

2025 Community Health Implementation Strategy and Plan

St. Luke's Health Lakeside Hospital

Adopted October 2025



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At-a-Glance Summary

<p>Community Served</p> 	<p>St. Luke's Health – Lakeside Hospital serves a rapidly growing and diverse population of approximately 1.1 million residents across 26 ZIP codes in northern Greater Houston, including areas of Montgomery County and northern Harris County. The community includes suburban and semi-urban neighborhoods with economic and demographic diversity.</p> <p>Key community characteristics include:</p> <ul style="list-style-type: none">● Population: 1,098,053● Race/Ethnicity: 57.5% White, 28.6% Hispanic/Latino, 10.6% Black, 4.9% Asian● Median Household Income: \$92,741● Families Below Poverty: 7.0% (lower than Texas and U.S. rates)● Uninsured Adults: 16.4%● Unemployment Rate: 5.3%● High School Graduation Rate: 90% <p>This region has experienced rapid suburban growth, alongside emerging disparities in access to affordable care, chronic disease management, and behavioral health services.</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</p> <ul style="list-style-type: none">● Expand access to early detection and screening programs (breast, colorectal, and lung cancer).● Promote cancer awareness through community education events and partnerships with local clinics.● Support survivorship and patient navigation programs for uninsured or underinsured residents. <p>Healthcare Access & Quality</p>

- Strengthen referral pathways for uninsured and underinsured populations through partnerships with HOPE Clinic, Tri-County Health Network, and community health centers.
- Provide Medicaid enrollment assistance and charity care for medically necessary services.
- Support preventive care outreach, including immunizations, wellness visits, and dental screenings.

Heart Disease & Stroke

- Conduct heart health and stroke awareness campaigns, including CPR and hypertension education.
- Support community blood pressure screenings and linkage to primary care providers.
- Participate in regional cardiac rapid-response and post-discharge follow-up initiatives.

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 Mission and Spiritual Care Office St. Luke's Health – Lakeside Hospital 1101 Bates Avenue Houston, TX 77030 or by email to fawn.preuss@commonspirit.org

Our Hospital and the Community Served

About the Hospital

St. Luke's Health Lakeside Hospital serves as a trusted health partner for families and residents throughout Montgomery County and northern Harris County 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.

Lakeside Hospital provides a wide range of inpatient, outpatient, and specialty services, including advanced cardiovascular care, oncology, orthopedic and spine surgery, neurology, and imaging. The hospital also offers comprehensive emergency and surgical services, designed to deliver high-quality, patient-centered care close to home. Its physicians and caregivers are part of an integrated network that includes academic and research affiliations with the Texas Heart Institute and Baylor College of Medicine, ensuring patients benefit from the latest innovations and evidence-based practices.

Beyond its clinical excellence, Lakeside Hospital plays a vital role in promoting health and well-being throughout the surrounding region. The hospital regularly hosts community health screenings, education workshops, and outreach events focused on prevention, chronic disease management, and wellness. It partners closely with local health departments, nonprofit agencies, and faith-based organizations to address barriers to care, improve access for underserved populations, and respond to the most pressing community health needs.

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 a diverse and rapidly growing population of approximately 1.1 million residents across 26 ZIP codes in northern Greater Houston. A summary description of the community is below, and additional details can be found in the CHNA report online.

The community encompasses suburban and semi-urban neighborhoods throughout Montgomery County and northern Harris County, characterized by economic diversity, expanding housing developments, and evolving health needs.

Community Profile Highlights

- Population: 1,098,053 residents
- Race/Ethnicity: 57.5% White | 28.6% Hispanic/Latino | 10.6% Black | 4.9% Asian
- Age Distribution: Majority between 25–64 years; 9.2% aged 65–74 years
- Median Household Income: \$92,741
- Families Below Poverty: 7.0% (lower than both Texas and U.S. rates)
- Uninsured Adults: 16.4% (higher than national average)
- Educational Attainment: 90% have a high school diploma or higher

The community includes both high-income neighborhoods and areas of concentrated socioeconomic need, particularly in ZIP codes 77306, 77320, and 77328, where residents experience higher poverty, lower access to care, and elevated rates of chronic disease.

Community Characteristics

Geography: Suburban and semi-urban areas with proximity to Houston's medical corridor and regional employers.

Economy: Driven by healthcare, manufacturing, technology, and education sectors.

Assets: Strong local partnerships, growing healthcare infrastructure, and engaged nonprofit sector.

Health Inequities: Disparities in chronic disease prevalence, insurance coverage, and access to behavioral health services.

A map and additional demographic detail are available in the 2025 Community Health Needs Assessment for Lakeside Hospital.

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	Cancer remains a leading cause of illness and death within the Lakeside service area. Residents cited concerns about limited access to affordable screening and early detection, particularly for breast, colorectal, and lung cancers. Rates of mammography and colon cancer screening are below state and national averages, especially among uninsured populations.	•
Healthcare Access & Quality	Access to affordable, coordinated, and culturally competent care emerged as one of the most critical issues. Residents experience long appointment wait times, gaps in primary care, and challenges navigating insurance and social service systems. Preventable hospital stays and uninsurance rates remain higher than the national average.	•
Heart Disease & Stroke	Cardiovascular disease and stroke continue to affect residents across age groups, with higher-than-average rates of ischemic heart disease, atrial fibrillation, and hypertension among Medicare beneficiaries. Community members emphasized the need for improved education, early screening, and care management resources.	•
Mental Health	Although not selected as a primary focus area for this Implementation Strategy, mental health concerns especially depression, anxiety, and social isolation were widely discussed throughout community engagement sessions. The hospital will continue to support regional mental health partners where possible.	
Older Adults	Older adults in the service area face increased rates of chronic disease, mobility challenges, and social isolation. Transportation and affordable housing were identified as key barriers to aging well in place.	

Significant Needs the Hospital Does Not Intend to Address

While all identified needs are important to the overall well-being of the community, Lakeside Hospital will concentrate its resources on Cancer, Healthcare Access & Quality, and Heart Disease & Stroke during this implementation cycle.

The remaining needs Mental Health and Older Adults are being addressed by other organizations and community networks across Montgomery County. The hospital will continue to participate in collaborative discussions and align with regional efforts as appropriate.

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.

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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 LakesideHospital 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 Lakeside’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, Lakeside 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?

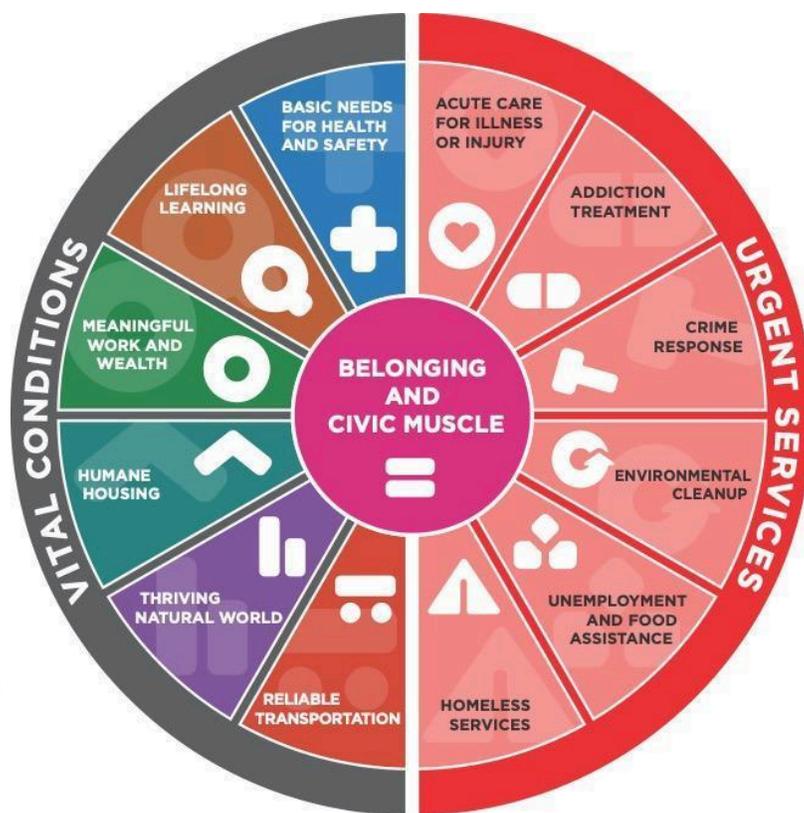
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

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, women aged 40 +, and medically underserved populations in high-need ZIP codes (77306, 77320, 77328)				
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)
Cancer Screening and Early Detection Initiative	<ul style="list-style-type: none"> Expand access to low-cost or free breast, cervical, and colorectal screenings through hospital-sponsored community events and partnerships with HOPE Clinic, Lone Star Family Health Center, and the American Cancer Society. Integrate patient navigation to assist with scheduling, follow-up, and referral to treatment. Provide culturally relevant education on prevention and early detection. 	•	•		VC
Community Cancer Education & Survivorship Support	<ul style="list-style-type: none"> Host quarterly “Cancer Awareness & Wellness Days” offering education, healthy-living workshops, and survivorship panels. Provide referrals to psychosocial and financial resources for patients and families. 			•	VC
Oncology Navigation and Continuum Coordination	<ul style="list-style-type: none"> Enhance coordination between primary care, specialty oncology, and rehabilitation services. Track time-to-diagnosis and completion 	•	•		US

Health Need:	Cancer				
	of treatment protocols.				
Planned Resources:	Hospital community-benefit funding; oncology service line; marketing and outreach support; volunteer clinicians.				
Planned Collaborators:	American Cancer Society, HOPE Clinic, Lone Star Family Health Center, Texas Oncology, and local faith coalitions.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased screening and early-detection rates	Number of residents receiving screenings	Hospital and partner event logs
Reduced late-stage diagnoses	Percentage of screenings with completed follow-up	EMR / Navigation tracking
Improved survivorship support	Reduction in late-stage diagnosis rates (by zip code)	State Cancer Registry / Hospital registry

Health Need:	Healthcare Access & Quality				
Population(s) of Focus:	Uninsured and underinsured adults, low-income families, older adults, and immigrant populations facing barriers to care				
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)
Community Care Access and Coverage Assistance	<ul style="list-style-type: none"> • Provide Medicaid and Marketplace enrollment assistance through trained navigators. • Offer charity care education and plain-language materials in English and Spanish. • Partner with local libraries and faith organizations for enrollment events. 	•		•	US
Preventive Care and Wellness Outreach	<ul style="list-style-type: none"> • Host monthly community health fairs offering blood pressure, glucose, and cholesterol screenings. • Distribute educational materials on nutrition, exercise, and chronic disease prevention. • Promote annual wellness visits and immunizations through local employers and schools. 		•	•	VC
Connected Community Network (CCN)	<ul style="list-style-type: none"> • Implement a referral platform to link patients to social-service resources (food, housing, transportation). • Train hospital staff to screen for social determinants of health (SDoH). 	•		•	VC

Health Need:	Healthcare Access & Quality
Planned Resources:	Community benefit funding; Mission and Spiritual Care team; Community Health Improvement Grants; marketing and data support.
Planned Collaborators:	Tri-County Health Network, Lone Star Family Health Center, Montgomery County Public Health District, local school districts, and faith-based organizations.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased insurance enrollment	Number of individuals assisted with coverage enrollment	Hospital tracking forms
Expanded access to preventive care	Percentage of participants connected to primary care or support services	CCN platform analytics
Improved care coordination; enhanced linkages to social supports.	Preventable hospitalization rate (per 100,000 Medicare enrollees)	CMS data / Quality department

Health Need:	Heart Disease & Stroke
Population(s) of Focus:	Adults aged 45 + with hypertension or high cholesterol; low-income and older residents in high-risk ZIP codes

Health Need:	Heart Disease & Stroke				
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)
Heart Health & Stroke Awareness Campaign	<ul style="list-style-type: none"> Deliver education through community health talks, faith organizations, and employer partnerships. Provide free blood pressure screenings and CPR training at community events. Distribute stroke FAST recognition materials in multiple languages. 		•	•	VC
Hypertension Management Program	<ul style="list-style-type: none"> Enroll patients with uncontrolled blood pressure in self-monitoring and lifestyle coaching programs. Coordinate follow-up with primary care and cardiology clinics. Offer virtual and in-person education on nutrition and stress reduction. 	•	•		US
Rapid Response and Care Transitions Initiative	<ul style="list-style-type: none"> Collaborate with Emergency Services to reduce door-to-treatment times for stroke and cardiac events. Implement post-discharge follow-up calls within 72 hours to support medication adherence and appointment compliance. 	•			US
Planned Resources:	Cardiovascular service line; community benefit funds; hospital clinicians and volunteers; public health outreach team.				
Planned Collaborators:	American Heart Association, Houston Fire Department EMS, Montgomery County Public Health District, and local faith coalitions.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved blood pressure control	Number of individuals screened for hypertension	Community event records
Reduced stroke and heart attack readmissions	Rate of patients with controlled blood pressure	Clinical EMR data
Increased community awareness of preventive measures	Door-to-treatment time for stroke cases	Quality metrics / AHA Get With The Guidelines data