28.8%	196,940	14.6%	24.2%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who are "Not Insured" in the SLPMC community, we first look at the column "In Poverty" under SLPMC community and then go down to the row "Not Insured" under Health Insurance. Here we find that of those "In Poverty" in the SLPMC community, 59.6% are "Not Insured".

[5] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

Appendix 7 Preventive Services Indicators

Table 1 Preventive Services obtained by Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Ever had Mammography[5]	27,024	71.8%	50,948	82.3%	25,243	90.9%	81.1%	140,404	75.3%	351,465	91.1%	139,501	91.5%	87.1%
Ever had a Pap Test[6]	91,125	89.7%	96,281	87.8%	45,906	95.9%	90.0%	417,261	87.1%	646,245	92.2%	250,227	88.5%	89.8%
Ever had Blood Stool Test[7]	13,176	43.1%	31,084	49.1%	19,988	62.1%	51.0%	49,629	37.0%	204,118	53.4%	140,500	65.6%	54.0%
Ever had a Sigmoidoscopy or Colonoscopy[8]	6,481	18.7%	44,077	55.7%	28,422	62.8%	49.6%	49,803	27.5%	294,024	60.5%	193,590	65.2%	55.8%
Ever Tested for HIV[9]														
Yes, within last 12 months	30,587	20.1%	22,723	14.2%	5,558	8.0%	15.4%	162,098	22.2%	229,867	20.0%	59,931	15.1%	19.8%
Yes, but not in the last 12 months	48,084	31.7%	47,839	29.8%	9,980	11.4%	27.7%	225,269	30.8%	413,064	35.9%	80,093	20.2%	31.5%
No, never tested	73,238	48.2%	89,929	56.0%	53,722	77.6%	56.8%	343,550	47.0%	508,172	44.1%	256,946	64.7%	48.6%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "Not Insured" reported ever having had a mammography, we first look at the column "Not Insured" under SLPMC community and then go down to the row "Ever had a Mammography". Here we find that of those "Not Insured" in the SLPMC community, 71.8% reported they have had a mammography.

[5] This question was asked to females between 35 and 74yo.

[6] This question was asked to females 18 and older.

[7] This question was asked to adults 45-75yo. (Not asked in mail survey.)

[8] This question was asked to adults 45-75yo.

[9] This question was asked to adults 18yo and older. (Not asked in mail survey.)

Table 2 Preventive Services obtained by Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Ever had Mammography[5]	33,884	76.3%	23,862	77.9%	45,469	86.9%	81.1%	196,144	82.8%	132,416	82.1%	302,810	92.7%	87.1%
Ever had a Pap Test[6]	96,845	93.1%	58,407	86.1%	78,060	89.5%	90.0%	481,147	88.3%	288,443	87.4%	544,143	92.6%	89.8%
Ever had Blood Stool Test[7]	13,828	40.6%	11,338	40.4%	39,082	61.2%	51.0%	79,579	45.1%	71,294	45.2%	243,373	61.4%	54.0%
Ever had a Sigmoidoscopy or Colonoscopy[8]	15,802	36.1%	16,740	46.1%	46,439	58.7%	49.6%	108,735	43.8%	99,478	47.9%	329,206	64.8%	55.8%
Ever Tested for HIV[9]														
Yes, within last 12 months	26,655	20.5%	11,820	13.3%	20,393	12.5%	15.4%	156,663	21.9%	96,188	19.4%	199,044	18.7%	19.8%
Yes, but not in the last 12 months	46,908	36.1%	17,338	19.5%	41,657	25.6%	27.7%	195,438	27.3%	138,639	27.9%	384,350	36.0%	31.5%
No, never tested	56,457	43.4%	59,788	67.2%	100,644	61.9%	56.8%	364,119	50.8%	261,711	52.7%	482,838	45.3%	48.6%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "In Poverty" reported ever having had a mammography, we first look at the column "In Poverty" under SLPMC community and then go down to the row "Ever had a Mammography". Here we find that of those "In Poverty" in the SLPMC community, 76.3% reported they have had a mammography.

[5] This question was asked to females between 35 and 74yo.

[6] This question was asked to females 18 and older.

[7] This question was asked to adults 45-75yo. (Not asked in mail survey.)

[8] This question was asked to adults 45-75yo.

[9] This question was asked to adults 18yo and older. (Not asked in mail survey.)

Appendix 8 Prenatal Care Indicators

Table 1 Prenatal Care obtained by Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Ever Breastfeed[5]	28,878	91.1%	7,631	95.6%	89	4.0%	87.4%	114,058	83.5%	73,359	85.4%	9,414	50.1%	81.6%
Breastfed for at Least Six Months[5]	13,183	45.7%	4,215	55.2%	89	100.0%	47.8%	60,905	53.4%	35,728	48.7%	1,380	14.7%	49.8%
Reason for No Prenatal Care[6]														
Cost or no insurance	1,456	14.3%	0	0.0%	0	0.0%	11.2%	14,896	39.3%	1,970	17.1%	815	15.8%	32.4%
No Medicaid card	0	0.0%	0	0.0%	605	28.6%	4.6%	1,262	3.3%	0	0.0%	1,196	23.2%	4.5%
Did not know was pregnant	3,201	31.5%	0	0.0%	1,508	71.4%	36.2%	7,295	19.2%	5,146	44.7%	1,620	31.4%	25.7%
Other	3,984	39.3%	760	100.0%	0	0.0%	36.4%	11,938	31.5%	4,181	36.3%	0	0.0%	29.5%
DK or refused	1,508	14.9%	0	0.0%	0	0.0%	11.6%	2,550	6.7%	216	1.9%	1,532	29.7%	7.9%
Late Prenatal Care[5]	7,259	23.1%	0	0.0%	2,086	98.8%	22.5%	27,781	20.6%	4,616	5.5%	5,025	23.2%	16.0%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "Not Insured" reported ever having breastfed, we first look at the column "Not Insured" under SLPMC community and then go down to the row "Ever Breastfeed". Here we find that of those "Not Insured" in the SLPMC community, 91.1% reported they have breastfed a child.

[5] These questions were asked to women aged 54 and younger who indicated they had given birth to a child in the last five years.

[6] This question was asked to women aged 54 and younger who indicated they had given birth to a child in the last five years and did not obtain prenatal care.

Table 2 Prenatal Care obtained by Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Ever Breastfeed[5]	23,002	82.3%	9,882	100.0%	3,713	91.4%	87.4%	100,097	79.6%	44,306	81.7%	52,428	85.5%	81.6%
Breastfed for at Least Six Months[5]	12,570	54.6%	2,867	29.0%	2,051	55.2%	47.8%	58,240	58.2%	12,364	27.9%	27,410	52.3%	49.8%
Reason for No Prenatal Care[6]														
Cost or no insurance	1,456	17.0%	0	0.0%	0	0.0%	11.2%	11,032	35.4%	6,369	38.5%	280	4.1%	32.4%
No Medicaid card	605	7.1%	0	0.0%	0	0.0%	4.6%	2,065	6.6%	394	2.4%	0	0.0%	4.5%
Did not know was pregnant	1,789	20.9%	2,920	65.4%	0	0.0%	36.2%	4,749	15.2%	5,316	32.1%	3,995	57.9%	25.7%
Other	3,970	46.4%	775	17.4%	0	0.0%	36.4%	11,048	35.5%	2,886	17.4%	2,186	31.7%	29.5%
DK or refused	738	8.6%	771	17.3%	0	0.0%	11.6%	2,270	7.3%	1,584	9.6%	444	6.4%	7.9%
Late Prenatal Care[5]	7,771	28.1%	1,575	15.9%	0	0.0%	22.5%	26,914	22.5%	7,384	13.8%	3,160	5.2%	16.0%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "In Poverty" reported ever having breastfed, we first look at the column "in Poverty" under SLPMC community and then go down to the row "Ever Breastfeed". Here we find that of those "In Poverty" in the SLPMC community, 82.3% reported they have breastfed a child.

[5] These questions were asked to women aged 54 and younger who indicated they had given birth to a child in the last five years.

[6] This question was asked to women aged 54 and younger who indicated they had given birth to a child in the last five years and did not obtain prenatal care.

Appendix 9 Risk Factors

Table 1 Risk Factors of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Smoked 100 Cigarettes or More Lifetime	71,130	38.2%	105,616	46.9%	39,360	41.8%	42.8%	307,306	34.6%	500,926	34.4%	269,225	48.8%	37.2%
Current Smoking Pattern[5]														
Every day	35,404	49.8%	29,393	27.8%	9,164	23.3%	34.2%	120,659	39.3%	122,820	24.5%	70,618	26.2%	29.2%
Some days	14,287	20.1%	16,746	15.9%	5,516	14.0%	16.9%	70,674	23.0%	63,800	12.7%	37,192	13.8%	15.9%
Not at all	17,578	24.7%	59,477	56.3%	24,680	62.7%	47.1%	107,792	35.1%	309,076	61.7%	159,146	59.1%	53.5%
DK/Ref	3,861	5.4%	0	0.0%	0	0.0%	1.8%	8,181	2.7%	5,230	1.0%	2,269	0.8%	1.5%
Days Engaged in Physical Activity in last 7 Days														
0	57,591	31.0%	58,175	25.8%	16,935	18.0%	26.3%	230,296	25.9%	290,182	19.9%	112,801	20.4%	21.9%
1 – 2	19,021	10.2%	35,264	15.7%	20,723	22.0%	14.8%	197,989	22.3%	285,584	19.6%	99,582	18.0%	20.1%
3 – 4	44,956	24.2%	62,115	27.65	28,882	30.7%	26.9%	195,022	21.9%	393,674	27.0%	150,490	27.3%	25.5%
5 – 6	32,875	17.7%	39,312	17.55	8,945	9.5%	16.1%	116,190	13.1%	244,805	16.8%	80,760	14.6%	15.2%
7	31,632	17.0%	30,382	13.5%	18,628	19.8%	16.0%	149,447	16.8%	241,557	16.6%	108,517	19.7%	17.2%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "Not Insured" reported ever having "Smoked 100 Cigarettes or More in a Lifetime", we first look at the column "Not Insured" under SLPMC community and then go down to the row "Smoked 100 Cigarettes or More Lifetime". Here we find that of those "Not Insured" in the SLPMC community, 38.2% reported they have "Smoked 100 Cigarettes or More in a Lifetime".

[5] This question was only asked to participants who said they had smoke 100 or more cigarettes in their entire lifetime.

Table 2 Risk Factors of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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 100 Cigarettes or More Lifetime	67,538	40.2%	46,191	37.0%	102,378	48.1%	42.8%	317,168	34.8%	229,649	36.1%	530,641	39.3%	37.2%
Current Smoking Pattern[5]														
Every day	18,050	26.7%	23,894	51.7%	32,018	31.3%	34.2%	106,413	33.6%	81,598	35.5%	126,085	23.8%	29.2%
Some days	18,333	27.1%	3,462	7.5%	14,753	14.4%	16.9%	70,703	22.3%	31,389	13.7%	69,574	13.1%	15.9%
Not at all	27,295	40.4%	18,835	40.8%	55,607	54.3%	47.1%	134,388	42.4%	114,319	49.8%	327,307	61.7%	53.5%
DK/Ref	3,861	5.7%	0	0.0%	0	0.0%	1.8%	5,663	1.8%	2,342	1.0%	7,675	1.4%	1.5%
Days Engaged in Physical Activity in last 7 Days														
0	50,470	30.1%	28,520	30.9%	43,710	20.5%	26.3%	224,715	24.6%	147,085	23.1%	261,479	19.4%	21.9%
1 – 2	20,877	12.4%	22,334	17.9%	31,796	14.9%	14.8%	202,286	22.2%	127,670	20.1%	253,199	18.8%	20.1%
3 – 4	46,125	27.5%	21,529	17.2%	68,299	32.1%	26.9%	211,885	23.2%	145,946	22.9%	381,356	28.3%	25.5%
5 – 6	26,128	15.6%	16,104	12.9%	38,900	18.3%	16.1%	106,832	11.7%	81,580	12.8%	253,343	18.8%	15.2%
7	24,251	14.4%	26,364	21.1%	30,027	14.1%	16.0%	166,544	18.3%	133,700	21.0%	199,276	14.8%	17.2%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "In Poverty" reported ever having "Smoked 100 Cigarettes or More in a Lifetime", we first look at the column "In Poverty" under SLPMC community and then go down to the row "Smoked 100 Cigarettes or More Lifetime". Here we find that of those "In Poverty" in the SLPMC community, 40.2% reported they have "Smoked 100 Cigarettes or More in a Lifetime".

[5] This question was only asked to participants who said they had smoke 100 or more cigarettes in their entire lifetime.

Appendix 10 Neighborhood, Environment and Housing Conditions

Table 1 Neighborhood, Environment and Housing Conditions of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Type of Residence														
House	119,035	64.0%	199,223	88.4%	73,183	77.8%	77.4%	512,437	57.6%	1,213,208	83.3%	397,696	72.0%	73.3%
Duplex	631	0.3%	270	0.1%	458	0.5%	0.3%	36,609	4.1%	20,069	1.4%	14,205	2.6%	2.4%
Apartment	54,193	29.1%	23,524	10.4%	16,131	17.1%	18.6%	288,516	32.5%	206,428	14.2%	126,009	22.8%	21.4%
Mobile home	12,214	6.6%	2,231	1.0%	4,340	4.6%	3.7%	51,381	5.8%	16,096	1.1%	14,240	2.6%	2.8%
Own or Rent														
Own	85,953	46.2%	170,192	75.6%	70,830	75.3%	64.7%	364,456	41.0%	1,123,708	77.2%	352,654	63.9%	63.5%
Rent	94,906	51.0%	49,997	22.2%	2,1123	22.4%	32.8%	493,812	55.6%	295,841	20.3%	178,518	32.3%	33.4%
Other arrangements	5,215	2.8%	5,058	2.2%	2,159	2.3%	2.5%	30,675	3.5%	36,252	2.5%	20,979	3.8%	3.0%
Fresh Fruits and Vegetables Available	154,260	82.9%	196,778	87.4%	74,234	78.9%	84.1%	717,532	80.7%	1,269,651	87.2%	445,316	80.7%	84.0%
Violence and Crime a Problem	30,891	16.6%	38,828	17.2%	17,752	18.9%	17.3%	232,618	26.2%	363,925	25.0%	159,150	28.8%	26.1%
Stray Dogs and Cats a Problem	68,513	36.8%	82,263	36.5%	34,612	36.8%	36.7%	382,147	43.0	465,878	32.0%	215,869	39.1%	36.7%
Water Pollution a Problem	21,760	11.7%	26,444	11.7%	18,806	20.0%	13.3%	116,620	13.1%	117,888	8.1%	60,688	11.0%	10.2%
Drinking Water a Problem	40,468	21.7%	43,045	19.1%	21,920	23.3%	20.9%	187,310	21.1%	252,315	17.3%	103,576	18.8%	18.8%
Fumes from Traffic a Problem	47,307	25.4%	50,116	22.2%	22,244	23.6%	23.7%	182,254	20.5%	229,000	15.7%	87,869	15.9%	17.2%
Fumes from Industry a Problem	76,911	41.3%	92,158	40.9%	47,363	50.3%	42.8%	147,655	16.6%	200,818	13.8%	80,020	14.5%	14.8%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "Not Insured" reported living in a "House", we first look at the column "Not Insured" under SLPMC community and then go down to the row "House" under Type of Residence. Here we find that of those "Not Insured" in the SLPMC community, 64% reported they live in a "House".

Table 2 Neighborhood, Environment and Housing Conditions of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Type of Residence														
House	103,176	61.5%	99,129	79.4%	189,137	88.9%	77.4%	533,094	58.4%	456,558	71.8%	1,133,689	84.1%	73.3%
Duplex	404	0.2%	209	0.2%	746	0.4%	0.3%	33,767	3.7%	14,532	2.3%	22,584	1.7%	2.4%
Apartment	56,468	33.6%	17,803	14.3%	19,577	9.2%	18.6%	303,507	33.3%	139,744	22.0%	177,703	13.2%	21.4%
Mobile home	7,805	4.6%	7,710	6.2%	3,271	1.5%	3.7%	41,894	4.6%	25,148	4.0%	14,676	1.1%	2.8%
Own or Rent														
Own	79,845	47.6%	90,233	72.3%	156,897	73.8%	64.7%	379,357	41.6%	418,002	65.7%	1,043,460	77.4%	63.5%
Rent	84,145	50.1%	31,318	25.1%	50,562	23.8%	32.8%	487,290	53.4%	201,791	31.7%	279,090	20.7%	33.4%
Other arrangements	3,861	2.3%	3,299	2.6%	5,272	2.5%	2.5%	45,615	5.0%	16,188	2.5%	26,103	1.9%	3.0%
Fresh Fruits and Vegetables Available	129,467	77.1%	101,801	81.5%	194,003	91.2%	84.1%	699,741	76.7%	531,718	83.6%	1,201,041	89.1%	84.0%
Violence and Crime a Problem	38,077	22.7%	20,578	16.5%	28,817	13.5%	17.3%	261,564	28.7%	184,263	29.0%	309,866	23.0%	26.1%
Stray Dogs and Cats a Problem	68,476	40.8%	42,043	33.7%	74,869	35.2%	36.7%	399,690	43.8%	252,542	39.7%	411,662	30.5%	36.7%
Water Pollution a Problem	33,559	20.0%	14,953	12.0%	18,498	8.7%	13.3%	131,397	14.4%	66,987	10.5%	96,812	7.2%	10.2%
Drinking Water a Problem	43,899	26.2%	30,359	24.3%	31,175	14.7%	20.9%	205,214	22.5%	133,547	21.0%	204,440	15.2%	18.8%
Fumes from Traffic a Problem	55,245	32.9%	20,542	16.5%	43,879	20.6%	23.7%	189,873	20.8%	104,460	16.4%	204,789	15.2%	17.2%
Fumes from Industry a Problem	74,425	44.3%	54,133	43.4%	87,873	41.3%	42.8%	151,053	16.6%	107,088	16.8%	170,352	12.6%	14.8%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "In Poverty" reported living in a "House", we first look at the column "In Poverty" under SLPMC community and then go down to the row "House" under Type of Residence. Here we find that of those "In Poverty" in the SLPMC community, 61.5% reported they live in a "House".

Appendix 11 Social Support Indicators

Table 1 Social Support of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLPMC Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Someone to Help with Daily Chores if Sick														
None of the time	34,797	18.7%	21,416	9.5%	12,114	12.9%	13.5%	162,429	18.3%	131,316	9.0%	67,395	12.2%	12.5%
A little of the time	18,150	9.8%	18,733	8.3%	11,493	12.2%	9.6%	115,264	13.0%	107,385	7.4%	44,486	8.1%	9.2%
Some of the time	48,710	26.2%	41,426	18.4%	17,313	18.4%	21.3%	200,338	22.5%	221,284	15.2%	109,930	19.9%	18.3%
Most of the time	24,828	13.3%	49,631	22.0%	25,734	27.3%	19.8%	151,231	17.0%	370,439	25.4%	123,298	22.3%	22.3%
All of the time	59,590	32.0%	94,042	41.8%	27,459	29.2%	35.8%	259,681	29.2%	625,378	43.0%	207,041	37.5%	37.7%
Someone to Relax with														
None of the time	17,932	9.6%	21,518	9.6%	3,486	3.7%	8.5%	116,625	13.1%	73,370	5.0%	47,546	8.6%	8.2%
A little of the time	25,926	13.9%	19,673	8.7%	8,.975	9.5%	10.8%	134,935	15.2%	113,642	7.8%	49,803	9.0%	10.3%
Some of the time	59,632	32.0%	56,347	25.0%	39,748	42.2%	30.8%	264,791	29.8%	346,811	23.8%	168,399	30.5%	26.9%
Most of the time	37,285	20.0%	54,859	24.4%	16,687	17.7%	21.5%	183,111	20.6%	407,292	28.0%	132,267	24.0%	24.9%
All of the time	45,299	24.3%	72,851	32.3%	25,218	26.8%	28.4%	189,481	21.3%	514,685	35.4%	154,137	27.9%	29.6%
Someone to Understand Problems														
None of the time	21,922	11.8%	22,740	10.1%	8,166	8.7%	10.5%	139,042	15.6%	88,926	6.1%	64,903	11.8%	10.1%
A little of the time	20,586	11.1%	9,290	4.1%	14,234	15.1%	8.7%	96,855	10.9%	97,544	6.7%	44,379	8.0%	8.2%
Some of the time	44,601	24.0%	29,483	13.1%	16,258	17.3%	17.9%	174,196	19.6%	240,506	16.5%	104,075	18.8%	17.9%
Most of the time	39,941	21.5%	74,169	32.9%	21,137	22.5%	26.8%	190,131	21.4%	384,696	26.4%	118,933	21.55	23.95
All of the time	59,024	31.7%	89,567	39.8%	34,318	36.5%	36.2%	288,719	32.5%	644,130	44.2%	219,860	39.8%	39.8%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "Not Insured" reported having Someone to Help with Daily Chores if Sick "None of the time", we first look at the column "Not Insured" under SLPMC community and then go down to the row "None of the time" under Someone to Help with Daily Chores if Sick. Here we find that of those "Not Insured" in the SLPMC community, 18.7% reported they had someone to help with daily chores if sick "None of the time".

Table 2 Social Support of Adults[1] in the St. Luke's Patients Medical Center Community and Harris County[2] by Poverty Level[3,4]

	SLPMC 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	%	%
Someone to Help with Daily Chores if Sick														
None of the time	26,377	15.7%	24,067	19.3%	17,883	8.4%	13.5%	144,324	15.8%	88,807	14.0%	128,010	9.5%	12.5%
A little of the time	18,548	11.1%	10,787	8.6%	19,041	9.0%	9.6%	107,267	11.8%	59,108	9.3%	100,761	7.5%	9.2%
Some of the time	38,831	23.1%	31,751	25.4%	36,867	17.3%	21.3%	194,434	21.3%	134,772	21.2%	202,345	15.0%	18.3%
Most of the time	36,245	21.6%	17,154	13.7%	46,792	22.0%	19.8%	167,513	18.4%	139,325	21.9%	338,131	25.1%	22.3%
All of the time	47,851	28.5%	41,092	32.9%	92,148	43.3%	35.8%	298,723	32.7%	213,970	33.6%	579,406	43.0%	37.7%
Someone to Relax with														
None of the time	17,116	10.2%	13,354	10.7%	12,467	5.9%	8.5%	112,527	12.3%	58,461	9.2%	66,552	4.9%	8.2%
A little of the time	28,275	16.8%	12,734	10.2%	13,565	6.4%	10.8%	126,174	13.8%	68,211	10.7%	103,995	7.7%	10.3%
Some of the time	58,808	35.0%	50,452	40.4%	46,466	21.8%	30.8%	279,624	30.7%	208,094	32.7%	292,282	21.7%	26.9%
Most of the time	29,167	17.4%	19,459	15.6%	60,205	28.3%	21.5%	180,755	19.8%	136,322	21.4%	405,594	30.1%	24.9%
All of the time	34,486	20.5%	28,853	23.1%	80,028	37.6%	28.4%	213,180	23.4%	164,893	25.9%	480,230	35.6%	29.6%
Someone to Understand Problems														
None of the time	22,232	13.2%	18,397	14.7%	12,198	5.7%	10.5%	145,216	15.9%	68,536	10.8%	79,118	5.9%	10.1%
A little of the time	25,590	15.2%	9,579	7.7%	8,940	4.2%	8.7%	101,351	11.1%	55,695	8.8%	81,732	6.1%	8.2%
Some of the time	40,056	23.9%	21,288	17.1%	28,997	13.6%	17.9%	168,550	18.5%	136,149	21.4%	214,080	15.9%	17.9%
Most of the time	32,359	19.3%	32,465	26.0%	70,423	33.1%	26.8%	162,441	17.8%	150,119	23.6%	381,200	28.3%	23.9%
All of the time	47,615	28.4%	43,121	34.5%	92,172	43.3%	36.2%	334,703	36.7%	225,483	35.5%	592,523	43.9%	39.8%

[1] Adults aged 18 and over

[2] St. Luke's Patients Medical Center community (SLPMC community) and Harris County data were obtained from analyses of the 2010 Health of Houston Survey conducted by the University of Texas, School of Public Health, Institute for Health Policy. The SLPMC community is defined by the St. Luke's Patients Medical Center Service Area.

[3] We define "In Poverty" as < 100% of the Federal Poverty Level, "Near Poverty" as 100 – 199.9% of FPL, and "Not in Poverty" as 200% or more above the FPL.

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLPMC community who are "In Poverty" reported having Someone to Help with Daily Chores if Sick "None of the time", we first look at the column "In Poverty" under SLPMC community and then go down to the row "None of the time" under Someone to Help with Daily Chores if Sick. Here we find that of those "In Poverty" in the SLPMC community, 15.7% reported they had someone to help with daily chores if sick "None of the time".

Appendix 12 SLPMC Hospital Advisory Team Summary Report

Attendees: Paul Hanson (SLPMC), Cheryl Willis (SLPMC), Tamara Bourda (EHC), Pamela Diamond (UT), Maria Fernandez-Esquer (UT), Andria Rusk (UT)

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.

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 primary service area is Harris County; patients mainly come from Pasadena, Deerpark and Pearland
  - The community definition for the CHNA will be based on the data, and the community and stakeholders will prioritize the identified needs

- Community unmet needs
  - Health resources specifically for the Hispanic population
    - There is a lack of information on nutrition, obesity and diabetes to help support the large Hispanic community in the area
    - Community is lower income and there is an overall high cost of healthcare, prescription drugs and lab costs
  - Pediatrics
    - The hospital does not have a pediatric unit or pediatric physicians on staff; there are many children in the area with diverse health needs
    - Many families are lower income and do not have resources to positively influence their children's health behaviors
  - Cancer
    - From personal observations, there seems to be high cancer rates in the area; in the past couple years an influx of cancer diagnoses – lung, brain, breast, leukemia, etc.
    - The hospital borders an industrial environment, and many cancers may be a result of prior exposure to chemicals or industrial work
    - There are no radiation services in Pasadena; the closest facility is Southeast Memorial and patients have to travel far for treatment
    - When patients have cancer diagnoses, they have to go to other cancer center to be outpatients before they can be taken as inpatient; this is difficult for those without transportation

- Transportation
    - No public transportation available in Pasadena
    - Gold card patients prefer to come to SLPMC rather than Galveston or Downtown
    - The Southmore Hospital, which was in the area, closed in early 2000s. It served a large Medicaid population that now goes to Bayshore Hospital because many do not have transportation to get to SLPMC.
- Access to Care
    - Shortage of primary care physicians
    - Patients tend to not go to clinics, rather wait and go to the ER
- Elder population
    - There is a large aging population and a lack of primary care physicians to serve them

- Existing services and relationships
    - Healthy Living Series- informational health topics are offered to the community once a month for free
    - Health fairs and safety fairs that include free glucose, cholesterol, and blood pressure checks are offered for community groups and nearby companies
    - Occupational health services- hospital addresses on the job injuries, accident drug screens, and workers compensation issues for area industrial companies

- New ideas and strategies to address needs
    - Develop wellness programs that reach out to the Hispanic community to give resources on seeking educational and healthcare information
    - Partner with the schools to address pediatric health needs
    - Although there are no opportunities to expand inpatient or ER services, the hospital can increase outpatient service usage
    - Partner with area facilities to refer cancer patients; MD Anderson, Christus, and HCA have campuses in Clear Lake

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 September 26 board meeting
- Board approved report will be submitted to the System for filing with taxes

Action items

- Cheryl will send documentation of community activities to Tamara

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

Appendix 13 Community Stakeholder Summary Report

Introduction

In accordance with Federal law, a Community Health Needs Assessment 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 stakeholders, facilitated focus groups, and developed the community stakeholder summary report. Gathering the community input for St. Luke's Patients Medical Center (SLPMC) 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 community stakeholders:

- 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, and 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 Patients Medical Center Community Health Needs Assessment on Thursday, August 8, 2013, from 9:00 am – 10:30 am at The Bridge Over Troubled Waters, Inc. in Pasadena. This conversation included twelve 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 SLPMC. The Group Conversation 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 does not seek specific answers or responses – all input was welcome. 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 form 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

Twenty-two organizations and community members 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 Patients Medical Center. Collectively, these groups 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 first-hand 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 Patients Medical Center Group Conversation on August 8, 2013. As described above, the group includes 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, and populations with chronic disease needs, in the community served by the hospital facility.

	Name	Title	Organization
1	Angela Balch	Coordinated School Health Specialist	Pasadena ISD
2	Tammy De Los Santos	Recreation Manager	Madison Jobe Senior Center
3	Anna Duron	Membership/Healthy Living Director	San Jacinto YMCA
4	Rick Guerrero		Pasadena Hispanic Business Council
5	Becky Kyles	Grants Compliance Manager	The Bridge
6	Deborah Moseley	Executive Director	The Bridge
7	Ana Perez	Social Worker	Pasadena ISD
8	Donaji Stelzig	Clinic Health Educator	Harris Health System
9	John Sweitzer	CEO	Pasadena Health Center
10	Pam Tevis	Instructional Specialist Health/PE	Pasadena ISD
11	Diane Thompson	CIO	Pasadena Health Center
12	Sherry Trainer	President/CEO	Pasadena Chamber of Commerce

Community Stakeholder Feedback

Below is a description of participant feedback from the Group Conversation held in the community served by SLPMC. Data is organized according to the four questions posed to participants.

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

- **Access to Care.** Many participants focused on access to care as an important health problem in the Pasadena community. Participants highlighted several factors that affect access to care in Pasadena including lack of transportation, lack of adequate health insurance, and access to specialty services and screenings.

- Transportation – Participants observed that many people cannot access health care because they have a difficult time finding affordable transportation to the hospital or doctor appointments. Transportation is a health care need for the population in general and especially for seniors.
- Health Insurance – Participants identified having health insurance as a key healthcare need related to access in the community. While some health clinics are actively working to enroll individuals in insurance programs through the Affordable Care Act, access to insurance remains an unmet need in the community overall.
- Specialty Services and Screenings – Access to specialists and health screenings is an unmet need in the community. While participants acknowledged that many services are available through health clinics and health centers in the community, referrals to specialists for services such as orthopedics and cardiology remain an unmet need. Participants also named cardiac screenings for children and sexual assault exams as being significant healthcare needs that are not available in the Pasadena community.

- **Mental Health**. Several participants identified mental health services for adults and children as a significant unmet healthcare need in the Pasadena community. For adults with mental health needs, cost and cultural understanding/awareness can be barriers to getting mental health services. Participants noted that obtaining mental health services for children is especially difficult, sometimes taking up to seven days to place a child.
    - Substance Abuse- Several participants noted that there is a problem with substance abuse in the community. They also noted that there are not enough treatment centers in the area and that existing centers are not affordable. One participant also cited a need for support services related to substance abuse treatment, such as a place for children to go while their parents are receiving treatment.
    - Obesity- Several participants identified obesity as a major health problem in the community. While participants acknowledged that obesity is a health problem for people of all ages in the community, there was a particular focus among participants on addressing childhood obesity.
    - Childhood Obesity – Participants suggested that beginning to develop healthy eating habits in children at the pre-K level in schools is important. Other participants noted that this should be accompanied by parent education on healthy habits. While participants acknowledged the significant barriers to addressing childhood obesity in families, such as time for parent education and cost/access to healthy foods, they highlighted the importance of addressing this health need as it contributes to other health problems in the community.
    - Nutrition – Access to nutritional foods was identified as an important need related to obesity in the Pasadena community. Participants noted a need to integrate nutrition into education and tailoring nutrition education to the types of foods that are available in the community.

- **Education, Prevention, and Communication.** Participants identified the interrelated issues of education, prevention, and communication as healthcare needs in the Pasadena community.
    - Education and Prevention – The topics of education and prevention were a focus of conversation around childhood obesity. Education for children and adults on healthy eating and general healthy habits was important to participants. Participants also acknowledged the broader benefits of education and prevention in terms of lowering rates of chronic

disease, improving health of the overall community, and reducing demand for hospital/emergency services.
    - Communication – Communication among health care providers, community service organizations, and the general public emerged several times in the conversation about unmet health needs in the community. Specific lines of communication that could improve health of the community include communication between schools and health clinics, communication between community organizations and those they serve, and communication among social service organizations that are working toward similar goals.

- **Care for Seniors.** Participants identified adequate and effective care for seniors as an unmet health care need in the community. Factors contributing to this need include lack of transportation, financial resources for transportation and prescription medications, appropriate follow-up from health care professionals, nutrition, and social interaction.

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

- **Poor Communication**. Many participants identified poor communication as a challenge to meeting healthcare needs in the Pasadena community. Participants noted a lack of communication specifically between schools and clinics and among social service and healthcare agencies. Participants noted that lack of communication leads to possible duplication of services and patients not accessing available resources.

- **Transportation**. Several participants noted that the lack of public and affordable transportation in Pasadena is a barrier to addressing healthcare needs in the community. Participants specifically noted that accessing transportation is an issue for seniors in the community. Seniors that are able to obtain vouchers for transportation often still are not able to afford enough trips to meet daily needs, keep doctor appointments, and travel to recreational opportunities at places such as senior centers.

- **Language and Cultural Barriers.** Participants characterized Pasadena as having a significant minority population. They also noted that Pasadena has a significant transient community. These characteristics of Pasadena often translate into language and cultural barriers that create challenges for the community in terms of healthcare.
    - Language Barrier – Several participants noted that a language barrier keeps a patient from being able to communicate effectively with nurses and physicians, especially for the Hispanic community. Participants acknowledged that there are nurses and doctors that speak Spanish in hospitals and health clinics but often there are not enough to keep up with the volume of patients that speak languages other than English.
    - Cultural Barrier – Participants noted that cultural barriers such as lack of total understanding that doctors and providers want to help patients, skepticism about services and providers, and stigmas for certain needs such as mental health create significant challenges to addressing community health needs.
    - Transient Community – Participants noted that one challenge to addressing healthcare needs is the fact that Pasadena is a somewhat transient community, making follow-up care a significant challenge for healthcare providers.

- **Time and Financial Resources.** Participants identified scarcity of time and financial resources as barriers to meeting healthcare needs in the community. Participants noted that even when services and initiatives such as educational programs for adults around healthy eating are offered to the public, many adults who often work multiple jobs do not have time to attend classes. In addition, the cost of services – specifically mental health services and substance abuse treatment – often discourage the community from seeking services.

- **Relationships.** Participants noted that underlying many of the barriers listed above is a lack of trust among healthcare providers, social service organizations, and the community at large. Participants noted a need for passionate service providers that are willing to build relationships and trust in the community and to follow-up with patients.

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

Participants named two priorities for addressing healthcare needs in their community.

- First, participants cited promoting healthy eating and exercise as a way to help prevent obesity.
- Second, participants noted the importance of addressing mental health needs for children.

While these two priorities were named specifically, it is clear from the Group Conversation overall that participants feel strongly about many health needs in their community that could be considered priorities, including coordination of services, communication among providers, access to healthcare, education and prevention, and awareness of services.

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 many existing resources and programs that address health in the community. Identifying these resources began to build bridges, foster understanding, and increase awareness of services for the participants. The available resources discussed in the Group Conversation are listed below.

- Community Health Workers – Community Health Workers are certified to help bridge the gap between members of a community and healthcare and social service providers. Many Community Health Workers are available in the Pasadena community but are an underutilized resource. While participants had a high level of interest around Community Health Workers and returned to this topic several times during the Group Conversation, there was a general lack of understanding about how to access Community Health Workers in Pasadena.
- Healthy Choices Classes – The Bridge sponsors classes for family units on making healthy and informed choices.
- Pasadena Parks Department – Pasadena has an impressive Parks Department that is willing to hold classes on obesity prevention.
- Healthy Eating Courses for Youth – A local community organization sponsors a free summer program for youth that promotes healthy lifestyles through nutrition and exercise.
- Pasadena ISD School Health Advisory Council – The School Health Advisory Council for the Pasadena ISD is responsible for 54,000 children and provides a framework for collaboration among community health and social service organizations.

- Churches and the Faith Community – Pasadena is known as a "City of Churches" and has an active faith community. This faith community could be a resource for reaching the community to promote health.
- Health Fairs – Several community organizations such as schools, senior centers, and YMCAs sponsor health fairs that provide great opportunities for community members to meet local healthcare providers.
- Meals on Wheels – The Salvation Army sponsors a Meals on Wheels program that provides nutritional meals to seniors in the community.
- Recreational Opportunities – The YMCA and Madison Jobe Senior Center provide much-needed recreational and social opportunities for the community and for seniors.
- Television – Participants noted that television is an excellent way to reach the Hispanic population and the community at large with health-related public service announcements.

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, and populations with chronic disease needs; and knowledge of the SLPMC community. The participants identified their primary area of knowledge/expertise and the community they serve as including the following areas in general: medical, dental, pharmacy, x-ray, ultrasound, counseling, insurance, community health, indigent care, homeless, Pasadena ISD, medical social work, mental health, general health and wellness/physical activity, community, real estate, seniors, domestic violence, public health, and community outreach. 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 Patients Medical Center?	11	1
Are you a person with knowledge or expertise in public health?	8	3
Are you a representative of a federal, tribal, regional, state, or local health department or agency?	4	6
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 Patients Medical Center?	6	5
Are you a leader, representative, or member of a population served by the St. Luke's Patients Medical Center that could be characterized as medically underserved, low income, minority, or having chronic disease needs?	10	2

Recommendations made by Community Stakeholders

Several specific ideas for how St. Luke's Patients Medical Center 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 like access to health care and prevention are complex and multi-

layered, there were a number of ideas and recommendations put forward by the community for the hospital's consideration, including the following:

- Coordination of community resources through the provision of a comprehensive community health resources database that is updated on a regular basis
- Hosting or facilitating a meetings on a regular basis for the many social services organizations in Pasadena to promote communication and coordination of services
- Establishing a Task Force for Health (with the hospital leading or attending) in partnership with community organizations such as the Chamber of Commerce in order to promote overall community health
- Adding several Community Health Workers to the hospital staff in order to promote health among hospital patients during and after hospital stays and to prevent future hospital visits

In addition to offering these ideas and recommendations for addressing health needs of the community, participants expressed great interest in receiving a copy of – or having access to – the Community Health Needs Assessment report. There was a general sense at the close of the Group Conversation that organizations were energized and motivated to move forward in partnership with each other and other health care entities such as St. Luke's Patients Medical Center to promote a healthy Pasadena community.

Appendix 14 Public Health Experts Summary Report

Introduction

In accordance with Federal law, a Community Health Needs Assessment 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 Community Health Needs Assessments for all six hospitals in the St. Luke's Health System (St. Luke's Hospital at Texas Medical Center, St. Luke's Patients Medical Center, St. Luke's Sugar Land Hospital, St. Luke's Hospital The Woodlands, St. Luke's Lakeside Hospital, St. Luke's Vintage Hospital) on Thursday, August 8, 2013, from 2:30 pm – 4:00 pm at the Episcopal Health Charities in Houston, Texas. This conversation included twelve participants from a city, county, regional, and states 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. The Group Conversation 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 welcome. 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 includes persons with special knowledge of or expertise in public health as it relates to the community 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	Department of State Health Services
6	Lisa Mayes	Executive Director	Harris County Healthcare Alliance
7	Bakeyah Nelson	Public Health Analyst	HCPHES
8	Beverly Nichols PsyD, MS, RN	Senior Staff Analyst	City of 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 is 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 admits to the hospital, and suggested that elevating the idea of a healthy community is a healthcare need in the Houston community. Participants also noted specific unmet healthcare needs in the community including access, communication, chronic disease, mother/infant/prenatal care, behavioral health care, environmental health, and 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 health care settings is a problem for many in Houston.
- **Knowledge.** Some participants felt that many people simply do not understand how to obtain health care resources and services. This problem is especially evident as it relates to prenatal and behavioral health care 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 E.R.
- **Communication**. Participants indicated that more effective communication around health care in the Greater Houston community is an unmet healthcare need. Specifically, participants felt that better communication is needed from health care providers to inform the community about services and resources that are available. In addition, better communication is needed between health care providers and health departments/public health agencies.
- **Chronic Disease**. Participants suggested 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. 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 Houston community. Participants felt that more individuals need to be screened for chronic diseases, and 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 Houston community. Participants cited high rates of maternal and infant mortality and high rates of pre-term birth and fetal mortality as evidence of this problem. Participants further noted that high rates of poor birth outcomes leads 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 encounter many barriers to obtaining these services such as transportation, funding, access, finding a doctor, and making an appointment.
- **Behavioral Health Care**. Several participants suggested that mental health and chronic mental illness are important health care issues in the 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 people 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 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 can also lead to long-term chronic health problems such as respiratory problems, heart attack, stroke, and asthma.
- **Health Disparities**. Participants suggested that disparity issues are a major health care concern in the Houston community. One participant provided the example that there are correlations between ethnicity and individuals that do not get regular or necessary health care 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 level, organizational level, and the community level.

- **Barriers for Individuals.** Barriers to addressing unmet healthcare needs for individuals in the Houston community relate to access to care issues. Transportation, insurance and financial resources, and scarcity of time are all barriers to addressing unmet health care needs for individuals in the Greater Houston community.
    - Transportation – Transportation to and from health care services is a significant barrier to obtaining health care services for many individuals the 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 health care, they do not have the financial resources to access health care services.
    - Time – Participants acknowledged that time is a precious resource for individuals in Houston and acknowledged that scarcity of time is often a barrier to accessing health care services. In particular, participants noted a need for individuals to understand the difference between after-hours facilities and emergency rooms 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 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 health care as priorities.

- Empowering the Individual – Participants suggested that communities do a pretty 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 health care.
- 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 health care.
- **Referrals between Hospitals and FQHC's.** Participants named developing a working relationship between hospitals and FQHC's to efficiently and effectively refer patients to the appropriate health care provider as a priority for the community. Participants acknowledged that it is not only best for the patient to be seen in the right health care setting, but it also helps relieve over-use of E.R. facilities. 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 health care 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 health care for immigrants should be a priority for the 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 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 that struggle with asthma.

Group Conversation Evaluation

All participants were asked to evaluate whether his or her organization represents the broad interests of the community 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 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 Hospital	6	-----
St. Luke's Hospital at The Vintage	3	-----
St. Luke's Patients Medical Center	4	-----
St. Luke's Sugar Land Hospital	1	-----
St. Luke's Woodlands Hospital	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 like access to health care 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 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 facilities