Community Health Implementation Strategy

Memorial Hermann The Woodlands Medical Center

MEMORIAL HERMANN
The Woodlands
Medical Center

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The Woodlands Medical Center

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MEMORIAL HERMANN
The Woodlands Medical Center

At-a-Glance Summary

Community Served 	Memorial Hermann, The Woodlands Medical Center, serving 1,356,193 persons living in 31 zip codes in Harris, Montgomery, and Waller counties.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address were identified in the hospital's most recent Community Health Needs Assessment (CHNA).

Health Care Priorities

- 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

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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 objectives.

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.
- Establish new care delivery sites to underserved areas of the Northern Market and increase access to chronic disease management services by 25% compared to baseline.
- Strengthen access to primary and preventive health care by maintaining a strong partnership with Interfaith Community Clinic and expanding the availability of free health resources and services to underserved community members.
- Refer ≥70% of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ER settings with identified Non-Medical Driver of Health (NMDOH) needs to Community Care Coordination Team (C3T) Community Health Workers (CHWs) for a documented intervention and outcome.

Access to Healthy Food

- 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.

Maternal & Infant Health

- Improve maternal and infant health outcomes by enhancing the quality and safety of perinatal care within the Women's Services scope with a focus on reducing preventable complications and promoting equitable care for birthing parents and newborns.

Mental Health & Substance Use

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

Economic Opportunity and Educational Access

- Expand access to nursing education and career advancement opportunities by strengthening academic partnerships and scaling professional development pipelines, with a focus on underrepresented and economically disadvantaged populations.
- 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.

Our Hospital and the Community Served

Memorial Hermann The Woodlands Medical Center

Memorial Hermann The Woodlands Medical Center 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.

Rooted in the Woodlands for more than 40 years, Memorial Hermann, The Woodlands Medical Center has provided family- and patient-centered, trusted care to the many communities of Montgomery County, north Harris County and beyond. We regularly invest in campus expansion and renovation projects to tailor our advanced, personalized services to meet the health needs of area families. Our welcoming campus, located at 9250 Pinecroft Drive, consists of a main hospital with 457 beds across three patient bed towers, plus five medical plaza office buildings.

A team of more than 1,400 affiliated physicians - representing more than 90 medical specialties - is supported by over 3,300 employees and 300 volunteers. We are a designated Level II trauma center and were the first and only hospital in Montgomery County for over a decade granted Magnet® status – an international prestigious honor for demonstrated nursing excellence and quality care by the American Nurses Credentialing Center (ANCC).

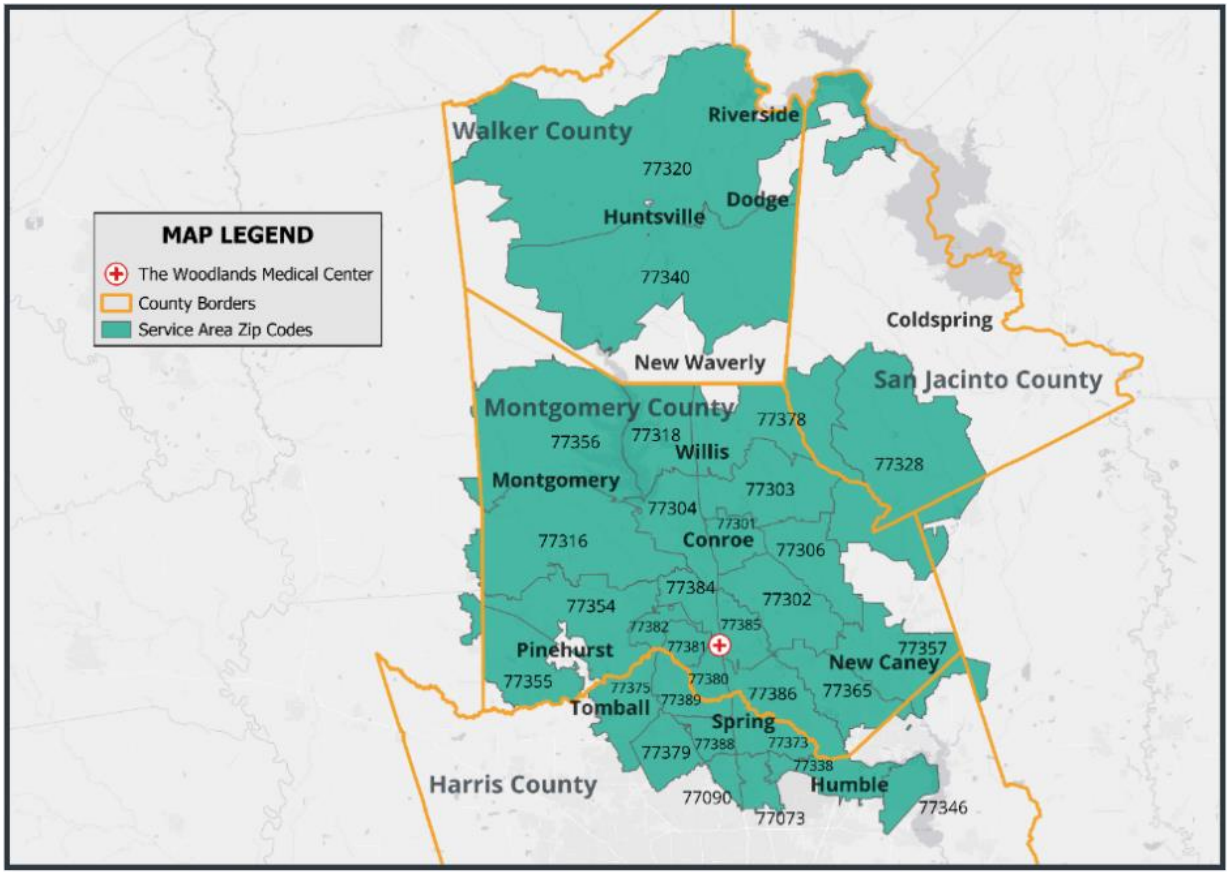
In January 2025, we again achieved ANCC Magnet re-designation for the fourth time – this time, the new ANCC Magnet with Distinction® designation! From wellness to complex procedures, Memorial Hermann The Woodlands provides an impressive depth and breadth of services, including robot-assisted and minimally invasive surgical services, an advanced heart and vascular institute, the Mischer Neuroscience Center for outpatient care as it relates to the brain, spine and central nervous system and the Neurosciences Patient Care Unit with dedicated inpatient beds, a neurological ICU and epilepsy seizure monitoring unit. It is also home to nationally recognized TIRR Memorial Hermann outpatient and inpatient medical rehabilitation, plus Memorial Hermann | Rockets Orthopedics.

Area families appreciate the renovated Family Life Center, the Children's Memorial Hermann neonatal ICU able to care for newborns at any gestational age and the variety of affiliated, full-time pediatric subspecialists right on campus. Additionally, community cancer survivors and their caregivers have helped grow the Canopy Cancer Survivorship Center in Medical Plaza 1, its free programs open to guests with any type of cancer, regardless of where treatment was received.

Description of the Community Served

Memorial Hermann The Woodlands Medical Center Metropolitan Service Area (MSA) has a population of approximately 1,356,193 persons serving 31 zip codes in Harris, Montgomery, and Waller counties. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. MEMORIAL HERMANN THE WOODLANDS MEDICAL CENTER METROPOLITAN SERVICE AREA BY ZIP CODES



Source: MHHS facilities values from Claritas (2024)

Community Assessment and Significant Needs

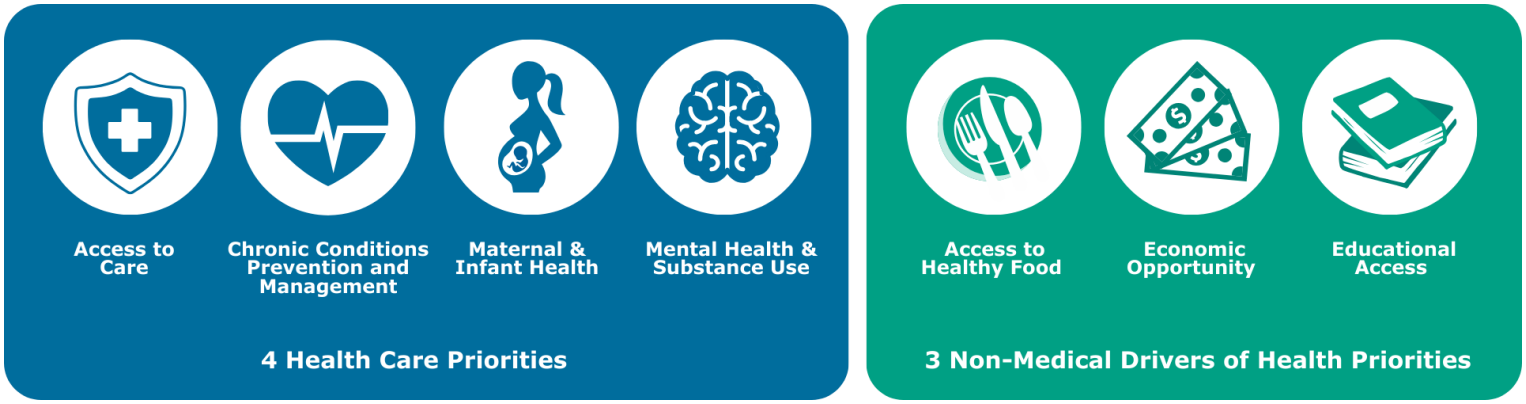
The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted on June 26, 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, communityhealth@memorialhermann.org.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors or health care services, and health-related social and community needs that have an impact on health and well-being.



Significant Needs the Hospital Does Not Intend to Address

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

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities. Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

Memorial Hermann The Woodlands Medical Center 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 The Woodlands Medical Center, and other hospital leadership.

During initial planning meetings, representatives from HCI and Memorial Hermann The Woodlands Medical Center 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 The Woodlands Medical Center 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 Strategy presented on the following pages outlines, in detail, the individual strategies and activities The Woodlands Medical Center 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 The Woodlands Medical Center 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: **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—patient achieving improvement in focus health measures (e.g. A1c; BMI) for targeted disease states
- Percent—screening rate for patients identified as high-risk for NMDOH encountered in the ER and Inpatient setting
- Percent—resource referral rate for patients identified as high-risk for NMDOH encountered in the ER & Inpatient setting

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
ER Navigation Program	Community Health Network	Baseline TBD by end of FY26	• Volume - referrals to community partner locations • Percent - show rate of referred to community partners • 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/ UT Closed Loop Referral Pilot

			• Percent – show rate of referred to navigated resources • Percent – decrease of MVP revisits within 180 days of navigated.

Target/Intended Population(s):

- Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS The Woodlands Medical Center 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.
- UT Closed Loop Referral Pilot is a new initiative to gauge viability of a closed loop referral system. It is being piloted at MHHS the Woodlands campus only for MVP. It engages UT, Houston Food Bank and other anchor partners to gauge technology capabilities.
- Inpatient Navigation Program focuses on supporting admitted patients identified as high-risk for NMDOH with support services upon discharge.
- Baseline data to be established for FY26 and built upon in subsequent years during implementation plan period.

Collaboration Partners (Internal and External):

- Coordinated Care; ER; ISD; community nonprofit agencies; Strategy division

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

FY26-FY28 Goal: Establish new care delivery sites to underserved areas of the Northern Market and increase access to chronic disease management services by 25% compared to baseline.

FY26 Objective: Leverage existing clinical infrastructure, community partnerships, and digital health tools to support service delivery.

FY26 KPIs:
- Percent -increase in MyChart adoption in Northern zip codes
- Percent - patients screened for NMDOH

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Northern Market Expansion Initiatives	Senior Operations leaders	N/A	• Completion - capital secured • Date - construction initiated

Target/Intended Population(s):
- Greater Houston population with emphasis on North of The Woodlands, Texas

Please provide any additional insights or explanations on the initiative(s) listed.
- Construction on northern presence not set to begin until summer 2026 – after this KPIs can be established for health drivers

Collaboration Partners (Internal and External):
- Strategy, CAC, Construction/Real Estate, Epic team/ambulatory network

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

FY26-FY28 Goal: Strengthen access to primary and preventive health care by maintaining a strong partnership with Interfaith Community Clinic and expanding the availability of free health resources and services to underserved community members.

FY26 Objective: Enhance access to comprehensive, community-based care by deepening collaboration with Interfaith Community Clinic to offer targeted services such as screenings and navigation support. Additionally, amplifying the marketing for Canopy Cancer Survivorship Center will ensure survivors and their families receive free, ongoing support during their cancer journey.

FY26 KPIs:
- Number – funds allocated year over year
- Number – unique encounters

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Interfaith Community Clinic Support	Business Development	Baseline TBD post-FY26	• Number – funds allocated (imaging, lab, and screenings) • Number – unique encounters • Number – in kind lab/imaging support year over year
Canopy Cancer Survivorship Program	Business Development	Baseline TBD post-FY26	• Number – donations attributed YoY • Number – visits per program

Target/Intended Population(s):
- Interfaith – A free charity clinic located in The Woodlands serving patients without PCP who are uninsured/under insured
- Canopy Program – All patients and families battling breast cancer regardless of health care or insurance provider can join

Please provide any additional insights or explanations on the initiative(s) listed.
- N/A

Collaboration Partners (Internal and External):
- Interfaith Community Clinic

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

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

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

Target/Intended Population(s):

- Food insecure; uninsured; Medicaid; Residing in target communities surrounding The Woodlands and community health resources

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:

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

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

FY26 KPIs:

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

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Community Health Worker (CHW) Hub	• Community Health Network • Ambulatory Services	Baseline TBD post-FY26	• Go-Live Date • Percent – referrals received • Number – NMDOH assessment screenings completed • Number – appointment scheduled • Percent - show rates of scheduled • Percent - positive patient satisfaction scores
MyChart NMDOH Assessment Initiative	Community Health Network	Baseline TBD post-FY26	• Number - MyChart NMDOH Assessments completed • Percent - patients indicating "Yes" for referral support upon MyChart NMDOH assessment completion • Percent – routed to CHW Hub

Target/Intended Population(s):

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

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

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

Collaboration Partners (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: Educational Access**
- **Secondary Prioritized Need Area: Economic Opportunity**

FY26-FY28 Goal: Expand access to nursing education and career advancement opportunities by strengthening academic partnerships and scaling professional development pipelines, with a focus on underrepresented and economically disadvantaged populations.

FY26 Objective: Advance equitable access to nursing careers by providing structured academic and career support – such as mentorship and clinical placement – to students from varying backgrounds, ensuring successful progression from education to employment.

FY26 KPIs:

- Percent – increase in wages (PSN)
- Percent – increase in wages (NRP)
- Number – CEUs provided to school nurses

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
PSN to NRP Program	Medical Staff Education	Baseline TBD post-FY26	• Percent – PSN graduation rate • Percent – PRN conversion to NRP

Tier I Partnership with Sam Houston State University (SHSU)	Medical Staff Education	Tier 1 Partnership began in 2025	• Number – students from SHSU • Percent – student conversion to staff • Number – staff on faculty • Number – mock interviews conducted (for job preparation)
Conroe School Nurse Symposium	Medical Staff Education	Baseline TBD post-FY26	• Number – participants in the class • Number – class evaluations • Number – CEUs provided
Target/Intended Population(s): • Nursing students - Students enrolled in a nursing program (PSN); Students graduated from a nursing program (NRP); School nurses (symposium)			
Please provide any additional insights or explanations on the initiative(s) listed. • N/A			
Collaboration Partners (Internal and External): • System education; Campus professional development / education team; Conroe ISD; Sam Houston State University			

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

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

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

FY26 KPIs:

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

Strategic Approach

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

Target/Intended Population(s):

- Greater Houston Community

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

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

Collaboration Partners (Internal and External):

- Human Resources, local nonprofit partners and collaboratives, Community Health Network, MHHS The Woodlands Medical Center

Community Priority: Maternal and Infant Health

- **Primary Prioritized Need Area: Maternal and Infant Health**
- **Secondary Prioritized Need Area: Access to Healthcare**

FY26-FY28 Goal: Improve maternal and infant health outcomes by enhancing the quality and safety of perinatal care within the Women's Services scope with a focus on reducing preventable complications and promoting equitable care for birthing parents and newborns.

FY26 Objective: Enhance maternal and infant health outcomes by expanding access to high-quality, culturally response prenatal and postnatal educational programs to empower parents with the knowledge and skills needed for safe, confident care during the perinatal period.

FY26 KPIs:

- Percent - patients achieving improvement in focus health measures (e.g. breast feeding) for targeted population
- Percent – patients achieving improvement in support and education pre and post hospitalization

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Pre- or post-hospital Newborn Care Class	Patient Care- Perinatal Education Team	Baseline TBD post-FY26	• Number - patient roster • Number - survey of class (patient feedback)
Pre-Hospital Breastfeeding Basics Class and Support Group	Patient Care- Perinatal Education Team	Baseline TBD post-FY26	• Number - patient roster • Number - survey of class (patient feedback) • Number – exclusive breastfeeding rates
Pre-Hospital Preparing for Childbirth Class	Patient Care- Perinatal Education Team	Baseline TBD post-FY26	• Number - patient roster • Number - survey of class (patient feedback)
BLS Training for Physician Offices	Patient Care- Perinatal Education Team	Baseline TBD post-FY26	• Number – physician offices p participating

Target/Intended Population(s):

- All new parents regardless of payer type or demographics

Please provide any additional insights or explanations on the initiative(s) listed. • N/A
Collaboration Partners (Internal and External): • System Women's services; OB physicians; physician offices

Community Priority: Mental Health and Substance Use

- **Prioritized Need Area: Mental Health and Substance Use**
- **Secondary Prioritized Need Area: Access to Care**

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 being served by Memorial HermannThe Woodlands Campus.

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
- Number – attendees to community events

Strategic Approach

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

Target/Intended Population(s):

- Broader Greater Houston community with emphasis on families residing in surrounding service areas.

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 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

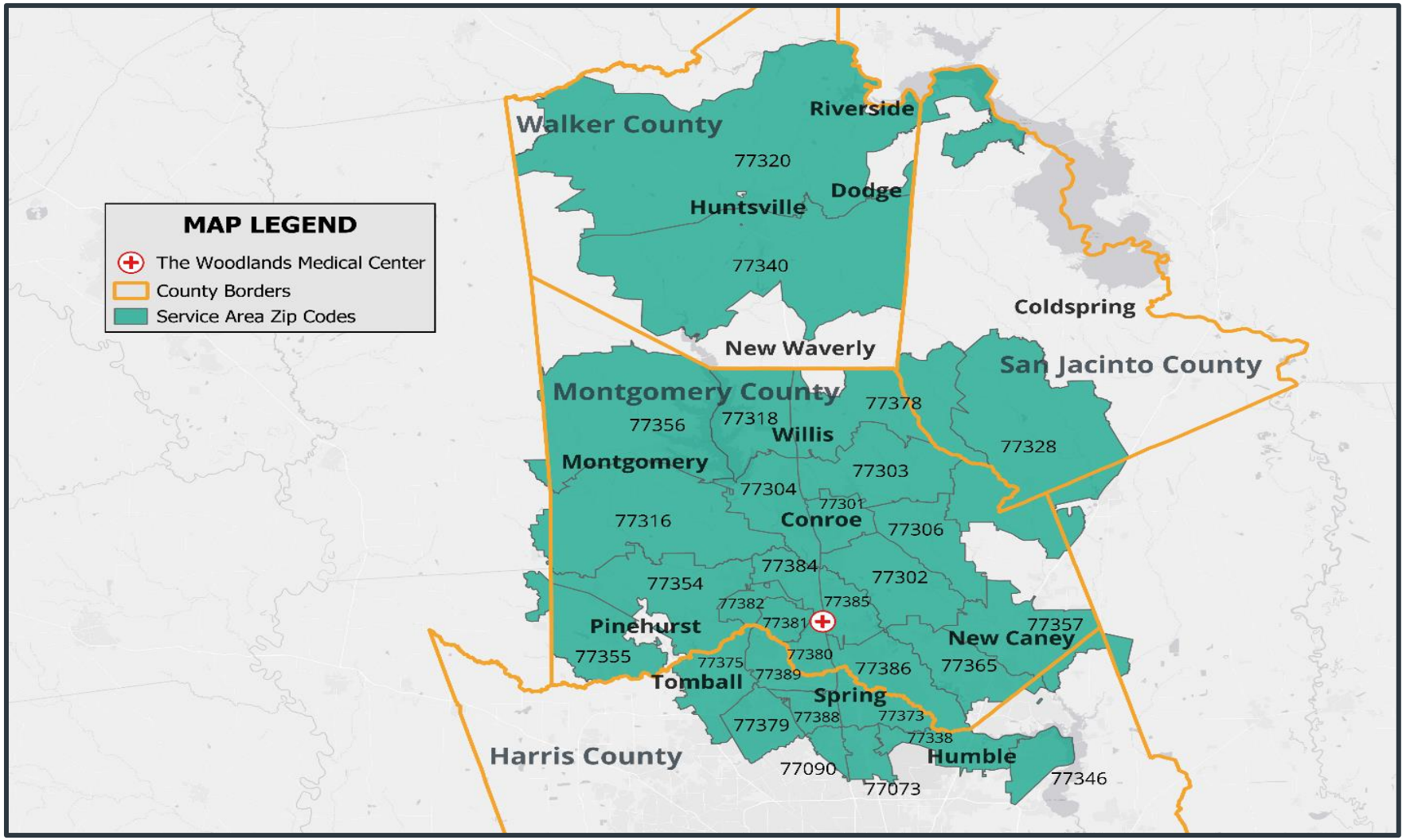
MEMORIAL HERMANN

Appendices

Appendix A. Memorial Hermann The Woodlands Medical Center Supplementary Findings

The MSA for Memorial Herman- The Woodlands Medical Center includes 31 zip codes in Harris, Montgomery, and Waller counties.

FIGURE 1. MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA

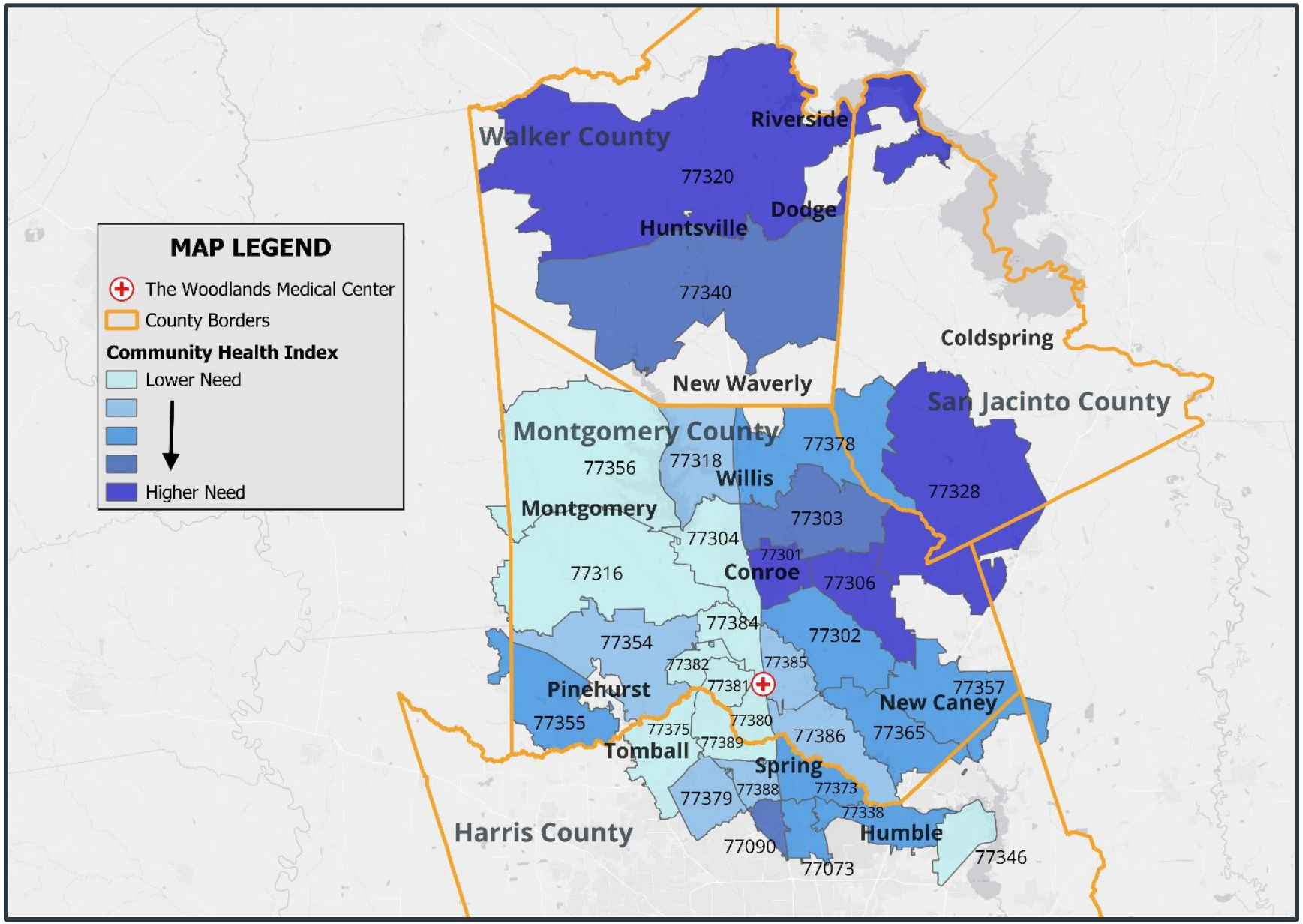


Key Findings: Access to Care

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 The Woodlands Medical Center MSA, the zip codes with the highest CHI scores are:

- 77328 (CHI=89.6)
- 77306 (88.3)
- 77320 (81.0)

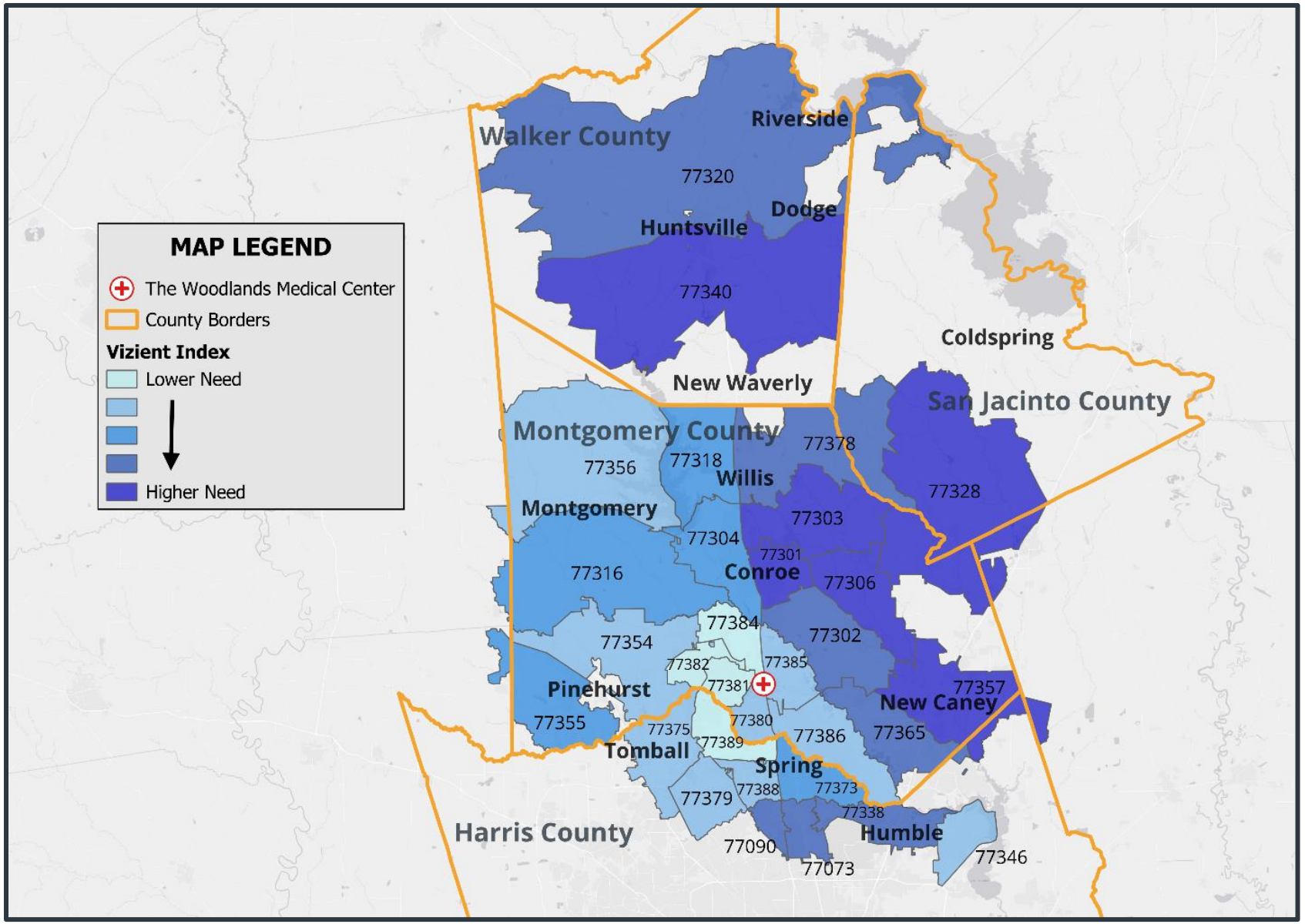
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN THE WOODLANDS MEDICAL CENTER MSA



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 Woodlands Medical Center MSA, the zip codes with the greatest healthcare needs, based on this index score, are:

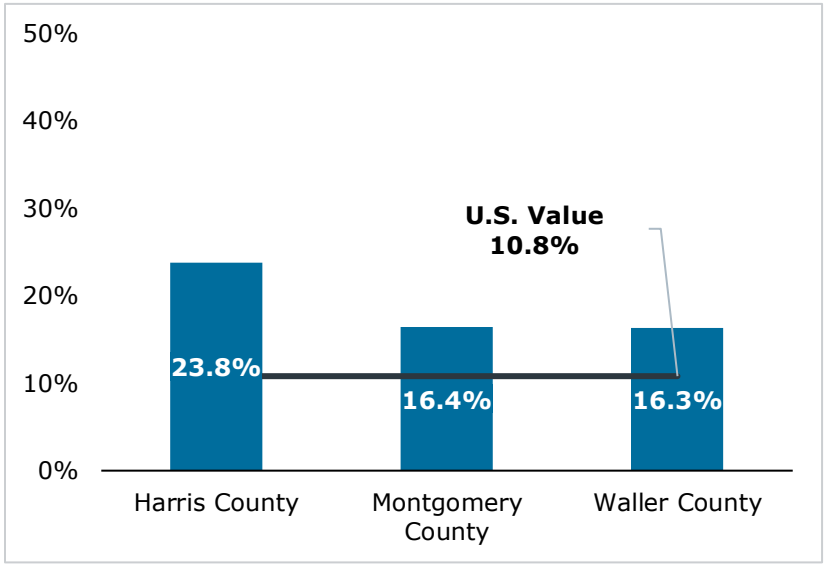
- 77328 (VVI=1.19)
- 77306 (1.18)
- 77357 (1.05)
- 77303 (1.03)

FIGURE 3. VIZIENT SCORE BY ZIP CODE: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA



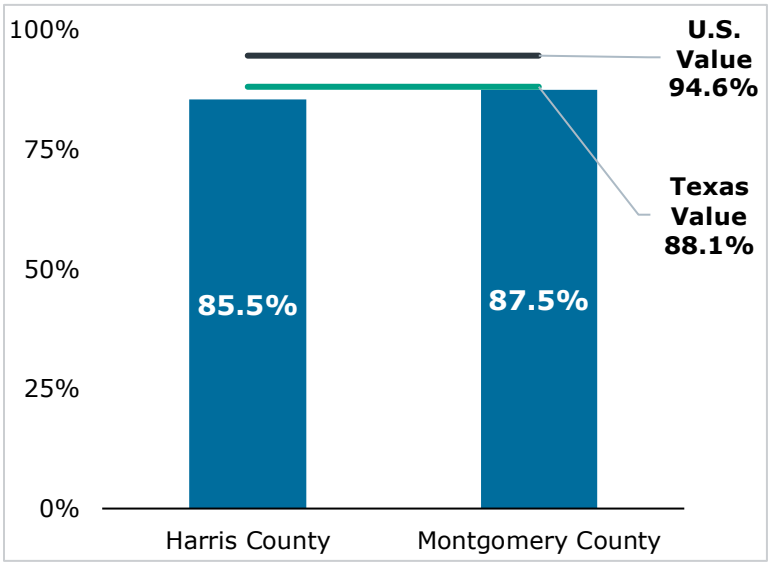
The following figures illustrate indicators of concern in Harris and/or Montgomery and/or Waller counties, based on scoring of secondary data related to **Access to Care.**

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



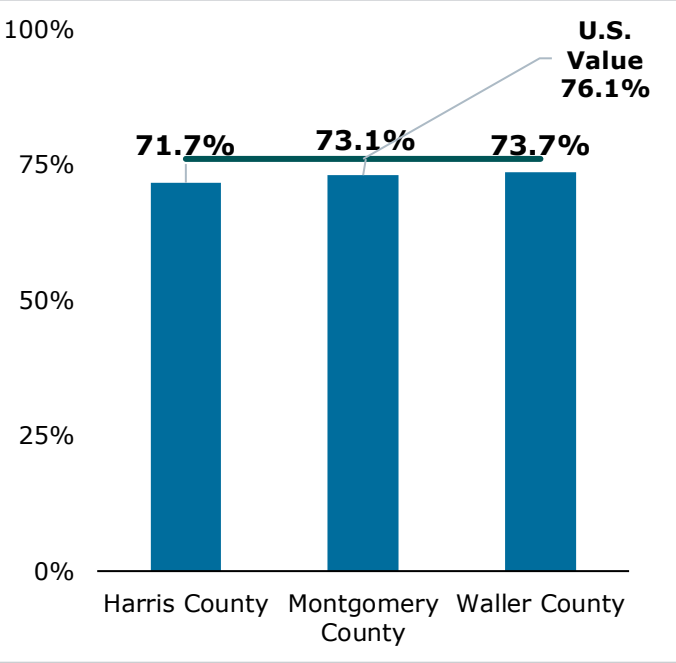
CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



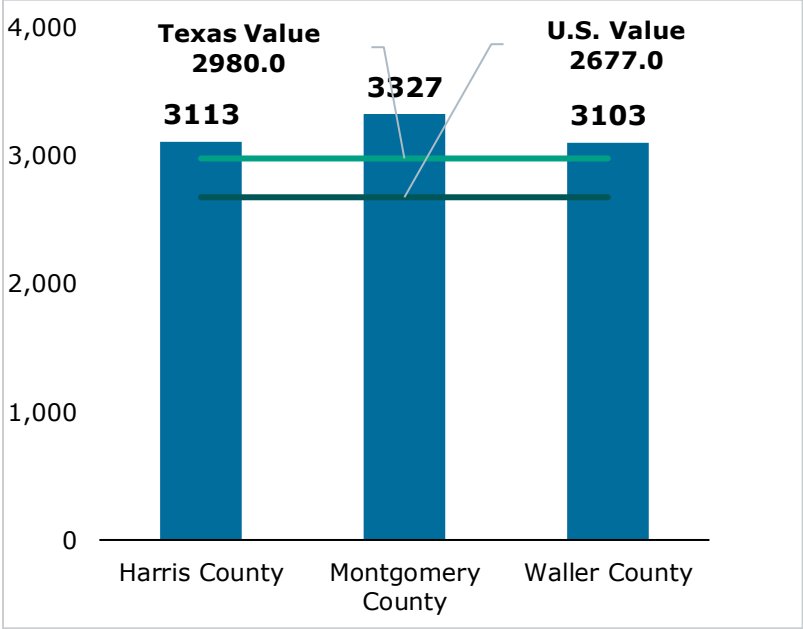
American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



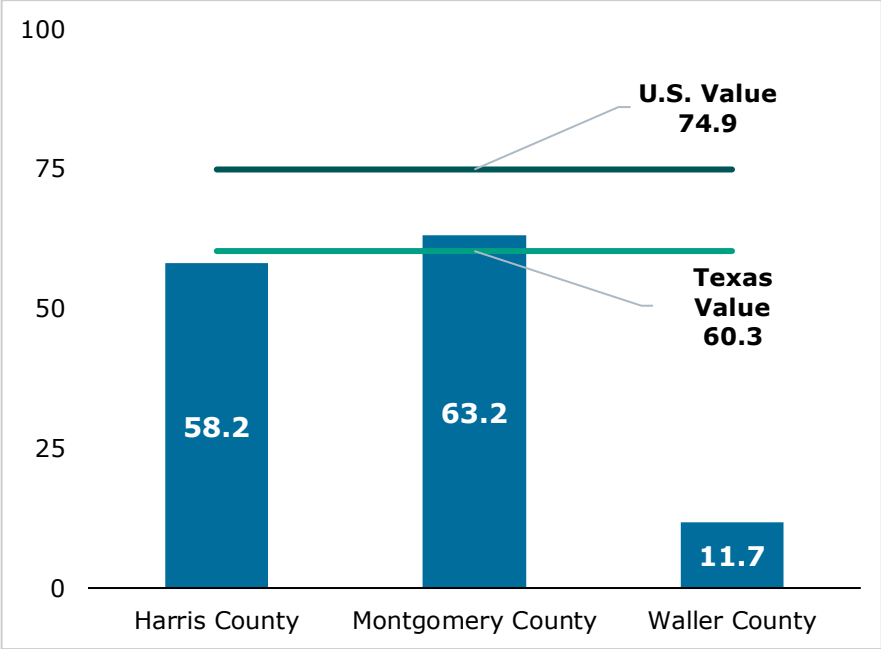
CDC – PLACES (2022)

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



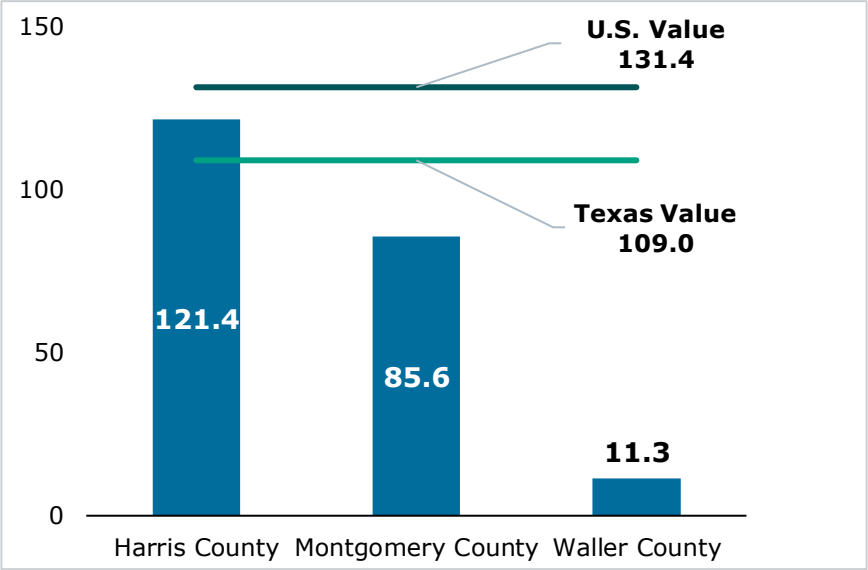
Centers for Medicare & Medicaid Services (2022)

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)

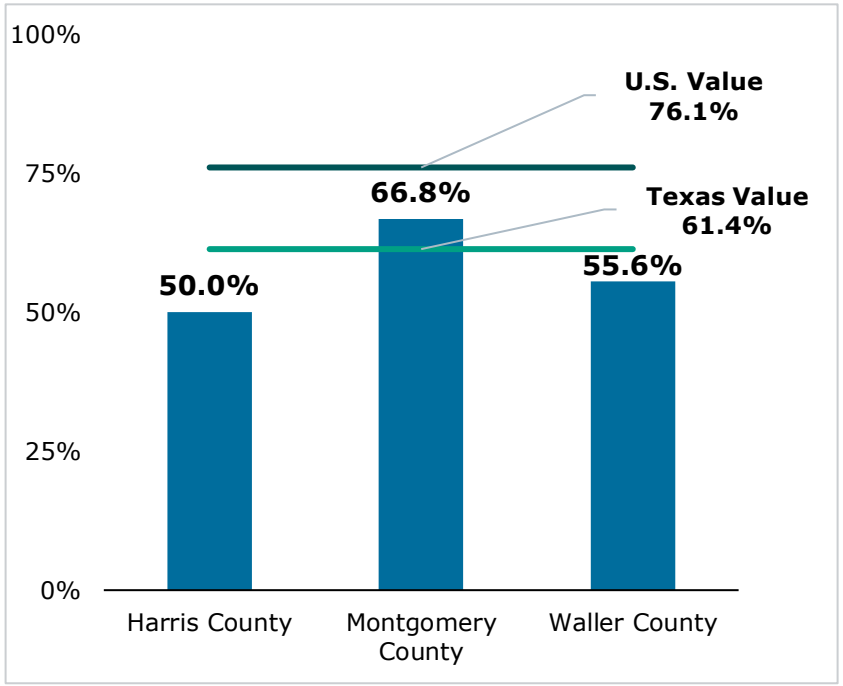


County Health Rankings (2023)

Key Findings: Maternal & Infant Health

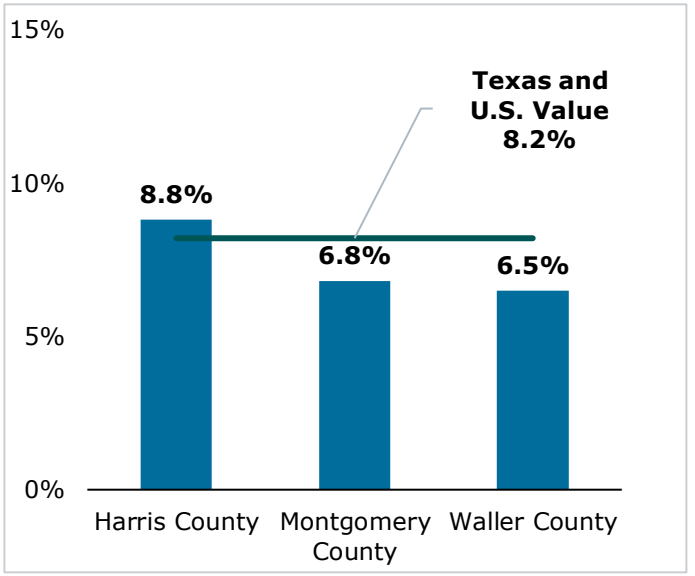
The following figures illustrate indicators of concern in Harris and/or Montgomery and/or Waller counties, based on scoring of secondary data related to Maternal and Infant Health.

FIGURE 10. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



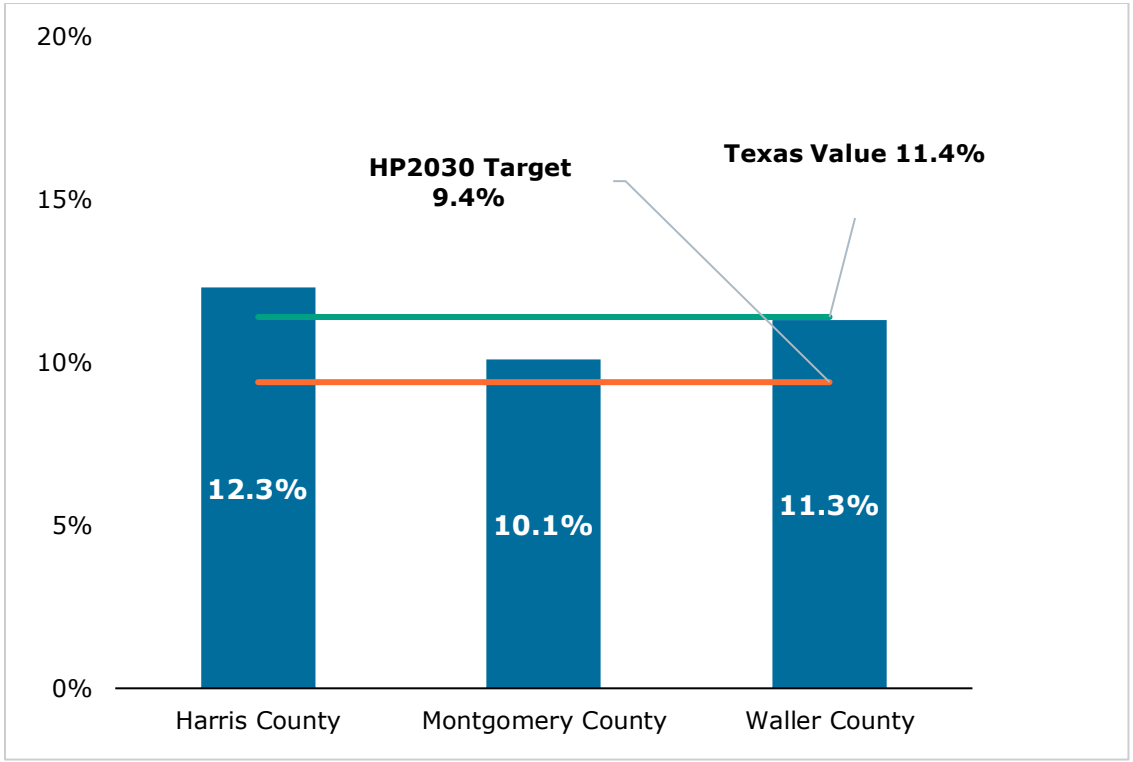
Texas Department of State Health Services (2020)

FIGURE 11. BABIES WITH LOW BIRTHWEIGHT



Texas Department of State Health Services (2020)

FIGURE 12. PRETERM BIRTHS

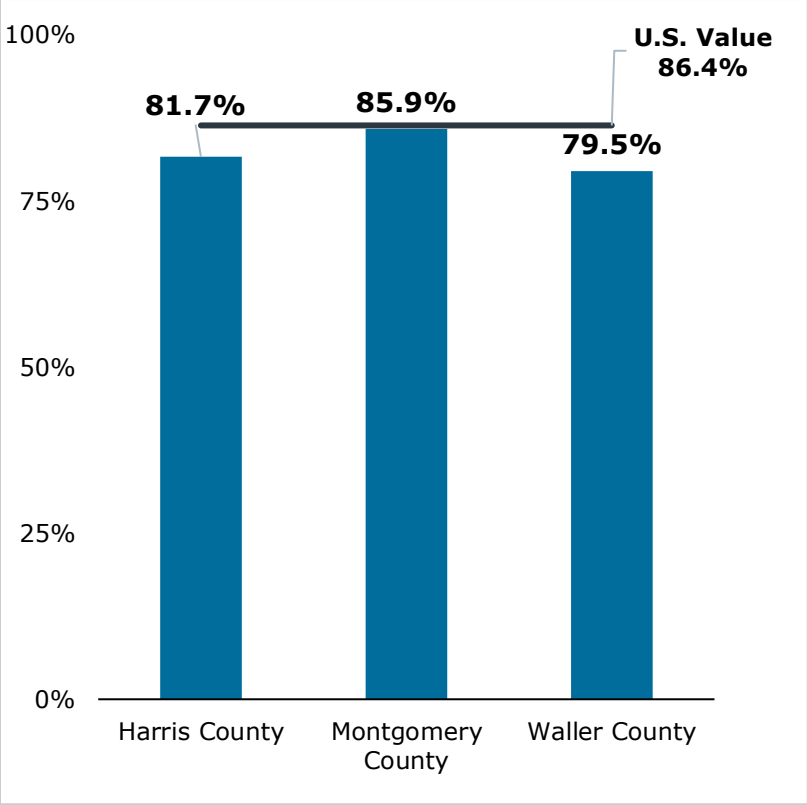


Texas Department of State Health Services (2021)

Key Findings: Chronic Condition Prevention & Management

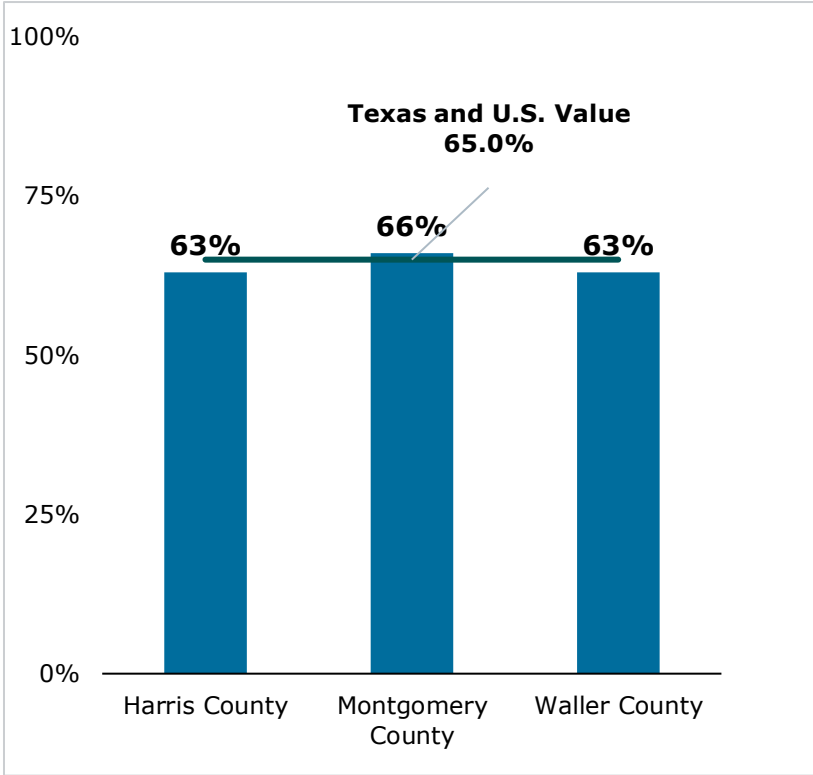
The following figures illustrate indicators of concern in Harris and/or Montgomery and/or Waller counties, based on scoring of secondary data related to Chronic Condition Prevention & Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



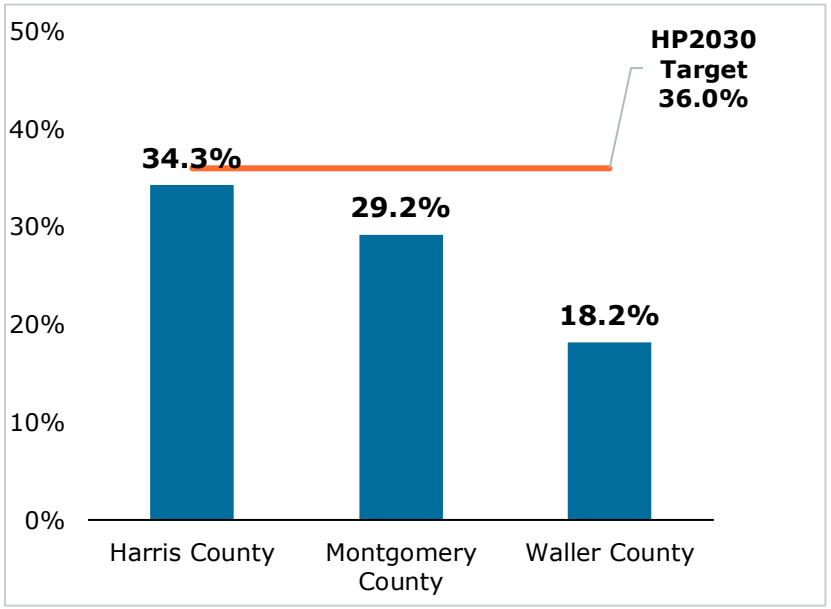
CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



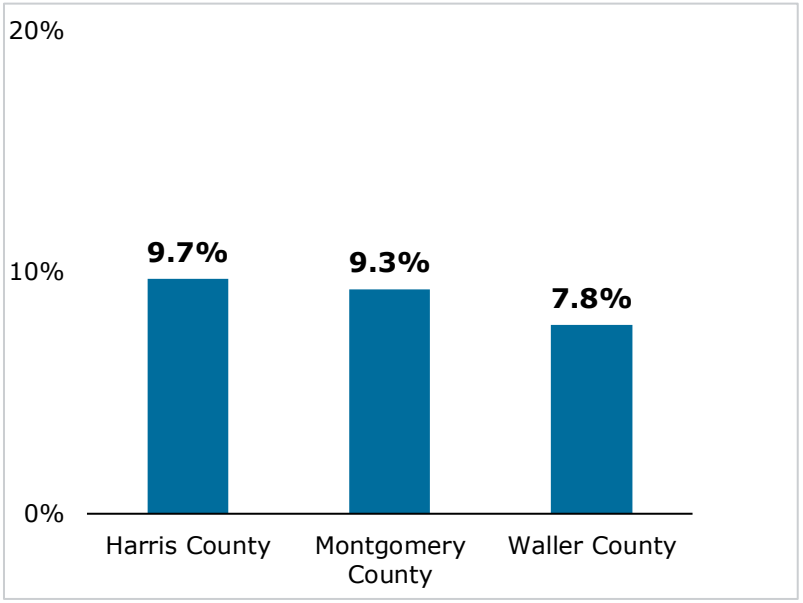
Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



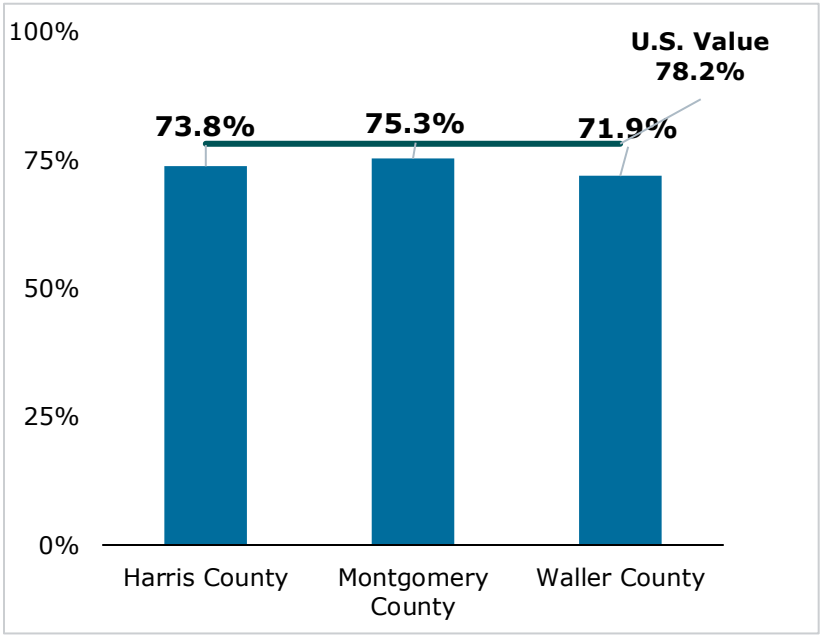
CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



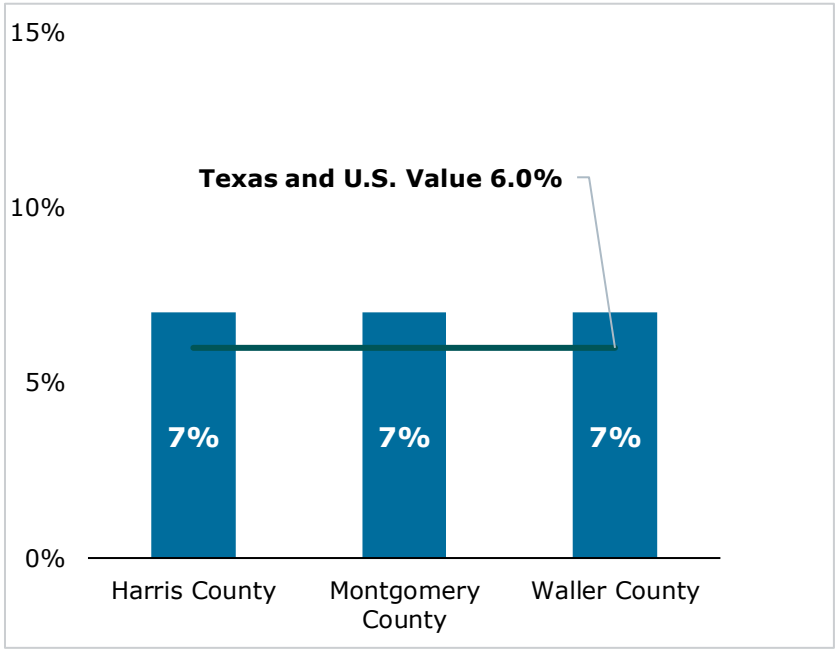
CDC (2021)

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



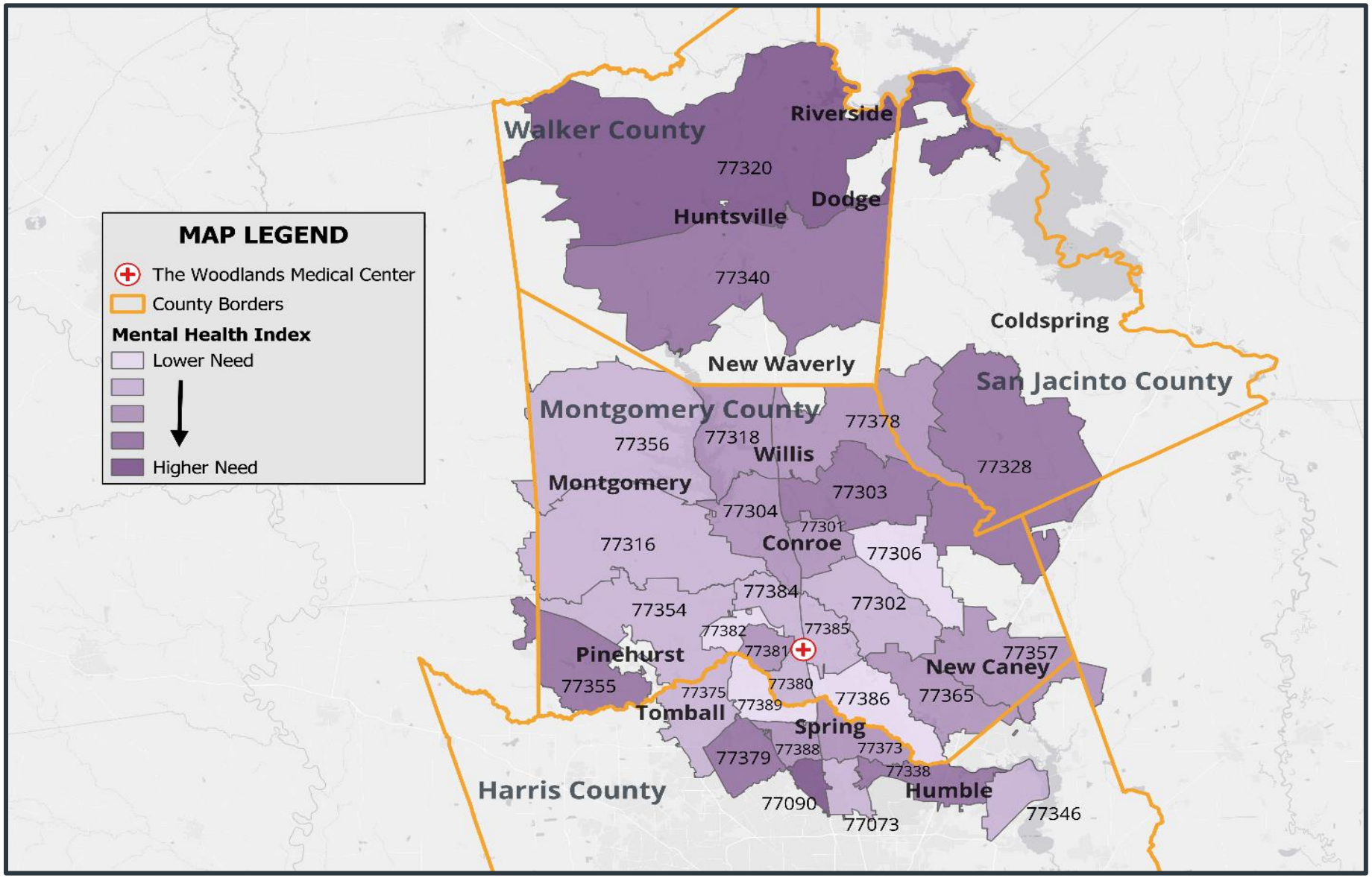
Centers for Medicare & Medicaid Services (2022)

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 Memorial Hermann Woodlands Medical Center MSA, the zip codes with the highest MHI scores are:

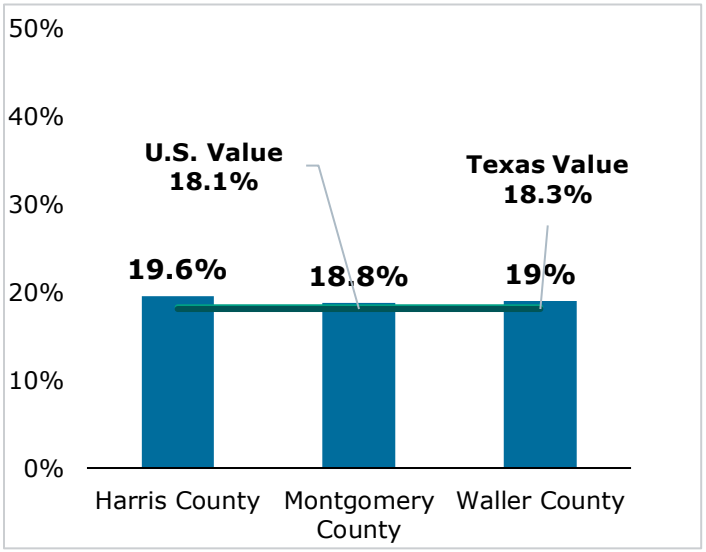
- 77090 (MHI=82.1)
- 77320 (75.7)

FIGURE 19. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S MENTAL HEALTH INDEX BY ZIP CODE: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA



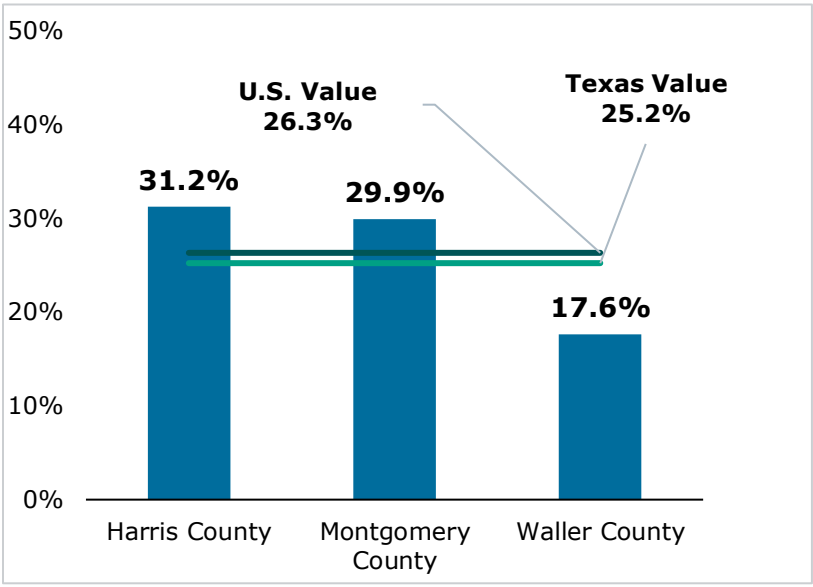
The following figures illustrate indicators of concern in Harris and/or Montgomery and/or Waller counties, based on scoring of secondary data related to Mental Health and Substance Use.

FIGURE 20. ADULTS WHO DRINK EXCESSIVELY



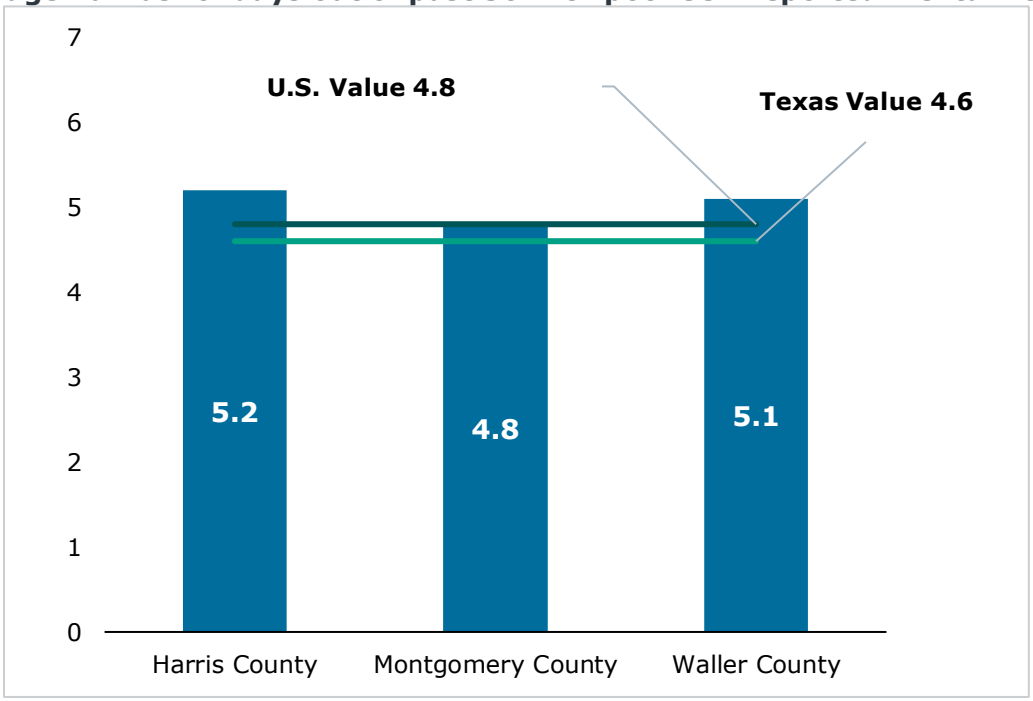
County Health Rankings (2021)

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)



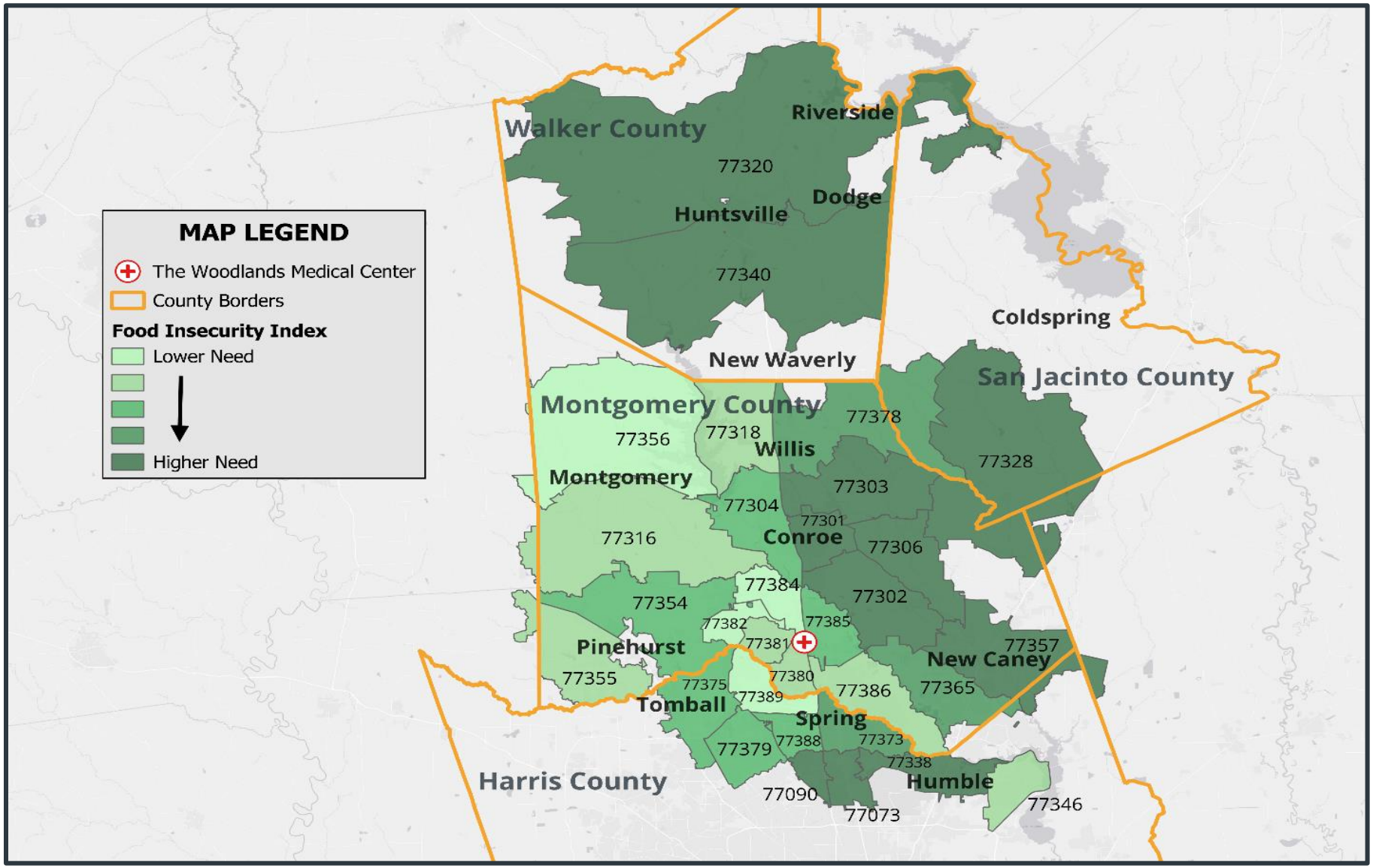
County Health Rankings (2021)

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 Woodlands Medical Center MSA, the zip codes with the highest FII scores are:

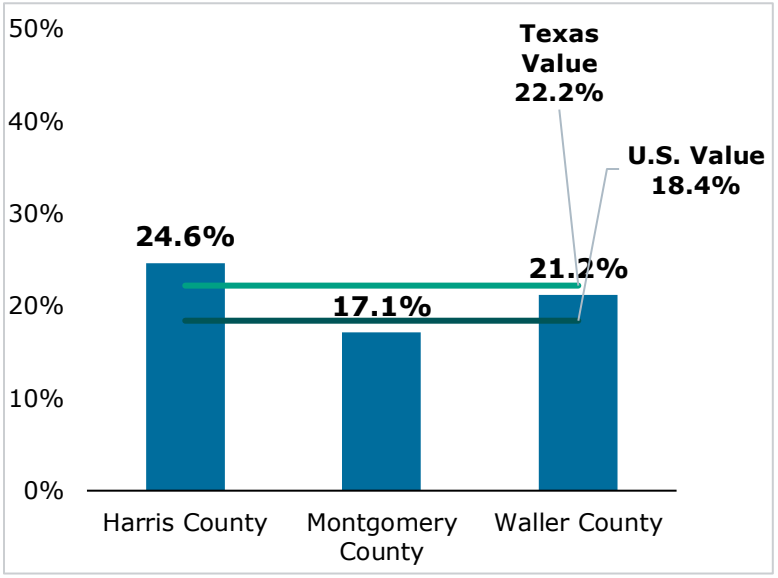
- 77090 (FII=97.6)
- 77340 (91.7)
- 77301 (89.0)
- 77328 (88.3)
- 77073 (87.8)
- 77320 (87.2)

FIGURE 23. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S FOOD INSECURITY INDEX BY ZIP CODE: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA



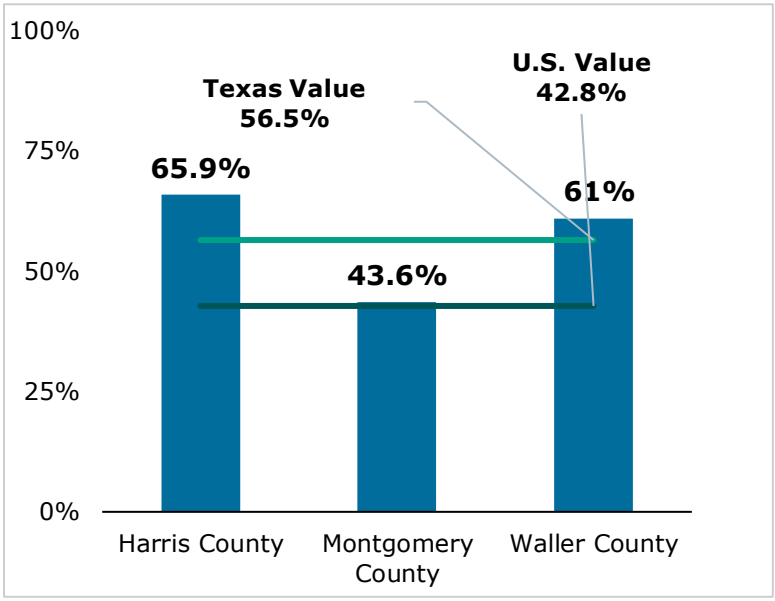
The following figures illustrate indicators of concern in Harris and/or Montgomery and/or Waller counties, based on scoring of secondary data related to Access to Healthy Food.

FIGURE 24. CHILD FOOD INSECURITY RATE



Feeding America (2022)

FIGURE 25. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM



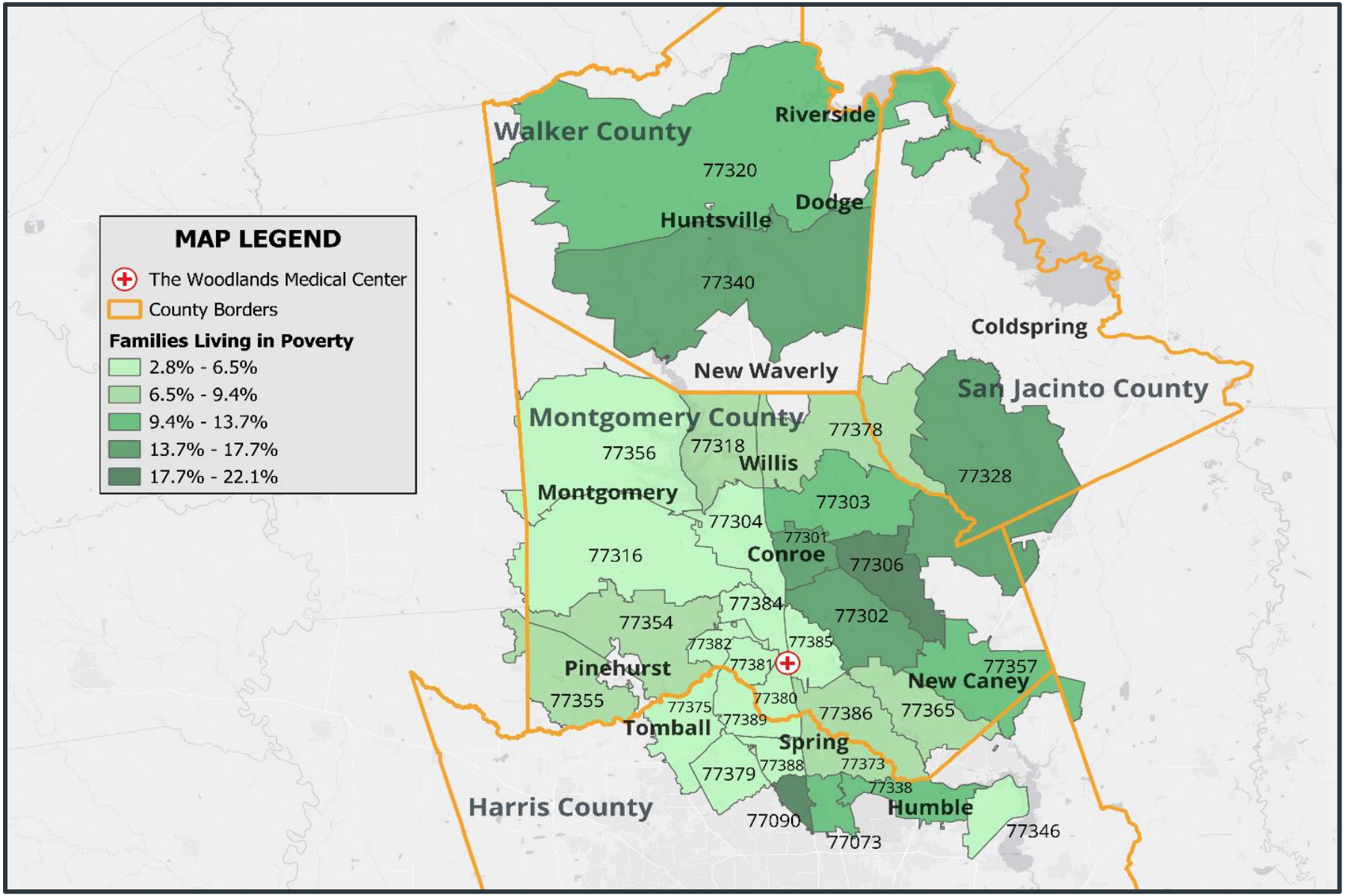
National Center for Education Statistics (2022-2023)

Key Findings: Economic Opportunity

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

- 77090 (22.1%)
- 77306 (18.9%)
- 77328 (17.7%)
- 77301 (17.0%)
- 77302 (15.4%)

FIGURE 26. POVERTY BY ZIP CODE: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA

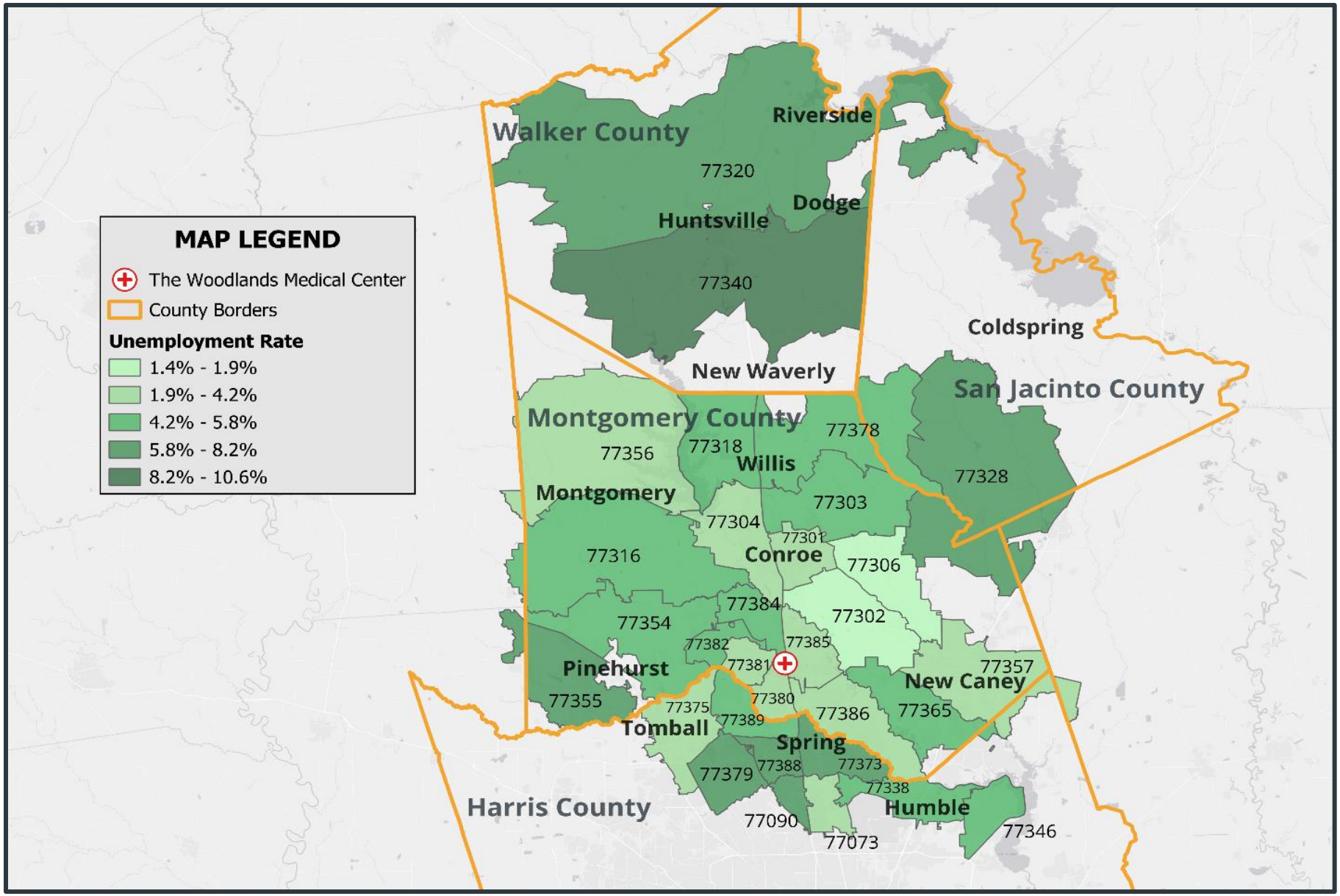


Claritas (2024)

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

- 77340 (10.6%)
- 77328 (8.2%)
- 77379 (8.0%)
- 77320 (7.7%)
- 77355 (7.6%)
- 77090 (6.7%)
- 77373 (6.5%)

FIGURE 27. UNEMPLOYMENT BY ZIP CODE: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA

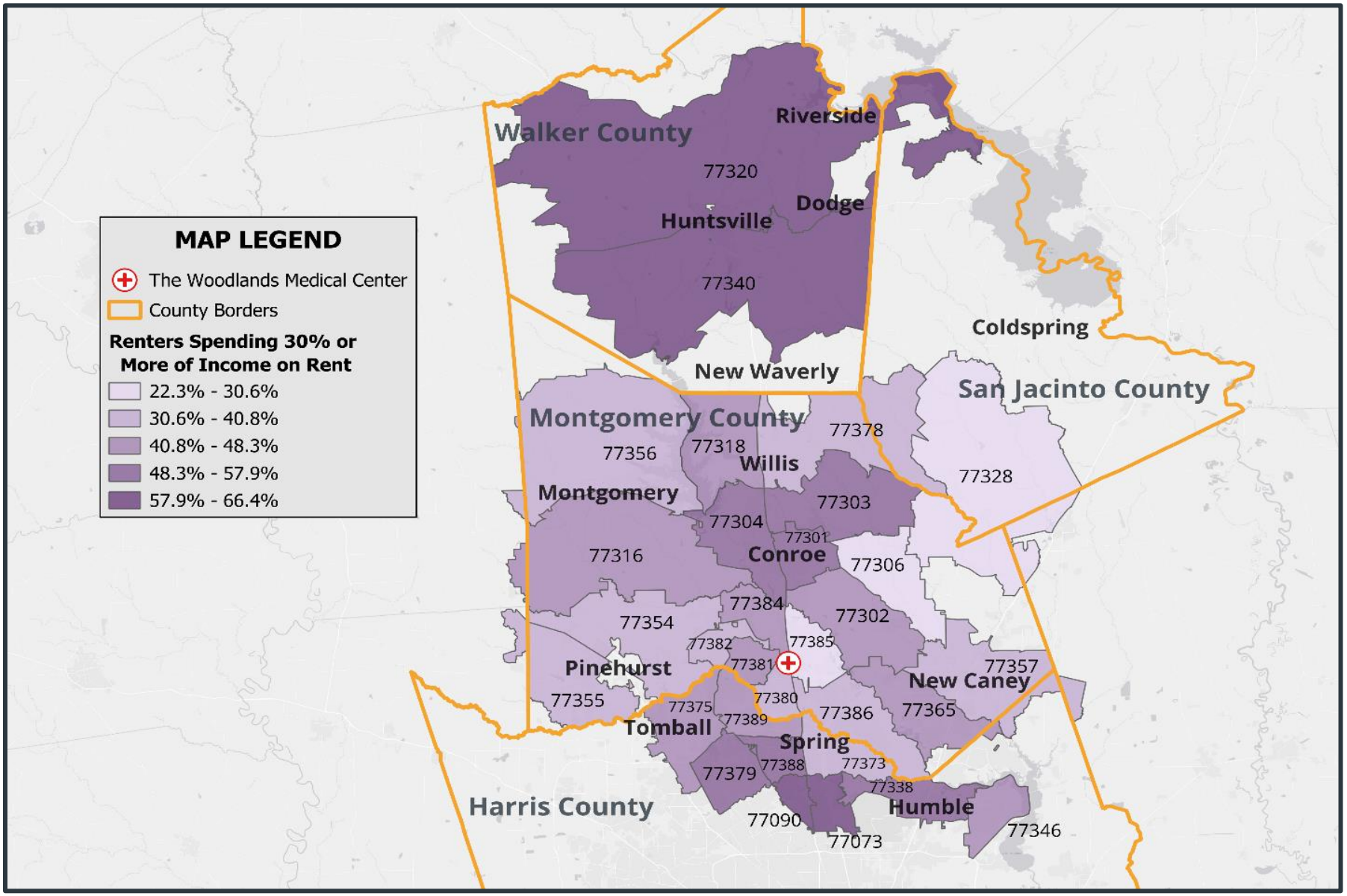


Claritas (2024)

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

- 77320 (66.4%)
- 77090 (65.9%)
- 77073 (62.1%)
- 77340 (61.3%)

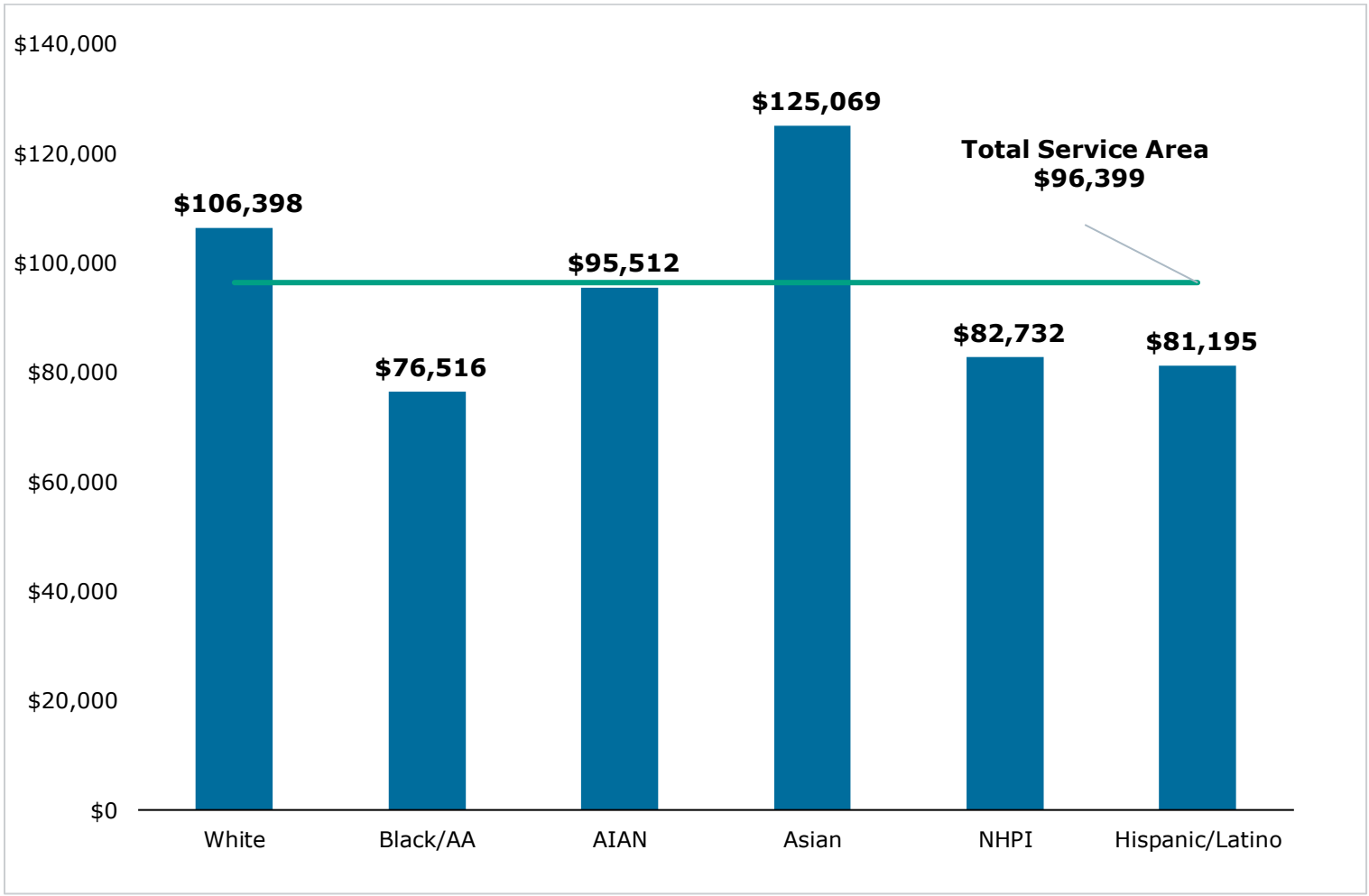
FIGURE 28. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA



American Community Survey (2018-2022)

Across the Memorial Hermann Woodlands Medical Center MSA, income differs substantially by race and ethnicity. The median household income for Black/African American is $20,000 lower than the overall median household income, while the median household income for Native Hawaiian/Pacific Islander and Hispanic/Latino is more than $10,000 below the overall median.

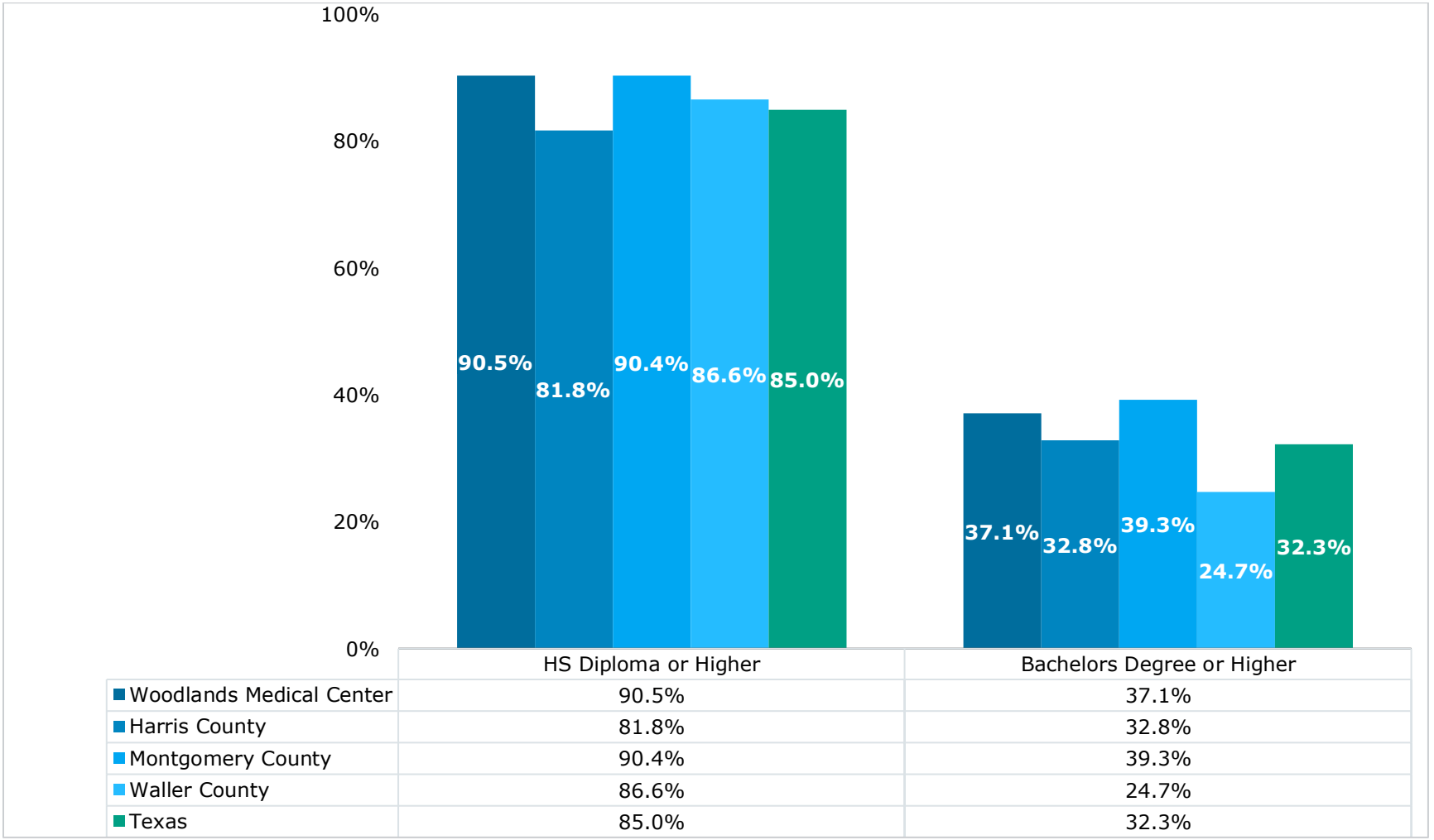
FIGURE 29. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: MEMORIAL HERMANN WOODLANDS MEDICAL CENTER MSA



Claritas (2024)

Key Findings: Educational Access

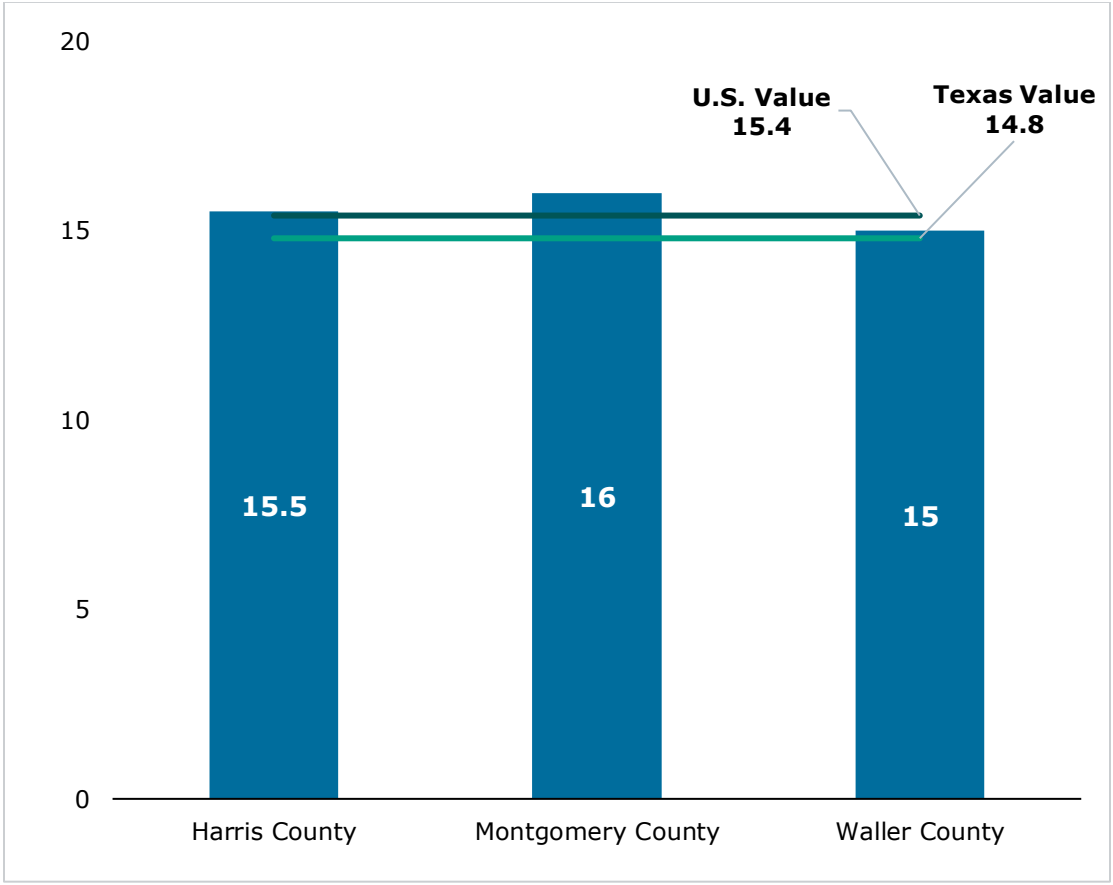
FIGURE 30. EDUCATIONAL ATTAINMENT



	HS Diploma or Higher	Bachelors Degree or Higher
Woodlands Medical Center	90.5%	37.1%
Harris County	81.8%	32.8%
Montgomery County	90.4%	39.3%
Waller County	86.6%	24.7%
Texas	85.0%	32.3%

Claritas (2024)

FIGURE 31. STUDENT-TO-TEACHER RATIO



National Center for Education Statistics (2022-2023)