2025 Community Health Implementation Strategy and Plan

The Vintage Hospital

Adopted October 2025

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At-a-Glance Summary

Community Served	St. Luke's Health The Vintage Hospital serves northern Harris County, Texas, encompassing 20 ZIP codes across the rapidly growing suburban areas surrounding Cypress Creek, Champions Forest, and Tomball. The service area's population is approximately 982,000 residents, reflecting a diverse racial and ethnic composition: 38% White, 20% Black/African American, 9% Asian, and 36% Hispanic/Latino. While the area is home to high-income neighborhoods, pockets of economic vulnerability persist particularly in ZIP codes 77088, 77086, and 77038 where higher poverty and unemployment rates are linked to limited healthcare access and poorer outcomes.
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: ● 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: **Health Care Access & Quality** ● Expand access to primary and preventive care for uninsured and underinsured residents through partnerships with San José Clinic, Lone Star Family Health Center, and TOMAGWA HealthCare Ministries. ● Continue Medicaid enrollment assistance and financial aid for eligible patients. ● Host community health fairs and screening events for early detection of chronic conditions. ● Support language access and cultural competency training to reduce barriers for diverse populations. ● Leverage Community Health Improvement Grant funding to support nonprofit partners addressing social determinants of health (e.g., transportation, nutrition, and digital access). **Heart Disease & Stroke** ● Provide free and low-cost blood pressure and cholesterol screenings in collaboration with the American Heart Association and community clinics. ● Offer education on stroke signs and response through worksite wellness and faith-based programs.

- Support cardiac rehabilitation and risk-reduction programs for high-risk and post-discharge patients.
- Integrate heart-health promotion into community outreach events with local schools and employers.
- Expand screenings and referrals through community health fairs and mobile clinics targeting ZIP codes with high stroke mortality.

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 The Vintage Hospital 20171 Chasewood Park Drive Houston, TX 77070 or by e-mail to fawn.preuss@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Luke's Health The Vintage 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.

The Vintage Hospital serves the rapidly growing suburban and semi-urban communities of northern Harris County.

The hospital offers a comprehensive range of inpatient and outpatient services, including emergency medicine, heart and vascular care, cancer treatment, orthopedics, imaging, and women's health. With a focus on compassionate, high-quality, and accessible care, The Vintage Hospital operates as part of St. Luke's Health's north-Houston hub, supporting coordinated specialty and primary care through its clinical network and community partners.

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 20-ZIP-code area located in northern Harris County and portions of Montgomery County, Texas. A summary description of the community is below, and additional details can be found in the CHNA report online.

This diverse suburban region encompasses neighborhoods such as Cypress Creek, Champions Forest, and Tomball, representing a blend of established residential areas and rapidly expanding developments.

- Total population: Approximately 982,400 residents
- Racial/Ethnic composition: 38% White, 20% Black/African American, 9% Asian, and 36% Hispanic/Latino
- Economic indicators: Median household income $84,919; 10% of families live below the poverty line
- Insurance coverage: 26% of residents are uninsured or underinsured, with higher uninsured rates in ZIPs 77088, 77086, and 77038
- Language diversity: 36% of households speak a language other than English at home
- Education: 86.6% of adults hold a high school diploma or higher; 34.1% hold a bachelor's degree or higher

While the area includes economically prosperous neighborhoods, significant disparities persist particularly among older adults, immigrants, and low-income families. High-need ZIP codes identified by Conduent's Community Health Index (77038, 77086, and 77088) demonstrate elevated levels of poverty, uninsured rates, and chronic disease burden.

The Vintage Hospital collaborates with community-based organizations, faith partners, and federally qualified health centers to improve access to primary and preventive care, reduce chronic disease disparities, and strengthen overall community well-being.

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?
Health Care Access & Quality	Limited access to affordable and timely primary, preventive, and specialty care; shortages of providers in high-need ZIP codes; language barriers and insurance gaps among low-income and immigrant populations.	●
Heart Disease & Stroke	High prevalence of hypertension, ischemic heart disease, and stroke mortality rates above state and national averages; lower rates of blood-pressure management, cholesterol screening, and medication adherence.	●
Cancer	Elevated incidence of prostate, breast, and cervical cancer, particularly among Black and Hispanic populations; delayed screenings and limited navigation support.	
Mental Health	Increasing rates of anxiety, depression, and limited access to behavioral-health specialists; shortages of culturally competent care.	
Older Adults	Rising chronic-disease burden, mobility limitations, and poverty among seniors; gaps in caregiver and aging-in-place supports.	

Significant Needs the Hospital Does Not Intend to Address

While all identified needs are important to the health of the community, The Vintage Hospital will focus its community benefit resources on Health Care Access & Quality and Heart Disease & Stroke, as these represent areas of greatest community impact and alignment with the hospital's expertise.

Other significant needs such as Cancer, Mental Health, and Older Adults are being addressed through regional partnerships, community-based organizations, and public-health initiatives, including:

- Baylor St. Luke's Medical Center and St. Luke's Health The Woodlands cancer-screening and specialty-care networks
- Tri-County Behavioral Health, Mosaic of Mercy, and Mission Northeast behavioral-health programs
- Area Agency on Aging initiatives focused on chronic-disease management, housing, and caregiver support

The hospital will continue to collaborate and advocate for these partners while concentrating its direct strategies on the two selected priorities.

2025 Implementation Strategy and Plan

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

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

Creating the Implementation Strategy

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

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

The Implementation Strategy was created through collaboration among 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.

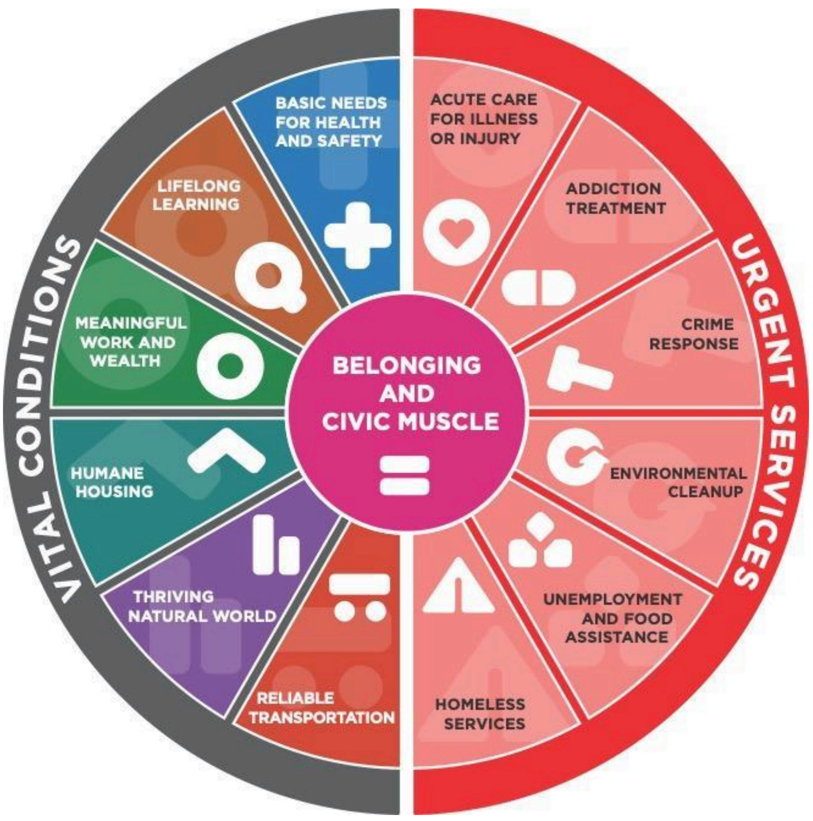
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of 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 Care Access & Quality**				
Population(s) of Focus:	Uninsured and underinsured adults; immigrant and low-income families; residents in high-need ZIP codes 77088, 77086, 77038, and 77090.				
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)**
Expand Access to Affordable Primary and Preventive Care	• Provide enrollment assistance for Medicaid, CHIP, and Marketplace insurance. • Offer sliding-scale and free screenings (blood pressure, diabetes, cancer). • Embed bilingual patient navigators to guide residents through coverage and referral systems.	●	●		VC: Reliable health care access US: Timely clinical services
Strengthen Community Clinic Partnerships	• Collaborate with San José Clinic, Lone Star Family Health Center, and TOMAGWA HealthCare Ministries to expand hours and specialty referrals. • Support mobile-clinic operations and telehealth integration.	●		●	VC
Culturally Responsive Care and Language Access Training	• Provide annual training to staff on health literacy, bias awareness, and inclusive communication. • Expand availability of interpreters and translated materials.		●	●	VC
Community Health Improvement Grant	• Award annual mini-grants (up to $25,000) to local organizations that			●	VC

Health Need:	**Health Care Access & Quality**				
Program	address social determinants of health such as transportation, nutrition, and digital access. ● Prioritize projects serving zip codes with highest Community Health Index scores.				
Planned Resources:	Community Benefit funding, Mission & Ministry Fund grants, staff time for outreach and training, volunteers, and marketing support.				
Planned Collaborators:	San José Clinic, Lone Star Family Health Center, TOMAGWA HealthCare Ministries, Interfaith of The Woodlands, American Heart Association, Meals on Wheels, United Way of Greater Houston.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved access to preventive and primary care; increased insurance coverage; reduction in avoidable emergency department visits; strengthened community partnerships.	Number of individuals enrolled in coverage programs	Hospital and clinic enrollment data
	Preventive screenings provided through community events	Event and partner reports
	Reduction in preventable hospital stays (Medicare population)	CMS Hospital Compare
	Participation in language access training	Hospital HR records

Health Need:	**Heart Disease & Stroke**				
Population(s) of Focus:	Adults ages 40 and older; Black and Hispanic residents with elevated risk factors; low-income and uninsured patients in high-mortality ZIP codes.				
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 Screening and Education Campaign	• Host free community screenings for blood pressure, cholesterol, and BMI in partnership with **American Heart Association** and faith-based organizations. • Provide educational materials on stroke symptoms and response.	●	●	●	US
Cardiac Rehabilitation and Risk Reduction Program	• Offer post-discharge follow-up, exercise support, and nutrition counseling for cardiac patients. • Track readmission rates and medication adherence.	●	●	●	VC
Faith and Workplace Wellness Initiatives	• Deliver Heart-Healthy Workplace and "Know Your Numbers" programs at local businesses and churches. • Train community ambassadors to promote blood-pressure checks and emergency response.	●	●	●	VC
Healthy Food and Nutrition Access	• Partner with local food banks, H-E-B, and United Way to increase availability of low-sodium, heart-healthy foods. • Integrate nutrition education into	●	●	●	VC

Health Need:	**Heart Disease & Stroke**				
	screening and rehab events.				
Planned Resources:	Clinical staff time, community benefit funds, educational materials, marketing and communications support, and collaborative grant resources.				
Planned Collaborators:	American Heart Association, March of Dimes, YMCA of Greater Houston, local faith coalitions, H-E-B, United Way, Meals on Wheels, and city parks and recreation departments.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved heart-health screening rates; reduced stroke mortality; increased awareness of risk factors; enhanced post-discharge care and rehabilitation compliance.	Number of participants screened for hypertension and cholesterol	Event and partner reports
	Reduction in 30-day readmissions for cardiac patients	Hospital Quality and Safety data
	Number of community and faith-based wellness events held	Community Outreach logs
	Distribution of nutrition education and heart-healthy resources	Community Benefit tracking