Memorial Hermann Health System

Memorial Hermann Katy Hospital

Community Benefits Strategic Implementation Plan 2016

September 20, 2016

MEMORIAL HERMANN

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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:

Deborah Ganelin
Associate Vice President, Community Benefit Corporation
Email: Deborah.Ganelin@memorialhermann.org
909 Frostwood Avenue, Suite 2.205
Houston, TX 77024

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 Katy Hospital

Located in Katy, Memorial Hermann Katy Hospital (hereafter MH Katy) has been caring for families since 1981. Memorial Hermann Katy employs state-of-the-art technology and a team of highly trained affiliated physicians to offer world-class care close to home. Some of these programs include the Memorial Hermann Katy Emergency Room, a fully-accredited Chest Pain Center, and specialty services including orthopedics, women's and children's services, heart and vascular services, sports medicine and rehabilitation, diabetes self-management, and advanced diagnostic imaging. As the only Level IV state designated trauma facility in Katy and through Memorial Hermann Life Flight service, MH Katy is equipped to stabilize patients for transfer to Memorial Hermann-Texas Medical Center for Katy's most critical and urgent medical emergencies.

The Memorial Hermann Katy Hospital Community

MH Katy's community encompasses four counties: Austin, Fort Bend, Harris, and Waller. MH Katy defines its community as the top 75% of zip codes corresponding to inpatient discharges in fiscal year 2015. These selected zip codes correspond to the communities of Brookshire, Fulshear, Houston, Katy, Richmond, and Sealy within the Counties of Austin, Fort Bend, Harris, and Waller. A large majority of MH Katy inpatient discharges in fiscal year 2015 occurred among residents of Harris County (57.3%) and Fort Bend County (31.7%); only a small proportion of inpatient discharges occurred among Austin County residents (5.6%) or Waller County (5.4%). At a city level, most MH Katy inpatient discharges occurred among residents of Katy (73.4%) followed by Houston (8.6%).

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 KATY HOSPITAL

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

PRIORITY COMMUNITY NEEDS FOR MH KATY 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 critria, 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 Katy.

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 Katy, and the other twelve MHHS hospitals (MH Greater Heights, 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 Katy CHNA and Strategic Implementation Plan Work Group

- Aaron Bayles, Chest Pain and Stroke Program Coordinator
- Christa Clifton, Director of Business Development
- Diana Schauer-Tran, Marketing Director
- Sandra Moses, Director of Finance
- Nichole Rydahl, Director of Business Development

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 KATY HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: Healthy Living **Goal 1: Improve the health of our community by providing resources and strategies for healthy living.**					
Early Detection and Screening **Objective 1.1: Increase screening and early detection resources in our community**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of early detection resources distributed	500/year	2,325	304	8,361	1000/year
• Number of people screened in community outreach programs	100/year	125	55	75	250/year
• Number of people participating in activities or events (number of staff members who participate and number of community member participants)	2,500/year	42,191	7,365	13,337	7,500/year
• Number of student athlete heart screenings	20	18	31	24	20
• Number of concussion testing	733	540	263	151	500
• Flu shots at hospital health fair	100	0	0	0	200
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.1.1: Provide screenings for head and neck cancer. Screenings will be provided at no cost					1, 2
1.1.2: Provide discounted heart screenings to student athletes					1,2,3
1.1.3: Provide concussion screenings for student athletes in high-impact sports					1,2,3
1.1. Provide free flu shots at hospital health fair		No information available	We were not able to provide flu shots this year	We were not able to provide flu shots this year	2,3
Monitoring/Evaluation Approach: • Track resources distributed • Student rosters for screenings • Count of kits • Surveys					

Priority 1:	**Healthy Living**
Goal 1:	**Improve the health of our community by providing resources and strategies for healthy living.**

Potential Partners:

- Schools including Katy ISD, Faith West
- YMCA
- Christ Clinic
- Senior Group (possibly AARP)
- UT Cardiology
- Private Physicians
- Sport Organizations (i.e., Katy Cavaliers)

Priority 1: Healthy Living **Goal 1: Improve the health of our community by providing resources and strategies for healthy living.**					
Obesity Prevention **Objective 1.2: Reduce obesity in the community**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of educational information distributed (nutrition, diabetes, BMI, etc.)	1,000/year	2,325	5,135	9,000	5,000/year
• Number of people attending monthly weight loss seminar	20/year	11	18	7	36/year
• Number of people attending healthy shopping events at grocery stores	20	0	0	0	20/year
• Number of children attending workshop about healthier diet choices	Establish baseline in Year 1	0	30	0	100/year
• Number of children attending Katy High School Running program	Establish baseline in Year 1	0	25	0	TBD
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.2.1: Collaborate with Friends of Sundown/Attack Poverty to develop a healthy eating workshop and provide speakers on the topics of obesity, diabetes and exercise for children					1, 2
1.2.2: Conduct free monthly weight loss seminars				Physician support for these programs stopped	1,2,3
1.2.3: "Walk with a Doc": collaborate with doctor who walks around lake with patients and engages in informal educational conversation.(See 1.4.3)		Event was cancelled	This event did not happen this year		1,2,3
1.2. 4: Conduct free workshop about healthy eating and exercise for kids 8-12 years of age			We are holding these classes in FY19 and report at year end	Were not able to allocate resources to implement this program	2
1.2. 5: Provide trainers and education in support of the Katy High School running program, which includes low income, at-risk kids		Reached out to Katy HS running program and reassessing		Program did not come to fruition, decided to move in another direction	1, 2, 3

Priority 1: Healthy Living **Goal 1: Improve the health of our community by providing resources and strategies for healthy living.**
Monitoring/Evaluation Approach: • Attendance records • Survey • Participation records from workshops/seminars
Potential Partners: • Katy ISD • American Hospital Association (Walk a Doc) • Fit • Attack Poverty • University of Texas

Priority 1: Healthy Living **Goal 1: Improve the health of our community by providing resources and strategies for healthy living.**					
Access to Healthy Food **Objective 1.3: Increase awareness as well as access to healthy food in our community**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of educational information materials distributed (nutrition, diabetes, BMI, etc.)	1,000/year	80	865	9,000	5,000/ year
• Number of people attending workshop on how to plan, purchase and prepare	0	0	0	69	100/year
• Number of people attending grocery shopping events	0	0	0	0	20/year
• Number of ER patients screened for food insecurity via the ER Navigation program	884	1,113	1,208	222	884
• Number of CHW referrals to community food pantries via the ER Navigation program	133	136	172	20	133
• Number of supported community events hosted by local partners via the ER Navigation program	0	0	6	Planned ER Navigation Diabetic Education provided by Hosptial Dietitians	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				MH ER Navigation program at Katy was discontinued 9/2018; returned 10/19	1,2,3
1.3.2: Collect food to support food pantries or special events hosted by community partners					1,2,3

Priority 1:	**Healthy Living**				
Goal 1:	**Improve the health of our community by providing resources and strategies for healthy living.**				
1.3.3:	Conduct the Heart Healthy program, which provides staff to go grocery shopping with diabetic patients and provide recipe cards		There are plans to do this in FY 19	While this program did not occur, we created recipe cards and host a farmers market 1x a month	2 or 3
1.3.4:	Distribute flyer about nutrition and BMI to school nurses, at health fairs and grocery store events	No information available			1, 2, 3
1.3.5:	Develop and conduct workshop on how to plan, purchase and prepare healthy meals	No information available			2, 3

Monitoring/Evaluation Approach:

- Attendance
- Survey
- Number of flyers distributed
- Patient activity documented and reported within the ER Navigation electronic record system

Potential Partners:

- HEB (grocery store)
- Community associations
- Katy Christian Ministries
- Grace Point Food Pantry
- St. Bartholomew Church
- Memorial Hermann Community Benefit Corporation

Priority 1: Healthy Living

Goal 1: Improve the health of our community by providing resources and strategies for healthy living.

Time for/Safety During Physical Activity

Objective 1.4: Encourage, educate and provide opportunities for the community to get active

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of people attending April Pools Day event	175 year	375	150	150	250 year
• Number of PSAs	4/year	0	4	5	4/year
• Number of sunscreen packets distributed	500	1,200	150	150	1,000
• Number of 4th and 5th graders participating in Read, Deed and Run @ Elementary Schools	Baseline to be established in Year 2		400	0	TBD
• Number of participants at Walk with a Doc	500/year	0	0	15	750/year

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.4.1: Promote April Pool's Day program on pool safety and drowning awareness				1,2,3
1.4.2: Provide public service announcements on skin cancer and pool safety and distribute sunscreen at local waterparks	Renegotiating contract			1
1.4.3: "Walk with a Doc": collaborate with doctor who walks around lake with patients and engages in informal educational conversation (See 1.2.3)	Unable to implement this year and will reassess	This event did not occur this year		1, 2, 3
1.4.4: Provide staff and financial support for the Read, Deed and Run at elementary school by providing speakers and education materials on staying fit and eating healthy			This program did not occur. Instead attended health fairs and information to schools hosting already existing events	2, 3

Monitoring/Evaluation Approach:

- Attendance/participation
- Survey
- Count of materials distributed

Priority 1:	**Healthy Living**
Goal 1:	**Improve the health of our community by providing resources and strategies for healthy living.**

Potential Partners:

- Typhoon Texas
- YMCA
- Katy Aquatic
- AHA
- Katy ISD

Priority 1: Healthy Living

Goal 1: Improve the health of our community by providing resources and strategies for healthy living.

Chronic Disease Management

Objective 1.5: Improve chronic disease management among high-risk populations

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of participants in support groups	100	110	27	60	200/year
• Number of participants in Smoking Cessation classes	Establish baseline year 1	0	0	0	TBD
• Number of Congestive Heart Failure (CHF) support groups formed	Establish baseline year 3		0	0	4/year
• Number of educators trained on diabetes navigation	Establish baseline Year 3		7	7	TBD
• Number of participants educated in diabetes program	10 per class	83	850	9,000	20 per class

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.5.1: Conduct diabetes and stroke support groups				1, 2, 3
1.5.2: Initiate and conduct Congestive Heart Failure (CHF) Support Group		This group was not formed this year	No plans to create this group at this time.	3
1.5.3: Conduct ongoing smoking cessation programming or provide education materials about smoking cessation to those who qualify	No classes were offered this year	Planning vaping classes for schools this FY	Planning smoking/vaping education for KISD next year	1, 2, 3
1.5.4: Train a cadre of educators to provide diabetes education and navigation to patients				3
1.5.5: Support Diabetes Health Fair and provide educational materials				

Monitoring/Evaluation Approach:

- Survey
- Attendance at support groups
- Attendance at education programs
- Roster of trainers trained

Potential Partners:

- Mended Heart
- High risk Katy area employers for smoking
- MH TIRR

Priority 2: Access to Health Care

Priority 2: Health Care Access **Goal 2: Improve health care access to provide and sustain better health outcomes.**					
Availability of Primary Care and Specialty Providers **Objective 2.1: Increase access to primary care and specialty providers**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of primary care physician fact sheets distributed	Establish baseline year 1	250	2,595	3,500	500
• Amount of financial support to community clinics	$1,000	$1,850	1,000	1,000	$1,750
• Number of community resource flyers distributed	500	3,600	5,433	3,500	500
• Number of telemedicine consultations	460 ytd for 2016	409	557	782	
Strategies:		**Year 1 Notes**	**Year 2 Note**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.1.1 Provide a fact sheet to patients at discharge that do not have a primary care physician on the importance of having a primary care doctor					1,2, 3
2.1. 2: Continue to provide Community Resource Guide for follow-up care for patients (in multiple formats) (See 2.4.4)					1,2,3
2.1.3: Continue to provide financial support to Christ Clinic					1,2,3
2.1.4 Provide 24/7 neurological consultations to Katy Hospital 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: • Hiring records • Counts of flyers • Telemedicine consults					
Potential Partners: • UT • Katy ISD					

Priority 2: Health Care Access

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

Health Insurance Coverage and Costs

Objective 2.2: Increase health insurance coverage and reduce costs to ensure better health outcomes

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of new enrollees in Medicaid	559 new enrollees (Calendar year 2015)	671	380	341	

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.2.1: Contract with Resource Corporation of America (RCA) to increase enrollment in Medicaid RCA 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

Monitoring/Evaluation Approach:

- RCA records

Potential Partners:

- Katy ISD
- University of Texas (UT)
- RCA

Priority 2: Health Care Access

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

Transportation

Objective 2.3: Improve access for the indigent population by providing transportation

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Amount of financial support to Katy Area Ride Service (KARS)	$1,000	$1,000	0	0	$1,500
• Number of cab vouchers redeemed	107	$7,727	165	191	107
• Number of psychiatric unit transports	28	56	126	249	28

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.3.1: Continue to provide financial support to KARS, which provides very low cost transportation to the elderly and disabled		We were not able to donate FY18	No longer support this program financially	1, 2, 3
2.3.2: Continue to provide cab vouchers to patients who are in need of transportation assistance				1, 2, 3
2.3.3: Continue to provide free transportation to psychiatric unit in Harris County for indigent population				1, 2,3

Monitoring/Evaluation Approach:

- Count of brochures distributed
- Count of vouchers, survey

Potential Partners:

- KARS

Priority 2: Health Care Access

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

Health Care Navigation

Objective 2.4: Provide education to navigate patients to the appropriate level of care

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of Katy hospital's associated counties' calls to Nurse Health Line (Austin, Fort Bend, Harris, and Waller)	31,289 calls	31,114	32,863	32,486	31,289 calls
• Number of patients enrolled in the ER Navigation Program	927	1,092	1,209	222	927
• Number of ER Navigation patient encounters	1,817	2,620	2,733	0	1,817
• Number of ER Navigation referrals to community resources	4,583	5,071	2,636	0	4,583
• Number of ER Navigation scheduled appointments	112	169	138	0	112
• Number of printed education documents distributed	0	33,000	11,725	9,000	500
• Number of Community Resource Guides distributed	Baseline established in year one	0	2,500	1,800	
• Number of hits/views online for the Community Resource Guide	Baseline established in year one	0	0	0	
• Number of non-emergent patients triaged in the ER	Baseline established in year one	419	114	213	

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..				1, 2,3
2.4.2 Continue to participate in the MH ER Navigation program in which patients are referred to a medical home	No information available		MH ER Navigation program at Katy was discontinued 9/2018; returned 10/19	1,2,3
2.4.3: Provide educational flyers about when to go to the ER, Urgent Care, or and when to go to the doctor.	No information available			1,2,3

Priority 2: Health Care Access **Goal 2: Improve health care access to provide and sustain better health outcomes.**				
2.4.4: Continue to provide Community Resource Guide for follow-up care for patients (in multiple formats) via Case Managers, EMS, school nurses, and clinics		Program in place, unable to confirm the numbers		1,2,3
Monitoring/Evaluation Approach: • Patient activity documented and reported within the ER Navigation electronic record system • Nurse Help Line call log • Quarterly review of website hits • Count of guides				
Potential Partners: • Access Health Community Health Center • Spring Branch Community Health Center • Christ Clinic • 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 Katy 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 # ER encounters that result in psychiatric inpatient stay	1,146	1,213	1,135	1,687	1,089 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay – Katy	134	144	130	199	127
• Number of 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 Katy		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

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:

- 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**	**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
• KT ER Sitter Trainings	16 trainings (24 hours total/90 minutes each)	0	0	6 trainings (15 hours total/150 minutes each)	16 trainings (24 hours total/90 minutes each)
• KT ER nurse trainings	5 trainings (3.75 hours total/45 minutes each)	0	1	0	5 trainings (3.75 hours total/45 minutes each)
• KT ICU Training – 2 training (7 hours) (time includes training material development and implementation)	2 training (7 hours)	0	0	0	KT ICU Training – 2 training (7 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		71		1,2,3
3.2.2: Work with employer solutions group to provide education and training with corporations on MH topics (stress, PTSD)		8		1,2,3

Monitoring/Evaluation Approach:

- Requests for presentations and sessions tracked via calendar/excel

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Potential Partners:

- System acute care campuses
- System Marketing and Communications
- Employer solutions group

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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 and complex health co-morbidity. As a result the Crisis Clinic and Psychiatric Response Case Management programs have seen an increase in difficult and challenging patients with increased complex social needs.	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

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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	The lack of crisis housing resources and the target population's over-reliance on the acute care system produces an ongoing challenge in reducing ER utilization of 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