Topic

Building a Regional Alliance

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Raymond A. Grahe, CEO, Trivergent Health Alliance, MSO

June 1, 2015
Discussion Agenda – Case Study – Trivergent Health

Stages of Affiliation Discussions and Management / Board Decision Points

• Preliminary Affiliation Considerations Based on Meetings with CEOs (Fall 2012)
  – Background of the three hospitals
  – Cultural fit
  – Maryland regulatory environment
  – Maryland and National trends in M&A and reimbursement

• Hospital management departments’ planning for consolidation (Jan. 2014 to June 2014) / Go live (July 1, 2014)
  – Cultural change management
  – Location issues
  – Selection of management team
  – Operationalizing consolidation
  – Achieving efficiencies
  – Difficulties encountered

• Development of Horizon Maps for MSO and by Division to include Mission, Vision, Values
  – Performance first year
  – Start up activities
  – Initial achievements

• Population Health Initiatives and Shared Quality goals
Stage 1 – Preliminary Affiliation Considerations
Based on Meetings with CEO’s (Fall 2012)

- Background of the three hospitals
- Cultural fit
- Maryland regulatory environment
- Maryland and National trends in M&A and reimbursement
## Mission, Vision, Values

<table>
<thead>
<tr>
<th></th>
<th>Frederick</th>
<th>Meritus</th>
<th>Western Maryland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mission</strong></td>
<td>The mission of Frederick Memorial Hospital is to contribute to the health and well-being of area residents by providing quality healthcare in a caring, cost efficient, safe and convenient manner through a coordinated program of prevention, diagnosis and treatment, rehabilitation and support.</td>
<td>Meritus Health exists to improve the health status of our region by providing comprehensive health services to patients and families.</td>
<td>Demonstrated leader in the delivery of exceptional healthcare services throughout the tri-state region.</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Superb Quality, Superb Service. All the time.</td>
<td>Meritus Health will relentlessly pursue excellence in quality, service and performance</td>
<td>Superior care for all we serve.</td>
</tr>
</tbody>
</table>

**HFMA Maryland Chapter**

healthcare financial management association
<table>
<thead>
<tr>
<th></th>
<th>Frederick Regional Health System</th>
<th>Western Maryland Health System</th>
<th>Meritus Medical Center</th>
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<tr>
<td>Revenue</td>
<td>$350 mil</td>
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<tr>
<td>Net Income</td>
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<td>Total Assets</td>
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<td>18,091</td>
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<td>LOS</td>
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<td>Case Mix</td>
<td>.93</td>
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<td>Patient Days</td>
<td>78,334</td>
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<tr>
<td>Average Daily Census</td>
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<td>201</td>
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<tr>
<td>Age of Plant (in years)</td>
<td>10.5</td>
<td>9</td>
<td>6</td>
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<tr>
<td>Days Cash on Hand</td>
<td>162</td>
<td>140</td>
<td>126</td>
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<tr>
<td>Debt to Cap Ratio</td>
<td>52%</td>
<td>71%</td>
<td>55%</td>
</tr>
</tbody>
</table>
Maryland Market Considerations

- Maryland is an all payer rate regulated State subject to meeting Medicare waiver requirements annually. The Maryland Health Services Cost Review Commission (HSCRC) regulates hospital rates.
- Cost pressures will continue to be predominant for at least the next 3-5 years
- However, with the shift to population health, the HSCRC may be willing to explore new payments models such as:
  - Integrated rate structure
  - System-wide Revenue Cap
  - Population Based Revenue Cap for the System
- Maryland’s new waiver test and reimbursement initiatives encourages hospital to “go global”
- No For-Profit hospitals in Maryland. Large national chains are hesitant to invest in Maryland due to our regulatory environment.
Maryland Market Considerations

- Trends in Maryland parallel national trends driving mergers and consolidations to address capital needs, improve efficiency and protect markets
- Expansion by academic medical centers—Johns Hopkins and University of Maryland into western regions of the state drawing cases with higher acuity to Baltimore
- Competition from major medical centers and systems in adjacent markets—Washington, D.C. (MedStar, Washington Hospital Center), University of West Virginia, and Virginia (Winchester/Valley Health)
- Closures of 10 community hospitals and consolidation of others with the major systems in recent years have substantially reduced the number of independent hospitals
- Pressure on community and regional hospitals to join larger systems
Impact of Federal Healthcare Reform

• Affordable Care Act will reduce payments to hospitals while forcing them to invest in expensive IT systems
• Hospitals will need to manage the health of populations (which is outside their historical comfort zone and risk tolerance)
• Expense inflation will likely outpace reimbursement rate inflation
• Reforms favor efficient, high quality, large providers, which may necessitate more takeovers of weak organizations by larger and/or for-profit chains
• Creation of ACOs and other integrated delivery systems not really financially feasible for a stand-alone hospital (lacking critical mass and capital)
A Closer Look at Hospital Merger Transactions by Objective
(Primary reason for merger)

• Ensure Survival
• Improve Profitability
• Enhance Competitive Position for better access, cost, etc.
• Invest in Healthcare
• Mission Preservation
• Volume Preservation
• Population Health Management (more recent reason to merge, not in source book)

Source: Hospital Mergers – Why They Work, Why They Don’t by Larry Scanlan
Note: Objectives in Red are the principal considerations for this affiliation
## Community Benefits of Affiliation

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical consolidation &amp; access to physicians</td>
<td>Quality / Cost</td>
</tr>
<tr>
<td>Reduction in variation in patient outcomes</td>
<td>Quality / Cost</td>
</tr>
<tr>
<td>Investments (IT and medical equipment)</td>
<td>Cost / Quality</td>
</tr>
<tr>
<td>Medical education and screenings for community</td>
<td>Access / Cost</td>
</tr>
<tr>
<td>Rationalization of capital spending / Improved geographical distribution</td>
<td>Access / Cost</td>
</tr>
<tr>
<td>Back office consolidation</td>
<td>Cost / Income</td>
</tr>
<tr>
<td>Supply chain efficiencies</td>
<td>Cost</td>
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</tbody>
</table>
Distance, Geography, & Historical Referral patterns make Inter-Facility Referrals Challenging

- **WMHS is too far for convenient referrals to FMH.** MH more likely to refer to FMH than WMHS. By road, WMHS is 72 miles (1hr 17 min.) from MH. MH is 25 miles (30 min.) from FMH. And WMHS is 90 miles (1hr 30 min.) from FMH.

- **WMHS traditionally refers to the west (WV).** Referral patterns from WMHS 55% go to UWV/Morgantown 74 miles (1hr 20 min.) from WMHS.

- **Mountains between MH and WMHS.** Tend to serve as a natural barrier to referrals.

- **MH is closer to FMH than Wash. D.C. and Baltimore but FMH refers traditionally to Baltimore and Wash. D.C.** From FMH to Baltimore is 52 miles (1 hr.) and from FMH to Wash. D.C. is 49 miles (1hr 6 min.)
Clinical Integration Challenges

- Significant differences in patient demographics from Frederick primary market to Western Maryland primary market
  - Population was poorer, older and declining further west
  - Business activity declines from east to west meaning weakening economics
- Competency with population health and managed care varied considerably between systems
  - Western Maryland and Meritus had greater experience with managed care and strong physician organization than Frederick
  - Meritus developing ACO
- No overlap of primary service area. Minor overlap of secondary service area.
Clinical Integration Challenges

• Physician culture
  – Wide range of perceptions of value of alliance and integration with other systems, from acceptance to skepticism
  – Uncertainty about effects of Maryland capped reimbursement system (TPR)
  – Varying levels of trust in hospital administration
  – Low trust between medical staffs due primarily to lack of familiarity
  – Few inter-facility affiliations

• Wide variations in specialist needs
  – Western Maryland has significant gaps due to recruitment challenges
  – Frederick has significant specialty coverage issues
  – Not clear that staffs would cover gaps for other systems
Population Health—Potential for ACO Risk Sharing

Western Maryland Health System
- Garrett County: 30,097
- Allegany County: 75,087

Meritus Health
- Washington County: 147,430

Frederick Memorial Hospital
- Frederick County: 233,385
- Carroll County: 167,134
- Montgomery County: 971,777

Total Medicare (over 65) Population is approximately 62,000 for Allegany, Washington and Frederick Counties-combined versus (23,000) for Washington county alone.
Quality of Care Potential Initiative

General Opportunities

• Create a system approach to quality improvement
  – Evidence based medicine
  – Protocol development
  – Best practices
• Optimize existing relationships with GPO’s and other vendors
• Create regional learning opportunities for clinicians

Specific Opportunities

(Partial list)

• Chronic disease management tools, diabetes, COPD
• End of life care
• Maryland MHAC, QBR, readmissions policy (VBP)
• Regulatory compliance
• Ambulatory case management
• Coordinate clinical education and learning
• Primary care, NCQA certification
• Urgent care, occupational medicine
Quality of Care Conclusions

• Cost savings and economies of scale may be able to be employed with software tool contracts
  – Premier – Quality Advisor, Infection Surveillor
  – 3M – Potentially Preventable Complications, Computer Assisted Coding
  – Press Ganey – HCAHPS

• Strategic advantages from system-approach to Quality Improvement
  – Collaborative, solution-sharing environment can be created within a 3-hospital system, where current quality environment discourages sharing of ideas and strategies

• Cost savings are NOT likely from a Quality departmental staffing perspective
  – Due to regulatory review requirements, there is little redundancy between hospitals
  – Individual hospital Quality leadership will still be necessary
  – Some functions, such as data analytics, may be able to be combined
Regionalization of Services

- Pharmacy Function
  - Unified formulary
  - Centralized purchases of supplies, medications and equipment
  - Standardized IT platform

- Laboratory Function
  - Centralized in-house function to perform complex tests and reduce need for reference laboratory services
  - Centralized purchases of supplies, equipment and blood
  - Single laboratory EMR
Regionalization of Services

• Care Management Functions
  – Sharing of best practices, particularly in managing in total cost cap environment
  – Support for population health strategies and ACO project
  – Opportunities for pilots and incubator programs
Regionalization of Services

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Primary Areas for Efficiencies Identified - MSO Focus Areas

• Information Technology
• Human Resources
• Revenue Cycle
• Supply Chain
• Finance / Accounting
• Purchased Services
• Insurance Captive
• Community & Public Relations
• Laboratory Services
• Pharmacy Services
Factors Guiding Choice of Structures

- In choosing a preferred model, each Board considered a number of factors:
  - The importance of local autonomy and governance for each system
  - Potential gains in efficiency from consolidation of various operations
  - Promotion of clinical goals across a region as compared to preserving existing medical staff culture
  - The relative ease or difficulty in combining assets and operations
  - The development of trust between the systems as a platform for deeper integration in the future
Board Decision

• In October 2013 the three hospitals announced a Letter of Intent (LOI)
  – The parties agreed to explore new initiatives for cooperation and mutual support that will advance key components of healthcare reform such as better care, reduced costs and focus on population health management
  – The parties determined to pursue an Alliance to accomplish the objectives of the Preferred Model

• The LOI identified 4 initiatives:
  – Formation of a Regional Alliance Board to guide discussions
  – Creation of a jointly-owned Management Services Organization
  – Commitments to quality improvement programs
  – Consideration of a joint ACO proposal

• Each Board had discretion and a responsibility to consider alternatives to the Alliance as well
Elements of the Alliance

• Trivergent Health Alliance, LLC which is an entity governed by a jointly appointed board including community members and health system leadership, through which the systems can share best practices and pursue regional initiatives

• Trivergent Health Alliance MSO, LLC, which is a vendor of management services to the three systems, governed by a board consisting of the member organizations CEOs and CFOs and jointly owned by the systems. This organization will ultimately have approximately 1200 FTEs and provide the following services: Materials Management, Revenue Cycle, Human Resources, Information Technology, Pharmacy, Laboratory and Finance.

• Trivergent Alliance MSO to form 501 E for General Purchasing purposes

• Regional quality initiatives beyond the ACO to enhance physician integration and demonstrate value to the Alliance
Stage 3 – Validating the Model / Antitrust issues (Oct. 2013 to Jan. 2014)

- Work groups of department management and BRG experts
- Development of business plan
- Antitrust issues
Hospital Management Workgroups

• To validate the model, the systems organized a cluster of management workgroups charged with developing a plan for each business element to be included within the proposed MSO

• Workgroups consisted of three to nine representatives with equal representation from each system

• CEO and CFO leadership was important to demonstrate the will to collaborate and give impetus to the effort

• A BRG specialist supported each workgroup

• Objective was to develop a comprehensive business plan within 3 months from the kick-off—a two day retreat
Hospital Management Workgroups

- Workgroups included:
  - Revenue cycle
  - Materials management
  - Information technology
  - Human resources
  - Lab
  - Pharmacy
  - Urgent care (initially)
  - Finance
  - CFOs
  - CEOs
MSO Business Plan Template

- Key areas to be standardized
- Current state: number of FTEs and salary with fringe benefits at each hospital
- Number of FTEs to be centralized. Number of FTEs to remain at local hospital. Related rationale.
- Organizational chart of new structure (without names) / governance
- Estimated 3 year budget (identify one-time transition costs separately) by year
- Location recommendation and rationale
- Information technology (current state, planned solution)
- Estimated implementation timeline (phasing, urgent requirements, existing contract hurdles, etc.)
- Vendor issues / opportunities
- Performance requirements / metrics
- Allocation of cost recommendation
- Estimated savings after first year (operating and Cap Ex)
- How will pre-migration information be handled after consolidation? (i.e. collection of receivables?)
- Expected personnel issues, retention issues, etc.
- Benefits expected
- Risks / concerns
Consolidation Guiding Principles

• Everything should be considered in the MSO, unless the working group convinces management that some function should not be included

• All planning discussions should be kept confidential at this stage (communication should generally be at Vice President and Director levels only)

• Cooperative synergistic approach to planning

• In developing new organizational chart keep names off chart and specific people for positions should not yet be considered

• Allocated consolidated costs should be less than current costs for each hospital

• MSO should achieve efficiency of a high performing organization

• Establishment of metrics for performance and quality

• Minimize initial cap-Ex and transition costs

• Anti-trust issues will require ongoing confidentiality and firewalls in certain areas
Minimum Criteria to Consider in Determining Location of MSO Services

- Workforce availability
- Workforce education (possible creation of community college programs)
- Compensation differences
- Facility availability (cost / location / lease / available hospital space / parking availability)
- Current state expertise
- Appropriate grouping of services
- Existing infrastructure (i.e., I.T.)
- Central location of facility to workforce
- Ability to work at home (coders, transcription, etc.)
- Continued need at local hospital
Basic Anti-Trust Considerations Regarding Affiliation Discussions and Sharing of Information

• The systems jointly engaged knowledgeable antitrust counsel to provide context for discussions and counsel provided the following guidelines:
  – The Health Systems should be considered competitors, even though developing an affiliation for certain common objectives
  – Be mindful of antitrust considerations when drafting documents and consult with counsel if there are concerns
  – Avoid speculation about how competitors will react to a proposed affiliation
  – Do not assume the ability of any party to raise prices or reduce services in any projections
Basic Anti-Trust Considerations Regarding Affiliation Discussions and Sharing of Information

– Increased margins that may result from the affiliation should accrue from cost savings or other efficiencies
– Firewalls will need to be built into the MSO systems to prevent the sharing of pricing and other sensitive information
– Discussion of general and necessary operational issues to integrate the entities such as IT systems, benefits, legal issues, and union issues is permitted
– The parties may not share any sensitive proprietary data such as fee schedules, chargemasters, strategic plans, marketing plans, business plans, cost data, reimbursement rates, non-public salary info, or anything that could result in reduced competition
Infrastructure Organizational Chart

CEO 1FTE

Assistant 1 FTE
Legal Support
Compliance

Revenue Cycle
- Exec/PFS Dir/Mngr 34.5 FTE
- HIM Dir/Mngr 7.0 FTE
- Staff 326.8 FTE

HR
- Exec/Dir/Mngr 10.0 FTE
- Coordinator 3.0 FTE
- Professional 17.2 FTE
- Technical 12.5 FTE
- Administrative 3.0 FTE

I.T.
- Exec/Dir/Mngr 18.0 FTE
- Analyst 58.9 FTE
- Systems Support 9.0 FTE
- Network Support 32.7 FTE
- Computer Op 4.5 FTE
- Database Admin 1.0 FTE
- Admin Assist/Other 2.0 FTE

Lab
- Exec/Dir/Mngr 21.0 FTE
- Support Staff 54.9 FTE
- Clerical 14.8 FTE
- Phlebotomist 121.3 FTE
- Technical 127.98 FTE

Pharmacy
- Exec/Dir/Mngr 10.0 FTE
- Pharm/IT Pharm 55.2 FTE
- Oncology/OPAC 4.0 FTE
- Tech/Support 56.9 FTE
- Clinical 6.0 FTE
- Resident 4.0 FTE

Supply Chain

Future Additions
- Imaging
- Care Mgmt
- Perf. Improvement
- Insurance

Compliance

Accounting 2 FTE

Assistant 1 FTE

Legal Support
# MSO Investment Return Projection

(in millions of dollars)

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Capital Needs</td>
<td>($4.8)</td>
<td>($6.4)</td>
<td>($0.9)</td>
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<td>One-time Transition Costs</td>
<td>(1.8)</td>
<td>(0.7)</td>
<td>(0.7)</td>
<td>(3.2)</td>
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<td>Severance</td>
<td>(0.8)</td>
<td>(0.3)</td>
<td>0.0</td>
<td>(1.1)</td>
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<td>Net Synergy Savings</td>
<td>7.4</td>
<td>15.0</td>
<td>21.1</td>
<td>43.5</td>
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<td>Cumulative Savings</td>
<td>$0.0</td>
<td>$7.6</td>
<td>$19.5</td>
<td>$27.1</td>
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Management Services Organization – Centralized locations

- **Revenue Cycle**
  - Pre-access / scheduling – FMH
  - Hospital PFS – MMC
  - Physician PFS – WMHS

- **Supply Chain** – FMH

- **Human Resources**
  - 40% in MSO at FMH
  - 60% remain at hospital locations

- **Information Technology**
  - Servers at WMHS
  - Virtual at hospitals

- **Lab**
  - Core lab – MMC
  - Pathology lab (major) – FMH
  - Pathology lab (minor) – WMHS
  - Microbiology lab – WMHS

- **Pharmacy** – WMHS
Management Services Organization – Timeline

**Human Resources**
- Design MSO benefits, pay structure, HR policies and job desc.
- Contract for benefit plans
- Migrate employees and processes to MSO
- Fully operationalize HR centralized operations
- HR FTE reductions fully implemented

**Pharmacy**
- Plan all pharmacy changes
- Centralized P & T implemented
- Drug utilization (formularies and order sets)
- Drug purchase standardization
- Wholesale agreement

**Lab**
- IT overlay to connect all labs
- Renovate current lab spaces and move equipment
- Establish new courier routes
- Bring pathology groups into co-management agreements
- Begin implementation of staff FTE reductions
- New lab model operational
- Complete FTE staff reductions

**Information Technology**
- Develop plan to consolidate infrastructure
- Conclude on standard system platform
- Complete vendor negotiations
- IT staff realignment and organizational changes
- Migrate key systems to single data center
- Fully realize IT staff reductions
- Complete transition to standard system platform
Management Services Organization – Timeline (Cont.)

Supply Chain
- Develop detailed plan for combined supply chain function
- Standardization of supplies and purchasing negotiations
- Distribution changes
- Reorganize supply chain system resources
- Fully realize FTE reductions

Revenue Cycle
- Restructure department
- Deploy best practices, standards, metrics
- Implement ICD-10
- Develop telecommuting infrastructure
- Match staff to new positions
- Select vendors and begin implementation
- Renovate space for consolidated functions
- Shift to new MSO organizational structure
- Begin Meditech 6.1 deployment

Finance and MSO Infrastructure
- Establish MSO finance platform
- Renegotiate vendor contracts (audit, tax)
- Consolidate Payroll and Cash disbursements
- Develop Internal Audit and Compliance
- Consolidate insurance captives
Transition Plan – 120 Day
Infrastructure

• Legal/ Organization Structure/Contracting
• Management Design & Selection/Reporting Structure
• Finalize Revenue Model
• Finance – Infrastructure/Accounting/Working Capital/Reporting/Controls/Policies/Payroll/AP
• HR – Develop Compensation & Incentives Plan/Job Descriptions/Locations/Severance
• IT Requirements & Phasing Plan
• Insurance & Licenses
• Compliance Function Contracting
• Communications Plan
• Governance Requirements
Divisional Transition Plans

- Performance Metrics/Service Goals
- People Plan
- Financial Savings Targets
- Prerequisites/Support Requirement
- Relocation Requirements
- Allocations to Hospital – Operating and Capital
- Policies & Procedures
- Timeline
Board Decision

• Board approved business plan

• Board approved funding of capital needs and start-up costs

• Board approved formation of:
  – Regional Alliance Corporation (Trivergent Health)
  – Management Services Corporation (Trivergent MSO, LLC)

• Board approved Trivergent name, and logo to create identity

• Tax status as pass through entities
Stage 4 – Hospital management departments’ planning for consolidation (Jan. 2014 to June 2014) / Go Live (July 1, 2014)

- Cultural change management
- Location issues
- CEO Executive search
- Selection of management team
- Operationalizing consolidation
- Achieving efficiencies
- Difficulties encountered
Vision: Achievement of per capita savings in Healthcare delivery through innovation and values driven service

Horizon 1 2015
- Achieve projected savings of $5.6m.
- Improve HR efficiency, streamline processes
- Standardize IS support platforms, install connectivity across all customer sites.
- Achieve vendor and denial projected expense savings, prepare for ICD-10 implementation, implement systems infrastructure to work across hospitals
- Develop Performance Management system and process

Horizon 2 2016
- Achieve additional projected savings Year 2 of $8.9m, totaling $20.1m for 2 years
- Initiate disaster recovery opportunities, standardize project management structure and initiate common HIS platform
- Determine additional areas to add to the MSO

Horizon 3 2017
- Achieve additional projected savings of $6m in year 3 to total $40.5m for 3 years
- Complete in-source of Lab reference testing
- Facilitate customer decision on common Clinical and Financial HIS platform and initiate implementation of Common HIS platform.
- Determine additional areas to add to the MSO
**Vision:** Achievement of per capita savings in Healthcare delivery through innovation and values driven service

- Implement pharmacy collected home med list for 95% admissions and train for process improvement/LEAN.
- Reduce preventable medication errors as depicted in the Pharmacy Scorecard.
- Improve patient satisfaction to top quartile as compared to benchmarks.
- Continue to standardize drug formulary, standardize pharmacy practice models, implement pharmacy concurrent support to 2 core measures, continue performance improvement events to eliminate waste and build on improvements from Horizon 1.
- Provide leadership development and teambuilding initiatives for host hospitals, develop an employee wellness initiative.
- Incorporation of LEAN initiatives throughout HR processes.
- Continued improvement for patient satisfaction-communications and assist to improve quality measure support to top decile as compared to benchmarks.
- Achieve denial, vendor expense and efficiency savings, implement ICD-10 and reorganize to cross hospital structure.
- Achieve benchmark goals for drug utilization in 2 drug classes.
- Continued improvement patient satisfaction-communication and sustain quality measures to top decile as compared to benchmarks.
- “Best in Class” Supply Chain.
- Achieve denial and vendor expense and efficiency savings.
Horizon Map: Trivergent Health Alliance MSO - October, 2014, Cont’d

**Vision:** Achievement of per capita savings in Healthcare delivery through innovation and values driven service

**Enabler**

- Implement systems interconnectivity of all 3 laboratories to hub, standardize instrument platforms, in-source reference tests, establish courier routes
- Standardize and implement bedside medication education
- Implement ABN software at all hospitals
- Implementation of common purchasing platform
- Implement Productivity Model to facilitate staffing efficiencies
- Perform Customer Satisfaction Survey

- Complete operation of Trivergent Central Warehouse
- Fully implement interconnectivity to all 3 labs; in-source reference tests
- Implement HRIS System
- Finalize implementation of common purchasing platform and have member facilities fully utilizing for ordering of supplies
- Initiate HIS system selection process
- Operationalize Productivity Model to facilitate staffing efficiencies
- Implement centralized scheduling software and collection software

- Complete fully functional member Point of Use Supply Chain System
- Continue with Productivity Improvement consistent with MSO model
- Provide Leadership & Team Building activities for Sponsor Hospitals
<table>
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<tr>
<th>MISSION</th>
<th>VISION</th>
<th>VALUES</th>
</tr>
</thead>
</table>
| The provision of unprecedented savings through the power of collaboration to support achievement of exemplary clinical outcomes. | Achievement of per capita savings in Healthcare delivery through innovation and values driven service. | - Quality  
- Stewardship – Efficient Effective Service  
- Respect  
- Integrity  
- Collaboration & Teamwork |
<table>
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<tr>
<th>Division</th>
<th>Savings</th>
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<td>Lab</td>
<td>$367,900</td>
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<td>Pharmacy</td>
<td>$2,122,876</td>
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<td>Supply Chain</td>
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<td>Information Technology</td>
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<td>Human Resources</td>
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<td>Revenue Cycle</td>
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<th>Category</th>
<th>Savings</th>
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<tr>
<td>Salary and Fringe Benefits</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$5,805,203</strong></td>
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## Trivergent Health Alliance, MSO Savings Share by Division and Hospital (As of December 2014 and Projected to June 2015)

### Savings by Hospital

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<tr>
<th>Hospital</th>
<th>Total</th>
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<tr>
<td>Frederick Memorial Hospital</td>
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<td>Meritus Medical Center</td>
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</tr>
<tr>
<td>Western Maryland Health System</td>
<td>1,442,875</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$5,042,385</strong></td>
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### Salary and Fringe Benefits

<table>
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<tr>
<th></th>
<th>Total</th>
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<tbody>
<tr>
<td>Salary and Fringe Benefits</td>
<td>762,801</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$5,805,203</strong></td>
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### Value Adds

<table>
<thead>
<tr>
<th>Add</th>
<th>Total</th>
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<tbody>
<tr>
<td>Revenue Opportunity</td>
<td>$1,055,000</td>
</tr>
<tr>
<td>Capital</td>
<td>809,862</td>
</tr>
<tr>
<td>Cost Avoidance</td>
<td>383,975</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,248,837</strong></td>
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</table>

### Grand Total

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>$8,054,040</strong></td>
</tr>
</tbody>
</table>
OVERALL

• On-boarded 1200 Trivergent employees with salaries and benefits
• Reorganized Materials Management, IT, Revenue Cycle, HR
• FY 2016 Budget in process/affirming Year 2 savings of $9.3 / maintain $6.1 million for current year
• Considering other strategic opportunities to partner with entities pursuing similar goals in areas such as population health, strategic sourcing, clinical improvement, etc.
• Finalized policies for foundational management and operating issues
• Completed divisional director goals and detailed performance metrics reports for ongoing monitoring
• Implemented Operations Advisor Productivity and Benchmarking products
• Trademark – Name has been reserved
• Anticipate final revisions to Management Services Agreement and Services Addenda for execution within next 30 days; changes address issues raised by hospitals as well as changes identified to pursue tax-exempt status
Trivergent Health Alliance MSO Update – 4/1/15

FINANCE

• Expanded savings scorecards to consistently measure savings anticipated and achieved on supply and purchased service contracts – confirmed specific first year savings potential of $6M+
• Establish Key Performance Indicator Methodology and reporting for quality, service, finance and programs
• Updated all business plans for FY15 final budgets and savings projections; updated horizon maps from 120-day initial timeframe to 1-3 year visions
• Performed first quarter distribution of funds to patron hospitals developing mechanics of calculation
• Prepared first draft summary financial statements using recommended hospital service co-operative descriptions and formatting
• Evaluating cost-effective options to ensure business integrity and that compliance risks are assessed and managed appropriately
Trivergent Health Alliance MSO Update – 4/1/15

PROGRAMS

• Adopted quarterly schedule of CEO meetings with Trivergent staff at all three hospitals with topical input from corporate directors; corporate directors all regularly spend time at each hospital
• Developed first Trivergent employee benefit plans with open enrollment commencing November 2015
• Contracted to create lab reference software application connecting all three hospitals; implementation scheduled for July
• Medline Contract for Supplies Finalized and in place
• Implemented FMH Warehouse March 2015
• Joined Premier under FMH’s agreement
• Centralized P&T - 200 recommendations/95% accepted/projected to achieve $2.2 million in savings by June 30, 2015
TRIVERGENT HEALTH ALLIANCE MSO UPDATE – 4/1/15

PROGRAMS

• Executed contract with CareFusion for pharmacy dispensing equipment projecting $5M savings over 8 year term (Implementation October 2015)
• ICD-10 – Fall 2015
• Encoder – Fall 2015
• Advanced Beneficiary Notice Software (on contracting phase)
• GHX Purchasing Suite Software – 2015
• Tecsys Inventory Management Overlay Software in process
• Clinical Value Analysis Team to standardize supply spend – in process
Trivergent Health Alliance MSO Next Steps

- Finalize FY 16 Budget/Verify Savings
- Savings Distribution – Quarters 3 and 4
- Update Horizon Maps
- List of Major Initiatives by Division for FY 2016

- **Human Resources**
  - Workers’ comp and employee safety evaluation/central safety function
  - Evaluate possible opportunities for in-house mail order pharmacy via wholesale pharmacy at central warehouse
  - HRIS RFP in process
  - HR Benefit Assessment

- **Laboratory**
  - Explore and review pathology professional contracts to be implemented in FY17
List of Major Initiatives by Division for FY 2016

- **Revenue Cycle**
  - Computer-Assisted Coding
  - Collection/Reporting Software packages
  - Reorganization of management across all hospital revenue functions

- **IT**
  - Security System Initiatives
  - IT Assessment in Progress
Trivergent Health Alliance MSO Next Steps

List of Major Initiatives by Division for FY 2016

- **Pharmacy**
  - Implement LEAN initiatives at each pharmacy
  - Proactively address financial impact of oncology drugs via central P&T committee
  - Target focused drug spending per hospital to identify additional savings (TPA, antibiotics, etc.)
  - Implement formulary software

- **Materials Management**
  - Inter-hospital courier expansion for transporting lab samples and supplies
  - Licensed wholesale pharmacy at FMH warehouse
  - Consolidate MMC warehouse to FMH by 4/2016
Summary of Projected Savings for Fiscal Years Ending 6/30/15 and 6/30/16

<table>
<thead>
<tr>
<th>Division</th>
<th>Estimated Savings Projected to 6/30/2015 as of 3/31/2015</th>
<th>Estimated Savings Projected to 6/30/2016 as of 3/31/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>$2,382,000</td>
<td>$2,300,000</td>
</tr>
<tr>
<td>Materials Management</td>
<td>1,891,000</td>
<td>2,600,000</td>
</tr>
<tr>
<td>Human Resources</td>
<td>250,000</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Information Services</td>
<td>557,000</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Lab</td>
<td>534,000</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Revenue Cycle</td>
<td>1,061,000</td>
<td>4,700,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,675,000</strong></td>
<td><strong>$14,700,000</strong></td>
</tr>
<tr>
<td>Original Target</td>
<td><strong>$5,600,000</strong></td>
<td><strong>$8,900,000</strong></td>
</tr>
<tr>
<td>Actual Savings over Target</td>
<td><strong>$1,075,000</strong></td>
<td><strong>$5,800,000</strong></td>
</tr>
</tbody>
</table>
Horizon Map: Trivergent Health Alliance

**Vision**: Improve Population Health delivering best in class outcomes so that every person can achieve their highest potential for health.

**Horizon 1**  
**Short Term**
- Develop/pursue Community Collaboration and Partnerships
- Replicate P & T success
- Leverage common physician groups
- Begin population health business planning process
- Establish a culture of excellence committed to achieving best clinical outcomes
- Determine additional areas to add to MSO

**Horizon 2**  
**Long Term**
- Achieve Community Collaboration and Partnerships
- Regional Leader/national model for Population Health/Wellness Promotion
- Leader in Clinical Quality through common data platforms, engaged medical staff and patient engagement
- Achieve a culture of excellence committed to providing best clinical outcomes
- Provide significant value to Trivergent Members
Horizon Map: Trivergent Health Alliance

**Vision:** Improve Population Health delivering best in class outcomes so that every person can achieve their highest potential for health.

- Pursue community physician buy-in to Population Health through community collaboration and education
- Support annual medical staff leadership retreats
- Eliminate unnecessary clinical variation
- Work toward top decile quality scores
- Develop common data platforms (patient)
- Achieve successful chronic disease management
- Provide community education
- Lead transformation to high quality/cost effective care through end of life
- Achieve top decile quality scores
- Deliver unprecedented savings
- Continue to seek clinical & operational advantage
Shared Alliance Quality Initiatives

- **Sepsis Screening & Treatment**  
  - Improved screening tool with elements of screening protocol

- **C difficile reduction**  
  - Collaborated on hand hygiene initiatives and ideas and strategies to increase compliance  
  - Shared ‘C dif rounds’ concept

- **Shared mortality efforts – especially coding accuracy initiatives**  
  - Shared their mechanisms for real-time preliminary coding

- Have collaborated on CHF & COPD readmission reduction ideas among all three hospitals. All three still have opportunities for improvement

- Shared outpatient clinic concepts extensively with other care management departments and service lines, including psych.
Shared Alliance Quality Initiatives

• Shared coding procedures for Maryland Hospital Acquired Condition ‘hypotension’

• Nursing leadership has met on multiple occasions to discuss and share information related to best practices on clinical quality measures

• Staff have made many visits to examine pressure ulcer and fall best practices among the three organizations

• FMH used the Meritus & WMHS models of DVT prophylaxis to design its own, which was implemented last year

• Shared its blood transfusion reduction initiatives; all three organizations now have similar transfusion rates around 8%
Population Demographics of the three county area

Chronic Conditions – Total Population (2012)

- The top 2 chronic conditions in all 3 counties are HTN and lipid disease. The 3rd most common varies by county – diabetes, mental health (not cognitive or mood) (Allegany), cardiac arrhythmias (Frederick), diabetes (Washington).
- Chronic conditions were statistically significantly higher compared to statewide average: mood disorders: Allegany – CAD, HTN, mental health; Frederick – cardiac arrhythmia, lipid disorders, mental health; Washington – COPD.
- Chronic conditions in the Medicare FFS population are higher than the statewide average: hyperlipidemia in all 3 counties, arthritis, hypertension (Allegany), ischemic heart disease (Frederick), and COPD, diabetes, and depression (Washington).
- For every chronic condition, the rates paid by Medicare were higher than the statewide average.

Note: Data sources include: Community Needs Assessments conducted by Frederick Memorial Hospital, Meritus Health, and Allegany County (jointly performed by Western Maryland Health System and the county health department), the Health Services Cost Review Commission, U.S. Census, County Health Rankings (a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute), The Centers for Medicare & Medicaid Services (CMS) Chronic Condition Warehouse, Maryland Vital Statistics, the Maryland Department of Planning, and the Behavioral Health Risk Factor Surveillance System.
Population Demographics Continued

Chronic Conditions – Medicare FFS Population (Different data set, and not statewide numbers) (2012)

- The top 2 chronic conditions in all 3 counties were the same (Hypertension and hyperlipidemia). The 3rd most common again varied by county – arthritis (Allegany), Ischemic heart disease (Frederick), and Diabetes (Washington).
- Chronic conditions statistically significantly higher than the statewide average: arthritis, COPD, depression, hyperlipidemia, diabetes, hypertension, ischemic heart disease (Allegany), ischemic heart disease (Frederick), and asthma, diabetes, and HTN (Washington).
High Utilizers – Chronic conditions (2012)

- The top chronic condition for high utilizers in all 3 counties as well as the state as a whole is HTN. The 2\textsuperscript{nd} and 3\textsuperscript{rd} most common varies by county – mood disorder, diabetes (Allegany), cardiac arrhythmias, lipid disease (Frederick), lipid disease, cardiac arrhythmias (Washington).
- Chronic conditions statistically significantly higher than the statewide average: mental health “other” in all 3 counties, CAD, mood disorders, COPD, lipid, mood, osteoarthritis (Frederick), and COPD (Washington).

High Utilizers by Payer – most common DRGs (2014)

- The 3 most common DRGs for Medicare FFS populations included “other pneumonia” in all three counties: Heart failure (Allegany, Frederick), septicemia and disseminated infections (Frederick, Washington), rehabilitation (Allegany), and COPD (Washington).
Population Demographics Cont’d

Leading Causes of Death

- The leading causes of death are heart disease and malignant neoplasms, respectively, which have substantially higher rates than the 3rd cause, cerebrovascular disease ( Allegany, Frederick) and chronic lower respiratory disease (Washington).

- Death rates as a whole, Allegany and Washington have much higher death rates (per 100,000 population) than the state as a whole.
Population Demographics Cont’d

Patient Survey (BRFSS, 2013)

- Many people rate their general health as excellent/very good, a number note that their physical and/or mental health was poor 8+ days in the past month. Allegany has a significantly lower percentage of the population that rate their health as very good/excellent, while Frederick has a significantly higher percentage.
- Frederick has a lower rate of pneumonia vaccines, while Washington has a higher rate.

The majority of people responding to the survey are overweight or obese, in all counties (significant comorbidity).
### Population Health Demographics

- **Comparative Health Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Allegany</th>
<th>Frederick</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health outcomes (rank)</td>
<td>22</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Length of Life (rank)</td>
<td>15</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Quality of Life (rank)</td>
<td>23</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Health Factors (rank)</td>
<td>19</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Health Behaviors (rank)</td>
<td>18</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Clinical Care (rank)</td>
<td>18</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Social &amp; Economic Factors (rank)</td>
<td>18</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Physical Environment (rank)</td>
<td>19</td>
<td>17</td>
<td>22</td>
</tr>
</tbody>
</table>
Current Health Strategies

• The Alliance’s population health strategy places particular focus on aging populations, frail elders and patients with chronic medical conditions and serious behavioral health related illnesses.

• Emphasis on primary care, prevention, and reduction of risk factors, by reaching patients where they are, whether inside or outside of traditional health care settings.

• Specifically, incorporates and builds on the aims and objectives of existing Local Health Improvement Coalition (LHIC) health action plans, and leverages LHICs’ experience and expertise summarized below:
<table>
<thead>
<tr>
<th>LHIC:</th>
<th>Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACHPC/WHMS</td>
<td>Tobacco and substance use reduction and promote regular chronic disease screenings.</td>
</tr>
<tr>
<td></td>
<td>Bridges to Opportunity – addressing poverty</td>
</tr>
<tr>
<td></td>
<td>Access to appropriate care – Community Health Worker program, reduce transportation barriers, assess food needs</td>
</tr>
<tr>
<td></td>
<td>Increase health choices and behavioral changes</td>
</tr>
<tr>
<td></td>
<td>Disease management targeting individuals with multiple conditions, diabetes, heart disease, and asthma and focus on prevention and self-management and connection to primary care provider</td>
</tr>
<tr>
<td></td>
<td>Availability of Behavioral Health services - screening for depression and anxiety</td>
</tr>
<tr>
<td></td>
<td>Mental Health Frist Aid</td>
</tr>
<tr>
<td></td>
<td>Multiple outpatient clinics within WMHS</td>
</tr>
<tr>
<td></td>
<td>Community Care Coordination</td>
</tr>
<tr>
<td></td>
<td>Pilot program of providers within designated skilled nursing facilities</td>
</tr>
<tr>
<td><strong>Frederick, Washington and Howard counties with Way Station, Inc.</strong></td>
<td>Behavioral Health Home; increasing access to Primary Care collocated in BH as well as integrated care within PC, and increase in consumer engagement in care through integrated recovery protocol</td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>
| **FRHS** | Community based education and wellness events  
Chronic Disease Management  
Mental Health improvement plan  
Navigation services  
Health Information Exchange access  
Women and children; pediatric asthma  
Engagement of community volunteer force  
Partnerships across the continuum – focused on high, moderate and low risk populations  
Community-based senior services |
| **Meritus/MMC** | Decrease obesity  
Increase physical activity, organize 5K walks, BMI screening, aid with healthy food choices, nutrition counseling in schools,  
Diabetes care specialists at discharge and partnered with DOH and local faith communities providing Diabetes program in the community  
Community-wide blood pressure campaign and CDC Million Hearts campaign and partnering with parish nurses  
Decrease cancer morality by expanding access to care; recruiting additional oncologists and opening cancer centers  
Improving access to mental health treatment – ED utilization for mental health visits was 17% higher than the MD state average. |
POPULATION HEALTH/QUALITY FOCUS NEXT STEPS

- Gain understanding of the health status and health needs of the Trivergent Community
- Review ‘building blocks’ of Trivergent’s care delivery transformation plan
- Discuss HSCRC Regional Planning Grant Application Process
- Organizing committees comprised of members from each hospital
- Review of Quality Management Plans as Promulgated by HSCRC and MHCC
- Review current position of each hospital
- Review current collaborative quality efforts
- Discuss Scope and Need of Trivergent Region
- Review draft Model Concept and Population Health Strategies
- Identify Critical Community Partners and discuss ideas to Formalize Partnerships/Advisory Groups
- Discuss Financial Sustainability and Value-Based Payment Models
- Develop Governance Model, Planning Process and High Level Horizon Map
Kim Repac  
CFO, Western Maryland Health System  
krepac@wmhs.com

Michelle Mahan  
CFO, Frederick Regional Health System  
mmahan@fmh.org

Raymond (Ray) A. Grahe, FHFMA, CPA  
CEO, Trivergent Health Management Services Organization  
Raymond.grahe@trivergenthealth.com
Kimberly S. Repac
CFO, Western Maryland Health System

Kim is Sr. Vice President/Chief Financial Officer for Western Maryland Health System, a position she has held since 1996. Prior to the formation of the Western Maryland Health System in 1996, she held a similar position with Sacred Heart Hospital since 1991. She worked in various financial capacities since starting her career in 1980. Kim holds a Bachelor in Accounting and a Masters in Business Administration. She is a 2010 graduate of Leadership Maryland. She has been intricately involved in a number of significant activities including the purchase of a hospital with conversion to a nursing home; the affiliation of a secular and religious hospital into the current Western Maryland Health System, the termination and buyout interest of one of the owners of WMHS, and a bond restructuring and financing of a 275 bed, $356 HUD mortgaged backed replacement facility to replace the former two hospitals. Kim was involved in the transformation under TPR from volume based care to value based care delivery model. She played an instrumental part in the formation and implementation of the Trivergent Health Alliance. Kim serves on numerous State and Local committees and boards. She is actively involved with the Maryland Hospitals Association and its various Councils related to the financial aspects of health care in Maryland. She serves/served on various non-profit and for-profit boards at the state and local level. She is a past member of the Maryland Economic Development Commission.
Speaker Biography

Michelle Mahan
CFO, Frederick Regional Health System

Ms. Mahan began her employment with Frederick Memorial Health System in 2008. Ms. Mahan brings over 30 years of financial leadership as a chief financial officer and as a senior leader in public accounting. Prior to joining FMH, Ms. Mahan served as Chief Financial Officer at both St. Joseph Medical Center in Towson, Maryland and Children’s National Medical Center in Washington, DC. Prior to that time she was a manager in the Washington, DC consulting practice for E&Y and worked at Scripps Health in La Jolla, California. In all of these roles, Ms. Mahan was responsible for strategic financial planning, capital management, investments and improving financial performance through implementing revenue cycle enhancements, and cost efficiencies in labor and supply chain processes. Ms. Mahan received her B.S. in Business Administration from the University of Southern California, and her CPA in California. Ms. Mahan is a former Board Member of the Financial Executives International, and is a member of the Healthcare Financial Management Association. She also has served on the board of Woman to Woman Mentoring in Frederick.
Raymond A. Grahe, CEO, Trivergent Health Alliance MSO (65) Mr. Grahe is the Chief Executive Officer of the Trivergent Health Alliance MSO, a $250 million organization with 1,150 employees serving Frederick Memorial Hospital, Western Maryland Health System and Meritus Medical Center. Formerly, he was the Senior Vice President – Chief Financial Officer and Treasurer of the Meritus Medical Center, Inc. and was responsible for all financial services of Meritus Health Inc. He joined the administrative staff of Washington County Hospital in 1979. He is a member of the American Institute of Certified Public Accountants and the Maryland Association of Certified Public Accountants and a fellow of the Healthcare Financial Management Association. Mr. Grahe is Chairman of the Board of Directors of Maryland Physicians Care, a Medicaid HMO with 200,000 members statewide. Mr. Grahe is a past member of The Columbia Bank Board, chairman of the Colonial Regional Alliance Board of Managers and Treasurer of the TriState Health Partners Inc. Board of Directors. Mr. Grahe has been a member of various committees of the Maryland Hospital Association for many years, largely on the finance committee and the rate negotiation committees. Mr. Grahe received a B.S. from the University of Maryland and an M.B.A. from Loyola College.