Memorial Hermann Health System

Memorial Hermann Northeast Hospital

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 Northeast Hospital

Located in the Lake Houston and Kingwood area, Memorial Hermann Northeast Hospital (hereafter MH Northeast) has been caring for families in the northeast region of Houston since 1977. MH Northeast's affiliated doctors span a variety of disciplines. Among its health care services, MH Northeast provides specialty care for cancer, sleep disorders, neonatal intensive care, orthopedics and sports medicine, and women's health. MH Northeast also has a freestanding Outpatient Imaging Center featuring advanced procedures and leading technology and provides comprehensive outpatient chronic wound management through a state-of-the-art hyperbaric and advanced center. The hospital is the anchor for the innovative Memorial Hermann Convenient Care Center (CCC) Summer Creek, the first CCC within MHHS, providing one-stop, highly coordinated access to an extensive array of Memorial Hermann services. MH Northeast also serves as a healthcare provider to passengers traveling through Houston's George Bush International Airport.

About Memorial Hermann Northeast Hospital

The MH Northeast community encompasses three counties, Harris, Montgomery, and Liberty. MH Northeast 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 Cleveland, Houston, Huffman, Humble, Kingwood, New Caney, Porter, Splendora, and Spring within the counties of Harris, Montgomery and Liberty. A large majority of MH Northeast inpatient discharges in fiscal year 2015 occurred among residents of Harris County (84.5%) or Montgomery County (12.9%); only a small proportion of inpatient discharges occurred among Liberty County residents (2.6%).

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 NORTHEAST HOSPITAL

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

PRIORITY COMMUNITY NEEDS FOR MH NORTHEAST HOSPITAL

The following key health issues emerged most frequently from a review of the available data across all MHHS hospitals and were considered in the selection of the system-wide Strategic Implementation Plan (SIP) health priorities:

- Health Care Access
- Issues Related to Aging
- Behavioral Health, Including Substance Abuse and Mental Health
- Transportation
- Healthy Eating, Active Living, and Overweight/Obesity
- Chronic Disease Management

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

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

- Heather Ingalls, Employer Liaison
- Pam Johnson, Manager ER Registration
- Tricia Racine, Director of Business Development
- Rebecca Tucker, Vice President, Finance

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 NORTHEAST HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1:	**Healthy Living**				
Goal 1:	**Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.**				
Early Detection and Screening **Objective 1.1: Facilitate early identification of, and intervention for, key health conditions to decrease mortality from these conditions**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of contacts for screenings health fairs	9,775	25 contacts 11, 650 attendees	10,765	18 contacts 10,650 served	10,200
• Number of cancer screening events	2	3	3	11	3
• Number of schools as partners	15	22	22	10	15
• Number of students per year examined	4,500	6080	11,331	38,500	4,725
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.1.1: Conduct athletic physicals in public schools in MS and HS (full physicals and EKG); partner with schools to provide a concussion trained PCP or ED physician on site at HS games (See 1.4.1)					1,2,3
1.1.2: Host free health screenings (1 screening/quarter for community) to cover: prostate/skin cancer, cholesterol, BP, blood glucose (See 1.2.2)					1,2,3
1.1.3: Facilitate employer health fairs (31/year): provide resources for ancillary services and prevention, direct access to schedule appointments for abnormal screenings (See 1.2.4, strategies of Objective 1.5)					1,2,3
1.1.4: Conduct education and outreach “Lunch and Learns” by providers to senior group, employers, and community on topics re: nutrition/weight management, stroke support, cancer support, etc. (2/mon, 24 per year)					1,2,3
1.1.5: Conduct BMI screening and body fat percentage.(see 1.1.3)					1,2,3

Priority 1:	**Healthy Living**
Goal 1:	**Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.**

Monitoring/Evaluation Approach:

- Athletic Physicals – Keep a log of numbers for each school event
- Health Screenings – Track number of participants registered
- Health Fairs – Document number of giveaways given to participants
- Lunch and Learns – Keep a log of number of participants at each event

Potential Partners:

- School districts
- Employers
- Physicians and Mid-level providers
- Staff
- Free Standing EDs and Urgent Cares
- Lake Houston Area, Kingwood and East Montgomery County Chambers of Commerce
- Media

Priority 1: Healthy Living

Goal 1: Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.

Obesity Prevention
Objective 1.2: Decrease obesity for all ages as measured by body fat percentage and/or BMI

Outcome Indicators:	Baseline	Year 1	Year 2	Year 3	FY 2020 Target
• Number of attendees at lunch and learn	40	1,235	X reference to 1.1.4	X reference to 1.1.4 360 served	45
• Number of lunch and learn sessions	2	3	X referemce tp 1.1.4	X reference to 1.1.4 3 sessions	3
• Participation number in wellness center	440	762	186	171	475
• Number of contacts for screenings health fairs	4,750	11,650	10,765	18 contacts 10, 650 served	4,980

Strategies:	Year 1 Notes	Year 2 Notes	Year 3 Notes	Timeline: Year 1,2,3
1.2.1: Facilitate lunch and learn sessions with endocrinologists for employers and seniors on nutrition and weight management (see 1.1.4)				1,2,3
1.2.2: Host health screenings (1 screening/quarter for community) to cover: prostate/skin cancer, cholesterol, BP, blood glucose (see 1.1.2)				1,2,3
1.2.3: Provide subsidized health and wellness services to community at on-site Wellness Center (Senior Balance, yoga, Zumba, etc.)				1,2,3
1.2.4: Host employer health fairs and provide screenings for body fat percentage and/or BMI				1,2,3

Monitoring/Evaluation Approach:

- Lunch and Learns – Keep log of number of attendees at each function
- Health Screenings – Track number of participants registered
- Health Fairs – Document number of giveaways given to participants

Priority 1:	**Healthy Living**
Goal 1:	**Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.**

Potential Partners:

- School districts
- Employers
- Physicians and Mid-level providers
- Staff
- Free Standing EDs and Urgent Cares
- Chamber of Commerce
- Media

Priority 1: Healthy Living

Goal 1: Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.

Access to Healthy Food
Objective 1.3: Support access to healthy food, especially for those most in need

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	1,786	2208	2528	3672	1,786
• Number of CHW referrals to community food pantries via the ER Navigation program	283	368	715	754	283
• Number of ER Navigation supported community events hosted by local partners	2	2	8	ER Navigation supported events in other parts of the community	4
• Number of pounds of food raised in food drive	18,000 lbs.	7400	20,873	The hospital no longer partners with HAAM to raise food	19,000
• Number of families in need impacted	725	HAAM disperses the food	HAAM disperses the food	The hospital no longer partners with HAAM for food drives	760

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 (Conduct biannual food drive with sister agency– HAAM disperses through Food Bank)				1,2,3

Monitoring/Evaluation Approach:
- Food Drives – Keep log of pounds weighed
- Patient activity documented and reported within the ER Navigation electronic record system

Priority 1:	**Healthy Living**
Goal 1:	**Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.**

Potential Partners:

- HAAM
- Media
- School districts
- Staff
- Family Time
- Memorial Hermann Community Benefit Corporation

Priority 1: Healthy Living

Goal 1: Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.

Time for/Safety During Physical Activity

Objective 1.4: Increase the number of community members informed about strategies for making time for and ensuring safety during physical activity

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of presentations	3	19	2	MHNE no longer hosts safety during physical activity presentations	4
• Number of attendees at presentations	120	2000	1200	N/A	126
• Number of health fairs (proper mechanics and exercise demonstrations)	4	1	5	MHNE no longer hosts this kind of demonstration	5
• Number of attendees at health fairs	2,500	800	3,250	N/A	2,625

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
1.4.1: Provide liaison to work with Athletic Trainers at each school and provide hotline back to our physician to address issues of hydration, stretching, etc. Provide athletic physicals for these schools. (see 1.1.1)				1,2,3
1.4.2: Address issues of hydration and body mechanics via Employer Fairs (see 1.1.3)				1,2,3
1.4.3: Conduct senior fairs addressing seasonally-relevant topics such as sunburn, mosquito bites				1,2,3
1.4.4: Discuss ways to include workout activities throughout the work day at physician facilitated Employer Lunch and Learns (see 1.1.4)				1,2,3

Monitoring/Evaluation Approach:

- Health Fairs – Document number of giveaways given to participants
- Lunch and Learns – Keep log of number of attendees at each function

Priority 1:	**Healthy Living**
Goal 1:	**Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.**

Potential Partners:

- University of Houston School of Pharmacy
- MHHS athletic trainer team
- Chambers of Commerce
- Media
- Physicians and Mid-level Providers
- Staff
- Employers
- Community Seniors

Priority 1: Healthy Living

Goal 1: Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.

Chronic Disease Management

Objective 1.5: Increase the number of patients who are maintaining their current health status through compliance with recommended and/or prescribed regimens for chronic disease management

Outcome Indicators:	Baseline	Year 1	Year 2	Year 3	FY 2020 Target
• Number of health/employer fairs	18	25	20	X Ref 1.1.3	19
• Number of attendees at health/employer fairs	9,775	11,650	X ref to 1.1.3	X Ref 1.1.3	10,200
• Number of presentations	9	8	1	5 Lunch and Learns	10
• Number of attendees at presentations	610	36	35	35	640
• Number of stroke support meetings	5	6	4	0-sessions cancelled after no turnout	6
• Number of attendees at stroke support meetings	62	36	15	0-no turnout	65
• Number of breast cancer support meetings	5	12	11	11	6
• Number of attendees at breast cancer support meetings	52	147	139	100	55

Strategies:	Year 1 Notes	Year 2 Notes	Year 3 Notes	Timeline: Year 1,2,3
1.5.1: Provide nutritionists and dieticians at health fairs and employer fairs to discuss specific plans for those with diabetes and provide information on chronic pain management (see 1.1.3)				1,2,3
1.5.2: Provide carotid artery screening (prevention and management) (see 1.1.3)				1,2,3
1.5.3: Conduct bone density screening (see 1.1.3)				1,2,3
1.5.4: Conduct BMI screening and body fat percentage (see 1.1.3)				1,2,3
1.5.5: Conduct ABI screenings for artery disease (see 1.1.3				1,2,3
1.5.6: Conduct presentations for sleep disorders, diabetes, heart conditions (see 1.1.4)				1,2,3
1.5.7: Conduct a Stroke Support Group				1,2,3
1.5.8: Conduct EKG screenings at community and employer health fairs (see 1.1.3)				1,2,3
1.5.9: Conduct a Breast Cancer Support Group.				1,2,3

Priority 1:	**Healthy Living**
Goal 1:	**Prevent avoidable injury and prevent and/or manage chronic diseases to ensure optimal health and safety for community residents.**

Monitoring/Evaluation Approach:

- Health Fairs – Document number of giveaways given to participants
- Presentations – Keep log of number of attendees at each function
- Screenings – Keep log of number of attendees at each function
- Support Groups – Log in sheets

Potential Partners:

- Physician practices
- Staff
- Employers
- Media
- Community members
- Chambers of Commerce

Priority 2: Access to Health Care

Priority 2: Health Care Access

Goal 2: Ensure all patients have access to appropriate care at the time and place they need it, regardless of ability to pay.

Availability of Primary Care and Specialty Providers
Objective 2.1: Connect patients to appropriate medical homes, care and benefits, and reduce inappropriate ER use

Outcome Indicators:	Baseline	Year 1	Year 2	Year 3	FY 2020 Target
• Number of patients enrolled in the ER Navigation Program	1,930	2162	2, 479	3453	1,930
• Number of ER Navigation patient encounters	4,532	5712	6,936	4808	4,532
• Number of ER Navigation referrals to community resources	4,864	4890	5,481	7639	4,864
• Number of ER Navigation scheduled appointments	204	259	246	125	204
• Number of appointments attempted	511	488	242	No longer tracked	511
• Number of physicians recruited annually	9	5	7	7	10
• Number of referrals and completed appointments made by health fairs (quarterly)	47	488 referrals based on number attempted/ completed appointments were not tracked	49	No longer tracked at health fairs	50

Strategies:	Year 1 Notes	Year 2 Notes	Year 3 Notes	Timeline: Year 1,2,3
2.1.1: Continue to participate in the MH ER Navigation program in which patients are referred to a medical home (See 2.4.2) ER navigator works with ER unfunded patients, facilitates access to county clinics, assists with gold card, etc.				1,2,3
2.1.2: Recruit specialists thru UT, existing community practices, MH Medical Group, and MNA (Mischer Neuroscience Associates) to ensure adequate emergency care, acute care and quality post acute care.				1,2,3
2.1.3: Provide a PCP Coordinator to identify patients who do not have a PCP, regardless of ability to pay; provide fact sheets; make follow up appointments for them while still inpatient; also refer to neighborhood health center if appropriate.				1,2,3

Monitoring/Evaluation Approach:
- Data from Memorial Hermann Medical Group on Health Fairs
- Patient activity documented and reported within the ER Navigation electronic record system

Priority 2:	**Health Care Access**
Goal 2:	**Ensure all patients have access to appropriate care at the time and place they need it, regardless of ability to pay.**

Potential Partners:

- University of Texas (UT) Physicians
- Memorial Hermann Medical Group
- Mischer Neurosciences Associates
- Aligned MHMD Physician Practices
- MHHS
- Neighborhood Health Center Northeast
- Memorial Hermann Community Benefit Corporation

Priority 2: Health Care Access

Goal 2: Ensure all patients have access to appropriate care at the time and place they need it, regardless of ability to pay.

Health Insurance Coverage and Costs

Objective 2.2: Help patients apply for and secure coverage to access appropriate care

Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of Class D Prescriptions provided to the Nimitz and Burbank School Based Health Centers	235	252	628	266	235
• % of patients screened, % patients who complied with application process, % patients who qualified for assistance	92% of uninsured screened 84% complied with application process 84% qualified for assistance	Patients screened IP – 99% Ou- 95% 85% patients complied with application process 93% patients who qualified for assistance	Patients screened 99% IP 97% OU 75% complied with application process, 80% qualified for assistance	Patients screened 99% iP 95% OU 88% compliled with application process 75% qualified for assistance	95% of uninsured screened 84% complied with application process 84% qualified for assistance

Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.2.1: Provide Class D Prescriptions to the Nimitz and Burbank 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: Continue to screen patients and advise on governmental programs for coverage; state employees receive benefits on site				1,2,3
2.2.3: Continue cooperative agreement with Northeast Hospital Foundation to enable the uninsured to access screening mammographies and treatment as appropriate				1,2,3

Monitoring/Evaluation Approach:

- Track % of patients screened through reporting tool

Potential Partners:

- Third-Party eligibility vendors
- Northeast Hospital Foundation
- Memorial Hermann Community Benefit Corporation

Priority 2: Health Care Access **Goal 2: Ensure all patients have access to appropriate care at the time and place they need it, regardless of ability to pay.**					
Transportation **Objective 2.3: Facilitate transportation home upon discharge for patients in need**					
Outcome Indicators:	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**FY 2020 Target**
• Number of taxi vouchers	238	282	238	361	238
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Year 3 Notes**	**Timeline: Year 1,2,3**
2.3.1: Provide cab vouchers for transport back home after discharge					1,2,3
Monitoring/Evaluation Approach: • Track in log book					
Potential Partners: • Cab companies					

Priority 2: Health Care Access

Goal 2: Ensure all patients have access to appropriate care at the time and place they need it, regardless of ability to pay.

Health Care Navigation

Objective 2.4: Assist patients with effective utilization of, and self-direction on, resources to meet their health care needs

Outcome Indicators:	Baseline	Year 1	Year 2	Year 3	FY 2020 Target
• Number of hospital's associated counties' calls to Nurse Health Line (Harris, Liberty, and Montgomery Counties)	30,323	30,226	31,459	31,191	30,323
• Number of touches in ER (navigation)	4,532	2162	2479	3453	4,532
• Number of touches (oncology)	600	500	1111	441 – patients who were referred to and utilized community resource Project Mammmogram	630
• Number of patients assisted in accessing Patient Portal	1,192	2860	2447	No longer tracked	1,192
• Number of PCP referrals	511	2162	2479	3453	511
• Number of referrals to community resources	4,864	4890	5,481	7639	4,864

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 (See 1.3.1)				1,2,3
2.4.3: Provide nurse navigator for oncology patients				1,2,3
2.4.4: Provide medical social worker for all patients to help them connect with appropriate care settings post discharge				1,2,3
2.4.7: Provide local staff to help patients link to the patient portal and learn how to access/use it on their smart devices so they can connect upon discharge				1,2,3

Monitoring/Evaluation Approach:

- Track patients visited by PCP Coordinator
- Patient activity documented and reported within the ER Navigation electronic record system

Priority 2:	**Health Care Access**
Goal 2:	**Ensure all patients have access to appropriate care at the time and place they need it, regardless of ability to pay.**

Potential Partners:

- Neighborhood Health Center Northeast
- 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 Northeast 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 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay – Northeast	108	134	131	135	103
• 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 Northeast.		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)

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.**

Potential Partners:

- System acute care campuses
- MHMG
- 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
• NE Management and communication with disruptive patients	1 training (4 hours) offered two times per year	0	0	0	1 training (4 hours) offered two times per year
• 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

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

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				