Memorial Hermann Health System

Memorial Hermann Rehabilitation Hospital - Katy
Community Benefits Strategic Implementation Plan 2016

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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 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 Rehabilitation Hospital - Katy

Located in Katy, Memorial Hermann Rehabilitation Hospital-Katy (hereafter MH Rehabilitation Hospital-Katy) is a rehabilitation facility that has been delivering state-of-the art care since 2006 to individuals recovering from injuries or suffering from chronic diseases that have affected their physical or cognitive functioning. As the only inpatient rehabilitation hospital in the area, MH Rehabilitation Hospital-Katy offers the most advanced, innovative rehabilitation services available, with a focus on personalized, patient-centered care. MH Rehabilitation Hospital-Katy offers the latest technologies in diagnostic imaging, inpatient and outpatient rehabilitation, outpatient therapy for adults and children, and specialized care for stroke and neurological disorders, speech disorders, hard-to-heal wounds, orthopedic therapy and sleep disorders.

The Memorial Hermann Rehabilitation Hospital - Katy Community

MH Rehabilitation Hospital-Katy encompasses five counties: Austin, Colorado, Fort Bend, Harris, and Waller. MH Rehabilitation Hospital-Katy 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 seven communities of Brookshire, Columbus, Fulshear, Houston, Katy, Richmond, and Sealy within the Counties of Austin, Colorado, Fort Bend, Harris, and Waller. A large majority of MH Rehabilitation Hospital-Katy inpatient discharges in fiscal year 2015 occurred among residents of Harris County (66.1%) and Fort Bend County (24.0%); only a small proportion of inpatient discharges occurred among Austin (4.2%), Waller (3.5) and Colorado (2.1%) County residents. At a city level, most MH Rehabilitation Hospital-Katy inpatient discharges occurred among residents of Katy (54.8%), followed by Houston (28.9%).

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 REHABILITATION HOSPITAL - KATY

To ensure that MH Rehabilitation Hospital- Katy's community benefit activities and programs are meeting the health needs of the community, MH Rehabilitation Hospital-Katy 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 Rehabilitation Hospital – Katy's diverse community.

PRIORITY COMMUNITY NEEDS FOR MH REHABILITATION HOSPITAL - KATY

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 Rehabilitation Hospital – Katy.

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 Rehabilitation Hospital – Katy, and the other twelve MHHS hospitals (MH Katy, MH Greater Heights, MH Northeast, MH Memorial City, MH Southeast, 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 TIRR and Memorial Hermann Rehabilitation Hospital -- Katy CHNA and Strategic Implementation Plan Work Group

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RATIONALE FOR PRIORITY COMMUNITY NEEDS NOT ADDRESSED

The mission of the MH Rehabilitation Hospital -- Katy is focused on inpatient rehabilitation for individuals recovering from injuries or suffering from chronic diseases that have affected their physical or cognitive functioning. All treatment is customized to maximize function and independence with a goal of returning patients back to the community. The mission therefore does not focus on aspects of primary and secondary prevention associated with the topics below.

Although MH Rehabilitation Hospital – Katy's patient community needs the same education and access to prevention programs for the priority needs identified in the CHNA, as a 35-bed rehabilitation hospital, it must focus on addressing conditions related to its expertise and capabilities. For those interrelated needs outside of its expertise and capabilities, Katy Rehab connects patients within the vast support system network provided by Memorial Hermann, in particular, TIRR Memorial Hermann and the nearby Memorial Hermann Katy Hospital.

Priority 1: Healthy Living
    1.1 Early Detection and Screening
    1.2 Obesity Prevention
    1.3 Access to Healthy Food
    1.4 Time for/Safety During Physical Activity
The above interrelated prevention and secondary conditions must be addressed, if not through direct services, then through an effective referral network. As part of Memorial Hermann Health System, Katy Rehabilitation has access to such a network.

Priority 2: Access to Health Care

2.2 Health Insurance Coverage and Costs

Patients at Katy Rehabilitation Hospital are typically referred to this hospital from other facilities and providers who address insurance coverage as part of their community benefits program.

2.3 Transportation

Katy Rehab does not address the need for transportation services as this is not a primary part of our mission.

MH REHABILITATION HOSPITAL - KATY STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living				
Goal 1: Achieve long-term improved health for people with chronic and long-term disabilities.				
Early Detection and Screening: See "Rationale for Priority Community Needs Not Addressed""				
Obesity Prevention: See "Rationale for Priority Community Needs Not Addressed"				
Access to Healthy Food: See "Rationale for Priority Community Needs Not Addressed"				
Time for/Safety During Physical Activity: See "Rationale for Priority Community Needs Not Addressed"				
Chronic Disease Management **Objective 1.5:** Reduce progression or preventable side effects of chronic diseases				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of participants in support groups	10 - 15 participants	89	40	20 participants
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**
1.5.1 Conduct support groups for stroke survivors				1, 2, 3
		Monitoring/Evaluation Approach: • Support group participation records		
		Potential Partners: • Memorial Hermann Katy Hospital • Memorial Hermann Stroke Coordinators		

Priority 2: Access to Health Care

Priority 2: Health Care Access				
Goal 2: Ensure ease of access to care, services, and supports for people with chronic and long term disabilities.				
Availability of Primary Care and Specialty Providers **Objective 2.1:** Reduce barriers to care for people with disabilities				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (MH Katy Rehab - Austin, Colorado, Fort Bend, Harris, Waller)	31,333	29,072	32,890	31,333
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**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
		Monitoring/Evaluation Approach: • Nurse Health Line call logs			
		Potential Partners: • Memorial Hermann Community Benefit Corporation			
	Health Insurance Coverage and Costs: See "Rationale for Priority Community Needs Not Addressed"			
	Transportation: See "Rationale for Priority Community Needs Not Addressed"			

Health Care Navigation					
Objective 2.4: Provide opportunities for patients with disabilities to get the services they need when, where, and how they need it					
Outcome Indicators:		Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of hospital's associated counties' calls to Nurse Health Line (MH Katy Rehab - Austin, Colorado, Fort Bend, Harris, Waller)		31,333	29,072	32,890	31,333
Strategies:		Year 1 Notes	Year 2 Notes	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	
		Monitoring/Evaluation Approach: • Nurse Health Line call logs			
		Potential Partners: • 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 Rehabilitation Hospital - Katy but to the community at large.

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:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Decrease in number of ER encounters that result in psychiatric inpatient stay	1,146	1,213	1,135	1,089 5% reduction of baseline
• Number of Memorial Hermann Crisis Clinic total visits	5,400	5,590	5,154	5% over baseline
• Number of Psychiatric Response Care Management total visits	1,200	1,103	1,259	5% over baseline
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
3.1.1: Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7 at Katy Rehab.		An uptick in acute care volume over the past fiscal year has contributed to a higher number of psychiatric transfers overall.	An increase in acute care volume and number of acute care sites over the past fiscal year have contributed to a higher number of psychiatric transfers overall.	1,2,3

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.			
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		Recruiting mental health providers willing to commit to a non-traditional schedule remains a challenge. Continuing this urgent care model of treatment remains a priority, due to limited mental health treatment access in the community.	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	Staffing issues impeded year one target. Identifying appropriately licensed clinicians willing to consider a career that is community based with the requirement of making home visits and working non – traditional hours is an ongoing challenge.	Case Managers partner with their clients to identify specific recovery goals and utilize evidence-based practices to facilitate client achievement. We continue to partner with community providers to address the mental health needs of the Greater Houston Community.	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:		**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of presentations/educational sessions for healthcare professionals within MHHS		50 sessions per year	63	71	5% increase over baseline
• Number of presentations/educational sessions for corporations		5	7	8	5% over baseline
• Training on Acute Care Concepts - system nurse resident program		15 trainings (45 hours total/3 hours each)*	18	9	15 trainings (45 hours total/3 hours each)*
• Training on CMO Roundtable - system-wide		1 training (2 hours)*	0	4	1 training (2 hours)*
*Total time includes training material development and implementation				531.6	
Strategies:			**Year 1 Notes**	**Year 2 Notes**	**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:			Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of Memorial Hermann Crisis Clinic follow-ups post discharge with clinic patients			7,716	6,431	5,154	5% over baseline
• Psychiatric Response Case Management reduction in system ER utilization			54.4%	53.0%	50%	5% increase over baseline
Strategies:			Year 1 Notes	Year 2 Notes	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			The goal is to continue to educate the community, including other health systems, about the crisis clinic level of care so that when someone is experiencing a mental health crisis or needs immediate access to a behavioral health provider, the clinic will be the identified referral source.	The System has seen an overall increase in patient acuity with complex physical and behavioral health needs requiring higher levels of care. The Crisis Clinic and Psych Response Case Management Programs continue to meet the needs of patients with behavioral health conditions by providing immediate access to a mental health provider.	1,2,3

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.**			
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	The lack of crisis housing resources and the target population's over-reliance on the acute care system produces an ongoing challenge in reducing ER utilization of program enrollees.	Case Managers continue to partner with community agencies in an effort to connect program enrollees to resources for ongoing wellness. Program clinicians continue to use evidence-based practice interventions to reduce ER utilization and improve quality of life.	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		