Memorial Hermann Health System

Memorial Hermann Sugar Land Hospital

Community Benefits Strategic Implementation Plan 2016

September 30, 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 Sugar Land Hospital

Located in Fort Bend County, Memorial Hermann Sugar Land Hospital (hereafter MH Sugar Land) is a full-service, acute care facility that brings together the ultimate in healthcare technology, expertise and healing for families in their community. The Quality Texas Foundation awarded MH Sugar Land Hospital, the first Houston area recipient, the Texas Award for Performance Excellence in 2015, a prestigious award recognizing strong dedication to quality and high performance. Among the specialty services and programs offered by MH Sugar Land are an emergency center, imaging services, a sports medicine and rehabilitation program, and a Sleep Disorders Center.

The Memorial Hermann Sugar Land Hospital Community

The MH Sugar Land community encompasses three counties, Fort Bend, Harris, and Wharton. MH Sugar Land 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 ten communities of East Bernard, El Campo, Houston, Missouri City, Needville, Richmond, Rosenberg, Stafford, Sugar Land, and Wharton within the counties of Fort Bend, Harris, and Wharton. A large majority of MH Sugar Land inpatient discharges in fiscal year 2015 occurred among residents of Fort Bend County (80.4%) and Wharton County (14.3%); only a small proportion of inpatient discharges occurred among Harris County residents (5.4%). At a city level, most MH Sugar Land inpatient discharges occurred among residents of Richmond (28.1%) followed by Sugar Land (20.2%) and Rosenberg (15.3%).

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 SUGAR LAND HOSPITAL

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

PRIORITY COMMUNITY NEEDS FOR MH SUGAR LAND 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 Sugar Land.

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

- Robert Bayman, Director of Business Office
- Jeroen Bergen, Director of Food and Nutrition
- Courtney Diepraam, Director of Business Development
- Lori Dittler, Director of Case Manager
- Steven Ramirez, Sports Medicine and Outreach
- Bonnie Reagan, Manager of Business office

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 except where noted below.

Priority 2: Health Care Access

Transportation: Sugar Land does not address the need for transportation services as this is not a primary part of our mission and we can achieve greater impact in allocating our resources to other issues of access.

MH SUGAR LAND HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living **Goal 1: Increase overall wellness of community members in our primary and secondary service areas.**				
Early Detection and Screening **Objective 1.1: To maintain current education and screening efforts, as well as increasing screening as identified in the CHNA.**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of events held	34	23	37	45
• Number of community members receiving screenings	240	5,162	20,595	300
• Number of Lunch and Learns held	8	1	1	12
• Number of employer groups that we collaborate with	3	1	3	5
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.1.1: Provide free screening at screening/health fair events for blood pressure, BMI, EKG, ortho evals, mammography party, physicals for children, heart fair, men's health fair, skin cancer, diabetes (See 1.2.3)				1,2,3 Monthly
1.1.2: Provide financial support to the Pink in the Park Breast Cancer Awareness event				1,2,3 Yearly
1.1.3: Conduct education presentations to 55+ community on a variety of topics including early detection specific to Del Webb community				1,2,3 Bi monthly
1.1.4: Conduct Lunch and Learns for employer groups and at the YMCA				1,2,3 Bi Monthly
		Monitoring/Evaluation Approach: • Event tracking • Attendance records • Screening records		
		Potential Partners: • MD Anderson • Texana • YMCA • Fluor Daniel • NRG • Schlumberger		

Priority 1: Healthy Living

Goal 1: Increase overall wellness of community members in our primary and secondary service areas.

Obesity Prevention

Objective 1.2: Provide education and healthy choices for multiple age groups in our community

Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of seminars and education sessions	Quarterly	3 seminars	5	Quarterly
• Number of community members reached during education sessions	50	27	173	100
• Number of bariatric surgical cases	34	51	65	50

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.2.1: Conduct bariatric seminars and support groups			1,2,3 Quarterly
1.2.2: Conduct education events for students and staff at school districts to discuss obesity			1,2,3 Annually
1.2.3: Provide BMI referrals from Health Fair screenings (See 1.1.1)			1,2,3 Quarterly
1.2.4: Financially support running events, such as Finish Line Sports 30K, USA Fit Marathon, and Commonwealth Elementary School Fun Run			1,2,3 Quarterly

Monitoring/Evaluation Approach:

- Attendance records
- Bariatric Surgical case reports

Potential Partners:

- LCISD
- FBISD
- Fort Bend Fit
- Finish Line Sports
- Texas Running Company
- Local elementary schools (Commonwealth Elementary)

Priority 1: Healthy Living

Goal 1: Increase overall wellness of community members in our primary and secondary service areas.

Access to Healthy Food

Objective 1.3: Support efforts of MH system and local community partners in improving the community's access to healthy food.

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of ER patients screened for food insecurity via the ER Navigation program	803	1,433	1,264	803
• Number of CHW referrals to community food pantries via the ER Navigation program	114	583	355	114
• Number of ER Navigation supported community events hosted by local partners	0	3	7	2
• Level of financial contributions for food insecurity collaborative efforts	0	$8,502	0	1,500
• Number of customers at the farmers market	80	80	0	120

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:	Collect food to support food pantries or special events hosted by community partners			1,2,3
1.3.3:	Provide free space for cooking classes for community groups focusing on heart healthy eating for Seniors			1,2,3 Quarterly
1.3.4:	Host an on-site farmers market open to the public			1,2,3 Quarterly
1.3.5:	Provide financial support to Lunches of Love, which provides healthy meals to children on weekends and during the summer		Did not provide funding due to budget constraints	1,2,3 Yearly
1.3.6:	Provide financial support to Meals on Wheels for senior citizens		Did not provide funding due to budget constraints	1,2,3 Yearly
1.3.7:	Provide education for student athletes on healthy eating for competition, etc.			1,2,3 Yearly

Monitoring/Evaluation Approach:

- Patient activity documented and reported within the ER Navigation electronic record system
- Attendance records for education events

Priority 1:	**Healthy Living**	
Goal 1:	**Increase overall wellness of community members in our primary and secondary service areas.**	
		Potential Partners: • Produce companies • Community leaders • St. John Fisher Catholic Church • Second Mile • Westside Social Services • United Helping Hands Outreach • Fort Bend County Social Services • Catholic Charities • Lunches of Love

Priority 1: Healthy Living

Goal 1: Increase overall wellness of community members in our primary and secondary service areas.

Time for/Safety During Physical Activity

Objective 1.4: Increasing the avenues for the community to participate in activities that promote safe physical activity

Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of equipment drives	1	0	0	2
• Number of participants in activities and education sessions	200	1,830	152	300
• Number of people served by the Joint Camp	75	107	25	100
• Maintain financial contributions	6	0	0	6
• Number of referrals into the pro bono clinic	25	40	7	35

Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.4.1:	Conduct education sessions for sports teams and running clubs, including biomechanical analysis, and exercise physiology related components of running			1,2,3 Yearly
1.4.2:	Provide informational session with joint center physician regarding information and answers on joint pain and possible solution for those affected by joint pain			1,2,3 Quarterly
1.4.3:	Conduct Coaching for Coaches to provide evidence based practices and applications for training of youth athletes. Information covered include topics such as concussions, orthopedic evaluations and diet/nutrition			1,2,3 Quarterly (by sports season)
1.4.4:	Conduct annual soccer drive to collect equipment for underprivileged children who cannot afford it. Equipment is then distributed by the local YMCA	We were unable to do this to date.	Soccer organization we partnered with in the past moved onto a different healthcare partner	1,2,3 Annually
1.4.5:	Provide financial support to Fort Bend Fit, which encourages participation in running and conducts speaker engagements (monthly)		Sponsorship was removed, no longer affiliated with FB Fit	1,2,3 Annual
1.4.6:	Provide concussion screening/testing for soccer players			1,2,3 Annual
1.4.7:	Conduct a Wednesday night injury clinic (pro bono) for the FB Youth Football league			1,2,3 August - November

Monitoring/Evaluation Approach:

- Record of attendees in external joint camps
- Track access into pro bono clinic
- Track/trend the number of coaches signed up and attending the coaching clinics
- Pre/post event evaluations regarding operations and Opportunity for Improvements (OFIs)
- Review Monthly Operations Reports (MOR) and ambulatory business from events

Priority 1:	**Healthy Living**	
Goal 1:	**Increase overall wellness of community members in our primary and secondary service areas.**	
		Potential Partners: • LCISD, surrounding school districts (Needville, Wharton, El Campo, Brazos, Columbia, Halletsville High Schools), possibly FBISD • Local YMCAs (Richmond/Missouri City) • Ironman Sports Medicine Institute (ISMI)/UT Physicians/Memorial Hermann Medical Group • Sugar Land Skeeters • Ft Bend Youth Football League • Eclipse Soccer, Lamar Soccer Club • Ft Bend Fit • Texas Running Company • Finish Line Sports/Andy Stewart • Athlete Training + Health (ATH) (formerly known as CES Performance)

Priority 1: Healthy Living

Goal 1: Increase overall wellness of community members in our primary and secondary service areas.

Chronic Disease Management

Objective 1.5: Improve the quality of life through resources and supports for disease management

Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of participants at school education events	60	740	134	80
• Number of screenings performed	0	4,260	3	50

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.5.1: Conduct BMI and blood pressure screenings (See 1.1.1)			1,2,3 Yearly
1.5.2: Conduct education and awareness to schools on smoking, diabetes, and cancers (See 1.2.2)			1,2,3 Yearly

Monitoring/Evaluation Approach:

- Monitor and review total number of attendees in support groups and workshops
- Track and trend the number of screenings at events
- Attendance records and school education events

Potential Partners:

- Local pharmacies
- Assisted living facilities - DelWebb
- Community primary care and specialty practices
- Home Health agencies
- Dialysis centers

Priority 2: Access to Health Care

Priority 2: Health Care Access

Goal 2: Identify and overcome barriers for patients getting appropriate and cost effective care when and where they need it.

Priority 2: Health Care Access

Goal 2: Identify and overcome barriers for patients getting appropriate and cost effective care when and where they need it.

Availability of Primary Care and Specialty Providers

Objective 2.1: Increase patients' access to their primary and specialty providers, and compliance to care plan, to prevent readmissions and unnecessary and/or avoidable emergency department visits

Outcome Indicators:	Annual Baseline	Year 1	Year 2	FY 2020 Target
• Number of hospital's associated counties' calls to Nurse Health Line (Fort Bend, Harris, and Wharton)	31,211	31,022	32,755	31,211
• Number of patients enrolled in the ER Navigation Program	869	1,364	1,154	869
• Number of ER Navigation patient encounters	1,573	3,448	3,503	1,573
• Number of ER Navigation referrals to community resources	2,035	2,993	2,745	2,035
• Number of ER Navigation scheduled appointments	181	264	157	181
• Readmission rate (CHF, AMI, PNE, Hip & Knee, COPD) - Only Medicare	10.2%	22.6%	12.4%	
• Number of Nurse Navigators	1	4	2	3

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:	Continue to participate in the MH ER Navigation program in which patients are referred to a medical home (See 2.4.2)			1,2,3
2.1.3:	Work with Memorial Hermann Medical Group to increase primary care physicians' availability through recruitment and extended office hours	We recruited with MHMG 2 family physicians and 1 pediatrician		1,2,3 Yearly
2.1.4:	Increase the number of hospital patient navigators to reduce LOS and readmission rates. Overall intent is to decrease readmissions. Patients who come into the hospital and are identified as needing assistance with help along the care continuum are assigned to a navigator that helps the patient/family along with the plan of care. This help is provided from the hospital setting to the post-acute care setting. (See 2.4.3)			1,2,3 Yearly as needed

Monitoring/Evaluation Approach:

- Patient activity documented and reported within the ER Navigation electronic record system
- Patient calls documented within the Nurse Health Line electronic record system

Potential Partners:

- Access Health Community Health Center
- Physicians of Sugar Creek
- St. Hope Foundation Community Health Center
- MH Community Benefit Corporation

Priority 2: Health Care Access

Goal 2: Identify and overcome barriers for patients getting appropriate and cost effective care when and where they need it.

Health Insurance Coverage and Costs

Objective 2.2: Ensure that patients are aware of what is available and know how to take advantage of cost savings for health insurance coverage

Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of Class D Prescriptions to the Terry School-Based Health Center	476	426	486	476
• Number of patients screened/engaged by RCA (Baseline set Jan – Jun 2016)	$6,030 (annualized/year)	929	988	Flex based on hospital volumes
• Number of patients assisted/qualified by RCA (Baseline set Jan – Jun 2016)	$2,522 (annualized/year)	281	360	Flex based on hospital volumes

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
2.2.1: Provide Class D Prescriptions to the Terry School-Based Health Center in support of primary medical care provided to uninsured children and teens at no cost			1,2,3
2.2.2: Contract with RCA to provide services on-site to assist patients with connecting to third party programs (e.g., Medicaid, disability, affordable care act coverage, etc.) RCA is a third-party eligibility vendor (paid by MHSL) to assist patients with the application process for Medicaid, County Indigent, Affordable Care Act Insurance Exchange, and other third-party payors.			1,2,3 Ongoing
2.2.3: Provide case management to assist patients with access to prescription drug programs			1,2,3

Monitoring/Evaluation Approach:
- RCA data
- Prescription data

Potential Partners:
- RCA
- MH Community Benefit Corporation

Priority 2: Health Care Access **Goal 2: Identify and overcome barriers for patients getting appropriate and cost effective care when and where they need it.**
Transportation **See "Rational for Priority Community Needs Not Addressed"**

Priority 2: Health Care Access

Goal 2: Identify and overcome barriers for patients getting appropriate and cost effective care when and where they need it.

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	FY 2020 Target
• Number of hospital's associated counties' calls to Nurse Help Line (Fort Bend, Harris, and Wharton)	31,211	31,022	32,755	31,211
• Number of patients enrolled in the ER Navigation Program	869	1,364	1,154	869
• Number of ER Navigation patient encounters	1,573	3,448	3,503	1,573
• Number of ER Navigation referrals to community resources	2,035	2,993	2,745	2,035
• Number of ER Navigation scheduled appointments	181	264	157	181
• Readmission rate	10.2%	14.6%	13.3%	9.0%
• ED throughput door to discharge	177 minutes	150 minutes	140 minutes	150 minutes
• Length of stay	3.5	2.68	3.24	3.0
• Increased patient understanding of discharge and care plan		65%	0	85-90%

Strategies:				Timeline: Year 1,2,3
2.4.1:	Provide a 24/7 free resource via the Nurse Help 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 also 1.3.1, 2.1.2)			1,2,3
2.4.3:	Increase the number of hospital patient navigators (See 2.1.5)			Yearly
2.4.4:	Provide phone support and navigation via the Medicine Navigator on the medicine floors to assist patients with readmissions			
2.4.5:	Increase ED Case Manager coverage from 5 days a week for 8 hours a day, to 7 days a week for 10 hours per day			
2.4.6:	Partner with FB EMS Community Paramedic Program to visit accepted patients in their homes to provide education on discharge instructions, medications, and healthy living. They also provide aid for return visits to PCPs.		There is currently no partnership with EMS to collect this information	1,2,3

Priority 2: Health Care Access **Goal 2: Identify and overcome barriers for patients getting appropriate and cost effective care when and where they need it.**		
		Monitoring/Evaluation Approach: • Patient activity documented and reported within the ER Navigation electronic record system • Patient calls documented within the Nurse Health Line electronic record system • Readmission data • ED throughput data • Length of stay data • Patient surveys
		Potential Partners: • Access Health Community Health Center • Physicians of Sugar Creek • St. Hope Foundation Community Health Center • 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 Sugar Land 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 number of ER encounters that result in psychiatric inpatient stay at Sugar Land	36	58	51	34
• 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 Sugar Land		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	63	5% increase over baseline
• Number of presentations/educational sessions for corporations	5	7	7	5% over baseline
• Sugarland de-escalation training (total time includes training material development and implementation)	1 training (2 hours)	0	1	1 training (2 hours)
• Training on Acute Care Concepts - system nurse resident program	15 trainings (45 hours total/3 hours each)*	18	18	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				

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 Groups

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 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**			
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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		