

2025 Community Health Implementation Strategy and Plan

The Woodlands Hospital

Adopted October 2025



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At-a-Glance Summary

<p>Community Served</p> 	<p>St. Luke's Health The Woodlands Hospital serves residents across northern Greater Houston, including portions of Montgomery, Harris, Walker, and Trinity counties.</p> <p>The defined service area encompasses 27 ZIP codes, selected based on inpatient discharge data that represent the majority of hospital admissions.</p> <p>The community has a total population of approximately 1 million residents and continues to experience rapid growth and suburban expansion.</p> <p>The area is racially and economically diverse with 57 percent White, 29 percent Hispanic/Latino, 10.8 percent Black/African American, and 4.9 percent Asian and varied levels of income and health coverage. While many residents benefit from strong local economies and high educational attainment, pockets of disadvantage remain.</p> <p>Neighborhoods such as ZIP codes 77306, 77301, and 75862 show higher concentrations of poverty, uninsured populations, and transportation barriers, highlighting the importance of equitable access to care and preventive services across the region.</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>The hospital will dedicate resources, staff engagement, and partnerships to address these priorities through targeted initiatives that promote early detection, equitable access, and chronic disease prevention. Examples include:</p> <p>Cancer</p> <ul style="list-style-type: none">• Expand access to cancer screenings and prevention education through community events such as The Woodlands Health Expo and Diva Night.

- Collaborate with the American Cancer Society, Interfaith Community Clinic, and local partners to increase awareness of breast, colorectal, and prostate cancer screening.
- Provide patient navigation and survivorship resources for underserved and minority populations.

Health Care Access & Quality

- Enhance Medicaid enrollment assistance, financial counseling, and charity-care programs for uninsured and underinsured patients.
- Support mobile health units, preventive clinics, and community-based education to reduce avoidable emergency-department visits.
- Award Community Health Improvement Grants to partners expanding access to primary and behavioral health care.

Heart Disease & Stroke

- Promote blood-pressure and cholesterol screening and stroke-education campaigns at community events.
- Partner with the American Heart Association to provide free CPR training and heart-health awareness activities.
- Strengthen care-transition programs and clinical-community linkages to reduce readmissions and improve cardiovascular outcomes.

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 on the hospital's website. Written comments on this strategy and plan may be submitted to: Mission and Spiritual Care Office St. Luke's Health The Woodlands Hospital 17400 St. Luke's Way The Woodlands, TX 77384 or by email to fawn.preuss@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Luke's Health The Woodlands 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 Woodlands Hospital is a leading acute-care facility located in The Woodlands, Texas, serving a rapidly growing population in northern Greater Houston and the surrounding counties of Montgomery, Harris, Walker, and Trinity.

Since opening in 2003, The Woodlands Hospital has evolved into a regional hub for advanced specialty care and a trusted provider for families in both suburban and rural communities.

Key features include:

- 242 licensed beds and a full range of inpatient and outpatient services.
- Comprehensive cardiovascular, oncology, women's, and emergency services, including advanced stroke care and cardiac catheterization.
- The St. Luke's Health Cancer Center – The Woodlands, offering diagnosis, treatment, and survivorship programs in collaboration with community partners.
- Emergency Center – Springwoods Village, expanding access for residents in south Montgomery County and north Harris County.

Interdisciplinary teams focused on quality improvement, health equity, and patient safety. The Woodlands Hospital operates within the St. Luke's Health system, maintaining deep integration with academic and community partners to expand access to primary, specialty, and preventive care throughout the market.

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 27 ZIP codes encompassing communities across Montgomery, Harris, Walker, and Trinity counties. A summary description of the community is below, and additional details can be found in the CHNA report online.

This diverse and expanding suburban corridor includes a mix of master-planned neighborhoods, developing rural areas, and growing business districts that contribute to both opportunity and disparity in health outcomes.

Community Profile

- Total population: 1,056,000 residents
- Race/Ethnicity: 57% White, 29% Hispanic/Latino, 10.8% Black/African American, 4.9% Asian
- Median household income: \$91,983 (though poverty rates exceed 17% in several ZIP codes such as 77301 and 77306)
- Uninsured adults: 16.4% (above the national average)
- Education: Nearly 90% hold a high-school diploma or higher
- Housing burden: Up to 20% of households in parts of Harris County face severe housing problems
- Broadband access: Over 90% of households maintain an internet subscription, supporting telehealth and health-literacy outreach.

Despite many assets including robust hospital and clinic networks, faith-based and nonprofit organizations, and an engaged business community inequities persist.

Challenges such as transportation barriers, limited affordable health coverage, and disparities in preventive care and chronic-disease management continue to affect uninsured and low-income residents.

The hospital remains committed to partnering with local agencies, clinics, and community organizations to ensure that all residents, especially those in high-need ZIP codes have equitable opportunities to live healthy, thriving lives.

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 one of the leading causes of morbidity and mortality in the service area. Lower screening rates for colorectal, cervical, and prostate cancers contribute to late detection, particularly among uninsured, Latino, and African American residents.	•
Health Care Access & Quality	Many residents experience barriers to preventive and primary care due to lack of insurance, long wait times, and limited provider availability. These barriers result in higher preventable hospitalization rates and delayed diagnoses.	•
Heart Disease & Stroke	Cardiovascular disease continues to affect residents across age groups, with high rates of hypertension, hyperlipidemia, and stroke among the Medicare population. Disparities are more pronounced among Black /African American adults.	•
Mental Health	High levels of stress, depression, and anxiety were reported, with limited access to behavioral health services. Stigma and provider shortages remain major barriers.	
Older Adults	Seniors face challenges related to chronic disease management, fixed incomes, and isolation. Many lack affordable housing or transportation to care.	
Alcohol & Drug Use	Substance use and misuse were highlighted in focus groups but are being addressed by specialized community agencies and law enforcement partners.	

Significant Needs the Hospital Does Not Intend to Address

While The Woodlands Hospital recognizes the importance of all identified health issues, the hospital will focus resources on three priority areas Cancer, Health Care Access & Quality, and Heart Disease & Stroke to achieve measurable community impact and align with organizational expertise.

The remaining needs, including Mental Health, Older Adults, and Alcohol & Drug Use, are being addressed by partner organizations such as Tri-County Behavioral Health, Interfaith Community Clinic, Catholic Charities, and county public health agencies. The hospital will continue to collaborate with these partners as part of system-wide initiatives and community grantmaking efforts.

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 The Woodlands 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 The Woodlands' 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, The Woodlands Hospital identified Cancer, 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?

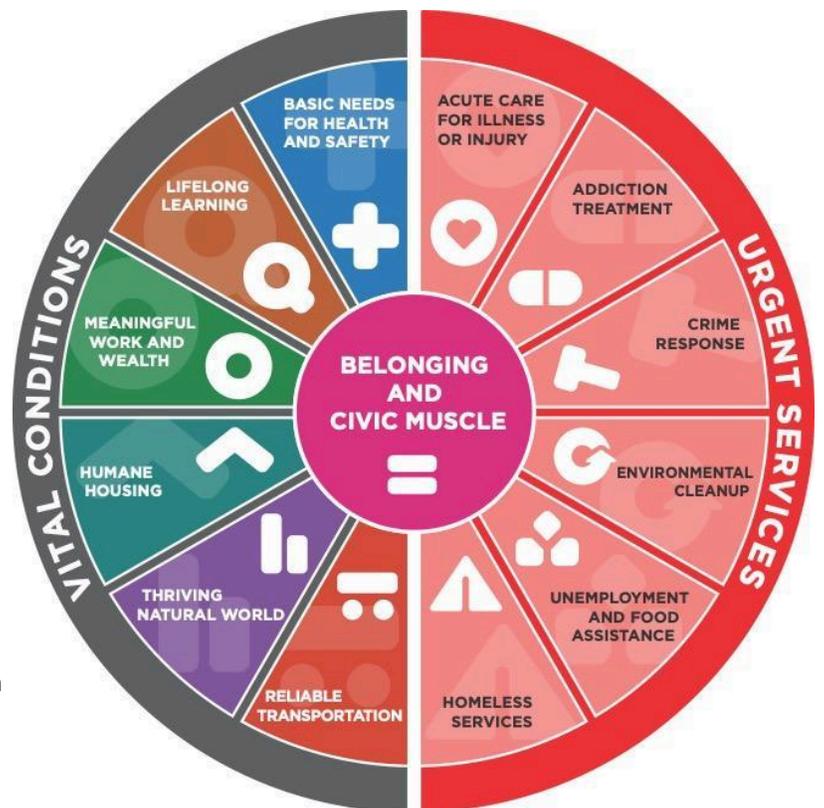
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

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