Memorial Hermann Southeast Hospital
Community Health Needs Assessment
IMPLEMENTATION PLAN 2013

Introduction
A comprehensive Community Health Needs Assessment (CHNA) was conducted for Memorial Hermann Southeast Hospital (Memorial Hermann Southeast) from August 2012 to June of 2013. The goal of the assessment was to clarify the health needs of Memorial Hermann Southeast’s study area, defined as Brazoria and Harris Counties that represents 87.3% of the hospital’s inpatient discharges.

The analysis included a careful review of the most current health data available and input from numerous community representatives with special knowledge of public health. Findings indicated that there were eight main needs in the communities served by Memorial Hermann Southeast. The CHNA Team, consisting of leadership from Memorial Hermann Health System (Memorial Hermann), prioritized those eight needs by studying them within the context of the hospital’s overall strategic plan and the availability of finite resources, with the following prioritization, in descending order, resulting:

<table>
<thead>
<tr>
<th>IDENTIFIED PRIORITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Education and prevention for diseases and chronic conditions</td>
</tr>
<tr>
<td>2. Address issues with service integration, such as coordination among providers and the fragmented continuum of care</td>
</tr>
<tr>
<td>3. Address barriers to primary care, such as affordability and shortage of providers</td>
</tr>
<tr>
<td>4. Address unhealthy lifestyles and behaviors</td>
</tr>
<tr>
<td>5. Address barriers to mental healthcare, such as access to services and shortage of providers</td>
</tr>
<tr>
<td>6. Decrease health disparities by targeting specific populations</td>
</tr>
<tr>
<td>7. Increased access to affordable dental care</td>
</tr>
<tr>
<td>8. Increased access to transportation</td>
</tr>
</tbody>
</table>

This implementation plan addresses the top six of those eight needs. The need for “increased access to affordable dental care” and the need for “increased access to transportation,” are not addressed largely due to their positions (last and second to last) on the prioritized list, the fact that dental and transportation services are not core business functions of the health system and the limited capacity of each hospital to address those needs. Furthermore, the hospitals do not have the expertise to address access to transportation, and the system views this issue as a larger city and county infrastructure related concern. Memorial Hermann fully supports local governments in their efforts to impact these issues.

However, there are some dental services initiatives which are being addressed at the system level. Memorial Hermann funds various Federally Qualified Health Centers and private not-for-profit clinics which offer dental services (notably Spring Branch Community Health Center and Interfaith Community
Clinic) and funds and operates two dental vans offering preventive and restorative dental procedures to pre-kindergarten to twelfth grade students at 40 schools as a part of its school-based healthcare initiative.

The end result of the assessment process was the development of a strategic plan to address the major needs identified. This document is the Implementation Strategy for Memorial Hermann Southeast Hospital. It details the rationale for each priority, the current services and activities supporting each priority, and the planned objectives and activities determined by Memorial Hermann Southeast Hospital leadership to further support each priority.

PRIORITY #1 RATIONALE: Data suggests that there are high rates of various diseases and chronic conditions in the study area and in the Houston-Baytown-Sugar Land MSA. As of 2009, heart disease and cancer are the first and second leading causes of death in the study area. Harris County and Brazoria County, which compose 63.8% and 23.5% respectively of Southeast’s patient base, have higher mortality rates for both diseases than Texas. Brazoria County has both higher lung/bronchus cancer incidence rates than the majority of the study area as well as higher respiratory/lung cancer mortality rates. There are also higher Alzheimer’s mortality rates in the study area as well as higher respiratory/lung cancer mortality rates. According to the Behavioral Risk Factor Surveillance System (BRFSS), diabetes is also a prevalent condition in the Houston-Baytown-Sugar Land MSA. In the survey conducted by Memorial Hermann, more than 90% of respondents indicated that promoting chronic disease management and improving access to preventive care (screenings for diseases) were important or very important initiatives for residents in the community. Hypertension, heart failure, cancer, and diabetes were consistently reported as top conditions in the community (questions ranging from top health problems, most prevalent conditions and top preventable hospitalizations).

PRIORITY #1 RESPONSE: Memorial Hermann Southeast Hospital is currently addressing education and prevention for diseases and chronic conditions (heart disease, cancer, diabetes, and Alzheimer’s) through community programs such as education sessions, screenings, support groups and health education publications. The purpose of these programs is to provide populations with information and tools to assist them in optimizing their health and well-being. The short term goal is to positively influence the health behavior of individuals and communities; the longer term goal is to prevent disease, disability, and premature death. In FY 2012, the following individuals were served:
• Women’s Cardiovascular Health – 120 individuals participated
• Stroke Support Group – 60 individuals participated
• Women’s Cancer Seminar – 110 individuals participated
• Screening/Prostate Cancer – 155 individuals participated
• Screening/Skin Cancer – 40 individuals participated
• Education/Outreach for Seniors – 80 individuals participated
• Alzheimer’s Monthly Support Group for Family Members – 80 individuals participated

As a community hospital serving a diverse population, Southeast provides a variety of medical services to address the community’s need for disease and chronic care management.

**Esophageal Disease Educational Seminars** are held twice a year with the goal of educating patients about available resources and available treatments for various esophageal related illnesses, including cancer and other rare illnesses. Content is prepared and presented by a gastroenterologist or surgeon, designed to educate patients of possible symptoms of heartburn, GERD (gastroesophageal reflux disease), acid reflux, as well as possible treatment options. Patients are encouraged to ask questions throughout the presentation and have the opportunity to speak to a gastroenterologist/surgeon following each presentation. An oncology nurse navigator (ONN) is at the events to assist patients with access to care, and to follow-up with patients’ needs after the event. The comprehensive education is intended to assist with the implementation of treatment/intervention in the initial stages of the disease. In 2012, 34 patients attended the seminars.

Memorial Hermann Southeast Hospital offers an **Outpatient Diabetes Self - Management Education Program** and has an inpatient diabetes educator to assist nursing staff with patient education. The goal of the program is to assist individuals living with diabetes in the surrounding community with increased self-management skills that will aid in controlling blood sugar levels. The diabetes educator provides a structured educational outpatient program that has received recognition status from the American Diabetes Association (ADA). The goal is to reduce diabetes related complications and hospital readmissions. The diabetes educator provides 64.5 hours of direct patient education per month for both inpatients and outpatients. In 2012, 158 outpatients received ongoing education and support.

Southeast’s **Lung Nodule Clinic** provides patients with access to specialized care in the diagnosis and treatment of lung nodules, with a focus on diagnosing lung cancer (and other cancers) at an early stage, and decreasing the time from diagnosis to treatment to improve survivorship and quality of life. The use of a dedicated pulmonologist and oncology nurse navigator in the care, education, treatment and follow-up of the patients promotes a continuum of care, and updates on the patient’s status and treatment plan are provided to the patient’s primary care physician (PCP). The clinic sees patients every Thursday, with diagnostic studies and procedures scheduled within the next few days. Thus, the time frame in accessing the necessary physicians, procedures and treatment is greatly shortened. Thirteen patients were seen in 2012; two positive cancer diagnoses were made at early stages, with surgery required for only one patient.
PRIORITY #1 STRATEGY:

Objective #1.1: To continue to address the interrelated chronic conditions of heart disease, cancer, diabetes and Alzheimer’s through the existing infrastructure.

Implementation Activities:

- Increase awareness of the community education, screening, and support groups provided as reflected by increased participation.
  - Establish baseline metrics (2014)
  - Increase participation over baseline (2015)
  - Report metrics (2015, 2016)
- Implement regular, ongoing community education courses on heart disease.
  - Explore program options (2014)
  - Implement select program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)
- Explore linking the existing Outpatient Diabetes Self-Management Education Program with the Stanford Patient Education Model for Diabetes. This model is a unique education program, designed to last six weeks, for groups between 12 to 16 individuals, and to help people gain self-confidence in their ability to control their symptoms and improve their lives.
  - Conduct a needs assessment to determine community response to the program (2014)
  - Identify area organizations licensed to provide chronic disease self-management workshops; identify staff to be trained to implement the model (2014, 2015)
  - Implement and establish baseline metrics (2016)

PRIORITY #2 RATIONALE: Findings suggest that there are various issues that fall under the “service integration” category in the communities served by Memorial Hermann Hospitals. The Houston Hospitals Emergency Department Use Study (2010) demonstrates the frequent inappropriate use of emergency departments for primary care related conditions in the community. Many interviewees noted frustrations about the lack of record sharing among providers in the community and many said that patients must be transitioned out of the Emergency Department settings and into primary care settings. Another common concern was that too much of the patient population lacks a viable primary care access point or “medical home” focused on primary care.

PRIORITY #2: Address issues with service integration, such as coordination among providers and the fragmented continuum of care

- Lack of information and record sharing, such as electronic medical records
- Lack of communication between providers
- Patient needs for medical homes
- Inappropriate ED use
**PRIORITY #2 RESPONSE:** Memorial Hermann Southeast is currently addressing information sharing, patients’ needs for medical homes, and inappropriate ED use through several significant programs.

The following programs are designed to improve communication between and among providers for improved access to and outcomes of care:

- Southeast is responding to the community’s concern about the lack of record sharing among providers through the **Memorial Hermann Information Exchange (MHE)** which uses a secure, encrypted electronic network to integrate and house patients’ digital medical records so they are easily accessible to authorized MHiE caregivers. The service is free to patients and only requires their consent. Since September 2011, 47% of Memorial Hermann Southeast’s patients have registered to participate. Another initiative is for all inpatient, outpatient, and emergency room progress notes to be electronic providing for up-to-date provider access anytime, anywhere.

- Research shows that cancer patients who have help navigating the medical system have better outcomes. A nurse navigator specializing in oncology acts as a patient client advocate and “go-to” person when questions arise or help is needed when navigating the medical system. The nurse navigator works within the multidisciplinary cancer care team across the continuum of care, providing information and support to patients and caregivers, as well as other health care professionals. Nurse navigators also serve as moderators for the physicians who collaborate on improved care through the Tumor Board.

- The **Breast Work Group** and the **Cancer Tumor Board** are weekly conferences attended by oncologists, radiation oncologists, pathologists, radiologists, surgeons, a cancer registrar representative, the oncology nurse navigator (ONN), and open to primary care physicians (PCPs). The team-based conferences discuss recently diagnosed patients, determine plans of care with input from aforementioned disciplines, and promote continuity in care for the patient through ONN follow-up from time of diagnosis, through treatment, and survivorship. Through this physician communication and ONN follow-up, patients access appropriate and recommended treatment and care, the timeframe from diagnosis to treatment is shortened, and the continuum of care is promoted.

- Memorial Hermann Southeast offers education to emergency medicine responders and EMS team members through in-house education programs on a quarterly basis with a cardiologist; catheterization lab observations; and STEMI (segment elevation myocardial infarction) reviews. During the STEMI reviews, EMS providers are given real time feedback regarding patient treatments and outcomes of patients they have transported to Memorial Hermann Southeast. This communication and education increases awareness of recognition of cardiac issues and treatment options and provides in-depth education for EMS on high-risk cardiac procedures.

- The increasing elderly population drove the need for the addition of a **Palliative Care Team** to provide patients with the ability to prepare for their end of life care. Palliative Care is a medical specialty designed to assist patients and families with symptom management, emotional and spiritual support, and advanced care planning. As an inpatient consulting service at Memorial Hermann Southeast, palliative care, made up of a Board Certified Palliative physician and an RN, works with the primary care team to provide complimentary services that help to ensure...
positive treatment outcomes. Whether it is pain management with patients seeking aggressive treatment in the early stages of the disease process or advanced care planning and emotional support at the end-of-life, palliative care is a valuable resource to keep patients at the end of their life receiving the right care in the right place. The program, begun in 2012, has incurred 35 consults to date.

- Memorial Hermann Southeast operates a busy emergency room, 27.2% of which are unfunded patients. A case manager is on-site to decrease inappropriate use of the emergency department by connecting uninsured and underinsured patients who access the emergency room for primary care purposes with “the right care, in the right place, at the right cost”.
- A school-based health center resides within Southeast’s service area and receives critical pharmacy support from Southeast. The school-based health center (Memorial Hermann Health Centers for Schools - WAVE Clinic) serves as the medical home for uninsured children at six Pasadena area schools, pre-kindergarten through eighth grade. The center incurs 3,500 visits a year.

PRIORITY #2 STRATEGY:

Objective #2.1: To increase participation in the Health Information Exchange (HIE).

Implementation Activities:
- Continued education of staff responsible for offering the service to patients for consent (ongoing).
  - 70% of all registered patients will consent to the Health Information Exchange (HIE) (2014, 2015)

Objective #2.2: To continue emergency room programming that will reduce the community’s reliance on the ER for primary care purposes and to increase their connection with medical homes.

Implementation Activities:
- Implement a Navigation/CHW ER program to collaborate with the ER case manager and navigate uninsured and Medicaid patients to a medical home.
  - Conduct assessment regarding hours of on-site coverage (2014)
  - Implement program and establish baseline metrics (2014, 2015)
  - Report on reduced ER reliance for primary care (2015, 2016)
  - Continue support of school-based healthcare as reflected by 3,500 annual clinic visits.
  - Continue to promote the importance of having a PCP and a medical home in the community health newsletters by including a related topic each quarter.

Objective #2.3: To continue to improve service integration and the continuity of care.

Implementation Activities:
- Continue support of the Palliative Care Team.
  - Develop metrics quantifying reductions in emergency room visits and readmissions; increases in patient satisfaction (2014)
• Implement education and training to the area Senior facilities’ staff on inpatient quality metrics to assist in disease management, the continuum of care, and the reduction of readmissions by recognizing potential problems.
  o Design program and establish baseline metrics (2014)
  o Implement and monitor metrics (2015)
  o Report metrics (2016)
• Implement programs designed to improve communication between providers.
  o Explore program options (2014)
  o Implement select program(s) and establish baseline metrics (2015)
  o Report metrics (2015, 2016)
• Expand Case Management to assist with medical home and community resource connections.
  o Explore recruiting options (2014)
  o Implement expanded program (2015)
  o Report metrics (2015, 2016)

**PRIORITY #3 RATIONALE:** According to the most recently released (in August of 2012) census data, more than one fourth of residents in Texas are uninsured. Nearly 30% of residents in Harris County and slightly more than 21% in Brazoria County are uninsured. Furthermore, many of the residents (18.8%) in the Houston-Baytown-Sugarland MSA experience medical cost barriers with regard to accessing healthcare. The *Health of Houston Survey 2010: A First Look* also indicated that women who didn’t receive the appropriate prenatal care often cited cost and insurance barriers (34%). There was a perception among interviewees that primary care providers are “running at full capacity” and there is a need for additional primary care providers to serve the communities both in the general population and the safety net population. The *Safety Net Review Key Informant Study* suggests that lack of availability of primary care services and difficulty accessing primary care are two of the top three problems among the safety net. Finally, in the survey conducted by Memorial Hermann and CHC Consulting, “Lack of coverage/financial hardship” was ranked first with regard to barriers to access to primary and preventive care for low income residents in the community. The lack of capacity (e.g. insufficient providers/extended wait times) ranked third.

**PRIORITY #3 RESPONSE:** As a part of Memorial Hermann, the largest not-for-profit health system in Southeast Texas, Memorial Hermann Southeast plays a significant role in Memorial Hermann’s annual $309.3 million dollar contribution to the community. This represents financial assistance and means-tested government programs, community health improvement services and community benefit operations, health professions education, subsidized health services, research, and cash and in-kind
contributions for community health, and is representative of costs using the IRS 990 schedule H reporting.

To secure a payment source for uninsured and underinsured patients, Memorial Hermann Southeast has a financial counseling program. Counselors help patients enroll in government programs or find other sources of coverage. Specifically, the counselors assist patients with financial assistance applications, setting up payment plans or applying for charity care. The program covers both inpatients and emergency room patients, seven days a week, with five counselors each working with 15 patients a shift.

In order to ensure specialty coverage for uninsured and underinsured populations, Memorial Hermann Southeast contracts with 73 physicians covering 12 specialties (cardiology, general surgery, internal medicine, neonatal, neurology, OB/GYN, orthopedics, otolaryngology, pediatrics, pediatric surgery, urology and vascular surgery) to provide on-call ER coverage 24 hours a day, seven days a week. Thus patients accessing the Southeast emergency room for emergent conditions are guaranteed emergent specialty care. Additional physician support for the busy Southeast emergency room are two primary care Nocturnalists (hospital-based physicians who only work at night). The Nocturnalists provide continuity of care from 8 p.m. to 6 a.m., assisting the emergency room staff with streamlining patient’s admissions.

Three initiatives support the growing Primary Care Physician (PCP) shortage: Internal Medicine Call Group, the Memorial Hermann Medical Group, and Memorial Hermann Physician Network.

The Internal Medicine (IM) Call Group provides coverage to patients through the ER as well as the nursing floors. Through an overnight admission service program, the IM Call Group assures private practice physicians of patient coverage from 6:00 p.m. to 7:00 a.m. seven evenings a week, relieving them of hospital visits evenings and nights.

Memorial Hermann Medical Group (MHMG) has been instrumental in recruiting PCPs to the Southeast service area. MHMG is an umbrella organization that employs physicians and provides business services such as billing, collections, insurance reimbursement contracts, and medical records maintenance and information technology, allowing participating physicians to spend more time practicing medicine and less time running a business.

Through the Memorial Hermann Physician Network MHMD, community primary care physicians who strive to be certified as a patient centered medical home by NCQA (National Committee for Quality Assurance) can be supported in the endeavor. NCQA certified physician practices serve the community as a true medical home and are held accountable for meeting a set of standards that describe clear and specific criteria about organizing care around patients, working in teams and coordinating and tracking care over time. There are 50 family medicine physicians, internists and OB/GYNs in Southeast’s service area that have signed a contract to be in MHMD’s medical home initiative and have either achieved or are working towards certification.
PRIORITY #3 STRATEGY:

**Objective #3.1:** To develop recruiting strategies for PCPS within the Memorial Hermann Southeast Hospital service area.

**Implementation Activities:**
- Recruit an additional 3 primary care physicians and 2 mid-level providers within MHMG (2014)
- Recruit an additional 35 primary care (family practice, internal medicine, OB/GYNs, and pediatricians) medical home physicians within MHMD (2013-2016)

**Objective #3.2:** Promote the use of the admission service program to the medical staff through introducing, educating, and encouraging service buy-in by more physicians.

**Implementation Activity:**
- Report medical staff members admitting via the Internal Medicine Call Group and Admission Services Program (2013-2016)

**Objective #3.3:** To increase community resources for primary care.

**Implementation Activities:**
- Provision of an Urgent Care Clinic in a nearby community.
  - Conduct business plan (2014, 2015)
  - Implement business plan and establish baseline metrics (2014, 2015)
  - Report metrics (2015, 2016)

---

PRIORITY #4: Address unhealthy lifestyles and behaviors

- **Obesity**
- **Communicable diseases (chlamydia, gonorrhea, AIDS, tuberculosis, syphilis)**
- **Accidents**

**PRIORITY #4 RATIONALE:** Findings suggest that there is a need to address unhealthy lifestyles and behaviors in the community, such as obesity, communicable diseases (chlamydia, gonorrhea, AIDS, tuberculosis, and syphilis), and accidents. Harris County has high rates of chlamydia (413.8 per 100,000) and gonorrhea (127.8 per 100,000), while Brazoria County’s chlamydia (242.5 per 100,000) and gonorrhea (44.7 per 100,000) rates are lower. Furthermore, as of 2009, Harris County’s tuberculosis, primary and secondary syphilis and AIDS rates have been higher than the state’s rates since 2007. According to BRFSS, more than 76% of residents in the Houston-Baytown-Sugar Land MSA do not consume the recommended daily intake of fruits and vegetables and more than 23% do not engage in any “leisure time physical activity.” Houston youth were more likely than Texas youth to engage in 14 different risky behaviors, ranging from physical violence, to obtaining cigarettes by purchasing them from a store or gas station, to sexual intercourse before 13, to never being taught in school about HIV or AIDS, and various nutrition and physical activity indicators. In the survey conducted by Memorial
Hermann, adult and childhood obesity ranked as the third and fourth most important health problems in the community. More than 82% of respondents believe that obesity is the second most prevalent chronic disease in the community and more than 70% rated nutrition and weight management programs as inadequate or very inadequate in the community.

**PRIORITY #4 RESPONSE:** An unhealthy lifestyle means more illness and more expense to treat those illnesses. Programs provided to patients, the community, and employees to assist with lifestyle changes are:

- Wellness and Nutrition Seminar – 30 individuals participated
- Men’s Health Seminar – 44 individuals participated
- Health Fairs – 5,380 individuals participated
- Community Health Newsletters – 75,000 households reached quarterly
- “NewStart” Meetings and Webinars – 285 individuals participated in community and online educational sessions presenting surgical weight loss options
- The Bariatric Support Group provides support, encouragement, and education to Weight Loss Surgery patients. Meeting topics include Grocery Shopping Makeover, Think Thin! (Losing the “diet” mentality); Healthy Eating Out Tips; Setting Realistic Goals; Healthy Summertime Treats; Healthy Recipes; Habits for Mental Health; Importance of Exercise; Back on Track; Weight Management Through Hypnosis; Healthy Thanksgiving Recipes and Cooking Tips; and Avoid Holiday Weight Gain – 10 individuals participated
- The Freshstart Tobacco Cessation Course is an American Cancer Society program which educates participants on tobacco’s health risks to the individual and others around them, methods available to help quit, and preventative benefits of quitting. The class encourages therapeutic discussion between the instructor (oncology nurse navigator) and attendees. The program is a benefit to participants who quit by decreasing the risks of cancers, stroke, cardiovascular ailments and disease, and pulmonary illness while promoting health and fitness. Approximately 35 individuals attend.
- The Sports Concussion education program includes education to coaches and trainers in the Pasadena Independent School District, Lutheran South Academy and Bay Area Christian School. The program includes tips on concussion prevention, as well as recommended concussion treatment plans. In 2012, the program was presented to over 200 coaches and trainers to aid in concussion prevention.
- A sports concussion baseline screening was held for over 2,000 athletes in the Pasadena Independent School District, Lutheran South Academy and Bay Area Christian School. It involved a neuro capacity baseline test. The screening provides vital baseline data for when an athlete presents with a potential concussion.
- Memorial Hermann, one of the largest employers in the Houston area, has numerous employee programs promoting healthy lifestyle living and behavior changes. Among them are:
  - Required annual physicals (for employees participating in the Edge insurance program)
  - Incentive based weight loss program—in FY 2012 156 Memorial Hermann Southeast employees lost 681 pounds on the Leaner Weigh program
o Financial penalty for smoking for existing employees and a “no smokers” hiring policy for new employees. Memorial Hermann Southeast is a non-smoking campus.

o **Wellness & You** Program which incorporates fresh and delicious recipes that meet established guidelines into daily retail food offerings

o **My Fitness Pal**, which, free for iPhone and Android, provides a personalized diet profile to one’s unique weight loss goals

o **Cooking for Wellness** where chefs and dietitians in the Café host cooking demonstrations using healthy cooking techniques

o **Meatless Mondays** which encourages reduction of meat consumption by 15% to improve personal health and the health of the planet

o **Eat This...Not That** signage to drive awareness of options, calories, and ingredients

- To address the increasing rate of HIV, especially among the African American population, Memorial Hermann Southeast provides routine HIV testing for all emergency room patients ages 18-65, and younger patients with symptoms--unless they opt out. Since April, 2011, Southeast has screened 3,591 patients with 14 patients (newly) diagnosed with positive results.

**PRIORITY #4 STRATEGY:**

**Objective #4.1:** To continue to reinforce healthy lifestyles and influence and encourage behavior change.

**Implementation Activities:**

- Provide on-going education on healthy lifestyles and healthy choices in the schools as measured by programs and attendees.
  
  o Explore program options (2014)
  
  o Implement select program(s) and establish baseline metrics (2015)
  
  o Report metrics (2015, 2016)

- Implement ongoing community education courses for weight management and exercise.
  
  o Explore program options (2014)
  
  o Implement select program(s) and establish baseline metrics (2015)
  
  o Report metrics (2015, 2016)

- Provide meeting room space at no cost to health and community related groups as measured by collaboration with community groups.
  
  o Establish baseline metrics (2014)
  
  o Increase participation over baseline by 10% (2015)
  
  o Report metrics (2015, 2016)

- Implement Memorial Hermann System Wellness Initiatives.
  
  o Continue current wellness programs including incentive/disincentive for wellness/non-wellness selections (2013-2016)
  
  o Expand on the successful Pilot “Eat This...Not That” (2013-2016)
  
  o Implement vending program revisions (2014)
  
  o Implement catering menu revisions (2014)
  
  o Implement patient menu revisions (2014)
• Report metrics on reduced caloric intake and reduced weight gain (2015, 2016)
• Open a wellness center/gym on the Memorial Hermann Southeast campus.
  • Conduct business plan (2014, 2015)
  • Implement business plan and establish baseline metrics (2014, 2015)
  • Report metric results (2015, 2016)

PRIORIT Y #5: Address barriers to mental healthcare, such as access to services and shortage of providers

• Number of providers
• Adequacy and access issues
• Substance abuse services

PRIORIT Y #5 RATIONALE: Access to mental health services ranked as a top concern over and over again in the survey conducted by Memorial Hermann. For example, 79.5% of respondents indicated that the needs of persons with mental illness were being either inadequately or very inadequately met. Mental health problems ranked as the number one most important health problem in the community, with 71% of respondents ranking it first. More than 85% of respondents said that access to mental/behavioral healthcare services for low income residents was difficult or very difficult. Finally, more than 80% of respondents indicated “inadequate or very inadequate” for services provided for mental health screenings. Interviewees also noted the need to address barriers to mental healthcare, such as the inadequacy of mental and behavioral health treatment programs available in the community, the limited number of beds for inpatient mental health services and the critical need for substance abuse intervention and rehabilitation programs.

PRIORIT Y #5 RESPONSE: Houston is struggling with a mental health crisis. With a shortage of psychiatric facilities and a lack of financial resources, insured as well as uninsured patients are left seeking services from emergency room physicians and nurses untrained in psychiatry. They face problems that are pressing and real, yet typically wait while ER personnel attend to others with more pressing physical needs. Within the Memorial Hermann System, two innovative mental health programs operate.

Since 2000, on call day and night, Memorial Hermann’s Psych Response Team acts as mental health experts for the ERs. They are a team of mental health professionals, responding to calls from Memorial Hermann’s emergency rooms and medicine patients when patients present with symptoms of mental illness, such as depression, psychosis, or chemical dependency. They stabilize, evaluate, arrange referrals, and follow-up to maintain patient compliance.

The team refers to 30 mental health community treatment providers. This size enables the program to leverage the mental health community’s resourced patients (72%) to obtain care for the community’s
non-resource patients (28%). No longer is it one ER/Nurse/MD competing with the rest of the ERs for a limited amount of psychiatric resources. Rather, there is a coordinated approach, and the community’s psychiatric programs accept Psych Response Team referrals because it is in their best interests. A report is shared monthly, detailing the number of resource and non-resource patients referred throughout the community. In 2012, 737 Southeast patients were assessed and treatment recommendations were made.

The Memorial Hermann Prevention and Recovery Center (PaRC), the number one drug rehab and alcohol treatment program in Houston providing detoxification, residential treatment, intensive outpatient programs, and an aftercare program is a substance abuse referral source for Memorial Hermann Southeast Hospital. The PaRC has 30 years of experience treating addiction as the chronic, progressive, primary illness research and medical technology have shown it to be. The CEO of the PaRC participates on numerous boards and councils promoting mental health awareness, policy, and expansion of services including: membership on the THA (Texas Hospital Association) Psychiatry and Chemical Dependency Services Constituency Council, membership on the Coalition of Behavioral Health Providers, chairmanship of the Treatment Services Subcommittee for the Houston/Harris County Office of Drug Policy, advisory board membership on MCMHTF (Montgomery County Mental Health Treatment Facility), president of TAAP (Texas Association of Addiction Professionals), and an informal advisor and provider of in-kind donations to The Men’s Center and Santa Maria Hostel, local non-profits that serve homeless and disadvantaged substance abusing men (Men’s Center) and women with children (Santa Maria).

Memorial Hermann Southeast offers several on-site mental health support services including a staff psychiatrist and a support group for post-surgery heart disease patients experiencing depression. The Southeast CEO is on the THA (Texas Hospital Association) and AHA (American Hospital Association) Councils for Policy Development that address mental health issues at a statewide level.

**PRIORITY #5 STRATEGY:**

**Objective #5.1:** To address Behavioral Health/Substance Abuse readmission rates.

**Implementation Activities:**
- To partner with the Psych Response Team to provide case management of post-discharge behavioral health patients in order to encourage compliance in prescribed health maintenance activities.
  - Identify individuals whose chronic mental illness predicts they will likely have repeat visits to the ER and connect them with case management services for follow-up after discharge (2014)
  - Establish and monitor metrics of reduction in the 30-day behavioral health/substance abuse readmission rate (2015)
  - Report metrics (2015, 2016)
- To partner with the Psych Response Team to provide a crisis stabilization clinic that will provide rapid access to initial psychiatric treatment and outpatient services.
- Identify individuals with behavioral health needs that, if addressed immediately, may avoid unnecessary use of emergency departments, hospitalization or incarceration (2014)
- Establish and monitor metrics of reduction in the 30-day behavioral health/substance abuse readmission rate (2015)
- Report metrics (2015, 2016)

**Objective #5.2:** To address mental health needs of area teenagers.

**Implementation Activities:**
- Explore topics for ‘teen chats’ (2014)
- Implement select program(s) and establish baseline metrics (2015)
- Report metrics (2015, 2016)

---

**PRIORIT #6: Decrease health disparities by targeting specific populations**
- Safety net population (under/uninsured, working poor, indigent)
- Unemployed
- Children
- Elderly and “almost elderly” (those who are not yet eligible for Medicare)
- Asian immigrant population
- Homeless

**PRIORIT #6 RATIONALE:** Data suggests that there are various health disparities among specific populations in the community. There are disparities among those who face medical cost barriers with regard to gender, race/ethnicity, income and education. The *Health of Houston Survey 2010: A First Look* indicates that health insurance and access to care is a particular concern for the Houston area, with Hispanic and Vietnamese residents having much higher uninsured rates than the average. The *Health of Houston Survey 2010: A First Look* also indicates that there are disparities among children’s access to insurance. According to BRFSS, there are mental health disparities with regard to gender, race/ethnicity, income and age. There are also disparities among those who report diabetes, those who are overweight or obese and those who do not participate in any leisure time physical activity. Interview data also reflects these disparities. The populations most at risk include the safety net population, the unemployed, children, elderly and “almost elderly,” non-English speaking minorities, Asian immigrant populations and the homeless.

**PRIORIT #6 RESPONSE:** Memorial Hermann programs for the safety net, uninsured, and elderly populations include COPE and Chronic Disease Management.
Since 2008, Memorial Hermann Southeast uninsured patients with a pattern of repeat emergency room use and hospital readmissions have had access to COPE (Community Outreach for Personal Empowerment), a program which, through education, guidance, and follow-up by social workers, educates individuals about the health and social service resources available to them. Through this education and referral to accessible resources, the program has demonstrated success in many areas, including reduced use of hospital admissions and emergency room visits. The program requires active interventions, tools, and empowering communication to help patients identify, access and obtain community based services. In FY 2012, 1,374 patients were enrolled in the COPE program, Memorial Hermann systemwide.

Since 2006, Memorial Hermann Southeast’s uninsured, Medicaid and Medicare patients with chronic conditions such as congestive heart failure, diabetes and chronic obstructive pulmonary disease have had access to the Memorial Hermann Chronic Disease Management Program. Through regular telephone support by a registered nurse trained in chronic management patients, patients are encouraged to follow the instructions of their physicians for medication compliance, exercise, diet, lab work and office follow-ups. With patient consent, physicians receive prompt notification if the nurse notices any emergent problems that require immediate attention. The program has demonstrated success in many areas, including improved quality of life, decreased disease burden, and reduced hospital admissions and emergency room visits.

In response to its diverse community, Southeast addresses health disparities through the following programs:

- Quarterly giving by the Southeast Administration and Leadership team through the Leadership Development Institute. Recipients include: the American Heart Association; The Houston Area Women’s Center and SEARCH Homeless Services.
- Cultural sensitivity training from a clinical perspective conducted by the Chaplain Service.
- Southeast program covers medications for those who cannot pay and any other service needed to facilitate the discharge process including paying for a nursing home. In FY 12 there were approximately 72 patients served at a cost of $25,000.
- Participation at the Asian Festival and Temple Health Fair serving the Asian Indian population.
- Recruitment of a Vietnamese general surgeon.

**PRIORITY #6 STRATEGY:**

**Objective #6.1:** To expand programs that support the safety net population, including the unemployed and ‘almost’ elderly.

**Implementation Activities:**

- Expand COPE Program.
  - Determine level of need of increased penetration (2014)
  - Establish baseline metrics covering decreased emergency room visits, observation stays, and inpatients admissions (2015)
Report metrics (2015, 2016)

Objective #6.2: To expand support of school-based health care.

Implementation Activity:
  • To provide pharmacist support for a new school-based health center. (2014, 2015)

Objective #6.3: To expand programs that supports the homeless.

Implementation Activity:
  • Create and distribute throughout the hospital lists of local food pantries, local shelters, low cost prescription programs and low cost and free clinics. (2013-2016)

Objective #6.4: To expand programs that support Asian populations.

Implementation Activity:
  • To recruit a Vietnamese cardiologist. (2014, 2015)