# Memorial Hermann Health System

## Memorial Hermann Southeast Hospital

## Community Benefits Strategic Implementation Plan 2016

September 20, 2016

MEMORIAL® HERMANN

Health Resources in Action

*Advancing Public Health and Medical Research*

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Please address written comments on the Community Health Needs Assessment (CHNA) and Strategic Implementation Plan (SIP) and requests for a copy of the CHNA or SIP to:

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# INTRODUCTION

## Memorial Hermann Health System

Proudly working for individuals and families for more than 109 years, Memorial Hermann Health System (MHHS) is the largest non-profit healthcare system in Southeast Texas. Memorial Hermann's 13 hospitals and numerous specialty programs and services serve the Greater Houston area, the fifth largest metropolitan area in the United States. To fulfill its mission of providing high quality health services in order to improve the health of the people in Southeast Texas, Memorial Hermann annually contributes more than $451 million in uncompensated care, community health improvement, community benefits, health professions education, subsidized health services, research, and community education and awareness.

## Memorial Hermann Community Benefit Corporation

Established in 2007, Memorial Hermann Community Benefit Corporation (MHCBC) is a subsidiary of Memorial Hermann Health System. MHCBC's mission is to test and measure innovative solutions that reduce the impact of the lack of access to care on the individual, the health system and the community. MHCBC works in collaboration with other healthcare providers, government agencies, business leaders and community stakeholders to move closer to completion of an infrastructure for the Houston and Harris County region that will ensure a healthy, productive workforce.

Committed to making the greater Houston area a healthier and more vital place to live, MHHS and its subsidiary, MHCBC work together to provide or to collaborate with the following initiatives:

- Health Centers for Schools
- Mobile Dental Vans
- ER Navigators
- Nurse Health Line
- STEP Healthy to Reduce Obesity
- Neighborhood Health Centers
- Psychiatric Response Team
- Mental Health Crisis Clinics
- Home Behavioral Health Services

Since 2007, MHCBC has worked collaboratively with health related organizations, physicians groups, research and educational institutes, businesses, nonprofits, and government organizations to identify, raise awareness and to meet community health needs. Conducted every three years for each of MHHS's hospitals, the Community Health Needs Assessments (CHNA) guide MHCBC and the entire MHHS to better respond to each community's unique health challenges. The CHNA process enables each hospital within MHHS to develop programs and services that advance the health of its community, building the foundation for systemic change across the greater Houston area.

## About Memorial Hermann Southeast Hospital

Located in the heart of southeast Houston, Memorial Hermann Southeast Hospital (hereafter MH Southeast) has been caring for families in the Bay Area of Houston since 1986. Memorial Hermann Southeast employs state-of-the-art technology and a team of highly trained and experienced affiliated physicians to offer exceptional care close to home. Some of these programs include the Convenient Care Center in Pearland, a breast cancer center, an emergency and trauma center, an esophageal disease center, an imaging center, a sleep disorders center, and alcohol and drug rehabilitation, cancer care, children's care, diabetes management, heart and vascular care, industrial medicine services, maternal fetal medicine, neuroscience, orthopedics and sports medicine, physical therapy, surgery, weight loss, wound care, women's care, and inpatient rehabilitation.

### The Memorial Hermann Southeast Hospital Community

The MH Southeast community encompasses the three counties of Brazoria, Galveston, and Harris. MH Southeast defines its community geographically as the top 75% of zip codes corresponding to inpatient discharges in fiscal year 2015. These selected zip codes correspond to the ten communities of Alvin, Deer Park, Friendswood, Houston, La Porte, League City, Manvel, Pasadena, Pearland, and South Houston within the counties of Brazoria, Galveston, and Harris. A large majority of MH Southeast inpatient discharges in fiscal year 2015 occurred among residents of Harris County (63.4%) and Brazoria County (28.8%); only a small proportion of inpatient discharges occurred among Galveston County residents (7.8%). At a city level, most MH Southeast inpatient discharges occurred among residents of Houston (49.1%) followed by Pearland (19.5%).

It is important to recognize that multiple factors have an impact on health, and there is a dynamic relationship between people and their lived environments. Where we are born, grow, live, work, and age—from the environment in the womb to our community environment later in life—and the interconnections among these factors are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing stock. The social determinants of health framework addresses the distribution of wellness and illness among a population. While the data to which we have access is often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies.

In addition to considering the social determinants of health, it is critical to understand how these characteristics disproportionately affect vulnerable populations. Health equity is defined as all people having the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance." When examining the larger social and economic context of the population (e.g., upstream factors such as housing, employment status, racial/ethnic discrimination, the built environment, and neighborhood level resources), the disparities and inequities that exist for traditionally underserved groups need to also be considered.

## COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR MH SOUTHEAST HOSPITAL

To ensure that MH Southeast's community benefit activities and programs are meeting the health needs of the community, MH Southeast conducted a Community Health Needs Assessment (CHNA).

The CHNA was guided by a participatory, collaborative approach, which examined health in its broadest sense over a six-month period. This process included integrating existing secondary data on social, economic, and health issues in the region with qualitative information from 11 focus groups with community residents and service providers and 27 interviews with community stakeholders. Focus groups and interviews were conducted with individuals from the Greater Houston area and from within MH Southeast's diverse community.

## PRIORITY COMMUNITY NEEDS FOR MH SOUTHEAST HOSPITAL

The following key health issues emerged most frequently from a review of the available data across all MHHS hospitals and were considered in the selection of the system-wide Strategic Implementation Plan (SIP) health priorities:

- Health Care Access
- Issues Related to Aging
- Behavioral Health, Including Substance Abuse and Mental Health
- Transportation
- Healthy Eating, Active Living, and Overweight/Obesity
- Chronic Disease Management

HRiA facilitated MHHS leadership in an initial narrowing of the priorities based on key criteria, outlined in Figure 1, which could be applied across all CHNAs in the system. MHHS applied these criteria to select system-level priorities for approval by representatives from MH Southeast.

**Figure 1: Criteria for Prioritization**

| **RELEVANCE**<br>*How Important Is It?* | **APPROPRIATENESS**<br>*Should We Do It?* | **IMPACT**<br>*What Will We Get Out of It?* | **FEASIBILITY**<br>*Can We do It?* |
|---|---|---|---|
| • Burden (magnitude and severity, economic cost; urgency of the problem)<br>• Community concern<br>• Focus on equity and accessibility | • Ethical and moral issues<br>• Human rights issues<br>• Legal aspects<br>• Political and social acceptability<br>• Public attitudes and values | • Effectiveness<br>• Coverage<br>• Builds on or enhances current work<br>• Can move the needle and demonstrate measureable outcomes<br>• Proven strategies to address multiple wins | • Community capacity<br>• Technical capacity<br>• Economic capacity<br>• Political capacity/will<br>• Socio-cultural aspects<br>• Ethical aspects<br>• Can identify easy short-term wins |

The top three key priorities identified by this process were:

1. Healthy Living
2. Behavioral Health
3. Health Care Access

In May 2016, HRiA led a two-hour, facilitated conversation with Memorial Hermann Health System (MHHS), MH Southeast, and the other twelve MHHS hospitals (MH Katy, MH Greater Heights, MH Northeast, MH Memorial City, MH Rehabilitation - Katy, MH Southwest, MH Sugar Land, MH TIRR, MH TMC, MH The Woodlands, MH First Colony Surgical Hospital, MH Kingwood Surgical Hospital) participating in its 2016 CHNA-SIP process. This conversation included a presentation of the priorities identified by the Community Health Needs Assessment (CHNA) across all MHHS hospitals, including a discussion of the key criteria for prioritization and the impact of these health issues on the most vulnerable populations. After discussion among all hospital facilities, representatives came to consensus on these three top key priorities for each hospital facility and agreed, as they develop their hospital's Strategic Implementation Plan (SIP), to set hospital-specific goals, objectives, and strategies within them that addressed the facility's specific service area and populations served.

These three overarching priorities reflect all of the needs identified system-wide in the CHNAs including transportation (reflected under Access to Health Care), substance abuse (reflected under Behavioral Health), and issues related to aging (considered as one of several vulnerable populations addressed across the SIPs).

## THE STRATEGIC IMPLEMENTATION PLAN (SIP)

The goal of the 2016-2019 Strategic Implementation Plan is to:

- Develop a 3-year plan for the hospital to address the top priority health issues identified by the CHNA process
- Describe a rationale for any priority health issues the hospital does not plan to address
- Develop goals and measurable objectives for the hospital's initiatives
- Select strategies, taking into account existing hospital programs, to achieve the goals and objectives
- Identify community partners who will help address each identified health priority.

The 2016-2019 Strategic Implementation Plan is designed to be updated quarterly, reviewed annually and modified as needed.

### Memorial Hermann Southeast CHNA and Strategic Implementation Plan Work Group

- Corrina Abrego, Director of Marketing
- Kelli Davison, Documentation specialist
- Nikole Keenan, Director of Patient Care
- Rebecca Lilley, Director of Community Outreach
- Jennie Maldonado, Coordinator, Patient Access
- Megan Risinger, Emergency Center Clinical Manager

## RATIONALE FOR PRIORITY COMMUNITY NEEDS NOT ADDRESSED

All priority community needs identified by the Community Health Needs Assessment are addressed in this Strategic Implementation Plan through either MH Southeast Hospital or MHHS initiatives.

# MH SOUTHEAST HOSPITAL STRATEGIC IMPLEMENTATION PLAN

## Priority 1: Healthy Living

| **Priority 1: Healthy Living**<br>**Goal 1: Serve and be recognized as the community resource for preventative medicine.** | | |
|---|---|---|
| **Early Detection & Screening**<br>**Objective 1.1: Identify and treat chronic conditions early to prevent inappropriate ER admissions and disease advancement** | | |
| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
| • Number of health fairs offered | 20 | 22/year |
| • Number of participants in Diabetes Prevention Program | 30 | 30 |
| • Number of Health and Wellness articles | 16 | 16 |
| • Number of Health and Wellness webinars | 2 | 2 |
| **Strategies:** | | **Timeline: Year 1,2,3** |
| 1.1.1: Conduct quarterly community outreach via health fairs, employer events, speaker bureaus, lunch and learns. Screen for: head and neck, skin cancer, oral cancer, smoking cessation, BP, BMI, bone density, signs of stroke | | 1, 2, 3 |
| 1.1.2: Partner with community partners (YMCA and others) to underwrite Diabetes Prevention Program | | 1, 2, 3 |
| 1.1.3: Education and Outreach: Provide Health and Wellness articles in biannual newsletter, online webinars with physicians (recorded and archived on website) | | 1, 2, 3 |
| 1.1.4: Explore support for post-partum depression (investigate needs, partners) | | 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• Sign in sheets for health fairs<br>• Participant roster/list for Diabetes Prevention Program<br>• Count of articles and webinars | | |
| **Potential Partners:**<br>• YMCA<br>• Employers<br>• Other CBO's (community based organizations) | | |

**Priority 1: Healthy Living**

**Goal 1: Serve and be recognized as the community resource for preventative medicine.**

**Obesity Prevention**

**Objective 1.2: Prevent and reduce obesity and its related conditions/comorbidities**

| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
|---|---|---|
| • Number of nutrition focused classes offered (bariatric surgery, pediatric nutrition, general nutrition/weight management) | 78 | 81, 85, 90 (5%/year) |
| • Number of participants in bariatric and breastfeeding support groups | 200 | 5%/year |
| • Number of participants in Pediatric Weight Management Program | Establish baseline Y1 | TBD |
| • Number of participants in the YMCA health cooking classes | Establish baseline Y2 | TBD |
| • Industrial employers engaged in nutrition counseling | 1 Industrial employer | 3, 6, 9 |
| • Number of employees participating across all employers | 95 | 3%/year |

| **Strategies:** | | **Timeline: Year 1,2,3** |
|---|---|---|
| 1.2.1: | Host pre and post support group for Bariatric surgery patients | 1, 2, 3 |
| 1.2.2: | Provide nutrition outreach at community events, like Healthy Kids Day | 1, 2, 3 |
| 1.2.3: | Facilitate employer Wellness and Nutrition talks (Lunch and Learns, hosted by physicians and dieticians/nutritionists) | 1, 2, 3 |
| 1.2.4: | Provide support groups for breastfeeding and link to community resources (e.g., Lactation Foundation) | 1, 2, 3 |
| 1.2.5: | Conduct prenatal outreach on the benefits of breastfeeding and maternal health; provide free prenatal guide to all OB providers to standardize education for mothers throughout conception, pregnancy, and post-partum | 1, 2, 3 |
| 1.2.6: | YMCA: currently strategizing to use teaching kitchen to offer healthy cooking classes; intend to pilot and add exercise component | 2, 3 |
| 1.2.7: | Partner with industrial employers to provide nutrition visits and 1:1 counseling with dietician on-site | 1, 2, 3 |
| 1.2.8: | Offer free Pediatric Weight Management Program to kids and parents in a bilingual format, promoted via schools and pediatricians. Topics include: packing healthy lunch, exercise and conclude with program graduation | 1, 2, 3 |
| 1.2.9: | Provide classrooms for WIC instructors to teach their patients (Medicaid moms) and Southeast's Spanish-speaking patients about prenatal care and breastfeeding | 2, 3 |

**Monitoring/Evaluation Approach:**

- Class rosters and sign in sheets
- Classroom utilization calendar
- Scheduling of employer sites/employees for counseling

**Potential Partners:**

- YMCA
- Local Schools
- WIC
- State Dept of Health

**Priority 1: Healthy Living**

**Goal 1: Serve and be recognized as the community resource for preventative medicine.**

**Access to Healthy Food**

**Objective 1.3: Enhance access to healthy food for all patients in the Southeast community**

| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
|---|---|---|
| • Money raised to support local food pantries | $25,000 | TBD |
| • Pounds of food/families served via food drives | Establish baseline Y1 | TBD |
| • Number of ER patients screened for food insecurity via the ER Navigation program | 1,823 | 1,823 |
| • Number of CHW referrals to community food pantries via the ER Navigation program | 478 | 478 |
| • Number of supported special events hosted by community partners | 2 | 4 |
| • Number of participants in YMCA Diabetes Management classes | 50 | 100 |
| • Number of YMCA Diabetes Management classes | 6/year | 6/year |

| **Strategies:** | | **Timeline: Year 1,2,3** |
|---|---|---|
| 1.3.1: | Continue to participate in the MH ER Navigation program in which participants are screened for food insecurity and referred to food pantries if necessary | 1, 2, 3 |
| 1.3.2: | Collect food to support food pantries or special events hosted by community partners to improve access to healthy foods | 1, 2, 3 |
| 1.3.3: | Support system-wide Food Drive/Pantry which provides financial support to local pantries; and provide financial support to ten local pantries | 1, 2, 3 |
| 1.3.4: | Underwrite YMCA for Diabetes Management program which includes vouchers for local food pantries to provide access to local fruits and vegetables | 1, 2, 3 |

**Monitoring/Evaluation Approach:**

- YMCA report
- Patient activity documented and reported within the ER Navigation electronic record system

**Potential Partners:**

- YMCA
- School districts
- Cleveland Ripley Neighborhood Center
- Harbach Ripley Neighborhood Center
- Clearlake Food Pantry
- Pearland Neighborhood Center
- Pasadena Community Ministries
- LINC's Pasadena Pantry
- Memorial Hermann Community Benefit Corporation

**Priority 1: Healthy Living**

**Goal 1: Serve and be recognized as the community resource for preventative medicine.**

**Time for/Safety During Physical Activity**
**Objective 1.4: Prevent injuries and promote active lifestyles**

| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
|---|---|---|
| • Number of sports physicals conducted each year | Establish baseline in Year 2 | 150/year |
| • Number of patients seen at Saturday morning injury clinics | 5 | 10 per week in football season per year |
| • Number of concussion education sessions taught | Establish baseline in Year 2 | 3/year |
| • Number of participants in Concussion Education Program | Establish baseline in Year 2 | Target TBD |
| • Number of bicycle helmets provided | Establish baseline in Year 2 | Target TBD |
| • Number of classes held for expectant mothers | 150 | Increase by 3% each year |
| • Number of participants in classes for expectant mothers | Establish baseline Year 1 | TBD |
| • Number of events for Shattered Dreams and Live Your Dream | Establish baseline in Year 2 | 1/year |

| **Strategies:** | **Timeline: Year 1,2,3** |
|---|---|
| 1.4.1: Schools: Provide sports physicals at local schools for student athletes | 2, 3 |
| 1.4.2: Offer concussion education to promote awareness and prevent injury/reinjury | 2, 3 |
| 1.4.3: Provide Saturday morning injury clinics where sports medicine doctors are available to prevent/treat school athletes | 2, 3 |
| 1.4.4: Partner with the MH Trauma Institute to provide bicycle helmets for kids | 2, 3 |
| 1.4.5: Partner with YMCA to provide injury prevention education through Livestrong Program (See 1.5.6) | 1, 2, 3 |
| 1.4.6: Drowning prevention: conduct outreach at events, provide educational materials from Trauma Institute | 2, 3 |
| 1.4.7: Offer on-site (low cost) classes for expectant mothers | 1, 2, 3 |
| 1.4.8: Partner with local schools to deliver drunk driving/distracted driving education (Shattered Dreams and Live Your Dream) | 2, 3 |

**Monitoring/Evaluation Approach:**
- Class rosters
- Class schedules
- Sign in sheets
- Count of helmets distributed

**Potential Partners:**
- Schools
- MH Trauma Institute

**Priority 1: Healthy Living**

**Goal 1: Serve and be recognized as the community resource for preventative medicine.**

**Chronic Disease Management**

**Objective 1.5: Help patients manage chronic diseases to prevent decline in overall health and well-being**

| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
|---|---|---|
| • Number of new patient consults in Diabetes Clinic | Establish baseline in Year 1 (have not had an educator) | 50/year |
| • Number of ongoing disease management patients in Diabetes Clinic | Establish baseline in Year 1 | 50/year |
| • Number of participants in post stroke support group/number of offerings | 8 attendees per quarter | 15 – 20 per meeting (year 2 bi monthly) |
| • Number of post discharge patients reached | Establish baseline in Year 1 | 35% (increase by 3% in year 2, 3) |
| • Number of participants in Bariatric Support Group/number of offerings | 12 with 381 participants | Increase 5% year over year |
| • Number of patients seen in Pharmacy Wellness Clinic | 20 | 75/year |

| **Strategies:** | **Timeline: Year 1,2,3** |
|---|---|
| 1.5.1: Host post stroke support group for patients and families | 1, 2, 3 |
| 1.5.2: Conduct post-discharge callbacks to ensure compliance with recommended treatment | 1, 2, 3 |
| 1.5.3: Provide outpatient consults in Diabetes Education clinic | 1, 2, 3 |
| 1.5.4: Host Bariatric Support Group for surgical patients and their families to ensure compliance with weight loss program | 1, 2, 3 |
| 1.5.5: Pharmacy Medication and Wellness Therapy clinic for patients: Medical evaluation, education for complex drug therapies, prevention for infectious disease screenings and flu vaccine administration, tobacco cessation counseling. 2 visits free of charge | 1, 2, 3 |
| 1.5.6: Partner with community partners (YMCA and others) to underwrite Livestrong Survivor Program (see 1.4.5) | 1, 2, 3 |

**Monitoring/Evaluation Approach:**

- Patient direct portal (electronic)
- Class schedules
- Rosters/sign in sheets

**Potential Partners:**

American Diabetes Association (ADA)

## Priority 2: Access to Health Care

| | | | |
|---|---|---|---|
| **Priority 2:** | **Health Care Access** | | |
| **Goal 2:** | **Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.** | | |
| **Availability of Primary Care and Specialty Providers**<br>**Objective 2.1: Increase the availability of primary care and specialty providers in local settings** | | | |
| **Outcome Indicators:** | | **Baseline** | **FY 2020 Target** |
| • Number of new specialty recruits/hires MHMG | | 13.5 | 22 |
| • Number of patients referred to lactation consultants | | 91 participants per year | 3% year over year growth |
| • Number of appointments made with PCP's and specialty preventive care services at outreach fairs | | Establish baseline Y1 | TBD |
| • Number of Telemedicine Consultations | | 750 | 750 |
| **Strategies:** | | | **Timeline: Year 1,2,3** |
| 2.1.1: | Partner with UT Health and their Physician Group to recruit and align subspecialists with community needs and provide services in the community. (UT provides desired academic affiliation and Southeast provides local clinical practice) | | 1, 2, 3 |
| 2.1.2: | Offer PCP outreach fairs and events where community members can sign up for appointment with PCP, specialty preventive care services (e.g., mammograms, colonoscopies) | | 1, 2, 3 |
| 2.1.3: | Provide dedicated lactation consultants at no charge to evaluate patients for additional care needs and connect them to appropriate resources. (WIC, Lactation Foundation, etc.) | | 1, 2, 3 |
| 2.1.4: | A project of Memorial Hermann-Pearland, the Telemedicine Program provides 24/7 neurological consultations in our network hospitals, through the use of telemedicine technologies such as digital imaging and real-time video conferencing providing patients with continuity in treatment, a fast-tracked process, and the most effective drug therapies. | | 1, 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• Monthly reports for who is onboarded<br>• List of patient referrals to lactation consultants | | | |
| **Potential Partners:**<br>• ACO<br>• WIC<br>• Lactation Foundation<br>• UT Teleneurology | | | |

| | | |
|---|---|---|
| **Priority 2: Health Care Access**<br>**Goal 2: Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.** | | |
| **Health Insurance Coverage and Costs**<br>**Objective 2.2: Facilitate coverage of prescription medication for uninsured children** | | |
| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
| • Number of class D prescriptions to two Pasadena school-based health centers | 619 | 619 |
| **Strategies:** | | **Timeline: Year 1,2,3** |
| 2.2.1: Provide class D Prescriptions to the WAVE and Kruse School-Based Health Centers in support of primary medical care provided to uninsured children and teens at no cost | | 1, 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• SBHC medical records | | |
| **Potential Partners:**<br>• WAVE SBHC<br>• Kruse SBHC | | |

| | | |
|---|---|---|
| **Priority 2: Health Care Access**<br>**Goal 2: Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.** | | |
| **Transportation**<br>**Objective 2.3: Provide patients in need with just-in-time transportation resources/supports** | | |
| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
| • Number of vouchers provided | 2 | 4 |
| • Number of patients served by transport services provided by Cancer Center | 2 | 4 |
| • Number of gas cards | 2 | 4 |
| **Strategies:** | | **Timeline: Year 1,2,3** |
| 2.3.1: Conduct needs assessment upon patient discharge, provide vouchers for transportation back home and alignment with other local resources | | 1, 2, 3 |
| 2.3.2: Cancer Center: transport services for ongoing chemotherapy($25 gas cards) | | 1, 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• Voucher receipt book | | |
| **Potential Partners:**<br>• Community based organizations (CBO's) who provide transportation services (e.g., Uber, Yellow Cab, Metro, etc.) | | |

| | | |
|---|---|---|
| **Priority 2: Health Care Access**<br>**Goal 2: Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.** | | |
| **Health Care Navigation**<br>**Objective 2.4: Provide single source patient advocate to help coordinate treatment and services along the care continuum** | | |
| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
| • Number of Southeast hospital's associated counties' calls to Nurse Health Line (Brazoria, Galveston, and Harris) | 30, 939 calls | 30, 939 calls |
| • Number of nurse navigators in the Center of Excellence services | Establish baseline in Year 1 (currently without) | .5 (shared with SW) |
| • Number of patients served by nurse navigators via Center of Excellence services | Establish baseline in Year 1 | 50 |
| • Number of patients served by Diabetes educator | 12 | Increase 3% each year |
| • Number of patients enrolled in the ER Navigation Program | 1,985 | 1,985 |
| • Number of ER Navigation patient encounters | 3,441 | 3,441 |
| • Number of ER Navigation referrals to community resources | 4,280 | 4,280 |
| • Number of ER Navigation scheduled appointments | 210 | 210 |
| **Strategies:** | | **Timeline: Year 1,2,3** |
| 2.4.1 Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the MHHS community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources | | 1, 2, 3 |
| **2.4.2** Continue to participate in the MH ER Navigation program in which patients are referred to a medical home (See 1.3.1) | | 1, 2, 3 |
| 2.4.3: Provide nurse navigators and care coordinators for all Center of Excellence services (Bariatric Center, Joint, Chest Pain/Stroke, Esophageal Disease, Cancer Center. Navigator coordinates appointments, education classes, follow up care, etc.<br><br>Occupational Medicine liaison works with local employers re: OSHA reportables and work related injuries. Expedites treatment for patient | | 1, 2, 3 |
| 2.4.4: Diabetes Educator provides care coordination for this patient base | | 1, 2, 3 |
| 2.4.5: Dedicated Perinatal Educator: provides education, follow up, gestational diabetes pre and post-natal follow up | | 1, 2, 3 |
| 2.4.6: Occupational Medicine liaison works with local employers re: OSHA reportables and work related injuries to expedite treatment for patient | | 1, 2, 3 |
| 2.4.7: Athletic Trainer for Sports Medicine: Provide outreach in local schools, help to navigate care for student athletes post injury (ER, imaging, specialty care, etc.). Provide same-day game coverage | | 1, 2, 3 |

| | |
|---|---|
| **Priority 2:** | **Health Care Access** |
| **Goal 2:** | **Coordinate care among all levels of physicians (primary to specialists and everyone in between), and strengthen ACO members/network of supports, to ensure patients receive the highest quality care at the appropriate levels and cost.** |

**Monitoring/Evaluation Approach:**

- Monthly patient access report
- Class Schedule roster /sign in sheets
- Patient activity documented and reported within the ER Navigation electronic record system

**Potential Partners:**

- Schools
- Local employers
- Physicians
- VCARE Clinic
- Pasadena Community Health Center
- Stephen F Austin Community Health Center
- Central Care Community Health Center
- Ibn Sina Foundation Clinic
- Memorial Hermann Community Benefit Corporation

## Priority 3: Behavioral Health

The following tables provide strategies and outcome indicators that reflect an MHHS system-wide approach to Behavioral Health. Data is not specific to MH Southeast Hospital but to the community at large with the exception of reduction in ER encounters that result in a psychiatric inpatient stay through linkages with a network of behavioral partners.

| **Priority 3:** | **Behavioral Health** | | |
|---|---|---|---|
| **Goal 3:** | **Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.** | | |
| **Objective 3.1:** | **Create nontraditional access points around the community (crisis/ambulatory, acute care, and community-based chronic care management), and link those who need services to permanent providers and resources in the community** | | |
| **Outcome Indicators:** | | **Baseline** | **FY 2020 Target** |
| • Decrease in number of ER encounters that result in psychiatric inpatient stay | | 1,146 | 1,089<br>5% reduction of baseline |
| • Decrease in number of ER encounters that result in psychiatric inpatient stay -- Southeast | | 106 | 101 |
| • Decrease in number of ER encounters that result in psychiatric inpatient stay -- Pearland | | 36 | 34<br>5% reduction over baseline |
| • Number of MHCC Memorial Hermann Crisis Clinic total visits | | 5,400 | 5% over baseline |
| • Number of Psychiatric Response Care Management total visits | | 1,200 | 5% over baseline |
| **Strategies:** | | | **Timeline:**<br>**Year 1,2,3** |
| 3.1.1: | Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7 at Southeast. | | 1, 2, 3 |
| 3.1.2: | Provide mental health assessment, care, and linkage to services at Pearland/SE | | 1, 2, 3 |
| 3.1.3: | Create nontraditional community access to psychiatric providers for individuals experiencing a mental health crisis. Clinical Social Workers connect the target population to on-going behavioral health care | | 1, 2, 3 |
| 3.1.4: | Engage individuals with a chronic mental illness and work to maintain engagement with treatment and stability in the community via enrollment in community-based mental health case management program | | 1, 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• EMR/registration system (track and trend daily, weekly, monthly) | | | |
| **Potential Partners:**<br>• System acute care campuses<br>• Memorial Hermann Medical Group<br>• Network of public and private providers | | | |

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|---|---|---|
| **Priority 3:** | **Behavioral Health** | |
| **Goal 3:** | **Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.** | |
| **Objective 3.2:** | **Reduce stigma in order to promote mental wellness and improve community awareness that mental health is part of physical health and overall well-being** | |
| **Outcome Indicators:** | **Baseline** | **FY 2020 Target** |
| • Number of presentations/educational sessions for healthcare professionals within MHHS | 50 sessions per year | 5% increase over baseline |
| • Number of presentations/educational sessions for corporations | 5 | 5% over baseline |
| • Training on Acute Care Concepts - system nurse resident program | 15 trainings (45 hours total/3 hours each)* | 15 trainings (45 hours total/3 hours each)* |
| • Training on CMO Roundtable - system-wide | 1 training (2 hours)* | 1 training (2 hours)* |
| *Total time includes training material development and implementation | | |
| **Strategies:** | | **Timeline: Year 1,2,3** |
| 3.2.1: Provide mental health education sessions within the MH health system for nurses and physicians | | 1, 2, 3 |
| 3.2.2: Work with employer solutions group to provide education and training with corporations on MH topics (stress, PTSD) | | 1, 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• Requests for presentations and sessions tracked via calendar/excel | | |
| **Potential Partners:**<br>• System acute care campuses<br>• System Marketing and Communications<br>• Employer solutions group | | |

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|---|---|---|---|
| **Priority 3:** | **Behavioral Health** | | |
| **Goal 3:** | **Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.** | | |
| **Objective 3.3:** | **Quality of mental health and substance abuse services: access, link, and practice utilizing evidence-based practice to promote overall wellness** | | |
| **Outcome Indicators:** | | **Baseline** | **FY 2020 Target** |
| • Number of Memorial Hermann Crisis Clinic follow-ups post discharge with clinic patients | | 7,716 | 5% over baseline |
| • Psychiatric Response Case Management reduction in system ER utilization | | 54.4% | 5% increase over baseline |
| **Strategies:** | | | **Timeline: Year 1,2,3** |
| 3.3.1: | Social workers follow-up with discharged patients and their families to assess well-being and connect them to community resources | | 1, 2, 3 |
| 3.3.2: | Psychiatric Response Case Management Program utilizes evidence-based practice interventions (motivational interviewing, MH First Aid, CAMS, etc.) to reduce ER utilization for program enrollees | | 1, 2, 3 |
| **Monitoring/Evaluation Approach:**<br>• Social work logs (Excel spreadsheet) | | | |
| **Potential Partners:**<br>• System acute care campuses<br>• Community-based clinical providers<br>• Network of public and private providers | | | |