Memorial Hermann Health System

Memorial Hermann Memorial City Medical Center

Community Benefits Strategic Implementation Plan 2016

September 20, 2016

MEMORIAL HERMANN

TABLE OF CONTENTS

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 Memorial City Medical Center

Located in the heart of west Houston, Memorial Hermann Memorial City Medical Center (hereafter MH Memorial City) has been serving area families since 1971. MH Memorial City is recognized as a 5 star hospital by *Hospital Compare*, placing it as one of the top 2.2% of hospitals in the nation and it has been named one of the nation's 100 Top Hospitals by Truven Analytics, one of only two hospitals in Houston. Since 2009, MH Memorial City has been recognized for the quality of its nursing by the American Nurses Credentialing Center Magnet Recognition Program. MH Memorial City offers a wide variety of leading specialty services and programs, including Heart & Vascular Institute, Women's & Children's, Neurosciences, IRONMAN Sports Medicine Institute, Center for Advanced Orthopedics, Digestive Health Center, Emergency services and more.

The Memorial Hermann Memorial City Medical Center Community

The MH Memorial City community encompasses two counties, Fort Bend and Harris. MH Memorial City 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 communities of Cypress, Houston, and Katy within the counties of Fort Bend and Harris. A large majority of MH Memorial City inpatient discharges in fiscal year 2015 occurred among residents of Harris County (97.4%); only a small fraction of inpatient discharges occurred among residents of Fort Bend County (2.6%). At a city level, most MH Memorial City inpatient discharges occurred among residents of Houston (87.1%) followed by Katy (9.6%).

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 MEMORIAL CITY MEDICAL CENTER

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

PRIORITY COMMUNITY NEEDS FOR MH MEMORIAL CITY MEDICAL CENTER

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 Memorial City.

Figure 1: Criteria for Prioritization

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

The top three key priorities identified by this process were:

1. Healthy Living
2. Behavioral Health
3. Health Care Access

In May 2016, HRiA led a two-hour, facilitated conversation with Memorial Hermann Health System (MHHS), MH Memorial City, and the other twelve MHHS hospitals (MH Greater Heights, MH Katy, MH Rehabilitation Hospital - Katy, MH Northeast, 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 Memorial City CHNA and Strategic Implementation Plan Work Group

- Byron Auzenne, Service Line Leader, Heart & Vascular
- Rhonda Elmore, Marketing Director
- Harold Gottlieb, M.D., Chief Medical Officer
- Trudy Ivins, Service Line Leader, Digestive Health
- Gail McNeal, Manager, Case Management
- Kathy Nipper-Johnson, Director, Case Management (previous)
- Shabana Qureshi, Marketing & Communications Representative
- Jennifer Todd, Service Line Leader, Women's & Children's
- Alla Vargo, North Regional Director, Oncology

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 MEMORIAL CITY MEDICAL CENTER STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living

Goal 1: Encourage and foster healthy lifestyles through education, awareness and early detection to prevent illness.

Early Detection and Screening

Objective 1.1: Decrease morbidity and mortality through early detection and screening to enhance the quality of life for our community

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of community and education events hosted by/attended MHMC	16 health fairs/2,615 attendees 9 seminars/718 attendees 8 blog posts	22 health fairs/ seminars- 2,075 attendees 23 blog post	13 health fairs/ seminars- 1,414 attendees 11 blog post	3 Health fairs - 390 attendees 12 blog post 3 Community events – 80 attendees; seminar - 44 attendees	16 health fairs 15 seminars 10 blog posts
• Number of sports physicals performed	1,110	1,576	1,085	1,774	1,110

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.1.1: Provide health fairs, webinars, screenings and blog posts to the community and area employers				1, 2, 3
1.1.2: Provide low cost/free athletic physicals biannually to Spring Branch ISD students (See 1.4.1)				1, 2
1.1.3 Provide financial support to athletic programs at Spring Branch schools	$98,000	$98,000		1, 2

Monitoring/Evaluation Approach:

- Documentation from each event including # of attendees, staff time, giveaways, marketing, etc.
- Documentation of athletic physicals performed

Potential Partners:

- Major Area Employers
- School District
- Chamber of Commerce
- American Heart Association
- Local city municipality
- American Stroke Association
- American Cancer Society
- Local YMCA
- Local media

Obesity Prevention **Objective 1.2: Increase awareness for lifestyle changes that decrease obesity rates in our community**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**2020 Target**
• Amount raised and donated to the American Heart Association for Heart Walk	$40,830	49,207.81 raised $250.00 in giveaways	1,575 raised Did not hold a heart walk fundraiser due to Hurricane Harvey	$39,752 was raised	$42,000
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.2.1: Financially support the Heart Walk					1, 2, 3
1.2.2: Provide financial support and first aid at Spring Branch Independent School District (SBISD) Running for the Arts		$3000 (this is included in the $98,000 in 1.1.3)	$3000 (this is included in the $98,000 in 1.1.3)	Spring Branch ISD decided to do away with Running for the Arts this year	1, 2, 3
Monitoring/Evaluation Approach: • Post-event assessment for walks					
Potential Partners: • American Heart Association • Spring Branch ISD					

Access to Healthy Food **Objective 1.3: Increase awareness and education about healthy food choices to encourage healthy eating habits**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**2020 Target**
• Pounds of food donated to selected charities	2,510	1380 pounds of food and $650 (these dollars provide 1950 meals	Food Drive Discontinued	Food Drive Discontinued	2,600
• Number of oncology nutrition consults	70	60	56	21	80
• Number of participants in Oncology Nutrition 101 class	11	Class cancelled due to lack of attendance replaced with a weight management class in last quarter	18	21	20
• Number of ER patients screened for food insecurity via the ER Navigation program	952	1555	1333	1548	952
• Number of CHW referrals to community food pantries via the ER Navigation program	145	122	126	29	145
• Number of ER Navigation supported community events hosted by local partners	0	1	13	0	2
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.3.1: Continue to participate in the MH ER Navigation program in which participants are screened for food insecurity and referred to food pantries if necessary (See 2.4.2)				ER Navigation supported events in different parts of the community	1,2,3
1.3.2: Collect food to support food pantries or special events hosted by community partners. (Hold annual Summer of Sharing Food Drive benefiting Fairhaven Food Panty and the Mission of Yahweh.)			Food Drive discontinued	Food Drive discontinued	1,2,3
1.3.3: Provide free Oncology Nutrition Therapy consults and Nutrition 101 class to cancer patients and their caregivers (See 1.5.2)					1, 2, 3
Monitoring/Evaluation Approach: • Post food drive assessment • Document number of oncology consults • Document number of oncology nutrition 101 classes • Patient activity documented and reported within the ER Navigation electronic record system.					

Priority 1: Healthy Living

Goal 1: Encourage and foster healthy lifestyles through education, awareness and early detection to prevent illness.

Potential Partners:

- Fairhaven Food Panty
- Mission of Yahweh
- Meals on Wheels
- WIC
- American Cancer Society

Time for/Safety During Physical Activity Objective 1.4: Encourage healthy lifestyles through safe exercise practices					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of education sessions with youth sports organizations	4	5	5	8	4
• Number of people screened through IMPACT testing	177	84	84	1	177
• Number of attendees at cancer yoga classes	518	501	347	665	518
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.4.1: Partner with local youth sports organizations to provide safe sports health education to kids, parents and coaches (See 1.1.2)					1, 2, 3
1.4.2 Provide outreach trainer and/or physician coverage at select athletic events		Athletic Trainer not available to provide information		Athletic Trainer coverage provided – 425 served; Student Trainer Athletic workshop – 100 attended	1, 2, 3
1.4.3: Implement baseline IMPACT concussion testing with local youth sports organization					1, 2, 3
1.4.4: Provide free Monday/Wednesday Injury Clinics to treat young athletes		45 athletes were served during the time period of 8/1-12/14 and 1/9-5/29	24 athletes seen in FY18	The system no longer doing free injury clinics	1, 2, 3
1.4.5: Offer free yoga classes to cancer patients and their caregivers – open to the public (See 1.5.2)					1, 2, 3

Monitoring/Evaluation Approach:

- Document number of baseline IMPACT concussion tests performed
- Document number of people screened at injury clinics
- Document number of attendees at yoga classes

Potential Partners:

- Spring Branch ISD
- Spring Branch Memorial Sports Association
- Albion Hurricanes
- Memorial Boys LaCrosse
- Memorial Knights LaCrosse
- Post Oak Little League
- American Cancer Society
- IMPACT Concussion Testing

Chronic Disease Management Objective 1.5: Increase awareness to prevent the onset of chronic diseases as well as minimize the impact for patients who suffer from chronic illness					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Readmission rates for chronic disease - medicare patients (Acute Myocardial Infarction, Congestive Heart Failure, Penumonia, Chronic Obstructive Pulmonary Disease)	AMI: 14.1% CHF: 21% Pneumonia: 13.4% COPD: 15.4%	AMI 6.7% CHF 18.7% Pneumonia 14.4% COPD 12.8%	AMI: 23.8% CHF: 22% Pneumonia: 13.2% COPD: 16.7%	AMI: 10.9% CHF: 11.5% Pneumonia: 10.7% COPD: 14.8%	AMI: 12.69% CHF: 18.9% Pneumonia: 12.06% COPD: 13.86%
• Number of attendees at Mended Hearts	300	300	300	300	300
• Number of attendees at Lymphedema Support Group	20	71	59	69	20
• Number of attendees at Huntington's Disease Support Group	360	190	30	Program inactive	360
• Number of attendees at Stroke Support Group	120	180	45	149	130
• Number of attendees at CMT Support Group	240	129	Program inactive	Program inactive	240
• Number of attendees at Breast Cancer Support Group	58	101 English 58 Spanish	98 English; 126 Spanish	88 English; 121 Spanish	58
• Number of attendees at Oncology Prehab and Wellness	38	23	9	Included in the Lymphedema support Group	40
• Number of attendees at Techniques for Stress Relief Education	17	22	2	Class discontined	20
• Number of attendees at Self Guided Creative Healing Through Art	36	105	38	468	40
• Number of attendees at Self Guided Meditation	15	56	72	49	15
• Number of attendees at Look Good Feel Better	30	42	38	12	30
• Number of attendees at Creative Healing Through Art	166	190	202	468	166
• Number of people who participate in Fresh Start	27	16	14	11	27
• Number of free telephone medication management consultations	2,270	2,596	2,423	No longer providing service; clinic program was closed June 2018	2,270
• Number of reduced fee medication management clinic visits	20	32	64	0-no longer offering this service	20

Priority 1: Healthy Living

Goal 1: Encourage and foster healthy lifestyles through education, awareness and early detection to prevent illness.

Strategies:		Year 1 Notes	Year 2 Notes	Year 3 Notes	Timeline: Year 1,2,3
1.5.1:	Continue to offer support group services for chronic diseases (Mended Hearts, Lyphedema) and other conditions (Huntington's Disease, stroke, Charcot-Marie-Tooth, breast cancer).				1, 2, 3
1.5.2:	Continue to provide comprehensive cancer survivorship and education services (e.g. Look Good Feel Better, Art Therapy, etc.).		**Additional patients served total: 171** Better Breathers-7 Advance Directives- 7 Crochet and Knitting – 154 Zentangle Meditation - 3	**Additional patients served Total: 271** Advance Directives 4 Better Breathers -5 Crochet and Knitting -262	1, 2, 3
1.5.3	Provide discounted medication management clinic visits for self-pay for about 20 patients/year				
1.5.4:	Provide free smoking cessation education/classes at MHMC through Fresh Start program created by American Cancer Society				1, 2, 3

Monitoring/Evaluation Approach:

- Document number of attendees at each support group, cancer survivorship and cancer education class

Post class evaluation for freshstart smoking cessation

Potential Partners:

- American Heart/Stroke Association
- American Cancer Society
- Houston Aphasia Recovery Center
- Memorial Drive Methodist Church
- Charcot Marie Tooth Association
- Cancare
- TIRR

Priority 2: Access to Health Care

Priority 2: Health Care Access **Goal 2: Improve community knowledge about health care access points and reduce perceived barriers to care.**					
Availability of Primary Care and Specialty Providers **Objective 2.1: Educate community on how to access primary care and specialty resources for the most cost effective care**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (MH Memorial City – Fort Bend and Harris)	31,071	28,624	32,616	32,216	31,071
• Number of patients enrolled in the ER Navigation Program	1,038	1388	1255	1452	1,038
• Number of ER Navigation patient encounters	2,179	3678	3836	2011	2,179
• Number of ER Navigation referrals to community resources	2,855	4205	3804	4143	2,855
• Number of ER Navigation scheduled appointments	200	255	123	104	200
• Utilization of the Emergency Center for non-emergent care (patients screened out, not charged and referred to a neighborhood clinic)	2,100	2000	Social worker no longer provide services in the ER	Social worker no longer provide services in the ER	2,100
• Number of navigational meetings regarding financials and community resources	222	0	0	No longer tracking	222
• Number of Telemedicine Consultations	240 (in 2015)	218	233	387	240
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.1.1: Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the MHHS community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources.) (See 2.4.1)					1, 2, 3
2.1.2 Continue to participate in the MH ER Navigation program in which patients are referred to a medical home (See 1.3.1, 2.4.2)					1,2,3
2.1.3: Employ social worker in the ER to direct care for uninsured, including connecting patients to Harris County Gold Card application to access care through County clinics and refering them to neighborhood clinics for follow up care (See 2.4.3)			Social worker no longer provide services in the ER	Social worker no longer provide services in the ER	1, 2, 3
2.1.4: Utilize Nurse Navigators (cancer services, digestive health) to direct community to appropriate resources based on ability to pay (See 2.4.4)				No longer tracking	1, 2, 3

Priority 2: Health Care Access **Goal 2: Improve community knowledge about health care access points and reduce perceived barriers to care.**				
2.1.5: Provide 24/7 neurological consultations for Memorial City 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	218	233	387	1, 2, 3
Monitoring/Evaluation Approach: • Nurse Health Line data • Monthly evaluation of case management referrals • Nurse Navigator resource referrals				
Potential Partners: • Nurse Health Line • Harris County Hospital District • Neighborhood Health Center • Spring Branch Community Health Center • Houston Area Community Services • Legacy Clinic • El Centro de Corazon • IBN Sina Foundation • Memorial Hermann Community Benefit Corporation				

Health Insurance Coverage and Costs

Objective 2.2: Improve awareness among providers and community on available resources for cost effective insurance coverage and other free/low-cost health services

Outcome Indicators:	Baseline	Year 1	Year 2	Year 3	FY 2020 Target
Amount of annual prescription expense provided to those in need	$6,231	$315	$35,658	9,620	$6,321
Amount spent on room and board for nursing home and rehab	$116,351	$0	$63,981	$37,322	$116,351
Number of wigs/prostheses distributed	12 wigs 28 prostheses	15 wigs 12 protheses	18 wigs 16 protheses	6	12 wigs 28 prostheses
Number of containers donated to Project C.U.R.E.	192 bins	528 (mix of pallets, bins, bags, barrels and cans	277	261	192 bins

Strategies:	Year 1 Notes	Year 2 Notes	Year 3 Notes	Timeline: Year 1,2,3
2.2.1: Continue to contract with Allegis to assist patients in finding health care insurance coverage	Program continued	Program continued	New Company or Company change name but the Program continues	1, 2, 3
2.2.2: Provide short-term medications/prescriptions upon discharge for uninsured			$9,619.47	1, 2, 3
2.2.3: Provide skilled nursing services upon discharge for those awaiting medicaid approval	$7,000	$1,620	$204, 112.06	1, 2, 3
2.2.4 Provide short-term home health infusion thearpy services (IV antibiotics) for uninsured	$2,920	$24,438	$32, 001.94	1, 2, 3
2.2.5 Provide post hospitalization follow-up visit for uninsured			occurred	
2.2.6: Offer free breast prostheses and wig closet for cancer patients				1, 2, 3
2.2.7: Coordinate Project C.U.R.E. for used medical equipment to serve those in need				1, 2, 3

Monitoring/Evaluation Approach:

- Document number of referrals to Allegis
- Document cost of prescriptions
- Document number of wigs and prostheses distributed

Priority 2:	**Health Care Access**
Goal 2:	**Improve community knowledge about health care access points and reduce perceived barriers to care.**

Potential Partners:

- Allegis
- Memorial Assistance Ministries
- American Cancer Society
- Memorial Hermann Home Health
- Neighborhood Health Center
- Legend Oaks West Houston
- Walgreens
- Memorial City Health and Rehab Center
- Coram Alternative Site Services
- Metropolitan Orthopedic
- American Medical Direct
- Highland Park Care Center

Transportation **Objective 2.3: Decrease limitations to health care access to due to lack of transportation**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
Number of yellow cab transportation vouchers distributed	300	264	339 Yellow cab 816 bus	350 patients/ $12,411,16	300
Number of patients provided with free ambulance transportation	420	744	1,063	275 patients/ $231,076.01	420
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline:** **Year 1,2,3**
2.3.1: Provide yellow cab transportation for uninsured or those without family/friend assistance					1, 2, 3
2.3.2: Provide ambulance transportation to uninsured or those without family/friend assistance so they may go to the next level of care					1, 2, 3
Monitoring/Evaluation Approach: • Document transportation costs for those who cannot pay • Document number of vouchers distributed					
Potential Partners: • METRO • Yellow Cab					

Health Care Navigation **Objective 2.4: Connect patients to appropriate community health resources to help them navigate their health care journey**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
Number of hospital's associated counties' calls to Nurse Health Line (MH Memorial City – Fort Bend and Harris)	31,071	30,915	32,616	32,216	31,071
Number of patients enrolled in the ER Navigation Program	1,038	1388	1255	1452	1,038
Number of ER Navigation patient encounters	2,179	3678	3836	2011	2,179
Number of ER Navigation referrals to community resources	2,855	4205	3804	4143	2,855
Number of ER Navigation scheduled appointments	200	255	123	104	200
Number of referrals to neighborhood clinics by social workers	120	2000	X ref 2.1.3- discontinued	X ref 2.1.3 - discontinued	120
Number of navigational meetings regarding financials and community resources	222	Service provided by ER Navigation (CHW services reflected above)	Service provided by ER Navigation (CHW services reflected above)	Service provided by ER Navigation (CHW services reflected above)	222
Number of new mothers referred to WIC and other resources	975	1,103	1,175	1143	975

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**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 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: Employ social worker in the ER to direct care for uninsured, including connecting patients to Harris County Gold Card application to access care through County clinics and refering them to neighborhood clinics for follow up care (See 2.1.3)				1, 2, 3
2.4.4: Utilize Nurse Navigators (cancer services, digestive health) to direct community to appropriate resources based on ability to pay (See 2.1.4)				1, 2, 3
2.4.5: Provide lactation consultant provides navigation services to self-pay new mothers to connect them with WIC and other organizations who can provide free or reduced services				1, 2, 3

Priority 2: Health Care Access **Goal 2: Improve community knowledge about health care access points and reduce perceived barriers to care.**
Monitoring/Evaluation Approach: • Patient activity documented and reported within the ER Navigation electronic record system • Nurse Health Line call log • Social worker records • Nurse Navigator records • Lactation consultant records
Potential Partners: • Harris County Hospital District • WIC • American Cancer Society • American Heart/Stroke Association • Nurse Health Line • Spring Branch ISD • Spring Branch Community Health Center • Legacy Health Community Center • Houston Area Community Services • Thomas Street Clinic – Harris Health • El Centro de Corazon • IBN Sina Foundation

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 Memorial City 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**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Decrease in number of ER encounters that result in psychiatric inpatient stay	1,146	1,213	1,135	1,687	1,089% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay – Memorial City	143	126	141	161	136
• Number of MHCC Memorial Hermann Crisis Clinic total visits	5,400	5,590	5,154	4,702	5% over baseline
• Number of Psychiatric Response Care Management total visits	1,200	1,103	1,259	1,646	5% over baseline
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
3.1.1: Provide mental health assessment, care, and linkage to services in an acute care setting, 24x7 at Memorial City.		An uptick in acute care volume over the past fiscal year has contributed to a higher number of psychiatric transfers overall.	An increase in acute care volume and number of acute care sites over the past fiscal year have contributed to a higher number of psychiatric transfers overall.	An increase in acute care volume and number of acute care sites over the past fiscal year have contributed to a higher number of psychiatric transfers overall.	1,2,3

Priority 3:	**Behavioral Health**				
Goal 3:	**Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.**				
3.1.2:	Create nontraditional community access to psychiatric providers for individuals experiencing a mental health crisis. Clinical Social Workers connect the target population to on-going behavioral health care		Recruiting mental health providers willing to commit to a non-traditional schedule remains a challenge. Continuing this urgent care model of treatment remains a priority, due to limited mental health treatment access in the community.	Continuing this urgent care model of treatment to include nontraditional hours remains a priority, due to limited mental health treatment access in the community. Innovative strategies and quality measures have been implemented to enhance best practices and support sustainability measures.	1,2,3
3.1.3:	Engage individuals with a chronic mental illness and work to maintain engagement with treatment and stability in the community via enrollment in community-based mental health case management program	Staffing issues impeded year one target. Identifying appropriately licensed clinicians willing to consider a career that is community based with the requirement of making home visits and working non – traditional hours is an ongoing challenge.	Case Managers partner with their clients to identify specific recovery goals and utilize evidence-based practices to facilitate client achievement. We continue to partner with community providers to address the mental health needs of the Greater Houston Community.	Case Managers partner with their clients to identify specific recovery goals and utilize evidence-based practices to facilitate client achievement. We continue to partner with community providers to address the mental health needs of the Greater Houston Community.	1,2,3

Monitoring/Evaluation Approach:

- EMR/registration system (track and trend daily, weekly, monthly)

Potential Partners:

- System acute care campuses
- Memorial Hermann Medical Group
- Network of public and private providers

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**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of presentations/educational sessions for healthcare professionals within MHHS	50 sessions per year	63	71	121	5% increase over baseline
• Number of presentations/educational sessions for corporations	5	7	8	6	5% over baseline
• MH Memorial City EEG Department Training (total time includes training material development and implementation)	1 training (4 hours)	0	0	0	1 training (4 hours)
• Training on Acute Care Concepts - system nurse resident program	15 trainings (45 hours total/ 3 hours each)*	18	9	5 trainings (20 hours total/ 4 hours each)	15 trainings (45 hours total/3 hours each)*
• Training on CMO Roundtable - system-wide	1 training (2 hours)*	0	4	0	1 training (2 hours)*
*Total time includes training material development and implementation		531.6			
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
3.2.1: Provide mental health education sessions within the MH health system for nurses and physicians					1,2,3
3.2.2: Work with employer solutions group to provide education and training with corporations on MH topics (stress, PTSD)					1,2,3
Monitoring/Evaluation Approach: • Requests for presentations and sessions tracked via calendar/excel					
Potential Partners: • System acute care campuses • System Marketing and Communications • Employer solutions group					

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**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of Memorial Hermann Crisis Clinic follow-ups post discharge with clinic patients	7,716	6,431	5,154	4,702	5% over baseline
• Psychiatric Response Case Management reduction in system ER utilization	54.4%	53.0%	50%	51%	5% increase over baseline
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
3.3.1: Social workers follow-up with discharged patients and their families to assess well-being and connect them to community resources		The goal is to continue to educate the community, including other health systems, about the crisis clinic level of care so that when someone is experiencing a mental health crisis or needs immediate access to a behavioral health provider, the clinic will be the identified referral source.	The System has seen an overall increase in patient acuity with complex physical and behavioral health needs requiring higher levels of care. The Crisis Clinic and Psych Response Case Management Programs continue to meet the needs of patients with behavioral health conditions by providing immediate access to a mental health provider.	The Crisis Clinic and Psychiatric Response Case Management programs continue to see difficult and challenging patients with increased complex social needs. As the system has grown, there has been an overall increase in patient acuity and patients with complex health co-morbidity.	1,2,3

Priority 3:	**Behavioral Health**				
Goal 3:	**Ensure that all community members who are experiencing a mental health crisis have access to appropriate psychiatric specialists at the time of their crisis, are redirected away from the ER, are linked to a permanent, community based mental health provider, and have the necessary knowledge to navigate the system, regardless of their ability to pay.**				
3.3.2:	Psychiatric Response Case Management Program utilizes evidence-based practice interventions (motivational interviewing, MH First Aid, CAMS, etc.) to reduce ER utilization for program enrollees		Case Managers continue to partner with community agencies in an effort to connect program enrollees to resources for ongoing wellness. Program clinicians continue to use evidence-based practice interventions to reduce ER utilization and improve quality of life.	Case Managers continue to partner with community agencies in an effort to connect program enrollees to resources for ongoing wellness. Program clinicians continue to use evidence-based practice interventions to reduce ER utilization and improve quality of life.	1,2,3

Monitoring/Evaluation Approach:

- Social work logs (Excel spreadsheet)

Potential Partners:

- System acute care campuses
- Community-based clinical providers
- Network of public and private providers