Community Health Implementation Strategy

Memorial Hermann - Texas Medical Center

MEMORIAL® HERMANN
Texas Medical Center

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At-a-Glance Summary

Community Served	Memorial Hermann- Texas Medical Center includes Children's Memorial Hermann Hospital, Memorial Hermann Rockets Orthopedic Hospital and Memorial Hermann Cypress Hospital, serving 5,881,535 persons serving 131 zip codes across 9 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

Implementation Strategy Goals for FY26-FY28

Over the next three years, the hospital will implement and closely monitor a series of programs, activities, and milestones aligned with its established priorities. The following snapshot outlines these initiatives, many of which include overlapping secondary objective.

Access to Care

- Reduce unnecessary Memorial Hermann ER Utilization by ≥2% & ≥1% reduction of Memorial Hermann readmission rates of target population encountered by Community Health services residing in high poverty zip codes across Greater Houston.
- By FY28, to increase the charitable contributions dedicated to placement and transportation support by 1% to help remove logistical barriers to care. This investment will expand access for individuals in need, ensuring they can reach essential health services and follow through with their treatment plans.
- Refer ≥70% of Memorial Hermann Accountable Care Organization (ACO) patients discharged from acute or ED settings with identified Non-Medical Driver of Health (NMDOH) needs to Community Care Coordination Team (C3T) Community Health Workers (CHWs) for a documented intervention and outcome.

Access to Healthy Food

- To expand access to nutritious food for food insecure populations working at or served by the Memorial Hermann- Texas Medical Center service area by increasing the number of patients, families, and team members receiving emergency food support
- 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.
- Improve community wellness efforts driven by the Memorial Hermann TMC's Cypress campus by increasing activity offerings 5% above baseline year over year beginning in fiscal year 2026 and ending in fiscal year 2028.

Economic Opportunity and Educational Access

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

Maternal & Infant Health

- To advance maternal and infant health by increasing access to prenatal, postpartum, and nutrition education, expanding support groups, and promoting breastmilk donations. By FY28, the target is to achieve a 10% increase in both breastmilk donations and participation in these programs compared to baseline year of FY25.

Mental Health & Substance Use

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

Our Hospital and the Community Served

Memorial Hermann - Texas Medical Center

Memorial Hermann- Texas Medical Center includes Children's Memorial Hermann Hospital, Memorial Hermann Orthopedic & Spine Hospital and memorial Hermann Cypress Hospital which are 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.

Founded in 1925, Memorial Hermann- Texas Medical Center (TMC) is the primary teaching hospital for the McGovern Medical School at The University of Texas Health Science Center at Houston (UTHealth). Memorial Hermann-TMC provides leading-edge care in heart, neuroscience, orthopedics, women's health, general surgery, organ transplantation and much more. As one of only two certified Level I trauma centers in the greater Houston area, the hospital provides 24/7 emergency and trauma care. Memorial Hermann Life Flight® provides emergency rescue within a 150-mile radius.

Children's Memorial Hermann Hospital

Children's Memorial Hermann Hospital, 332-bed quaternary care women and children's hospital, has provided the highest level of care to children and women across the region for nearly four decades. It serves as the only hospital in Greater Houston capable of treating the entire family unit in the same facility, including neonatal, pediatric and adult specialists. Centers and specialties include Children's Heart Institute, Children's Neuroscience Center, Pediatric Digestive Health, Pediatric Ear, Nose & Throat, Pediatric Emergency Care, The Fetal Center, Pediatric General and Thoracic Surgery, NICU & Neonatal Care, Pediatric Ophthalmology, Pediatric Orthopedics, Pediatric Plastic and Reconstructive Surgery, Pediatric Transplant Center, Pediatric Urology, The Women's Center, Pediatric Virtual Care and other specialties focused on women's and children's care.

Memorial Hermann | Rockets Orthopedic Hospital (MHROH)

The Memorial Hermann | Rockets Orthopedic Hospital (MHROH) brings Memorial Hermann's exemplary standards for patient safety, quality and excellence to a facility that is focused solely on orthopedic and spine care. This hospital is dedicated to the highest quality service with easy access and optimum outcomes for patients across Greater Houston undergoing orthopedic and spine surgery. From affiliated physicians to support personnel, the staff is specially trained and dedicated to helping patients undergo

procedures that restore or improve functionality and allow them to return to an active lifestyle. The convenient central location and small size make it ideal for outpatient surgery and services such as knee, shoulder and hip pain treatments as well as rehabilitation. MHROH specializes in: elective orthopedic surgery, neurosurgery for spine-related conditions, sports-related spine and orthopedic conditions and injuries.

Memorial Hermann Cypress Hospital

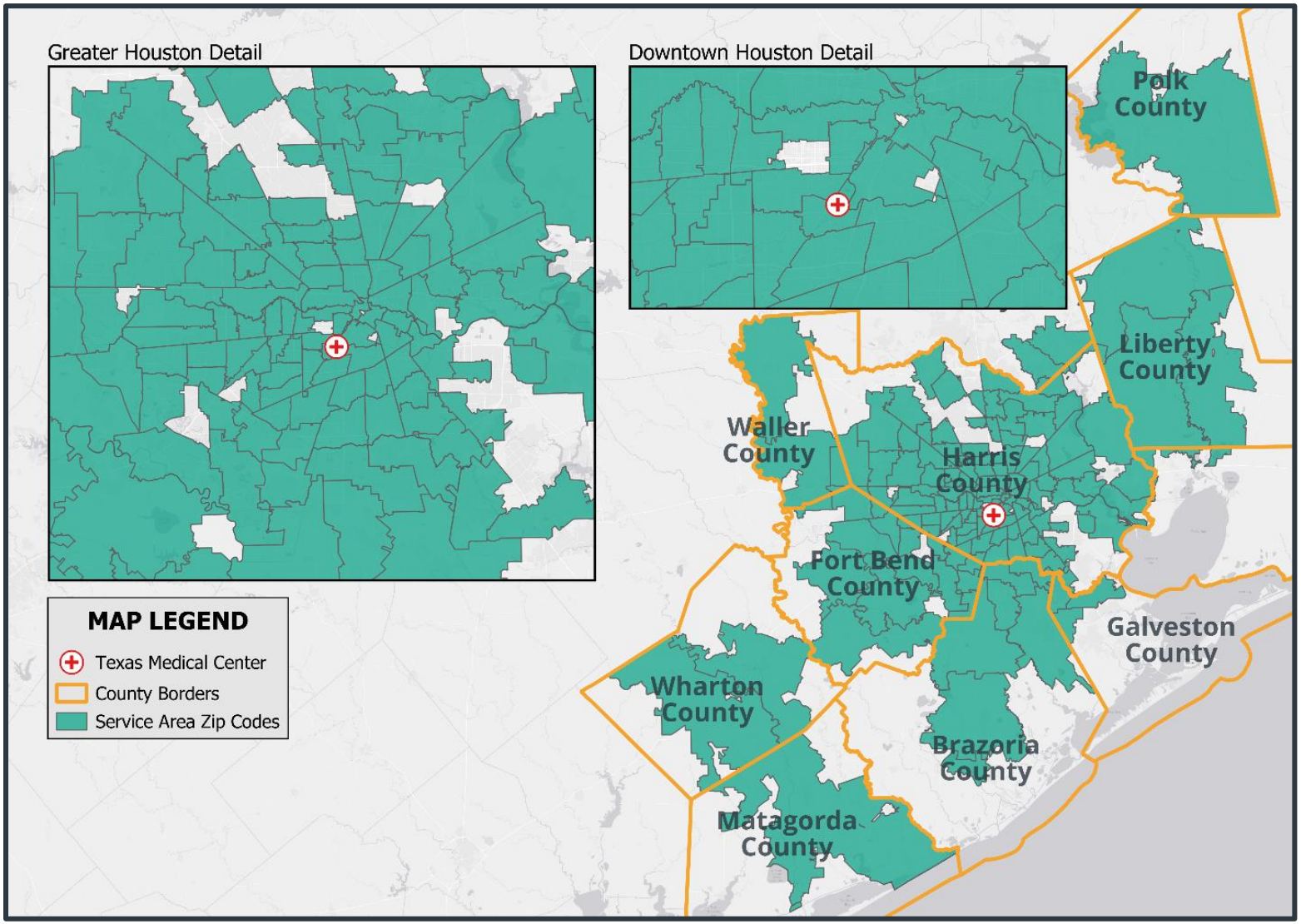
Located in the dynamic and fast-growing Cypress area, Memorial Hermann Cypress Hospital brings the expertise of the Memorial Hermann Health System, including the region's experienced medical specialists, to families in the northwest Houston, Cypress and Waller communities. Affiliated, board-certified physicians and health care professionals employ advanced medical equipment and state-of-the-art technology to address the community's health care needs, from routine outpatient visits to complex inpatient procedures in the143-bed facility.

In just over eight years, Memorial Hermann Cypress has continued to exceed expectations, including a $25 million expansion after its first year of operation, a nearly $72 million expansion that concluded in 2023 and is currently undergoing a third expansion, $277.5 million, which will add an additional patient bed tower, expand emergency, operating room, cath lab and women's services. The expansion will also bring TIRR Memorial Hermann to the community.

Description of the Community Served

Texas Medical Center 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. MEMORIAL HERMANN TEXAS MEDICAL CENTER METROPOLITIAN SERVICE AREA BY ZIP CODES



Source: MHHS facilities values from Claritas (2024)

Community Assessment and Significant Needs

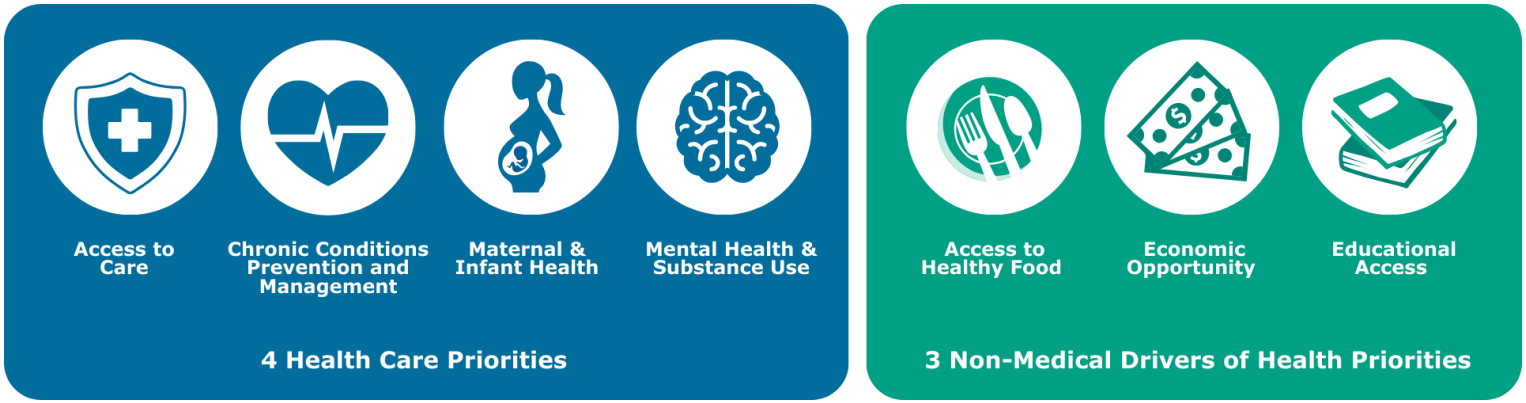
The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted on June 26, 2025. The CHNA report includes:

- 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 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- Texas 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- TMC, and other hospital leadership.

During initial planning meetings, representatives from HCI and Memorial Hermann- Texas 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 Texas 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 Plan presented below outlines in detail the individual strategies and activities Memorial Hermann-Texas 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 below:

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 Texas 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: **2% Reduction of Unnecessary MHHS ER Utilization & ≥1% reduction of MHHS Readmission Rates of target population encountered by Community Health services residing in high-poverty zip codes across Greater Houston.**

FY26 Objective: Decrease avoidable readmissions and unnecessary ER revisits for patients living in high-poverty ZIP codes with diabetes, cardiovascular disease, hypertension or obesity, through interventions that address NMDOH and expand affordable, community-based care pathways. (Baseline to be determined by end of FY26 to drive the annual 0.5% reduction of year-over-year revisits and annual 0.25% reduction of year-over-year readmissions.)

FY26 KPIs:

- Percent—decrease in ER revisits
- Percent—decrease in Inpatient readmissions of target population
- Percent—patient achieving improvement in focus health measures (e.g. A1c; BMI) for targeted disease states
- Percent—screening rate for patients identified as high-risk for NMDOH encountered in the ER and Inpatient setting
- Percent—resource referral rate for patients identified as high-risk for NMDOH encountered in the ER & Inpatient setting

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
ER Navigation Program	Community Health Network	Baseline TBD by end of FY26	• Volume - referrals to NHC upon discharge • Volume - referrals to community partner locations • Percent - show rate of referred to NHC • Percent - decrease of ER revisits within180 days (6 months) of navigated

Multi-Visit Patient Program	Community Health Network	Baseline TBD by end of FY26	• Volume – unique referrals to MVP Program • Volume – unique referrals to external community partner locations • Percent – show rate of referred to navigated resources • Percent – decrease of MVP revisits within 180 days of navigated.
Inpatient Navigation Program	Community Health Network	Baseline TBD by end of FY26	• Percent - 90-day readmission rate of navigated • Volume – patients referred to NHC post-discharge • Volume – referrals to community partner locations • Percent – show rate of patients referred to support services
SafeRide Program	Community Health Network	426 Completed Rides (universal May 2025)	• Volume – number of rides completed • Percent - completed rides to PCP/ Doctor appointment
TMC: Blood Pressure and Carotid Screenings	Stroke Team	• 2024: BP Screenings = 301 • Carotid Screenings = 258	• Number – screenings completed • Percent – screenings positive • Number – referrals made
Target/Intended Population(s): • Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS Texas 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. • 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.			

- SafeRide is a non-emergency medical transportation (NEMT) program leveraged by patients who screen positive for transportation needs. The focus is getting patients to follow up appointments after they have been discharged from the hospital.

Collaboration Partners (Internal and External):

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

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

FY26-FY28 Goal: By FY28, to increase the charitable contributions dedicated to placement and transportation support by 1% to help remove logistical barriers to care. This investment will expand access for individuals in need, ensuring they can reach essential health services and follow through with their treatment plans.

FY26 Objective: To reduce avoidable hospital days caused by lack of funded transportation through targeted charitable support and care coordination. Success will be measured by tracking the number of patients receiving transportation assistance

FY26 KPIs:

- Number – patients screened for transportation insecurity
- Number – patients receiving transportation assistance
- Amount – charitable contributions allocated to support
- Number – rides deployed

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Charitable Placements	Social Work	$2.7M provided	• Amount – amount of dollars given for charitable placements
TMC: Transportation Vouchers	Social Work	• zTrip: $30,089.54 • LYFT: $72,701.64 • Metro bus passes: $7,900.00	• Amount – amount of dollars given to safely transport patients home after discharge • Number – rides deployed • Number – patients receiving transportation assistance

			• Number - avoidable days due to transportation barriers

Target/Intended Population(s):

- Uninsured; Medicaid; High-poverty priority ZIPs in surrounding MHHS- Texas Medical Center campus

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

- Both programs support transfer of patients to the appropriate level of care

Collaboration Partners (Internal and External):

- UT Health Center; Local Skilled Nursing Facilities, Nursing Homes, and Private Care Homes; Social Work; Case Management

Prioritized Need Area: Access to Care

FY26-FY28 Goal: ≥70% of MHHS ACO patients discharged from acute or ERsettings with identified NMDOH needs will be referred to Community Care Coordination Team (C3T) CHWs for a documented intervention and outcome.

FY26 Objective: ≥50% of MHHS ACO patients discharged from acute or ER settings with identified NMDOH needs will be referred to Community Care Coordination Team CHWs for a documented intervention.

FY26 KPIs:

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

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Transitional Care Management	• Population Health • ISD • Analytics	Baseline TBD post- FY26	• Capture Rate – of NMDOH needs, referrals, and outcomes in Epic
ED Management	• Population Health • ISD • Analytics	Baseline TBD post- FY26	• Capture Rate - of NMDOH needs, referrals, and outcomes in Epic

Target/Intended Population(s):

- Any ACO life being cared for by acute hospitals, PHSO, and community providers

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

- Memorial Hermann ACO consists of a network of affiliated physicians that unite independent and employed physicians of every specialty throughout the Houston area in a common commitment to quality and accountability. These physicians practice evidence-based medicine proven to result in better clinical outcomes and shorter hospital stays

Collaboration Partners (Internal and External):

- Acute Case Management, MHMG, MHMD, ISD, and Analytics

Community Priority: Access to Healthy Food

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

FY26-FY28 Goal: **To expand access to nutritious food for food insecure populations working at or served by the Memorial Hermann- TMC service area by increasing the number of patients, families, and team members receiving emergency food support**

FY26 Objective: Increase availability of healthy food options for patients, families, and team members in our community who are in need.

FY26 KPIs:

- Ensure all families of hospitalized pediatric inpatients have adequate, healthy food while at the hospital.
- Create pathway for team members to obtain adequate food through dignified pathway.

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
CMHH: Family/Caregiver Meal Trays for IP	• MH Foundation • Operations Leadership	Baseline TBD post-FY26	• Number—Caregivers receiving trays through Foundation funded program
TMC: Employee Food Pantry	• TMC Partners in Caring Committee • TMC Campus Administration • TMC Security	Baseline TBD post-FY26	• Number—Badges who access the food pantry
Cypress: Annual Food Drives with Cypress Assistance Ministry	Hospital Operations	• 3,500 pounds of food donated • 0 items of food donated to Waller ISD families	• Number—pounds of food donated to CAM • Number—food boxes donated to Waller ISD students

Target/Intended Population(s):

- Underserved communities in northwest Houston, Cypress and Waller County, All payors, Caregivers of food-insecure pediatric inpatients at CMHH

- Food-insecure Memorial Hermann - TMC team members and their families

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

- TMC onsite food pantry anticipated opening early CY 2026
- CMHH caregiver tray program in final phases of pilot. Epic build finalization Q2 FY26.
- Host food drives throughout the year which benefit Cypress Assistance Ministries (CAM) and Waller ISD students to assist with their access to healthy food

Collaboration Partners (Internal and External):

- Memorial Hermann Foundation; TMC Partners in Caring Committee; Waller ISD; Cypress Assistance Ministries; MHHS Cypress employees and providers

- **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.

FY26 KPIs:

- Percent – patients screened for food insecurity
- Percent – food-insecure patients referred to food assistance (external)
- Percent – food-insecure patients referred to food assistance (internal pantries)

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Community Health Worker (CHW) Hub	• Community Health Network • Ambulatory Services	Baseline TBD post-FY26	• Percent – food insecure referrals received • Number – food access appointment scheduled
Community Resource Centers	Community Health Network	Baseline TBD post-FY26	• Volume – unique members of households served • Percent – referrals for food insecure • Percent – show rate of food insecure referred patients

			• Number – additional NMDOH services rendered • Percent – referred to external nonprofits • Number – SNAP eligible benefits received for referred
Food as Health Program	Community Health Network	Baseline TBD post-FY26	• Volume – patients/community members accessing FAH program support • Number – Pounds of food distributed • Percent – supported residing in priority communities
Target/Intended Population(s): • Food insecure; uninsured; Medicaid; residing in target communities surrounding Memorial Hermann-TMC and Community Health Resources			
Please provide any additional insights or explanations on the initiative(s) listed. • Community Resource Centers are in four locations across Greater Houston but is working to expand to additional sites to meet the needs of Memorial Hermann patients and community members. Focused on addressing NMDOH. TMC receives patients from across Greater Houston making the CRC a viable option for some of the underserved cared for at TMC. • 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 Care**

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

FY26 Objective: ≥25% of Memorial Hermann Texas Medical Center Hospital, including their supported campus of Cypress, 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
- Go-Live—Epic optimization

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

Nursing Admission Assessment Screenings	• Nursing • Social Work • Providers	N/A – Will pull baseline post Epic	• Process – Epic optimization to automate Social Work Referral based on Nursing documentation • Number – consults entered • Number – consults completed
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. • SDOH screenings include patient and family determinants. The Social Work team focuses on resources available based on that patient's individual condition, needs, and geographical location.			
Collaboration Partners (Internal and External): • NMDOH Workgroup; System; ISD; Digital; Ambulatory Services; Local FQHCs; Local Social Service Agencies; Social Work team			

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

FY26-FY28 Goal: Improve community wellness efforts driven by the TMC's Cypress campus by increasing activity offerings 5% above baseline year over year beginning in fiscal year 2026 and ending in fiscal year 2028.

FY26 Goals: Improve community wellness by increasing activity offerings 5% above baseline results for blood pressure screenings, glucose screenings and other community health driven initiatives to support mitigation of development of chronic diseases. This initiative will be driven by the Memorial Hermann Cypress location which is under the Texas Medical Center support structure.

FY26 KPIs:

- Number – glucose screenings
- Number -blood pressure screenings
- Number – new monthly memberships & utilization

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Cypress: Community Screenings: Blood Pressure & Glucose	• Nursing Department • Marketing Division	• 15 screenings for on-campus seminars • 100 screenings for Community Health Expo • 20 Referrals/Find a Physician cards for glucose screenings • 30 Referrals/Find a Physician cards for blood pressure screenings	• Number – glucose screenings • Number – blood pressure screenings • Number – referral cards for glucose screenings • Number – referral cards for blood pressure screenings
Cypress: Physical Fitness Initiative: Gym Access	Hospital Operations	15 new memberships per month	Number – new monthly memberships
Cypress: High School Physicals	Athletic Trainers	700 physicals performed per high school	Number – physicals performed per high school

Target/Intended Population(s):

- Broader Greater Houston community; older Adults / aging population; athletes; Managed Care, Medicare Advantage and Medicaid payors

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

- Provide free glucose and blood pressure screenings at hospital-hosted events and community sponsored events. For those needing follow-up care, we provide education and Referral via 'Find a Physician' card
- Provide discounted gym membership for community members in partnership with Athlete Training & Health.
- Provide high school physicals at a discounted rate each spring season in partnership with Cy-Fair ISD (six high schools).
- MHHS Cypress has sports medicine agreement with Cy-Fair ISD, where we provide athletic trainers for six of the 12 high schools.

Collaboration Partners (Internal and External):

- Cy-Fair ISD; Athlete Training and Health (partner for Memorial Hermann Sports Parks); MHHS Cypress Nursing Staff

Community Priority: Economic Opportunity and Educational Access

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

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

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

FY26 KPIs:

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

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
TMC/ Cypress/ CMHH: Community Service Corps: Skills-based volunteerism	Community Health Network	Baseline TBD post-FY26	• Number – employees volunteer hires • Number – nonprofit agencies supported
TMC: PCT to LVN Program	Nursing Leadership	• 2024: 10 selected, 7 completed and passed • 2025: 8 enrolled	• Number - PCTs enrolled • Percent- participants who pass and become MH nurses
Cypress: Student Clinical Rotations for Lone Star College – Cy-Fair & Tomball students	MH Cypress Education Team	35 clinical rotations per semester	• Number- clinical rotations for Fall and Spring semesters (target 5% increase by FY28)

TMC: Partners in Caring: Share & Care Event	TMC Partners in Caring Committee	2024: 440 employees attended and took free items	• Number- employees attended • Percent- low income employees attended
Cypress: Dress for Success and Cypress Assistance Ministries (CAM) Clothing Drives	• Operations • Marketing	• 50 items donated per year to Dress for Success • 100 items donated per year to CAM	• Number - items donated (target: 10% increase by FY28)
TMC/ Cypress/ CMHH: 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; TMC – any employee in need; Cypress – underserved communities in northwest Houston, Cypress and Waller County; All payors

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, MHHS TMC Campus; Lone Star College – Cy-Fair; Lone Star College – Tomball; MHHS Cypress employees; Partners in Caring, MHHS Administration, MHHS Volunteers; Cypress Assistance Ministries (CAM); Waller ISD; MHHS Cypress employees and providers

Community Priority: Maternal and Infant Health

Prioritized Need Area: Maternal & Infant Health

FY26-FY28 Goal: To advance maternal and infant health by increasing access to prenatal, postpartum, and nutrition education, expanding support groups, and promoting breastmilk donations. By FY28, the target is to achieve a 10% increase in both breastmilk donations and participation in these programs compared to baseline year of FY 25.

FY26 Objective: To achieve at least a 3% to 4% increase in breastmilk donations and in participation in prenatal, postpartum, and support group programs compared to previous fiscal year, putting Memorial Hermann Cypress on track to meet the three-year target of 10%.

Cypress FY26 KPIs:

- Volume – ounces of breast milk donated
- Number – attendees to classes and support groups

Strategic Approach

Programs/Activities	Owner	Baseline	Milestones/ Measures of Success FY26
Cypress: Drop-off location for Mother's Milk Bank of Austin	Women's Educators	800 ounces donated per month	• Volume – breast milk ounces donated per month
Cypress: Community Prenatal & post-partum educational	Women's Educators	• 9 attendees per class per month • 9 attendees per support group per month • 4 teen parent attendees per class per month • 4 teen parent attendees per support group per month	• Number- attendees per class and support group per month • Number—teen parent attendees per class and support group per month
CMHH: March of Dimes partnership Mom's Milk and Cookies weekly event	• March of Dimes NICU Family Support Program • NICU Lactation team	• # of events = 55 • 250 mothers attended (NICU & Antepartum)	• Number- events • Number - attendees
CMHH: Pre-discharge parenting classes	Nursing	Baseline TBD	• Number- events • Number - attendees

CMHH: Onsite Ronald McDonald House (RMH)	RMH Team	• # of families = 841 • # of meals = 9,060	• Number- families who utilized overnight lodging • Number- meals provided

Target/Intended Population(s):

- Soon-to-be parents and/or parents; Teen parents; All payors

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

- MHHS is the only health system in the Cypress area to provide prenatal education classes
- Serve as a free drop-off location for mother's donating their breast milk to Mother's Milk Bank of Austin
- Provide prenatal & post-partum educational classes & support groups to the community, these classes are free for parents 21 and younger. Providing Cy-Fair ISD and Waller ISD with these educational resources for their teen parents.
- CMHH partners with March of Dimes for Mom's Milk and Cookies weekly event. This event coach's new moms in real time with breastfeeding their newborn.
- CMHH is hosting parenting classes for antepartum patients and new parents before discharge. First classes est. to begin in FY26.
- CMHH has an onsite Ronald McDonald House providing free overnight stays and meals on Campus for parents and families with critically ill children.

Collaboration Partners (Internal and External):

- Mother's Milk Bank of Austin; MHHS Cypress Women's Community Educators; Waller ISD; Cy-Fair ISD

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 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 the Memorial Hermann- Texas Medical Center and supported campuses.

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
- Percentage—Zero Suicide call back rate (increase by 5%)
- Number—TMC team members educated on Charlie Health referral process post Epic build
- Go-Live—referral Optimization Process

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

CMHH: Zero Suicide Program	• Quality and Safety • Social Work	FY24: 67% call back rate per encounter	• Number— high-risk suicide patients with touchpoints 1 week, 30 days, and 60 days post discharge • Percent— patients engaging in phone calls post discharge • Go- Live— Epic optimization for tracking & documentation
TMC: Charlie Health Mental Health and Substance Abuse referrals	• Charlie Health • Behavioral Health	FY 24: • 118 Referred • 52 Intake Appt	• Number— referrals • Percent— referrals who attend an intake appointment • Go-Live— Epic build for easy referrals

Target/Intended Population(s):

- Broader Greater Houston community; parents and students within HISD area
- Charlie Health: All populations served at Memorial Hermann- TMC plus their caregivers/family
- Zero Suicide: CMHH patients with a moderate to high risk of self-harm upon discharge

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

- Memorial Hermann Psychiatric Response Team, and on demand virtual psychiatry works 24/7 across the system and provides behavioral health expertise to all acute care campuses, delivering services to ERs and inpatient units.
- Memorial Hermann Mental Health Crisis Clinics (MHCCs) are outpatient specialty clinics open to the community, meant to serve individuals experiencing mental health challenges or those needing more immediate access to outpatient providers to meet their behavioral health needs.
- Memorial Hermann Collaborative Care Program (CoCM) strives to facilitate systematic coordination of general and behavioral health care. Integrating physical and behavioral health services; facilitating seamless access to care.
- Human Resources - Behavioral Health Services Employees
- Operating Resources – Computers, EMR, Virtual technology, and other documentation tools
- Capital Resources – Offices and other facilities
- Post Epic build, additional information to all staff on Charlie Health referrals
- Charlie Health Mental Health and Substance Abuse referrals are for patients and their families (ages 8-64)

Collaboration Partners (Internal and External):

- Collaboration with all the Memorial Hermann Facilities, Leadership, Case Management, Medical staff, Community Service Providers, and other community partners; Charlie Health; CMHH Zero Suicide Program Staff; Social Work; Child Life; Chaplains

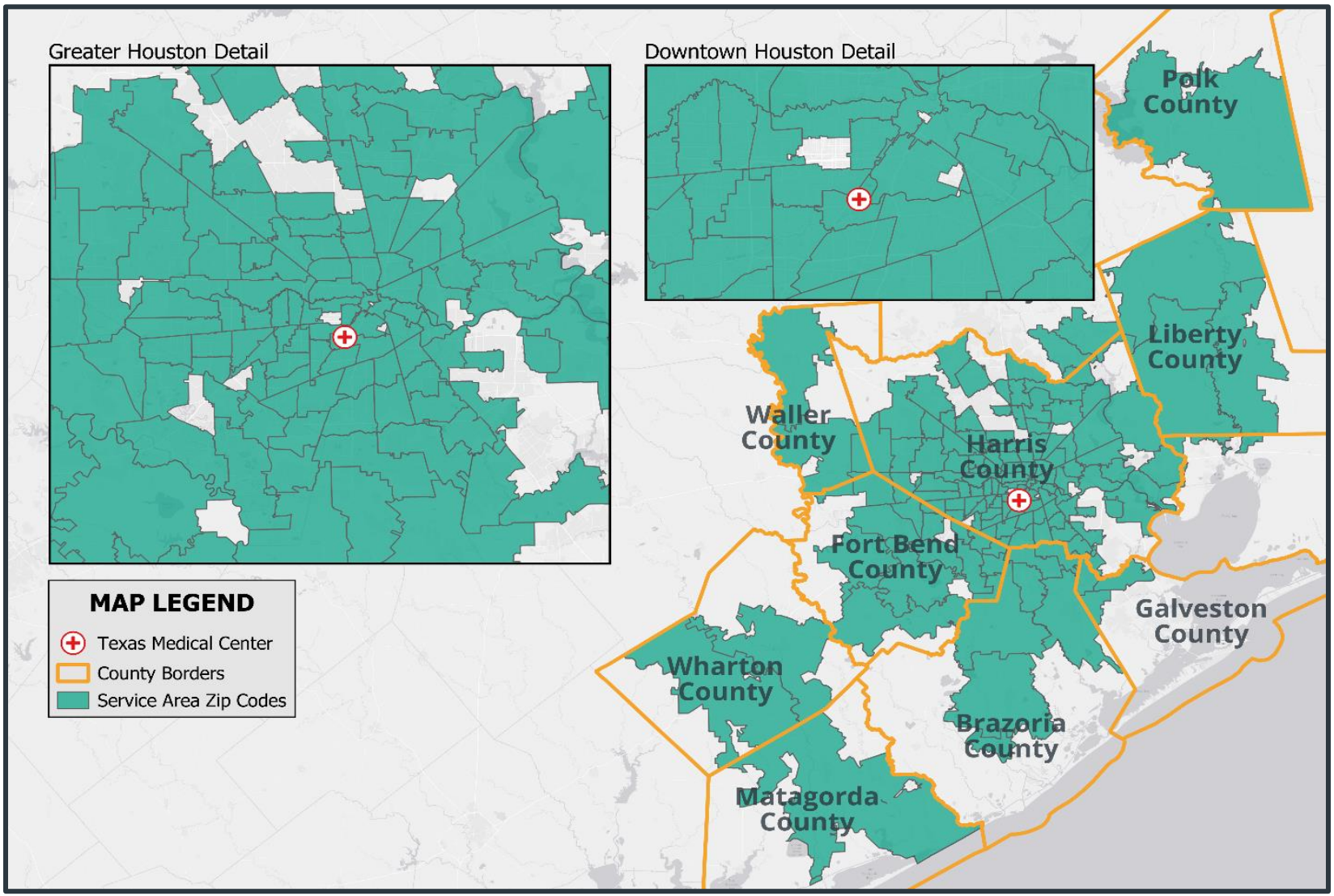
MEMORIAL HERMANN

Appendices

Appendix A. Memorial Hermann Texas Medical Center Supplementary Findings

The primary service area for Memorial Hermann Texas Medical Center includes 131 zip codes across 9 counties.

FIGURE 1. MEMORIAL HERMANN- TEXAS MEDICAL CENTER PRIMARY SERVICE AREA

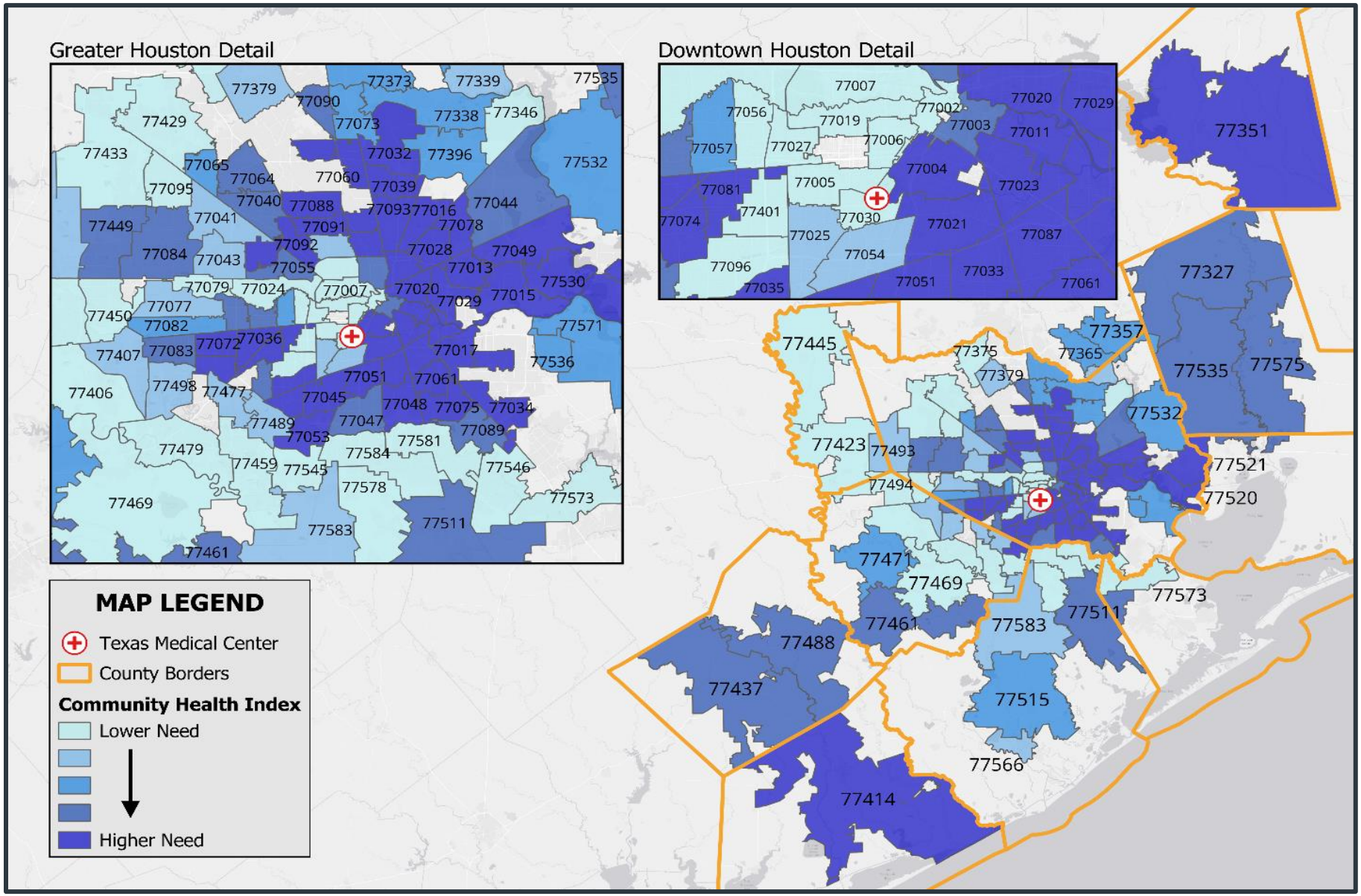


Key Findings: Access to Care

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 Texas Medical Center service area, 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)

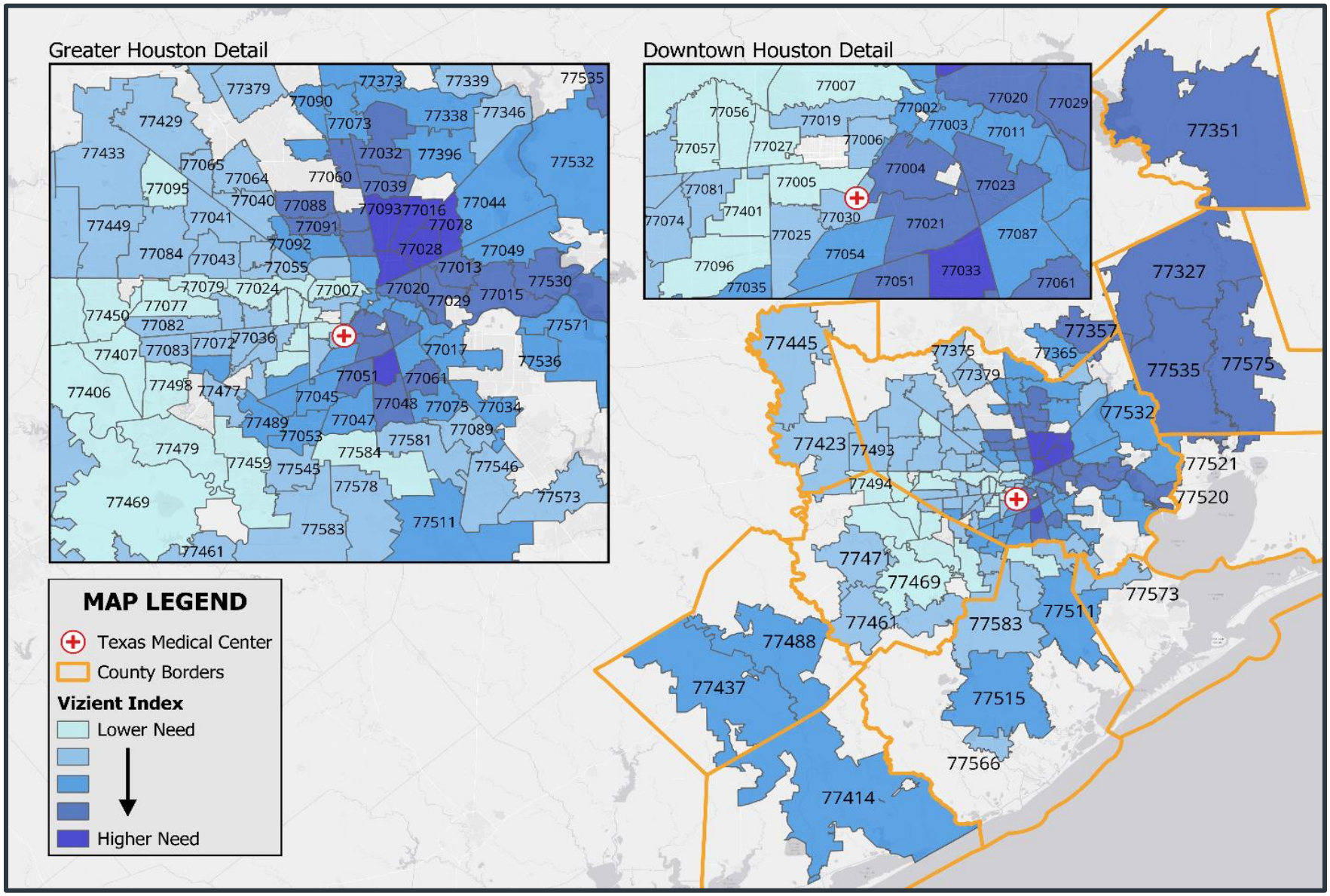
FIGURE 2. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S COMMUNITY HEALTH INDEX BY ZIP CODE: TEXAS MEDICAL CENTER SERVICE AREA



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 Texas Medical Center service area, the zip codes with the greatest healthcare needs, based on this index score, are:

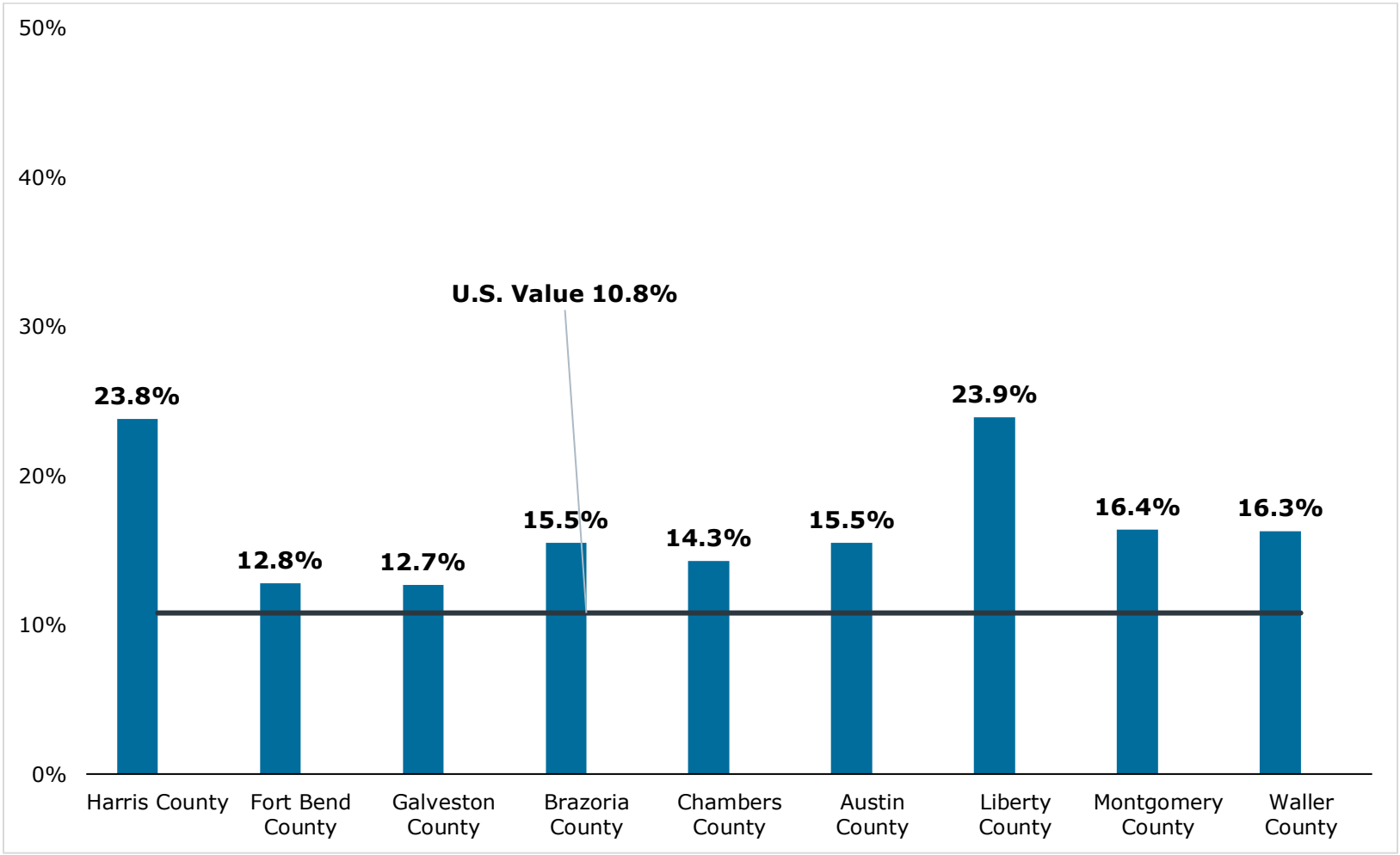
- 77028 (VVI = 2.41)
- 77016 (2.34)
- 77078 (2.10)
- 77026 (2.06)
- 77093 (1.83)

FIGURE 3. VIZIENT SCORE BY ZIP CODE: TEXAS MEDICAL CENTER SERVICE AREA



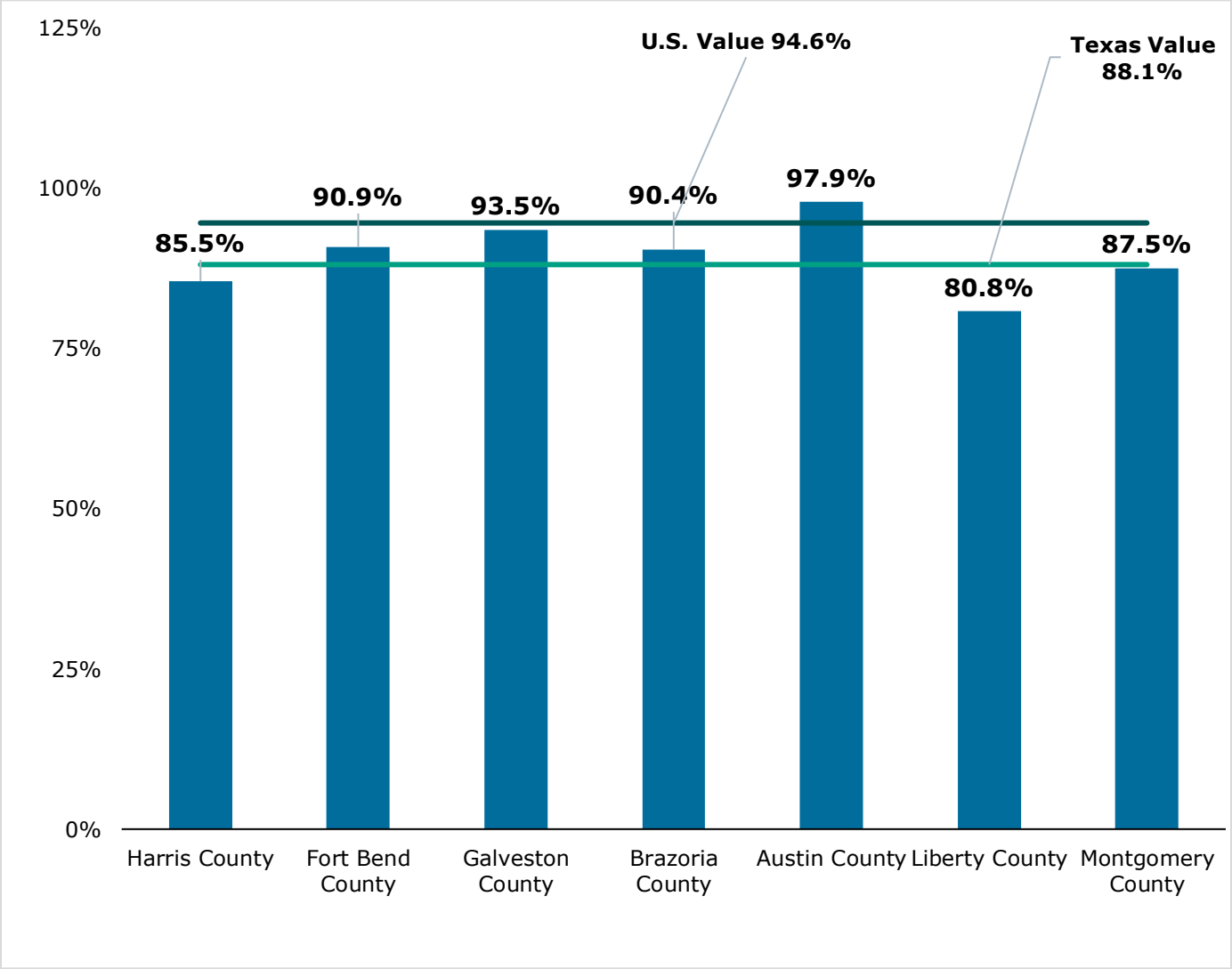
The following figures illustrate indicators of concern in counties that fall under Texas Medical Center Service Area, based on scoring of secondary data related to **Access to Health Care.**

FIGURE 4. ADULTS WITHOUT HEALTH INSURANCE



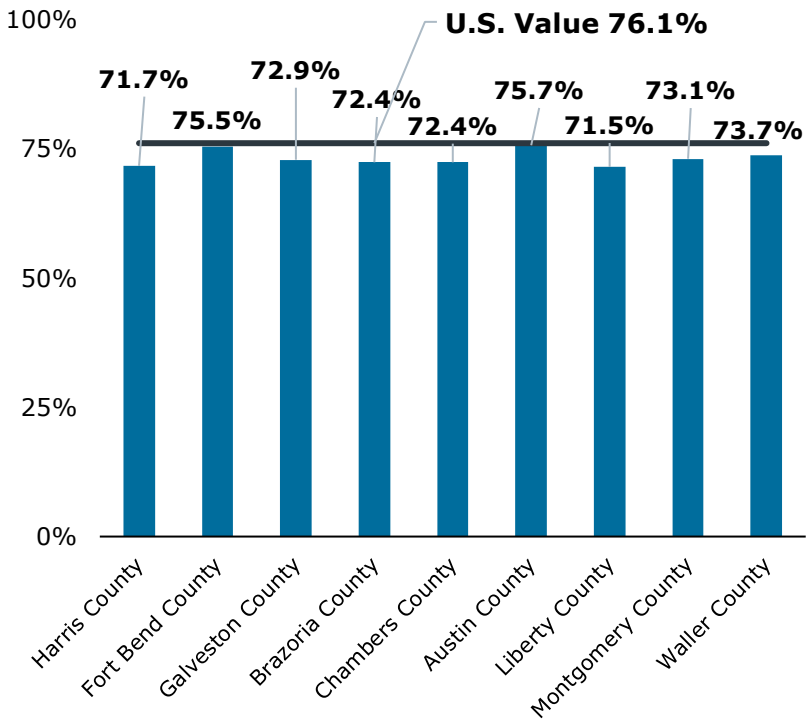
Source: CDC – PLACES (2022)

FIGURE 5. CHILDREN WITH HEALTH INSURANCE



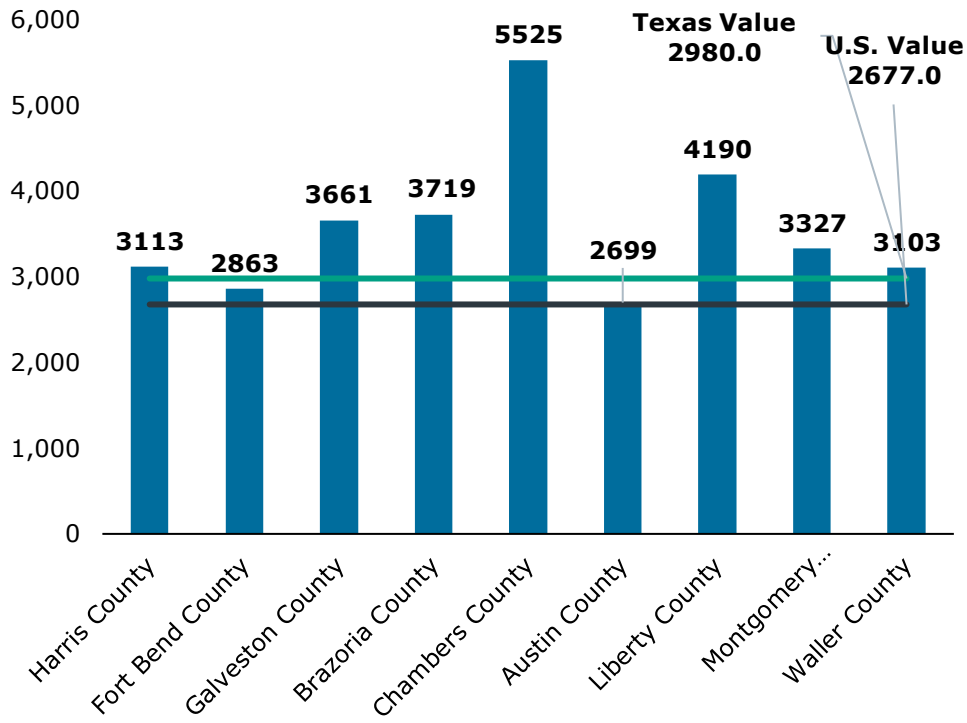
Source: American Community Survey (2023)

FIGURE 6. ADULTS WHO HAVE HAD A ROUTINE CHECKUP



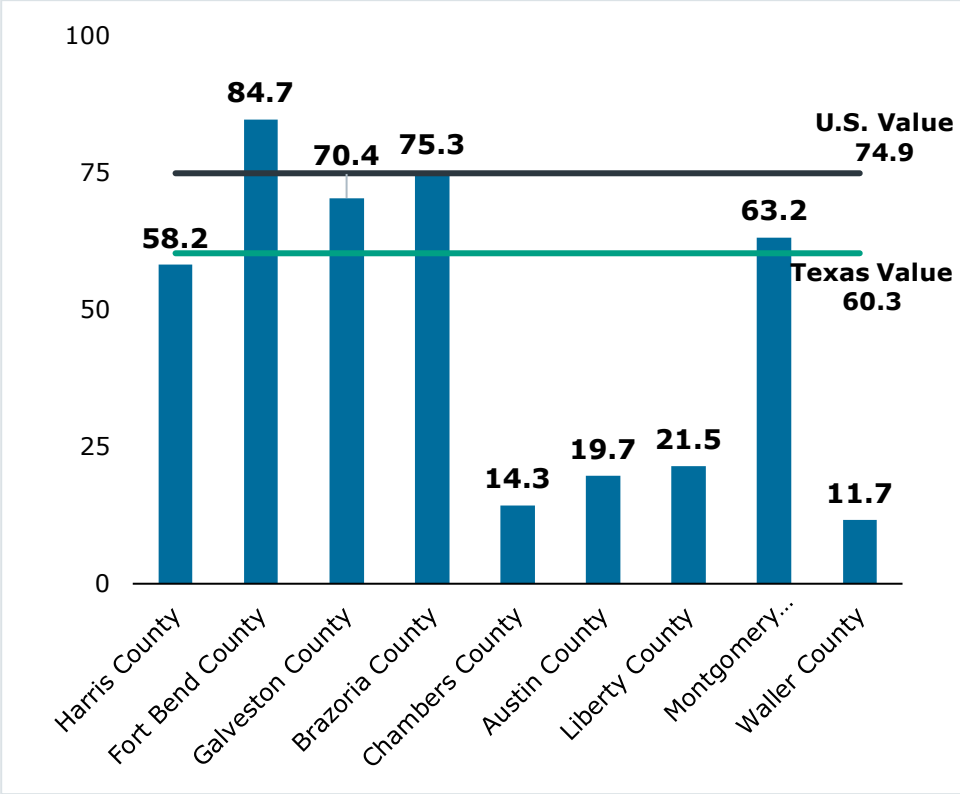
CDC – PLACES (2022)

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



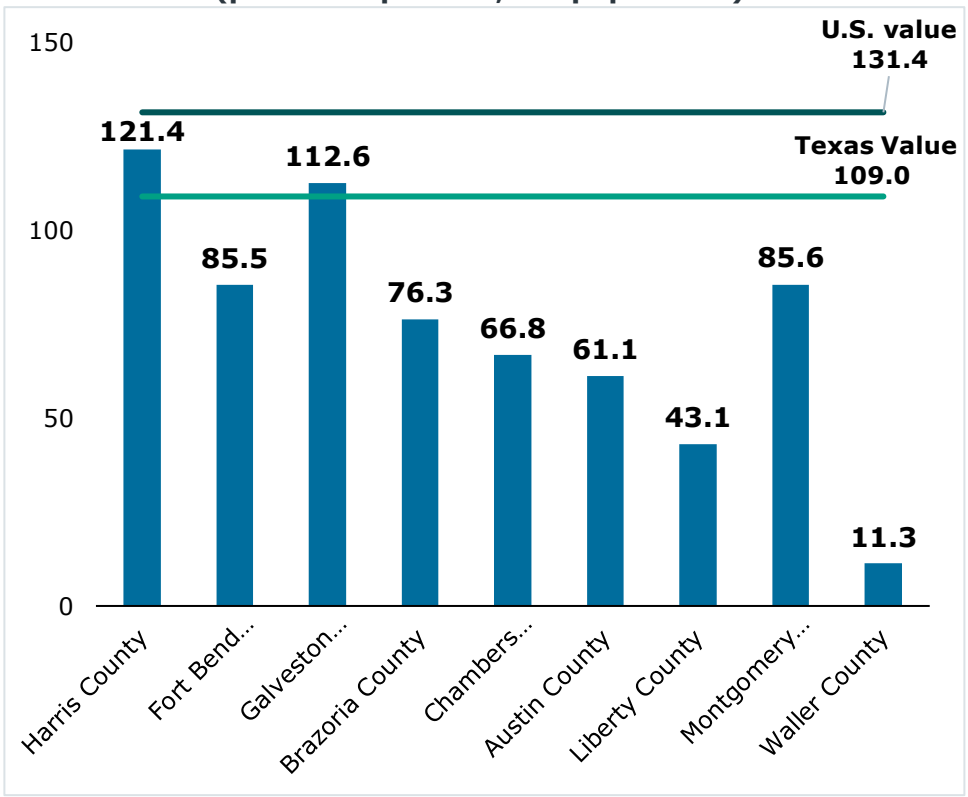
Centers for Medicare & Medicaid Services (2022)

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)

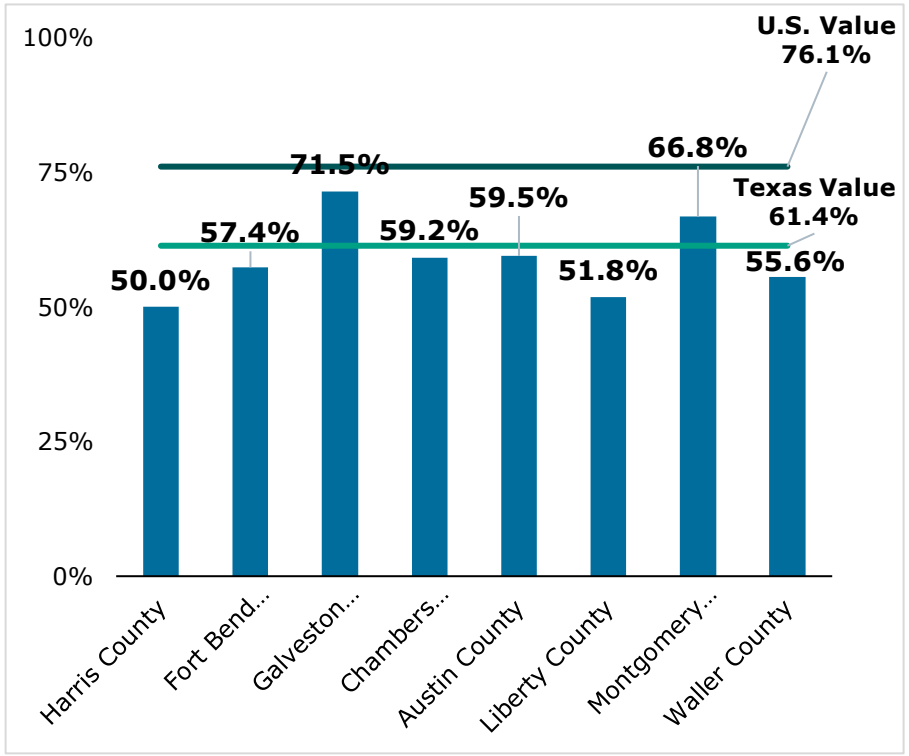


County Health Rankings (2023)

Key Findings: Maternal & Infant Health

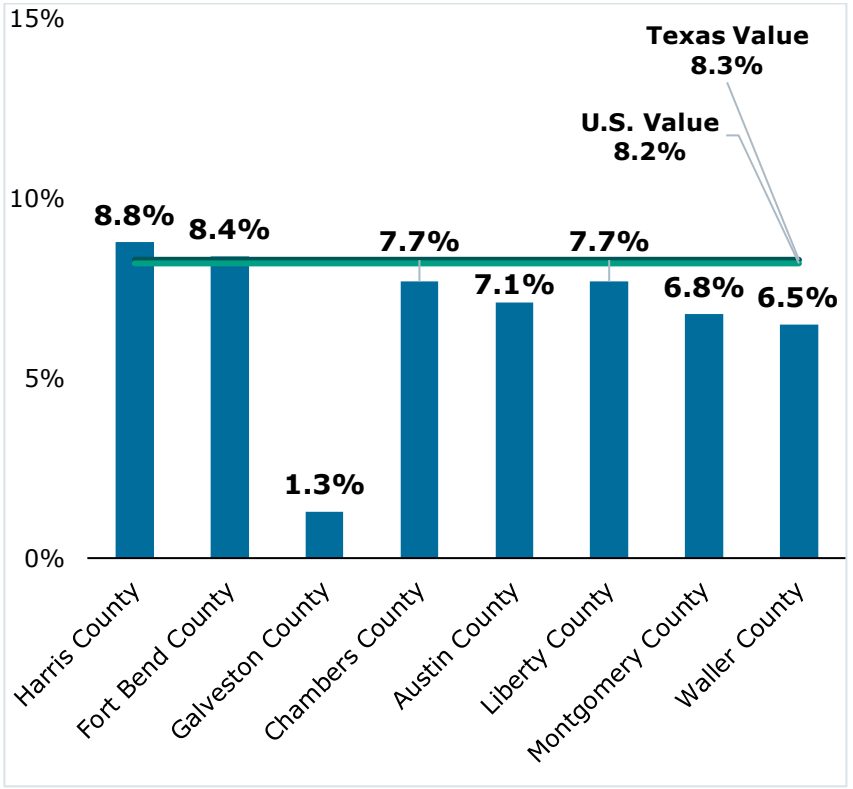
The following figures illustrate indicators of concern in counties that fall under Texas Medical Center Service Area, based on scoring of secondary data related to Maternal and Infant Health.

FIGURE 10. MOTHERS WHO RECEIVED EARLY PRENATAL CARE



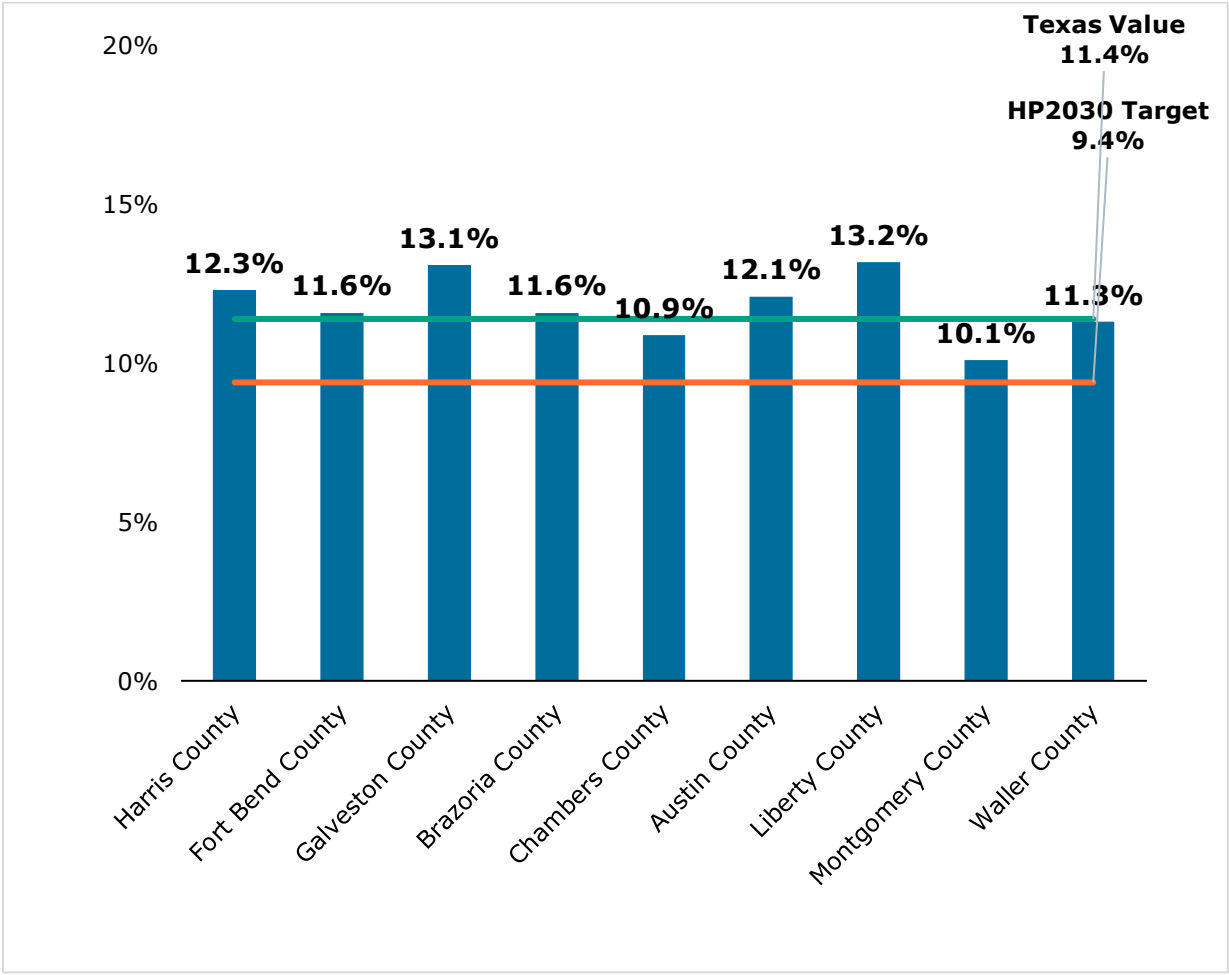
Texas Department of State Health Services (2020)

FIGURE 11. BABIES WITH LOW BIRTHWEIGHT



Texas Department of State Health Services (2020)

FIGURE 12. PRETERM BIRTHS

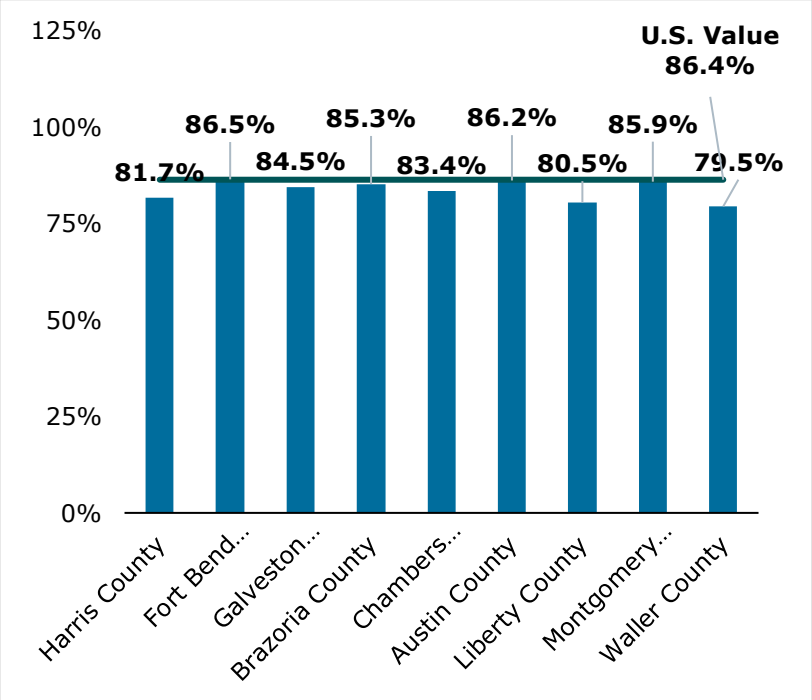


Texas Department of State Health Services (2021)

Key Findings: Chronic Condition Prevention & Management

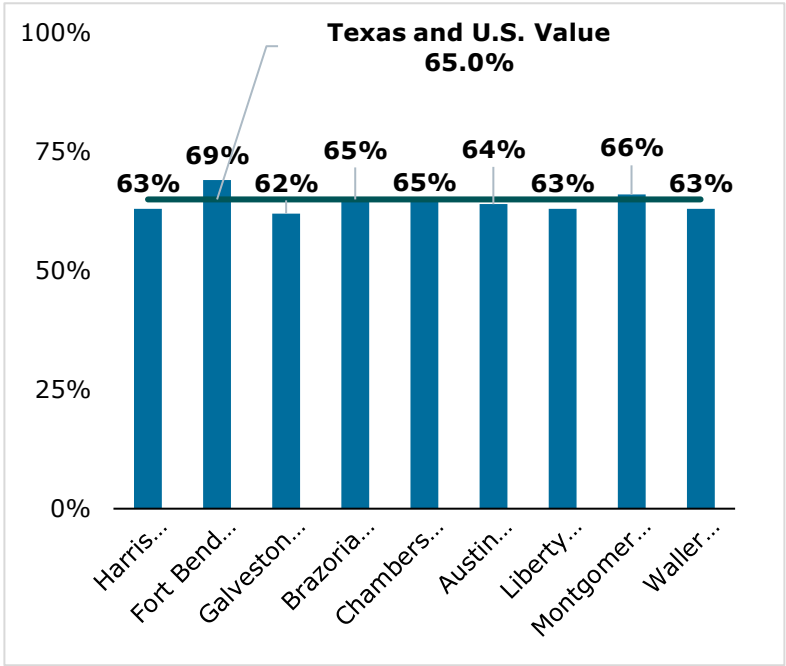
The following figures illustrate indicators of concern in counties that fall under Texas Medical Center Service Area, based on scoring of secondary data related to Chronic Condition Prevention & Management.

FIGURE 13. CHOLESTEROL TEST HISTORY



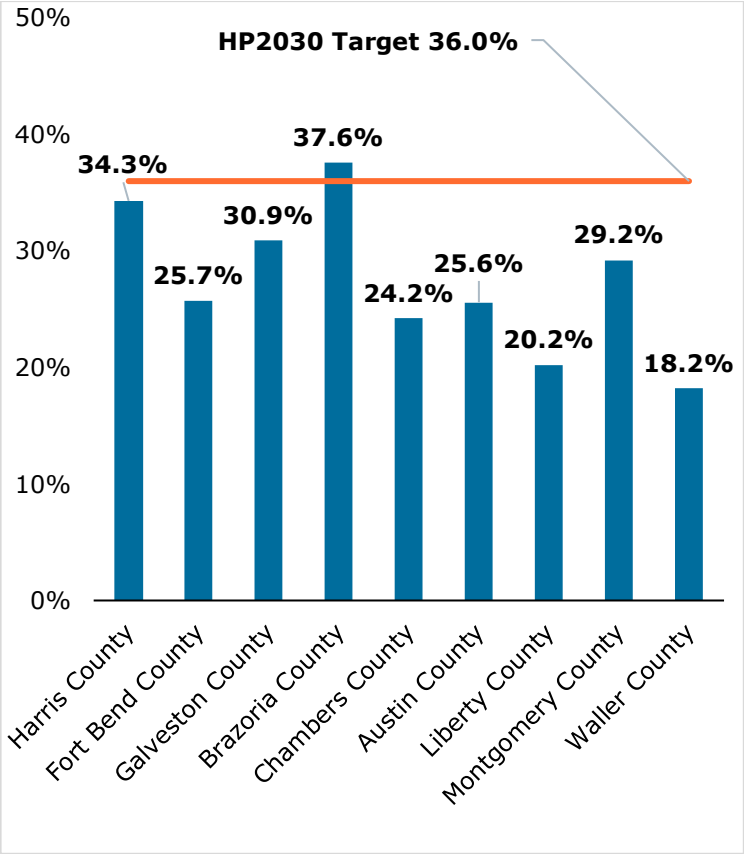
CDC – PLACES (2021)

FIGURE 14. HYPERLIPIDEMIA: MEDICARE POPULATION



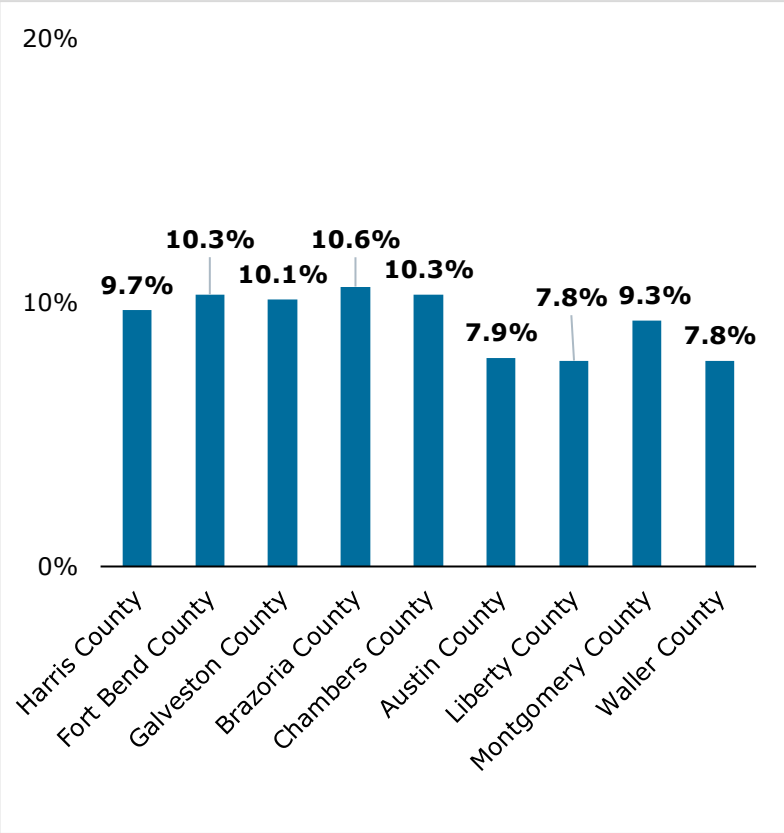
Centers for Medicare & Medicaid Services (2022)

FIGURE 15. ADULTS 20+ WHO ARE OBESE



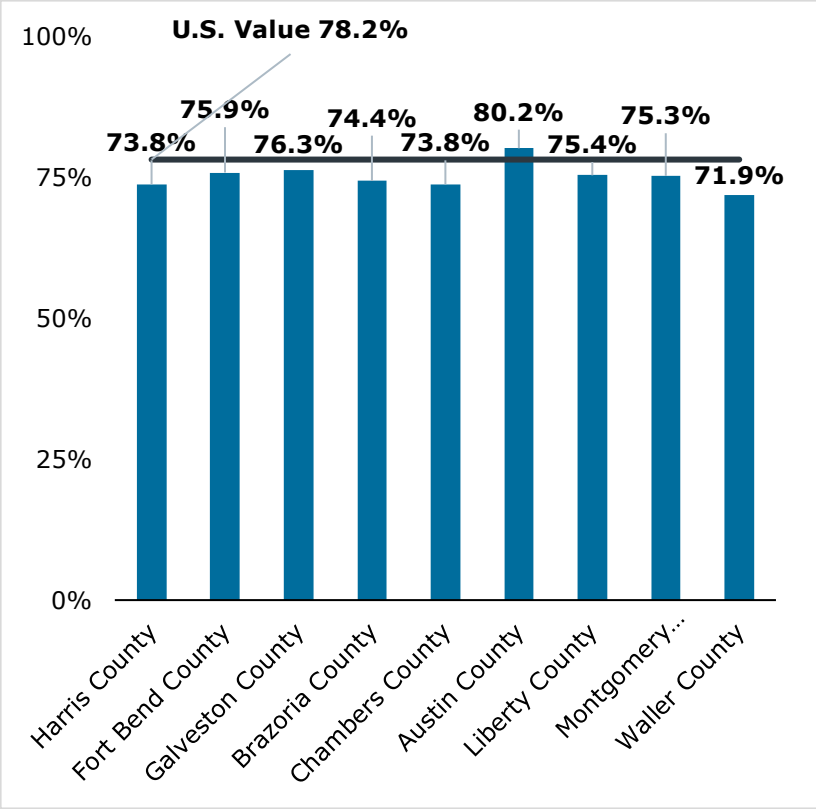
CDC (2021)

FIGURE 16. ADULTS 20+ WITH DIABETES



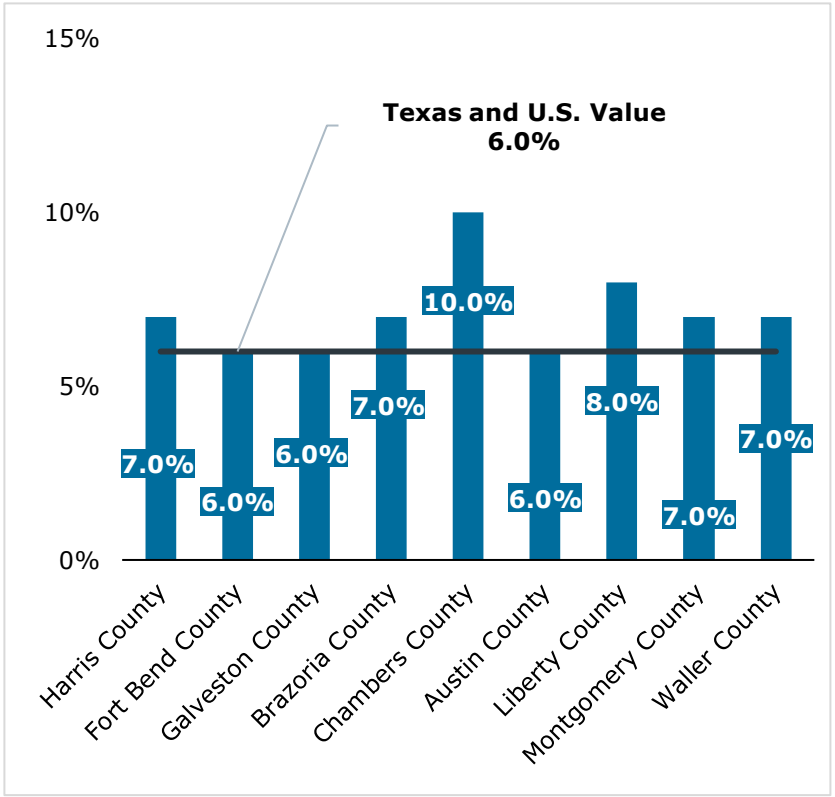
CDC (2021)

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



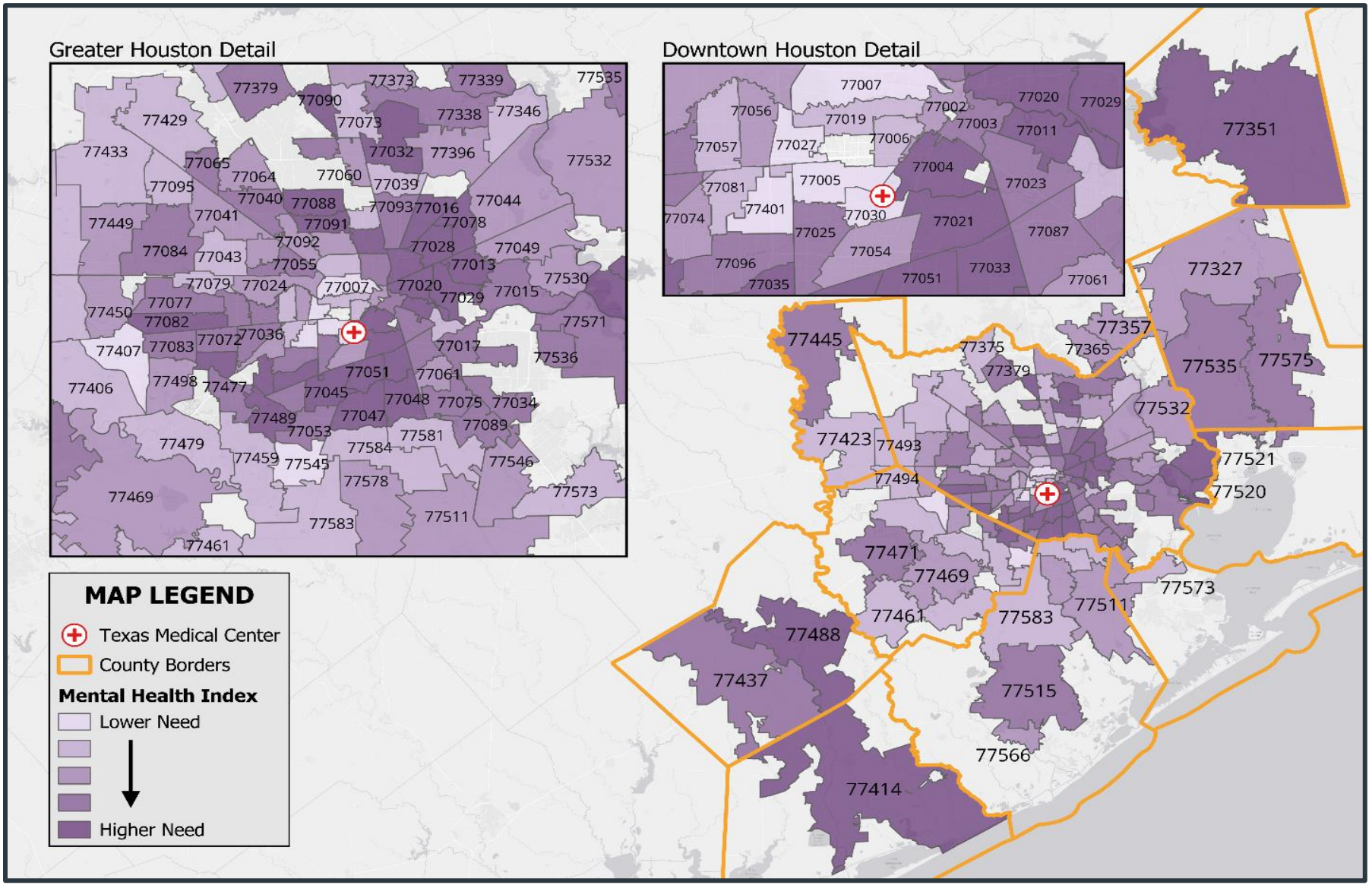
Centers for Medicare & Medicaid Services (2022)

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 Texas Medical Center service area, the zip codes with the highest MHI scores are:

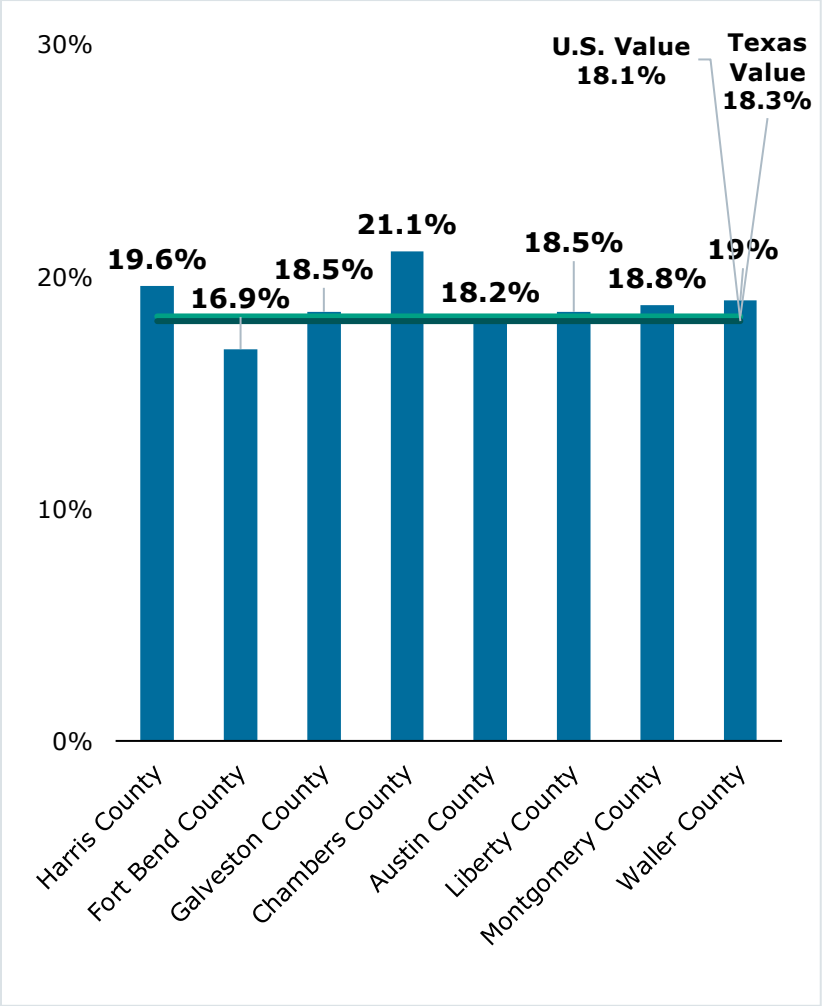
- 77051 (MHI =99.1)
- 77026 (98.3)
- 77021 (98.3)
- 77033 (98)
- 77048 (97.8)

FIGURE 19. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S MENTAL HEALTH INDEX BY ZIP CODE: TEXAS MEDICAL CENTER SERVICE AREA



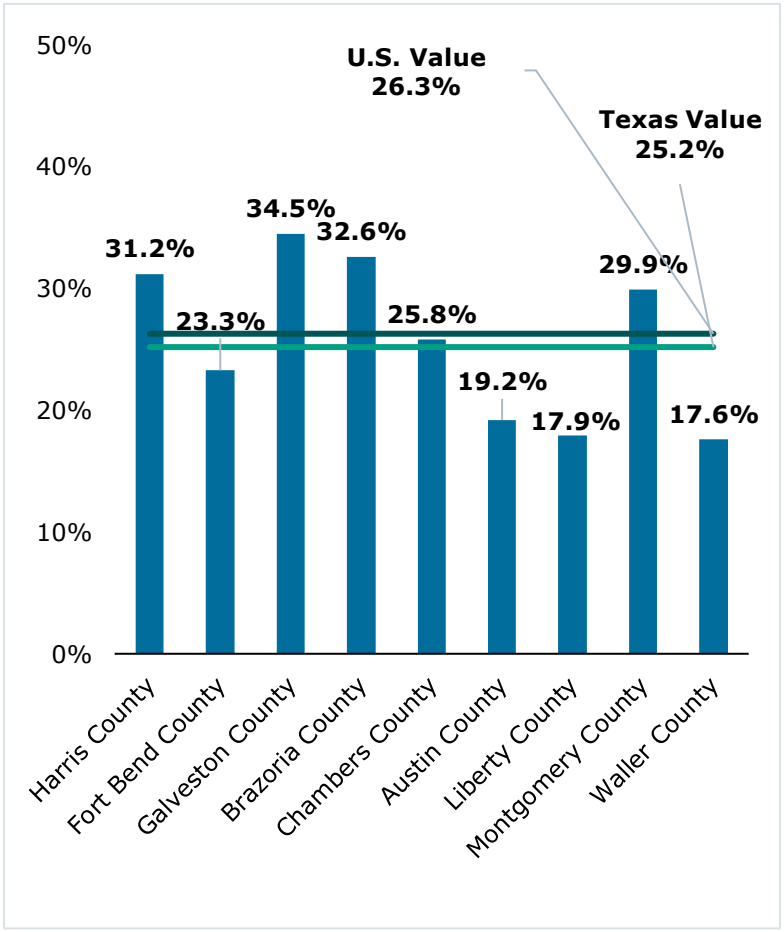
The following figures illustrate indicators of concern in counties that fall under Texas Medical Center Service Area, based on scoring of secondary data related to Mental Health and Substance Use.

FIGURE 20. ADULTS WHO DRINK EXCESSIVELY



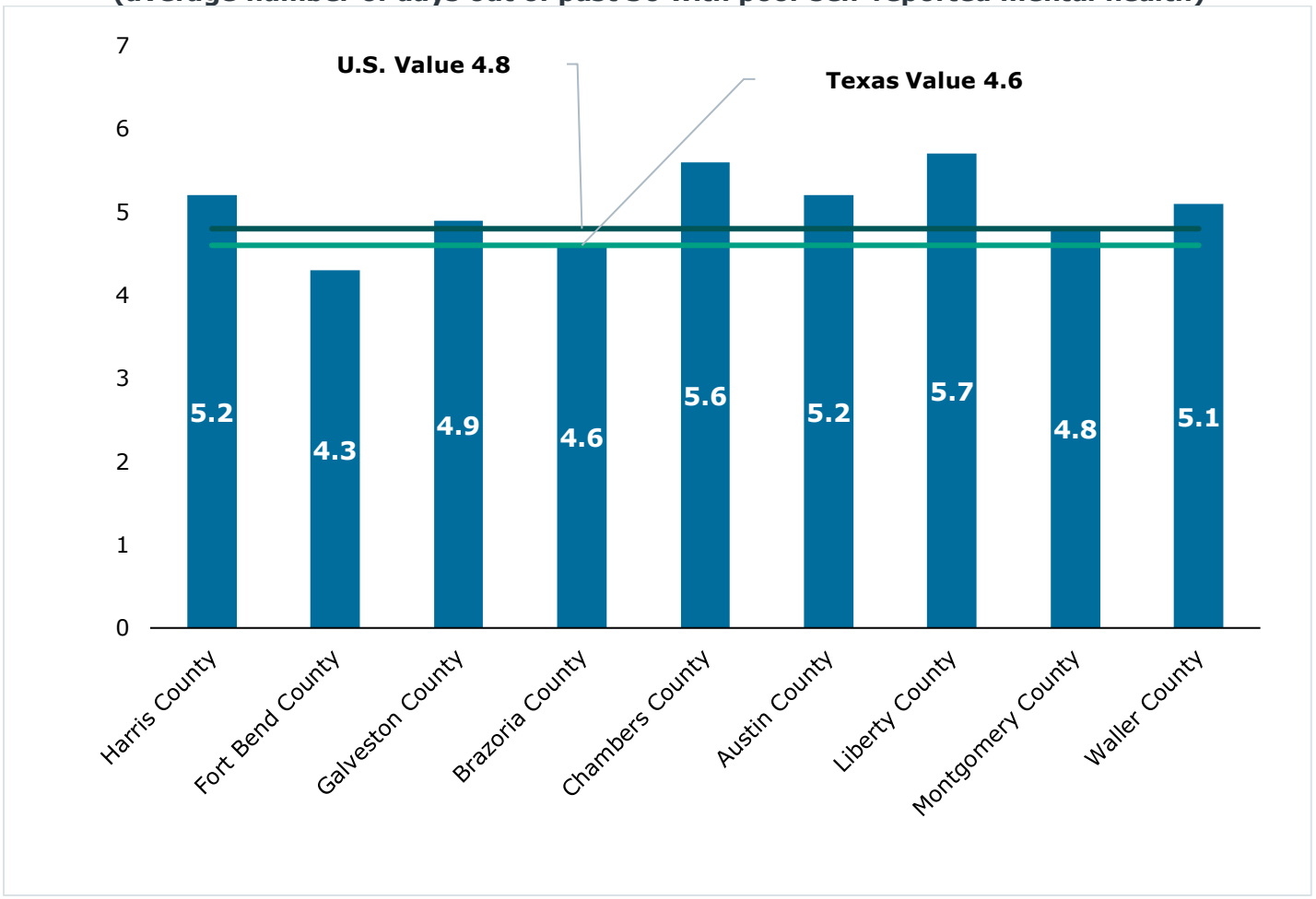
County Health Rankings (2021)

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)

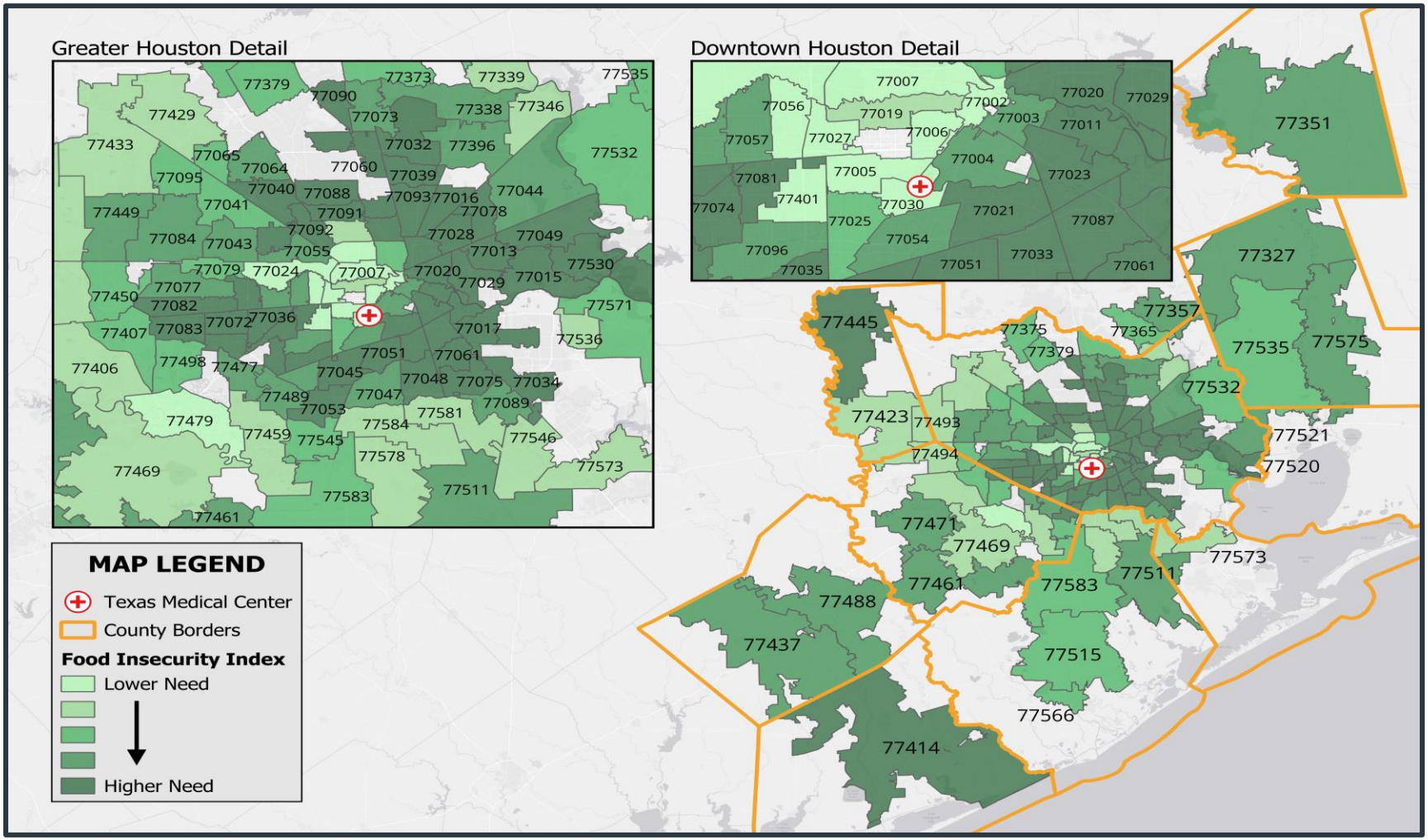
Key Findings: Access to Healthy Food

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 Texas Medical Center service area, 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)

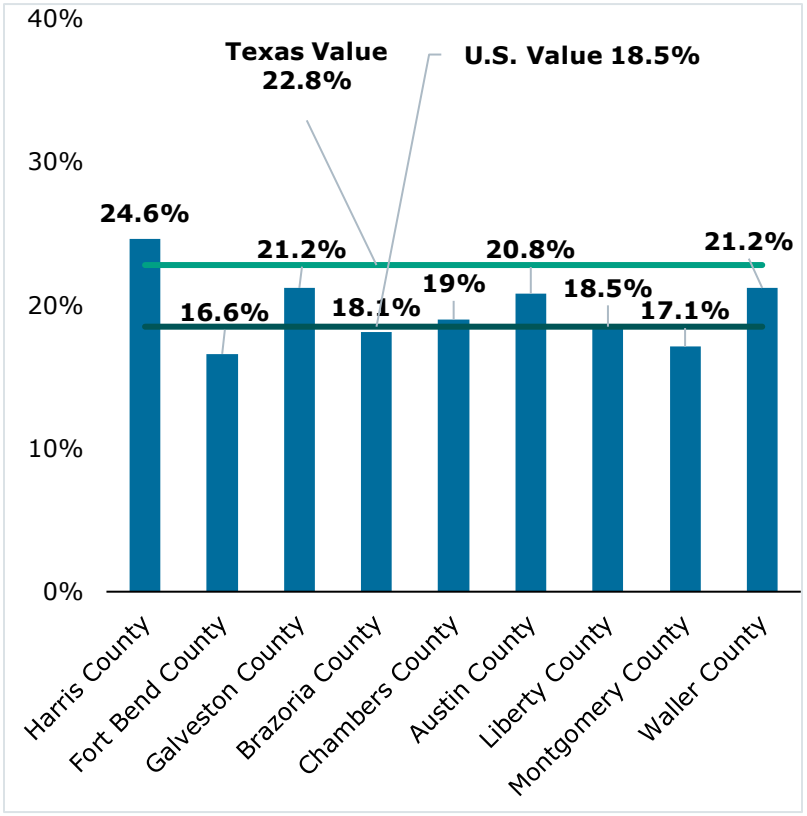
Notably, half of the zip codes in this service area (45 out of 131) have a FII score above 90, indicating generally high rates of food insecurity across the entire region, compared to other U.S. zip codes.

FIGURE 23. CONDUENT HEALTHY COMMUNITIES INSTITUTE'S FOOD INSECURITY INDEX BY ZIP CODE: TEXAS MEDICAL CENTER SERVICE AREA



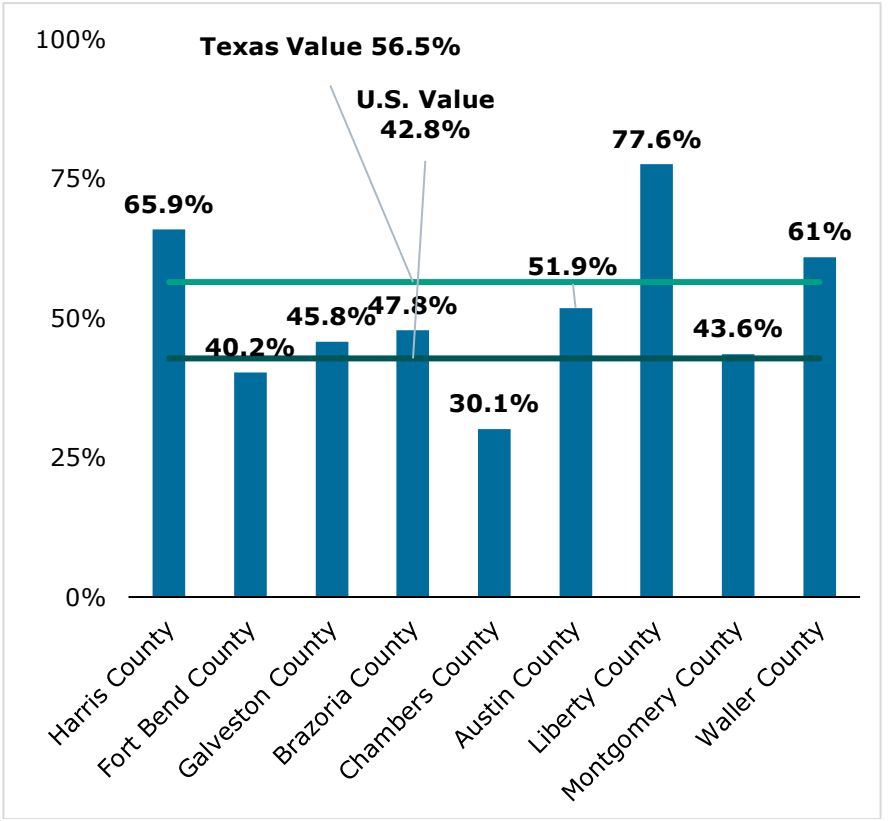
The following figures illustrate indicators of concern in counties that fall under Texas Medical Center Service Area, based on scoring of secondary data related to Access to Healthy Food.

FIGURE 24. CHILD FOOD INSECURITY RATE



Feeding America (2022)

FIGURE 25. STUDENTS ELIGIBLE FOR FREE LUNCH PROGRAM



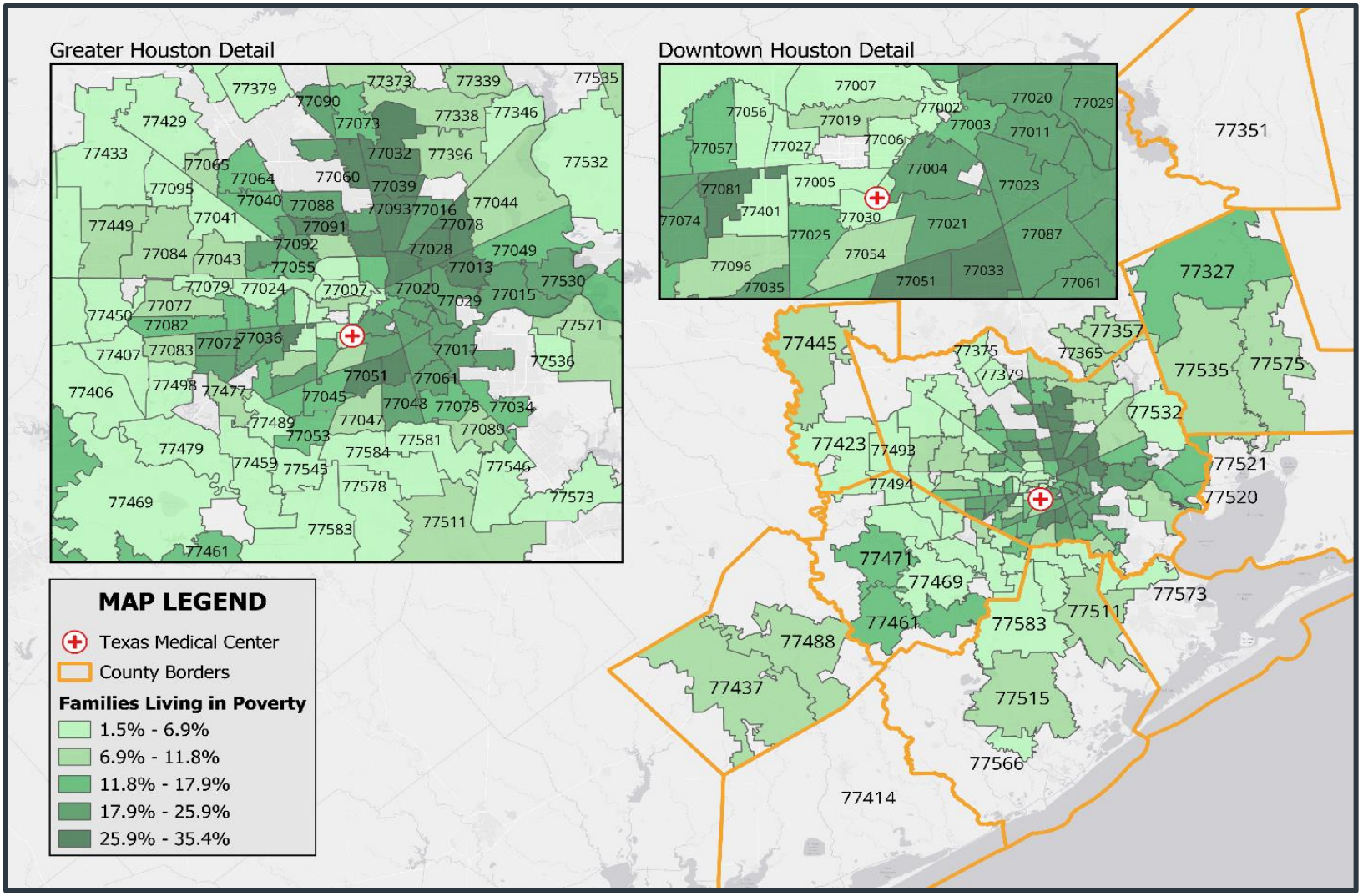
National Center for Education Statistics (2022-2023)

Key Findings: Economic Opportunity

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

- 77060 (35.4%)
- 77093 (34.7%)
- 77033 (32.2%)
- 77051 (30.6%)
- 77032 (30.5%)

FIGURE 26. POVERTY BY ZIP CODE: TEXAS MEDICAL CENTER SERVICE AREA

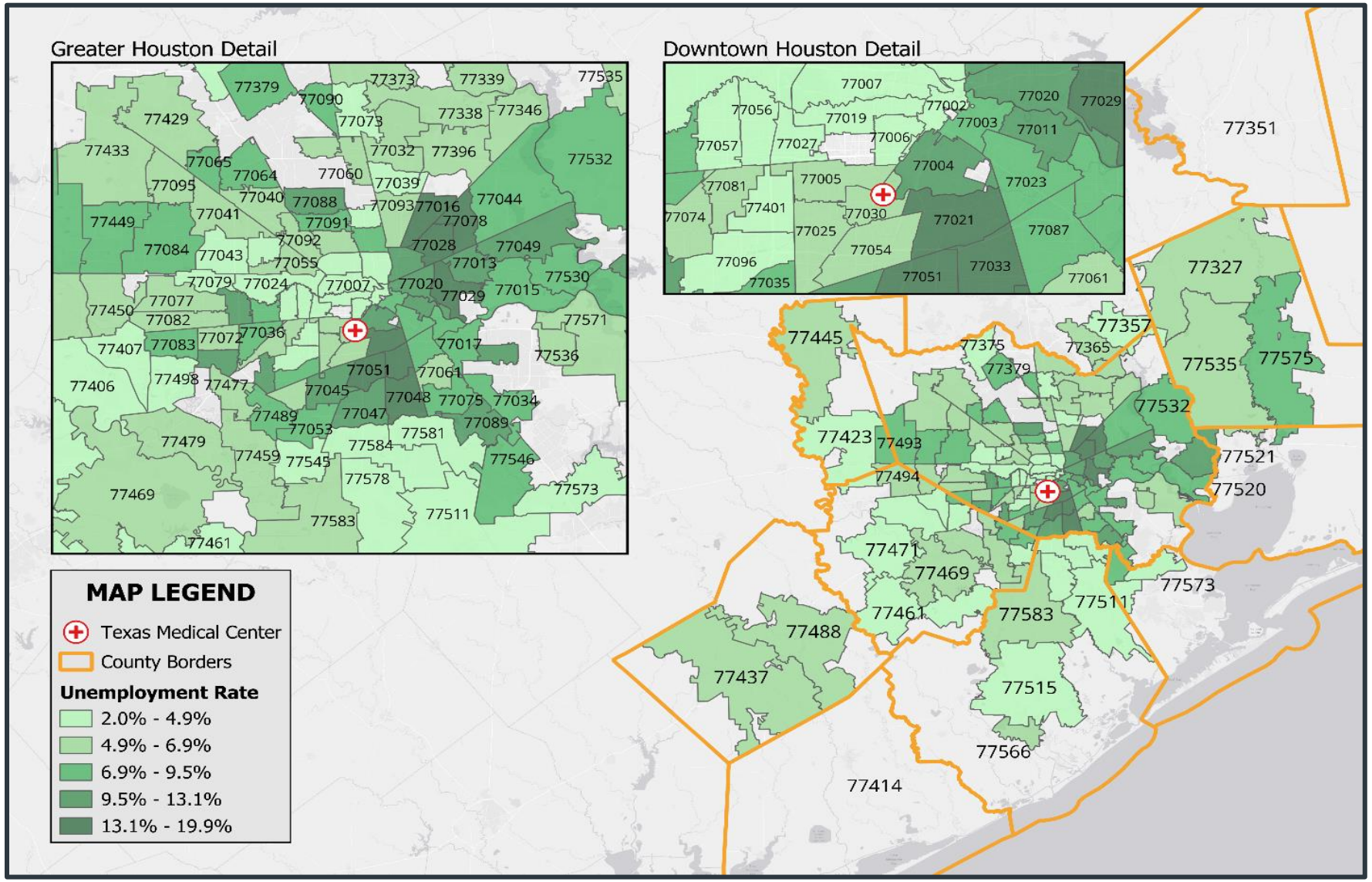


Claritas (2024)

Across Texas, the overall rate of unemployment is 4.7%. Across the Texas Medical Center service area, 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: TEXAS MEDICAL CENTER SERVICE AREA

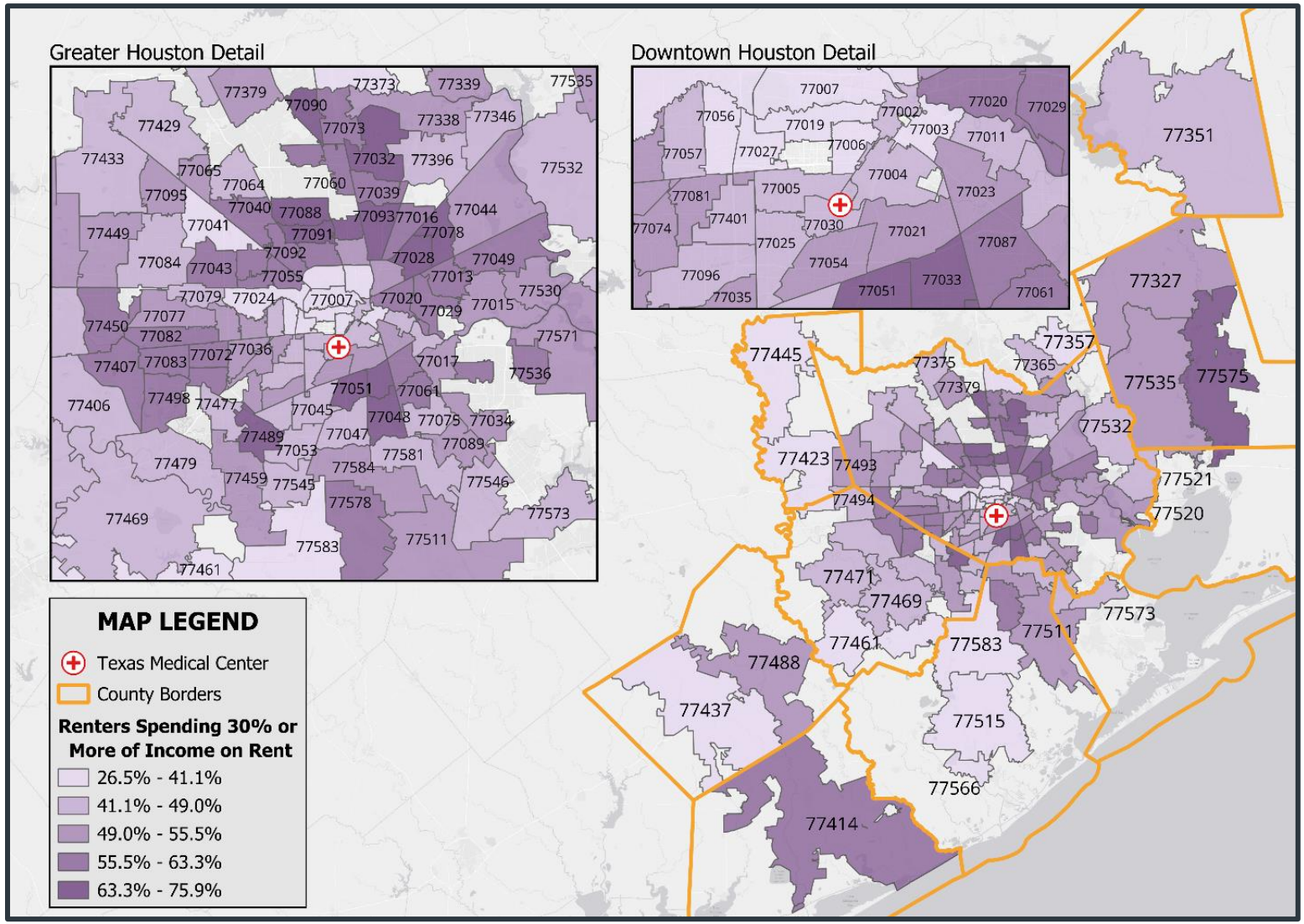


Claritas (2024)

Across Texas, the overall rate of renters spending at least 30% of their income on rent is 50.7%. Across the Texas Medical Center service area, 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%)

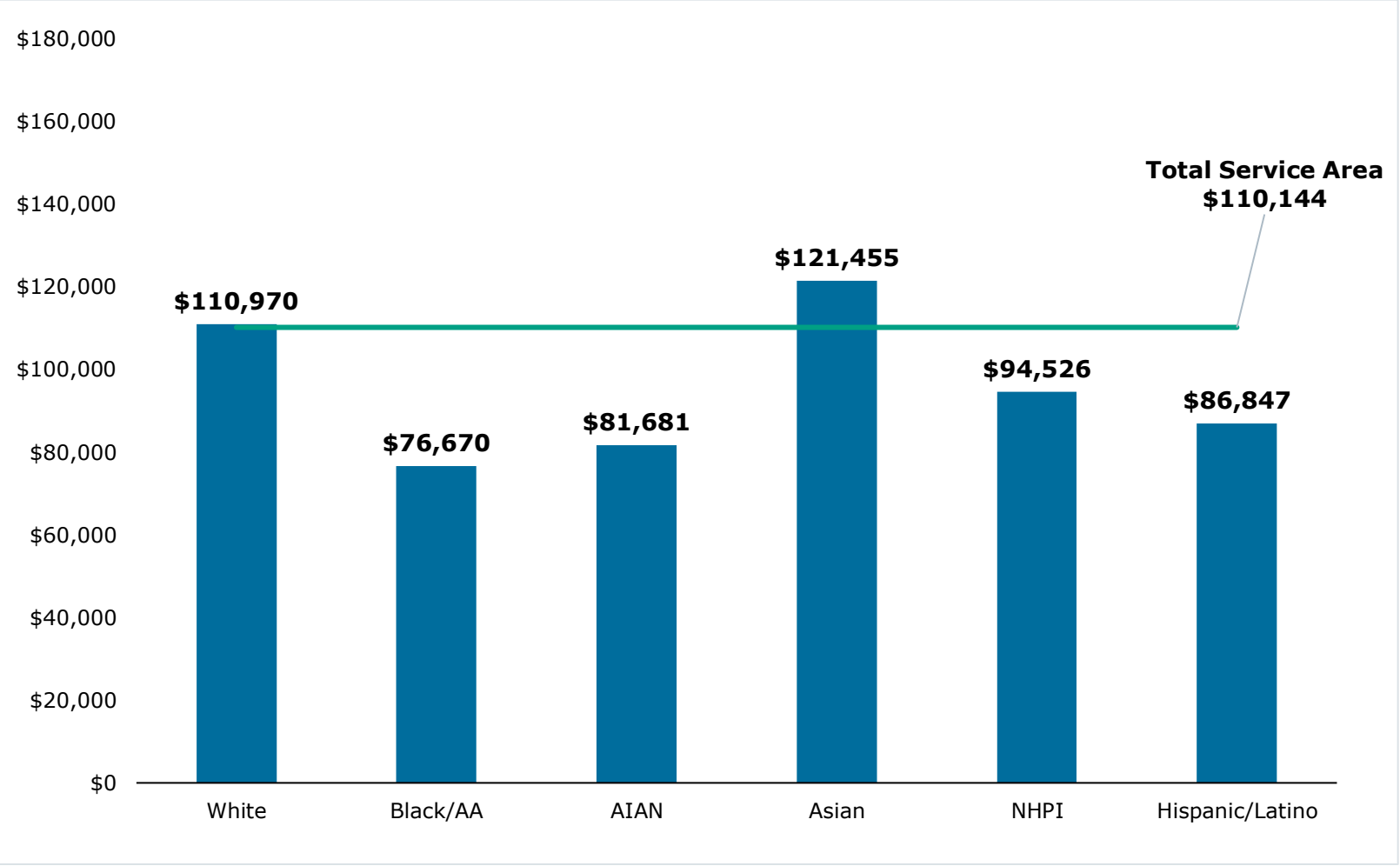
FIGURE 28. PERCENTAGE OF RENTERS WITH HIGH RENT BURDEN BY ZIP CODE: TEXAS MEDICAL CENTER SERVICE AREA



American Community Survey (2018-2022)

Across the Texas Medical Center service area, income differs substantially by race and ethnicity. The median household income for Black/African American, American Indian/Alaskan Native (AIAN), and Hispanic Latino residents of the service area are both more than $25,000 lower than the overall median household income.

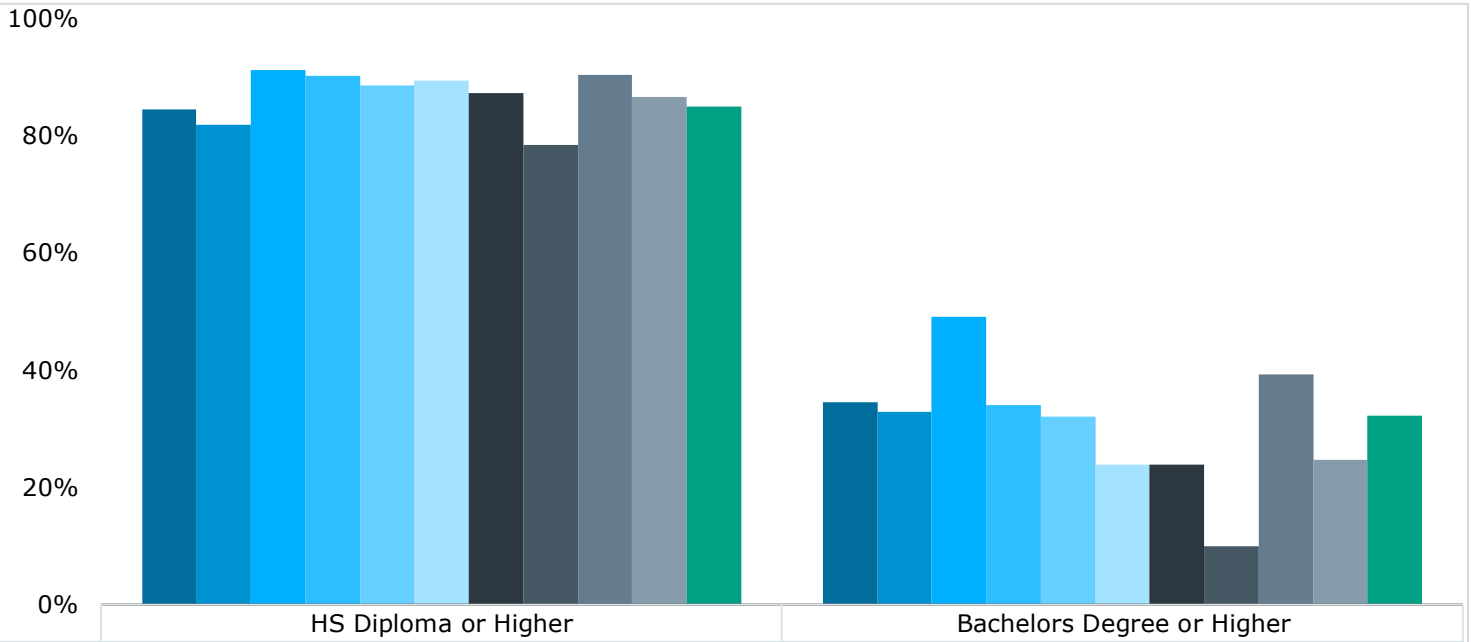
FIGURE 29. MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY: TEXAS MEDICAL CENTER SERVICE AREA



Claritas (2024)

Key Findings: Educational Access

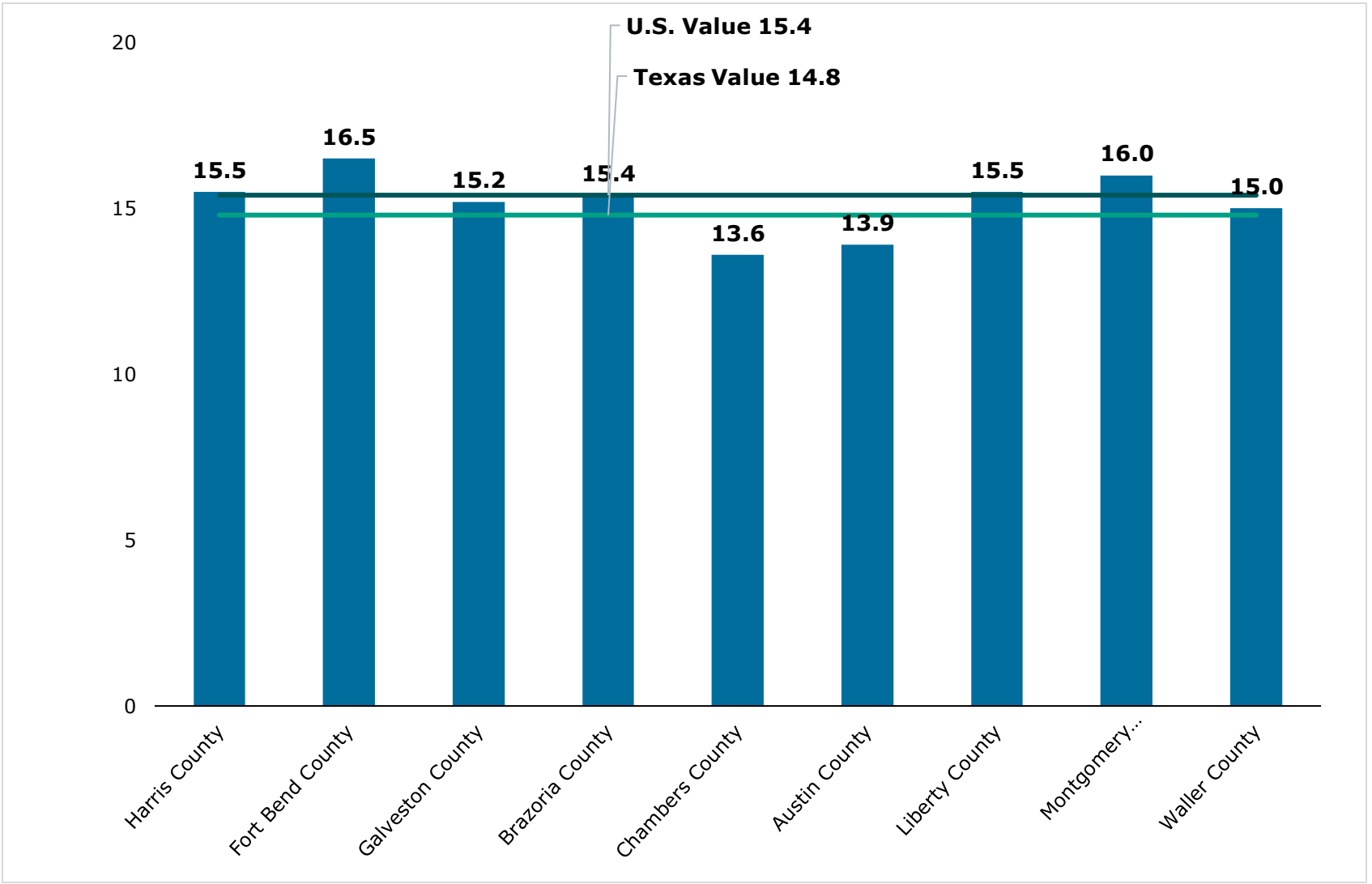
FIGURE 30. EDUCATIONAL ATTAINMENT



	HS Diploma or Higher	Bachelors Degree or Higher
TMC	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)