COMMUNITY HEALTH NEEDS ASSESSMENT

2021

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Questions and/or comments regarding Oakbend Medical Center's Community Health Needs Assessment may be directed to:

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EXECUTIVE SUMMARY

Internal Revenue Code (IRC) Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the Affordable Care Act, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- Conduct a community health needs assessment (CHNA) every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA as well as a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The CHNA must consider input from persons including those with special knowledge of or expertise in public health, those who serve or interact with vulnerable populations and those who represent the broad interest of the community served by the hospital facility. The hospital facility must make the CHNA widely available to the public.

This CHNA, which describes both a process and a document, is intended to document Oakbend Medical Center's ("Hospital" or "OMC") compliance with IRC Section 501(r)(3). Health needs of the community have been identified and prioritized so that the Hospital may adopt an implementation strategy to address specific needs of the community.

This document is a summary of all the available evidence collected during the CHNA conducted during in 2021 and 2022. It will serve as a compliance document, as well as a resource, until the next assessment cycle. Both the process and document serve as the basis for prioritizing the community's health needs and will aid in planning to meet those needs.

Oakbend Medical Center is an acute care hospital located in Richmond, Texas. For the purposes of this CHNA, the Medical Center's has defined its "community" as Fort Bend and Wharton Counties which account for the most significant portion the Medical Center's patients. While the Medical Center may serve patients across a broader region, defining its community will allow it to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

Identified health needs were prioritized with input from members of the Medical Center's management team utilizing a weighting method that weighs 1) the size of the problem, 2) the seriousness of the problem, 3) the impact of the issues on vulnerable populations, 4) how important the issue is to the community and 5) the prevalence of common themes. Significant needs were further reviewed and analyzed regarding how closely the need aligns with the Medical Center's mission, current and key service lines, and/or strategic priorities.

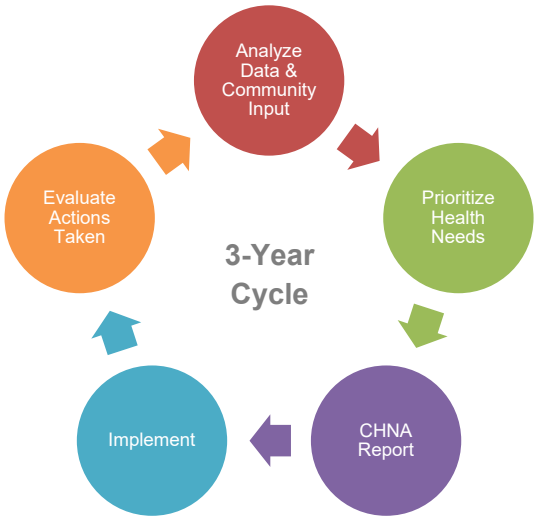
Based on the information gathered through this CHNA and the prioritization process described later in this report, the following priorities were identified. Opportunities for health improvement exist in each area. The Medical Center will work to identify areas where it can most effectively focus its resources to have significant impact and develop an Implementation Strategy for 2022-2024 for the some or all of the needs identified below.

- Access to care
- Shortage of healthcare workers
- Treatment of and management of chronic diseases and conditions
- Access to and use of preventative care treatments
- Access to primary care physicians
- Access to medical specialists
- Access to COVID-19 treatment, testing, and vaccines
- Healthy behaviors and healthy lifestyle choices
- Access to mental health services - adults and children
- Access to drug and alcohol treatment services
- Poverty and lack of financial resources
- Uninsured and under-insured
- Health education
- Obesity
- Transportation
- Access to services for the aging
- Access to and use of wellness programs
- Access to healthy food options
- Preventable hospital stays

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

EVALUATION OF PROGRESS SINCE PRIOR CHNA

The CHNA process should be viewed as a 3-year cycle. An important piece of that cycle is revisiting the progress made on priority health topics set forth in the preceding CHNA. By reviewing the actions taken to address a priority health issue and evaluating the impact those actions have made in the CHNA Community, it is possible to better target resources and efforts during the next round of the CHNA cycle.



PRIORITIZED GOALS FROM PRECEDING CHNA

The 2018 CHNA prioritized the following goals for action between 2019 and 2021:

1. Access to care
2. Access to primary care
3. Access to specialists
4. Chronic diseases (Heart Disease, Stroke, Cancer, Diabetes)
5. Economic security and housing
6. Lack of health knowledge and education
7. Mental health and addiction
8. Nutrition
9. Obesity
10. Preventative care
11. Services for children
12. Services for the aging
13. Transportation

COMMUNITY FEEDBACK FROM PRECEDING CHNA & IMPLEMENTATION PLAN

Oakbend Medical Center's preceding CHNA is available to the public via the website https://www.oakbendmedcenter.org. OMC provided a contact on its webpage for questions and comments on its prior CHNA. No substantive comments have been received.

HOW THE ASSESSMENT WAS CONDUCTED

Oakbend Medical Center partnered with BKD, LLP ("BKD") to conduct this community health needs assessment. BKD is one of the largest CPA and advisory firms in the United States, with approximately 3,000 partners and employees in 40 offices. BKD serves hospitals and health care systems across the country. The CHNA was conducted during 2021.

The CHNA was conducted to support its mission responding to the needs in the community it serves and to comply with Internal Revenue Code Section 501(r) and federal tax-exemption requirements. Identified health needs were prioritized to facilitate the effective allocation of hospital resources to respond to the identified health needs. Based on guidance from the United States Treasury and the Internal Revenue Service, the following steps were conducted as part of the CHNA:

- Community benefit initiatives, which were implemented over the course of the last three years, were evaluated.
- The "community" served by the Medical Center was defined by utilizing inpatient and outpatient data regarding patient origin and is inclusive of medically underserved, low-

income, minority populations and people with limited English proficiency. This process is further described in Community Served by the Medical Center.

- Population demographics and socioeconomic characteristics of the community were gathered and assessed utilizing various third parties.
- The health status of the community was assessed by reviewing community health status indicators from multiple sources, including those with specialized knowledge of public health and members of the underserved, low-income and minority population or organizations serving their interests.
- Community input was also obtained through key stakeholder interviews of community leaders. See Appendix B for a listing of key stakeholders that provided input through interviews.
- Identified health needs were then prioritized considering the community's perception of the significance of each identified need as well as the ability for the Medical Center to impact overall health based on alignment with its mission and the services it provides. The Medical Center's leadership participated in identifying and prioritizing significant health needs.
- An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared.

LIMITATIONS AND INFORMATION GAPS

This assessment was designed to provide a comprehensive and broad picture of the health in the overall community served by the Medical Center; however, there may be a few of medical conditions that are not specifically addressed in this report due to various factors, including but not limited to, publicly available information or limited community input.

In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English. Efforts were made to obtain input from these specific populations through key stakeholder interviews.

As with all data collection efforts, there are limitations related to the CHNA's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2021 may be the most current year available for data, while 2020 or 2019 may be the most current year for other sources.

GENERAL DESCRIPTION OF OAKBEND MEDICAL CENTER

OakBend Medical Center is an independent nonprofit hospital in the Greater Houston Area. The hospital serves Fort Bend County and surrounding communities at all of our locations including our hospitals, emergency rooms, surgery centers, physical therapy clinics, physician offices, and many more.

All of OMC's hospitals operate under a single license. Therefore, the CHNA community has been defined as the aggregate community served by the three hospital facilities and a single CHNA report has been prepared. The hospital facilities included in this report are:

- OakBend Medical Center – Jackson Street Hospital Campus
- OakBend Medical Center – Williams Way Hospital Campus
- OakBend Medical Center – Wharton Hospital Campus

Oakbend Medical Center is home to Fort Bend's Most Advanced:

- Acute Care for the Elderly (ACE) Unit
- Geriatric Psychiatric Program
- Skilled Nursing Facility

OakBend Medical Center Facts:

- 550 Physicians on staff
- 1,200 + Employees and contractors
- 274 Beds
- 50+ Locations
- 4,000 Annual inpatient admissions
- 100,000 Annual outpatients
- 38,000 Annual Emergency Room visits

MISSION STATEMENT

To provide exceptional, compassionate health care for our community, regardless of ability to pay.

VALUES

- Excellence
- Integrity
- Ownership
- Compassion

OUR VISIONARY GOAL

To be the best community health care organization

DESCRIPTION OF SERVICES PROVIDED BY OAKBEND MEDICAL CENTER

Oakbend Medical Center provides the following services:

- ACE Unit
- Cardiology & Vascular Services
- Cardiopulmonary
- Emergency Services
- Food & Nutrition
- Imaging
- Intensive Care Unit
- Labor & Delivery
- Laboratory
- Lifestyles at OakBend
- Medical/Surgical Inpatient Unit
- Neonatal Intensive Care Unit
- Physical Therapy & Rehabilitation
- Senior Behavioral Health Unit
- Skilled Nursing Facility
- Sleep Lab
- Stroke Services
- Surgical Services
- Women's Imaging
- Wound Care Unit

COMMUNITY SERVED BY OAKBEND MEDICAL CENTER

The Medical Center is in Richmond, Texas in Fort Bend County. Richmond is approximately forty-five minutes away from Houston, Texas and an hour and a half away from Galveston, Texas. It is accessible from Interstate 69.

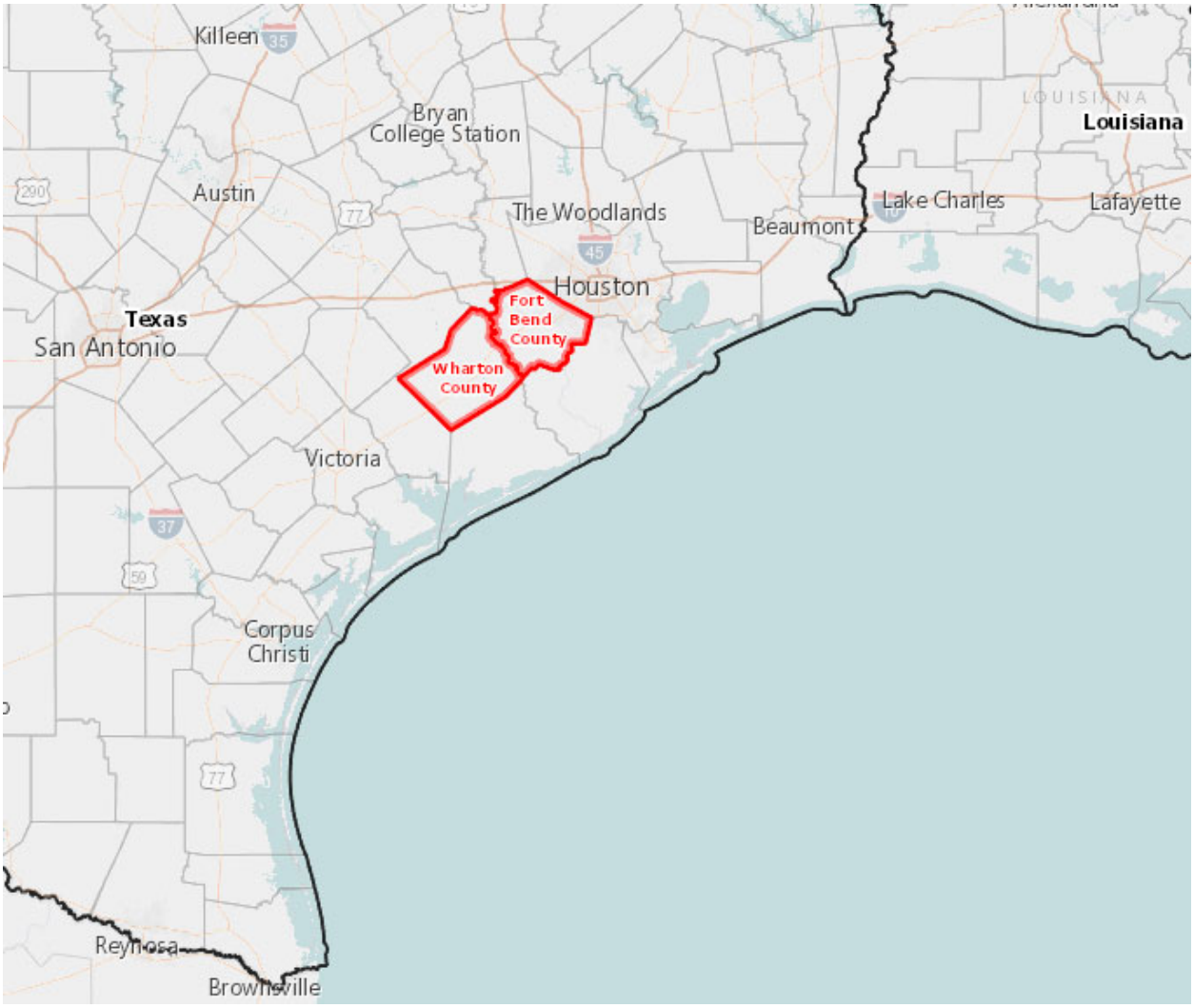
DEFINED COMMUNITY

A community is defined as the geographic area from which a significant number of the patients utilizing the Medical Center's services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community. Based on the patient origin of inpatient and outpatient discharges, management has identified the CHNA community to include Fort Bend and Wharton Counties, hereafter referred to as the "CHNA Community". Based on analysis of patient discharge zip codes, the CHNA community represents the majority of total discharges.

COMMUNITY DETAILS

IDENTIFICATION AND DESCRIPTION OF GEOGRAPHICAL COMMUNITY

The following map geographically illustrates the Medical Center's community. The map below displays its geographic relationship to the community, as well as significant roads and highways.



COMMUNITY POPULATION AND DEMOGRAPHICS

The U.S. Bureau of Census has compiled population and demographic data. The data below shows the total population of the CHNA community. It also provides the breakout of the CHNA community between the male and female population, age distribution, race/ethnicity and the Hispanic population.

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. The population of the CHNA community by race illustrates different categories of race such as, white, black, Asian, other, and multiple races.

Demographic Characteristics

Gender	CHNA Community	Fort Bend County	Wharton County	TX	US
Total Population	806,971	765,394	41,577	28,260,856	324,697,795
Total Male Population	396,331	375,912	20,419	14,034,009	159,886,919
Total Female Population	410,640	389,482	21,158	14,226,847	164,810,876
Percent Male	49.11%	49.11%	49.11%	49.66%	49.24%
Percent Female	50.89%	50.89%	50.89%	50.34%	50.76%

Population Age Distribution

Age Group	Percent of CHNA Community	Percent of Fort Bend County	Percent of Wharton County	Percent of TX	Percent of US
0 - 4	6.90%	6.90%	6.82%	7.08%	6.09%
5 - 17	20.67%	20.75%	19.16%	18.89%	16.53%
18 - 24	8.34%	8.30%	9.10%	9.88%	9.44%
25 - 34	12.23%	12.23%	12.26%	14.70%	13.87%
35 - 44	15.09%	15.29%	11.33%	13.53%	12.62%
45 - 54	13.93%	14.05%	11.76%	12.48%	12.96%
55 - 64	11.90%	11.85%	12.92%	11.20%	12.86%
65+	10.94%	10.63%	16.65%	12.24%	15.63%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

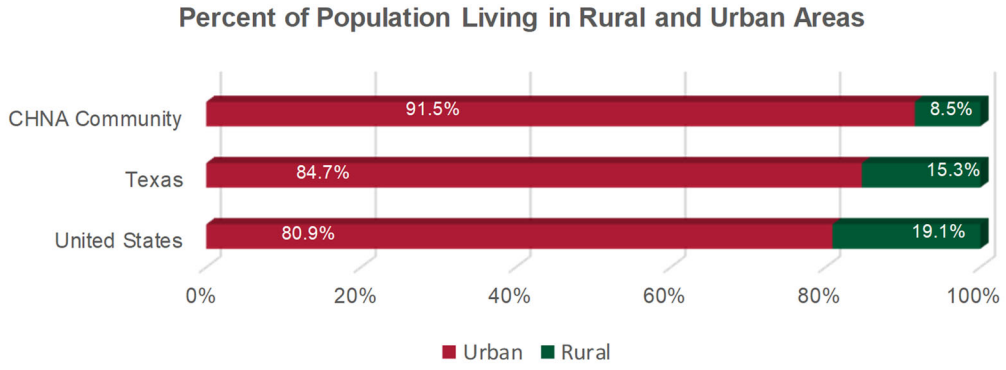
Total Population by Race Alone

Race	Percent of CHNA Community	Percent of Fort Bend County	Percent of Wharton County	Percent of TX	Percent of US
White	53.21%	51.73%	80.58%	73.97%	72.49%
Black	20.21%	20.53%	14.30%	12.13%	12.70%
Asian	19.16%	20.19%	0.34%	4.80%	5.52%
Native American / Alaska Native	0.33%	0.34%	0.06%	0.50%	0.85%
Native Hawaiian / Pacific Islander	0.05%	0.05%	0.00%	0.09%	0.18%
Some Other Race	4.31%	4.34%	3.74%	5.82%	4.94%
Multiple Race	2.73%	2.82%	0.98%	2.69%	3.32%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Total Population by Ethnicity Alone

Ethnicity	Percent of CHNA Community	Percent of Fort Bend County	Percent of Wharton County	Percent of TX	Percent of US
Hispanic or Latino	25.37%	24.50%	41.39%	39.34%	18.01%
Non-Hispanic or Latino	74.63%	75.50%	58.61%	60.66%	81.99%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

The graphic below shows the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban. Per the graph below, the population of the CHNA Community has a nearly even split living in an urban and rural areas.



SOCIOECONOMIC CHARACTERISTICS OF THE COMMUNITY

The socioeconomic characteristics of a geographic area influence the way residents access health care services and perceive the need for health care services within society. The economic status of an area may be assessed by examining multiple variables within the CHNA community. The following exhibits are a compilation of data that includes median household income, unemployment rates, poverty, uninsured population, and educational attainment for the CHNA community. These standard measures will be used to compare the socioeconomic status of the community to Texas and the United States.

INCOME AND EMPLOYMENT

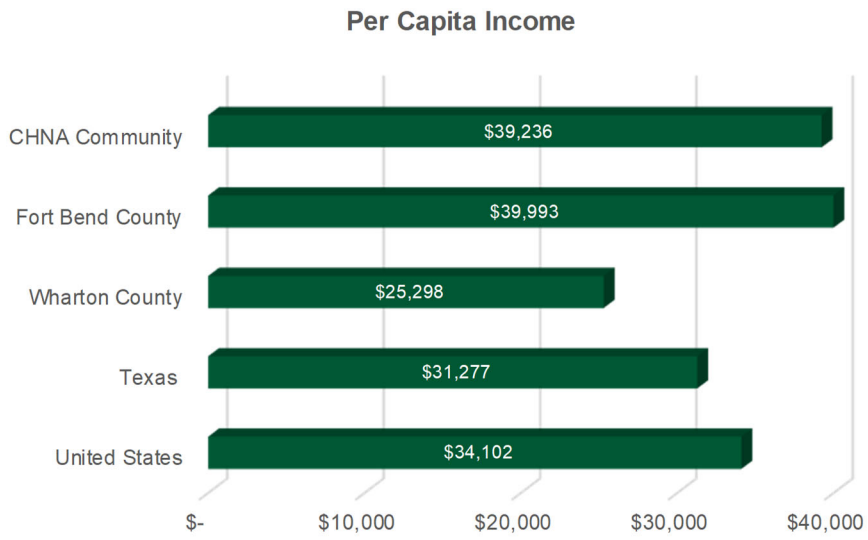
INCOME

The median household income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one-person, average household income is usually less than average family income. The median household income in Fort Bend County exceeds the median household income of both Texas and the United States. However, Wharton County's median household income falls below both Texas and the United States.

Median Household Income		
CHNA Community		N/A
Fort Bend County	$	97,743
Wharton County	$	48,310
Texas	$	61,874
United States	$	62,843

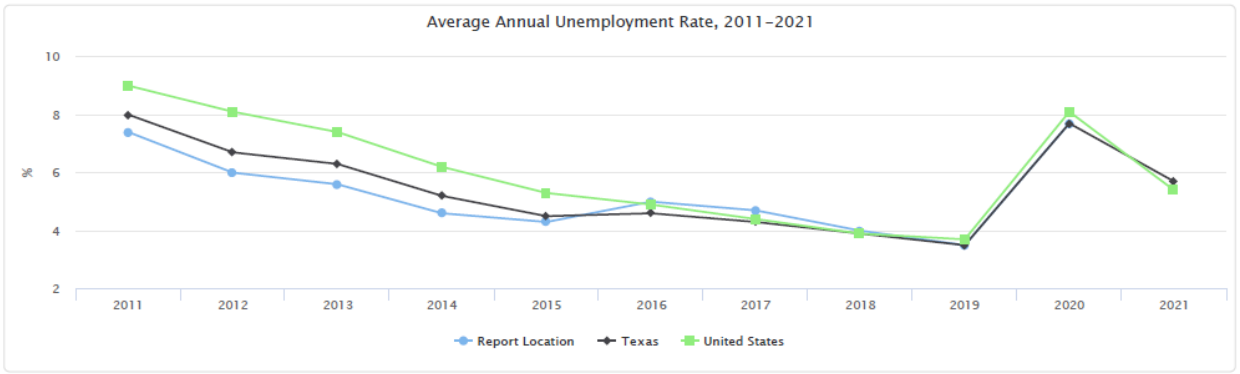
The per capita income for the CHNA Community is $39,236. This includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income in this report area is the average

(mean) income computed for every man, woman, and child in the specified area. The per capita income for Fort Bend County exceeds the per capita income for both Texas and the United States. The per capita income for Wharton County is below the per capita income for both Texas and the United States.



UNEMPLOYMENT RATE

The following graph presents the average annual unemployment rate from 2011 through 2021 for the CHNA Community, as well as the trend for Texas and the United States. The unemployment rates for the CHNA Community are slightly lower than the Texas and United States rates for 2011-2015 and then nearly identical to rates for Texas and the United States (within ±0.5%).



POVERTY

Poverty is considered a key driver of health status.

Percent Population Below 100% FPL	
CHNA Community	7.93%
Fort Bend County	7.41%
Wharton County	17.59%
Texas	14.73%
United States	13.42%

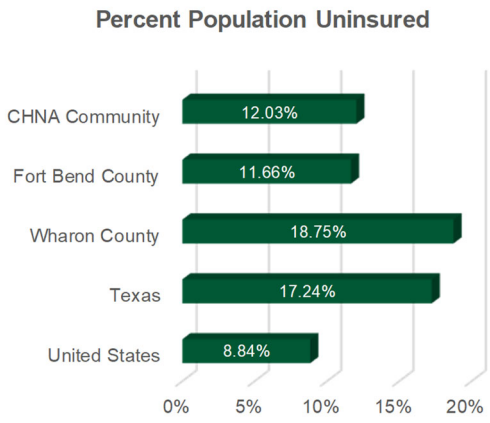
Within the CHNA Community 7.93% or 63,463 individuals are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. Fort Bend County's percentage compares favorably to both Texas and United States percentages of individuals living in households below 100% of FPL. Whereas Wharton County's percentage compares unfavorably to both Texas and United States.

Percent Population Under Age 18 in Poverty	
CHNA Community	9.98%
Fort Bend County	9.17%
Wharton County	25.89%
Texas	20.92%
United States	18.52%

In the CHNA Community, 9.98% or 22,062 children aged 0-17 are living in households with income below the FPL. Like the percentages for total poverty, Fort Bend County compares favorably to both Texas and United States percentages of individuals under age 18 living in households below 100% of FPL. Whereas Wharton County compares unfavorable to Texas and the United States.

UNINSURED

The percentage of the total civilian non-institutionalized population without health insurance coverage is represented in this graphic. The rate of uninsured persons in the report area is less than the state average of 17.24% This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Approximately 96,384 persons are uninsured in the CHNA community. The uninsured rate is estimated to be 12.03 for the CHNA Community compared to 17.24% for Texas and 8.84% for the United States.



EDUCATION

Nearly 45% of the population of the CHNA Community age twenty-five and older have obtained a bachelor's degree or higher compared to 30% in Texas and 32% in the United States. This indicator is relevant because educational attainment has been linked to positive health outcomes.

Percent Population Age 25+ with Bachelor's Degree or Higher	
CHNA Community	44.75%
Fort Bend County	46.22%
Whaton County	18.01%
Texas	29.90%
United States	32.15%

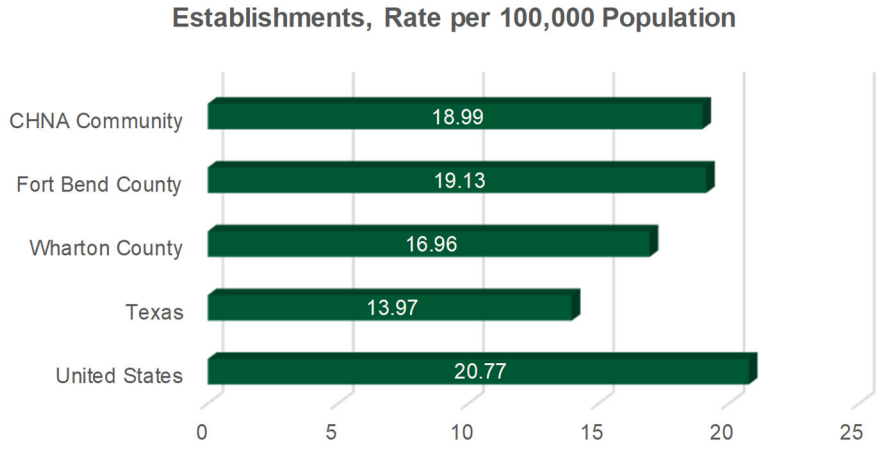
Education levels obtained by community residents may also impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors indirectly influence community health.

PHYSICAL ENVIROMENT OF THE COMMUNITY

A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned throughout the report.

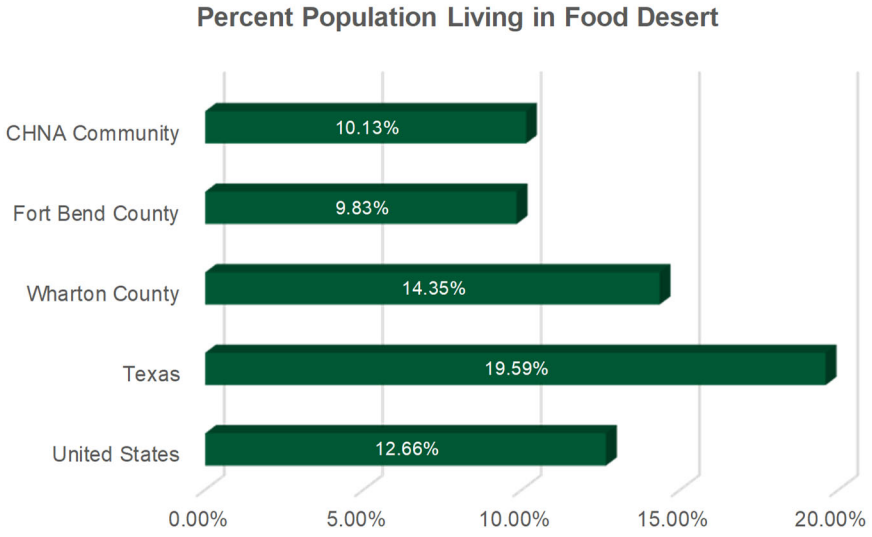
GROCERY STORE ACCESS

Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables and fresh and prepared meats, such as fish and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors. The CHNA Community compares favorably to Texas but unfavorably to the United States.



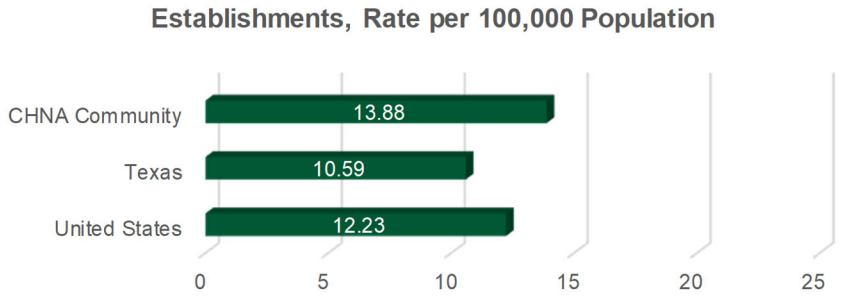
FOOD ACCESS/FOOD DESERTS

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery stores. The information in is relevant because it highlights populations and geographies facing food insecurity. The CHNA Community has a population of 63,482 or 10.13% living in food deserts compared to 19.59% for Texas and 12.66% for the United States.



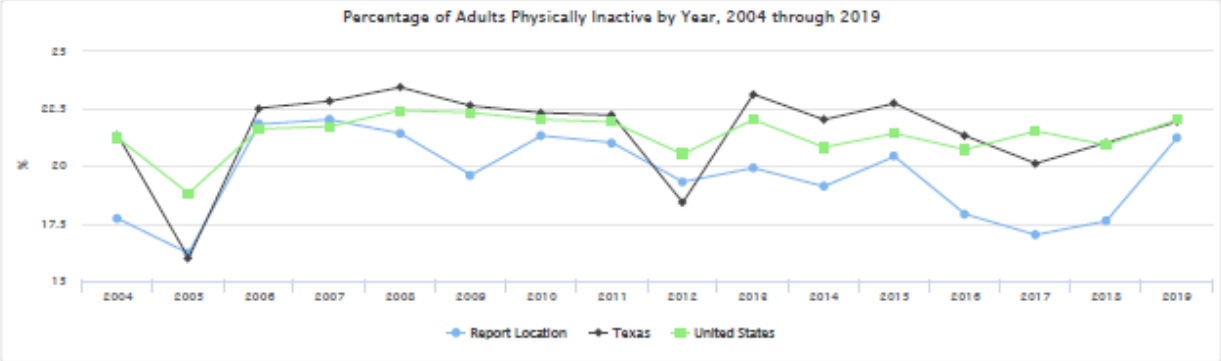
RECREATION AND FITNESS FACILITY ACCESS

This indicator reports the number per 100,000-population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. It is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors. The rate of fitness establishments available to the residents of the CHNA Community compares favorably to the rate for Texas and the United States.



The trend graph below shows the percentage of adults who are physically inactive by year (2004 through 2019) for the CHNA Community and compared to Texas and the United States. For 2019, the rate for the CHNA Community was 21.2% compared to 21.9% for Texas and 22.0% for

the United States. From 2013 to 2018, the CHNA Community's percentage of adults who were physically inactive ranged from a low of 16.2% in 2005 to a high of 22.0% in 2007. The CHNA Community's year over year trend followed that of Texas and the United States.



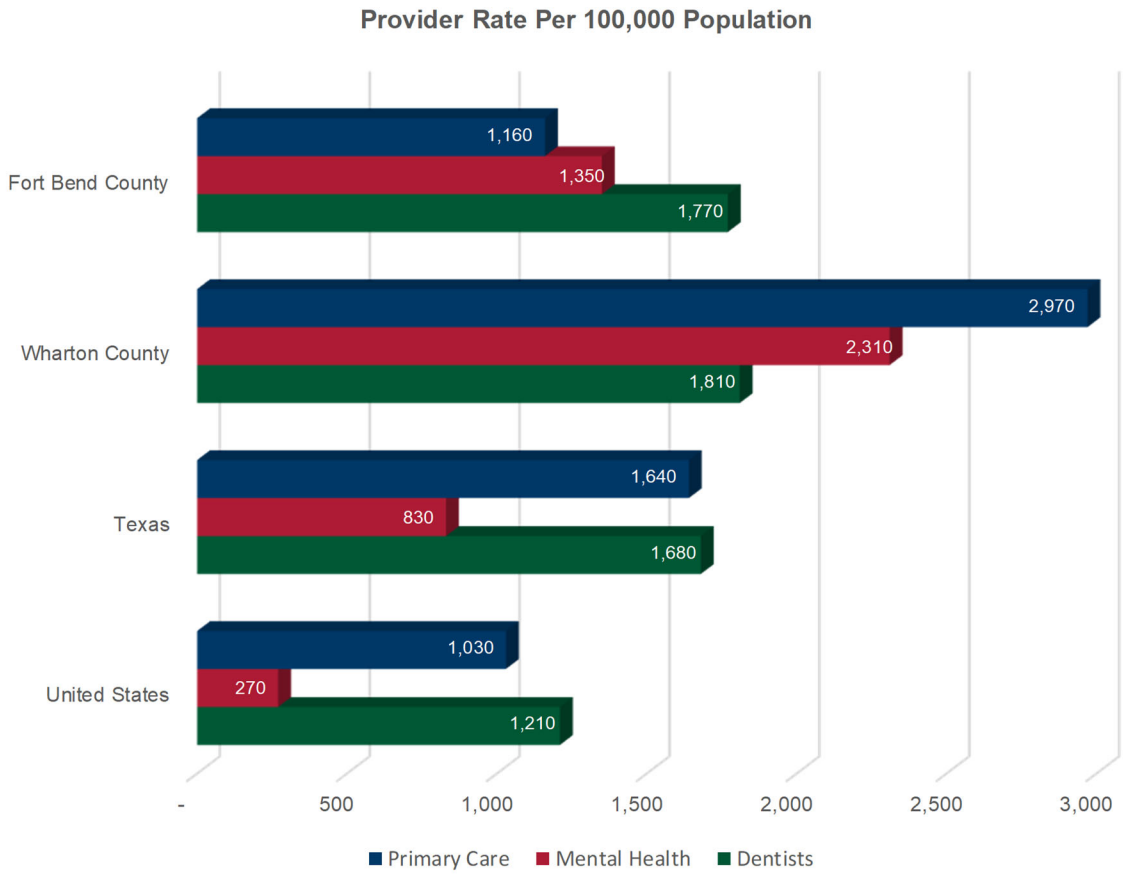
CLINICAL CARE OF THE COMMUNITY

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

Rates of morbidity, mortality and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

ACCESS TO CARE

Doctors classified as "primary care physicians" by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. The primary care physician ratio for Fort Bend County compares favorably to Texas but unfavorably to the United States. The primary care physician ratio for Wharton County compares unfavorably to both Texas and the United States. In addition, the number of mental health providers and dentists practicing in the counties of the CHNA Community compares unfavorably to the ratios for both Texas and the United States.



HEALTH STATUS OF THE COMMUNITY

This section of the assessment reviews the health status of the CHNA community and its residents. As in the previous section, comparisons are provided with the state of Texas and the United States. This in-depth assessment of the mortality and morbidity data, health outcomes, health factors and mental health indicators of the county residents that make up the CHNA community will enable the Hospital to identify priority health issues related to the health status of its residents.

Good health can be defined as a state of physical, mental, and social well-being, rather than the absence of disease or infirmity. According to Healthy People 2020, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes, and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services.

Studies by the American Society of Internal Medicine conclude that up to 70% of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities, and premature death.

The interrelationship among lifestyle/behavior, personal health attitude and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury, and mortality is defined as the incidence of death. Such information provides useful indicators of health status trends and permits an assessment of the impact of changes in health services on a resident population during an established period. Community attention and health care resources may then be directed to those areas of greatest impact and concern.

LEADING CAUSES OF DEATH

The data below reflects the leading causes of death for the CHNA Community and compares the crude death rates to the state of Texas and the United States.

Area	CHNA Community	Fort Bend County	Wharton County	Texas	United States
Cancer	107.80	102.20	212.90	143.40	183.50
Heart Disease	56.50	51.50	151.50	91.10	112.50
Lung Disease	15.30	14.50	30.20	36.80	48.00
Stroke	27.90	25.60	71.00	38.20	45.70
Unintentional Injury	23.80	22.10	54.20	39.30	53.40
Motor Vehicle	6.90	6.20	19.70	13.20	11.90
Drug Poisoning	7.80	7.50	13.90	12.40	23.90
Homicide	4.50	4.50	0.00	6.10	6.20
Suicide	10.60	10.20	17.70	13.30	14.30

Note: Crude Death Rate (Per 100,000 Pop.)

The table above shows leading causes of death within the CHNA Community as compared Texas and the United States. The crude death rate is shown per 100,000 residents. The rates in red represent the CHNA Community and corresponding leading causes of death that are higher than the national rates.

HEALTH OUTCOMES AND FACTORS

An analysis of various health outcomes and factors for a community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture, and environment. This portion of the community health needs assessment utilizes information from County Health Rankings.

The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state, and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks all 50 states and the counties within each state, based on the measurement of two types of health outcomes for each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by programs and policies at the local, state, and federal levels.

Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g., 1 or 2, are the "healthiest". Counties are ranked relative

to the health of other counties in the same state based on health outcomes and factors, clinical care, economic status, and the physical environment.

A number of different health factors shape a community's health outcomes. The County Health Rankings (www.countyhealthrankings.org) model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following tables include the 2018 and 2021 indicators reported by County Health Rankings for Fort Bend and Wharton Counties. The health indicators that are unfavorable when compared to the United States rates are listed in red.

Health Outcomes	Fort Bend County: 2018	Fort Bend County: 2021	Change	Texas: 2021	Top US Performers: 2021
Mortality: Texas County Ranking	**3**	**2**			
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	4,300	4,200	-	6,600	5,400
Morbidity: Texas County Ranking	**20**	**4**			
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	14%	15%	-	19%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	2.9	3.0	-	3.8	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.0	3.4	-	3.8	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	9.0%	9.0%	-	8.0%	6.0%

Health Outcomes	Fort Bend County: 2018	Fort Bend County: 2021	Change	Texas: 2021	Top US Performers: 2021
Health Behaviors: Texas County Ranking	1	2			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	12.0%	12.0%	NC	14.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	25.0%	26.0%	-	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.4	8.0	+	5.9	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	22.0%	18.0%	+	23.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	84.0%	89.0%	+	81.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	18.0%	18.0%	NC	19.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	36.0%	27.0%	+	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	346.2	422.4	-	517.6	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	15.0	11.0	+	31.0	12.0
Clinical Care: Texas County Ranking	8	8			
Uninsured adults – Percent of population under age 65 without health insurance	13.0%	13.0%	NC	20.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	1,250:1	1,160:1	+	1,640:1	1,030:1
Dentists – Ratio of population to dentists	1,930:1	1,770:1	+	1,680:1	1,210:1
Mental health providers – Ratio of population to mental health providers	1,670:1	1,350:1	+	830:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	43.0	41.8	+	47.9	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	61.0%	38.0%	-	37.0%	51.0%

Health Outcomes	Fort Bend County: 2018	Fort Bend County: 2021	Change	Texas: 2021	Top US Performers: 2021
Social and Economic Factors: Texas County Ranking	**13**	**8**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	93.0%	91.0%	-	84.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	75.0%	77.0%	+	62.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	5.0%	3.5%	+	3.5%	2.6%
Children in poverty – Percent of children under age 18 in poverty	11.0%	7.0%	+	19.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	4.1	4.1	NC	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	22.0%	19.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	4.9	4.7	-	7.5	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	262.0	246.0	+	420.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	33.0	35.0	-	58.0	59.0
Physical Environment: Texas County Ranking	**239**	**177**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	11.4	10.1	+	7.3	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	15.0%	14.0%	+	17.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	82.0%	82.0%	NC	81.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	58.0%	59.0%	-	39.0%	16.0%

Health Outcomes	Wharton County: 2018	Wharton County: 2021	Change	Texas: 2021	Top US Performers: 2021
Mortality: Texas County Ranking	**73**	**89**			
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,435	8,100	+	6,600	5,400
Morbidity: Texas County Ranking	**206**	**195**			
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	22%	25%	-	19%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.0	4.6	-	3.8	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.8	4.7	-	3.8	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	10.0%	9.0%	-	8.0%	6.0%

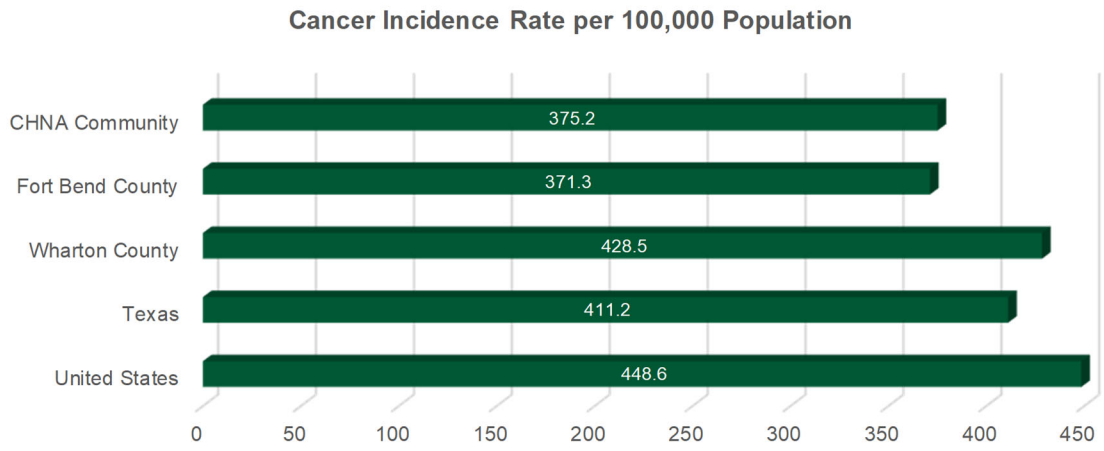
Health Outcomes	Wharton County: 2018	Wharton County: 2021	Change	Texas: 2021	Top US Performers: 2021
Health Behaviors: Texas County Ranking	**161**	**125**			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	16.0%	19.0%	-	14.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	31.0%	37.0%	-	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.4	7.2	-	5.9	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	27.0%	24.0%	+	23.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	75.0%	63.0%	-	81.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	17.0%	18.0%	-	19.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	28.0%	13.0%	+	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	410.5	295.5	+	517.6	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	53.0	43.0	+	31.0	12.0
Clinical Care: Texas County Ranking	**130**	**168**			
Uninsured adults – Percent of population under age 65 without health insurance	22.0%	23.0%	-	20.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	2,440:1	2,970:1	-	1,640:1	1,030:1
Dentists – Ratio of population to dentists	2,200:1	1,810:1	+	1,680:1	1,210:1
Mental health providers – Ratio of population to mental health providers	2,980:1	2,310:1	+	830:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	61.0	61.1	-	47.9	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	49.0%	34.0%	-	37.0%	51.0%

Health Outcomes	Wharton County: 2018	Wharton County: 2021	Change	Texas: 2021	Top US Performers: 2021
Social and Economic Factors: Texas County Ranking	**127**	**137**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	95.0%	78.0%	-	84.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	50.0%	54.0%	+	62.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	5.0%	3.4%	+	3.5%	2.6%
Children in poverty – Percent of children under age 18 in poverty	25.0%	22.0%	+	19.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	5.0	5.4	+	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	37.0%	31.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	16.9	15.4	-	7.5	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	412.0	439.0	-	420.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	67.0	69.0	-	58.0	59.0
Physical Environment: Texas County Ranking	**115**	**155**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	9.0	8.3	+	7.3	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	15.0%	16.0%	-	17.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	84.0%	87.0%	-	81.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	28.0%	29.0%	-	39.0%	16.0%

The following data shows a more detailed view of certain health outcomes and factors. The percentages for the CHNA Community are compared to the state of Texas and the United States.

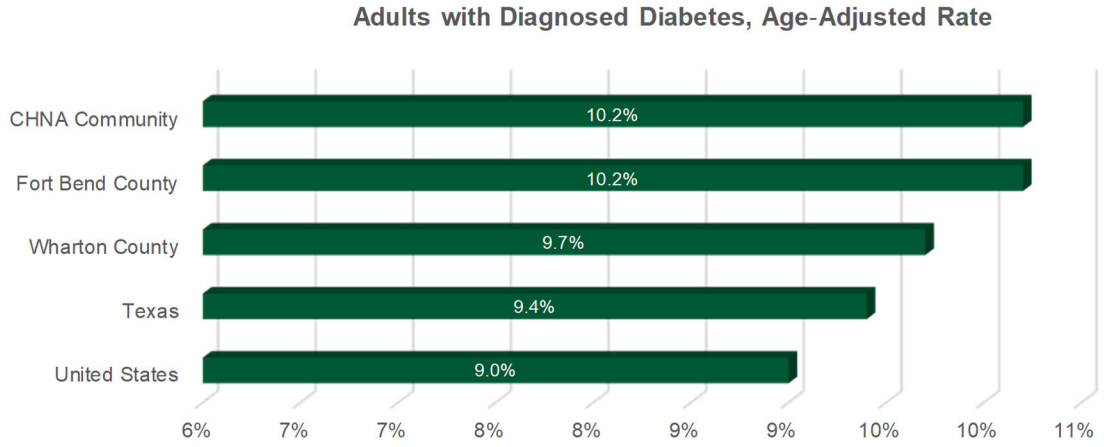
CANCER INCIDENCE

The CHNA Community's cancer incidence rate is 375.2 for every 100,000 of total population. Within the CHNA Community, there were 2,814 new cases of cancer reported. This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).



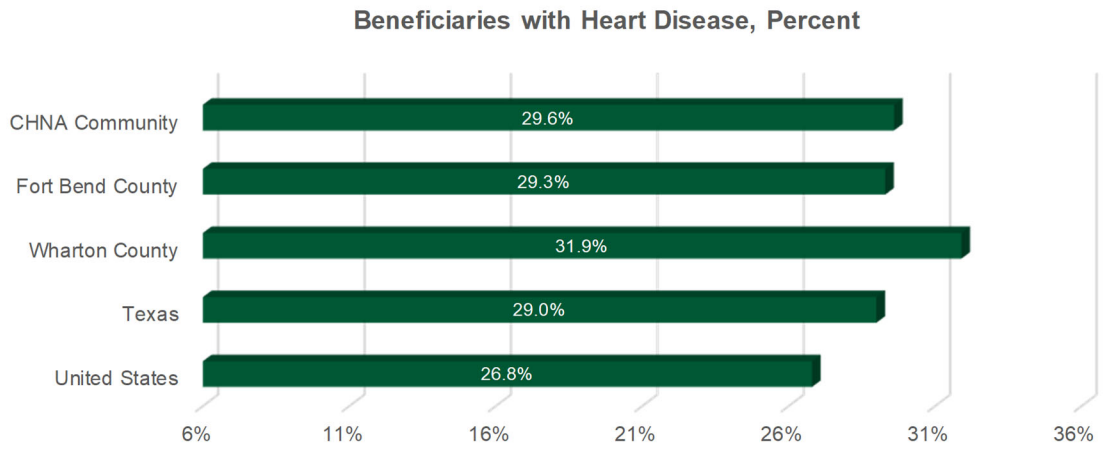
DIABETES (ADULT)

The CHNA Community's percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes is higher than the state rate and national rate. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.



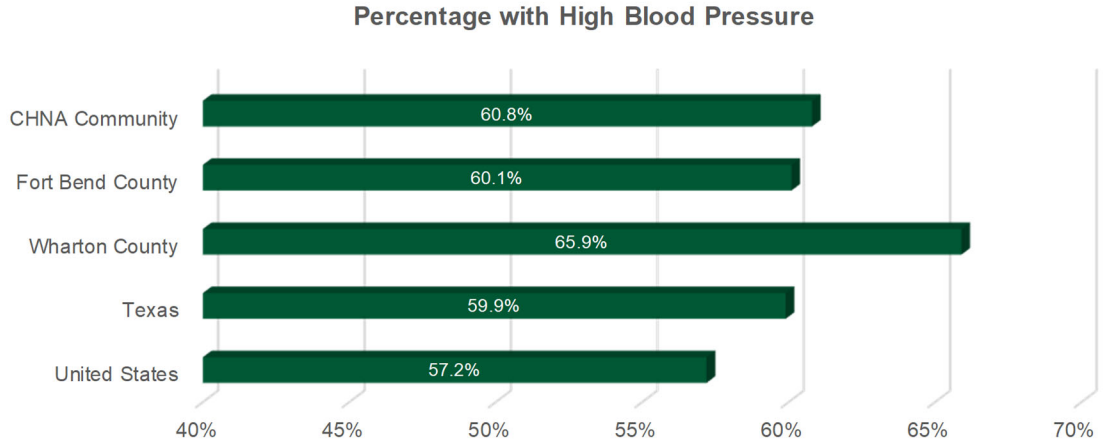
HEART DISEASE (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with Heart Disease is the higher than the state rate and national rate. This indicator reports the number and percentage of the Medicare fee-for-service population with ischemic heart disease.



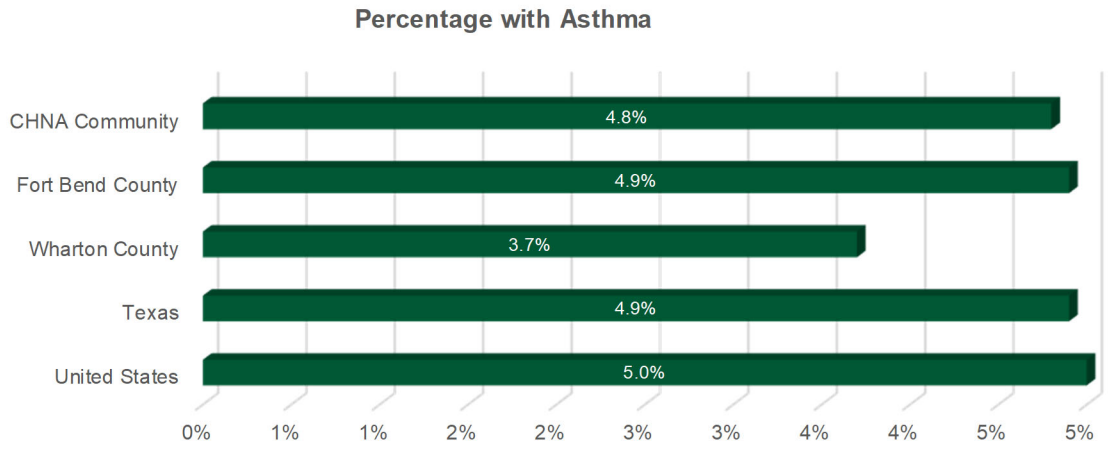
HIGH BLOOD PRESSURE (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with hypertension (high blood pressure) is higher than the state rate and national rates. This indicator reports the number and percentage of the Medicare fee-for-service population with hypertension (high blood pressure).



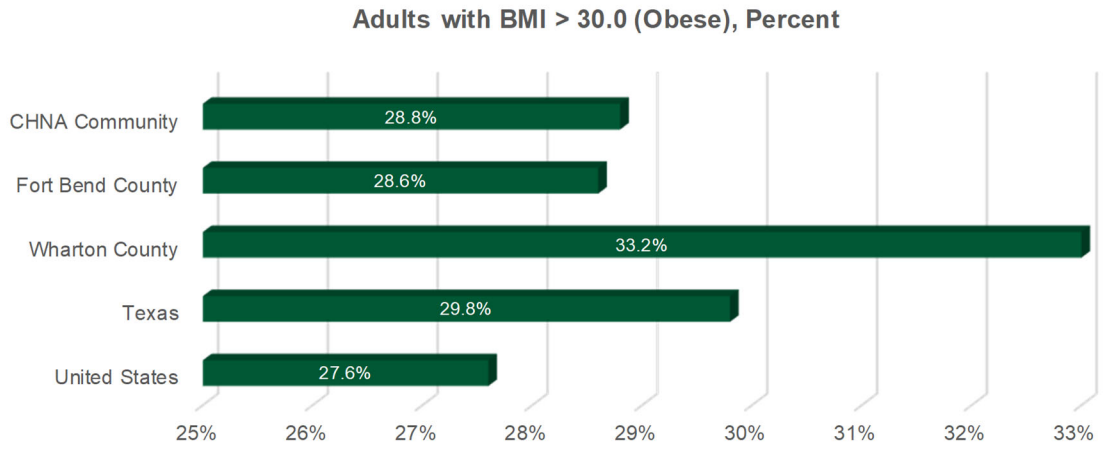
ASTHMA (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with asthma is lower than the state rate and national rate. This indicator reports the number and percentage of the Medicare fee-for-service population with asthma.



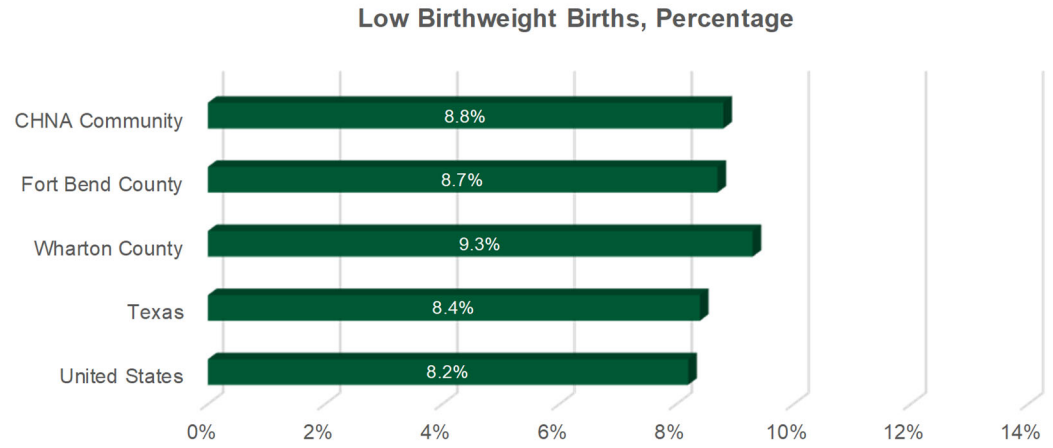
OBESITY

The CHNA Community's percentage of adults aged 20 and older that self-reported that they have a Body Mass Index (BMI) greater than 30.0 (obese) is lower than the state rate but higher than the national rates. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.



LOW BIRTH WEIGHT

The CHNA Community's percentage of total births that are low birth weight (under 2500g) is higher than the state and the national rates. This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.



PRIMARY DATA ASSESSMENT

Obtaining input from key stakeholders (persons with knowledge of or expertise in public health, persons representing vulnerable populations, or community members who represent the broad interest of the community, or) is a technique employed to assess public perceptions of the CHNA Community's health status and unmet needs. Key stakeholder input is intended to ascertain opinions among individuals likely to be knowledgeable about the community and influential over the opinions of others about health concerns in the community.

METHODOLOGY

Surveys completed by fifteen key informants to obtain their input on the health needs of the CHNA Community. The survey participants were determined based on their a) specialized knowledge or expertise in public health, b) their affiliation with local government, schools, or c) their involvement with underserved and minority populations and represent a broad aspect of the community.

A representative from Oakbend Medical Center assisted in contacting and scheduling all individuals selected for surveys. Their knowledge of the community, and the personal relationships they held with the potential survey participants added validity to the data collection process. Surveys were distributed and data was accumulated using an web-based survey tool.

All surveys utilized a standard format. Survey participant's opinions were collected without judging the truthfulness or accuracy of their remarks. Participants provided comments on the following issues:

- Health and quality of life for residents of the community
- Barriers to improving health and quality of life for residents of the community
- Opinions regarding the important health issues that affect the residents of the CHNA Community and the types of services that are important for addressing these issues
- Delineation of the most important health care issues or services discussed and actions necessary for addressing those issues

Survey data was collected and analyzed. Themes in the data were identified from the data to illustrate the themes. Survey participants were assured that personal identifiers such as name or organizational affiliations would not be connected in any way to the information presented in this report. Therefore, any quotes included in the report may have been altered slightly to preserve confidentiality. This technique does not provide a quantitative analysis of the leaders' opinions but reveals some of the factors affecting the views and sentiments about overall health and quality of life within the community.

KEY INFORMANT PROFILES

Key informants from the community worked for the following types of organizations and agencies:

- Local, county, and state government
- Public health agencies
- Medical providers

Input from these health care and non-health care professionals was obtained utilizing a standard 15 question interview format.

KEY INFORMANT INTERVIEW QUESTIONS

Input from these health care and non-health care professionals was obtained utilizing a standard 12-question survey format. The questions included were as follows:

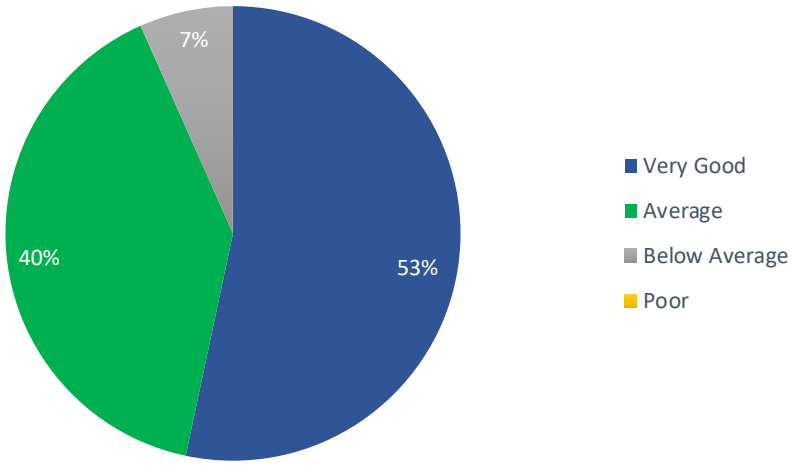
1. Name
2. Organization
3. County of Residence
4. In general, how would you rate the health and quality of life in the community served by Oakbend Medical Center?
5. In your opinion, in the past three years has the health and quality of life in the community served by Oakbend Medical Center improved, declined, or stayed the same?
6. Please provide what factors influenced your answer in the previous question and describe why you feel the health and quality of life has improved, declined or stayed the same?

7. What barriers, if any, exist to improving health and quality of life of patients served by Oakbend Medical Center?
8. In your opinion, what needs to be done to address the barriers identified in the previous question?
9. How could the services provided by Oakbend Medical Center be improved to better meet the needs of its patients and patient's families?
10. In your opinion, what groups of people in the community served by Oakbend Medical Center have the most serious unmet health care needs? Describe the causes? What should be done to address the needs of these groups of people?
11. In your opinion, what are the three most critical health needs in the community served by Oakbend Medical Center?
12. What needs to be done to address the critical health needs issues identified in the previous question?

RESULTS FROM COMMUNITY INPUT

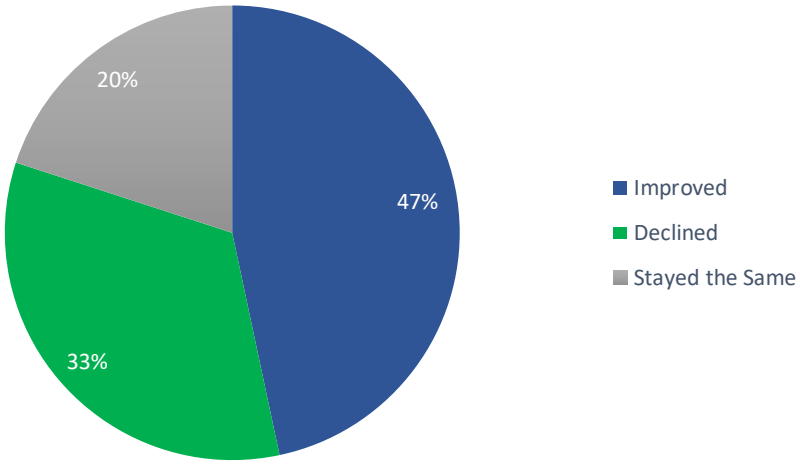
Below is a summary of key informant survey interview responses to the questions listed above.

In general, how would you rate the health and quality of life in the community served by Oakbend Medical Center?



A majority of survey respondents rate the health of the CHNA Community as "Very Good". Only seven percent of survey respondents rate the health of the CHNA Community as "Below Average" or "Poor".

In your opinion, in the past three years has the health and quality of life in the community served by Oakbend Medical Center improved, declined, or stayed the same?



What factors influenced your answer in the previous question and describe why you feel the health and quality of life has improved, declined, or stayed the same?

- Communication regarding resources available in the CHNA Community has improved.
- Oakbend Medical Center has been able to mitigate the changing challenges of COVID to keep the community healthy as possible. The advocated for the vaccinations of everyone in the community
- The pandemic and economy have adversely impacted the health and quality of life in the CHNA Community
- Oakbend Medical Center has stabilized its workforce by reducing turnover rate
- Increased unemployment benefits have helped improve the health of the community during COVID
- COVID has created more mental health issues in the community
- Lack of adequate childcare is a problem in the community
- Oakbend Medical Center provides a “No wait” emergency room, air ambulance, and excellent physicians and staff
- The families and individuals find it difficult to schedule doctors’ appointments.
- COVID, poverty, and lack of health insurance have adversely affected the health of the community
- Oakbend medical Center has developed programs that are beneficial to the community and been flexible to accommodate the urgent needs during crisis, flood and freezes

What barriers, if any, exist to improving health and quality of life of patients served by Oakbend Medical Center?

- Connecting with those individuals in the community that may be hesitant to take advantage of what is health care resources available
- Shortages of health care staffing
- Economics. The cost of living, and the cost of health care services, in the community has increased
- Lack of medical insurance
- Transportation

How could the services provided by Oakbend Medical Center be improved to better meet the needs of its patients and patient's families?

- Expanded engagement with other organizations to meet the needs of the underserved in the community
- More communication regarding health issues with the community
- Increase the number of primary care physicians in the community
- Increase the number of specialists
- Expand facilities to meet future population demand
- Increased communication with the community about available resources and services
- Outreach programs to promote good health and preventative medicine
- More support by county government
- Provide more health education

What groups of people in the community served by Oakbend Medical Center have the most serious unmet health care needs? Describe the causes? What should be done to address the needs of these groups of people?

- Individuals without financial means
- Uninsured or under-insured individuals
- Elderly
- Immigrants
- Individuals living in single parent households

What are the three most critical health needs in the community served by Oakbend Medical Center?

- General health awareness
- Lack of disease prevention services and education
- Illness detection
- Difficulty getting COVID vaccinations and promoting COVID vaccinations to the unvaccinated

- Childhood vaccinations
- Lack of mental health services
- Diabetes
- Obesity
- Improved communications between medical group and hospital
- Diabetic wounds and conditions
- Outpatient wound care
- Cardiopulmonary
- Lack of affordable specialty care for the uninsured and Medicaid
- Increase of chronic diseases
- Heart disease
- Emergency services
- COVID
- Poverty
- Lack of health insurance
- Lack of wellness programs
- Lack of health education targeted at high school students
- Lack of education for seniors regarding Medicare benefits

HEALTH ISSUES OF VULNERABLE POPULATIONS

According to Dignity Health's Community Need Index (see *Appendix D*), the Fort Bend County has a CNI score of 3.4, whereas Wharton County has a CNI score of 4.2 The CNI score is an average of five different barrier scores that measure socioeconomic indicators of each community (income, cultural, education, insurance, and housing). The scores range from 1 (lowest) to 5 (highest). The zip codes that have the highest need in the Medical Center's CHNA Community are detailed on the following table:

Zip Code	CNI Score	Population	City	County
77053	4.6	33,362	Houston	Fort Bend
77471	4.8	47,023	Rosenberg	Fort Bend
77477	4.2	41,132	Stafford	Fort Bend
77420	4.2	2,453	Boling	Wharton
77437	4.6	17,415	El Campo	Wharton
77455	4.2	2,014	Louise	Wharton
77488	4.8	14,047	Wharton	Wharton

Based on information obtained through key informant surveys, the following populations are vulnerable or underserved in the community and the identified needs are listed:

- Uninsured and under-insured population
  - Transportation
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
- Elderly
  - Transportation
  - Cost of prescriptions and medical care
  - Lack of health knowledge regarding how to access services
  - Shortage of physicians (limit on patients who are on Medicare)
- Low income
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
  - Access to services
- Immigrants
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
  - Access to services
  - Language barriers prevent needs from being met

PRIORITIZATION OF IDENTIFIED HEALTH NEEDS

Priority setting is a required step in the community benefit planning process. The IRS regulations indicate that the CHNA must provide a prioritized description of the community health needs identified through the CHNA and include a description of the process and criteria used in prioritizing the health needs.

Using findings obtained through the collection of primary and secondary data, the Hospital completed an analysis of these inputs (see Appendices) to identify community health needs. The following data was analyzed to identify health needs for the community:

LEADING CAUSES OF DEATH

Leading causes of death for the community and the death rates for the leading causes of death for the county within the Hospital's CHNA Community were compared to U.S. adjusted death rates.

Causes of death in which the county rate compared unfavorably to the U.S. adjusted death rate resulted in a health need for the Hospital's CHNA Community.

HEALTH OUTCOMES AND FACTORS

An analysis of the County Health Rankings health outcomes and factors data was prepared for the county within Oakbend Medical Center's CHNA Community. County rates and measurements for health behaviors, clinical care, social and economic factors, and the physical environment were compared to state benchmarks.

County rankings in which the county rate compared unfavorably (by greater than 30% of the national benchmark) resulted in an identified health need.

PRIMARY DATA

Health needs identified through key informant surveys were included as health needs. Needs for vulnerable populations were separately reported on the analysis in order to facilitate the prioritization process.

HEALTH NEEDS OF VULNERABLE POPULATIONS

Health needs of vulnerable populations were included for ranking purposes.

PRIORITIZATION METHODOLOGY

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following factors (each factor received a score):

1. **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.
2. **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.
3. **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.
4. **How important the problem is to the community?** Needs identified through community interviews and/or focus groups were rated for this factor.
5. **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, health outcomes and factors and primary data) identified the need.

Each need was ranked based on the prioritization metrics. As a result, the following summary list of needs was identified:

Identified Health Needs	How Many People Are Affected by the Issue? (1 Low - 5 High)	What Are the Consequences of Not Addressing This Problem? (1 Low - 5 High)	What is the Impact on Vulnerable Populations? (1 Low - 5 High)	How Important is it to the Community? (1 Low - 5 High)	Prevalence of Common Themes (1 Low - 2 High)	Alignment with Mission (1 Low - 5 High)	Alignment with Programs & Strategic Priorities (1 Low - 5 High)	Total Score
Access to care	5	4	5	4	2	5	5	30
Shortage of healthcare workers	5	4	3	4	2	5	5	28
Treatment of & mgmt of chronic diseases & conditions	4	5	3	4	2	5	5	28
Access to and use of preventative care treatments	5	3	3	4	2	5	5	27
Access to primary care physicians	5	3	3	4	2	5	5	27
Access to medical specialists	5	3	3	4	2	5	5	27
Access to COVID-19 treatment, testing, and vaccines	5	4	3	4	1	5	5	27
Healthy behaviors and healthy lifestyle choices	3	4	5	3	2	5	2	24
Access to mental health services - adults and children	5	3	3	4	2	5	1	23
Access to drug and alcohol treatment services	5	3	3	4	2	5	1	23
Poverty and lack of financial resources	2	4	5	4	2	5	1	23
Uninsured and under-insured	3	3	4	3	2	5	3	23
Health education	3	3	5	3	2	5	1	22
Obesity	3	5	3	3	2	5	1	22
Transportation	3	3	4	4	2	5	1	22
Access to services for the aging	3	3	5	4	1	3	3	22
Access to and use of wellness programs	5	3	3	3	1	5	1	21
Access to healthy food options	5	3	3	3	1	5	1	21
Preventable hospital stays	2	2	2	3	1	5	5	20
Wound care services	2	2	2	2	1	5	5	19
Access to dental health services	5	2	3	4	2	1	1	18
Childhood vaccinations	3	4	4	3	1	1	1	17
Emergency services	3	3	3	3	1	3	1	17
Children in poverty	2	2	5	4	1	1	1	16
Sexually transmitted infections	2	3	3	3	1	1	3	16
Children in single-parent households	2	2	5	3	1	1	1	15
Teen birth rate	1	1	3	3	1	3	2	14
Alcohol-impaired driving deaths	2	2	1	3	1	1	1	11

MANAGEMENT'S PRIORITIZATION PROCESS

For the health needs prioritization process, the Hospital engaged the leadership team to review the most significant health needs identified in the current process, using the following criteria:

- Current area of Hospital focus
- Established relationships with community partners to address the health need
- Organizational capacity and existing infrastructure to address the health need

This data was reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community. As a result of the analysis described above, seven "Priority Areas" have been identified by OMC based on the needs identified in the community health needs assessment:

- Access to care
- Shortage of healthcare workers
- Treatment of and management of chronic diseases and conditions
- Access to and use of preventative care treatments
- Access to primary care physicians
- Access to medical specialists
- Access to COVID-19 treatment, testing, and vaccines
- Healthy behaviors and healthy lifestyle choices
- Access to mental health services - adults and children
- Access to drug and alcohol treatment services
- Poverty and lack of financial resources
- Uninsured and under-insured
- Health education
- Obesity
- Transportation
- Access to services for the aging
- Access to and use of wellness programs
- Access to healthy food options
- Preventable hospital stays

The Hospital's next steps include developing an implementation strategy to address these priority areas.

COMMUNITY RESOURCES

The availability of health care resources is a critical component to the health of a county's residents and a measure of the soundness of the area's health care delivery system. An adequate number of health care facilities and health care providers are vital for sustaining a community's health status. Fewer health care facilities and health care providers can impact the timely delivery of services. A limited supply of health resources, especially providers, results in the limited capacity of the health care delivery system to absorb charity and indigent care as there are fewer providers upon which to distribute the burden of indigent care.

HOSPITALS

The Medical Center has 280 beds and is the only hospital facility located within the CHNA community. Residents of the community can take advantage of services provided by hospitals in neighboring counties, as well as services offered by other facilities and providers.

The following table summarizes hospitals available to the residents of the CHNA Community. The facilities listed are located within the CHNA Community served by the Medical Center.

Facility Name	Type of Facility	City, State Zip
OakBend Medical Center	Hospital	Richmond, TX 77469
OakBend Medical Center	Hospital	Wharton, TX 77488
Memorial Hermann Sugar Land Hospital	Hospital	Sugar Land, TX 77479
Memorial Herman Surgical Hospital First Colony	Hospital	Sugar Land, TX 77479
Atrium Medical Center	Hospital	Stafford, TX 77477
El Campo Memorial Hospital	Hospital	El Campo, TX 77437
Encompass Health Rehabilitaion Hospital	Hospital	Sugar Land, TX 77478
Houston Methodist Sugar Land Hospital	Hospital	Sugar Land, TX 77479
Kindred Hospital Sugar Land	Hospital	Sugar Land, TX 77479
Pam Health Rehabilitation Hospital of Sugar Land	Hospital	Sugar Land, TX 77479
St. Lukes Sugar Land Hospital	Hospital	Sugar Land, TX 77478
St. Michael's Elite Hospital	Hospital	Sugar Land, TX 77479
United Memorial Medical Center	Hospital	Sugar Land, TX 77478

OTHER HEALTH CARE FACILITIES

Short-term acute care hospital services are not the only health services available to members of the Hospital's CHNA Community. Within the CHNA Community there are numerous community health centers, clinics, and health care providers located within retail facilities like CVS and Walgreens.

PHYSICIANS

The Medical Center regularly monitors physician supply and demand. The key informant surveys indicated the need for additional primary care physicians and specialists.

HEALTH DEPARTMENT

The Department of Health and Human Services is Fort Bend County's principal agency for protecting the health of county residents and providing essential human services, especially for those who are least able to help themselves. The Department includes subordinate departments and programs, covering a wide spectrum of activities.

The departments and programs within the Health & Human Services Agency include:

- Clinical Health Services
- Emergency Medical Services
- Environmental Health
- Social Services
- Indigent Health Care
- Pinnacle Senior Center
- Public Health Preparedness

APPENDICES

APPENDIX A – ANALYSIS OF DATA

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: FORT BEND COUNTY

Area	United States	(A) 10% of United States Crude Rate	Fort Bend County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	183.50	18.35	102.20	-81.30	
Heart Disease	112.50	11.25	51.50	-61.00	
Lung Disease	48.00	4.80	14.50	-33.50	
Stroke	45.70	4.57	25.60	-20.10	
Unintentional Injury	53.40	5.34	22.10	-31.30	
Motor Vehicle	11.90	1.19	6.20	-5.70	
Drug Poisoning	23.90	2.39	7.50	-16.40	
Homicide	6.20	0.62	4.50	-1.70	
Suicide	14.30	1.43	10.20	-4.10	

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: WHARTON COUNTY

Area	United States	(A) 10% of United States Crude Rate	Wharton County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	183.50	18.35	212.90	29.40	Health Need
Heart Disease	112.50	11.25	151.50	39.00	Health Need
Lung Disease	48.00	4.80	30.20	-17.80	
Stroke	45.70	4.57	71.00	25.30	Health Need
Unintentional Injury	53.40	5.34	54.20	0.80	
Motor Vehicle	11.90	1.19	19.70	7.80	Health Need
Drug Poisoning	23.90	2.39	13.90	-10.00	
Homicide	6.20	0.62	0.00	-6.20	
Suicide	14.30	1.43	17.70	3.40	Health Need

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH OUTCOMES: FORT BEND COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Fort bend County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	12.0%	-4.0%	
Adult obesity	26.0%	7.8%	26.0%	0.0%	
Food environment index	8.7	2.6	8.0	(0.7)	
Physical inactivity	19.0%	5.7%	18.0%	-1.0%	
Access to exercise opportunities	91.0%	27.3%	89.0%	-2.0%	
Excessive drinking	15.0%	4.5%	18.0%	3.0%	
Alcohol-impaired driving deaths	11.0%	3.3%	27.0%	16.0%	Health Need
Sexually transmitted infections	161.2	48.4	422.4	261.2	Health Need
Teen birth rate	12.00	3.60	11.00	(1.00)	
Uninsured adults	6.0%	1.8%	13.0%	7.0%	Health Need
Primary care physicians	1,030	309	1,160	130	
Dentists	1,210	363	1,770	560	Health Need
Mental health providers	270	81	1,350	1,080	Health Need
Preventable hospital stays	25.7	7.7	41.8	16.1	Health Need
Mammography screening	51.0%	15.3%	38.0%	-13.0%	
Children in poverty	10.0%	3.0%	7.0%	-3.0%	
Children in single-parent households	14.0%	4.2%	19.0%	5.0%	Health Need

ANALYSIS OF HEALTH OUTCOMES: WHARTON COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Wharton County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	19.0%	3.0%	
Adult obesity	26.0%	7.8%	37.0%	11.0%	Health Need
Food environment index	8.7	2.6	7.2	(1.5)	
Physical inactivity	19.0%	5.7%	24.0%	5.0%	
Access to exercise opportunities	91.0%	27.3%	63.0%	-28.0%	
Excessive drinking	15.0%	4.5%	18.0%	3.0%	
Alcohol-impaired driving deaths	11.0%	3.3%	2.0%	-9.0%	
Sexually transmitted infections	161.2	48.4	295.5	134.3	Health Need
Teen birth rate	12.0	3.6	43.0	31.0	Health Need
Uninsured adults	6.0%	1.8%	23.0%	17.0%	Health Need
Primary care physicians	1,030	309	2,970	1,940	Health Need
Dentists	1,210	363	1,810	600	Health Need
Mental health providers	270	81	2,310	2,040	Health Need
Preventable hospital stays	2,565.0	769.5	61.1	(2,503.9)	
Mammography screening	51.0%	15.3%	34.0%	-17.0%	
Children in poverty	10.0%	3.0%	22.0%	12.0%	Health Need
Children in single-parent households	14.0%	4.2%	31.0%	17.0%	Health Need

ANALYSIS OF PRIMARY DATA – KEY INFORMANT SURVEYS

Identified Needs
Access to care
Shortage of healthcare workers
Access to and use of preventative care treatments
Treatment of and management of chronic diseases & conditions
Access to primary care physicians
Access to medical specialists
Healthy behaviors and healthy lifestyle choices
Access to mental health services - adults and children
Access to COVID-19 treatment, testing, and vaccines
Health education
Obesity
Access to services for the aging
Poverty and lack of financial resources
Transportation
Childhood vaccinations
Wound care services
Emergency services
Uninsured and under-insured
Access to and use of wellness programs

ISSUES OF UNINSURED PERSONS, LOW-INCOME PERSONS AND MINORITY/VULNERABLE POPULATIONS

Population	Issues
Uninsured and under-insured population	○ Transportation ○ High cost of health care prevents needs from being met ○ Healthy lifestyle and health nutrition education
Elderly	○ Transportation ○ Cost of prescriptions and medical care ○ Lack of health knowledge regarding how to access services ○ Shortage of physicians (limit on patients who are on Medicare)
Low Income	○ High cost of health care prevents needs from being met ○ Healthy lifestyle and health nutrition education ○ Access to services
Immigrants	○ High cost of health care prevents needs from being met ○ Healthy lifestyle and health nutrition education ○ Access to services ○ Language barriers prevent needs from being met

APPENDIX C – ACKNOWLEDGEMENT OF KEY INFORMANTS

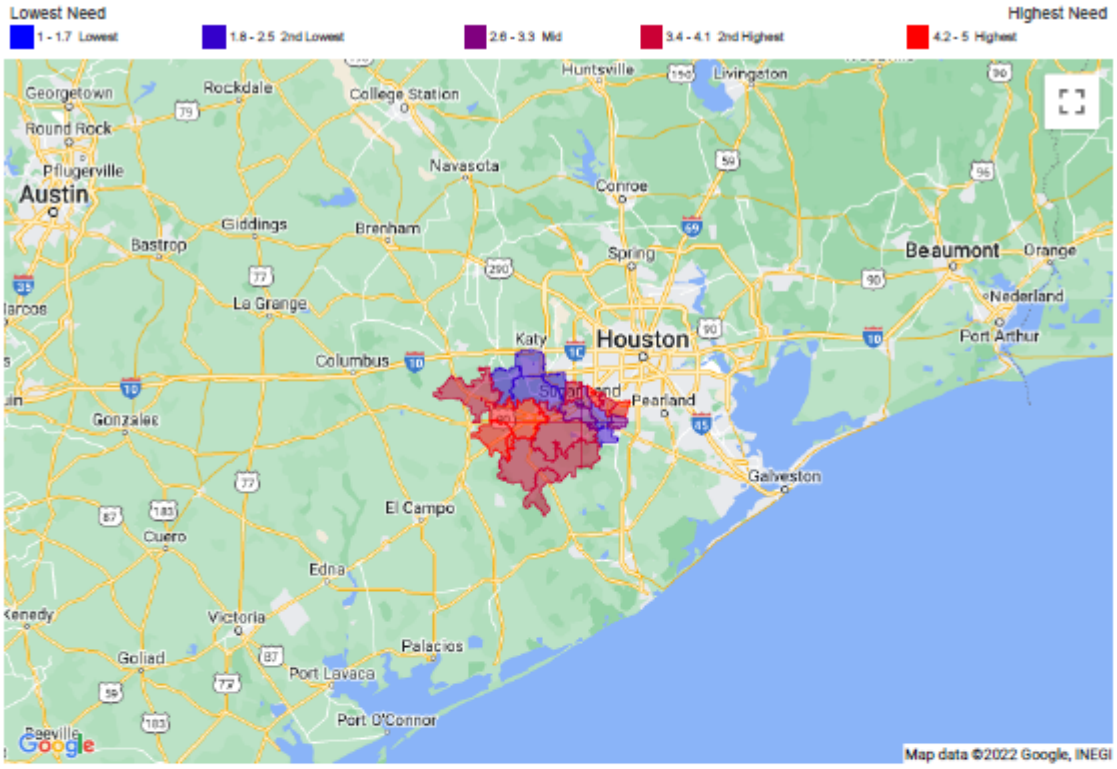
KEY INFORMANTS

Thank you to the following individuals who participated in our key informant survey process:

Name	Organization
Donna Ferguson	OakBend Medical Center
Adam Pisani	The Pisani Agency
James Patterson	Community Member
Ron Sanders	Wharton Chamber of Commerce
Tim Kaminski	Gingerbread Kids Academy
Gary Gillen	Gillen Pest Control
Karen Heintschel	Wharton Economic Development Corporation
Jess Stuart	YMCA
Palak Jalan	AccessHealth
Sheree Oehlke	Oakbend Medical Center
Priscilla Metcalf	Wharton Eye Associates
Milton Wright	Retired Police
May Tape	May W. Tape, DDS, PC
Barbara Reed	Oakbend Medical Center
Bill Rickert	Fort Bend County Treasurer

APPENDIX D – DIGNITY HEALTH COMMUNITY NEED INDEX (CNI) REPORT

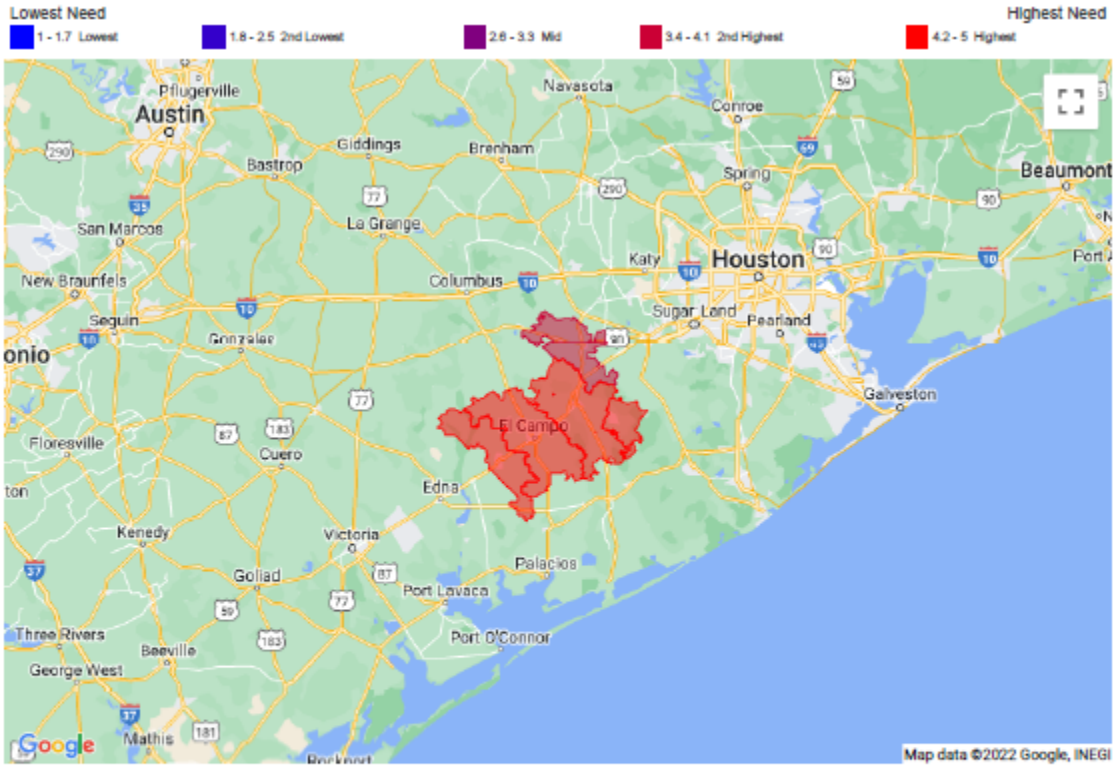
DIGNITY HEALTH CNI SCORE DETAIL – FORT BEND COUNTY



Mean(zipcode): 3.4 / Mean(person): 3 | CNI Score Median: 3.4 | CNI Score Mode: 2.4,4

Zip Code	CNI Score	Population	City	County	State
77053	4.6	33362	Houston	Fort Bend	Texas
77406	2.4	53729	Richmond	Fort Bend	Texas
77407	2.4	61425	Richmond	Fort Bend	Texas
77417	4.2	2698	Beasley	Fort Bend	Texas
77441	2.2	14352	Fulshear	Fort Bend	Texas
77444	4	1216	Guy	Fort Bend	Texas
77459	2.4	77717	Missouri City	Fort Bend	Texas
77461	3.8	12638	Needville	Fort Bend	Texas
77469	4	53301	Richmond	Fort Bend	Texas
77471	4.8	47023	Rosenberg	Fort Bend	Texas
77477	4.2	41132	Stafford	Fort Bend	Texas
77478	3.2	28118	Sugar Land	Fort Bend	Texas
77479	2.6	102503	Sugar Land	Fort Bend	Texas
77485	4	4992	Wallis	Fort Bend	Texas
77489	3.4	40932	Missouri City	Fort Bend	Texas
77494	2.2	128069	Katy	Fort Bend	Texas
77498	3.4	62961	Sugar Land	Fort Bend	Texas
77545	3	27212	Fresno	Fort Bend	Texas

DIGNITY HEALTH CNI SCORE DETAIL – WHARTON COUNTY



Mean(zipcode): 4.3 / Mean(person): 4.5 CNI Score Median: 4.2 CNI Score Mode: 4,4.2

Zip Code	CNI Score	Population	City	County	State
77420	4.2	2453	Boling	Wharton	Texas
77435	4	5864	East Bernard	Wharton	Texas
77437	4.6	17415	El Campo	Wharton	Texas
77443	4	158	Glen Flora	Wharton	Texas
77455	4.2	2014	Louise	Wharton	Texas
77488	4.8	14047	Wharton	Wharton	Texas

APPENDIX E – COMMUNITY SURVEY QUESTIONS

Oakbend Medical Center is gathering information as part of a plan to improve health and quality of life in the community it serves. Community input is essential to this process. This survey is being used to engage community members. You have been selected to complete the survey below because of your knowledge, insight, and familiarity with the community and the services provided by the medical center. Some of the following survey questions are open-ended. In these instances, we are trying to gather your thoughts and opinions. There are no right or wrong answers. The themes that emerge from these questions will be summarized and made available to the public; however, your identity will be kept strictly confidential. It will take approximately fifteen minutes to complete the survey. Your participation in this survey is completely voluntary. There are no foreseeable risks associated with this project. However, if you feel uncomfortable answering any questions, you can withdraw from the survey at any point. It is very important for us to learn your opinions. Oakbend Medical Center has engaged the independent advisory firm, BKD, LLP, to assist with the assessment. If you have questions at any time about the survey or the procedures, you may contact Aaron Hershberger at (513) 562-5560 or by email at ahershberger@bkd.com. Thank you very much for your time and support. Please start with the survey now by clicking on the "Start" button below.

Name:

Organization:

County of residence?

In general, how would you rate the health and quality of life in the community served by Oakbend Medical Center?

1. Very Good
2. Average
3. Below Average
4. Poor

In your opinion, in the past three years has the health and quality of life in the community served by Oakbend Medical Center improved, declined, or stayed the same?

1. Improved
2. Declined
3. Stayed the same

Please provide what factors influenced your answer in the previous question and describe why you feel the health and quality of life has improved, declined or stayed the same?

What barriers, if any, exist to improving health and quality of life of patients served by Oakbend Medical Center?

In your opinion, what needs to be done to address the barriers identified in the previous question?

How could the services provided by Oakbend Medical Center be improved to better meet the needs of its patients and patient's families?

In your opinion, what groups of people in the community served by Oakbend Medical Center have the most serious unmet health care needs? Describe the causes? What should be done to address the needs of these groups of people?

In your opinion, what are the three most critical health needs in the community served by Oakbend Medical Center?

What needs to be done to address the critical health needs issues identified in the previous question?

APPENDIX F – SOURCES

Data Indicator	Source
Total Population	US Census Bureau, American Community Survey, 2015-19.
Total Population Change, 2000 - 2010	US Census Bureau, Decennial Census, 2000 - 2010.
Total Population Change, 2010-2020	US Census Bureau, Decennial Census, 2020.
Urban and Rural Population	US Census Bureau, Decennial Census, 2010.
Group Quarters Population	US Census Bureau, Decennial Census, 2020.
Female Population	US Census Bureau, American Community Survey, 2015-19.
Families with Children	US Census Bureau, American Community Survey, 2015-19.
Median Age	US Census Bureau, American Community Survey, 2015-19.
Male Population	US Census Bureau, American Community Survey, 2015-19.
Population Under Age 18	US Census Bureau, American Community Survey, 2015-19.
Population Age 0-4	US Census Bureau, American Community Survey, 2015-19.
Population Age 5-17	US Census Bureau, American Community Survey, 2015-19.
Population Age 18-64	US Census Bureau, American Community Survey, 2015-19.
Population Age 18-24	US Census Bureau, American Community Survey, 2015-19.
Population Age 25-34	US Census Bureau, American Community Survey, 2015-19.
Population Age 35-44	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Population Age 45-54	US Census Bureau, American Community Survey, 2015-19.
Population Age 55-64	US Census Bureau, American Community Survey, 2015-19.
Population Age 65+	US Census Bureau, American Community Survey, 2015-19.
Population with Any Disability	US Census Bureau, American Community Survey, 2015-19.
Population in Limited English Households	US Census Bureau, American Community Survey, 2015-19.
Population with Limited English Proficiency	US Census Bureau, American Community Survey, 2015-19.
Population Geographic Mobility	US Census Bureau, American Community Survey, 2015-19.
Foreign-Born Population	US Census Bureau, American Community Survey, 2015-19.
Hispanic Population	US Census Bureau, American Community Survey, 2015-19.
Non-Hispanic White Population	US Census Bureau, American Community Survey, 2015-19.
Black or African American Population	US Census Bureau, American Community Survey, 2015-19.
Citizenship Status	US Census Bureau, American Community Survey, 2015-19.
Veteran Population	US Census Bureau, American Community Survey, 2015-19.
Migration Patterns - Total Population	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Migration Patterns - Young Adult	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Commuter Travel Patterns - Driving Alone to Work	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Commuter Travel Patterns - Long Commute	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Overview	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Overview 2	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Public Transportation	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Walking or Biking	US Census Bureau, American Community Survey, 2015-19.
Employment - Business Creation	US Census Bureau, Statistics of U.S. Businesses, 2018-2019.
Employment - Employment Change	US Census Bureau, Business Dynamics Statistics, 2018-2019.
Employment - Job Sectors, Largest	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Jobs and Earnings by Sector	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Jobs Sectors, Highest Earnings	US Department of Commerce, US Bureau of Economic Analysis.
Employment - Labor Force Participation Rate	US Census Bureau, American Community Survey, 2015-19.
Gross Domestic Product (GDP)	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Unemployment Rate	US Department of Labor, Bureau of Labor Statistics, 2021 - December.
Income - Earned Income Tax Credit	IRS - Statistics of Income, 2018.
Income - Families Earning Over $75,000	US Census Bureau, American Community Survey, 2015-19.
Income - Income and AMI	US Census Bureau, American Community Survey, 2015-2019.

Data Indicator	Source
Income - Inequality (Atkinson Index)	US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11.
Income - Inequality (GINI Index)	US Census Bureau, American Community Survey, 2015-19.
Income - Median Family Income	US Census Bureau, American Community Survey, 2015-19.
Income - Median Household Income	US Census Bureau, American Community Survey, 2015-19.
Income - Net Income of Farming Operations	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Income - Per Capita Income	US Census Bureau, American Community Survey, 2015-19.
Income - Proprietor Employment and Income	US Department of Commerce, US Bureau of Economic Analysis, 2016.
Income - Public Assistance Income	US Census Bureau, American Community Survey, 2015-19.
Income - Transfer Payments	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Poverty - Children Below 100% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Children Below 200% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data, 2019-20.
Poverty - Population Below 100% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Population Below 100% FPL (Annual)	US Census Bureau, Small Area Income and Poverty Estimates, 2020.
Poverty - Population Below 185% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Population Below 200% FPL	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Poverty - Population Below 50% FPL	US Census Bureau, American Community Survey, 2015-19.
Access - Head Start	US Department of Health & Human Services, HRSA - Administration for Children and Families, 2019.
Access - Preschool Enrollment (Age 3-4)	US Census Bureau, American Community Survey, 2015-19.
Access - Public Schools	National Center for Education Statistics, NCES - Common Core of Data, 2019-2020.
Attainment - Associate's Level Degree or Higher	US Census Bureau, American Community Survey, 2015-19.
Attainment - Bachelor's Degree or Higher	US Census Bureau, American Community Survey, 2015-19.
Attainment - High School Graduation Rate	US Department of Education, EDFacts, 2018-19.
Attainment - No High School Diploma	US Census Bureau, American Community Survey, 2015-19.
Attainment - Overview	US Census Bureau, American Community Survey, 2015-19.
Attainment - Some Post-secondary Education	US Census Bureau, American Community Survey, 2014-18.
Chronic Absence Rate	U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18.
Proficiency - Student Math Proficiency (4th Grade)	US Department of Education, EDFacts, 2018-19.
Proficiency - Student Reading Proficiency (4th Grade)	US Department of Education, EDFacts, 2018-19.
Family Households - Overview	US Census Bureau, American Community Survey, 2015-19.
Households - Overview	US Census Bureau, American Community Survey, 2015-19.
Affordable Housing	US Census Bureau, American Community Survey, 2015-2019.

Data Indicator	Source
Affordable Housing - Low Income Tax Credits	US Department of Housing and Urban Development, 2019.
Affordable Housing - Assisted Housing Units	US Department of Housing and Urban Development, US Census Bureau, American Community Survey, 2019.
Evictions	Eviction Lab, 2016.
Household Structure - Older Adults Living Alone	US Census Bureau, American Community Survey, 2015-19.
Household Structure - Single-Parent Households	US Census Bureau, American Community Survey, 2015-2019.
Housing Costs - Cost Burden (30%)	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Cost Burden, Severe (50%)	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Owner Costs	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Owner Costs by Mortgage Status	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Renter Costs	US Census Bureau, American Community Survey, 2015-19.
Housing Quality - Overcrowding	US Census Bureau, American Community Survey, 2015-19.
Housing Quality - Substandard Housing	US Census Bureau, American Community Survey, 2015-19.
Housing Quality - Substandard Housing, Severe	US Census Bureau, American Community Survey, 2011-2015.
Housing Stock - Age	US Census Bureau, American Community Survey, 2015-19.
Housing Stock - Housing Unit Value	US Census Bureau, American Community Survey, 2015-19.
Housing Stock - Modern Housing	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Housing Stock - Mortgage Lending	Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014.
Housing Stock - Net Change	US Census Bureau, Decennial Census, US Census Bureau, American Community Survey, 2015-19.
Housing Stock - Residential Construction	US Department of Housing and Urban Development, 2014.
Housing Units - Overview	US Census Bureau, Census Population Estimates.
Housing Units - Single-Unit Housing	US Census Bureau, American Community Survey, 2015-19.
Tenure - Mortgage Status	US Census Bureau, American Community Survey, 2015-19.
Tenure - Owner-Occupied Housing	US Census Bureau, American Community Survey, 2015-19.
Tenure - Renter-Occupied Housing	US Census Bureau, American Community Survey, 2015-19.
Vacancy (ACS)	US Census Bureau, American Community Survey, 2015-19.
Vacancy (HUD)	US Department of Housing and Urban Development, 2020-Q4.
Area Deprivation Index	University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2021.
Food Insecurity Rate	Feeding America, 2017.
Homeless Children & Youth	US Department of Education, EDFacts, 2019-2020.
Households with No Motor Vehicle	US Census Bureau, American Community Survey, 2015-19.
Incarceration Rate	Opportunity Insights, 2018.
Insurance - Insured Population and Provider Type	US Census Bureau, American Community Survey, 2015-2019.

Data Indicator	Source
Insurance - Medicare Enrollment Demographics	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Insurance - Population Receiving Medicaid	US Census Bureau, American Community Survey, 2015-19.
Insurance - Uninsured Adults	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Insurance - Uninsured Children	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Insurance - Uninsured Population (ACS)	US Census Bureau, American Community Survey, 2015-19.
Insurance - Uninsured Population (SAHIE)	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Opportunity Index	Opportunity Nation.
Racial Diversity (Theil Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2020.
Racial Segregation (Interaction Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2010.
SNAP Benefits - Households Receiving SNAP (ACS)	US Census Bureau, American Community Survey, 2015-19.
SNAP Benefits - Population Receiving SNAP (SAIPE)	US Census Bureau, Small Area Income and Poverty Estimates, 2019.
Social Capital Index	Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014.
Social Vulnerability Index	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2018.
Student Loan Debt	Debt in America, The Urban Institute, 2021.
Teen Births	Centers for Disease Control and Prevention, National Vital Statistics System, 2013-2019.
Teen Births (ACS)	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Violent Crime - Assault	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Violent Crime - Rape	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Violent Crime - Robbery	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Violent Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Property Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014&2016.
Voter Participation Rate	Townhall.com Election Results, 2016.
Young People Not in School and Not Working	US Census Bureau, American Community Survey, 2015-2019.
Air & Water Quality - Drinking Water Safety	US Environmental Protection Agency, 2018-19.
Air & Water Quality - Ozone	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Air & Water Quality - Particulate Matter 2.5	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2016.
Air & Water Quality - Respiratory Hazard Index	EPA - National Air Toxics Assessment, 2014.
Air & Water Quality - RSEI Score	US Environmental Protection Agency, 2019.
Built Environment - Banking Institutions	US Census Bureau, County Business Patterns, 2019.
Built Environment - Broadband Access	National Broadband Map, Dec 2020.
Built Environment - Households with No Computer	US Census Bureau, American Community Survey, 2015-19.
Built Environment - Households with No or Slow Internet	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Built Environment - Liquor Stores	US Census Bureau, County Business Patterns, 2019.
Built Environment - Recreation and Fitness Facility Access	US Census Bureau, County Business Patterns, 2019.
Built Environment - Social Associations	US Census Bureau, County Business Patterns, 2019.
Built Environment - Tobacco Product Compliance Check Violations	US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-2020.
Climate & Health - Climate-Related Mortality Impacts	Climate Impact Lab.
Climate & Health - Dominant Land Cover	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Climate & Health - Drought Severity	US Drought Monitor, 2017-2019.
Climate & Health - Flood Vulnerability	Federal Emergency Management Agency, National Flood Hazard Layer.
Climate & Health - High Heat Index Days (Relative)	Center for Disease Control and Prevention, CDC National Environmental Public Health Tracking, 2017-2019.
Climate & Health - High Heat Index Days (Absolute)	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS) , 2014.
Climate & Health - National Risk Index	Federal Emergency Management Agency, National Risk Index, 2020.
Climate & Health - Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Community Design - Park Access (CDC)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Community Design - Park Access (ESRI)	US Census Bureau, Decennial Census, ESRI Map Gallery, 2013.
Food Environment - Fast Food Restaurants	US Census Bureau, County Business Patterns, 2019.
Food Environment - Food Desert Census Tracts	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.

Data Indicator	Source
Food Environment - Grocery Stores	US Census Bureau, County Business Patterns, 2019.
Food Environment - Leading Agricultural Products (1)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Leading Agricultural Products (2)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Low Income & Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Modified Retail Food Environment Index	Centers for Disease Control and Prevention, CDC - Division of Nutrition, Physical Activity, and Obesity, 2011.
Food Environment - SNAP-Authorized Food Stores	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2021.
Orchards	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012.
Threatened and Endangered Species	US Fish and Wildlife Service, Environmental Conservation Online System, 2019.
Cancer Screening - Mammogram (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Cancer Screening - Mammogram (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Cancer Screening - Pap Smear Test	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Cancer Screening - Sigmoidoscopy or Colonoscopy	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Dental Care Utilization	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Diabetes Management - Hemoglobin A1c Test	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Prevention - High Blood Pressure Management	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2018.

Data Indicator	Source
Hospitalizations - Preventable Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020.
Hospitalizations - Emergency Room Visits	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Inpatient Stays	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Heart Disease	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2016-2018.
Hospitalizations - Stroke	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2016-2018.
Late or No Prenatal Care	Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2019.
Opioid Drug Claims	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Prevention - Annual Wellness Exam (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Prevention - Seasonal Influenza Vaccine	Centers for Disease Control and Prevention, CDC - FluVaxView, 2019-20.
Prevention - Cholesterol Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - Recent Primary Care Visit (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - Recent Primary Care Visit (Medicare)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Prevention - Core Preventative Services for Men	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Prevention - Core Preventative Services for Women	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Readmissions - All Cause (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Readmissions - Chronic Obstructive Pulmonary Disease	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.

Data Indicator	Source
Readmissions - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.
Readmissions - Heart Failure	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.
Readmissions - Pneumonia	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.
Timely and Effective Care - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-19.
Timely and Effective Care - Elective Delivery	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-19.
Timely and Effective Care - Stroke	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-16.
Alcohol - Heavy Alcohol Consumption	University of Wisconsin Population Health Institute, County Health Rankings, 2018.
Alcohol - Binge Drinking	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Alcohol - Expenditures	Nielsen, Nielsen SiteReports, 2014.
Breastfeeding - Ever	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Any)	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Exclusive)	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Fruit/Vegetable Expenditures	Nielsen, Nielsen SiteReports, 2014.
Physical Inactivity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Soda Expenditures	Nielsen, Nielsen SiteReports, 2014.
STI - Chlamydia Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.

Data Indicator	Source
STI - Gonorrhea Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
STI - HIV Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
STI - HIV Prevalence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
Tobacco Expenditures	Nielsen, Nielsen SiteReports, 2014.
Tobacco Usage - Current Smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Insufficient Sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Walking or Biking to Work	US Census Bureau, American Community Survey, 2015-19.
Alcohol Use Disorder (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Cancer Incidence - All Sites	State Cancer Profiles, 2014-18.
Cancer Incidence - Breast	State Cancer Profiles, 2014-18.
Cancer Incidence - Cervical	State Cancer Profiles, 2014-18.
Cancer Incidence - Colon and Rectum	State Cancer Profiles, 2014-18.
Cancer Incidence - Lung	State Cancer Profiles, 2014-18.
Cancer Incidence - Prostate	State Cancer Profiles, 2014-18.
Chronic Conditions - Alzheimer's Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Asthma (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.

Data Indicator	Source
Chronic Conditions - Asthma Prevalence (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Cancer (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions – Chronic Obstructive Pulmonary Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Chronic Obstructive Pulmonary Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Depression (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Diabetes (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Chronic Conditions - Newly Diagnosed Diabetes (Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018.
Chronic Conditions - Diabetes (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Heart Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Kidney Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Heart Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - High Blood Pressure (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - High Blood Pressure (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - High Cholesterol (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - High Cholesterol (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Multiple Chronic Conditions (Medicare Population)	Centers for Medicare and Medicaid Services, 2018.

Data Indicator	Source
Chronic Conditions - Kidney Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Deaths of Despair (Suicide + Drug/Alcohol Poisoning)	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Low Birth Weight (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2013-2019.
Mortality - Infant Mortality (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2013-2019.
Mortality - Cancer	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Coronary Heart Disease	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Poisoning	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Heart Disease	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Homicide	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Life Expectancy	Institute for Health Metrics and Evaluation, 2017.
Mortality - Life Expectancy (Census Tract)	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project, 2010-15.
Mortality - Lung Disease	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash, Alcohol-Involved	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2015-2019.
Mortality - Motor Vehicle Crash, Pedestrian	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2015-2019.
Mortality - Opioid Overdose	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.

Data Indicator	Source
Mortality - Premature Death	University of Wisconsin Population Health Institute, County Health Rankings, 2017-2019.
Mortality - Stroke	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Suicide	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Unintentional Injury (Accident)	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Obesity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Mortality - Influenza & Pneumonia	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Firearm	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Teeth Loss	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor or Fair Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Mental Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor Mental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Physical Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor Physical Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Mental Health - Mental Health and Substance Use Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Stroke (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Stroke (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.

Data Indicator	Source
Substance Use Disorder (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Access to Care - Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021.
Access to Care - Buprenorphine Providers	US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Feb. 2021.
Access to Care - Dental Health	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2015.
Access to Care - Dental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021.
Access to Care - Mental Health	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2020.
Access to Care - Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021.
Access to Care - Nurse Practitioners	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021.
Access to Care - Primary Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2017.
Access to Care - Primary Care Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021.
Federally Qualified Health Centers	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, September 2020.
Hospitals with Cardiac Rehabilitation Units	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2019.
Health Professional Shortage Areas - All	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
Health Professional Shortage Areas - Dental Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
Population Living in a Health Professional Shortage Area	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
COVID-19 - Confirmed Cases	Johns Hopkins University, 2021.

Data Indicator	Source
Discharges by Zip Code	Oakbend Medical Center
County Health Rankings	County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/explore-health-rankings
Sparkmap Data Analysis	https://sparkmap.org/report/
Dignity Health Community Need Index	http://cni.dignityhealth.org/