Memorial Hermann Sugar Land Hospital
Community Health Needs Assessment
IMPLEMENTATION PLAN 2013

Introduction
A comprehensive Community Health Needs Assessment (CHNA) was conducted for Memorial Hermann Sugar Land Hospital (Memorial Hermann Sugar Land) from August 2012 to June of 2013. The goal of the assessment was to clarify the health needs of Memorial Hermann Sugar Land’s study area, defined as Fort Bend and Harris Counties that represents 82.2% 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 Sugar Land. 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:

**IDENTIFIED PRIORITIES**

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

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 Sugar Land 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 Sugar Land leadership to further support each priority.

**PRIORITY #1: Education and prevention for diseases and chronic conditions**

- Heart disease
- Cancer
- Diabetes
- Alzheimer’s

**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, which comprises 17.2% of Sugar Land’s discharges has higher mortality rates for both diseases than Texas, while Fort Bend, which comprises 65% of Sugar Land’s discharges, experiences rates lower than Texas’ rates for both diseases. There are higher Alzheimer’s mortality rates in the study area than there are in Texas. 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 Sugar Land 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. Sugar Land has a dedicated Education Department and professional volunteers who implement the year-round community health education programs. In FY 2012, the following individuals were served:
• “Tune Up for Life” Men’s Health Event – 500 individuals participated
• “Girl’s Night Out” Women’s Health Event – includes a physician speaker, blood pressure screening and mammogram scheduling, a bi-monthly event serving 450 individuals
• Screening/Breast Cancer – 80 individuals participated
• WATCH Fair – Provided blood pressure screenings, bone density scans, glucose testing, and scheduled mammograms and flu shots at this annual Fort Bend Independent School District event serving 3,000 individuals
• Outpatient diabetes self-management program – three visits with approximately four weeks gap between the visits for the first year and then one visit every year – 146 individuals participated
• Education/Outreach for Seniors – bi-monthly physician speaker, blood pressure screenings, flu shots for seniors in Del Webb community

Diabetes affects many organs that can be disabling and life threatening. The Memorial Hermann Sugar Land Wound Care Center opened in December 2008 with a mission to improve the quality of life of patients with chronic and acute wounds and to reduce the number of amputations. Wound care patients, with diabetes in particular, benefit from Sugar Land’s hyperbaric oxygen therapy (HBOT) services used to enhance the body’s natural healing and strengthen the immune system. The center has a multi-disciplinary approach to address the diverse co-morbidities with which this population is challenged. Early intervention and follow-up improves outcomes and reduces hospital admissions. A total of 646 hyperbaric patients were seen in 2012.

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.
  o Establish baseline metrics (2014)
  o Increase participation over baseline by 5% (2015)
  o Report metrics (2015, 2016)
• Implement regular, ongoing community education courses on heart disease.
  o Explore program options (2014)
  o Implement select program(s) and establish baseline metrics (2015)
  o Report metrics (2015, 2016)
• Implement education and coping skills programs for caregivers of loved ones with dementia.
  o Explore program options (2014)
  o Implement select program(s) and establish baseline metrics (2015)
  o Report metrics (2015, 2016)
• Explore expanding the existing Diabetes self-management program to the Stanford Patient Education Model for Diabetes Self-Management Program. This model is a unique education
program, designed to last 6 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)

**Objective #1.2:** To implement a Medical Therapy Management Clinic to assist physicians in the monitoring of patients for anticoagulation, hypertension and diabetes.

**Implementation Activities:**

- Implement pharmacist operated clinic program.
  - Develop clinic model which will assist patients with procurement of medications, therapy adherence, monitoring of pertinent labs, and communication with physicians for continuity of care (2013)
  - Implement program and establish baseline metrics (2014)
  - Report metric results (2015, 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 RESPONSE:** Memorial Hermann Sugar Land is currently addressing information sharing, patients’ needs for medical homes, and inappropriate ED use through several significant programs.

- Sugar Land 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, 41% of Memorial Hermann Sugar Land’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.

- To facilitate emergency room patients’ connections with a medical home, in 2011, Memorial Hermann Sugar Land implemented a Financial Counseling Program for non-resource patients at the time of discharge. A financial counselor works with the patient to complete a financial information form, Medicaid application, and Fort Bend County Indigent program application. In addition, the financial counselor ensures that the patient understands the role of a Primary Care Provider or “medical home”. The patient is given a list of providers and clinics in the area of their residence. In FY 2012, 1,446 self-pay patients received financial counseling.

- To facilitate inpatients’ connections with a medical home, in 2009, Sugar Land implemented the Patient Connection into a Medical Home Program. A Physician Coordinator visits with each unassigned Managed Care, Medicare, and Managed Medicaid inpatient and helps them decide on a medical home physician or clinic. The intent of this program is designation of a medical home, reduced readmissions and reduced emergency room visits for primary care. In FY 2012, 723 patients were linked to medical homes.

- Access to school-based health centers provides medical homes for students and reduces their use of an emergency room. Two school-based health centers reside within Sugar Land’s service area and receive critical pharmacy support from Memorial Hermann Sugar Land. The school-based health centers (Memorial Hermann Health Centers for Schools—Terry Clinic and Lamar Clinic) serve as the medical home for uninsured children at 18 Houston area schools, pre-kindergarten through twelfth grade in two Lamar Consolidated Independent School District feeder patterns.

**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)
- Area Federally Qualified Health Center to become MHIE participant. (2014)

**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 Financial Counseling Program 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)
• Strengthen collaboration with area Federally Qualified Health Centers (FQHCs).
  o FQHCs to sign MHIE agreements (2014)
  o Establish ER referral program via navigators (2014, 2015)
  o Establish metrics of referral numbers and number of patients enrolled and retained by the FQHCs (2014, 2015)
  o Report metrics (2015, 2016)
• Continue support of school-based healthcare as reflected by 4,800 annual clinic visits (2013-2016).

Objective #2.3: Increase patients’ connections with medical homes.

Implementation Activities:
• Expand the Patient Connection into a Medical Home Program which presently addresses the needs of unassigned Managed Care, Medicare, and Managed Medicaid patients’ connections with medical homes to all payor classes.
  o Conduct cost analysis
  o Establish metrics surrounding reduced readmissions and reduced emergency room visits for primary care
  o Report metrics

Objective #2.4: To continue to improve service integration and the continuity of care.

Implementation Activities:
• Partner with Walgreens Pharmacy to deliver prescribed medications to the bedside prior to discharge.
  o Implement inpatient program (2013)
  o Develop metrics quantifying reductions in emergency room visits and readmissions (as a result of reduced medication non-compliance); increases in patient satisfaction (2013, 2014)
  o Report metric results (2014, 2015)

PRIORITY #3: Address barriers to primary care, such as affordability and shortage of providers
• Number of providers
• Cost

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 20% of residents in Fort Bend County are uninsured. In addition, nearly 30% of residents in Harris County are uninsured. Many 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, “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 Sugar Land 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 Sugar Land 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, five days a week, with two counselors each working with approximately six patients per day.

In order to ensure specialty coverage for all populations, Memorial Hermann Sugar Land contracts with physicians covering nine specialties (cardiology, gastroenterology, general surgery, general medicine, OB/GYN, orthopedics, plastic surgery, urology, and neurology) to provide On-Call ER Coverage 24 hours a day, seven days a week. Thus patients accessing the Memorial Hermann Sugar Land emergency room for emergent conditions are guaranteed emergent specialty care.

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

Memorial Hermann Sugar Land has hired six hospitalists so that PCPs are freed up to stay in their offices and add more practice hours. Hospitalists are board-certified internists who are available, in MH-Sugar Land’s case, 24 hours a day, 7 days a week, in the hospital to meet with family members, order follow-up tests, answer nurses’ questions, and simply deal with problems that may arise. In many instances, hospitalists may see a patient more than once a day to assure that care is going according to plan, and to explain test findings to patients and family members. A total of 160 Memorial Hermann Sugar Land physicians presently admit through the Hospitalist Program; and in 2012 3,108 patients were managed.

Memorial Hermann Sugar Land has been instrumental in recruiting PCPs and needed specialists to the Sugar Land service area. In 2012, eight family medicine and four obstetrics/gynecologist physicians were added into Memorial Hermann Medical Group (MHMG), 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 16 family medicine and internists in Sugar Land’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 Sugar Land Hospital service area.

**Implementation Activities:**
- Recruit an additional 2 primary care physicians and 3 mid-level providers within MHMG. (2014)
- Recruit an additional 45 primary care (family practice, internal medicine, OB/GYNs, and pediatricians) medical home physicians within MHMD. (2013-2016)

**Objective #3.2:** To promote the Hospitalist Service to the medical staff to introduce, educate, and encourage service buy-in by more physicians.

**Implementation Activity:**
- Report medical staff members admitting via the Hospitalists. (2013-2016)

**Objective #3.3:** To continue to capitalize on community resources for primary care.

**Implementation Activities:**
- Strengthen collaboration with area Federally Qualified Health Centers (FQHCs)
  - FQHCs to sign MHIE agreements (2014)
  - Establish ER referral program via navigators (2014, 2015)
  - Establish metrics of referral numbers and number of patients enrolled and retained by the FQHCs (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. 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:

- Women’s Health Symposium: Schedule Mammograms – 350 individuals attended
- Community Health Education – 35,000 households reached through quarterly health newsletters
- Memorial Hermann Sugar Land physicians provide ImPACT baseline concussion testing for the National Fusion Soccer league. This testing provides a baseline measure in the event of a suspected traumatic head injury and serves as a guide for healthcare providers to diagnose and follow-up on injuries.
- Care to Chat is an annual community event for parents only publicized through the school districts. Discussion topics include healthy lifestyles, in particular obesity, bullying and preventative care for tweens and teens. Attendance is approximately 300.
- UHealth, a partnership with Lamar Independent School District for teachers with obesity/hypertension, is held bi-monthly in five schools. Focused on preventing heart disease and obesity, a physician speaks on a health topic, and a nurse takes blood pressure at the beginning and end of the school year.
- Corporate Lunch and Learns provide education to employees in Fort Bend area companies in regards to living a healthier lifestyle. Blood pressure screenings and flu shots are also provided.
- Memorial Hermann Sugar Land supports Jack and Jill, Inc., a national community service organization that is dedicated to the improvement of all children by providing constructive educational, cultural, civic, recreational and service programs, presented First Aid and CPR training to 30 middle schoolers.
- 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 67 Memorial Hermann Sugar Land employees lost 172 pounds on the Leaner Weigh program
Financial penalty for smoking for existing employees and a “no smokers” hiring policy for new employees. Memorial Hermann Sugar Land is a non-smoking campus.

- Wellness & You Program which incorporates fresh and delicious recipes that meet established guidelines into daily retail food offerings
- My Fitness Pal which, free for iPhone and Android, provides a personalized diet profile to one’s unique weight loss goals
- Cooking for Wellness where chefs and dietitians in the Sugar Land Cafe host cooking demonstrations using healthy cooking techniques
- Meatless Mondays which encourages reduction of meat consumption by 15% to improve personal health and the health of the planet
- Eat This...Not That signage to drive awareness of options, calories, and ingredients

**PRIORITY #4 STRATEGY:**

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

**Implementation Activities:**

- Provide on-going education on healthy lifestyles and healthy choices as measured by programs and attendees.
  - Explore program options (2014)
  - Implement selected program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)
- Implement regular, ongoing community education courses for weight management and exercise.
  - Explore program options (2014)
  - Implement select program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)
- Provide meeting room space at no cost to health and community related groups as measured by collaboration with community groups.
  - Establish baseline metrics (2014)
  - Increase participation over baseline by 5% (2015)
  - Report metrics (2015, 2016)
- Expand UHealth to Fort Bend County.
  - Conduct a needs assessment to identify schools/school nurses to be served (2014)
  - Implement program and establish baseline metrics (2015)
  - Report metrics (2016)
- Implement Memorial Hermann System Wellness Initiatives.
  - Continue current wellness programs including incentive/disincentive for wellness/non-wellness System Wellness Initiatives.
  - Expand on the successful Pilot “Eat This...Not That” (2013-2016)
  - Implement vending program revisions (2014)
  - Implement catering menu revisions (2014)
Implement patient menu revisions (2014)
Report metrics on reduced caloric intake and reduced weight gain (2015, 2016)

PRIORITY #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

PRIORITY #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.

PRIORITY #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 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-resources 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, nine Sugar Land patients were assessed and treatment recommendations were made. Use of the program is intended to grow.

The Memorial Hermann Prevention and Recovery Center (PaRC), the number one drug rehab and alcohol program in Houston providing detoxification, residential treatment, intensive outpatient programs, and an aftercare program is a substance abuse referral source for Memorial Hermann Sugar Land Hospital. The PaRC has 30 years of experience treating addiction as the chronic, progressive, primary illness that 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).

**PRIORITY #5 STRATEGY:**

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

**Implementation Activity:**
- 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)

**Implementation Activity:**
- 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 quickly, 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)
PRIORITY #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 demonstrates 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.

PRIORITY #6 RESPONSE: In order to be proactive in addressing community issues, Memorial Hermann Sugar Land established a Development/Advisory Committee. Composed of a diverse cross-section of the Sugar Land community, the Committee provides insightful direction for new hospital initiatives.

Memorial Hermann programs for the safety net, uninsured, and elderly populations include COPE and Chronic Disease Management.

Since 2008, Memorial Hermann Sugar Land 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 Sugar Land’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 telephonic 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 immediate notification if the nurse notices any emergent problems that require quick 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 the need for emergency room services for children in Fort Bend County, Memorial Hermann Sugar Land staffs a Pediatric ER for eight hours per day. This service covers all pediatric emergency department patients as well as pediatric admissions during these hours. This is the only pediatric ER in Fort Bend County. In 2012, ER visits totaled 7,511.

Addressing the needs of the homeless population is challenging. Memorial Hermann Sugar Land discharges the patient back to the homeless shelter and ensures that they obtain their basic needs such as clothing and food through community resources.

**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:** Expand programs that serve children.

**Implementation Activities:**
- Continue support of school-based healthcare as reflected by 4,800 annual medical clinic visits. (ongoing)
- Expand pediatric ER coverage via a pediatric hospitalist program. (2015)

**Objective #6.3:** Implement programs that support the needs of the elderly.

**Implementation Activities:**
- Implement Medical Therapy Management Clinic.
- Develop pharmacist operated clinic model which will assist patients with procurement of medications, therapy adherence, monitoring of pertinent labs, and communication with physicians for continuity of care (2013)
- Implement program and establish baseline metrics (2014)
- Report metrics (2015, 2016)

**Objective #6.4:** Expand programs that support 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 #6.5:** To expand programs that support Asian and other immigrants.

**Implementation Activities:**
- Explore the need to expand translated communication materials.
  - Establish a review process to determine whether and which hospital-wide education pieces need to be translated into other languages (2014)
  - Set goals for accomplishing translation (2015)
  - Monitor progress (2015, 2016)