Community Health Needs Assessment and Implementation Strategy

St. Luke's Sugar Land Hospital

November 8, 2013

The Community Health Needs Assessment and Implementation Strategy for the St. Luke's Sugar Land Hospital were conducted and developed between April 22 and October 14, 2013 in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. The Community Health Needs Assessment was reviewed and the Implementation Strategy was approved by the St. Luke's Sugar Land Hospital Board of Directors on December 13, 2013.

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Introduction

A Community Health Needs Assessment (CHNA) for the St. Luke's Sugar Land Hospital (SLSL) was conducted by SLSL and Episcopal Health Charities (the Charities) between April 22 and September 26, 2013 in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. The CHNA process involved the review of secondary data sources describing the health needs of the community served by SLSL and a series of focus groups with hospital, public health and community stakeholders to identify the priority community health needs. This CHNA document was developed with the SLSL hospital advisory team and includes a description of the community served by the SLSL; the process and methods used to conduct the assessment; a description of how SLSL included input from persons who represent the broad interests of the community served by SLSL; a prioritized description of all of the community health needs identified through the CHNA; and, a description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA. The accompanying Implementation Strategy provides an overview of SLSL's plan to address the identified priority community health needs.

Description of Community Served by the Hospital

The community served by St. Luke's Sugar Land Hospital is described by the geographic area of hospital and the contiguous zip codes determined by 2012 SLSL hospital discharge data. Located in Fort Bend County, the hospital service area contains both a large urban complex, as well as smaller rural communities, and is home to nearly 600,000 residents. This county is one of the fastest growing in the United States, with an annual growth rate twice that of the state of Texas. The Primary Service Area (PSA) is based on 75% of discharges and the Secondary Service Area (SSA) reflects an additional 5%; therefore, the overall service area used for this report is defined by the residential location for 80% of the hospital discharges in 2012. The remaining 20% of discharges are outside of the areas considered for this report.

The 2010 Health of Houston Survey (HHS) allowed us to create a database that matched each hospital's discharge data, as the HHS contains weighted data that can be aggregated at the zip code level and can be customized to the PSA and SSA of each hospital. This tailored database allowed us to identify health data pertinent to each hospital community and to make direct comparisons with Harris County to identify the most salient health trends. The HHS provided in-depth information for the majority of SLSL PSA and SSA zip codes. From here forward, the SLSL community refers to PSA and SSA data that was matched to the available zip codes in the HHS, and the data was compared to HHS Harris County data as a reference. SLSL primary and secondary service area map and zip codes are included in Appendix 1.

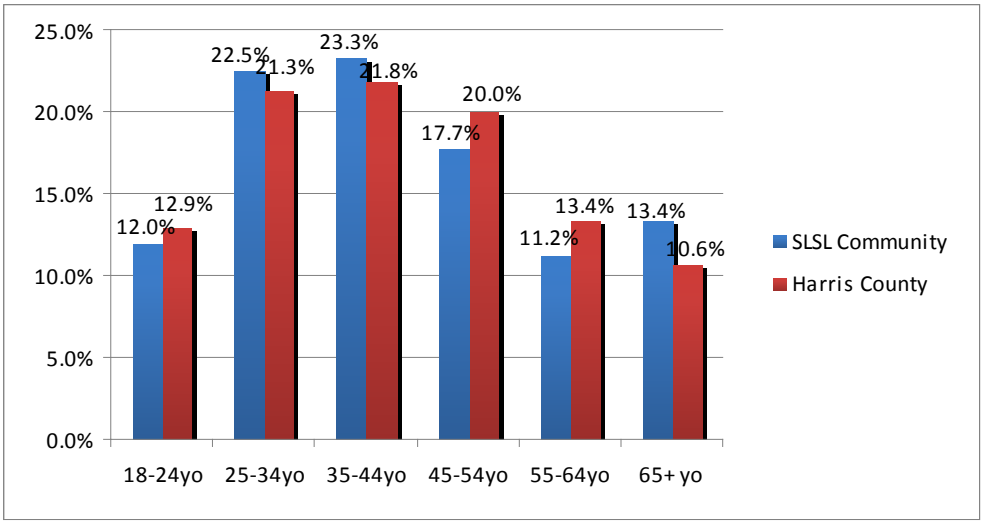
Community Demographics

Demographic data was collected and analyzed using comparisons within the SLSL community and with the aggregated zip code data representing Harris County. Overall, the community served by SLSL compared to Harris County has slightly more 35-44 year olds, is majority Hispanic, and half has a college education. A full description of the data from the SLSL's service area zip codes as represented in the 2010 Health of Houston Survey can be found in Appendix 2.

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

- ***Age***- One-fourth (23.3%) of those living in the SLSL community are between 35-44 years old. Nearly one-fifth (22.5%) are between 25-34 years old and another fifth (17.7%) are between 45-54 years old. The 65 and over category was the fourth largest group (13.4%), followed closely by 18-24 year olds (12.0%) and those aged 55-64 made up nearly one-tenth of the SLSL community (11.2%). The age distribution of Harris County resembles those in the SLSL community (Figure 1).

Figure 1. Age distribution for SLSL community and Harris County



- ***Race/Ethnicity*** - The majority of the SLSL community identify as Hispanic (39.1%). This differs somewhat from the distribution by race/ ethnicity for all of Harris County, where 37.7% are White non-Hispanic and 36.8% are Hispanic. The Black/non-Hispanic community in SLSL is also higher than in Harris (23.5% vs. 17.4%). (Table 1).

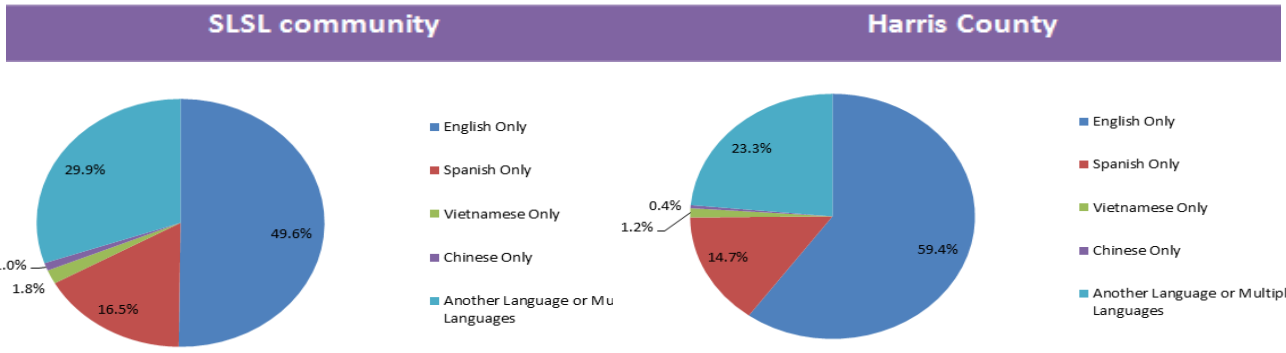
Table 1. Race/ethnicity distribution for SLSL community and Harris County

Race / Ethnicity	SLSL Community	Harris County
White/ non-Hispanic	25.7%	37.7%
Black/ non-Hispanic	23.5%	17.4%
Hispanic	39.1%	36.8%
Asian/ non-Hispanic	9.6%	4.9%
Other/ non-Hispanic	2.1%	3.2%

- ***Nationality***- One half (52.7%) of the SLSL community were born in the United States. Of those that were not born in the United States, 46.9% as compared to 52.5% in Harris County are not United States citizens.
- ***Language***- About half (49.6%) of the households in the SLSL community speak English only, 16.5% speak Spanish only, 1.6% speak Vietnamese only, 1.0% speak Chinese only and 29.9% speak another language or multiple languages. In Harris County, 59.4% speak English only,

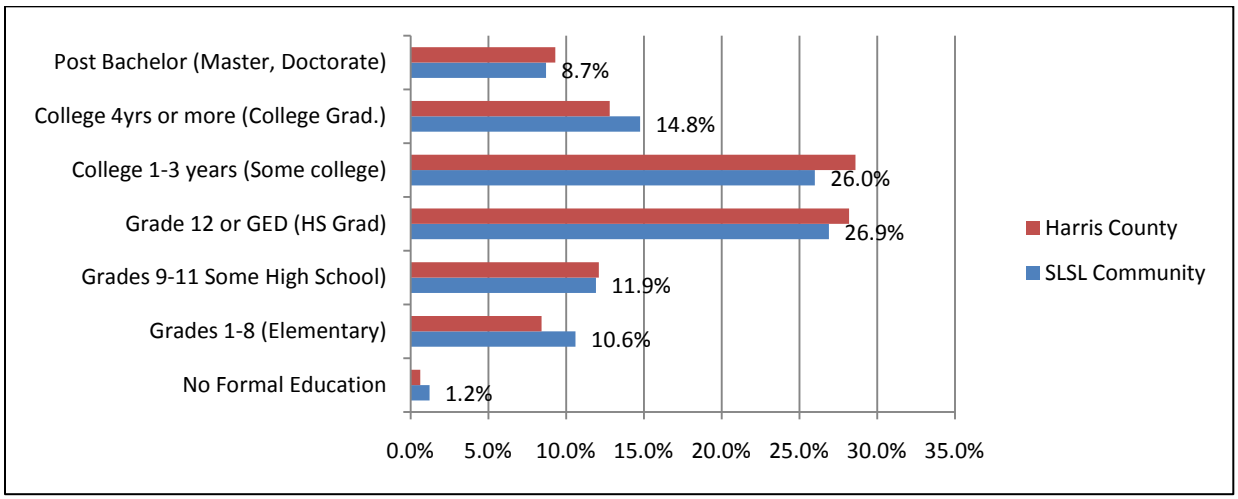
14.7% speak Spanish only, 1.2% speak Vietnamese only, 0.4% speak Chinese only and 23.3% speak another language or multiple languages (Figure 2).

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



- ***Gender***- The gender of those in the SLSL community is evenly distributed between males and females (52.2% and 47.8%, respectively). This breakdown closely resembles the Harris County gender rates of 49.5% males and 50.5% females.
- ***Education***- One-fourth (23.7%) of the SLSL community have less than a high school or GED education and half (49.45%) have a college education. Harris County data resembles the SLSL. In Harris County one-fourth (21.1%) of respondents have less than a high school or GED education and half (50.7%) are college educated.

Figure 3. Educational attainment rates for SLSL community and Harris County



Description of the Process and Methods Used to Conduct the CHNA

Episcopal Health Charities was contracted to manage the Community Health Needs Assessment for St. Luke's Health System, which includes St. Luke's Sugar Land Hospital. The Charities, affiliated with the Episcopal Diocese of Texas, is a research informed grant-maker dedicated to funding programs that improve the health of underserved people throughout 57 counties in Texas. Founded in 1997, the Charities is a unique funder committed to taking healthcare beyond the walls of conventional healthcare and out into the community. A one-of-a-kind entity in Texas, the Charities utilizes research practices built on community partnerships that support more effective interventions and improved health outcomes. To date, the Charities has touched 17 million lives with $90 million distributed through 1,851 research-informed grants to nonprofit community health service programs throughout Southeast Texas. The Charities developed a nationally recognized Center for Community-Based Research through partnering with area institutions, universities, and national and local funders to help reduce health disparities. Using a mixed method approach, which includes epidemiological data and community-based participatory research, the Charities' has written twelve technical reports and conducted nine community needs assessments with the goal of creating systemic change and measurable improvement in overall community health status and individual well-being.

The Charities collaborated with the SLSL hospital team, subject matter experts from the University of Texas School of Public Health and Clarus Consulting Group, public health experts, community organizations, and community stakeholders to conduct the SLSL CHNA. The SLSL hospital advisory team met regularly with the Charities team in-person and communicated via email and conference calls to offer input and provide guidance on the CHNA. The SLSL hospital team consisted of executive leadership staff including the Chief Financial Officer, Chief Nursing Officer, Director of Business Development, and Manager of Volunteer Services and Community Relations. The Charities collaborated with the University of Texas, School of Public Health to research secondary data sources to obtain quantitative information on existing needs assessments, community demographics, county resources, and hospital service data. Clarus Consulting Group facilitated focus groups and analyzed qualitative data obtained from

community input focus groups. Appendix 3 lists the names, titles, and roles of those involved in the CHNA, including the data analysis and community input portions.

Public Health Data

Public health data collection, review, and analysis efforts were guided by two main questions: what are the health needs of the community served by the hospital facility, and what are the characteristics of the populations experiencing these health needs. Quantitative data were obtained and analyzed during April to September, 2013 from the 2010 Health of Houston Survey (HHS), the 2012 St. Luke's Health System hospital discharge data, and 2012 Behavioral Risk Surveillance System (BRFSS).

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

Hospital Discharge Data

Data on all hospital discharges for 2012 was provided by the St. Luke's Health System. Data was aggregated by the 5 digit ICD-9 diagnosis code and divided by inpatient and outpatient discharges. ICD-9 codes were further aggregated into more relevant and less clinically specific categories. Discharge data was summarized for SLSL and the categories reflecting the most frequently occurring diagnoses were highlighted (Appendix 4).

For those diagnoses with high prevalence, the categories were disaggregated to a level that aided understanding if the main description was extremely broad. Classifications are presented for inpatient (N = 2,648), outpatient (N = 16,306), and total patient load (N = 18,954). Overall, the leading discharge categories were *Symptoms, Signs, and Ill-Defined Conditions* (23.8%), *Injury and Poisoning* (19.4%), and *Diseases of the Respiratory System* (12.7%). The next most commonly occurring were *Diseases of the Musculoskeletal System and Connective Tissue* (6.9%) and *Diseases of the Digestive System* (6.0%).

Among the 2012 SLSL inpatient discharges, one-fifth (18.5%) were for *Diseases of the Circulatory System*. Within this classification, the most commonly occurring conditions were *ischemic heart disease* (23.2%), *cerebrovascular disease* (12.9%), and *other forms of heart disease* (36.7%). *Diseases of the Digestive System* accounted for 18.4% of inpatient discharges. Within this category, 13.1% of discharges were for *diseases of esophagus, stomach, and duodenum*, and 10.2% were for *noninfective enteritis and colitis*. One-quarter (24.0%) of inpatient digestive system discharges were for *other diseases of intestines and peritoneum*, and 39.6% were for *other diseases of digestive system*. *Diseases of the Respiratory System* accounted for 13.3% of inpatient discharges. *Pneumonia and influenza* accounted for 41.3% of these discharges, and chronic *obstructive pulmonary disease and allied conditions* accounted for 37.0%. *Other diseases of respiratory system* accounted for 16.5%

Among the 2012 SLSL outpatient discharges, 26.9% were for *Symptoms, Signs, and Ill-Defined Conditions*. Almost all (99.4%) discharges within this grouping were classified as *Symptoms*. The category *Injury and Poisoning* accounted for 21.4% of outpatient discharges. One-quarter (23.8%) of these discharges were for *sprains and strains of joints and adjacent muscles*, 11.7% were for *contusion with intact skin surface*, and 9.7% were for *certain traumatic complications and unspecified injuries*. *Diseases of the Respiratory System* accounted for 12.6% of outpatient discharges. Within this category, 62.4% of discharges were for *acute respiratory infections*, 20.0% were for *pneumonia and influenza*, and 14% were for chronic obstructive pulmonary disease and allied conditions.

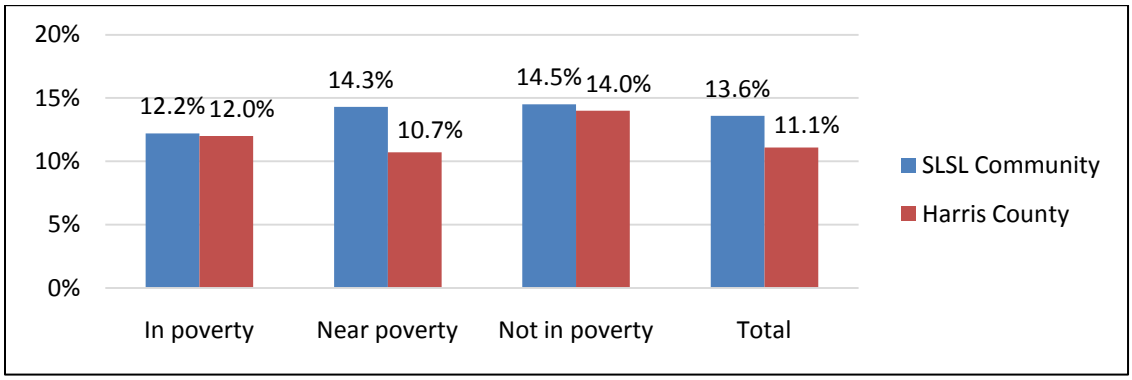
Key Indicators and Health Disparities

The SLSL community key indicators and health disparities were identified and compared to the Harris County population (Appendices 2, 4-11). Data reviewed indicate that sufficient health information is already available from local public health sources to allow for the identification of some of the most important health needs of the SLSL community. There were no identified information gaps in the gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. The data were analyzed in relation to poverty to identify potential disparities that may exist between socioeconomic groups. Poverty was divided into three categories: in poverty (<100% of the Federal Poverty Level), near poverty (100-199.9% of the FPL), and not in poverty (200% or more above the FPL).

The SLSL community as compared to Harris County has a lower uninsured population, higher rates of cancer and diabetes, and similar rates of mental health needs. The below indicators reflect analyses from the 2010 Health of Houston Survey and the 2011 Behavioral Risk Surveillance System for the SLSL community.

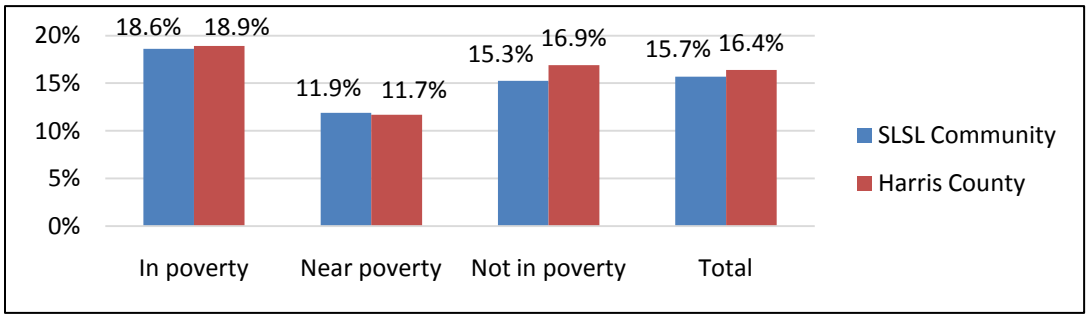
- ***Health Insurance and Access to Care***- According to the 2013 National County Health Rankings, the uninsured rate in Fort Bend is 20%, Brazoria County is 21% and Harris County is 30%. Respondents from the BRFSS survey report 40.8% of the SLSL community that lives in poverty reported delaying seeing a doctor in the previous year due to cost or lack of insurance compared to 35.3% of those in poverty in Harris County. Appendices 2 and 6 display data that corresponds to those community members that responded to the BRFSS survey.
- ***Cancer***- Reported rates of cancer diagnosis are slightly higher in the SLSL community (8.1%) compared to Harris County (6.1%). The SLSL community in poverty and near poverty reported higher rates of cancer (9.6% and 5.7%) compared to cancer rates reported in Harris County (6.8% in poverty, and 4.1% near poverty). (Appendix 5)
- ***Diabetes***- Diabetes rates in the SLSL community are higher (13.6%) compared to Harris County (11.1%). The SLSL community near poverty reported higher rates of diabetes (14.3%) compared to Harris County (10.7%) (Figure 4). (Appendix 5)

Figure 4. Diabetes rates by poverty for SLSL community and Harris County



- ***High Blood Pressure***- High blood pressure rates in the SLSL community are slightly lower than in Harris County (28.6% SLSL; 30.1% Harris). The SLSL community near poverty reported higher rates of high blood pressure (32.1%) compared to those in poverty in Harris County (28.9%). (Appendix 5)
- ***Mental Health***- Similar rates of people in the SLSL and Harris County reported they had felt like talking to a health professional in the previous year for a mental health, emotional, or substance use problem (15.7% SLSL; 16.4% Harris County). Rates of mental health needs in the SLSL community are comparable Harris County across poverty levels. In both communities those in poverty report a similar need for mental health (18.6% SLSL and 18.9% Harris) (Figure 5). (Appendix 5)

Figure 5. Mental Health need by poverty for SLSL community and Harris County



- ***Cardiovascular Disease***- Those in poverty in the SLSL community reported slightly higher rates of coronary heart disease than those in poverty in Harris County (4.9% SLSL, 4.1% Harris County). Compared to Harris County, the SLSL community reported similar rates of

heart attack (3.4% SLSL; 3.2% Harris County) and lower rates of stroke (1.9% SLSL; 2.7% Harris County). The SLSL community in poverty reported lower rates of stroke (2.3% SLSL; 4.0% Harris County) (Table 2). (Appendix 5)

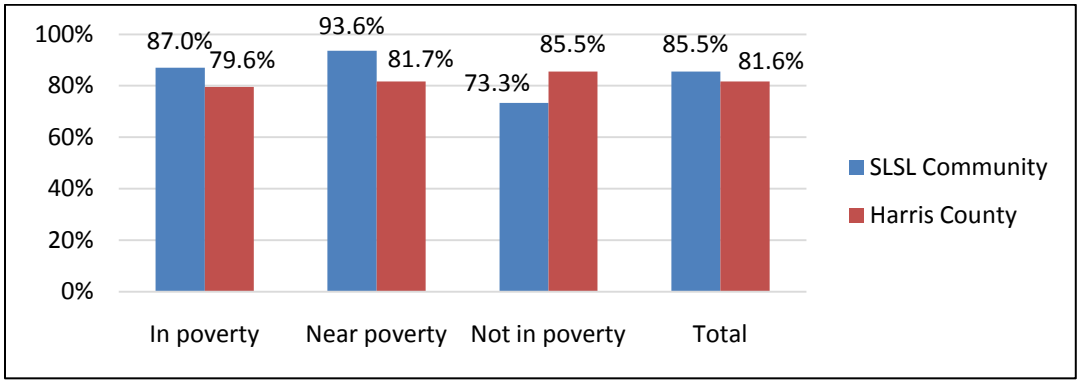
Table 2. Cardiovascular disease diagnosis for SLSL community and Harris County

	SLSL Community				Harris County			
	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)
Ever diagnosed with coronary heart disease	4.9	3.0	4.8	4.4	4.1	2.8	4.4	4
Ever diagnosed with heart attack	3.0	4.5	3.1	3.4	3.7	3.1	2.9	3.2
Ever diagnosed with stroke	2.3	3.0	1.0	1.9	4	2.7	1.9	2.7

- ***Use of Preventive Services***- Compared to Harris County, the SLSL community reported slightly higher rates of mammography (88.6% SLSL; 87.1% Harris County), comparable rates of blood stool testing (55.4% SLSL; 54.0% Harris County), and lower rates of Pap tests (86.1% SLSL; 89.8% Harris County) and sigmoidoscopy or colonoscopy screenings (51.6% SLSL; 55.8% Harris County). Rates of HIV testing in the last 12 months were higher in the SLSL compared Harris County (23.3% SLSL; 19.8% Harris County). Fifty-five percent (55.0%) of those in poverty in the SLSL community reported ever being tested for HIV in their lifetime; this is higher than rates reported in Harris County (50.8%). (Appendix 7)
- ***Prenatal Care***- Among the SLSL community, the most common reasons for not getting prenatal care were costs or lack of insurance (56.0% SLSL; 32.4% Harris County). Sixty-two percent of those in poverty reported not getting prenatal care due to costs or lack of insurance compared to 35.4% of those in poverty in Harris County. Compared to Harris County, higher breastfeeding rates are reported among those in the SLSL community in poverty (87.0% SLSL; 79.6% Harris County) and near poverty (93.6% SLSL; 81.7% Harris County) (Figure 6). Lower rates of breastfeeding were reported among those not in poverty in the SLSL community (73.3%) compared to 85.5% in Harris County. Higher rates of late

prenatal care were reported in the SLSL community (24.1%) compared to Harris County (16.0%). (Appendix 8)

Figure 6. Lifetime Breastfeeding in SLSL community and Harris County



- ***Smoking***- The SLSL community reported lower rates of lifetime smoking than Harris County (30.9% SLSL; 37.2% Harris County). (Appendix 9)
- ***Environmental and Neighborhood Factors***- The SLSL community reported higher rates of environmental problems when compared to Harris County. Water pollution was higher in the SLSL community (13.9%) than in Harris (10.2%). Stray dogs and cats in the SLSL community were reported more commonly as a problem than in Harris County (42.0% SLSL; 36.7% Harris County). Higher rates of drinking water as a problem was reported in SLSL community (21.5% SLSL; 18.8% Harris County). A higher percentage of individuals in poverty in the SLSL community reported renting a home compared to Harris (60.8% SLSL; 53.4% Harris County) (Table 3). (Appendix 10)

Table 3. Environmental and neighborhood factors for SLSL community and Harris County

	SLSL community				Harris County			
	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)	In Poverty (%)	Near Poverty (%)	Not in Poverty (%)	Total (%)
Fumes from Traffic	19.4	17.8	12.3	16.2	20.8	16.4	15.2	17.2
Fumes from Industry	9.8	8.1	4.0	7.1	16.6	16.8	12.6	14.8
Water Pollution	19.5	11.7	10.1	13.9	14.4	10.5	7.2	10.2
Drinking Water	28.5	27.0	11.7	21.5	22.5	21	15.2	18.8

- ***Violence***- With respect to crime and violence, 34.9% of the SLSL community reported this was a problem compared to 26.1% of Harris County. This question specifically refers to if participants that responded to the Health of Houston Survey felt that crime and violence were a problem in their neighborhood. (Appendix 10)

- ***Social Support***- The SLSL community reported having someone to understand their problems "all of the time" in similar rates to Harris County (38.2% and 39.8%). Compared to Harris County, the SLSL community reported lower rates of having someone to help with daily chores "all of the time" (34.7% SLSL; 37.7% Harris County), and lower rates of having someone to relax with "all of the time" (24.9% SLSL; 29.6% Harris County). (Appendix 11)

Description of Community Input

A broad representation of the community was engaged through multiple meetings, focus groups, interviews and written correspondence. Stakeholders were identified based on those with special knowledge of or expertise in public health; state, regional, or local health departments with current data or other information relevant to the health needs of the community served by SLSL; and leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by SLSL. Community input was obtained from the SLSL hospital advisory team, SLSL community stakeholders, and Public Health experts. Appendix 3 lists the participants involved in the CHNA including names, titles, and roles.

<u>SLSL Hospital Advisory Team Input</u>

A CHNA kickoff meeting was held on April 24 to inform leadership of St. Luke's Health System hospitals of the new IRS requirement to conduct a CHNA. The hospital leadership discussed their community's health needs, as well as identified existing resources, programs and community stakeholders. Individual hospital meeting notes were developed and distributed approximately one week after the meeting. Hospital advisory teams were identified and meetings were held from June to August to discuss the CHNA requirements and the

process of conducting a CHNA. The hospital advisory team received updates of the progress being made on the CHNA, information regarding the community meeting specific to their community, and deadlines for submitting the Implementation Strategy.

On June 3, the SLSL hospital advisory team met to provide input on the most significant health needs of their community, existing gaps in available health care, and strategies to address the community needs, while keeping in mind the underserved, minority, uninsured, and elderly communities. There was also a discussion on key stakeholders and resources that currently exist within the community. The SLSL hospital advisory team summary report can be found in Appendix 12. The hospital advisory team identified the following areas of need:

- ***Access to Care***- The area served by the hospital has experienced significant population growth in recent years that has caused a shortage in primary care coverage.
- ***Communication of Community Resources***- There is a need for more communication regarding education and treatment programs, services, and referrals for those with mental health needs and those with specific chronic diseases.
- ***Mental Health Services***- The hospital does not have a mental health department, and there are very few local facilities to receive transfers or referrals. There are no local resources for mental health evaluations or inpatient care. This is particularly challenging for the uninsured.
- ***Pain Management Services***- There is a unique sickle-cell patient population in the community that requires pain management services that are currently limited in the area. SLSL has a pain specialist on staff that manages these issues for inpatient needs, but a gap exists for long-term management and coordinated care of these patients.

<u>SLSL Community Stakeholder Input</u>

Through active outreach to key community stakeholders, a broad representation from the communities served by SLSL was identified to participate in the community input portion of the CHNA. A focus group was held on Friday, August 9, 2013, from 9:00 am – 11:00 am at The Fort Bend Family YMCA in Missouri City, Texas. The event brought people from different roles and organizations together to discuss matters that are important to the health needs of the

community served by the hospital. There were ten stakeholders and organizations represented a range of community based organizations, health clinics and Federally Qualified Health Centers, school districts, and business organizations. The SLSL community stakeholder summary report can be found in Appendix 13. Stakeholders identified the following areas of need:

- ***Access to Care*-** Stakeholders focused on general access to care issues that are common in the community including transportation, after hours care, and health insurance. Stakeholders noted that many physicians in the area do not accept Medicaid, so individuals defer care until they must seek hospital emergency services. Stakeholders also acknowledged that policy related to access to care is a complex and wide-ranging issue and lack of health insurance is a major challenge.
- ***Access to Specific Services*-** Participants spoke about access to a number of specific health care services as being a problem in the Fort Bend community. These specific services include specialty care, mental health care, specialty pediatric services, services for the disabled, elder care, and diagnostic and imaging services.
- ***Communication of Community Resources*-** Stakeholders indicated that effective communication about available services is a health problem. Because Fort Bend is such a large area with with a growing array of services, people often find it difficult to find the needed health services.
- ***Human Resources*-** Stakeholders suggested that in rural areas of Fort Bend County, clinics and other health care facilities have a difficult time finding specialized and skilled personnel. Stakeholders indicated that workforce development in the healthcare profession is a problem in the community.

<u>Public Health Experts Input</u>

A focus group was held for Public Health Experts on Thursday, August 8, 2013, from 2:30 pm – 4:00 pm at the Episcopal Health Charities in Houston, TX. This discussion included twelve representatives from local, county, regional, and state governmental public health organizations. In general, participants noted the correlation between a healthy community and fewer admissions to the hospital, and suggested that elevating the idea of a healthy community

is a health need in the community. Stakeholders also noted specific unmet healthcare needs in the community include access to care, communication, chronic disease, maternal and child health, behavioral health care, environmental health, and health disparities. The Public Health Experts summary report can be found in Appendix 14. The Public Health Experts identified the following areas of need:

- ***Access to Care*-** Public Health Experts expressed that access to care was the most important health problem in the community. The group acknowledged that there is sufficient number of health clinics in the area but that access to care remains an issue for a significant portion of the population. Several factors that contribute to the access to care issue include transportation, knowledge, and insurance and finances.
- ***Chronic Disease*-** Public Health Experts suggested that the rate of chronic disease such as diabetes, obesity, high cholesterol, hypertension, heart disease, and asthma (especially in children) is an important health problem in the community. It was noted that the rate of adults with diabetes or pre-diabetes is 60%, which illustrates the significance and alarming nature of the chronic disease problem. Individuals felt that more individuals need to be screened for chronic diseases, and more information about how to access help for chronic diseases needs to be disseminated.
- ***Communication*-** Public Health Experts indicated that more effective communication around health care is an unmet health need. Specifically, individuals expressed that better communication is needed from health care providers to inform the community about services and resources that are available. In addition, better communication is needed between health care providers and health departments/public health agencies.
- ***Environmental Health*-** Public Health Experts suggested that poor environmental health causes both acute and chronic health issues in the community. The importance of the relationship between environmental health and chronic disease was highlighted and it was suggested that the community should be offered more educational initiatives around this relationship. Individuals noted that environmental problems such as air quality or road construction can be obstacles to healthy communities in that it discourages individuals from

going outside to exercise but can also lead to long-term chronic health problems such as respiratory problems, heart attack, stroke, and asthma.

- ***Health Disparities*****-** Public Health Experts suggested that health disparities are a major health care concern in the community. It was noted that there are correlations between ethnicity and individuals that do not get regular or necessary health care screenings.
- ***Maternal and Child Health*****-** Public Health Experts focused on maternal, infant, and prenatal care as being an important health issue in the community. Individuals cited high rates of maternal and infant mortality and high rates of pre-term birth and fetal mortality as evidence of this problem. It was further noted that high rates of poor birth outcomes leads to higher numbers of children with special needs. Overall, the experts suggested that women are aware of the importance of maternal, infant, and prenatal care but encounter many barriers to obtaining these services such as transportation, funding, access, finding a doctor, and making an appointment.
- ***Mental Health Services***- Public Health Experts suggested that mental health and chronic mental illness are important health issues. While it was specifically noted that individuals with schizophrenia, bipolar disorder, and depression rarely get the care that they need, there has also been progress in addressing this need, such as the police department helping to place people with mental health issues in treatment centers instead of placing them in the law enforcement system.

Description of Identifying and Prioritizing Community Health Needs

Community health needs were identified through an analysis of four major data sources: SLSL Hospital Advisory Team Input, SLSL Community Stakeholders Input, Public Health Experts Input, and Health of Houston Survey Data for the SLSL community. This process involved a detailed review of the priorities identified in each separate data source and the determination of the most important health priorities.

Identifying Community Health Needs

Key criteria for identifying community health needs were: 1) importance of the problem for the community, 2) impact of the problem on vulnerable populations and 3) lack of existing resources to address the problem. Health status and social determinants of health were incorporated into the analysis of areas of need, challenges, and barriers. The community health needs were designated by source and the data was compared and cross-validated with the analysis of secondary data. Table 4 displays the areas of need, challenges, and barriers from the data sources.

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

Data Source	Areas of Need	Challenges and Barriers
SLSL Hospital Advisory Team Input	Access to Care Communication of Community Resources Mental Health Services Pain Management Services	Limited mental health services High need patients come through ER Few Primary Care Physicians
SLSL Community Stakeholders Input	Access to Care Access to Specific Services Communication of Community Resources Human Resources	Transportation Health insurance Education and communication of available resources and services Language and cultural barriers Safety and security
Public Health Experts Input	Access to Care Chronic Disease Communication Environmental Health Health Disparities Maternal and Child Health Mental Health Services	Lack of public transportation Lack of health service navigation knowledge Lack of health and orientation services for immigrants Lack of health insurance, financial resources Environmental issues (pollution, crime, recreation facilities, food deserts) Lack of funding for programs
HHS Survey Data for the SLSL community	Access to Care Chronic Disease Cancer Crime and Violence	Income disparities Lack of health insurance

Prioritizing Community Health Needs

The identified community health needs were discussed and prioritized through a triangulation process that looked at the priorities identified in each of the three sources of data separately, and compared and contrasted across sources. . The team involved in the analysis of quantitative and qualitative data ranked the priority community health needs. (Figure 7)

Figure 7. Community health needs triangulation process

Priority Community Health Needs Identified for SLSL

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

1. Access to care – There is a shortage of primary care physicians, limited access to specialty services, and lack of transportation.
2. Chronic disease- Screening, diagnosis and education on chronic disease was seen as a priority need. Chronic diseases such as sickle cell, cardiovascular disease, and diabetes were concerns from the both hospital and community stakeholders.
3. Communication about community resources – There is lack of communication and awareness about local health services and community resources.
4. Mental Health – This priority includes not only availability of mental health services, but also the need to provide mental health evaluation and inpatient care.

Description of Community Resources

Within the community engagement meetings and focus groups, existing resources and programs that address health in the community were discussed. Identifying these resources began to build bridges, foster understanding, and increase awareness of existing services. The available resources identified in the SLSL community are below:

- ***Area Agency on Aging*** – The Area Agency on Aging implements preventive programs for seniors that promote health for this important sector of the population.
- ***Asthma-Related Support Services*** – Although funding is no longer available for this initiative, participants noted a program that provided healthy alternatives for the home for families with children that suffer from asthma. The program was a relatively small resource to address a large problem, but it made a difference for children and families that struggle with asthma.
- ***Civic Clubs and Social Clubs*** – Civic and social clubs are an important part of communities in Houston and could be a great avenue to reach communities to address health priorities.
- ***Church and Faith-Based Community*** – The active church and faith-based communities throughout Houston are often involved in all aspects of life, including health and wellness.
- ***Fort Bend Independent School District*** – Fort Bend ISD provides health resources for its employees, who make up a significant part of the community.
- ***Gateway to Care (Houston)*** – Gateway to Care in Houston is a program through which doctors, hospitals, and other healthcare providers volunteer time and resources to those in need. While this program does not exist in Fort Bend County, it could be a great model for Fort Bend County to follow.
- ***Personal Prevention*** – Personal Prevention is a program that helps employers provide incentives to employees around healthy living through an employer sponsored point system.
- ***Service to Seniors***- SLSL educates senior to visit the hospital after falls and to seek care with other medical issues such as UTIs.

- ***Shape Up Fort Bend*** – Shape Up Fort Bend is a program that connects the Fort Bend community with resources for a healthy lifestyle. The Shape Up Fort Bend website could be used as a central site for publishing community healthcare resources and services.
- ***United Way*** – The United Way is a great resource in Houston that addresses a myriad of health-related issues in the community. Participants specifically noted programs of the United Way related to cancer screenings and transportation to health related services.
- ***Women's 3D Mammogram Program*** –this program at SLSL includes speakers, education, screening, and referral
- ***YMCA*** – The YMCA in Fort Bend County provides services to many different populations within the Fort Bend population. The YMCA is not only a resource for exercise and healthy living, but it is a resource for social interaction, stress relief, and many other services for "the mind, body, and spirit."

Community Health Needs Assessment Summary

The Community Health Needs Assessment for St. Luke's Sugar Land Hospital spanned from April through September, 2013. A CHNA kickoff meeting was held on April 24 to inform hospital leadership of the new IRS requirement to conduct a CHNA and develop a 3 year Implementation Strategy for each hospital. Hospital advisory teams were identified and met with the Charities team from June to July to discuss the CHNA requirement. An overview of the CHNA process was provided and the hospitals were given an opportunity to discuss their community's health needs, as well as identify any existing resources, programs and community stakeholders. Individual hospital meeting notes were developed and distributed to the hospital advisory teams approximately one week after each meeting.

For the community input portion of the CHNA, the Charities team solidified meeting locations, scheduled community meetings for each hospital, and invited community organizations and stakeholders. Through active outreach to key community stakeholders, the Charities team obtained a broad representation from the communities served by the hospitals to participate in the community input portion of the CHNA. Focus groups were held to identify and prioritize community health needs with three stakeholder groups: hospital advisory team,

community stakeholders, and public health experts. These events brought key stakeholders together to discuss community health needs, challenges, and priorities for the communities served by SLSL.

The Charities team analyzed secondary data and gathered background information on community health needs. The data include national, state, local and hospital specific sources. Additional public health data include community demographics, health indicators, health risk factors, access to health care and social determinants of health. The identified community health needs were then prioritized through a triangulation process that looked at the priorities identified in each of the sources of data, compared and contrasted across sources, and identified specific commonalities. The highest priority health needs for the community served by SLSL are:

1. Access to care – There is a shortage of primary care physicians, limited access to specialty services, and lack of transportation.
2. Chronic disease- Screening, diagnosis and education on chronic disease was seen as a priority need. Chronic diseases such as sickle cell, cardiovascular disease, and diabetes were concerns from the both hospital and community stakeholders.
3. Communication about community resources – There is lack of communication and awareness about local health services and community resources.
4. Mental Health – This priority includes not only availability of mental health services, but also the need to provide mental health evaluation and inpatient care.

From September 26- October 14, the hospital advisory team reviewed the CHNA and developed the SLSL Implementation Strategy. The timeframe included in the Implementation Strategy are 2013-2015 (Years 1-3). The CHNA and Implementation Strategy were submitted for approval to the SLSL Board of Directors at the November 25, 2013 board meeting, and it was approved at the December 13, 2013 meeting. The CHNA and Implementation Strategy will be made widely available to the public on the St. Luke's Health System and St. Luke's Sugar Land Hospital websites.

Implementation Strategy

Introduction

As an integral part of St. Luke's Health System, St. Luke's Sugar Land Hospital's (SLSL) mission is to contribute to enhancing community health by delivering superior value in high-quality, cost-effective acute care since 2008. SLSL, a 84-bed facility located in Sugar Land, Texas, offers clinical and diagnostic services, including cardiovascular and heart, surgical, orthopedics, women's, sleep, neurology, and neurosurgical services. In collaboration with the medical staff, we are dedicated to excellence and compassion in caring for the whole person—body, mind and spirit. Located in Fort Bend County, the hospital service area contains both a large urban complex, as well as smaller rural communities, and is home to nearly 600,000 residents. This county is one of the fastest growing in the United States, with an annual growth rate twice that of the state of Texas. We also are committed to the growth and development of our care providers and employees, and to securing the health of future generations by creating, applying and disseminating health knowledge through education and research.

Through our commitment to deliver faith-based, compassionate, quality and cost-effective care, SLSL shall be the provider of choice in the Greater Fort Bend community. SLSL adopts the five core values of the St. Luke's Health System, which are central to everything we do:

- *Integrity*—being honest is the basis for our actions
- *Valuing People*—taking care of people, including patients, employees and medical staff—is the reason we exist
- *Goal Orientation*—focusing on what we want to achieve helps us design the best way to realize our vision
- *Excellence*—striving to enhance high quality is our constant pursuit
- *Stewardship*—enhancing our stewardship through transparency, fiscal discipline, accountability, efficient management and maximization of resources throughout our Health System to best meet the needs of the community.

In fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code, a Community Health Needs Assessment (CHNA) was conducted collaboratively with the

SLSL hospital advisory team, Episcopal Health Charities, and other partners between April 22-August 29, 2013; the Implementation Strategy was developed by the SLSL hospital advisory team from September 26- October 14, 2013. The CHNA and Implementation Strategy was submitted for approval to the SLSL Board of Directors and approved at the board meeting on December 13, 2013. The timeframe included in the Implementation Strategy are 2013-2015 (Years 1-3).

SLSL is a hospital facility that conducted a CHNA and adopted an Implementation Strategy in 2013 (Year 1). From 2014-2015 (Years 2-3), SLSL will implement at strategies to meet the health needs identified through that CHNA. SLSL will address each of the priority health needs by the last day of 2015 (Year 3). The CHNA and Implementation Strategy will be made widely available to the public on the St. Luke's Health System and St. Luke's Sugar Land Hospital websites.

Overview of the Community Served by SLSL

The community served by SLSL is described by the geographic area of SLSL and the contiguous zip codes determined by 2012 SLSL hospital discharge data. Located in Fort Bend County, the hospital service area contains both a large urban complex, as well as smaller rural communities. The Primary Service Area (PSA) is based on 75% of discharges and the Secondary Service Area (SSA) reflects an additional 5%; therefore, the overall service area used for this report is defined by the residential location for 80% of the hospital discharges in 2012. The remaining 20% are outside of the areas considered for this report. SLSL service area zip codes and service area map are included in Appendix 1.

SLSL serves an area that is home to a population of over 600,000 residents that represent many diverse ethnicities, backgrounds, and needs. Key descriptors of the community served by SLSL include:

- ***Age***- One-fourth (23.3%) of those living in the SLSL community are between 35-44 years old. Nearly one-fifth (22.5%) are between 25-34 years old and another fifth (17.7%) are between 45-54 years old. The 65 and over category was the fourth largest group (13.4%), followed closely by 18-24 year olds (12.0%) and those aged 55-64 made up nearly one-tenth of the SLSL community (11.2%).

- ***Race/Ethnicity*** – The majority of the SLSL community identify as Hispanic (39.1%). The SLSL community identifies as 25.7% White/ non-Hispanic, 23.5% Black/ non-Hispanic, 9.6% Asian/ non-Hispanic, and 2.1% Other/non-Hispanic.
- ***Nationality***- One half (52.7%) of the SLSL community were born in the United States.
- ***Health Insurance and Access to Care***- According to the 2013 National County Health Rankings, the uninsured rate in Fort Bend is 20%, Brazoria County is 21% and Harris County is 30%.

Development of the Implementation Strategy

The CHNA was conducted collaboratively with the SLSL hospital advisory team, Episcopal Health Charities, and other partners between April 22 and September 26, 2013; the Implementation Strategy was developed by the SLSL hospital advisory team from September 26- October 14, 2013. The SLSL hospital advisory team consists of the Chief Financial Officer, Chief Nursing Officer, Director of Business Development, and Manager of Volunteer Services and Community Relations. Appendix 3 lists the names, titles, and roles of all involved in the CHNA and Implementation Strategy.

Overview of the Identification and Prioritization of Community Health Needs

As a component of the CHNA, community health needs were identified through an analysis of four major data sources: SLSL Hospital Advisory Team, SLSL Community Focus Group Discussion, Public Health Experts Focus Group Discussion and Health of Houston Survey Data for the SLSL community. This process involved a detailed review of the key priorities identified in each separate data source and the determination of the most important health priorities. Key criteria for identifying priorities were: 1) importance of the problem for the community, 2) impact of the problem on vulnerable populations and 3) lack of existing resources to address the problem. Health status and social determinants of health were incorporated into the analysis of the areas of needs, challenges, and barriers. The community health needs were designated by source and the data was compared and cross-validated with the analysis of secondary data (See Table 4). The identified community health needs were then prioritized

through a triangulation process that looked at the priorities identified in each of the three sources of data separately, and compared and contrasted across sources (See Figure 7).

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

1. Access to care – There is a shortage of primary care physicians, limited access to specialty services, and lack of transportation.
2. Chronic disease- Screening, diagnosis and education on chronic disease was seen as a priority need. Chronic diseases such as sickle cell, cardiovascular disease, and diabetes were concerns from the both hospital and community stakeholders.
3. Communication about community resources – There is lack of communication and awareness about local health services and community resources.
4. Mental Health – This priority includes not only availability of mental health services, but also the need to provide mental health evaluation and inpatient care.

Action Plan to Address Priority Community Health Needs

From September 26 to October 14, 2013 the SLSL hospital advisory team discussed the health needs as prioritized by the community in the CHNA and identified strategies to address those needs. The hospital advisory team carefully reviewed the CHNA and made recommendations based on data from the SLSL hospital advisory team notes, SLSL community stakeholder summary report, public health experts summary report, and the local public health data. The hospital advisory team also discussed the activities and the programs that SLSL is already doing to address the priority community health needs.

As a result of extensive analysis and discussion of both quantitative and qualitative data, the priority health needs identified in St. Luke's Sugar Land Hospital Community Health Needs Assessment will be addressed through the following strategies for FY 2013-2015:

Access to Care – SLSL will develop, maintain or implement the following strategies to address access to care:

1. Fort Bend County does not offer public transportation and the City of Houston's public transportation system does not come to Fort Bend County. The lack of public transportation serving Fort Bend County creates challenges for residents living in the SLSL defined community to access the hospital or physicians. SLSL will work with private transportation companies to assure patients receive transportation needed for medical care.
2. Utilized the Sugar Land Doctor Group primary care physicians to treat the uninsured or underinsured.
3. Continue to recruit specialty physicians to medical staff to help ease the limited access patients have to specialty care.

Chronic Disease- SLSL will implement the following strategies to provide education and promote better health in the community:

1. SLSL will continue to provide health education to the community. Through relationships with Exchange Club of Fort Bend County, Sugar Land Senior Center, Civic Clubs, area churches, schools and other organizations, SLSL will provide health related lectures to community organizations-bringing healthcare to the community.
2. SLSL will host a lecture series at the hospital to educate and raise awareness of chronic disease to the community. Topics will include, but not limited to, diabetes, heart disease, colon cancer, the importance of mammograms and nutrition.
3. SLSL will continue to educate the community regarding chronic diseases through the four-page editorial pull-out the hospital has in Living Magazine. Each month the hospital highlights three or four health related topics as well as tips for healthier lifestyles.

Communication of Community Resources – To address the lack of communication and awareness about local health services and community resources, SLSL with implement the following strategies to address this issue:

1. SLSL will increase awareness of hospital sponsored events on the website, social media and paid advertisement.
2. SLSL will develop a resource center for the public to be able to access health related information.

Mental Health Services – SLSL will develop, maintain or implement the following strategies to address mental health issues:

1. Currently, SLSL has an agreement with West Oaks Hospital to provide psychological needs assessments to patients in the emergency department and hospital inpatients utilizing their multidisciplinary assessment team (MAT). After the assessment is performed and further treatment is deemed necessary, West Oaks Hospital assists SLSL in locating available community resources for the patient, and if necessary, arranges for appropriate transfer for the patient.
2. SLSL will explore partnering with Texana Center. Texana Center is a 501(c)3 public, not for profit, organization that provides behavioral healthcare and developmental disabilities services to residents of a six county area. SLSL with utilize their resources to provide education to hospital staff on identifying mental illness in patients. Texana is opening an inpatient psychiatric hospital which will help ease the placement of patients presenting to the ER with a mental health crisis needing inpatient care.

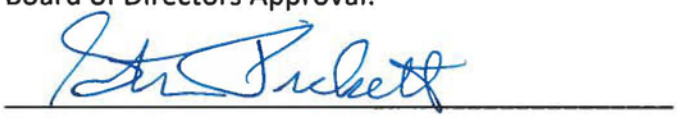
Community Health Needs Not Being Addressed

All four of the priority health needs identified in the CHNA are being addressed. There is no limit to the number of issues to which a healthcare institution could devote resources. Time, people, and money often are limiting factors for why we cannot do more. However, prevailing wisdom suggests an organization like SLSL must focus on a high priority projects as identified in the CHNA. SLSL will also make every effort to avoid duplication and encourage collaboration and coordination with other organizations and community groups. As SLSL assessed unmet health needs and determined its priorities, we also evaluated those issues that are being addressed by others.

Approval

The St. Luke's Sugar Land Hospital Board of Directors approves the Implementation Strategy for the priorities identified in the Community Health Needs Assessment. This report was prepared for the November 25, 2013 Board of Directors meeting.

Board of Directors Approval:



By Name

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Title

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Date

References

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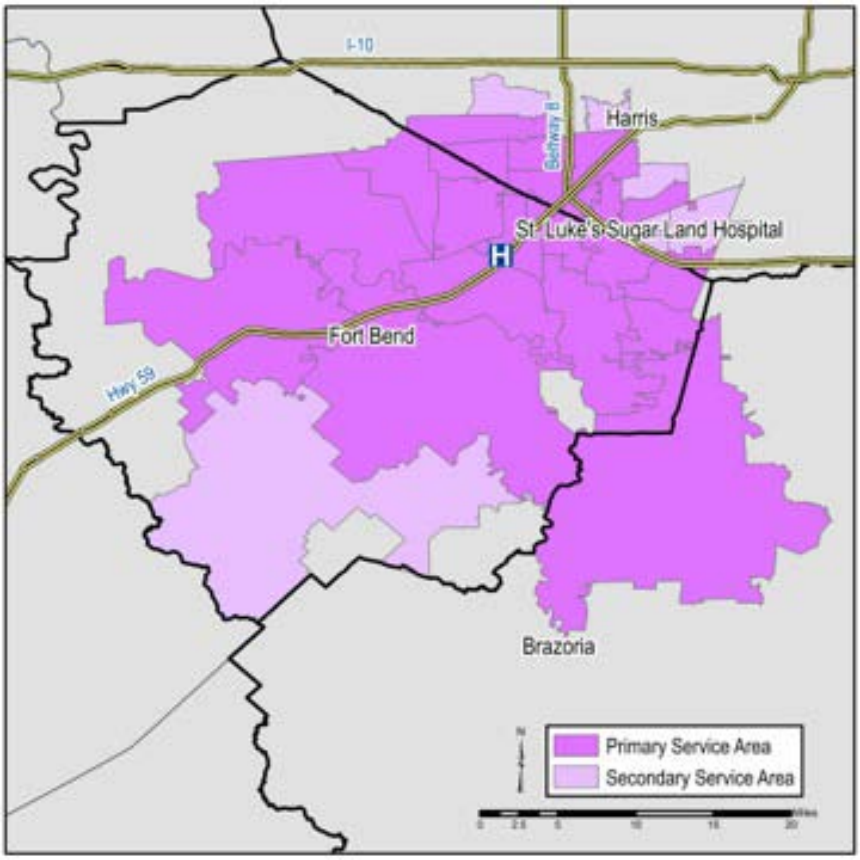
St. Luke's Sugar Land Hospital 2012 Hospital Discharge Data. Obtained by request from St. Luke's Health System.

Appendix 1 Primary and Secondary Service Area Map and Zip Codes

The community served by the SLSL consists of adjacent zip codes determined by 2012 hospital discharge data provided by the St. Luke Health System. The Primary Service Area is based on 75% of discharges and the Secondary Service Area reflects an additional 5% of discharges. The service area used for this report is defined by the location for 80% of the hospital discharges in 2012. The Primary Service Area for SLSL includes the following zip codes: 77031, 77035, 77036, 77053, 77071, 77072, 77074, 77082, 77083, 77099, 77406, 77407, 77459, 77469, 77471, 77477, 77478, 77479, 77489, 77498, 77545, and 77583. The Secondary Service Area for SLSL includes the following zip codes: 77045, 77063, 77077, 77085, 77096, and 77461. The map below displays the SLSL community.



Appendix 2 Demographics of Community served by SLSL

Table 1 Demographics of Adults[1] in the SLSL Community and Harris County[2] by Poverty[3,4]

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Gender														
Male	68,161	40.1%	65,737	57.5%	111,882	60.0%	52.2%	367,659	40.3%	305,793	48.1%	760,732	56.4%	49.5%
Female	101,658	59.9%	48,643	42.5%	74,718	40.0%	47.8%	544,693	59.7%	330,188	51.9%	587,921	43.6%	50.5%
Race/Ethnicity														
White non-Hispanic	16,030	9.4%	29,889	26.1%	75,153	40.3%	25.7%	137,238	15.0%	189,524	29.8%	763,965	56.6%	37.7%
Black non-Hispanic	32,822	19.3%	26,705	23.3%	51,201	27.4%	23.5%	194,338	21.3%	106,240	16.7%	202,923	15.0%	17.4%
Hispanic	104,895	61.8%	42,721	37.3%	36,530	19.6%	39.1%	530,282	58.1%	270,681	42.6%	264,850	19.6%	36.8%
Asian non-Hispanic	12,034	7.1%	11,832	10.3%	21,314	11.4%	9.6%	31,031	3.4%	34,147	5.4%	77,551	5.8%	4.9%
Other non-Hispanic	4,039	2.4%	3,234	2.8%	2,402	1.3%	2.1%	19,371	2.1%	35,389	5.6%	39,364	2.9%	3.2%
Age														
18-24	23,033	13.6%	16,727	14.6%	16,648	8.9%	12.0%	157,140	17.2%	98,544	15.5%	118,090	8.8%	12.9%
25-34	48,793	28.7%	16,889	14.8%	40,208	21.5%	22.5%	195,353	21.4%	123,300	19.4%	298,788	22.2%	21.3%
35-44	40,862	24.1%	31,100	27.2%	37,625	20.2%	23.3%	219,757	24.1%	139,050	21.9%	271,655	20.1%	21.8%
45-54	19,360	11.4%	20,603	18.0%	43,290	23.2%	17.7%	148,245	16.3%	128,637	20.2%	302,610	22.4%	20.0%
55-64	17,477	10.3%	12,671	11.1%	22,532	12.1%	11.2%	105,652	11.6%	78,490	12.3%	204,189	15.1%	13.4%
65 or older	20,295	12.0%	16,391	14.3%	26,297	14.1%	13.4%	86,114	9.4%	67,960	10.7%	153,321	11.4%	10.6%
Marital Status														
Married	70,579	41.6%	70,507	61.6%	107,696	57.7%	52.8%	408,851	44.8%	344,985	54.2%	850,517	63.1%	55.4%
Living with Partner	15,613	9.2%	4,621	4.0%	12,446	6.7%	6.9%	95,139	10.4%	35,490	5.6%	84,519	6.3%	7.4%

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Divorced	15,266	9.0%	7,657	6.7%	18,431	9.9%	8.8%	65,712	7.2%	57,653	9.1%	119,582	8.9%	8.4%
Widowed	4,718	2.8%	6,899	6.0%	7,786	4.2%	4.1%	47,409	5.2%	41,866	6.6%	41,472	3.1%	4.5%
Separated	13,230	7.8%	2,688	2.4%	9,035	4.8%	5.3%	58,492	6.4%	18,203	2.9%	21,641	1.6%	3.4%
Never Married	50,415	29.7%	22,009	19.2%	31,207	16.7%	22.0%	236,658	25.9%	137,784	21.7%	230,922	17.1%	20.9%
Education														
No Formal Education	4,315	2.5%	786	0.7%	398	0.2%	1.2%	13,474	1.5%	3,324	0.5%	398	<0.1%	0.6%
Grades- 1-8 (Elementary)	37,701	22.2%	10,085	8.8%	2,270	1.2%	10.6%	173,163	19.0%	48,352	7.6%	23,232	1.7%	8.4%
Grades 9-11 (Some high School)	32,293	19.0%	11,913	10.4%	11,736	6.3%	11.9%	204,256	22.4%	90,864	14.3%	55,382	4.1%	12.1%
Grades 12 or GED (HS Grad)	50,536	29.8%	31,751	27.8%	44,346	23.8%	26.9%	296,520	32.5%	204,941	32.2%	315,585	23.4%	28.2%
College 1-3 years (Some College)	32,381	19.1%	33,912	29.6%	55,986	30.0%	26.0%	168,179	18.4%	186,031	29.3%	473,011	35.1%	28.6%
College ≥4 years (College Grad.)	9,195	5.4%	18,335	16.0%	41,786	22.4%	14.7%	38,026	4.2%	68,687	10.8%	264,095	19.6%	12.8%
Post Bachelor (Master, Doctorate)	3,397	2.0%	7,590	6.6%	30,079	16.1%	8.7%	18,643	2.0%	33,782	5.3%	216,951	16.1%	9.3%
Country of Birth														
US or Territories	64,464	38.0%	56,551	49.4%	127,159	68.1%	52.7%	451,546	49.5%	391,809	61.6%	1,082,435	80.3%	66.5%
Mexico	47,443	27.9%	23,686	20.7%	7,616	4.1%	16.7%	302,882	33.2%	142,338	22.4%	70,796	5.2%	17.8%
Vietnam	3,996	2.4%	4,803	4.2%	6,012	3.2%	3.1%	12,125	1.3%	15,585	2.5%	25,148	1.9%	1.8%
China / Taiwan / Hong Kong	793	0.5%	1,747	1.5%	4,579	2.5%	1.5%	4,078	0.4%	3,122	0.5%	9,166	0.7%	0.6%
El Salvador	19,982	11.8%	4,045	3.5%	10,516	5.6%	7.3%	47,461	5.2%	14,281	2.2%	14,106	1.0%	2.6%

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Other	31,209	18.4%	21,766	19.0%	28,481	15.3%	17.3%	85,196	9.3%	58,178	9.1%	130,586	9.7%	9.5%
Dk/Ref	1,932	1.1%	1,783	1.6%	2,238	1.2%	1.3%	8,973	1.0%	10,668	1.7%	16,416	1.2%	1.2%
Language Spoken at Home														
English only	58,198	34.3%	53,334	46.6%	121,780	65.3%	49.6%	401,709	44.0%	331,837	52.2%	987,248	73.2%	59.4%
Spanish only	55,799	32.9%	12,765	11.2%	9,072	4.9%	16.5%	274,454	30.1%	99,634	15.7%	52,835	3.9%	14.7%
Vietnamese only	3,310	1.9%	2,690	2.4%	2,603	1.4%	1.8%	9,900	1.1%	7,868	1.2%	16,186	1.2%	1.2%
Chinese only	612	0.4%	564	0.5%	3,337	1.8%	1.0%	2,964	0.3%	4,355	0.7%	5,406	0.4%	0.4%
Other or multiple languages	48,649	28.6%	43,365	37.9%	48,762	26.1%	29.9%	212,241	23.3%	185,894	29.2%	277,570	20.6%	23.3%
DK/Refused	3,250	1.9%	1,662	1.5%	1,046	0.6%	1.3%	10,993	1.2%	6,393	1.0%	9,407	0.7%	0.9%
US Citizen[5]														
Yes	30,830	29.8%	22,367	39.9%	33,414	58.4%	40.0%	117,318	26.0%	94,271	40.4%	140,444	56.2%	37.6%
No	60,651	58.6%	23,577	42.1%	17,300	30.2%	46.9%	299,029	66.2%	120,806	51.7%	71,176	28.5%	52.5%
Application Pending	3,671	3.5%	627	1.1%	441	0.8%	2.2%	8,045	1.8%	1,127	0.5%	5,859	2.3%	1.6%
Don't Know	0	0.0%	2,458	4.4%	651	1.1%	1.4%	1,281	0.3%	3,464	1.5%	651	0.3%	0.6%
Refused	8,271	8.0%	7,019	12.5%	5,397	9.4%	9.5%	26,070	5.8%	13,836	5.9%	31,671	12.7%	7.7%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Not Insured" who are Male in the SLSL community, we first look at the column "Not Insured" under SLSL community and then go down to the row "Male" under Gender. Here we find that of those "Not Insured" in the SLSL community, 40.1% are Male.

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

Table 2 Demographics of Adults[1] in the St. Luke's Sugar Land Hospital Community and Harris County[2] by Health Insurance Coverage[3,4]

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Gender														
Male	87,040	48.8%	102,026	53.6%	56,715	55.6%	52.2%	409,704	46.1%	755,123	51.9%	269,266	48.8%	49.5%
Female	91,391	51.2%	88,325	46.4%	45,303	44.4%	47.8%	479,238	53.9%	700,678	48.1%	282,885	51.2%	50.5%
Race/Ethnicity														
White non-Hispanic	19,448	10.9%	58,103	30.5%	43,522	42.7%	25.7%	125,792	14.2%	734,715	50.5%	230,220	41.7%	37.7%
Black non-Hispanic	29,026	16.3%	57,445	30.2%	24,256	23.8%	23.5%	124,923	14.1%	235,326	16.2%	143,253	25.9%	17.4%
Hispanic	113,555	63.6%	49,504	26.0%	21,086	20.7%	39.1%	576,396	64.8%	346,417	23.8%	143,001	25.9%	36.8%
Asian non-Hispanic	14,209	8.0%	21,383	11.2%	9,588	9.4%	9.6%	36,265	4.1%	87,120	6.0%	19,343	3.5%	4.9%
Other non-Hispanic	2,194	1.2%	3,915	2.1%	3,566	3.5%	2.1%	25,566	2.9%	52,224	3.6%	16,334	3.0%	3.2%
Age														
18-24	22,515	12.6%	21,519	11.3%	12,374	12.1%	12.0%	148,069	16.7%	146,425	10.1%	79,280	14.4%	12.9%
25-34	60,053	33.7%	38,984	20.5%	6,853	6.7%	22.5%	251,659	28.3%	331,842	22.8%	33,940	6.1%	21.3%
35-44	54,220	30.4%	43,161	22.7%	12,205	12.0%	23.3%	247,050	27.8%	334,849	23.0%	48,563	8.8%	21.8%
45-54	23,683	13.3%	54,086	28.4%	5,484	5.4%	17.7%	154,334	17.4%	378,158	26.0%	47,001	8.5%	20.0%
55-64	16,587	9.3%	27,374	14.4%	8,719	8.5%	11.2%	84,014	9.5%	243,424	16.7%	60,894	11.0%	13.4%
65 or older	1,373	0.8%	5,226	2.7%	56,384	55.3%	13.4%	3,817	0.4%	21,103	1.4%	282,474	51.2%	10.6%
Marital Status														
Married	90,206	50.6%	116,541	61.2%	42,035	41.2%	52.8%	446,703	50.3%	938,312	64.5%	219,338	39.7%	55.4%
Living with Partner	23,667	13.3%	5,058	2.7%	3,954	3.9%	6.9%	112,534	12.7%	76,100	5.2%	26,514	4.8%	7.4%
Divorced	16,580	9.3%	13,547	7.1%	11,227	11.0%	8.8%	63,063	7.1%	116,231	8.0%	63,653	11.5%	8.4%

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Widowed	1,861	1.0%	1,992	1.0%	15,549	15.2%	4.1%	15,098	1.7%	22,345	1.5%	93,304	16.9%	4.5%
Separated	9,040	5.1%	13,951	7.3%	1,962	1.95	5.3%	40,013	4.5%	37,078	2.5%	21,245	3.8%	3.4%
Never Married	37,077	20.8%	39,262	20.6%	27,291	26.8%	22.0%	211,533	23.8%	265,735	18.3%	128,096	23.2%	20.9%
Education														
No Formal Education	1,184	0.7%	0	0.0%	4,315	4.2%	1.2%	9,391	1.1%	2,523	0.2%	5,283	1.0%	0.6%
Grades- 1-8 (Elementary)	31,724	17.8%	9,360	4.9%	8,972	8.8%	10.6%	155,324	17.5%	47,446	3.3%	41,977	7.6%	8.4%
Grades 9-11 (Some high School)	32,917	18.4%	12,601	6.6%	10,424	10.2%	11.9%	180,904	20.4%	73,671	5.1%	95,927	17.4%	12.1%
Grades 12 or GED (HS Grad)	57,466	32.2%	44,590	23.4%	24,586	24.1%	26.9%	305,668	34.4%	339,485	23.3%	171,893	31.1%	28.2%
College 1-3 years (Some College)	41,499	23.3%	46,917	24.6%	33,863	33.2%	26.0%	182,240	20.5%	485,123	33.3%	159,859	29.0%	28.6%
College ≥4 years (College Grad.)	11,446	6.4%	42,821	22.5%	15,048	14.8%	14.75	40,655	4.6%	285,940	19.6%	44,213	8.0%	12.8%
Post Bachelor (Master, Doctorate)	2,195	1.2%	34,062	17.9%	4,809	4.7%	8.7%	14,762	1.7%	221,614	15.2%	33,001	6.0%	9.3%
Country of Birth														
US or Territories	55,393	31.0%	119,094	62.6%	73,687	72.2%	52.7%	367,838	41.4%	1,106,428	76.0%	451,524	81.8%	66.5%
Mexico	60,707	34.0%	15,226	8.0%	2,812	2.8%	16.7%	357,880	40.3%	114,845	7.9%	43,291	7.8%	17.8%
Vietnam	6,214	3.5%	5,080	2.7%	3,517	3.4%	3.1%	17,543	2.0%	27,700	1.9%	7,615	1.4%	1.8%
China / Taiwan / Hong Kong	1,722	1.0%	4,661	2.45	736	0.7%	1.55	2,690	0.3%	12,511	0.9%	1,164	0.2%	0.6%
El Salvador	20,297	11.4%	13,221	6.9%	1,025	1.0%	7.3%	45,529	5.1%	25,592	1.8%	4,726	0.9%	2.6%
Other	32,845	18.45	31,204	16.4%	17,407	17.1%	17.3%	90,252	10.2%	149,421	10.3%	34,289	6.2%	9.5%
Dk/Ref	1,253	0.75	1,865	1.0%	2,836	2.8%	1.3%	7,211	0.8%	19,303	1.3%	9,542	1.7%	1.2%

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Language Spoken at Home														
English only	56,022	31.4%	107,391	56.4%	69,000	68.5%	49.6%	308,040	34.7%	1,019,842	70.1%	392,912	71.2%	59.4%
Spanish only	51,462	28.8%	17,917	9.4%	8,256	8.1%	16.5%	289,688	32.6%	90,693	6.2%	46,541	8.4%	14.7%
Vietnamese only	4,229	2.4%	1,457	0.8%	2,917	2.9%	1.8%	14,359	1.6%	14,340	1.0%	5,255	1.0%	1.2%
Chinese only	1,567	0.9%	2,427	1.3%	519	0.5%	1.0%	2,582	0.3%	9,546	0.7%	597	0.1%	0.4%
Other or multiple languages	63,619	35.7	59,915	31.5%	17,242	16.9%	29.9%	265,898	29.9%	312,548	21.5%	97,259	17.6%	23.3%
DK/Refused	1,531	0.9%	1,244	0.7%	3,184	3.1%	1.3%	8,375	0.9%	8,831	0.6%	9,587	1.7%	0.9%
US Citizen[5]														
Yes	29,433	24.2%	37,894	54.6%	19,283	75.6%	40.0%	125,932	24.5%	167,396	50.7%	58,705	64.5%	37.6%
No	75,857	62.3%	23,635	34.1%	2,036	8.0%	46.9%	345,474	67.2%	119,912	36.3%	25,625	28.1%	52.5%
Application Pending	4,057	3.3%	681	1.0%	0	0.0%	2.2%	7,246	1.4%	7,785	36.3%	0	0.0%	1.6%
Don't Know	2,460	2.0%	537	0.8%	112	0.4%	1.4%	4,197	0.8%	582	0.2%	617	0.7%	0.6%
Refused	9,978	8.2%	6,645	9.6%	4,065	15.9%	9.5%	31,044	6.0%	34,395	10.4%	6,139	6.7%	7.7%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who are Male in the SLSL community, we first look at the column "In Poverty" under SLSL community and then go down to the row "Male" under Gender. Here we find that of those "In Poverty" in the SLSL community, 48.8% are Male.

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

Appendix 3 Participants Involved in the CHNA

Name	Title	Organization	Role
SLSL Hospital Advisory Team			
John Beauchamp	Chief Financial Officer	St. Luke's Sugar Land Hospital	Hospital Advisory Team
Sharon Galloway	Director, Business Development	St. Luke's Sugar Land Hospital	Hospital Advisory Team
Katina Scott	Manager of Volunteer Services and Community Relations	St. Luke's Sugar Land Hospital	Hospital Advisory Team
St. Luke's Health System Team			
Melinda Grady	Tax Director	St. Luke's Health System	General Oversight
David Gruener	Senior Vice President, Chief Finance Officer	St. Luke's Health System	General Oversight
Kenneth Zieren	Administrative Director of Compliance	St. Luke's Health System	General Oversight
Episcopal Health Charities Team			
Tamara Brickham Bourda, MPH	Manager, Special Programs	Episcopal Health Charities	Overall CHNA Project Management
Patricia Gail Bray, PhD	Executive Director	Episcopal Health Charities	Technical Assistance
Jeanne Hanks, DrPh	Assistant Director of Operations	Episcopal Health Charities	Technical Assistance
Maria Fernandez-Esquer, PhD	Associate Professor	University of Texas School of Public Health	CHNA Project Management
Pamela M. Diamond, PhD	Associate Professor	University of Texas School of Public Health	CHNA Project Management
John Atkinson, DrPH	Faculty Associate	University of Texas School of Public Health	Quantitative Data Analysis
Andria Rusk, MScGH	Graduate Assistant	University of Texas School of Public Health	Qualitative Data Analysis
Erica Cantu, MPH	Graduate Assistant	University of Texas School of Public Health	Quantitative Data Analysis
Lynn Elgin	Community Engagement Manager	Clarus Consulting Group	Community Engagement Coordination
Taylor Cooper	Community Engagement Associate	Clarus Consulting Group	Community Engagement Coordination
Community Stakeholders and Public Health Experts			
Naeem Ahmed	Executive Officer	Ibn Sina Foundation	Community Stakeholder
Aijaz Ali Khowaja	CEO	Ibn Sina Foundation, Inc.	Community Stakeholder
Brian Byrne	Administrator	Greatwood at Sugar Land/Aide in Aid	Community Stakeholder
Christine Clinton	Health Promotions Coordinator	Cigna/Fort Bend ISD	Community Stakeholder
Carol V. Edwards	CEO	AccessHealth	Community Stakeholder
Francis Lerma, RN	Former Chief Nursing Officer		Community Stakeholder

Kimberly Hinojosa	Community Relations Director	Colonial Oaks Assisted Living and Memory Care	Community Stakeholder
Shena Timberlake	Director of Behavior Healthcare Services	Texana Center	Community Stakeholder
Tacanesha Turner	Health Promotion Manager	Cigna Healthcare (Fort Bend/St. Luke's SugarLand)	Community Stakeholder
Deborah Nicole Volek	Physical therapy assitant, clinical instructor	Shape Up Fort Bend founder, Home Health Resources agency PTA, Fort Bend Seniors board member, Texas Physical Therapy Association	Community Stakeholder
Denise Williams	Publisher	Community Magazines LLC	Community Stakeholder
Latrice Babin, PhD	Environmental Toxicologist	Harris County Pollution Control Services Department	Public Health Expert
June Hanke	Strategic Analyst/Planner	Harris Health System	Public Health Expert
Dr. Nicole Hare-Everline, CHES	City of Houston Wellness/EAP Director	City of Houston	Public Health Expert
Robert Hines	Epidemiologist	Houston Department of Health and Human Services	Public Health Expert
Haley Jackson, MPH	Public Health Team Lead	Texas Department of State Health Services	Public Health Expert
Lisa Mayes	Executive Director	Harris County Healthcare Alliance	Public Health Expert
Bakeyah Nelson, PhD	Public Health Analyst	Harris County Public Health and Environmental Services	Public Health Expert
Beverly Nichols PsyD, MS, RN	Senior Staff Analyst	Houston Department of Health and Human Services	Public Health Expert
Kimberly Nicholson	Program Specialist II	Texas Department of State Health Services	Public Health Expert
Ebun Odeneye	Senior Health Educator	City of Houston	Public Health Expert
Yan Shi	Management Analyst III	Houston Department of Health and Human Services	Public Health Expert
Lindsey Wiginton	Epidemiologist	Houston Department of Health and Human Services	Public Health Expert

Appendix 4 2012 SLSL discharges by ICD-9 Code

Data on all hospital discharges for 2012 were provided by the St. Luke's Health System. Data were available for SLSL and was aggregated by the 5 digit ICD-9 diagnosis code and broken down by inpatient and outpatient discharges. No demographic or personally identifying information was provided; therefore, the below information represents the types of health problems experienced by people who made use of the SLSL during 2012. In order to summarize the data more effectively, the ICD-9 codes were further aggregated into more relevant and less clinically specific categories.

Table 1 St. Luke's Sugar Land Hospital, 2012 Hospital Discharges by ICD-9 Code[1]

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
1. Infectious and Parasitic Diseases 001–139	**185**	**7.1%**	**393**	**2.4%**	**578**	**3.1%**
2. Neoplasms 140–239	**51**	**2.0%**	**33**	**0.2%**	**84**	**0.4%**
3. Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders 240–279	**197**	**7.5%**	**284**	**1.7%**	**481**	**2.5%**
4. Diseases of the Blood and Blood-Forming Organs 280–289	**90**	**3.4%**	**166**	**1.0%**	**256**	**1.4%**
5. Mental Disorders 290–319	**22**	**0.8%**	**317**	**1.9%**	**339**	**1.8%**
• ***290-294 organic psychotic conditions***	12	54.5%	11	3.5%	23	6.8%
• ***295-299 other psychoses***	3	13.6%	73	23.0%	76	22.4%
• ***300-316 neurotic disorders, personality disorders, and other nonpsychotic mental disorders***	7	31.8%	231	72.9%	238	70.2%
• ***317-319 intellectual disabilities***	0	0.0%	2	0.6%	2	0.6%
6. Diseases of the Nervous System and Sense Organs 320–389	**63**	**2.4%**	**733**	**4.5%**	**796**	**4.2%**
7. Diseases of the Circulatory System 390–459	**482**	**18.5%**	**467**	**2.9%**	**949**	**5.0%**
• ***390-392 acute rheumatic fever***	0	0.0%	0	0.0%	0	0.0%
• ***393-398 chronic rheumatic heart disease***	0	0.0%	0	0.0%	0	0.0%
• ***401-405 hypertensive disease***	41	8.5%	157	33.6%	198	20.9%
• ***410-414 ischemic heart disease***	112	23.2%	30	6.4%	142	15.0%
• ***415-417 diseases of pulmonary circulation***	32	6.6%	2	0.4%	34	3.6%
• ***420-429 other forms of heart disease***	177	36.7%	129	27.6%	306	32.2%
• ***430-438 cerebrovascular disease***	62	12.9%	73	15.6%	135	14.2%
• ***440-449 diseases of arteries, arterioles, and capillaries***	10	2.15	7	1.5%	17	1.8%

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
• *451-459 diseases of veins and lymphatics, and other diseases of circulatory system*	48	10.0%	69	14.8%	117	12.3%
8. Diseases of the Respiratory System 460-519	**346**	**13.3%**	**2051**	**12.6%**	**2397**	**12.7%**
• *460-466 acute respiratory infections*	8	2.3%	1279	62.4%	1287	53.7%
• *470-478 other diseases of upper respiratory tract*	2	0.6%	31	1.5%	33	1.4%
• *480-488 pneumonia and influenza*	143	41.3%	410	20.0%	553	23.1%
• *490-496 chronic obstructive pulmonary disease and allied conditions*	128	37.0%	288	14.0%	416	17.45
• *500-508 pneumoconioses and other lung diseases due to external agents*	8	2.3%	3	0.1%	11	0.5%
• *510-519 other diseases of respiratory system*	57	16.5%	40	2.0%	97	4.0%
9. Diseases of the Digestive System 520-579	**480**	**18.4%**	**656**	**4.0%**	**1136**	**6.0%**
• *520-529 diseases of oral cavity, salivary glands, and jaws*	5	1.0%	145	22.1%	1150	13.2%
• *530-539 diseases of esophagus, stomach, and duodenum*	63	13.1%	109	16.6%	172	15.1%
• *540-543 appendicitis*	41	8.5%	21	3.2%	62	5.5%
• *550-553 hernia of abdominal cavity*	17	3.5%	12	1.8%	29	2.6%
• *555-558 noninfective enteritis and colitis*	49	10.2%	112	17.1%	161	14.2%
• *560-569 other diseases of intestines and peritoneum*	115	24.0%	158	24.1%	273	24.0%
• *570-579 other diseases of digestive system*	190	39.6%	99	15.1%	289	25.4%
10. Diseases of the Genitourinary System 580-629	**217**	**8.3%**	**866**	**5.3%**	**1083**	**5.7%**
• *580-589 nephritis, nephrotic syndrome, and nephrosis*	83	38.2%	17	2.0%	100	9.2%
• *590-599 other diseases of urinary system*	107	49.3%	580	67.0%	687	63.4%
• *600-608 diseases of male genital organs*	8	3.7%	51	5.9%	59	5.4%
• *610-612 disorders of breast*	2	0.9%	25	2.9%	27	2.5%
• *614-616 inflammatory disease of female pelvic organs*	4	1.8%	64	7.4%	68	6.3%
• *617-629 other disorders of female genital tract*	13	6.0%	129	14.9%	142	13.1%
11. Complications of Pregnancy, Childbirth, and the Puerperium 630–677	**19**	**0.7%**	**354**	**2.2%**	**373**	**2.0%**
12. Diseases of the Skin and Subcutaneous Tissue 680–709	**93**	**3.6%**	**584**	**3.6%**	**677**	**3.6%**
13. Diseases of the Musculoskeletal System and Connective Tissue 710-739	**73**	**2.8%**	**1239**	**7.6%**	**1312**	**6.9%**
• *710-719 arthopathies and related disorders*	16	21.9%	249	20.1%	265	20.2%
• *720-724 dorsopathies*	23	31.5%	672	54.2%	695	53.0%
• *725-729 rheumatism, excluding the back*	26	35.6%	298	24.1%	324	24.7%
• *730-739 osteopahies, chondropathies, and acquired musculoskeletal deformities*	8	11.0%	20	1.6%	28	2.1%
14. Congenital Anomalies 740-759	**2**	**0.1%**	**3**	**< .01%**	**5**	**< .01%**

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
15. Certain Conditions Originating in the Perinatal Period 760–779	**0**	**0.0%**	**10**	**.01%**	**10**	**.01%**
16. Symptoms, Signs, and Ill-Defined Conditions 780-799	**117**	**4.5%**	**4379**	**26.9%**	**4496**	**23.8%**
• ***780-789 symptoms***	110	94.0%	4352	99.4%	4462	99.2%
• ***790-796 nonspecific abnormal findings***	6	5.1%	23	0.5%	29	0.6%
• ***797-799 ill-defined and unknown causes of morbidity and mortality***	1	0.9%	4	0.1%	5	0.1%
17. Injury and Poisoning 800-899	**172**	**6.6%**	**3482**	**21.4%**	**3654**	**19.4%**
• ***800-804 fracture of skull***	2	1.2%	35	1.0%	37	1.0%
• ***805-809 fracture of spine and trunk***	14	8.1%	39	1.1%	53	1.5%
• ***810-819 fracture of upper limb***	3	1.75	256	7.4%	259	7.1%
• ***820-829 fracture of lower limb***	36	20.9%	134	3.8%	170	4.7%
• ***830-839 dislocation***	0	0.0%	78	2.2%	78	2.1%
• ***840-848 sprains and strains of joints and adjacent muscles***	0	0.0%	829	23.8%	829	22.7%
• ***850-854 intracranial injury, excluding those with skull fracture***	4	2.3%	117	3.4%	121	3.3%
• ***860-869 internal injury of chest, abdomen, and pelvis***	1	0.6%	5	0.1%	6	0.2%
• ***870-879 open wound of head, neck, and trunk***	0	0.0%	290	8.3%	290	7.9%
• ***880-887 open wound of upper limb***	4	2.3%	209	6.0%	213	5.8%
• ***890-897 open wound of lower limb***	0	0.0%	90	2.6%	90	2.5%
• ***900-904 injury to blood vessels***	0	0.0%	0	0.0%	0	0.0%
• ***905-909 late effects of injuries, poisonings, toxic effects, and other external causes***	0	0.0%	0	0.0%	0	0.0%
• ***910-919 superficial injury***	1	0.6%	201	5.8%	202	5.5%
• ***920-924 contusion with intact skin surface***	1	0.6%	409	11.7%	410	11.2%
• ***925-929 crushing injury***	0	0.0%	7	0.2%	7	0.2%
• ***930-939 effects of foreign body entering through orifice***	1	0.6%	56	1.6%	57	1.6%
• ***940-949 burns***	1	0.6%	40	1.1%	41	1.1%
• ***950-957 injury to nerves and spinal cord***	0	0.0%	0	0.0%	0.0	0.0%
• ***958-959 certain traumatic complications and unspecified injuries***	2	1.2%	337	9.7%	339	9.3%
• ***960-979 poisoning by drugs, medicinals and biological substances***	33	19.2%	61	1.8%	94	2.6%
• ***980-989 toxic effects of substances chiefly nonmedical as to source***	2	1.2%	33	0.9%	35	1.0%
• ***990-995 other and unspecified effects of external causes***	2	1.2%	204	5.9%	206	5.6%
• ***996-999 complications of surgical and medical care, not elsewhere classified***	65	37.8%	52	1.5%	117	3.2%
18. Sickle-cell Disease 282.60-282.69	**37**	**1.4%**	**78**	**0.5%**	**115**	**0.7%**
• ***282.60 sickle-cell disease unspecified***	0	0.0%	0	0.0%	0	0.0%
1. 282.61 Hb-SS disease without crisis	0	0.0%	0	0.0%	0	0.0%
2. 282.62 Hb-SS disease with crisis	31	83.8%	76	97.4%	107	93.0%
3. 282.63 Sickle-cell/Hb-C disease without crisis	0	0.0%	0	0.0%	0	0.0%

Diagnostic Group (ICD-9)	Inpatient		Outpatient		Total	
	N	%	*N*	%	*N*	%
4. 282.64 Sickle-cell/Hb-C disease with crisis	0	0.0%	0	0.0%	0	0.0%
5. 282.68 other sickle-cell disease without crisis	0	0.0%	0	0.0%	0	0.0%
6. 282.69 other sickle-cell disease with crisis	6	16.2%	2	2.6%	8	7.0%
V Codes Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01-V83)	**2**	**0.1**	**211**	**1.3**	**213**	**1.1**
E Codes Supplementary Classification of External Causes of Injury and Poisoning (e800-e999)	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**

[1] Data are presented for inpatient, outpatient, and total discharged patients. For some categories such as #1, Infectious and Parasitic Diseases, the bolded numbers indicate the number of discharges for that diagnosis. For example, there were 185 inpatient discharges in this category which represented 7.1% of all inpatient discharges. Similarly, there were 393 outpatient discharges which accounted for2.4% of all outpatient discharges. In total, there were 578 discharges for this category, and these cases accounted for 3.1% of total discharges. For categories such as #5, Mental Disorders, the bolded numbers are to be interpreted similarly. For example, 22 inpatients were diagnosed with a mental disorder, and these represented 0.8% of inpatient discharges. The additional rows under this heading represent sub-diagnostic categories. For example, 12 of the 12 inpatient discharges were for "organic psychotic conditions." As indicated, these cases accounted for 54.5% of the inpatient discharges for a mental disorder.

Appendix 5 Health Status Indicators

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Reported Health Status														
Excellent	21,371	12.0%	27,933	14.7%	13,508	13.2%	13.3%	92,828	10.4%	232,222	16.0%	54,749	9.9%	13.1%
Very Good	53,798	30.2%	62,858	33.0%	31,445	30.8%	31.5%	227,111	25.5%	538,929	37.0%	127,486	23.1%	30.8%
Good	52,149	29.2%	62,389	32.85	32,553	31.9%	31.2%	332,533	37.4%	510,794	35.1%	188,846	34.2%	35.6%
Fair	43,140	24.2%	35,729	18.8%	16,036	15.7%	20.2%	187,845	21.1%	150,016	10.3%	126,619	22.9%	16.0%
Poor	7,973	4.5%	1,442	0.8%	8,476	8.3%	3.8%	48,627	5.5%	23,839	1.6%	54,452	9.9%	4.4%
Ever diagnosed with diabetes														
Yes	17,427	9.8%	28,868	15.2%	17,824	17.5%	13.6%	74,642	8.4%	133,888	9.2%	112,693	20.4%	11.1%
Borderline pre-diabetes	2,937	1.6%	6,559	3.4%	2,305	2.3%	2.5%	7,556	0.8%	43,812	3.0%	22,782	4.1%	2.6%
Yes, during pregnancy	299	0.2%	901	0.5%	670	0.7%	0.4%	11,162	1.3%	4,057	0.3%	2,377	0.4%	0.6%
Ever diagnosed with cancer	6,184	3.5%	10,617	5.6%	21,160	20.7%	8.1%	29,345	3.3%	53,535	3.7%	93,764	17.0%	6.1%
Ever diagnosed with high blood pressure														
Yes	37,025	20.8%	52,503	27.6%	45,311	44.4%	28.6%	179,512	20.2%	408,945	28.1%	282,139	51.1%	30.1%
Yes, but only during pregnancy	1,722	1.0%	3,472	1.8%	939	0.9%	1.3%	19,611	2.2%	21,278	1.5%	12,404	2.2%	1.8%
Ever diagnosed with coronary heart disease	2,863	1.6%	3,136	1.6%	14,876	14.6%	4.4%	14,482	1.6%	39,677	2.7%	60,742	11.0%	4.0%
Ever diagnosed with a heart attack	2,466	1.4%	3,293	1.7%	10,305	10.1%	3.4%	9,859	1.1%	31,926	2.2%	51,498	9.3%	3.2%
Ever diagnosed with a stroke	1,514	0.8%	676	0.4%	6,902	6.8%	1.9%	9,727	1.1%	23,109	1.6%	46,676	8.5%	2.7%
Ever diagnosed with asthma	12,514	7.0%	18,722	9.8%	8,058	7.9%	8.3%	48,570	5.5%	139,747	9.6%	72,353	13.1%	9.0%
Mental Health Need Last 12 Months	22,487	15.2%	24,377	15.8%	12,476	16.3%	15.7%	122,194	16.7%	182,732	15.9%	69,022	17.4%	16.4%

[1] Adults aged 18 and over

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

[3] We define "Not Insured" as not having any medical insurance; "Private Insurance" as self/employer purchased and Tricare/Champus; "Medicare / Other Public" as Medicare, Medicaid, Champ VA, VA [4] The percentages in this table are column percentages. For example, to find the percentage of those "Not Insured" who reported "Excellent" health status in the SLSL community, we first look at the column "Not Insured" under SLSL community and then go down to the row "Excellent" under Reported Health Status. Here we find that of those "Not Insured" in the SLSL community, 12% reported having "Excellent" Health Status.

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Reported Health Status														
Excellent	19,089	11.2%	15,280	13.4%	28,444	15.2%	13.3%	96,356	10.6%	98,156	15.4%	185,287	13.7%	13.1%
Very Good	30,679	18.1%	47,802	41.8%	69,620	37.3%	31.5%	175,844	19.3%	201,995	31.8%	515,687	38.2%	30.8%
Good	60,708	35.7%	29,527	25.8%	56,857	30.5%	31.2%	365,662	40.1%	208,968	32.9%	457,542	33.9%	35.6%
Fair	47,443	27.9%	17,437	15.2%	30,025	16.1%	20.2%	206,363	22.6%	103,442	16.3%	154,676	11.5%	16.0%
Poor	11,901	7.0%	4,334	3.8%	1,655	0.9%	3.8%	68,036	7.5%	23,420	3.7%	35,462	2.6%	4.4%
Ever diagnosed with diabetes														
Yes	20,647	12.2%	16,333	14.3%	27,139	14.5%	13.6%	109,639	12.0%	68,081	10.7%	143,503	106.0%	11.1%
Borderline pre-diabetes	4,267	2.5%	1,147	1.0%	6,387	3.4%	2.5%	19,061	2.1%	11,669	1.8%	43,421	3.2%	2.6%
Yes, during pregnancy	834	0.5%	135	0.1%	901	0.5%	0.4%	10,410	1.1%	3,856	0.6%	3,330	0.2%	0.6%
Ever diagnosed with cancer	16,326	9.6%	6,548	5.7%	15,087	8.1%	8.1%	62,141	6.8%	26,103	4.1%	88,401	6.6%	6.1%
Ever diagnosed with high blood pressure														
Yes	40,836	24.0%	36,663	32.1%	57,339	30.7%	28.6%	254,095	27.9%	183,761	28.9%	432,740	32.1%	30.1%
Yes, but only during pregnancy	1,234	0.7%	1,398	1.2%	3,501	1.9%	1.3%	23,578	2.6%	12,494	2.0%	17,221	1.3%	1.8%
Ever diagnosed with coronary heart disease	8,381	4.9%	3,463	3.0%	9,031	4.8%	4.4%	37,702	4.1%	17,927	2.8%	59,272	4.4%	4.0%
Ever diagnosed with a heart attack	5,112	3.0%	5,098	4.5%	5,853	3.1%	3.4%	34,116	3.7%	19,470	3.1%	39,698	2.9%	3.2%
Ever diagnosed with a stroke	3,872	2.3%	3,377	3.0%	1,843	1.0%	1.9%	36,504	4.0%	17,047	2.7%	25,961	1.9%	2.7%
Ever diagnosed with asthma	13,318	7.8%	7,711	6.7%	18,264	9.8%	8.3%	67,281	7.4%	60,641	9.5%	132,748	9.8%	9.0%
Mental Health Need Last 12 Months	26,435	18.6%	10,880	11.9%	22,026	15.25	15.7%	135,271	18.9%	58,195	11.7%	180,482	16.9%	16.4%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who reported "Excellent" health status in the SLSL community, we first look at the column "In Poverty" under SLSL community and then go down to the row "Excellent" under Reported Health Status. Here we find that of those "In Poverty" in the SLSL community, 11.2% reported having "Excellent" Health Status.

Appendix 6 Health Access Indicators

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Poverty Status[5]														
In poverty	93,113	52.2%	32,432	17.0%	44,275	43.4%	36.1%	486,272	54.7%	185,428	12.7%	240,561	43.6%	31.5%
Near poverty	47,758	26.8%	45,509	23.95	21,114	20.7%	24.3%	239,668	27.0%	275,779	18.9%	120,534	21.8%	22.0%
Not in poverty	37,561	21.1%	112,410	59.1%	36,629	35.9%	39.6%	163,003	18.3%	994,594	68.3%	191,056	34.6%	46.6%
Personal Doctor or Health Care Provider														
Yes, only one	68,221	38.25	119,374	62.7%	65,758	64.55	53.8%	302,385	34.0%	939,954	64.5%	344,226	62.3%	54.7%
More than one	8,088	4.5%	30,626	16.1%	11,891	11.7%	10.7%	72,347	8.1%	252,398	17.3%	92,395	16.7%	14.4%
No, not anyone	102,122	57.2%	40,351	21.2%	24,369	23.9%	35.4%	514,211	57.8%	264,350	18.2%	115,530	20.9%	30.9%
Type of Health Care Place														
Doctor's office	37,652	21.1%	113,587	59.7%	42,588	41.7%	41.2%	210,334	23.7%	1,021,207	70.1%	276,096	50.0%	52.0%
Clinic/health center	78,694	44.1%	54,603	28.7%	31,761	31.1%	35.1%	353,806	39.8%	274,791	18.9%	188,568	34.2%	28.2%
Emergency room	8,835	5.0%	2,946	1.5%	4,567	4.5%	3.5%	56,923	6.4%	16,183	1.1%	18,408	3.3%	3.2%
More than one place	837	0.5%	4,240	2.2%	3,913	3.8%	1.9%	1,919	0.2%	10,542	0.7%	11,939	2.2%	0.8%
No one place	38,931	21.8%	14,383	7.6%	12,641	12.4%	14.0%	220,961	24.9%	117,960	8.1%	47,117	8.5%	13.3%
Some other place	1,750	1.0%	435	0.2%	1,967	1.9%	0.9%	8,107	0.9%	7,996	0.5%	4,055	0.7%	0.7%
DK/Ref	11,731	6.6%	158	0.1%	4,581	4.5%	3.5%	36,893	4.2%	7,122	0.5%	5,968	1.1%	1.7%
Delayed Seeing Doctor	85,447	47.9%	24,252	12.7%	16,922	16.6%	26.9%	413,934	46.6%	205,442	14.1%	82,586	15.0%	24.2%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find the percentage of those "Not Insured" who are in poverty in the SLSL community, we first look at the column "Not Insured" under SLSL community and then go down to the row "In Poverty" under Poverty Status. Here we find that of those "Not Insured" in the SLSL community, 52.2% are "In Poverty".

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

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Health Insurance[5]														
Not Insured	93,113	54.8%	47,758	41.8%	37,561	20.1%	37.9%	486,272	53.3%	239,668	37.7%	163,003	12.1%	30.7%
Private Insurance	32,432	19.1%	45,509	39.8%	112,410	60.2%	40.4%	185,428	20.3%	275,779	43.4%	994,564	73.7%	50.3%
Medicare/Other Public	44,275	26.0%	21,114	18.5%	36,629	19.6%	21.7%	240,561	26.4%	120,534	19.0%	191,056	14.2%	19.1%
Personal Doctor or Health Care Provider														
Yes, only one	74,479	43.9%	60,917	53.3%	117,957	63.2%	53.85	428,716	47.0%	347,992	54.7%	808,956	60.0%	54.7%
More than one	11,879	7.0%	11,100	9.7%	27,627	14.8%	10.75	80,876	8.9%	87,492	13.8%	248,772	18.4%	14.4%
No, not anyone	83,462	49.1%	42,363	37.0%	41,016	22.0%	35.4%	402,669	44.1%	200,497	31.5%	290,925	21.6%	30.9%
Type of Health Care Place														
Doctor's office	38,163	22.5%	48,432	42.3%	107,231	57.5%	41.2%	298,425	32.7%	304,317	47.9%	904,895	67.1%	52.0%
Clinic/health center	79,259	46.7%	39,879	34.9%	45,920	24.6%	35.1%	353,312	38.7%	202,979	31.9%	260,874	19.3%	28.2%
Emergency room	11,956	7.0%	2,019	1.8%	2,372	1.3%	3.5%	60,147	6.6%	14,945	2.3%	16,422	1.2%	3.2%
More than one place	5,231	3.15	2,748	2.4%	975	0.55	1.9%	12,446	1.4%	6,831	1.1%	5,123	0.4%	0.8%
No one place	25,747	15.2%	16,684	14.6%	23,524	12.6%	14.0%	158,597	17.4%	87,875	13.8%	139,565	10.3%	13.3%
Some other place	1,301	0.8%	2,416	2.1%	435	0.2%	0.9%	7,148	0.8%	7,162	1.1%	5,848	0.4%	0.7%
DK/Ref	8,162	4.8%	2,165	1.9%	6,143	3.3%	3.5%	22,187	2.4%	11,871	1.9%	15,925	1.2%	1.7%
Delayed Seeing Doctor	69,371	40.8%	33,041	28.9%	24,209	13.0%	26.9%	321,980	35.3%	183,042	28.8%	196,940	14.6%	24.2%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find the percentage of those "In Poverty" who are "Not Insured" in the SLSL community, we first look at the column "In Poverty" under SLSL community and then go down to the row "Not Insured" under Health Insurance. Here we find that of those "In Poverty" in the SLSL community, 54.8% are "Not Insured".

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

Appendix 7 Preventive Services Indicators

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Ever had Mammography[5]	23,564	79.4%	51,037	93.1%	20,784	89.6%	88.6%	140,404	75.3%	351,465	91.1%	139,501	91.5%	87.1%
Ever had a Pap Test[6]	78,406	85.8%	79,402	89.9%	36,042	79.6%	86.1%	417,261	87.1%	646,245	92.2%	250,227	88.5%	89.8%
Ever had Blood Stool Test[7]	8,110	32.9%	31,383	58.2%	23,982	66.5%	55.4%	49,629	37.0%	204,118	53.4%	140,500	65.6%	54.0%
Ever had a Sigmoidoscopy or Colonoscopy[8]	9,346	28.3%	36,906	53.1%	32,907	64.9%	51.6%	49,803	27.5%	294,024	60.5%	193,590	65.2%	55.8%
Ever Tested for HIV[9]														
Yes, within last 12 months	37,729	25.5%	37,360	24.2%	13,239	17.3%	23.3%	162,098	22.2%	229,867	20.0%	59,931	15.1%	19.8%
Yes, but not in the last 12 months	42,722	28.9%	50,283	32.6%	16,998	22.1%	29.0%	225,269	30.8%	413,064	35.9%	80,093	20.2%	31.5%
No, never tested	67,299	45.5%	66,788	43.2%	46,505	60.65	47.7%	343,550	47.0%	508,172	44.1%	256,946	64.7%	48.6%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "Not Insured" reported ever having had a mammography, we first look at the column "Not Insured" under SLSL community and then go down to the row "Ever had a Mammography". Here we find that of those "Not Insured" in the SLSL community, 79.4% reported they have had a mammography.

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

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

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

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

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

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Ever had Mammography[5]	34,292	86.7%	22,323	87.5%	38,771	91.0%	88.6%	196,144	82.8%	132,416	82.1%	302,810	92.7%	87.1%
Ever had a Pap Test[6]	84,057	82.7%	43,410	89.2%	66,383	88.8%	86.1%	481,147	88.3%	288,443	87.4%	544,143	92.6%	89.8%
Ever had Blood Stool Test[7]	15,294	48.3%	11,325	43.2%	36,856	65.0%	55.4%	79,579	45.1%	71,294	45.2%	243,373	61.4%	54.0%
Ever had a Sigmoidoscopy or Colonoscopy[8]	21,116	48.2%	17,803	48.4%	40,240	55.3%	51.6%	108,735	43.8%	99,478	47.9%	329,206	64.8%	55.8%
Ever Tested for HIV[9]														
Yes, within last 12 months	30,892	21.7%	27,563	30.1%	29,874	20.6%	23,3%	156,663	21.9%	96,188	19.4%	199,044	18.7%	19.8%
Yes, but not in the last 12 months	33,131	23.3%	28,999	31.6%	47,873	33.0%	29.0%	195,438	27.3%	138,639	27.9%	384,350	36.0%	31.5%
No, never tested	78,221	55.0%	35,073	38.3%	67,297	46.4%	47.7%	364,119	50.8%	261,711	52.7%	482,838	45.3%	48.6%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "In Poverty" reported ever having had a mammography, we first look at the column "In Poverty" under SLSL community and then go down to the row "Ever had a Mammography". Here we find that of those "In Poverty" in the SLSL community, 86.7% reported they have had a mammography.

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

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

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

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

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

Appendix 8 Prenatal Care Indicators

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Ever Breastfeed[5]	27,659	93.0%	8,083	79.9%	2,811	53.6%	85.5%	114,058	83.5%	73,359	85.4%	9,414	50.1%	81.6%
Breastfed for at Least Six Months[5]	16,698	60.4%	2,274	28.1%	1,142	40.6%	52.2%	60,905	53.4%	35,728	48.7%	1,380	14.7%	49.8%
Reason for No Prenatal Care[6]														
Cost or no insurance	5,553	62.0%	38	3.9%	815	53.7%	56.0%	14,896	39.3%	1,970	17.1%	815	15.8%	32.4%
No Medicaid card	351	3.9%	0	0.0%	591	38.9%	8.2%	1,262	3.3%	0	0.0%	1,196	23.2%	4.5%
Did not know was pregnant	1,344	15.0%	793	82.3%	112	7.4%	19.7%	7,295	19.2%	5,146	44.7%	1,620	31.4%	25.7%
Other	1,429	16.0%	0	0.0%	0	0.0%	12.5%	11,938	31.5%	4,181	36.3%	0	0.0%	29.5%
DK or refused	273	3.1%	132	13.7%	0	0.0%	3.5%	2,550	6.7%	216	1.9%	1,532	29.7%	7.9%
Late Prenatal Care[5]	8,301	28.7%	918	9.2%	1,406	26.8%	24.1%	27,781	20.6%	4,616	5.5%	5,025	23.2%	16.0%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "Not Insured" reported ever having breastfed, we first look at the column "Not Insured" under SLSL community and then go down to the row "Ever Breastfeed". Here we find that of those "Not Insured" in the SLSL community, 93% reported they have breastfed a child.

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

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

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Ever Breastfeed[5]	25,250	87.0%	7,030	93.6%	6,273	73.3%	85.5%	100,097	79.6%	44,306	81.7%	52,428	85.5%	81.6%
Breastfed for at Least Six Months[5]	15,444	61.2%	1,880	26.7%	2,789	44.5%	52.2%	58,240	58.2%	12,364	27.9%	27,410	52.3%	49.8%
Reason for No Prenatal Care[6]														
Cost or no insurance	5,591	62.1%	815	64.2%	0	0.0%	56.0%	11,032	35.4%	6,369	38.5%	280	4.1%	32.4%
No Medicaid card	726	8.1%	217	17.1%	0	0.0%	8.2%	2,065	6.6%	394	2.4%	0	0.0%	4.5%
Did not know was pregnant	1,344	14.9%	112	8.8%	793	68.8%	19.7%	4,749	15.2%	5,316	32.1%	3,995	57.9%	25.7%
Other	1,349	15.0%	80	6.3%	0	0.0%	12.5%	11,048	35.5%	2,886	17.4%	2,186	31.7%	29.5%
DK or refused	0	0.0%	45	3.5%	360	31.2%	3.5%	2,270	7.3%	1,584	9.6%	444	6.4%	7.9%
Late Prenatal Care[5]	8,360	28.8%	1,112	16.6%	1,153	13.7%	24.1%	26,914	22.5%	7,384	13.8%	3,160	5.2%	16.0%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "In Poverty" reported ever having breastfed, we first look at the column "in Poverty" under SLSL community and then go down to the row "Ever Breastfeed". Here we find that of those "In Poverty" in the SLSL community, 87% reported they have breastfed a child.

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

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

Appendix 9 Risk Factors

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Smoked 100 Cigarettes or More Lifetime	47,710	26.7%	49,936	26.2%	47,726	46.8%	30.9%	307,306	34.6%	500,926	34.4%	269,225	48.8%	37.2%
Current Smoking Pattern[5]														
Every day	15,311	32.1%	12,341	24.7%	10,249	21.5%	26.1%	120,659	39.3%	122,820	24.5%	70,618	26.2%	29.2%
Some days	10,109	21.2%	6,980	14.0%	10,463	21.9%	19.0%	70,674	23.0%	63,800	12.7%	37,192	13.8%	15.9%
Not at all	20,289	42.5%	29,533	59.1%	26,607	55.7%	52.6%	107,792	35.1%	309,076	61.7%	159,146	59.1%	53.5%
DK/Ref	2,000	4.2%	1,082	2.2%	407	0.9%	2.4%	8,181	2.7%	5,230	1.0%	2,269	0.8%	1.5%
Days Engaged in Physical Activity in last 7 Days														
0	39,075	21.9%	37.608	19.8%	21,455	21.0%	20.8%	230,296	25.9%	290,182	19.9%	112,801	20.4%	21.9%
1 – 2	48,469	27.1%	36,879	19.4%	16,457	16.1%	21.6%	197,989	22.3%	285,584	19.6%	99,582	18.0%	20.1%
3 – 4	47,641	26.7%	62,583	32.9%	25,929	25.4%	28.9%	195,022	21.9%	393,674	27.0%	150,490	27.3%	25.5%
5 – 6	18,208	10.2	29,586	15.5%	18,913	18.5%	14.2%	116,190	13.1%	244,805	16.8%	80,760	14.6%	15.2%
7	25,038	14.0%	23,695	12.4%	19,266	18.9%	14.4%	149,447	16.8%	241,557	16.6%	108,517	19.7%	17.2%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "Not Insured" reported ever having "Smoked 100 Cigarettes or More in a Lifetime", we first look at the column "Not Insured" under SLSL community and then go down to the row "Smoked 100 Cigarettes or More Lifetime". Here we find that of those "Not Insured" in the SLSL community, 26.7% reported they have "Smoked 100 Cigarettes or More in a Lifetime".

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

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Smoked 100 Cigarettes or More Lifetime	37,115	21.9%	38,999	34.1%	69,259	37.1%	30.9%	317,168	34.8%	229,649	36.1%	530,641	39.3%	37.2%
Current Smoking Pattern[5]														
Every day	15,299	41.2%	10,962	28.1%	11,641	16.8%	26.1%	106,413	33.6%	81,598	35.5%	126,085	23.8%	29.2%
Some days	4,447	12.0%	6,982	17.9%	16,123	23.3%	19.0%	70,703	22.3%	31,389	13.7%	69,574	13.1%	15.9%
Not at all	16,537	44.65	20,511	52.6%	39,381	56.9%	52.6%	134,388	42.4%	114,319	49.8%	327,307	61.7%	53.5%
DK/Ref	832	2.2%	544	1.4%	2,114	3.1%	2.4%	5,663	1.8%	2,342	1.0%	7,675	1.4%	1.5%
Days Engaged in Physical Activity in last 7 Days														
0	36,013	21.2%	28,542	25.0%	33,583	18.0%	20.8%	224,715	24.6%	147,085	23.1%	261,479	19.4%	21.9%
1 – 2	37,027	21.8%	26,935	23.5%	37,843	20.3%	21.6%	202,286	22.2%	127,670	20.1%	253,199	18.8%	20.1%
3 – 4	51,977	30.6%	21,386	18.75	62,790	33.6%	28.9%	211,885	23.2%	145,946	22.9%	381,356	28.3%	25.5%
5 – 6	12,750	7.5%	22,090	19.3%	31,867	17.1%	14.2%	106,832	11.7%	81,580	12.8%	253,343	18.8%	15.2%
7	32,053	18.9%	15,429	13.5%	20,517	11.0%	14.4%	166,544	18.3%	133,700	21.0%	199,276	14.8%	17.2%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "In Poverty" reported ever having "Smoked 100 Cigarettes or More in a Lifetime", we first look at the column "In Poverty" under SLSL community and then go down to the row "Smoked 100 Cigarettes or More Lifetime". Here we find that of those "In Poverty" in the SLSL community, 21.9% reported they have "Smoked 100 Cigarettes or More in a Lifetime".

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

Appendix 10 Neighborhood, Environment and Housing Conditions

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Type of Residence														
House	74,021	41.5%	140,535	73.8%	64,690	63.4%	59.3%	512,437	57.6%	1,213,208	83.3%	397,696	72.0%	73.3%
Duplex	9,335	5.2%	5,596	2.9%	2,986	2.9%	3.8%	36,609	4.1%	20,069	1.4%	14,205	2.6%	2.4%
Apartment	95,075	53.3%	43,683	22.9%	33,934	33.3%	36.7%	288,516	32.5%	206,428	14.2%	126,009	22.8%	21.4%
Mobile home	0	0.0%	537	0.3%	408	0.4%	0.2%	51,381	5.8%	16,096	1.1%	14,240	2.6%	2.8%
Own or Rent														
Own	57,050	32.0%	149,890	74.0%	65,922	64.6%	56.0%	364,456	41.0%	1,123,708	77.2%	352,654	63.9%	63.5%
Rent	115,402	64.7%	42,685	22.4%	35,161	34.5%	41.0%	493,812	55.6%	295,841	20.3%	178,518	32.3%	33.4%
Other arrangements	5,979	3.4%	6,776	3.6%	936	0.9%	2.9%	30,675	3.5%	36,252	2.5%	20,979	3.8%	3.0%
Fresh Fruits and Vegetables Available	142,240	79.7%	167,905	88.2%	84,529	82.9%	83.8%	717,532	80.7%	1,269,651	87.2%	445,316	80.7%	84.0%
Violence and Crime a Problem	53,605	30.0%	72,029	37.8%	38,553	37.8%	34.9%	232,618	26.2%	363,925	25.0%	159,150	28.8%	26.1%
Stray Dogs and Cats a Problem	81,004	45.4%	76,274	40.1%	40,693	39.9%	42.0%	382,147	43.0%	465,878	32.0%	215,869	39.1%	36.7%
Water Pollution a Problem	28,145	15.8%	24,032	12.6%	13,091	12.8%	13.9%	116,620	13.1%	117,888	8.1%	60,688	11.0%	10.2%
Drinking Water a Problem	50,753	28.4%	32,798	17.2%	17,565	17.2%	21.5%	187,310	21.1%	252,315	17.3%	103,576	18.8%	18.8%
Fumes from Traffic a Problem	3,005	16.8%	34,387	18.1%	11,905	11.7%	16.2%	182,254	20.5%	229,000	15.7%	87,869	15.9%	17.2%
Fumes from Industry a Problem	13,638	7.6%	15,673	8.2%	4,037	4.0%	7.1%	147,655	16.6%	200,818	13.8%	80,020	14.5%	14.8%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "Not Insured" reported living in a "House", we first look at the column "Not Insured" under SLSL community and then go down to the row "House" under Type of Residence. Here we find that of those "Not Insured" in the SLSL community, 41.5% reported they live in a "House".

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Type of Residence														
House	80,952	47.7%	65,146	57.0%	133,149	71.4%	59.3%	533,094	58.4%	456,558	71.8%	1,133,689	84.1%	73.3%
Duplex	4,212	2.5%	7,377	6.4%	6,328	3.4%	3.8%	33,767	3.7%	14,532	2.3%	22,584	1.7%	2.4%
Apartment	84,247	49.6%	41,858	36.6%	46,587	25.0%	36.7%	303,507	33.3%	139,744	22.0%	177,703	13.2%	21.4%
Mobile home	408	0.2%	0	0.0%	537	0.3%	0.2%	41,894	4.6%	25,148	4.0%	14,676	1.1%	2.8%
Own or Rent														
Own	59,010	34.7%	66,041	57.7%	138,810	74.4%	56.0%	379,357	41.6%	418,002	65.7%	1,043,460	77.4%	63.5%
Rent	103,270	60.8%	45,642	39.9%	44,335	23.8%	41.0%	487,290	53.4%	201,791	31.7%	279,090	20.7%	33.4%
Other arrangements	7,539	4.4%	2,968	2.4%	3,455	1.95	2.9%	45,615	5.0%	16,188	2.5%	26,103	1.9%	3.0%
Fresh Fruits and Vegetables Available	135,618	79.9%	90,989	79.5%	168,067	90.1%	83.8%	699,741	76.7%	531,718	83.6%	1,201,041	89.1%	84.0%
Violence and Crime a Problem	60,705	35.7%	39,005	34.1%	64,478	34.6%	34.9%	261,564	28.7%	184,263	29.0%	309,866	23.0%	26.1%
Stray Dogs and Cats a Problem	80,731	47.5%	48,915	42.8%	68,325	36.6%	42.0%	399,690	43.8%	252,542	39.7%	411,662	30.5%	36.7%
Water Pollution a Problem	33,048	19.5%	13,368	11.7%	18,852	10.1%	13.9%	131,397	14.4%	66,987	10.5%	96,812	7.2%	10.2%
Drinking Water a Problem	48,336	28.5%	30,855	27.0%	21,925	11.7%	21.5%	205,214	22.5%	133,547	21.0%	204,440	15.2%	18.8%
Fumes from Traffic a Problem	32,892	19.4%	20,381	17.8%	23,024	12.3%	16.2%	189,873	20.8%	104,460	16.4%	204,789	15.2%	17.2%
Fumes from Industry a Problem	16,568	9.8%	9,298	8.1%	7,481	4.0%	7.1%	151,053	16.6%	107,088	16.8%	170,352	12.6%	14.8%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "In Poverty" reported living in a "House", we first look at the column "In Poverty" under SLSL community and then go down to the row "House" under Type of Residence. Here we find that of those "In Poverty" in the SLSL community, 47.7% reported they live in a "House".

Appendix 11 Social Support Indicators

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

	SLSL Community							Harris County						
	Not Insured		Private Insurance		Medicare/Other Public		Total	Not Insured		Private Insurance		Medicare/Other Public		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Someone to Help with Daily Chores if Sick														
None of the time	44,592	25.0%	20,385	10.7%	8,989	8.8%	15.7%	162,429	18.3%	131,316	9.0%	67,395	12.2%	12.5%
A little of the time	28,785	16.1%	15,381	8.1%	6,423	6.3%	10.7%	115,264	13.0%	107,385	7.4%	44,486	8.1%	9.2%
Some of the time	28,422	15.9%	32,346	17.0%	17,131	16.8%	16.55	200,338	22.5%	221,284	15.2%	109,930	19.9%	18.3%
Most of the time	27,344	15.3%	52,227	27.4%	25,197	24.7%	22.35	151,231	17.0%	370,439	25.4%	123,298	22.3%	22.3%
All of the time	49,288	27.6%	70,011	36.8%	44,279	43.4%	34.7%	259,681	29.2%	625,378	43.0%	207,041	37.5%	37.7%
Someone to Relax with														
None of the time	30,824	17.3%	6,481	3.4%	6,163	6.0%	9.2%	116,625	13.1%	73,370	5.0%	47,546	8.6%	8.2%
A little of the time	33,773	18.9%	18,476	9.7%	7,785	7.6%	12.8%	134,935	15.2%	113,642	7.8%	49,803	9.0%	10.3%
Some of the time	45,813	25.7%	54,861	28.8%	33,846	33.2%	28.6%	264,791	29.8%	346,811	23.8%	168,399	30.5%	26.9%
Most of the time	33,458	18.8%	50,293	26.4%	31,856	31.2%	24.6%	183,111	20.6%	407,292	28.0%	132,267	24.0%	24.9%
All of the time	34,563	19.4%	60,240	31.65	22,369	21.9%	24.9%	189,481	21.3%	514,685	35.4%	154,137	27.9%	29.6%
Someone to Understand Problems														
None of the time	30,630	17.2%	13,663	7.2%	10,954	10.7%	11.7%	139,042	15.6%	88,926	6.1%	64,903	11.8%	10.1%
A little of the time	31,091	17.4%	15,521	8.2%	5,058	5.0%	11.0%	96,855	10.9%	97,544	6.7%	44,379	8.0%	8.2%
Some of the time	30,889	17.3%	46,898	24.6%	14,100	13.8%	19.5%	174,196	19.6%	240,506	16.5%	104,075	18.8%	17.9%
Most of the time	28,039	15.7%	35,062	18.4%	29,018	28.4%	19.6%	190,131	21.4%	384,696	26.4%	118,933	21.55	23.9%
All of the time	57,782	32.4%	79,207	41.6%	42,888	42.0%	38.2%	288,719	32.5%	644,130	44.2%	219,860	39.8%	39.8%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "Not Insured" reported having Someone to Help with Daily Chores if Sick "None of the time", we first look at the column "Not Insured" under SLSL community and then go down to the row "None of the time" under Someone to Help with Daily Chores if Sick. Here we find that of those "Not Insured" in the SLSL community, 25.0% reported they had someone to help with daily chores if sick "None of the time".

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

	SLSL Community							Harris County						
	In Poverty		Near Poverty		Not in Poverty		Total	In Poverty		Near Poverty		Not in Poverty		Total
	N	%	N	%	N	%	%	N	%	N	%	N	%	%
Someone to Help with Daily Chores if Sick														
None of the time	36,312	21.4%	15,410	13.5%	22,245	11.9%	15.7%	144,324	15.8%	88,807	14.0%	128,010	9.5%	12.5%
A little of the time	23,164	13.6%	14,787	12.9%	12,638	6.8%	10.7%	107,267	11.8%	59,108	9.3%	100,761	7.5%	9.2%
Some of the time	34,696	20.4%	22,836	20.0%	20,367	10.9%	16.5%	194,434	21.3%	134,772	21.2%	202,345	15.0%	18.3%
Most of the time	26,164	15.4%	25,127	22.0%	53,477	28.7%	22.3%	167,513	18.4%	139,325	21.9%	338,131	25.1%	22.3%
All of the time	49,484	29.1%	36,220	31.7%	77,873	41.7%	34.7%	298,723	32.7%	213,970	33.6%	579,406	43.0%	37.7%
Someone to Relax with														
None of the time	24,222	14.3%	11,425	10.0%	7,820	4.2%	9.2%	112,527	12.3%	58,461	9.2%	66,552	4.9%	8.2%
A little of the time	25,980	15.3%	18,615	16.3%	15,440	8.3%	12.8%	126,174	13.8%	68,211	10.7%	103,995	7.7%	10.3%
Some of the time	52,129	30.7%	33,913	29.6%	48,477	26.0%	28.6%	279,624	30.7%	208,094	32.7%	292,282	21.7%	26.9%
Most of the time	31,402	18.5%	28,604	25.0%	55,600	29.8%	24.6%	180,755	19.8%	136,322	21.4%	405,594	30.1%	24.9%
All of the time	36,085	21.2%	21,823	19.1%	59,262	31.8%	24.9%	213,180	23.4%	164,893	25.9%	480,230	35.6%	29.6%
Someone to Understand Problems														
None of the time	32,177	18.9%	12,838	11.2%	10,232	5.5%	11.7%	145,216	15.9%	68,536	10.8%	79,118	5.9%	10.1%
A little of the time	20,179	11.9%	15,241	13.3%	16,250	8.7%	11.0%	101,351	11.1%	55,695	8.8%	81,732	6.1%	8.2%
Some of the time	27,148	12.6%	26,932	23.5%	37,807	20.3%	19.5%	168,550	18.5%	136,149	21.4%	214,080	15.9%	17.9%
Most of the time	21,448	12.6%	26,524	23.2%	44,145	23.7%	19.6%	162,441	17.8%	150,119	23.6%	381,200	28.3%	23.9%
All of the time	68,867	40.5%	32,844	28.7%	78,166	41.9%	38.2%	334,703	36.7%	225,483	35.5%	592,523	43.9%	39.8%

[1] Adults aged 18 and over

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

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

[4] The percentages in this table are column percentages. For example, to find out what percentage of those in the SLSL community who are "In Poverty" reported having Someone to Help with Daily Chores if Sick "None of the time", we first look at the column "In Poverty" under SLSL community and then go down to the row "None of the time" under Someone to Help with Daily Chores if Sick. Here we find that of those "In Poverty" in the SLSL community, 21.4% reported they had someone to help with daily chores if sick "None of the time".

Appendix 12 SLSL Hospital Advisory Team Summary Report

Attendees: John W. Beauchamp (SLSL), Francis Lerma (SLSL), Katina Scott (SLSL), Tamara Bourda (EHC), Pamela Diamond (UT), Maria Fernandez-Esquer (UT), Andria Rusk (UT)

Introduction and review of CHNA kickoff meeting

The assessment and hospital teams were introduced and an overview of the needs assessment process was provided. The CHNA process includes reaching out to the community to collect needs, leveraging existing data sets, assessing health needs by county, focus group discussions, and possibly conducting a community survey.

Hospital's perspective on community needs

There was a discussion of the hospital's view on the needs of the community, focus of the assessment and what may not show up in the reports, and ways to discover new data rather than repeat old efforts.

- The perception from the hospital team's discussion is that:
    - Approx 50% of patients come from outside the Hospital service area
        - From Harris County and are Gold card patients
        - High need patients come through the ER with very few direct admits – not many PCPs admit

- Community unmet needs
    - Mental Health services
        - Must divert services, patients hard to place, nowhere to send them for evaluation or inpatient
        - Redirect to Austin state hospital if must be committed, as a transfer
        - No public health agency is onboard, no place to send them for mental health
        - Nowhere to go if they're uninsured
    - Pain Management services
        - Unique sickle cell population with no coordinated services to manage pain consistently
        - Memorial Hermann has a clinic but not for the ER
        - There is a pain doctor on staff, but only for management while patient is in hospital
        - No clear issue resolution and a need for continuity of care
        - Suggestions for addressing need
            - Coordinate with an organization called Operation Hydration; currently targets the sickle cell community that educates on testing and treatment options
            - Potential for hospital to assist with education and refer to people who test but there are liabilities issues and red tape for the hospital to engage in care
            - Develop a program or clinic for this population that employs a physician and offers multiple services – instead of having patients primarily use ER

- Existing services and relationships
    - Needs assessment resources include Fort Bend County assessment that was conducted by the Ft. Bend Chamber of Commerce
    - Visibility of the hospital in the community has improved
        - Improved outreach as a result of efforts initiated 2 years ago
    - Women's 3D mammogram program
        - Setup in December and includes speakers, education
        - Great flow process for positive mammograms to 3D, referrals
    - Relationship with Matagorda County
        - Recently developed in the last month or two
        - Local physician has clinic and refers to hospital every Friday, hospital performs their caths
        - Working on more full cardiac service, as that is an unmet need
    - Service to seniors
        - Encourage ER visits for falls, UTIs requiring treatment and other medical issues
        - Seniors have resistance to visiting ER
    - Hospital is a member of the Rotary Club, Chamber of Commerce, Economic Development Council
    - Hospital did not participate in the DSRIP program / 1115 waiver project

- New ideas and strategies to address needs
    - Enhanced relationship with school districts
        - Hospital currently does fundraisers for school supplies
        - There's an opportunity for more clinics to keep kids in school
        - Need to extend clinic hours beyond typical business hours to increase access
        - Opportunity for more community education, outreach, sports medicine, internal medicine, family medicine, more partnership
        - Underserved areas identified are Rosenberg and Richmond; Lamar is smaller school district with the possibility for bigger impact; Ft Bend is large
    - Expand primary care coverage
        - Significant county population growth
        - Don't have exact data, believe there is a shortage in provider coverage
        - Methodist is expanding beds, but the county needs more PCPs
        - Working on a 501(3)a to cover this area

Review of IRS requirements

- Assessment and implementation plan must be submitted together at the end of the tax year, Dec 2013
- Implementation plan should demonstrate how the hospital is addressing the needs
    - IRS may use the documentation to follow up on action items for the next 3 years
    - Sample strategies include developing a referral service, not necessarily building a mental health wing of the hospital

Next Steps

- Proposed timeline
    - Assessment team will give Hospital a snapshot and composite feedback from community
    - Draft report completed by September 14
    - Complete report for review at October 21 board meeting
    - Final report submitted 2 weeks before board meeting to be reviewed included in board packet
    - Approved report submitted to the System for filing after board approval

Action Items

- **Bill-**have Sharon Galloway send the primary and secondary patient analysis done as a part of the business strategy; send a copy of the Fort Bend County assessment and the strategic plan (Done)
- **Hospital-** may bring a team person onboard to be point-person for community feedback going forward

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

Appendix 13 Community Stakeholder Summary Report

Introduction

In accordance with Federal law, a Community Health Needs Assessment must take into account "input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health." Gathering this community input for St. Luke's Sugar Land Hospital (SLSL) took place through a carefully designed process of community engagement that included a Group Conversation. The sections that follow describe how this community engagement met and exceeded Federal requirements to engage:

- Persons with special knowledge of or expertise in public health;
- Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and
- Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

Overview of Group Conversation

A Group Conversation was held in support of the St. Luke's Sugar Land Hospital Community Health Needs Assessment on Friday, August 9, 2013, from 9:00 am – 10:30 am at the Fort Bend Family YMCA in Missouri City, Texas. This conversation included ten participants from a range of community organizations and health-related groups. The Group Conversation was an organized event that brought people from different roles and organizations together to discuss matters that are important to the health needs of the community served by the hospital. The Group Conversation was a dynamic process that allowed participants to share their thoughts and views, listen to other perspectives, and build on one another's ideas. The Group Conversation did not seek specific answers or responses – all input was welcome. The exchange that occurred in the Group Conversation allowed participants to share ideas and thoughts with one another in a structured way.

Format of Group Conversation

In the Group Conversation, participants were seated at tables that form a "U" shape facing the front of the room so that participants could see one another when speaking and listening. The Group Conversation was led by a facilitator that guided the discussion by introducing the topic of discussion and posing four questions to the group. Before the Group Conversation began, the facilitator informed participants of several guidelines and protocols for the discussion, including:

- Comments made in the meeting will not be associated with a participant's name or organization. Feedback will be analyzed and reported in a summary format so that participants' comments remain anonymous.
- Because speaking and listening are key components of the Group Conversations, participants should not engage in side conversations and participants should speak one at a time.

- The questions asked in the Group Conversation are designed to be non-directive and open-ended in order to allow for dynamic and open conversation.

Participants spent approximately 15 minutes discussing each question. At the end of discussion for the fourth question, the facilitator shared a brief report of what she heard from the group and offered an opportunity to ask questions and contribute additional comments. The following four questions were asked during the Group Conversation:

1. What are the most important health problems or unmet healthcare needs in the community?
2. What are the challenges and/or barriers to addressing unmet healthcare needs in the community?
3. What healthcare needs do you see as priorities that should be addressed first? Second? Third?
4. What resources may be already available in the community that can help address the unmet health priorities?

Community Stakeholder Recruitment

Thirty-two individuals and organizations were identified as key stakeholders in the community and invited via email and follow-up telephone calls to attend the Group Conversation for St. Luke's Sugar Land Hospital. Collectively, these groups not only represent the broad interests of the community, but they also represent significant knowledge and expertise in public health. Below is a list of the types of organizations that were invited to attend the Group Conversation and the unique perspective that each group has on health needs of the community.

- *Health Clinics and Federally Qualified Health Centers (FQHC)* – Health clinics and FQHCs serve a medically underserved area or population and have first-hand knowledge of the health needs of these communities, as well as general knowledge of public health.
- *Regional and Local Health Department* – Regional, county, and local public health departments are responsible for the general health of citizens in a certain area. Health departments often provide health-related services and maintain current statistics and data on the health of a given population.
- *Health Related Support Groups* – National associations that support research and prevention of diseases, illnesses, and health risk factors often sponsor local support groups. These health related support groups address health needs of local communities.
- *School Districts* – School Districts have health services departments and staff in each school within a district. These professionals support general student health, access to health services, and appropriate intervention for students with high-risk or chronic medical needs.
- *Community Organizations* – Community organizations range in scope and mission from serving minority and low-income populations, to promoting healthy communities, to advocating for a range of community needs. Community organizations effectively serve as representatives of the individuals and communities they serve.
- *Business Organizations* – Business organizations, such as chambers of commerce, often work to promote economic development and quality of life in communities. They have unique perspectives on quality of life issues including education and health.

- *Services for the Disabled* – Agencies and organizations that provide services for the disabled have a unique perspective on community health needs and priorities. Individuals with mental and/or physical disabilities are often underrepresented in communities.
- *Services for Seniors* – Agencies and organizations that provide services for seniors have a unique perspective on community health needs. Elderly and aging populations often have chronic health needs but encounter significant obstacles to obtaining access to services to meet those needs.

Community Stakeholder Attendance

Below is a list of participants who contributed to the Group Conversation held in support of the St. Luke's Sugar Land Group Conversation on August 9, 2013. As described above, the group includes persons with special knowledge of or expertise in public health; state and local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

	Name	**Title**	**Organization**
1	Naeem Ahmed	Executive Officer	Ibn Sina Foundation
2	Al Jaz Au'Khowaja	CEO	Ibn Sina Foundation, Inc.
3	Brian Byrne	Administrator	Greatwood at Sugar Land / Aide in Aid
4	Christine Clinton	Health Promotions Coordinator	Cigna/Fort Bend ISD
5	Carol V. Edwards	CEO	AccessHealth
6	Kimberly Hinojosa	Community Relations Director	Colonial Oaks Assisted Living and Memory Care
7	Shena Timberlake	Director of Behavior Healthcare Services	Texana Center
8	Tacanesha Turner	Health Promotion Manager	Cigna Healthcare (Fort Bend/St. Luke's Sugar Land)
9	Deborah Nicole Volek	Physical therapy assistant, clinical instructor	Shape Up Fort Bend founder, Home Health Resources agency PTA, Fort Bend Seniors board member, Texas Physical Therapy Association
10	Denise Williams	Publisher	Community Magazines LLC

Community Stakeholder Feedback

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

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

When asked to identify the most important health problems and unmet healthcare needs in the community served by St. Luke's Sugar Land Hospital, participants primarily focused on access to care in general and access to specialized services in particular. Participants also noted that communication around availability of services and human resource in the healthcare profession are problems in the community.

- **Access to Health Care.** Several participants focused on general access to care issues that are common in the community including transportation, after hours care, and insurance.
  - Transportation – Transportation to and from healthcare settings is a significant problem in Fort Bend County. Participants noted that transportation is especially problematic for seniors.
  - After Hours Care – Participants suggested that for the many daily wage earners in Fort Bend County, access to care after normal business hours is a problem. Many after-hours clinics actually are not open at night, and daily wage earners are unable to forfeit work during the day to seek healthcare services.
  - Insurance – While participants spoke in great detail about existing policy issues related to insurance (see "Healthcare Policy" below), several participants noted that insurance is an important problem in the community. Participants observed that many physicians do not accept Medicaid so individuals defer care until they must seek emergency services. Other participants noted that healthcare and insurance is a problem for the middle class, as well, because insurance premiums can often be prohibitively high.

- **Access to Specific Services.** Participants spoke about access to a number of specific health care services as being a problem in the Fort Bend community. These specific services include specialty care, mental health care, specialty pediatric services, services for the disabled, elder care, and diagnostic and imaging services.
  - Access to Specialty Care – Participants suggested that access to specialty care, such as services for individuals diagnosed with cancer, is an important unmet healthcare need in the community. Participants noted that this problem is especially detrimental to the uninsured population of Fort Bend County. One participant noted that the lack of a hospital district in Fort Bend County is part of the access to specialty care problem.
  - Access to Mental Health Care – Several participants focused on access to mental health care as an unmet healthcare need in Fort Bend County. One participant noted that while there are some outpatient services related to mental health in the community, there are no inpatient beds in Fort Bend County. In addition, the community is lacking in other mental health support services such as respite care, licensed group homes, and housing options for individuals with mental illness. (Similar problems in terms of housing and transitional housing exist for the homeless population in Fort Bend County.) One participant expressed

that juvenile mental health services are lacking in the community, with only one psychiatrist in the area that will bill insurance for mental health services.

- Access to Specialty Pediatric Services – While participants acknowledged that Texas Children's operates a health center in Sugar Land, there is a lack of treatment services for children with special needs. In addition, there is a lack of pediatric nursing and home health services in the community. Several participants focused specifically on the need for specialty pediatric services for children with autism. Autism screening and early support services are needed, as well as home health support for families with children with autism.
- Services for the Disabled – Participants suggested that access to services for disabled children, adults, and seniors is a healthcare problem in the community. This problem involves not only access to care but also access to appropriate recreational opportunities such as universally accessible parks.
- Elder Care – Participants focused on a range of issues associated with elder care as being health problems in the community. While participants acknowledged that sufficient assisted living opportunities exist in the community, quality of care in skilled nursing facilities and nursing homes is a problem. In addition, low-income seniors do not have adequate access to nursing homes, with the average wait list for Medicaid beds for seniors lasting between six and nine months. Accessing reimbursement and nursing benefits through insurance is also a problem in terms of elder care services.
- Diagnostic and Imaging Services – Patients noted that there is a lack of diagnostic and imaging services and centers in the community. This lack of services is a problem for physicians in the process of accurately diagnosing patient illness and disease.

- **Communication.** Several participants indicated that effective communication about available services is a health problem in the Fort Bend County community. Participants suggested that because Fort Bend is such a large area and because there is a growing array of services, people often find it difficult to find accurate information about services.

- **Human Resources.** Participants suggested that in rural areas of Fort Bend County, clinics and other health care facilities have a difficult time finding specialized and skilled personnel. Participants indicated that workforce development in the healthcare profession is a problem in the community, with particular difficulty finding radiologists, x-ray technicians, RN's, and bilingual staff. Sugar Land and Fort Bend County healthcare facilities often lose skilled healthcare personnel in the community to larger, more competitive medical facilities in Houston.

- **Healthcare Policy.** While participants acknowledged that healthcare policy is a complex and wide-ranging issue, several participants focused on several aspects of healthcare policy as being major challenges to healthcare in Fort Bend County. Overall, participants expressed that affordable care and access to care should be universal and that achieving this goal is a social justice issue.

- At the national level, participants focused on a need for policy change as it relates to reimbursements and physician acceptance of Medicaid.
- At the regional and local level, participants identified a need to develop more community clinics and an independent emergency center in order to offload from hospitals and develop affordable community-based primary and preventive care facilities.
- At all levels, participants felt that healthcare systems should shift to focus on primary care and prevention instead of disease control.

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

- **Transportation.** Several participants focused on lack of transportation in Fort Bend County as a challenge to addressing healthcare needs in the community.
- **Insurance.** Participants communicated that insurance is a barrier to addressing healthcare needs in the community. For individuals that are uninsured or underinsured, deferral of care is common. This deferral of care leads to poor health outcomes and strains on emergency care services. For individuals with insurance, cost of insurance premiums – which is higher in Texas than many other states – is a significant barrier to healthcare.
- **Education.** Education and communication about available healthcare resources and services in Fort Bend County is a barrier to addressing healthcare needs. Participants cited the large size of Fort Bend County and the growing array of services in the community as factors affecting individuals' ability to find accurate information about resources and services.
- **Language and Cultural Barriers.** Participants identified language and cultural barriers as challenges to addressing healthcare needs of the Fort Bend County community. A lack of healthcare professionals that are bilingual is a barrier to communication and care in many healthcare settings. In addition, cultural barriers, especially around mental health, are a challenge to accessing care. Participants noted the importance of working with children to change community perception of cultural barriers in healthcare.
- **Safety and Security.** One participant noted the importance of increasing security for staff at after-hours facilities, as well as in neighborhoods around Fort Bend County. When neighborhoods are not safe for citizens to go outside for exercise, safety becomes a barrier to healthy communities.

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

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

- Access to care was a top priority for participants. Participants felt that priorities within access to care include specialty care services, vision and dental care, sufficient and qualified staff, and follow-up care after patients are discharged from a healthcare facility.
- Access to accurate information about availability of services, especially for indigent and non-English speaking populations, was a priority for participants.
- Establishment of a hospital district in Fort Bend County was a priority for participants.

While these priorities were named specifically, it is clear from the Group Conversation overall that participants feel strongly about many health needs in their community that could be considered

priorities including broader access to care issues, communication between service providers and the community, and healthcare policy.

4. What resources may be already available in the community that can help address the unmet health priorities?

In answer to this specific question, as well as throughout the Group Conversation, participants noted several existing resources and programs that address health in the community. The available resources discussed in the Group Conversation are listed below.

- Shape Up Fort Bend – Shape Up Fort Bend is a program that connects the Fort Bend community with resources for a healthy lifestyle. The Shape Up Fort Bend website could be used as a central site for publishing community healthcare resources and services.
- Gateway to Care (Houston) – Gateway to Care in Houston is a program through which doctors, hospitals, and other healthcare providers volunteer time and resources to those in need. While this program does not exist in Fort Bend County, it could be a great model for Fort Bend County to follow.
- YMCA – The YMCA in Fort Bend County provides services to many different populations within the Fort Bend population. The YMCA is not only a resource for exercise and healthy living, but it is a resource for social interaction, stress relief, and many other services for "the mind, body, and spirit."
- Fort Bend Independent School District –Fort Bend ISD provides health resources for its employees, who make up a significant part of the community.
- Personal Prevention – Personal Prevention is a program that helps employers provide incentives to employees around healthy living through an employer sponsored point system.

Group Conversation Evaluation

All participants were asked to evaluate their knowledge and expertise of public health; knowledge of or involvement with medically underserved, low-income, and minority populations, and populations with chronic disease needs; and knowledge of the SLSL community. The participants identified their primary area of knowledge/expertise and the community they serve as including the following areas in general: public health, health care administration, community health centers, primary medical, dental care, long-term care (senior assisted living, nursing, home health, personal care), pediatric health care needs, pediatric special needs, behavioral health, mental health, home health, health and wellness, community of Sienna Plantation, Fort Bend County, and the Fort Bend Independent School District. More specifically, participants answered the following questions about their knowledge/expertise.

Question	Yes	No
In your opinion, do you feel that you or your organization represent the broad interests of the community served by the St. Luke's Sugar Land Hospital?	9	0
Are you a person with knowledge or expertise in public health?	9	0
Are you a representative of a federal, tribal, regional, state, or local health department or agency?	7	2
Does the organization you represent have current data or other information relevant to the health needs of the community served by the St. Luke's Sugar Land Hospital?	8	0
Are you a leader, representative, or member of a population served by the St. Luke's Sugar Land Hospital that could be characterized as medically underserved, low income, minority, or having chronic disease needs?	7	2

Recommendations Made by Community Stakeholders

Several specific ideas for how St. Luke's Sugar Land Hospital could engage with the community to meet overall health needs of the community emerged from the Group Conversation. Although health problems and needs in the community like access to health care, prevention, and healthcare policy are complex and multi-layered, there were a number of ideas and recommendations put forward by the community for the hospital's consideration, including the following:

- Coordination of community resources through the provision of a comprehensive community health resources database that is updated on a regular basis
- Coordination of community resources through the establishment of a physical place where community members can go to locate and learn about resources
- Collaborate with community organizations to get involved in access and prevention at the local level, especially in areas beyond affluent pockets within Fort Bend County
- Donate time and resources to – or help start – a program like Gateway to Care (Houston) that provides no-cost healthcare services to those in need

In addition, participants expressed that their general sense is that St. Luke's Sugar Land Hospital is a community-based and charity-based hospital and that they are grateful for its services. At the same time, participants expressed hope that St. Luke's would continue in this community-focused role after the sale of the hospital and see this change as an opportunity to engage with the community in a new way – perhaps by taking on some of the community's recommendations listed above.

Appendix 14 Public Health Experts Summary Report

Introduction

In accordance with Federal law, a Community Health Needs Assessment must take into account "input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health." In collaboration with Episcopal Health Charities, Clarus Consulting Group identified and invited Public Health Experts, facilitated focus groups, and developed the Public Health Experts summary report. Gathering the community input for the hospitals in the St. Luke's Health System took place through a carefully designed process of community engagement that included a "Group Conversation", or targeted focus group. The sections that follow describe how this community engagement met and exceeded Federal requirements to engage federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility.

Overview of Group Conversation

A Group Conversation was held in support of the Community Health Needs Assessments for all six hospitals in the St. Luke's Health System (St. Luke's Hospital at Texas Medical Center, St. Luke's Sugar Land Hospital, St. Luke's Patients Medical Center, St. Luke's Hospital The Woodlands, St. Luke's Lakeside Hospital, St. Luke's Vintage Hospital) on Thursday, August 8, 2013, from 2:30 pm – 4:00 pm at the Episcopal Health Charities in Houston, Texas. This conversation included twelve participants from a city, county, regional, and states public health organizations. The Group Conversation was an organized event that brought public health experts together to discuss matters that are important to the health needs of the community served by the hospital system. The Group Conversation involved a dynamic process that allowed all participants to share their thoughts and views, listen to other perspectives, and build on one another's ideas. The Group Conversation did not seek specific answers or responses – all input was welcome. The exchange that occurred in the Group Conversation allowed participants to share ideas and thoughts with one another in a structured way.

Format of Group Conversation

In the Group Conversation, participants and a facilitator were seated around a conference table so that participants could see one another when speaking and listening. The Group Conversation was led by a facilitator that guided the discussion by introducing the topic of discussion and posing four questions to the group. Before the Group Conversation began, the facilitator informed participants of several guidelines and protocols for the discussion, including:

- Comments made in the meeting will not be associated with a participant's name or organization. Feedback will be analyzed and reported in a summary format so that participants' comments remain anonymous.
- Because speaking and listening are key components of the Group Conversations, participants should not engage in side conversations and participants should speak one at a time.
- The questions asked in the Group Conversation are designed to be non-directive and open-ended in order to allow for dynamic and open conversation.

Participants spent approximately 15 minutes discussing each question. At the end of discussion for the fourth question, the facilitator shared a brief report of what she heard from the group and offered an opportunity to ask questions and contribute additional comments.
The following four questions were asked during the Group Conversation:

- What are the most important health problems or unmet healthcare needs in the community?
- What are the challenges and/or barriers to addressing unmet healthcare needs in the community?
- What healthcare needs do you see as priorities that should be addressed first? Second? Third?
- What resources may be already available in the community that can help address the unmet health priorities?

Public Health Experts Recruitment

Twenty-four public health organizations and individuals were identified as key stakeholders in the field of public health and invited via email to attend the Group Conversation for St. Luke's Health System. Collectively, these groups represent significant knowledge and expertise in public health. Regional, county, and local public health departments are responsible for the general health of citizens in a certain area. Health departments often provide health-related services and maintain current statistics and data on the health of a given population.

Public Health Experts Attendance

Below is a list of participants who contributed to the Group Conversation held in support of the St. Luke's Health System Group Conversation on August 8, 2013. As described above, the group includes persons with special knowledge of or expertise in public health as it relates to the community served by the St. Luke's Health System.

	Name	**Title**	**Organization**
1	Latrice Babin, PhD	Environmental Toxicologist	Harris County Pollution Control Services Department
2	June Hanke	Strategic Analyst/Planner	Harris Health System
3	Dr. Nicole Hare-Everline, CHES	City of Houston Wellness/EAP Director	City of Houston
4	Robert Hines	Epidemiologist	Houston Department of Health and Human Services
5	Haley Jackson	Team Lead	Department of State Health Services
6	Lisa Mayes	Executive Director	Harris County Healthcare Alliance
7	Bakeyah Nelson	Public Health Analyst	HCPHES
8	Beverly Nichols PsyD, MS, RN	Senior Staff Analyst	City of Houston Department of Health and Human Services
9	Kimberly Nicholson	Program Specialist II	Texas Department of State Health Services
10	Ebun Odeneye	Senior Health Educator	City of Houston
11	Yan Shi	Management Analyst III	Houston Department of Health and Human Services
12	Lindsey Wiginton	Epidemiologist	Houston Department of Health and Human Services

Public Health Experts Feedback

Below is a description of participant feedback from the Group Conversation held for Public Health Experts. Data is organized according to the four questions posed to participants.

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

In general, participants noted the correlation between a healthy community and fewer admits to the hospital, and suggested that elevating the idea of a healthy community is a healthcare need in the Houston community. Participants also noted specific unmet healthcare needs in the community including access, communication, chronic disease, mother/infant/prenatal care, behavioral health care, environmental health, and disparity issues

- **Access.** Collectively, participants felt that access to care was the most important health problem in the community. Participants acknowledged that there is sufficient number of health clinics in the area but that access to care remains an issue for a significant portion of the population. Several factors contribute to the access to care issue.
- **Transportation.** Houston is a very spread out city, and transportation to and from health care settings is a problem for many in Houston.
- **Knowledge.** Some participants felt that many people simply do not understand how to obtain health care resources and services. This problem is especially evident as it relates to prenatal and behavioral health care needs.
- **Insurance and Finances**. Many people do not have access to care because they do not have the financial resources to pay for care. Many people do not have insurance and do not know how to pay for care. This often leads to a deferral of care and higher admittance to the E.R.
- **Communication.** Participants indicated that more effective communication around health care in the Greater Houston community is an unmet healthcare need. Specifically, participants felt that better communication is needed from health care providers to inform the community about services and resources that are available. In addition, better communication is needed between health care providers and health departments/public health agencies.
- **Chronic Disease**. Participants suggested that the rate of chronic disease such as diabetes, obesity, high cholesterol, hypertension, heart disease, and asthma (especially in children) is an important health problem in the community. One participant noted that the rate of adults with diabetes or pre-diabetes is 60%, which illustrates the significance and alarming nature of the chronic disease problem in the Houston community. Participants felt that more individuals need to be screened for chronic diseases, and more information about how to access help for chronic diseases needs to be disseminated.
- **Mother/Infant/Prenatal Care**. Several participants focused on maternal, infant, and prenatal care as being an important health problem in the Houston community. Participants cited high rates of maternal and infant mortality and high rates of pre-term birth and fetal mortality as evidence of this problem. Participants further noted that high rates of poor birth outcomes leads to higher numbers of children with special needs. Participants suggested that, overall, women are aware of the importance of maternal, infant, and prenatal care but encounter many barriers to obtaining these services such as transportation, funding, access, finding a doctor, and making an appointment.
- **Behavioral Health Care**. Several participants suggested that mental health and chronic mental illness are important health care issues in the Houston community. While participants specifically noted that individuals with schizophrenia, bipolar disorder, and depression rarely get care they need, they also cited some progress in addressing this need, such as the police department helping to place people with mental health issues in treatment centers instead of placing them in the law enforcement system.

- **Environmental Health**. Participants suggested that poor environmental health causes both acute and chronic health issues in the community. Participants noted the importance of the relationship between environmental health and chronic disease and suggested that the Houston community needs more educational initiatives around this relationship. Participants noted that environmental problems such as air quality or road construction can be obstacles to healthy communities in that they discourage individuals from going outside to exercise but can also lead to long-term chronic health problems such as respiratory problems, heart attack, stroke, and asthma.
- **Health Disparities**. Participants suggested that disparity issues are a major health care concern in the Houston community. One participant provided the example that there are correlations between ethnicity and individuals that do not get regular or necessary health care screenings.

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

Participants discussed the challenges and barriers to addressing unmet healthcare needs in the community at the individual level, organizational level, and the community level.

- **Barriers for Individuals.** Barriers to addressing unmet healthcare needs for individuals in the Houston community relate to access to care issues. Transportation, insurance and financial resources, and scarcity of time are all barriers to addressing unmet health care needs for individuals in the Greater Houston community.
    - Transportation – Transportation to and from health care services is a significant barrier to obtaining health care services for many individuals the Houston community.
    - Insurance and Financial Resources – Many individuals in Houston lack insurance and/or do not know how to access Medicaid funds. Participants indicated that while most individuals are educated about the benefits of health care, they do not have the financial resources to access health care services.
    - Time – Participants acknowledged that time is a precious resource for individuals in Houston and acknowledged that scarcity of time is often a barrier to accessing health care services. In particular, participants noted a need for individuals to understand the difference between after-hours facilities and emergency rooms in terms of accessing care.
- **Barriers for Organizations**
    - Political Climate and Acceptance of Available Funds – Participants voiced that the political climate is a barrier for some health-related organizations in the Houston community. Specifically, participants noted that governing bodies that serve as a funding source for health-related organizations often do not want to accept funds that may be politically controversial, such as funds associated with Medicaid expansion. Participants noted that some organizations are seeking assistance with this challenge at the state level but have not seen much progress made in terms of this unique funding barrier.
- **Barriers for Communities.** At the community level, participants observed that poverty, resources for individuals, and access to healthy foods are barriers to addressing unmet healthcare needs.
    - Poverty – Several participants stated that from a community perspective, the high rate of poverty is a barrier to addressing unmet healthcare needs. Poverty is a growing issue in Houston, and communities with high rates of poverty often are not able to place exercise and accessing health care as priorities.
    - Empowering the Individual – Participants suggested that communities do a pretty good job of educating the public, but that education needs to be followed up on the community level by empowering individuals to act on the information they receive related to health care.
    - Access to Healthy Foods – Participants noted that many communities in Houston are considered “Food Deserts” because they lack access to fresh, healthy foods. Access to

healthy foods is a basic principle in creating healthy communities and many communities in Houston lack such access.

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

- **Infant and Maternal Health.** Participants identified maternal, infant, and prenatal health as an important unmet healthcare need in the community. Participants agreed that this is a priority healthcare need in the community.
- **Access and Awareness.** Participants suggested that a range of issues related to access and awareness should be a priority in the community. Access to transportation, healthy foods, information about chronic diseases such as diabetes and asthma, cancer screenings, and preventive care were access/awareness issues named specifically by participants. Participants also emphasized that a focus on outreach to communities dealing with high rates of poverty should be a priority for providing access to health care.
- **Referrals between Hospitals and FQHC's.** Participants named developing a working relationship between hospitals and FQHC's to efficiently and effectively refer patients to the appropriate health care provider as a priority for the community. Participants acknowledged that it is not only best for the patient to be seen in the right health care setting, but it also helps relieve over-use of E.R. facilities. Participants also noted that part of this referral system should be the provision of transportation and appropriate follow up to ensure that patients received care through the appropriate health care setting.
- **Health Services (and Orientation to Services) for Immigrants.** Participants noted that Houston is a "city of immigrants" and that working to establish a holistic approach to providing social services and health care for immigrants should be a priority for the Houston community. A partnership with the Office of Immigration to provide education around navigating the health system and introducing health as a way of life could be a part of this priority.
- **Promoting Availability of Services.** Participants suggested that promoting awareness about availability of services should be a priority in the Houston community. Promoting availability of services should occur through broad communication efforts.
- **Promote Healthy Communities.** Participants felt that promoting healthy communities overall should be a priority. From a policy standpoint, communities should look at policies that form the behavior of hospitals and the incentive to participate in community level work.

4. What resources may be already available in the community that can help address the unmet health priorities?

In answer to this specific question, as well as throughout the Group Conversation, participants noted several existing resources and programs that address health in the community.

- Active and Engaged Civic Clubs and Social Clubs – Civic and social clubs are an important part of communities in Houston and could be a great avenue to reach communities to address health priorities.
- Active Church and Faith-Based Community – The active church and faith-based communities throughout Houston are often involved in all aspects of life, including health and wellness.
- United Way – The United Way is a great resource in Houston that addresses a myriad of health-related issues in the community. Participants specifically noted programs of the United Way related to cancer screenings and transportation to health related services.
- Area Agency on Aging – The Area Agency on Aging implements preventive programs for seniors that promote health for this important sector of the population.

- Asthma-Related Support Services – Although funding is no longer available for this initiative, participants noted a program that provided healthy alternatives for the home for families with children that suffer from asthma. The program was a relatively small resource to address a large problem, but it made a difference for children and families that struggle with asthma.

Group Conversation Evaluation

All participants were asked to evaluate whether his or her organization represents the broad interests of the community served by the St. Luke's Health System, and whether the organization he or she represents has current data or other information relevant to the health needs of the communities served by the St. Luke's Health System. Participants were also asked which of the six hospital communities in the St. Luke's Health System he or she is most closely familiar with. Participants answered these questions according to the chart below.

Question	Yes	No
In your opinion, do you feel that you or your organization represent the broad interests of the communities served by the St. Luke's Health System Hospitals?	10	0
Does the organization you represent have current data or other information relevant to the health needs of the communities served by the St. Luke's Hospitals?	10	0
Which of the following hospital service area health needs do you feel that you are most closely familiar with? (Mark all that apply.)		
St. Luke's Hospital	6	-----
St. Luke's Hospital at The Vintage	3	-----
St. Luke's Patients Medical Center	4	-----
St. Luke's Sugar Land Hospital	1	-----
St. Luke's Woodlands Hospital	3	-----
St. Luke's Lakeside Hospital	1	-----

Recommendations made by Public Health Experts

Several specific ideas for how St. Luke's Health System could engage with the community to meet overall health needs of the community emerged from the Group Conversation. Although health problems and needs in the community like access to health care and prevention are complex and multi-layered, there were a number of ideas and recommendations put forward by public health experts for the hospitals' consideration, including the following:

- Development of a resource center for chronic diseases, similar to a diabetes resource center
- Promotion of available resources in the community – and healthy communities in general – by engaging with the local community to become aware of and promote available resources instead of waiting for community members and organizations to come to hospital
- Development of partnerships and collaboration between hospitals and public health departments and agencies based on similarities in accreditation processes and health needs assessments for both entities
- Support policies that promote health in rural communities, such as complete streets policies
- Develop a partnership with METRO to help publish transportation system maps that include hospital and clinic locations
- Partner with external facilities that can help with services that the hospital would like to address, such as emergency facilities

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