Memorial Hermann Health System

Memorial Hermann Texas Medical Center

Community Benefits Strategic Implementation Plan 2016

September 20, 2016

MEMORIAL® HERMANN

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 Memorial Hermann Texas Medical Center

Located in the heart of the Texas Medical Center in Houston, Memorial Hermann Texas Medical Center (hereafter MH Texas Medical Center) has been caring for families since 1925. Memorial Hermann Texas Medical Center is the primary teaching hospital for The University of Texas Health Science Center at Houston and provides leading-edge care in heart, neuroscience, orthopedics, pediatrics, women's health, general surgery, and organ transplantation. MH Texas Medical Center is also home to the Memorial Hermann Heart and Vascular Institute, which provides world-class care and innovations. As a Level I state designated trauma facility for both adults and children, and through Memorial Hermann Life Flight, MH Texas Medical Center cares for the most critical and urgent medical emergencies in a 150-mile radius in the Greater Houston area.

The Memorial Hermann Texas Medical Center Community

MH Texas Medical Center's community includes the counties of Harris, Brazoria, Fort Bend, Liberty, and Matagorda. MH Texas Medical Center defines its community geographically as the top 50% of zip codes corresponding to inpatient discharges in fiscal year 2015. These selected zip codes correspond to 16 cities and towns in the counties of Brazoria, Fort Bend, Harris, Liberty, and Matagorda. The large majority of MH Texas Medical Center inpatient discharges in fiscal year 2015 occurred among residents of Harris County (83.1%); only a small proportion of inpatient discharges occurred among Liberty County (1.3%) or Matagorda County (1.1%) residents.

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 TEXAS MEDICAL CENTER

To ensure that MH Texas Medical Center's community benefit activities and programs are meeting the health needs of the community, MH Texas Medical Center conducted a Community Health Needs Assessment (CHNA) to prioritize the health needs of its community, delineated using geographic cut-points based on its main service area.

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 Texas Medical Center's diverse community.

PRIORITY COMMUNITY NEEDS FOR MH TEXAS 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 Texas Medical Center.

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 Texas Medical Center, 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 TIRR, 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 Texas Medical Center CHNA and Strategic Implementation Plan Work Group

- Sara Abbott, Injury Prevention Coordinator & Outreach Education
- Ellen Bubak, Director of Hospital Operations
- Sheila Gibson, Manager, Case Management
- Rebecca Hamilton, Manager, Patient Business Services
- Brian Keys, Administrative Fellow
- Toni Vonwenckstern, Administrative Director, Trauma

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 TEXAS MEDICAL CENTER STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living **Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.**					
Early Detection and Screening **Objective 1.1: Decrease mortality in the community, especially for vulnerable populations, through prevention, early detection and screening of key risk factors**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Total number of community members educated through programs	5,308	8,847	4641	6953	5,838
• Number of free child safety seats distributed	100	81	74	139	150
• Number of Emergency Room (ER) patients screened for (Hepatitis C and Human Immunodeficiency Virus (Hep C and HIV)	5,354	7982-HIV 5,510 – HEP C	We do perform routine screening for HIV in the ED for patients aged 18-65 who are able to opt out. We re-started the program in late 2017. 2017 tested = 2366 Jan 2018-May 2018 = 2411 **Total: 4777** We previously performed HCV screening through a grant from Gilead Pharmaceuticals but not at this time.	9002	5,621

Priority 1: Healthy Living **Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.**					
• Percent of patients tested for (Hep C and HIV) referred for therapy	1.68%	100% of patients tested for Hep C and HIV referred for therapy	Percentages are calculated using total positives, not total tests done since that would lead to very small percentages and we don't refer negative results to therapy. 21.1% HIV patients referred to therapy 63.2% HIV patients found to already be in care and receiving therapy 84.3% HIV patients in total receiving therapy for diagnosis. 15.7% HIV patients not receiving any form of therapy.		1.68%
• Number of research studies related to prevention, early detection, or screening	26	48	45	58	29
• Number of study subjects enrolled	1,798	No active studies	156	783	1,977
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.1.1: Implement Live Your DREAMS, a multi-level, varying intensity approach, injury prevention program to include community, classroom and hospital-based education and training. Collaboration with community partners re: traffic safety (Graduated Drivers Licensing, increase seat belt use, reduce impaired and distracted driving among teens)					1,2,3
1.1.2: Coordinate child safety seat distribution and education program for low income families					1,2,3

1.3:	Provide infant safety curriculum to University of Texas (UT) School of Nursing students in the Newborn and New Parent Care program to educate pregnant and parenting teens to increase preventative behaviors (topics include: Safe sleep, water safety, child passenger safety, Period of Purple shaken baby syndrome/brain trauma, crying, postpartum depression, nutrition, etc.)		School of Nursing request to redirect program	We have continued to be involved in community outreach, task force and coalitions in regards to infant safety. Unfortunately our faculty source resigned with UT. We have done outreach in the form of infant safety classes with one of our EMS partners; Harris County Emergency Corps. We had 10 new mother-to –be in our class on 10/19/19. We are actively involved in the Safe Sleep workgroup from the Harris County Child Fatality Committee. We are also actively encouraging infant and child related topics to pitch to Media via Communications team. We have also established the Injury Free for Kids Coalition site in partnership with UT Department of Pediatrics. Acceptance letter received on 12/4/2019.	2,3

Priority 1: Healthy Living **Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.**				
1.1.4: Test ER patients for HIV and HEP C for early identification and immediate treatment			9002 HIV Screening tests	1,2,3

Priority 1: Healthy Living **Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.**					
1.1.5:	Continue education and outreach related to stroke prevention and early detection by conducting the following: • monthly Stroke Support Group • highlight Stroke Month in May every year - educating employees and patients on how to quickly identify and respond to stroke • create and distribute Stroke Prevention Brochures; • provide financial support to Stomp Out Stroke (a community event focused on stroke education, screening, and prevention) • host healthy cooking classes, free to the community, to promote brain health (with Monica Pope and Food as Medicine) • Host Yatsu Day – a Stroke Continuing Medical Education event for healthcare providers			TMC support group meets the third Wednesday of every month with 5-8 average attendees. Stroke Month was cancelled due to flood in May. Was rescheduled for June 8th and became a part of Stomp Out Stroke Festival. Went to Discovery Green and provided health screenings, assessments and education. Approximately 1000 attendees. Developed stroke prevention brochures to be handed out at community events and on campus Had dietician come to support group meetings to talk about diet guidelines for stroke patients. 11th Annual Yatsu Day Women and Stroke Evaluation and Treatment of Cerebrovascular Disease. Approximately 200 attendees.	1,2,3

Priority 1: Healthy Living **Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.**				
1.1.6: Continue to support research activities to decrease mortality through prevention, early detection, and screening of key risk factors		45 research studies related to prevention, early detection, and screening. 156 study subjects were enrolled in these studies.	Unavailable	1,2,3
Monitoring/Evaluation Approach: • Participation lists for education programs • Roster and released signed for car seats • Release from parents on helmet distribution/inventory levels • Clinical research database • Documentation through Hep C and HIV grant program.				
Potential Partners: • Texas Department of Transportation, Department of State Health Services (DSHS) • Child Fatality Review Team, Children at Risk • Local high schools • SouthEast Texas Regional Advisory Council (SETRAC), Governor's EMS & Trauma Advisory Council (GETAC • Safe Kids Greater Houston • UT School of Nursing • Community partners for Traffic Safety (Watch UR BAC, Houston Fire Department (HFD), Department of Public Safety (DPS), Krysta's Karing Angels, Mothers Against Drunk Driving (MADD), State Farm, etc.)				

Priority 1: Healthy Living

Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.

Obesity Prevention

Objective 1.2: Support efforts of local community partners in preventing or reducing obesity in adults and children

Outcome Indicators:	Baseline	Year 1	Year 2	Year 3	FY 2020 Target
• Number of events supported	0		Planned for FY19	Bariatrics Monthly (11 times) Support Group held at UT MIST clinic for patients and potential new patients.	2

Strategies:	Year 1 Notes	Year 2 Notes	Year 3 Notes	Timeline: Year 1,2,3
1.2.1: Provide financial support and/or staffing for events hosted by community partners that provide education and outreach in reducing or preventing obesity	Planned for FY19	Planned for FY19	Monthly support groups for Bariatrics.	2,3

Monitoring/Evaluation Approach:

- Feedback from community partners

Potential Partners:

- Children at Risk
- Houston Food Bank
- United States Department of Agriculture (USDA)
- Centers of Disease Control (CDC)
- Texas Department of Agriculture
- Texas Medicaid/Children's Health Insurance Program (CHIP) programs

Priority 1: Healthy Living

Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.

Access to Healthy Food

Objective 1.3: Support efforts of MH system and local community partners in improving the community's access to healthy food

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of ER patients screened for food insecurity via the ER Navigation program	1,881	3081	2524	2507	1,881
• Number of community health worker (CHW) referrals to community food pantries via the ER Navigation program	189	524	792	209	189
• Number of ER Navigation program supported community events hosted by local partners	0 (to be determined in Y1)	0	20	2	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)				1,2,3
1.3.2: Collect food to support food pantries or special events hosted by community partners.				1,2,3

Monitoring/Evaluation Approach:

- Patient activity documented and reported within the ER Navigation electronic record system
- Record of events attended

Potential Partners:

- Houston Food Bank
- United Way
- Greater Grace Outreach Church
- Gulf Coast Community Services Association, Inc.
- Interfaith Ministries
- Leonel Castillo Community Center
- DePelchin Children's Services
- Memorial Hermann Community Benefit Program

Priority 1: Healthy Living

Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.

Time for/Safety During Physical Activity
Objective 1.4: Increase education and resources/tools to promote safety during physical activity

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Total number of community members educated through programs	1,180	625	Planned for FY19	Program did not occur due to lack of funding	1,298

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.4.1: Provide community education outreach to elementary grade students highlighting bicycle helmet safety. Host annual event re: injury prevention for elementary grade students				2,3
1.4.2: Provide education on safety and prevention topics to Boy Scouts as part of earning their safety merit badge				2,3
1.4.3: Provide community education outreach and training program for parents on water sports safety, heat, and proper hydration				2,3
1.4.4: Provide exercise instruction workshops for teens at local high schools				2,3

Monitoring/Evaluation Approach:
- Signed releases for helmets
- Attendance rosters

Potential Partners:
- Boy Scouts of America
- Houston-Galveston Area Council (H-GAC)
- Greater Houston Off Road Biking Association
- YMCA of Houston, Harris County Aquatic Program
- Texas Drowning Alliance, USA Swimming foundation
- Houston Independent Pool and Spa Association

Priority 1: Healthy Living **Goal 1: Provide community members with the necessary information and resources to make informed choices for sustained healthy living.**					
Chronic Disease Management **Objective 1.5: Connect community members to appropriate resources and care settings to facilitate chronic disease management.**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Brazoria, Fort Bend, Harris, Liberty, and Matagorda)	32,698	32,907	34,459	33,954	32,698
• 30-day all-cause readmission rate (excluding trauma patients)	6.70%	6.65	6.08%	Rolling 12 months: 9.77% FYTD: 9.08%	5%
Strategies:					
1.5.1: Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the Memorial Hermann Health System (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 and 2.4.1)					1, 2, 3
Monitoring/Evaluation Approach: • Report from the Nurse Health Line in TMC community • Hospital readmission data from cost accounting system					
Potential Partners: • Memorial Hermann Care Management • Memorial Hermann Community Benefit Corporation					

Priority 2: Access to Health Care

Priority 2: Health Care Access **Goal 2: Improve health care access to provide better health outcomes.**					
Availability of Primary Care and Specialty Providers **Objective 2.1: Ensure availability of primary care and specialty providers to maintain Level One Trauma Center status**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Brazoria, Fort Bend, Harris, Liberty, and Matagorda)	32,698	32,907	34,459	33,954	32,698
• Percentage of inpatient and observation patients discharged by hospitalist service	13.5%	13.35%	7.7%	Inpatient – Hospitalist – 6,783 Total cases – 25,958 % of Ttl – 26.1% Observation – Hospitalist – 106 Total cases – 6,017 % of Ttl – 1.8%	15%
• Number of trauma divert hours	223	34 hours	14.5 hours	61.03 hours (0.7%) during fiscal year 2019.	200
• Number of transfer denials due to capacity because services not available	105	88	194	Capacity – no beds: 2,949 Capacity – staffing: 1 ER divert status: 367 Grand total: 3317	84
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 1.5.1 and 2.4.1)					1, 2, 3

Priority 2: Health Care Access **Goal 2: Improve health care access to provide better health outcomes.**					
2.1.2:	Partner with Memorial Hermann Medical Group (MHMG) to increase the number of primary care physicians in the region affiliated with MHHS. Includes succession planning and placement to fill vacancies based on volume/openings.	12 candidates were interviewed and placed around the TMC market in FY17			1
2.1.3:	Maintain agreements with UT and other private practice physicians to ensure adequate number of specialty providers related to Level I trauma status serving under and uninsured populations	We renewed the FY17 Annual Funding Agreement (AFA) to ensure proper support to University of Texas for our Trauma Program. We've continued to mmet and maintain the guidelines of the American College of Surgeons for our Level 1 Trauma Designation	We renewed the FY17 Annual Funding Agreement (AFA) to ensure proper support to University of Texas for our Trauma Program. We've continued to meet and maintain the guidelines of the American College of Surgeons for our Level 1 Trauma Designation	We renewed the FY17 Annual Funding Agreement (AFA) to ensure proper support to University of Texas for our Trauma Program. We've continued to meet and maintain the guidelines of the American College of Surgeons for our Level 1 Trauma Designation	1
Monitoring/Evaluation Approach: • Hospital financial accounting by discharging physician • Trauma database of diversion hours • System Transfer Center • Alegis					
Potential Partners: • University of Texas Health Science Center at Houston • Memorial Hermann Medical Group					

Priority 2: Health Care Access

Goal 2: Improve health care access to provide better health outcomes.

Health Insurance Coverage and Costs

Objective 2.2: Educate patients about and/or help them to acquire healthcare insurance to ensure needs are addressed, coverage is continuous, and benefits are optimized

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of Class D Prescriptions provided to the Lamar and Alief School Based Health Centers	1,324	1141	1065	803	1,324
• Number of length of stay outliers (outliers - over the total charge threshold defined by Medicare)	1,704	3,500 for all TMC, 1896 for adult, 753 for children	3,627 for all TMC, 1122 for children, 58 for trans care	2,684 adult cases 697 children cases Total=3,381	1,534
• 30-day all-cause readmission rate (excluding trauma patients)	6.70%	8.9%	10.4%	Rolling 12 months: 9.77% FYTD: 9.08%	5%
• Number of case conversions from unfunded to funded	5,600	3,981	3154	Unavailable	6,160

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.2.1: Provide Class D Prescriptions to the Lamar and Alief School Based Health Centers in support of primary medical care provided to uninsured children and teens at no cost				1, 2, 3
2.2.2: Financial counseling team works with inpatients regarding options re: Health Exchange, COBRA, County Indigent, Crime Victim; also have on site Medicaid workers and facilitate Medicaid applications				1

Monitoring/Evaluation Approach:

- Patient experience scores re: coordination of care
- Percentage of patients classified as “Self Pay”
- Hospital case management length of stay outlier report
- Hospital case management case conversion report

Potential Partners:

- Texas DSHS
- Centers of Medicare & Medicaid Services (CMS)
- Memorial Hermann Community Benefit Corporation

Priority 2: Health Care Access

Goal 2: Improve health care access to provide better health outcomes.

Transportation

Objective 2.3: Ensure patients are transported to the next level of care or to their final destination in a timely, safe, and cost-effective a manner

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Cost of subsidized transportation	$597,000	$745,009	$887, 434	$561,545	$597,000

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.3.1: Participate in system relationship with American Medical Response (AMR) ambulance company and Yellow Cab to triage transportation options based on patient needs (insurance benefit or subsidized by TMC)				1,2,3
2.3.2: Provide Life Flight or other plane programs free of charge to transport long distance patients				1,2,3
2.3.3: Provide bus tokens for Greyhound and discharge home				1,2,3

Monitoring/Evaluation Approach:

- Case Management non-resource fund cost center

Potential Partners:

- AMR Ambulance
- Yellow Cab
- Greyhound Bus

Priority 2: Health Care Access

Goal 2: Improve health care access to provide better health outcomes.

Health Care Navigation

Objective 2.4.: Connect uninsured patients without a primary care provider who access the ER for lower acuity conditions with a medical home

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Brazoria, Fort Bend, Harris, Liberty, and Matagorda)	32,698	32,907	34,459	33,954	32,698
• Number of patients enrolled in the ER Navigation Program	2063	2929	2337	2347	2063
• Number of ER Navigation patient encounters	4275	7784	6343	3265	4275
• Number of ER Navigation referrals to community resources	3426	5605	4856	3962	3426
• Number of ER Navigation scheduled appointments	380	292	171	138	380

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 1.5.1 and 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

Monitoring/Evaluation Approach:

- Patient activity documented and reported within the ER Navigation electronic record system

Potential Partners:

- Memorial Hermann Community Benefit Corporation
- Memorial Hermann Care Management
- Central Care Community Health Center
- Legacy Community Health Center
- 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 Texas Medical Center 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	1146	1,213	1,135	1,687	1089 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay - Children's	30	19	18	10	29
• Decrease in number of ER encounters that result in psychiatric inpatient stay - Hermann	173	180	115	193	164
• Number of Memorial Hermann Crisis Clinic (MHCC) 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 Children's and Hermann		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 Herman 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**	**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
• 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 Chief Medical Officer (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, post-traumatic stress disorder)				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**	**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
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

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.**

Monitoring/Evaluation Approach:

- Social work logs (Excel spreadsheet)

Potential Partners:

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