2025 Community Health Implementation Strategy and Plan

St. Luke's Health Memorial Lufkin Hospital

Adopted October 2025

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At-a-Glance Summary

Community Served

St. Luke's Health Memorial Lufkin serves residents of Angelina County and the surrounding tri-county region of Deep East Texas, including Lufkin (Angelina County), Livingston (Polk County), and San Augustine (San Augustine County).

This largely rural and semi-rural area is home to approximately 228,000 residents, with an estimated 151,000 in Lufkin's primary service area. The population is diverse about 63 percent White, 19 percent Black/African American, and 12 percent Hispanic/Latino and experiences significant socioeconomic variation. Roughly 13.6 percent of families live below the poverty level, and unemployment (7.4 percent) exceeds state and national rates. Barriers such as transportation, provider shortages, and health-literacy gaps contribute to inequities in access and 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:

- 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

- Partner with The Rose and other regional screening organizations to expand breast and cervical cancer screening for uninsured and underinsured women.
- Continue community education through The Mermaid Project and targeted prevention campaigns.
- Support mobile mammography and colon cancer screening outreach events in rural zip codes.

Health Care Access & Quality

- Enhance transportation navigation and resource-connection support for patients lacking reliable transit.
- Increase awareness of financial assistance programs and coverage enrollment options.

- Collaborate with Federally Qualified Health Centers (FQHCs) and local clinics to improve coordination of primary and specialty care.
- Advance telehealth utilization and digital-literacy education to overcome rural-access barriers.

Heart Disease & Stroke

- Offer community blood-pressure screenings and education through local health fairs and churches.
- Support stroke-response and prevention initiatives in partnership with EMS and regional cardiology practices.
- Provide chronic-disease self-management workshops and nutrition counseling, emphasizing early detection and control.

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, 1201 W. Frank Avenue, Lufkin, TX 75904, or by email to fawn.preuss@commonspirit.org

Our Hospital and the Community Served

About the Hospital

St. Luke’s Health Memorial Lufkin 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 hospital serves as a regional referral and acute care center for the residents of Angelina, Polk, and San Augustine Counties, offering a broad range of services to meet the needs of Deep East Texas.

Memorial Lufkin provides comprehensive inpatient and outpatient services including:

- Cancer care and infusion services
- Cardiology and cardiovascular surgery
- Neurology and stroke care
- Women’s and children’s services
- Surgical and imaging services
- Rehabilitation and emergency medicine

The hospital’s medical staff includes skilled physicians, nurses, and allied health professionals dedicated to improving access to care and advancing health equity in rural communities. As part of the larger St. Luke’s Health system, Memorial Lufkin collaborates with sister hospitals in Livingston and San Augustine to strengthen the continuum of care, expand specialty access, and support the region’s preventive and community health priorities.

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 Memorial Lufkin serves a tri-county region of East Texas Angelina, Polk, and San Augustine Counties representing a mix of rural and semi-rural communities. A summary description of the community is below, and additional details can be found in the CHNA report online.

The hospital's primary service area includes 10 ZIP codes in and around Lufkin, home to approximately 151,000 residents. The broader tri-county service area totals about 228,000 people.

Community Profile

- Population: 151,079 (Lufkin service area)
- Race/Ethnicity: 63 % White, 19 % Black/African American, 12 % Hispanic/Latino
- Poverty Rate: 13.6 % of families live below the poverty level
- Unemployment: 7.4 % (higher than state and national averages)
- Education: 83 % high-school graduates or higher
- Insurance: Adults insured – 74.6 %; Children insured – 91.8 %

The community faces persistent health and social challenges, including high rates of chronic disease, limited public transportation, provider shortages, and gaps in health literacy and broadband access. Despite these barriers, the region benefits from strong partnerships among local health departments, federally qualified health centers, schools, and faith-based organizations working to promote prevention, wellness, and equitable access to 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	High cancer incidence rates, low screening participation, and disparities in preventive care particularly for colon, breast, and cervical cancer. Barriers include cost, health literacy, and access to local oncology services.	●
Health Care Access & Quality	Persistent barriers to affordable, high-quality care including low insurance coverage, workforce shortages, and transportation challenges. Higher preventable hospitalization rates and delayed diagnoses highlight unmet needs.	●
Heart Disease & Stroke	High prevalence of hypertension, ischemic heart disease, and stroke, particularly among older adults and Black/African American residents. Contributing factors include limited access to specialists, cost of medication, and lifestyle risks.	●
Maternal & Infant Health	Disparities in prenatal care and postpartum support; limited culturally competent maternal education and language-access resources for uninsured and undocumented mothers.	
Mental Health	High rates of depression and Alzheimer's disease in the Medicare population; limited access to	

Significant Health Need	Description	Intend to Address?
	local behavioral health providers and teletherapy options.	
Wellness & Lifestyle	Poor physical health scores, obesity, insufficient sleep, and low physical activity levels driven by poverty, environment, and health-literacy gaps.	

Significant Needs the Hospital Does Not Intend to Address

The hospital acknowledges the importance of Maternal & Infant Health, Mental Health, and Wellness & Lifestyle to the overall well-being of the community. However, these areas will not be directly addressed within this Implementation Strategy due to:

- Limited hospital-based resources and specialized staffing in these areas,
- The presence of community partners and local agencies (such as WIC, and regional health providers) already addressing these needs, and
- The intent to focus hospital resources where they can have the greatest measurable impact and alignment with clinical expertise.

The hospital will continue to support community-led initiatives and partnerships that advance mental wellness, maternal health, and preventive lifestyle programming across the region.

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 Memorial Lufkin 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 Memorial Lufkin'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, Memorial Lufkin 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 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.

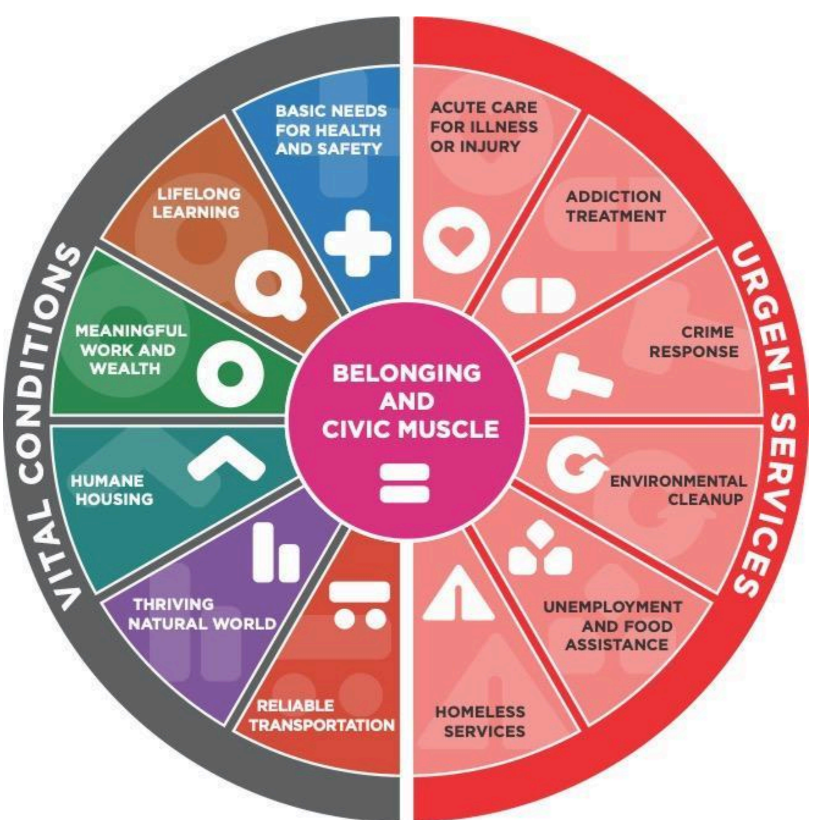
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of 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 and underinsured residents; Medicaid beneficiaries; older adults; rural and transportation-limited populations.				
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)**
The Rose Partnership – Breast & Cervical Screening Expansion	• Continue partnership with *The Rose* to provide free or reduced-cost mammograms and diagnostic follow-up for uninsured and underinsured women. • Host quarterly mobile mammography events across Angelina, Polk, and San Augustine Counties. • Provide bilingual navigation support for screening appointments.	●	●		US
Rural Cancer Outreach & Screening Days	• Partner with local clinics, faith-based organizations, and county health departments to host screening days for colon, lung, and prostate cancers. • Distribute educational materials on healthy living and tobacco cessation. • Track participation and follow-up diagnostic referrals.	●		●	VC
Planned Resources:	Hospital Community Health team, Oncology Service Line, Mission & Spiritual Care, mobile screening partners, and marketing support.				
Planned Collaborators:	The Rose, Burke Center, local FQHCs, Angelina County Health District, faith-based coalitions, and regional public health programs.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase preventive screening rates and early-stage diagnoses for breast, cervical, and colon cancer.	# of individuals screened through mobile and clinic events	Program records / partner reports
	% of screenings with completed diagnostic follow-up	Hospital and partner tracking data

Health Need:	**Health Care Access & Quality**				
Population(s) of Focus:	Uninsured and underinsured residents; Medicaid beneficiaries; older adults; rural and transportation-limited populations.				
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)**
Transportation & Resource Navigation Program	• Provide transportation vouchers and ride-share coordination to medical appointments. • Offer community health worker (CHW) navigation to connect patients with Medicaid, SNAP, and charity-care programs. • Monitor reduction in missed appointments.	●		●	VC: Reliable Transportation US: Urgent Access to Care
Coverage & Financial Assistance Outreach	• Expand community awareness of hospital financial-assistance policies and public coverage enrollment. • Deploy bilingual materials and navigator staff at community events. • Track application volume and approvals.	●	●		VC: Basic Needs for Health & Safety US: Financial Relief
Connected Care & Telehealth Access	• Increase utilization of telehealth and remote monitoring for patients in rural zip codes. • Provide digital-literacy training and loaner devices through partnerships with libraries and community centers. • Evaluate user satisfaction and reduction in preventable hospitalizations.		●	●	VC: Technology for Health US: Continuity of Care

Health Need:	**Health Care Access & Quality**
Planned Resources:	Mission & Community Health staff, Patient Financial Services, IT and telehealth teams, marketing, and grant support.
Planned Collaborators:	Burke Center, FQHCs, Area Agency on Aging, local church coalitions, Angelina County Health District, and Conduent HCI.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve health-care access for uninsured and rural residents; reduce preventable hospital stays and readmissions; enhance continuity of care.	# of patients assisted with transportation or coverage enrollment	Navigator logs / CHW reports
	Preventable hospitalization rate (Medicare population)	Hospital quality data / CMS measures

Health Need:	**Heart Disease & Stroke**				
Population(s) of Focus:	Older adults, low-income and minority populations, individuals with hypertension or diabetes, and rural residents with limited specialist access.				
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 & Stroke Screenings and Education Events	• Conduct free blood-pressure, cholesterol, and stroke-risk screenings at health fairs and faith-based sites. • Provide education on medication adherence and emergency response signs. • Refer participants to primary care or cardiology services as needed.	●		●	VC: Basic Needs for Health & Safety US: Preventive Health Services
Chronic-Disease Self-Management Workshops	• Offer six-week Stanford model workshops for adults with heart disease or hypertension. • Facilitate peer support and goal-setting. • Measure pre/post self-efficacy and hospital utilization changes.		●	●	VC: Meaningful Work & Wealth US: Chronic-Care Support
Stroke Response and Prevention Collaboration	• Partner with EMS and regional stroke centers to strengthen rapid-response systems and public awareness. • Conduct education for staff and community on BE FAST signs. • Track door-to-treatment times and outcomes.	●	●		VC: Civic Muscle & Public Safety US: Emergency Response

Health Need:	**Heart Disease & Stroke**
Planned Resources:	Cardiology and Rehabilitation Departments, Mission & Spiritual Care, Community Health team, nursing staff, and marketing support.
Planned Collaborators:	Burke Center, American Heart Association, local EMS and fire departments, faith-based organizations, schools, and senior centers.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Reduce heart-disease and stroke mortality rates	# of community screenings and participants	Event logs / partner records
Increase early detection and self-management capacity among high-risk populations; strengthen care continuum for cardiac patients.	Change in age-adjusted heart-attack and stroke mortality rates	County Health Rankings / state vital statistics