Memorial Hermann Community Benefit Corporation

An Evolution of Thinking

MEMORIAL HERMANN

Memorial Hermann Facts and Figures

FACTS & FIGURES (FISCAL YEAR END 2008)

- Total hospitals: 11
- Acute care: 9
- Children's: 1
- Rehabilitation: 1
- Heart & Vascular Institutes: 3
- Managed acute care hospitals: 3
- Sports Medicine & Rehabilitation Centers: 27
- Ambulatory surgery centers: 10
- Diagnostic laboratories: 12
- Imaging Centers: 21
- Retirement/nursing center: 1
- Home health agency: 1
- Annual emergency visits: 377,256
- Annual deliveries: 25,411
- Annual Life Flight air ambulance missions: 2,960
- Employees: 19,500
- Beds (licensed): 3,514
- Medical staff members: 4,178
- Residency programs: 26
- Fellowship programs: 48
- Physicians in training: 1,324 (physicians and fellows)
- Annual payroll: $1,091,207,000
- Annual community benefit: $300,357,000

- **32% Uninsured or 1.14 million people**
- **County based governmental accountability for indigent care**
- **Safety net primary care infrastructure significantly undersized**
- **Access to specialty care an even bigger issue**
- **Loss of University of Texas Medical Branch at Galveston**
  - **Burn unit**
  - **One of three Level 1 Trauma Centers**
  - **Psychiatric unit**
  - **Significant indigent care provider**

Mid 90's
Memorial Hermann
Committed to a 10% Tithe of
Net Operating Revenue

How do you spend it?

What difference does it make?

How do you evaluate success or failure?

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Hospital Centric Model

Projects brought forward to Committee

Very political

Lots of cost shift – only a few programmatic efforts survived

However Focus Areas and Tenets Emerged From Initial Efforts

- **Focus on Children**
- **Programs have measurable, sustainable outcomes**
- **Focus on health and healthcare – our strengths**
- **Work in collaboration, not in isolation**
- **Educate and advocate on the impact of inaction**
- **Don’t just write checks**

Momentum Fades . . .

- **Accountants hate tithes and accruals across fiscal years**
- **Tough financial years place strain on sustaining programs**
- **Moved from tithe to budgeted amount**
- **Amount varied by strategic direction of Corporation**

All the While -

- **Core programs were winning State and National Awards**
  - **Texas Association of Partners in Education (TAPE) Gold Award**
  - **American Hospital Association (AHA) NOVA**
  - **Induction into the HISD Hall of Fame**
  - **Voluntary Hospitals of America (VHA) Leadership for Community Benefits**
  - **Texas Hospital Association (THA Excellence of Community Service)**
  - **Texas Dental Association Certificate of Merit**

All the While -

- **Memorial Hermann Leadership Became Very Engaged in Community Efforts**
  - **Public Health Task Force**
  - **Community Leader's Forum**
  - **Gateway to Care**
  - **Houston Healthcare Alliance**
  - **Greater Houston Partnership**
  - **Provider Health Task Force**
  - **Children's Defense Fund**

- **Memorial Hermann Boards and Employees were largely unaware of the efforts and market place impact**

SO WHAT'S THE NEXT STEP?

FORMALIZED AND CONSOLIDATED ALL COMMUNITY BENEFIT ACTIVITIES INTO A SEPARATE CORPORATION

What Would a Separate Corporation Achieve?

- **Dedicated Board**
  - **Focus on the issues**
  - **Help craft solutions**
  - **Advocate at local, state and national levels**
  - **Own the initiatives**
- **Responds to continued scrutiny of non-profits**
- **Corporation can retain a bottom line – money can be accumulated to tackle larger efforts**
- **Focused grant writing and funding efforts – distinct from Foundation efforts**
- **Indication to internal and external communities importance placed on these functions**
- **Provides some separation in reporting**

Corporation was formed January, 2008
Where are we today . . . .

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Thirteen member Board committed and engaged

Commitment of $5,000,000 per year for the next three years

Dedicated grant writer in place

Numerous programs operational

Three pilot programs operational

MISSION

Memorial Hermann Community Benefit Corporation will 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. Proven programs will be actively shared and promoted for broad implementation within the community.

VALUES

- **We collaborate with others to improve the community's infrastructure for the uninsured.**
- **We focus on children.**
- **We embrace innovative approaches.**
- **We are advocates at the local, state and national levels to achieve 100% access to basic care.**
- **We support educational efforts focused on prevention and appropriate use of our community's healthcare resources.**
- **We measure the outcomes of each effort and only sustain and expand those with demonstrable outcomes.**
- **We are committed to engaging our employees, volunteers and medical staffs in our efforts.**

A CHANCE TO PILOT PROGRAMS

INSPITE OF TIGHT BUDGETS

ER NAVIGATION PROGRAM

NON HOSPITALIZED ED VISITS TO ALL HOSPITALS (N=25) BY HARRIS COUNTY AREA RESIDENTS

Type of Visit	All
Number	25
CATEGORIZED VISITS	
Non-Emergent	146,963
Emergent, Primary Care Treatable	162,192
Emergent, ED Care Needed - Preventable/Avoidable	56,800
Total Primary Care Related Visits	**365,955**
Emergent, ED Care Needed - NOT Preventable/Avoidable	82,485
Total Categorized Visits	**448,440**
NON-CATEGORIZED ED VISITS	
Injury	166,872
Mental Health Related	10,466
Alcohol or Drug Related	5,297
Unclassified	78,421
Total Non-Categorized Visits	**261,056**
Total Visits	**709,496**
Percent	
DETAIL - CATEGORIZED ED VISITS	
Non-Emergent	32.8%
Emergent - Primary Care Treatable	36.2%
ED Care Needed - Prev./Avoid.	12.7%
% Total Primary Care Related	81.6%
ED Care Needed - NOT Prev./Avoid.	18.4%
TOTAL	
Non-Emergent	20.7%
Emergent - Primary Care Treatable	22.9%
ED Care Needed - Prev./Avoid.	8.0%
% Total Primary Care Related	51.6%
ED Care Needed - NOT Prev./Avoid.	11.6%
% Categorized ED Visits	63.2%
Injury	23.5%
Mental Health Related	1.5%
Alcohol or Drug Related	0.7%
Unclassified	11.1%
% All Visits	100.0%

If given true options and connections – will people stop using the ER for primary care?

ER Navigator Program

GOALS

- **Peer-to-peer advisors who are state-certified community workers**
- **Connection with a medical home (health care safety net services)**
- **Reduced reliance on the ER for primary care**

Outcome Measurement

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Quantitative Data

- **ER visits—6 months before and 6 months after for each individual patient**
  - **Goal is to reduce ED visits to, at minimum, cover the cost of the program**

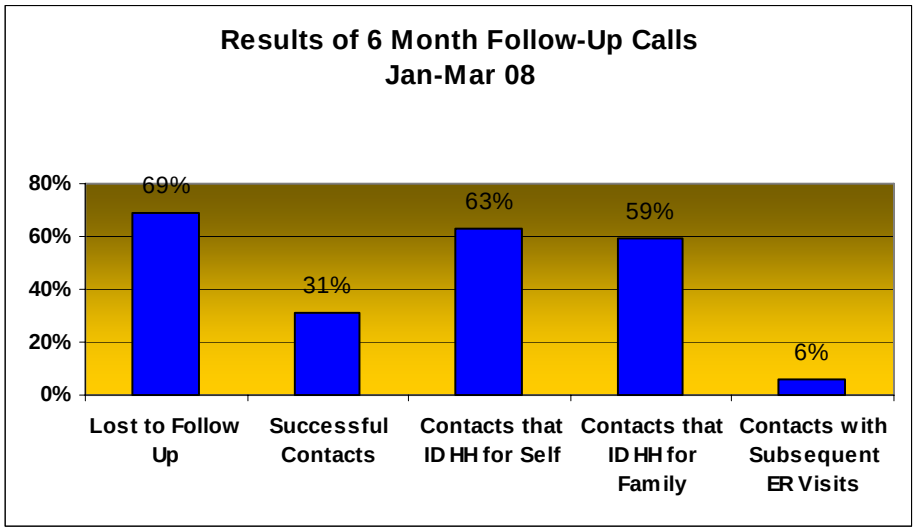
ER Navigator
Annual Salary: $35,000
Benefits Cost: 8,000
Total Annual Cost: $43,000

Cost per ER Visit $400

108 Visit reduction
Pays for Salary

OUTCOMES MEASUREMENT

- **Qualitative Data**
- **6 month phone calls measuring effectiveness of connection:**
- **Acknowledged use of a medical home**
- **Times visited the ER since receiving navigation**



COPE
Community Outreach for Personal Empowerment

Uninsured patients with three or more admissions in the past sixteen months are encouraged to enroll

After discharge case management with a social work model

COPE

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Program Goals

1. **Empower participants to take control of their healthcare**
2. **Establish participants with a Primary Medical Health Home**
3. **Improve and maintain participants' general health and well being through the use of available local community resources**
4. **Decrease hospital Emergency Center visits, Observation stays, and Inpatient admissions**
5. **Decrease Cost per Case of Emergency Center visits and Inpatient admissions**

COPE

	Pre-Enrollment (E.R.)						
	1-3 months	4-6 months	7-9 months				Total
Visits	70	152	9				231
Cost	41891.68	67033.4	4480.62				113,405.70

	Post-Enrollment (E.R.)								
	1-3 months	4-6 months	7-9 months				Total		% Change
Visits	22	45	5				72	-159	-68.8%
Cost	8840.18	17840.26	2219.93				28,900.37	(84,505.33)	-74.5%

	Pre-Enrollment (In-Patient)						
	1-3 months	4-6 months	7-9 months				Total
Visits	5	24	3				32
Cost	34146.75	193774.07	45281.6				273,202.42

	Post-Enrollment (In-Patient)								
	1-3 months	4-6 months	7-9 months				Total		% Change
Visits	0	2	0				2	-30	-93.8%
Cost	0	15030.36	0				15,030.36	(258,172.06)	-94.5%

	Pre-Enrollment (Observation)						
	1-3 months	4-6 months	7-9 months				Total
Visits	7	15	0				22
Cost	25277.44	29107.99	0				54,385.43

	Post-Enrollment (Observation)								
	1-3 months	4-6 months	7-9 months				Total		% Change
Visits	0	9	1				10	-12	-54.5%
Cost	0	22168.61	1775.15				23,943.76	(30,441.67)	-56.0%

Community Based Case Management CHF

- **Traditional disease specific case management**
- **Congestive Heart Failure (CHF) protocols help to ensure people with CHF receive the appropriate care by coordinating with hospitals and clinics that provide affordable treatment and primary care, each hospital admission avoided b this program saves an estimated $7,000**

CHF

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Program Goals

- **Coordinate and strengthen healthcare services for patients with chronic disease, in particular, Congestive Heart Failure**
- **Provide clinical preventative services that are proven effective in managing chronic disease**
- **Utilize Patient Navigator services to support coordination of care with hospitals, physicians and clinics that provide treatment and primary care**

CHF Results

	Pre-Enrollment (E.R.)						
	1-3 months	4-6 months	7-9 months	10-12 months	13-18 months	19-24 months	Total
Visits	2	13	25	10	31	5	86
Cost	508.5	6369.29	14910.31	6219.8	11136.91	3177.87	42,322.68

	Post-Enrollment (E.R.)								
	1-3 months	4-6 months	7-9 months	10-12 months	13-18 months	19-24 months	Total	Change	% Change
Visits	0	21	4	0	3	3	31	-55	-64.0%
Cost	0	11851.89	1690.77	0	1829.74	1961.65	17,334.05	(24,988.63)	-59.0%

	Pre-Enrollment (In-Patient)						
	1-3 months	4-6 months	7-9 months	10-12 months	13-18 months	19-24 months	Total
Visits	13	71	140	77	115	20	436
Cost	190207.72	741271.04	1638868	871102.25	1306094.78	194659.6	4,942,203.41

	Post-Enrollment (In-Patient)								
	1-3 months	4-6 months	7-9 months	10-12 months	13-18 months	19-24 months	Total		% Change
Visits	1	103	14	16	32	7	173	-263	-60.3%
Cost	1031.88	1097932.4	157811.12	123424.14	387617.16	69121.66	1,836,938.36	(3,105,265.05)	-62.8%

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CAN THIS PROGRAM BECOME COMMUNITY BASED SUPPORTED BY MULTIPLE HOSPITALS?

Neighborhood Health Centers

- **Neighborhood Health Centers are located near three of Houston's busiest emergency centers providing care to working families without access to insurance and who do not quality for other programs**
  - **Three operational**
  - **Federal earmark funding received**
  - **Mid level 7-day a week clinics that serve as a medical home**
  - **Fixed price model**
  - **Designed for +200% FPL without insurance**

School-based Health Care
A sustaining & Growing Commitment since 1996

MEMORIAL HERMANN HEALTH CENTERS FOR SCHOOLS

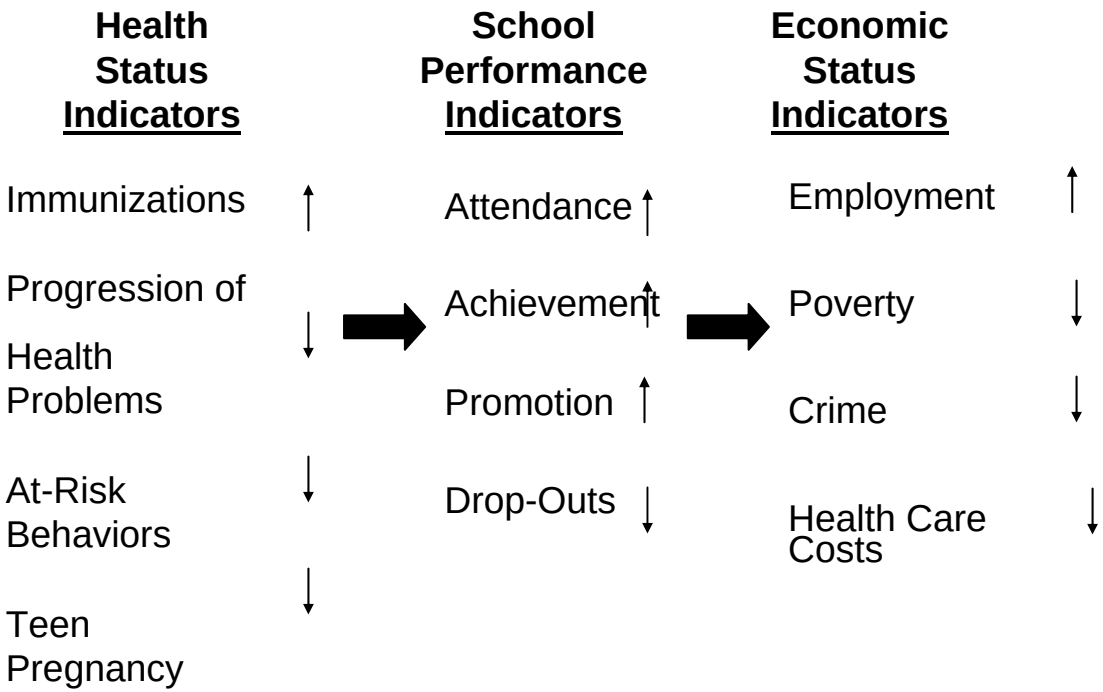
Who we are . . .

- **Five school-based health center sites**
- **One mobile dental van**
- **Three school districts – 31 schools with student population of 24,000 served**
- **Free primary medical, mental health, nutritional and dental care provided**

Why we exist . . . the uninsured children of our community

- **US** **15%**
- **Texas** **24%**
- **Harris County** **32%**
- **31 schools served** **69%**

Visit numbers alone do not represent SBHC impact

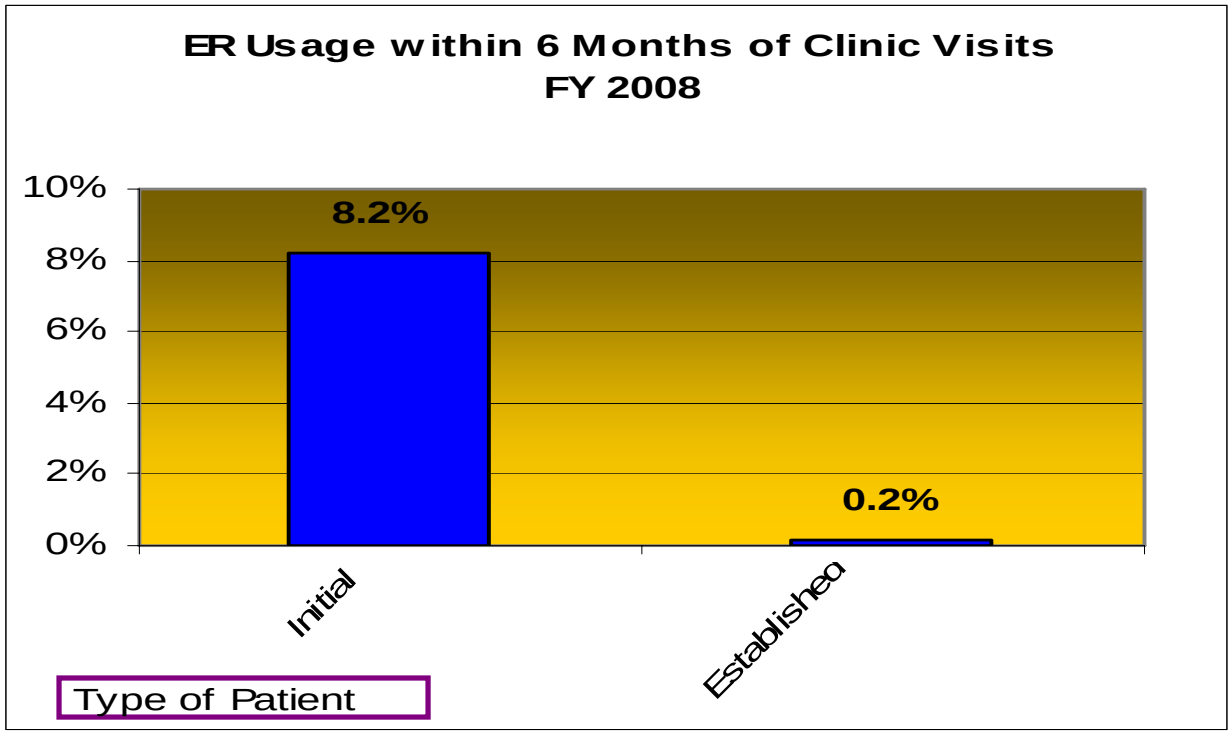


In FY 08, Memorial Hermann Health Centers for Schools monitored ten (10) measurable objectives in six (7) categories:

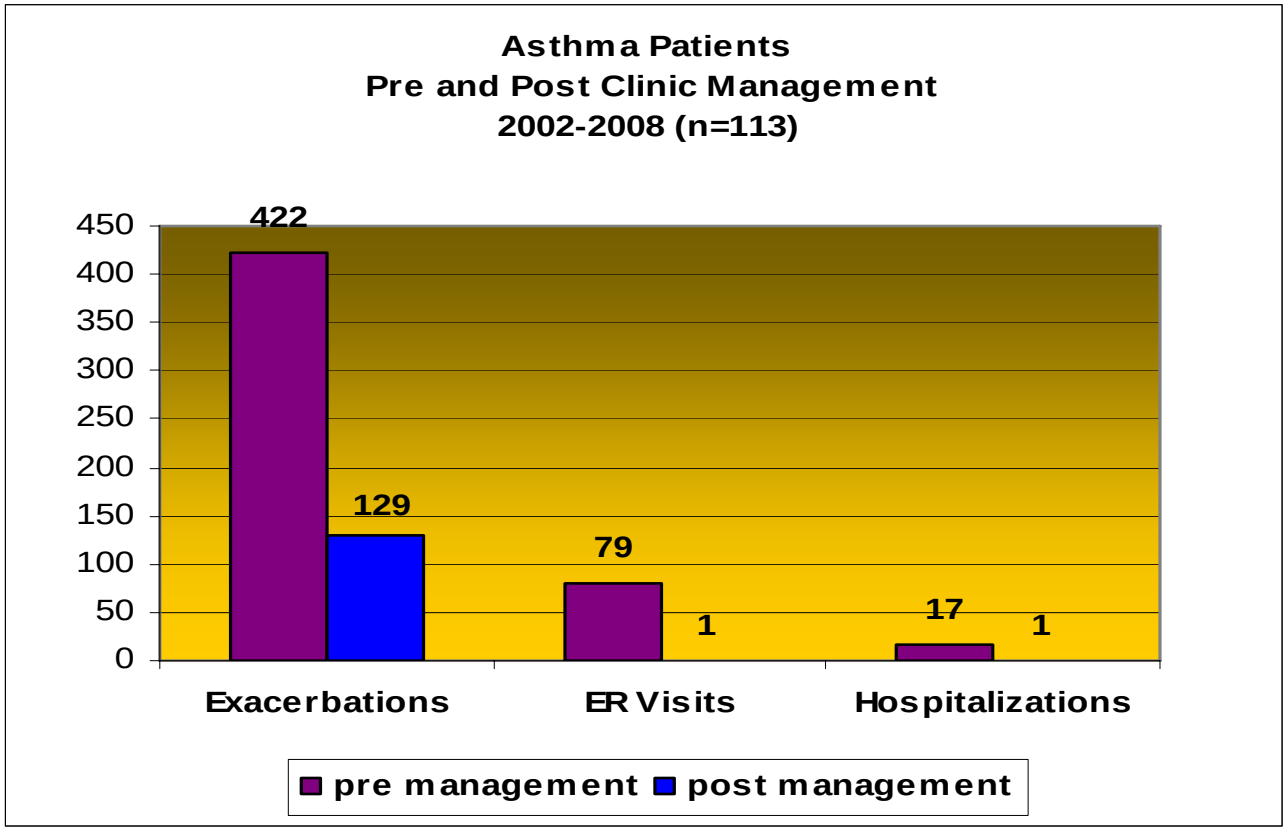
- **Healthcare access**
- **Asthma management**
- **Cholesterol Management**
- **Education**
- **Dental care**
- **Mental Health Care**
- **Reproductive Knowledge**

ACCESS

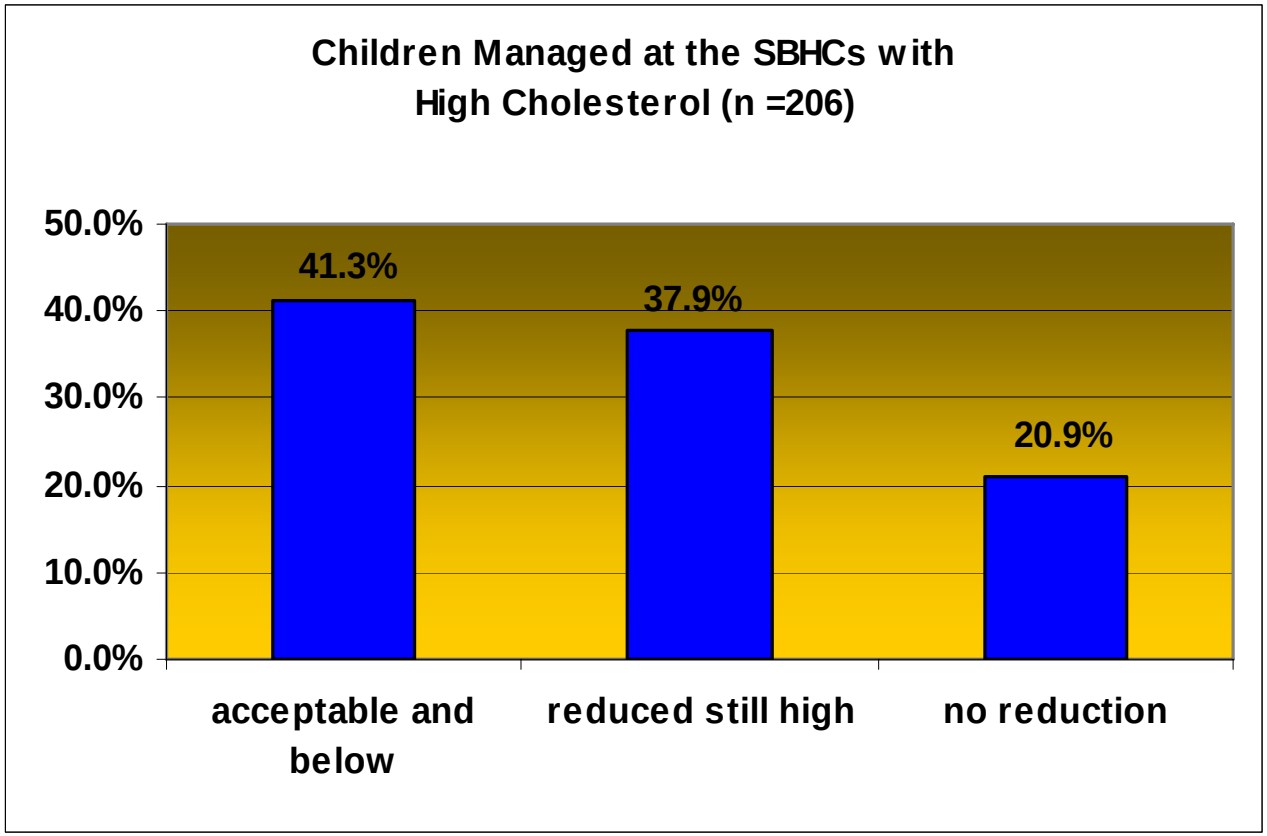
Inappropriate ER usage within six months of clinic visit



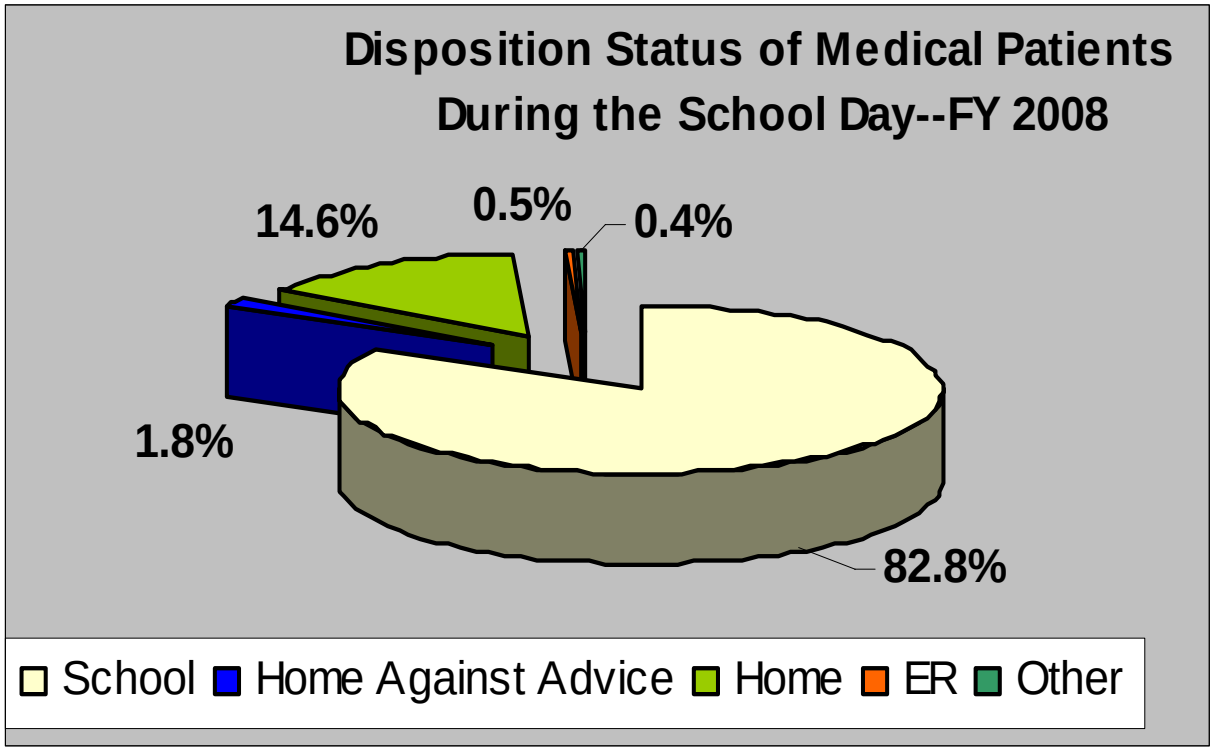
ASTHMA MANAGEMENT



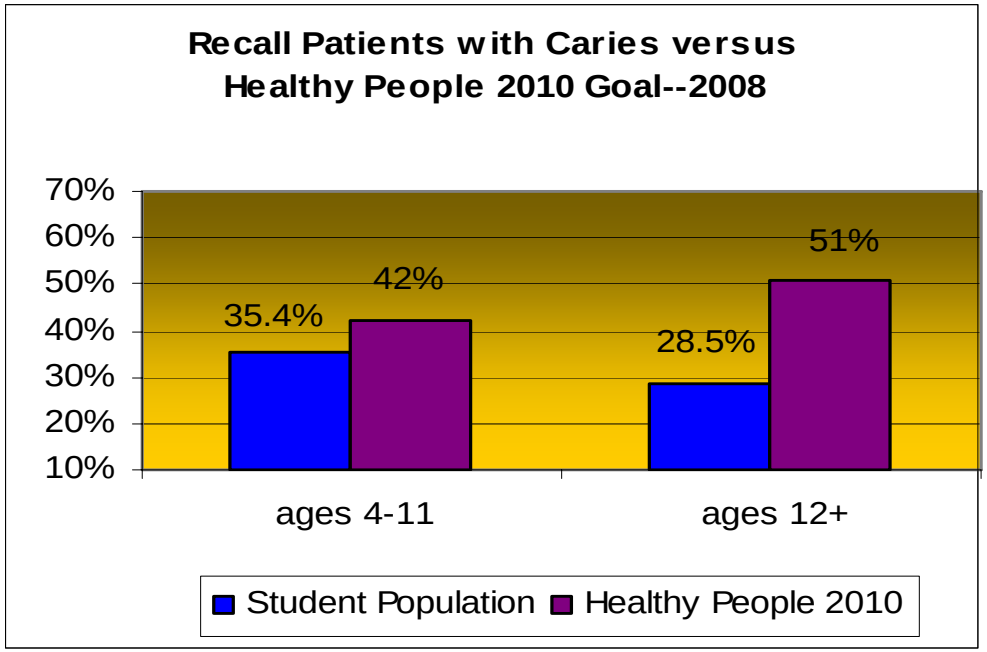
CHOLESTEROL MANAGEMENT



EDUCATION


Disposition Status of Medical Patients During the School Day--FY 2008
14.6%
0.5%
0.4%
1.8%
82.8%
School
Home Against Advice
Home
ER
Other

Dental Care



The program has surpassed the Healthy People 2010 goals for caries at recall for both age groups.

HEALTHCARE LEADERS, INCLUDING GOVERNANCE, MUST FOCUS NOT ON HOW TO CONNECT AND REPORT WHAT IS BEING DONE, BUT RATHER ON ENSURING THAT WHAT IS BEING DONE REALLY MAKES A DIFFERENCE.

Richard L. Clarke
President & CEO HFMA

MEMORIAL HERMANN

It isn’t about just what we can do . . .

Collaboration also grows

PROVIDER HEALTH NETWORK

- 638 Physicians
- 32 Hospitals
- 37 Other Providers
- 11,661 medical, hospital diagnostic & navigation services
- $5.8 million in charity care provided

$1.1 Million infrastructure

Grant from local foundation

- People
- Recruitment
- Drugs & transportation

4 dollars of service have been provided for every dollar of infrastructure[1]

- **Foundation support to develop PHN in neighboring county**

[1]**Source: University of Texas School of Public Health, December 2008**

MEMORIAL HERMANN ROLE

- **Fiscal agent for grant**
- **Provide TPA services for claims and reporting**
- **Facilities and physicians key players in PHN**
- **Recruit, Recruit, Recruit**