Memorial Hermann Health System

Memorial Hermann Southwest Hospital

Community Benefits Strategic Implementation Plan 2016

September 20, 2016

MEMORIAL HERMANN

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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 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 Southwest Hospital

Located in the heart of southwest Houston, Memorial Hermann Southwest Hospital (hereafter MH Southwest) has been caring for families since 1977. Memorial Hermann Southwest employs state-of-the-art technology and a team of highly trained affiliated physicians to offer world-class care close to home. MH Southwest engages the diverse community that it serves through innovative programs designed to meet each demographic group's unique health and cultural needs. Some of these programs include the Memorial Hermann Heart and Vascular Institute, a cancer center, a joint replacement program, a neuroscience center, specialized services for women and the Asian community, a digestive health center, and an imaging program. As a Level III state designated trauma facility and with support provided by Memorial Hermann's Life Flight service, MH Southwest is equipped for Houston's most critical and urgent medical emergencies. MH Southwest is also home to the University Place Retirement Community, an award-winning 180-unit senior living residence.

The Memorial Hermann Southwest Hospital Community

The MH Southwest community encompasses three counties, Harris, Fort Bend, and Wharton. MH Southwest defines 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 Houston, Missouri City, Sugar Land, Stafford, El Campo, and Richmond. A large majority of MH Southwest inpatient discharges in fiscal year 2015 occurred among residents of Harris County (84.8%) or Fort Bend (13.9%); only a small proportion of inpatient discharges occurred among Wharton County residents (1.3%). At a city level, most MH Southwest inpatient discharges occurred among residents of Houston (84.8%) followed by Missouri City (5.3%).

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 SOUTHWEST HOSPITAL

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

PRIORITY COMMUNITY NEEDS FOR MH SOUTHWEST 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 Southwest.

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

- Gillian Alexander, VP/Chief Nursing Officer
- Malisha Patel, SVP/ CEO
- Kristel Poffinbarger, VP/ Chief Medical Officer
- Rebecca Tucker, VP/ Chief Financial Officer

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 SOUTHWEST HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living **Goal 1: Provide information and education on healthy living to promote health and wellness.**				
Early Detection and Screening **Objective 1.1: Decrease morbidity and mortality through education to enhance quality of life for our community**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of educational sessions offered around health and wellness with local organizations	12	12	19	12
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.1.1: Provide free or reduced cost educational services around healthy living				1, 2, 3
1.1.2: Develop Senior Resource Center to provide educational opportunities for people aged 55+				1,2,3
1.1.3: Conduct educational presentations to community on a variety of topics including early detection				1,2,3 Monthly
1.1.4: Conduct Lunch and Learns for employer groups				1,2,3 Ongoing
		Monitoring/Evaluation Approach: • Attendance records at seminars		
		Potential Partners: • Primary Care Physicians • Dietitian • YMCA • Schlumberger • Crown • Weatherford • Transcanada • Southwest Management District • Women's Voice for Better America • Houston Metropolitan Chamber		

Obesity Prevention **Objective 1.2: Increase awareness for lifestyle changes that decrease obesity rates in our community**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**2020 Target**
• Financial support towards YMCA Annual Fun Run	$2,500/year	$1,350	$1,500	$2,500/year
• Number of educational sessions offered	4	6	13	4
• Number of participants in Diabetes Support Group	35	35	20	40
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.2.1: Support and promote YMCA efforts around importance of physical activities in children				1, 2, 3
1.2.2: Continue to host Diabetes Support Group and Stroke Support Group to sustain lifestyle changes (See 1.5.5)				1, 2, 3
		Monitoring/Evaluation Approach: • Hours of Clinic Operation-Monday through Friday 8am-5pm • Amount of financial support- Insurance and private pay		
		Potential Partners: • Diabetes Nurse Educator/Certified Diabetes Educator • Diabetes Dietician Educator/Certified Diabetes Educator • YMCA		

Access to Healthy Food **Objective 1.3: Promote importance of healthy eating and educate community on how to access healthy food in the community**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**2020 Target**
• Number of ER patients screened for food insecurity via the ER Navigation program	941	2,035	1,261	941
• Number of CHW referrals to community food pantries via the ER Navigation program	166	565	289	166
• Number of ER Navigation supported community events hosted by local partners	3	11	6	6
• Amount of food in pounds collected	18,881 lbs.	7,916	2,283	18,881 lbs.
• Number of educational sessions offered	4	24	3	4
• Number of families impacted	4,720 individuals	3,287	81	4,720 individuals

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**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: Attend or support food pantries or special events hosted by community partners to improve access to healthy foods (e.g., ECHOS Food Drive)			1,2,3
1.3.3: Provide a wide variety of services to meet the needs of un/under-insured patients, via case workers and social workers including: • education on finding healthy food for family • the importance of breastfeeding • access to Meals on Wheels • access to WIC counselors • Patient navigation services • Assisting patients in completing application for Harris Country Gold Card to access care through their clinic (see 2.1.2, 2.2.7)			1,2,3
1.3.4 Provide consultation for all patients through registered dietitians to help them develop a healthy dietary plan			1,2,3

Monitoring/Evaluation Approach:
- Amount of financial donation and food in pounds collected
- Sign In sheet
- Patient activity documented and reported within the ER Navigation electronic record system

Priority 1: Healthy Living **Goal 1:** Provide information and education on healthy living to promote health and wellness.		
		Potential Partners: • ECHOs • House of Amos • My Brother's Keeper Outreach • Braes Interfaith Ministries • Southwest Multi Service Center • Baker-Ripley Neighborhood Center • Memorial Hermann Community Benefit Corporation

Time for/Safety During Physical Activity **Objective 1.4: Promote safety while engaged in physical activities**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of participants in Joint Class	312	0	275	350
• Number of patients trained on gait training	262	0	275	262
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.4.1: Offer a Joint Class for uninsured, under-insured and under-served patients undergoing joint replacement to promote safe return to physical activity		Will begin tracking this for FY 18		1, 2, 3
1.4.2: Conduct/Provide Gait training to uninsured, under-insured and under-served patients at rehab to prevent injury.		Will begin tracking this for FY 18		1, 2, 3
1.4.3: Provide financial support of American Heart Association's Heart Walk.				1, 2, 3
		Monitoring/Evaluation Approach: • Joint Class Roster • Hospital IP Rehab census		
		Potential Partners: • Joint Nurse Navigator • Orthopedic Surgeons • Orthopedic Clinics • Case Management		

Chronic Disease Management **Objective 1.5: Assist patients in managing chronic diseases to improve their overall health and well-being**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of participants in Diabetes Support Group and Mended Hearts Support Group	118	118	300	130
• Number of seminars offered, diabetes education, oncology awareness education, chronic kidney disease, changes in lifestyle in relation to chronic diseases in Asian community and senior population	12	12	4	12
• Discounted Diabetes Education	$31,416.00/year (Discount $102/session x 308 patients = $31,416.00/year)	$3,376.50	$31,416	$31,416.00/ year
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.5.1: Continue to offer educational seminars, such as heart and stroke, diabetes, blood pressure, oncology, chronic kidney disease				1, 2, 3
1.5.2: Continue support group programs, such as Diabetes Support Group, Mended Hearts, and Stroke				1, 2, 3
1.5.3: Conduct outpatient diabetes program				1, 2, 3
1.5.4: Educate Asian community on chronic disease based on lifestyle through education events, partnering with Asian PCPs, and providing education materials				1, 2, 3
1.5.5: Provide a wide variety of services to un/under- insured patients via case workers and social workers. These services include: providing information on where to get local and appropriate follow up care (See 1.3.3)				1, 2, 3
		Monitoring/Evaluation Approach: • Participant sign-in sheet • Pre/Post evaluation forms • Referral tracking system		
		Potential Partners: • Post-Acute Care Network • Diabetes Educator • Nutritionist • Primary Care Physicians • Marketing Department • Case Management		

Priority 2: Access to Health Care

Priority 2: Health Care Access **Goal 2: Assist in coordination of care in partnership with physicians and providers to ensure members of community are aware of access points.**				
Availability of Primary Care and Specialty Providers **Objective 2.1: Increase access to primary care physicians and specialists so that patients receive appropriate care**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Harris, Fort Bend, and Wharton)	31,211	31,022	32,755	31,211
• Navigation hours (CM and Social Workers) for community health workers to meet with uninsured patients	$93,825.60 or 220 hours/month (AHR CM/SW $35.54 x 220 hours/month = $93,825.60)	768 hours or $27,486.72	1,579 hours or $59,992.50	$93,825.60 or 220 hours/month
• Number of telemedicine consultations	254 (in 2015)	245	215	254
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
2.1.2: Provide a wide variety of services to meet the needs of un/under insured patients via case workers and social workers including: • education on finding healthy food for family • the importance of breastfeeding • access to Meals on Wheels • access to WIC counselors • Assisting patients in completing application for Harris Country Gold Card to access care through their clinic (see 1.3.3)				1, 2, 3
2.1.3: Provide primary care to the under- and uninsured via the Family Practice Residency program at Southwest (UTMB – Galveston) supervised by residency director				1, 2, 3
2.1.4: Provide subsidized support to medical groups (Sound Physicians, TeamHealth OB) who provide services to under- and uninsured				1, 2, 3
2.1.5: Provide 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

Priority 2:	**Health Care Access**	
Goal 2:	**Assist in coordination of care in partnership with physicians and providers to ensure members of community are aware of access points.**	
		Monitoring/Evaluation Approach: • Medicare and Medicaid enrollment • Health Nurse Line Log • Record of patients assisted by navigators
		Potential Partners: • Texas Department of Health and Human Services • Memorial Hermann Health Solutions • Primary Care Physicians • Case Management • University of Texas (UT) Teleneurology

Health Insurance Coverage and Costs **Objective 2.2: Increase community members covered by health insurance and provide education on cost savings**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**2020 Target**
• Number of Class D Prescriptions provided to the Sharpstown and Elrod School Based Health Centers	189	167	209	189
• Amount of prescription medication provided to patients free of charge	$37,666.85/year	$37,666	$140,898	$37,666.85/year
• Number of new insurance enrollees within catchment area – assistance provided by Texas Department of Health and Human Services, Cardon Outreach and Memorial Hermann Health Solutions		6,531	6,011	
• Cost of Post-Acute Care	$35,298.48/year		$690,111.47	$35,298.48/year
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
2.2.1: Provide Class D Prescriptions to the Sharpstown and Elrod School Based Health Centers in support of primary medical care provided to uninsured children and teens at no cost				1, 2, 3
2.2.2: Provide prescription medications to patients who do not have coverage to pay for medications				1, 2, 3
2.2.3: Provide financial support for post-acute care for indigent patients				1, 2, 3
2.2.4: Contract with Cardon Health Care to provide services to help patients find and apply for coverage through Medicaid or other programs				1, 2, 3
2.2.5: Provide a wide variety of services to meet the needs of un/under- insured patients via case workers and social workers including: • education on finding healthy food for family • the importance of breastfeeding • access to on Wheels • access to WIC counselors • Assisting patients in completing application for Harris Country Gold Card to access care through their clinic				
		Monitoring/Evaluation Approach: • Cardon Records • Cost center statement • Walgreen's Invoice • DME log		
		Potential Partners: • Case Management • Social Worker • Cardon Outreach • Memorial Hermann Community Benefit Corporation		

Transportation **Objective 2.3: Provide patients in need with just-in-time transportation resources/support**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**2020 Target**
• Cost of vouchers provided	$1,500	$1,375	$14,750	$1,500
• Cost of medical transportation and ambulance services	$231,440.37	$359,084	$298,584	$231,440.37
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
2.3.1: Provide cab vouchers and bus tokens for patients who are being discharged home				1,2,3
2.3.2: Provide ambulance services and medical transport for urgent care transfers for patients without coverage				1,2,3
		Monitoring/Evaluation Approach: • Cost center statement		
		Potential Partners: • Operations Administrators • Case Management • Ambulance services		

Health Care Navigation **Objective 2.4: Connect patients to resources to help them understand and navigate their healthcare journey to improve patient outcomes**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Harris, Fort Bend, and Wharton)	31,211	31,022	32,755	31,211
• Number of patients enrolled in the ER Navigation Program	1,197	1,850	1,192	1,197
• Number of ER Navigation patient encounters	2,272	4,872	3,510	2,272
• Number of ER Navigation referrals to community resources	3,086	4,299	2,537	3,086
• Number of ER Navigation scheduled appointments	136	289	120	136

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
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

		Monitoring/Evaluation Approach: • Referrals to Harris County Gold Card • Patient Log - Nurse Navigators • Referral Log to PCP • Patient activity documented and reported within the ER Navigation electronic record system.
		Potential Partners: • Case management • Primary Care Physicians • Nurse Health Care Line • Physicians of Sugarcreek • 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 Southwest 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:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
Decrease in # ER encounters that result in psychiatric inpatient stay	1,146	1,213	1,135	1,089 5% reduction of baseline
Decrease in # ER encounters that result in psychiatric inpatient stay - Southwest	137	105	34	130
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 Southwest.		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)		

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.**	
		Potential Partners: System acute care campuses Memorial Hermann Medical Group Network of public and private providers

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
SW Management and communication with disruptive patients (total time includes training material development and implementation)	1 training (4 hours)	0	6	1 training (4 hours)
SW Med Floor Nursing debriefing	1 training (2 hours)	0	0	1 training (2 hours)
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		

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 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
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		