COMMONWEALTH of VIRGINIA

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State Health Commissioner

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December 20, 2017

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner
Virginia Department of Health
109 Governor Street
Richmond, Virginia 23219

Dear Dr. Levine:

As Chair of the Technical Advisory Panel of the Cooperative Agreement (TAP), I am pleased to submit to you this report from the TAP. The TAP met three times in order to craft the recommendations for active supervision of the new health system that it is submitting to you. The report consists of the minutes of those three meetings; a set of short-term expectations for the new health system; and a set of long-term measures and performance indicators for the new health system.

It is the TAP's hope that its discussions and recommendations will be helpful to you in defining the metrics for the active supervision of the cooperative agreement. Please feel free to contact me if you have any questions or wish to discuss the TAP's report.

Sincerely,

M. Norman Oliver

M. Norman Oliver, MD, MA
Deputy Commissioner for Population Health

MNO/csw

Enclosure

Short Term Milestones to Ensure Success of Plan Development to be Achieved Within 12 Months of Closing of Merger

A

For the following plans required by conditions:

- Rural Health Services Plan (condition 33)
- Behavioral Health Services Plan (condition 34)
- Children's Health Services Plan (condition 35)
- Population Health Plan (condition 36)

  - New health system will update the Office of Licensure and Certification of the progress of the plan preparation at 90 days following closing
  - A draft of the plan will be submitted to the Office of Licensure and Certification 30 days before submission of the final plan
  - Submission of final draft plan to VDH Office of Licensure and Certification staff within 6 months of closing

B

For the following plans required by conditions:

- Plan to Develop and Provide Access to Patient Electronic Health Information (condition 8)
- Post-Graduate Training Plan (condition 24)
- Plan for Investment in the Research Enterprise (condition 25)

  - New health system will update the Office of Licensure and Certification of the progress of the plan preparation at six months following closing
  - A draft of the plan will be submitted to the Office of Licensure and Certification 60 days before submission of the final plan.
  - Submission of final draft plan to VDH Office of Licensure and Certification staff within 12 months of closing

<u>Outcome 1: Create Value in the Marketplace</u>

Conditions: 6-7-8-9-10-11-26-29-30-31-42-43-44

1.1 - Submit the most recent data from the Anthem Q-HIP to VDH Office of Licensure and Certification staff

1.2 - Comprehensive Plan for New Infrastructure to Support a Risk-Based Business Model (see Performance Indicator 1C)

  - New health system will update the Office of Licensure and Certification of the progress of the plan preparation at six months following closing

- A draft of the plan will be submitted to the Office of Licensure and Certification 60 days before submission of the final plan.
- Submit final draft plan to VDH Office of Licensure and Certification staff within 12 months of closing

1.3 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on cost and quality and develop experience measure for employee and family population; desirable within six months but required at 12 months

1.4 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on existing health outreach programs for employers; desirable within six months but required at 12 months

1.5 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on spending with regional suppliers; desirable within six months but required at 12 months

Outcome 2: Improve health and well-being for a population

Conditions: 14-15

2.1 - Compile and submit to VDH Office of Licensure and Certification staff baseline data for all population health metrics for Southwest Virginia and for socioeconomic peer counties as well as other counties in the Commonwealth, as available; desirable within six months but required at 12 months

Outcome 3: Equitable access to services across the region

Conditions: 1-27-28-41-46

3.1 - Compile a comprehensive access plan (see Performance Indicator 3.B) and submit it to VDH Office of Licensure and Certification staff including baseline data for all access measures for Southwest Virginia

3.1.A - New health system will update the Office of Licensure and Certification of the progress of the plan preparation at three months following closing

3.1.B - A draft of the plan will be submitted to the VDH Office of Licensure and Certification 30 days before submission of the final plan

3.1.C. - Submit final draft plan to VDH Office of Licensure and Certification staff within 6 months of closing

3.2 - Compile and submit to VDH Office of Licensure and Certification staff baseline data for service delivery in Southwest Virginia for the following service categories:
Primary Care
Mental Health
Heart and Vascular
Muscular Skeletal
GI
Cancer

desirable at six months but required at 12 months

Outcome 4: Adequate providers to provide equitable services throughout the region

Conditions: 24-32

4.1 - Compile and submit to VDH Office of Licensure and Certification staff baseline data concerning health care providers in Southwest Virginia as part of the needs assessment and recruitment plan (Indicator 4.A)

Outcome 5: Benchmark operating performance

Conditions: 12-13-16-17-40-45

5.1 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on financial metrics; upon closing, the quarter prior and the next quarter, as available

5.1.A - Compile and submit to VDH Office of Licensure and Certification staff financial projection data within 120 days after closing

5.2 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on quality and service metrics; desirable at six months but required at 12 months

Outcome 6: Strong vibrant culture

Conditions: 18-20-21-22-38

6.1 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on initial Board engagement survey within 18 months of closing

6.2 - Compile and submit to VDH Office of Licensure and Certification staff baseline data on employee turnover at six and 12 months after the date of closing

Outcome 7: Strong academics and research impacting the region

Conditions: 25

7.1 - Compile and submit to VDH Office of Licensure and Certification staff baseline data as part of the investment in the research enterprise in the Virginia service area plan (Indicator 7.A)

Outcome 8: Monetary commitment

Conditions: 3-19-23-33-34-35-36-37

8.1 - Complete and submit to VDH Office of Licensure and Certification staff the short and long term monetary spending plan including goals of spending in southwest Virginia; desirable at six months but required at 12 months

8.2 - Establish the ongoing tracking mechanism for spending including dollars spent in Southwest Virginia and submit to VDH Office of Licensure and Certification staff; desirable at six months but required at 12 months

Active Supervision of the Cooperative Agreement: Draft Measures and Performance Indicators

Outcomes	Conditions	Measures	Performance Indicators
1 Create value in the market-place	Relevant Conditions 6-7-8-9-10-11-26-29-30-31-42-43-44 Integrated delivery system *Payer strategies *Health information network *IT and analytics *Non-employed health plan participation	-Triple aim for all at risk contract populations -Risk revenue as a percentage of overall revenue -Advancement of clinically integrated network -IT plan implementation -Economic impact in region	1.A - Satisfaction of rate cap conditions 1.B -Number of validated and unresolved complaints from payers (self-reporting with verification from payers and department and review by department) Number of contracts retained or added with payment for value elements; Number of lives covered in at-risk contracts; Amount of at risk revenue increasing to 30% by 2021 (self-reporting with verification from payers and department and review by department) 1.B.1 - Review of milestones at months 6, 12, and 18, and then annually thereafter. 1.C - Comprehensive plan for the new infrastructure to support a risk based business model with six month milestones approved by the health commissioner on an annual basis 1.C.1 - Initial infrastructure plan to be a five-year view 1.C.2 - review of milestones at months 6, 12, and 18, and then annually thereafter 1.D – the rate of increase of the total cost of care measured by per member per year for all risk based contracts is below the regional trend for similar payer populations on an annual basis calculated on a rolling three-year average 1.E – The results of the Anthem Q-HIP be communicated to the commissioner as it is available on an annual basis. These results shall include comparisons to the other Anthem Virginia network providers and percentiles where available. 1.F – Board level comprehensive IT and analytics plan complete within one year of agreement being signed with defined six months milestones. Milestones achieved on a rolling six-month basis. 1.G - Increasing percentage of independent physicians participating in the clinically integrated network on a year over year for five years. 1.H - Increasing percentage of independent physicians on the common IT platform increasing year over year for five years. 1.I - Improved overall health and experience while reducing cost for employee and family population 1.I.1 – Year over year improvement on cost on per member per year 1.I.2 – year over year improvement in Quality metrics for employee populations 1.I.3 –Year over year improvement in Experience metrics for employee populations

			1.J - Increasing relationships with employers in the region with existing health outreach programs with employers, adding new employer customers each year 1.K - Demonstrated improvement in outcomes where the services are being provided to employer customers 1.L - Increased spending year over year by new system on ongoing operations with regional suppliers at or below market value for products and services
2 Improve health and well-being for a population	Relevant Conditions 14-15 Population health *Charity Care	-Social - determinants of health -Amount of charity care -Length and Quality of life	2.A - Comprehensive plan for improving health of the population with six month milestones complete and approved by the health commissioner within six months after signing date 2.A.1 - Ongoing review of six month milestones achieving those milestones 90% of the time 2.B - Year over year improvement in defined measures of health exceed the year over year improvement in socio economic peer counties

Measures, Descriptions, and Sources Table

	Measure	Description	Source
2.6 #	Mothers who smoke during pregnancy	Percentage of mothers who report smoking during pregnancy (%).	VDH Division of Health Stats – Birth Certificate Data
2.7 * #	Youth Tobacco Use	Percentage of High School Students who self-reported currently using tobacco (used cigarettes, cigars, chewing tobacco, snuff, or pipe tobacco within the 30 days before the survey).	National Survey on Drug Use and Health
2.16 * #	Obesity Subpopulation Measure	Increase the proportion of physician office visits that include counseling or education related to weight and physical activity.	Data Collection to be led by the New Health System
2.19 #	Breastfeeding Initiation	Percent of live births whose birth certificates report that baby is breastfed. US Value: Proportion of infants who are ever breastfed.	VDH Division of Health Stats – Birth Certificate Data CDC National Immunization Survey
2.24 #	NAS (Neonatal Abstinence Syndrome) Births	Number of reported cases with clinical signs of withdrawal per 1,000 Virginia resident live births.	Active case reports submitted by clinicians OR through VDH's inpatient hospitalization database (VHI data)
2.30	Children – On-time Vaccinations	Children receiving on-time vaccinations (% of children aged 24 months receiving 4:3:1:FS:3:1:4 series).	Virginia Immunization Information System

2.31 * #	Vaccinations – HPV Females	Percentage of females aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
2.32 * #	Vaccinations – HPV Males	Percentage of males aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
2.37 * #	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years.	VDH Division of Health Stats – Birth Certificate Data
2.38 * #	Third Grade Reading Level	3rd graders scoring "proficient" or "advanced" on reading assessment (%).	Fourth grade reading level is available through KIDS COUNT data center
2.40 * #	Children receiving dental sealants	Children receiving dental sealants on permanent first molar teeth (%, 6–9 years).	Data Collection to be led by the New Health System
2.42 #	Frequent Mental Distress	Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System
2.44 * #	Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	VDH Division of Health Stats – Birth Certificate Data

Note:* represents 10 measures proposed by new system
represent 25 measures proposed by Tennessee

2.C - The total amount of annual charity care will be reported by the new system with an explanation of any variation from previous years.

2.D - The new health system providers will present measures of disparity and equity and their measurement technique to the Commissioner.

3.A - Comprehensive access plan including all defined measures, spending rates on key services, quality and experience on key services, length and quality of life and primary and specialty care access with six month milestones complete and approved by the health commissioner on an annual basis

3.A.1 - Ongoing review of six month milestones

3.A.2 - Annual plan establishes metrics and targets for year to year improvement and that they meet 80% of targets established

Measures, Descriptions, and Sources Table

				Measure	Description	Source
3 Equitable access to services across the region	Relevant Conditions 1-27-28-41-46 Regional Services *Tertiary hospitals *Mental health services *Specialty services	-Equity of service levels -Essential services -Access to services -Primary care and specialty care access	3.1	Population within 10 miles of an urgent care center (%)	Population within 10 miles of any urgent care center; urgent care centers may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses
			3.2	Population within 10 miles of an urgent care center open nights and weekends (%)	Population within ten (10) miles of any urgent care center open at least three (3) hours after 5pm Monday to Friday and open at least five (5) hours on Saturday and Sunday; urgent care center may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses
			3.3	Population within 10 miles of an urgent care facility or emergency department (%)	Population within 10 miles of any urgent care center or emergency room; urgent care centers and emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses
			3.4	Population within 15 miles of an emergency department (%)	Population within 15 miles of any emergency room; emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses
			3.5	Population within 15 miles of an acute care hospital (%)	Population within 15 miles of any acute care hospital; acute care hospital may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses
			3.6	Pediatric Readiness of Emergency Department	Average score of New Health System Emergency Departments on the National Pediatric Readiness Project Survey from the National EMSC Data Analysis Resource Center	Self-assessment performed by New Health System
			3.7	Excessive Emergency Department Wait Times	Percentage of all hospital emergency department visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe.	New Health System Records; CDC National Center for Health Statistics National Hospital Ambulatory Care Survey
			3.8	Specialist Recruitment and Retention	Percentage of recruitment and retention targets set in the Physician Needs Assessment for specialists and subspecialists to address identified regional shortages	New Health System Records

3.9	Personal Care Provider	Percentage of adults who reported having one person they think of as a personal doctor or health care provider	Behavioral Risk Factor Surveillance System
3.10	Preventable Hospitalizations – Medicare	Number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	Hospital Discharge Data
3.11	Preventable Hospitalizations – Adults	Number of discharges for ambulatory care-sensitive conditions per 1,000 adults aged 18 years and older	Hospital Discharge Data
3.12	Screening – Breast Cancer	Percentage of women aged 50-74 who reported having a mammogram within the past two years	Behavioral Risk Factor Surveillance System
3.13	Screening – Cervical Cancer	Percentage of women aged 21-65 who reported having had a pap test in the past three years	Behavioral Risk Factor Surveillance System
3.14	Screening - Colorectal Cancer	Percentage of adults who meet U.S. Preventive Services Task Force recommendations for colorectal cancer screening	Behavioral Risk Factor Surveillance System
3.15	Screening – Diabetes	Percentage of diabetes screenings performed by the New Health System for residents aged 40 to 70 who are overweight or obese; Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	New Health System Records
3.16	Screening – Hypertension	Percentage of hypertension screenings performed by the New Health System for residents aged 18 or older	New Health System Records
3.17	Asthma ED Visits – Age 0-4	Asthma Emergency Department Visits Per 10,000 (Age 0-4)	Hospital Discharge Data
3.18	Asthma ED Visits – Age 5-14	Asthma Emergency Department Visits Per 10,000 (Age 5-14)	Hospital Discharge Data
3.19	Prenatal care in the first trimester	Percentage of live births in which the mother received prenatal care in the first trimester	
3.20	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and had an outpatient visit, and intensive outpatient encounter or a partial hospitalization with a mental health	New Health System Records; NCQA *The State of Health Care Quality Report*

		practitioner within seven (7) days post-discharge	
3.21	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and had an outpatient visit, and intensive outpatient encounter or a partial hospitalization with a mental health practitioner within thirty (30) days post-discharge	New Health System Records; NCQA *The State of Health Care Quality Report*
3.22	Antidepressant Medication Management – Effective Acute Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 84 days (12 weeks)	New Health System Records; NCQA *The State of Health Care Quality Report*
3.23	Antidepressant Medication Management – Effective Continuation Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 180 days (6 months)	New Health System Records; NCQA *The State of Health Care Quality Report*
3.24	Engagement of Alcohol or Drug Treatment	Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug dependence within 30 days of the initiation visit.	New Health System Records; NCQA *The State of Health Care Quality Report*
3.25	SBIRT administration - hospital admissions	Percentage of patients admitted to a New Health System hospital who are screened for alcohol and substance abuse, provided a brief intervention, and referred to treatment (SBIRT)	New Health System Records
3.26	Rate of SBIRT administration - ED visits	Percentage of patients admitted to a New Health System emergency department who are screened for alcohol and substance abuse, provided a brief intervention, and referred to treatment (SBIRT)	New Health System Records
3.27	Patient Satisfaction and Access Surveys	Successful completion of patient satisfaction and access surveys, according to Section 4.02(c)(iii)	New Health System Records

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<tr><td>3.28</td><td>Patient Satisfaction and Access Survey – Response Report</td><td>Report documents a satisfactory plan for the New Health System to address deficiencies and opportunities for improvement related to perceived access to care services and documents satisfactory progress towards the plan.</td><td>New Health System Records</td></tr>
</table>
3.B - Residents of Southwest Virginia have equitable access to key services in the following areas:
*Primary Care
*Mental health
*Heart and vascular
*Muscular skeletal
*GI
*Cancer

3.C – The new health system will provide a plan for access to primary care for residents of Southwest Virginia

3.D –The new health system will provide a plan for specialty access to all six major service categories at 5 days or less for residents of Southwest Virginia
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<td>4
Adequate providers to provide equitable services throughout the region</td>
<td>Relevant Conditions
24-32

Post graduate training of clinical staff

Residency program

Recruitment plan</td>
<td>-Ratio of providers by discipline to serve the population by community

-Trained and prepared clinical staff</td>
<td>4.A - The new health system shall complete a comprehensive physician/physician extender needs assessment and recruitment plan every three years, starting within the first full fiscal year, in each Virginia community served by the new health system.

4.B - Progress in closure of clinical staff gaps in Southwest Virginia with year over year improvement

4.C - Post graduate training plan developed and submitted to the health commissioner within 12 months of signed agreement

4.D - Twelve month milestones achieved as defined</td>
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5 Bench-mark operating performance	Relevant Conditions 12-13-16-17-40-45 Annual quality metrics Adverse events Operating results	Operating performance against benchmark for quality, finance and adverse events	5.A - Comprehensive operating plan for finance, quality and experience with six month milestones complete and reviewed by the health commissioner on an annual basis 5.A.1 - Plan to include specific strategies and tactics for Southwest Virginia 5.B - Adherence to public reporting schedules and required department reporting. Sustained improvement from baseline on CMS safety domain measures to reduce adverse events and improve overall patient safety. Pressure ulcer rate Iatrogenic pneumothorax rate Central venous catheter-related blood stream infection rate Central venous catheter-related blood stream infection rate Postoperative Hip Fracture Rate PSI 09 Perioperative Hemorrhage or Hematoma Rate PSI 10 Postoperative Physiologic and Metabolic Derangement Rate PSI 11 Postoperative Respiratory Failure Rate PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PSI 13 Postoperative Sepsis Rate PSI 14 Postoperative Wound Dehiscence Rate PSI 15 Accidental Puncture or Laceration Rate Central Line-Associated Bloodstream Infection (CLABSI Rate) Catheter-Associated Urinary Tract Infection (CAUTI Rate) Surgical Site Infection (SSI) Rate Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate Clostridium Difficile Infection (CDI or C-Diff) Rate 5.C - Timely reporting of key financial metrics included in all filings with EMMA for evaluation by the commissioner; maintain compliance with bond covenants via submission of attestation and independent audit criteria; reporting of associated metrics to the Commissioner at least annually in concert with annual agency reviews. 5.D - System wide best practices identified on an annual basis and no fewer than 3 being spread actively throughout the system at any one time 5.E - Annual plan for improving quality and satisfaction among selected measures with year to year improvement and that they meet 80% of the targets established

Quality Monitoring Measures Table

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
	General information- Structural measures		
5.1	SM-PART-NURSE	Participation in a systematic database for nursing sensitive care	Nursing Care Registry
5.2	ACS-REGISTRY	Participation in a multispecialty surgical registry	Multispecialty Surgical Registry
5.3	SM-PART-GEN-SURG	Participation in general surgery registry	General Surgery Registry
5.4	OP-12	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data	Able to receive lab results electronically
5.5	OP-17	Tracking Clinical Results between Visits	Able to track patients' lab results, tests, and referrals electronically between visits
5.6	OP-25	Safe surgery checklist use (outpatient)	Uses outpatient safe surgery checklist
5.7	SM-SS-CHECK	Safe surgery checklist use (inpatient)	Uses inpatient safe surgery checklist
	Survey of patient's experiences- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)		
5.8	H-COMP-1-A-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Always" communicated well
5.9	H-COMP-1-U-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Usually" communicated well
5.10	H-COMP-1-SN-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Sometimes" or "Never" communicated well
5.11	H-COMP-2-A-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Always" communicated well
5.12	H-COMP-2-U-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Usually" communicated well

			5.13	H-COMP-2-SN-P	Communication with doctors (composite measure)	Patients who reported that their doctors “Sometimes” or “Never” communicated well	
			5.14	H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they “Always” received help as soon as they wanted	
			5.15	H-COMP-3-U-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they “Usually” received help as soon as they wanted	
			5.16	H-COMP-3-SN-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they “Sometimes” or “Never” received help as soon as they wanted	
			5.17	H-COMP-4-A-P	Pain management (composite measure)	Patients who reported that their pain was “Always” well controlled	
			5.18	H-COMP-4-U-P	Pain management (composite measure)	Patients who reported that their pain was “Usually” well controlled	
			5.19	H-COMP-4-SN-P	Pain management (composite measure)	Patients who reported that their pain was “Sometimes” or “Never” well controlled	
			5.20	H-COMP-5-A-P	Communication about medicines (composite measure)	Patients who reported that staff “Always” explained about medicines before giving it to them	
			5.21	H-COMP-5-U-P	Communication about medicines (composite measure)	Patients who reported that staff “Usually” explained about medicines before giving it to them	
			5.22	H-COMP-5-SN-P	Communication about medicines (composite measure)	Patients who reported that staff “Sometimes” or “Never” explained about medicines before giving it to them	
			5.23	H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Always” clean	
			5.24	H-CLEAN-HSP-U-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Usually” clean	
			5.25	H-CLEAN-HSP-SN-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Sometimes” or “Never” clean	

				5.26	H-QUIET-HSP-A-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Always” quiet at night	
				5.27	H-QUIET-HSP-U-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Usually” quiet at night	
				5.28	H-QUIET-HSP-SN-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Sometimes” or “Never” quiet at night	
				5.29	H-COMP-6-Y-P	Discharge information (composite measure)	Patients who reported that YES, they were given information about what to do during their recovery at home	
				5.30	H-COMP-6-N-P	Discharge information (composite measure)	Patients who reported that NO, they were not given information about what to do during their recovery at home	
				5.31	H-COMP-7-SA	Care Transition (composite measure)	Patients who “Strongly Agree” they understood their care when they left the hospital	
				5.32	H-COMP-7-A	Care Transition (composite measure)	Patients who “Agree” they understood their care when they left the hospital	
				5.33	H-COMP-7-D-SD	Care Transition (composite measure)	Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital	
				5.34	H-HSP-RATING-9-10	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	
				5.35	H-HSP-RATING-7-8	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	
				5.36	H-HSP-RATING-0-6	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	

5.37	H-RECMND-DY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would definitely recommend the hospital
5.38	H-RECMND-PY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would probably recommend the hospital
5.39	H-RECMND-DN	Willingness to recommend the hospital (global measure)	Patients who reported NO, they would probably not or definitely not recommend the hospita
	Timely & effective care- Colonoscopy follow-up		
5.41	OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy
5.42	OP-30	Endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps - avoidance of inappropriate use	Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe
	Timely & effective care- Heart attack		
5.43	OP-3b	Median time to transfer to another facility for acute coronary intervention	Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital
5.44	OP-5	Median time to ECG	Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG
5.45	OP-2	Fibrinolytic therapy received within 30 minutes of emergency department arrival	Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival
5.46	OP-4	Aspirin at arrival	Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department

				Timely & effective care- Emergency department (ED) throughput			
			5.47	EDV	Emergency department volume	Emergency department volume	
			5.48	ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients	Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient	
			5.49	ED-2b	Admit decision time to emergency department departure time for admitted patient	Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room	
			5.50	OP-18b	Median time from emergency department arrival to emergency department departure for discharged emergency department patients	Average (median) time patients spent in the emergency department before leaving from the visit	
			5.51	OP-20	Door to diagnostic evaluation by a qualified medical professional	Average (median) time patients spent in the emergency department before they were seen by a healthcare professional	
			5.52	OP-21	Median time to pain medication for long bone fractures	Average (median) time patients who came to the emergency department with broken bones had to wait before getting pain medication	
			5.53	OP-22	Patient left without being seen	Percentage of patients who left the emergency department before being seen	
			5.54	OP-23	Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	

	Timely & effective care- Preventive care		
5.55	IMM-2	Immunization for influenza	Patients assessed and given influenza vaccination
5.56	IMM-3-OP-27-FAC-ADHPCT	Influenza Vaccination Coverage among Healthcare Personnel	Healthcare workers given influenza vaccination
	Timely & effective care- Stroke care		
5.57	STK-4	Thrombolytic Therapy	Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started
	Timely & effective care- Blood clot prevention & treatment		
5.58	VTE-6	Hospital acquired potentially preventable venous thromboembolism	Patients who developed a blood clot while in the hospital who *did not* get treatment that could have prevented it
5.59	VTE-5	Warfarin therapy discharge instructions	Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine
	Timely & effective care- Pregnancy & delivery care		
5.60	PC-01	Elective delivery	Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary
	Complications- Surgical complications		
5.61	COMP-HIP-KNEE	Hospital level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Rate of complications for hip/knee replacement patients
5.62	PSI-90-SAFETY	Complication/patient safety for selected indicators (composite)	Serious complications

			5.63	PSI-4-SURG-COMP	Death rate among surgical inpatients with serious treatable complications	Deaths among patients with serious treatable complications after surgery	
				Complications- Healthcare-associated infections (HAI)			
				Readmissions & deaths- 30 day rates of readmission			
			5.64	READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients	
			5.65	READM-30-AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Rate of readmission for heart attack patients	
			5.66	READM-30-HF	Heart failure (HF) 30-day readmission rate	Rate of readmission for heart failure patients	
			5.67	READM-30-PN	Pneumonia (PN) 30-day readmission rate	Rate of readmission for pneumonia patients	
			5.68	READM-30-STK	Stroke 30-day readmission rate	Rate of readmission for stroke patients	
			5.69	READM-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day readmission rate	Rate of readmission for coronary artery bypass graft (CABG) surgery patients	
			5.70	READM-30-HIP-KNEE	30-day readmission rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Rate of readmission after hip/knee replacement	
			5.71	READM-30-HOSP-WIDE	30-day hospital-wide all- cause unplanned readmission (HWR)	Rate of readmission after discharge from hospital (hospital-wide)	
				Readmissions & deaths- 30-day death (mortality) rates			
			5.72	MORT-30-COPD	COPD 30-day mortality rate	Death rate for COPD patients	
			5.73	MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	Death rate for heart attack patients	
			5.74	MORT-30-HF	Heart failure (HF) 30-day mortality rate	Death rate for heart failure patients	
			5.75	MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Death rate for pneumonia patients	
			5.76	MORT-30-STK	Stroke 30-day mortality rate	Death rate for stroke patients	
			5.77	MORT-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day mortality rate	Death rate for CABG surgery patients	
				Use of medical imaging- Outpatient imaging efficiency			

5.78	OP-8	MRI Lumbar Spine for Low Back Pain	Outpatients with low-back pain who had an MRI without trying recommended treatments (such as physical therapy) first. If a number is high, it may mean the facility is doing too many unnecessary MRIs for low-back pain.
5.79	OP-9	Mammography Follow-Up Rates	Outpatients who had a follow-up mammogram, ultrasound, or MRI within the 45 days after a screening mammogram
5.80	OP-10	Abdomen CT - Use of Contrast Material	Outpatient CT scans of the abdomen that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).
5.81	OP-11	Thorax CT - Use of Contrast Material	Outpatient CT scans of the chest that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).
5.82	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (if a number is high, it may mean that too many cardiac scans were done prior to low-risk surgeries).

			5.83	OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	Outpatients with brain CT scans who got a sinus CT scan at the same time (if a number is high, it may mean that too many patients have both a brain and sinus scan, when a single scan is all they need).
6 Strong, vibrant culture	Relevant Conditions 18-20-21-22-38 Employee management Strong medical staff Strong board of directors	-Attrition management -Medical staff make-up -Board of directors survey -Employee development	6.A - Annual turnover rate be reduced on a year by year basis 6.B - The new health system will alter the board survey to measure board relationships in the first year and thereafter improve board relationships year over year measured by its annual board survey			
7 Strong academics and research impacting regional issues	Relevant Conditions 25 Academics and research	Dollars and impact of research	7.A - Within 12 months of the closing date of the merger, the new health system will develop and submit to the Commissioner, for review and approval, a plan for investment in the research enterprise in the Virginia service area.			

8 Monetary commitment	Relevant Conditions 3-19-23-33-34-35-36-37 All	Target spreading in defined areas of commitment	8.A - Target spending be defined by need and be shown to be independent of geography 8.B - Goals of spending in SW Virginia with specific measures of performance success defined and reported on an annual basis 8.C - Monetary Commitments and Annual Baseline Spending Levels

MONETARY COMMITMENTS TABLE

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Expanded Access to HealthCare Services	Behavioral Health Services	$1,000,000	$4,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	**$85,000,000**
	Children's Services	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**27,000,000**
	Rural Health Services	1,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**28,000,000**
Health Research & Graduate Medical Education		3,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**85,000,000**
Population Health Improvement		1,000,000	2,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**75,000,000**
Region-wide Health Information Exchange		1,000,000	1,000,000	750,000	750,000	750,000	750,000	750,000	750,000	750,000	750,000	**8,000,000**
Totals		$8,000,000	$17,000,000	$28,750,000	$33,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	**$308,000,000**

Conditions related to all outcomes: 2-4-5-39-47-48-49

Technical Advisory Panel of the Cooperative Agreement
Minutes
November 14, 2017 – 10:00 a.m.
Southwest Virginia Higher Education Center, Room CR222
One Partnership Circle
Abingdon, Virginia

Members present: Dr. Norm Oliver (Virginia Department of Health "VDH"), Chair; Don Beatty (Virginia Bureau of Insurance); Bobby Cassell (consumer); Dr. Stephen Combs (Wellmont Health System "WHS"); Todd Dougan (WHS); Tom Eckstein (Arundel Metrics); George Hunnicutt, Jr. (Pepsi Cola Bottling of Norton); Pete Knox (Peter Knox Consulting); Lynn Krutak (Mountain States Health Alliance "MSHA"); Sarah Milder (Arundel Metrics); Andy Randazzo (Anthem); and Dr. Morris Seligman (MSHA).

Members absent: Sean Barden (Mary Washington Healthcare) and Dr. Ron Clark (Virginia Commonwealth University Health System).

VDH staff present: Erik Bodin, Director, Office of Licensure and Certification and Joseph Hilbert, Director, Governmental and Regulatory Affairs.

Others Present: Amanda Lavin, Office of the Attorney General; Dr. Sue Cantrell, Director, Lenowisco Health District and Acting Director, Cumberland Plateau Health District; Tony Keck, MSHA; Stacey Ealey, MSHA; Elliot Moore, MSHA; and Todd Norris, WHS.

Welcome and Introductions

Dr. Oliver called the meeting to order at 10:00 a.m. He briefly described the purpose of the Technical Advisory Panel (TAP). Each of the members introduced themselves.

Amending of Agenda

Dr. Oliver explained that the TAP was a public body whose meetings are subject to the provisions of the Virginia Freedom of Information Act (FOIA). He told the TAP that the meeting agenda did not include a public comment period. However, given that there were some members of the public in attendance, he told the TAP that he would like to entertain a motion to amend the agenda to include a public comment period as the final agenda item. Mr. Eckstein made a motion, properly seconded, to amend the agenda to include a public comment period as the final agenda item. The motion was approved unanimously by voice vote.

Draft Policy on Electronic Attendance

Dr. Oliver briefed the TAP on the ability of a public body, as authorized by Virginia Code § 2.2-3708 to hold a public meeting in which some of its members participate electronically from a remote location that is open to the public. He also briefed the TAP on the ability of a public body, as authorized by Virginia Code § 2.2-3708.1 to hold a public meeting in which some of its members participate electronically from a remote location that this not open to the public. Dr. Oliver explained that, in order for a public body to utilize the authority granted by Virginia Code § 2.2-3708.1, the public body must first adopt a written policy allowing for and governing

participation of its members by electronic means, including an approval process for such participation. Dr. Oliver then presented a draft written policy allowing for and governing participation of TAP members by electronic means, including an approval process for such participation. Dr. Seligman made a motion, seconded by Dr. Combs, to approve the draft policy. The motion was approved unanimously by voice vote.

Southwest Virginia's Blueprint for Health

Dr. Cantrell briefed the TAP concerning a variety of health status outcomes and indicators for the Lenowisco Health District and the Cumberland Plateau Health District. She also reviewed the aims and goals in the Southwest Virginia Health Authority's Blueprint for Health Improvement and Health-Enabled Prosperity. The TAP members did not have any questions for Dr. Cantrell.

Addressing Health-Related Social Needs

Mr. Knox provided the TAP with his perspective, based on his prior experience as Executive Vice President and Chief Learning and Innovation Officer for Bellin Health, on the role that hospitals and health systems can play to address health-related social needs, and to improve the health and well-being of the communities that they serve. The TAP members did not have any questions for Mr. Knox.

Presentation of Short and Long Term Measures

Dr. Oliver directed the TAP members' attention to the draft set of proposed short-term expectations and long-term measures and performance indicators contained in the meeting packet. He reminded the members that the TAP's task is to develop metrics to recommend to Commissioner Levine for actively supervising the New Health System. He told the TAP that the draft expectations, measures, and performance indicators were intended to serve as a starting point for discussion. In developing the draft long-term measures and performance indicators, Dr. Oliver said that VDH had looked at the 49 conditions that Dr. Levine attached to the Order authorizing the cooperative agreement and tried to envision what it would look like if one year from now, or three years from now, the NHS was fulfilling its commitments and meeting those conditions. In developing the short-term expectations, VDH then envisioned the steps and actions that would need to be taken in the next 90 days, 120 days, and 180 days to ensure that the New Health System will meet the 49 conditions over the long-term. Dr. Oliver told the TAP that VDH wants and needs to hear its ideas concerning the proposed expectations, measures, and performance indicators, including any other measures that should be added, any measures that should be deleted, any measures that should be modified, and any other thoughts concerning what should be recommended to the Commissioner.

Mr. Knox then presented the proposed long-term measures and performance indicators to the TAP. He told the TAP that the long-term measures and performance indicators were organized and grouped into one of eight outcomes:

1. Create value in the marketplace,
2. Improve health and well-being for a population,
3. Equitable access to services across the region,
4. Adequate providers to provide equitable services throughout the region,

5. Benchmark operating performance,
6. Strong vibrant culture,
7. Strong academics and research impacting regional issues, and
8. Monetary commitment.

Mr. Knox also explained that the conditions with which VDH believes each of the proposed measures and performance indicators is associated are identified in the document.

Mr. Knox then began to review the proposed performance indicators for Outcome 1 – Creating Value in the Marketplace. There was extensive discussion among the TAP members concerning the proposed performance indicators. The discussion generally focused on the following:

- The extent to which several of the proposed performance indicators may actually constitute new conditions to which the New Health System has previously not agreed;

- The extent to which several of the proposed performance indicators are actually associated with specific relevant conditions, as portrayed by VDH;

- The extent to which the proposed performance indicators are aligned with the Southwest Virginia Health Authority's Blueprint for Health and Health-Enabled Prosperity, Virginia's Plan for Well-Being, and the Tennessee Terms of Certification;

- The extent to which several of the proposed performance indicators actually constitute targets to be achieved, without any associated baseline, peer group to which the New Health System's performance is to be compared, or date by which the target is to be achieved;

- The extent to which the proposed performance indicators would increase the New Health System's cost of compliance with the cooperative agreement;

- The extent to which the proposed performance indicators could be measured using data that is already being collected by the New Health System;

- The extent to which the proposed performance indicators are necessary for the Commissioner to actively supervise the approved cooperative agreement and its 49 attached conditions;

- The extent to which the New Health System's failure to achieve the target of any one performance indicator would influence the Commissioner's decision concerning whether or not to seek to revoke the cooperative agreement;

- How the Commissioner would "score" or objectively determine whether or not the New Health System had satisfied the various performance indicators;

- The possibility for a small subset of TAP members to meet with VDH staff concerning technical questions and issues with respect to certain of the proposed performance indicators, and

- The process that the TAP would use to determine the specific performance indicators that would be included in its recommendation to the Commissioner.

There was further discussion concerning several of the specific performance indicators included as part of Outcome 1.

Performance Indicator – Comprehensive plan for managing payer relationships with six month milestones complete and approved by the health commissioner on an annual basis.
-Plan to include specific strategies and tactics for payer relationships in Southwest Virginia
-Ongoing review of six month milestones.

Discussion – There was a request for greater specificity concerning the elements that VDH expected to be included within the "six month milestones." The MSHA representatives on the TAP said that information submitted as part of this comprehensive plan, if recommended by the TAP, would need to be labeled as proprietary.

Performance Indicator – Comprehensive plan for the new infrastructure to support a risk-based business model with six month milestones complete and approved by the health commissioner on an annual basis.
-Initial infrastructure plan to be a five year view.
-Ongoing review of milestones.

Discussion – There was a request for greater specificity concerning the elements that VDH expected to be included within the "six month milestones." The MSHA representatives on the TAP said that information submitted as part of this comprehensive plan would need to be labeled as proprietary.

Performance Indicator – Total cost of care measured by PMPY for all risk-based contracts increasing at half the regional trend for similar populations on an annual basis.

Discussion – It was suggested by the MSHA representatives that this performance indicator, if recommended by the TAP, should focus on risk-based contracts with large payers rather than all payers. There was also discussion concerning the appropriate peer group, and baseline, that would be used to evaluate "half the regional trend for similar populations . . . ."

Performance Indicator – Improved year over year quality and satisfaction performance in agreed upon indicators in all risk-based agreements.

Discussion – Mr. Dougan said that this indicator should not be based on "all" risk-based agreements, as there will always be "hiccups" in performance. He said that this performance indicator should be based on comparison to peer organizations. Mr. Knox said that this performance indicator refers to metrics that are already in payer contracts. Ms. Krutak asked if the TAP could look toward a common set of metrics across all contracts held by the New Health System.

Performance Indicator – Increasing percentage of overall revenue coming from risk-based agreements achieving 30% by 2021.

Discussion – Ms. Krutak asked if this performance indicator is referring to gross revenue or net revenue. Mr. Randazzo said that the performance indicator was actually referring to "total spend." Mr. Dougan asked if this performance indicator was based on allowable charges.

Performance Indicator – Comprehensive IT and analytics plan complete within one year of agreement being signed with defined six month milestones. Milestones achieved on a rolling six-month basis.

Discussion – Ms. Krutak said that these performance indicators go way beyond the identification of quality, cost, and access metrics, which she said is the purpose of the TAP per Virginia's regulations (12VAC-221-120 – Technical Advisory Panel). Dr. Oliver responded that, per 12VAC5-100 (Ongoing and Active Supervision), VDH is also responsible for establishing quantitative measures used to evaluate the proposed and continuing benefits of the cooperative agreement. According to the regulations, the quantitative measures shall include measures of the cognizable benefits of the cooperative agreement in at least the following categories:

- Population health,
- Access to health services,
- Economic,
- Patient safety,
- Patient satisfaction, and
- Other cognizable benefits.

Ms. Krutak said that the TAP should be focused on the plans and steps needed to implement the clinically integrated network.

Performance Indicator – Comprehensive plan for the new infrastructure to support a risk-based business model with six month milestones complete and approved by the Commissioner on an annual basis.
-Initial infrastructure plan to be a five-year view
-Ongoing review of milestones

Discussion – Ms. Krutak said that the TAP should be mindful of the amount of additional work that would need to be done, and the cost, in order to report on these performance indicators.

Performance Indicator – Increasing percentage of independent physicians participating in the clinically integrated network achieving 80% by 2021.

Discussion – The MSHA representatives called into question the need for the 80% target. They suggested that instead a baseline be established and then measure subsequent improvements over the baseline.

Performance Indicator – Increasing percentage of independent physicians on the common IT platform achieving 80% by 2021.

Discussion – Dr. Seligman said that the New Health System can encourage, but cannot force, independent physicians to utilize the common IT platform or to participate in the clinically integrate network. For that reason, he said that a fixed percentage established as a target is not

realistic. Mr. Knox said that there needs to be a goal to get independent physicians into the system. He also said that the New Health System needs "to put a stake in the ground" concerning this. Mr. Knox acknowledged that 80% may not be an appropriate target, but a specific target is needed.

Performance Indicator – Improved overall health and experience while reducing cost for employee and family population.
 -Cost on PMPY minimum of half the regional trend.
 -Quality metrics for employee populations at upper quartile performance.
 -Experience metrics for employee populations at upper quartile.

Discussion – Dr. Seligman requested clarification concerning the timeline for the New Health System to achieve upper quartile performance. Dr. Oliver suggested that the cost component of the indicator could be revised to state that costs would be held flat at first, and then trend down over time. Dr. Seligman asked about quality measures that were included in the Commonwealth's State Innovation Models grant. Dr. Oliver responded by encouraging the TAP members to submit any specific suggested revisions to the proposed measures and performance indicators.

Performance Indicator – Increasing relationships with employers in the region with new customers added each year.

Performance Indicator – Demonstrated improvement in cost control, quality and experience for employer customers year over year.
 -Cost on PMPY minimum of half the regional trend.
 -Quality metrics for employee populations at upper quartile performance.
 -Experience metrics for employee populations at upper quartile performance.

Performance Indicator – Increased spending by new system on ongoing operations with regional suppliers year over year to a minimum of 70% by 2021.

Discussion – Dr. Seligman inquired concerning the origin of this performance indicator and said that this was another example of a target, not a measure. He said that he was not sure why this economic constraint was being placed around the New Health System. Ms. Krutak said that she considers this to be a new condition, and that MSHA cannot afford to do this. Mr. Eckstein asked MSHA and WHS what their current baseline was for spending with regional suppliers. The MSHA representatives said they did not know. Mr. Dougan said that WHS' current baseline was 5%. Ms. Milder stated that, in her opinion, this performance indicator would be supportive of population health improvement efforts. Mr. Randazzo said that he generally shared that assessment.

Mr. Knox then began to review the proposed performance indicators for Outcome 2 – Improve Health and Well-Being for a Population. Ms. Krutak offered to submit a proposed set of performance indicators, including baselines and targets, that are aligned with the Southwest Virginia Health Authority's goals. Mr. Hunnicutt suggested that those performance indicators that are directly related to hospital care should be addressed first. Mr. Eckstein said that performance indicators should also be items that are not health-care related.

Next Steps

Mr. Hilbert said that, should members of the TAP wish to submit written questions to VDH concerning any of the proposed indicators, VDH would prepare a response.

Dr. Oliver told the TAP that he anticipated the need for at least two or three additional meetings. He also said that he anticipated that the TAP's recommendations to the Commissioner would be decided based on a vote of a simple majority of the members.

The members agreed that the next meeting would be held on December 4-5 at a location to be determined in the Richmond area. The meeting will be for a full day on December 4, and a half day on December 5. VDH staff will arrange for an appropriate meeting location.

The members also agreed that the TAP should also meet on December 14, at a location to be determined.

It was agreed by general consensus that the TAP's recommendations need to be submitted to the Commissioner by December 31.

Public Comment

Mr. Keck addressed the TAP. He said that the discussion during the meeting had been valuable. He said that there is only so much money to be allocated or spent in southwest Virginia as a result of the merger. He also said that the focus on measures is important, but measurement does have a cost. Finally, he said that VDH needs to be careful about not getting between the payers and the providers in the course of its active supervision of the cooperative agreement.

Adjourn

The meeting adjourned at approximately 4:00 p.m.

Technical Advisory Panel of the Cooperative Agreement
Minutes
December 4, 2017 – 9:00 a.m.
Office of Emergency Medical Services, Class Room A & B
1041 Technology Park Drive
Glen Allen, Virginia

Videoconference Location
Wise County Health Department
134 Roberts Avenue SW
Wise, Virginia

Members present: Dr. Norm Oliver (Virginia Department of Health "VDH"), Chair; Sean Barden (Mary Washington Healthcare); Don Beatty (Virginia Bureau of Insurance); Bobby Cassell by videoconference (consumer); Dr. Stephen Combs (Wellmont Health System "WHS"); Todd Dougan (WHS); Tom Eckstein (Arundel Metrics); George Hunnicutt, Jr. (Pepsi Cola Bottling of Norton); Pete Knox (Peter Knox Consulting); Lynn Krutak (Mountain States Health Alliance "MSHA"); Sarah Milder (Arundel Metrics); Andy Randazzo (Anthem); and Dr. Morris Seligman (MSHA).

Member absent: Dr. Ron Clark (Virginia Commonwealth University Health System).

VDH staff present: Erik Bodin, Director, Office of Licensure and Certification; Joseph Hilbert, Director, Governmental and Regulatory Affairs; and Catherine West, Administrative Assistant.

Others Present: Amanda Lavin, Office of the Attorney General.

Welcome and Introductions

Dr. Oliver called the meeting to order at 9:00 a.m. He told the Technical Advisory Panel (TAP) that a quorum of members was present. Each of the members introduced themselves.

Approval of Minutes

Dr. Oliver asked the members if any changes needed to be made to the draft minutes from the November 14, 2017 TAP meeting. Mr. Hunnicutt asked that the minutes be amended to more accurately reflect one of his comments during the meeting; specifically, in the last paragraph on page six, the third sentence should read: "Mr. Hunnicutt suggested that those performance indicators that are directly related to hospital care should be addressed first." Dr. Seligman made a motion to adopt the draft minutes as amended with Mr. Eckstein seconding the motion. The minutes were approved unanimously by a voice vote.

Comments by Dr. Seligman

Dr. Seligman provided the TAP with some introductory comments including that the role of the TAP is to make recommendations for quantitative measures which substantiate achievement of the ongoing cognizable benefits of the cooperative agreement. He said that the Commissioner has clearly set forth certain plan requirements and associated criteria or milestones in the

conditions. Dr. Seligman said that the plans set forth by the Commissioner will include associated qualitative and quantitative measures which must be accepted by the Commissioner in the context of those plans. Development of the plans is necessary prior to establishment of such measures, and the TAP should defer to the planning process and the Commissioner's approval process for solidification of plan specific measures. He said further that the focus of the TAP should be on fulfillment of the plans required by the Commissioner and that additional plans should not be suggested.

Long-Term Measures – Active Supervision of the Cooperative Agreement: Draft Measures and Performance Indicators

Dr. Oliver told the panel that it is the TAP's task to develop metrics to recommend to Commissioner Levine for actively supervising the new health system. Dr. Oliver discussed the process for reviewing the draft set of long-term measures and performance indicators contained in the meeting packet.

Dr. Oliver explained that draft long-term measures and performance indicators are organized and grouped into eight outcomes:

1. Create value in the marketplace;
2. Improve health and well-being for a population;
3. Equitable access to services across the region;
4. Adequate providers to provide equitable services throughout the region;
5. Benchmark operating performance;
6. Strong vibrant culture;
7. Strong academics and research impacting regional issues; and
8. Monetary commitment.

Dr. Oliver told that TAP that, for ease of discussion, individual indicators within each outcome have been given a number and letter; e.g., 1.A, 1.B, 1.B.1, etc. Each indicator will be referred to by its reference number for the minutes.

Mr. Dougan provided the TAP with a document, Technical Advisory Panel Recommendations (attached). The document contained a suggested approach in reviewing the long-term measures and performance indicators as well as some suggested alternate language with respect to certain indicators.

While all non-roll call votes were by show of hands, in all instances, Mr. Cassell's vote was cast by voice method.

Outcome 1 – Create Value in the Marketplace

Performance Indicator 1.A

Mr. Eckstein made a motion to approve Indicator 1.A with Mr. Hunnicutt seconding the motion. The motion was approved unanimously by a voice vote.

Performance Indicator 1.B

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Mr. Dougan made a motion to replace all of the existing language in 1.B with the following language: "Number of validated and unresolved complaints from payers (self-reporting with verification from payers and department and review by department); Number of contracts retained or added with payment for value elements; Number of lives covered in at-risk contracts; and Amount of at risk revenue increasing to 30% by 2021 (self-reporting with verification from payers and department and review by department)." Ms. Krutak seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 10 ayes, two nays, and one abstention. The motion was approved.

Performance Indicator 1.B.1

Ms. Krutak made a motion to remove this indicator in its entirety with Dr. Seligman seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 13 ayes and 0 nays. The motion was approved.

Indicator 1.B.2

Mr. Dougan made a motion approve this indicator by replacing all of the existing language in 1.B.2 with the following language: "Review of milestones at months 6, 12, and 18, and then annually thereafter." Mr. Barden seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 13 ayes and 0 nays. The motion was approved.

Indicator 1.C

Mr. Knox made a motion to approve this indicator with Mr. Hunnicutt seconding the motion. During discussion by the panel members, an amendment was proposed to remove the words "complete and" between the words "six month milestones" and "approved by the health commissioner." The amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 1.C.1

Mr. Hunnicutt made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was nine ayes and four nays. The motion was approved.

Indicator 1.C.2

Mr. Hunnicutt made a motion to approve this indicator with Mr. Knox seconding the motion. During discussion by the panel members, an amendment was proposed to remove the first word "ongoing" and add the words "at months 6, 12, and 18, and then annually thereafter" to the end of the sentence. The indicator now reads: "Review of milestones at months 6, 12, and 18, and then annually thereafter." The proposed language was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes, four nays, and one abstention. The motion was approved.

Indicator 1.D

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, an amendment was proposed to replace "PMPY" with the words "per member per year;" replace the words "at half the" with the words "one quarter to one half the multi-state between the words "increasing" and "regional trend;" add the word "payer" between the words "for similar" and "populations;" and add the words "calculated on a rolling three year average" after the word "basis" to end the sentence. The indicator now reads: "Total cost of care measured by per member per year for all risk based contracts increasing at one quarter to one half the multi-state regional trend for similar payer populations on an annual basis calculated on a rolling three year average." The proposed language was agreed to. After discussion by the panel members, Mr. Hunnicutt made a motion to table the pending motion which was properly seconded. Dr. Oliver called for a roll-call vote to table the motion. The vote was seven ayes (Mr. Cassell, Mr. Eckstein, Mr. Hunnicutt, Mr. Knox, Ms. Milder, Dr. Oliver, and Mr. Randazzo) and six nays (Mr. Barden, Mr. Beatty, Dr. Combs, Mr. Dougan, Ms. Krutak, and Dr. Seligman). The motion was approved.

After a brief break, Dr. Seligman told the members that perhaps it would be best to make a global motion to table discussion on those indicators that required data analysis. Dr. Oliver told the panel that it would be best to table those indicators individually on an as-needed basis as the panel discussed them. Dr. Seligman agreed to this approach.

Indicator 1.E

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. During discussion by the panel members, Ms. Krutak made a motion to table the pending motion with Dr. Seligman seconding the motion. Dr. Oliver called for a vote by show of hands to table the motion. The vote was seven ayes and six nays. The motion was approved.

Indicator 1.F

Ms. Milder made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Ms. Milder amended her motion so that the indicator will be deleted in its entirety. Mr. Randazzo seconded the amended motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 13 ayes and 0 nays. The motion was approved.

Indicator 1.G

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, an amendment was proposed to add the words "Board level" before the first word "comprehensive." The proposed amendment was agreed to. Dr. Oliver called for a vote on the amended motion by show of hands. The vote was eight ayes and five nays. The motion was approved.

Indicator 1.H

Mr. Hunnicutt made a motion to approve this indicator with Mr. Knox seconding the motion. During discussion by the panel members, Mr. Eckstein made a motion to table the pending motion which was properly seconded. Dr. Oliver called for a vote by show of hands to table the motion. The vote was nine ayes and four nays. The motion was approved.

Indicator 1.I

After a brief break for the TAP members to pick up their lunches, Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Dr. Seligman made a motion to table the pending motion with Mr. Dougan seconding the motion. After further discussion by the panel members, Dr. Seligman withdrew his motion to table the pending motion. Ms. Milder made a motion to amend the wording of the indicator that was seconded by Dr. Combs. A further amendment of the wording was made by Mr. Eckstein to replace the words "achieving 80% by 2021" with the words "on a year over year for five years" at the end of the sentence. The proposed amendment was agreed to. The indicator now reads: "Increasing percentage of independent physicians on the common IT platform increasing year over year for five years." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was six ayes, five nays, and two abstentions. The motion was approved.

Indicator 1.J

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was seven ayes and six nays. The motion was approved.

Indicator 1.J.1

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Ms. Krutak made a motion to amend the wording of the indicator that was seconded by Dr. Seligman. A further amendment of the wording was made by Mr. Eckstein to replace the words "Year over year improvement on" at the beginning of the sentence in front of the word "cost;" replace the word "PMPY" with the words "per member per year;" and remove the words "minimum of half the regional trend" at the end of the sentence. The proposed amendment was agreed to. The indicator now reads: "Year over year improvement on cost on per member per year." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and two nays. The motion was approved.

Indicator 1.J.2

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Knox proposed an amendment to the wording to add the words "Year over year improvement in" at the beginning of the sentence before the words "quality metrics;" and to delete the words "at upper quartile performance" at the end of the sentence. The indicator now reads: "Year over year improvement in quality metrics for employee populations." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and two nays. The motion was approved.

Indicator 1.J.3

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. During discussion by the panel members, Mr. Eckstein proposed an amendment to the wording to add the words "Year over year improvement in" at the beginning of the sentence before the words "experience metrics;" and to delete the words "at upper quartile performance" at the end of the sentence. The indicator now reads: "Year over year improvement in experience metrics for employee populations." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and two nays. The motion was approved.

Indicator 1.K

Mr. Knox made a motion to approve this indicator with Ms. Milder seconding the motion. During discussion by the panel members, Mr. Eckstein proposed an amendment to the wording to add the words "existing health outreach programs with employers, adding" between the words "the region with" and "new;" adding the word "employer" after the word "new" and before the word "customer;" and deleting the word "added" between the words "customer" and "each year." The proposed amendment was agreed to. The indicator now reads: "Increasing relationships with employers in the region with existing health outreach programs with employers, adding new employer customers each year." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes and one nay. The motion was approved.

Indicator 1.L

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Knox proposed an amendment to the wording to add the words "outcomes where the services are being provided to employer customers" after the words "demonstrated improvement in;" and to delete the words "cost control, quality and experience for employer customers year over year" at the end of the sentence. He further moved that indicators 1.L.1, 1.L.2, and 1.L.3 be deleted in their entirety. The indicator now reads: "Demonstrated improvement in outcomes where the services are being provided to employer customers." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was nine ayes and four nays. The motion was approved.

Indicator 1.M

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein made a motion to table the pending motion. Hearing no second, this motion failed. During further discussion by the panel members, an amendment was proposed to add the words "year over year" between the words "Increased spending" and "by new system;" delete the words "year over year to a minimum of 70%" after the words "regional suppliers;" add the words "at or below market value for products and services;" and delete the words "by 2021" from the end of the sentence. The proposed amendment was agreed to. The indicator now reads: "Increased spending year over year by new system on ongoing operations with regional suppliers at or below market value for products and services." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was seven ayes and six nays. The motion was approved.

Indicator 1.D

Mr. Barden made a motion to take the pending motion for indicator 1.D from the table with Ms. Milder seconding the motion. Dr. Oliver called for a vote by show of hands to take up the pending motion from the table. The vote was 11 ayes, 0 nays, and 2 abstentions. The motion was approved.

During discussion by the panel members, an amendment was proposed to replace the current wording in this indicator, along with the proposed amendments made earlier in the meeting, and to replace it with the following wording: "The rate of increase of the total cost of care measured by per member per year for all risk based contracts is below the regional trend for similar payer populations on an annual basis calculated on a rolling three year average." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was nine ayes and four nos. The motion was approved.

Outcome 2 – Improve Health and Well-Being for a Population

Table 2 – Measures, Descriptions, and Sources

Mr. Dougan made a motion to keep measures 2.7, 2.16, 2.31, 2.32, and 2.40 (Youth Tobacco Use, Obesity Subpopulation Measure, Vaccinations – HPV Females, Vaccinations HPV – Males, and Children receiving dental sealants) and delete the rest of the measures in this table with Dr. Seligman seconding the motion. The measures to keep read as follows:

2.7 * #	Youth Tobacco Use	Percentage of High School Students who self-reported currently using tobacco (used cigarettes, cigars, chewing tobacco, snuff, or pipe tobacco within the 30 days before the survey).	National Survey on Drug Use and Health
2.16 * #	Obesity Subpopulation Measure	Increase the proportion of physician office visits that include counseling or education related to weight and physical activity.	Data Collection to be led by the New Health System
2.31 * #	Vaccinations – HPV Females	Percentage of females aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
2.32 * #	Vaccinations – HPV Males	Percentage of males aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
2.40 * #	Children receiving dental sealants	Children receiving dental sealants on permanent first molar teeth (%, 6–9 years).	Data Collection to be led by the New Health System

Dr. Oliver called for a vote by show of hands on the motion. The vote was 11 ayes and two nays. The motion was approved.

Dr. Oliver then asked if the panel would like to reinsert any of the measures contained in Table 2.. Ms. Milder made a motion to add 2.6 (Mothers who smoke during pregnancy) and 2.19 (Breastfeeding Initiation). The motion was properly seconded. During discussion by the panel members, measures 2.24, 2.30, 2.37, 2.38, 2.42, 2.44, and 2.51 were also proposed to be added. The proposed amendment was agreed to. The measures to be added back read as follows:

2.6 #	Mothers who smoke during pregnancy	Percentage of mothers who report smoking during pregnancy (%).	VDH Division of Health Stats – Birth Certificate Data
2.19 #	Breastfeeding Initiation	Percent of live births whose birth certificates report that baby is breastfed. US Value: Proportion of infants who are ever breastfed.	VDH Division of Health Stats – Birth Certificate Data CDC National Immunization Survey
2.24 #	NAS (Neonatal Abstinence Syndrome) Births	Number of reported cases with clinical signs of withdrawal per 1,000 Virginia resident live births.	Active case reports submitted by clinicians OR through VDH's inpatient hospitalization database (VHI data)
2.30	Children – On-time Vaccinations	Children receiving on-time vaccinations (% of children aged 24 months receiving 4:3:1:FS:3:1:4 series).	Virginia Immunization Information System
2.37 * #	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years.	VDH Division of Health Stats – Birth Certificate Data
2.38 * #	Third Grade Reading Level	3rd graders scoring "proficient" or "advanced" on reading assessment (%).	Fourth grade reading level is available through KIDS COUNT data center
2.42 #	Frequent Mental Distress	Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System
2.44 * #	Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	VDH Division of Health Stats – Birth Certificate Data
2.51 #	Premature Death Ratio	Ratio of years lost before age 75 per 100,000 population for higher density counties to lower density counties.	Virginia death certificate data

Dr. Oliver called for a vote by show of hands on each measure individually. For measure 2.6, the vote was eight ayes and five nays; this motion was approved. For measure 2.19, the vote was

10 ayes and three nays; this motion was approved. For measure 2.24, the vote was nine ayes and four nays; this motion was approved. For measure 2.30, the vote was nine ayes and four nays; this motion was approved. For measure 2.27, the vote was 13 ayes and 0 nays; this motion was approved. For measure 2.38, the vote was 13 ayes and 0 nays; this motion was approved. For measure 2.42, the vote was seven ayes and six nays; this motion was approved. For measure 2.44, the vote was 13 ayes and 0 nays; this motion was approved. For measure 2.51, the vote was six ayes and seven nays; this motion failed.

The approved table is as follows:

2.6 #	Mothers who smoke during pregnancy	Percentage of mothers who report smoking during pregnancy (%).	VDH Division of Health Stats – Birth Certificate Data
2.7 * #	Youth Tobacco Use	Percentage of High School Students who self-reported currently using tobacco (used cigarettes, cigars, chewing tobacco, snuff, or pipe tobacco within the 30 days before the survey).	National Survey on Drug Use and Health
2.16 * #	Obesity Subpopulation Measure	Increase the proportion of physician office visits that include counseling or education related to weight and physical activity.	Data Collection to be led by the New Health System
2.19 #	Breastfeeding Initiation	Percent of live births whose birth certificates report that baby is breastfed. US Value: Proportion of infants who are ever breastfed.	VDH Division of Health Stats – Birth Certificate Data CDC National Immunization Survey
2.24 #	NAS (Neonatal Abstinence Syndrome) Births	Number of reported cases with clinical signs of withdrawal per 1,000 Virginia resident live births.	Active case reports submitted by clinicians OR through VDH's inpatient hospitalization database (VHI data)
2.30	Children – On-time Vaccinations	Children receiving on-time vaccinations (% of children aged 24 months receiving 4:3:1:FS:3:1:4 series).	Virginia Immunization Information System
2.31 * #	Vaccinations – HPV Females	Percentage of females aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
2.32 * #	Vaccinations – HPV Males	Percentage of males aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System

2.37 * #	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years.	VDH Division of Health Stats – Birth Certificate Data
2.38 * #	Third Grade Reading Level	3rd graders scoring "proficient" or "advanced" on reading assessment (%).	Fourth grade reading level is available through KIDS COUNT data center
2.40 * #	Children receiving dental sealants	Children receiving dental sealants on permanent first molar teeth (%, 6–9 years).	Data Collection to be led by the New Health System
2.42 #	Frequent Mental Distress	Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System
2.44 * #	Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	VDH Division of Health Stats – Birth Certificate Data

Indicator 2.A

After a brief break, Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 10 ayes and 3 abstentions. The motion passed.

Indicator 2.A.1

Mr. Knox made a motion to approve this indicator with Mr. Randazzo seconding the motion. During discussion by the panel members, an amendment was proposed to replace the word "target" with the words "those milestones" between the words "milestones achieving" and "90% of the time." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 10 ayes and three nays. The motion was approved.

Indicator 2.B

Mr. Eckstein made a motion to approve this indicator by replacing the words "achieving upper quartile performance in all metrics by 2021" with the words "exceed the year over year improvement in socio economic peer counties" with Mr. Knox seconding the motion. The indicator now reads: "Year over year improvement in defined measures of health exceed the year over year improvement in socio economic peer counties." Dr. Oliver called for roll-call vote on the motion. The vote was eight ayes (Mr. Barden, Mr. Cassell, Mr. Eckstein, Mr. Hunnicutt, Mr. Knox, Ms. Milder, Dr. Oliver, and Mr. Randazzo)and five nays (Mr. Beatty, Dr. Combs, Mr. Dougan, Ms. Krutak, and Dr. Seligman). The motion was approved.

Indicator 2.C

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Dougan proposed an amendment to replace the existing wording in its entirety with the following: "The total amount of annual charity care will

be reported by the new health system with an explanation of any variation from previous years." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 13 ayes and 0 nays. The motion was approved.

Indicator 2.D

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Dr. Seligman made a motion to table the pending motion with Mr. Hunnicutt seconding the motion. After further discussion by the panel members, Dr. Seligman withdrew his motion to table the pending motion. Mr. Eckstein made a motion to amend the wording of the indicator by replacing the existing wording in its entirety with the following: "The new health system providers will present measures of disparity and equity and their measurement technique to the Commissioner." This motion was seconded by Mr. Barden and the amended motion was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 13 ayes and 0 nays. The motion was approved.

Dr. Oliver closed the discussion on the draft measures and performances for this meeting.

Public Comment

Dr. Oliver opened the public comment period. One individual at the Glen Allen location signed up to speak during the public comment period.

Anthony Keck, MSHA, addressed the TAP. He said that the TAP should consider limiting the number of metrics that Ballad will held accountable for, so that improvement efforts can be focused and concentrated in a few areas. He also urged the TAP to consider the approach that Tennessee had taken. While Mr. Keck said that Tennessee had included far too many metrics, it had allowed for a ramp-up period prior to the metrics taking full effect.

Dr. Oliver closed the public comment period.

Adjourn

The meeting adjourned at approximately 5:00 p.m.

December 5, 2017 – 8:00 a.m.
Office of Emergency Medical Services, Class Room A & B
1041 Technology Park Drive
Glen Allen, Virginia

Videoconference Location
Wise County Health Department
134 Roberts Avenue SW
Wise, Virginia

Members present: Dr. Norm Oliver (Virginia Department of Health "VDH"), Chair; Sean Barden (Mary Washington Healthcare); Don Beatty (Virginia Bureau of Insurance); Bobby Cassell by videoconference (consumer); Dr. Stephen Combs (Wellmont Health System "WHS");

Todd Dougan (WHS); Tom Eckstein (Arundel Metrics); George Hunnicutt, Jr. (Pepsi Cola Bottling of Norton); Pete Knox (Peter Knox Consulting); Lynn Krutak (Mountain States Health Alliance "MSHA"); Sarah Milder (Arundel Metrics); Andy Randazzo (Anthem); and Dr. Morris Seligman (MSHA).

Member absent: Dr. Ron Clark (Virginia Commonwealth University Health System).

VDH staff present: Erik Bodin, Director, Office of Licensure and Certification; Joseph Hilbert, Director, Governmental and Regulatory Affairs; and Catherine West, Administrative Assistant.

Others Present: Amanda Lavin, Office of the Attorney General.

Welcome

Dr. Oliver called the meeting to order at 8:00 a.m. He told the Technical Advisory Panel (TAP) that a quorum of members was present.

Dr. Seligman requested that the TAP members be informed of the Commissioner's timetable for making her decision concerning the metrics that would be used to actively supervise the Cooperative Agreement. Dr. Oliver said that the timetable would be provided at the appropriate time.

Long-Term Measures – Active Supervision of the Cooperative Agreement: Draft Measures and Performance Indicators

Dr. Oliver told the TAP that today's meeting would continue with the discussion of the draft measures and performance indicators that had not been discussed at the December 4th meeting.

Outcome 3 – Equitable Access to Services Across the Region

Table 1 – Measures, Descriptions, and Sources

Mr. Eckstein made a motion to adopt this table with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was seven ayes and four abstentions (Mr. Beatty and Mr. Hunnicutt were not present for the vote). The motion was approved.

There was a brief discussion in which Dr. Oliver explained to the TAP that the failure of Ballad to achieve the established target for any specific measure or measures would not, in and of itself, be used by VDH as the basis seeking to initiate action adverse to the continuation of the cooperative agreement. Dr. Seligman stated that it would be very helpful to Ballad to have that concept expressed in writing from the Commissioner.

Indicator 3.A

Mr. Knox made a motion to approve this indicator with Mr. Hunnicutt seconding the motion. There was a discussion among the panel about the definition of "southwest Virginia," with Mr. Knox suggesting that a change could be made to the wording to include the word "rural" in the

indicator. Dr. Oliver called for a vote by show of hands on the motion. The vote was six ayes and seven nays. The motion failed.

Indicator 3.A.1

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a roll-call vote on the motion. The vote was six ayes (Mr. Eckstein, Mr. Hunnicutt, Mr. Knox, Ms. Milder, Dr. Oliver, and Mr. Randazzo) and seven nays (Mr. Barden, Mr. Beatty, Mr. Cassell, Dr. Combs, Mr. Dougan, Ms. Krutak, and Dr. Seligman). The motion failed.

Indicator 3.B

Mr. Knox made a motion to approve this indicator with Mr. Hunnicutt seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 3.B.1

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 3.B.2

Mr. Hunnicutt made a motion to approve this indicator with Mr. Knox seconding the motion. During discussion by the panel members, Mr. Knox made an amendment to delete the word "all" between the words "improvement in" and "metrics;" add the words "targeted within the" between the words "metrics" and "achieving target;" delete the words "achieving target;" and delete the word "in" between the words "established" and "plan." The indicator would now read: "Year over year improvement in metrics targeted within the established plan." During further discussion by the panel members, Mr. Eckstein proposed replacing the existing wording and Mr. Knox's proposed amendment with the following: "Annual plan establishes metrics and targets for year to year improvement and that they meet 80% of targets established." This proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was nine ayes and four nays. The motion passed.

Indicator 3.C

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed amending the language by replacing the words "Spending per capita, on a risk adjusted basis, in six major service categories in Southwest Virginia equal to the highest level in any community in the serviced area" with the words "Service delivery in the six major categories is equal among the various regions in Southwest Virginia." After further discussion by the panel members, Mr. Eckstein withdrew his motion and Dr. Oliver proposed changing the words "Spending per capita, on a risk adjusted basis, in six major service categories in Southwest Virginia equal to the highest level in any community in the serviced area" with the words "Residents of Southwest Virginia have equitable

access to key services in the following areas:." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes, four nays, and 1 abstention. The motion passed.

Indicator 3.D

Mr. Hunnicutt made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was five ayes, six nays, and two abstentions. The motion failed.

Indicator 3.E

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, an amendment was proposed to replace the words "Same day" with the words "The new health system will provide a plan for" at the start of the sentence; delete the word "all" between the words "primary care for" and "residents of;" and delete the words "measured by 3rd available appointment." The proposed amendment was agreed to. The indicator now reads: "The new health system will provide a plan for same day access to primary care for all residents of Southwest Virginia." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was nine ayes and four nays. The motion was approved.

Indicator 3.F

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, an amendment was proposed to add the words "The new health system will provide a plan for" before the word "Specialty" at the start of the sentence; delete the word "all" between the words "less for" and "residents of;" and delete the words "measured by 3rd available appointment." The proposed amendment was agreed to. The indicator now reads: "The new health system will provide a plan for specialty access to all six major service categories at 5 days or less for all residents of Southwest Virginia." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 4.A

After a brief break, Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Mr. Dougan made a motion to replace all of the existing language in 4.A with the following: "The new health system shall complete a comprehensive physician/physician extender needs assessment and recruitment plan every three years, starting within the first full fiscal year, in each Virginia community served by the new health system." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 10 ayes and three nays. The motion was approved.

Indicator 4.A.1

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was four ayes and nine nays. The motion failed.

Indicator 4.B

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, an amendment was proposed to add the word "with" between the words "Southwest Virginia" and "year over year;" add the word "improvement" after the words "year over year;" and delete the words "with all gaps closed by 2021" at the end of the sentence. The proposed amendment was agreed to. The indicator now reads: "Progress in closure of clinical staff gaps in Southwest Virginia with year over year improvement." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 4.C

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Dougan proposed amending the language by replacing the words "including six month milestones defined approved by" with the words "and submitted to the." The proposed amendment was agreed to. The indicator now reads: "Post graduate training plan developed and submitted to the health commissioner within 12 months of signed agreement." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 4.D

Mr. Eckstein made a motion to approve this indicator with the replacement of the word "Six" with the word "Twelve" at the start of the sentence. Ms. Milder seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 6.A

Dr. Oliver asked that Indicator 5 be laid aside and to proceed with Indicator 6. Mr. Knox made a motion to approve Indicator 6.A with Mr. Eckstein seconding the motion. Dr. Oliver called for a vote for show of hands on the motion. The vote was six ayes, six nays, and one abstention. The motion failed.

Indicators 6.A.1 and 6.A.2

Dr. Oliver told the panel that these two indicators failed since they both rely on Indicator 6.A and it failed.

Indicator 6.B

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was two ayes, six nays, and five abstentions. The motion failed.

There was a discussion concerning the extent to which the measures being considered by the TAP do or do not represent an intrusion into the discretion of Ballad management and the fiduciary responsibility of the Ballad Board of Directors. Mr. Hilbert explained to the TAP VDH's need to operationally define active supervision of the cooperative agreement.

Indicator 6.C

Mr. Knox made a motion to approve this indicator with Ms. Milder seconding the motion. During discussion by the panel members, Mr. Eckstein proposed amending the language by deleting the words "Reduction in" at the start of the sentence; adding the words "be reduced on a year by year basis;" and by deleting the words "achieving and maintaining top quartile performance for health systems nationally" at the end of the sentence. The proposed amendment was agreed to. The indicator now reads: "Annual turnover rate be reduced on a year by year basis." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was seven ayes and six nays. The motion was approved.

Indicator 6.D

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. Several adjustments to the language of this indicator were discussed by the panel members. Dr. Oliver called for a vote by show of hands on the motion. The vote was five ayes, seven nays, and one abstention. The motion failed.

Indicator 6.E

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed amending the language by replacing the word "Improved" with the words "The new health system will alter the board survey to measure board relationships in the first year and thereafter improve" at the start of the sentence and changing the word "an" to the word "its" by the words "measured by" and "annual board survey." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was six ayes, five nays, and two abstentions. The motion was approved.

Indicator 6.F

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was four ayes, seven nays, and two abstentions. The motion failed.

Indicator 6.G

This indicator failed due to a lack of receiving a motion to approve.

Outcome 7 – Strong Academics and Research Impacting Regional Issues

Indicator 7.A

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed amending the language by replacing the existing words in their entirety with the words "Within 12 months of the closing date of the merger, the new health system will develop and submit to the Commissioner, for review and approval, a plan for investment in the research enterprise in the Virginia service area." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes and one nay. The motion was approved.

Indicator 7.B

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. Several adjustments to the language of this indicator were discussed by the panel members. Dr. Oliver called for a vote by show of hands on the motion. The vote was six ayes and seven nays. The motion failed.

Indicator 7.C

Mr. Knox made a motion to approve this indicator with Mr. Randazzo seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was three ayes, eight nays, and two abstentions. The motion failed.

Outcome 8 – Monetary Commitment

Indicator 8.A

Mr. Knox made a motion to approve this indicator with Dr. Oliver seconding the motion. During discussion by the panel members, Mr. Eckstein proposed amending the language by replacing the existing words "by community defined and achieved on an annual basis with demonstrated equal allocation to SW Virgina and the specific issues faced by the region" with the words "be defined by need and be shown to be independent of geography." The proposed amendment was agreed to. The indicator now reads: "Target spending be defined by need and be shown to be independent of geography." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes (one member was not in the room during the vote) and 0 nays. The motion was approved.

Indicator 8.B

Mr. Knox made a motion to approve this indicator with the replacement of the words "a quarterly" with "an annual" between the words "reported on" and "basis." Mr. Barden seconded

the motion. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and two nays. The motion was approved.

Indicator 8.C

Mr. Eckstein made a motion to approve this indicator with Ms. Milder seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 13 ayes and 0 nays. The motion was approved.

Outcome 5 – Bench-Mark Operating Performance

Indicator 5.A

After a brief break for the TAP members to pick up their lunches, Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. During discussion by the panel members, Mr. Eckstein amended the wording by replacing the word "approved" with the word "reviewed" between the words "complete and" and "by the health commissioner." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 10 ayes and three nays. The motion was approved.

Indicator 5.A.1

Mr. Eckstein made a motion to approve this indicator with Mr. Knox seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and five nays. The motion was approved.

Indicator 5.A.2

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. After discussion by the panel members, Mr. Knox withdrew his motion. The motion failed.

Indicator 5.B

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Dougan proposed amending the language by deleting the existing wording in its entirety and replacing it with the following wording: "Adherence to public reporting schedules and required department reporting. Sustained improvement from baseline on CMS safety domain measures to reduce adverse events and improve overall patient safety.
Pressure ulcer rate
Iatrogenic pneumothorax rate
Central venous catheter-related blood stream infection rate
Central venous catheter-related blood stream infection rate
Postoperative Hip Fracture Rate
PSI 09 Perioperative Hemorrhage or Hematoma Rate
PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
PSI 11 Postoperative Respiratory Failure Rate
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate

PSI 13 Postoperative Sepsis Rate
PSI 14 Postoperative Wound Dehiscence Rate
PSI 15 Accidental Puncture or Laceration Rate
Central Line-Associated Bloodstream Infection (CLABSI Rate)
Catheter-Associated Urinary Tract Infection (CAUTI Rate)
Surgical Site Infection (SSI) Rate
Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate
Clostridium Difficile Infection (CDI or C-Diff) Rate"

The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the motion. The vote was 13 ayes and 0 nays. The motion was approved.

Indicator 5.C

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein suggested several adjustments to the language of this indicator but ultimately withdrew his suggestions. Ms. Krutak made a motion to replace all of the words of the existing indicator, including the subsections 5.C.1 through 5.C.17, with the following language "Timely reporting of key financial metrics included in all filings with EMMA for evaluation by the commissioner; maintain compliance with bond covenants via submission of attestation and independent audit criteria; reporting of associated metrics to the Commissioner at least annually in concert with annual agency reviews." Mr. Dougan seconded the motion and the amended motion was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes and one nay. The motion passed.

Indicator 5.D

Mr. Knox made a motion to approve this indicator with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed changing the language of the indicator by replacing the word "with" with the word "and" between the words "annual basis" and "no fewer than;" to add the word "actively" between the words "being spread" and "throughout the system;" and by adding the words "at any one time" to the end of the sentence. The proposed amendment was agreed to. The indicator now reads: "System wide best practices identified on an annual basis with and no fewer than 3 being spread actively throughout the system at any one time." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes and 0 nays (Ms. Krutak was no longer at the meeting). The motion was approved.

Table 1: Quality Monitoring Measures

Dr. Oliver requested that the panel consider all of the measures contained in this table as a block. Mr. Eckstein made a motion to approve the table as a block with Dr. Combs seconding the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 12 ayes and 0 nays (Ms. Krutak was no longer at the meeting). The motion was approved.

Indicator 5.E

Mr. Eckstein made a motion to approve this indicator by replacing the existing language in its entirety with the following language: "Annual plan for improving quality and satisfaction among selected measures with year to year improvement and that they meet 80% of the targets established." Dr. Combs seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 12 ayes and 0 nays (Ms. Krutak was no longer at the meeting). The motion was approved.

Public Comment

There were no comments from any member of the public.

Next Steps

Dr. Oliver told the TAP that the next meeting is scheduled for December 14, 2017 in the same location as today's meeting. The meeting will start at 8:00 a.m. The TAP will discuss the short-term measures as well as the tabled item from the December 4th meeting.

Dr. Seligman asked if the TAP would be allowed to see the final report of the TAP prior to it being submitted to the Commissioner. Dr. Oliver responded that the TAP would be provided with the final report prior to its submission to the Commissioner.

Mr. Dougan said that many of the items in the short term expectations have already been discussed, and requested that VDH staff edit the list of short term expectations accordingly.

Adjourn

The meeting adjourned at approximately 1:10 p.m.

Technical Advisory Panel Recommendations

Suggested Approach

Measurement Alignment with Conditions: In the order, the Commissioner set forth a robust set of conditions and has subsequently set forth a set of desired outcomes which provide clear expectations for ongoing evaluation of the cognizable benefits of the Cooperative Agreement. These conditions were formulated based on exhaustive engagement with key regional stakeholders and based on recommendations from the Southwest Virginia Health Authority—in concert with the Virginia Plan for Well-Being and the Blueprint for a Healthy Appalachia.

The eight outcome criteria set forth and the conditions the Department and its consultants have attributed to them fulfill the requirements of the regulations for cognizable benefits in population health; access to health services; economic; patient safety; patient satisfaction; and other benefits.

The role of the Technical Advisory Panel is to make recommendations for quantitative measures which substantiate achievement of this ongoing benefit. Where possible, the conditions should be the basis for definition of those measures and new measures outside the expectations set forth in the commitments should not be included.

Measurements Dependent on the Planning Process: The Commissioner has clearly set forth certain plan requirements and associated criteria or milestones in the conditions. Additional plans should not be suggested by the Technical Advisory Panel. The plans set forth by the Commissioner will include associated qualitative and quantitative measures which must be accepted by the Commissioner in the context of those plans. Development of the plans is necessary prior to establishment of such measures, and the Panel should defer to the planning process and the Commissioner's approval process for solidification of plan specific measures. The focus of the Panel should be on fulfillment of the plans required by the Commissioner.

Evaluation Reliance on Active Supervision of Complaint and Reporting Process: The COPA Compliance Officer and the COPA Monitor, as set forth in the active supervision requirements, will provide additional support to the Commissioner for the receipt of any complaints or concerns from various stakeholder groups. They will work to formally record, substantiate and resolve such complaints. As noted in the measures below, validated or unresolved complaints will be visible to the Commissioner for evaluation of ongoing benefit where quantitate measures include the number of valid or unresolved complaints from payers, patients, providers, internal stakeholders, or members of the community.

ATTACHMENT A

Outcome 1: Create value in the marketplace

Conditions: 5-6-7-8-9-10-11-26-29-30-31-42-43-44

C5 Satisfaction of Rate Cap Requirements in Addendum 1

Measures:

1. Achievement of Addendum 1 requirements as verified by VDH (worth at least $80 million in market value over 10 years);
2. Number of unresolved payer complaints (self-reporting with verification from payers and department and review by department)

C6 Negotiate in good faith

Measures:

1. Number of validated and unresolved complaints from payers (self-reporting with verification from payers and department and review by department)

C7 No network exclusivity

Measures:

1. Number of unresolved complaints from payers (self-reporting with verification from payers and department and review by department)

C8 Regional HIE Participation

Measures:

1. Plan submitted and accepted
2. Amount spent
3. Increasing % of independent physician participation;

C9 Clinical Services Network

Measures:

1. Increasing % of independent provider participants enrolled now to 2021;

C10 Quality, value, shared financial alignment with large payers

Measures:

1. Number of contracts retained or added with payment for value elements;
2. Number of lives covered in at-risk contracts;
3. Amount of at risk revenue increasing to 30% by 2021 (self-reporting with verification from payers and department and review by department)

C11 DMAS value-based payments

Measures:

1. Number of at-risk lives under DMAS/MSO contracts;
2. Amount of at risk $ with verification from DMAS (self-reporting with verification from payers and department and review by department)

C26 Common Clinical IT Platform w/in 48 months

Measures:

1. Amount spent;
2. 6 month milestones;
3. Number of common clinical protocols added;
4. Number of patient portal activations;
5. Increasing % of independent physicians participating on common platform by 2021

C29 Open Medical Staffs

Measures:

1. Number of unresolved complaints based on department review of adherence to credentialing policy and medical staff practice

C30 No requirement for exclusive independent physician practice

Measures:

1. Number of unresolved complaints

C31 No prohibitions for independent physicians in health plans or health networks controlled

Measures:

1. Number of unresolved complaints

C42 No most favored nation pricing with health plans

Measures:

1. Number of unresolved complaints (self-reporting with verification from payers and department and review by department)

C43 No exclusive physician contracting except for hospital based providers

Measures:

1. Number of unresolved complaints

C44 DMAS ARTS program participation

Measures:

1. Number of patients served within program annually (DMAS verification)

Other:

1. To support the local economy, use local vendors or suppliers where feasible based on comparable cost and quality to vendors or suppliers outside the market (include summary in annual report)

Outcome 2: Improve health and well-being for a population

Conditions: 14-15-36

C14 Charity Care

Measures:

1. Total amount of annual charity care with explanation of any annual variance from previous years;

2. Number of valid patient complaints regarding policy compliance

C15 Uninsured/Underinsured discount

Measures:

1. Total amount of annual discount to patients;
2. Number of valid patient complaints regarding policy compliance

C36 Population health plan and spending requirements

Measures:

1. Show improvement over regional baseline for priority population health measures (See Outcome 8)
2. In accordance with overall population health access goals, establish Ballad Health team member health plan goals for improved rates of preventative screenings, engagement with health coaches, participation in health improvement activities
3. In accordance with overall population health access goals, establish goals for increasing engagement with regional businesses for health promotion and wellness activities, screenings, and associated improvement tracking
4. See C36 for additional population health measures related to the $75 million population health spending requirement

Outcome 3: Equitable Access

Conditions: 1-27-28-41-46

C1 No realignment or termination without cause between approval & effective date

Measures:

1. Number of services realigned or terminations without cause in Virginia facilities during the period (demonstrated compliance with condition)

C27 All hospitals are to remain open for 5 years as clinical and health care institutions (per definition)

Measures:

1. Compliance with sub-requirements of C27

C28 Maintain at least 3 tertiary hospitals

Measures:

1. Number and type of tertiary services offered at 3 tertiary centers

C33 Essential services

Measures:

1. Essential services by county as defined in conditions and demonstrated against current baseline
2. Increasing % of same day or preferred day access to primary care as measured against 3rd next available appointment
3. Increasing % of specialty access for all six major service categories at 5 days or less measured by 3rd next available appointment
4. Maintained or enhanced services for maternal and pre-natal health from current baseline

5. Enhancement to regional pediatric access as approved in the rural health services and pediatric services plans
6. Improved access to preventative and restorative dental and corrective vision services as agreed upon in the rural health services and pediatrics services plan
7. Maintained or enhanced emergency access, transport, and transfer as agreed upon in the rural health services plan

C41 Adherence to alignment policy

Measures:

1. Number of valid complaints from internal and community stakeholders as evaluated by the department

C46 Treatment of Virginia Medicaid patients

Measures:

1. Ratio of pre-admission screenings to Medicaid patients served;
2. Number of participating plans as % of potential plans;
3. Compliance with pricing requirements;
4. Number of valid Medicaid patient complaints for lack of access

Outcome 4: Adequate Providers & Equitable Services

Conditions: 24-32

C24 Post-graduate training

Measures:

1. Convene collaborative within 45 days of closing according to parameters set forth in condition;
2. Plan submitted and accepted within 12 months;
3. Ongoing achievement of agreed plan milestones;
4. Number of total program participants

C32 Physician/extender needs assessment and recruitment plan

Measures:

1. % recruitments goals achieved by established milestones

Outcome 5: Benchmarks of Operating Performance

Conditions: 12-13-16-17-40-45

C12 Robust quality improvement program

Measures:

1. Adherence to public reporting schedules and required department reporting
2. Sustained improvement from baseline on CMS Safety Domain measures to reduce adverse events and improve overall patient safety

   a) Pressure Ulcer Rate
   b) Iatrogenic Pneumothorax Rate
   c) Central Venous Catheter-Related Blood Stream Infection Rate

d) Postoperative Hip Fracture Rate
e) PSI 09 Perioperative Hemorrhage or Hematoma Rate
f) PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
g) PSI 11 Postoperative Respiratory Failure Rate
h) PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
i) PSI 13 Postoperative Sepsis Rate
j) PSI 14 Postoperative Wound Dehiscence Rate
k) PSI 15 Accidental Puncture or Laceration Rate
l) Central Line-Associated Bloodstream Infection (CLABSI Rate)
m) Catheter-Associated Urinary Tract Infection (CAUTI Rate)
n) Surgical Site Infection (SSI) Rate
o) Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate
p) Clostridium Difficile Infection (CDI or C-Diff) Rate

3. Monitoring and reporting of all CMS quality measures
4. Monitoring and reporting of all CMS HCACPS Measures for Patient Satisfaction (see attached)
5. Ratio of rural to urban equity in quality and patient satisfaction

C13 Hospital accreditation

Measures:

1. Achievement of expectations for accreditation set forth by the Department for each hospital

C16 Notice of Material Default

Measures:

1. Finding of compliance or non-compliance by the Department

C17 Notice of material adverse event

Measures:

1. Finding of compliance or non-compliance by the Department

C40 Quarterly Financial Metrics

Measures:

1. Timely reporting of key financial metrics included in all filings with EMMA for evaluation by the commissioner;
2. Maintain compliance with bond covenants via submission of attestation and independent audit criteria;
3. Reporting of associated metrics to the Commissioner at least annually in concert with annual rating agency reviews

C45 Clinical Council

Measures:

1. Evaluation by the Commissioner according to criteria set forth in C45;
2. Reports of Clinical Council activity related to common clinical protocols and criteria for medical staff credentialing and ongoing evaluation of practice
3. Number of system-wide best practices identified and spread across system

Outcome 6: Strong Vibrant Culture

Conditions: 18-20-21-22-38

C18 Honor prior service of team members

Measures:

1. Number of validated team member complaints regarding prior service commitment

C20 Severance policy

Measures:

1. Policy submitted to the Commissioner and published to Ballad Health team members;
2. Number of team member validated complaints during the five year period as

C21 No terminations except for cause

Measures:

1. Report provided to and accepted by the Commissioner;
2. Number of team member validated complaints

C22 Career development

Measures:

1. Report provided to the Commissioner outlining Ballad Health career development program;
2. Number of participants in career ladder programs or career development activities annually
3. Improve employee satisfaction by year 3 based on regular employee satisfaction surveys

C38 Ballad Health Board Requirements

Measures:

1. Report of demonstrated compliance with Virginia membership requirements annually
2. Conduct regular board self-evaluation and board development plan

Outcome 7: Strong Academics and Research

Conditions: 25

C25 Plan for Virginia research investment

Measures:

1. Convene co-chaired collaborative team within 45 days of closing;
2. Plan submitted and accepted by Commissioner within 12 months in compliance with criteria set forth in the conditions A-E in C25 including spending goals and new program requirements
3. Submission and acceptance of new 3 year plan within 90 days of current plan expiration
4. Research report demonstrating alignment of research activities with priority regional health issues

Outcome 8: Monetary Commitments and Outcomes

Conditions: 3-19-23-33-34-35-36-37

C3 Monetary obligations shall be incremental

Measures:

1. Baseline data submitted to Commissioner and annual reports demonstrating achievement of spending benchmarks set forth in approved plans

C19 $70 million spending to eliminate differences in salary/pay rates and employee benefit structures

Measures:

1. Plan submitted to the Commissioner with progress reports and spending updates as implementation occurs

C23 $85 million spending over 10 fiscal years on Health Research and Graduate Medical Education

Measures:

1. Plan submitted to and approved by the Commissioner;
2. Annual demonstration of incremental amounts spent in accordance with plan;
3. Annual updates and plan compliance reports detailing metrics as defined in 12 month plan.

C33 $28 million spending over 10 fiscal years on rural health services

Measures:

1. Development and submission of plan approved by Commissioner within six months of closing;
2. Achievement of sub-plan conditions as agreed to by Commissioner, and set forth in annual updates, including those set forth in C33 sub-bullets and additional detailed criteria;
3. Annual demonstration of incremental amounts spent in accordance with plan;
4. **Demonstrated maintenance of essential services as required in order to support the access requirements of the cooperative agreement**

C34 $85 million spending over 10 fiscal years on behavioral health services

Measures:

1. Development and submission of plan approved by Commissioner within six months of closing;
2. Achievement of sub-plan conditions as agreed to by Commissioner, and set forth in annual updates, including those set forth in C34 additional detailed criteria;
3. Annual demonstration of incremental amounts spent in accordance with plan

C35 $27 million spending over 10 fiscal years on pediatric health services

Measures:

1. Development and submission of plan approved by Commissioner within six months of closing;
2. Achievement of sub-plan conditions as agreed to by Commissioner, and set forth in annual updates, including those set forth in C35 additional detailed criteria;
3. Annual demonstration of incremental amounts spent in accordance with plan

C36 $75 million spending over 10 fiscal years on population health improvement

Measures:

1. Development and submission of plan approved by Commissioner within six months of closing;
2. Achievement of sub-plan conditions as agreed to by Commissioner, and set forth in annual updates, including those set forth in C35 additional detailed criteria;
3. Annual demonstration of incremental amounts spent in accordance with plan;
4. Fulfillment of Accountable Care Community requirements set forth;
5. Establishment of department of population health as set forth in conditions;
6. Achievement of the population health index criteria adopted by the Commissioner

7. Achieve improvement off Virginia baseline for recommended areas of focus consistent with VA Plan for Well-Being and SWVA Blueprint:
    - **Youth tobacco use**
    - **Adult obesity counseling and education;**
    - **children receiving dental sealants**
    - **Vaccinations- HPV females**
    - **Vaccinations- HPV males**

    Alternate areas of focus
    - **Third grade reading level**
    - **Infant mortality**
    - **Vaccinations- Flu vaccine, older adults**
    - **Teen pregnancy rate**

8. Select additional monitoring measures for ongoing plan evaluation and confirmation of priority measures.

C37 Reimbursement to Southwest Virginia Health Authority for cost up to $75,000 annually

Measures:

1. Invoices and receipts demonstrating compliance

Technical Advisory Panel of the Cooperative Agreement
Minutes
December 14, 2017 – 8:00 a.m.
Office of Emergency Medical Services, Class Room A & B
1041 Technology Park Drive
Glen Allen, Virginia

Videoconference Location
Wise County Health Department
134 Roberts Avenue SW
Wise, Virginia

Members present: Dr. Norm Oliver (Virginia Department of Health "VDH"), Chair; Don Beatty (Virginia Bureau of Insurance); Bobby Cassell by videoconference (consumer); Dr. Stephen Combs (Wellmont Health System "WHS"); Todd Dougan (WHS); Tom Eckstein (Arundel Metrics); George Hunnicutt, Jr. by videoconference (Pepsi Cola Bottling of Norton); Pete Knox (Peter Knox Consulting); Lynn Krutak (Mountain States Health Alliance "MSHA"); Sarah Milder (Arundel Metrics); Andy Randazzo (Anthem); and Dr. Morris Seligman (MSHA).

Members absent: Sean Barden (Mary Washington Healthcare) and Dr. Ron Clark (Virginia Commonwealth University Health System).

VDH staff present: Erik Bodin, Director, Office of Licensure and Certification; Joseph Hilbert, Director, Governmental and Regulatory Affairs; and Catherine West, Administrative Assistant.

Others Present: Amanda Lavin, Office of the Attorney General.

Welcome, Introductions, and Review of Agenda

Dr. Oliver called the meeting to order at 8:00 a.m. He told the Technical Advisory Panel (TAP) that a quorum of members was present at the Glen Allen location. Dr. Oliver told the TAP that this meeting would cover one item, Indicator 1.E from the Long-Term Measures – Active Supervision of the Cooperative Agreement: Draft Measures and Performance Indicators that was tabled at the last meeting. The panel would also review and adopt short term measures as well as discuss the timeline for submission of the panel's recommendations to the Commissioner and next steps. Dr. Oliver told the panel that after the December 4 and 5, 2017 meeting, VDH staff revised the short term measures document that will be discussed today so that it linked with the long term measures the TAP previously approved and suggested time frames such as 60 days, 120 days, and 180 days. For ease of discussion, those measures have been assigned a designator (e.g., A, B, 1.1, etc.). There was a brief discussion of the update on the cooperative agreement that was provided at the Southwest Virginia Health Authority meeting that was held on December 13, 2017. Dr. Levine and Dr. Melton attended the meeting with Dr. Oliver, Mr. Bodin, and Mr. Hilbert attending by telephone. The Authority will be providing the Commissioner with recommendations for active supervision.

Dr. Oliver told the videoconference participants that since the Glen Allen location is unable to see them when a document is being viewed over the videoconference equipment, if they wish to speak during any of the discussions, to interrupt as necessary so that they can be heard.

While all non-roll call votes were by show of hands, in all instances, Mr. Cassell's and Mr. Hunnicutt's votes were cast by voice method.

Approval of Minutes

Dr. Oliver asked the members if any changes needed to be made to the draft minutes from the December 4 and 5, 2017 TAP meeting. Hearing no discussion, Ms. Milder made a motion to adopt the draft minutes with Mr. Beatty seconding the motion. The minutes were approved unanimously by a voice vote.

Long-Term Measures – Active Supervision of the Cooperative Agreement: Draft Measures and Performance Indicators

Outcome 1 – Create Value in the Marketplace

Indicator 1.E

Mr. Dougan made a motion to approve this indicator by replacing the existing wording in its entirety with the following: "The results of the Anthem Q-HIP be communicated to the Commissioner as it is available on an annual basis." Dr. Seligman seconded the motion.

There was a discussion pertaining to the history of the Anthem Q-HIP, applicability of the Q-HIP metrics to the Medicare and pediatric populations, the extent to which the Q-HIP metrics are revised based on periodic review, and how Anthem compares Q-HIP results across different facilities.

During discussion by the panel members, Mr. Eckstein proposed an amendment to add the following sentence to the end of Mr. Dougan's proposed amendment: "These results shall include comparisons to the other Anthem providers and percentiles where available." Mr. Randazzo proposed adding the words "Virginia network" between the words "Anthem" and providers in this sentence. Both of these amendments were agreed to. The indicator now reads: "The results of the Anthem Q-HIP be communicated to the Commissioner as it is available on an annual basis. These results shall include comparisons to the other Anthem Virginia network providers and percentiles where available." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes and 0 nays. The motion was approved.

Short Term Milestones to Ensure Success of Plan Development to be Achieved Within 12 Months of Closing of Merger

There was an initial discussion concerning the rationale underlying VDH's staff recommendation for an initial detailed outline, and first draft plan, to be submitted prior to the new health system's final submission of the various plans required as conditions to the Commissioner's Order. Mr. Hilbert said that the intention of the short term metrics is to help enable the new health system to be successful. Ms. Krutak stated that it is not the new health system's intention

to develop the required plans "in a vacuum" without ongoing communication with the Commissioner. Mr. Beatty said that it was important for there to be a relationship between the Commissioner and the new health system based on "mutual, arms-length respect." There was further discussion concerning the extent to which the proposed short term metrics may suggest that the Commissioner does not trust the New Health System to satisfy the conditions set forth in the Order. Mr. Knox stated that the new health system has lots of talented people working for it, but also explained that 70 percent of all mergers fail and 70 percent of all planned strategies never actually get implemented. Consequently, he said that the "deck is stacked against" the new health system.

Short Term Item A

Mr. Eckstein made a motion to approve this item as a block as written with Mr. Knox seconding the motion. During discussion by the panel members, Mr. Eckstein amended his motion to change the wording for the first two sub-items to "New health system will update the Office of Licensure and Certification of the progress of the plan preparation at 90 days following closing" and "A draft of the plan will be submitted to the Office of Licensure and Certification 30 days before submission of the final plan." The last sub-item remains as proposed, "Submission of final draft plan to VDH Office of Licensure and Certification staff within 6 months of closing." Dr Oliver called for a vote by show of hands on the amended motion. The vote was 10 ayes and two nays. The motion was approved.

Short Term Item B

Mr. Knox made a motion to approve this item as a block as written with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed an amendment to make the wording similar for this item as for Item A above. The proposed amendment was agreed to. The first sub-item is now "New health system will update the Office of Licensure and Certification of the progress of the plan preparation at six months following closing." The second sub-item is now "A draft of the plan will be submitted to the Office of Licensure and Certification 60 days before submission of the final plan." The last sub-item remains the same as proposed, "Submission of final draft plan to VDH Office of Licensure and Certification staff within 12 months of closing." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was nine ayes and three nays. The motion was approved.

Item 1.2

After a brief break, Dr. Oliver proposed that the TAP may want to review other conditions that are worded in the same manner as Items A and B so that the panel could discuss making similar amendments to those items as was done in Items A and B. Mr. Eckstein made a motion to approve this item with amendments to sub-items 1 and 2 with Ms. Milder seconding the motion. Sub-item 1 now reads: "New health system will update the Office of Licensure and Certification of the progress of the plan preparation at six months following closing." Sub-item 2 now reads: "A draft of the plan will be submitted to the Office of Licensure and Certification 60 days before submission of the final plan." The last sub-item remains as proposed. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and four nays. The motion was approved.

Item 3.1

Mr. Knox made a motion to approve this item with Mr. Eckstein seconding the motion. During discussion by the panel members, it was decided to include 3.1.A, 3.1.B, and 3.1.C in the discussion and to amend the wording in a similar manner as were Items A and B. Mr. Eckstein proposed adding the words "a comprehensive access plan (see Performance Indicator 3.B)" between the words "Compile" and "and submit;" add the word "it" between the words "submit" and "to VDH Office of;" add the word "including" between the words "staff" and "baseline data;" and delete the words "to be included in comprehensive access plan (see Performance Indicator 3B)" between the words "access measures" and "for Southwest Virginia." In addition, Mr. Eckstein proposed replacing all of the wording in 3.1.A with the following: "New health system will update the Office of Licensure and Certification of the progress of the plan preparation at three months following closing." Finally, Mr. Eckstein proposed the following changes to 3.1.B: replace the words "Submit initial" with the word "A" at the start of the sentence; add the words "of the" between the words "draft" and "plan;" add the words "will be submitted" between the words "plan" and "to;" add the word "the" between the words "to" and "VDH Office;" add the words "30 days before submission of the final plan "after the words "Licensure and Certification;" and delete the words "staff within 4 months of closing for review and comment." Item 3.1.C remains as proposed. The proposed amendment was agreed to. Item 3.1 now reads:

> 3.1 -Compile a comprehensive access plan (see Performance Indicator 3,B) and submit it to VDH Office of Licensure and Certification staff including baseline data for all access measures for Southwest Virginia
> 3.1.A - New health system will update the Office of Licensure and Certification of the progress of the plan preparation at three months following closing
> 3.1.B - A draft of the plan will be submitted to the VDH Office of Licensure and Certification 30 days before submission of the final plan
> 3.1.C - Submit final draft plan to VDH Office of Licensure and Certification staff within 6 months of closing

Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes and four nays. The motion was approved.

Item 1.1

Mr. Knox made a motion to approve this item by replacing the existing wording in its entirety with the following: " Submit the most recent data from the Anthem Q-HIP to VDH Office of Licensure and Certification." Ms. Krutak seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 12 ayes and 0 nays. The motion was approved.

Item 1.3

Mr. Knox made a motion to approve this item with Ms. Milder seconding the motion. During discussion by the panel members, Mr. Eckstein proposed adding the words "and" between the

words "cost" and "quality;" adding the word "develop" between the words "and" and "experience;" add the word "measure" between the words "experience" and the words "for employee;" and adding the words "desirable within six months but required at 12 months" to the end of the sentence. The item now reads: "Compile and submit to VDH Office of Licensure and Certification staff baseline data on cost and quality and develop experience measure for employee and family population; desirable within six months but required at 12 months." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and one nay. The motion was approved.

Item 1.4

Mr. Knox made a motion to approve this item by adding the words "desirable within six months but required at 12 months" after the words "programs for employers." Mr. Eckstein seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and four nays. The motion was approved.

Item 1.5

Mr. Eckstein made a motion to approve this item by adding the words "desirable within six months but required at 12 months" after the words "programs for employers." Mr. Knox seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was eight ayes and four nays. The motion was approved.

Item 2.1

Mr. Dougan made a motion to approve this item by adding the words "desirable within six months but required at 12 months" after the words "peer counties." Mr. Eckstein seconded the motion. During discussion by the panel members, Mr. Eckstein proposed an amendment to add the words "as well as other counties in the Commonwealth, as available;" after the words "peer counties" and before the words added by Mr. Dougan "desirable within six months." The proposed amendment was agreed to. The item now reads: "Compile and submit to VDH Office of Licensure and Certification staff baseline data for all population health metrics for Southwest Virginia and for socioeconomic peer counties as well as other counties in the Commonwealth, as available; desirable within six months but required at 12 months." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 12 ayes and 0 nays. The motion was approved.

Item 3.2

Mr. Eckstein made a motion to approve this item by adding the words "desirable at six months but required at 12 months" as the last sentence of the item. Ms. Milder seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 12 ayes and 0 nays. The motion was approved.

Item 4.1

Mr. Eckstein made a motion to approve this item by adding the words "desirable at six months but required at 12 months" after the words "providers in Southwest Virginia." Mr. Knox

seconded the motion. During discussion by the panel members, this wording was changed to "as part of the needs assessment and recruitment plan (Indicator 4.A)." The proposed amendment was agreed to. The item now reads: "Compile and submit to VDH Office of Licensure and Certification staff baseline data concerning health care providers in Southwest Virginia as part of the needs assessment and recruitment plan (indicator 4.A)." Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and 0 nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 5.1

Mr. Eckstein made a motion to approve this item with Mr. Knox seconding the motion. During discussion by the panel members, an amendment was proposed to add the words "; upon closing, the quarter prior and the next quarter, as available" after the words "financial metrics." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and 0 nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 5.A.1

Mr. Eckstein made a motion to add the following language: "Compile and submit to VDH Office of Licensure and Certification staff financial projection data within 120 days after closing," which would constituent Item 5.A.1. Ms. Krutak seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 11 ayes and 0 nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 5.2

Mr. Knox made a motion to approve this item with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed adding the words "desirable at closing but required at 12 months" after the words "quality and service metrics." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was 11 ayes and 0 nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 6.1

Mr. Eckstein made a motion to approve this item with Mr. Knox seconding the motion. During discussion by the panel members, Ms. Krutak proposed adding the word "initial" between the words "data on" and "Board engagement" as well as adding the words "survey within 18 months of closing" after the words "Board engagement." The item now reads: "Compile and submit to VDH Office of Licensure and Certification staff baseline data on initial Board engagement survey within 18 months of closing." The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was eight ayes and three nays (Ms. Milder was no longer at the meeting). The motion was approved.

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Item 6.2

Mr. Knox made a motion to approve this item with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed adding the words ‘at six and 12 months after the date of closing” after the words “on employee turnover.” The proposed amendment was agreed to. Dr. Oliver called for a vote by show of hands on the amended motion. The vote was seven ayes and four nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 7.1

Mr. Knox made a motion to approve this item with Mr. Eckstein seconding the motion. During discussion by the panel members, Mr. Eckstein proposed replacing the word “on” with the words “as part of the” between the words “baseline data” and “investment in the research” and adding the words “plan (Indicator 7.A)” after the words “Virginia service area.” The proposed amendment was agreed to. The item now reads: “Compile and submit to VDH Office of Licensure and Certification staff baseline data as part of the investment in the research enterprise in the Virginia service area plan (indicator 7.A).” Dr. Oliver called for a vote by show of hands on the amended motion. The vote was seven ayes and four nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 8.1

Mr. Eckstein made a motion to approve this item with Mr. Knox seconding the motion. During discussion by the panel members, Mr. Knox proposed replacing the words “dollars to be allocated to Southwest Virginia with specific goals defined” with the words “goals of spending in southwest Virginia; desirable at six months but required at 12 months” after the words “spending plan including.” The proposed amendment was agreed to. The item now reads: “Complete and submit to VDH Office of Licensure and Certification staff the short and long term monetary spending plan including goals of spending in southwest Virginia.” Dr. Oliver called for a vote by show of hands on the amended motion. The vote was nine ayes and two nays (Ms. Milder was no longer at the meeting). The motion was approved.

Item 8.2

Mr. Eckstein made a motion to approve this item by adding the words “desirable at six months but required at 12 months” after the words “Licensure and Certification staff.” Mr. Knox seconded the motion. Dr. Oliver called for a vote by show of hands on the motion. The vote was 11 ayes and 0 nays (Ms. Milder was no longer at the meeting). The motion was approved.

Public Comment

There were no comments from any member of the public.

Next Steps

After a brief break for the TAP members to pick up their lunches, Dr. Oliver told the panel members that the work on the short-term milestones and long-term indicators was completed. The regulations require that the TAP provide recommendations to the Commissioner and the

report that the TAP will submit to the Commissioner will consist of the approved short-term milestones and long-term indicators as well as the final minutes from the November 14, 2017 and December 4 and 5, 2017 meetings and the draft minutes from today's meeting, December 14, 2017. Dr. Oliver also told the panel that it was clear from the votes during the discussions of the short-term milestones and long-term indicators that there was no clear consensus on those items. Dr. Oliver recommended that panel members who feel strongly about recommendations that should not should not be considered share those concerns on an individual basis with the Commissioner. He further stated that the regulations indicate that the Commissioner has the final authority on active supervision of the cooperative agreement. Dr. Oliver further stated that the Southwest Virginia Health Authority would be submitting recommendations to the Commissioner regarding active supervision of the cooperative agreement.

There was a brief discussion on a timeline for the submission of recommendations to the Commissioner; that the final report of the panel would be sent to all TAP members as well as posting it online; the process by which the Commissioner would share her decision with the new health system; and future meetings of the TAP.

Adjourn

The meeting adjourned at approximately 12:04 p.m.

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