Harris County
Public Health
Building a Healthy Community

Community Health Improvement Plan Quarterly Report

2026 Jan - Mar

HCPHTX.ORG

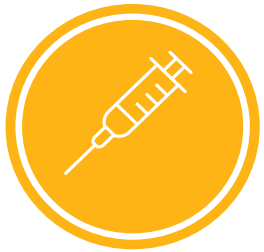
CHA-CHIP Background

The Community Health Assessment (**CHA**) & Community Health Improvement Plan (**CHIP**) work together to improve community health, reduce health differences, and achieve fair health for everyone.

The CHA identifies the county's current health status and highlights disparities across populations. The CHIP is a five-year action plan that addresses the top health priorities identified in the CHA through coordinated, community-driven strategies.

Guided by the **CHA–CHIP Steering Committee**—three priority areas were selected for 2024–2029:

Health Insurance & Care Access



Preventative Care

Mental Health

The CHIP's goals, objectives, and activities were co-developed with local public health agencies and community organizations. As a **living document**, it will evolve as new data and community input emerge.

Together, the CHA and CHIP provide a shared framework for aligning resources, coordinating efforts, and driving measurable progress toward a healthier Harris County.

2024 Community Health Assessment Report

2024 Community Health Improvement Plan

Community Health Improvement Plan (CHIP)

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WHY IT MATTERS

The CHIP Quarterly Report highlights key initiatives across the three priority issues and additional information can be found in the appendix.

2026 Q1 ACTIVITY SNAPSHOT

20+
Cross-sector partnerships

52,000+
Community members reached

8,000+
Immunizations delivered

BOTTOM LINE

Q1 focused on building a **strong implementation foundation**, aligning partner activities, launching data collection, and expanding community outreach.

PRIORITY AREA | Health Insurance & Care Access

GOAL | Residents have a trusted, medical home for healthcare and health information that meets their cultural and language needs.

WHY THIS MATTERS

Many residents are eligible for care but face barriers to enrollment and navigation.

2026 Q1 ACTIVITY SNAPSHOT

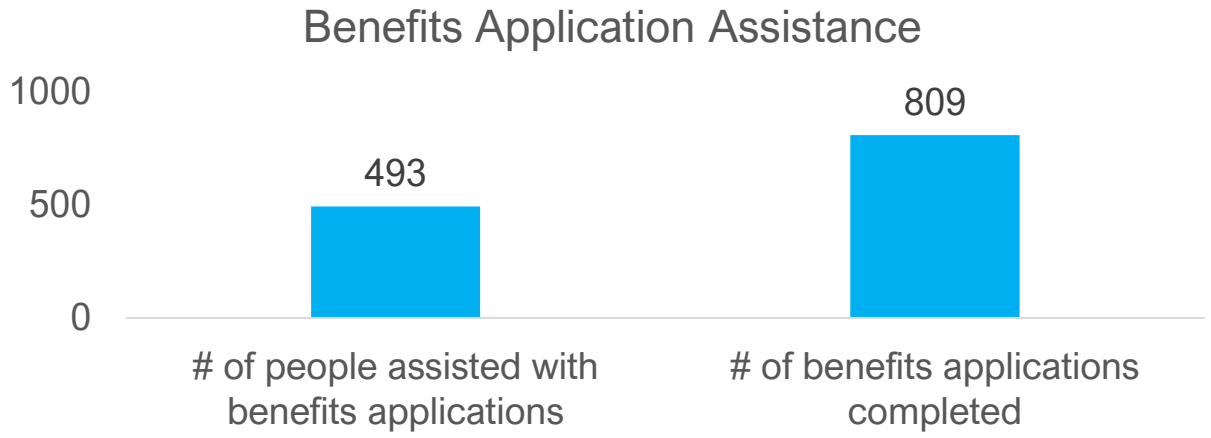
493
People assisted with benefit applications

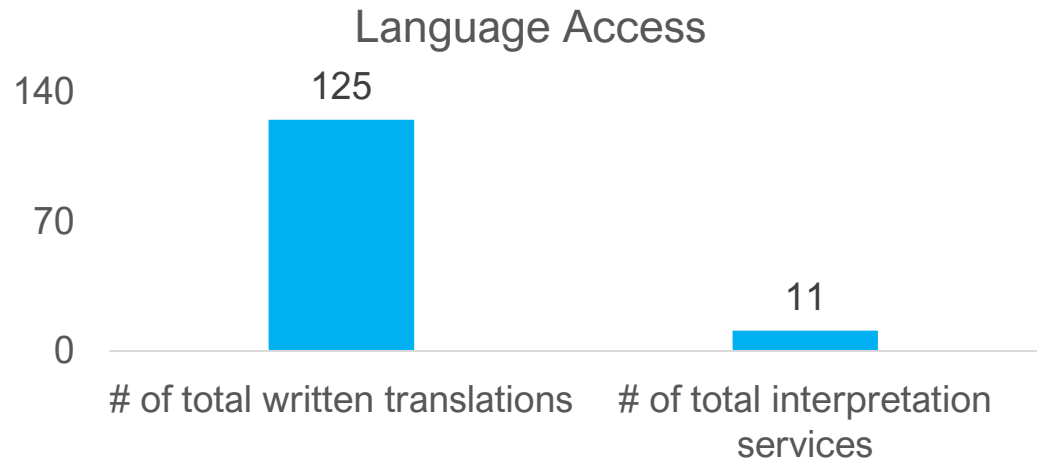
698
Connections to community resources

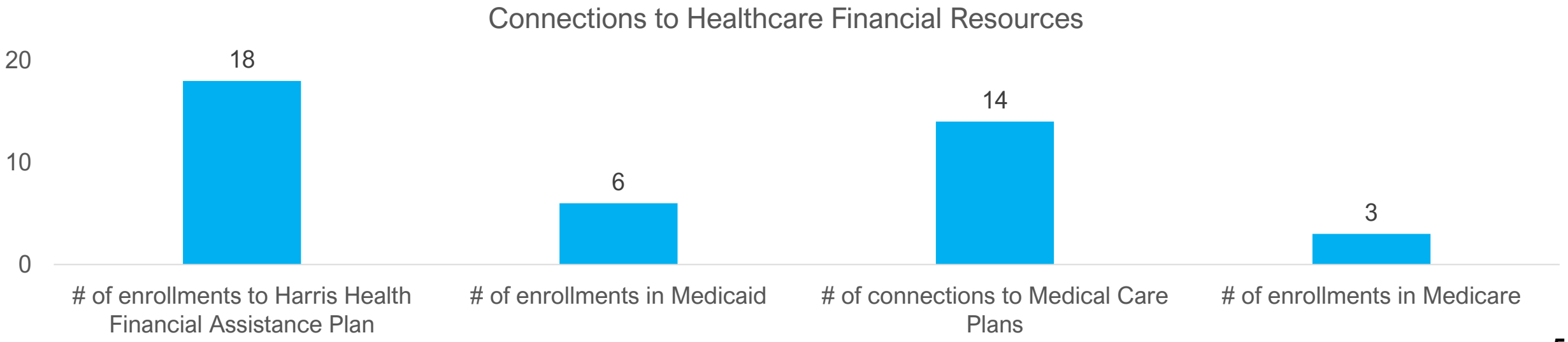
KEY INSIGHT

High demand for care navigation services → need to scale access points

PRIORITY AREA | Health Insurance & Care Access







PRIORITY AREA | Preventative Care

GOAL | Residents have the information and resources they need to prevent disease and stay healthy.

Goal

Access to preventative care reduces disease burden, improves quality money, and reduces cost for both individual community members and the healthcare system.

2026 Q1 ACTIVITY SNAPSHOT

16,011
People engaged through outreach

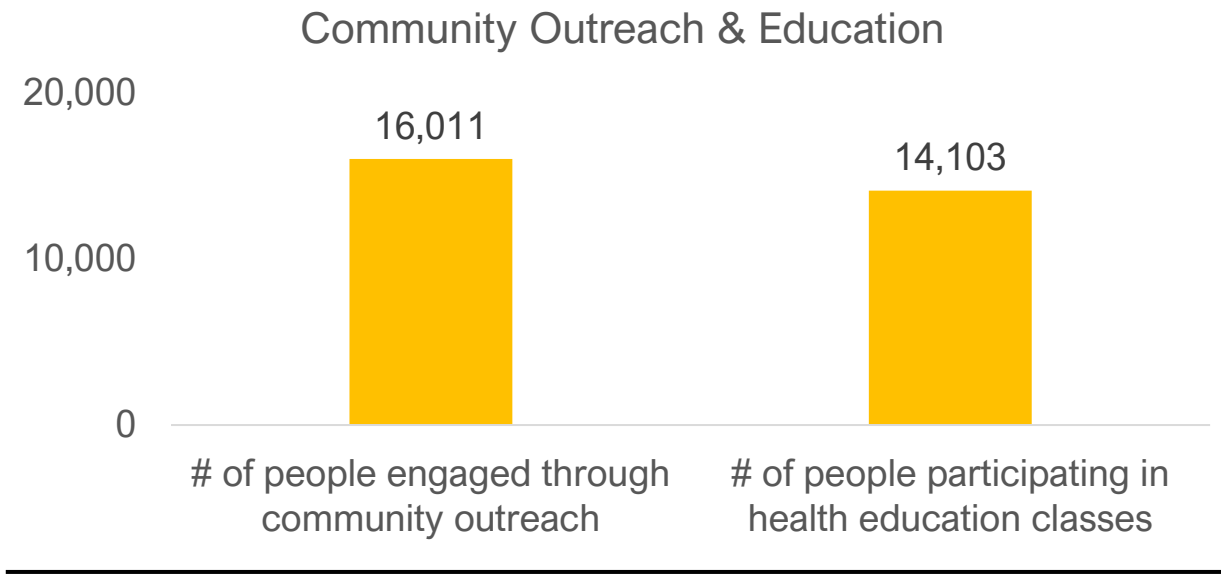
14,103
Participants in health education

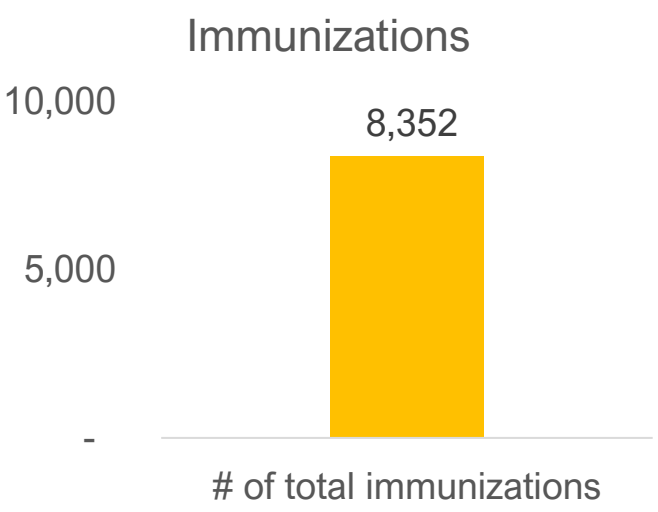
8,352
Immunizations delivered

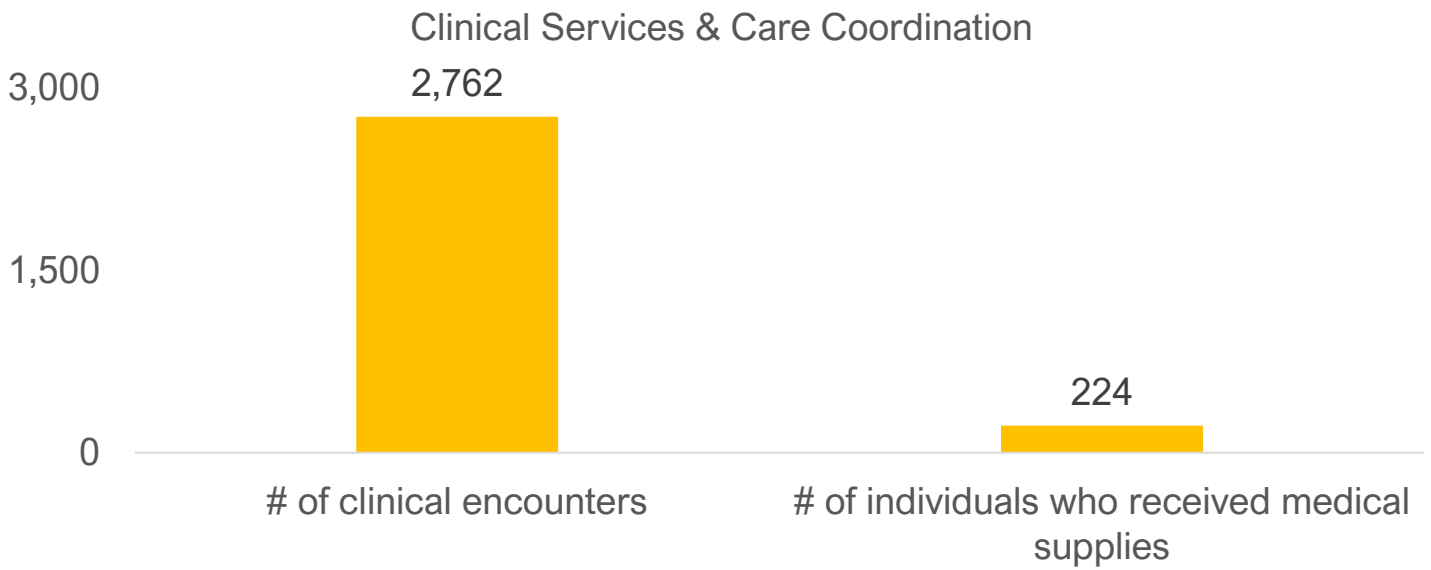
KEY INSIGHT

Strong engagement signals opportunity to expand preventative services

PRIORITY AREA | Preventative Care







PRIORITY AREA | Mental Health

GOAL | Residents can access timely, high-quality mental health care that supports both mental and physical health.

WHY THIS MATTERS

Mental health needs are rising, with gaps in early intervention and access.

2026 Q1 ACTIVITY SNAPSHOT

400
Mental health needs survey responses

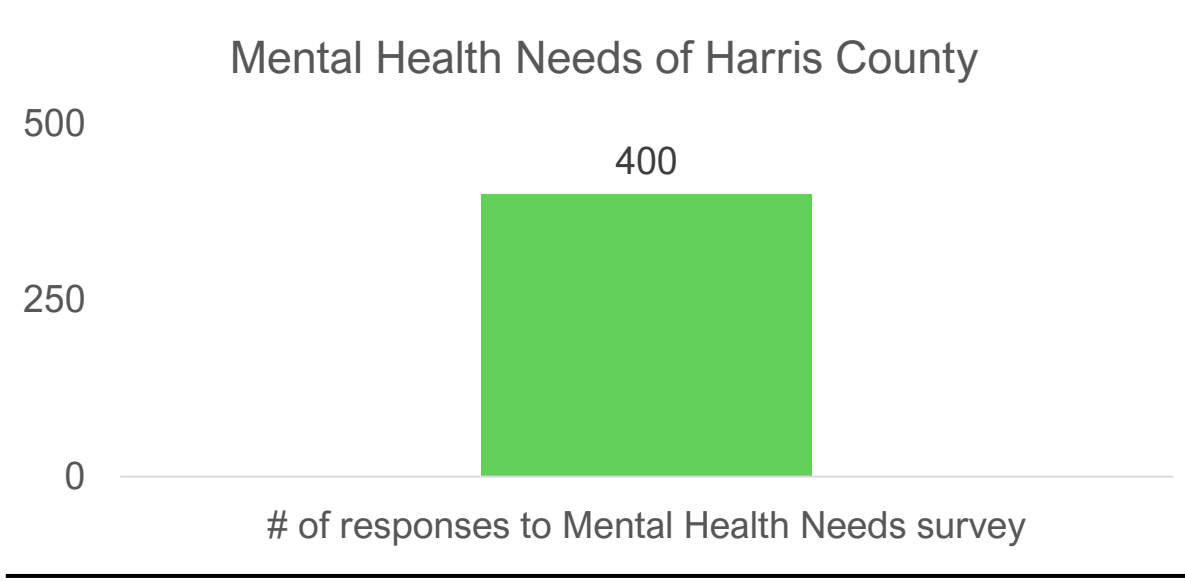
1,121
Community members educated on overdose prevention

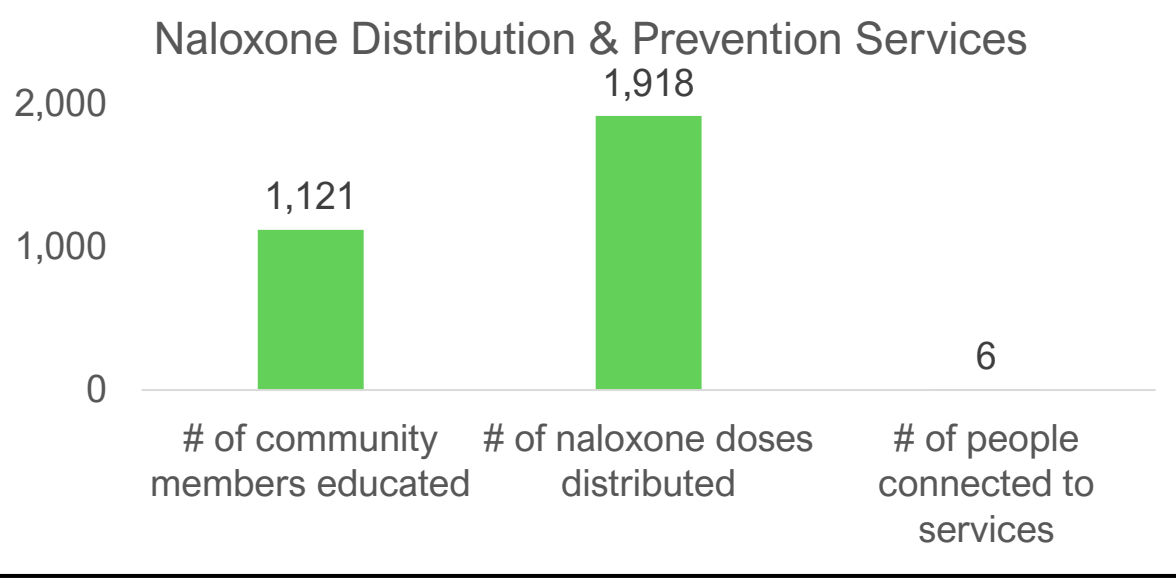
126
Naloxone doses distributed

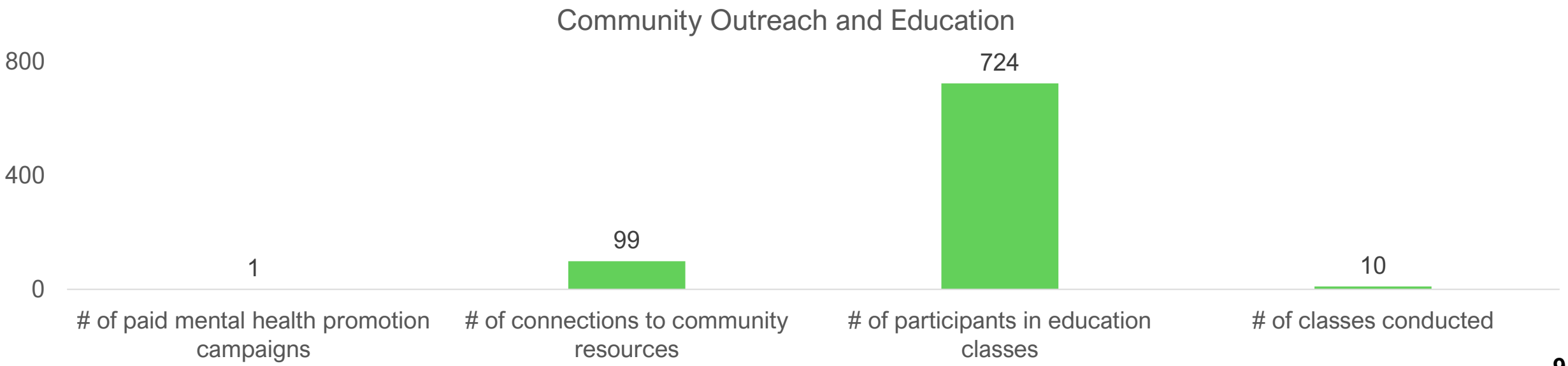
KEY INSIGHT

Rapid partnership growth → opportunity to scale training and awareness

PRIORITY AREA | Mental Health







Partnerships & Collaboration

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20+
Active partners

5
New partners in 2026 Q1

SPOTLIGHT | Living Hope Wheelchair Association

Through CHIP collaboration, Living Hope Wheelchair Association expanded engagement with HCPH by participating in planning efforts, supporting community outreach, and donating wheelchairs for residents in need. This relationship-building effort now serves as a model for future CHIP stakeholder engagement.

LIVING HOPE WHEELCHAIR ASSOCIATION

"This partnership has strengthened our ability to serve our community and expand access to essential resources."

KEY TAKEAWAYS

Cross-sector collaboration is driving system-level impact

What's Next? Q2 Focus

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KEY ACTIONS

- **Health Insurance & Care Access Subcommittee:** Integrate the new digital **Find Care Tool** into existing activities to improve healthcare access and navigation.
- **Preventative Care Subcommittee:** Expand preventative care outreach through initiatives such as ***Healthy in Harris County*** *and* sharing best practices across organizations.
- **Mental Health Subcommittee:** Increase **Mental Health First Aid** trainings across community partners, led by Harris Center.

PARTNERSHIP OPPORTUNITIES

- Improve access to healthcare based on upcoming system-wide findings
  HCPH and HHD will publish an Access to Healthcare Assessment and Report in July with recommendations to improve access to primary care, dental care, and behavioral/mental health care. HCPH, HHD, HHS, and Harris Center have agreed to collaborative on key activities and welcome additional partners to collaborate.

- Collaborate with schools on child health strategies
  HCPH will soon work with independent school districts throughout Harris County to develop a holistic child health strategy. There will be opportunities for CHIP partners to support this work.

- Develop joint mental health awareness campaigns
  The Mental Health Subcommittee plans to create a mental health awareness campaign that can be promoted by multiple organizations. If your organization is interested in creating and sharing the campaign, please join the Mental Health Subcommittee.

Supplemental Slides

Harris County Public Health

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CHIP Community Partners

STEERING COMMITTEE

Episcopal Health Foundation
Harris County Public Health
Harris Health System
Harris Center for Mental Health and IDD
Houston Food Bank
Houston Health Department
Living Hope Wheelchair Association
the Montrose Center
Rice University Kinder Institute for Urban Research

Health Insurance & Care Access Subcommittee

DIFY Foundation
Episcopal Health Foundation
Harris County Public Health
Harris Health System
Houston Health Department
Living Hope Wheelchair Association
Rice University Kinder Institute for Urban Research
Special Kids, Inc.

Preventative Care Subcommittee

DIFY Foundation
Episcopal Health Foundation
Family Alliance Network
Harris County Public Health
Harris Health System
Houston Food Bank
Houston Health Department
Living Hope Wheelchair Association
Memorial Hermann Healthcare Systems
Rice University Kinder Institute for Urban Research
Special Kids, Inc.
Texas A&M AgriLife

Mental Health Subcommittee

Christ the Redeemer Catholic Church
DIFY Foundation
Episcopal Health Foundation
Family Alliance Network
Harris Center for Mental Health & IDD
Harris County Public Health
Harris Health System
Living Hope Wheelchair Association
Memorial Hermann Healthcare Systems
the Montrose Center
Northwest Assistance Ministries
Rice University Kinder Institute for Urban Research
Special Kids, Inc.
Texas A&M AgriLife
Texas Opioid Prevention for Students

CHIP Activity | Health Insurance & Care Access

Goal 1.1 | Residents have a trusted, medical home for healthcare and health information that meets their cultural and language needs.
All Harris County community members are empowered to routinely use a trusted, culturally competent, and high-quality medical home for their health information and comprehensive healthcare needs.

Obj. 1.1.1 | Expand access to clear, culturally appropriate health information.
Increase the number of organizations that will implement or enhance processes and programmatic initiatives to increase the number of adults in Harris County who receive culturally and linguistically appropriate health information and services.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Benefit Application Assistance	HCPH HHD	Provides support to community members in enrolling in federal, state, and local benefit programs by helping them navigate eligibility and application processes, while connecting them to additional health and social services. This activity reduces financial barriers to care and improves access, utilization, and overall health outcomes among underserved populations.	# of persons assisted with benefits applications	493
			# of applications completed	809
Connections to Community Resources	HCPH LHWA	Connects Harris County residents with health, social, and supportive services through culturally and linguistically responsive outreach, navigation, referrals, and care coordination. This activity helps residents identify needs, access appropriate resources, and receive support that promotes well-being, stability, and self-sufficiency.	# of individuals reached through community outreach	15,287
			# of total connections to community resources	698
			# of enrollments in Harris Health Financial Assistance Plan	18
			# of enrollements in Medicaid	6
			# of connections to Medical Care Plans	14
			# of enrollments in Medicare	3
			# of connections to private insurance	0
Langage Access	HCPH	Ensures individuals with limited or non-English proficiency can access health information and services through translation, interpretation, and culturally and linguistically appropriate communication. This activity promotes equitable access, improves understanding and engagement, and supports better health outcomes across diverse communities.	# of total written translations	125
			# of total interpretation services	11

Obj. 1.1.2 | Strengthen partnerships to improve care navigation and service coordination.
Establish and strengthen existing community partnerships between local health/social service providers and community hubs (faith-based organizations, schools, libraries, community centers, etc.) to improve community members' ability to effectively navigate and use critical services and resources.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Integrated Resource Navigation	HCPH	Provides coordinated, person-centered support to assess individual needs and connect community members to health, social, and benefit resources through referrals and follow-up. This approach improves access, reduces fragmentation, and supports sustained engagement and self-sufficiency.	# of total sites	102
			# of re-occuring sites	43

CHIP Activity | Preventative Care

Goal 2.1 | Residents have the information and resources they need to prevent disease and stay healthy.
Harris County community members are well-informed of and provided with culturally competent, high-quality preventative care and resources.

Obj. 2.1.1 | Increase awareness and use of preventative services.
Increase awareness and education about the importance of preventative care and how to access services, especially among Harris County communities with low utilization rates and high needs.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Community Outreach & Education	HCPH HFB LHWA	Delivers culturally relevant health education, outreach, and resource navigation through community-based engagement, events, and campaigns to increase awareness of health topics, preventive practices, and available services. This activity improves knowledge, access, and utilization of care and resources, ultimately supporting healthier behaviors and outcomes across diverse populations.	# of people engaged through community outreach	20,122
			# of people served in all health education programs	14,103
			# of people served through Asthma Control Program	0
			# of people served through Nutrition & Physical Activity Program	7,288
			# of people served through Tobacco and Vaping Cessation Program	3,981
			# of people served through Diabetes Prevention Program	2,834
			# of total paid health promotion campaigns	26

Obj. 2.1.2 | Expand access to preventative services in priority communities.
Increase preventative care services to priority populations to strategically address geographic healthcare disparities.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Clinical Services & Care Coordination	HCPH LHWA MHHS	Provides preventive, diagnostic, and treatment services alongside coordinated care that supports individuals across care settings, including follow-up after hospital or emergency visits and access to essential medical supplies. This activity improves continuity of care, aligns patients with appropriate services, and addresses medical and non-medical needs to improve health outcomes and reduce avoidable utilization.	# of total clinical encounters	2,762
			# of individuals served with medical supplies	224
Food as Medicine	HFB MHHS	Integrates access to nutritious food into healthcare delivery by connecting individuals to food resources through clinical and community partnerships. This activity addresses food insecurity, supports chronic disease prevention and management, and improves overall health outcomes.	# of total referrals received	63
			# of total referrals enrolled in the FoodRx Program	26
Immunizations	HCPH MHHS	Provides vaccines through community- and school-based delivery models to protect individuals from preventable diseases. This activity increases vaccination coverage, reduces disease transmission, and improves population health outcomes.	# of total immunizations	83,252

CHIP Activity | Mental Health

Goal 3.1 | Residents can access timely, high-quality mental health care that supports both mental and physical health.
Harris County community members receive timely, culturally competent, and high-quality mental health services through a model of care that treats both physical and mental health.

Obj. 3.1.1 | Identify gaps and prioritize mental health needs.
Conduct a comprehensive needs assessment of mental health disparities in Harris County among priority populations that analyzes data by geography and creates an action plan to address the disparities.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Mental Health Needs of Harris County	Harris Center Montrose Center	Assesses community mental and behavioral health needs through data collection, stakeholder engagement, and population-specific research to identify service gaps, workforce shortages, and funding priorities. This activity informs system-level planning, resource allocation, and policy strategies to improve access to care and mental health outcomes.	# of respondents to Mental Health Needs survey	400

Obj. 3.1.2 | Expand community-based mental health training.
Increase mental health first aid training using a tiered training model for community partners, community members, and first responders.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Mental Health First Aid Training	Harris Center	Provides training to equip individuals with the skills to recognize, respond to, and support people experiencing mental health challenges or crises. This activity increases early intervention, reduces stigma, and strengthens community capacity to address mental health needs.	# of community members trained	0

Obj. 3.1.3 | Reduce stigma and increase awareness of mental health services.
Increase awareness and education to reduce mental health stigma and promote mental health services in priority populations, emphasizing themes related to access barriers, cultural competency, and the impacts of COVID-19.

Activity	Partner Organizations	Description	Metrics	1/1/26-3/31/26
Community Outreach and Education	HCPH Montrose Center TOPS	Delivers targeted health education, prevention programming, and public awareness campaigns through community engagement, schools, and media to address key health issues such as mental health and substance use. This activity increases knowledge, promotes healthy decision-making, and connects individuals to needed services and supports.	# of total paid health promotion campaigns in mental health	1
			# of education classes	10
			# of participants in education classes	724
			# of connections to community resources	99
Naloxone Distribution & Prevention Services	HCPH NAM Montrose Center	Provides naloxone distribution, overdose response training, and substance use prevention education through community and partner-based efforts. This activity increases overdose preparedness, reduces stigma, and supports harm reduction to prevent opioid-related deaths.	# of community members educated	1,121
			# of naloxone doses distributed	1,918
			# of people connected to services	6