

Memorial Hermann Health System

TIRR Memorial Hermann

Community Benefits Strategic Implementation Plan 2016

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Health Resources in Action
Advancing Public Health and Medical Research

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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 TIRR Memorial Hermann

Located in the world-renowned Texas Medical Center, TIRR Memorial Hermann (hereafter TIRR MH) has been treating individuals with a range of disabilities since 1959. In the last 26 years, TIRR Memorial Hermann has continuously been recognized as one of America's best rehabilitation hospitals by U.S. News and World Report. TIRR MH has also been recognized for their long-standing commitment to educating patients, families, healthcare professionals, caregivers and the general public about rehabilitation. TIRR MH is a national leader in medical rehabilitation and research. Interdisciplinary teams at TIRR MH provide a comprehensive continuum of medical rehabilitation at the acute rehabilitation hospital, Outpatient Medical Clinic, and the TIRR Memorial Hermann Adult and Pediatric Outpatient Rehabilitation at Kirby Glen Center. These comprehensive medical rehabilitation programs are for individuals who have experienced traumatic brain injury, stroke, spinal cord injury, amputation, multiple trauma, multiple sclerosis, Parkinson's disease, other neurological or

neuromuscular disorders, and complex orthopedic injuries. TIRR MH is also a teaching hospital for Baylor College of Medicine and The University of Texas Medical School at Houston.

The TIRR Memorial Hermann Community

TIRR MH's community corresponds to the counties of Brazoria, Brazos, Fort Bend, Galveston, Harris, Montgomery, and Victoria. A large majority of TIRR MH inpatient discharges in fiscal year 2015 occurred among residents of Harris County (73.1%). About 10% of inpatient discharges were from Fort Bend County and far fewer came from the counties of Brazoria, Brazos, Galveston, Montgomery and Victoria.

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 TIRR MEMORIAL HERMANN

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

PRIORITY COMMUNITY NEEDS FOR TIRR MEMORIAL HERMANN

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 TIRR MH.

Figure 1: Criteria for Prioritization

RELEVANCE <i>How Important Is It?</i>	APPROPRIATENESS <i>Should We Do It?</i>	IMPACT <i>What Will We Get Out of It?</i>	FEASIBILITY <i>Can We do It?</i>
<ul style="list-style-type: none"> Burden (magnitude and severity, economic cost; urgency of the problem) Community concern Focus on equity and accessibility 	<ul style="list-style-type: none"> Ethical and moral issues Human rights issues Legal aspects Political and social acceptability Public attitudes and values 	<ul style="list-style-type: none"> Effectiveness Coverage Builds on or enhances current work Can move the needle and demonstrate measureable outcomes Proven strategies to address multiple wins 	<ul style="list-style-type: none"> 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), TIRR MH, and the other twelve MHHS hospitals (MH Greater Heights, MH Katy, MH Rehabilitation Hospital - Katy, MH Northeast, MH Memorial City, MH Southeast, MH Southwest, MH Sugar Land, MH TMC, MH The Woodlands, MH First Colony Surgical Hospital, MH Kingwood Surgical Hospital) participating in its 2016 CHNA-SIP process. This conversation included a presentation of the priorities identified by the Community Health Needs Assessment (CHNA) across all MHHS hospitals, including a discussion of the key criteria for prioritization and the impact of these health issues on the most vulnerable populations. After discussion among all hospital facilities, representatives came to consensus on these three top key priorities for each hospital facility and agreed, as they develop their hospital’s Strategic Implementation Plan (SIP), to set hospital-specific goals, objectives, and strategies within them that addressed the facility’s specific service area and populations served.

These three overarching priorities reflect all of the needs identified system-wide in the CHNAs including transportation (reflected under Access to Health Care), substance abuse (reflected under Behavioral Health), and issues related to aging (considered as one of several vulnerable populations addressed across the SIPs).

THE STRATEGIC IMPLEMENTATION PLAN (SIP)

The goal of the 2016-2019 Strategic Implementation Plan is to:

- Develop a 3-year plan for the hospital to address the top priority health issues identified by the CHNA process
- Describe a rationale for any priority health issues the hospital does not plan to address
- Develop goals and measurable objectives for the hospital’s initiatives
- Select strategies, taking into account existing hospital programs, to achieve the goals and objectives
- Identify community partners who will help address each identified health priority.

The 2016-2019 Strategic Implementation Plan is designed to be updated quarterly, reviewed annually and modified as needed.

Memorial Hermann TIRR and Katy Rehab CHNA and Strategic Implementation Plan Work Group

- Jerry Ashworth, AVP Operations, TIRR Memorial Hermann
- Giovanni Cleaver, Business Analyst, TIRR Memorial Hermann
- Mary Ann Euliarte, VP /CNO, TIRR Memorial Hermann and Katy Rehab
- Carl Josehart, VP/CEO, TIRR Memorial Hermann and Katy Rehab
- Jennifer Kuck, Director of Rehabilitation, Katy Rehab
- Jennifer Lee, Physician Liaison, Katy Rehab
- Tanya Philips, Director of Nursing, Katy Rehab
- Susan Thomas, Manager of Communications, TIRR Memorial Hermann and Katy Rehab
- Marissa Demaya, Educator, TIRR Memorial Hermann and Katy Rehab

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 those noted below:

Priority 2: Health Care Access

Health Insurance Coverage and Costs

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

TIRR MEMORIAL HERMANN STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living		
Goal 1: Achieve long-term improved health for people with chronic and long-term disabilities.		
Early Detection and Screening		
Objective 1.1: Reduce long term complications of the disabled population through key screenings and preventive care.		
Outcome Indicators:	Baseline	FY 2020 Target
<ul style="list-style-type: none"> Number of post polio patients, veterans and research subjects supported by special funds 	4	5
<ul style="list-style-type: none"> Number of patients who received equipment rental, medication and/or patient supplies from the General Excellence Fund 	50	50
Strategies:		Timeline: Year 1,2,3
1.1.1: Draw from philanthropic funds to provide coverage for uninsured patients <ul style="list-style-type: none"> Special philanthropic fund for uninsured children and post polio patients to fund gaps in coverage Special fund for veterans for gaps in coverage Special fund to defray costs for participation in research protocols for those with economic barriers TIRR Military Veteran Fund: 1 patient - \$4,860 (outpatient services) Weil/Vallbona Fund (assistance to post-polio patients in need of financial assistance for essential items like equipment or medication): 1 patient – \$2,001 (assistance for adaptive driving equipment and orthotics) Spencer Fund (outpatient services for pediatric patients) : 2 patients - \$4,732 (co-pays for outpatient services at Kirby Glen; services for 3- year-old patient participating in medical trial) TIRR Sports Fund should be included as these are provided for community teams. FY16 disbursements were \$22,144. 		1,2,3
1.1.2 Provide resources for un or underinsured that have gaps in coverage through the General Excellence Fund		1,2,3
Monitoring/Evaluation Approach:		
<ul style="list-style-type: none"> Quarterly review of fund disbursements 		
Potential Partners:		
<ul style="list-style-type: none"> Memorial Hermann Foundation 		

Priority 1: Healthy Living

Goal 1: Achieve long-term improved health for people with chronic and long-term disabilities.

Obesity Prevention

Objective 1.2: Teach people with chronic and long-term disabilities compensatory strategies to prevent health problems associated with lack of activity

Outcome Indicators:	Baseline	FY 2020 Target
• Number of participants in adaptive sports camps for kids with disabilities	34	50
• Amount of financial support for traveling sports disability players	39	50
• Number of open gym fees provided at reduced cost to patients caregivers (Strength Unlimited Program)	< 10/month	10

Strategies:	Timeline: Year 1,2,3
1.2.1: Provide low/no cost membership to Strength Unlimited Program: health and wellness program offered to community, people buy membership and do supervised exercise to meet needs of disabled population; reduced cost to patients caregivers for monthly charge	1,2,3
1.2.2: Run sports camps for kids with disabilities throughout the year, participate in adaptive ways	1,2,3
1.2.3: Provide financial support three (3) adaptive sports leagues: basketball juniors, basketball adults, wheelchair rugby	1,2,3

Monitoring/Evaluation Approach:

- Sports team rosters

Potential Partners:

- National Wheelchair Basketball Association
- National Wheelchair Rugby Association
- West Gray Adaptive Recreation Center

Priority 1: Healthy Living

Goal 1: Achieve long-term improved health for people with chronic and long-term disabilities.

Access to Healthy Food

Objective 1.3: Find long-term solutions to help people reduce barriers and improve adherence to medically appropriate diets

Outcome Indicators:	Baseline	FY 2020 Target
• Number of patients who participate in community outings	780	880
Strategies:		Timeline: Year 1,2,3
1.3.1: Conduct community outings with inpatient and outpatient population, which include: <ul style="list-style-type: none">• teaching them how to shop• going to grocery store (several a week)• patient to peer dinners		1,2,3
Monitoring/Evaluation Approach:		
• Community outing records		
Potential Partners:		
• Local establishments, restaurants, Houston Livestock and Rodeo Show etc.		

Priority 1: Healthy Living

Goal 1: Achieve long-term improved health for people with chronic and long-term disabilities.

Time for/Safety During Physical Activity

Objective 1.4: Prevent injury during physical activity for the disabled population

Outcome Indicators:	Baseline	FY 2020 Target
<ul style="list-style-type: none">• Number of patients trained in using the Metro System	50	50
<ul style="list-style-type: none">• Number of patients taken to airport (Project Airport) to demo traveling process, after facing a disability	25	25
Strategies:		Timeline: Year 1,2,3
1.4.1: Provide training on site to patients on how to get on/off buses in collaboration with Houston Metro System (See 2.3.1)		1,2,3
1.4.2 Conduct a program for patients with disabilities where we take patients to airport to acclimate and to train on the physical needs associated with travel after a disability (See 2.3.2)		1,2,3
Monitoring/Evaluation Approach:		
<ul style="list-style-type: none">• Training rosters/records		
Potential Partners:		
<ul style="list-style-type: none">• Houston METRO• United Airlines		

Priority 1: Healthy Living

Goal 1: Achieve long-term improved health for people with chronic and long-term disabilities.

Chronic Disease Management

Objective 1.5: Reduce progression or preventable side effects of chronic diseases

Outcome Indicators:	Baseline	FY 2020 Target
<ul style="list-style-type: none"> Up-to-date website on Caregiver and Community Resources dedicated to community education and research on brain injury and stroke 	TBD	TBD
<ul style="list-style-type: none"> Number of participants in support groups for dysautonomia, amputee, brain injury, and AA 	100 participants	100 participants
<ul style="list-style-type: none"> Number of Spinal Cord Injury manuals and Stroke Manuals distributed 	600 manuals	600 manuals
Strategies:		Timeline: Year 1,2,3
1.5.1	Continue to update the library and website so individuals can find resources, research and general information related to disabilities resulting from brain and neurological impairments and spinal cord injuries	1,2,3
1.5.2	Up to date website on Caregiver and Community Resources dedicated to community education and research on brain injury and stroke	1,2,3
1.5.3	Conduct support groups for dysautonomia, amputee, brain injury, and AA	1, 2, 3
1.5.4	Provide free spinal cord injury manuals and stroke manuals to patients with information on nutrition needs, bladder management, community resources, stay active ideas, skin care, anatomy, etc.	1,2,3
Monitoring/Evaluation Approach:		
<ul style="list-style-type: none"> Support group participation records Printing and distribution records for manuals 		
Potential Partners:		
<ul style="list-style-type: none"> Experts in the SCI and stroke fields 		

Priority 2: Access to Health Care

Priority 2: Health Care Access		
Goal 2: Ensure ease of access to care, services, and supports for people with chronic and long term disabilities.		
Availability of Primary Care and Specialty Providers		
Objective 2.1: Reduce barriers to care for people with disabilities		
Outcome Indicators:	Baseline	FY 2020 Target
<ul style="list-style-type: none"> Number of hospital's associated counties' calls to Nurse Health Line (MH Katy Rehab - Austin, Colorado, Fort Bend, Harris, Waller) 	31,333	31,333
<ul style="list-style-type: none"> Number of published journals 	4 (quarterly)	4 (quarterly)
<ul style="list-style-type: none"> Number of promotions distributed 	30,000	30,000
<ul style="list-style-type: none"> Number of clinical services and research opportunities provided to those who cannot afford services 	TBD	TBD
Strategies:		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: Publish quarterly journal on research, best practices, clinical care available online, promoted through social media and print publications mailed to 30,000+ target audience: rehabilitation professionals nation-wide and general public through web and social posts		1,2,3
2.1.3: Provide funding for research on those with disabilities (the amount not funded by any grants)		1,2,3
Monitoring/Evaluation Approach:		
<ul style="list-style-type: none"> Health Nurse Line Call Log Count of journals Count of promotions Research funding records 		
Potential Partners:		
<ul style="list-style-type: none"> UTHealth Baylor College of Medicine Memorial Hermann Community Benefit Corporation 		

Priority 2: Health Care Access

Goal 2: Ensure ease of access to care, services, and supports for people with chronic and long term disabilities.

Health Insurance Coverage and Costs

See “Rationale for Priority Community Needs Not Addressed”

Priority 2: Health Care Access

Goal 2: Ensure ease of access to care, services, and supports for people with chronic and long term disabilities.

Transportation

Objective 2.3: Reduce barriers to community participation (work, play, education, etc.) including access to health care

Outcome Indicators:	Baseline	FY 2020 Target
<ul style="list-style-type: none">• Number of patients trained in using the Metro System	50	50
<ul style="list-style-type: none">• Number of patients taken to airport (Project Airport) to demo traveling process, after facing a disability	25	25
Strategies:		Timeline: Year 1,2,3
2.3.1: Provide training on site to patients on how to get on/off busses in collaboration with Houston Metro System (See 1.4.1)		1,2,3
2.3.2 Conduct a program for patients with disabilities to take them to an airport to acclimate and to train on the physical needs associated with travel after a disability (See 1.4.2)		1,2,3
Monitoring/Evaluation Approach:		
<ul style="list-style-type: none">• Records for the Metro program• Records for outings to airport		
Potential Partners:		
<ul style="list-style-type: none">• Houston METRO• United Airlines		

Priority 2: Health Care Access

Goal 2: Ensure ease of access to care, services, and supports for people with chronic and long term disabilities.

Health Care Navigation

Objective 2.4: Provide opportunities for patients with disabilities to get the services they need when, where, and how they need it

Outcome Indicators:	Baseline	FY 2020 Target
<ul style="list-style-type: none"> Number of hospital's associated counties' calls to Nurse Health Line (MH TIRR - Brazoria, Brazos, Fort Bend, Galveston, Harris, Montgomery, and Victoria) 	35,059	35,059
<ul style="list-style-type: none"> Number of individuals receiving technical assistance (webinars, training educational materials, and calls to consumer line) 	2500 persons attend on-line webinars, in person trainings	2500
Strategies:		Timeline: Year 1,2,3
2.4.1 Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the MHHS community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources (see 2.1.1)	1, 2, 3	
2.4.2: Provide technical assistance for individuals and groups world-wide, such as designers and builders, to provide help and resources about reasonable accommodations for including people with disabilities in various settings, particularly health care facilities and the workplace	1,2,3	
Monitoring/Evaluation Approach: <ul style="list-style-type: none"> Nurse Health Line call log Count of individuals receiving technical assistance 		
Potential Partners: <ul style="list-style-type: none"> 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 TIRR MH but to the community at large.

Priority 3: Behavioral Health		
Goal 3: Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.		
Objective 3.1: Create nontraditional access points around the community (crisis/ambulatory, acute care, and community-based chronic care management), and link those who need services to permanent providers and resources in the community		
Outcome Indicators:	Baseline	FY 2020 Target
• Decrease in number of ER encounters that result in psychiatric inpatient stay	1,146	1,089 5% reduction of baseline
• Number of Memorial Hermann Crisis Clinic total visits	5,400	5% over baseline
• Number of Psychiatric Response Care Management total visits	1,200	5% over baseline
Strategies:		Timeline: Year 1,2,3
3.1.1: Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7		1,2,3
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		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		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:	Baseline	FY 2020 Target
• Number of presentations/educational sessions for healthcare professionals within MHHS	50 sessions per year	5% increase over baseline
• Number of presentations/educational sessions for corporations	5	5% over baseline
• Training on Acute Care Concepts - system nurse resident program	15 trainings (45 hours total/3 hours each)*	15 trainings (45 hours total/3 hours each)*
• Training on CMO Roundtable - system-wide	1 training (2 hours)*	1 training (2 hours)*
*Total time includes training material development and implementation		
Strategies:		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:		
<ul style="list-style-type: none"> • System acute care campuses • System Marketing and Communications • Employer solutions group 		

Priority 3: Behavioral Health		
Goal 3: Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.		
Objective 3.3: Quality of mental health and substance abuse services: access, link, and practice utilizing evidence-based practice to promote overall wellness		
Outcome Indicators:	Baseline	FY 2020 Target
• Number of Memorial Hermann Crisis Clinic follow-ups post discharge with clinic patients	7,716	5% over baseline
• Psychiatric Response Case Management reduction in system ER utilization	54.4%	5% increase over baseline
Strategies:	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	1,2,3	
3.3.2: Psychiatric Response Case Management Program utilizes evidence-based practice interventions (motivational interviewing, MH First Aid, CAMS, etc.) to reduce ER utilization for program enrollees	1,2,3	
Monitoring/Evaluation Approach:		
• Social work logs (Excel spreadsheet)		
Potential Partners:		
<ul style="list-style-type: none"> • System acute care campuses • Community-based clinical providers • Network of public and private providers 		