2025 Community Health Implementation Strategy and Plan

St. Luke's Health Patients Medical Center

Adopted September 2025

St. Luke's Health™

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At-a-Glance Summary

Community Served 	St. Luke's Health Patient's Medical Center (PMC) serves communities in the eastern portion of the Greater Houston Metropolitan Area. The defined service area includes 14 ZIP codes, covering a diverse population of approximately 490,871 residents. Key demographics include: 67.2% Hispanic/Latino, 34.0% White, 9.6% Black/African American, and 3.9% Asian. More than 53% speak a language other than English at home, with Spanish being the most common. 14.6% of households live below the poverty line, and unemployment in the service area is higher than state and national averages (9.2%). The community experiences barriers such as high uninsured rates, limited primary care availability, and challenges related to transportation, housing stability, and digital access.
Significant Community Health Needs Being Addressed 	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). Needs the hospitals intends to address with strategies and programs are: • Cancer • Diabetes • Health Care Access & Quality • Heart Disease & Stroke • Mental Health
Strategies and Programs to Address Needs 	The hospital intends to take actions and to dedicate resources to address these needs, including: • PMC will dedicate resources and collaborate with community partners to address these needs. Planned strategies include: • Health Care Access & Quality: Strengthen access to primary and preventive care through financial assistance, enrollment

support for insurance programs, and partnerships that expand culturally competent care.

- Heart Disease & Stroke: Promote cardiovascular risk reduction through screening events, chronic disease management, and cardiac rehabilitation support.

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 on the hospital’s website. Written comments on this strategy and plan can be submitted to St. Luke’s Health Patient’s Medical Center Mission and Spiritual Care Office, 4600 E Sam Houston Pkwy S Pasadena, TX 77505 or via email to fawn.preuss@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Luke's Health Patient's Medical Center (PMC) is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Located in Pasadena, Texas, PMC serves the eastern portion of the Greater Houston Metropolitan Area. The hospital provides a range of inpatient and outpatient services, including primary and specialty care, cardiology, oncology, diagnostic imaging, surgical services, and emergency care. As part of the St. Luke's Health network, PMC is committed to advancing clinical excellence while addressing the needs of the surrounding community.

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

PMC serves a defined region of 14 ZIP codes in eastern Harris County, strategically identified through inpatient discharge data to reflect the areas most reliant on the hospital's services. A summary description of the community is below, and additional details can be found in the CHNA report online.

The total service area population is approximately 490,871 residents, characterized by:

- 67.2% Hispanic/Latino, 34.0% White, 9.6% Black/African American, and 3.9% Asian.
- More than 53% of residents speak a language other than English at home, with Spanish as the dominant language.
- 14.6% of households live below the poverty level, and median household income is lower than state and national averages.
- The unemployment rate is 9.2%, higher than Texas (5.7%) and U.S. (5.2%) levels.
- The community experiences inequities in access to health insurance (23.8% of adults uninsured), preventive care, transportation, and stable housing.
- These factors reflect both the diversity and the challenges within the community, underscoring the importance of PMC's efforts to address health disparities and promote equity in care

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 in the community. Screening rates for colon, breast, and cervical cancers are below state and national averages, and disparities exist by race/ethnicity, with Black	

Significant Health Need	Description	Intend to Address?
	and Hispanic residents experiencing higher rates of late diagnoses and mortality.	
Diabetes	Nearly 10% of adults in Harris County are living with diabetes, placing the county among the highest in Texas. Diabetes-related mortality is disproportionately higher for Black/African American residents and men.	
Health Care Access & Quality	High uninsured rates (nearly 1 in 4 adults), limited availability of primary care, and preventable hospitalizations highlight barriers to accessing timely and quality care.	●
Heart Disease & Stroke	Cardiovascular conditions are common and severe in the community, with high rates of stroke, heart failure, and hypertension, particularly among Medicare recipients. Mortality rates due to coronary heart disease and stroke are higher than Healthy People 2030 targets.	●
Mental Health	Residents report high levels of poor mental health days, with nearly 1 in 5 adults experiencing two weeks or more of poor mental health in a month. Access to behavioral health providers is limited, with long wait times, affordability challenges, and a lack of culturally competent services.	
Older Adults	Seniors in the community face high rates of poverty, chronic conditions such as osteoporosis, cardiovascular disease, and dementia, and difficulty navigating fragmented systems of care.	

After careful consideration of mission alignment, available resources, and the ability to make meaningful impact, PMC will focus its Implementation Strategy on:

- Health Care Access & Quality
- Heart Disease & Stroke

These needs align with hospital strengths, clinical service lines, and opportunities for collaboration with community partners.

Significant Needs the Hospital Does Not Intend to Address

PMC will not directly address the following needs in this Implementation Strategy:

- Cancer
- Diabetes
- Mental Health
- Older Adults

While these issues remain significant in the community, PMC determined that other organizations are better positioned to lead efforts in these areas or that they fall outside the scope of PMC's resources for this cycle. PMC will continue to support community partners addressing these needs through referrals, collaborations, and alignment with system-wide initiatives.

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 benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

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

The Implementation Strategy was created through collaboration among PMC 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 PMC'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, PMC 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 Portfolio[1] 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.

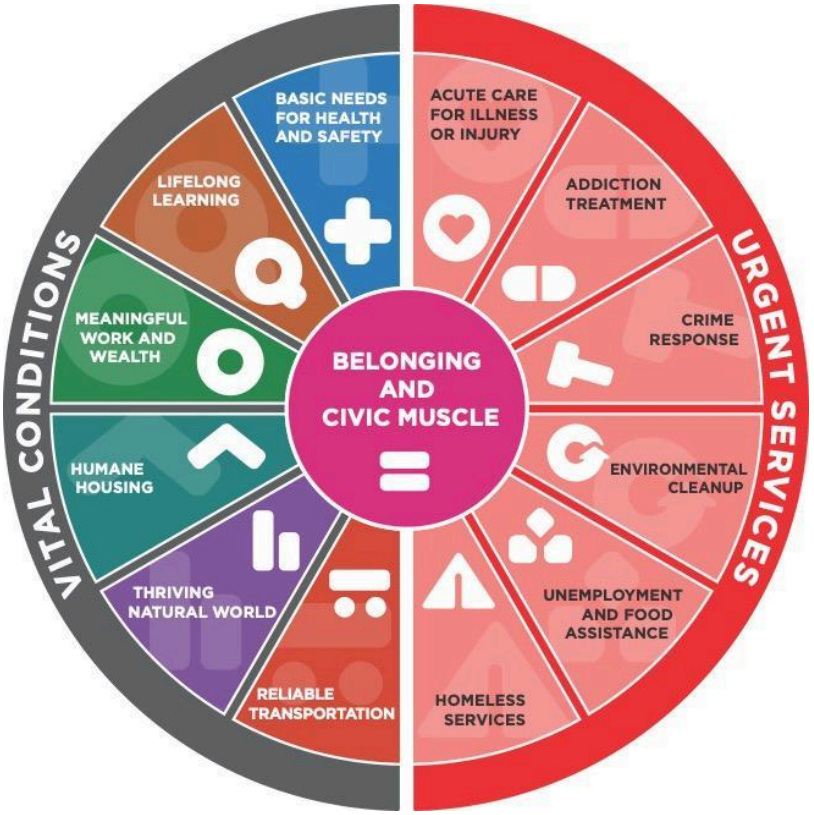
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of 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:	Health Need: Health Care Access & Quality				
Population(s) of Focus:	Uninsured and underinsured adults and children; low-income families; Hispanic/Latino populations; older adults in the service area.				
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)**
Palliative Care Consult (future)	Implement structured referrals for palliative care to improve quality of end-of-life support.	●	●		Urgent Service
Back to School Supply Drive	Annual donation and distribution of school supplies for Pasadena ISD students.			●	Vital Condition - Basic Needs
Community Outreach (Chamber, Trunk or Treat, Town Events)	Participation in community events to promote hospital services and share resources.			●	Vital Condition – Belonging & Civic Muscle
Pasadena ISD Employee Health Fair (annual)	Provide cardiovascular screenings, wellness education, and preventive resources to district employees.	●	●	●	Vital Condition – Education & Health Care Access
Emergency Department Services Awareness Campaign	Public education on ED services and when to seek emergency vs. primary care.	●		●	Vital Condition – Access to Care
Madison Jobe Senior Center: Education & Screenings	Provide wound care checks, diabetic foot screenings, and preventive education for seniors.	●	●	●	Vital Condition – Access to Care
Planned Resources:	Palliative Care Team, Case Management; hospital staff volunteers; sponsorships and supplies; wound care team; health educators; on-site screening staff; marketing/outreach materials.				

Health Need:	Health Need: Health Care Access & Quality
Planned Collaborators:	Case Management Department; Pasadena Chamber of Commerce; Pasadena ISD; American Heart Association (AHA); Madison Jobe Senior Center; Nursing; Rehab; community partners.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Expanded preventive care and education; Increased access to resources for vulnerable populations; Improved care navigation; Stronger hospital–community partnerships	Number of referrals; Screenings completed; Supplies distributed; Outreach events, and participants engaged	Hospital records; Community surveys; Event logs; Departmental donation tracking, Quality reporting metrics

Health Need:	Heart Disease & Stroke				
Population(s) of Focus:	General community; older adults and high-risk populations in the service area.				
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)**
CP/Stroke Center Designation (future)	Obtain certifications for STEMI and stroke care; expand hospital's formal response capacity.	●	●		Urgent Service
AHA Heart Walk	Sponsor and participate in AHA Heart Walk to raise awareness and engage the community in cardiovascular health.			●	Vital Condition
24/7 Cardio/STEMI Coverage	Maintain continuous cardiac emergency response capacity.	●			Urgent Service
Madison Jobe Senior Center – Education & BP Screenings	Blood pressure screenings and stroke education for seniors.		●	●	Vital Condition
Planned Resources:	Stroke/CP Coordinator FTE, Facility-wide education, Staff Participation, Hospital Sponsorship, Cardiology Team, ED Staff, Clinical Staff, BP Monitors, Education Materials				
Planned Collaborators:	American Heart Association, Internal hospital departments, Madison Jobe Senior Center, Nursing, Rehab				

Anticipated Impacts (overall long-term goals)	Measure	Data Source

Increased community awareness of heart health; strengthened partnerships; improved preventive care use; reduced preventable hospitalizations	Number of patients receiving financial assistance; insurance enrollment rates; preventive screening rates	Hospital data; Medicaid/ACA reports; hospital/community records