Memorial Hermann Health System

Memorial Hermann The Woodlands Hospital

Community Benefits Strategic Implementation Plan 2016

September 20, 2016

MEMORIAL HERMANN

TABLE OF CONTENTS

Health Resources in Action

Advancing Public Health and Medical Research

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 health care 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 The Woodlands Hospital

Located north of Houston, Memorial Hermann The Woodlands Hospital (hereafter MH The Woodlands) has been caring for families in south Montgomery County and surrounding communities in north Harris County since 1985. MH The Woodlands is a full-service, acute care facility that brings together the best healthcare technology, clinical expertise, and support for families. MH The Woodlands has grown to be a nationally recognized, regional medical center offering a broad range of advanced care options. It offers a variety of specialty services including the Chest Pain Center and the Primary Stroke Center, outpatient imaging, an American College of Surgeons accredited cancer program, and pediatric and women's health care programs. MH The Woodlands is an accredited, Level III trauma center. It is the first and only hospital in Montgomery County to be granted Magnet® status for nursing excellence by the American Nurses Credentialing Center.

Memorial Hermann The Woodlands Hospital Community

The MH The Woodlands community encompasses two counties, Harris and Montgomery. MH The Woodlands defined its community as the top 75% of zip codes corresponding to inpatient discharges in fiscal year 2015. These selected zip codes correspond to the communities of Spring, Conroe, Montgomery, Magnolia, Tomball, and Willis within the counties of Harris and Montgomery. A large majority of MH The Woodlands inpatient discharges in fiscal year 2015 occurred among residents of Montgomery County (73.2%). At a city level, most MH The Woodlands inpatient discharges occurred among residents of Spring (59.2%) followed by Conroe (22.7%).

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 be considered.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR MH THE WOODLANDS HOSPITAL

To ensure that MH The Woodlands' community benefit activities and programs are meeting the health needs of the community, MH The Woodlands 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 The Woodlands's diverse community.

PRIORITY COMMUNITY NEEDS FOR MH THE WOODLANDS 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 The Woodlands.

Figure 1: Criteria for Prioritization

RELEVANCE *How Important Is It?*	**APPROPRIATENESS** *Should We Do It?*	**IMPACT** *What Will We Get Out of It?*	**FEASIBILITY** *Can We do It?*
• Burden (magnitude and severity, economic cost; urgency of the problem) • Community concern • Focus on equity and accessibility	• Ethical and moral issues • Human rights issues • Legal aspects • Political and social acceptability • Public attitudes and values	• Effectiveness • Coverage • Builds on or enhances current work • Can move the needle and demonstrate measureable outcomes • Proven strategies to address multiple wins	• Community capacity • Technical capacity • Economic capacity • Political capacity/will • Socio-cultural aspects • Ethical aspects • 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 The Woodlands, and the other twelve MHHS hospitals (MH Greater Heights, MH Katy, MH Rehabilitation Hospital - Katy, MH Northeast, MH Memorial City, MH Southeast, MH Southwest, MH Sugar Land, MH TIRR, MH TMC, 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 The Woodlands CHNA and Strategic Implementation Plan Work Group

- Carolyn Allsen, Oncology Nurse Navigator
- Justin Kendrick, Chief Operating Officer
- Linda Kuitert, Director Case Management
- Edmund Lee, Director Patient Relations
- Amanda Pedro, Marketing Manager
- Kelly Wortham, Director Business Development
- Daphne Roque, Case Management 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.

MH THE WOODLANDS HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**		
Early Detection and Screening **Objective 1.1: Increase screening to promote early detection and reduce advanced stages of diseases**		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of participants in screenings (e.g. skin cancer and mammograms.)	Skin 40 Mammogram 300	Skin 45 Mammogram 315
• Number of low dose CT scans at a reduced cost to catch lung cancer earlier	0 (new program) Establish baseline in Y1	Establish target once baseline is established
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See also 1.2, 1.3, 1.4)	14 Groups 220 Attendees	14 Groups 254 Attendees (5% annually)
Strategies:		**Timeline: Year 1,2,3**
1.1.1: Provide education/awareness health talks at area schools and/or local businesses (See 1.2.3, 1.3.5, 1.4.5, 1.5.1)		1, 2, 3
1.1.2: Provide free screening mammograms and breast ultrasounds as needed for Interfaith Community Clinic patients and under/uninsured patients of private physicians		1, 2, 3
1.1.3: Provide free annual screenings for skin cancer during an annual event		1, 2, 3
1.1.4: Conduct low dose CT scans for older adults to diagnose lung cancer at earlier stages to prevent Stage 3 & 4 cancer at a reduced cost (communicate to PCPs via their support paperwork for these patients to make them aware of this service)		1, 2, 3
Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager, Oncology Nurse Navigator, and Imaging Directors. • Mammogram screenings tracked by Outpatient Imaging		
Potential Partners: • Community companies/employers (health fairs, talks, screenings) • Area schools (health fairs, talks, screenings) • Community organizations that work with low income patients (e.g. The Rose, Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs, like In the Pink and Lung Cancer CT scans to their patients)		

Priority 1: HEALTHY LIVING

Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.

Obesity Prevention
Objective 1.2 Increase educational offerings that promote healthy eating and exercise

Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See 1.1)	See 1.1	See 1.1
• Number of exercise classes, food demonstrations and healthy food education for cancer survivors and family	Establish baseline in Y1	Establish target once baseline is established

Strategies:	**Timeline: Year 1,2,3**
1.2.1: Conduct no cost support groups for weight loss and for conditions where obesity plays a role - diabetes, heart disease, and stroke	1, 2, 3
1.2.2: Provide facilities on-campus for Canopy program to conduct exercise classes to cancer survivors and their caregivers (e.g., yoga, ballroom dancing, line dancing, guided meditation, tai chi) (See 1.4.2) and free food demonstrations and education about healthy food options for cancer survivors and families via nutritionists and dietary staff (See 1.3.1)	1, 2, 3
1.2.3: Provide education/awareness health talks at area schools and/or local businesses	1, 2, 3

Monitoring/Evaluation Approach:
- Patient/participant experience surveys
- Events log maintained by Marketing Manager & Occupational Medicine Liaison
- Canopy programs maintained by Canopy Coordinator

Potential Partners:
- Community companies/employers (health fairs, talks, screenings)
- Area schools (health fairs, talks, screenings)
- Community organizations that work with low income patients (e.g. Interfaith Community Clinic)
- Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)

Priority 1: HEALTHY LIVING

Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.

Access to Healthy Food
Objective 1.3: Increase education about healthy foods to improve access and awareness

Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Pounds of food donated to local food pantries	14,000 lbs.	16,300 lbs. total (5% annually)
• Number of Farmer's Markets held (number of participant transactions)	0 (new program) Establish baseline in Y1	Sessions: 3 total Transactions: 50/session
• Number of food demonstrations and healthy food education for cancer survivors and family	See 1.2	See 1.2
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See 1.1)	See 1.1	See 1.1
• Number of attendees at weekly breastfeeding support group	26 weekly	26 weekly

Strategies:		**Timeline: Year 1,2,3**
1.3.1:	Nutritionists and dietary staff provide free food demonstrations and education about healthy food options for cancer survivors and families via the program at Canopy (See strategy 1.2.2)	1, 2, 3
1.3.2:	Collect food to support food pantries or special events hosted by community partners such as the Montgomery County Food Bank and/or Interfaith Food Pantry	1, 2, 3
1.3.3:	Offer Farmer's Markets on-campus for staff, patients, patient families, and community members	2, 3
1.3.4	Provide education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)	1, 2, 3
1.3.5	Provide education/awareness on breastfeeding benefits for mother and baby (nutrition, bonding, low cost alternative to formula, immunity boosting, etc.) via Baby Fair and breastfeeding support group	1, 2, 3

Monitoring/Evaluation Approach:

- Patient/participant experience surveys (Patient Satisfaction survey on hospital food)
- Events log maintained by Marketing Manager, Occupation Medicine Liaison, and Oncology Nurse Navigator
- Food Bank report

Potential Partners:

- Interfaith Food Pantry; Montgomery County Food Bank
- Community companies/employers (health fairs, talks)
- Area schools (health fairs, talks)
- Community organizations that work with low income patients (e.g. Interfaith Community Clinic)
- Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)
- Local growers of fresh produce/farmers

Priority 1: HEALTHY LIVING

Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.

Time for/Safety During Physical Activity
Objective 1.4: Increase the avenues for the community to participate in activities that promote safe physical activity

Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of events where we provide medical support/athletic trainers	350	350
• Number of educational talks/events like health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of exercise classes to cancer survivors and their caregivers	Establish baseline in Y1	Establish target once baseline is established
• Financial support of walk/runs	4	4

Strategies:	**Timeline: Year 1,2,3**
1.4.1: Provide financial support to four (4) runs; 10 for Texas, CBI Tri, Muddy Trails and Run Thru The Woods in the community	1, 2, 3
1.4.2: Provide facilities on-campus for Canopy program to conduct exercise classes to cancer survivors and their caregivers (e.g., yoga, ballroom dancing, line dancing, guided meditation, tai chi) (See 1.2.2)	1, 2, 3
1.4.3: Provide medical support/trainer presence and first aid supplies at community sporting events and other annual events (runs, walks, and clubs)	1, 2, 3
1.4.4: Conduct education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)	1, 2, 3

Monitoring/Evaluation Approach:
- Participant experience surveys
- Events log maintained by Marketing Manager , Occupational Medicine Liaison and Oncology Nurse Navigator

Potential Partners:
- Community companies/employers (health fairs, talks)
- Area schools (health fairs, talks)
- Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**		
Chronic Disease Management: **Objective 1.5: Provide support to those impacted with a chronic disease to help them effectively control and monitor their progress.**		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 53 (10% annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees. (See 1.1)	See 1.1	See 1.1
• Number of patients receiving free prosthetics, wigs and scarves	126	168 (10% annually)
Strategies:		**Timeline:** **Year 1,2,3**
1.5.1: Conduct education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)		1, 2, 3
1.5.2: Conduct no cost support groups for weight loss and for conditions where obesity plays a role - diabetes, heart disease, and stroke (See strategy 1.2.1)		1, 2, 3
1.5.3 Provide Nurse Oncology Navigator support and/or Canopy coordinator support to fit patients with free prosthesis, wigs and scarves provided by Canopy		1, 2, 3
Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager & Occupational Medicine Liaison • Oncology Nurse Navigator to maintain log of prosthetics, wigs and scarves		
Potential Partners: • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)		

Priority 2: Access to Health Care

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**		
Availability of Primary Care and Specialty Providers **Objective 2.1: Increase the number of primary care and specialty care providers in local settings**		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Montgomery and Harris) (See 2.4.1)	30,089	30,089
• People served through Interfaith Community Clinic	2,107 patients 8,681 visits	2,212 patients 9,115 visits
• Number of telemedicine consultations	275/year (in 2015)	275/year
Strategies:		**Timeline:** **Year 1,2,3**
2.1.1 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. (see 2.4.1)		1, 2, 3
2.1.2 Provide funding support for the Interfaith Community Clinic which provides free care to underserved populations.		1, 2, 3
2.1.3: Provide telemedicine consults free of charge for stroke and pediatric surgery patients, to determine if additional transfer and associated expense is necessary or could be avoided (See 2.3.2)		1, 2, 3
Monitoring/Evaluation Approach: • Patient/participant experience surveys • Interfaith Community Clinic feedback • ER visits and Interfaith Community Clinic funding tracked through finance • Telemedicine consults maintained in the ER • Nurse Health Line calls		
Potential Partners: • Government relations office • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • Memorial Hermann Community Benefit Corporation		

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**		
Health Insurance Coverage and Costs **Objective 2.2 Increase health insurance coverage for uninsured and underinsured populations**		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of people successfully insured through RCA	1,400	1,621 (5% annually)
Strategies:		**Timeline:** **Year 1,2,3**
2.2.1: Contract with Resource Corporation of America (RCA) to provide services to increase insurance coverage for community RCA is a third-party eligibility vendor (paid by MHTW) to assist patients with the application process for Medicaid, County Indigent, Affordable Care Act Insurance Exchange, and other third-party payors.		1, 2, 3
Monitoring/Evaluation Approach: • Log of insured through RCA		
Potential Partners: • Case Workers		

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**		
Transportation **Objective 2.3: Reduce the barrier of transportation to more efficiently access health care services**		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of patients who did not need to be transferred due to telemedicine consults	Stroke 200 Pediatric – Establish baseline in Y1	Stroke 231 (5% annually) Pediatric (once baseline established)
• Number of vouchers used	182	211 (5% annually)
Strategies:		**Timeline: Year 1,2,3**
2.3.1: Provide transportation vouchers for patients to return home following care		1, 2, 3
2.3.2: Provide telemedicine consults free of charge for stroke and pediatric surgery patients, to determine if additional transfer and associated expense is necessary or could be avoided (See 2.1.3)		1, 2, 3
Monitoring/Evaluation Approach: • Patient experience surveys • Telemedicine consults maintained in the ER • Voucher count maintained by case management		
Potential Partners: • Area physicians (to promote free or low cost programs to their patients) • Community organizations that work with low income patients (e.g. The Rose, Interfaith Community Clinic)		

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**		
Health Care Navigation **Objective 2.4: Connect patients to resources to help them better navigate the health care system**		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Montgomery and Harris) (See 2.1.1)	30,089	30,089
• Number of patient navigators	1	1-2
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 (See 2.1.1)		1, 2, 3
2.4.2: Increase number of patient navigators to provide services to our cancer patients		1, 2, 3
Monitoring/Evaluation Approach: • Patient/participant experience surveys • Nurse Health Line call log		
Potential Partners: • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • 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 The Woodlands 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 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay – The Woodlands		157	149
• Number of 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:** **Year 1,2,3**
3.1.1:	Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7 at The Woodlands		1,2,3
3.1.2:	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
3.1.3:	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: • EMR/registration system (track and trend daily, weekly, monthly)			
Potential Partners: • System acute care campuses • Memorial Hermann Medical Group • Network of public and private providers			

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
• TW Stress management (total time includes training material development and implementation)	1 training (6.5 hours)*	1 training (6.5 hours)*
• 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: • Requests for presentations and sessions tracked via calendar/excel		
Potential Partners: • System acute care campuses • System Marketing and Communications • Employer solutions group		

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: • Social work logs (Excel spreadsheet)		
Potential Partners: • System acute care campuses • Community-based clinical providers • Network of public and private providers		