

DEFINING AND IMPLEMENTING THE FUTURE OF HEALTH CARE

2015 ANNUAL REPORT

MHMD • Memorial Hermann Physician Network



MHMD
MEMORIAL HERMANN Physician Network

MHMD Mission



OUR MISSION is to lead the transformation of medical practice in collaboration with patients, payers and caregivers, through the use of evidence-based medicine. We establish a culture of physician accountability and create and deploy new methods of health care that will improve the quality, safety and cost efficiency of the care we provide for the populations we manage.

MHMD

Physician Compact

PHYSICIANS AGREE TO:

- Practice evidence-based medicine
- Uphold regulatory, quality and safety goals
- Report quality data
- Meet Clinical Integration criteria
- Attend meetings and feedback sessions
- Receive MHMD information
- Accept decisions of physician committees
- Be flexible and professional
- Collaborate with colleagues and hospitals
- Share ideas

MHMD AGREES TO:

- Be loyal to physicians
- Negotiate well to align incentives
- Include physicians in work decisions
- Provide clear and timely information
- Offer vital services and education
- Seek feedback from physicians
- Maintain confidentiality
- Communicate with physicians
- Host informative meetings
- Create leadership training





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MHMD Leadership (left to right):

Michael Davidson, MD, CMO;

Sandra Gomez, MD, Medical Director, supportive medicine;

Shawn Griffin, MD, Chief Quality & Informatics Officer;

Emily Scott, VP, Accountable Care Organization;

Rachel Taylor, AVP, Strategic Initiatives;

Keith Fernandez, MD, MHMD President & Physician-in-Chief;

Mary Folladori, Director, Care Management;

Chris Lloyd, CEO;

Nicole Clarke-Luck, VP, Finance and

LeTasha Montgomery, COO

MHMD

Executive Leadership Team



Executive Summary

Transforming the Practice of Medicine

The year 2015 was another year of explosive growth and industry-leading success for MHMD, one of the largest physician organizations in the country, and Memorial Hermann Health System, one of the most advanced, fully integrated health systems in the nation. Together, these organizations have formed and operationalized the Memorial Hermann Accountable Care Organization (MHACO), which has allowed alignment with clinically integrated physicians under a single-signature contracting structure. With approximately 2,000 physicians in the MHACO serving both commercial and Medicare contracts, it has emerged as the top performing ACO in the country in the Medicare Shared Savings Program for two consecutive years.

With the largest primary care network in the Houston market area, MHMD collaborates with narrow network payers to bring value to employers who offer health insurance to their employees. Our tightly integrated physicians

are able to better manage each patient's gaps in care with the visibility of patient records across the electronic health record continuum available to MHMD providers. We continue to enhance innovative services and data sharing to simultaneously improve the physician's productivity and patient experience.

The MHMD physician network in its entirety now includes more than 4,000 members and the Clinical Programs Committee has expanded to include 57 physician-led sub-committees. These committees elevate quality across the enterprise by driving evidence-based protocols and standards.

In Fiscal Year 2015, MHMD also embarked on a new adventure in the journey toward population health through the initiation of the Accountable Care Organization Service Line (ACOSL) Projects. Under the umbrella of the MHACO, the ACOSL projects aim to increase efficiency and decrease cost for Medicare inpatients in the areas

of Orthopedics, Heart and Vascular, and Hospital Medicine.

The ACOSL projects more closely align MHMD physicians with hospital leadership and provide a venue to tackle complex efficiency and care opportunities. These projects uniquely bring together multidisciplinary team members to identify, analyze and solve key challenges on each hospital campus. Each team is focused on enhancing quality, length of stay, observation hours, supply savings and patient satisfaction in the inpatient setting. In its inaugural year, the ACOSL projects have contributed by improving quality and reducing costs. The savings generated through these projects are directly attributable to the efforts and commitment of our physicians, who provide the very best evidence-based care in the most efficient and coordinated way possible.

In 2015, the accountable care network expanded to more than 400,000 covered lives. Working collaboratively with insurance companies,



Chris Lloyd, Chief Executive Officer

employers, and Memorial Hermann Health System, the network continues to produce impactful results in cost savings while improving healthcare quality provided to patients. The accountable care network is supported by a unique and robust Care Management program that was developed based on evidence-based guidelines from various sources, including medical and behavioral healthcare specialty societies. The program uses a member-centric approach, encourages self-care, integrates behavioral change principles, links with community resources and assists with navigating the healthcare system.

Also launched in 2015, the MHMD University program, offered in conjunction with the Jones School of Business at Rice University, allowed 26 physician leaders and System executives to further develop their knowledge and leadership skills while learning side by side about leadership, strategy, finance and operations. Participants also worked in teams throughout the program to tackle a capstone project that explored an area of strategic priority to the Memorial Hermann

system. We believe by investing in both executive and physician future leadership, we will position Memorial Hermann to remain at the forefront of the healthcare industry.

The Supportive Medicine program, an innovative outgrowth of traditional palliative medicine programs, offers early intervention to effectively support patients with chronic illness through the course of their disease process and treatment in order to optimize the patients' quality of life. In 2015, Supportive Medicine teams consulted over 4,500 hospitalized patients across Memorial Hermann Health System, representing a 27 percent increase over the previous year. Patients reported a significant improvement in their symptom control after involvement by the Supportive Medicine team. These patients also experienced a shorter length of stay and considerable cost savings due to their participation in the program.

The MHMD strategy continues to produce impressive results as we lean on our culture

of quality medicine and accountability. Our investment in physician education, innovative industry-leading tools, data systems and technologies supported by the strength of the MHMD Board and CPCs are key ingredients to the success of the MHMD Physician Network. As we move into the future, MHMD will continue to work closely with aligned physicians across the market and will keep identifying the most innovative solutions in the ever-changing healthcare environment.

We will persist in tackling challenging issues with resolve to offer the most advanced, quality healthcare services in the Houston market area, supported by the most robust and respected primary care network.



Peter Jung, MD
Pediatrics

CHM
Children's Hospital of
Miami

The MHMD

Physician Network of Quality Care

The MHMD Physician Network continues to set the example for networks across the country. With the largest PCP network in the Houston market area and growing, MHMD involves and engages physicians in impacting the quality of patient care at all of the Memorial Hermann campuses. As the healthcare environment becomes more complex, physicians are challenged to stay abreast of the continuous changes. Valued members of the MHMD network receive ongoing updates and education on the ever-changing healthcare environment and are shielded from the unilateral fee schedule reductions that payers apply annually to individual contracted physicians.

In 2015, MHMD continued to grow ending the year with approximately 400,000 covered lives, which include both exchange and commercial products. With its success, the MHMD network is influencing health care as an industry and the Houston marketplace. Area employers are able to offer their employees a quality healthcare experience, utilizing a tighter

referral network, which lowers the cost to employers. And, because the MHMD network is able to share information more readily, patients experience reduced duplication of services and an improved continuum of care.

In order to support the growing number of covered lives and the complex healthcare landscape, the MHMD organization has become more sophisticated. MHMD is evaluating and implementing programs that are leading the market and providing solutions to patients and employers, including value-based contracting, retail medicine, telemedicine, global payment, virtual medicine, population health and other consumer-driven solutions.

The organization also continues to enhance the established programs to become more effective, including transitions of care, EMR utilization, pharmacy, complex care, supportive medicine, coding education, diabetes services, psychiatry, preventive care gaps and social services. As the network has matured, those physicians

who choose to be more tightly aligned have become part of the Advanced Network. This includes Advanced Primary Care Practices, Advanced Pediatric Practices and Memorial Hermann Physician Partners. The following outlines membership engagement requirements of these tightly integrated network membership levels:

Advanced Primary Care Practices (APCPs) and Advanced Pediatric Practices (APPs) are highly aligned, primary care medical practices that engage in the practice of evidence-based medicine and work with network physicians and MHMD staff to facilitate the development of a coordinated system of care between multiple providers to offer integrated, timely and effective care. These practices also participate in population health management processes to identify patients eligible for wellness or preventive care services, chronic disease management services and complex case management.



Memorial Hermann Physician Partners (MHPPs) are highly aligned medical specialists in the areas of cardiology, gastroenterology, neurology and orthopedics who engage in the practice of evidence-based medicine and work with network physicians to provide streamlined referrals and enhanced communication with the referring physician. These practices also participate in the IT initiatives supported by MHMD that enhance and facilitate care coordination.

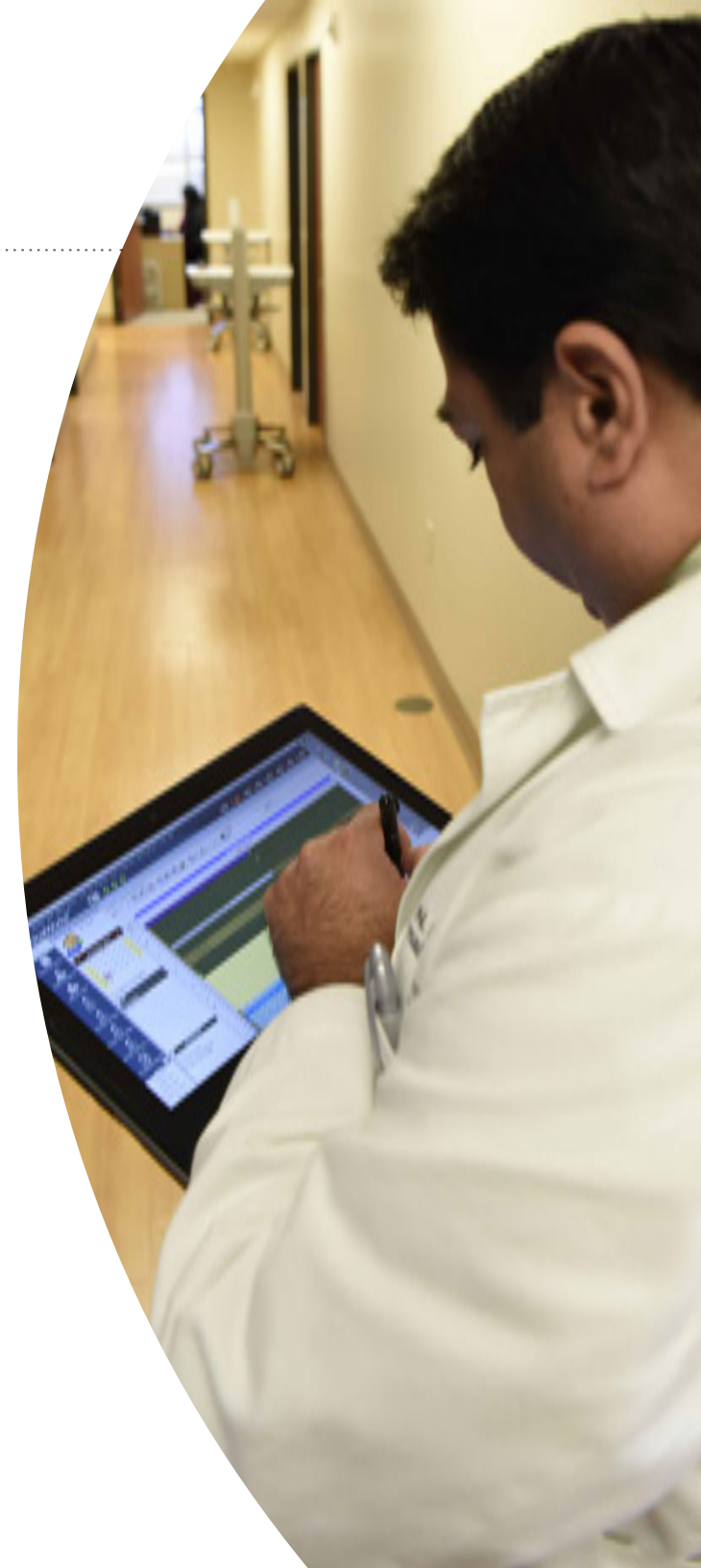
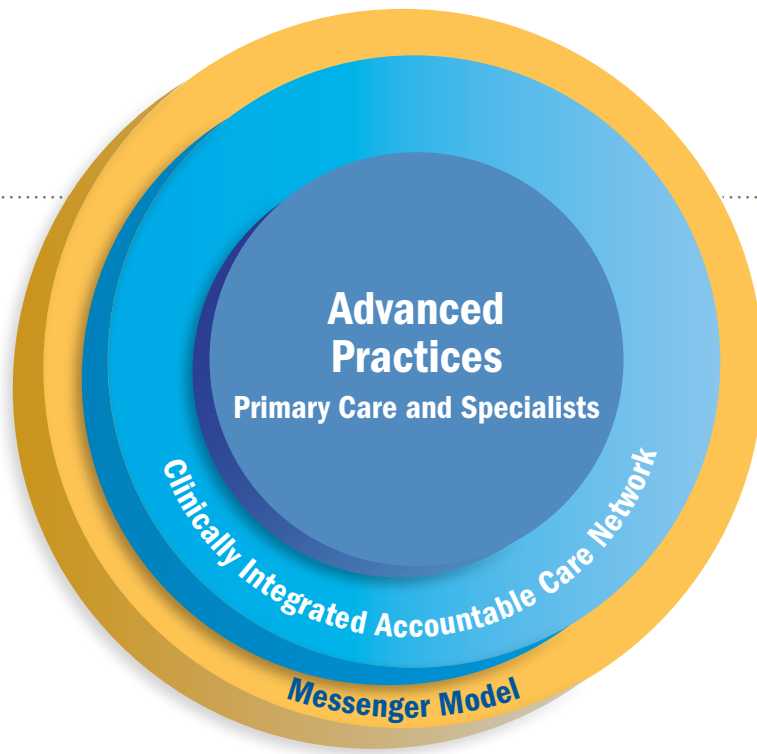
By working closely together, the Advanced Practices are able to better manage the quality and cost of care by sharing information, which eliminates the need to duplicate tests or

services. This also provides the patient with the most seamless continuum of care as the industry moves toward a more value-based healthcare model.

Our contracting strategy has included the successful creation of narrow network products. These products, through benefit and plan design, provides members with more direct access to care inside Memorial Hermann Health System and the Physician Network. To date, these narrow network products represent 135,000 attributed and covered lives in the market.

The organization continues to hardwire a culture where physicians are accountable for

quality, costs and outcomes. In addition to aligning goals and incentives for the entire care team, the MHMD team is focused on more sophisticated tools to support transparency so providers can work together and monitor both population and individual health. For example, our narrow network relationship with Aetna stressed the management of key determinants of clinical outcomes and transparent communication. Data sharing with Aetna, MHMD's first narrow network payer, included claims, lab, pharmacy, care management, status and admission information, which have been key components of the product's success. "Our relationship with Aetna allows us to be more focused on the patient and this is



why we have been able to show value to our employers,” says LeTasha Montgomery, COO of MHMD.

As part of their collaborative clinical approach to care, MHMD and the payers regularly look at population health data so they can identify and address opportunities for improvement and track results. Besides pure cost and quality data, the teams also address issues such as how to shift care to more appropriate settings, and how to provide a better, more convenient experience for the patients. “A major use of the technology we are deploying helps physicians to identify, find and track those patients who are not actively seeking

care and lets physicians see what has been happening with those patients’ health,” says Michael Davidson, MD, chief medical officer of MHMD. “Since this information travels across the continuum of care, patients will not receive tests the day they leave the hospital and then repeat the same tests two days later because their providers do not have the results.”

Montgomery continues, “Our goal is not just to transform care for any one patient or population but for the entire practice of medicine.”

Memorial Hermann ACO

Continues to Lead the Nation in the Medicare Shared Savings Program

The Memorial Hermann Accountable Care Organization (MHACO) recorded nearly \$53 million in savings during 2014, which resulted in a payment from CMS to the MHACO of nearly \$23 million. For the second year in a row, the MHACO was the top performing Medicare Shared Savings Program (MSSP) ACO in the country, earning 57 percent more than the next highest earner. In 2014 alone, 20 Pioneer and 333 Shared Savings Program ACOs generated more than \$411 million in savings, which includes all ACO's savings and losses. Notably, MHACO's exceptional performance was responsible for 13 percent of CMS' total savings.

During this period, the MHACO provided care for more than 40,000 Medicare beneficiaries – an increase of 6,000 more patients over the prior period. The quality score for the year was 88 percent, an improvement over the previous year of 83 percent.

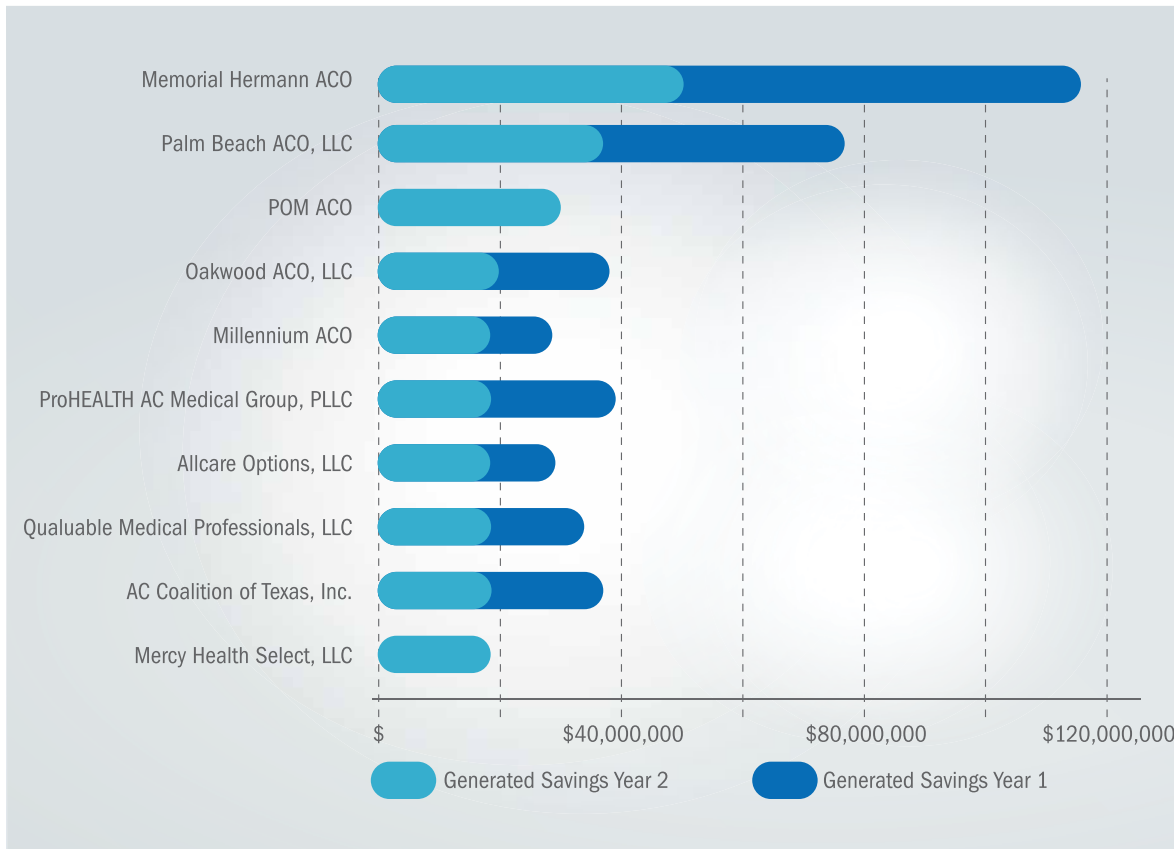
Patient satisfaction scores related to how well the doctor communicated and the overall rating of the doctor were exceptional. And, the MHACO performed in the top ten percent in several key quality metrics while having among the lowest risk standardized readmission rates in the country.

At the heart of the MHACO success is its alignment with physicians and our collaborative approach to care, cultivated eight years ago with our commitment to Clinical Integration (CI). When the Affordable Care Act stimulated the formation of ACOs, the MHMD CI program provided the needed physician organization to make the transition seamless, as we already had an established group of top physicians with access to innovative technology working together to ensure cost effective and high-quality outcomes.

Since it first began participation in the MSSP, the Memorial Hermann ACO has saved more than \$110 million while continuing to grow the number of beneficiaries participating in the program. And, the MHACO has been selected to continue participation in the Medicare Shared Savings Program for years 2016 through 2018. The ACO physician network is dedicated and committed to continuing to accomplish unprecedented improvements in safety, quality and efficiency throughout Memorial Hermann Health System.

Dedication to quality and accountability are central to the healthcare philosophy and at the heart of this program's achievements. And, the ACO's success continues to be recognized nationwide, serving as a model across the United States for clinical collaboration.

Combined Savings from Years 1 and 2: The Top 10 ACOs in the Country



MHMD Recognized with Memorial Hermann Impact Award

MHMD received the Impact Award, a Memorial Hermann Health System-wide recognition for the Memorial Hermann ACO’s participation in the Medicare Shared Savings Program (MSSP). The ACO was recognized for serving as a strong example of functioning as “One Memorial Hermann.” This program has unified the campuses, employed physicians, independent physicians, payers and the MHMD team to achieve the most impressive results of an ACO in the country. All of the clinical, operational, analytical and technical resources were critical to the MSSP positive results. The success and favorable outcomes in this initiative have been recognized and admired by other leading organizations across the country.

Also, the MHMD Supportive Medicine team was featured as a Finalist in the Care Delivery category for the unique and impactful service they provide.



MHMD

Case Management Tools

MHMD

MHMD Case Management - Patient

MHMD

Care Management

Transforming Quality Care

As part of MHMD's expanding functionality as an ACO, the MHMD Care Management department was designed utilizing a multidisciplinary team to care for members. The multidisciplinary team is comprised of RNs, LVNS, social workers, health coaches, experts in diabetes and clinical pharmacists.

MHMD's Care Management (CM) program was designed to support the mission of MHMD by enhancing the quality of member management and satisfaction. The services Care Management provides promote continuity of care and cost effectiveness through the integration of care management within the entire care continuum. The Triple Aim concept as defined by the Institute for Healthcare Improvement (IHI) includes improving the member experience of care including quality and satisfaction, improving the health of populations and reducing the per capita cost of healthcare. These elements were also included in the quality initiatives of the program. The CM program is offered to

individuals attributed to the population that MHMD serves. The program provides intensive, personalized care management services and goal-setting for members who have transitional and complex medical needs. A wide variety of resources are available to support members as they manage their health and work to improve their quality of life. Services are provided in a collaborative process that assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

Evidence-Based Care Management Program

The MHMD Care Management program was developed based on evidence-based guidelines from various sources, including medical and behavioral healthcare specialty societies.

The Care Management program design was based on the AHRO's Re-Engineered Discharge (RED) program, California Quality

Collaborative: Complex Case Management Toolkit and Case Management Society of America's (CMSA) Standards of Practice for Case Management, which are the voluntary practice guidelines for the case management industry. Specifically, the program uses a member-centric approach, encourages self-care, integrates behavioral change principles, links with community resources and assists with navigating the healthcare system. The program promotes quality outcomes and has established periodic assessments to measure and track the outcomes. The roles of the care coordinators are consistent with those outlined in the guidelines: assessment, care planning, communication and coordination, education, empowering and advocacy. The program follows the care management process detailed in the guidelines: member identification and selection, assessment and problem/opportunity identification, development of care plan, implementation of interventions, and evaluation of progress and termination of the care management process.



Programs and Services

Transition of Care Program – Patients and caregivers are provided education and resource assistance when transitioning from a facility or emergency center visit.

Complex Care Program – Patients with chronic illness(es) are provided with individualized education and resources to better manage their health.

Preventive Care Gap Services – Patients receive information and education regarding the importance of completing preventive health screenings and can receive assistance making appointments to complete those screenings.

Health Coach Services – Patients receive individualized coaching that supports shared decision-making to lead a healthy lifestyle and educational materials to advance their ability to experience a full and rewarding life.

Social Services – A social worker is available to connect the patient with community resources,

assessing and intervening on financial and psychosocial needs, and assisting with advance care planning while providing counseling support.

Pharmacy services – A clinical pharmacist is available to provide medication reconciliation support for optimal, safe and cost-effective therapy to improve overall health. Resources may be available for those who are not able to afford their prescriptions.

Supportive Medicine Services – Services focus on improving the quality of life for patients and their families by reducing the physical and emotional burdens of chronic illness achieved through expert use of symptom management, supportive counseling and communication with the patient and family.

Diabetes Services – A service that focuses on individuals with diabetes, elevated A1C, and complications due to diabetes-related conditions. MHMD care managers strive to be available for patients or designated caregivers when it is

convenient for them by offering extended work hours and the ability to assess patients over the phone to develop individualized care plans that meet the patient's specific healthcare needs.

Demonstrating Success in the Continuum of Care

In May of 2015, the Memorial Hermann Physician Network received Honorable Mention for the Case in Point Platinum Awards, for its Care Management program. This awards program, sponsored by Dorland Health, sets the standard for recognizing professionals and organizations that demonstrate sustained success across a variety of models and settings in the overarching continuum of care coordination.

The submission, entitled Care Management Operations and Clinical Integration: A Foundation for Success in Accountable Care, provides an in-depth look into how the Memorial Hermann Accountable Care Organization Care Management strategy was

designed and operationalized. Healthcare systems across the country are racing to develop sustainable models of care that will produce high-quality care, while still ensuring survival in today's constricted financial marketplace. Memorial Hermann's leadership theorized that by providing physicians with an integrated ambulatory care management service, the right information technology tools and actionable data, physicians would lead the way in providing high-quality, cost-effective care.

The success of this strategy was irrefutably established when the Centers for Medicare & Medicaid Services (CMS) announced that the Memorial Hermann Accountable Care Organization was among the top three in the country participating in the Medicare Shared Savings Program.

Michael Davidson, MD, Chief Medical Officer, and Mary Folladori, RN, MSN, CMAC, System Director of Care Management, discussed the journey to designing a successful

Ambulatory Care Management department that was designed to ensure physician engagement and support. Key steps taken to generate organizational synergy, which is necessary to produce improved population health outcomes, were highlighted. Those steps include providing regionalized care management services among MHMD physicians across the communities served. In the outpatient setting, care team professionals work alongside physicians and their patients to design and implement patient-centric education and action plans. These plans subsequently lead to enhanced patient engagement with their physicians and the Memorial Hermann Health System.

Because of the combined efforts of Leadership and the Care Management team, these steps have proven effective in building accountability between the patient, family, physician and the Care Management team. And, these relationships built over time reduce fragmentation in care during times of transition.



Using Innovative Technology to Care for High-Risk Patients

In order to better manage high-risk patients, MHMD Care Management (CM) implemented a new, innovative technology to regularly connect with these patients and monitor their symptoms. Virtual Care Check (VCC) is a remote patient monitoring program developed by Memorial Hermann Health System to provide additional clinical support for medically complex patients.

“The goals of the program are to teach and support members in the community to independently manage their health and reduce avoidable hospital readmissions,” says MHMD Care Management Director, Mary Folladori. MHMD’s CM Program has been designed to support the mission of MHMD by enhancing the quality of member management and satisfaction, promoting continuity of care, and providing cost effectiveness through the integration and functions of care management.

Recently, the Centers for Medicare & Medicaid Services decreased reimbursement to hospitals for excessive risk-standardized readmissions, which has strongly incentivized hospitals to reduce readmission rates for heart failure (HF) patients. Given this initiative to reduce readmissions and the complexity of managing HF, it is paramount to develop heart failure programs that enhance care for HF patients, improve patient outcomes and optimize the use of health care within their community.

The MHMD Care Management team partnered with the VCC team to conduct a pilot program to bring Virtual Care Check to 20 Medicare Shared Savings Program (MSSP) members who were identified as medically complex and could benefit from additional clinical support.

Members were identified by the Care Management team based on patient risk stratification assessments. All patients participating in the program are provided a tablet computer with a Bluetooth-enabled blood pressure device, pulse oximeter and weight scale. Each day, patients obtain vital sign readings on their tablet and answer health assessment questions that gauge their health status. This program has proven that engaging patients in the maintenance of their own health leads to positive behavioral



**Virtual Care
Check**

Remote Patient Monitoring from MEMORIAL HERMANN



change that fortifies prolonged health benefits and outcomes.

Mary Richardson, a program participant since October 2015, states, "I am overwhelmed with the attention that I have received regarding my health. Memorial Hermann staff has been very professional and caring. My blood pressure is now under control and I am even a little more conscious of everything I eat."

The data received via tablet is transferred to a web-based, secure Caregiver portal where a Memorial Hermann registered nurse reviews and trends the data daily. Based on the information provided through the tablet, patients may be contacted via telephone to verify readings or symptoms. Education can be provided or reinforced based on findings as part of the conversation with the patient.

Telemonitoring nursing staff oftentimes communicate with the physician if the patient's vital sign ranges are outside of established parameters that are defined in the Memorial

Hermann Clinical Guidelines for Physician Specific Reportable Measures. Fax reports of vital signs, health surveys and interventions are sent every two weeks to the primary care physicians and any designated specialty care physicians.

"The ability to communicate with a multidisciplinary care team fosters a tailored approach to deliver quality care. Daily monitoring and weekly biometric data allows me to observe my patient's health status in real time," says Health Coach David Garcia. "Care plan goals and health coaching objectives are collaboratively established during the

patient's observatory period. This enhances the development of positive health outcomes for the patient and the physician."

Virtual Care Check is not only bringing care to patients within the comfort of their own home and at their fingertips, but it is also enhancing MHMD's mission to lead the transformation of medicine. The team is establishing a culture of physician accountability and creating and deploying new and innovative models of health care that will improve the quality, safety and cost efficiency of the care we provide for the populations we manage.

MHMD University





Left to right, Front row: **Chuck Stokes**, MHHS Executive Vice President & COO;
Jon Gogola, MD; **Chris Lloyd**, CEO, MHMD & MHACO;
Richard Blakely, MD, MHMD Physician Advisor;
Rod Brace, MHHS SVP, Regional President, Service Lines;
Keith Fernandez, MD, MHMD President & Physician-in-Chief;
Michael Shabot, MD, MHHS EVP & Chief Clinical Officer;

Middle row: **Hina Pandya**, MD; **Peter Sabonghy**, MD; **Faraz Khan**, MD;
Justin Kendrick, VP Hospital Operations, Memorial Hermann The Woodlands Hospital;
Sherif Zaafran, MD; **Tiffany Albritton**, MD; **Kevin Giglio**, MD;
Charlotte Alexander, MD, MHMD Board Chair; **John Vanderzyl**, MD;
Lance Ferguson, VP Hospital Operations, Memorial Hermann Texas Medical Center;
Amanda Hammel, VP, IT Operations and Population Health;
LeTasha Montgomery, COO, MHMD; **Deepti Mishra**, MD
Kyle Stanzel, MHHS CEO Chief of Staff;

Back row: **Kouros Keyhani**, MD; **Emmett McDonald**, MD;
Chris Shea, VP Corporate Counsel; **Allen Tseng**, VP Hospital Operations,
Memorial Hermann Memorial City Medical Center; **Sohail Noor**, MD;
Jeff Gubbels, MD; **Chris Prihoda**, MD; **Glen Garner**, MD.

MHMD University

Aligning Leaders

Twenty-six Memorial Hermann Physician Network (MHMD) physician leaders and system executives completed the inaugural offering of MHMD University in August 2015. This program, offered in conjunction with the Jones School of Business at Rice University (Rice), allowed Memorial Hermann Health System physicians and executives to further develop their knowledge and leadership skills while learning side by side. Topics including leadership, strategy, finance and operations, among others, were taught over five Friday/Saturday sessions throughout 2015. These topics were specifically identified due to industry relevance and the need to equip future leaders with these tools. Participants completed extensive outside reading and case studies as part of the program.

Leadership

Rice professors worked with physicians and executives to learn the importance of coaching for performance. Through effective coaching, MHMD leaders are able to develop

high-potentials among their staff, adapt their organizations to new external environmental realities and raise performance within their organizations. In addition, each student learned that effective leadership is established through a comprehensive understanding of oneself. All personalities and leadership styles have their own strengths and limitations.

Strategy

Memorial Hermann leaders fine-tuned their strategic knowledge as well. They learned about several strategies, including creating advantage through positioning. The lessons emphasized the importance of understanding strategy as winning, as having the competitive advantage, as creating a unique competitive position, and as doing “it” differently. In addition, they focused on competitive strategy, where growth can occur through innovation. The three phases of disruptive innovation include: the innovation first creates a new market that is almost entirely independent of the old market; the new market expands

and begins to grow at a much faster rate than the old market; and over time, the disruptive innovation improves tremendously in terms of its features and values, and begins to consume the old market and creates sustainable growth.

Finance

Physicians and executives alike reviewed key accounting and financial concepts to help tie quality of care back to the bottom line and to create a common language for understanding the nature of financial statements and financial decision-making. The class took a deep dive into understanding how financial statements are created along with how to use key ratios to evaluate performance. Several concepts included the accounting equation, transaction analysis balance sheets, income statements, revenue and expense recognition and assessing financial risks. In addition, the students were familiarized with capital budget and financial performance metrics. These concepts were included in MHMD University’s curriculum to help teach several key concepts, including

understanding interaction between decisions as managers and the metrics used to evaluate financial performance, a basic treatment of valuation and capital budgeting, and metrics for creating value for shareholders.

Operations

Operations is a management function in every organization's core that transforms inputs, such as people, materials and money, into outputs, which for Memorial Hermann are healthcare services. Strategy, supply chain and processes within an organization as well as quality improvement and maintenance are key to successful operations management. Leaders learned about how the operating model and the business model affect one another as well as how process analysis and performance measurement can improve operations. They faced examples of how poor quality is directly related to high costs when operations are not properly managed. One way that quality can be improved is by closing gaps in service.

Team Projects

In addition to the above areas of study, participants worked in teams throughout the program to tackle a capstone project that explored an area of strategic priority to the System, including Medicare profitability, leadership collaboration, population health and information technology, and patient satisfaction. Each team included both physician and administrative executive members and was sponsored by a System senior executive who was engaged with the team for vision and strategic oversight of the project. In addition, a Rice faculty advisor was available to each team, providing insight, direction and guidance on analysis, thought processes and content. Each team researched a System issue, developed recommendations and presented their projects to all participants accompanied by a white paper outlining the issue and the team recommendations.

"Many participants commented how valuable it was to work on a team with individuals





from across the entire organization who they had never worked with before,” commented John Giglio, MD, primary care physician and MHMD Board Member. “The value of unique perspectives, skill sets and leadership styles contributed to what was, for each of the teams, a successful and valuable experience.” One attendee stated, “The Rice professors were great. I don’t think you can get too much of this type of experience.” Another was “sad to see it end.” Over half of the attendees desired to have an expanded role or deeper involvement addressing the challenges of our System. While sponsored by MHMD, Chris Lloyd, chief executive officer of MHMD, pointed out that this opportunity is designed to further the effectiveness of the entire System, with particular attention to the increasingly important need for physician and executive collaboration and teamwork. Lloyd commented, “The future is here now, and the need for new structures and close integration between the activities of highly aligned physicians and the System cannot be overstated.”

Team 1
Medicare Profitability as a Leading Indicator of an Organization’s Ability to Manage Risk in a Population.

- Dr. Sohail Noor
- Dr. Charlotte Alexander
- Dr. Glen Garner
- Dr. Faraz Khan
- Dr. Brian Heaps
- Mr. Allen Tseng
- Mr. Chris Shea

Executive Sponsor:
Dennis Laraway, EVP, MHHS CFO
Faculty Support:
Prof. James Weston

Team 2
Physician and Executive Cross-Functional Collaboration, Performance Development and Succession Planning.

- Dr. Sherif Zaafran
- Dr. Joseph Cali, Jr.
- Dr. Emmett McDonald
- Dr. Jeff Gubbels
- Dr. Kourosh Keyhani
- Mr. Heath Rushing
- Dr. Tejas Mehta

Executive Sponsor:
Rod Brace, SVP, MHHS Regional President, Service Lines
Faculty Support:
Prof. Brent Smith



Team 3

Using Information Technology to Impact Quality Outcomes in Population Health.

Dr. Hina Pandya
Dr. Kevin Giglio
Dr. James McCarthy
Dr. Chris Prihoda
Dr. Deepti Mishra
Mr. Lance Ferguson
Mrs. LeTasha Montgomery

Executive Sponsor:

David Bradshaw, EVP, MHHS Chief Strategy & Information Officer

Faculty Support:

Prof. Amit Pazgal



Team 4

Improving Patient Satisfaction Metrics Consistent with the Needs of an Accountable Care Organization.

Dr. John Vanderzyl
Dr. David Reininger
Dr. Tiffany Albritton
Dr. Peter Sabonghy
Mr. Justin Kendrick
Mrs. Victoria King

Executive Sponsor:

Chuck Stokes, EVP, MHHS COO

Faculty Support:

Prof. Bob Westbrook



ACO Service Line Projects

Pave the Way to Population Health

In Fiscal Year 2015, MHMD utilized the ACO umbrella to further align incentives around operational improvements and launched the Accountable Care Organization Service Line (ACOSL) Projects. The ACOSL Projects aim to increase efficiency and decrease cost for Medicare inpatients in the areas of Orthopedics, Heart and Vascular, and Hospital Medicine. Each of the nine hospital campuses host a team for each represented specialty totaling 28 active projects. In its inaugural year, the ACOSL Projects have contributed by improving quality and reducing costs, impacting the care provided at Memorial Hermann facilities each day.

ACOSL Project Objectives:

- To improve and coordinate care for Medicare beneficiaries
- To provide high-quality and safe care every time
- To reach Medicare profitability
- To effectively manage our population (population management)
- To prepare for potential prepayment contracts

These savings were directly attributable to the efforts and commitment of the highly engaged physicians.

These physician-led projects also aim to enhance the collaborative relationship between hospital administration and the more than 350 MHMD physicians participating in the ACOSL projects. Teams meet quarterly, with many campuses electing to meet more frequently. Meetings provide a venue to tackle complex efficiency and care challenges by leveraging the collective knowledge of a multidisciplinary team. Each team is focused on improving performance in the five key areas in the inpatient setting: length of stay, observation hours, supply savings, quality, and patient satisfaction.

UT Orthopedic Surgeon Michael Kent, MD, has been working with the team at Memorial Hermann Sugar Land Hospital to identify opportunities for improvement and to create solutions to positively impact patient care.

“The biggest change I have noticed in orthopedics has been in length of stay. For the past 10 years, we averaged between three and four days for a total knee replacement,” said Dr. Kent. “By paying attention to processes, we have reduced the average length of stay down to 1.7 or 1.8 days and patients are prepared and motivated to go home with a shorter hospital stay.”

Improvement initiatives, such as the length of stay project at Memorial Hermann Sugar Land, serve to further prepare Memorial Hermann to efficiently manage the health of populations. Efficient and effective management of populations is critical as the pendulum shifts from fee-for-service toward a new model of care built around alternative payment models and value-based care.

“We are not lowering the bar or making it easier for patients to be discharged,” explained Dr. Kent. “In fact, the safe parameters established for patients to go home have not changed. Rather, we are setting initiatives in place allowing

us to meet these parameters quicker. Really, it ends up working for everyone because receiving services at our facility costs less money for the patient. Not only are we providing those services at a lower cost, but we are achieving better outcomes,” said Dr. Kent.

Additionally, the ACOSL Projects serve as a mechanism to disseminate local and national best practices. Each month, the performance results of all 28 ACOSL Projects are shared in a System dashboard distributed to all physician and administrative leaders, allowing monthly comparison of results and sharing of lessons learned across the System with the goal of improving patient care.

During the third and fourth calendar quarter of 2015, the ACOSL Service Line Project Teams showed continued improvement in every category measured.

“In orthopedics, the ACO Service Line Project has worked really well for total hip and total knee replacements. It has provided us with

opportunities to establish a specific patient care plan. We know we have quality outcomes, valuable results and we are further implementing our best practices as we continue to improve our overall metrics,” reported Kevin Coupe, MD, orthopedic surgeon and co-physician leader of the ACOSL at Memorial Hermann The Woodlands Hospital.

Pragnesh Shah, MD, physician leader of the Hospital Medicine Service line project at Memorial Hermann Sugar Land Hospital, worked with his project team to identify the groups of specialists whose performance is characterized by high-quality care, prompt response time and excellent communication with referring physicians and other providers. Patients referred to these groups experienced significant decreases in length of stay in both the inpatient and observation settings.

Through the ACOSL, clinical care teams are interacting in much more dynamic ways. Opportunities for improvement are brought



Physician Participation Criteria

Physicians must meet strict criteria and requirements in order to participate in the ACOSL Projects.

- Member of a quality improvement initiative, such as a CPC, APCP, etc.
- MHMD status or affiliate
- Not employed by competitor
- Not a member of a competing ACO
- Meets quality metrics threshold for core measures, readmission rate, mortality rate and total charges
- Minimum volume threshold established by CPC and approved by MHMD necessary to affect quality of care and influence metrics





to each campus team, which is comprised of representatives from quality, patient safety, infection control, case management and documentation. For example, led by Cardiologist Shahid Rahman, MD, the Memorial Hermann Greater Heights Hospital's Heart and Vascular ACOSL Project was instrumental in decreasing the incidence of acute kidney injury (AKI) by 76 percent in the fourth quarter of Fiscal Year 2015, when compared with the service line's performance in Fiscal Year 2014.

"I am seeing impressive results in our numbers, but even more importantly, in our mindset," said Dr. Rahman. "We feel empowered; everyone who is involved with the ACO Service Line Project is realizing that they are impacting significant changes.

"Value based health care is the future; the day where physicians think we can just do more to gain success is gone. In the end, success has to be defined by quality, and that's

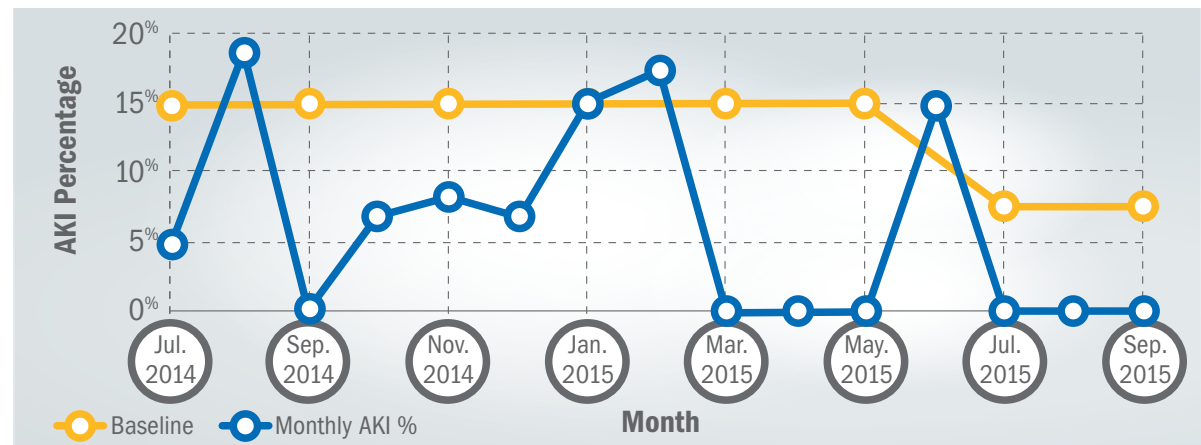
a better measure than quantity," continued Dr. Rahman.

The ACOSL Projects are centered on maximizing value for Medicare beneficiaries by increasing clinical quality and patient satisfaction, while decreasing cost of providing and receiving the services offered. By identifying barriers, creating solutions and readily adapting and evolving to meet

health care's dynamic climate, Memorial Hermann can positively impact patient care.

"There is really no downside to saving money and increasing patient satisfaction. So whether it's on behalf of an accountable care organization or on behalf of another entity that's driving us to increase savings, ultimately if we save money and we make patients happier, then everybody wins," stated Dr. Kent.

Greater Heights Acute Kidney Injury (AKI): FY15 to FY16 YTD





Clinical Programs Committee

Nurturing Growth and Innovation

For the last 15 years, the MHMD Clinical Programs Committee (CPC) has functioned as the clinical arm of MHMD. With physician representation from all Memorial Hermann hospitals, the CPC continues to partner with Memorial Hermann, aligning the quality and safety programs of the hospital system and the physician organization. There are now more than 50 specialty subcommittees and task forces composed of more than 450 physicians, nurses, pharmacists, care managers and administrators, representing each of the hospitals within Memorial Hermann Health System. Each subcommittee supports the Memorial Hermann vision of advancing the health of our community by implementing evidence-based measures and metrics related to managing the health of populations.

Some of the accomplishments achieved by these committees in 2015 include:

- Development of a compassionate extubation policy that focuses on consistently making

the withdrawal of mechanical ventilation at the end of life as comfortable and peaceful as possible, for patients and families alike

- Standardization of perioperative glucose management to proactively manage glucose levels for optimal patient outcomes
- Implementation of protocols to enhance patient safety where the pain scale overlaps, thus preventing any pain medication duplication



- Proposed development of a consistent preoperative clinic process to be offered at all hospitals in order to improve clinical outcomes, decrease resource utilization and provider greater patient-centered continuity of care throughout the preoperative, intraoperative and postoperative periods
- Adding duration to inpatient antibiotic orders to avoid unnecessary risk of antibiotic resistance
- Limiting admission orders by Emergency Department physicians to those required for safe patient transport only
- Standardization of the peer review process and changing its focus to performance improvement rather than corrective action
- Proposing standardization of ICU physician staffing

Observing that many of these achievements involve clinical issues that are multidisciplinary, in 2015 MHMD began reorganizing the entire CPC structure to foster greater collaboration between the subcommittees. CPC leaders



were asked to list the most significant opportunities for impactful improvement in clinical outcomes within Memorial Hermann and MHMD. The list included post-acute care transitions and services, enhancements in information technology, detection and management of sepsis, prevention of deep vein thrombosis (DVT), and coordination of efforts between the CPC subcommittees and among providers of care. While the legacy CPC model created many specialty-specific subcommittees, their work was largely conducted in silos.

Charlotte Alexander, MD, MHMD president and chair of the MHMD Board of Directors stated, "As an orthopedist, I am not the best person to treat hypertension, but I should recognize it and refer my patients for

treatment. I may not manage my patient's diabetes, but it is my responsibility to see that it is managed before performing surgery."

Assuming a key role in the wellness of our patients will increasingly become an expectation of each MHMD physician no matter what the specialty. Coordination of care will require increased interaction among the CPC subcommittees, thus the CPC redesign includes the following eight "programs" within the greater CPC: primary care, post-acute care, hospital-based specialties, hospital medicine, cardiovascular medicine, surgical services, critical care and clinical compliance. Each of the specialty subcommittees will be placed within one of these programs. The result will greatly enhance communication and collaboration

between the subcommittees with an enriched capability to address multidisciplinary issues in a coordinated fashion.





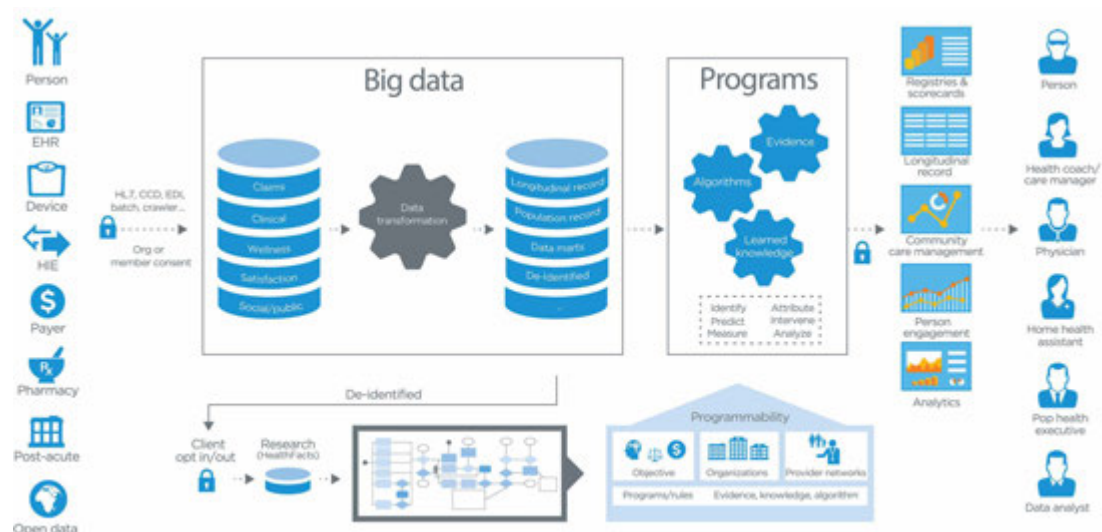
Advancing the Technology Infrastructure for Population Health

As the healthcare industry continues to advance to a population health model, the sharing of data becomes more integral to the efficient, safe management of patients. Healthcare systems across the country are plagued with a lack of information to effectively achieve this goal. Memorial Hermann's partnership with Cerner gives our system the unique and unprecedented ability to drill down and apply customized technology to all patient data, revealing a new level of transparency across all populations. In order for physicians to have the ability to reduce duplication of services and manage the expenses of health care in this new environment, they need to be given the opportunity to see the full picture of each patient's healthcare experience across the continuum of care.

MHMD physicians who share data through the Memorial Hermann Information Exchange (MHIE) have experienced the value of accessing patient information through a

secure network. They are able to access test results and office visit notes, and are better able to manage the healthcare needs of their patients without duplicating services. While this has been beneficial, the current system is dependent on patient consent in order to grant access to the data related to each patient visit.

The SmartData platform extracts data from multiple sources and consolidates all of the information into one record for patients who have been provided care by Memorial Hermann Health System or an MHMD physician. This platform provides easier, more manageable connections to claims and clinical data, utilizing the new SmartData warehouse.



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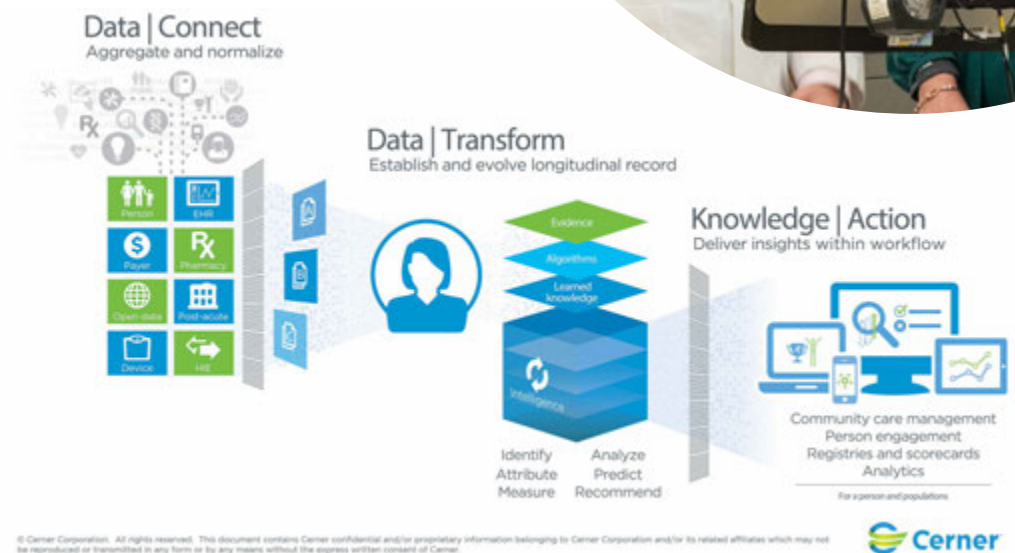


Data sources include claims data, physician office visit records, emergency and hospital visit records, and data from the MHiE. Additional data sources are under review and include connectivity with post-acute records and additional EMR data.

The SmartData platform provides a consolidated view of data to risk stratify the population and manage high-risk patients. This data prepares Memorial Hermann for a full population health model and the ability to share risk with payers.

With all of the patient data housed in this new platform, the ability to create applications specific to the care provider's workflow is realized.

Current applications being used with this platform include SmartRecord, SmartRegistry and SmartAnalytics.



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SmartRecord

SmartRecord is a consolidated view of MHiE consented data. Currently available in the Care4 and Clinic Care4 application, this platform was reviewed and approved by a group of physicians to validate the rollup of clinical concepts to reduce duplication.

SmartRegistry

The SmartRegistry platform is designed to help clinicians manage the health of a population, one person at a time. Used for preventive care, evidence-based disease management, population health management, physician alignment and clinical integration, this application helps each practice impact the



quality of each patient's healthcare experience. SmartRegistry is a comprehensive health management tool that places patients into different registries based on certain health conditions. The goal is to improve and optimize care of individuals and the populations served. The current Accountable Care Organization (ACO) Measures of Excellence are the metrics tracked in SmartRegistry, which includes 12 registries and more than 60 measures. The development and maintenance of these measures is governed by the Ambulatory MIC subcommittee.

SmartRegistry is designed to be valuable to the physician since it uses all data available from SmartData. Multiple members of the patient's care team, including the primary care physician (PCP), case managers and payers, are permitted to access the information or receive reports. Viewing this data helps the care team raise the patient's awareness to gaps in care and provide assistance in accessing these services.

SmartAnalytics

Using data housed in the SmartData platform, the SmartAnalytics application is able to organize the information in a range of custom reports and dashboards to track important metrics. This application provides accurate data to the network physicians and physician leadership, allowing them to respond in a timely manner.

Key metrics the platform measures include:

- Payer Member Months
- Risk Scores
- Risk Adjusted PMPM
- Admits per 1000
- ED Visits per 1000
- Generic Drug Utilization
- High Cost Imaging
- SmartRegistry Gaps in Care
- Narrow Views of High-Risk and High-Utilization Patients

The tool also has the ability to run valuable reports measuring factors impacting healthcare

costs, including in-network utilization, quality metrics by physician, network claim totals by diagnosis and procedure, and contract payer metrics for optimizing care efforts.

DocbookMD

DocbookMD is a secure messaging application for smartphone and tablet devices and is also available on the web. The tool creates a secure community for sharing critical patient information and collaborating with medical colleagues. DocbookMD was initially deployed to provide a network directory tool to participating Memorial Hermann Accountable Care Organization (MHACO) physicians, allowing direct communication within the app. Since implementation, further development has resulted in integration with automated notifications from the inpatient and ER environments. Now, MHMD network physicians can receive real-time secure notifications regarding admissions, discharges and transfers within Memorial Hermann Health System for their patients. Our physicians can locate local

aligned providers and communicate regarding referrals and shared patients. Sensitive content, such as patient details and photos, resides on Memorial Hermann's cloud-based servers, not the user's device, and remote disabling of the app is available if a device is lost or stolen. As the MHMD network continues to grow, participation is encouraged so physicians are equipped to easily identify quality referral sources within the network.

eNotify

eNotify is the Memorial Hermann physician notification program that provides real-time notifications to physicians when a patient is seen in the ER, admitted, transferred or discharged. The original program allowed physicians to opt-in to text message alerts from the hospital regarding updates on their patients. With the deployment of DocbookMD, the notification is performed in a HIPAA-secure messaging platform that provides patient name and medical record information to the provider.

Schedule Now

ScheduleNow is a free, online scheduling tool for patients to search and book real-time appointments. This tool supports provider connectivity and accessibility that is a key component of ACOs and patient-centered medical homes. From physician office visits to mammograms and even ER reservations, patients can book their appointments at the click of a mouse. To schedule appointments online, patients visit memorialhermann.org, select the ScheduleNow icon, and choose doctor visit, mammogram, diagnostic imaging, physical therapy, colonoscopy or ER. Then, they follow the prompts to schedule their appointment. ScheduleNow provides appointment reminders via email, as well as a link to a map for directions. Appointments can be made 24/7 from any Internet-connected device. ScheduleNow is

supported by the 713.222.CARE (2273) call center for direct appointments, streamlining the appointment scheduling process by eliminating the warm transfer to the doctor's office. Patients discharged from a Memorial Hermann hospital or Emergency Center can be scheduled for follow-up appointments prior to leaving the campus, which improves clinical outcomes and decreases the likelihood of readmission. ScheduleNow offers unprecedented convenience and accessibility for patients while helping physicians improve the continuum of care they deliver.

MHMD continues to identify opportunities to enhance the technology and information available to physicians, giving them the ability to provide a seamless continuum of care for each and every patient.



Patient Concierge Services

Quickly Connecting Patients with Specialty Referrals

Beginning in late 2014, Memorial Hermann established a Patient Concierge Services (PCS) department to process and manage referrals from the MHMD Advanced Practices. These practices that had adopted the patient-centered medical home model needed an efficient way to provide patient referrals to in-network specialists and services not offered within the primary care practices.

As the PCS department expanded during 2015, it maintained and matured its focus on providing patients with timely specialist appointments best meeting their specific care needs and availability. For example, during a primary care visit, the physician may identify a need for a referral to a specialist, or for diagnostic imaging, physical, occupational or speech therapy, sleep studies, wound care, and so on. At that point, the Primary Care Provider office contacts the Patient Referral Center (PRC), using an online referral management tool, which is seamlessly

integrated with the ScheduleNow capability in the Advanced Practices.

A PRC representative contacts the patient directly and offers to coordinate the referral, including offering to actually schedule the appointment. The PRC representative then forwards the relevant clinical information and documentation to the specialty provider so that the services are rendered with a clear understanding of the context and care needs.

Memorial Hermann Assistant Vice President of Enterprise Scheduling, TraQuenna Smith Branch, leads the PCS and PRC departments. "The Patient Concierge Services team assists both the provider and the patient," says Smith Branch. "Besides making the referral appointment and visit process easy for the patient including minimizing the possibility of incurring out-of-network charges, we help the providers by identifying the most appropriate specialist based on the needs



PCS utilizes its referral management tool to educate APCP and APP providers about providers who are in network. In addition, the technology allows PCS team members to track out-of-network activity, which assists in identifying gaps in our network due to insurance or specialty coverage. Finally, ScheduleNow is integrated with the tool to help minimize required calls to the specialist offices.





and the health plan of the patient,” she adds. “We can efficiently process requests and quickly schedule the appointments. The Patient Referral Center helps us identify gaps in our network and makes the referral process easier, allowing us to arrange referral services to the highest quality of care while avoiding unnecessary and duplicative costs.”

“In my opinion, Patient Concierge Services has the potential to significantly reduce the amount of time spent by clinic staff confirming insurance coverage and arranging

appointments with specialist offices,” says Tiffany Albritton, MD, family medicine physician with Memorial Hermann Medical Group. “I have received immediate responses from PCS staff regarding urgent referrals. They were able to schedule patients for same-day and next-day visits within minutes of their appointment with me. This is a tremendous benefit to both my clinic and the patient.”

The PCS team is in the process of implementing automated notifications for the PCPs that will simplify the payer authorization process and

keep it updated with the MHMD- and MHACO-contracted health plans.

All in all, the PCS and the referral service together help provide our patients with the best possible experience in the most efficient and seamless manner possible. This enhances both patient and physician satisfaction, and clearly enhances the quality of health care within MHMD and Memorial Hermann.

New in FY15

Developing the Perioperative Surgical Home

The Perioperative Surgical Home (PSH) is a collaborative, physician-led initiative, focused on the Triple Aim Goals (IHI) of improving the surgical experience by providing patients the highest value of perioperative care delivered through increased quality at a lower cost. This value is evidenced by, but not limited to, improved readmission rates, length of stay, case cancellation rates and physician satisfaction.

Through the initiation of evidence-based, standardized processes, the PSH enhances patient optimization throughout the perioperative continuum, which includes the preoperative, intraoperative, postoperative and post-discharge periods.

The PSH is led by a Joint Operating Council (JOC) along with executive sponsor Emily Scott, vice president of the Memorial Hermann Accountable Care Organization, and co-chairs Sherif Zaafran, MD, anesthesiologist affiliated with Memorial Hermann The Woodlands Hospital, and Christophe Salcedo, MD, general

surgeon affiliated with Memorial Hermann Greater Heights Hospital. The multidisciplinary council is comprised of more than 30 members who meet regularly to discuss protocols and PSH initiatives.

The PSH JOC has already been successful in standardizing the care patients receive during their perioperative experience. Multiple protocols and tools developed in the last year were approved through the System Quality Council for implementation in the upcoming PSH Pilot programs.

During the next fiscal year, the PSH team will be working toward the design and implementation of pilot programs throughout Memorial Hermann Health System. These pilot programs will offer a coordinated level of care to the perioperative population through risk stratification, disease management and patient optimization.



MEMORIAL HERMANN HEALTH SYSTEM

One of the largest not-for-profit health systems in the nation, Memorial Hermann is an integrated system with an exceptional medical staff and more than 24,000 employees.

The system serves Southeast Texas and the Greater Houston community with 14 hospitals (including four in the Texas Medical Center), an academic medical center with Level I adult and pediatric trauma centers, a hospital for children, an orthopedic and spine hospital, and one of the top rehabilitation hospitals in the United States, as well as nine suburban hospitals and a second rehabilitation hospital in Katy. The system also operates three Memorial Hermann Heart & Vascular Institutes; the Memorial Hermann Mischer Neuroscience Institute at the Texas Medical Center; the Memorial Hermann IRONMAN Sports Medicine Institute at three locations; Women's Memorial Hermann; Memorial Hermann Life Flight®, the busiest air ambulance service in the United States; the Memorial Hermann Prevention and Recovery Center, an award-winning chemical dependency treatment center; and a comprehensive array of home health services, sports medicine and rehabilitation centers, outpatient imaging and laboratory services. Patients enjoy unique access to the expertise of multiple subspecialties and clinical research trials through MHMD's community physicians and McGovern Medical School at UTHealth.



National Recognitions

Memorial Hermann Was “Most Wired” Healthcare System – Again. For the 11th consecutive year, the Memorial Hermann Health System was selected as one of the nation’s “Most Wired” healthcare systems, according to data released by the American Hospital Association. The announcement was made in *Hospitals & Health Networks* magazine, which sponsors the annual survey to measure how fully information technology has been adopted by hospitals and healthcare systems in the United States.

Memorial Hermann Earned Magnet Designation. Memorial Hermann The Woodlands Hospital, Memorial Hermann Memorial City Medical Center and Memorial Hermann-Texas Medical Center achieved one

of the highest levels of recognition a hospital can receive through the Magnet Recognition Program® by the American Nurses Credentialing Center. The Program recognizes healthcare organizations for quality patient care, nursing excellence and innovation in nursing practice.

Houston Chronicle Listed Memorial Hermann among Houston’s Top Workplaces. Memorial Hermann was ranked No. 13 among large employers on the *Houston Chronicle’s* Top Workplaces list, becoming one of only a handful of organizations to earn the recognition for six consecutive years.

Memorial Hermann Was Recognized as One of Houston’s Best Places to Work. Memorial Hermann retained the No. 3 spot on the *Houston Business Journal’s* Best Places to Work list, making it the top health system in the city. This was the 11th consecutive year the organization has been included in the annual ranking.

The Leapfrog Group’s “A” Grade. Memorial Hermann was the first health system in Southeast Texas to achieve an “A” from The Leapfrog Group – the survey organization’s top safety score for preventable medical errors, injuries, accidents, and infections – at all nine of its hospitals.

Memorial Hermann-Texas Medical Center Won Prestigious Quality Leadership Award.

For the second consecutive year, Memorial Hermann-Texas Medical Center was awarded the Bernard A. Bimbaum, MD, Quality Leadership Award, formerly named the University Health System Consortium (UHC) Quality Leadership Award. Presented by UHC, an alliance of the nation's leading nonprofit academic medical centers, the award is given to members that demonstrate superior performance as measured by the UHC Quality and Accountability Study. Memorial Hermann-TMC was one of only 13 member hospitals across the country chosen as a 2015 award winner.

Six Memorial Hermann Facilities Became Press Ganey Guardian of Excellence Award® Winners.

Six Memorial Hermann facilities – Memorial Hermann Southeast Hospital, Memorial Hermann The Woodlands Hospital, Memorial Hermann Pearland Convenient Care Center Emergency Room, Memorial Hermann The Woodlands Free-Standing Emergency Room, Memorial Hermann Prevention and Recovery Center (PaRC) and University Place – were named 2015 Guardian of Excellence Award® winners by Press Ganey Associates, Inc.

Malcolm Baldrige National Quality Award Finalist.

Memorial Hermann Sugar Land Hospital was named a finalist for the 2015

Malcolm Baldrige National Quality Award, the nation's highest honor for performance excellence given by the U.S. President. High-performing organizations that are candidates for the national award but are not selected as a recipient are eligible for recognition of their best practices in six of the seven Baldrige Criteria categories. Memorial Hermann Sugar Land was recognized by the Baldrige judges for its best practices in the strategy category and the only applicant recognized for its best practices in 2015.



Texas Award for Performance Excellence.

Memorial Hermann Sugar Land Hospital became the first Houston area hospital, and one of just three organizations in the state, to earn the 2015 Texas Award for Performance Excellence from the Quality Texas Foundation. The organization called the hospital a “shining light and a role model for other healthcare facilities in the state and nation.”

American College of Surgeons National Surgical Quality Improvement Program Recognition.

Memorial Hermann Katy Hospital, Memorial Hermann Northeast Hospital, and Memorial Hermann The Woodlands Hospital were three of only 52 participating hospitals in the nation to achieve validation of their meritorious outcomes for surgical care from the American College of Surgeons National Surgical Quality Improvement Program.

BetterDoctor

Memorial Hermann ranked No. 4 out of 4,788 hospitals across the country for low readmission, complication, and death rates, according to BetterDoctor, a national doctor search and database website. The organization studied data from hospitals nationwide, examining 19 critical factors for ensuring quality care.

TIRR Memorial Hermann Was Ranked No. 2 in Nation by U.S. News & World Report.

TIRR Memorial Hermann is the No. 2 rehabilitation hospital in the nation – and the best in Texas – according to *U.S. News & World Report's* annual rankings across 16 specialties. Memorial Hermann-Texas Medical Center was also cited for its gynecology, nephrology, and urology programs, and Children's Memorial Hermann Hospital was recognized for its nephrology, neurology and neurosurgery programs.

TIRR is a registered trademark of TIRR Foundation.

GLOSSARY OF TERMS

Accountable Care Organization (ACO)

A group of healthcare providers working voluntarily with Medicare to provide high-quality care at the right time, in the right setting.

ACO Service Line Projects (ACOSL)

Service Line-based projects that measure key metrics to manage quality and costs in acute care facilities. These projects are allowed under the umbrella of the Accountable Care Organization as a way to work collaboratively with physicians in order to prepare for bundled payments and value-based care.

Advanced Pediatric Practices (APP)

Highly aligned, pediatric medical practices that engage in the practice of evidence-based medicine and work with network physicians to offer integrated, timely and effective care to their patients. These practices also participate in population health management processes to identify patients eligible for wellness or preventive care services or chronic disease management services.

Advanced Primary Care Practices (APCP)

Highly aligned, primary care medical practices that engage in the practice of evidence-based medicine and work with network physicians and MHMD staff to facilitate the development of a



coordinated system of care between multiple providers to offer integrated, timely and effective care. These practices also participate in population health management processes to identify patients eligible for wellness or preventive care services, chronic disease management services and complex case management.

Clinical Integration (CI)

An agreement by independent physicians from every specialty to come together in a common commitment to quality and accountability.

Clinical Programs Committee (CPC)

Physician committees serving as the primary source of evidence-based practices intended to improve quality and efficiency of care.

CPOE or eOrdering

A computerized physician order entry system for medical orders integrated with adverse event data to streamline delivery of safer patient care.

Continuity-of-Care Document

The accepted electronic format for the exchange of clinical information, including patient demographics, medications and allergies.



Diagnosis-Related Group (DRG)

A coding system used in determining reimbursement that classifies hospital cases into groups to identify the products/procedures that a hospital provides.

Electronic Health Record (EHR)

An electronic healthcare tool that can be used to facilitate, inform, measure and sustain improvements in the quality, efficiency and safety of health care.

Evidence-Based Medicine

A collaborative effort between scientific researchers and physicians to deliver better patient outcomes based on patient observation and scientific data.

Meaningful Use

The incentivized use of certified electronic health records technology to achieve health and efficiency goals through data capture and information sharing.

Medical Home

A model of care that builds a long-term healing relationship between the patient and a physician-led care team and uses advanced IT tools, patient care reminders and biometric screenings to optimize patient health.

Medicare Shared Savings Program (MSSP)

An initiative established by the Centers for Medicare & Medicaid Services (CMS) to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs by sharing monetary savings with participating ACOs.

Memorial Hermann Physician Partner (MHPP)

Highly aligned medical specialists in the areas of orthopedics, gastroenterology, cardiology and neurology who engage in the practice of evidence-based medicine and work with network physicians to provide streamlined referrals and enhanced communication with the referring physician. These practices

also participate in the IT initiatives supported by MHMD that enhance and facilitate care coordination.

National Care Quality Association (NCOA)

Organization that provides accreditation and certification of Patient-Centered Medical Homes and provider organizations.

Order Sets

Standard collection of predetermined medications and interventions appropriate to a particular disease, condition or procedure and proven to lead to better clinical outcomes.

Population Health Management

A model for providing care for large populations of people based on establishing ongoing primary care and specialty care relationships for individuals, and assisting physicians in analyzing data across entire patient populations.



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