2025 Community Health Needs Assessment

Report adopted by Hospital Advisory Board May 2025

St. Joseph Health™

A member of CommonSpirit

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Community Health Needs Assessment – At a Glance

St. Joseph Health - Regional Hospital

Data Analysis Overview

Secondary Data
Topic score of 1.50 or higher

Listening Sessions
Frequency topic was discussed during interviews

Community Partner Survey
Selected by 20% or more of respondents as a priority health issue

Secondary data, or numerical health indicators, from HCI's 200+ community indicator database, were analyzed and scored based on their values.

Listening Sessions were conducted with **over 60 community groups , organizations, and hospital leaders** that represent the broad demographics or underserved populations in the community.

The Community Partner Survey was distributed across the region to gather quantitative data regarding community-serving organizations and their views on the health needs within the service area.

Prioritized Significant Health Needs

- Cancer
- Health Care Access & Quality
- Heart Disease & Stroke
- Mental Health
- Respiratory Diseases
- Weight Status
- Women's Health

*Topic scores reflect the relative severity of issues based on standardized data; a score of 1.50 or higher indicates a higher-than-average concern compared to state or national benchmarks.

Executive Summary

Introduction & Purpose

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by St. Luke's Health Regional, Rehabilitation, and College Station Hospitals. The priorities identified in this report guide the hospital's community health improvement programs, community benefit activities, and collaborative efforts with other organizations sharing the mission to improve community health. This CHNA meets the requirements of the Patient Protection and Affordable Care Act, mandating not-for-profit hospitals to conduct a CHNA at least every three years.

CommonSpirit Health Commitment and Mission Statement

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission.

Our Mission

As a member of CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all—inspired by faith, driven by innovation, and powered by our humanity.

Our Values

- **Compassion**: Care with listening, empathy, and love; accompany and comfort those in need of healing.
- **Inclusion**: Celebrate each person's gifts and voice; respect the dignity of all.
- **Integrity**: Inspire trust through honesty; demonstrate courage in the face of inequity.
- **Excellence**: Serve with fullest passion, creativity, and stewardship; exceed expectations of others and ourselves.
- **Collaboration**: Commit to the power of working together; build and nurture meaningful relationships.

CHNA Collaborators

St. Luke's Regional, Rehabilitation, and College Station Hospitals collaborated with various community organizations, local health departments, and healthcare providers. Conduent Healthy

Communities Institute (HCI) was contracted to facilitate data collection, analysis, and community engagement efforts.

Community Definition

The community served by St. Luke's Health Regional, Rehabilitation, and College Station Hospitals spans across multiple counties in central and eastern Texas, including Burleson, Grimes, Madison, and the broader College Station area. This defined community comprises 27 zip codes, selected based on inpatient discharge data, ensuring representation of the geographic areas with the highest utilization of St. Luke's healthcare services.

Process and Criteria to Identify and Prioritize Significant Health Needs

Health needs were prioritized based on magnitude and community impact, considering secondary data indicators, stakeholder input, and collaborative discussions. The process involved a comprehensive review of the available data, alongside surveys and input from key stakeholders, including healthcare professionals, community leaders, and residents. This collaborative approach ensured that diverse perspectives were considered, leading to a well-rounded understanding of the community's most pressing health concerns.

Upon identifying the significant health needs, the team categorized them into themes such as chronic disease prevention, mental health support, access to healthcare services, and health education. Each category was then evaluated to determine its potential impact on the community's overall well-being and its alignment with the hospital's mission and resources.

The prioritization process also considered the feasibility of addressing these needs, considering available resources, potential partnerships, and existing community initiatives. By aligning efforts with ongoing programs and leveraging partnerships, St. Luke's Health Regional, Rehabilitation, and College Station Hospitals aims to maximize the effectiveness of its community health improvement strategies.

As a result, the prioritized health needs will guide the development of targeted interventions and programs designed to address gaps in care and improve health outcomes for all community members, particularly those who are most vulnerable. These efforts are intended to foster a healthier, more resilient community, where everyone has the opportunity to thrive.

List of Prioritized Significant Health Needs

Health needs were ranked based on their significance and potential impact on the community. This prioritization process incorporated a comprehensive review of secondary data indicators, insights gathered through stakeholder interviews and focus groups, and collaborative discussions with community partners. The resulting list of prioritized needs reflects both the prevalence and urgency of issues affecting the population.

The identified priority health needs include:

Cancer | Health Care Access & Quality | Heart Disease & Stroke | Mental Health | Respiratory Diseases | Weight Status | Women's Health

Each of these areas represent a significant concern that affects health outcomes and quality of life for residents across the defined community. More detailed data, justification for prioritization, and summaries of community input are provided in subsequent sections of this report. Additional data tables, methodology details, and community input documentation are available in the appendices.

Resources Potentially Available

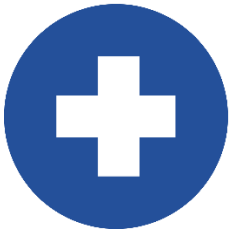
Resources potentially available to address these needs include existing community programs, local nonprofit partnerships, healthcare infrastructure investments, and ongoing collaborations with community-based organizations targeting the identified significant health needs within the service area.

Report Adoption, Availability and Comments

This CHNA report was adopted by the St. Luke's Health Regional, Rehabilitation, and College Station Hospitals advisory board in June 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at the hospital's Mission and Spiritual Care Office. Written comments on this report can be submitted to the Mission and Spiritual Care Office, 2801 Franciscan Dr, Bryan, TX 77802 or by e-mail to fawn.preuss@commonspirit.org

Looking Back: Evaluation of Progress since prior CHNA

Over the past three years, St. Joseph Health Regional and College Station Hospitals have demonstrated a strong commitment to community health improvement by implementing targeted strategies aligned with their 2022 Implementation Strategy. These efforts prioritized Access to Care, Chronic Disease Management, Mental Health, and Preventive Practices, with a focus on community health and vulnerable populations across all service areas.



Access to Care Initiatives

- Provided Medicaid counseling and enrollment services to support uninsured and low-income individuals.
- Supported Health Resource Centers (HRCs) in four counties, offering referrals and utility/health service assistance.
- Deployed Health Navigators for diabetes, cardiac, breast health, and senior care coordination.

Funded several Community Health Improvement Grants

- The Prenatal Clinic – $50,000 for one-year postpartum services.
- The Rose – $25,000 for uninsured breast health services.
- Twin City Mission – $20,000 for homeless medical transportation.
- Ride2Health – $20,000 for behavioral health access via transportation.
- Expanded community clinic partnerships with HealthPoint and Health for All.
- Launched an Emergency Department Diversion Program for high-utilizer and uninsured patients.
- Grew the Home Visit Program for chronic disease patients (e.g., diabetes, COPD, heart failure).

Chronic Disease Management

Mental Health Initiatives

- Hosted diabetes education classes and support groups focused on nutrition and lifestyle.
- Provided 1:1 diabetes counseling for disease self-management.
- Operated the HeartSmart Program for cardiac rehab and coaching.
- Delivered navigation services for breast and lung cancer patients.
- Continued the Senior Renewal Program offering counseling for aging-related mental health needs.
- Partnered with Texas A&M Behavioral Telehealth Counseling Clinic to expand rural access.
- Conducted depression screenings through community programs for early detection.

Preventive Health & Wellness

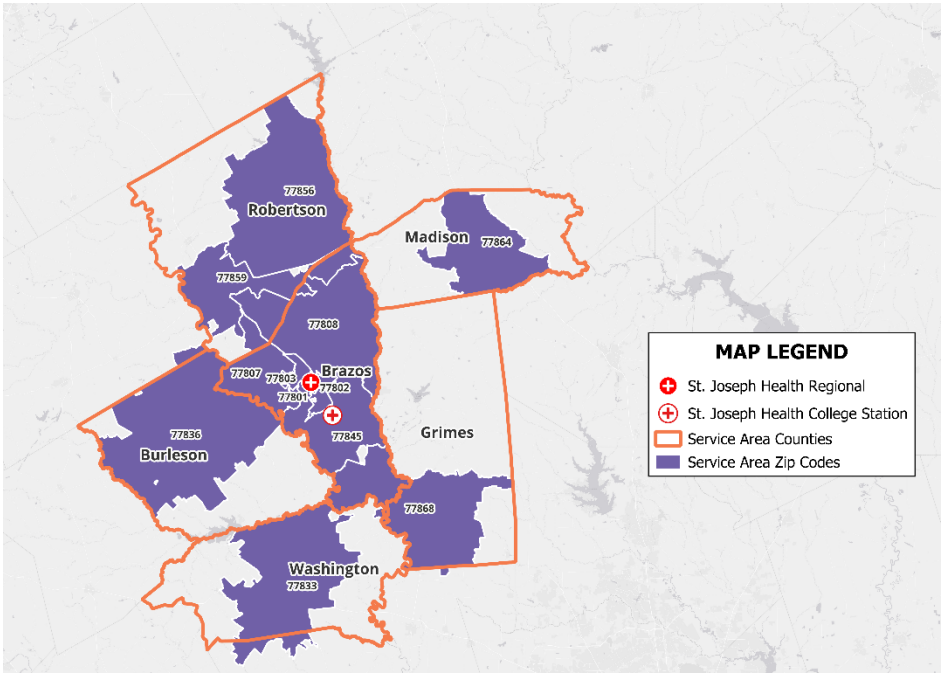
- Hosted free screenings for blood pressure, diabetes, and cholesterol.
- Partnered on vaccination campaigns and preventive care outreach.
- Provided prenatal and breastfeeding education for new mothers.
- Ran senior fall prevention classes ("A Matter of Balance") to reduce injury risk.

Defining the Community

The community served by St. Luke's Health Regional, Rehabilitation, and College Station Hospitals spans across multiple counties in central and eastern Texas, including Burleson, Grimes, Madison, and the broader College Station area. This defined community comprises 27 zip codes, selected based on inpatient discharge data, ensuring representation of the geographic areas with the highest utilization of St. Luke's healthcare services.

The service area represents a mix of rural and suburban settings and includes a diverse population of over 400,000 residents combined. These communities vary significantly in racial/ethnic composition, age distribution, income, and language access. A detailed map of the service area can be found in Figure 1, and demographic highlights including age, race/ethnicity, poverty levels, and insurance coverage are summarized in the Core Demographics section.

FIGURE 1. REGIONAL HOSPITAL SERVICE AREA



Demographic Profile

Geography and Data sources

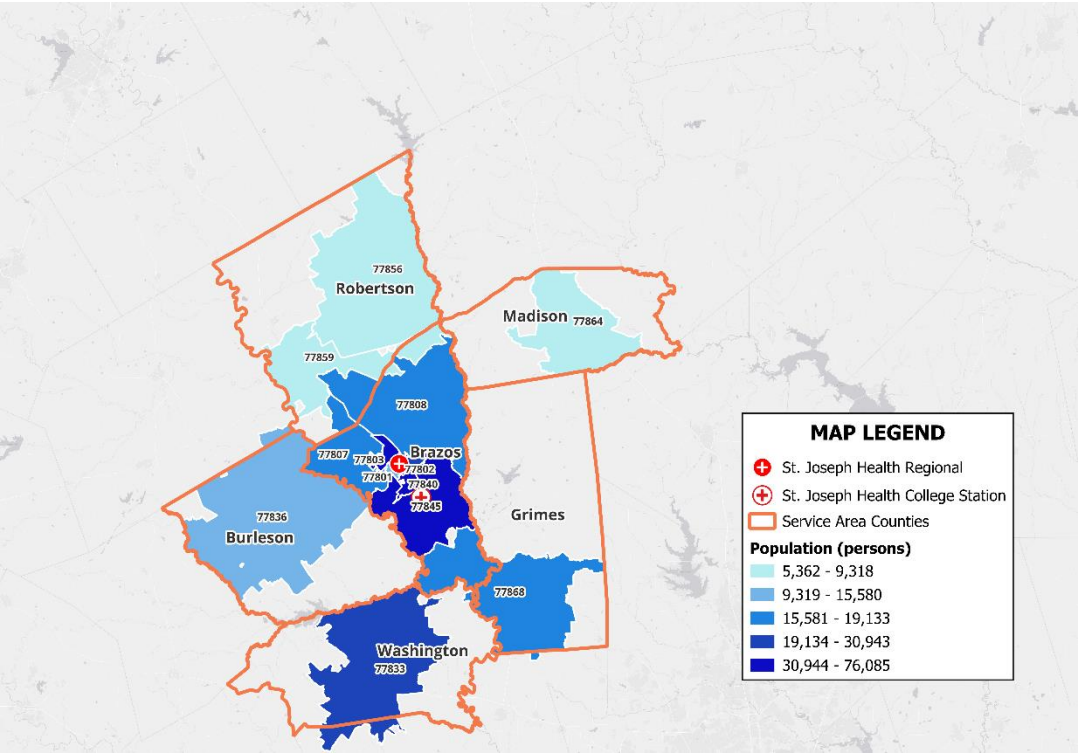
The following section explores the demographic profile of St. Joseph's Health Regional primary service area, which includes 13 zip codes in and around Brazos County. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

Unless otherwise indicated, all demographic estimates are sourced from Claritas® (2024 population estimates). Claritas demographic estimates are primarily based on U.S. Census and American Community Survey (ACS) data. Claritas uses proprietary formulas and methodologies to calculate estimates for the current calendar year.

Population

The Regional primary service area has an estimated population of 332,069 persons. Figure 2 shows the population breakdown for the service area by zip code.

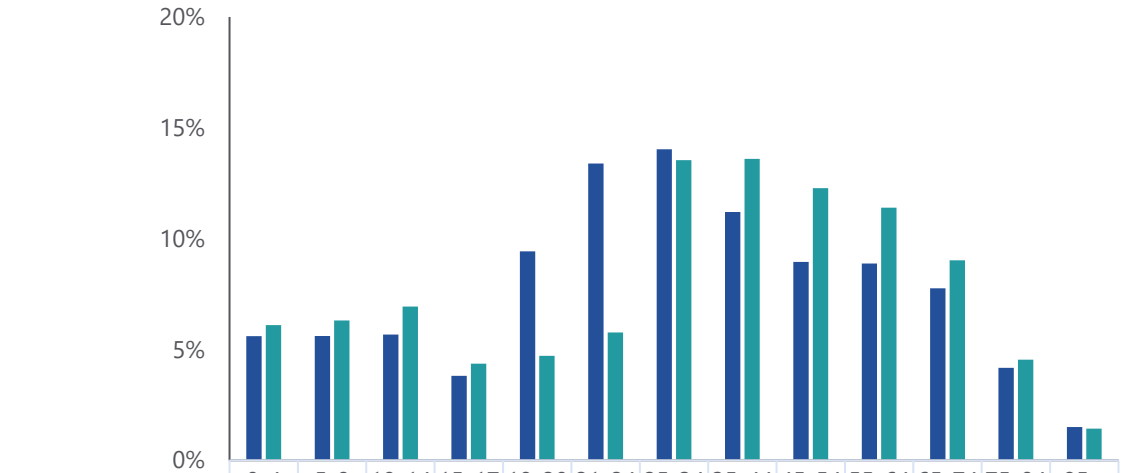
FIGURE 2. REGIONAL HOSPITAL PRIMARY SERVICE AREA POPULATION DISTRIBUTION BY ZIP CODE



Age

Figure 3 shows the population of Regional Hospital's primary service area broken down by age group, with comparisons to the state-wide Texas population. Overall, the age distribution of Regional Hospital is younger than the state-wide Texas population. About half of the population (48.0%) is between 18 to 44 years old.

FIGURE 3. POPULATION BY AGE: REGIONAL HOSPITAL SERVICE AREA

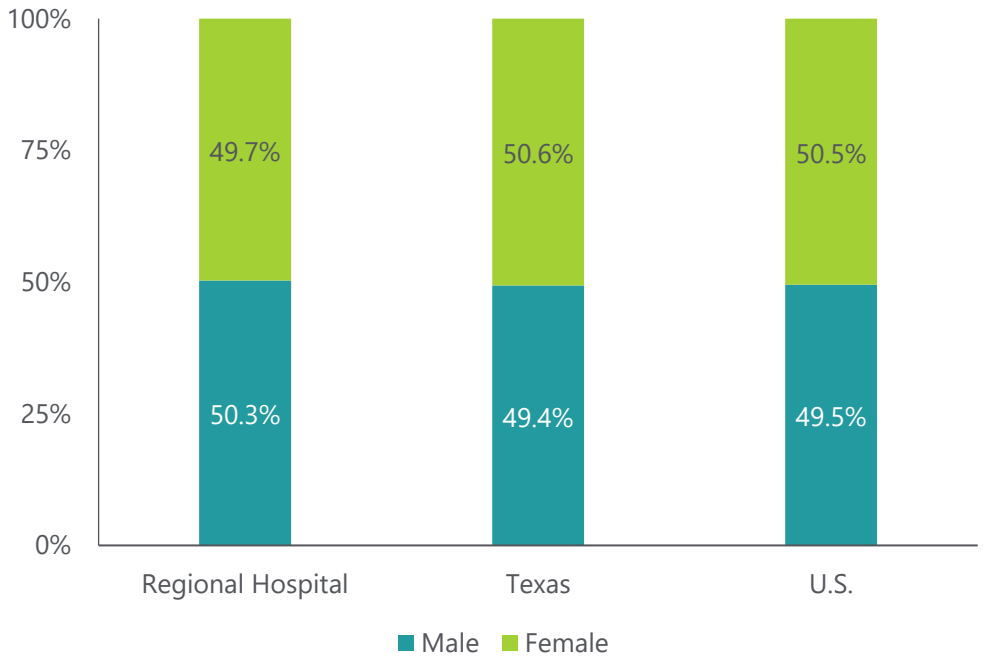


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Regional Hospital	5.6%	5.6%	5.7%	3.8%	9.4%	13.4%	14.0%	11.2%	9.0%	8.9%	7.8%	4.2%	1.5%
Texas	6.1%	6.3%	6.9%	4.4%	4.7%	5.8%	13.5%	13.6%	12.3%	11.4%	9.0%	4.5%	1.4%

Sex

As seen in Figure 4, 49.7% of the Regional Hospital population is female, which is similar to both state and national populations (50.6% and 50.5%, respectively).

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



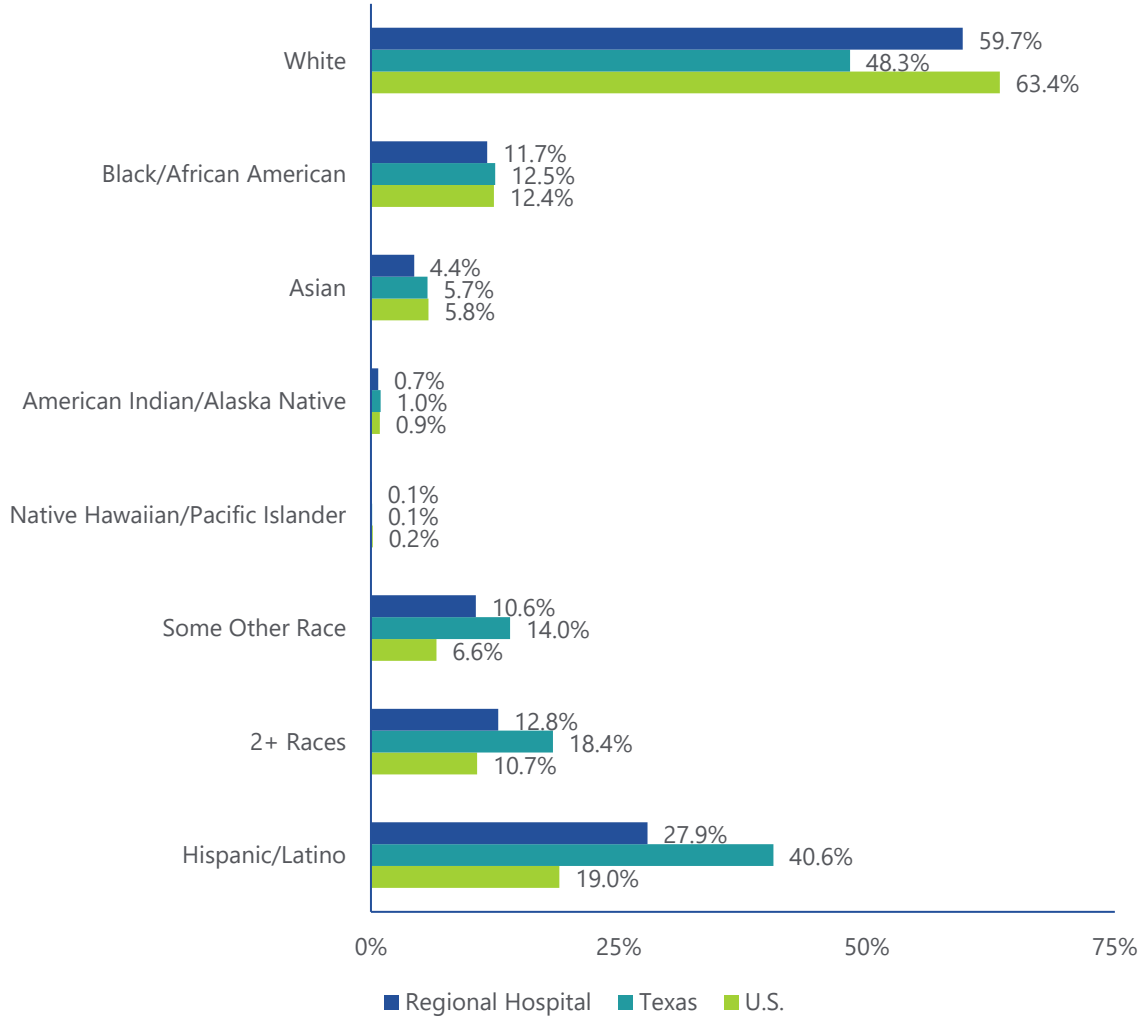
U.S. value taken from American Community Survey (2019-2023)

Race and Ethnicity

Considering the racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

Compared to the state, Regional Hospital has a higher percentage of residents who identify as White (59.7% vs. 48.3%.) The percentage of residents who identify as Black/African American, Asian, American Indian/Alaskan Native, and Native Hawaiian/Pacific Islander is similar to the state and nation-wide rates.

FIGURE 5. POPULATION BY RACE AND ETHNICITY



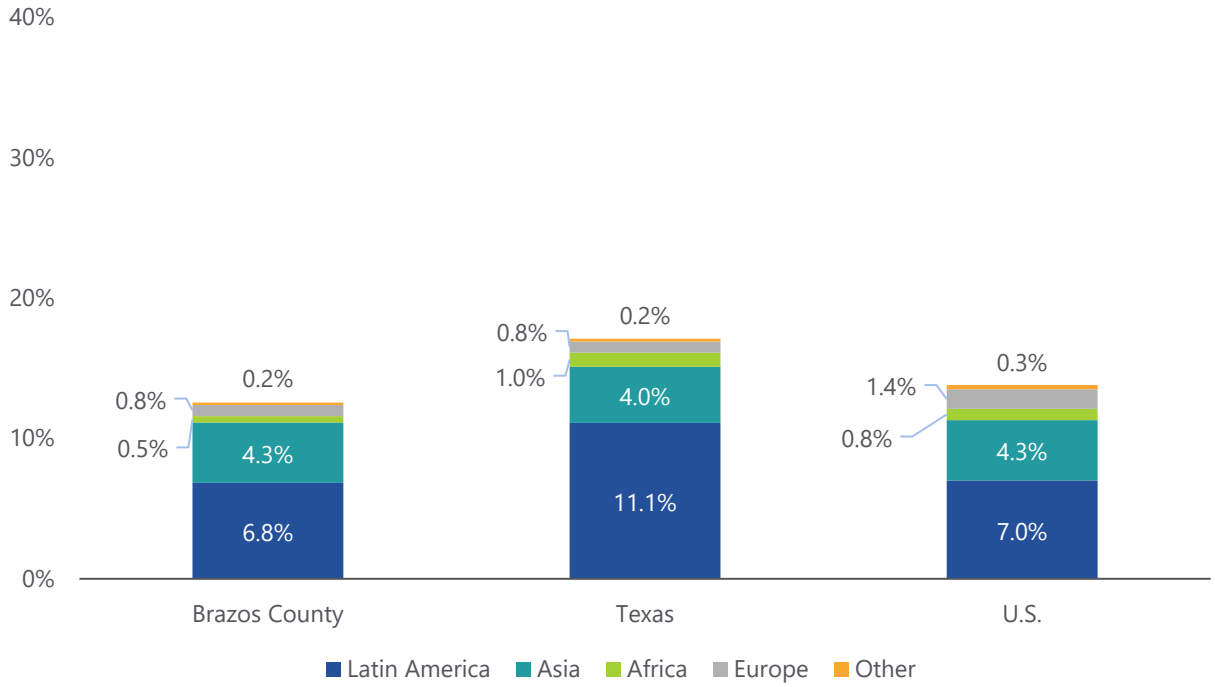
U.S. value taken from American Community Survey (2019-2023)

Language and Immigration

Understanding countries of origin and difficulty in speaking language can help inform the cultural and linguistic context. According to the American Community Survey, 12.6% of residents in Brazos County are born outside the U.S., which is lower than the state value (17.2%) and national value (13.9%).

Figure 6 provides a breakdown of region of birth for any persons born outside the country. Compared to both Texas and the U.S. overall, Brazos County has a lower percentage of residents born in Latin America (6.8%).

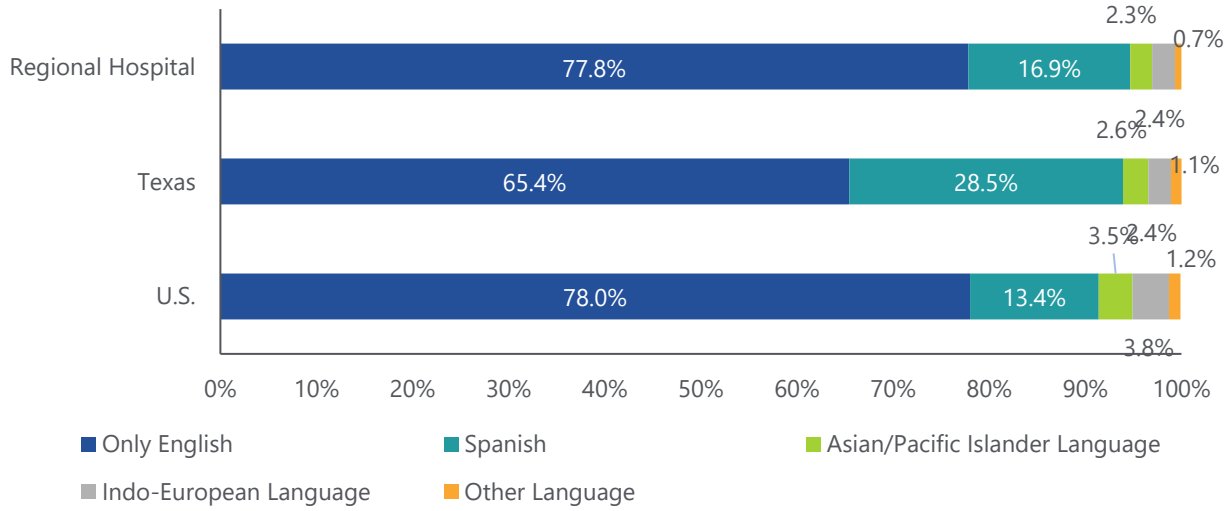
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY



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

As shown in Figure 7, 22.2% of residents in the Regional Hospital primary service area speak a language other than English at home. The Regional Hospital population is more likely than the nation-wide population to speak Spanish (16.9% vs. 13.4%).

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

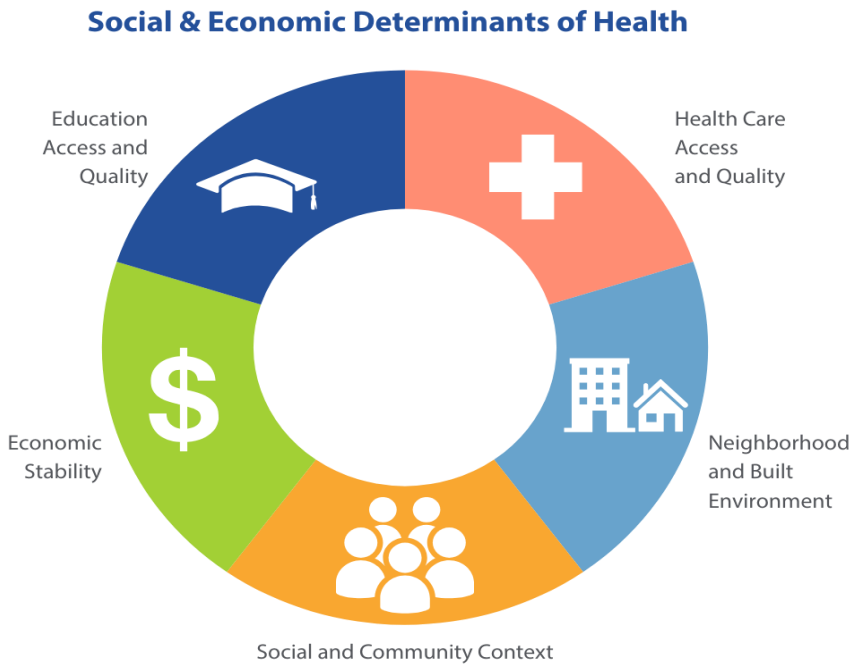


U.S. value taken from American Community Survey (2019-2023)

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Regional Hospital primary service area. Social Determinants of Health (SDOH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The SDOH can be grouped into five domains. Figure 8 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022).

FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH

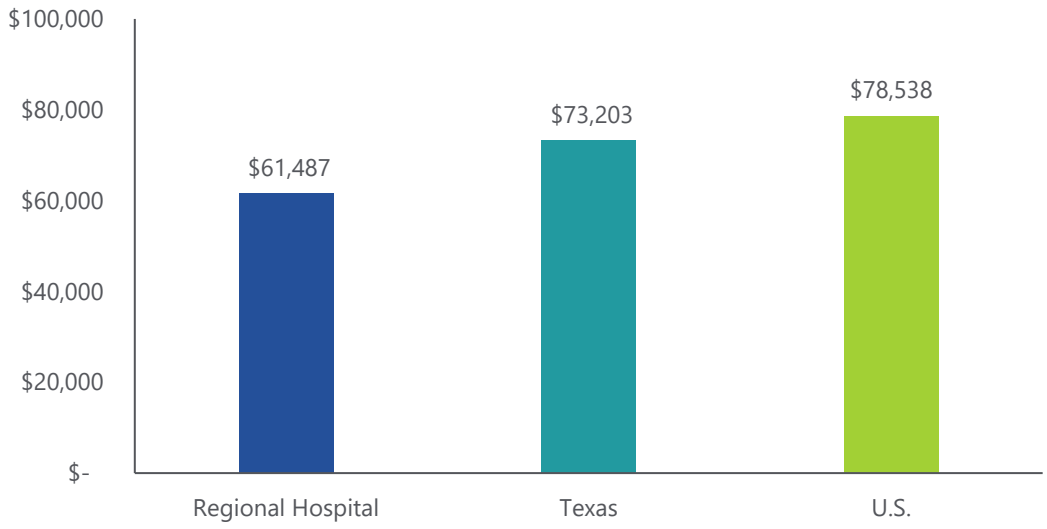


Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.

Figure 9 provides the median household income in the service area, compared to the state and nation.

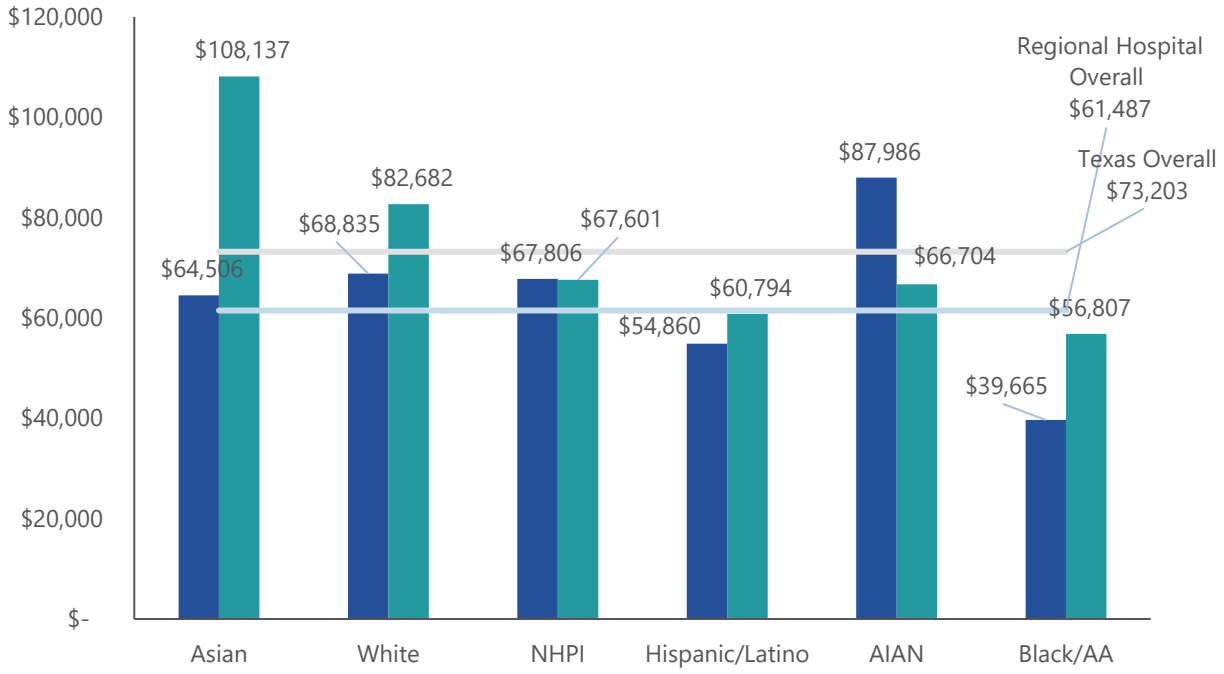
FIGURE 9. MEDIAN HOUSEHOLD INCOME BY: COUNTY, STATE AND U.S. COMPARISONS



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

Disparities in median household income exist between racial and ethnic groups within the Regional Hospital service area. As shown in Figure 10, the Black/African American and Hispanic/Latino communities have a lower median income than the overall service area median income. For example, the Black/African American median income is more than $20,000 lower than the overall median income ($39,665 vs. $61,487).

FIGURE 10. MEDIAN HOUSEHOLD INCOME BY RACE & ETHNICITY



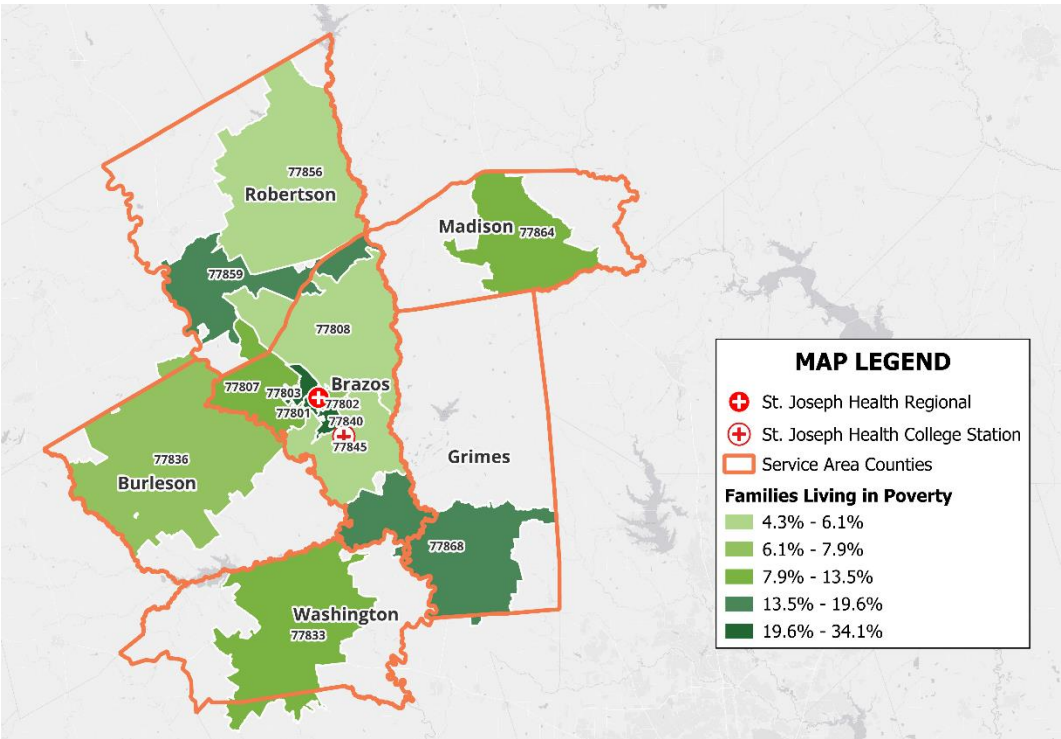
Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[1]

[1] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Overall, 11.7% of families in the Regional primary service area live below the poverty level, which is higher than the state value of 11.0% and the national value of 8.7%. The map in Figure 11 shows the percentage of families living below the poverty level by zip code. The darker green colors represent a higher percentage of families living below the poverty level.

FIGURE 11. PERCENT OF FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE



The percentage of families living below poverty for each zip code in the service area is provided in Table 1. The two zip codes in the service area with the highest concentration of poverty are 77801 and 77803. (34.1% and 24.2%, respectively).

TABLE 1. FAMILIES LIVING IN POVERTY: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

Zip Code	% Families in Poverty	Zip Code	% Families in Poverty
77801	34.1%	77833	8.1%
77803	24.2%	77802	7.1%
77840	22.0%	77836	6.8%
77868	16.1%	77808	5.6%
77859	16.0%	77845	4.6%
77807	12.9%	77856	4.3%
77864	9.7%		

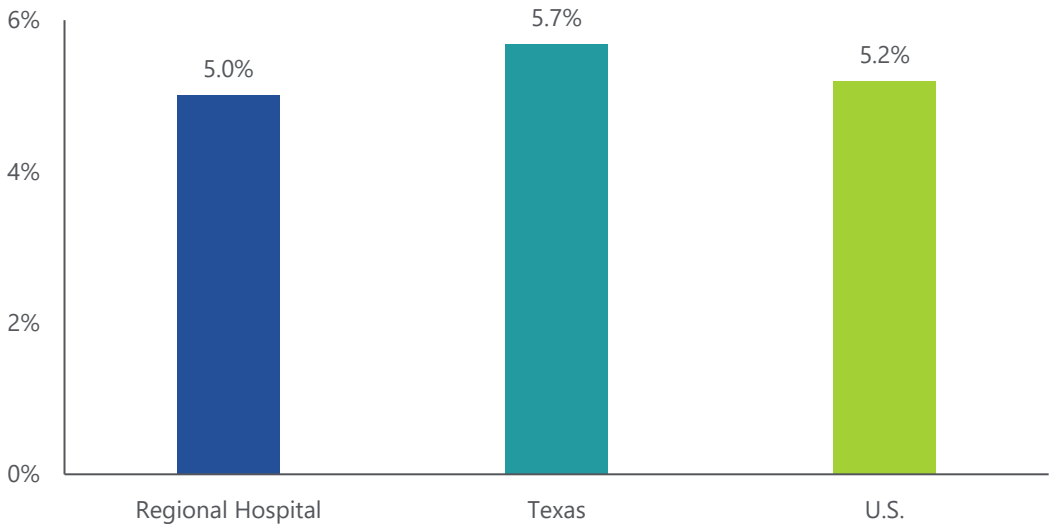
Employment

A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[2]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[2] Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[2]

Figure 12 shows the population aged 16 and over who are unemployed. The unemployment rate for the Regional Hospital primary service area is 5.0%, which is higher than both the state-wide and nation-wide unemployment rates (5.7% and 5.2%, respectively).

FIGURE 12. POPULATION 16+ UNEMPLOYED: COUNTY, STATE, AND U.S.



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

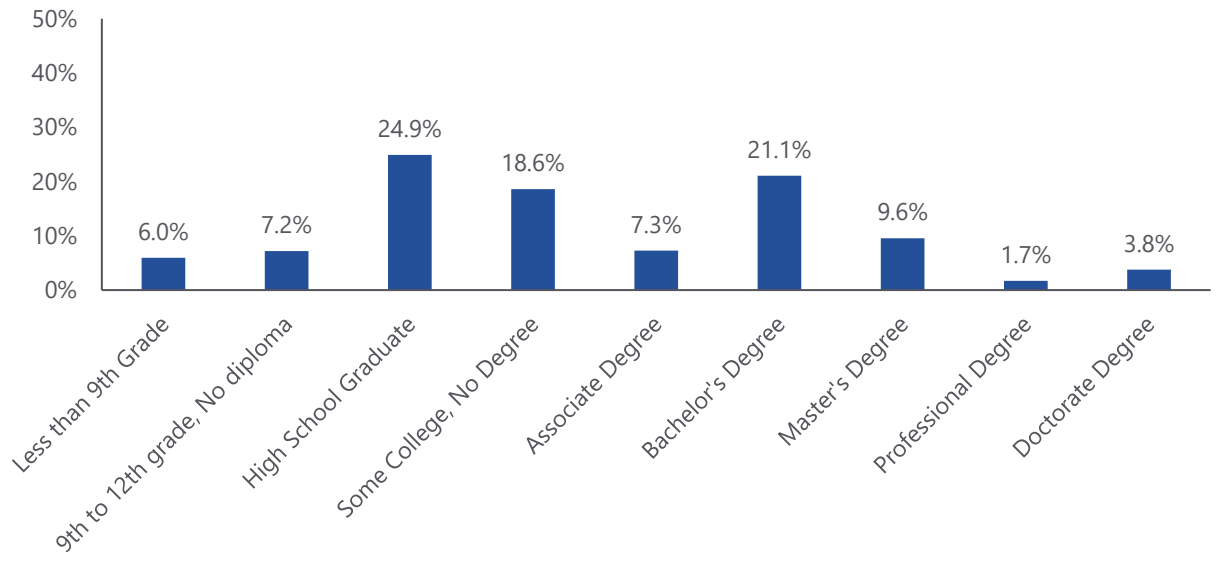
[2] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment

Education

Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. A high school diploma in particular is a requirement for many employment opportunities, and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[3] Further, people with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[4]

Figure 13 shows the detailed breakdown of the Regional Hospital primary service area by educational attainment, among those aged 25 and up. As shown in Figure 14, most of the Regional Hospital population has a high school diploma or higher (86.9%), which is somewhat higher than the state-wide rate (85.1%), but lower than the nation-wide rate (89.4%). The Regional Hospital population is also more likely than the state-wide population to have a Bachelor's Degree or higher (36.1% vs. 32.3%).

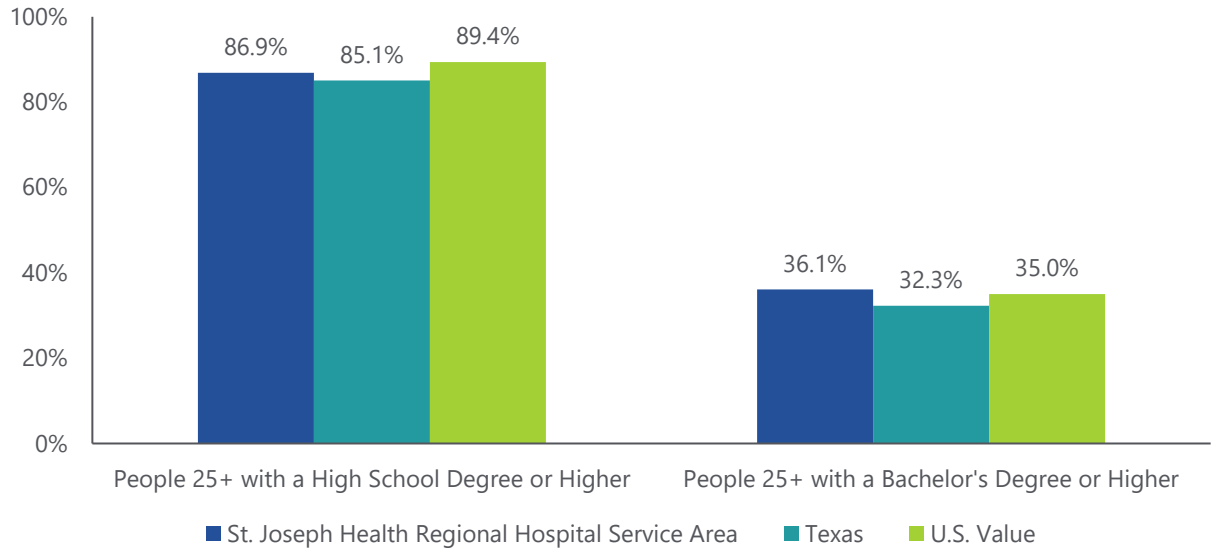
FIGURE 13. REGIONAL HOSPITAL PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+



[3] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health

[4] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/educationmatters-for-health.html

FIGURE 14. POPULATION 25+ BY EDUCATIONAL ATTAINMENT



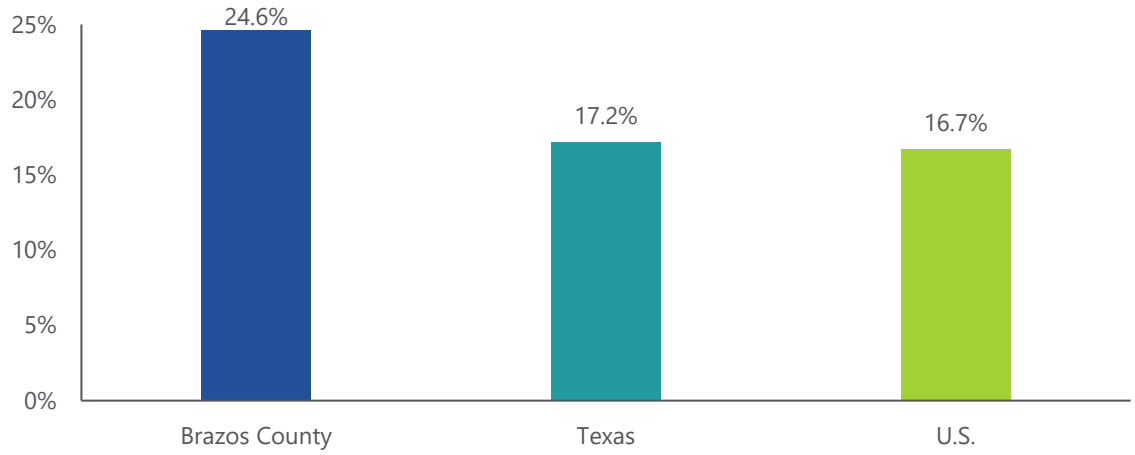
U.S. value taken from American Community Survey (2019-2023)

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[5]

As shown in Figure 15, 1 in 4 households in Brazos County (24.6%) have severe housing problems, indicating that they have at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. This is higher than both the state-wide and nation-wide rates (17.2% and 16.7%, respectively).

FIGURE 15. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



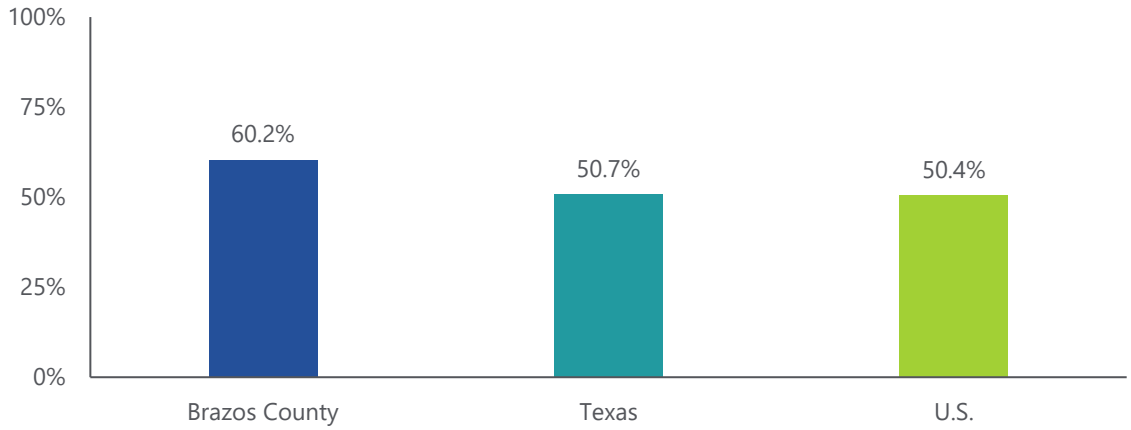
County, state, and U.S. values taken from County Health Rankings (2016-2020)

[5] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[6]

Figure 16 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Brazos County (60.2%) is higher than both the state value (50.7%) and the national value (50.4%).

FIGURE 16. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT: COUNTY, STATE, AND U.S. COMPARISONS



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

Neighborhood and Built Environment

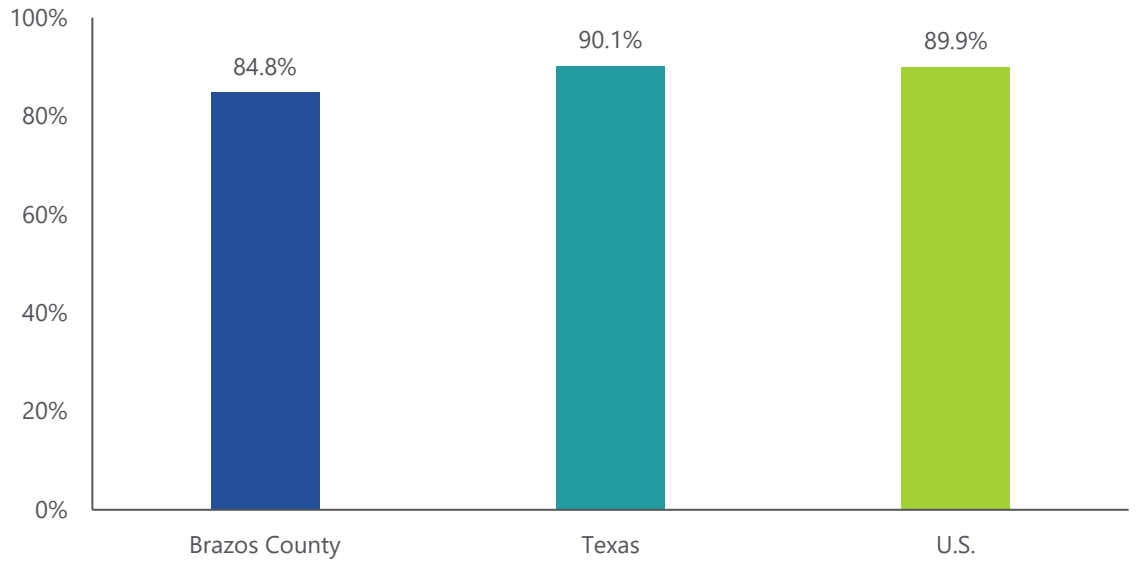
Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet also helps expand healthcare access through home-based telemedicine services, which has been particularly critical during the COVID-19 pandemic.[7] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[7]

[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

[7] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Figure 17 shows the percentage of households that have an internet subscription. The rate in Brazos County (84.8%) is lower than both the state value (90.1%) and the national value (89.9%).

FIGURE 17. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION



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

Primary and Secondary Data Methodology and Key Findings

St. Jospeh's Health Regional, Rehabilitation, and College Station Hospitals employed a mixed-methods approach that integrated both quantitative (secondary) data and qualitative (primary) input to create a comprehensive picture of health needs, disparities, and opportunities for community improvement. This approach ensures that health priorities are informed not only by statistical trends but also by the lived experiences and perspectives of the community.

Quantitative Data: Secondary Sources

Secondary data analysis provided measurable insights into health status, social determinants of health, and system performance across the community. Sources included national, state, and local public health databases, as well as internal hospital data. The Healthy Communities Institute database was leveraged with over 200 indicators in both health and quality of life topic areas for the Secondary Data Analysis of the Health Service Area. Key Indicators analyzed include:

 **Quality of Life**	 **Health**	
Community	Adolescent Health	Men's Health
Economy	Alcohol & Drug Use	Mental Health & Mental Disorders
Education	Cancer	Older Adults
Environment	Children's Health	Oral Health
Transportation	Diabetes	Prevention & Safety
	Disabilities	Physical Activity
	Environmental Health	Respiratory Diseases
	Family Planning	Tobacco Use
	Health Care Access and Quality	Women's Health
	Heart Disease & Stroke	Wellness & Lifestyle
	Immunizations and Infectious Diseases	Weight Status
	Maternal, Fetal & Infant Health	

*All data were scored using a standardized index to assess severity and disparities across zip codes.

Qualitative Data: Primary Sources

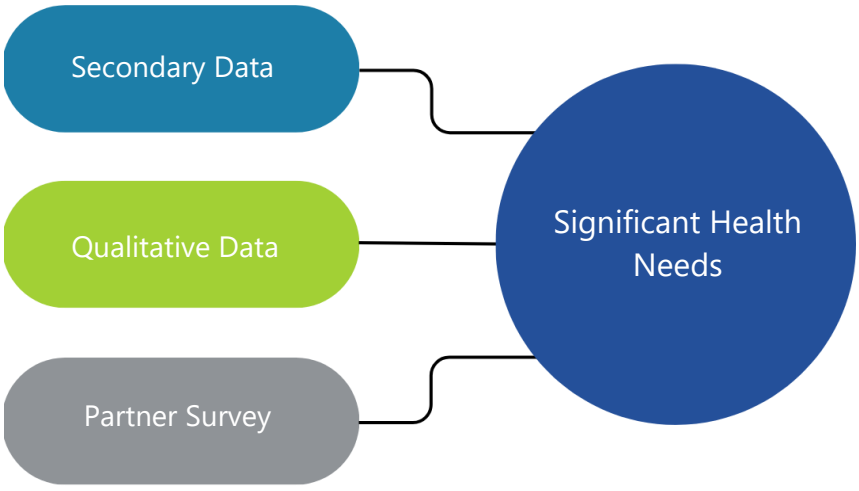
Primary data were collected through community engagement activities designed to elevate voices from across the hospital's defined service area. These activities included:

Partner Survey
An online survey was distributed to over 60 organizational partners and stakeholders, including representatives from public health departments, healthcare providers, social service agencies, and nonprofit organizations. The survey captured perspectives on health priorities, gaps in care, barriers to service delivery, and populations most impacted by health inequities.

Key Informant Interviews and Listening Sessions
Conducted with dozens of individuals representing a range of sectors including public health, healthcare, housing, education, behavioral health, and community-based organizations. These participants included:

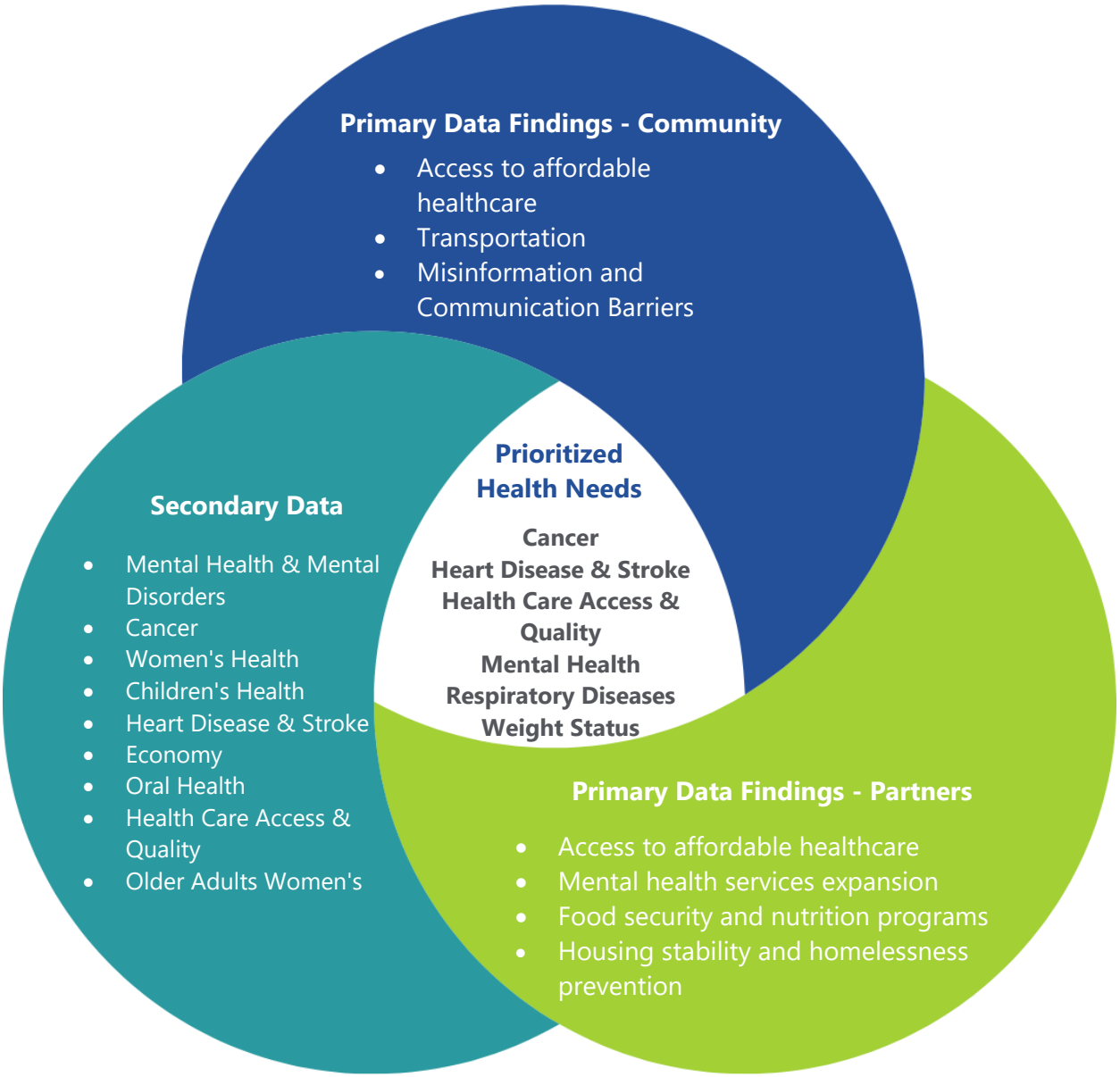
- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

Participants were asked to share their views on community strengths, emerging challenges, and opportunities for collaboration. Themes were identified in relation to access to care, behavioral health, transportation, and the lingering impacts of COVID-19 and natural disasters. A detailed summary of participating organizations, and input themes is available in Appendix [X].



By combining data-driven analysis with community perspectives, the process ensures a comprehensive understanding of health needs and identifies priority areas for future intervention, collaboration, and investment.

Data Synthesis



Significant Health Needs

Through comprehensive data analysis and community input process, the following health needs have been identified as the most pressing in St. Jospeh's Health Regional, Rehabilitation, and College Station Hospitals' service area:

Cancer | Health Care Access & Quality | Heart Disease & Stroke | Mental Health | Respiratory Diseases | Weight Status | Women's Health

Identification of Significant Health Needs

The criteria for identifying the most pressing health needs involve a three-pronged approach:

Secondary Data Topic Score: A score of 1.50 or higher is deemed significant. This threshold was chosen because it represents a midway point in the scoring system used, which ranges from 0 to 3. A score of 1.50 or above indicates that the health issue is notably worse than state and national benchmarks, signaling a substantial area of concern that requires attention.

Frequency of Discussion in Qualitative Sessions: These criteria involve analyzing how often a health issue is mentioned during community partner listening sessions. The frequency of discussion provides qualitative insights into the community's perception and experiences regarding specific health needs, enhancing the quantitative data by highlighting what is actively affecting the community.

Priority Selection by 20% or More of Partner Survey Respondents: This metric involves assessing the priority level assigned to health needs by respondents in the community partner survey. If 20% or more participants identify a health issue as a priority, it underscores its importance within the community. This helps to validate and contextualize the data, ensuring that the identified needs align with community priorities and concerns.

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

Cancer

From the secondary data scoring results, Cancer ranked 2nd in the data scoring of all topic areas with a score of 1.80. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. Indicators of concern for Brazos County are listed in Table 2 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 2. BRAZOS COUNTY DATA SCORING RESULTS: CANCER

SCORE	CANCER	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.71	Cancer: Medicare Population	*percent*	14.0	-	11.0	12.0			-
2.29	Cervical Cancer Screening: 21-65	*Percent*	74.4	-	-	82.8			-
2.12	Colon Cancer Screening: USPSTF Recommendation	*percent*	58.4	-	-	66.3			-
1.59	Mammogram in Past 2 Years: 50-74	*percent*	72.3	80.3	-	76.5			-

In Brazos County, the most concerning cancer-related indicator is *Cancer: Medicare Population*, with a value of 14.0% in the county. This is higher than both the state-wide and nation-wide rates (11.0% and 12.0%, respectively), and is also one of the highest county rates across all U.S. counties.

Brazos county residents are also less likely than the overall U.S. population to receive screenings for cervical cancer, colon cancer, and breast cancer (mammograms). For example, the rate for *Cervical Cancer Screening: 21-65* is 74.4% of the female population in Brazos County, which is one of the lowest county rates across all U.S. counties.

The Black/African American population of Brazos County experiences a greater risk for certain cancer-related outcomes, compared to the overall county population. *Prostate Cancer Incidence Rate* for the Black/African American population is 204.2 cases per 100,000 males, compared to 119.8 for the overall county. The county's Black/African American population also has a greater risk of death of any type of cancer (172.0 deaths per 100,000). Additionally, the county's male population has a greater risk of cancer-related death than the female population (158.2 deaths per 100,000 vs. 104.9).

FIGURE 18. PROSTATE CANCER INCIDENCE RATE, BY RACE/ETHNICITY (CASES PER 100,000 MALES)

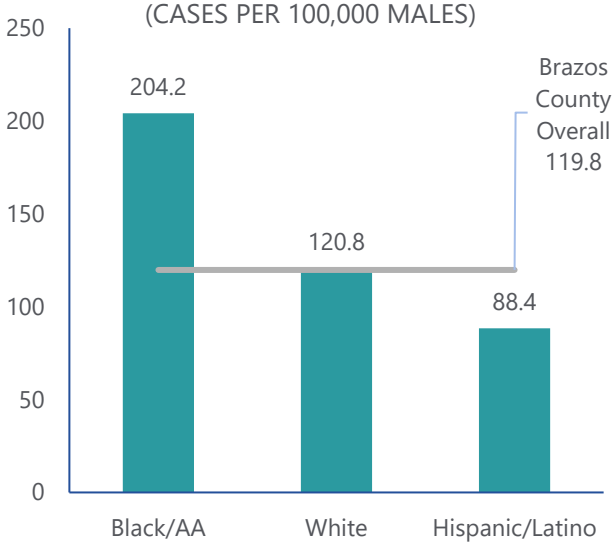


FIGURE 19. AGE-ADJUSTED DEATH RATE DUE TO CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000)

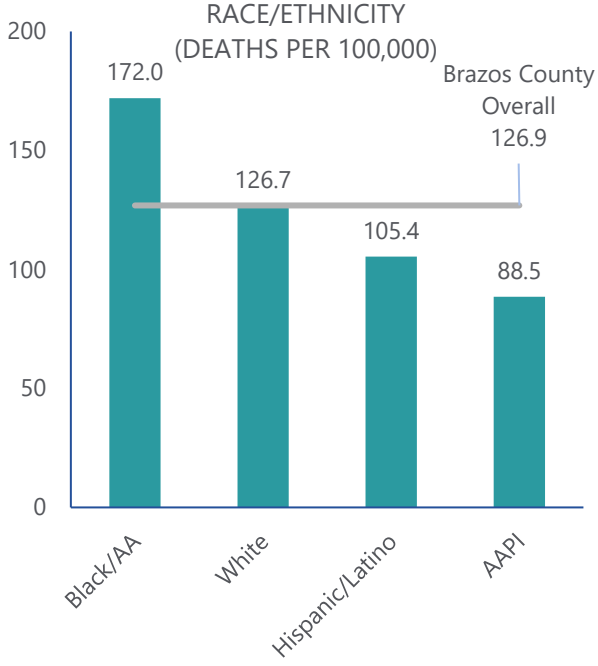
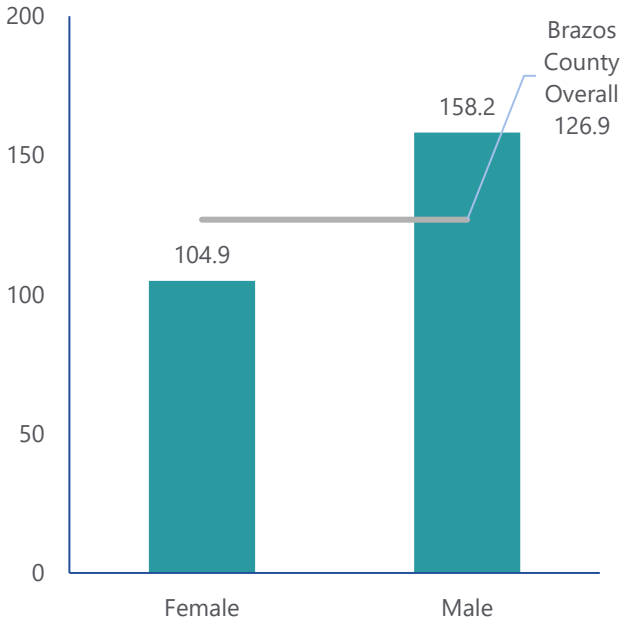


FIGURE 20. AGE-ADJUSTED DEATH RATE DUE TO CANCER, BY SEX (DEATHS PER 100,000)



Cancer prevention, screening, and treatment were also prioritized due to consistently high secondary data scores. Listening session attendees noted barriers such as lack of insurance, limited oncology specialists, and geographic distance to treatment centers. Early detection and education, particularly for breast, colorectal, and lung cancers, were emphasized as urgent needs.

Health Care Access & Quality

From the secondary data scoring results, Health Care Access and Quality ranked 8th in the data scoring of all topic areas with a score of 1.58. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. Indicators of concern for Brazos County are listed in Table 3 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 3. BRAZOS COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS & QUALITY

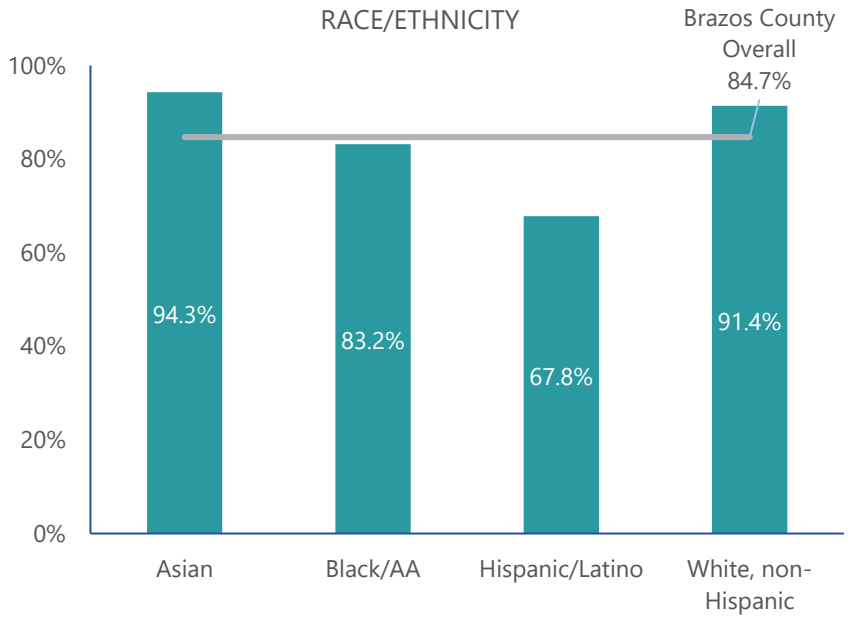
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.12	Adults who have had a Routine Checkup	*percent*	71.4			76.1			
1.88	Adults 65+ without Health Insurance	*percent*	1.5		1.9	0.8			
1.74	Adults with Health Insurance	*percent*	85.7		77.6	88.7			
1.62	Children with Health Insurance	*percent*	92.8		89.1	94.9			
1.59	Adults who Visited a Dentist	*percent*	56.8			63.9			
1.59	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	79.3		109.0	131.4			

In Brazos County, the most concerning indicator related to health care access and quality was *Adults who have had a Routine Checkup*. The county rate is 71.4%, which is lower than the U.S. rate of 76.1%. Adults were also less likely to visit a dentist. The county rate for *Adults who Visited a Dentist* was 56.8%, compared to the U.S. rate of 63.9%.

Children, adults, and older adults in Brazos County were all less likely to have insurance than those nation-wide. The county rate for *Adults 65+ without Health Insurance* is nearly twice the national rate (1.5% vs. 0.8%). Further, the county rates for *Adults with Health Insurance* (85.7%) and *Children with Health Insurance* (92.8%) were lower than the national rates (88.7% and 94.9%, respectively). We did, however, find that the county rate of *Children with Health Insurance* was significantly improving over time.

The Hispanic/Latino population of Brazos County is less likely than the overall county population to be insured. Across Brazos County, 84.7% of adults have health insurance, compared to only two-thirds of the Hispanic/Latino population (67.8%).

FIGURE 21. ADULTS WITH HEALTH INSURANCE, BY RACE/ETHNICITY



Conduent's Community Health Index (CHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Each zip code is ranked based on its index value to identify relative levels of need. Table 4 provides the index values and local ranking for each zip code. The map in Figure 22 illustrates that the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue) are zip codes 77803 and 77801 with index scores of 96.6 and 93.7, respectively.

FIGURE 22. COMMUNITY HEALTH INDEX: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

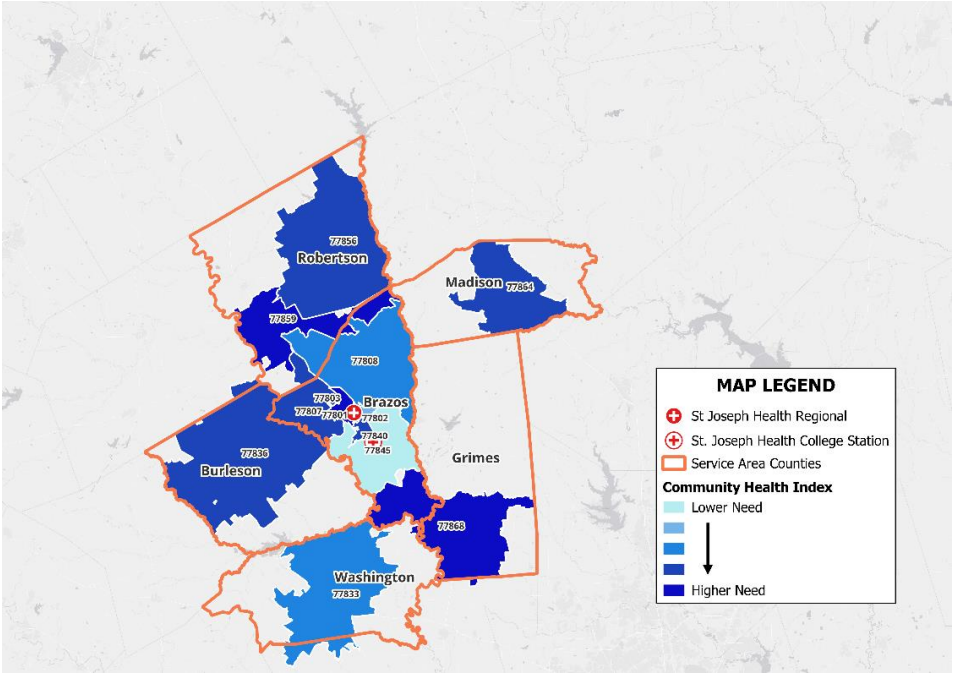


TABLE 4. COMMUNITY HEALTH INDEX: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77803	96.6	77836	54.1
77801	93.7	77840	53.1
77868	89.3	77833	36.0
77859	85.7	77808	25.6
77807	78.7	77802	20.4
77864	67.6	77845	8.1
77856	60.5		

Access to affordable and high-quality healthcare services emerged as the highest-ranked priority across all service areas. Qualitative feedback reflected a shortage of providers, long wait times, and challenges in navigating systems, particularly for those who are uninsured or underinsured. One listening session participant shared, **"There are primary care clinics, but very few specialists, and capacity is not infinite"**

Heart Disease & Stroke

From the secondary data scoring results, Heart Disease and Stroke ranked 5th in the data scoring of all topic areas with a score of 1.64. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were

categorized as indicators of concern. Indicators of concern for Brazos County are listed in Table 5 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 5. BRAZOS COUNTY DATA SCORING RESULTS: HEART DISEASE AND STROKE

SCORE	HEART DISEASE & STROKE	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.71	Atrial Fibrillation: Medicare Population	*percent*	16.0		14.0	14.0			
2.29	Cholesterol Test History	*percent*	76.8			86.4			
2.18	Hyperlipidemia: Medicare Population	*percent*	67.0		65.0	65.0			
2.12	Adults who Have Taken Medications for High Blood Pressure	*percent*	70.4			78.2			
2.12	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	94.3		61.2				
1.88	Heart Failure: Medicare Population	*percent*	13.0		12.0	11.0			
1.82	Hypertension: Medicare Population	*percent*	68.0		66.0	65.0			
1.53	Ischemic Heart Disease: Medicare Population	*percent*	23.0		22.0	21.0			

In Brazos County, the most concerning indicator related to heart disease and stroke was *Atrial Fibrillation: Medicare Population*. The county rate for this indicator was 16.0%, one of the highest rates across all U.S. counties. Other indicators of concern were related to Brazos County Medicare recipients, specifically. Among the county's Medicare population, the rates of hyperlipidemia (67.0%), heart failure (13.0%), hypertension (68.0%), and ischemic heart disease (23.0%) were all higher than both the over Texas and U.S. rates.

Certain forms of prevention and treatment related to heart disease were less common in Brazos County. The county rates of *Cholesterol Test History* (76.8%) and *Adults who Have Taken Medications for High Blood Pressure* (70.4%) are some of the lowest county rates across all U.S. counties. These lower levels of prevention and treatment may contribute to relatively high *Age-Adjusted Death Rate due to Heart Attack*. In the county, this death rate is 94.3 deaths / 100,000 population 35+ years, which is higher than the Texas rate of 61.2.

In Brazos County, the Black/African American population has a risk of hospitalization due to heart failure that is more than twice that of the general county population (95.4 vs. 34.2 hospitalizations per 10,000). This population also was significantly more likely than the county

population to die due to coronary heart disease (133.3 vs. 79.5 deaths per 100,000). The male population is also more likely to experience cardiovascular health issues, including coronary heart disease and accurate myocardial infarction, as seen in Figures 22 and 23. Finally, the risk of heart disease increases significantly with age. For example, the risk of hospitalization due to heart failure for the population 85 and up is three times that of the 65-84 year-old population, which is three times that of the 45-64 year-old population (360.6 vs. 112.2 vs. 30.2 hospitalizations per 10,000, respectively).

FIGURE 22. HOSPITALIZATION RATE DUE TO HEART FAILURE, BY RACE/ETHNICITY (HOSPITALIZATIONS PER 10,000 POPULATION)

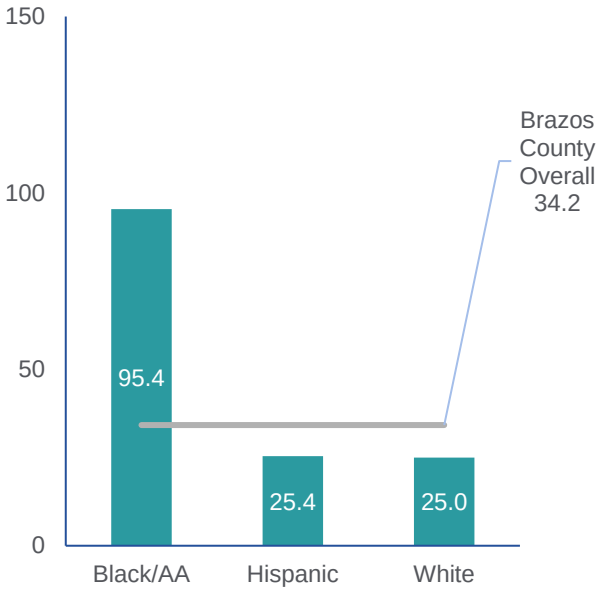


FIGURE 23. AGE-ADJUSTED DEATH RATE DUE TO CORONARY HEART DISEASE, BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)

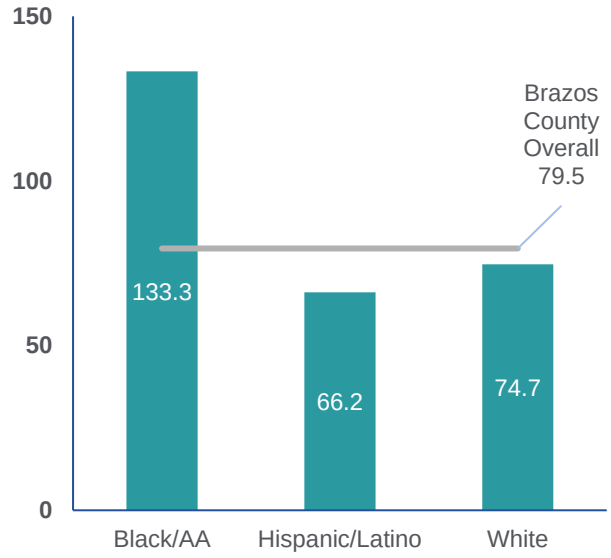


FIGURE 24. AGE-ADJUSTED DEATH RATE DUE TO CORONARY HEART DISEASE, BY SEX (HOSPITALIZATIONS PER 100,000 POPULATION)

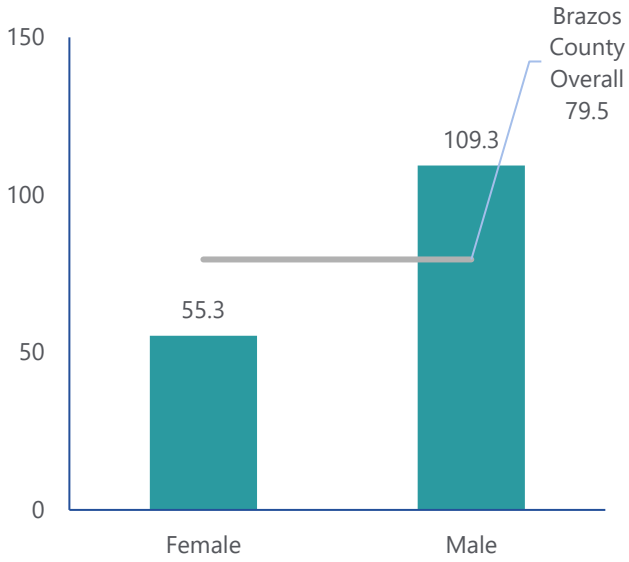


FIGURE 25. AGE-ADJUSTED HOSPITALIZATION RATE DUE TO ACUTE MYOCARDIAL INFARCTION, BY RACE/ETHNICITY (HOSPITALIZATIONS PER 10,000 POPULATION)

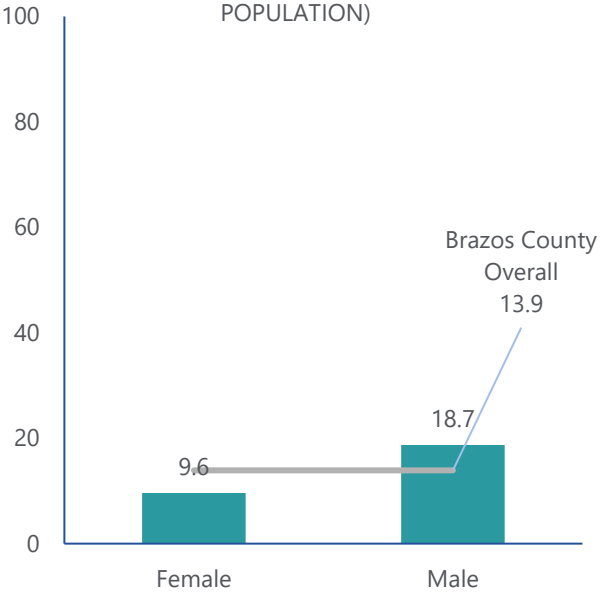


FIGURE 26. HOSPITALIZATION RATE DUE TO ACUTE MYOCARDIAL INFARCTION, BY AGE (HOSPITALIZATIONS PER 10,000 POPULATION)

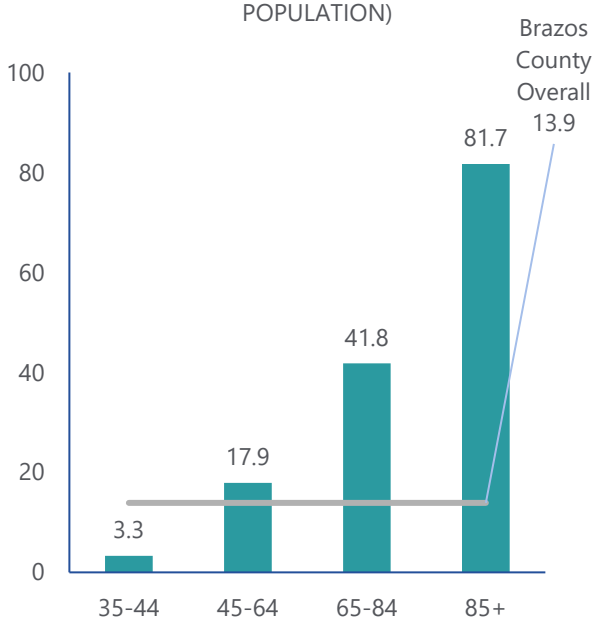
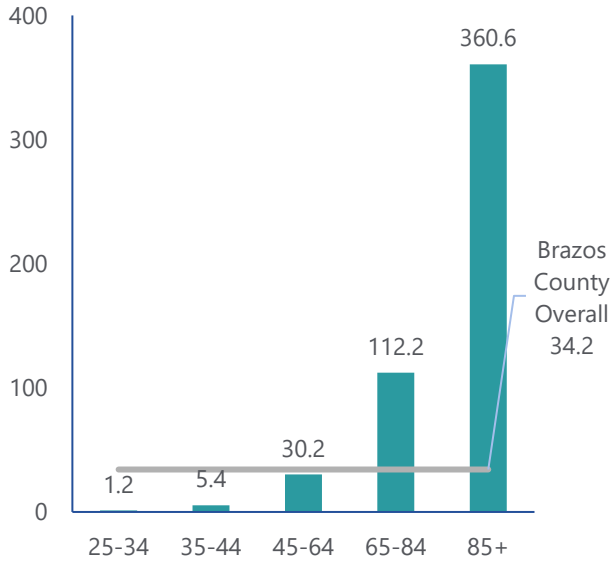


FIGURE 27. HOSPITALIZATION RATE DUE TO HEART FAILURE, BY AGE (HOSPITALIZATIONS PER 10,000 POPULATION)



Community voices cited gaps in early detection and management, particularly among uninsured populations and aging residents. The lack of cardiology services in rural areas and limited capacity to address chronic conditions highlight the importance of investments in cardiovascular care.

Mental Health

From the secondary data scoring results, Mental Health and Mental Disorders ranked 1st in the data scoring of all topic areas with a score of 1.93. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. Indicators of concern for Brazos County are listed in Table 6 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 6. BRAZOS COUNTY DATA SCORING RESULTS: MENTAL HEALTH & MENTAL DISORDERS

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.65	Poor Mental Health: Average Number of Days	*days*	5.5		4.6	4.8			
2.21	Depression: Medicare Population	*percent*	18.0		17.0	16.0			
2.12	Adults Ever Diagnosed with Depression	*percent*	24.2			20.7			
2.12	Poor Mental Health: 14+ Days	*percent*	19.0			15.8			
1.71	Alzheimer's Disease or Dementia: Medicare Population	*percent*	7.0		7.0	6.0			

In Brazos County, the most concerning indicator related to mental health and mental disorders is *Poor Mental Health: Average Number of Days*. On average, county residents report 5.5 days of poor mental health out of the last 30 days, which is higher than the state and national rates (4.6 and 4.8 days, respectively), and has also been trending upward over time. Additionally, county residents are more likely than the overall U.S. population to report at least 14 days of poor mental health out of the last 30 (19.0% vs. 15.8%).

Depression is more common in Brazos County among both adults and the Medicare population, specifically. The county rates for *Depression: Medicare Population* (18.0%) and *Adults ever Diagnosed with Depression* (24.2%) are both higher than the nation-wide rates (16.0% and 20.7%, respectively).

Conduent's Mental Health Index (MHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor mental health. Each zip code is ranked based on its index value to

identify relative levels of need. Table 7 provides the index values and local ranking for each zip code. The map in Figure 28 illustrates that the zip codes with the highest risk for poor mental health (as indicated by the darkest shade of purple) are 77859, 77833, and 77803 with index scores of 88.5, 70.6, and 70.4, respectively.

FIGURE 28. MENTAL HEALTH INDEX: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

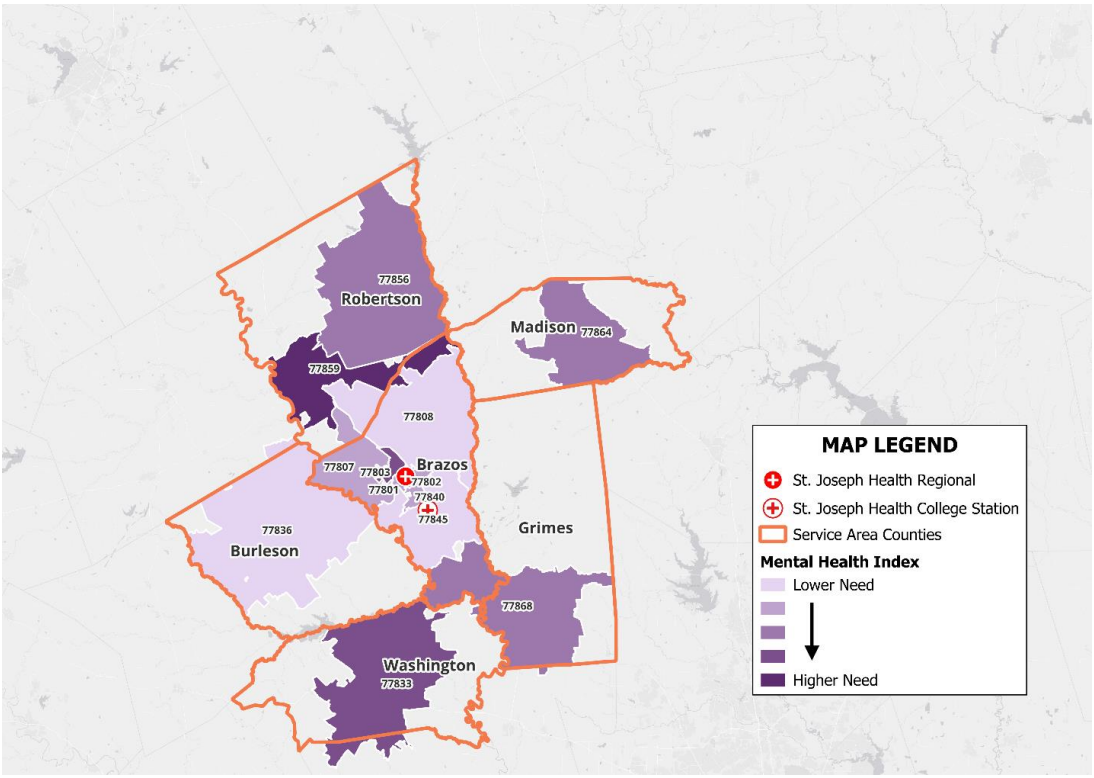


TABLE 7. MENTAL HEALTH INDEX: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77859	88.5	77840	55.5
77833	70.6	77807	53.0
77803	70.4	77802	51.9
77856	65.1	77836	26.8
77864	64.9	77808	21.4
77868	60.9	77845	20.5
77801	56.2		

Mental health was a dominant theme in qualitative data and a top-scoring topic in all service areas. Anxiety, depression, and substance use were frequently mentioned in listening sessions. A participant explained, **"There are few behavioral health providers, and those we do have are overwhelmed or underpaid."** Lack of psychiatric beds, stigma, and long waitlists for services were highlighted as major barriers.

Respiratory Diseases

From the secondary data scoring results, Respiratory Diseases ranked 19th in the data scoring of all topic areas with a score of 0.91. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. We did not identify any indicators of concern within this topic area for Brazos County. The three highest scoring indicators are listed in Table 8 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 8. BRAZOS COUNTY DATA SCORING RESULTS: RESPIRATORY DISEASES

SCORE	RESPIRATORY DISEASES	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
1.41	Proximity to Highways	*percent*	3.1		5.6				
0.94	Asthma: Medicare Population	*percent*	6.0		7.0	7.0			
0.88	Adults who Smoke	*percent*	12.1	6.1		12.9			

In Brazos County, 3.1% of the population lives close to highways, a rate which is lower than the overall U.S. rate (5.6%). According to the Centers for Disease Control and Prevention, exposure to traffic-related air pollution is associated with poor health outcomes, including asthma exacerbation and childhood asthma. The county rate of Asthma among Medicare recipients (6.0%) is also lower than the national rate (7.0%), and the rate of adults who smoke in the county (12.1%) is one of the lowers across all U.S. counties, although it is about twice that of the Health People 2030 target (6.1%).

The Black/African American population of Brazos County has a greater risk of poor health outcomes related to respiratory health. The Black/African American population is more than three times as likely as the general county population to be hospitalized due to asthma (4.7 vs. 1.2 hospitalizations per 10,000 population), and is twice as likely to be hospitalizations due to COPD (7.9 vs. 3.9 hospitalizations per 10,000 population 18+ years).

FIGURE 29. AGE-ADJUSTED HOSPITALIZATION RATE DUE TO ASTHMA, BY RACE (HOSPITALIZATIONS PER 10,000 POPULATION)

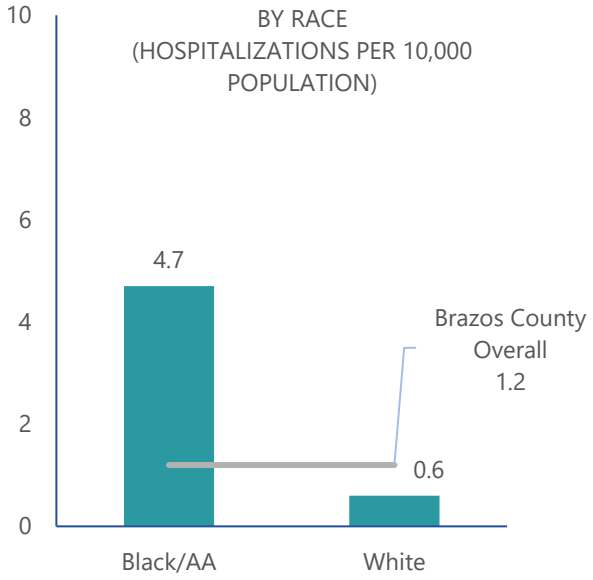
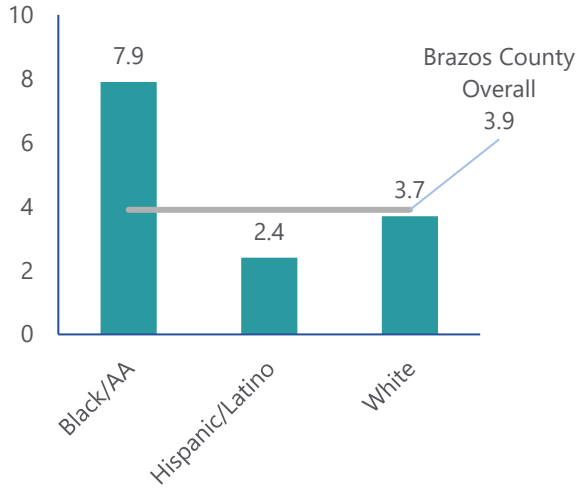


FIGURE 30. AGE-ADJUSTED HOSPITALIZATION RATE DUE TO COPD, BY RACE/ETHNICITY (HOSPITALIZATIONS PER 10,000 POPULATION 18+ YEARS)



Challenges related to environmental exposures, asthma management, and delayed care due to lack of insurance were frequently discussed.

Weight Status

From the secondary data scoring results, not enough indicators were available to score the topic of Weight Status, however the topic of Physical Activity ranked 14th in the data scoring of all topic areas with a score of 1.18. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. Only one indicator of concern was identified within this topic for Brazos County. The three highest scoring indicators are listed in Table 9 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 9. BRAZOS COUNTY DATA SCORING RESULTS: PHYSICAL ACTIVITY

SCORE	PHYSICAL ACTIVITY	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
1.71	Adults 20+ Who Are Obese	*percent*	29.3	36.0					
1.35	Adults 20+ who are Sedentary	*percent*	16.4						
0.79	Access to Exercise Opportunities	*percent*	86.7		81.8	84.1			

The only indicator of concern in Brazos County related to physical activity is *Adults 20+ Who Are Obese*. The county rate is 29.3%, which is lower than the Healthy People 2030 target, but is one

of the highest obesity rates across Texas counties. Additionally, the county rate for *Adults 20+ who are Sedentary* is 16.4%, which is higher than most other Texas counties. Both of these rates have been improving non-significantly.

Weight-related conditions such as obesity, diabetes, and hypertension were pervasive themes in both data and discussion. Participants emphasized the need for more community-based prevention programs, fitness access, and healthy food availability.

Women's Health

From the secondary data scoring results, Women's Health ranked 3rd in the data scoring of all topic areas with a score of 1.74. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. Only two indicators of concern were identified within this topic for Brazos County. The three highest scoring indicators are listed in Table 10 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 10. BRAZOS COUNTY DATA SCORING RESULTS: WOMEN'S HEALTH

SCORE	WOMEN'S HEALTH	UNITS	BRAZOS COUNTY	HP2030	TX	U.S.	TX Counties	U.S. Counties	Trend
2.29	Cervical Cancer Screening: 21-65	*Percent*	74.4			82.8			
1.59	Mammogram in Past 2 Years: 50-74	*percent*	72.3	80.3		76.5			
1.29	Mammography Screening: Medicare Population	*percent*	46.0		42.0	47.0			

The most concerning indicator related to women's health is *Cervical Cancer Screening: 21-65*. The county rate for this indicator is 74.4%, which is lower than the U.S. rate (82.8%) and also one of the lowest county rates across all U.S. counties. Brazos County's female population is also less likely to get a mammogram than the overall U.S. population. The county rate for *Mammogram in Past 2 Years: 50-74* is 72.3%, which is lower than the U.S. rate (76.5%) and also lower than the Healthy People 2030 target (80.3%). The county rate for *Mammography Screening: Medicare Population* is 46.0%, which is also lower than the U.S. rate (47.0%), but is higher than the Texas rate (42.0%).

Women's health, including access to reproductive care and maternal services, received strong concern throughout the region. Stakeholders shared the limited number of OB/GYN providers and prenatal care resources in rural counties. One participant said, **"There are high-risk moms with few local specialists to support them."**

Other Health Needs of Concern

In addition to the prioritized health needs identified in this assessment, several other topics emerged as significant areas of concern based on analysis of both secondary data indicators and community input. These topics reflect ongoing challenges and disparities that impact many residents across St. Jospeh's Health Regional, Rehabilitation, and College Station Hospitals' service area.

While these issues were determined to be important, St. Jospeh's Health Regional, Rehabilitation, and College Station Hospitals will not directly focus on them in its upcoming Implementation Strategy, due to limitations in resources, alignment with current strategic initiatives, or because other community partners are better positioned to lead these efforts. Each need is presented below in alphabetical order with a summary of findings and community insight.

Children's Health

From the secondary data scoring results, Children's Health ranked 4th in the data scoring of all topic areas, with a score of 1.68. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Brazos County:

- *Food Insecure Children Likely Ineligible for Assistance* (36.0%)
- *Substantiated Child Abuse Rate* (9.5 cases per 1,000 children)
- *Child Food Insecurity Rate* (22.6%)
- *Children with Health Insurance* (92.8%)

Children's health received high scores across all counties. Community input called for improved school-based services, pediatric care access, and nutrition programs. Focused conversations expressed concern for children affected by poverty, food insecurity, and lack of mental health support in schools.

Nutrition and Healthy Eating

Conduent's Food Insecurity Index (FII) uses socioeconomic data to estimate which zip codes are at greatest for poor food access. The map in Figure 31 illustrates that the zip codes with the highest risk of food insecurity are 77801, 77803, and 77859, with index scores of 94.5, 91.2, and 89.1, respectively.

FIGURE 31. FOOD INSECURITY INDEX: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

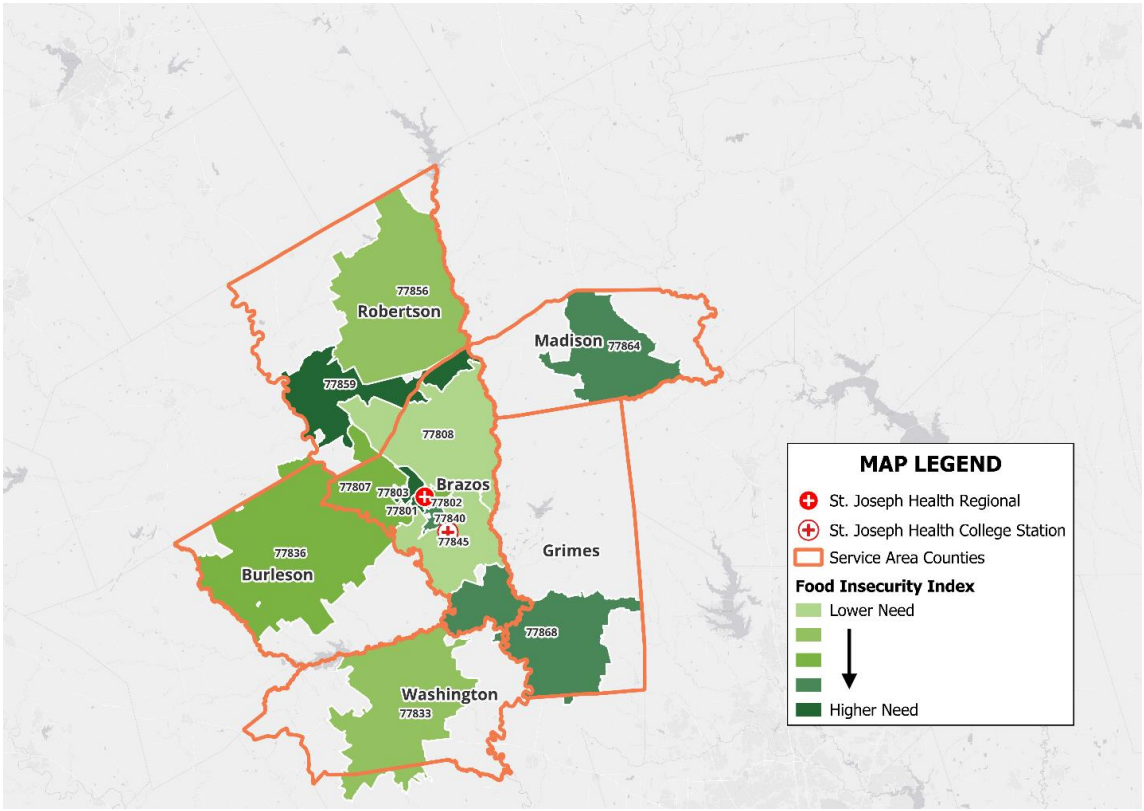


TABLE 11. FOOD INSECURITY INDEX: REGIONAL & COLLEGE STATION PRIMARY SERVICE AREA

Zip Code	Value	Zip Code	Value
77801	94.5	77836	41.0
77803	91.2	77807	39.9
77859	89.1	77856	37.6
77864	74.3	77833	36.2
77840	67.9	77808	31.3
77868	62.8	77845	29.7
77802	48.0		

Food security and nutrition were emphasized in both survey and listening session data. One participant remarked, **"If you have to choose between rent and vegetables, vegetables don't win."** The connection between food insecurity and chronic illness was a recurring theme.

Older Adults

From the secondary data scoring results, Older Adults ranked 9th in the data scoring of all topic areas, with a score of 1.50. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Brazos County:

- *Atrial Fibrillation: Medicare Population* (16.0%)
- *Cancer: Medicare Population* (14.0%)
- *Depression: Medicare Population* (18.0%)
- *Hyperlipidemia: Medicare Population* (67.0%)
- *Adults 65+ with Total Tooth Loss* (16.1%)
- *Adults 65+ without Health Insurance* (1.5%)
- *Heart Failure: Medicare Population* (13.0%)
- *Hypertension: Medicare Population* (68.0%)
- *Alzheimer's Disease or Dementia: Medicare Population* (7.0%)
- *Diabetes: Medicare Population* (26.0%)
- *Rheumatoid Arthritis or Osteoarthritis: Medicare Population* (36.0%)
- *Osteoporosis: Medicare Population* (11.0%)
- *People 65+ Living Alone (Count)* (5,250)
- *Ischemic Heart Disease: Medicare Population* (23.0%)

The aging population is growing, particularly in counties like Burleson and Grimes. Concerns included gaps in geriatric care, caregiver support, and affordable housing. As one community member shared, **"Older residents on fixed incomes often skip medications or appointments due to cost and transportation."**

Oral Health

From the secondary data scoring results, Oral Health ranked 7th in the data scoring of all topic areas, with a score of 1.62. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Brazos County:

- *Adults 65+ with Total Tooth Loss* (16.1%)
- *Adults who Visited a Dentist* (56.8%)

Oral health emerged as a top concern within the service area. Dental care is often inaccessible for uninsured adults, and Medicaid coverage gaps further limit preventive services. Several stakeholders described dental issues as "the silent epidemic" of rural health.

Barriers to Care

A crucial element of the St. Jospeh's Health Regional, Rehabilitation, and College Station Hospitals CHNA involved recognizing the obstacles that hinder community members from accessing timely, equitable, and high-quality health care. Throughout the service areas, several significant challenges were revealed through a mix of secondary data analysis, listening sessions, and partner survey. These barriers encompass social, economic, and systemic domains, disproportionately affecting marginalized and high-need populations.

Provider Shortages

Listening session participants emphasized that provider availability—particularly for specialty care, behavioral health, and women's health—is limited. "We are seeing patients drive hours for cardiology or OB/GYN appointments. The waitlists are long, and there just aren't enough providers," shared one stakeholder.

Insurance Coverage Gaps

A significant portion of the population remains uninsured or underinsured, leading to delays in care, increased emergency department usage, and reduced preventive care. One agency noted, "So many fall in the gap—too much income for Medicaid but nowhere near enough for private insurance."

Transportation & Geographic Isolation

Rural residents face long travel times to reach healthcare providers, compounded by limited or nonexistent public transit options. While programs like Ride2Health provide some relief, demand far exceeds current resources. For those without reliable vehicles, accessing care becomes nearly impossible.

Limited Health Literacy & Awareness

Many individuals are unaware of available services, eligibility criteria, or how to navigate complex healthcare systems. As one provider shared, "We have the resources, but people don't know where to go or who to ask for help."

Mental Health Stigma and Access

The shortage of behavioral health professionals and the persistence of stigma prevent individuals from seeking care. Providers also noted that existing mental health services are overwhelmed or have long waitlists, particularly for uninsured residents.

Technology Barriers

Telehealth expansion efforts are often hampered by lack of broadband access in rural areas and limited digital literacy among older adults. Programs like Senior Tech Connect made strides, but sustainability remains a concern.

Conclusion

The 2025 Community Health Needs Assessment for St. Joseph Health Regional, Rehabilitation, and College Station Hospitals reflects the complex interplay of structural, socioeconomic, and geographic factors influencing health outcomes across the service area.

Through comprehensive analysis of quantitative indicators, partner surveys, and deep listening to community voices, the assessment identified seven prioritized health needs: Health Care Access, Heart Disease & Stroke, Cancer, Women's Health, Respiratory Diseases, Weight Status, and Mental Health. These issues are interconnected and shaped by persistent disparities in income, education, insurance status, and rural infrastructure.

The community also voiced concern for Children's Health, Nutrition & Healthy Eating, Older Adult Health, and Oral Health—areas that, while not prioritized in the implementation strategy, remain critical for population well-being.

Residents, community-based organizations, and healthcare providers expressed a strong desire to collaborate more effectively, reduce the disparity of services, and expand outreach to the most vulnerable individuals. Despite the barriers identified, the region is home to committed partners, robust pilot programs, and a resilient community spirit.

As St. Joseph Health and its partners embark on the next phase of planning and implementation, this CHNA provides a roadmap to targeted, measurable, and collaborative action.

Appendices Summary

The following appendices provide supplemental data, documentation, and references supporting the findings and processes detailed in this Community Health Needs Assessment:

Data Sources and Methodology Details

Includes methodology overview, data scoring criteria and tables, and a summary of how qualitative and quantitative data were collected and analyzed. This section also includes any supplemental information from the previous CHNA to support comparison and context.

Stakeholder and Community Engagement Summary

Lists all organizations that contributed input through interviews, surveys, or listening sessions, including representatives of public health agencies, medically underserved, low-income, and minority populations. Also includes data collection tools such as survey instruments and discussion guides used during community engagement.

Community Partner List

Provides a structured list or table of community-based organizations, coalitions, and programs available to address each prioritized health need identified in the report.

References and Citations

A complete list of all data sources, literature, and tools used throughout the CHNA.