

2025 Community Health Implementation Strategy and Plan

St. Joseph Health Burleson Hospital




Adopted October 2025



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At-a-Glance Summary

<p>Community Served</p> 	<p>St. Joseph Health Burleson Hospital serves a primarily rural population in Burleson County, with additional patients from surrounding areas of the Brazos Valley region. The hospital's service area includes four ZIP codes with the highest concentration of inpatient and outpatient utilization. The total population is approximately 32,900 residents, with 62.8% White, 22.6% Hispanic/Latino, and 10.2% Black/African American residents. Nearly 14% of residents live below the poverty level, and the uninsured rate exceeds state and national averages.</p> <p>Burleson County's economy is largely agricultural and service-oriented, and many residents commute to nearby Brazos County for employment or specialty care. The community has strong civic engagement, faith-based networks, and a growing collaboration among healthcare and social-service partners.</p>
<p>Significant Community Health Needs Being Addressed</p> 	<p>The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA).</p> <p>Needs the hospitals intends to address with strategies and programs are:</p> <ul style="list-style-type: none">• Cancer• Healthcare Access & Quality• Heart Disease & Stroke
<p>Strategies and Programs to Address Needs</p> 	<p>The hospital intends to take actions and to dedicate resources to address these needs, including:</p> <p>Cancer Mobile screening events, navigation and survivorship programs in partnership with The Rose and local clinics.</p> <p>Healthcare Access & Quality Expansion of the Burleson Health Resource Center, Medicaid enrollment support, Ride2Health transportation services, and clinic partnerships.</p> <p>Heart Disease & Stroke Community screening events, cardiac rehabilitation (HeartSmart Program), and home-visit chronic-disease management.</p>

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the St. Joseph Health Burleson Hospital,

Administrative Office 1101 Woodson Drive, Caldwell, TX 77836 or email fawn.preuss@commonspirit.org

Our Hospital and the Community Served

About the Hospital

St. Joseph Health Burleson Hospital is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Located in Caldwell, Texas, is part of CommonSpirit Health, one of the nation's largest nonprofit health systems. The hospital provides emergency care, inpatient and outpatient services, cardiac rehabilitation, imaging, and primary-care access for the Burleson County community. The facility also serves as a hub for community outreach, preventive screenings, and partnerships with local organizations.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.



Description of the Community Served

The hospital serves small towns and rural communities that depend on St. Joseph Health for acute and preventive care. A summary description of the community is below, and additional details can be found in the CHNA report online.

- Population: 32,900
- Median Household Income: \$70,081
- Families Below Poverty: 8.6% overall; higher in ZIP 77879 (13.9%)
- Uninsured Adults: 15.5%
- Education: 85.2% with HS diploma or higher; 18.3% with Bachelor’s degree or higher
- High-Need ZIPs: 77879 and 76567 (based on Community Health Index scores)

Persistent rural-access challenges, provider shortages, and transportation barriers contribute to disparities in preventive care and chronic-disease outcomes.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital’s community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in June 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital’s service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital’s website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Cancer	High incidence and late-stage diagnosis; low screening rates for breast, cervical, and colorectal cancers; limited oncology access.	•
Healthcare Access & Quality	Provider shortages, high uninsured rates, and lack of transportation create barriers to routine and specialty care.	•

Significant Health Need	Description	Intend to Address?
Heart Disease & Stroke	Elevated heart-attack mortality, high hypertension rates, limited preventive screening and follow-up capacity.	•
Mental Health	Shortage of mental-health providers; stigma and limited crisis capacity.	
Respiratory Diseases	COPD and smoking rates above benchmarks.	
Weight Status / Wellness & Lifestyle	Obesity and limited access to exercise opportunities.	
Women's Health	Lower preventive-screening rates; included under Cancer strategies.	

Significant Needs the Hospital Does Not Intend to Address

Burleson Hospital will not independently lead initiatives on mental health, respiratory disease, or weight status due to limited capacity and the presence of specialized regional agencies. The hospital will continue to collaborate, refer patients, and support community initiatives in these areas.

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its staff, clinicians and board, and in collaboration with community partners.



The 2025 Implementation Strategy was developed following adoption of the Community Health Needs Assessment (CHNA) and reflects hospital and system-wide priorities for the next three years.

The Implementation Strategy was created through collaboration among Burleson and CommonSpirit Health leadership, including:

- Care Coordination and Clinician Services
- Nursing and Patient Care Services
- Mission and Spiritual Care
- Community Health and Outreach Mission
- Strategy / Planning
- Finance and Administration
- Quality and Patient Safety

Community input for the Implementation Strategy was primarily derived from the 2025 CHNA process, which included:

- Partner Survey – over 60 organizational stakeholders identified priority populations, service gaps, and barriers to care.
- Key Informant Interviews and Listening Sessions community members, leaders, and service providers highlighted barriers such as cost, transportation, and workforce shortages, as well as opportunities to expand mental health and chronic disease prevention services.

- Collaborative Prioritization Sessions – hospital leaders and community representatives reviewed CHNA findings and ranked health needs based on magnitude, impact, and feasibility.

The programs and initiatives described here were selected based on:

- Alignment with Burleson’s mission to improve the health of the vulnerable and advance social justice.
- Evidence of effectiveness from existing programs and best practices.
- Ability to leverage hospital strengths and clinical expertise.
- Potential for measurable outcomes in community health.
- Opportunities to collaborate with community partners to maximize reach and impact.

Through this process, Burleson identified Health Care Access & Quality and Heart Disease & Stroke as the significant health needs it will address in this Implementation Strategy.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- **Core Strategy 1:** Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2:** Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3:** Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio¹ to help plan and communicate about strategies and programs.

Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen “vital conditions” or provide “urgent services,” both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?

These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?

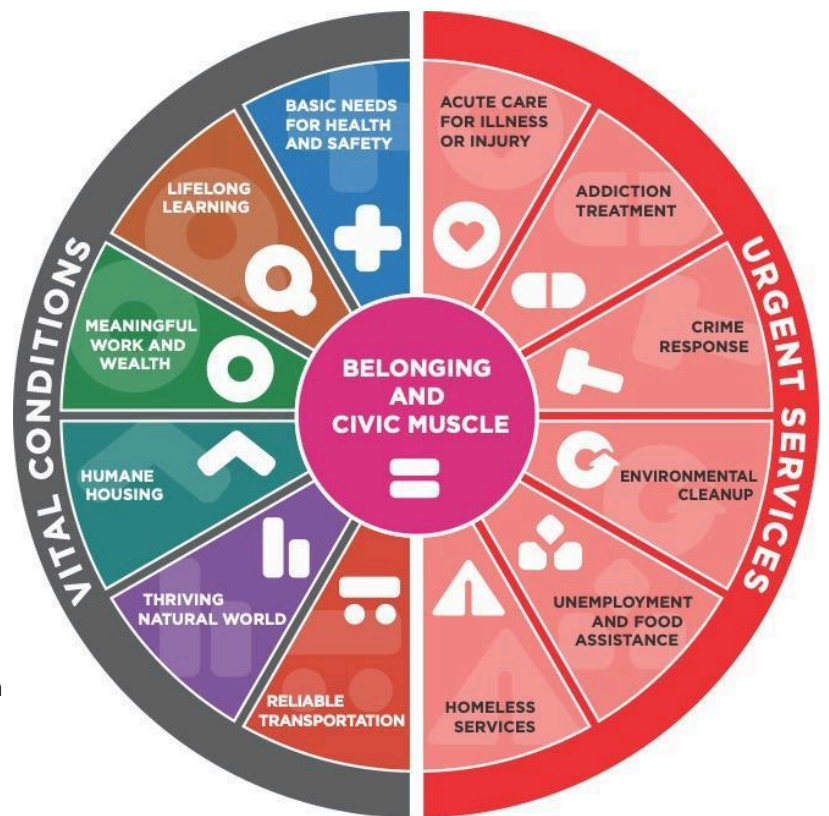
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?

This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan

The hospital’s planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.



¹ The Vital Conditions framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit <https://rippel.org/vital-conditions/> to learn more.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

Strategies and Program Activities by Health Need

Community Health Improvement Grants

As part of St. Luke's Health's continued commitment to improving the health and well-being of the communities we serve, the hospital will allocate annual Community Health Improvement Grant funding to support local organizations and programs addressing priority health needs identified in the most recent Community Health Needs Assessment (CHNA).

These grants will provide annual awards to nonprofit organizations, coalitions, and community-based partners that advance equitable access to care, promote prevention and wellness, and address social and structural determinants of health. Funding priorities will focus on initiatives that demonstrate measurable community impact, alignment with the hospital's strategic health priorities, and sustainability beyond the grant period.

These investments aim to:

- Strengthen cross-sector partnerships to address root causes of poor health outcomes.
- Support evidence-informed interventions that improve health literacy, disease prevention, and chronic disease management.
- Advance equity-driven programs that reduce barriers to care.

By investing in community-led solutions, St. Luke's Health seeks to build capacity, foster innovation, and strengthen collaboration across sectors to improve health outcomes for vulnerable and underserved populations. Specific grant cycles, eligibility criteria, and funded projects will be announced annually through the hospital's Community Benefit office.

Communications Strategy

St. Luke's Health recognizes that transparent, consistent, and proactive communication is essential to the success of its Implementation Strategy. The hospital's Community Health Communications Strategy serves as an overarching framework to inform, educate, and engage both internal and external audiences about key initiatives, partnerships, and outcomes that support community health improvement.

The St. Luke's Health Community Health Communications Strategy serves as a cohesive framework to connect hospital-led initiatives, community partnerships, and health improvement outcomes through clear, consistent, and engaging

communication. This approach ensures that the hospital's Implementation Strategy is understood, celebrated, and supported across all audiences both internal and external.

Key objectives include:

- Increase awareness and visibility of hospital and community health initiatives through coordinated media outreach, storytelling, and digital engagement.
- Promote collaboration and trust by maintaining clear communication with community partners, local leaders, and stakeholders.
- Advance health literacy and education by developing accessible, culturally relevant materials for patients and the broader community.
- Strengthen internal alignment by engaging employees, clinicians, and leadership as ambassadors of community health and mission-driven impact.

Core tactics include earned and owned media campaigns, development of educational and promotional collateral, participation in community events, and regular dissemination of progress updates through hospital communication channels. These efforts are measured through media impressions, community engagement metrics, and feedback from both community partners and hospital staff.

Together, the Community Health Improvement Grants and the Communications Strategy ensure that St. Luke's Health's Implementation Strategy is not only actionable and measurable but also visible, inclusive, and deeply connected to the community it serves.

Health Need:	Cancer				
Population(s) of Focus:	Uninsured and underinsured adults, particularly women aged 21–65 and Medicare-aged men and women at elevated risk for breast, cervical, colorectal, and prostate cancers.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Breast and Cervical Cancer Screening & Navigation	<ul style="list-style-type: none"> Partner with The Rose and local clinics to provide low- or no-cost breast and cervical screenings for uninsured women. Support diagnostic follow-up and navigation services for abnormal findings. Offer outreach and mobile mammography events in rural counties. 	•	•		US
Colorectal Cancer Awareness Campaign	<ul style="list-style-type: none"> Promote early detection and education on colon cancer risk factors. Distribute FIT kits and coordinate colonoscopy referrals through community health fairs and primary care clinics. Target outreach in ZIP codes 77801 and 77803. 		•	•	VC
Cancer Survivorship & Support Programming	<ul style="list-style-type: none"> Provide group education, counseling, and resource connections for cancer survivors. Facilitate access to nutrition, exercise, and emotional support programs post-treatment. Collaborate with Texas A&M Health Science Center and American Cancer Society. 	•		•	VC

Health Need:	Cancer
Planned Resources:	Mission and Ministry Fund, Community Health Improvement Grants, community benefit funds, health education team, and volunteer support.
Planned Collaborators:	The Rose, American Cancer Society, HealthPoint, Texas A&M Health Science Center, Pink Alliance, and Brazos County Health Department.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased early detection and screening rates for breast, cervical, and colorectal cancers.	% increase in completed mammograms, Pap tests, and colon cancer screenings	Program tracking, partner reports
Improved care coordination and reduced late-stage diagnosis rates.	# of individuals served through navigation programs	Hospital and partner reports
Enhanced survivorship resources for post-treatment recovery.	# of community education events and participants	Outreach documentation

Health Need:	Healthcare Access & Quality				
Population(s) of Focus:	Uninsured and underinsured adults, seniors with chronic conditions, and residents in rural and high-poverty ZIP codes (77801, 77803, 77868).				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Health Resource Centers (HRCs) and Navigation Services	<ul style="list-style-type: none"> Operate and support local HRCs offering utility assistance, health navigation, and referrals for care. Provide on-site Medicaid and insurance enrollment support. Assist with transportation and access to specialists for chronic conditions. 	●	●	●	US
Ride2Health Transportation Program	<ul style="list-style-type: none"> Provide transportation assistance for medical, behavioral, and preventive appointments for low-income residents. Prioritize seniors and individuals without reliable vehicles. 	●	●	●	US
Community Clinic Partnerships & Expansion	<ul style="list-style-type: none"> Collaborate with HealthPoint and Health for All to expand affordable primary and dental care. Support additional mobile or rural outreach clinics. Fund telehealth and broadband access initiatives. 	●	●	●	VC
Emergency Department Diversion Program	<ul style="list-style-type: none"> Identify frequent ED utilizers and connect them to primary care and chronic disease management resources. 	●	●	●	US

Health Need:	Healthcare Access & Quality				
	<ul style="list-style-type: none"> Offer case management for uninsured and underinsured individuals. 				
Planned Resources:	Community Health Improvement Grants, Pathways Community HUB model, Ride2Health funding, hospital case management team, volunteer network.				
Planned Collaborators:	HealthPoint, Health for All, Twin City Mission, Brazos County Health District, Texas A&M Telehealth Clinic, local faith-based coalitions.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased access to affordable preventive and primary care services.	# of individuals enrolled in insurance programs	HRC and Navigator reports
Reduced emergency department utilization among uninsured individuals.	# of Ride2Health trips completed	Transportation logs
Improved care continuity and reduced readmission rates.	Reduction in ED visits among target population	Hospital utilization data

Health Need:	Heart Disease & Stroke				
Population(s) of Focus:	Adults aged 45+, uninsured or underinsured residents with hypertension, hyperlipidemia, or diabetes; rural seniors with limited access to preventive services.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
HeartSmart Program (Cardiac Rehab & Education)	<ul style="list-style-type: none"> • Provide comprehensive cardiac rehabilitation and lifestyle modification classes. • Offer blood pressure, cholesterol, and weight management counseling. • Expand outreach to rural residents through virtual education. 	•	•		VC
Community Screenings and “Know Your Numbers” Campaign	<ul style="list-style-type: none"> • Host free screenings for blood pressure, cholesterol, BMI, and diabetes risk. • Conduct educational outreach during community fairs, churches, and senior centers. • Provide referrals to primary care for abnormal results. 		•	•	US
Home Visit Program for Chronic Disease Management	<ul style="list-style-type: none"> • Provide in-home visits for patients with heart failure, diabetes, or COPD. • Offer care coordination, medication management, and connection to nutrition and exercise resources. 	•		•	VC
Planned Resources:	Hospital clinical staff, community health workers, telehealth services, grant funding for screenings and supplies.				

Health Need:	Heart Disease & Stroke
Planned Collaborators:	American Heart Association, Texas A&M Health, HealthPoint, local pharmacies, and senior centers.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved management and control of hypertension and cholesterol.	# of screenings and participants	Event reports
Increased screening and early detection of cardiovascular risk.	% of participants achieving improved BP or cholesterol	Program tracking
Reduced hospital readmissions and cardiovascular-related mortality.	30-day readmission rates for cardiac patients	Hospital quality metrics