Memorial Hermann Health System

Memorial Hermann Greater Heights Hospital
Community Benefits Strategic Implementation Plan 2016

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Health Resources in Action
Advancing Public Health and Medical Research

Please address written comments on the Community Health Needs Assessment (CHNA) and
Strategic Implementation Plan (SIP) and requests for a copy of the CHNA or SIP to:

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INTRODUCTION

Memorial Hermann Health System

Proudly working for individuals and families for more than 109 years, Memorial Hermann Health System (MHHS) is the largest non-profit health care system in Southeast Texas. Memorial Hermann's 13 hospitals and numerous specialty programs and services serve the Greater Houston area, the fifth largest metropolitan area in the United States. To fulfill its mission of providing high quality health services in order to improve the health of the people in Southeast Texas, Memorial Hermann annually contributes more than $451 million in uncompensated care, community health improvement, community benefits, health professions education, subsidized health services, research, and community education and awareness.

Memorial Hermann Community Benefit Corporation

Established in 2007, Memorial Hermann Community Benefit Corporation (MHCBC) is a subsidiary of Memorial Hermann Health System. MHCBC's mission is to test and measure innovative solutions that reduce the impact of the lack of access to care on the individual, the health system and the community. MHCBC works in collaboration with other healthcare providers, government agencies, business leaders and community stakeholders to move closer to completion of an infrastructure for the Houston and Harris County region that will ensure a healthy, productive workforce.

Committed to making the greater Houston area a healthier and more vital place to live, MHHS and its subsidiary, MHCBC work together to provide or to collaborate with the following initiatives:

- Health Centers for Schools
- Mobile Dental Vans
- ER Navigators
- Nurse Health Line
- STEP Healthy to Reduce Obesity
- Neighborhood Health Centers
- Psychiatric Response Team
- Mental Health Crisis Clinics
- Home Behavioral Health Services

Since 2007, MHCBC has worked collaboratively with health related organizations, physicians groups, research and educational institutes, businesses, nonprofits, and government organizations to identify, raise awareness and to meet community health needs. Conducted every three years for each of MHHS's hospitals, the Community Health Needs Assessments (CHNA) guide MHCBC and the entire MHHS to better respond to each community's unique health challenges. The CHNA process enables each hospital within MHHS to develop programs and services that advance the health of its community, building the foundation for systemic change across the greater Houston area.

About Memorial Hermann Greater Heights Hospital

Located in the heart of Houston adjacent to The Houston Heights, Memorial Hermann Greater Heights Hospital (hereafter MH Greater Heights) has been caring for families since 1966. A facility with more than 600 affiliated doctors, MH Greater Heights provides a wide range of medical specialties, including heart and vascular care, orthopedics, cancer treatment, sleep labs, diagnostic imaging, rehabilitation, women's care and wound care.

The Memorial Hermann Greater Heights Hospital Community

The MH Greater Heights community is defined by the city of Houston, located within Harris County. MH Greater Heights defines its community geographically as the top 75% of zip codes corresponding to inpatient discharges in fiscal year 2015. These selected zip codes correspond to the city of Houston in Harris County. All MH Greater Heights inpatient discharges in fiscal year 2015 occurred among residents of Harris County (100.0%).

It is important to recognize that multiple factors have an impact on health, and there is a dynamic relationship between people and their lived environments. Where we are born, grow, live, work, and age—from the environment in the womb to our community environment later in life—and the interconnections among these factors are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing stock. The social determinants of health framework addresses the distribution of wellness and illness among a population. While the data to which we have access is often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies.

In addition to considering the social determinants of health, it is critical to understand how these characteristics disproportionately affect vulnerable populations. Health equity is defined as all people having the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance." When examining the larger social and economic context of the population (e.g., upstream factors such as housing, employment status, racial/ethnic discrimination, the built environment, and neighborhood level resources), the disparities and inequities that exist for traditionally underserved groups need to be considered.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR MH GREATER HEIGHTS HOSPITAL

To ensure that MH Greater Heights' community benefit activities and programs are meeting the health needs of the community, MH Greater Heights conducted a Community Health Needs Assessment (CHNA).

The CHNA was guided by a participatory, collaborative approach, which examined health in its broadest sense over a six-month period. This process included integrating existing secondary data on social, economic, and health issues in the region with qualitative information from 11 focus groups with community residents and service providers and 27 interviews with community stakeholders. Focus groups and interviews were conducted with individuals from the Greater Houston area and from within MH Greater Heights' diverse community.

PRIORITY COMMUNITY NEEDS FOR MH GREATER HEIGHTS HOSPITAL

The following key health issues emerged most frequently from a review of the available data across all MHHS hospitals and were considered in the selection of the system-wide Strategic Implementation Plan (SIP) health priorities:
- Health Care Access
- Issues Related to Aging
- Behavioral Health, Including Substance Abuse and Mental Health
- Transportation
- Healthy Eating, Active Living, and Overweight/Obesity
- Chronic Disease Management

HRiA facilitated MHHS leadership in an initial narrowing of the priorities based on key criteria, outlined in Figure 1, which could be applied across all CHNAs in the system. MHHS applied these criteria to select system-level priorities for approval by representatives from MH Greater Heights.

RELEVANCE	APPROPRIATENESS	IMPACT	FEASIBILITY
How Important Is It?	*Should We Do It?*	*What Will We Get Out of It?*	*Can We do It?*
• Burden (magnitude and severity, economic cost; urgency of the problem) • Community concern • Focus on equity and accessibility	• Ethical and moral issues • Human rights issues • Legal aspects • Political and social acceptability • Public attitudes and values	• Effectiveness • Coverage • Builds on or enhances current work • Can move the needle and demonstrate measureable outcomes • Proven strategies to address multiple wins	• Community capacity • Technical capacity • Economic capacity • Political capacity/will • Socio-cultural aspects • Ethical aspects • Can identify easy short-term wins

The top three key priorities identified by this process were:
1. Healthy Living
2. Behavioral Health
3. Health Care Access

In May 2016, HRiA led a two-hour, facilitated conversation with Memorial Hermann Health System (MHHS), MH Greater Heights, and the other twelve MHHS hospitals (MH Katy, MH Rehabilitation Hospital - Katy, MH Northeast, MH Memorial City, MH Southeast, MH Southwest, MH Sugar Land, MH TIRR, MH TMC, MH The Woodlands, MH First Colony Surgical Hospital, MH Kingwood Surgical Hospital) participating in its 2016 CHNA-SIP process. This conversation included a presentation of the priorities identified by the Community Health Needs Assessment (CHNA) across all MHHS hospitals, including a discussion of the key criteria for prioritization and the impact of these health issues on the most vulnerable populations. After discussion among all hospital facilities, representatives came to consensus on these three top key priorities for each hospital facility and agreed, as they develop their hospital's Strategic Implementation Plan (SIP), to set hospital-specific goals, objectives, and strategies within them that addressed the facility's specific service area and populations served.

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

THE STRATEGIC IMPLEMENTATION PLAN (SIP)

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

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

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

Memorial Hermann Greater Heights CHNA and Strategic Implementation Plan Work Group

- Stephanie Campbell, Manager Case Management
- Tamara Lee-Constable, RN Emergency Room
- Jason Glover, Director Operations
- Ivee Sauls, Senior Marketing/Communication Representative
- Shannan Dillard, Director Business Office
- Sandra Cummins, Employer Liaison Occupational Medicine
- Christine Goodson, Diabetes Educator
- Angela Sisk, Oncology Nurse Navigator

RATIONALE FOR PRIORITY COMMUNITY NEEDS NOT ADDRESSED

All priority community needs identified by the Community Health Needs Assessment are addressed in this Strategic Implementation Plan.

MH GREATER HEIGHTS HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1:	Healthy Living	
Goal 1:	**Empower individuals to manage their health and be proactive in their care to maximize healthy living for future generations.**	
Early Detection and Screening **Objective 1.1:** Increase awareness and provide early detection screenings for our community		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of screenings provided	Establish Baseline	5% > Baseline
• Number of education/support group events hosted or participated in	61/year	75/year
Strategies:	**Timeline:** **Year 1,2,3**	
1.1.1: Conduct free screenings (cancer, HIV, Hepatitis C, Vascular (screening for blocked arteries diabetes, etc.)	1, 2, 3	
1.1.2: Conduct support groups on diabetes, cancer, wound care, amputation, COPD, and stroke (See 1.5.1)	1, 2, 3	
1.1.3: Conduct Lunch and Learns for employers, organizations and community members (See 1.3.5)	1, 2, 3	
1.1.4: Provide information on services available and conduct education sessions at health fairs (See 1.2.3 and 1.3.5)	1, 2, 3	
Monitoring/Evaluation Approach: • Counts and data assessed and entered in a database at the conclusion of each event • Quarterly Community Benefit Steering Committee Review		
Potential Partners: • Community organizations that work with at-risk populations – churches, county clinics, safety- net resources • Chambers of Commerce, businesses and employers		

Priority 1:	Healthy Living

Priority 1:   Healthy Living

Goal 1:   Empower individuals to manage their health and be proactive in their care to maximize healthy living for future generations.

Obesity Prevention
Objective 1.2:   Educate the community to live healthier lifestyles through nutrition and exercise

Outcome Indicators:	Baseline	FY 2020 Target
• Pounds of produce distributed to community partners via community garden	Establish Baseline Year 1	5% > Baseline
• Number of times co-op distributes food at facility	Establish Baseline Year 1	Monthly
• Number educational events connected with nutrition and exercise	5	10

Strategies:	Timeline: Year 1,2,3
1.2.1: Provide financial support and coordinate volunteers to establish a community garden with a lower income neighborhood (See 1.3.3)	1, 2, 3
1.2.2: Establish a co-op for fresh fruits and vegetables at the hospital for staff and community members (See 1.3.4)	1, 2, 3
1.2.3: Host educational sessions about nutrition and exercise (See 1.1.4)	1, 2, 3

Monitoring/Evaluation Approach:
- Weighing pounds of food donated/distributed
- Amount of time co-op pick-up is available at hospital
- Count of education events/participants that have nutrition focus aggregated and entered in after each event
- Quarterly review by Community Benefit Steering Committee

Potential Partners:
- Diabetes organizations
- Local schools, churches, civic organizations, HOAs and employers
- Local farmer's market

Priority 1:	**Healthy Living**		
Goal 1:	**Empower individuals to manage their health and be proactive in their care to maximize healthy living for future generations.**		

Access to Healthy Food

Objective 1.3: Provide education on healthy food options and healthier food at a lower cost for our community members

Outcome Indicators:	Baseline	FY 2020 Target
• Number of ER patients screened for food insecurity via the MH ER Navigation program	2,162	2,162
• Number of CHW referrals to community food pantries via the MH ER Navigation program	709	709
• Number of supported community events hosted by local partners via the MH ER Navigation program	0	2
• Establishment of community garden	Not Implemented	Implemented
• Pounds of produce distributed to community partners	Establish Baseline Year 1	5% > Baseline

Strategies:	Timeline: Year 1,2,3
1.3.1 Continue to participate in the MH ER Navigation program in which participants are screened for food insecurity and referred to food pantries if necessary (See 2.4.2)	1, 2, 3
1.3.2: Collect food to support food pantries or special events hosted by community partners	1,2,3
1.3.3: Provide financial support and coordinate volunteers to establish a community garden with a lower income neighborhood (See 1.2.1)	1,2,3
1.3.4: Establish a co-op for fresh fruits and vegetables at the hospital for staff and community members (See 1.2.2)	1,2,3
1.3.5: Provide education about healthy portions and healthy food choices to employers, organizations and community members via health fairs and Lunch and Learns (See strategies under Objective 1.1)	1,2,3

Monitoring/Evaluation Approach:
- Community Garden Workplan Milestones
- Co-op distribution frequency and participants
- Count of educational events/participants
- Patient activity documented and reported within the MH ER Navigation electronic record system

Potential Partners:
- Local schools, churches, civic organizations, HOAs and employers
- Local farmer's market
- Ministry Assistance of the New Northwest Alliance (MANNA)
- Wesley Community Center
- LINC's Greenspoint Pantry
- Comunidad de Gracia
- MH Community Benefit Corporation

Priority 1: Healthy Living		
Goal 1: Empower individuals to manage their health and be proactive in their care to maximize healthy living for future generations.		

Time for/Safety During Physical Activity **Objective 1.4:** Encourage healthy lifestyles through safe exercise practices		
Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of students reached in coordination with free physicals	102/year	150
• Partner with local organizations to create safe recreational areas	0 locations	3 locations
Strategies:	**Timeline:** **Year 1,2,3**	
1.4.1: Provide financial support to local Little League to support space for fields.	1, 2, 3	
1.4.2: Provide free physical examinations for the area schools (i.e., Waltrip and other high schools)	1,2,3	
1.4.3: Provide financial support for the revitalization of Little Thicket Park, Woodlawn Park, and Shady Acres Park	2	
Monitoring/Evaluation Approach: • Roster of student physicals provided • Dollars invested in revitalizing parks		
Potential Partners: • Physicians • Local schools, organizations and employers • TIRZ 5 • Sports associations		

Priority 1:   Healthy Living

Goal 1:   Empower individuals to manage their health and be proactive in their care to maximize healthy living for future generations.

Chronic Disease Management
Objective 1.5:   Provide chronic disease management services to increase overall health and well-being of high-risk populations

Outcome Indicators:	Baseline	FY 2020 Target
• Number of types of chronic disease support groups (Diabetes, COPD)	4	6
• HIV Screenings in ER	561/year	600/year

Strategies:	Timeline: Year 1,2,3
1.5.1: Maintain current support groups and establish new chronic disease support groups (e.g., diabetes, COPD, CHF) (See 1.1.2)	1,2,3
1.5.2: Conduct HIV screenings in the ER through the CDC grant	1,2,3

Monitoring/Evaluation Approach:
- Count of support group/participants
- Count of HIV screenings/ % tested positive

Potential Partners:
- Local schools
- Churches
- Civic organizations
- HOAs
- Employers
- Vendors with chronic disease education material

Priority 2: Access to Health Care

Priority 2:	Health Care Access
Goal 2:	**Help the patient get to the right location, at the right cost, at the right time.**

Availability of Primary Care and Specialty Providers
Objective 2.1:   Provide multiple options and avenues for patients to access primary and specialty providers

Outcome Indicators:	Baseline	FY 2020 Target
• Number of visits at Greater Heights affiliated MH-Urgent Care	1,209 (March – July)	9,000 / year
• Number of visits at Neighborhood Health Center Northwest	6,829	7,000
• Number of ER referrals to the Neighborhood Health Center Northwest	330	345
• Number of Memorial Hermann Medical Group PCPs & NPs	4	6
• Number of telemedicine consultations	187/year	187/year

Strategies:	Timeline: Year 1,2,3
2.1.1: Recruit Primary and Specialty Care Providers to meet community need	1,2,3
2.1.2: Establish a second urgent care center in the Greater Heights community	1,2,3
2.1.3: Provision of 24/7 neurological consultations to Greater Heights patients, through the use of telemedicine technologies such as digital imaging and real-time video conferencing providing patients with continuity in treatment, a fast-tracked process, and the most effective drug therapies	1,2,3

Monitoring/Evaluation Approach:
- Count of MHMG PCPs and NPs – Size of Panels
- Track volumes of under/uninsured treated at Urgent Care, Neighborhood Health Center and CCC

Potential Partners:
- Other MHHS entities
- Local schools, churches, civic organizations, HOAs and employers

Priority 2:	**Health Care Access**		
Goal 2:	**Help the patient get to the right location, at the right cost, at the right time.**		

Health Insurance Coverage and Costs
Objective 2.2: Provide resources to increase awareness, education, and health insurance coverage and reduce costs for uninsured and underinsured populations

Outcome Indicators:	**Baseline**	**FY 2020 Target**
• Number of Class D Prescriptions to the Hogg School- Based Health Center in support of primary medical care provided to uninsured children and teens at no cost	1,709	1,709
• Neighborhood Health Center GH vouchers issued	330	345
• Neighborhood Health Center GH vouchers used	228	240
• % of patients Cardon is able to help assist to get medical insurance coverage	21%	23%

Strategies:	**Timeline:** **Year 1,2,3**
2.2.1: Provide Class D Prescriptions to the Hogg School Based Health Center in support of primary medical care provided to uninsured children and teens at no cost	1, 2, 3
2.2.2: Subsidize the cost for vouchers that are provided for community members to obtain free and reduced cost care at the Neighborhood Health Center GH located next to the emergency room	1,2,3
2.2.3: Contract with Cardon to consult on all patients who are uninsured or underinsured to connect them with available payor resources Cardon is a third-party eligibility vendor (paid by MHSL) to assist patients with the application process for Medicaid, County Indigent, Affordable Care Act Insurance Exchange, and other third-party payors.	1,2,3
2.2.4 Contract with physicians to provide care for uninsured patients	1,2,3

Monitoring/Evaluation Approach:
• Count of vouchers issued and used on a monthly basis
• Count of patients consulted/converted by Cardon on a monthly basis

Potential Partners:
• Neighborhood Health Center Greater Heights
• Local schools, churches, civic organizations, HOAs and employers
• Harris Health (Community Safety Net)
• Cardon
• Memorial Hermann Community Benefit Corporation

Priority 2:	Health Care Access		
Goal 2:	**Help the patient get to the right location, at the right cost, at the right time.**		

Transportation
Objective 2.3:   Provide patients in need with just-in-time transportation resources

Outcome Indicators:	Baseline	FY 2020 Target
• Patient Transportation Fees	$48,000/year	$50,000 year

Strategies:	Timeline: Year 1,2,3
2.3.1: Provide bus passes, cab vouchers, and ambulances, and wheelchair vans for free transportation to and from appointments	1,2,3

Monitoring/Evaluation Approach:
• Number of vouchers or dollars contributed to subsidized transportation monthly

Potential Partners:
• Metro, taxi, bus system
• Partner organizations who provide free or reduced cost for transportation

Priority 2:	Health Care Access

Goal 2: Help the patient get to the right location, at the right cost, at the right time.

Health Care Navigation

Objective 2.4: Connect patients to resources to help them understand and navigate their healthcare journey to improve patient outcomes

Outcome Indicators:	Baseline	FY 2020 Target
• Number of hospital's associated counties' calls to Nurse Health Line (Harris)	28,581	28,581
• Number of patients enrolled in the ER Navigation Program	2,332	2,332
• Number of ER Navigation patient encounters	4,500	4,500
• Number of ER Navigation referrals to community resources	5,671	5,671
• Number of ER Navigation scheduled appointments	302	302
• Number of disease specific nurse navigators on campus (excluding ER)	4	5
• Number of education/support group events hosted or participated in (Objective 1.1)	61/year	75/year

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	1, 2, 3
2.4.2 Continue to participate in the MH ER Navigation program in which patients are referred to a medical home (See 1.3.1)	1, 2, 3
2.4.3: Provide Nurse Navigators for disease specific care including oncology, joint, bariatric, and amputation prevention	1,2,3
2.4.4 Provide health care screenings, educational events, health fairs, physicals and utilize the appropriate resources at each event to connect patients with the necessary tools to navigate their healthcare journey (See strategies under Objective 1.1)	1,2,3

Monitoring/Evaluation Approach:
- Patient activity documented and reported within the ER Navigation electronic record system
- Patient calls documented within the Nurse Health Line electronic record system

Potential Partners:
- Ibn Sina Foundation Clinic
- Spring Branch Community Health Center
- St. Hope Community Health Center
- Legacy Community Health Center
- Houston Area Community Services (HACS)
- Memorial Hermann Community Benefit Corporation

Priority 3: Behavioral Health

The following tables provide strategies and outcome indicators that reflect an MHHS system-wide approach to Behavioral Health. Data is not specific to MH Greater Heights Hospital but to the community at large with the exception of reduction in ER encounters that result in a psychiatric inpatient stay through linkages with a network of behavioral partners.

Priority 3:	Behavioral Health		
Goal 3:	Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.		
Objective 3.1:	Create nontraditional access points around the community (crisis/ambulatory, acute care, and community-based chronic care management), and link those who need services to permanent providers and resources in the community		
Outcome Indicators:		**Baseline**	**FY 2020 Target**
• Decrease in the number of ER encounters that result in psychiatric inpatient stay		1,146	1,089 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay at Greater Heights		114	108
• 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 to services at Greater Heights	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
• Number of trainings at GH ER Nursing Trainings (time includes training material development and implementation)	5 trainings (8 hours)	5 trainings (8 hours)
• GH Med Floor Nursing debriefing	1 training (3 hours)	1 training (3 hours)
• GH Management and communication with disruptive patients (time includes training material development and implementation)	1 training (4 hours)	1 training (4 hours)
• 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:
• 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: MHCC 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:
- System acute care campuses
- Community-based clinical providers
- Network of public and private providers