2025 Community Health Needs Assessment

Report adopted by Hospital Advisory Board May 2025

St. Luke's Health™

A member of CommonSpirit

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Community Health Needs Assessment – At a Glance

St. Luke's Health – The Woodlands Hospital/Springwoods Village

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 that St. Luke's Health - The Woodlands-Springwoods. 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, requiring not-for-profit hospitals to conduct a CHNA 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

St. Luke's Health - The Woodlands-Springwoods 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–The Woodlands Hospital includes a broad and growing population centered in northern Greater Houston and surrounding suburban areas. This defined service area encompasses 27 zip codes, selected based on inpatient discharge data and representing the majority of hospital admissions. These geographic boundaries ensure that the Community Health Needs Assessment (CHNA) captures the health needs and utilization patterns of the population most impacted by and reliant on the hospital's services.

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, St. Luke's Health-The Woodlands-Springwoods 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 St. Luke's Health -The Woodlands 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, 17400 St Lukes Way, The Woodlands, TX 77384 or by e-mail to fawn.preuss@commonspirit.org.

Looking Back: Evaluation of Progress since prior CHNA

Over the past three years, St. Luke's Health–The Woodlands Hospital has made significant progress in addressing the community health needs identified in the 2022 Implementation Strategy. The hospital system implemented initiatives focused on access to care, preventive health, behavioral health, community engagement, and workforce development, with a focus on health equity and vulnerable populations.

Access to Care Initiatives

- Provided Medicaid counseling and enrollment assistance to 3,207 individuals.
- Delivered charity care and financial assistance for uninsured and underinsured patients.
- Strengthened community partnerships to improve equity and care access.
- Funded transportation for 1,032 individuals through Modivcare rides.
- Awarded $75,000 to Interfaith Community Clinic to expand access, address SDOH, and extend clinic hours.

Preventive Health & Community Outreach

- Hosted The Woodlands Health Expo with 300+ attendees receiving BP checks and stroke education.
- Delivered monthly colonoscopy education sessions to promote early detection of colorectal cancer.
- Held flu shot and preventive care clinics for at-risk populations.
- Reached 30,000 attendees at the LPGA Golf Tournament with education on stroke and cancer.
- Promoted women's health at events like Diva Night.
- Partnered with AHA to provide free CPR training to 200 people.

Mental Health Initiatives

- Participated in the Montgomery County Community Crisis Collaborative and Sequential Intercept Model workshops.
- Expanded mental health screening and referrals, particularly for depression and serious mental illness.

Community Contributions & Events

- Supported Hands of Justice's "Fashion for Freedom" to raise awareness of human trafficking.
- Provided EMS medical standby services at the Big as Texas Music Festival to ensure community safety.

- Collaborated with Tri-County Clinic and Lone Star Family Health Center to improve behavioral health access.
- Awarded $50,000 to Catholic Charities for expanding behavioral health services for the uninsured.

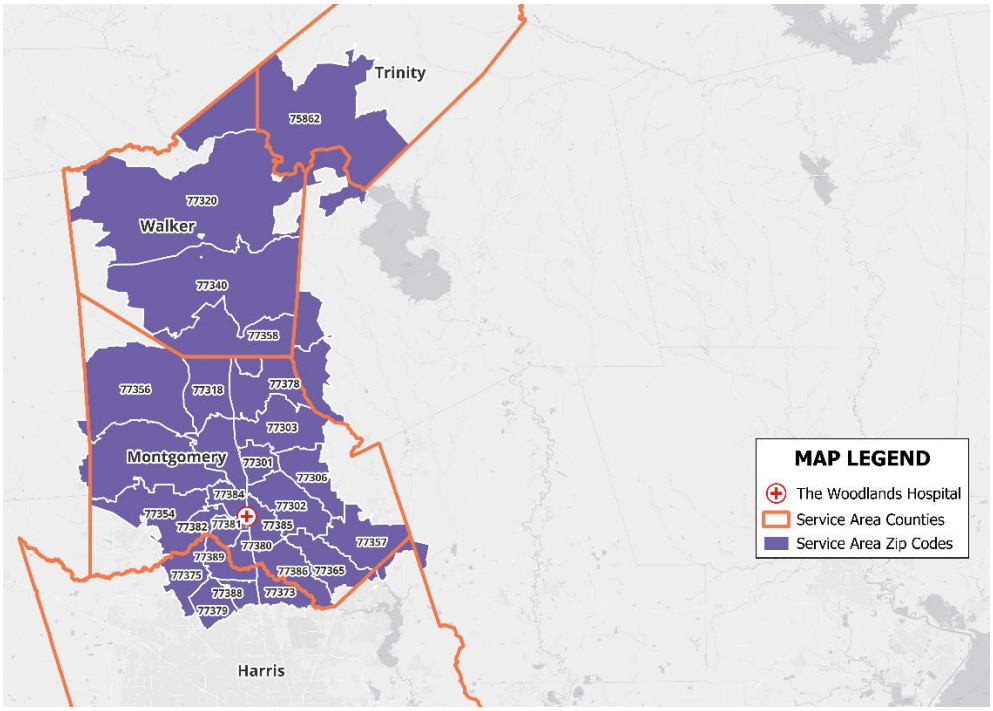
Health Professions Education

- Invested $79,572 in health professions education and training programs.
- Hosted clinical rotations for nursing, medical, EMT, and allied health students.

Defining the Community

The Woodlands Hospital serves a community that is racially, ethnically, and economically diverse, with a total population of over 1 million residents. The population is predominantly White (57%) but includes significant Black/African American (10.8%), Asian (4.9%), and Hispanic/Latino (29%) communities. This diversity contributes to a complex landscape of health disparities, particularly in areas related to income, education, and access to care. A detailed map of The Woodlands Hospital service area is provided below and in Figure 1, and demographic data, including population size, poverty rates, race/ethnicity, and insurance coverage, are outlined in the Core Demographics section.

FIGURE 1. THE WOODLANDS SERVICE AREA



Demographic Profile

Geography and Data sources

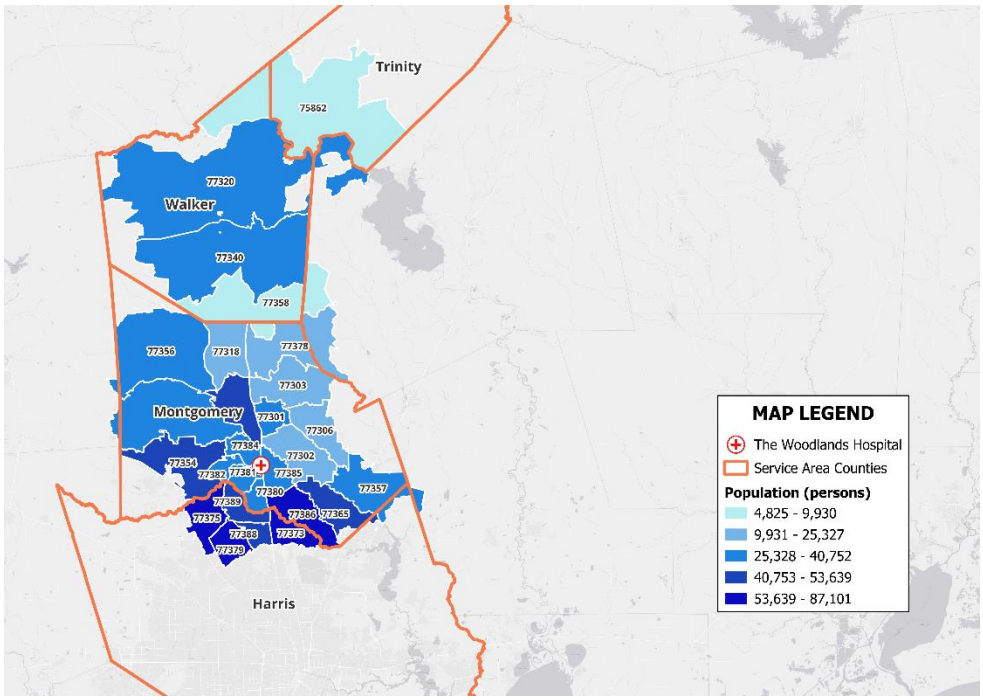
The following section explores the demographic profile of the BSLMC primary service area, which includes 27 zip codes in Harris, Montgomery, Walker, and Trinity Counties. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic groups may have 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 Woodlands primary service area has an estimated population of 1,056,317 persons. Figure 2 shows the population breakdown for the service area by zip code.

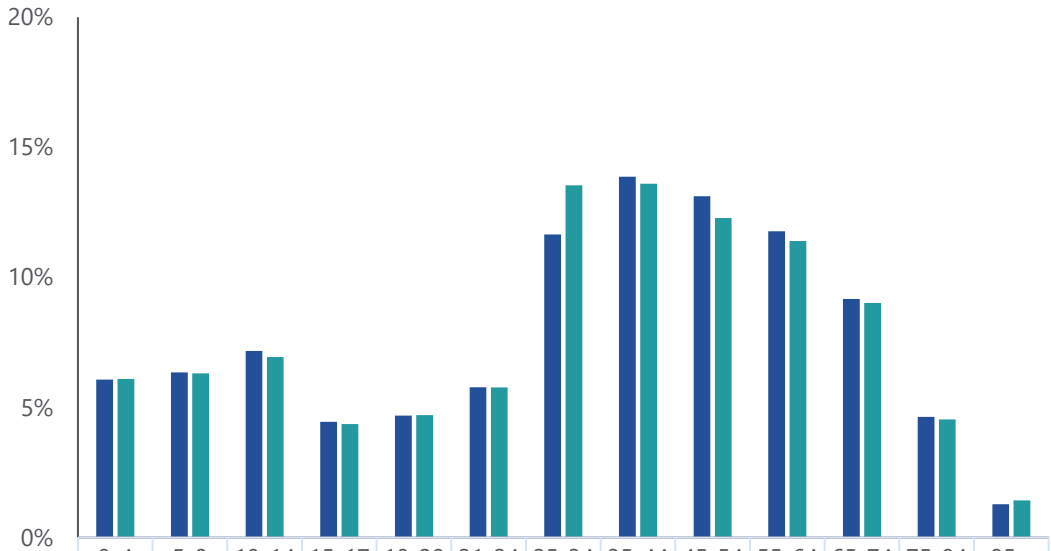
FIGURE 2. POPULATION DISTRIBUTION: THE WOODLANDS-SPRINGWOODS HOSPITAL PRIMARY SERVICE AREA



Age

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

FIGURE 3. POPULATION BY AGE: THE WOODLANDS-SPRINGWOODS HOSPITAL SERVICE AREA

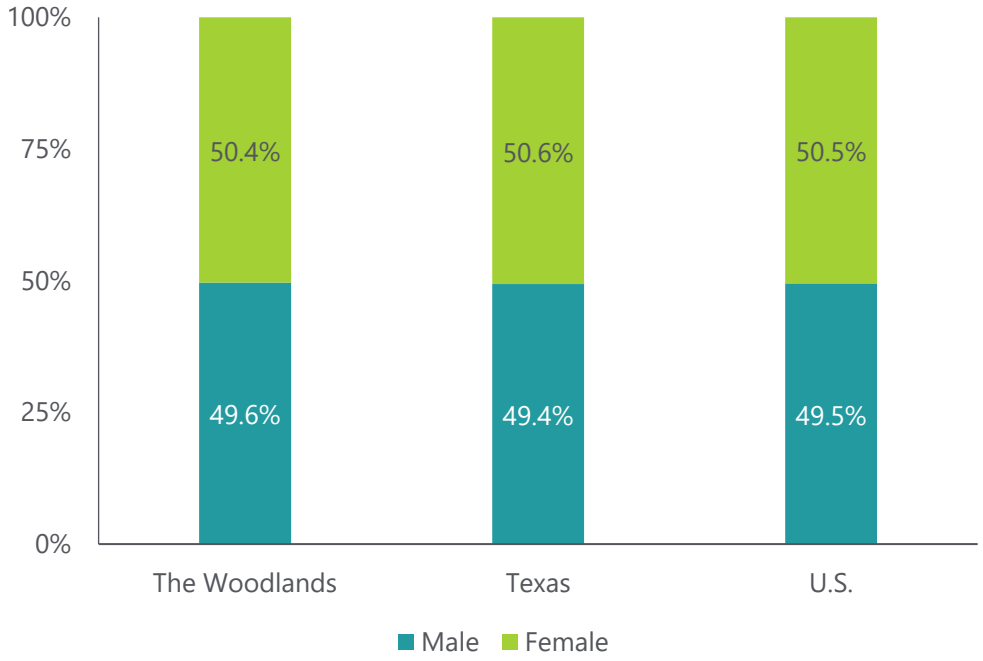


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
The Woodlands	6.1%	6.4%	7.2%	4.5%	4.7%	5.8%	11.7%	13.9%	13.1%	11.8%	9.2%	4.6%	1.3%
Texas	6.1%	6.3%	6.9%	4.4%	4.7%	5.8%	13.5%	13.6%	12.3%	11.4%	9.0%	4.5%	1.4%

Sex

As seen in Figure 4, 50.4% of the Woodlands population is female, which is similar to both state and national populations (50.6% and 50.5%, respectively).

FIGURE 4. POPULATION BY SEX: COUNTY, STATE, AND U.S. COMPARISONS



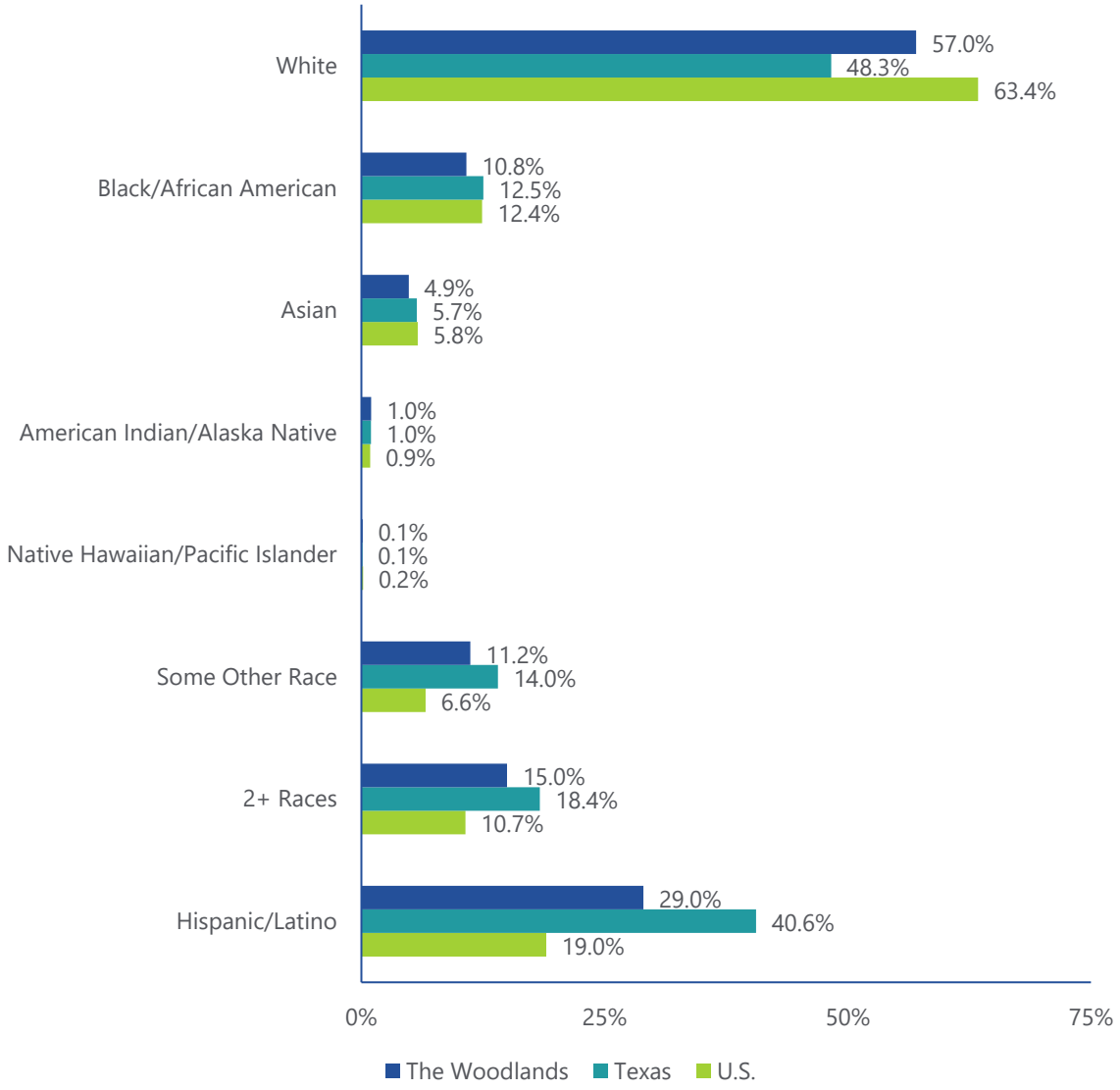
U.S. value taken from American Community Survey (2019-2023)

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 Woodlands primary service area has a racially and ethnically diverse population. The Woodlands primary service area has a higher percentage of White residents than the Texas population, and a lower percentage of nearly all other racial/ethnic groups.

FIGURE 5. POPULATION BY RACE AND ETHNICITY



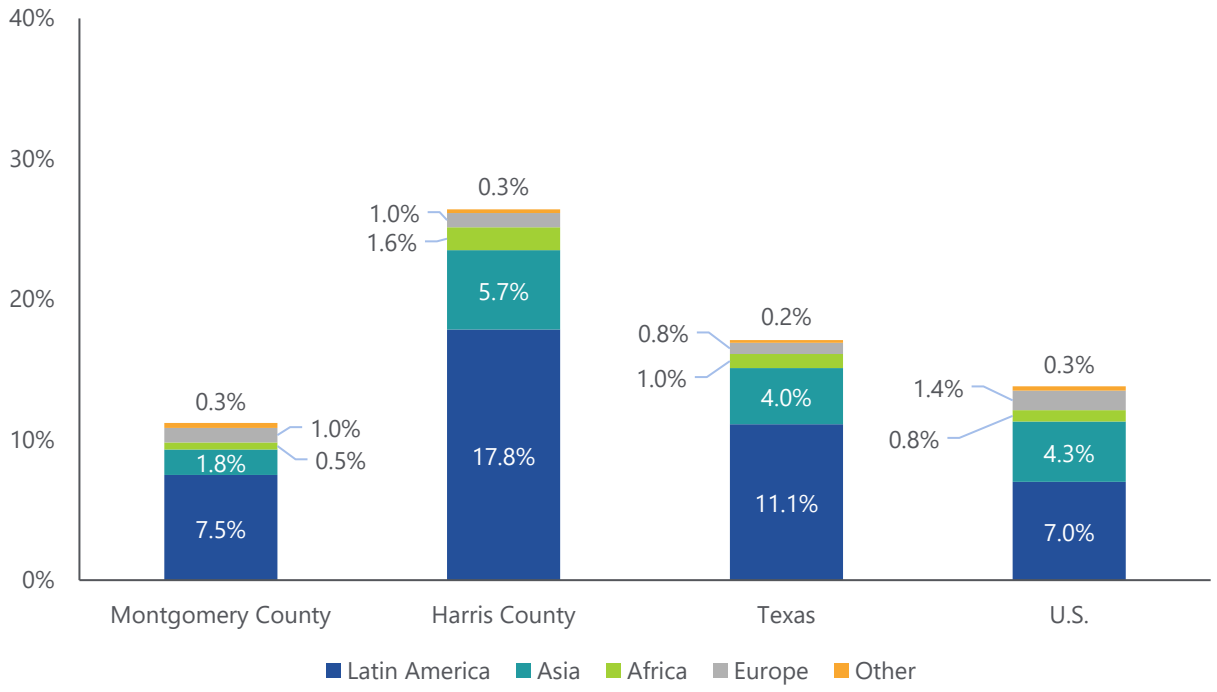
U.S. value taken from American Community Survey (2019-2023)

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 are born outside the U.S., which is higher than the state value (17.2%) and national value (13.9%). Conversely, 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 both Texas and the U.S. overall, Harris County has a larger percentage of residents born in Latin America (17.8%). Additionally, 1 in 20 Harris County residents were born in Asia (5.7%), which is also higher than both the Texas and U.S. populations overall.

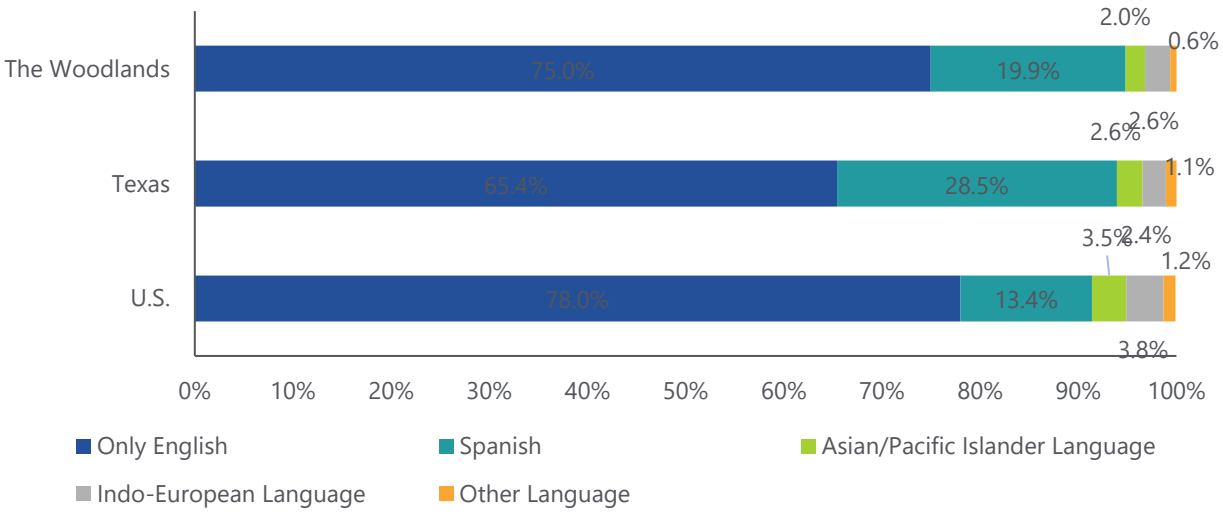
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY



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

As shown in Figure 7, a quarter of the residents in the Woodlands primary service area (25.0%) speak a language other than English at home. The Woodlands population is less likely than the state-wide Texas population to speak Spanish (19.9% vs. 28.5%).

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

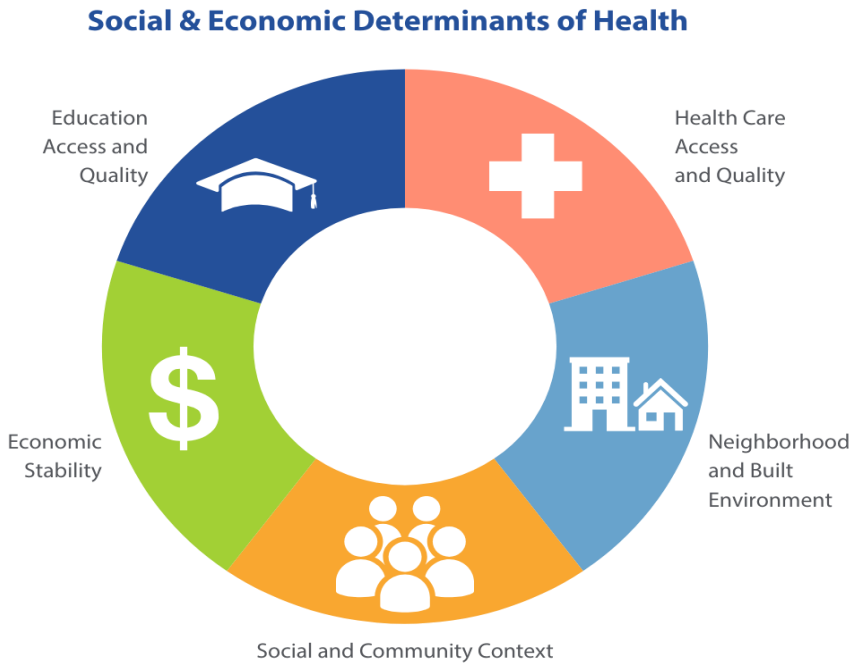


U.S. value taken from American Community Survey (2019-2023)

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting The Woodlands 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).

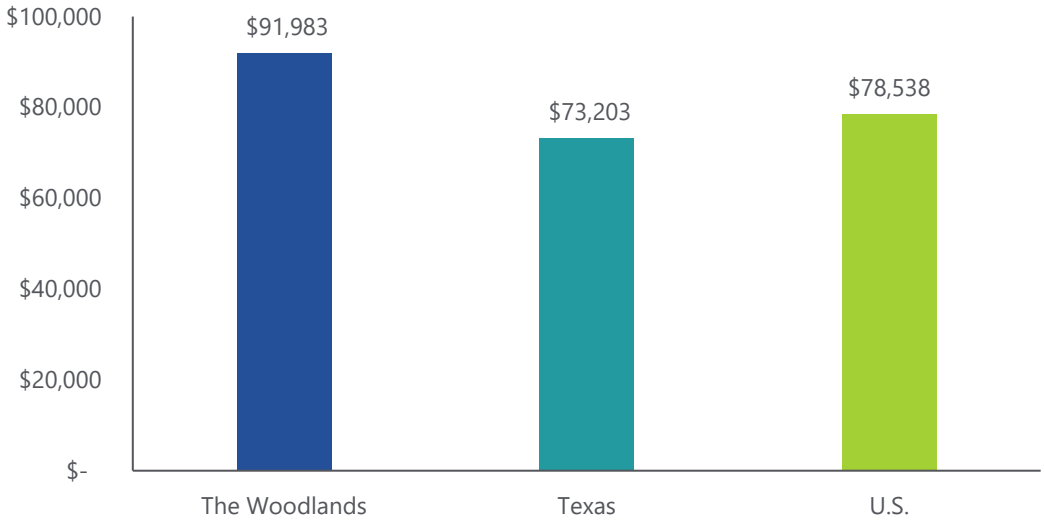
FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH



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.

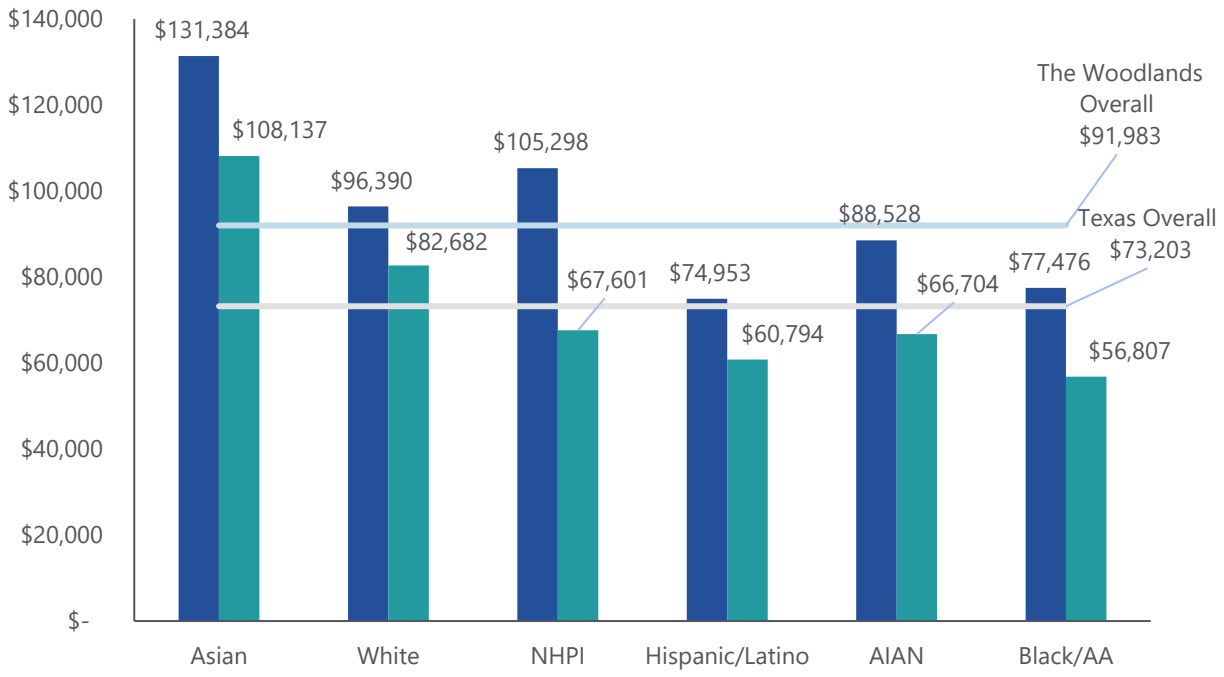
FIGURE 9. MEDIAN HOUSEHOLD INCOME BY: COUNTY, STATE AND U.S. COMPARISONS



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, American Indian/Alaska Native, and Hispanic/Latino communities of the Woodlands 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 $17,000 lower than the overall median income ($74,953 vs. $91,983). 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



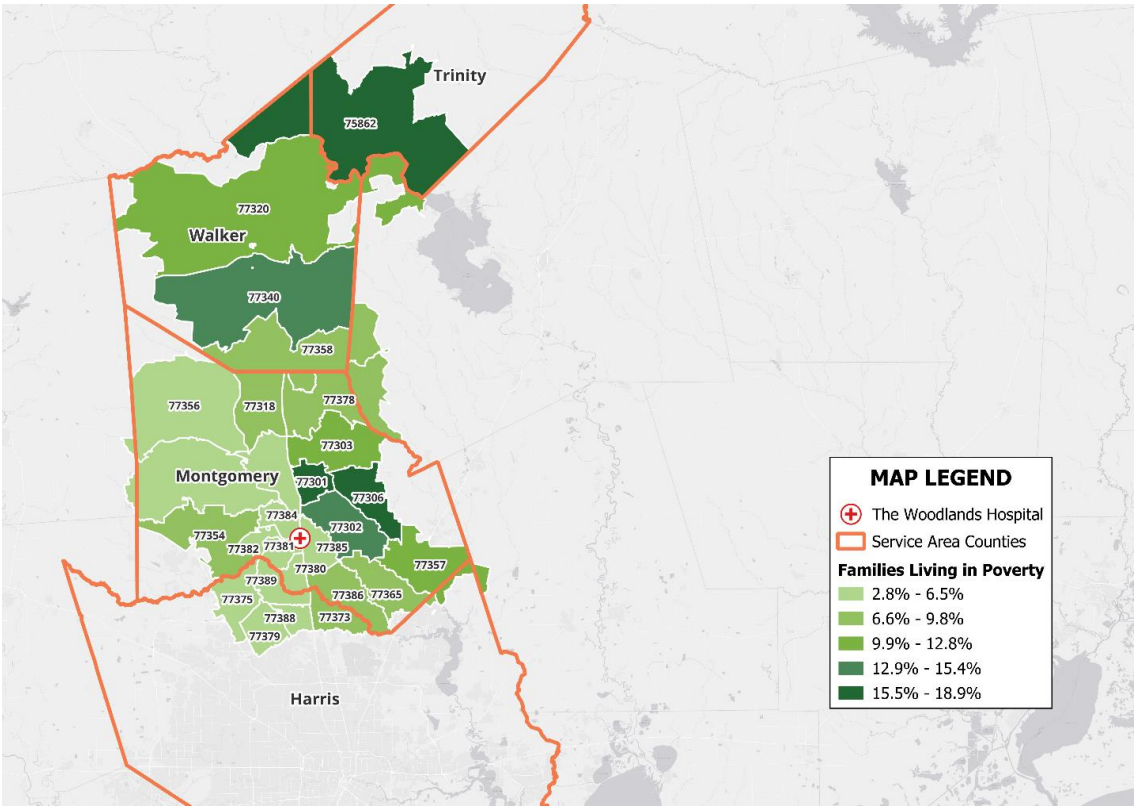
Poverty

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, 7.9% of families in the Woodlands 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 two zip codes in the service area with the highest concentration of poverty are 77306 (18.9%) and 77301 (17.0%).

TABLE 1. FAMILIES LIVING IN POVERTY: THE WOODLANDS-SPRINGWOODS HOSPITAL PRIMARY SERVICE AREA

Zip Code	% Families in Poverty	Zip Code	% Families in Poverty
77306	18.9%	77354	7.7%
77301	17.0%	77385	6.5%
75862	16.9%	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%
77357	11.6%	77304	4.9%
77358	9.8%	77375	4.8%
77386	9.4%	77316	4.7%
77373	9.3%	77356	4.5%
77365	8.4%	77381	4.4%
77378	8.1%	77384	2.8%
77318	7.9%		

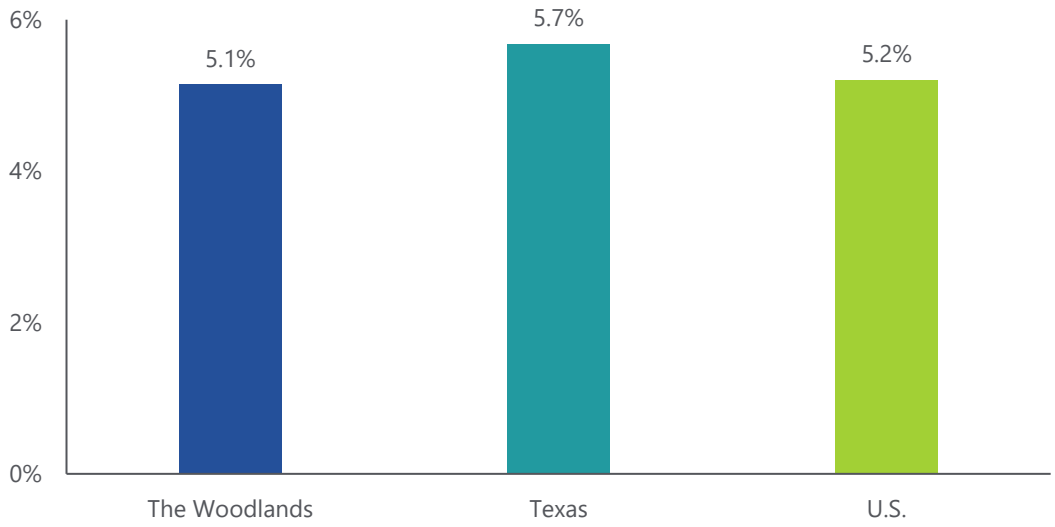
Employment

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 Woodlands primary service area is 5.1%, which is lower 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)

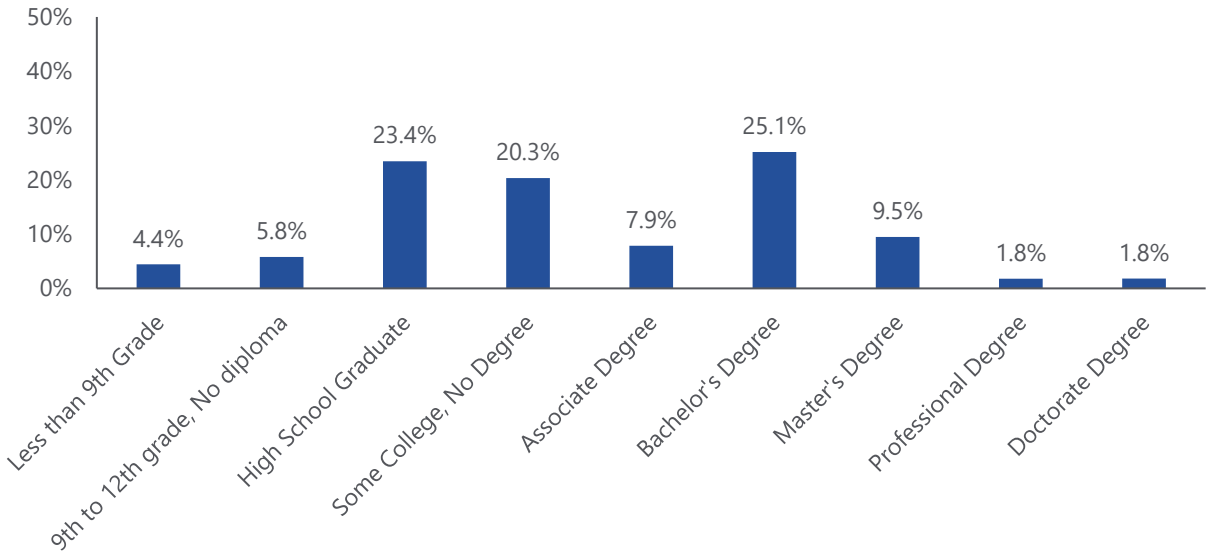
[2] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment

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 Woodlands primary service area by educational attainment, among those aged 25 and up. As shown in Figure 14, most of the Woodlands population has a high school diploma or higher (89.8%), which is similar to the U.S. rate (89.4%) and higher than the Texas rate (85.1%).

FIGURE 13. THE WOODLANDS-SPRINGWOODS HOSPITAL PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+

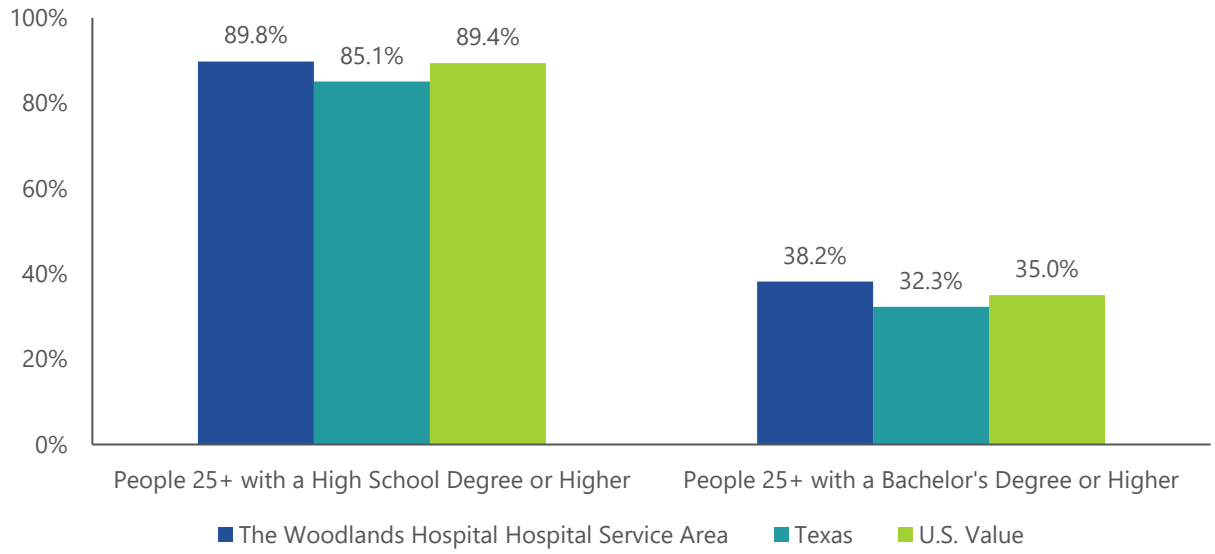


U.S. value taken from American Community Survey (2019-2023)

[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)

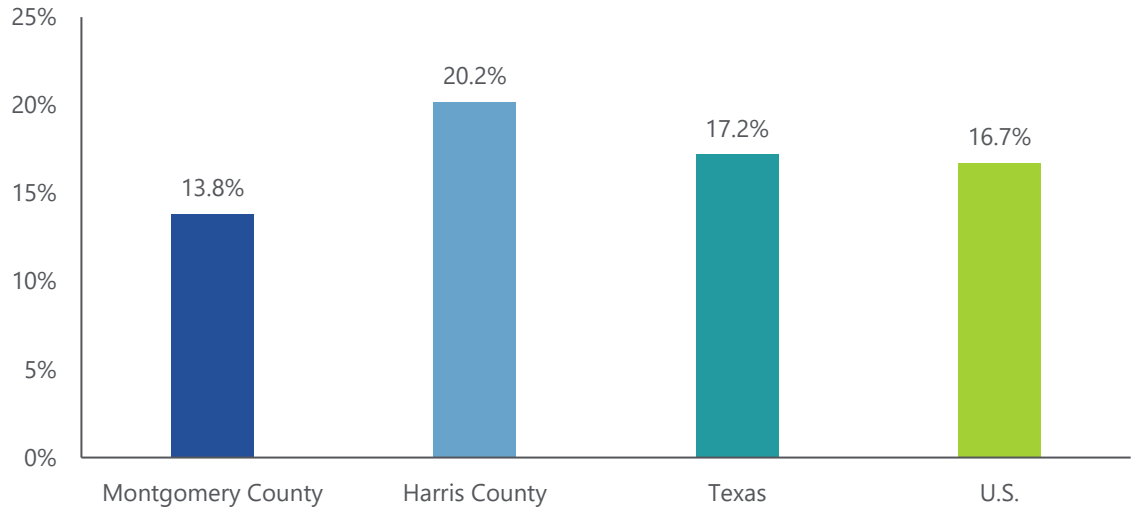
Housing

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 and 1 in 5 households in Harris County (20.2%) have severe housing problems, indicating that they have at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Harris County has higher rates of households with severe housing problems 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.

[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

FIGURE 15. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



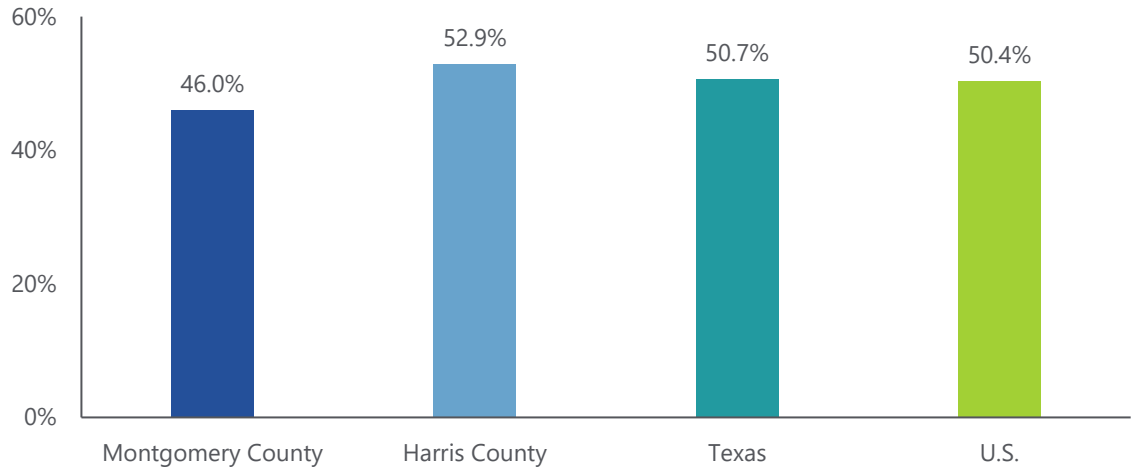
County, State, and U.S. values taken from County Health Rankings (2016-2020)

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]

Figure 16 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Harris County (52.9%) is higher than both the state value (50.7%) and the national value (50.4%), while the value in Montgomery County (46.0%) is lower.

[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. 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)

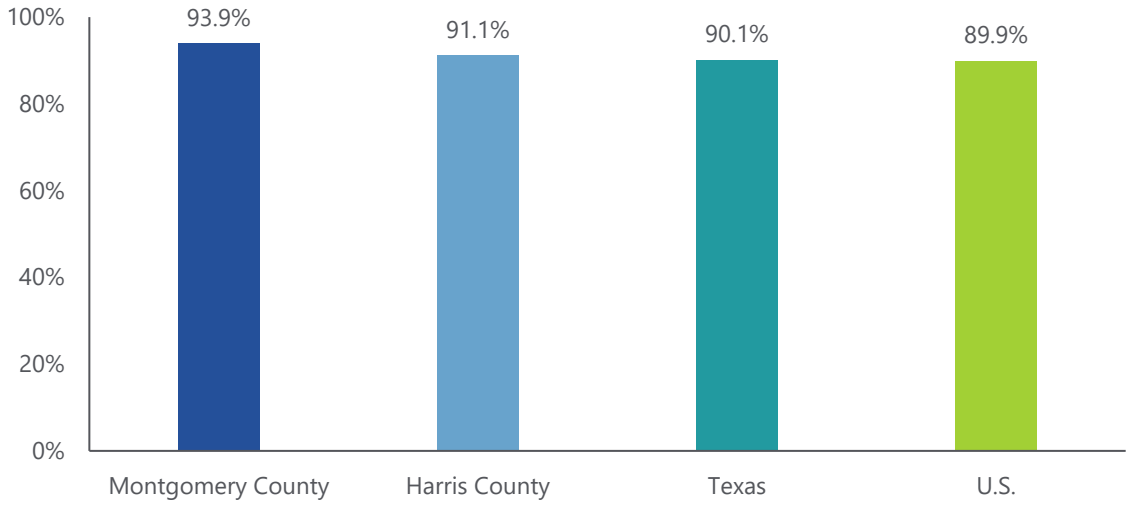
Neighborhood and Built Environment

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 Harris County (91.1%) and Montgomery County (93.9%) are slightly higher than both the state value (90.1%) and the national value (89.9%).

[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

FIGURE 17. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION



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

Primary and Secondary Data Methodology and Key Findings

St. Luke's Health-The Woodlands 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

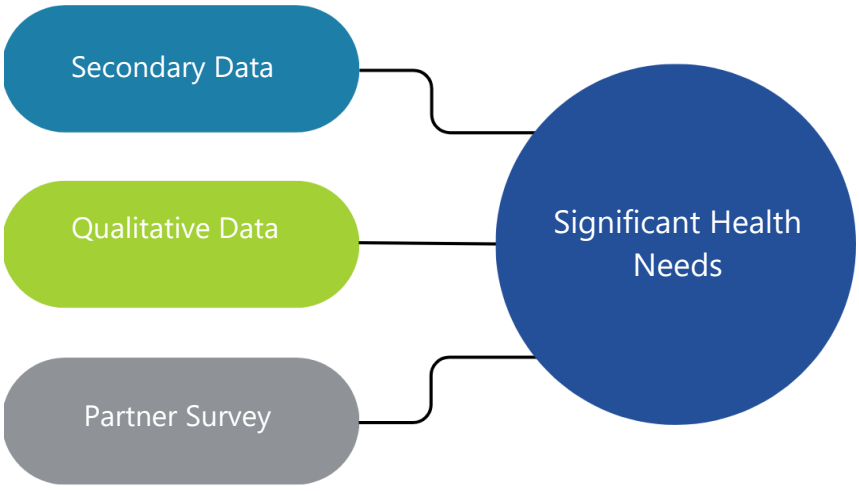
Primary data were collected through community engagement activities designed to elevate voices from across the hospital's defined service area. These activities included:

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:

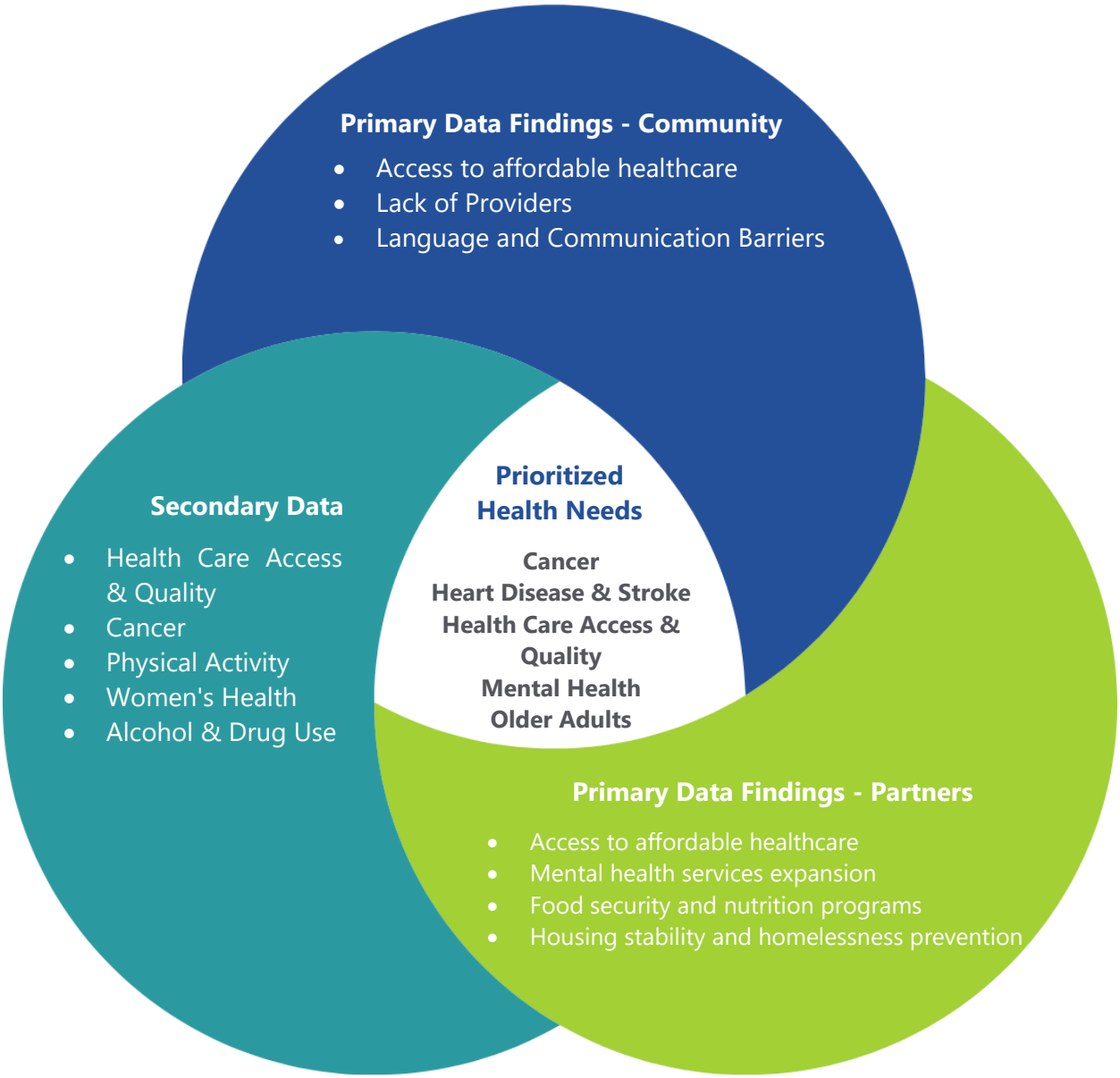
- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

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 ongoing effects of COVID-19 and natural disasters. A detailed summary of participating organizations, and input themes is available in Appendix [X].



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 St. Luke's Health-The Woodlands-Springwoods 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.

Identifying the frequency of discussion in Qualitative Sessions: These criteria involve analyzing how often a health issue is discussed 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 are aligned with the community's priorities and concerns.

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

Cancer

From the secondary data scoring results, Cancer ranked 4th in the data scoring of all topic areas with a score of 1.49. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 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. In Montgomery County, the rate for *Cancer: Medicare Population* is 12.0%, which is slightly higher than the Texas rate (11.0%). Additionally, the Medicare population is less likely than the state and national Medicare populations to get mammography screening (41.0% vs. 42.0% and 47.0% 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.

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 are concerning in Harris County. Harris County's male population is more likely than the overall Texas male population to develop prostate cancer (111.9 vs. 108.3 cases per 100,000), and Harris County's female population is more likely to develop cervical cancer (9.8 cases per 100,000) 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 cancer 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 actually received this screening in Harris County, which is one of the worst 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, Black women are 50% more likely than the overall county population to die due to breast cancer (30.6 vs. 20.4 deaths per 100,000), and Black men are nearly twice as likely to die due to prostate cancer (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), and the same is true for White women (132.0 vs. 117.1). We also found that Hispanic and Latina women were more likely to develop cervical cancer than the overall county population (12.8 vs. 9.8 cases per 100,000).

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

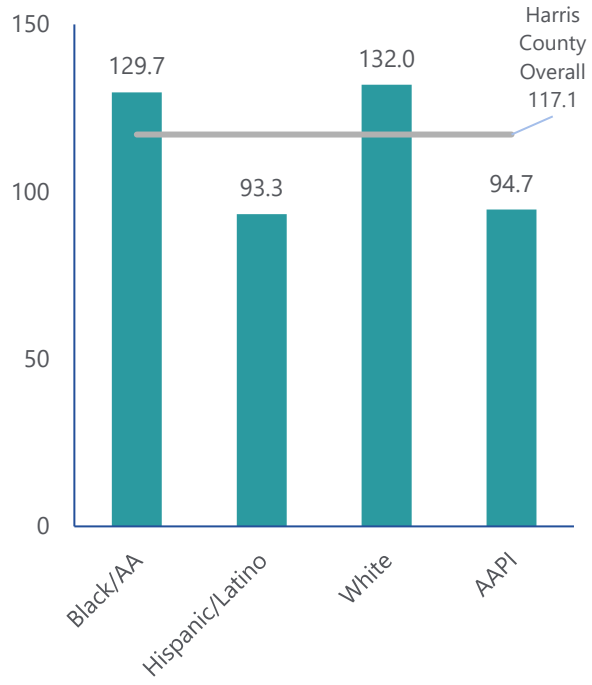


FIGURE 19. CERVICAL CANCER INCIDENCE, BY RACE/ETHNICITY (CASES PER 100,000 FEMALES)

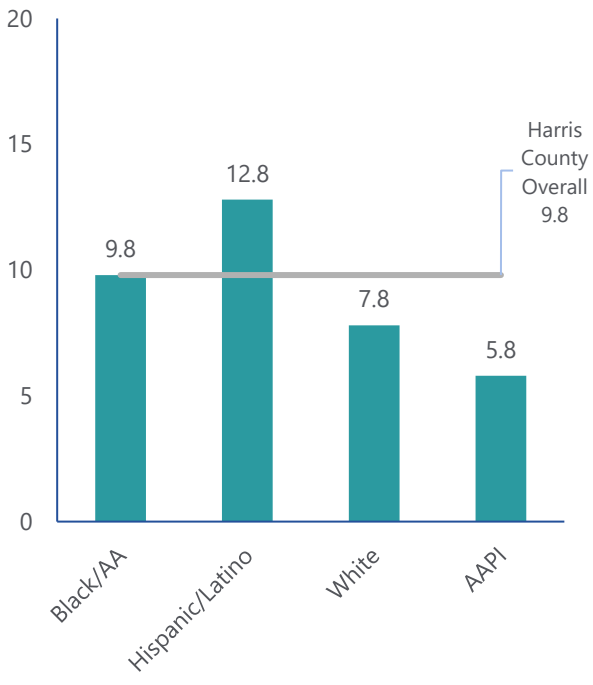


FIGURE 20. AGE-ADJUSTED DEATH RATE DUE TO BREAST CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000 FEMALES)

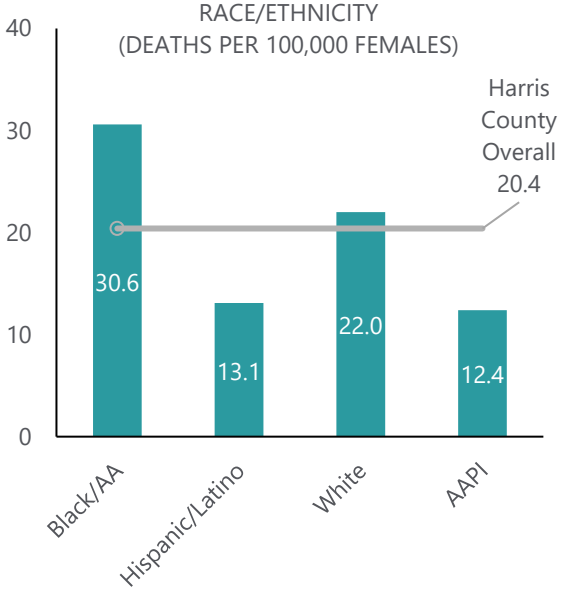
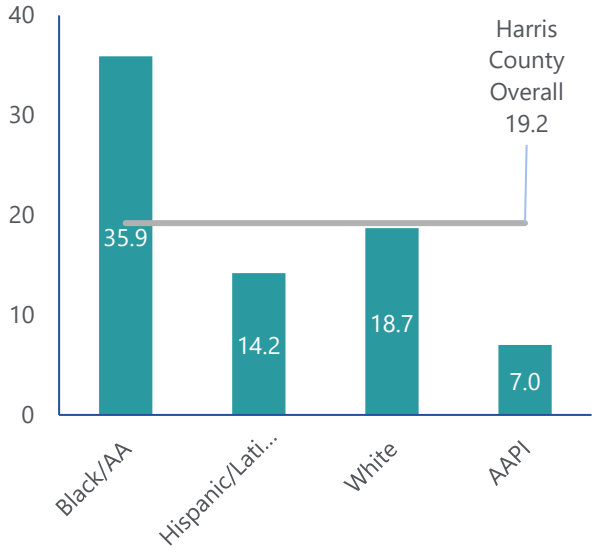


FIGURE 21. AGE-ADJUSTED DEATH RATE DUE TO PROSTATE CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000 MALES)



Survey respondents identified cancer as a persistent concern due to late detection and lack of access to screenings for uninsured populations. In focus groups, several participants mentioned that financial insecurity often delays preventative care, with one participant stating, **"People don't go [to the doctor] until something is very wrong — by then, it's too late."** Despite the availability of oncology services, disparities in access in particular among Latino and African American communities remain a concern.

Health Care Access & Quality

From the secondary data scoring results, Health Care Access & Quality ranked 12th in the data scoring of all topic areas with a score of 1.50. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 4 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 4. MONTGOMERY COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS & 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	Adults with Health Insurance	percent	81.5		77.6	88.7			
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 uninsured population. 16.4% of adults do not have health insurance, which is 6% lower than the national rate. Additionally, 9% of children in Montgomery County do not have health insurance, which is more than the state (10.9%), but higher than the nation (5.1%).

Other concerning indicators regard routine care. Only 73.1% of adults have had a routine checkup, and only 55.8% visited a dentist. A lower rate of primary care providers than both state-wide and nation-wide rates (85.6 providers / 100,000 vs. 109.0 and 131.4, respectively) could contribute to routine check ups and preventable hospital stays.

Adult's lack of access to routine and preventative care may contribute to burdens on hospital systems. Medicare recipients of Montgomery County have a higher rate of preventable hospital stays than the state-wide or nation-wide rates (3,327 discharges / 100,000 Medicare enrollees vs. 2,980 and 2,677, respectively).

TABLE 5. 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
2.08	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. Only 71.7% of adults have had a routine checkup, and only half (50.1%) visited a dentist, which are some of the worst county rates across all U.S. counties. Two factors that may contribute are cost and availability. Harris County has one of the lowest rates of children with health insurance (85.5%) and adults with health insurance (73.8%) across all U.S. counties. Further, Harris County has a lower rate of primary care providers than both state-wide and nation-wide rates (58.2 providers / 100,000 vs. 60.3 and 74.9, respectively).

Finally, adults' lack of access to routine and preventative care may contribute to burdens on hospital systems. Medicare recipients of Harris County have a higher rate of preventable hospital stays than the state-wide or nation-wide rates (3,025 discharges / 100,000 Medicare enrollees vs. 2,991 and 2,769, respectively).

Access to affordable, high-quality healthcare emerged as the top priority for The Woodlands Hospital's service area. Survey responses and qualitative feedback echoed the urgent need for more accessible services, particularly for uninsured and underinsured residents, the most frequently served population among partner organizations.

Participants in listening sessions emphasized how complexity in navigating services, cost barriers, and long wait times hinder access. A community listening session participant noted, **"It's not just about whether the services exist. It's whether people can get to them, understand them, and afford them"** Transportation issues and limited clinic hours were also identified as structural barriers, particularly affecting working families and older individuals.

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 6 provides the index values and local ranking for each zip code. The map in Figure 22 illustrates that the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue) are zip codes 75862 and 77306, with index values of 92.3 and 88.3, respectively.

FIGURE 22. COMMUNITY HEALTH INDEX: THE WOODLANDS PRIMARY SERVICE AREA

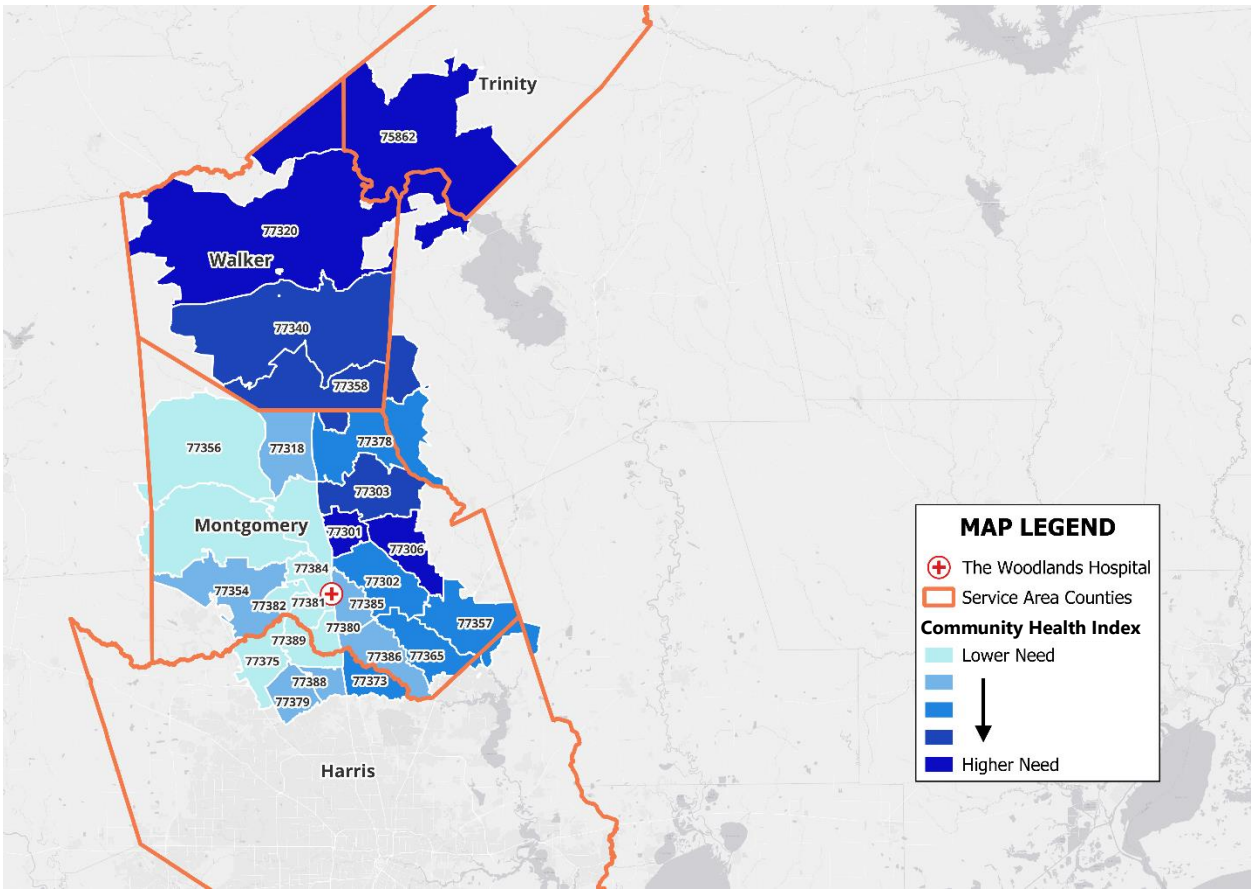


TABLE 6. COMMUNITY HEALTH INDEX: THE WOODLANDS PRIMARY SERVICE AREA

Zip Code	Value		Zip Code	Value
75862	92.3		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
77358	67.8		77356	13.2
77303	66.9		77316	12.3
77302	52.0		77375	12.2
77365	52.0		77304	11.2
77378	50.5		77380	8.4
77373	47.1		77389	5.7
77357	42.5		77381	4.7
77388	33.3		77382	4.2
77318	30.4			

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 7 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 7. 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 worst 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.

TABLE 8. 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 age-adjusted death rate due to 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 well above 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 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 due to coronary heart disease (see Figure 23). For example, the rate of deaths due to heart disease per 100,000 is 86.6 among the overall county population, compared to 111.0 among the county's Black/African American population.

FIGURE 23. AGE-ADJUSTED DEATH RATE DUE TO CORONARY HEART DISEASE, BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)

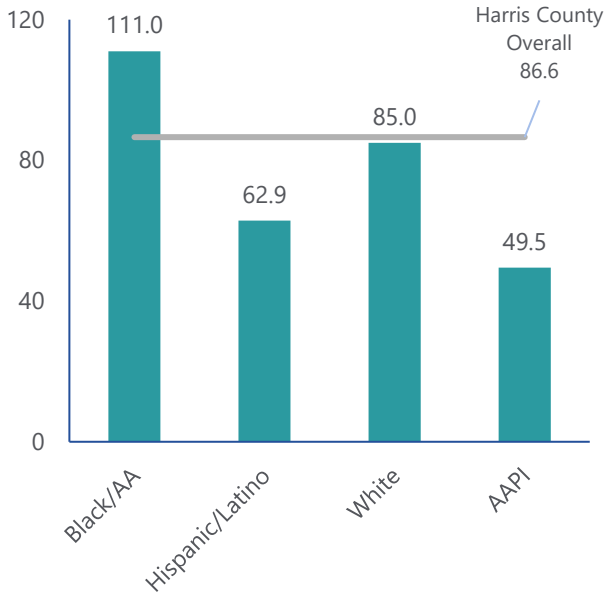
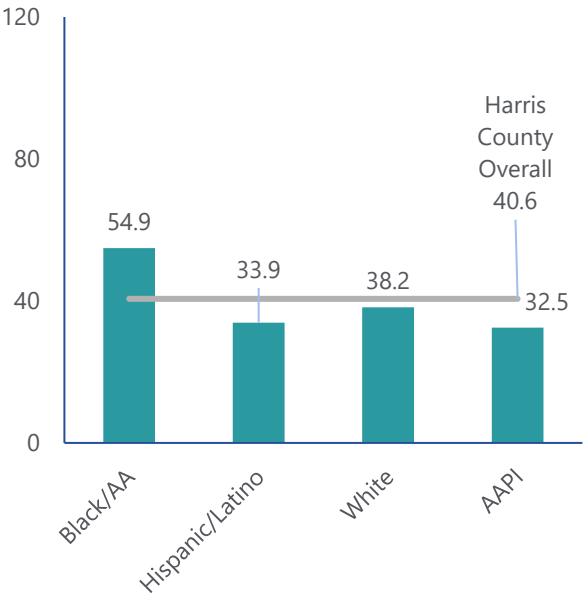


FIGURE 24. AGE-ADJUSTED DEATH RATE DUE TO CEREBROVASCULAR DISEASE (STROKE), BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)



Heart disease and stroke received a high secondary data score, indicating a significant burden in the service area. Community Voice participants linked the challenge to low health literacy, poor nutrition, and chronic disease management gaps. Many community-based organizations noted the difficulties in sustaining long-term care plans due to limited follow-up and socioeconomic limitations.

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 9 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 9. MONTGOMERY COUNTY DATA SCORING RESULTS: MENTAL HEALTH & 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 poor mental health days 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.

TABLE 10. 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, of the past 30 days, Harris County residents report an average of 5.2 days 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 at least 2 weeks of poor mental health in the past 30 days, compared to 15.8% across the country.

The prevalence of Alzheimer's Disease and Dementia is also higher in Harris County, compared to the U.S. overall (7% vs. 6%).

Mental health and mental disorders were highlighted as the #1 concern by survey respondents and listening session participants. Community members described high levels of stress, anxiety, and depression, exacerbated by social isolation, poverty, and limited access to behavioral health services.

One participant shared, **"There's still a stigma. People are struggling silently because they don't know where to go or don't trust they'll be helped."** Additionally, organizations reported long waitlists and staffing shortages, limiting capacity to meet demand.

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 11 provides the index values and local ranking for each zip code. The map in Figure 25 illustrates that the zip codes with the highest risk for poor mental health (as indicated by the darkest shade of purple) are zip codes 75862 (MHI = 95.7), 77358 (75.8), and 77320 (75.7).

FIGURE 25. MENTAL HEALTH INDEX: THE WOODLANDS PRIMARY SERVICE AREA

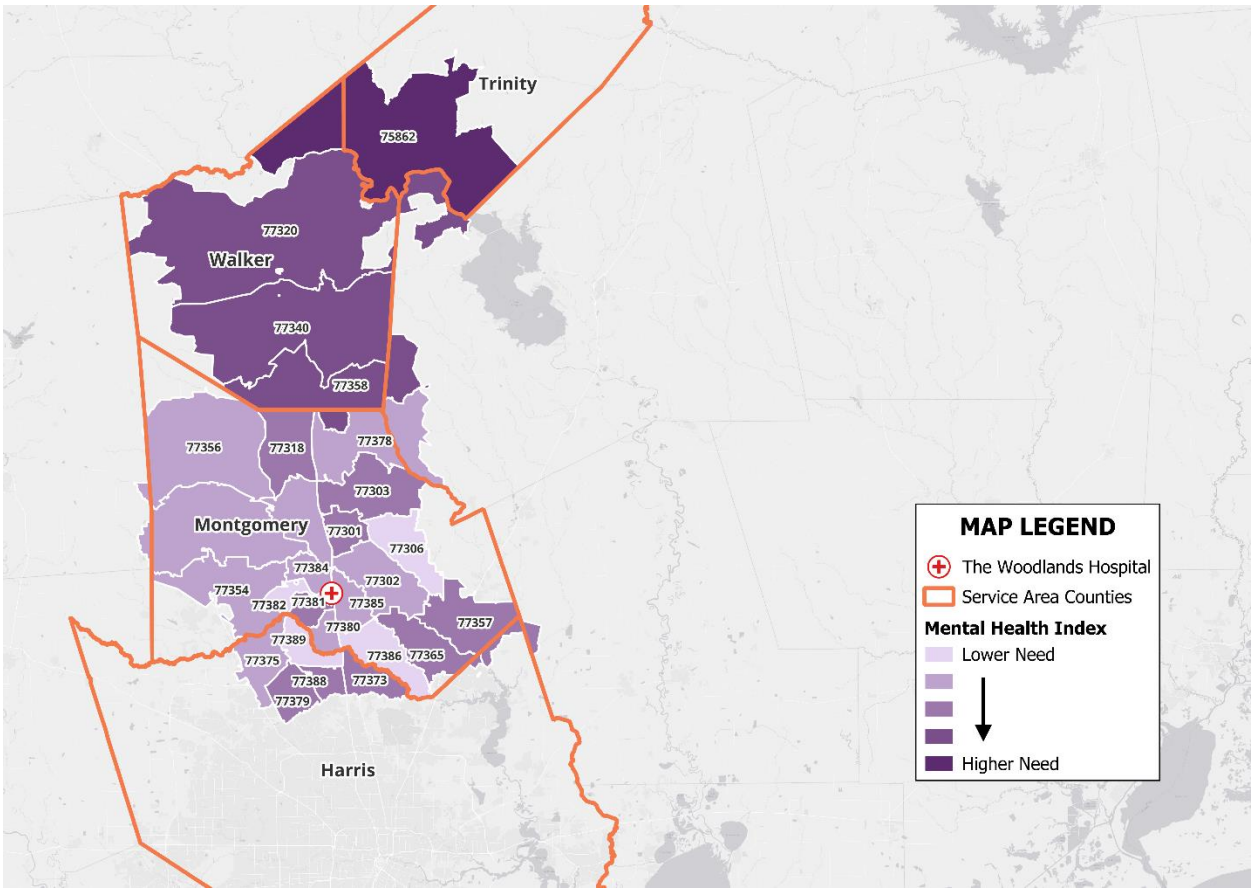


TABLE 11. MENTAL HEALTH INDEX: THE WOODLANDS PRIMARY SERVICE AREA

Zip Code	Value		Zip Code	Value
75862	95.7		77378	36.7
77358	75.8		77380	35.5
77320	75.7		77356	34.9
77340	66.7		77384	34.9
77379	56.6		77375	34.0
77303	50.5		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
77357	41.7		77386	11.8
77301	41.2		77389	8.2
77381	40.4		77306	7.6
77304	37.5			

Older Adults

From the secondary data scoring results, Older Adults ranked 10th in the data scoring of all topic areas with a score of 1.42. 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 12 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 12. 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, some race/ethnicities are disproportionately affected by chronic disease. For example, cancer within the Medicare population is higher in the American Indian/Alaskan Native population than the overall county (16% vs. 12%).

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.

FIGURE 26. CANCER: MEDICARE POPULATION, BY RACE/ETHNICITY

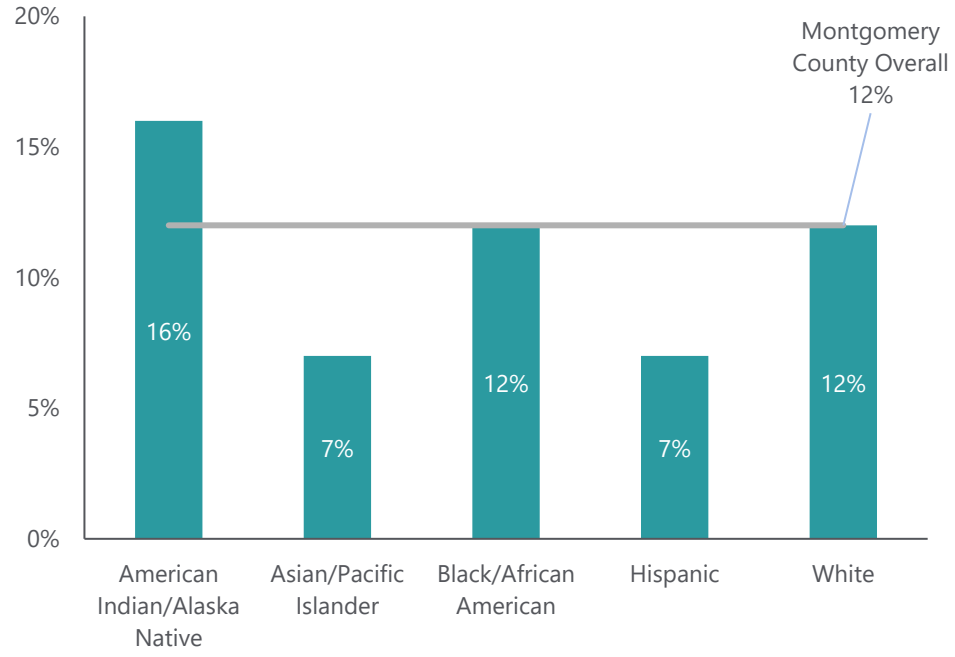


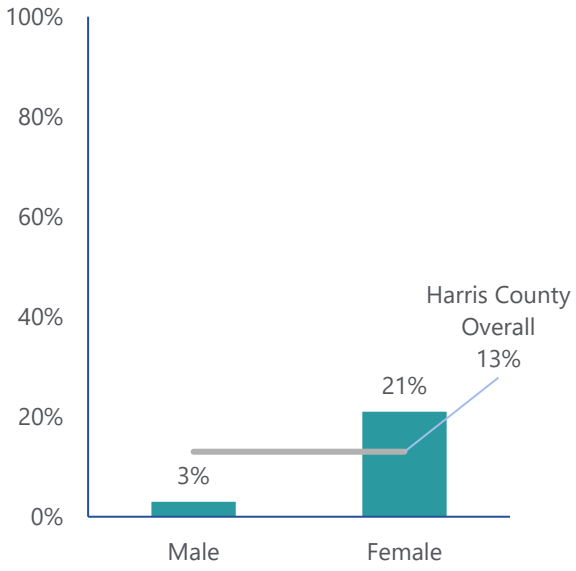
TABLE 13. HARRIS COUNTY DATA SCORING RESULTS: OLDER ADULTS

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 the rate of poverty among people aged 65 and above. 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 27. OSTEOPOROSIS: MEDICARE POPULATION



The health of older adults was another high-priority issue, and was commonly mentioned during qualitative sessions. Rising housing costs, mobility challenges, and isolation among seniors were frequently discussed, with fixed incomes making it hard for many to afford medications or services. One participant reflected, **"Our seniors are choosing between groceries and prescriptions and that's not an exaggeration."** Older adults with disabilities or limited transportation were particularly vulnerable, emphasizing the need for wraparound services and stronger aging-in-place support systems.

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 St. Luke's Health-The Woodlands service area.

While these issues were determined to be important, St. Luke's Health-The Woodlands 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.

Alcohol & Drug Use

From the secondary data scoring results, Alcohol and Drug Use ranked 5th in the data scoring of all topic areas, with a score of 1.52. 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)

Stakeholders expressed concern about youth and adult substance misuse and a lack of treatment options in non-urban parts of the service area. A listening session participant stated, **"There's a substance use issue that's growing quietly and access to help is limited unless you're in crisis."** Partner organizations cited limited funding for prevention efforts and called for greater investment in upstream strategies such as school- and community-based education.

Nutrition & 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 28 illustrates that the zip codes with the highest risk of food insecurity are 77340 and 77306, with index scores of 86.7 and 84.4, respectively.

FIGURE 28. FOOD INSECURITY INDEX: THE WOODLANDS HOSPITAL/SPRINGWOODS HOSPITAL PRIMARY SERVICE AREA

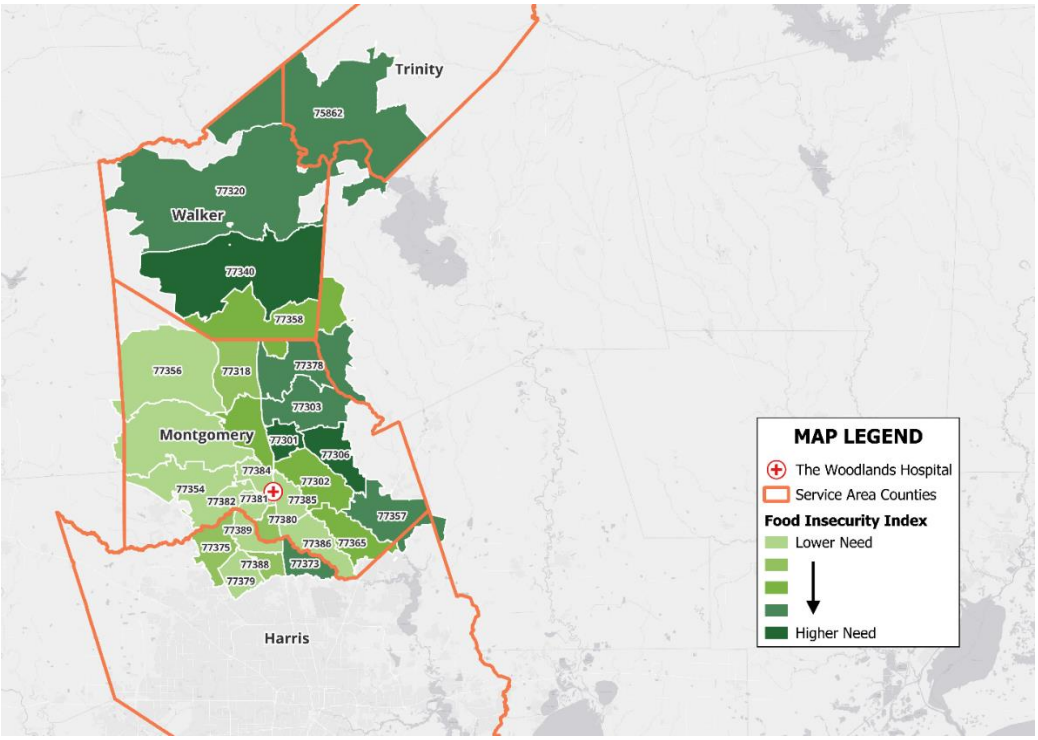


TABLE 14. FOOD INSECURITY INDEX: THE WOODLANDS HOSPITAL/SPRINGWOODS HOSPITAL PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77340	86.7	77375	33.5
77306	84.4	77380	29.0
77301	78.9	77388	26.7
75862	72.8	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
77357	57.8	77384	11.9
77358	49.9	77389	11.3
77304	42.9	77316	9.7
77302	40.8	77381	5.3
77365	39.9	77382	2.7
77318	34.4		

While not prioritized, nutrition and food access issues were consistently raised during community voices sessions. One participant noted, **"People don't just need food they need nutritious food they can actually afford."** Community members expressed support for more education and food access programs, especially those that integrate cultural competency and affordability.

Physical Activity

From the secondary data scoring results, Physical Activity 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:

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

Survey and listening session participants acknowledged that while parks and trails exist in The Woodlands area, they are not equitably accessible. One participant said, **"If you don't live near the nice neighborhoods, you're not walking to a gym or trail. It's not safe or nearby."** Built environment and lifestyle-related barriers limit daily activity for many low-income families.

Women's Health

From the secondary data scoring results, Women's Health ranked 4th in the data scoring of all topic areas, with a score of 1.54. A full list of indicators categorized within this topic can be found in Appendix A. There was one indicator of concern in Montgomery County: *Mammography Screening: Medicare Population* (41.0%).

Women's health was highlighted as a concern by both survey respondents and listening session participants. Stakeholders emphasized the need for more accessible prenatal care, screenings, and maternal mental health resources, especially for uninsured women and women of color. Providers serving rural and suburban fringe areas within The Woodlands zip codes noted gaps in postpartum follow-up and reproductive health education.

Barriers to Care

Despite progress made through strategic community benefit efforts, residents within The Woodlands Hospital service area continue to face a number of barriers that impede their ability to access timely, high-quality healthcare. These barriers are particularly impactful for uninsured individuals, older adults, single-parent households, and underserved populations in remote or low-income areas.

Cost and Insurance Status

Many community members remain uninsured or underinsured, limiting their ability to afford preventive services, specialty care, or prescriptions. Partner survey data identified uninsured individuals as the most frequently served population by local organizations.

Transportation Challenges

Transportation remains a structural barrier; especially in areas without consistent public transit. Participants described logistical issues like inconvenient bus routes, restrictions on what can be carried on buses, and missed appointments due to lack of transportation.

System Complexity and Navigation Issues

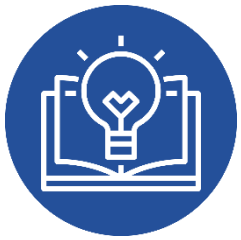
Community members shared that navigating healthcare and social service systems can be overwhelming, especially for those with limited digital literacy or language proficiency.

Workforce Shortages and Wait Times

Listening sessions and surveys revealed that long waitlists for mental health services, lack of specialty providers, and gaps in evening/weekend availability continue to hinder access. This is particularly burdensome for working families and caregivers.

Stigma and Mistrust in Mental Health Services

Mental health needs are high, yet stigma and lack of culturally competent care limit service utilization. Community participants emphasized the need for reliable messengers and integrated services.



Lack of Awareness of Available Resources
Despite the presence of numerous nonprofits and clinics, residents and service providers acknowledged that programs often operate in silos

Conclusion

The findings from this Community Health Needs Assessment demonstrate that while St. Luke's Health–The Woodlands Hospital has made measurable progress in expanding access, promoting prevention, and strengthening mental health care, persistent challenges remain. Community input emphasized the complexity and urgency of community health in a region characterized by economic diversity, population growth, and service gaps. Needs continue around health care access, mental health, chronic disease management, and services for older adults. Structural barriers such as transportation, cost, and system navigation must be addressed through continued collaboration and innovation.

Looking ahead, St. Luke's Health is committed to deepening partnerships, aligning resources, and mobilizing shared action to drive equitable outcomes across its service area. The insights from this CHNA will directly inform the 2025 Implementation Strategy, ensuring that future investments are both responsive and measurable in improving community health.

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.