2024 ANNUAL REPORT

POPULATION HEALTH

HARRISHEALTH — WE LIVE THIS

CONTENTS

"Today, life expectancy differs by as much as 20 years across Harris County. This difference is unjust, and we believe we have the responsibility to do something about it. Health is a human right."

Chethan Bachireddy, MD, chief health officer, Harris Health

SHEILA JACKSON LEE CENTER FOR ACCELERATING HEALTH OUTCOMES

Executive Summary

The Harris Health Sheila Jackson Lee Center for Accelerating Health Outcomes launched in 2024 to address critical health disparities in our community. In Houston, there is an eight-year life expectancy gap between Black and White residents—a disparity that is both unjust and preventable. The Center serves as Harris Health's central hub for coordinating and accelerating health outcomes initiatives, with an initial focus on cardiovascular health outcomes where significant racial disparities persist. The Center advances health outcomes and human flourishing by investing in exceptional care and creating conditions for good health where people live, work and play. The Center coordinates systemwide efforts to address community needs, with particular attention on traditionally underserved Black and Hispanic populations.

Leadership

Under the direction of Chethan Bachireddy, MD, chief health officer, Harris Health, the Center brings together clinical expertise, public health experience and community engagement. Bachireddy's background in care delivery transformation and policy implementation positions the Center to drive meaningful change.

Fiscal Year 2024 Achievements

Inaugural Community Listening Session to Launch the Center

On Aug. 2, 2024, the Center hosted its first community listening session, marking a significant milestone in our commitment to community-driven healthcare transformation. The three-hour session brought community leaders and stakeholders together to shape the Center's direction and priorities.

Key insights from community leaders included:

- Need for sustained, authentic and regular community dialogue and engagement
- Importance of building trust through transparent communication and data
- Opportunities for expanding educational and workforce pipelines
- Value of data-driven initiatives aligned with community needs

Listening session participants provided valuable perspectives that will guide our work going forward:

- "This session demonstrated Harris Health's commitment to meaningful community engagement and real systemic change."
- "The focus on both healthcare delivery and broader community impact shows promise for addressing root causes of health inequities."

Strategic Focus Areas

1. **Community Collaboration**
   - Authentic community engagement through structured listening sessions
   - Partnership development with local organizations and leaders
2. **Exceptional Healthcare**
   - Data-driven focus on heart health outcomes
   - Systemwide coordination of health outcomes goals and initiatives
3. **Health Outcomes Innovation**
   - Development of comprehensive health outcomes dashboards
   - Implementation of targeted interventions for identified disparities
4. **Workforce Development**
   - Commitment to building a workforce that reflects our community
   - Enhanced partnerships with educational institutions
5. **Community Investment**
   - Strategic procurement partnerships with minority and women-owned businesses
   - Place-based investments in community health

"The Center for Accelerating Health Outcomes exists to bring all our efforts together, creating a unified approach that truly amplifies our impact on health outcomes across Harris Health and the Houston community."

Himika Rahman, MD, deputy director, Health Outcomes, Harris Health

Additional Fiscal Year 2024 Milestones

- Successfully launched The Sheila Jackson Lee Center for Accelerating Health Outcomes with strong community support.
- Established heart health as a primary focus area.
- Created foundational partnerships with community and health outcomes organizations.

Looking Ahead

2025 Priorities

- Implement a comprehensive community engagement strategy.
- Host an inaugural Health Outcomes Symposium.
- Launch heart health outcomes workgroups.
- Develop detailed heart health dashboards and mapping.

Long-Term Impact Measures

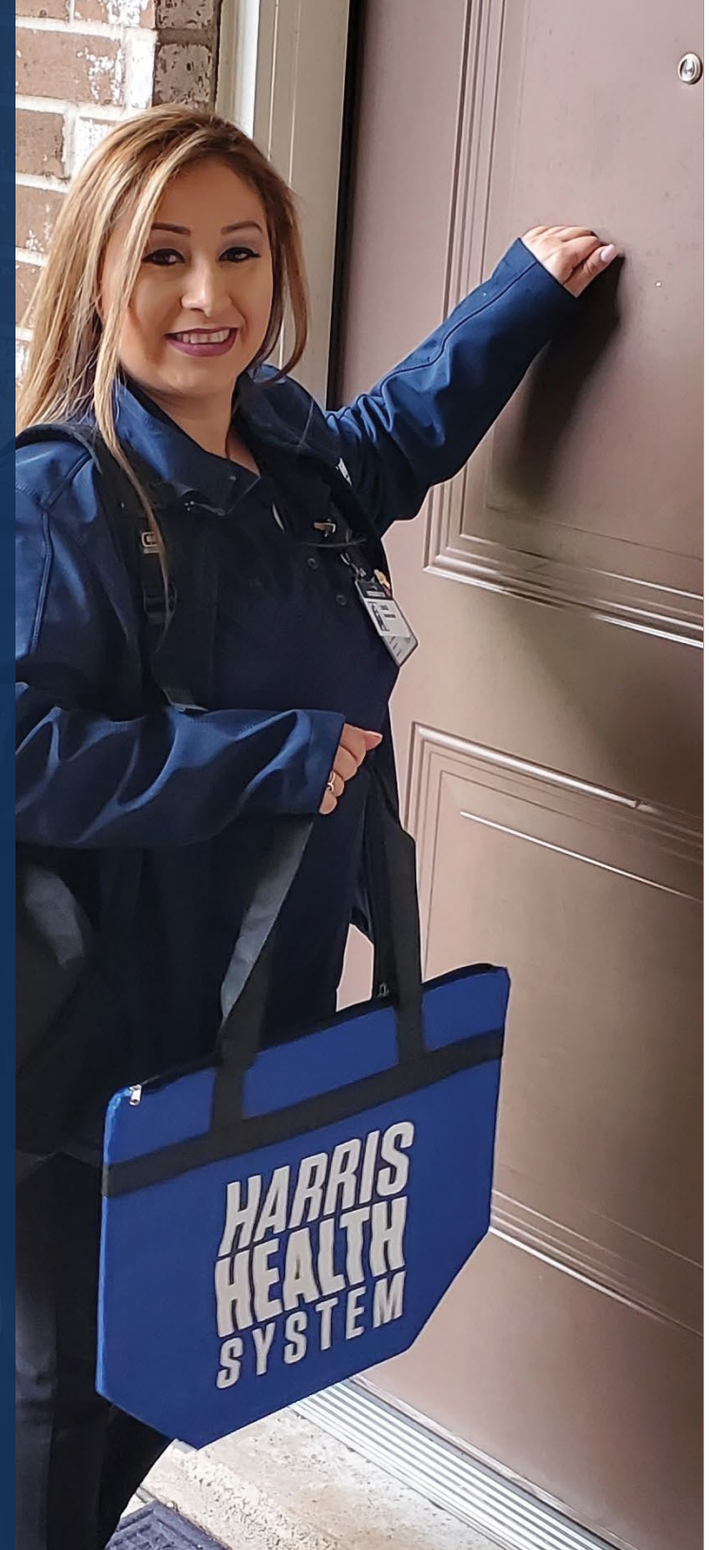
- Reduction in heart health disparities.
- Enhanced community trust and partnerships.
- Recognition as a regional leader in health outcomes initiatives.

COMMUNITY HEALTH WORKERS

Executive Summary

The Community Health Worker (CHW) Program commenced its pilot initiative in 2017 to support the A1-115 DSRIP program. Following its successful implementation at Harris Health Cypress Health Center, the program swiftly expanded to multiple Harris Health sites. Distinguished as pioneers, the CHW team proactively screen all patients for health-related social needs and became the first to foster telehealth visits involving clinical providers such as patient educators and dietitians. Notably, in 2022, the CHW Home Visit Program received recognition from America's Essential Hospitals with the Gage Award in Population Health. Today, CHWs conduct an array of patient engagement services including home and virtual visits.

PATIENT ELIGIBILITY CRITERIA	• Type 2 diabetes diagnosis with HbA1c > 9% • Emergency center utilization or hospitalization within the past year • Harris Health Financial Assistance Plan eligibile • Current Harris Health primary care provider (PCP) or intent to establish care
PROGRAM STRUCTURE	• Nine full-time community health workers • Optimized caseload: 30–35 patients per CHW • Average four-month enrollment period • Coverage across major facilities: – Harris Health Ben Taub Hospital and Emergency Center – Harris Health Lyndon B. Johnson Hospital and Emergency Center – Connections to 11 primary care centers
CARE DELIVERY COMPONENTS	• Home and virtual visit options • Social determinants of health screening with Care Management connections • Integration of telehealth services with clinical providers to enhance engagement in treatment plans and improve A1c levels • Patient education and dietitian involvement • Transition support to medical home nurse patient educators for step-down care



Key Partnerships

The CHW Program connects patients to a variety of diabetes care team members to provide comprehensive and coordinated care. Regular interactions and collaborations with team members ensure that the patient's goals and concerns are addressed holistically, thus promoting better health outcomes and overall satisfaction with their care. The integration of Harris Health Care Management also allows our CHW team to utilize direct referrals to select community organizations to address the health-harming social needs of patients. Key community partners include Epiphany Community Health Outreach Services (ECHOS), Interfaith Ministries, Houston Food Bank, Baker Ripley, Harris County Rides and ACCESS Harris County. Key internal partners include registered dietitians, clinical pharmacists, primary care physicians, nurse patient educators, clinical care managers and social workers.

Fiscal Year 2024 Program Outcomes

520
Engaged 520 unique patients

8.7%
Reduced average A1c from 11.1% to 8.7% (2.4% improvement)

78%
Achieved 78% reengagement rate with primary care providers and 71% with ancillary services

Fiscal Year 2024 Achievements

Presentations

The strengths of the CHW Program—impacting healthcare utilization, integrating CHWs into the care team and developing the CHW workforce—were featured at the following conferences:

- Presented at Healthier Texas Summit to highlight the value of community health workers in promoting appropriate use of emergency services and outpatient care, aiming to reduce reliance on emergency departments by high utilizers.
- Poster presentation at the Association of Diabetes Care & Education Specialists (ADCES) Annual Conference and Harris County Public Health's Healthy Communities Conference to highlight how Population Health has integrated CHWs to serve as a bridge between patients and the healthcare system, transforming care delivery through a multidisciplinary approach.
- Participated in the panel discussion "Beyond the Bridge: Visiting Our CHW Roots and Moving the Field Forward" at the Harris County Public Health's Healthy Communities Conference. The panel highlighted CHW field experts who shared successes, challenges, valuable skills gained and insights on establishing a rewarding career as a CHW.

To strengthen CHW competencies and continue advancing workforce development goals, the CHW Home Visit Program participated in the following events:

- Dia de la Mujer – CHW Proclamation Day Advocacy Day Conference.
- Texas Association of Promotores/CHW Breaking Down the Silos Conference.
- University of Houston CHW Initiative Conference.
- CHW Workshop: Addressing Mental Health Disparities in Harris County.
- South Texas Promotores – Get it D.O.N.E Conference.
- Texas Gulf Coast CHW Promotores Association Quarterly Meetings.
- Health Equity Collective Early Adopters Cohort Meetings.

GAGE AWARDS
Innovation and Excellence

In the Community

Our CHW team strengthened its work and deepened engagement by giving back to the community through participation in various events. These efforts supported the community and helped drive our mission forward.

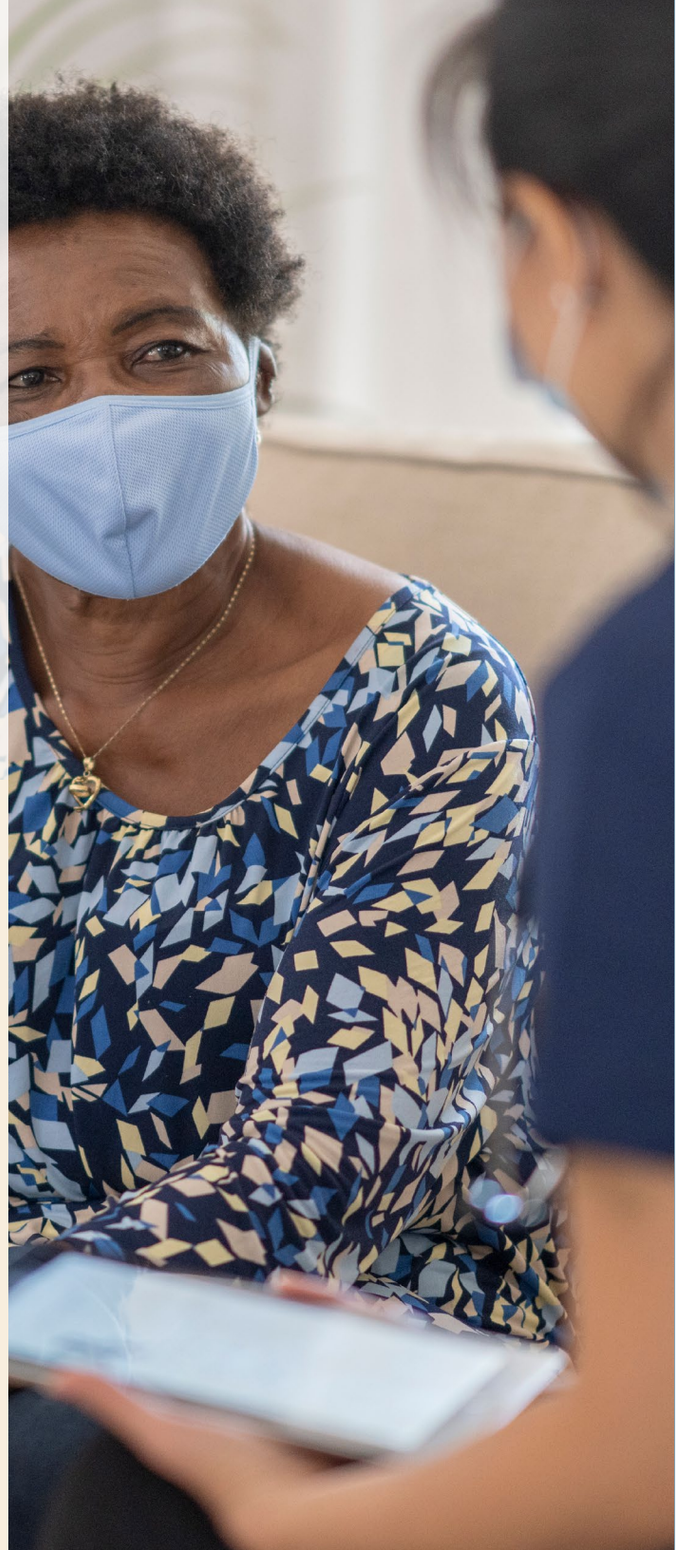
- Assisted with registration and additional needs at the Harris County Hospital District Foundation Swing for the Green Golf Tournament.
- Supported the Harris Health Breast Cancer Survivor Pink Out event at Smith Clinic, including setup, coordination and registration.
- As a team, volunteered at the Community Family Center Christmas Food Drive, the largest food drive of the year, which supports families through the holidays during a time when children are out of school. Over 1,500 families received help the day of the Food Drive.
- Supported Health Center Week by bringing incentives and providing care navigation services to patients.
- Loaded food into cars during the rain at the Harris Health Settegast Health Center Health Fair.
- Participated in the Kashmere Gardens Walk & Learn community event with Health Equity Collective + Fit Houston.

Looking Ahead

The CHW team intends to explore the creation of a system Community Healthy Worker Hub with a focus on community capacity building, CHW education, skills development and closing healthcare gaps with the overarching goal of combating health disparities. Given the strengths of the CHW Program, there is an opportunity to expand to other chronic diseases who need "just in time" intervention and navigation services of the healthcare system to decrease operational waste and delayed patient care.

"All of our community health workers live or have lived in the communities they serve, allowing them to connect and understand what patients may be facing. No one wants to be sick. Some just need a little more help to improve their health."

Alma G. Aranda, MHA, director, Care Integration, Harris Health



HEALTHYCONNECT

Executive Summary

Harris Health faced challenges managing patients' uncontrolled hypertension through traditional primary care management. To address these challenges, Population Health aligned CareSignal, an innovative remote monitoring platform, with Harris Health patient education, medication tracking and social and system navigation to create HealthyConnect. This new tool is integrated with Epic, allowing primary care provider teams to view patient-submitted blood pressure readings in real time. HealthyConnect licensed vocational nurse (LVN) care coordinators monitor these submissions in the patient's electronic medical record and follow protocols to respond to out-of-range readings.

Harris Health Ambulatory Care Services and Population Health leadership teams launched this multidisciplinary intervention in 2019 at Harris Health Martin Luther King Jr. Health Center, chosen because it serves the largest number of patients with uncontrolled hypertension (blood pressure above 140/90). In 2022 and 2023, the program further expanded to Harris Health Acres Home and Settegast health centers and Smith Clinic.

In February 2024, HealthyConnect expanded to provide remote monitoring services to its high-risk pregnancy patients who were previously excluded from participating in the program due to their unique health needs. HealthyConnect has been adapted to provide additional support and monitoring for high-risk prenatal patients receiving care at Harris Health Outpatient Center and Harris Health Ben Taub Tower in collaboration with the Maternal Health service line. Patients enrolled in the program are supported by a LVN patient care coordinator who monitors home blood pressure readings and intervenes based on preestablished guidelines to address out-of-range readings, as well as provide education on hypertension in pregnancy, warning signs of preeclampsia and the importance of following a care plan. Patients benefit from the support of an LVN and a certified doula/CHW in the postpartum period to reinforce newborn care, provide breastfeeding support and act as a primary care link for both baby and mom.

Fiscal Year 2024 Program Outcomes

1,512
Uniquely impacted patients

11%
Decrease in diastolic blood pressure, decrease by 9 mmHg for graduated patients

16%
Decrease in systolic blood pressure, decrease by 25 mmHg for graduated patients

95%
Medication adherence, self-reported by patients

"Our HealthyConnect Program empowers patients to take control of their blood pressure while staying connected to their medical home and primary care provider. It's more than just a tool. It's a bridge to care between office visits, a lifeline for those with high-risk social needs and a way to make healthcare more accessible and convenient for every patient."

Krystal Andrews Gamarra, MBA, LCSW, CCM, administrative director, Clinical Integration & Transformation, Harris Health

Key Partners

HealthyConnect collaborates with professional organizations to provide standardized hypertension and heart health education for patients at a literacy level that meets the needs of our patient population. HealtyConnect's remote monitoring platform is powered by CareSignal with patient data fully integrated into the patient's EMR in Epic, making blood pressure measurements and patient-reported medication adherence available to the entire healthcare team. Key external partners include American Heart Association, CareSignal, Preeclampsia Foundation and Harmonious Birthing. Key internal partners include Ambulatory Care Nursing and Operations, primary care clinicians, clinical pharmacists, LVN patient care coordinators and community health workers.

Fiscal Year 2024 Achievements

Primary Care Program Outcomes

- Engaged 789 unique patients who graduated
  - Graduation criteria: enrolled for over four months (average six months); blood pressure (BP) readings <140/90 stable for at least 30 days and eight readings; self-reported medication adherence >80%; and care plan goals, social determinants of health (SDOH) and medical home access addressed.
- Achieved an average decrease in systolic BP by 25 mmHg and an average decrease in diastolic BP by 10 mmHg.
- Achieved average patient self-reported medication adherence of 95%.
- Patient satisfaction rates of 95% – "You are getting the best possible care from Harris Health."
- Utilization metrics include 89,817 automated text messages and 8,407 automated phone calls.

Maternal Health Enrollment

- Enrolled 206 unique patients since program launch in February 2024.
- Developed and tested program scorecard to track process and quality.

American Heart Association Target: BP Recognition

Annual recognition from the American Heart Association and the American Medical Association to confirm an organization's commitment to measurement accuracy and achieving an exceptional 70% or greater blood pressure control rate with the adult patient population and attestation to at least four of six evidence-based blood pressure measurement criteria. Ambulatory Care Services (ACS) GOLD+ clinics: Harris Health Baytown, Casa de Amigos, Danny Jackson, El Franco Lee, Gulfgate, Northwest, Strawberry, Squatty Lyons and Vallbona health centers.

In the Community

- Participated in the Harris County Hospital District Foundation Texas Med Center Fun Run to raise funds for the Maternal Health remote patient monitoring program.
- Participated in Good Hope's Health & Wellness ministry in partnership with Ben Taub Hospital's Black Maternal Health Week Community Fair. The HealthyConnect Primary Care and Maternal teams obtained blood pressure readings for pregnant and general client populations and provided education on hypertension.
- Attended the Harris County Public Health's Maternal and Child Health Conference to gain knowledge and awareness of maternal and child health issues, as well as expand advocacy efforts. The conference focused on "ReGrounding our efforts, ReBuilding for equity and ReUniting through transformative dialogue."
- Participated in a collaborative health/resource fair and block party with Harris County Public Health, Settegast and City of Houston Super Neighborhoods. The HealthyConnect Primary Care team obtained blood pressure readings and provided education on hypertension.
- The Maternal patient care coordinators and community health workers completed a four-day doula training in partnership with Harmonious Birthing. They learned about breaking down biases and racism in maternal health, how to advocate for mothers and fathers, labor stages, comfort measures, baby wearing and belly binding. After completing the course and compiling their personal doula branding portfolios, they all became certified doulas.

Looking Ahead

HealthyConnect will expand from four to 10 primary care sites by adding the program to Harris Health Aldine, Cypress, Northwest, Squatty Lyons and Strawberry health centers and The Outpatient Center. The expanded program will integrate clinical pharmacists as part of the HealthyConnect Virtual Care team, shifting from remote patient monitoring to remote patient management.
Our goal is to understand from clinical literature, our patients and other subject matter experts how best to engage our marginalized patients and overcome barriers (other than health-related social needs) that impede patients' abilities to obtain and maintain blood pressure control. We will incorporate findings into intervention plans as appropriate to close gaps that exist with controlling hypertension. Additionally, we plan to develop data around smoking habits and statin use for the HealthyConnect patient population to help guide future incorporation of smoking cessation tools and to appropriately identify patients who need statin therapy or statin therapy optimization.

DIABETES PREVENTION PROGRAM – HARRIS COUNTY PUBLIC HEALTH

Executive Summary

The Harris County Public Health (HCPH) Diabetes Prevention Program (DPP) is a free lifestyle change program for individuals in Harris County who are over the age of 18 and have prediabetes. The goal of the DPP is to make it easier for individuals with prediabetes to participate in an affordable, high-quality program to reduce their risk of developing type 2 diabetes and improve their overall health. The year-long program is divided into two phases: a core phase and a maintenance phase. The core phase occurs weekly for 16 sessions followed by the maintenance phase that occurs monthly for eight sessions.

Objectives

The goal of this collaborative partnership is to bridge the gap and build capacity for direct referrals of Harris Health patients to the Diabetes Prevention Program, sponsored and delivered through HCPH.

- Increase care coordination between clinical and community-based settings for education.
- Create a closed-loop referral process between patients at HCPH and DPP programming.
- Increase accessibility to DPP services through the reduction of transportation barriers.

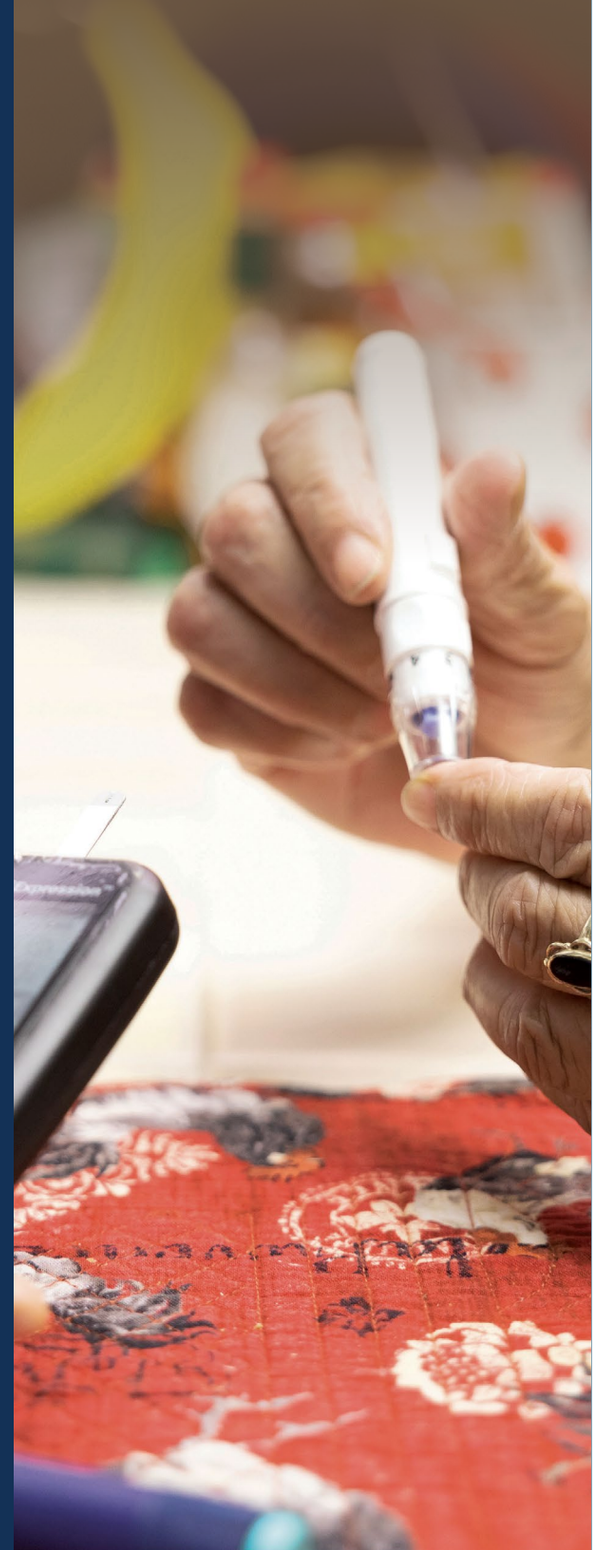
Fiscal Year 2024 Achievements

A prediabetes workflow was established as part of the closed-loop referral process to HCPH DPP. This prediabetes workflow was introduced as a pilot project at Harris Health Acres Home and Vallbona health centers. The prediabetes workflow includes the following steps:

1. Prediabetes registry of patients is stratified by risk factors to identify a high-risk population.
2. Identified high-risk patients are sent a prescreening ADA risk test via MyHealth. If this is not completed, a best practice advisory (BPA) alerts the nurse to complete the risk test at the next visit.
3. The BPA alerts the nurse to pend orders during pre-visit planning and identifies care gaps.
4. During this process, if the patient's HbA1c is 5.7%–6.4%, it triggers a BPA to alert the provider to utilize the prediabetes SmartSet, which includes prompting to order medication, lab and appropriate referrals (including a referral order to HCPH DPP).

Key Partnerships

The contract for initiation of HCPH DPP at the Acres Home and Vallbona locations was approved by Commissioners Court on April 23, 2024. Classes began in the clinics in October 2024 (Fiscal Year 2025). The primary community partner is Harris County Public Health, and internal partners include IT, Physician Champions, ACS Nursing, ACS Operations, Clinical Pharmacy and Data Science.



FOOD RX

Executive Summary

Since the 2019 launch of the first Food Farmacy at Strawberry Health Center, Harris Health has remained committed to addressing food and nutrition insecurity across its extensive network through the Food Rx program. In partnership with community collaborators, Food Rx integrates a population health approach as part of the standard care for chronic disease management. The program strategically targets patients with identified social needs and uncontrolled diabetes, aiming to improve health outcomes through various interventions. Harris Health's goal is to bridge the gap between food insecurity and overall well-being, ultimately enhancing the health outcomes of all Harris Health patients.

Objectives

The primary objective of Food Rx is to improve the health of patients with chronic illnesses who also screen positive for food insecurity through the provision of healthy food and chronic disease management education. Success is measured by several key metrics, including:

- Nutrition knowledge.
- Daily fruit and vegetable consumption.
- HbA1c improvement (primary biometric of interest).
- Number of patient visits.
- Pounds of food redeemed.

Fiscal Year 2024 Achievements

In Fiscal Year 2024, Harris Health was awarded a $500,000 donation from Cigna and a $663,144 grant from Harris County via the American Rescue Plan Act (ARPA) to expand Food Rx across the system. Cigna's $500,000 will be utilized to launch food lockers at Harris Health Casa De Amigos and Thomas Street at Quentin Mease health centers during Fiscal Year 2025. ARPA funding will support expansion to three additional brick and mortar Food Farmacies at Gulfgate, El Franco Lee and MLK health centers, as well as fund the launch of community partnership Food Rx programs at Harris Health Cypress and Squatty Lyons health centers.

Fiscal Year 2024 Program Outcomes

1.29%
Decrease in A1c*

10,480
Patient visits**

4.40
Daily fruit and vegetable servings consumed*

2,888
Households served**

3.66%
Increase in nutrition knowledge*

314,400
Pounds of food redeemed**

* Based on data from Food Rx graduates-Patients enrolled in Food Rx for at least 7.5 months with an average of one visit per month

** Based on data from First Link and Food Rx

Key Partners

The continued success of the Food Rx program relies heavily on robust partnerships. Key collaborators include:

- Houston Food Bank – Remains the primary food provider and a critical partner in identifying opportunities for program expansion.
- UTHealth Houston School of Public Health – This partnership has facilitated the growth of the culinary medicine program, including evaluation of Food Rx programming and research collaborations to test and adopt the best Food Rx practices.
- H-E-B – Provides ongoing support with food vouchers to assist patients in the transition from Food Rx graduation to community pantry onboarding.
- Port of Houston and Harris County – Both have contributed funding for expansion efforts at additional clinics.
- Other external partners include Cigna and Baytown Hearts and Hands. Internal partners include ACS Leadership at Strawberry, Acres Home and Baytown health centers, LBJ Outpatient Clinic and Food and Nutrition Services.

In the Community

The Food Rx team presented at the following events during Fiscal Year 2024:

- Houston Food Bank Nutrition Summit in March 2024.
- TMF Health Quality Institute in March 2024.
- ADCES Annual Conference in August 2024.
- Strawberry Health Center Food Farmacy five-year anniversary event in September 2024.

FOOD RX FOR OBSTETRICS

Executive Summary

The Obstetrics (OB) Food Rx research project focuses on assessing the feasibility and preliminary effects of a home-delivery produce prescription program with varying doses for low-income, ethnically diverse pregnant mothers. The program aims to improve a broad range of clinical and nonclinical outcomes, ensuring pregnant women at risk receive the necessary nutrition support through home delivery.

Objectives

- Evaluate the impact of differing doses of produce prescriptions on maternal and child health.
- Use data and IT systems to identify and track high-risk OB patients.
- Build public and private partnerships to sustain and scale the program.

Fiscal Year 2024 Achievements

- Successfully transitioned from phase 1 (recruited 21 women) to phase 2 (a recruitment goal of 200 women, currently in progress).
- Built out IT infrastructure to identify and report high-risk OB patients from specified clinics.
- Established partnerships between Planet Harvest, Brighter Bites and Harris Health to enhance service delivery.
- As of Sept. 19, 2024, 39 moms have consented and enrolled in the program.

Key Partners

Key external partners include UTHealth Houston School of Public Health, Planet Harvest, Brighter Bites and DoorDash. Key internal partners include LBJ Outpatient Clinic, Ben Taub Hospital, Aldine, Northwest, Vallbona and El Franco Lee health centers and Food Farmacy.

In the Community

- Presented at the Community Health Fair at Ben Taub High-Risk Clinic 2024.
- Participated in the American Heart Association Healthcare by Food Initiative 2024.
- Presented at the American Public Health Association 2023 and 2024.
- Participated in the Healthier Texas Summit 2024.
- Formed a Mom Community Advisory Group (MomCAG) consisting of patients from Harris Health and other Food Is Medicine programs to provide feedback and improve services.

FOOD RX FOR CHRONIC KIDNEY DISEASE

Executive Summary

Kidney Health is a research project that assesses whether proactive identification, program engagement and altered dietary habits for patients in the early stages of chronic kidney disease can delay the progression of kidney damage.

Objectives

- Support patients in adopting kidney-friendly eating patterns.
- Slow the progression of kidney injury through early intervention.

Fiscal Year 2024 Achievements

The team enrolled 67 patients as of Aug. 28, 2024, demonstrating early success in patient engagement and program outreach.

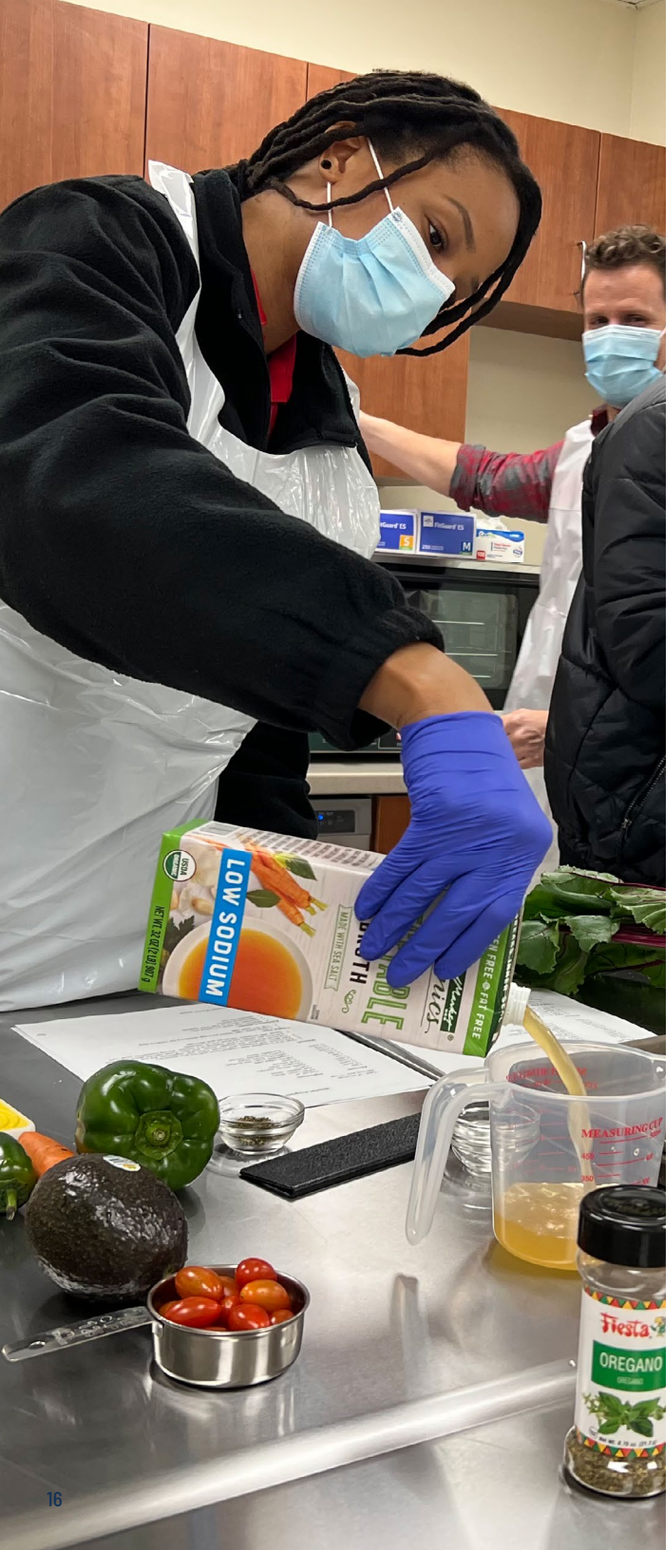
Key Partners

- Key external partners include Factor Health and The University of Texas at Austin Dell Medical School.
- Key internal partners include LBJ Hospital, MLK Health Center and Food Farmacy.

The expansion of the original Food Rx program to include novel research partnerships and initiatives reflects Harris Health's commitment to addressing the unique needs of vulnerable patient populations by integrating food and nutrition support into chronic disease management. The program continues to grow, thanks to strong community partnerships, data-driven interventions and patient-centered feedback.

"Our Food Rx efforts empower our patients to manage their health more effectively and improve their quality of life through increased access to nutritious food, meaningful education, and connection to reliable community resources."

Maria De La Cruz, director, Care Integration, Food Rx, Harris Health



CULINARY MEDICINE

Executive Summary

In 2019, as part of a collaborative project with UTHealth Houston School of Public Health, a patient-centered culinary medicine curriculum was developed. Since that time and based on patient participation and feedback, the five-class series was reduced to a three-class series. This three-class culinary medicine curriculum incorporates motivational interviewing practices with nutrition education. Patients who are enrolled in the Food Rx program through their Food Farmacy can participate in the culinary medicine program to learn culinary skills. The goal of the culinary medicine program is to provide patients the skills and knowledge to create healthy meals at home from foods they receive through the Food Farmacy. The main objectives of the class include healthy and mindful eating, goal setting, healthy habits, meal planning and an emphasis on healthy carbohydrates.

Fiscal Year 2024 Achievements

The Culinary Medicine program saw statistically significant self-reported behavior changes in the following measures: fruit and vegetable consumption, daily consumption from each food group, improved perception of healthy food and cooking habits, utilization of grocery lists, meal planning, eating breakfast regularly, making homemade meals and adjusting meals to be healthier. Additionally, at the beginning of this fiscal year, the Culinary Medicine program was adapted and expanded to the Lyndon B. Johnson Hospital Food Farmacy location to serve cancer survivors. The curriculum was developed in collaboration with a partnership through The University of Texas MD Anderson Cancer Center and focuses on a plant-based diet and foods to support cancer survivorship. Based on patient requests and feedback, all recipes used in this class are vegetarian.

Key Partnerships

Key community partners include UTHealth Houston School of Public Health and MD Anderson Cancer Center. Internal partners include Food Farmacy, Food and Nutrition Services and leadership from the Outpatient Center and Smith Clinic.

In the Community

- The Culinary Medicine program was featured in an October 2023 article and video in the *Houston Chronicle* called "Harris Health's Food Farmacy, Cooking Class Teaches Patients Healthy Eating to Treat Illnesses."
- The team presented a poster at ADCES in August 2024.
- The team participated in the Food Farmacy's five-year anniversary event in September 2024.

HEALTHY LIFESTYLE HABITS CLASS

Executive Summary

In September 2023, Harris Health launched the Healthy Lifestyle Habits class taught by board-certified health and wellness coaches. It is a modified version of the Centers for Disease Control and Prevention's Diabetes Prevention Program. The program was established as a risk-stratified approach to help capture patients who were referred to the clinical nutrition department for weight management, prediabetes and metabolic syndrome that would benefit from lifestyle changes. The program is one year in length and is divided into two phases: a core phase and a maintenance phase. The core phase includes classes scheduled every other week for six sessions. The maintenance phase includes monthly classes for nine sessions. The goal of this program is to establish a modified DPP at Harris Health using board-certified health and wellness coaches to help patients reduce their risk of type 2 diabetes and improve their overall health. The year-long program teaches patients skills to make lasting lifestyle changes such as eating healthier, adding physical activity to their daily routine and improving coping skills.

Fiscal Year 2024 Achievements

The program has continued to grow with each cohort of patients. Classes have expanded to Harris Health Strawberry, Gulfgate and MLK health centers as well as the addition of a virtual class option. The program has also incorporated cooking classes into its monthly sessions at the Acres Home location.

First Cohort Program Outcomes

The first cohort launched at the Acres Home, Settegast and El Franco Lee health centers and enrolled 99 participants with 58% of them completing at least four sessions. Of those participants, 84% were successful in losing weight. Among the 23 patients who completed the one-year program (at least nine sessions), 70% lost weight, and 30% reduced their A1c to below 5.7%.

Key Partnerships

Key internal partners include ACS Operations, ACS Leadership, Food Farmacy and Food and Nutrition Services. The team was able to present at the ACS Town Hall in October 2023.

"Through collaborative community programs like Food Farmacies, Cancer Resource Centers, Diabetes and Nutrition Education, HealthyConnect Remote Patient Monitoring and Community Health Workers, we empower patients and make a powerful, collective impact on the health and well-being of our community."

Hope Galvan, vice president, Population Health Transformation & Care Integration, Harris Health

BE WELL™ ACRES HOMES

Executive Summary

Be Well™ Acres Homes, launched in 2021 by The University of Texas MD Anderson Cancer Center with support from Harris Health, Memorial Hermann, UTHealth Houston and over 30 community organizations, is a resident-led initiative to promote wellness and reduce cancer and chronic disease risks in the Acres Homes community.

Objectives

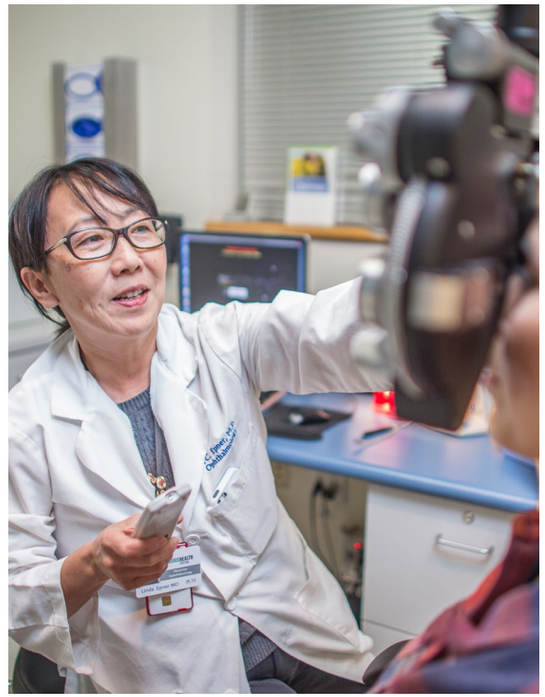
- Support Be Well Acres Homes initiative – Provide ongoing coordination support and active participation in Steering Committee and Stakeholder meetings.
- Promote health at Acres Home Health Center – Attend at least one community event every other month, resulting in 18 events per year and engaging over 3,000 attendees regarding health resources.
- Support Acres Homes – community programming through engagement activities, including walking trail promotion and culinary medicine at Acres Home Health Center.
- Implement Cancer Patient Needs Assessment – In collaboration with MD Anderson, support quality improvement projects for cancer patients facing food insecurity.
- Transition the Community Farm at LBJ Hospital to a satellite location and build capacity for produce growth and education.

Fiscal Year 2024 Achievements

Community partnerships cultivated through Be Well Acres Homes secured 25 air fryer donations for the Our Kitchen initiative and onboarded Civic Heart to the Harris Health direct referral program.

Key Partners

Key collaborators include MD Anderson, Memorial Hermann Community Benefit Corporation, UTHealth Houston School of Public Health, over 30 community organizations and Acres Homes residents.

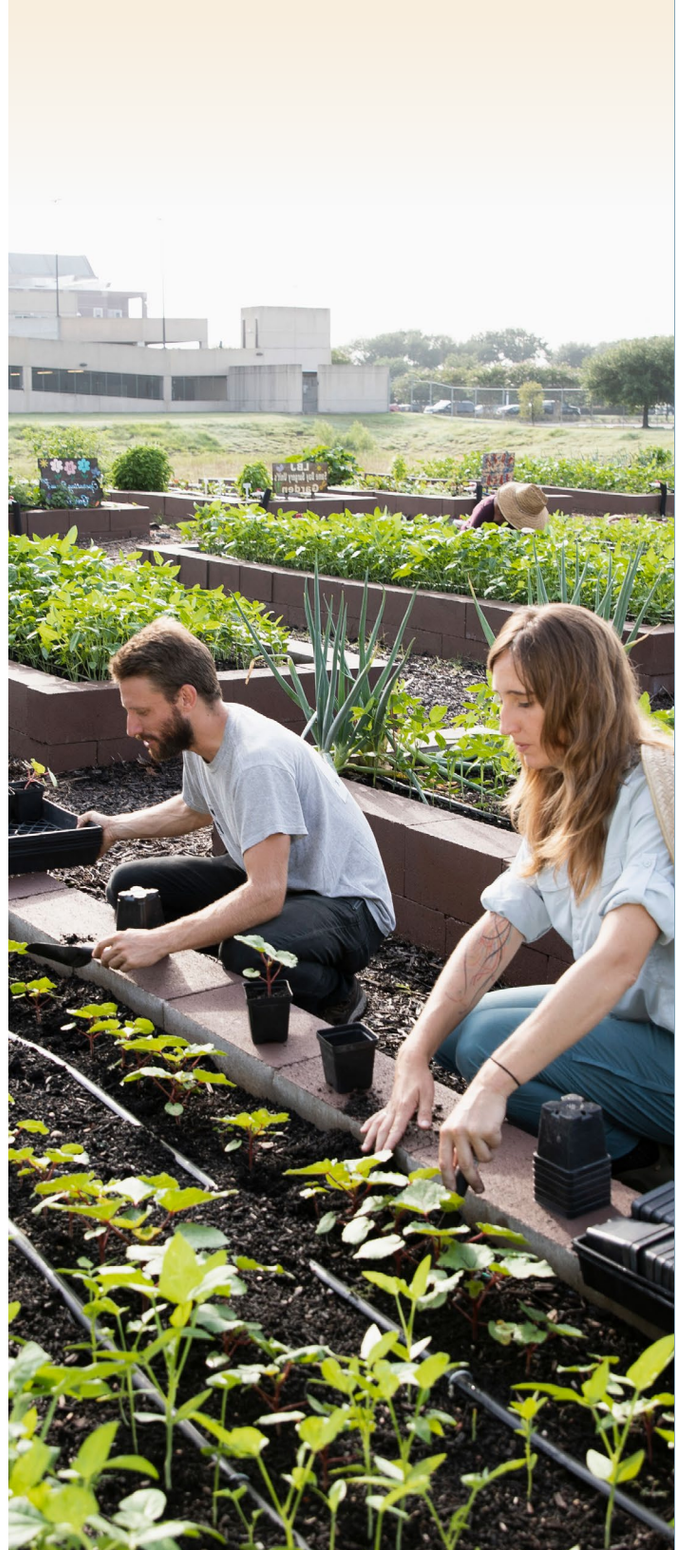


In the Community

Q1 **(Sept –Nov 2023)**	• 09/14: DAWN Grand Opening (100 attendees) • 10/21: AAMWA UpliftHER Mental Health Day (300 attendees) • 10/21: Bike Rodeo (50 attendees) • 10/31: Trunk or Treat (500 attendees) • 11/18: PVAMU Men's Diabetes Event (75 attendees)
Q2 **(Dec 2023 – Feb 2024)**	• 12/09: Community Blood Drive (75 attendees) • 12/16: Acres Homes Holiday Market (40 attendees) • 12/17: Vogel Creek Greenway Ribbon Cutting (300 attendees) • 02/24: AHCAG Health Fair (125 attendees)
Q3 **(Mar – May 2024)**	• 03/21: Wellness Night – Goodman Elementary (300 attendees) • 03/27: PVAMU Wellness Health Fair (50 attendees) • 04/06: Community Health Fair – Drew Academy (120 attendees) • 05/14: All of Us Journey Health (100 attendees) • 05/25: Bike Rodeo – Smith Academy (200 attendees)
Q4 **(June – Aug 2024)**	• 06/29: Black Fathers Matter – Highland Park (200 attendees) • 07/27: ACHAG Back to School – Acres Homes Multi-Purpose (500 attendees) • 08/03: Natural Head Corp. Back to School Bash – Little York Villas (150 attendees)

"Our programs and community partnerships are designed to equip patients with skills for healthier living and aimed at advancing health outcomes through accessible nutrition education and support."

Heather Shepard, MS, RD, CFO, LD, CNSC, director, Care Integration, Harris Health



CANCER RESOURCE CENTER

Executive Summary

The Cancer Resource Center (CRC) provides education, support and assistance to patients and survivors living with cancer. Staff at LBJ Hospital and Smith Clinic support patients throughout their treatment with emotional guidance and connect them to beneficial resources. CRC offers prevention and education to the community in alignment with accreditation Standard 8.2 and emotional support for survivors to meet accreditation Standard 4.8 of the Commission on Cancer. The primary goal of CRC is to improve the quality of life for cancer patients through emotional support and resource navigation.

Objectives

- Provide orientation classes for newly diagnosed patients and their families.
- Introduce Harris Health cancer services and set expectations for the treatment process.
- Offer emotional support through art therapy support groups and provide items to alleviate appearance-related side effects from treatment.
- Educate patients and provide navigation to available support services.

Fiscal Year 2024 Achievements

CRC collaborated with Corporate Communications to publish an annual Breast Cancer Survivor calendar featuring 12 survivors.

In 2024, Esther Martinez (Community Health Worker II) received the Harris Health Excellent Care Recognition award for her extraordinary kindness with a patient.

Key Partners

External partners include MD Anderson Cancer Center, Baylor College of Medicine, Look Good Feel Better Foundation, American Cancer Society, Susan G. Komen, the Leukemia and Lymphoma Society and CancerCare. Internal partners include Accreditation and Regulatory Affairs, Oncology Clinic, Infusion Clinic, Clinical Case Management, Mammography Case Management, Child Life Services, Physical Therapy and Rehabilitation Services, Nutrition Services and Food Farmacy.

In the Community

- Harris Health Colorectal Cancer Awareness March 2024 – Partnered with LBJ Hospital GI Lab to celebrate colon cancer survivorship and promote colon cancer screening.
- Settegast Resource Fair and Block Party June 2024 – Provided education on lung cancer and resources for smoking cessation. Knowledge gained was measured through pre- and post-surveys, with outcomes reported to the Cancer Committee.
- National Cancer Survivors Day June 2024 – Celebrated cancer survivors and raised awareness for cancer prevention with games and prizes at the Outpatient Center and Smith Clinic.
- Art Therapy Road Show August 2024 – During Health Center Week, patients' artwork from the Art Therapy Support Group was displayed in the Outpatient Center and Smith Clinic lobbies to promote the healing benefits of creative expression.
- Pink Out October 2023 – Honored and celebrated breast cancer survivors, their families and the life-saving cancer care provided by Harris Health, MD Anderson Cancer Center, UTHealth Houston and Baylor College of Medicine.

MEDICAL LEGAL PARTNERSHIP

Executive Summary

At the core, Medical-Legal Partnership (MLP) is the integration of legal expertise into healthcare settings to help clinicians, case managers and social workers address the needs or barriers that drive health inequities. At Harris Health, our MLP functions as a partnership—our Care Management teams identify patients with upstream legal needs, South Texas College of Law-Houston (STCL-Houston) provides legal services and UTHealth Houston School of Public Health conducts program evaluation to determine the effectiveness and outcomes of the MLP. It should be noted that STCL-Houston takes on Harris Health patients as their clients via their legal clinics, which are comprised of second- and third-year law students overseen by a licensed, practicing attorney. The first two years of MLP (through December 2024) were funded by the Episcopal Health Foundation. The partnership started in October 2022 and is currently available to patients at the Aldine, Vallbona and Gulfgate health centers, the Pediatric and Adolescent Health Center - C.E. Odom and through the House Calls program.

Objectives

- Identify and address health-harming legal needs (HHLNs) in Harris Health patients. HHLNs are the unmet social needs that negatively affect a person's health and can be addressed through legal services (e.g., housing issues, family-related legal issues and personal safety).
- Create a closed-loop partnership with STCL-Houston to address HHLNs.
- Provide experiential opportunities for STCL-Houston law students to support community health.
- Evaluate MLP's impact for both patients and the health system.

Fiscal Year 2024 Achievements

In 2023, one out of 11 patients screened had a health-harming legal need, resulting in 56 referrals to STCL-Houston with 70% of the referrals accepted. As of September 2024, MLP is managing over 66 active cases addressing issues such as guardianship, landlord/tenant conflicts and estate planning. Twenty-three of these cases were added between January and August 2024.

This year we featured MLP's work, including patient stories, at the Care Transitions Integration Monthly Operational Review and Harris Health Board of Trustees Quality Committee meetings.

Key Partners

MLP's success is the result of collaborative partnerships between STCL-Houston, UTHealth Houston School of Public Health and Harris Health Population Health, Care Management and Health Information Management Systems. The School of Public Health began conducting qualitative interviews with patients who qualified for but declined legal services and those with closed cases. Population Health is working to provide the data needed to begin the quantitative piece of the outcome evaluation.

In the Community

- MLP is part of the Texas MLP Coalition (TXMLPC). Sheebani Patel, director of strategic initiatives, Population Health, Harris Health sits on the TXMLPC Board of Directors for the 2024–2025 term.
- In addition to the evaluation work, the MLP team presented and conducted a panel discussion/ class featuring frontline care management staff at STCL-Houston, and presented about MLP at health center all-staff meetings.
- STCL-Houston also conducts ongoing office hours and question and answer sessions with Care Management staff.

WE ASK BECAUSE WE CARE

Executive Summary

We Ask Because We Care is a best-practice campaign around the collection of race, ethnicity and language (REL) data. Harris Health leveraged We Ask Because We Care to frame the start of our health outcome journey—the collection of updated demographic and social needs data to support the understanding of disparities in our community and patient population. The data we now collect systemwide is REL, sexual orientation and gender identity (SOGI), and health-related social needs (HRSN) . We began collecting HRSN data in the outpatient setting in August 2023 and at LBJ and Ben Taub hospitals in November 2023. In January 2024, we launched systemwide data collection around both REL and SOGI.

Fiscal Year 2024 Achievements

The overarching accomplishment of We Ask Because We Care was the endorsement of a systemwide effort to collect this data. It included communications geared toward both staff and patients from late 2023 through Q1 2024:

- System and pavilion eblasts and weekly newsletters plus intranet and internet pages.
- Communication from executive leaders.
- Training for all Harris Health staff, including frontline staff collecting the data.
- Digital and printed posters at registration, waiting areas and exam rooms.
- Language embedded in MyHealth and paper screeners.
- Presentations at systemwide meetings (e.g., town halls), key committee meetings (e.g., SNEC, SNAC, PNAC) and a roadshow for the health centers.
- Presented at the American Essential Hospitals 2024 VITAL Conference.

Finally, the data collection rates indicated the campaign's success. In August 2024:

- REL data was collected at a rate of 100% across ACS, Ben Taub and LBJ.
- Sexual orientation data was collected at a rate of 62.9% in ACS, with a continuous trend upward from the go-live in January 2024.
- Gender identity data was collected at a rate of 68.6% in ACS, with a continuous trend upward from the go-live in January 2024.
- HRSN data was collected at a rate of 89.2% in the inpatient setting and is consistently around 91% per month.
- The SDOH dashboard, which shares HRSN data collection systemwide, went live in September 2024 in Epic for all Harris Health staff to view.

Key Partners

One of the hallmarks of this work is the deep collaboration across 12+ stakeholder teams in Harris Health, coordinated by Population Health. Key partners include IT, Data Science and Informatics, Care Management, Quality, Nursing, Enterprise Project Management Offices (EPMOs), Patient Access, Ben Taub, LBJ, ACS and Corporate Communications.

"The collection of updated demographic and social needs data is critical to understanding the needs of our growing population and fundamental to our goal of advancing health outcomes in our community."

Sheebani Patel, director, Strategic Initiatives, Harris Health

TEXAS HEALTH EQUITY ALLIANCE FOR BREAST CANCER (THEAL)

Executive Summary

The Texas Health Equity Alliance for Breast Cancer (THEAL) is a multi-sector collaborative led by MD Anderson Cancer Center that focuses on reducing breast cancer disparities in Greater Houston. Harris Health received approval of its 2024 proposal to address barriers to mammography and treatment appointments and held a kickoff meeting in September 2024.

Objectives

- Develop a process map to document a patient's journey through the continuum of care.
- Report baseline data for transportation barriers in no-show and treatment appointments.
- Perform quality improvement exercise and report to explore the root cause of no-show rates for mammography and treatment clients.

Fiscal Year 2024 Achievements

Harris Health was awarded $50,000 for Fiscal Year 2025 to implement a THEAL Quality Improvement project and $60,000 for Fiscal Year 2025 to support THEAL as a backbone member.

Key Partners

Key partners include Harris Health Ambulatory Care Services, Harris Health Care Management, Harris Health Mammography Case Management and MD Anderson Cancer Center.

In the Community

The team attended the Texas Southern University We Roar Against Breast Cancer Program in October 2024, a breast cancer awareness event featuring discussions on breast cancer awareness from community experts and local screening resources. The team also attended monthly Steering Committee meetings to foster cross-sector collaboration, gather information and outreach between meetings, and provide updates on progress toward project goals. The team participated in working groups for Health System Data and Health Communication.

"Participating in a strong, multi-sector collaborative with a shared goal such as THEAL gives us the opportunity to intentionally identify barriers and weave together a stronger community, where no woman falls through the cracks."

Denise LaRue, administrative director, Clinical Integration & Transformation, Harris Health

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