Community Health Implementation Strategy

TIRR Memorial Hermann

TIRR MEMORIAL HERMANN
Rehabilitation & Research

Table of Contents

At-a-Glance Summary

Community Served	TIRR Memorial Hermann, serving 5,881,535 persons living in 131 zip codes across 9 counties. TIRR Memorial Hermann is a registered trademark of the TIRR foundation.
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

- Expand access to care and wellness for patients with physical disabilities by developing partnerships and impact investment in accessible green spaces and parks, integrating adaptive fitness, therapy, and community health programming to reduce barriers to physical activity.
- Nurse Health Line - Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within greater Houston can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources.
- Open and expand rehabilitation locations across Houston to increase the number of clinics and services available for patients.

Access to Healthy Food

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

Chronic Conditions Prevention and Management

- 40% of MHHS patients screened at least 1 Non-Medical Driver of Health (NMDOH) with ≥50% high-risk receiving referral to resource support by FY28.
- Adaptive and Inclusive Sports - Provide opportunity for community members to participate in adapted physical activity including sports leagues. By FY28, increase equitable access to adaptive and inclusive recreation opportunities so that ≥60% of eligible participants report measurable improvements in at least one health or social determinant outcome (physical function, mental well-being, or community engagement), with ≥75% of returning participants maintaining or improving their outcome scores.
- To expand access to support groups by increasing the number of groups available across Greater Houston at TIRR Memorial Hermann facilities and improving recruitment efforts for participation in such groups.
- Weight Management – clinic efforts to help patients with weight management

Economic Opportunity and Educational Access

- Mental Health Well-being TIRR Memorial Hermann will provide screening, assessment and treatment services to rehab patient population while providing additional education to the broader patient and caregiver community on supporting these needs for overall improved health outcomes of community members.
- To ensure that ≥ 75% of Health Equity Academy students complete the program with ≥ 50% of program graduates admitted into a rehabilitation health professions degree program.

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

TIRR Memorial Hermann

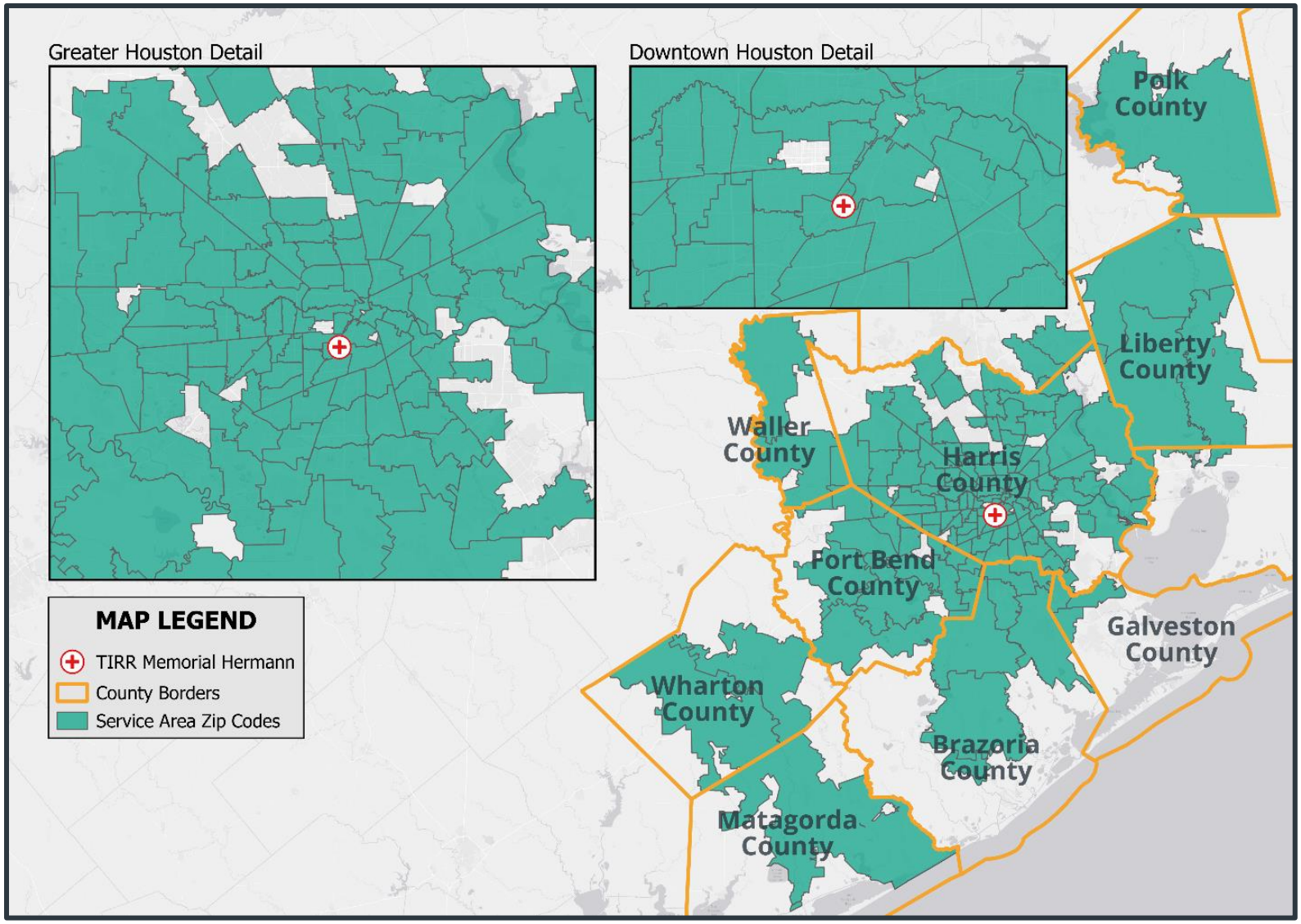
TIRR is a part of Memorial Hermann Health System (MHHS), one of the largest nonprofit health systems in Texas, with 17* hospitals and more than 6,600 affiliated physicians, 34,000 employees across 270 care delivery sites throughout the Greater Houston area.

TIRR Memorial Hermann does more than provide therapy. We provide rehabilitation for children and adults with a disabling injury or illness and help people regain the skills and confidence they need to re-integrate into the community and continue living full and meaningful lives. Our teams develop personalized goals and treatment plans to maximize independence, restore function, and improve a patient's quality of life after a traumatic brain injury, stroke, spinal cord injury and more. TIRR Memorial Hermann is ranked #2 in the nation for medical rehab by *U.S. News & World Report* 2025- 2026 "Best Hospitals" list. Learn more at memorialhermann.org/TIRR.

Description of the Community Served

TIRR Memorial Hermann Metropolitan Service Area (MSA) has a population of approximately 5,881,535 persons serving 131 zip codes across 9 counties. See Appendix A Supplementary Findings for secondary data related to health care needs throughout the region.

FIGURE 1. TIRR MEMORIAL HERMANN METROPOLITIAN SERVICE AREA BY ZIP CODES



Source: MHHS facilities values from Claritas (2024)

Community Assessment and Significant Needs

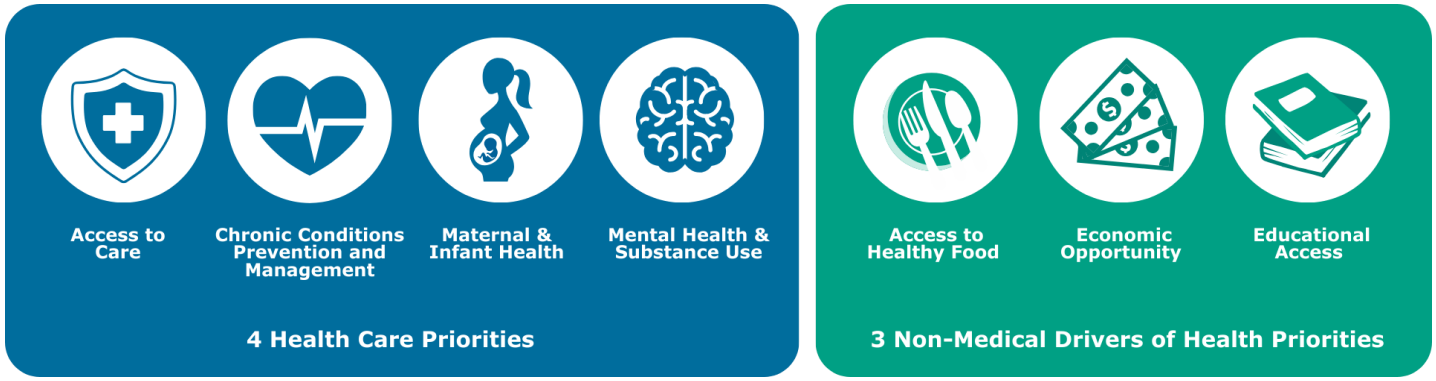
The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted on June 26, 2025. The CHNA report includes:

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

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

Significant Health Needs

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



Significant Needs the Hospital Does Not Intend to Address

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

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

TIRR Memorial Hermann Hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Following the identification of the seven priority health needs, the Community Benefit team began subsequent work on implementation planning. Hospital contacts and participants were identified, and representation included TIRR Memorial Hermann, and other hospital leadership.

During initial planning meetings, representatives from HCI and TIRR Memorial Hermann 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 TIRR Memorial Hermann 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 TIRR Memorial Hermann 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 following pages:

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

TIRR Memorial Hermann Implementation Plan

Community Priority: Access to Care

- **Primary Prioritized Need Area: Access to Care**
- **Secondary Prioritized Need Area: Economic Opportunity**

FY26-FY28 Goal: Expand access to care and wellness for patients with physical disabilities by developing partnerships and impact investment in accessible green spaces and parks, integrating adaptive fitness, therapy, and community health programming to reduce barriers to physical activity.

FY26 Objective: To complete an assessment of access barriers and existing greenspace and park assets to establish a baseline for improving care and wellness opportunities for patients with physical disabilities residing in priority target ZIP communities.

FY26 KPIs:

- Completion – Greenspace needs assessment for priority communities from which TIRR patients primarily reside
- Number – patients identified with physical disabilities residing in target 58 ZIPs

Strategic Approach

Programs/Activities	Responsible	Baseline	Milestones/ Measures of Success FY26
Greenspace and Physical Disability Patient Discovery Initiative	• Community Health Network • TIRR Memorial Hermann	Baseline TBD post- FY26	• Number – TIRR patients residing in priority ZIP • Number – greenspaces in surrounding priority ZIPs accessible based on determined disabilities

Target/Intended Population(s):

- Target high-poverty ZIP communities; Uninsured; Medicaid; ALICE populations served via TIRR

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

- N/A

Collaboration Partners (Internal and External):

- Local nonprofit partners and collaboratives, Strategy Division, TIRR Memorial Hermann

- **Primary Prioritized Need Area: Access to Care**

FY26-FY28 Goal: Nurse Health Line - Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within greater Houston can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources.

FY26 Objective: Expand access to care for Greater Houston community member, including those with complex rehab needs, by implementing a 24/7 Nurse Health line resource that provides clinical guidance, care navigation, and referrals to appropriate services, improving timely access and reducing unnecessary emergency department utilization.

FY26 KPIs:

- Number—calls received to the Nurse Health line from Greater Houston residents
- Percent—callers connected to appropriate follow-up care within 72 hours
- Percent—high-risk rehab patients utilizing the service
- Percent—caller satisfaction rate (via post-call survey)

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Nurse Health Line referral protocols Outpatient Clinic and Acute Rehab Discharge Integrations	• OMC leadership • Case Management	Baseline TBD post- FY26	• Protocol implemented by Q3 FY26 – 80% of eligible patients receive Nurse Health Line info at discharge
Nurse Health Line staff Training for complex Rehab patients	• Nurse Health Line Program Manager • OMC Leadership	Baseline TBD post- FY26	• Rate - 100% of Nurse Health Line staff trained within first 60 days of launch. Post-training assessment scores all within passing.

Target/Intended Population(s):

- All payer types; Broader Greater Houston community

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

- Since we cannot staff 24/7 in-house, we can leverage Memorial Hermann's existing Nurse Health Line (or another accredited nurse triage vendor) to provide after-hours and weekend coverage. Negotiate an integration agreement so their staff is trained to handle calls specific to rehab and complex populations.
- Develop call routing so the Nurse Health line is accessible via:
  - A dedicated direct phone number for community use
  - An after-hours voicemail/auto-attendant option on the main clinic number that redirects to the Nurse Health line

- Any urgent follow-up items are emailed/faxed to clinic for next day review.
- No additional clinic staffing cost for after-hours coverage.
- 24/7 access for patients and community without operational overhaul.
- Provide a "Resource Playbook" with clinic contact details, local urgent care, program resources, home health, and community resource contacts, escalation guidelines.
- Review technology platform options to potentially transcribe voicemails and/or enhance ability to triage patient needs.

Collaboration Partners (Internal and External):

- Internal: Outpatient Clinic and Acute Rehab Medical Directors; Case Management and Social Work teams, Marketing and Communications, IT/HER Support, Quality & Performance Improvement Team
- External: Memorial Hermann Nurse Health Line Team, Local health departments, Rehab-focused nonprofit organizations, Insurance partners and charity care programs, EMS and urgent care centers

- **Primary Prioritized Need Area: Access to Care**

FY26-FY28 Goal: Open and expand rehabilitation locations across Houston to increase the number of clinics and services available for patients.

FY26 Objective: Promote and host grand openings for TIRR Memorial Hermann Pediatric Outpatient- Katy, TIRR Memorial Herman Outpatient Rehabilitation – Cypress and celebrate the expansion of TIRR Memorial Hermann Outpatient Rehabilitation – The Woodlands.

FY26 KPIs:
- Number—attendees at each event
- Number—website and social media impressions

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Promotion of new locations	TIRR Memorial Hermann Marketing	n/a	• Number- new patients at each location (target: 50)

Target/Intended Population(s):
- All potential patients and referring physicians in the Greater Houston area

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

Collaboration Partners (Internal and External):
- TIRR Business Development, TIRR Public Relations team; Community partners in Katy, Cypress and The Woodlands

Community Priority: Access to Healthy Food

- **Primary Prioritized Need Area: Access to Healthy Food**

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—admitted patients screened for food insecurity
- Percent—patients receiving information on how to pursue food assistance
- Number—patients identified as high risk for food insecurity added as an automatic referral for transitional navigator f/u

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Social Work Discharge Planning Assessment – Food Insecurity Screening	TIRR Memorial Hermann Social Work	100%	• Number - completed screenings
Food Assistance Application Support	TIRR Memorial Hermann Social Work	TBD post FY26	• Number – patients/families receiving information on how to get help with food (211, MH CRC, Houston Food Bank, etc.) and assistance in completing applications as needed.
Transitional Navigation for Food Insecure Patients	TIRR Memorial Hermann Social Work	TBD post FY26	• Number – referrals to Transitional Navigator based on patients identified as high-risk for food

Target/Intended Population(s):

- All IPR patients at TIRR

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

- Most food pantries are generally specific to residence zip code and have eligibility criteria, so referrals to larger organizations that help connect people to these specific resources is more efficient and time manageable
- Any patients identified as high-risk for food insecurity by self-report or SW assessment will be provided with information/assistance to pursue/apply for food assistance
- Any patients identified as high-risk for food insecurity by self-report or SW assessment will be automatically referred to Transitional Navigator for post discharge follow-up.

Collaboration Partners (Internal and External):

- 211 service, Memorial Hermann Community Resource Centers, Houston Food Bank

- **Primary Prioritized Need Area: Access to Health 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, with a target of 50% of identified patients receive direct access to food support and community-based nutrition resources.

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			
Please provide any additional insights or explanations on the initiative(s) listed. • Community Resource Centers are in four locations across Greater Houston but are working to expand to additional sites to meet the needs of Memorial Hermann patients and community members. Focused on addressing NMDOH. • Food as Health is the umbrella program managing all food and nutrition programs for Memorial Hermann including operating food pantries, community gardens and more.			
Collaboration Partners (Internal and External): • Ambulatory Services; local food nonprofit agencies			

Community Priority: Chronic Disease Management and Prevention

- **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 TIRR Memorial Hermann patients will be screened for at least 1 NMDOH, with ≥50% identified as high-risk receiving referral to resource support.

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 - positive patient satisfaction scores
MyChart NMDOH Assessment Initiative	Community Health Network	Baseline TBD post- FY26	• Number - MyChart NMDOH Assessments completed • Percent - patients indicating "Yes" for referral support upon MyChart NMDOH assessment completion • Percent – routed to CHW Hub

Target/Intended Population(s):

- All payer types; broader Greater Houston community

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

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

Collaboration Partners (Internal and External):

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

- **Primary Prioritized Need Area: Chronic Condition Prevention & Management**

FY26-FY28 Goal: Adaptive and Inclusive Sports - Provide opportunity for community members to participate in adapted physical activity including sports leagues. By FY28, increase equitable access to adaptive and inclusive recreation opportunities so that ≥60% of eligible participants report measurable improvements in at least one health or social determinant outcome (physical function, mental well-being, or community engagement), with ≥75% of returning participants maintaining or improving their outcome scores.

FY26 Objective: By the end of FY26, enroll at least 200 unique participants in adaptive sports/inclusive recreation and therapeutic recreation outings, with ≥50% showing a clinically or self-reported improvement in physical activity levels, mental well-being (PHQ-9, GAD-7), or community participation scores.

FY26 KPIs:

- Number—patients in therapeutic/recreation outings
- Percent—participants with improved self-reported mental well-being (PHQ-9 or GAD-7 reduction ≥2 points)
- Percent—participants with improved physical function scores (patient-reported mobility or independence measures)
- Percent—participants who report increased weekly physical activity minutes (≥150 min/week threshold)
- Percent—participation retention rate from one season/year to the next
- Number—new partnerships with community organizations serving underrepresented or rural populations
- Percent— participants from historically underserved demographics (equity measure)

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26

Digital Engagement	• TIRR Memorial Hermann Marketing • TIRR Memorial Hermann Finance • TIRR Memorial Hermann Business Development	Baseline TBD post- FY26	• Number – website visitors • Number – social media impressions and landing page views
Adaptive Sports Programs	TIRR Memorial Hermann Adaptive Sports team	151 participants from FY25	• FY26 Milestone: ≥175 sports participants; ≥50% with improved physical activity levels; ≥40% with improved mental well-being
Therapeutic and Inclusive Recreation Outings	Therapeutic Recreational Team	284 participants FY25	• FY26 Milestone: ≥300 participants; ≥50% with increased community engagement scores
Inclusive Recreation and Exercise Events	• Recreation and Arts Inclusion Lead and Committee • Exercise is Medicine Lead and Committee	New	• FY26 Milestone: ≥50% of participants report adopting at least one new activity into their routine/lifestyle
Targeted Outreach to Underserved Groups	• TIRR Marketing • Manager • Adapted Sports/Community Outreach team	New	• FY26 Milestone: ≥30% of participants from underserved/rural backgrounds

Target/Intended Population(s):

- All TIRR Memorial Hermann patients (inpatient and outpatient), Greater Houston community with emphasis on individuals with disabilities, chronic conditions, and those from underserved or rural areas.

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

- Participating in physical activity and on a team has a proven profound positive effect on weight management, mental health, healthy social skill development, independence and more for this population.
- Participation in adaptive sports and inclusive recreation improves not only physical health but also mental health, independence, and social connectedness. By embedding outcome measures (physical function, mental well-being, community participation) into all programming, we will shift from solely counting attendance to demonstrating tangible, life-enhancing results for participants.
- Adaptive Sports Programs include wheelchair rugby, basketball, cycling, pickleball, golf

Collaboration Partners (Internal and External):

- Internal: TIRR Marketing, Adapted Sports Coordinators, Manager and Director of Adapted Sports/Community Outreach, Recreation and Arts Inclusion Lead and Committee, Exercise is Medicine Lead and Committee

- External: Local nonprofits, local businesses that provide inclusive recreation and arts activities, school districts, municipal recreation departments, disability advocacy groups, health care providers, and veteran support organizations

- **Primary Prioritized Need Area: Chronic Condition Prevention & Management**

FY26-FY28 Goal: To expand access to support groups by increasing the number of groups available across Greater Houston at TIRR Memorial Hermann facilities and improving recruitment efforts for participation in such groups.

FY26 Objective: By end of FY26, initiate two new support groups at TIRR Memorial Hermann facilities as well as increase attendance at existing groups.

FY26 KPIs:
- Percent—attendance increase over course of the fiscal year
- Number—new support groups meetings over FY26

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Support Group Outreach	• TIRR Memorial Hermann Marketing • TIRR Memorial Hermann Mental Health Lead and Committee	Initial attendance for meeting at start of fiscal year	• Number - initiation of 2 more support groups • Percent – increase of attendance at existing and new support groups by 15%

Target/Intended Population(s):

- All TIRR Memorial Hermann patients (inpatient and outpatient), Greater Houston community with emphasis on individuals with disabilities, chronic conditions, and those from underserved or rural areas.

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

- n/a

Collaboration Partners (Internal and External):

- Internal: TIRR Memorial Hermann and MHHS Marketing, Rehab Therapy Managers, Support Group Facilitators, Community Outreach Leads

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

FY26-FY28 Goal: Weight Management – clinic efforts to help patients with weight management

FY26 Objective: To implement a standardized weight management screening and referral process for all eligible adult patients (≥18 years) seen in the outpatient medical clinic, achieving at least an 85% completion rate for BMI and weight-related health risk screenings, and ensuring that at least 70% of patients identified as overweight/obese receive a tailored weight management plan and referral to available internal or external resources.

FY26 KPIs:

- Percentage—eligible patients screened for BMI and weight-related health risks at each clinic visit. (Target: ≥85% completion by Q4 FY26)
- Percentage—patients identified as obese (>30 BMI or >27 with comorbidities) who receive a documented weight management plan and referral. (Target: ≥50% completion by Q4 FY26)

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
EMR-integrated weight management screening tool	• Clinic Nurse Manager • Nursing Staff • MAs	Baseline TBD post-FY26	• ≥85% screening rate achieved by June 2026
Patient education for maintaining health weight and resources	• Nursing Staff • System Communications	Baseline TBD	• ≥80% of identified patients receive education materials by June 2026
Referral pathway to internal dietitian/pharmacy support	• Clinic Nurse Manager • Patient Access Team • Dietitian • Pharmacy	Baseline TBD	• ≥50% of identified patients referred by June 2026

Target/Intended Population(s):

- Adults (≥18 years) seen in the outpatient medical clinic for any reason, with targeted focus on those with BMI ≥25 or obesity-related chronic conditions (diabetes, hypertension, hyperlipidemia).
- Greater Houston Area.
- Medicare, Medicaid, commercial insurance; attention to coverage options for weight management services.

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

- Limited in-house dietitian and pharmacy support necessitate leveraging community programs, virtual resources, and insurance wellness benefits.
- Screenings integrated into rooming process to avoid additional provider burden.
- Materials and counseling tailored to the diverse Greater Houston population.
- Epic EMR reporting to automate tracking and minimize manual data entry.
- Process designed for scalability with future staffing or grant opportunities.

Collaboration Partners (Internal and External):

- Internal: Primary Care Providers; Specialty Physicians (Endocrinology, Cardiology); Clinic Nursing Staff & Mas; Patient Access Team; Pharmacy; Dietitians; System Communications & Marketing; Quality Improvement Team
- External: Local dietitians (private practice and community health centers); YMCA Diabetes Prevention Program; Community weight management groups (e.g., Weight Watchers, hospital-based classes); Retail pharmacies offering weight loss counseling; Insurance-provided wellness programs; Virtual health platforms offering tele-nutrition and coaching

Community Priority: Economic Opportunity and Educational Access

- **Primary Prioritized Need Area: Educational Access**

FY26-FY28 Goal: Mental Health Well-Being – TIRR Memorial Hermann will provide screening, assessment and treatment services to rehab patient population while providing additional education to the broader patient and caregiver community on supporting these needs for overall improved health outcomes of community members.

FY26 Objective: To increase knowledge of mental health needs and resources among our patient communities and frontline clinical team members through expansion of targeted educational programs,

FY26 KPIs:

- Number - symposium registrations
- Percentage- response rate from Qualtrics Survey question "How much would you say the staff cared about you as a person?"

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Education Symposium: ""Beyond the Discharge: Psychosocial Adaptation Following Major Medical Events" on 5/16/26	Neurology	Baseline TBD post- FY26	• Rate - completion of educational activity • Number- attendees of symposium
Training and Education: Identification And Effective Referral for Psychological Concerns Among Patients	• Neurology • Outpatient leaders	84.7% for all TIRR OP	• Delivery of educational materials to all Rehab Network clinicians
Training and Education: Managing Behaviors Following a Neurological Injury	Clinical Education	Baseline TBD post- FY26	• Completion rate- 80% of all direct care licensed clinicians will complete the following two MHU modules: "Psychosocial Issues When Working with Patients with Spinal Cord Injury" and "Caring for the Neurobehavioral Patient."
Training and Education:	Clinical Education	Baseline TBD post- FY26	• Number - 100 external browser views of the course

Managing Behaviors Following a Neurological Injury			"Psychosocial Issues When Working with Patients with Spinal Cord Injury"

Target/Intended Population(s):

- Rehabilitation and Mental Health Clinicians delivering services to individuals with brain injury and individuals with spinal cord injury

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

- Delivery of these two MHU course to all Rehabilitation Network clinicians: 1. Psychosocial Issues When Working with Patients with Spinal Cord Injury; 2. Caring for the Neurobehavioral Patient
- Delivery of referral information for mental health resources to all outpatient therapists

Collaboration Partners (Internal and External):

- TIRR Memorial Hermann Department of Psychology/Neuropsychology; TIRR Memorial Hermann Education Department; Family Houston outpatient mental health services; TIRR Memorial Hermann Marketing

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

FY26-FY28 Goal: To ensure that ≥ 75% of Health Equity Academy students complete the program with ≥ 50% of program graduates admitted into a rehabilitation health professions degree program.

FY26 Objective: ≥ 50% of Health Equity Academy students complete the program with ≥ 25% of program graduates admitted into a rehabilitation health professions degree program.

FY26 KPIs:

- Percent—program graduates admitted into a rehabilitation program
- Percent—self-efficacy and empowerment scores
- Percent—program completion rate

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Health Equity Academy Summer Internship	• Clinical Education • Human Resources	Baseline TBD post- FY26	• Percent - 50% admission into rehabilitation program within 3 years • Percent - 20% increase in self-efficacy and empowerment scores.

			• Percent - 80% of interns complete program and present on a specific health inequity.

Target/Intended Population(s):

- Greater Houston

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

- Health Equity Academy – We provide an internship to undergraduate students interested in careers in occupational therapy, physical therapy, speech language pathology or rehabilitation nursing. Participants receive exposure to these fields, education about health equity challenges in the current health care environment; and mentorship in preparing for a health care career.
- The program has run for two summers successfully.

Collaboration Partners (Internal and External):

- TIRR Education Academy, MHHS hospitals, TIRR locations, MHHS Sports Med and Rehab; MHHS Health Access; Greater Houston universities

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

Target/Intended Population(s):

- Broader Greater Houston community; 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 health care. Integrating physical and behavioral health services; facilitating seamless access to care.
- Human Resources - Behavioral Health Services Employees
- Operating Resources – Computers, EMR, Virtual technology, and other documentation tools
- Capital Resources – Offices and other facilities

Collaboration Partners (Internal and External):

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

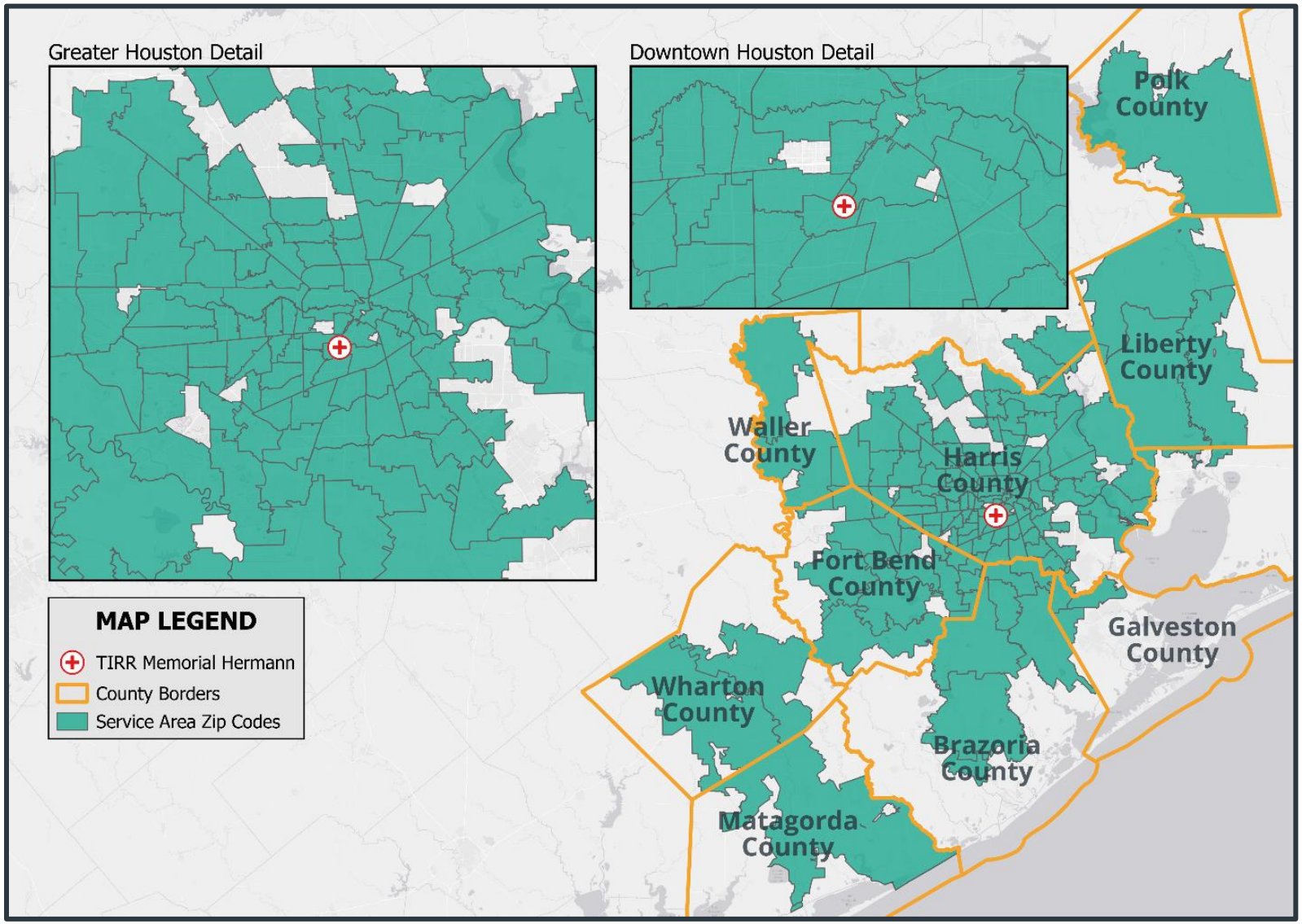
MEMORIAL HERMANN

Appendices

Appendix A. TIRR Memorial Hermann Supplementary Findings

The MSA for TIRR Memorial Hermann includes 131 zip codes across 9 counties.

FIGURE 1. TIRR MEMORIAL HERMANN MSA

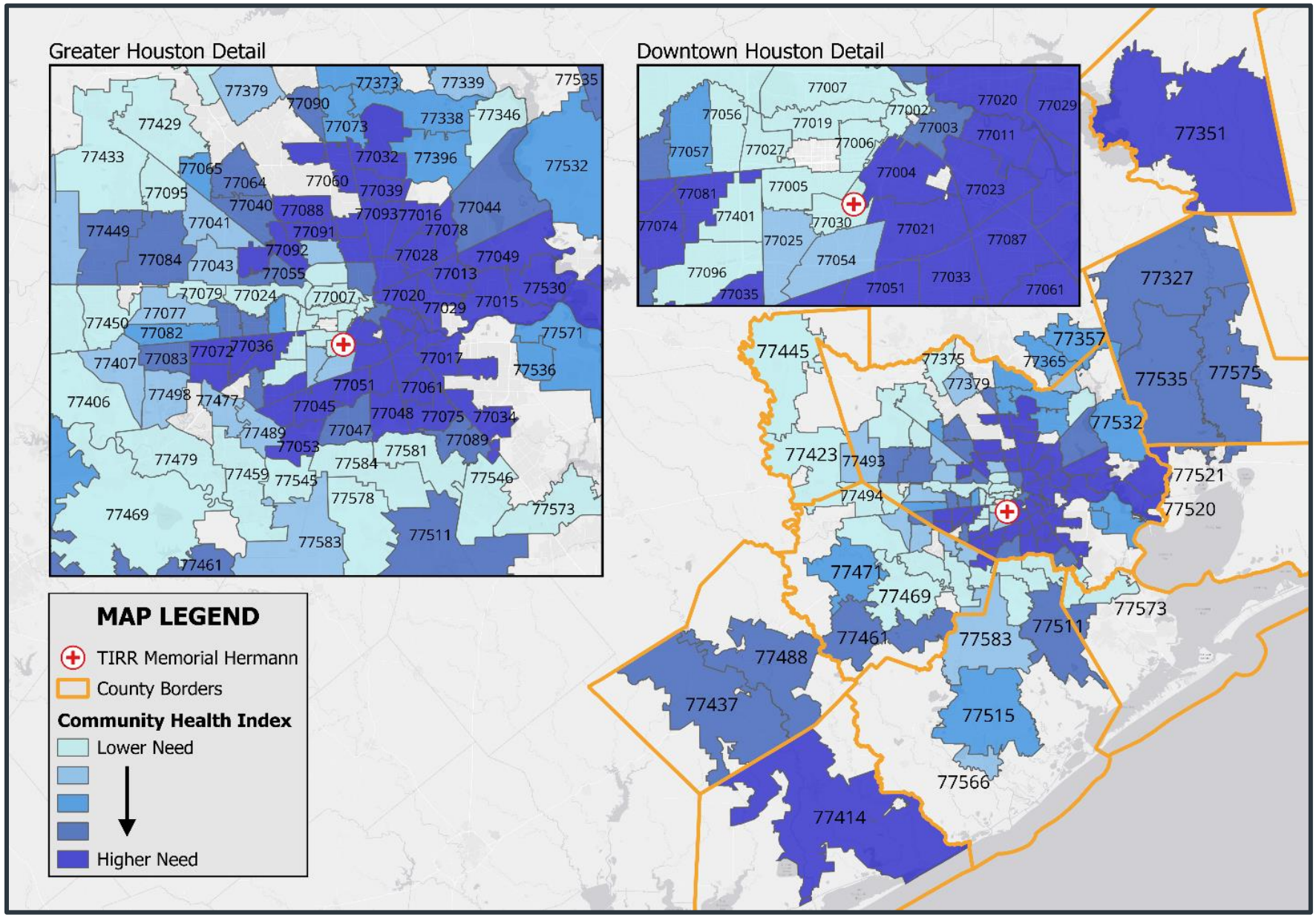


Key Findings: Access to Care

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

- 77033 (CHI = 99.4)
- 77029 (99.3)
- 77013 (99.2)
- 77093 (99.2)
- 77011 (98.8)
- 77028 (98.8)
- 77016 (98.7)
- 77060 (98.7)
- 77078 (98.7)
- 77026 (98.6)
- 77022 (98.4)
- 77081 (98)

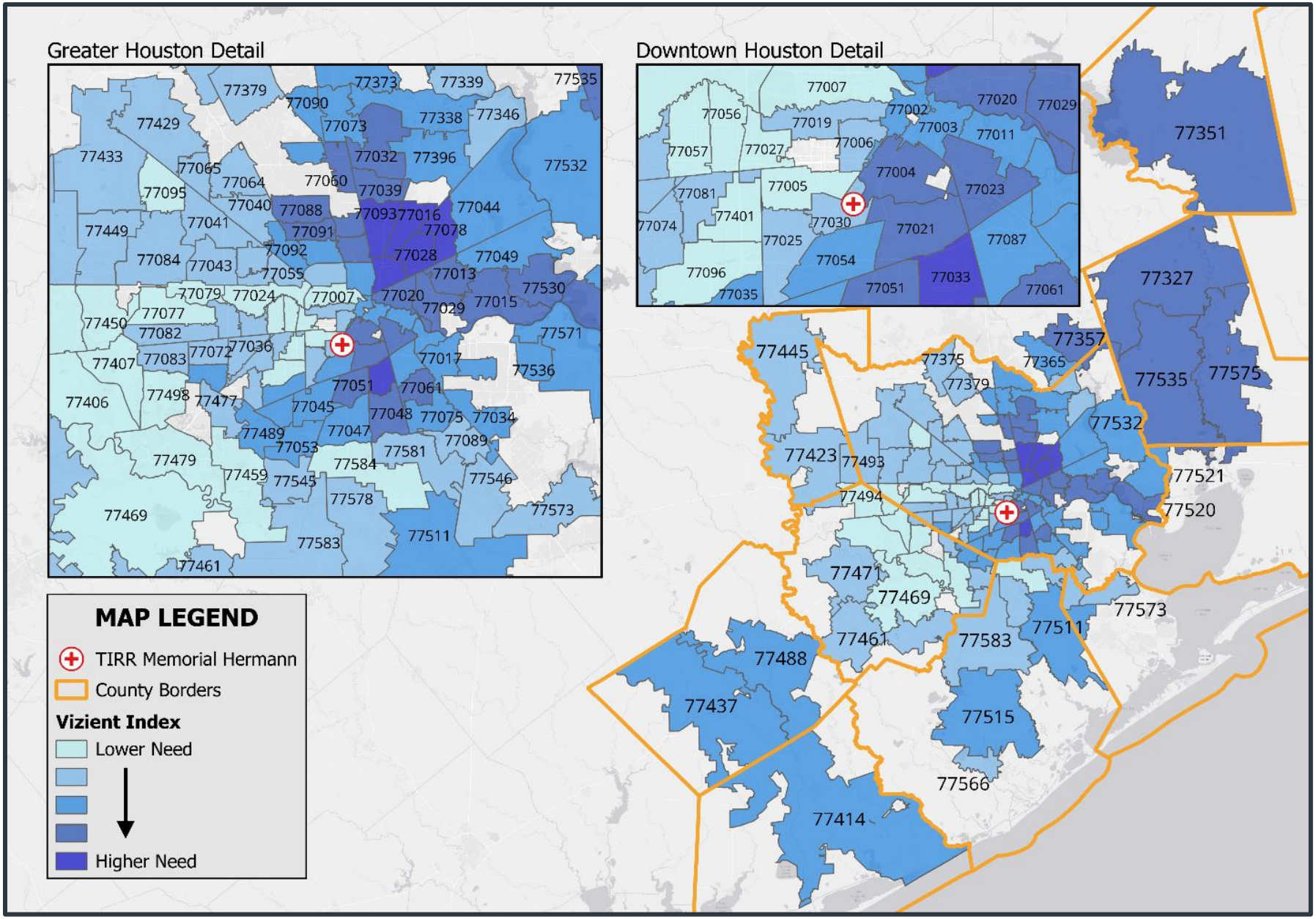
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: TIRR MEMORIAL HERMANN MSA



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

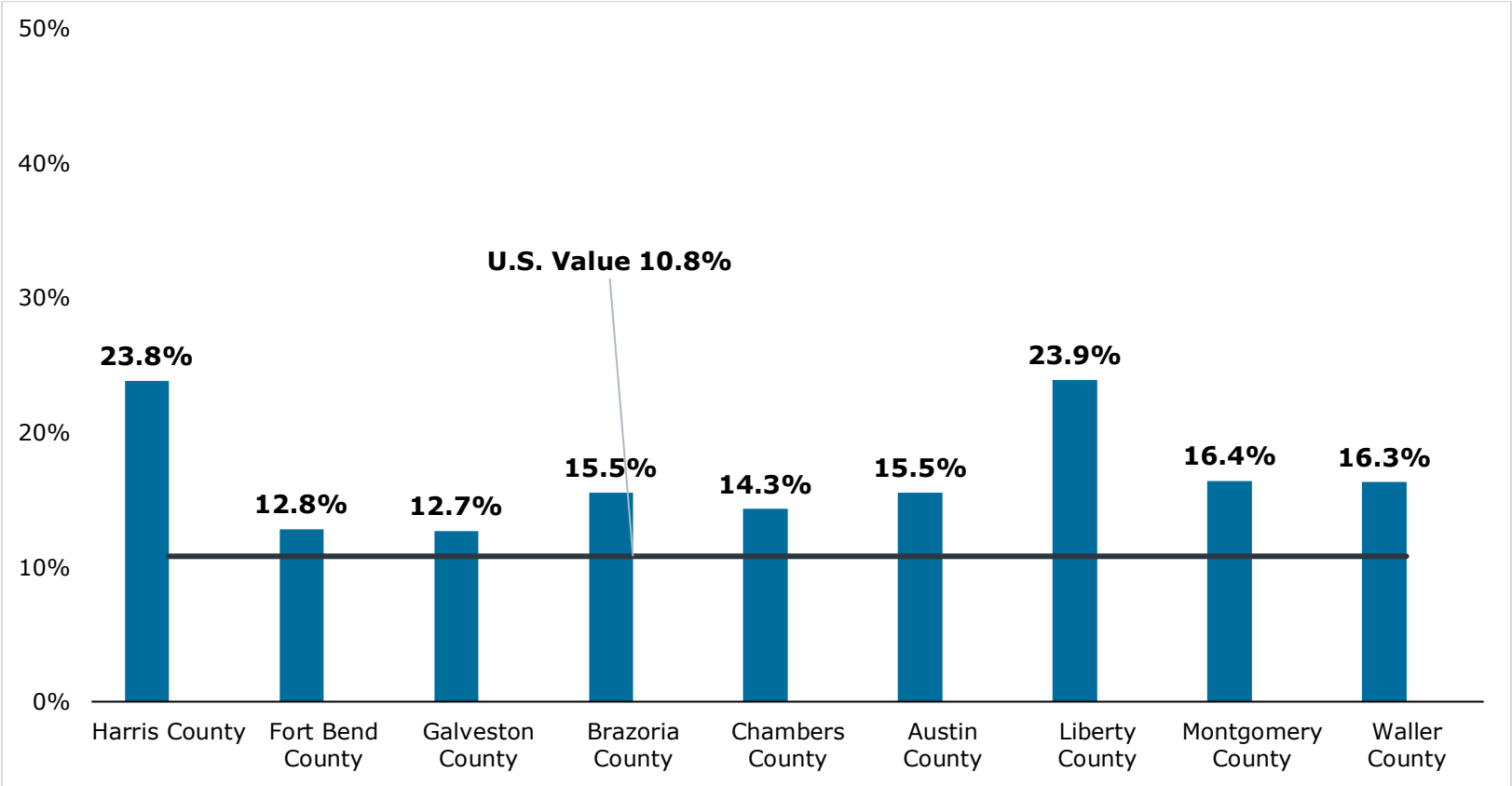
- 77028 (VVI = 2.41)
- 77016 (2.3)
- 77078 (2.1)
- 77026 (2.1)
- 77093 (1.8)
- 77033 (1.6)

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



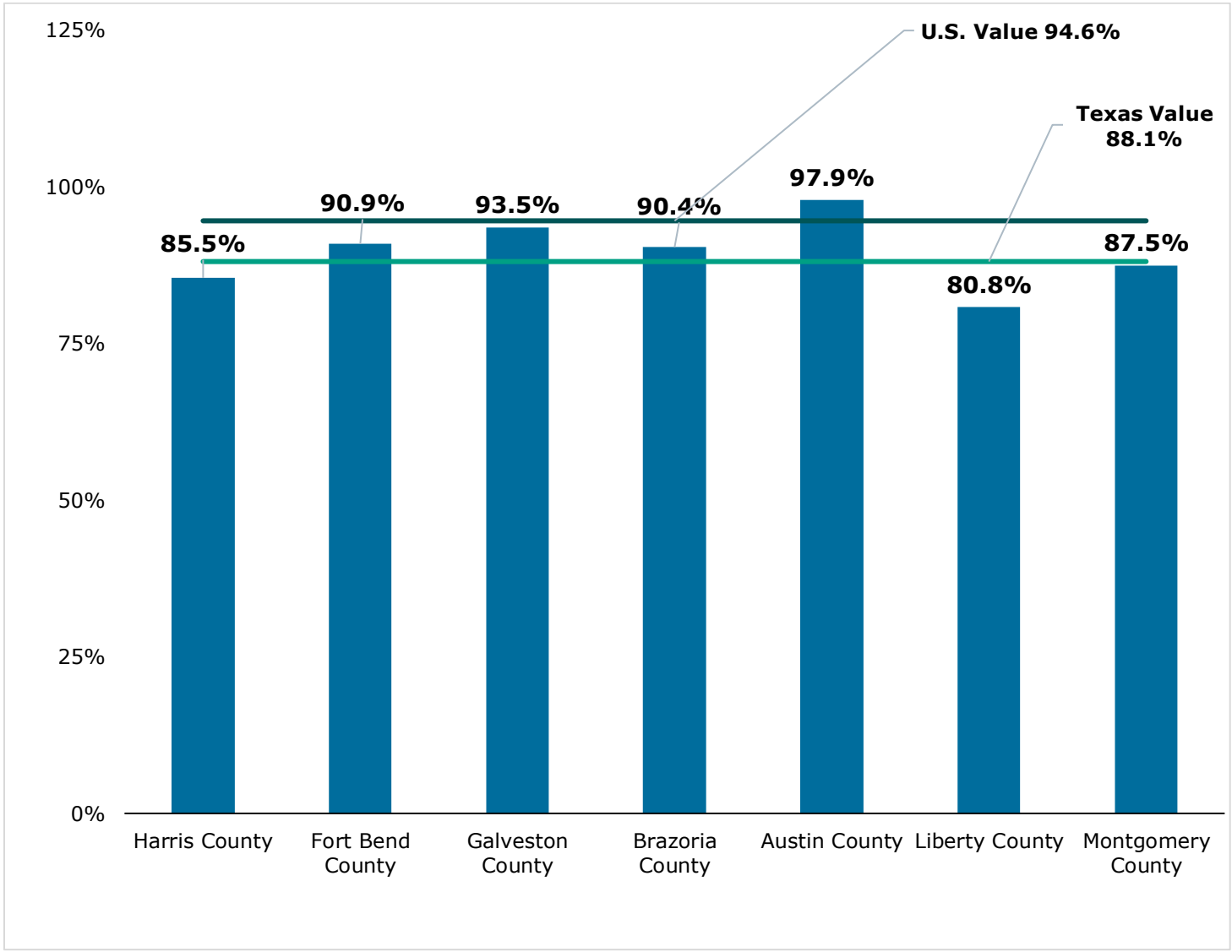
The following figures illustrate indicators of concern in Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and/or Waller counties, based on scoring of secondary data related to **Access to Care.**

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



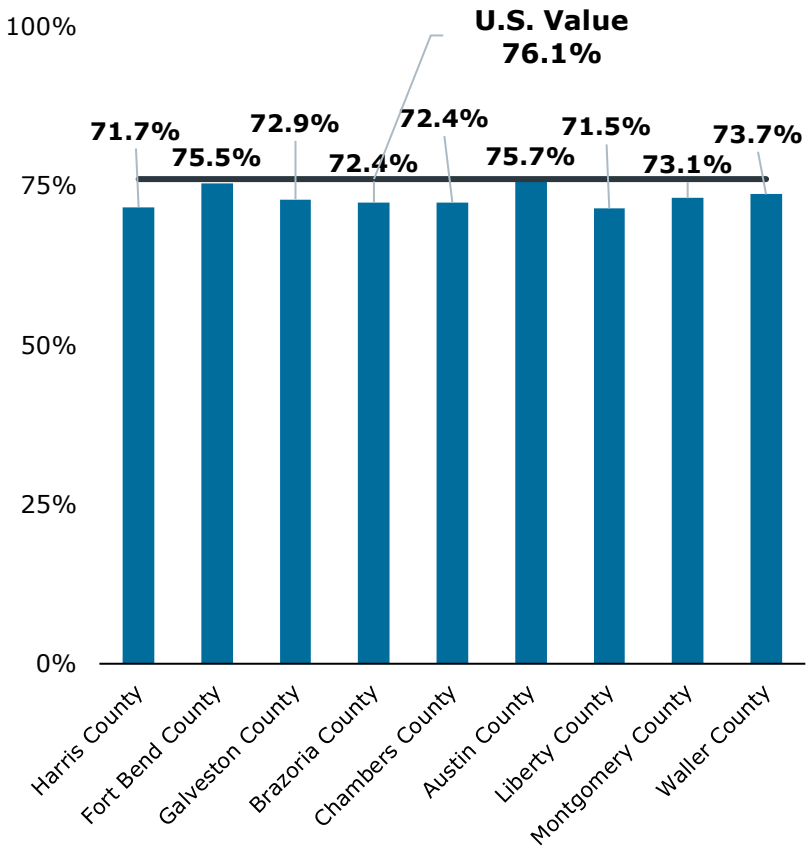
Source: CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



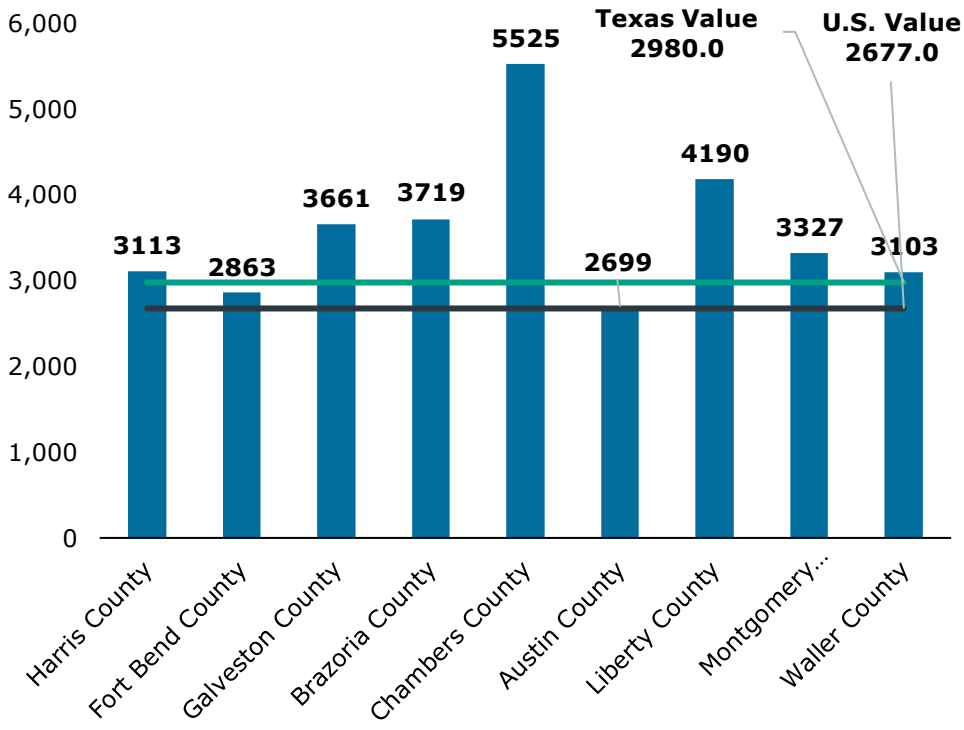
Source: American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



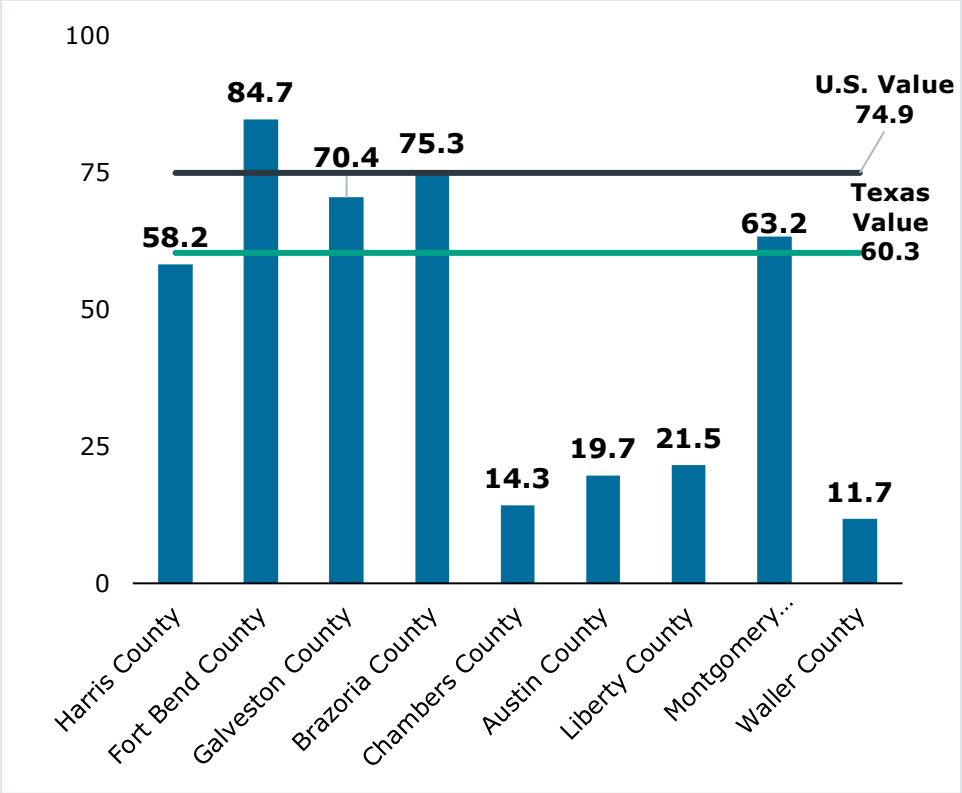
CDC – PLACES (2022)

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



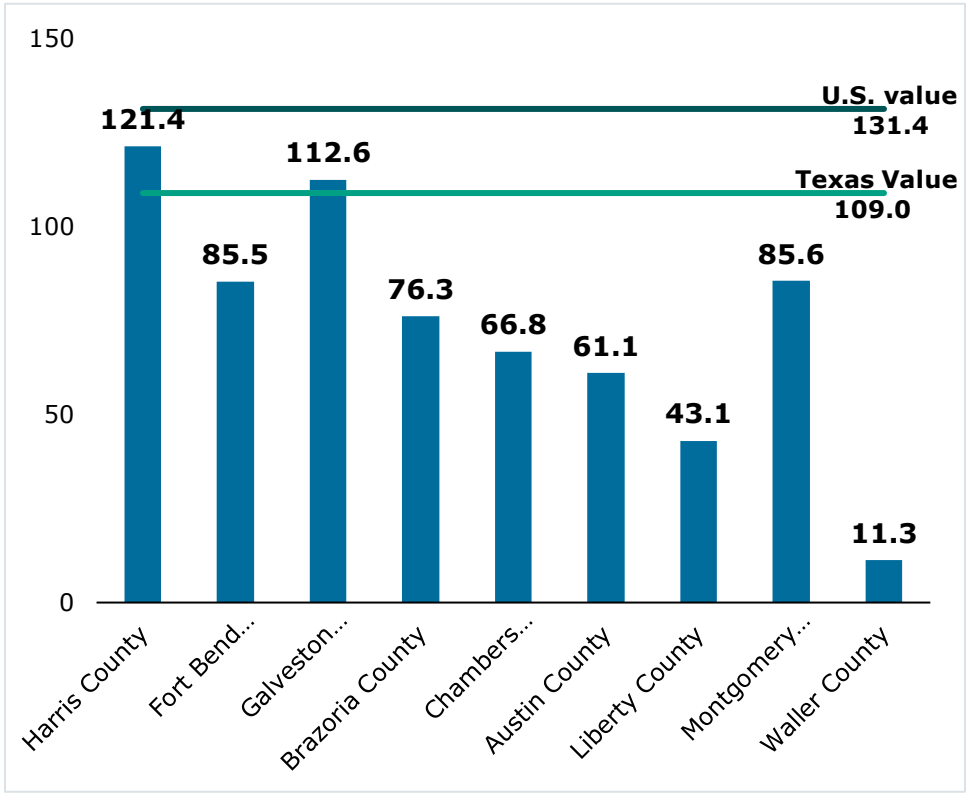
Centers for Medicare & Medicaid Services (2022)

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)

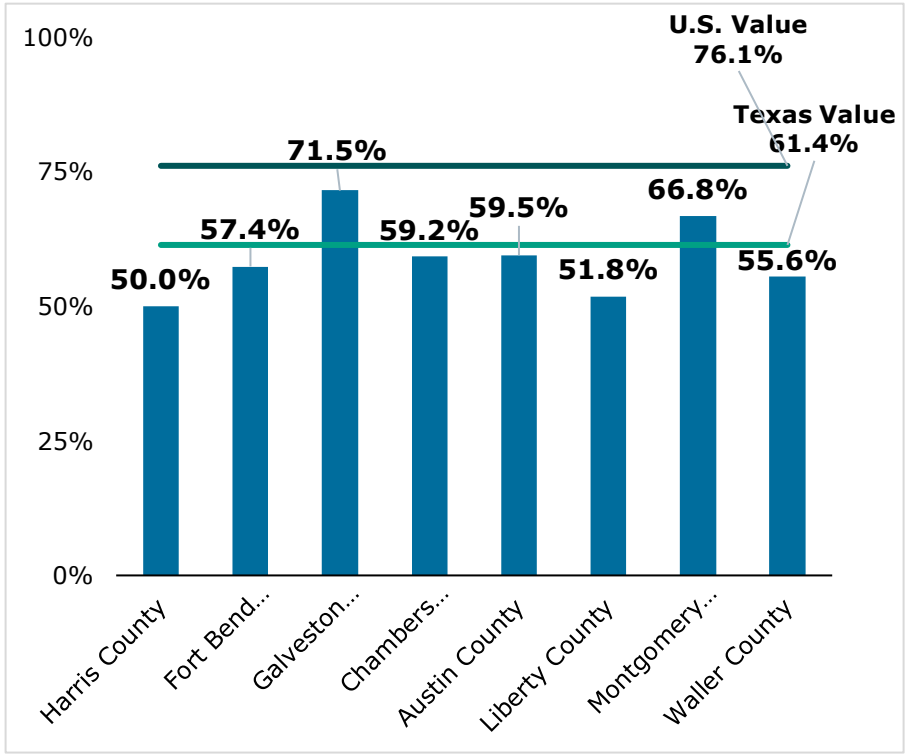


County Health Rankings (2023)

Key Findings: Maternal & Infant Health

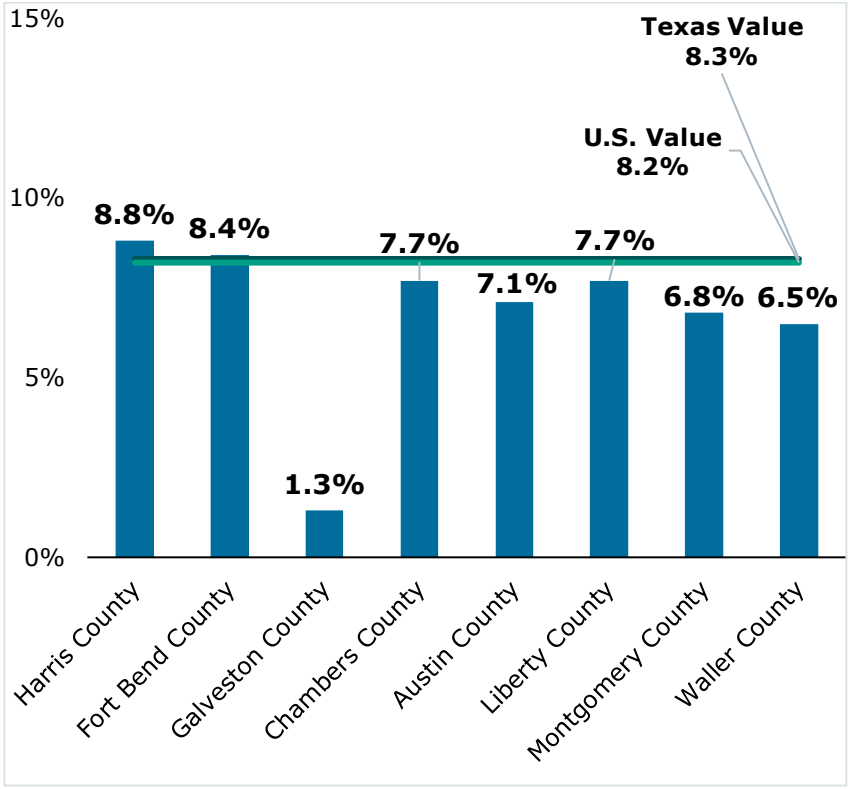
The following figures illustrate indicators of concern in Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and/or Waller counties, based on scoring of secondary data related to Maternal and Infant Health.

FIGURE 10. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



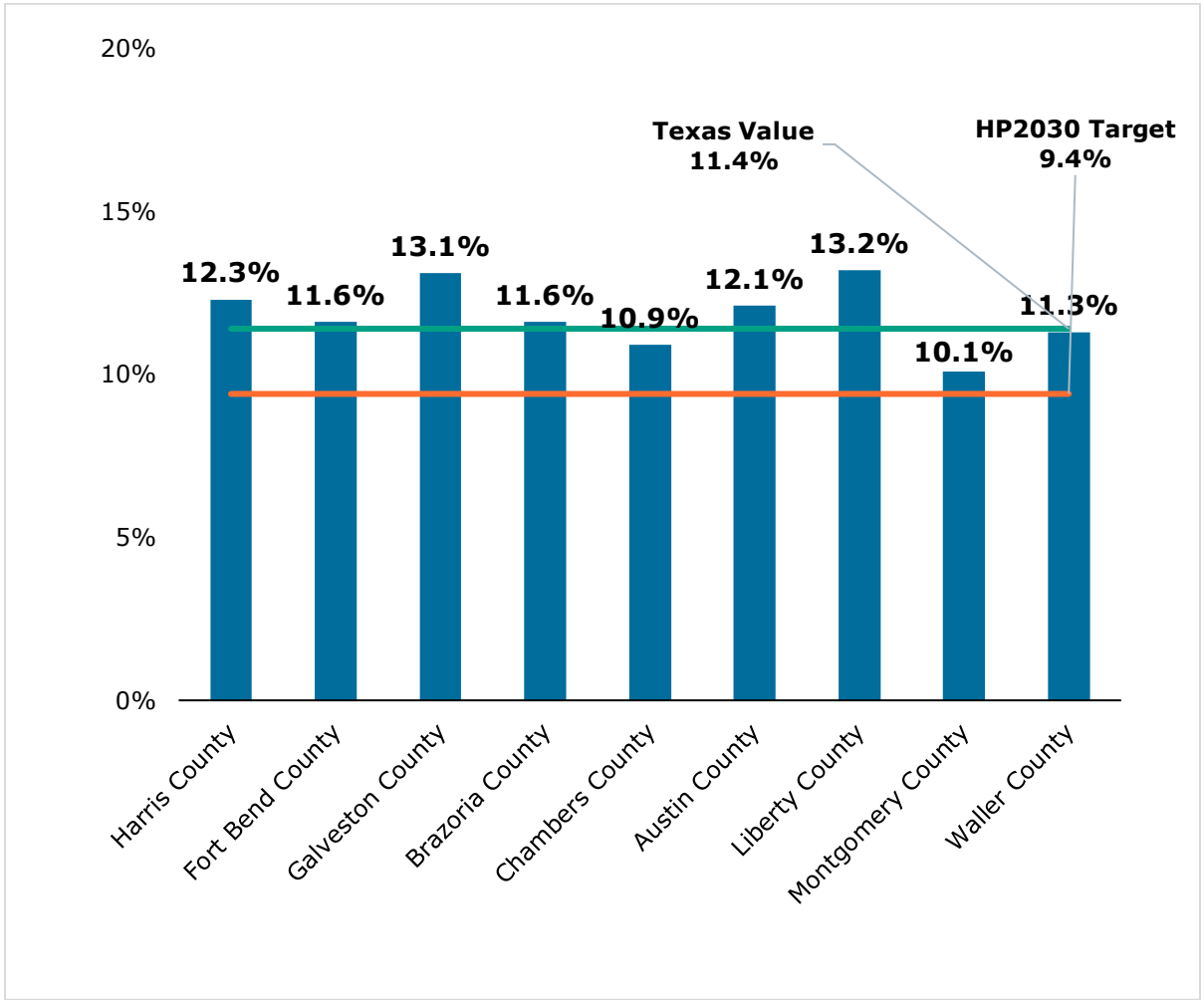
Texas Department of State Health Services (2020)

FIGURE 11. BABIES WITH LOW BIRTHWEIGHT



Texas Department of State Health Services (2020)

FIGURE 12. PRETERM BIRTHS

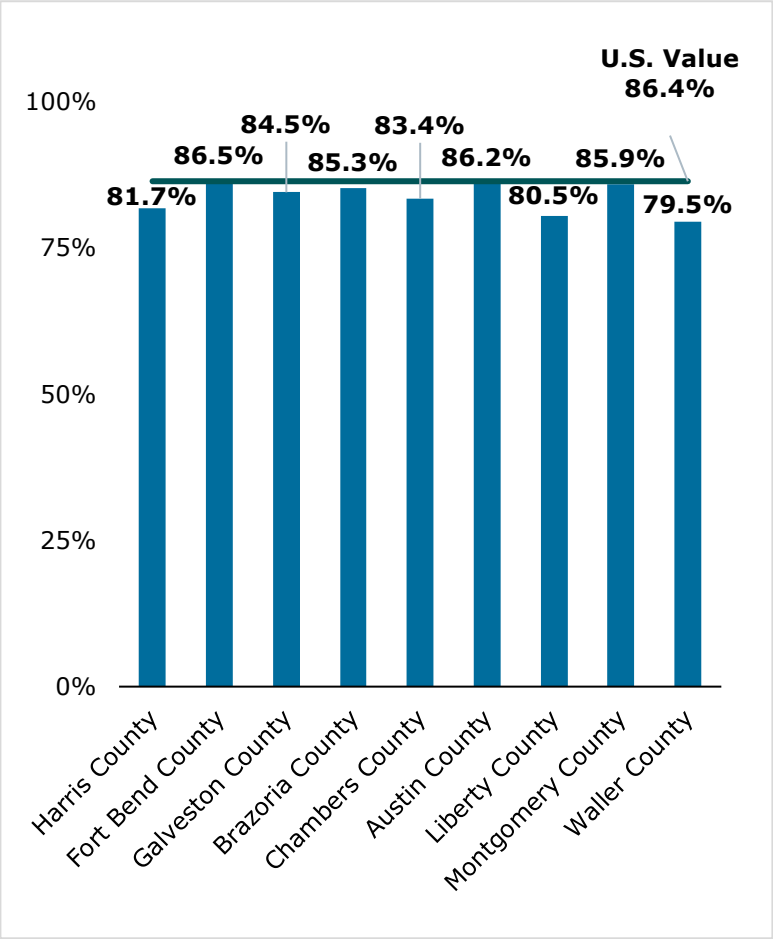


Texas Department of State Health Services (2021)

Key Findings: Chronic Condition Prevention & Management

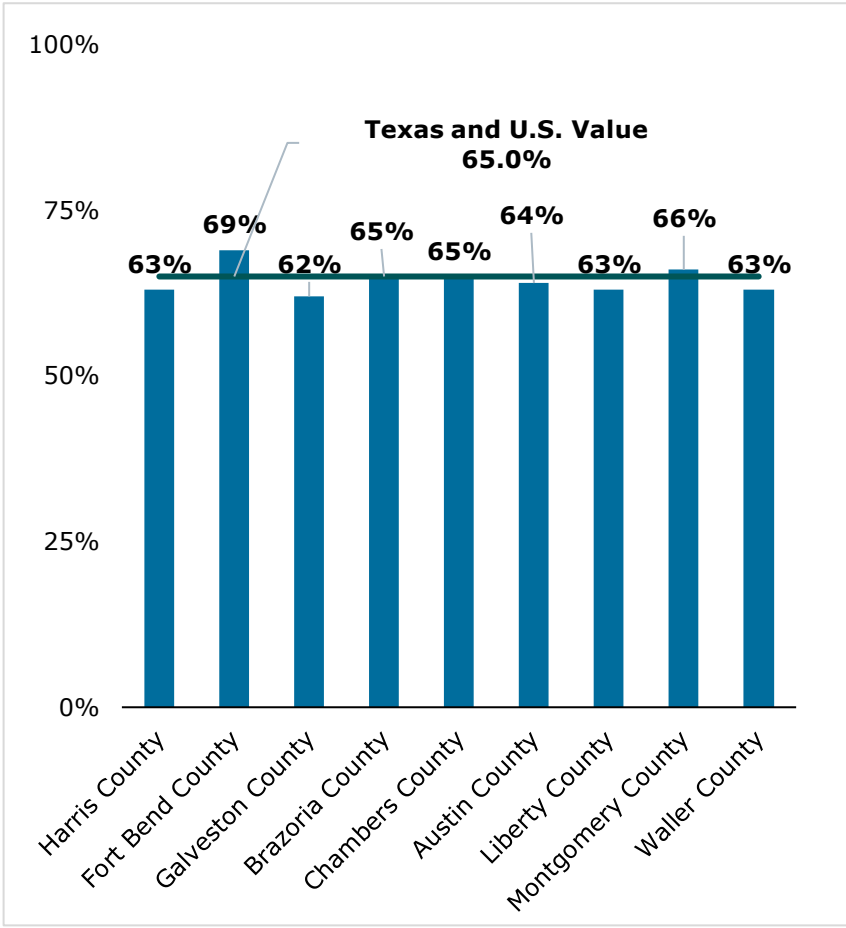
The following figures illustrate indicators of concern in Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and/or Waller counties, based on scoring of secondary data related to Chronic Condition Prevention & Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



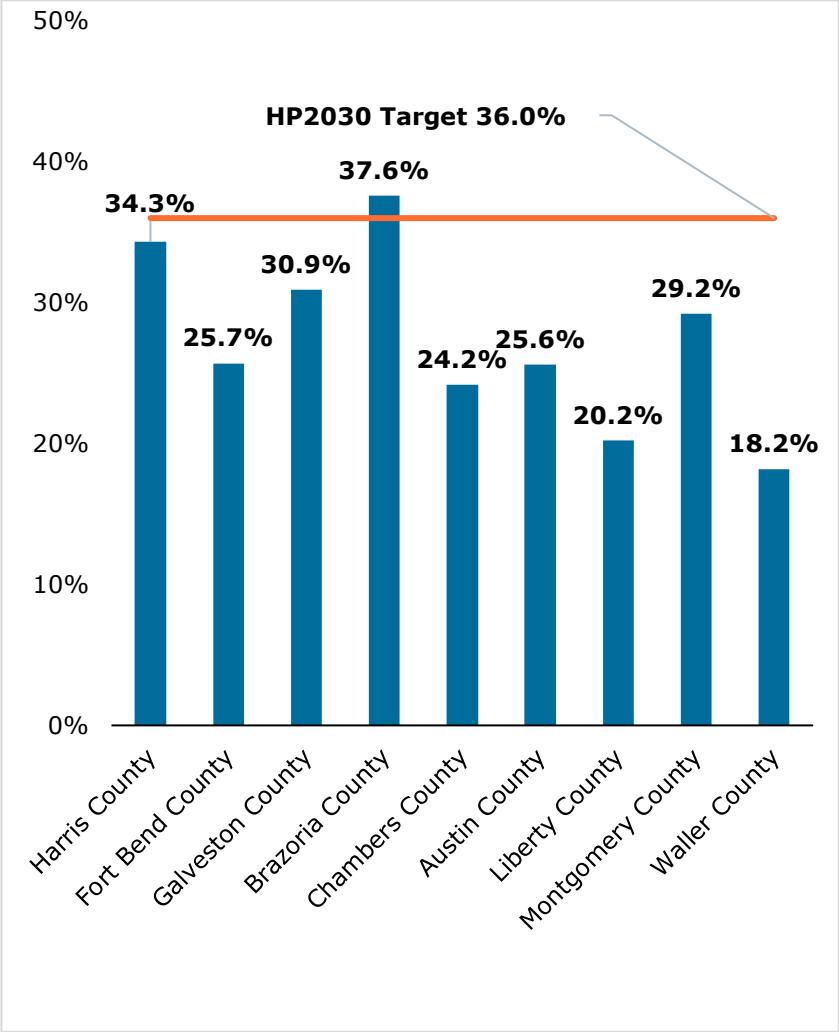
CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



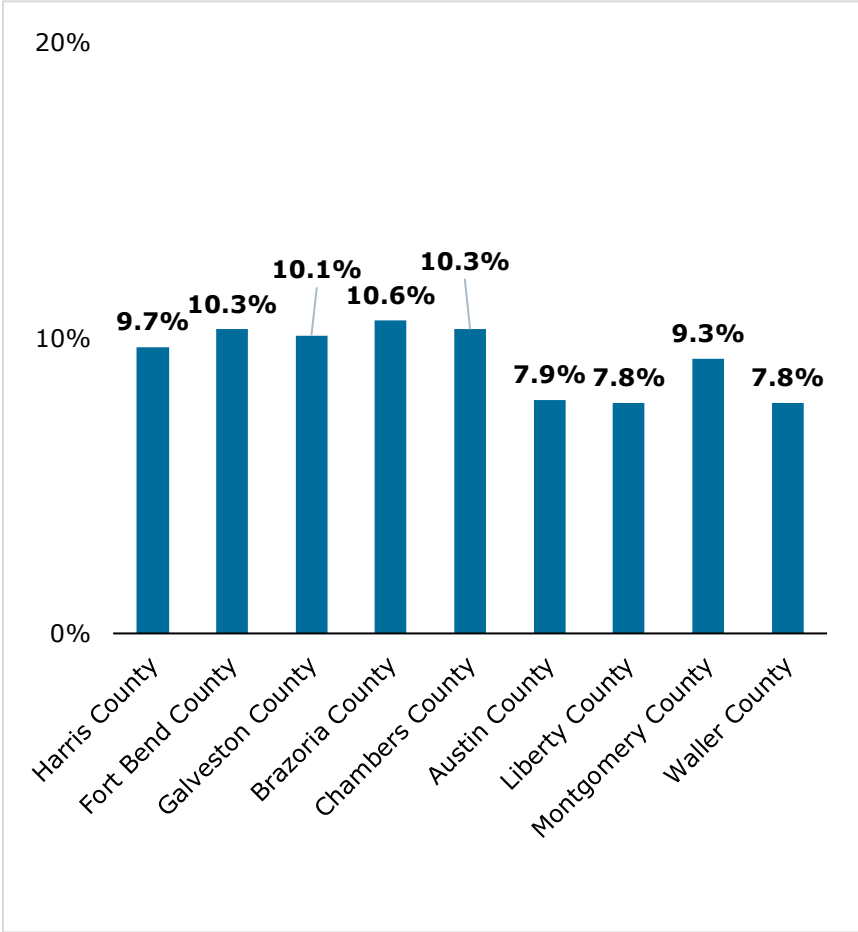
Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



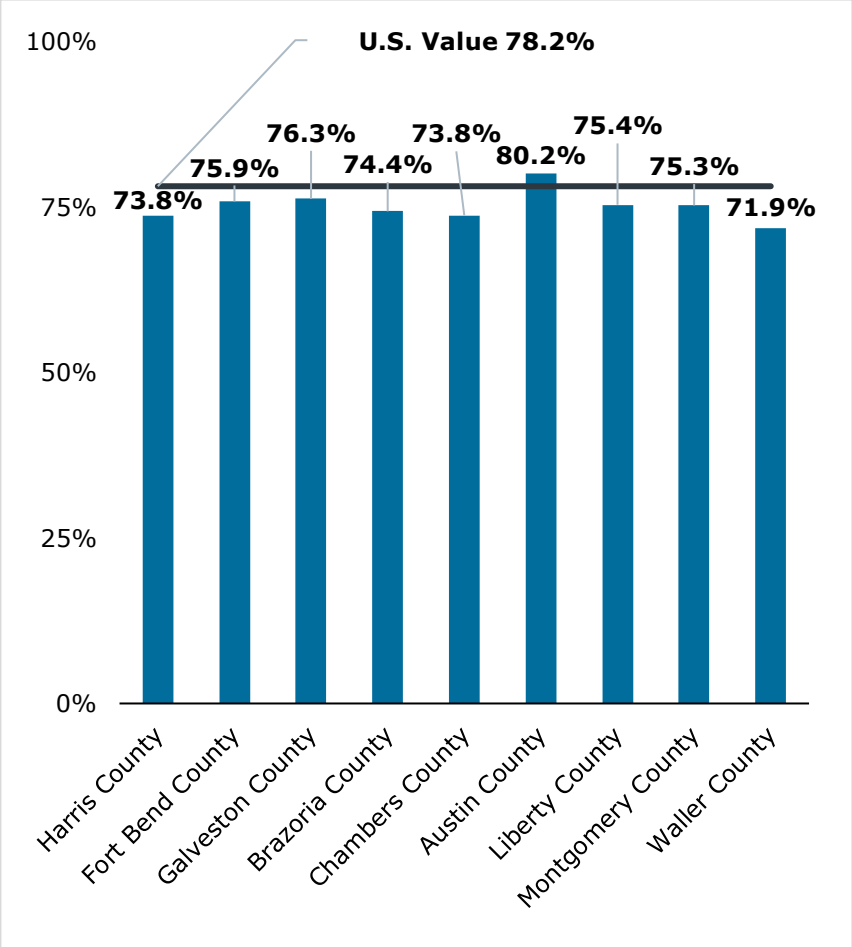
CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



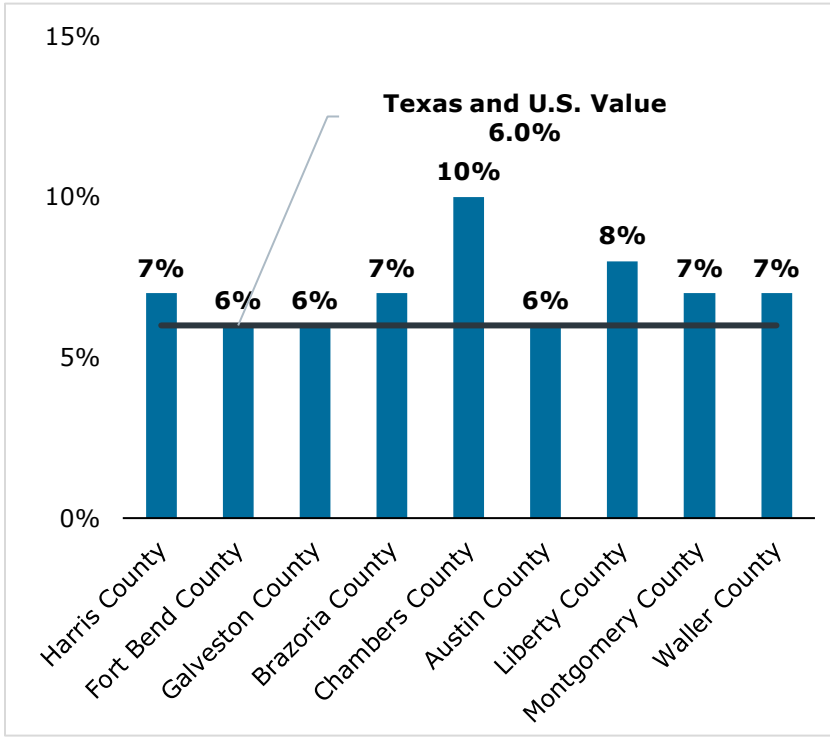
CDC (2021)

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



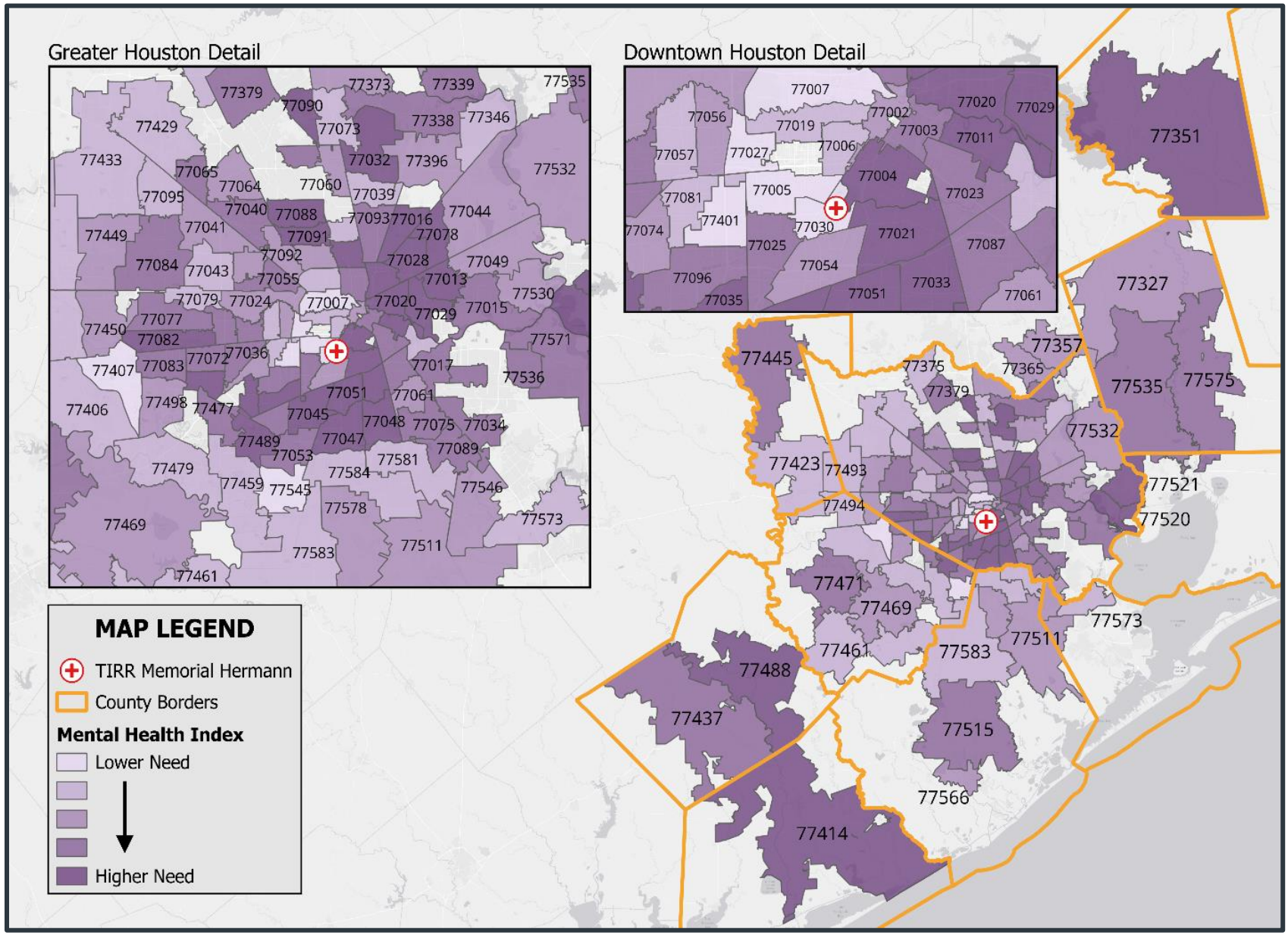
Centers for Medicare & Medicaid Services (2022)

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

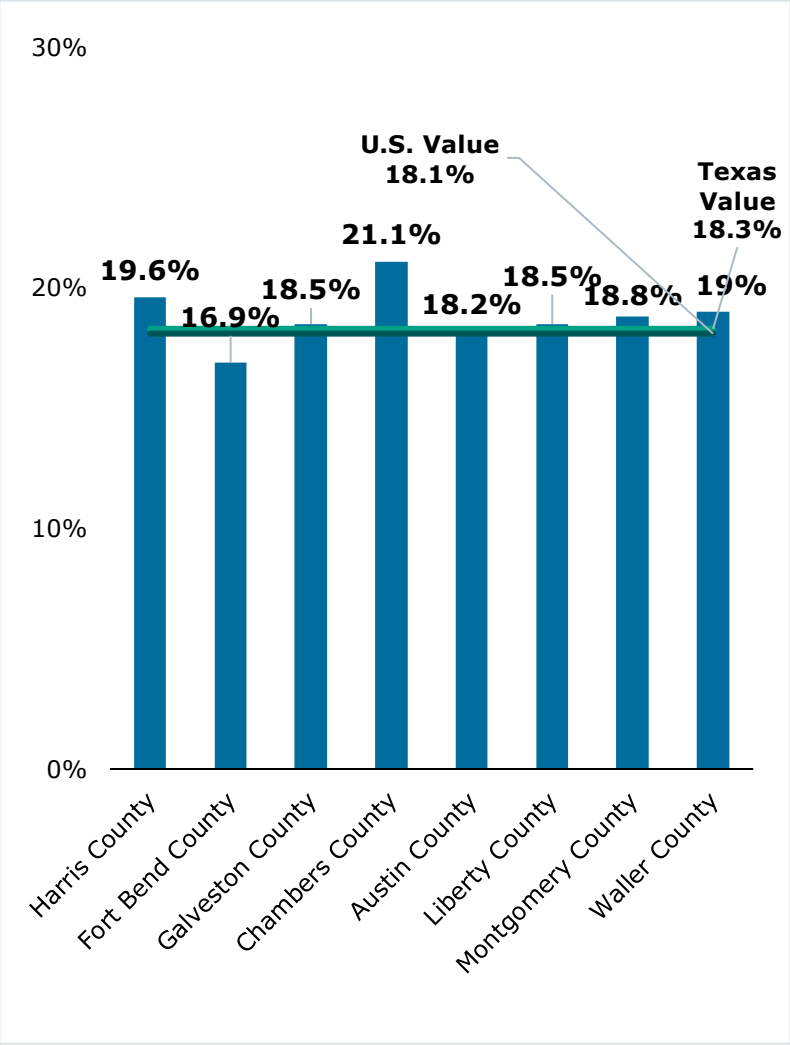
- 77051 (MHI = 99.1)
- 77026 (98.3)
- 77021 (98.3)
- 77033 (98)
- 77048 (97.8)
- 77028 (97.7)
- 77016 (97.4)

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



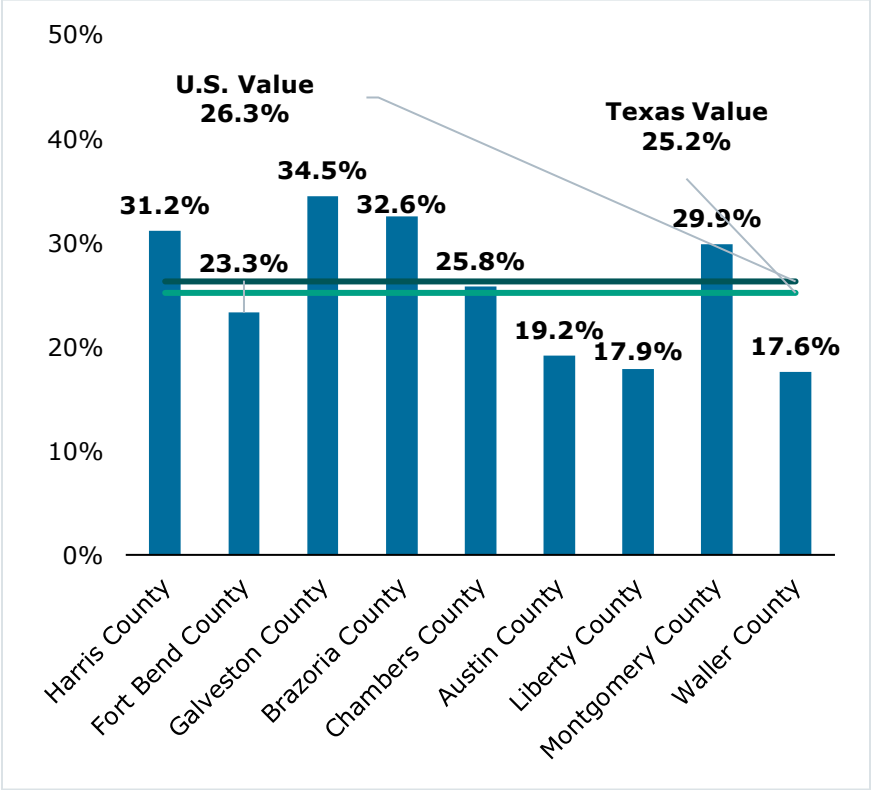
The following figures illustrate indicators of concern in Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and/or Waller counties, based on scoring of secondary data related to Mental Health and Substance Use.

FIGURE 20. ADULTS WHO DRINK EXCESSIVELY



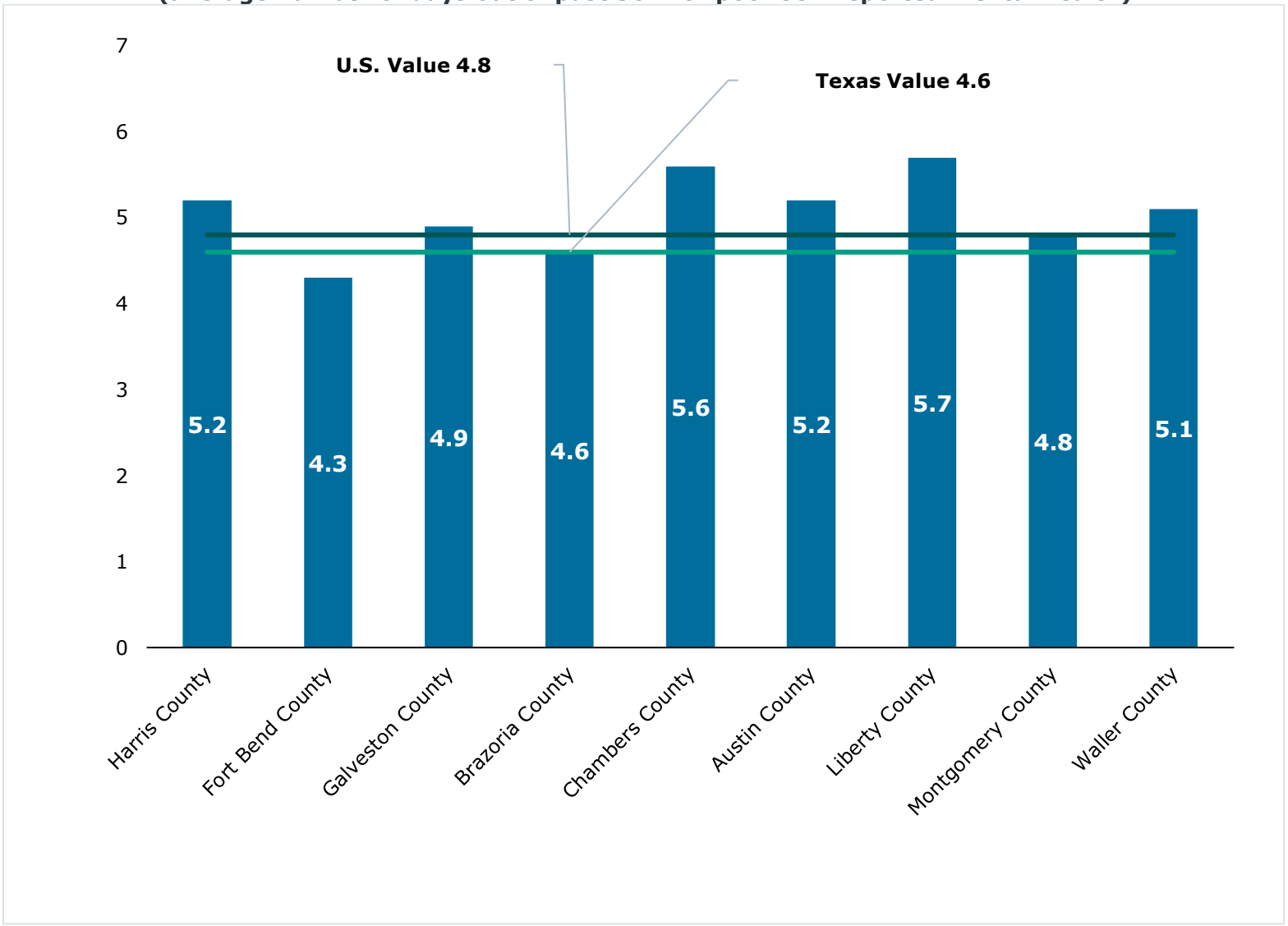
County Health Rankings (2021)

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)

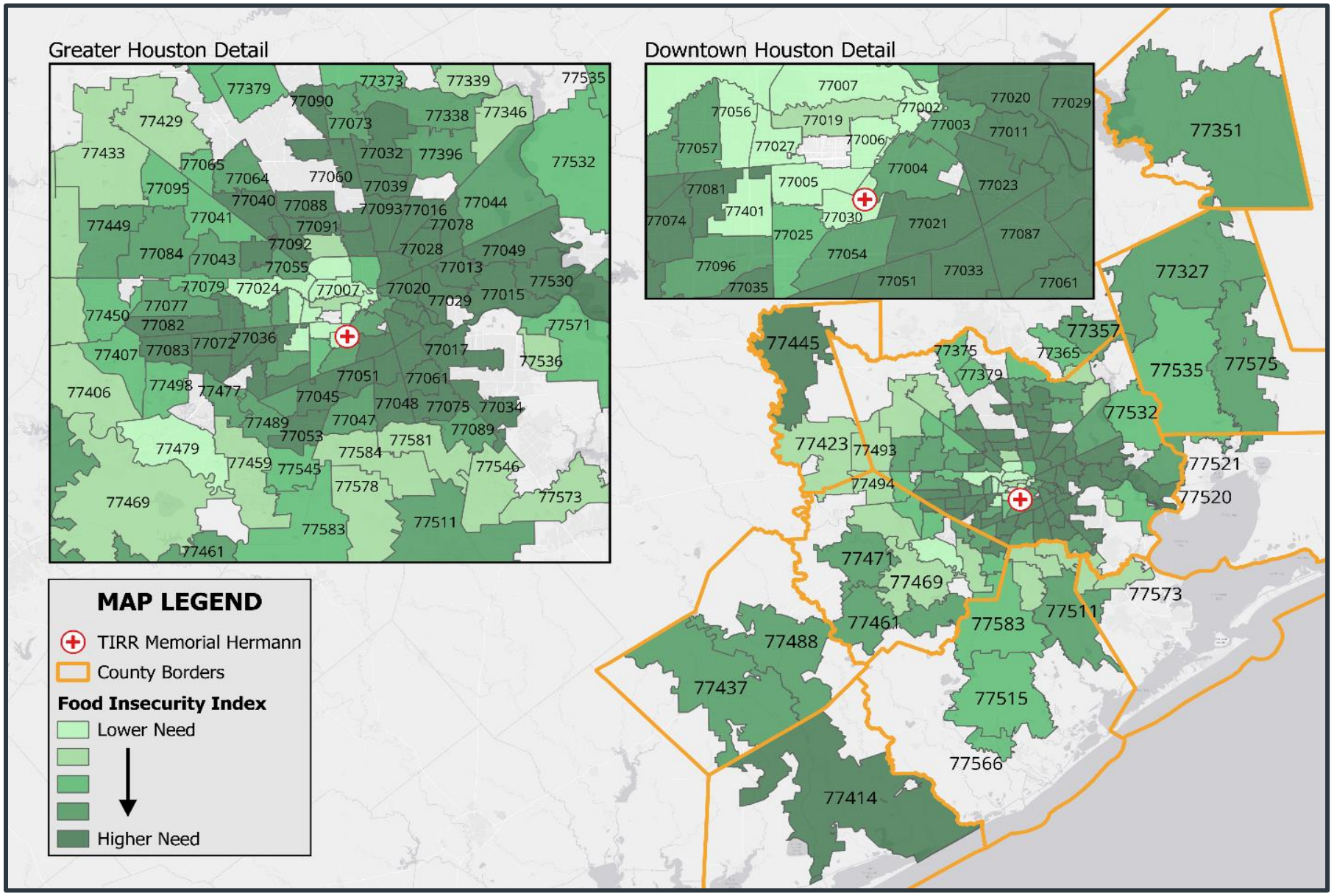
Key Findings: Access to Healthy Food

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

- 77032 (FII = 99.7)
- 77028 (99.5)
- 77060 (99.5)
- 77093 (99.4)
- 77078 (99.3)
- 77013 (98.9)
- 77076 (98.9)
- 77051 (98.8)
- 77033 (98.8)
- 77039 (98.1)
- 77048 (98)

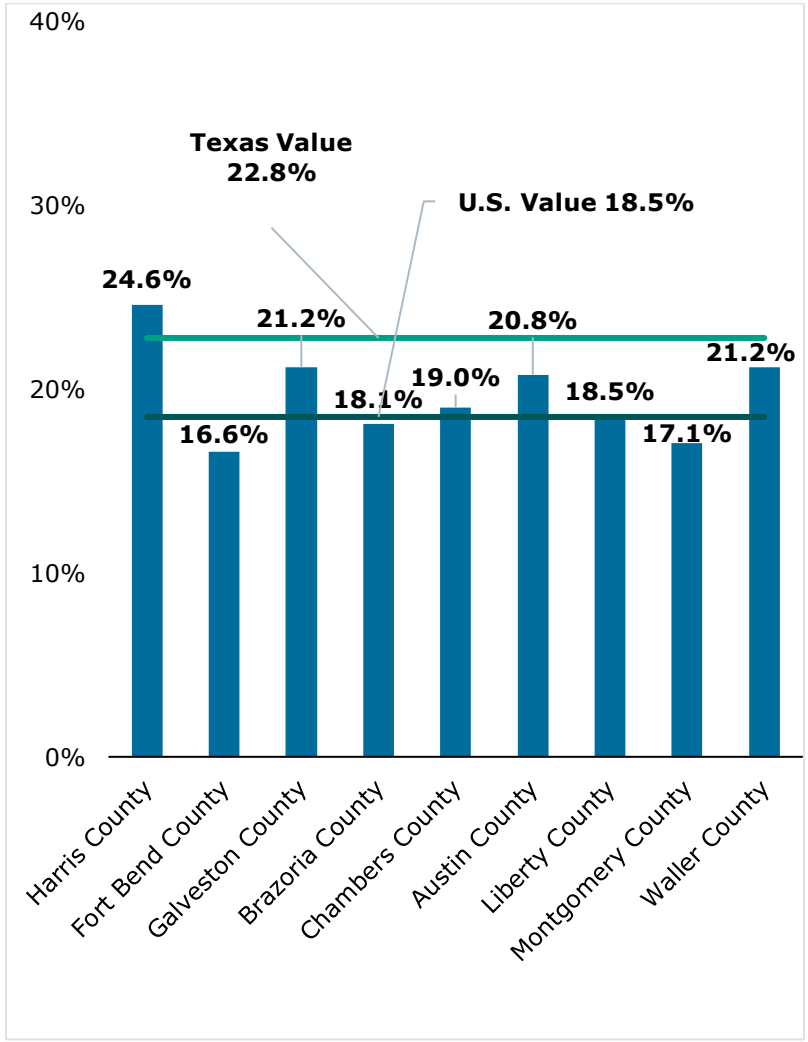
Notably, half of the zip codes in this MSA (22 out of 44) have a FII score above 75, indicating generally high rates of food insecurity across the entire region, compared to other U.S. zip codes.

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



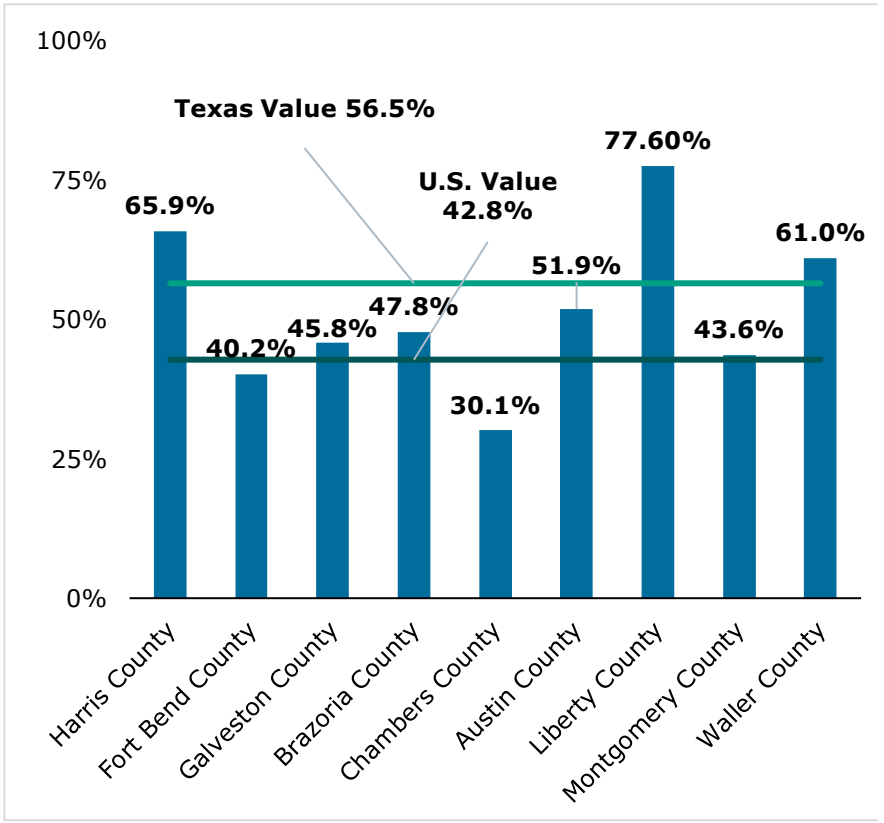
The following figures illustrate indicators of concern in Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and/or Waller counties, based on scoring of secondary data related to Access to Healthy Food.

FIGURE 24. CHILD FOOD INSECURITY RATE



Feeding America (2022)

FIGURE 25. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM



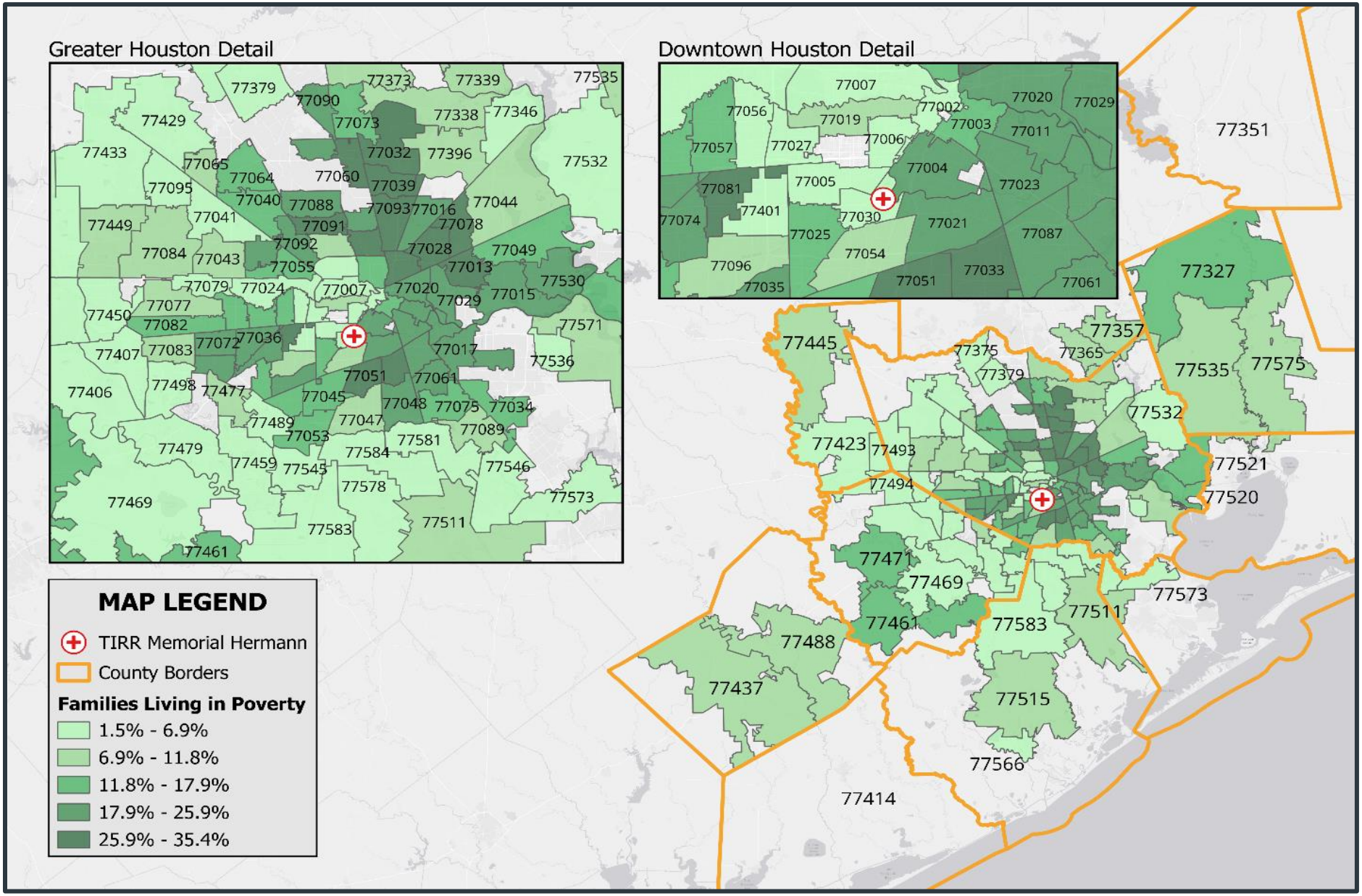
National Center for Education Statistics (2022-2023)

Key Findings: Economic Opportunity

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

- 77060 (35.4%)
- 77093 (34.7%)
- 77033 (32.2%)
- 77051 (30.5%)
- 77032 (30.5%)
- 77078 (30.2%)

FIGURE 26. POVERTY BY ZIP CODE: TIRR MEMORIAL HERMANN MSA

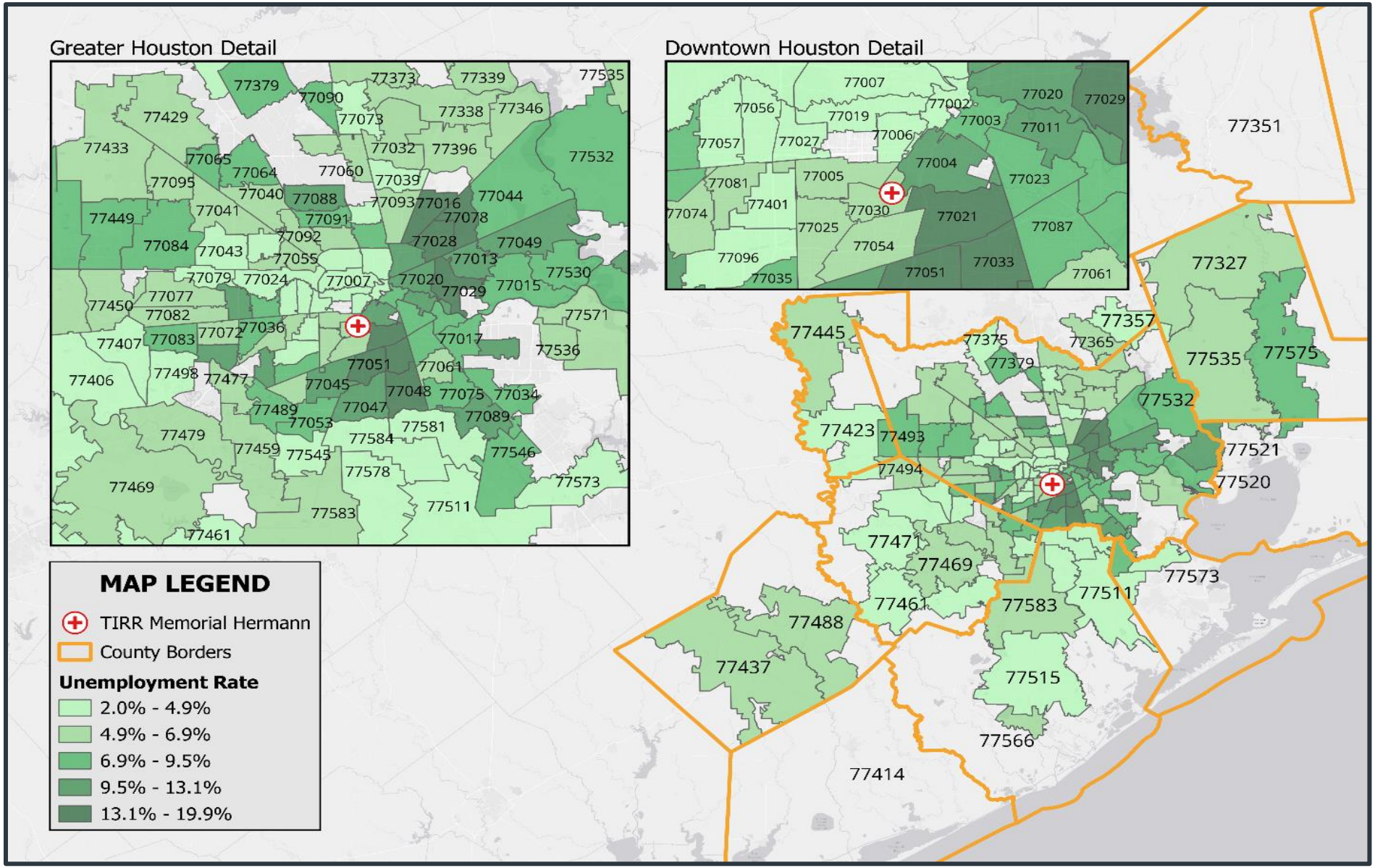


Claritas (2024)

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

- 77048 (19.9%)
- 77033 (17.8%)
- 77051 (16.4%)
- 77028 (15.2%)
- 77029 (15.2%)

FIGURE 27. UNEMPLOYMENT BY ZIP CODE: TIRR MEMORIAL HERMANN MSA

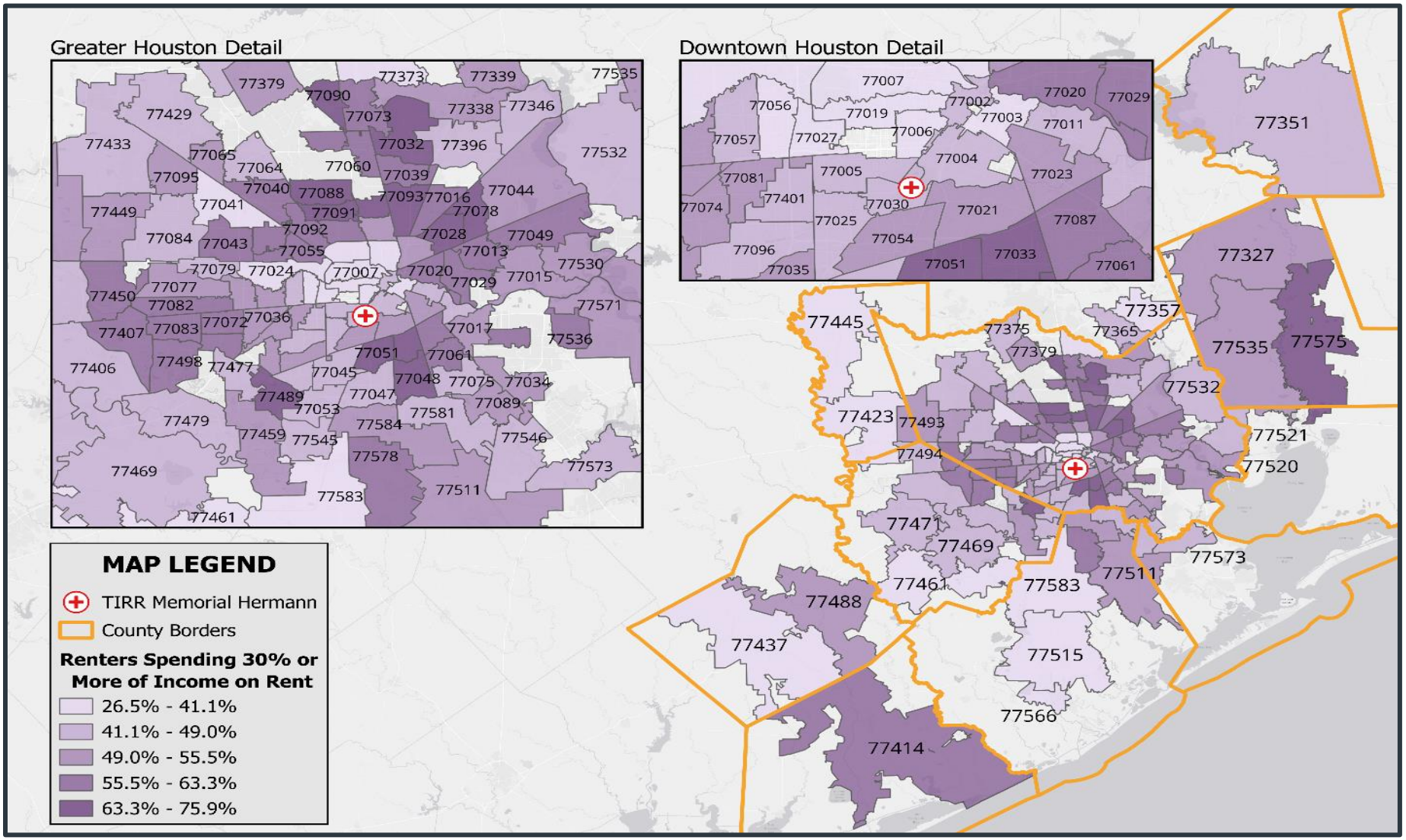


Claritas (2024)

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

- 77028 (75.9%)
- 77051 (72.8%)
- 77032 (72.3%)
- 77048 (69.7%)
- 77033 (69.3%)

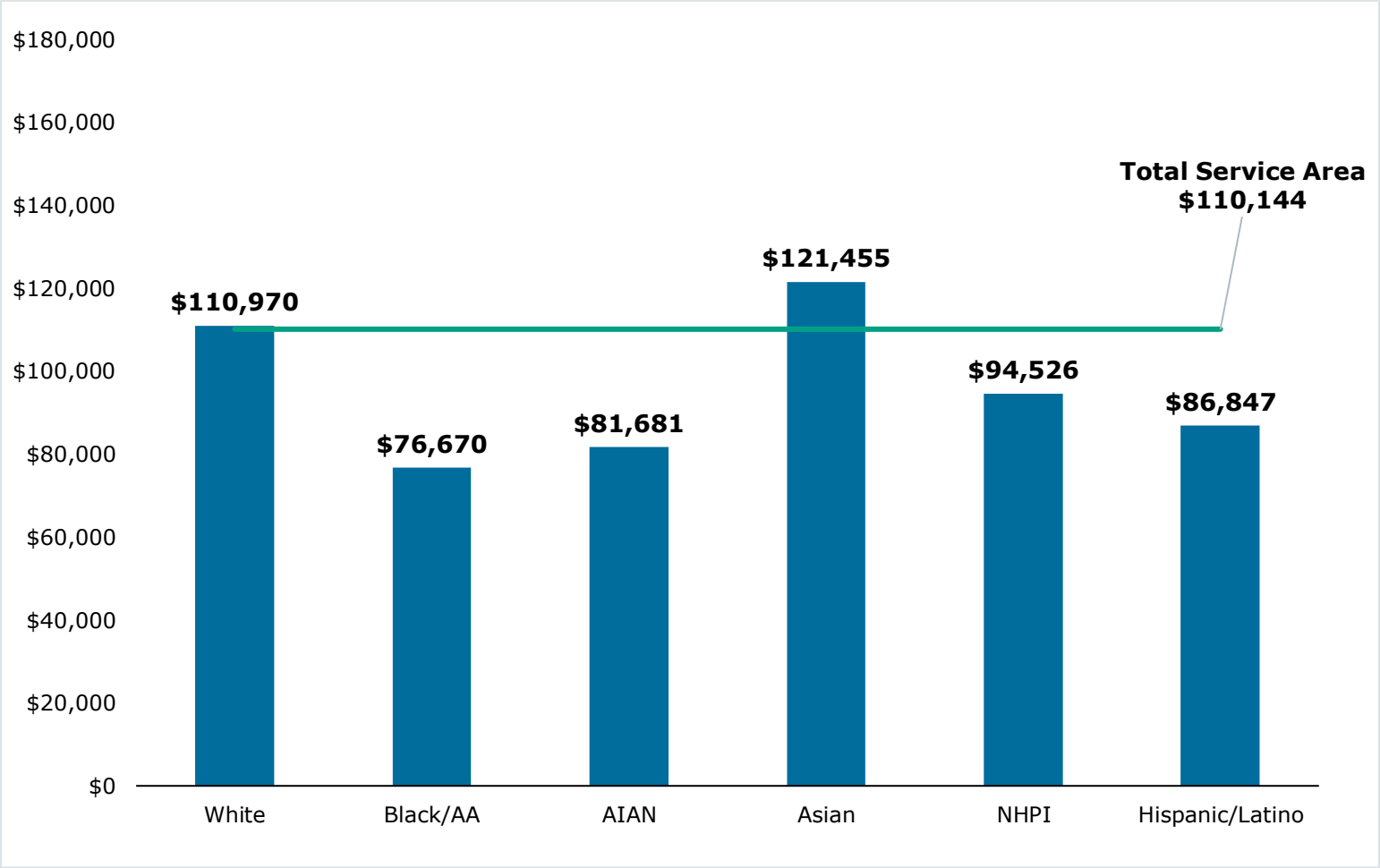
FIGURE 28. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: TIRR MEMORIAL HERMANN MSA



American Community Survey (2018-2022)

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

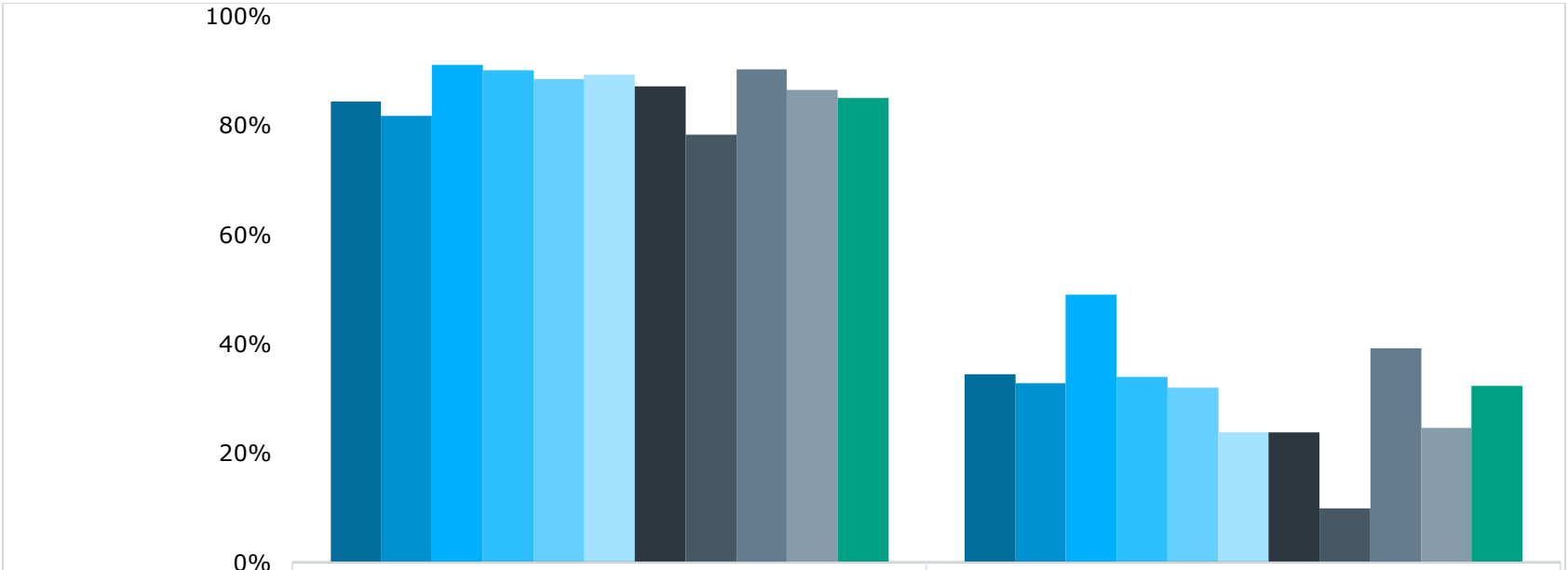
FIGURE 29. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: TIRR MEMORIAL HERMANN MSA



Claritas (2024)

Educational Access: TIRR Memorial Hermann

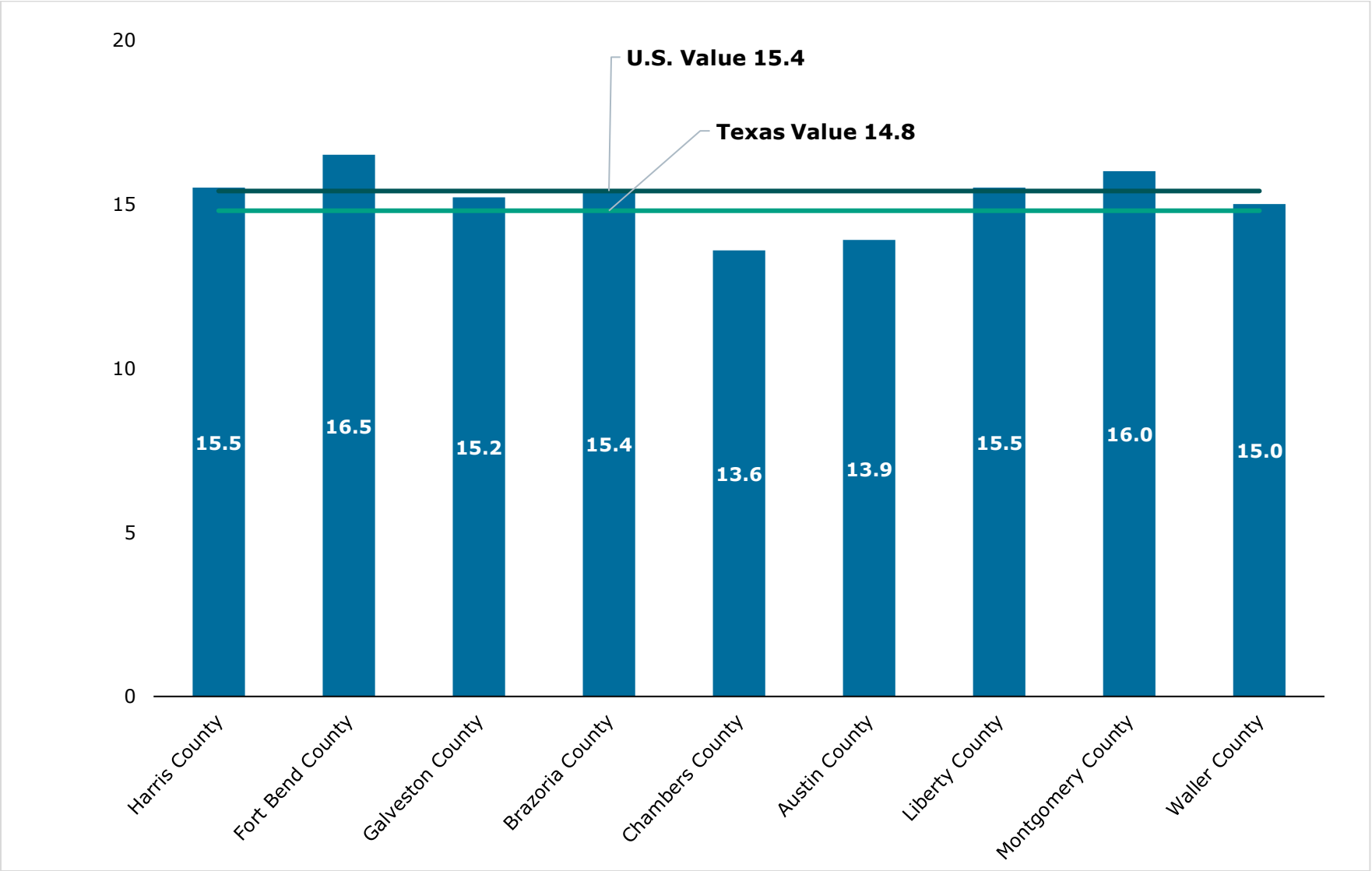
FIGURE 30. EDUCATIONAL ATTAINMENT



	HS Diploma or Higher	Bachelors Degree or Higher
TIRR	84.4%	34.5%
Harris County	81.8%	32.8%
Fort Bend County	91.1%	49.1%
Galveston County	90.2%	34.0%
Brazoria County	88.5%	32.0%
Chambers County	89.4%	23.9%
Austin County	87.2%	23.8%
Liberty County	78.36%	9.92%
Montgomery County	90.4%	39.3%
Waller County	86.60%	24.70%
Texas	85.0%	32.3%

Claritas (2024)

FIGURE 31. STUDENT-TO-TEACHER RATIO



National Center for Education Statistics (2022-2023)