2025 Community Health Needs Assessment

Report adopted by Hospital Advisory Board May 2025

St. Luke's Health™

A member of CommonSpirit

Table of Contents

Community Health Needs Assessment – At a Glance

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 Sugar Land 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

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 Mission

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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

Sugar Land 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

St. Luke's Health Sugar Land Hospital serves a dynamic and rapidly growing area within the Greater Houston Metropolitan Region. The hospital's defined service area encompasses 24 zip codes, which are based on inpatient discharge data to reflect the communities that most frequently utilize the hospital's services. These zip codes represent the primary geographic area for this CHNA and ensure that the assessment captures the most impacted population by the hospital's health interventions and community benefit programs.

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, Sugar Land Hospital intends to enhance 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 chance 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.

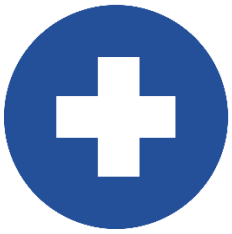
Resources Potentially Available

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 Sugar Land 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



Access to Care Initiatives

- Medicaid/CHIP Enrollment Support
- Assisted 2,301 low-income individuals with insurance enrollment and Medicaid counseling.

Charity Care & Financial Assistance

- Provided over $10.7 million in charity care in FY23 alone.
- Partnerships Enhancing Access:
- Collaborated with San José Clinic to provide medical, dental, pharmacy, and behavioral care for the uninsured.
- Partnered with Fort Bend Transit to improve medical transportation for mobility-limited patients.

Partnerships Enhancing Access

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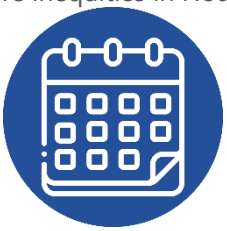
- Partnered with Fort Bend Transit to improve medical transportation for mobility-limited patients.

Health Equity & Cultural Competence

- Delivered annual culturally competent care training to clinical staff.
- Expanded language access services to reduce disparities.
- Produced the "ExamiNATION" video series on healthcare inequities in Houston

Chronic Disease Management & Prevention Community Screenings & Awareness

- Hosted free diabetes, hypertension, and cardiovascular screenings.



Signature Wellness Events

- Led the 2024 Fort Bend Health & Wellness Expo, promoting early detection and prevention.

- Conducted public health education on nutrition, exercise, and disease management.

Grantmaking for Disease Management

- Awarded $51,500 to San José Clinic for chronic disease and stroke prevention among the uninsured.
- Preventive Practices & Community Outreach
- Maternal & Child Health:
- Offered free prenatal education and breastfeeding support for expectant families.

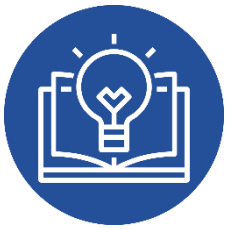
Human Trafficking Response

- Participated in the Houston Area Human Trafficking Healthcare Consortium and PATH Collaborative.
- Trained 4,000+ healthcare providers since 2020 on identifying and supporting victims.

- Sponsored the 2023 Fort Bend Infrastructure Conference for community awareness.

Preventive Practices & Community Outreach
Maternal & Child Health

- Offered free prenatal education and breastfeeding support for expectant families.



Community Investment & Workforce Development

- Invested $72,240 in student training for nursing, radiology, pharmacy, and therapy.
- Raised funds for The Rose (breast cancer) and donated to local food pantries via community drives.
- Participated in the Jingle Bell Run supporting the Arthritis Foundation.

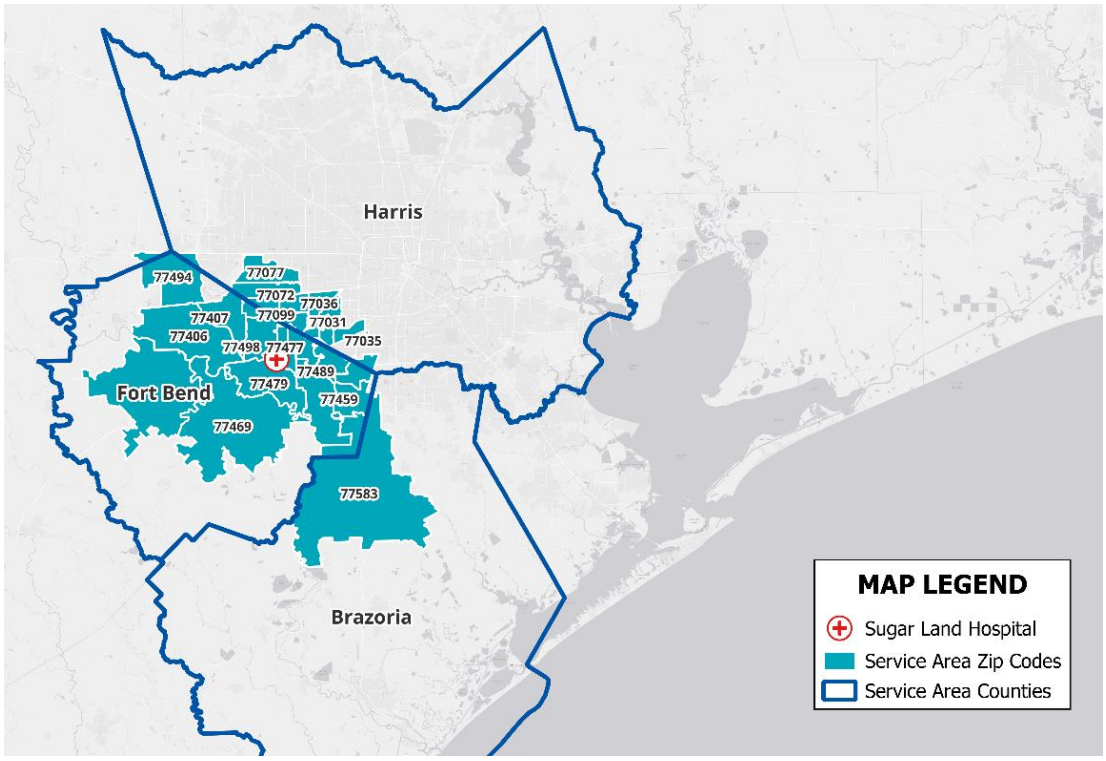
Defining the Community

St. Luke's Health Sugar Land Hospital serves a dynamic and rapidly growing area within the Greater Houston Metropolitan Region. The hospital's defined service area encompasses 24 zip codes, selected based on inpatient discharge data to reflect the communities that most frequently utilize the hospital's services. These zip codes represent the primary geographic footprint for this CHNA and ensure that the assessment captures the population most impacted by the hospital's health interventions and community benefit programs.

The Sugar Land service area is located within Fort Bend County, a region characterized by suburban expansion, economic diversity, and significant racial and ethnic plurality. According to Claritas 2024 estimates, this service area is home to approximately 1.39 million residents, representing one of the most populous sub-regions in the St. Luke's Health system.

A complete list of the zip codes in the Sugar Land Hospital service area can be found in the Appendix. Additional demographic tables, index scores, and social determinant profiles are presented in the Core Demographics section.

FIGURE 1. SUGAR LAND HOSPITAL SERVICE AREA



Demographic Profile

Geography and Data sources

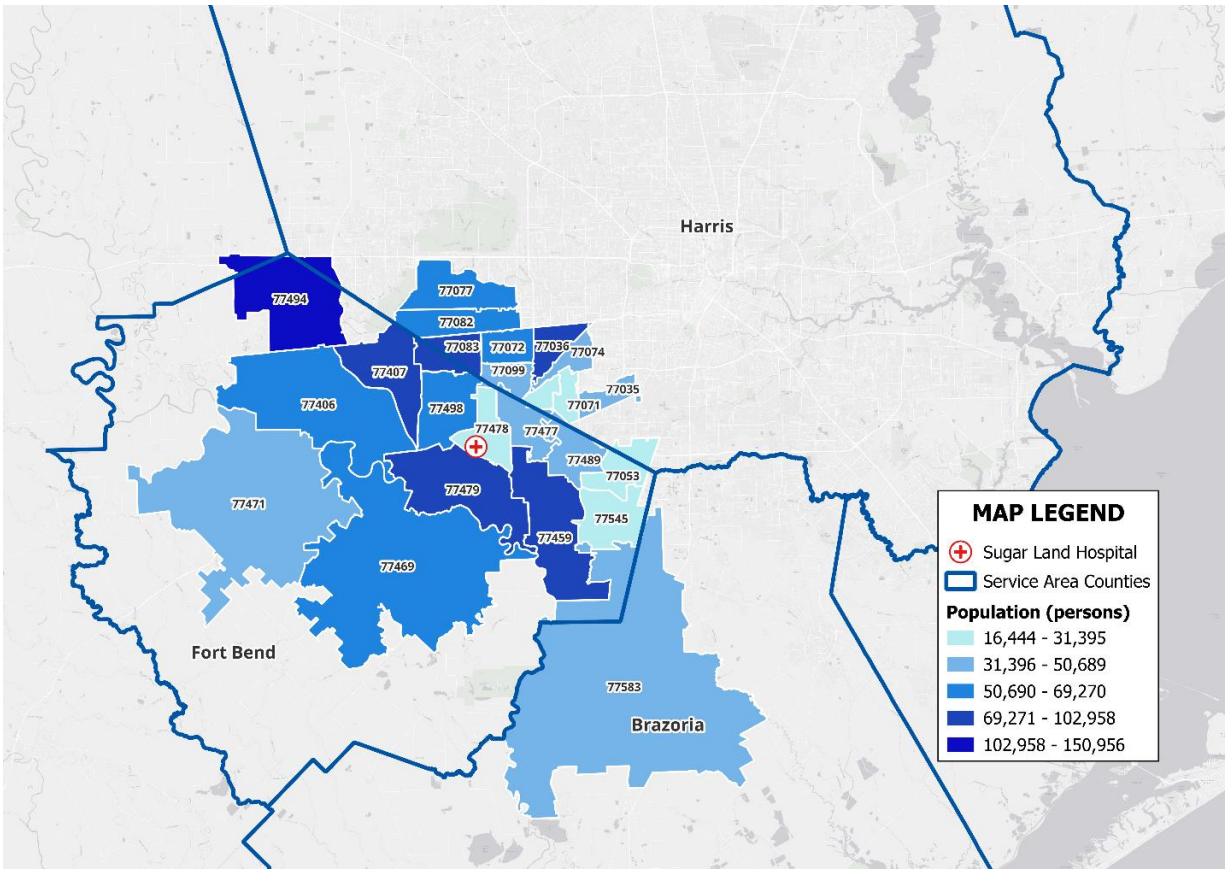
The following section explores the demographic profile of the Sugar Land Hospital's primary service area, which includes 24 zip codes in Fort Bend County, Harris County, and Brazoria County. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic 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 Sugar Land primary service area has an estimated population of 1,391,937 persons. Figure 2 shows the population breakdown for the service area by zip code.

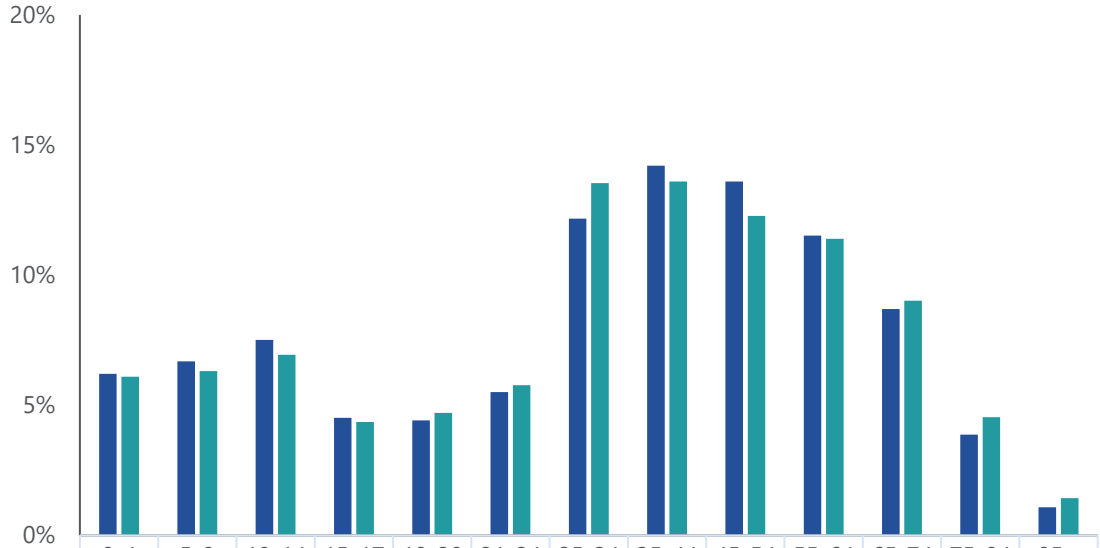
FIGURE 2. POPULATION DISTRIBUTION: SUGAR LAND PRIMARY SERVICE AREA



Age

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

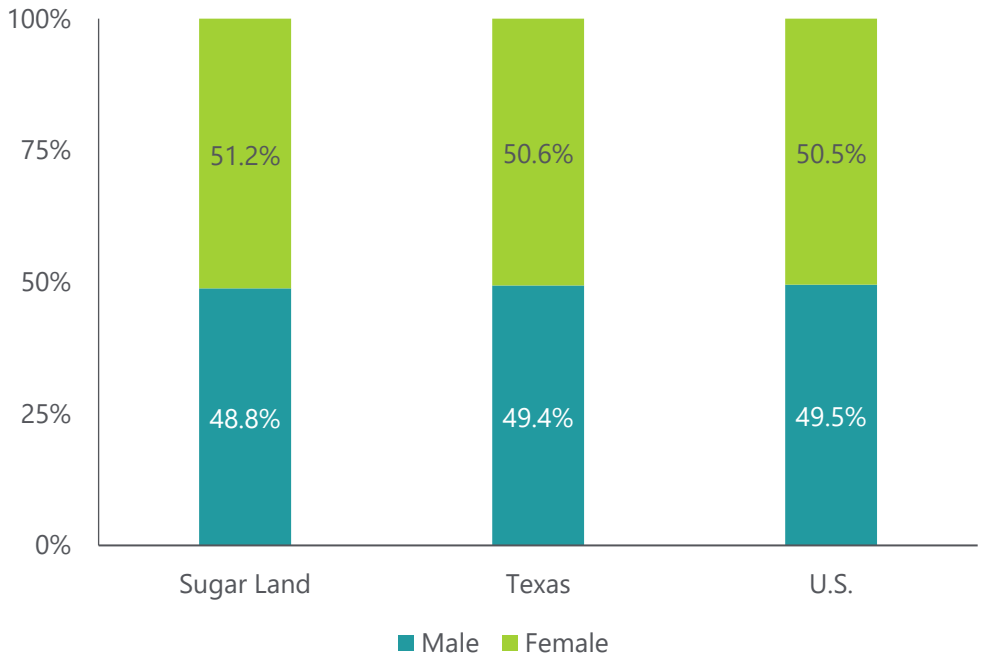


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Sugar Land	6.2%	6.7%	7.5%	4.5%	4.4%	5.5%	12.2%	14.2%	13.6%	11.5%	8.7%	3.9%	1.1%
Texas	6.1%	6.3%	6.9%	4.4%	4.7%	5.8%	13.5%	13.6%	12.3%	11.4%	9.0%	4.5%	1.4%

Sex

As seen in Figure 4, 51.2% of the Sugar Land 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



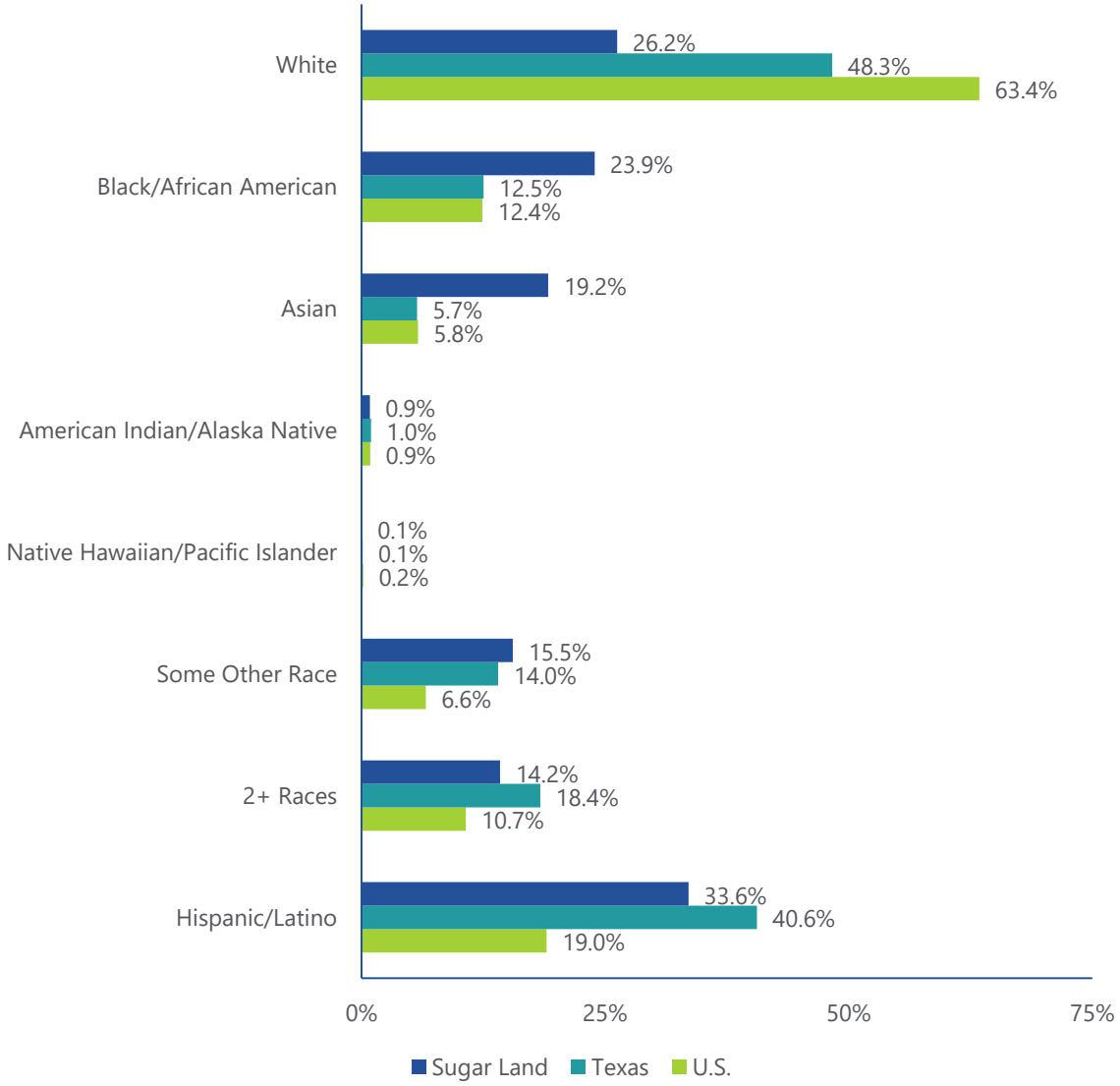
U.S. value taken from American Community Survey (2019-2023)

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 Sugar Land primary service area has a racially and ethnically diverse population. Sugar Land has a higher percentage of both Black/African American and Asian American residents than statewide or nationwide populations.

FIGURE 5. POPULATION BY RACE AND ETHNICITY



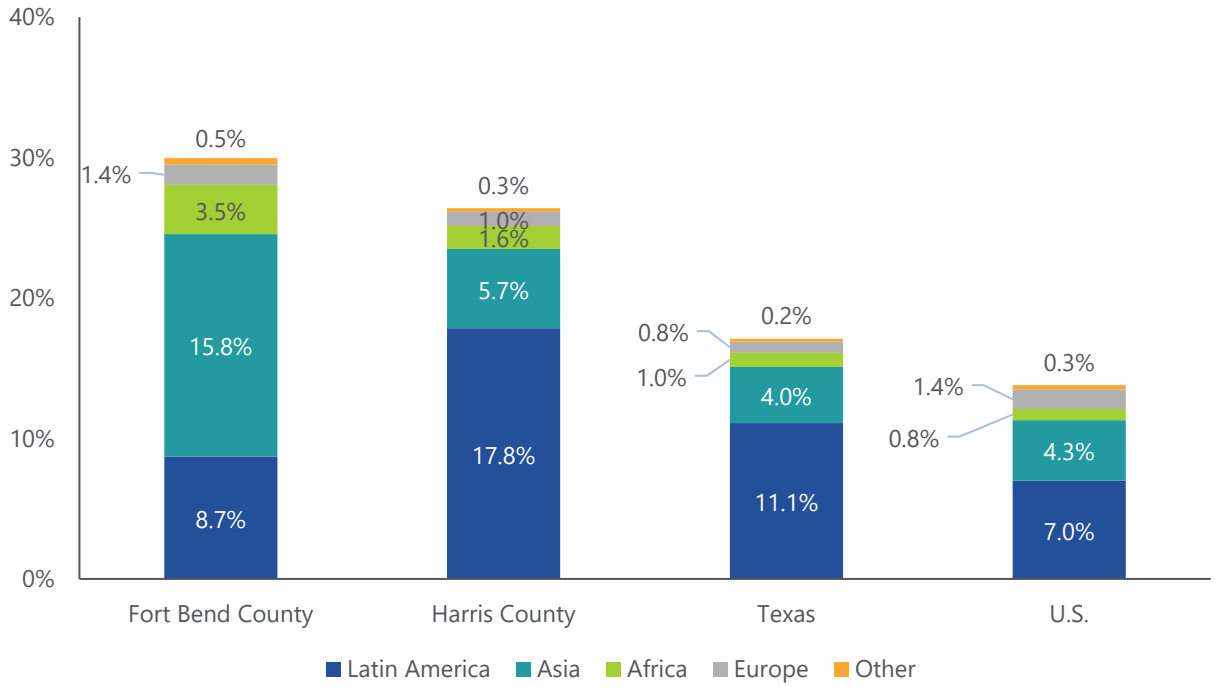
U.S. value taken from American Community Survey (2019-2023)

Language and Immigration

Understanding countries of origin and difficulty in speaking language can help inform the cultural and linguistic context. According to the American Community Survey, 26.4% of residents in Harris County and 29.9% of residents in Fort Bend 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%) and Asia (5.7%). Fort Bend County also has a larger percentage of residents born in Asia (15.8%), compared to the state and national percentages.

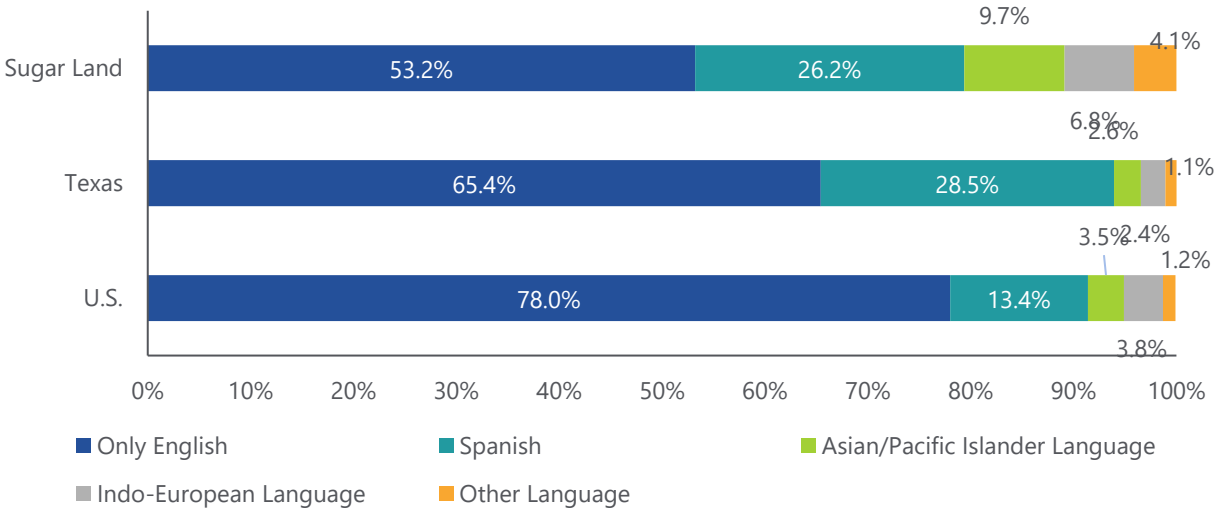
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY



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

As shown in Figure 7, almost half of the residents in the Sugar Land primary service area (46.8%) speak a language other than English at home. The Sugar Land population is more likely than the nation-wide population to speak Spanish (26.2% vs. 13.4%) and is also more likely to speak an Asian or Pacific Islander language than the state-wide and nation-wide population (9.7% vs. 2.6% and 3.5, respectively).

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

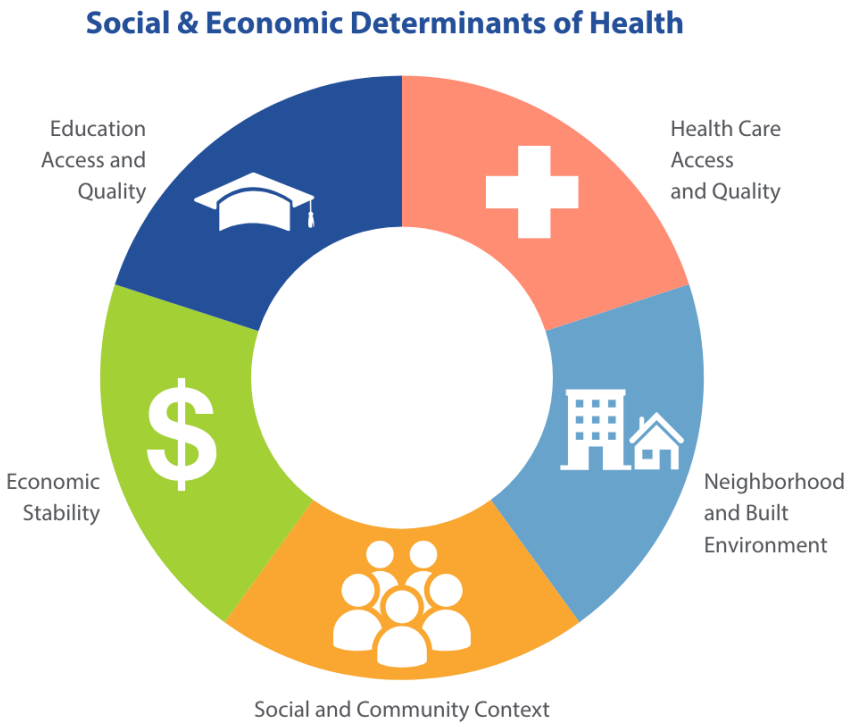


U.S. value taken from American Community Survey (2019-2023)

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Sugar Land's 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).

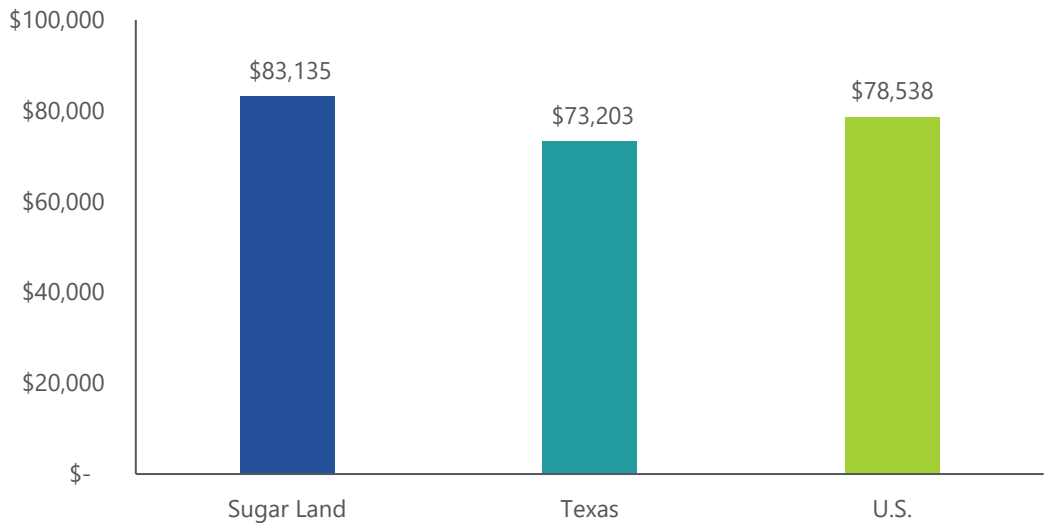
FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH



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.

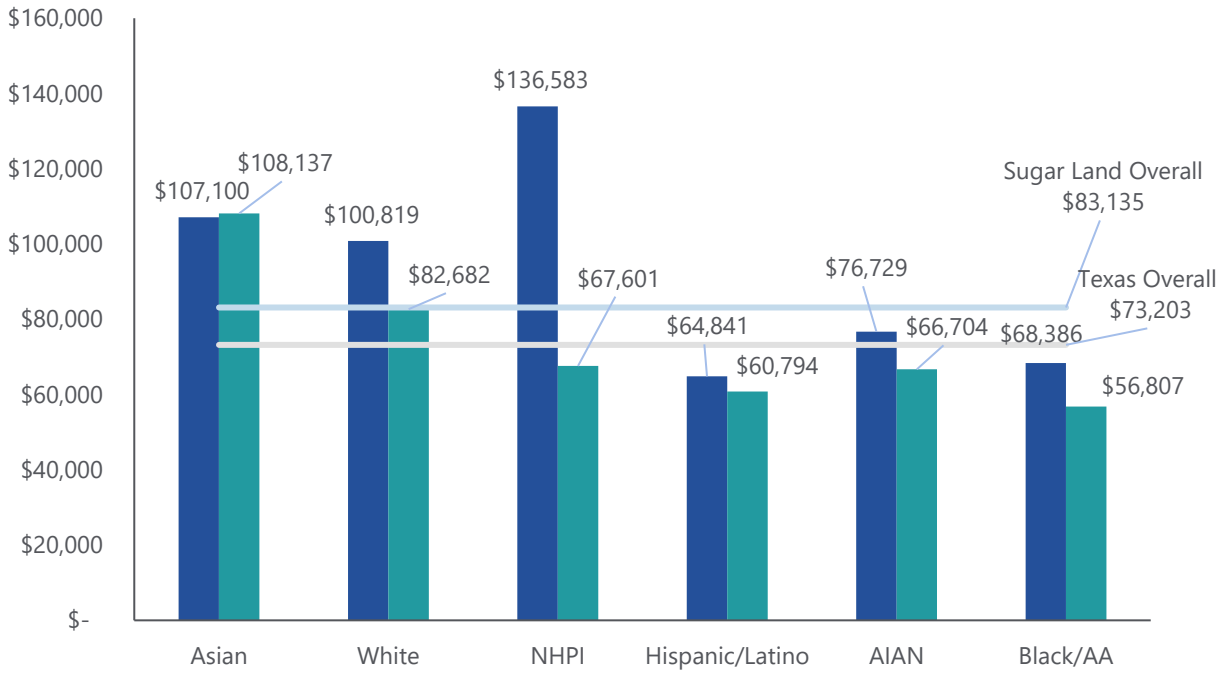
FIGURE 9. MEDIAN HOUSEHOLD INCOME



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 Black/African American, American Indian/Alaska Native, and Hispanic/Latino communities of the Sugar Land service area all have a lower median income than the overall service area median income. For example, the Hispanic/Latino median income is more than $18,000 lower than the overall median income ($64,841 vs. $83,135).

FIGURE 10. MEDIAN HOUSEHOLD INCOME BY RACE & ETHNICITY

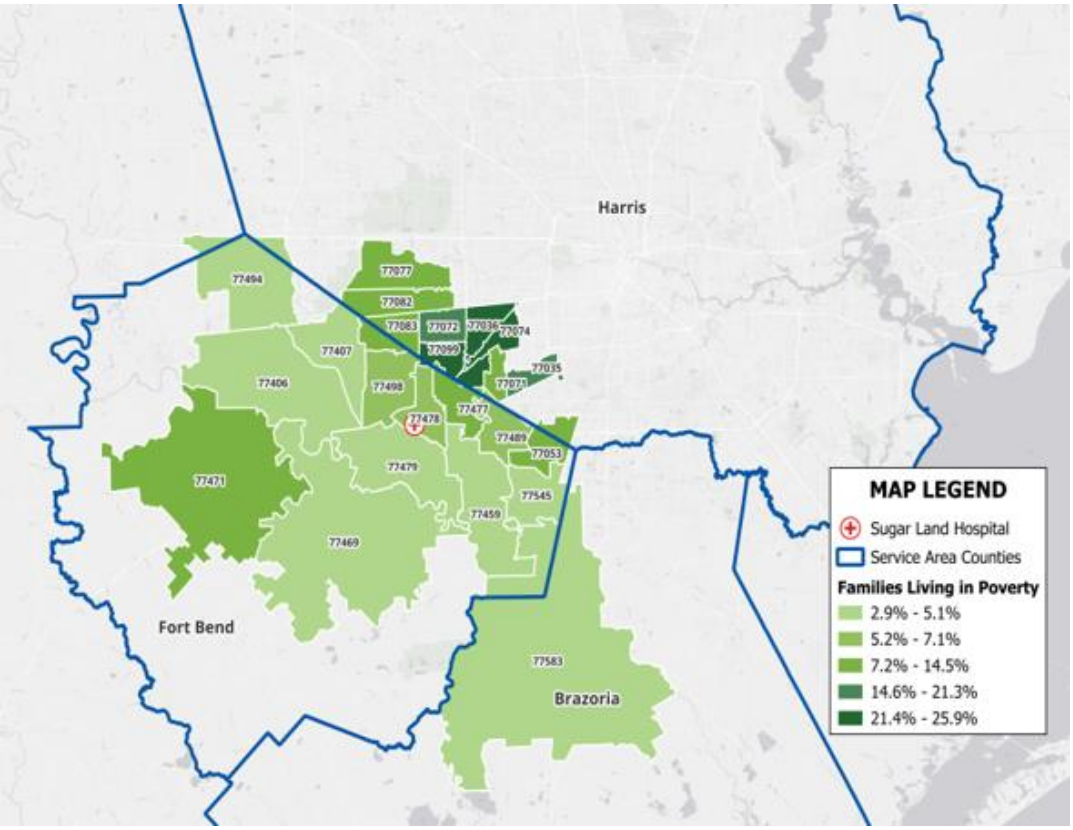


Poverty

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, 10.0% of families in the Sugar Land primary service area live below the poverty level, which is lower than the state value of 11.0%, but higher than 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



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 77074 and 77031. In both zip codes, a quarter of families live below poverty (25.9% and 25.7%, respectively).

[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

TABLE 1. FAMILIES LIVING IN POVERTY: SUGAR LAND PRIMARY SERVICE AREA

ZIP CODE	% FAMILIES IN POVERTY	ZIP CODE	% FAMILIES IN POVERTY
77074	25.9%	77477	10.0%
77031	25.7%	77478	7.1%
77099	23.8%	77489	6.9%
77036	23.5%	77498	6.2%
77072	21.3%	77545	5.1%
77035	19.7%	77407	5.0%
77082	14.5%	77494	4.7%
77071	13.5%	77583	4.7%
77471	13.3%	77406	4.6%
77053	13.1%	77469	4.3%
77083	11.8%	77479	4.1%
77077	10.9%	77459	3.0%

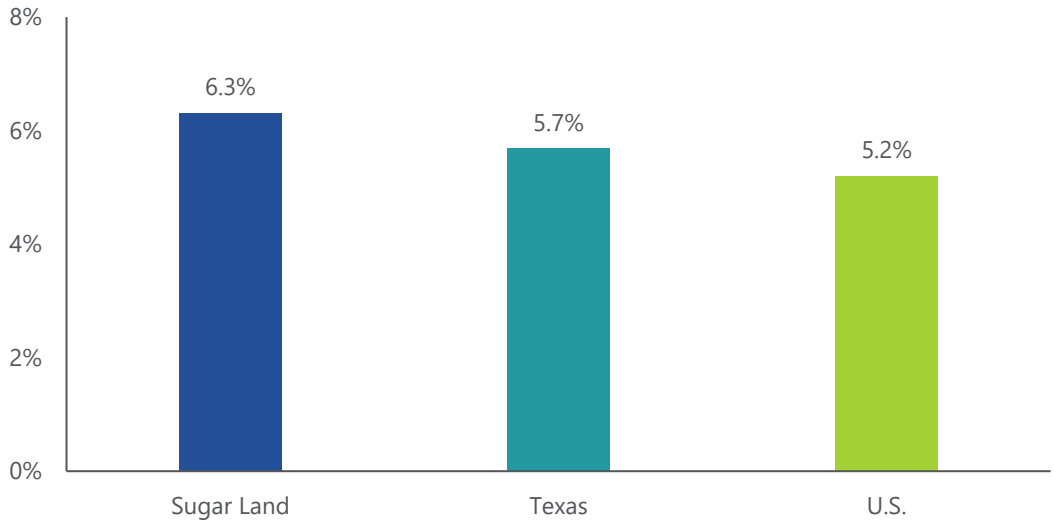
Employment

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 Sugar Land primary service area is 6.3%, which is higher than both the state-wide and nation-wide unemployment rates (5.7% and 5.2%, respectively).

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



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

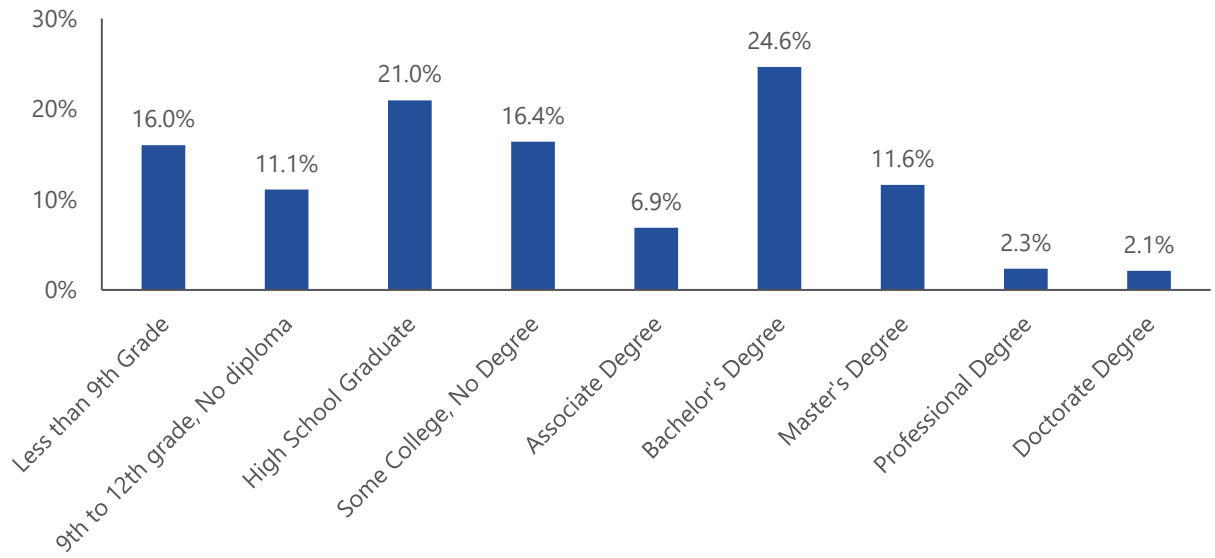
[2] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment

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 in particular 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 Sugar Land primary service area by educational attainment, among those aged 25 and up. As shown in Figure 14, most of the Sugar Land population has a high school diploma or higher (84.9%), which is similar to the Texas rate (85.1%). In contrast, the Sugar Land population is somewhat more likely than the state-wide and nation-wide population to have a Bachelor's Degree or higher (40.7% vs. 32.3% and 35.0%, respectively).

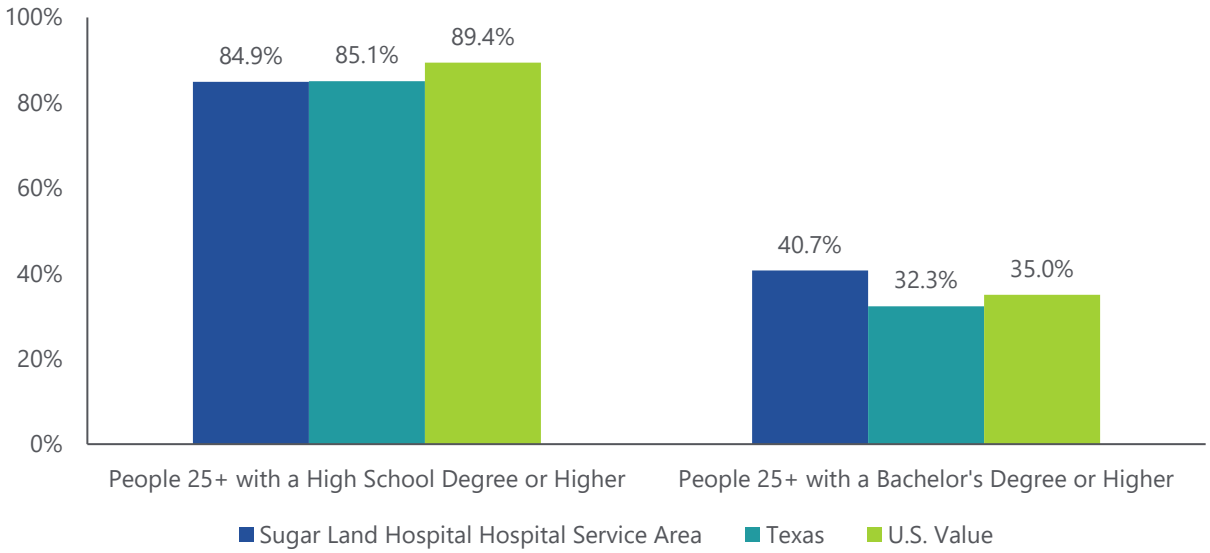
FIGURE 13. SUGAR LAND PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+



[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



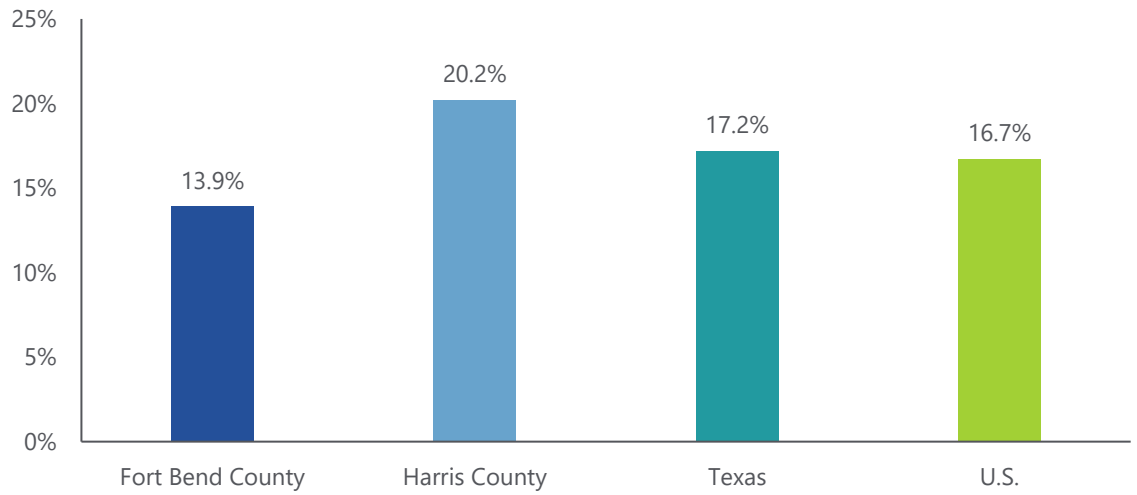
U.S. value taken from American Community Survey (2019-2023)

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, 13.9% of households in Fort Bend County and 20.2% of households in Harris 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. Compared to both the state and the nation, Fort Bend has a lower rate of severe housing problems, but Harris has a higher rate.

FIGURE 15. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



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

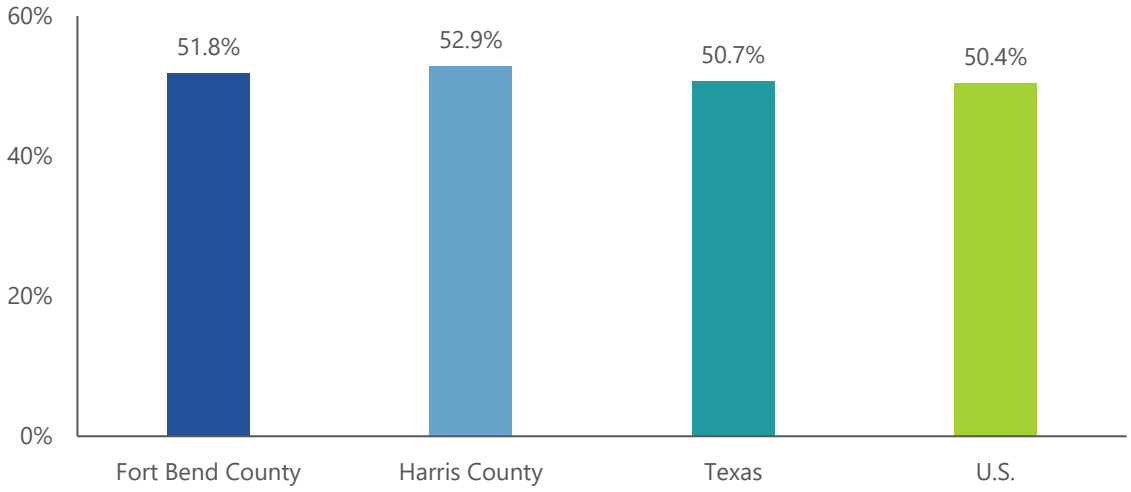
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[6]

[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 values in Harris County (52.9%) and Fort Bend County (51.8%) are 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



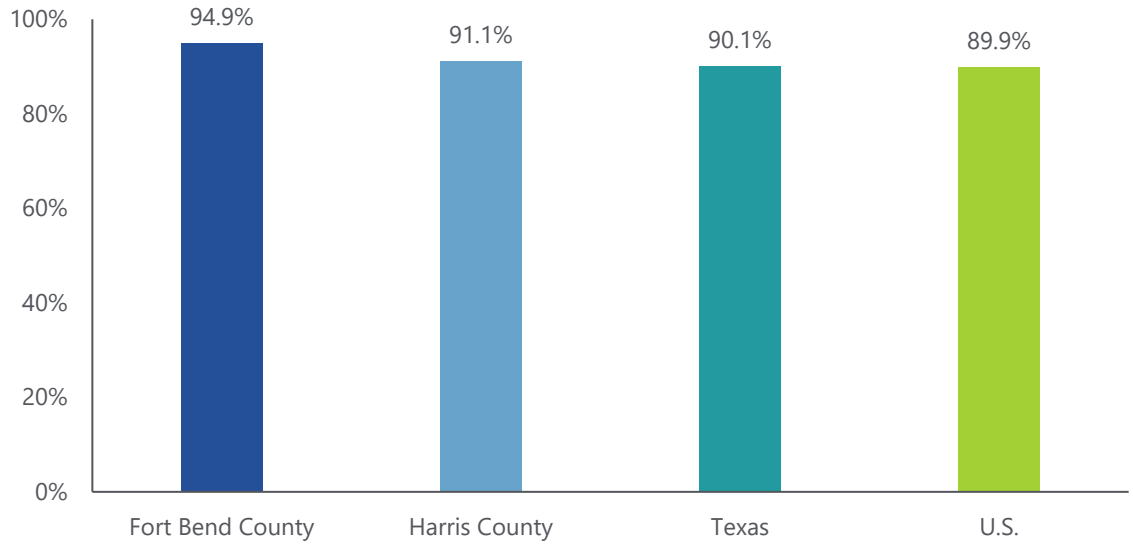
County, State, and U.S. values taken from American Community Survey (2019-2023)

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%) and Fort Bend County (94.9%) 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

Sugarland Hospital's CHNA 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.

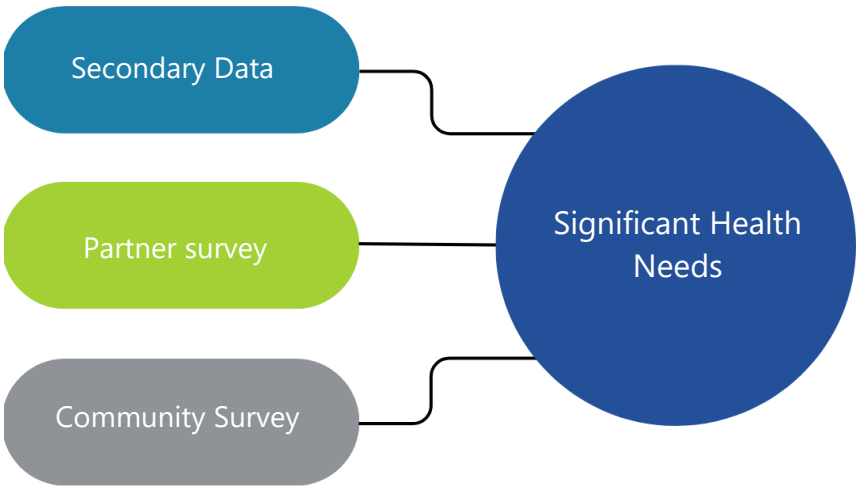
Qualitative Data: Primary Sources
Primary data were collected through community engagement activities designed to elevate voices from across the hospital's defined service area. These activities included:

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:

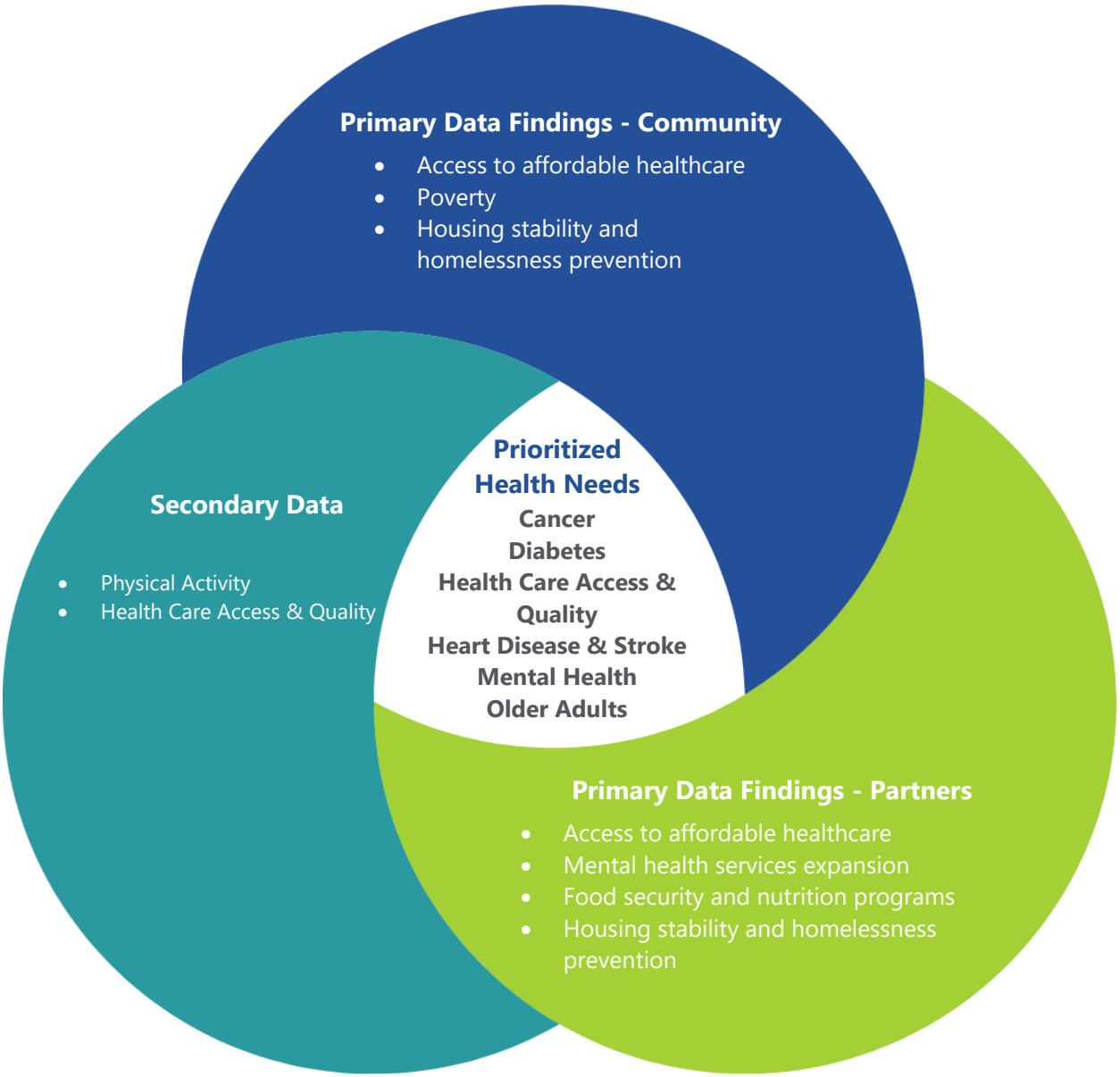
- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

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.



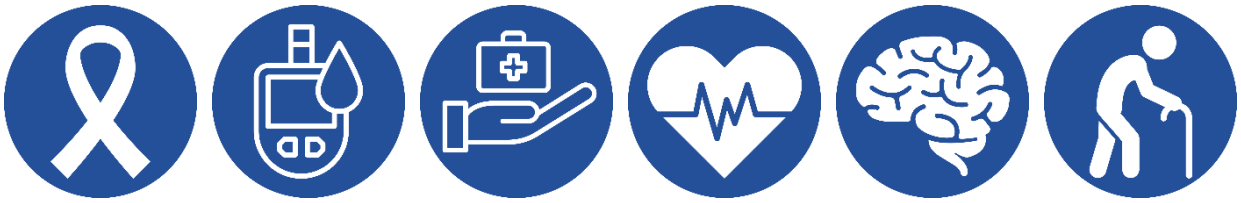
By combining data-driven analysis with community perspectives, the process ensures a comprehensive understanding of health needs and identifies priority areas for future intervention, collaboration, and investment.

Data Synthesis



Significant Health Needs

Through a comprehensive data analysis and community input process, the following health needs have been identified as the most pressing in Sugar Land Hospital'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.

The prioritized health needs; Cancer, Diabetes, Healthcare Access & Quality, Heart Disease & Stroke, Mental Health, and Older Adults 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.

Cancer

From the secondary data scoring results, Cancer ranked 5th in the data scoring of all topic areas with a score of 1.44. 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. Indicators of concern for Fort Bend and Harris County are listed in Tables 2 and 3 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 2. FORT BEND COUNTY DATA SCORING RESULTS: CANCER

Score	Cancer Indicator	Units	Fort Bend County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.12	Colon Cancer Screening: USPSTF Recommendation	percent	57.3			66.3			--
2.00	Cancer: Medicare Population	percent	12.0		11.0	12.0			--
1.59	Cervical Cancer Screening: 21-65	percent	78.6			82.8			--

Residents of Fort Bend County are less likely to receive both colon cancer screenings and cervical cancer screenings, compared to the overall U.S. population. For example, among those who meet USPSTF recommendations for colorectal cancer screening, only 57.3% in Fort Bend have actually received a colon cancer screening. This is one of the lowest rates among all U.S. counties. Additionally, the prevalence of cancer among Fort Bend's Medicare population is higher than that of the overall Texas population (12.0% vs. 11.0%).

Further analysis indicates that some populations in Fort Bend experience a greater risk for certain cancer-related health outcomes. As seen in Figure 18, the American Indian/Alaskan Native population of Fort Bend has the highest risk of any cancer diagnosis, compared to other racial/ethnic groups in the county (635.8 cases per 100,000). There are also substantial differences in risk with regard to prostate cancer, specifically. Fort Bend's Black/African American male population is nearly twice as likely to develop prostate cancer, compared to Fort Bend's overall male population (211.8 vs. 123.0 cases per 100,000). Further, Black/African American males are twice as likely to die from prostate cancer, compared to the overall county population (32.1 vs. 16.0 deaths per 100,000).

FIGURE 18. ALL CANCER INCIDENCE, BY RACE/ETHNICITY
(CASES PER 100,000 POPULATION)

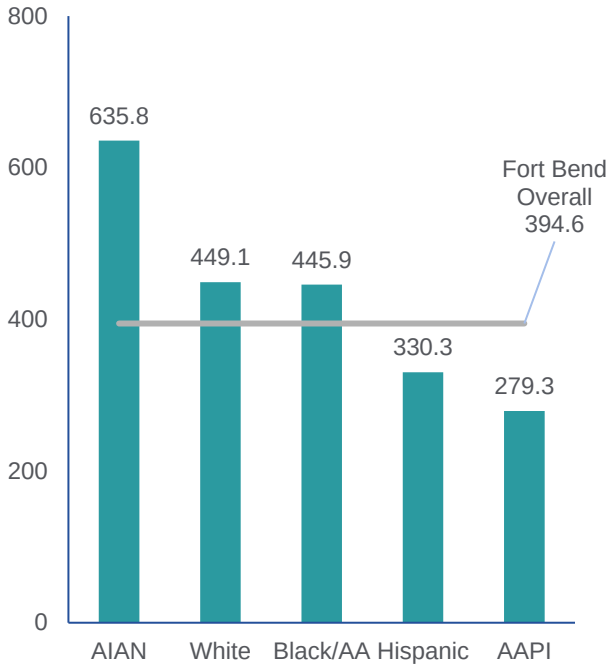


FIGURE 19. PROSTATE CANCER INCIDENCE, BY RACE/ETHNICITY
(CASES PER 100,000 POPULATION)

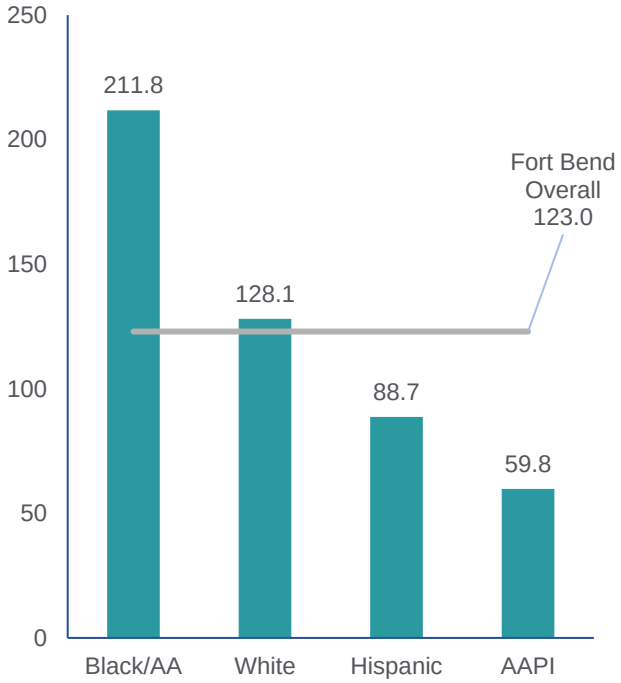


FIGURE 20. AGE-ADJUSTED DEATH RATE DUE TO PROSTATE CANCER, BY RACE/ETHNICITY
(DEATHS PER 100,000 POPULATION)

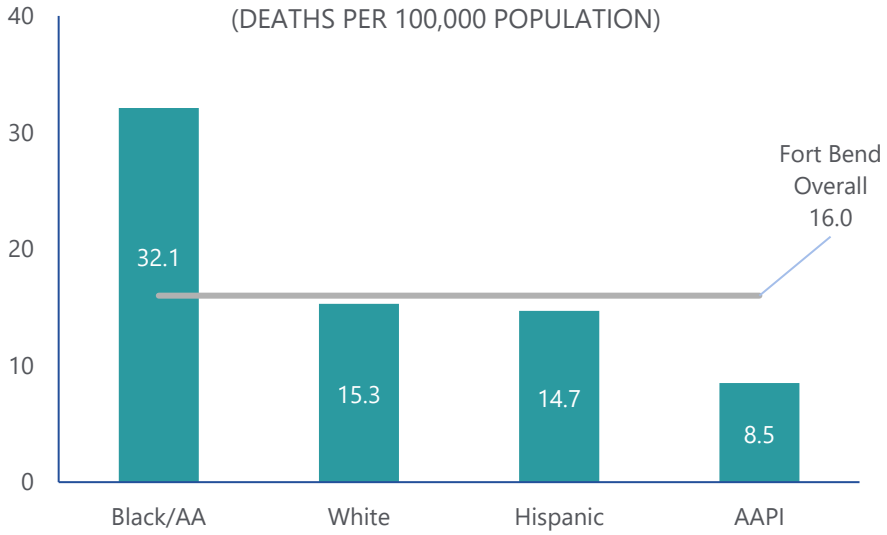


TABLE 3. HARRIS COUNTY DATA SCORING RESULTS: CANCER

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

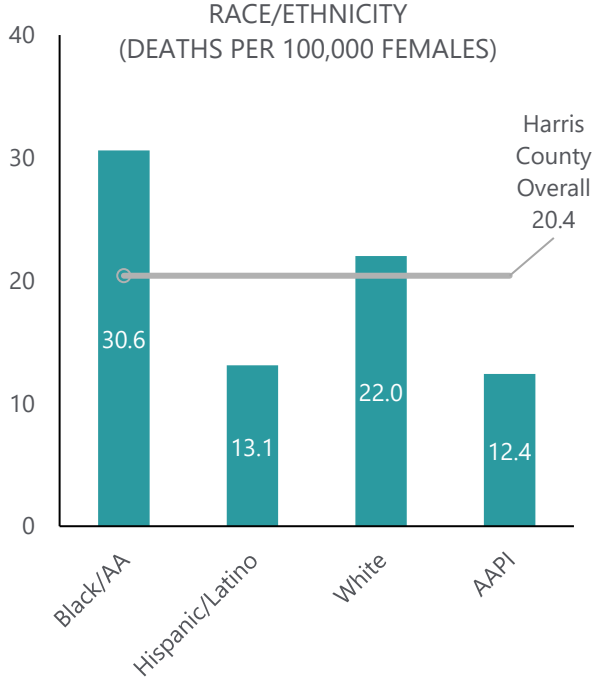


FIGURE 22. AGE-ADJUSTED DEATH RATE DUE TO PROSTATE CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000 MALES)

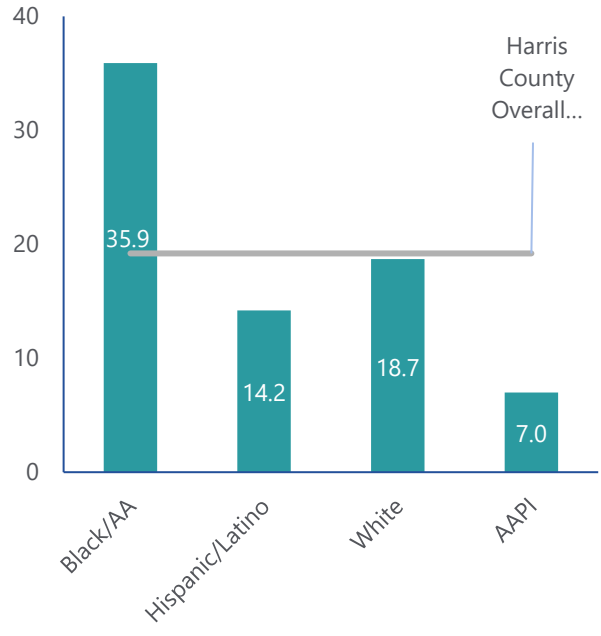


FIGURE 23. BREAST CANCER INCIDENCE, BY RACE/ETHNICITY (CASES PER 100,000 FEMALES)

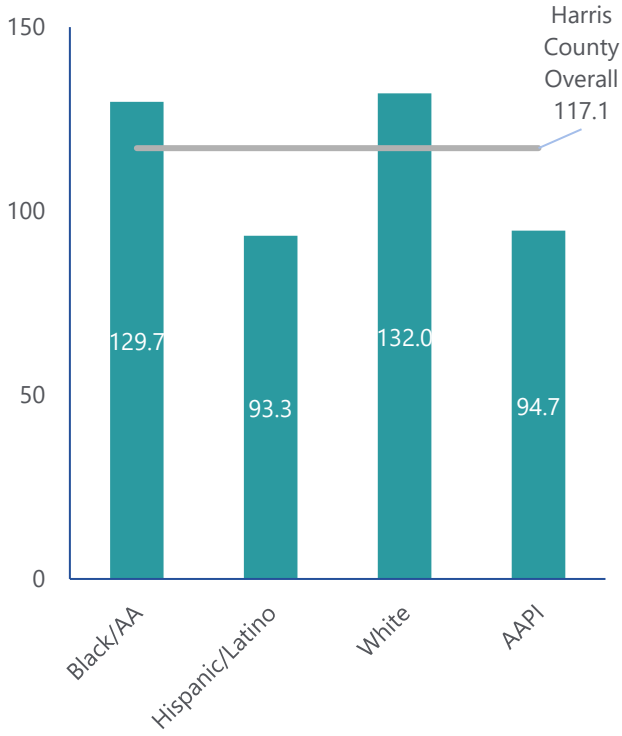
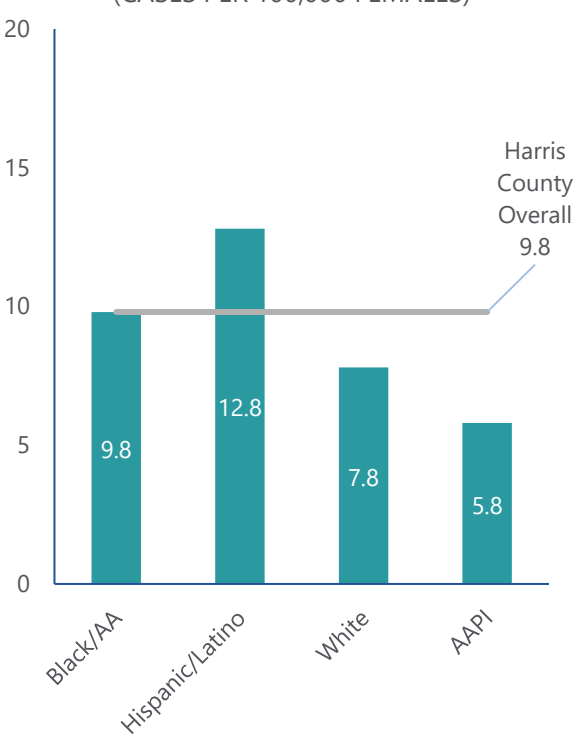


FIGURE 24. CERVICAL CANCER INCIDENCE, BY RACE/ETHNICITY (CASES PER 100,000 FEMALES)



Community partners emphasized the need for early detection, access to oncology specialists, and education about screening guidelines as critical gaps. Listening session participants noted delays in care-seeking due to affordability concerns and limited local access to diagnostic services.

Diabetes

From the secondary data scoring results, Diabetes ranked 3rd in the data scoring of all topic areas with a score of 1.50. The highest-scoring indicators in Fort Bend and Harris counties are listed in Tables 4 and 5 below. See Appendix A for additional details.

TABLE 4. FORT BEND COUNTY DATA SCORING RESULTS: DIABETES

Score	Diabetes Indicator	Units	Fort Bend County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.18	Adults 20+ with Diabetes	percent	10.3						
2.06	Diabetes: Medicare Population	percent	28.0		25.0	24.0			--

As shown in Table 4, 10.3% of adults age 20 and above in Fort Bend County have diabetes. This is one of the highest county rates of diabetes among all counties across Texas and the nation. This rate has also been worsening, although not significantly. The Medicare population in particular also experiences a higher rate of diabetes in Fort Bend, compared to both the state and nation (28.0% vs. 25.0% and 24.0%, respectively).

Diabetes-related health risks vary by population within Fort Bend. For example, the risk of hospitalization due to Type 2 diabetes increases with age, as illustrated in Figure 25. Even after adjusting for age, hospitalizations due to Type 2 diabetes are more common among Fort Bend's male population, and are also more common among the county's Black/African American and Hispanic/Latino populations, as seen in Figures 26 and 27. For example, Black/African American adults in Fort Bend county have a risk of 22.6 hospitalizations per 100,000, which is nearly twice that of the county's overall population risk (12.4 hospitalizations per 100,000).

FIGURE 25. HOSPITALIZATION RATE DUE TO TYPE 2 DIABETES, BY AGE
(HOSPITALIZATIONS PER 100,000)

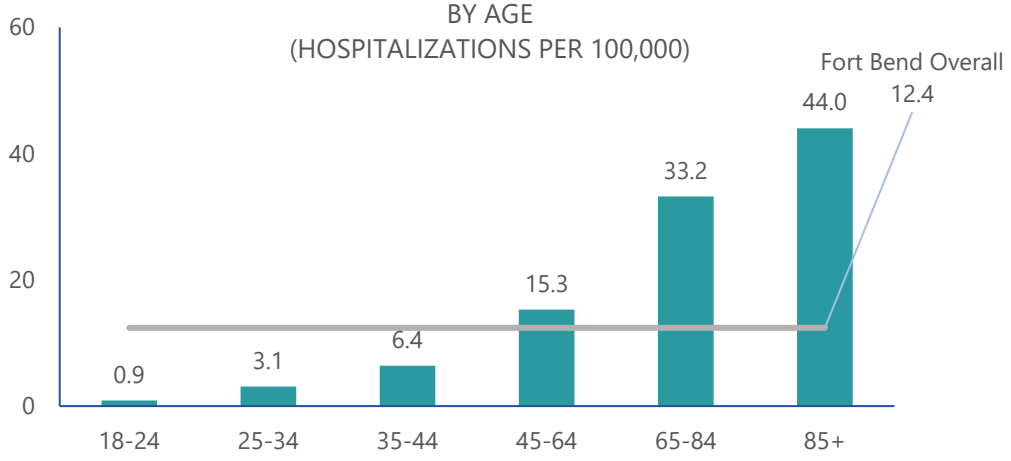


FIGURE 26. AGE-ADJUSTED HOSPITALIZATION RATE DUE TO TYPE 2 DIABETES, BY SEX (HOSPITALIZATIONS PER 100,000 POPULATION 18+ YEARS)

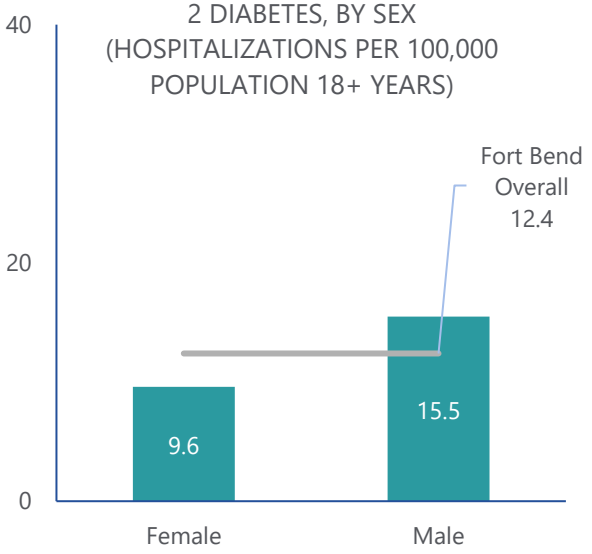


FIGURE 27. AGE-ADJUSTED HOSPITALIZATION RATE DUE TO TYPE 2 DIABETES, BY RACE/ETHNICITY (HOSPITALIZATIONS PER 100,000 POPULATION 18+ YEARS)

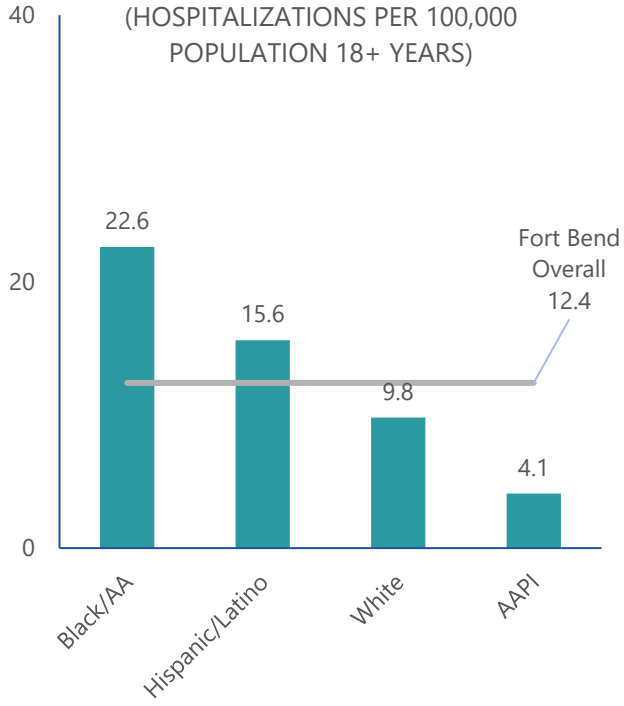


TABLE 5. HARRIS COUNTY DATA SCORING RESULTS: DIABETES

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 5, 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 5, 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 28. AGE-ADJUSTED DEATH RATE DUE TO DIABETES, BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)

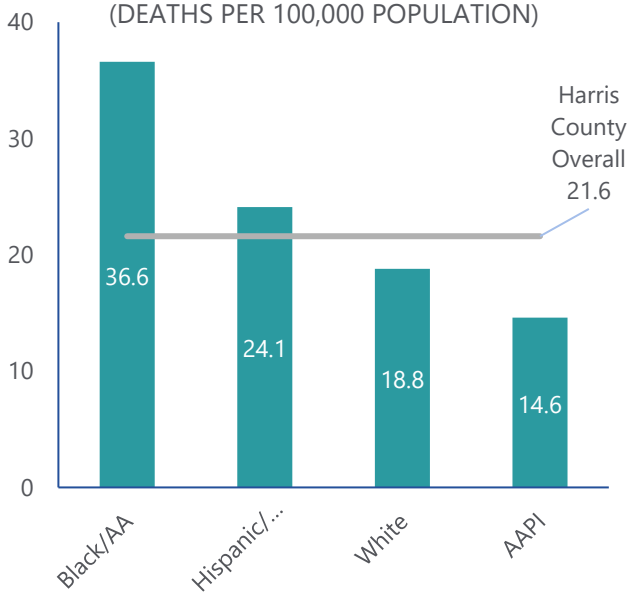
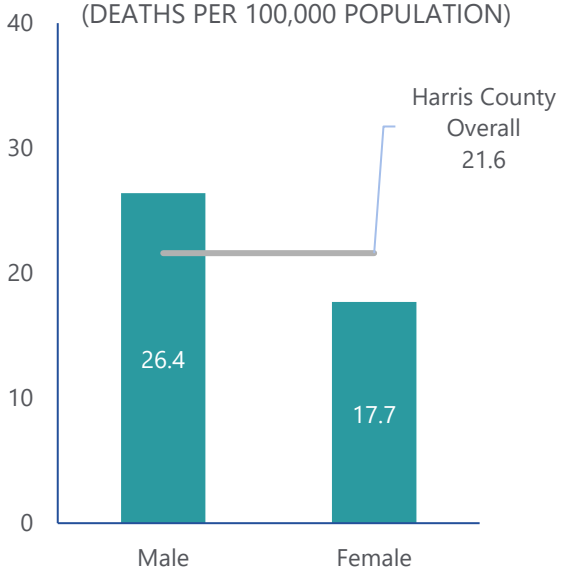


FIGURE 29. AGE-ADJUSTED DEATH RATE DUE TO DIABETES, BY SEX (DEATHS PER 100,000 POPULATION)



Diabetes was identified as a prevalent chronic condition affecting residents across age and racial groups. This issue intersects with social determinants like food insecurity and limited access to nutrition education. Providers noted a lack of culturally competent diabetes education and ongoing challenges in self-management support. In qualitative responses, chronic disease (especially diabetes) was cited as one of the most important conditions that need to be addressed due to its long-term impact on families and communities.

Healthcare Access & Quality

From the secondary data scoring results, Health Care Access & Quality ranked 2nd in the data scoring of all topic areas with a score of 1.55. 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. Indicators of concern for Fort Bend and Harris counties are listed in Tables 6 and 7 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 6. FORT BEND COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS & QUALITY

Score	Health Care Access & Quality Indicator	Units	Fort Bend County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.41	Adults 65+ without Health Insurance	percent	2.4		1.9	0.8			
1.91	Children with Health Insurance	percent	92.8		89.1	94.9	--		
1.76	Adults without Health Insurance	percent	12.8			10.8			--
1.59	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	85.5		109.0	131.4			

The population of Fort Bend has relatively high rates of uninsured individuals. Adults age 65 and over are about three times more likely to be uninsured in Fort Bend County, compared to the nation-wide population of older adults (2.4% vs. 0.8%). The broader adult population in Fort Bend, as well as the child population, are also more likely to be uninsured than the nation overall.

Further analysis indicates that among adults, those under the age of 35 are least likely to be insured in Fort Bend, as seen in Figure 30. Additionally, the Hispanic/Latino and multiracial populations of Fort Bend are less likely to be insured than the overall county population (75.2% and 76.9% vs. 85.1%).

Uninsured people are less likely to receive medical care, including services for major health conditions and chronic diseases. Health insurance is particularly important for children, who require regular checkups, dental and vision care.

FIGURE 30. ADULTS WITH HEALTH INSURANCE, BY AGE

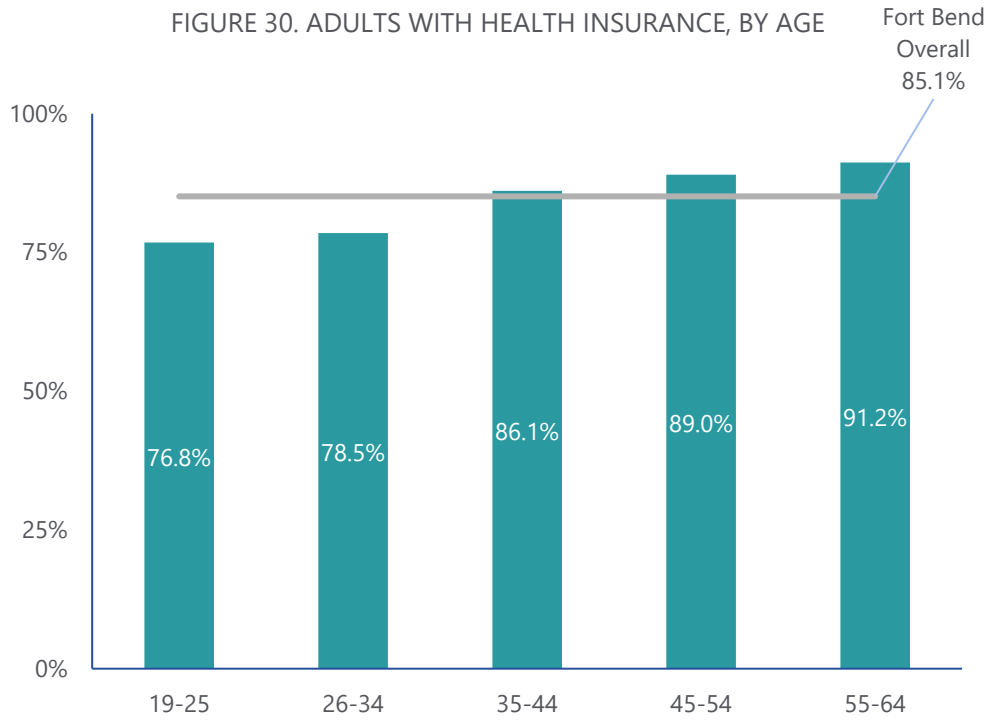


FIGURE 31. ADULTS WITH HEALTH INSURANCE, BY RACE AND ETHNICITY

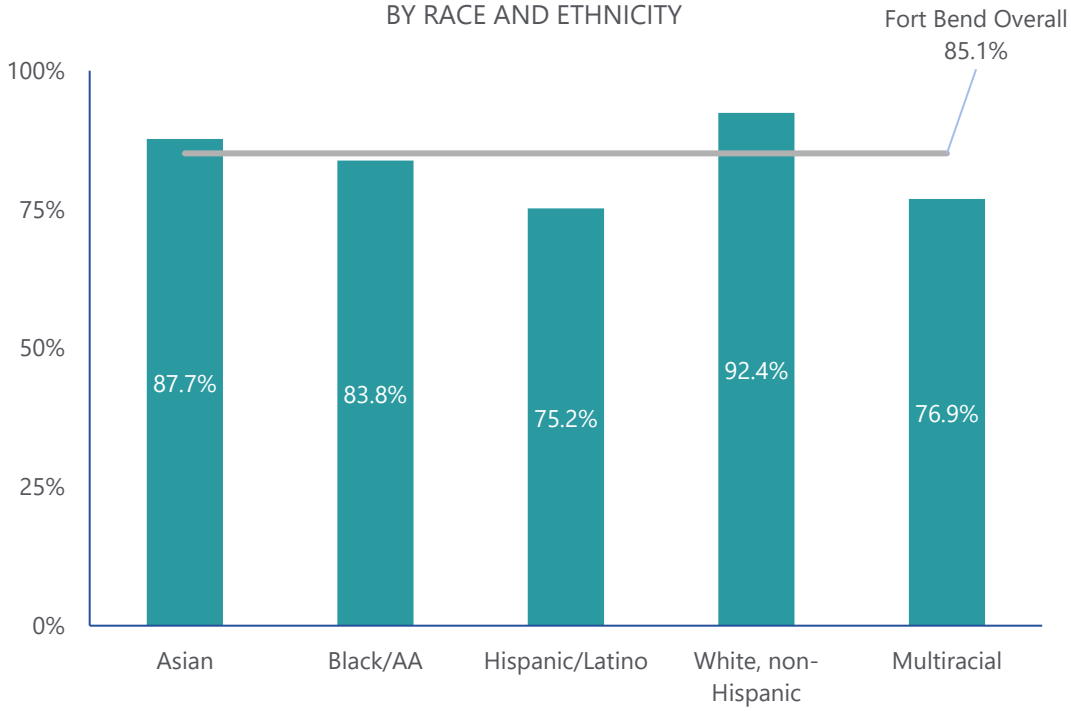


TABLE 7. HARRIS COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS & QUALITY

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 8 provides the index values and local ranking for each zip code. The map in Figure 32 illustrates that the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue) are 77036, 77074, and 77031 with index values of 97.4, 97.3, and 96.9, respectively.

FIGURE 32. COMMUNITY HEALTH INDEX: SUGAR LAND PRIMARY SERVICE AREA

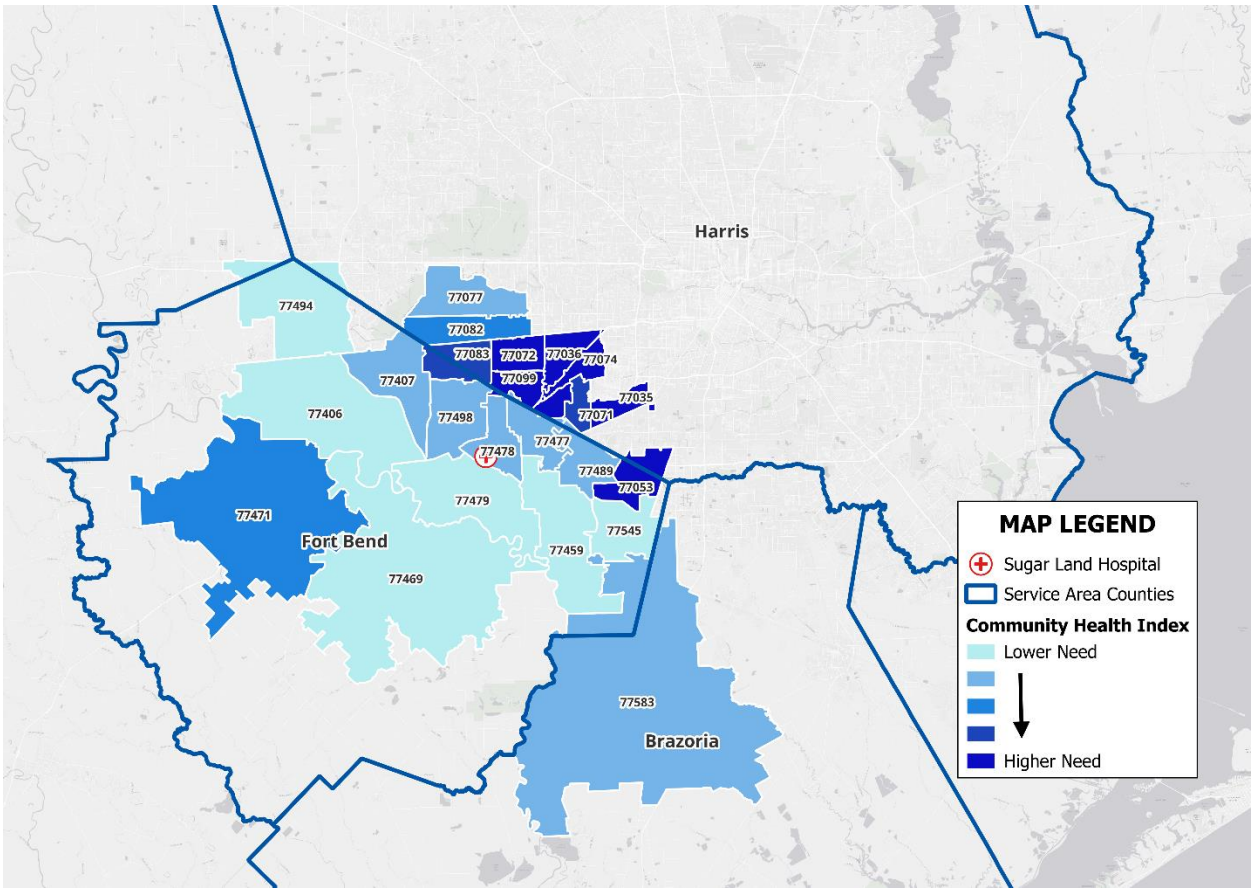


TABLE 8. COMMUNITY HEALTH INDEX: SUGAR LAND PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77036	97.4	77489	28.0
77074	97.3	77477	27.8
77031	96.9	77407	21.2
77099	95.4	77498	20.2
77072	89.8	77077	20.2
77035	87.5	77478	16.9
77053	85.6	77545	13.6
77071	74.8	77469	13.4
77083	72.8	77406	7.7
77471	56.6	77494	7.2
77082	50.0	77459	6.5
77583	31.4	77479	6.0

Community voices emphasized transportation, limited appointment availability, and lack of awareness about existing services as ongoing issues. Partner survey respondents also prioritized **"access to affordable, high-quality health services—including mental health care"** as a top community need.

Heart Disease & Stroke

From the secondary data scoring results, Heart Disease and Stroke ranked 13th in the data scoring of all topic areas with a score of 1.23. 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. Indicators of concern in Fort Bend and Harris counties are listed in Tables 9 and 10 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 9. FORT BEND COUNTY DATA SCORING RESULTS: HEART DISEASE AND STROKE

Score	Heart Disease & Stroke Indicator	Units	Fort Bend County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.35	Hyperlipidemia: Medicare Population	percent	69.0		65.0	65.0			--
1.94	Adults who Have Taken Medications for High Blood Pressure	percent	76.2			78.2			--
1.82	Hypertension: Medicare Population	percent	68.0		66.0	65.0			--

In Fort Bend County, Hyperlipidemia and Hypertension are each more common than in Texas or the U.S., specifically among Medicare recipients. For example, 69.0% of all Fort Bend Medicare recipients have hyperlipidemia, which is among the worst 25% of county rates across the nation. Adherence to blood pressure medication is also an issue of concern. In Fort Bend, 76.2% of adults with high blood pressure have taken any medication to treat the condition, which is among the lowest rates across all U.S. counties.

Further analysis demonstrates that health risks related to heart disease and stroke increase with age. For example, the risk for hospitalization due to heart failure increases dramatically after the age of 65. Even after accounting for age, both the male population and the Black/African American populations of Fort Bend experience a particularly high risk for hospitalization due to heart failure. For example, Black/African American adults in Fort Bend are nearly twice as likely to be hospitalized due to heart failure, compared to the general county population (52.8 vs. 28.8 hospitalizations per 10,000). Finally, among Fort Bend's Medicare population, American Indian/Alaska Native Medicare recipients are about twice as likely to have been treated for a stroke, compared to the overall county Medicare population (16.0% vs. 7.0%).

FIGURE 33. HOSPITALIZATION RATE DUE TO HEART FAILURE, BY AGE
(HOSPITALIZATIONS PER 10,000 POPULATION)

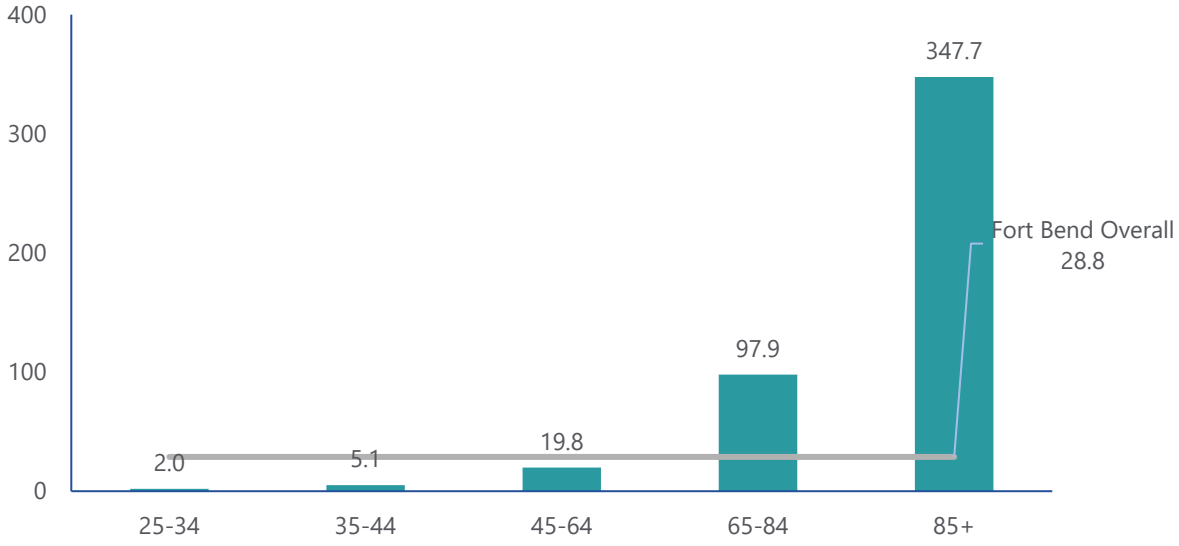


FIGURE 34. AGE-ADJUSTED HOSPITALIZATION RATE
DUE TO HEART FAILURE, BY SEX
(HOSPITALIZATIONS PER 10,000 POPULATION 18+
YEARS)

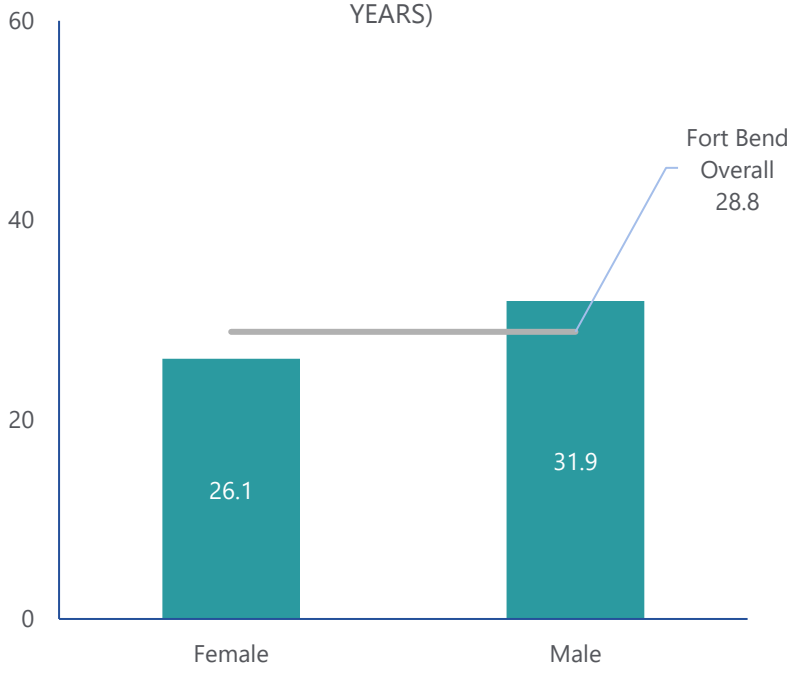


FIGURE 35. AGE-ADJUSTED HOSPITALIZATION RATE DUE TO HEART FAILURE, BY RACE/ETHNICITY (HOSPITALIZATIONS PER 10,000 POPULATION 18+ YEARS)

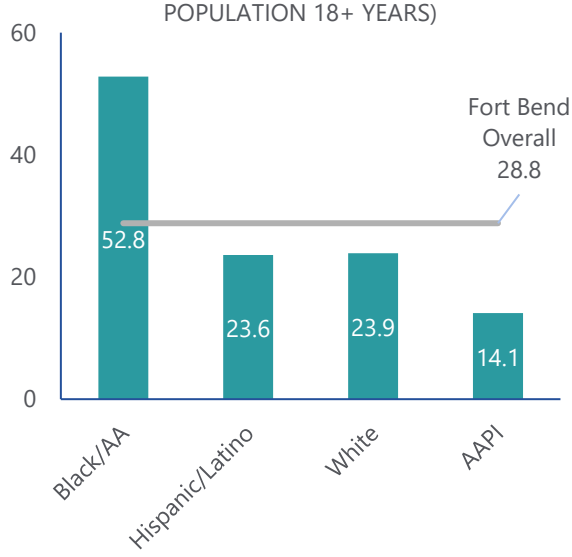


FIGURE 36. STROKE: MEDICARE POPULATION, BY RACE/ETHNICITY

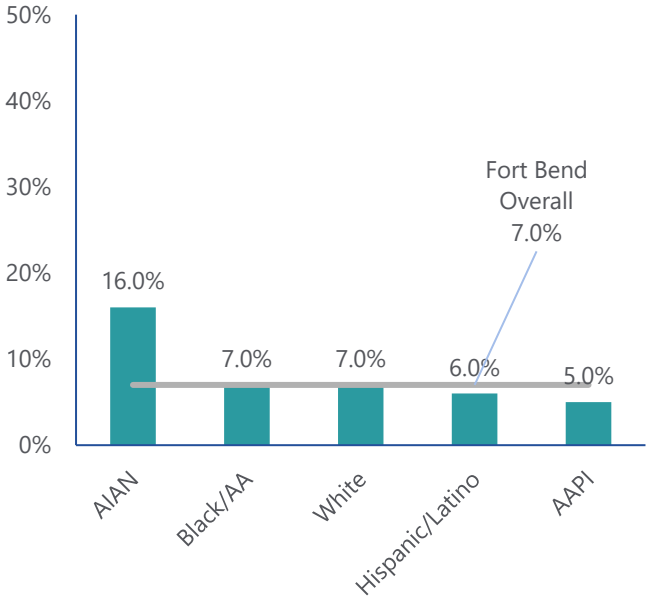


TABLE 10. HARRIS COUNTY DATA SCORING RESULTS: HEART DISEASE AND STROKE

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

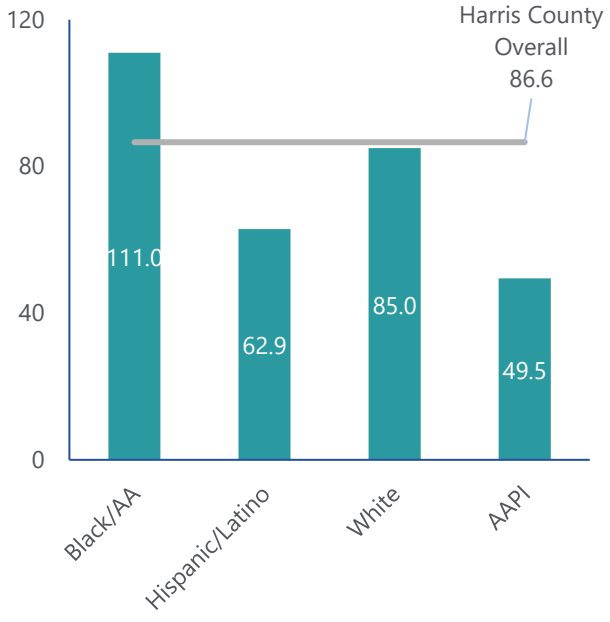
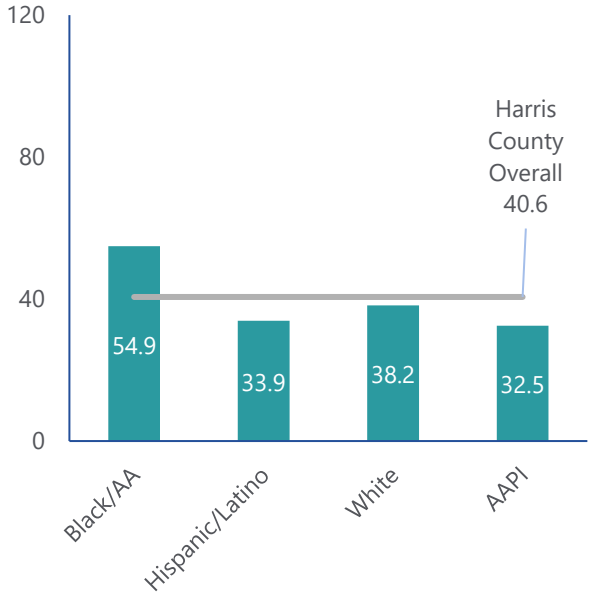


FIGURE 38. AGE-ADJUSTED DEATH RATE DUE TO CEREBROVASCULAR DISEASE (STROKE), BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)



Cardiovascular disease continues to be a leading cause of premature death and hospitalization. Survey and session participants observed that comorbid conditions such as hypertension and diabetes often go untreated due to the cost or lack of care continuity.

Mental Health

From the secondary data scoring results, Mental Health and Mental Disorders ranked 18th in the data scoring of all topic areas with a score of 1.04. 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. We did not identify any indicators of concern within this topic area for Fort Bend County, and so Table 11 includes the three highest scoring indicators. Indicators of concern in Harris County are listed in Table 12. See Appendix A for the full list of indicators categorized within this topic.

TABLE 11. FORT BEND COUNTY DATA SCORING RESULTS: MENTAL HEALTH & MENTAL DISORDERS

Score	Mental Health & Mental Disorders Indicator	Units	Fort Bend County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
1.41	Mental Health Provider Rate	providers/ 100,000 population	107.9		156.7	313.9			
1.06	Poor Mental Health: Average Number of Days	days	4.3		4.6	4.8			
0.88	Poor Mental Health: 14+ Days	percent	14.5			15.8			

As seen in Table 11, none of the indicators related to mental health that were available for Fort Bend County had a concerning score (at or above 1.50). The most concerning indicator within this topic area is mental health provider rate, which is lower than the overall Texas and U.S. mental health provider rates, but has been significantly improving over time. Generally, however, Fort Bend's population report fewer days of poor mental health and are also less likely to report having 14 or more days of poor mental health in the past 30 days, compared to the overall U.S. population. Table 12 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 12. 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%).

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 13 provides the index values and local ranking for each zip code. The map in Figure 39 illustrates that the zip codes with the highest risk for poor mental health (as indicated by the darkest shade of purple) are zip codes 77071 (MHI = 91.9) and 77035 (85.0).

FIGURE 39. MENTAL HEALTH INDEX: SUGAR LAND PRIMARY SERVICE AREA

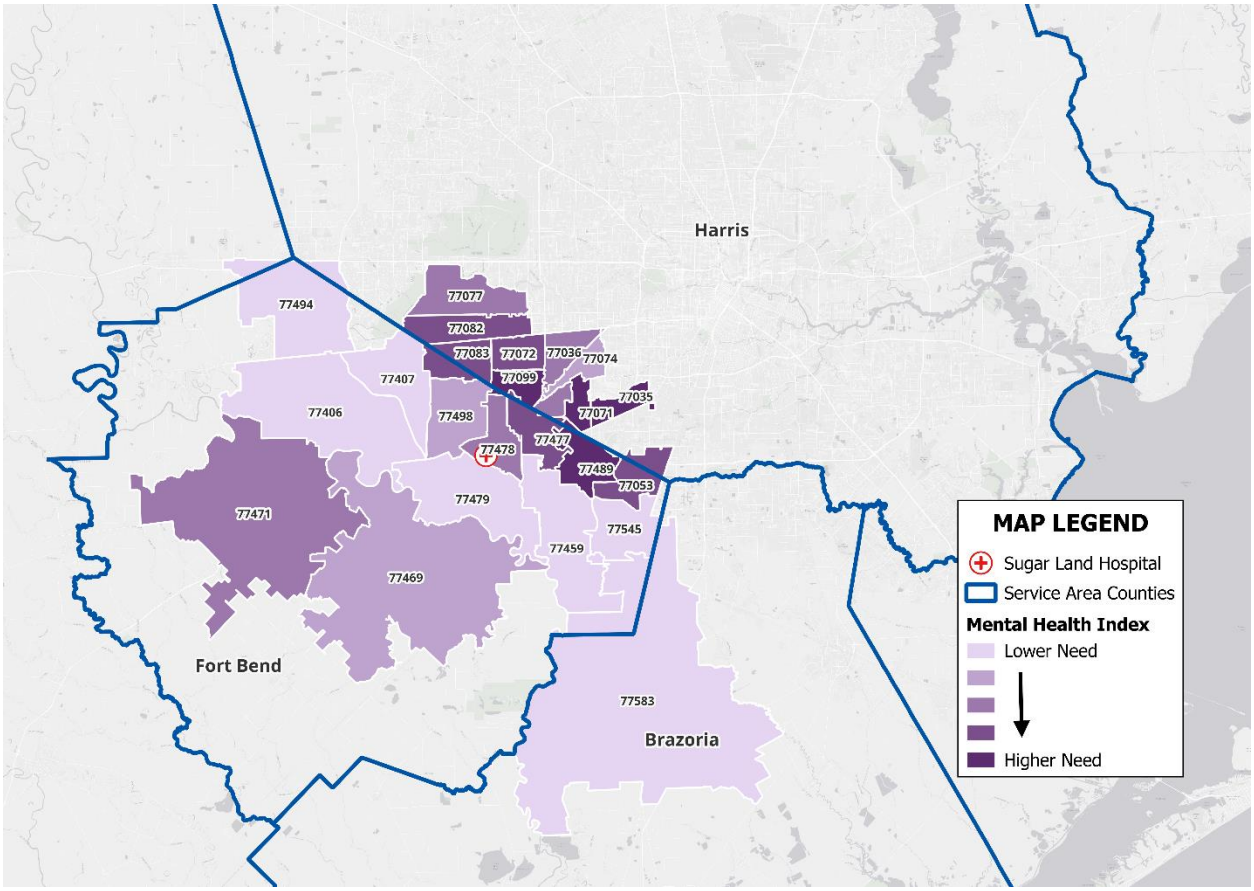


TABLE 13. MENTAL HEALTH INDEX: SUGAR LAND PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77071	91.9	77471	59.0
77035	85.0	77478	52.9
77099	83.8	77074	44.4
77489	83.3	77469	43.1
77082	77.5	77498	40.0
77053	73.4	77406	29.4
77072	73.3	77583	29.4
77083	69.4	77459	29.0
77477	68.5	77479	27.6
77031	62.2	77494	21.5
77077	60.3	77545	18.9
77036	59.3	77407	15.1

Mental health was a consistently prioritized issue in both the Partner Survey and listening sessions. Mental Health remains prevalent throughout all age groups, particularly in light of COVID-19's lingering effects. Participants discussed barriers including stigma, provider shortages, and lack of culturally relevant services.

Older Adults

From the secondary data scoring results, Older Adults ranked 4th in the data scoring of all topic areas with a score of 1.45. 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. Indicators of concern in Fort Bend and Harris counties are listed in Tables 14 and 15 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 14. FORT BEND COUNTY DATA SCORING RESULTS: OLDER ADULTS

Score	Older Adults Indicator	Units	Fort Bend County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.71	People who have Difficulty Speaking English: 65+	percent	20.6		14.0	8.6			
2.41	Adults 65+ without Health Insurance	percent	2.4		1.9	0.8			
2.35	Hyperlipidemia: Medicare Population	percent	69.0		65.0	65.0			--
2.35	Osteoporosis: Medicare Population	percent	12.0		11.0	11.0			--
2.26	Older Adult Homeowners Spending 30% or More of Household Income on Housing Costs	percent	27.8		23.1	25.5			
2.06	Diabetes: Medicare Population	percent	28.0		25.0	24.0			--
2.00	Cancer: Medicare Population	percent	12.0		11.0	12.0			--
1.94	People 65+ Living Below Poverty Level (Count)	people	7731						
1.82	Hypertension: Medicare Population	percent	68.0		66.0	65.0			
1.65	Asthma: Medicare Population	percent	7.0		7.0	7.0			
1.65	People 65+ Living Alone (Count)	people	14309						

Notably, many of the indicators of concern impacting older adults in Fort Bend County are also indicators of concern within other prioritized health topics, including cancer, diabetes, health care access, and heart disease. Each of these health topics are discussed in more detail in other sections of this report, and include a number of health risks that are particularly impactful for older adults.

Isolation and poverty may also have an impact on health risks for older adults in Fort Bend. For example, about one in five adults 65 and older (20.6%) have difficulty speaking English, a rate which is one of the highest among all U.S. counties and has been increasing over time. This language difficulty may limit their ability to seek needed health care. Additionally, 27.8% of older adults in Fort Bend spend 30% or more of their income on housing costs, a rate which is higher than the majority of other U.S. counties. This may indicate a high level of financial hardship among Fort Bend's older adult population, which could limit the population's access to other necessary expenses, such as food, transportation, and medical care.

TABLE 15. HARRIS COUNTY DATA SCORING RESULTS: OLDER ADULTS

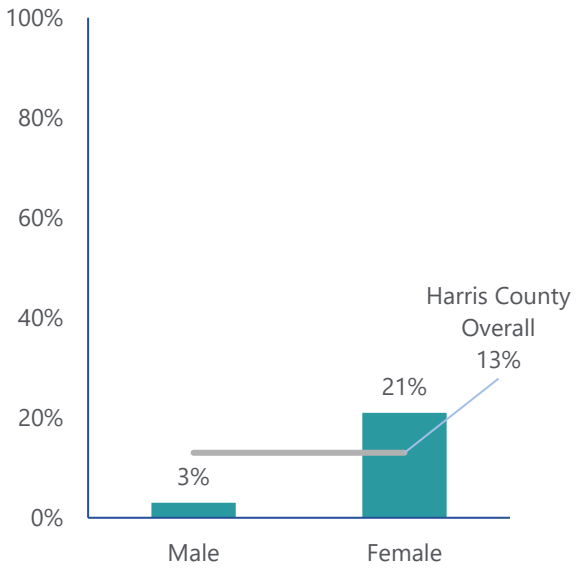
Score	Older Adults Indicator	Units	Harris County	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.42	People 65+ Living Below Poverty Level	percent	12.7	--	11.7	10.4			
2.33	Osteoporosis: Medicare Population	percent	13.0	--	11.0	12.0			--
2.33	Stroke: Medicare Population	percent	7.0	--	6.0	6.0			--
2.08	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*. This 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 X. OSTEOPOROSIS: MEDICARE POPULATION



The elderly population in Sugar Land face challenges in managing multiple chronic conditions, obtaining transportation to appointments, and accessing in-home or long-term support services. Listening sessions highlighted a growing need for care navigation, affordable medication access, and social isolation prevention programs for elderly.

Other Health Needs of Concern

In addition to the prioritized areas, the following health topics emerged as significant, though not ranked among the top-tier priorities. These remain important issues that may warrant collaborative or targeted support.

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 40 illustrates that the zip codes with the highest risk of food insecurity are 77099, 77074, and 77036 with index scores of 95.7, 93.0, and 92.8, respectively.

FIGURE 40. FOOD INSECURITY INDEX: SUGAR LAND PRIMARY SERVICE AREA

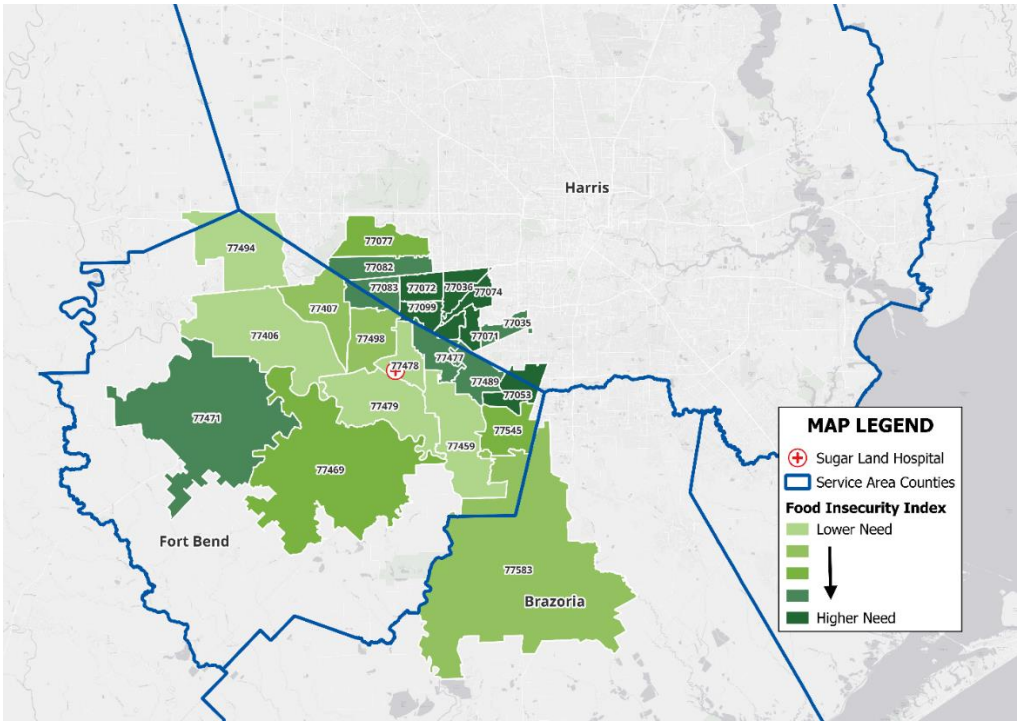


TABLE 16. FOOD INSECURITY INDEX: SUGAR LAND PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77099	95.7	77082	74.4
77074	93.0	77545	61.9
77036	92.8	77469	49.9
77072	91.4	77077	45.9
77053	89.1	77583	30.7
77071	86.3	77498	30.1
77031	85.2	77407	27.2
77471	83.2	77478	12.6
77477	79.7	77459	10.6
77035	79.5	77406	10.2
77083	76.6	77494	7.8
77489	74.9	77479	2.7

Nutrition and food access are underlying drivers of multiple chronic health issues identified in this assessment. Although not prioritized as a standalone category, it is closely linked to diabetes and obesity. Partner organizations cited food insecurity and lack of culturally appropriate nutrition education as persistent problems, particularly in high-need zip codes identified in the Food Insecurity Index.

Physical Activity

From the secondary data scoring results, Physical Activity ranked 1st in the data scoring of all topic areas, with a score of 1.88. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Fort Bend County:

- *Workers who Walk to Work* (0.6%)
- *Adults 20+ who are Sedentary* (18.5%)
- *Adults 20+ who are Obese* (25.7%)

Stakeholders emphasized the lack of safe parks in low-income neighborhoods, and the need for more inclusive wellness programs. In the partner survey, several respondents connected the lack of safe outdoor space to disparities in chronic disease outcomes.

Barriers to Care

Despite progress made since the last CHNA, residents of the Sugar Land Hospital service area continue to face numerous barriers to accessing timely, high-quality healthcare. These barriers are both structural and social in nature, and disproportionately impact vulnerable populations including the uninsured, elderly, individuals with limited English proficiency, and those with low incomes. These barriers, as identified through both qualitative and quantitative sources including listening sessions, partner survey, and secondary data, underscore the importance of continuing to advance access, community health and system-level collaboration in the region.

Insurance Coverage & Cost

Many community members remain uninsured or underinsured, with affordability cited as a primary concern. Even insured patients report challenges in meeting deductibles or navigating complex billing systems.

Transportation Limitations

Individuals with limited mobility or without personal vehicles often face difficulty accessing routine care. Despite recent partnerships like Fort Bend Transit, gaps persist in non-emergency medical transportation, especially for seniors and rural residents.

Language and Health Literacy

A significant portion of the population speaks a language other than English at home, creating communication barriers in clinical settings. Community stakeholders reported that patients often lack awareness of available services or struggle to navigate the healthcare system, particularly for specialty or preventive care.

Mental Health Stigma and Shortages

Despite increased awareness, stigma surrounding mental health care persists. Shortages in culturally competent mental health providers were noted in both survey data and listening sessions.

Workforce Capacity & Awareness Gaps

Local organizations identified healthcare workforce shortages and lack of coordination between community partners as ongoing barriers to seamless care delivery. Participants emphasized the need for better service integration and public education campaigns.

Conclusion

The 2025 Community Health Needs Assessment for Sugar Land Hospital reflects a comprehensive effort to identify, prioritize, and address the most pressing health challenges facing the community. Through robust engagement with local partners, residents, and data-driven analysis, the CHNA has surfaced six priority health needs: Cancer, Diabetes, Health Care Access & Quality, Heart Disease & Stroke, Mental Health, and Older Adults.

These priorities align with significant disparities and trends across the hospital's 24-zip code service area. The community is marked by economic diversity, linguistic and cultural complexity, and population growth all of which contribute to unique health challenges. Although many strengths exist, including high levels of education and strong nonprofit engagement, persistent gaps remain in equitable access to care, particularly for uninsured individuals, individuals of color, and those living in high-need zip codes.

Over the past three years, Sugar Land Hospital has demonstrated a deep commitment to improving health outcomes and collaborating with community partners. These efforts have resulted in increased access to screenings, improved support for maternal and child health, enhanced community health initiatives, and continued investment in workforce and community development.

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.