Memorial Hermann Health System

Memorial Hermann The Woodlands 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 The Woodlands Hospital

Located north of Houston, Memorial Hermann The Woodlands Hospital (hereafter MH The Woodlands) has been caring for families in south Montgomery County and surrounding communities in north Harris County since 1985. MH The Woodlands is a full-service, acute care facility that brings together the best healthcare technology, clinical expertise, and support for families. MH The Woodlands has grown to be a nationally recognized, regional medical center offering a broad range of advanced care options. It offers a variety of specialty services including the Chest Pain Center and the Primary Stroke Center, outpatient imaging, an American College of Surgeons accredited cancer program, and pediatric and women's health care programs. MH The Woodlands is an accredited, Level III trauma center. It is the first and only hospital in Montgomery County to be granted Magnet® status for nursing excellence by the American Nurses Credentialing Center.

Memorial Hermann The Woodlands Hospital Community

The MH The Woodlands community encompasses two counties, Harris and Montgomery. MH The Woodlands defined 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 Spring, Conroe, Montgomery, Magnolia, Tomball, and Willis within the counties of Harris and Montgomery. A large majority of MH The Woodlands inpatient discharges in fiscal year 2015 occurred among residents of Montgomery County (73.2%). At a city level, most MH The Woodlands inpatient discharges occurred among residents of Spring (59.2%) followed by Conroe (22.7%).

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 THE WOODLANDS HOSPITAL

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

PRIORITY COMMUNITY NEEDS FOR MH THE WOODLANDS 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 The Woodlands.

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 The Woodlands, 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 TMC, 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 The Woodlands CHNA and Strategic Implementation Plan Work Group

- Carolyn Allsen, Oncology Nurse Navigator
- Justin Kendrick, Chief Operating Officer
- Linda Kuitert, Director Case Management
- Edmund Lee, Director Patient Relations
- Amanda Pedro, Marketing Manager
- Kelly Wortham, Director Business Development
- Daphne Roque, Case Management Manager

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 THE WOODLANDS HOSPITAL STRATEGIC IMPLEMENTATION PLAN

Priority 1: Healthy Living

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
Early Detection and Screening **Objective 1.1: Increase screening to promote early detection and reduce advanced stages of diseases**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of participants in screenings (e.g. skin cancer and mammograms.)	Skin 40 Mammogram 300	Skin Cancer 53 Mammograms 314	Skin Cancer 25 Mammograms 311	Skin 45 Mammogram 315
• Number of low dose CT scans at a reduced cost to catch lung cancer earlier	0 (new program) Establish baseline in Y1	63 Lung CT Scans	84 Lung CT Scans	Low Dose Lung CTs 70
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	Events: 29 Attendees: 1,635	Events: 25 (6 health fairs, 19 talks) Attendees: 3,339	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See also 1.2, 1.3, 1.4)	14 Groups 220 Attendees	Events: 16 Attendees: 3,920	Groups: 26 Attendees: 2,785	14 Groups 254 Attendees (5% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.1.1: Provide education/awareness health talks at area schools and/or local businesses (See 1.2.3, 1.3.5, 1.4.5, 1.5.1)				1, 2, 3
1.1.2: Provide free screening mammograms and breast ultrasounds as needed for Interfaith Community Clinic patients and under/uninsured patients of private physicians		47 breast ultrasounds performed for underserved women	67 breast ultrasounds performed for underserved women	1, 2, 3
1.1.3: Provide free annual screenings for skin cancer during an annual event		53 screened for skin cancer; 26 referred for a biopsy and 12 Basal Cell Carinomas and 3 Melanomas diagnosed	25 screened for skin cancer; 6 referred for a biopsy and 1 Squamous Cell Carinoma diagnosed.	1, 2, 3
1.1.4: Conduct low dose CT scans for older adults to diagnose lung cancer at earlier stages to prevent Stage 3 & 4 cancer at a reduced cost (communicate to PCPs via their support paperwork for these patients to make them aware of this service)		63 screened; 65% had another significant finding leading to follow-up with specialist (e.g. emphasema)	84 people screened	1, 2, 3

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**		
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager, Oncology Nurse Navigator, and Imaging Directors. • Mammogram screenings tracked by Outpatient Imaging
		Potential Partners: • Community companies/employers (health fairs, talks, screenings) • Area schools (health fairs, talks, screenings) • Community organizations that work with low income patients (e.g. The Rose, Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs, like In the Pink and Lung Cancer CT scans to their patients)

Obesity Prevention **Objective 1.2 Increase educational offerings that promote healthy eating and exercise**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500	28 annually Attendees 4,000	Events: 25 (6 health fairs, 19 talks) Attendees: 3,339	Events: 32 (annually) Attendees: 4,200 (5% annually)
• Number of Support Groups, number of attendees (See 1.1)	See 1.1	4 groups Attendees: 700	3 groups Attendees: 740	5 groups Attendees: 800
• Number of exercise classes, food demonstrations and healthy food education for cancer survivors and family	Establish baseline in Y1	8 Events Attendees: 1,000	10 events Attendees: 1,389	10 Events Attendees: 1,200
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.2.1: Conduct no cost support groups for weight loss and for conditions where obesity plays a role - diabetes, heart disease, and stroke		4 groups	3 groups	1, 2, 3
1.2.2: Provide facilities on-campus for Canopy program to conduct exercise classes to cancer survivors and their caregivers (e.g., yoga, ballroom dancing, line dancing, guided meditation, tai chi) (See 1.4.2) and free food demonstrations and education about healthy food options for cancer survivors and families via nutritionists and dietary staff (See 1.3.1)		Demo kitchen, flexible space for fitness activities or events	Demo kitchen, flexible space for fitness activities or events; have expanded these to include children of a cancer survivor too.	1, 2, 3
1.2.3: Provide education/awareness health talks at area schools and/or local businesses		Health fair screenings: BMI, nutritionist, diabetes info, heart info, blood pressure and/or stroke risk assessments	Health fair screenings: BMI, nutritionist, diabetes info, heart info, blood pressure and/or stroke risk assessments – trauma is also educating the public on balance and strength.	1, 2, 3
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager & Occupational Medicine Liaison • Canopy programs maintained by Canopy Coordinator		

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**		
		Potential Partners: • Community companies/employers (health fairs, talks, screenings) • Area schools (health fairs, talks, screenings) • Community organizations that work with low income patients (e.g. Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)

Access to Healthy Food **Objective 1.3: Increase education about healthy foods to improve access and awareness**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Pounds of food donated to local food pantries	14,000 lbs.	Donated 2,471lbs and $4,531 in cash donated; this translates to 25, 126lbs of food	Memorial Hermann food drive discontinued	16,300 lbs. total (5% annually)
• Number of Farmer's Markets held (number of participant transactions)	5 sessions $1,750 in sales on avg /session	5 events, $1,750 avg/session – 8/16 $1,400 in sales; 9/16 $2,100; 10/16 $1,700; 3/17 $1,900; and 4/17 $1,800	5 sessions May 31, April 5, Nov. 17, Oct. 26, Sept. 27	Sessions: 3 total Sales of $2,000/session
• Number of food demonstrations and healthy food education for cancer survivors and family	8 evemts Attendees: 637	8 events, 637 attendees – cooking demos 70 attendess; Oncology nutrition 117, Cooking together (kids) 60; Special Functions with healthy foods (end of year survivor events 120, Breast Friends Christmas party 130, Valentine's Tea 42, Cinco de Mayo Fiesta 98	41 total events 489 attendees • Eating Well Thru Cancer • Cooking Demos • Oncology Nutrition • Cooking Together • Val Tea • Cinco de Mayo Christmas	10 events Attendees 800
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 40 annually Attendees: 500		X reference to 1.2.1.	Events: 40 (annually) Attendees: 580 (5% annually)
• Number of Support Groups, number of attendees (See 1.1)	See 1.1		X reference to 1.1.1	See 1.1
• Number of attendees at weekly breastfeeding support group	26 weekly		34	26 weekly
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline:** **Year 1,2,3**

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
1.3.1:	Nutritionists and dietary staff provide free food demonstrations and education about healthy food options for cancer survivors and families via the program at Canopy (See strategy 1.2.2)	Canopy cancer survivorship center has a demo kitchen, flexible space for fitness activities or events. At Canopy, supplies and food are paid for using Foundation monies; this is why there are no charges in those areas	Canopy cancer survivorship center has a demo kitchen, flexible space for fitness activities or events. At Canopy, supplies and food are paid for using Foundation monies; this is why there are no charges in those areas	1, 2, 3
1.3.2:	Collect food to support food pantries or special events hosted by community partners such as the Montgomery County Food Bank and/or Interfaith Food Pantry	Donated to the Interfaith Food Bank – we broke a 6-yr record in FY17!	No food drive in FY18.	1, 2, 3
1.3.3:	Offer Farmer's Markets on-campus for staff, patients, patient families, and community members	Held in the Healing Garden at the Campus and once in the Cafeteria due to rain.	Held in the Healing Garden at the Campus and once in the Cafeteria due to rain. There was an attempt to extend the farmer's market in part by setting up produce bins in the Cafeteria. This was not overly successful, and also our cafeteria is very small and crowded and lines can be long. *No financial sales data received for FY18 by deadline*	2, 3

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
1.3.4	Provide education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)	**TOTALS FY17: 943 people served / 15 events** **TOTALS: 604 attendees / 13 events** -Halliburton Series: Navigating Nutrition Labels (9/1/16, **46**, 2 s hr) -Huntsman Corp. Talks (2-3 locations rotating): Diabetes Preventions (Plant Site, 7/26, **32**, 2 v hr, 1 s hr); Diabetes Prevention(9/2, **81**, 2 v hr, 1 s hr); Stress Mgt. (Plant Site, 11/1, **29**, 2 s hr); Stress Mgt. (2/24/17, **84**, 2 s hr); Diabetes (3/15, **45**, 2 v hr, 1 s hr); Cholesterol Mgt (Plant Site, 3/28, **38**, 2 v hr, 1 s hr); Colorectal Cancer (6/14, **35**, 2 v hr, 1 s hr). -Strike Corp. Talks: Diabetes (8/2/16, **37**, 2 v hr, 1 s hr); Men's Health (9/6, **48**, 6 v hr, 2 s hr); Women's Health (10/4, **35**, 6 v hr, 2 s hr); Heart Health & Cholesterol Baby Fair: 200 attendees (free event and included in Priority 1); MHTW has 9 lactation consultants	**TOT FY18: 961 ppl / 8 events** • Huntsman Talks • Senior Woodlands Township Talks • Lone Star College Adult Lifelong Learning: Doc Talks • Canopy Doc Talks • Pelvic Floor Community Talk • Heart Healthy Talk • Trauma Symposium National Night Out at Auburn Lakes (first aid and health info given out	1, 2, 3

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
1.3.5	Provide education/awareness on breastfeeding benefits for mother and baby (nutrition, bonding, low cost alternative to formula, immunity boosting, etc.) via Baby Fair and breastfeeding support group	Support groups meet in perinatal classroom behind lactation center and support groups are facilitated by a lactation consultant nurse	Support groups meet in perinatal classroom behind lactation center and support groups are facilitated by a lactation consultant nurse *No Baby Fair in FY18*.	1, 2, 3
	31 weekly attendees All About Moms Support Group: 15 moms weekly on avg. Adventures in Breastfeeding Support Group: 16 moms weekly on avg.	**Monitoring/Evaluation Approach:** • Patient/participant experience surveys (Patient Satisfaction survey on hospital food) • Events log maintained by Marketing Manager, Occupation Medicine Liaison, and Oncology Nurse Navigator • Food Bank report		
		Potential Partners: • Interfaith Food Pantry; Montgomery County Food Bank • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Community organizations that work with low income patients (e.g. Interfaith Community Clinic) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • Local growers of fresh produce/farmers		

		Time for/Safety During Physical Activity Objective 1.4: Increase the avenues for the community to participate in activities that promote safe physical activity			
Outcome Indicators:		**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of events where we provide medical support/athletic trainers		350 Events	**FY 17: 414 events** 395 athletic events at schools where MHTW provided Athletic Trainer coverage; 19 community events where ATs, first aid and a physician were provided for medical coverage 52 free injury screenings at ISMI for school age athletes 3,900 student physicals where a nominal fee was charged and all funds were donated back to the schools in the form of a donation from MHTW…in FY17 this totaled $82,365		350 Events
• Number of educational talks/events like health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)		Events: 40 annually Attendees: 500			Events: 40 (annually) Attendees: 580 (5% annually)

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
• Number of exercise classes to cancer survivors and their caregivers	Events: 8 Attendees 1,000	**12 events,** **1,665 attendees** Cooking and Nutrition related offerings at Canopy in FY17: cooking demos **70** attendees, oncology nutrition **117**; Cooking Together (kids) **60**; special functions with healthy foods (end of yr survivor event **120**, Breast Friends Christmas party **130**, Valentine's Tea **42**, Cinco de Mayo Fiesta **98**) Fitness related classes at Canopy Cancer Survivorship Center in FY17: dancing **35** attendees, Pilates **40**, Yoga **754**, Tai Chi **199**	**10 events** **Attendees: 1,389** • Yoga • Tai Chi • Pilates • Guided Meditation • Eating Well Thru Cancer • Cooking Demos • Oncology Nutrition • Cooking Together • Active After Cancer • Cancer Rehab	Events: 10 Attendees: 1,200

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
• Financial support of walk/runs	4 Events	**FY17: 15 events** **American Heart Assoc. Heart Walk:** Nov. 2016, $5,000 contribution, our MHTW staff teams raised another $21,000! **Conroe ISD Kids Running for Kids:** $500 contribution **Leukemia & Lymphoma Society's Light the Night:** Oct. 2016, $5,000 contribution **Multiple Sclerosis Society's Walk MS:** Oct. 2016, $1,000 contribution **Woodlands United Methodist School's Walk/Run:** $500 contribution **Resolve Walk of Hope (Infertility):** $500 contribution **March of Dimes' March for Babies:** $3,500 contribution, plus our MHTW staff team raised another $8,700 **YMCA's Dragon Boat Races:** First Aid coverage for 4 days and two teams came to a $4,800 contribution (funds raised benefit YMCA	**15 Events** FY18 Events and Contributions: • AHA Heart Walk $5K • CISD Kids Running for Kids $500 • L&LS Light the Night $5K • Walk MS $1K • WUM Walk Run $500 • Walk of Hope $500 • MoD March for Babies $3.5K • YMCA Dragon Boat Races $4.8K • YMCA Run Thru The Woods $9,166 • CB&I Tri $9,166 • Muddy Trails $9,166 • 10 for Texas $9,166 • Relay for Life $1K • Woodforest Charity Run $750 Birdies for Parkinson's $2K **Total: $61,214.00**	4 Events

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**			
Strategies:	**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.4.1: Provide financial support to four (4) runs; 10 for Texas, CBI Tri, Muddy Trails and Run Thru The Woods in the community	These four are part of The Woodlands Township sponsored runs, but we contribute and/or participate in far more (listed above).	These four are part of The Woodlands Township sponsored runs, but we contribute and/or participate in far more (listed above).	1, 2, 3
1.4.2: Provide facilities on-campus for Canopy program to conduct exercise classes to cancer survivors and their caregivers (e.g., yoga, ballroom dancing, line dancing, guided meditation, tai chi) (See 1.2.2)	In FY17, also performed 52 free injury screenings for student athletes in our ISMI Clinic.	10 events Attendees: 1,389	1, 2, 3
1.4.3: Provide medical support/trainer presence and first aid supplies at community sporting events and other annual events (runs, walks, and clubs)	We performed 3,900 student physicals at a nominal fee, which we in turn donated BACK to the schools. Area schools received a total of $82,365 from Memorial Hermann from these physicals. We performed cardiac screenings for students in grades 7-12 at a nominal cost. 63 students took advantage at The Woodlands High School and 2 of those were referred to affiliated pedi cardiologist Faustino Ramos, MD	We did continue to perform school physicals for a nominal fee and donated back to individual schools. We also continued to perform cardiac heart screenings for students at a nominal charge.	1, 2, 3

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**			
1.4.4: Conduct education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)		**TOT FY18: 961 ppl / 8 events** • Huntsman Talks • Senior Woodlands Township Talks • Lone Star College Adult Lifelong Learning: Doc Talks • Canopy Doc Talks • Pelvic Floor Community Talk • Heart Healthy Talk • Trauma Symposium National Night Out at Auburn Lakes (first aid and health info given out)	1, 2, 3
		Monitoring/Evaluation Approach: • Participant experience surveys • Events log maintained by Marketing Manager , Occupational Medicine Liaison and Oncology Nurse Navigator	
		Potential Partners: • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)	

Chronic Disease Management: **Objective 1.5: Provide support to those impacted with a chronic disease to help them effectively control and monitor their progress.**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of educational talks/events, such as health fairs (handouts with preventative information); number of attendees (See also 1.2, 1.3, 1.4)	Events: 6 annually Attendees: 300	**FY 17: 309 attendees / 6 events** -Woodlands Township Senior Community Talks: Arthritis (9/30, **79**, 2 v hr, 1 s hr) -Huntsman Corp. Talks (2-3 locations rotating): Diabetes Prevention (Plant Site, 7/26, **32**, 2 v hr, 1 s hr); Diabetes Prevention (9/2, **81**, 2 v hr, 1 s hr); Diabetes (3/15/17, **45**, 2 v hr, 1 s hr); and Colorectal Cancer (6/14, **35**, 2 v hr, 1 s hr). -Strike Corp. Talks: Diabetes (8/2/16, **37**, 2 v hr, 1 s hr)		Events: 8 Attendees: 350

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
• Number of Support Groups, number of attendees. (See 1.1)	8 groups Attendees: 1000	**FY 17: 12 groups / 2,310 attendees** -Mended Hearts: 9/15/16 **41** attendees; 11/7 **40**; 1/19/17 **18**; 3/16 **18**; and 5/18 **18** (10 s hr total); $1,080 catering -Diabetes Support Group: 7/13 **8**; 8/18 **10**; 9/14 **13**; 10/20 **8**; 11/9 **17**; 12/15 **12**; 1/11/17 **16**; 2/8 **9**; 4/20 **22**; 5/3 **11**; 6/14 **7** (22 staff hrs) -Weight Loss Support Group: Meets 2x mo, about 18-20 attendees /session **456** attendees (12 v hr) -Parkinson's Support Group: Meets mo, 7-15 attendees /session…**144** attendees (14 s hr) -Multiple Sclerosis (MS) Support Group: Meets mo, 10-15 attendees /session…**144** attendees (14 s hr) -Dysautonomia Support Group: Meets mo, 2-4 attendees /session…**36** attendees (14 s hr) -Cancer Education & -Cancer Widows Support Group: **42** attendees for FY17 (14 s hr)		10 groups Attendees: 1,250

Priority 1: HEALTHY LIVING **Goal 1: Promote healthy living and provide resources to encourage the community to be proactive in their overall health.**				
• Number of patients receiving free prosthetics, wigs and scarves	126	**FY17: 88 items** 64 wigs, 24 breast prosthesis, and 22 scarves provided free of charge	**FY18: 92 items** Wigs and prosthesis, plus 26 scarves	168 (10% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
1.5.1: Conduct education/awareness health talks at area schools and/or local businesses (See strategy 1.1.1)				1, 2, 3
1.5.2: Conduct no cost support groups for weight loss and for conditions where obesity plays a role - diabetes, heart disease, and stroke (See strategy 1.2.1)				1, 2, 3
1.5.3 Provide Nurse Oncology Navigator support and/or Canopy coordinator support to fit patients with free prosthesis, wigs and scarves provided by Canopy		Canopy cancer survivorship center has a salon like room for shaving parties, wig fittings, scarves and prosthesis fittings	Canopy cancer survivorship center has a salon like room for shaving parties, wig fittings, scarves and prosthesis fittings	1, 2, 3
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Events log maintained by Marketing Manager & Occupational Medicine Liaison • Oncology Nurse Navigator to maintain log of prosthetics, wigs and scarves		
		Potential Partners: • Community companies/employers (health fairs, talks) • Area schools (health fairs, talks) • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)		

Priority 2: Access to Health Care

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**				
Availability of Primary Care and Specialty Providers **Objective 2.1: Increase the number of primary care and specialty care providers in local settings**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Montgomery, Walker and Harris) (See 2.4.1)	30,089	30,130 Top 3 adult concerns: abdominal pain, vaginal symptoms and chest pain. Top 3 pediatric concerns: fever, vomiting and coughing.	31,407	30,089
• People served through Interfaith Community Clinic	2,107 patients 8,681 visits	$682,275 in charity care 2,190 patients Number of Visits: 9,686	$685,059.25 in charity care 2,184 patients Number of Visits: 9,846	2,212 patients 9,115 visits
• Number of telemedicine consultations	275/year (in 2015)	**FY17 Total: 324** Stroke: **284** Pediatric Surgery: **40**	**FY18 Total: 282** Stroke: **266** Pediatric Surgery: **16**	275/year
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**			
2.1.1: Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the MHHS community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources. (see 2.4.1)	More than 46% of all patients seen in the Emergency Room are there for Primary Care related conditions. Open 24/7, 365 days a year with English and Spanish-speaking RNs According to the Nurse Health Line, 78% who would have gone to the ER for care…were redirected to primary care Also according to the Nurse Health Line, of those that were triaged by the RN on the phone, 49% were directed to PCP, 33% to the ER, and 18% to self-care at home		1, 2, 3
2.1.2: Provide funding support for the Interfaith Community Clinic which provides free care to underserved populations.	The Clinic is located across I45 from MHTW.	The Clinic is located across I45 from MHTW.	1, 2, 3

Priority 2: HEALTH CARE ACCESS **Goal 2: Improve access points to primary care and specialty providers by reducing barriers.**				
2.1.3: Provide telemedicine consults free of charge for stroke and pediatric surgery patients, to determine		Pedi telemedicine consults in the ER and in the NICU; of the 40, only 9 had to be transferred to CMHH in the TMC; 21 were admitted or stayed admitted at MHTW; and 10 were treated and d/c to home Stroke Consults in the ER with the TMC; of those consults, 27 were given tPA and 13 were transferred to the TMC		1, 2, 3
		Monitoring/Evaluation Approach: • Patient/participant experience surveys • Interfaith Community Clinic feedback • ER visits and Interfaith Community Clinic funding tracked through finance • Telemedicine consults maintained in the ER • Nurse Health Line calls		
		Potential Partners: • Government relations office • Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients) • Memorial Hermann Community Benefit Corporation		

Health Insurance Coverage and Costs **Objective 2.2 Increase health insurance coverage for uninsured and underinsured populations**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
Number of people successfully insured through RCA	1,400 patients screened	**1,842** patients screened. A total of 678 of these patients were able to be placed into a program to assist them with medical costs.	**1,230** patients screened. A total of **584** of these patients were able to be placed into a program to assist them with medical costs	1,621 (5% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
2.2.1: Contract with Resource Corporation of America (RCA) to provide services to increase insurance coverage for community RCA is a third-party eligibility vendor (paid by MHTW) to assist patients with the application process for Medicaid, County Indigent, Affordable Care Act Insurance Exchange, and other third-party payors.		Of those screened: 55 placed into Medicaid for Aged & Disabled; 240 into County programs; 273 into traditional Medicaid; 96 into Social Sec Disability; 14 into VVC (Crime Victims' Assistance)	Placed among: Medicaid for Aged & Disabled; County programs; traditional Medicaid; Social Sec Disability; VVC (Crime Victims' Assistance	1, 2, 3
		Monitoring/Evaluation Approach: • Log of insured through RCA		
		Potential Partners: • Case Workers		

Transportation **Objective 2.3: Reduce the barrier of transportation to more efficiently access health care services**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of patients who did not need to be transferred due to telemedicine consults	Stroke 200 Pediatric – Establish baseline in Y1 40	Pedi telemedicine consults in the ER and in the NICU; of the **40**, only 9 had to be transferred to CMHH in the TMC; 21 were admitted or stayed admitted at MHTW; and 10 were treated and d/c to home --- **284** Stroke Consults in the ER with the TMC; of those consults, 27 were given tPA and 13 were transferred to the TMC		Stroke 231 (5% annually) Pediatric (once baseline established) 50
• Number of vouchers used	182	211	240	211 (5% annually)
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
2.3.1: Provide transportation vouchers for patients to return home following care		Average of **18** taxi vouchers per month per OA Richard Smedley, RN	Average of **20** taxi vouchers per month per OA Richard Smedley, RN	1, 2, 3
2.3.2: Provide telemedicine consults free of charge for stroke and pediatric surgery patients, to determine if additional transfer and associated expense is necessary or could be avoided (See 2.1.3)		231	262	1, 2, 3
		Monitoring/Evaluation Approach: • Patient experience surveys • Telemedicine consults maintained in the ER • Voucher count maintained by case management		
		Potential Partners: • Area physicians (to promote free or low cost programs to their patients) • Community organizations that work with low income patients (e.g. The Rose, Interfaith Community Clinic)		

Health Care Navigation **Objective 2.4: Connect patients to resources to help them better navigate the health care system**				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of hospital's associated counties' calls to Nurse Health Line (Montgomery, Walker, and Harris) (See 2.1.1)	30,089	**30,130** Top 3 adult concerns: abdominal pain, vaginal symptoms and chest pain. Top 3 pediatric concerns: fever, vomiting and coughing.	31326	30,089
• Number of patient navigators	1	1	2	1-2
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
2.4.1: Provide a 24/7 free resource via the Nurse Health Line that community members (uninsured and insured) within the MHHS community can call to discuss their health concerns, receive recommendations on the appropriate setting for care, and get connected to appropriate resources (See 2.1.1)				1, 2, 3
2.4.2: Increase number of patient navigators to provide services to our cancer patients		Still just the one – Carolyn Allsen, RN who is now officed in Canopy (Cancer Survivorship Center)		1, 2, 3

Monitoring/Evaluation Approach:
- Patient/participant experience surveys
- Nurse Health Line call log

Potential Partners:
- Area physicians (to give talks, be at health fairs, and/or promote free or low cost programs to their patients)
- 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 The Woodlands 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:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Decrease in number of ER encounters that result in psychiatric inpatient stay	1,146	1,213	1,135	1,089 5% reduction of baseline
• Decrease in number of ER encounters that result in psychiatric inpatient stay – The Woodlands	157	166	179	149
• Number of Memorial Hermann Crisis Clinic total visits	5,400	5,590	5,590	5% over baseline
• Number of Psychiatric Response Care Management total visits	1,200	1,103	1,259	5% over baseline
Strategies:		**Year 1 Notes**	**Year 2 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 The Woodlands		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.	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.	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.	1,2,3
		Monitoring/Evaluation Approach: • EMR/registration system (track and trend daily, weekly, monthly)		
		Potential Partners: • System acute care campuses • Memorial Hermann Medical Group • Network of public and private providers		

Objective 3.2: Reduce stigma in order to promote mental wellness and improve community awareness that mental health is part of physical health and overall well-being				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of presentations/educational sessions for healthcare professionals within MHHS	50 sessions per year	63	71	5% increase over baseline
• Number of presentations/educational sessions for corporations	5	7	8	5% over baseline
• TW Stress management (total time includes training material development and implementation)	1 training (6.5 hours)*	0	1	1 training (6.5 hours)*
• Training on Acute Care Concepts - system nurse resident program	15 trainings (45 hours total/3 hours each)*	18	9	15 trainings (45 hours total/3 hours each)*
• Training on CMO Roundtable - system-wide	1 training (2 hours)*	0	4	1 training (2 hours)*
*Total time includes training material development and implementation			531.6	
Strategies:		**Year 1 Notes**	**Year 2 Notes**	**Timeline: Year 1,2,3**
3.2.1: Provide mental health education sessions within the MH health system for nurses and physicians				1,2,3
3.2.2: Work with employer solutions group to provide education and training with corporations on MH topics (stress, PTSD)				1,2,3

Monitoring/Evaluation Approach:
- Requests for presentations and sessions tracked via calendar/excel

Potential Partners:
- System acute care campuses
- System Marketing and Communications
- Employer solutions group

Objective 3.3: Quality of mental health and substance abuse services: access, link, and practice utilizing evidence-based practice to promote overall wellness				
Outcome Indicators:	**Annual Baseline**	**Year 1**	**Year 2**	**FY 2020 Target**
• Number of Memorial Hermann Crisis Clinic follow-ups post discharge with clinic patients	7,716	6,431	5,154	5% over baseline
• Psychiatric Response Case Management reduction in system ER utilization	54.4%	53.0%	50%	5% increase over baseline
Strategies:		**Year 1 Notes**	**Year 2 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.	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.	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		