COMMONWEALTH of VIRGINIA

Department of Health

M. NORMAN OLIVER, MD, MA
STATE HEALTH COMMISSIONER

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

February 7, 2020

Mr. Alan Levine
Executive Chairman,
President and CEO
Ballad Health
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Dear Mr. Levine:

Pursuant to 12VAC5-221-100, the attached report includes revised performance metrics and quarterly reporting templates that Ballad Health will utilize when submitting and reporting data to the Virginia Department of Health (VDH), beginning July 1, 2020.

Over the past several months, in partnership with the Tennessee Department of Health, Ballad Health leadership, and other agency stakeholders, VDH's Active Supervision team thoroughly and thoughtfully evaluated the existing Cooperative Agreement measurement framework. In November 2019, VDH's Active Supervision team proposed a set of revised metrics and quarterly reporting templates to Virginia's Technical Advisory Panel of the Cooperative Agreement (TAP). The revised metrics, which were approved by the TAP, as well as additional metrics and recommendations developed by VDH staff following the TAP meeting in November, are included in the attached report.

The revised metrics, reporting templates, and measurement framework will provide VDH with a clearer picture of the *quantifiable* outcomes and long-term impacts of the Cooperative Agreement. VDH's Active Supervision team is looking forward to continued collaboration with Ballad Health and welcomes further discussion pertaining to the attached metrics, reporting templates, and measurement framework.

Respectfully,

M. Norman Oliver, MD, MA
State Health Commissioner
Virginia Department of Health

Ballad Health Cooperative Agreement

Technical Advisory Panel (TAP) Report and Staff Recommendations

February 7, 2020

Background

Pursuant to Virginia Code § 15.2-5384.1(G), the cooperative agreement (CA) is entrusted to the State Health Commissioner (Commissioner) for active and continuing supervision to ensure compliance with Virginia Code § 15.2-5384.1, Virginia's Regulations Governing Cooperative Agreements (12VAC5-221), and the Virginia Order and Letter Authorizing a Cooperative Agreement (Virginia Order). Virginia's Regulations Governing Cooperative Agreements also require the Commissioner to appoint a Technical Advisory Panel (TAP) to provide:

- initial recommendations to the Commissioner as to the quality, cost, and access measures and benchmarks to be considered to objectively track the benefits and disadvantages of a cooperative agreement and
- ongoing input to the Commissioner on the evolution of these and other new measures and the progress of the parties with respect to the achievement of commitments with respect to these measures.

The TAP's initial report to the Commissioner and recommended expectations, measures, and performance indicators for Ballad Health (Ballad) are included in **Attachment 1** to this report. The existing measures and performance indicators that Ballad is required to report to the Commissioner are included in **Attachment 2** of this report.

Pursuant to the Conditions of the Virginia Order, in addition to various operational, quality, cost, and access measures, Ballad is required to submit, for the Commissioner's review and approval, the following three-year plans:

- Regional Health Information Exchange (HIE)
  - Minimum spending requirement for the first ten fiscal years (beginning July 1, 2018):
    - Eight million dollars
- Health Research and Graduate Medical Education (HR/GME)
  - Minimum spending requirement for the first ten fiscal years (beginning July 1, 2018):
    - Eighty-five million dollars
- Rural Health Services
  - Minimum spending requirement for the first ten fiscal years (beginning July 1, 2018):
    - Twenty-eight million dollars
- Behavioral Health Services
  - Minimum spending requirement for the first ten fiscal years (beginning July 1, 2018):
    - Eighty-five million dollars
- Children's Health Services
  - Minimum spending requirement for the first ten fiscal years (beginning July 1, 2018):
    - Twenty-seven million dollars
- Population Health
  - Minimum spending requirement for the first ten fiscal years (beginning July 1, 2018):
    - Seventy-five million dollars

Each of Ballad's plans contain strategies and activities aimed at improving the health and well-being of the population Ballad serves. The Virginia Department of Health (VDH) and the Tennessee Department of Health (TDH) have developed and refined an Active Supervision Framework to track Ballad's progress developing and implementing its plans and to measure the effectiveness of Ballad's plans. As Ballad's plans have become more refined, so too has the need to develop additional "line of sight" measures that link Ballad's strategies, activities, and outputs to the desired long-term outcome measures and population health impacts.

At their meeting in April of 2019, the TAP recommended that a Metrics Workgroup, comprised of individuals from Ballad, TDH, and VDH convene to ensure that the process, outcome, quality, access, and impact metrics Ballad is required to report accurately measure Ballad's progress in the region.

Beginning in July of 2019, the Metrics Workgroup convened in-person monthly and held weekly conference calls to evaluate and refine the existing active supervision metrics and measurement framework. This report includes quarterly (including quality), access, and population health measures as well as a reporting timeline and quarterly update template that the TAP voted to recommend adopting at their meeting in November of 2019. The metrics, templates, and timelines are a composite of recommendations voted on by the TAP in November and further metrics discussions between Ballad, TDH, and VDH. All recommendations voted on by the TAP can be viewed in **Attachment 3**.

Should the Commissioner approve the following recommendations and notify Ballad of the revised metrics and measurement framework in writing, Ballad will begin utilizing the quarterly meeting update templates submitted in this recommendation beginning the first quarter of Fiscal Year 2021, though it is recommended that Ballad begin incorporating the templates in the remaining Fiscal Year 2020 quarterly meetings. Further, VDH will begin working with Ballad to develop a template for Ballad's Quarterly Reports to be utilized in the first quarter of Fiscal Year 2021 and a template for Ballad's Annual Report to be utilized in Ballad's Fiscal Year 2020 Annual Report. Ballad will submit all data reports in PDF and Excel format. Ballad will also submit raw data, with all calculations removed, in Excel format.

Annual Performance Review and Data Submission Timeline

To facilitate VDH's ongoing and active supervision of the CA, the TAP recommends the following Annual Performance Review and Data Submission Timeline:

Proposed Annual Performance Review and Data Submission Timeline

January 2020

Dedicated to the 3-year plans; review prior six-month performance (metrics and milestones); sufficient time to understand and share challenges barriers concerns and share discuss solutions and activities for next 6 months; brief update on system activities

April 2020

With one quarter remaining in FY, focus on system performance with brief overview of status of plans (focusing on areas not on track)

July 2020

Dedicated to the 3-year plans; review final plan performance on the plans for FY20 (% of unmet milestones, status of metrics); review implementation roadmaps for FY21 (new milestones and metrics); brief update on system activities

October 2020 Meeting

- **Quarterly Check In: Johnson City**
- FY 2020 Q4 Quarterly Report Q&A
- Ballad will provide an in-depth system update, with a focus on FY 2020 performance
- Annual Report preview
- Ballad will provide an update on three improvement quality metrics
- Update on plan implementation barriers
- **States to attend Ballad Health Board Meeting**

January 2021 Meeting

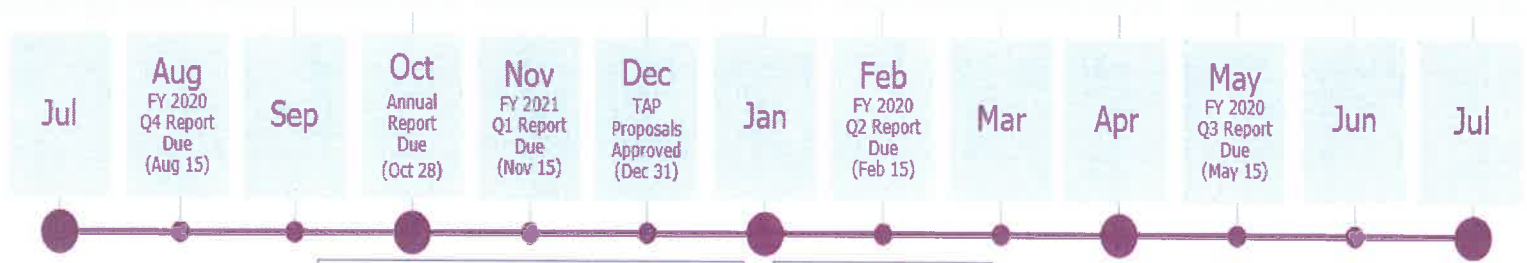
- **Quarterly Check In: Nashville**
- FY 2021 Q1 Quarterly Report Q&A
- Annual Report Q&A
- Updates on Ballad's three improvement quality metrics
- Ballad will provide in-depth update on the plans, including review of 6-month performance (metrics, milestones, successes, and A3s for problem areas and barriers)
- Ballad will provide brief system performance updates

April 2021 Meeting

- **Quarterly Check In: Johnson City**
- FY 2021 Q2 Quarterly Report Q&A
- Ballad will provide an in-depth system performance update for Q1-Q3
- Ballad will provide an update on three improvement quarterly metrics
- Update on plan implementation barriers
- **States to attend Ballad Health Board Meeting**

July 2021 Meeting

- **Quarterly Check In: Richmond**
- FY 2021 Q3 Quarterly Report Q&A
- Updates on Ballad's three improvement quality metrics
- Ballad will provide in-depth update on the plans, including review of Final FY21 performance (metrics, milestones, successes, and A3s for problem areas and barriers) as well as review of FY22 implementation roadmaps
- Ballad will provide brief system performance updates



Technical Advisory Panel Meeting (November)
- Review Ballad's proposed quality improvement metrics
- Discuss retired metrics
- Discuss modifications to Peer Hospital Group
- Discuss revisions to the existing measurement framework
- Discuss revisions to the existing active supervision metrics

States' Determination of Public Advantage (February)

Quarterly Reporting Metrics and Updates

Pursuant to Condition 12 of the Virginia Order, Ballad is required to submit monthly quality reports at the individual facility level as well as the system level. At their meeting in April of 2019, the TAP noted that monthly reporting of these quality measures generated a significant amount of "noise." The TAP recommended that the Commissioner reduce the reporting frequency of these measures from monthly to quarterly. VDH staff recommend that Condition 12 be modified to reduce the reporting frequency of quality measures from monthly to quarterly.

If the Commissioner reduces the reporting frequency of the quality metrics from monthly to quarterly, the following categories of measures will be reported on a quarterly basis:

- Rural Quality-Inpatient Monitoring Metrics
- Rural Quality-Outpatient Patient Satisfaction Monitoring Metrics
    - VDH will not publish measures that do not achieve sufficient sample size and/or statistical significance.
    - Ballad will continue to explore opportunities to further capture patient quality and patient experience data, such as patient focus groups, texting surveys, etc.
- Quality-Patient Safety Priority Metrics
- Quality-Mortality and Readmission Monitoring Metrics
- Quality-Patient Satisfaction Monitoring Metrics
    - VDH will not publish measures that do not achieve sufficient sample size and/or statistical significance.
    - Ballad will continue to explore opportunities to increase survey response rates and capture patient quality and patient experience data, such as patient focus groups, texting surveys, etc.
- Quality-Timely and Effective Care Monitoring Metrics
- Cooperative Agreement Financial and Operational Updates

Should quality reporting be modified from monthly to quarterly, quality data will be submitted to VDH within 45 days of the end of the fiscal quarter. VDH will be given the opportunity to provide feedback and ask questions pertaining to quarterly reports at the quarterly in-person check in meetings and as needed. Quality data will be publicly displayed at the system level, by state, and by facility or facility group as proposed. VDH will spend early 2020 working with Ballad to develop Quarterly Report templates.

Quality data will be presented to VDH, by data stratification level, quarterly using control charts containing:

- Quarterly plotting of the metric values
- Baseline reference lines for FY2017 with data continuing from baseline to present.
- Control lines & measurements
- Indications of the median, 25th, 75th, and 90th percentile of the metric among peer hospital systems
    - Peer hospital systems will be selected utilizing the following criteria:
        - Not-for-profit health system
        - Comparable net revenue
        - Aligned with Premier as quality partner
        - Comparable bed size and number of hospitals
        - Consists of rural hospitals and similar services
        - Geographic location that could allow for a site visit
        - Utilizes EPIC Electronic Health Records
    - The current peer hospital group is comprised of the following health systems:
        - Aurora Health

        - Baptist Memorial Health Care Corporation
        - Carilion Clinic
        - Mercury Health
        - Texas Health
        - Unity Point Health
    - VDH and/or Ballad may propose revisions to the peer hospital group annually

If a "special-cause event" occurs, Ballad will notify VDH within 30 days and propose a mitigation strategy should one be necessary. A "special-cause event" is defined as:

- One data point that is more than three standard deviations from the center line of the control chart;
- Two out of three data points that are more than two standard deviations from the center line on the same side of the control chart; or
- Four out of five data points that are more than one standard deviation from the center line on the same side of the control chart.

Ballad will notify VDH, within six months of being informed by their data vendor, should any measure monitored by said data vendor be retired and convene a workgroup meeting by November 1 to determine which measure(s) should replace retired measure(s). Further, Ballad will notify VDH of any plans to change data vendors.

A more detailed overview of each metric, including definitions, sources, format, baseline year, and other information are included in **Attachment 5**.

Quality data will be reported publicly at the system level and at the state level.

Rural Quality-Inpatient Monitoring Metrics

Metric	Data Source	Data Stratification
CDC-NHSN Annual Survey (Antibiotic Stewardship)	CDC-NHSN Annual Survey	
Care Transition: Patient reported they understood the purpose for taking their medication	Press Ganey (Ballad will notify VDH if vendor changes occur)	System Level By State By Facility
Care Transition/Patient Preference: Hospital Staff took my preferences and those of my family		
Care Transition/Patient Preference: Patients reported-Quietness of the hospital environment		
Falls with Injury: All documented patient falls with an injury level of moderate or greater on eligible unit types in a calendar quarter. (Total number of injury falls / Patient days) X 1000	Ballad Risk Management Software	

Rural Quality-Outpatient Patient Satisfaction Monitoring Metrics

Metric	Data Source	Data Stratification
CG-CAHPS: In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Press Ganey (Ballad will notify VDH if vendor changes occur)	System Level By State By Facility
CG-CAHPS: In the last 6 months, how often did this provider listen carefully to you?		
CG-CAHPS: In the last 6 months, how often did this provider explain things in a way that was easy to understand?		
CG-CAHPS: Overall Provider Rating- On a scale from 1-10, with 10 being the highest likely, how likely would you refer your provider		

Quality-Patient Safety Priority Metrics

Metric	Data Source	Data Stratification
Pressure Ulcer Rate	Premier (Ballad will notify VDH if vendor change occurs)	System Level By State By Facility
Iatrogenic Pneumothorax 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		
Sep 1 – Sepsis Bundle		
CLABSI		
CAUTI		
SSI COLON Surgical Site Infection		
SSI HYST Surgical Site Infection		
MRSA		
CDIFF		

Quality-Mortality and Readmission Monitoring Metrics

Metric	Data Source	Data Stratification
Readmission Rates for Top 10 Causes of Readmission (Ballad to Establish Top 10 and Baseline from FY 2017) Mortality Rates for Top 10 Causes of Mortality (Ballad to Establish Top 10 and Baseline from FY 2017)	Premier (Ballad will notify VDH if vendor changes occur)	System Level By State By Facility

Quality-Patient Satisfaction Monitoring Metrics

Metric	Data Source	Data Stratification
HCOMP1A P Patients who reported that their nurses "Always" communicated well HCOMP2A P Patients who reported that their doctors "Always" communicated well HCLEAN HSPAP Patients who reported that their room and bathroom were "Always" clean HCOMP7SA Patients who "Strongly Agree" they understood their care when they left the hospital HRECMND DY Patients who reported "YES", they would definitely recommend the hospital	Premier (Ballad will notify VDH if vendor changes occur)	System Level By State By Facility

Quality-Timely and Effective Care Monitoring Metrics

Metric	Data Source	Data Stratification
ED-1b Average time patients spent in ED before they were admitted to the hospital as an inpatient ED-2b Average time patients spent in the ED after the doctor decided to admit them before leaving the ED for their inpatient room OP-18b Average time patients spent in the ED before leaving from the visit OP-22 Percentage of patients who left the ED before being seen OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival	Premier (Ballad will notify VDH if vendor change occurs)	System Level By State By Facility

Cooperative Agreement Financial and Operational Updates

CA Attachments to be Submitted Quarterly	
Deliverables Table with Item, Status (date submitted), and Applicable TOC/CA Requirements	Post-Acute Services Offered by Competitors
Any revisions to Ballad's Charity Care Policy Pursuant to TOC:4.03(e) /CA: 14 and 38	Any requirements or commitments outlined in the TOC or the Index which Ballad will not meet or anticipates it will not meet
Population Health and Social Responsibility Committee Meeting Summary (includes attendance) Pursuant to TOC:4.03(e), Exhibit G/ CA:35	Compliance Officer Quarterly Report
Balance Sheet	Status of any outstanding Cues, Corrective Actions, or other remedial actions - TOC: Exhibit G/ CA:16
Statements of Income	Facility/Service Line Closure Plans
Statement of Cash Flow	Facility/ Service Line Closure Progress
Year-to-date internal spending report	Facility/ Service Line Opening Plans
Grants Distributed	Facility/Service Line Opening Progress
Ancillary Services Offered by Competitors	

Quality Improvement Metrics

In November of every year, Ballad will propose three Quality-Patient Safety Priority Metrics for targeted Quality Improvement (QI) initiatives should such measure perform at below the 25th percentile of the national average and have a great impact on patient safety, presenting the following:

- Logic: Why was the metric selected?
- Measurement: How is the metric measured?
- Historical Data
- Metric history, if proposed metric is outside of monitoring metrics
- Improvement Strategies: What are Ballad's planned interventions and actions for improvement?
- Goals: What are Ballad's implementation and improvement goals in the coming year?
- Note: Quality Improvement Metrics may be metrics that are included in the proposed monitoring metrics list or in addition to the following proposed monitoring metrics.

Every quarter, Ballad will provide an update on their three QI Metrics with an overview of to date quality improvement activities to improve performance on each metric, implementation barriers, and next steps for quality improvement if performance targets are not met.

Quarterly Update Meeting Reporting Templates

Overview

To facilitate meaningful discussion during quarterly check in meetings between Ballad, TDH, and VDH, templates for each quarterly meeting have been prepared for consideration containing the following elements:

- Quarterly Report Q&A
- Annual Report Q&A, when applicable
- Quality Improvement Metrics Update
- Plan Implementation Barriers Updates
- In-Depth Plan Implementation Update
- Ballad System Updates
- Annual Report Preview, when applicable

The proposed update meeting reporting template slides are attached.

Annual Reporting Metrics and Updates

Overview

In addition to Ballad's quarterly reporting requirements, Ballad must also submit an annual report to VDH. Ballad's Annual Report will include data and narratives to provide updates on the following:

- Population Health Plan/STRONG Families and Children Plan Implementation Metrics
- Behavioral Health Plan Metrics
- Children's Health Plan Metrics
- Rural Health Plan Metrics
- Health Information Exchange Plan Metrics
- Health Research & Graduate Medical Education Metrics
- Access Metrics
- Fiscal Year Quality Metrics
- Additional CA Commitment Metrics
- CA Financial, Operational, and Plan Implementation Updates

Annual reporting metrics are to be submitted to VDH by October 28 throughout the Active Supervision period. VDH will be given the opportunity to provide feedback and ask questions pertaining to Ballad's Annual Report at the January in-person check in meetings. VDH will spend early 2020 working with Ballad to develop an Annual Report template.

A more detailed overview of each metric, including definitions, sources, format, baseline year, and other information are included in attachments accompanying this document.

Population Health Improvement Plan

Ballad's Population Health Improvement Plan to Increase STRONG Starts for Children and Families includes the following strategies and associated performance metrics:

- Increase Birth Outcomes and STRONG Starts
- Increase Educational Readiness and Performance
- Increase healthy behaviors in children, youth, and their support systems to improve health and strengthen economic vitality
- Change social norms to support parents, families, and the community
    - Develop population health infrastructure within the health system and community
    - Position Ballad as a community health improvement organization
    - Enable community resources and sound health policy
    - Increase community understanding and response to at-risk children and families

The Population Health Improvement metrics are proposed to be stratified in three categories:

- Plan Implementation/Output Metrics
    - Measures that demonstrate that Ballad is executing their Population Health Improvement Plan.
- Outcome Metrics
    - Measures that reflect short to mid-term population health improvements (3-10 years) based on the execution of Ballad's Population Health Improvement Plan.
- Impact Metrics
    - Measures that reflect long-term population health improvement (11+ years) based on the execution of Ballad's Population Health Improvement Plan.
    - Impact metrics will be measured and evaluated as a focal point of Ballad's Longitudinal Study with Eastern Tennessee State University (ETSU) and other research partners.

To monitor and evaluate the implementation of Ballad's Population Health Improvement Plan, Ballad will submit, where applicable, denominators for each output metric. Additionally, in conjunction with the 2020 Annual Report, Ballad will develop a plan for collaborating with the Southwest Virginia Accountable Care Community to identify denominators for output metrics and to explore data collection opportunities.

Population Health Improvement Output Metrics

Strategy	Activity	Metric	Data Source
Increase Birth Outcomes and STRONG Starts	Increase contraceptive access to all women of child bearing age	Number of partners who provide contraceptives	Ballad, Southwest Virginia and Northeast Tennessee Accountable Care Communities
	Enhance provider and facility practices to support breastfeeding	Number of Value-Based Contracts (VBCs) that include breastfeeding initiation	
	Increase maternal cessation programs	Number of partners who provide maternal cessation	
	Increase lactation support programs	Number of women in Ballad L&D that receive lactation consultation	
	Increase VLARC provision with at-risk populations (incarcerated, addicted)	Number of partner sites providing VLARC to at-risk populations	

	Increase provider practices using best practice cessation counseling and referral	Number of providers receiving education/CME on best practice cessation counseling and referral	
	Increase VLARC adoption at facilities immediately following NAS birth	Number of sites providing VLARC immediately following NAS birth	
	Expand maternal MAT and other recovery programs	Number of maternal MAT/best practice maternal recovery sites	
	Increase access to contraceptives for teens	Number of partner sites providing contraceptives to teens	
	Expand best practice parent programming for healthy relationships/safe sex	Number of sites providing parenting education	
	Leverage the 2 day postpartum pediatric visit to include maternal assessment	Number of providers trained to conduct maternal assessment	
	Expand provider education on maternal mental health assessment	Number of maternal mental health education sessions	
Increase Birth Outcomes and STRONG Starts	Ensure provider best practices on safe sleep education for patients	Number of safe sleep best practice provider communication/maternal and infant health communication sessions	Ballad, Southwest Virginia and Northeast Tennessee Accountable Care Communities
	Increase prenatal programs/supports across facilities	Number of prenatal programs/supports provided by behavioral health facilities	
	Increase VLARC provision in Labor and Delivery and first Postpartum environment	Number of sites providing VLARC in L&D setting and first post-partum	
Increase Educational Readiness & Performance	Increase high quality childcare access	Number of childcare partners	
	Increase parenting education on early childhood success	Number of sites providing parenting education	
	Train and support childcare providers in best practice early childhood	Number of childcare partners	
	Increase availability of reading mentors for children at-risk of not at grade level reading	Number of sites who provide reading mentorship	
	Enhance early literacy programming across	Number of partners providing	

	sectors (community, clinical, etc.)	early literacy programming	
	Support parents' ability to serve as literacy mentors	Number of sites providing parent literacy programs	
	Expand mentoring opportunities for all ages	Number of sites providing mentoring	
Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality	Expand best practice recovery sites and programming	Number of partners providing best practice recovery and programming	
	Expand Narcan use	Number of partner sites providing/promoting Narcan	
	Increase certified peer recovery specialist workforce and training programs	Number of internal certified peer recovery specialists and with partner sites	
	Increase best practice adult cessation programs	Number of partner sites providing adult cessation programs	
Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality	Increase provider practices using best practice cessation counseling and referral	Number of providers coding counseling and referral to cessation internally	Ballad, Southwest Virginia and Northeast Tennessee Accountable Care Communities
	Subsidize NRT and cessation medications	Number of partner sites providing NRT and subsidized medications	
	Expand family nutrition counseling and education across sectors (business, education, healthcare, CBO/FBOs)	Number of partner sites providing nutrition programming to families	
	Increase best practice nutrition programming in schools, after-school programs, and other child service community-based organizations	Number of partner sites/schools providing best practice nutrition programming	
	Expand physical activity programs in schools, after-school programs and other child service community-based organizations	Number of partner sites/schools providing physical activity programming	
Change Social Norms to Support Parents, Families, and the Community	Delivery System Design	Number of lives covered under VBC/CIN/HQEP	
	Create supportive environment-Expand the Business Health Collaborative	Number of businesses participating in the Business Health Collaborative	
	Information System and Decision Support	Number of Community Based Organizations on EPIC	
	Support the regional Accountable Care Community (ACC)	Number of community partners with signed contracts to be ACC	

		members	
	Self-management/develop personal skills	Number of team member support programs	
		Number of B-well initiatives	
	Support the Population Health Clinical Steering Committee	Number of providers in committee	
	Educational campaigns to promote the prevention of early initiation of sex and substance use, prenatal care in 1st trimester, breastfeeding benefits, safe sleep, maternal support, stigma reduction, social justice, community empowerment, early literacy, mentoring, substance use prevention, vaping, program availability and community programming	Number of educational campaigns developed and implemented	
Change Social Norms to Support Parents, Families, and the Community	Implement Project COMPASSion	Number of provider sites enrolled	Ballad, Southwest Virginia and Northeast Tennessee Accountable Care Communities
	Implement Family Resource hub and spoke model	Launch pilot	
	Increase ACEs and social risk assessments across sectors	Number of partners providing ACEs and/or social risk assessments	
	Strengthen Community Action	Number of RFP pilot sites	
	Strengthen Community Action-Creation of Trauma Informed/Resilient Communities and Sites	Number of trauma aware trainings provided	
	Build healthy public policy-second chance programs, food environment in schools, physical activity in schools, telehealth, barrier crimes, community paramedicine, etc.	Number of legislators/government officials engaged	
	Advocate for breastfeeding friendly facilities	Number of breastfeeding friendly businesses and employers	
	Support the Implementation of Community Paramedicine	Number of EMS Agencies Providing Community Paramedicine	

Population Health Improvement Outcome Metrics

Metric	Data Source	First Year of Public Display
Maternity Practices in Infant Nutrition and Care Survey Scores	Center for Disease Control (CDC)	2021
Breastfeeding Initiation	Vital Statistics	2022
Mothers Who Smoke During Pregnancy	Vital Statistics	2022
Neonatal Abstinence Syndrome Births	Inpatient Discharge Data	2023
Overweight and Obese Children	Virginia Youth Survey, TBD for TN	2024
Kindergarten Readiness	PALS Testing Scores, TBD for TN	2024
Third Grade Reading Levels	PALS Testing Scores, TBD for TN	2025
8th Grade Math and English	TBD	2025
Teen Births	Vital Statistics	2026
Drug Deaths	Vital Statistics	2026
Youth Tobacco	Virginia Youth Survey, TBD for TN	2027
Prenatal Care	Vital Statistics	2027

Population Health Impact Metrics

Metric	Data Source
High School Graduation	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study. Other Virginia academic institutions are to be included in the planning process.
Substance Abuse	
Adult Obesity	
Infant Mortality	
Adult Smoking	
Suicide	
Employment	
Children in Poverty	
Per Capita Income	
Median Household Income	
Leading Causes of Death and Disease	
Adverse Childhood Experiences (ACEs) Metrics (TBD)	
Homelessness	

Behavioral Health Services Plan

Ballad's Behavioral Health Plan to increase access to quality behavioral health services includes the following strategies and associated performance metrics:

- Develop Necessary Ballad Behavioral Health Services Infrastructure
- Achieve a high level of integration of Behavioral Health services into primary care (PCBHI)
- Expand Telebehavioral Health Options
- Supplement Existing Regional Crisis System
- Enhance and Expand Resources for Addiction Treatment

Behavioral Health Services Metrics

Strategy	Activity	Metric	Data Stratification
Develop Necessary Ballad Behavioral Health Services Infrastructure	Hire CMO, project manager, clinical data analyst and evaluate the other roles needed for the division	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
Achieve a high level of integration of Behavioral Health services into primary care (PCBHI)	Hire the BHCNs (Behavioral Health Care Navigators) to get a set of four that will work in regional PODS	Number of lives touched by a Behavioral Health Care Navigator	By State By Zip Code of Residence By Payer Type
	Place Counseling Services in Outpatient Clinics	Number of sites with counseling services	By State By County
		Number of unique patients who were counseled in a Primary Care Setting	By State By Facility
		Number of referrals from a Ballad BCBHI model to a behavioral health specialist	By State By Facility
		Ballad PCBHI Programs	By State By County
Expand Telebehavioral Health Options	Installation of comprehensive telehealth equipment at all Ballad EDs	Number of Patients receiving telebehavioral health services from a Ballad Emergency Department	By State By Facility By Specialty
		Number of Ballad Emergency Departments providing telebehavioral health services	By State

	Expand access to telebehavioral health services across the region	Number of telebehavioral health visits	By State By Zip Code of Residence By Payer Type By Adult Visits By Pediatric Visits
		Number of telebehavioral health patients	By State By Zip Code of Residence By Payer Type By Adult Visits By Pediatric Visits
		Number of Ballad access sites for telebehavioral health	By State By County
	Evaluate opportunities to leverage existing telemedicine services within select school systems to provide behavioral health counseling services	Number of schools offering telebehavioral health	By State By County
		Number of children treated through school-based telebehavioral health	By State By County
Supplement Existing Regional Crisis System	Provide QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention	Number of clinicians receiving QPR training	By State
	Provide REACH Patient Centered Mental Health In Pediatric Primary Care training to clinicians	Number of clinicians receiving REACH training	By State
	Expand crisis transportation services	Number of behavioral health transports	By State By County
		Number of Ballad hospitals where Respond has been implemented	By State
Enhance and Expand Resources for Addiction Treatment	Education of Ballad clinicians in MAT	Number of providers educated in MAT	By State By County
	Expansion of MAT services in Primary Care	Number of patients who have received MAT services from a Ballad provider	By State By Zip Code of Residence By Payer Type By Facility
		Number of Ballad Primary Care clinicians providing MAT services	By State By County
	Expansion of Peer Recovery Specialist	Number of facilities with	By State

	services	access to Peer Recovery Services	By County
		Number of Ballad primary care practices in Virginia with Preferred OBOT Designation	By State By County
		Number of patients receiving treatment from Preferred OBOT Ballad Providers	By State By County
		Plan Spending	By Strategy

Children's Health Services Plan

Ballad's Children's Health Plan to increase access to quality children's health services includes the following strategies and associated performance metrics:

- Develop Necessary Ballad Children's Health Services Infrastructure
- Establish ED Capabilities and Pediatric Specialty Centers in Kingsport and Bristol
- Develop Telemedicine and Rotating Specialty Clinics in Rural Hospitals
- Recruit and Retain Subspecialists
- Develop CRPC Designation at Niswonger Children's Hospital Recruitment of physician specialists to meet rural access needs

Children's Health Services Metrics

Strategy	Activity	Metric	Data Stratification
Develop Necessary Ballad Children's Health Services Infrastructure	Hire CMO, project manager, clinical data analyst	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
	Establish Pediatric Advisory Council with Ballad and non-Ballad pediatricians to establish clinical protocols for inpatient, emergency department, urgent care and outpatient initiatives.	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
Establish ED Capabilities and Pediatric Specialty Centers in Kingsport and Bristol	Complete necessary renovations to one of Ballad's Kingsport hospitals and to Bristol Regional Medical Center in order to better accommodate pediatric patients and their families.	Number of Pediatric Emergency Department Visits	By Facility By Zip Code of Residence By Payer Type
	Expand dedicated emergency medicine provider coverage for pediatrics to ensure 24/7 coverage.		
	Implement operational changes including the development of a dedicated pediatric triage line, urgent care triage protocols, and transfer protocols to Niswonger ED.		
Develop Telemedicine	Installation of comprehensive telehealth equipment	Number of pediatric	By Zip Code of

and Rotating Specialty Clinics In Rural Hospitals	at all Ballad EDs (see Rural Health Plan). This will allow connectivity to Niswonger Children's Hospital from all Ballad Hospital EDs. Expand pediatric access to telehealth services for those in the service area unable to travel to a Niswonger pediatric specialty location. Such access will be provided through locations established at rural hospitals and Ballad Medical Associates locations.	telehealth visits by location and type	Residence By Payer Type By Location By Specialty Type
Recruit and Retain Subspecialists	Recruit or partner for access to pediatric subspecialists (11.5 FTEs)	Number and type of pediatric subspecialists accessible to the system	
		Plan Spending	By Strategy

Rural Health Services Plan

Ballad's Rural Health Plan to increase access to quality primary and specialty care includes the following strategies and associated performance metrics:

- Expand access to primary care practices through additions of primary care physicians and mid-level providers to practices in counties of greatest need.
- Recruitment of physician specialists to meet rural access needs
- Implement team-based care models to support primary care providers, beginning with pilots in high need counties
- Develop and deploy virtual care services
- Coordinate preventative health care services

Rural Health Services Metrics

Strategy	Activity	Metric	Data Stratification
Expand access to Primary Care practices through additions of Primary Care physicians and mid-levels to practices in counties of greatest need		Number of patients treated by additional Primary Care providers	By State By Zip Code of Residence By Payer Type
Recruitment of physician specialists to meet rural access needs		Number of patients treated by additional specialists	By State By Zip Code of Residence By Payer Type By Specialty
Implement team-based care models to support Primary Care Providers, beginning with pilots in high need	Evaluate and determine appropriate team-based model for rural populations and implement one pilot each year, beginning in 2019	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	

counties	Recruit positions to support regional programs - outlining a schedule of rotation for the teams. Teams to include: o Care Coordinator o Community Health Worker o Health Coach o Pharmacist		
Develop and deploy virtual care services	Create a centralized virtual health team (leadership and support staff) that is resourced to support deployment of virtual health strategies and assess gaps. Deploy and/or realign necessary infrastructure, including staff and technology, to support the envisioned virtual care network.		
	Add telehealth equipment to ensure all Ballad hospitals have at least one comprehensive cart for high-acuity episodes (e.g., tele-stroke) and one secondary cart for lower-acuity episodes (e.g., consults).	Percent of Ballad hospitals with at least one comprehensive telehealth cart for high-acuity episodes	By State By Facility
		Percent of Ballad hospitals with at least one secondary telehealth cart for high-acuity episodes	By State By Facility
	Expand tele-stroke services to a broader geography, providing enhanced access to this critical service.	Number of tele-stroke patients	By State By Zip Code of Residence By Payer Type
	Expand behavioral health telemedicine services by adding 10 outpatient sites for low acuity patients. This capability will support a "hub and spoke" model for behavioral telehealth with Ballad hospital-based services.	Number of tele-behavioral outpatient sites for low acuity patients	By State
	Build on Ballad's EPIC roll-out and plan for the deployment of E-visits (email) as an additional means of access to care.	Number of Ballad e-visits	By State By Zip Code of Residence By Specialty
		Plan Spending	By Strategy

Health Information Exchange Plan

Ballad's Health Information Exchange Plan to increase connectivity between Ballad and Virginia/Tennessee data reporting programs as well as community-based organizations and providers includes the following strategies and associated performance metrics:

- Establish Ballad HIE Steering Committee
- Conduct Geographic Service Area Interoperability Research
- Identify Optimal Portfolio of Interoperability and Assemble Deployment Strategies

- Develop an HIE Recruitment and Support Plan
- Participate in ConnectVirginia's HIE and Other TN/VA Regulatory Programs

Health Information Exchange Metrics

Strategy	Activity	Metric	Data Stratification
Participate in ConnectVirginia's HIE and Other TN/VA Regulatory Programs	Ballad will continue to participate in the VA Emergency Department Care Coordination (EDCC) Program and roll out to the Tennessee facilities	Percent of Ballad Virginia Emergency Departments Participating in Virginia's Emergency Department and Care Coordination Program	
	Ballad will continue to participate in the TN and VA Immunizations Programs and Syndromic Surveillance programs	Number of Ballad sites participating in Virginia and Tennessee Immunization program	
Develop an HIE Recruitment and Support Plan	Ballad will design and deploy an HIE Recruitment Plan. The plan will include communications both within Ballad and with the Independent Providers. It will include marketing activities and materials to approach the Independent Providers within the region regarding the menu offerings	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
Identify Optimal Portfolio of Interoperability and Assemble Deployment Strategies	Develop an HIE plan with deployment strategies. Based on the initial assessment of the current interoperability environment in the GSA and the market survey gauging interest of area providers, Ballad will formulate a future state and develop an HIE plan that address gaps between where it wants to be and where it is today.	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
Establish Ballad HIE Steering Committee	Establish a Ballad HIE Steering Committee to guide the development, deployment and ongoing maintenance of Ballad's HIE efforts	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
Conduct Geographic Service Area Interoperability Research	Leveraging its initial assessment, Ballad will conduct research to gauge interest in menu offerings. This will allow Ballad to educate and survey Independent Providers within the region to understand their interest in the interoperability options.	Number of Non-Ballad Providers in Service Area with committed interest in pursuing HIE data sharing agreements	By Organization Type
		Plan Spending	By Strategy

Health Research & Graduate Medical Education Plan

Ballad's Health Information Exchange Plan to increase capacity with Ballad and the region to conduct robust health research and expand Graduate Medical Education Programs (GME) includes the following strategies and associated performance metrics:

- Establish the Tennessee/Virginia Regional Health Sciences Consortium

- Identify Targeted Hiring Needs to Build Research Capacity and Academic Growth
- Develop and Operationalize Consortium Research Infrastructure to Support Health Research in the Region
- Develop & Operationalize an Education and Training Infrastructure to Support the Region

Health Research & Graduate Medical Education Metrics

Strategy	Activity	Metric	Data Stratification
Establish the Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC)	Develop Governance	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
	Develop Sub-Committees		
Identify Targeted Hiring Needs to Build Research Capacity and Academic Growth	Workforce Analysis	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
Develop and Operationalize Consortium Research Infrastructure to Support Health Research in the Region	Research Infrastructure	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
	Develop Health Professions Office within Ballad	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
	Increase Addiction Medicine Education Opportunities	Number of consortium led regional education sessions related to addiction medicine	
	Evaluate Regional Health Professional Recruitment and Retention Barriers	See CA Financial, Operational, and Plan Update Attachments for reporting requirements	
	Support Dental Workforce Development	Number of workforce development partnerships	
	Support Nursing Workforce Development	Number of workforce development partnerships	
	Support Allied Health Workforce Development	Number of allied health incentive and career progression programs	
		Plan Spending	By Strategy

Access

Ballad is required to report various metrics to the States that relate to regional access to quality healthcare services ranging from primary care access to geographic proximity to emergency and urgent care services. In reference to geographic access to services, Ballad has committed to submit an evaluation to VDH that outlines

Ballad's plans in the event that the closure of a non-Ballad facility has an adverse effect on geographic access to emergency and urgent care services.

Access Metrics

Metric	Data Source	Data Stratification
Population within 10 miles of a Ballad urgent care center	Facility Addresses and ACS Census Data	By State
Population within 10 miles of a Ballad urgent care center open nights and weekends	Facility Addresses and ACS Census Data	By State
Population within 10 miles of a Ballad urgent care facility or emergency department	Facility Addresses and ACS Census Data	By State
Population within 15 miles of a Ballad emergency department	Facility Addresses and ACS Census Data	By State
Population within 15 miles of a Ballad acute care hospital	Facility Addresses and ACS Census Data	By State
Pediatric Readiness of Emergency Department	National EMSC Data Analysis Resource Center	By Facility
Access to Specialty Care-Time to third appointment for Ballad specialist	Ballad EMR	By State By Pediatric Specialty By Gerontologist By Specialty
Access to Primary Care-Time to third appointment for Ballad primary care providers	Ballad EMR	By State By Pediatric PCPs By General Practices
Preventable Hospitalizations – Medicare	Inpatient Discharge Data	By State By Diagnosis By Zip Code of Pt. Residence
Preventable Hospitalizations – Adults	Inpatient Discharge Data	By State By Diagnosis By Zip Code of Pt. Residence By Payer Type
Screening – Breast Cancer	Ballad EMR	By State By Zip Code of Residence By Payer Type
Screening – Cervical Cancer	Ballad EMR	By State By Zip Code of Residence By Payer Type

Screening – Colorectal Cancer	Ballad EMR	By State By Zip Code of Residence By Payer Type
Screening – Diabetes	Ballad EMR	By State By Zip Code of Residence By Payer Type
Screening – Hypertension	Ballad EMR	By State By Zip Code of Residence By Payer Type
Follow-Up After Hospitalization for Mental Illness (7 Days)	Ballad EMR; NCQA The State of Health Care Quality Report	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)
Follow-Up After Hospitalization for Mental Illness (30 Days)	Ballad EMR; NCQA The State of Health Care Quality Report	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)
Antidepressant Medication Management –Effective Acute Phase Treatment	Ballad EMR; NCQA The State of Health Care Quality Report	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)
Antidepressant Medication Management-Effective Continuation Phase Treatment	Ballad EMR; NCQA The State of Health Care Quality Report	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)
SBIRT Administration-Emergency Departments	Ballad EMR	By State By Facility
SBIRT Administration-Outpatient Facilities	Ballad EMR	By State By Facility
Patient Satisfaction and Access Surveys	Ballad to Populate	By Facility
Patient Satisfaction and Access Survey – Response Report	Ballad to Populate	By Facility
Screening-Lung Cancer	Ballad EMR	By State By Zip Code of Residence By Payer Type

Fiscal Year Quality Metrics

Ballad will submit to VDH fiscal year composites of all quality metrics for which Ballad will also be reporting on quarterly. The data will be submitted to the States with the same data stratification.

Ballad will also submit to VDH a fiscal year composite of their three QI Metrics with an overview of why the metrics were selected, quality improvement activities to improve performance on each metric, implementation barriers, and next steps for quality improvement if performance targets are not met.

Additional CA Reporting Requirements

To ensure Ballad's employees, regional employers, and community members are not negatively impacted as a result of the CA, Ballad will report to VDH miscellaneous measures pertaining to employee health initiatives, employer health outreach, value-based contracting, and staffing ratios.

Additional CA Metrics

Category	Metric	Data Source	Data Stratification
Employee Health	% of Team members achieving all 8 BeWell Attributes (Add attributes)	Ballad	N/A
Value-Based Contracting	Total Cost of Care measured by PMPM (4 VBC arrangements at risk)	Ballad	By Contract Type
	Financial Impact (total financial impact not net)	Ballad	By Contract Type
	Number of contracts in 5 different arrangement types according to VBC dashboard (shared-savings; hospital-based; full-risk, pay-for gap /care coordination and other)	Ballad	By Contract Type
	Total lives in VBC arrangements	Ballad	By Contract Type
Employer Health Outreach	Number of employers with employer health contracts with Ballad	Ballad's business health contracts	By State
Staffing	Turnover-Team Members	Ballad's human resource records	By Facility
	Turnover-Benefited RNs	Ballad's human resource records	By Facility

CA Financial, Operational, and Plan Update Attachments to be Submitted Annually

Attachment	Notes
Summary comparison by category of patient-related prices charged during the year in review and the preceding year (in such categories as are specified by the Department);	Patient-related prices charged; Section 6.04(b)(i).
Summary of steps taken to reduce costs and improve efficiency;	Cost-efficiency steps taken; Section 6.04(b)(ii).
Update on the status of the Equalization Plan and any implementation achieved, along with any summary of changes in full-time equivalent personnel that occurred during the year in review with analysis of resulting cost savings;	Equalization Plan status; Section 6.04(b)(iii).
Report on any services or functions that were consolidated during the year in review and the resulting cost savings in excess of Two Million Dollars ($2,000,000);	Services or Functions Consolidated; Section 6.04(b)(v).
Report on any material changes in volume or availability of any inpatient or outpatient services offered during the year in review;	Changes in volume or availability of inpatient or outpatient services;

	Section 6.04(b)(vi).
Summary containing the number of accredited resident positions for each residency program operated in the Geographic Service Area and the number of such positions that are filled, along with copies of the relevant pages of the Medicare cost reports, as available, showing the number of full time equivalent residents;	Summary of residency program; Section 6.04(b)(vii).
Description of any affiliation agreements moving resident "slots" from one Ballad Hospital to another pursuant to Medicare rules, resident programs moved from one Ballad Hospital to another, and new programs started;	Movement of any residency "slots"; Section 6.04(b)(viii).
Summary of Ballad's performance in meeting the quality performance standards and best practices requirements established by the Clinical Council	Summary of quality performance standards and best practices established by the Clinical Counsel in Section 4.02(b); Section 6.04(b)(xi).
Plan of Separation	Updated Plan of Separation; Section 6.04(b)(xii).
Summary comparison of Ballad with similar health systems, along with a comparison to one or more rating agency indices for ratio of salaries and benefits to net patient revenue, ratio of operating EBITDA to net revenue, ratio of operating income to net revenue, ratio of capital expenditures to depreciation, ratio of net income to net revenue (excess margin), days of cash on hand, days of net patient revenue outstanding, ratio of long-term debt to capitalization, ratio of unrestricted reserves to long term debt and debt service coverage ratio, along with a schedule of values for each component required to make the various ratio calculations;	Comparison of NHS financial ratios with similar health systems; Section 6.04(b)(xiii).
Summary of Total Charity Care	Total Charity Care information described in Section 4.03(f); Section 6.04(b)(xiv).
Updated Ballad Organizational Chart, including an updated listing of the corporate officers and members of the Board;	Updated NHS organizational chart including listing of corporate officers and members of the Board; Section 6.04(b)(xv).
Career Development Plan and implementation status overview	Explanation of implementation and results of the career development program described in Section 3.08(c);
Reports or System Updates on any other information expressly required for the Annual Report pursuant to the form of Annual Report, any other Section of the Terms of Certification, or the COPA Act.	
Summary of facility maintenance and capital expenditures, including a schedule of all maintenance and repair expenses and capital expenditures during the year	Capital Plan; Section 3.07(b).

Determination of meeting or exceeding aggregate capital expenditure spending requirements.	
Overview of the Ballad Clinical Counsel, to include Counsel roster, common standard of care, credentialing standards, consistent multidisciplinary peer review, and best practices	Section 4.02(b)(v).
Summary of Ballad's Integrated Delivery System Measures, including common and comprehensive set of measures and protocols that will be part of the IDS; track and monitor opportunities to improve health care and access;	Section 4.02(c)(i).
Summary of Staffing Ratios. Including hours of patient care delivered per patient and ratio of RN to LPN and other caregivers	Section 4.02(c)(iv).
Results of the 3-year survey of medical, hospital and nursing staff	Section 4.02(c)(v).
Summary of comparison by COPA Hospital or other applicable healthcare provider affiliated with the NHS of price increase for the NHS to Measured Payors	Addendum 1, Section 9.1(d)(i).
Summary of comparison by COPA Hospital or other applicable healthcare provider affiliated with the NHS of price decreases for the NHS to Measured Payors	Addendum 1, Section 9.1(d)(ii).
Summary comparison and by the applicable NHS provider, showing gross revenue and net revenue by Measured Payors;	Addendum 1, Section 9.1(d)(iii).
A list of any new Payors which executed Managed Care Contracts during the preceding calendar year and a verified certification from the New Health System Chief Financial Officer that the pricing for such contracts complies with Addendum 1;	Addendum 1, Section 9.1(d)(iv).
All charges and charge increases from non-hospital outpatient services, Physician Services, Charge-Based Items and Cost-Based Items;	Addendum 1, Section 9.1(d)(v).
A report of chargemaster increases, by year and by provider, showing the impact on Measured Payors of such increase;	Addendum 1, Section 9.1(d)(vi).
A summary of all value-based payments, broken out by COPA Hospital and by Measured Payor, including a comparison of such payments to the prior year's value-based payments from such Measured Payor	Addendum 1, Section 9.1(d)(vii).
Physician/Physician Extender Needs Assessment and Recruitment Plan	
Overview of any deficiencies or noncompliance identified by the Joint Commission	
Ballad Health Information Exchange Recruitment Plan (including internal and external recruitment plans)	Health Information Exchange Plan
Regional HIE Portfolio, Environmental Scan, and Interoperability Strategic Plan, Including the results of a regional interoperability market survey	Health Information Exchange Plan
Overview of Ballad HIE Steering Committee Governance Structure	Health Information Exchange Plan

Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Roster	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Gap Analyses	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Coordinating Council Roster and Meeting Schedule	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Academic Council Roster and Meeting Schedule	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Research Council Roster and Meeting Agenda	Health Research & Graduate Medical Education Plan
Overview and summary of grants applied for by the TVRHSC, including dollars requested, program(s) proposed, partners, etc.	Health Research & Graduate Medical Education Plan; Academic partnerships – money spent, summary of research, status of grant(s); Section 6.04(b)(ix). Outcomes of previously reported research projects; Section 6.04(b)(x).
Overview and summary of grants secured by the TVRSHC, including dollars awarded, program(s) to be implemented, partners, proposed outcomes, evaluation strategies, etc.	Health Research & Graduate Medical Education Plan Academic partnerships – money spent, summary of research, status of grant(s); Section 6.04(b)(ix). Outcomes of previously reported research projects; Section 6.04(b)(x).
TVRHSC Research Timeline and Metrics	Health Research & Graduate Medical Education Plan
Overview of research projects Initiated in region with TVRHSC assistance	Health Research & Graduate Medical Education Plan
Overview of research projects completed in region with TVRHSC Assistance, with executive summaries	Health Research & Graduate Medical Education Plan
Overview of Ballad research workforce analysis implemented strategies	Health Research & Graduate Medical Education Plan
Inventory of Regional Research Capacity	Health Research & Graduate Medical Education Plan
Annual Research Symposium Agenda and Attendee Roster	Health Research & Graduate

	Medical Education Plan
Roster of Filled Ballad Research and Academic Positions	Health Research & Graduate Medical Education Plan
Recruitment and Retention Study Timeline and Executive Summary	Health Research & Graduate Medical Education Plan
Update and Overview of Southwest Virginia Addiction Medicine Fellowship Program Planning and Implementation, to include metrics planning for future HR & GME Plans, updates/plans to engage/partner in VA Higher-Ed Institutions to provide regional support (i.e. UVA-Wise, V-Tech, VCOMM).	Health Research & Graduate Medical Education Plan
Update and Overview of Dental Residency Development Planning and Implementation, to include metrics planning for future HR & GME Plans	Health Research & Graduate Medical Education Plan
Update and Overview of Nurse Rotations by State and Facility, to include metrics planning for future HR & GME Plans	Health Research & Graduate Medical Education Plan
Update and Overview of Allied Health Career Progression Planning and Implementation, to include metrics planning for future HR & GME Plans, Allied Health Professions Gap Analysis, Partner Organizations, and Proposed Incentives	Health Research & Graduate Medical Education Plan
Nursing Education, Recruitment, Retention, and Career Advancement Plan	Health Research & Graduate Medical Education Plan
Allied Health Incentive and Career Progression Plan	Health Research & Graduate Medical Education Plan
Overview of Staffing Structure in Ballad Professions Office	Health Research & Graduate Medical Education Plan
Residency Expansion Updates	Health Research & Graduate Medical Education Plan
Summary of positions posted and hired for the execution of Ballad's Behavioral Health Plan, to include the CMO, project manager, clinical data analyst and evaluate the other roles needed for the division	Behavioral Health Plan
Summary of Ballad's participation in Virginia's Addiction and Recovery Treatment Services (ARTS) program, including an update on Ballad development of preferred OBOTs	Behavioral Health Plan
Summary of Ballad's implementation of team-based care models, including an overview on Ballad's hiring of Community Health Workers, Care Coordinators, and Health Coaches	Rural Health Plans
Summary of positions posted and hired for the execution of Ballad's Children's Health Plan, to include the CMO, project manager, clinical data analyst and evaluate the other roles needed for the division	Children's Health Plan
Summary of Pediatric Advisory Council activities, including Council roster, meeting schedule, recommendations, and recommendation implementation status	Children's Health Plan

Summary of new and existing partnerships to increase access to pediatric specialists	Children's Health Plan

Attachments

1. **December 2017 TAP Report**
2. **Existing Measures and Performance Indicators**
3. **Summary of Proposed TAP Recommendations**
4. **Proposed Annual Reporting Timeline**
5. **Detailed Quarterly Metrics Overview**
6. **Proposed Quarterly Update Meeting Templates**
7. **Proposed Population Health Metrics Line of Sight and Metrics Overview**
8. **Proposed Behavioral Health Metrics Line of Sight and Metrics Overview**
9. **Proposed Children's Health Metrics Line of Sight and Metrics Overview**
10. **Proposed Rural Health Metrics Line of Sight and Metrics Overview**
11. **Proposed Health Information Exchange Metrics Line of Sight and Metrics Overview**
12. **Proposed Health Research & Graduate Medical Education Metrics Line of Sight and Metrics Overview**
13. **Detailed Access Metrics Overview**
14. **Proposed Additional Cooperative Agreement Reporting Metrics**
15. **Proposed Cooperative Agreement Financial, Operational, and Plan Update Attachments**
16. **2019 Ballad Technical Advisory Panel (TAP) April Meeting Minutes**
17. **2019 Ballad Technical Advisory Panel (TAP) November Meeting Minutes**

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

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

Outcome 1: Create Value in the Marketplace

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

<table>
<tr><td></td><td></td><td></td><td>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</td></tr>
<tr><td>2
Improve health and well-being for a population</td><td>Relevant Conditions 14-15

Population health

*Charity Care</td><td>-Social - determinants of health

-Amount of charity care

-Length and Quality of life</td><td>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
<table>
<tr><th></th><th>Measure</th><th>Description</th><th>Source</th></tr>
<tr><td>2.6
#</td><td>Mothers who smoke during pregnancy</td><td>Percentage of mothers who report smoking during pregnancy (%).</td><td>VDH Division of Health Stats – Birth Certificate Data</td></tr>
<tr><td>2.7

*
#</td><td>Youth Tobacco Use</td><td>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).</td><td>National Survey on Drug Use and Health</td></tr>
<tr><td>2.16
*
#</td><td>Obesity Subpopulation Measure</td><td>Increase the proportion of physician office visits that include counseling or education related to weight and physical activity.</td><td>Data Collection to be led by the New Health System</td></tr>
<tr><td>2.19
#</td><td>Breastfeeding Initiation</td><td>Percent of live births whose birth certificates report that baby is breastfed.

<u>US Value</u>: Proportion of infants who are ever breastfed.</td><td>VDH Division of Health Stats – Birth Certificate Data

CDC National Immunization Survey</td></tr>
<tr><td>2.24
#</td><td>NAS (Neonatal Abstinence Syndrome) Births</td><td>Number of reported cases with clinical signs of withdrawal per 1,000 Virginia resident live births.</td><td>Active case reports submitted by clinicians OR through VDH's inpatient hospitalization database (VHI data)</td></tr>
<tr><td>2.30</td><td>Children – On-time Vaccinations</td><td>Children receiving on-time vaccinations (% of children aged 24 months receiving 4:3:1:FS:3:1:4 series).</td><td>Virginia Immunization Information System</td></tr>
</table></td></tr>
</table>

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**
	Relevant Conditions 1-27-28-41-46			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 Equitable access to services across the region	Regional Services *Tertiary hospitals *Mental health services *Specialty services	-Equity of service levels -Essential services -Access to services -Primary care and specialty care access		3.2	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

			3.28 | Patient Satisfaction and Access Survey – Response Report | 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. | New Health System Records 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
4 Adequate providers to provide equitable services throughout the region	Relevant Conditions 24-32 Post graduate training of clinical staff Residency program Recruitment plan	-Ratio of providers by discipline to serve the population by community -Trained and prepared clinical staff	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

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.

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

DRAFT – NOT APPROVED

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.

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.

COMMONWEALTH of VIRGINIA
Department of Health

MARISSA J. LEVINE, MD, MPH, FAAFP
STATE HEALTH COMMISSIONER

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

January 12, 2018

Mr. Alan Levine
President and CEO
Mountain States Health Alliance
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Mr. Bart Hove
President and CEO
Wellmont Health Systems
1905 American Way
Kingsport, Tennessee 37660

RE: Final Cooperative Agreement Measures

Dear Mr. Levine and Mr. Hove:

Pursuant to 12 VAC 5-221-100, attached are the quantitative measures that will be used to evaluate the proposed and continuing benefits of the cooperative agreement. These measures reflect the input of many different stakeholders, including the Technical Advisory Panel (TAP), you (the parties), and the Southwest Virginia Health Authority.

With respect to the Rural Health Services Plan (Condition 33), the Behavioral Health Services Plan (Condition 34), the Children's Health Services Plan (Condition 35), and the Population Health Plan (Condition 36), our goal is to work closely with you to arrive in 6 months with plans that reflect a dialogue over time with the parties. During the meetings of the Technical Advisory Panel, representatives from your organizations supported this concept. To this end, and in addition to the submission of final plans as required by the respective Conditions, I request the following be submitted to the Virginia Department of the Health (VDH) Office of Licensure and Certification within the time frames noted to promote the dialogue:

1. Detailed plan outlines within 3 months of closing for review and comment; and
2. Initial draft plans within 5 months of closing for review and comment.

With respect to the plan for the expenditure of funds to develop and provide readily and easily accessible access to patient electronic health information (Condition 8), the post-graduate training plan (condition 24), and the plan for investment in the research enterprise (Condition 25), our goal is to work closely with you to arrive in 12 months with plans that reflect a dialogue over time with the parties. During the meetings of the TAP, representatives from your organizations supported this concept. To this end, and in addition to the submission of final plans as required by the respective Conditions, I request the following be submitted to the VDH Office of Licensure and Certification within the time frames noted to promote the dialogue:

1. Detailed plan outlines within 6 months of closing for review and comment; and
2. Initial draft plans within 10 months of closing for review and comment.

In accordance with 12 VAC 5-221-120, the TAP will provide ongoing input to me on the evolution of the attached measures and other new measures and will meet at least annually. I will seek input from other sources as well, such as the Southwest Virginia Health Authority and other local stakeholders. After considering the recommendations of the TAP and other stakeholders, I may adjust the measures as needed to maintain active and continuing supervision of the parties and to ensure compliance with the Cooperative Agreement and its Conditions that, if substantially met, are expected to assure that the benefits of the merger outweigh the disadvantages from a reduction in competition in southwest Virginia.

We look forward to frequent and productive communication with you in the coming months. Please direct any questions you may have to Mr. Erik Bodin in the Office of Licensure and Certification.

Sincerely,

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Enclosure

cc: Erik Bodin
John J. Dreyzehner, MD, MPH
Marissa J. Levine, MD, MPH, FAAFP
Jeff Mitchell (Southwest Virginia Health Authority)
Jeff Ockerman
Allyson Tysinger, Esq.

Active Supervision of the Cooperative Agreement between Mountain States Health Alliance and Wellmont Health Systems: Measures and Performance Indicators

Performance Indicators

1. The New Health System shall comply with all of the Conditions in the Virginia State Health Commissioner's Order and Letter Authorizing a Cooperative Agreement, dated October 30, 2017.
2. The New Health System shall report the following measures to the Commissioner in the annual report:
   a. The number of validated and unresolved complaints from payers (self-reporting with verification from payers and department and review by department), the number of contracts retained or added with payment for value elements, and the number of lives covered in risk-based contracts
   b. Information to demonstrate fulfillment of each component of condition 10.
   c. The rate of increase of the total cost of care measured by per member per year for all risk based contracts demonstrating that the rate of increase is below the regional trend for similar payer populations on an annual basis calculated on a rolling three-year average.
      i. Within 12 months of closing of the merger, the New Health System will compile and submit to the VDH Office of Licensure and Certification baseline data on cost, quality, and customer experience for all current risk-based or value-based payer contracts.
      ii. Within 12 months of closing of the merger, the New Health System will compile and submit to the VDH Office of Licensure and Certification baseline data on cost, quality, and customer experience for the New Health System's employees and their family members who are provided health insurance through the New Health System.
   d. The results of the Anthem Q-HIP. These results shall include comparisons to the other Anthem Virginia network providers and percentiles where available.
   e. The percentage of independent physicians participating in the clinical services network. This percentage should increase each year for the first five years. The baseline percentage shall be provided to the VDH Office of Licensure and Certification within 12 months of closing of the merger.
   f. The percentage of independent physicians on the Common Clinical IT Platform. This percentage should increase each year for the first five years. The baseline percentage shall be provided to the VDH Office of Licensure and Certification within 12 months of closing of the merger.
   g. The number of employers with whom the New Health System has health outreach programs. This number should increase each year. The baseline number of employers shall be provided to the VDH Office of Licensure and Certification within 12 months of closing of the merger.
      i. Participant outcomes where health outreach programs are being provided to employers. Improvement in participant outcomes should be shown on an annual basis.
3. The Population Health Plan required by Condition 36 will include, but not be limited to, provisions that address how the following measures will be improved:
   a. total cost of care,
   b. health outcomes of the New Health System's employees, and
   c. the use of information technology and analytics in meeting the New Health System's population health goals and objectives.
      i. The Population Health Plan will address and seek to improve the scores of the southwest Virginia population on the measures contained in Table A. The Plan will include targets for each measure and timelines within which the New Health System expects to reach the applicable target. Each year, the New Health System will select at least one measure from Table A for focused improvement on which it will be evaluated. The measure(s) selected in any given year shall not be the same as the ones selected in any of the preceding three years. Measures selected for focused improvement by the New Health System should maintain the improved performance level or continue to demonstrate improvement in subsequent years.

ii. Within 12 months of the closing of the merger, the New Health System will provide the VDH Office of Licensure and Certification with baseline data for the measures contained in Table A for the southwest Virginia population and socioeconomic peer counties selected by the New Health System and approved by the Commissioner.

iii. The New Health System will monitor all of the measures in Table A and report on each measure for the southwest Virginia population in the annual report. The annual report should show that 90% of the targets established in the Population Health Plan are on track to be or were achieved in accordance with the timelines set in the Plan.

Table A. Measures, Descriptions, and Sources

Item	Measure	Description	Source
A1	Mothers who smoke during pregnancy	Percentage of mothers who report smoking during pregnancy (%).	VDH Division of Health Stats – Birth Certificate Data
A2	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, Virginia Youth Survey
A3	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
A4	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
A5	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)
A6	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 and Tennessee Immunization Registry
A7	Vaccinations – HPV Females	Percentage of females aged 13 to 17 years who received adequate doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
A8	Vaccinations – HPV Males	Percentage of males aged 13 to 17 years who received adequate doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
A9	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years.	VDH Division of Health Stats – Birth Certificate Data
A10	Third Grade Reading Level	3rd graders scoring "proficient" or "advanced" on reading assessment (%).	Fourth grade reading level is available through KIDS COUNT data center

Table A. Measures, Descriptions, and Sources (continued)

Item	Measure	Description	Source
A11	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
A12	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
A13	Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	VDH Division of Health Stats – Birth Certificate Data

4. The Plans required by Conditions 33, 34, and 35 will include, but not be limited to, provisions that address how the following measures will be improved:
   - spending rates on the key services identified in the plans
   - quality and experience on key services,
   - length and quality of life, and
   - primary and specialty care access. (Specialty care access includes the following services: mental health, including addiction; heart and vascular; gastrointestinal; cancer, including medical and surgical oncology; obstetrics; and endocrinology.)

   a. The Rural Health Services Plan, the Behavioral Health Services Plan, and the Children's Health Services Plan, as applicable, will address and seek to improve the scores of the southwest Virginia population on the measures contained in Table B. The Plans will include targets for each measure and timelines within which the New Health System expects to reach the applicable target. Each year, the New Health System will select at least one measure from Table B for focused improvement on which it will be evaluated. The measure(s) selected in any given year shall not the same as the ones selected in any of the preceding three years. Measures selected for focused improvement by the New Health System should maintain the improved performance level or continue to demonstrate improvement in subsequent years.

   b. Within 12 months of the closing of the merger, the New Health System will provide the VDH Office of Licensure and Certification with baseline data for the measures contained in Table B for the southwest Virginia population.

   c. The New Health System will monitor all of the measures in Table B and report on each measure for the southwest Virginia population in the annual report. The annual report should show that 80% of the targets established in the Plans are on track to be or were achieved in accordance with the timelines set in the Plans.

Table B. Measures, Descriptions, and Sources

Item	Measure	Description	Source
B1	Population within 25 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
B2	Population within 25 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
B3	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
B4	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
B5	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
B6	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
B7	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
B8	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

Table B. Measures, Descriptions, and Sources

Item	Measure	Description	Source
B9	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
B10	Preventable Hospitalizations – Medicare	Number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	Hospital Discharge Data
B11	Preventable Hospitalizations – Adults	Number of discharges for ambulatory care-sensitive conditions per 1,000 adults aged 18 years and older	Hospital Discharge Data
B12	Screening – Breast Cancer	Percentage of women aged 50-74 who reported having a mammogram within the past two years	Behavioral Risk Factor Surveillance System and the All Payers Claim Database
B13	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
B14	Screening – Colorectal Cancer	Percentage of adults who meet U.S. Preventive Services Task Force recommendations for colorectal cancer screening	Behavioral Risk Factor Surveillance System and the All Payers Claim Database
B15	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
B16	Screening – Hypertension	Percentage of hypertension screenings performed by the New Health System for residents aged 18 or older	New Health System Records
B17	Asthma ED Visits – Age 0-4	Asthma Emergency Department Visits Per 10,000 (Age 0-4)	Hospital Discharge Data
B18	Asthma ED Visits – Age 5-14	Asthma Emergency Department Visits Per 10,000 (Age 5-14)	Hospital Discharge Data
B19	Prenatal care in the first trimester	Percentage of live births in which the mother received prenatal care in the first trimester	
B20	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 seven (7) days post-discharge	New Health System Records; NCQA *The State of Health Care Quality Report*

Table B. Measures, Descriptions, and Sources (continued)

Item	Measure	Description	Source
B21	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*
B22	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*
B23	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*
B24	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*
B25	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
B26	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
B27	Patient Satisfaction and Access Surveys	Successful completion of patient satisfaction and access surveys, according to Section 4.02©(iii)	New Health System Records

Table B. Measures, Descriptions, and Sources (continued)

Item	Measure	Description	Source
B28	Patient Satisfaction and Access Survey – Response Report	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.	New Health System Records
B29	Screening for lung cancer	Percentage of people age 55-80 who have a 30-pack year smoking history and currently smoke or have quit within the past 15 years who have a low dose CT in the past 15 months.	All Payers Claim Database, Relevant regional data that includes uninsured populations

5. The comprehensive physician/physician extender needs assessment and recruitment plan required by Condition 32 will identify clinical staff gaps and will include targets and their associated measures to close identified gaps and timelines within which the New Health System expects to reach the applicable target. The annual report should show that the targets established in the plan are on track to be or were achieved in accordance with the timelines set in the plan.
   a. Within 12 months of closing of the merger, the New Health System will provide the VDH Office of Licensure and Certification with baseline data concerning physician/physician extenders in southwest Virginia.

6. The New Health System will comply with the reporting requirements of Condition 12.
   a. Through its quality improvement program, the CMS safety domain measures listed below will be monitored. Within 12 months of closing of the merger, the New Health System will provide the VDH Office of Licensure and Certification with baseline data for the measures listed below. The New Health System's quality improvement program should establish targets for improvement of each measure and timelines within which the New Health System expects to reach the applicable target. The annual report should contain data on each measure and show that 80% of the targets established by the New Health System are on track to be or were achieved in accordance with the timelines set in the quality improvement program.

      - 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

b. Through its quality improvement program, the measures in Table C will be monitored. Within 12 months of closing of the merger, the New Health System will provide the VDH Office of Licensure and Certification with baseline data for the measures in Table C.

Table C. Quality Monitoring Measures

Item	Measure Identifier	Technical Measure Title	Measure as Posted on Hospital Compare
General information- Structural measures			
C1	SM-PART-NURSE	Participation in a systematic database for nursing sensitive care	Nursing Care Registry
C2	ACS-REGISTRY	Participation in a multispecialty surgical registry	Multispecialty Surgical Registry
C3	SM-PART-GEN-SURG	Participation in general surgery registry	General Surgery Registry
C4	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
C5	OP-17	Tracking Clinical Results between Visits	Able to track patients' lab results, tests, and referrals electronically between visits
C6	OP-25	Safe surgery checklist use (outpatient)	Uses outpatient safe surgery checklist
C7	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)		
C8	H-COMP-1-A-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Always" communicated well
C9	H-COMP-1-U-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Usually" communicated well

Table C. Quality Monitoring Measures (continued)			
Item	**Measure Identifier**	**Technical Measure Title**	**Measure as Posted on Hospital Compare**
C10	H-COMP-1-SN-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Sometimes" or "Never" communicated well
C11	H-COMP-2-A-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Always" communicated well
C12	H-COMP-2-U-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Usually" communicated well
C13	H-COMP-2-SN-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Sometimes" or "Never" communicated well
C14	H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Always" received help as soon as they wanted
C15	H-COMP-3-U-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Usually" received help as soon as they wanted
C16	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
C17	H-COMP-4-A-P	Pain management (composite measure)	Patients who reported that their pain was "Always" well controlled
C18	H-COMP-4-U-P	Pain management (composite measure)	Patients who reported that their pain was "Usually" well controlled
C19	H-COMP-4-SN-P	Pain management (composite measure)	Patients who reported that their pain was "Sometimes" or "Never" well controlled
C20	H-COMP-5-A-P	Communication about medicines (composite measure)	Patients who reported that staff "Always" explained about medicines before giving it to them
C21	H-COMP-5-U-P	Communication about medicines (composite measure)	Patients who reported that staff "Usually" explained about medicines before giving it to them

Table C. Quality Monitoring Measures (continued)			
Item	**Measure Identifier**	**Technical Measure Title**	**Measure as Posted on Hospital Compare**
C22	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
C23	H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Always" clean
C24	H-CLEAN-HSP-U-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Usually" clean
C25	H-CLEAN-HSP-SN-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Sometimes" or "Never" clean
C26	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
C27	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
C28	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
C29	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
C30	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
C31	H-COMP-7-SA	Care Transition (composite measure)	Patients who "Strongly Agree" they understood their care when they left the hospital
C32	H-COMP-7-A	Care Transition (composite measure)	Patients who "Agree" they understood their care when they left the hospital
C33	H-COMP-7-D-SD	Care Transition (composite measure)	Patients who "Disagree" or "Strongly Disagree" they understood their care when they left the hospital

Table C. Quality Monitoring Measures (continued)

Item	Measure Identifier	Technical Measure Title	Measure as Posted on Hospital Compare
C34	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)
C35	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)
C36	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)
C37	H-RECMND-DY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would definitely recommend the hospital
C38	H-RECMND-PY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would probably recommend the hospital
C39	H-RECMND-DN	Willingness to recommend the hospital (global measure)	Patients who reported NO, they would probably not or definitely not recommend the hospital
Timely & effective care- Colonoscopy follow-up			
C40	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
C41	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			
C42	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
C43	OP-5	Median time to ECG	Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG

Table C. Quality Monitoring Measures (continued)			
Item	**Measure Identifier**	**Technical Measure Title**	**Measure as Posted on Hospital Compare**
C44	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
C45	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			
C46	EDV	Emergency department volume	Emergency department volume
C47	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
C48	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
C49	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
C50	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
C51	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
C52	OP-22	Patient left without being seen	Percentage of patients who left the emergency department before being seen

Table C. Quality Monitoring Measures (continued)			
Item	**Measure Identifier**	**Technical Measure Title**	**Measure as Posted on Hospital Compare**
C53	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			
C54	IMM-2	Immunization for influenza	Patients assessed and given influenza vaccination
C55	IMM-3-OP-27-FAC-ADHPCT	Influenza Vaccination Coverage among Healthcare Personnel	Healthcare workers given influenza vaccination
Timely & effective care- Stroke care			
C56	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			
C57	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
C58	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			
C59	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

Table C. Quality Monitoring Measures (continued)			
Item	**Measure Identifier**	**Technical Measure Title**	**Measure as Posted on Hospital Compare**
Complications- Surgical complications			
C60	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
C61	PSI-90-SAFETY	Complication/patient safety for selected indicators (composite)	Serious complications
C62	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			
C63	READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients
C64	READM-30-AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Rate of readmission for heart attack patients
C65	READM-30-HF	Heart failure (HF) 30-day readmission rate	Rate of readmission for heart failure patients
C66	READM-30-PN	Pneumonia (PN) 30-day readmission rate	Rate of readmission for pneumonia patients
C67	READM-30-STK	Stroke 30-day readmission rate	Rate of readmission for stroke patients
C68	READM-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day readmission rate	Rate of readmission for coronary artery bypass graft (CABG) surgery patients
C69	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
C70	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			
C71	MORT-30-COPD	COPD 30-day mortality rate	Death rate for COPD patients

Table C. Quality Monitoring Measures (continued)			
Item	**Measure Identifier**	**Technical Measure Title**	**Measure as Posted on Hospital Compare**
C72	MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	Death rate for heart attack patients
C73	MORT-30-HF	Heart failure (HF) 30-day mortality rate	Death rate for heart failure patients
C74	MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Death rate for pneumonia patients
C75	MORT-30-STK	Stroke 30-day mortality rate	Death rate for stroke patients
C76	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			
C77	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.
C78	OP-9	Mammography Follow-Up Rates	Outpatients who had a follow-up mammogram, ultrasound, or MRI within the 45 days after a screening mammogram
C79	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).
C80	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).

Table C. Quality Monitoring Measures (continued)

Item	Measure Identifier	Technical Measure Title	Measure as Posted on Hospital Compare
C81	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).
C82	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).

7. The New Health System will report its health system and Virginia employee turnover rates in the annual report.
   a. Within 12 months of closing of the merger, the New Health System will provide the VDH Office of Licensure and Certification with baseline data on health system and Virginia employee turnover.

8. The New Health System will report the number of Board development activities, including a description of each activity, conducted each year in the annual report. The New Health System will also identify in the annual report the Board development activities that will be undertaken in the upcoming year.

Attachment 3. Technical Advisory Panel of the Cooperative Agreement (TAP) Metrics Recommendations			
Metric Category	**Metrics Considered by the TAP**	**TAP Comments**	**TAP Vote**
Quality - Patient Safety	Pressure Ulcer Rate Iatrogenic Pneumothorax 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 Sep 1 – Sepsis Bundle CLABSI CAUTI SSI COLON Surgical Site Infection SSI HYST Surgical Site Infection MRSA CDIFF	1. Stratifying data by payer type may not be possible or valuable. 2. Explore grouping by facility size.	Unanimously Approved
Quality - Mortality and Readmissions	Readmission Rates for Top 10 Causes of Readmissions Mortality Rates for Top 10 Causes of Mortality	1. "Lock In" Top 10 Cause Metrics from FY 2017 Baseline and monitor over the course of the CA. 2. Explore grouping by facility size. 3. Stratifying data by payer type may not be possible or valuable.	Unanimously Approved
Quality - Patient Satisfaction	HCOMP1A P Patients who reported that their nurses "Always" communicated well HCOMP2A P Patients who reported that their doctors "Always" communicated well HCLEAN HSPAP Patients who reported that their room and bathroom were "Always" clean HCOMP7SA Patients who "Strongly Agree" they understood their care when they left the hospital HRECMND DY Patients who reported "YES", they would definitely recommend the hospital	1. Expore grouping by facility size. 2. Stratifying data by payer type may not be possible or valuable.	Unanimously Approved

Quality - Timely and Effective Care	ED-1b Average time patients spent in ED before they were admitted to the hospital as an inpatient ED-2b Average time patients spent in the ED after the doctor decided to admit them before leaving the ED for their inpatient room OP-18b Average time patients spent in the ED before leaving from the visit OP-22 Percentage of patients who left the ED before being seen OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival	1. Explore grouping by facility size 2. Stratifying data by payer type may not be possible or valuable.	Unanimously Approved
Rural Quality - Inpatient	CDC-NSHN Annual Survey (Antibiotic Stewardship) Care Transition: Patient reported they understood the purpose for taking their medication Care Transition/Patient Preference: Hospital Staff took my preferences and those of my family Care Transition/Patient Preference: Patients reported-Quietness of the hospital environment Falls Risk Assessment or Falls with Injury (NQF 0202)	1. Define metric for "Falls Risk Assessment or Falls with Injury." 2. Explore grouping by facility size. 3. Stratifying data by payer type may not be possible or valuable.	Unanimously Approved
Rural Quality - Outpatient Patient Satisfaction	CG-CAHPS: In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed? CG-CAHPS: In the last 6 months, how often did this provider listen carefully to you? CG-CAHPS: In the last 6 months, how often did this provider explain things in a way that was easy to understand? CG-CAHPS:Overall Provider Rating-- On a scale from 1-10, with 10 being the highest likely, how likely would you refer your provider? CG-CAHPS: In the last 6 months, how often did this provider explain things in a way that was easy to understand? Medication Reconciliation Post-Discharge (NQF 0097 USPSTF)	1. Research validity of self-report metrics begining with "In the last 6 months..." 2. Stratifying data by payer type may not be possible or valuable. 3. Remove duplicate measure, "CG-CAHPS: In the last 6 months, how often did this provider explain things in a way that was easy to understand?" 4. Ballad, like many other health systems nationwide, has low patient satisfaction survey response rates. Ballad is exploring ways to increase response rates. Survey results that are statstically insignificant due to small sample size should be supressed.	Unanimously Approved
Rural Quality - Outpatient Prevention	Tobacco Use: Screening and Cessation Intervention (USPSTF/ NQF 0028) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (USPSTF/ NQF 0059) Screening for Clinical Depression and Follow-up Plan (USPSTF/ NQF 0418) Body Mass Index (BMI) Screening and Follow-up (USPSTF/0421) Controlling High Blood Pressure (USPSTF/ NQF 0018) Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (NQF 0024)	1. Crosswalk metrics with Access metrics to ensure there is no duplication of metrics.	Unanimously Approved
	Deliverables Table with Item, Status (date submitted), and Applicable TOC/CA Requirements Any revisions to Ballad Health's Charity Care Policy Pursuant to TOC:4.03(e) /CA: 14 and 38		

COPA/CA Financial and Operational Quarterly Updates	Population Health and Social Responsibility Committee Meeting Summary (includes attendance) Pursuant to TOC:4.03(e), Exhibit G/ CA:35 Balance Sheet Statements of Income Statement of Cash Flow Year-to-date internal spending report Grants Distributed Ancillary Services Offered by Competitors Post-Acute Services Offered by Competitors Any requirements or commitments outlined in the TOC or the Index which Ballad Health will not meet or anticipates it will not meet Compliance Officer Quarterly Report Status of any outstanding Cues, Corrective Actions, or other remedial actions - TOC: Exhibit G/ CA:16 Facility/Service Line Closure Plans Facility/ Service Line Closure Progress Facility/ Service Line Opening Plans Facility/Service Line Opening Progress		Unanimously Approved
Access	Population within 10 miles of an urgent care center Population within 10 miles of an urgent care center open nights and weekends Population within 10 miles of an urgent care facility or emergency department Population within 15 miles of an emergency department Population within 15 miles of an acute care hospital Pediatric Readiness of Emergency Department Average time to 3rd appointment for Ballad specialist Sites providing specialty care Population-weighted % of residents across all Census blocks that reside within 30 miles of a specialty care clinic Average time to 3rd appointment for Ballad PCP Sites providing primary care Population-weighted % of residents across all Census blocks that reside within 20 miles of a primary care clinic Preventable Hospitalizations – Medicare Preventable Hospitalizations – Adults Screening – Breast Cancer Screening – Cervical Cancer Screening – Colorectal Cancer Screening – Diabetes Screening – Hypertension Follow-Up After Hospitalization for Mental Illness (7 Days) Follow-Up After Hospitalization for Mental Illness (30 Days) Antidepressant Medication Management –Effective Acute Phase Treatment Antidepressant Medication Management-Effective Continuation Phase Treatment SBIRT Administration-Emergency Departments SBIRT Administration-Outpatient Facilities Patient Satisfaction and Access Surveys Patient Satisfaction and Access Survey – Response Report Screening-Lung Cancer	1. Include narrative that highlights VDH's desire to monitor not only geographic access to services, but also access to telemedicine. 2. Include both time to third appointments and geographic access to services for now. 3. Decide whether or not to include on Ballad facilities or all facilities in geographic service area. 4. Explore opportunities to measure Ballad and population access. 5. Measures that utlize Ballad's EMR data only capture access for Ballad's patients. Consider using population data when possible. 6. Ballad does not consider the first five of these measures to be value-added.	Unanimously Approved
	Number of partners who provide contraceptives		

Population Health/STRONG Families and Children: Increase Birth Outcomes & Strong Starts Output Metrics	Number of VBC conblocks that include breastfeeding initiation Number of partners who provide maternal cessation Number of women in Ballad Health L&D that receive lactation consultation Number of partner sites providing VLARC to at-risk populations Number of providers receiving education/CME on best practice cessation counseling and referral Number of sites providing VLARC immediately following NAS birth Number of maternal MAT/best practice maternal recovery sites Number of partner sites providing contraceptives to teens Number of sites providing parenting education Number of providers trained to conduct maternal assessment Number of maternal mental health education sessions Number of safe sleep best practice provider communication/maternal and infant health communication sessions Number of prenatal programs/supports provided by behavioral health facilities Number of sites providing VLARC in L&D setting an first post-partum	1. Ballad needs to define metrics in more meaningful way. 2. VDH and Ballad need to develop plans to capture denominators for population health output metrics.	Unanimously Approved
Population Health/STRONG Families and Children: Increase Educational Readiness and Performance Output Metrics	Number of childcare partners Number of sites providing parenting education Number of childcare partners Number of sites who provide reading mentorship Number of partners providing early literacy programming Number of sites providing parent literacy programs Number of sites providing mentoring	1. Ballad needs to define metrics in more meaningful way. 2. VDH and Ballad need to develop plans to capture denominators for population health output metrics.	Unanimously Approved
Population Health/STRONG Families and Children: Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality Output Metrics	Number of partners providing best practice recovery and programming Number of partner sites providing/promoting Narcan Number of internal certified peer recovery specialist and with partner sites Number of partner sites providing adult cessation programs Number of providers coding counseling and referral to cessation internally Number of partner sites providing NRT and subsidized medications Number of partner sites providing nutrition programming to families Number of partner sites/schools providing best practice nutrition programming Number of partner sites/schools providing physical activity programming	1. Ballad needs to define metrics in more meaningful way. 2. VDH and Ballad need to develop plans to capture denominators for population health output metrics.	Unanimously Approved
Population Health/STRONG Families and Children: Change Social Norms to Support Parents, Families, and the Community Output Metrics	Number of lives covered under VBC/CIN/HQEP Number of businesses participating in the Business Health Collaborative Number of sites on EPIC Number of community partners with signed conblocks as ACC members Number of team member support programs Number of B well initiatives Number of providers in committee Number of educational campaigns developed and implemented Number of provider sites enrolled Launch pilot Number of partners providing ACEs and/or social risk assessments Number of RFP pilot sites Number of trauma aware trainings provided Number of legislators/government officials engaged Number of breastfeeding friendly businesses and employers Number of EMS Agencies Providing Community Paramedicine	1. Ballad needs to define metrics in more meaningful way. 2. VDH and Ballad need to develop plans to capture denominators for population health output metrics.	Unanimously Approved
	Maternity Practices in Infant Nutrition and Care Survey Scores		

Population Health/STRONG Families and Children Proposed Outcome Measures	Breastfeeding Initiation Prenatal Care Neonatal Abstinence Syndrome (NAS) Births Mothers Who Smoke During Pregnancy Kindergarten Readiness Youth Tobacco Teen Births Third Grade Reading Levels Drug Deaths Overweight and Obese Children 8th Grade Math and English		Unanimously Approved
Population Health/STRONG Families and Children Proposed Impact Measures	High School Graduation Substance Abuse Adult Obesity Infant Mortality Adult Smoking Suicide Employment Children in Poverty Per Capita Income Median Household Income Leading Causes of Death and Disease Homelessness	1. Add measures associated with Adverse Childhood Experiences (ACEs)	Unanimously Approved
Proposed Annual Performance Review and Data Submission Timeline	N/A		Unanimously Approved
Proposed Quarterly In-Person Update Templates	N/A		Unanimously Approved

Proposed Annual Performance Review and Data Submission Timeline

January 2020

Dedicated to the 3-year plans; review prior six-month performance (metrics and milestones); sufficient time to understand and share challenges/barriers/concerns and share/discuss solutions and activities for next 6 months; brief update on system activities

April 2020

With one quarter remaining in FY, focus on system performance with brief overview of status of plans (focusing on areas not on track)

July 2020

Dedicated to the 3-year plans; review final plan performance on the plans for FY20 (% of unmet milestones, status of metrics); review implementation roadmaps for FY21 (new milestones and metrics); brief update on system activities

October 2020 Meeting

- **Quarterly Check In: Johnson City**
- FY 2020 Q4 Quarterly Report Q&A
- Ballad will provide an in-depth system update, with a focus on FY 2020 performance
- Annual Report preview
- Ballad will provide an update on three improvement quality metrics
- Update on plan implementation barriers
- **States to attend Ballad Health Board Meeting**

January 2021 Meeting

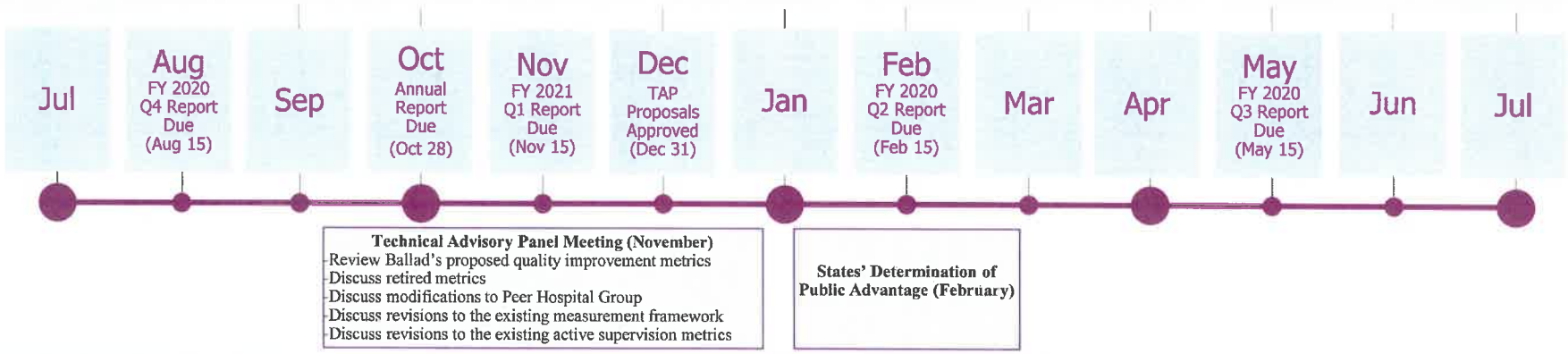
- **Quarterly Check In: Nashville**
- FY 2021 Q1 Quarterly Report Q&A
- Annual Report Q&A
- Updates on Ballad's three improvement quality metrics
- Ballad will provide in-depth update on the plans, including review of 6-month performance (metrics, milestones, successes, and A3s for problem areas and barriers)
- Ballad will provide brief system performance updates

April 2021 Meeting

- **Quarterly Check In: Johnson City**
- FY 2021 Q2 Quarterly Report Q&A
- Ballad will provide an in-depth system performance update for Q1-Q3
- Ballad will provide an update on three improvement quarterly metrics
- Update on plan implementation barriers
- **States to attend Ballad Health Board Meeting**

July 2021 Meeting

- **Quarterly Check In: Richmond**
- FY 2021 Q3 Quarterly Report Q&A.
- Updates on Ballad's three improvement quality metrics
- Ballad will provide in-depth update on the plans, including review of Final FY21 performance (metrics, milestones, successes, and A3s for problem areas and barriers) as well as review of FY22 implementation roadmaps
- Ballad will provide brief system performance updates



Attachment 5. Ballad Health Cooperative Agreement
Quarterly Reporting Measures

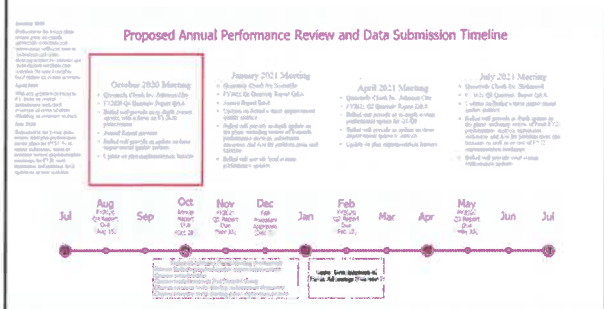
Submitted to the States quarterly and annually
Improvement Quality Metrics to be Presented to the States during Quarterly In-Person Check In Meetings at the State Level
States to provide feedback and request additional information during quarterly check in meetings

Category		Measure	Data Source	Data Steward	Data Type	Data Stratification	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Monitoring	Rural Quality-Inpatient	CDC-NSHN Annual Survey (Antibiotic Stewardship)	CDC-NSHN Annual Survey	Ballad Health	Score	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Care Transition: Patient reported they understood the purpose for taking their medication	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Percent Reported Always (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Care Transition/Patient Preference: Hospital Staff took my preferences and those of my family	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Percent Reported Always (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Care Transition/Patient Preference: Patients reported-Quietness of the hospital environment	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Percent Reported Always (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Falls with Injury: All documented patient falls with an injury level of moderate or greater on eligible unit types in a calendar quarter. (Total number of injury falls / Patient days) X 1000	RL Solutions (Ballad will notify VDH if vendor changes occur)	Ballad Health	Injury Falls per 1,000 patient days	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
	Rural Quality-Outpatient Patient Satisfaction	CG-CAHPS: In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Percent Reported Always (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		CG-CAHPS: In the last 6 months, how often did this provider listen carefully to you?	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Percent Reported Always (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		CG-CAHPS: In the last 6 months, how often did this provider explain things in a way that was easy to understand?	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Percent Reported Always (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		CG-CAHPS:Overall Provider Rating- On a scale from 1-10, with 10 being the highest likely, how likely would you refer your provider	Press Ganey (Ballad will notify VDH if vendor changes occur)	Ballad Health	Top Box Score % (Scale 9-10)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Pressure Ulcer Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Iatrogenic Pneumothorax Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Postoperative Hip Fracture Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		PSI 09 Perioperative Hemorrhage or Hematoma Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		PSI 10 Postoperative Physiologic and Metabolic Derangement Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		PSI 11 Postoperative Respiratory Failure Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	

Priority-Ballad to choose 3 per year to focus	Quality-Patient Safety	PSI 13 Postoperative Sepsis Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	*Quality data will be presented to the States quarterly using control charts, which will contain: • Monthly plotting of the metric values • Baseline reference lines for FY2017 with data continuing from baseline to present. • Control lines & measurements: What control lines and highlighted measures will best inform the states? • Indications of the median, 25th and 75th percentile of the metric among Peer Hospital Systems. *Control charts will be presented at the Health System level, state level, and at "reporting granularity" level. *When a "special-cause event", or a spike in adverse outcomes based on unpredictable environmental factors occurs, Ballad will notify the states and propose a mitigation strategy should one be necessary. *Every year, Ballad will propose three (3) performance measures for targeted Quality Improvement (QI) initiatives should such measure perform at below the 25th percentile of the national average and have the great impact on patient safety. States will approve targeted measures. For each metric, Ballad will present the following: • Logic: Why was the metric selected? • Measurement: How is the metric measured? • Historical Data*: Metric history, if proposed metric is outside of monitoring metrics • Improvement Strategies: What are Ballad's planned interventions and actions for improvement? • Goals: What are Ballad's implementation and improvement goals in the coming year? Goals should, at a minimum, represent an improvement from the 2017 baseline. *Ballad will notify the states, within six (6) months, should any measure by Premier or Press Ganey be retired and convene a discussion by November 1 to determine which measure(s) should replace retired measure(s). *Data will be presented, and be easily accessible, on Ballad Health's website, TDH's website, and VDH's website. *States may request additional monitoring metrics to the Technical Advisory Panel (TAP) annually. *Peer Hospital Systems will be selected utilizing the following criteria: • Not-for-profit health system • Comparable net revenue • Aligned with Premier as quality partner • Comparable bed size and number of hospitals • Consists of rural hospitals and similar services • Geographic location that could allow for a site visit • Utilizes EPIC Electronic Health Records • Is identified as a "Top Performer" by Premier *Must be documented *Preliminary Peer Hospital System Group • Aurora Health • Baptist Memorial Health Care Corporation • Carilion Clinic • Mercury Health • Texas Health • Unity Point Health * States or Ballad may propose revisions to the Peer Hospital System group to the Technical Advisory Panel (TAP) annually.
		PSI 14 Postoperative Wound Dehiscence Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		PSI 15 Accidental Puncture or Laceration Rate	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Sep 1 – Sepsis Bundle	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		CLABSI	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		CAUTI	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		SSI COLON Surgical Site Infection	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		SSI HYST Surgical Site Infection	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		MRSA	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		CDIFF	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
Monitoring	Quality-Mortality and Readmission Metrics	Readmission Rates for top 10 causes of readmissions (Set Top 10 from FY 2017 Baseline)(Not included in Original COPA/CA)	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		Mortality Rates for Top 10 causes of mortality (Set Top 10 from FY 2017 Baseline)(Not included in Original COPA/CA)	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Rate	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
	Quality-Patient Satisfaction	HCOMP1A P Patients who reported that their nurses "Always" communicated well	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		HCOMP2A P Patients who reported that their doctors "Always" communicated well	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		HCLEAN HSPAP Patients who reported that their room and bathroom were "Always" clean	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		HCOMP7SA Patients who "Strongly Agree" they understood their care when they left the hospital	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		HRECMND DY Patients who reported "YES", they would definitely recommend the hospital	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
	Quality-Timely and Effective Care Metrics	ED-1b Average time patients spent in ED before they were admitted to the hospital as an inpatient	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Time-Minutes	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		ED-2b Average time patients spent in the ED after the doctor decided to admit them before leaving the ED for their inpatient room	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Time-Minutes	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		OP-18b Average time patients spent in the ED before leaving from the visit	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Time-Minutes	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		OP-22 Percentage of patients who left the ED before being seen	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	
		OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival	Premier (Ballad will notify VDH if vendor change occurs)	Ballad Health	Percent (Include Numerator and Denominator)	System Level By State By Facility	2017	Ballad to submit by 2020 Annual Report Due Date	Yes, at the system level and by State	

Attachment 6. Ballad Health Quarterly Update Templates

October Update Meeting Template



FY 2020 Fourth Quarter Report Q&A

- The States will provide feedback and ask questions pertaining to Ballad's FY2020 Fourth Quarter Report
- Questions will be submitted to Ballad a week in advance of the meeting

Quality Improvement Metrics

- Improvement Metric 1
- Improvement Metric 2
- Improvement Metric 3

Improvement Metric 1 Control Chart(s)

Improvement Metric 2 Control Chart(s)

Improvement Metric 3 Control Chart(s)

Quality Improvement Metrics

Metric	Accomplishments	Challenges	Plan for Next 180 Days
Improvement Metric 1			
Improvement Metric 2			
Improvement Metric 3			

Population Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Rural Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Children's Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Behavioral Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Health Information Exchange Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Health Research & Graduate Medical Education Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

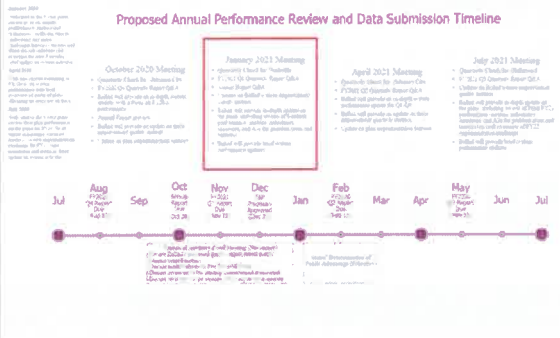
Ballad Health In-Depth System Update

- Ballad will insert slides that provide an in-depth system update, with a focus on FY 2020 performance

Annual Report Preview

- Ballad will insert slides that provide a preview of the upcoming annual report

January Update Meeting Template



FY 2021 First Quarter Report Q&A

- The States will provide feedback and ask questions pertaining to Ballad's FY 2021 First Quarter Report
- Questions will be submitted to Ballad a week in advance of the meeting

FY 2020 Annual Report Q&A

- The States will provide feedback and ask questions pertaining to Ballad's FY2020 Annual Report
- Questions will be submitted to Ballad a week in advance of the meeting

Quality Improvement Metrics

- Improvement Metric 1
- Improvement Metric 2
- Improvement Metric 3

Improvement Metric 1 Control Chart(s)

Improvement Metric 2 Control Chart(s)

Improvement Metric 3 Control Chart(s)

Quality Improvement Metrics

Metric	Accomplishments	Challenges	Plan for Next 180 Days
Improvement Metric 1			
Improvement Metric 2			
Improvement Metric 3			

In-Depth Plan Updates

- Ballad will provide in-depth update on the plans, including review of 6-month performance (metrics, milestones, successes, and A3s for problem areas and barriers)

Population Health Plan Strategies

- Increase Birth Outcomes and STRONG Starts
- Increase Educational Readiness and Performance
- Increase healthy behaviors in children, youth, and their support systems to improve health and strengthen economic vitality
- Change social norms to support parents, families, and the community
  - Develop population health infrastructure within the health system and community
  - Position Ballad Health as a community health improvement organization
  - Enable community resources and sound health policy
  - Increase community understanding and response to at-risk children and families

Increase Birth Outcomes & STRONG Starts

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Increase contraceptive access to all women of childbearing age	Number of partners who provide contraceptives					
Enhance provider and facility practices to support breastfeeding	Number of VBC contracts that include breastfeeding initiation					
Increase maternal cessation programs	Number of partners who provide maternal cessation					
Increase lactation supports	Number of women in Ballad Health L&D that receive lactation consultation					
Increase VLARC provision with at-risk populations (incarcerated, addicted)	Number of partner sites providing VLARC to at-risk populations					
Increase provider practices using beset practice cessation counseling and referral	Number of providers receiving education/CME on best practice cessation counseling and referral					

To be Completed by Ballad

Increase Birth Outcomes & STRONG Starts

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Increase VLARC adoption at facilities immediately following NAS birth	Number of sites providing VLARC immediately following NAS birth					
Expand maternal MAT and other recovery programs	Number of maternal MAT/best practice maternal recovery sites					
Increase access to contraceptives for teens	Number of partner sites providing contraceptives to teens					
Expand best practice parent programming for healthy relationships/safe sex	Number of sites providing parenting education					
Leverage the 2 day postpartum pediatric visit to include maternal assessment	Number of providers trained to conduct maternal assessment					
Expand provider education on maternal mental health assessment	Number of maternal mental health education sessions					

Increase Birth Outcomes & STRONG Starts

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Ensure provider best practices on safe sleep education for patients	Number of safe sleep best practice provider communication/maternal and infant health communication sessions					
Increase prenatal programs/supports across facilities	Number of prenatal programs/supports provided by behavioral health facilities					
Increase VLARC provision in labor and delivery and first postpartum environment	Number of sites providing VLARC in L&D setting an first post-partum					

Increase Educational Readiness & Performance

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Increase high quality childcare access	Number of childcare partners					
Increase parenting education on early childhood success	Number of sites providing parenting education					
Train and support childcare providers in best practice early childhood	Number of childcare partners					
Increase availability of reading mentors for children at-risk of not at grade level reading	Number of sites who provide reading mentorship					
Enhance early literacy programming across sectors (community, clinical, etc.)	Number of partners providing early literacy programming					
Support parents ability to serve as literacy mentors	Number of sites providing parent literacy programs					
Expand mentoring opportunities for all ages	Number of sites providing mentoring					

Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Expand best practice recovery sites and programming	Number of partners providing best practice recovery and programming					
Expand Narcan use	Number of partner sites providing/promoting Narcan					
Increase certified peer recovery specialist workforce and training programs	Number of internal certified peer recovery specialist and with partner sites					
Increase best practice adult cessation programs	Number of partner sites providing adult cessation programs					
Increase provider practices using best practice cessation counseling and referral	Number of providers coding counseling and referral to cessation internally					
Subsidize NRT and cessation medications	Number of partner sites providing NRT and subsidized medications					

Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Expand family nutrition counseling and education across sectors (business, education, healthcare, CBO/FBOs)	Number of partner sites providing nutrition programming to families					
Increase best practice nutrition programming in schools, after-school programs, and other child service community based organizations	Number of partner sites/schools providing best practice nutrition programming					
Expand physical activity programs in schools, after-school programs and other child service community based organizations	Number of partner sites/schools providing physical activity programming					

Change Social Norms to Support Parents, Families, and the Community

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Delivery System Design	Number of lives covered under VBC/CIN/HQEP					
Information System and Decision Support	Number of sites on EPIC					
Support the regional Accountable Care Community (ACC)	Number of community partners with signed contracts as ACC members					
Self management/develop personal skills	Number of team member support programs					
	Number of B well initiatives					
Support the Population Health Clinical Steering Committee	Number of providers in committee					

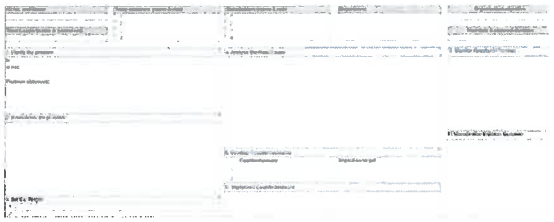
Change Social Norms to Support Parents, Families, and the Community

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Educational campaigns prevention of early initiation of sex and substance use, prenatal care in 1st trimester, breastfeeding benefits, safe sleep, maternal support, stigma reduction, social justice, community empowerment, early literacy, mentoring, substance use prevention, vaping, program availability and community programming	Number of educational campaigns lost					
Implement Project COMPASSion	Number of provider sites enrolled					
Implement Family Resource hub and spoke model	Launch pilot					
Increase ACEs and social risk assessments across sectors	Number of partners providing ACEs and/or social risk assessments					

Change Social Norms to Support Parents, Families, and the Community

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Strengthen Community Action	Number of RFP pilot sites					
Strengthen Community Action- Creation of Trauma Informed/Resilient Communities and Sites	Number of trauma aware trainings provided					
Build healthy public policy-second chance programs, food environment in schools, physical activity in schools, telehealth, barrier crimes, community paramedicine, etc.	Number of legislators/government officials engaged					
Advocate for breastfeeding friendly facilities	Number of breastfeeding friendly businesses and employers					

A3(s) for Problem Population Health Measures



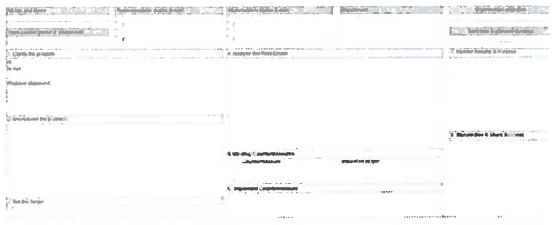
Rural Health Plan Strategies

- Expand access to primary care practices through additions of primary care physicians and mid-level providers to practices in counties of greatest need.
- Recruitment of physician specialists to meet rural access needs
- Implement team-based care models to support primary care providers, beginning with pilots in high need counties
- Develop and deploy virtual care services
- Coordinate preventative health care services

Rural Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of patients treated by additional primary care providers					
Number of patients treated by additional specialists					
Number of lives impacted by a team-based care model					
Number of Ballad hospitals with at least one comprehensive care for high acuity episodes and one secondary care for lower-acuity episodes					
Number of tele-stroke patients					
Number of tele-behavioral outpatient sites for low acuity patients					
Number of tele-pediatric patients					
Number of Ballad Health e-visits					
Patients receiving navigation services					

A3(s) for Problem Rural Health Measures



Children's Health Plan Strategies

- Develop Necessary Ballad Children's Health Services Infrastructure
- Establish ED Capabilities and Pediatric Specialty Centers in Kingsport and Bristol
- Develop Telemedicine and Rotating Specialty Clinics In Rural Hospitals
- Recruit and Retain Subspecialists
- Develop CRPC Designation at Niswonger Children's Hospital Recruitment of physician specialists to meet rural access needs

Children's Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Hire staff					
Implementation of standardized clinical protocols for children with asthma and other priorities (to be identified)					
Number of Pediatric ED visits in Kingsport					
Number of Pediatric ED visits in Bristol					
Patients served in rural pediatric emergency departments					
Pediatric Asthma Patients Enrolled in Pediatric Asthma Care Plan					
Number of tele-neonatology visits in Kingsport					
Number of tele-neonatology visits in Bristol					
Number of pediatric telemedicine visits					

Children's Health Plan

Measure		Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Average wait time for pediatric telemedicine visits					
Number of children treated through school based behavioral health telemedicine					
Number of existing partnerships to access specialists					
Number of new partnerships to access specialists					
Trauma informed care sessions					
Trauma Informed Care site partners					
Number of children treated through pediatric triage line					
Pediatric Advisory Council Established and Convened					
Evidence-based standard clinical protocols for the management of pediatric conditions implemented					

Children's Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of children treated through school based telemedicine					
Pediatric Patients Seen by Pediatric Pulmonologist					
Pediatric Subspecialists Recruited or Contracted					

A3(s) for Problem Children's Health Measures

Behavioral Health Plan Strategies

- Develop Necessary Ballad Behavioral Health Services Infrastructure
- Achieve a high level of integration of Behavioral Health services into primary care (PCBHI)
- Expand Telebehavioral Health Options
- Supplement Existing Regional Crisis System
- Enhance and Expand Resources for Addiction Treatment

Behavioral Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Rite staff					
Number of lives touched by a Behavioral Health Care Navigator					
Number of MAT settings across the Primary Care footprint					
Number of sites with counseling services					
Number of unique patients who were counseled in a Primary Care Setting					
Number of referrals to extended services/advanced levels of care					
Number of telebehavioral health visits					
Number of children treated through school-based telebehavioral health					

Behavioral Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of Ballad Health access sites for telebehavioral health					
Number of clinicians receiving QPR training					
Number of clinicians receiving REACH training					
Number of screens provided (based on [illegible])					
Number of behavioral health transports					
Number of providers educated in MAT					
Number of patients who have received MAT services from a Ballad provider					
Number of Ballad Primary Care clinicians providing MAT services					
Number of facilities with access to Peer Recovery Services					

Behavioral Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Patients with relationship with a peer recovery [illegible]					
Patients treated by Overmountain Residential Addiction Treatment Program					
Providers receiving zero-suicide training					
Number of Ballad Health hospitals where Respond has been implemented					
Patients referred to Community Services Boards					
Primary Care Practices with Same Day Behavioral Health Access					
Emergency Department Visits with Primary Behavioral Health Diagnosis					
Patients treated by Ballad Health PCBHI					

A3(s) for Problem Behavioral Health Measures

Health Information Exchange Plan Strategies

- Establish Ballad Health HIE Steering Committee
- Conduct Geographic Service Area Interoperability Research
- Identify Optimal Portfolio of Interoperability and Assemble Deployment Strategies
- Develop an HIE Recruitment and Support Plan
- Participate in ConnectVirginia's HIE and Other TN/VA Regulatory Programs

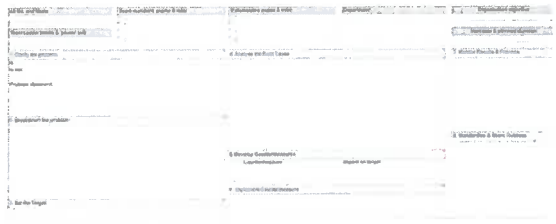
Health Information Exchange Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Percent of Ballad Health Virginia Emergency Departments Participating in Virginia's Emergency Department and Care Coordination Program					
Number Ballad Health Virginia PCPs Receiving EDCC Feeds					
Number of Ballad Health VA hospitals participating in ConnectVirginia PDMP program					
Number of Ballad Health primary care providers participating in Virginia and Tennessee immunization program					
Number of Ballad Health hospitals participating in Virginia and Tennessee immunization program					
Number of Ballad Health Providers participating in Prescription Drug Monitoring Programs					
Number of Ballad Health facilities in either TN and VA regulatory programs					
Recruitment plan designed and developed					
Portfolio designed					

Health Information Exchange Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Engagement and education for independent providers on HIE options					
Assessment completed					
Creation of a well-developed HIE governance structure					
Number of Emergency Medical Services Providers in Service Area Sharing Real-time Electronic Information with Ballad					
Number of Non-Ballad Health Medical Providers in Service Area Sharing Real-time Electronic Information with Ballad					
Number of Non-Ballad Providers in Service Area Identified as Owning Interoperable Electronic Health Record Systems					
Number of Non-Ballad Providers in Service Area Recruited to Engage in Datasharing Agreements					
Number of Community Based Organizations in Service Area Sharing Real-time Electronic Information with Ballad					

A3(s) for Problem HIE Measures



Health Research and Graduate Medical Education Plan Strategies

- Establish the Tennessee/Virginia Regional Health Sciences Consortium
- Identify Targeted Hiring Needs to Build Research Capacity and Academic Growth
- Develop and Operationalize Consortium Research Infrastructure to Support Health Research in the Region
- Develop & Operationalize an Education and Training Infrastructure to Support the Region

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Consortium/ster developed					
Establishment and maintenance of Coordinating Council					
Establishment and maintenance of Academic Council					
Establishment and maintenance of Research Council					
Evaluate staffing and technology in the region related to Academics and Research					
Develop gap analysis					
Resource investment in consortium efforts					
Workforce analysis completed and strategies implemented					
Identify and Hire workforce to address regional needs					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Develop and deploy research strategies based on assessment					
Implement internal outcome studies based on COPA/CA plans					
Complete inventory of current research capacity in the region					
Develop plans for closure of identified gaps in capacity					
Invest in Ballad research infrastructure					
Develop annual research symposium					
Evaluate current staffing in Ballad					
Hire identified critical research and academic positions					
Consortium develops and prioritizes key educational challenges in the region					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Grow identified educational programs					
Develop Ballad facility specific training rubric					
Complete development of Addiction Medicine Fellowship with ETSU					
Develop Addiction Medicine Fellowship in SWVA					
Fund studies to understand recruitment and retention in the region					
Develop strategies to address recruitment and retention factors identified					
Invest in technology to allow for improved access to employment opportunities					
Implement dental residency program in Abingdon					
Develop infrastructure for dental care training and access in the region					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Academic partners working on dental health support					
Develop strategy for nursing education, recruitment, retention and career advancement					
Develop and implement Allied Health incentive and career progression models					
Align growth strategies for training programs for Allied Health					
Grant funds applied for					
Grant funds secured					
Matching funds provided					
Nurses rotating at Ballad Health's Virginia facilities					
Filled Internal Medicine residency slots					

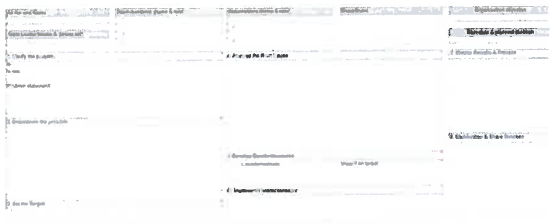
HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Filled Family Medicine residency slots					
Partners with signed contracts as SVRHSC partners					
SVRHSC Attrition Rate					
SVRHSC Meeting Attendance Rate					
Baseline and Metrics Established for Research Priorities					
Research Projects Initiated in Region with SVRHSC Assistance					
Research Projects Completed in Region with SVRHSC Assistance					
Filled Optometry residency slots					
Number of health care workers in an Allied Health career progression program					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of Southwest Virginia Addiction Medicine Fellows					
Filled Dental residency slots					

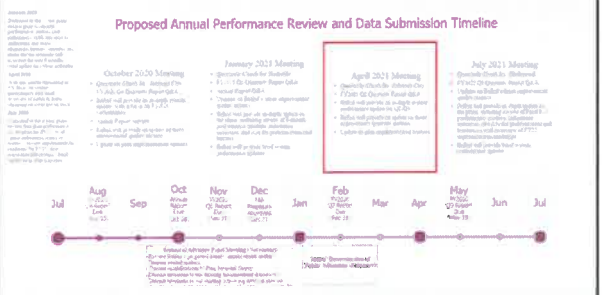
A3(s) for Problem HR & GME Measures



Ballad Health Brief System Update

- Ballad to provide any additional System updates to the States

April Update Meeting Template



FY 2021 Second Quarter Report Q&A

- The States will provide feedback and ask questions pertaining to Ballad's FY2021 Second Quarter Report
- Questions will be submitted to Ballad a week in advance of the meeting

Quality Improvement Metrics

- Improvement Metric 1
- Improvement Metric 2
- Improvement Metric 3

Improvement Metric 1 Control Chart(s)

Improvement Metric 2 Control Chart(s)

Improvement Metric 3 Control Chart(s)

Quality Improvement Metrics

Metric	Accomplishments	Challenges	Plan for Next 180 Days
Improvement Metric 1			
Improvement Metric 2			
Improvement Metric 3			

Population Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Rural Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Children's Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Behavioral Health Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Health Information Exchange Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

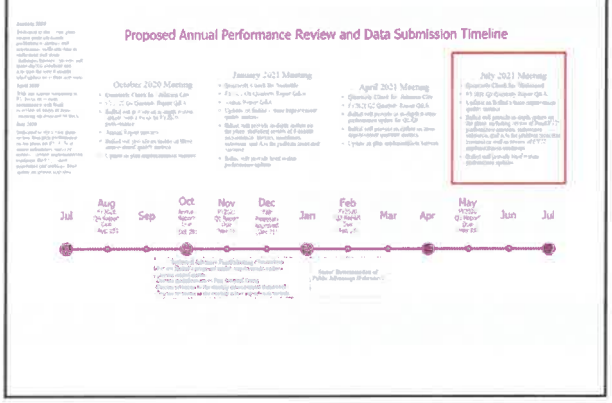
Health Research & Graduate Medical Education Plan Implementation Barriers

Overview	Impacted Strategies, Activities, and/or Tactics	Plan for Next 90 Days

Ballad Health In-Depth System Update

- Ballad will insert slides that provide an in-depth system update, with a focus on FY 2021 Q1-Q3

July Update Meeting Template



FY 2021 Third Quarter Report Q&A

- The States will provide feedback and ask questions pertaining to Ballad's FY 2021 Third Quarter Report
- Questions will be submitted to Ballad a week in advance of the meeting

Quality Improvement Metrics

- Improvement Metric 1
- Improvement Metric 2
- Improvement Metric 3

Improvement Metric 1 Control Chart(s)

Improvement Metric 2 Control Chart(s)

Improvement Metric 3 Control Chart(s)

Quality Improvement Metrics

Metric	Accomplishments	Challenges	Plan for Next 180 Days
Improvement Metric 1			
Improvement Metric 2			
Improvement Metric 3			

FY 2021 In-Depth Plan Updates

- Ballad will provide in-depth update on the plans, including review of FY 2021 performance (metrics, milestones, successes, and A3s for problem areas and barriers)

Population Health Plan Strategies

- Increase Birth Outcomes and STRONG Starts
- Increase Educational Readiness and Performance
- Increase healthy behaviors in children, youth, and their support systems to improve health and strengthen economic vitality
- Change social norms to support parents, families, and the community
  - Develop population health infrastructure within the health system and community
  - Position Ballad Health as a community health improvement organization
  - Enable community resources and sound health policy
  - Increase community understanding and response to at-risk children and families

Increase Birth Outcomes & STRONG Starts

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Increase contraceptive access to all women of childbearing age	Number of partners who provide contraceptives					
Enhance provider and facility practices to support breastfeeding	Number of VBC contracts that include breastfeeding initiation					
Increase maternal cessation programs	Number of partners who provide maternal cessation					
Increase lactation supports	Number of women in Ballad Health L&D that receive lactation consultation					
Increase VLARC provision with at-risk populations (incarcerated, addicted)	Number of partner sites providing VLARC to at-risk populations					
Increase provider practices using beset practice cessation counseling and referral	Number of providers receiving education/CME on best practice cessation counseling and referral					

To be Completed by Ballad

Increase Birth Outcomes & STRONG Starts

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Increase VLARC adoption at facilities immediately following NAS birth	Number of sites providing VLARC immediately following NAS birth					
Expand maternal MAT and other recovery programs	Number of maternal MAT/best practice maternal recovery sites					
Increase access to contraceptives for teens	Number of partner sites providing contraceptives to teens					
Expand best practice parent programming for healthy relationships/safe sex	Number of sites providing parenting education					
Leverage the 2 day postpartum pediatric visit to include maternal assessment	Number of providers trained to conduct maternal assessment					
Expand provider education on maternal mental health assessment	Number of maternal mental health education sessions					

Increase Birth Outcomes & STRONG Starts

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Ensure provider best practices on safe sleep education for patients	Number of safe sleep best practice provider communication/maternal and infant health communication sessions					
Increase prenatal programs/supports across facilities	Number of prenatal programs/supports provided by behavioral health facilities					
Increase VLARC provision in Labor and Delivery and first Post-partum environment	Number of sites providing VLARC in L&D setting an first post-partum					

Increase Educational Readiness & Performance

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Increase high quality childcare access	Number of childcare partners					
Increase parenting education on early childhood success	Number of sites providing parenting education					
Train and support childcare providers in best practice early childhood	Number of childcare partners					
Increase availability of reading mentors for children at-risk of not at grade level reading	Number of sites who provide reading mentorship					
Enhance early literacy programming across sectors (community, clinical, etc.)	Number of partners providing early literacy programming					
Support parents ability to serve as literacy mentors	Number of sites providing parent literacy programs					
Expand mentoring opportunities for all ages	Number of sites providing mentoring					

Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Expand best practice recovery sites and programming	Number of partners providing best practice recovery and programming					
Expand Narcan use	Number of partner sites providing/promoting Narcan					
Increase certified peer recovery specialist workforce and training programs	Number of internal certified peer recovery specialist and with partner sites					
Increase best practice adult cessation programs	Number of partner sites providing adult cessation programs					
Increase provider practices using best practice cessation counseling and referral	Number of providers coding counseling and referral to cessation internally					
Subsidize NRT and cessation medications	Number of partner sites providing NRT and subsidized medications					

Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Expand family nutrition counseling and education across sectors (business, education, healthcare, CBO/FBOs)	Number of partner sites providing nutrition programming to families					
Increase best practice nutrition programming in schools, after-school programs, and other child service community based organizations	Number of partner sites/schools providing best practice nutrition programming					
Expand physical activity programs in schools, after-school programs and other child service community based organizations	Number of partner sites/schools providing physical activity programming					

Change Social Norms to Support Parents, Families, and the Community

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Delivery System Design	Number of lives covered under VBC/CIN/HQEP					
Information System and Decision Support	Number of sites on EPIC					
Support the regional Accountable Care Community (ACC)	Number of community partners with signed contracts as ACC members					
Self management/develop personal skills	Number of team member support programs					
	Number of B well initiatives					
Support the Population Health Clinical Steering Committee	Number of providers in committee					

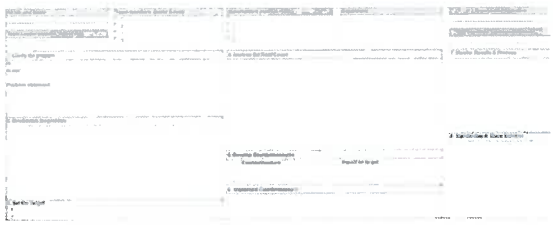
Change Social Norms to Support Parents, Families, and the Community

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Educational campaigns prevention of early initiation of sex and substance use prenatal care in 1st trimester, breastfeeding benefits, safe sleep, maternal support, stigma reduction, social justice, community empowerment, early literacy, mentoring, substance use prevention, vaping, program availability and community programming	Number of educational campaigns lost					
Implement Project COMPASSion	Number of provider sites enrolled					
Implement Family Resource hub and spoke model	Launch pilot					
Increase ACEs and social risk assessments across sectors	Number of partners providing ACEs and/or social risk assessments					

Change Social Norms to Support Parents, Families, and the Community

Activity	Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Strengthen Community Action	Number of RFP pilot sites					
Strengthen Community Action- Creation of Trauma Informed/Resilient Communities and Sites	Number of trauma aware trainings provided					
Build healthy public policy-second chance programs, food environment in schools, physical activity in schools, telehealth, barrier crimes, community paramedicine, etc.	Number of legislators/government officials engaged					
Advocate for breastfeeding friendly facilities	Number of breastfeeding friendly businesses and employers					

A3(s) for Problem Population Health Measures



Rural Health Plan Strategies

- Expand access to primary care practices through additions of primary care physicians and mid-level providers to practices in counties of greatest need.
- Recruitment of physician specialists to meet rural access needs
- Implement team-based care models to support primary care providers, beginning with pilots in high need counties
- Develop and deploy virtual care services
- Coordinate preventative health care services

Rural Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of patients treated by additional primary care providers					
Number of patients treated by additional specialists					
Number of lives impacted by a team-based care model					
Number of Ballad hospitals with at least one comprehensive care for high acuity episodes and one secondary care for lower-acuity episodes					
Number of tele-stroke patients					
Number of tele-behavioral outpatient sites for low acuity patients					
Number of tele-pediatric patients					
Number of Ballad Health e-visits					
Patients receiving navigation services					

A3(s) for Problem Rural Health Measures

Children's Health Plan Strategies

- Develop Necessary Ballad Children's Health Services Infrastructure
- Establish ED Capabilities and Pediatric Specialty Centers in Kingsport and Bristol
- Develop Telemedicine and Rotating Specialty Clinics In Rural Hospitals
- Recruit and Retain Subspecialists
- Develop CRPC Designation at Niswonger Children's Hospital Recruitment of physician specialists to meet rural access needs

Children's Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Hire staff					
Implementation of standardized clinical protocols for children with asthma and other priorities (To be identified)					
Number of Pediatric ED visits in Kingsport					
Number of Pediatric ED visits in Bristol					
Patients served in rural pediatric emergency departments					
Pediatric Asthma Patients Enrolled in Pediatric Asthma Care Plan					
Number of tele-neonatology visits in Kingsport					
Number of tele-neonatology visits in Bristol					
Number of pediatric telemedicine visits					

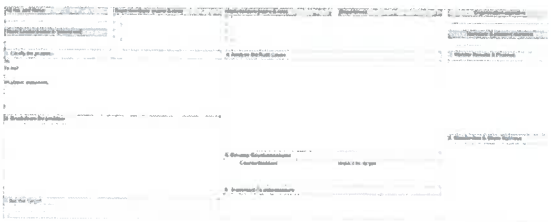
Children's Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Average wait time for pediatric telemedicine visits					
Number of children treated through school based behavioral health telemedicine					
Number of existing partnerships to access specialists					
Number of new partnerships to access specialists					
Trauma Informed care sessions					
Trauma Informed Care site partners					
Number of children treated through pediatric triage line					
Pediatric Advisory Council Established and Convened					
Evidence-based standard clinical protocols for the management of pediatric conditions implemented					

Children's Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of children treated through school based telemedicine					
Pediatric Patients Seen by Pediatric Pulmonologist					
Pediatric Subspecialists Recruited or Contracted					

A3(s) for Problem Children's Health Measures



Behavioral Health Plan Strategies

- Develop Necessary Ballad Behavioral Health Services Infrastructure
- Achieve a high level of integration of Behavioral Health services into primary care (PCBHI)
- Expand Telebehavioral Health Options
- Supplement Existing Regional Crisis System
- Enhance and Expand Resources for Addiction Treatment

Behavioral Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Hire staff					
Number of lives touched by a Behavioral Health Care Navigator					
Number of MAT settings across the Primary Care footprint					
Number of sites with counseling services					
Number of unique patients who were counseled in a Primary Care Setting					
Number of referrals to extended services/advanced levels of care					
Number of telebehavioral health visits					
Number of children treated through school-based telebehavioral health					

Behavioral Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of Bellad Health access sites for telebehavioral health					
Number of clinicians receiving QPR training					
Number of clinicians receiving REACH training					
Number of screens provided (based on SBIRT)					
Number of behavioral health transports					
Number of providers educated in MAT					
Number of patients who have received MAT services from a Bellad provider					
Number of Bellad Primary Care clinicians providing MAT services					
Number of facilities with access to Peer Recovery Services					

Behavioral Health Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Patients with relationship with a peer recovery specialist					
Patients treated by Overmountain Residential Addiction Treatment Program					
Providers receiving zero-suicide training					
Number of Bellad Health hospitals where Respond has been implemented					
Patients referred to Community Services Boards					
Primary Care Practices with Same Day Behavioral Health Access					
Emergency Department Visits with Primary Behavioral Health Diagnosis					
Patients Treated by Bellad Health PCBHI					

A3(s) for Problem Behavioral Health Measures

Health Information Exchange Plan Strategies

- Establish Ballad Health HIE Steering Committee
- Conduct Geographic Service Area Interoperability Research
- Identify Optimal Portfolio of Interoperability and Assemble Deployment Strategies
- Develop an HIE Recruitment and Support Plan
- Participate in ConnectVirginia's HIE and Other TN/VA Regulatory Programs

Health Information Exchange Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Percent of Ballad Health Virginia Emergency Departments Participating in Virginia's Emergency Department and Care Coordination Program					
Number Ballad Health Virginia PCPs Receiving ED CC Feeds					
Number of Ballad Health VA hospitals participating in ConnectVirginia PDMP program					
Number of Ballad Health primary care providers participating in Virginia and Tennessee immunization program					
Number of Ballad Health hospitals participating in Virginia and Tennessee immunization program					
Number of Ballad Health Providers participating in Prescription Drug Monitoring Programs					
Number of Ballad Health facilities in other TN and VA regulatory programs					
Recruitment plan designed and developed					
Portfolio designed					

Health Information Exchange Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Engagement and education for independent providers on HIE options					
Assessment completed					
Creation of a well-developed HIE governance structure					
Number of Emergency Medical Services Providers in Service Area Sharing Real-time Electronic Information with Ballad					
Number of Non-Ballad Health Medical Providers in Service Area Sharing Real-time Electronic Information with Ballad					
Number of Non-Ballad Providers in Service Area Identified as Owning Interoperable Electronic Health Record Systems					
Number of Non-Ballad Providers in Service Area Recruited to Engage in Datasharing Agreements					
Number of Community Based Organizations in Service Area Sharing Real-time Electronic Information with Ballad					

A3(s) for Problem HIE Measures

Health Research and Graduate Medical Education Plan Strategies

- Establish the Tennessee/Virginia Regional Health Sciences Consortium
- Identify Targeted Hiring Needs to Build Research Capacity and Academic Growth
- Develop and Operationalize Consortium Research Infrastructure to Support Health Research in the Region
- Develop & Operationalize an Education and Training Infrastructure to Support the Region

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Consortium roster developed					
Establishment and maintenance of Coordinating Council					
Establishment and maintenance of Academic Council					
Establishment and maintenance of Research Council					
Evaluate staffing and technology in the region related to Academics and Research					
Develop gap analysis					
Resource investment in consortium efforts					
Workforce analysis completed and strategies implemented					
Identify and hire workforce to address regional needs					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Develop and deploy research strategies based on assessment					
Implement internal outcome studies based on COPA/CA plans					
Complete inventory of current research capacity in the region					
Develop plans for closure of identified gaps in capacity					
Invest in Ballad research infrastructure					
Develop annual research symposium					
Evaluate current staffing in Ballad					
Hire identified critical research and academic positions					
Consortium develops and prioritizes key educational challenges in the region					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Grow identified educational programs					
Develop Ballad facility specific training matrix					
Complete development of Addiction Medicine Fellowship with ETSU					
Develop Addiction Medicine Fellowship in Bristol					
Fund studies to understand recruitment and retention in the region					
Develop strategies to address recruitment and retention factors identified					
Invest in technology to allow for improved access to employment opportunities					
Implement dental residency program in Abingdon					
Develop infrastructure for dental care training and access in the region					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Academic partners working on dental health support					
Develop strategy for nursing education, recruitment, retention and career advancement					
Develop and implement Allied Health incentive and career progression models					
Align growth strategies for training programs for Allied Health					
Grant funds applied for					
Grant funds secured					
Matching funds provided					
Nurses rotating at Ballad Health's Virginia facilities					
Filled Internal Medicine residency slots					

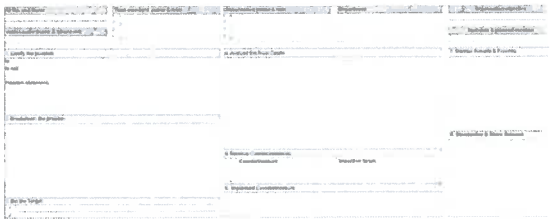
HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Filled Family Medicine residency slots					
Partners with signed contracts as TVRHSC partners					
TVRHEC Attrition Rate					
TVRHSC Meeting Attendance Rate					
Timeline and Metrics Established for Research Priorities					
Research Projects Initiated in Region with TVRHSC Assistance					
Research Projects Completed in Region with TVRHSC Assistance					
Filled Optometry residency slots					
Number of health care workers in an Allied Health career progression program					

HR & GME Plan

Measure	Baseline	Current Data Point	Accomplishments	Challenges	Plan for Next 90 Days
Number of Southwest Virginia Addiction Medicine Fellows					
Filled Dental residency slots					

A3(s) for Problem HR&GME Measures



Ballad Health Brief System Update

- Ballad to provide any additional System updates to the States

Attachment 7. Population Health Metrics Line of Sight

Legend	
Outputs/Leading Indicators	
Outcome Metrics	
Impact Measures	
CDC Resilience Model Categories	Backlistening

** PARTNER SITES MAY INCLUDE INTERNAL PARTNERS SUCH AS OUTPATIENT SITES, RURAL CLINICS,PARISH NURSING, ETC.

			Year 1	Year 2	Year 3	Year 4 Outputs	Year 4 Outcome Metrics	Year 5 Outputs	Year 5 Outcome Metrics	Year 6 Outputs	Year 6 Outcome Metrics
	STRATEGIES	ACTIVITIES									
	Increase Birth Outcomes and STRONG Starts-intervene to lessen harms and prevent future risk	Increase contraceptive access to all women of child bearing age			# of partners who provide contraceptives	# of women receiving contraceptives at partner sites		# of partner sites providing contraceptives to vulnerable populations such as rural and minority		# of women receiving contraceptives at partner sites and # of new partner sites	
		Enhance provider and facility practices to support breastfeeding		# of VBC contracts that include breastfeeding initiation	# of VBC contracts that include breastfeeding initiation	# of provider trainings/CME on best practice breastfeeding		# of providers receiving education/CME on best practice breastfeeding initiation methods		# of providers receiving education/CME on best practice breastfeeding initiation methods	
		Increase maternal cessation programs			# of partners who provide maternal cessation	# of sites providing maternal cessation		# of women enrolled in maternal cessation		# of women who have completed program successfully	
		Increase lactation supports			# of women in Ballad Health L&D that receive lactation consultation	# of women in Ballad Health L&D that receive lactation consultation		# of women in Ballad Health L&D that receive lactation consultation		# of women in Ballad Health L&D that receive lactation consultation	
		Increase VLARC provision with			# of partner sites providing VLARC to at-risk	# of at-risk women receiving VLARC		# of at-risk women receiving VLARC and # of new		# of at-risk women receiving VLARC and # of new	
		Increase provider practices using best practice cessation counseling and referral			# of providers receiving education/CME on best practice cessation counseling and referral	# of indicated tobacco users who receive in-office counseling and referral		# of indicated tobacco users who receive in-office counseling and referral		# of indicated tobacco users who receive in-office counseling and referral	
		Increase VLARC adoption at		# of sites providing VLARC immediately	# of sites providing VLARC immediately following	# of sites providing VLARC immediately		# of sites providing VLARC immediately following		# of sites providing VLARC immediately following	
		Expand maternal MAT and other recovery programs			# of maternal MAT/best practice maternal recovery sites	# of maternal MAT/best practice maternal recovery sites		# of maternal MAT/best practice maternal recovery sites		# of maternal MAT/best practice maternal recovery sites	
		Increase access to contraceptives for teens			# of partner sites providing contraceptives to teens	# of providers receiving education/CME on best practice contraceptive conversation for teens		# of teens receiving contraceptives from partner sites		# of teens receiving contraceptives from partner sites and # of new partner sites providing contraceptives to teens	
		Expand best practice parent programming for healthy relationships/safe sex			# of sites providing parenting education	# of sites providing parenting education who receive training on healthy relationships/safe sex conversations		# of sites who use best practice parent programming for healthy relationship/safe sex		# of sites who use best practice parent programming for healthy relationship/safe sex	
		Leverage the 2 day postpartum			# of providers trained to conduct maternal	# of providers who receive education/CME on		# of providers who employ maternal assessment		# of providers who employ maternal assessment	
		Expand provider education on maternal mental health assessment			# of maternal mental health educations sessions	# of providers who receive education/CME on maternal mental health assessment and referral		# of providers who receive education/CME on maternal mental health assessment and referral		# of providers who receive education/CME on maternal mental health assessment and referral	
		Ensure provider best practices on safe sleep education for patients			# of safe sleep best practice provider communication/maternal and infant health communication sessions	# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication		# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication		# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication	
		Increase prenatal programs/supports across facilities			# of prenatal programs/supports provided by BH facilitates	# of prenatal programs/supports provided by BH facilitates		# of sites and # of women receiving programming/support		# of sites and # of women receiving programming/support	
		Increase VLARC provision in			# of sites providing VLARC in L&D setting and first	# of sites providing VLARC in L&D setting and		# of sites and # of women receiving VLARC		# of sites and # of women receiving VLARC	
	Increase Educational Readiness and Performance-Provider quality care and education early in life	Increase high quality childcare access			# of childcare partners	# of childcare partners		# of children enrolled with partner sites		# of children enrolled with partner sites	
		Increase parenting education on early childhood success			# of partner sites providing parenting education	# of partner sites receiving best practice early childhood curriculum		# of partner sites using best practice early childhood curriculum		# of parents receiving best practice education on early childhood	
		Train and support childcare providers in best practice early childhood		# of childcare partners	# of childcare partners	# of childcare partner sites receiving childcare provider training		# of childcare partner sites receiving childcare provider training		# of childcare partner sites receiving childcare provider training	
		Increase availability of reading mentors for children at-risk of not at grade level reading		# of partner sites who provide reading mentorship	# of partner sites who provide reading mentorship	# of mentors at partner sites		# of children receiving reading mentorship		# of children receiving reading mentorship	
		Enhance early literacy programming across sectors (community, clinical, etc.)			# of partner sites providing early literacy programming	# of partner sites providing early literary programming		# of partner sites providing early literacy programming		# of children enrolled with partner site programming	
		Support parents ability to serve			# of partner sites providing parent literacy	# of partner sites providing parent literacy		# of partner sites providing parent literacy		# of parents receiving literacy programming	
		Expand mentoring		# of sites providing mentoring	# of partner sites providing mentoring	# of partner sites providing mentoring		# of mentors at partner sites		# of mentors at partner sites	
	Increase healthy behaviors in children, youth and their support systems to improve health and strengthen economic vitality-Strengthen economic supports to	Expand best practice recovery sites and programming			# of partners providing best practice recovery and programming	# of partners providing best practice recovery and programming		# of persons being served by partner sites		# of persons being served by partner sites	
		Expand Narcan use			# of partner sites providing/promoting Narcan	# of partner sites providing/promoting Narcan		# of community trainings conducted by partner		# of community trainings conducted by partner	
		Increase Certified Peer		# of Certified Peer Recovery Specialists	# of Certified Peer Recovery Specialists internal	# of Certified Peer Recovery Specialists internal		# of Certified Peer Recovery Specialists internal		# of Certified Peer Recovery Specialist Trainers	
		Increase best practice adult cessation programs			# of partner sites providing adult cessation programs	# of partner sites providing adult cessation programs		# of adults enrolled in partner site cessation programming		# of adults enrolled in partner site cessation programming	
		Increase provider practices using best practice cessation counseling and referral		# of providers coding counseling and referral to cessation internally	# of providers coding counseling and referral to cessation internally	# of providers receiving education/CME on best practice cessation counseling and referral		# of providers coding counseling and referral to cessation internally		# of providers coding counseling and referral to cessation internally	
		Subsidize NRT and cessation			# of partner sites providing subsidized NRT and	# of partner sites providing subsidized NRT and		# of dollars committed to NRT and cessation		# of dollars committed to NRT and cessation	
		Expand family nutrition counseling and education across sectors (business, education, healthcare, CBO/FBOs)			# of partner sites providing nutrition programming to families	# of partner sites providing nutrition programming to families		# of families receiving programming at partner sites		# of families receiving programming at partner sites	
Population			Infrastructure and				Maternity Practices in Infant		Breasfeeding Initiation		Neonatal Abstinence

Year 7		Year 8		Year 9		Year 10			
Outputs	Outcome Metrics	Outputs	Outcome Metrics	Outputs	Outcome Metrics	Outputs	Outcome Metrics	Years 11-15	Years 15-20
# of women receiving contraceptives at partner sites and # of new partner sites		# of women receiving contraceptives at partner sites and # of new partner sites		# of women receiving contraceptives at partner sites and # of new partner sites		# of women receiving contraceptives at partner sites and # of new partner sites			
# of VBC contracts that include breastfeeding initiation		# of VBC contracts that include breastfeeding initiation		# of VBC contracts that include breastfeeding initiation		# of VBC contracts that include breastfeeding initiation			
# of women who completed successfully and # still quit at follow up		# of women who completed successfully and # still quit at follow up		# of women who completed successfully and # still quit at follow up		# of women who completed successfully and # still quit at follow up			
# of women in Ballad Health L&D that receive lactation consultation		# of women in Ballad Health L&D that receive lactation consultation		# of women in Ballad Health L&D that receive lactation consultation		# of women in Ballad Health L&D that receive lactation consultation			
# of at-risk women receiving VLARC		# of at-risk women receiving VLARC		# of at-risk women receiving VLARC		# of at-risk women receiving VLARC and #			
# of indicated tobacco users who receive in-office counseling and referral		# of indicated tobacco users who receive in-office counseling and referral		# of indicated tobacco users who receive in-office counseling and referral		# of indicated tobacco users who receive in-office counseling and referral			
# of sites providing VLARC immediately		# of sites providing VLARC immediately		# of sites providing VLARC		# of sites providing VLARC immediately			
# of maternal MAT/best practice maternal recovery sites		# of maternal MAT/best practice maternal recovery sites		# of maternal MAT/best practice maternal recovery sites		# of maternal MAT/best practice maternal recovery sites			
# of teens receiving contraceptives from partner sites and # of new partner sites providing contraceptives to teens		# of teens receiving contraceptives from partner sites and # of new partner sites providing contraceptives to teens		# of teens receiving contraceptives from partner sites and # of new partner sites providing contraceptives to teens		# of teens receiving contraceptives from partner sites and # of new partner sites providing contraceptives to teens			
# of sites who use best practice parent programming for healthy relationship/safe sex		# of sites who use best practice parent programming for healthy relationship/safe sex		# of sites who use best practice parent programming for healthy relationship/safe sex		# of sites who use best practice parent programming for healthy relationship/safe sex			
# of providers who employ maternal		# of maternal assessments conducted		# of maternal assessments conducted		# of maternal assessments conducted at			
# of providers who receive education/CME on maternal mental health assessment and referral		# of providers who receive education/CME on maternal mental health assessment and referral		# of providers who receive education/CME on maternal mental health assessment and referral		# of providers who receive education/CME on maternal mental health assessment and referral			
# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication		# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication		# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication		# of providers who receive education/CME on best practice safe sleep/maternal and infant health communication			
# of sites and # of women receiving programming/support		# of sites and # of women receiving programming/support		# of sites and # of women receiving programming/support		# of sites and # of women receiving programming/support			
# of sites and # of women receiving		# of sites and # of women receiving		# of sites and # of women receiving		# of sites and # of women receiving			
# of children enrolled with partner sites and # of new partner sites		# of children enrolled with partner sites and # of new partner sites		# of children enrolled with partner sites and # of new partner sites		# of children enrolled with partner sites and # of new partner sites			
# of parents receiving best practice education on early childhood		# of parents receiving best practice education on early childhood		# of parents receiving best practice education on early childhood		# of parents receiving best practice education on early childhood			
# of children enrolled with partner sites who have received training		# of children enrolled with partner sites who have received training		# of children enrolled with partner sites who have received training		# of children enrolled with partner sites who have received training and # of new sites trained			
# of children receiving mentorship and # of new mentors		# of children receiving mentorship and # of new mentors		# of children receiving mentorship and # of new mentors		# of children receiving mentorship and # of new mentors			
# of children enrolled with partner site programming		# of children enrolled with partner site programming		# of children enrolled with partner site programming		# of children enrolled with partner site programming and # of new sites			
# of parents receiving literacy		# of parents receiving literacy		# of parents receiving literacy		# of parents receiving literacy			
# of children receiving mentoring from		# of children receiving mentoring from		# of children receiving mentoring from		# of children receiving mentoring and #			
# of persons being served by partner sites		# of persons being served by partner sites		# of persons being served by partner sites		# of persons being served by partner sites			
# of person trained by partner sites for		# of person trained by partner sites for		# of person trained by partner sites		# of person trained by partner sites for			
# of trainings providing by trainers		# of trainings providing by trainers		# of credentialed Certified Peer		# of credentialed Certified Peer Recovery			
# of adults still quit at follow-up		# of adults still quit at follow-up		# of adults still quit at follow-up		# of adults still quit at follow-up and # of newly enrolled			
# of patients successfully referred to cessation programs		# of patients successfully referred to cessation programs		# of patients successfully referred to cessation programs		# of patients successfully referred to cessation programs			
# of dollars committed to NRT and		# of persons receiving subsidized NRT		# of persons receiving subsidized NRT		# of persons receiving subsidized NRT and			
# of families receiving programming at partner sites	Mothers who smoke during	# of families receiving programming at partner sites	Teen Births	# of families receiving programming at partner sites	Third Grade Reading Levels	# of families receiving programming at partner sites and # of new sites	8th Grade Math/English	High School Graduation Substance Use Adult Obesity	Employment Homelessness Children in Poverty

Health/STRONG Children and Families	families	Increase best practice nutrition programming in schools, after-school programs, and other child service community based organizations	**Capacity Development**		# of partner sites/schools providing best practice nutrition programming	# of partner sites/schools providing best practice nutrition programming	Nutrition and Care Survey Scores	# of sites/schools receiving education on best practice nutrition programming	Early Prenatal Care	# of sites/schools receiving education on best practice nutrition programming	Syndrome (NAS)
		Expand physical activity programs in schools, after-school programs and other child service community based organizations			# of partner sites/schools providing physical activity programming	# of partner sites/schools providing physical activity programming		# of sites/schools receiving education on physical activity programming		# of sites/schools receiving education on physical activity programming	
		Create Supportive Environment-Expand the Business Health Collaborative		# of businesses participating in the Business Health Collaborative	# of businesses participating in the Business Health Collaborative	#of businesses participating in the Business Health Collaborative		# of educational sessions providing by the Business Health Collaborative		# of businesses implementing elements learned through the Business Health Collaborative	
		Delivery system design			# of lives covered under VBC/CIN/HQEP	# of lives covered under VBC/CIN/HQEP		# of lives covered under VBC/CIN/HQEP		VBC/CIN/HQEP performance	
					% of revenue collected from risk-based contracts	% of revenue collected from risk-based contracts		% of revenue collected from risk-based contracts		% of revenue collected from risk-based contracts	
		Information System and Decision Support		# of sites on EPIC	# of sites on EPIC	# of sites on EPIC		# of sites on EPIC		# of sites who use EPIC Care Link	
		Support the regional		# of community partners with signed	# of initiatives launched by the ACC	# of initiatives launched by the ACC		Initiative performance indicator success		Initiative performance indicator success	
		Self Mgmt/Develop Personal Skills		# of team member support programs, # of B Well initiatives	# of team member support programs, # of B Well initiatives	# of team member support programs, # of B Well initiatives, # of team members participating		# of team member support programs, # of B Well initiatives, # of team members participating		# of team member support programs, # of B Well initiatives, # of team members participating	
		Support the Population Health		# of providers in committee	# of providers in committee	# of initiatives launched by committee		# of initiatives launched by committee		# of initiatives launched by committee	
		Educational campaigns prevention of early initiation of sex and substance use, prenatal care in 1st trimester, breastfeeding benefits, safe sleep, maternal support, stigma reduction, social justice, community empowerment, early literacy, mentoring, substance use prevention, vaping, program availability and community programming		# of educational campaigns launched	# of educational campaigns launched	# reached by educational campaigns		# of new educational campaigns and reach of existing		# of new educational campaigns and reach of existing	
	1. Develop population health infrastructure within the health system and the community; 2. Position Ballad Health as a community health improvement organization; 3. Enable community resources and sound health policy; 4. Increase community understanding and response to at-risk children and families- Change social norms to support parents	Create Supportive Environment-Implement Project COMPASSion		Implement pilot	# of provider sites enrolled	# of uninsured being served		# of uninsured being served and new provider sites		# of uninsured being served and new provider sites	
		Implement Family Resource hub and spoke model		Completion of model development	Successful launch of pilot	Successful launch of full model		# served by program		# served by program	
		Increase the use of ACEs and social risk assessment across sectors (business, healthcare, CBO/FBOs, education)			# of partner sites utilizing ACEs and/or social risk assessment	# of partner sites utilizing ACEs and/or social risk assessment		# of partner sites utilizing ACEs and/or social risk assessment		# of persons identified through assessment who are successfully referred	
		Strengthen Community Action		# of RFP pilot sites	RFP milestone accomplishment percentage	# of RFPs to scale/replicate		# of RFPs to scale/replicate		Sites' milestone accomplishment percentage	
		Support the Implementation of Community Paramedicine			Number of EMS Agencies Providing Community Paramedicine	Number of EMS Agencies Providing Community Paramedicine		Number of EMS Agencies Providing Community Paramedicine		Number of EMS Agencies Providing Community Paramedicine	
		Strengthen Community Action-Creation of Trauma Informed/Resilient Communities and Sites		# of Trauma Aware trainings	# of Trauma Aware trainings	# of Trauma Informed pilot CBOs		# of sites that have implemented trauma informed practices		# of sites that have implemented trauma informed practices	
		Build healthy public policy-second chance programs, breast feeding friendly, food environment in schools, physical activity in schools, telehealth, barrier crimes, community paramedicine, etc.		# of legislators/gov officials engaged	# of legislators/gov officials engaged, # of schools engaged in policy conversation, # of employers engaged in policy conversation	# of sessions conducted		# of policy endorsements		# of successful policy adoptions/laws	

	pregnancy Kindergarten Rediness		Youth Tobacco Use		Drug Deaths		Overweight/Obese Youth	Infant Mortality Adult Smoking Suicide ACEs Measure(s)	Per Capita Income Median Household Income Leading causes of death and disease ACEs Measure(s)
# of partner sites/schools providing best practice nutrition programming		# of partner sites/schools providing best practice nutrition programming		# of children receiving best practice nutrition programming at partner sites/schools		# of children receiving best practice nutrition programming at partner sites/schools			
# of partner sites/schools providing physical activity programming		# of partner sites/schools providing physical activity programming		# of children receiving physical activity programming at partner sites/schools		# of children receiving physical activity programming at partner sites/schools			
# of businesses implementing elements learned through the Business Health Collaborative		# of businesses implementing elements learned through the Business Health Collaborative		# of businesses implementing elements learned through the Business Health Collaborative		# of businesses implementing elements learned through the Business Health Collaborative			
VBC/CIN/HQEP performance		VBC/CIN/HQEP performance		VBC/CIN/HQEP performance		VBC/CIN/HQEP performance			
% of revenue collected from risk-based contracts		% of revenue collected from risk-based contracts		% of revenue collected from risk-based contracts		% of revenue collected from risk-based contracts			
# of sites who use EPIC Care Link		# of sites who use EPIC Care Link		# of sites who use EPIC Care Link		# of sites who use EPIC Care Link			
Initiative performance indicator		Initiative performance indicator		Initiative performance indicator		Initiative performance indicator success			
# of team member support programs, # of B Well initiatives, # of team members participating		# of team members in healthy range for B Well Attributes		# of team members in healthy range for B Well Attributes		# of team members in healthy range for B Well Attributes			
# of initiatives launched by committee		# of initiatives launched by committee		# of initiatives launched by committee		# of initiatives launched by committee			
# of new educational campaigns and reach of existing		# of new educational campaigns and reach of existing		# of new educational campaigns and reach of existing		# of new educational campaigns and reach of existing			
# of uninsured being served and new provider sites		# of uninsured being served and new provider sites		# of uninsured being served and new provider sites		# of uninsured being served and new provider sites			
# served by program		# served by program		Program performance indicator success		Program performance indicator success			
# of persons identified through assessment who are successfully referred		# of persons identified through assessment who are successfully referred		# of persons identified through assessment who are successfully referred		# of low ACEs and social risk scores			
Sites' milestone accomplishment percentage		Sites' milestone accomplishment percentage and # of new sites		Sites' milestone accomplishment percentage		Sites' milestone accomplishment percentage			
Number of EMS Agencies Providing Community Paramedicine		Number of EMS Agencies Providing Community Paramedicine		Number of EMS Agencies Providing Community Paramedicine		Number of EMS Agencies Providing Community Paramedicine			
# of sites that have implemented trauma informed practices		Trauma informed/Resilient performance indicator success		Trauma informed/Resilient performance indicator success		Trauma informed/Resilient performance indicator success			
# of successful policy adoptions/laws		# of successful policy adoptions/laws		# of successful policy adoptions/laws		# of successful policy adoptions/laws			

Attachment 7. Ballad Health Cooperative Agreement
Population Health Measures

Submitted to the States Annually and Reported during Quarterly Check In Meetings
*Stratified Data only to be reported in Annual Report

Category	Strategy	Activity	Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification*	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Output Measures	Increase Birth Outcomes and STRONG Starts	Increase contraceptive access to all women of child bearing age	Number of partners who provide contraceptives	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Enhance provider and facility practices to support breastfeeding	Number of VBCconblocksthat include breastfeeding initiation	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase maternal cessation programs	Number of partners who provide maternal cessation	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase lactation supports	Number of women in Ballad Health L&Dthat receive lactation consultation	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase VLARC provision with at-risk populations (incarcerated,addicted)	Number of partner sites providing VLARC to at-risk populations	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increaseprovider practices using best practice cessation counseling and referral	Number of providers receiving education/CME on best practice cessation counseling and referral	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase VLARC adoption at facilities immediately following NAS birth	Number of sites providing VLARC immediately following NAS birth	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Expand maternal MAT and other recovery programs	Number of maternal MAT/best practice maternal recovery sites	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase access to contraceptives for teens	Number of partner sites providing contraceptives to teens	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Expand best practiceparent programming for healthy relationships/safe sex	Number of sites providing parenting education	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Leveragethe 2 day postpartum pediatric visit to include maternal assessment	Number of providers trained to conduct maternal assessment	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Expand provider education on maternal mental health assessment	Number of maternal mental health education sessions	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Ensure provider best practices on safe sleep education for patients	Numberof safe sleep best practice provider communication/maternal and infant health communication sessions	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase prenatal programs/supports across facilities	Number of prenatal programs/supports provided by behavioral health facilities	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase VLARC provision in Labor and Delivery and first Post-partum environment	Number of sites providing VLARC in L&D setting an firstpost-partum	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Increase Educational Readiness & Performance	Increase high quality childcare access	Number of childcare partners	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase parenting education on early childhood success	Numberof sites providing parenting education	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Train and support childcare providers in best practice early childhood	Numberof childcare partners	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increaseavailability of reading mentors for children at-risk of not at grade level reading	Number of sites who provide reading mentorship	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Enhance early literacy programming across sectors (community,clinical, etc.)	Number of partners providing early literacy programming	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Support parents ability to serve as literacy mentors	Number of sites providing parent literacy programs	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Expand mentoring opportunities for all ages	Number of sites providing mentoring	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality	Expand best practice recovery sites and programming	Number of partnersproviding best practice recovery and programming	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		ExpandNarcanuse	Number of partner sites providing/promotingNarcan	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase certified peer recovery specialistworkforce and training programs	Number of internal certified peer recovery specialist and with partner sites	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Increase best practice adult cessation programs	Number of partnersites providing adult cessation programs	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	As the Accountable Care Community continues convening, Ballad will work to produce denominators and percentages for each output
		Increase provider practices using best practice cessation counseling and referral	Number of providers coding counseling and referral to cessation intemply	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Subsidize NRT and cessation medications	Number of partnersites providing NRT and subsidized medications	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Expand family nutrition counseling and education across sectors (business, education, healthcare, CBO/FBOs)	Number of partner sites providing nutrition programming to families	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	

Change Social Norms to Support Parents, Families, and the Community	Increase best practice nutrition programming in schools, after-school programs, and other child service community based organizations	Number of partnersites/schools providing best practice nutrition programming	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Expand physical activity programs in schools, after-school programs and other child service community based organizations	Number of partner sites/schools providing physicalactivity programming	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Delivery System Design	Number of lives covered under VBC/CIN/HQEP	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Create supportive environment-Expand the Business Health Collaborative	Number of businesses participating in the Business Health Collaborative	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Information System and Decision Support	Number of Community Based Organizations on EPIC	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Support the regional AccountableCare Community (ACC)	Number of community partners with signedconblocksas ACC members	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Selfmanagement/develop personal skills	Number of team membersupport programs	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
		Number of B well initiatives	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Supportthe Population Health Clinical Steering Committee	Number of providers in committee	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Educational campaigns to promote the prevention of early initiation of sex and substance use, prenatal care in 1st trimester, breastfeeding benefits, safe sleep, maternal support, stigma reduction, social justice, community empowerment, early literacy, mentoring, substance use prevention, vaping, program availability and community programming	Number of educational campaignsdeveloped and implemented	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	ImplementProjectCOMPASSion	Number of provider sites enrolled	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Implement Family Resource hub and spoke model	Launchpilot	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Increase ACEs and social risk assessments across sectors	Number of partners providing ACEs and/or social risk assessments	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Strengthen Community Action	Number of RFP pilot sites	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	StrengthenCommunity Action-Creation of Trauma Informed/Resilient Communities and Sites	Number of trauma aware trainings provided	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Build healthy public policy-second chance programs, food environment in schools, physical activity in schools,telehealth, barrier crimes, communityparamedicine, etc.	Number of legislators/governmentofficials engaged	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Advocatefor breastfeeding friendly facilities	Number of breastfeeding friendly businesses and employers	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
	Support the implementation of Community Paramedicine	Number of EMS Agencies Providing Community Paramedicine	Ballad to populate	Ballad Health	Ballad Health, Southwest Virginia and Northeast Tennessee Accountable Care Communities	Counts	N/A	2019	N/A	TBD	
Outcome		Maternity Practices in Infant Nutrition and Care Survey Scores	The CDC's national survey of Maternity Practices in Infant Nutrition and Care (mPINC) assesses maternity care practices and provides feedback to encourage hospitals to make improvements that better support breastfeeding. About every 2 years, CDC invites all hospitals across the country to complete the mPINC survey. The questions focus on specific parts of hospital maternity care that affect how babies are fed.	Center for Disease Control (CDC)	Ballad Health	Score	By Facility	Ballad to Populate	Ballad to Populate	Yes	Will appear on public dashboard in 2021.
		Breastfeeding Initiation	Percentage of live births in Ballad service area whose birth certificates report that baby is breastfed.	Vital Statistics	Virginia Department of Health, TN Department of Health	Percent	By County of Residence By Race	2020	TBD	Yes	Will appear on public dashboard in 2022.
		Mothers Who Smoke During Pregnancy	Percentage of mothers in Ballad service area who report smoking during pregnancy	Vital Statistics	Virginia Department of Health, TN Department of Health	Percent	By County of Residence By Race	2020	TBD	Yes	Will appear on public dashboard in 2024.
		Neonatal Abstinence Syndrome Births	Number of reported cases in Ballad service area with clinical signs of withdrawal, excluding mothers enrolled in MAT, per 1,000 live births	Inpatient Discharge Data	Virginia Department of Health, TN Department of Health	Rate	By County of Residence By Race	2020	TBD	Yes	Will appear on public dashboard in 2023.
		Overweight and Obese Children	Ballad to Populate	Virginia Youth Survey, TBD for TN	Virginia Department of Health, Virginia Department of Education	TBD	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2027
		Kindergarten Readiness	Ballad to Populate	PALS Testing Scores, TBD for TN	Virginia Department of Education, TBD for TN	TBD	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2024.
		Third Grade Reading Levels	Ballad to Populate	PALS Testing Scores, TBD for TN	Virginia Department of Education, TBD for TN	TBD	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2026.
		8th Grade Math and English	Ballad to Populate	TBD	TBD	TBD	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2027. *States will convene working group with DOEs to develop meaningful measure for proposal to the TAP in 2020.
		Teen Births	Rate of births per 1,000 females aged 15-19 years of age	Vital Statistics	Virginia Department of Health, TN Department of Health	Rate	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2025.
		Drug Deaths	Deaths in Ballad service area attributed to a fentanyl, heroin, or prescription opioid overdose.	Vital Statistics	Virginia Department of Health, TN Department of Health	Count	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2026.

	Youth Tobacco	Ballad To Populate	Virginia Youth Survey, TBD for TN	TBD	TBD	By County of Residence	2020	TBD	Yes	Will appear on public dashboard in 2025.
	Prenatal Care	Percent of births with adequate prenatal care, as measured using the Kotelchuck Index. Virginia, 2013-2017 The Kotelchuck Index is also called the Adequacy of Prenatal Care Utilization (APNCU) Index, uses the date of initiation of care and the number of prenatal visits from the time care began until the time of delivery.	Vital Statistics	Virginia Department of Health, TN Department of Health	Percent	By County of Residence By Race	2020	TBD	Yes	Will appear on public dashboard in 2022.
	High School Graduation	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Substance Abuse	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Adult Obesity	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Infant Mortality	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Adult Smoking	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Suicide	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
Impact	Employment	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	Impact measures will be developed and outlined in partnership with researchers, the States, and other stakeholders.
	Children In Poverty	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Per Capita Income	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Median Household Income	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Leading Causes of Death and Disease	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Adverse Childhood Experiences (ACEs) Metrics	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
	Homelessness	To be developed in partnership with ETSU and other research entities in execution of Ballad's Longitudinal Study.	TBD	TBD	TBD	TBD	TBD	TBD	Yes	
Plan Spending		Ballad dollars spent towards Population Health Improvement Plan implementation activities, and strategies. Grant dollars cannot be used to reach minimum spending requirements.	Ballad Health	Ballad Health	Dollars	By Strategy	N/A	N/A	Yes	

Attachment 8. Ballad Health Behavioral Health Metrics Line of Sight

Legend	
Spread and Scale/Outputs	
Impact Measures	

	STRATEGIES	ACTIVITIES	Year 1	Year 2	Year 3	Year 3 Outcome Statement	Years 10-15	Years 15-20
Behavioral Health	Develop Necessary Ballad Behavioral Health Services Infrastructure	Hire CMO, project manager, clinical data analyst and evaluate the other roles needed for the division	Hire staff to support various identified initiatives			Behavioral Health Division key leadership and programmatic resources identified and hired	**An increase in the access points for Behavioral Health Services to patients of the region**	**Increased family and community resilience as evidenced by: a decrease in suicides; a decrease in overdose deaths; a decrease in NAS births**
	Achieve a high level of integration of Behavioral Health services into primary care (PCBHI)	Hire the BHCNs (Behavioral Health Care Navigators) to get a set of four that will work in regional PODS Place counseling services in outpatient clinics Expansion of MAT services in Primary Care Provide training to PC locations on trauma-informed care Provide REACH suicide prevention training to clinicians	Number of lives touched by a BHCN (Behavioral Health Care Navigators) Number of MAT settings across the PC footprint Number of sites with counseling services Number of unique patients who were counseled in a PC setting Number of referrals to extended services/ advanced levels of care			Improved patient access to behavioral health services in a PC setting		
	Expand Telebehavioral Health Options	Installation of comprehensive telehealth equipment at all Ballad Expand access to telebehavioral health services across the Evaluate opportunities to leverage existing telemedicine	Number of telebehavioral health visits Number of children treated through school-based telebehavioral health Number of Ballad access sites for telebehavioral health			Increased access to telebehavioral health services throughout the region		
	Supplement Existing Regional Crisis System	Expand Screening, Brief Intervention, and Referral to Treatment Provide QPR (Question, Persuade, and Refer) Gatekeeper Provide REACH suicide prevention training to clinicians Expand crisis transportation services	Number of clinicians receiving QPR training Number of clinicians receiving REACH training Number of screens provided (based on SBIRT) Number of behavioral health transports			The Regional Crisis System has been supplemented to allow for efficient and effective service delivery. Screening of patients to facilitate early identification of at-risk		
	Enhance and Expand Resources for Addiction Treatment	Expansion of RATC (Residential Addiction Treatment Center) Education of Ballad clinicians in MAT Expansion of MAT services in Primary Care Expansion of Peer Recovery Specialist services	Number of clinicians educated in MAT Number of patients who have received MAT services from a Ballad clinician Number of Ballad Primary Care clinicians providing MAT services Number of facilities with access to Peer Recovery Services Number of Ballad Health counseling FTEs focused on substance abuse, including peers Number of Smyrna RATC patients served			Expansion of addiction services; increased clinician addiction practice knowledge; increased access points		

Attachment 8. Ballad Health Cooperative Agreement
Behavioral Health Measures: Years 1-3

Submitted to the States Annually and Reported During Bi-Annual Update Meetings
Implementation Barriers to be Presented to the States during Bi-Annual Update Meetings
***Stratified Data only to be reported in Annual Report**

Strategy	Activity	Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification*	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Develop Necessary Ballad Behavioral Health Services Infrastructure	Hire CMO, project manager, clinical data analyst and evaluate the other roles needed for the division										
Achieve a high level of integration of Behavioral Health services into primary care (PCBHI)	Hire the BHCNs (Behavioral Health Care Navigators) to get a set of four that will work in regional PODS	Number of lives touched by a Behavioral Health Care Navigator	Number of unique patients served by behavioral health navigators	EMR	Ballad	Count	By State By Zip Code of Residence By Payer Type	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Place Counseling Services in Outpatient Clinics	Number of sites with counseling services	Number of sites providing counseling services	Ballad	Ballad	Count	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Number of unique patients who were counseled in a Primary Care Setting	Number of unique patients who received counseling services in a Ballad primary care facility	EMR	Ballad	Count	By State By Facility	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Ballad Health PCBHI Programs	Number of existing Ballad Health PCBHI programs	Ballad	Ballad	Count	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
Expand Telebehavioral Health Options	Installation of comprehensive telehealth equipment at all Ballad Health EDs	Number of Patients receving telehealth services from a Ballad Emergency Department	Number of Patients receving telehealth services from a Ballad Emergency Department	Ballad Health	Ballad	Count	By State By Facility By Specialty	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Number of Ballad Health Emergency Departments providing telehealth services	Number of Ballad Health Emergency Departments providing telehealth services	Ballad Health	Ballad	Count and Percent	By State	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expand access to telebehavioral health services across the region	Number of telebehavioral health visits	Number of tele visits in PY	EMR/ Billing	Ballad	Count	By State By Zip Code of Residence By Payer Type By Adult Visits By Pediatric Visits	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Number of telebehavioral health patients	Number of patients treated through tele-behavioral services	EMR/ Billing	Ballad	Count	By State By Zip Code of Residence By Payer Type By Adult Visits By Pediatric Visits	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Number of Ballad Health access sites for telebehavioral health	Number of Ballad Health access sites for telebehavioral health	Ballad	Ballad	Count	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Evaluate opportunities to leverage existing telemedicine services within select school systems to provide behavioral health counseling services	Number of children treated through school-based telebehavioral health	Number of children treated through school-based telebehavioral health	EMR/ Billing	Ballad	Count	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
Supplement Existing Regional Crisis System	Provide QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention	Number of clinicians receiving QPR training	Number and percent of clinicians receiving QPR training	Ballad	Ballad	Count and Percent	By State	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Provide REACH Patient Centered Mental Health in Pediatric Primary Care training to clinicians	Number of clinicians receiving REACH training	Number of clinicians receiving REACH training	Ballad	Ballad	Count and Percent	By State	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expand crisis transportation services	Number of behavioral health transports	Number of behavioral health transports	Ballad	Ballad	Count	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Number of Ballad Health hospitals where Respond has been implemented	Number of Ballad Health hospitals where Respond has been implemented				By State	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
Enhance and Expand Resources for Addiction Treatment	Education of Ballad clinicians in MAT	Number of providers educated in MAT	Number of clinicians trained in Medication Assisted Treatment (MAT)	Ballad	Ballad	Count and percent of eligible	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expansion of MAT services in Primary Care	Number of patients who have received MAT services from a Ballad provider	Number of patients who have received MAT services from a Ballad provider	EMR/ Billing	Ballad	Count and percent increase from prior	By State By Zip Code of Residence By Payer Type By Facility	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expansion of Peer Recovery Specialist services	Number of facilities with access to Peer Recovery Services	Number of facilities with peer recovery specialists	Ballad	Ballad	Count	By State By County	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Plan Spending	Ballad dollars spent towards Behavioral Health Plan implementation, activities, and strategies. Grant dollars cannot be used to reach minimum spending requirements.				By Strategy			Yes	

Attachment 9. Ballad Health Children's Health Metrics Line of Sight

Legend	
Spread and Scale/Outputs	
Impact Measures	

	STRATEGIES	ACTIVITIES	Year 1	Year 2	Year 3	Year 3 Outcome Statement	Years 10-15	Years 15-20
Children's Health	Develop Necessary Ballad Children's Health Services Infrastructure	Hire CMO, project manager, clinical data analyst	Hire staff to support various identified initiatives			Build a coordinated children's health program across Ballad Health's service area and expand Ballad's pediatric clinical capabilities with a core support infrastructure, including additional leadership and partnerships.	**Provide pediatric ED and specialty care closer to home so children and their families do not have to travel as far to obtain high quality services in a manner that maximizes limited resources**	**Provide pediatric ED and specialty care closer to home so children and their families do not have to travel as far to obtain high quality services in a manner that maximizes limited resources**
		Establish Pediatric Advisory Council with Ballad and non-Ballad pediatricians to establish clinical protocols for inpatient, emergency department, urgent care and outpatient initiatives.	Implementation of standardized clinical care protocols for children with asthma and other priority areas to be identified					
	Establish ED Capabilities and Pediatric Specialty Centers in Kingsport and Bristol	Complete necessary renovations to one of Ballad Health's	Number of Pediatric ED visits in Kingsport; Number of Pediatric ED Visits in Bristol			Establish pediatric specialty centers and ED capabilities in Kingsport and Bristol to allow pediatric patients to receive care closer to		
		Expand dedicated emergency medicine provider coverage						
		Implement operational changes including the development						
	Develop Telemedicine and Rotating Specialty Clinics in Rural Hospitals	Installation of comprehensive telehealth equipment at all	Number of pediatric telemedicine visits; Number of tele-neonatology visits in Kingsport; Number of tele-neonatology visits in Bristol			Access to Pediatric care through telemedicine and/or rotating clinics allows Niswonger specialty capabilities to expand to serve the		
		Expand pediatric access to telehealth services for those in						
		Evaluate opportunities to leverage existing telemedicine	Number of children treated through school-based behavioral health telemedicine					
	Recruit and Retain Subspecialists	Recruit or partner for access to pediatric subspecialists (11.5	Current number of existing partnerships to access specialists; Number of specialists accessible through new partnerships			Increase access to pediatric subspecialists to meet community need and support CRPC certification.		
		Survey employed pediatric subspecialists to understand						
		Reassess (at least every three years) workforce analyses to						
		Explore relationship with East Tennessee State University						
		Work with State of Tennessee on CRPC guidelines for rural						
	Develop CRPC Designation at Niswonger Children's Hospital	Recruit and retain pediatric subspecialists per Strategy #4	Improve trauma care provided to children in the region			CRPC designation establishes the Niswonger ED as the regional hub for treating pediatric trauma patients without the need to transfer out of the		
		Address additional operational and service needs as detailed						
		Hire additional administrative and clinical personnel as						

Attachment 9. Ballad Health Cooperative Agreement
Children's Health Plan Measures: Years 1-3

Submitted to the States Annually and Reported During Quarterly Update Meetings
Implementation Barriers to be Presented to the States during Bi-Annual Update Meetings
***Stratified Data only to be reported in Annual Report**

Strategy	Activity	Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification*	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Develop Necessary Ballad Children's Health Services Infrastructure	Hire CMO, project manager, clinical data analyst										
	Establish Pediatric Advisory Council with Ballad and non-Ballad pediatricians to establish clinical protocols for inpatient, emergency department, urgent care and outpatient initiatives.										
Establish ED Capabilities and Pediatric Specialty Centers in Kingsport and Bristol	Complete necessary renovations to one of Ballad Health's Kingsport hospitals and to Bristol Regional Medical Center in order to better accommodate pediatric patients and their families.	Number of Pediatric ED visits	Number of Pediatric Visits by Location	Ballad EMR	Ballad Health	Count	By Facility By Zip Code of Residence By Payer Type	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expand dedicated emergency medicine provider coverage for pediatrics to ensure 24/7 coverage.										
	Implement operational changes including the development of a dedicated pediatric triage line, urgent care triage protocols, and transfer protocols to Niswonger ED.										
Develop Telemedicine and Rotating Specialty Clinics in Rural Hospitals	Install/refer comprehensive telehealth equipment at all Ballad Health EDs (see Rural Health Plan). This will allow connectivity to Niswonger Children's Hospital from all Ballad Health EDs. Expand pediatric access to telehealth services for those in the service area unable to travel to a Niswonger pediatric specialty location. Such access will be provided through locations	Number of pediatric telehealth visits by location and type	Number of pediatric telehealth visits by location and type	Ballad EMR	Ballad Health	Count	By Zip Code of Residence By Payer Type By Location By Specialty Type	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
Recruit and Retain Subspecialist	Recruit or partner for access to pediatric subspecialists (11.5 FTEs)	Number and type of pediatric subspecialists accessible to the system	Number and type of pediatric subspecialists accessible to the system	Ballad EMR	Ballad Health	Count	By State By Specialty	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
~~Develop CRPC Designation at Niswonger Children's Hospital~~											
		Plan Spending	Ballad dollars spent towards Children's Health Plan implementation, activities, and strategies. Grant dollars cannot be used to reach minimum spending requirements.	Ballad	Ballad Health	Dollars	By Strategy			Yes	

Attachment 10. Ballad Health Rural Health Metrics Line of Sight

Legend	
Spread and Scale/Outputs	
Impact Measures	

	STRATEGIES	ACTIVITIES	Year 1	Year 2	Year 3	Year 3 Outcome Statement	Years 10-15	Years 15-20
Rural Health	Expand access to Primary Care practices through additions of Primary Care physicians and mid-levels to practices in counties of greatest need	Target counties with low appointment availability and limited PCP or urgent care infrastructure relative to the county population.	Number of patients treated by additional Primary Care providers			Increased access to primary care for rural populations	**A system of comprehensive care that that better serves rural populations throughout the region**	**Eliminate the inequity in care between rural and urban populations**
		Within high-needs counties, evaluate specific practices that have a high proportion of attributed lives, space capacity, and support staff to prioritize order of deployment.						
		Hire at least one additional primary care physician in 2019 in Unicoi and Russell counties and one pediatrician in Wise County in 2020. Continue evaluation of primary care needs in rural counties and respond with updated recruitment plans as needed.						
		Develop recruitment plan and hire two mid-levels in 2019, one in 2020, and two in 2021. When adding midlevel practitioners, ensure they have availability to support walk-in appointments, and in select practices, expand evening/ weekend hours, thereby more effectively supporting current physicians on staff.						
		Ballad to complete its initial provider needs assessment for the rural communities within the service area.						
	Recruitment of physician specialists to meet rural access needs	Review and revise system-wide recruitment plan for rural counties, taking into consideration community-based need, rural hospital medical staff needs, and growing telehealth capabilities.	Number of patients treated by additional specialists			Increased access to specialty care for rural populations		
		Execute on Ballad recruitment plan, based on priorities by specialty and by location. Access to specialty care provided through: Locating specialty practice full-time in rural communities Providing rotating specialty clinics in rural communities Providing rural residents with telehealth access to specialists Providing preferred/reserved appointment scheduling for rural residents traveling to urban areas for specialist care						
		Coordinate with Ballad's ongoing Health Research and GME Plan workgroup to leverage opportunities for recruitment and development from regional medical schools and networks.						
		Review needs and progress annually and update as						
		Ballad to complete its initial provider needs assessment for						
	Implement team-based care models to support Primary Care Providers,	Evaluate existing Ballad and private practitioner care coordination resources to ensure effective resourcing within each region, and maximum impact for patients.	Number of patient lives impacted by a team-based care model			Implementation of team-based care to better		
		Evaluate and determine appropriate team-based model for rural populations and implement one pilot each year, beginning in 2019						
		Focus on team-based care models that address chronic care needs outside of behavioral health (note: Integration of primary care and behavioral health addressed in Behavioral Health Plan).						

beginning with pilots in high need counties	Recruit positions to support regional programs - outlining a schedule of rotation for the teams. Teams to include: o Care Coordinator o Community Health Worker o Health Coach o Pharmacist		serve the needs of the population		
	Leverage virtual health as available to extend access to specialty care within the system.				
Develop and deploy virtual care services	Create a centralized virtual health team (leadership and support staff) that is resourced to support deployment of virtual health strategies and assess gaps. Deploy and/or realign necessary infrastructure, including staff and technology, to support the envisioned virtual care network.	Number of Ballad hospitals with at least one comprehensive care for high acuity episodes and one secondary care for lower acuity episodes Number of tele-stroke patients Number of tele-behavioral patients Number of current tele-behavioral outpatient sites for low acuity patients Number of current tele-pediatric patients Number of Ballad Health e-visits	Implementation of a comprehensive virtual care model that better meets the needs of the population		
	Add telehealth equipment to ensure all Ballad hospitals have at least one comprehensive cart for high-acuity episodes (e.g., tele-stroke) and one secondary cart for lower-acuity episodes (e.g., consults).				
	Expand tele-stroke services to a broader geography, providing enhanced access to this critical service.				
	Expand behavioral health telemedicine services by adding 10 outpatient sites for low acuity patients. This capability will support a "hub and spoke" model for behavioral telehealth with Ballad hospital-based services.				
	Build on Ballad Health's EPIC roll-out and plan for the deployment of E-visits (email) as an additional means of access to care.				
	Collectively, these telehealth resources in Ballad's rural communities will provide additional access to both adult and pediatric specialists.				
Coordinate Preventative Health Care Services	Increase the current reach of dental sealant programming in schools (Realign with proposed STRONG Conceptual Model in Population Health Plan)	See Population Health Plan			
	Increase the availability of additional preventative and	See Health Research and GME Plan			
	Increase the reach of current community based vision	See Population Health Plan			

Attachment 10. Ballad Health Cooperative Agreement
Rural Health Measures: Years 1-3

Submitted to the States Annually and Reported During Quarterly Update Meetings
Implementation Barriers to be Presented to the States during Bi-Annual Update Meetings
***Stratified Data only to be reported in Annual Report**

Strategy	Activity	Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification*	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Expand access to Primary Care practices through additions of Primary Care physicians and mid-levels to practices in counties of greatest need		Number of patients treated by additional Primary Care providers	Number of unique patients treated by additional Primary Care providers	Ballad EMR	Ballad Health	Count	By State By Zip Code of Residence By Payer Type	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
Recruitment of physician specialists to meet rural access needs		Number of patients treated by additional specialists	Number of unique patients treated by additional specialists	Ballad EMR	Ballad Health	Count	By State By Zip Code of Residence By Payer Type By Specialty	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
Implement team-based care models to support Primary Care Providers, beginning with pilots in high need counties	Evaluate and determine appropriate team-based model for rural populations and implement one pilot each year, beginning in 2019										
	Recruit positions to support regional programs - outlining a schedule of rotation for the teams. Teams to include: o Care Coordinator o Community Health Worker o Health Coach o Pharmacist										
Develop and deploy virtual care services	Create a centralized virtual health team (leadership and support staff) that is resourced to support deployment of virtual health strategies and assess gaps. Deploy and/or realign necessary infrastructure, including staff and technology, to support the envisioned virtual care network.										
	Add telehealth equipment to ensure all Ballad hospitals have at least one comprehensive cart for high-acuity episodes (e.g., tele-stroke) and one secondary cart for lower-acuity episodes (e.g., consults).	Percent of Ballad hospitals with at least one comprehensive telehealth cart for high-acuity episodes	Percent of Ballad hospitals with at least one comprehensive telehealth cart for high-acuity episodes	Ballad Health	Ballad Health	Count and Percent	By State By Facility	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Percent of Ballad hospitals with at least one secondary telehealth cart for high-acuity episodes	Percent of Ballad hospitals with at least one comprehensive telehealth cart for high-acuity episodes	Ballad Health	Ballad Health	Count and Percent	By State By Facility	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expand tele-stroke services to a broader geography, providing enhanced access to this critical service.	Number of tele-stroke patients	Number of tele-stroke patients	Ballad EMR	Ballad Health	Count	By State By Zip Code of Residence By Payer Type	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Expand behavioral health telemedicine services by adding 10 outpatient sites for low acuity patients. This capability will support a "hub and spoke" model for behavioral telehealth with Ballad hospital-based services.	Number of tele-behavioral outpatient sites for low acuity patients	Number of tele-behavioral outpatient sites for low acuity patients	Ballad EMR	Ballad Health	Count	By State	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Build on Ballad Health's EPIC roll-out and plan for the deployment of E-visits (email) as an additional means of access to care.	Number of Ballad Health e-visits	Number of Ballad Health e-visits	Ballad EMR	Ballad Health	Count	By State By Zip Code of Residence By Specialty	Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
		Plan Spending	Ballad dollars spent towards Rural Health Plan implementation, activities, and strategies. Grant dollars cannot be used to reach minimum spending requirements.	Ballad Health	Ballad Health	Dollars	By Strategy			Yes	

Attachment 11. Ballad Health Health Information Exchange Metrics Line of Sight

Legend	
Spread and Scale/Outputs	
Impact Measures	

	STRATEGIES	ACTIVITIES	Year 1	Year 2	Year 3	Year 3 Outcome Statement	Years 10-15	Years 15-20
Health Information Exchange	Establish Ballad Health HIE Steering Committee	Establish a Ballad Health HIE Steering Committee to guide Appoint an HIE Program Director Establish an HIE Steering Committee charter, governance model and operating guidelines	Creation of a well-developed HIE governance structure to ensure the successful deployment and ongoing management of the Ballad's HIE strategies and initiatives			Independent Providers will benefit from a well governed steering committee that is responsive to their/ the Geographic Service Area's HIE needs.	**Support robust health information exchange aimed at ensuring providers have appropriate information to better manage their patient population by having a more complete view into the care they receive throughout the region**	**Support robust health information exchange aimed at ensuring providers have appropriate information to better manage their patient population by having a more complete view into the care they receive throughout the region**
	Conduct Geographic Service Area Interoperability Research	Leveraging its initial assessment, Ballad Health will conduct research to gauge interest in menu offerings. This will allow Ballad Health to educate and survey Independent Providers within the region to understand their interest in the interoperability options.	Engagement and education for independent providers on HIE options. Completed assessment.			Market research will allow Ballad Health to better understand the actual interest, readiness and willingness to pay of Geographic Service Area Independent Providers to engage in HIE within the region		
	Identify Optimal Portfolio of Interoperability and Assemble Deployment Strategies	Develop an HIE plan with deployment strategies. Based on the initial assessment of the current interoperability environment in the GSA and the market survey gauging interest of area providers, Ballad Health will formulate a future state and develop an HIE plan that address gaps between where it wants to be and where it is today.	Portfolio developed.			The goal is to obtain maximum concentration of patient encounters from the available funding. This will require prioritizing interoperability options in such a way that generates the maximum benefit and coverage with the least cost. The approach will be to layer the most impactful solution first, then the second most impactful solution and so forth.		
	Develop an HIE Recruitment and Support Plan	Ballad Health will design and deploy an HIE Recruitment Ballad Health will identify a marketing staff member who will	Recruitment plan designed and developed.			A recruitment and support plan will identify and engage practices interested in Ballad Health's		
	Participate in ConnectVirginia's HIE and Other TN/VA Regulatory Programs	Ballad Health will continue to participate in the VA Ballad Health will continue to participate in the TN Ballad Health will participate in the Tennessee Hospital	Number of Ballad Health VA EDs participating in ConnectVirginia EDCC program; Number of Ballad Health VA hospitals participating in ConnectVirginia PDMP program; Number of Ballad Health hospitals participating in Virginia Immunization program;			This participation enables interoperability among Ballad Health, other health organizations and Independent Providers which improves		

Attachment 11. Ballad Health Cooperative Agreement
Health Information Exchange Measures: Years 1-3

Submitted to the States Annually and Reported During Quarterly Update Meetings
Implementation Barriers to be Presented to the States during Bi-Annual Update Meetings
***Stratified Data only to be reported in Annual Report**

Strategy	Activity	Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification*	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Participate in ConnectVirginia's HIE and Other TN/VA Regulatory Programs	Ballad Health will continue to participate in the VA Emergency Department Care Coordination (EDCC) Program and roll out to the Tennessee facilities	Percent of Ballad Health Virginia Emergency Departments Participating in Virginia's Emergency Department and Care Coordination Program	Percent of Ballad Health Virginia Emergency Departments Participating in Virginia's Emergency Department and Care Coordination Program	Ballad Health	Ballad Health	Count and Percent		Ballad to submit in 2020 Annual Report	Ballad to submit in 2020 Annual Report	Yes	
	Ballad Health will continue to participate in the TN Immunizations Programs and Syndromic Surveillance (TN & VA) program	Number of Ballad Health sites participating in Virginia and Tennessee immunization program	Number of Ballad Health sites participating in Virginia and Tennessee immunization program	Ballad Health	Ballad Health	Count and Percent					
Develop an HIE Recruitment and Support Plan	Ballad Health will design and deploy an HIE Recruitment Plan. The plan will include communications both within Ballad Health and with the independent Providers. It will include marketing activities and materials to approach the independent Providers within the region regarding the menu offerings										
Identify Optimal Portfolio of Interoperability and Assemble Deployment Strategies	Develop an HIE plan with deployment strategies. Based on the initial assessment of the current interoperability environment in the GSA and the market survey gauging interest of area providers, Ballad Health will formulate a future state and develop an HIE plan that address gaps between where it wants to be and where it is today.										
Establish Ballad Health HIE Steering Committee	Establish a Ballad Health HIE Steering Committee to guide the development, deployment and ongoing maintenance of Ballad Health's HIE efforts										
Conduct Geographic Service Area Interoperability Research	Leveraging its initial assessment, Ballad Health will conduct research to gauge interest in menu offerings. This will allow Ballad Health to educate and survey independent Providers within the region to understand their interest in the interoperability options.	Number of Non-Ballad Providers in Service Area with committed interest in pursuing HIE data sharing agreements	Number of Non-Ballad Providers in Service Area with committed interest in pursuing HIE data sharing agreements	Ballad Health	Ballad Health	Count	By Organization Type				
		Plan Spending	Ballad dollars spent towards Health Information Exchange Plan implementation, activities, and strategies. Grant dollars cannot be used to reach minimum spending requirements.	Ballad Health	Ballad Health	Dollars	By Strategy			Yes	

Attachment 12. Ballad Health Research and Graduate Medical Education Metrics Line of Sight

Legend	
Spread and Scale/Outputs	
Impact Measures	

	STRATEGIES	ACTIVITIES	Year 1	Year 2	Year 3	Year 3 Outcome Statement	Years 10-15	Years 15-20
Health Research and GME	Establish the Tennessee/Virginia Regional Health Sciences Consortium	Develop Governance	Establish and support roster of consortium participants.			Functional and collaborative Consortium with focus on regional needs improvement	**Dynamic and inclusive system for professional growth, development, and research, focused on the unique needs of the region. Initiation of a change in the health and employment prospects for the citizens of this region.**	**Established norms and expectations for professional development and community health that contributes to changing perceptions of life in the region from those living within and those external. Model of health, educational, industry, and research priorities that serve as a centerpiece for the reimagination of rural America and the potential that purposeful coordination can provide.**
		Develop Sub-Committees	Establish, develop, and support Coordinating Council, Academic Council, and Research Council. Potential for additional sub-councils to form as workgroups.					
		Develop Infrastructure	Evaluate current staffing and technology within the region related to Academics and Research with emphasis on Ballad Health Resources. Develop gap analysis. Invest in resources needed to support the Consortium efforts.					
	Identify Targeted Hiring Needs to Build Research Capacity and Academic Growth	Workforce analysis	Initiate and complete workforce analysis	Partner with regional partners on prioritized plans for closing gaps identified on workforce analysis	Update and further close gaps revealed in the workforce analysis as well as address new gaps	Adaptive process for identifying and addressing regional workforce needs.		
		Targeted hires	Identify and prioritize key hiring to address the regional needs in academics and research					
	Develop and Operationalize Consortium Research Infrastructure to Support Health Research in the Region	Research Strategy	Develop and deploy research priorities and strategies based on assessment and input of regional partners. Ballad implementation of internal studies of outcomes based on COPA/CA plans.			Functional and innovative research network focused on the issues unique to this region.		
		Research Infrastructure	Complete inventory of current research capabilities in the region. Develop plans for closure of identified gaps in capabilities. Investments in Ballad Infrastructure. Development of annual symposium.					
	Develop & Operationalize an Education and Training Infrastructure to Support the Region	Health Professions Office within Ballad Health	Evaluate current staffing within Ballad. Targeted hiring to fill critical roles in academics and research.			Mature system of educational opportunities and structure supportive of the regional needs and responsive to the changing demands of the health of the region, the workforce, and employers		
		Educational challenges	Utilize consortium to develop and prioritize key educational challenges in the region. Utilize the work of the Consortium to foster thoughtful growth of programs. Develop rubric related to training within Ballad facilities.					
		Industry challenges	Utilize outcomes of workforce analysis within the regional business and industry sector to partner and develop plans for growth in key training programs even outside of health-related education.					
		Addiction Medicine	Complete development of Addiction Medicine Fellowship with ETSU. Develop Addiction Medicine Fellowship in SW VA.					
		Recruitment and retention	Fund studies to understand the issue of recruitment and retention in the region. Isolate and prioritize key factors with the Consortium. Address those factors together with members of the Consortium. Invest in technology platform to allow for improved access to employment opportunities across the region.					
		Dental care	Implement dental training program in Abingdon VA. Develop infrastructure around training and access for dental care in the region. Partner with Academic institutions on programs designed to support dental health.					
		Nursing	Utilize workforce analysis to develop strategy around nursing education, recruitment, retention, and career ladder. Continue the work on rotation site availability and coordination within Ballad and the region.					
		Allied Health	Develop and implement Allied Health incentive and career progression models. Align with regional partners on growth of priority training programs.					

Attachment 12. Ballad Health Cooperative Agreement

Health Research & Graduate Medical Education Measures: Years 1-3

Implementation Barriers to be Presented to the States during Bi-Annual Update Meetings
Submitted to the States Annually and Reported During Quarterly Update Meetings

Strategy	Activity	Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Establish the Tennessee/Virginia Regional Health Sciences Consortium	Develop Governance										
	Develop Sub-Committees										
Identify Targeted Hiring Needs to Build Research Capacity and Academic Growth	Workforce Analysis										
Develop and Operationalize Consortium Research Infrastructure to Support Health Research in the Region	Research Infrastructure										
	Develop Health Professions Office within Ballad Health										
	Increase Addiction Medicine Education Opportunities	Number of consortium led regional education sessions related to addiction medicine	Number of consortium led regional education sessions related to addiction medicine	Ballad Health	Ballad Health	Count					
	Evaluate Regional Health Professional Recruitment and Retention Barriers										
	Support Dental Workforce Development	Number of workforce development partnerships	Number of workforce development partnerships	Ballad Health	Ballad Health	Count					
	Support Nursing Workforce Development	Number of workforce development partnerships	Number of workforce development partnerships	Ballad Health	Ballad Health	Count					
	Support Allied Health Workforce Development	Number of allied health incentive and career progression programs	Number of allied health incentive and career progression programs	Ballad Health	Ballad Health	Count					
		Plan Spending	Ballad dollars spent towards Health Research and Graduate Medical Education Plan implementation, activities, and strategies. Grant dollars cannot be used to reach minimum spending requirements.	Ballad Health	Ballad Health	Dollars	By Strategy			Yes	

Attachment 13. Ballad Health Cooperative Agreement
Access Measures

Submitted to the States Annually

Measure	Definition	Data Source	Data Steward	Data Type	Data Stratification	Baseline Year	Baseline	Publically Facing on Dashboard	Notes
Population within 10 miles of a Ballad Health urgent care center	Population-weighted % of residents across all Census blocks that reside within 10 miles of a Ballad Health urgent care center. Urgent care centers may or may not be located in the geographic service area. In the event that a non-Ballad closure has an adverse effect on access, Ballad will submit an evaluation plan to the States.	Facility Addresses and ACS Census Data	Ballad Health	Percent	By State	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	Develop Maps for Dashboard and Annual Reports. Develop narrative outlining requirements for services to remain in county. Ballad will submit an evaluation plan when non-Ballad facilities close.
Population within 10 miles of a Ballad Health urgent care center open nights and weekends	Population-weighted % of residents across all Census blocks that reside within 10 miles of a Ballad Health urgent care center open nights and weekends, to be defined as open at least three (3) hours after 5 pm Monday to Friday and open at least five (5) hours on Saturday and Sunday. Urgent care centers may or may not be located in the geographic service area. In the event that a non-Ballad closure has an adverse effect on access, Ballad will submit an evaluation plan to the States.	Facility Addresses and ACS Census Data	Ballad Health	Percent	By State	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Population within 10 miles of a Ballad Health urgent care facility or emergency department	Population-weighted % of residents across all Census blocks that reside within 10 miles of a Ballad Health urgent care facility or emergency department. Urgent care centers or emergency departments may or may not be located in the geographic service area. In the event that a non-Ballad closure has an adverse effect on the outcome, Ballad will submit an evaluation plan to the States.	Facility Addresses and ACS Census Data	Ballad Health	Percent	By State	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Population within 15 miles of a Ballad Health emergency department	Population-weighted % of residents across all Census blocks that reside within 15 miles of a Ballad Health emergency department. Emergency Departments may or may not be located in the geographic service area in the event that a non-Ballad closure has an adverse effect on access, Ballad will submit an evaluation plan to the States.	Facility Addresses and ACS Census Data	Ballad Health	Percent	By State	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	Critical Access Hospitals must be 25 miles from the nearest 24/7 Emergency Department
Population within 15 miles of a Ballad Health acute care hospital	Population-weighted % of residents across all Census blocks that reside within 15 miles of a Ballad Health acute care hospital. Acute care centers may or may not be located in the geographic service area. In the event that a non-Ballad closure has an adverse effect on access, Ballad will submit an evaluation plan to the States.	Facility Addresses and ACS Census Data	Ballad Health	Percent	By State	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Pediatric Readiness of Emergency Department	Score of Ballad Health Emergency Departments on the National Pediatric Readiness Project Survey from the National EMSC Data Analysis Resource Center	National EMSC Data Analysis Resource Center	Ballad Health	Score	By Facility	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Average time to 3rd appointment for Ballad specialist	Average time to 3rd appointment for Ballad specialist	Ballad EMR	Ballad Health	Days	By State By Pediatric Specialty By Gerontologist By Specialty	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	Produce maps for annual report
Average time to 3rd appointment for Ballad PCP	Average time to 3rd appointment for Ballad PCP	Ballad EMR	Ballad Health	Days	By State By Pediatric PCPs By General Practices	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	Produce maps for annual report
Preventable Hospitalizations – Medicare	Number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	Inpatient Discharge Data	Ballad Health	Rate	By State By Diagnosis By Zip Code of Pt. Residence	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Preventable Hospitalizations – Adults	Number of discharges for ambulatory care-sensitive conditions per 1,000 adults aged 18 years and older	Inpatient Discharge Data	Ballad Health	Rate	By State By Diagnosis By Zip Code of Pt. Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Screening – Breast Cancer	biennial screening mammography for women 50-74 years.	Ballad EMR	Ballad Health	Ballad to Submit in 2020 Annual	By State By Zip Code of Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Screening – Cervical Cancer	screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	Ballad EMR	Ballad Health	Ballad to Submit in 2020 Annual Report	By State By Zip Code of Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Screening – Colorectal Cancer	screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.	Ballad EMR	Ballad Health	Ballad to Submit in 2020 Annual	By State By Zip Code of Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Screening – Diabetes	Percent of Ballad Health patients at risk for diabetes screened for diabetes. Type 2 diabetes testing is indicated for all asymptomatic adults who are overweight or obese (BMI >25 or >23 in Asian Americans) and who have one or more diabetes risk factors, including: -Physical inactivity -First-degree relative with diabetes -High-risk race/ethnic group -Women who delivered a baby >9 pounds or were diagnosed with gestational diabetes -High-density lipoprotein cholesterol <35mg/dl +triglyceride >250mg/dl. -Hypertension (>140/90 mm Hg or on therapy) -A1C >5.7%, impaired glucose tolerance (IGT) or impaired fasting glucose (IFG) on previous testing -Conditions associated with insulin resistance (eg, severe obesity, acanthosis nigricans, polycystic ovarian syndrome) -Cardiovascular disease history For all other patients, testing should begin at age 45 years. If results are normal, testing should be repeated at minimum of three year intervals with more frequent testing depending on initial testing results and risk status.	Ballad EMR	Ballad Health	Ballad to Submit in 2020 Annual Report	By State By Zip Code of Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	

Screening – Hypertension	Controlling High Blood Pressure (USPSTF/ NQF 0018)	Ballad EMR	Ballad Health	Ballad to Submit in 2020 Annual	By State By Zip Code of Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Follow-Up After Hospitalization for Mental Illness (7 Days)	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, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner within (7) days post-discharge	Ballad Health EMR; NCQA The State of Health Care Quality Report	Ballad Health	Count and Percent	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Follow-Up After Hospitalization for Mental Illness (30 Days)	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, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner within (30) days post-discharge	Ballad Health EMR; NCQA The State of Health Care Quality Report	Ballad Health	Count and Percent	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
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)	Ballad Health EMR; NCQA The State of Health Care Quality Report	Ballad Health	Count and Percent	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
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)	Ballad Health EMR; NCQA The State of Health Care Quality Report	Ballad Health	Count and Percent	By State By Zip Code of Residence By Payer Type (MSSP & Team Member)	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
SBIRT Administration-Emergency Departments	Number of SBIRTS provided in Ballad Health Emergency Departments	Ballad Health EMR	Ballad Health	Count	By State By Facility	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
SBIRT Administration-Outpatient Facilities	Number of SBIRTS provided in Ballad Health Outpatient Facilities	Ballad Health EMR	Ballad Health	Count	By State By Facility	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Patient Satisfaction and Access Surveys	Ballad to Submit in 2020 Annual Report	Ballad to Submit in 2020 Annual Report	Ballad Health	Ballad to Submit in 2020 Annual	By Facility	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Patient Satisfaction and Access Survey – Response Report	Ballad to Submit in 2020 Annual Report	Ballad to Submit in 2020 Annual Report	Ballad Health	Ballad to Submit in 2020 Annual	By Facility	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	
Screening-Lung Cancer	annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	Ballad Health EMR	Ballad Health	Ballad to Submit in 2020 Annual Report	By State By Zip Code of Residence By Payer Type	Most Current Data Point as of February 1, 2018	Ballad to submit in 2020 Annual Report	Yes, at the state level	

Attachment 14. Ballad Health Cooperative Agreement
Additional Cooperative Agreement Metrics

Submitted to the States Annually

Category	Measure	Data Source	Data Steward	Data Type	Data Stratification	Baseline Year	Baseline	Publicly Facing on Dashboard	Notes
Employee Health	% of Team members achieving all 8 BeWell Attributes (Blood Pressure, LDL cholesterol, HgbAIC, BMI, Nicotine Free, Emotional Health Index, PCP once/yr, Recommended Immunizations)	Ballad Health	Ballad Health	TBD	N/A	TBD	TBD	No	
Value-Based Contracting	Total Cost of Care measured by PMPM (4 VBC arrangements at risk)	Ballad Health	Ballad Health	Dollars	By Contract Type	TBD	TBD	No	MSSP, Human MA, UHS MA, and Team Members
	Financial Impact (total financial impact not net)	Ballad Health	Ballad Health	Dollars	By Contract Type	TBD	TBD	No	
	Number of contracts in 5 different arrangement types according to VBC dashboard (shared-savings; hospital-based; full-risk, pay-for gap /care coordination and other)	Ballad Health	Ballad Health	Count	By Contract Type	TBD	TBD	No	
	Total lives in VBC arrangements	Ballad Health	Ballad Health	Count	By Contract Type	TBD	TBD	No	
Employer Health Outreach	Number of employers with employer health contracts with Ballad Health	Ballad Health's business health contracts	Ballad Health	Count	By State	TBD	TBD	Yes	
Staffing	Turnover-Team Members	Ballad Health's human resource records	Ballad Health	Count	By Facility	TBD	TBD	No	
	Turnover-Benefited RNs	Ballad Health's human resource records	Ballad Health	Count	By Facility	TBD	TBD	No	

Attachment 15. CA Attachments to be Submitted Annually	
Attachment	**Notes**
Summary comparison by category of patient-related prices charged during the year in review and the preceding year (in such categories as are specified by the Department);	Patient-related prices charged; Section 6.04(b)(i).
Summary of steps taken to reduce costs and improve efficiency;	Cost-efficiency steps taken; Section 6.04(b)(ii).
Update on the status of the Equalization Plan and any implementation achieved, along with any summary of changes in full-time equivalent personnel that occurred during the year in review with analysis of resulting cost savings;	Equalization Plan status; Section 6.04(b)(iii).
Report on any services or functions that were consolidated during the year in review and the resulting cost savings in excess of Two Million Dollars ($2,000,000);	Services or Functions Consolidated; Section 6.04(b)(v).
Report on any material changes in volume or availability of any inpatient or outpatient services offered during the year in review	Changes in volume or availability of inpatient or outpatient services; Section 6.04(b)(vi)
Summary containing the number of accredited resident positions for each residency program operated in the Geographic Service Area and the number of such positions that are filled, along with copies of the relevant pages of the Medicare cost reports, as available, showing the number of full time equivalent residents	Summary of residency program; Section 6.04(b)(vii).
Description of any affiliation agreements moving resident "slots" from one Ballad Hospital to another pursuant to Medicare rules, resident programs moved from one Ballad Hospital to another, and new programs started	Movement of any residency "slots"; Section 6.04(b)(viii).
Summary of Ballad's performance in meeting the quality performance standards and best practices requirements established by the Clinical Council	Summary of quality performance standards and best practices established by the Clinical Counsel in Section 4.02(b); Section 6.04(b)(xi).
Plan of Separation	Updated Plan of Separation; Section 6.04(b)(xii).
Summary comparison of Ballad Health with similar health systems, along with a comparison to one or more rating agency indices for ratio of salaries and benefits to net patient revenue, ratio of operating EBITDA to net revenue, ratio of operating income to net revenue, ratio of capital expenditures to depreciation, ratio of net	Comparison of NHS financial ratios with similar health systems; Section
income to net revenue (excess margin), days of cash on hand, days of net patient revenue outstanding, ratio of long term debt to capitalization, ratio of unrestricted reserves to long term debt and debt service coverage ratio, along with a schedule of values for each component required to make the various ratio calculations;	6.04(b)(xiii).
Summary of Total Charity Care	Total Charity Care information described in Section 4.03(f); Section 6.04(b)(xiv).
Updated Ballad Health Organizational Chart, including an updated listing of the corporate officers and members of the Board;	Updated NHS organizational chart including listing of corporate officers and members of the Board; Section 6.04(b)(xv).
Career Development Plan and implementation status overview	Explanation of implementation and results of the career development program described in Section 3.08(c);

Reports or System Updates on any other information expressly required for the Annual Report pursuant to the form of Annual Report, any other Section of the Terms of Certification, or the COPA Act.	
Summary of facility maintenance and capital expenditures, including a schedule of all maintenance and repair expenses and capital expenditures during the year	Capital Plan; Section 3.07(b).
Determination of meeting or exceeding aggregate capital expenditure spending requirements.	
Overview of the Ballad Health Clinical Counsel, to include Counsel roster, common standard of care, credentialing standards, consistent multidisciplinary peer review, and best practices	Section 4.02(b)(v).
Summary of Ballad's Integrated Delivery System Measures, including common and comprehensive set of measures and protocols that will be part of the IDS; track and monitor opportunities to improve health care and access;	Section 4.02(c)(i).
Summary of Staffing Ratios. Including hours of patient care delivered per patient and ratio of RN to LPN and other caregivers	Section 4.02(c)(iv).
Results of the 3-year survey of medical, hospital and nursing staff	Section 4.02(c)(v).
Summary of comparison by Ballad Hospital or other applicable healthcare provider affiliated with Ballad Health of price increases for Ballad to Measured Payors	Addendum 1, Section 9.1(d)(i).
Summary of comparison by COPA Hospital or other applicable healthcare provider affiliated with Ballad Health of prices decreases for Ballad to Measured Payors	Addendum 1, Section 9.1(d)(ii).
Summary comparison and by the applicable NHS provider, showing gross revenue and net revenue by Measured Payors	Addendum 1, Section 9.1(d)(iii).
A list of any new Payors which executed Managed Care Contracts during the preceding calendar year and a verified certification from the Ballad Chief Financial Officer that the pricing for such contracts complies with Addendum	Addendum 1, Section 9.1(d)(iv).
All charges and charge increases from non-hospital outpatient services, Physician Services, Charge-Based Items and Cost-Based Items	Addendum 1, Section 9.1(d)(v).
A report of chargemaster increases, by year and by provider, showing the impact on Measured Payors of such increase	Addendum 1, Section 9.1(d)(vi).
A summary of all value-based payments, broken out by COPA Hospital and by Measured Payor, including a comparison of such payments to the prior year's value-based payments from such Measured Payor	Addendum 1, Section 9.1(d)(vii).
Physician/Physician Extender Needs Assessment and Recruitment Plan	
Overview of any deficiencies or noncompliance identified by the Joint Commission	
Ballad Health Health Information Exchange Recruitment Plan (including internal and external recruitment plans)	Health Information Exchange Plan
Regional HIE Portfolio, Environmental Scan, and Interoperability Strategic Plan, including the results of a regional interoperability market survey	Health Information Exchange Plan
Overview of Ballad Health HIE Steering Committee Governance Structure	Health Information Exchange Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Roster	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Gap Analyses	Health Research & Graduate Medical Education Plan

Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Coordinating Council Roster and Meeting Schedule	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Academic Council Roster and Meeting Schedule	Health Research & Graduate Medical Education Plan
Tennessee/Virginia Regional Health Sciences Consortium (TVRHSC) Research Council Roster and Meeting Agenda	Health Research & Graduate Medical Education Plan
Overview and summary of grants applied for by the TVRHSC, including dollars requested, program(s) proposed, partners, etc.	Health Research & Graduate Medical Education Plan; Academic partnerships – money spent, summary of research, status of grant(s); Section 6.04(b)(ix). Outcomes of previously reported research projects; Section 6.04(b)(x).
Overview and summary of grants secured by the TVRSHC, including dollars awarded, program(s) to be implemented, partners, proposed outcomes, evaluation strategies, etc.	Health Research & Graduate Medical Education Plan; Academic partnerships – money spent, summary of research, status of grant(s); Section 6.04(b)(ix). Outcomes of previously reported research projects; Section 6.04(b)(x).
TVRHSC Research Timeline and Metrics	Health Research & Graduate Medical Education Plan
Overview of research projects initiated in region with TVRHSC assistance	Health Research & Graduate Medical Education Plan
Overview of research projects completed in region with TVRHSC Assistance, with executive summaries	Health Research & Graduate Medical Education Plan
Overview of Ballad Health research workforce analysis implemented strategies	Health Research & Graduate Medical Education Plan
Inventory of Regional Research Capacity	Health Research & Graduate Medical Education Plan
Annual Research Symposium Agenda and Attendee Roster	Health Research & Graduate Medical Education Plan
Roster of Filled Ballad Health Research and Academic Positions	Health Research & Graduate Medical Education Plan
Recruitment and Retention Study Timeline and Executive Summary	Health Research & Graduate Medical Education Plan
Update and Overview of Southwest Virginia Addiction Medicine Fellowship Program Planning and Implementation, to include metrics planning for future HR & GME Plans, updates/plans to engage/partner in VA Higher-Ed Institutions to provide regional support (i.e. UVA-Wise, V-Tech, VCOMM).	Health Research & Graduate Medical Education Plan
Update and Overview of Dental Residency Development Planning and Implementation, to include metrics planning for future HR & GME Plans	Health Research & Graduate Medical Education Plan
Update and Overview of Nurse Rotations by State and Facility, to include metrics planning for future HR & GME Plans	Health Research & Graduate Medical Education Plan

Update and Overview of Allied Health Career Progression Planning and Implementation, to include metrics planning for future HR & GME Plans, Allied Health Professions Gap Analysis, Partner Organizations, and Proposed Incentives	Health Research & Graduate Medical Education Plan
Nursing Education, Recruitment, Retention, and Career Advancement Plan	Health Research & Graduate Medical Education Plan
Allied Health Incentive and Career Progression Plan	Health Research & Graduate Medical Education Plan
Overview of Staffing Structure in Ballad Health Health Professions Office	Health Research & Graduate Medical Education Plan
Residency Expansion Updates	Health Research & Graduate Medical Education Plan
Summary of positions posted and hired for the execution of Ballad's Behavioral Health Plan, to include the CMO, project manager, clinical data analyst and evaluate the other roles needed for the division	Behavioral Health Plan
Summary of Ballad Health's participation in Virginia's Addiction and Recovery Treatment Services (ARTS) program, including an update on Ballad development of preferred OBOTs	Behavioral Health Plan
Summary of Ballad Health's implementation of team-based care models, including an overview on Ballad's hiring of Community Health Workers, Care Coordinators, and Health Coaches	Rural Health Plans
Summary of positions posted and hired for the execution of Ballad's Children's Health Plan, to include the CMO, project manager, clinical data analyst and evaluate the other roles needed for the division	Children's Health Plan
Summary of Pediatric Advisory Council activities, including Council roster, meeting schedule, recommendations, and recommendation implementation status	Children's Health Plan
Summary of new and existing partnerships to increase access to pediatric specialists	Children's Health Plan
Niswonger Children's Hospital CRPC Designation Update	Children's Health Plan

Technical Advisory Panel of the Cooperative Agreement
Meeting Minutes
April 2, 2019 – 10:00 a.m.
James Madison Building
Mezzanine Conference Room
109 Governor Street
Richmond, Virginia 23218

Videoconference Location:
Wise County Health Department
134 Roberts Avenue SW
Wise, Virginia 24239

Members present: Joseph Hilbert (Virginia Department of Health "VDH"), Chair; Don Beatty (Virginia Bureau of Insurance); Dr. Ron Clark (Virginia Commonwealth University Health System); Dr. Jerry Blackwell (Ballad Health); Tom Eckstein (Arundel Metrics); Pete Knox (Peter Knox Consulting); Lynn Krutak (Ballad Health); Sarah Milder (Arundel Metrics); Sean Barden (Mary Washington Hospital); and Kevin Barger on behalf of Andy Randazzo (Anthem).

Members participating via videoconference: Bobby Cassell (consumer) and George Hunnicutt, Jr. (consumer).

Members absent: None

VDH staff present: Erik Bodin, Director, Division of COPN/ MCHIP/ Cooperative Agreement, Office of Licensure and Certification; Kevin Meyer, Cooperative Agreement Analyst, Division of COPN/MCHIP/ Cooperative Agreement, Office of Licensure and Certification; Dr. Carole Pratt, Senior Advisor and Confidential Assistant for Policy, Office of the Commissioner; Brenden Rivenbark, Senior Policy Analyst, Office of the Commissioner; and Lina Zimmerman, Cooperative Agreement Analyst, Division of COPN/ MCHIP/ Cooperative Agreement, Office of Licensure and Certification.

Tennessee Department of Health (TDH) staff present: Judi Knecht, Population Health Program Manager, Division of Health Planning

Tennessee Certificate of Public Advantage Monitor: Larry Fitzgerald

Virginia Office of the Attorney General: Amanda Lavin

Welcome and Introductions

Mr. Hilbert called the meeting to order at 10:00 a.m. He told the Technical Advisory Panel (TAP) that a quorum of members was present. Mr. Hilbert introduced himself and briefly described the role of the TAP. Mr. Hilbert asked each of the TAP members to introduce themselves. After the TAP members introduced themselves, Mr. Hilbert asked others in the room to introduce themselves as well.

Draft Policy on Electronic Participation in TAP Meetings

Mr. Hilbert directed the TAP members' attention to a copy of the draft policy allowing for and governing electronic participation in TAP meetings. Mr. Hilbert asked if there were any objections to electronic participation in TAP meetings. There were no objections to electronic participation in TAP meetings.

Approval of Draft Minutes

Mr. Hilbert directed the TAP members' attention to a copy of the draft minutes from the December 14, 2017 TAP meeting. He asked if any changes needed to be made to the draft minutes. No changes were requested. Ms. Krutak made a motion to adopt the draft minutes. Mr. Eckstein seconded the motion. The minutes were approved unanimously.

Overview of the Past Year

Mr. Bodin provided an overview of activity pertaining to the active supervision of the Cooperative Agreement since the TAP last met in December of 2017. Mr. Bodin included the following points in his overview:

- The Virginia State Health Commissioner (Commissioner) sent the measures and performance indicators that the TAP developed in 2017 to Ballad
- Ballad has submitted all six of their required plans to the States
- Some of these plans are still under review, but this was a tremendous amount of work from Ballad
- Ballad is planning to consolidate and restructure trauma services
- Condition 27 of the Virginia Order and Letter Authorizing A Cooperative Agreement (Virginia Order) requires a trauma services plan be submitted to the Commissioner
- VDH and TDH have been discussing the trauma consolidation with Ballad
- Ballad is also planning to make changes to neonatal intensive care centers
- TDH is reviewing this and VDH is watching this
- VDH & TDH are excited about Ballad's Accountable Care Community (ACC)
- Ballad has stepped in to reopen Lee County Hospital
    - Ballad plans to reopen Lee County Hospital as a Critical Access Hospital (CAH) operated by the Lee County Hospital Authority
- The States and Ballad have been working closely over the past year
    - Weekly calls between the TN and VA
    - Bi-weekly Ballad/TN/VA calls
    - Ms. Knecht from TDH is here with us today
    - VDH listened in on TN's Local Advisory Council's (LAC) public hearing
- May 15th is the states' first "deep dive" meeting in Johnson City
- The "deep dive" will be an opportunity for the states to review Ballad's process towards achieving their desired outcomes
- VDH has hired new staff to assist in the active supervision of the Cooperative Agreement
    - Lina Zimmerman, Cooperative Agreement Analyst (Richmond-based)

        - Responsible for analyzing submissions from Ballad and complaints related to the Conditions of the Virginia Order
    - Kevin Meyer, Cooperative Agreement Analyst (Pulaski-based)
        - "Boots on the ground"
        - Responsible for interfacing with local community members/leaders
        - Will work closely with Larry Fitzgerald, COPA Monitor
        - Will attend Southwest Virginia Health Authority (SWVHA) meetings
    - TDH & VDH have been working closely with consultants:
        - Pete Knox (Pete Knox Consulting)
        - Tom Eckstein and Sarah Milder (Arundel Metrics)
    - VDH is still working on completing an MOA with the SWVHA to formalize their role in the active and ongoing supervision of the Cooperative Agreement
        - VDH would like the SWVHA to have a similar role to the LAC in TN
        - Mr. Bodin and Jeff Mitchell will be meeting soon to finalize the MOA
    - In the 2018 session of the Virginia General Assembly, a bill sponsored by Delegate Kilgore that allowed for increased reimbursement by Ballad of expenses incurred by VDH as part of active supervision of the Cooperative Agreement passed.
        - The Code of Virginia originally limited reimbursement to $75,000
        - Ballad can offer suggestions to reduce cost and expenses of active supervision
        - Pursuant to the Code of Virginia, the cost of VDH's active supervision of the Cooperative Agreement is at the sole discretion of the Commissioner.

After Mr. Bodin finished his overview of the year, Mr. Hilbert asked the TAP members if there were any questions for Mr. Bodin. There were no questions for Mr. Bodin.

Overview of the Active Supervision Framework

Mr. Hilbert reminded the TAP members that the Code of Virginia requires the Commissioner to actively supervise the Cooperative Agreement. Mr. Hilbert told the TAP members that performance indicators are extremely important in the active supervision process. He said VDH needs the TAP member's advice and input on how to incorporate performance indicators and measures into a larger framework to guide the active supervision process and to ensure that performance indicators and measures are used as effectively as possible.

Mr. Knox and Ms. Knecht guided the TAP through a PowerPoint presentation overview of the Active Supervision Framework. Mr. Knox and Ms. Knecht highlighted the following in their overview of the Active Supervision Framework:

- The TN Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health (TOC) and the Virginia Order require Ballad to submit various plans and reports to the States for review.
- TDH and VDH have developed a framework to actively supervise the Cooperative Agreement.

- The framework is a data-centered approach to understanding performance improvement and progress toward the desired outcomes.
- The core concept of the Active Supervision Framework is the Plan Do Check Act (PDCA) continuous improvement model.
- The Active Supervision Framework includes five categories of measures:
    1. Tactical
    2. Spread and Scale
    3. Sub-Index Measures
    4. Leading Indicators
    5. Risk-based Population Indicators
    6. Health Equity Indicators
- Each measurement area serves an important purpose in a linked system of measures. The linked system of measures provides a valuable "line of sight" in the active supervision process.
- The Active Supervision Framework Reporting Process consists of "light dives," "deep dives," and "between dives."
- Objectives of "Light" Reporting:
    - Update on progress associated with Ballad's plans, strategies, and tactics
    - Update on barriers and successes
    - Update on the focus of work in the next reporting cycle
- Objectives of "Deep Dive" Reporting:
    - In-depth update
    - Overview of successes, areas of concern, and barriers
    - Provide a clean "line of sight"
    - Build confidence in Ballad's ability and capability to deliver results
- Objectives between reporting cycles:
    - Provide ongoing open communication
        - Build trust
        - Clarify roles and expectations
        - Provide guidance
        - Facilitate connections
- Cadence of the Reporting Process:
    - Light dives 1st and 3rd quarters
    - Deep dives 2nd and 4th quarters

Mr. Hilbert asked the TAP members if they had questions about the Active Supervision Framework.

Mr. Knox emphasized the importance of rhythm in the active supervision process. He said that the States were trying to reduce the burden of the monthly reporting by incorporating monthly reports into light and deep dives instead.

10-Minute Break

Quarterly Quality Metrics Report

Mr. Eckstein presented Ballad's February 2019 Monthly Quality Priority Metrics Report. Mr. Eckstein addressed the following points during his presentation:

- Quality metrics are collected continuously and reported monthly/quarterly
- Two groups of metrics:
    1. Quality Target Measures (17 items)
    2. Quality Priority Metrics (13 items)
- Various levels of reporting
    - System
    - State
    - Hospital
- Criteria
    - Comparison to baseline
    - Improvement overtime
- Items for discussion/ areas for improvement
    - Baseline compared to national norms
        - Are the baselines in the bottom quartile, middle, or top quartiles… relative to nationwide
    - Limitations to improvement
        - Difficult to continue to improve if you are almost perfect
    - "Freeze" data dates
        - When does Ballad freeze data?
    - Retirement of measures
        - Centers for Medicare and Medicaid Services (CMS) measures that are retired/replaced
    - Efficient data transfer
        - Data is submitted in PDF format currently
    - Indications of statistical significance
        - Statistical significance needs to be brought into the reports in some way
    - Need for monthly data
        - Ballad would like to provide quarterly data instead of monthly data
- Ballad's reports are "very well done."
    - Easy to read
    - Straightforward
    - Color coded
        - Green indicates improvement from baseline
- Looking for trends that last for multiple quarters and hospitals that are consistently better or worse than others
    - If better, duplicate best practices
    - If worse, need more information to understand why
- Quality Target Measures

- Strengths
  - Continuing improvement baseline to FY18
    - PSI 6
    - PSI 13
    - SSI-Hysterectomy
  - Improvement, with bumps or stagnation
    - PSI 9
    - PSI 11
    - PSI 12
    - PSI 15
    - CDIFF
- Challenges
  - Declined each period (FY18, Q1 FY19, Q2 FY19)
    - CAUTI
  - Declined, with bumps and stagnation
    - MRSA
    - CLABSI
    - SSI-Colon

- Quality Priority Metrics (System-wide)
  - Strengths
    - Communication
    - Median times in the emergency department
  - Challenges
    - Left without being seen
    - Sepsis in-house mortality
    - Levofloxacin day of therapy per 1,000 patient days
    - Sepsis management bundle
- Quality Priority Metrics (Virginia Hospitals)
  - Hospitals are difficult to compare
    - Variation may be due to differences in patient mixes (e.g. demographics, health status, underlying conditions, different procedures, different acuity levels etc.)
  - What is going on at Johnston Memorial? Some metrics are green and others are red.
  - Is 0 a value of 0 or data that is not available?

Mr. Hunnicutt asked how "rate" was defined. Mr. Eckstein said that it depends on the measure. Mr. Hunnicutt asked how "rate" was defined for PSI 8 (Hip Fractures). Ms. Krutak commented that PSIs are publically reported CMS data.

Break for Lunch

Discussion of Metrics and Suggested Changes

The TAP members discussed the advantages and disadvantages of Ballad reporting quality data on a monthly basis. Mr. Barden commented that there is a lot of "noise" in monthly data. Ms. Krutak commented that it is costly and time consuming to generate monthly reports.

Mr. Hilbert directed the TAP member's attention to a series of recommendations for quality program monitoring and reporting that Ballad recently provided to the States. Mr. Hilbert stated that he would like Dr. Blackwell or Ms. Krutak to walk the TAP members through those recommendations and take questions. Dr. Blackwell walked the TAP members through the recommendations.

Dr. Blackwell noted that most of Ballad's hospitals are small, rural hospitals so the "n" is very small for many measures. He also noted that Johnston Memorial Hospital is an outlier in this regard. He said that because the "n" is so small, many of these variables reported on a monthly basis have little to no value to someone practicing, especially in a rural location. Furthermore, he noted that reporting many of these variables on a monthly basis does not capture useful movement or trends in the data.

Mr. Barger noted that, from a quality prospective, there's too much noise in monthly data. He said Anthem reports metrics over a rolling 12 month period.

Dr. Blackwell noted that previously this information was reported at a hospital level, and that Ballad is trying to create a system of care with checks and balances. Ballad has established a clinical council that is enthusiastic about improving quality metrics.

Mr. Hilbert asked Dr. Blackwell what Ballad meant by "remove structural measures?" Mr. Eckstein said that those measures are checkmarks that Ballad has already met and therefore did not need to be reported monthly.

Mr. Barger asked if process measures that get retired will still be tracked internally by Ballad. Dr. Blackwell said that these measures would be monitored, just not reported as frequently.

Dr. Clark suggested that Ballad roll up numbers for hospital-acquired conditions. He commented that a rate is less relevant, especially to physicians, compared to knowing the number of patients. Dr. Clark also suggested documenting where Ballad is relevant to nationwide deciles or quartiles.

Dr. Blackwell commented that Ballad would like to do this as well, and that they are monitoring this internally already. He also noted that once you reach a certain percentile it is difficult to continue to improve.

Dr. Clark asked Dr. Blackwell if Ballad has system-wide priorities. Dr. Blackwell said "the generic answer is no" but noted that Ballad's clinical council had picked CDIFF. Since Ballad has seen improvement in CDIFF, the council is now turning its attention to CAUTI.

Mr. Eckstein asked the panel what method of reporting (monthly, rolling 12, or quarterly) was best for actively supervising the Cooperative Agreement. Mr. Knox suggested that Ballad and

the States get into a rhythm and sync the reporting cycle with the Active Supervision Framework.

Ms. Krutak noted that reporting monthly is an administrative burden for Ballad. Furthermore, she noted that Ballad's FY end is June 30th, and that Ballad would like reporting quarters to be consistent with FY quarters. She said Ballad's preference would be to report quality data quarterly and FYTD.

Ms. Knecht asked if monthly data would be available to if needed.

Ms. Krutak said that Ballad collects the data monthly, it just isn't useful to report monthly because of the noise. Dr. Blackwell added that reporting monthly was work that did not lead to improvement.

Ms. Knecht asked if the data would be posted on Ballad's website. She suggested that a press release could be helpful because the data is mostly positive.

Dr. Blackwell noted that even if 16 of 17 measures show improvement, individuals who are concerned with the quality of Ballad's care might focus on the one item that does not improve.

Mr. Eckstein suggested that an annual meeting be held to talk about PSI measures and make recommendations to the Commissioner.

Mr. Hilbert asked for a motion to adopt Ballad's recommendations as a block, with the exception that the recommendation to report quality metrics quarterly be removed from the block for separate consideration. Dr. Clark moved and Ms. Krutak seconded. The motion was approved unanimously.

Mr. Hilbert asked if there was a motion for recommendation to report quality metrics quarterly, integrated within the larger Active Supervision Framework. Mr. Eckstein moved and Mr. Knox seconded. The motion passed unanimously.

Mr. Hilbert noted that Dr. Clark's suggestions, (1) formatting that shows performance against target (e.g. top decile, or top quarter), (2) breaking the data down so that we can see VA hospitals performance instead of whole system, (3) aggregate roll up numbers instead of rates, and (4) something that demonstrates metrics that are of specific focus and activity would be included in the meeting minutes and the report of the TAP.

Mr. Hilbert told the TAP members that VDH is planning on convening another meeting of the TAP later this year, probably in mid-November. He added that some of these items could be resolved at that meeting.

Mr. Hilbert asked if there were questions or comments in response to Dr. Clark's suggestions. Dr. Blackwell commented that Dr. Clark's suggestions were great ideas and asked if the TAP needed to see Ballad as a top decile performer. After some discussion, the panel came to the consensus that the TAP wants to know whether or not Ballad is achieving the targets they have set for themselves. The TAP's role is not to measure the Cooperative Agreement based on whether or not Ballad reaches its aspirational goals.

Mr. Hilbert stated that the sentiment of the group seems to be to take the four items that Dr. Clark identified under advisement, to discuss them with Ballad between now and the next TAP meeting, and to identify one or more of these items to present to the TAP as a written recommendation. Mr. Hilbert stated that the panel had identified a series of suggestions/issues that will be included in the meeting minutes and the TAP report, with the intention of continuing to work on these suggestions and bringing written recommendations to the next TAP meeting.

Process and Output Measures

Ms. Zimmerman directed the TAP member's attention to Ballad's March 18, 2019 letter with proposed "line of sight" metrics. Ms. Zimmerman read Ballad's proposed "line of sight" metrics to the TAP.

Ms. Zimmerman noted that each of Ballad's six plans contained strategies intended to achieve long-term outcomes. Specifically, Ballad identified 31 strategies across their six plans. She explained that outputs are the amount of product/and or service that you intend to deliver and that outcomes are benefits of your activities. Ms. Zimmerman noted that not all of Ballad's plans/strategies were included in their March 18th letter. She emphasized that the States' believe additional process and output measures pertaining to all of Ballad's strategies are necessary to assess the extent to which and likelihood that Ballad's strategies will achieve the intended long-term outcomes.

Discussion of Process and Output Measures

Ms. Milder noted that a lot of Ballad's proposed "line of sight" metrics do not have denominators.

Mr. Eckstein asked what percentage of the plans/strategies were included in the March 18th letter. Mr. Hilbert stated that additional measures were needed for the population health, GME/HR, and HIE plans.

Mr. Knox noted that he would like to add equity to the proposed metrics (e.g. number of tele-stroke patients from SWVA). Mr. Knox also noted that most of the proposed metrics measure scale, but he would like to see measures of spread as well. For example, Mr. Knox would like to know how many care gaps Ballad has closed.

Ms. Krutak noted that these measures related to certain strategies within the plans and that there are other measures. She agreed that infrastructure measures were important and noted that the plans have milestones and spending requirements.

Mr. Hilbert asked if there were any additional questions or suggestions for Ms. Krutak or Dr. Blackwell. There were no additional questions or suggestions.

Mr. Hilbert asked the TAP members for a motion to adopt Ballad's proposed "line of sight" metrics from the March 18th letter with the understanding that there are gaps and that there would be further discussion between Ballad and the States and that some measures might exist elsewhere in the plans but not be identified as Category 2 measures.

Dr. Clark motioned and Mr. Beatty seconded the motion.

Mr. Hilbert asked the TAP if there was any discussion of the motion.

Mr. Knox and Dr. Clark noted that there should be a timeline/deadline to identify additional Category 2 measures. Dr. Clark added that the group should come to a consensus about what measures are currently missing.

Mr. Hilbert suggested that the motion to adopt the recommendations could be withdrawn and that Ballad's March 18th letter be included as an appendix to the TAP report with a recommendation to the Commissioner that VDH continue to work with Ballad to develop Category 2 Spread and Scale Measures.

Dr. Clark withdrew his motion.

Mr. Hilbert noted that the TAP would revisit these measures in November.

Next Steps

Mr. Hilbert asked if there were any additional comments or questions before the meeting adjourned. There were no additional comments or questions.

Adjourn

The meeting adjourned at approximately 2:30 p.m.

DRAFT – Not Approved

Technical Advisory Panel of the Cooperative Agreement
November 18, 2019 – 10:00 a.m. to 4:00 p.m. Meeting Minutes
Office of Emergency Medical Services, Echo Conference Room
1041 Technology Park Drive, Glen Allen, Virginia 23059

Videoconference Location:
Wise County Health Department
134 Roberts Avenue SW
Wise, Virginia 24239

Members present: Joseph Hilbert (Virginia Department of Health "VDH"), Chair; Don Beatty (Virginia Bureau of Insurance); Tom Eckstein (Arundel Metrics); Lynn Krutak (Ballad Health); Sarah Milder (Arundel Metrics); Andy Randazzo (Anthem); and Dr. Clay Runnels (Ballad Health)

Members participating via videoconference: Bobby Cassell (consumer) and George Hunnicutt, Jr. (consumer)

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

VDH staff present: Erik Bodin, Director, Division of Certificate of Public Advantage, Managed Care Health Insurance Plans, and Cooperative Agreement, Office of Licensure and Certification; Kevin Meyer, Cooperative Agreement Analyst, Division of Certificate of Public Need, Managed Care Health Insurance Plans, and Cooperative Agreement, Office of Licensure and Certification; Stephanie Norris, Health Economist, Office of Health Equity; Brenden Rivenbark, Senior Policy Analyst, Office of the Commissioner; and Lina Zimmerman, Cooperative Agreement Analyst, Division of Certificate of Public Need, Managed Care Health Insurance Plans, and Cooperative Agreement, Office of Licensure and Certification

Tennessee Department of Health (TDH) staff present: Judi Knecht, Population Health Program Manager, Division of Health Planning

Tennessee Certificate of Public Advantage Monitor: Larry Fitzgerald

Virginia Office of the Attorney General staff present: Amanda Lavin, Assistant Attorney General

Ballad Health officials present: Todd Norris, Senior Vice President, Community Health and System Advancement

Welcome and Introductions

Mr. Hilbert called the meeting to order at 10:17 a.m. and announced that a quorum of Technical Advisory Panel (TAP) members was present. Mr. Hilbert introduced himself and asked each of the TAP members to introduce themselves. After the TAP members introduced themselves, Mr.

Hilbert asked others in the room and participating via videoconference to introduce themselves as well.

Once everyone had an opportunity to introduce themselves, Mr. Hilbert made the following opening remarks to the TAP:

- The purpose of the TAP is to provide ongoing input to the Commissioner on the evolution of measures and benchmarks that should be used to objectively track the benefits and disadvantages of the Cooperative Agreement (CA), as well as measures and benchmarks that should be use to track the progress of Ballad Health with respect to achievement of commitments that have been made

- The TAP's work and recommendations are an important component of VDH's capability to actively supervise the CA

- VDH's efforts with respect to active supervision are ongoing, and evolving in coordination and cooperation with our colleagues at TDH. Mr. Erik Bodin will be providing an update concerning our active supervision efforts

- Today, VDH is bringing to you a proposal for certain revisions to the set of measures that are currently in place. As you can see from the agenda, Brenden Rivenbark of our staff will be presenting the different components of the proposal to you, including metrics pertaining to quality, access and population health

- VDH's proposal addresses what would be measured, how it would be measured and when it would be measured

- The TAP recommended at their meeting in April that a Metrics Workgroup with representation from Ballad Health, TDH, and VDH be established

- That workgroup was convened and their work is reflected in various parts of this proposal. The Panel also recommended that additional focus be given to quality measures that were more directly pertinent to rural facilities. VDH will be discussing that as well as part of the proposal

- If you have a question or comment for Mr. Rivenbark while he is making his presentation, please place your tent card on its end so that I know to call on you. For Mr. Honeycutt and Mr. Castle on videoconference, please speak up if you have a question or wish to make a comment

- Following the presentation of each component, I will ask for a motion and a second to adopt the proposed measures in a block – so that we have something specific on the table to discuss.

- My intent would be for the Panel to discuss the motion, including any questions or comments members have concerning any of the proposed metrics. At that time, if any

member of the Panel would like for one or more proposed measures to be taken out of the block to be discussed and voted on separately, we will do so without objection

- I will then ask the Panel to proceed to a vote by a show of hands on the remaining measures in the block. We will vote by show of hands

- After that, we will return to any other measures that have been removed from the block. I will ask for a motion and second to adopt each of those measures, whereupon we would discuss the motion and then proceed to a vote

- To the extent that certain components of our proposal pertain to reporting structures, timelines or templates – as opposed to specific measures, I will ask for a motion and a second to adopt the structure, timeline or template, and then have discussion on that motion prior to a vote

- Recommendations from the TAP will be sent to the Commissioner in the form of a written report

- Following this meeting, VDH will prepare a draft report which reflects the discussion and actions taken by the panel. We will provide that draft report to each of the Panel members for their review and comment prior to submitting it to the Commissioner by the end of December. Those recommendations will help to inform, but will not necessarily dictate, the Commissioner's final decision concerning any changes to the current set of measures. Any member of the Panel who wishes to submit a dissenting opinion for inclusion in the report may do so.

- Finally, I would note that there is no fixed deadline for the Commissioner's decision concerning new or revised metrics. There are a number of discussions ongoing between VDH, TDH, and Ballad related to the continued evolution of the Active Supervision Framework. It is VDH's intention to ensure that its metrics remain closely aligned with other components of the Active Supervision Framework.

Mr. Hilbert asked the TAP if there were any questions concerning the agenda. Hearing none, Mr. Hilbert directed the TAP members' attention to a copy of the draft minutes from the April 2, 2019 TAP meeting.

Approval of Draft Minutes

Mr. Hilbert gave the TAP a few minutes to review the draft minutes. Mr. Hilbert then asked if any changes needed to be made to the draft minutes. No changes were requested. Mr. Hilbert asked the TAP members for a motion to adopt the minutes from the April 2, 2019 meeting. Mr. Eckstein motioned and Ms. Krutak seconded the motion. The minutes were approved unanimously.

Overview of Active Supervision

Mr. Bodin provided a brief overview of activity pertaining to the active supervision of the Cooperative Agreement since the TAP last met in April of 2019. Mr. Bodin included the following points in his overview:

- Over the past several months, as we have continued to implement and refine the Active Supervision Framework, VDH has formalized a team and structure to support our work to include:
    - A Full-Time Cooperative Agreement Analyst/Complaint Intake Specialist within the Office of Licensure and Certification;
    - A Full-Time Cooperative Agreement Analyst/Complaint Intake Specialist, based in Southwest Virginia, within the Office of Licensure and Certification;
    - Active Supervision management from the Division Director of COPN, MCHIP, and the Cooperative Agreement within the Office of Licensure and Certification;
    - Active Supervision management from the Deputy Commissioner for Governmental and Regulatory Affairs;
    - A Part-Time Health Economist within VDH's Office of Health Equity;
    - A Part-Time Rural Health Manager within VDH's Office of Health Equity;
    - Dedicated support from a Senior Policy Advisor and Senior Policy Analyst within the Office of the Commissioner; and
    - A VDH Cooperative Agreement Active Supervision Committee with membership from:
        - Cooperative Agreement staff
        - Deputy Commissioner for Population Health
        - District Director for our Mount Rogers Health District
        - District Director for our LENOWISCO and Cumberland Plateau Health Districts
        - Director for our Office of Family Health Services
        - Division Director for Population Health Data
        - Division Director for Primary Care and Rural Health
        - Division Director for Social Epidemiology
        - Data and evaluation experts from sister agencies, including the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services
        - Other key VDH staff, as needed
    - This Committee has convened twice and will convene quarterly

- VDH will continue to assess staffing needs as we continue to implement and refine the Active Supervision Framework. VDH still has funding for three additional full-time equivalents, if needed.

Wise/Norton Hospital Consolidation

- Ballad requested authorization under the Virginia Order to make the following changes in Wise County and the City of Norton:
    - Relocate medical/surgical and Intensive Care Unit services offered at Mountain View Regional Hospital (MVRH) in Norton and consolidate them with the same services currently offered at Lonesome Pine Hospital (LPH) in Wise.
    - Close the Emergency Department at MVRH.
    - Transition MVRH laboratory services to a contracted service provided by Norton Community Hospital (NCH) in Norton.
    - Transition MVRH radiology services to a contracted service provided by NCH.
    - Transition MVRH pharmacy services to a contracted service provided by NCH.
    - De-license 59 licensed hospital beds at MVRH, resulting in a total licensed bed count of 59 beds at MVRH, including 44 beds certified for long-term/skilled care.
- VDH considered all applicable Conditions of the Virginia Order that must be taken into account prior to approval of a request to adjust the scope of services or service lines and concluded that approval of the request was warranted based on the following:
    - The proposed project is consistent with the applicable Conditions of the Virginia Order.
    - The existing acute care hospital system in Wise County and the City of Norton is duplicative, inefficient, and not sustainable.
    - The population of Wise County and the City of Norton cannot continue to successfully support three full-service hospitals long term.
    - Ballad's current plan will help address the unnecessary duplication of resources in Wise County.
    - The consolidation should result in cost-savings and recouped resources that Ballad can reallocate to population health or other health care improvement.
- VDH is looking forward to reviewing Phase II of Ballad's plan for Wise County

- Staff are currently reviewing a Certificate of Public Need application to move inpatient rehab from NCH to MVRH

- Staff anticipate that Ballad's proposal will include additional behavioral health services for the Wise/Norton community

Southwest Virginia Health Authority

- VDH is working to finalize a Memorandum of Agreement (MOA) with the Southwest Virginia Health Authority (Authority).

- The Authority formed the Virginia Cooperative Agreement Task Force to undertake the responsibilities of the Authority with respect to monitoring Ballad's Cooperative Agreement.

- The Virginia Cooperative Agreement Task Force met on October 7, 2019

    - The Task Force Chairman, Delegate Todd Pillion, tabled consideration of the MOA until the next Task Force meeting to give the Task Force time to select nominees for three or four additional members of the Task Force from the public and to review the MOA.

Areas for Improvement/ Suggestions to Ballad

- VDH has identified the following suggestions for Ballad to improve on:

    - As has been displayed by the public sentiment associated with Ballad's decision to consolidate services across facilities in its service area; proactive, intentional, and culturally empathic communication from Ballad is critical to developing a more successful relationship with public, employees, and community organizations. Ballad, in its future proposals and requests to the states should include communications plans and community outreach strategies.

    - Leverage every opportunity to highlight the regional Virginia work and projects Ballad is undertaking to improve hospital quality of care, population health outcomes, behavioral health outcomes, successful partnerships and collaborations, etc. rather than focusing more on organizational structure changes, financial successes, etc.

    - Maintain close and active communication with the States– provide advance notice, as outlined in the states' COPA/CA, of changes in services/access, potential compliance issues, etc. so that the States are prepared to respond to constituents.

Overview of the Metrics Workgroup

Mr. Hilbert reminded members of the TAP that at their last meeting, in April of 2019, they recommended that a metrics workgroup with representation from VDH, TDH, and Ballad Health convene to develop a comprehensive set of "line of sight" measures that could be utilized to

actively supervise Ballad Health. Mr. Rivenbark provided the TAP with a brief overview of the Metrics Workgroup's progress over the past few months. Mr. Rivenbark's PowerPoint presentation noted the following key points:

- The TAP recommended that a Metrics Workgroup convene
- The Workgroup was tasked with assessing the Cooperative Agreement metrics and measurement framework and with developing a proposal for the TAP to review at their next meeting
- The Workgroup was led by staff from Ballad Health, TDH, and VDH
- Ballad Health, TDH, and VDH staff who participated in the Metrics Workgroup solicited feedback from internal and external subject matter experts throughout the process
- The Workgroup met in-person on July 25th, August 26th, August 27th, and October 8th and held weekly check-in conference calls from July 11th to October 24th
- The Metrics Workgroup will continue meeting and collaborating to develop "line of sight" documents, outputs, and outcome measures for each of Ballad Health's plans

Mr. Rivenbark asked if the TAP members had any questions. Hearing none, Mr. Rivenbark began presenting the proposed Quarterly (Quality) measures.

Presentation of Quarterly (Quality) Measures

Mr. Rivenbark's PowerPoint presentation noted the following:

- Quality data will be presented to the States quarterly using control charts
- Control charts will be presented at the system level, state level, and facility level
- When a "special-cause event" occurs, Ballad will notify the States and propose a mitigation strategy should one be necessary
- Annually, Ballad will propose three performance measures for targeted Quality Improvement (QI) initiatives
- Ballad will notify the States, within six months, should any measure by Premier or Press Ganey be retired and convene a discussion to determine which measure(s) should replace the retired measure(s)
- States may propose additional monitoring metrics to the TAP

- The states or Ballad may propose revisions to the Peer Hospital System group to the TAP annually

Mr. Hilbert asked if there were any questions or comments for Mr. Rivenbark at this time. Hearing none, Mr. Rivenbark read aloud the Quality-Patient Safety (slides 9 & 10), Quality-Mortality and Readmissions (slide 11), Quality-Patient Satisfaction (slide 12), Quality-Timely and Effective Care (slide 13), Rural Quality-Inpatient (slide 14), Rural Quality-Outpatient Patient Satisfaction (slide 15), Rural Quality-Outpatient Prevention (slide 16) and COPA/CA Financial and Operational Quarterly Updates (slide 17).

Discussion of Proposed Quarterly (Quality) Metrics

Mr. Hilbert asked if there were any questions or comments on the Quality measures as presented by Mr. Rivenbark.

Mr. Eckstein asked if the readmission rates for the top 10 causes of readmissions and the mortality rates for the top 10 causes of mortality (slide 11) would change overtime and noted that if the top 10 causes change annually, the data cannot be tracked longitudinally. Mr. Eckstein suggested that the States "lock" some of the top 10 causes so that they can monitor Ballad Health's progress longitudinally.

Dr. Runnels noted that Ballad Health does not normally separate many of these measures by payer type and was surprised by the number of measures that listed "payer type" as a data stratification because this was not discussed by the Metrics Workgroup. Additionally, Dr. Runnels noted that for some measures reporting by payer type might be difficult.

Mr. Rivenbark confirmed that data stratification by payer type had not yet been discussed by the Metrics Workgroup.

Dr. Runnels stated that Ballad Health cannot commit to reporting all of the measures by payer type at this time. Mr. Hilbert acknowledged Dr. Runnels' concerns and stated that VDH would follow up with Ballad Health to discuss which measures could be reported by payer type.

Mr. Eckstein suggested that the States and Ballad consider pulling out certain aggregate payer types – for example, Medicaid and Non-Medicaid payers.

Mr. Hilbert asked if there were any additional comments or questions pertaining to the Quality-Patient Safety (slides 9 & 10), Quality-Mortality and Readmissions (slide 11), Quality-Patient Satisfaction (slide 12), Quality-Timely and Effective Care (slide 13), Rural Quality-Inpatient (slide 14), Rural Quality-Outpatient Patient Satisfaction (slide 15), Rural Quality-Outpatient Prevention (slide 16) and COPA/CA Financial and Operational Quarterly Updates (slide 17).

Hearing none, Mr. Hilbert asked the TAP what level of data should be displayed publically. Mr. Eckstein suggested that the states group smaller facilities together to increase the sample size "n" and to reduce random variation "noise." Mr. Rivenbark agreed that the smaller hospitals could be grouped together to eliminate noise.

Mr. Eckstein noted that the perceptual questions (e.g. patient satisfaction measures) would be difficult, especially in the smaller facilities. One or two bad surveys could "spike" the data. Dr. Runnels agreed with Mr. Eckstein, and noted that one event can really skew the data when the "n" is small.

Mr. Rivenbark suggested that Ballad report the data to the States by facility but that the States would present the data in aggregate.

Mr. Eckstein noted that "n" could also be increased by looking at a longer period of time – increasing the number of data points from one facility. However, Mr. Eckstein recommended that the States group smaller facilities together to increase "n." Dr. Runnels supported Mr. Eckstein's recommendation.

Mr. Hilbert asked if there were any additional questions or comments about the Quarterly (Quality) Measures as presented.

Vote – Quality – Patient Safety Measures

Hearing none, Mr. Hilbert asked the TAP members for a motion to adopt the proposed Quality-Patient Safety Measures (slides 9 & 10). Mr. Eckstein motioned and Ms. Milder seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Dr. Runnels reiterated, for the record, that Ballad Health could not commit to reporting all of the measures by payer type at this time and noted that Ballad Health is still using two different Electronic Medical Record (EMR) systems, further complicating reporting each measure by payer type.

Mr. Hilbert asked if there were any additional comments on the motion to adopt the proposed Quality-Patient Safety Measures (slides 9 & 10). Hearing none, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Quality – Mortality and Readmissions Measures

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Quality-Mortality and Readmissions Measures (slide 11). Mr. Eckstein motioned and Ms. Milder seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Mr. Eckstein reiterated his suggestion that the States "lock" some of the top 10 causes of mortality and readmissions so that they can monitor Ballad Health's progress longitudinally.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Quality – Patient Satisfaction

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Quality-Patient Satisfaction Measures (slide 12). Mr. Eckstein motioned and Dr. Runnels seconded. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Mr. Eckstein suggested that smaller hospitals be grouped together to increase sample size for these measures.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Quality – Timely and Effective Care

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Quality – Timely and Effective Care Measures (slide 13). Mr. Eckstein motioned and Ms. Milder seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Rural Quality – Inpatient Measures

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Rural Quality – Inpatient Measures (slide 14). Mr. Eckstein motioned and Ms. Milder seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Ms. Milder asked for the definition of the Metric titled "Falls Risk Assessment or Falls with Injury (NQF 0202)." Mr. Rivenbark noted that the Metrics Workgroup was still discussing the definition of some measures.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Rural Quality – Outpatient Patient Satisfaction Measures

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Rural Quality – Outpatient Satisfaction Measures (slide 15). Mr. Eckstein motioned and Dr. Runnels seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Ms. Krutak raised concerns about the stability of the Clinical and Group Survey Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) "In the last six months…" metrics and noted that the source of the data, Ballad Health's EMR, might create some noise because Ballad Health is still on two separate EMRs.

Ms. Krutak asked if the Metrics Workgroup had discussions about Ballad Health's EMRs. Mr. Rivenbark stated that the Metrics Workgroup did discuss Ballad Health's EMRs. Dr. Runnels noted that it might be difficult to pull data from the past six months for facilities that will be transitioning to EPIC.

Mr. Eckstein suggested that the States display access measures alongside Press Ganey's perception measures to show perception vs. reality. Ms. Krutak and Mr. Runnels agreed that showing perception vs. reality was a good idea.

Ms. Milder asked why the metrics about providers listening carefully and explaining things in a way that was easy to understand were selected for *Rural* Quality. Mr. Eckstein noted that most of the facilities in Virginia were rural facilities.

Mr. Hunnicutt asked if Ballad Health tracked return rates of Press Ganey surveys and noted that usually only patients who have a very negative experience or very positive experience complete and return Press Ganey surveys. Mr. Hunnicutt also asked if any other sources had been considered for the patient satisfaction measures.

Dr. Runnels stated that Ballad Health does track return rates and that the rate varies across facilities. Dr. Runnels also noted that while return rates are low, this is an issue for hospitals across the country, and it is the source Ballad Health utilizes for HCAPS.

Mr. Eckstein asked if Ballad had any initiatives to increase Press Ganey returns. Dr. Runnels stated that Ballad does look into initiatives to increase returns and that Ballad wants more feedback from patients.

Dr. Runnels asked if the data source should explicitly say "Press Ganey" and noted that the data source could change. Mr. Hilbert stated that VDH would consider changing the data source if a better source becomes available.

Mr. Eckstein noted that the third Rural Quality – Outpatient Patient Satisfaction Measure (Slide 15) was identical to the fifth measure. Mr. Hilbert stated that the fifth measure would be removed.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Rural Quality: Outpatient Prevention

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Rural Quality – Outpatient Prevention Measures (slide 16). Ms. Milder motioned and Mr. Eckstein seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

COPA/CA Financial and Operational Quarterly Updates

Mr. Hilbert asked the TAP members for a motion to adopt the COPA/CA Financial and Operational Quarterly Updates (slide 17). Mr. Eckstein motioned and Ms. Krutak seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Ms. Krutak acknowledged that Ballad Health currently updates the states on these items quarterly.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

10-Minute Break

Presentation of Proposed Access Measures

Mr. Rivenbark began presenting the Proposed Access Measures to the TAP. Mr. Rivenbark's PowerPoint presentation noted the following:

- Ballad is required to report various metrics to the States that measure timely access to quality healthcare services
- Ballad has committed to submit an evaluation plan to the States in the event that the closure of a non-Ballad facility has an adverse effect on geographic access to emergency and urgent care services
- Brenden noted the following changes to the Access measures:
    - SBIRT administration in Emergency Departments and Outpatient Facilities
    - Geographic Access to primary care and specialty care

Dr. Runnels commented on how difficult it is to find doctors who are willing to work in rural areas and noted that this often leads to doctors with low patient volumes earning high salaries. Low patient volume is a quality of care concern for Ballad.

Dr. Runnels stated that Ballad does not consider "population-weighted percentage of residents across all census blocks that reside within 30 miles of a specialty care clinic" and "population-weighted percentage of residents across all census blocks that reside within 20 miles of a primary care clinic" to be value-added measures. Dr. Runnels contended that Ballad would prefer to measure time to third appointment.

Mr. Beatty asked why the States wanted to measure the "population-weighted percentage of residents across all census blocks that reside within 30 miles of a specialty care clinic" and the "population-weighted percentage of residents across all census blocks that reside within 20 miles of a primary care clinic."

Ms. Milder commented that, the percentage of residents within a certain distance, in contrast to time to the third available appointment, gets at social determinants of health – "it's looking at can you get to a clinic."

Dr. Runnels contended that the measure is inaccurate because proximity to a clinic does not mean access. Dr. Runnels explained that a Medicaid patient may live one mile from a clinic, but that clinic may not be accepting Medicaid patients and reiterated that time to third appointment would be a better measure of access to care.

Ms. Krutak pointed out this measure would be difficult to track as clinics open and close frequently in the region and noted that it is Ballads understanding that these measures were for all clinics, not just Ballad Health clinics.

Mr. Hilbert asked if there were any additional comments on the Proposed Access Measures.

Mr. Eckstein cautioned against utilizing zip code of residence because zip codes can often mask problem areas.

Vote: Proposed Access Measures

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Access Measures (slides 20, 21, and 22). Mr. Eckstein motioned and Ms. Milder seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Ms. Milder noted that for some of the measures the data source listed is "Ballad EMR." Thus, these measures are only looking at Ballad's patients, not the larger population. Ms. Milder contended that, where available, population data would be better.

Dr. Runnels reiterated, for the record, that Ballad does not consider "population-weighted percentage of residents across all census blocks that reside within 30 miles of a specialty care clinic" and "population-weighted percentage of residents across all census blocks that reside within 20 miles of a primary care clinic" to be value-added measures. Dr. Runnels contended that Ballad would prefer to measure time to third appointment.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Presentation of Proposed Population Health Measures

Mr. Rivenbark began presenting the Proposed Population Health Measures to the TAP. Mr. Rivenbark's PowerPoint presentation noted the following:

- On June 18, 2019, Ballad Health submitted their STRONG Children and Families Population Health Plan to the States

- The Metrics Workgroup reviewed the Plan, Ballad's proposed population health outcome measures, and Ballad's proposed impact measures to develop a "line of sight" connecting Plan strategies and activities to outcome and impact measures

- Ballad Health's STRONG Children and Families Population Health Plan included the following strategies:

    - Increase Birth Outcomes and STRONG Starts

    - Increase Educational Readiness and Performance

    - Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality

    - Change Social Norms to Support Parents, Families, and the Community

        - Develop population health infrastructure within the health system and community

        - Position Ballad Health as a community health improvement organization

        - Enable community resources and sound health policy

Mr. Hilbert asked if there were any questions or comments for Mr. Rivenbark at this time. Hearing none, Mr. Rivenbark read aloud the Proposed Output Measures: Increase Birth Outcomes & Strong Starts (slides 26 and 27), Proposed Output Measures: Increase Educational Readiness and Performance (slide 28), Proposed Output Measures: Increase Healthy Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality (slide 29), Proposed Output Measures: Change Social Norms to Support Parents, Families, and the Community (slides 30 and 31), Proposed Outcome Measures (slide 32), and Proposed Impact Measures (slide 33).

Discussion of Proposed Population Health Measures

Mr. Hilbert asked the TAP members if they had any questions or comments for Mr. Rivenbark.

Ms. Milder asked why so many measures were numbers instead of percentages or rates. Mr. Rivenbark explained that the Metrics Workgroup found that some measures did not have a reasonable denominator at this time. Mr. Eckstein stated that it is important to establish rate-based measures early, so that the States can identify areas of success and areas for improvement.

Mr. Eckstein asked why the proposed output metric for "Increase prenatal programs/supports across facilities" is "Number of prenatal programs/supports provided by behavioral health facilities" (slide 27). Specifically, Mr. Eckstein wanted clarification as to why the metric was limited to behavioral health facilities.

Mr. Rivenbark asked if Mr. Norris had an explanation. Mr. Norris was unsure but suggested a different output measure might capture the number of prenatal programs/supports provided across facilities.

Mr. Hilbert stated that VDH would take a closer look at that metric.

Mr. Rivenbark noted that there is considerable overlap between these metrics and the behavioral health plan metrics.

Mr. Eckstein recommended that the activity "Expand maternal MAT and other recovery programs" (slide 26) be modified to include "best-practice programs."

Mr. Hunnicutt asked what a business-health collaborative is. Mr. Norris explained that participating businesses in the region come together to collaboratively work on strategies to improve the health status of the region.

Mr. Runnels asked if the Metrics Workgroup had discussions around the baseline year. Mr. Rivenbark stated that the baseline year would be pre-merger when available. Mr. Runnels commented that Ballad Health would like for all the baselines to be pre-merger.

Mr. Eckstein noted that Ballad's STRONG initiative is centered around reducing ACEs and asked if there was a program to monitor/measure ACEs in the community. Additionally, Mr. Eckstein noted that some ACEs, including inter-partner violence, are not included although they seem relevant to Ballad Health's initiative.

Vote: Proposed Output Measures – Increase Birth Outcomes and STRONG Starts

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Output Measures – Increase Birth Outcomes and STRONG Starts (slides 26 and 27). Ms. Krutak motioned and Mr. Eckstein seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Mr. Eckstein commented that many of these metrics need denominators.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Proposed Output Measures – Increase Educational Readiness and Performance

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Output Measures – Increase Educational Readiness and Performance (slide 28). Mr. Eckstein motioned and Dr. Runnels seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Mr. Eckstein reiterated his comment that many of these metrics need denominators.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Proposed Output Measures – Increase Health Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Output Measures – Increase Health Behaviors in Children, Youth, and their Support Systems to Improve Health and Strengthen Economic Vitality (slide 29).

Ms. Milder motioned and Mr. Eckstein seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Proposed Output Measures – Change Social Norms to Support Parents, Families, and the Community

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Output Measures – Change Social Norms to Support Parents, Families, and the Community (slides 30 and 31). Mr. Eckstein motioned and Dr. Runnels seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Ms. Milder asked how the number of sites on EPIC was a measure of changing social norms and suggested that the measure be modified so that it is clear how it relates to the goal.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Proposed Outcome Measures

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Outcome Measures (slide 32). Mr. Eckstein motioned and Dr. Runnels seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Vote: Proposed Impact Measures

Mr. Hilbert asked the TAP members for a motion to adopt the proposed Impact Measures (slide 33). Mr. Eckstein motioned and Ms. Milder seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Mr. Eckstein recommended that ACEs be added as an impact measure.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Lunch

Public Comment Period

Mr. Hilbert announced that the TAP members would now hear public comment. Mr. Hilbert asked if there were any members of the public in attendance who would like to comment. Hearing none, the public comment period ended.

Presentation of Reporting Structure/ Timeline

Mr. Rivenbark guided the members of the TAP through the Proposed Annual Performance Review and Data Submission Timeline.

Dr. Runnels noted that Ballad Health is generally supportive of the timeline and that there were ongoing conversations between VDH and Ballad Health regarding when the quarterly meetings would occur.

Vote: Reporting Structure/Timeline

Mr. Hilbert asked the TAP members for a motion to adopt the Proposed Annual Performance Review and Data Submission Timeline. Dr. Runnels motioned and Mr. Eckstein seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Presentation of Proposed Quarterly Update Templates

Mr. Rivenbark guided the TAP through the Proposed Quarterly Update Templates.

Mr. Hilbert asked the TAP members if they had any question or comments about the Proposed Quarterly Update Templates. Mr. Eckstein noted that there might be a way to streamline the templates.

Mr. Rivenbark suggested that the templates could be restructured so that there is a section for measures that Ballad is achieving and a separate section for measures that Ballad is behind on.

Ms. Krutak noted that there is still discussion around the data submission format and that Ballad Health may prefer to continue using their performance management system.

Vote: Proposed Quarterly Update Templates

Mr. Hilbert asked the TAP members for a motion to adopt the Proposed Annual Performance Review and Data Submission Timeline. Dr. Runnels motioned and Mr. Eckstein seconded the motion. Mr. Hilbert asked the TAP members if there was any discussion of the motion.

Hearing no additional comments, Mr. Hilbert called for a vote by show of hands on the motion. The motion was approved unanimously.

Next Steps

Mr. Hilbert stated that in the next few weeks VDH would prepare a draft report which reflects the discussion and actions taken by the TAP. Mr. Hilbert noted that VDH would provide a copy of the draft report to each member of the TAP for their review and comment prior to submitting it to the Commissioner by the end of December. Mr. Hilbert reminded the TAP that their recommendations will help inform, but will not necessarily dictate, the Commissioner's final decision concerning any changes to the current set of measures.

Dr. Runnels thanked Joe for facilitating the meeting.

Mr. Eckstein thanked Mr. Rivenbark and the team members who put the proposed measures together and noted that a lot of progress had been made in the past year or two.

Mr. Bodin asked Mr. Hilbert if he would like the group to meet in April 2020 or November 2020. Mr. Hilbert stated that the group would meet again in November 2020.

Adjourn

The meeting Adjourned at approximately 2:15 p.m.