COMMUNITY HEALTH NEEDS ASSESSMENT

2024

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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") 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 in tax year 2024. 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 Hospital 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 Hospital'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 Hospital'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 2025-2027 for the some or all of the needs identified below.

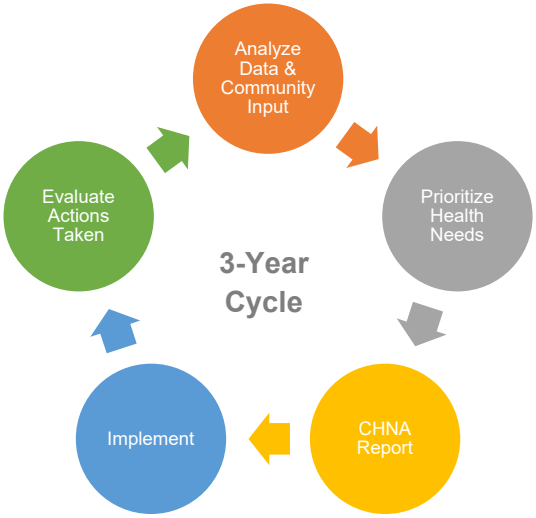
- Access to Care
- Treatment and Management of Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Access to Primary Care Physicians
- Access to and Use of Preventative Care Treatments
- Healthy Behaviors / Healthy Lifestyle Choices
- Uninsured / Limited Insurance / Access
- Lack of Health Knowledge / Education
- Obesity
- Access to Mental Health / Addiction Providers
- Poverty and Lack of Financial Resources
- Access to Services for Children
- Access to Services for the Aging
- Transportation
- Physical Inactivity / Lack of Exercise
- Preventable Hospital Stays
- Language and Cultural Barriers
- Access to Dental Health Services
- Teen Birth Rate
- Unintentional Injury

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

- Gain a better understanding of health care needs of the community served
- Serve as a foundation for developing an implementation strategy to direct resources where they are needed most and impact is most beneficial
- Identify collaboration opportunities with community partners
- Lead to actions which will improve the health of the community

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.



PRIORITY AREAS FROM PRECEDING CHNA

The implementation strategy for years ending December 31, 2022 through December 31, 2024, focused on three priorities to address identified health needs. Based on the Hospital's most recent evaluation, the Hospital has made significant progress in meeting its goals and strategies outlined in the prior implementation strategy as reported below.

The 2021 implementation strategy focused on six priorities for action between 2020 and 2024:

1. Access to primary care physicians
2. Access to medical specialists
3. Treatment and management of chronic diseases and conditions
4. Access to healthy food options
5. Access and use of preventative care treatments
6. Access to services for the aging

COMMUNITY FEEDBACK FROM PRECEDING CHNA AND IMPLEMENTATION PLAN

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

HOW THE ASSESSMENT WAS CONDUCTED

OakBend Medical Center partnered with Forvis Mazars to conduct this community health needs assessment. Ranked among the top 10 public accounting firms in the country, Forvis Mazars serves clients in all 50 states as well as across the globe. Forvis Mazars serves hospitals and health care systems across the country. The CHNA was conducted during 2024.

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 in order 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 Hospital 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 Hospital.
- 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 informant surveys of thirty community leaders. See Appendix B for a listing of key stakeholders that provided input.
- 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 Hospital to impact overall health based on alignment with the Hospital's mission and the services it provides. The Hospital'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 Hospital; 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 or Spanish. Efforts were made to obtain input from these specific populations through key stakeholder surveys.

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, 2023 may be the most current year available for data, while 2022 or 2021 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 offers a wide array of services including most inpatient and outpatient surgical specialties, catheterization laboratory, obstetrics, medical and surgical hospitalization, emergency care, wound care, imaging, laboratory, cardiopulmonary, and nutritional education, among other services.

OakBend distinguishes itself among its healthcare peers in Fort Bend County by housing several unique programs and facilities including the county's only no-wait emergency departments, hospital-based skilled nursing facility, advanced trauma program, acute care for the elderly (ACE) unit, geriatric psychiatric program, and permanent hospital-based air ambulance. It also has numerous programs designed to meet the needs of the community including advanced wound care services, a heart attack program, and a Gold Plus-rated stroke program.

In addition to the medical services it provides, OakBend is also committed to the community's overall health and wellness. The hospital conducts and participates regularly in community health fairs to provide blood pressure, glucose, and other tests at no cost. OakBend also collaborates with local organizations such as AccessHealth, Texana Center, EMS operators, Fort Bend County Department of Health and Human Services, Child Advocates of Fort Bend County, Richmond State School, and the Mamie George Community Center, among others.

MISSION

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

VISION

To be the best community health care organization

VALUES

- Excellence: We pay attention to detail, provide exceptional professional services, maintain the safety and quality of those services, and collaborate professionally with families, patients, and doctors.
- Integrity: We always do the right thing, even when no one is watching.
- Ownership: We take responsibility for every action, every time.
- Compassion: We are kind, friendly, understanding, and empathetic to those we service and to one another.

DESCRIPTION OF SERVICES PROVIDED BY OAKBEND MEDICAL CENTER

Oakbend Medical Center provides the following services:

- Acute Care for the Elderly (ACE) Unit
- Cardiopulmonary
- Food & Nutrition
- Cardiovascular Specialists
- Medical Imaging Services
- No Wait Emergency Rooms
- Intensive Care Unit
- Labor & Delivery Unit
- Medical & Surgical Inpatient Unit
- Neonatal Intensive Care Unit
- Physical Therapy & Rehabilitation
- Skilled Nursing Facility
- Laboratory
- Lifestyles at OakBend
- Senior Behavioral Health Unit
- 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.

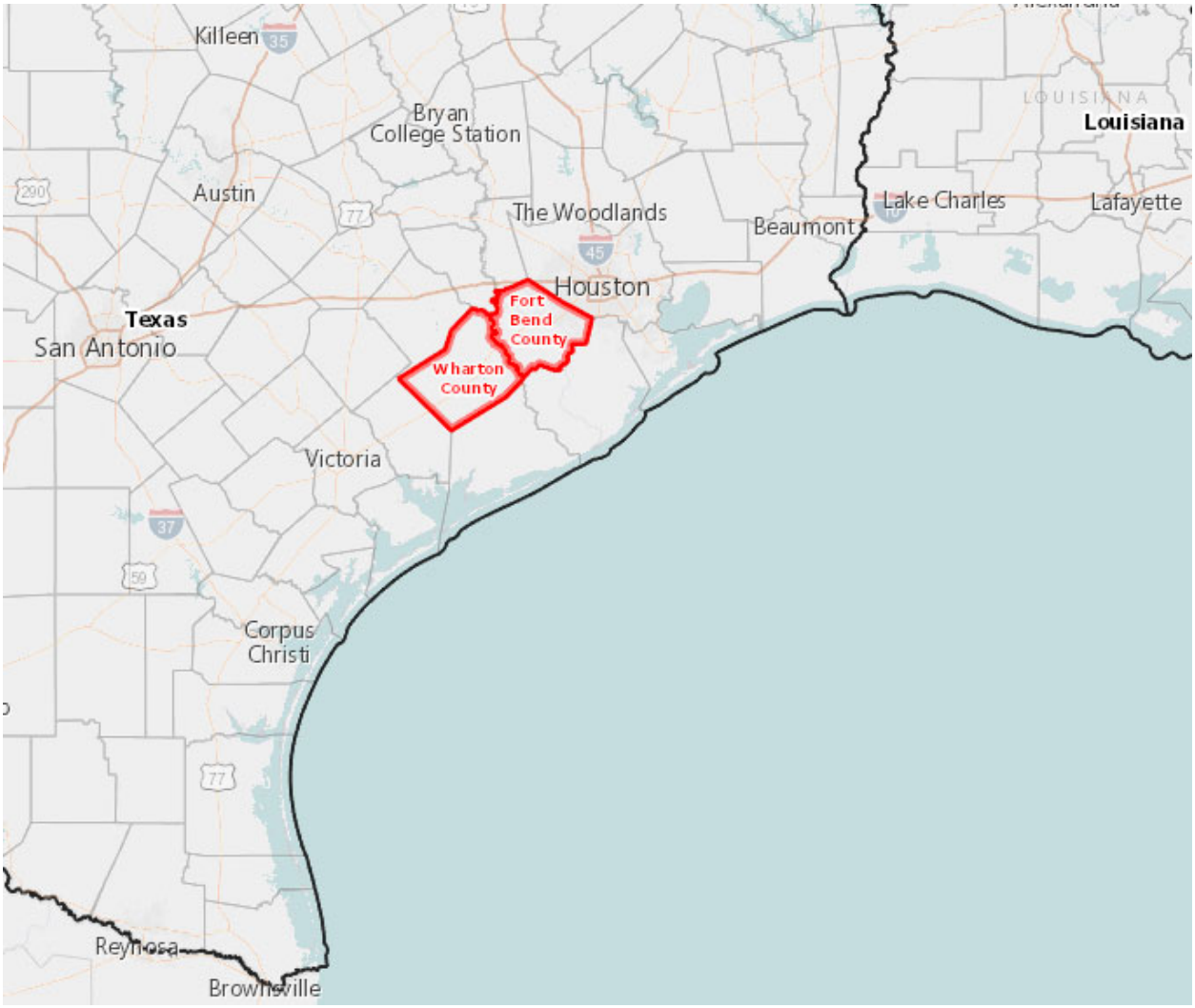
DEFINED COMMUNITY

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	874,221	832,607	41,614	29,243,342	331,097,593
Total Male Population	432,381	411,621	20,761	14,624,638	164,200,298
Total Female Population	441,839	420,986	20,853	14,618,704	166,897,295
Percent Male	49.46%	49.44%	49.89%	50.01%	49.59%
Percent Female	50.54%	50.56%	50.11%	49.99%	50.41%

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	6.36%	6.34%	6.80%	6.58%	5.74%
5 - 17	20.59%	20.67%	18.96%	18.71%	16.37%
18 - 24	8.62%	8.61%	8.86%	10.04%	9.45%
25 - 34	11.64%	11.64%	11.71%	14.44%	13.71%
35 - 44	15.35%	15.46%	13.11%	13.84%	12.93%
45 - 54	13.93%	14.09%	10.71%	12.30%	12.41%
55 - 64	11.50%	11.44%	12.62%	11.20%	12.86%
65+	12.01%	11.75%	17.23%	12.89%	16.53%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

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.

TOTAL POPULATION BY RACE ALONE

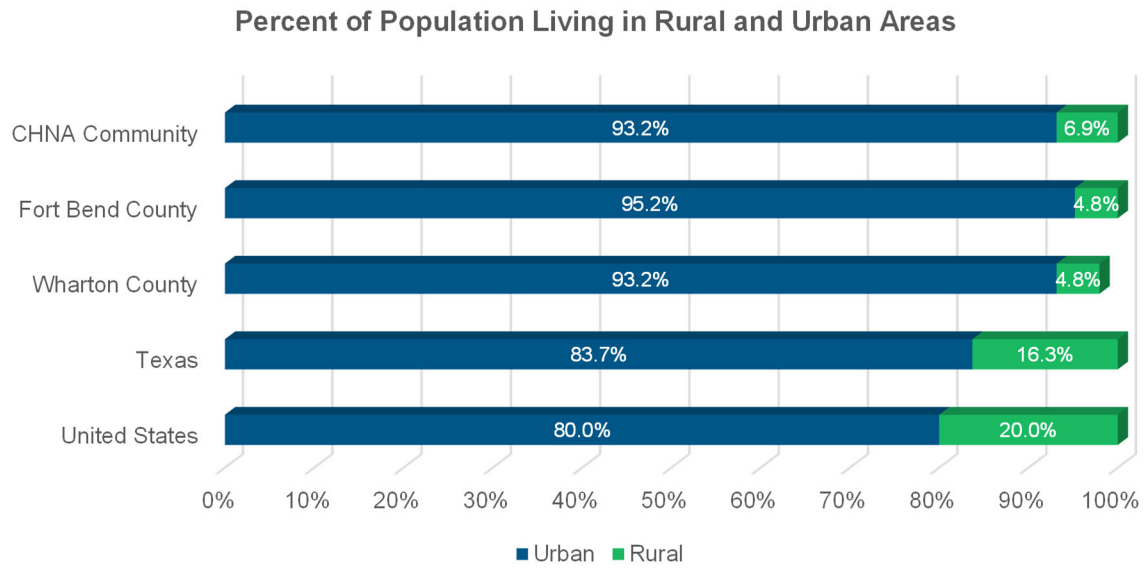
Race	Percent of CHNA Community	Percent of Fort Bend County	Percent of Wharton County	Percent of TX	Percent of US
White	42.34%	40.92%	70.80%	59.14%	65.88%
Black	19.96%	20.31%	12.93%	12.15%	12.47%
Asian	20.39%	21.39%	0.46%	5.17%	5.77%
Native American / Alaska Native	0.31%	0.32%	0.02%	0.58%	0.84%
Native Hawaiian / Pacific Islander	0.04%	0.05%	0.00%	0.09%	0.19%
Some Other Race	5.83%	5.91%	4.32%	7.80%	6.05%
Multiple Race	11.13%	11.10%	11.47%	15.07%	8.80%
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	25.97%	25.12%	43.00%	39.89%	18.65%
Non-Hispanic or Latino	74.03%	74.88%	57.00%	60.11%	81.35%
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. This graphic could help to understand why transportation is considered

a need within the community, especially within the rural and outlying populations. Per the graphic below, CHNA Community lives majority in urban areas.

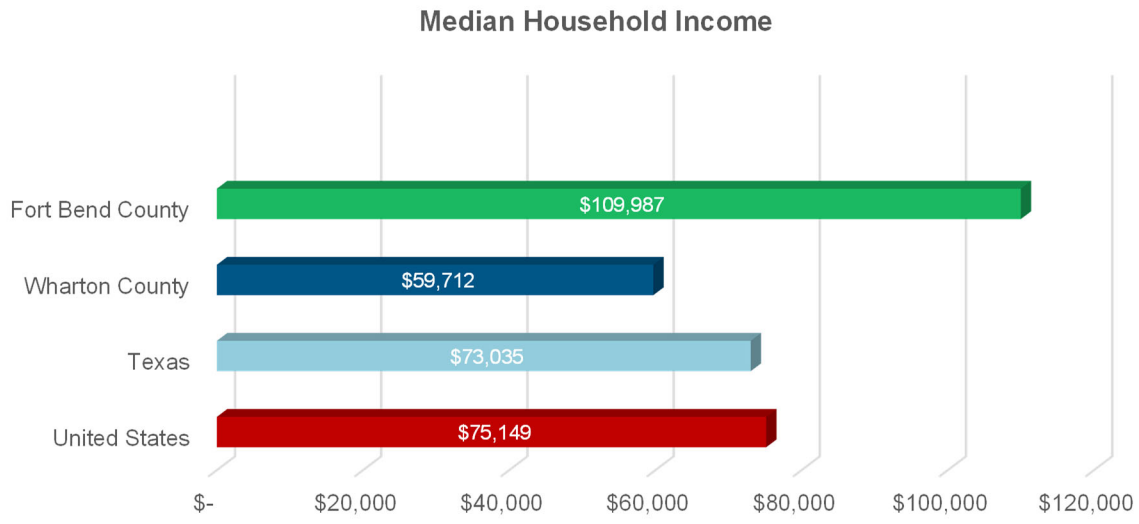


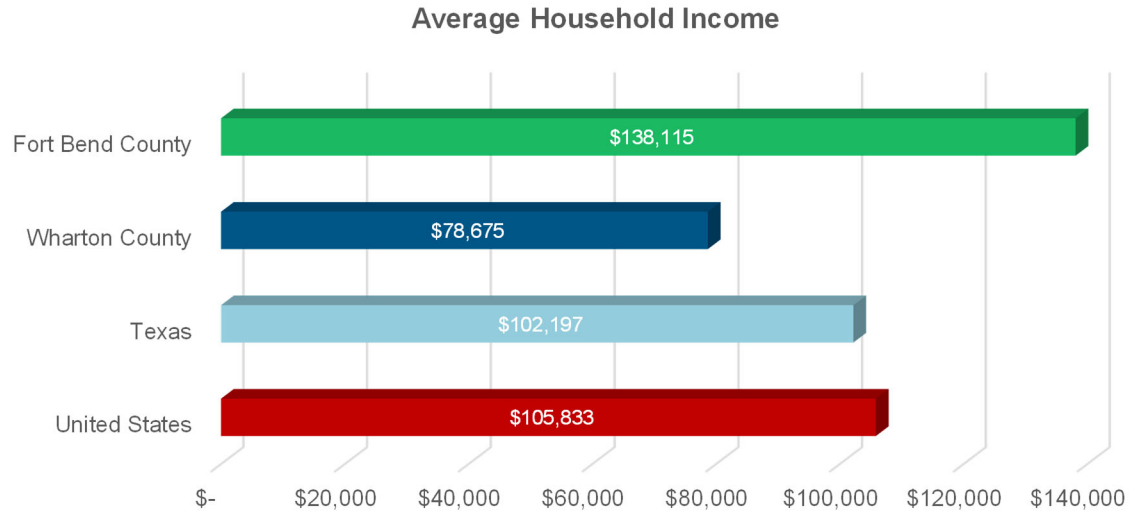
SOCIOECONOMIC CHARACTERISTICS OF THE COMMUNITY

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.

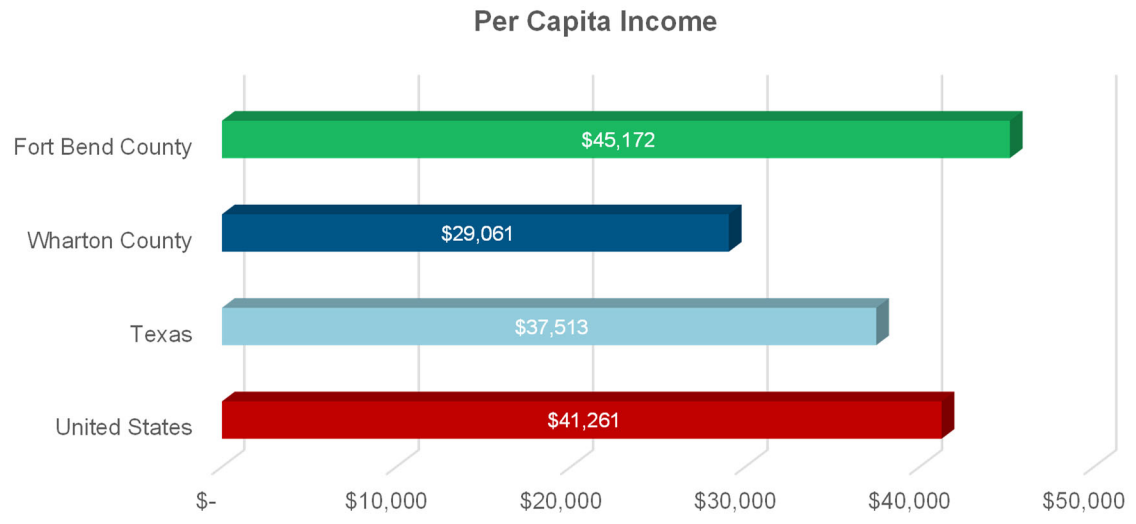
INCOME AND EMPLOYMENT

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, median household income is usually less than average family income. Wharton has a median household income below Texas and the United States while Fort Bend County exceeds Texas and the United States.



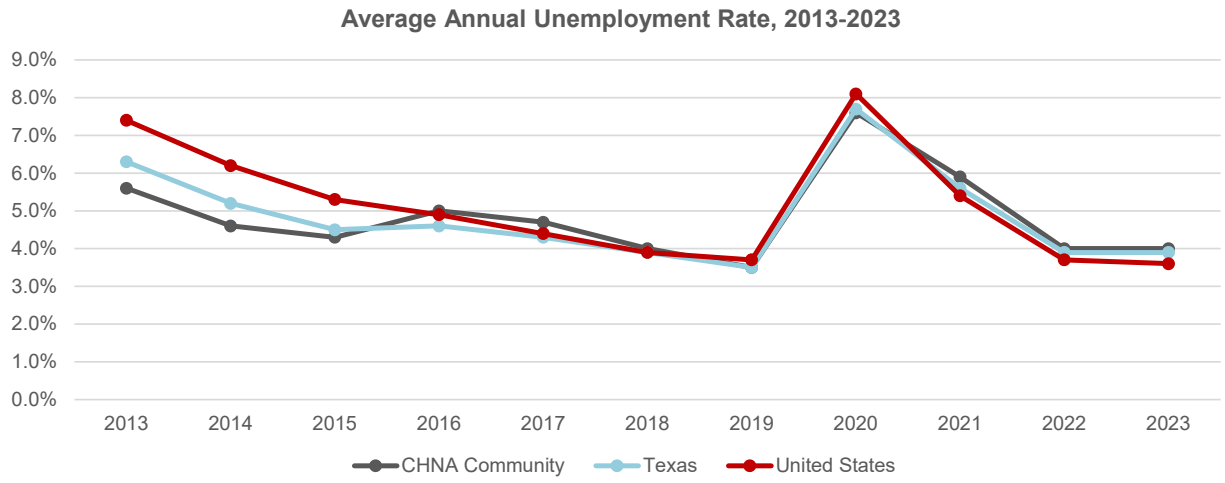


The per capita income is $45,172 and $29,061 for Fort Bend County and Wharton County, respectively. These amounts include all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income for Wharton County is below the per capita income for both Texas and the United States. Fort Bend County exceeds per capita income for both Texas and the United States.



UNEMPLOYMENT RATE

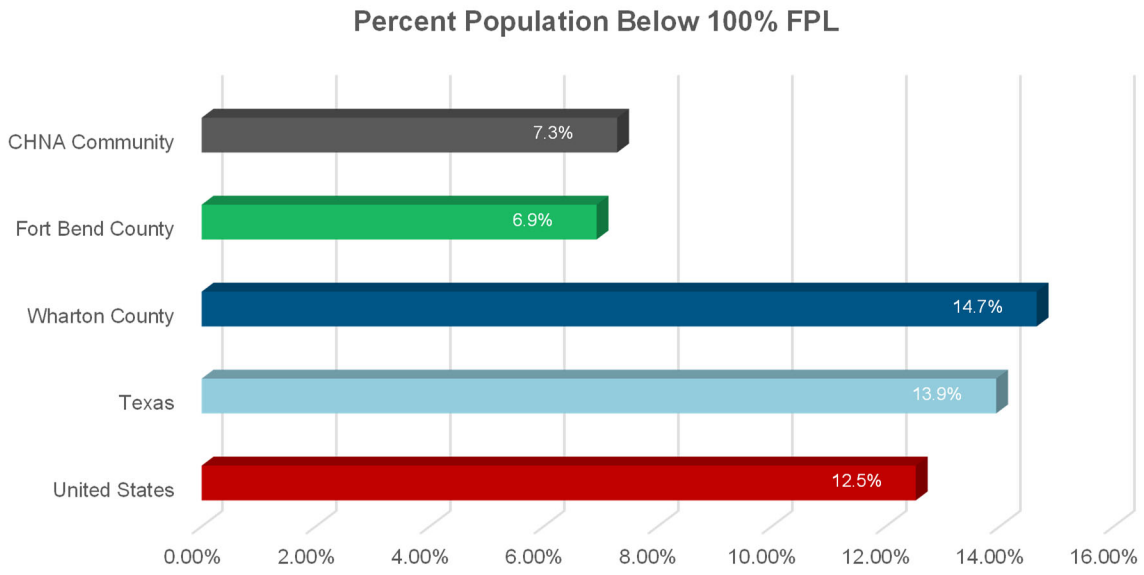
The graph below presents the average annual unemployment rate from 2013 through 2023 for the CHNA Community, as well as the trend for Texas and the United States. Since 2016, the unemployment rates for the CHNA Community are similar to both Texas and the United States.



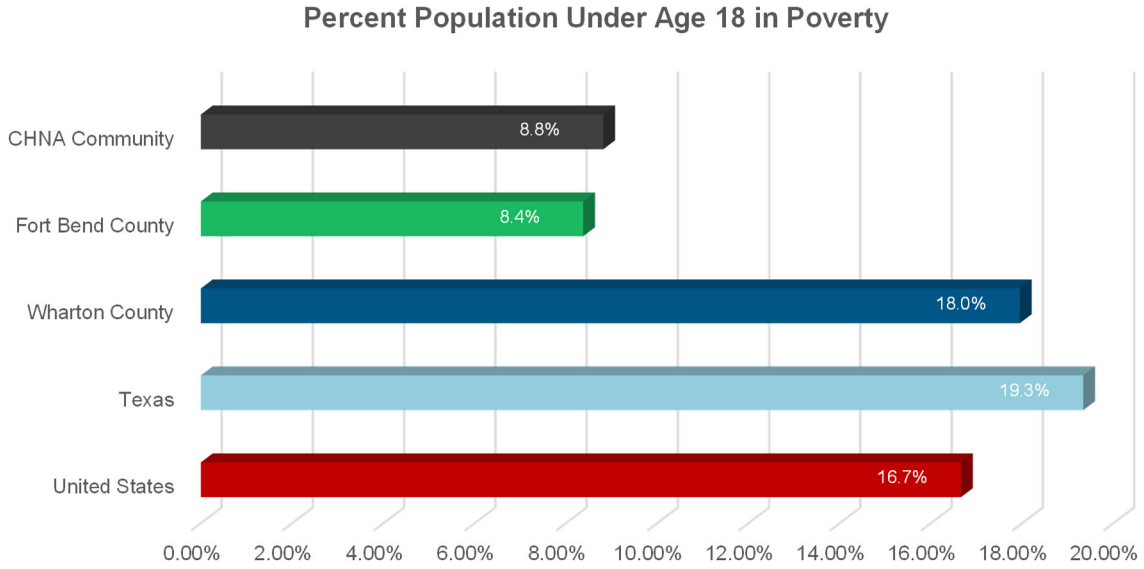
POVERTY

Poverty is a key driver of health status and is relevant because poverty creates barriers to access, including health services, healthy food choices and other factors that contribute to poor health.

The CHNA Community's 7.3% rate of individuals living below 100% of the Federal Poverty Level ("FPL") is less than the 13.9% Texas rate and the 12.50% national rate. Counties within the CHNA Community with the highest rates of unemployment are Wharton (14.7%) and Fort Bend (6.9%).

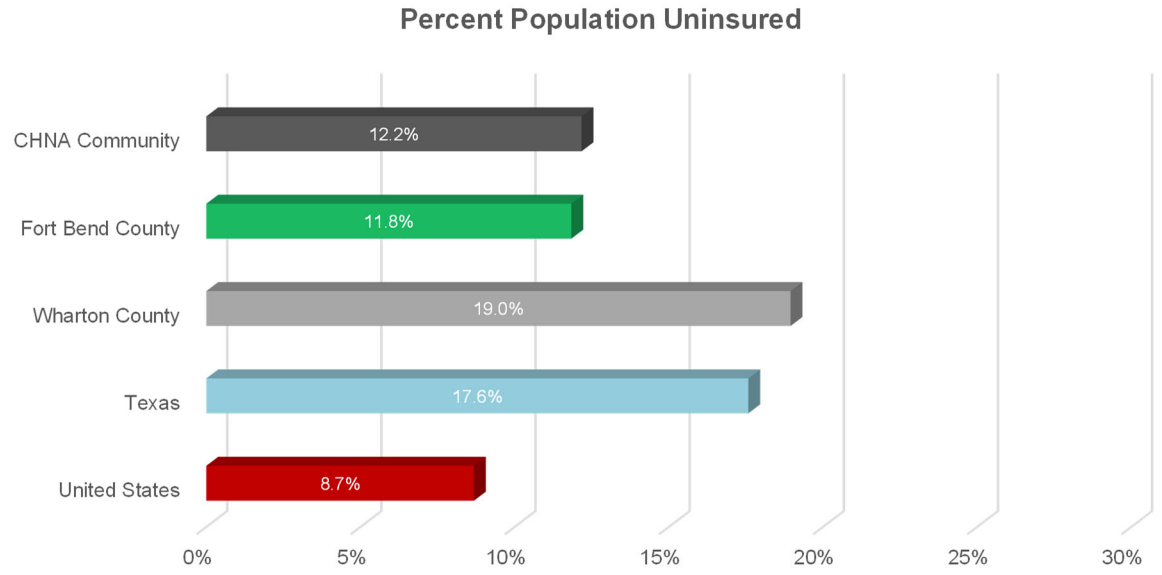


In the CHNA Community, 8.8% children aged 0-17 are living in households with income below the FPL. Like the percentages for total poverty, the CHNA Community, compares favorably to both Texas and United States percentages of individuals under age 18 living in households below 100% of FPL.



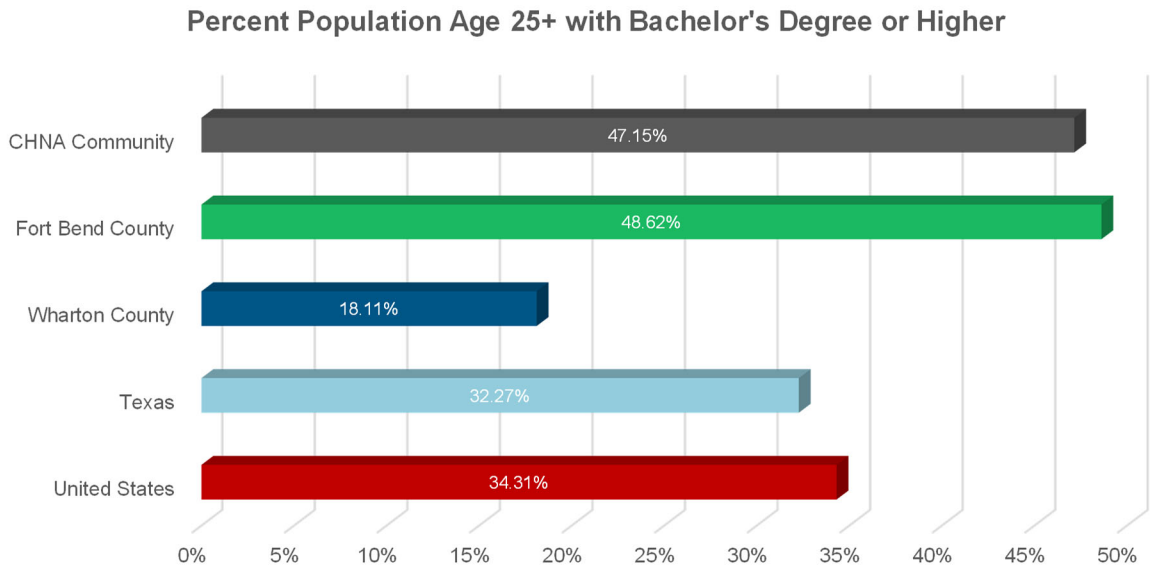
UNINSURED

The percentage of the total civilian non-institutionalized population without health insurance coverage is represented in this graphic. 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. Within the CHNA community, approximately 105,765 persons are uninsured based on 5-year estimates produced by the U.S. Census Bureau, 2018 - 2022 American Community Survey. The 2022 uninsured rate is estimated to be 12.2% for the CHNA Community compared to 17.6% for Texas and 8.7% for the United States.



EDUCATION

47% of the population of the CHNA Community age twenty-five and older have obtained a bachelor's degree or higher compared to 32% in Texas and 34% in the United States.
Education levels obtained by community residents may impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors may indirectly influence community health. The percent of residents within the CHNA Community is above the state and national percentages.

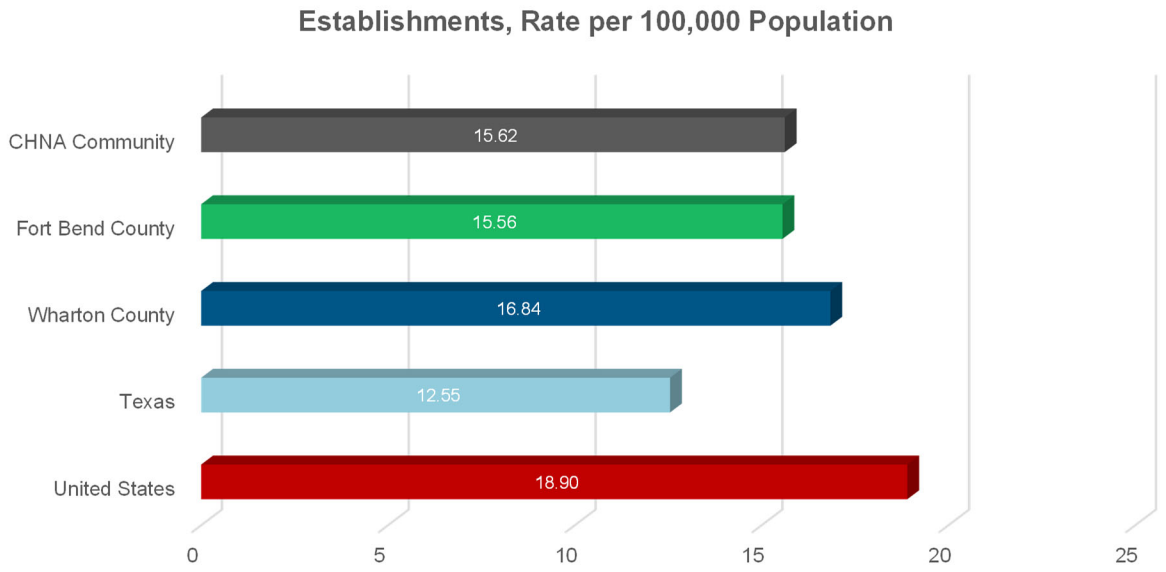


PHYSICAL ENVIROMENT OF THE COMMUNITY

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.

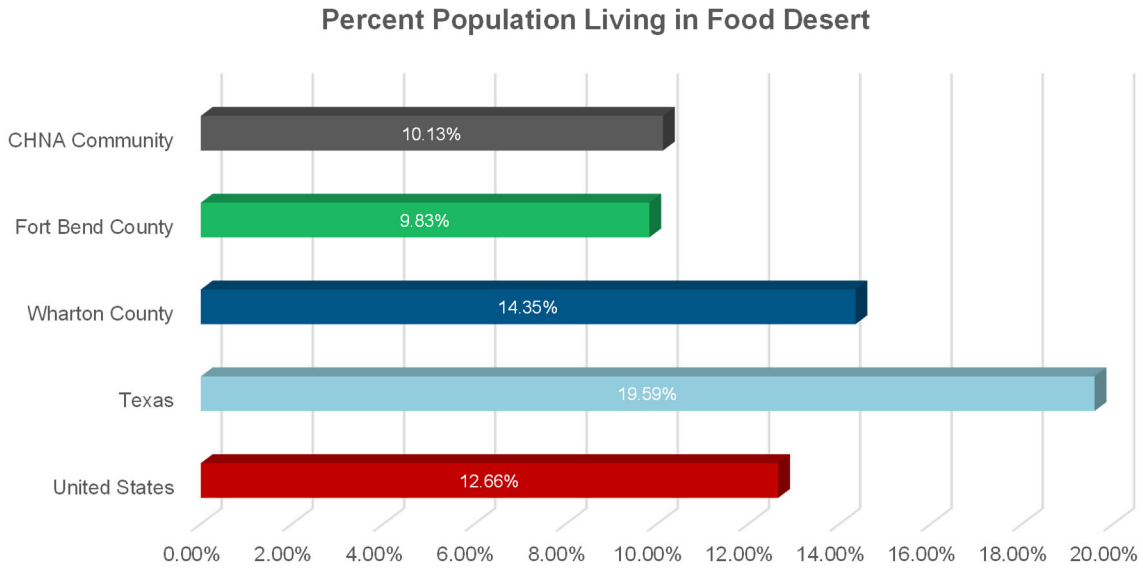
GROCERY STORE ACCESS

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 compared to Texas but unfavorably to the United States.



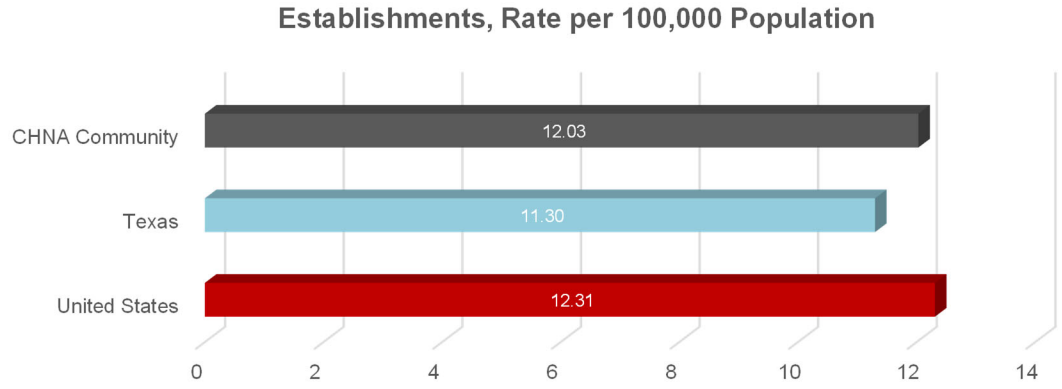
FOOD ACCESS/FOOD DESERTS

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.

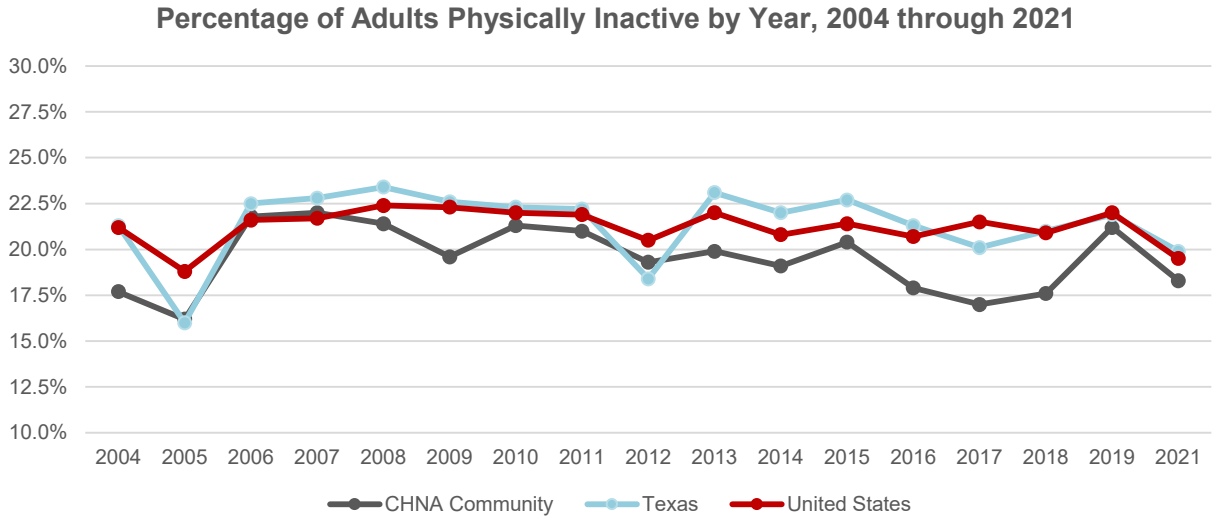


RECREATION AND FITNESS FACILITY ACCESS

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. There are less fitness establishments available to the residents of the CHNA Community. This compares favorably to the rates for Texas and unfavorably to the rates for the United States.

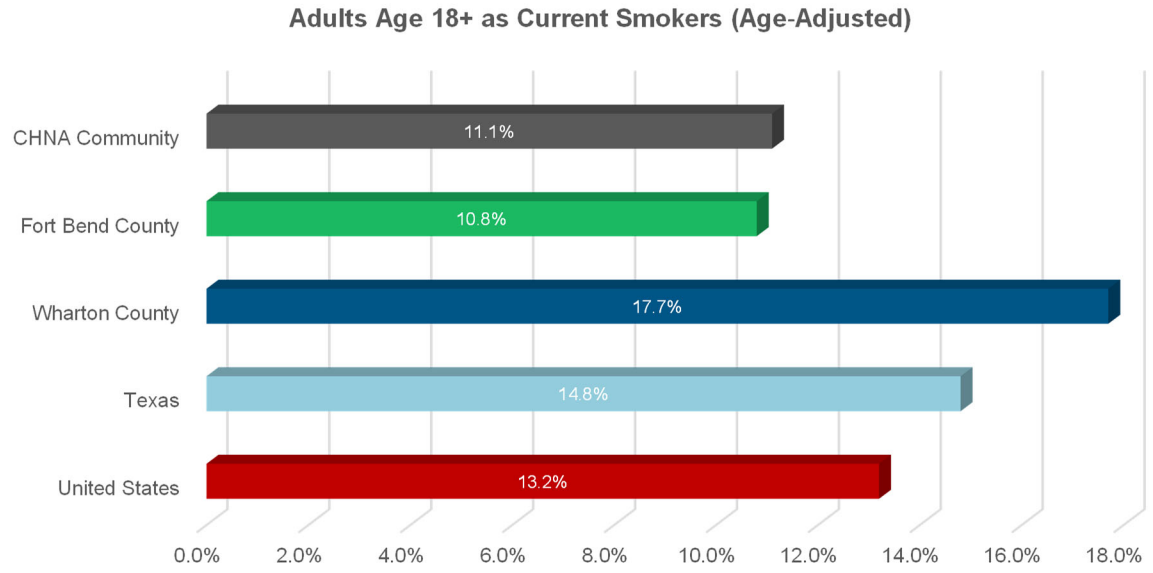


The trend graph below shows the percentage of adults who are physically inactive by year (2004 through 2021) for the CHNA Community and compared to Texas and the United States. For 2021, the rate for the CHNA Community was 18.3% compared to 19.9% for Texas and 19.5% for the United States. During the period 2004 through 2021, the CHNA Community's highest rate of inactivity was 22.0% in 2007.



TOBACCO USAGE - CURRENT SMOKERS

This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.



Of the total population within the CHNA Community, there are 11.1% adults age 18+ who have smoked and currently smoke which compares favorably to Texas and the United States. However, within the CHNA Community, the percentage of Wharton County's total population of adults age 18+ who have smoked and currently smoke compares unfavorably to Texas and the United States.

CLINICAL CARE OF THE COMMUNITY

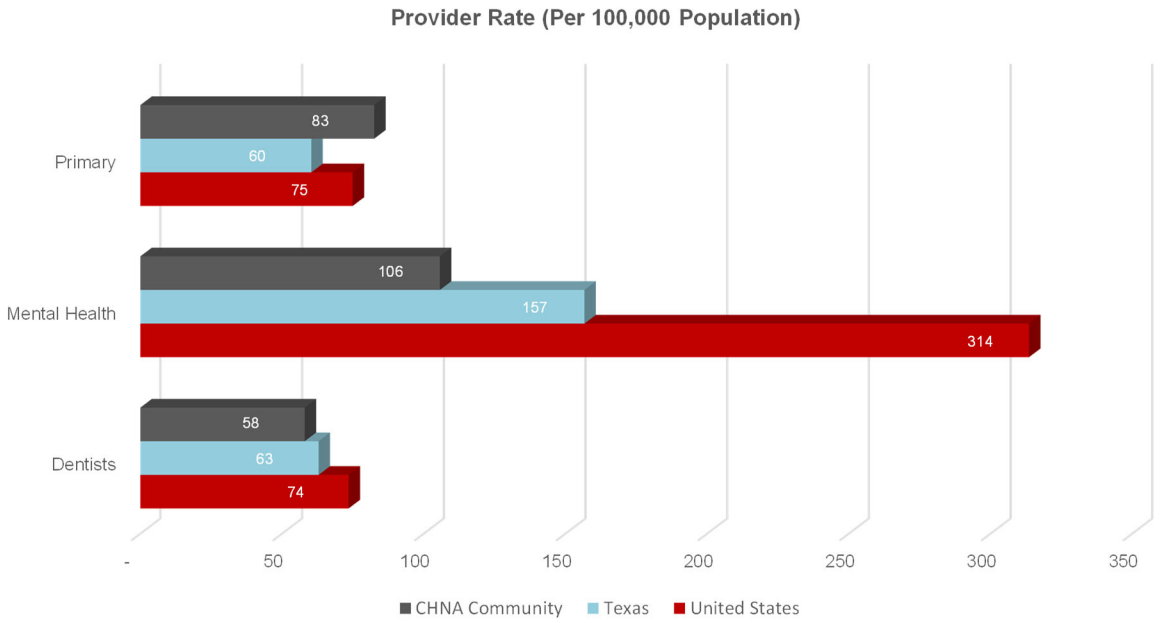
A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

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 PRIMARY CARE PROVIDERS, MENTAL HEALTH PROVIDERS, AND DENTISTS

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 age 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 the CHNA Community compares favorably to the ratio for Texas, but unfavorable to the United States. The number of mental health providers practicing in the CHNA Community compares unfavorably to the ratios for Texas and the United States. In addition, the number of dentists practicing in the CHNA Community compares unfavorably to the ratio for the United States, but favorable to Texas.



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. 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 rates to the state of Texas and the United States.

The tables below show leading causes of death within the CHNA Community as compared to the state of Texas and the United States. The crude 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.

Location	Cancer	Coronary Heart Disease	Heart Disease
CHNA Community	108.8	59.0	117.1
Fort Bend County	104.1	54.7	107.8
Wharton County	**202.0**	**143.9**	**304.2**
Texas	143.5	91.6	166.7
United States	182.7	112.5	206.7

Location	Lung Disease	Stroke	Unintentional Injury
CHNA Community	15.4	29.1	29.0
Fort Bend County	14.5	26.4	27.2
Wharton County	**33.6**	**83.0**	**65.3**
Texas	35.5	39.2	44.3
United States	46.0	47.7	60.2

Location	Poisoning (Including Drug Overdose)	Life Expectancy (Years)	Suicide
CHNA Community	9.5	81.1	10.2
Fort Bend County	9.2	81.4	10.0
Wharton County	15.3	**74.6**	14.4
Texas	15.3	77.2	13.8
United States	28.5	77.6	14.5

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

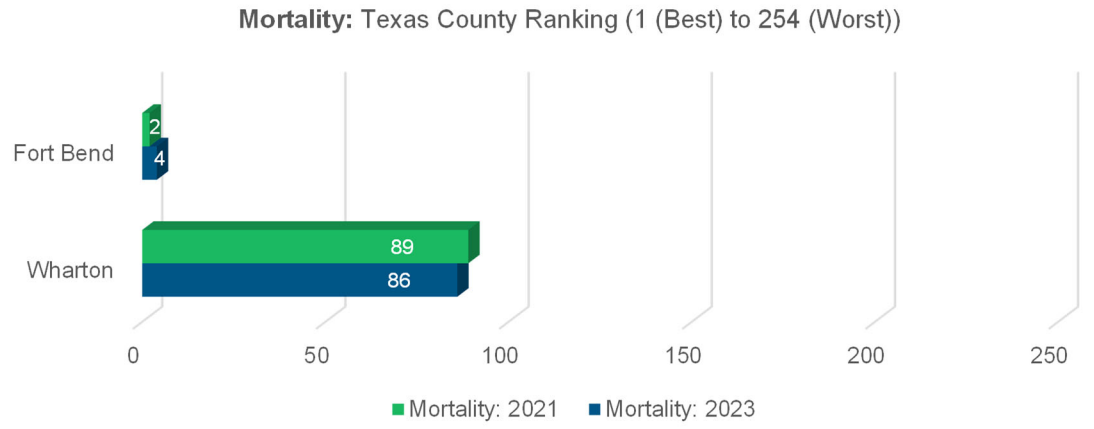
HEALTH OUTCOMES AND FACTORS

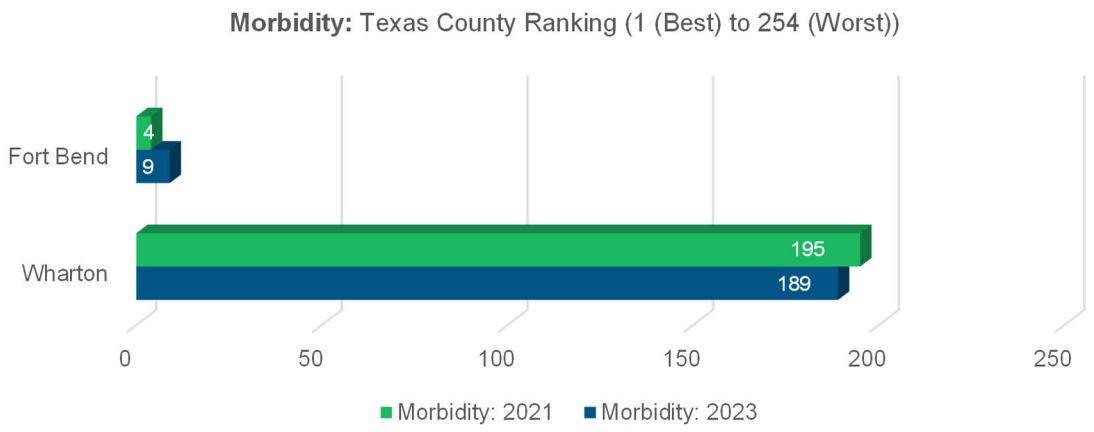
An analysis of various health outcomes and factors for a community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and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

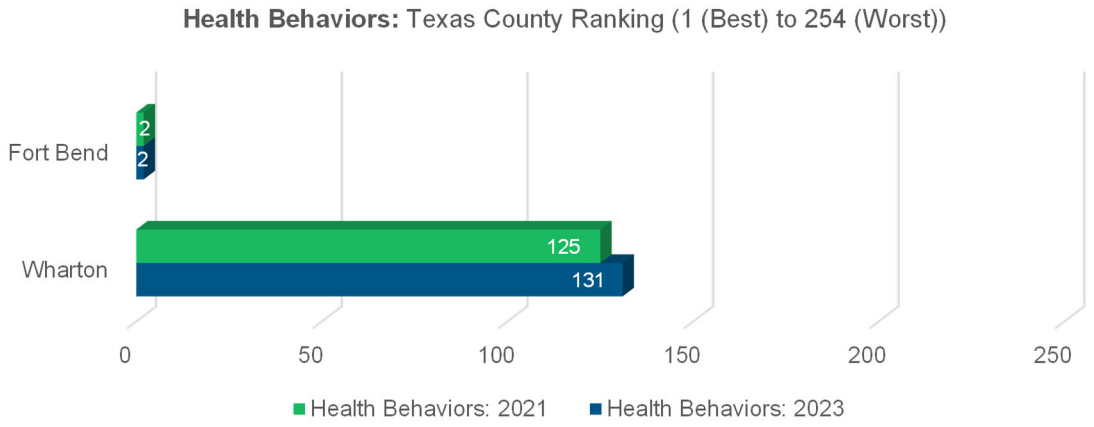
The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks 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.

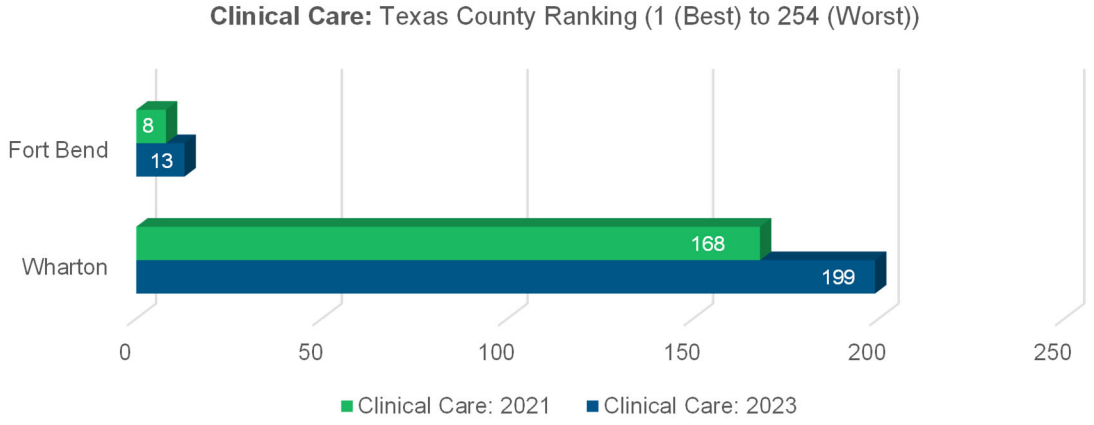
Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g. 1 or 2, are the "healthiest". Counties are ranked relative to the health of other counties in the same state based on health outcomes and factors, clinical care, economic 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 graphs include the 2021 and 2023 indicators reported by County Health Rankings. A complete table of all community health rankings is provided at Appendix C.

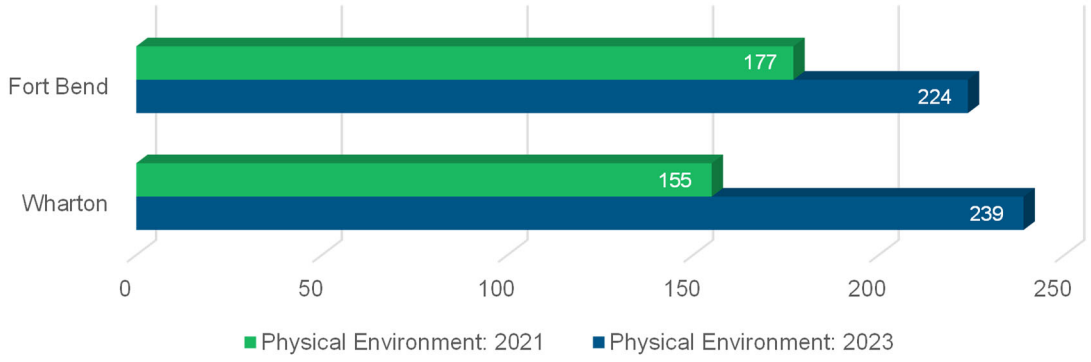



Morbidity: Texas County Ranking (1 (Best) to 254 (Worst))
Fort Bend
Wharton
4
9
195
189
0
50
100
150
200
250
Morbidity: 2021
Morbidity: 2023

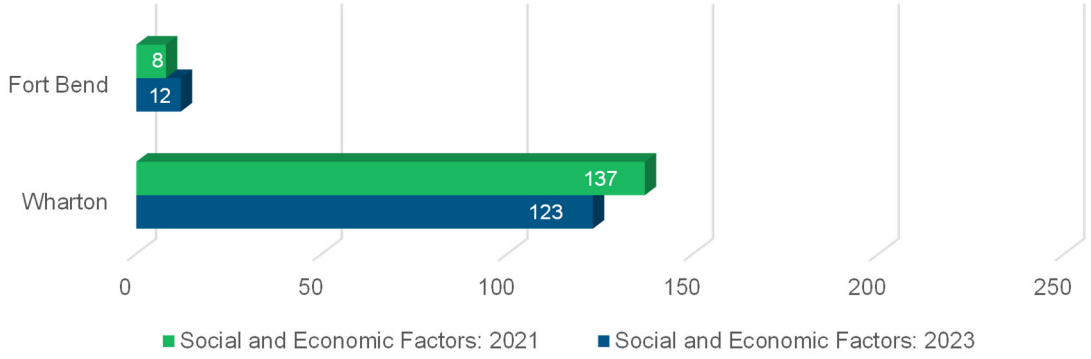

Health Behaviors: Texas County Ranking (1 (Best) to 254 (Worst))
Fort Bend
Wharton
2
2
125
131
0
50
100
150
200
250
Health Behaviors: 2021
Health Behaviors: 2023


Clinical Care: Texas County Ranking (1 (Best) to 254 (Worst))
Fort Bend
Wharton
8
13
168
199
0
50
100
150
200
250
Clinical Care: 2021
Clinical Care: 2023

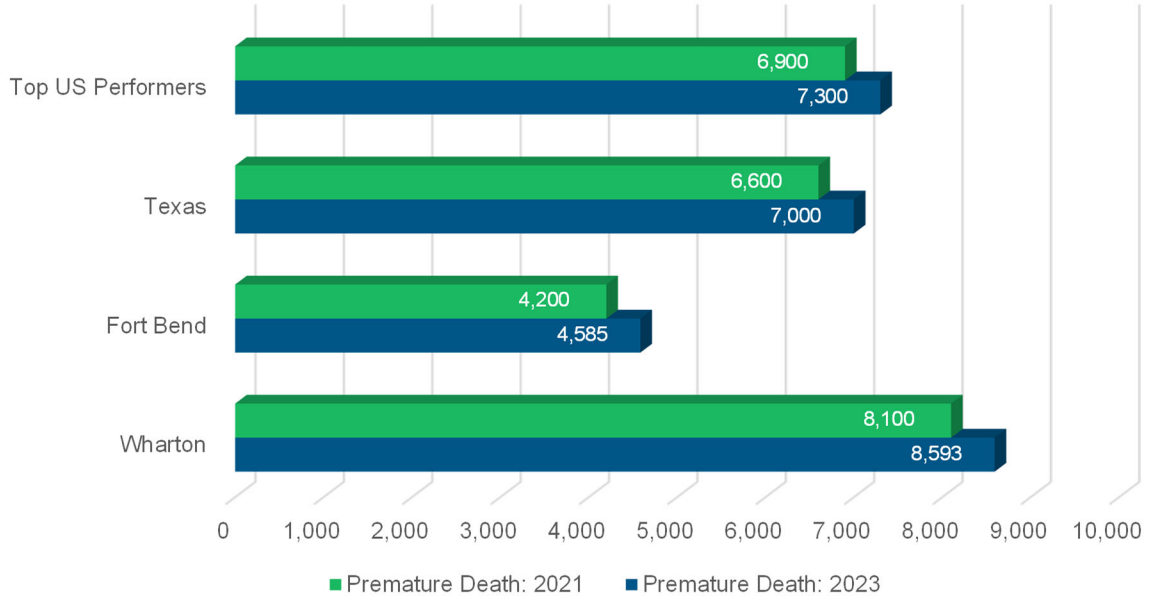
Physical Environment: Texas County Ranking (1 (Best) to 254 (Worst))



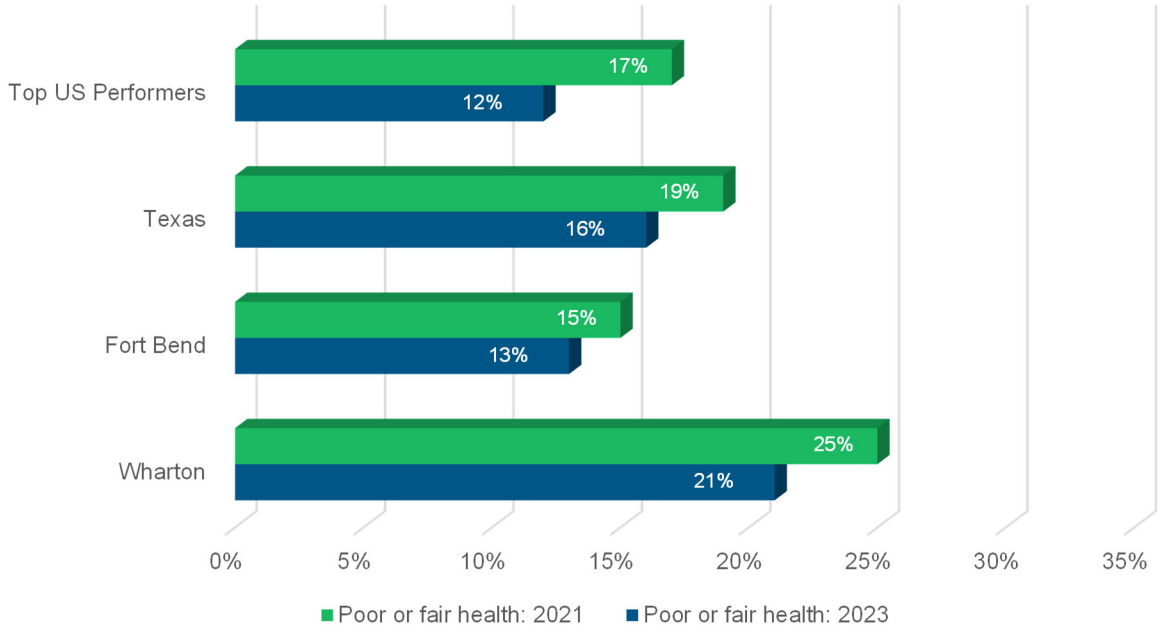
Social and Economic Factors: Texas County Ranking (1 (Best) to 254 (Worst))



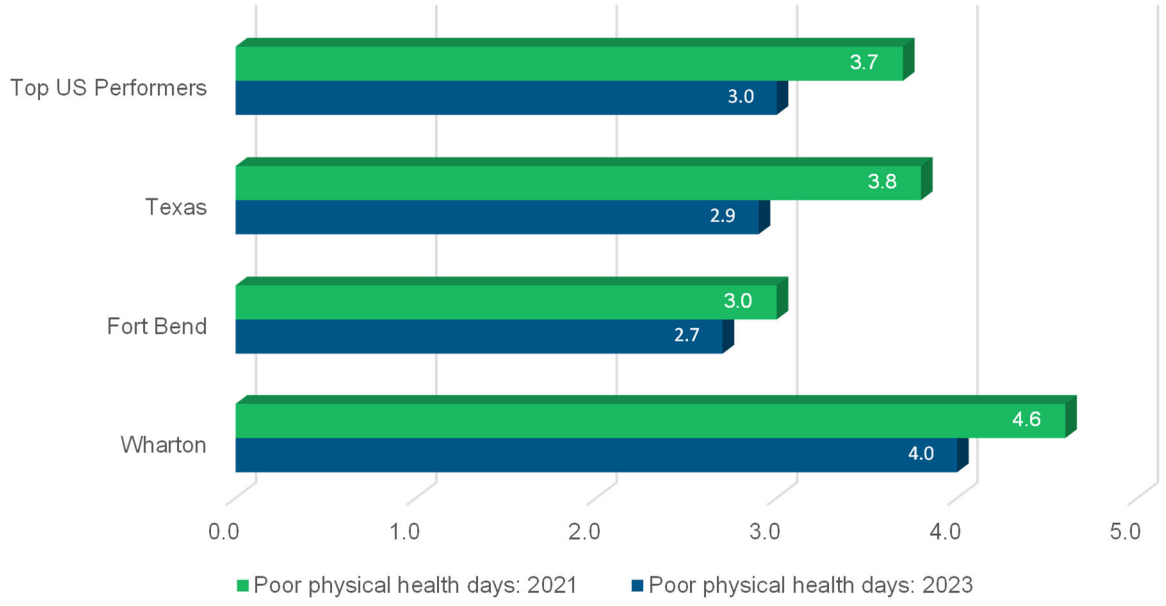
Premature Death – Years of potential life lost before age 75 per 100,000 population (age-adjusted): 2021 vs 2024



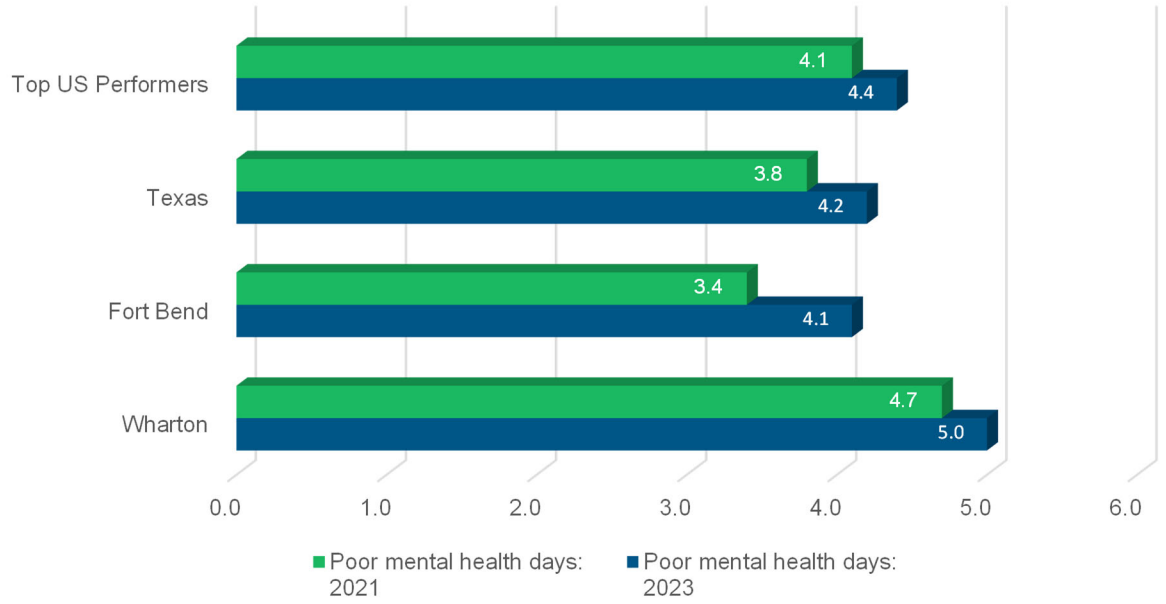
Poor or Fair Health – Percent of adults reporting fair or poor health (age-adjusted)



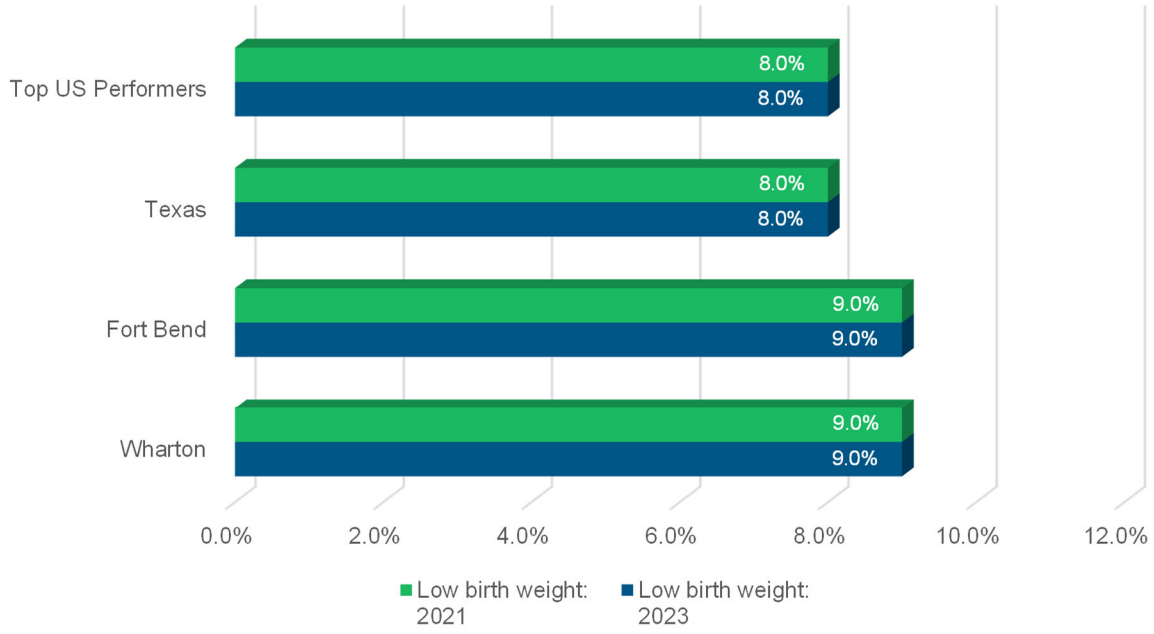
Poor Physical Health Days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)



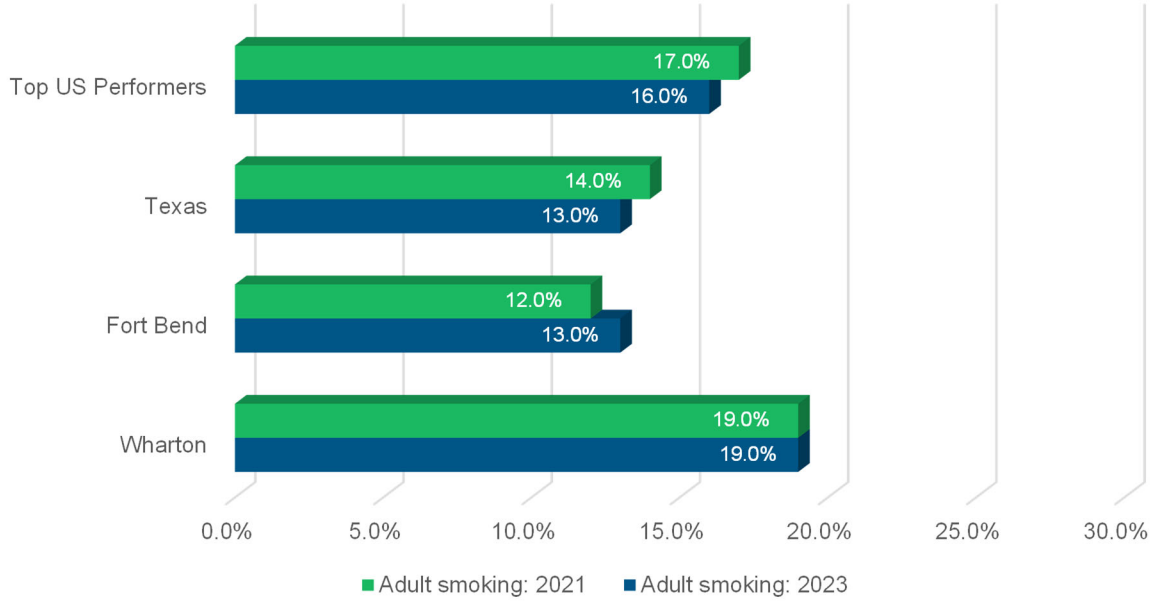
Poor Mental Health Days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)



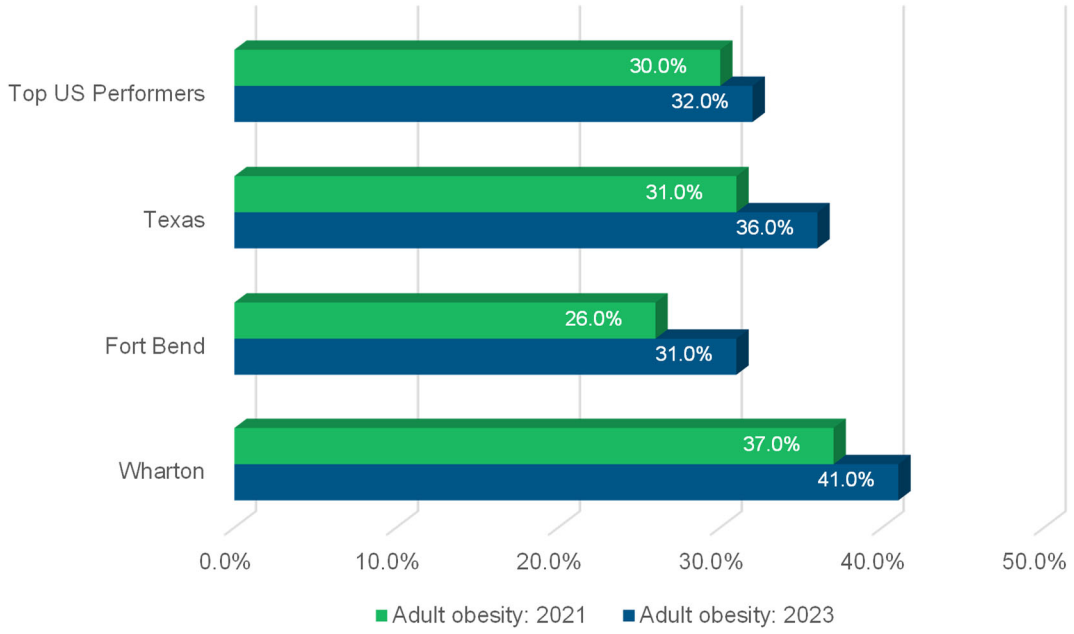
Low Birth Weight – Percent of live births with low birth weight (<2500 grams)



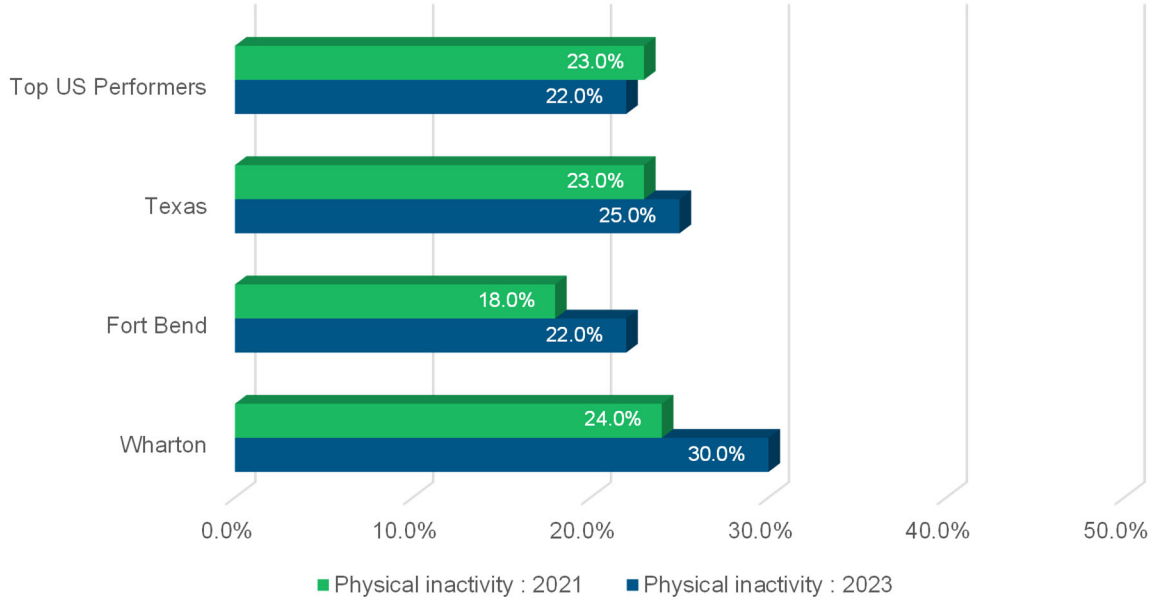
Adult Smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke)



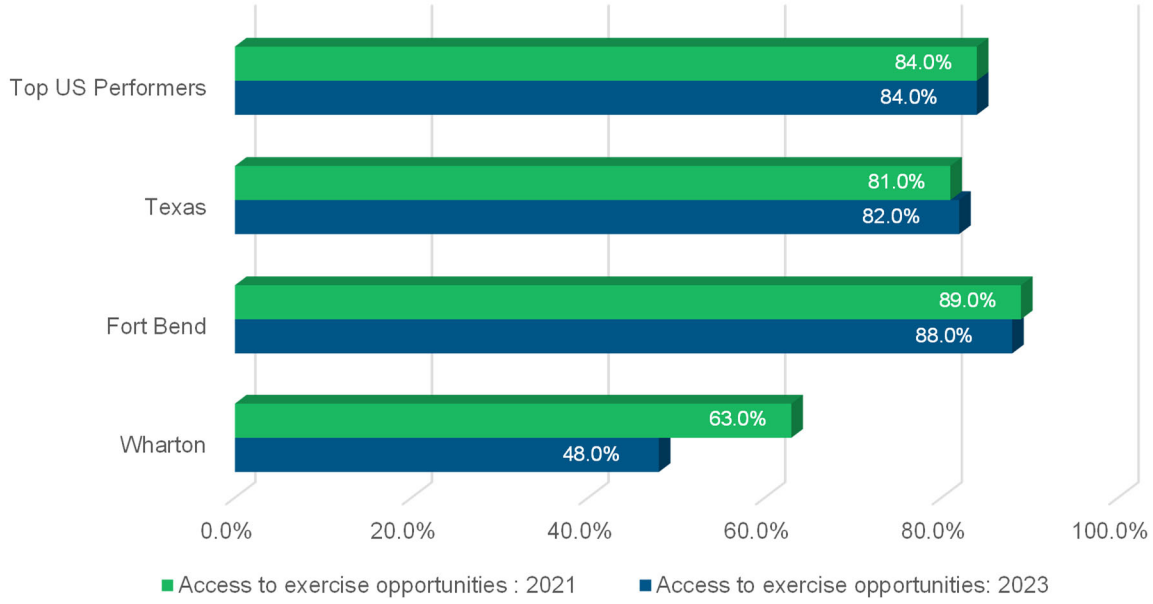
Adult Obesity – Percent of adults that report a BMI >= 30



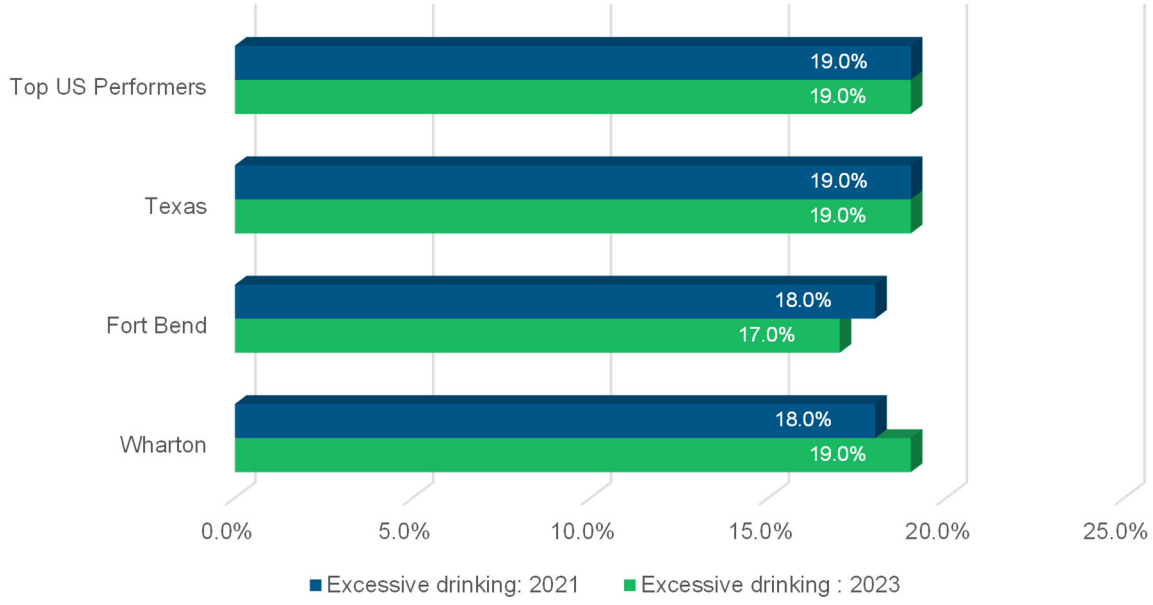
Physical Inactivity – Percent of adults age 20 and over reporting no leisure time physical activity



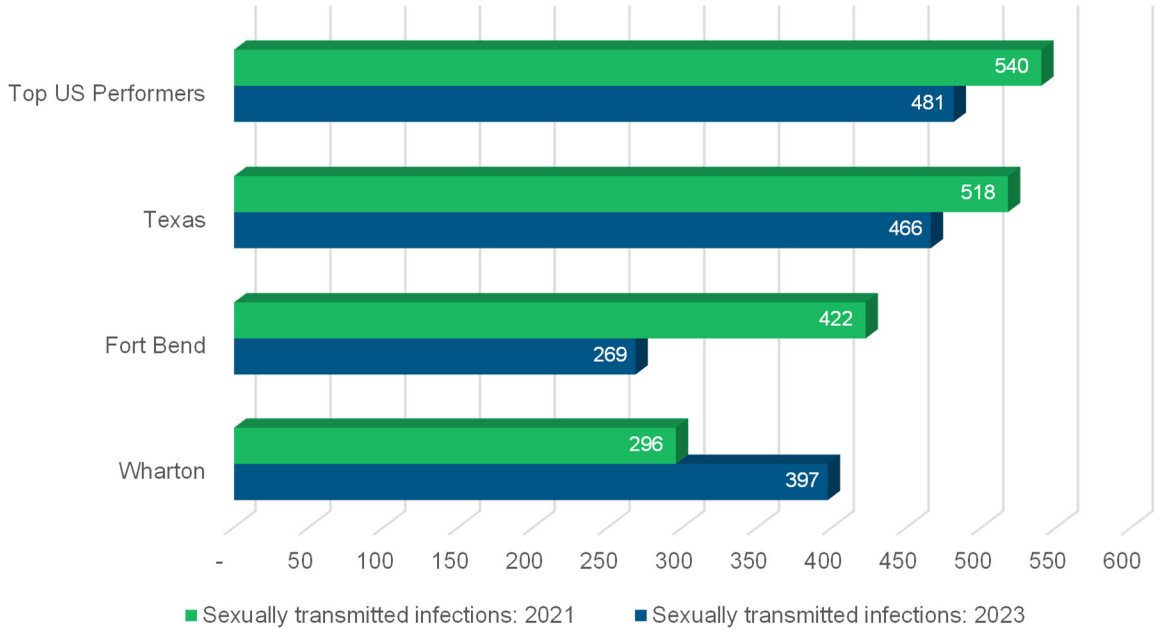
Access to Exercise Opportunities – Percentage of population with adequate access to locations for physical activity



Excessive Drinking – Percent of adults that report excessive drinking in the past 30 days

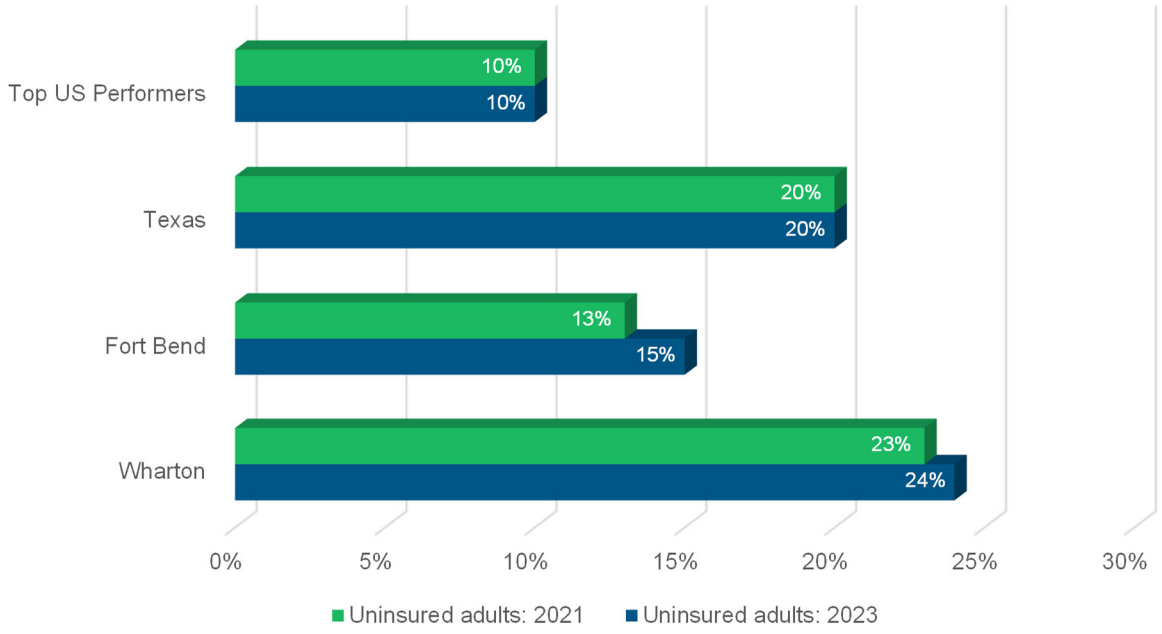


Sexually Transmitted Infections – Chlamydia rate per 100K population

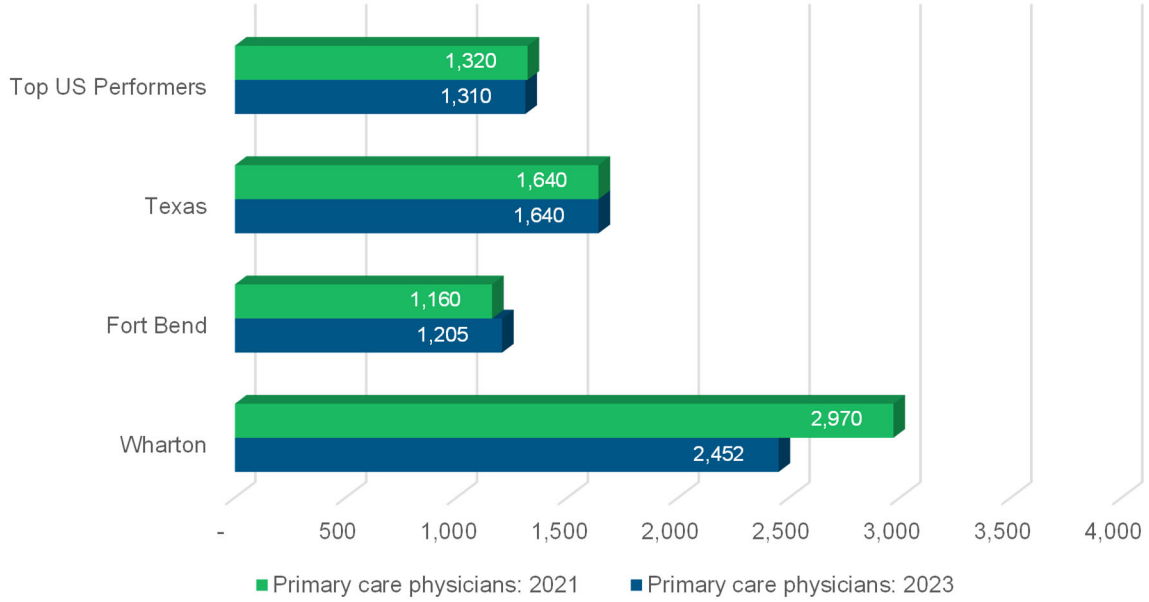


Teen Birth Rate – Per 1,000 female population, ages 15-19

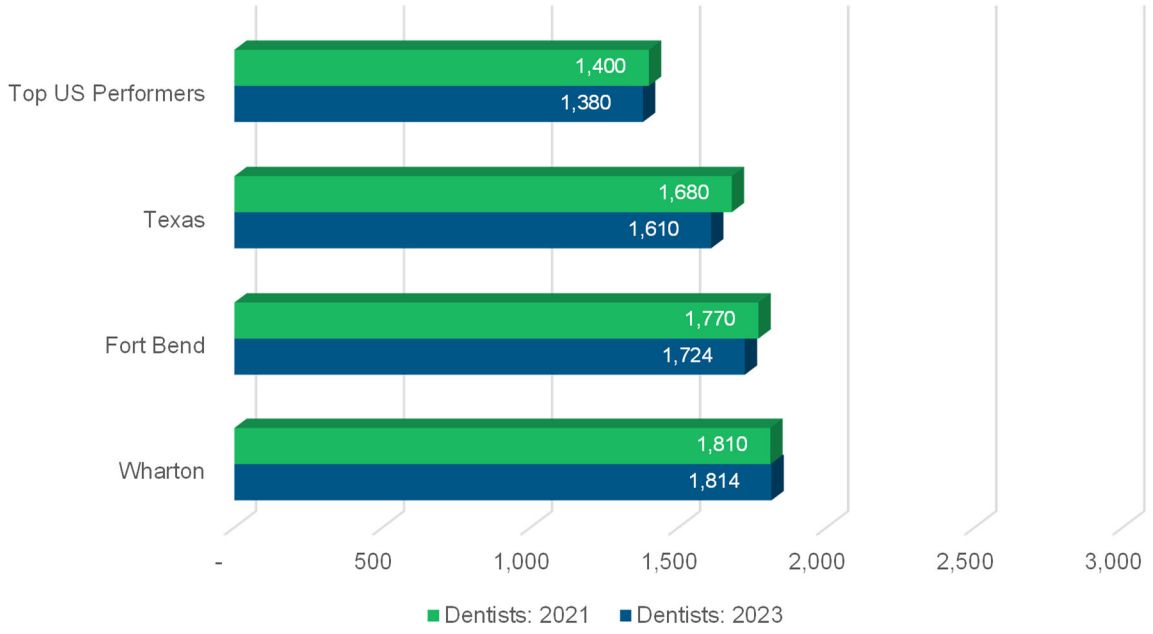
Uninsured Adults – Percent of population under age 65 without health insurance



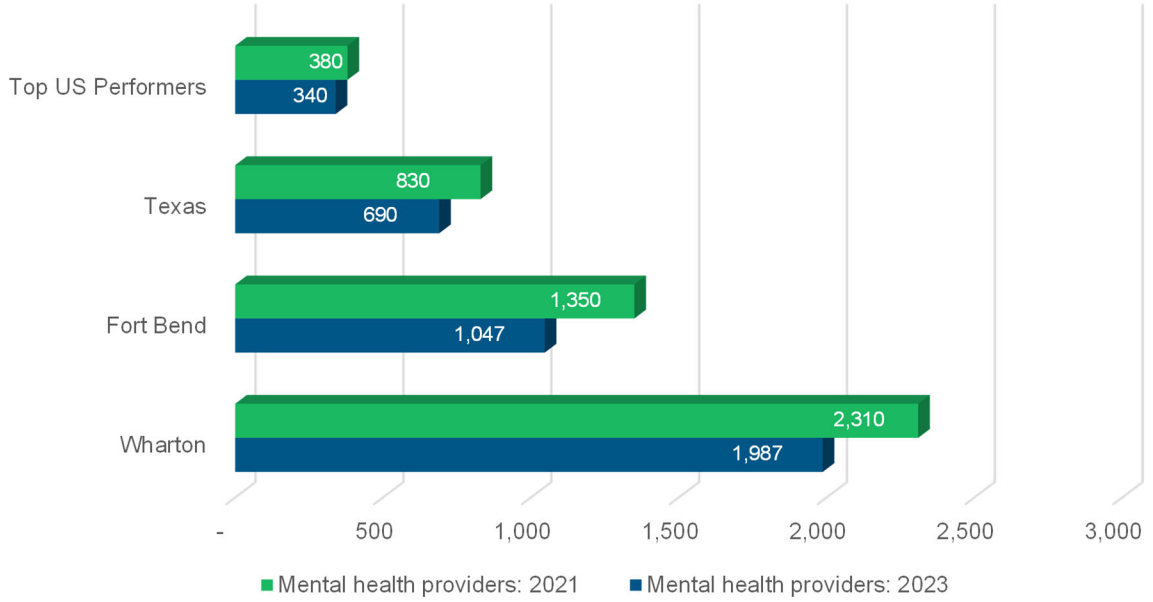
Primary Care Physicians – Ratio of population to primary care physicians (# of physicians: 1)



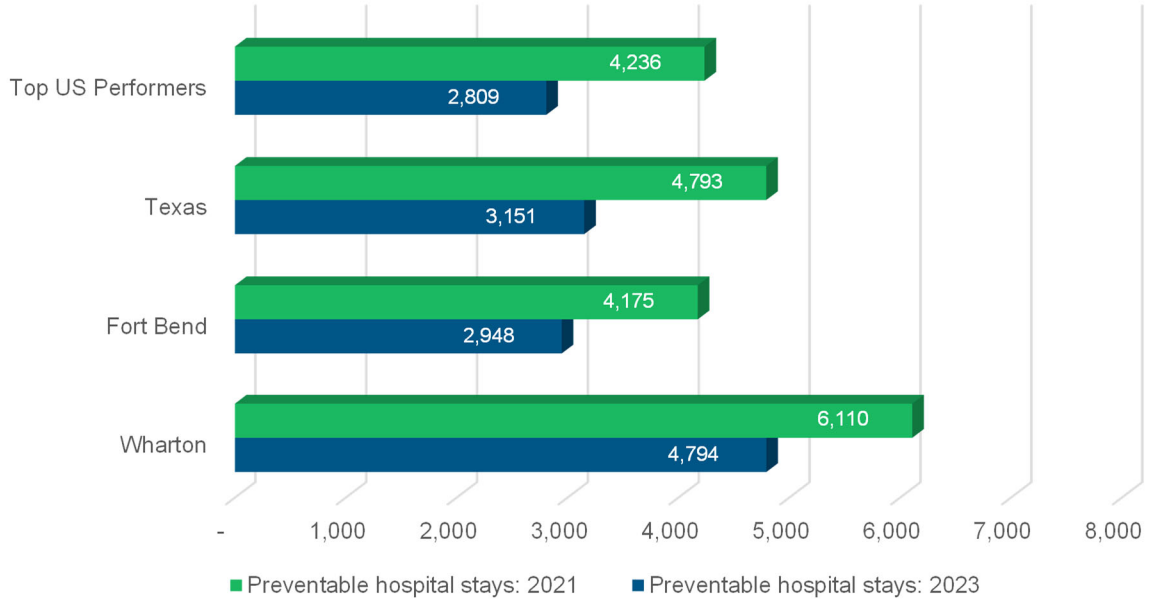
Dentists – Ratio of population to dentists (# of dentists: 1)



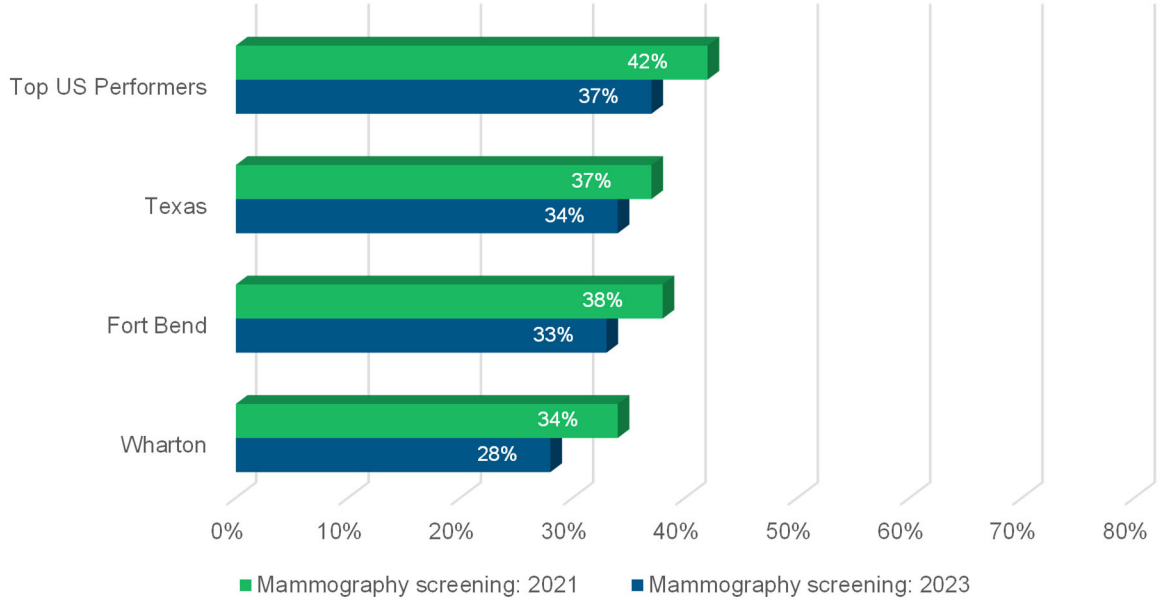
Mental Health Providers – Ratio of population to mental health providers (# of mental health providers: 1)



Preventable Hospital Stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees



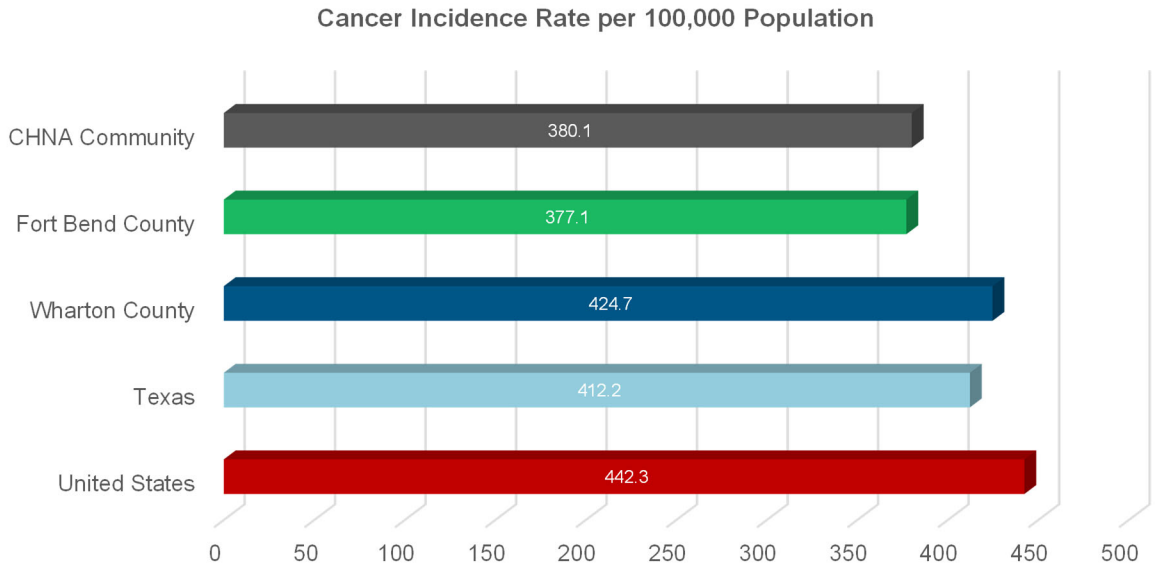
Mammography Screening – Percent of female Medicare enrollees that receive mammography screening



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.

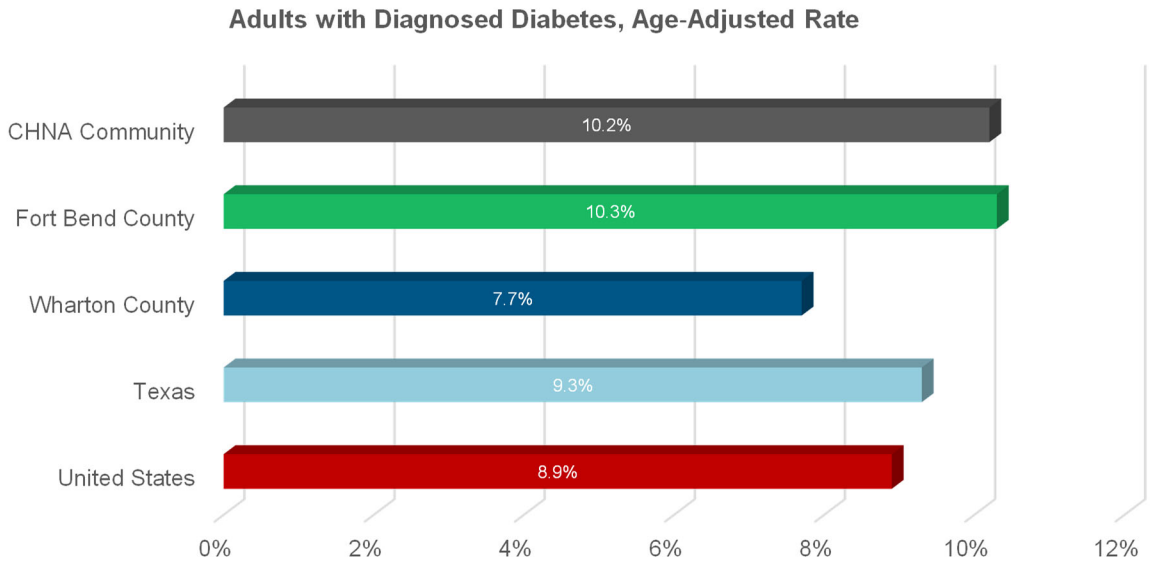
CANCER INCIDENCE

The CHNA Community's cancer incidence rate is 380.1 for every 100,000 of total population. This rate is lower than the state and national rate. Within the CHNA Community, there were 3,130 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)

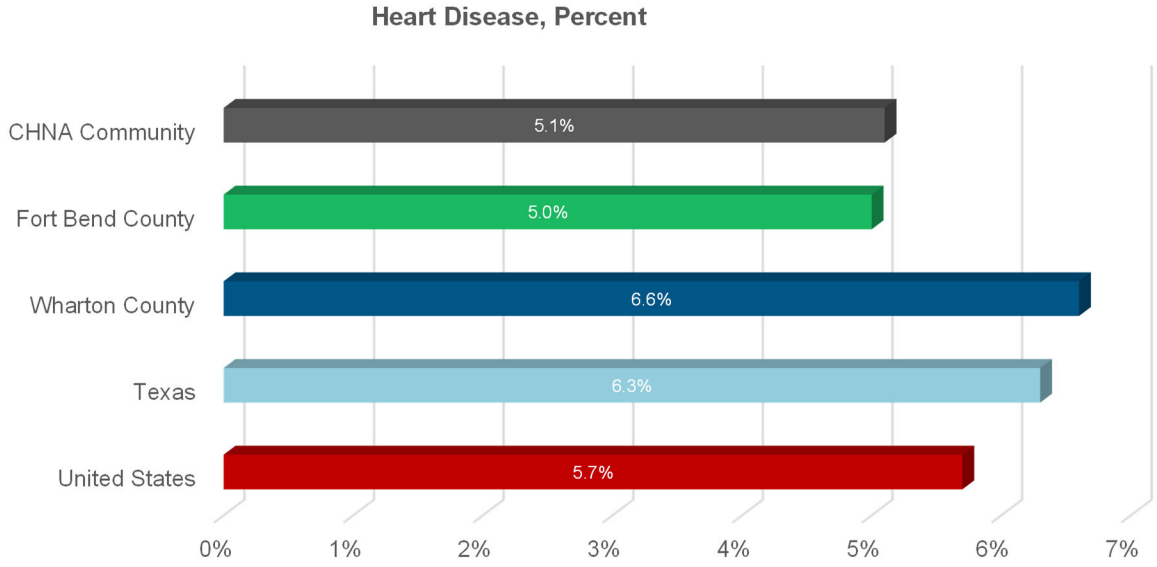
The CHNA Community's percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes is higher than the state and the national rate. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals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



HEART DISEASE (ADULT)

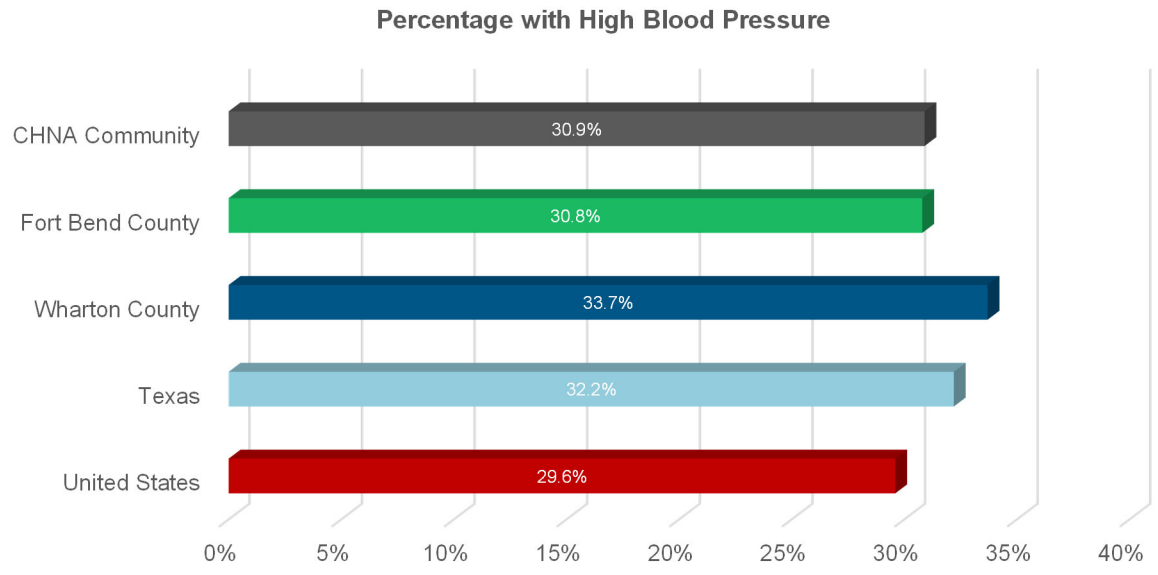
This indicator reports the percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

Within the CHNA Community, there were 5.2% of adults 18 and older who reported having coronary heart disease of the total population age 18 and older.



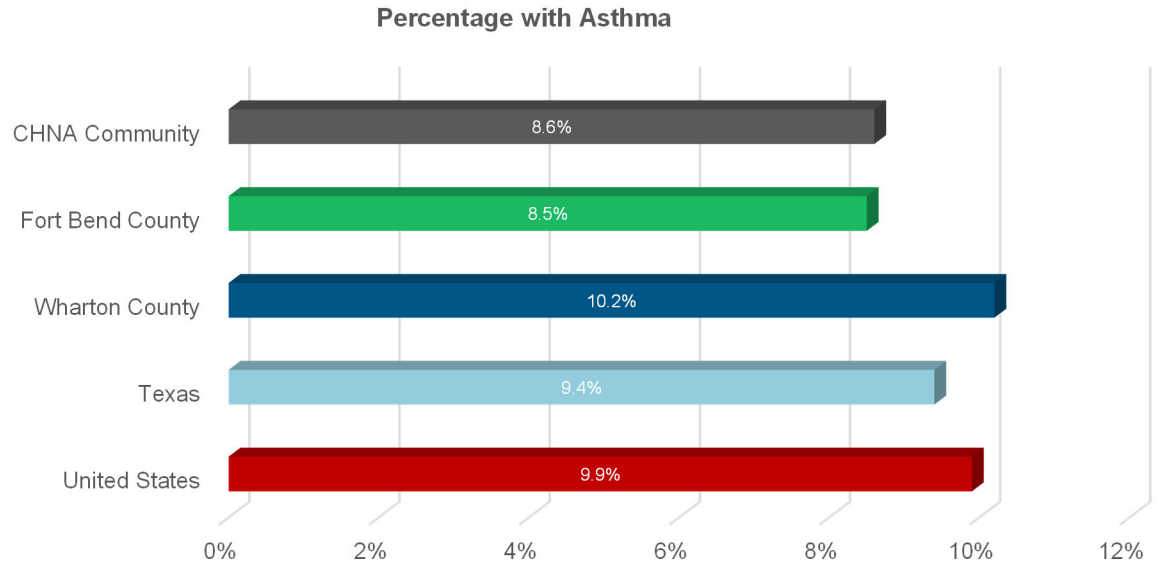
HIGH BLOOD PRESSURE (ADULT)

The CHNA Community's percentage adults aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension is lower than the state rate but higher than the national rate.



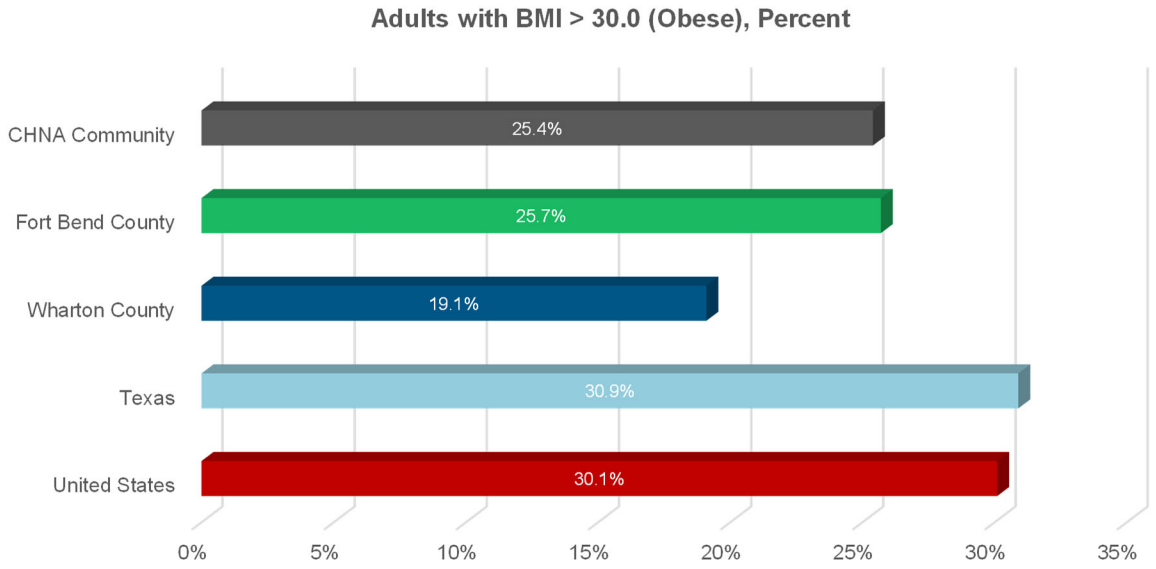
ASTHMA (ADULT)

The CHNA Community's percentage adults age 18+ with Asthma population with asthma is lower than the state rate and national rates. This indicator reports the percentage of adults age 18 and older who answer "yes" to both of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have asthma?" and the question "Do you still have asthma?"



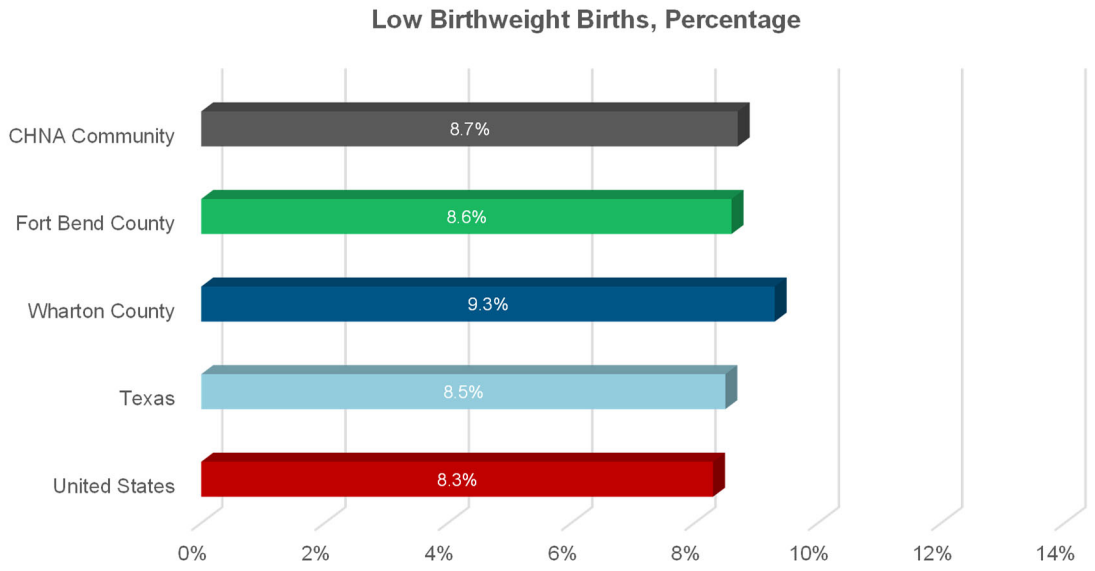
OBESITY

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 and 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 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 of fifteen key informants were conducted in 2024. 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.

All surveys utilized a standard format. Survey participant's opinions were collected without judging the truthfulness or accuracy of their remarks. Survey 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. 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. 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
- Community and business leaders

Input from these health care and non-health care professionals was obtained utilizing a standard 10 question interview format.

KEY INFORMANT SURVEY QUESTIONS

Input from these health care and non-health care professionals was obtained utilizing a standard 10-question interview format. The questions included were as follows:

1. Name, organization/title, and county of residence?
2. In general, how would you rate the health and quality of life in the community served by OakBend Medical Center?
3. 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?
4. 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?
5. What barriers, if any, exist to improving health and quality of life of patients served by OakBend Medical Center?
6. In your opinion, what needs to be done to address the barriers identified in the previous question?
7. How could the services provided by OakBend Medical Center be improved to better meet the needs of its patients and patient's families?
8. 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?
9. In your opinion, what are the three most critical health needs in the community served by OakBend Medical Center?
10. 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 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?

Thirteen percent of survey respondents rate the health of the CHNA Community as “Very Good”, Sixty percent as “Average”, and Twenty-seven percent as “Below Average.”

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?

Fifty-three percent of survey respondents indicated the health of the community “Improved”, forty percent indicated “Stayed the Same”, and Seven percent indicated “Declined.”

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?

Below is a sampling of responses:

- The volume of mental health and violence has increased
- Services are attainable within the community that in the past they would sometimes have to drive far to get help. Providers have an increased interest in serving the community. Transportation availability has improved. Community and staff are more engaged with each other.
- The hospital and its services are improving.
- The health and quality of life has improved because of community awareness and access to more resources.
- The number of reportable diseases has stayed the same in the past three years.
- Health consequences of obesity, lack of exercise, and poor diet plague our community, especially the poor stratum.

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

- Lack of health education
- Culture of the community that has some negative impact on healthy behaviors
- Transportation
- Financial considerations including the cost of healthcare and inadequate or lack of medical insurance coverage
- Language barriers

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?

- Children
- Uninsured / under-insured
- Low income
- Elderly
- Undocumented immigrants

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

- Transportation
- Chronic diseases (heart disease, diabetes, cancer)
- Obesity
- Lack of health knowledge and medical education
- Access to mental health services - adults and children
- Access to preventative care
- Lack of services for the aging
- Lack of insurance (and under-insured)
- More locations and times for better access to care
- Unhealthy behaviors / lifestyle choices / lack of physical activity

HEALTH ISSUES OF VULNERABLE POPULATIONS

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

- Children
- Uninsured / under-insured
- Low income
- Elderly
- Undocumented immigrants

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 counties 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. **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.
5. **Alignment with hospital's mission.** Identified health needs which have a high degree of alignment with the hospital's mission.
6. **Alignment with hospital's programs and strategic priorities.** Identified health needs which have a high degree of alignment with the hospital's programs and strategic priorities.

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)	Prevalence of Common Themes (1 Low - 2 High)
Access to Care	5	4	5	2
Treatment and Management of Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)	4	5	3	2
Access to Primary Care Physicians	5	3	3	2
Access to and Use of Preventative Care Treatments	5	3	3	2
Healthy Behaviors / Healthy Lifestyle Choices	3	4	5	2
Uninsured / Limited Insurance / Access	3	3	4	2
Lack of Health Knowledge / Education	3	3	5	2
Obesity	3	5	3	2
Access to Mental Health / Addiction Providers	5	3	3	2
Poverty and Lack of Financial Resources	2	4	5	2
Access to Services for Children	3	3	5	1
Access to Services for the Aging	3	3	5	1
Transportation	3	3	4	2
Physical Inactivity / Lack of Exercise	5	3	3	1
Preventable Hospital Stays	2	2	2	1
Language and Cultural Barriers	2	2	3	1
Access to Dental Health Services	5	2	3	1
Teen Birth Rate	1	1	3	1
Unintentional Injury	1	1	2	1

	Alignment with Mission (1 Low - 5 High)	Alignment with Programs & Strategic Priorities (1 Low - 5 High)	Total Score
Access to Care	5	5	26
Treatment and Management of Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)	5	5	24
Access to Primary Care Physicians	5	5	23
Access to and Use of Preventative Care Treatments	5	5	23
Healthy Behaviors / Healthy Lifestyle Choices	5	2	21
Uninsured / Limited Insurance / Access	5	3	20
Lack of Health Knowledge / Education	5	1	19
Obesity	5	1	19
Access to Mental Health / Addiction Providers	5	1	19
Poverty and Lack of Financial Resources	5	1	19
Access to Services for Children	3	3	18
Access to Services for the Aging	3	3	18
Transportation	5	1	18
Physical Inactivity / Lack of Exercise	5	1	18
Preventable Hospital Stays	5	5	17
Language and Cultural Barriers	3	3	14
Access to Dental Health Services	1	1	13
Teen Birth Rate	3	2	11
Unintentional Injury	2	2	9

MANAGEMENT'S PRIORITIZATION PROCESS

For the health needs prioritization process, the Hospital engaged the leadership team to review the most significant health needs reported in the prior CHNA, as well 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, the following health needs were identified as the most significant health needs for the community:

The Hospital's next steps include developing an implementation strategy to address some or all of these identified needs.

- Access to Care
- Treatment and Management of Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Access to Primary Care Physicians
- Access to and Use of Preventative Care Treatments
- Healthy Behaviors / Healthy Lifestyle Choices
- Uninsured / Limited Insurance / Access
- Lack of Health Knowledge / Education
- Obesity
- Access to Mental Health / Addiction Providers
- Poverty and Lack of Financial Resources
- Access to Services for Children
- Access to Services for the Aging
- Transportation
- Physical Inactivity / Lack of Exercise
- Preventable Hospital Stays
- Language and Cultural Barriers
- Access to Dental Health Services
- Teen Birth Rate
- Unintentional Injury

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	County	City, State Zip
Oakbend Medical Center	Fort Bend	Richmond, TX 77469
Oakbend Medical Center	Fort Bend	Richmond, TX 77469
Oakbend Medical Center	Wharton	Wharton, TX 77488
El Campo Memorial Hospital	Wharton	El Campo, TX 77437
Houston Methodist Sugar Land Hospital	Fort Bend	Sugar Land, TX 77479
Atrium Medical Center	Fort Bend	Stafford, TX 77477
Kindred Hospital Sugar Land	Fort Bend	Sugar Land, TX 77479
St. Luke's Health - Sugar Land Hospital	Fort Bend	Sugar Land, TX 77478
St. Michael's Elite Hospital	Fort Bend	Sugar Land, TX 77479
Memorial Hermann Sugar Land Hospital	Fort Bend	Sugar Land, TX 77479

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.

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.

APPENDICES

APPENDIX A – ANALYSIS OF DATA

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH

CHNA COMMUNITY

Area	United States	(A) 10% of United States Crude Rate	CHNA	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	182.70	18.27	108.80	-73.90	
Coronary Heart Disease	112.50	11.25	59.00	-53.50	
Heart Disease	206.70	20.67	117.10	-89.60	
Lung Disease	46.00	4.60	15.40	-30.60	
Stroke	47.70	4.77	29.10	-18.60	
Unintentional Injury	60.20	6.02	29.00	-31.20	
Poisoning (Including Drug Over	28.50	2.85	9.50	-19.00	
Life Expectancy	77.60	7.76	81.10	3.50	
Suicide	14.50	1.45	10.20	-4.30	

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

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	182.70	18.27	104.10	-78.60	
Coronary Heart Disease	112.50	11.25	54.70	-57.80	
Heart Disease	206.70	20.67	107.80	-98.90	
Lung Disease	46.00	4.60	14.50	-31.50	
Stroke	47.70	4.77	26.40	-21.30	
Unintentional Injury	60.20	6.02	27.20	-33.00	
Poisoning (Including Drug Over	28.50	2.85	9.20	-19.30	
Life Expectancy	77.60	7.76	81.40	3.80	
Suicide	14.50	1.45	10.00	-4.50	

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

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	182.70	18.27	202.00	19.30	Health Need
Coronary Heart Disease	112.50	11.25	143.90	31.40	Health Need
Heart Disease	206.70	20.67	304.20	97.50	Health Need
Lung Disease	46.00	4.60	33.60	-12.40	
Stroke	47.70	4.77	83.00	35.30	Health Need
Unintentional Injury	60.20	6.02	65.30	5.10	
Poisoning (Including Drug Over	28.50	2.85	15.30	-13.20	
Life Expectancy	77.60	7.76	74.60	-3.00	
Suicide	14.50	1.45	14.40	-0.10	

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

ANALYSIS OF HEALTH OUTCOMES

FORT BEND COUNTY

Health Outcomes	Top US Performers: 2023	(A) 30% of National Benchmark	Fort Bend County: 2023	(B) County Rate Less National Benchmark 2023	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	13.0%	-3.0%	
Adult obesity	32.0%	9.6%	31.0%	-1.0%	
Physical inactivity	22.0%	6.6%	22.0%	0.0%	
Access to exercise opportunities	84.0%	25.2%	88.0%	4.0%	
Excessive drinking	19.0%	5.7%	17.0%	-2.0%	
Sexually transmitted infections	481.3	144.4	268.5	(212.8)	
Teen birth rate	19.0	5.7	10.0	-9.0	
Uninsured adults	10.0%	3.0%	15.0%	5.0%	Health Need
Primary care physicians	1,310	393	1,205	(105)	
Dentists	1,380	414	1,724	344	Health Need
Mental health providers	340	102	1,047	707	Health Need
Preventable hospital stays	2,809.0	842.7	2,948.0	139.0	
Mammography screening	37.0%	11.1%	33.0%	-4.0%	

WHARTON COUNTY

Health Outcomes	Top US Performers: 2024	(A) 30% of National Benchmark	Wharton County: 2024	(B) County Rate Less National Benchmark 2024	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	19.0%	3.0%	
Adult obesity	32.0%	9.6%	41.0%	9.0%	
Physical inactivity	22.0%	6.6%	30.0%	8.0%	Health Need
Access to exercise opportunities	84.0%	25.2%	48.0%	-36.0%	Health Need
Excessive drinking	19.0%	5.7%	19.0%	0.0%	
Sexually transmitted infections	481.3	144.4	397.1	(84.2)	
Teen birth rate	19.0	5.7	43.0	24.0	Health Need
Uninsured adults	10.0%	3.0%	24.0%	14.0%	Health Need
Primary care physicians	1,310	393	2,452	1,142	Health Need
Dentists	1,380	414	1,814	434	Health Need
Mental health providers	340	102	1,987	1,647	Health Need
Preventable hospital stays	2,809.0	842.7	4,794.0	1,985.0	Health Need
Mammography screening	37.0%	11.1%	28.0%	-9.0%	

ANALYSIS OF PRIMARY DATA – KEY INFORMANT SURVEYS

Identified Needs
Access to care
Uninsured / Underinsured
Lack of physical activity
Access to and use of preventative care treatments
Treatment of and management of chronic diseases and conditions
Access to mental health services - adults and children
Access to services for the aging
Obesity
Access to services for children
Healthy behaviors and healthy lifestyle choices
Lack of health knowledge and education
Transportation
Poverty and lack of financial resources
Language barriers
More healthcare locations and appointment times for better healthcare access

ISSUES VULNERABLE POPULATIONS

Population	Issues
Uninsured and under-insured population	Transportation High cost of health care prevents needs from being met Services for children
Children	Transportation Access to services for children Lack of financial resources Inconvenient healthcare facility hours Shortage of physicians
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 Lack of financial resources Transportation Access to services
Undocumented immigrants	Transportation High cost of health care prevents needs from being met Healthy lifestyle and health nutrition education Services for children Access to services Lack of financial resources

APPENDIX B – ACKNOWLEDGEMENT OF KEY INFORMANTS

KEY INFORMANTS

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

Name	Organization
Barry Beard	Polly Ryon Foundation City of Richmond
Christy Gonzales	City of Wharton EMS
Rhonda Mayfield	OakBend Medical Center
Donna Ferguson	OakBend Medical Center
Sheree Oehlke	OakBend Medical Center
Elizabeth King	Moerer & King, LLP
Adam Pisani	The Pisani Agency, Inc.
Tom Crayton	Crayton & Associated LLC
Leroy Hodge Jr	Oak Bend Medical Center
Shena Ureste	Texana Center
Nicolette Janoski	Fort Bend County HHS
Tom Crayton	Crayton & Associates LLC
Edward Uthman, MD, FCAP	CommunityMember
Jess Stuart	TW Davis YMCA
Michael Dotson	AccessHealth

APPENDIX C – COUNTY HEALTH RANKINGS

FORT BEND COUNTY

Health Outcomes	Fort Bend County: 2021	Fort Bend County: 2023	Change	Texas: 2023	Top US Performers: 2023
Mortality: Texas County Ranking	**2**	**4**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	4,200	4,585	-	7,000	7,300
Morbidity: Texas County Ranking	**4**	**9**	-		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	15%	13%	+	16%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.0	2.7	+	2.9	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.4	4.1	-	4.2	4.4
Low birth weight – Percent of live births with low birth weight (<2500 grams)	9.0%	9.0%	NC	8.0%	8.0%

Health Outcomes	Fort Bend County: 2021	Fort Bend County: 2023	Change	Texas: 2023	Top US Performers: 2023
Health Behaviors: Texas County Ranking	**2**	**2**	NC		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	12.0%	13.0%	-	13.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	26.0%	31.0%	-	36.0%	32.0%
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	18.0%	22.0%	-	25.0%	22.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	89.0%	88.0%	-	82.0%	84.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	18.0%	17.0%	+	19.0%	19.0%
Sexually transmitted infections – Chlamydia rate per 100K population	422.4	268.5	+	466.0	481.3
Teen birth rate – Per 1,000 female population, ages 15-19	11.0	10.0	+	29.0	19.0
Clinical Care: Texas County Ranking	**8**	**13**	-		
Uninsured adults – Percent of population under age 65 without health insurance	13.0%	15.0%	-	20.0%	10.0%
Primary care physicians – Ratio of population to primary care physicians	1,160:1	1,205:1	-	1,640:1	1,310:1
Dentists – Ratio of population to dentists	1,770:1	1,724:1	+	1,610:1	1,380:1
Mental health providers – Ratio of population to mental health providers	1,350:1	1,047:1	+	690:1	340:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	4,175	2,948	+	3,151	2,809
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	38.0%	33.0%	-	34.0%	37.0%

Health Outcomes	Fort Bend County: 2021	Fort Bend County: 2023	Change	Texas: 2023	Top US Performers: 2023
Social and Economic Factors: Texas County Ranking	**8**	**12**	-		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	91.0%	91.0%	NC	85.0%	89.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	77.0%	76.0%	+	64.0%	67.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	3.5%	5.9%	-	5.7%	3.7%
Children in poverty – Percent of children under age 18 in poverty	7.0%	9.0%	-	20.0%	16.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	4.1	4.0	-	4.8	4.9
Children in single-parent households – Percent of children that live in household headed by single parent	19.0%	16.0%	+	26.0%	25.0%
Social associations – Number of membership associations per 10,000 population	4.7	4.7	NC	7.4	9.1
Injury deaths – Number of deaths due to injury per 100,000 population	35.0	37.0	-	60.0	80.0
Physical Environment: Texas County Ranking	**177**	**224**	-		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	10.1	10.7	-	8.6	7.4
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	14.0%	14.0%	NC	17.0%	17.0%
Driving alone to work – Percentage of the workforce that drives alone to work	82.0%	76.0%	+	77.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	59.0%	57.0%	+	39.0%	36.0%

Wharton County

Health Outcomes	Wharton County: 2021	Wharton County: 2023	Change	Texas: 2023	Top US Performers: 2023
Mortality: Texas County Ranking	**89**	**86**	+		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	8,100	8,593	-	7,000	7,300
Morbidity: Texas County Ranking	**195**	**189**	+		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	25%	21%	+	16%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.6	4.0	+	2.9	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.7	5.0	-	4.2	4.4
Low birth weight – Percent of live births with low birth weight (<2500 grams)	9.0%	9.0%	NC	8.0%	8.0%

Health Outcomes	Wharton County: 2021	Wharton County: 2023	Change	Texas: 2023	Top US Performers: 2023
Health Behaviors: Texas County Ranking	**125**	**131**	-		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	19.0%	19.0%	NC	13.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	37.0%	41.0%	-	36.0%	32.0%
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	24.0%	30.0%	-	25.0%	22.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	63.0%	48.0%	-	82.0%	84.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	18.0%	19.0%	-	19.0%	19.0%
Sexually transmitted infections – Chlamydia rate per 100K population	295.5	397.1	-	466.0	481.3
Teen birth rate – Per 1,000 female population, ages 15-19	43.0	43.0	NC	29.0	19.0
Clinical Care: Texas County Ranking	**168**	**199**	-		
Uninsured adults – Percent of population under age 65 without health insurance	23.0%	24.0%	-	20.0%	10.0%
Primary care physicians – Ratio of population to primary care physicians	2,970:1	2,452:1	+	1,640:1	1,310:1
Dentists – Ratio of population to dentists	1,810:1	1,814:1	-	1,610:1	1,380:1
Mental health providers – Ratio of population to mental health providers	2,310:1	1,987:1	+	690:1	340:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	6,110	4,794	+	3,151	2,809
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	34.0%	28.0%	-	34.0%	37.0%

Health Outcomes	Wharton County: 2021	Wharton County: 2023	Change	Texas: 2023	Top US Performers: 2023
Social and Economic Factors: Texas County Ranking	**137**	**123**	+		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	78.0%	81.0%	+	85.0%	89.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	54.0%	55.0%	+	64.0%	67.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	3.4%	5.7%	-	5.7%	3.7%
Children in poverty – Percent of children under age 18 in poverty	22.0%	23.0%	-	20.0%	16.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	5.4	5.2	-	4.8	4.9
Children in single-parent households – Percent of children that live in household headed by single parent	31.0%	27.0%	+	26.0%	25.0%
Social associations – Number of membership associations per 10,000 population	15.4	14.9	-	7.4	9.1
Injury deaths – Number of deaths due to injury per 100,000 population	69.0	76.0	-	60.0	80.0
Physical Environment: Texas County Ranking	**155**	**239**	-		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	8.3	9.5	-	8.6	7.4
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	16.0%	19.0%	-	17.0%	17.0%
Driving alone to work – Percentage of the workforce that drives alone to work	87.0%	85.0%	+	77.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	29.0%	32.0%	-	39.0%	36.0%

Data Source: Countyhealthrankings.org

APPENDIX D – SOURCES

Data Indicator	Data Source
Total Population	US Census Bureau, American Community Survey, 2017-21.
Total Population (Census 2020)	US Census Bureau, Decennial Census, 2020.
Total Population Change, 2010 - 2020	US Census Bureau, Decennial Census, 2020.
Total Population Change, 2000 - 2010	US Census Bureau, Decennial Census, 2000 - 2010.
Urban and Rural Population (2020) - Rural	US Census Bureau, Decennial Census, 2020.
Urban and Rural Population (2020) - Urban	US Census Bureau, Decennial Census, 2020.
Group Quarters Population	US Census Bureau, Decennial Census, 2020.
Urban and Rural Population (Incorporated) (Census 2020)	US Census Bureau, Decennial Census, 2020.
Median Age	US Census Bureau, American Community Survey, 2017-21.
Female Population	US Census Bureau, American Community Survey, 2017-21.
Male Population	US Census Bureau, American Community Survey, 2017-21.
Population Under Age 18	US Census Bureau, American Community Survey, 2017-21.
Population Age 0-4	US Census Bureau, American Community Survey, 2017-21.
Population Age 5-17	US Census Bureau, American Community Survey, 2017-21.
Population Age 18-64	US Census Bureau, American Community Survey, 2017-21.
Population Age 18-24	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Population Age 25-34	US Census Bureau, American Community Survey, 2017-21.
Population Age 35-44	US Census Bureau, American Community Survey, 2017-21.
Population Age 45-54	US Census Bureau, American Community Survey, 2017-21.
Population Age 55-64	US Census Bureau, American Community Survey, 2017-21.
Population Age 65+	US Census Bureau, American Community Survey, 2017-21.
Population with Any Disability	US Census Bureau, American Community Survey, 2017-21.
Population in Limited English Households	US Census Bureau, American Community Survey, 2017-21.
Population with Limited English Proficiency	US Census Bureau, American Community Survey, 2017-21.
Population Geographic Mobility	US Census Bureau, American Community Survey, 2017-21.
Foreign-Born Population	US Census Bureau, American Community Survey, 2017-21.
Hispanic Population	US Census Bureau, American Community Survey, 2017-21.
Non-Hispanic White Population	US Census Bureau, American Community Survey, 2017-21.
Black or African American Population	US Census Bureau, American Community Survey, 2017-21.
Citizenship Status	US Census Bureau, American Community Survey, 2017-21.
Veteran Population	US Census Bureau, American Community Survey, 2017-21.
Migration Patterns - Total Population (2010-2020)	IRS - Statistics of Income, 2010-2020.
Migration Patterns - Total Population (2000-2010)	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.

Data Indicator	Data Source
Migration Patterns - Young Adult (2000-2010)	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, 2017-21.
Commuter Travel Patterns - Long Commute	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Overview	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Overview 2	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Public Transportation	US Census Bureau, American Community Survey, 2017-21.
Commuter Travel Patterns - Walking or Biking	US Census Bureau, American Community Survey, 2017-21.
Employment - Business Creation	US Census Bureau, Business Dynamics Statistics, 2010-2020.
Employment - Employment Change	US Census Bureau, Business Dynamics Statistics, 2019-2020.
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, 2021.
Employment - Jobs Sectors, Highest Earnings	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Labor Force Participation Rate	US Census Bureau, American Community Survey, 2017-21.
Employment - Unemployment Rate	US Department of Labor, Bureau of Labor Statistics, 2023 - September.
Gross Domestic Product (GDP)	US Department of Commerce, US Bureau of Economic Analysis, 2021.
Income - Earned Income Tax Credit	IRS - Statistics of Income, 2018.
Income - Families Earning Over $75,000	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Income - Income and AMI	US Census Bureau, American Community Survey, 2017-21.
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, 2017-21.
Income - Median Family Income	US Census Bureau, American Community Survey, 2017-21.
Income - Median Household Income	US Census Bureau, American Community Survey, 2017-21.
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, 2017-21.
Income - Proprietor Employment and Income	US Department of Commerce, US Bureau of Economic Analysis, 2021.
Income - Public Assistance Income	US Census Bureau, American Community Survey, 2017-21.
Income - Transfer Payments	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Poverty - Children Below 100% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Children Below 200% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data, 2020-2021.
Poverty - Households in Poverty by Family Type	US Census Bureau, American Community Survey, 2017-21.
Poverty - Population Below 100% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Population Below 100% FPL (Annual)	US Census Bureau, Small Area Income and Poverty Estimates, 2021.
Poverty - Population Below 185% FPL	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
Poverty - Population Below 200% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Population Below 50% FPL	US Census Bureau, American Community Survey, 2017-21.
Poverty - Poverty Profile	US Census Bureau, American Community Survey, 2021.
Debt - Student Loan Debt	Debt in America, The Urban Institute, 2017-21.
Debt - Any Debt in Collections	Debt in America, The Urban Institute, 2017-21.
Access - Childcare Centers	Department of Homeland Security, Homeland Infrastructure Foundation-Level Data, 2010-2022.
Access - Head Start	US Department of Health & Human Services, HRSA - Administration for Children and Families, 2022.
Access - Childcare Cost Burden	The Living Wage Calculator, Small Area Income and Poverty Estimates, 2022&2021.
Access - Preschool Enrollment (Age 3-4)	US Census Bureau, American Community Survey, 2017-21.
Access - Public Schools	National Center for Education Statistics, NCES - Common Core of Data, 2021-2022.
Attainment - Overview	US Census Bureau, American Community Survey, 2017-21.
Attainment - Associate's Level Degree or Higher	US Census Bureau, American Community Survey, 2017-21.
Attainment - Bachelor's Degree or Higher	US Census Bureau, American Community Survey, 2017-21.
Attainment - No High School Diploma	US Census Bureau, American Community Survey, 2017-21.
Attainment - Some Post-secondary Education	US Census Bureau, American Community Survey, 2017-21.
Attainment - High School Graduation Rate	US Department of Education, EDFacts, 2019-20.
Chronic Absence Rate	U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18.

Data Indicator	Data Source
Attainment - No High School Diploma	US Census Bureau, American Community Survey, 2017-21.
Attainment - Some Post-secondary Education	US Census Bureau, American Community Survey, 2017-21.
Attainment - High School Graduation Rate	US Department of Education, EDFacts, 2019-20.
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, 2020-21.
Proficiency - Student Reading Proficiency (4th Grade)	US Department of Education, EDFacts, 2020-21.
Public School Revenue	National Center for Education Statistics, NCES - Common Core of Data, 2019-20.
Public School Expenditures	National Center for Education Statistics, NCES - Common Core of Data, 2019-20.
School Funding Adequacy	School Finance Indicators Database, SFID - School Finance Indicators Database, 2020.
School Segregation Index	National Center for Education Statistics, NCES - School Segregation Index, 2021-2022.
Housing Units - Overview (2020)	US Census Bureau, Decennial Census, 2020.
Housing Units - Annual Trends	US Census Bureau, US Census Population Estimates.
Households and Families - Overview	US Census Bureau, American Community Survey, 2017-21.
Families - Overview	US Census Bureau, American Community Survey, 2017-21.
Affordable Housing	US Census Bureau, American Community Survey, 2017-21.
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, 2017-21.

Data Indicator	Data Source
Household Structure - Families with Children	US Census Bureau, American Community Survey, 2017-21.
Household Structure - Single-Parent Households	US Census Bureau, American Community Survey, 2017-21.
Household Structure - Older Adults Living Alone	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Cost Burden (30%)	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Cost Burden, Severe (50%)	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Owner Costs	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Owner Costs by Mortgage Status	US Census Bureau, American Community Survey, 2017-21.
Housing Costs - Renter Costs	US Census Bureau, American Community Survey, 2017-21.
Housing Quality - Overcrowding	US Census Bureau, American Community Survey, 2017-21.
Housing Quality - Substandard Housing	US Census Bureau, American Community Survey, 2017-21.
Housing Quality - Substandard Housing, Severe	US Census Bureau, American Community Survey, 2011-2015.
Housing Stock - Age	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Housing Unit Value	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Modern Housing	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Mortgage Lending	Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014.
Housing Stock - Net Change	US Census Bureau, American Community Survey, 2017-21.
Housing Stock - Residential Construction	US Department of Housing and Urban Development, 2021.

Data Indicator	Data Source
Housing Units - Single-Unit Housing	US Census Bureau, American Community Survey, 2017-21.
Tenure - Mortgage Status	US Census Bureau, American Community Survey, 2017-21.
Tenure - Owner-Occupied Housing	US Census Bureau, American Community Survey, 2017-21.
Tenure - Renter-Occupied Housing	US Census Bureau, American Community Survey, 2017-21.
Vacancy (ACS)	US Census Bureau, American Community Survey, 2017-21.
Vacancy (HUD)	US Department of Housing and Urban Development, 2021-Q4.
Evictions	Eviction Lab, 2016.
Area Deprivation Index	University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2020.
Food Insecurity Rate	Feeding America, 2021.
Homeless Children & Youth	US Department of Education, EDFacts, 2019-2020.
Households with No Motor Vehicle	US Census Bureau, American Community Survey, 2017-21.
Incarceration Rate	Opportunity Insights, 2018.
Insurance - Insured Population and Provider Type	US Census Bureau, American Community Survey, 2017-21.
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, 2017-21.
Insurance - Uninsured Adults	US Census Bureau, Small Area Health Insurance Estimates, 2021.
Insurance - Uninsured Children	US Census Bureau, Small Area Health Insurance Estimates, 2021.

Data Indicator	Data Source
Insurance - Uninsured Population (ACS)	US Census Bureau, American Community Survey, 2017-21.
Insurance - Uninsured Population (SAHIE)	US Census Bureau, Small Area Health Insurance Estimates, 2021.
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, 2017-21.
SNAP Benefits - Population Receiving SNAP (SAIPE)	US Census Bureau, Small Area Income and Poverty Estimates, 2020.
Social Capital - Social Capital Index	Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014.
Social Capital - 501c3 organizations	IRS - Exempt Organizations Business Master File, 2020.
Social Capital - ACS Self-response Rate	US Census Planning Database; ACS 2015-19; CARES, 2022.
Social Capital - Voter Participation Rate	Townhall.com Election Results, 2020.
Social Vulnerability Index (SoVI)	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2020.
Teen Births	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2014-2020.
Teen Births (ACS)	US Census Bureau, American Community Survey, 2017-21.
Arrests - Juvenile Arrest Rate	Office of Juvenile Justice and Delinquency Department, Easy Access to State and County Juvenile Court Case Counts (EZACO), 2019.
Property Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014&2016.
Violent Crime - Assault	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Rape	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.

Data Indicator	Data Source
Violent Crime - Robbery	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Housing + Transportation Affordability Index (H+T Index)	Center for Neighborhood Technology, 2022.
Young People Not in School and Not Working	US Census Bureau, American Community Survey, 2017-21.
Gender Pay Gap	US Census Bureau, American Community Survey, 2017-2021.
Opportunity Index	Opportunity Nation, 2018.
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, 2019.
Air & Water Quality - Particulate Matter 2.5	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2019.
Air & Water Quality - Respiratory Hazard Index	EPA - National Air Toxics Assessment, 2018.
Air & Water Quality - RSEI Score	US Environmental Protection Agency, 2019.
Built Environment - Banking Institutions	US Census Bureau, County Business Patterns, 2020.
Built Environment - Broadband Access	FCC FABRIC Data, June, 2023.
Built Environment - Households with No Computer	US Census Bureau, American Community Survey, 2017-21.
Built Environment - Households with No or Slow Internet	US Census Bureau, American Community Survey, 2017-21.
Built Environment - Liquor Stores	US Census Bureau, County Business Patterns, 2020.
Built Environment - Recreation and Fitness Facility Access	US Census Bureau, County Business Patterns, 2020.

Data Indicator	Data Source
Built Environment - Social Associations	US Census Bureau, County Business Patterns, 2020.
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.
Population Directly Affected by Wildfire	University of Missouri, Center for Applied Research and Engagement Systems, 2010-2020.
Climate & Health - Climate-Related Mortality Impacts	Climate Impact Lab.
Climate & Health - Dominant Land Cover	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2021.
Climate & Health - Drought Severity	US Drought Monitor, 2017-2019.
Climate & Health - Flood Vulnerability	Federal Emergency Management Agency, National Flood Hazard Layer, 2011.
Climate & Health - High Heat Index Days (Absolute)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking, 2019-21.
Climate & Health - High Heat Index Days (Relative)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking, 2019-21.
Climate & Health - National Risk Index	Federal Emergency Management Agency, National Risk Index, 2021.
Climate & Health - Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2021.
Community Design - Distance to Public Transit	Environmental Protection Agency, EPA - Smart Location Database, 2021.
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.
Community Design - Road Network Density	Environmental Protection Agency, EPA - Smart Location Database, 2021.
Community Design - Walkability Index Score	Environmental Protection Agency, EPA - Smart Location Database, 2021.
Community Design - Community Diversity (Emp. + Housing)	Environmental Protection Agency, EPA - Smart Location Database, 2021.

Data Indicator	Data Source
Food Environment - Fast Food Restaurants	US Census Bureau, County Business Patterns, 2020.
Food Environment - Food Desert Census Tracts	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Grocery Stores	US Census Bureau, County Business Patterns, 2020.
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, 2023.
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.
Access to Exercise Opportunities	ArcGIS Business Analyst and Living Atlas of the World, YMCA & US Census Tigerline Files, 2022&2020.
Cancer Screening - Mammogram (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
Cancer Screening - Mammogram (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Cancer Screening - Cervical Cancer Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Cancer Screening - Sigmoidoscopy or Colonoscopy	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Dental Care Utilization	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.

Data Indicator	Data Source
Diabetes Management - Hemoglobin A1c Test	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Hospitalizations - Preventable Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
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 , 2017-2019.
Hospitalizations - Stroke	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2017-2019.
Late or No Prenatal Care	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2019.
Opioid Drug Claims	Centers for Medicare & Medicaid Services, CMS - Part D Opioid Drug Mapping Tool, 2019.
Prevention - Annual Wellness Exam (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
Prevention - Seasonal Influenza Vaccine	Centers for Disease Control and Prevention, CDC - FluVaxView, 2021.
Prevention - Cholesterol Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Prevention - High Blood Pressure Management (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Prevention - High Blood Pressure Management (Medicare)	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2018.
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, 2020.
Prevention - Recent Primary Care Visit (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Prevention - Core Preventative Services for Women	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.

Data Indicator	Data Source
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 , 2018-20.
Readmissions - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Heart Failure	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Pneumonia	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Elective Delivery	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Stroke	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Alcohol - Heavy Alcohol Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Alcohol - Binge Drinking	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Alcohol - Expenditures	Nielsen, Nielsen SiteReports, 2014.
Breastfeeding - Ever	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Any)	U.S. Census Bureau, National Survey of Children's Health, 2018.
Breastfeeding (Exclusive)	U.S. Census Bureau, 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.

Data Indicator	Data Source
STI - Chlamydia Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - Gonorrhea Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - HIV Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - HIV Prevalence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
Tobacco Expenditures	Nielsen, Nielsen SiteReports, 2014.
Insufficient Sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Tobacco Usage - Current Smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Walking or Biking to Work	US Census Bureau, American Community Survey, 2017-21.
Birth Outcomes - Infant Mortality (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2014-2020.
Birth Outcomes - Low Birth Weight (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2014-2020.
Cancer Incidence - All Sites	State Cancer Profiles, 2016-20.
Cancer Incidence - Breast	State Cancer Profiles, 2016-20.
Cancer Incidence - Cervical	State Cancer Profiles, 2016-20.
Cancer Incidence - Colon and Rectum	State Cancer Profiles, 2016-20.
Cancer Incidence - Lung	State Cancer Profiles, 2016-20.
Cancer Incidence - Prostate	State Cancer Profiles, 2016-20.
Chronic Conditions - Alcohol Use Disorder (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.

Data Indicator	Data Source
Chronic Conditions - Alzheimer's Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Asthma (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Asthma Prevalence (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - Cancer (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions – Chronic Obstructive Pulmonary Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Chronic Obstructive Pulmonary Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - Depression (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Diabetes Incidence (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018.
Chronic Conditions - Diabetes Prevalence (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Chronic Conditions - Diabetes Prevalence (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Heart Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - Heart Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - High Blood Pressure (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - High Blood Pressure (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - High Cholesterol (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Chronic Conditions - High Cholesterol (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Kidney Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.

Data Indicator	Data Source
Chronic Conditions - Kidney Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Mental Health and Substance Use Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020.
Chronic Conditions - Opioid Use Disorder	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2021.
Chronic Conditions - Substance Use Disorder (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Multiple Chronic Conditions (Medicare Population)	Centers for Medicare and Medicaid Services, 2018.
Deaths of Despair (Suicide + Drug/Alcohol Poisoning)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Cancer	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Coronary Heart Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Firearm	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Heart Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Homicide	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Influenza & Pneumonia	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Life Expectancy	University of Wisconsin Population Health Institute, County Health Rankings, 2018-2020.
Mortality - Life Expectancy	Institute for Health Metrics and Evaluation, 2019.
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 - Liver Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Lung Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.

Data Indicator	Data Source
Mortality - Motor Vehicle Crash (NVSS)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash (NHTSA)	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2018-2020.
Mortality - Motor Vehicle Crash, Alcohol-Involved	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2016-2020.
Mortality - Motor Vehicle Crash, Pedestrian	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2016-2020.
Mortality - Drug Overdose (All Substances)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Opioid Overdose	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Poisoning	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Premature Death	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2018-2020.
Mortality - Stroke	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Suicide	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Unintentional Injury (Accident)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Obesity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Poor Dental Health - Teeth Loss	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Poor or Fair Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Poor Mental Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.
Poor Mental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Poor Physical Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2020.

Data Indicator	Data Source
Poor Physical Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Stroke (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.
Stroke (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Access to Care - Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Buprenorphine Providers	US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Oct. 2023.
Access to Care - Dental Health	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2021.
Access to Care - Dental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Mental Health	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2022.
Access to Care - Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Nurse Practitioners	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
Access to Care - Primary Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2020.
Access to Care - Primary Care Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2023.
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 Census Bureau, American Community Survey, 2017-21.
Population Living in a Health Professional Shortage Area	US Census Bureau, American Community Survey, 2017-21.

Data Indicator	Data Source
COVID-19 - Confirmed Cases	Johns Hopkins University, 2022.
COVID-19 - Mortality	Johns Hopkins University, 2022.
COVID-19 Fully Vaccinated Adults	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2022.
Social Distancing - Mobility Reports (Google)	Google Mobility Reports, Feb 01, 2022.
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/