Community Health Implementation Strategy

Memorial Hermann Sugar Land Hospital

MEMORIAL® HERMANN
Sugar Land

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At-a-Glance Summary

Community Served	Memorial Hermann Sugar Land Hospital, serving 890,831 persons living in 17 zip codes in Fort Bend, Harris, Wharton, 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 ≥2% & ≥1% reduction of Memorial Hermann readmission rates of target population encountered by Community Health services residing in high poverty zip codes across Greater Houston.
- Implement a mobile vaccine program that aims to provide vaccinations to 1,000 unique students annually at the 10 Health Centers for Schools locations, with the goal of vaccinating 3,000 students by FY28.
- 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

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

Chronic Conditions Prevention and Management

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

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

- By FY28, increase participation in maternal, newborn, and parenting education programs by 20% to improve maternal health literacy, breastfeeding rates, and early childhood health outcomes in the Memorial Hermann Sugar Land PSA.

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 Sugar Land Hospital

Memorial Hermann Sugar Land 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.

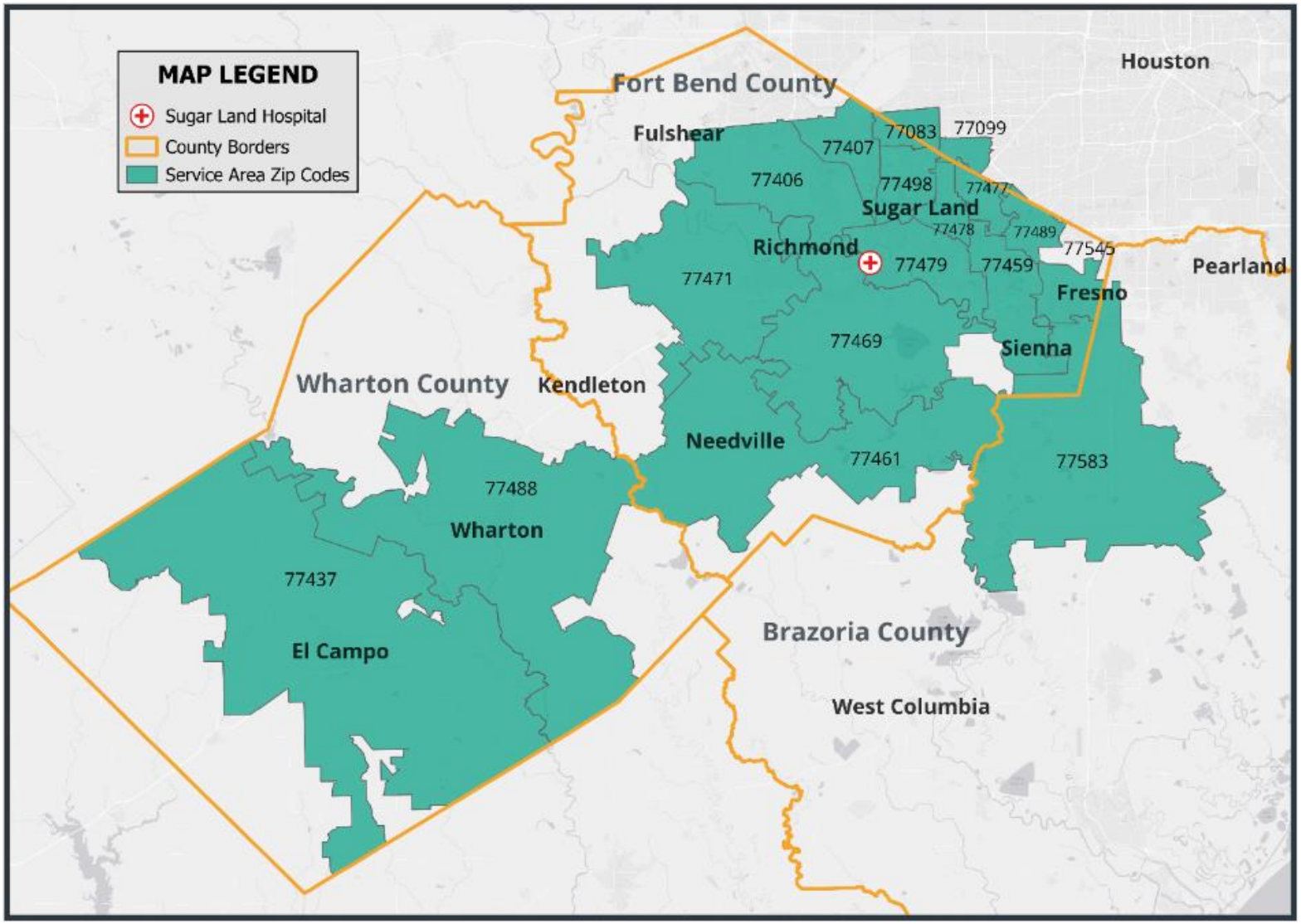
Memorial Hermann Sugar Land Hospital is a 179-bed, full-service acute care facility serving Fort Bend County and surrounding communities. From routine outpatient procedures to complex inpatient surgeries, we offer advanced medical technology and high-quality care delivered in a healing environment designed with families in mind. All patient rooms are private and thoughtfully designed with premium amenities to enhance comfort and privacy. Our commitment to safety and quality is supported by a highly trained team of affiliated physicians and staff, who provide compassionate, patient-centered care across a wide range of specialties.

At Memorial Hermann Sugar Land Hospital, we're recognized for our strong, family-centered culture and innovative services, including pediatric emergency care in partnership with Children's Memorial Hermann Hospital, advanced neuroscience services and leading-edge orthopedics through the Memorial Hermann | Rockets Sports Medicine Institute. We offer more than 87 medical specialties, delivering experienced, compassionate, high-quality care close to home.

Description of the Community Served

Memorial Hermann Sugar Land Hospital Metropolitan Service Area (MSA) has a population of approximately 890,831 persons serving 17 zip codes in Fort Bend, Harris, Wharton, and Brazoria counties. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. MEMORIAL HERMANN SUGAR LAND 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 in 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 Sugar Land 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 Sugar Land Hospital, and other hospital leadership.

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

The Implementation Plan presented in the following pages outlines in detail the individual strategies and activities Memorial Hermann Sugar Land 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 Sugar Land Hospital Implementation Plan

Community Priority: Access to Care

- **Primary Prioritized Need Area:** **Access to Care**
- **Secondary Prioritized Need Area:** **Chronic Disease Management & Prevention**

FY26-FY28 Goal: **To have a 2% reduction of unnecessary MHHS ER utilization & ≥1% reduction of MHHS 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 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.
Operationalize Congenital Heart Failure (CHF) Navigator Program	Performance Excellence Department	Current CHF Readmission Rate	• Volume – unique CHF patient visits • Percent – rate of CHF patient receiving documented post-discharge follow-up calls
SafeRide Program	Community Health Network	426 Completed Rides (universal May 2025)	• Volume – number of rides completed • Percent - completed rides to PCP/ Doctor appointment
Medicaid & Social Service Enrollment	Business Office	510 Enrolled	• Volume - people enrolled
Diabetic Education Sessions	Diabetic Educator	12 Sessions	• Volume - events Held • Volume - unique individuals reached
Bariatric Support Group Attendees	Performance Excellence Department	35 Attendees	• Volume - unique attendees • Volume - events Held
Orthopedic Education Classes	Performance Excellence Department	3 Events	• Volume - events held • Percent – reduce unnecessary ED usage
Target/Intended Population(s): • Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS Sugar Land campus • Discharged CHF patients			

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.
- CHF Navigator workflows prioritize post-discharge follow-up within 48 hours, PCP follow-up appointments within 7 days. ER Revisits and readmission rates are tracked to validate success.
- 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; Case Management; Business Office

- **Primary Prioritized Need Area:** **Access to Care**
- **Secondary Prioritized Need Area:** **Chronic Disease Prevention & 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 Houston ISD and Alief ISD feeder patterns with opportunity for expansion to Fort Bend ISD and Lamar ISD.

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 campus.

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

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

Collaboration Partners (Internal and External):

- Independent School Districts; community nonprofit agencies

Prioritized Need Area: Access to Care

FY26-FY28 Goal: ≥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 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
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 appointment scheduled
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
Food, Health, & Nutrition Community Outreach	• Performance Excellence • Diabetes Educator	100 People Reached	• Volume – number of events held • Volume – number of people reached

Target/Intended Population(s): • Food-insecure; uninsured; Medicaid; residing in target communities
Please provide any additional insights or explanations on the initiative(s) listed. • The Community Partner Network is a new initiative that focuses on formalized partnership with local nonprofit agencies committed to addressing NMDOH impacting patients served between Memorial Hermann and the partner. • 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 Disease Management & Prevention**
- **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 Sugar Land 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
Please provide any additional insights or explanations on the initiative(s) listed. • CHW Hub will be piloted to increase NMDOH screening and resource referrals across the system with primary feeder during FY26 from MyChart. Referrals will ensure patients get connected to health and social service support with the intended downstream impact of improving community health. • The MyChart NMDOH Assessment Initiative is focused on allowing patients the choice to self-disclose about NMDOH.
Collaboration Partners (Internal and External): • NMDOH Workgroup; System; ISD; Digital; Ambulatory Services; Local FQHCs; Local Social Service Agencies

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)
Hands-On Health Care Workforce Event	Education Department	Baseline TBD post-FY26	• Volume – number of opportunity youth reached

Target/Intended Population(s): • Target high-poverty ZIP communities; uninsured; Medicaid; ALICE populations
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. • Hands on Health care builds a local health care workforce pipeline
Collaboration Partners (Internal and External): • Human Resources, Local nonprofit partners and collaboratives, Finance, Strategy Division, MHHS Sugar Land Campus; local Educational Institutions

Community Priority: Maternal & Infant Health

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

FY26-FY28 Goal: By FY28, increase participation in maternal, newborn, and parenting education programs by 20% to improve maternal health literacy, breastfeeding rates, and early childhood health outcomes in the MHHS Sugar Land PSA.

FY26 Objective: ≥5% increase of participation in maternal, newborn, and parenting education programs to improve maternal health literacy, breastfeeding rates, and early childhood health outcomes.

FY26 KPIs:

- Percent—increase in class participation month over month and year over year
- Number—breast feeding participants (monthly class volumes)
- Percent—breastfeeding confidence score

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Breastfeeding Class	Maternal & Neonatal Program Teams	FY25 Totals	• Volume – monthly class participation • Percentage – breastfeeding statistics
Newborn & Prepared Childbirth Class	Maternal Program Team	FY25 Totals	• Volume – monthly class participation • Percentage – maternal confidence score
Mom4Mom Club	Performance Excellence	FY25 Totals	• Volume – monthly class participation • Percentage – maternal confidence score

Target/Intended Population(s):

- Expectant mothers, new parents, and caregivers in the PSA, including underserved populations who may face barriers to maternal education, breastfeeding support, and early childhood health resources.

Please provide any additional insights or explanations on the initiative(s) listed. • Community feedback and hospital data indicate a gap in maternal and newborn health literacy, especially among first-time parents and underserved groups. Increasing participation in structure education programs can improve health outcomes, breastfeeding initiation, parental confidence, and early childhood development. National and local evidence links prenatal and postnatal education with reduced maternal complications, higher breastfeeding rates, and improved infant health.
Collaboration Partners (Internal and External): • MHHS Sugar Land Neonatal & Maternal Program Teams; MHHS Women's & Children's Service Line; local OB/Gyns & Pediatricians; WIC; Fort Bend County Public Health Department; other local community organizations focused on maternal and pediatric health

Community Priority: Mental Health & Substance Use

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

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

FY 26 Objective: Increase awareness and availability of mental health services in the community to improve quality of life for patients, family members, and employees being served by the MHHS Sugar Land 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
- Number – attendees to community events

Strategic Approach

Programs/Activities	Responsible	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 HISD area

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 Crisis Program (CoCM) strives to facilitate systematic coordination of general and behavioral healthcare. 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

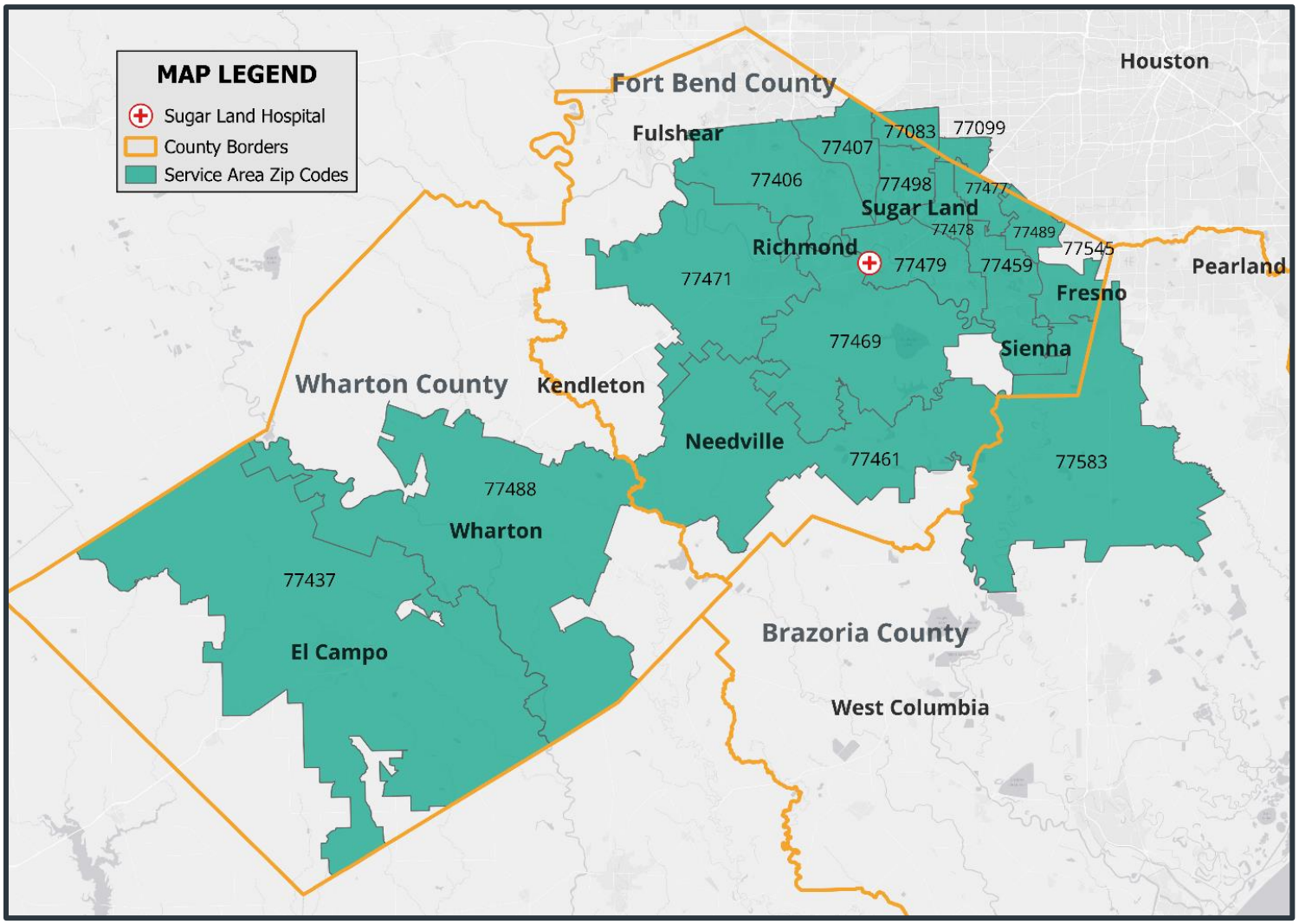
MEMORIAL HERMANN

Appendices

Appendix A: Memorial Hermann Sugar Land Hospital Supplementary Findings

The MSA for Memorial Hermann Sugar Land Hospital includes 17 zip codes in Fort Bend, Harris, Wharton, and Brazoria counties.

FIGURE 1. MEMORIAL HERMANN SUGAR LAND HOSPITAL PRIMARY MSA

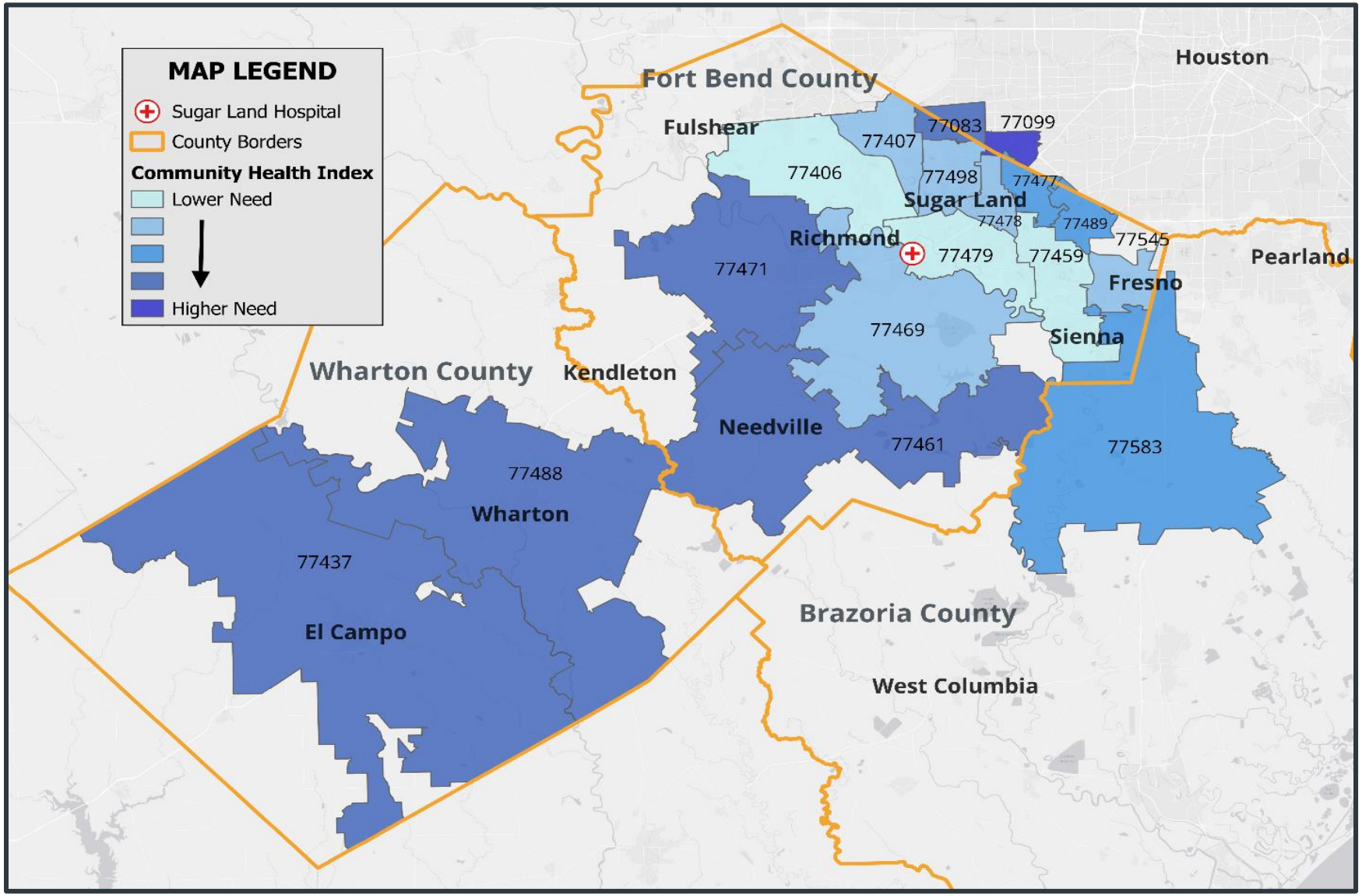


Key Findings: Access to Care

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

- 77099 (CHI = 95.4)
- 77437 (74.7)
- 77083 (72.8)

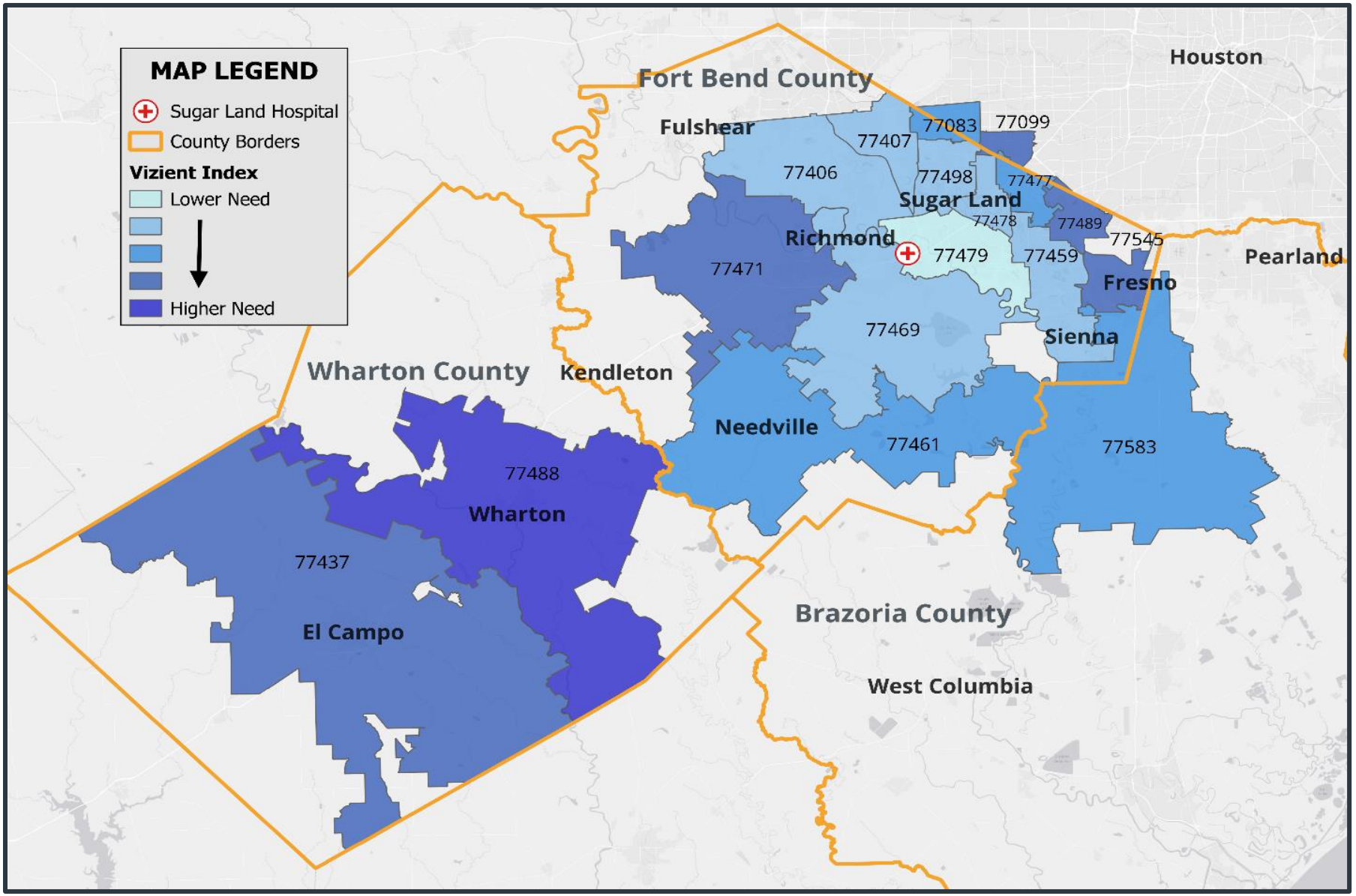
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN SUGAR LAND HOSPITAL MSA



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

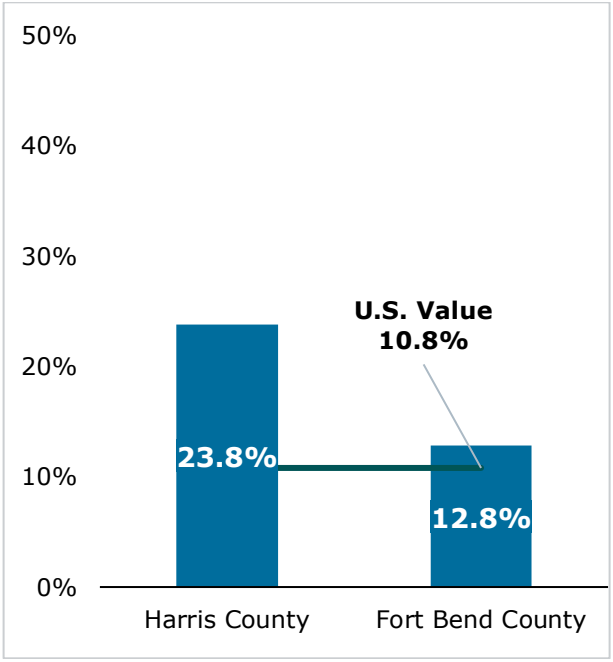
- 77488 (VVI = 0.59)
- 77489 (0.26)
- 77099 (0.18)
- 77437 (0.18)

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



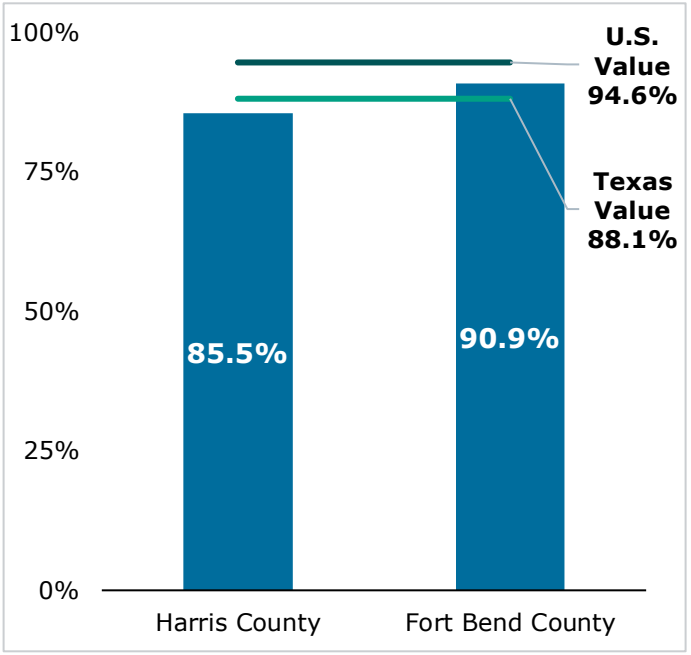
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to **Access to Care.**

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



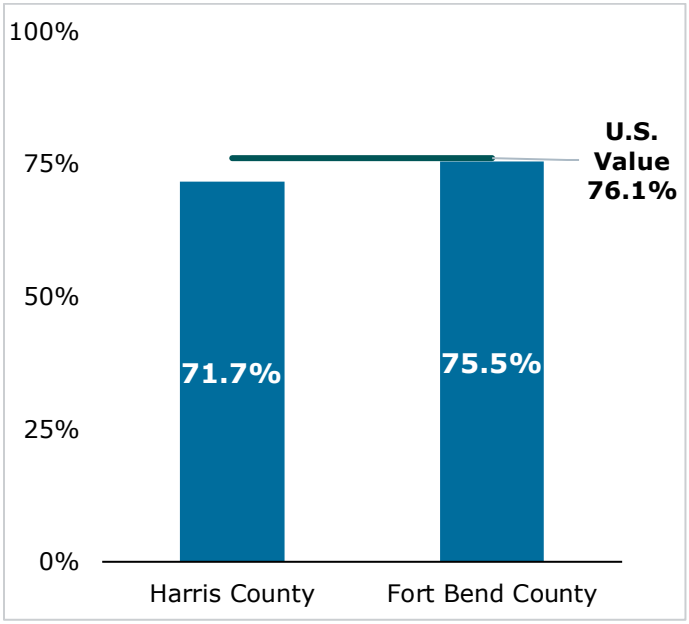
CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



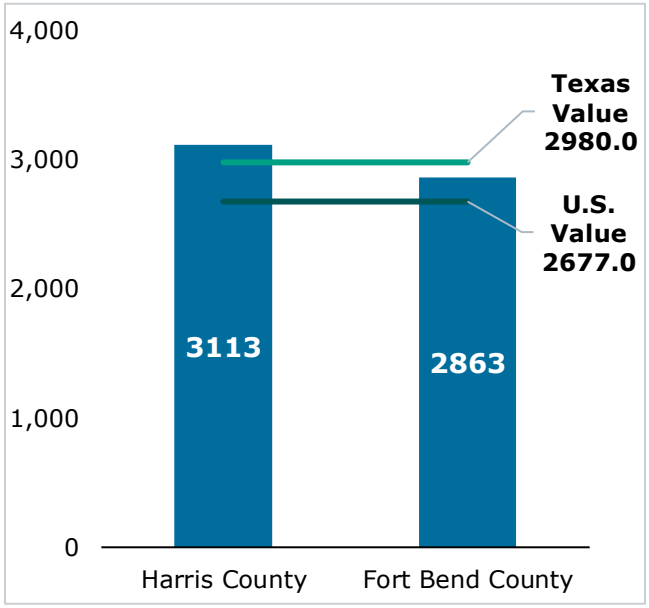
American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



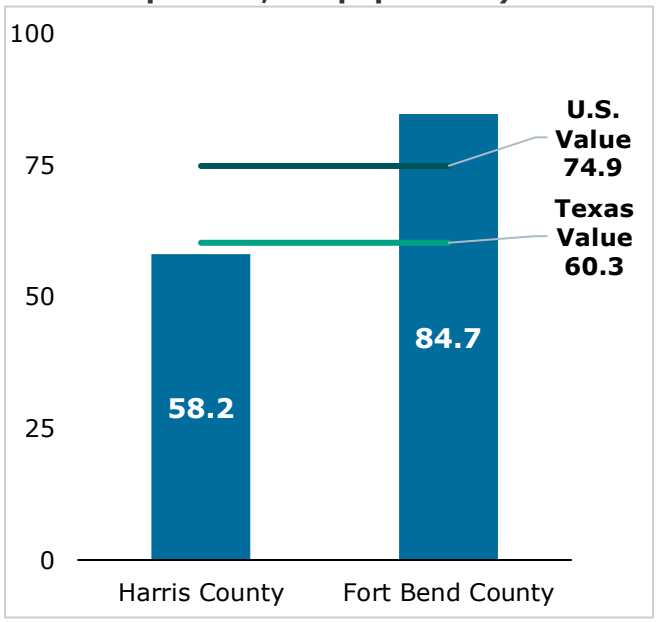
CDC – PLACES (2022)

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



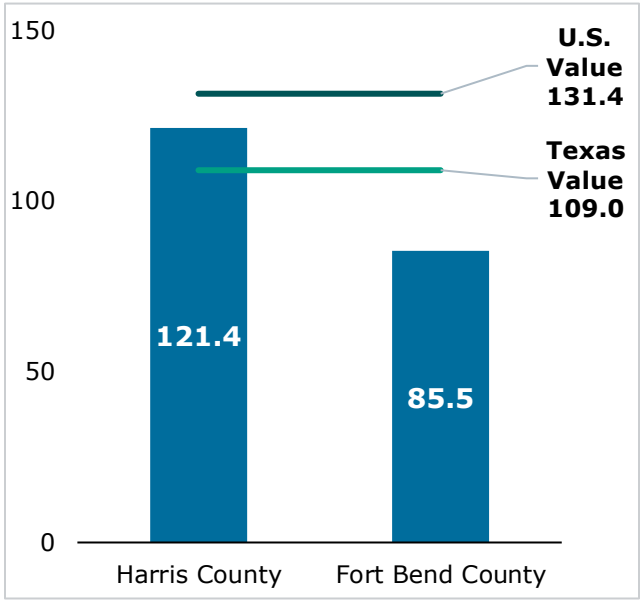
Centers for Medicare & Medicaid Services (2022)

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)

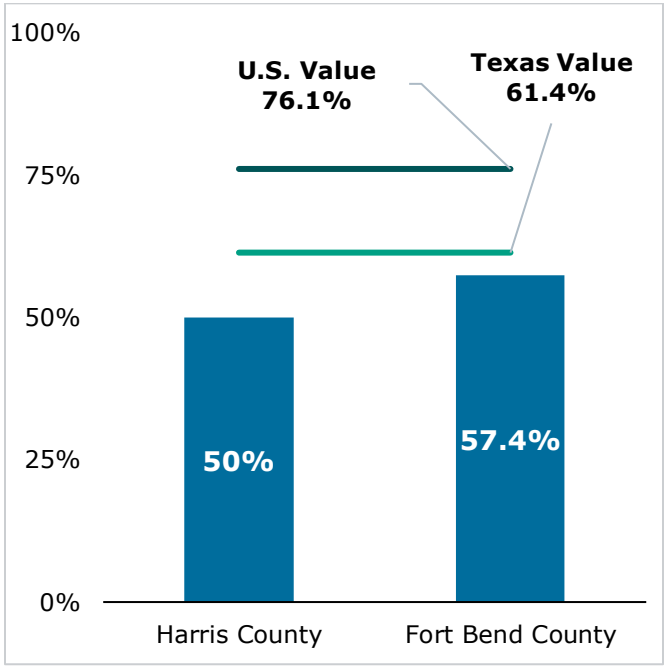


County Health Rankings (2023)

Key Findings: Maternal & Infant Health

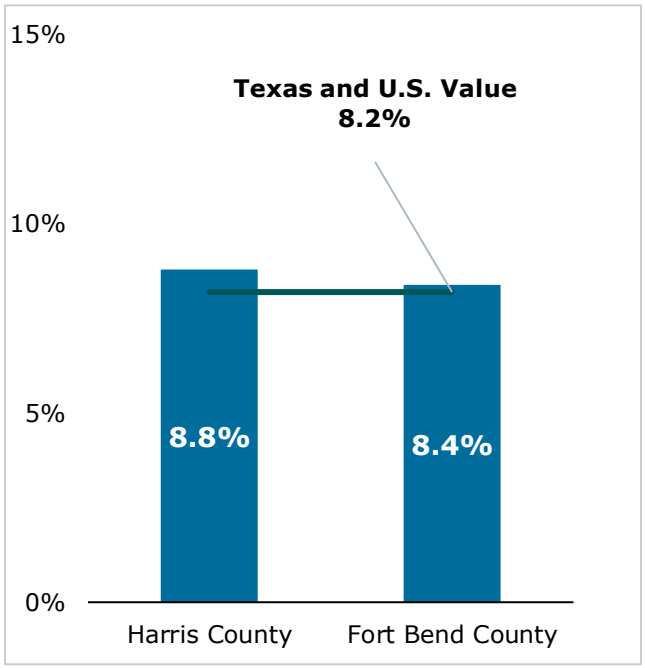
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Maternal and Infant Health.

FIGURE 10. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



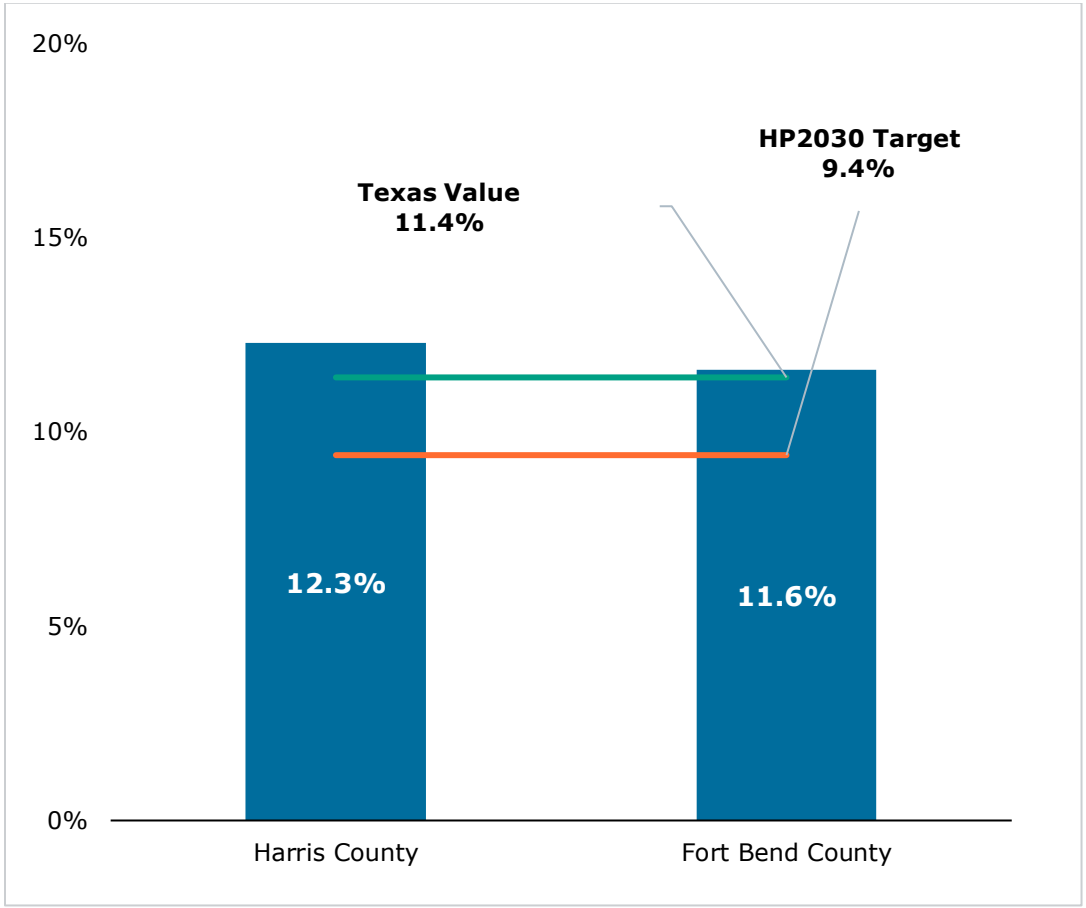
Texas Department of State Health Services (2020)

FIGURE 11. BABIES WITH LOW BIRTHWEIGHT



Texas Department of State Health Services (2020)

FIGURE 12. PRETERM BIRTHS

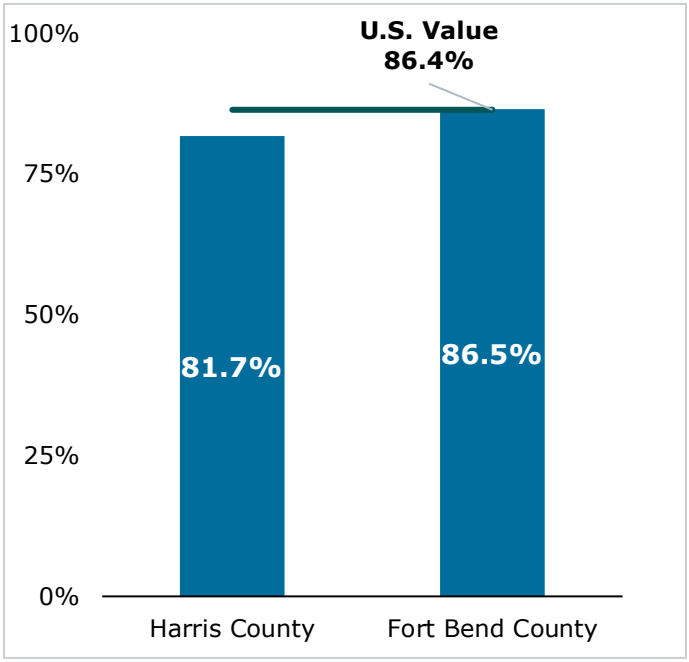


Texas Department of State Health Services (2021)

Key Findings: Chronic Condition Prevention & Management

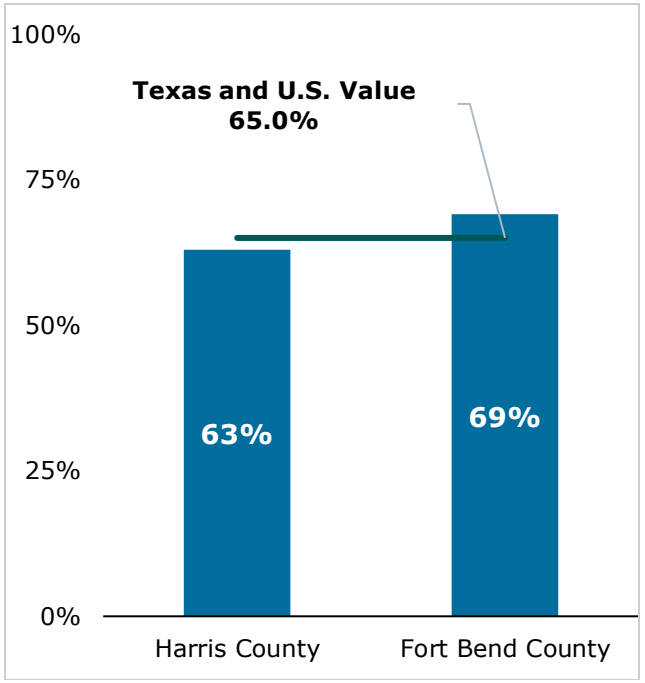
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Chronic Condition Prevention & Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



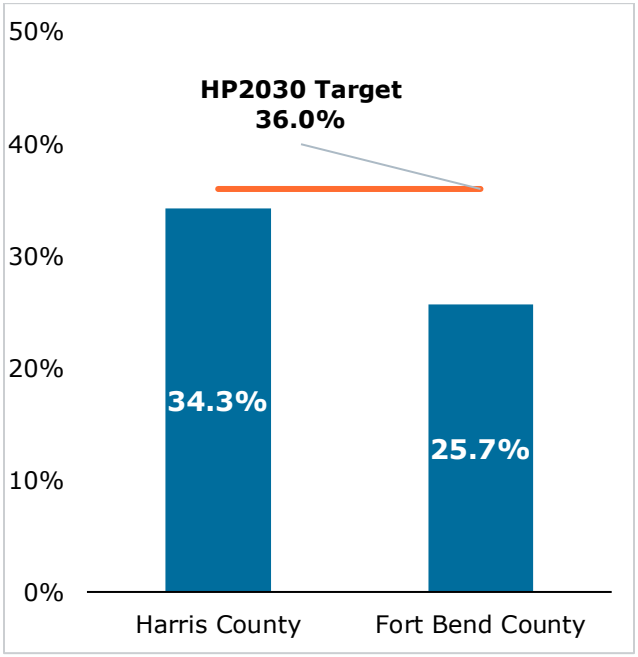
CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



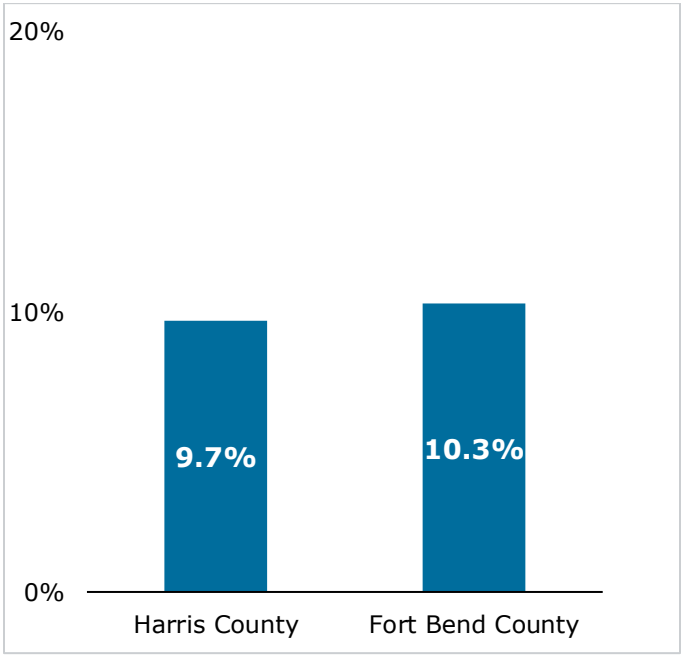
Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



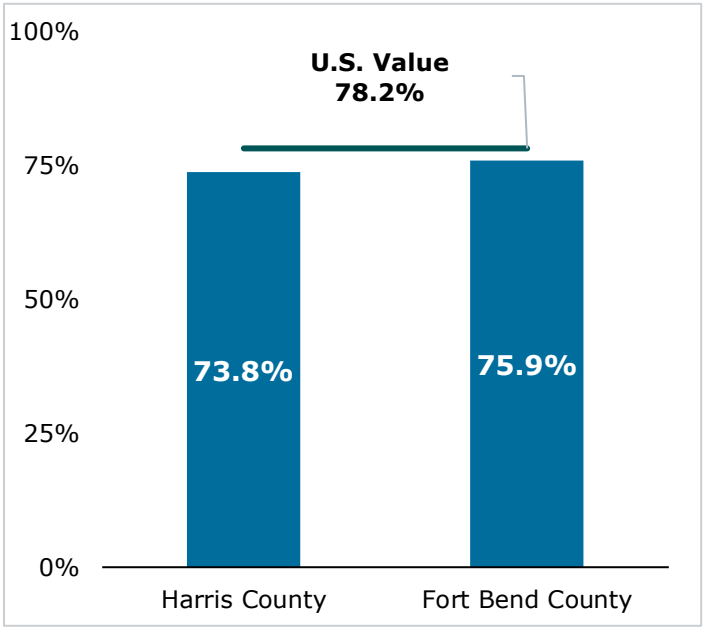
CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



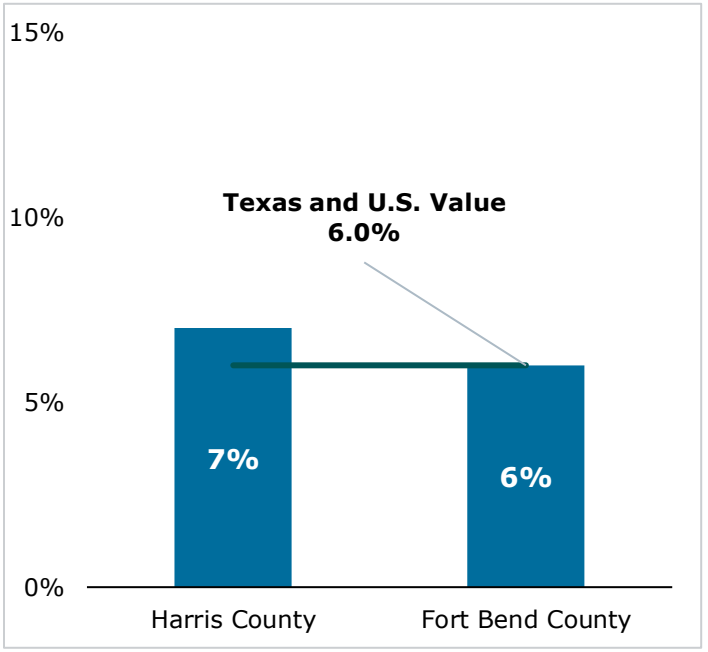
CDC (2021)

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



CDC (2021)

FIGURE 18. STROKE: MEDICARE POPULATION



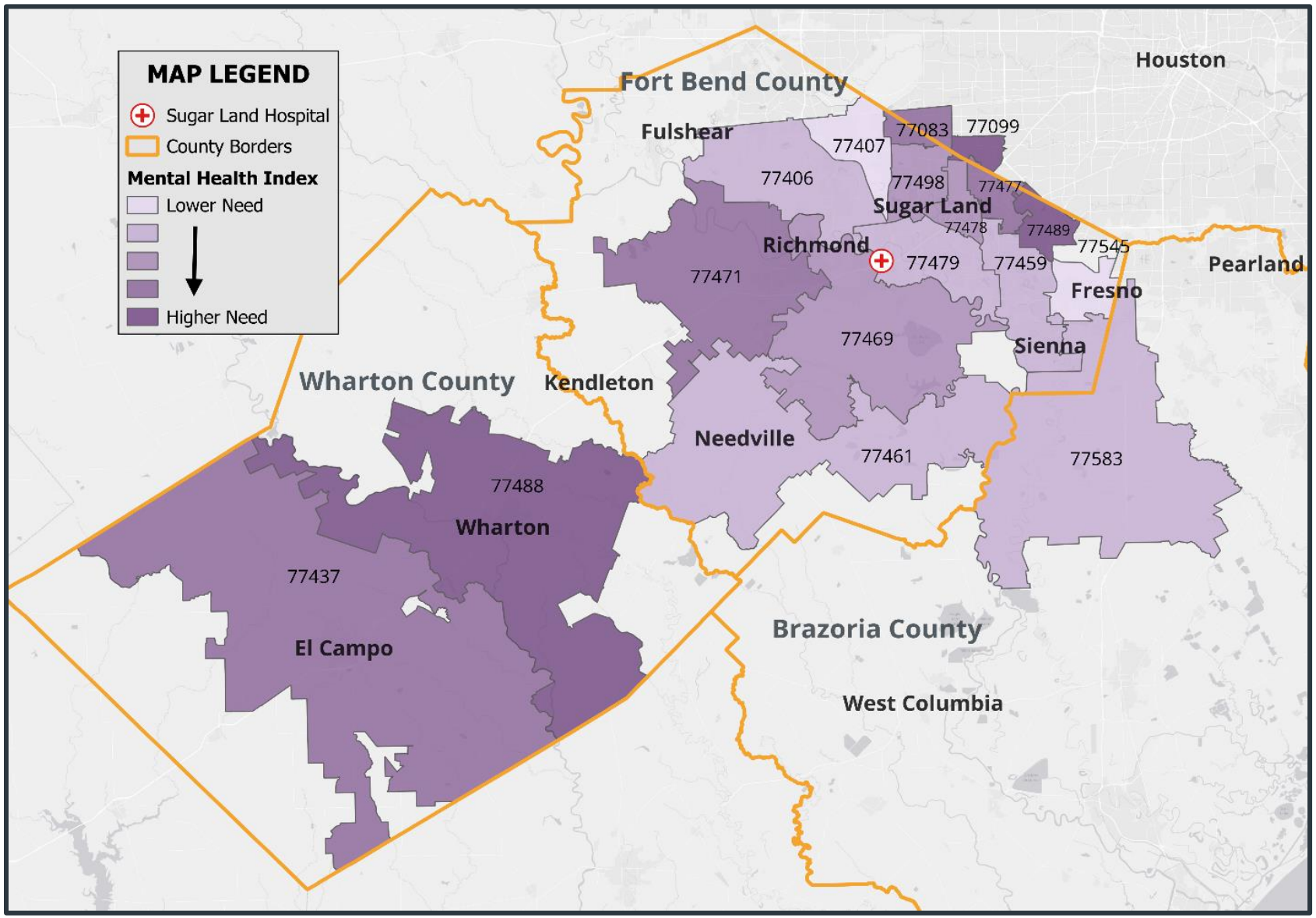
Centers for Medicare & Medicaid Services (2022)

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

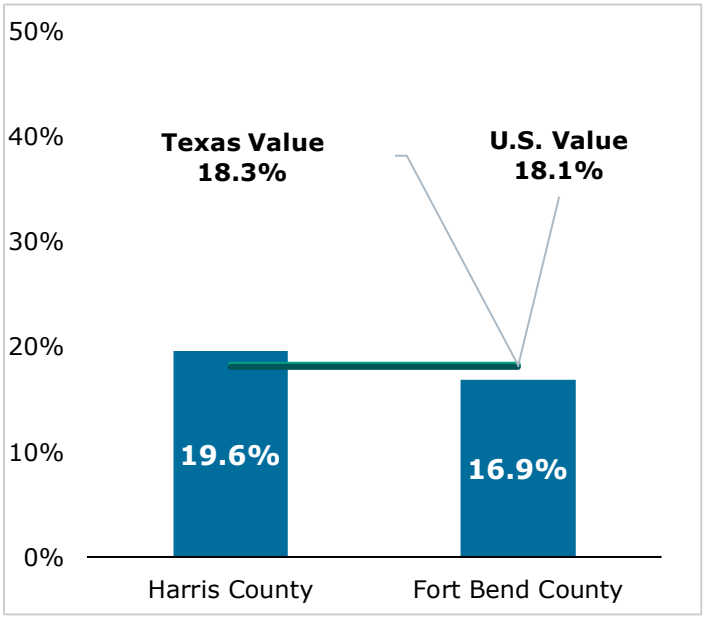
- 77099 (MHI = 83.8)
- 77489 (83.3)
- 77488 (82.6)

FIGURE 19. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S MENTAL HEALTH INDEX BY ZIP CODE: MERMORIAL HERMANN SUGAR LAND HOSPITAL MSA



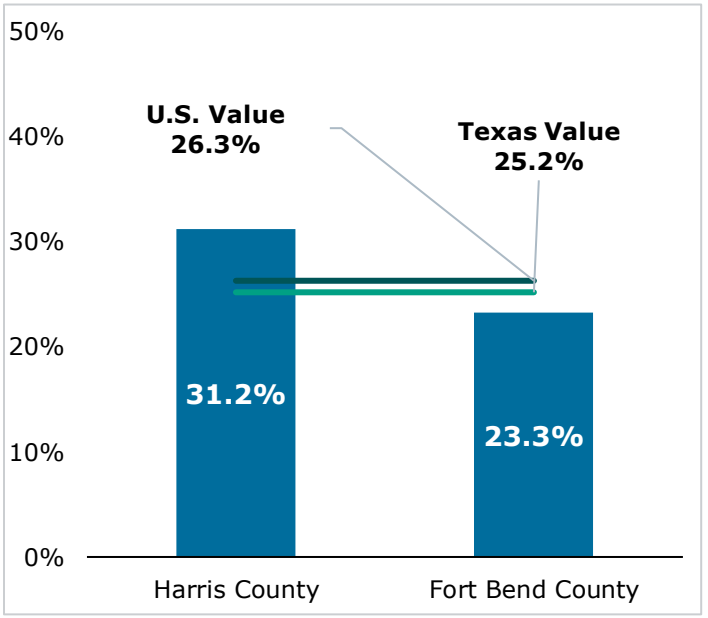
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to Mental Health and Substance Use.

FIGURE 20. ADULTS WHO DRINK EXCESSIVELY



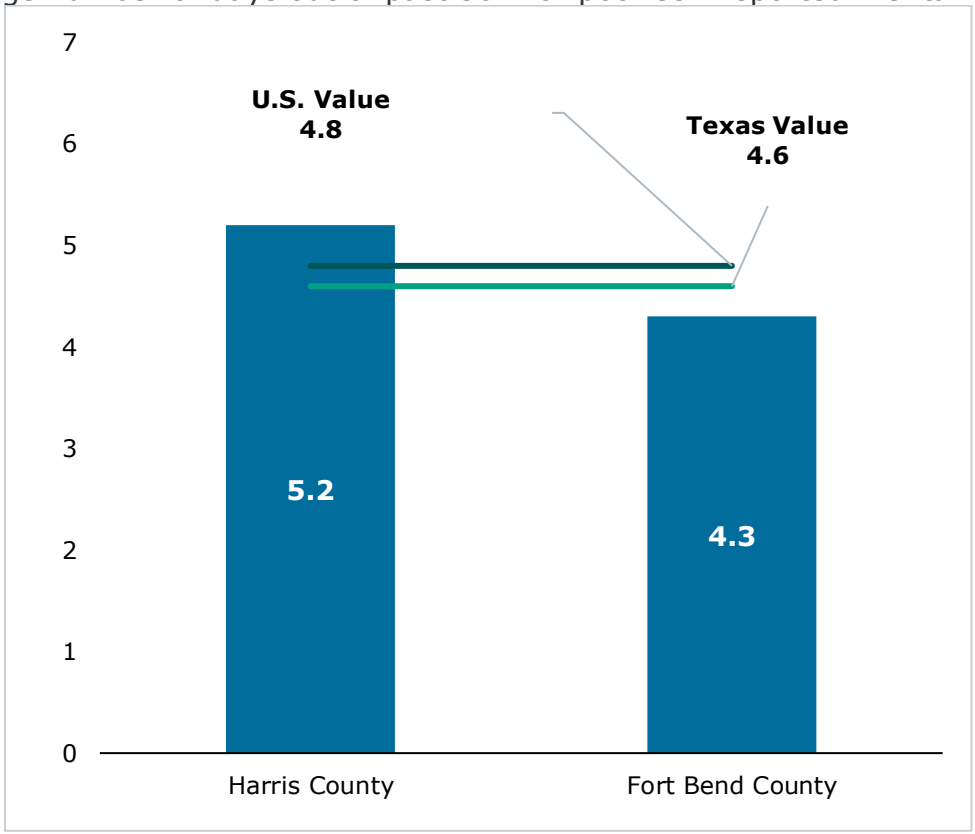
County Health Rankings (2021)

FIGURE 21. ALCOHOL-IMPAIRED DRIVING DEATHS (percent of driving deaths involving alcohol)



County Health Rankings (2017-2021)

FIGURE 22. POOR MENTAL HEALTH DAYS
(average number of days out of past 30 with poor self-reported mental health)



County Health Rankings (2021)

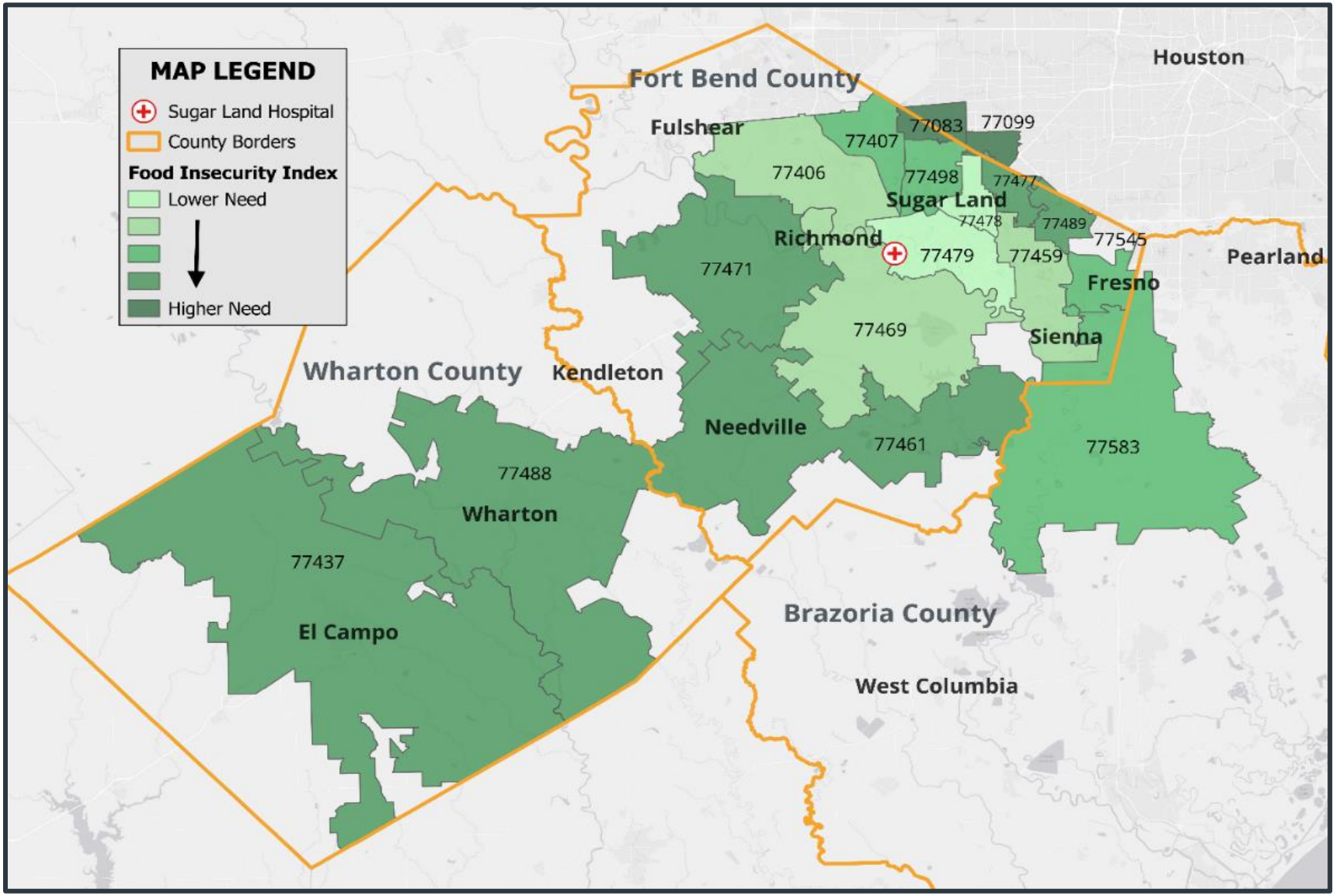
Access to Healthy Food: Memorial Hermann Sugar Land Hospital

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

- 77081 (FII = 97.8)
- 77099 (90.1)
- 77036 (84.8)
- 77074 (81.0)
- 77072 (80.4)

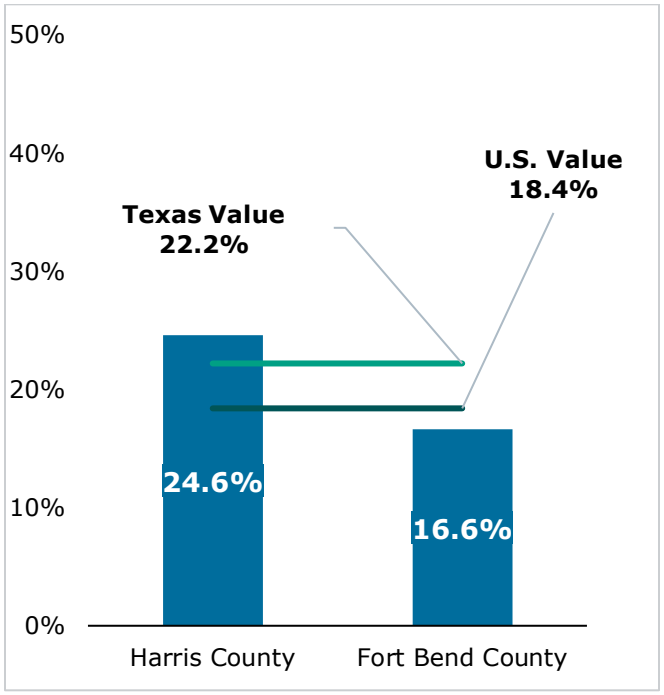
Notably, the majority of zip codes in this MSA (12 out of 17) have a FII score above 50, indicating that the region generally has higher rates of food insecurity compared to other U.S. zip codes.

FIGURE 23. CONDUENT HEALTHY COMMUNITIES INSTITUTE'SFOOD INSECURITY INDEX BY ZIP CODE: SUGAR LAND HOSPITAL MSA



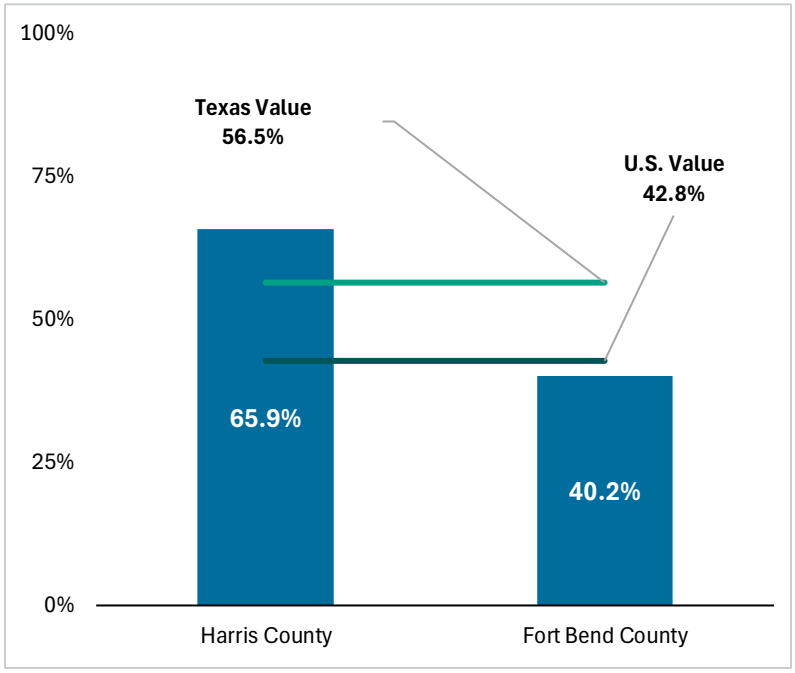
The following figures illustrate indicators of concern in Harris and/or Fort Bend counties, based on scoring of secondary data related to **Access to Healthy Food.**

FIGURE 24. CHILD FOOD INSECURITY RATE



Feeding America (2022)

FIGURE 25. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM



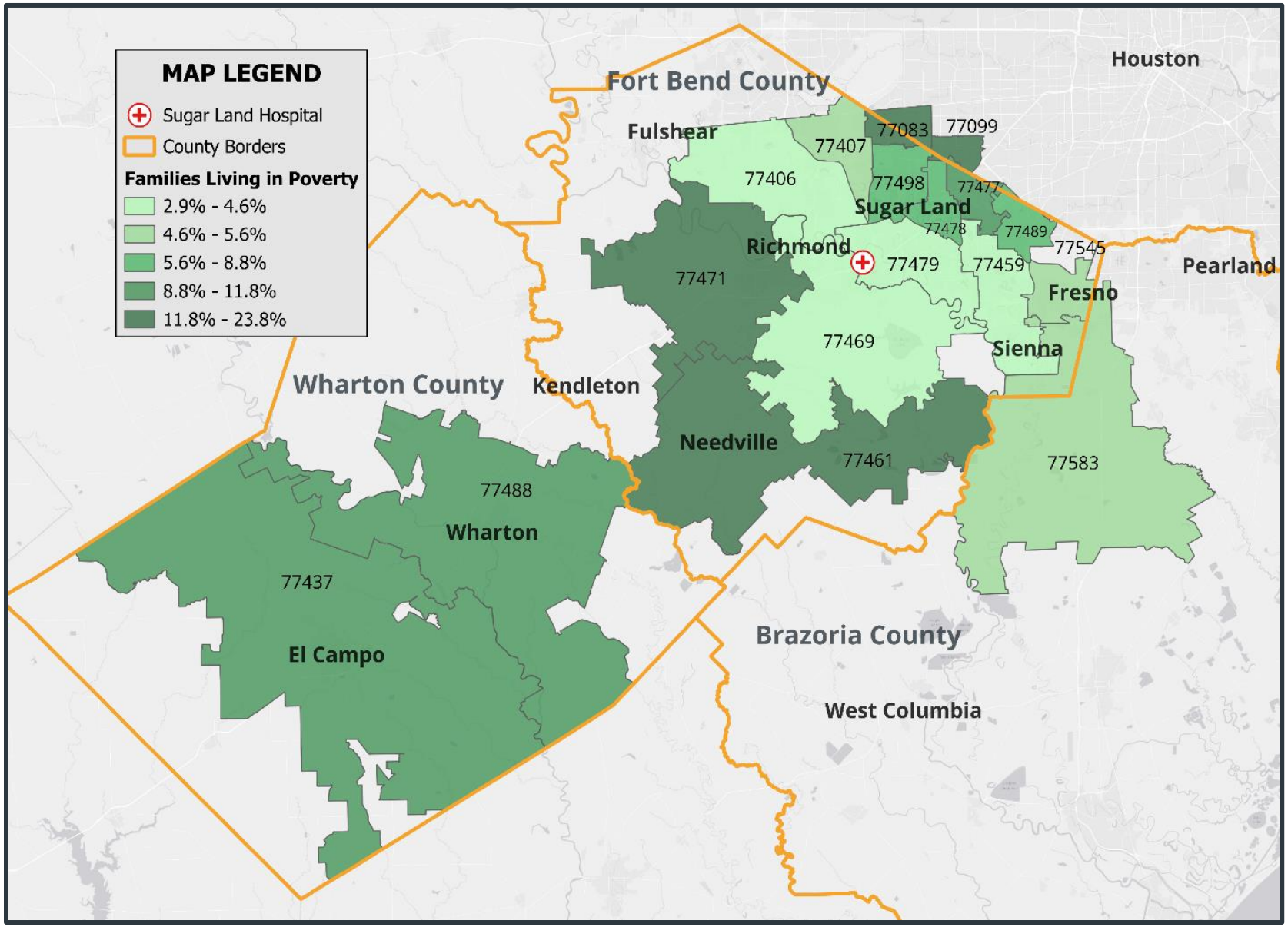
National Center for Education Statistics (2022-2023)

Economic Opportunity: Memorial Hermann Sugar Land Hospital

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

- 77099 (23.8%)
- 77461 (14.9%)
- 77471 (13.3%)
- 77083 (11.8%)

FIGURE 26. POVERTY BY ZIP CODE: SUGAR LAND HOSPITAL MSA

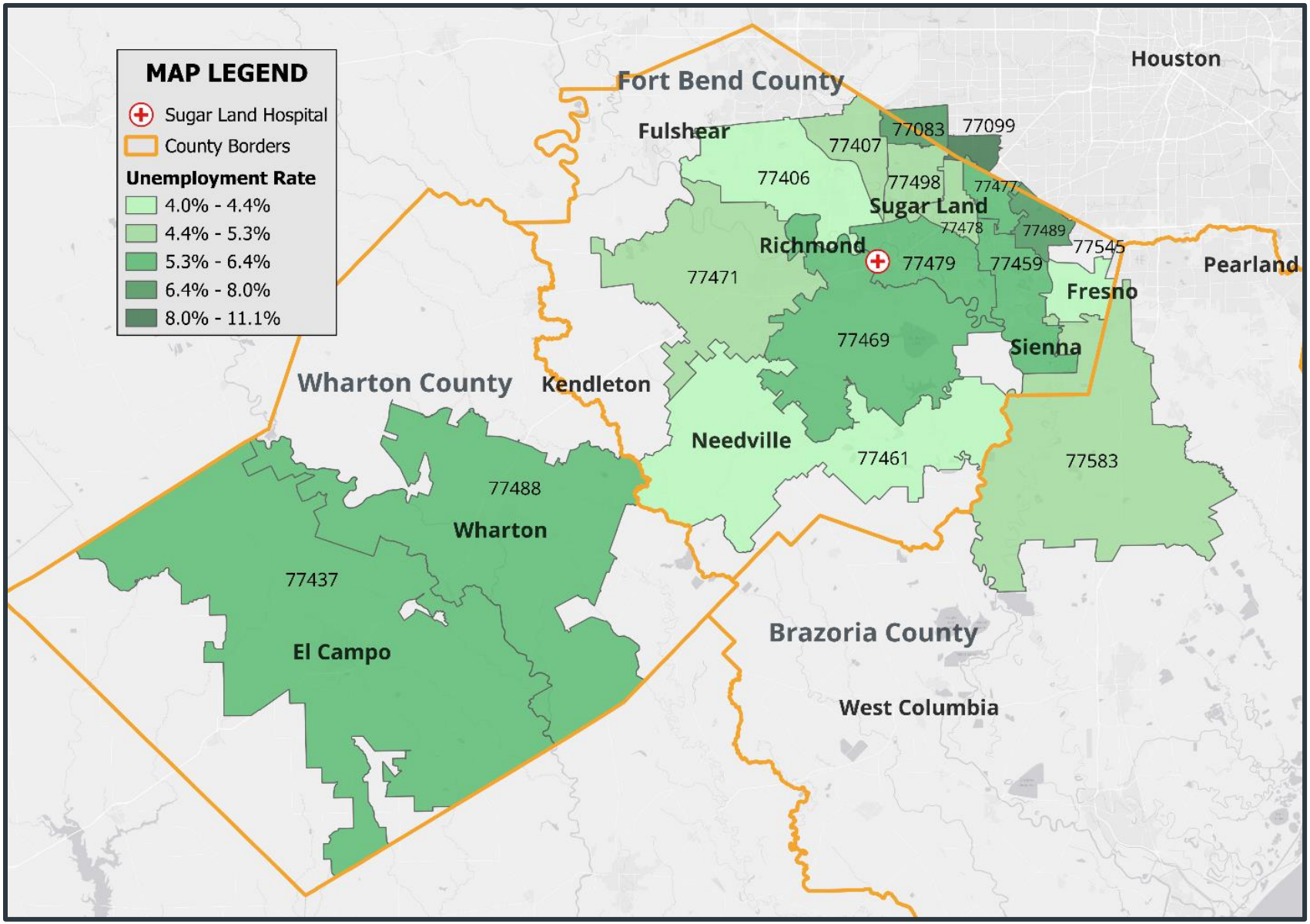


Claritas (2024)

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

- 77099 (11.1%)
- 77083 (8.0%)
- 77489 (7.5%)
- 77477 (6.4%)

FIGURE 27. UNEMPLOYMENT BY ZIP CODE: SUGAR LAND HOSPITAL MSA

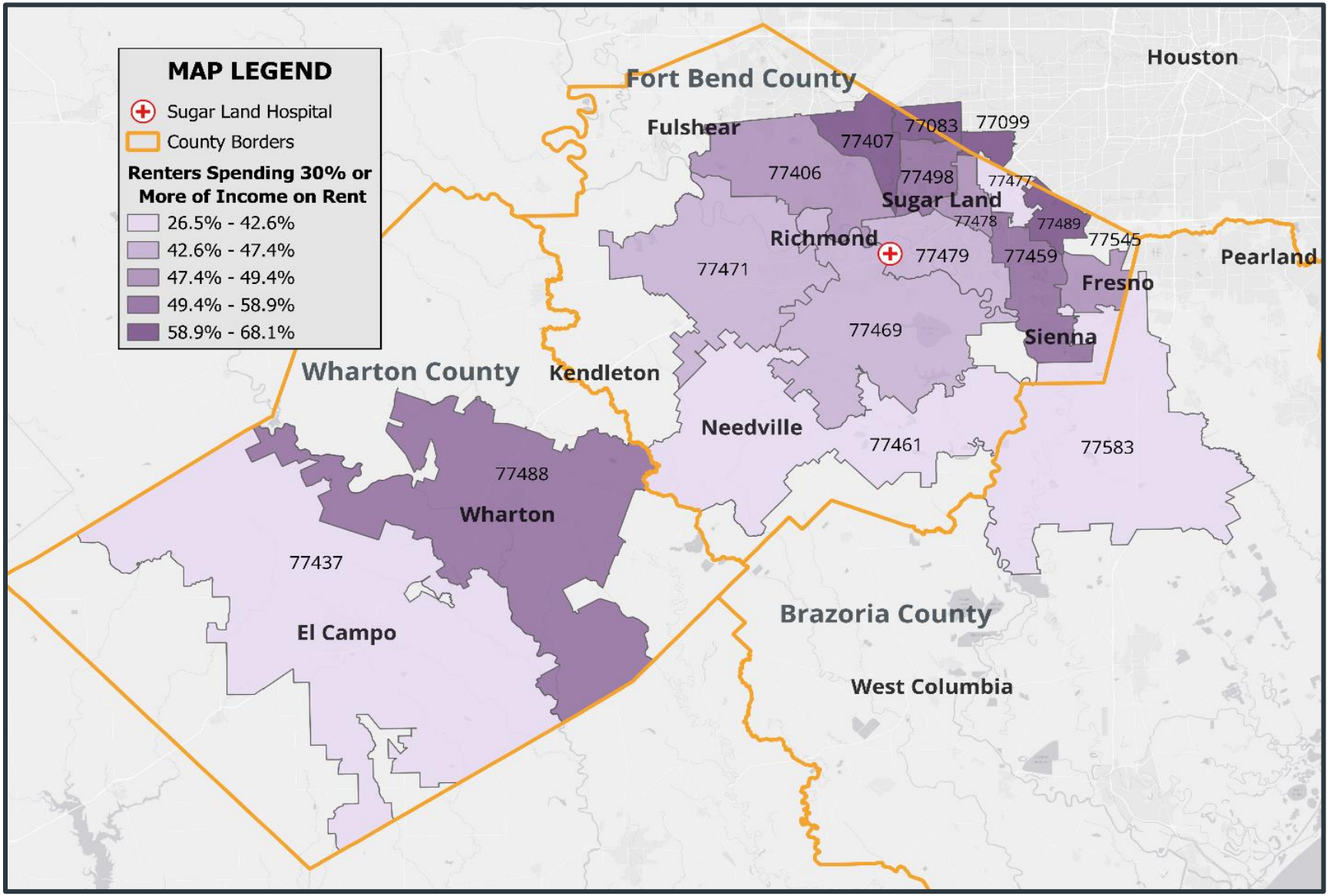


Claritas (2024)

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

- 77489 (68.1%)
- 77099 (60.8%)
- 77407 (59.6%)
- 77083 (58.9%)

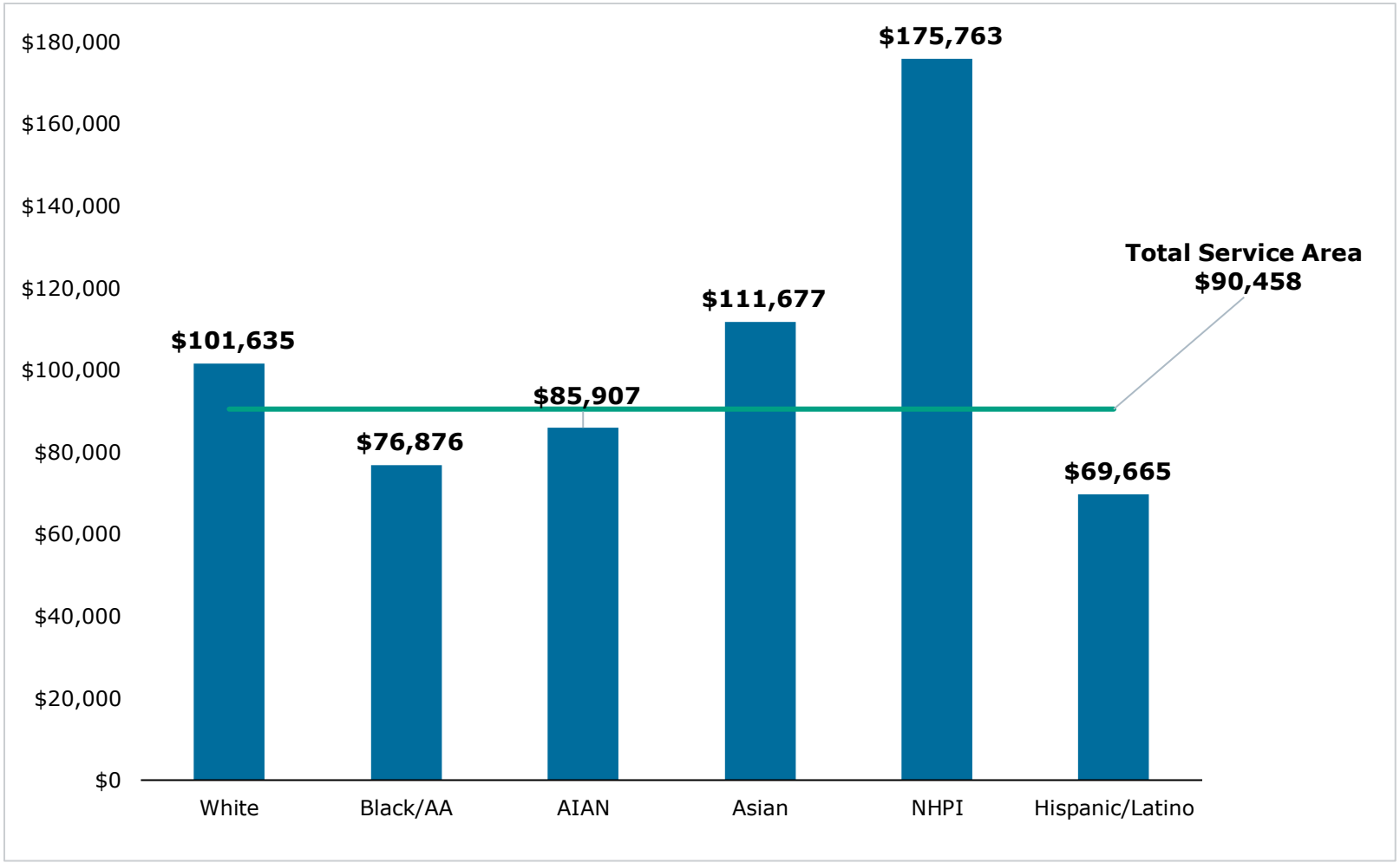
FIGURE 28. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: SUGAR LAND HOSPITAL MSA



American Community Survey (2018-2022)

Across the Sugar Land 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 $13,000 lower than the overall median household income.

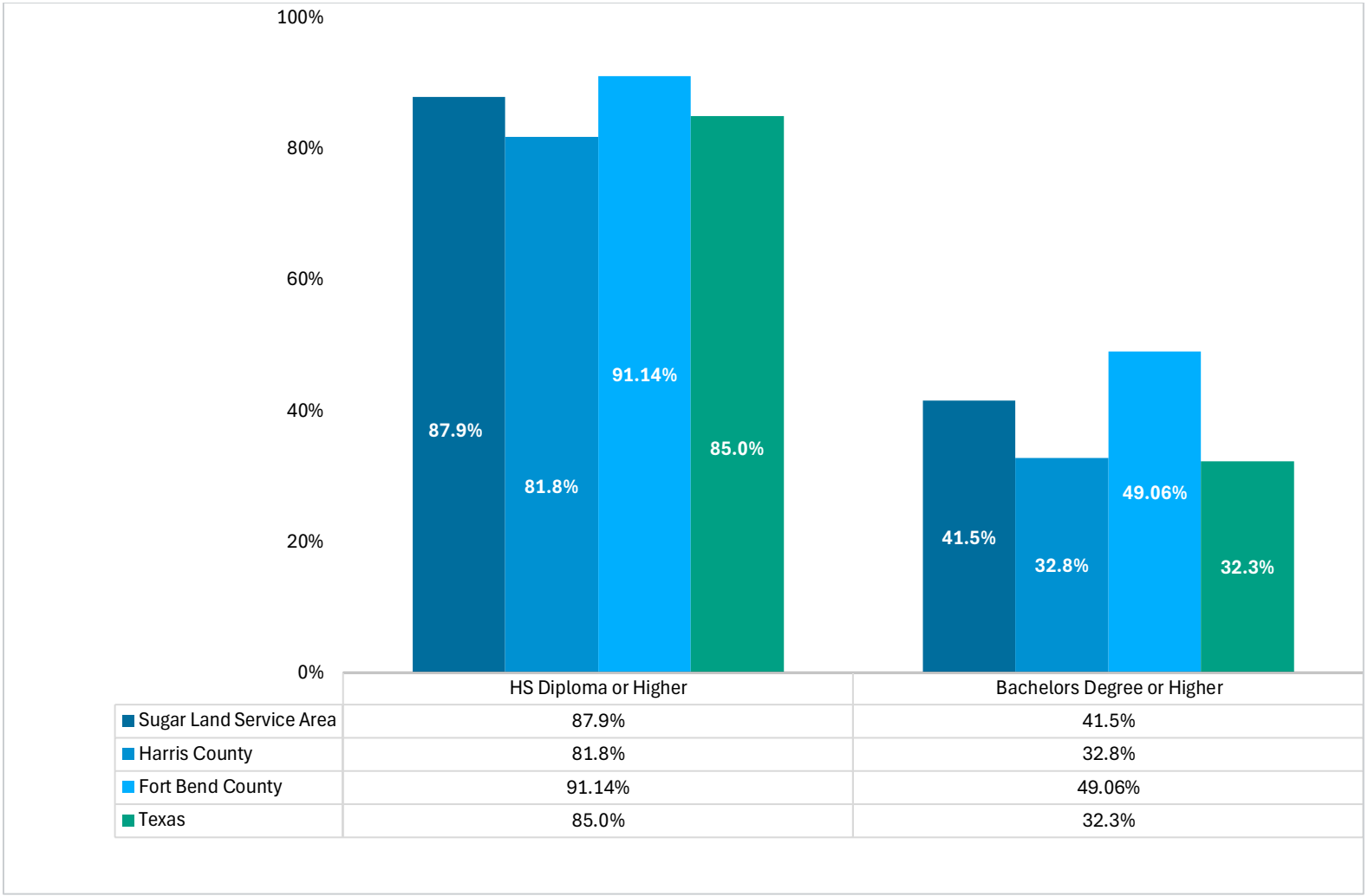
FIGURE 29. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: SUGAR LAND HOSPITAL MSA



Claritas (2024)

Educational Access: Memorial Hermann Sugar Land Hospital

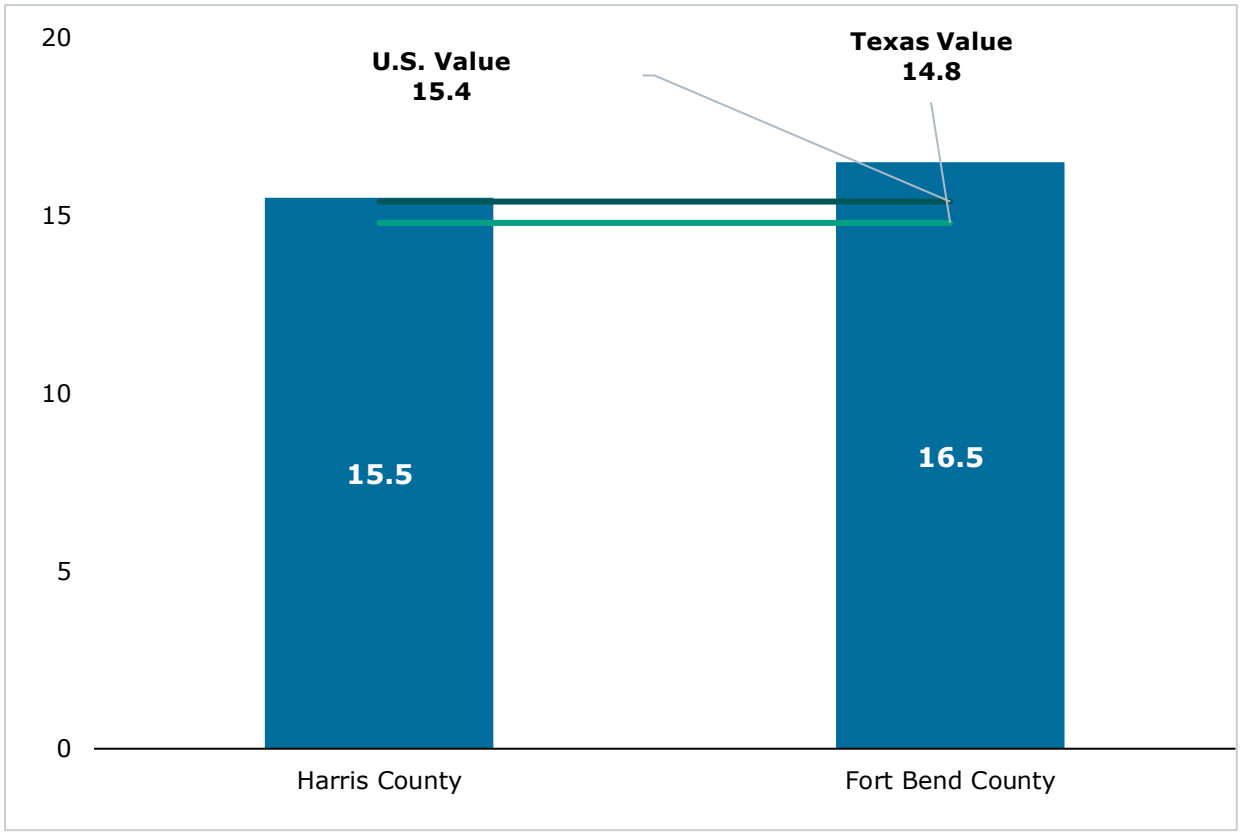
FIGURE 30. EDUCATIONAL ATTAINMENT



	HS Diploma or Higher	Bachelors Degree or Higher
Sugar Land Service Area	87.9%	41.5%
Harris County	81.8%	32.8%
Fort Bend County	91.14%	49.06%
Texas	85.0%	32.3%

Claritas (2024)

FIGURE 31. STUDENT-TO-TEACHER RATIO



National Center for Education Statistics (2022-2023)