2025 Community Health Needs Assessment

Report adopted by Hospital Advisory Board June 2025

St. Luke's Health™

A member of CommonSpirit

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Community Health Needs Assessment – At a Glance

St. Luke's Health - Lakeside Hospital

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
- Health Care Access & Quality
- Heart Disease & Stroke
- Mental Health
- 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 Lakeside Hospital. 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

Lakeside Hospital 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

The community served by St. Luke's Health –Lakeside Hospital spans a diverse and rapidly growing area in Greater Houston, encompassing 26 ZIP codes. This defined service area includes suburban and semi-urban neighborhoods characterized by economic diversity, demographic change, and evolving health needs. The Lakeside community represents a patient population of over 1,055,000 residents, with a demographic profile that includes 57.5% White, 10.6% Black, 4.9% Asian, and 28.6% identifying as Hispanic/Latino.

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, Lakeside Hospital 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 | 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 Lakeside Hospital 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, 1101 Bates Avenue, Houston, TX 77030 or by e-mail to fawn.preuss@commonspirit.org.

Looking Back: Evaluation of Progress since prior CHNA

Over the past three years (FY22–FY24), St. Luke's Health – Lakeside Hospital implemented a range of strategies outlined in its 2022 Implementation Plan, with a strong focus on Access to Care, Preventive Health, and Mental Health. These efforts have positively impacted vulnerable populations, strengthened local partnerships, and supported long-term community well-being.

Access to Care

- Provided Medicaid enrollment assistance to 267 individuals, improving access to insurance and financial support.
- Delivered charity care and financial assistance for uninsured and underinsured patients seeking medically necessary services.
- Strengthened partnerships with local healthcare providers, civic organizations, and nonprofits to expand referral pathways and service access.
- Supported transportation services to ensure patients could attend medical appointments and follow-up care.

Preventive Health & Community Outreach

- Hosted monthly Total Joint Camp workshops, reaching over 1,000 participants with education on hip and knee replacement care.
- Sponsored community outreach events focused on preventive screenings, immunizations, and wellness education.
- Delivered flu shot clinics and health fairs to promote early detection and vaccination in the community.
- Provided CPR and First Aid training, empowering residents with life-saving skills.

Mental Health

- Partnered with Tri-County Clinic and Lone Star Family Health Center to expand behavioral health access.
- Enhanced mental health and depression screenings, improving early identification and timely referrals.
- Engaged in the Behavioral Health and Suicide Prevention Task Force, contributing to early intervention and public awareness strategies.

Community Engagement & Education

- Collaborated with Montgomery County Food Bank to support food sorting and distribution, serving over 3,500 individuals.
- Sponsored school-based education programs to introduce high school students to healthcare career pathways.
- Conducted Texas Workforce Commission sessions to support adult learners and job seekers in Montgomery and Harris counties.

- Participated in public health awareness campaigns and forums, promoting preventive care and healthy living practices.

Health Professions Training

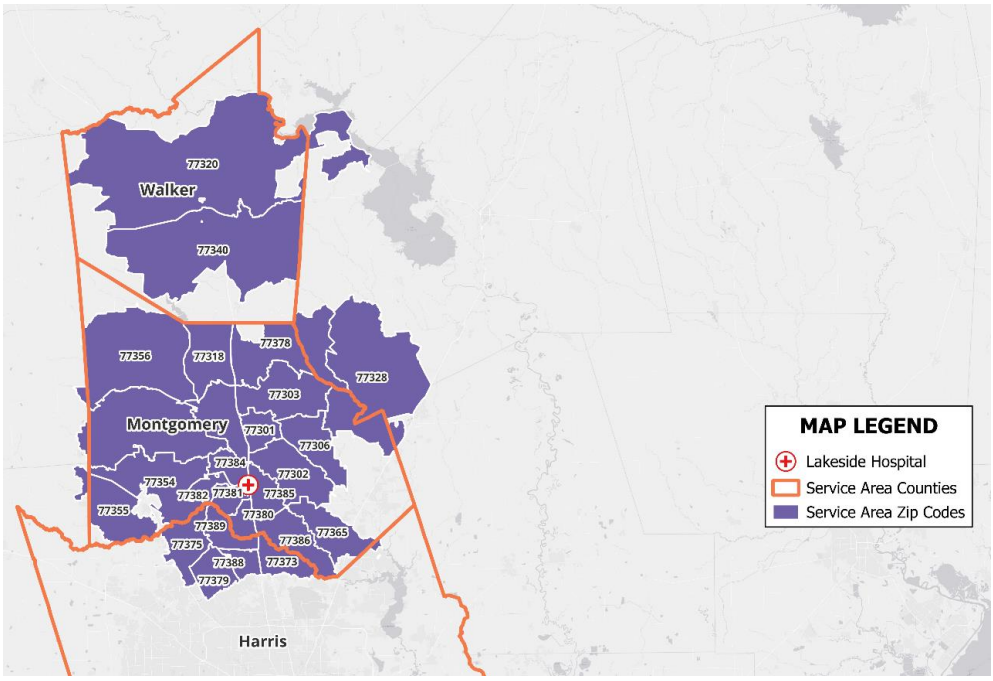
- Offered clinical rotations and training for students in nursing, emergency medical services, pharmacy, and allied health fields.
- Partnered with local educational institutions to support hands-on training and workforce development for future healthcare professionals.

Defining the Community

The community served by Lakeside Hospital spans a diverse and rapidly growing area in Greater Houston, encompassing 26 zip codes. This defined service area includes suburban and semi-urban neighborhoods characterized by economic diversity, demographic change, and evolving health needs. The Lakeside community represents a patient population of over 1,055,000 residents, with a demographic profile that includes 57.5% White, 10.6% Black, 4.9% Asian, and 28.6% identifying as Hispanic/Latino.

A map of the Lakeside Hospital service area is provided below to illustrate the defined geographic scope. Additional details, including zip code listings and core demographic data such as race/ethnicity, insurance coverage, and income levels, are summarized in the Core Demographics and Appendix sections.

FIGURE 1 LAKESIDE HOSPITAL SERVICE AREA



Demographic Profile

Geography and Data sources

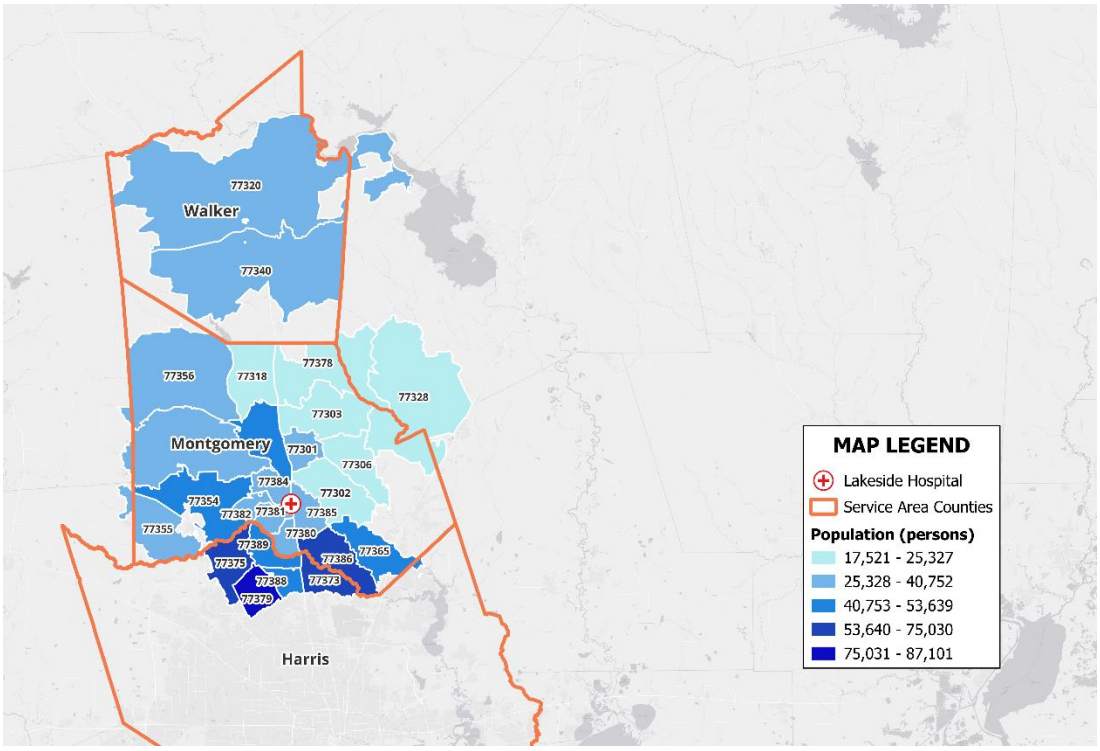
The following section explores the demographic profile of Lakeside Hospital's primary service area, which includes 26 zip codes in and around Montgomery County. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic groups may have unique needs 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 Lakeside Hospital primary service area has an estimated population of 1,098,053 persons. Figure 2 shows the population breakdown for the service area by zip code.

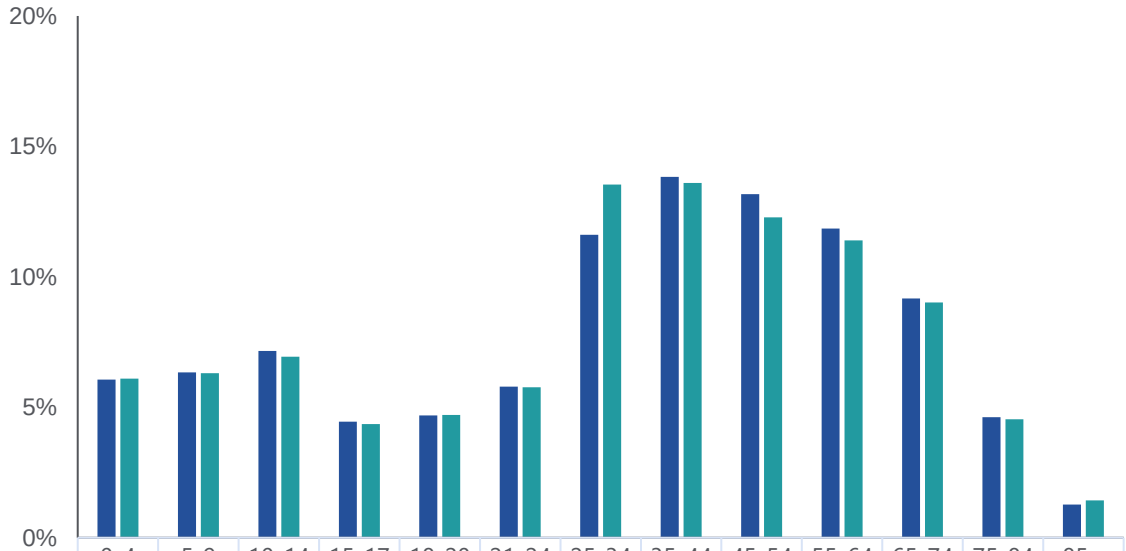
FIGURE 2. LAKESIDE PRIMARY SERVICE AREA POPULATION DISTRIBUTION BY ZIP CODE



Age

Figure 3 shows the population of Lakeside Hospital's primary service area broken down by age group, with comparisons to the state-wide Texas population. Overall, the age distribution of Lakeside 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

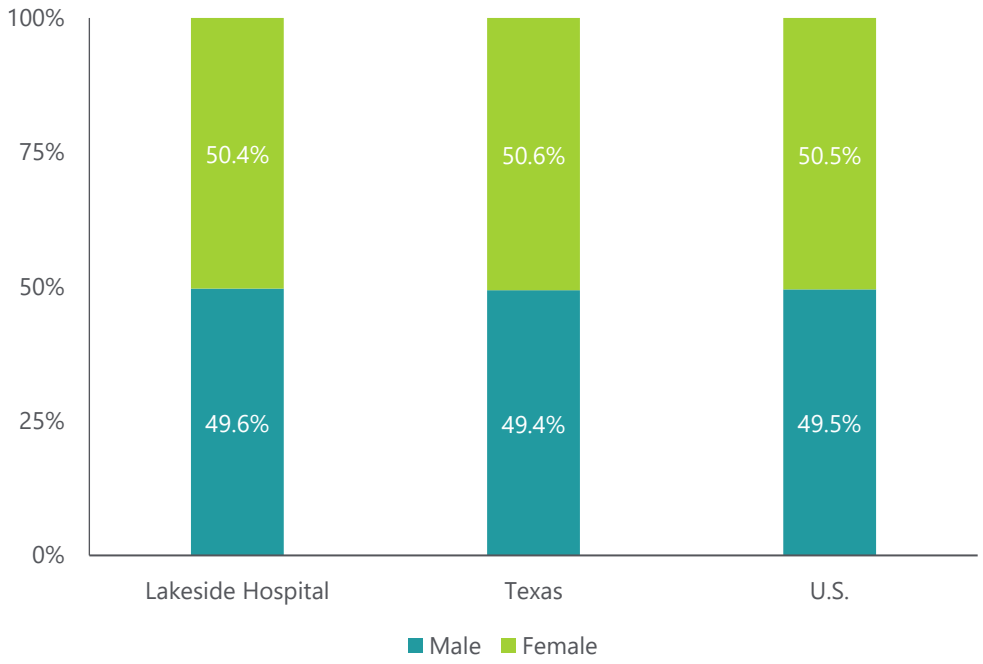


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Lakeside	6.1%	6.3%	7.2%	4.5%	4.7%	5.8%	11.6%	13.8%	13.2%	11.9%	9.2%	4.6%	1.3%
Texas	6.1%	6.3%	6.9%	4.4%	4.7%	5.8%	13.5%	13.6%	12.3%	11.4%	9.0%	4.5%	1.4%

Sex

As seen in Figure 4, 50.4% of the Lakeside Hospital 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



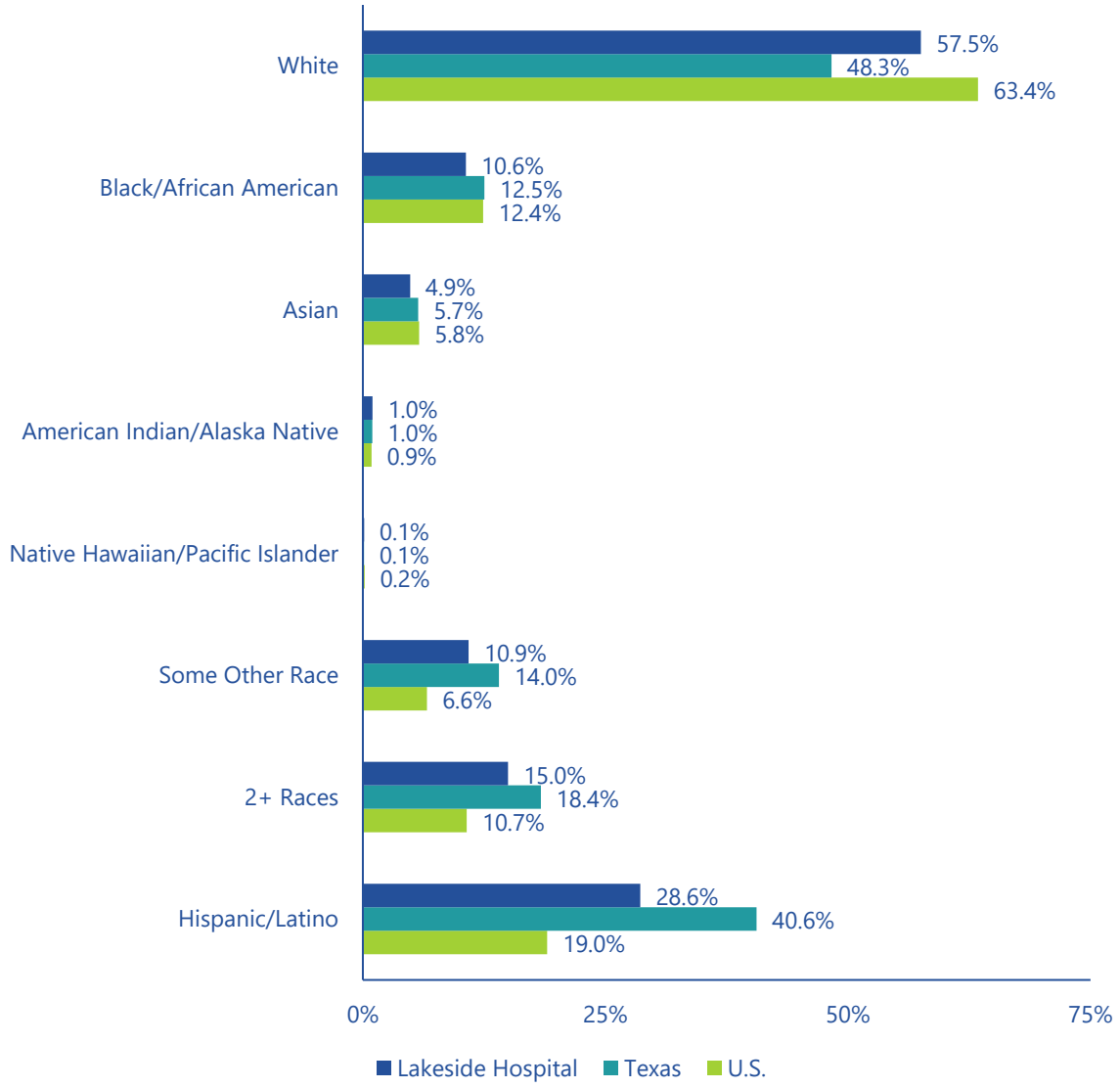
U.S. value taken from American Community Survey (2019-2023)

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 majority of the population in the Lakeside Hospital service area identifies as White (57.5%), which is lower than the nation-wide rate (63.4%), but higher than the state-wide rate (48.3%).

FIGURE 5. POPULATION BY RACE AND ETHNICITY

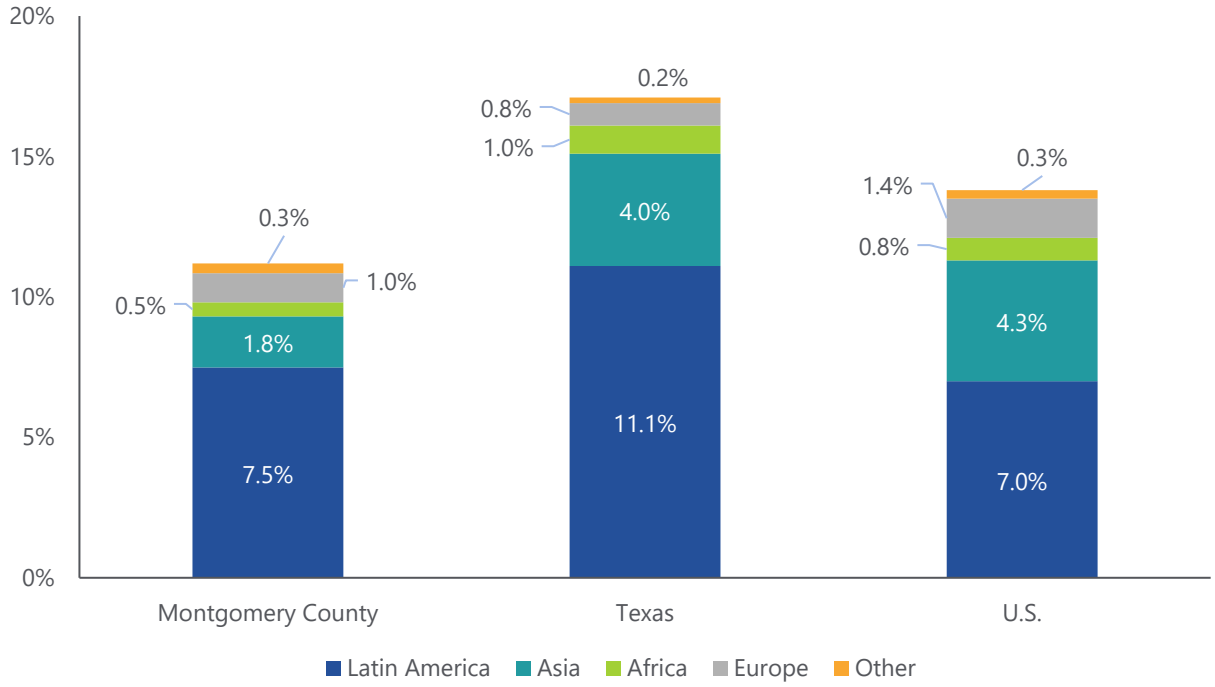


Language and Immigration

Understanding countries of origin and spoken languages can help inform a community's cultural and linguistic context. According to the American Community Survey, 11.1% of Montgomery County residents are born outside the U.S., which is lower than the state and national value.

Figure 6 provides a breakdown of region of birth for any persons born outside the country. Compared to the U.S. overall, Montgomery County has a larger percentage of residents born in Latin America (7.5% vs. 7.0%).

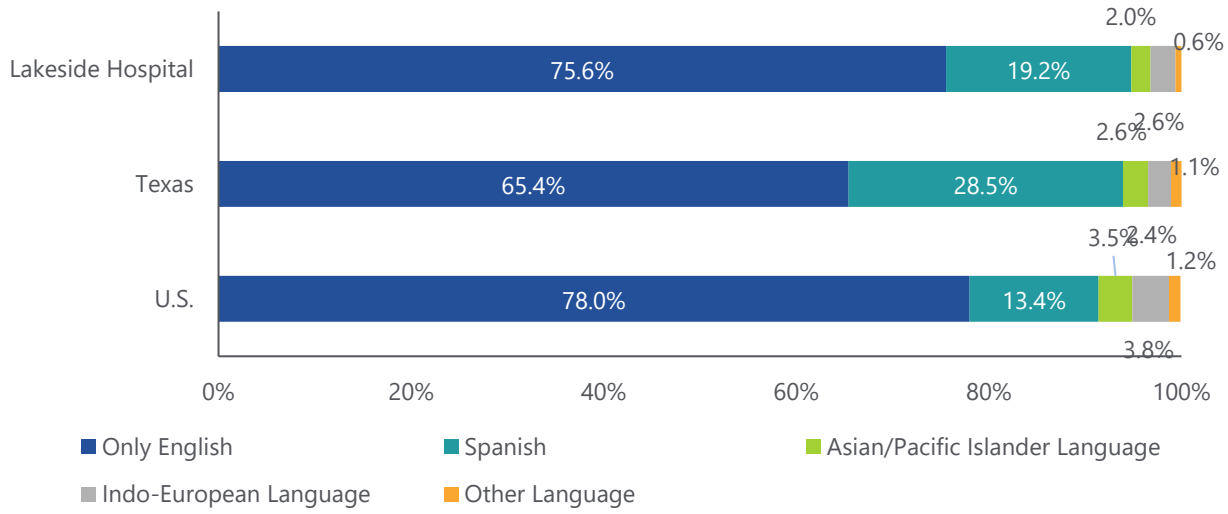
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY



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

As shown in Figure 7, the majority of the Lakeside Hospital service area speaks only English at home (75.6%). The Lakeside population is more likely than the nation-wide Texas population to speak Spanish (19.2% vs. 13.4%) but is less likely than the state-wide Texas population to speak Spanish (28.5%).

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

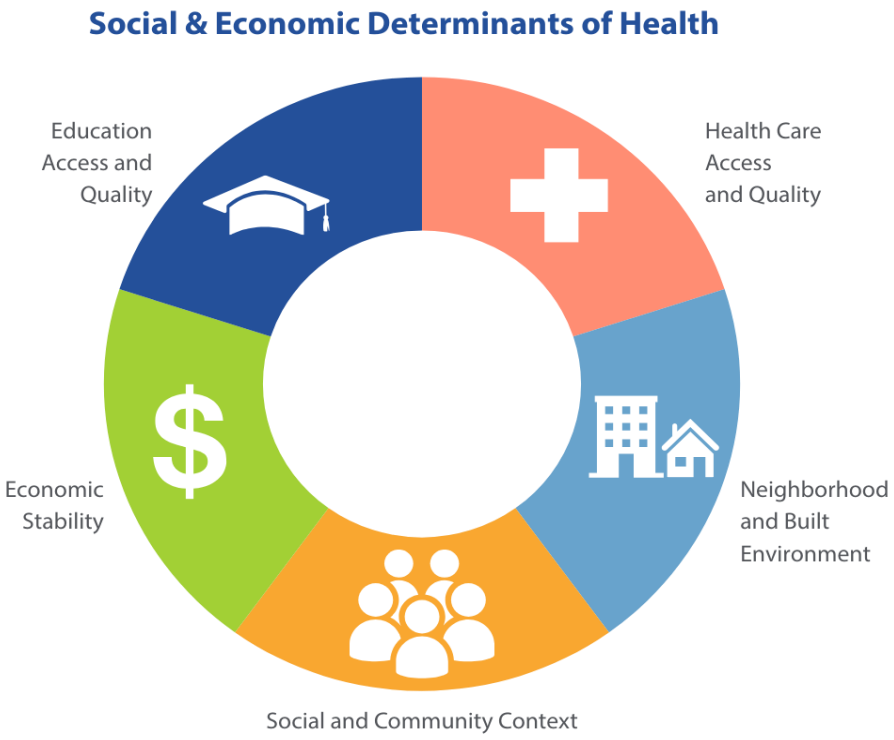


U.S. value taken from American Community Survey (2019-2023)

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Lakeside Hospital 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).

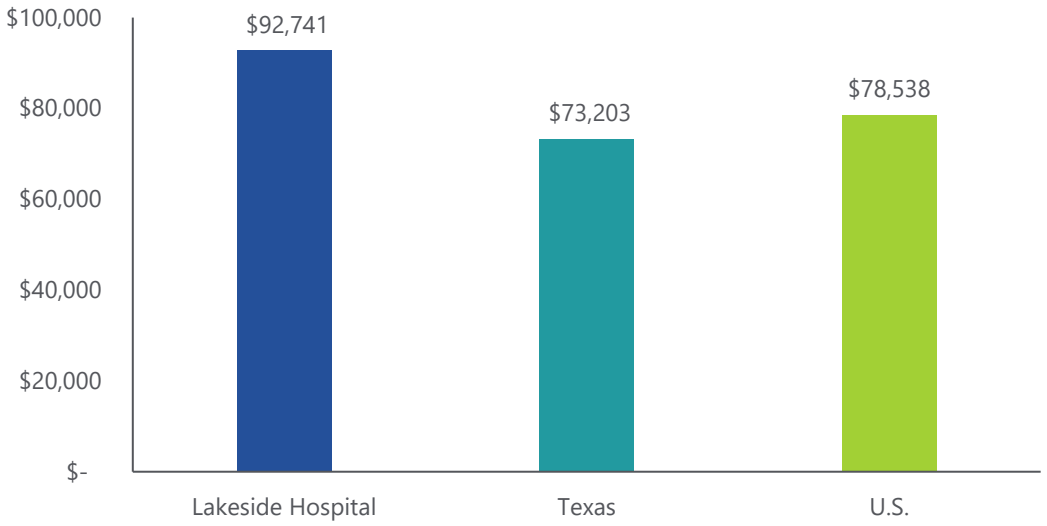
FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH



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.

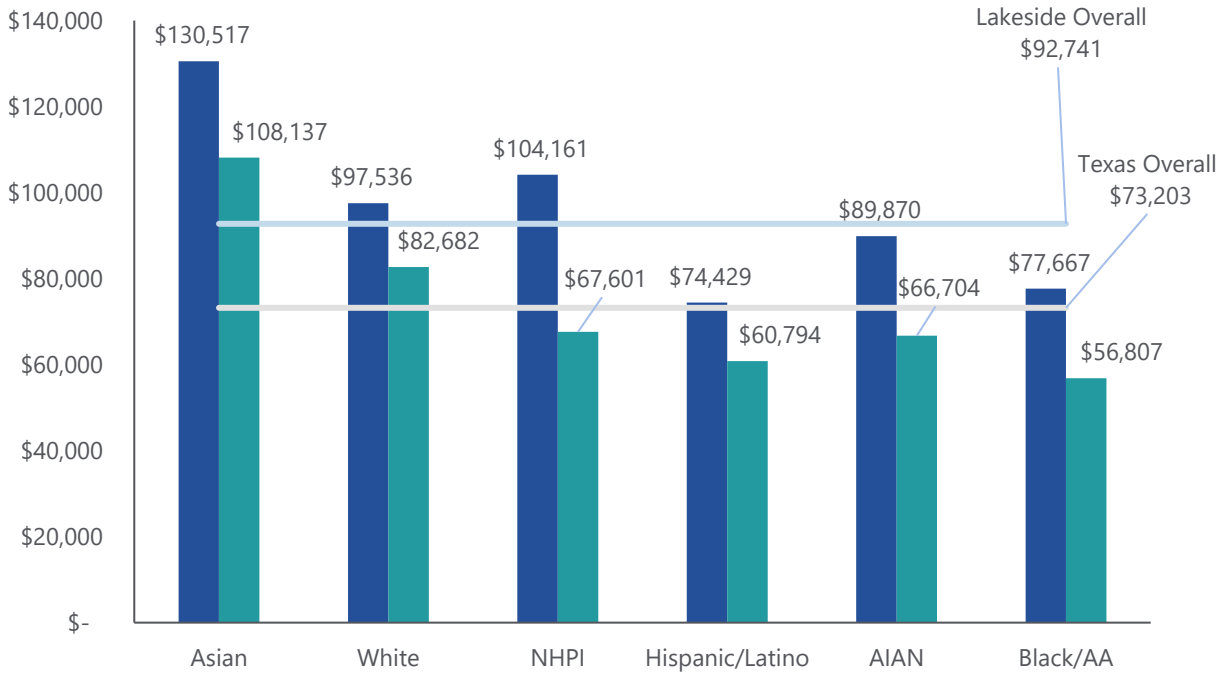
FIGURE 9. MEDIAN HOUSEHOLD INCOME BY: COUNTY, STATE AND U.S. COMPARISONS



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 Black/African American and Hispanic/Latino communities of the Woodlands service area both have a lower median income than the overall service area median income. For example, the Hispanic/Latino median income is $17,030 lower than the overall median income ($74,429 vs. $92,741). However, Figure 10 shows that all racial and ethnic groups listed have higher median incomes than Texas overall.

FIGURE 10. MEDIAN HOUSEHOLD INCOME BY RACE & ETHNICITY



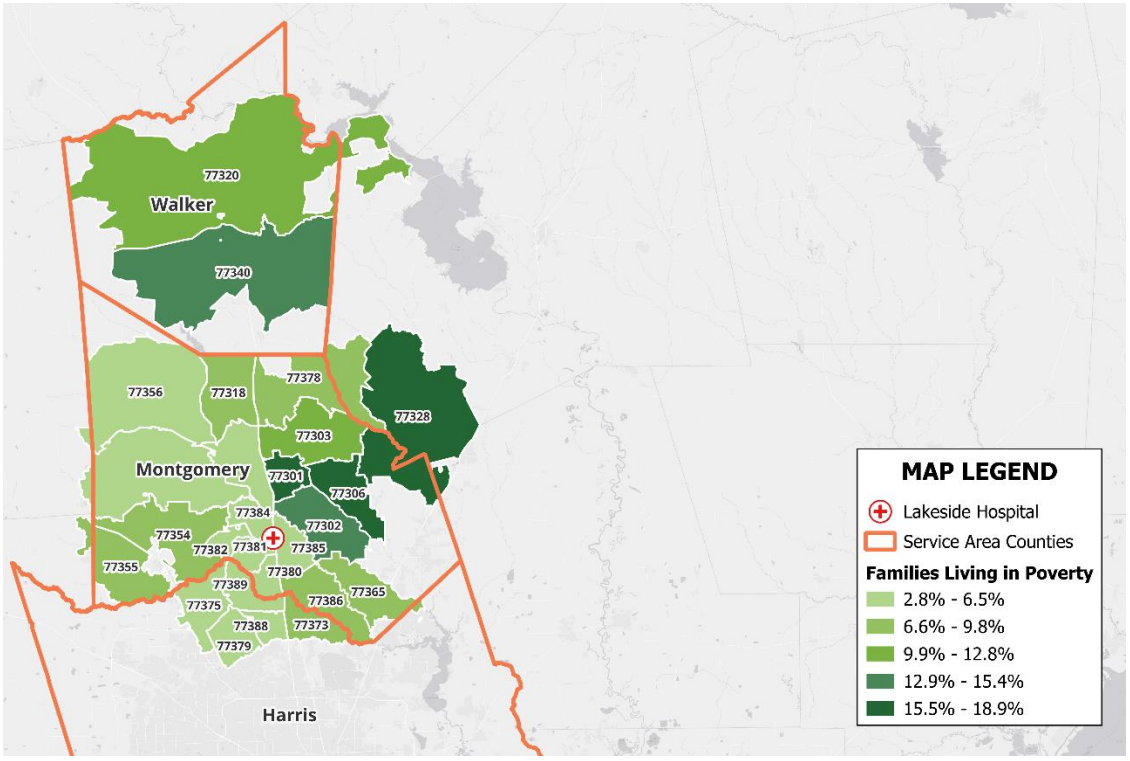
Poverty

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, 7.0% of families in the Lakeside Hospital primary service area live below the poverty level, which is lower 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.

[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

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



The percentage of families living below poverty for each zip code in the service area is provided in Table 1. The zip code in the service area with the highest concentration of poverty is 77306 (18.9%) and the zip code with the lowest concentration of poverty is 77384 (2.8%).

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

Zip Code	% Families in Poverty	Zip Code	% Families in Poverty
77306	18.9%	77354	7.7%
77328	17.7%	77385	6.5%
77301	17.0%	77379	6.1%
77302	15.4%	77388	5.6%
77340	14.8%	77380	5.3%
77320	12.8%	77389	5.3%
77303	11.7%	77382	5.1%
77386	9.4%	77304	4.9%
77373	9.3%	77375	4.8%
77355	8.9%	77316	4.7%
77365	8.4%	77356	4.5%
77378	8.1%	77381	4.4%
77318	7.9%	77384	2.8%

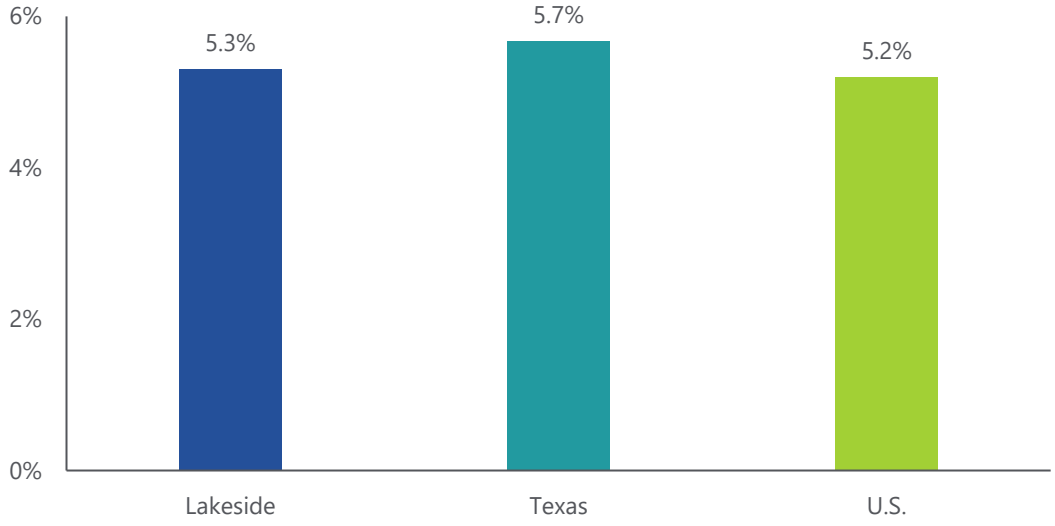
Employment

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 Lakeside primary service area is 5.3%, which is lower than the Texas unemployment rate (5.7%).

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



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

Education

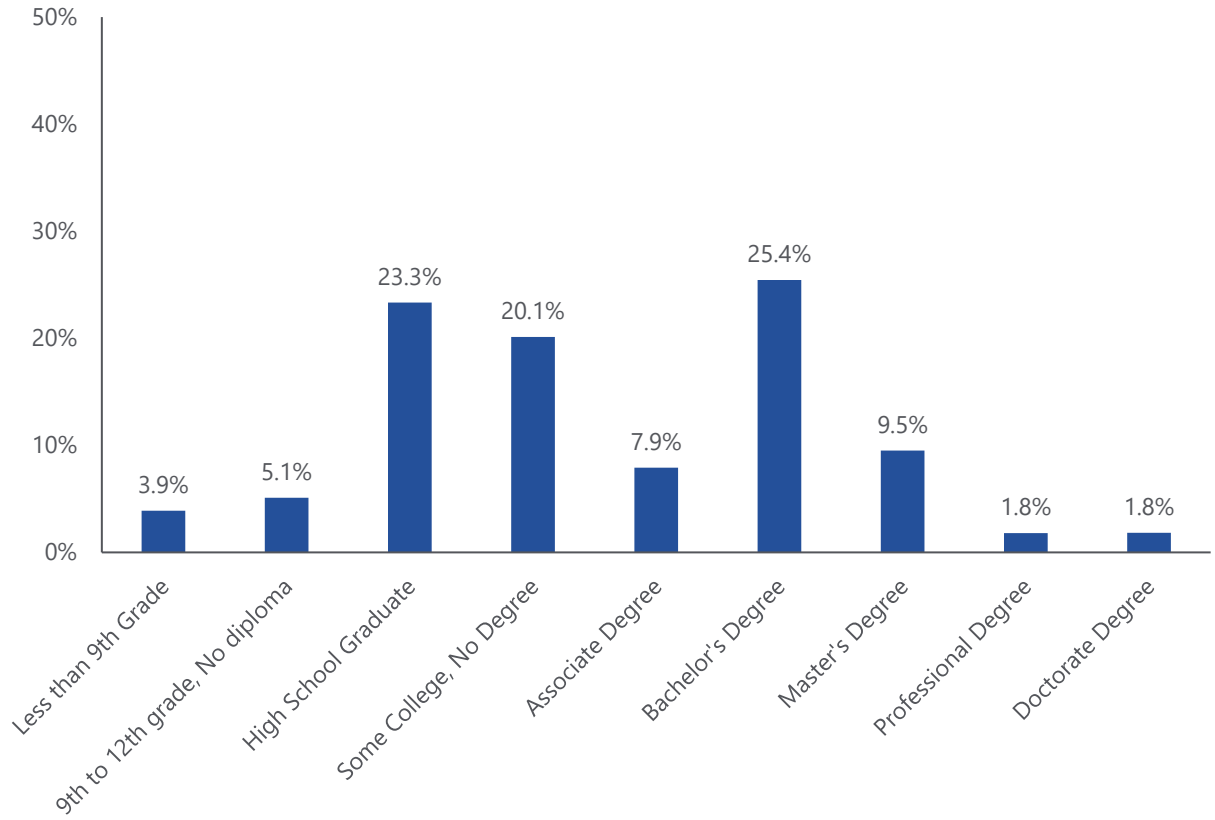
Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. A high school diploma is a requirement for many employment opportunities, and for higher education. Not

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

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 Lakeside primary service area by educational attainment, among those aged 25 and up. As shown in Figure 14, most of the Lakeside population has a high school diploma or higher (90.0%), which is higher than both the state-wide and nation-wide rates (85.1% and 89.4%, respectively).

FIGURE 13. PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+

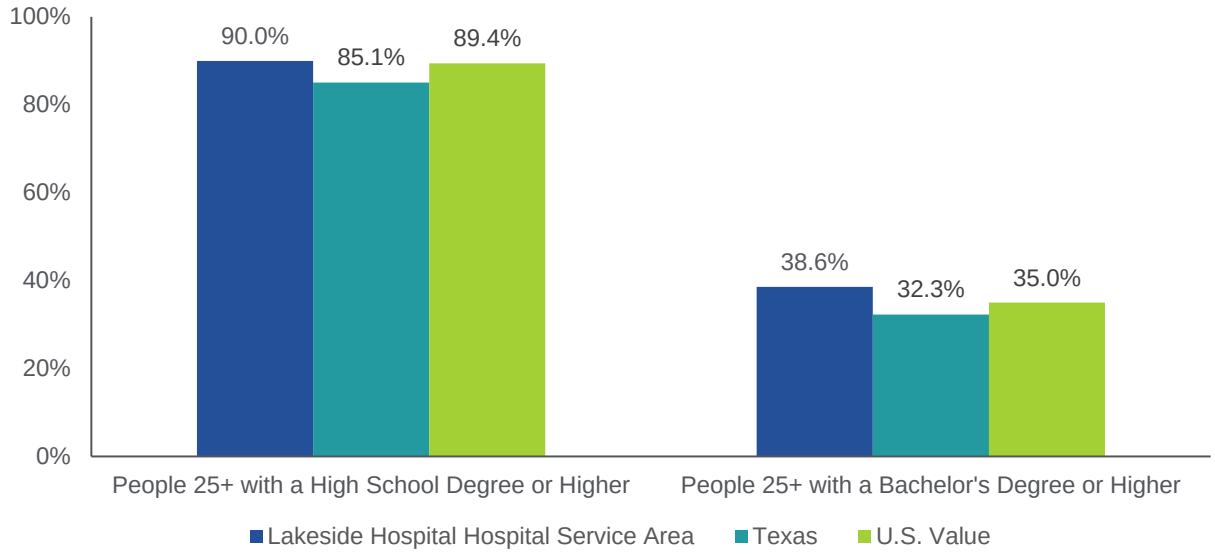


U.S. value taken from American Community Survey (2019-2023)

[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. POPULATION 25+ BY EDUCATIONAL ATTAINMENT



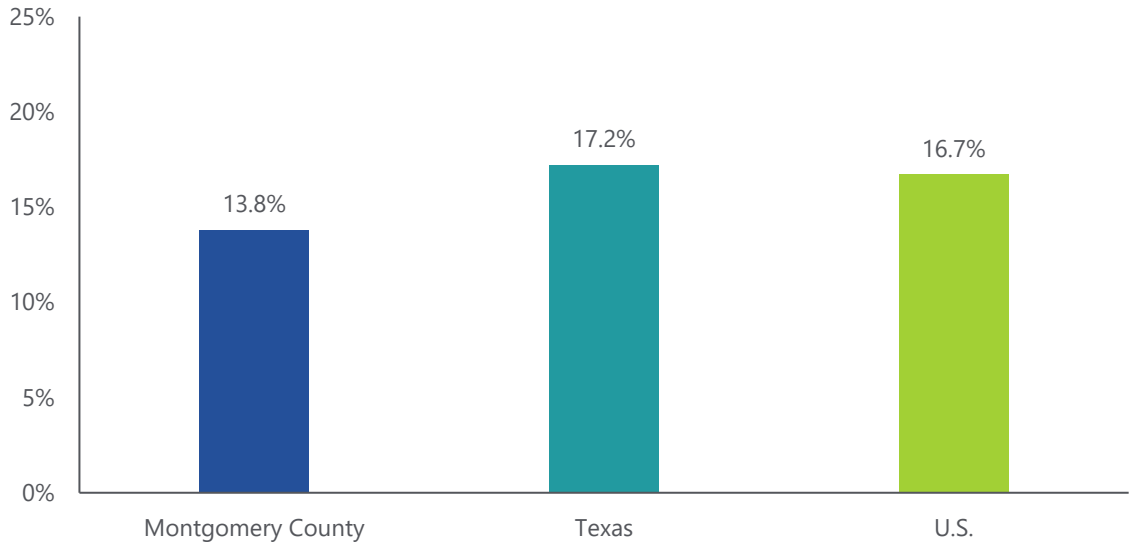
U.S. value taken from American Community Survey (2019-2023)

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, 13.8% of households in Montgomery County 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 lower than both the state-wide and nation-wide rates (17.2% and 16.7%, respectively). Montgomery County has a lower percentage of severe housing problems than both the state and nation-wide rates.

FIGURE 15. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



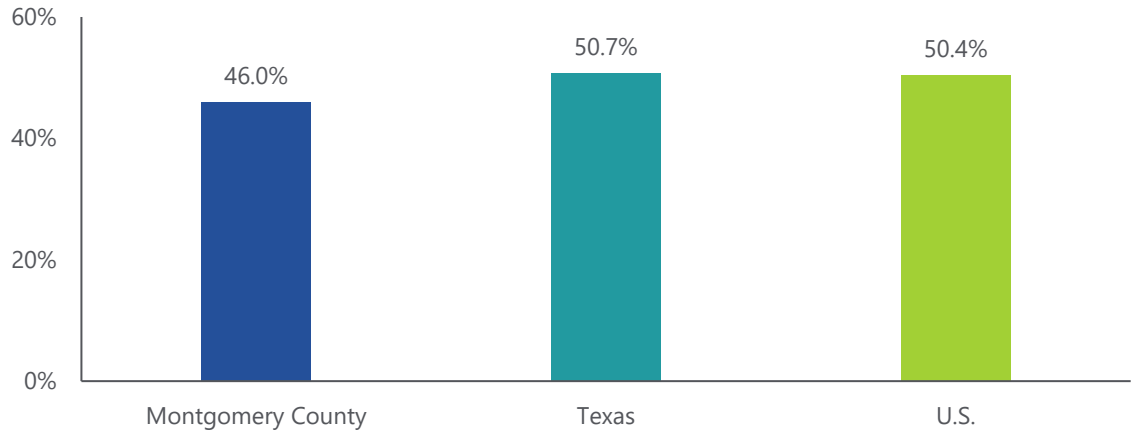
County, State, and U.S. values taken from County Health Rankings (2016-2020)

[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

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]

Figure 16. shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Montgomery County (46.0%) is lower 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. COMPARISONS



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

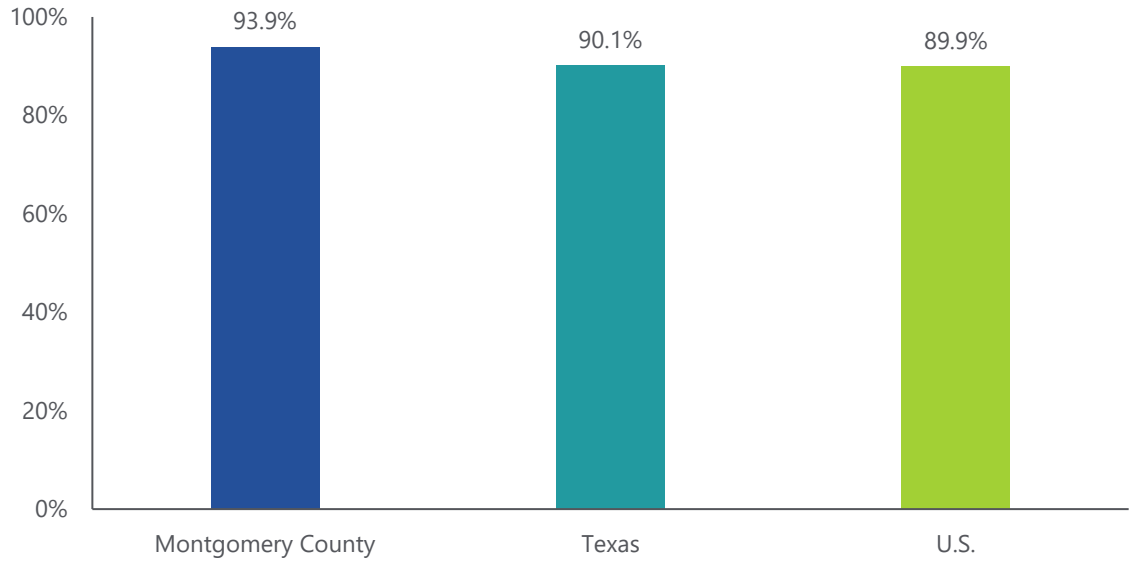
[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

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 rates in Montgomery County (93.9%) are 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

Lakeside Hospital's CHNA process 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

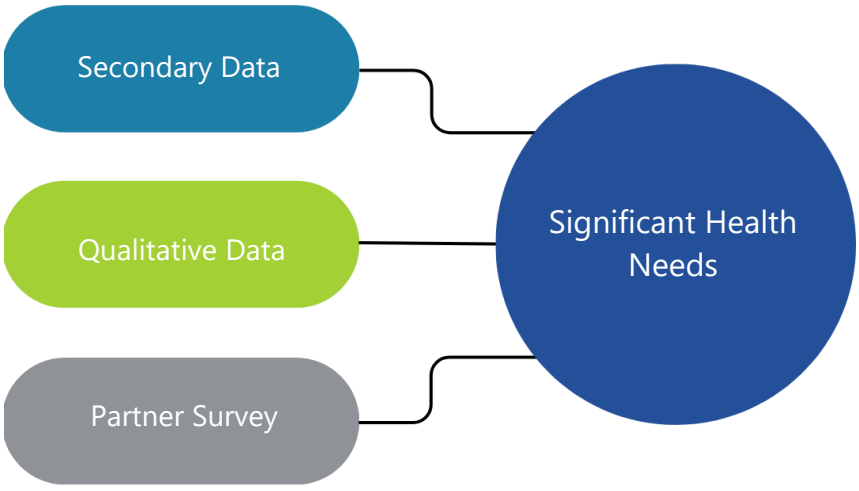
An online survey was distributed to over 60 organizational partners and stakeholders, including representatives from public health departments, healthcare providers, social service agencies, and nonprofit organizations. The survey captured perspectives on health priorities, gaps in care, barriers to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

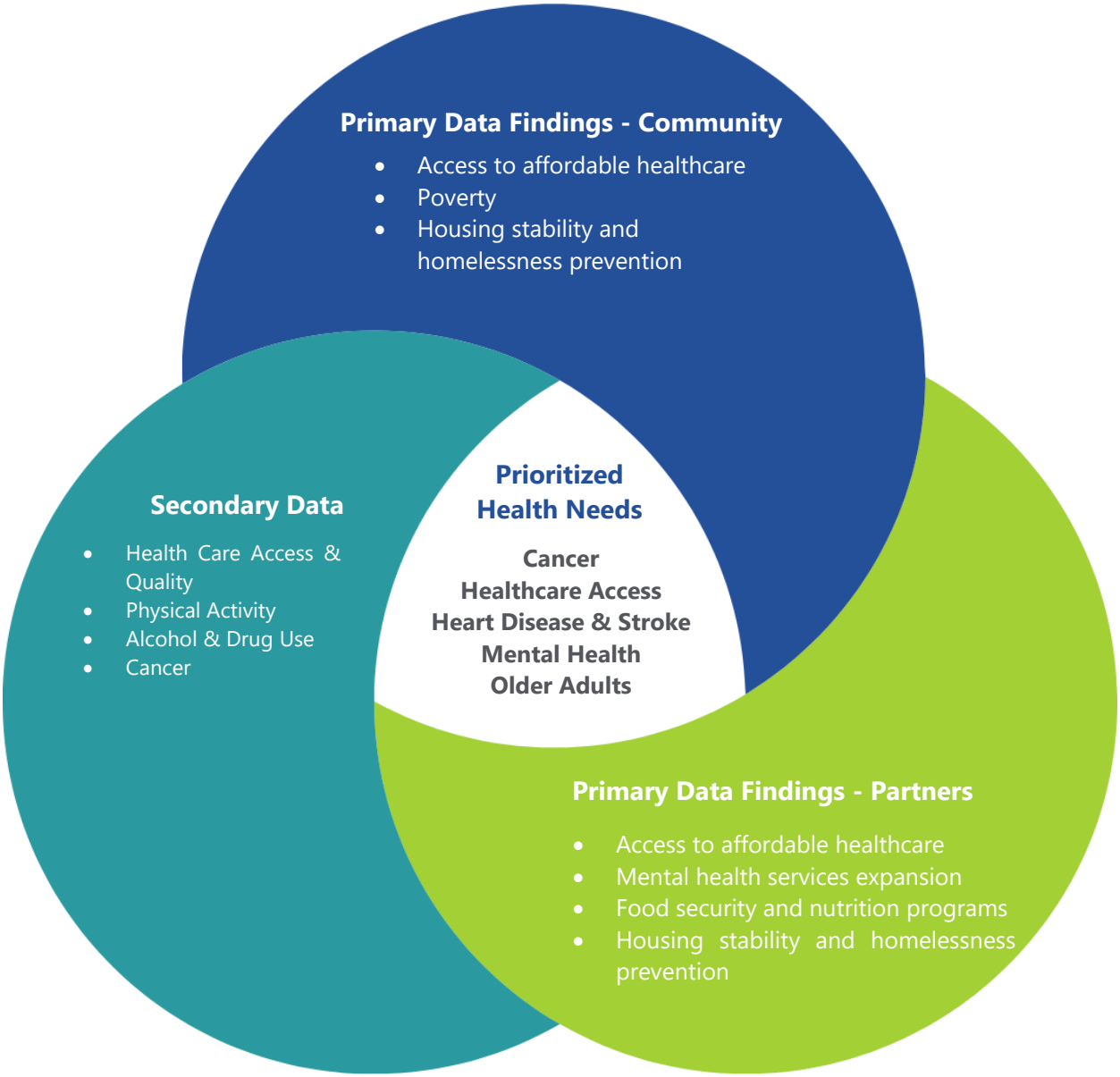
- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

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 Lakeside Hospital's service area:

Cancer | 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.

The prioritized health needs are deeply intertwined with the community concerns identified across both listening sessions and interactive surveys. Through open dialogue and lived experiences, residents and service providers illuminated the barriers that highlighted disparities, and the

structural changes needed to promote healthier outcomes. The report outlines several major health concerns as identified by the prioritization process.

Cancer

From the secondary data scoring results, Cancer ranked 4th 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 2 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 2. MONTGOMERY COUNTY DATA SCORING RESULTS: CANCER

Score	Cancer Indicator	Units	Montgomery County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.00	Cancer: Medicare Population	percent	12.0		11.0	12.0			--
1.76	Colon Cancer Screening: USPSTF Recommendation	percent	60.8			66.3			
1.53	Mammography Screening: Medicare Population	percent	41.0		42.0	47.0			--

Secondary data indicate that cancer is prevalent among the Medicare population in Montgomery County. 12% of Montgomery County's Medicare population has cancer, which is similar to the state and national rates (11% and 12% respectively). Additionally, the Medicare population is less likely than the state and national Medicare population to get mammography screening (41% vs. 42% and 47% respectively). Colon cancer screening in Montgomery County is also lower than the national average. Among those who meet US Preventive Service Task Force recommendations for colorectal cancer screening, only 60.8% received screening compared to 66.3% nationally.

Community feedback highlighted the burden of cancer-related illness, particularly among uninsured or underinsured individuals who delay diagnosis or treatment due to cost. Barriers such as limited availability of screening services, fear of diagnosis, and mistrust in the healthcare system were raised during community engagement sessions. Strengthening early detection and treatment pathways, particularly for breast, colorectal, and lung cancers, is a priority in reducing preventable deaths and disparities.

Health Care Access & Quality

From the secondary data scoring results, Health Care Access & Quality ranked 1st in the data scoring of all topic areas with a score of 1.70. 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 3 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 3. MONTGOMERY COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS AND QUALITY

Score	Health Care Access & Quality Indicator	Units	Montgomery County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.12	Adults without Health Insurance	percent	16.4			10.8			--
2.06	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	3327.0		2980.0	2677.0			
2.00	Adults 65+ without Health Insurance	percent	1.3		1.9	0.8			
1.94	Adults who have had a Routine Checkup	percent	73.1			76.1			
1.62	Children with Health Insurance	percent	91.0		89.1	94.9			
1.59	Adults who Visited a Dentist	percent	55.8			63.9			--
1.59	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	85.6		109.0	131.4			

Montgomery County has a relatively high rate of *Adults without Health Insurance* (16.4%), which is higher than the national rate (10.8%). Likewise, the Montgomery rate for *Children with Health Insurance* is lower than the U.S. rate (91.0% vs. 94.9%), however the county insured rate for children is higher than the overall Texas rate (89.1%).

Other concerning indicators regard routine care. Only 73.1% of adults have had a routine checkup, and only 55.8% visited a dentist. Montgomery County also has a lower *Non-Physician Primary Care Provider Rate* than Texas (85.6 vs. 109.0 providers / 100,000). The lack of routine care in Montgomery may contribute to burdens on hospital systems. Montgomery's rate of *Preventable Hospital Stays: Medicare Population* is higher than the Texas rate (3,327 vs. 2,980 discharges / 100,000 Medicare enrollees), and both of these rates are higher than the U.S. rate (2,677).

Access to care emerged as one of the most critical health needs in the Lakeside service area, reflected in both quantitative and qualitative findings. With a weighted topic score of 1.66, communities reported experiencing challenges in navigating a complex and often fragmented

> "Lack of access to healthcare and social services, lack of transportation and immigration status. – Listening Session Participant"

healthcare system. Key barriers include insurance gaps, particularly among working class residents who are underinsured, transportation limitations, and long appointment wait times.

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 4 provides the index values and local ranking for each zip code. The map in Figure 18 illustrates that the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue) are zip codes 77328 (HEI = 89.6), 77306 (88.3), and 77320 (81.0).

FIGURE 18. COMMUNITY HEALTH INDEX: LAKESIDE PRIMARY SERVICE AREA

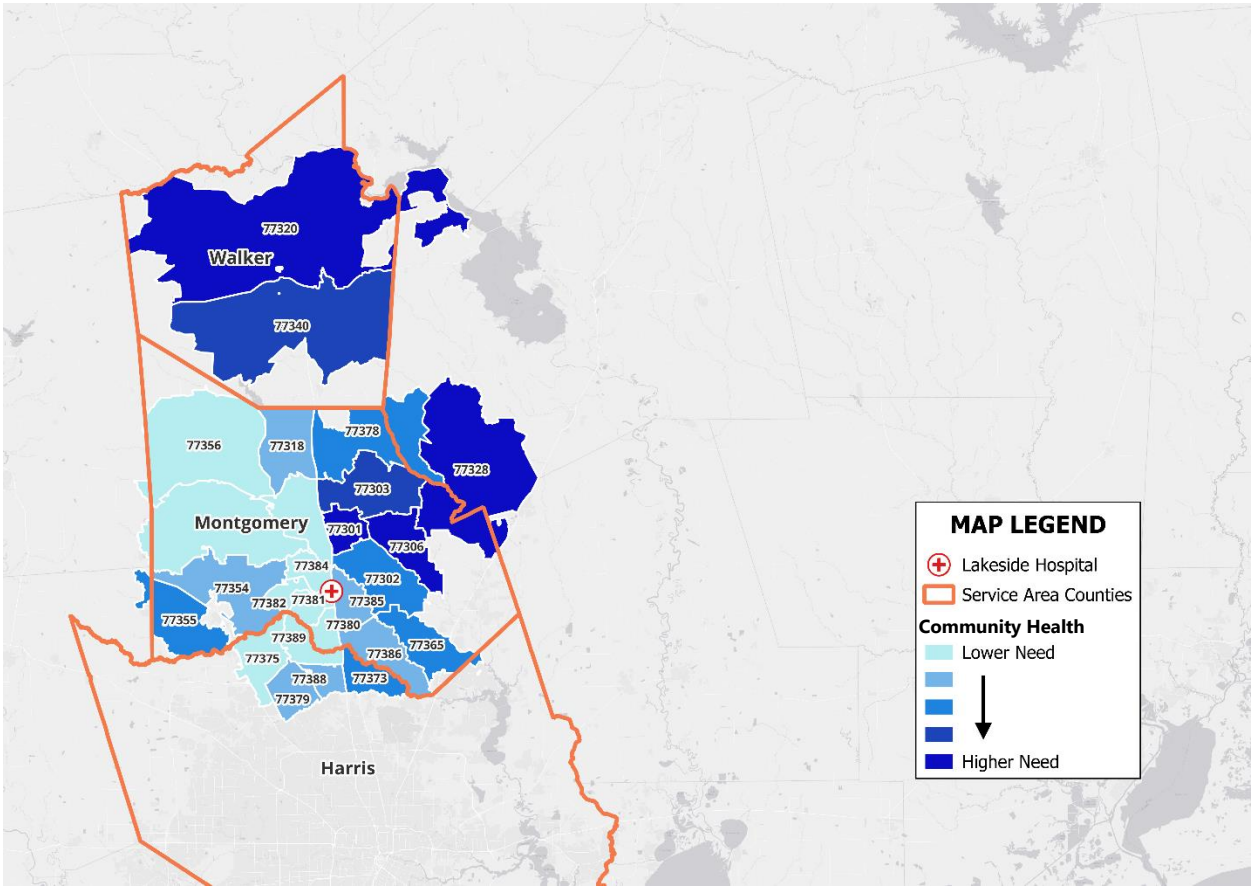


TABLE 4. COMMUNITY HEALTH INDEX: LAKESIDE PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77328	89.6	77385	26.2
77306	88.3	77379	23.7
77320	81.0	77354	19.0
77301	78.9	77386	17.7
77340	72.4	77384	15.7
77303	66.9	77356	13.2
77302	52.0	77316	12.3
77365	52.0	77375	12.2
77378	50.5	77304	11.2
77355	50.4	77380	8.4
77373	47.1	77389	5.7
77388	33.3	77381	4.7
77318	30.4	77382	4.2

Heart Disease & Stroke

From the secondary data scoring results, Heart Disease and Stroke ranked 15th 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 5 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 5. MONTGOMERY COUNTY DATA SCORING RESULTS: HEART DISEASE AND STROKE

Score	Heart Disease & Stroke Indicator	Units	Montgomery County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.53	Stroke: Medicare Population	percent	7.0		6.0	6.0			--
2.12	Adults who Have Taken Medications for High Blood Pressure	percent	75.2			78.2			
2.00	Atrial Fibrillation: Medicare Population	percent	15.0		14.0	14.0			
2.00	Hyperlipidemia: Medicare Population	percent	66.0		65.0	65.0			--
1.53	Ischemic Heart Disease: Medicare Population	percent	23.0		22.0	21.0			--

In Montgomery County, Stroke, Atrial Fibrillation, 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 highest county rates across the nation.

Secondary data also indicate that Montgomery County residents may be less likely to engage in certain forms of prevention and treatment related to heart disease. For example, only 75.2% 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.

Focus group discussions and community feedback further highlighted the need for improved heart health education, early screening, and follow-up care, particularly in underserved neighborhoods.

Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders ranked 16th 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 6 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 6. MONTGOMERY COUNTY DATA SCORING RESULTS: MENTAL HEALTH AND MENTAL DISORDERS

Score	Mental Health & Mental Disorders Indicator	Units	Montgomery County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
1.76	Poor Mental Health: 14+ Days	percent	18.1			15.8			
1.59	Adults Ever Diagnosed with Depression	percent	22.8			20.7			--

Self-reported poor mental health is relatively common among Montgomery County residents. For example, 18.1% of Montgomery County residents had 14+ poor mental health days, which is 2.3% more than the national average. A relatively higher percentage of adults in Montgomery County are diagnosed with depression, compared to the U.S. (22.8% vs. 20.7%). These numbers are trending upwards.

Community Voices cited widespread issues with anxiety, depression, and substance use, exacerbated by isolation, trauma, and economic stress—particularly post-COVID-19. Community members emphasized the need for expanded mental health services, reduced stigma, and integration of behavioral health in primary care and schools.

> **Anxiety, depression, and other mental health conditions are top concerns in the community. – Partner Survey**

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 7 provides the index values and local ranking for each zip code. The map in Figure 19 illustrates that the zip codes with the highest risk for poor mental health (as indicated by the darkest shade of purple) are zip codes 77320 (MHI = 75.7), 77340 (66.7), and 77379 (56.6).

FIGURE 19. MENTAL HEALTH INDEX: LAKESIDE PRIMARY SERVICE AREA

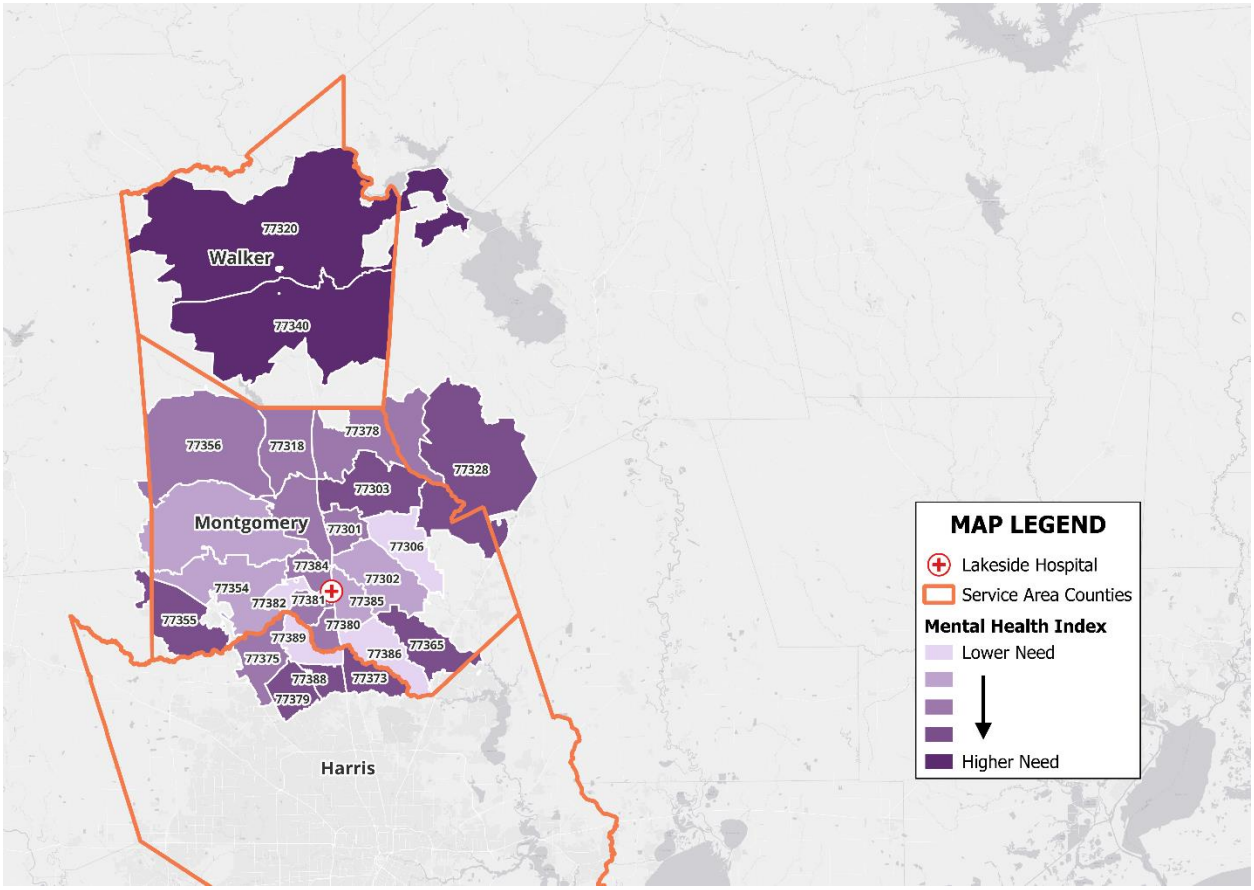


TABLE 7. MENTAL HEALTH INDEX: LAKESIDE PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77320	75.7	77378	36.7
77340	66.7	77380	35.5
77379	56.6	77356	34.9
77303	50.5	77384	34.9
77328	50.4	77375	34.0
77355	49.9	77354	30.7
77365	46.2	77302	28.5
77388	46.1	77385	27.2
77373	44.4	77316	23.8
77318	41.9	77382	15.7
77301	41.2	77386	11.8
77381	40.4	77389	8.2
77304	37.5	77306	7.6

Older Adults

From the secondary data scoring results, Older Adults ranked 11th in the data scoring of all topic areas with a score of 1.38 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 8 below. See Appendix A for the full list of indicators categorized within this topic.

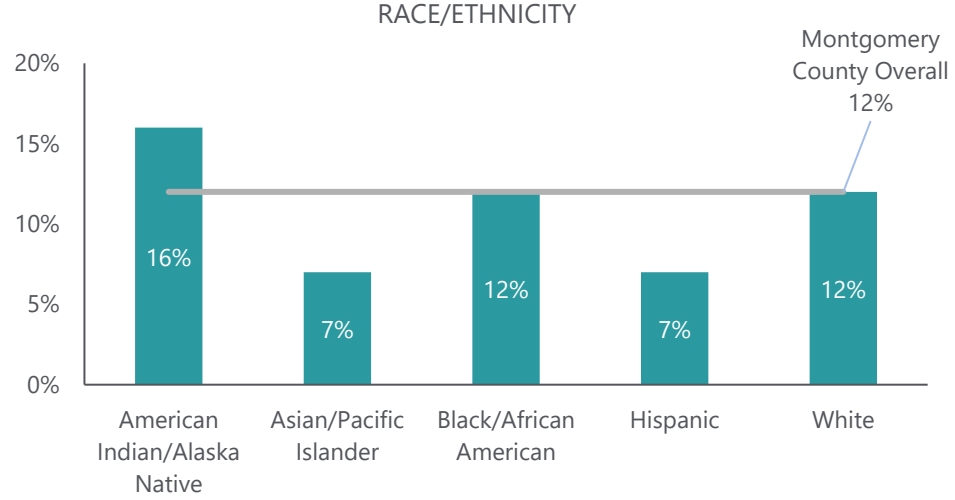
TABLE 8. MONTGOMERY COUNTY DATA SCORING RESULTS: OLDER ADULTS

Score	Older Adults Indicator	Units	Montgomery County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.53	Stroke: Medicare Population	percent	7.0		6.0	6.0			
2.00	Adults 65+ without Health Insurance	percent	1.3		1.9	0.8			
2.00	Atrial Fibrillation: Medicare Population	percent	15.0		14.0	14.0			--
2.00	Cancer: Medicare Population	percent	12.0		11.0	12.0			--
2.00	Hyperlipidemia: Medicare Population	percent	66.0		65.0	65.0			--
1.82	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	36.0		35.0	35.0			
1.65	COPD: Medicare Population	percent	12.0		11.0	11.0			--
1.65	Osteoporosis: Medicare Population	percent	10.0		11.0	11.0			--
1.65	People 65+ Living Alone (Count)	people	16814						
1.65	People 65+ Living Below Poverty Level (Count)	people	6928						
1.53	Ischemic Heart Disease: Medicare Population	percent	23.0		22.0	21.0			
1.53	Mammography Screening: Medicare Population	percent	41.0		42.0	47.0			--

The most concerning indicator related to older adult health are chronic conditions among the Medicare population. Stroke, Atrial Fibrillation, Cancer, Hyperlipidemia, Rheumatoid Arthritis or Osteoarthritis, COPD, and Ischemic Heart Disease are all slightly higher than the state and national averages. As seen in the figure below, the rate of *Cancer: Medicare Population* in Montgomery

County is higher among the American Indian/Alaskan Native population than the overall county (16% vs. 12%).

FIGURE 20. CANCER: MEDICARE POPULATION, BY RACE/ETHNICITY



The indicators also show concerns for adults 65 and older living alone and below poverty level. Additionally, 1.3% of adults 65+ do not have health insurance, which is in the worst 25th quartile of U.S. Counties.

Older residents face mobility issues, isolation, and limited access to specialized care, particularly for Alzheimer's and related dementias. Community providers expressed concern about gaps in transportation, caregiving support, and affordable housing options for seniors. Expanding home-based services, preventative care, and age-friendly environments was recommended across several listening sessions.

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 Lakeside Hospital's service area.

While these issues were determined to be important, Lakeside Hospital 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; Alcohol & Drug Use, Nutrition and Health Eating, and Physical Activity 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.

Alcohol & Drug Use

From the secondary data scoring results, Alcohol & Drug Use ranked 3rd in the data scoring of all topic areas, with a score of 1.60. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Montgomery County:

- Adults who Binge Drink Excessively (18.4%)
- Alcohol-Impaired Driving Deaths (29.9% of driving deaths)

Although not prioritized, stakeholders frequently referenced substance use disorders and the lack of accessible, affordable treatment services. Community members expressed concern over opioid misuse, teen vaping, and alcohol-related incidents. Participants also emphasized the link between substance use and underlying mental health issues, advocating for expanded prevention, early intervention, and recovery support programs, particularly in underserved areas.

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 21 illustrates that the zip codes with the highest risk of food insecurity are: 77340, 77306, and 77301.

FIGURE 21. FOOD INSECURITY INDEX: BSLMC PRIMARY SERVICE AREA

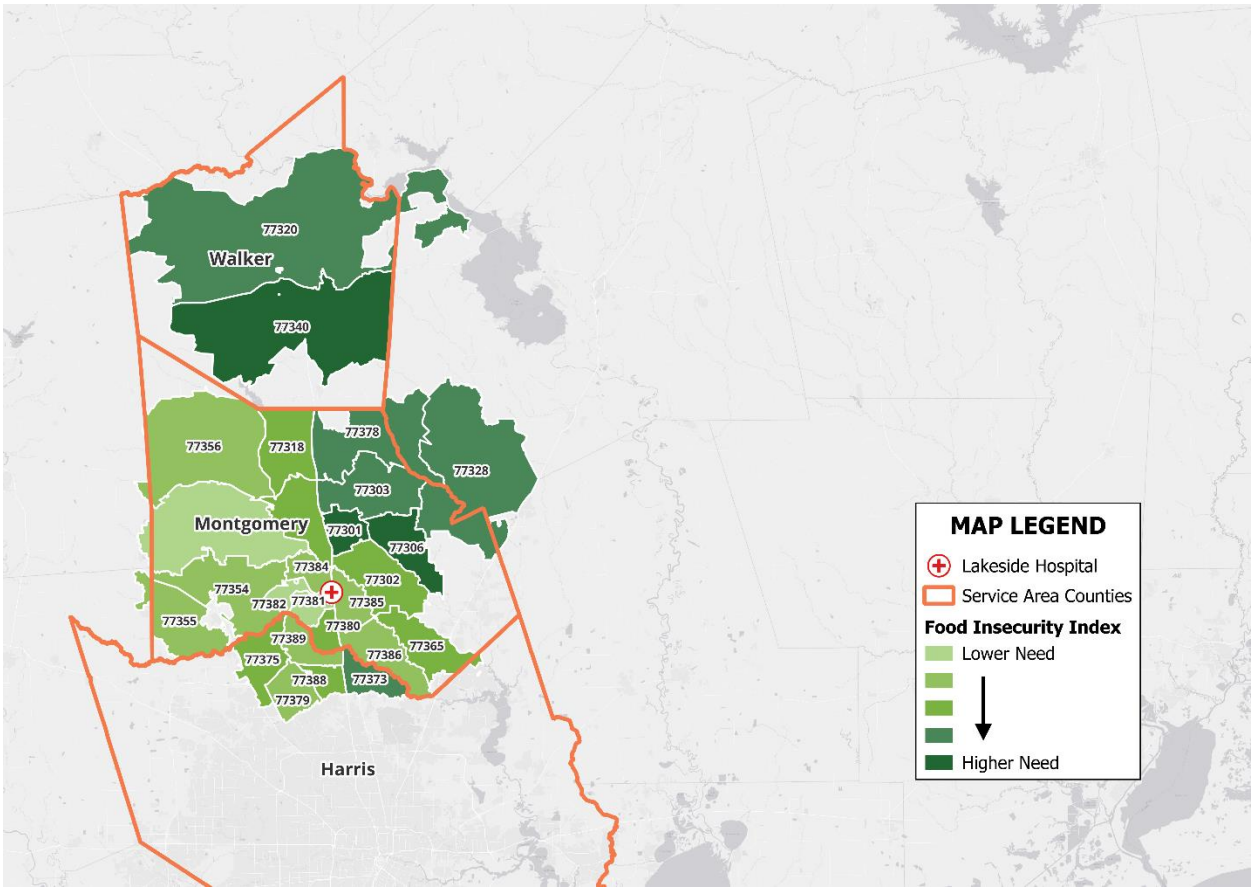


TABLE 9. FOOD INSECURITY INDEX: BSLMC PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77340	86.7	77380	29.0
77306	84.4	77388	26.7
77301	78.9	77355	22.2
77328	73.7	77354	19.0
77303	72.3	77379	18.2
77320	71.9	77385	16.2
77378	65.6	77386	15.1
77373	61.1	77356	13.5
77304	42.9	77384	11.9
77302	40.8	77389	11.3
77365	39.9	77316	9.7
77318	34.4	77381	5.3
77375	33.5	77382	2.7

While not prioritized, poor nutrition and food insecurity remain pervasive issues in the Lakeside community. Barriers such as affordability, low health literacy, and limited access to fresh produce and nutritional education contribute to high rates of obesity, diabetes, and cardiovascular conditions.

> **If you don't have safe, adequate housing, everything is kind of going down from there… lack of nutrition education to combat chronic disease. – Listening Session Participant**

Physical Activity

From the secondary data scoring results, Physical Activity ranked 2nd in the data scoring of all topic areas, with a score of 1.66. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Montgomery County:

- Workers who Walk to Work (0.8%)
- Adults 20+ Who Are Obese (29.2%)
- Adults 20+ who are Sedentary (17.5%)

Although not prioritized, community stakeholders noted that lack of safe parks, sidewalks, and recreational spaces inhibits regular exercise, particularly for children and older adults. High rates of sedentary behavior, coupled with long commuting times and digital lifestyles, contribute to the region's burden of chronic disease. Community input suggested the need for safe, inclusive, and accessible spaces that promote movement and well-being.

Barriers to Care

Barriers to care within the Lakeside Hospital service area reflect a complex intersection of socioeconomic challenges, structural limitations, and systemic inequities. Despite higher-than-average median household income and educational attainment levels, significant segments of the population, particularly in underserved zip codes, face persistent obstacles in accessing timely, affordable, and culturally appropriate care.

Transportation and Geography

Limited transportation options, particularly for low-income and older adult populations, pose significant challenges to healthcare access. Many residents in high-need zip codes lack reliable transportation, creating delays or preventing attendance for appointments, especially for specialty or mental health services

Language, Literacy, and System Navigation

More than one-third of residents in the Lakeside service area speak a language other than English at home. Language barriers, low health literacy, and limited system navigation support exacerbate disparities, especially for immigrant families and non-native English speakers.

Insurance Coverage and Affordability

Many working families fall into a coverage gap, earning too much to qualify for public assistance yet not enough to afford private insurance or out-of-pocket costs. These financial pressures delay preventive care, discourage follow-up, and increase emergency room dependence.

Mental Health Stigma and Workforce Shortage

Stigma, cultural perceptions, and a shortage of culturally competent mental health providers limit access to behavioral health services. Participants shared that wait times, insurance barriers, and fear of being labeled prevent many from seeking help.

Structural and Policy Barriers

System-level challenges including eligibility rules, lack of integration across social and health services, and long wait times discourage continuity of care. These issues disproportionately impact vulnerable groups such as seniors, people with disabilities, and undocumented residents.

Conclusion

The 2025 CHNA for Lakeside Hospital reveals both strengths and significant gaps in health outcomes and access across the hospital's 26 zip code service area. While the Lakeside region benefits from high levels of educational attainment, relatively low poverty rates, and a diverse population, deep disparities persist especially in high-need communities identified through Community Health, Mental Health, and Food Insecurity Indices.

Despite the challenges identified, Lakeside's community-based organizations, healthcare providers, and engaged residents demonstrate strong assets, resilience, and a shared commitment to improving community health. Moving forward, the findings of this CHNA will serve as a foundation for developing Lakeside Hospital's Implementation Strategy, aimed at addressing the prioritized needs through coordinated, measurable actions in partnership with the broader community.

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.