Memorial Hermann Southwest Hospital’s Community Health Needs Assessment IMPLEMENTATION PLAN 2013

Introduction
A comprehensive Community Health Needs Assessment (CHNA) was conducted for Memorial Hermann Southwest Hospital (Memorial Hermann Southwest) from August 2012 to June of 2013. The goal of the assessment was to clarify the health needs of Memorial Hermann Southwest’s study area, defined as Fort Bend and Harris Counties that represents 91.9% of the hospital’s inpatient discharges.

The analysis included a careful review of the most current health data available and input from numerous community representatives with special knowledge of public health. Findings indicated that there were eight main needs in the communities served by Memorial Hermann Southwest. The CHNA Team, consisting of leadership from Memorial Hermann Health System (Memorial Hermann), prioritized those eight needs by studying them within the context of the hospital’s overall strategic plan and the availability of finite resources, with the following prioritization, in descending order, resulting:

**IDENTIFIED PRIORITIES**

1. Education and prevention for diseases and chronic conditions
2. Address issues with service integration, such as coordination among providers and the fragmented continuum of care
3. Address barriers to primary care, such as affordability and shortage of providers
4. Address unhealthy lifestyles and behaviors
5. Address barriers to mental healthcare, such as access to services and shortage of providers
6. Decrease health disparities by targeting specific populations
7. Increased access to affordable dental care
8. Increased access to transportation

This implementation plan addresses the top six of those eight needs. The need for “increased access to affordable dental care” and the need for “increased access to transportation,” are not addressed largely due to their positions (last and second to last) on the prioritized list, the fact that dental and transportation services are not core business functions of the health system and the limited capacity of each hospital to address those needs. Furthermore, the hospitals do not have the expertise to address access to transportation, and the system views this issue as a larger city and county infrastructure related concern. Memorial Hermann fully supports local governments in their efforts to impact these issues.

However, there are some dental services initiatives which are being addressed at the system level. Memorial Hermann funds various Federally Qualified Health Centers and private not-for-profit clinics which offer dental services (notably Spring Branch Community Health Center and Interfaith Community...
Clinic) and funds and operates two dental vans offering preventive and restorative dental procedures to pre-kindergarten to twelfth grade students at 40 schools as a part of its school-based healthcare initiative.

The end result of the assessment process was the development of a strategic plan to address the major needs identified. This document is the Implementation Strategy for Memorial Hermann Southwest Hospital. It details the rationale for each priority, the current services and activities supporting each priority, and the planned objectives and activities determined by Memorial Hermann Southwest Hospital leadership to further support each priority.

PRIORITY #1: Education and prevention for diseases and chronic conditions

- Heart disease
- Cancer
- Diabetes
- Alzheimer’s

PRIORITY #1 RATIONALE: Data suggests that there are high rates of various diseases and chronic conditions in the study area and in the Houston-Baytown-Sugar Land MSA. As of 2009, heart disease and cancer are the first and second leading causes of death in the study area. Harris County, which comprises 75.6% of Memorial Hermann Southwest’s discharges, has higher mortality rates for both diseases than Texas. Fort Bend County comprises 16.3% of Southwest’s discharges, and this adjacent county’s rates are lower than Texas’ rates for both diseases. There are higher Alzheimer’s mortality rates in the study area than there are in Texas. According to the Behavioral Risk Factor Surveillance System (BRFSS), diabetes is also a prevalent condition in the Houston-Baytown-Sugar Land MSA. In the survey conducted by Memorial Hermann, more than 90% of respondents indicated that promoting chronic disease management and improving access to preventive care (screenings for diseases) were important or very important initiatives for residents in the community. Hypertension, heart failure, cancer, and diabetes were consistently reported as top conditions in the community (questions ranging from top health problems, most prevalent conditions and top preventable hospitalizations).

PRIORITY #1 RESPONSE: Memorial Hermann Southwest Hospital is currently addressing education and prevention for diseases and chronic conditions (heart disease, cancer, diabetes, and Alzheimer’s) through community programs such as education sessions, screenings, support groups and health education publications. The purpose of these programs is to provide populations with information and tools to assist them in optimizing their health and well-being. The short term goal is to positively influence the health behavior of individuals and communities; the longer term goal is to prevent disease, disability, and premature death. In FY 2012, the following individuals were served:

- Screening/Blood Pressure – 150 individuals participated
- Yoga for Cancer Survivors – 165 individuals participated
- Screening/Colorectal Cancer – 80 individuals participated
- Screening/Prostate Cancer – 80 individuals participated
- Oncology Nutrition Class – 3 individuals participated
- Men’s Tune Up for Life Health Fair – 400 individuals participated
- Diabetes Education – 563 individuals participated
- Support Groups (Cancer, Cardiac, Diabetes) – 872 individuals participated
- Education/Outreach for Seniors – 200 individuals participated
- Education including CEUs/Alzheimer’s – 53 community members, staff and other healthcare professions participated

As a community hospital serving a very diverse population including a large elderly population, Southwest provides a variety of medical services to address the community’s need for disease and chronic care management.

Since 2010, Memorial Hermann Southwest has provided Cardiac Rehabilitation, a multi-dimensional, medically supervised program designed to help patients recover as quickly as possible from heart disease. With a comprehensive focus on exercise, education and lifestyle change, the program is specially designed to improve patients’ overall physical and mental functioning.

In response to documented increased risks of certain forms of cancer among first- and second-degree relatives of affected individuals, Memorial Hermann Southwest has established a Genetic Cancer Program based on the National Comprehensive Cancer Network (NCCN) Guidelines aimed at facilitating a multidisciplinary approach in the management of individuals at increased risk for cancer. Genetic screening, risk assessment, testing, counseling, and medical management are available at a comprehensive clinic with University of Texas Health Science Center genetic counselors.

Diabetes affects many organs that can be disabling and life threatening. The Memorial Hermann Southwest Wound Care Center opened in November 2007 with a mission to improve the quality of life of patients with chronic and acute wounds and to reduce the number of amputations. Wound care patients, with diabetes in particular, benefit from Southwest’s hyperbaric oxygen therapy (HBOT) services used to enhance the body’s natural healing and strengthen the immune system. The center has a multidisciplinary approach to address the diverse co-morbidities which this population is challenged. Early intervention and follow-up improves outcomes and reduces hospital admissions. In FY 2012, 30 patients benefited from Hyperbaric Oxygen Therapy.

In an effort to provide 24/7 access to stroke experts, Southwest is partnering with University of Texas Health Science Center to place a stroke robot in the Emergency Center. This robot allows physicians to be able to communicate with neurologists at any time of the day or night. The provision of immediate assessment and treatment guidance limits stroke related brain damage.

**PRIORITY #1 STRATEGY:**

**Objective #1.1:** To continue to address the interrelated chronic conditions of heart disease, cancer, diabetes and Alzheimer’s through the existing infrastructure.
Implementation Activities:

- Increase awareness of the community education, screening, and support groups provided as reflected by increased participation.
  - Establish baseline metrics (2014)
  - Increase participation over baseline by 10% (2015)
  - Report metrics (2015, 2016)

- Implement regular, ongoing community education courses on heart disease.
  - Explore program options (2014)
  - Implement select program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)

- Implement education and training to the area Senior facilities’ staff on inpatient quality metrics to assist in disease management, the continuum of care, and the reduction of readmissions through the Seniors Providers Group.
  - Design program and establish baseline metrics (2014)
  - Implement and monitor metrics (2015)
  - Report metrics (2016)

- Implement education and coping skills programs for caregivers of loved ones with dementia.
  - Explore program options (2014)
  - Implement select program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)

- Explore linking community education programming with the Stanford Patient Education Model for Diabetes Self-Management Program. This model is a unique education program, designed to last six weeks, for groups of between 12 to 16 individuals, and to help people gain self-confidence in their ability to control their symptoms and improve their lives.
  - Conduct a needs assessment to determine community response to the program (2014)
  - Identify area organizations licensed to provide chronic disease self-management workshops; identify staff to be trained to implement the model (2014, 2015)
  - Implement and establish baseline metrics (2016)
PRIORITY #2: Address issues with service integration, such as coordination among providers and the fragmented continuum of care

- Lack of information and record sharing, such as electronic medical records
- Lack of communication between providers
- Patient needs for medical homes
- Inappropriate ED use

PRIORITY #2 RATIONALE: Findings suggest that there are various issues that fall under the “service integration” category in the communities served by Memorial Hermann Hospitals. The *Houston Hospitals Emergency Department Use Study (2010)* demonstrates the frequent inappropriate use of emergency departments for primary care related conditions in the community. Many interviewees noted frustration about the lack of record sharing among providers in the community and many said that patients must be transitioned out of the Emergency Department settings and into primary care settings. Another common concern was that too much of the patient population lacks a viable primary care access point or “medical home” focused on primary care.

PRIORITY #2 RESPONSE: Memorial Hermann Southwest is currently addressing information sharing, patients’ needs for medical homes, and inappropriate ED use through several significant programs. The following programs are designed to improve communication between and among providers for improved access to and outcomes of care.

- Southwest is responding to the community’s concern about the lack of record sharing among providers through the *Memorial Hermann Information Exchange (MHE)* which uses a secure, encrypted electronic network to integrate and house patients’ digital medical records so they are easily accessible to authorized MHiE caregivers. The service is free to patients and only requires their consent. Since September 2011, 28% of Memorial Hermann Southwest’s patients have registered to participate. Another initiative is for all inpatient, outpatient, and emergency room progress notes to be electronic providing for up-to-date provider access anytime, anywhere.
- To provide an effective continuum of care for patients diagnosed with Alzheimer’s and other dementias, Southwest collaborates with Methodist Outpatient Neurological Institute for both inpatient and outpatient services.
- Research shows that cancer patients who receive help navigating the medical system have better outcomes. A nurse navigator specializing in oncology acts as a patient client advocate and “go-to” person when questions arise or help is needed when navigating the medical system. The nurse navigator works within the multidisciplinary cancer care team across the continuum of care, providing information and support to patients and caregivers, as well as other health care professionals. Nurse navigators also serve as moderators for the physicians who collaborate on improved care through the Tumor Board.
• The increasing elderly population drove the need for the addition of a Palliative Care Team to provide patients with the ability to prepare for their end of life care. Palliative Care is a medical specialty designed to assist patients and families with symptom management, emotional and spiritual support, and advanced care planning. As an inpatient consulting service at Memorial Hermann Southwest, Palliative Care, made up of a Board Certified Palliative physician and an RN, works with the primary care team to provide complimentary services that help to ensure positive treatment outcomes. Whether it is pain management with patients seeking aggressive treatment in the early stages of the disease process or advanced care planning and emotional support at the end-of-life, Palliative Care is a valuable resource to keep patients at the end of their life receiving the right care in the right place. The program, begun in 2010, has incurred 1,255 consults to date.

• Southwest ensures patients without resources have access to post-acute care by operating the Transitional Care Unit for the Memorial Hermann Health System, receiving referrals from other hospitals to provide patients with the appropriate continuum of care. In 2012, 109 patients were admitted to the unit.

Memorial Hermann Southwest operates a busy emergency room, 40% of which are unfunded patients. A Primary Care Provider (PCP) Coordinator, an ER community health worker, and a low cost clinic are initiatives intended to respond to the community’s inappropriate use of the emergency room for primary medical care and need for medical homes.

• To facilitate connections with a medical home, in 2010 Southwest implemented the Patient Connection into a Medical Home Program. A Primary Care Provider (PCP) Coordinator visits with all unassigned managed care patients in the ER and the hospital and helps them decide on a new medical home physician or clinic. The intent of this program is designation of a medical home, reduced readmissions and reduced emergency room visits for primary care. In FY 2012, 532 patients were linked to medical homes.

• Since August, 2011, a certified community health worker, or navigator, has worked with uninsured and underinsured emergency patients who access the emergency room for primary care purposes to connect them with “the right care, in the right place, at the right cost”. The navigator works with 8-12 patients per shift and continues to follow-up with them by phone to determine if the referrals provided were effective, or if different referrals or support is necessary. Program metrics are analysis of return to ER patterns of the population navigated.

• In 2012, a Memorial Hermann Clinic, Neighborhood Health Center-Southwest, moved adjacent to the Southwest emergency room to serve as a medical home to patients without insurance, but capable of paying for medical care at cost. The clinic’s goal is to break-even and success is dependent upon referrals from not only the community, but the very busy Memorial Hermann Southwest Emergency Room. The Center exists as a partnership with Memorial Hermann Southwest.

• Two school-based health centers reside within Southwest’s service area and receive critical pharmacy support from Southwest. The school-based health centers (Memorial Hermann Health Centers for Schools—Jane Long Clinic and Elrod Clinic) serve as the medical home for
uninsured children at 11 Houston area schools, pre-kindergarten through twelfth grade, in two Houston Independent School District feeder patterns.

**PRIORITY #2 STRATEGY:**

**Objective #2.1:** To increase participation in the Health Information Exchange (HIE).

**Implementation Activities:**
- Continued education of staff responsible for offering the service to patients for consent (ongoing)
- 70% of all registered patients will consent to the Health Information Exchange (HIE) (2014, 2015)
- Area Federally Qualified Health Centers to become MHIE participants (2 minimum) (2013, 2014)

**Objective #2.2:** To continue emergency room programming that will reduce the community’s reliance on the ER for primary care purposes and to increase their connection with medical homes.

**Implementation Activities:**
- Increase navigation/CHW ER support as reflected by number of patients navigated to a medical home.
  - Establish baseline metrics (2013)
  - Increase participation over baseline by 5% (2014)
- Strengthen collaboration with area Federally Qualified Health Centers (FQHCs).
  - FQHCs to sign MHIE agreements (2 minimum) (2013, 2014)
  - Establish ER referral program via navigators (2013, 2014)
  - Establish metrics of referral numbers and number of patients enrolled and retained by the FQHCs (2013, 2014)
- Increase use of the Neighborhood Health Center – Southwest
  - Conduct business plan (2013, 2014)
  - Establish baseline metrics (2014)
- Continue support of school-based healthcare as reflected by 3,600 annual medical clinic visits.
- Continue to promote the importance of having a PCP and a medical home in the community health newsletters by including a related topic each quarter.

**Objective #2.3:** To continue to improve service integration and the continuity of care.

**Implementation Activities:**
- Continue support of the Palliative Care Team.
  - Develop metrics quantifying reductions in emergency room visits and readmissions; increases in patient satisfaction (2013, 2014)
- Explore implementing a Pediatric Follow-Up Clinic to serve former NICU (Neonatal Intensive Care Unit) patients enhancing the coordination and continuum of care.
  - Explore program options (2014)
  - If program approved, design clinic and establish baseline metrics (2014, 2015)
  - Implement and monitor metrics (2015, 2016)
  - Report metrics (2016)

**PRIORITY #3: Address barriers to primary care, such as affordability and shortage of providers**
- Cost
- Number of providers

**PRIORITY #3 RATIONALE:** According to the most recently released (in August of 2012) census data, more than one fourth of residents in Texas are uninsured. Nearly 30% of residents in Harris County and approximately 20% of residents in Fort Bend County are uninsured. Furthermore, many of the residents (18.8%) in the Houston-Baytown-Sugarland MSA experience medical cost barriers with regard to accessing healthcare. The *Health of Houston Survey 2012: A First Look* also indicated that women who did not receive the appropriate prenatal care often cited cost and insurance barriers (34%). There was a perception among interviewees that primary care providers are “running at full capacity” and there is a need for additional primary care providers to serve the communities both in the general population and the safety net population. The *Safety Net Review Key Informant Study* suggests that lack of availability of primary care services and difficulty accessing primary care are two of the top three problems among the safety net. Finally, in the survey conducted by Memorial Hermann, “Lack of coverage/financial hardship” was ranked first with regard to barriers to access to primary and preventive care for low income residents in the community. The lack of capacity (e.g. insufficient providers/extended wait times), ranked third.

**PRIORITY #3 RESPONSE:** As a part of Memorial Hermann, the largest not-for-profit health system in Southeast Texas, Memorial Hermann Southwest plays a significant role in Memorial Hermann’s annual $309.3 million dollar contribution to the community. This represents financial assistance and means-tested government programs, community health improvement services and community benefit operations, health professions education, subsidized health services, research, and cash and in-kind contributions for community health, and is representative of costs using the IRS 990 schedule H reporting.

To secure a payment source for uninsured and underinsured patients, Memorial Hermann Southwest has a financial counseling program. Counselors help patients enroll in government programs or find other sources of coverage. Specifically, the counselors assist patients with financial assistance applications, setting up payment plans or applying for charity care. The program covers both inpatients and emergency room patients, 24/7, with 15 counselors each working with eight to ten patients per day.
In order to ensure specialty coverage for uninsured and underinsured populations, Memorial Hermann Southwest contracts with physicians covering 15 specialties (cardiology, interventional cardiology, general surgery, obstetrics/gynecology, endoscopic retrograde cholangiopancreatography (ERCP), gastroenterology, family and internal medicine, nephrology, neurology, oral and maxillofacial surgery (OMFS), orthopedics, plastics, podiatry, trauma, and vascular surgery) to provide On-Call ER Coverage 24 hours a day, seven days a week. Thus patients accessing the Southwest emergency room for emergent conditions are guaranteed emergent specialty care.

One of the most significant on-call coverage specialties provided is that of the OB ER call group. In-house physician coverage (including evaluation and treatment, admission and on-going inpatient management services) is provided for unassigned or emergent obstetric patients and unassigned emergent gynecology patients for the hospital twenty-four (24) hours per day, three hundred sixty-five (365) days per year. This group also provides evaluation, treatment, admission, and ongoing inpatient management services to patients of private physicians with obstetric or emergency surgical gynecologic needs, upon request of the private physician.

Three initiatives support the growing Primary Care Physician (PCP) shortage: the Hospitalist Program, Memorial Hermann Medical Group, and Memorial Hermann Physician Network.

Memorial Hermann Southwest has hired hospitalists so that PCPs are freed up to stay in their offices and add more practice hours. Hospitalists are board-certified internists who are available, in Memorial Hermann Southwest’s case, 24 hours a day, seven days a week, in the hospital to meet with family members, order follow-up tests, answer nurses’ questions, and manage any problems. In many instances, hospitalists may see a patient more than once a day to assure that care is going according to plan, and to explain test findings to patients and family members. Fifty-six Memorial Hermann Southwest physicians presently admit through the Hospitalist Program; the program began in December 2009 and 1,974 patients have been managed in FY2013 through February.

Memorial Hermann Medical Group (MHMG) has been instrumental in recruiting PCPs to the Southwest service area. MHMG is an umbrella organization that employs physicians and provides business services such as billing, collections, insurance reimbursement contracts, and medical records maintenance and information technology, allowing participating physicians to spend more time practicing medicine and less time running a business.

Through the Memorial Hermann Physician Network MHMD, community primary care physicians who strive to be certified as a patient centered medical home by NCQA (National Committee for Quality Assurance) can be supported in the endeavor. NCQA certified physician practices serve the community as a true medical home and are held accountable for meeting a set of standards that describe clear and specific criteria about organizing care around patients, working in teams and coordinating and tracking care over time. There are 111 family medicine physicians and internists in Southwest’s service area that have signed a contract to be in MHMD’s medical home initiative and have either achieved or are working towards certification.
**PRIORITY #3 STRATEGY:**

**Objective #3.1:** To develop recruiting strategies for PCPs within the Memorial Hermann Southwest Hospital service area.

**Implementation Activities:**
- Recruit an additional 2 primary care physicians and 3 mid-level providers within MHMG (2014)
- Recruit an additional 55 primary care (family practice, internal medicine, OB/GYNs, and pediatricians) medical home physicians within MHMD (2013-2016)

**Objective #3.2:** Promote the Hospitalist Service to the medical staff to introduce, educate, and encourage service buy-in by more physicians.

**Implementation Activity:**
- Report medical staff members admitting via the Hospitalists (2013-2016)

**Objective #3.3:** To continue to capitalize on community resources for primary care.

**Implementation Activities:**
- Determine appropriate use of the Neighborhood Health Center – Southwest.
  - Conduct business plan (2014)
  - Establish baseline metrics (2014)
- Strengthen collaboration with area Federally Qualified Health Centers (FQHCs).
  - Establish ER referral program via navigators (2014)
  - FQHCs to sign MHIE agreements (2014)
  - Establish metrics of referral numbers and number of patients enrolled and retained by the FQHCs (2013, 2014)

**PRIORITY #4: Address unhealthy lifestyles and behaviors**
- Obesity
- Communicable diseases (chlamydia, gonorrhea, AIDS, tuberculosis, syphilis)
- Accidents

**PRIORITY #4 RATIONALE:** Findings suggest that there is a need to address unhealthy lifestyles and behaviors in the community, such as obesity, communicable diseases (chlamydia, gonorrhea, AIDS, tuberculosis, and syphilis), and accidents. Harris County has high rates of chlamydia (413.8 per 100,000) and gonorrhea (127.8 per 100,000), while Fort Bend County’s chlamydia (196.2 per 100,000) and gonorrhea (52.3 per 100,000) rates are lower. Furthermore, as of 2009, Harris County’s tuberculosis, primary and secondary syphilis and AIDS rates have been higher than the state’s rates. According to
BRFSS, more than 76% of residents in the Houston-Baytown-Sugar Land MSA do not consume the recommended daily intake of fruits and vegetables and more than 23% do not engage in any “leisure time physical activity.” Houston youth were more likely than Texas youth to engage in 14 different risky behaviors, ranging from physical violence, to obtaining cigarettes by purchasing them from a store or gas station, to sexual intercourse before 13, to never being taught in school about HIV or AIDS, and various nutrition and physical activity indicators. In the survey conducted by Memorial Hermann, adult and childhood obesity ranked as the third and fourth most important health problems in the community. More than 82% of respondents believe that obesity is the second most prevalent chronic disease in the community and more than 70% rated nutrition and weight management programs as inadequate or very inadequate in the community.

**PRIORITY #4 RESPONSE:** An unhealthy lifestyle means more illness and more expense to treat those illnesses. Programs provided to patients, the community, and employees to assist with lifestyle changes are:

- **Southwest’s Fresh Start Tobacco Cessation Class** offered in conjunction with the American Cancer Society to help smokers plan a successful “quit” attempt by providing essential information, skills for coping with cravings and group support — 32 individuals participated
- **Screening/Obesity** – 100 individuals participated
- **Pulmonary Rehabilitation** designed to reduce dyspnea, increase functional exercise capacity and improve quality of life for patients with stable, chronic lung problems – 58 individuals participated
- **Women’s Health Education** – 50 individuals participated
- In late 2012, Southwest created a **Women’s Advisory Council** made of influential women from the Southwest Houston community, ranging in age from 20 to 75. The goal of this new council is to promote women’s health issues in the Southwest community through clinical programs, education and events.
- **Community Health Education** – 944 individuals participated
- **Health Fairs** – 760 individuals participated
- **Community Education – Physician’s Newsletter** – 9,300 individuals received
- **Community Health Newsletter** – 235,000 individuals received
- **Memorial Hermann**, one of the largest employers in the Houston area, has numerous employee programs promoting healthy lifestyle living and behavior changes. Among them are:
  - **Required annual physicals** (for employees participating in the Edge insurance program)
  - Incentive based weight loss program—in FY 2012 156 Memorial Hermann Southwest employees lost 681 pounds on the Leaner Weigh program
  - **Financial penalty for smoking** for existing employees and a “no smokers” hiring policy for new employees. Memorial Hermann Southwest is a non-smoking campus.
  - **Wellness & You** Program which incorporates fresh and delicious recipes that meet established guidelines into daily retail food offerings
  - **My Fitness Pal**, which, free for iPhone and Android, provides a personalized diet profile to one’s unique weight loss goals
Cooking for Wellness where chefs and dietitians in the Café host cooking demonstrations using healthy cooking techniques

Meatless Mondays which encourages reduction of meat consumption by 15% to improve personal health and the health of the planet

Eat This...Not That signage to drive awareness of options, calories, and ingredients

To address the increasing rate of HIV, especially among the African American population, Memorial Hermann Southwest provides routine HIV testing for all emergency room patients ages 18-65, and younger patients with symptoms--unless they opt out. Since September 2009, Southwest has screened 25,723 patients with 284 patients (newly) diagnosed with positive results. Additionally, basic information regarding HIV/AIDS, Syphilis and Hepatitis B, in English and Spanish, is given to every patient upon admission into Labor & Delivery. More than 3,900 patients received information in FY2012.

PRIORITY #4 STRATEGY:

Objective #4.1: To continue to reinforce healthy lifestyles and influence and encourage behavior change.

Implementation Activity:

- Provide on-going education on healthy lifestyles and healthy choices as measured by programs and attendees.
  - Explore program options (2014)
  - Implement select program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)

- Implement regular, ongoing community education courses for weight management and exercise.
  - Explore program options (2014)
  - Implement select program(s) and establish baseline metrics (2015)
  - Report metrics (2015, 2016)

- Provide meeting room space at no cost to health and community related groups as measured by collaboration with community groups.
  - Establish baseline metrics (2014)
  - Increase participation over baseline by 10% (2015)
  - Report metrics (2015, 2016)

- Implement Memorial Hermann System Wellness Initiatives.
  - Continue current wellness programs including incentive/disincentive for wellness/non-wellness selections (2013-2016)
  - Expand on the successful Pilot “Eat This...Not That” (2013-2016)
  - Implement vending program revisions (2014)
  - Implement catering menu revisions (2014)
  - Implement patient menu revisions (2014)
  - Report metrics on reduced caloric intake and reduced weight gain (2015,2016)
PRIORITY #5 RATIONALE: Access to mental health services ranked as a top concern over and over again in the survey conducted by Memorial Hermann. For example, 79.5% of respondents indicated that the needs of persons with mental illness were being either inadequately or very inadequately met. Mental health problems ranked as the number one most important health problem in the community, with 71.1% of respondents ranking it first. More than 85% of respondents said that access to mental/behavioral healthcare services for low income residents was difficult or very difficult. Finally, more than 80% of respondents indicated “inadequate or very inadequate” for services provided for mental health screenings. Interviewees also noted the need to address barriers to mental healthcare, such as the inadequacy of mental and behavioral health treatment programs available in the community, the limited number of beds for inpatient mental health services and the critical need for substance abuse intervention and rehabilitation programs.

PRIORITY #5 RESPONSE: Houston is struggling with a mental health crisis. With a shortage of psychiatric facilities and a lack of financial resources, insured as well as uninsured patients are left seeking services from emergency room physicians and nurses untrained in psychiatry. They face problems that are pressing and real, yet typically wait while ER personnel attend to others with more pressing physical needs. Within the Memorial Hermann System, two innovative mental health programs operate.

Since 2000, on call day and night, Memorial Hermann’s Psych Response Team acts as mental health experts for the ERs. They are a team of mental health professionals, responding to calls from Memorial Hermann’s emergency rooms when patients present with symptoms of mental illness, such as depression, psychosis, or chemical dependency. They stabilize, evaluate, arrange referrals, and follow-up to maintain patient compliance.

The team refers to 30+ mental health community treatment providers within Harris, Fort Bend and Montgomery Counties. This size enables the program to leverage the mental health community’s resourced patients (72%) to obtain care for the community’s non-resource patients (28%). No longer is it one ER/Nurse/MD competing with the rest of the ERs for a limited amount of psychiatric resources. Rather, there is a coordinated approach, and the community’s psychiatric programs accept Psych Response team referrals because it is in their best interests. A report is shared monthly, detailing the number of resource and non-resource patients referred throughout the community. In 2012, 390 Southwest patients were assessed and treatment recommendations were made.
The Memorial Hermann Prevention and Recovery Center (PARc), the number one drug rehab and alcohol treatment program in Houston providing detoxification, residential treatment, intensive outpatient programs, and an aftercare program is a substance abuse referral source for Memorial Hermann Southwest Hospital. The PARc has 30 years of experience treating addiction as the chronic, progressive, primary illness that research and medical technology have shown it to be. The CEO of the PARC participates on numerous boards and councils promoting mental health awareness, policy, and expansion of services including: membership on the THA (Texas Hospital Association) Psychiatry and Chemical Dependency Services Constituency Council, membership on the Coalition of Behavioral Health Providers, chairmanship of the Treatment Services Subcommittee for the Houston/Harris County Office of Drug Policy, advisory board membership on MCMHTF (Montgomery County Mental Health Treatment Facility), president of TAAP (Texas Association of Addiction Professionals), and an informal advisor and provider of in-kind donations to The Men’s Center and Santa Maria Hostel, local non-profits that serve homeless and indigent substance abusing men (Men’s Center) and women with children (Santa Maria).

Memorial Hermann Southwest is the only hospital system in the Houston-Metropolitan area that provides comprehensive mental health services to the geriatric population. All admitting patients enter through the Senior Emergency Room and are assessed by social workers trained specifically in geriatric-psychiatric care. The 18-bed STAR Unit, for seniors 65 years and older, is staffed with board certified geropsychiatrists and geriatricians, and has partnered with local post-acute care facilities to provide behavioral continuity of care. In addition, the program has collaborated with the Alzheimer’s Association to provide professional and peer education, the Methodist Neurological Institute Outpatient Nantz National Alzheimer Center to provide inpatient services that are not provided by their system, and various Assisted Living Facilities to provide pre-admission psychiatric evaluations for potential residents. An outpatient geropsychiatric clinic offers post discharge mental health follow-up.

**PRIORITY #5 STRATEGY:**

**Objective #5.1:** To address Behavioral Health/Substance Abuse readmission rates.

**Implementation Activity:**
- To partner with the Psych Response Team to provide case management of post-discharge behavioral health patients in order to encourage compliance in prescribed health maintenance activities.
  - Identify individuals whose chronic mental illness predicts they will likely have repeat visits to the ER and connect them with case management services for follow-up after discharge (2014)
  - Establish and monitor metrics of reduction in the 30-day behavioral health/substance abuse readmission rate (2015)
  - Report metrics (2015, 2016)
- To partner with the Psych Response Team to provide a crisis stabilization clinic that will provide rapid access to initial psychiatric treatment and outpatient services.
  - Identify individuals with behavioral health needs that, if addressed quickly, may avoid unnecessary use of emergency departments, hospitalization or incarceration (2014)
Objective #5.2: To expand the current geropsychiatric inpatient and outpatient services.

Implementation Activity:
- Assess opportunities for programmatic expansions.
  - To expand the current geropsychiatric unit (2014-2016)
  - To add an outpatient partial hospitalization program (2014-2016)
  - To recruit 1-2 staff psychiatrists (2014, 2015)

PRIORITY #6: Decrease health disparities by targeting specific populations

- Safety net population (under/uninsured, working poor, indigent)
- Unemployed
- Children
- Elderly and “almost elderly” (those who are not yet eligible for Medicare)
- Asian immigrant population
- Homeless

PRIORITY #6 RATIONALE: Data suggests that there are various health disparities among specific populations in the community. There are disparities among those who face medical cost barriers with regard to gender, race/ethnicity, income and education. The Health of Houston Survey 2010: A First Look indicates that health insurance and access to care is a particular concern for the Houston area, with Hispanic and Vietnamese residents having much higher uninsured rates than the average. The Health of Houston Survey: 2010 also indicates that there are disparities among children’s access to insurance. According to the Behavioral Risk Factor Surveillance System, there are mental health disparities with regard to gender, race/ethnicity, income and age. There are also disparities among those who report diabetes, those who are overweight or obese and those who do not participate in any leisure time physical activity. Interview data also reflects these disparities. The populations most at risk include the safety net population, the unemployed, children, elderly and “almost elderly,” non-English speaking minorities, Asian immigrant populations and the homeless.

PRIORITY #6 RESPONSE: As a result of its diverse community, Southwest addresses health disparities through the following programs:

- Since 2008, Memorial Hermann Southwest’s uninsured patients with a pattern of repeat emergency room use and hospital readmissions have had access to COPE (Community Outreach for Personal Empowerment), a program which, through education, guidance, and follow-up by social workers, educates individuals about the health and social service resources available to them. Through this education and referral to accessible resources, the program has
demonstrated success in many areas, including reduced use of hospital admissions and emergency room visits. The program requires active interventions, tools, and empowering communication to help patients identify, access and obtain community based services. In FY 2012, 1,374 patients were enrolled in the COPE program, Memorial Hermann systemwide.

- Since 2006, Memorial Hermann Southwest’s uninsured, Medicaid and Medicare patients with chronic conditions such as congestive heart failure, diabetes and chronic obstructive pulmonary disease have had access to the Memorial Hermann Chronic Disease Management Program. Through regular telephone support by a registered nurse trained in chronic management, patients are encouraged to follow the instructions of their physicians for medication compliance, exercise, diet, lab work and office follow-ups. With patient consent, physicians receive prompt notification if the nurse notices any emergent problems that require immediate attention. The program has demonstrated success in many areas, including improved quality of life, decreased disease burden, and reduced hospital admissions and emergency room visits.

- Through a partnership with the March of Dimes’ Healthy Babies are Worth the Wait Initiative and in collaboration with Clinica Hispana, which provides well-woman care and prenatal visits to women in the community, Southwest has been able to improve the outcomes of infants delivered at the hospital. A patient navigator helps patients from Clinica Hispana access care at the hospital. Staff provides written information to patients seeking care in the Labor and Delivery department and in the emergency room. Some of the topics include: Signs of Preterm Labor, Importance of Prenatal Care, and Risks of Smoking during Pregnancy. Eleven classes have been held on pregnancy nutrition and becoming a mom. Also through March of Dimes, bags were created for the Clinic and emergency room that provide pregnant women with information on local shelters, low-cost clinics and the importance of waiting to deliver, as well as a free prenatal vitamin voucher, which may be used at the Walgreens on the Southwest Hospital campus.

- The University of Texas Health Science Center’s Maternal Fetal Medicine Clinic has an increasing presence on the Southwest campus for high-risk moms and underserved moms with complications.

- Southwest is the only hospital outside of the medical center to provide Transcatheter Aortic Valve Replacements (TAVR), a newly FDA approved procedure that allows patients who don’t qualify for open heart procedures to have an aortic valve replacement.

- One specific population, historically underserved, is the nearby Asian Community. Southwest is serving the needs of the Chinese/Vietnamese community members by offering:
  - A dedicated Chinese/Vietnamese hospital wing
  - Bilingual nursing staff
  - Chinese/Vietnamese medical interpreters available throughout the hospital
  - Patient dining menu featuring Asian entrees
  - Asian TV programs available in all patients’ rooms
  - Radio and TV health discussions, and community health fairs specific to the Chinese/Vietnamese populations
• Addressing the needs of the homeless population is challenging. Memorial Hermann Southwest discharges the patient back to the homeless shelter and ensures that they obtain their basic needs such as clothing and food through community resources.

**PRIORITY #6 STRATEGY:**

**Objective #6.1:** To expand programs that support the safety net population, including the unemployed and “almost” elderly.

**Implementation Activities:**
- Expand COPE Program.
  - Determine level of need of increased penetration (2014)
  - Establish baseline metrics covering decreased emergency room visits, observation stays, and inpatients admissions (2015)
  - Report metrics (2015, 2016)

**Objective #6.2:** To expand programs that support children.

**Implementation Activity:**
- To create a pediatrician referral process by utilizing a referral coordinator. (2013-2014)

**Objective #6.3:** To expand programs that support the homeless.

**Implementation Activity:**
- Create and distribute throughout the hospital lists of local food pantries, local shelters, low cost prescription programs and low cost and free clinics. (2013-2016)

**Objective #6.4:** To expand programs that support Asian and other immigrants.

**Implementation Activities:**
- To recruit a Chinese OB/GYN. (2014, 2015)
- Patient dining menu to include South Asian entrée options. (2014)
- To provide South Asian TV programs. (2014)
- To address translation gaps by putting Memorial Hermann’s core clinical applications in Spanish.