Community Health Implementation Strategy

Memorial Hermann Northeast Hospital

MEMORIAL® HERMANN Northeast

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At-a-Glance Summary

Community Served 	Memorial Hermann Northeast Hospital, serving 788,449 persons living in 19 zip codes in Harris, Montgomery, and Liberty counties.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA):

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 FY28.
- By FY28, increase access to preventative and diagnostic breast assessments and mammograms by 30%, and enhance early detection and treatment access through the Project Mammogram Program.
- Refer ≥70% of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ER settings with identified Non-Medical Driver of Health (NMDOH) needs to Community Care Coordination Team (C3T) Community Health Workers (CHWs) for a documented intervention and outcome.

Access to Healthy Food

- To 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 nutrition 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.
- By end of FY28, ensure that at least 20% of attendees at community chronic disease management events who are identified as at-risk or already living with a chronic condition schedule and complete a follow up provider visit for active disease management.

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.
- To develop a robust, targeted preceptor program for Aldine ISD Heal High School students, maintaining a 5% student-to-preceptor ratio. The program will provide hands-on learning across key career pathways including rehabilitation, pharmacy, and medical imaging, ensuring students receive dedicated, high-quality training experiences.

Maternal & Infant Health

- To increase infant and maternal health by increasing breastfeeding rates to >85% and > 20% of infants who are exclusively breastfed by end of FY28.

Mental Health & Substance Use

- 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 preventive wellness outpatient services and navigation care coordination.

Our Hospital and the Community Served

Northeast Hospital

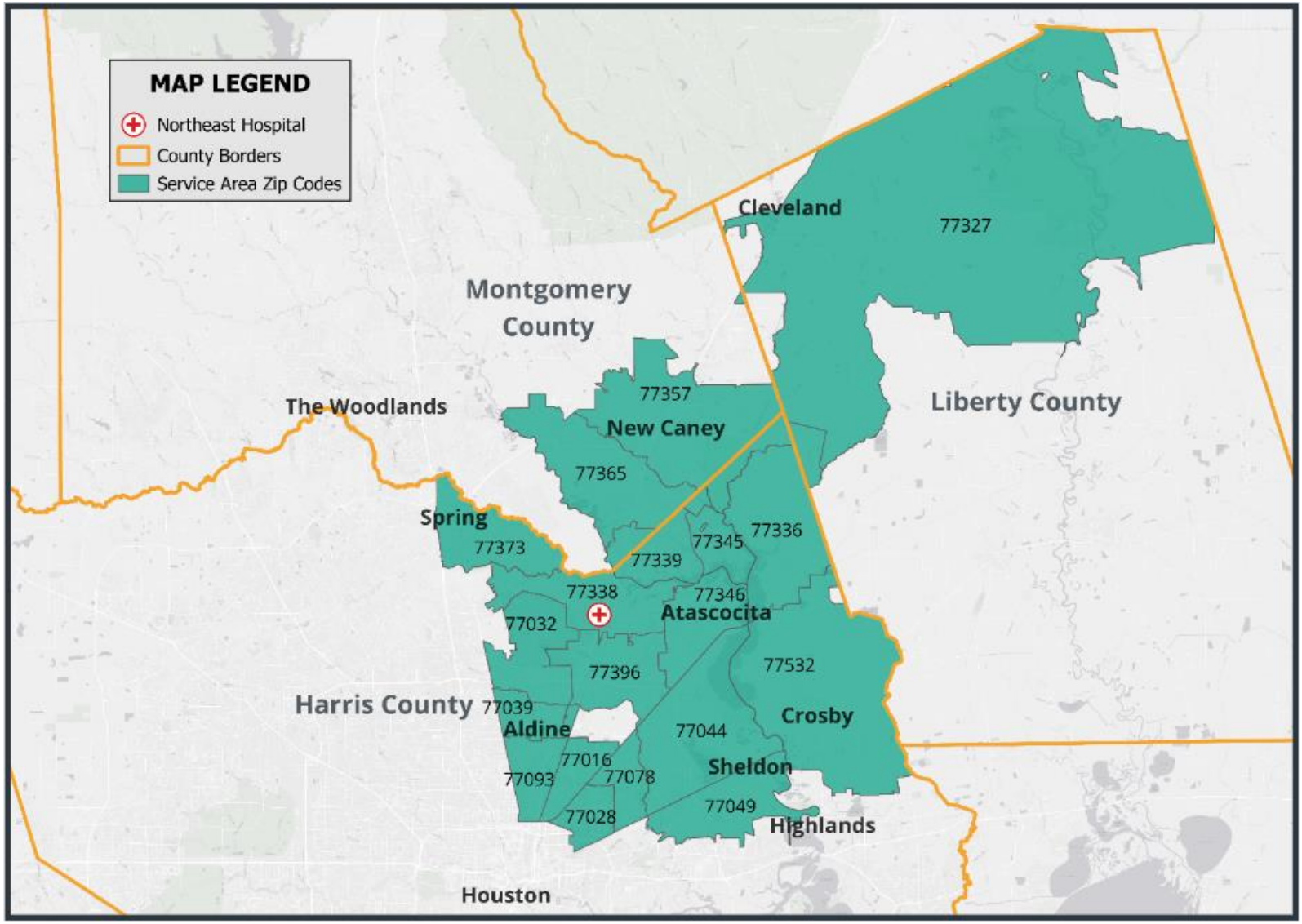
Northeast Hospital is a part of Memorial Hermann Health System (MHHS), one of the largest nonprofit health systems in Texas, with 17* hospitals and more than 6,600 affiliated physicians, 34,000 employees across 270 care delivery sites throughout the Greater Houston area.

A 257-bed facility, Memorial Hermann Northeast Hospital has been caring for families in the Lake Houston and Kingwood area for more than 47 years, offering world-class care close to home. Its affiliated doctors span a wide variety of services including cancer care, children's emergency and NICU care, heart and vascular care, orthopedics, neurosciences, digestive health, sleep health, wound care, and women's care. The hospital is the anchor for the innovative Memorial Hermann Convenient Care Center providing one-stop, highly coordinated access to an extensive array of Memorial Hermann services. Additionally, Memorial Hermann Northeast serves as the official health care provider to passengers traveling through Houston's George Bush International Airport.

Description of the Community Served

Northeast Hospital Metropolitan Service Area (MSA) has a population of approximately 788,449 persons serving 19 zip codes in Harris, Montgomery, and Liberty counties. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. MEMORIAL HERMANN NORTHEAST HOSPITAL 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 anticipated impacts of these activities. Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

Memorial Hermann Northeast 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 Benefit team began subsequent work on implementation planning. Hospital contacts and participants were identified, and representation included Memorial Hermann Northeast Hospital, and other hospital leadership.

During initial planning meetings, representatives from HCI and Memorial Hermann Northeast 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 Northeast 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 Northeast Hospital 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 that follow:

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 Northeast 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 within180 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: NE Neighborhood Health Center	Community Health Network	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
Target/Intended Population(s):			

- Uninsured; Medicaid; high-poverty priority ZIPs in surrounding MHHS Northeast campus

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.

Collaboration Partners (Internal and External):

- Coordinated Care; ER; ISD; community nonprofit agencies; Strategy division; Project Mammogram; The Rose

- **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 Program 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 Northeast campus.

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.

Collaboration Partners (Internal and External):

- Independent School Districts; community nonprofit agencies

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

FY26-FY28 Goal: By FY 28, increase access to preventive and diagnostic breast assessments and mammograms by 30%, and enhance early detection and treatment access through the Project Mammogram Program.

FY26 Objective: To increase the diversity of clients served by achieving a 10% overall increase in breast exams, including a 10% increase among African American clients.

FY26 KPIs:

- Percent – increased number of breast exam clients by 10%
- Percent – increased diversity of clients served
- Percent – increased volume of breast exams provided to African American clients by 10%
- Number - increased community mammogram days to 2 for immediate screenings and early detection.
- Number- increased community presentations provided to raise awareness of risks of breast cancer

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Breasts Assessments	• Memorial Hermann Northeast Hospital Outpatient Imaging • Project Mammogram	329 breast assessments FY25	• Completion –new streamlined process for access • Completion – marketing collateral for awareness • Number- days dedicated to breast assessments
Breast Diagnostic Imaging Exams	• Northeast Hospital Outpatient Imaging • Project Mammogram	534 Breast Images performed FY25	• Completion –new streamlined process for access • Completion – educational material on prevention and access to care options
Community Outreach Presentations: Introduction to Project Mammogram Program	• Project Mammogram • Northeast Hospital Outpatient Imaging	23 presentations given to community groups (FY25)	• Number – Presentations conducted • Number – community partners engaged • Number – attendees to presentations

Community Mammogram days	• Marketing • Outpatient Imaging • Project Mammogram	1 Community Mammogram Day	• Dates – community mammogram days • Number – reserved appointment slots available for community mammograms • Completion – awareness • Number – community partners engaged for target populations (African American women)
Neighborhood Health Centers: Mammograms Access	• Community Health Network • Project Mammograms	Baseline TBD by end of FY26	• Number – scheduled appointments for mammograms • Percent – show rates of patients scheduled for mammograms • Number – referrals to main NE campus for additional services

Target/Intended Population(s):

- Women and men that are uninsured or under insured that have limited access to screening mammograms and subsequent diagnostic testing and treatment in the Project Mammogram coverage zip codes

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

- Project Mammogram is a program that is housed out of the Memorial Hermann Northeast Campus facilities
- It provides breast exams and access to mammograms, biopsies, and surgery.
- Project Mammogram covers 25 zip codes in Harris County, East Montgomery County, and West Liberty County

Collaboration Partners (Internal and External):

- Project Mammogram; Memorial Herman Northeast Radiation Center; Memorial Hermann Northeast OPID; Northeast Hospital Authority; Northeast Hospital Foundation; Humble ISD; New Caney ISD; Local Churches/Community Organizations

Prioritized Need Area: **Access to Care**

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

FY26 Objective: ≥50% of MHHS ACO patients discharged from acute or ER settings with identified NMDOH needs will be referred to Community Care Coordination Team CHW's 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
ER 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: **To 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 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 food insecure 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
NE Community Garden & Employee Driven Food Support	• Community Health Network • Memorial Hermann Northeast Clinical Nutrition Department	• 223.74 pounds in FY25 • 5 recipes developed in FY25	• Number –pounds of food collected and donated (target: 100lbs more than FY25) • Number – recipes created for nutrition support • Number – recipes distributed to community members
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 are 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. • Memorial Hermann NE will focus on increasing pounds of food distributed to community members identified as food insecure with majority of donations coming from the local community garden. Efforts will include working with nutrition department to develop healthy recipes on using donated fresh produce. Will also collaborate with the Community Health Network's Community Resource Centers to ensue community member engagement is measured.			
Collaboration Partners (Internal and External): • Ambulatory Services; local food nonprofit agencies (Urban Harvest; etc.); Clinical Nutrition Department; Community Health Network – Community Resource Centers			

Community Priority: Chronic Conditions Prevention and Management

- **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 Northeast 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 of patients screened
- Percent high-risk patients referred to resources
- Number of 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 Contact Center	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

Target/Intended Population(s):

- All payer types; Broader Greater Houston community

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

- CHW Hub will be piloted to increase NMDOH screening and resource referrals across the system with primary feeder during FY26 from MyChart. Referrals will help 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

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

FY 26 -28 Goal: By end of FY28, ensure that at least 20% of attendees at community chronic disease management events who are identified as at-risk or already living with a chronic condition schedule and complete a follow-up provider visit for active disease management.

FY26 Objective: By the end of FY26, collect baseline data from at least 50% of community event attendees through an administered survey, and conduct a six-month follow-up to assess compliance with recommended care and utilization of follow-up care resources.

FY26 KPIs:

- Rate – baseline date collection rate
- Rate – six-month follow-up completion rate
- Number – surveys distributed
- Number – community events

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Community education symposiums: Chronic Diseases	Marketing Division	TBD-post FY26	• Completion – schedule for education symposium • Completion – survey development (pre & post) • Number- attendees to education symposium sessions
Senior health fair screening for HTN (BP) and Diabetes (Blood glucose)	• Marketing Division • Project Mammogram	TBD-post FY26	• Completion – survey development (pre & post) • Number – screenings completed by disease focus • Number – people screened

Target/Intended Population(s):

- Community members with chronic conditions or risk of chronic conditions to include CHF, Diabetes, HTN, other conditions that lead to Stroke

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

- Utilize senior health fair that is presented as a partnership with Memorial Hermann Northeast and Northeast Hospital Foundation to provide education on health risks and conditions as well as health screens. It also introduces providers and resources in the community to prevent and treat chronic health conditions in the aging population of 55 and up.
- Survey to be distributed to ensure the education provided is making an impact in direct care for timely evaluation and treatment.

Collaboration Partners (Internal and External):

- Memorial Hermann Northeast Marketing Leadership; Northeast Hospital Authority; Partnership Lake Houston; Memorial Hermann Northeast Community Resource Center; Northeast Hospital Foundation

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 Northeast campus

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

FY26-FY28 Goal: **To develop a robust, targeted preceptor program for Aldine ISD Heal High School students, maintaining a 5% student-to-preceptor ratio. The program will provide hands on learning across key career pathways including rehabilitation, pharmacy, and medical imaging, ensuring students receive dedicated, high-quality training experiences.**

FY26 Objective: To establish a formalized preceptor program by identifying and assigning one dedicated preceptor for each targeted pathway: Rehabilitation, Pharmacy, and Medical Imaging.

FY26 KPIs:

- Completion – creation of the program format and structure with a formalized manual.
- Number - onboarded preceptors by program
- Number – onboarded key content experts to teach didactic curriculum in the career pathways

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Preceptor Program Development	Nursing: Heal Program	N/A	• Completion Date – HEAL taskforce creation • Completion Date - program structure • Number - preceptors in target career pathways

Dedicated Preceptor Pool	Nursing: Heal Program	TBD at end of FY26	• Number – preceptor onboarded career pathway pool • Number –preceptor trainings in target career pathways conducted • Start Date – go-live/kick-off date of first cohort of preceptors with 9th grade student cohort FY27
Dedicated Hospital Based Didactic Instructor Pool	Nursing: Heal Program	TBD at end of FY26	• Number - hospital based didactic Instructors in rehabilitation, pharmacy, and medical imaging • Number- hospital based didactic instructor trainings completed • Start Date – go-live/kick-off date of first cohort of hospital based didactic instructors with 9th grade student cohort FY27

Target/Intended Population(s):

- Students from Aldine ISD that have been accepted into the HEAL High School Program
- Memorial Hermann Northeast employees in one of the key educational/career pathways in rehabilitation, pharmacy, and medical imaging.

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

- The HEAL High School program provides targeted high school education in health care career pathways to support successful completion and potential employment upon graduation.
- This program provides students from potentially at-risk areas the opportunity to learn tangible career skills for employment and progression in career fields related to health care.
- In addition, it allows direct education and mentoring from health care professionals throughout the high school years.

Collaboration Partners (Internal and External):

- HEAL High School Leadership and Hospital-based Instructors; Memorial Hermann Nursing Institute Leadership; Aldine ISD Leadership; Memorial Hermann Department Leadership and staff in Rehabilitation, Pharmacy, and Medical imaging; Memorial Hermann Education Leadership

Community Priority: Maternal & Infant Health

- **Primary Prioritized Need Area: Maternal & Infant Health**

FY26-FY28 Goal: To increase infant and maternal health by increasing breastfeeding rates to >85% and > 20% of infants who are exclusively breastfed by end of FY28.

FY26 Objective: To increase participation in prenatal education by achieving a 30% increase in attendance for breastfeeding preparation classes. In parallel, design and pilot a structured breastfeeding support group model that offers ongoing education peer support, and resource navigation for new and expectant mothers, with the goal of a formal program launch by or in FY27.

FY26 KPIs:

- Percent – increase in class attendance
- Number – unique participants in classes
- Completion – framework for breastfeeding support group
- Rates – participant satisfaction rates (pre & post)

Strategic Approach

Programs/Activities	Responsible	Baseline	Milestones/ Measures of Success FY26
African American Maternal Health at Community Mammogram Events	• Women's Services Division • Marketing Division	TBD post-FY26	• Completion – development of maternal health educational content targeting African American Women • Completion – schedule for Community Mammogram Days • Number – community mammogram events held/attended
Breastfeeding Initiative: Support Groups & Classes	• Women's Services Division • Marketing • Nursing Patient Care Leadership	60 annually for FY25	• Number – community breastfeeding classes attended providing education • Number – attendees at community breastfeeding classes • Number – providers engaged for breastfeeding awareness educational offerings • Completion – plan for breastfeeding support group creation

			• Number – attendees to breastfeeding support group

Target/Intended Population(s):

- Women in the PSA that are of childbearing years with or without providers that deliver at Memorial Hermann Northeast

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

- Breastfeeding provides health benefits for both the infant and the mother.
- This will create a supportive environment for mothers and their infants to be successful at increased incidence and duration of breastfeeding.
- Baseline data is 80% of mothers who deliver at Memorial Hermann Northeast breastfeed, but the incidence of exclusive breastfeeding falls well below this.

Collaboration Partners (Internal and External):

- Project Mammogram; Memorial Hermann Marketing; Memorial Hermann Women's services

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.

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
- Number – attendees to community events

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 ED
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
Community Events: Mental Health Resources Initiative	• Marketing • MHMG	• 1,100 – Suicide Walk booth attendees (FY25)	• Number – community partners engaged • Completion – development of survey to assess mental health needs in community

	• Mental Health Crisis Clinic	• 600 - Health & Wellness Fair booth attendees (FY25)	• Date – Humble ISD Health & Wellness Fair • Number – attendees to Humble ISD Health & Wellness Fair booth who are provided educational materials • Date – of Humble ISD Suicide Walk • Number – attendees to Suicide Walk booth who are provided educational material

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
- The Community Events are a partnership with the local school district and Memorial Hermann Northeast to spread awareness and resources. Targeting parents and students within Humble ISD

Collaboration Partners (Internal and External):

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

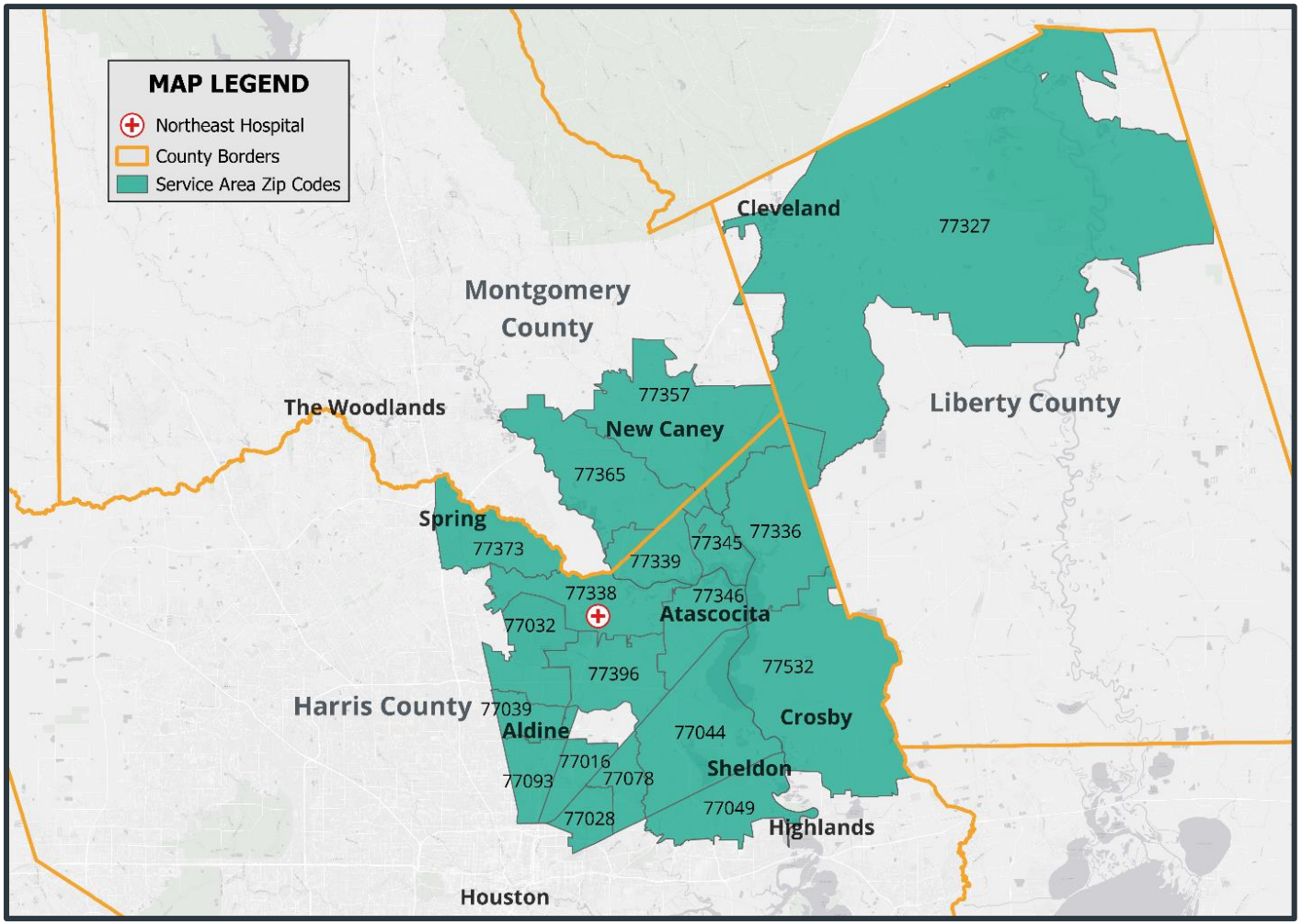
MEMORIAL HERMANN

Appendices

Appendix A: Memorial Hermann Northeast Hospital Supplementary Findings

The MSA for Memorial Hermann Northeast Hospital includes 19 zip codes in Harris, Montgomery, and Liberty counties.

FIGURE 1. MEMORIAL HERMANN NORTHEAST HOSPITAL PRIMARY MSA

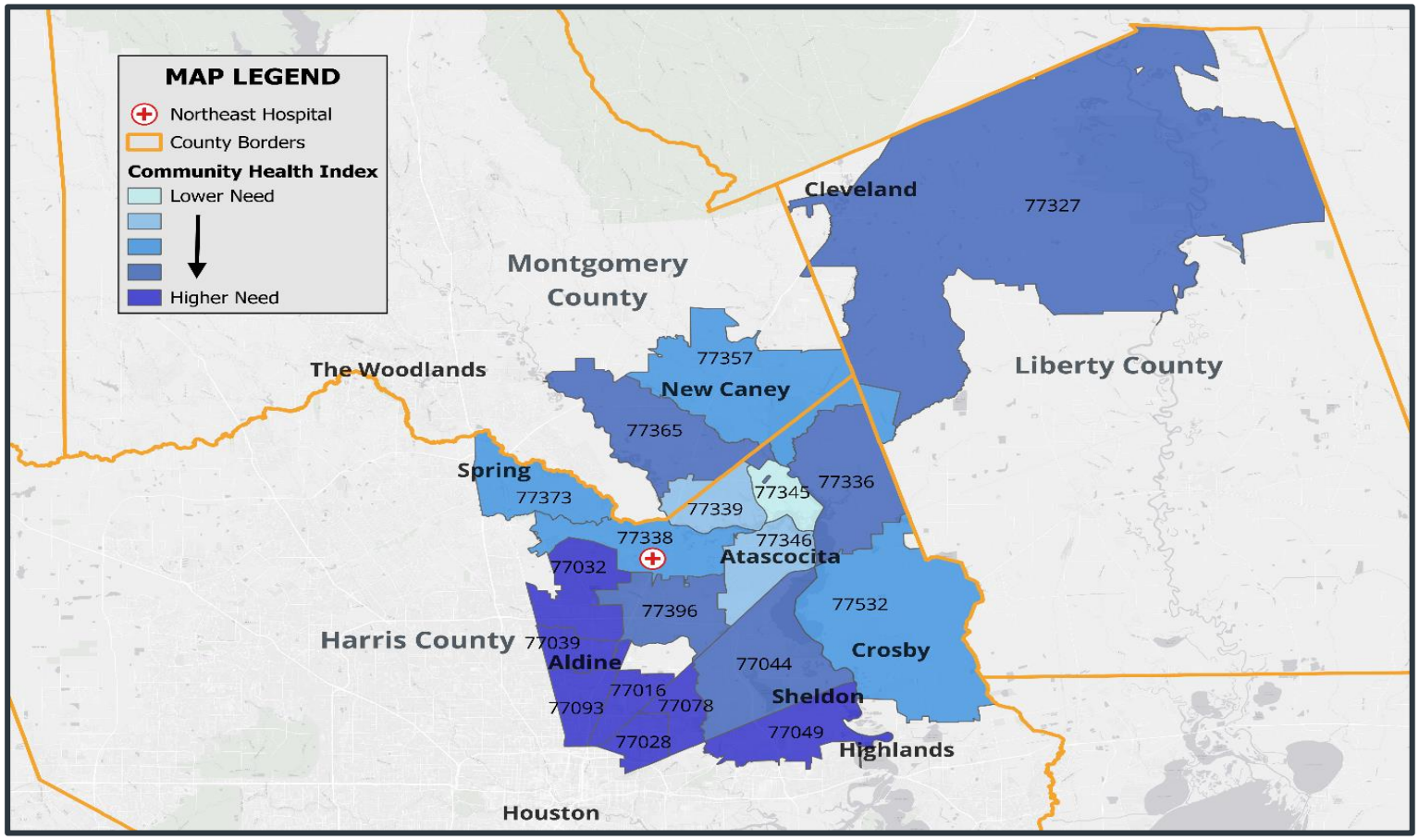


Key Findings: Access to Care

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 Memorial Hermann Northeast Hospital MSA, the zip codes with the highest CHI scores are:

- 77093 (CHI = 99.2)
- 77028 (98.8)
- 77016 (98.7)
- 77078 (98.7)
- 77039 (97.8)

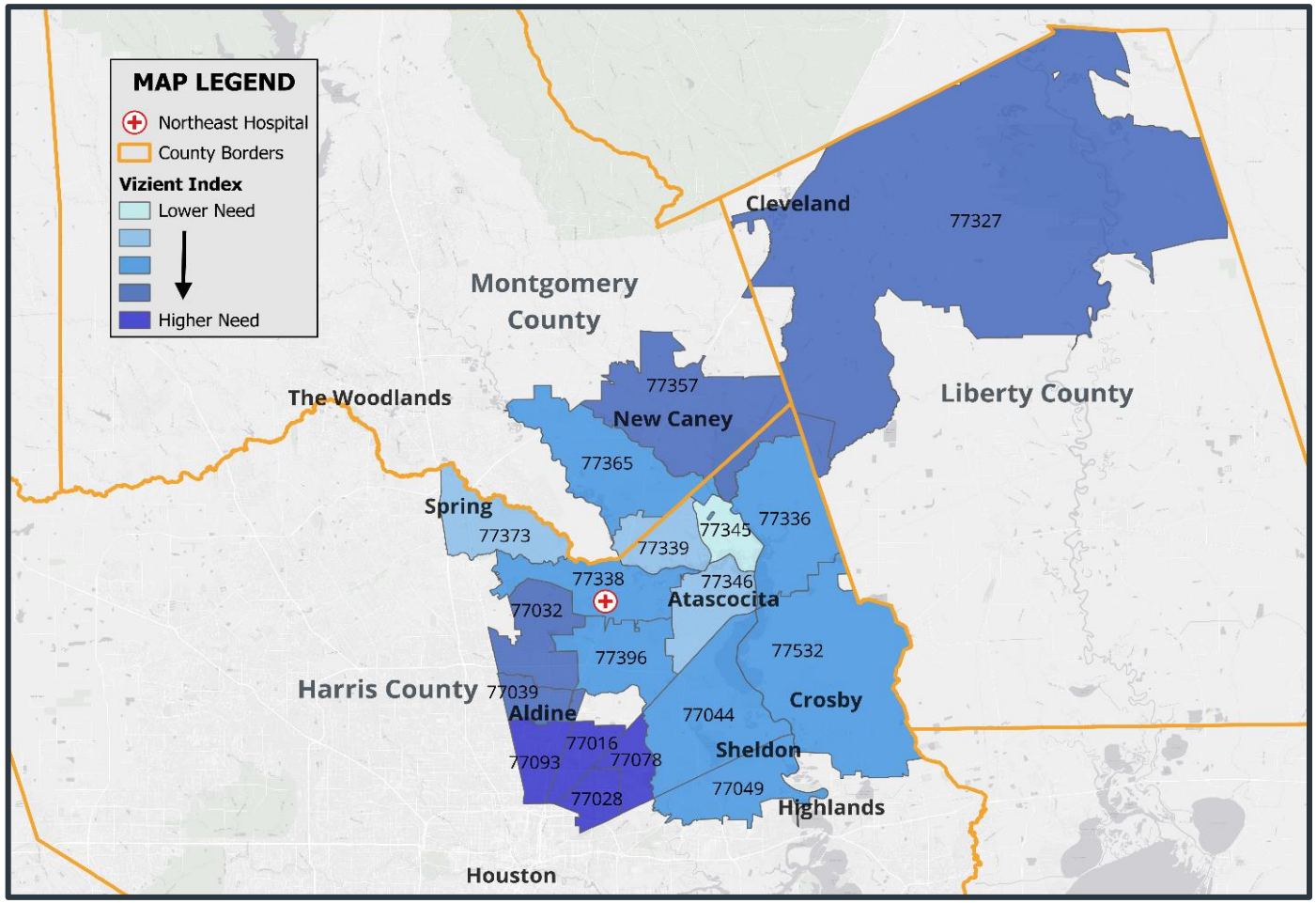
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA



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 Memorial Hermann Northeast Hospital MSA, the zip codes with the greatest health care needs, based on this index score, are:

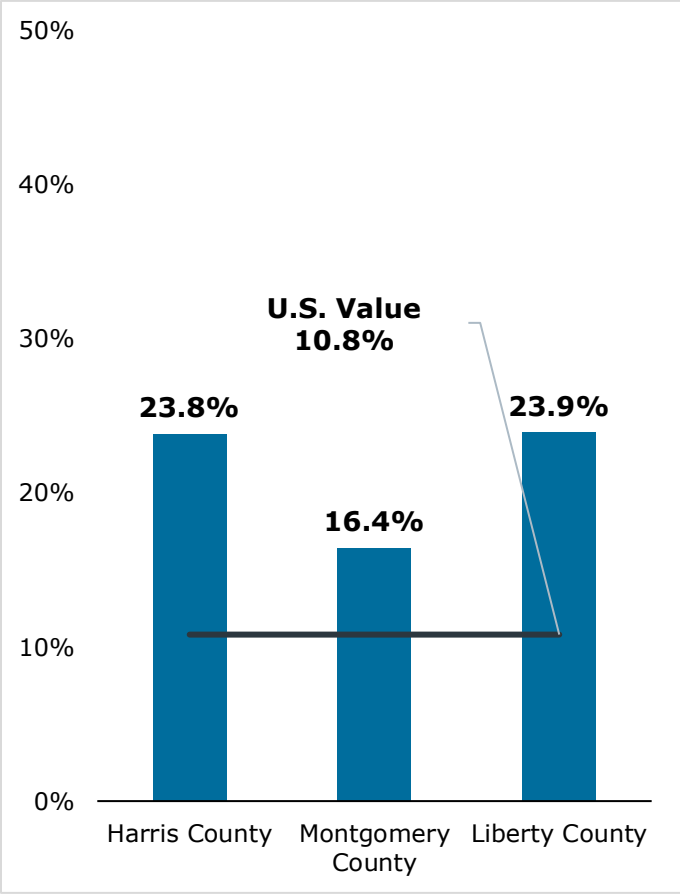
- 77028 (VVI = 2.41)
- 77016 (2.34)
- 77078 (2.10)
- 77093 (1.83)

FIGURE 3. VIZIENT SCORE BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA



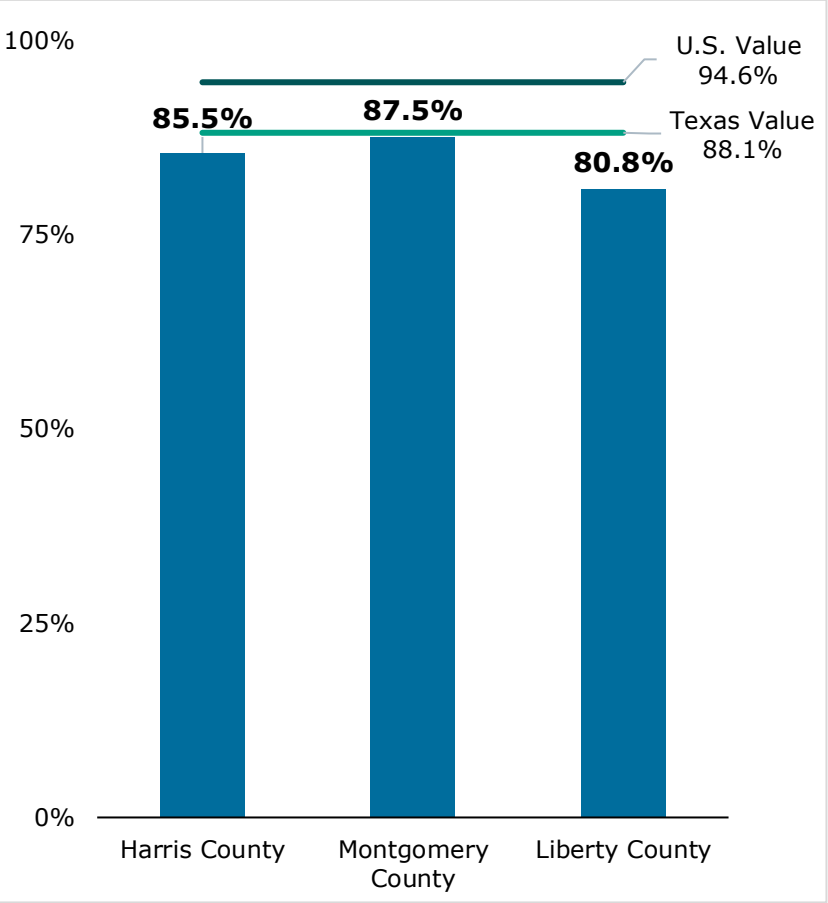
The following figures illustrate indicators of concern in Harris, Montgomery, and/or Liberty counties, based on scoring of secondary data related to **Access to Care.**

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



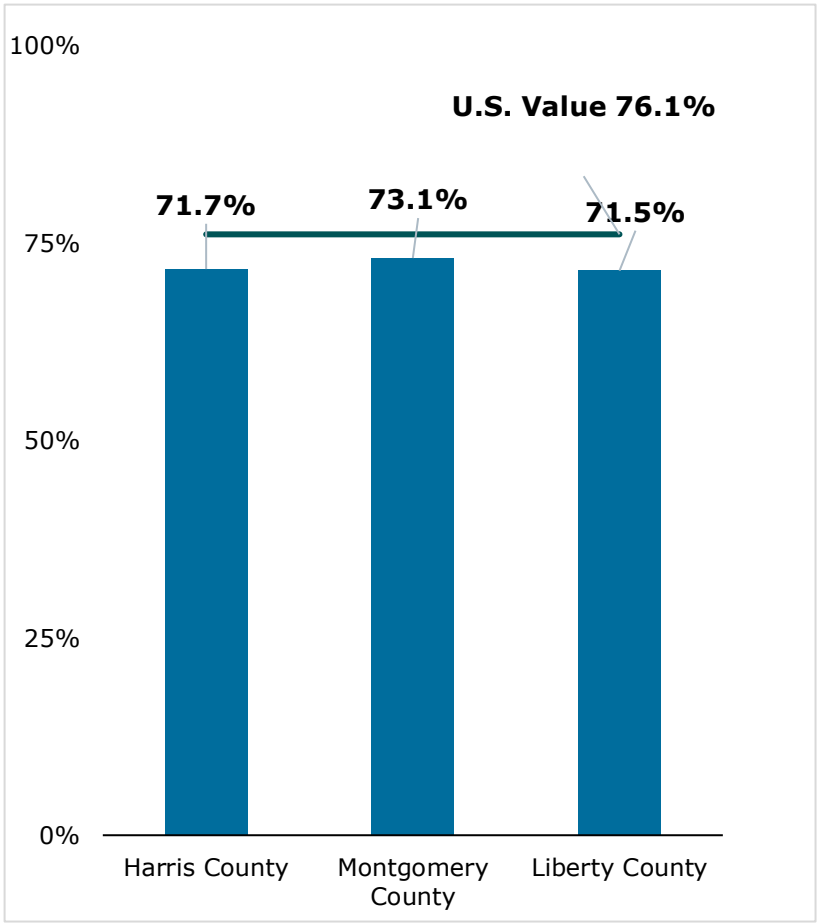
Source: CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



Source: American Community Survey (2023)

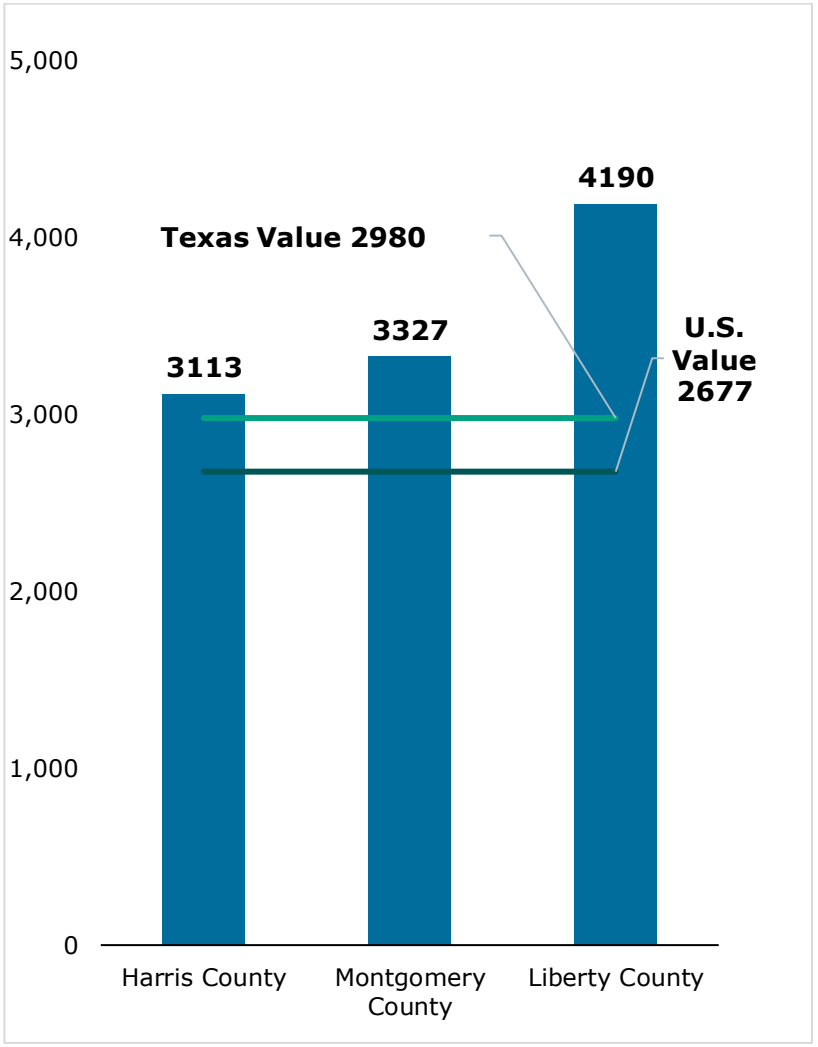
FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



Source: CDC – PLACES (2022)

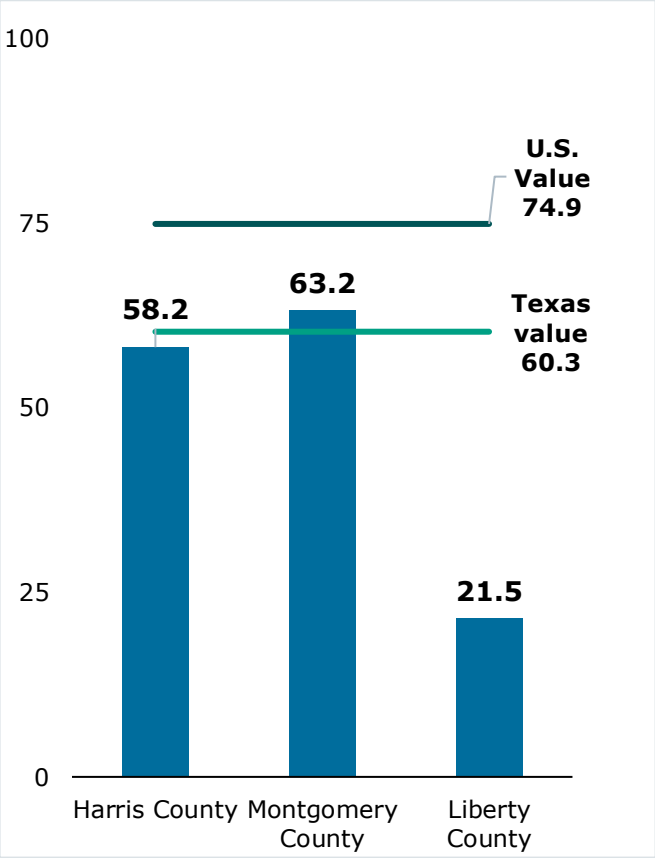
FIGURE 7. PREVENTABLE HOSPITAL STAYS: MEDICARE POPULATION

(discharges per 100,000 Medicare enrollees)



Source: Centers for Medicare & Medicaid Services (2022)

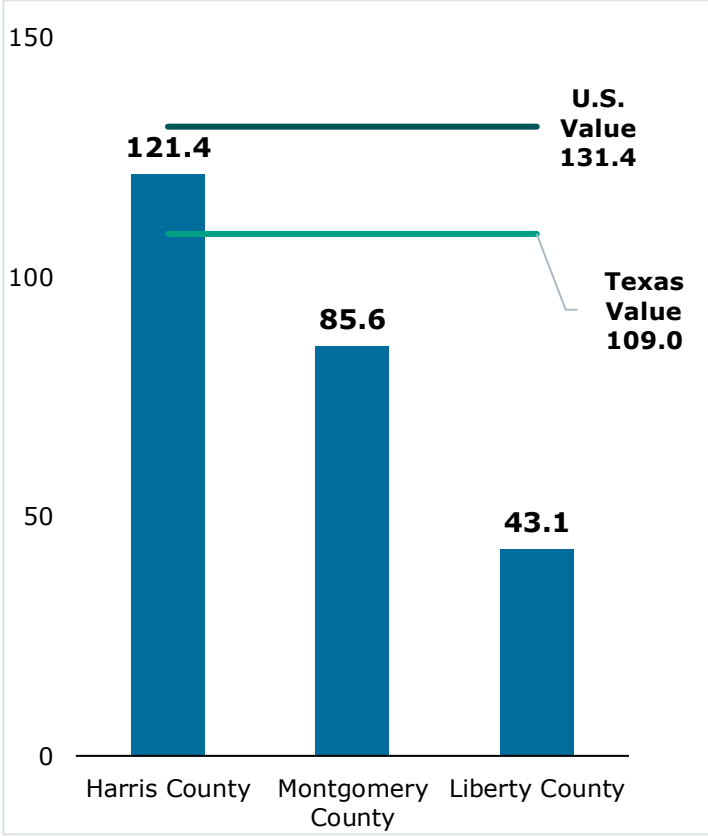
FIGURE 8. PRIMARY CARE PROVIDER RATE (providers per 100,000 population)



Source: County Health Rankings (2021)

FIGURE 9. NON-PHYSICIAN PRIMARY CARE PROVIDER RATE

(providers per 100,000 population)



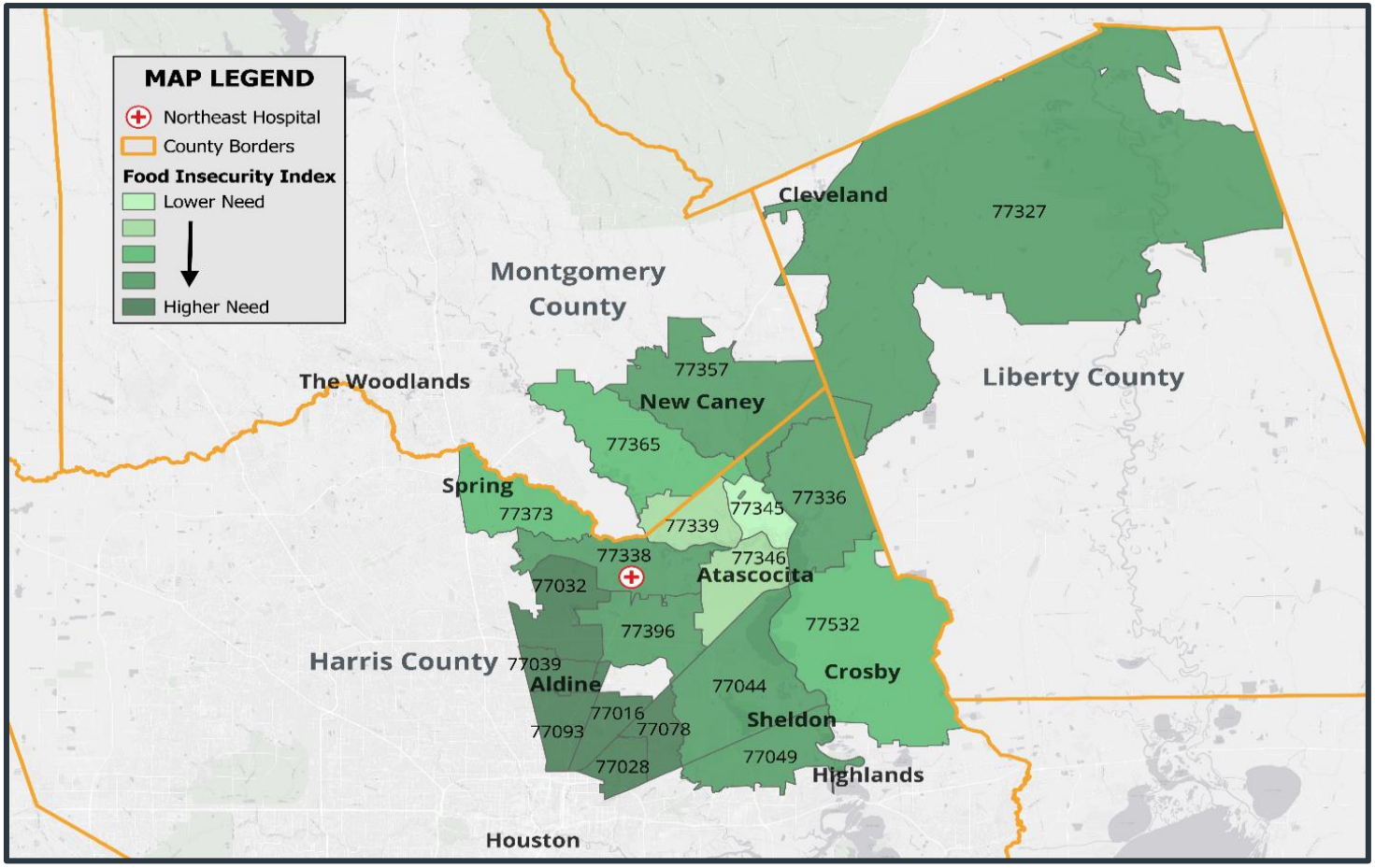
Source: County Health Rankings (2023)

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 Memorial Hermann Northeast Hospital MSA, the zip codes with the highest FII scores are:

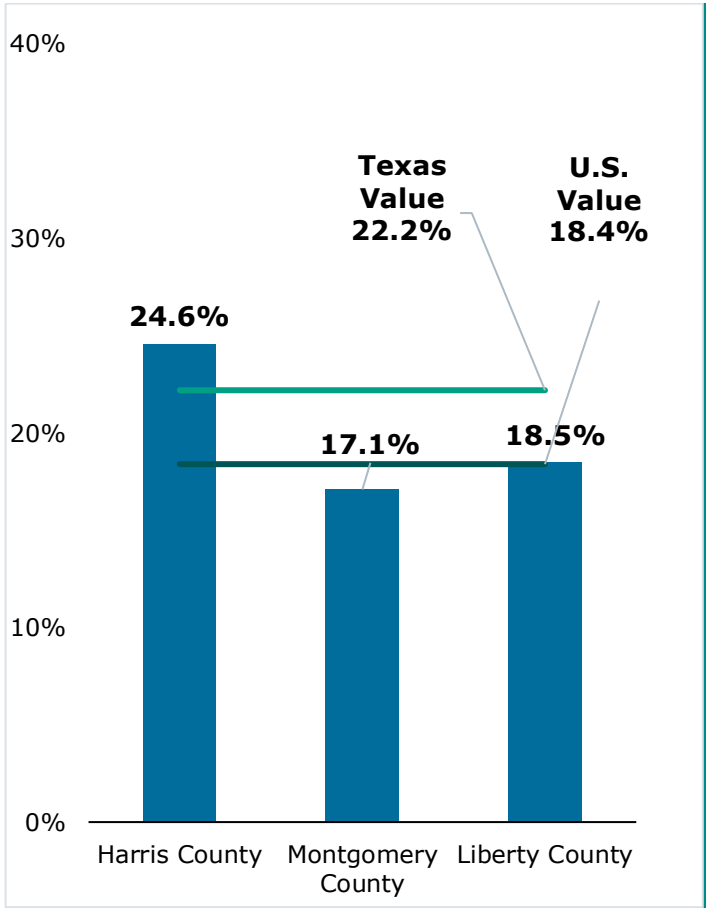
- 77032 (FII = 99.7)
- 77028 (99.5)
- 77093 (99.4)
- 77078 (99.3)
- 77039 (98.1)

FIGURE 10. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S FOOD INSECURITY INDEX BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA



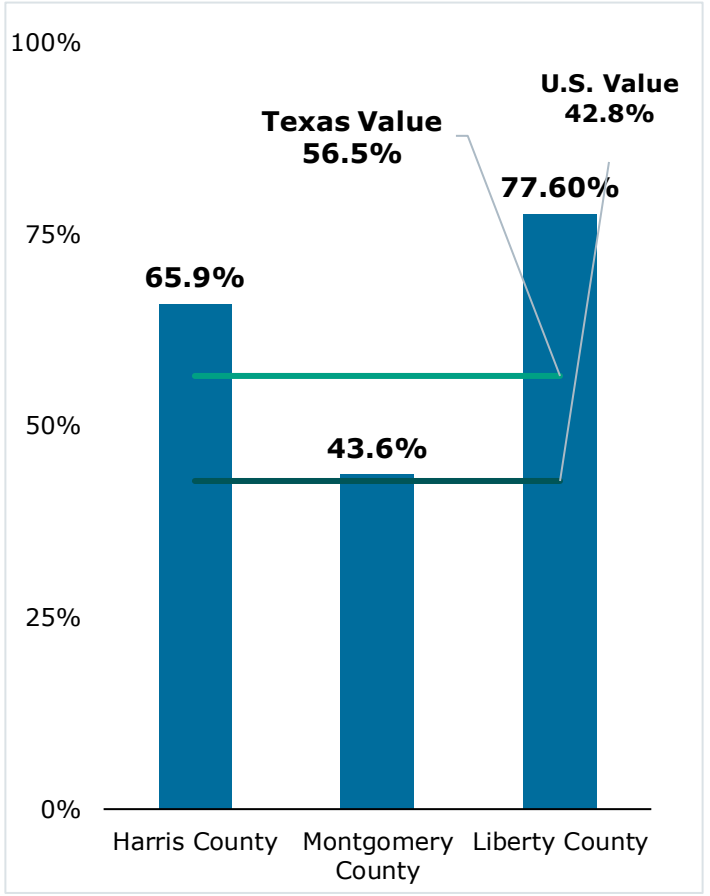
The following figures illustrate indicators of concern in Harris, Montgomery, and/or Liberty counties, based on scoring of secondary data related to **Access to Healthy Food.**

FIGURE 11. CHILD FOOD INSECURITY RATE



Source: Feeding America (2022)

FIGURE 12. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM

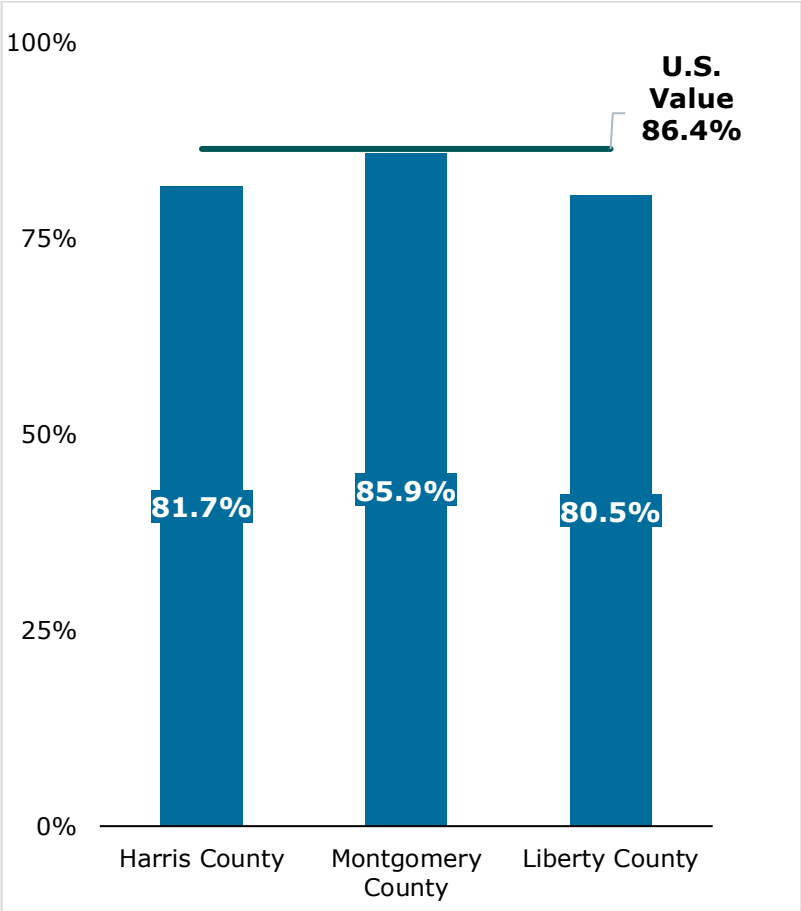


Source: National Center for Education Statistics (2022-2023)

Key Findings: Chronic Conditions Prevention and Management

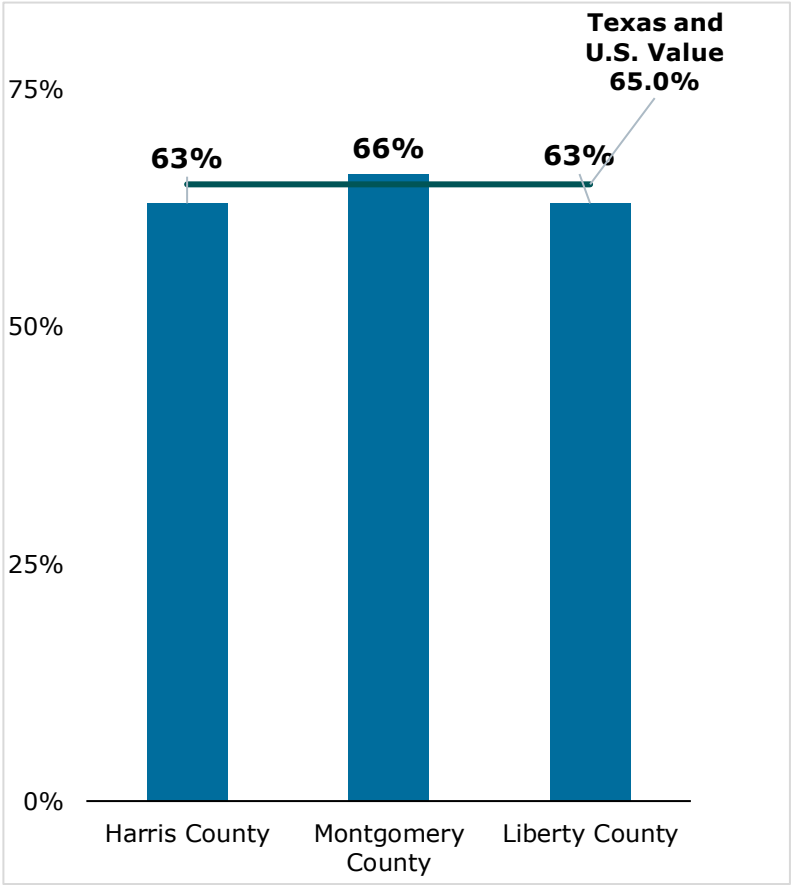
The following figures illustrate indicators of concern in Harris, Montgomery, and/or Liberty counties, based on scoring of secondary data related to Chronic Conditions Prevention and Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



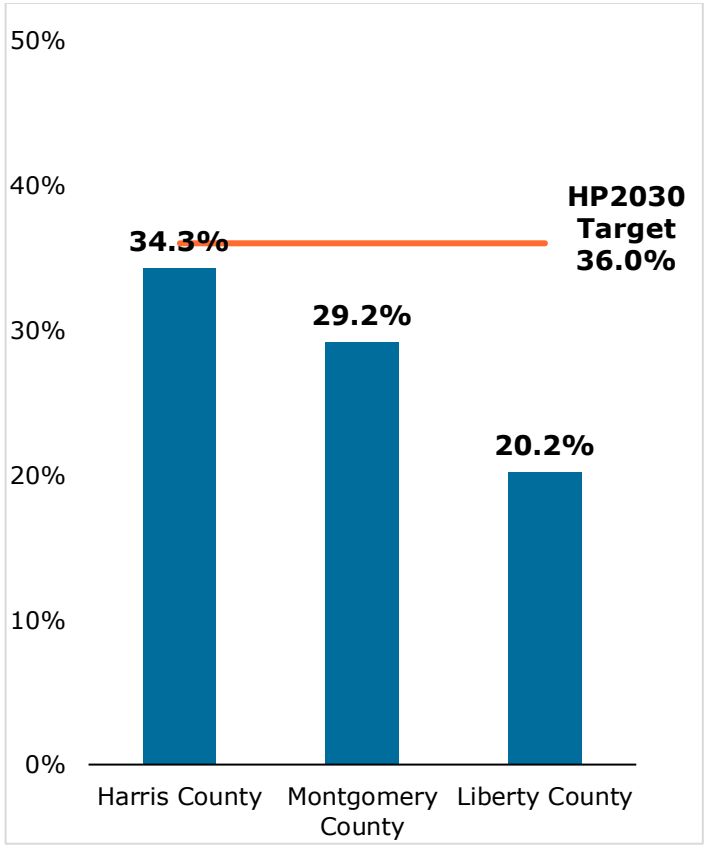
Source: CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



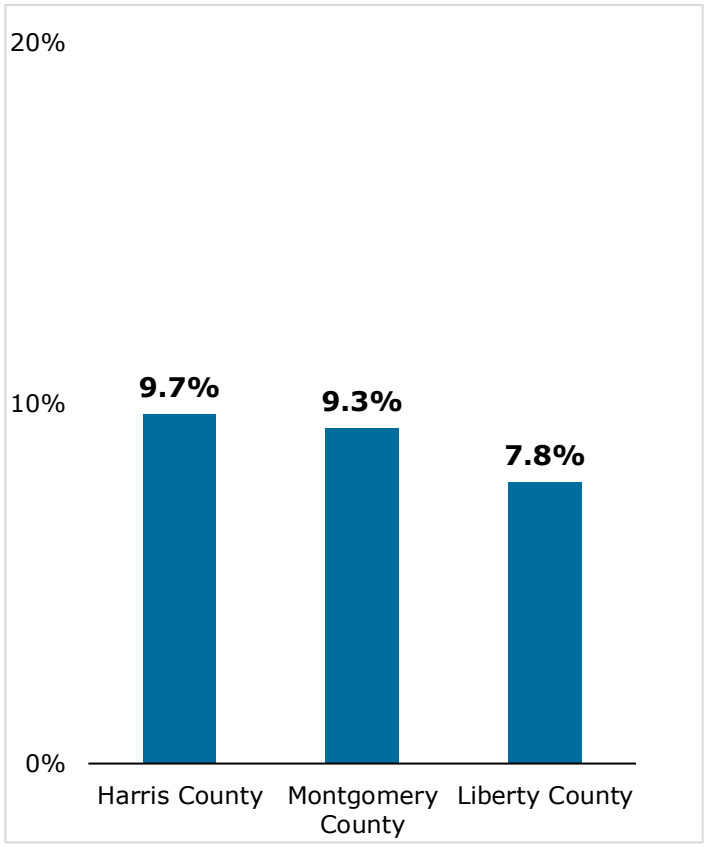
Source: Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



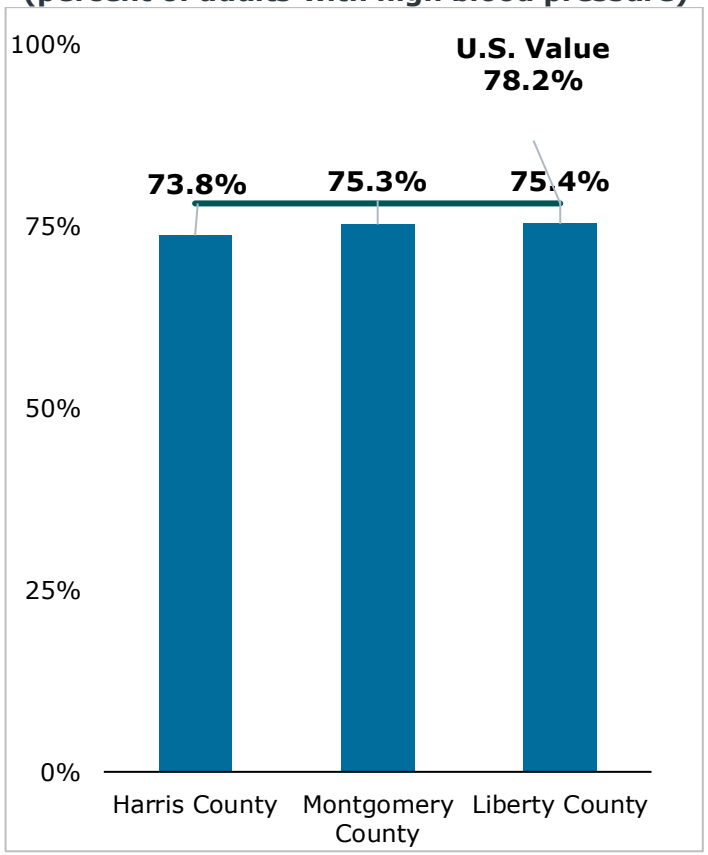
Source: CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



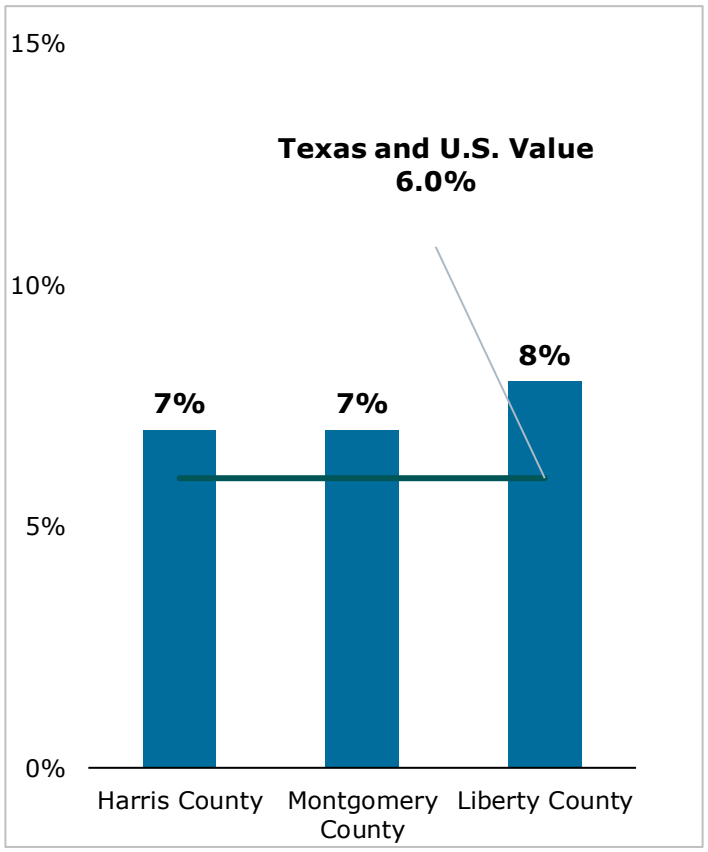
Source: CDC (2021)

FIGURE 17. ADULTS WHO HAVE TAKEN MEDICATION FOR HIGH BLOOD PRESSURE
(percent of adults with high blood pressure)



Source: CDC (2021)

FIGURE 18. STROKE: MEDICARE POPULATION



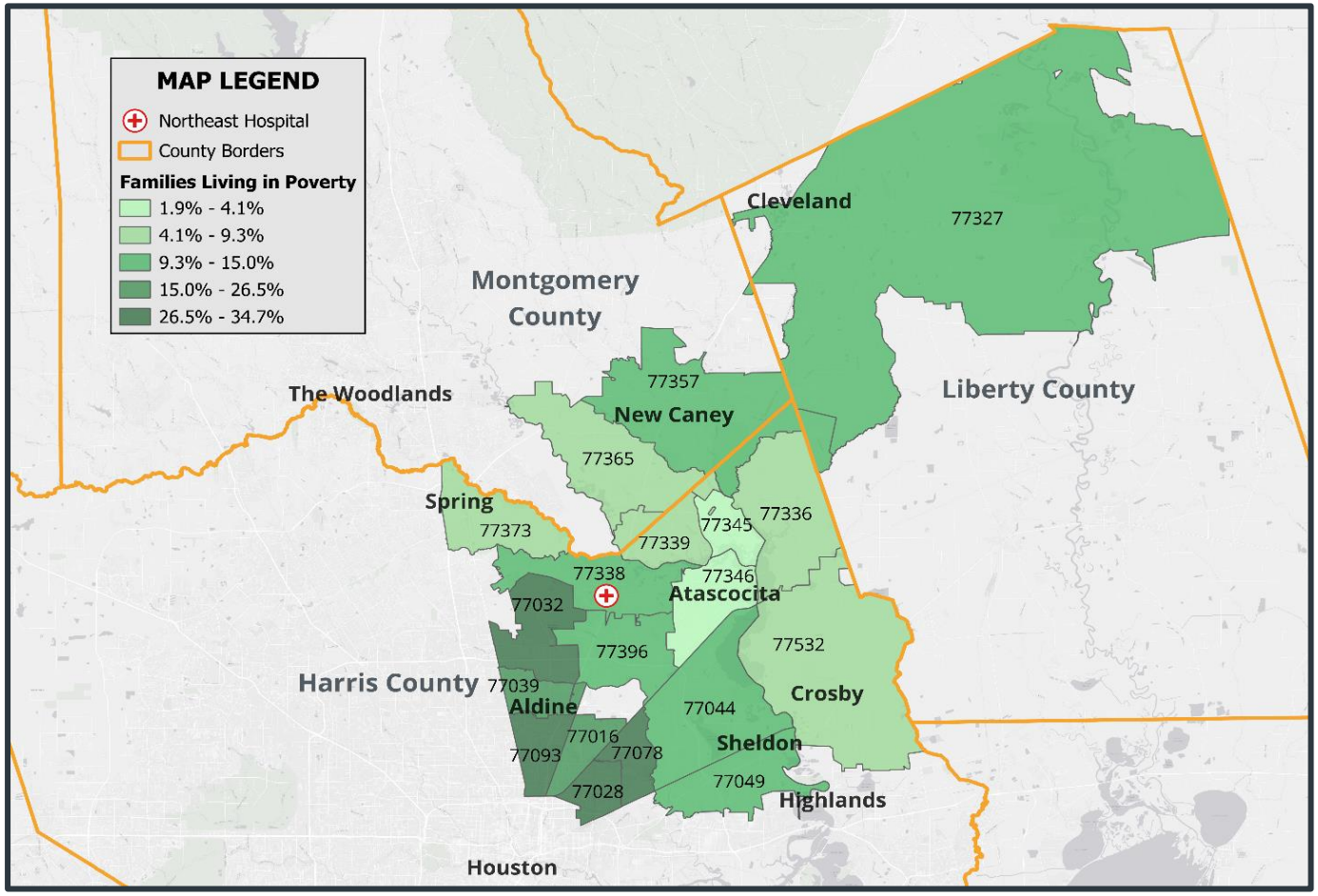
Source: Centers for Medicare & Medicaid Services (2022)

Key Findings: Economic Opportunity

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

- 77093 (34.7%)
- 77032 (30.5%)
- 77078 (30.2%)
- 77028 (29.0%)

FIGURE 19. POVERTY BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA

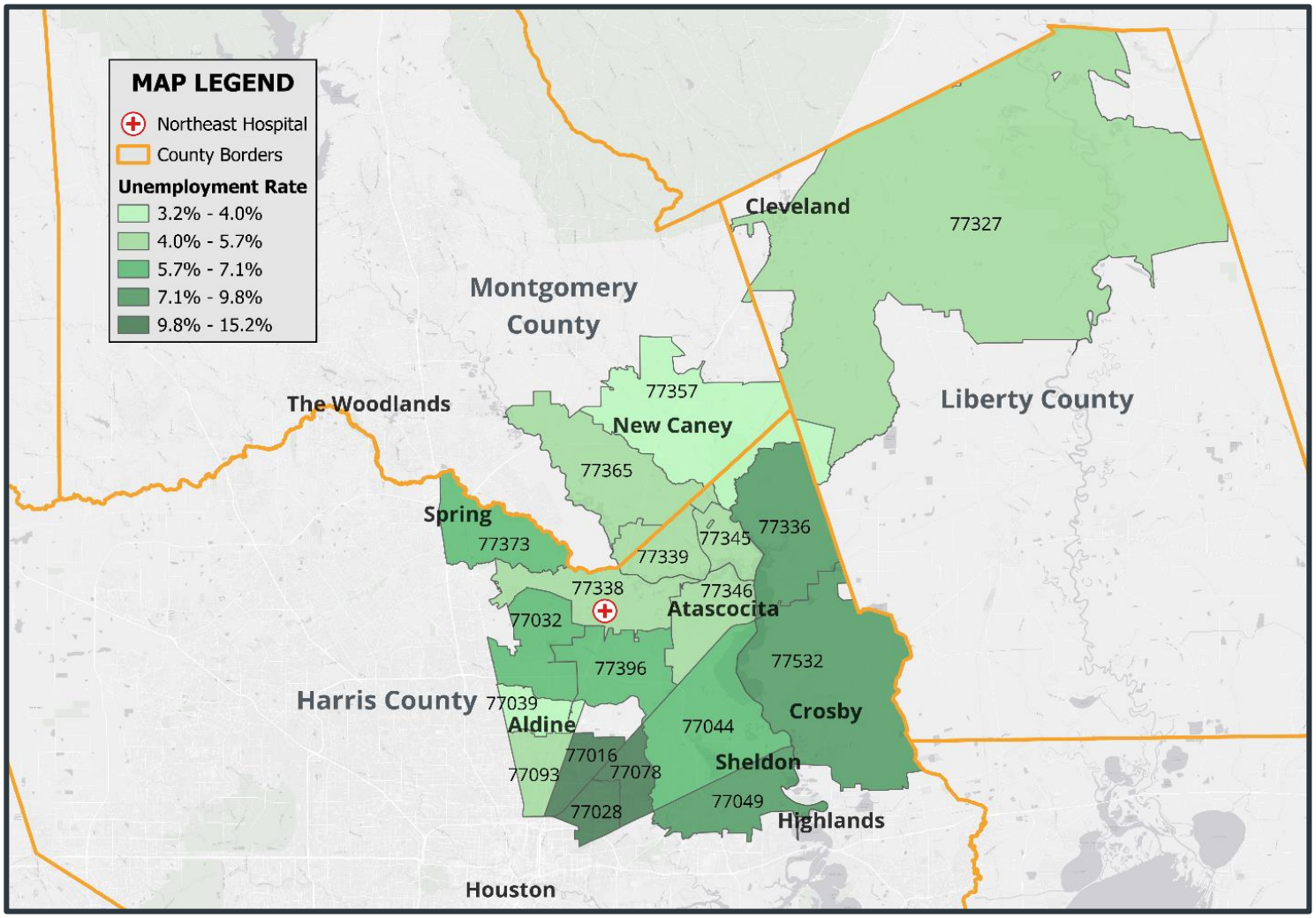


Source: Claritas (2024)

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

- 77028 (15.2%)
- 77078 (14.6%)
- 77016 (14.6%)
- 77049 (9.8%)

FIGURE 20. UNEMPLOYMENT BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA

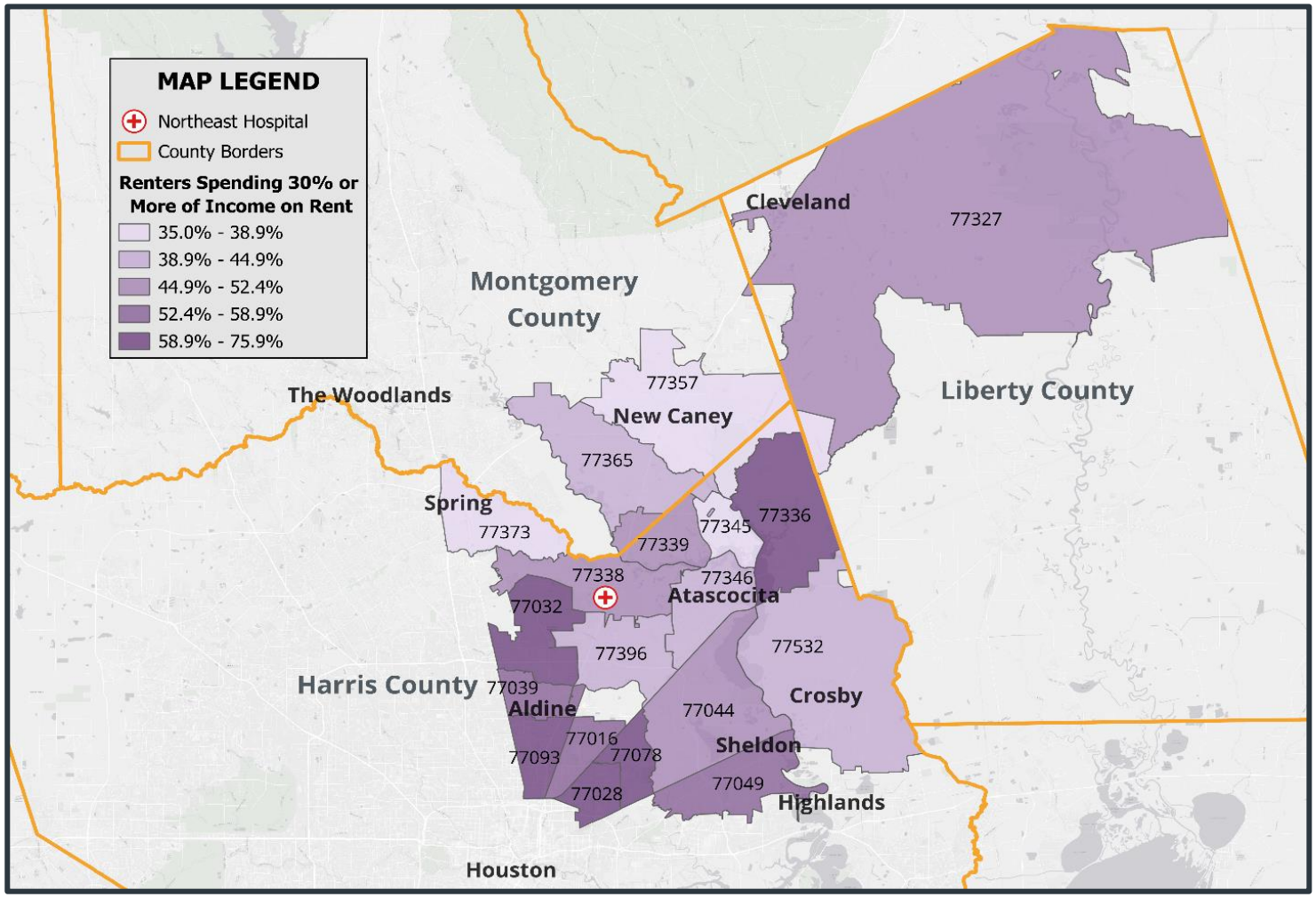


Source: Claritas (2024)

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

- 77028 (75.9%)
- 77336 (73.9%)
- 77032 (72.3%)

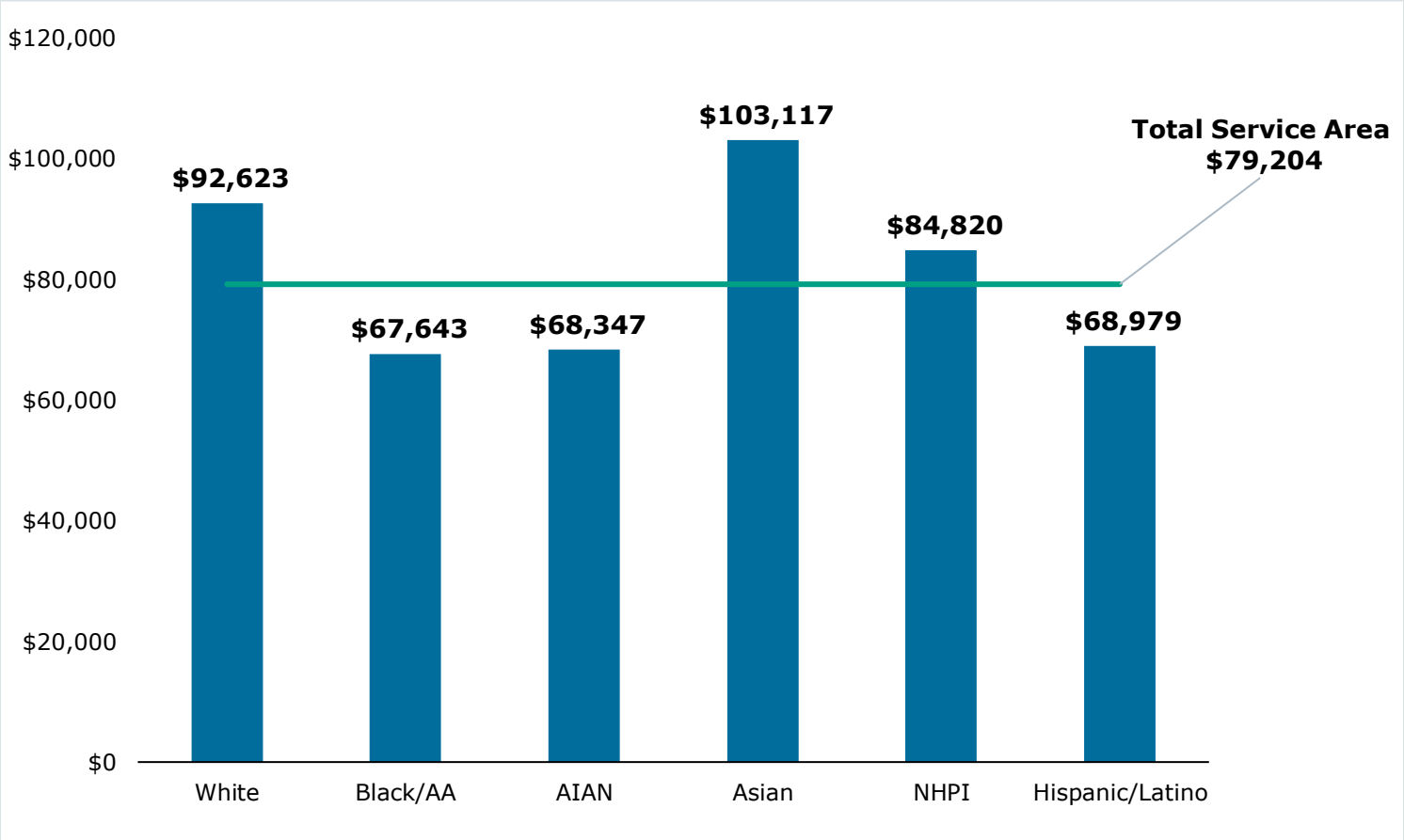
FIGURE 21. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA



Source: American Community Survey (2018-2022)

Across the Memorial Hermann Northeast Hospital MSA, income differs substantially by race and ethnicity. The median household income for Black/African American, American Indians/Alaskan Natives (AIAN), and Hispanic Latino residents of the MSA are both more than $10,000 lower than the overall median household income.

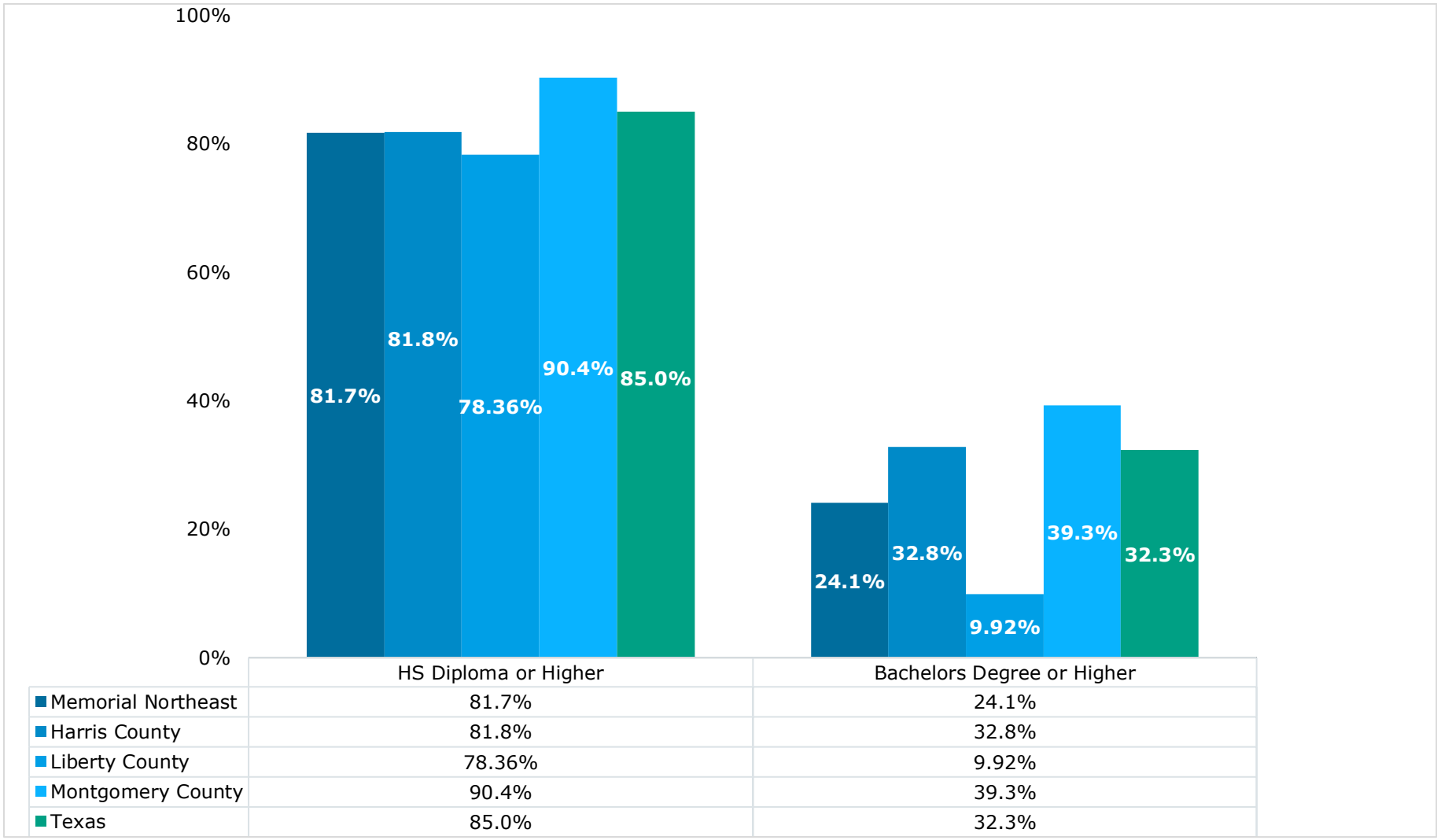
FIGURE 22. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA



Source: Claritas (2024)

Key Findings: Educational Access

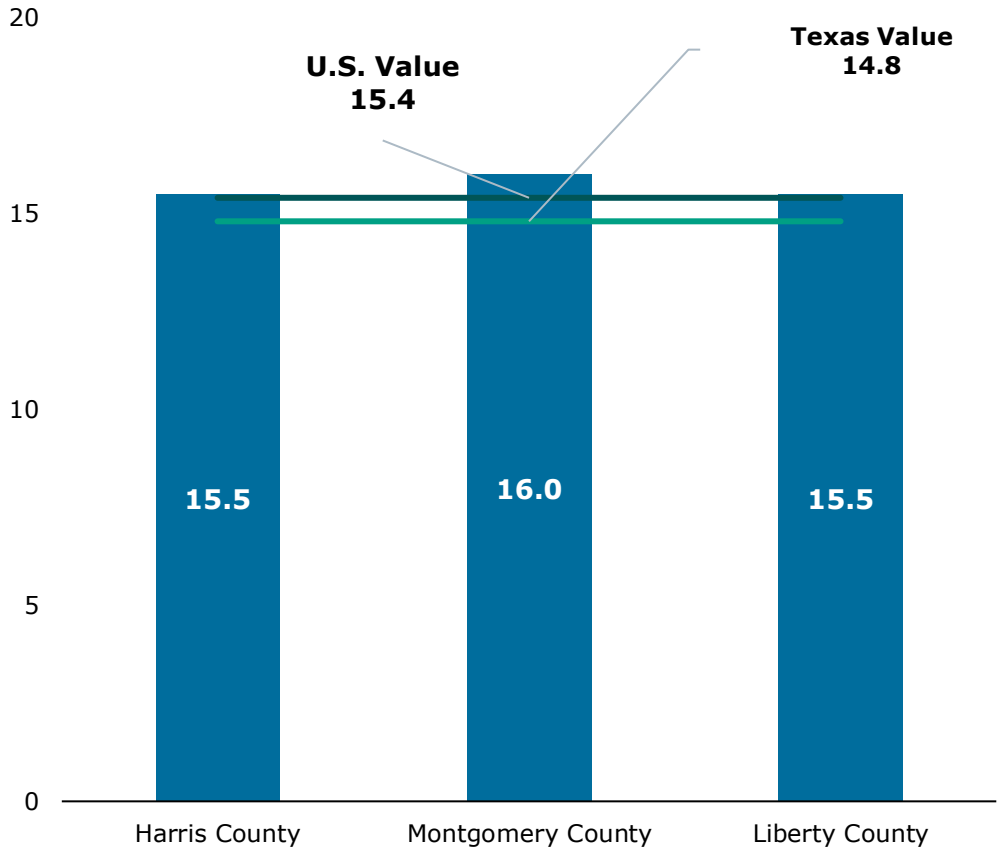
FIGURE 23. EDUCATIONAL ATTAINMENT



	HS Diploma or Higher	Bachelors Degree or Higher
Memorial Northeast	81.7%	24.1%
Harris County	81.8%	32.8%
Liberty County	78.36%	9.92%
Montgomery County	90.4%	39.3%
Texas	85.0%	32.3%

Source: Claritas (2024)

FIGURE 24. STUDENT-TO-TEACHER RATIO

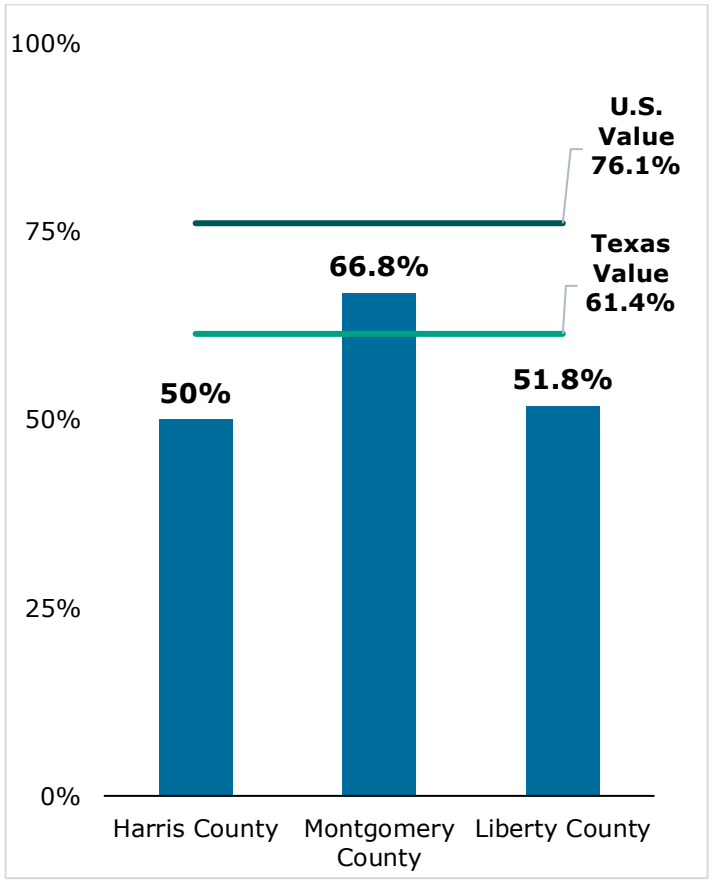


Source: National Center for Education Statistics (2022-2023)

Key Findings: Maternal & Infant Health

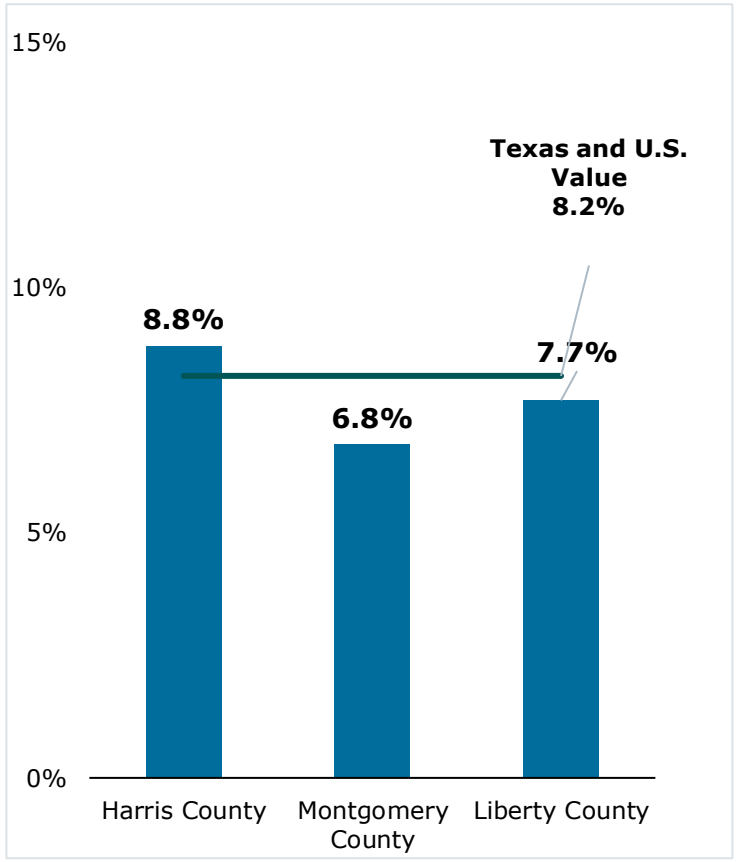
The following figures illustrate indicators of concern in Harris and/or Montgomery and/or Liberty counties, based on scoring of secondary data related to Maternal & Infant Health.

FIGURE 25. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



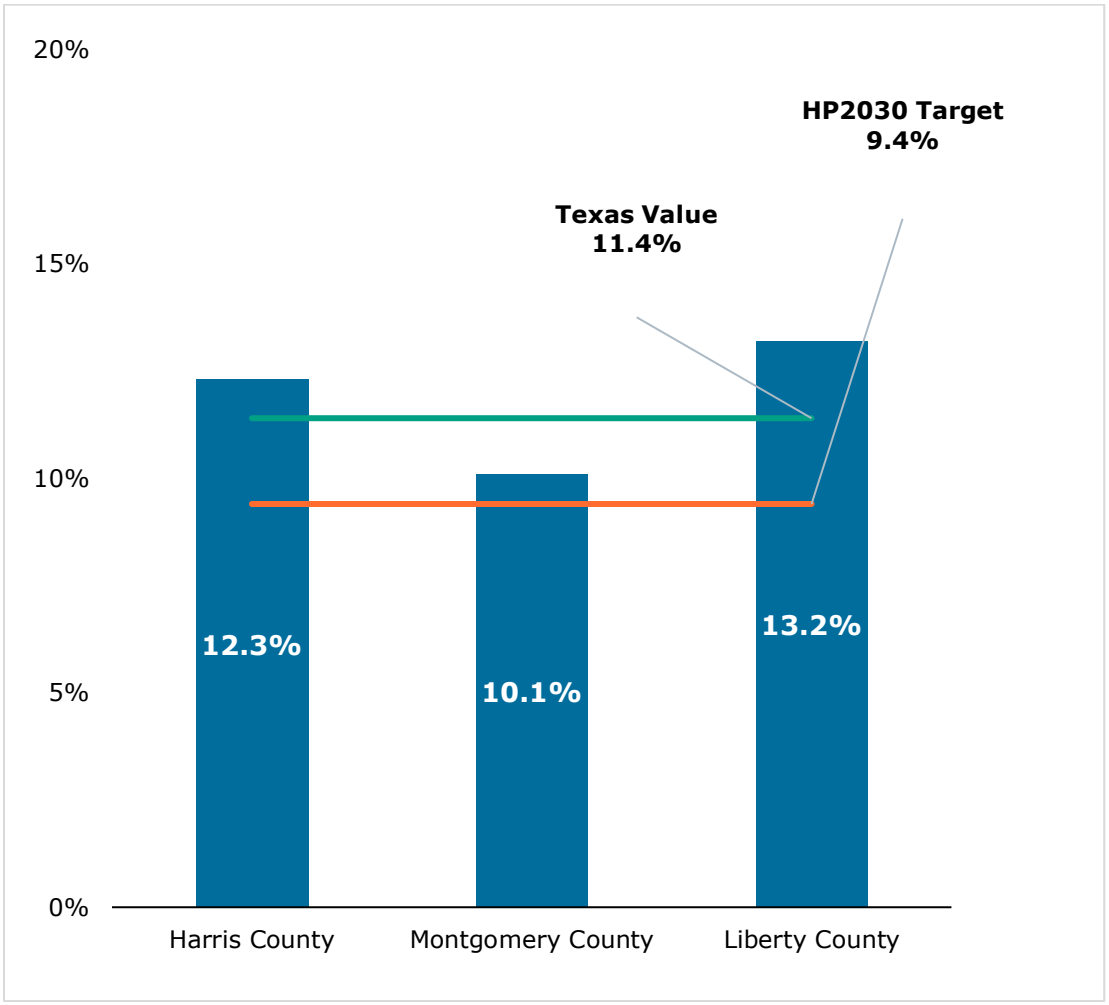
Source: Texas Department of State Health Services (2020)

FIGURE 26. BABIES WITH LOW BIRTHWEIGHT



Source: Texas Department of State Health Services (2020)

FIGURE 27. PRETERM BIRTHS



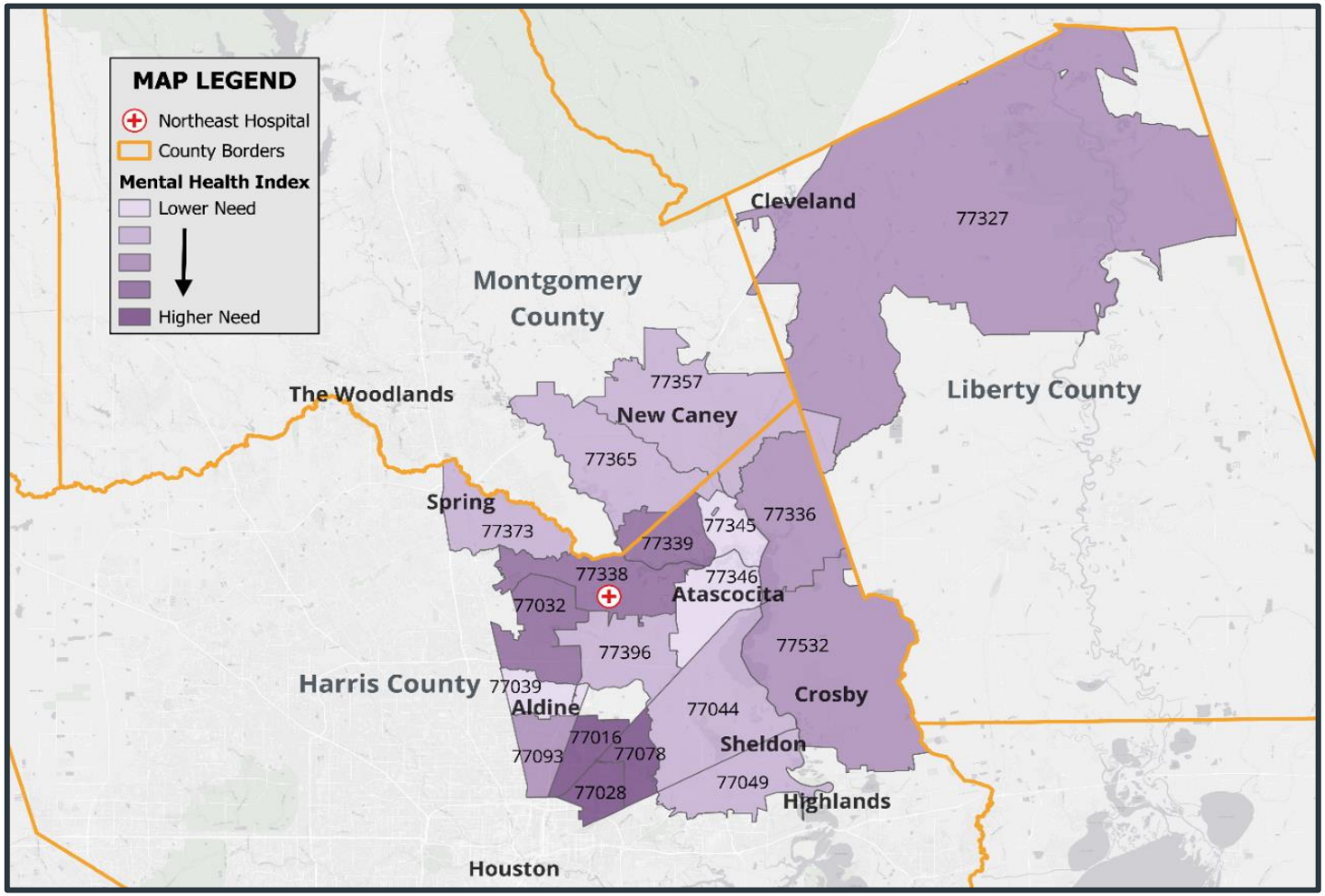
Source: Texas Department of State Health Services (2021)

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 Memorial Hermann Northeast Hospital MSA, the zip codes with the highest MHI scores are:

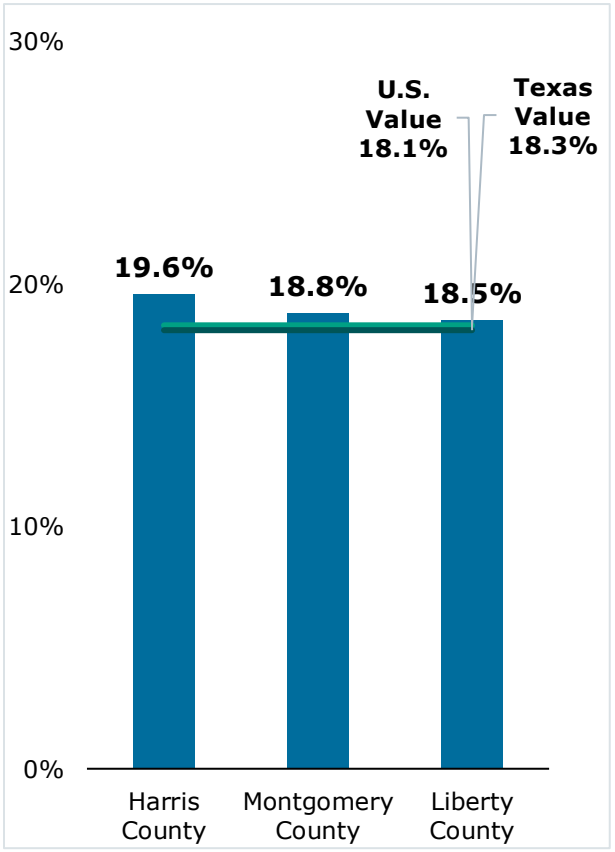
- 77028 (MHI = 97.7)
- 77016 (97.4)
- 77078 (93.1)

FIGURE 28. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S MENTAL HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN NORTHEAST HOSPITAL MSA



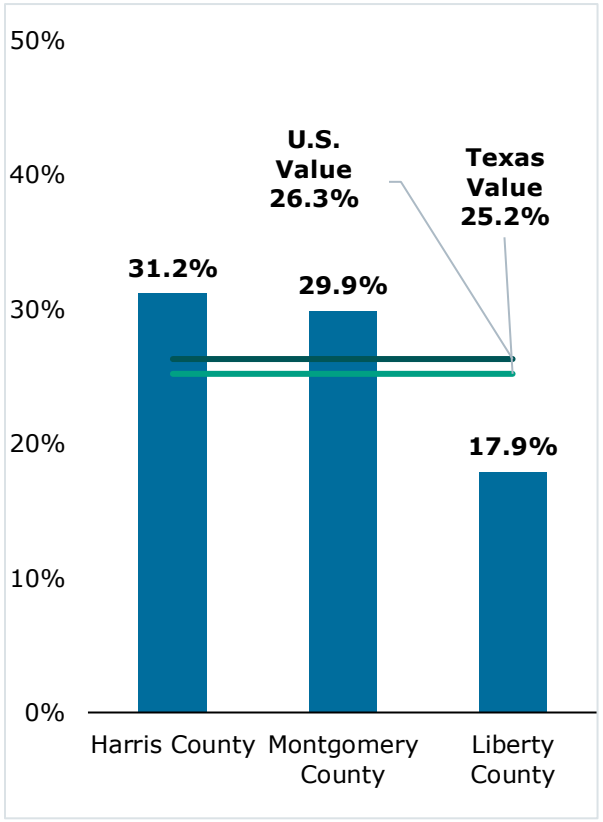
The following figures illustrate indicators of concern in Harris, Montgomery, and/or Liberty counties, based on scoring of secondary data related to Mental Health & Substance Use.

FIGURE 29. ADULTS WHO DRINK EXCESSIVELY



Source: County Health Rankings (2021)

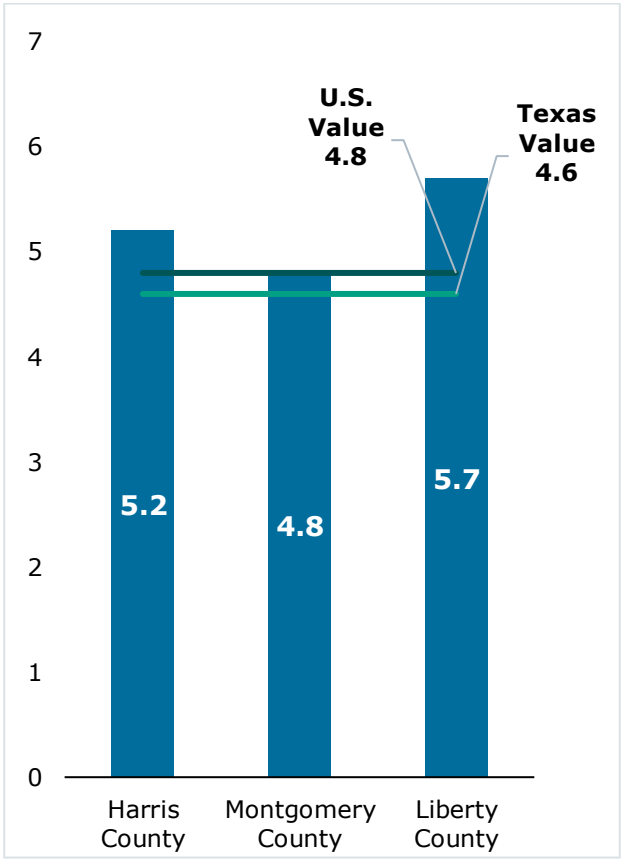
FIGURE 30. ALCOHOL-IMPAIRED DRIVING DEATHS (percent of driving deaths involving alcohol)



Source: County Health Rankings (2017-2021)

FIGURE 31. POOR MENTAL HEALTH DAYS

(average number of days out of past 30 with poor self-reported mental health)



Source: County Health Rankings (2021)