Community Health Implementation Strategy

Memorial Hermann Greater Heights Hospital

MEMORIAL® HERMANN
Greater Heights

Table of Contents

At-a-Glance Summary

Community Served	Memorial Hermann Greater Heights Hospital, serving 1,080,972 persons living in 29 zip codes within Harris County.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address were identified in the hospital's most recent Community Health Needs Assessment (CHNA):

Health Care Priorities	**Non-Medical Drivers of Health Priorities**
• Access to Care • Chronic Conditions Prevention and Management • Maternal & Infant Health • Mental Health & Substance Use	• Access to Healthy Food • Economic Opportunity • Educational Access

Implementation Strategy Goals for FY26-FY28

Over the next three years, the hospital will implement and closely monitor a series of programs, activities, and milestones aligned with its established priorities. The following snapshot outlines these initiatives, many of which include overlapping secondary objective.

Access to Care

- Reduce unnecessary Memorial Hermann ER Utilization by ≥2% & ≥1% reduction of Memorial Hermann readmission rates of target population encountered by Community Health services residing in high poverty zip codes across Greater Houston.
- Implement a mobile vaccine program that aims to provide vaccinations to 1,000 unique students annually at the 10 Health Centers for Schools locations, with the goal of vaccinating 3,000 students by FY 28.
- Refer ≥70% of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ED settings with identified Non-Medical Driver of Health (NMDOH) needs to Community Care Coordination Team (C3T) Community Health Workers (CHW) for a documented intervention and outcome.

Access to Healthy Food

- Expand access to nutritious food for food insecure populations across Greater Houston by increasing the number of patients and community members receiving emergency food support and participating in food and nutritious education programs at each Memorial Hermann campus, helping families redirect limited income toward other essential needs and reduce overall cost burden.

Chronic Conditions Prevention and Management

- Screen ≥40% of Memorial Hermann patients for at least 1 NMDOH with ≥50% high risk receiving referral to resource support by FY28.
- Strengthen stroke prevention and management at Greater Heights by expanding the Bridge to Rehab initiative, community stroke education and support groups, achieving an increase program participation and improved post stroke care coordination.
- Increase community engagement in chronic disease prevention and management through hosting annual community education events, symposiums, and support groups focused on conditions such as diabetes, heart, obesity and related health risks.

Economic Opportunity and Educational Access

Improve opportunity for socioeconomic mobility through expansion of workforce initiatives and efforts that lead to livable wage careers while investing in local nonprofit capacity building via skills-based volunteerism.

Maternal & Infant Health

- Increase access to timely and comprehensive Maternal and Infant health services for community members residing in target neighborhoods by reducing missed post-partum follow up visits and expanding access to care navigation or support services and improving newborn care through increased availability of services.

Mental Health & Substance Use

- Memorial Hermann will implement initiatives that connect and care for the community, including those who are experiencing mental health challenges: access to appropriate psychiatric and behavioral health specialists; reducing unnecessary ER visits; increase connection to more appropriate preventive wellness outpatient services and navigation care coordination.

Our Hospital and the Community Served

Memorial Hermann Greater Heights Hospital

Memorial Hermann Greater Heights Hospital is part of Memorial Hermann Health System (MHHS), one of the largest nonprofit health systems in Texas, with 17* hospitals and more than 6,600 affiliated physicians, 34,000 employees across 270 care delivery sites throughout the Greater Houston area.

Serving the Greater Heights community for almost 60 years, Memorial Hermann Greater Heights Hospital is known for providing award-winning care to families in the community. Memorial Hermann Greater Heights focuses on Service Line growth & creating intentional partnerships to address the unique community needs.

Memorial Hermann Greater Heights is committed to advancing health and personalizing the care of those we serve through excellent clinical quality, caring service, and outstanding physician engagement. More than 600 affiliated, board-certified physicians and health care professionals employ advanced medical equipment and state-of-the-art technology to address the community's health care needs.

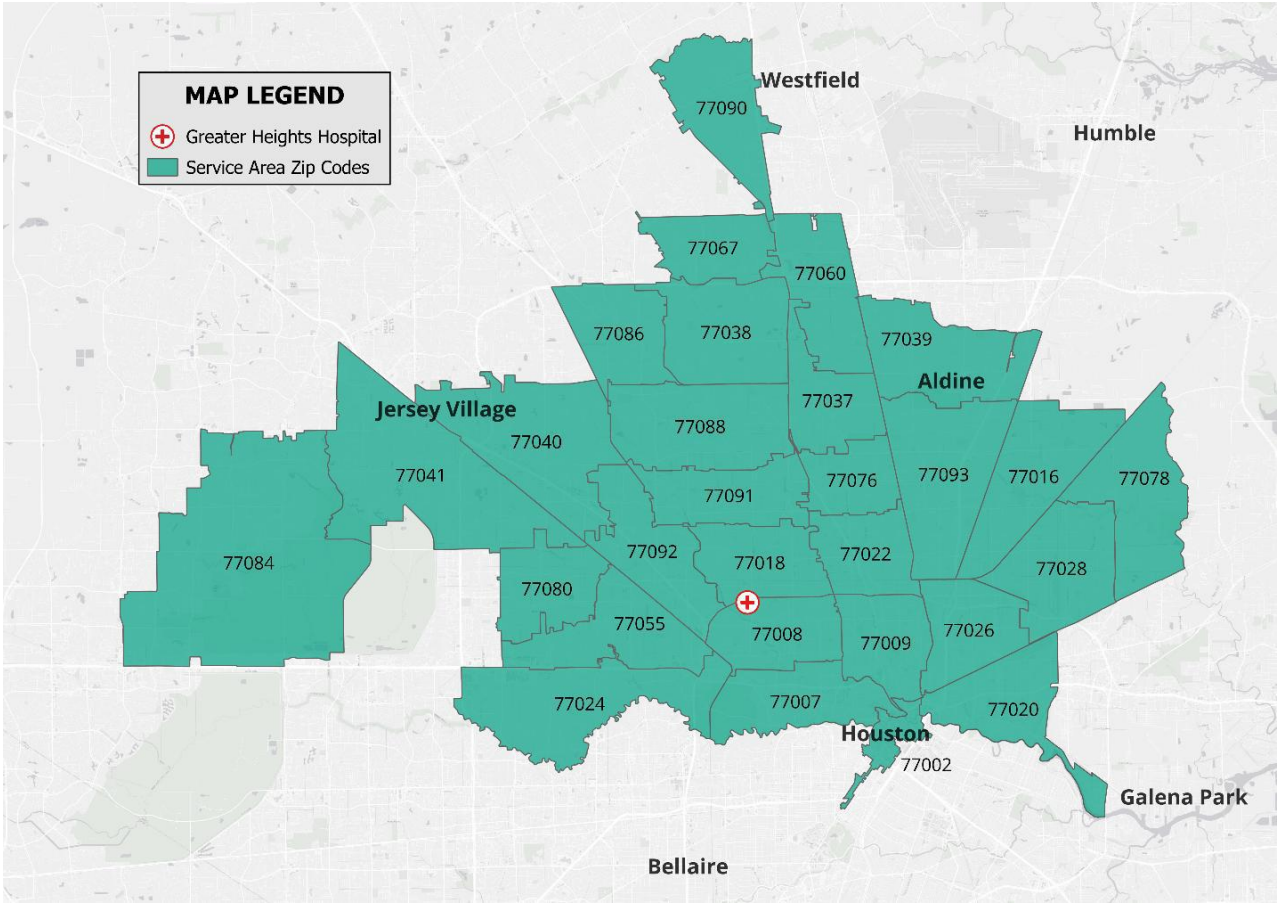
Memorial Hermann Greater Heights provides a wide range of medical specialties, including heart and vascular, cancer treatment, total joint replacement, rehabilitation, and women's care. When emergencies arise, Memorial Hermann Greater Heights's Emergency Center offers services 24/7. The Chest Pain and Stroke Centers are fully accredited to provide fast, effective treatment for heart attack and Stroke patients.

Memorial Hermann Greater Heights' 260-bed facility features a Family Birthing Center, a 22-bed intensive care unit, 10 Operating rooms, an 8-bed Cardiovascular ICU as well as a Medical Surgical and Inpatient Rehab unit. In addition to a full complement of inpatient services Greater Heights offers an Outpatient Testing Center, Cancer Treatment Center, and Adult and Pediatric Outpatient therapy through the TIRR Memorial Hermann Rehabilitation Network.

Description of the Community Served

Memorial Hermann Greater Heights Hospital Metropolitan Service Area (MSA) has a population of approximately 1,080,972 persons serving 29 zip codes in Harris County. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. MEMORIAL HERMANN GREATER HEIGHTS METROPOLITIAN SERVICE AREA BY ZIP CODES



Source: MHHS facilities values from Claritas (2024)

Community Assessment and Significant Needs

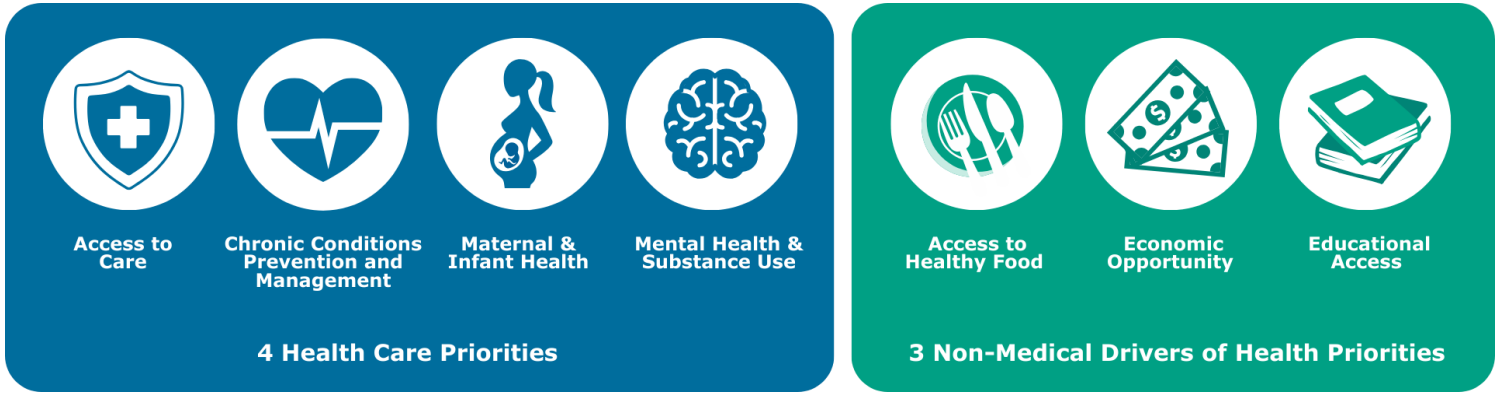
The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted on June 26, 2025. The CHNA report includes:

- 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, communityhealth@memorialhermann.org.

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 health-related social and community needs that have an impact on health and well-being.



Significant Needs the Hospital Does Not Intend to Address

Memorial Hermann Health System (MHHS) did not elect to explicitly prioritize the following health needs that emerged from the primary and secondary data with the 2025 implementation plan to include: Immunizations & Infectious Diseases and Community (Environment, Prevention, & Safety). However, they are related to the selected priority areas and will be interwoven in the forthcoming Implementation Strategy and in future work addressing health needs through strategic partnerships with community partners.

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 anticipate 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

Memorial Hermann Greater Heights Hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Following the identification of the seven priority health needs, the Community Health team began subsequent work on implementation planning. Hospital contacts and participants were identified, and representation included Memorial Hermann Greater Heights, and other hospital leadership.

During initial planning meetings, representatives from HCI and Memorial Hermann Greater Heights Hospital reviewed the hospital's most recent implementation plan (2023-2025), noting strengths and areas of improvement to inform the development of the new implementation plans.

Hospital representatives from Memorial Hermann Greater Heights Hospital were invited to participate in an Implementation Strategy Kick-Off meeting. The meeting was held on July 16, 2025 for all 13 facility hospital representatives. A total of 26 participants attended. Following the initial planning meetings, several implementation strategy office support hours were held to support the development of initial goals and objectives.

The Implementation Plan presented in the following pages outlines in detail the individual strategies and activities Memorial Hermann Greater Heights will implement to address the health needs identified though the CHNA process that the facility is best resourced to address. The following components are outlined in detail in the tables in the following pages:

1) Actions the hospital intends to take to address the health needs identified in the CHNA
2) The anticipated impact of these actions as reflected in the Process and Outcomes measures for each activity
3) The resources the hospital plans to commit to each strategy
4) Any planned collaboration to support the work outlined.

Memorial Hermann Greater Heights Hospital Implementation Plan

Community Priority: Access to Care

- **Primary Prioritized Need Area: Access to Care**
- **Secondary Prioritized Need Area: Chronic Conditions Prevention and Management**

FY26-FY28 Goal: Reduce unnecessary Memorial Hermann ER Utilization by ≥2% & ≥1% reduction of Memorial Hermann readmission rates of target population encountered by Community Health services residing in high poverty zip codes across Greater Houston.

FY26 Objective: Decrease avoidable readmissions and unnecessary Emergency Room revisits for patients living in high-poverty ZIP codes with diabetes, cardiovascular disease, hypertension or obesity, through interventions that address NMDOH and expand affordable, community-based care pathways. *Baseline to be determined by end of FY26 to drive the annual 0.5% reduction of year over year revisits and annual 0.25% reduction of year over year readmissions.*

FY26 KPIs:

- Percent - decrease in ER revisits
- Percent - decrease in Inpatient readmissions of target population
- Percent - patients achieving improvement in focus health measures (e.g. A1c; BMI) for targeted disease states
- Percent—screening rate for patients identified as high-risk for NMDOH encountered in the ER and Inpatient setting
- Percent—resource referral rate for patients identified as high-risk for NMDOH encountered in the ER & Inpatient setting

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
ER Navigation Program	Community Health Network	Baseline TBD by end of FY26	• Volume - referrals to NHC upon discharge • Volume - referrals to community partner locations • Percent - show rate of referred to NHC • Percent - decrease of ER revisits within 180 days (6 months) of navigated
Multi-Visit Patient Program	Community Health Network	Baseline TBD by end of FY26	• Volume – unique referrals to MVP Program • Volume – unique referrals to external community partner locations • Percent – show rate of referred to navigated resources

			• Percent – decrease of MVP revisits within 180 days of navigated.
Inpatient Navigation Program	Community Health Network	Baseline TBD by end of FY26	• Percent - 90-day readmission rate of navigated • Volume – patients referred to NHC post-discharge • Volume – referrals to community partner locations • Percent – show rate of patients referred to support services
SafeRide Program	Community Health Network	426 Completed Rides (universal May 2025)	• Volume – number of rides completed • Percent - completed rides to PCP/ Doctor appointment
Medical Home Establishment: GH Neighborhood Health Center	• Community Health Network • MHHS Greater Heights clinical teams	Baseline TBD by end of FY26	• Volume – referrals received from Navigation Programs • Percent – show rate of referred from Navigation Programs • Number – scheduled appointments for endocrinology • Percent – show rate of patients to scheduled endocrinology appointments • Percent – Navigation program patients presenting to ER post NHC encounters
Nurse Health Line	Community Benefit Corporation – Nurse Health Line	Baseline TBD by end of FY26	• Volume - calls from counties comprising MHGH's primary service area (Harris) • Percent- Caller satisfaction ratings • Percent – Caller follow through rate
My Health Advocate	Case Management	Baseline TBD by end of FY26	• Number - Stroke patients screened • Number - Diabetes/Obesity patients screened • Number - CHF patients screened
Target/Intended Population(s): • Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS Greater Heights campus • For My Health Advocate - Older adults; Young mothers; MHHS Greater Heights ER patients with emerging chronic diseases			

Please provide any additional insights or explanations on the initiative(s) listed.

- The Multi-Visit Patient Program (MVP) is located at all MHHS hospital campuses and focuses on supporting patients visiting the ER 10+ times in 12 months.
- The ER Navigation Program targets all MHHS patients identified as needing health and social service navigation support upon discharge.
- Inpatient Navigation Program focuses on supporting admitted patients identified as high risk for NMDOH with support services upon discharge.
- Neighborhood Health Centers (NHC) are MHHS charitable clinics located in three locations across Greater Houston with plans to expand to a fourth in calendar year 2026
- Baseline data to be established for FY26 and built upon in subsequent years during implementation plan period.
- Nurse Health Line provides a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the greater Houston community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources.
- My Health Advocate connects patients dealing with chronic condition to case management to prevent readmission.
- SafeRide is a non-emergency medical transportation (NEMT) program leveraged by patients who screen positive for transportation needs. The focus is getting patients to follow up appointments after they have been discharged from the hospital.

Collaboration Partners (Internal and External):

- Coordinated Care; ER; ISD; community nonprofit agencies; Strategy division; Nurse Health Line management and operations; Neighborhood Health Center management and operations; Community Resource Center management and operations; Marketing

- **Primary Prioritized Need Area:** **Access to Care**
- **Secondary Prioritized Need Area:** **Chronic Conditions Prevention and Management**

FY26-FY28 Goal: **Implement a mobile vaccine program that aims to provide vaccinations to 1,000 unique students annually at the 10 Health Centers for Schools locations, with the goal of vaccinating 3,000 students by FY 28.**

FY26 Objective: To collaborate with schools and community stakeholders to vaccinate students during the school year using the Community Cares Immunization van. The goal is to vaccinate 1,000 students starting in 2026. Target areas for 2026 include HISD and Alief ISD feeder patterns.

FY26 KPIs:

- Volume - unique students receiving vaccinations
- Volume - vaccinations administered
- Number - vaccination types

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Community Cares Immunization Program	Community Health Network	Baseline TBD post-FY26	• Completion - start date of new program • Volume - unique students receiving vaccinations • Volume - vaccinations administered • Number - vaccination types

Target/Intended Population(s):

- Uninsured; Medicaid; School-age children residing in Greater Houston with emphasis on schools serving high poverty ZIP communities surrounding the Memorial Hermann Greater Heights campus (e.g. Hogg Middle School.).

Please provide any additional insights or explanations on the initiative(s) listed.

- Health Centers for Schools is a Community Health Network program focused on providing access to health care for school-age children.
- Baseline data to be established for FY26 and built upon in subsequent years during plan period.
- 2026 is the pilot year for this effort.

Collaboration Partners (Internal and External):

- Independent School Districts; community nonprofit agencies

- **Prioritized Need Area: Access to Care**

FY26-FY28 Goal: Refer ≥70% of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ED settings with identified NMDOH needs to Community Care Coordination Team (C3T) Community Health Workers (CHW) for a documented intervention and outcome.

FY26 Objective: ≥50% of MHHS ACO patients discharged from acute or ED settings with identified NMDOH needs will be referred to Community Care Coordination Team CHWs for a documented intervention.

FY26 KPIs:

- Percent - MHHS ACO patients screened by PHSO and acute case management partners
- Percent - ACO patients referred to C3T program
- Number - NMDOH interventions provided

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Transitional Care Management	• Population Health • ISD • Analytics	Baseline TBD post-FY26	• Capture Rate – of NMDOH needs, referrals, and outcomes in Epic
ED Management	• Population Health • ISD • Analytics	Baseline TBD post-FY26	• Capture Rate - of NMDOH needs, referrals, and outcomes in Epic

Target/Intended Population(s):

- Any ACO life being cared for by acute hospitals, PHSO, and community providers

Please provide any additional insights or explanations on the initiative(s) listed.

- Memorial Hermann ACO consists of a network of affiliated physicians that unite independent and employed physicians of every specialty throughout the Houston area in a common commitment to quality and accountability. These physicians practice evidence-based medicine proven to result in better clinical outcomes and shorter hospital stays

Collaboration Partners (Internal and External):

- Acute Case Management, MHMG, MHMD, ISD, and Analytics

Community Priority: Access to Healthy Food

- **Primary Prioritized Need Area: Access to Healthy Food**
- **Secondary Prioritized Need Area: Economic Opportunity**

FY26-FY28 Goal: Expand access to nutritious food for food insecure populations across Greater Houston by increasing the number of patients and community members receiving emergency food support and participating in food and nutritious education programs at each Memorial Hermann campus, helping families redirect limited income toward other essential needs and reduce overall cost burden.

FY26 Objective: Develop a standardized systemwide process in partnership with the Food as Health program to connect all high-risk patients falling within the surrounding Community Health target population ZIPs who are screened as food insecure to onsite food pantries and/or localized nonprofit food partners.

FY26 KPIs:

- Percent – patients screened for food insecurity
- Percent – food insecure patients referred to food assistance (external)
- Percent – food insecure patients referred to food assistance (internal pantries)

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Community Health Worker (CHW) Hub	• Community Health Network • Ambulatory Services	Baseline TBD post- FY26	• Percent – food insecure referrals received • Number – food access appointments scheduled
Community Resource Centers	Community Health Network	Baseline TBD post- FY26	• Volume – unique members of households served • Percent – referrals for food insecure • Percent – show rate of referred patients • Number – additional NMDOH services rendered • Percent – referred to external nonprofits • Number – SNAP eligible benefits received for referred
Food as Health Program	Community Health Network	Baseline TBD post- FY26	• Volume – patients/community members accessing FAH program support • Number – Pounds of food distributed • Percent – supported residing in priority communities

Target/Intended Population(s) • Food insecure; Uninsured; Medicaid; residing in target communities
Please provide any additional insights or explanations on the initiative(s) listed. • Community Resource Centers are in four locations across Greater Houston but is working to expand to additional sites to meet the needs of Memorial Hermann patients and community members. Focused on addressing NMDOH. • Food as Health is the umbrella program managing all food and nutrition programs for Memorial Hermann including operating food pantries, community gardens and more. Community Health Network will work with employees to conduct food drives to support pantry efforts.
Collaboration Partners (Internal and External): • Ambulatory Services; Local food nonprofit agencies; Memorial Hermann Greater Heights employees

Community Priority: Chronic Conditions Prevention and Management

- **Primary Prioritized Need Area: Chronic Conditions Prevention and Management**
- **Secondary Prioritized Need Areas (s): Access to Care**

FY26-FY28 Goal: Strengthen stroke prevention and management at MHHS Greater Heights by working to decrease likelihood of development of hypertension (leading cause of stroke), expanding the Bridge to Rehab initiative, community stroke education and support groups, achieving an increase program participation and improved post stroke care coordination.

FY26 Objective: To host 10 stroke support groups and two community education events. In addition, in FY 26, Greater Heights will focus on increasing the number of patients scheduling appointments and post stroke physical therapy to ensure long term improved health outcomes.

FY26 KPIs:

- Percent - patients screened
- Percent - high-risk patients referred to resources
- Number - nonprofit partners for Community Partner Network

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Bridge to Rehab: Improving Access after Stroke	• Neuroscience Service Line • TIRR Outpatient Rehab	Baseline TBD post-FY26	• Number -post-Stroke PTs seen at rehab • Percent – percent post-Stroke with controlled BP • Percent - positive Satisfaction Scores • Number -appointments scheduled • Percent -Show rates
Precision Learning: Stroke Education for Every Community	• System Neuroscience Service Line • MHHS Greater Heights Neuroscience Service Line • Stroke Educator	Baseline TBD post-FY26	• Number - completed regulatory education • Number - stroke education guides disseminated • Number - GH attendees/representation at system Neuro education update meetings • Percent - positive stroke outcomes
Stroke Support Group	Performance Excellence-Stroke Coordinator	• Sessions: 10 • Participants: 10	• Number – support group sessions • Number - average # of participants

Stroke Community Engagement	Neuroscience Service Line	Community Events: 2	• Number – community events hosted • Number –events targeted to Spanish-speaking population • Number – events in collaboration w/CRC • Number – average # of participants
Target/Intended Population(s): • All payer types; broader Greater Houston community in target ZIP codes; MHHS Greater Heights ER patients with emerging chronic diseases			
Please provide any additional insights or explanations on the initiative(s) listed. • Greater Heights campus is focused on increasing awareness/knowledge of nutrition as it relates to Diabetes/Obesity, Cardiovascular Conditions, and Hypertension. All programs are designed to reduce the incidence and burden of living with a chronic disease, improve quality of life, and reduce mortality. • Hypertension is an area of focus for the system related to chronic conditions. By focusing on stroke patients, the campus has an opportunity to monitor prevalence of high blood pressure which is a leading cause of stroke. • Stroke Community Engagement: Emphasize "Do Not Wait" education as our hospital population often presents beyond the optimal treatment window for stroke; 1 event aimed at Spanish-speaking population; 1 event w/Community Resource Center			
Collaboration Partners (Internal and External): • NMDOH Workgroup; System; ISD; Digital; Ambulatory Services; Local FQHCs; Local Social Service Agencies • Collaboration with Leadership, Case Management, Medical Staff, and Community Service providers			

- **Primary Prioritized Need Area: Chronic Conditions Prevention and Management**
- **Secondary Prioritized Need Areas (s): Access to Healthy Food; Access to Care**

FY26-FY28 Goal: Screen ≥40% of Memorial Hermann patients for at least 1 NMDOH with ≥50% high risk receiving referral to resource support by FY28.

FY26 Objective: ≥25% of Memorial Hermann Greater Heights Hospital patients will be screened for at least 1 NMDOH, with ≥50% identified as high-risk receiving referral to resource support when residing in target communities.

FY26 KPIs:

- Percent - patients screened
- Percent - high-risk patients referred to resources
- Number - nonprofit partners for Community Partner Network

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Community Health Worker (CHW) Hub	• Community Health Network • Ambulatory Services	Baseline TBD post- FY26	• Go-Live Date • Percent – referrals received • Number – NMDOH assessment screenings completed • Number – appointment scheduled • Percent - show rates of scheduled • Percent - positive patient satisfaction scores
MyChart NMDOH Assessment Initiative	Community Health Network	Baseline TBD post- FY26	• Number - MyChart NMDOH Assessments completed • Percent - patients indicating "Yes" for referral support upon MyChart NMDOH assessment completion • Percent – routed to CHW Hub
Employee NMDOH Training	• MHHS Greater Heights Education • Leadership	Baseline TBD post- FY26	• Number- clinical staff trained on NMDOH integration • Number - NMDOH assessment screenings completed • Percent - positive Patient Satisfaction scores • Number – appointments scheduled • Percent - referrals received • Percent - show rates

Target/Intended Population(s):

- All payer types; broader Greater Houston community in target ZIP codes
- Greater Heights ER patients with emerging chronic diseases

Please provide any additional insights or explanations on the initiative(s) listed.

- Community Partner Network is a formalized partnership with local external nonprofit agencies to support resource connection for those high risk for NMDOH
- CHW Hub will be piloted to increase NMDOH screening and resource referrals across the system with primary feeder during FY26 from MyChart. Referrals will ensure patients get connected to health and social service support with the intended downstream impact of improving community health.
- The MyChart NMDOH Assessment Initiative is focused on allowing patients the choice to self-disclose about NMDOH.

Collaboration Partners (Internal and External):

- NMDOH Workgroup; System; ISD; Digital; Ambulatory Services; Local FQHCs; local social service agencies
- Collaboration with leadership, Case Management, Medical Staff, and Community service providers

- **Primary Prioritized Need Area: Chronic Conditions Prevention and Management**
- **Secondary Prioritized Need Area: Educational Access**

FY26-FY28 Goal: By FY28, Greater Heights campus will increase community engagement in chronic disease prevention and management through hosting annual community education events, symposiums, and support groups focused on conditions such as diabetes, heart disease, obesity and related health risks.

FY26 Objective: By end of FY26, to host a minimum of four community events and minimum 10 support group sessions for Mended Hearts.

FY26 KPIs:
- Number – education sessions hosted
- Number – support group sessions hosted–
- Number – attendees to education & support groups

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Diabetes/Obesity Education (Community Presentations)	• Dietitians • Marketing	• Community Events: 2 • Recipe Cards: 100	• Number - recipe cards disseminated • Number - community events held (speaking engagements: dietician support) • Number - YMCA speaking engagements
Mended Hearts Support Group	Cardiac Rehab	• Sessions: 10 • # of Participants: 10	• Number – support group sessions • Number - Average # of participants

Target/Intended Population(s):

- Greater Houston community; target high-poverty ZIP communities; uninsured

Please provide any additional insights or explanations on the initiative(s) listed.

- Diabetes/Obesity Education (Community Presentations): Campus dietitian to participate in AT LEAST 2 speaking events at YMCA, Expos, etc.
- Mended Heart Support Group is a national volunteer-based peer support program for people living with heart disease, as well as their family and caregivers.

Collaboration Partners (Internal and External):

Local nonprofit partners and collaboratives, MHHS Greater Heights Campus; Community Health Network; MHMG

Community Priority: Economic Opportunity and Educational Access

- **Primary Prioritized Need Area: Economic Opportunity**
- **Secondary Prioritized Need Area: Educational Access**

FY26-FY28 Goal: Improve opportunity for socioeconomic mobility through expansion of workforce initiatives and efforts that lead to livable wage careers while investing in local nonprofit capacity building via skills-based volunteerism.

FY26 Objective: To advance community health efforts that contribute to socioeconomic mobility through the development and expansion of career and workforce initiatives in alignment with system wide strategies. This will include partnering with internal stakeholders to connect residents to career pathways and strengthening local nonprofit capacity through skills-based volunteerism.

FY26 KPIs:

- Percent – new hires
- Number **–** events/activities held to support job attainment and upskilling (ex. Career fairs, info sessions)
- Number – campus employees providing skills-based volunteer time/hours
- Number – nonprofit agencies receiving support via skills-based

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Skills-Based Volunteerism via Community Service Corps	Community Health Network	Baseline TBD post-FY26	• Number – employees volunteer hires • Number – nonprofit agencies supported
Workforce and Career Opportunity Initiatives	Human Resources	Baseline TBD post-FY26	• Number – campus employees providing skills-based volunteer time/hours • Number – nonprofit agencies receiving support via skills-based • Number – events/activities held to support job attainment (ex. Career fairs, info sessions)

Target/Intended Population(s):

- Greater Houston community

Please provide any additional insights or explanations on the initiative(s) listed.

- Community Service Corps: This is the health care system's employee volunteer program offering opportunities for employees to donate time and talents. Skills-based volunteerism leverages the unique skillsets of employees to support capacity building efforts with local nonprofit agencies, expanding the nonprofits' ability to serve more of the community in need without the direct financial impact often incurred when paying for services.

Collaboration Partners (Internal and External):

- Human Resources, local nonprofit partners and collaboratives, Community Health Network, MHHS Greater Heights campus

Community Health: Maternal & Infant Health

- **Primary Prioritized Need Area: Maternal & Infant Health**
- **Secondary Prioritized Need Area: Access to Care**

FY26-FY28 Goal: To increase access to timely and comprehensive Maternal and Infant health services for community members residing in target neighborhoods by reducing missed postpartum follow-up visits and expanding access to care navigation or support services and improving newborn care through increased availability of services.

FY26 Objective: Reduce missed postpartum follow-up visits by 5% and increase participation in newborn care services—including immunizations by 10% among families residing in identified high-need neighborhoods, through expanded access to care navigation and targeted community outreach.

FY26 KPIs:

- Percent - postpartum patients referred to CRC
- Number - scheduled appointments
- Number - vaccinations administered
- Number - vaccination types

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Newborn Immunizations Initiative	MHHS Greater Heights Fetal Birthing Center	Baseline TBD post- FY26	• Number - vaccinations administered • Number - vaccination types • Number - unique households served
Post-Partum Discharge Callbacks/Follow-ups	• Maternal & NICU Coordinator • Lactation Specialists	Baseline TBD post- FY26	• Number - appropriate referrals • Percent - increase in compliance rate • Percent - show rate • Number - scheduled appointments • Percent - positive satisfaction scores
Referrals to Community Resource Centers (Maternal & NICU)	• Maternal & NICU Coordinator • Community Health Network	Baseline TBD post- FY26	• Go-live date • Percent - patients with improved post-partum outcomes • Percent - decrease in readmission rates • Number -scheduled appointments

			• Percent -show rate referred to community resource centers
Maternal & Infant Health Community Engagement	• FBC Leadership • Marketing • Maternal & NICU Coordinators	Community Events: 2	• Number - food drives held • Number - attendees at birthing classes • Number - high school speaking engagements
Target/Intended Population(s): • Target high-poverty ZIP communities; uninsured; Medicaid; young mothers			
Please provide any additional insights or explanations on the initiative(s) listed. • Newborn Immunization Initiative is a state funded program designed to provide free immunizations for newborns, specifically targeting uninsured and underinsured minority populations. • The Direct Referrals to Community Resource Center Program streamlines the referral process by allowing nurses to submit referrals directly to the CRC, helping to prevent delays in care or discharge that may occur while waiting for a social worker. The initiative strengthens collaboration between nursing and social work, effectively bridging the gap between the two roles. • Maternal and infant health community engagement: Food Drives w/CRC, Birthing Classes, High School Speaking Engagements, Maternal Health Literacy Workshops			
Collaboration Partners (Internal and External): • Coordinated Care; Community Health Network			

Community Priority: Mental Health & Substance Use

- **Prioritized Need Area: Mental Health & Substance Use**

FY26-FY28 Goal: Memorial Hermann Health System will implement initiatives that connect and care for the community, including those who are experiencing mental health challenges: access to appropriate psychiatric and behavioral health specialists; reducing unnecessary ER visits; increase connection to more appropriate preventative wellness outpatient services and navigation care coordination

FY 26 Objective: Increase awareness and availability of mental health services in the community to improve quality of life for patients, family members, and employees being served by the Greater Heights Campus.

FY26 KPIs:

- Percent – decrease of patients needing evaluation in ER
- Number – unique patients evaluated via programs
- Number – referrals to programs
- Number – patients engaged by program type

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Memorial Hermann 24/7 Psychiatric Response Team	Behavioral Health Division	Baseline TBD post-FY26	• Percent - decrease of patients evaluated in the ER
Memorial Hermann Mental Health Crisis Clinics: Community Setting	Behavioral Health Division	Baseline TBD post-FY26	• Number - unique patients evaluated
Memorial Hermann Collaborative Care Program (CoCM)	Behavioral Health Division	Baseline TBD post-FY26	• Number - referrals received from PCP • Number - patients engaged in CoCM services

Target/Intended Population(s):

- Broader Greater Houston community

Please provide any additional insights or explanations on the initiative(s) listed.

- Memorial Hermann Psychiatric Response Team, and on demand virtual psychiatry works 24/7 across the System and provides behavioral health expertise to all acute care campuses, delivering services to ERs and inpatient units.
- Memorial Hermann Mental Health Crisis Clinics (MHCCs) are outpatient specialty clinics open to the community, meant to serve individuals experiencing mental health challenges or those needing more immediate access to outpatient providers to meet their behavioral health needs.
- Memorial Hermann Collaborative Care Program (CoCM) strives to facilitate systematic coordination of general and behavioral health care. Integrating physical and behavioral health services; facilitating seamless access to care.
- Human Resources - Behavioral Health Services Employees
- Operating Resources – Computers, EMR, Virtual technology, and other documentation tools
- Capital Resources – Offices and other facilities

Collaboration Partners (Internal and External):

- Collaboration with all the Memorial Hermann Facilities, Leadership, Case Management, Medical staff, Community service providers, and other community partners

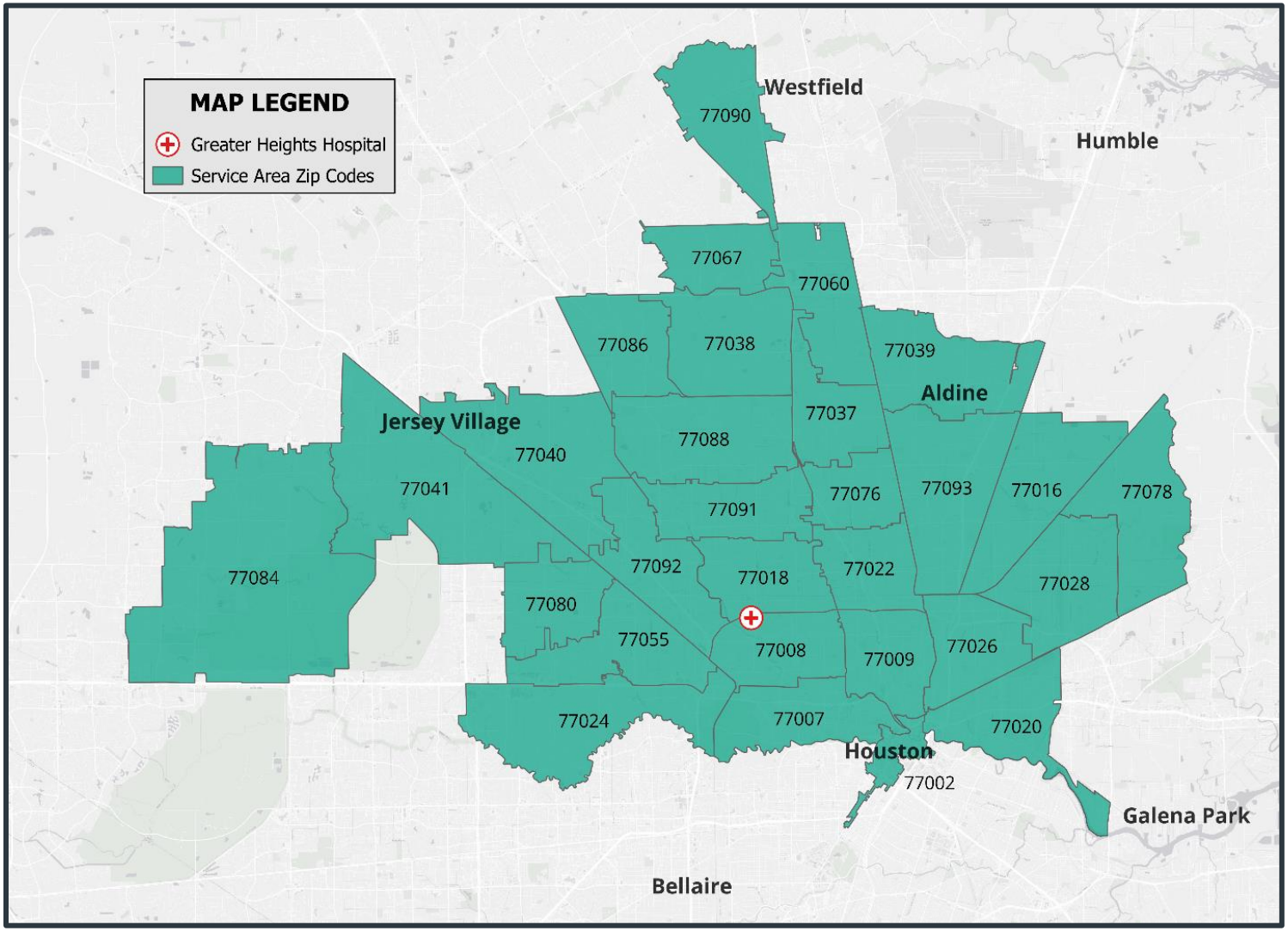
MEMORIAL HERMANN

Appendices

Appendix A: Memorial Hermann Greater Heights Hospital Supplementary Findings

The MSA for Memorial Hermann Greater Heights Hospital includes 29 zip codes in Harris County.

FIGURE 1. MEMORIAL HERMANN GREATER HEIGHTS HOSPITAL MSA



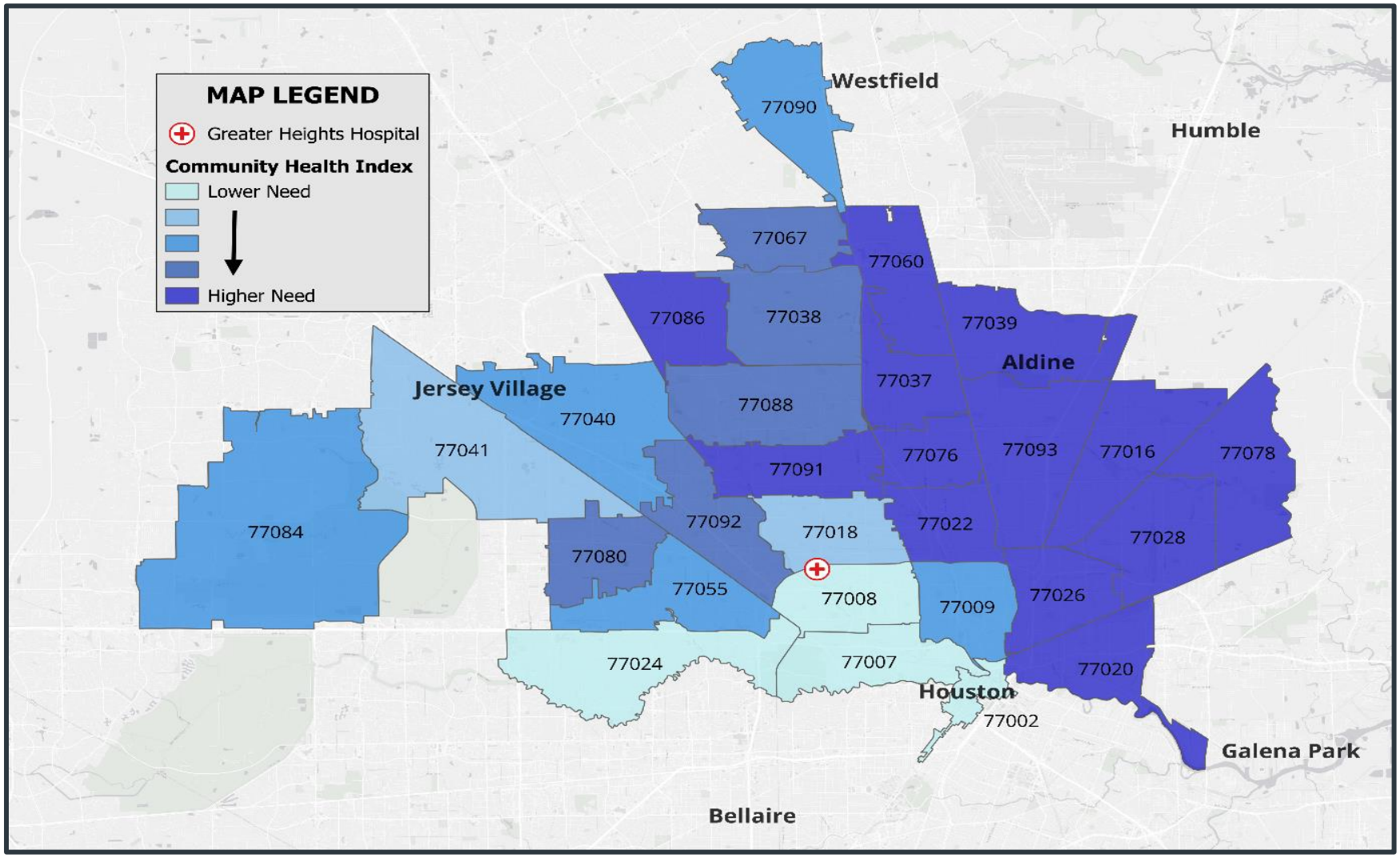
Key Findings: Access to Care

The Community Health Index (CHI) can help to identify specific geographies with greater health care needs, based on widely available data on non-medical drivers of health. This index can be helpful in planning where greater access to care may be needed. Across the Greater Heights Hospital MSA, the zip codes with the highest CHI scores are:

- 77037 (CHI = 99.3)
- 77093 (99.2)
- 77028 (98.8)
- 77016 (98.7)
- 77060 (98.7)

Notably, more than half of the MSA zip codes (16 out of 29) have a CHI score above 90, indicating concerning levels of health care needs across the entire region, compared to other U.S. zip codes.

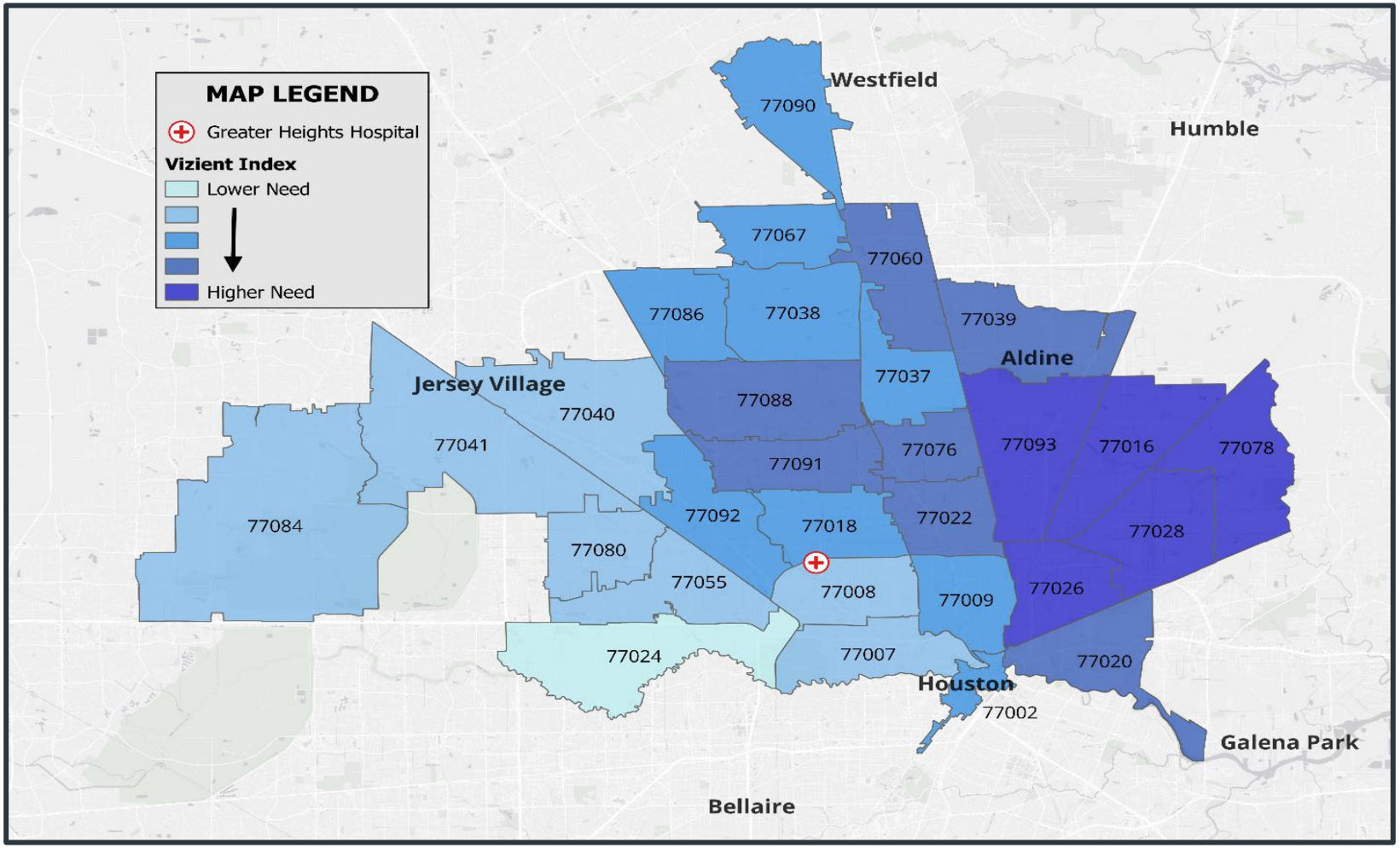
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN GREATER HEIGHTS HOSPITAL MSA



The 2024 Vizient Vulnerability Index (VVI) similarly identifies social needs and obstacles by calculating a score based on nine domains: economy, education, health care access, neighborhood resources, housing, clean environment, social environment, transportation, and public safety. Across the Greater Heights Hospital MSA, the zip codes with the greatest health care needs, based on this index score, are:

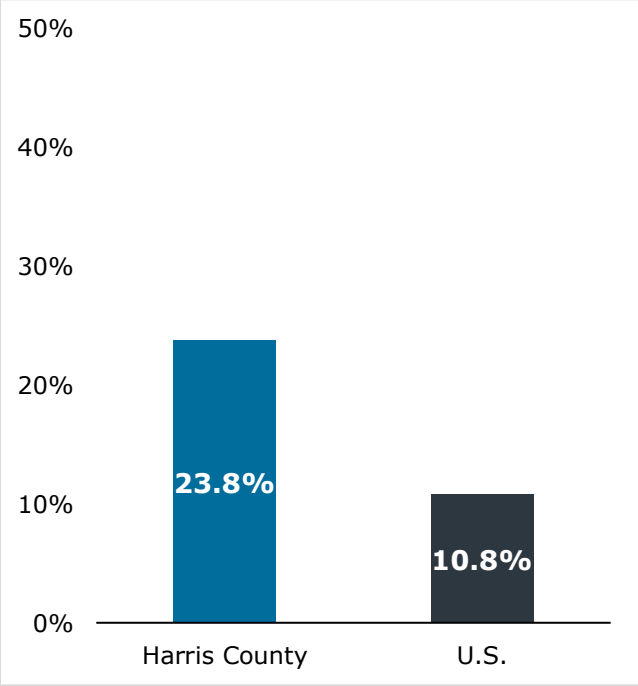
- 77028 (VVI = 2.41)
- 77016 (2.34)
- 77078 (2.10)
- 77026 (2.06)
- 77093 (1.83)

FIGURE 3. VIZIENT SCORE BY ZIP CODE: GREATER HEIGHTS HOSPITAL MSA



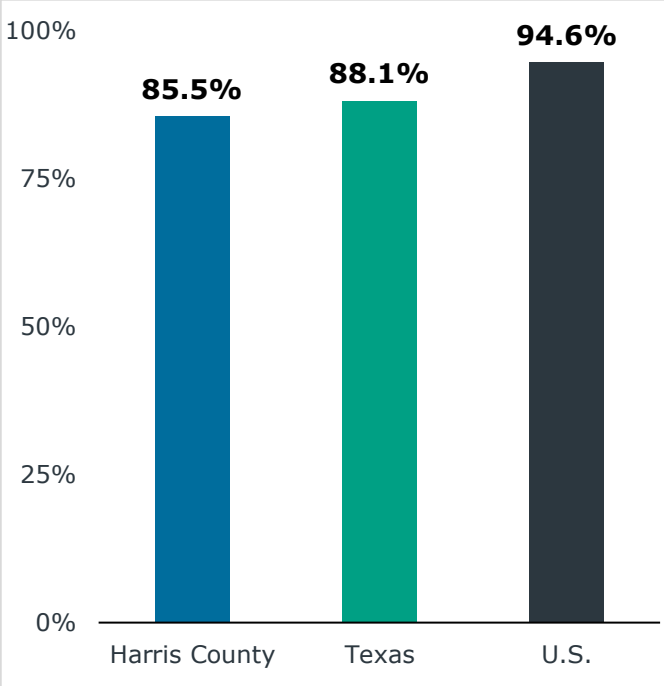
The following figures illustrate indicators of concern in Harris County, based on scoring of secondary data related to **Access to Care.**

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



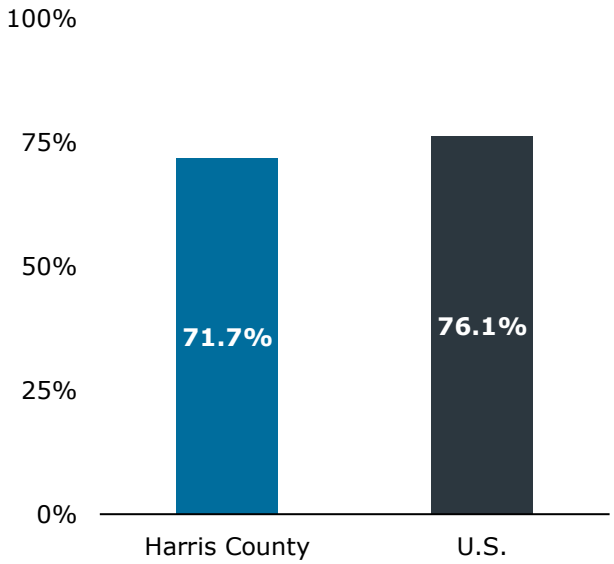
Source: CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



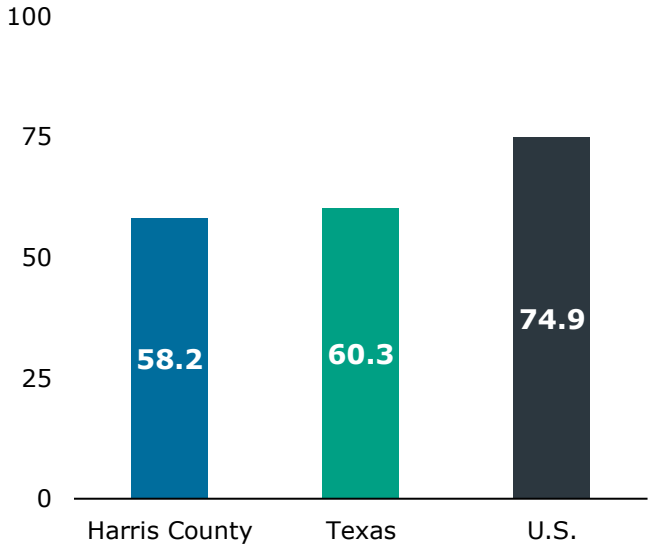
Source: American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



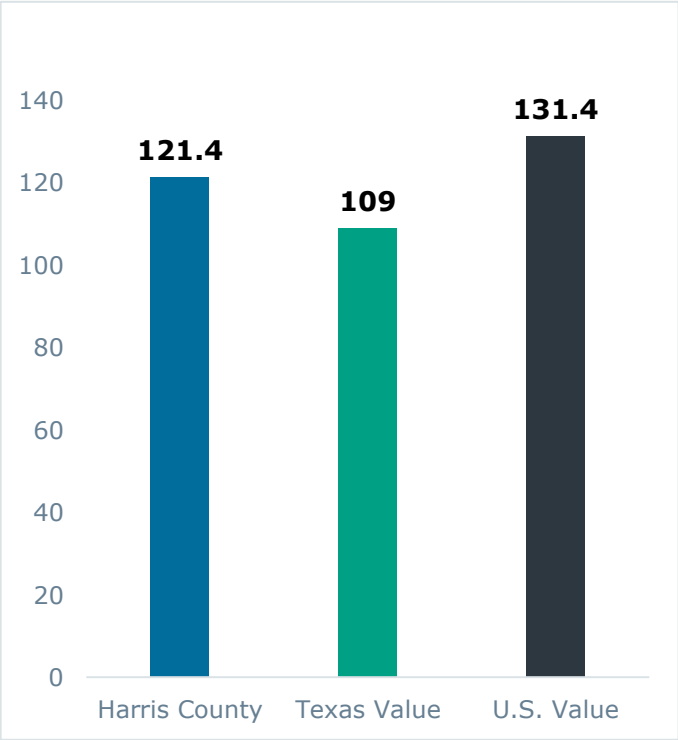
Source: CDC – PLACES (2022)

FIGURE 7. PRIMARY CARE PROVIDER RATE (providers per 100,000 population)



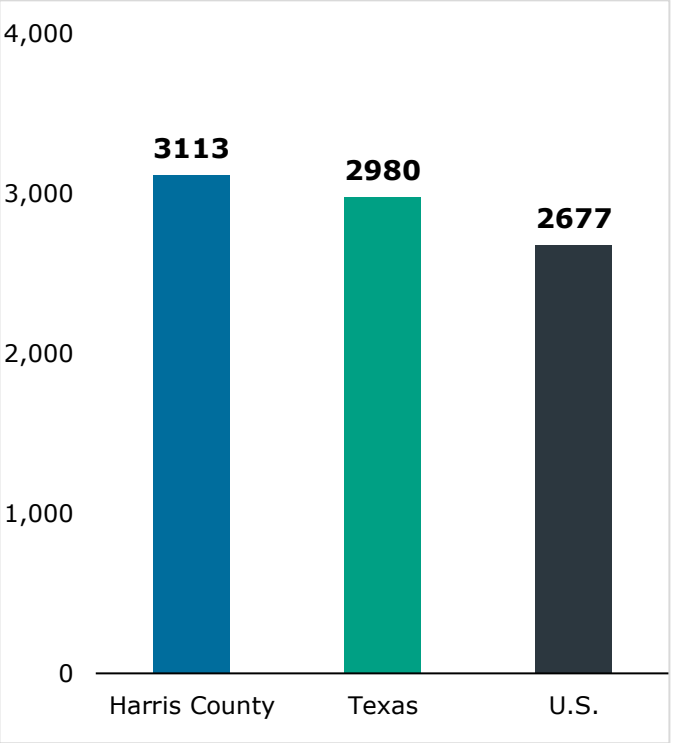
Source: County Health Rankings (2021)

FIGURE 8. NON-PHYSICIAN PRIMARY CARE PROVIDER RATE (providers per 100,000 population)



Source: County Health Rankings (2023)

FIGURE 9. PREVENTABLE HOSPITAL STAYS: MEDICARE POPULATION (discharges per 100,000 Medicare enrollees)



Source: Centers for Medicare & Medicaid Services (2022)

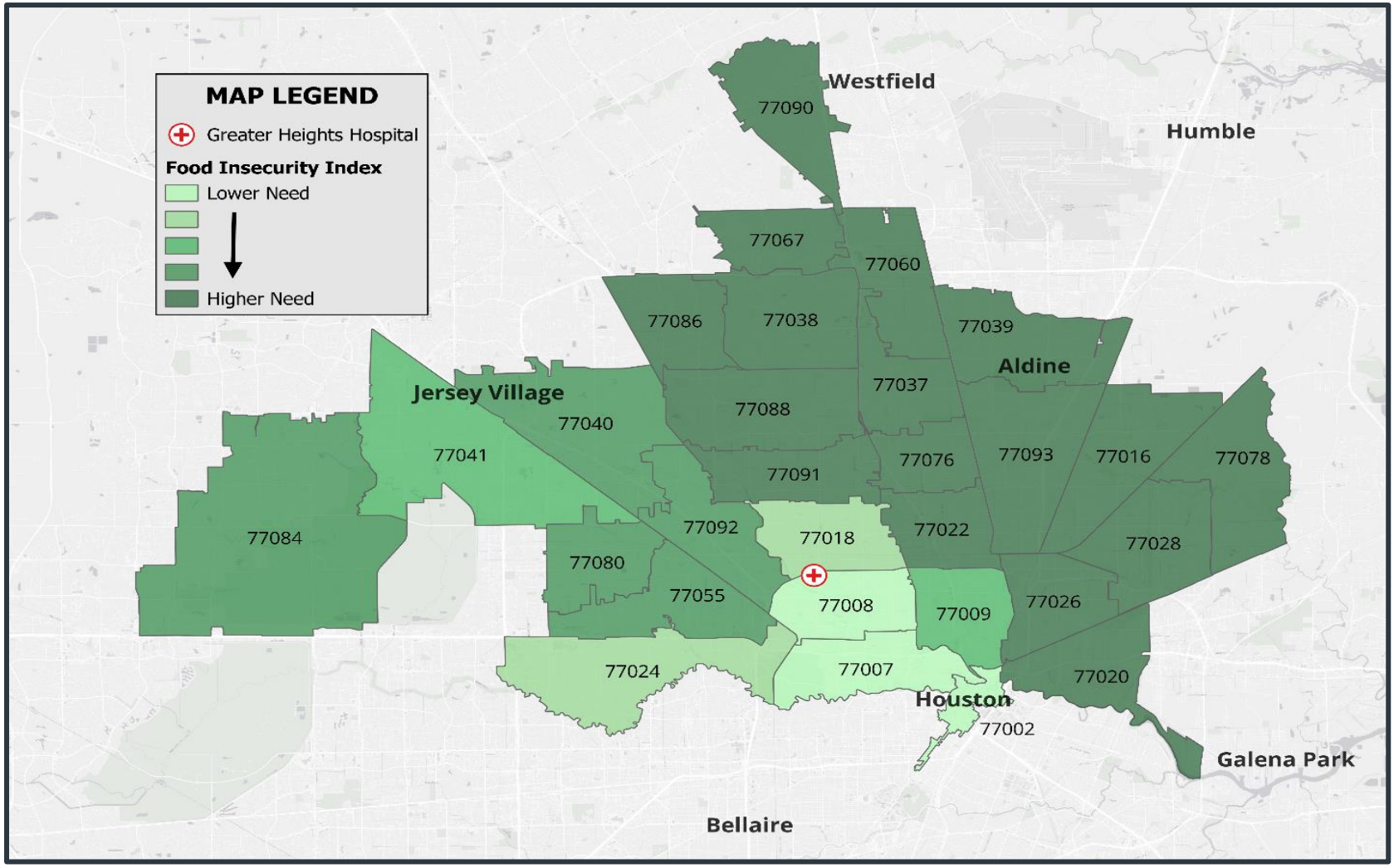
Key Findings: Access to Healthy Food

The Food Insecurity Index (FII) can help to identify specific geographies with greater needs regarding food access, based on widely available data on non-medical drivers of health. Across the Greater Heights Hospital MSA, the zip codes with the highest FII scores are:

- 77028 (FII = 99.5)
- 77060 (99.5)
- 77093 (99.4)
- 77078 (99.3)
- 77076 (98.9)
- 77039 (98.1)

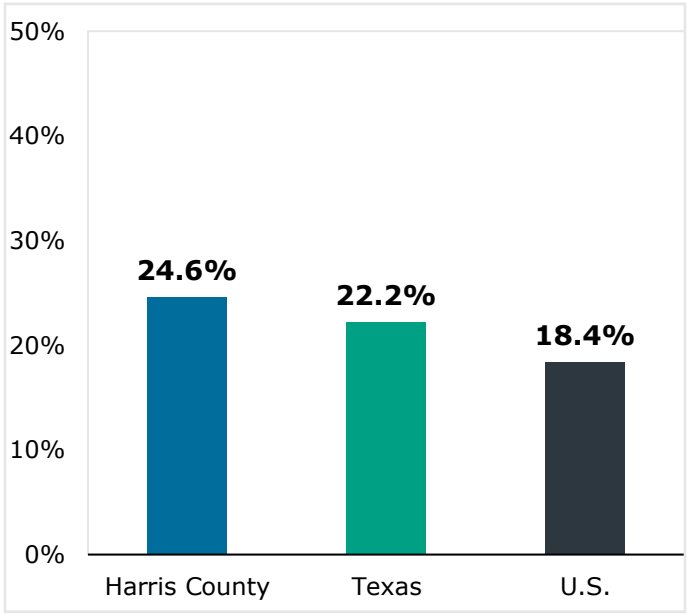
Notably, more than half of the MSA zip codes (18 out of 29) have a FII score above 90, indicating concerning rates of food insecurity across the entire region, compared to other U.S. zip codes.

FIGURE 10. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S FOOD INSECURITY INDEX BY ZIP CODE: GREATER HEIGHTS HOSPITAL MSA



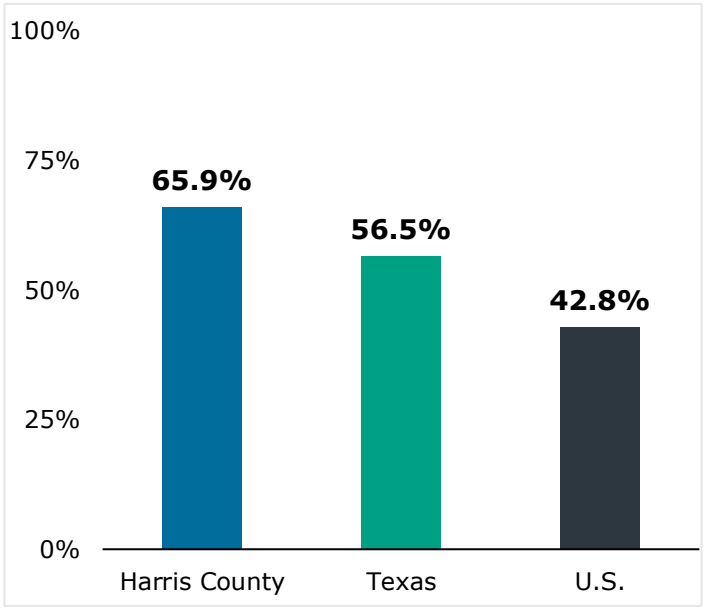
The following figures illustrate indicators of concern in Harris County, based on scoring of secondary data related to Access to Healthy Food.

FIGURE 11. CHILD FOOD INSECURITY RATE



Source: Feeding America (2022)

FIGURE 12. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM

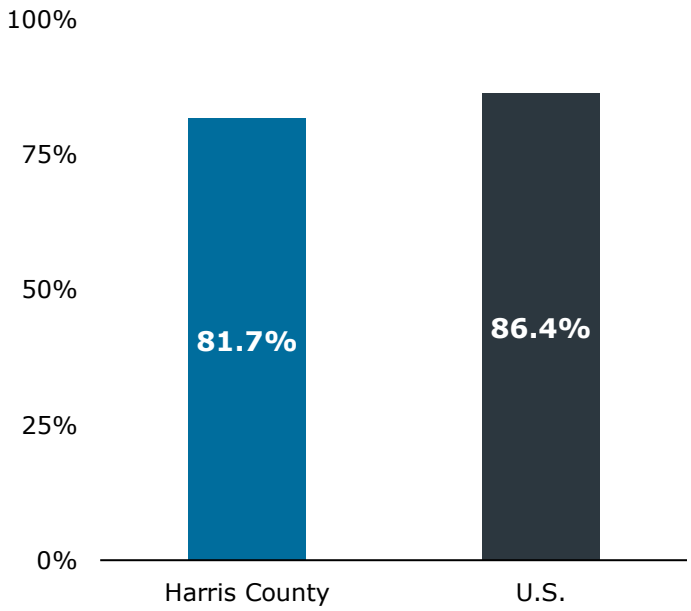


Source: National Center for Education Statistics (2022-2023)

Key Findings: Chronic Conditions Prevention and Management

In Harris County, 9.7% of adults age 20+ have diabetes. Although comparative state and U.S. rates are unavailable, this county rate is among the highest of all Texas counties. The following figures illustrate additional indicators of concern in Harris County, based on scoring of secondary data related to Chronic Conditions Prevention and Management.

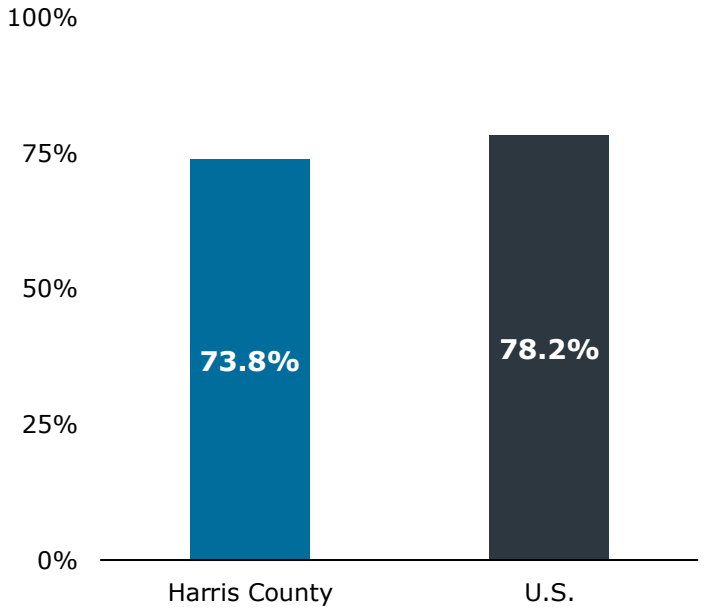
FIGURE 13. CHOLESTEROL TEST HISTORY



Source: CDC – PLACES (2021)

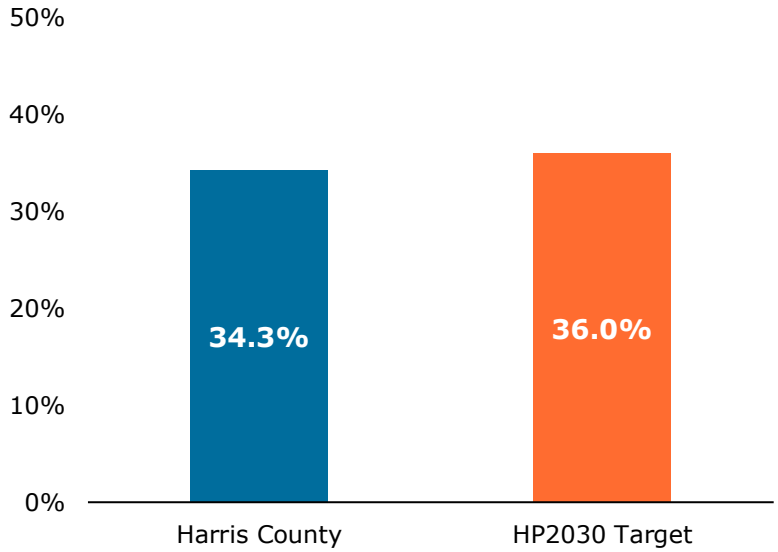
FIGURE 14. ADULTS WHO HAVE TAKEN BLOOD PRESSURE MEDICATION

(percent of adults with high blood pressure)



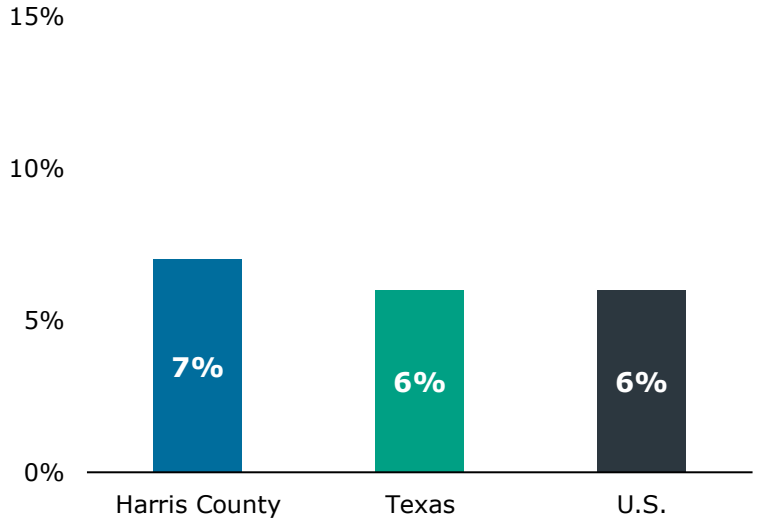
Source: CDC (2021)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



Source: CDC (2021)

FIGURE 16. STROKE: MEDICARE POPULATION



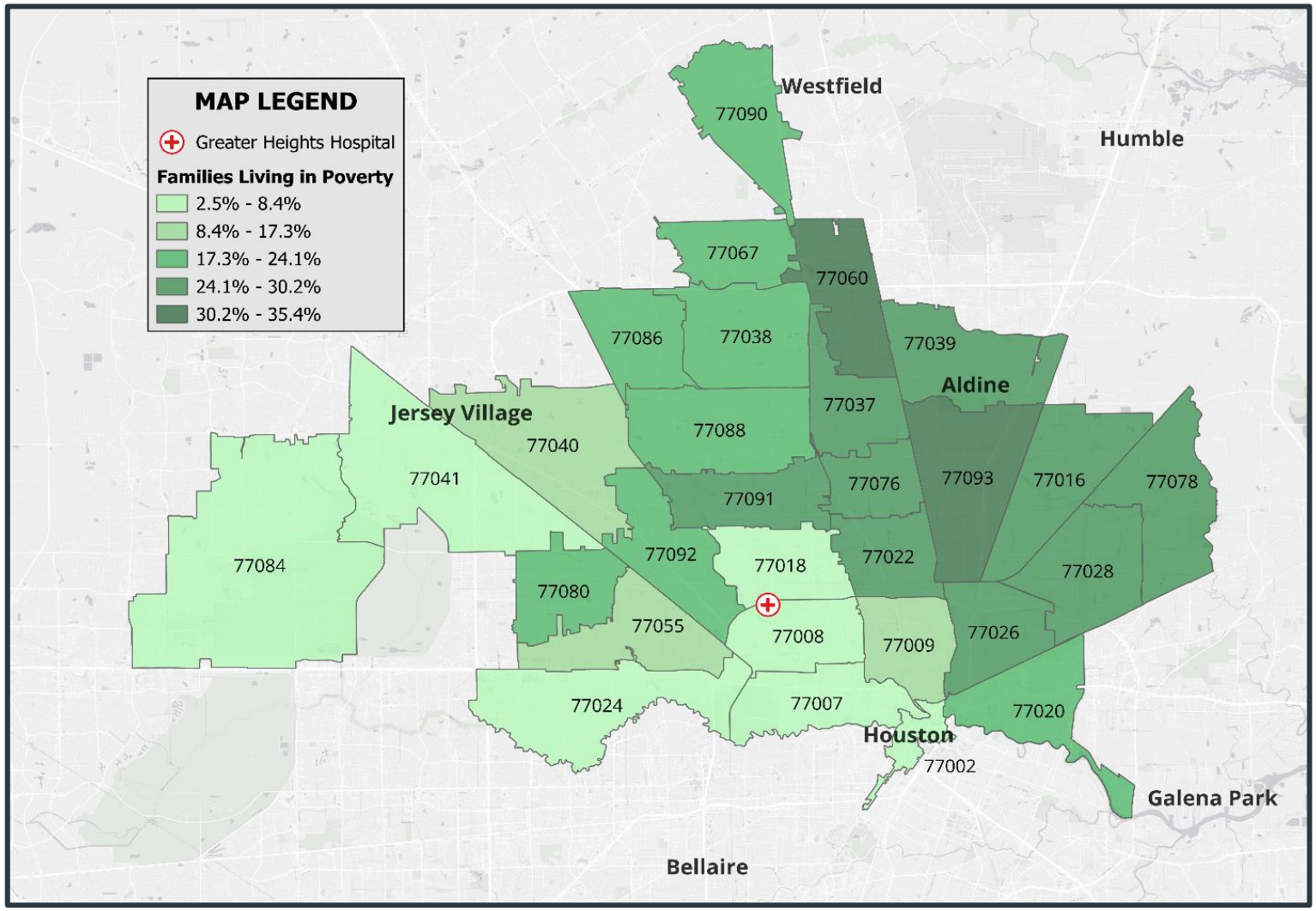
Source: CDC (2021)

Key Findings: Economic Opportunity

Across Texas, the overall rate of families living below the federal poverty level is 10.8%. Across the Greater Heights Hospital MSA, the highest percentages of households below the federal poverty level are in zip codes:

- 77060 (35.4%)
- 77093 (34.7%)
- 77078 (30.2%)

FIGURE 17. POVERTY BY ZIP CODE: GREATER HEIGHTS HOSPITAL MSA

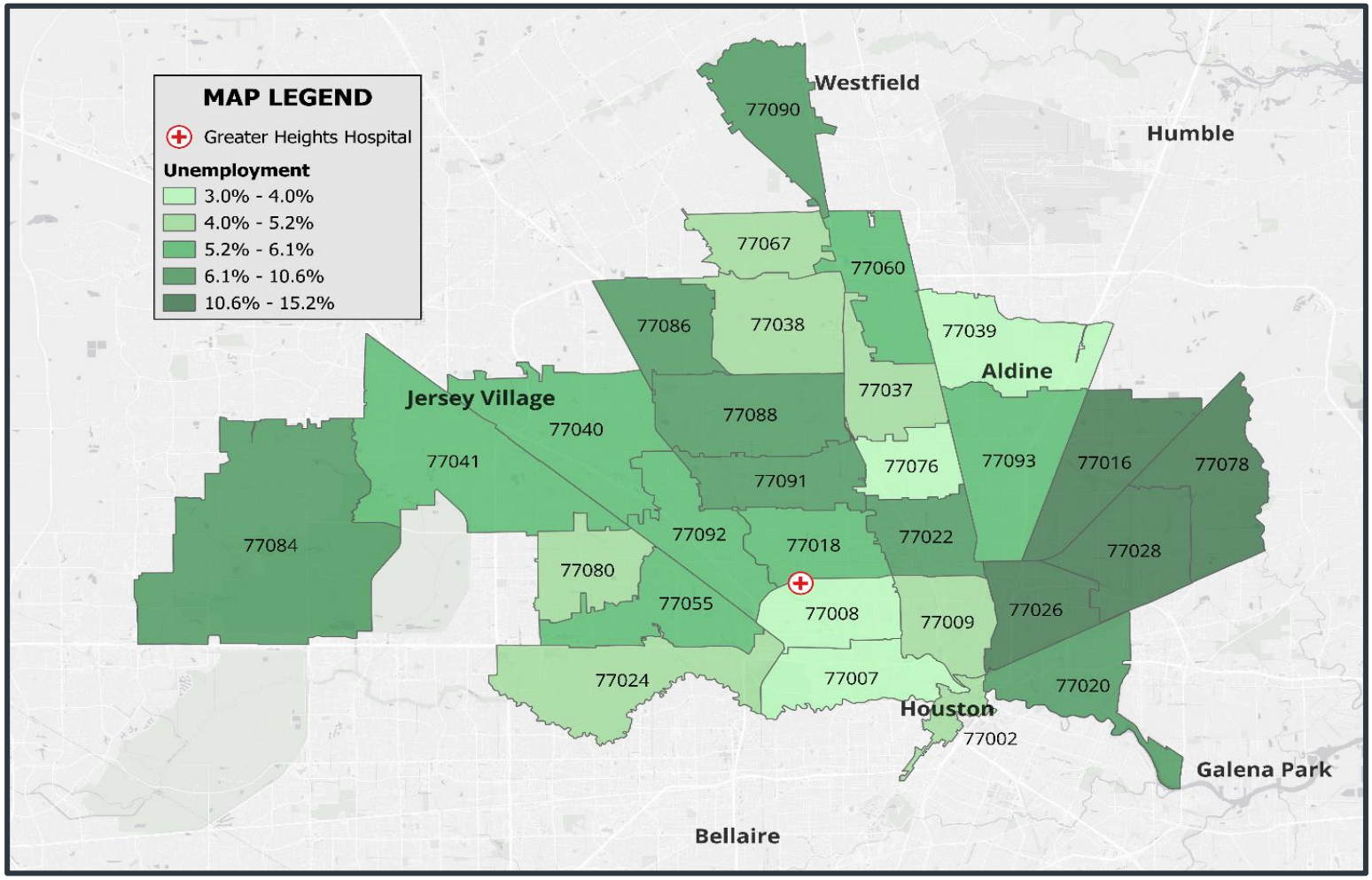


Source: Claritas (2024)

Across Texas, the overall rate of unemployment is 4.7%. Across the Greater Heights Hospital MSA, the highest levels of unemployment are in zip codes:

- 77028 (15.2%)
- 77078 (14.6%)
- 77016 (14.6%)
- 77026 (13.1%)
- 77020 (10.6%)

FIGURE 18. UNEMPLOYMENT BY ZIP CODE: GREATER HEIGHTS HOSPITAL MSA

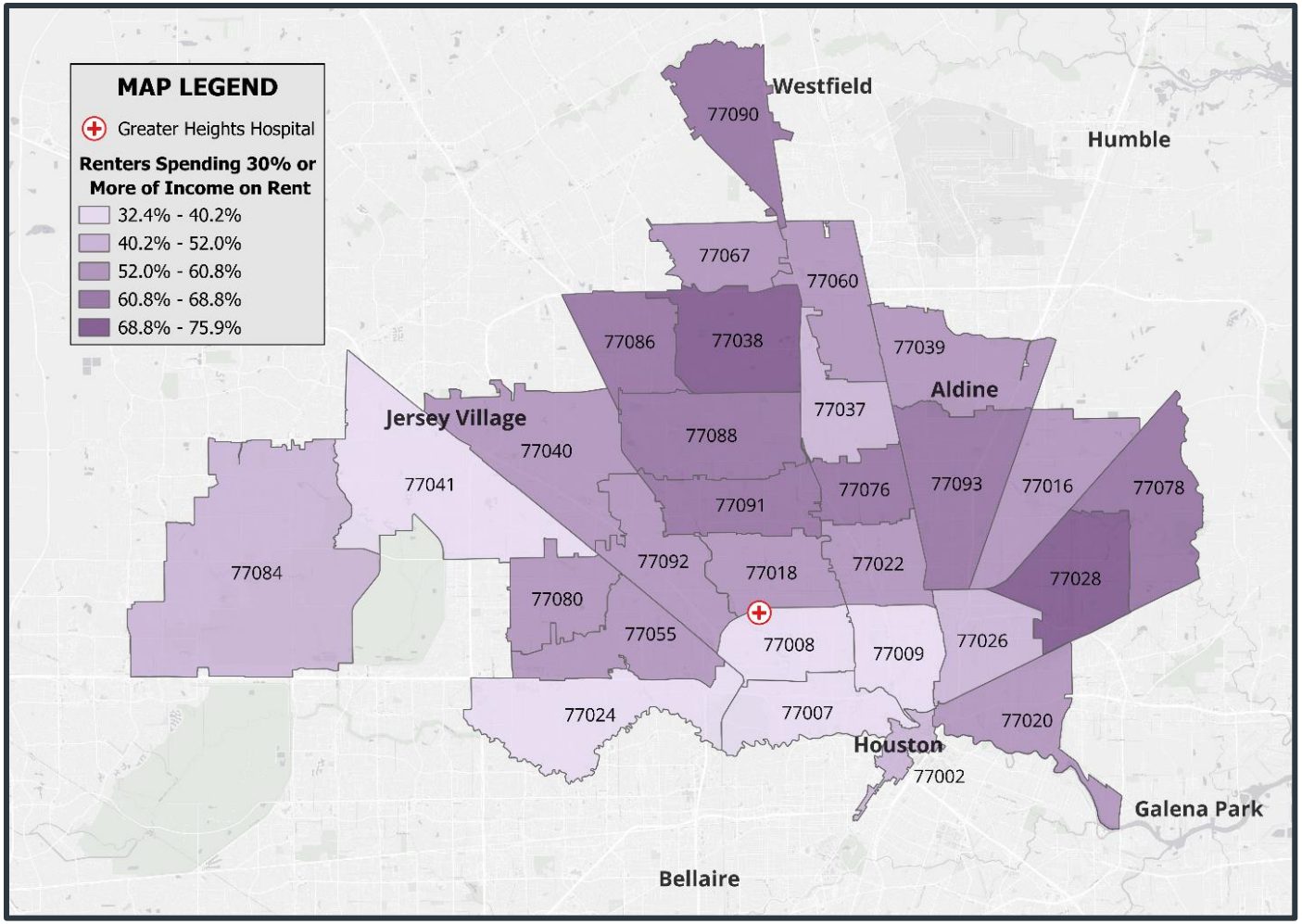


Source: Claritas (2024)

Across Texas, the overall rate of renters spending at least 30% of their income on rent is 50.7%. Across the Greater Heights Hospital MSA, the highest percentages of renters spending at least 30% of their income on rent are in zip codes:

- 77028 (75.9%)
- 77038 (73.1%)
- 77088 (68.8%)

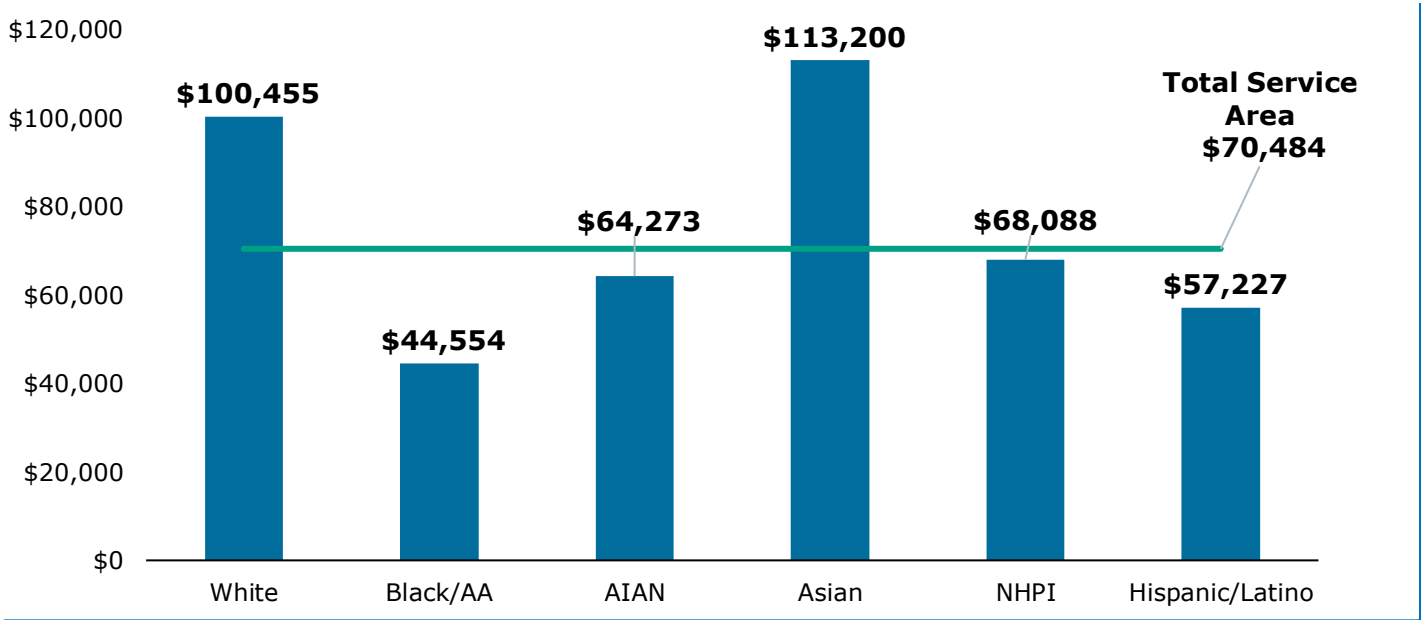
FIGURE 19. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: GREATER HEIGHTS HOSPITAL MSA



Source: American Community Survey (2018-2022)

Across the Greater Heights Hospital MSA, income differs substantially by race and ethnicity. The median household income for Black/African American and Hispanic Latino residents of the MSA are both more than $10,000 lower than the overall median household income.

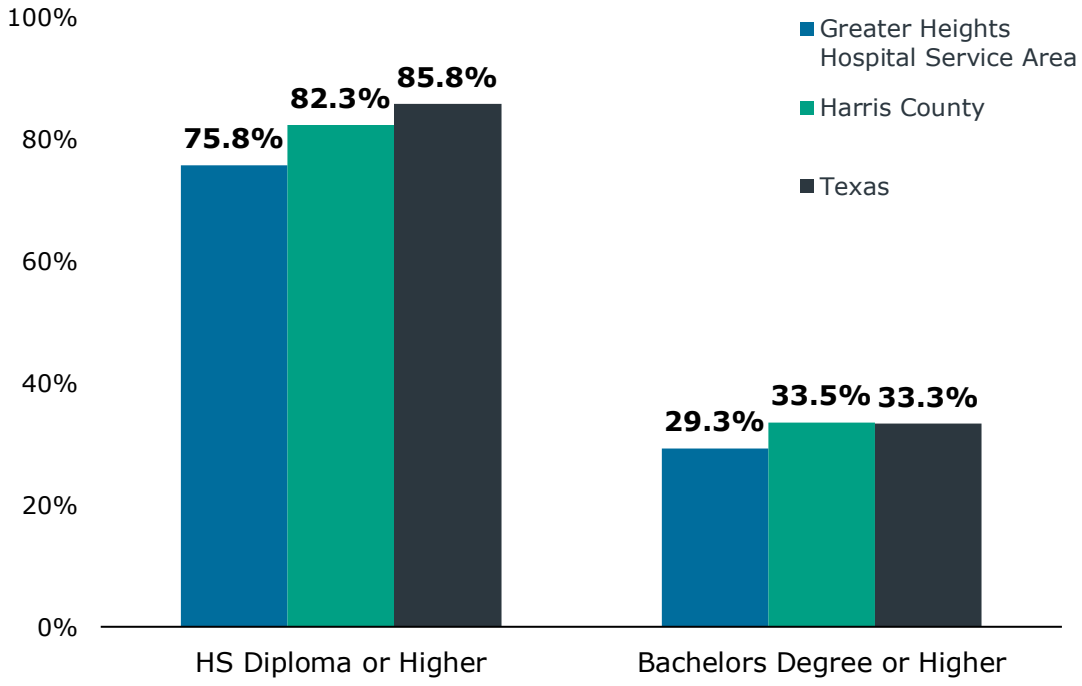
FIGURE 20. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: GREATER HEIGHTS HOSPITAL MSA



Source: Claritas (2024)

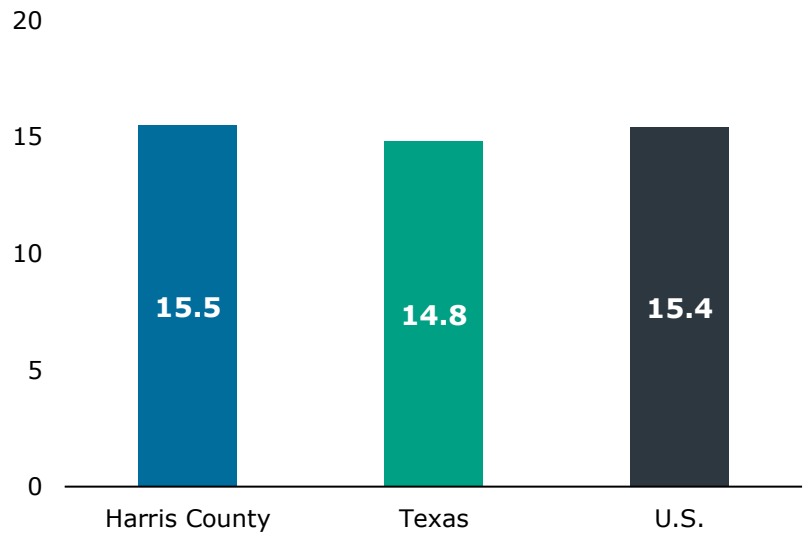
Key Findings: Educational Access

FIGURE 21. EDUCATIONAL ATTAINMENT



Source: National Center for Education Statistics (2022-2023)

FIGURE 22. STUDENT-TO-TEACHER RATIO

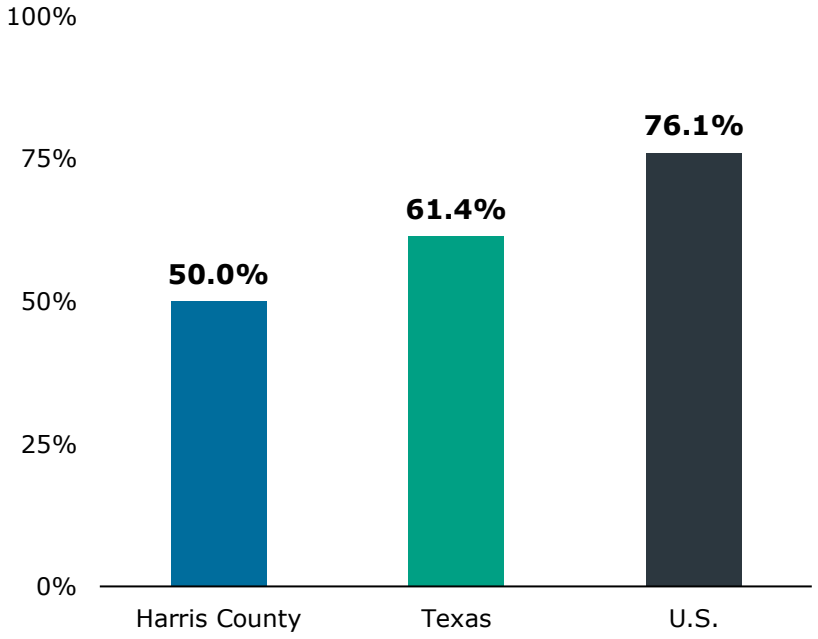


Source: Claritas (2024)

Key Findings: Maternal & Infant Health

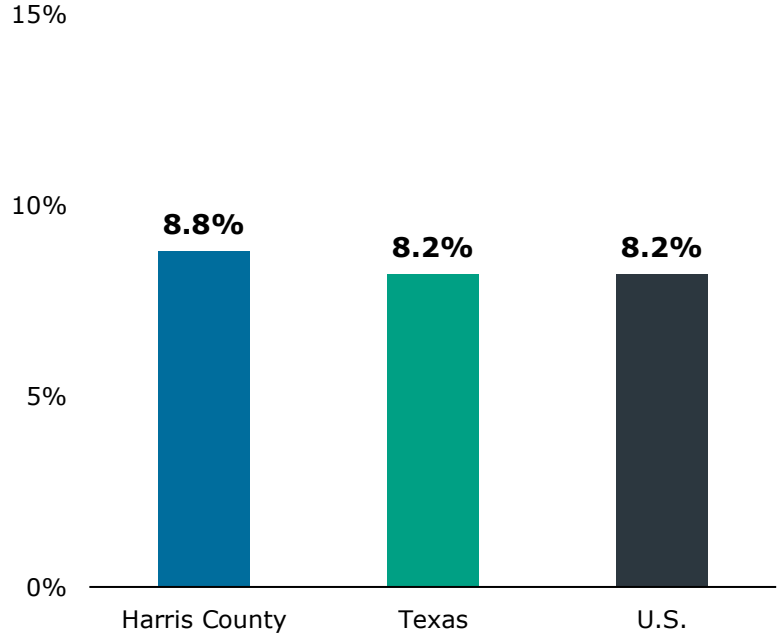
The following figures illustrate indicators of concern in Harris County, based on scoring of secondary data related to Maternal & Infant Health.

FIGURE 23. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



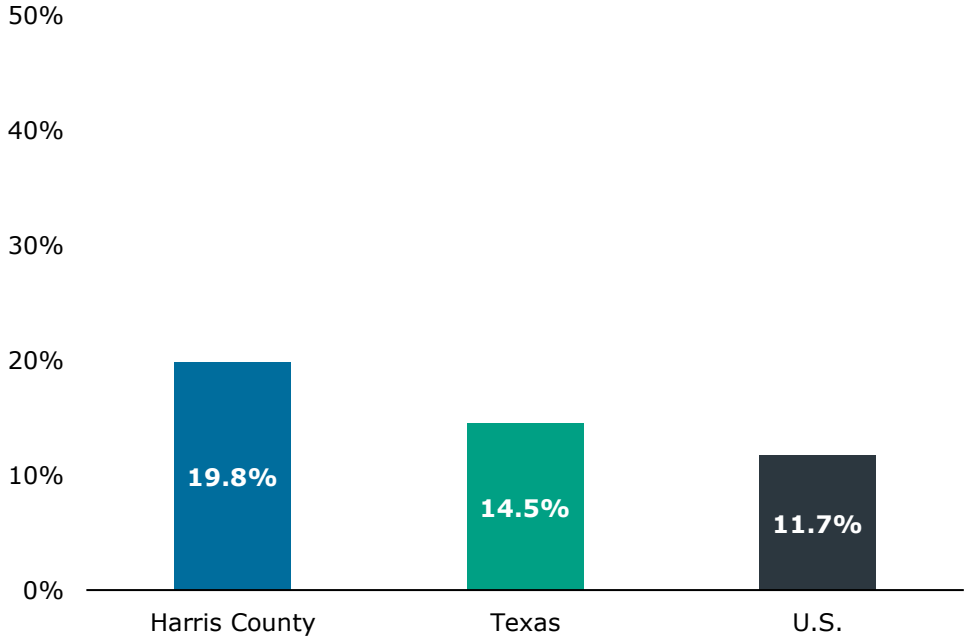
Source: Texas Department of State Health Services (2020)

FIGURE 24. BABIES WITH LOW BIRTHWEIGHT



Source: Texas Department of State Health Services (2020)

FIGURE 25. INFANTS BORN TO MOTHERS WITH LESS THAN 12 YEARS OF EDUCATION



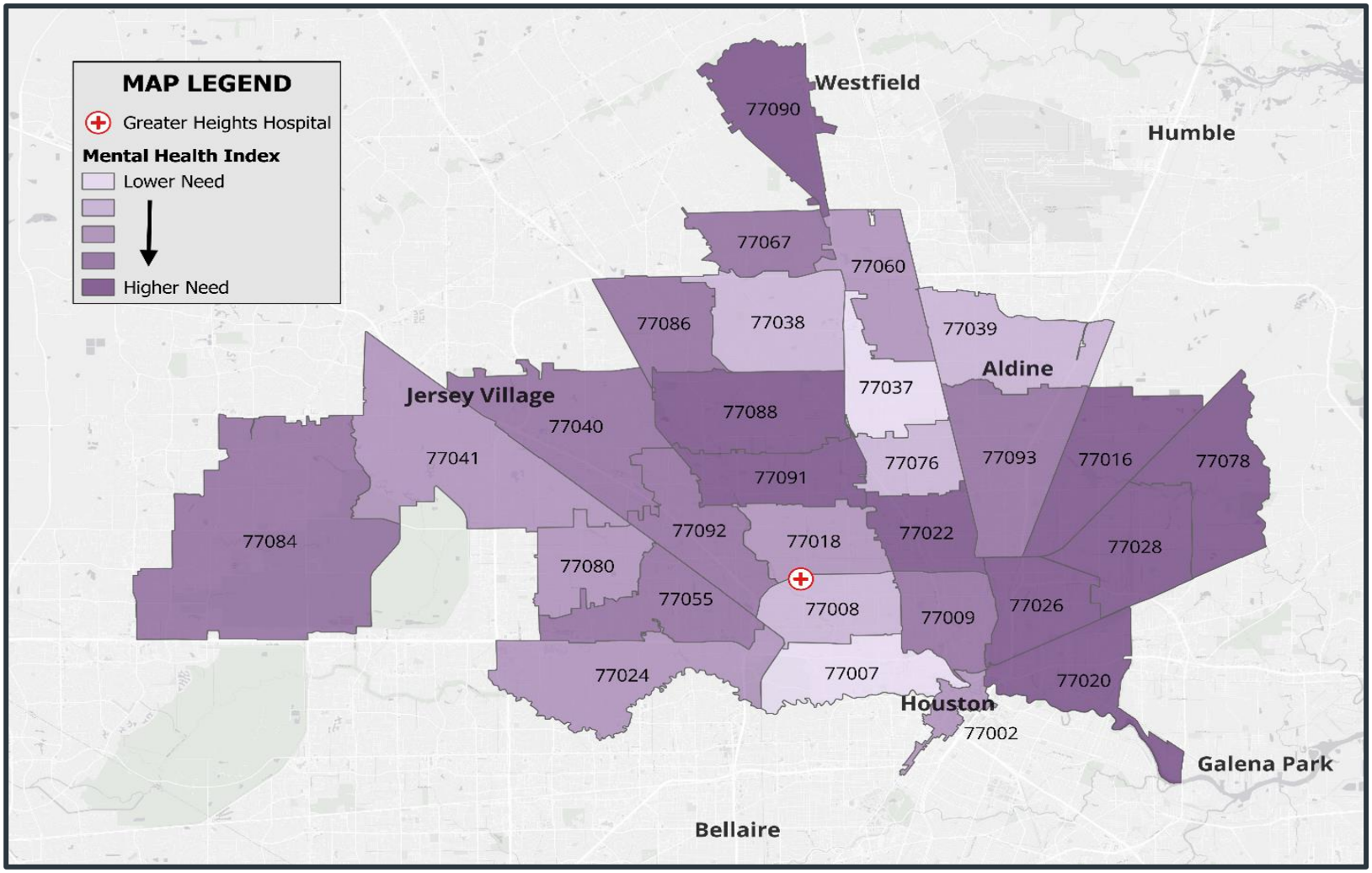
Source: Texas Department of State Health Services (2020)

Key Findings: Mental Health & Substance Use

The Mental Health Index (MHI) can help to identify specific geographies with greater needs regarding mental health, based on widely available data on non-medical drivers of health. Across the Greater Heights Hospital MSA, the zip codes with the highest MHI scores are:

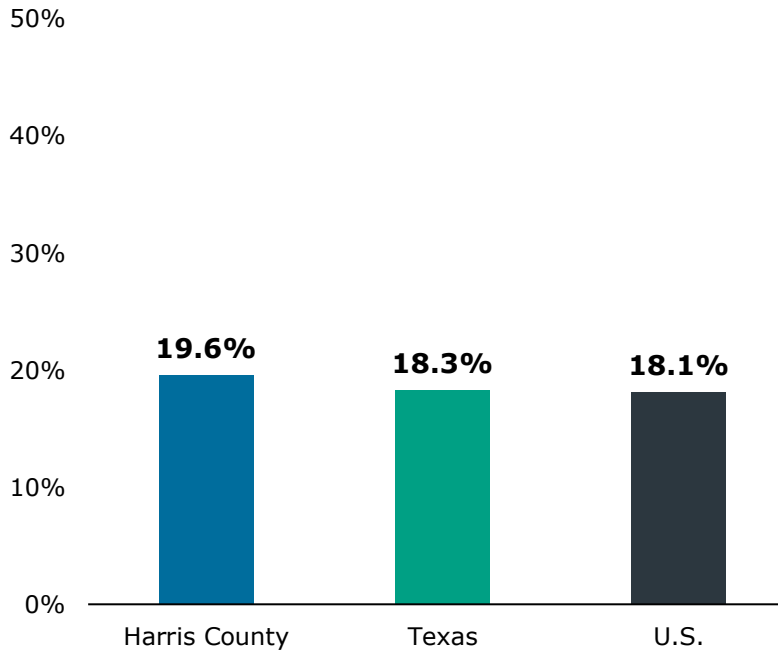
- 77026 (MHI = 98.3)
- 77028 (97.7)
- 77016 (97.4)
- 77078 (93.1)
- 77091 (91.7
- 77088 (90.7)

FIGURE 26. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S MENTAL HEALTH INDEX BY ZIP CODE: GREATER HEIGHTS HOSPITAL MSA



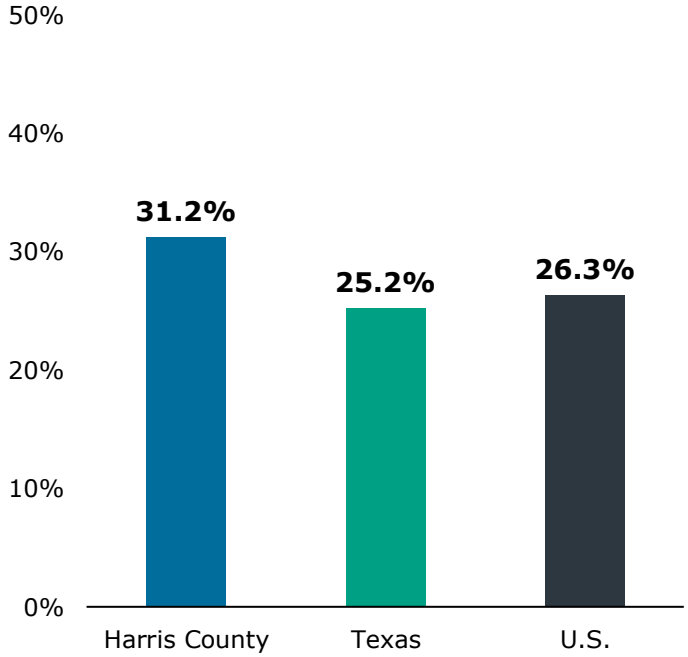
The following figures illustrate indicators of concern in Harris County, based on scoring of secondary data related to Mental Health & Substance Use.

FIGURE 27. ADULTS WHO DRINK EXCESSIVELY



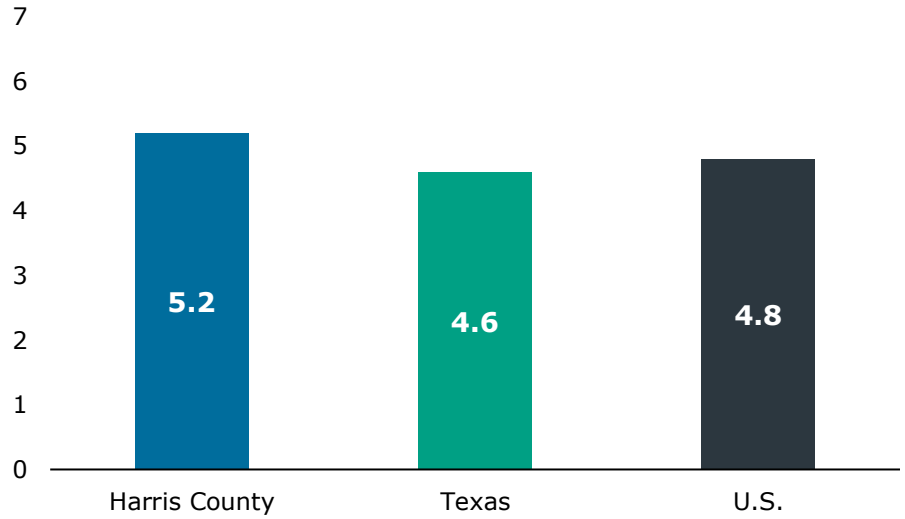
Source: County Health Rankings (2021)

FIGURE 28. ALCOHOL-IMPAIRED DRIVING DEATHS (percent of driving deaths involving alcohol)



Source: County Health Rankings (2017-2021)

FIGURE 29. POOR MENTAL HEALTH DAYS
(average number of days out of past 30 with poor self-reported mental health)



Source: County Health Rankings (2021)