



Community Health Implementation Strategy

Memorial Hermann Southeast Hospital

MEMORIAL
HERMANN
SOUTHEAST

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At-a-Glance Summary

Community Served 	Memorial Hermann Southeast Hospital includes Memorial Hermann Pearland Hospital and serves 1,124,663 persons living in 28 zip codes Harris, Fort Bend, Galveston, and Brazoria 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 • Access to Care • Chronic Conditions Prevention and Management • Maternal & Infant Health • Mental Health & Substance Use	Non-Medical Drivers of Health Priorities • 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 $\geq 2\%$ & $\geq 1\%$ reduction of Memorial Hermann readmission rates of target population encountered by Community Health services residing in high poverty zip codes across Greater Houston.
- Refer $\geq 70\%$ of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ER settings with 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

- 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 $\geq 40\%$ of Memorial Hermann patients for at least 1 NMDOH with $\geq 50\%$ high-risk receiving referral to resource support by FY28.

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

- Reduce morbidity/mortality rates by $\geq 1\%$ for obstetric patients by decreasing the number of patients developing severe sepsis by the 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

Memorial Hermann Southeast Hospital

Memorial Hermann Southeast 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.

Welcoming both patients and their loved ones into the healing process is our philosophy of patient and family-centered care. Memorial Hermann Southeast Hospital has upheld its commitment to bringing the best in health care, providing high-quality care with the latest technology, close to home in its current facility since 1986, though the hospital's history of service to the community dates back to 1963. Memorial Hermann Southeast Hospital offers a broad range of medical staff specialties and care including: Breast Care Center, Cancer Care, Children's Care, Convenient Care Center, Day Surgery, Diabetes Management, Digestive Health, Ear, Nose & Throat, Emergency & Trauma Center, Esophageal Disease Center, Heart & Vascular Care, Imaging Center, Industrial Medicine Services, Neuroscience, Orthopedics and Sports Medicine, Physical, Speech & Occupational Therapy, Sleep Disorders Center, Weight Loss, Wound Care, Women's Health & Gynecology, and Inpatient Rehabilitation.

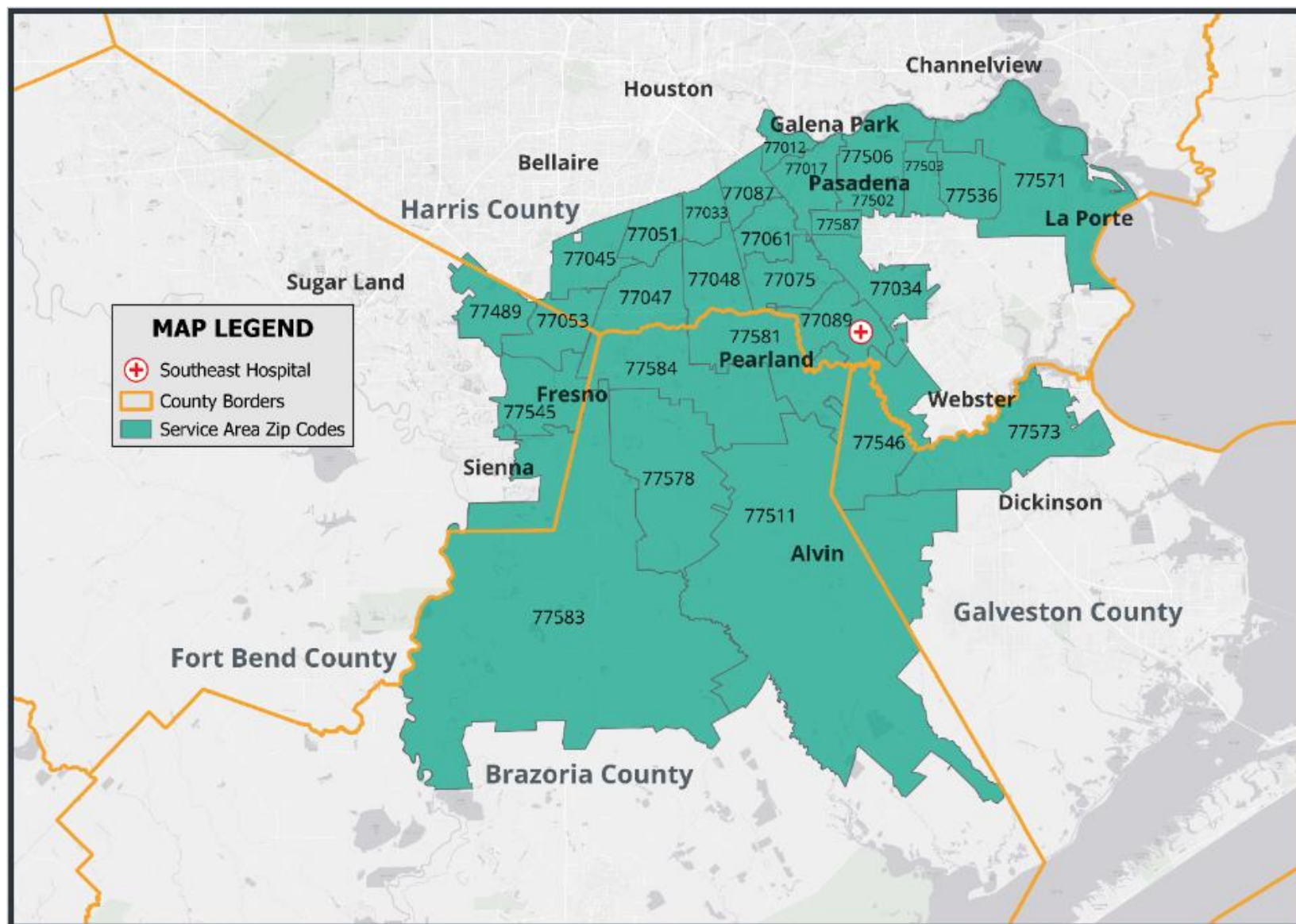
Memorial Hermann Pearland Hospital

Memorial Hermann Pearland Hospital brings the expertise of the Memorial Hermann Health System close to home, making the region's experienced medical specialists available to families in the Pearland/Brazoria County area. The hospital features advanced medical equipment and state-of-the-art technology used to address diverse health care needs, from quick outpatient visits to procedures requiring highly specialized inpatient care. Designed to expand to 128 beds within the next five years, Memorial Hermann Pearland currently offers 97 inpatient beds (medical/surgical, intensive and cardiac care). The hospital also features operating rooms, cardiac catheterization, nuclear medicine and endoscopy suites. If a higher level of care is needed, Memorial Hermann Pearland patients can be transported to Memorial Hermann Southeast Hospital, Memorial Hermann-Texas Medical Center or Children's Memorial Hermann Hospital by Memorial Hermann Life Flight®.

Description of the Community Served

Memorial Hermann Southeast Hospital Metropolitan Service Area (MSA) has a population of approximately 1,124,663 persons serving 28 zip codes in Harris, Fort Bend, Galveston, and Brazoria counties. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. MEMORIAL HERMANN SOUTHEAST HOSPITAL METROPOLITAN 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 Southeast 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 Southeast Hospital, and other hospital leadership.

During initial planning meetings, representatives from HCI and Memorial Hermann Southeast 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 Southeast 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 on the following pages outlines in detail the individual strategies and activities Memorial Hermann Southeast Hospital will implement to address the health needs identified through 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 Southeast 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 $\geq 2\%$ & $\geq 1\%$ 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 ER 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—patient 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 community partner locations • Percent - show rate of referred to community partner locations • 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 – 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

Target/Intended Population(s):

- Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS Southeast 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.
- 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

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

FY26-FY28 Goal: ≥10% Memorial Hermann Southeast hospitalized inpatients being discharged to home with a diagnosis of stroke, will have a follow-up appointment set with a provider at discharge by FY28

FY26 Objective: ≥ 1% of **Memorial Hermann** Southeast hospitalized inpatients being discharged to home with a diagnosis of stroke, will have a follow-up appointment set with a provider at discharge by FY26

FY26 KPIs:

- Percent—patients scheduled
- Percent—30-day readmission rate for patient diagnosed with stroke

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Referral Management Optimization	Referral Management	Baseline TBD post-FY26	• Date - approval of FTEs • Completion – development of optimizations for After Visit Summary • Completion – development of disease specific scheduling work queues • Date - pilot Go-live • Completion - performance measurement (gathering baseline data) plan

Target/Intended Population(s):

- All payer types; patients with stroke diagnoses

Please provide any additional insights or explanations on the initiative(s) listed. This information is to support Community Health team for additional reporting/ awareness.

- Develop necessary infrastructure to operationalize management of referrals, including scheduling appointments for outpatient follow-up with Neurology, for stroke patients being discharged from the hospital.
- To assist and/or facilitate follow-up appointments with a neurologist for this high-risk patient population within the first few weeks after discharge from the acute care setting.
- According to a Systematic Review and Meta-Analysis published by Preventing Chronic Disease, outpatient follow-up visits may be an effective way to reduce 30-day readmissions for patients discharged with stroke.

Collaboration Partners:

- Referral Management; Neuroscience Service Line; Value Management; MHHS Southeast Campus; MHHS SE Stroke Program

- Prioritized Need Area: Access to Care**

FY26-FY28 Goal: ≥70% of MHHS ACO patients discharged from acute or ER settings with identified NMDOH needs will be referred to Community Care Coordination Team (C3T) CHWs 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 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
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 unites 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 • Percent - show rates of scheduled for food support
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
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.			
Collaboration Partners (Internal and External): Ambulatory Services; Local food nonprofit agencies			

Community Priority: Chronic Conditions Prevention and Management

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

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

FY26 Objective: ≥25% of Memorial Hermann Southeast 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

Target/Intended Population(s):

- All payer types; Broader Greater Houston community in high-poverty ZIPs

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:

- NMDOH Workgroup; System; ISD; Digital; Ambulatory Services; Local FQHCs; Local Social Service Agencies

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 Southeast Campus

Community Priority: Maternal & Infant Health

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

FY26-FY28 Goal: Reduce morbidity/mortality rates by $\geq 1\%$ for obstetric patients by decreasing the number of patients developing severe sepsis by the end of FY28.

FY26 Objective: Reduce morbidity/mortality rates at the Memorial Hermann Southeast campus by $\geq 1\%$ for obstetric patients by decreasing the number of patients developing severe sepsis by the end of FY26

FY26 KPIs:

- Percent—staff educated
- Percent—incidence rate of sepsis in the maternal patient population
- Percent—maternal morbidity/mortality rates related to infection

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Sepsis Initiative - Education	Maternal/Infant Service Line at MHHS Southeast	Baseline TBD post- FY26	• Rate - increase awareness and knowledge • Rate - early recognition and intervention • Number – patients developing sepsis • Percent – maternal morbidity rates

Target/Intended Population(s):

- All payer type, high-risk race/ethnicity groups; Southeast Houston

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

- To reduce the incidence of maternal sepsis through early recognition, timely intervention and implementation of standardized evidence-base guidelines
- The Texas Mortality and Morbidity Review Committee determined, after reviewing maternal deaths from 2016-2020 in Texas, that infection was the leading cause of pregnancy-related deaths.

Collaboration Partners (Internal & External):

- Texas AIM; Texas Department of State Health Services; MHHS Southeast campus; OB; Perinatal Program

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 bby the Southeast 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):

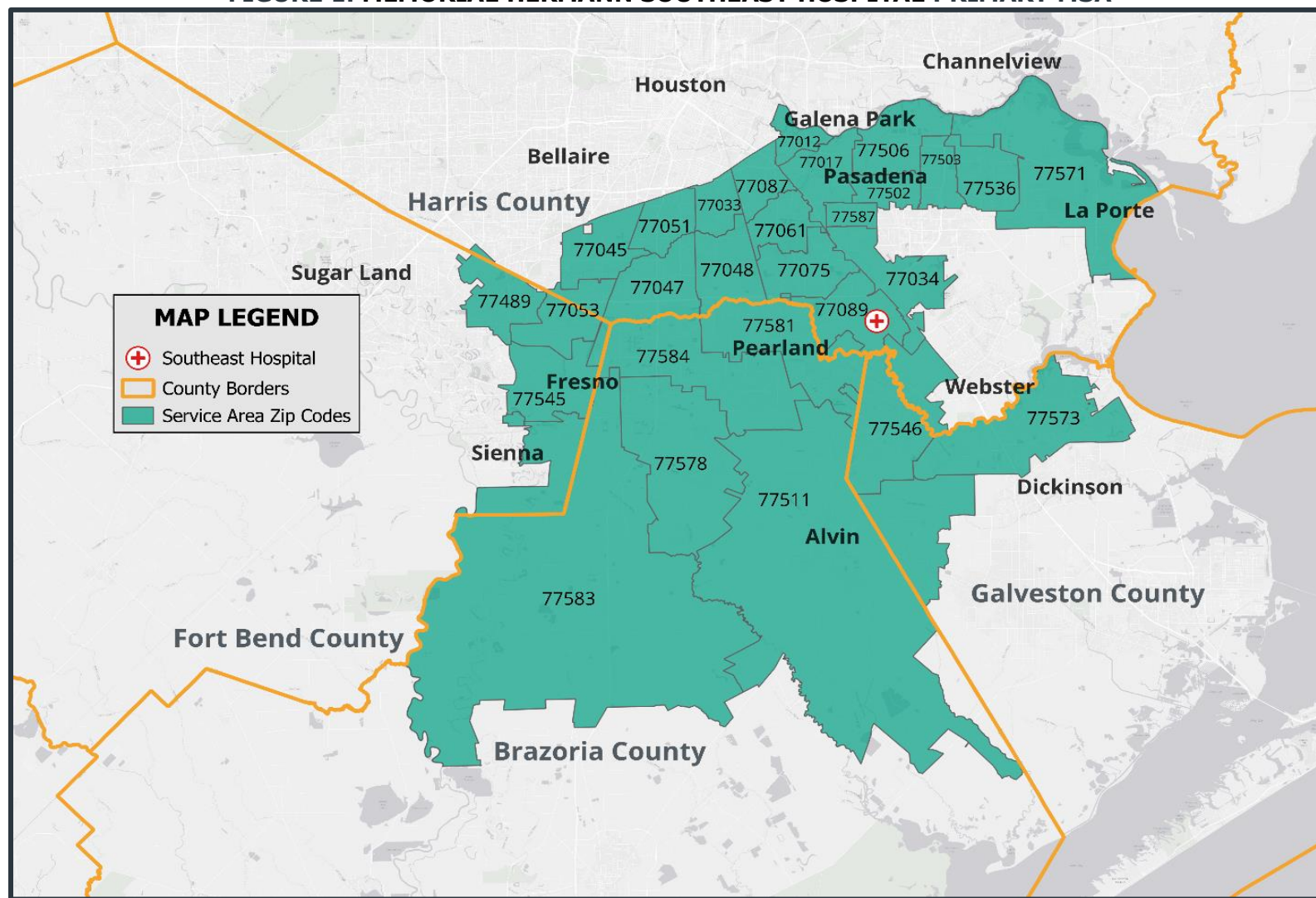
- Collaboration with all the Memorial Hermann facilities, Leadership, Case Management, Medical staff, Community Service Providers, and other community partners

Appendices

Appendix A: Memorial Hermann Southeast Hospital Supplementary Findings

The MSA for Memorial Hermann Southeast Hospital includes 28 zip codes in Harris, Fort Bend, Galveston, and Brazoria counties.

FIGURE 1. MEMORIAL HERMANN SOUTHEAST HOSPITAL PRIMARY MSA



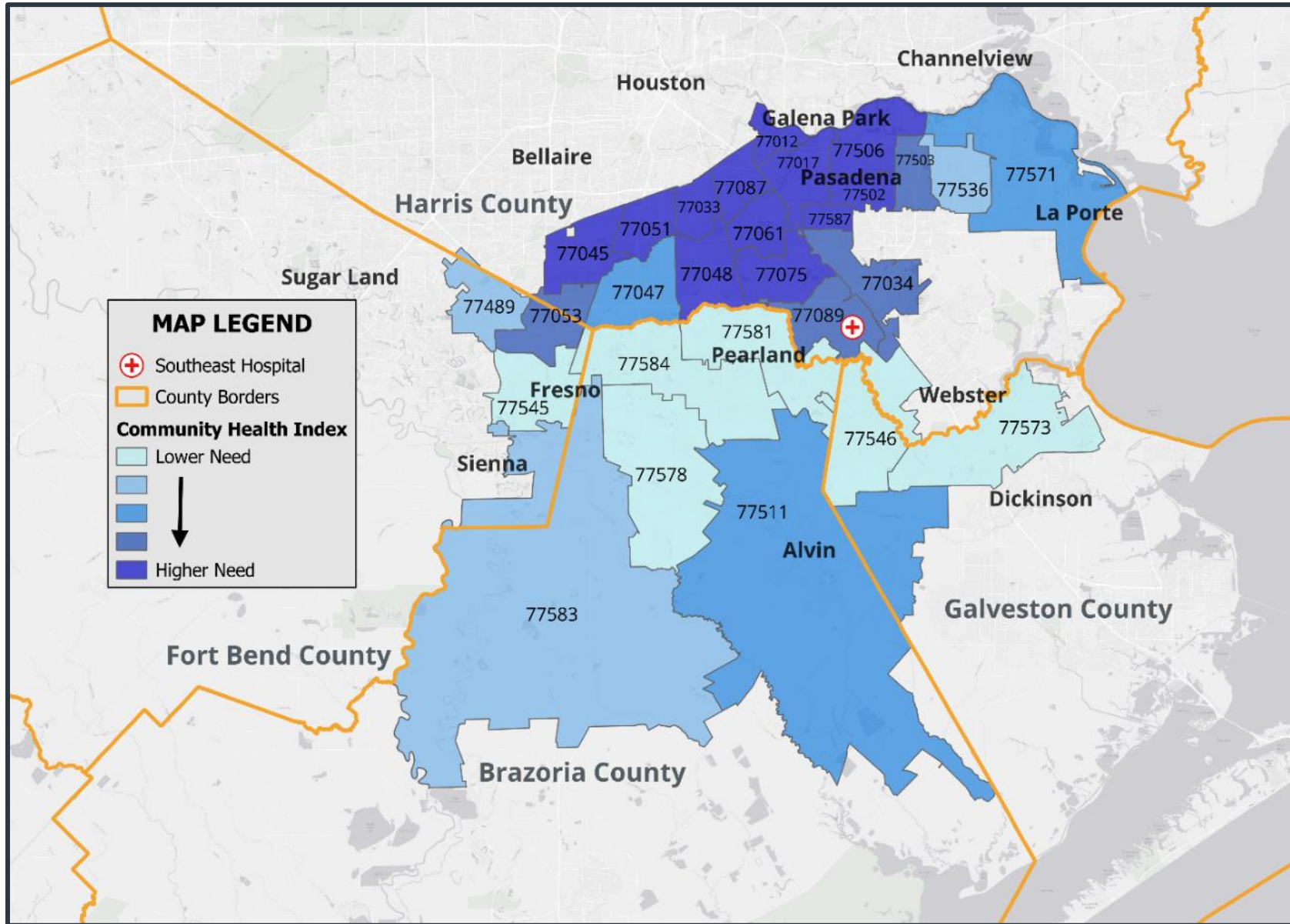
Key Findings: Access to Care

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 Southeast Hospital MSA, the zip codes with the highest CHI scores are:

- 77033 (CHI = 99.4)
- 77506 (98.9)
- 77048 (97.6)
- 77012 (97.5)
- 77087 (97.5)
- 77502 (97.5)

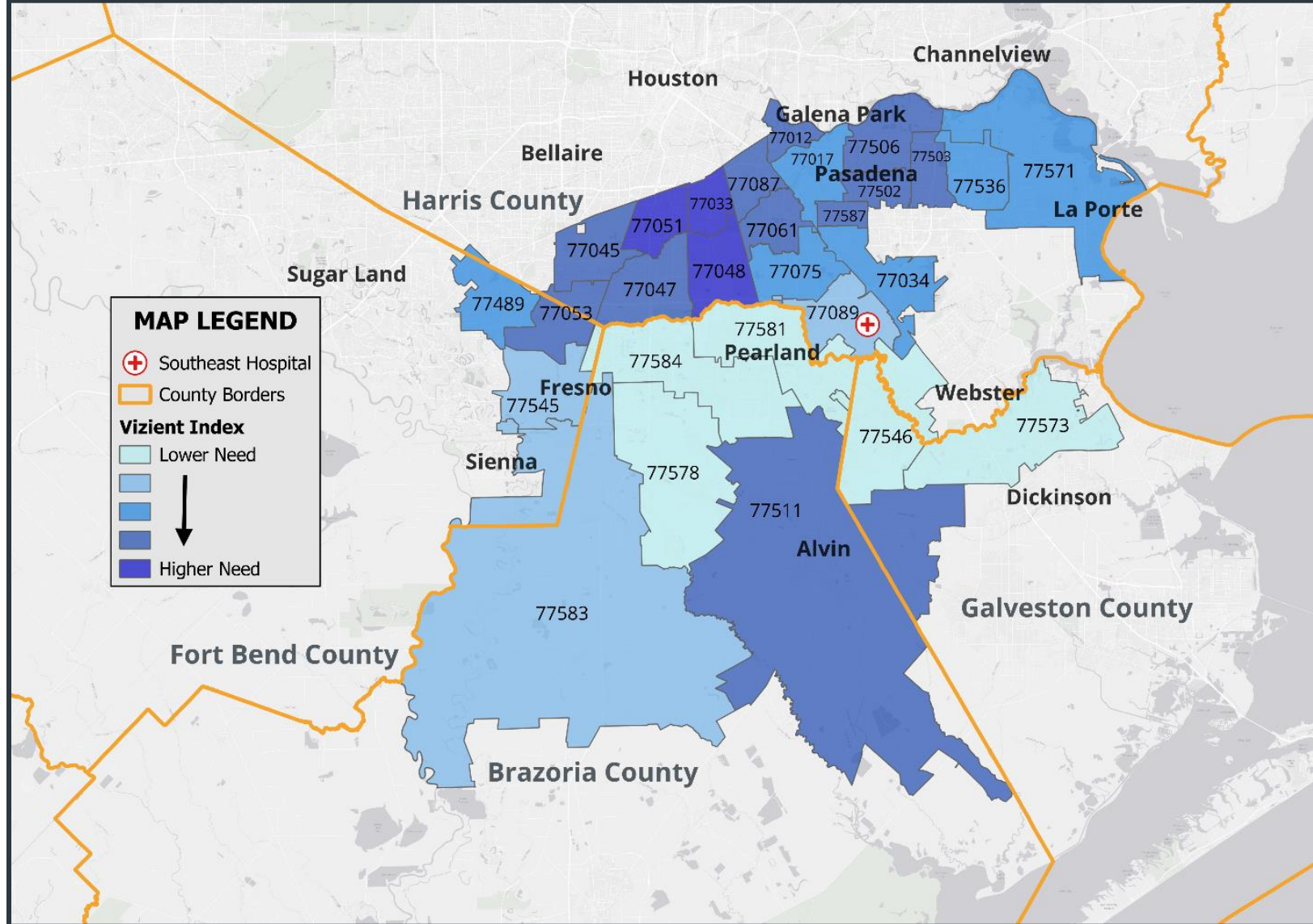
**FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE:
MEMORIAL HERMANN SOUTHEAST HOSPITAL MSA**



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

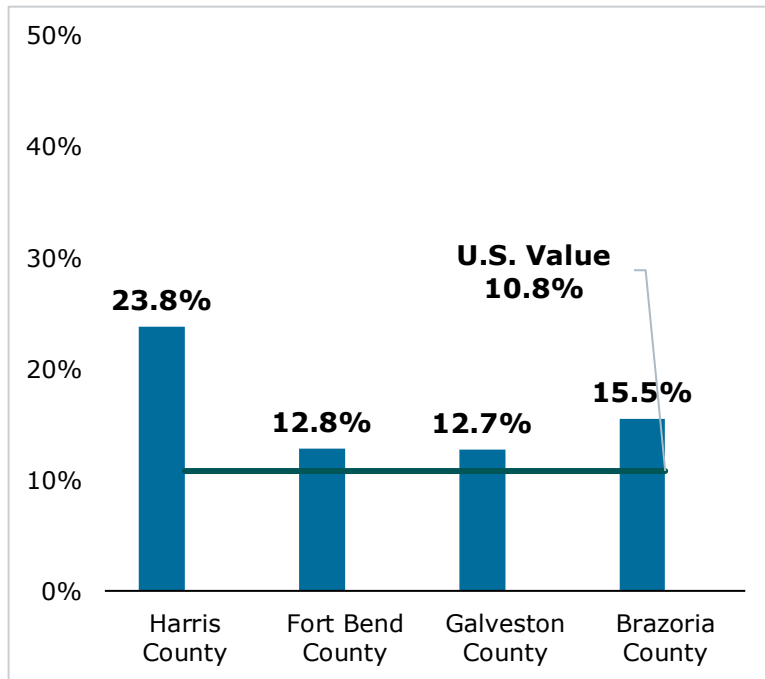
- 77033 (VVI = 1.66)
- 77051 (1.41)
- 77048 (1.36)
- 77061 (0.92)

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



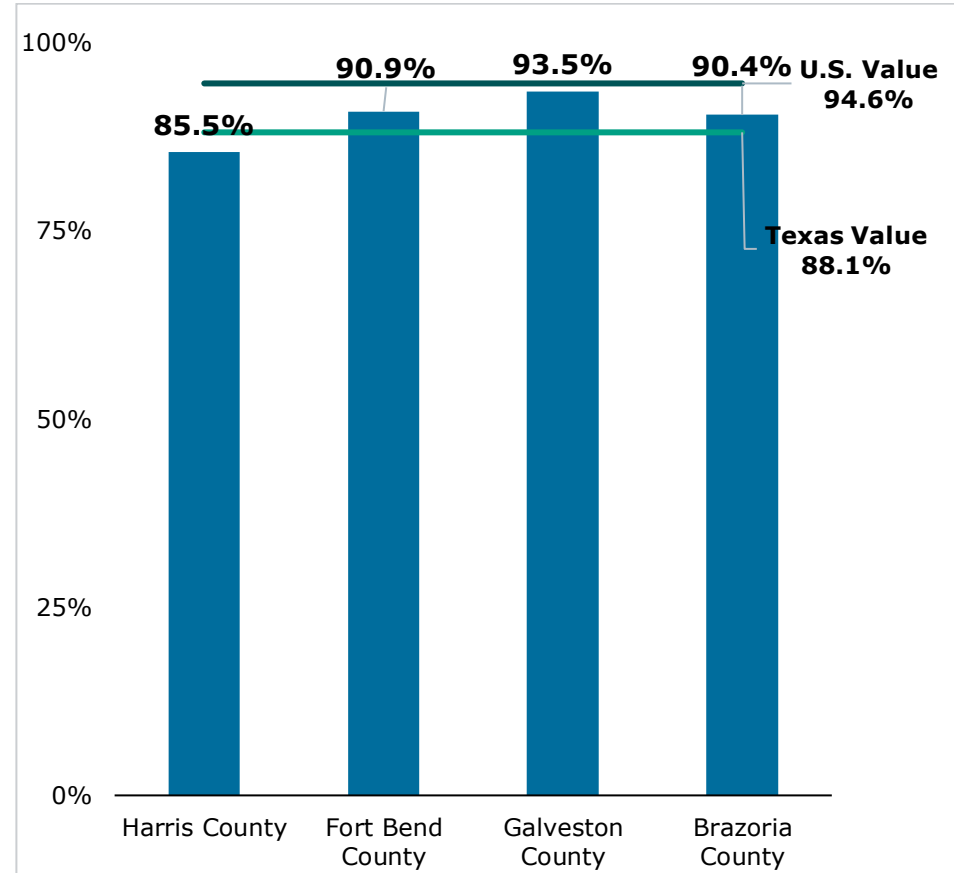
The following figures illustrate indicators of concern in Harris, Fort Bend, Galveston, and/or Brazoria counties, based on scoring of secondary data related to **Access to Care**.

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



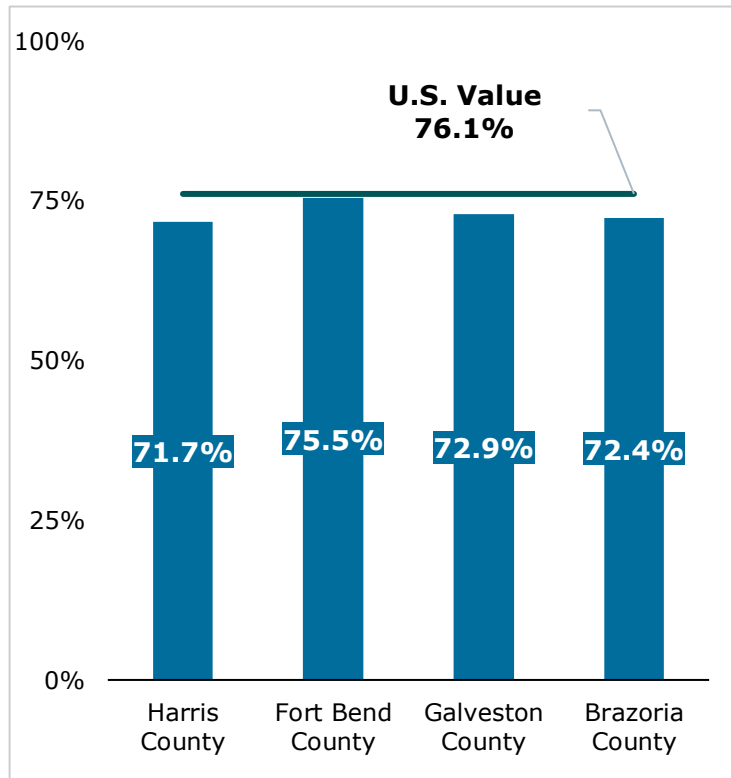
Source: CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



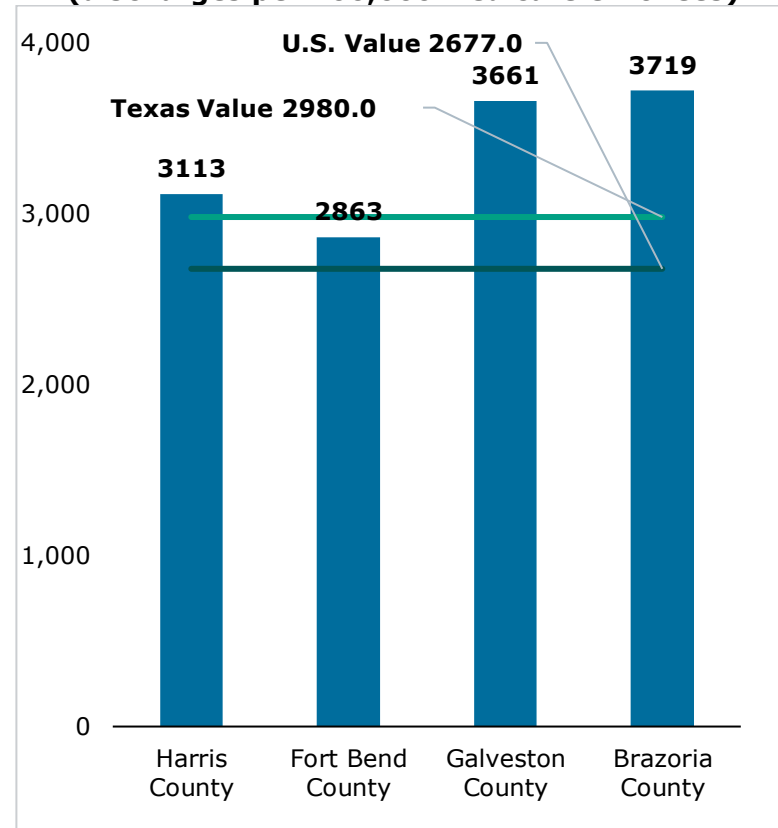
Source: American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



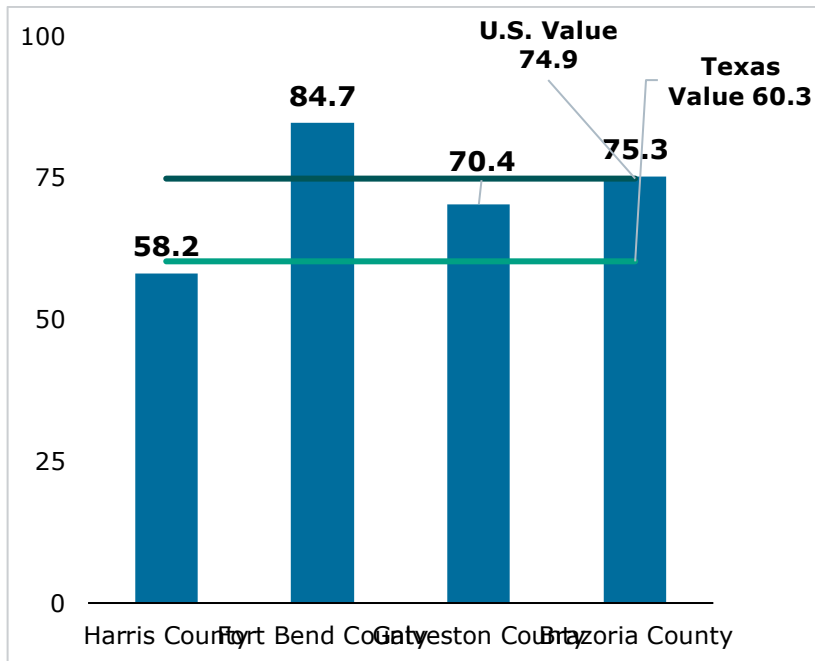
Source: CDC – PLACES (2022)

FIGURE 7. PREVENTABLE HOSPITAL STAYS: MEDICARE POPULATION (discharges per 100,000 Medicare enrollees)



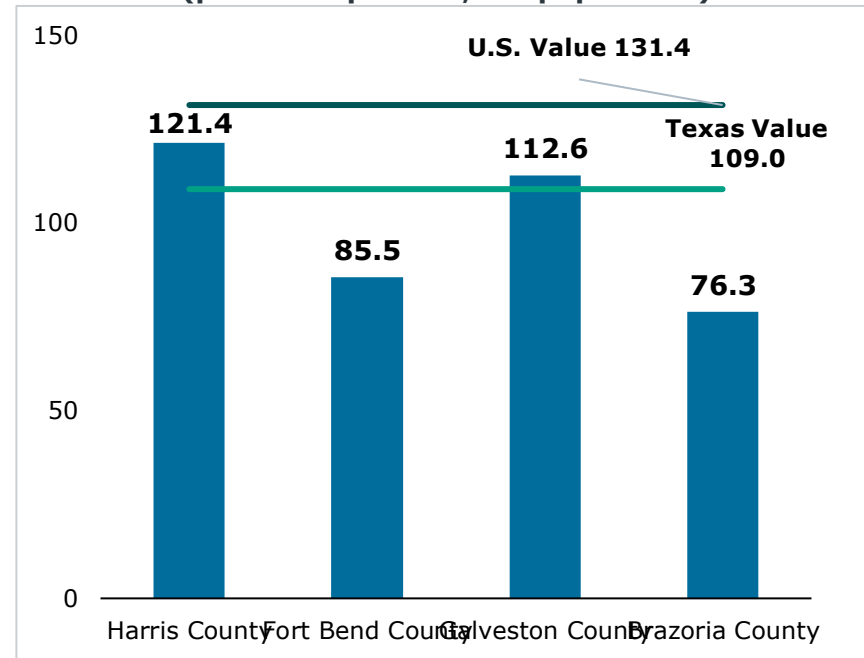
Source: Centers for Medicare & Medicaid Services (2022)

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)



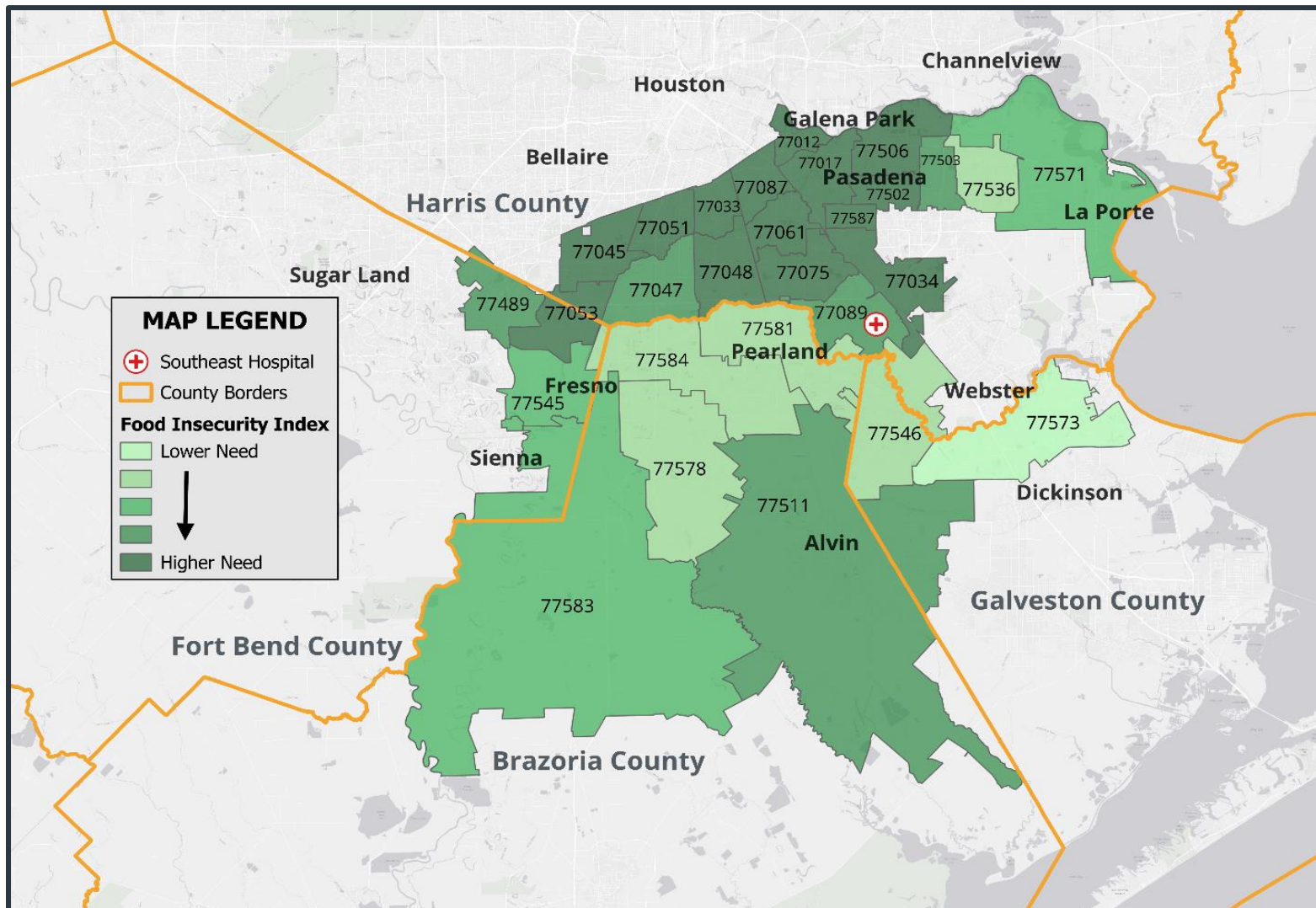
Source: County Health Rankings (2023)

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 Southeast Hospital MSA, the zip codes with the highest FII scores are:

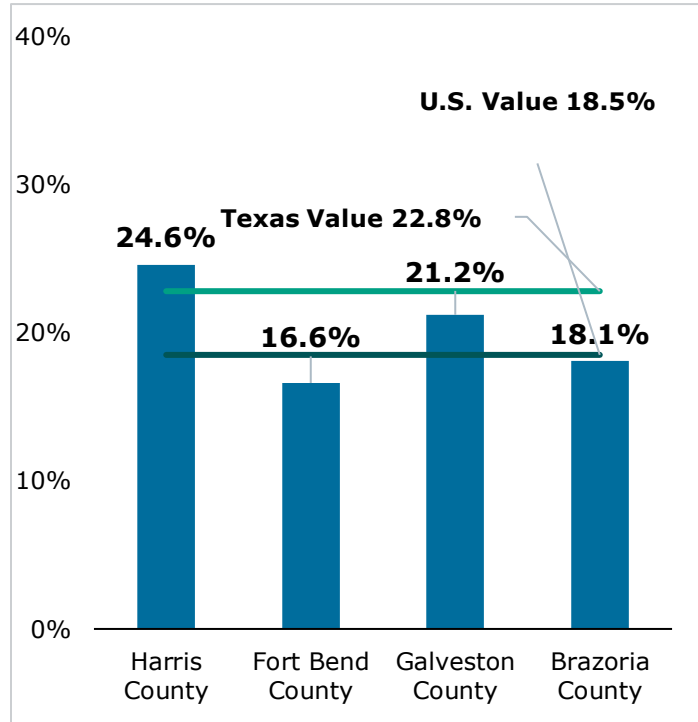
- 77051 (FII = 98.8)
- 77033 (98.8)
- 77048 (98.0)
- 77587 (96.8)
- 77061 (96.8)

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



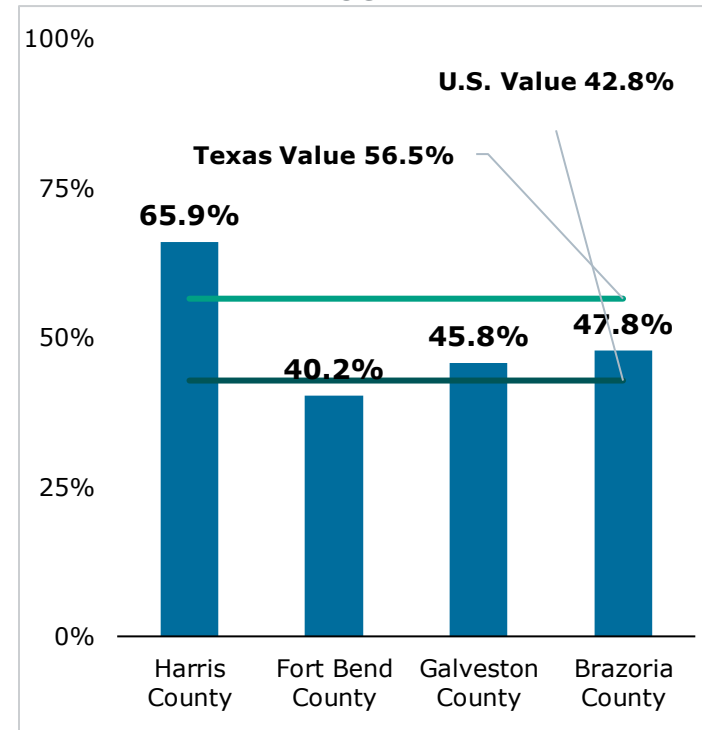
The following figures illustrate indicators of concern in Harris, Fort Bend, Galveston, and Brazoria counties, based on scoring of secondary data related to **Access to Healthy Food**.

FIGURE 11. CHILD FOOD INSECURITY RATE



Source: Feeding America (2022)

FIGURE 12. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM

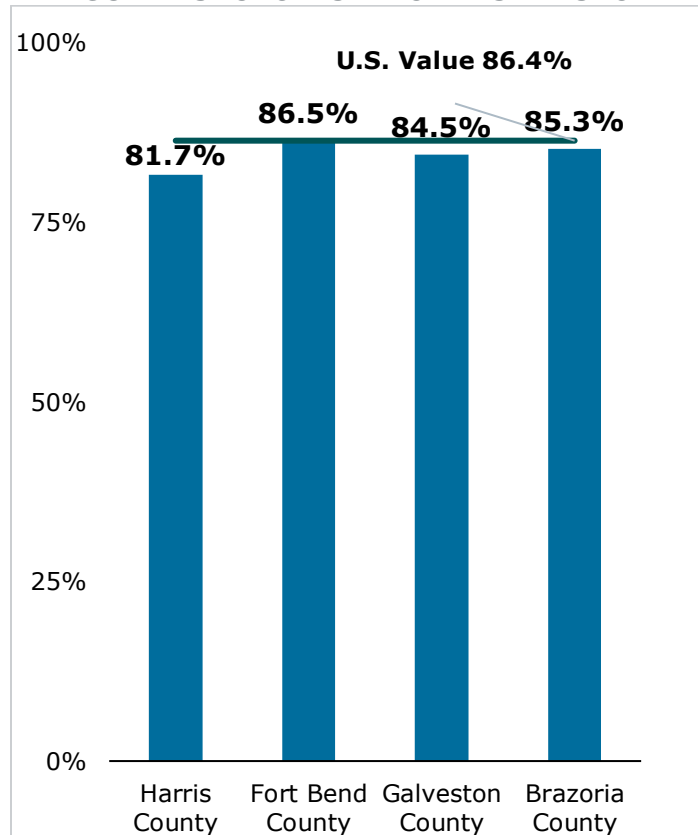


Source: National Center for Education Statistics (2022-2023)

Key Findings: Chronic Conditions Prevention and Management

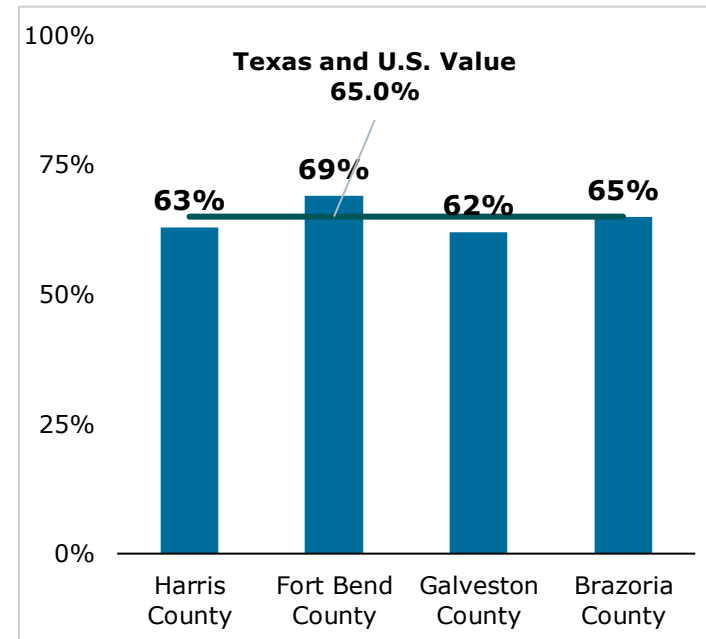
The following figures illustrate indicators of concern in Harris, Fort Bend, Galveston, and/or Brazoria counties, based on scoring of secondary data related to Chronic Conditions Prevention and Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



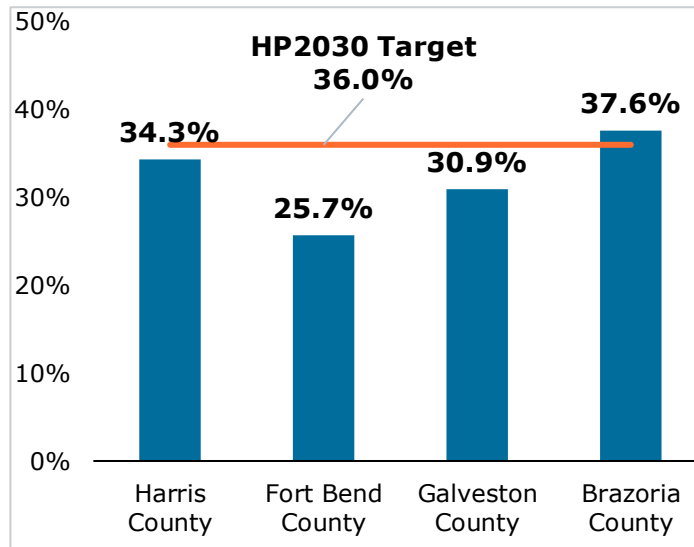
Source: CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



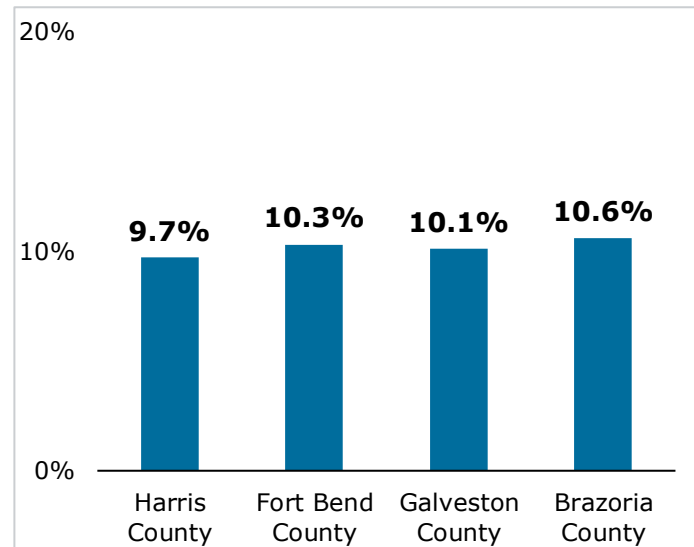
Source: Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



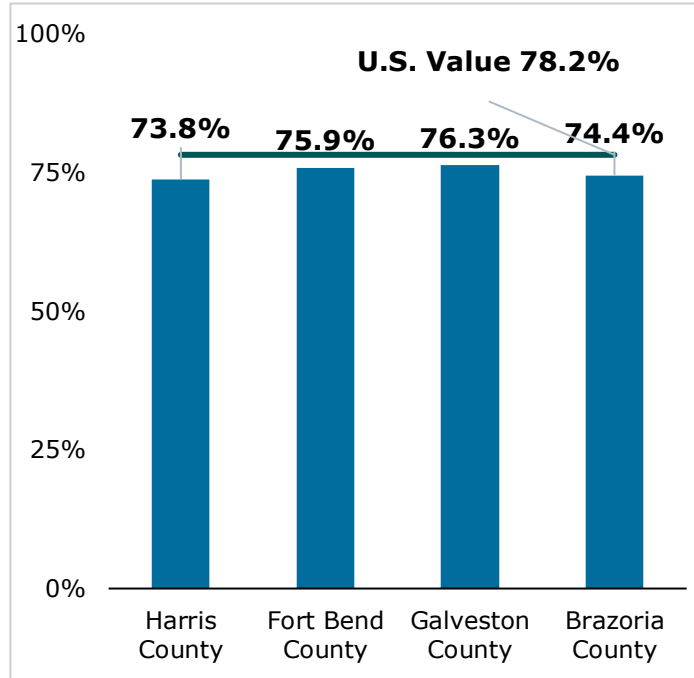
Source: CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



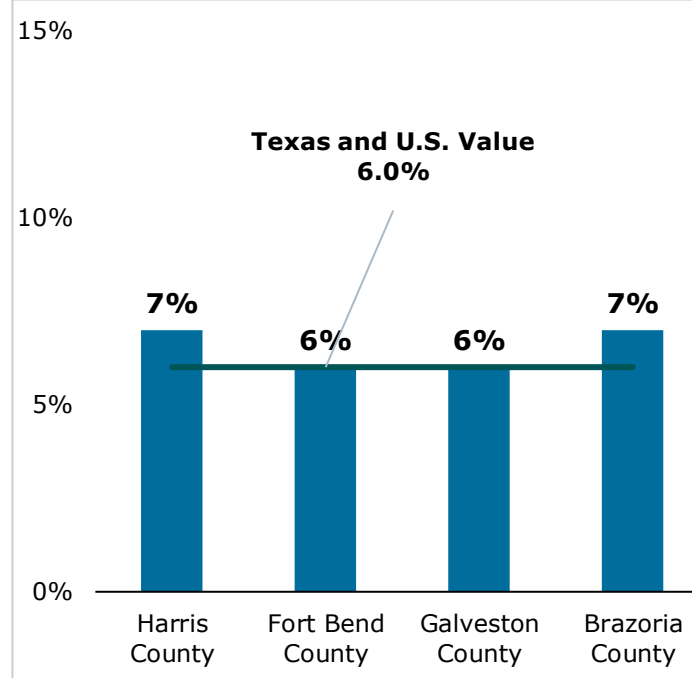
Source: CDC (2021)

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



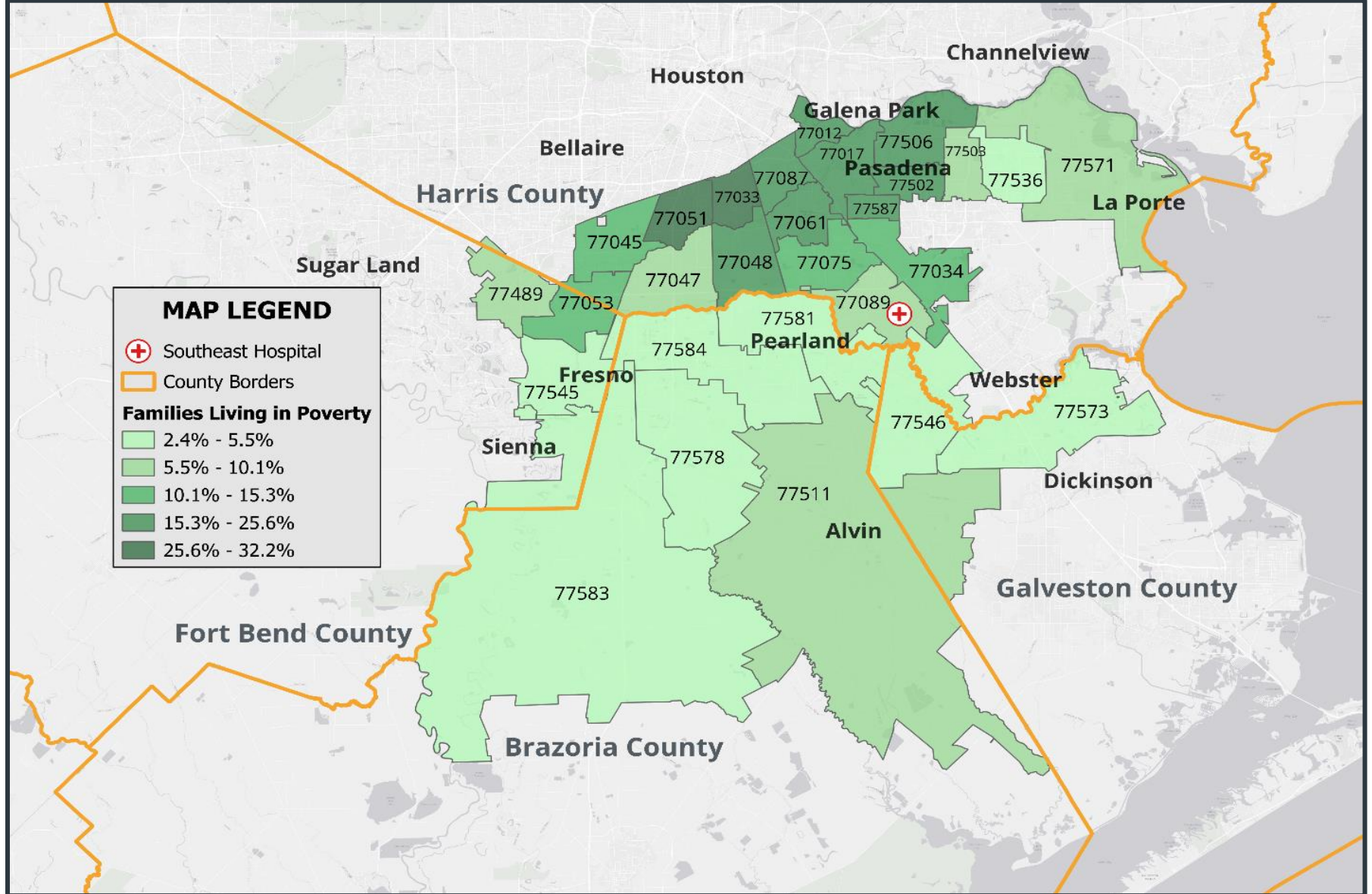
Source: Centers for Medicare & Medicaid Services (2022)

Key Findings: Economic Opportunity

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

- 77033 (32.2%)
- 77051 (30.6%)
- 77012 (25.6%)
- 77048 (23.6%)
- 77502 (21.6%)

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

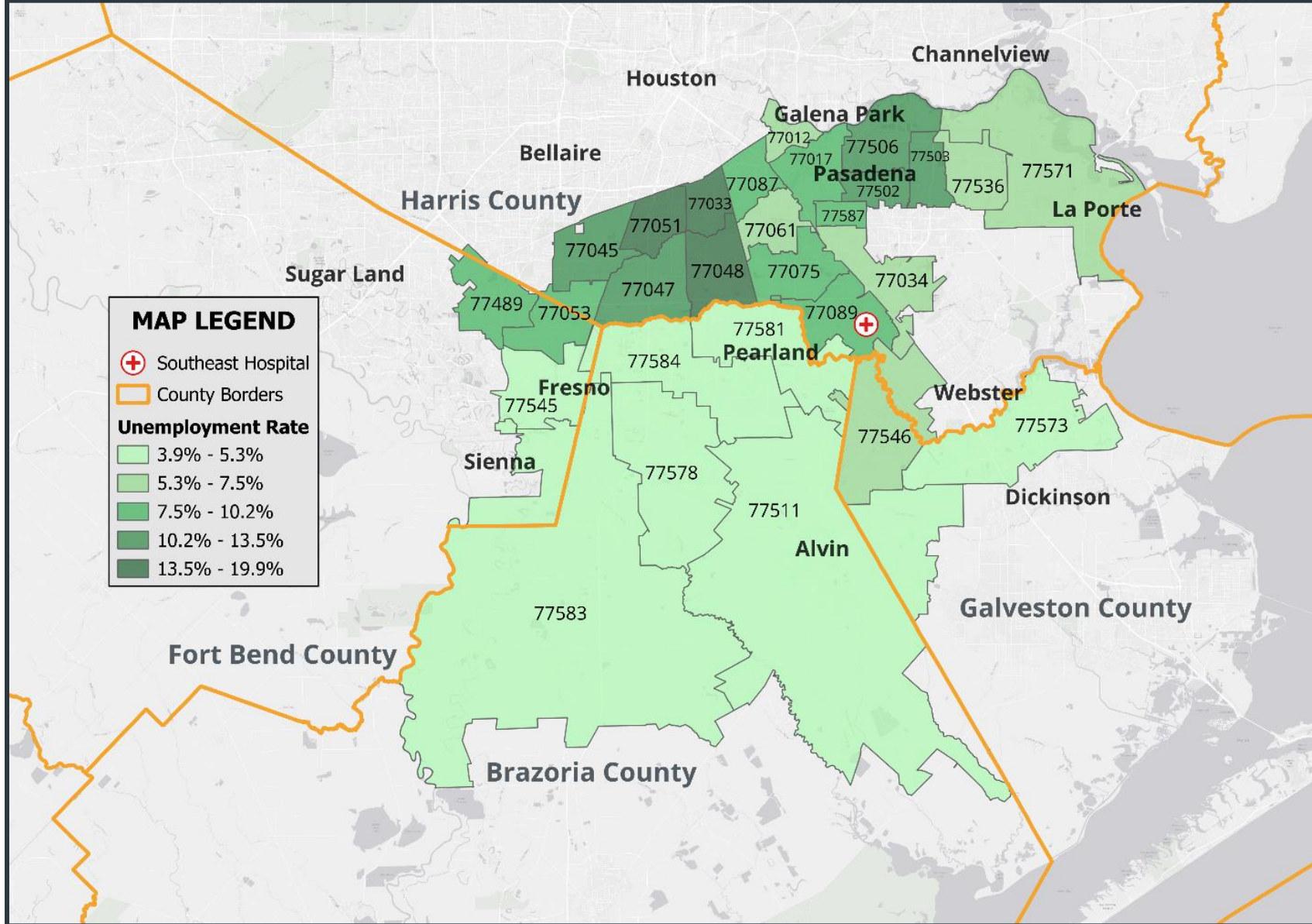


Source: Claritas (2024)

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

- 77048 (19.9%)
- 77033 (17.8%)
- 77051 (16.4%)
- 77506 (13.5%)
- 77503 (12.5%)

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

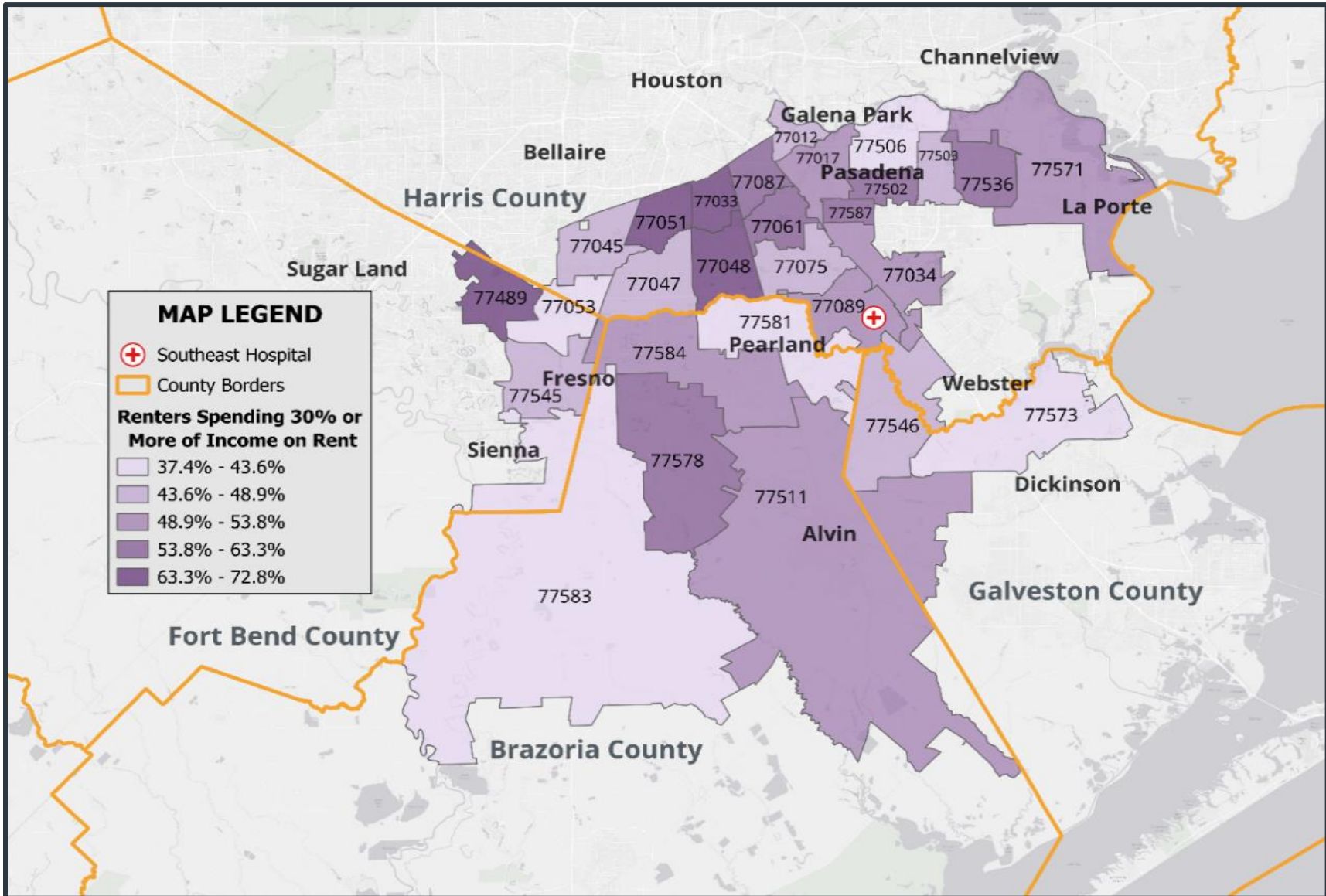


Source: Claritas (2024)

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

- 77051 (72.8%)
- 77048 (69.7%)
- 77033 (69.3%)
- 77489 (68.1%)
- 77578 (63.3%)
- 77502 (61.9%)

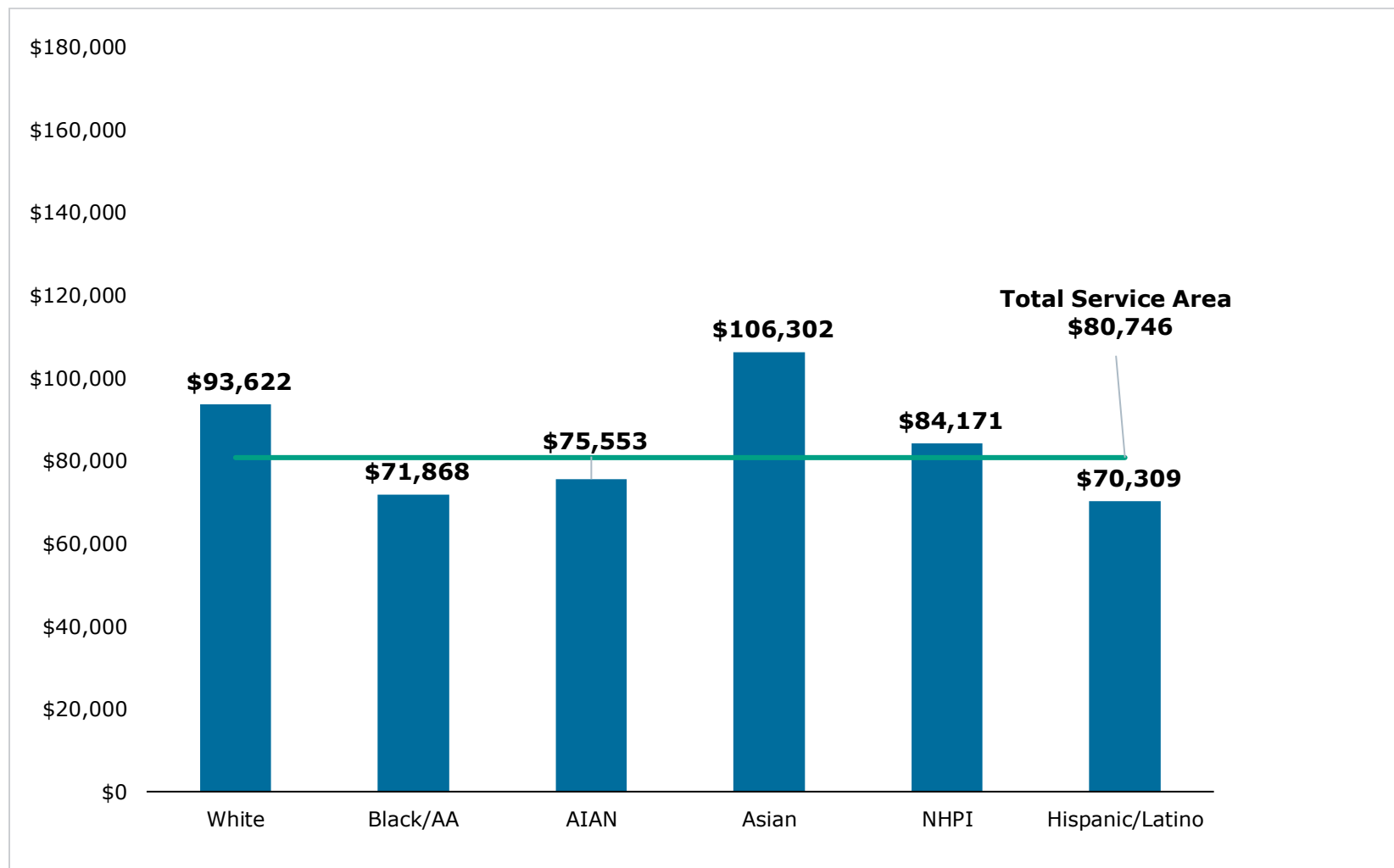
**FIGURE 21. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE:
MEMORIAL HERMANN SOUTHEAST HOSPITAL MSA**



Source: American Community Survey (2018-2022)

Across the Memorial Hermann Southeast Hospital MSA, income differs by race and ethnicity. The median household income for Black/African American and Hispanic Latino residents of the MSA are both around \$10,000 lower than the overall median household income.

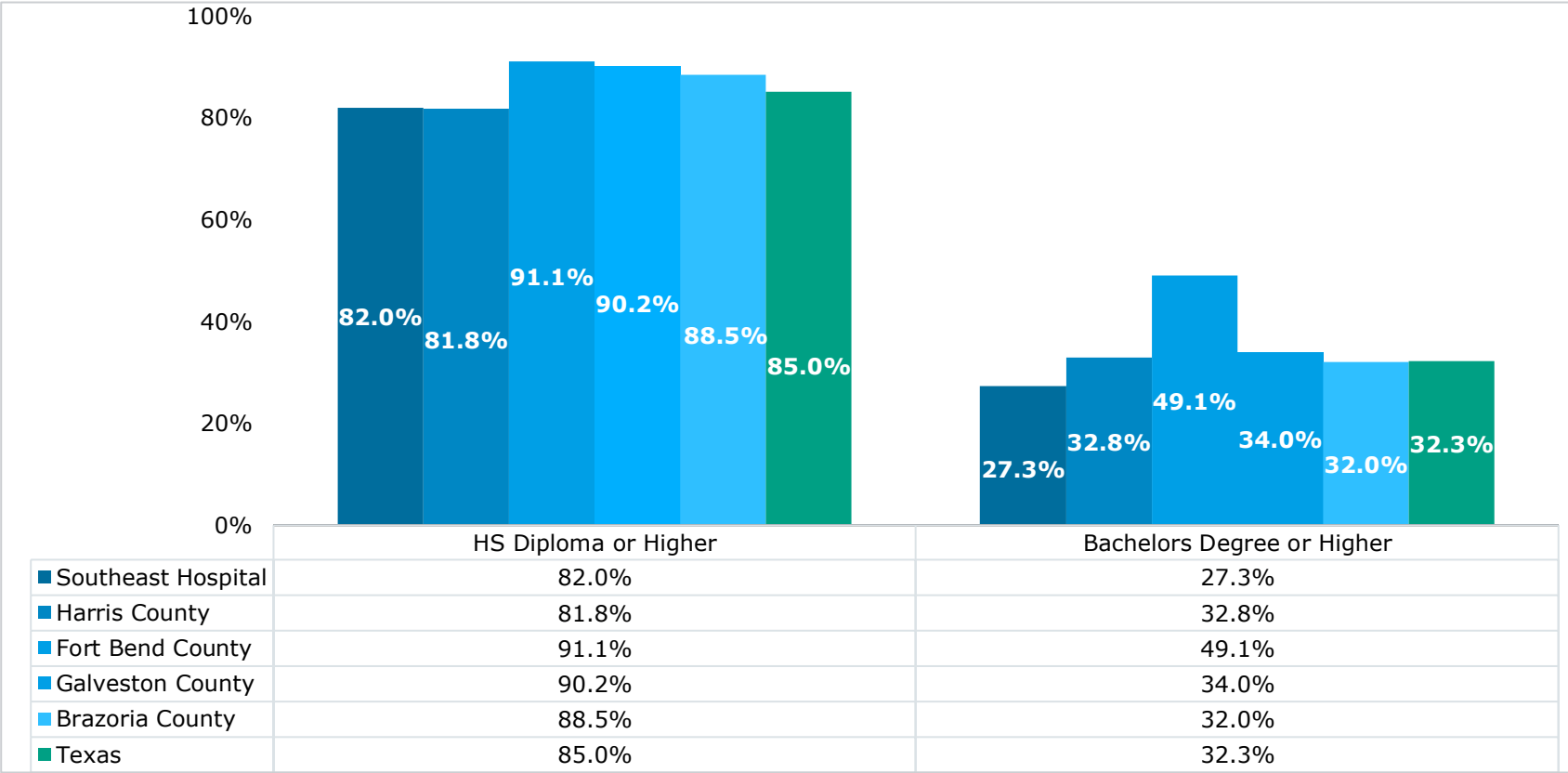
**FIGURE 22. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY:
MEMORIAL HERMANN SOUTHEAST HOSPITAL MSA**



Source: Claritas (2024)

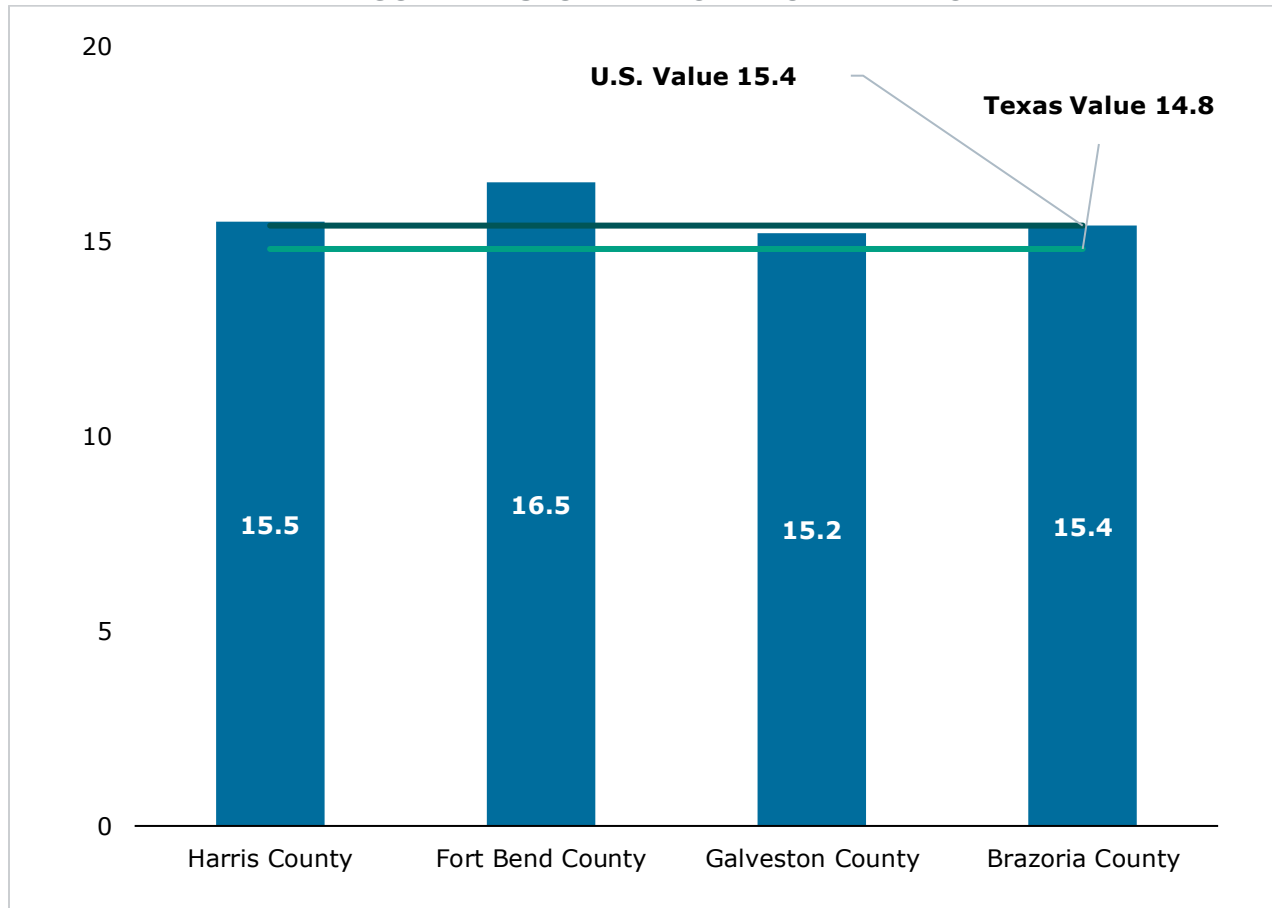
Key Findings: Educational Access

FIGURE 23. EDUCATIONAL ATTAINMENT



Source: Claritas (2024)

FIGURE 24. STUDENT-TO-TEACHER RATIO

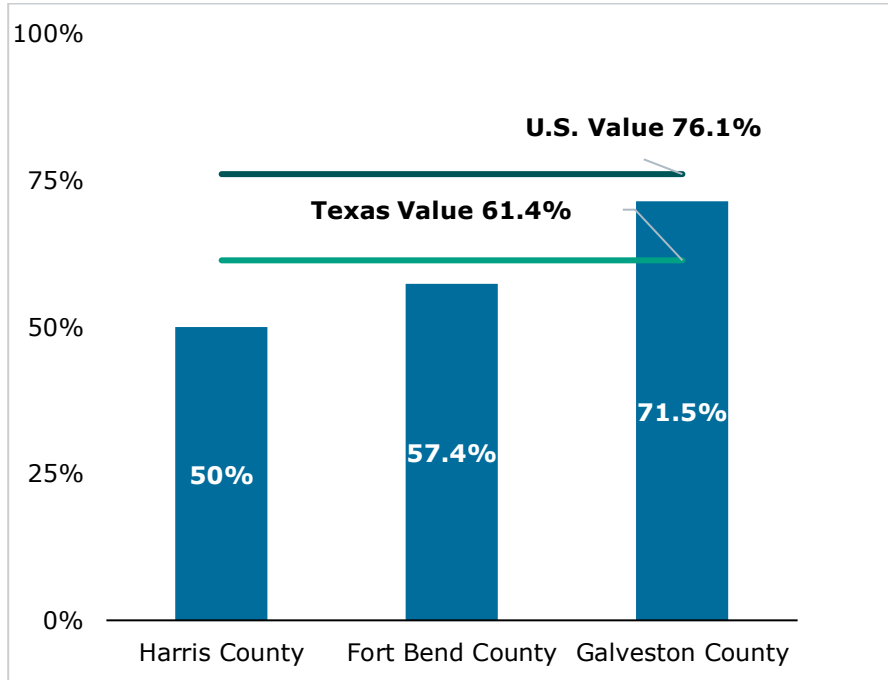


Source: National Center for Education Statistics (2022-2023)

Key Findings: Maternal & Infant Health

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

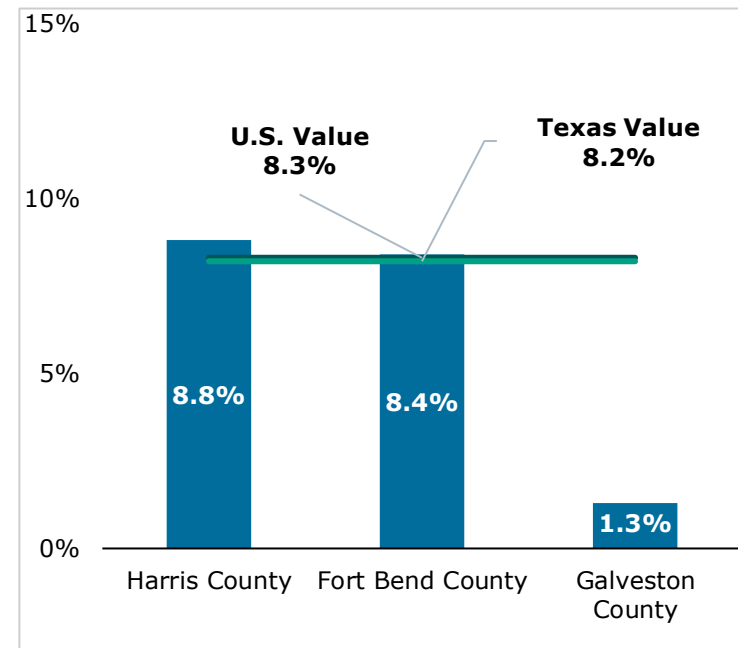
FIGURE 25. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



No data available for Brazoria

Source: Texas Department of State Health Services (2020)

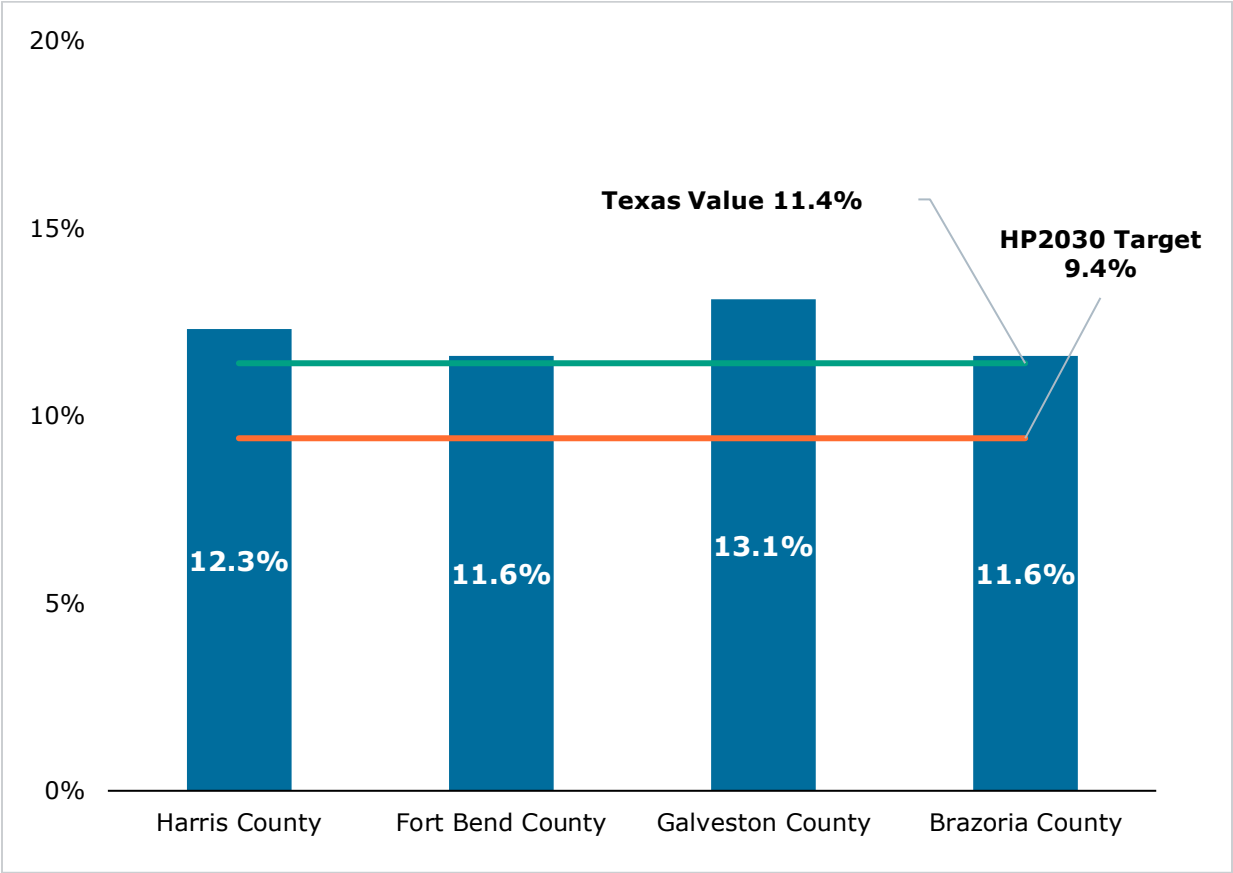
FIGURE 26. BABIES WITH LOW BIRTHWEIGHT



No data available for Brazoria

Source: Texas Department of State Health Services (2020)

FIGURE 27. PRETERM BIRTHS



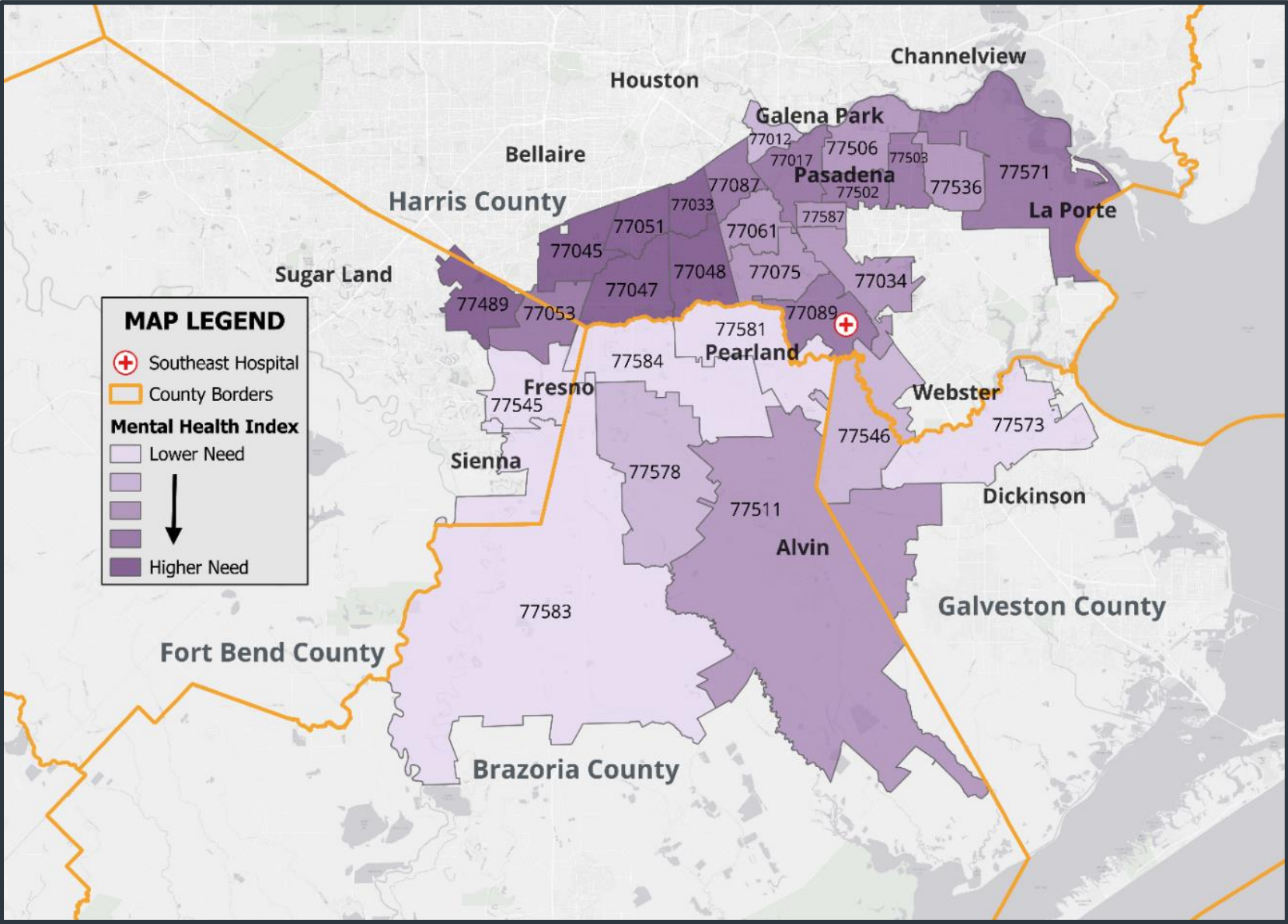
Source: Texas Department of State Health Services (2021)

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 Southeast Hospital MSA, the zip codes with the highest MHI scores are:

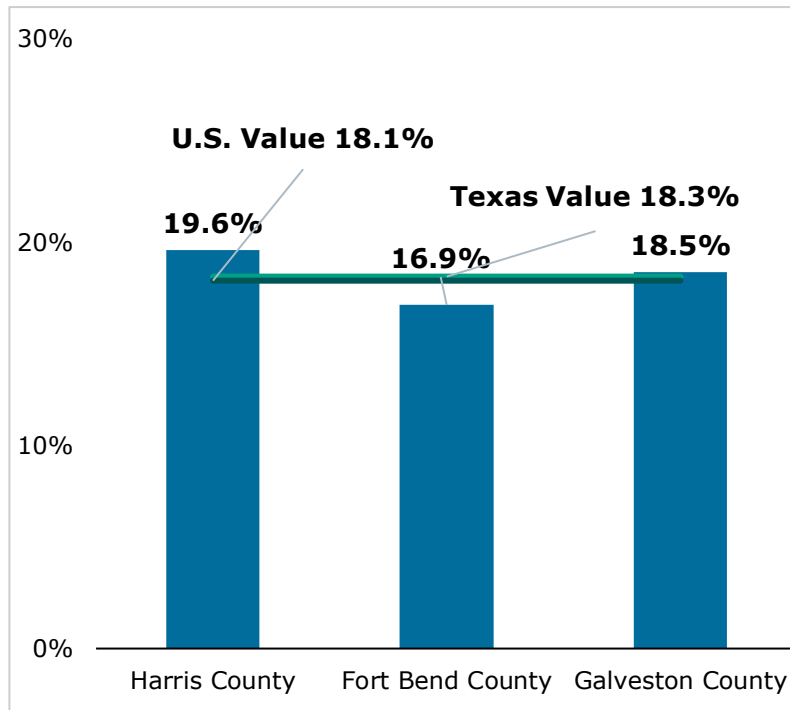
- 77051 (MHI = 99.1)
- 77033 (98.0)
- 77048 (97.8)

**FIGURE 28. CONDUENT HEALTHY COMMUNITIES INSTITUTE’S MENTAL HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN
SOUTHEAST HOSPITAL MSA**



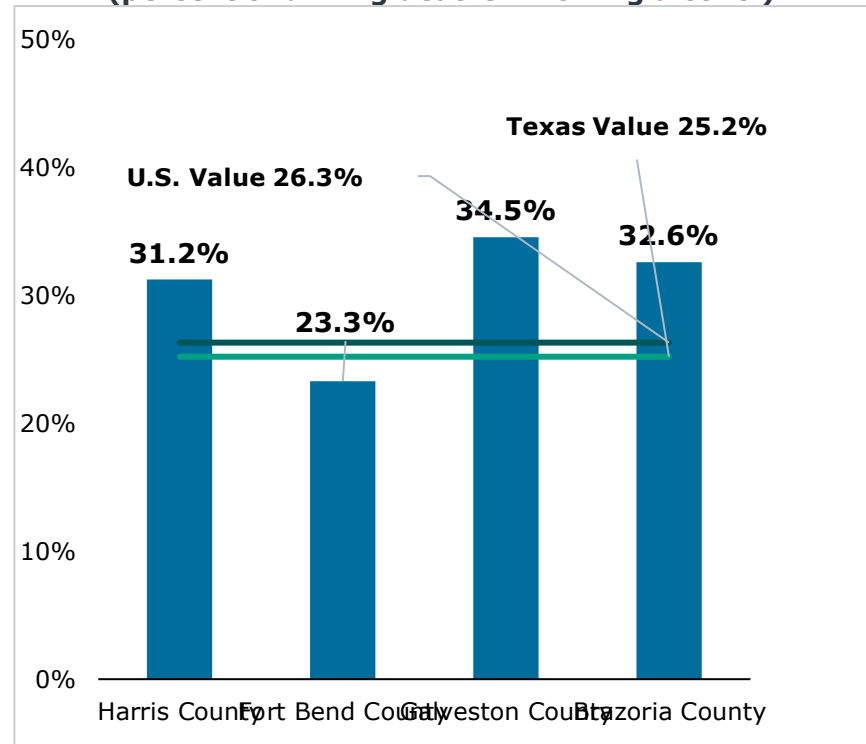
The following figures illustrate indicators of concern in Harris, Fort Bend, Galveston, and/or Brazoria counties, based on scoring of secondary data related to Mental Health & Substance Use.

FIGURE 29. ADULTS WHO DRINK EXCESSIVELY



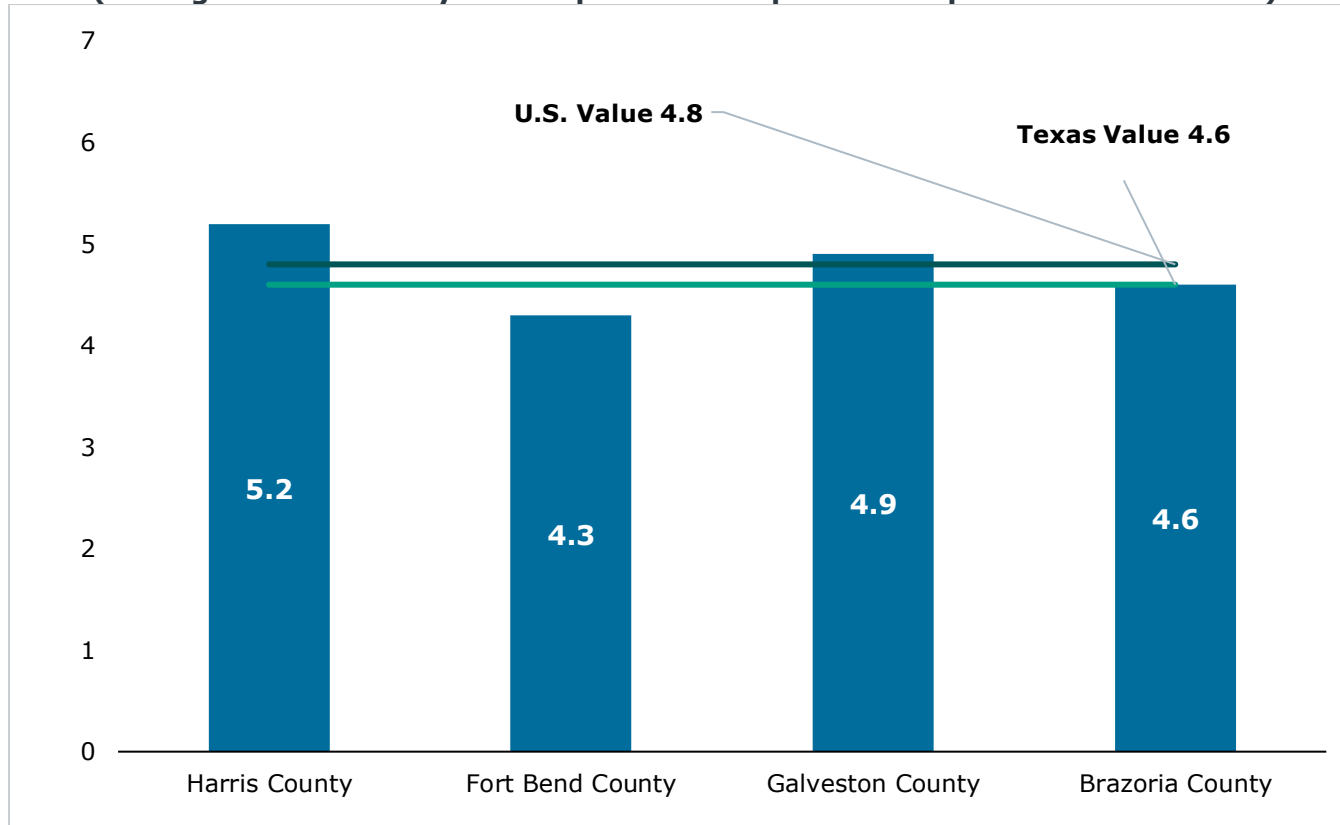
Source: County Health Rankings (2021)

**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)