Community Health Implementation Strategy

Memorial Hermann Southwest Hospital

MEMORIAL® HERMANN Southwest

Table of Contents

At-a-Glance Summary

Community Served	Memorial Hermann Southwest Hospital, serving 1,608,636 persons living in 30 zip codes in Harris and Fort Bend 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.
- To 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.
- Refer ≥70% of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ED settings with identified Non-Medical Driver of Health (NMDOH) needs to Community Care Coordination Team (C3T) Community Health Workers (CHWs) for a documented intervention and outcome.

Access to Healthy Food

- Increase annual referrals from Memorial Hermann's Primary Care Service Line and Neighborhood Health Centers (NHC) to the FoodRx program for diabetic patients with A1c >7.5, BMI in the obesity range ≥30, or diagnoses of hypertension to improve nutrition access and drive measurable improvement in chronic disease outcomes.
- 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

- ≥40% of MHHS patients screened for at least 1 NMDOH with ≥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

- ≥10% reduction of MHHS Severe Maternal Morbidity (SMM) rates of target population encountered by Community Health services residing in high-poverty zip codes within Greater Houston.

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 Southwest Hospital

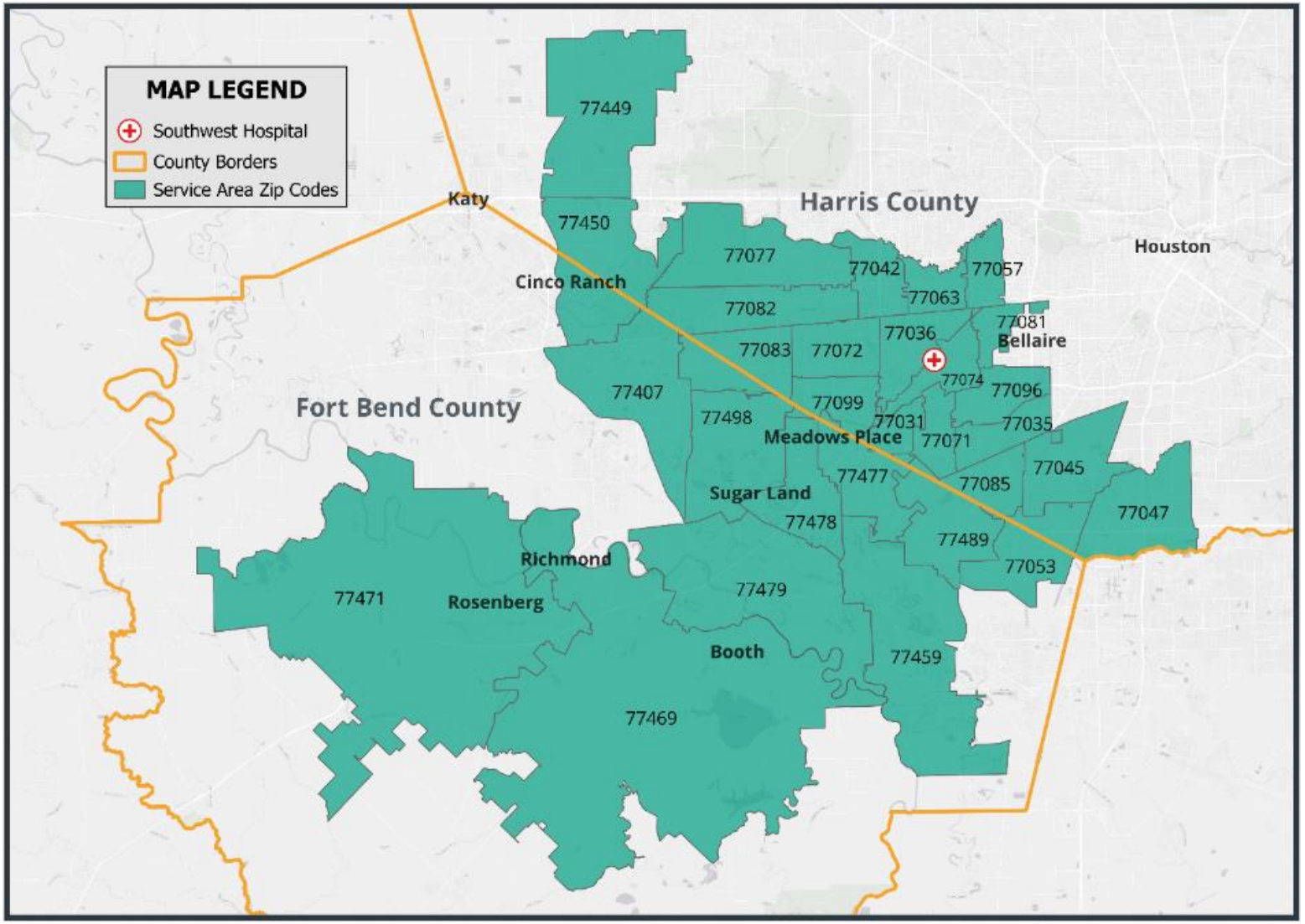
Memorial Hermann Southwest Hospital is a part of Memorial Hermann Health System (MHHS), one of the largest nonprofit health systems in Texas, with 17* hospitals and more than 6,600 affiliated physicians, 34,000 employees across 270 care delivery sites throughout the Greater Houston area.

Memorial Hermann Southwest Hospital has been caring for families since 1977. A 541-bed facility, Memorial Hermann Southwest Hospital employs state-of-the-art technology and a team of highly trained affiliated physicians to offer high-quality care close to home. Memorial Hermann Southwest Hospital has been serving the communities of Southwest Houston, including Bellaire, Meyerland, the Galleria area, Missouri City, Sharpstown and beyond, since 1977. The hospital campus is designated as a Comprehensive Stroke Center by The Joint Commission. Specialties and programs include: Arrhythmia Clinic, Breast Care Center, Cancer Services, Diabetes Management Program, Digestive Health Center, Heart & Vascular Institute, Imaging Center, Neuroscience Program, Orthopedics & Sports Medicine, Rehabilitation Services, Vascular and Interventional Radiology Services, Women's Health & Maternity, Level III NICU, and Wound Care."

Description of the Community Served

Memorial Hermann Southwest Hospital Metropolitan Service Area (MSA) has a population of approximately 1,608,636 persons serving 30 zip codes in Harris and Fort Bend counties. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. MEMORIAL HERMANN SOUTHWEST HOSPITAL METROPOLITIAN SERVICE AREA BY ZIP CODES



Source: MHHS facilities values from Claritas (2024)

Community Assessment and Significant Needs

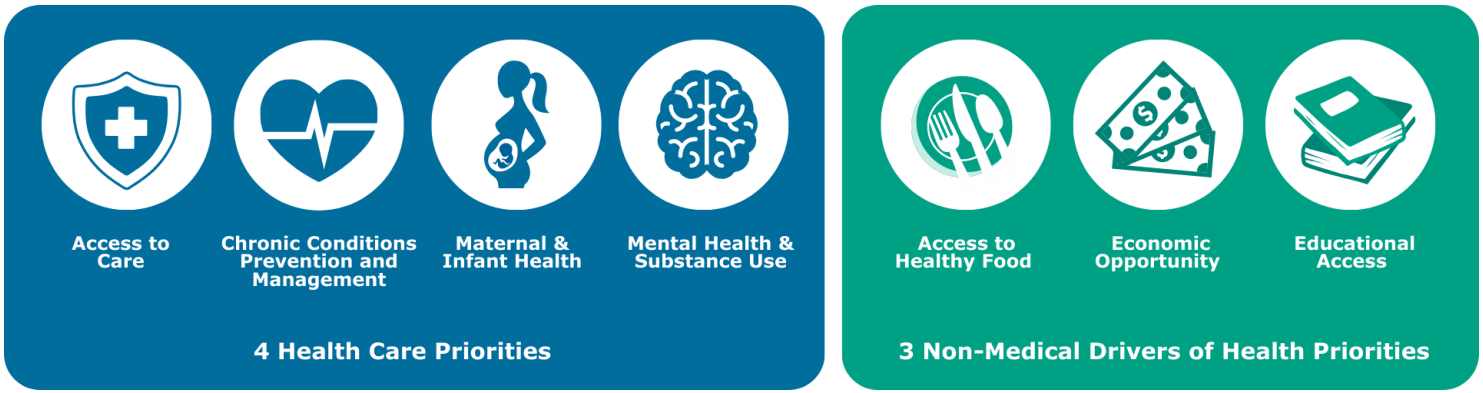
The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted on June 26, 2025. The CHNA report includes:

- 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 also 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 Southwest 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 Southwest Hospital, and other hospital leadership.

During initial planning meetings, representatives from HCI and Memorial Hermann Southwest 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 Southwest 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 Southwest 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 Southwest Hospital Implementation Plan

Community Priority: Access to Care

- **Primary Prioritized Need Area:** **Access to Care**
- **Secondary Prioritized Need Area(s):** **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 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—patients of 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: Guide Health Effort	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 • Volume - patients enrolled in FoodRx Program
Medical Home Establishment: SW 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
SafeRide Program	Community Health Network	426 Completed Rides (universal May 2025)	• Volume – number of rides completed • Percent - completed rides to PCP/ Doctor appointment
Community Outreach Events: Chest Pain, Stroke	• MHHS Southwest Marketing	FY25 Totals	• Volume – number of events held by disease focus type • Number – participants to events

Education & Diabetes Boot Camp	• Diabetes Education Team • Community Health Network		• Number – participants to Diabetes Boot Camp

Target/Intended Population(s):

- Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS Southwest 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.
- Inpatient Navigation is piloting a value-based care model via Guide Health in collaboration with the Strategy Team. The program combines the patient navigation program with intensive wrap around support to deploy early interventions- especially for those with frequent utilization and risk of readmissions.
- 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.
- 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:

- Coordinated Care; ER; ISD; community nonprofit agencies; Strategy division; MHHS Southwest Ultrasound; Diabetes Education Team; and Business Office

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

FY26-FY28 Goal: **To 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.**

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

FY26 KPIs:

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

Strategic Approach

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

Target/Intended Population(s):

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

Please provide any additional insights or explanations on the initiative(s) listed. Health Centers for Schools is a Community Health program focused on providing access to health care for school-age children.

- Baseline data to be established for FY26 and built upon in subsequent years during plan period.
- 2026 is the pilot year for this effort.

Collaboration Partners:

- Independent School Districts; community nonprofit agencies

Prioritized Need Area: **Access to Care**

FY26-FY28 Goal: **≥70% of MHHS ACO patients discharged from acute or ED 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 ER settings with identified NMDOH needs will be referred to Community Care Coordination Team CHWs for a documented intervention.

FY26 KPIs:

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

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Transitional Care Management	• Population Health • ISD • Analytics	Baseline TBD post- FY26	• Capture Rate – of NMDOH needs, referrals, and outcomes in Epic
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 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 (s): Chronic Conditions Prevention and Management**

FY26-FY28 Goal: To increase annual referrals from Memorial Hermann's Primary Care division and Neighborhood Health Centers (NHC) to the FoodRx program for diabetic patients with A1c >7.5, BMI in the obesity range ≥30, or diagnoses of hypertension to improve nutrition access and drive measurable improvement in chronic disease outcomes.

FY26 Objective: To develop a referral pathway for Memorial Hermann Primary Care and Neighborhood Health Center- Southwest that integrates baseline biometrics and physical fitness into the FoodRx program, creating a holistic model of care to mitigate and manage chronic conditions.

FY26 KPIs:

- Percent - patients achieving improvement in focus health measures (e.g. A1c; BMI) for targeted disease states
- Percent – patients enrolled and graduating FoodRx program
- Volume – unique referrals to FoodRx from MHMG Primary Care & NHCs

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
FoodRx Program Expansion	Community Health Network	Baseline TBD post- FY26	• Volume – referrals received to FoodRx • Percent – enrolled in FoodRx • Percent- graduation of enrollee • Percent - change in biometric readings/health measures
Exercise is Medicine Program Integrations	Community Health Network	Baseline TBD post- FY26	• Go-live date of EIM offering within FoodRx • Percent – participation rate of FoodRx enrollees to EIM sessions
Diabetes Support Groups and Community Outreach	Diabetes Education Team	FY25 Totals	• Volume – number of people reached • Volume – number of events held

Target/Intended Population(s):

- Southwest community; Medicaid; uninsured; target disease state diagnosis; expansion to insured populations when viable

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

- FoodRx is a Community Health Network driven initiative operating at the Southwest campus with goals to expand to other locations across MHHS. The program is a health care initiative that provides patients with access to healthy foods prescribed by a clinician to support prevention/management of chronic conditions. This program integrates nutrition education, access to healthy food, and a dietitian to support positive outcomes.
- Exercise is Medicine is a Community Health Network driven initiative operating at different locations across Greater Houston that focuses on providing patients and community members with education on the importance of physical fitness while offering access to walking groups to support easing into exercise. It can be prescribed by clinicians to support prevention/management of chronic conditions like obesity, diabetes, and more.

Collaboration Partners:

MHMG Primary Care; ISD; Diabetes Education Team

- **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 appointment scheduled
Community Resource Centers	Community Health Network	Compass Rose	• 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	• Epic • Compass Rose	• 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: • 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 Areas (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 Southwest 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 Contact Center 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

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 & 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
- Percent - patients achieving improvement in focus health measures (e.g. A1c; BMI) for targeted disease states in Impact communities

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Southwest Coalition: CHW Workforce Pipeline	Community Health Network	Baseline TBD post- FY26	• Number – program participants from MHHS surrounding priority ZIPs • Percent – cohort completion • Percent – hired post program training (target 50%) • Percent – retained 90 Days • Percent – retained 12 Months
Cultivating Future Health care Professionals Summer Camp	• Memorial Hermann Southwest • Houston Christian University	FY25 Totals	• Volume – number of attendees • Percent – increased student enthusiasm to pursue careers in health care
MHSW Patient Care Technician Program	• Memorial Hermann Southwest	FY25 Totals	• Volume – number of attendees • Percent – cohort completion

	• Alief High School		
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. CHW Workforce Pipeline program is a pilot workforce initiative via Southwest Coalition focused on career pathways for Community Health Workers identified from priority six neighborhoods across Greater Houston and Memorial Hermann service areas, in partnership with Baker Ripley.

- Southwest Coalition: A collaborative formed in 2022 by Memorial Hermann comprised of local nonprofit organizations located within or serving the southwest region of Houston.
- 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:

- Human Resources, local nonprofit partners and collaboratives, MHHS SW Campus, Houston Christian University, Alief High School

Community Priority: Maternal & Infant Health

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

FY26-FY28 Goal: ≥10% reduction of MHHS Severe Maternal Morbidity (SMM) rates of target population encountered by Community Health services residing in high-poverty zip codes within Greater Houston.

FY26 Objective: Reduce severe maternal morbidity (SMM) among community health patients living in target ZIP codes in southwest Harris County. (Baseline to be established at the end of FY26 measurement period)

FY26 KPIs:

- Volume - unique patients served
- Percent – patients absent of SMM indicators upon/post delivery
- Percent - deliveries that received prenatal care visit in the 1st trimester (or 13 weeks),
- Percent - deliveries that had a postpartum visit on or between seven (high risk) and 84 days after delivery
- Percent - patients screened for NMDOH and connected to resources

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Mom & Baby Mobile Health Unit	Community Health Network	Baseline TBD post- FY26	• Number - unique sites visited by unit • Volume - patients served via mobile unit • Number – established patient visits • Percent - patients screened for NMDOH • Volume - unique services provided on mobile unit (E.g. doulas; food support)
Obstetrics Emergency Department (OB-ED): High Risk Patient Initiative	Community Health Network	Baseline TBD post-FY26	• Volume - unique referrals from the OB-ED to Mom & Baby Mobile Health Unit • Percent - show rate of ER referrals to Mom & Baby Mobile Health Unit/NHC • Percent - ER revisit rate of referred prior to planned delivery window

Target/Intended Population(s):

- Medicaid; Uninsured; Residing in Target ZIPS; Patients less than 22 weeks in OB-ED at MHHS Southwest.

Please provide any additional insights or explanations on the initiative(s) listed. SMM are women who survive childbirth but experience life-threatening conditions (e.g. hemorrhage-related, heart failure, sepsis, etc.)

- Mom & Baby Mobile Health Unit is operated by the Neighborhood Health Centers located in MHHS Southwest and offers maternal care to underserved residing in the SW Zip Codes with emphasis on high poverty ZIPs.
- OB-ED High Risk Patient Initiative is a partnership with the SW OB-ED to ensure underserved women identified as needing prenatal care while in the ED can receive a referral to the Mom & Baby Unit. This supports the goal to increase healthy deliveries.
- Established patient for this goal is defined as 2+ visits each trimester.
- Partner with local organizations to offer classes focused on maternal and pediatric health

Collaboration Partners:

- Women & Children's Service Line, Neighborhood Health Centers, March of Dimes, Blue Cross Blue Shield, Legacy Community Health, WIC

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 ED 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 ED
- 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 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

Target/Intended Population(s):

- Broader Greater Houston community; parents and students within community school districts

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

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

Collaboration Partners (Internal and External):

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

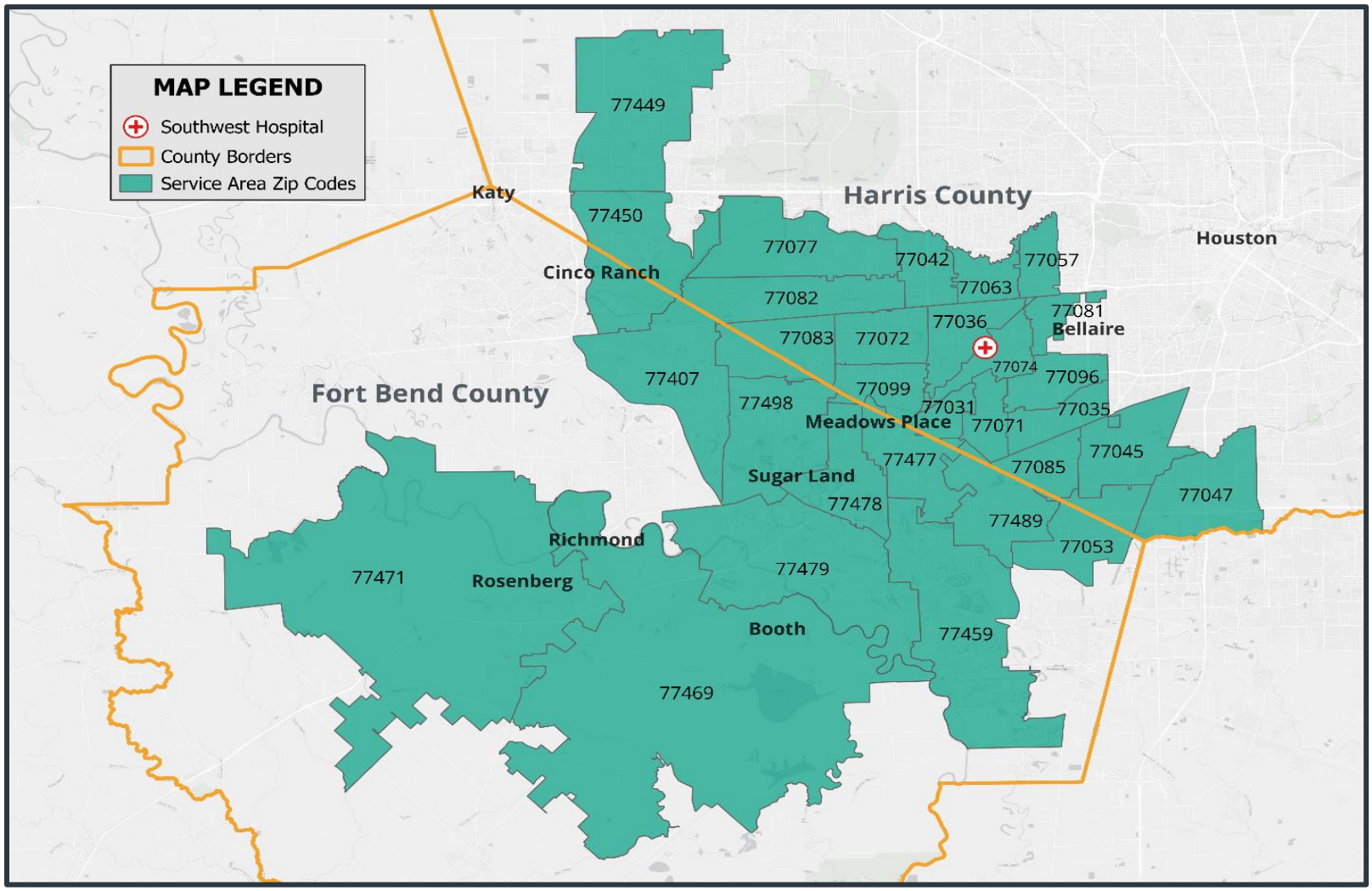
MEMORIAL HERMANN

Appendices

Appendix A. Memorial Hermann Southwest Hospital Supplementary Findings

The MSA for Memorial Hermann Southwest Hospital includes 30 zip codes in Harris and Fort Bend counties.

FIGURE 1. MEMORIAL HERMANN SOUTHWEST HOSPITAL PRIMARY MSA

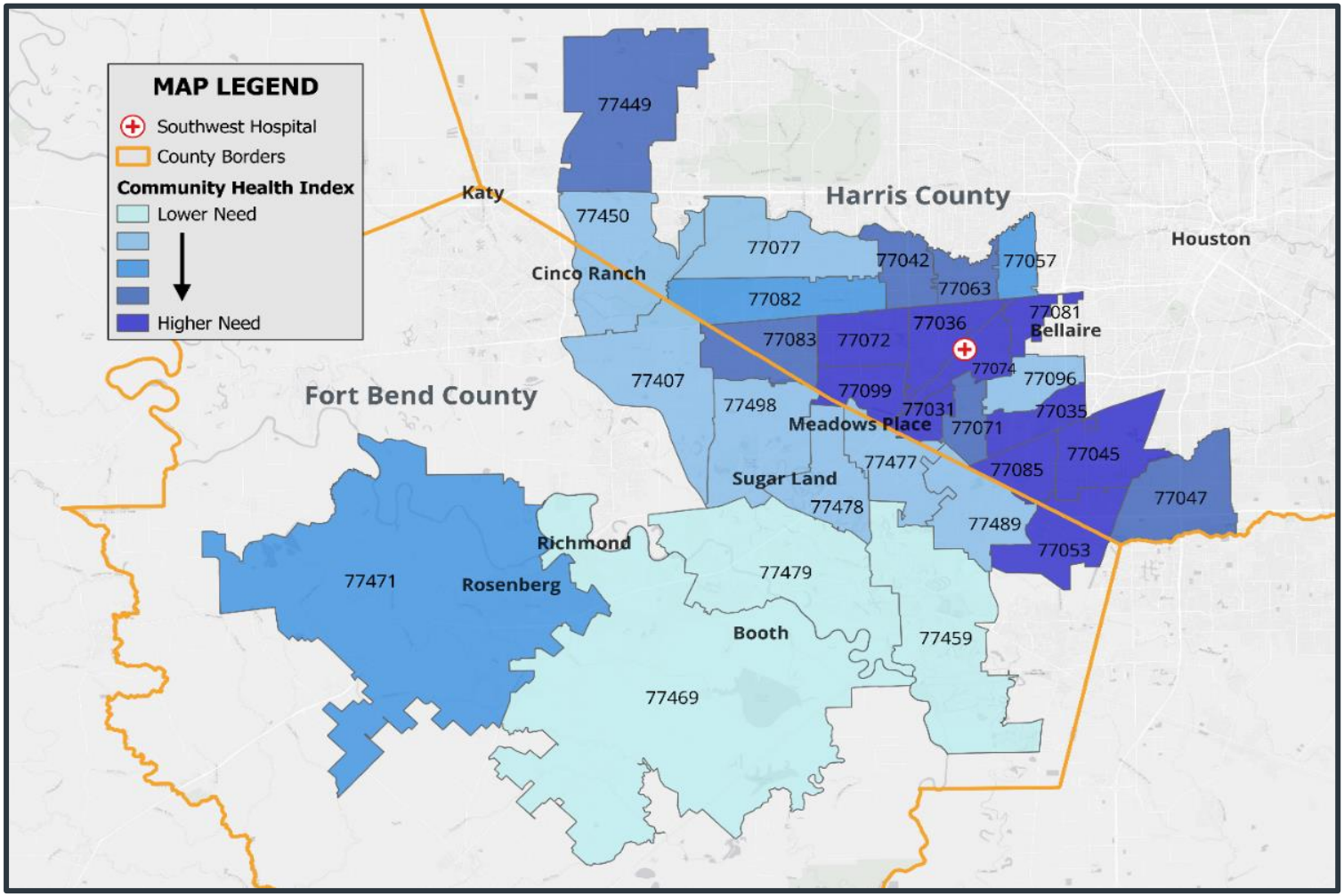


Key Findings: Access to Care

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

- 77081 (CHI = 98.0)
- 77036 (97.4)
- 77074 (97.3)
- 77031 (96.9)
- 77099 (95.4)
- 77045 (94.3)

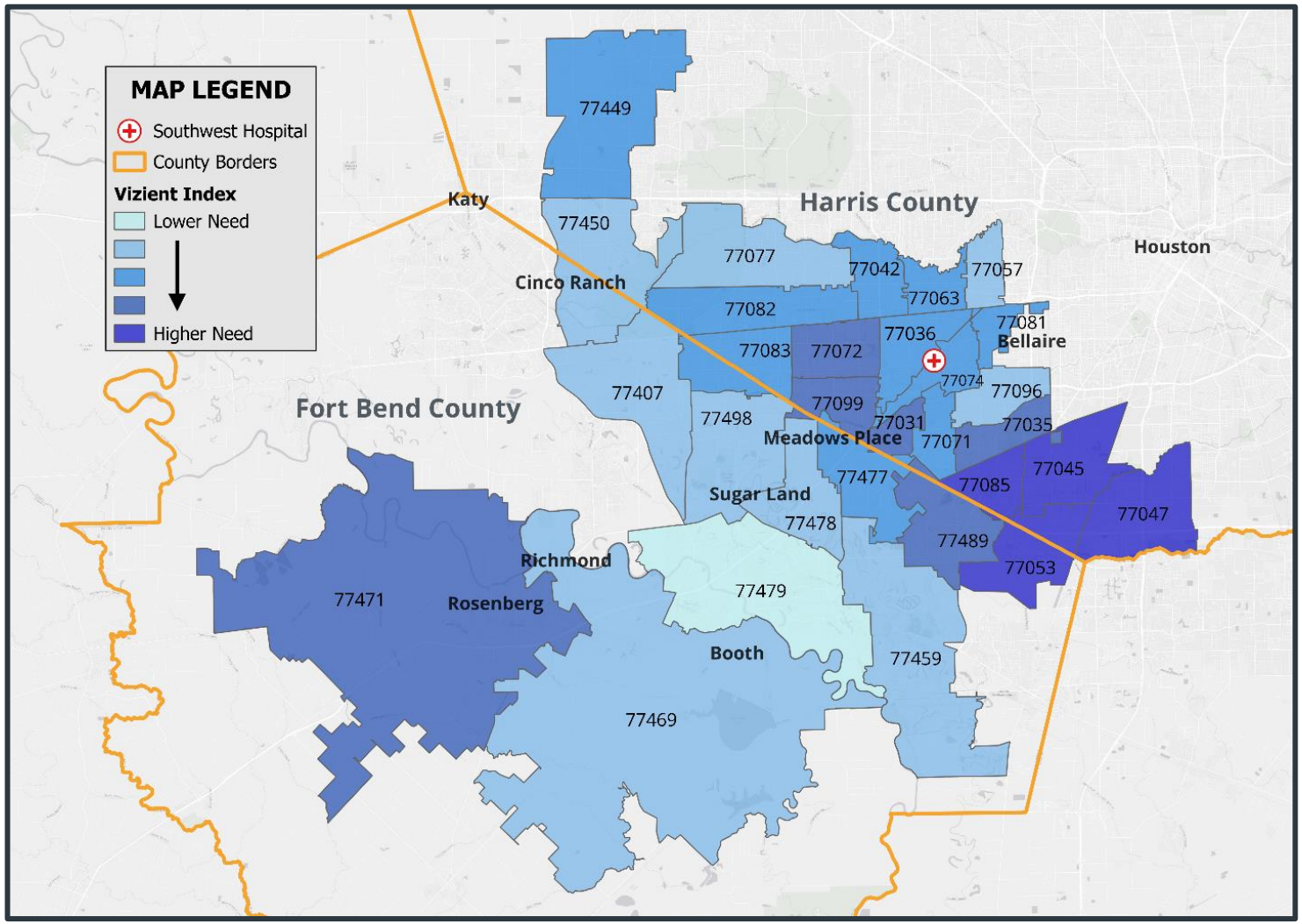
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN SOUTHWEST HOSPITAL MSA



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

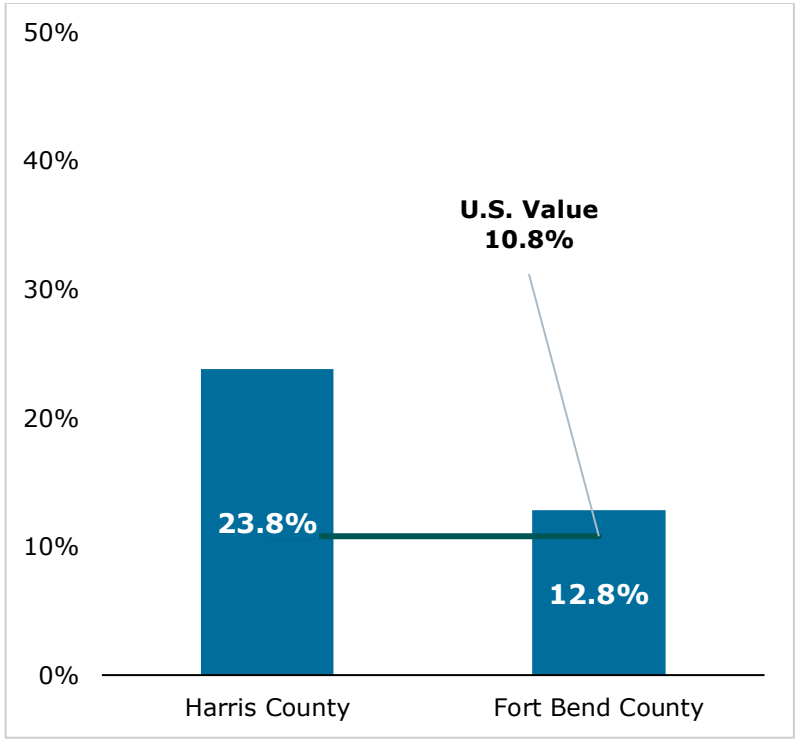
- 77047 (VVI = 0.76)
- 77053 (0.71)
- 77045 (0.56)
- 77085 (0.42)

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



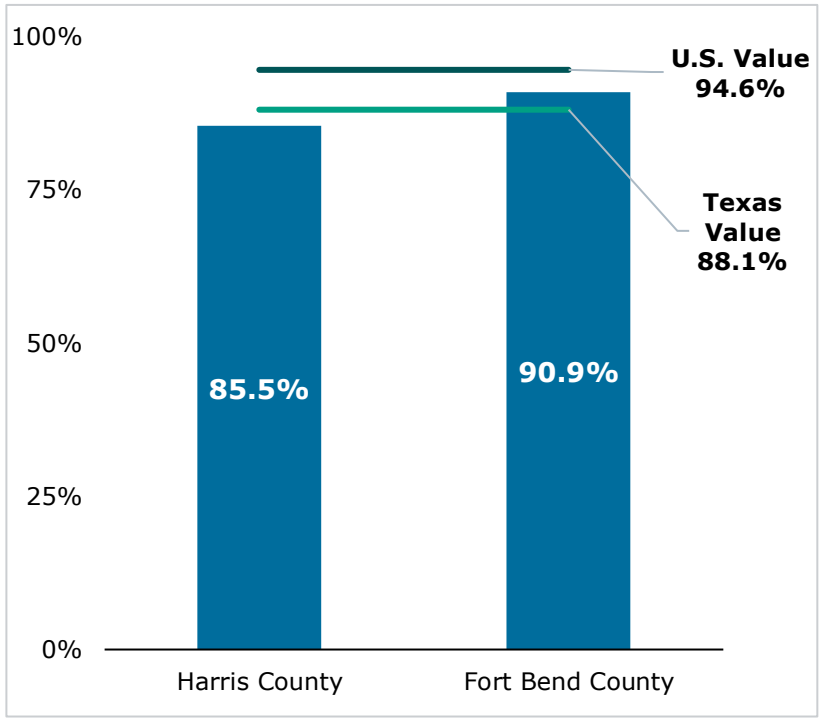
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Access to Care.

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



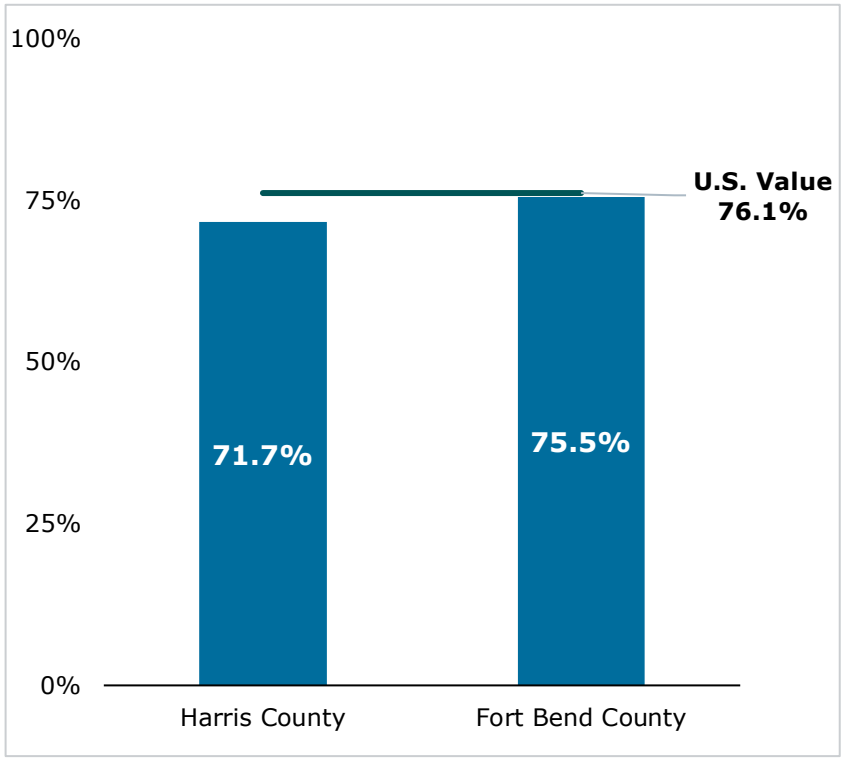
Source: CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



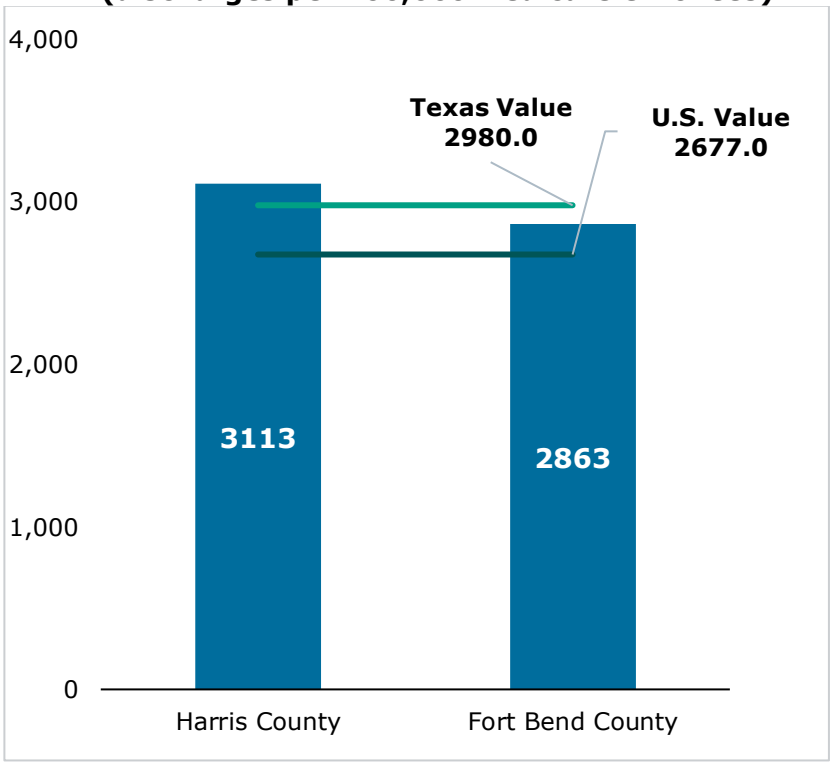
Source: American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



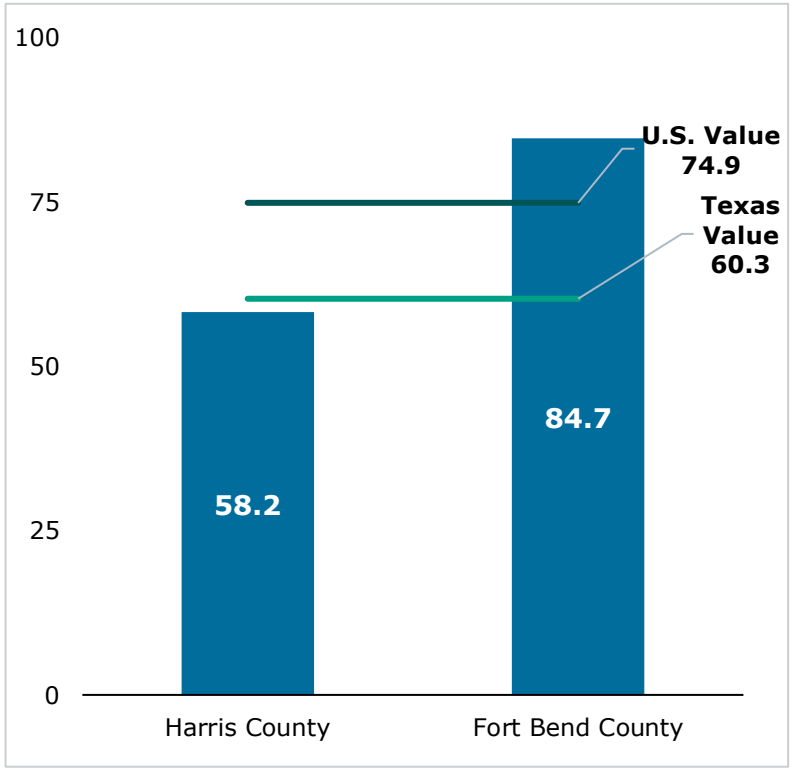
Source: CDC – PLACES (2022)

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



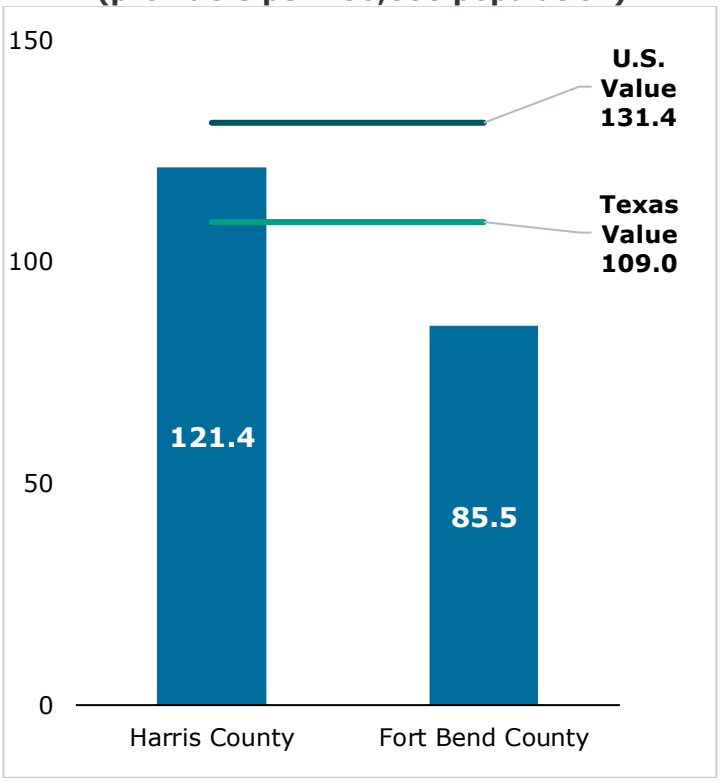
Source: Centers for Medicare & Medicaid Services (2022)

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



County Health Rankings (2021)

FIGURE 9. NON-PHYSICIAN PRIMARY CARE PROVIDER RATE (providers per 100,000 population)



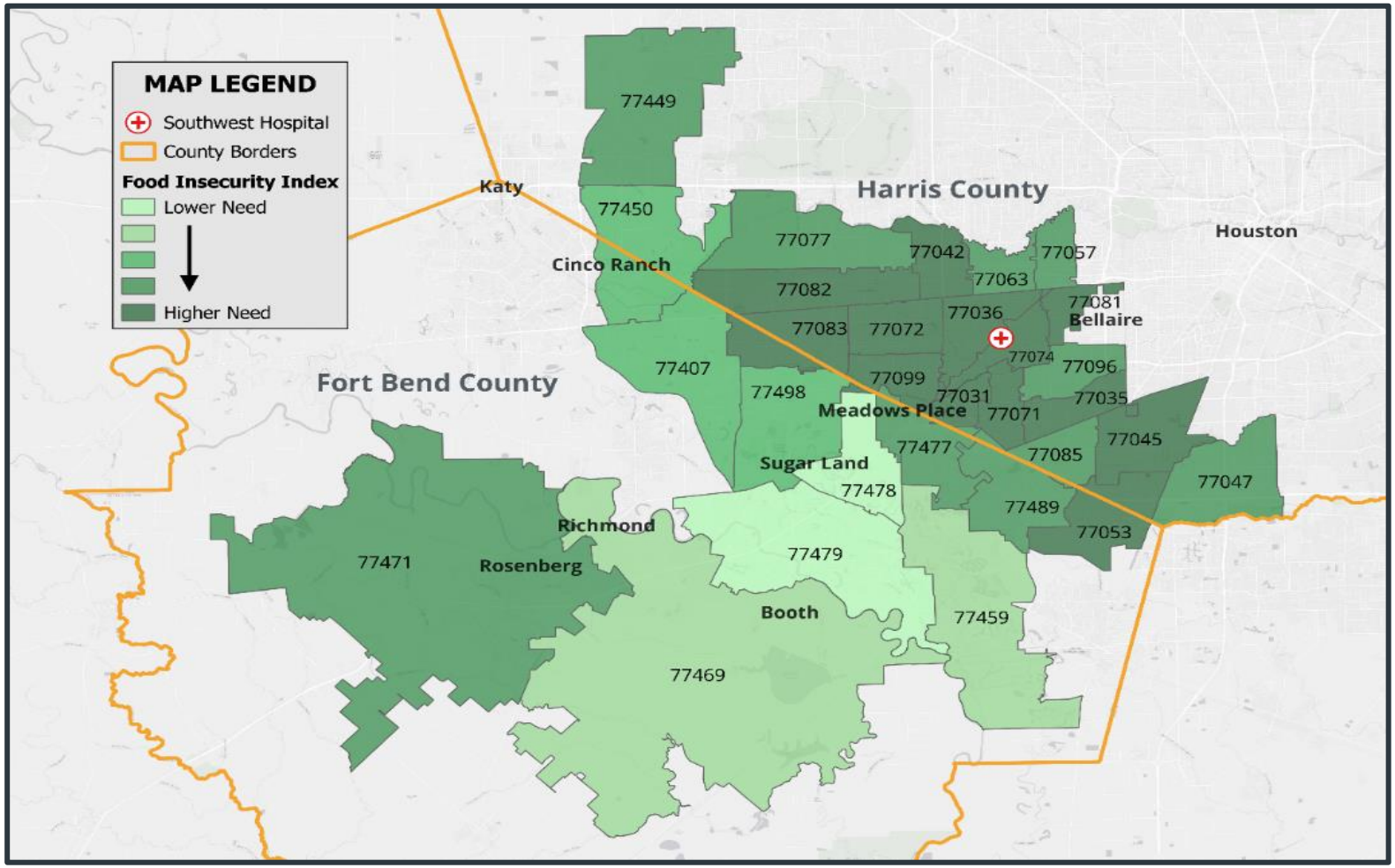
County Health Rankings (2023)

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

- 77081 (FII = 97.9)
- 77099 (97.8)
- 77036 (97.5)
- 77074 (97.2)
- 77072 (97.1)

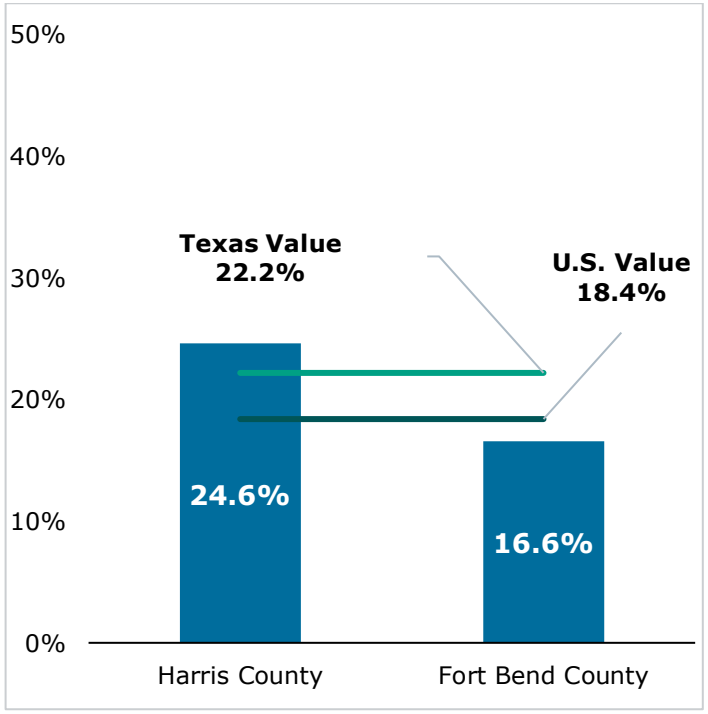
FIGURE 10. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S FOOD INSECURITY INDEX BY ZIP CODE: MEMORIAL HERMANN SOUTHWEST HOSPITAL MSA



Notably, most of the zip codes in this MSA (23 out of 30) have a FII score above 75, indicating generally high rates of food insecurity across the entire region, compared to other U.S. zip codes.

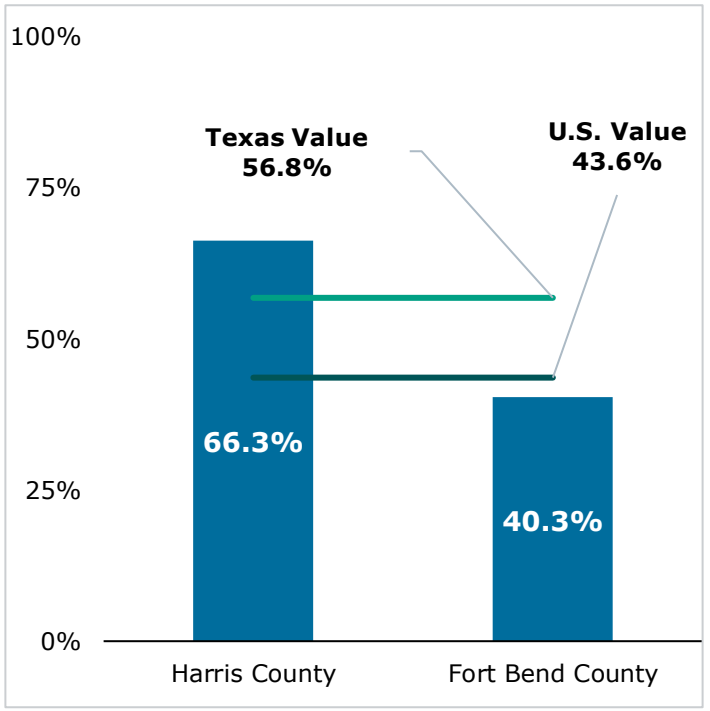
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to **Access to Healthy Food.**

FIGURE 11. CHILD FOOD INSECURITY RATE



Source: Feeding America (2022)

FIGURE 12. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM

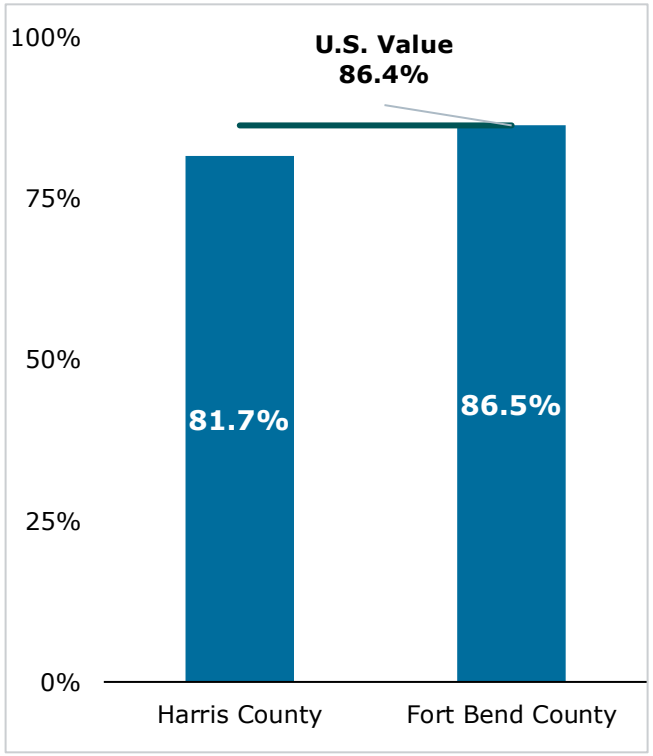


Source: National Center for Education Statistics (2022-2023)

Key Findings: Chronic Conditions Prevention and Management

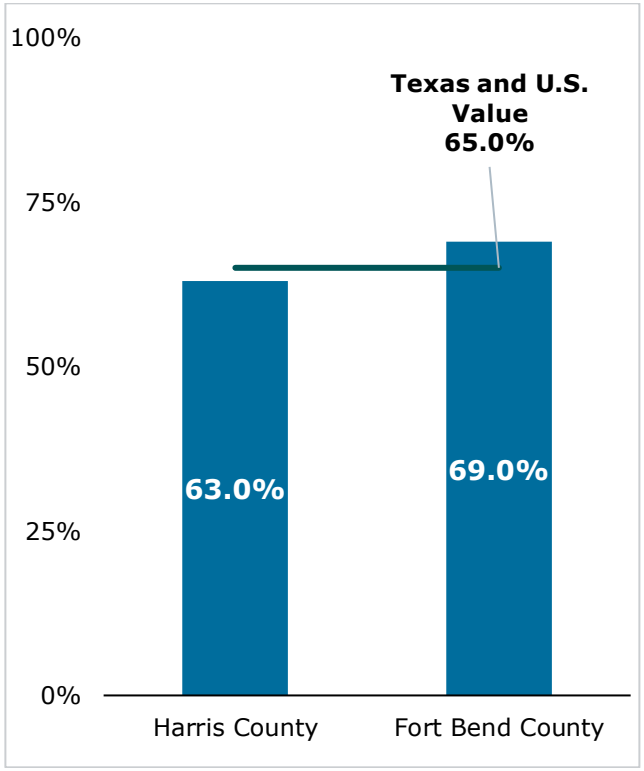
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Chronic Conditions Prevention and Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



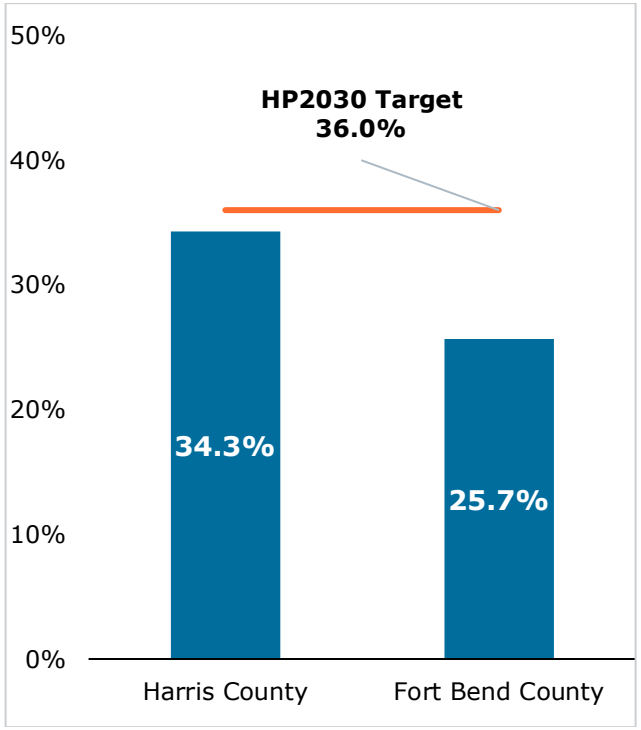
Source: CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



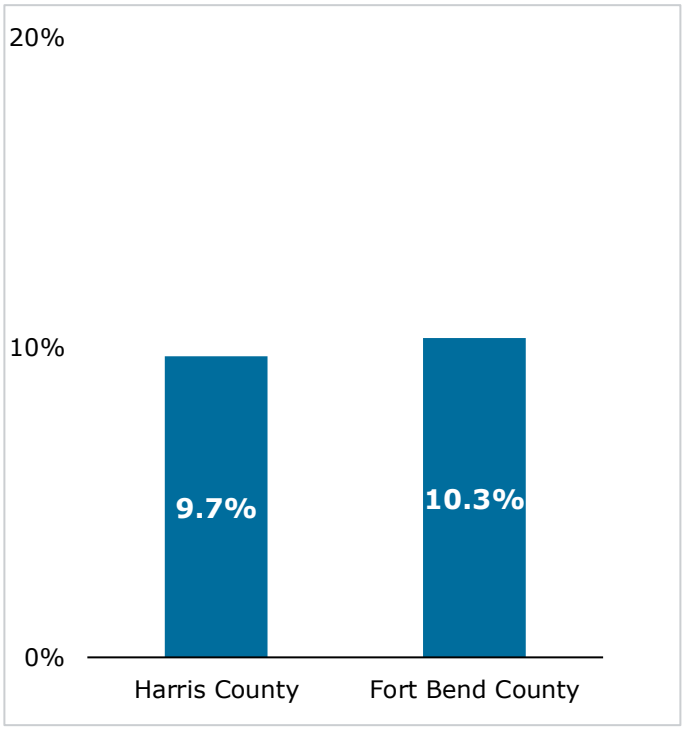
Source: Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



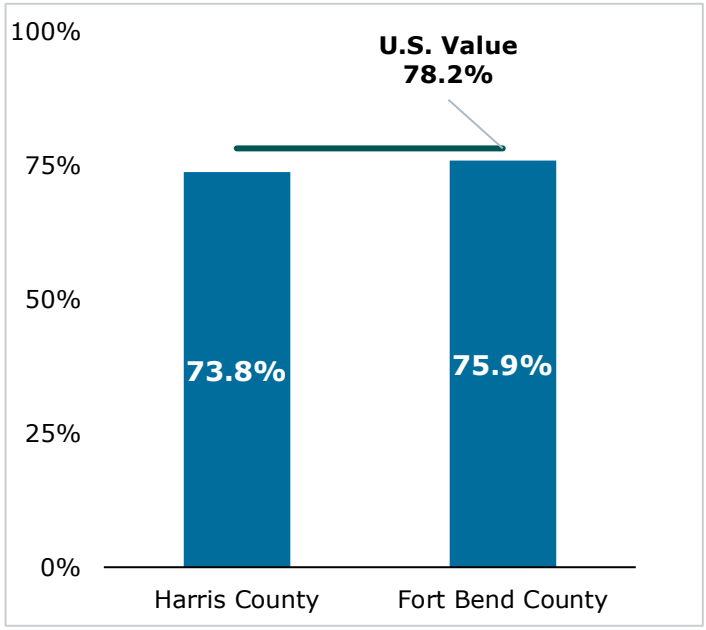
Source: CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



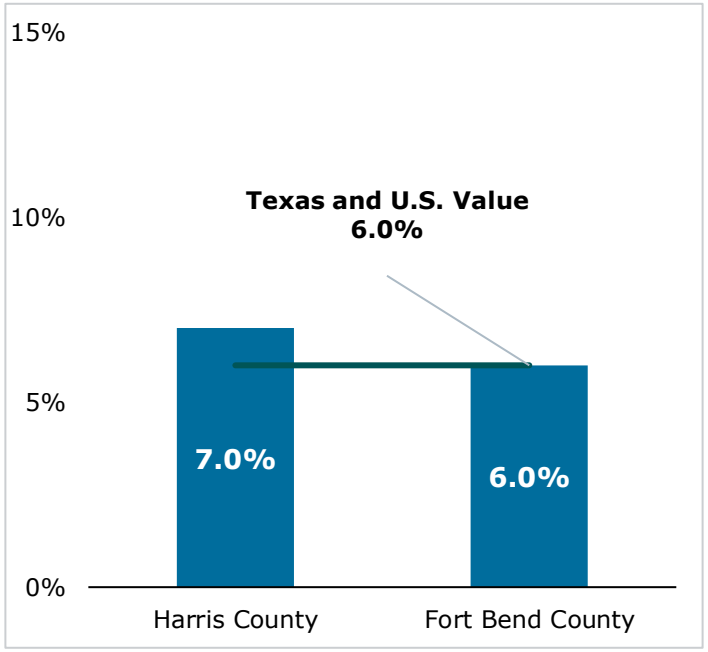
Source: CDC (2021)

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



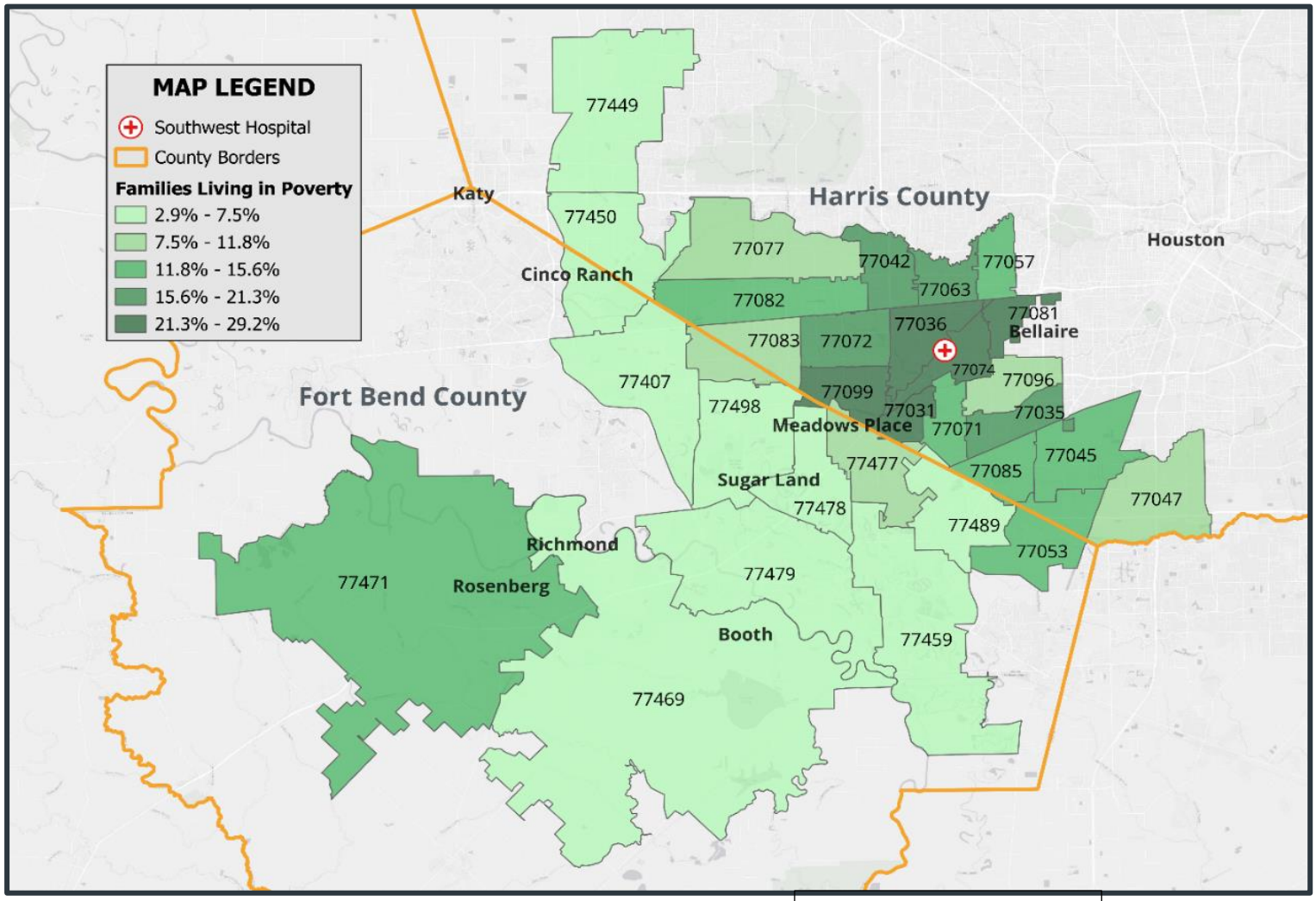
Source: Centers for Medicare & Medicaid Services (2022)

Key Findings: Economic Opportunity

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

- 77081 (29.2%)
- 77074 (25.9%)
- 77031 (25.7%)
- 77099 (23.8%)
- 77036 (23.5%)

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

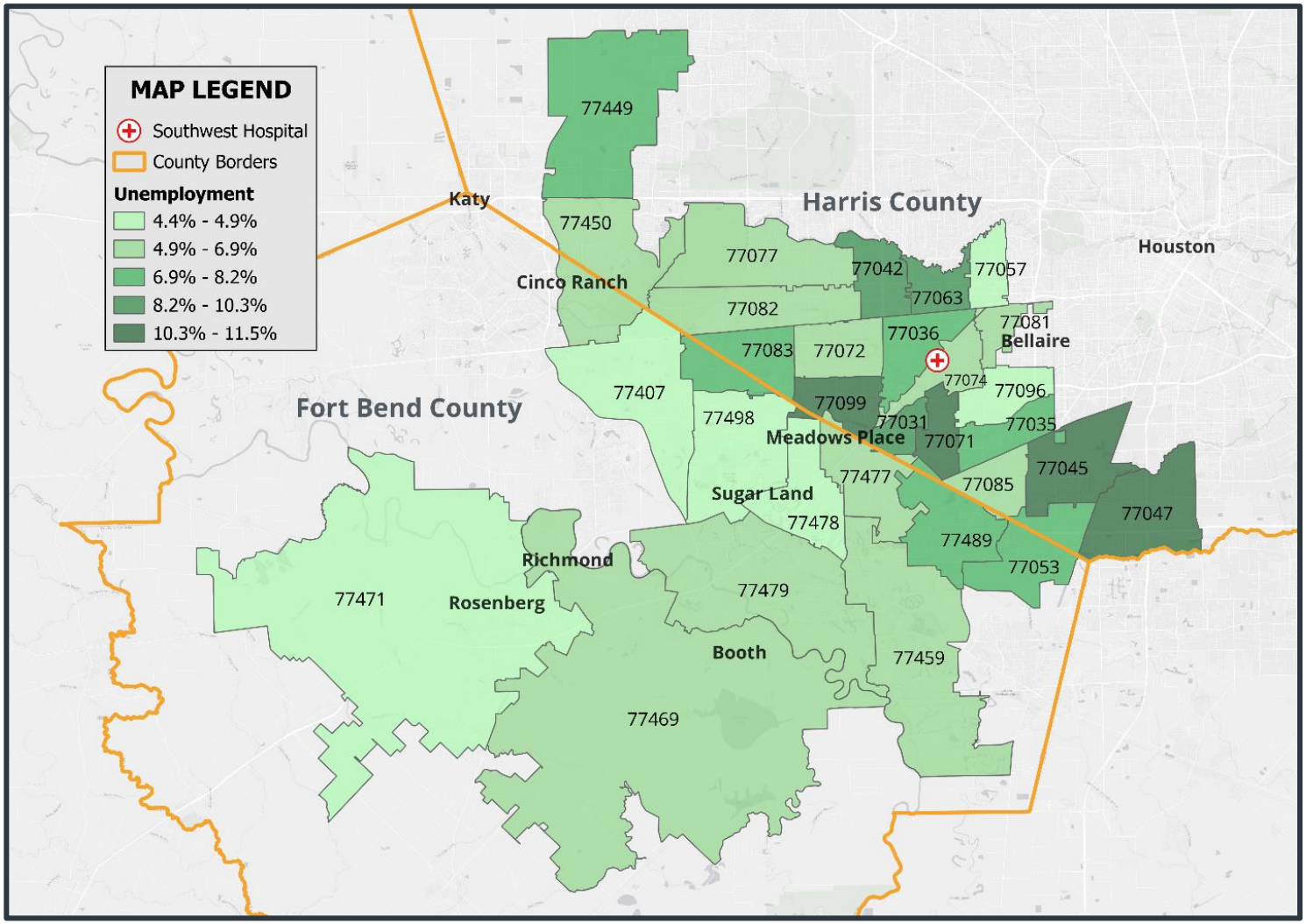


Source: Claritas (2024)

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

- 77047 (11.5%)
- 77071 (11.4%)
- 77045 (11.2%)
- 77099 (11.1%)

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

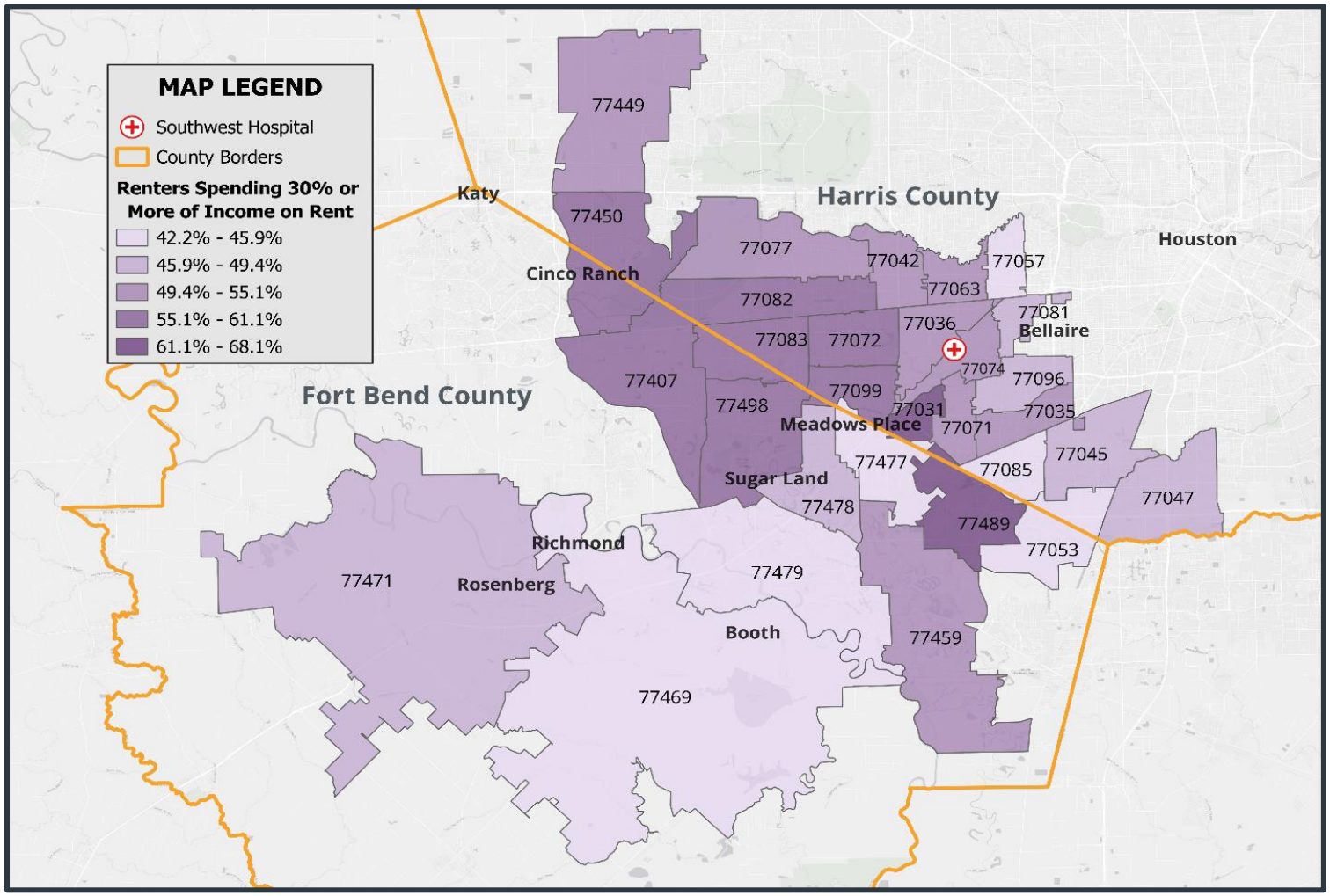


Source: Claritas (2024)

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

- 77489 (68.1%)
- 77031 (63.1%)
- 77072 (61.1%)

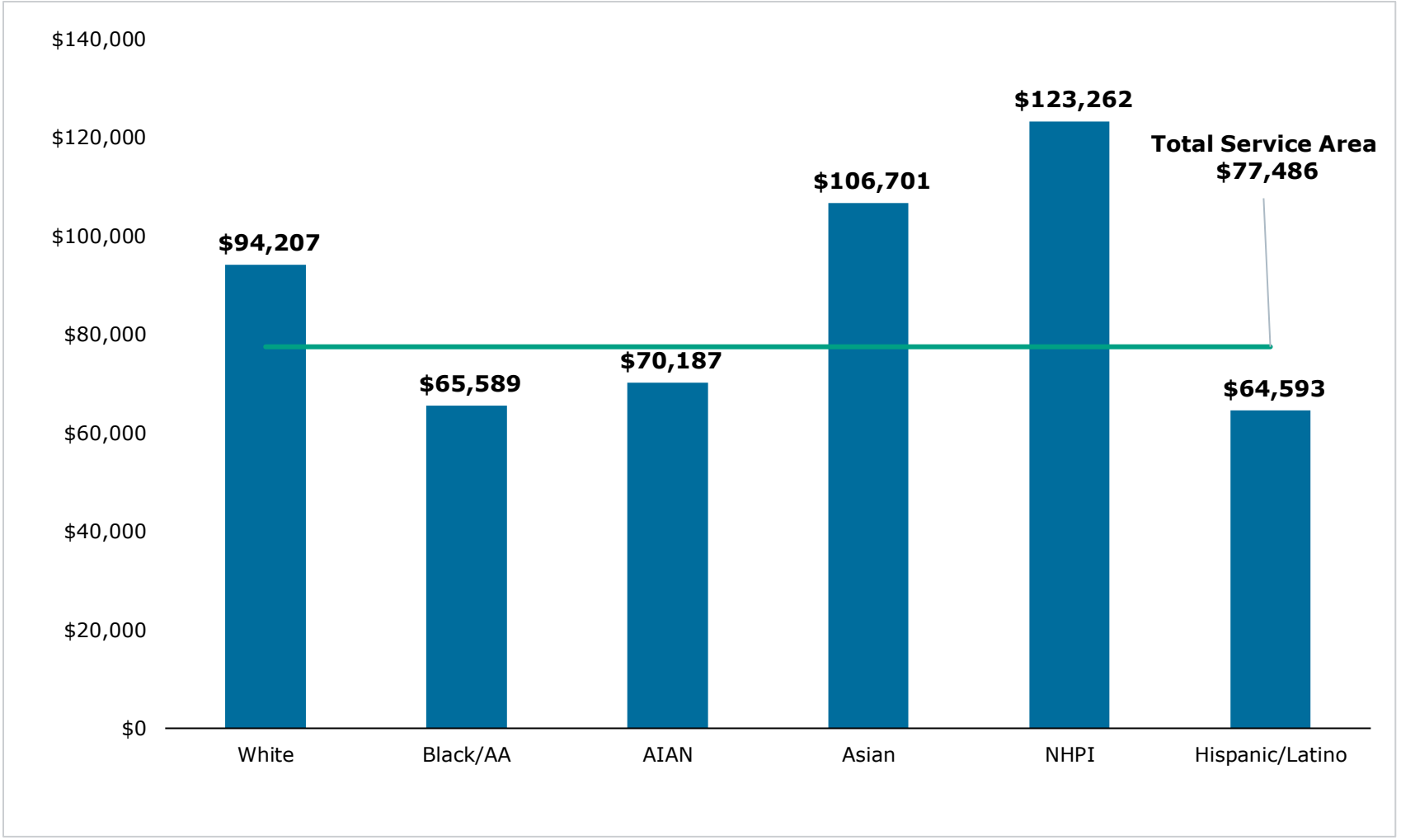
FIGURE 21. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: MEMORIAL HERMANN SOUTHWEST HOSPITAL MSA



Source: American Community Survey (2018-2022)

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

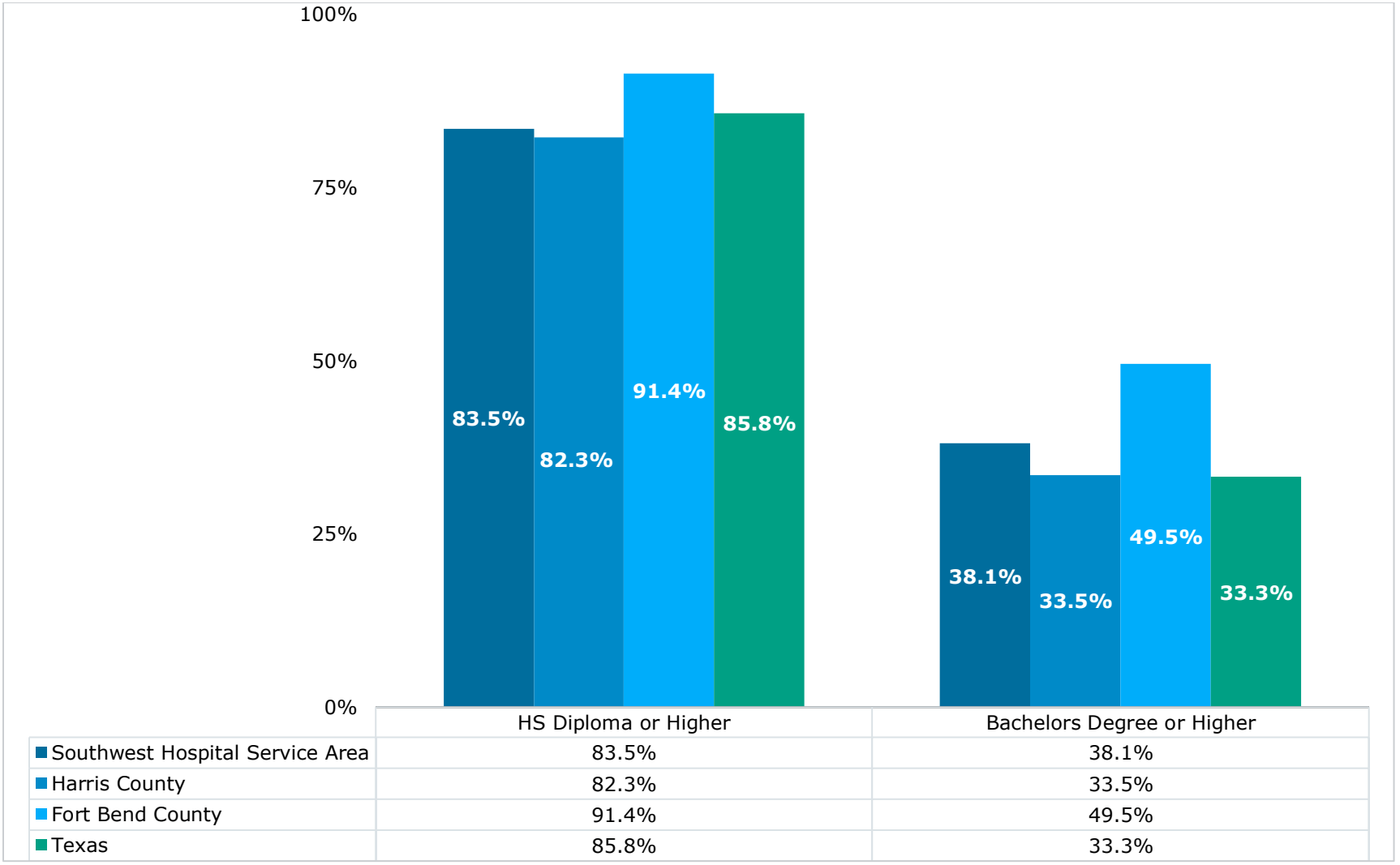
FIGURE 22. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: MEMORIAL HERMANN SOUTHWEST HOSPITAL MSA



Source: Claritas (2024)

Key Findings: Educational Access

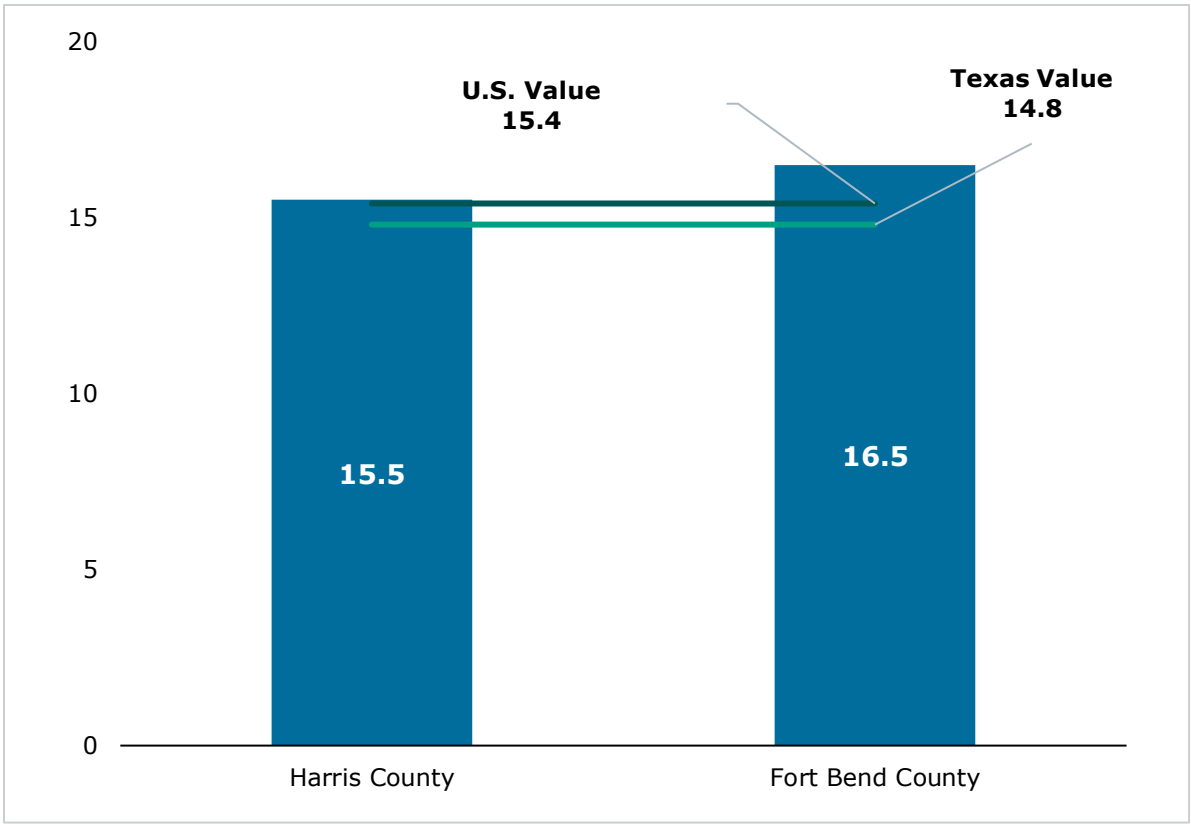
FIGURE 23. EDUCATIONAL ATTAINMENT



	HS Diploma or Higher	Bachelors Degree or Higher
Southwest Hospital Service Area	83.5%	38.1%
Harris County	82.3%	33.5%
Fort Bend County	91.4%	49.5%
Texas	85.8%	33.3%

Source: Claritas (2024)

FIGURE 24. STUDENT-TO-TEACHER RATIO

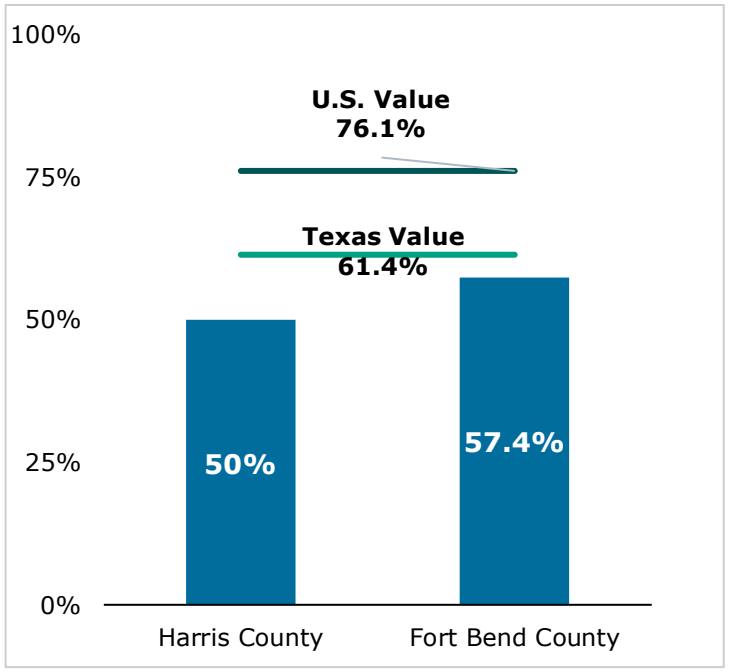


Source: National Center for Education Statistics (2022-2023)

Key Findings: Maternal & Infant Health

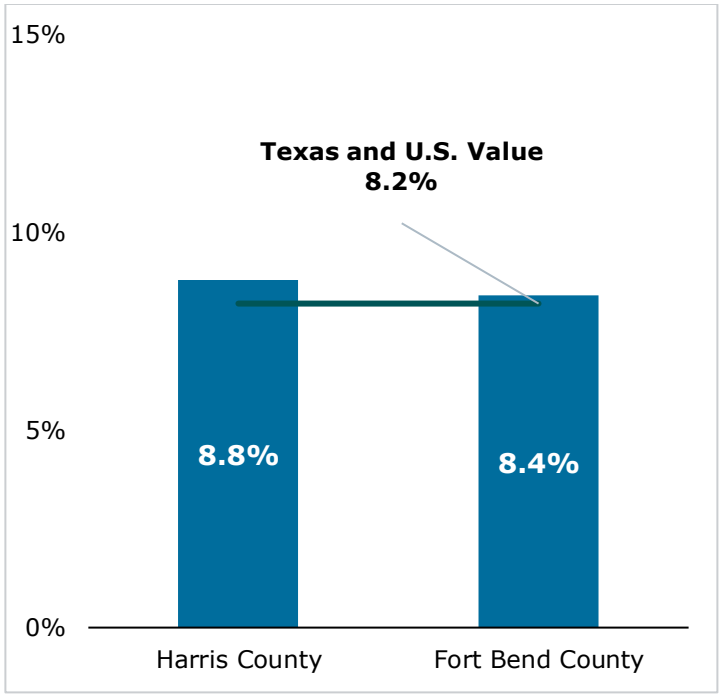
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Maternal & Infant Health.

FIGURE 25. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



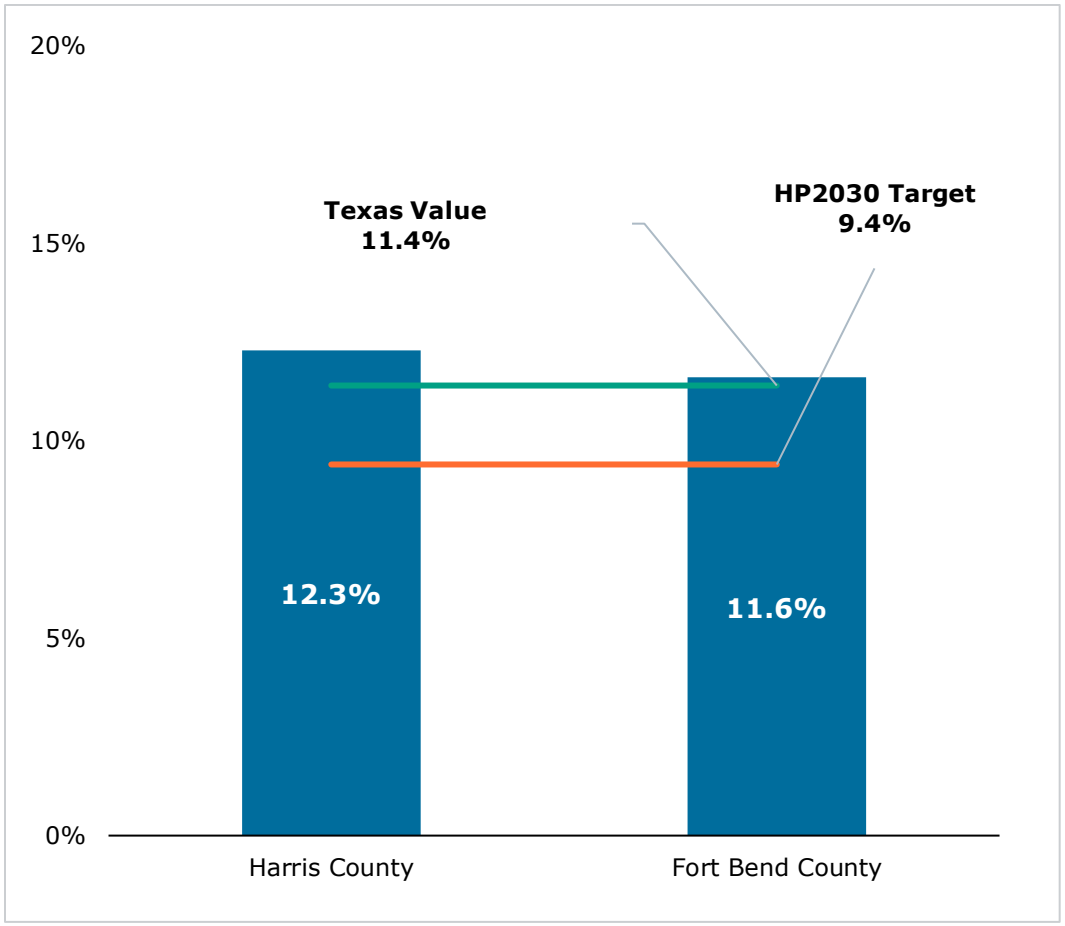
Source: Texas Department of State Health Services (2020)

FIGURE 26. BABIES WITH LOW BIRTHWEIGHT



Source: Texas Department of State Health Services (2020)

FIGURE 27. PRETERM BIRTHS



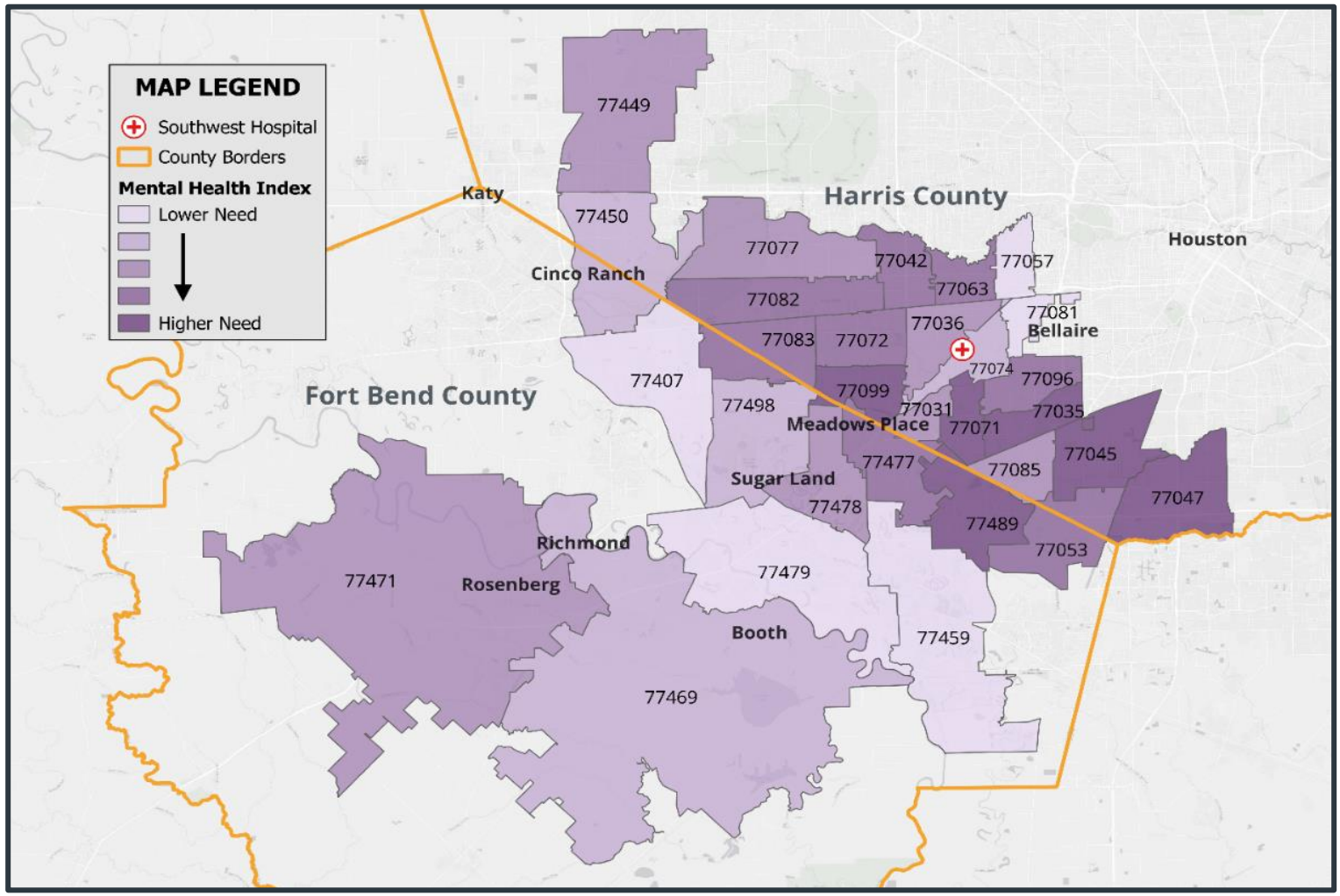
Source: Texas Department of State Health Services (2021)

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

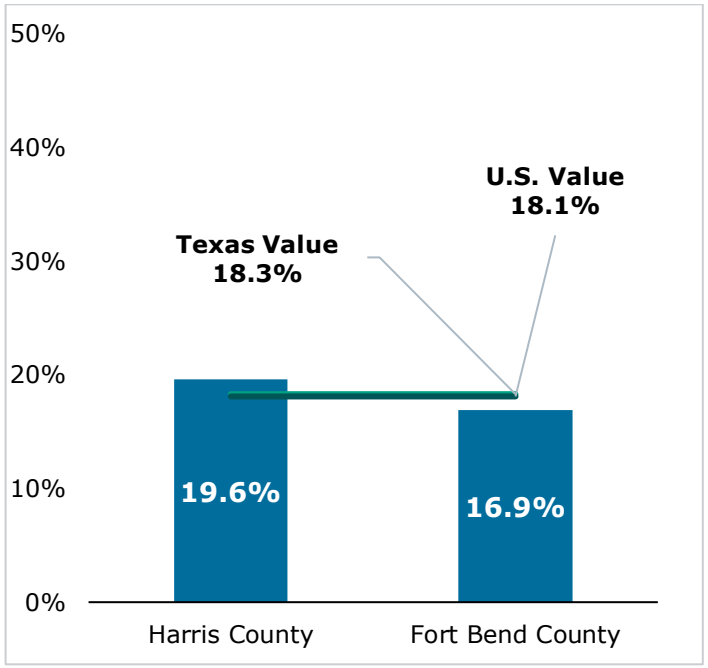
- 77071 (MHI = 91.9)
- 77045 (87.6)
- 77047 (87.3)
- 77035 (85.0)

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



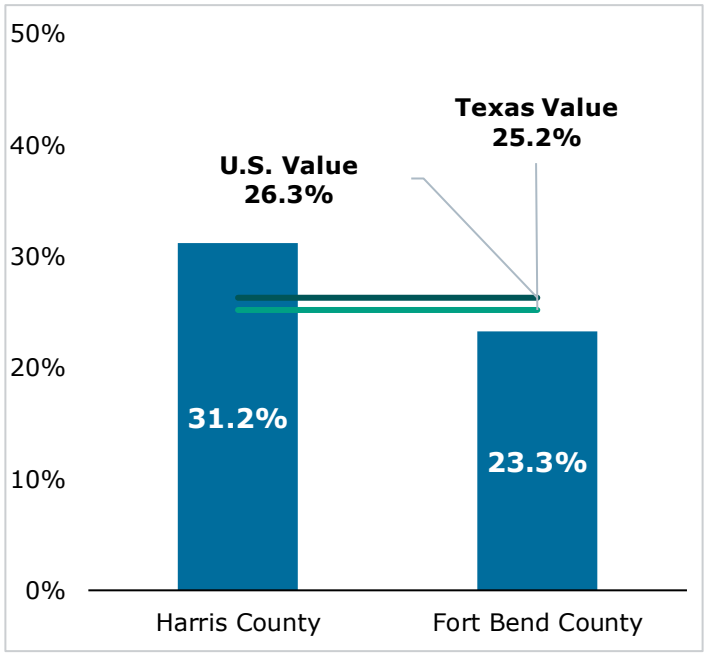
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Mental Health & Substance Use.

FIGURE 29. ADULTS WHO DRINK EXCESSIVELY



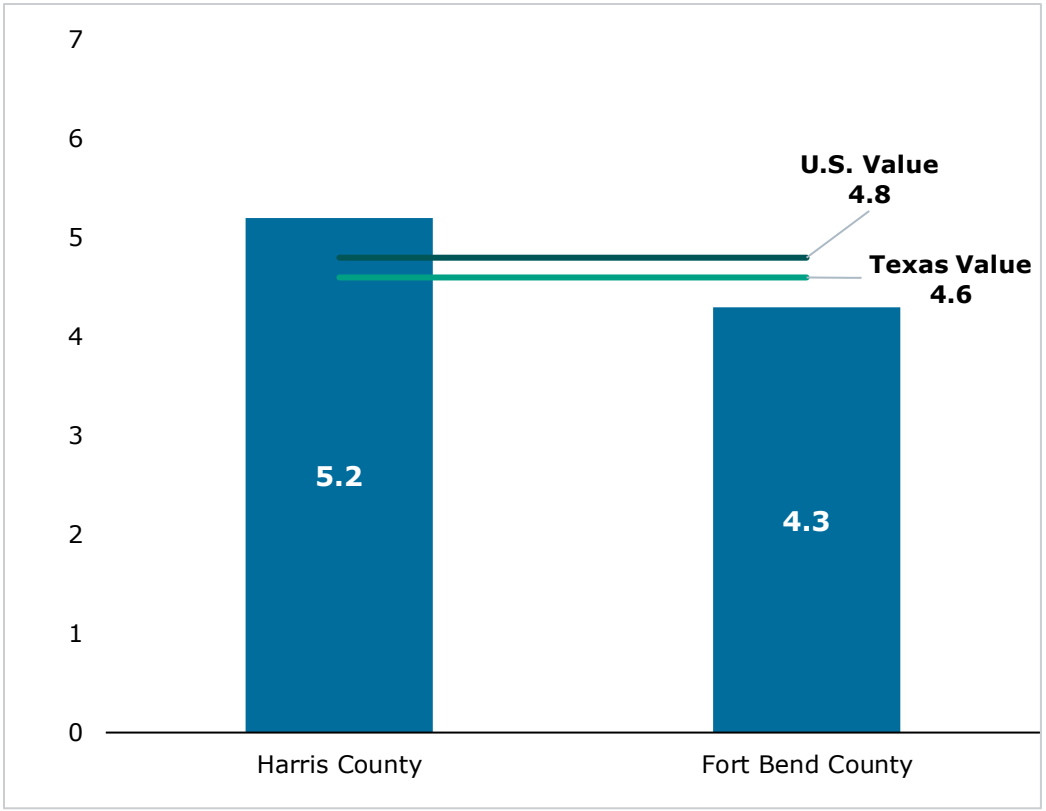
Source: County Health Rankings (2021)

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)