2025 Community Health Needs Assessment

Report adopted by Hospital Advisory Board May 2025

St. Luke's Health™

A member of CommonSpirit

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Community Health Needs Assessment – At a Glance

St. Luke's Health – Patient's Medical Center (PMC)

Data Analysis Overview

Secondary Data
Topic score of 1.50 or higher

Secondary data, or numerical health indicators, from HCI's 200+ community indicator database, were analyzed and scored based on their values.

Listening Sessions
Frequency topic was discussed during interviews

Listening Sessions were conducted with **over 60 community groups , organizations, and hospital leaders** that represent the broad demographics or underserved populations in the community.

Community Partner Survey
Selected by 20% or more of respondents as a priority health issue

The Community Partner Survey was distributed across the region to gather quantitative data regarding community-serving organizations and their views on the health needs within the service area.

Prioritized Significant Health Needs

- Cancer
- Heart Disease & Stroke
- Diabetes
- Mental Health
- Health Care Access & Quality
- Older Adults

*Topic scores reflect the relative severity of issues based on standardized data; a score of 1.50 or higher indicates a higher-than-average concern compared to state or national benchmarks.

Executive Summary

Introduction & Purpose

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by Patients Medical Center (PMC). The priorities identified in this report guide the hospital's community health improvement programs, community benefit activities, and collaborative efforts with other organizations sharing the mission to improve community health. This CHNA meets the requirements of the Patient Protection and Affordable Care Act, mandating not-for-profit hospitals to conduct a CHNA at least every three years.

CommonSpirit Health Commitment and Mission Statement

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission.

Our Mission

As a member of CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all—inspired by faith, driven by innovation, and powered by our humanity.

Our Values

- **Compassion**: Care with listening, empathy, and love; accompany and comfort those in need of healing.
- **Inclusion**: Celebrate each person's gifts and voice; respect the dignity of all.
- **Integrity**: Inspire trust through honesty; demonstrate courage in the face of inequity.
- **Excellence**: Serve with fullest passion, creativity, and stewardship; exceed expectations of others and ourselves.
- **Collaboration**: Commit to the power of working together; build and nurture meaningful relationships.

CHNA Collaborators

Patients Medical Center (PMC) collaborated with various community organizations, local health departments, and healthcare providers. Conduent Healthy Communities Institute (HCI) was contracted to facilitate data collection, analysis, and community engagement efforts.

Community Definition

Patients Medical Center (PMC) serves communities in the eastern portion of the Greater Houston Metropolitan Area, encompassing a mix of urban and suburban neighborhoods. The hospital's defined service area includes 14 zip codes, identified through inpatient discharge data to reflect the geographic regions with the highest utilization of PMC's services. This targeted approach ensures the Community Health Needs Assessment (CHNA) accurately captures the health needs of the populations most reliant on PMC for care.

Process and Criteria to Identify and Prioritize Significant Health Needs

Health needs were prioritized based on magnitude and community impact, considering secondary data indicators, stakeholder input, and collaborative discussions. The process involved a comprehensive review of the available data, alongside surveys and input from key stakeholders, including healthcare professionals, community leaders, and residents. This collaborative approach ensured that diverse perspectives were considered, leading to a well-rounded understanding of the community's most pressing health concerns.

Upon identifying the significant health needs, the team categorized them into themes such as chronic disease prevention, mental health support, access to healthcare services, and health education. Each category was then evaluated to determine its potential impact on the community's overall well-being and its alignment with the hospital's mission and resources.

The prioritization process also considered the feasibility of addressing these needs, considering available resources, potential partnerships, and existing community initiatives. By aligning efforts with ongoing programs and leveraging partnerships, PMC aims to maximize the effectiveness of its community health improvement strategies.

As a result, the prioritized health needs will guide the development of targeted interventions and programs designed to address gaps in care and improve health outcomes for all community members, particularly those who are most vulnerable. These efforts are intended to foster a healthier, more resilient community, where everyone has the opportunity to thrive.

List of Prioritized Significant Health Needs

Health needs were ranked based on their significance and potential impact on the community. This prioritization process incorporated a comprehensive review of secondary data indicators, insights gathered through stakeholder interviews and focus groups, and collaborative discussions with community partners. The resulting list of prioritized needs reflects both the prevalence and urgency of issues affecting the population.

The identified priority health needs include:

Cancer | Diabetes | Health Care Access & Quality | Heart Disease & Stroke | Mental Health | Older Adults

Each of these areas represent a significant concern that affects health outcomes and quality of life for residents across the defined community. More detailed data, justification for prioritization, and summaries of community input are provided in subsequent sections of this report. Additional data tables, methodology details, and community input documentation are available in the appendices.

Resources Potentially Available

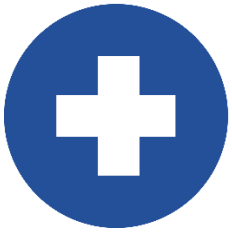
Resources potentially available to address these needs include existing community programs, local nonprofit partnerships, healthcare infrastructure investments, and ongoing collaborations with community-based organizations targeting the identified significant health needs within the service area.

Report Adoption, Availability and Comments

This CHNA report was adopted by the PMC advisory board in June 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at the hospital's Mission and Spiritual Care Office. Written comments on this report can be submitted to the Mission and Spiritual Care Office, 4600 E Sam Houston Pkwy S, Pasadena, TX 77505 or by e-mail to fawn.preuss@commonspirit.org.

Looking Back: Evaluation of Progress since prior CHNA

Over the past three years (FY22–FY24), Patient's Medical Center implemented initiatives aligned with the 2022 Implementation Strategy, focusing on Access to Care, Chronic Disease Management, and Preventive Practices.



Access to Care Initiatives

- Provided financial assistance to eligible patients unable to pay for medically necessary care.
- Delivered health equity education to staff and the community to enhance cultural understanding and communication in healthcare delivery.

Chronic Disease Management

- Strengthened collaborations with local providers, civic organizations, and nonprofits to improve chronic disease management resources.
- Promoted healthy lifestyles through partnerships with schools, faith-based groups, and community organizations.

Preventive Practices

- Participated in community-led outreach activities, including screenings, immunizations, and health education.
- Promoted annual wellness visits and regular screenings to encourage early detection and ongoing care.

Community Engagement

- Fostered a culture of volunteerism to support patients, staff, and visitors, enhancing the care environment.

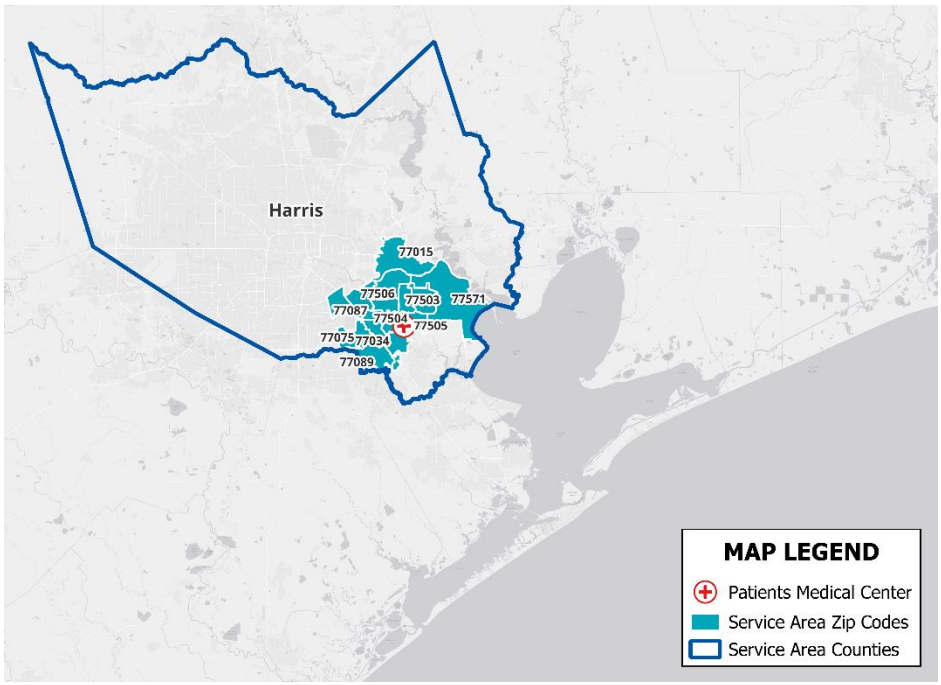
Defining the Community

Patients Medical Center (PMC) serves a defined region within the eastern portion of the Greater Houston Metropolitan Area. This area encompasses a diverse blend of urban and suburban neighborhoods, spanning 14 zip codes that collectively represent the primary service area for PMC. These zip codes were strategically selected based on inpatient discharge data to ensure the CHNA addresses the geographic regions with the highest utilization of PMC's healthcare services.

The total population of PMC's service area is approximately 490,871 residents, characterized by significant racial, ethnic, linguistic, and socioeconomic diversity. According to 2024 Claritas data, 67.2% of the population identifies as Hispanic/Latino, and 34.0% as White, with additional representation from Black/African American (9.6%) and Asian (3.9%) communities. Language diversity is also pronounced—only 46.5% of residents speak English only, while a significant proportion speak Spanish and other languages at home.

This community also experiences high levels of socioeconomic need. Approximately 14.6% of households live below the poverty line, and median household income is lower than state and national averages. Barriers to care are exacerbated by issues related to housing stability, food insecurity, employment, and insurance coverage. PMC's service area has elevated scores in the Community Health Index and Mental Health Index, reflecting disproportionate challenges related to preventable hospitalizations, poor mental health, and social determinants of health.
A full list of included zip codes is available in the Appendix, and key demographic and socioeconomic data are summarized in the Core Demographics section of this report.

FIGURE 1. BRAZOSPORT HOSPITAL SERVICE AREA



Demographic Profile

Geography and Data sources

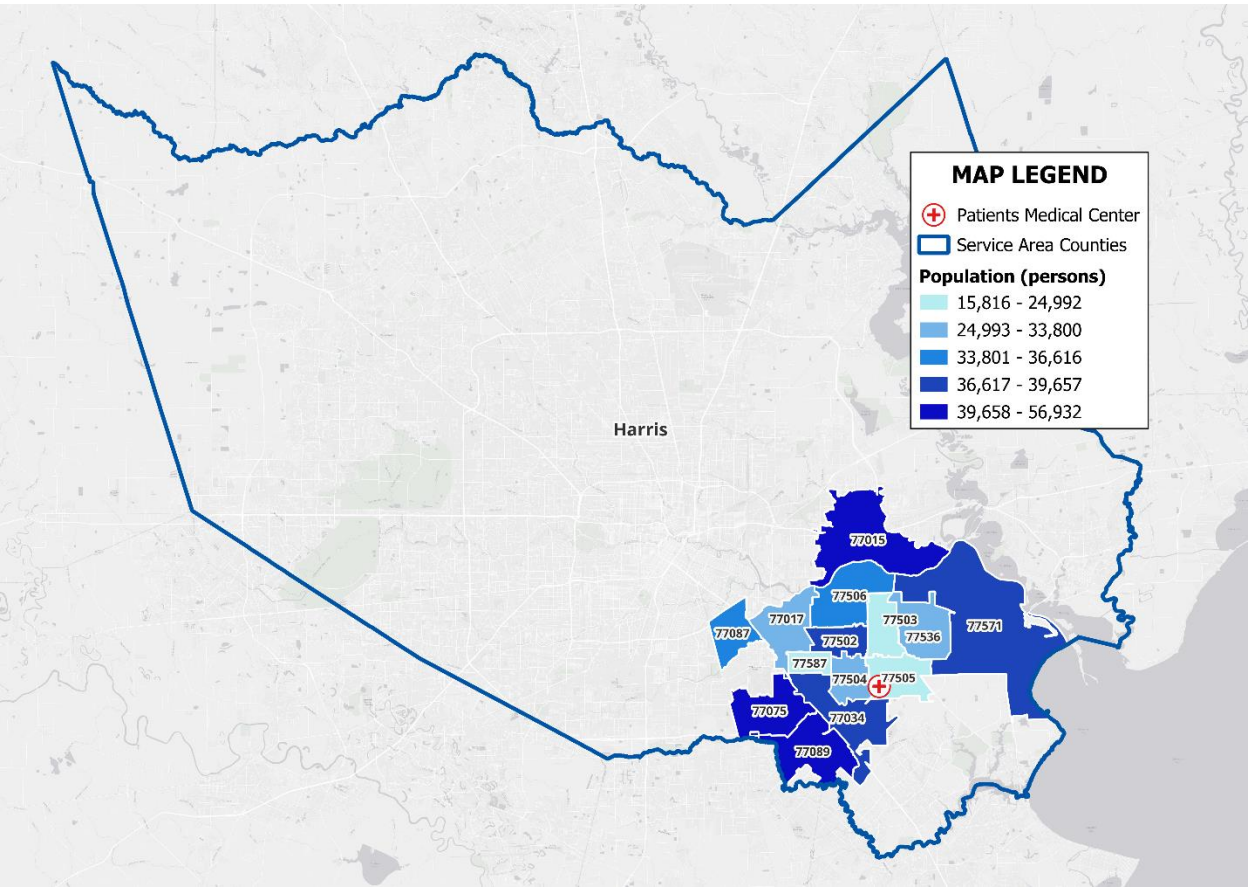
The following section explores the demographic profile of the Patient Medical Center's (PMC) primary service area, which includes 14 zip codes in Harris County. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

Unless otherwise indicated, all demographic estimates are sourced from Claritas® (2024 population estimates). Claritas demographic estimates are primarily based on U.S. Census and American Community Survey (ACS) data. Claritas uses proprietary formulas and methodologies to calculate estimates for the current calendar year.

Population

The PMC primary service area has an estimated population of 490,871 persons. Figure 2 shows the population breakdown for the service area by zip code.

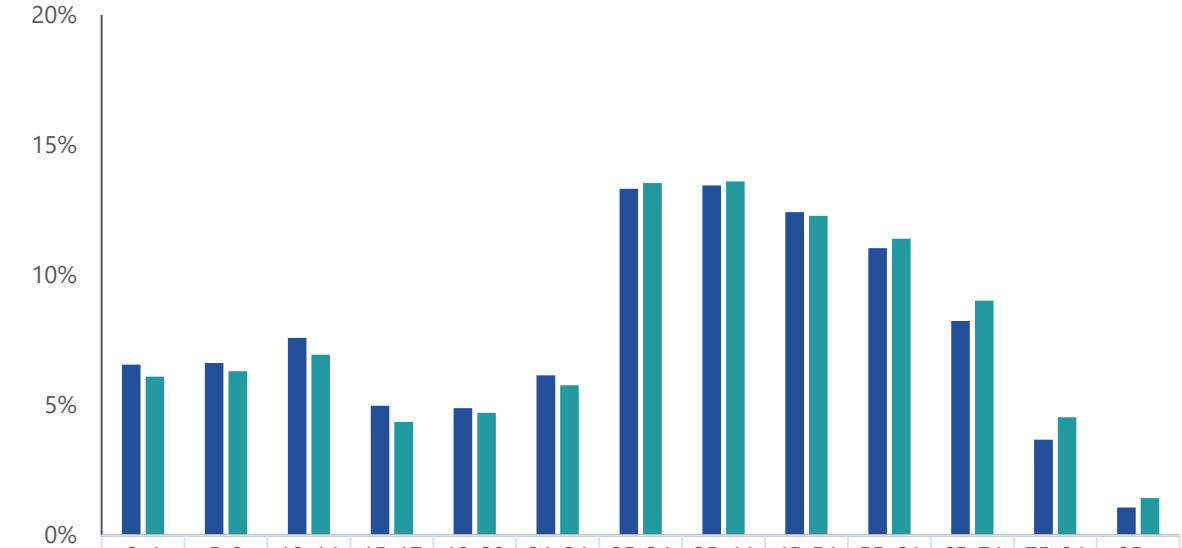
FIGURE 2. POPULATION DISTRIBUTION: PMC PRIMARY SERVICE AREA



Age

Figure 3 shows the population of PMC's primary service area broken down by age group, with comparisons to the state-wide Texas population. Overall, the age distribution of PMC is similar to the state-wide Texas population. Most of the population is between 25 and 64 years old.

FIGURE 3. PERCENT POPULATION BY AGE: PRIMARY SERVICE AREA AND STATE

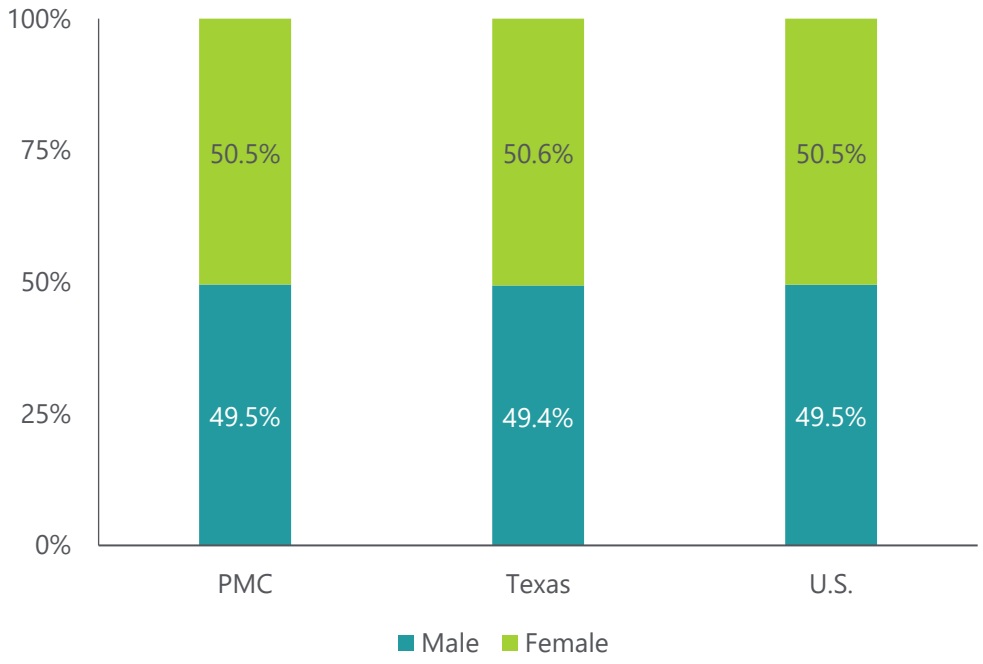


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
PMC	6.6%	6.6%	7.6%	5.0%	4.9%	6.2%	13.3%	13.5%	12.4%	11.0%	8.2%	3.7%	1.1%
Texas	6.1%	6.3%	6.9%	4.4%	4.7%	5.8%	13.5%	13.6%	12.3%	11.4%	9.0%	4.5%	1.4%

Sex

As seen in Figure 4, 50.5% of the PMC population is female, which is similar to both state and national populations (50.6% and 50.5%, respectively).

FIGURE 4. PERCENT POPULATION BY SEX: PRIMARY SERVICE AREA, STATE, AND NATION



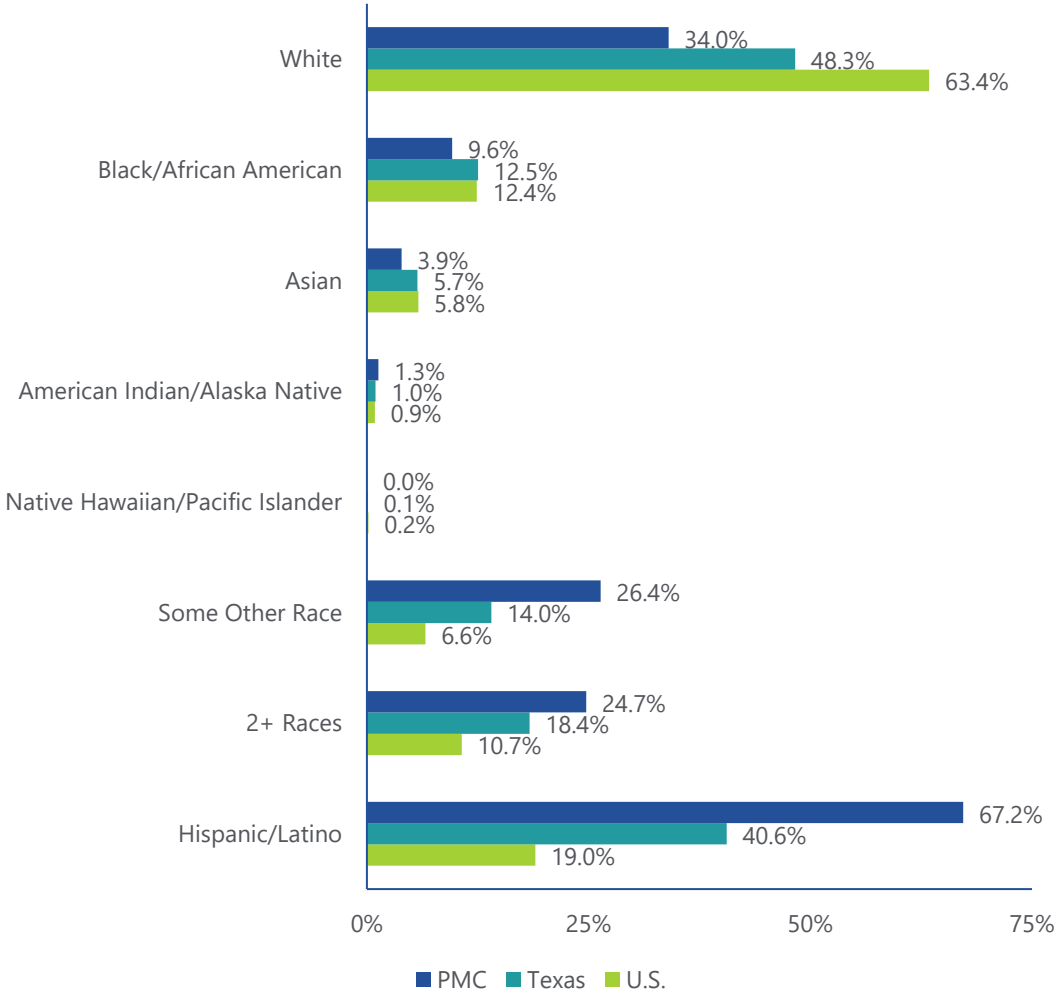
U.S. value taken from American Community Survey (2019-2023)

Race and Ethnicity

Considering the racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

The PMC primary service area has a racially and ethnically diverse population. The majority of the PMC service area population identify as Hispanic/Latino (67.2%), which is higher than statewide or nationwide populations (40.6% and 19.0%, respectively). Additionally, PMC has a higher percentage of residents who identify with more than one race (24.7%) compared to state and nation-wide percentages (18.4% and 10.7%, respectively).

FIGURE 5. POPULATION BY RACE AND ETHNICITY



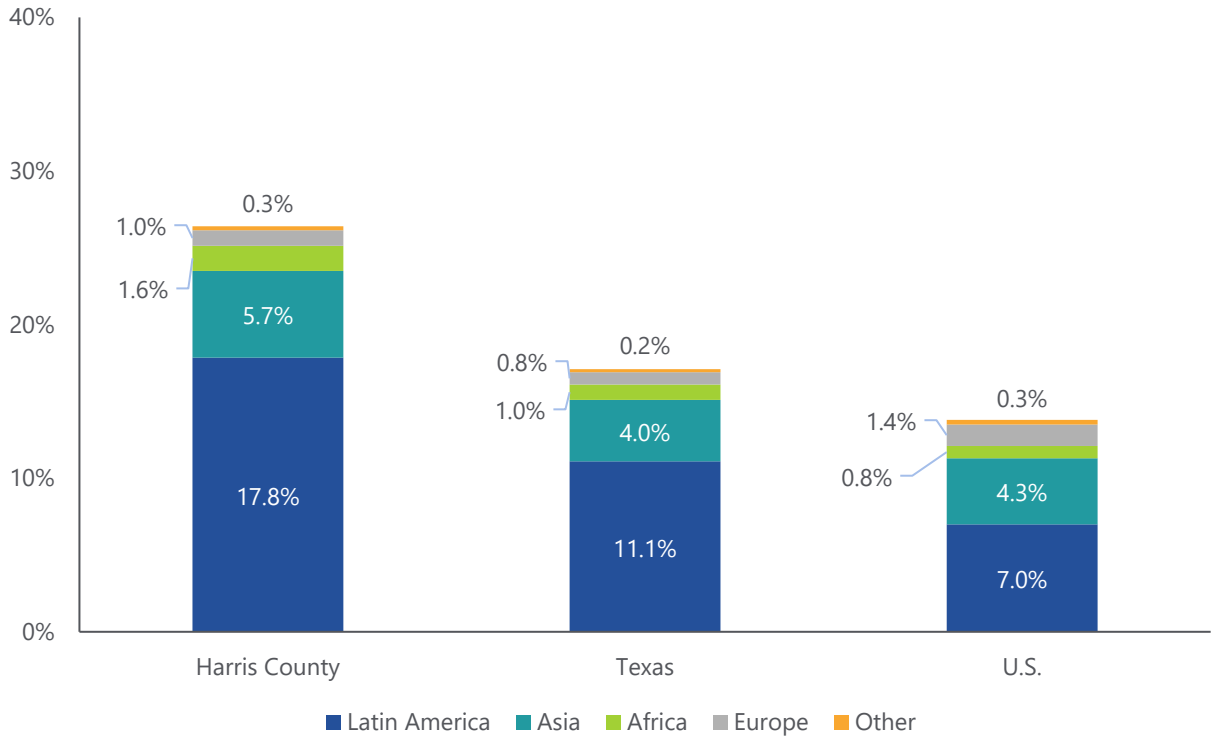
U.S. value taken from American Community Survey (2019-2023)

Language and Immigration

Understanding countries of origin and spoken languages can help inform a community's cultural and linguistic context. According to the American Community Survey, 26.4% of residents in Harris County are born outside the U.S., which is higher than the state value (17.2%) and national value (13.9%).

Figure 6 provides a breakdown of region of birth for any persons born outside the country. Compared to both Texas and the U.S. overall, Harris County has a larger percentage of residents born in Latin America (17.8%). Additionally, 1 in 20 Harris County residents were born in Asia (5.7%), which is also higher than both the Texas and U.S. populations overall.

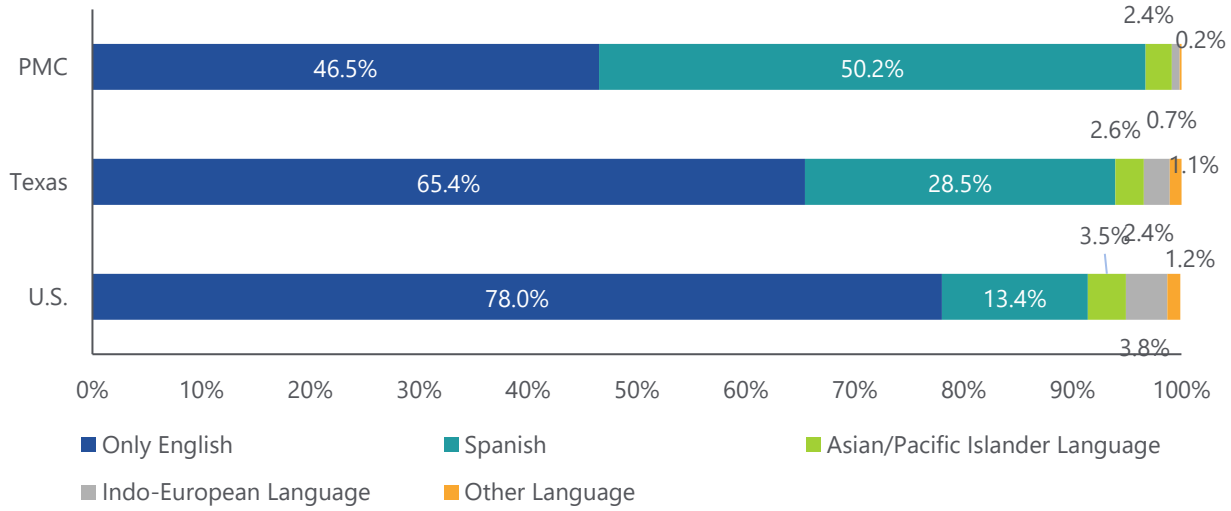
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY



County, State, and U.S. values taken from American Community Survey (2019-2023)

As shown in Figure 7, more than half of the residents in the PMC primary service area (53.5%) speak a language other than English at home. The PMC population is also more likely than the state-wide Texas population to speak Spanish, specifically (50.2% vs. 28.5%).

FIGURE 7. POPULATION AGE 5+ BY LANGUAGE SPOKEN AT HOME

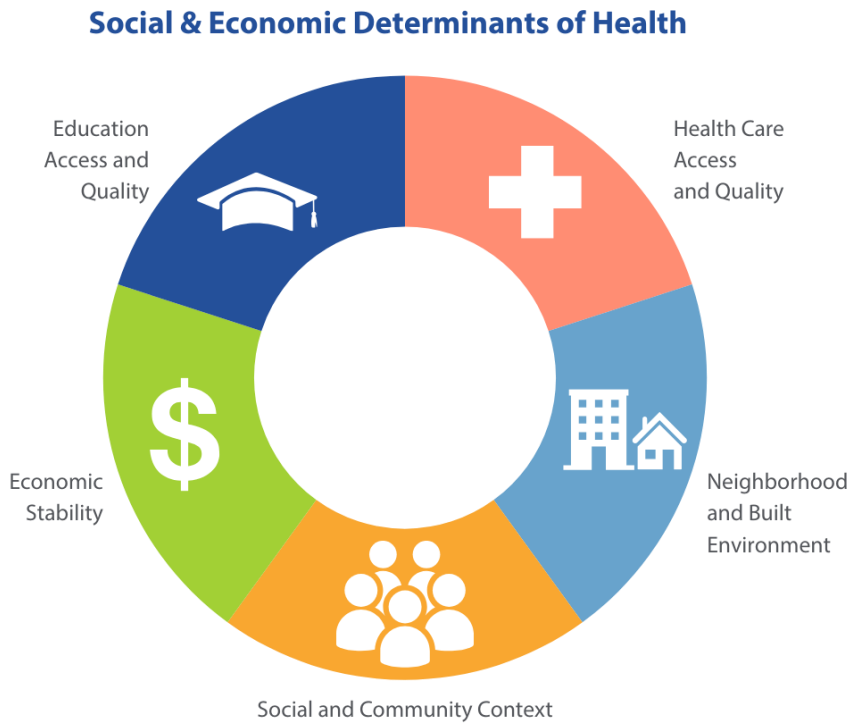


U.S. value taken from American Community Survey (2019-2023)

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the PMC primary service area. Social Determinants of Health (SDOH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The SDOH can be grouped into five domains. Figure 8 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022).

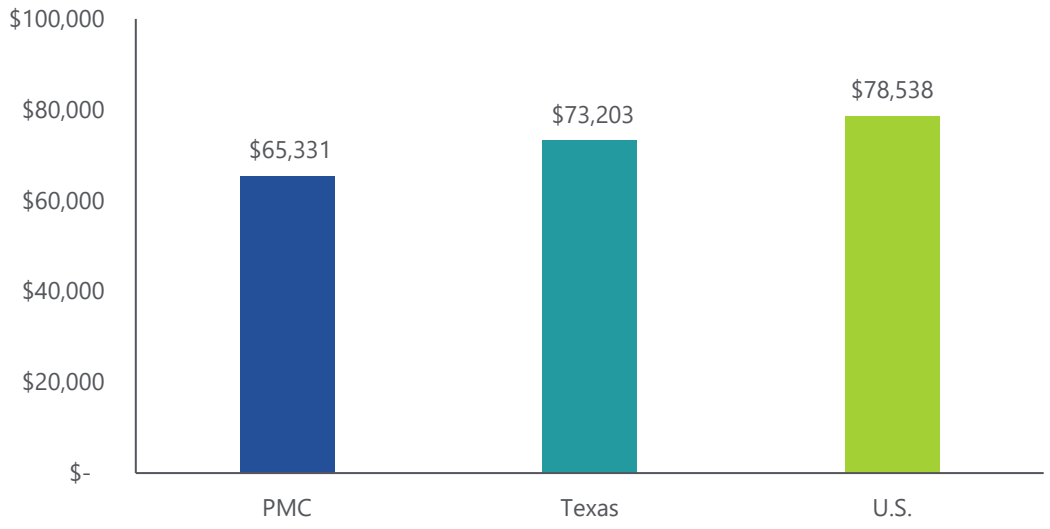
FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH



Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work. Figure 9 provides the median household income in the service area, compared to the state and nation.

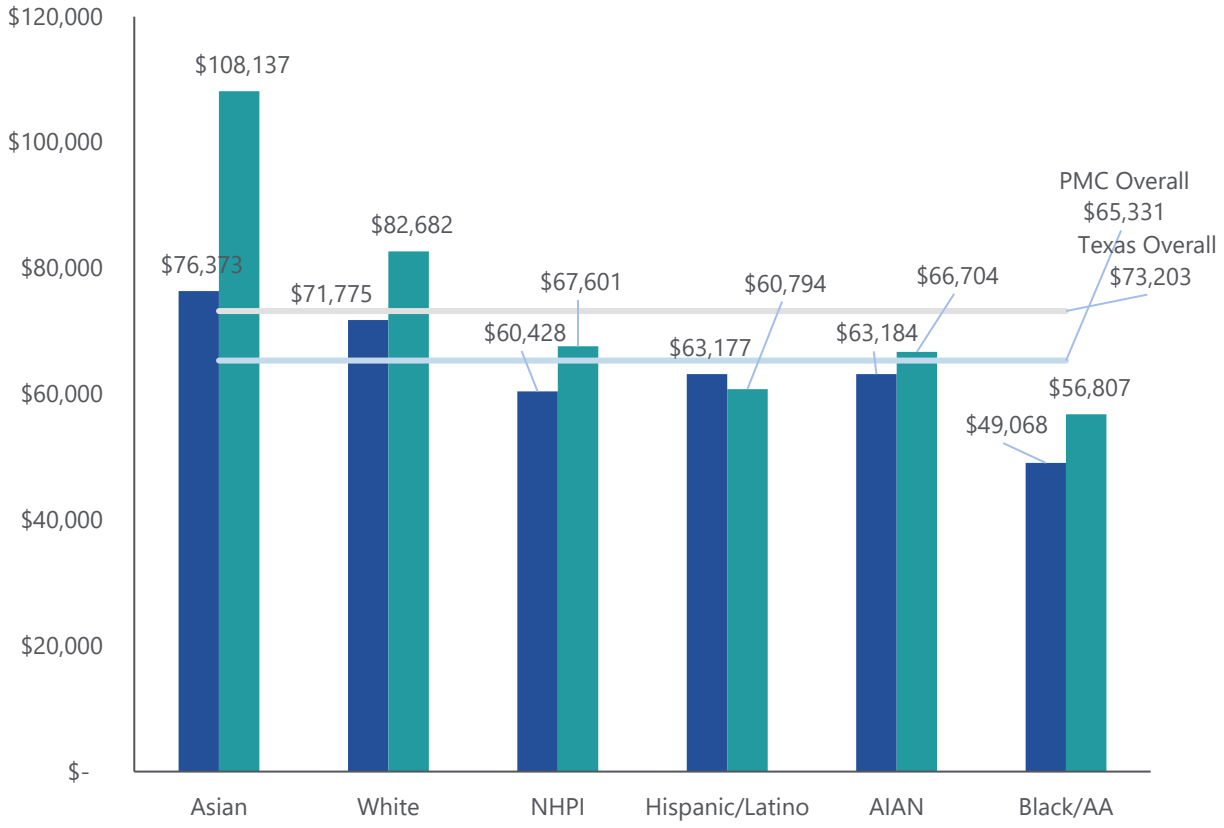
FIGURE 9. MEDIAN HOUSEHOLD INCOME



U.S. value taken from American Community Survey (2019-2023)

Disparities in median household income exist between racial and ethnic groups within the county. As shown in Figure 10, the Native Hawaiian/Pacific Islander, Black/African American, American Indian/Alaska Native, and Hispanic/Latino communities of the PMC service area all have a lower median income than the overall service area median income. For example, the Black/African American median income is $16,263 lower than the overall median income ($49,068 vs. $65,331).

FIGURE 10. MEDIAN HOUSEHOLD INCOME BY RACE & ETHNICITY

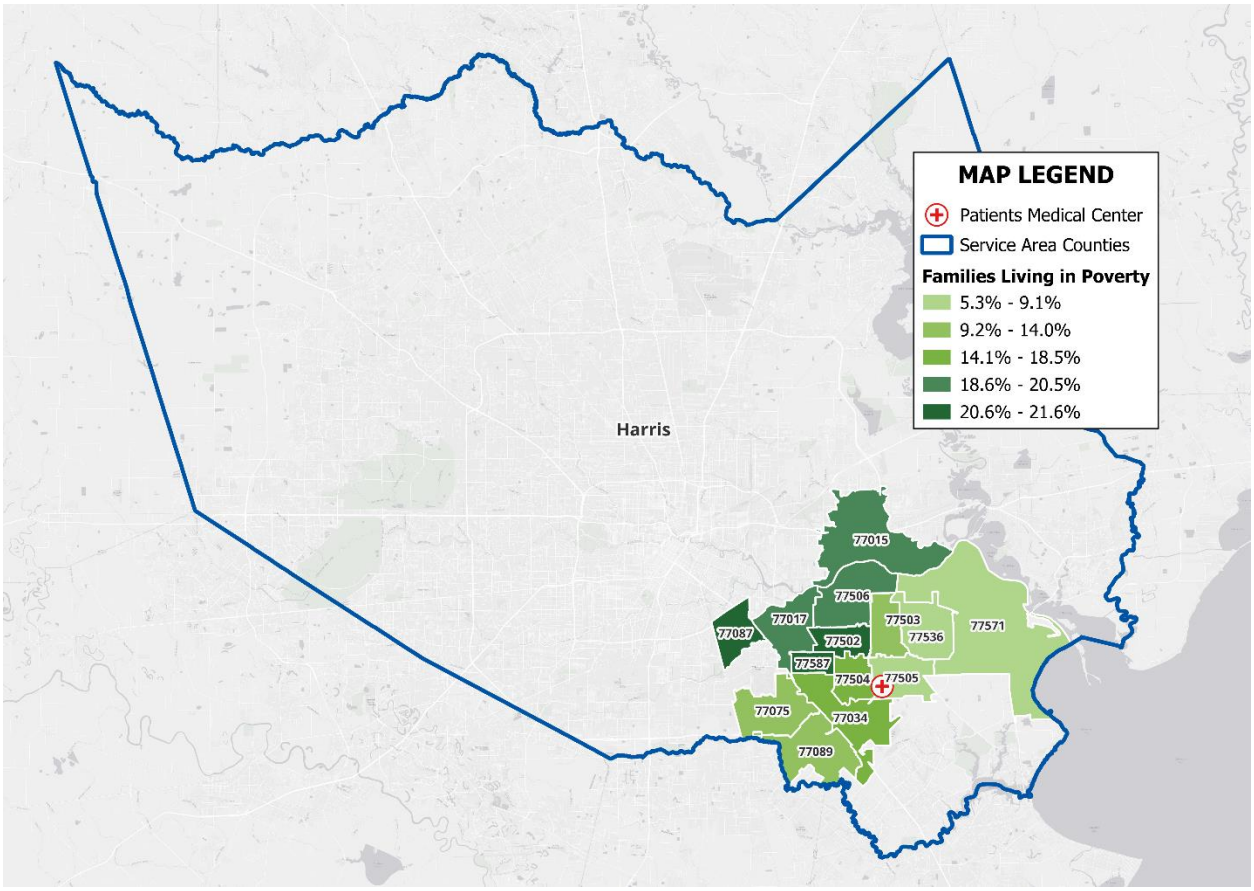


Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[1]

Overall, 14.6% of families in the PMC primary service area live below the poverty level, which is higher than the state value of 11.0% and the national value of 8.7%. The map in Figure 11 shows the percentage of families living below the poverty level by zip code. The darker green colors represent a higher percentage of families living below the poverty level.

FIGURE 11. PERCENT OF FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE



[1] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

The percentage of families living below poverty for each zip code in the service area is provided in Table 1. The two zip codes in the service area with the highest concentration of poverty are 77502 and 77087. In both zip codes, more than a fifth of families live below poverty (21.6% and 21.3%, respectively).

TABLE 1. FAMILIES LIVING IN POVERTY: PMC PRIMARY SERVICE AREA

Zip Code	% Families in Poverty	Zip Code	% Families in Poverty
77502	21.6%	77034	15.3%
77087	21.3%	77075	13.7%
77587	20.8%	77089	10.1%
77506	20.3%	77503	9.9%
77017	20.1%	77571	8.1%
77015	19.1%	77505	7.1%
77504	16.2%	77536	5.3%

Employment

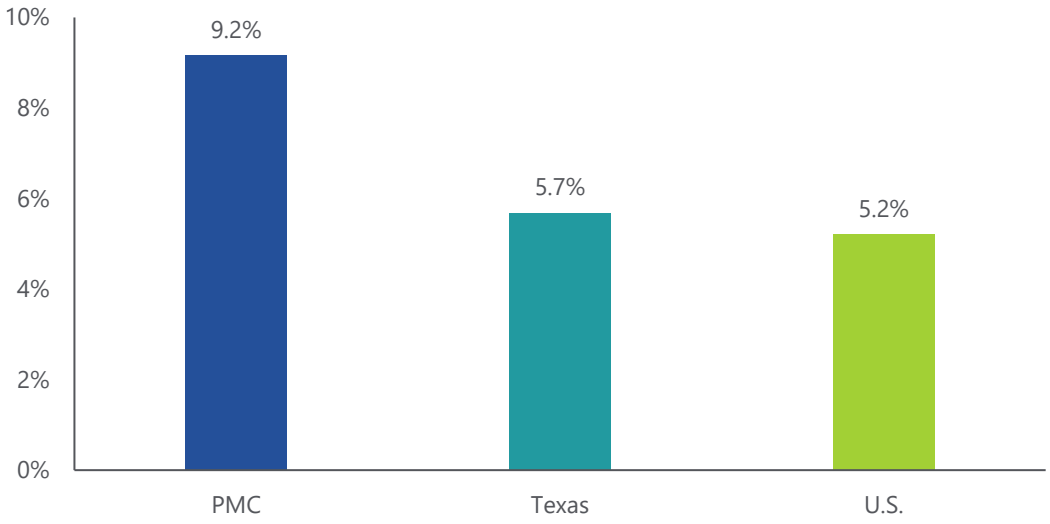
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[2]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[2] Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[2]

Figure 12 shows the population aged 16 and over who are unemployed. The unemployment rate for the PMC primary service area is 9.2%, which is higher than both the state-wide and nation-wide unemployment rates (5.7% and 5.2%, respectively).

[2] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment

FIGURE 12. POPULATION 16+ UNEMPLOYED: COUNTY, STATE, AND U.S.



U.S. value taken from American Community Survey (2019-2023)

Education

Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. A high school diploma is a requirement for many employment opportunities, and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[3] Further, people with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[4]

Figure 13 shows the detailed breakdown of the PMC primary service area by educational attainment, among those aged 25 and up. As shown in Figure 13, most of the PMC population has a high school diploma or higher (72.9%), although this is lower than both the state-wide and nation-wide rates (85.1% and 89.4%, respectively).

[3] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health

[4] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/educationmatters-for-health.html

FIGURE 14. PMC PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+

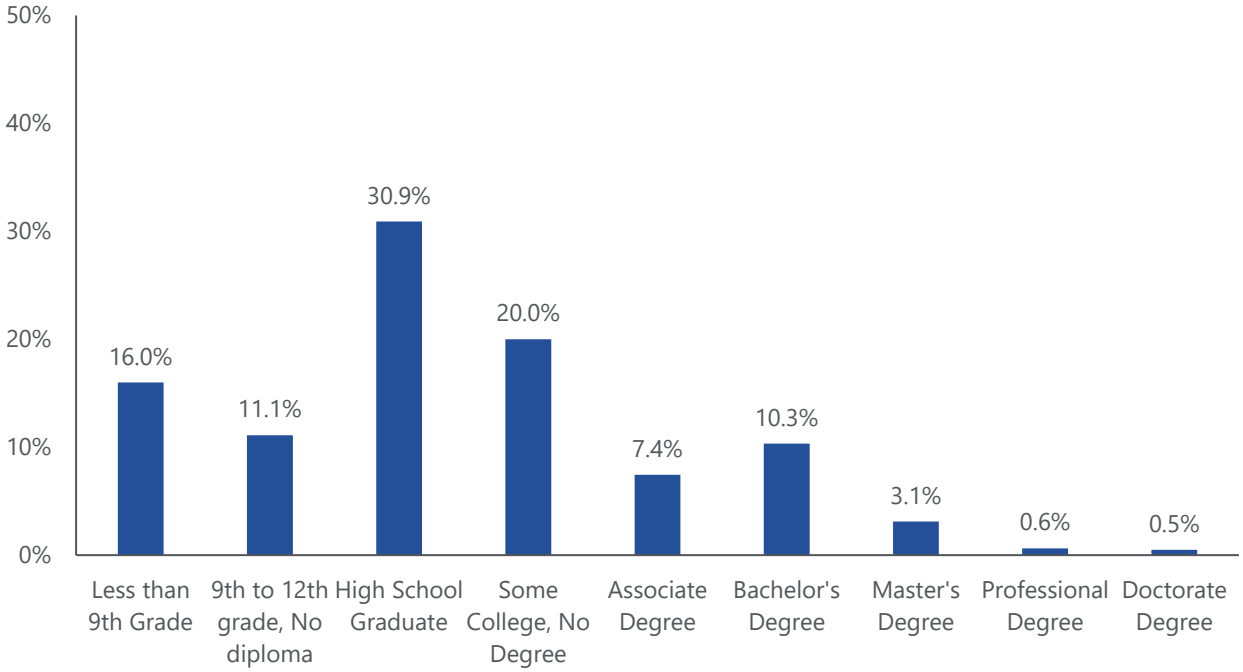
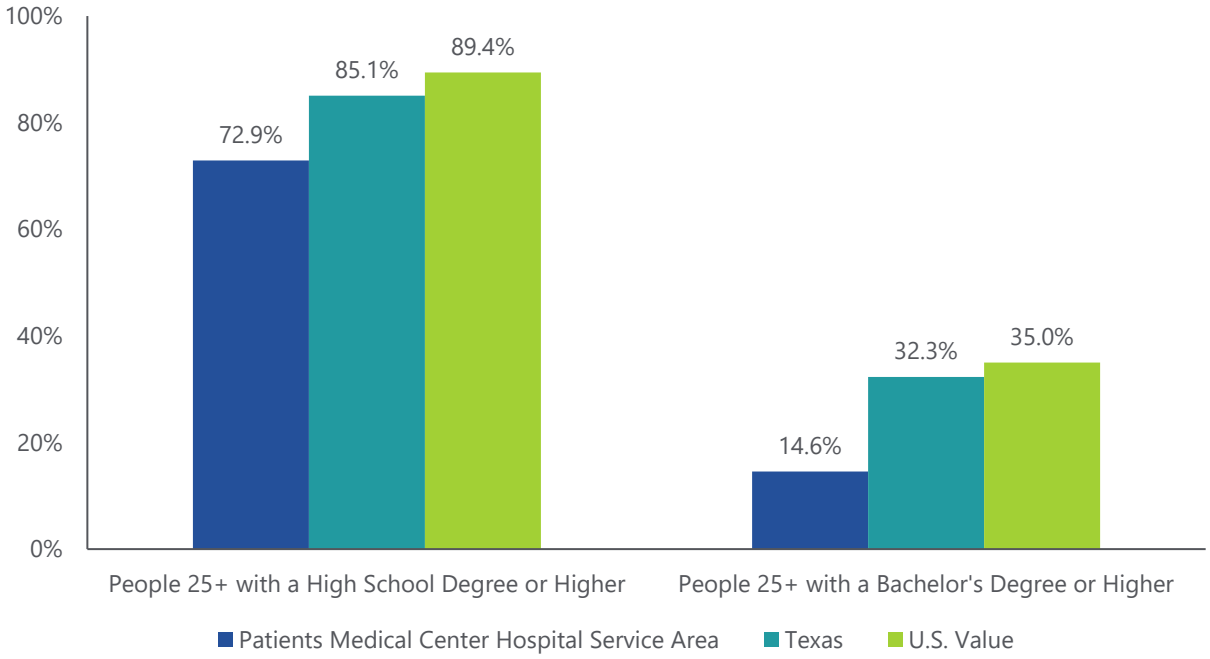


FIGURE 14. POPULATION 25+ BY EDUCATIONAL ATTAINMENT



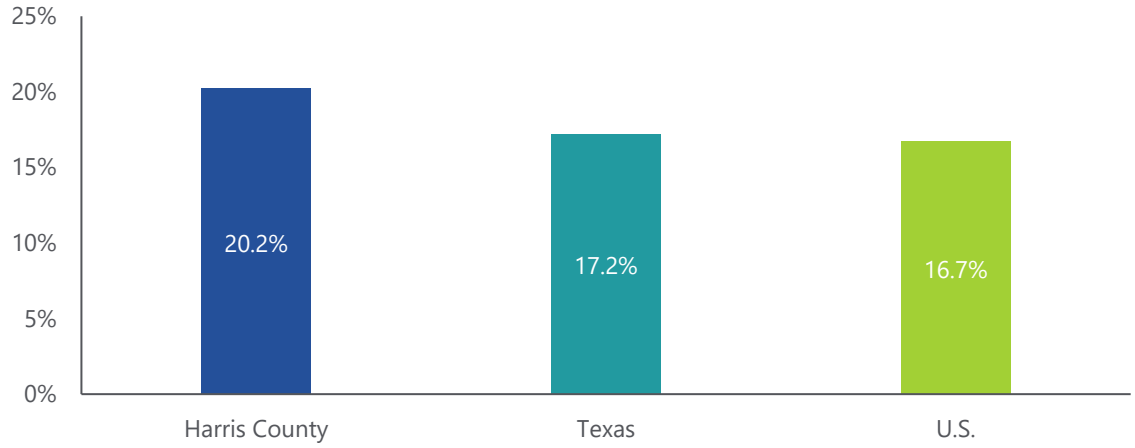
U.S. value taken from American Community Survey (2019-2023)

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[5]

As shown in Figure 15, 1 in 5 households in Harris County (20.2%) have severe housing problems, indicating that they have at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. This is higher than both the state-wide and nation-wide rates (17.2% and 16.7%, respectively).

FIGURE 15. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



County, State, and U.S. values taken from County Health Rankings (2016-2020)

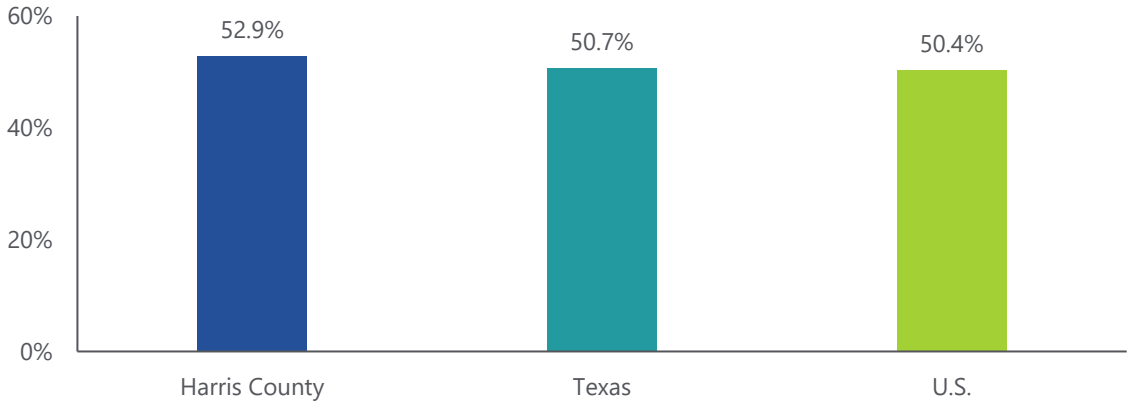
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[6]

[5] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Figure 16 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Harris County (52.9%) is higher than both the state value (50.7%) and the national value (50.4%).

FIGURE 16. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT



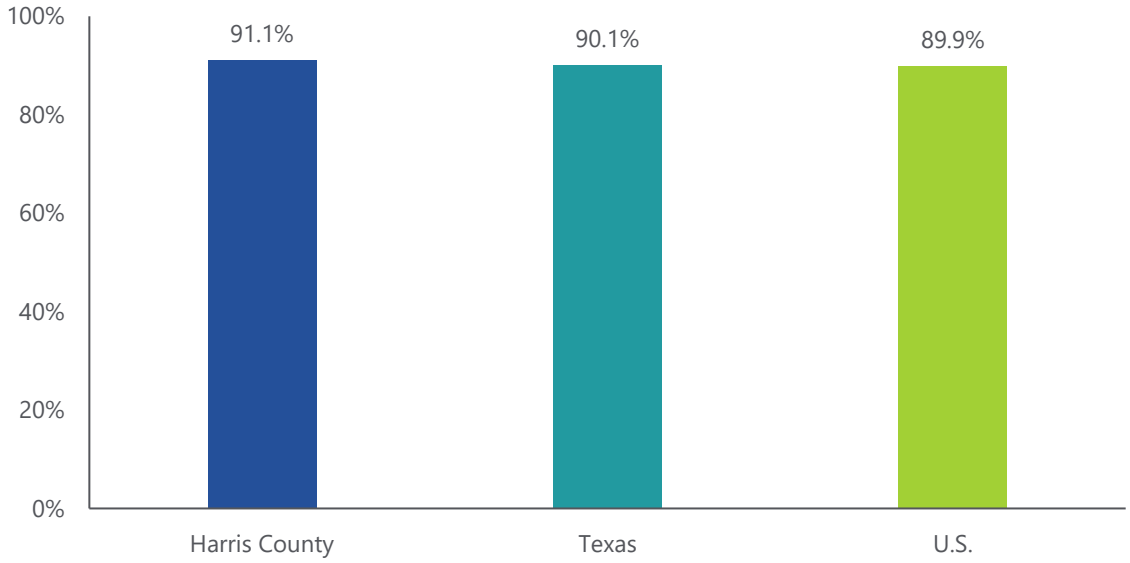
County, State, and U.S. values taken from American Community Survey (2019-2023)

Neighborhood and Built Environment

Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet also helps expand healthcare access through home-based telemedicine services, which has been particularly critical during the COVID-19 pandemic.[7] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[7]

Figure 17 shows the percentage of households that have an internet subscription. The rate in Harris County (91.1%) is slightly higher than both the state value (90.1%) and the national value (89.9%).

FIGURE 17. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION



County, State, and U.S. values taken from American Community Survey (2019-2023)

[7] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Primary and Secondary Data Methodology and Key Findings

PMC employed a mixed-methods approach that integrated both quantitative (secondary) data and qualitative (primary) input to create a comprehensive picture of health needs, disparities, and opportunities for community improvement. This approach ensures that health priorities are informed not only by statistical trends but also by the lived experiences and perspectives of the community.

Quantitative Data: Secondary Sources

Secondary data analysis provided measurable insights into health status, social determinants of health, and system performance across the community. Sources included national, state, and local public health databases, as well as internal hospital data. The Healthy Communities Institute database was leveraged with over 200 indicators in both health and quality of life topic areas for the Secondary Data Analysis of the Health Service Area. Key Indicators analyzed include:

 **Quality of Life**	 **Health**	
Community	Adolescent Health	Men's Health
Economy	Alcohol & Drug Use	Mental Health & Mental Disorders
Education	Cancer	Older Adults
Environment	Children's Health	Oral Health
Transportation	Diabetes	Prevention & Safety
	Disabilities	Physical Activity
	Environmental Health	Respiratory Diseases
	Family Planning	Tobacco Use
	Health Care Access and Quality	Women's Health
	Heart Disease & Stroke	Wellness & Lifestyle
	Immunizations and Infectious Diseases	Weight Status
	Maternal, Fetal & Infant Health	

*All data were scored using a standardized index to assess severity and disparities across zip codes.

Qualitative Data: Primary Sources

Primary data were collected through community engagement activities designed to elevate voices from across the hospital's defined service area. These activities included:

Partner Survey

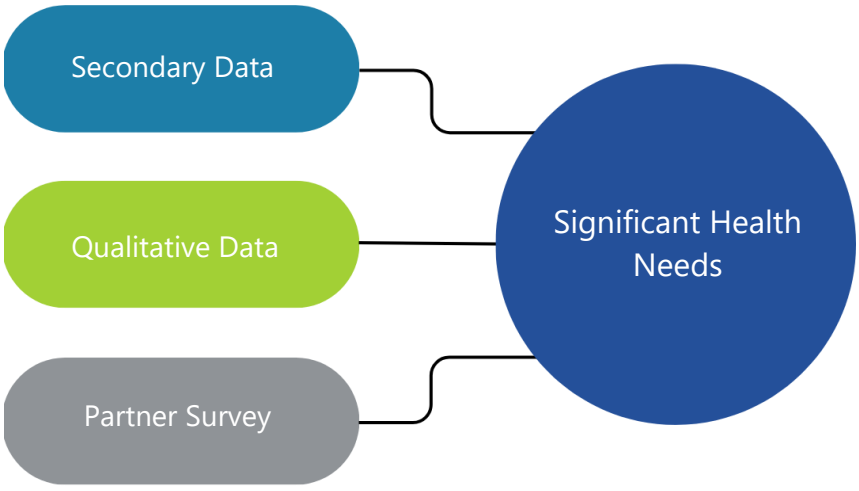
An online survey was distributed to over 60 organizational partners and stakeholders, including representatives from public health departments, healthcare providers, social service agencies, and nonprofit organizations. The survey captured perspectives on health priorities, gaps in care, barriers to service delivery, and populations most impacted by health inequities.

Key Informant Interviews and Listening Sessions

Conducted with dozens of individuals representing a range of sectors including public health, healthcare, housing, education, behavioral health, and community-based organizations. These participants included:

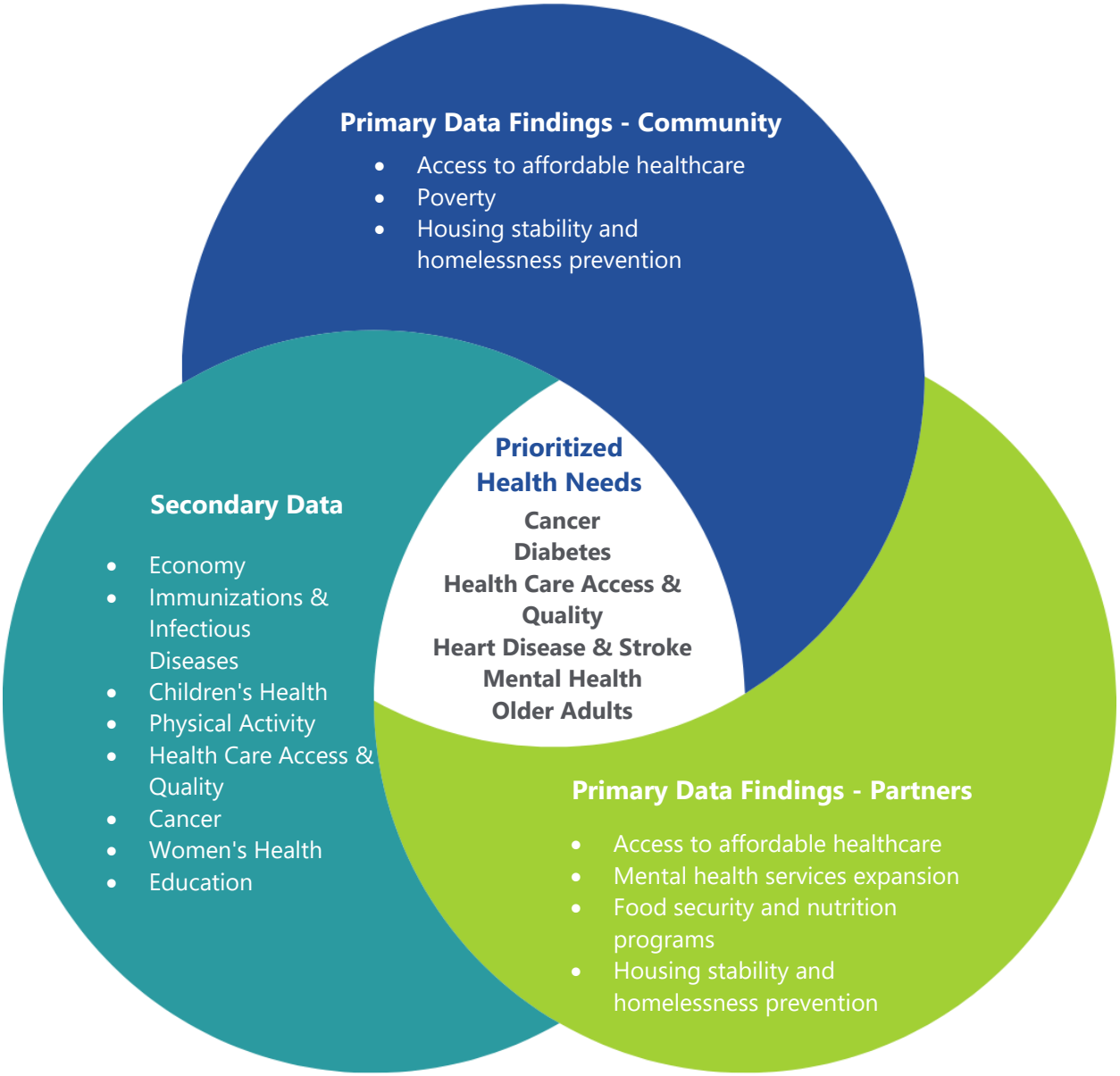
- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

Participants were asked to share their views on community strengths, emerging challenges, and opportunities for collaboration. Themes were identified in relation to access to care, behavioral health, transportation, and the lingering impacts of COVID-19 and natural disasters. A detailed summary of participating organizations, and input themes is available in the Appendix.



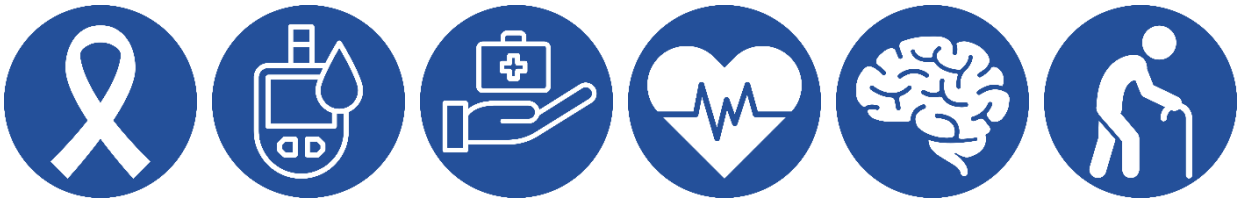
By combining data-driven analysis with community perspectives, the process ensures a comprehensive understanding of health needs and identifies priority areas for future intervention, collaboration, and investment.

Data Synthesis



Significant Health Needs

Through comprehensive data analysis and community input process, the following health needs have been identified as the most pressing in PMC's service area:



Cancer | Diabetes | Health Care Access & Quality | Heart Disease & Stroke | Mental Health | Older Adults

Identification of Significant Health Needs

The criteria for identifying the most pressing health needs involve a three-pronged approach:

Secondary Data Topic Score: A score of 1.50 or higher is deemed significant. This threshold was chosen because it represents a midway point in the scoring system used, which ranges from 0 to 3. A score of 1.50 or above indicates that the health issue is notably worse than state and national benchmarks, signaling a substantial area of concern that requires attention.

Frequency of Discussion in Qualitative Sessions: These criteria involve analyzing how often a health issue is mentioned during community partner listening sessions. The frequency of discussion provides qualitative insights into the community's perception and experiences regarding specific health needs, enhancing the quantitative data by highlighting what is actively affecting the community.

Priority Selection by 20% or More of Partner Survey Respondents: This metric involves assessing the priority level assigned to health needs by respondents in the community partner survey. If 20% or more participants identify a health issue as a priority, it underscores its importance within the community. This helps to validate and contextualize the data, ensuring that the identified needs align with community priorities and concerns.

Together, these criteria offer a comprehensive approach: the quantitative scores highlight areas of statistical concern, while the qualitative and survey components ensure that the data is grounded in actual community experiences and priorities.

Cancer

From the secondary data scoring results, Cancer ranked 19th in the data scoring of all topic areas with a score of 1.22. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 2 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 2. **HARRIS COUNTY DATA SCORING RESULTS: CANCER**

Score	Cancer Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.25	Colon Cancer Screening: USPSTF Recommendation	*percent*	54.7	--	--	66.3			--
2.08	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	111.9	--	108.3	113.2			
1.83	Cancer: Medicare Population	*percent*	12.0	--	11.0	12.0			--
1.78	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	9.8	--	9.6	7.5	--		
1.69	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20.4	15.3	19.7	19.3	--		
1.61	Mammogram in Past 2 Years: 50-74	*percent*	73.4	80.3	--	76.5			--
1.53	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	19.2	16.9	18.2	19.0	--		
1.50	Mammography Screening: Medicare Population	*percent*	42.0	--	44.0	39.0			--

Secondary data indicate that the incidence of both prostate and cervical cancer is concerning in Harris County. Harris County's *Prostate Cancer Incidence Rate* is higher than the overall Texas rate (111.9 vs. 108.3 cases per 100,000 males), and Harris County's *Cervical Cancer Incidence Rate* (9.8 cases per 100,000 females) is higher than the Texas and U.S. rates (9.6 and 7.5, respectively). Although the incidence of cervical cancer has been significantly improving over time, the county-wide prostate cancer rate has been worsening, although not significantly.

Certain forms of cancer-related mortality are also concerning in Harris County. The age-adjusted death rates due to breast cancer and prostate cancer are higher in Harris County than the state-wide and nation-wide rates, and they are also both well above the Healthy People 2030 targets.

Lower rates of certain cancer screenings may contribute to some of these concerning rates of cancer incidence and death. Harris County residents are less likely to have received a colon cancer

screening or mammogram, compared to nationwide rates. For example, among those who meet US Preventive Service Task Force recommendations for colorectal cancer screening, only 54.7% have received this screening in Harris County, which is one of the lowest county rates across the country.

Finally, we found that certain racial/ethnic groups experienced greater risk than others for certain cancer-related outcomes. For example, the county *Age-Adjusted Death Rate due to Breast Cancer* is 50% higher among Black women, compared to the overall county population (30.6 vs. 20.4 deaths per 100,000), and *Age-Adjusted Death Rate due to Prostate Cancer* is nearly twice as high among Black men, compared to the county population (35.9 vs. 19.2 deaths per 100,000). Black women are also more likely than the overall county population to develop breast cancer (129.7 vs. 117.1 cases per 100,000). The same is true for White women (132.0 vs. 117.1). We also found that Hispanic and Latina women were more likely to develop cervical cancer than the overall county population (12.8 vs. 9.8 cases per 100,000).

FIGURE 18. AGE-ADJUSTED DEATH RATE DUE TO BREAST CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000 FEMALES)

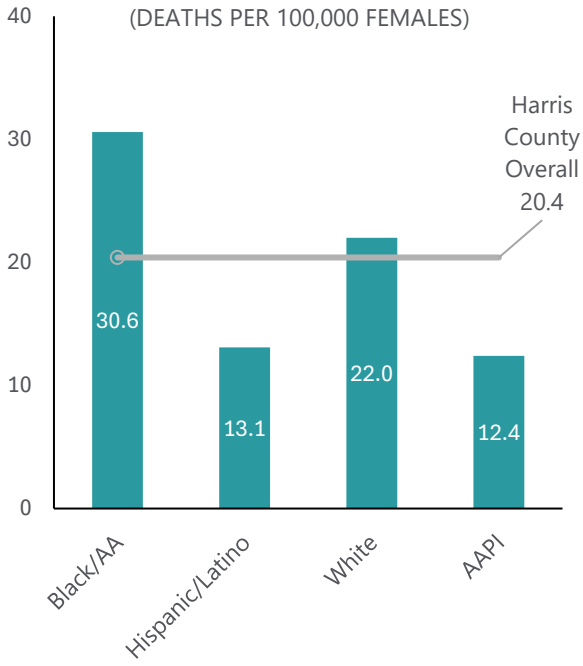


FIGURE 19. AGE-ADJUSTED DEATH RATE DUE TO PROSTATE CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000 MALES)

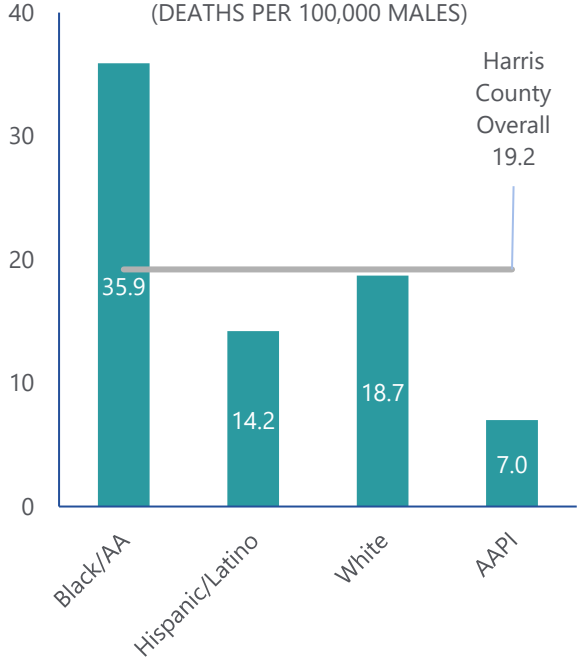


FIGURE 20. BREAST CANCER INCIDENCE, BY RACE/ETHNICITY (CASES PER 100,000 FEMALES)

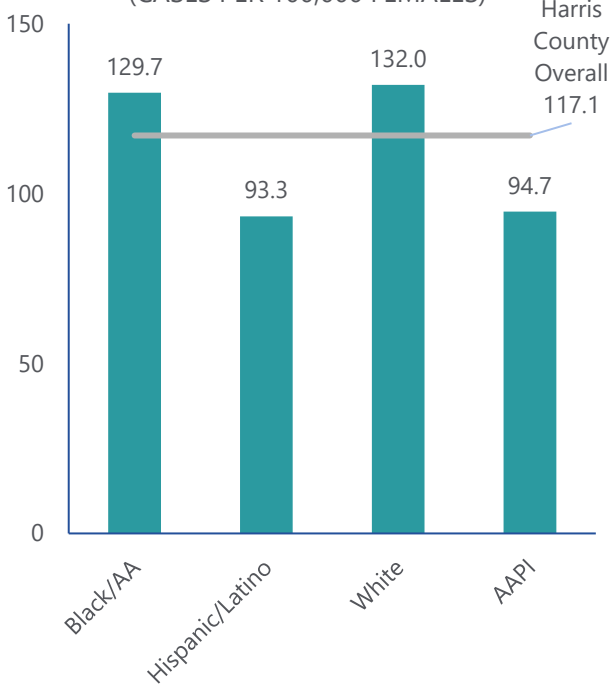
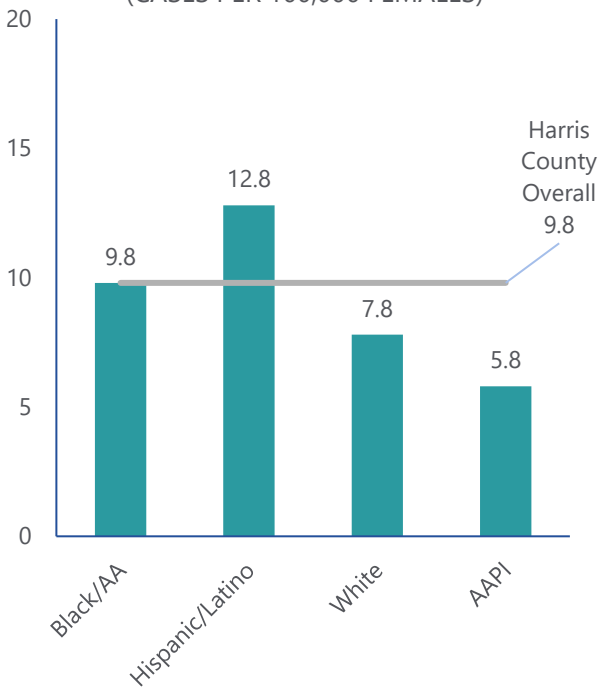


FIGURE 21. CERVICAL CANCER INCIDENCE, BY RACE/ETHNICITY (CASES PER 100,000 FEMALES)



Community stakeholders noted concerns about late diagnoses, barriers to preventive screenings (e.g., mammograms, colonoscopies), and lack of awareness around early warning signs. Participants also cited financial challenges and transportation as obstacles to receiving timely cancer care.

Diabetes

From the secondary data scoring results, Diabetes ranked 13th in the data scoring of all topic areas with a score of 1.50. Only three indicators were available to describe this topic, one of which scored above the threshold of 1.50 and was thus considered an indicator of concern. All three diabetes-related indicators are listed in Table 3 below. See Appendix A for additional details.

TABLE 3. HARRIS COUNTY DATA SCORING RESULTS: DIABETES

Score	Diabetes Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
1.86	Adults 20+ with Diabetes	percent	9.7	--	--	--			
1.33	Diabetes: Medicare Population	percent	25.0	--	25.0	24.0			--
1.31	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	21.6	--	23.8	22.6			

As shown in Table 3, 9.7% of adults age 20 and above in Harris County have diabetes. This is one of the highest county rates of diabetes among all counties across Texas and is also among the top 25% of worst county rates across the nation. Although this rate has been improving, these improvements are not significant.

As also shown in Table 3, the age-adjusted death rate due to diabetes in Harris County is lower than the state-wide and nation-wide rates. However, we found that certain populations experience a greater risk of diabetes-related death than others. The *Age-Adjusted Death Rate due to Diabetes* in Harris County is higher among the Black/African American population than the overall county population (36.6 vs. 21.6 deaths per 100,000 population). Harris County's male population is also more likely than the county's female population to die due to diabetes (26.4 vs. 17.7 deaths per 100,000).

FIGURE 22. AGE-ADJUSTED DEATH RATE DUE TO DIABETES, BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)

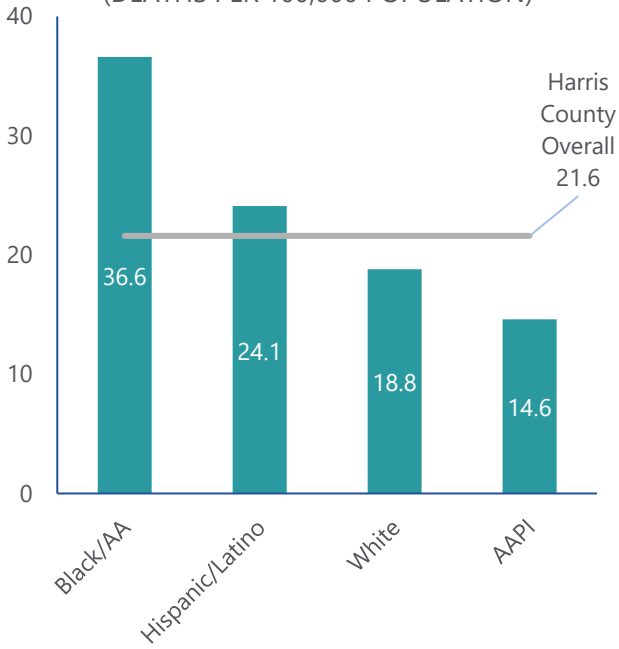
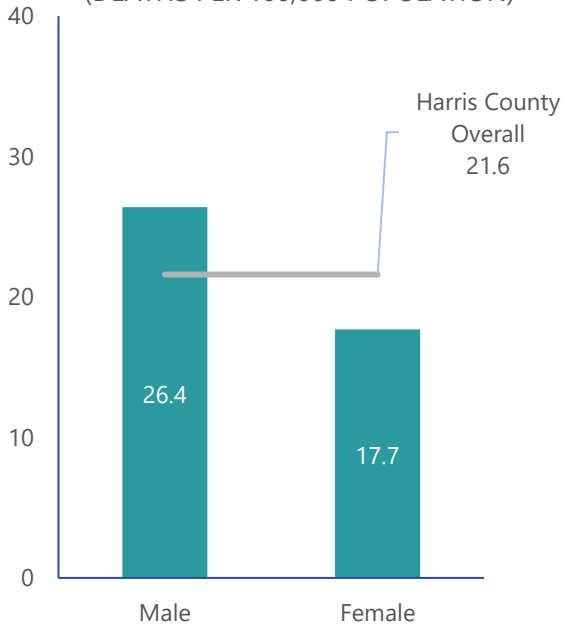


FIGURE 23. AGE-ADJUSTED DEATH RATE DUE TO DIABETES, BY SEX (DEATHS PER 100,000 POPULATION)



Diabetes continues to be a pressing issue in the region, with stakeholders citing both high prevalence and a lack of effective disease management strategies. A community leader shared,

> **There's still a huge gap in knowledge about how to manage diabetes on a daily basis—especially when people can't afford healthy food or consistent medication.**

Health Care Access & Quality

From the secondary data scoring results, Health Care Access & Quality ranked 14th in the data scoring of all topic areas with a score of 1.49. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 4 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 4. HARRIS COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS & QUALITY

Score	Health Care Access & Quality Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.25	Adults without Health Insurance	percent	23.8	--	--	10.8			--
2.08	Adults who have had a Routine Checkup	percent	71.7	--	--	76.1			--
2.08	Adults who Visited a Dentist	percent	50.1	--	--	63.9			--
1.78	Children with Health Insurance	percent	85.5	--	88.1	94.6	--		
1.67	Adults with Health Insurance	percent	73.8	--	78.3	89.0	--		
1.67	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	3025.0	--	2991.0	2769.0			--
1.64	Primary Care Provider Rate	providers/ 100,000 population	58.2	--	60.3	74.9			--

Some of the most concerning indicators regard routine care. The rate for *Adults who have had a Routine Checkup* is 71.7% in Harris County, and *Adults who Visited a Dentist* is only half the county population (50.1%). These are among the top 25% of the worst county rates across the U.S. counties. Both cost and availability may be related to these low rates of routine care. Harris County has one of the lowest county rates across the U.S. for *Children with Health Insurance* (85.5%) and *Adults with Health Insurance* (73.8%). Further, Harris County has a lower *Primary Care Provider*

Rate than both state-wide and nation-wide rates (58.2 providers / 100,000 vs. 60.3 and 74.9, respectively).

Finally, the county's low rates of routine care may contribute to burdens on hospital systems. The Harris County rate for *Preventable Hospital Stays: Medicare Population* (3,025 discharges / 100,000 Medicare enrollees) is higher than the state-wide and nation-wide rates (2,991 and 2,769, respectively).

Conduent's Community Health Index (CHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Each zip code is ranked based on its index value to identify relative levels of need. Table 5 provides the index values and local ranking for each zip code. The map in Figure 24 illustrates that the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue) are zip codes 77506 (HEI = 98.9), 77502 (97.5), and 77087 (97.5).

FIGURE 24. COMMUNITY HEALTH INDEX: PMC PRIMARY SERVICE AREA

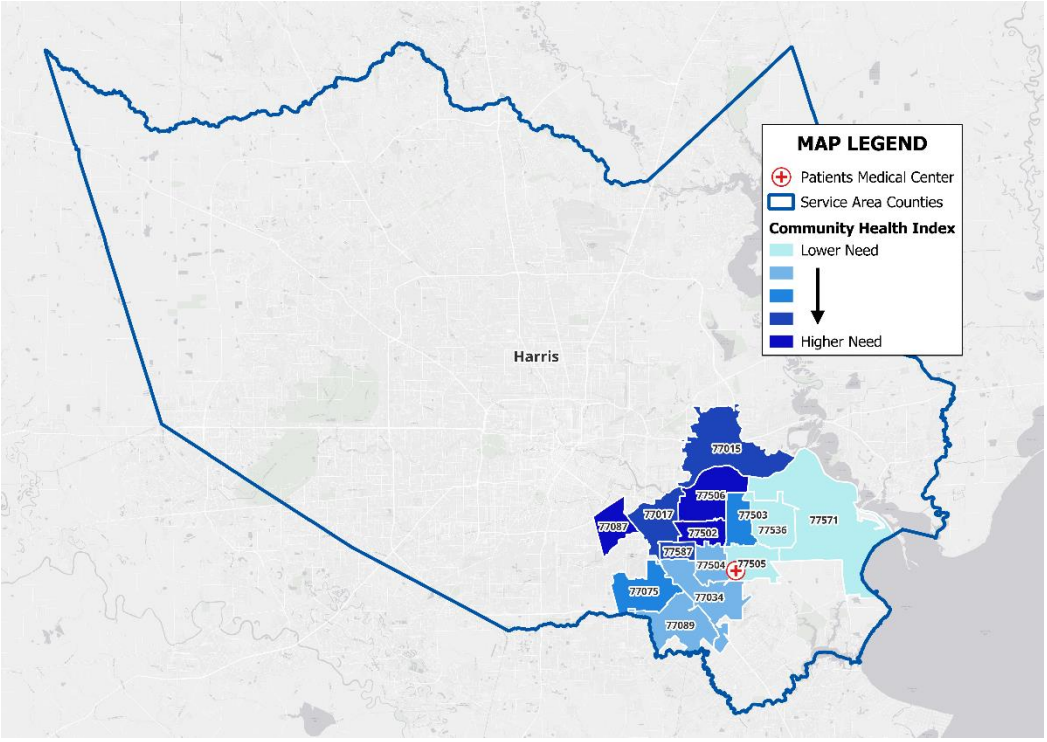


TABLE 5. COMMUNITY HEALTH INDEX: PMC PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77506	98.9	77503	90.2
77502	97.5	77504	89.1
77087	97.5	77034	86.5
77587	97.1	77089	78.5
77017	97.0	77571	49.4
77015	92.9	77505	49.4
77075	91.7	77536	38.9

Health care access emerged as a top concern across all data sources. Qualitative data from listening sessions highlighted long wait times, difficulty navigating eligibility processes, limited specialty care, and a lack of provider availability, particularly for low-income and aging individuals. Community partners emphasized the need for coordinated outreach, more culturally responsive care, and streamlined access to social services. One participant shared,

> **We don't have enough providers. People are desperate and calling dozens of clinics just to find one that accepts their insurance"**

Heart Disease & Stroke

From the secondary data scoring results, Heart Disease and Stroke ranked 17th in the data scoring of all topic areas with a score of 1.37. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 6 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 6. **HARRIS COUNTY DATA SCORING RESULTS: HEART DISEASE AND STROKE**

Score	Heart Disease & Stroke Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.33	Stroke: Medicare Population	*percent*	7.0	--	6.0	6.0			--
2.08	Adults who Have Taken Medications for High Blood Pressure	*percent*	73.8	--	--	78.2			--
2.00	Heart Failure: Medicare Population	*percent*	13.0	--	12.0	11.0			--
1.92	Cholesterol Test History	*percent*	81.7	--	--	86.4			--
1.83	Ischemic Heart Disease: Medicare Population	*percent*	24.0	--	23.0	21.0			--
1.61	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.6	33.4	40.1	37.6			
1.50	Hyperlipidemia: Medicare Population	*percent*	65.0	--	66.0	66.0			--

In Harris County, stroke, heart failure, ischemic heart disease, as well as hyperlipidemia are all more common than in Texas or the U.S., specifically among Medicare recipients. For example, 7% of all Harris County Medicare recipients have experienced a stroke, which is among the worst county rates across the nation. Stroke-related mortality is also higher among the Harris County population, overall. The county's *Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)*

is 40.6 deaths / 100,000 population, which is similar to the Texas rate of 40.1, but higher than the U.S. rate (37.6) and the Healthy People 2030 target (33.4).

Secondary data also indicate that Harris County residents may be less likely to engage in certain forms of prevention and treatment related to heart disease. For example, only 73.8% of adults with high blood pressure have taken any medication to treat the condition, which is among the lowest county rates across Texas or U.S. counties. Harris County adults are also less likely to have had their blood cholesterol checked in the last 5 years, compared to the nationwide rate (81.7% vs. 86.4%).

Finally, we found that Black/African American residents of Harris County have a greater risk of death due to stroke or coronary heart disease. For example, the *Age-Adjusted Death Rate due to Coronary Heart Disease* is 111.0 deaths per 100,000, which is higher than the county's overall rate (86.6).

FIGURE 25. AGE-ADJUSTED DEATH RATE DUE TO CORONARY HEART DISEASE, BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)

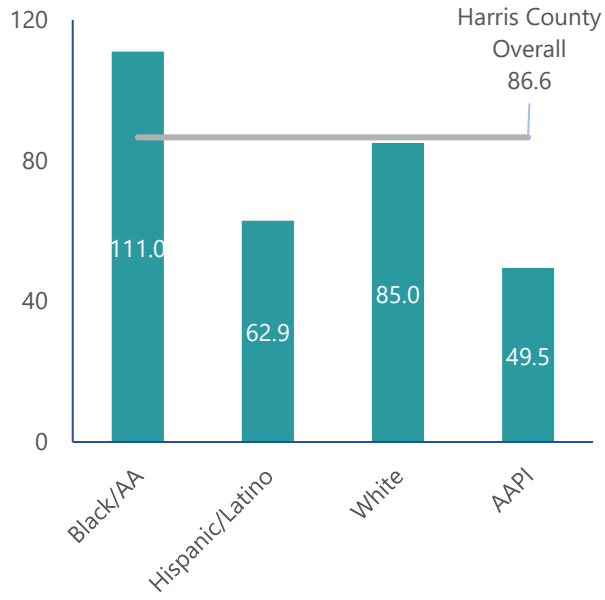
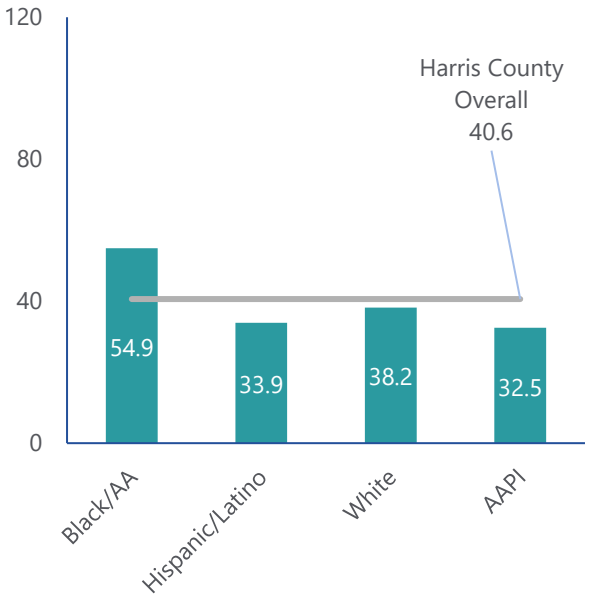


FIGURE 26. AGE-ADJUSTED DEATH RATE DUE TO CEREBROVASCULAR DISEASE (STROKE), BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)



The burden of chronic conditions related to heart health is particularly concerning for older adults, men, and Hispanic residents. Partners also noted gaps in preventive care, health care, and early intervention. Addressing these disparities will require enhanced chronic disease management, increased blood pressure screening, and improved access to cardiac rehabilitation services.

Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders ranked 18th in the data scoring of all topic areas with a score of 1.25. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 7 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 7. HARRIS COUNTY DATA SCORING RESULTS: MENTAL HEALTH & MENTAL DISORDERS

Score	Mental Health & Mental Disorders Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.08	Poor Mental Health: Average Number of Days	days	5.2	--	4.6	4.8			
1.92	Poor Mental Health: 14+ Days	percent	18.7	--	--	15.8			--
1.67	Alzheimer's Disease or Dementia: Medicare Population	percent	7.0	--	7.0	6.0			--

Self-reported poor mental health is relatively common among Harris County residents. For example, the county population reports an average of 5.2 days out of the past 30 where their mental health was not good. This is higher than both the Texas and U.S. averages (4.6 and 4.8 days, respectively), and has also been significantly trending upward. Additionally, nearly 1 in 5 residents (18.7%) report 14 or more days of poor mental health in the past 30 days, compared to 15.8% across the country. Additionally, the rate of *Alzheimer's Disease and Dementia: Medicare Population* is higher in Harris County than most other U.S. counties and is also higher than the overall U.S. rate (7% vs. 6%).

Mental health and well-being were consistently ranked as top community concerns in the partner survey and listening sessions, with 73% of respondents identifying anxiety, depression, and related conditions as key issues. The Mental Health Index scores for PMC-area zip codes were among the highest in the region, signaling elevated needs related to access, insurance, and health literacy. Participants also shared how substance use, housing instability, and lack of culturally appropriate mental health services contribute to causing mental health issues across age groups. Local nonprofits identified the need for school-based mental health support and increased funding for behavioral health providers.

Conduent's Mental Health Index (MHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor mental health. Each zip code is ranked based on its index value to identify relative levels of need. Table 8 provides the index values and local ranking for each zip code. The map in Figure 27 illustrates that the zip codes with the highest risk for poor mental health (as indicated by the darkest shade of purple) are zip codes 77504 and 77503, with index scores of 81.8 and 73.7, respectively.

FIGURE 27. MENTAL HEALTH INDEX: PMC PRIMARY SERVICE AREA

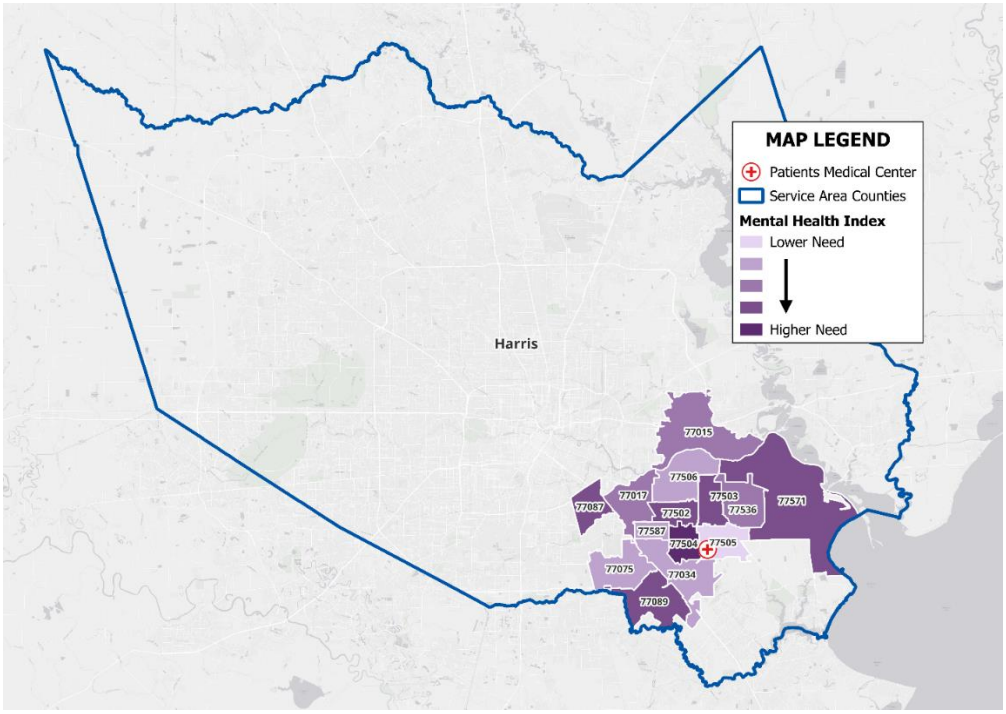


TABLE 8. MENTAL HEALTH INDEX: PMC PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77504	81.8	77015	61.9
77503	73.7	77536	60.9
77571	66.7	77587	58.5
77087	66.5	77506	58.1
77089	65.2	77034	57.1
77502	64.2	77075	56.9
77017	62.2	77505	53.1

Older Adults

From the secondary data scoring results, Older Adults ranked 12th in the data scoring of all topic areas with a score of 1.54. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 9 below. See Appendix A for the full list of indicators categorized within this topic.

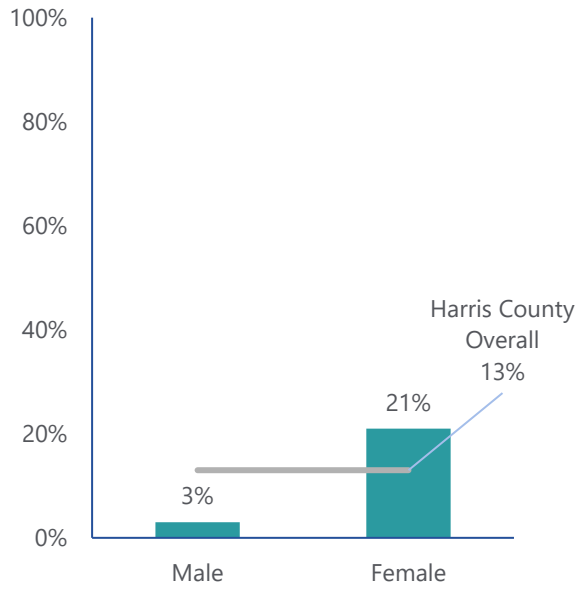
TABLE 9. HARRIS COUNTY DATA SCORING RESULTS: OLDER ADULTS

Score	Older Adults Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.42	People 65+ Living Below Poverty Level	percent	12.7	--	11.7	10.4			
2.33	Osteoporosis: Medicare Population	percent	13.0	--	11.0	12.0			--
2.33	Stroke: Medicare Population	percent	7.0	--	6.0	6.0			--
2.08	Prostate Cancer Incidence Rate	cases/ 100,000 males	111.9	--	108.3	113.2			
2.00	Heart Failure: Medicare Population	percent	13.0	--	12.0	11.0			--
1.83	Cancer: Medicare Population	percent	12.0	--	11.0	12.0			--
1.83	Ischemic Heart Disease: Medicare Population	percent	24.0	--	23.0	21.0			--
1.67	Alzheimer's Disease or Dementia: Medicare Population	percent	7.0	--	7.0	6.0			--
1.67	Chronic Kidney Disease: Medicare Population	percent	19.0	--	19.0	18.0			--
1.50	Asthma: Medicare Population	percent	7.0	--	7.0	7.0			--
1.50	Hyperlipidemia: Medicare Population	percent	65.0	--	66.0	66.0			--
1.50	Mammography Screening: Medicare Population	percent	42.0	--	44.0	39.0			--

The most concerning indicator related to older adult health is *People 65+ Living Below Poverty Level*. The older adult population experiences a higher rate of poverty in Harris County than the state-wide and nation-wide rates (12.7% vs. 11.7% and 10.4%, respectively). Further, this county-wide poverty rate has been significantly increasing over time.

Chronic disease, broadly, is particularly burdensome for the older adult population of Harris County. Many of the health-related indicators that are most concerning for older adults in Harris County are health topics previously discussed in this report, such as cancer, cardiovascular health, and Alzheimer's disease and dementia. Osteoporosis is also a particularly concerning chronic condition for this population. In Harris County, 13.0% of Medicare recipients have osteoporosis, which is falls among the worst 25% of county-wide rates across Texas. Additionally, women are disproportionately impacted by these rates of osteoporosis. Among female Medicare recipients, 1 in 5 of those in Harris County (21.0%) have osteoporosis, compared to 3.0% of male Medicare recipients.

FIGURE 28. OSTEOPOROSIS: MEDICARE POPULATION



The aging population in PMC's service area presents unique health challenges, particularly in the absence of coordination of geriatric care and long-term support. Older adults experience high rates of poverty, transportation barriers, and difficulty navigating health systems. The listening session participants spoke about the strain on caregivers and the need for home-based services. Community partners emphasized the importance of enhancing services like home health care, fall prevention programs, dental care, and mobility support.

Other Health Needs of Concern

In addition to the prioritized health needs identified in this assessment, several other topics emerged as significant areas of concern based on analysis of both secondary data indicators and community input. These topics reflect ongoing challenges and disparities that impact many residents across PMC's service area.

While these issues were determined to be important, PMC will not directly focus on them in its upcoming Implementation Strategy, due to limitations in resources, alignment with current strategic initiatives, or because other community partners are better positioned to lead these efforts. Each need is presented below in alphabetical order with a summary of findings and community insight.

Although not selected as top priorities for the CHNA Implementation Strategy, the following health needs, Children's Health, Immunizations & Infectious Diseases, Nutrition and Healthy Eating, Physical Activity, and Women's Health were identified as significant in both the secondary data scoring process and qualitative community feedback. These issues remain important to community well-being and may be interwoven into broader strategies addressing chronic disease, health access, and social determinants of health.

Children's Health

From the secondary data scoring results, Children's Health ranked 3rd in the data scoring of all topic areas, with a score of 1.74. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern:

- *Child Food Insecurity Rate* (24.8%)
- *Child Care Centers* (4.3 per 1,000 population under age 5)
- *Children with Health Insurance* (85.5%)

The health of children in the PMC service area remains a concern due to disparities in preventive care access, developmental screenings, and early mental health support. Community members cited a need for improved care coordination between pediatricians, schools, and family support agencies. Preventive dental care and nutrition support for children were also highlighted in the listening sessions.

Immunizations & Infectious Diseases

From the secondary data scoring results, Immunizations and Infectious Diseases ranked 6th in the data scoring of all topic areas, with a score of 1.62. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern:

- *Gonorrhea Incidence Rate* (185.8 cases per 100,000 population)
- *Syphilis Incidence Rate* (12.0 cases per 100,000 population)
- *Chlamydia Incidence Rate* (583.5 cases per 100,000 population)
- *Tuberculosis Incidence Rate* (5.7 cases per 100,000 population)

- *HIV Diagnosis Rate* (24.9 cases per 100,000 population)
- *Cervical Cancer Incidence Rate* (9.8 cases per 100,000 population)

Survey respondents and listening session participants noted that misinformation, vaccine hesitancy, and limited public health infrastructure post-COVID continue to hinder vaccination efforts. The COVID-19 pandemic also left lasting gaps in trust and education around communicable disease prevention.

Nutrition and Healthy Eating

Conduent's Food Insecurity Index (FII) uses socioeconomic data to estimate which zip codes are at greatest for poor food access. The map in Figure 29 illustrates that the zip codes with the highest risk of food insecurity are 77015 and 77587, with index scores of 89.8 and 89.5, respectively.

FIGURE 29. FOOD INSECURITY INDEX: PMC PRIMARY SERVICE AREA

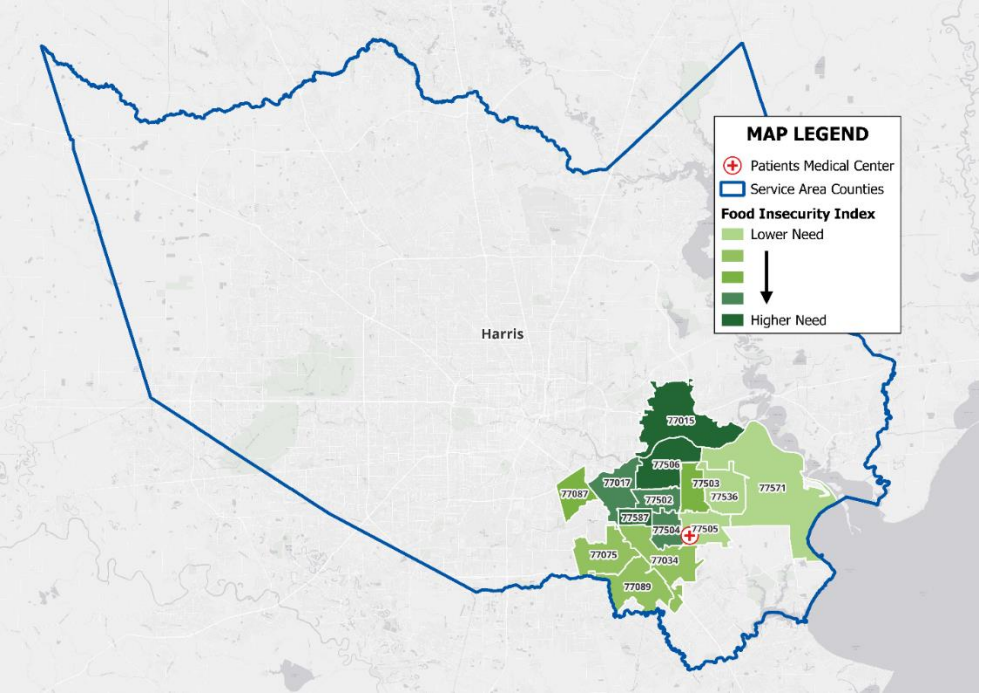


TABLE 10. FOOD INSECURITY INDEX: PMC PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77015	89.8	77503	83.5
77587	89.5	77034	82.5
77506	87.8	77075	80.7
77502	87.0	77089	48.8
77504	86.9	77571	43.6
77017	86.8	77536	40.7
77087	84.8	77505	31.3

Access to healthy and affordable food was a recurring theme across all listening sessions, especially for uninsured, elderly, and single-parent households. One participant noted,

> **People skip the doctor, but they also skip meals. It's a survival mindset.**

Food insecurity and lack of culturally relevant nutrition education were cited as root causes of many chronic diseases in the community.

Physical Activity

From the secondary data scoring results, Physical Activity ranked 9th in the data scoring of all topic areas, with a score of 1.59. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern:

- *Adults 20+ who are Obese* (34.3%)
- *Workers who Walk to Work* (1.4%)
- *Adults 20+ who are Sedentary* (21.3%)

Residents shared that walkability, safety concerns, and lack of accessible recreation spaces limit opportunities for physical activity, particularly for youth and older adults.

Women's Health

From the secondary data scoring results, Women's Health ranked 11th in the data scoring of all topic areas, with a score of 1.58. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern:

- *Cervical Cancer Incidence Rate* (9.8 cases per 100,000 females)
- *Age-Adjusted Death Rate due to Breast Cancer* (20.4 deaths per 100,000 females)
- *Mammogram in Past 2 Years: 50-74* (73.4%)
- *Mammography Screening: Medicare Population* (42.0%)

Concerns included access to affordable reproductive care, maternal health services, and postpartum mental health support. Participants emphasized the need for trauma-informed care and expanded support services for new mothers, particularly in underserved and minority communities.

Barriers to Care

A crucial element of the PMC's Community Health Needs Assessment involved recognizing the obstacles that hinder community members from accessing timely, equitable, and high-quality health care. Throughout PMC's service areas, several significant challenges were revealed through a mix of secondary data analysis, listening sessions, and partner survey. These barriers encompass social, economic, and systemic domains, disproportionately affecting marginalized and high-need populations.

Insurance and Affordability Challenges:
Many residents in the PMC service area lack health insurance or fall into the gap between qualifying for public assistance and affording private coverage. Even among insured patients, high out-of-pocket costs often deter individuals from seeking routine or specialty care.

Provider Availability and Capacity
Community members reported difficulty accessing timely appointments due to a shortage of providers accepting public or low-cost insurance plans. Behavioral health services, in particular, were reported as inaccessible due to long waitlists and a limited number of trained providers.

Transportation Limitations
While urban in setting, many neighborhoods in the PMC region experience transportation gaps, especially for seniors or low-income individuals without reliable vehicles. Public transportation may not operate during evening or weekend hours, making it difficult to attend medical appointments.

Language and Cultural Barriers
Language barriers remain a significant obstacle to navigating care. Stakeholders emphasized the importance of culturally competent communication and bilingual staff across health systems.

Digital and Health Literacy
Telehealth and online scheduling tools have expanded access for some, digital literacy and broadband gaps persist, particularly among older adults. Additionally, many community members struggle to navigate complex healthcare systems and eligibility processes.

Conclusion

The 2025 Community Health Needs Assessment for Patients Medical Center reaffirms the community's resilience, diversity, and ongoing challenges. Through a robust analysis of secondary data, partner surveys, and listening sessions, six priority health needs were identified.

These priorities reflect not only health indicators but also the voices of those who live and work in the PMC service area. Residents and providers shared a strong desire to improve affordability, access, education, and care coordination, especially for those historically marginalized or medically underserved. While other health issues such as women's health, children's health, immunizations, physical activity, and nutrition also remain areas of concern, PMC will direct its focus toward the areas of greatest need and impact.

PMC's work over the past three years, especially in improving access to care and engaging the community through preventive services and chronic disease partnerships, demonstrates a continued commitment to community health and shared action.

Appendices Summary

The following appendices provide supplemental data, documentation, and references supporting the findings and processes detailed in this Community Health Needs Assessment:

Data Sources and Methodology Details

Includes methodology overview, data scoring criteria and tables, and a summary of how qualitative and quantitative data were collected and analyzed. This section also includes any supplemental information from the previous CHNA to support comparison and context.

Stakeholder and Community Engagement Summary

Lists all organizations that contributed input through interviews, surveys, or listening sessions, including representatives of public health agencies, medically underserved, low-income, and minority populations. Also includes data collection tools such as survey instruments and discussion guides used during community engagement.

Community Partner List

Provides a structured list or table of community-based organizations, coalitions, and programs available to address each prioritized health need identified in the report.

References and Citations

A complete list of all data sources, literature, and tools used throughout the CHNA.