2025 Community Health Implementation Strategy and Plan

Sugar Land Hospital

Adopted October 2025

St. Luke's Health™

A member of CommonSpirit

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At-a-Glance Summary

Community Served 	St. Luke's Health Sugar Land Hospital serves a rapidly growing and demographically diverse area within the Greater Houston metropolitan region, encompassing 24 ZIP codes across Fort Bend, Harris, and Brazoria Counties. The service area is home to an estimated 1.39 million residents and is characterized by strong suburban expansion, racial and cultural diversity, and varied socioeconomic conditions. While many communities experience high educational attainment and household income, pockets of persistent poverty and limited English proficiency remain particularly in ZIP codes 77036, 77074, and 77031, which exhibit the region's highest Health Equity Index values. These communities experience barriers related to affordable healthcare access, transportation, and chronic disease management, making targeted outreach and preventive programming a system priority.
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 ● Health Care Access & Quality ● Heart Disease & Stroke
Strategies and Programs to Address Needs 	The hospital intends to take actions and to dedicate resources to address these needs, including: **Cancer** ● Free and low-cost screening events for breast, cervical, prostate, and colorectal cancers in partnership with The Rose and San José Clinic. ● Community education through the ExamiNATION awareness campaign and culturally tailored outreach. ● Oncology navigation and survivorship support connecting patients to specialists, insurance enrollment, and psychosocial care. **Healthcare Access & Quality** ● Continuation of financial-assistance policies and Medicaid/CHIP enrollment support for uninsured individuals. ● Strengthened partnerships with San José Clinic and HOPE Clinic to expand affordable primary and behavioral healthcare.

- Collaboration with Fort Bend Transit to provide medical-transportation vouchers.
- Annual cultural-competency and health-literacy training for staff to improve patient experience and equity in care.

Heart Disease & Stroke

- Community-based cardiovascular screenings for blood pressure and cholesterol, coupled with nutrition and exercise education.
- Faith-based “Know Your Numbers” programs to build community engagement and promote heart-healthy behaviors.
- Post-discharge cardiac follow-up to reduce readmissions and strengthen care continuity.
- Planned resources include hospital community-benefit funds, staff expertise, and CommonSpirit Mission & Ministry Fund grants.
- Key collaborators include The Rose, San José Clinic, HOPE Clinic, Fort Bend Public Health Department, Fort Bend Transit, the American Heart Association, and local faith-based and nonprofit partners.
- Anticipated long-term impacts include increased cancer-screening and early-detection rates, improved insurance coverage and care continuity for uninsured residents, and reduced cardiovascular mortality and hospital readmissions.

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

Located in Fort Bend County, the hospital provides comprehensive acute and specialty care services to a dynamic and rapidly growing population in the Greater Houston Region. St. Luke's Health Sugar Land offers emergency and surgical services, cardiovascular and stroke care, oncology, women's health, orthopedics, and diagnostic imaging, among other lines of service.

The facility continues to expand its reach through outpatient centers, telehealth programs, and partnerships that improve access to care for uninsured and underserved residents throughout the service area.

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 St. Luke's Health Sugar Land Hospital serves a 24-ZIP-code area spanning Fort Bend, Harris, and Brazoria Counties. A summary description of the community is below, and additional details can be found in the CHNA report online.

The service area is home to approximately 1.39 million residents (Claritas 2024). It is largely suburban, with well-developed neighborhoods interspersed with emerging mixed-use communities and areas of persistent need.

Demographic highlights:

- Race & Ethnicity: The population is racially and ethnically diverse, with substantial Asian (19%), Black/African American (12%), and Hispanic/Latino (26%) communities.
- Income: The median household income is approximately $83,135, though disparities exist—Hispanic/Latino and Black/African American households earn more than $18,000 below the area median.
- Education: About 85% of residents hold a high-school diploma or higher, and 41% hold a bachelor's degree or higher.
- Poverty: Roughly 10% of families live below the federal poverty level, with the highest concentrations in ZIP codes 77074 and 77031.
- Insurance: Nearly 13% of adults lack health insurance coverage, limiting access to preventive and specialty care.
- Language & Culture: Almost 47% of residents speak a language other than English at home, underscoring the need for linguistically appropriate health information.
- Key community assets include a strong local public-health network, nonprofit health partners such as San José Clinic, HOPE Clinic, and The Rose, robust school-district collaborations, and active faith-based organizations.

Despite these strengths, the community continues to face challenges related to affordable healthcare, transportation, chronic-disease prevention, and cultural-linguistic access particularly in the highest-need ZIP codes identified through the Health Equity Index.

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the Mission & Spiritual Care Office, 1317 Lake Pointe Pkwy, Sugar Land, TX 77478 or emailed to fawn.preuss@commonspirit.org

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 October 2025. The CHNA report includes:

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

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

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Cancer	High cancer incidence and mortality among certain populations—particularly prostate cancer in Black/African American men and breast/cervical cancer in women—paired with low screening rates.	●
Healthcare Access & Quality	Barriers to timely, affordable, and culturally appropriate healthcare services; high uninsured rates and provider shortages in high-need ZIP codes.	●
Heart Disease & Stroke	Elevated hypertension, hyperlipidemia, and heart-failure hospitalization rates, particularly among older adults and Black/African American residents.	●
Diabetes	High prevalence among adults (10.3% in Fort Bend) and disparities by race/ethnicity. Closely linked to obesity and food insecurity.	
Mental Health	Increasing reports of poor mental-health days, limited behavioral-health workforce, and stigma surrounding treatment.	

Significant Health Need	Description	Intend to Address?
Older Adults	Growing senior population with multiple chronic conditions, social isolation, and affordability barriers for care and housing.	

Significant Needs the Hospital Does Not Intend to Address

While St. Luke's Health Sugar Land Hospital recognizes the importance of all needs identified in the CHNA; the hospital will focus its community-benefit resources on the three prioritized areas Cancer, Healthcare Access & Quality, and Heart Disease & Stroke where it can have the greatest measurable impact.

Other needs, such as Diabetes, Mental Health, and Older Adults, will continue to be supported through:

- Collaborative efforts with community partners, including San José Clinic, Fort Bend Public Health, and United Way of Greater Houston;
- CommonSpirit's regional and system-level initiatives such as the Connected Community Network, Pathways Community HUB, and Mission and Ministry Fund grants; and
- Ongoing hospital-wide strategies in patient safety, chronic-disease management, and culturally responsive care.

The hospital may reassess and expand its focus in future CHNA cycles as new data and partnerships emerge.

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 Sugar Land'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, Sugar Land identified Health Cancer, 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.

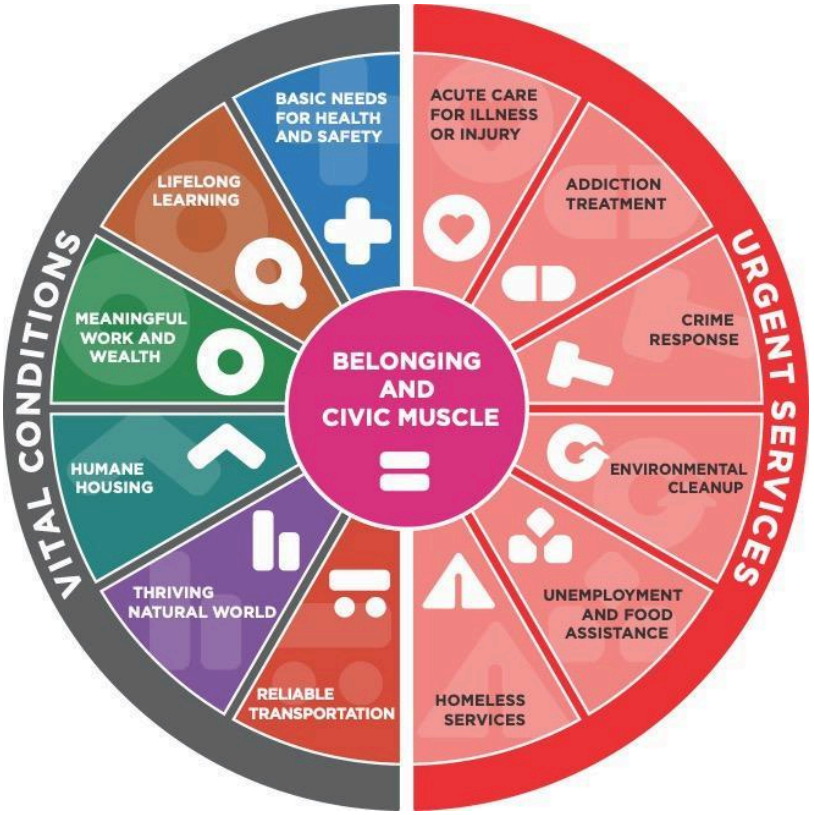
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of 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:	Cancer				
Population(s) of Focus:	Uninsured adults, older adults, and racial/ethnic minorities (particularly Black/African American men and Hispanic women) in high-need ZIP codes 77036, 77074, 77031.				
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 Events	• Provide free or low-cost breast, cervical, prostate, and colorectal screenings in partnership with *The Rose* and *San José Clinic*. • Focus outreach in high-need areas identified in CHNA. • Include culturally tailored education materials and mobile screening units. • *Metrics:* # screened and # referred for diagnostic follow-up.	•	•	•	VC
Cancer Awareness and Prevention Campaigns	• Annual *ExamiNATION* media series and community education workshops focused on screening and risk reduction. • Target populations with highest mortality disparities (Black/African American and Hispanic communities). • *Metrics:* campaign reach and surveyed awareness change.	•	•	•	VC
Oncology Navigation and Survivorship Support	• Provide navigation services linking diagnosed patients to oncology specialists, insurance enrollment, and support groups.	•	•	•	US

Health Need:	Cancer				
	• Collaborate with *American Cancer Society* and hospital social work team. • *Metrics:* # patients navigated; % attending follow-up within 30 days.				
Planned Resources:	Hospital community benefit funds; Mission & Ministry Fund grants; oncology staff time; marketing and outreach support				
Planned Collaborators:	The Rose; San José Clinic; American Cancer Society; Fort Bend Public Health Department; local faith-based organizations.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase screening rates and early detection; reduce cancer-related mortality disparities; improve care navigation.	Screening counts and follow-up rates	Texas Cancer Registry, Hospital EHR

Health Need:	**Healthcare Access & Quality**				
Population(s) of Focus:	Uninsured, Medicaid-eligible, and linguistically isolated residents across the Sugar Land 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)**
Financial Assistance & Coverage Enrollment	• Continue CommonSpirit charity-care policy and Medicaid/CHIP enrollment assistance for uninsured patients. • Host quarterly bilingual enrollment events and educational sessions. • *Metrics:* # applications completed; % enrolled in coverage.	•			US
Community Clinic Partnerships	• Strengthen collaborations with *San José Clinic* and *HOPE Clinic* to expand primary care, dental, and behavioral health access for uninsured adults and children. • *Metrics:* # patients served through referrals; continuity of care rate.	•	•		VC
Transportation Access Enhancement	• Partner with *Fort Bend Transit* to provide or subsidize non-emergency medical transportation for low-income patients and seniors. • *Metrics:* # rides provided; missed-appointment rate reduction.			•	VC
Cultural Competency & Health Literacy Training	• Conduct annual training for clinical and front-line staff on culturally responsive care and language access. • Distribute multilingual materials on		•	•	VC

Health Need:	**Healthcare Access & Quality**				
	preventive care and chronic disease management. • *Metrics:* # staff trained; patient satisfaction scores.				
Planned Resources:	Charity-care budget; staff educators; community benefit funds; volunteer navigators.				
Planned Collaborators:	San José Clinic; HOPE Clinic; Fort Bend Transit; United Way of Greater Houston; local faith networks.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Reduce uninsured rate and preventable hospitalizations; increase use of primary care; advance equitable service delivery.	Enrollment data, preventable stay rates (CMS)	Patient satisfaction surveys.

Health Need:	**Heart Disease & Stroke**				
Population(s) of Focus:	Adults 40 and older, particularly Black/African American and Hispanic residents in high-need ZIP codes 77036, 77074, 77031.				
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)**
Cardiovascular Screening & Education Initiative	• Offer free blood-pressure and cholesterol checks at community events, clinics, and faith sites. • Provide nutrition and exercise counseling to reduce risk factors. • *Metrics:* # screened; % referred for follow-up.	•	•		VC
Faith-Based Heart Health Program	• Partner with local churches to host "Know Your Numbers" workshops and walking clubs promoting hypertension management and healthy eating. • *Metrics:* # participants; self-reported behavior change.			•	VC
Post-Discharge Cardiac Follow-Up Program	• Implement case-management model to reduce readmissions for heart failure and stroke patients, including tele-check visits and medication adherence support. • *Metrics:* 30-day readmission rate; medication adherence rate.	•			US
Planned Resources:	Clinical educators; cardiology staff; community benefit funds; communications materials.				
Planned Collaborators:	American Heart Association; Fort Bend Public Health Department; faith-based organizations, local fitness centers; pharmacy partners				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve hypertension control and stroke response; reduce cardiovascular mortality; increase preventive screening uptake.	Hospital readmission data; event logs;	BRFSS hypertension prevalence.