
# 2025 Community Health Needs Assessment

**Report adopted by Hospital Advisory Board May 2025**

St. Luke's Health™

A member of CommonSpirit

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# Community Health Needs Assessment – At a Glance

## Data Analysis Overview

Secondary Data
Topic score of 1.50 or higher

Listening Sessions
Frequency topic was discussed during interviews

Community Partner Survey
Selected by 20% or more of respondents as a priority health issue

**Secondary data**, or numerical health indicators, from HCI's 200+ community indicator database, were analyzed and scored based on their values.

Listening Sessions were conducted with **over 60 community groups , organizations, and hospital leaders** that represent the broad demographics or underserved populations in the community.

The Community Partner Survey was distributed across the region to gather quantitative data regarding community-serving organizations and their views on the health needs within the service area.

## Prioritized Significant Health Needs

Cancer

Maternal/Infant Health

Health Care Access & Quality

Mental Health

Heart Disease & Stroke

Wellness & Lifestyle

St. Luke's Health Memorial – Lufkin

*Topic scores reflect the relative severity of issues based on standardized data; a score of 1.50 or higher indicates a higher-than-average concern compared to state or national benchmarks.

# Executive Summary

## Introduction & Purpose

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by St. Luke's Health Memorial Lufkin. The priorities identified in this report guide the hospital's community health improvement programs, community benefit activities, and collaborative efforts with other organizations sharing the mission to improve community health. This CHNA meets the requirements of the Patient Protection and Affordable Care Act, mandating not-for-profit hospitals to conduct a CHNA at least every three years.

## CommonSpirit Health Commitment and Mission Statement

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission.

### Our Mission

As a member of 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.

### Our Vision

A healthier future for all—inspired by faith, driven by innovation, and powered by our humanity.

### Our Values

- **Compassion**: Care with listening, empathy, and love; accompany and comfort those in need of healing.
- **Inclusion**: Celebrate each person's gifts and voice; respect the dignity of all.
- **Integrity**: Inspire trust through honesty; demonstrate courage in the face of inequity.
- **Excellence**: Serve with fullest passion, creativity, and stewardship; exceed expectations of others and ourselves.
- **Collaboration**: Commit to the power of working together; build and nurture meaningful relationships.

## CHNA Collaborators

St. Luke's Health Memorial Lufkin collaborated with various community organizations, local health departments, and healthcare providers. Conduent Healthy Communities Institute (HCI) was contracted to facilitate data collection, analysis, and community engagement efforts.

## Community Definition

The community served by St. Luke's Health–Memorial Hospital encompasses the tri-county region of Lufkin (Angelina County), Livingston (Polk County), and San Augustine (San Augustine County) in Deep East Texas. This region reflects a mix of rural and semi-rural communities with significant variations in socioeconomic status, healthcare access, and health outcomes.

The defined service area includes 20 zip codes, identified based on hospital utilization and community impact. These zip codes represent the primary geographic areas where the hospital provides essential medical services, community health programming, and preventive care.

## Process and Criteria to Identify and Prioritize Significant Health Needs

Health needs were prioritized based on magnitude and community impact, considering secondary data indicators, stakeholder input, and collaborative discussions. The process involved a comprehensive review of the available data, alongside surveys and input from key stakeholders, including healthcare professionals, community leaders, and residents. This collaborative approach ensured that diverse perspectives were considered, leading to a well-rounded understanding of the community's most pressing health concerns.

Upon identifying the significant health needs, the team categorized them into themes such as chronic disease prevention, mental health support, access to healthcare services, and health education. Each category was then evaluated to determine its potential impact on the community's overall well-being and its alignment with the hospital's mission and resources.

The prioritization process also considered the feasibility of addressing these needs, considering available resources, potential partnerships, and existing community initiatives. By aligning efforts with ongoing programs and leveraging partnerships, St. Luke's Health-Memorial Lufkin aims to maximize the effectiveness of its community health improvement strategies.

As a result, the prioritized health needs will guide the development of targeted interventions and programs designed to address gaps in care and improve health outcomes for all community members, particularly those who are most vulnerable. These efforts are intended to foster a healthier, more resilient community, where everyone has the opportunity to thrive.

## List of Prioritized Significant Health Needs

Health needs were ranked based on their significance and potential impact on the community. This prioritization process incorporated a comprehensive review of secondary data indicators, insights gathered through stakeholder interviews and focus groups, and collaborative discussions with community partners. The resulting list of prioritized needs reflects both the prevalence and urgency of issues affecting the population.

The identified priority health needs include:

Cancer | Health Care Access & Quality | Heart Disease & Stroke | Maternal/ Infant Health | Mental Health | Wellness & Lifestyle

Each of these areas represent a significant concern that affects health outcomes and quality of life for residents across the defined community. More detailed data, justification for prioritization, and summaries of community input are provided in subsequent sections of this report. Additional data tables, methodology details, and community input documentation are available in the appendices.

## Resources Potentially Available

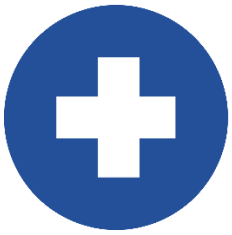
Text goes here

## Report Adoption, Availability and Comments

This CHNA report was adopted by the St. Luke's Health-Memorial Lufkin advisory board in June 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at the hospital's Mission and Spiritual Care Office. Written comments on this report can be submitted to the Mission and Spiritual Care Office, 1201 W Frank Ave, Lufkin, TX 75904 or by e-mail to fawn.preuss@commonspirit.org.

# Looking Back: Evaluation of Progress since prior CHNA

Between FY22 and FY24, St. Luke's Health Memorial Hospitals in Lufkin, Livingston, and San Augustine implemented strategic actions outlined in their 2022 Implementation Strategy. Efforts centered on improving access to care, managing chronic diseases, expanding mental health services, promoting preventive practices, and strengthening community partnerships. These initiatives addressed longstanding barriers to community health and contributed to measurable improvements across those communities.



### Access to Care

- Lufkin: 5,818 individuals assisted; $545,439 in aid.
- Support for Uninsured/Underinsured
- Over 3,000 individuals supported through screenings and program enrollments
- Collaborated with Burke Center and local health districts

### Transportation & Navigation Support

- Promoted Medicaid transportation options in San Augustine.
- Partnered with agencies to ensure medical appointment access

### Chronic Disease Management

- Delivered educational sessions on chronic conditions
- Hosted free community health screenings
- Cancer Prevention
- Expanded lung cancer screenings in Lufkin
- Continued The Mermaid Project for uninsured women

### Mental Health & Behavioral Health Screenings and Counseling Access

- Increased services in collaboration with Burke Center
- Substance Use and Recovery
- Supported community-based addiction recovery initiatives.
- Suicide Prevention
- Delivered education with local churches and health departments

**Preventive Practices & Outreach Health Fairs & Immunizations**

- Hosted flu shot clinics and educational events.
- Provided screenings for diabetes, heart disease, and cancer.
- Health Education & Workforce Training
- Supported clinical rotations for students in nursing and allied health.
- Invested in health professional training for long-term impact.

**Community Investments & Special Programs**

- Burke Center: $64,209 for mental health services
- The Rose: $20,000 for breast cancer screenings across all 3 hospitals
- Cash Donations & Sponsorships
- Lufkin: $18,110 to local causes and events
- Human Trafficking Education
- Delivered training to hospital staff in collaboration with state advocacy groups.

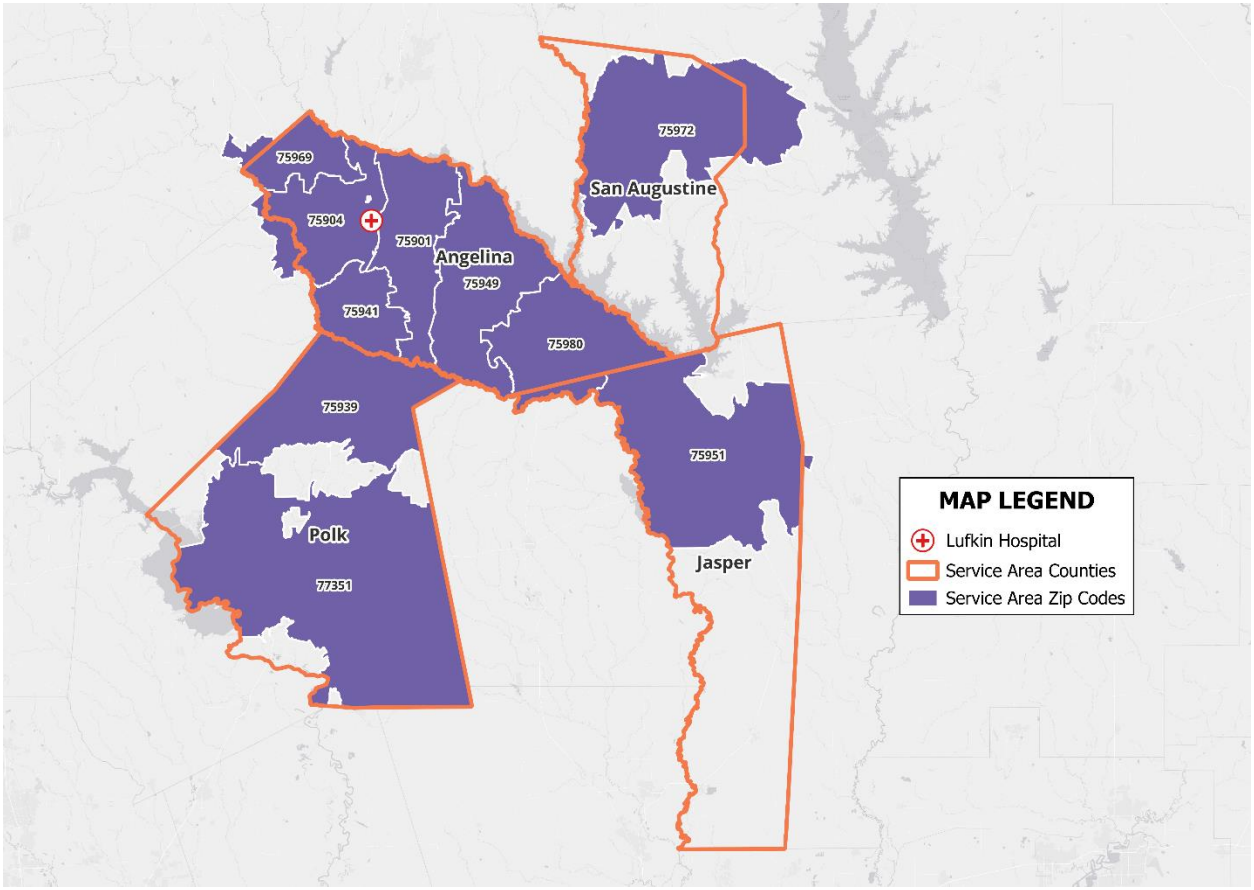
# Defining the Community

The community served by St. Luke's Health–Memorial Hospital encompasses the tri-county region of Lufkin (Angelina County), Livingston (Polk County), and San Augustine (San Augustine County) in Deep East Texas. This region reflects a mix of rural and semi-rural communities with significant variations in socioeconomic status, healthcare access, and health outcomes.

This three-county area is home to over 228,000 residents, with Lufkin representing the largest population at approximately 150,000 individuals. The demographic composition includes predominantly White populations, but each county also has a significant number of Black/African American residents, along with Hispanic/Latino communities.

A complete list of zip codes included in this assessment is available in the Appendix, and demographic indicators such as poverty levels, racial/ethnic composition, insurance coverage, and community health index scores are detailed in the Core Demographics section of the report.

FIGURE 1. MEMORIAL LUFKIN SERVICE AREA



# Demographic Profile

## Geography and Data sources

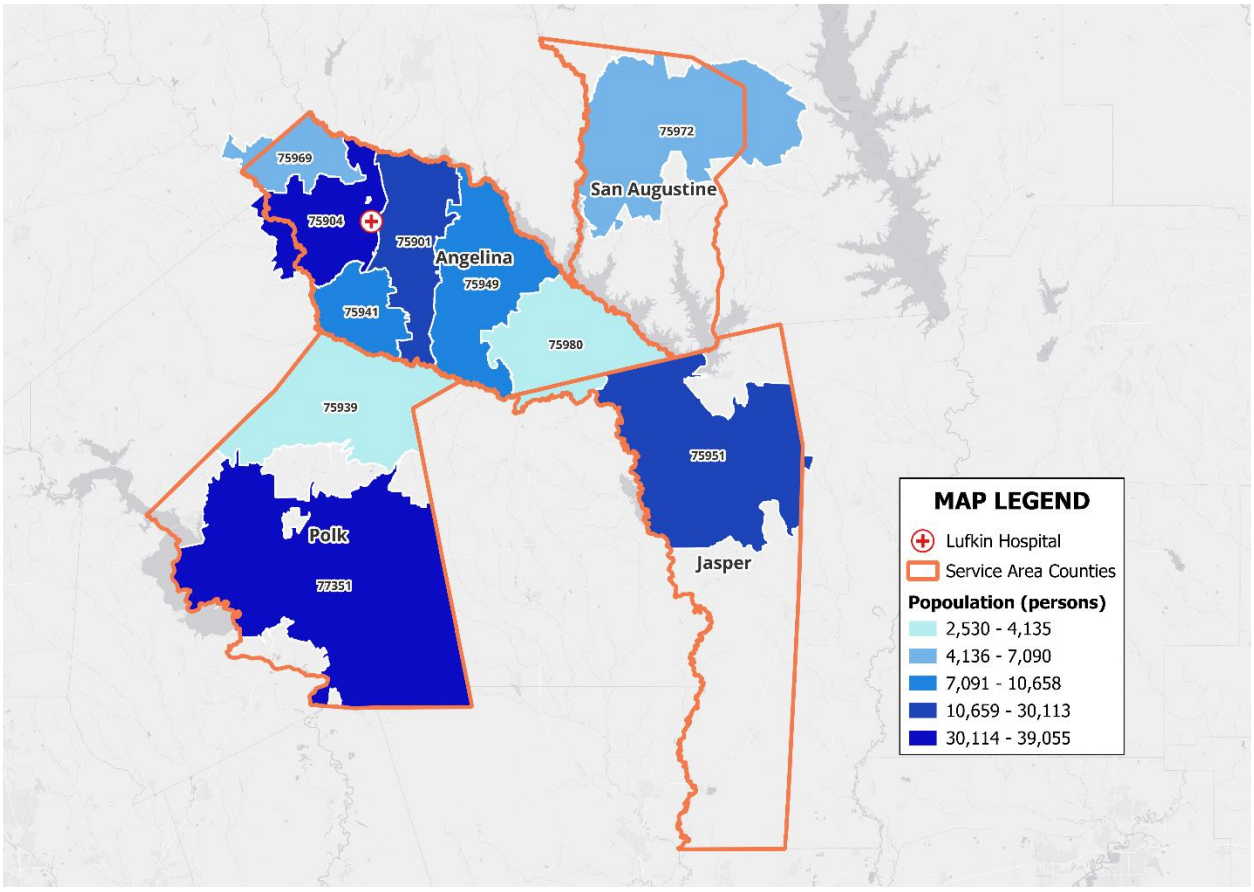
The following section explores the demographic profile of the St. Luke's Health-Memorial Lufkin primary service area, which includes 10 zip codes in and around Angelina County. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

Unless otherwise indicated, all demographic estimates are sourced from Claritas® (2024 population estimates). Claritas demographic estimates are primarily based on U.S. Census and American Community Survey (ACS) data. Claritas uses proprietary formulas and methodologies to calculate estimates for the current calendar year.

## Population

The Lufkin Memorial Hospital primary service area has an estimated population of 151,079 persons. Figure 2 shows the population breakdown for the service area by zip code.

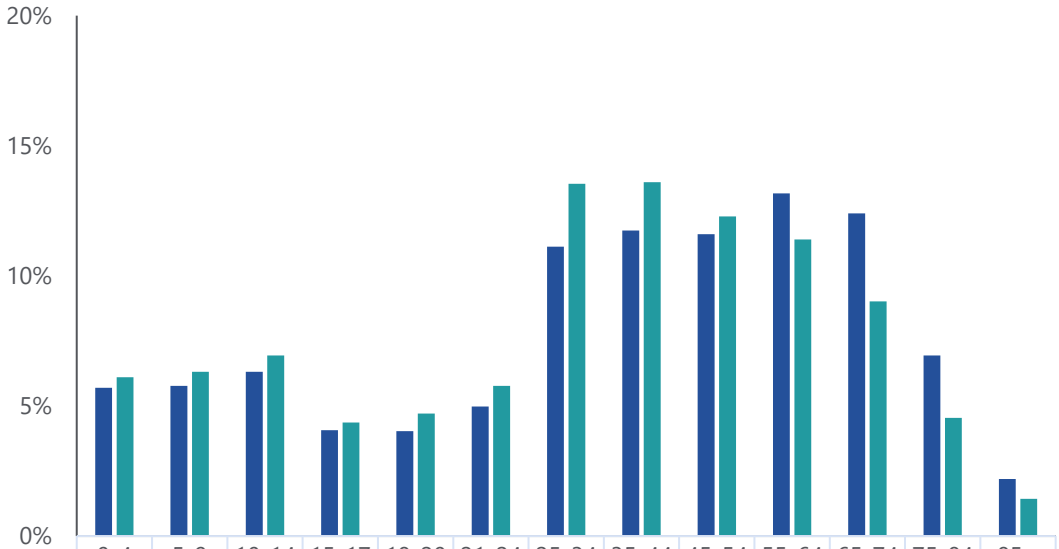
FIGURE 2. MEMORIAL LUFKIN PRIMARY SERVICE AREA POPULATION DISTRIBUTION BY ZIP CODE



## Age

Figure 3 shows the population of Lufkin's primary service area broken down by age group, with comparisons to the state-wide Texas population. Overall, the age distribution of Lufkin is slightly older than the state-wide Texas population. Most of the population is between 25 and 74 years old.

FIGURE 3. POPULATION BY AGE: MEMORIAL LUFKIN SERVICE AREA

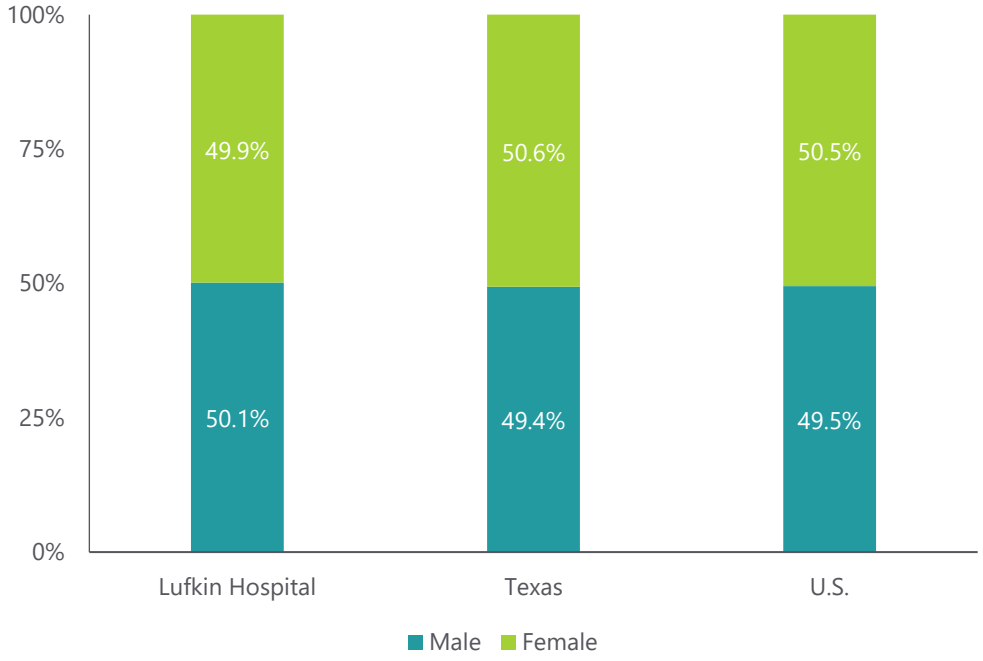



| | 0-4 | 5-9 | 10-14 | 15-17 | 18-20 | 21-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | 85+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Lufkin Hospital | 5.7% | 5.8% | 6.3% | 4.1% | 4.0% | 5.0% | 11.1% | 11.7% | 11.6% | 13.2% | 12.4% | 6.9% | 2.2% |
| Texas | 6.1% | 6.3% | 6.9% | 4.4% | 4.7% | 5.8% | 13.5% | 13.6% | 12.3% | 11.4% | 9.0% | 4.5% | 1.4% |

## Sex

As seen in Figure 4, 49.9% of the Lufkin Memorial Hospital population is female, which is similar to both state and national populations (50.6% and 50.5%, respectively).

FIGURE 4. POPULATION BY SEX: COUNTY, STATE, AND U.S. COMPARISONS



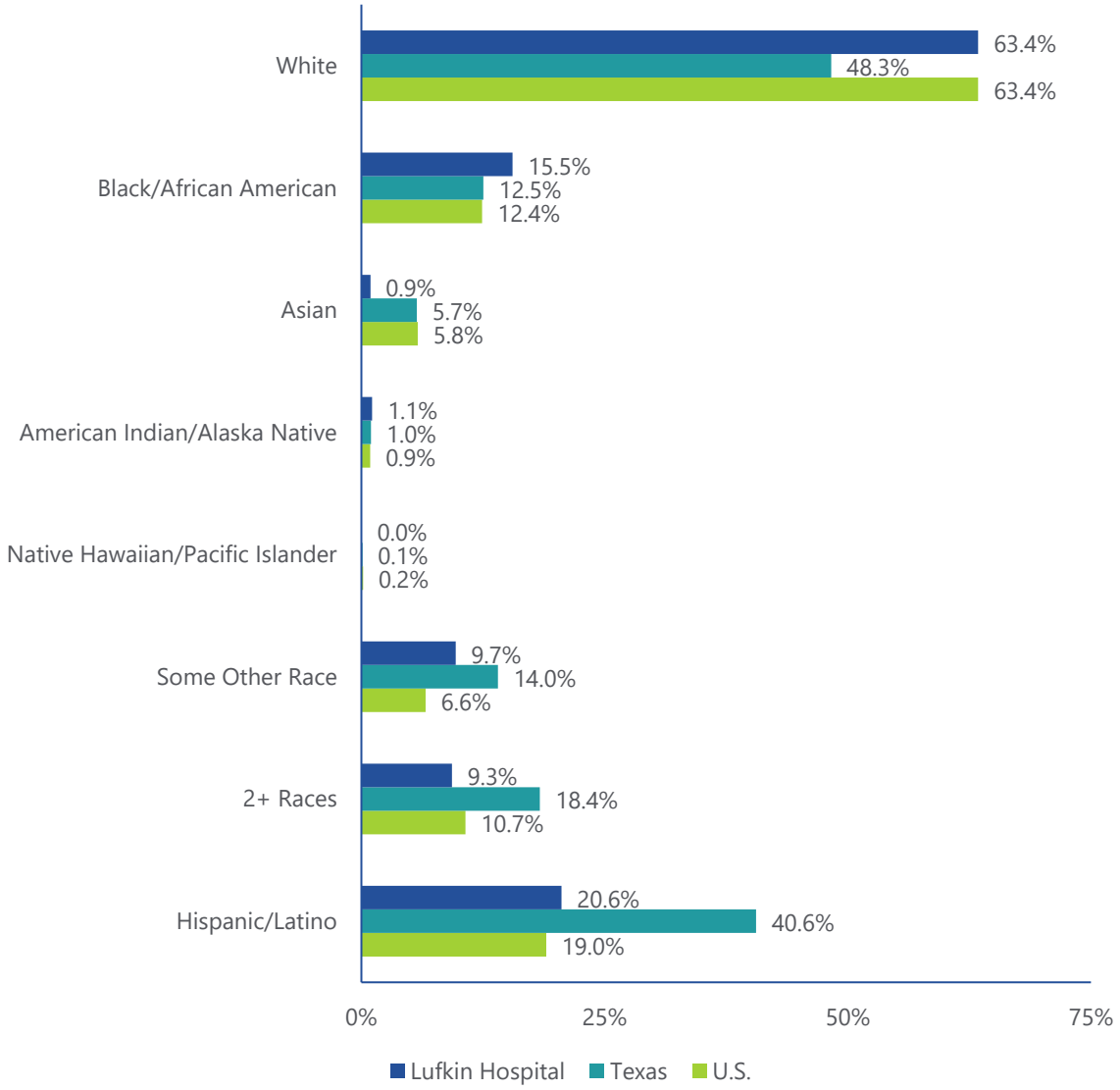

*U.S. value taken from American Community Survey (2019-2023)*

## Race and Ethnicity

Considering the racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

The Lufkin Memorial Hospital primary service area has a racially and ethnically diverse population. Lufkin has a higher percentage of Black/African American residents than statewide and nationwide populations. The majority of the population identifies as White (63.4%).

FIGURE 5. POPULATION BY RACE AND ETHNICITY



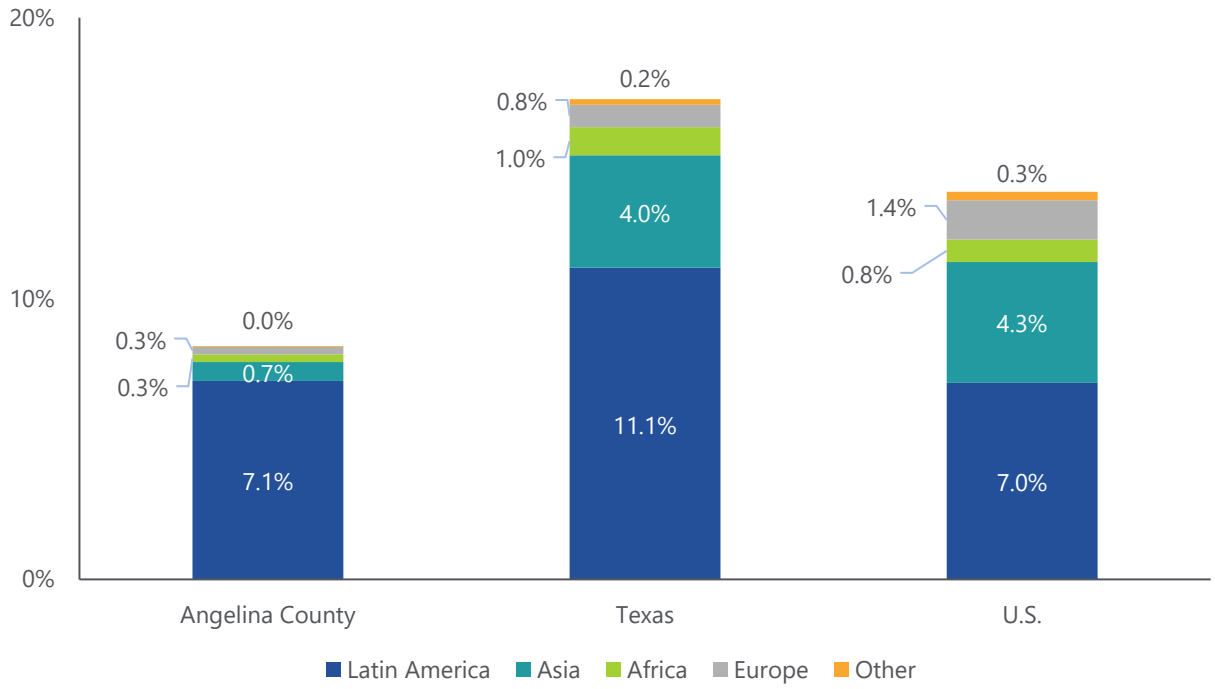

*U.S. value taken from American Community Survey (2019-2023)*

## Language and Immigration

Understanding countries of origin and difficulty in speaking language can help inform the cultural and linguistic context. According to the American Community Survey, 8.4% of residents in Amgelina County are born outside the U.S., which is lower than the state value (17.2%) and national value (13.9%).

Figure 6 provides a breakdown of region of birth for any persons born outside the country.

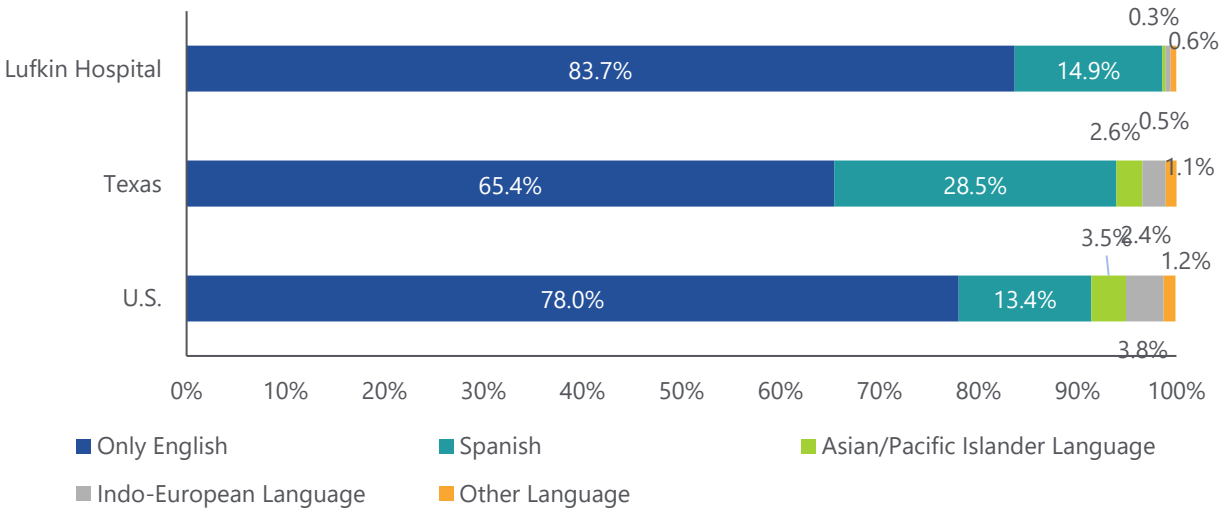
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY




*County, State, and U.S. values taken from American Community Survey (2019-2023)*

As shown in Figure 7, the majority of residents in the Lufkin Memorial Hospital primary service area (83.7%) speak a language other than English at home. The Lufkin population is more likely than the nation-wide population to speak Spanish (14.9% vs. 13.4%).

FIGURE 7. POPULATION AGE 5+ BY LANGUAGE SPOKEN AT HOME

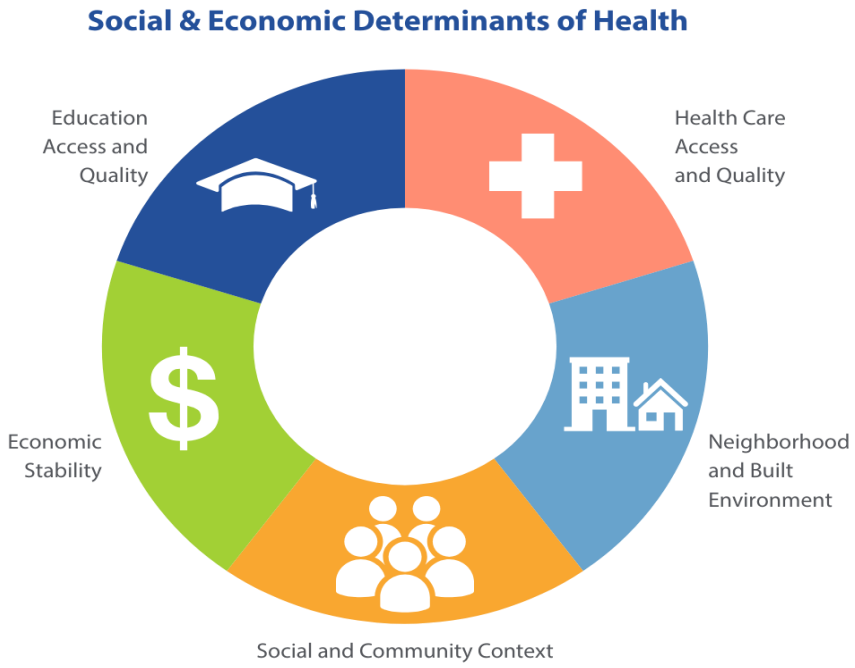



*U.S. value taken from American Community Survey (2019-2023)*

# Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Lufkin Memorial Hospital primary service area. Social Determinants of Health (SDOH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The SDOH can be grouped into five domains. Figure 8 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022).

FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH

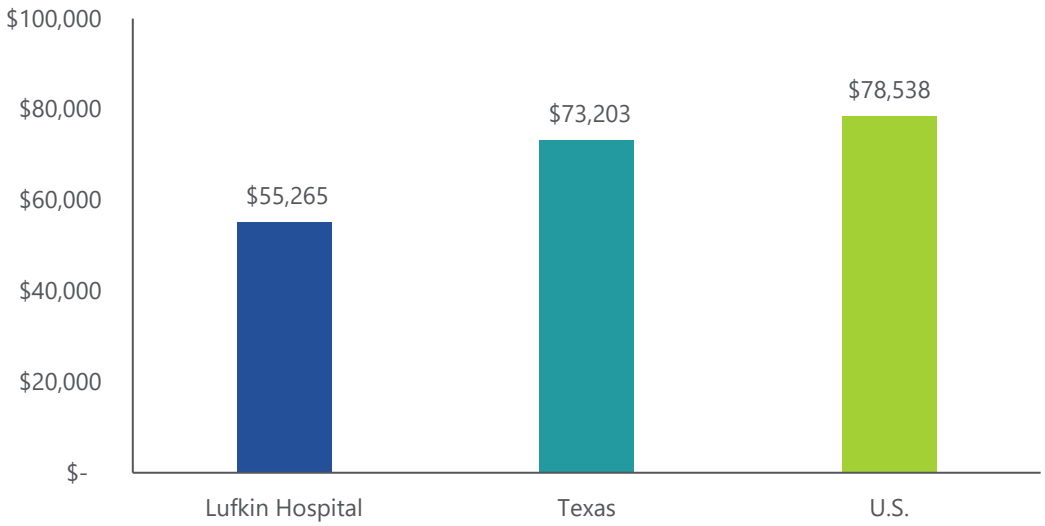


## Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.

Figure 9 provides the median household income in the service area, compared to the state and nation.

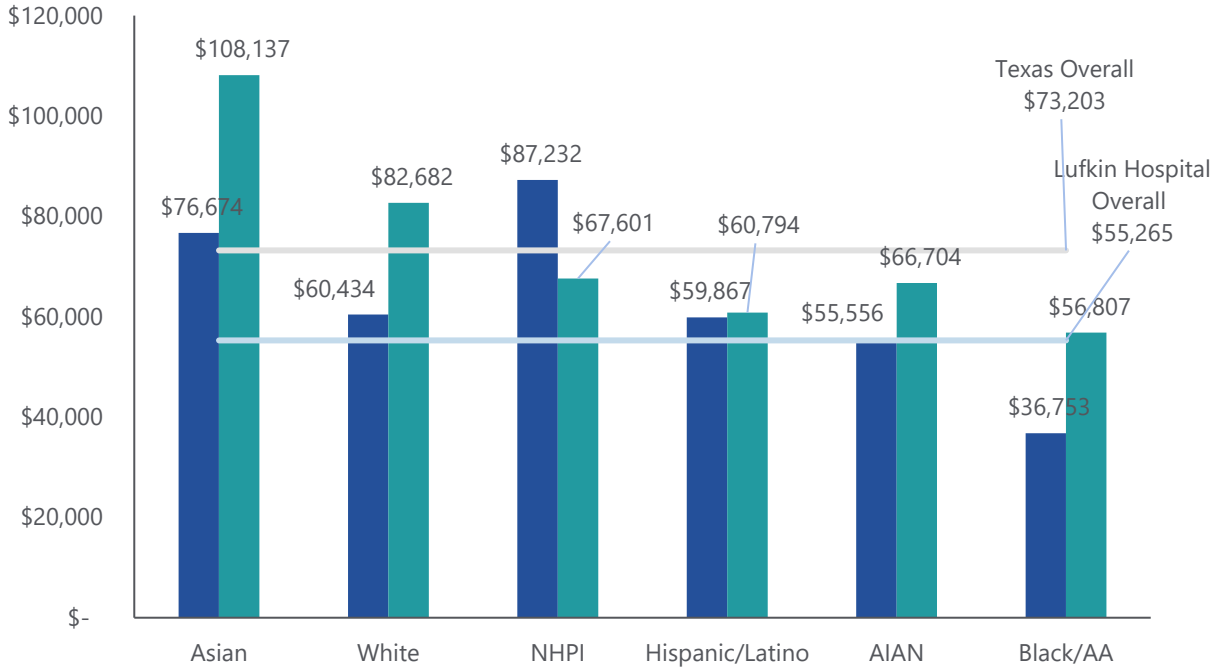
FIGURE 9. MEDIAN HOUSEHOLD INCOME BY: COUNTY, STATE AND U.S. COMPARISONS




*U.S. value taken from American Community Survey (2019-2023)*

Disparities in median household income exist between racial and ethnic groups within the county. As shown in Figure 10, the Black/African American median income is more than $18,000 lower than the overall median income ($36,753 vs. $55,265).

FIGURE 10. MEDIAN HOUSEHOLD INCOME BY RACE & ETHNICITY

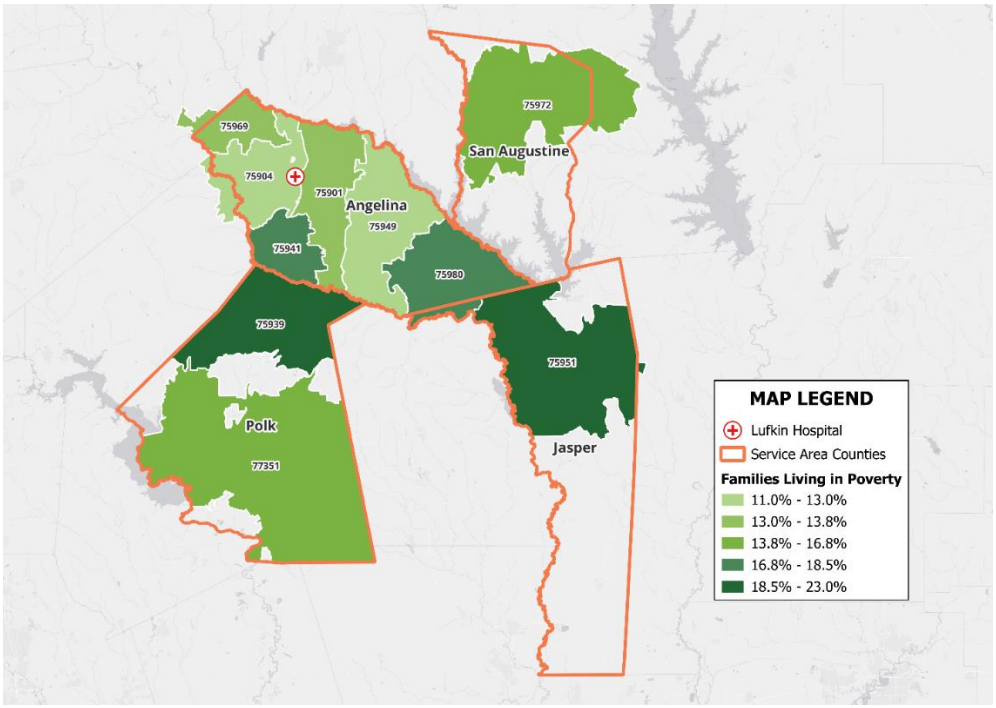


## Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[1]

Overall, 13.6% of families in the Lufkin Hospital primary service area live below the poverty level, which is higher than the state value of 11.0% and the national value of 8.7%. The map in Figure 11 shows the percentage of families living below the poverty level by zip code. The darker green colors represent a higher percentage of families living below the poverty level.

FIGURE 11. PERCENT OF FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE




The percentage of families living below poverty for each zip code in the service area is provided in Table 1. The zip code with the highest concentration of poverty is 75951 (23.0%) and the lowest concentration of poverty is in 75949 (11.0%).

[1] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

TABLE 1. FAMILIES LIVING IN POVERTY: LUFKIN PRIMARY SERVICE AREA

| Zip Code | % Families in Poverty | Zip Code | % Families in Poverty |
|---|---|---|---|
| 75951 | 23.0% | 77351 | 13.9% |
| 75939 | 18.6% | 75969 | 13.6% |
| 75980 | 18.5% | 75901 | 13.4% |
| 75941 | 17.5% | 75904 | 11.1% |
| 75972 | 16.4% | 75949 | 11.0% |

## Employment

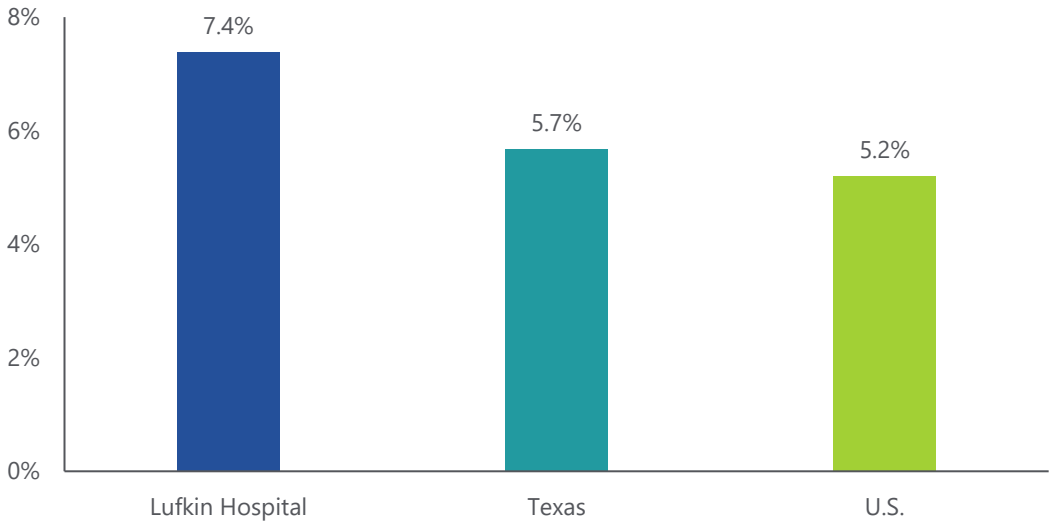
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[2]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[2] Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[2]

Figure 12 shows the population aged 16 and over who are unemployed. The unemployment rate for the Lufkin Hospital primary service area is 7.4%, which is higher than both the state-wide and nation-wide unemployment rates (5.7% and 5.2%, respectively).

[2] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment

FIGURE 12. POPULATION 16+ UNEMPLOYED: COUNTY, STATE, AND U.S.



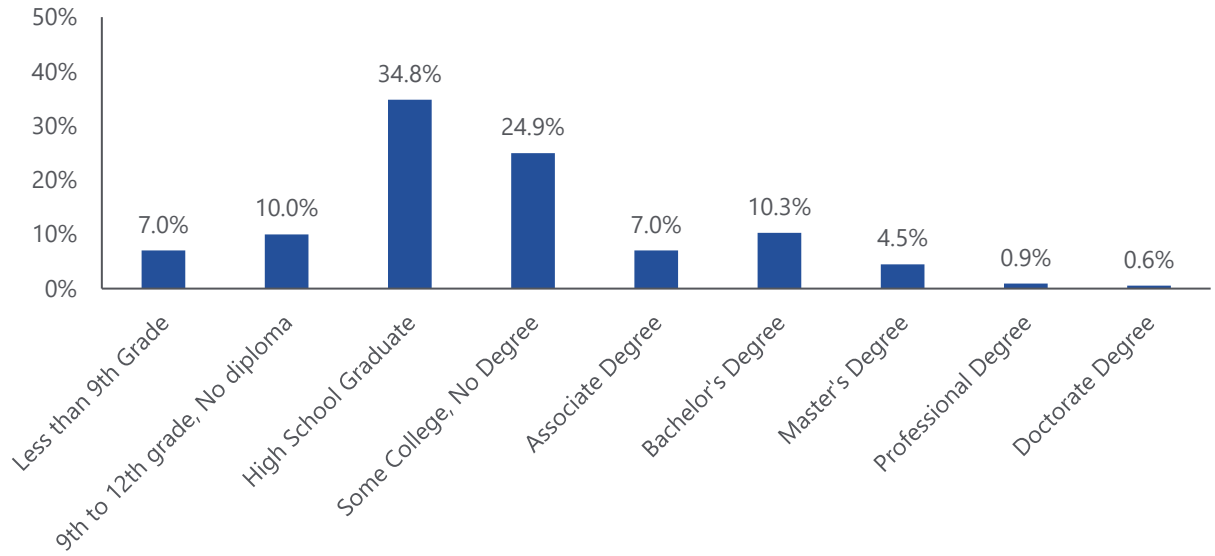

*U.S. value taken from American Community Survey (2019-2023)*

## Education

Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. A high school diploma in particular is a requirement for many employment opportunities, and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[3] Further, people with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[4]

Figure 13 shows the detailed breakdown of the Lufkin Hospital primary service area by educational attainment, among those aged 25 and up. As shown in Figure 14, most of the Lufkin population has a high school diploma or higher (83.0%), although this is somewhat lower than both the state-wide and nation-wide rates (85.1% and 89.4%, respectively).

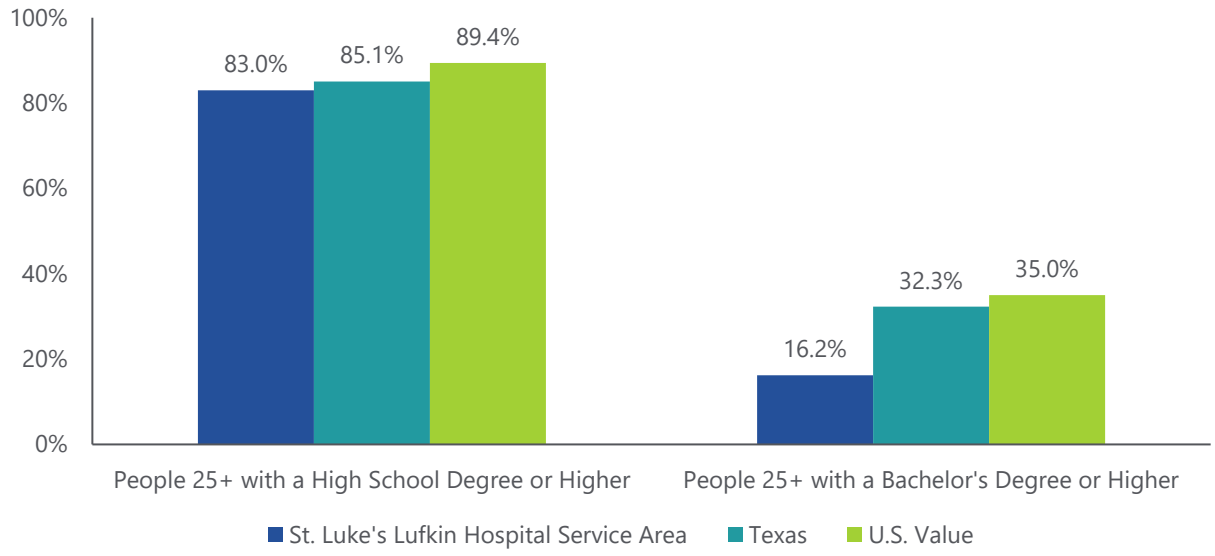
FIGURE 13. LUFKIN HOSPITAL PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+




[3] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health

[4] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/educationmatters-for-health.html

FIGURE 14. POPULATION 25+ BY EDUCATIONAL ATTAINMENT



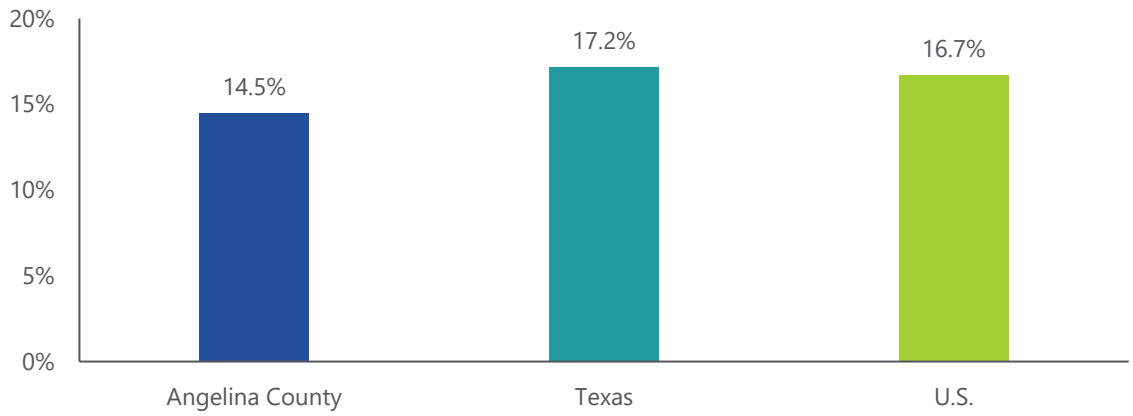

*U.S. value taken from American Community Survey (2019-2023)*

## Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[5]

As shown in Figure 15, 14.5% of households in Angelina County have severe housing problems, indicating that they have at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. This is lower than both the state-wide and nation-wide rates (17.2% and 16.7%, respectively).

FIGURE 15. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



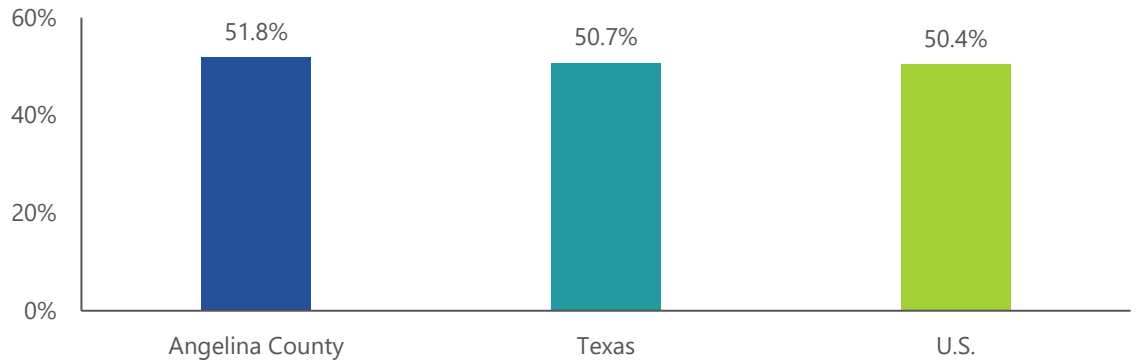

*County, State, and U.S. values taken from County Health Rankings (2016-2020)*

[5] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[6]

Figure 16 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Angelina County (51.8%) is slightly higher than both the state value (50.7%) and the national value (50.4%).

FIGURE 16. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT: COUNTY, STATE, AND U.S. COMPARISONS




*County, State, and U.S. values taken from American Community Survey (2019-2023)*

## Neighborhood and Built Environment

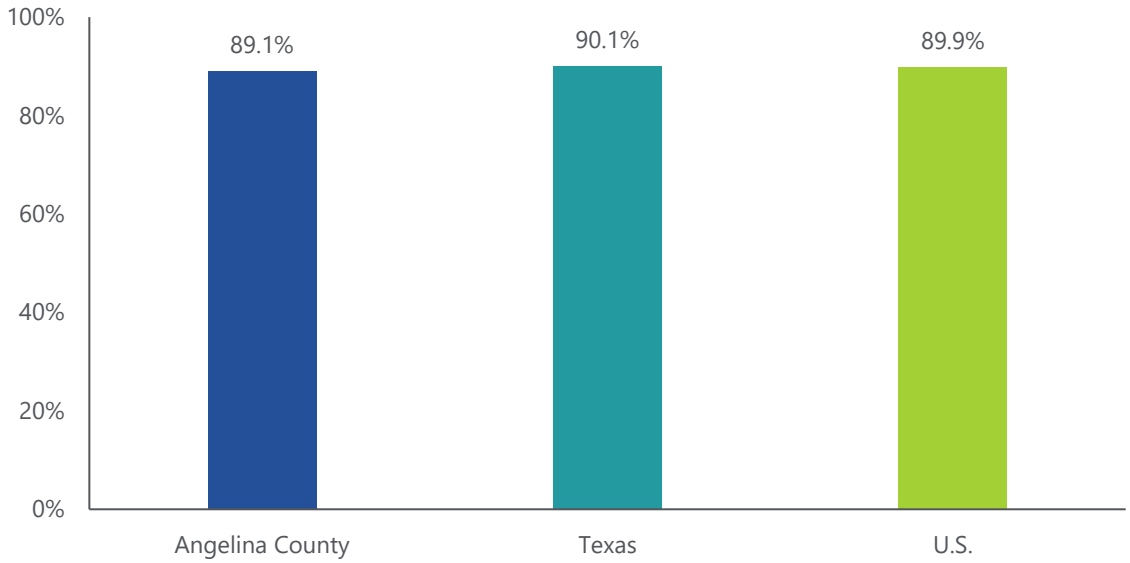
Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet also helps expand healthcare access through home-based telemedicine services, which has been particularly critical during the COVID-19 pandemic.[7] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[7]

Figure 17 shows the percentage of households that have an internet subscription. The rate in Angelina County (89.1%) is slightly lower than both the state value (90.1%) and the national value (89.9%).

[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

[7] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

FIGURE 17. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION




*County, State, and U.S. values taken from American Community Survey (2019-2023)*

# Primary and Secondary Data Methodology and Key Findings

St. Luke's Health-Memorial Lufkin employed a mixed-methods approach that integrated both quantitative (secondary) data and qualitative (primary) input to create a comprehensive picture of health needs, disparities, and opportunities for community improvement. This approach ensures that health priorities are informed not only by statistical trends but also by the lived experiences and perspectives of the community.

Quantitative Data: Secondary Sources

Secondary data analysis provided measurable insights into health status, social determinants of health, and system performance across the community. Sources included national, state, and local public health databases, as well as internal hospital data. The Healthy Communities Institute database was leveraged with over 200 indicators in both health and quality of life topic areas for the Secondary Data Analysis of the Health Service Area. Key Indicators analyzed include:

| Quality of Life | Health | |
|---|---|---|
| **Community** | Adolescent Health | Men's Health |
| **Economy** | Alcohol & Drug Use | Mental Health & Mental Disorders |
| **Education** | Cancer | Older Adults |
| **Environment** | Children's Health | Oral Health |
| **Transportation** | Diabetes | Prevention & Safety |
| | Disabilities | Physical Activity |
| | Environmental Health | Respiratory Diseases |
| | Family Planning | Tobacco Use |
| | Health Care Access and Quality | Women's Health |
| | Heart Disease & Stroke | Wellness & Lifestyle |
| | Immunizations and Infectious Diseases | Weight Status |
| | Maternal, Fetal & Infant Health | |

*All data were scored using a standardized index to assess severity and disparities across zip codes.

Qualitative Data: Primary Sources

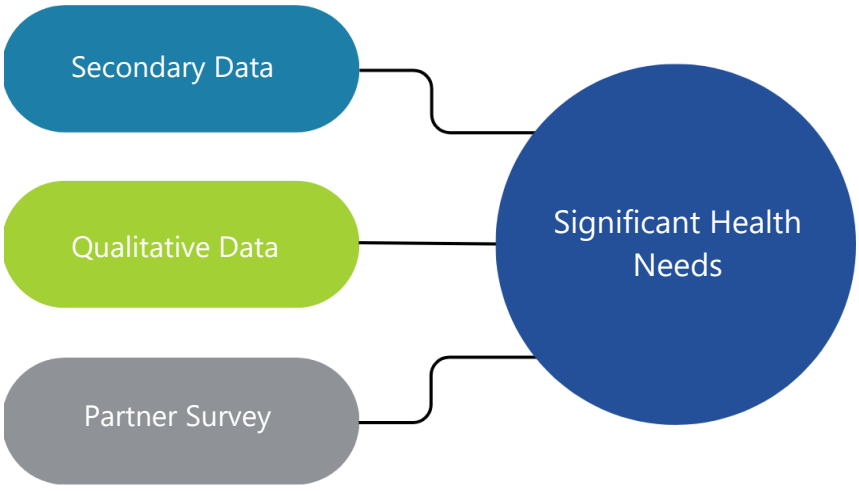
Primary data were collected through community engagement activities designed to elevate voices from across the hospital's defined service area. These activities included:

Partner Survey
An online survey was distributed to over 60 organizational partners and stakeholders, including representatives from public health departments, healthcare providers, social service agencies, and nonprofit organizations. The survey captured perspectives on health priorities, gaps in care, barriers to service delivery, and populations most impacted by health inequities.

Key Informant Interviews and Listening Sessions
Conducted with dozens of individuals representing a range of sectors including public health, healthcare, housing, education, behavioral health, and community-based organizations. These participants included:

- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

Participants were asked to share their views on community strengths, emerging challenges, and opportunities for collaboration. Themes were identified in relation to access to care, behavioral health, transportation, and the lingering impacts of COVID-19 and natural disasters. A detailed summary of participating organizations, and input themes is available in the Appendix.



By combining data-driven analysis with community perspectives, the process ensures a comprehensive understanding of health needs and identifies priority areas for future intervention, collaboration, and investment.

## Data Synthesis

## Significant Health Needs

Through comprehensive data analysis and community input process, the following health needs have been identified as the most pressing in St. Luke's Health-Memorial Lufkin's service area:

Cancer | Health Care Access & Quality | Heart Disease & Stroke | Maternal/ Infant Health | Mental Health | Wellness & Lifestyle

## Identification of Significant Health Needs

The criteria for identifying the most pressing health needs involve a three-pronged approach:

Secondary Data Topic Score: A score of 1.50 or higher is deemed significant. This threshold was chosen because it represents a midway point in the scoring system used, which ranges from 0 to 3. A score of 1.50 or above indicates that the health issue is notably worse than state and national benchmarks, signaling a substantial area of concern that requires attention.

Frequency of Discussion in Qualitative Sessions: These criteria involve analyzing how often a health issue is mentioned during community partner listening sessions. The frequency of discussion provides qualitative insights into the community's perception and experiences regarding specific health needs, enhancing the quantitative data by highlighting what is actively affecting the community.

Priority Selection by 20% or More of Partner Survey Respondents: This metric involves assessing the priority level assigned to health needs by respondents in the community partner survey. If 20% or more participants identify a health issue as a priority, it underscores its importance within the community. This helps to validate and contextualize the data, ensuring that the identified needs align with community priorities and concerns.

Together, these criteria offer a comprehensive approach: the quantitative scores highlight areas of statistical concern, while the qualitative and survey components ensure that the data is grounded in actual community experiences and priorities.

## Cancer

From the secondary data scoring results, Cancer ranked 9th in the data scoring of all topic areas with a score of 1.77. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 2 below. See Appendix A for the full list of indicators categorized within this topic.

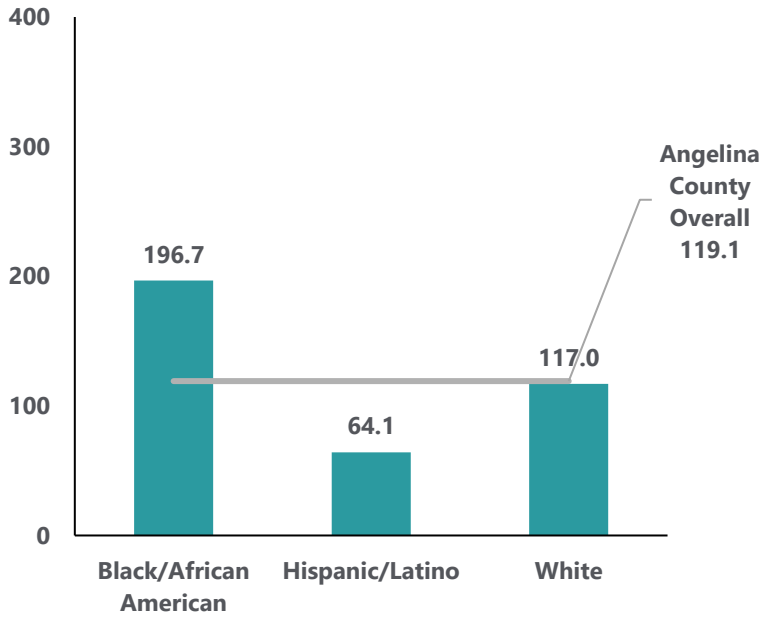
TABLE 2. **ANGELINA COUNTY DATA SCORING RESULTS: CANCER**

| SCORE | CANCER | UNITS | ANGELINA COUNTY | HP2030 | Texas | U.S. | TX Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|---|
| **2.12** | Colon Cancer Screening: USPSTF Recommendation | *percent* | 57.4 | | | 66.3 |  |  | |
| **2.03** | All Cancer Incidence Rate | *cases/ 100,000 population* | 454.3 | | 412.2 | 442.3 |  |  |  |
| **2.00** | Cancer: Medicare Population | *percent* | 12.0 | | 11.0 | 12.0 |  |  | |
| **1.59** | Cervical Cancer Screening: 21-65 | *Percent* | 78.7 | | | 82.8 |  |  | |
| **1.50** | Mammography Screening: Medicare Population | *percent* | 42.0 | | 42.0 | 47.0 |  |  | |

In Angelina County, the most concerning cancer-related indicator is *Colon Cancer Screening: USPSTF Recommendation*. In fact, Angelina County has lower rates than the U.S. population with regard to three cancer screenings: *Colon Cancer Screening: USPSTF Recommendation* (57.4% vs. 66.3%), *Cervical Cancer Screening: 21-65* (78.7% vs. 82.8%), and *Mammography Screening: Medicare Population* (42.0% vs. 47.0%). Cancer is also more common in Angelina County. The county's *All Cancer Incidence Rate* is 454.3 cases per 100,000 population, which is higher than the Texas rate (412.2).

Further investigation indicates that the Black/African American population may face a greater risk for prostate cancer in Angelina County. Black/African American males experience a risk of 196.7 cases per 100,000 for prostate cancer, which is higher than the overall county population rate (119.1).

FIGURE 18. PROSTATE CANCER INCIDENCE RATE
(CASES PER 100,000 MALES)




Cancer was frequently mentioned in the partner survey and was among the top scoring issues in secondary data analysis. Barriers to cancer care include a lack of early screening, delayed diagnoses, and low health literacy. Providers noted that residents often seek treatment only when symptoms become severe, due to costs or limited local oncology options. Mobile screening events and partnerships with FQHCs have been helpful, but gaps remain.

> **We are a rich county in resources, but the services are duplicated and not coordinated. People don't know what's available. – Listening Session Participant**

## Health Care Access & Quality

From the secondary data scoring results, Health Care Access & Quality ranked 17th in the data scoring of all topic areas with a score of 1.49. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 3 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 3. ANGELINA COUNTY DATA SCORING RESULTS: CANCER

| SCORE | HEALTH CARE ACCESS & QUALITY | UNITS | ANGELINA COUNTY | HP2030 | Texas | U.S. | TX Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|---|
| **2.29** | Adults who Visited a Dentist | *percent* | 48.0 | | | 63.9 |  |  | |
| **2.06** | Preventable Hospital Stays: Medicare Population | *discharges/ 100,000 Medicare enrollees* | 3331.0 | | 2980.0 | 2677.0 |  |  | |
| **1.97** | Adults with Health Insurance | *percent* | 74.6 | | 77.6 | 88.7 | |  |  |
| **1.62** | Children with Health Insurance | *percent* | 91.8 | | 89.1 | 94.9 | |  |  |

In Angelina County, the most concerning indicator related to health care access was *Adults who Visited a Dentist*. The county rate (48.0%) is lower than the U.S. rate (63.9%) and is also one of the lowest rates of all U.S. counties. Angelina's Medicare population is significantly more likely to experience preventable hospital stays than the Texas Medicare population (3,331 vs. 2,980 discharges per 100,000 Medicare enrollees) Finally, the rate of insured individuals among Angelina's population of adults (74.6%) and children (91.8%) is lower than the overall U.S. populations (88.7% and 94.9%, respectively).

Conduent's Community Health Index (CHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Each zip code is ranked based on its index value to identify relative levels of need. Table 4 provides the index values and local ranking for each zip code. The map in Figure 19 illustrates that the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue) are 75939 and 75972 with index values of 97.8 and 94.3, respectively.

FIGURE 19. COMMUNITY HEALTH INDEX: LUFKIN PRIMARY SERVICE AREA

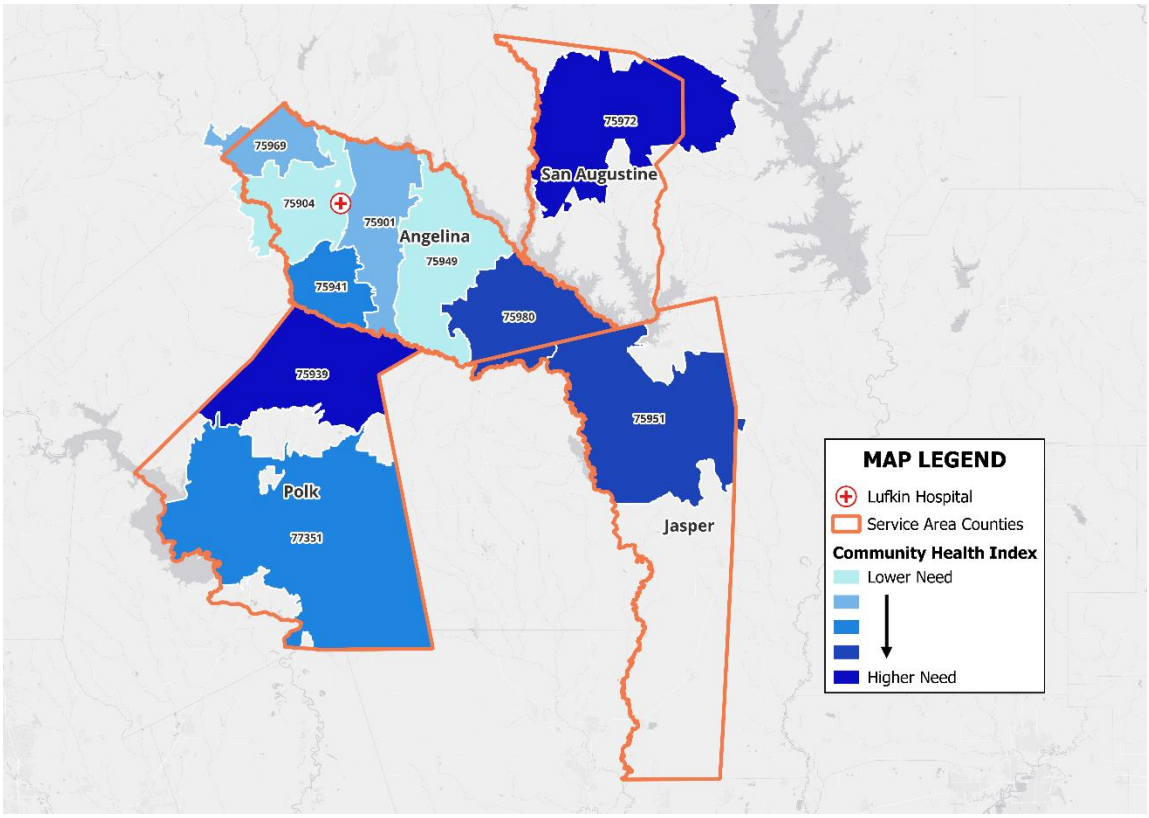



TABLE 4. COMMUNITY HEALTH INDEX: LUFKIN PRIMARY SERVICE AREA

| Zip Code | Value | Zip Code | Value |
|---|---|---|---|
| 75939 | 97.8 | 75941 | 87.2 |
| 75972 | 94.3 | 75969 | 79.2 |
| 75951 | 93.7 | 75901 | 75.5 |
| 75980 | 92.5 | 75949 | 61.6 |
| 77351 | 91.8 | 75904 | 51.3 |

Access to affordable, high-quality, and consistent healthcare remains a critical need in the Lufkin service area.

## Heart Disease & Stroke

From the secondary data scoring results, Heart Disease and Stroke ranked 2nd in the data scoring of all topic areas with a score of 2.11. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 5. **ANGELINA COUNTY DATA SCORING RESULTS: HEART DISEASE AND STROKE**

| SCORE | HEART DISEASE & STROKE | UNITS | ANGELINA COUNTY | HP2030 | Texas | U.S. | TX Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|---|
| **2.71** | Atrial Fibrillation: Medicare Population | *percent* | 16.0 | | 14.0 | 14.0 |  |  | |
| **2.71** | Hypertension: Medicare Population | *percent* | 74.0 | | 66.0 | 65.0 |  |  | |
| **2.53** | Stroke: Medicare Population | *percent* | 7.0 | | 6.0 | 6.0 |  |  | |
| **2.41** | Heart Failure: Medicare Population | *percent* | 16.0 | | 12.0 | 11.0 |  |  | |
| **2.35** | Hyperlipidemia: Medicare Population | *percent* | 70.0 | | 65.0 | 65.0 |  |  | |
| **2.29** | Age-Adjusted Death Rate due to Heart Attack | *deaths/ 100,000 population 35+ years* | 125.1 | | 61.2 | |  |  |  |
| **2.24** | Ischemic Heart Disease: Medicare Population | *percent* | 25.0 | | 22.0 | 21.0 |  |  | |
| **2.12** | High Blood Pressure Prevalence | *percent* | 40.4 | 41.9 | | 32.7 |  |  | |
| **1.94** | Adults who Experienced a Stroke | *percent* | 4.4 | | | 3.6 |  |  | |
| **1.94** | Adults who Experienced Coronary Heart Disease | *percent* | 8.6 | | | 6.8 |  |  | |
| **1.76** | Cholesterol Test History | *percent* | 82.5 | | | 86.4 |  |  | |

In Angelina County, the most concerning indicator related to heart disease and stroke was *Atrial Fibrillation: Medicare Population*. The county rate for this indicator was 16.0%, which is among the top 25% of highest county rates across the country. Several other indicators of concern were related to Angelina County Medicare recipients, specifically. Among the county's Medicare population, the rates of hypertension (74.0%), stroke (7.0%), heart failure (16.0%), hyperlipidemia (70.0%), and ischemic heart disease (25.0%) were all higher than both the Texas and U.S. rates.

Angelina's broader adult population experienced higher rates than the U.S. population for high blood pressure (40.4%), stroke (4.4%), and coronary heart disease (8.6%). Angelina also had a

higher *Age-Adjusted Death Rate due to Heart Attack* than Texas (70.0 vs. 61.2 deaths per 100,000 population 35+ years).

Among the Angelina County population, the risk of hospitalization due to heart failure increases significantly with age. The risk for the population 85 and up is more than twice that of the 65-84 year-old population, which is about twice that of the 45-64 year-old population (270.2 vs. 115.0 vs. 47.1 hospitalizations per 10,000, respectively). We also found that the risk for hospitalization due to heart failure differed by sex and race/ethnicity, even after accounting for age. The risk experienced by Angelina's male population is 46.8 cases per 10,000 population 18+ years, which is higher than the female population's risk (32.9). Additionally, the risk experienced by Angelina's Black/African American population is 73.3 hospitalizations per 10,000, which is greater than the county-wide risk of 39.4.

FIGURE 20. HOSPITALZATION RATE DUE TO HEART FAILURE, BY AGE (CASES PER 10,000 POPULATION 18+ YEARS)

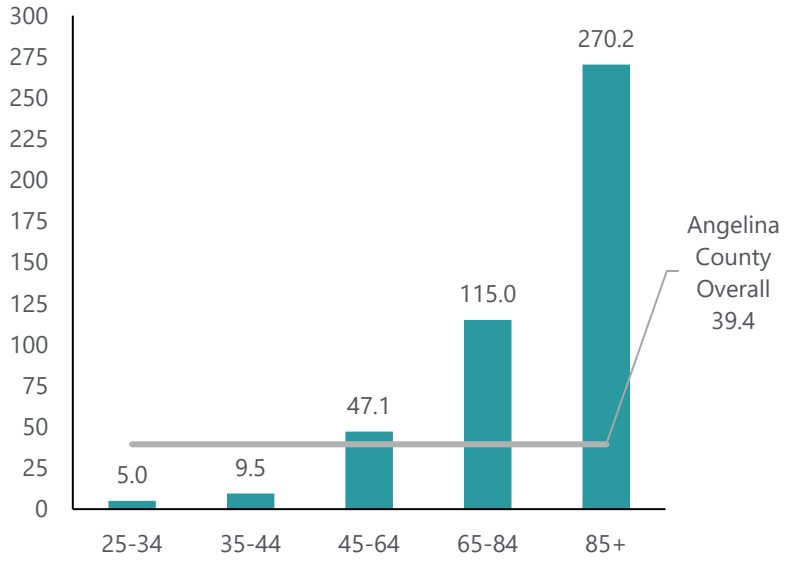


FIGURE 21: AGE-ADJUSTED HOSPITALZATION RATE DUE TO HEART FAILURE, BY SEX (CASES PER 10,000 POPULATION 18+ YEARS)

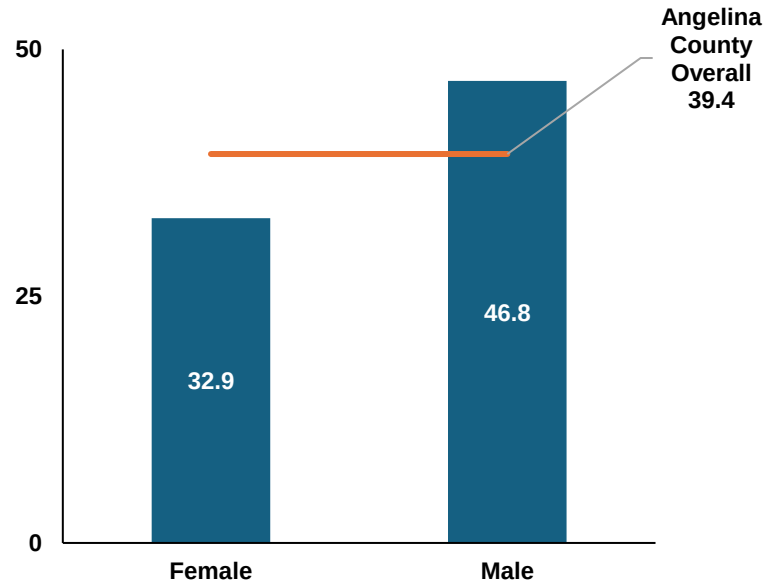
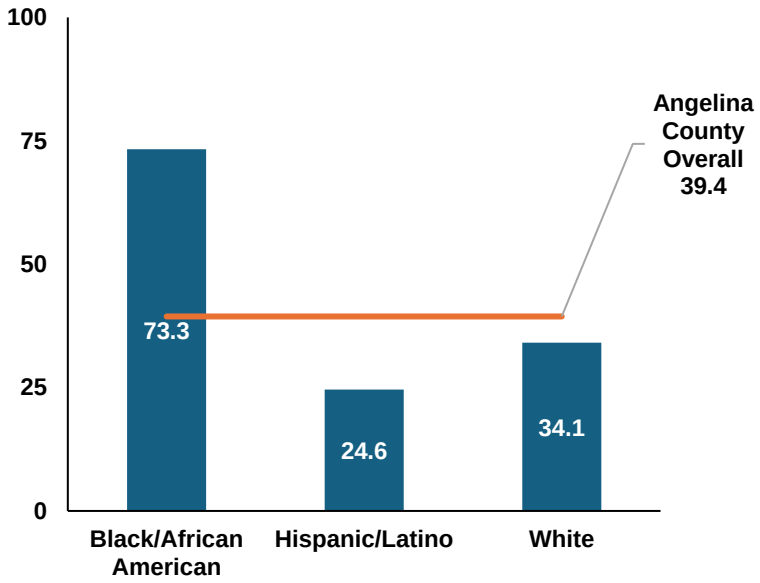



FIGURE 22: AGE-ADJUSTED HOSPITALZATION RATE DUE TO HEART FAILURE, BY RACE/ETHNICITY (CASES PER 10,000 POPULATION 18+ YEARS)



Cardiovascular disease is a top concern in the Lufkin region, particularly for older adults and low-income residents. In listening sessions, healthcare professionals linked delayed preventive care to chronic disease progression:

> We have clients who skip routine appointments because they don't have insurance—and then they're coughing up blood in the ER.

Lack of specialist access in rural areas, combined with the cost of medication and transportation to out-of-county providers, limits effective management.

## Maternal/ Infant Health

From the secondary data scoring results, Maternal, Fetal, & Infant Health ranked 18th in the data scoring of all topic areas with a score of 1.44. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern, and only one indicator under this topic area met that criterion. The two highest scoring indicators are listed in Table 6 below. See Appendix A for the full list of indicators categorized within this topic

.

TABLE 6. ANGELINA COUNTY DATA SCORING RESULTS: MATERNAL, FETAL, AND INFANT HEALTH

| SCORE | MATERNAL, FETAL & INFANT HEALTH | UNITS | ANGELINA COUNTY | HP2030 | Texas | U.S. | TX Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|---|
| **1.79** | Teen Births | *percent* | 2.4 | | 1.7 | 2.4 | | |  |
| **1.44** | Infants Born to Mothers with <12 Years Education | *percent* | 13.8 | | 14.5 | 11.7 |  | |  |

The rate of *Teen Births* in Angelina County is higher than that of Texas (2.4% vs. 1.7%), but similar to the overall U.S. rate (2.4%). This rate has also been increasing over time, although not significantly. A similar indicator, *Infants Born to Mothers with Less Than 12 Years of Education* has a lower rate in Angelina than Texas overall (13.8% vs. 14.5%), but is higher than the U.S. rate (11.7%). This indicator has been decreasing significantly over time.

Maternal and infant health emerged during qualitative sessions as a vulnerable and underserved area. Undocumented and uninsured mothers face multiple barriers, including language access and fear related to immigration status:

> **"We compromise care when patients don't understand instructions, especially in prenatal visits. Spanish speakers aren't getting the same level of explanation or follow-up."**

Gaps in postpartum care, breastfeeding support, and culturally competent maternal education also impact outcomes for mothers and infants in the Lufkin area.

## Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders ranked 3rd in the data scoring of all topic areas with a score of 2.08. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 7 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 7. ANGELINA DATA SCORING RESULTS: MENTAL HEALTH & MENTAL DISORDERS

| SCORE | MENTAL HEALTH & MENTAL DISORDERS | UNITS | ANGELINA COUNTY | HP2030 | Texas | U.S. | TX Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 2.71 | Depression: Medicare Population | *percent* | 19.0 | | 17.0 | 16.0 |  |  | |
| 2.41 | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 8.0 | | 7.0 | 6.0 |  |  | |
| 2.35 | Poor Mental Health: Average Number of Days | *days* | 5.6 | | 4.6 | 4.8 |  |  |  |
| 2.29 | Poor Mental Health: 14+ Days | *percent* | 20.2 | | | 15.8 |  |  | |
| 2.12 | Adults Ever Diagnosed with Depression | *percent* | 24.3 | | | 20.7 |  |  | |

In Angelina County, the two most concerning indicators related to mental health and mental disorders are each related to the Medicare population: *Depression: Medicare Population* (19.0%) and *Alzheimer's Disease or Dementia: Medicare Population* (8.0%). Both of these county rates are among the highest across all U.S. counties. The broader adult population in Angelina is also more likely to experience depression. In the county, the rate for *Adults Ever Diagnosed with Depression* (24.3%) is higher than the U.S. rate (20.7%).

The Angelina County population is more likely to self-report poor mental health. On average, Angelina County residents report having poor mental health on 5.6 of the last 30 days, which is higher than the Texas rate (4.6 days). Additionally, about one in five county residents (20.2%) report having at least 14 poor mental health days out of the past 30, which is higher than the U.S. rate (15.8%).

Conduent's Mental Health Index (MHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor mental health. Each zip code is ranked based on its index value to identify relative levels of need. Table 8 provides the index values and local ranking for each zip code. The map in Figure 23 illustrates that the zip code with the highest risk for poor mental health (as indicated by the darkest shade of purple) is zip codes 75972 with a score of 96.8.

FIGURE 23. MENTAL HEALTH INDEX: LUFKIN PRIMARY SERVICE AREA

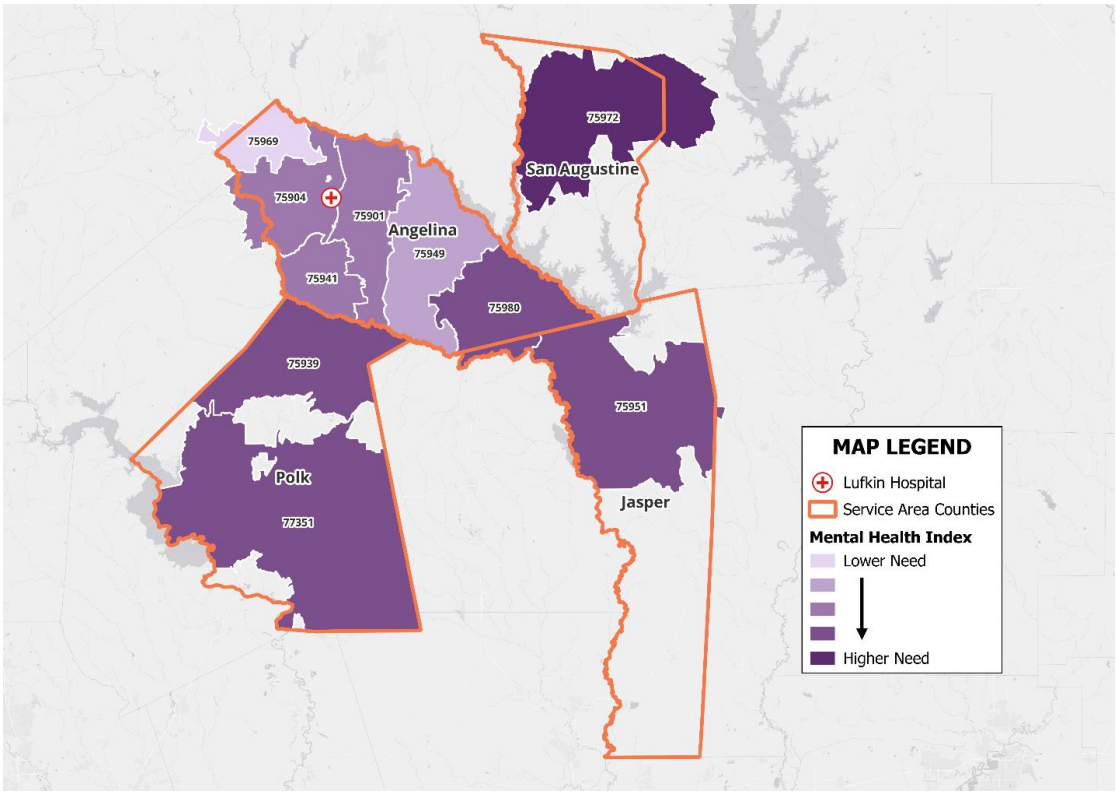



TABLE 8. MENTAL HEALTH INDEX: LUFKIN PRIMARY SERVICE AREA

| Zip Code | Value | Zip Code | Value |
|---|---|---|---|
| 75972 | 96.8 | 75904 | 82.2 |
| 75939 | 93.2 | 75901 | 80.7 |
| 77351 | 92.1 | 75941 | 79.9 |
| 75980 | 90.3 | 75949 | 71.6 |
| 75951 | 90.1 | 75969 | 66.4 |

Mental health conditions, including anxiety, depression, and substance use, were the #1 health issue identified in the partner survey. Both youth and adults in the Lufkin region face unmet mental health needs due to severe shortages of providers and funding:

> **There's nobody here. My wife treats patients at the jail with mental illness that go way beyond her training—but there's no psychiatrist to refer them to. – Listening Session Participant**

Stigma, lack of insurance, and logistical barriers such as broadband access for teletherapy also hinder access to care.

## Wellness & Lifestyle

From the secondary data scoring results, Wellness and Lifestyle ranked 1st in the data scoring of all topic areas with a score of 2.19. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 9 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 9. ANGELINA COUNTY DATA SCORING RESULTS: MENTAL HEALTH & MENTAL DISORDERS

| SCORE | WELLNESS & LIFESTYLE | UNITS | ANGELINA COUNTY | HP2030 | Texas | U.S. | TX Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|---|
| **2.41** | Poor Physical Health: Average Number of Days | *days* | 4.5 | | 3.3 | 3.3 |  |  |  |
| **2.29** | Insufficient Sleep | *percent* | 41.6 | 26.7 | | 36.0 |  |  | |
| **2.29** | Poor Physical Health: 14+ Days | *percent* | 16.5 | | | 12.7 |  |  | |
| **2.12** | High Blood Pressure Prevalence | *percent* | 40.4 | 41.9 | | 32.7 |  |  | |
| **2.12** | Self-Reported General Health Assessment: Poor or Fair | *percent* | 25.3 | | | 17.9 |  |  | |
| **2.03** | Life Expectancy | *years* | 73.4 | | 77.2 | 77.6 |  |  | |

In Angelina County, the most concerning indicator is *Poor Physical Health: Average Number of Days*. On average, county residents report 4.5 of poor physical health out of the past 30 days, which is higher than the Texas and U.S. rates (3.3 days for both). County residents are also more likely to report 14 or more days of poor physical health, compared to the overall U.S. population (16.5% vs. 12.7%). Finally, the Angelina population is more likely to report that their general health is poor or fair (25.3% vs. 17.9% for the U.S.).

More than two in five county residents get insufficient sleep (41.6%), which is one of the highest county rates across the country. Additionally, county residents are more likely than the U.S. population to have high blood pressure (40.4% vs. 32.7%), although this rate is below the Health People 2030 target (41.9%). Finally, the overall life expectancy in Angelina (73.4 years) is lower than that of Texas (77.2 years) or the U.S. (77.6 years).

Listening sessions revealed that even when community centers or gyms exist, lack of awareness, transportation, or financial barriers limit their use. One participant noted:

> **"The rec center has high foot traffic, but staff aren't equipped to help people find health or housing resources—it's a missed opportunity."**

# Other Health Needs of Concern

While not prioritized for immediate strategic focus, the following health issues were frequently mentioned in community conversations, surveys, and secondary data and remain important to address through partnerships and advocacy.

## Children's Health

From the secondary data scoring results, Children's Health ranked 10th in the data scoring of all topic areas, with a score of 1.75. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Child Food Insecurity Rate* (28.3%)
- *Child Mortality Rate: Under 20* (61.8 deaths per 100,000 population under 20)
- *Substantiated Child Abuse Rate* (12.6 cases per 1,000 children)
- *Children with Health Insurance* (91.8%)

Identified as an area of concern in survey responses, especially for access to preventive care, behavioral health services, and healthy nutrition. School partnerships and immunization outreach remain critical.

## Environmental Health

From the secondary data scoring results, Environmental Health ranked 12th in the data scoring of all topic areas, with a score of 1.58. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Air Pollution due to Particulate Matter* (9.3 micrograms per cubic meter)
- *Adults with Current Asthma* (11.0%)
- *PBT Released* (1,841.9 pounds)
- *Access to Exercise Opportunities* (65.8%)
- *Number of Extreme Heat Days* (46 days)
- *Recognized Carcinogens Released into Air* (9,533.4 pounds)
- *Weeks of Moderate Drought or Worse* (12 weeks per year)
- *Access to Parks* (28.0%)
- *Proximity to Highways* (5.1%)

Though not frequently cited in surveys, several listening session participants expressed concern about unsafe housing, water quality, and storm impacts; particularly in communities already facing poverty.

## Immunizations & Infectious Diseases

From the secondary data scoring results, Immunizations and Infectious Diseases ranked 15th in the data scoring of all topic areas, with a score of 1.52. Only one indicator in Angelina County was identified as concerning: *Pneumonia Vaccinations: Medicare Population* (5.0%). A full list of indicators categorized within this topic can be found in Appendix A.

The COVID-19 pandemic left lingering distrust in public health systems. Immunization rates remain below target in many Lufkin zip codes, especially for adults and marginalized populations.

## Nutrition and Healthy Eating

Conduent's Food Insecurity Index (FII) uses socioeconomic data to estimate which zip codes are at greatest for poor food access. The map in Figure 24 illustrates that the zip codes with the highest risk of food insecurity are 75951 and 75901 with index scores of 86.4 and 85.7, respectively.

FIGURE 24. FOOD INSECURITY INDEX: LUFKIN PRIMARY SERVICE AREA

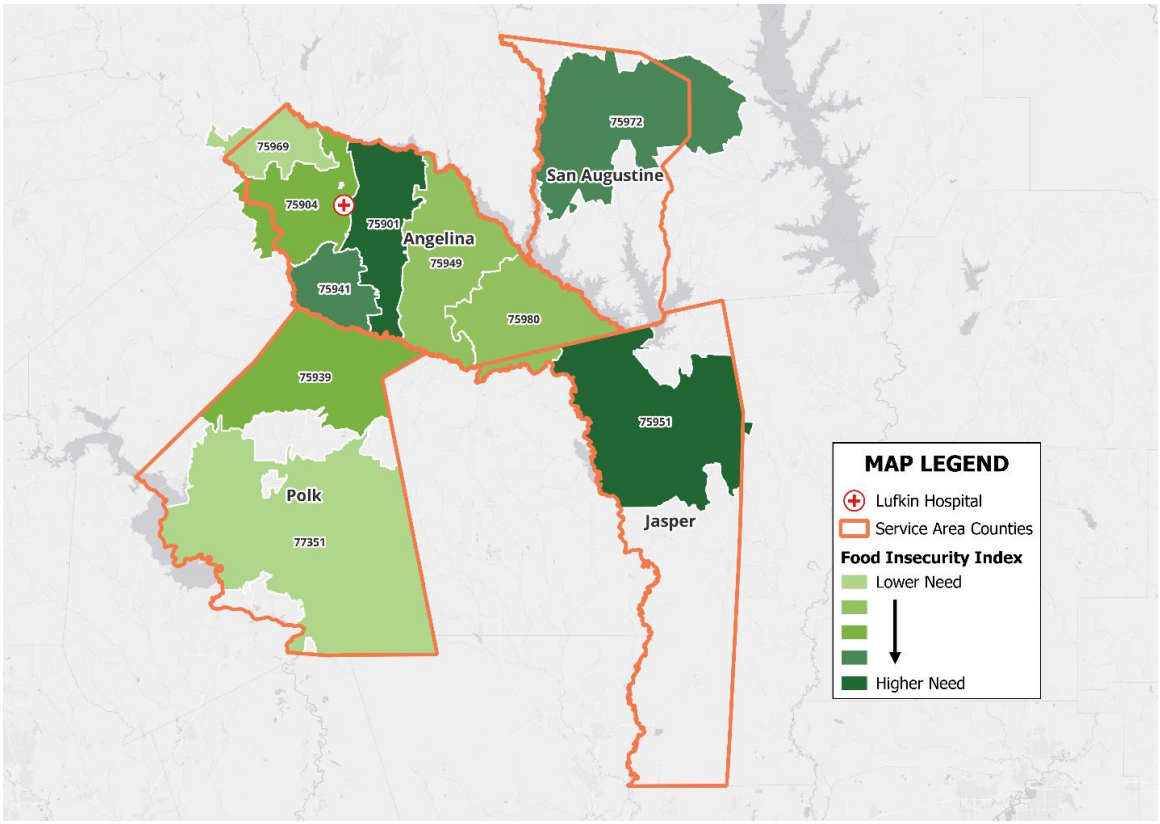



TABLE 10. FOOD INSECURITY INDEX: LUFKIN PRIMARY SERVICE AREA

| Zip Code | Value | Zip Code | Value |
|---|---|---|---|
| 75951 | 86.4 | 75904 | 81.5 |
| 75901 | 85.7 | 75949 | 80.9 |
| 75972 | 84.4 | 75980 | 75.1 |
| 75941 | 83.0 | 77351 | 64.0 |
| 75939 | 82.6 | 75969 | 61.0 |

Food insecurity affects many low-income residents, particularly those without access to transportation. Survey data and listening sessions emphasized a need for "one-stop" food access points and nutrition education.

## Older Adults

From the secondary data scoring results, Older Adults ranked 7th in the data scoring of all topic areas, with a score of 1.86. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Atrial Fibrillation: Medicare Population* (16.0%)
- *Depression: Medicare Population* (19.0%)
- *Hypertension: Medicare Population* (74.0%)
- *COPD: Medicare Population* (15.0%)
- *Stroke: Medicare Population* (7.0%)
- *Alzheimer's Disease or Dementia: Medicare Population* (8.0%)
- *Chronic Kidney Disease: Medicare Population* (25.0%)
- *Diabetes: Medicare Population* (30.0%)
- *Heart Failure: Medicare Population* (16.0%)
- *Hyperlipidemia: Medicare Population* (70.0%)
- *Osteoporosis: Medicare Population* (12.0%)
- *Ischemic Heart Disease: Medicare Population* (25.0%)
- *Cancer: Medicare Population* (12.0%)

As shared by the Area Agency on Aging, many older adults live on fixed incomes and face compounding issues—housing instability, food insecurity, and access barriers to healthcare and technology.

> **"I'm helping older adults who worked their whole lives, but can't afford groceries and glasses now."**

## Oral Health

From the secondary data scoring results, Oral ranked 8th in the data scoring of all topic areas, with a score of 1.79. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Adults who Visited a Dentist* (48.0%)
- *Adults 65+ with Total Tooth Loss* (17.6%)

Limited providers and coverage, especially for Medicaid recipients and older adults, leave many without preventive dental care worsening other chronic conditions.

## Physical Activity

From the secondary data scoring results, Physical Activity ranked 5th in the data scoring of all topic areas, with a score of 2.02. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Adults 20+ Who Are Obese* (40.4%)
- *Workers who Walk to Work* (1.2%)
- *Adults 20+ who are Sedentary* (28.3%)
- *Access to Exercise Opportunities* (65.8%)

- *Access to Parks* (28.0%)

While some recreation resources exist, transportation, unsafe walking environments, and lack of structured programming limit access. Collaborative programs in community centers could be a solution.

## Respiratory Diseases

From the secondary data scoring results, Respiratory Diseases ranked 6th in the data scoring of all topic areas, with a score of 1.99. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases* (62.5 deaths per 100,000)
- *COPD: Medicare Population* (15.0%)
- *Adults who Smoke* (18.9%)
- *Adults with COPD* (9.8%)
- *Adults with Current Asthma* (11.0%)
- *Proximity to Highways* (5.1%)

High rates of tobacco use, exposure to environmental allergens, and barriers to specialist care make asthma and COPD common concerns, particularly in older residents.

## Women's Health

From the secondary data scoring results, Women's Health ranked 14th in the data scoring of all topic areas, with a score of 1.52. A full list of indicators categorized within this topic can be found in Appendix A. The following were identified as indicators of concern in Angelina County:

- *Cervical Cancer Screening: 21-65* (78.7%)
- *Mammography Screening: Medicare Population* (42.0%)

Barriers to comprehensive women's health include cost, clinic hours, transportation, and limited access to reproductive health education and screenings.

# Barriers to Care

Throughout the Lufkin service area, residents experience persistent and multifaceted obstacles to accessing timely, affordable, and equitable healthcare. These barriers disproportionately affect low-income individuals, uninsured residents, older adults, immigrants, and rural populations. Themes identified through secondary data analysis, community partner surveys, and qualitative listening sessions highlight the following key challenges:

### Financial Barriers

High rates of uninsured individuals in Angelina County (17.2%) limit access to both routine and emergency services, with many individuals delaying care until health conditions worsen. Many community members fall into a coverage gap not qualifying for Medicaid, but unable to afford private insurance or out-of-pocket expenses.

Residents expressed concern about cost-related non-adherence, particularly around preventive care, chronic disease management, and mental health services.

### Geographic and Transportation Challenge

The rural nature of the Lufkin region makes transportation to care sites difficult, especially for those without personal vehicles or access to reliable public or Medicaid transportation services. Specialty care often requires travel to distant cities, creating additional costs and logistical complications for patients and caregivers.

### Workforce and Provider Shortages

There is a shortage of primary care and mental health providers, which strains existing services and limits appointment availability.
Patients often face long wait times, limited clinic hours, or are turned away due to insurance issues or capacity limitations.

### Language and Cultural Barriers

Language access issues, particularly for Spanish-speaking residents, limit understanding of care plans, medication instructions, and eligibility for services. Cultural competence and the availability of trained bilingual staff are insufficient across many healthcare settings, impacting the quality of communication and trust in providers.

**Technology and Health Literacy Gaps**
Limited broadband access and digital literacy make telehealth a less viable option for many rural and older residents. Confusion around appointment processes, eligibility requirements, and insurance navigation continues to delay care.

# Conclusion

The 2025 Community Health Needs Assessment for St. Luke's Health Memorial Lufkin reveals both urgent challenges and promising opportunities across the service area. While the region struggles with longstanding issues such as limited access to care, provider shortages, and financial obstacles, it also demonstrates resilience through community partnerships, outreach initiatives, and targeted health programs.

The prioritized health needs Healthcare Access, Heart Disease & Stroke, Cancer, Mental Health, Wellness & Lifestyle, and Maternal & Infant Health reflect both quantitative trends and lived experiences voiced by the community. Cross-sector collaboration, such as that between the hospital system, the Burke Center, local nonprofits, and faith-based organizations, offers a foundation to address these needs more holistically and sustainably.

# Appendices Summary

The following appendices provide supplemental data, documentation, and references supporting the findings and processes detailed in this Community Health Needs Assessment:

## Data Sources and Methodology Details

Includes methodology overview, data scoring criteria and tables, and a summary of how qualitative and quantitative data were collected and analyzed. This section also includes any supplemental information from the previous CHNA to support comparison and context.

## Stakeholder and Community Engagement Summary

Lists all organizations that contributed input through interviews, surveys, or listening sessions, including representatives of public health agencies, medically underserved, low-income, and minority populations. Also includes data collection tools such as survey instruments and discussion guides used during community engagement.

## Community Partner List

Provides a structured list or table of community-based organizations, coalitions, and programs available to address each prioritized health need identified in the report.

## References and Citations

A complete list of all data sources, literature, and tools used throughout the CHNA.