Ballad Health Annual Report

Reporting Period:
February 1 – June 30, 2018

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November 14, 2018 via: FedEx and Email

John Dreyzehner, MD, MPH, FACEOM
Commissioner, Tennessee Department of Health
5th Floor Andrew Johnson Tower
710 James Robertson Parkway
Nashville, Tennessee 37243

M. Norman Oliver, MD, MA
Commissioner Virginia Department of Health
109 Governor Street
Richmond, VA 23219

Dear Commissioners Dreyzehner and Oliver,

Pursuant to Section 6.04(b) of the Tennessee Terms of Certification and pursuant to the letter from Commissioner Marissa J. Levine, MD, MPH, FAAFP, dated January 12, 2018, we hereby submit Ballad Health's FY18 Annual Report and the COPA Compliance Office FY18 Annual Report. These Annual Reports cover the truncated Fiscal Year of 2018 that began February 1, 2018, and ended June 30, 2018 ("Reporting Period").

As always, we welcome any questions or comments that you may have.

Sincerely,

Gary Miller

Gary Miller, Senior Vice President Ballad Health
Interim COPA Compliance Officer

Cc via email: Jeff Ockerman, Director, Division of Health Planning
Janet Kleinfelter, Deputy Attorney General
Erik Bodin, Director, Office of Licensure and Certification
Allyson Tysinger, Sr. Assistant Attorney General/Chief
Larry Fitzgerald, COPA Monitor
Tim Belisle, General Counsel Ballad Health

Annual Report for FY18

Covering 02/01/2018 – 06/30/2018 ("Reporting Period")

Submitted pursuant to the Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health Pursuant to the Master Affiliation Agreement and Plan of Integration by and between Wellmont Health System and Mountain State Health Alliance Approved on September 19, 2017 and Issued on January 31, 2018 ("TOC") and the Virginia Order and Letter Authorizing a Cooperative Agreement dated October 30, 2017 ("CA").

CERTIFICATION OF COMPLIANCE WITH THE TOC AND THE CA

Pursuant to section 6.04(a) of the TOC and Condition 39 of the CA, the undersigned hereby certify the following report and its attachments are true and correct to the best of his/her knowledge after due inquiry and are accurate and complete.

Alan Levine
Executive Chairman
Chief Executive Officer
Ballad Health

Lynn Krutak
Executive Vice President
Chief Financial Officer
Ballad Health

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Ballad Health abbreviation key

Abbreviation	Full name
APP	Abingdon Physician Partners
BRMC	Bristol Regional Medical Center
BRMMC	Blue Ridge Medical Management Corporation
CHC	Community Home Care
CVA	Cardiovascular Associates
DCH	Dickenson Community Hospital
DME	Durable Medical Equipment
FWCH	Franklin Woods Community Hospital
HCH	Hancock County Hospital
HCMH	Hawkins County Memorial Hospital
HVMC	Holston Valley Medical Center
IPMC	Indian Path Medical Center
ISHN	Integrated Solutions Healthcare Network
JCCH	Johnson County Community Hospital
JCMC	Johnson City Medical Center
JMH	Johnston Memorial Hospital
LMG	Laughlin Medical Group
LMH	Laughlin Memorial Hospital
LPH	Lonesome Pine Hospital
MSMG	Mountain State Medical Group
MVRMC	Mountain View Regional Medical Center
NCH	Norton Community Hospital
NCPS	Norton Community Physicians Services
RCMC	Russell County Medical Center
SCCH	Smyth County Community Hospital
SNF	Skilled Nursing Facility
SSH	Sycamore Shoals Hospital
TRH	Takoma Regional Hospital
UCMH	Unicoi County Memorial Hospital
WCS	Wellmont Cardiology Services
WMA	Wellmont Medical Associates

Attachments

ANNUAL REPORT

1. Requirements. Section 6.04 and Exhibit G of the TOC and Virginia Code 15.2-5384.1 and 12 Virginia Administrative Code 5-221-110 requires the annual submission of certain items. The section of Exhibit G relevant to the Annual Reports is attached hereto as Attachment 1a. Virginia Code (VC) 15.2-5384.1 is attached hereto as Attachment 1b. 12 Virginia Administrative Code (VAC) 5-221-110 is attached hereto as Attachment 1c.

2. Description of Process. In compiling the information and materials for this Annual Report, the Ballad Health COPA Compliance Office (CCO) re-evaluated the departments responsible for gathering and preparing these materials. Leaders of the departments were identified and given responsibility to submit the required materials and information (Responsible Parties). The CCO revised the spreadsheets as necessary, assigning sections of the TOC and the Conditions of the CA to the appropriate Responsible Parties. The CCO resubmitted the spreadsheets to all Responsible Parties to allow them to certify, to their knowledge and belief after due inquiry, that Ballad Health is in compliance with the requirements of the TOC and CA. In instances where Responsible Parties had questions about the interpretation of the requirements or whether there might be concerns regarding compliance, they could make notes or provide qualifications.

3. Deliverables. Deliverables due to the State and the Commonwealth during this Reporting Period were submitted by the required times and are listed below in Table A. As part of the process described above, the Responsible Parties certified to the completion of those submissions.

Table A

ITEM	STATUS	PURSUANT TO TOC AND CA
Physician Specialties that Exceeded 35% Employment as of the Approval Date of the TOC	TDOH granted approval on 1/31.	TOC Section 5.05(e) CA Condition 5
Financial Assistance Policy (Charity Care, Ability to Pay, Uninsured, Underinsured)	Submitted on 1/30.	TOC Section 4.03(e) CA Condition 14
Baseline Spending Calculations	Submitted baseline data on 2/27, but subsequently received requests for additional clarifying information, with the final piece of information requested by Ken Conner being submitted on 5/3.	TOC Article 3 and Exhibit B

ITEM	STATUS	PURSUANT TO TOC AND CA
List of Ancillary Services and Post-Acute Services offered by competitors (Competing Services)	Submitted on 3/1and updated with each quarterly report as necessary.	TOC Section 5.04(a) CA Condition 5
Severance Policy	Submitted on 3/30.	CA Condition 20
Plan Outlines for Population Health, Pediatric Health, Rural Health and Behavioral Health	Submitted on 4/27.	TOC Section 3.02 CA Conditions 33, 34, 35, 36
Quarterly Report – 3rd quarter FY18	Submitted on 5/15. Reporting Period 2/1 – 3/31.	TOC Section 6.04 CA Condition 40
COPA Compliance Policies and Procedures	Submitted on 5/15.	
List of Entities Ballad Health does not exercise control or influence over managed care contracting	Submitted on 5/31.	TOC Addendum 1, Section 4
Payment Indices : 1. Inpatient 2. Outpatient 3. Physician Clinics 4. Ambulatory Surgery Centers	5/31: Submitted the Inpatient piece of the Payment Indices, along with a request for extension to complete the remaining pieces after a revised edition of Addendum 1 is complete.	TOC Addendum 1, Section 9.1(b)
Never Contracted Percentage	5/31: Submitted a request for additional time to discuss alternative calculation methods for never contracted payors.	TOC Addendum 1, Section 12(f)
TJC Notification	6/5: Submitted notification from TJC regarding Franklin Woods Community Hospital, Sycamore Shoals Hospital and Johnston Memorial Hospital.	TOC 4.02(a) and CA Condition 13
CMS Notification	6/6: Submitted a notification from CMS regarding Unicoi County Nursing Home.	TOC 4.02(a)(i)(B) and CA Condition 13

ITEM	STATUS	PURSUANT TO TOC AND CA
Establish Base Charity Care Amount	6/20: Submitted a request to Mr. Fitzgerald for a written addendum/revision to the TOC to revise charity reporting to a fiscal year basis to coincide with Ballad Health's reporting methodology. Additionally, Ballad Health requested the due date coincide with the IRS Form 990, due date of 5/15/19.	TOC 4.03(f)
CMS Notification	6/21: Submitted a notification from CMS regarding Lonesome Pine Hospital.	TOC 4.02(a)(i) and CA Condition 13
Baseline Spending Calculations	As of 6/26, the estimated baseline spending amounts set forth in TOC Exhibit B – Page 1 reflect the current best estimates of the baseline spending amounts.	TOC Article 3 and Exhibit B
Plan Drafts for Population Health, Pediatric Health, Rural Health and Behavioral Health	Submitted on 6/30.	CA Conditions 33-36
Equalization Plan	Submitted on 6/30.	TOC 3.08(b) and CA Condition 19
COPA Compliance Training Plan	Submitted on 6/30.	
Quarterly Report – 4th quarter FY18	Submitted on 8/15. Reporting Period 4/1 – 6/30.	TOC Section 6.04 CA Condition 40

4. Virginia-specific reporting requirements
    A. Activities conducted pursuant to the Cooperative Agreement – CA 12VAC5-221-110(A)(1). Attachment 2

    B. Actions taken in furtherance of commitments made by the Parties or terms imposed by the Commissioner as a condition for approval of the Cooperative Agreement – CA 12VAC5-221-110(A)(2). Attachment 3

    C. Charge master - 12VAC5-221-110(A)(5):

        - Ballad Health's charge masters are being submitted separately via electronic version.

D. Report on non-physician providers – CA 12VAC5-221-110(A)(6):

- Payor contracts and fee schedules are between Ballad Health and the payor. Non-physician providers are reimbursed based on the fee schedules within the contract.

E. Report on Risk-Based Model Contracting – CA: Cond. 10:

- All risk-based model components for Wellmont and Mountain States contracts that existed at close continue today. There have been no changes.
- Ballad Health is actively negotiating with multiple payors on new risk-based contracts, working towards the 1/1/2020 date to add one new contract.
- Ballad Health is actively negotiating with multiple payors on new risk-based contracts, working towards the 1/1/2021 date to add a second risk-based contract.
- Ballad Health is actively discussing new risk-based models with all large payors who currently have no risk-based components, working toward the 1/1/2022 target.

F. Report on the number of validated and unresolved complaints from payers, the number of contracts retained or added with payment for value elements and the number of lives covered in risk-based contracts – CA Quantitative Measures, Performance Indicator 2(a) & (b):

- 2(a): Ballad Health has received no complaints from payors.
- 2(b): Ballad Health had no change in value/risk-based contracts, either in the number of contracts or the membership, since 1/31. Twenty-five contracts have been retained, covering approximately 93,000 lives.

G. Results of the Anthem Q-HIP – CA Quantitative Measures, Performance Indicator 2(d). Attachment 4

H. Employee turnover rates – Quantitative Measure, Performance Indicator 7:

- Ballad Health's turnover rate for the entire organization from 2/1–6/30 is 8.5% (annualized 20.5%).
- Ballad Health's turnover rate for Virginia from 2/1–6/30 (annualized 20.7%).

I. Report of Board activities – CA Quantitative Measures, Performance Indicator 8: The number of Board development activities, including a description of each activity, conducted during the reporting period and the development activities that will be undertaken in the upcoming year. Attachment 5

5. Combined TOC and CA reporting requirements. Pursuant to § 6.04 of the TOC, Ballad Health is pleased to report as follows (using the outline of requirements on Exhibit G):

   A. Facility Maintenance and Capital Expenditures – TOC: 3.07(b), Exhibit G: Schedule of all maintenance and repair expenses and capital expenditures during the year pursuant to the Capital Plan:

      - The Capital Plan required by TOC 3.07(b) relating to FY2019 was not due until 7/31; therefore, no report on maintenance, repair expenses and capital expenditures is due for this Reporting Period.

   B. Career Development Plan – TOC: §3.08(c) / CA: Cond. 22: Explain implementation and results. Attachment 6 provides information supplemental to the Career Development Plan submitted 7/31 and required by TOC §3.08(c)/CA Condition 22.

   C. Clinical Council – TOC: §4.02(b)(v) / CA: Cond. 45: Common standard of care, credentialing standards, consistent multidisciplinary peer review and best practices. Attachment 7

   D. Integrated Delivery System (IDS) Measures – TOC: §4.02(c)(i) / CA: Cond. 12: 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:

      - The integrated delivery healthcare measures and protocols are represented by the Access to Care, Population Health and Quality Metrics. The Access to Care and Population Health Metrics are still under discussion. The Quality Metrics are provided in Section 5.E. below.

   E. Quality Indicators – TOC: §4.02(c)(ii) / CA: Cond. 12; Quantitative Measures, Performance Indicator 6(a); VC15.2-5384.1(G); 12VAC 5-221-110(A)(3) and (7): Summary of all results of quality indicators; include comparisons to similarly sized systems in the United States:

      - Summary of Quality Indicators. Attachment 8
      - Comparison to Systems Methodology. Attachment 9
      - Comparison to Similarly Sized Systems. Attachment 10

   F. Patient Satisfaction Survey – TOC: §4.02(c)(iii) / CA: Cond. 12: Results of the patient satisfaction surveys required of Ballad Health. Attachment 11

   G. Staffing Ratios – TOC: §4.02(c)(iv): Including hours of patient care delivered per patient and ratio of RN to LPN and other caregivers:

      - 9.82 Average Nursing Hours per Patient
      - 9.8:1 RN to LPN
      - 2.5:1 RN to Unlicensed

H. Staff Survey – TOC: §4.02(c)(v): Results of the 3-year survey of medical, hospital and nursing staffs:

- Employee Satisfaction Survey was not required to be completed during this Reporting Period

I. Monitoring Reports

i. Patient-related prices charged and Report on Actual Costs, Revenues, Profit Margins and Operating Costs – TOC: §6.04(b)(i) / CA: VC15.2-5384.1(G) & 12VAC5-221-110(A)(3) and (4). Attachment 12

- During the reporting period, Ballad Health did not implement a global price increase; however, as legacy systems during FY18, Mountain States Health Alliance implemented a 5% global price increase, excluding Critical Access Hospitals and Physician Clinics. Wellmont Health System did not implement a global price increase for FY18. Attachment 12 provides gross and average charges per claim by categories defined by the Tennessee Department of Health for fiscal years 2017 and 2018. Please reference Section I.ix., Attachment 16, for Ballad Health's financial ratios and key operating indicators.

ii. Cost-efficiency steps taken – TOC: §6.04(b)(ii) / CA: VC15.2-5384.1(G):

- During the reporting period, Ballad Health began a vigorous process of improving efficiencies and reducing unnecessary costs. A detailed summary of these actions can be found in Section 4.B., Attachment 3. Two specific undertakings were completed during the reporting period. Ballad Health eliminated duplicate corporate positions based on service needs of the facilities, resulting in $3.8 million reduction in costs. Additionally, one of three urgent care locations in Norton, Virginia, was closed in an effort to eliminate duplicate resources that could be utilized elsewhere. This effort resulted in approximately $400,000 reduction in costs associated with contract physician fees and lease expenses, and all employed team members were repurposed throughout the system. Furthermore, access to care was not impacted, since two urgent care locations remain within 10 miles of the population in Norton, Virginia.

iii. Equalization Plan status – TOC: §6.04(b)(iii). Attachment 13, supplemental to the Equalization Plan (which was required by TOC §3.08(b) and CA Condition 19) that was submitted 6/30:

- Summary of changes in full-time equivalent (FTE) personnel:
  - During this Reporting Period, there has been an increase of FTEs from 11,494 in February 2018 to 11,514 in June 2018.

iv. Updates and implementation of the Population Health Plan and the HR/GME Plan – TOC: §6.04(b)(iv):

- Population Health Plan: The Population Health Plan is in progress and has not yet been approved.
- HR/GME Plan: The HR/GME Plan is in progress.

v. Services or Functions Consolidated – TOC: §6.04(b)(v):

- There were no consolidations of services or functions that meet this criterion during the Reporting Period.

vi. Changes in volume or availability of inpatient or outpatient services – TOC: §6.04(b)(vi):

- There were no material changes in volume or availability of inpatient or outpatient services during the Reporting Period.

vii. Summary of residency program – TOC: §6.04(b)(vii) / CA: Cond. 24. Attachment 14

viii. Movement of any residency slots – TOC: §6.04(b)(viii) / CA: Cond. 24.

- During the Reporting Period, there was no movement of residency slots.

ix. Academic partnerships – money spent, summary of research and status of grants – TOC: §6.04(b)(ix). Attachment 15

x. Outcomes of previously reported research projects – TOC: §6.04(b)(x):

- There are no outcomes to report during this Reporting Period.

xi. Summary of quality performance standards and best practices established by the Clinical Council – TOC: §6.0()b)(xi) / CA: Cond. 45. Attachment 7

xii. Plan of Separation – TOC: §6.04(b)(xii) / CA: 12VAC5-221-110(B). Update the Plan of Separation annually and provide an independent opinion from a qualified organization:

- The Plan of Separation was not updated during this Reporting Period and remains unchanged from the previously submitted plan; therefore, no independent opinion was obtained in the Reporting Period.

xiii. Comparison of Ballad Health financial ratios with similar health systems – TOC: §6.04(b)(xiii). Attachment 16

xiv. Total Charity Care information – TOC: §6.04(b)(xiv). Attachment 17

xv. Updated Ballad Health organizational chart, including listing of corporate officers and members of the Board – TOC: §6.04(b)(xv). Attachment 18

xvi. Most recent verifiable values available for Measure in Index – TOC: §6.04(b)(xvi) and Report on Measures in Tables A and B of the CA Quantitative Measures – CA: Performance Indicators 3(c)(iii) and 4(c); VC 15.2-5384.1(G); 12VAC 5-221-110(A)(3) and (8):

- Ballad Health is in compliance with the terms and conditions of the TOC and CA. Due to the truncated Reporting Period, no documented benefits related to changes in price, cost, quality, access to care and population health improvement are reported for this Reporting Period. Significant efforts were extended during this timeframe to integrate the system and initiate efforts on these fronts, including but not limited to, system-wide quality reporting, developing the various 3-year plans, developing the population health department and holding discussions with the states on the access to care and population health metrics. Data discussions on sources, baselines and targets are ongoing at this time.

xvii. Information expressly required for the Annual Report pursuant to any other Section of the TOC or the COPA Act – TOC: §6.04(b)(xviii) and Report on the extent of the benefits realized and compliance with other terms and conditions of the approval – CA: VC 15.2-5384.1(G):

- These items are listed in Sections 4, above, and 5.J. below.

xviii. Summary of comparison by COPA Hospital or other applicable healthcare provider affiliated with Ballad Health of price increases for Ballad Health to Measured Payors – TOC: Addendum 1, §9.1(d)(i) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

xix. Summary of comparison by COPA Hospital or other applicable healthcare provider affiliated with Ballad Health of price decreases for Ballad Health to Measured Payors – TOC: Addendum 1, §9.1(d)(ii) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

xx. A summary comparison and by the applicable Ballad Health provider, showing gross revenue and net revenue by Measured Payors – TOC: Addendum 1, §9.1(d)(iii) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

xxi. A list of any new Payors which executed Managed Care Contracts during the preceding calendar year and verified certification from the Ballad Health Chief Financial Officer that the pricing for such contracts complies with Addendum 1 – TOC: Addendum 1, §9.1(d)(iv) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

xxii. All charges and charge increases from non-hospital outpatient services, Physician Services, Charge-Based Items and Cost-Based Items – TOC: Addendum 1, §9.1(d)(v) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

xxiii. A report of charge master increases, by year and by provider, showing the impact on Measured Payors of such increase – TOC: Addendum 1, §9.1(d)(vi) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

xxiv. A summary of all value-based payments, broken out by COPA Hospital and by Measured Payor, including a comparison of such payment to the prior year's value-based payments form such Measure Payor – TOC: Addendum 1, §9.1(d)(vii) / CA: Cond. 5:

- Per Addendum 1 §9.1(d), this item will be provided by 11/30/19.

J. Progress report on Accountable Care Community – TOC: §3.04(d). Attachment 19

ATTACHMENT 1

ANNUAL REPORT CONTENTS

- TOC, Exhibit G, Pages 1-2 – 1a
- Virginia Code 15.2-5384.1 – 1b
- 12 Virginia Administrative Code 5-221-110 – 1c

EXHIBIT G

Forms of Annual Report and Quarterly Report

ANNUAL REPORT CONTENTS:

- Facility Maintenance and Capital Expenditures. Schedule of all maintenance and repair expenses and capital expenditures during the year; Section 3.07(b). Beginning with the NHS Annual Report for third Fiscal Year, NHS shall report whether it has met or exceeded aggregate capital expenditure spending commitments for prior three years per Capital Plan; Section 3.07(b).
- Career Development Plan. Explain implementation and results; Section 3.08(c).
- Clinical Counsel. Common standard of care, credentialing standards, consistent multidisciplinary peer review, and best practices; Section 4.02(b)(v).
- Integrated Delivery System Measures. 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).
- Quality Indicators. Summary of all results of quality indicators; include comparisons to similarly sized systems in the United States; Section 4.02(c)(ii).
- Patient Satisfaction Survey. Results of the patient satisfaction surveys* required of the NHS; Section 4.02(c)(iii).
- Staffing Ratios. Including hours of patient care delivered per patient and ratio of RN to LPN and other caregivers**; Section 4.02(c)(iv).
- Staff Survey. Results of the 3-year survey of medical, hospital and nursing staffs***; Section 4.02(c)(v).
- Monitoring Reports
    - Patient-related prices charged; Section 6.04(b)(i).
    - Cost-efficiency steps taken; Section 6.04(b)(ii).
    - Equalization Plan status; Section 6.04(b)(iii).
    - Updates and implementation of the Population Health Plan and the HR/GME Plan; Section 6.04(b)(iv).
    - Services or Functions Consolidated; Section 6.04(b)(v).
    - Changes in volume or availability of inpatient or outpatient services; Section 6.04(b)(vi).
    - Summary of residency program; Section 6.04(b)(vii).
    - Movement of any residency “slots”; Section 6.04(b)(viii).
    - 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).

- Summary of quality performance standards and best practices established by the Clinical Counsel in Section 4.02(b); Section 6.04(b)(xi).
- Updated Plan of Separation; Section 6.04(b)(xii).
- Comparison of NHS financial ratios with similar health systems; Section 6.04(b)(xiii).
- Total Charity Care information described in Section 4.03(f); Section 6.04(b)(xiv).
- Updated NHS organizational chart including listing of corporate officers and members of the Board; Section 6.04(b)(xv).
- Most recent verifiable values available for Measures in Index; Section 6.04(b)(xvi).
- Information expressly required for the Annual Report pursuant to any other Section of this COPA or the COPA Act; Section 6.04(b)(xviii).
- 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).
- A 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).

*Form and frequency of survey shall be approved by the Department.
**The manner of calculating the exact ratios shall be approved by the Department.
***The Summary Form shall be approved by the Department.

§ 15.2-5384.1. Review of cooperative agreements

A. The policy of the Commonwealth related to each participating locality is to encourage cooperative, collaborative, and integrative arrangements, including mergers and acquisitions among hospitals, health centers, or health providers who might otherwise be competitors. To the extent such cooperative agreements, or the planning and negotiations that precede such cooperative agreements, might be anticompetitive within the meaning and intent of state and federal antitrust laws, the intent of the Commonwealth with respect to each participating locality is to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority, and to invest in the Commissioner the authority to approve cooperative agreements recommended by the Authority and the duty of active supervision to ensure compliance with the provisions of the cooperative agreements that have been approved. Such intent is within the public policy of the Commonwealth to facilitate the provision of quality, cost-efficient medical care to rural patients.

B. A hospital may negotiate and enter into proposed cooperative agreements with other hospitals in the Commonwealth if the likely benefits resulting from the proposed cooperative agreements outweigh any disadvantages attributable to a reduction in competition that may result from the proposed cooperative agreements. Benefits to such a cooperative agreement may include, but are not limited to, improving access to care, advancing health status, targeting regional health issues, promoting technological advancement, ensuring accountability of the cost of care, enhancing academic engagement in regional health, strengthening the workforce for health-related careers, and improving health entity collaboration and regional integration where appropriate.

C. 1. Parties located within any participating locality may submit an application for approval of a proposed cooperative agreement to the Authority. In such an application, the applicants shall state in detail the nature of the proposed arrangement between them, including without limitation the parties' goals for, and methods for achieving, population health improvement, improved access to health care services, improved quality, cost efficiencies, ensuring affordability of care, and, as applicable, supporting the Authority's goals and strategic mission. The Authority shall determine whether the application is complete. If the Authority determines that the application is not complete, the Authority shall notify the applicants in writing of the additional items required to complete the application. A copy of the complete application shall be provided to the Commissioner and the Office of the Attorney General at the same time that it is submitted to the Authority. If the applicants believe the materials submitted contain proprietary information that are required to remain confidential, such information must be clearly identified and the applicants shall submit duplicate applications, one with full information for the Authority's use and one redacted application available for release to the public.

2. The Authority, promptly upon receipt of a complete application, shall publish notification of the application in a newspaper of general circulation in the LENOWISCO and Cumberland Plateau Planning Districts and on the Authority's website. The public may submit written comments regarding the application to the Authority within 20 days after the notice is first

published. The Authority shall promptly make any such comments available to the applicants. The applicants may respond in writing to the comments within 10 days after the deadline for submitting comments. Following the close of the written comment period, the Authority shall, in conjunction with the Commissioner, schedule a public hearing on the application. The hearing shall be held no later than 45 days after receipt of the application. Notice of the hearing shall be mailed to the applicants and to all persons who have submitted written comments on the proposed cooperative agreement. The Authority, no later than 15 days prior to the scheduled date of the hearing, also shall publish notice of the hearing in a newspaper of general circulation in the LENOWISCO and Cumberland Plateau Planning Districts and on the Authority's website.

D. In its review of an application submitted pursuant to subsection C, the Authority may consider the proposed cooperative agreement and any supporting documents submitted by the applicants, any written comments submitted by any person, any written response by the applicants, and any written or oral comments submitted at the public hearing. The Authority shall review a proposed cooperative agreement in consideration of the Commonwealth's policy to facilitate improvements in patient health care outcomes and access to quality health care, and population health improvement, in rural communities and in accordance with the standards set forth in subsection E. Any applicants to the proposed cooperative agreement under review, and their affiliates or employees, who are members of the Authority, as well as any members of the Authority that are competitors, or affiliates or employees of competitors, of the applicants proposing such cooperative agreement, shall not participate as a member of the Authority in the Authority's review of, or decision relating to, the proposed cooperative agreement; however, this prohibition on such person's participation shall not prohibit the person from providing comment on a proposed cooperative agreement to the Authority or the Commissioner. The Authority shall determine whether the proposed cooperative agreement should be recommended for approval by the Commissioner within 75 days of the date the completed application for the proposed cooperative agreement is submitted for approval. The Authority may extend the review period for a specified period of time upon 15 days' notice to the parties.

E. 1. The Authority shall recommend for approval by the Commissioner a proposed cooperative agreement if it determines that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement.

2. In evaluating the potential benefits of a proposed cooperative agreement, the Authority shall consider whether one or more of the following benefits may result from the proposed cooperative agreement:

a. Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction;

b. Enhancement of population health status consistent with the regional health goals established by the Authority;

c. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;

d. Gains in the cost-efficiency of services provided by the hospitals involved;

e. Improvements in the utilization of hospital resources and equipment;

f. Avoidance of duplication of hospital resources;

g. Participation in the state Medicaid program; and

h. Total cost of care.

3. The Authority's evaluation of any disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement shall include, but need not be limited to, the following factors:

a. The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;

b. The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;

c. The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and

d. The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.

F. 1. If the Authority deems that the proposed cooperative agreement should be recommended for approval, it shall provide such recommendation to the Commissioner.

2. Upon receipt of the Authority's recommendation, the Commissioner may request from the applicants such supplemental information as the Commissioner deems necessary to the assessment of whether to approve the proposed cooperative agreement. The Commissioner shall consult with the Attorney General regarding his assessment of whether to approve the proposed cooperative agreement. On the basis of his review of the record developed by the Authority, including the Authority's recommendation, as well as any additional information received from the applicants as well as any other data, information, or advice available to the Commissioner, the Commissioner shall approve the proposed cooperative agreement if he finds after considering the factors in subsection E that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement. The Commissioner shall issue his decision in writing within 45 days of receipt of the Authority's recommendation. However, if the Commissioner has requested additional information from the applicants, the Commissioner shall have an additional 15 days, following receipt of the supplemental information, to approve or deny the proposed cooperative agreement. The Commissioner may reasonably condition approval of the proposed cooperative agreement upon the parties' commitments to achieving the improvements in population health, access to health care services, quality, and cost efficiencies identified by the parties in support of their application for approval of the proposed cooperative agreement. Such conditions shall be fully enforceable by the Commissioner. The Commissioner's decision to approve or deny an application shall constitute a case decision pursuant to the Virginia Administrative Process Act

(§ 2.2-4000 et seq.).

G. If approved, the cooperative agreement is entrusted to the Commissioner for active and continuing supervision to ensure compliance with the provisions of the cooperative agreement. The parties to a cooperative agreement that has been approved by the Commissioner shall report annually to the Commissioner on the extent of the benefits realized and compliance with other terms and conditions of the approval. The report shall describe the activities conducted pursuant to the cooperative agreement, including any actions taken in furtherance of commitments made by the parties or terms imposed by the Commissioner as a condition for approval of the cooperative agreement, and shall include information relating to price, cost, quality, access to care, and population health improvement. The Commissioner may require the parties to a cooperative agreement to supplement such report with additional information to the extent necessary to the Commissioner's active and continuing supervision to ensure compliance with the cooperative agreement. The Commissioner shall have the authority to investigate as needed, including the authority to conduct onsite inspections, to ensure compliance with the cooperative agreement.

H. If the Commissioner has reason to believe that compliance with a cooperative agreement no longer meets the requirements of this chapter, the Commissioner shall initiate a proceeding to determine whether compliance with the cooperative agreement no longer meets the requirements of this chapter. In the course of such proceeding, the Commissioner is authorized to seek reasonable modifications to a cooperative agreement, with the consent of the parties to the agreement, in order to ensure that it continues to meet the requirements of this chapter. The Commissioner is authorized to revoke a cooperative agreement upon a finding that (i) the parties to the agreement are not complying with its terms or the conditions of approval; (ii) the agreement is not in substantial compliance with the terms of the application or the conditions of approval; (iii) the benefits resulting from the approved agreement no longer outweigh the disadvantages attributable to the reduction in competition resulting from the agreement; (iv) the Commissioner's approval was obtained as a result of intentional material misrepresentation to the Commissioner or as the result of coercion, threats, or intimidation toward any party to the cooperative agreement; or (v) the parties to the agreement have failed to pay any required fee. All proceedings initiated by the Commissioner under this chapter and any judicial review thereof shall be held in accordance with and governed by the Virginia Administrative Process Act (§ 2.2-4000 et seq.).

I. The Commissioner shall maintain on file all cooperative agreements that the Commissioner has approved, including any conditions imposed by the Commissioner. Any party to a cooperative agreement that terminates its participation in such cooperative agreement shall file a notice of termination with the Commissioner within 30 days after termination.

J. The Commissioner shall be entitled to reimbursement from the parties seeking approval of a cooperative agreement for all reasonable and actual costs, not to exceed $75,000, incurred by the Commissioner in his review and approval of any cooperative agreement approved pursuant to this chapter. In addition, the Commissioner may assess an annual fee, in an amount established by regulation promulgated by the State Board of Health that does not exceed $75,000, for the supervision of any cooperative agreement approved pursuant to this chapter and to support the implementation and administration of the provisions of this chapter.

2015, c. 741.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

12VAC5-221-110. Annual Reporting.

A. Parties shall report annually to the Commissioner on the extent of the benefits realized and compliance with any terms and conditions placed on their Letter Authorizing Cooperative Agreement. The report shall:

1. Describe the activities conducted pursuant to the Cooperative Agreement;

2. Include any actions taken in furtherance of commitments made by the Parties or terms imposed by the Commissioner as a condition for approval of the Cooperative Agreement;

3. Include information related to changes in price, cost, quality, access to care, and population health improvement;

4. Include actual costs, revenues, profit margins, and operating costs;

5. Include a charge master;

6. Include information reflecting the contracted rates negotiated with non-physician providers, allied health professionals, and others;

7. Include any measures requested by the Department based on the recommendations of the Technical Advisory Panel appointed pursuant to 12VAC5-221-120; and

8. Include the current status of the quantitative measures established under 12VAC5-221-100(C) and the information requested by the Department for benchmarks established in 12VAC5-221-100(B).

B. The Parties shall be required to update the Parties' Plan for Separation annually and submit the updated Plan of Separation to the Department. The Parties shall provide an independent opinion from a qualified organization that states the Plan of Separation may be operationally implemented without undue disruption to essential health services provided by the Parties.

C. The Commissioner may require the Parties to supplement the annual report with additional information to the extent necessary to ensure compliance with the Cooperative Agreement and the Letter Authorizing Cooperative Agreement.

D. All annual reports submitted pursuant to this subsection shall be certified audited by a third-party auditor.

E. The fee due with the filing of the annual report shall be $20,000. If the Commissioner should determine that the actual cost incurred by the Department is greater than $20,000, the Parties shall pay any additional amounts due as instructed by the Department. The annual filing fee shall not exceed $75,000.

F. The Commissioner shall issue a written decision and the basis for the decision on an annual basis as to whether the benefits of the Cooperative Agreement continue to outweigh any disadvantages attributable to a reduction in competition that have resulted from the Cooperative Agreement.

ATTACHMENT 2

ACTIVITIES CONDUCTED PURSUANT TO THE COOPERATIVE AGREEMENT

Ballad Health Annual Report – Fiscal Year 2018
Reporting Period: February 1 – June 30, 2018

12VAC5-221-110. Annual Reporting.

A. Parties shall report annually to the Commissioner on the extent of the benefits realized and compliance with any terms and conditions placed on their Letter Authorizing Cooperative Agreement. The report shall:
    1. Describe the activities conducted pursuant to the Cooperative Agreement

B. **Submission of the following documents/deliverables as required by the COPA/CA:**
    - Ballad Health Organizational Chart (pre- merger)
    - Plan of Separation (pre-merger, 9/16)
    - Ballad Health Financial Assistance Policy (1/30/18)
    - List of Ancillary Services and Post-Acute Services offered by competitors (Competing Services) (3/1/18)
    - Severance Policy (3/30/18)
    - Outlines for the Health Services Plans (4/27/18)
        - Behavioral Health
        - Children's Health
        - Population Health
        - Rural Health
    - Quarterly report for truncated reporting period 2/1/18 through 3/31/18 submitted on 5/15/18.
        - COPA Compliance Policies and Procedures (5/15/18)
    - List of Entities Ballad Health Does Not Exercise Control or Influence Over for Managed Care Contracting (5/31/18)
    - Inpatient Payment Indices (5/30/18)
    - COPA Compliance Training and Education Plan (6/30/18)
    - Equalization Plan (6/30/18)
    - Drafts for the Health Services Plans (6/30/18)
        - Behavioral Health
        - Children's Health
        - Population Health
        - Rural Health
    - Quarterly report for reporting period 4/1/18 through 6/30/18 submitted on 8/15/18.

- **The following waiver requests were submitted to seek permission for any modification from the established requirements:**
    - Request to substitute Dr. Oppong for Dr. Gupta under the waiver previously granted (1/31/18) to employ a nephrologist at Johnston Memorial Hospital. Waiver granted 3/15/18.
    - Request to offer employment to certain neurosurgeons and physical medicine and rehabilitation physicians in Johnson City and Kingsport (2/1/18). Waiver granted 2/28/18.
    - Request to allow Johnson City Medical Center cardiovascular surgeons to cover at Bristol Regional Medical Center for a temporary gap in coverage (4/6/18). Temporary waiver granted 4/6/18.
    - Request to allow cross-credentialing of certain employed physicians to other facilities within Ballad Health (4/13/18). Waiting on approval from Commissioner.
    - Request for cardiothoracic coverage: Allow Johnson City Medical Center physicians Drs. Palazzo, Raudat and Helsel to provide coverage at Bristol Regional Medical Center (5/17/18). Waiting on approval from Commissioner.
    - Request for consolidation of cardiovascular cath lab operations in Kingsport (Tim Belisle sent request to Janet Kleinfelter on 6/4/18. Formal letter request signed by Alan Levine, CEO, and sent to Commissioner on 9/14/18). Waiver granted 9/20/18.

- **The following notifications were submitted regarding quality of care regulatory compliance:**
    - The Joint Commission (TJC) notification regarding Franklin Woods Community Hospital, Sycamore Shoals Hospital and Johnston Memorial Hospital (6/5/18)
    - CMS notification regarding Unicoi County Nursing Home (6/6/18)
    - CMS notification regarding Lonesome Pine Hospital (6/21/18)

- **The following requests were submitted for modifications/extensions for deliverables or definitions documented in the original merger agreements (TOC/CA)**
    - Request for extension on Payment Indices for Outpatient, Physician Clinics, Ambulatory Surgery Centers and Never Contracted Percent (5/30/18)
    - Base Charity Care: submitted a request to the COPA Monitor for a written addendum/revision to the TOC to adjust charity reporting to a fiscal year basis to coincide with Ballad Health's reporting methodology (6/20/18)
    - Letter regarding Timing Confirmations: Todd Norris (6/25/18)
    - Letter from Ballad Health general counsel to Tennessee Attorney General's office regarding Ballad Health Governance Modifications (6/27/18)
    - Request for measurement changes (Population Health Measures) (6/1/18)

ATTACHMENT 3

ACTIONS TAKEN IN FURTHERANCE OF COMMITMENTS

ATTACHMENT 3 - ACTIVITIES CONDUCTED PURSUANT TO THE COOPERATIVE AGREEMENT

A. Improving the Community's Health Status

Ballad Health has taken a number of concrete steps toward creating a comprehensive infrastructure to support our regional efforts to improve community health. This includes internal reorganization as well standing up a region-wide Accountable Care Community, a collaborative impact model, where community organizations identify a small number of clearly articulated goals of common interest. This effort will be supported by the Ballad Health infrastructure and will provide the critical mass of resources necessary to achieve success. Details of just some of the activities taken since the closing of the merger include:

1. Creating plans for population health improvement

a. Developed and Submitted the Population Health Plan

Ballad Health deployed a comprehensive process to gather input for and draft a population health plan, which was submitted to the Commonwealth of Virginia and State of Tennessee in June, 2018, for approval. We convened an executive steering team, which was aided in its analysis by national experts with experience in large-scale population health improvement. The steering team developed a "playbook" of evidence-based and promising practice interventions, which have the potential to be successfully implemented in our communities.

In addition, we gathered input from internal and external stakeholders to assess community health needs and refine the intervention playbook through approximately 150 interviews and 40 meetings with external groups, including the regional accountable care community steering committee, regional health departments, United Way agencies, chambers of commerce, schools and community organizations, as well as key internal groups such as the population health and social responsibility committee of the Ballad Health board of directors, the Ballad Health population health clinical committee, and hospital community boards.

Before drafting the initial population health plan, we worked with internal and external data experts and subject matter experts to ensure our approach to measuring and tracking population health and access metrics is reliable and in keeping with best practices. Meetings with both states continue to refine the data collection and reporting process which, we believe, is among the first of its kind in the country.

Through this intensive process, Ballad Health and its partner community organizations have determined that the overwhelming evidence from successful collaborative impact efforts elsewhere supports a focus on fewer measures that will have a definitive result in improving generational health. Ballad Health remains committed to investing in successful interventions that have a real opportunity for success.

b. *Developed and Submitted Community Health Need Assessments and Implementation Plans*
Ballad Health has implemented a new process for compiling robust and comprehensive Community Health Needs Assessments (CHNAs) that engage community stakeholders earlier and more often in the process. Eleven Ballad Health facilities were due for new CHNAs this year, based on a 3-year cycle required by the Internal Revenue Service for not-for-profit hospitals.

For the first time, COPA and cooperative agreement commitments were integrated into these assessments, as well as findings from key documents such as the health plans for Tennessee and Virginia, The Southwest Virginia Blueprint for Health Enabled Prosperity, historical CHNAs from Wellmont Health System and Mountain States Health Alliance, county health rankings, and the pre-merger workgroups report titled, "Key Priorities for Improving Health in Northeast Tennessee and Southwest Virginia: A Comprehensive Community Report."

The strategic planning department of Ballad Health piloted a model in Smyth County that improved stakeholder involvement through a community advisory committee. This approach goes well beyond the traditional model of simply conducting limited stakeholder interviews. A collaborative group met multiple times to discuss and refine both the needs assessment and implementation plan. Local participants included law enforcement, health departments, community services boards, education representatives including grade schools and higher education centers, and other local community organizations.

Community feedback regarding the collaborative assessment process has been extraordinarily positive, and stakeholders have expressed an interest in continuing to meet to help ensure their community's health needs are being met by playing an integral part of the implementation and monitoring efforts. Ballad Health will apply this model to all future CHNA activities moving forward. Importantly, Ballad Health is also represented on the Virginia Hospital and Healthcare Association's and the Virginia Commissioner of Health's *Partnering for a Healthier Virginia Advisory Committee* which seeks to increase collaboration between the health department and hospitals in the Community Health Needs Assessment and implementation planning process.

The Ballad Health Community Health Needs Assessments and Implementation Plans are available to the public and can be accessed at the Ballad Health website by clicking on the name of the hospital, and then clicking on the "Community Health Needs Assessment" link. An example of the Community Health Needs Assessment for Johnson City Medical Center may be found at:

https://www.balladhealth.org/sites/balladhealth/files/documents/JCMC_Community_Health_Needs_Assessment_2018.pdf

2. Developing a Population Health Infrastructure within Ballad Health and the Community

a. Established the Department of Population Health within Ballad Health

Since our merger in February of 2018, Ballad Health has built, from the ground up, a department of population health staffed by professionals in both community health and

value-based healthcare. The department is dedicated to developing solutions to improve health in the community at large, among selected populations based on assessed risk and prioritization, populations where Ballad Health has contractual arrangements to improve specific outcomes and manage cost (such as Medicare Advantage), and within Ballad Health's own team member and dependent population. The department's strategies are guided based upon Ballad Health's and its community partners' assessment of need in the community, which is the priority driver for dedication of resources. The population health and access metrics in the COPA and Cooperative Agreement are broad, and where alignment may occur with community need, those issues will be prioritized.

Efforts are led by the Chief Population Health Officer, who reports directly to the Chairman and Chief Executive Officer of Ballad Health. Additional leadership includes the Senior Vice President for Community Health and System Advancement, the Senior Vice President for Value-Based Care and Strategic Planning, the Vice President for Health Programs, and the Directors of Community and Clinical Engagement.

The new leadership hired and trained a group of community engagement specialists who are embedded in multiple communities in Northeast Tennessee and Southwest Virginia served by Ballad Health. These individuals have strong community ties and a deep understanding of the cultural nuances that impact population health in this unique region. The team is supported by a data analyst dedicated to tracking the deployment and impact of population health efforts throughout the service area.

Ballad Health has organized its grant department and community foundation under population health to align goals with, and provide support to, these community health initiatives. Ballad Health's intent is to advance the application process for external grants and funding for the various initiatives it will deploy with its community partners.

b. Established the Population Health Clinical Steering Committee

Immediately after the close of the merger in February, 2018, Ballad Health established its clinical council, comprising approximately 30 physicians nominated from the elected leadership of all Ballad Health hospitals, the health system's medical group, and independently practicing community physicians. The council meets monthly and reports directly to the quality committee of the Ballad Health board of directors. The group's goal is to ensure excellence in clinical care through physician engagement and leadership. The council employs a dyad leadership model, with each subcommittee – as well as the council itself – led by co-chairs representing both physician executives and those in full-time practice.

The clinical council is comprised of several committees, including the population health clinical steering committee. This clinical committee is composed of Ballad Health and independent community clinical providers representing physicians, pharmacists, advanced practice providers, and nursing. The committee is charged with providing guidance for Ballad Health's transformation to a community health improvement system. The group has met twice to establish its structure and focus, review existing health improvement metrics, establish a charter, and review the population health plan. Work has begun on care transitions planning, including identification of best approaches to screening activities and follow up for cancer, high blood pressure, obesity risk, and diabetes. Work in these areas is

geared toward creating seamless transitions between clinical interventions and community interventions.

c. *Established a Regional Accountable Care Community*

Ballad Health funded and has taken a lead role in the governance of a regional, multi-stakeholder Accountable Care Community (ACC) to address population health needs across a wide geographic region. Accountable Care Communities are coalitions of stakeholders who align their organizations' efforts around a focused set of population health and community well-being goals. The regional ACC will support the formation of local community action teams and expand the work of existing action teams, such as health councils who wish to align with the ACC efforts.

After a process in which Ballad Health solicited requests for proposals, the United Way of Southwest Virginia and Healthy Kingsport were selected to serve alongside Ballad Health as lead organizations for the ACC. Both of these organizations have successful track records of collective action in Virginia and Tennessee respectively. The lead organizations and ACC steering team identified an initial list of prospective member organizations across the 21 county region, and have established a membership agreement that will govern ACC participation. Membership recruitment is ongoing, and has surpassed 60 organizations as of October.

These inaugural members met in a series of focus groups to review existing consensus documents on community health needs such as department of health plans for Tennessee and Virginia, the Southwest Virginia Blueprint for Health Enabled Prosperity, historical CHNAs from Wellmont Health System and Mountain States Health Alliance, county health rankings, and the pre-merger workgroups report titled, "Key Priorities for Improving Health in Northeast Tennessee and Southwest Virginia: A Comprehensive Community Report." The group identified four collective impact strategies on which the ACC will focus its time and resources:

- Building a grassroots group of community partners;
- Aligning the activities, services and resources of those partners toward population health outcomes;
- Managing partnerships to direct momentum toward population health; and
- Mobilizing communities through shared responsibility to achieve collective impact.

d. Established the Community Benefit and Population Health Committee

The Ballad Health board of directors established the Community Benefit and Population Health committee of the board. This committee includes the Chief Executive Officer, Chief Operating Officer, Chief Clinical Officer and Chief Population Health Officer of Ballad Health, as well as regional leaders and multi-sector community representation. It is responsible for oversight and compliance with all population health-related COPA and cooperative agreement commitments and reporting. It is also responsible for governing the alignment of the COPA/cooperative agreement, community benefit/Community Health Needs Assessment, and value-based contracting strategies and initiatives to produce health improvement in the community.

To date, the group has established a charter and has conducted a number of education sessions on population health best practices, the Ballad Health population health plan, a revamped community health needs assessments (CHNAs) process, and value-based contracting. This committee has also reviewed, and recommended for adoption by the Ballad Health Board of directors, the population health plan and the most recent round of community health needs assessment and implementation plans.

e. Aligned Ballad Health's Business Health and population health infrastructure

Ballad Health is evolving the role of our business health services to support not only traditional business health support services (i.e., work site clinics, etc.) but to also incorporate employer-based community health programming. Our new strategy recognizes that while Ballad Health can bring value to employers through a number of our traditional business health services, employers can also bring value to Ballad Health by providing it access to their workforce to deliver health education, perform screenings, vaccinations, and provide other services in support of Ballad Health's COPA and cooperative agreement goals.

Now organized under the Senior Vice President for Value-Based Care and Strategic Planning, the business health services department is in the process of developing offerings with the Department of Health Programs, Integrated Solutions Health Network (which houses the Ballad Health Accountable Care Organization and team member wellness program), and our Health Resources Center, which focuses on community outreach and programming for health-related topics such as healthy eating, diabetes management and cardiovascular disease prevention. Business Health has outreached to individual employers and local chambers to further refine the opportunities for new services and partnerships

f. Growing the parish nurse program

Ballad Health's service region culturally is connected by faith, and Ballad Health believes connectivity to the faith community is critical for success. Parish (or faith-community) nursing combines professional nursing with health ministry, emphasizing health and healing in a faith community. Ballad Health's parish nursing program already consists of about 50 parish nurses serving approximately 30,000 parishioners in the region. Ballad Health is in the process of hiring its first full-time leader of the parish nurse program in preparation for expanding the number of parish nurses in the community, and to strengthen their connection to the health system and its population health and access goals. Ballad Health is aligning the efforts of the current program with the goals of the COPA and cooperative agreement, expanding access to other community health programming available within Ballad Health, and evaluating new technology that will provide parish nurses with more health information from Ballad Health about their parishioners.

g. Expanding Health Resources Center capabilities to other communities

The Health Resources Center (HRC) provides health education, screening and support groups based primarily in Johnson City and Kingsport. Since the merger, the HRC has been reorganized under the Senior Vice President of Value Based Care and Strategic Planning in order to work more closely with Ballad Health's care coordinators, navigators, health coaches, parish nurses the Department of Population Health; and business health services. These resources will focus more on the preventative and wellness of the community through various populations (i.e., employers, faith-based, general community, etc.). The Health Resources Center is expanding its

presence throughout the region to provide services in non-traditional settings such as mobile food distribution sites where it is easier to connect to individuals in need rather than requiring them to travel to our two current locations. Recently, Ballad Health cut the ribbon on a new, expanded, Health Resources Center (https://www.johnsoncitypress.com/Health-Care/2018/10/01/Ballad Health-cuts-ribbon-on-new-Health-Resources-Center).

3. Establishing Ballad Health as an Example for Community Health Improvement

We believe it is important for Ballad Health to set an example for how employers, community leaders, and individuals can make choices that lead to better health. We are adopting policies and practices to ensure that Ballad Health can serve as a positive example in our community.

First, Ballad Health has adopted a socially responsible investment policy for its cash reserves. Ballad Health's board of directors will steer investment portfolios away from companies that provide products or services that lead to poor health, for example, tobacco.

Also, Ballad Health is investing in new programs and technologies that enable patients to better manage their health and prevent disease. We are launching and piloting a number of these initiatives with our own team members and dependents – over 20,000 individuals who live within the Ballad Health service area and have the potential to act as influencers in their personal communities.

a. Established the Ballad Health as an Example Steering Committee

We have established an internal steering team and workgroups to identify target areas for intervention and improvement. These targets will impact the design of our health plan, our food and vending policies, our health promotion and wellness offerings, our team member communication and engagement activities, and our community outreach. This team is made up of multidisciplinary team members from across the organization.

b. Expanded Employee Health Risk Assessments and Health Coaching

We have expanded a comprehensive approach to screening and assessing health risks across our employee population using Applied Health Analytics to compile and analyze health risk assessments and biometrics. Ballad Health adopted a policy whereby team members and dependents who participate receive discounts on their health insurance premium. More than 11,000 team members and dependents have participated this year.

Results were shared with team members in a confidential, personalized format accessible online. Health coaches are reviewing health risks with team members who have or are at high risk for chronic disease. Ballad Health will use the aggregate data to inform programming and future benefit design to help address broad areas of opportunity for health improvement. For instance, if a significant number of team members are overweight or obese, Ballad Health may seek to provide incentives for participation in initiatives designed to mitigate the potential for a chronic condition and improve the health and well-being of those team members.

c. *Piloting an employee stress reduction intervention*

Ballad Health has developed a formal working relationship with a leading national research institution and health system to improve employee and community wellness. A mini-fellowship for a Ballad Health cardiologist was sponsored at this institution, and Ballad Health is in the process of piloting the first of a series of employee interventions designed to improve results on a number of key health risk factors such as blood sugar levels, blood pressure, body mass index and stress. A stress reduction intervention is the first of these pilots. If successful, additional pilots will be rolled out, the program will be scaled up to all Ballad Health employees and dependents, and will eventually be made available to employers throughout the region.

d. *Piloting a primary cardiovascular protection program*

Ballad Health has a strong relationship with the Pritikin Longevity Center and was selected as one of the first 10 sites in the United States to implement a Medicare-approved intensive cardiac rehab program. We are currently researching a new primary prevention program with Pritikin, which may demonstrate clear application and translation of Pritikin concepts to the reduction of disease development risk in at-risk individuals. This program is being piloted within the Ballad Health team member population.

4. Enabling Community Based Health Improvement & Sound Health Policy

a. *Strengthening Community Action and Partnerships*

Ballad Health is helping to fund and manage community efforts to implement evidence-based and promising public health programs and practices throughout the region. Outreach in several key areas has begun. The community engagement team is partnering with the Accountable Care Community, health councils, anti-drug coalitions, healthy community teams, and other grassroots groups to collectively identify those programs that contain best or promising practices to evaluate for resourcing and support. Once identified, programs will be selected for piloting resources and evaluation of impact and further assessment for scaling and replication.

i. Employer sector activities

- We have met with the chamber of commerce leaders from Bristol, Kingsport, and Johnson City along with large regional employers to begin a collaborative approach that will scale to the entire region. Initial areas for further pursuit include reducing opioid abuse in the workforce and benefit design that promotes high-value care.

ii. Maternal / child health activities

- We are working with a large local children's charity to assess the potential to align our funding and support of maternal and child health organizations in the region in support of COPA and cooperative agreement goals.
- With support from a grant by Mike and Nancy Christian, Niswonger Children's Hospital launched the Families Thrive program, which offers special support to families who are caring for a baby born with neonatal abstinence syndrome (NAS). https://www.BalladHealth.org/news/niswonger-childrens-hospital-launches-families-thrive
- Ballad Health Hospice hosted Camp Caterpillar, a free camp for children who have lost a loved one, with a goal of giving children and families coping tools to help them through the trauma associated with loss.

https://www.BalladHealth.org/news/camp-caterpillar-helps-grieving-children-and-families-find-solace-companionship-and-healing

- In response to a series of tragic child drownings in the region, Niswonger Children's Hospital partnered with Levi's Legacy to help raise awareness of water safety. https://www.BalladHealth.org/news/Niswonger-Childrens-Hospital-partners-Levis-Legacy-to-promote-water-safety

iii. School-based activities

- Since 2014, Niswonger Children's Hospital has reached outside the hospital walls and into the community to improve child literacy through the B.E.A.R. Buddies reading program, which pairs volunteer mentors with elementary school students who need a boost in their reading skills. When five new schools recently requested to join the program, it became apparent more volunteers would be needed to help fill the gap and Ballad Health Chairman and CEO Alan Levine issued a call to Ballad Health team members for help. To date, 100 volunteers for the 2020 school year have signed up. https://www.BalladHealth.org/news/Ballad-health-bear-buddies-child-literacy
- Ballad Health Foundation and Prevention Connection partnered to bring Project Fit America to Norton Elementary School. Project Fit provides the school a grant for fitness education that includes new gymnasium and playground equipment. https://www.BalladHealth.org/news/Ballad-health-project-fit-america-norton-elementary
- In partnership with the Bristol Tennessee and Virginia Public Schools, Ballad Health hosted a community wellness expo to promote good health involving physical activity and free health screenings. https://www.BalladHealth.org/news/power-health-expo-and-power-play-5k-set-april-28
- A key area of concern for the region is children in schools who are in mental health or behavioral health crisis. In meetings with school superintendents hosted by Congressman Phil Roe, the superintendents shared stories of children who are at risk, in crisis, or even potentially demonstrating suicidal thoughts. The gaps in services available often leave teachers and school leaders with the burden of navigating what to do for the child. Ballad Health has offered to create a telehealth assessment program in partnership with the school districts whereby Niswonger Children's Hospital mental health counselors will be available to assess the child, and if necessary, refer them for immediate services. Ballad Health will hire additional counselors to be deployed to the school districts for follow-up with these children so that intervention may occur, or proper hand-off can be done for the needed services by the most appropriate support organization.

iv. Collaborative opioid intervention activities

- Ballad Health is working with three other broad regional coalitions in Tennessee and Virginia that each received $200,000 planning grants from HRSA to coordinate efforts to fight the opioid crisis in our region. Fewer than 100 organizations nationwide were awarded the grants, which are geared toward helping communities collaborate to address the opioid crisis. Through the grant, Ballad Health will engage with a consortium of regional organizations to work collaboratively on a multi-sector approach to addressing the problem of opioid addiction in Northeast Tennessee and Southwest Virginia. The grant will support Ballad Health team members who will be deployed into local communities to work

with key stakeholders. Ballad Health will spearhead the initiative's lead consortium, which will establish other locally-governed consortia in rural communities throughout the region. Lead consortium members are the Bristol Chamber of Commerce, the Virginia Department of Health (VDH) Cumberland Plateau Health District, East Tennessee State University's Center for Prescription Drug Abuse Prevention and Treatment, Healthy Kingsport, the Johnson City Chamber of Commerce, the Kingsport Chamber of Commerce, VDH LENOWISCO Health District, VDH Mount Rogers Health District, the Northeast Tennessee Regional Health Office, Dr. Thomas Renfro of Norton Community Physician Services, Smyth County School District, Sullivan County Regional Health Department, and United Way of Southwest Virginia.

- Ballad Health joined forces with local chambers of commerce and Leadership Tennessee to rally our community at an opioid summit which featured author Sam Quinones, author of *Dreamland – A True Tale of America's Opioid Epidemic.*
- Ballad Health is the lead organization in a Smyth County Virginia community collation grant of $737,000 from the Rural Health Opioid Program, part of the U.S. Department of Health & Human Services. https://www.BalladHealth.org/news/smyth-county-address-national-opioid-crisis. The three-year grant will be used to form a multi-disciplinary opioid consortium focused on reducing mobility and mortality from opioid use disorder by:
    - Educating the community on overcoming the stigma of opioid addiction
    - Educating people battling addiction on available services in the community and help to guide them into treatment
    - Providing enhanced counseling for hands-on opioid addiction treatment
    - Providing expanded peer support opportunities
    - Providing care coordination to support people battling opioid addiction to help them get treatment, make appointments, and remove barriers to treatment (i.e. transportation issues, etc.).

v. Joined nationally recognized health systems to participate in the National Medicaid Transformation Project

- Through participation in the Medicaid Transformation Project, Ballad Health has joined 16 leading health systems nation-wide in addressing social determinants of health for the nearly 75 million Americans who rely on Medicaid. Co-led by AVIA and former CMS Acting Administrator Andy Slavitt, the Medicaid Transformation Project will develop actionable solutions that address the health and social needs of our nation's most vulnerable patients. The work will focus on five key areas of opportunity, four of which have already been identified: behavioral health, child and maternal health, substance use disorder and avoidable emergency department visits. Medicaid Transformation Project participants believe that the solutions that help address these key areas of need for Medicaid subscribers will have the added effect of improving care for all vulnerable populations, including the uninsured. https://www.balladhealth.org/news/17-health-system-project-vulnerable-populations

vi. Piloted the Accountable Health Communities Project

- Prior to Ballad Health, the two legacy systems and select community partners (Community Service Boards in Southwest Virginia, Virginia DMAS) were one of only

32 recipients nationwide of a $2.5 million CMMI Accountable Health Communities grant. Ballad Health has continued to move forward with this work, which involves screening 75,000 Virginia Medicaid and Medicare patients annually at hospitals and physician practices for five social determinants of health risks (transportation, food, housing, interpersonal violence, and utilities). Ballad Health has expanded this screening to include substance abuse.

When at least one of these risks is identified, the patient is provided a listing of available community resources that can help address those specific needs. For a randomly selected population with at least one risk factor and with two or more emergency room visits in the past 12 months, a navigator will follow up personally to provide further support in connecting these patients to the available community resources.

This program initiated with two separate pilot projects screening a total of 8,776 Medicaid, Medicare and uninsured patients between September 1, 2017, and July 31, 2018, preceding the projected go-live by fall/winter of 2018.

This award from the federal government could not have been possible without the support of commonwealth leaders in Virginia, which Ballad Health applauds. The Accountable Health Community will assist in bridging gaps in services needed between hospitalization and home and community-based services which are necessary for addressing social determinants of care. Ballad Health remains hopeful that a similar partnership can be established in Tennessee.

b. Building Healthy Public Policy

Ballad Health is engaging in research and advocacy at the local, state and federal level to promote the population health and access goals included in the COPA and cooperative agreement. To date, we have provided education sessions to local leadership groups including chambers of commerce, government officials, business leaders and policy makers to better inform them on the requirements of the COPA and cooperative agreement and to solicit input for legislative interest and advocacy development.

Ballad Health is in the process of cataloging and assessing best practice public policies that have been shown to improve population health metrics in other parts of the country. This effort is scheduled to be completed by the end of 2018 and will assist in prioritizing legislative education and advocacy.

Ballad Health continues to advocate for rural health on the national stage. Alan Levine, chairman and chief executive officer of Ballad Health, on September 25th testified to a subcommittee of the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP). Mr. Levine presented an oral and written summary outlining some of the most critical issues facing rural hospitals in the United States as well as legislative and regulatory strategies (i.e.: 340b Drug Discount Program, Medicare Area Wage Index, etc.) that can help communities address the health issues that disproportionately affect rural and non-urban residents throughout the country. His testimony highlighted steps Ballad Health is taking to transform rural hospitals, and to sustain services in a region of the nation heavily impacted

by the factors which are harming rural health care. Mr. Levine's written testimony is available here: https://www.help.senate.gov/imo/media/doc/Levine1.pdf and video testimony is available here: https://www.c-span.org/video/?c4751429/alan-levine-testimony

B. Improving Access to Healthcare Services

1. Virginia Medicaid expansion

A priority during the 2018 legislative session in Virginia was the passage of Medicaid expansion. Expansion was included in Virginia's biennial budget passed on June 7, 2018. Ballad Health worked closely with legislators in Virginia to educate them on the impact on health outcomes, access and economic development of providing approximately 400,000 uninsured, low-income Virginians (approximately 21,000 in Ballad Health's Virginia service area) with access to insurance.

Expansion takes effect January 1, 2019 with enrollment beginning November 1, 2018. Ballad Health is helping to raise awareness in the community about new options for coverage by deploying messaging in its hospitals and clinics in conjunction with the Virginia Department of Medical Assistance Services. We are also working with our enrollment services vendor to identify patients who will now qualify for Virginia Medicaid and encourage enrollment and are hosting 10 community events in November to meet face to face with patients and assist them in enrolling.

2. Hospital sponsored dental residency program will increase care for low-income individuals

One of the key gaps in health care rural regions, including the region served by Ballad Health, is access to dental care. Evidence shows that poor dental health can lead to diabetes, heart disease and other serious health conditions, in addition to harming the quality of life for each individual without access. Ballad Health has worked with a not-for-profit dental program to establish a hospital-based dental residency program at Johnston Memorial Hospital in Abingdon, Virginia. Dentists who enter dental residency are fully licensed dentists who wish to obtain advanced training in areas such as prosthodontics. This program would not only increase access to dental care for the underserved, but could also increase the supply of dentists locating in the area after their training. The application for a hospital-based dental residency has been submitted for review by the dental residency accrediting organization. This program has not been formally announced, as Ballad Health is awaiting approval first.

3. Addiction medicine fellowship partnership announced

Ballad Health and East Tennessee State University announced a partnership in June, 2018, to create a fellowship program in addiction medicine. Through the partnership, ETSU will apply to the Accreditation Council for Graduate Medical Education to create a new fellowship program in addiction medicine. As part of its commitment to expand education and training in the region, Ballad Health will fund any un-reimbursed costs of the fellowship program, which, over a 10-year period could cost more than $2.5 million. https://www.etsu.edu/news/2018/06-jun/nr_addiction_medicine_fellowship_program_application.aspx

4. Access to low/no cost pharmaceuticals increased for low income individuals

Hawkins County Memorial Hospital and Hancock County Hospital achieved 340B status designation from the U.S. Department of Health and Human Services, reflecting their important role in the community as a provider of essential healthcare services to individuals who cannot afford to pay for their care. This program will assist Ballad Health in ensuring patients can access needed medication.

5. JMH graduates first class of family medicine residents

Johnston Memorial Hospital graduated its first class of six family and internal medicine residents in June of 2018. Of these graduates, three are planning on staying in the community to provide primary care. Currently there are 31 residents in years one through three of their residency program at JMH.

6. Greene County Hospitals remain open by specializing and adding new 12-bed progressive care unit

While 80 rural hospitals throughout the nation, led in part by Tennessee, have closed or been forced to significantly curtail services since 2010, Ballad Health has implemented one of the core benefits of the merger through its vision of eliminating unnecessary and costly duplication that threatened the viability of these rural hospitals, and instead is sustaining the hospitals and adding services. In the fiscal year that just ended, the two hospitals in Greene County, Laughlin Memorial and Takoma Regional, saw combined operating losses of $11 million, with cumulative two-year losses totaling nearly $31 million. Under each hospital's previous ownership, in 2014 and 2015, deteriorating financial results led to discussions between the incumbent boards and management for a consolidation of the two hospitals. A mutual agreement could not be reached, which resulted in Takoma being acquired by Wellmont Health System, and Laughlin being acquired by Mountain States Health Alliance. The merger creating Ballad Health paved the way, with state approval, for this partnership to finally happen. Had the hospitals remained independent during the last two years as cash reserves declined, the evidence shows that at least one would likely have closed.

In its approval of the merger creating Ballad Health, the state of Tennessee agreed with Ballad Health officials that "significant duplication of services exists in Greene County, Tennessee as a result of the two rural hospitals located therein." Further, the state said Ballad Health, "may consolidate services into one of such rural hospitals and repurpose the other rural hospital … without prior approval from the department" under certain circumstances.

On August 1, Ballad Health announced plans to keep both community hospitals in Greene County open, allowing them to work together as one hospital with two campuses and enabling specialization of services that has been shown to lead to better outcomes for patients. Beginning in early 2019, Takoma Regional Hospital will focus its services on advanced outpatient and non-acute inpatient care, while Laughlin Memorial Hospital will focus on providing acute inpatient services. Services to be offered at Takoma will include inpatient rehabilitation, inpatient geriatric-psychiatric care, occupational medicine, sleep medicine, emergency medicine and advanced diagnostic imaging. Services to be offered at Laughlin will include inpatient surgery, inpatient medical/surgical care, same-day surgery, endoscopy, emergency medicine, ICU and obstetrics, including labor and delivery.

The hospitals will also work together to provide a combination of observation and short-stay care for pediatrics. In addition, a new 12-bed progressive care unit will be added at Laughlin.

The plans announced in Greene County illustrate how two rural hospitals that were previously competitors in an environment where both were financially struggling are now able collaborate in a manner that will preserve acute care services in Greeneville in accordance with the state's primary goal of preserving access, and will enhance the viability of the hospitals going forward. https://www.balladhealth.org/news/plans-sustainability-and-enhancement-greene-county-healthcare

7. Opened a new rural hospital in Unicoi County

Again, with 80 rural hospital closures or reductions in services throughout the nation, led in part by Tennessee, Ballad Health implemented its vision for a new kind of rural health access. In October 2018, Ballad Health opened a new rural hospital in Unicoi County, replacing an aging facility that was originally constructed in 1953. While the hospital is not financially feasible as a stand-alone entity, Ballad Health made good on a promise to the people of Unicoi County and has not only kept the community's hospital open, but has provided a new state-of-the-art facility that houses some of the most advanced technology within the health system and is introducing new services to the community.

The new hospital features limited, low-acuity inpatient acute care services, a 24-hour emergency department, physician office space, a chest pain center and standard and advanced diagnostics. Among the outpatient diagnostic offerings is CT Scanning, 3D mammography and a virtual theater MRI, which features a built-in movie screen and music to create a relaxing virtual experience for patients undergoing scans. The better patient experience allows patients to remain still longer, which results in more efficient, high-quality imaging. The virtual theater MRI is the first of its kind in the Ballad Health system.

In addition to these services, the new hospital introduced nuclear medicine services, allowing patients to receive cardiac stress tests close to home. The hospital also offers inpatient cardiology coverage seven days a week.

The hospital also is in a unique partnership with the International Storytelling Center (ISC) with the goal of being designated by summer 2019 as the world's first storytelling hospital and receiving only the second ISC Seal of Excellence to be awarded to an organization. The goal is to embed a storytelling culture for staff, patients, visitors and the community to help accomplish hospital goals of improved patient and staff satisfaction and wellbeing, better patient education, and more meaningful community engagement. Storytelling projects already accomplished or in the works include storytelling training for every staff member, a heritage wall that shares community history stories, community and staff stories collected at opening events, and signups for story circles beginning soon. A junior board from the local middle school has been selected and is in the planning stages of a storytelling legacy project to benefit the hospital and the community.

8. Recruitment of new physicians to the region

A key responsibility of Ballad Health is the recruitment and retention of physicians in the community. Failure to do so inhibits access to care, and requires the utilization of temporary

doctors, who are not residents locally. Because Ballad Health's service area receives among the lowest reimbursement in the nation from Medicare, and because many commercial payers base their reimbursement on Medicare rates and policies, it is extremely difficult for independently practicing doctors to generate the resources they could receive elsewhere, thereby undermining the region's competitiveness for doctors. Thus, particularly for specialists, if Ballad Health were not recruiting doctors – and in many cases subsidizing or employing them – the physicians simply would not be available to the residents of our region. The COPA contains limitations on Ballad Health's ability to employ needed physicians and to provide for those services timely. Ballad Health has complied with such limitations, which has created cost concerns and increased concerns related to coverage needs. Notwithstanding these limitations, Ballad Health's ultimate objective is to ensure access to needed services, and the board of directors of Ballad Health has directed management to ensure access always remains a priority. This remains an important issue for Ballad Health and the region, and Ballad Health will seek ongoing dialogue with the State of Tennessee to ensure any well-intended provisions or limitations do not create impairment to access.

Ballad Health has recruited new physicians and advanced practitioners to the region to improve access to primary care and specialty care. Areas of specialty include anesthesiology, cardiology, cardiothoracic surgery, endocrinology, family practice, general surgery, gynecology, hematology, hospitalist, intensivist, maternal-fetal medicine, nephrology, neurology, neurosurgery, OB/GYN, oncology, orthopedics, pain management, pediatrics, pulmonology, psychiatry, radiology, urology, wound care, and vascular medicine. Of the 79 providers recruited, 64 are employed by Ballad Health, and the remaining 15 were recruited to independent practices with assistance from Ballad Health through various means including recruitment incentives and income supplementation for doctors who join practices in the community. Eleven of the providers recruited in 2018 are in the area of family medicine.

Specialty	Hospital	Group (Red denotes private group)	Name
Anesthesiology	IPMC	Anesthesia and Pain	Helen Wilson, MD
Cardiology	SCCH	WMA	Dr. Villoch
Cardiology NP	JCMC	MSMG	Spencer Maden, NP
Cardiology NP	JMH	MSMG	Shannon Tally Nelms, NP
Cardiology NP	JMH	MSMG	Ashley Winegar, NP
Cardiology NP (structural heart)	JCMC	MSMG	McGahey
Cardiothoracic Surgery NP	HVMC	WMA - WCHI	Jordan Smith, PA
Endocrinology	HVMC	WMA	Rashid Mahboob, MD
Family Practice	HCMC	WMA	Crystal Stiltner, DO
Family Practice	IPMC	Mountain Region Family Medicine	Zachary Sumpter, DO
Family Practice	IPMC	Mountain Region Family Medicine	Brent Baker, MD
Family Practice	IPMC	Holston Medical Group	Mary Axelrad, MD
Family Practice	IPMC	MSMG	Teanna Moore, DO
Family Practice	JMH	MSMG	Elizabeth Dockery, DO
Family Practice Residency Director	JMH	MSMG - JMH	Jennifer Hanke, DO
Family Practice - NP	BRMC	WMA	Ashley Lindholm, NP
Family Practice - NP	JMH	MSMG	Rebecca Mabry, NP
Family Practice - NP	IPMC	MSMG	Deronna Moore, PA
Family Practice - NP	SSH	MSMG	Prabha Long, NP
General Surgery	BRMC	Bristol Surgical Assoc.	John Vance, MD
General Surgery	SSH	MSMG	Jeremy Meyer, MD
Gynecology - NP	SCCH	MSMG	Norah Nutter, NP
Hem/Oncology	MVRMC	WMA	Harish Madala, MD

Hospitalist	BRMC	WMA	Mark Sah, DO
Hospitalist	IPMC	MSMG	Jamie Bartley, DO
Hospitalist	IPMC	MSMG	Mark McCommons, MD
Hospitalist	HVMH	WMA	Alissa Hinkle, MD
Hospitalist	HCMH	WMA	Venkata Vedantam, MD
Hospitalist	HVMC	WMA	Aaron Towe, MD
Hospitalist	JCMC	MSMG	Brock (TJ) Mitchell, MD
Hospitalist	JMH	MSMG	Jeffrey Manfredonia, DO
Hospitalist	JMH	MSMG	Trent Keel, DO
Hospitalist	JMH	MSMG	Tambi
Hospitalist	TRH	WMA	Alexandra Bowling, DO
Hospitalist - NP	HVMC	WMA	Lucy Xayathone, NP
Hospitalist - NP	HVMC	WMA	Linda Moore, NP
Hospitalist - NP	SCCH	MSMG	Jenny Pruitt, NP
Hospitalist - NP	SCCH	MSMG	Amanda Daugherty, NP
Hospitalist - NP	SCCH	MSMG	Emily Fields, NP
Hospitalist - NP	JMH	MSMG	Justin Day, NP
Hospitalist, NP	IPMC	MSMG	Brad Moore, NP
Intensivist - NP	JCMC	MSMG	Brooklyn Beaupre, NP
Intensivist - NP	JCMC	MSMG	Leisa Morris, NP
Maternal Fetal	JCMC	ETSU OB	Willis
Nephrologist	JMH	MSMG	Pavan Annamaraju, MD
Neurology (clinic)	JCMC	MSMG	Marivi Neibauer, MD
Neurology - NP	JCMC	MSMG	Hannah Audia, NP
Neurology - NP	JCMC	MSMG	Jan Summer Osborne, NP
Neurology - NP	JMH	MSMG	Rachel Anderson, NP
Neurosurgeon	HVMC	WMA	Jon Traeau, MD
Neurosurgery - NP	JCMC	MSMG	Abbie Harris, NP
Neurosurgery - NP	IPMC	MSMG	Nina Tarlton, NP
OB/Gyn	IPMC	MSMG	Whitney Rich, MD
OB/GYN	LPH	WMA	Tara Moore, DO
OB/Gyn - NP	LPH	WMA	Jennifer Harrell, NP
OB/Gyn - NP	SCCH	MSMG	Nora Nutter, NP
Oncology - NP	JCMC	MSMG	Jamie Loveday, NP
Orthopedic	HVMC	Watauga Ortho	Scott MacDonald, MD
Orthopedic	HVMC	Watauga Ortho	Dustin Price, MD
Orthopedic	HVMC	Watauga Ortho	Tyler Duncan, MD
Orthopaedic	BRMC	Watauga Ortho	John Martino
Orthopaedic	BRMC	Watauga Ortho	Jason Fogleman, DO
Orthopedic	BRMC	Watauga Ortho	David Carver, MD
Orthopedic - PA	NCH	MSMG	Jay Bush, PA
Orthopedic Trauma	HVMC	WMA	Paul Hinkel, DO
Orthopedic Trauma- PA	HVMC	WMA	Kevin Hudson, PA
Pain Management – NP	HVMC	WMA - PM (Jett)	Serena Blevins, NP
Pain Management – NP	IPMC	MSMG - ETBS	Allison Raettig, NP
Pediatrics	LPH	WMA	Smita Akkinpally, MD
Pulmonary – NP	BRMC	WMA	Ashley Davis
Psychiatry - NP	TRH	WMA	Jessica McAfee, NP
Psychiatry - NP	RCMC	MSMG	Amanda Loughlin, NP
Psychiatry - NP	WOOD	MSMG	Blankenship
Radiology	HVMC	Blue Ridge Rad.	Laura Slusher, MD
Radiology	HVMC	Blue Ridge Rad.	Jonathan Suther, MD
Radiology	BRMC	Blue Ridge Radiology	Joseph Harpole, MD
Urology	JMH	MSMG	Brad Bauer, MD
Wound Care - NP	JCMC	MSMG	Kara Hill, NP
Vascular - NP	JCMC	MSMG	Hagerman, NP

9. Increased patients' choice by reducing restrictions on where physicians may practice

Prior to the merger, Mountain States and Wellmont had restrictions on certain specialty physicians such that they could not freely practice at the hospitals affiliated with the competing

system. While serving the competitive needs of the hospitals, this also limited access to the hospitals for the patients. Since the merger closed, Ballad Health has taken several steps to eliminate these restrictions, including standardizing hospital contracts so hospitalists may provide cross-coverage; allowing legacy Wellmont cardiovascular services surgeons to provide vascular coverage at Johnson City Medical Center and allowing legacy Mountain States cardiovascular services surgeons to provide call coverage for Bristol Regional Medical Center during provider absences. While the competitive restrictions have been removed, certain limitations in the Terms of Certification have impacted the ability of cardiologists to practice at the hospitals of their choice. To date, this issue remains unresolved.

10. Improved access to cardiovascular services for veterans

Ballad Health and the Mountain Home Veterans Administration Medical Center in Johnson City have established a national model for public-private partnership in cardiovascular service. Ballad Health provides physicians to help operate the VA's cardiovascular service line. This reduces wait times for veterans in our region in need of these services and reduces the necessity for them to travel elsewhere.

11. Expanded access to transitional care services in Kingsport

The transitional care unit at Indian Path Community Hospital in Kingsport has expanded to accept more patients, providing a customized setting for patients who need long-term treatment and helping to reduce length of stay in the acute hospital setting.

12. Expanded access to nursing and allied health care through support of new and expanded education and training programs

Nursing and other allied health professions are in short supply in rural areas nationwide, and our region is no different. Shortages in clinical staff can increase wait times for services, shut down nursing floors, and limit the availability of services. Ballad Health is committed to supporting training and education of nursing and allied health either directly or through partnerships with each college and university in the region. In particular, Ballad Health has:

a. Formed a steering committee to develop and deploy a system-wide nurse residency program.
b. Created a standardized certified nursing assistant (CNA) program and identified a schedule for increased frequency of CNA courses to be provided.
c. Standardized the nurse intern II program for the system, including job descriptions, application process, program components and curriculum.
d. Defined sexual assault nurse examiner (SANE) and forensic nursing course requirements, and the course to be provided, for team members in the system necessary to sit for nursing certification examination.
e. Increased collaboration with regional nursing programs to support additional capacity for nursing student admission in academic programs currently at capacity to produce additional new graduate nurses year round.
f. Contracted with Northeast State Community College (NESCC) for admission of 20 additional associate degree nursing students each spring semester starting January 2019, which will provide December graduates annually starting December 2020. The program did not previously graduate a December class, and this provides an additional 20 new graduate nurses annually above current capacity at NESCC program.

g. The first two classes of the ETSU/Holston Valley accelerated BSN program graduated in May and August, 2018, producing a net gain of 34 additional nurse graduates above previous program capacity.

13. Established the department of virtual health

A department of virtual health has been established at Ballad Health under the leadership of the Chief Clinical Officer. The new director of virtual health has over 20 years of experience establishing robust telemedicine capabilities in rural communities, academic medical centers and healthcare systems in Texas, Colorado, and Tennessee. Working with the support of the Chief Information Officer, this department will focus on initiatives to increase access to services in underserved communities, as well as identifying opportunities to leverage the data at our disposal to empower patients with their own health information. A number of virtual health goals are included in the behavioral health, pediatrics health and rural health plans submitted to the state, including linking all Ballad Health emergency departments to Niswonger Children's Hospital, expanding access to behavioral health consults for rural primary care practices, and expanding the telestroke program.

14. Improved patient access to care through the Epic patient portal

The Epic patient portal (MyChart) features have been expanded with the latest 2018 upgrade. The features are currently available for patients of former Wellmont facilities and clinics, as well as the newly operational Unicoi County Hospital. Ballad Health is investing more than $160 million to deploy a common health IT platform, which will result in all Ballad Health facilities being fully operational on this platform by March, 2020. Important new patient functionality includes:

- Patients can now share their health information with family members or with their providers, regardless of what information system the provider uses.
- Patients can now pull information into their Epic chart from other Epic locations.
- Patients can now complete e-visits with their providers through their mobile MyChart account.
- Patients can now schedule their mammography screenings through the patient portal.

C. Improving Healthcare Quality

Two areas of concern are typically raised by anti-trust regulators when health systems merge. First, the use of increased market power to increase pricing. Second, there is a question about the effect of mergers on the sustainability of quality in the absence of competition.

Ballad Health has complied with the provisions of the COPA/Cooperative Agreement related to the pricing concerns. Proprietary evidence exists that costs have actually decreased in some cases, and as demonstrated elsewhere in this report, Ballad Health is structurally positioning itself to be a high-value, lower-cost provider. Thus, there is no reason to believe that Ballad Health will violate the pricing limits contained within the COPA/Cooperative Agreement.

With respect to quality, Ballad Health has maintained that due to national public reporting, value-based contractual arrangements and increased patient mobility for higher acuity elective services, the environment remains highly competitive for inpatient services. Further, the outpatient environment in the local region remains highly competitive. The majority of Ballad Health's revenue is outpatient, and this trend is increasing.

Because of these competitive trends and increased transparency, and most importantly, because it is locally governed and operated by people who, themselves, are deeply concerned about the quality of care in the region, the commitment to high quality remains stronger than ever. Ballad Health is engaged in a number of initiatives and efforts to sustain its already high quality, and is on a path to becoming a top decile performing health system.

What follows are merely examples of the results of our work, and the systems being put in place to institutionalize the results.

1. Ballad Health receives national recognition for quality

Ballad Health hospitals, facilities and services lines received numerous awards, certifications and quality designations since February of 2018. Among these are:

a. Mountain States named in the top 20% of health systems by IBM/Watson

Mountain States Health Alliance, a subsidiary of Ballad Health, was named among the top 20 percent of America's health systems by IBM/Watson, based on performance in key quality metrics such as mortality rates, readmission rates, average length of stay, rate of Medicare spending per beneficiary, emergency department throughput, hospital-acquired conditions, and others. Other systems listed among the top 20 percent include the Cleveland Clinic, the Mayo Foundation, Mercy Health, and Sentara Healthcare. Mountain States was the only health system in its size category in Tennessee or Virginia to be recognized in the top 20 percent. https://www.balladhealth.org/news/ballad-health-legacy-systems-recognized-nationally-excellence

b. Highly successful accreditation surveys by the Joint Commission, the national accreditation agency for the U.S. Centers for Medicare and Medicaid Services.

The Joint Commission uses the most stringent criteria for accrediting hospitals, and hospitals are required to be resurveyed every three years. The hospitals do not know when the surveyors will come, and the surveys are designed to capture a real state of patient care in each hospital. Since the merger closed in February, nine Ballad Health hospitals have been surveyed by the Joint Commission. In those surveys, not one hospital was cited with a conditional level finding or threat to life. By comparison, year-to-date, the Joint Commission has cited 51.57% of hospitals surveyed nationally in 2018 with conditional level deficiencies, which requires another survey and additional expense to the facilities. **Ballad Health facilities are continuing to outperform most hospitals in the nation.**

c. Niswonger Children's Hospital and the JCMC Family Birth Center recertified as the state-designated perinatal center

Niswonger Children's Hospital and the Family Birth Center at Johnson City Medical Center received re-certification as the state-designated regional perinatal center. Funding is provided by the State of Tennessee to only five designated regional tertiary centers to ensure that the infrastructure for high-risk perinatal services is in place statewide. The system includes 24-hour telephone consultation with physicians and nurses, professional education within the region, transportation of high-risk pregnant

women and infants, and post-neonatal follow-up. Research indicates that ensuring high-risk pregnant women and newborns receive risk-appropriate care can reduce maternal and infant morbidity and mortality.

d. Overmountain Recovery receives CARF accreditation.

Overmountain Recovery achieved a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF), representing a tremendous achievement after one year of operation. Most newly operational addiction treatment facilities are awarded only a one-year certification.

Overmountain Recovery is a service of Ballad Health and East Tennessee State University in partnership with Frontier Health. It is the region's only medication-assisted therapy clinic offering comprehensive treatment of substance use disorder including methadone and buprenorphine therapy, intensive counseling services and wrap-around social services. During the two-day CARF survey, the commission evaluated the clinic's business and service practices to ensure they meet international standards of quality, and also assessed sustained organizational success and patient outcomes. As of September, the facility serves approximately 160 patients and has a 70 percent retention rate, which is higher than most national benchmarks.

e. Holston Valley interventional carotid care ranked #1 in US by CareChex®

For the third consecutive year, Holston Valley Medical Center was ranked as No. 1 in the country for medical excellence in interventional carotid care by CareChex®. Led by Dr. Chris Metzger, the carotid program at HVMC has developed a national reputation as a training and research leader. For the seventh year, Dr. Metzger hosted a team of Harvard endovascular fellows during a week-long training period that allowed the students to observe Dr. Metzger as he performed carotid artery stenting procedures. In addition to one-on-one training with the fellows, Metzger regularly performs carotid artery stenting procedures that are transmitted live to medical conferences in different locations in the country and across the globe. These include New Cardiovascular Horizons and Vascular Interventional Advances conference, which draws an attendance of more than 2,500 health care professionals, and TCT (Transcatheter Cardiovascular Therapeutics), which draws 12,000 attendees. https://www.balladhealth.org/news/dr-chris-metzger-shares-expertise-helps-train-harvard-endovascular-fellows

f. Norton Community Hospital Inpatient Rehab recognized at top decile performance

The Norton Community Hospital Inpatient Rehab Unit was recognized in 2018 for its twelfth consecutive year of top-decile performance – out of more than 800 facilities – for functional patient outcomes. The evaluation was based on the delivery of quality care that is effective, efficient, timely and patient-centered. To determine the rankings, Uniform Data System for Medical Rehabilitation (UDSMR) used a system that measures the efficiency and effectiveness of a hospital's rehabilitation programs by evaluating and tracking patient progress through the rehabilitation process. Patients' functional levels refer to their ability to return to their daily lives and activities without impairment. The unit first opened in 1998, and since that time, it has served nearly 4,000 patients recovering from a variety of injuries, illnesses and accidents.

g. *Lonesome Pine Hospital Family Medicine Residency program accredited*

The Lonesome Pine Hospital family medicine residency program achieved initial accreditation from the Accreditation Council for Graduate Medical Education (ACGME). The family medicine program can now accept medical school graduates with osteopathic medicine (DO) and medical doctor (MD) degrees, which means it can select residents from a larger number of quality applicants. To earn the accreditation, the residency program demonstrated its ability to operate with a well-developed educational curriculum, qualified faculty, supervision and graduated responsibility and ongoing evaluations of resident competence. The accreditation process also focused multiple criteria on safety and quality measures, requiring full participation from residents, faculty, medical staff and team members alike.

h. *Hawkins County Memorial Hospital recognized as Top 100 Hospital*

Hawkins County Memorial Hospital received national recognition from multiple agencies in 2018. The hospital was recently chosen as one of the Watson Health 100 Top Hospitals® 2018 winners. Previously known as the Truven Health Analytics® 100 Top Hospitals, Hawkins County Memorial also earned that honor in 2016 and 2017. Hawkins County Memorial was also named one of the Top 100 Rural & Community Hospitals by the Charter Center for Rural Health for 2018. The hospital also received that same recognition in 2016 and 2017, when iVantage Health Analytics issued the award. In addition, for the sixth straight years, the hospital has been ranked in the top 10 percent in the nation for patient satisfaction in overall hospital care by CareChex®, an information service of Quantros Inc.

i. *Franklin Woods Community Hospital recognized as Top 100 Hospital*

For the second year in a row, Franklin Woods Community Hospital was named one of the nation's "100 Top Hospitals" by Truven Health Analytics. The honor recognizes Franklin Woods for meeting the highest national standards in 11 key areas, including patient care, operational efficiency and financial stability. Making the list indicates hospitals deliver effective care at a reasonable cost, have systems in place that safeguard patients from medical errors, provide evidence-based treatments and produce superior outcomes. Other measurable areas include readmission rate, length of stay, mortality rate, patient throughput in the emergency department, cost per patient and patient satisfaction.

j. *Hancock County Hospital recognized by Becker's Healthcare*

Hancock County Hospital was named among 66 Critical Access Hospitals to Know by Becker's Healthcare in 2018. Hospitals on this list are recognized for clinical quality and excellence in care delivery based on awards and rankings from respected organizations including iVantage Health Analytics, The Chartis Group, the National Rural Health Association, CareChex, Healthgrades and Medicare star ratings.

k. *Bristol Regional Medical Center certified by Novalis for steriotactic radiosurgery*

Bristol Regional achieved certification from Novalis for stereotactic radiosurgery, demonstrating the hospital's ongoing commitment to radiotherapy patient safety and treatment quality. Novalis Certified is an independent accreditation program that promotes high standards of care in the delivery of cranial and body radiosurgery and

includes a review of organizational, personnel, technological and quality assurance practices.

2. Ballad Health Clinical Council established and providing clinical leadership

Early in the year, Ballad Health established its clinical council, comprising approximately 30 physicians from Ballad Health hospitals, the health system's medical group and community physicians. The council meets monthly and reports directly to the quality committee of the Ballad Health board of directors. The group's goal is to ensure excellence in clinical care through physician engagement and leadership.

A number of sub-committees have been formed to focus on specific priorities, each of which networks with other physicians both inside and outside the health system to advance common clinical goals. The subcommittees are:

- Evidence based medicine – high value care subcommittee
- Medical staff services subcommittee
- Surgical services/perioperative subcommittee
- P&T subcommittee
- Patient, family, physician experience subcommittee
- Opioid task force subcommittee
- Health information exchange subcommittee
- Population health subcommittee

The council employs a dyad leadership model, with each subcommittee – as well as the council itself – led by co-chairs representing both physician executives and those in full-time practice. Select activities and achievements of the Clinical Council include:

a. Reduced hospital-acquired C. diff infections by 45%

One of the first quality improvement initiatives of the clinical council was an ambitious campaign to reduce hospital-acquired clostridium difficile (C. diff) infections by 30% in 90 days. By coordinating clinical practices across the system, not only did the program succeed, but it surpassed its goal of 30% reduction and cut C. diff infections by 45%, with sustained results. Ballad Health data indicated a baseline of 22 cases per month when the program started. By the end of the program, the average dropped to 13 cases per month. Results are now at the top quartile based on Hospital Compare benchmarks.

b. Encouraging appropriate use of radiation in inpatient testing

In addition to the C. diff initiative, the clinical council has also designed and is preparing to implement initiatives tied to evidence based testing for the purpose of ensuring appropriateness of testing. This is a national initiative sponsored by the Choosing Wisely Campaign.

c. Development and deployment of best practices to reduce catheter-associated urinary tract infections

Holston Valley developed an interdisciplinary approach to the reduction of catheter-associated urinary tract infection (CAUTI) that included nurse-driven protocol for

catheter removal, implementation of accountability protocol for education and daily catheter assessment, and an updated catheter kit that includes bladder scanners and a new type of Foley catheter. The result was a significant reduction in CAUTI in this tertiary care environment, with zero CAUTIs in medical/surgical units for 26 months. The Holston Valley practice was rolled out to other hospitals throughout Ballad Health in October and has been presented as a best practice to the Tennessee Hospital Association and the American Organization of Nurse Executives.

d. Physician led alignment of physician preference items produces supply chain savings

The clinical council has established a formal, collaborative supply chain project between physician leadership and supply chain leadership to help align group purchasing and physician choice. Savings of $16-20 million are projected over the next 2 years based on work in cardiovascular services, ortho/trauma, and neuro services, and additional savings are expected in multiple other disciplines. While such initiatives reduce cost, they also improve quality by eliminating variation. Physician input in this process is critical, and the clinical council provides such a venue for physician input.

e. Promoting High Value Care

In August, Ballad Health was chosen for a national initiative that has the potential to improve the value of care patients receive while reducing healthcare spending nationwide. The High-Value Care Collaborative, a partnership of the American Hospital Association, the American Board of Internal Medicine Foundation's Choosing Wisely campaign, and the Costs of Care organization, brings together participants to improve efficiency in health care, decrease cost and improve quality. During the next year, Ballad Health, along with other selected health systems and medical groups, will seek to adopt strategies that reduce unnecessary cost and deliver evidence-based care that has been demonstrated to reduce the burden on patients. In deploying evidence-based practices, Ballad Health will share guidance with other leading health systems, while also learning from successful initiatives utilized in those systems. https://www.balladhealth.org/news/ballad-health-national-initiative-enhance-care-value

The group is also participating in the Virginia Center for Health Innovation's Virginia Choosing Wisely efforts promote high value care. More than 40 insurers, health systems, community organizations, professional societies, employer groups and the Virginia state government have aligned to pursue the aims outlined in the 2018 Virginia Health Value Dashboard. http://www.vahealthinnovation.org/virginia-health-value-dashboard/

f. Clinician Experience Project to reduce physician burnout

Ballad Health is committed to improving physician leadership and addressing physician burnout through a national program – The Clinician Experience Project. Led by Dr. Steve Beeson, this effort is a clinician skill-building community with over 70 partner health systems, 15,000 clinician members, and 500 clinician leaders. The goal is to equip clinicians with the skill and support to effectively manager burnout, leadership, team-based care and the patient experience and is support by more than 600 physician-designed video learning resources.

3. Quality Department Activities

Ballad Health combined the functions of the quality departments operating in the two legacy health systems and immediately began to standardize quality operations and achieve improved performance. The quality function now reports to the chief nursing officer and works closely with the newly established Ballad Health clinical council.

a. System-wide quality plan developed

The Inaugural FY 2018-2019 Ballad Health quality plan was developed to include the Quality, Service and Safety Committee Charter, the organizational structure, key relationships, the use and sharing of data both external and internal, Quality Assurance and Performance Improvement (QAPI), and priority metrics. These priorities were selected considering risk, volume, propensity for problems, impact on health outcomes, patient safety, and quality of care.

b. Sepsis teams established

Ballad Health multi-disciplinary performance improvement teams have been established to address the care of the patient with sepsis and the reduction in hospital-acquired pressure ulcers.

c. Quality scorecard developed

The quality department developed a system scorecard for the target measures, monitoring measures, and identified priorities established by the quality, service and safety committee and the clinical council. The scorecard guides improvement at the facility, market, state and system levels.

d. Quality policy, process and infrastructure unified across Ballad Health

Ballad Health has selected one policy repository for use system-wide. Two committees, administrative and clinical, have been established to achieve consolidation of policies and procedures to align system practices. As of October, 2018, 132 policies/procedures have been consolidated, and 893 out of date or unnecessary policies have been retired.

Examples of steps taken to institutionalize improvements in quality include:

- #### Infection prevention efforts standardized

  The facility infection prevention departments have been centralized into a unified team, led by the system director of infection prevention. This allows for system standardization, streamlining of work and system-wide implementation of best practices. The team meets on a monthly basis to share successes and struggles so that lessons learned and successful initiatives can be replicated across the system.

- #### Antibiotic stewardship committee established

  Legacy antibiotic stewardship teams were consolidated to create the Ballad Health antibiotic stewardship committee. This allows for standardization and system-wide implementation of best practices. The committee developed a process for pharmacy to review all C. diff orders for appropriateness,

contributing to system-wide improvements in C. diff rates. The committee also implemented clinical guidelines for pharmacy-led penicillin allergy testing.

- Isolation policies standardized

  Ballad Health standardized isolation policies and signage were developed, allowing team members, independent practitioners or contractors working in any facility to immediately recognize and comply with isolation guidelines.

- Influenza vaccination policy adopted

  The medical staff service subcommittee of the clinical council standardized and implemented the Ballad Health mandatory influenza vaccination policy.

- Joint Commission readiness standardized

  The approach for Joint Commission accreditation and continuous survey readiness program has been consolidated and standardized.

4. Nursing and Clinical Education Activities

a. General nursing and clinical education activities

- Nursing leadership

  The Ballad Health Nursing Institute Chief Nursing Officer Council (NICNOC) was created in February 2018 to help standardize professional practices and evidence based care across the health system. The council meets monthly, with other activities occurring in between meeting dates. The first Ballad Health nursing leadership conference was held in May, 2018.

- Servant's Heart Award

  Adopting a best practice from one of its legacy systems, Ballad Health developed its own Servant's Heart award process, recognizing team members across the system who go above and beyond the call of duty to care for patients, community members, and their fellow team members. Servant's Heart winners have an outstanding commitment to patient-centered care, setting a strong example for others to follow. The winners are nominated by fellow team members, leaders, physicians, volunteers, patients and family members. For the 2018 awards, there were 129 unique nominees coming from a total of 172 nomination submissions. Fourteen honorees were recognized with Servant's Heart awards at the annual Ballad Health service awards banquet on June 14.

b. Nursing policies and processes unified across Ballad Health

- Established nursing policy and procedure committees

  Ballad Health policy and procedure committees formalized and implemented for policy standardization and management, including administrative policy and procedure committee and clinical policy and procedure committee.

- Standardized policy and procedure on use of restraints

  Identified “Handle with Care” as the system educational approach for de-escalation and appropriate use of restraint techniques. This training is now provided in clinical team member orientation.

- Standardized medical professional screening and competency in Obstetrics

  Nursing standardized the Ballad Health Qualified Medical Professional Screening criteria and competency requirements for registered nurses performing obstetric patient screening for obstetric patients presenting to the obstetric department for evaluation consistent with the TN State Board of Nursing Registered Nurse Scope of Practice.

c. Education Activities

- Deployed the Ballad Health clinical education department.

  Ongoing education and development of team members is an important commitment of Ballad Health. Through direct efforts and the use of technology, Ballad Health seeks to sustain professional competencies, and ensure ongoing learning related to policies, best practices, and professional advancement. Work has been completed to align team member educational courses in the two current learning management systems. The use of technology in reaching our team members is an important component of sustaining competencies and ensuring ongoing learning related to policies, best practices and professional advancement.

- Unified educational assistance policies across Ballad Health

  One organizational policy for continuing education and tuition support for all team members was deployed. A Ballad Health scholarship plan for healthcare program students in critical healthcare roles of increased shortage/vacancy (not current team members) was deployed to support completion of education and future employment opportunity in multiple disciplines throughout the health system.

- Standardized the process for academic student affiliation

  Nursing standardized the process for academic student affiliation for clinical educational practicum experience at Ballad Health. Student processes were centralized under the clinical education department. For example:
  - A new orientation process for students was developed and deployed across Ballad Health
  - A new website and student orientation handbook was deployed
  - Student affiliation contract process has been approved and is in development for Ballad Health
  - Aligned the ACNEP scheduling process for Ballad Health
  - Created one point of contact for academic programs for student processing and contract negotiation

- Standardized orientation for clinical team members

  Ballad Health has standardized general human resource and clinical orientation for new team members alternating delivery of the program with the standardized content in rotating locations (JCMC, HVMC, BRMC and NCH) weekly.

D. Improving Financial Stability and Performance

1. Bond ratings upgraded and affirmed as a result of the merger

In April, Ballad Health's credit ratings were upgraded by S&P Global Ratings and Fitch Ratings, and affirmed by Moody's. Fitch increased the credit rating by two categories to a solid "A" rating with a stable outlook. S&P issued an "A-" rating with a stable outlook, and Moody's affirmed its existing ratings and outlook at BBB+.

Together, the three rating agencies cited a variety of strengths of Ballad Health that led to the upgrades and affirmation. Citing the strength and experience of the management team, historical disciplined financial management, a strong strategic vision and a solid plan for refinancing that will lead to immediate reductions in debt service, the nation's three leading rating agencies applauded the potential for the merger between Wellmont Health System and Mountain States Health Alliance to produce outstanding results.
https://www.balladhealth.org/news/credit-ratings-significantly-upgraded-affirmed

2. Debt refinancing and restructuring lowers interest payments and increases availability of cash for reinvestment

In May, 2018, Ballad Health refinanced $540 million of debt through issuance of a new series of bonds. Due in part to the merged health system's improved credit ratings, the market reacted very favorably to the issuance, and Ballad Health's bonds were oversubscribed by more than 10 times, with the health system receiving orders for more than $5.6 billion. Due to the extraordinarily high demand for its bonds, Ballad Health was able to obtain favorable interest rates, saving the health system $20 million per year in debt service payments and increasing the amount of cash available to reinvest in critical services for the community.

3. Value-based contracting to improve quality and service and reduce the total cost of care

Ballad Health has increasingly entered into "value-based contracts" with government and commercial payers. In contrast with typical "fee-for-service" contracts, which pay a flat fee for a specific service regardless of the outcome, value-based contracts tie payment to achieving certain levels of quality and service as well as managing the total cost of care. One of the objectives of Ballad Health is to reduce the growth in the total cost of care, while sustaining high quality. Value-based arrangements align those goals with the third-party payors who share these objectives.

Ballad Health has continued to perform well on value-based contracts in the most recent reporting period while expanding the number of value-based contracts we have with payors and strengthening our capacity to manage these contracts.

a. *Medicare Accountable Care Organization one of only 21 in the nation to achieve shared savings with the federal government for the five years the program has existed.*

Ballad Health's accountable care organization (ACO), AnewCare Collaborative, was one of only 21 ACOs in the country to achieve savings for the fifth year in a row through the Medicare Shared Savings Program (MSSP) administered by the U.S. Centers for Medicare and Medicaid Services (CMS). By delivering high-quality care and reducing the cost of care, Ballad Health saved CMS $3.2 million in spending, and the health system was awarded a $1.6 million shared savings distribution. While achieving these savings, AnewCare also achieved high marks on the quality scores within the program, with a quality score of 87.8 percent. Ballad Health has become a model for successful implementation of shared savings arrangements, and seeks to continue its collaboration with the federal government. Ballad Health believes this model is appropriate for other government-funded populations, like Medicaid and TennCare, and will seek such opportunities to reduce cost and improve outcomes with our state partners.

b. *Achieved Medicare Advantage performance goals and expanded value based contracts*

Ballad Health also has value-based contracts with a number of Medicare Advantage programs, which provide incentive payments to Ballad Health if certain quality, service and medical cost savings targets are achieved. This year, Ballad Health actually reduced the costs for a Medicare Advantage population, while achieving excellent outcomes on incentive-based payment and improving the accuracy of risk-adjusting the population. Ballad Health was rewarded for this effort though several million dollars of incentive payments for improvement of quality and service, with reduction in cost. Importantly, in addition to benefitting the patient, government and payors, this approach will benefit independently practicing physician groups that rely on their own risk-based contracting, since reduced overall costs will reduce their exposure.

While many hospital systems have expanded and merged with an eye toward leveraging higher pricing, Ballad Health's business model remains focused on reducing costs, improving outcomes and sharing in the resulting savings.

c. *Value-based contract dashboard expanded across Ballad Health*

Because the movement toward value-based purchasing is a new phenomenon, little has been invested nationally in the creation of data platforms and information that assists in the monitoring of such arrangements. Ballad Health has developed and deployed a proprietary, comprehensive tool that includes a dashboard highlighting performance on the various value-based contracts across the system. This includes full-risk contracts, shared savings contracts, pay for gaps/care coordination, hospital-based contracts, and other contracts across both legacy systems. The dashboard denotes the number of covered lives, maximum upside and downside potential, estimates of current performance overall as well as specific contract components and status. This information is reviewed on a regular basis by management and the community benefit and population health and finance committees of the Ballad Health board of directors, and assists in prioritization of efforts where opportunity exists.

4. First annual Ballad Health Management Action Plan completed; Five-Year Financial Plan completed

Ballad Health completed its first strategic plan cycle as a health system, resulting in the FY19 management action plan, five market plans, five service line plans, and over 20 corporate plans. Ballad Health has invested in, and utilizes, the MedeAnalytics Enterprise Performance Management tool to create visibility throughout the system on the progress with the plans, timelines, deliverables, and metrics. The COPA /Cooperative Agreement plans for behavioral health, children's health, rural services and population health will also be tracked by the MedeAnalytics tool. Ballad Health also expanded its project management department to assist management and staff in priority integration, efficiencies, and COPA cooperative plan development and implementation work.

The board of directors and management have begun a longer-term strategic planning process to map the direction of Ballad Health for the next 10 years. This plan will provide a roadmap for Ballad Health's evolution, and for each year's management action plan. Each year, as the management action plan is updated, performance targets and goals will be tied to the longer-term strategy.

5. Five-Year Financial Plan, Capital and Debt

As part of the planning process, Ballad Health maintains a disciplined, rolling five-year financial plan. Each year, the plan is updated based on current payment policy, projected volumes, strategic initiatives and projected expense and capital needs. The five-year plan currently projects that Ballad Health will make significant reductions in debt by year five, with such projections being influenced heavily based on how cash is utilized. If unknown capital needs arise, or if other needs materialize, cash may be utilized to provide for those needs. The importance of a conservative approach to capital and spending in the first five-year period relates to the number and amount of major capital projects undertaken more recently by Ballad Health and its legacy systems. Specifically, Ballad Health and its legacy organizations have brought five new hospitals online in recent years, and major capital projects were performed at other system hospitals, which brought new equipment and facilities. As newer projects begin to age after the first five-year plan is exhausted, it is important for Ballad Health to have the capacity on its balance sheet to provide for what will be expected capital needs. Thus, Ballad Health is taking a responsible and methodical approach to capitalization and debt reduction. These issues are intertwined, and an important part of ensuring ongoing capital needs can be met.

Capital issues are further complicated by the industry-wide slowdown in inpatient utilization. Fewer capital dollars are needed for inpatient related services as volumes decrease, while more capital is needed in areas like information technology and outpatient access. An example of the type of capital spending that combines the need for certain inpatient services with outpatient access is the recently opened Unicoi County Hospital. In that instance, an outpatient focused hospital was built in a rural community where high-acuity inpatient services do not need to be provided. High-quality diagnostics and emergency services are a major component of this project. As a community-based organization, Ballad Health remains committed to ensuring its facilities and assets are well-capitalized, and the board of directors has a long-term plan to ensure this occurs.

Ballad Health is pleased that in its first year, the expected capital expenditures will exceed the combined capital expenditures of each legacy health system over the last five years. **In a specific advantage related to the merger, the newly merged entity will spend more in capital in its first year than both systems did on a combined basis in any of the last five years.** Included in this capital spending is more than $160 million over three years to upgrade the information technology and move to a common information technology platform. This new platform will create significant opportunity for improved outcomes and reduced risk for patients, reduced costs, more patient engagement and more robust sharing of critical information between providers. Additional examples of capital deployed include: new MRI diagnostics, hybrid cardiovascular operating room, replacement CT scanners, new beds, a new hospital in Unicoi county, significant upgrades to exteriors of hospitals, advanced radiological diagnostics, and a host of other investments for the improvement of care.

6. Reducing unnecessary external signage and improving patient wayfinding

Rather than "rebranding" the new health system by replacing every external Mountain States and Wellmont sign one-for-one, Ballad Health adopted a system-wide strategy of "de-branding." Many signs that had been erected by legacy systems for purely competitive purposes are being permanently removed, and signs that are replaced with Ballad Health branding will be designed and placed according to patients' wayfinding needs. Not only will this reduce the visual clutter that external signs produce against our mountain landscape, it allows for money otherwise spent on signage to be redirected to improving patient care and services. The project involves local vendors, in an effort to keep expenditures in the region as much as possible.

7. Operational Excellence (Lean Management) Activities

Ballad Health has adopted lean management as its common approach to operational excellence. Lean management supports the concept of continuous improvement in performance (clinical quality, service, operations, financial) and takes a long-term approach to work that methodically strives to achieve incremental changes in processes to improve efficiency and quality. Since the merger, Ballad Health has developed and deployed an operational excellence (lean management) class for all new hires as part of the orientation process, revamped and consolidated the lean training program for leaders across Ballad Health, and developed new lean certification levels that incorporate practices from both legacy health systems.

8. First Quarter Results Reported – Strong Financial Results

Ballad Health reported its results for the first budgeted quarter as a merged health care system. The strong financial performance was driven by well-executed expense management. Overall, earnings before interest, taxes, depreciation and amortization (EBITDA) grew year-over-year by 25.2 percent to $52.6 million. With improvements in productivity, reductions in the use of temporary contract labor, focused management of supply cost and overall operational focus, the operating income went from a loss in the prior year period to a gain in the current year. This performance was achieved even with a continued 4.3 percent decline in admissions and a 0.7 percent decline in adjusted admissions. Two variables are driving the reductions in volume. First, rural and non-urban communities all over America are seeing reductions in volume as population growth has been stagnant. Second, Ballad Health is working collaboratively with its physician community to reduce unnecessary lower-acuity admissions. Both variables are impacting Ballad Health. Even while admissions have been declining, patient acuity, or the severity of patient needs, has increased by 2.5 percent, indicating that lower acuity admissions

are the primary driver of the decline in volume. This, combined with a modest increase in inpatient surgery (0.1 percent growth year over year) and an overall increase in total surgeries of 1.7% to 18,290 cases, supports the assertion that volume declines are largely through the effort of risk-based, shared savings and value-based arrangements to reduce lower acuity admissions.

An important component driving the merger of Mountain States Health Alliance with Wellmont Health System was the choice facing both systems related to whether to join larger out-of-region health systems or keep local governance control. An out-of-region acquisition of either system, or both, would likely have resulted in the loss of 1,000 or more jobs locally. This assertion is based on past evidence of what larger systems typically do when they acquire smaller regional systems. As administrative and support functions are no longer needed locally, they are consolidated into larger corporate centers. At the time of the merger, Ballad Health stipulated that there would be some local synergies between the systems, and those synergies are ongoing. However, these synergies are small relative to the alternative of a larger acquisition of the two legacy systems.

As a result of this approach, Ballad Health invested $267.1 million into the local economy through salaries, wages and benefits spending, an increase of $1.5 million from the prior year period. There has been no negative impact on aggregate labor spending resulting from the merger, and there has been an avoidance of massive reductions in workforce, which would have resulted had the legacy systems been acquired from outside organizations. Ballad Health identified this as one of the key benefits of the merger, and this benefit is being realized. Ballad Health estimates a 1,000-person reduction in the local workforce would have resulted in an annualized decrease in salary, wages and benefits of more than $100 million.

9. Implementing a common clinical and operational technology platform

Information technology is integral to any successful health system. Yet nationwide, many providers still cannot easily share information with each other, electronic health records are frustrating to interact with for both physicians and patients, and in many cases health systems installing new technology are hundreds of millions of dollars over budget and years behind on their technology implementation.

Ballad Health is committed to moving to a common clinical platform as part of the merger to improve patient care quality and experience and connect patients and physicians region wide to their health information.

a. Implementing the Epic electronic health record system wide

In April 2018, the Ballad Health board of directors approved the move to a common clinical platform and electronic health record, with Epic as the chosen vendor. Prior to the merger, Epic was in use by Wellmont Health System facilities but not Mountain States Health Alliance. Immediately following the board vote, work began on an implementation plan to bring the former Mountain States Health Alliance facilities onto the platform. Infrastructure enhancements began during the summer to support the expansion.

A common electronic health record across the new health system will allow patient information to be shared immediately at the point of service regardless of where a patient enters the Ballad Health system, providing clinical staff with information to better manage patients in the emergency room, the physician's office and the hospitals. Previously, patients who used both Mountain States and Wellmont services could not be assured that all of this information was available to at the time of treatment. Fragmented information "silos" have been routinely identified nationally as a key contributor to driving unnecessary costs (such as duplicate tests) and poor outcomes (such as when a provider does not have a complete medication list or list of known allergies).

The first facility transition in the Ballad Health Epic rollout plan occurred at the newly-constructed Unicoi County Hospital on October 23, 2018. As part of Ballad Health's commitment to supporting rural healthcare, the new facility was built to replace an aging rural hospital in Erwin, Tennessee, and the Epic launch was completed concurrent with the hospital's opening date. The next facility to go live with Epic will be Laughlin Memorial Hospital in Greeneville, Tennessee, in April 2019. The remaining physician clinics and 13 hospitals will go live with Epic in late 2019/early 2020. This will place all Ballad Health facilities on a common clinical platform and newly extend Epic functionality to hundreds of thousands of patients in the region.

b. Community connectivity

Discussion have begun with independent physicians to determine the best way to share clinical information across the region. EpicCare Link software, which allows physicians a simple web-link to view the content of patient records in Epic, has been made available to independent physician offices at no cost to them.

In addition, Epic's Community Connect program installs fully functional Epic software into independent physicians' offices to serve as their office EHR. Meetings have begun with several physician groups regarding this program.

An overall health information exchange plan required by the COPA and cooperative agreement is under development. This plan will propose a strategy for maximizing health information exchange across all providers in the Ballad Health service area, regardless of their particular choice of electronic health record. Final plans will be submitted to the states on January 31, 2019.

c. Unifying IT systems, applications, the network and domain

A review of all IT systems and applications is in process. The goal is to eliminate duplication and create a more efficient and standardized electronic health record. Several hundred applications are now running within Ballad Health; many of them are duplicative of each other or redundant of Epic capability. Rationalizing these applications will reduce cost to the health system as fewer licensing and maintenance fees will need to be paid, and will increase overall reliability of the system as updates and integration will be more reliable.

Work has also begun to create one network and one domain for Ballad Health. This will provide the infrastructure needed to establish the common clinical platform across Ballad Health and to extend to independent physician offices, providing for enhanced data interoperability.

d. Data governance

A governance structure has been developed for data and governance. This will be used to structure the databases and to produce metrics for population health, predictive analytics, COPA/CA metrics, etc. These analytics will be used to monitor the health improvements in our region.

ATTACHMENT 4

ANTHEM Q-HIP RESULTS

ATTACHMENT 5

BOARD OF DIRECTORS ACTIVITIES

Ballad Health

Board/Committee Development Activities

1. **Ballad Health Board of Directors:**
    a. Board of Directors Retreat held June 28th through June 29th, 2018
        i. Best Practices in Governance – Pamela Knecht [Accord Limited)
        ii. Restructuring Your Organization to Adapt to the New Real Realities in Healthcare – Nate Kaufman (Kaufman Strategic Advisors)
        iii. Education on Virginia Plan
        iv. Education on Efficiency Plans
        v. Innovation and Disruption in Healthcare - Governor Bobby Jindal
    b. COPA Compliance Board Education – July 31, 2018
    c. Trauma Workshop – October 10, 2018
    d. Upcoming education:
        i. Population Health
        ii. Industry Trends
        iii. Innovation
        iv. Quality/Safety Assurance
        v. Health IT

2. **Committee Education**
    a. Quality, Safety and Service Committee
        i. 2.1.2018 - Sepsis Collaborative—our Premier representative provided an educational session on the sepsis collaborative, which includes external community groups like ETSU, SOFHA, etc. (this collaborative was started in early 2017, with coordination through the Quality Department and Premier with updates / educational sessions provided to the Quality Committee on progress throughout the year).

        ii. 5.30.18 - Significant CAUTI Reduction at Holston Valley Medical Center — system Chief Nursing Officer presented an educational session on the process used at Holston Valley Medical Center to reduce CAUTI, including prevention timeline, events, protocol developed and deployed, equipment implemented, results, etc. and discussed how to implement this across the system working with the Clinical Council.

        iii. 6.27.18 - Maintaining Board Certification— director of Medical Staff Services presented an educational session on the Board Certification and Maintenance of Certification, including the current board eligibility

requirements within the two legacy systems, associated costs, requirements, legislature, etc.

iv. Patient Engagement— Chief Experience Officer presented the patient experience program, including history, different CMS programs, survey components, system focus, key drivers in the surveys, etc.

v. 7.25.18 - Antimicrobial Stewardship Program—a corporate pharmacist presented on our Antimicrobial Stewardship program, including the history, CDC call to action, core elements, how data is being monitored, strategies, and components of our system program.

vi. 10.24.18 - Joint Commission Update— lead consultant from The Joint Commission Resources will be providing an educational session on key drivers for immediate threats to patient health and safety, requirements for improvement, top 10 cited standards for hospitals, top 10 list of clinical findings and continuous service readiness program.

vii. The committee had presentations on the work being completed by the Clinical Council subcommittees across the system and the results to allow them to make recommendations / requests for actions needed:
    1. C. Diff 30/90 (30% reduction in C. diff rates in 90 days)---(5.30.18)
    2. High-Value Care Subcommittee—(8.29.18)
    3. Medical Staff Services Subcommittee—(9.26.18)
    4. The Quality, Safety and Service committee held presentations throughout the system to explain the work of the Clinical Council subcommittee, so the system would know what actions to recommend/request.

viii. Future Education Topics:
    1. Opioid Crisis
    2. What is Sepsis and What is the Evidence?
    3. Surgical Safety
    4. OPPE / FPPE

b. Community Benefit and Population Health Committee
    i. COPA and Cooperative Agreement Overview
    ii. Value-Based Contracting
    iii. Community Benefit and Community Health Needs Assessment Overview

c. IT Strategy Committee
    i. EPIC Project (EMR)

d. Audit & Compliance Committee
    i. Healthcare Compliance – April 12, 2018

ATTACHMENT 6

CAREER DEVELOPMENT PLAN UPDATE

Career Development Program Update June 30, 2018
Timeline for completion

Combined new team member general orientation	Completed September 2018
Move to one learning management system	Review in process, selection by December 2018, completion by July 2019
Offer leadership and professional development classes to all Ballad Health team members	In progress; launch January 2019
New leader onboarding program	In development; program launch January 2019
Physician Leadership Academy	In progress; goal of January 2019

ATTACHMENT 7

CLINICAL COUNCIL REPORT

Clinical Council Functions and Responsibilities – TOC: 4.02(b)(v); Condition 45

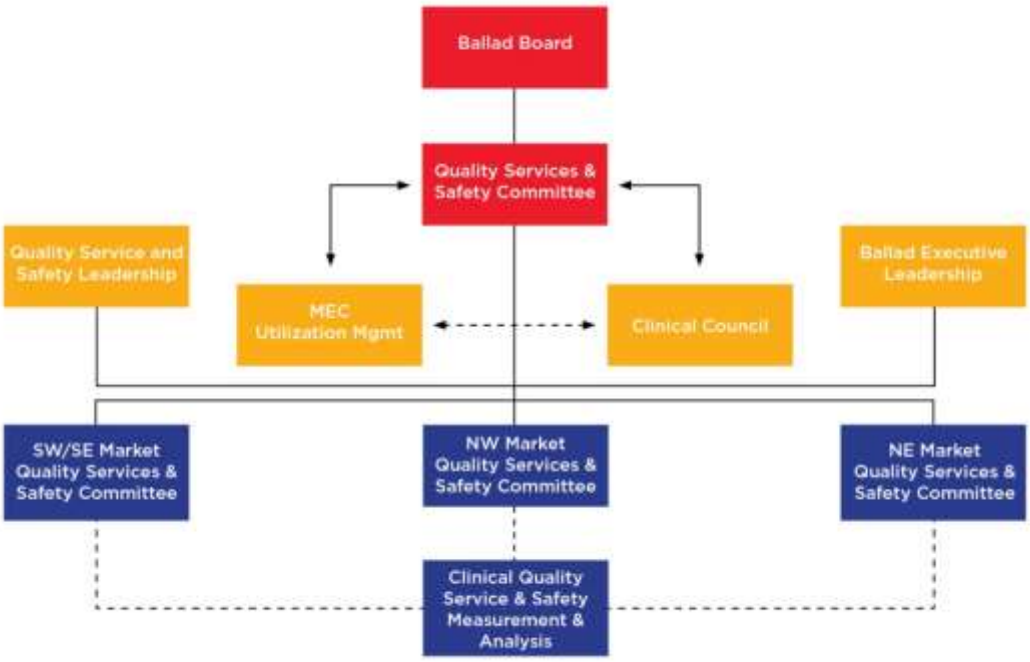
Clinical Council Annual Report – TOC: 6.04(b)(xi); Condition 45

- The Clinical Council established a charter to clarify committee direction and structure. Responsibilities are:
    - Evaluating practice patterns at Ballad Health and benchmarking these with respect to established best practices
    - Establishing metrics and triggers for data collection to monitor adoption of best practices and communicating these results to appropriate stakeholders
    - Evaluating opportunities for reduction in variations of care in the context of available scientific evidence, established best practices and regulatory requirements
    - Evaluating outcome and performance data in the context of evidence-based medicine and required third-party metrics
    - Establishing standardized credentialing, on-call and peer review processes to be followed by individual facilities and entities and monitoring adoption of these processes
    - Establishing standardized credentialing, on-call and peer review processes to be followed by individual facilities and entities and monitoring adoption of these processes
    - Overseeing the adoption of a standardized formulary and drug utilization standards
    - Monitoring adoption of standardized formulary and report opportunities for improvement to the appropriate MECs or Ballad Health entities
    - Supporting Ballad Health's risk-based initiatives as healthcare shifts to a value-based model

- As established in the Quality, Service and Safety Committee Charter, the Clinical Council is responsible for:
    - Promoting and ensuring a culture of collaborative evidence-based care
    - Prioritizing quality, service and safety improvement activities and establishing clear expectations to promote and improve health outcomes and patient safety
    - Promoting high-value care that is supported by the evidence and not duplicative
    - Promoting a transparent and non-punitive environment for reporting and evaluating patient safety and harm incidents
    - Giving guidance to the Quality, Service and Safety Committee regarding the credentialing and privileging process

- The Clinical Council completed an environmental assessment and analysis of key challenges considering rural areas, diversity of services, private practice and the conditions established by the State of Tennessee and the Commonwealth of Virginia. As a result, key subcommittees were developed to assist in completing focused work and counseling Ballad Health's board of directors; Quality, Service and Safety Committee; and Ballad Health's executive leadership. All committees report to the Clinical Council and the Quality, Service and Safety Committee.

- The Clinical Council is aligned with Ballad Health's board of directors and its Quality, Service and Safety Committee. The council assisted in establishing key quality and patient safety priorities considering risk, volume, propensity for problems (including incidence, prevalence and severity) and the impact on health outcomes, patient safety and quality of care.



- Below are the Quality, Service and Safety clinical priorities for the fiscal year 2018-2019, along with the 16 quality target measures established by the conditions of participation:

Quality	**Safety**	**Service**
Antibiotic stewardship	C. diff	Communication
Opioid use	CAUTI	
Sepsis	CLABSI	
Emergency department throughput	MRSA	
	Surgical safety	

- The established sub-committees of the Clinical Council are:

  Evidence-Based Medicine/High-Value Care Committee

  Purpose: To prioritize efforts aimed at promoting high-value care that are supported by evidence, are not duplicative and are truly necessary. The subcommittee will lead efforts to teach, optimize and operationalize safe clinical practices and reduce unwarranted clinical variation across Ballad Health.

  FY19 initiatives:

  1. Hospital-acquired Clostridium difficile (C. diff)
  2. Catheter-associated urinary tract infection (CAUTI)
  3. Antibiotic stewardship
  4. Inpatient MRI utilization
  5. Sepsis bundle compliance

All of the above initiatives have established baselines, active monitoring and established target measures. These are available on the Quality Priority Metrics Scorecard.

The first focused initiative, C. diff, has resulted in excellent clinical outcomes. Ballad Health has experienced a 45% reduction in hospital-acquired C. diff infections since the merger. Our most recent results are in the top quartile, based on Hospital Compare benchmarks.

Patient Experience Committee

Purpose: To provide the ultimate patient experience at Ballad Health facilities and clinics. By focusing on helping physicians and advanced practice providers reconnect with the reasons they went into medicine and putting the emphasis back into connecting with and caring for patients and their families, this subcommittee will focus on promoting effective communication and collaboration amongst healthcare providers and their patients/families. In addition, this subcommittee will focus on how physicians and advanced practice providers can build high-performing teams they are proud to be a part of. While striving to achieve patient service excellence, the subcommittee shall also give importance to providers' well-being and support organizational processes that help rekindle the passion for practicing medicine.

FY19 initiatives:

1. Develop and improve the patient-centered informed consent process
2. Develop communication framework for physicians to improve doctor/patient communication
3. Strengthen relationships between providers and nurses who are caring for patients
4. Provide support to physicians to prevent/cope with burnout
5. Grow understanding among providers of the role experience plays in safety, quality and patient compliance

Surgical Services and Perioperative Committee

Purpose: To provide leadership and oversight in the perioperative environment. The subcommittee is a multidisciplinary committee that addresses issues that impact the quality and safety of surgical patients' care.

The goals and objectives of the committee are:

1. To provide a multidisciplinary forum that will openly evaluate clinical processes for effective, high-quality patient care
2. To develop data metrics and benchmarks that effectively represent clinical operations and align with the COPA target measures
3. To analyze data and issues related to system failures that support the desired and expected outcomes
4. To evaluate and determine best practices
5. To reduce clinical variation in the perioperative environment
6. To oversee implementation of the adherence to procedures that set the standard of care
7. To effectively integrate quality and service while maintaining overall efficiency
8. Collaborate and provide guidance with Ballad Health's surgical services leadership team

FY19 initiatives:

1. Implementation of evidence-based practice colon bundles
2. Implementation of clinical practice guidelines for Enhanced Recovery After Surgery (ERAS) protocols
3. Standardization of surgical attire based on evidence-based practice guidelines
4. Reduction in post-operative discharge opioid prescribing

Medical Staff Committee

Purpose: The purpose of the Medical Staff Committee of the Clinical Council is to promote the effectiveness, efficiency and well-being of the medical staff and identify, evaluate and propose action and policy to the Clinical Council on medical staff issues. The focus of the subcommittee involves quality improvement by reducing variation in medical staff policies and processes across Ballad Health. The Medical Staff Committee completed work on physician orientation and implemented a system flu policy and a system process for application fees.

FY19 initiatives are:

1. System credentialing policy
2. Bylaws structure and content
3. Focus Provider Practice Evaluation (FPPE)
4. Ongoing Provider Practice Evaluation (OPPE)
5. Physician orientation processes
6. Physician education
7. Medical staff policies and procedures

Health Informatics Committee

Purpose: To prioritize efforts aimed at improving the creation, usability and exchange of health information through Ballad Health's Electronic Health Record (EHR) and related solutions. Review and recommend evidence-based best practices concerning EHR implementation, optimization and integration of current EHRs at Ballad Health. In addition, this subcommittee will work with the appropriate groups to maximize and standardize development and use of software and hardware of the Ballad Health Information Technology (IT) systems moving forward (up to and including the implementation of one common EHR for Ballad Health) for the benefit of creating meaningful clinical data at the point of care to support Ballad Health's desire to provide high-quality care and safe transitions of care to the patients and families we serve. Finally, this subcommittee will focus on identifying and implementing evidence-based best practices for EHRs to ensure physicians and care teams can efficiently and effectively use Ballad Health's EHRs and related IT solutions in a manner that promotes clinician well-being.

Pharmacy and Therapeutics Committee

Purpose: To oversee the effective and efficient operation of the medication use process (evaluation, appraisal, selection, procurement, storage, prescribing, transcription, distribution, administration, safety procedures, monitoring and use of medication) as consistent with The Joint Commission Medication Management Standards and assist in the formulation of broad

professional policies relating to medications to decrease variability in practice, improving patient outcomes throughout Ballad Health.

Opioid Task Force Committee

Purpose: To provide oversight of controlled substance therapy at Ballad Health entities and promote the safe use of controlled substances within the communities it serves through the efforts of its five subcommittees:

- Maternal, infant and child health (Neonatal Abstinence Syndrome)
- Substance Use Disorder (SUD) treatment and recovery
- Physician practices
- Hospital setting (including emergency department, surgery and diversion)
- Community partners (includes university/college health science centers, paramedical, legislative, judicial, church, schools, professional societies, law enforcement and Chambers of Commerce)

By optimizing treatment pathways and providing a framework to endorse community efforts surrounding the use of controlled substances, the task force will help promote best practices and efforts to address the epidemic of substance use disorder, misuse and overdoses. The task force will provide oversight of controlled substance metrics and track interventions made across the organization to improve clinical outcomes and minimize adverse outcomes related to the use of controlled substances.

- The Clinical Council engages supply chain as opportunities are identified to order standardized medical supplies. Standardization is key to reducing cost and clinical variation. Each supply chain/clinician engagement is an opportunity to share points of view in order to provide the best-suited medical supplies for patients. So far this fiscal year, the Ballad Health supply chain team has successfully collaborated with medical staff to reduce supply variation in cardiac, orthopedic and neurological surgical supplies.

- The Clinical Council has been educated on the quality, service and safety priorities and the established Ballad Health improvement scorecards. The Council is actively engaged in the quality, service and safety improvement efforts of Ballad Health. This is accomplished through monthly scorecard review, committee attendance and participation in improvement teams.

ATTACHMENT 8

SUMMARY OF QUALITY INDICATORS

Annual Quality Report to the Tennessee and Virginia departments of health

Summary of Quality Indicators

Report Contact: Melanie Stanton

Ballad Health Performance Improvement and Quality

Sept. 30, 2018

Report Summary

The summary of quality indicators report provides a summary of performance for quality indicators submitted via the Ballad Health Quality Metrics Scorecard for the fiscal year that ended June 30, 2018. Metrics include the COPA target measures and the COPA monitoring measures. FY18 performance is compared to the established baseline of Hospital Compare, July 2017 release. The target for Ballad Health's first year is to at least maintain or improve over each established baseline.

- Ballad Health is on track to meet 80% of the targets established for the COPA Target Measures (see below).
- Ballad Health met or exceeded 75% of the targets (12 out of 16), as of June 30, 2018.
- Review of the current year's internal monitoring through August 2018 indicates Ballad Health will meet the 80% threshold.

Target measures

MMYY	Measure	Baseline	Rate	Status
FY18	Pressure Ulcer Rate	0.71	1.12	✗
FY18	Iatrogenic Pneumothorax Rate	0.38	0.21	✓
FY18	In-Hospital Fall with Hip Fracture Rate	0.06	0.09	✗
FY18	Central Venous CatheterRelated Blood Stream Infection Rate	0.15	0.05	✓
FY18	PSI 09 Perioperative Hemorrhage or Hematoma Rate	4.15	1.66	✓
FY18	PSI 10 Postoperative Physiologic and Metabolic Derangement Rate	1.00	0.11	✓
FY18	PSI 11 Postoperative Respiratory Failure Rate	14.79	8.33	✓
FY18	PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	5.42	3.50	✓
FY18	PSI 13 Postoperative Sepsis Rate	8.81	3.88	✓
FY18	PSI 14 Postoperative Wound Dehiscence Rate	2.22	0.98	✓
FY18	PSI 15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate	1.34	0.98	✓
FY18	CLABSI	0.774	0.749	✓
FY18	CAUTI	0.613	0.603	✓
FY18	SSI	1.107	1.396	✗
FY18	MRSA	0.040	0.071	✗
FY18	CDIFF	0.585	0.584	✓

Monitoring measures

FY18	HCLEAN HSPAP Patients who reported that their room and bathroom were “Always” clean	73.64	72.524	✗
FY18	HCLEAN HSPSNP Patients who reported that their room and bathroom were “Sometimes” or “Never” clean	10.53	10.407	✓
FY18	HCLEAN HSPUP Patients who reported that their room and bathroom were “Usually” clean	16.41	17.968	✗
FY18	HCOMP1 SNP Patients who reported that their nurses “Sometimes” or “Never” communicated well	4.6	5.143	✗
FY18	HCOMP1A P Patients who reported that their nurses “Always” communicated well	82.12	77.796	✗
FY18	HCOMP1U P Patients who reported that their nurses “Usually” communicated well	13.05	14.206	✗
FY18	HCOMP2 SNP Patients who reported that their doctors “Sometimes” or “Never” communicated well	6.34	5.937	✓
FY18	HCOMP2A P Patients who reported that their doctors “Always” communicated well	80.02	80.060	✓
FY18	HCOMP2U P Patients who reported that their doctors “Usually” communicated well	13.63	14.008	✗
FY18	HCOMP3 SNP Patients who reported that they “Sometimes” or “Never” received help as soon as they wanted	9.11	9.107	✓
FY18	HCOMP3A P Patients who reported that they “Always” received help as soon as they wanted	67.63	66.972	✗
FY18	HCOMP3U P Patients who reported that they “Usually” received help as soon as they wanted	25.77	23.451	✓
FY18	HCOMP4 SNP Patients who reported that their pain was “Sometimes” or “Never” well controlled	9.32	8.266	✓
FY18	HCOMP4A P Patients who reported that their pain was “Always” well controlled	68.41	69.675	✓
FY18	HCOMP4U P Patients who reported that their pain was “Usually” well controlled	22.73	22.129	✓
FY18	HCOMP5 SNP Patients who reported that staff “Sometimes” or “Never” explained about medicines before giving it to them	18.69	18.617	✓
FY18	HCOMP5A P Patients who reported that staff “Always” explained about medicines before giving it to them	64.12	64.363	✓
FY18	HCOMP5U P Patients who reported that staff “Usually” explained about medicines before giving it to them	19.88	16.659	✓
FY18	HCOMP6N P Patients who reported that NO, they were not given information about what to do during their recovery at home	14.2	12.600	✓
FY18	HCOMP6Y P Patients who reported that YES, they were given information about what to do during their recovery at home	85.94	86.306	✓
FY18	HCOMP7A Patients who “Agree” they understood their care when they left the hospital	41.16	41.061	✓
FY18	HCOMP7D SD Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital	6.09	5.292	✓
FY18	HCOMP7SA Patients who “Strongly Agree” they understood their care when they left the hospital	52.14	50.560	✗
FY18	HHSP RATING06 Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	9.19	9.132	✓
FY18	HHSP RATING78 Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	19.49	19.263	✓
FY18	HHSP RATING910 Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	70.67	69.320	✓
FY18	HQUIETHSP AP Patients who reported that the area around their room was “Always” quiet at night	64.68	62.197	✗
FY18	HQUIETHSP SNP Patients who reported that the area around their room was “Sometimes” or “Never” quiet at night	10.58	9.460	✓
FY18	HQUIETHSP UP Patients who reported that the area around their room was “Usually” quiet at night	24.39	28.462	✗
FY18	HRECMND DN Patients who reported NO, they would probably not or definitely not recommend the hospital	6.48	6.009	✓
FY18	HRECMND DY Patients who reported YES, they would definitely recommend the hospital	71.34	71.569	✓
FY18	HRECMND PY Patients who reported YES, they would probably recommend the hospital	22.23	22.163	✓
FY18	OP29 Avg Risk Polyp Surveillance	0.73	0.833	✓
FY18	OP30 High risk Polyp Surveillance	0.83	0.890	✓
FY18	OP3b Median Time to Transfer AMI	47.42	34.570	✓
FY18	OP5 Median Time to ECG AMI and Chest Pain	5.22	8.730	✗
FY18	OP4 Aspirin at Arrival AMI Chest Pain	0.97	0.981	✓
FY18	ED1b ED Door to Transport	227.29	268.510	✗
FY18	ED2b ED Decision to Transport	124.5	82.980	✓
FY18	OP18b Avg time ED arrival to discharge	124.53	127.260	✗
FY18	OP20 Door to Diagnostic Evaluation	15.09	16.340	✗
FY18	OP21 Time to pain medicaton for long bone fractures	37.84	45.290	✗
FY18	OP22 Left without being seen	0.009	0.008	✓
FY18	OP23 Head CT stroke patients	0.632	0.768	✓
FY18	IMM2 Immunization for Influenza	0.974	0.982	✓
FY18	IMM3OP27 FACADHPCT HCW Influenza Vaccination	0.97	0.980	✓
FY18	VTE6 HAC VTE	0.017	0.032	✗
FY18	PC01 Elective Delivery	0.003	0.000	✓
FY18	Hip and Knee Complications	0.029	0.016	✓
FY18	PSI90 Complications / patient safety for selected indicators	0.83	1.050	✗
FY18	PSI4SURG COMP Death rate among surgical patients with serious treatable complications	140.6	176.718	✗
FY18	READM30 COPD Chronic obstructive pulmonary disease 30day readmission rate	0.182	0.194	✗
FY18	READM30 AMI Acute myocardial infarction (AMI) 30day readmission rate	0.129	0.129	✓
FY18	READM30HF Heart Failure 30Day readmissions rate	0.205	0.236	✗
FY18	READM30PN Pneumonia 30day readmission rate	0.177	0.167	✓
FY18	READM30 STK Stroke 30day readmission rate	0.093	0.104	✗
FY18	READM30 CABG Coronary artery bypass graft (CABG) surgery 30day readmission rate	0.087	0.125	✗
FY18	READM30 HIPKNEE 30day readmission rate following elective THA / TKA	0.038	0.038	✓
FY18	READM30 HOSPWIDE 30day hospitalwide allcause unplanned readmission	0.12	0.131	✗
FY18	MORT30 CABG Coronary artery bypass graft surgery 30day mortality rate	0.02	0.030	✗
FY18	MORT30 COPD 30day mortality rate COPD patients	0.018	0.026	✗
FY18	MORT30AMI Acute myocardial infarction (AMI) 30day mortality rate	0.047	0.047	✓
FY18	MORT30HF Heart failure 30day mortality rate	0.039	0.030	✓
FY18	MORT30PN Pneumonia 30day mortality rate	0.047	0.055	✗
FY18	MORT30STK Stroke 30day mortality rate	0.082	0.054	✓

ATTACHMENT 9

COMPARISON TO SYSTEMS METHODOLOGY

Annual Report to the Tennessee and Virginia departments of health

Methodology for Selection of Comparison Systems

Report Contact: Melanie Stanton

Ballad Health Performance Improvement and Quality

Sept. 30, 2018

This report provides a summary of the methodology for selection of similarly sized hospital systems, as established in the Tennessee Terms of Certification 4.02(c) (ii), Exhibit G.

Selection criteria, ranked by priority:

- Not-for-profit
- Net revenue
- Alignment with Premier as a quality partner – *allows for better benchmarking and best practice sharing*
- Bed size and number of hospitals
- Rural hospitals and similar services
- Location – *allows for travel to site visits*
- EPIC electronic medical record
- Top performers

	Aurora Health	**Baptist Memorial**	**Carilion Clinic**	**Mercy Health**	**Texas Health**	**Unity Point Health**
Net revenue	3.4	2.4	1.5	3.9	4.1	3.6
Bed size - staffed	2100	2760	908	3281	3630	3056
Number of hospitals	15	21	8	23	28	36
Location	Milwaukee, WI	Memphis, TN	Roanoke, VA	Cincinnati, OH	Arlington, TX	Des Moines IA
Ranking	#23	#24	NA	#15	#22	#19

- Five of the six selected healthcare systems are ranked in the top 25 of the largest not-for-profit hospital systems in America. The sixth selection is a Virginia-based hospital system near Ballad Health that meets most of the criteria. Having a Tennessee and Virginia-based system was important in the selection process for comparisons and benchmarking purposes.
- All selected healthcare organizations are not-for-profit systems, utilize Premier for the quality advisor vendor and utilize EPIC as the Electronic Health Record.
- All selected systems include rural hospitals and similar services.

ATTACHMENT 10

COMPARISON TO SIMILARLY SIZED SYSTEMS

Hospital Compare July 2018 Release

Color Coding Key

	Measure Desired Performane
Peer Group Basis	↓ Lower is Better
	↑ Higher Better

- ↓ System Performace is below Peer Comparative when a Lower Measure Performance is Desired
- ↑ System Performace is Above Peer Comparative when a Higher Measure Performance is Desired
- ↓ System Performace is Above Peer Comparative when a Lower Measure Performance is Desired
- ↑ System Performace is Below Peer Comparative when Da Higher Measure Performance is Desired

Target Quality Measures Rate	Desired Performance	Discharge Dates	Top Qtl	50%	Bot Qtl	Ballad Health (as compared to Peer Group)	Ballad Health Ranking	Aurora	Baptist	Carilion	Mercy	Texas Health	Unity	Peer Group
Pressure Ulcer Rate	↓	10/01/15-06/30/17	0.18	0.29	0.42	0.64	7	0.62	0.36	0.44	0.21	0.25	0.14	0.38
Iatrogenic Pneumothorax Rate	↓	10/01/15-06/30/17	0.26	0.28	0.30	0.31	4	0.31	0.27	0.40	0.29	0.29	0.33	0.31
Central Venous CatheterRelated Blood Stream Infection Rate	↓	Retired												
PSI08 In Hospital Fall w/ Hip Fracture Rate	↓	10/01/15-06/30/17	0.11	0.11	0.11	0.11		0.11	0.12	0.11	0.11	0.11	0.11	0.11
PSI 09 Perioperative Hemorrhage or Hematoma Rate	↓	10/01/15-06/30/17	2.42	2.55	2.73	2.26	1	3.54	2.36	3.27	2.54	2.57	2.67	2.74
PSI 10 Postoperative Physiologic and Metabolic Derangement Rate	↓	10/01/15-06/30/17	1.19	1.28	1.31	1.09	1	1.45	1.72	2.26	1.21	1.40	1.44	1.51
PSI 11 Postoperative Respiratory Failure Rate	↓	10/01/15-06/30/17	6.18	7.37	9.41	11.67	6	11.75	11.29	5.46	8.11	6.96	7.22	8.92
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	↓	10/01/15-06/30/17	3.26	3.69	4.21	4.03	5	3.66	4.68	4.42	3.50	3.63	3.47	3.91
PSI 13 Postoperative Sepsis Rate	↓	10/01/15-06/30/17	4.63	5.05	5.65	4.83	3	4.28	6.16	5.86	5.01	4.45	5.01	5.09
PSI 14 Postoperative Wound Dehiscence Rate	↓	10/01/15-06/30/17	0.73	0.80	0.84	0.70	1	0.88	0.79	1.73	0.70	0.75	0.77	0.90
PSI 15 Accidental Puncture or Laceration Rate	↓	10/01/15-06/30/17	1.17	1.25	1.37	1.40	6	1.22	1.19	1.50	1.37	1.13	1.32	1.30
CLABSI NHSN Obs Rate	↓	10/01/16-09/30/17	**0.000**	**0.226**	**0.825**	0.744	2	**1.217**	**1.509**	**0.559**	**1.325**	**1.673**	**1.014**	1.15
CAUTI NHSN Obs Rate	↓	10/01/16-09/30/17	**0.000**	**0.461**	**1.061**	0.593	**1**	**1.962**	**1.360**	**1.705**	**2.130**	**3.040**	**1.509**	1.76
SSI COLON Surgical Site Infection NHSN Obs Rate	↓	10/01/16-09/30/17	**0.000**	**1.299**	**3.125**	2.077	1	**6.592**	**5.344**	**2.505**	**3.637**	**5.126**	**2.383**	3.95
SSI HYST Surgical Site Infection NHSN Obs Rate	↓	10/01/16-09/30/17	**0.000**	**0.000**	**0.648**	0.552	2	**2.204**	**1.606**	**0.656**	**1.709**	**1.665**	**0.505**	1.27
MRSA NHSN Obs Rate	↓	10/01/16-09/30/17	**0.000**	**0.008**	**0.052**	0.045	1	**0.045**	**0.094**	**0.068**	**0.067**	**0.079**	**0.053**	0.06
CDIFF NHSN Obs Rate	↓	10/01/16-09/30/17	**0.419**	**0.463**	**0.662**	0.654	2	**1.204**	**1.499**	**1.010**	**1.305**	**2.090**	**0.329**	1.16

Color Coding Key

	Measure Desired Performane
Peer Group Basis	↓ Lower is Better
	↑ Higher Better

- ↓ System Performace is below Peer Comparative when a Lower Measure Performance is Desired
- ↑ System Performace is Above Peer Comparative when a Higher Measure Performance is Desired
- ↓ System Performace is Above Peer Comparative when a Lower Measure Performance is Desired
- ↑ System Performace is Below Peer Comparative when Da Higher Measure Performance is Desired

Target Quality Measures Rate	Desired Performance	Discharge Dates	Top Qtl	50%	Bot Qtl	**Ballad Health** (as compared to Peer Group)	Ballad Health Ranking	Aurora	Baptist	Carilion	Mercy	Texas Health	Unity	Peer Group
General Information-Structural Measures														
SMSSCHECK Safe Surgery Checklist														
Survey of Patient's Experiences - Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) %														
HCOMP1A P Patients who reported that their nurses "Always" communicated well	↑	10/01/16-09/30/17	**83.0**	**80.0**	**77.0**	**80.5**	**2**	**83.8**	**80.5**	**80.1**	**77.4**	**79.7**	**79.3**	80.20
HCOMP1U P Patients who reported that their nurses "Usually" communicated well			18.0	16.0	14.0	**15.0**		13.8	15.5	16.4	15.7	16.6	17.6	15.80
HCOMP1 SNP Patients who reported that their nurses "Sometimes" or "Never" communicated well			5.0	4.0	3.0	**4.5**		2.5	4.4	3.8	3.5	3.8	3.3	3.68
HCOMP2A P Patients who reported that their doctors "Always" communicated well	↑	10/01/16-09/30/17	**85.0**	**81.0**	**78.0**	**81.6**	**3**	**83.0**	**82.2**	**80.7**	**76.4**	**81.0**	**79.8**	80.68
HCOMP2U P Patients who reported that their doctors "Usually" communicated well			17.0	15.0	12.0	**14.1**		13.8	13.5	15.6	16.2	14.9	16.1	14.89
HCOMP2 SNP Patients who reported that their doctors "Sometimes" or "Never" communicated well			5.0	4.0	3.0	**4.3**		3.3	4.7	4.0	4.0	4.2	4.3	4.11
HCOMP3A P Patients who reported that they "Always" received help as soon as they wanted	↑	10/01/16-09/30/17	**75.0**	**68.0**	**63.0**	**68.0**	**2**	**70.3**	**64.8**	**67.3**	**62.5**	**67.0**	**63.3**	66.18
HCOMP3U P Patients who reported that they "Usually" received help as soon as they wanted			27.0	24.0	19.0	**23.5**		23.9	23.6	25.2	25.1	24.5	28.2	24.88
HCOMP3 SNP Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted			11.0	8.0	5.0	**8.5**		6.0	11.8	7.7	8.9	8.7	8.6	8.62
HCOMP4A P Patients who reported that their pain was "Always" well controlled	Suspended													
HCOMP4U P Patients who reported that their pain was "Usually" well controlled	Suspended													
HCOMP4 SNP Patients who reported that their pain was "Sometimes" or "Never" well controlled	Suspended													
HCOMP5A P Patients who reported that staff "Always" explained about medicines before giving it to them	↑	10/01/16-09/30/17	**69.0**	**65.0**	**61.0**	**65.7**	**2**	**68.9**	**63.0**	**61.7**	**61.2**	**64.6**	**61.7**	63.84
HCOMP5U P Patients who reported that staff "Usually" explained about medicines before giving it to them			19.0	18.0	16.0	**16.9**		17.4	17.7	19.6	17.8	17.3	20.1	18.13
HCOMP5 SNP Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them			20.0	17.0	14.0	**17.4**		13.8	19.6	19.0	17.5	18.3	18.3	17.70
HCLEAN HSPAP Patients who reported that their room and bathroom were "Always" clean	↑	10/01/16-09/30/17	**80.0**	**74.0**	**69.0**	**70.9**	**6**	**77.5**	**69.0**	**72.1**	**73.8**	**74.7**	**71.7**	72.83
HCLEAN HSPUP Patients who reported that their room and bathroom were "Usually" clean			21.0	18.0	15.0	**19.0**		17.1	20.1	19.2	18.0	17.5	20.4	18.76
HCLEAN HSPSNP Patients who reported that their room and bathroom were "Sometimes" or "Never" clean			10.0	7.0	5.0	**10.2**		5.5	11.2	9.0	8.1	7.9	8.1	8.56
HQUIETHSP AP Patients who reported that the area around their room was "Always" quiet at night	↑	10/01/16-09/30/17	**68.0**	**61.0**	**55.0**	**62.9**	**3**	**62.2**	**69.4**	**53.4**	**55.9**	**65.8**	**60.6**	61.46
HQUIETHSP UP Patients who reported that the area around their room was "Usually" quiet at night			33.0	30.0	25.0	**28.8**		30.2	24.6	34.7	31.3	26.2	31.1	29.55
HQUIETHSP SNP Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night			12.8	9.0	6.0	**8.2**		7.8	6.3	12.3	9.3	8.1	8.5	8.65
HCOMP6Y P Patients who reported that YES, they were given information about what to do during their recovery at home	↑	10/01/16-09/30/17	**90.0**	**88.0**	**85.0**	**87.2**	**4**	**90.5**	**84.3**	**86.6**	**85.5**	**88.3**	**88.6**	87.29
HCOMP6N P Patients who reported that NO, they were not given information about what to do during their recovery at home			15.0	12.0	10.0	**12.8**		9.6	15.9	13.6	10.9	11.8	11.5	12.31
HCOMP7SA Patients who "Strongly Agree" they understood their care when they left the hospital	↑	10/01/16-09/30/17	**56.0**	**52.0**	**48.0**	**53.6**	**1**	**39.6**	**43.0**	**45.5**	**41.6**	**40.1**	**43.9**	43.89
HCOMP7A Patients who "Agree" they understood their care when they left the hospital			46.0	43.0	39.0	**41.2**		57.2	51.6	50.3	50.8	55.2	52.1	51.21
HCOMP7D SD Patients who "Disagree" or "Strongly Disagree" they understood their care when they left the hospital			6.0	5.0	4.0	**5.2**		3.4	5.7	4.6	4.2	4.9	4.1	4.59

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Target Quality Measures Rate	Desired Performance	Discharge Dates	Top Qtl	50%	Bot Qtl	Ballad Health (as compared to Peer Group)	Ballad Health Ranking	Aurora	Baptist	Carilion	Mercy	Texas Health	Unity	Peer Group
HHSP RATING910 Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	↑	10/01/16-09/30/17	**78.0**	**73.0**	**68.0**	**74.2**	**4**	**78.3**	**72.1**	**73.0**	**71.4**	**76.9**	**74.9**	74.40
HHSP RATING78 Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)			23.0	20.0	16.0	**18.0**		17.2	20.3	20.7	18.3	16.9	19.1	18.64
HHSP RATING06 Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)			9.0	7.0	5.0	**7.8**		4.7	7.9	6.6	6.9	6.4	6.2	6.65
HRECMND DY Patients who reported YES, they would definitely recommend the hospital	↑	10/01/16-09/30/17	**78.0**	**73.0**	**66.0**	**74.5**	**5**	**77.8**	**73.0**	**74.7**	**69.0**	**77.8**	**74.8**	74.53
HRECMND PY Patients who reported YES, they would probably recommend the hospital			28.0	23.0	18.0	**20.9**		19.7	22.4	21.9	23.0	18.3	21.7	21.13
HRECMND DN Patients who reported NO, they would probably not or definitely not recommend the hospital			6.0	4.0	3.0	**4.6**		2.6	4.9	3.8	4.6	4.1	3.6	4.00

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Target Quality Measures Rate	Desired Performance	Discharge Dates	Top Qtl	50%	Bot Qtl	Ballad Health (as compared to Peer Group)	Ballad Health Ranking	Aurora	Baptist	Carilion	Mercy	Texas Health	Unity	Peer Group
Timely & Effective care Colonoscopy follow-up %														
OP29 Avg Risk Polyp Surveillance	↑	01/01/16-12/31/16	99.0	94.0	81.0	75.0	6	97.6	85.2	92.2	93.1	74.4	91.1	86.95
OP30 High risk Polyp Surveillance	↑	01/01/16-12/31/16	100.0	96.0	86.0	83.7	6	97.6	87.3	96.9	89.1	88.8	79.1	88.92
Timely & Effective Care Heart Attack														
OP3b Median Time to Transfer AMI	↓	10/01/16-09/30/17	42.0	54.5	69.0	59.5	5	37.4	125.9	na	55.3	50.8	54.0	63.82
OP4 Aspirin at Arrival AMI Chest Pain	↑	10/01/16-09/30/17	100.0	97.0	93.0	97.5	3	98.0	98.5	97.0	96.0	95.4	96.9	97.04
OP5 Median Time to ECG AMI and Chest Pain	↓	10/01/16-09/30/17	5.0	7.0	10.0	7.0	2	4.1	9.5	12.0	7.5	7.0	8.0	7.88
Timely & Effective Care- Emergency Department (ED) Throughput														
ED1b ED Door to Transport	↓	10/01/16-09/30/17	212.0	257.5	316.0	219.5	3	185.0	192.0	268.0	272.0	286.5	241.0	237.71
ED2b ED Decision to Transport	↓	10/01/16-09/30/17	57.0	86.0	130.0	62.0	3	49.0	46.0	81.0	100.0	127.0	99.0	80.57
OP18b Avg time ED arrival to discharge	↓	10/01/16-09/30/17	169.0	220.0	296.0	151.0	6	123.0	114.0	160.5	136.5	149.0	133.5	138.21
OP20 Door to Diagnostic Evaluation	↓	10/01/16-09/30/17	14.0	20.0	28.0	12.5	2	9.0	18.5	41.0	13.5	24.0	24.0	20.36
OP21 Time to pain medicaton for long bone fractures2	↓	10/01/16-09/30/17	38.0	48.0	60.0	40.5	3	24.5	55.4	68.0	51.5	46.5	39.0	46.49
OP22 Left without being seen	↓	10/01/16-09/30/17	1.0	1.0	2.0	0.9	1	1.0	1.7	3.0	1.5	2.2	1.1	1.65
OP23 Head CT stroke patients	↑	10/01/16-09/30/17	88.0	79.0	64.0	91.0	1	81.1	78.4	na	73.2	80.2	73.9	79.63
Timely & Effective Care Preventive Care %														
IMM2 Immunization for Influenza	↑	10/01/16-03/31/17	99.0	96.0	90.0	98.0	2	96.9	97.8	96.9	87.8	98.9	90.3	95.22
IMM3OP27 FACADHPCT HCW Influenza Vaccination	↑	10/01/16-03/31/17	96.0	91.0	79.0	97.6	2	98.1	94.1	73.9	90.0	87.8	94.7	90.89
Timely & Effective Care Blood Clot Prevention & Treatment %														
VTE6 HAC VTE	↓	10/01/16-09/30/17	0.0	0.0	3.0	0.7	1	na	na	13.0	na	2.0	na	5.24
Timely & Effective Care Pregnancy & delivery care %														
PC01 Elective Delivery	↓	10/01/16-09/30/17	0.0	0.0	3.0	1.1	2	2.0	1.0	4.0	8.5	2.8	2.4	3.10
Complications - Surgical Complications Rate														
Hip and Knee Complications2	↓	04/01/14-03/31/17	2.30	2.50	2.90	2.82	6	2.49	3.00	2.39	2.32	2.22	2.55	2.54
PSI90 Complications / patient safety for selected indicators	↓	10/01/15-06/30/17	0.90	0.97	1.06	0.98	6	0.97	1.04	0.69	0.88	0.93	0.90	0.91
PSI4SURG COMP Death rate among surgical patients with serious treatable complications	↓	10/01/15-06/30/17	150.68	160.89	172.28	170.20	5	171.92	152.05	207.82	152.92	165.07	169.16	169.88
Readmissions & deaths 30 day rates of readmission %														
READM30 COPD Chronic obstructive pulmonary disease 30day readmission rate	↓	07/01/14-06/30/17	18.9	19.5	20.3	19.5	4	19.8	20.2	19.3	19.7	19.4	19.3	19.60
READM30 AMI Acute myocardial infarction (AMI) 30day readmission rate	↓	07/01/14-06/30/17	15.3	16.0	16.7	16.9	7	14.7	15.6	14.6	15.8	15.6	15.0	15.46
READM30HF Heart Failure 30Day readmissions rate	↓	07/01/14-06/30/17	20.6	21.6	22.6	23.2	7	20.4	23.0	22.2	21.7	20.5	21.5	21.79
READM30PN Pneumonia 30day readmission rate	↓	07/01/14-06/30/17	15.8	16.6	17.5	17.9	7	16.3	17.8	16.8	16.9	16.1	16.3	16.89

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Target Quality Measures Rate	Desired Performance	Discharge Dates	Top Qtl	50%	Bot Qtl	Ballad Health (as compared to Peer Group)	Ballad Health Ranking	Aurora	Baptist	Carilion	Mercy	Texas Health	Unity	Peer Group
READM30 STK Stroke 30day readmission rate	↓	07/01/14-06/30/17	11.4	11.8	12.4	**12.6**	6	12.3	12.9	11.8	12.3	11.5	11.8	12.16
READM30 CABG Coronary artery bypass graft (CABG) surgery 30day readmission rate2	↓	07/01/14-06/30/17	12.3	13.2	14.1	**12.5**	2	11.3	14.5	14.4	13.7	14.4	13.2	13.44
READM30 HIPKNEE 30day readmission rate following elective THA / TKA	↓	07/01/14-06/30/17	3.9	4.1	4.4	**4.5**	7	4.0	4.4	4.0	4.2	4.1	4.2	4.21
READM30 HOSPWIDE 30day hospitalwide allcause unplanned readmission	↓	07/01/16-06/30/17	14.9	15.2	15.7	**16.0**	6	14.4	16.1	15.5	15.4	15.0	14.7	15.29

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Target Quality Measures Rate	Desired Performance	Discharge Dates	Top Qtl	50%	Bot Qtl	Ballad Health (as compared to Peer Group)	Ballad Health Ranking	Aurora	Baptist	Carilion	Mercy	Texas Health	Unity	Peer Group
Readmissions & deaths 30 day death (mortality) rates %														
MORT30 CABG Coronary artery bypass graft surgery 30day mortality rate	↓	07/01/14-06/30/17	2.60	3.05	3.70	2.98	3	2.57	4.62	2.44	4.26	4.50	3.77	3.59
MORT30 COPD 30day mortality rate COPD patients	↓	07/01/14-06/30/17	7.70	8.30	9.00	8.21	2	7.67	8.32	9.25	8.29	9.45	9.86	8.72
MORT30AMI Acute myocardial infarction (AMI) 30day mortality rate	↓	07/01/14-06/30/17	12.40	13.10	13.90	12.60	1	12.67	13.88	13.19	12.71	13.94	14.09	13.30
MORT30HF Heart failure 30day mortality rate	↓	07/01/14-06/30/17	10.70	11.70	12.90	12.45	6	11.44	11.97	11.57	11.05	12.21	13.87	12.08
MORT30PN Pneumonia 30day mortality rate	↓	07/01/14-06/30/17	14.60	15.80	17.00	16.50	7	14.00	15.09	15.98	15.14	16.20	16.99	15.70
MORT30STK Stroke 30day mortality rate	↓	07/01/14-06/30/17	13.30	14.20	15.20	15.54	6	14.89	13.76	15.47	13.50	14.53	15.06	14.68
Use of medical imaging Outpatient imaging efficiency %														
OP8 MRI Lumbar Spine for Low Back Pain	↑↓	07/01/16-06/30/17	35.8	40.4	44.7	42.7		45.0	38.6	33.9	39.6	40.7	33.9	39.20
OP9 Mammography Followup Rates	↑↓	07/01/16-06/30/17	5.9	8.0	10.4	6.4		6.0	8.0	6.1	8.6	7.1	9.0	7.29
OP10 Abdomen CT Use of Contrast Material	↑↓	07/01/16-06/30/17	3.4	5.9	9.5	6.8		8.9	6.2	6.6	5.4	5.0	3.0	5.99
OP11 Thorax CT Use of Contrast Material	↑↓	07/01/16-06/30/17	0.0	0.6	2.5	0.8		0.4	1.5	0.9	0.9	3.6	0.3	1.19
OP13 Outpatients who got cardiac imaging stress tests before lowrisk outpatient surgery	↑↓	07/01/16-06/30/17	3.3	4.4	5.5	4.5		6.3	4.3	5.1	4.3	4.9	3.4	4.66
OP14 Outpatients with brain CT scans who got a sinus CT scan at the same time	↑↓	07/01/16-06/30/17	0.4	0.8	1.2	1.0		0.9	0.7	0.8	1.0	0.8	0.6	0.81

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Pressure Ulcer Rate	↓	10/01/15-06/30/17	na	0.22	0.12	0.20	na	0.08	0.22	0.24	0.18	0.33	0.27	0.23	0.81	0.36	1.97	na	0.35	1.00
Iatrogenic Pneumothorax Rate	↓	10/01/15-06/30/17	na	0.27	0.26	0.31	na	0.27	0.27	0.32	0.27	0.28	0.28	0.27	0.28	0.29	0.34	na	0.28	0.39
Central Venous CatheterRelated Blood Stream Infection Rate	↓	Retired																		
PSI08 In Hospital Fall w/ Hip Fracture Rate	↓	10/01/15-06/30/17	na	0.11	0.11	0.11	na	0.10	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.14	na	0.11	0.11
PSI 09 Perioperative Hemorrhage or Hematoma Rate	↓	10/01/15-06/30/17	na	2.60	2.39	1.96	na	2.47	3.22	2.54	2.56	na	3.09	2.53	2.51	na	2.60	na	na	2.00
PSI 10 Postoperative Physiologic and Metabolic Derangement Rate	↓	10/01/15-06/30/17	na	1.20	1.24	1.30	na	1.19	1.23	1.30	1.29	na	1.31	1.30	1.29	na	0.89	na	na	0.89
PSI 11 Postoperative Respiratory Failure Rate	↓	10/01/15-06/30/17	na	8.88	11.24	13.74	na	8.96	9.47	6.83	5.92	na	7.10	10.18	8.21	na	13.97	na	na	10.43
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	↓	10/01/15-06/30/17	na	4.10	3.69	4.57	na	2.97	3.31	4.17	3.59	na	3.58	3.50	4.03	na	2.19	na	na	5.40
PSI 13 Postoperative Sepsis Rate	↓	10/01/15-06/30/17	na	3.90	5.08	5.52	na	4.84	5.15	5.00	4.89	na	5.05	4.99	6.30	na	4.64	na	na	4.21
PSI 14 Postoperative Wound Dehiscence Rate	↓	10/01/15-06/30/17	na	0.74	0.79	0.62	na	0.74	1.34	0.82	0.83	na	na	0.82	0.82	na	0.66	na	na	0.61
PSI 15 Accidental Puncture or Laceration Rate	↓	10/01/15-06/30/17	na	1.13	1.44	1.51	na	1.31	1.62	1.24	1.25	1.28	1.27	1.25	1.46	na	1.54	na	na	1.16
CLABSI NHSN Obs Rate	↓	10/01/16-09/30/17	na	0.679	0.568	0.655	na	0.000	1.786	0.000	0.000	3.774	0.000	0.000	0.000	0.000	0.994	na	0.000	0.960
CAUTI NHSN Obs Rate	↓	10/01/16-09/30/17	na	0.819	0.642	1.286	na	0.156	0.000	0.000	0.000	0.000	0.000	0.000	0.484	0.000	1.120	na	0.000	0.211
SSI COLON Surgical Site Infection NHSN Obs Rate	↓	10/01/16-09/30/17	na	4.098	2.174	1.493	na	4.054	3.226	0.000	0.000	na	na	3.704	0.000	na	0.781	na	0.000	1.667
SSI HYST Surgical Site Infection NHSN Obs Rate	↓	10/01/16-09/30/17	na	0.709	0.000	4.762	na	4.167	0.000	0.000	0.000	na	0.000	0.000	0.000	na	0.000	na	na	0.000
MRSA NHSN Obs Rate	↓	10/01/16-09/30/17	na	0.037	0.000	0.071	na	0.000	0.128	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.068	na	0.000	0.024
CDIFF NHSN Obs Rate	↓	10/01/16-09/30/17	na	0.523	1.141	0.496	na	0.703	0.401	0.581	0.287	0.000	0.000	0.446	0.147	0.000	0.850	na	0.259	0.906

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General Information-Structural Measures																				
SMSSCHECK Safe Surgery Checklist																				
Survey of Patient's Experiences - Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS																				
HCOMP1A P Patients who reported that their nurses "Always" communicated well	↑	10/01/16-09/30/17	**na**	**83**	**79**	**80**	**na**	**76**	**78**	**82**	**84**	**88**	**86**	**82**	**80**	**87**	**81**	**91**	**83**	**79**
HCOMP1U P Patients who reported that their nurses "Usually" communicated well			na	14	17	15	na	18	17	12	12	8	13	14	14	9	15	7	13	16
HCOMP1 SNP Patients who reported that their nurses "Sometimes" or "Never" communicated well			na	3	4	5	na	6	5	6	4	4	1	4	6	4	4	2	4	5
HCOMP2A P Patients who reported that their doctors "Always" communicated well	↑	10/01/16-09/30/17	**na**	**82**	**83**	**77**	**na**	**77**	**84**	**83**	**84**	**93**	**87**	**83**	**79**	**90**	**82**	**87**	**85**	**81**
HCOMP2U P Patients who reported that their doctors "Usually" communicated well			na	14	14	16	na	17	12	13	12	6	10	12	14	5	15	12	10	15
HCOMP2 SNP Patients who reported that their doctors "Sometimes" or "Never" communicated well			na	4	3	7	na	6	4	4	4	1	3	5	7	5	3	1	5	4
HCOMP3A P Patients who reported that they "Always" received help as soon as they wanted	↑	10/01/16-09/30/17	**na**	**70**	**63**	**68**	**na**	**57**	**72**	**77**	**72**	**74**	**78**	**74**	**72**	**76**	**67**	**88**	**81**	**65**
HCOMP3U P Patients who reported that they "Usually" received help as soon as they wanted			na	24	27	22	na	29	22	17	20	21	18	18	20	15	26	12	14	25
HCOMP3 SNP Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted			na	6	10	10	na	14	6	6	8	5	4	8	8	9	7	na	5	10
HCOMP4A P Patients who reported that their pain was "Always" well controlled	Suspended																			
HCOMP4U P Patients who reported that their pain was "Usually" well controlled	Suspended																			
HCOMP4 SNP Patients who reported that their pain was "Sometimes" or "Never" well controlled	Suspended																			
HCOMP5A P Patients who reported that staff "Always" explained about medicines before giving it to them	↑	10/01/16-09/30/17	**na**	**70**	**63**	**70**	**na**	**60**	**63**	**72**	**67**	**63**	**69**	**66**	**66**	**78**	**64**	**80**	**72**	**64**
HCOMP5U P Patients who reported that staff "Usually" explained about medicines before giving it to them			na	15	19	12	na	18	22	16	16	15	18	15	13	9	19	13	13	18
HCOMP5 SNP Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them			na	15	18	18	na	22	15	12	17	22	13	19	21	13	17	7	15	18
HCLEAN HSPAP Patients who reported that their room and bathroom were "Always" clean	↑	10/01/16-09/30/17	**na**	**82**	**78**	**64**	**na**	**69**	**67**	**79**	**71**	**82**	**85**	**81**	**73**	**83**	**61**	**94**	**81**	**63**
HCLEAN HSPUP Patients who reported that their room and bathroom were "Usually" clean			na	14	17	22	na	20	21	13	21	14	12	14	16	14	23	6	15	23
HCLEAN HSPSNP Patients who reported that their room and bathroom were "Sometimes" or "Never" clean			na	4	5	14	na	11	12	8	8	4	3	5	11	3	16	na	4	14
HQUIETHSP AP Patients who reported that the area around their room was "Always" quiet at night	↑	10/01/16-09/30/17	**na**	**72**	**62**	**55**	**na**	**59**	**58**	**69**	**58**	**65**	**70**	**68**	**70**	**72**	**61**	**81**	**73**	**59**
HQUIETHSP UP Patients who reported that the area around their room was "Usually" quiet at night			na	24	30	31	na	31	34	24	33	31	26	27	22	25	30	12	22	31
HQUIETHSP SNP Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night			na	4	8	14	na	10	8	7	9	4	4	5	8	3	9	7	5	10
HCOMP6Y P Patients who reported that YES, they were given information about what to do during their recovery at home	↑	10/01/16-09/30/17	**na**	**87**	**88**	**86**	**0**	**85**	**87**	**87**	**85**	**85**	**91**	**87**	**88**	**89**	**88**	**88**	**91**	**88**
HCOMP6N P Patients who reported that NO, they were not given information about what to do during their recovery at home			na	13	12	14	0	15	13	13	15	15	9	13	12	11	12	12	9	12
HCOMP7SA Patients who "Strongly Agree" they understood their care when they left the hospital	↑	10/01/16-09/30/17	**na**	**61**	**54**	**51**	**0**	**47**	**49**	**52**	**55**	**55**	**55**	**53**	**56**	**56**	**53**	**58**	**55**	**55**
HCOMP7A Patients who "Agree" they understood their care when they left the hospital			na	34	42	43	0	46	46	43	39	42	41	42	39	39	42	38	40	40
HCOMP7D SD Patients who "Disagree" or "Strongly Disagree" they understood their care when they left the hospital			na	5	4	6	0	7	5	5	6	3	4	5	5	5	5	4	5	5

Color Coding Key

Measure Desired Performane	
↓	Lower is Better
↑	Higher Better

Peer Group Basis

- System Performace is below Peer Comparative when a Lower Measure Performance is Desired
- System Performace is Above Peer Comparative when a Higher Measure Performance is Desired
- System Performace is Above Peer Comparative when a Lower Measure Performance is Desired
- System Performace is Below Peer Comparative when Da Higher Measure Performance is Desired

Target Quality Measures Rate	Desired Performance	Discharge Dates	DICKENSON COMMUNITY HOSPITAL	FRANKLIN WOODS COMMUNITY HOSPITAL	INDIAN PATH MEDICAL CENTER	JOHNSON CITY MEDICAL CENTER	JOHNSON COUNTY COMMUNITY HOSPITAL	JOHNSTON MEMORIAL HOSPITAL	LAUGHLIN MEMORIAL HOSPITAL, INC	LONESOME PINE HOSPITAL	NORTON COMMUNITY HOSPITAL	RUSSELL COUNTY MEDICAL CENTER	SMYTH COUNTY COMMUNITY HOSPITAL	SYCAMORE SHOALS HOSPITAL	TAKOMA REGIONAL HOSPITAL	UNICOI COUNTY MEMORIAL HOSPITAL	WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WELLMONT HANCOCK COUNTY HOSPITAL	WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WELLMONT HOLSTON VALLEY MEDICAL CENTER
HHSP RATING910 Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	↑	10/01/16-09/30/17	**na**	**82**	**74**	**67**	**0**	**68**	**73**	**73**	**73**	**75**	**76**	**76**	**76**	**70**	**76**	**91**	**84**	**73**
HHSP RATING78 Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)			na	13	19	21	0	20	20	18	17	19	19	17	15	20	18	1	9	20
HHSP RATING06 Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)			na	5	7	12	0	12	7	9	10	6	5	7	9	10	6	8	7	7
HRECMND DY Patients who reported YES, they would definitely recommend the hospital	↑	10/01/16-09/30/17	**na**	**85**	**77**	**67**	**0**	**63**	**74**	**71**	**72**	**69**	**68**	**77**	**76**	**73**	**77**	**83**	**75**	**77**
HRECMND PY Patients who reported YES, they would probably recommend the hospital			na	12	18	26	0	30	23	24	22	28	30	18	17	19	20	9	19	19
HRECMND DN Patients who reported NO, they would probably not or definitely not recommend the hospital			na	3	5	7	0	7	3	5	6	3	2	5	7	8	3	8	6	4

Color Coding Key

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Target Quality Measures Rate	Desired Performance	Discharge Dates	DICKENSON COMMUNITY HOSPITAL	FRANKLIN WOODS COMMUNITY HOSPITAL	INDIAN PATH MEDICAL CENTER	JOHNSON CITY MEDICAL CENTER	JOHNSON COUNTY COMMUNITY HOSPITAL	JOHNSTON MEMORIAL HOSPITAL	LAUGHLIN MEMORIAL HOSPITAL, INC	LONESOME PINE HOSPITAL	NORTON COMMUNITY HOSPITAL	RUSSELL COUNTY MEDICAL CENTER	SMYTH COUNTY COMMUNITY HOSPITAL	SYCAMORE SHOALS HOSPITAL	TAKOMA REGIONAL HOSPITAL	UNICOI COUNTY MEMORIAL HOSPITAL	WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WELLMONT HANCOCK COUNTY HOSPITAL	WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WELLMONT HOLSTON VALLEY MEDICAL CENTER
Timely & Effective care Colonoscopy follow-up %																				
OP29 Avg Risk Polyp Surveillance	↑	01/01/16-12/31/16	na	31	93	64	na	100	94	31	11	16	100	100	88	na	76	na	100	89
OP30 High risk Polyp Surveillance	↑	01/01/16-12/31/16	na	33	82	87	na	100	95	54	100	82	100	88	84	na	52	na	80	64
Timely & Effective Care Heart Attack																				
OP3b Median Time to Transfer AMI	↓	10/01/16-09/30/17	na	na	na	na	na	na	44	na	na	na	na	na	75	na	na	na	na	na
OP4 Aspirin at Arrival AMI Chest Pain	↑	10/01/16-09/30/17	na	96	88	na	100	100	100	95	97	97	100	97	100	96	na	na	98	na
OP5 Median Time to ECG AMI and Chest Pain	↓	10/01/16-09/30/17	na	8	10	na	7	2	7	6	10	6	4	6	10	8	na	na	10	na
Timely & Effective Care- Emergency Department (ED) Throughput																				
ED1b ED Door to Transport	↓	10/01/16-09/30/17	165	240	212	254	na	274	196	234	227	159	174	201	228	203	293	na	199	392
ED2b ED Decision to Transport	↓	10/01/16-09/30/17	12	75	68	82	na	99	58	53	66	40	44	70	46	48	91	na	41	143
OP18b Avg time ED arrival to discharge	↓	10/01/16-09/30/17	na	145	112	139	75	142	106	126	142	83	91	112	140	116	156	na	90	164
OP20 Door to Diagnostic Evaluation	↓	10/01/16-09/30/17	na	12	14	13	4	10	18	26	12	6	8	9	22	10	26	na	15	41
OP21 Time to pain medicaton for long bone fractures2	↓	10/01/16-09/30/17	na	42	48	36	26	26	56	77	59	20	21	37	78	38	58	na	39	67
OP22 Left without being seen	↓	10/01/16-09/30/17	na	1	1	1	1	0	1	0	1	0	0	1	2	1	2	na	1	1
OP23 Head CT stroke patients	↑	10/01/16-09/30/17	na	na	na	na	na	54	100	na	na	na	na	50	na	na	100	na	na	91
Timely & Effective Care Preventive Care %																				
IMM2 Immunization for Influenza	↑	10/01/16-03/31/17	100	99	100	97	na	99	100	99	99	100	100	99	94	84	98	na	99	97
IMM3OP27 FACADHPCT HCW Influenza Vaccination	↑	10/01/16-03/31/17	100	99	97	98	na	99	97	99	97	98	98	99	93	98	99	100	99	96
Timely & Effective Care Blood Clot Prevention & Treatment %																				
VTE6 HAC VTE	↓	10/01/16-09/30/17	na	na	0	2	na	na	na	na	na	na	na	na	na	na	0	na	na	0
Timely & Effective Care Pregnancy & delivery care %																				
PC01 Elective Delivery	↓	10/01/16-09/30/17	na	0	0	0	na	0	0	0	11	na	na	na	0	na	0	na	na	5
Complications - Surgical Complications Rate																				
Hip and Knee Complications2	↓	04/01/14-03/31/17	na	na	4.2	2.8	na	3.3	3.0	na	na	na	3.0	3.2	3.4	na	2.1	na	na	2.7
PSI90 Complications / patient safety for selected indicators	↓	10/01/15-06/30/17	na	0.9	1.0	1.2	na	0.9	1.0	0.9	0.9	1.0	0.9	1.0	1.2	1.0	1.5	na	1.0	1.2
PSI4SURG COMP Death rate among surgical patients with serious treatable complications	↓	10/01/15-06/30/17	na	154.5	155.9	179.9	na	156.9	147.7	na	na	na	na	na	na	na	172.6	na	na	174.7
Readmissions & deaths 30 day rates of readmission %																				
READM30 COPD Chronic obstructive pulmonary disease 30day readmission rate	↓	07/01/14-06/30/17	na	18.5	19.3	19.3	na	18.2	20.1	19.6	18.5	21.8	19.4	21.9	20.1	19.9	18.9	na	19.5	20
READM30 AMI Acute myocardial infarction (AMI) 30day readmission rate	↓	07/01/14-06/30/17	na	na	16.6	17.5	na	18.3	18.1	16.2	na	na	na	15.9	na	na	16.6	na	na	15.5
READM30HF Heart Failure 30Day readmissions rate	↓	07/01/14-06/30/17	na	22.6	22	23	na	25	23.5	24.1	25.2	23.6	21.4	21.4	22	23.7	23.1	na	20.8	22.5
READM30PN Pneumonia 30day readmission rate	↓	07/01/14-06/30/17	na	16.4	17	17.4	na	19.2	19	19.4	17.1	18.8	16.3	17.9	17.6	18.1	17.7	17.3	16.6	18.1

Color Coding Key

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	↑ Higher Better

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Target Quality Measures Rate	Desired Performance	Discharge Dates	DICKENSON COMMUNITY HOSPITAL	FRANKLIN WOODS COMMUNITY HOSPITAL	INDIAN PATH MEDICAL CENTER	JOHNSON CITY MEDICAL CENTER	JOHNSON COUNTY COMMUNITY HOSPITAL	JOHNSTON MEMORIAL HOSPITAL	LAUGHLIN MEMORIAL HOSPITAL, INC	LONESOME PINE HOSPITAL	NORTON COMMUNITY HOSPITAL	RUSSELL COUNTY MEDICAL CENTER	SMYTH COUNTY COMMUNITY HOSPITAL	SYCAMORE SHOALS HOSPITAL	TAKOMA REGIONAL HOSPITAL	UNICOI COUNTY MEMORIAL HOSPITAL	WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WELLMONT HANCOCK COUNTY HOSPITAL	WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WELLMONT HOLSTON VALLEY MEDICAL CENTER
READM30 STK Stroke 30day readmission rate	↓	07/01/14-06/30/17	na	na	12.3	12.3	na	12.3	12	na	14.1	na	11.6	na	12.3	na	14.4	na	na	11.5
READM30 CABG Coronary artery bypass graft (CABG) surgery 30day readmission rate2	↓	07/01/14-06/30/17	na	na	na	11.5	na	na	na	na	na	na	na	na	na	na	13.8	na	na	12.6
READM30 HIPKNEE 30day readmission rate following elective THA / TKA	↓	07/01/14-06/30/17	na	na	5	5.1	na	4.6	3.9	na	na	na	4.4	4.6	4.6	na	4	na	na	4.3
READM30 HOSPWIDE 30day hospitalwide allcause unplanned readmission	↓	07/01/16-06/30/17	na	15.5	15.2	16	na	17	15.8	15.8	15.9	16	15.9	16.5	16.2	16	15.7	15.3	15.1	15.8

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Target Quality Measures Rate	Desired Performance	Discharge Dates	DICKENSON COMMUNITY HOSPITAL	FRANKLIN WOODS COMMUNITY HOSPITAL	INDIAN PATH MEDICAL CENTER	JOHNSON CITY MEDICAL CENTER	JOHNSON COUNTY COMMUNITY HOSPITAL	JOHNSTON MEMORIAL HOSPITAL	LAUGHLIN MEMORIAL HOSPITAL, INC	LONESOME PINE HOSPITAL	NORTON COMMUNITY HOSPITAL	RUSSELL COUNTY MEDICAL CENTER	SMYTH COUNTY COMMUNITY HOSPITAL	SYCAMORE SHOALS HOSPITAL	TAKOMA REGIONAL HOSPITAL	UNICOI COUNTY MEMORIAL HOSPITAL	WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WELLMONT HANCOCK COUNTY HOSPITAL	WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WELLMONT HOLSTON VALLEY MEDICAL CENTER
Readmissions & deaths 30 day death (mortality) rates %																				
MORT30 CABG Coronary artery bypass graft surgery 30day mortality rate	↓	07/01/14-06/30/17	na	na	na	1.9	na	na	na	na	na	na	na	na	na	na	3.1	na	na	4.4
MORT30 COPD 30day mortality rate COPD patients	↓	07/01/14-06/30/17	na	6.5	9.1	9.5	na	7.8	9	7.2	6.5	7.5	7.9	6.5	9.1	8.3	8.3	na	8.5	9.8
MORT30AMI Acute myocardial infarction (AMI) 30day mortality rate	↓	07/01/14-06/30/17	na	na	12.2	11.6	na	13.3	13.5	13.6	13.8	12.7	14.7	14.2	na	na	13.7	na	na	12.2
MORT30HF Heart failure 30day mortality rate	↓	07/01/14-06/30/17	na	12.2	10.6	13.5	na	12.3	14.7	15.6	8.6	13.2	14.7	11.1	11.2	11.2	11.5	na	12	11.6
MORT30PN Pneumonia 30day mortality rate	↓	07/01/14-06/30/17	na	14.2	13.2	18.3	na	14.8	21.2	17.1	14	15.1	16.3	14.9	14.8	15.2	16.6	17.7	17.6	16.9
MORT30STK Stroke 30day mortality rate	↓	07/01/14-06/30/17	na	na	13.7	16.8	na	13.1	13.5	na	14.1	na	14.1	na	14.1	na	15.7	na	na	16.4
Use of medical imaging Outpatient imaging efficiency %																				
OP8 MRI Lumbar Spine for Low Back Pain	↑↓	07/01/16-06/30/17	na	51	na	31.9	na	40	46.7	44.6	na	na	35.6	na	na	na	45.2	na	na	40.8
OP9 Mammography Followup Rates	↑↓	07/01/16-06/30/17	na	na	8.2	6.3	6.9	3.3	14.3	6.4	11.6	6.4	6.1	7	12.3	6.1	8.4	na	5	3.4
OP10 Abdomen CT Use of Contrast Material	↑↓	07/01/16-06/30/17	na	14.7	7.8	6.1	15.7	2.3	8.3	4.4	5.1	2.3	1.5	7.4	1.6	9	6.2	na	11.3	13.6
OP11 Thorax CT Use of Contrast Material	↑↓	07/01/16-06/30/17	na	na	na	0.3	na	0.3	3.3	1.3	na	1.9	na	na	0.8	na	0.4	na	2.6	0.1
OP13 Outpatients who got cardiac imaging stress tests before lowrisk outpatient surgery	↑↓	07/01/16-06/30/17	na	8.2	1.4	2.8	na	7.1	4.4	3.2	3.1	na	5.5	4.7	3.5	na	5.1	na	na	4.5
OP14 Outpatients with brain CT scans who got a sinus CT scan at the same time	↑↓	07/01/16-06/30/17	na	1	na	1.4	na	0.8	1.6	1.5	na	na	1	na	1	na	0.9	na	na	1.1

ATTACHMENT 11

PATIENT SATISFACTION SURVEY RESULTS

Annual Quality Report to the Tennessee and Virginia departments of health

Summary of Quality Indicators

Report Contact: Melanie Stanton

Ballad Health Patient Experience

Sept. 30, 2018

Report Summary

This report provides a summary of performance for patient satisfaction with access to care in outpatient, emergency department and owned physician practice networks as represented in the calendar year Jan. 1, 2017 – Dec. 31, 2017, for the baseline period. The targets for Ballad Health's first year aim to at least maintain or improve over established baselines. The rate is for the time period Jan. 1, 2018 – June 30, 2018.

- Satisfaction with access is defined as patient satisfaction with timeliness/ease of appointment, time spent in waiting room, time spent waiting on answers and efficiency of check-in process in the owned medical practices. NOTE: Data unavailable for CY18 due to change in survey questions for legacy Wellmont Health System practices and the timing of pulse survey for legacy Mountain States Health Alliance-owned practices.
- Satisfaction with access in emergency services is defined as waiting time to treatment and waiting time to physician.
- Satisfaction with access in outpatient services is defined as patient satisfaction with waiting time in registration. Current performance is rated on legacy Mountain States only, as legacy Wellmont did not measure satisfaction with access survey.
- All services have since migrated to a standard survey, as of October 2018.

Target Measures

MMYY	Access Area	Baseline	Rate	Status
CY2018	Satisfaction with Access to Care in Owned Medical Practices	68.35	N/A	N/A
CY2018	Satisfaction with Access to Care in Emergency Services	84.25	84.25	
CY2018	Satisfaction with Access to Care in Outpatient Services	91.36	90.96	

ATTACHMENT 12

FINANCE REPORT ON PATIENT-RELATED PRICES CHARGES, COSTS, REVENUES, PROFIT MARGINS AND OPERATING COSTS

ATTACHMENT 13

EQUALIZATION PLAN STATUS UPDATE

Equalization Plan Update June 30, 2018
Timeline for completion

Step 1: Engage third-party consultants to survey legacy Mountain States and Wellmont team members	Complete
Step 2: Develop new Ballad Health benefit structure and retirement Plan	Complete
Step 3: Process necessary adjustments to team member compensation, related to historical incentive pay	Complete
Step 4: Develop new Ballad Health job codes, pay grades and pay ranges	Complete
Step 5: Evaluate historical Mountain States and Wellmont pay practices	In process; completion by Oct.1
Step 6: Reconcile historical pay rates/Ballad Health pay rates	In process; completion by Dec.31
Step 7: Conduct market rate review	Anticipated start in November. Six-eight month completion time

ATTACHMENT 14

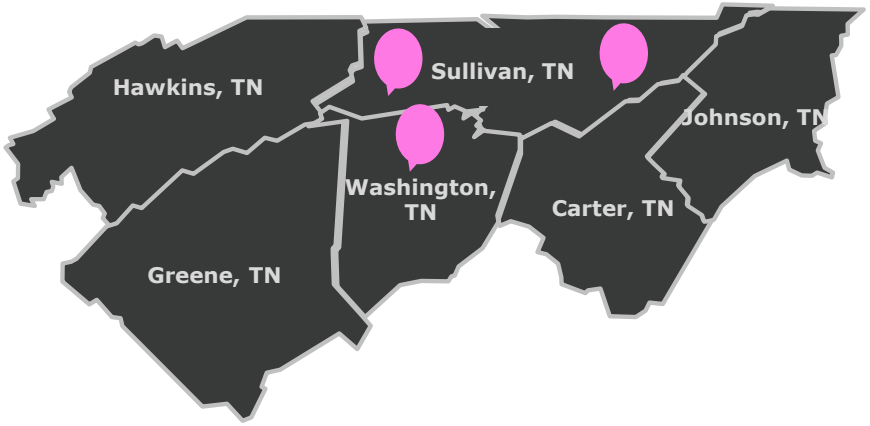
SUMMARY OF RESIDENCY PROGRAM

Virginia residency slots

	Johnston Memorial Hospital		Norton Community Hospital	Lonesome Pine Hospital	Totals
Program(s)	Internal Medicine	Family Medicine	Internal Medicine	Family Medicine	
Academic entity	Virginia College of Medicine		Lincoln Memorial University	Lincoln Memorial University	
Slots available	15	18	30	24	87
Slots filled	15	18	29	19	81

1 *Note: * New program, cap has not been set yet*
Source: ACGME and ETSU Data Points

Tennessee
Total residency slots by hospital



*Note: * New program, cap has not been set yet*
Source: ACGME and ETSU Data Points

Tennessee residency by specialty

Academic entity: East Tennessee State University

Program	Johnson City Medical Center	Holston Valley Medical Center	Bristol Medical Center	Woodridge Psychiatric Hospital	Slots available	Slots Filled
Internal medicine	15	12	5		80	32
Surgery	13	8	5		34	26
Psychiatry				7	25	7
Pediatrics	19				24	19
Family medicine – Bristol			24		24	24
Family medicine – Johnson City Medical Center	18				21	18
Family medicine – Holston Valley		18			18	18
Orthopedics		10			15	10
OB/GYN	12	1			13	13
Cardiology	5				9	5
Pulmonology and critical care	1	1.5	3.5		9	6
Pathology	4				8	4
Gastroenterology	2.5				6	2.5
Infectious disease	2				6	2
Oncology	5				6	5

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 44-0176 | Period: From 07/01/2016 To 03/31/2017 | Worksheet E Part A Date/Time Prepared: 8/25/2017 9:29 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,146,449	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,026,550	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	139,461	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	8,847,841	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	140.09	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	4.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	2.49	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	1.51	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	1.61	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	1.51	12.00
13.00	Total allowable FTE count for the prior year.	1.51	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	1.51	14.00
15.00	Sum of lines 12 through 14 divided by 3.	1.51	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	1.51	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.010779	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.010659	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.010659	21.00
22.00	IME payment adjustment (see instructions)	41,668	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	51,397	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	6.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.10	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.10	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000714	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000191	27.00
28.00	IME add-on adjustment amount (see instructions)	1,370	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	1,690	28.01
29.00	Total IME payment (sum of lines 22 and 28)	43,038	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	53,087	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	9.08	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.68	31.00
32.00	Sum of lines 30 and 31	30.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)	14.59	33.00
34.00	Disproportionate share adjustment (see instructions)	261,636	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 44-0176 | Period: From 07/01/2016 To 03/31/2017 | Worksheet E-4 | Date/Time Prepared: 8/25/2017 9:29 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			4.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			2.24	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			1.76	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.21	6.00
7.00	Enter the lesser of line 5 or line 6			1.21	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8 .00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	1.21	0.00	1.21	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	1.21	0.00	1.21	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	1.21	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.76	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.62	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.53	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	1.53	0.00		17.00
18.00	Per resident amount	82,745.58	0.00		18.00
19.00	Approved amount for resident costs	126,601	0	126,601	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			6.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			97,347.74	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			126,601	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	4,425	5,988		26.00
27.00	Total Inpatient Days (see instructions)	16,048	16,048		27.00
28.00	Ratio of inpatient days to total inpatient days	0.275735	0.373131		28.00
29.00	Program direct GME amount	34,908	47,239		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		6,675		30.00
31.00	Net Program direct GME amount			75,472	31.00

			1.00
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	14,243,410	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	42,894,050	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,728,915	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	51,368,740	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	474.57	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	83.14	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	83.14	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	95.64	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	83.14	12.00
13.00	Total allowable FTE count for the prior year.	63.96	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	63.96	14.00
15.00	Sum of lines 12 through 14 divided by 3.	70.35	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	70.35	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.148239	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.134108	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.134108	21.00
22.00	IME payment adjustment (see instructions)	4,033,333	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	3,626,119	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	7.80	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	12.50	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	7.80	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.016436	26.00
27.00	IME payments adjustment factor. (see instructions)	0.004372	27.00
28.00	IME add-on adjustment amount (see instructions)	249,805	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	224,584	28.01
29.00	Total IME payment (sum of lines 22 and 28)	4,283,138	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	3,850,703	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	9.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)	26.13	31.00
32.00	Sum of lines 30 and 31	36.10	32.00
33.00	Allowable disproportionate share percentage (see instructions)	19.00	33.00
34.00	Disproportionate share adjustment (see instructions)	2,714,030	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 44-0063 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-4 | Date/Time Prepared: 11/27/2017 1:37 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			63.96	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			63.96	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			95.64	6.00
7.00	Enter the lesser of line 5 or line 6			63.96	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	61.39	26.96	88.35	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	41.06	18.03	59.09	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	41.06	18.03		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	39.50	19.11		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	40.77	18.06		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	40.44	18.40		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	40.44	18.40		17.00
18.00	Per resident amount	82,745.58	82,745.58		18.00
19.00	Approved amount for resident costs	3,346,231	1,522,519	4,868,750	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			8.92	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			31.68	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			8.24	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			97,347.74	23.00
24.00	Multiply line 22 time line 23			802,145	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			5.670.895	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	36,615	34,507		26.00
27.00	Total Inpatient Days (see instructions)	149,496	149,496		27.00
28.00	Ratio of inpatient days to total inpatient days	0.244923	0.230822		28.00
29.00	Program direct GME amount	1,388,933	1,308,967		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		184,957		30.00
31.00	Net Program direct GME amount			2,512,943	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 49-0053 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/20/2017 10:00 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,150,702	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	19,379,977	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	146,548	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	9,241,380	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	110.72	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	14.48	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	14.48	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.130780	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.133888	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.130780	21.00
22.00	IME payment adjustment (see instructions)	1,759,064	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	636,731	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	1,759,064	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	636,731	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	8.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.80	31.00
32.00	Sum of lines 30 and 31	24.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.16	33.00
34.00	Disproportionate share adjustment (see instructions)	584,653	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 49-0053 | Period: From 07/01/2016 To 06/30/2017 | worksheet E-4 | Date/Time Prepared: 11/20/2017 10:00 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	14.48	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	14.48	0.00		17.00
18.00	Per resident amount	85,493.03	0.00		18.00
19.00	Approved amount for resident costs	1,237,939	0	1,237,939	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,237,939	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	15,026	5,648		26.00
27.00	Total Inpatient Days (see instructions)	30,610	30,610		27.00
28.00	Ratio of inpatient days to total inpatient days	0.490885	0.184515		28.00
29.00	Program direct GME amount	607,686	228,418		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		32,275		30.00
31.00	Net Program direct GME amount			803,829	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 49-0001 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Date/Time Prepared: 2/22/2018 10:29 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,508,262	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	16,683	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	3,005,628	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	60.67	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	14.78	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	4.52	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	19.30	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	21.46	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	19.30	12.00
13.00	Total allowable FTE count for the prior year.	19.18	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	19.30	14.00
15.00	Sum of lines 12 through 14 divided by 3.	19.26	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	19.26	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.317455	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.303385	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.303385	21.00
22.00	IME payment adjustment (see instructions)	995,295	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	459,645	22.01
	~~Indirect Medical Education Adjustment~~ for the Add-on for § 422 of the ~~MMA~~		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	2.16	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	995,295	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	459,645	29.01
	Disproportionate Share Adjustment		
30.00	~~Percentage of SSI re~~cipient patient days to Medicare Part A patient days (see instructions)	10.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.51	31.00
32.00	Sum of lines 30 and 31	34.95	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	195,248	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 49-0001 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-4 | Date/Time Prepared: 2/22/2018 10:29 am

Title XVIII | Hospital | PPS

					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.				0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)				14.78	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA				0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)				0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))				0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)				4.52	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts				19.30	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				21.46	6.00
7.00	Enter the lesser of line 5 or line 6				19.30	7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	21.46	0.00	21.46		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	19.30	0.00	19.30		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01
11.00	Total weighted FTE count	19.30	0.00			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	19.18	0.00			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	19.30	0.00			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	19.26	0.00			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	19.26	0.00			17.00
18.00	Per resident amount	94,011.25	0.00			18.00
19.00	Approved amount for resident costs	1,810,657	0	1,810,657		19.00
					1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)				0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)				2.16	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)				0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)				0.00	23.00
24.00	Multiply line 22 time line 23				0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)				1,810,657	25.00
		Inpatient Part A	Managed care			
		1.00	2.00	3.00		
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,821	1,724			26.00
27.00	Total Inpatient Days (see instructions)	10,255	10,255			27.00
28.00	Ratio of inpatient days to total inpatient days	0.470112	0.168113			28.00
29.00	Program direct GME amount	851,212	304,395			29.00
30.00	Reduction for direct GME payments for Medicare Advantage		43,011			30.00
31.00	Net Program direct GME amount			1,112,596		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 44-0012 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/15/2017 5:03 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	9,652,293	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	29,045,015	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	525,805	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	27,014,006	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	248.50	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	39.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	39.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	33.07	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	33.07	12.00
13.00	Total allowable FTE count for the prior year.	30.21	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	30.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	31.09	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	31.09	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.125111	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.121613	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.121613	21.00
22.00	IME payment adjustment (see instructions)	2,485,528	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	1,735,110	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	4.05	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-5.93	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	2,485,528	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,735,110	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)	11.50	31.00
32.00	Sum of lines 30 and 31	17.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.41	33.00
34.00	Disproportionate share adjustment (see instructions)	426,638	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 44-0012 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-4 | Date/Time Prepared: 11/15/2017 5:03 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			30.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			30.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			35.47	6.00
7.00	Enter the lesser of line 5 or line 6			30.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	29.21	4.68	33.89	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	24.71	3.96	28.67	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	24.71	3.96		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	24.69	3.56		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	25.24	4.04		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	24.88	3.85		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	24.88	3.85		17.00
18.00	Per resident amount	81,139.11	81,139.11		18.00
19.00	Approved amount for resident costs	2,018,741	312,386	2,331,127	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			4.80	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			5.47	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			4.59	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			94,457.76	23.00
24.00	Multiply line 22 time line 23			433,561	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,764,688	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	27,318	17,789		26.00
27.00	Total Inpatient Days (see instructions)	72,228	72,228		27.00
28.00	Ratio of inpatient days to total inpatient days	0.378219	0.246290		28.00
29.00	Program direct GME amount	1,045,658	680,915		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		96,213		30.00
31.00	Net Program direct GME amount			1,630,360	31.00

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	9,904,424	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	34,170,062	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	887,114	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	41,891,596	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	318.16	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	45.38	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	45.38	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	45.37	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	45.37	12.00
13.00	Total allowable FTE count for the prior year.	45.38	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	45.38	14.00
15.00	Sum of lines 12 through 14 divided by 3.	45.38	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	45.38	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.142633	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.141173	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.141173	21.00
22.00	IME payment adjustment (see instructions)	3,268,916	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	3,107,016	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422o f the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	6.23	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-0.01	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	3,268,916	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	3,107,016	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	7.51	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.38	31.00
32.00	Sum of lines 30 and 31	22.89	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.10	33.00
34.00	Disproportionate share adjustment (see instructions)	892,509	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 44-0017 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-4 | Date/Time Prepared: 11/15/2017 5:20 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ~~ending on or before~~ December 31, 1996.			34.91	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			34.91	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			46.56	6.00
7.00	Enter the lesser of line 5 or line 6			34.91	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	27.75	17.99	45.74	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	20.81	13.49	34.30	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	20.81	13.49		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	20.60	13.41		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	21.20	12.55		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	20.87	13.15		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	20.87	13.15		17.00
18.00	Per resident amount	81,131.02	81,131.02		18.00
19.00	Approved amount for resident costs	1,693,204	1,066,873	2,760,077	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			6.23	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			11.65	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			6.12	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			95,448.60	23.00
24.00	Multiply line 22 time line 23			584,145	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			3,344,222	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	23,392	24,365		26.00
27.00	Total Inpatient Days (see instructions)	76,968	76,968		27.00
28.00	Ratio of inpatient days to total inpatient days	0.303919	0.316560		28.00
29.00	Program direct GME amount	1,016,373	1,058,647		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		149,587		30.00
31.00	Net Program direct GME amount			1,925,433	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 49-0114 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/15/2017 1:13 pm

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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,414,834	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,662,681	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	0	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	2,354,457	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	101.36	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	19.65	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	19.65	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	13.81	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	13.81	12.00
13.00	Total allowable FTE count for the prior year.	14.91	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	14.60	14.00
15.00	Sum of lines 12 through 14 divided by 3.	14.44	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	14.44	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.142463	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.145808	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.142463	21.00
22.00	IME payment adjustment (see instructions)	454,720	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	176,160	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-5.84	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	454,720	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	176,160	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	11.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.68	31.00
32.00	Sum of lines 30 and 31	34.91	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	182,326	34.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 49-0114 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-4 | Date/Time Prepared: 11/15/2017 1:13 pm

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					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.				0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)				20.28	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA				0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)				0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))				0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)				0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts				20.28	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				15.26	6.00
7.00	Enter the lesser of line 5 or line 6				15.26	7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	14.86	0.00	14.86		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	14.86	0.00	14.86		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01
11.00	Total weighted FTE count	14.86	0.00			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	16.30	0.00			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	14.62	0.00			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	15.26	0.00			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	15.26	0.00			17.00
18.00	Per resident amount	92,231.02	92,231.02			18.00
19.00	Approved amount for resident costs	1,407,445	0	1,407,445		19.00
					1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)				0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)				0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)				0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)				0.00	23.00
24.00	Multiply line 22 time line 23				0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)				1,407,445	25.00
		Inpatient Part A	Managed care			
		1.00	2.00	3.00		
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	3,275	1,236			26.00
27.00	Total Inpatient Days (see instructions)	7,354	7,354			27.00
28.00	Ratio of inpatient days to total inpatient days	0.445336	0.168072			28.00
29.00	Program direct GME amount	626,786	236,552			29.00
30.00	Reduction for direct GME payments for Medicare Advantage		33,425			30.00
31.00	Net Program direct GME amount			829,913		31.00

ATTACHMENT 15

SUMMARY OF ACADEMIC PARTNERSHIPS

Academic partnerships

- East Tennessee State University – Johnson City
- University of Virginia – Charlottesville, Virginia
- King University – Bristol
- Emory & Henry College – Emory, Virginia
- Virginia College of Osteopathic Medicine – Blacksburg, Virginia

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
0318.15sd	Stepanov, Nonna	Industry	Chart Review	Tobacco Region Revitalization Committee	Cancer	Identifying Barriers to Screening and Treatment of Women's Cancers in the Appalachian Region of Virginia
0414.12sw	Paul, Timir K, MD	Not Funded	Chart Review	Non-Funded	Cardiology	Correlation between single photon emission computerized tomography (SPECT) Technetium99 myocardial perfusion imaging stress test & anatomically small caliber left anterior descending artery assessed by coronary angiogram
0516.1sw	Paul, Timir K, MD	Not Funded	Chart Review	Non-Funded	Cardiology	Coronary Artery Disease Management Outcomes in Patients with Baseline Thrombocytopenia
0117.3sw	Paul, Timir K, MD	Not Funded	Chart Review	Non-Funded	Cardiology	ACS outcomes for patients on anti-platelet medications
0417.18sw	Paul, Timir K, MD	Not Funded	Chart Review	Non-Funded	Cardiology	Causes and Prevention of Hospital Readmissions in Rural Northeastern Tennessee and Southern Virginia Compared to the Entire United States
0118.12sw	Smith, Steven MD	Not Funded	Chart Review	Non-Funded	Cardiology	Triple Rule our Cardiac CT Correlation to Disease State
0618.1sw	Lewis, Catherine MD	Not Funded	Chart Review	Non-Funded	General Surgery/Cancer	Disease Association among Patients with Coal Workers Pneumoconiosis
0216.10sw	Chakraborty, Kanishka, MD	Not Funded	Chart Review	Non-Funded	Internal Medicine/Oncology	The Diagnostic Role of Neutrophil to Lymphocyte Ratio's in Breast, Colorectal, and Lung cancer.
516.20sw	Chakraborty, Kanishka, MD	Not Funded	Chart Review	Non-Funded	Internal Medicine/Oncology	Influence of therapy to 'Time to Progression' in Microsatellite Instability-High (MSI-H) and Microsatellite Stable Tumors (MSS) - Stage III & Stage IV Colon Cancer in RCC
1117.16sd	Jones, Hannah DNP	Not Funded	Chart Review	Non-Funded	Nursing	Evaluating Mental Health Nursing Perspectives and Knowledge of Psychiatric Advance Directives: An Educational Intervention
0110.12sdw	Lowe, Krista, PT	Not Funded	Chart Review	Non-Funded	Nursing	CHOMP
1116.9s	Johnson, Michelle	Not Funded	Chart Review	Non-Funded	Nutrition	Creating a Scale for Preschoolers: Measuring Nutrition Knowledge, Beliefs, and Behaviors
0318.35sw	Olsen, Martin MD	Not Funded	Chart Review	Non-Funded	Obstetrics and Gynecology	Follow-up of neonates born to pregnant women weaned off buprenorphine
1017.8sw	Olsen, Martin MD	Not Funded	Chart Review	Non-Funded	Obstetrics and Gynecology	Follow-up Neonates born to pregnant women on buprenorphine
0617.3e	Patel, Archi	Not Funded	Chart Review	Non-Funded	Pathology	Correlation between PAP negative and HPV testing positive
0218.8sw	Zayko, Maria DO	Not Funded	Chart Review	Non-Funded	Pathology	The role of rapid on-site evaluation in correlating surgical and cytological specimens in lung masses
0616.6sw	Wood, David, MD	Not Funded	Chart Review	Non-Funded	Pediatrics	Development of a research database for studies of infants exposed to drugs that can cause neonatal abstinence syndrome (NAS)
0118.4sw	Brewster, Aaryn	Not Funded	Chart Review	None	Pharmaceutical Sciences	Effect of Adherence to Guidelines-Directed Therapy on Clinical Outcomes in the Treatment of Staphylococcus Aureus Bacteremia
1016.33sw	Lewis, Paul PharmD	Not Funded	Chart Review	Non-Funded	Pharmacy	Impact of a 72 hour automatic stop and pharmacist-led review on the empiric use of vancomycin

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
1015.13sw	Stewart, David, Pharmd, transferred from Lindquist, Desirae, PharmD	Not Funded	Chart Review	Non-Funded	Pharmacy	Comparison of Post-operative Bleeding in Patients Undergoing Total Hip Arthroplasty or Total Knee Arthroplasty Receiving Enoxaparin, Rivaroxaban, or Aspirin for Thromboprophylaxis
1017.23sw	Lewis, Paul PharmD	Not Funded	Chart Review	Non-Funded	Pharmacy	Accuracy of Antiretroviral Medication Prescribing in a Community Teaching Hospital: A Medication Use Evaluation
1017.21sw	Lines, Jacob PharmD	Not Funded	Chart Review	Non-Funded	Pharmacy	Evaluation of Vancomycin Dosing Targeting Conservative Trough Concentrations for the Treatment of Methicillin-Resistant Staphylococcus aureus Bloodstream Infections
1016.40sw	Davis, Olivia, PharmD	Not Funded	Chart Review	Non-Funded	Pharmacy Practice	Impact of a rapid diagnostic blood culture identification panel on timing of appropriate antimicrobial therapy in patients with bloodstream infections
1117.7sw	Ikele, Lilian	Not Funded	Chart Review	Non-Funded	Pharmacy Practice	Comparison of Guideline-Directed Therapy Versus Nonstandard Therapy For The Treatment of Clostridium Difficile Infection
0813.3sw	Mamudu, Hadii, MD	Not Funded	Chart Review	Non-Funded	Public Health	Cardiovascular Health Management
0117.2sw	Ramos, Trevy, DO	Not Funded	Chart Review	Non-Funded	Surgery	Gallbladder Cancer in Rural Appalachia: Incidence, Prevalence and Stage at Diagnosis
1013.6sw	Rush, Daniel, MD	Not Funded	Chart Review	Non-Funded	Vascular Surgery	Retrospective evaluation of peripheral vascular disease
0612.5s	Brahmbhatt, Vipul, M.D.	Industry	Device	St. Jude Medical	Cardiology	QUADRIPOLAR Pacing Post Approval Study
1110.3f	Khan, Ahmed, MD	Industry	Device	St. Jude Medical	Cardiology	QuickFlex Micro Model 1258 Left Heart Pacing Lead Post Approval Study
1116.11	Khan, Ahmed, MD	Industry	Device	St. Jude Medical	Cardiology	MultiPoint Pacing Post Market Study (MPP PMS)
0616.14	Shams, Tanzid MD	Industry	Device	Jan Medical Inc.	Neurology	Non-Blinded Data Collection Study of Concussion using the BrainPulse
1217.15f	Dodd, William, MD	Not Funded	Device	None	Pediatrics	Detecting Neonatal Abstinence Syndrome Through Accelerometry
0417.4	Reddy, Chakradhar, MD	Industry	Drug	Intercept	Internal Medicine/Gastroenterology	The REGENERATE 747-303 Clinical Study
0915.12f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	SJMB12: A Clinical and Molecular Risk-Directed Therapy for Newly Diagnosed Medulloblastoma
0416.8f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	RMS13: Risk adapted Focal Proton Beam Radiation and/or Surgery in Participants with Low, Intermediate and High Risk Rhabdomyosarcoma Receiving Standard or Intensified Chemotherapy
0215.14f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	ALLR18: A Phase II Study of Therapy for Pediatric Relapsed or Refractory Precursor B-Cell Acute Lymphoblastic Leukemia and Lymphoma
00-092f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	SJCRH, TOTAL XV: Total Therapy Study XV for Newly Diagnosed Patients with Acute Lymphoblastic Leukemia
07-070f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	Total Therapy Study XVI for Newly Diagnosed Pts. w/Acute Lymphoblastic Leukemia
08-209f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	HODO8: Reduced Duration Stanford V Chemotherapy w/Low-Dose Tailored-Field Radiation Therapy for Favorable Risk Pediatric Hodgkin Lymphoma

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
0713.4f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	NHL16: Study for newly diagnosed pts. w/ acute lymphoblastic lymphoma
1014.11f	Popescu, Marcela, MD	Industry	Drug	St. Jude, NIH	Pediatric Oncology	CSqHPV: Quadrivalent Human Papillomavirus (qHPV) Vaccine in Cancer Survivors: Phase II Open-Label Vaccine Trial
0515.24f	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	HLHR13: ADCETRIS (brentuximab vedotin) substituting vincreistine in the oepa/copdac regimen [treatment group 3 (TG3) of Euro-Net C1] with involved node radiation therapy for high risk pediatric Hodgkin's lymphoma IND# 118603
0710.7fw	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	TBANK: Protocol for Collecting, Banking, and Distributing Human Tissue Samples: TBANK St. Jude Children's Research Hospital Tissue Resources Core Facility
0417.10f	Popescu, Marcela, MD	Industry	Drug	St. Jude, NIH	Pediatric Oncology	TOT17: TOTAL THERAPY STUDY XVII (TOTXVII) for Newly Diagnosed Patients with Acute Lymphoblastic Leukemia and Lymphoma
318.26	Popescu, Marcela, MD	Industry	Drug	St. Jude	Pediatric Oncology	The REGENERATE 747-303 Clinical Study
1014.6	Goodkin, Karl, MD	Industry	Drug	AstraZeneca	Psychiatry	A 24-Month, Multicenter, Randomized, Double-blind, placebo-controlled, parallel-group, Efficacy, Safety, Tolerability, Biomarker, and Pharmacokinetic Study of AZD3293 in Early Alzheimer's Disease (the AMARANTH Study)
1217.7	Goodkin, Karl, MD	Industry	Drug	Eli Lilly	Psychiatry	I8D-MC-AZFD: A Randomized, Double-Blind,, Delayed-Start Study of LY3314814 (AZD3293) in Early Alzheimer's Disease Dementia (Extension of Study AZES, The AMARANTH Study)
1117.17	Goodkin, Karl, MD	Industry	Drug	Janssen	Psychiatry	A Double-Blind, Randomized, Placebo-controlled Study to Evaluate the Efficacy and Safety of Intranasal Esketamine in Addition to Comprehensive Standard of Care for the Rapid Reduction of the Symptoms of Major Depressive Disorder, Including Suicidal Ideaton, in Adult Subjects Assessed to be at Imminent Risk for Suicide
1015.9f	Colvett, Kyle, MD	Industry	Drug	Galera	Radiation Oncology	A Phase 2, Randomized, Double-Blind, Placebo-Controlled, Multi-Center, Trial of the Effects of Intravenous GC4419 on the Incidence and Duration of Severe Oral Mucositis (OM) in Patients Receiving Post-Operative or Definitive Therapy with Single-Agent Cisplatin plus IMRT for Locally Advanced, Non-Metastatic Squamous Cell Carcinoma of the Oral Cavity or Oropharynx
0518.14f	Colvett, Kyle, MD	Industry	Drug	Funded	Radiation Oncology	PREVLAR: A Phase 2a Randomized, Parallel Group, Open-Label, Multicenter Study to Assess the Safety and Efficacy of Different Schedules of RRx-001 in the Attenuation of Oral Mucositis in Patients Receiving Concomitant Chemoradiation for the Treatment of Locally Advanced Squamous Cell Carcinomas of the Oral Cavity or Oropharynx
0916.4f	Massey, Samuel, MD	Not Funded	HUD	Non-Funded	Neuroendovascular surgery	HUD 09-0222 Low-Profile Visualized Intraluminal Support Device (LVIS and LVIS Jr.)
0916.3f	Massey, Samuel, MD	Not Funded	HUD	Non-Funded	Neuroendovascular surgery	03-0101 Stryker Wingspan Stent System with Gateway PTA Balloon Catheter
09-247f	Massey, Samuel, MD	Industry	HUD	Cordis Neurovascular Inc	Neuroendovascular surgery	HUD Enterprise Vascular Reconstruction Device and Delivery System

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
06-178f	Massey, Samuel, MD	Industry	HUD	Boston Scientific	Neuroendovascular surgery	HUD the Neuroform Microdelivery Stent System A Humanitarian Use Device
06-044s	Bishop, Thomas, MD	Not Funded	Interview	None	Family Medicine/Psychology/Oncology	To Identify the Role of Patients' Personal-Familial-Cultural Experiences in Cancer Decision Making and to Develop an Effective Cancer Care Communication Training Module aka: Instructional Modules to Improve Cancer Communication
1213.12f	Hiremagalur, Shobha, MD	Industry	Observational	St. Jude Medical	Cardiology	St. Jude Medical Cardiac Lead Assessment Study
0917.13e	Click, Ivy, PhD	Not Funded	Survey	Non-Funded	Family Medicine	Knowledge, Attitudes, and Practices of East Tennessee Medical Providers towards Transgender Patients
1113.14e	Shah, Darshan, MD	Not Funded	Survey	Non-Funded	Neonatology	Feelings of Neonatal Intensive Care Unit's Nurses toward Neonatal Abstinence Syndrome and it's Effects on Care of Infant and Family
08-183E	Felty, Martha RN,MSN	Not Funded	Survey	Non-Funded	Nursing	A 24-Month, Multicenter, Randomized, Double-blind, placebo-controlled, parallel-group, Efficacy, Safety, Tolerability, Biomarker, and Pharmacokinetic Study of AZD3293 in Early Alzheimer's Disease (the AMARANTH Study)
1116.24e	Chesley, Colin, PhD	Not Funded	Survey	Non-Funded	Public Health	Merging Cultures: Organizational Behavior, Leadership, and Differentiation in a Health System Merger
0714.6s	Elgazzar, Mohamed, MD	Not Funded	Tissue Analysis	Non-Funded	Internal Medicine	microRNAs and myeloid cell development during sepsis
0612.8s	Shah, Darshan, MD	Institutional	Tissue Analysis	ETSU Major RDC	Neonatology	Correlation of Newborn's Clinical Course with Infant's Drug Testing and Maternal Drug Use
06-209sw	Barklow, Thomas, MD	Not Funded	Tissue Analysis	Non-Funded	Pathology	BER-EP4 Positive Staining in Bowen's Disease
0817.5f	Los, Evan, MD	Institutional	Tissue Analysis	Research Development Committee	Pediatrics	Biomarkers in Exhaled Breath of Glucose Fluctuation in Type 1 Diabetes
1014.30sw	Aboaziza, Ahmad, MD	Not Funded	N/A	Non-Funded	N/A	Comparing length of hospital stay amount Neonatal Abstinence Syndrome (NAS) babies
05-256f	Hamati, Fawwaz, MD	Industry	N/A	St. Jude Medical	N/A	HUD Jostent Coronary Stent Graft- H00001
1114.4	Morin, David, MD	Industry	N/A	Holston Medical Group/ Merck	N/A	A Phase III, Randomized, Placebo-Controlled, Parallel-Group, Double-Blind Clinical Trial to Study the Efficacy and Safety of MK-8931 (SCH 900931) in Subjects with Amnestic Mild Cognitive Impairment Due to Alzheimer's Disease (Prodromal AD)
1017.13s	Proffitt, Robin	Not Funded	N/A	Unknown	N/A	Introduction of the (qSOFA) Tool in the ED Setting: Nurse Perception and the Impact on Patient Care
1017.9sw	Reddy, Chakradhar, MD	Not Funded	N/A	Unknown	N/A	A Retrospective review assessing the efficacy of PPIs in preventing gastrointestinal bleeding in patients on DAPT
0315.3f	Shah, Darshan, MD	Industry	N/A	INC Research , LLC/Astella Pharma Europe B.V.	N/A	A Phase 3, Multicenter, Investigator-blind, Randomized, Parallel Group Study to Investigate the Safety and Efficacy of Fidaxomicin Oral Suspension or Tablets Taken q12h, and Vancomycin Oral Liquid or Capsules Taken q6h, for 10 Days in Pediatric Subjects with Clostridium difficile-associated Diarrhea
05-226f	Wiles, David, MD	Industry	N/A	East Tennessee Barin and Spine Center/ Metronic Inc.	N/A	Feelings of Neonatal Intensive Care Unit's Nurses toward Neonatal Abstinence Syndrome and it's Effects on Care of Infant and Family

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
552980-156	Metzger, D. Christopher	Industry	N/A	Cook Incorporated	N/A	Zilver PTX V
1167890-2	Metzger, D. Christopher	Industry	N/A	Endologix, Inc.	N/A	EVAS II Confirmatory Study: Prospective, Multicenter, Single Arm Safety and Effectiveness Confirmatory Study of Endovascular Abdominal Aortic Aneurysm Repair using the Nellix® System
1213351-1	Shafiei, Fereidoon	Industry	N/A	Investigator Initiated	N/A	AAD Loading Retrospective and AAD Loading Prospective-Afib Sub-study
751890-13	Metzger, D. Christopher	Industry	N/A	Mercator MedSystems, Inc.	N/A	DANCE: Delivery of Dexamethasone to the Adventitia to eNhance Clinical Efficacy after Femoropopliteal Revascularization
1125749-1	Metzger, D. Christopher	Industry	N/A	PQ Bypass, Inc.	N/A	Detour II
1035023-22	Whitaker, Jack	Industry	N/A	The Medicines Company	N/A	ORION-3 - An open label, active comparator extension trial to assess the effect of long term dosing of inclisiran and evolocumab given as subcutaneous injections in subjects with high cardiovascular risk and elevated LDL-C
706613-32	Metzger, D. Christopher	Federal	N/A	The National Institute of Neurological Disorders and Stroke (NINDS)	N/A	CREST 2: Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial; IDE #G130221
885338-27	Metzger, D. Christopher	Industry	N/A	TherOx, Inc.	N/A	IC-HOT STUDY: SS02 Therapy G120029/S008
834386-3	Shipstone, Asheesh	Industry	Biospecimen	C&M LabPro, LLC	N/A	Prospective Collection of Biospecimens for Research
837110-4	Shipstone, Asheesh	Industry	Biospecimen	Medical Research Network LLC	N/A	Multi-site collection of human bio fluids to be used in the development and or testing of new and existing in vitro diagnostic assays or evaluation of therapeutics.
813841-4	Shipstone, Asheesh	Industry	Biospecimen	SERATRIALS	N/A	SERATRIALS 15002 Prospective Collection of Samples for Research
414779-2	Abdel Nour, Souheil	Not Funded	Case Report	None	N/A	Purulant Pericarditis: A Case Report.
139032-11	Shipstone, Asheesh	Federal	Companion Study	NCI	N/A	CALGB 9497: Health Status and Quality of Life in Patients with Early Stage Hodgkin's Disease(A Companion Study to CALGB 9391)
835939-93	Merrill, James	Industry	Device	Medtronic	N/A	WRAP-IT: World-wide Randomized Antibiotic Envelope Infection Prevention Trial
1041021-8	Mayhew, Marc	Industry	Device	Philips Volcano	N/A	DEFINE PCI: Physiologic Assessment Of Coronary Stenosis Following PCI
950820-4	Kyker, Keith	Industry	Device	St. Jude Medical	N/A	MPP PMS - MultiPoint Pacing Post Market Study
351976-80	Merrill, James	Industry	Device	St. Jude Medical	N/A	Quad PAS: Quadripolar Pacing Post Approval Study
136635-21	Metzger, D. Christopher	Industry	Device	Abbott	Cardiology	GraftMaster RX; HDE #000001; Wellmont Holston Valley Medical Center, 130 W. Ravine Road, Kingsport, TN 37660
220884-78	Metzger, D. Christopher	Industry	Device	Abbott	Cardiology	EXCEL Clinical Trial: Evaluation of Xience PRIME or Xience V versus Coronary Artery Bypass Surgery for Effectiveness of Left Main Revascularization; Protocol 10-389
1047656-9	Metzger, D. Christopher	Industry	Device	Alucent Medical, Inc.	Cardiology	Alucent: Natural Vascular Scaffold (NVS) Therapy for the Treatment of Atherosclerotic Lesions in the Superficial Femoral Artery (SFA) and/or Proximal Popliteal Artery (PPA); IND 122324
921641-15	Gall, Jr., Stanley	Industry	Device	AtriCure, Inc.	Cardiology	ATLAS Study: AtriClip Left Atrial Appendage Exclusion Concomitant to Structural Heart Procedures
554424-27	Metzger, D. Christopher	Industry	Device	Boston Scientific	Cardiology	REINFORCE: Renal Denervation Using the Vessix Reduce Catheter and Vessix Generator for the Treatment of Hypertension. IDE G130240
543206-56	Metzger, D. Christopher	Industry	Device	CV Ingenuity Corporation	Cardiology	ILLUMENATE Pivotal Post-Approval Study: Prospective, Randomized, Single-Blind, U.S. Multi-Center Study to Evaluate Treatment of Obstructive Superficial Femoral Artery or Popliteal Lesions With A Novel Paclitaxel-Coated Percutaneous Angioplasty Balloon

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
1101277-13	Metzger, D. Christopher	Industry	Device	Eximo Medical	Cardiology	EXIMO: Safety And Effectiveness Evaluation Of EXIMO Medical's B-Laser™, A Hybrid Atherectomy Device, In Subjects Affected With PAD
810127-45	Metzger, D. Christopher	Industry	Device	Intact Vascular, Inc.	Cardiology	TOBA II: Tack Optimized Balloon Angioplasty Study for the Superficial Femoral and Proximal Popliteal Arteries Using the Tack Endovascular System™
463937-99	Metzger, D. Christopher	Industry	Device	Lutonix	Cardiology	BTK Trial: A Prospective, Multicenter, Single Blind, Randomized, Controlled Trial Comparing the Lutonix Drug Coated Balloon vs. Standard Balloon Angioplasty for Treatment of Below-the-Knee (BTK) Arteries. IDE: G130007
258203-426	Metzger, D. Christopher	Industry	Device	Lutonix	Cardiology	LEVANT 2: A prospective, multicenter, single blind, randomized, controlled trial comparing the Moxy Drug Coated Balloon vs. Standard Balloon Angioplasty for treament of femoropopliteal arteries. IDE# G100255
888290-8	Metzger, D. Christopher	Industry	Device	Lutonix	Cardiology	CONFIRM (LEVANT PAS #2): A Prospective, Multicenter, Single Arm, Post-Approval Study of the Lutonix Drug Coated Balloon for Treatment of Femoropopliteal Arteries in United States Females
333661-118	Metzger, D. Christopher	Industry	Device	Medtronic	Cardiology	IN.PACT SFA II: Randomized trial of IN.PACT (Paclitaxel) Admiral Drug-Eluting Balloon (DEB) vs Standard PTA for the Treatment of Atherosclerotic Lesions in the Superficial Femoral Artery (SFA) and/or Proximal Popliteal Artery (PPA) IDE: G110200
871390-49	Metzger, D. Christopher	Industry	Device	MicroVention, Inc., TERUMO Corporation	Cardiology	CONFIDENCE TRIAL: Carotid Stent Trial to Evaluate the Safety and Efficacy of the Roadsaver Stent Used in Conjunction with the Nanoparasol Embolic Protection System for Patients at Increased Risk for Adverse Events from Carotid Endarterectomy; IDE G140249
1104672-10	Metzger, D. Christopher	Industry	Device	Shockwave Medical, Inc.	Cardiology	Disrupt PAD III - Randomized study of the Shockwave Medical Peripheral Lithoplasty® System used in combination with DCB versus standard balloon angioplasty used in combination with DCB to treat moderate and severely calcified femoropopliteal arteries.
900799-12	Metzger, D. Christopher	Industry	Device	Silk Road Medical, Inc.	Cardiology	The ROADSTER 2 Registry
868512-17	Metzger, D. Christopher	Industry	Device	SurModics, Inc.	Cardiology	SurModics Early Feasibility Trial: A Prospective, Multi-Center, Single-Arm Trial to Assess the Safety and Feasibility of the SurModics Drug Coated Balloon in the Treatment of Subjects with De Novo Lesions of the Femoropopliteal Artery; IDE G150121
1143017-5	Metzger, D. Christopher	Industry	Device	Surmodics, Inc.	Cardiology	TRANSCEND Study: The Randomized and Controlled Noniferiority Trial to Evaluate Safety and Clinical Efficacy of the SurVeil Drug-Coated Balloon In the Treatment of Subjects with Stenotic Lesions of the Femoropopliteal Artery Compared to the Medtronic IN.PACT Admiral Drug-Coated Balloon.
978292-4	Metzger, D. Christopher	Industry	Device	TriReme Medical, LLC	Cardiology	Chocolate Touch Study: A Randomized Trial to confirm the Safety and Effectiveness of Chocolate Touch™ Paclitaxel Coated PTA Balloon Catheter, in Above the Knee Lesions; IDE G160085
999965-22	Metzger, D. Christopher	Industry	Device	TriVascular, Inc.	Cardiology	ELEVATE IDE Study: Expanding Patient Applicability with PoLymer SEaling OVATion Alto StEnt Graft IDE Study
465849-192	Metzger, D. Christopher	Industry	Device	W.L. Gore & Associates, Inc.	Cardiology	SCAFFOLD Clinical Study: The GORE Carotid Stent Clinical Study for the Treatment of Carotid Artery Stenosis in Patients at Increased Risk for Adverse Events from Carotid Endarterectomy. IDE #: G110127
648374-81	Metzger, D. Christopher	Industry	Device	W.L. Gore & Associates, Inc.	Cardiology	BES 10-07: Evaluation of the GORE® VIABAHN BALLOON EXPANDABLE ENDOPROSTHESIS (VIABAHN BX) for the Treatment of Occlusive Disease in the Common and External Iliac Arteries

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
883879-3	Whitaker, Jack	Industry	Device	Abbott	N/A	Graftmaster RX Coronary Stent Graft System; HDE #000001; Laughlin Memorial Hospital, 1420 Tusculum Boulevard Greeneville, TN 37745
351090-140	Metzger, D. Christopher	Industry	Device	Atrium Medical Corporation	N/A	ARTISAN: iCAST RX De Novo Stent Placement for the Treatment of Atherosclerotic Renal Artery Stensis in Patients with Resistant Hypertension; Protocol #: iCAST RX-ARAS-001; IDE G110194/A001
703550-21	McQueary, Jeffrey	Industry	Device	Boston Scientific	N/A	A Prospective, Non-Randomized, Parallel Cohort, Multi-center Study of UPHOLD LITE vs. Native Tissue for Treatment of Women with Anterior/Apical Pelvic Organ Prolapse.
1101637-5	Metzger, D. Christopher	Industry	Device	Cardiovascular Systems, Inc.	N/A	ECLIPSE: Evaluation of Treatment Strategies for Severe Calcific Coronary Arteries: Orbital Atherectomy vs. Conventional Angioplasty Technique Prior to Implantation of Drug-Eluting Stents
1021371-10	Morin, David	Industry	Drug	Eli Lilly and Company	Alzheimers	A Randomized, Double-Blind, Placebo-Controlled and Delayed-Start Study of LY3314814 in Mild Alzheimer's Disease Dementia (THE DAYBREAK STUDY)
424638-270	Metzger, D. Christopher	Industry	Drug	Abbott	Cardiology	Absorb III-IV-GT1 Randomized Controlled Trial
806111-58	Metzger, D. Christopher	Industry	Drug	AstraZeneca	Cardiology	TWILIGHT Study: Ticagrelor with Aspirin or Alone in High-Risk Patients after Coronary Intevention
887639-27	Whitaker, Jack	Industry	Drug	DalCor Pharma UK Ltd.	Cardiology	dal-GenE: A Phase III, Double-Blind, Randomized Placebo-Controlled Study to Evaluate the Effects of Dalcetrapib on Cardiovascular (CV) Risk in a Genetically Defined Population with a Recent Acute Coronary Syndrome (ACS)
1035566-20	Whitaker, Jack	Industry	Drug	Espeion Therapeutics Inc	Cardiology	CLEAR Outcomes - A randomized, double-blind, placebo-controlled study to assess the effects of bempedoic acid (ETC-1002) on the occurrence of major cardiovascular events in patients with, or at high risk for, cardiovascular disease who are statin intolerant
1215927-2	Blackwell, Gerald	Industry	Drug	GE Healthcare Ltd.	Cardiology	GE-265-303: A Phase 3, Open-Label, Multicentre Study of Flurpiridaz (18F) Injection for Positron Emission Tomography (PET) Imaging for Assessment of Myocardial Perfusion in Patients Referred for Invasive Coronary Angiography Because of Suspected Coronary Artery Disease
401333-67	Whitaker, Jack	Industry	Drug	Novartis	Cardiology	CANTOS: A Randomized, Double-Blind, Placebo-Controlled, Event-Driven Trial of Quarterly Subcutaneous Canakinumab in the Prevention of Recurrent Cardiovascular Events Among Stable Post-Myocardial Infarction Patients with Elevated hsCRP ACZ885/Canakinumab Study No.: CACZ885M2301
393668-107	Whitaker, Jack	Industry	Drug	sanofi	Cardiology	ODYSSEY OUTCOMES: A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Study to Evaluate the Effect of SAR236553/REGN727 on the Occurrence of Cardiovascular Events in Patients Who Have Recently Experienced an Acute Coronary Syndrome
775004-9	Shipstone, Asheesh	Cooperative Group	Drug	NCI NRG	Oncology	NCI CIRB NRG BR003 A Randomized Phase III Trial of Adjuvant Therapy Comparing Doxorubicin Plus Cyclophosphamide followed by weekly Paclitaxel with or without Carboplatin for Node Positive or High Risk Node Negative
1102986-5	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Bladder Cancer	NCI CIRB S1605 “Phase II Trial of Atezolizumab in BCG-Unresponsive Non-Muscle Invasive Bladder Cancer.” Study Chairs: Drs. P. Black, P. Singh, and S. Lerner.

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
147865-14	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Brain	RTOG 0424 Phase II Study of Temozolomide based chemoradiotherapy regimen for Hi Risk Low Grade Gliomas
496587-16	Shipstone, Asheesh	Cooperative Group	Drug	NCI-Alliance	Oncology: Brain	A221101 A Phase III Randomized, Double Blind Placebo Controlled Study of Armodafinil to Reduce Cancer related Fatigue in Patients with Glioblastoma Multiforme
875135-21	Shipstone, Asheesh	Industry	Drug	Cascadian Therapeutics	Oncology: Breast Cancer	ONT-380-206 Phase 2 Randomized, Double-Blinded, Controlled Study of Tucatinib vs. Placebo in Combination with Capecitabine and Trastuzumab in Patients with Pretreated Unresectable Locally Advanced or Metastatic HER2+ Breast Carcinoma (HER2CLIMB)
549174-69	Shao, Ryan	Industry	Drug	F. Hoffmann-La Roche Ltd	Oncology: Breast Cancer	BO28407- A Randomized, Multicenter, Open-label, Phase III Trial Comparing Trastuzumab Plus Pertuzumab Plus A Taxane Following Anthracyclines Versus Trastuzumab Emtansine Plus Pertuzumab Following Anthracyclines as Adjuvant Therapy in Patients With Operable HER2-Positive Primary Breast Cancer
830509-36	Shao, Ryan	Industry	Drug	F. Hoffmann-La Roche Ltd	Oncology: Breast Cancer	W029522 A Phase III, Multicenter Randomized Placebo Controlled Study of MPDL3280A in combination with NAB-Paclitaxel for patients with Previously Untreated metastatic Triple Negative Breast Cancer
149715-11	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	N9831Phase III Trial of Doxorubicin and Cyclophosphamide (AC) Followed by Weekly Paclitaxel with or without Trastuzumab as Adjuvant Treatment for women with HER-2 Overexpressing Node Positive Breast Cancer
177838-26	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	NSABP B40 A Randomized Phase III Trial of Neoadjuvant Therapy in Patients with Palpable and Operable Breast Cancer Evaluating the Effect on Pathologic Complete Response of adding capecitabine or gemcitiabine to Docetaxel when Administered Before AC with or without Bevacizumab and Correlative Science Studies Attempting to Identify Predictors of High Likelihood for pCR with Each of the Regimens.
221385-37	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	NCI CIRB S1007 A Phase III, Randomized Clinical Trial of Standard Adjuvant Endocrine Therapy +/- Chemotherapy in patients with 1-3 positive nodes, hormone receptor positive and HER2 Negative Breast Cancer with Recurrence Score of 25 or less
221389-26	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	NSABP B47 A Randomized Phase III Trial of Adjuvant Therapy comparing Chemotherapy Alone (6 cycles of Docetaxel plus Cyclophophamide or Four Cycles of Doxorubicin Plus Cyclophosphamide followed by weekly Paclitaxel) to Chemotherapy Plus Trastuzumab in Women with Node Postive or High Risk Node Negative HER2 Low Invasive Breast Cancer
332266-12	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	NSABP B-49 A Phase III Clinical Trial Comparing the Combination of Docetaxel Plus Cyclophosphamide to Anthracycline-Base Chemotherapy Regimens for Women with Node Positive or High Risk Node Negative, HER2 Negative Breast Cancer
610288-26	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	NCI CIRB E2112- A Randomized Phase III Trial of Endocrine Therapy plus Entinostat/Placebo in Postmenopausal Patients with Hormone Receptor-Positive Advanced Breast Cancer
139119-36	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Breast Cancer	ECOG E5103: A Double Blind Phase III Trial of Doxorubicin and Cyclophosphamide Followed by Paclitaxel with Bevacizumab or Placebo in Patients with Lymph Node Positive and High Risk Lymph Node Negative Breast Cancer
973587-9	Shipstone, Asheesh	Cooperative Group	Drug	NCI-Alliance	Oncology: Breast Cancer	A011401 RANDOMIZED PHASE III TRIAL EVALUATING THE ROLE OF WEIGHT LOSS IN ADJUVANT TREATMENT OF OVERWEIGHT AND OBESE WOMEN WITH EARLY BREAST CANCER

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
1000691-10	Shipstone, Asheesh	Cooperative Group	Drug	NCI-Alliance	Oncology: Breast Cancer	NCI CIRB A011502 A RANDOMIZED PHASE III DOUBLE BLINDED PLACEBO CONTROLLED TRIAL OF ASPIRIN AS ADJUVANT THERAPY FOR NODE POSTIVE HER2 NEGATIVE BREAST CANCER: THE ABC TRIAL
1228598-3	Shipstone, Asheesh	Cooperative Group	Drug	NCI-Alliance	Oncology: Breast Cancer	NCI CIRB A221505 PHASE III RANDOMIZED TRIAL OF HYPOFRACTIONATED POST MASTECTOMY RADIATION WITH BREAST RECONSTRUCTION
1131837-4	Shipstone, Asheesh	Cooperative Group	Drug	NSABP	Oncology: Breast Cancer	NSABP B58 MonarchE: A Randomized, Open-Label, Phase 3 Study of Abemaciclib Combined with Standard Adjuvant Endocrine Therapy versus Standard Adjuvant Endocrine Therapy Alone in Patients with High Risk, Node Positive, Early Stage, Hormone Receptor Positive, Human Epidermal Receptor 2 Negative, Breast Cancer
1154453-4	Shipstone, Asheesh	Cooperative Group	Drug	NSABP	Oncology: Breast Cancer	NSABP B59 A Randomized, Double-Blind, Phase III Clinical Trial of Neoadjuvant Chemotherapy with Atezolizumab or Placebo in Patients with Triple-Negative Breast Cancer Followed by Adjuvant Continuation of Atezolizumab or Placebo
280577-56	Shao, Ryan	Industry	Drug	Roche/Genentech	Oncology: Breast Cancer	BIG 4-11/BO25126/TOC4939G- A randomized multicenter, double-blind, placebo-controlled comparison of chemotherapy plus trastuzumab plus placebo versus chemotherapy plus trastuzumab plus pertuzumab as adjuvant therapy in patients with operable HER2-positive primary breast cancer
1021910-4	Shipstone, Asheesh	Cooperative Group	Drug	NCI RTOG	Oncology: Cervical Cancer	NCI CIRB RTOG 0724 PHASE III RANDOMIZED STUDY OF CONCURRENT CHEMOTHERAPY AND PELVIC NCIC IRB RTOG 0724 RADIATION THERAPY WITH OR WITHOUT ADJUVANT CHEMOTHERAPY IN HIGH-RISK PATIENTS WITH EARLY-STAGE CERVICAL CARCINOMA FOLLOWING RADICAL HYSTERECTOMY
146847-16	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Colorectal Cancer	E5204 Intergroup Randomized Phase III Study of Postoperative Oxaliplatin, 5FU, and Leucovorin vs. Oxaliplatin, 5FU, Leucovorin and Bevacizumab for patients with StageII or III Rectal cancer Receiving Preoperative Chemoradiation
139120-20	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Colorectal Cancer	ECOG E5202: A Phase III Study of 5-FU, Leucovorin and Oxalplatin vs. 5-fu, Leucovorin, Oxaliplatin and Bevacizumab in patients with Stage II Colon Cancer at High Risk for Recurrence
182686-43	Shipstone, Asheesh	Cooperative Group	Drug	NCI CALGB	Oncology: Colorectal Cancer	NCI CIRB CALGB 80702 A Phase III Trial of 6 versus 12 treatments of adjuvant FOLFOX plus Celecoxib or placebo for patients with resected stage III colon cancer
1167598-7	Shipstone, Asheesh	Cooperative Group	Drug	NCI NRG	Oncology: Colorectal Cancer	NCI CIRB NRG-GI004-Colorectal Cancer Metastatic dMMR Immuno-Therapy (COMMIT) Study: A Randomized Phase III Study of mFOLFOX6/Bevacizumab Combination Chemotherapy with or without Atezolizumab or Atezolizumab Monotherapy in the First-Line Treatment of Patients with Deficient DNA Mismatch Repair (dMMR) Metastatic Colorectal Cancer
1140004-5	Shipstone, Asheesh	Cooperative Group	Drug	NCI-Alliance	Oncology: Colorectal Cancer	NCI CIRB A021502 RANDOMIZED TRIAL OF STANDARD CHEMOTHERAPY ALONE OR COMBINED WITH ATEZOLIZUMAB AS ADJUVANT THERAPY FOR PATIENTS WITH STAGE III COLON CANCER AND DEFICIENT DNA MISMATCH REPAIR (ATOMIC: Adjuvant Trial of Deficient Mismatch Repair in Colon Cancer)
1249442-1	Shipstone, Asheesh	Cooperative Group	Drug	NSABP	Oncology: Colorectal Cancer	NSABP FC-11: A Phase II Study Evaluating the Combination of Neratinib Plus Trastuzumab or Neratinib Plus Cetuximab in Patients with Quadruple Wild-Type (KRAS/NRAS/BRAF/PIK3CA Wild-Type) Metastatic Colorectal Cancer Based on HER2 Status: Amplified, Non-Amplified (Wild-Type) or Mutated

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
830620-14	Shipstone, Asheesh	Cooperative Group	Drug	NCI SWOG	Oncology: Glands	NCI CIRB S1505 A Randomized Phase II Study of Perioperative mFOLFIRINOX versus Gemcitabine/nab-Paclitaxel as Therapy for Resectable Pancreatic Adenocarcinoma
160556-38	Shipstone, Asheesh	Cooperative Group	Drug	NCI RTOG	Oncology: Head & Neck	NCI CIRB RTOG 0920 A Phase III Study of Postoperative Radiation Therapy (IMRT) +/- Cetuximab for locally advanced Resected Head and Neck Cancer
173450-37	Shipstone, Asheesh	Cooperative Group	Drug	NCI CALGB	Oncology: Liver	NCI CIRB CALGB 80802 Phase III Randomized Study of Sorafenib Plus Doxorubicin versus Sorafenib in Patients with Advanced Hepatocellular Carcinoma
947263-20	Nakhoul, Ibrahim	Industry	Drug	TG Therapeutics	Oncology: Lymphoma	UTX-TGR-205 A Phase 2b Randomized Study to Assess the Efficacy and Safety of the Combination of Ublituximab + TGR-1202 and TGR-1202 alone in Patients with Previously Treated Diffuse Large B-Cell Lymphoma
256995-40	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Melanoma	NCI CIRB E1609 A Phase III Randomized Study of Adjuvant Ipilimumab Anti-CTLA4 Therapy Versus High Dose Interferon a-2b for Resected High Risk Melanoma
659258-20	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Melanoma	NCI CIRB S1320 A Randomized, Phase II Trial of Intermittent Versus Continuous Dosing of Dabrafenib (NSC-763760) and Trametinib (NSC-763093) in BRAFV600E/K Mutant Melanoma. Study Chairs: Drs. A. Algazi, A. Daud, and R.Lo
802083-24	Shipstone, Asheesh	Cooperative Group	Drug	NCI ECOG-ACRIN	Oncology: Melanoma	NCI CIRB EA6134 A Randomized Phase III trial of Dabrafenib + Trametinib followed by Ipilimumab + Nivolumab at Progression vs. Ipilimumab + Nivolumab followed by Dabrafenib + Trametinib at Progression in Patients With Advanced BRAFV600 Mutant Melanoma
781430-25	Nakhoul, Ibrahim	Industry	Drug	F. Hoffmann-La Roche Ltd	Oncology: Non-Small Cell Lung Cancer	GO29527 A Phase III, Open Label, Randomized Study to Investigate the efficacy and Safety of Atezolizumab (ANTI-PD-L1 Antibody) compared with best supportive care following adjuvant cisplatin-based chemotherapy in Patients with completely resected Stage Ib-IIIA Non Small Cell Lung Cancer
138974-13	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Non-Small Cell Lung Cancer	CALGB 79803: A Phase III Chemoprevention Trial of Selenium Supplementation in Person's with Resected Stage I Non Small Cell Cancer
139250-31	Shipstone, Asheesh	Federal	Drug	NCi	Oncology: Non-Small Cell Lung Cancer	RTOG 0617: A Randomized Phase III Comparison of Standard Dose (60 Gy) vs. High Dose (74 Gy) Conformal Radiotherapy with Concurrent and Consolidation Carboplatin/Paclitaxel with Stage IIIA/IIIB Non Small Cell Lung Cancer
658535-22	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Non-Small Cell Lung Cancer	NCI CIRB A081105 RANDOMIZED DOUBLE BLIND PLACEBO CONTROLLED STUDY OF ERLOTINIB OR PLACEBO IN PATIENTS WITH COMPLETELY RESECTED EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) MUTANT NON-SMALL CELL LUNG CANCER (NSCLC)
659165-26	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Non-Small Cell Lung Cancer	NCI CIRB E4512 A Randomized Phase III Trial for Surgically Resected Early Stage Non-Small Cell Lung Cancer: Crizotinib versus Observation for Patients with Tumors Harboring the Anaplastic Lymphoma Kinase (ALK) Fusion Protein.
909180-11	Shipstone, Asheesh	Cooperative Group	Drug	NCI ECOG-ACRIN	Oncology: Non-Small Cell Lung Cancer	NCI CIRB EA5142 Adjuvant Nivolumab in Resected Lung Cancers (ANVIL) – A Randomized Phase III Study of Nivolumab After Surgical Resection and Adjuvant Chemotherapy in Non-Small Cell Lung Cancers

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
1228568-3	Shipstone, Asheesh	Cooperative Group	Drug	NCI ECOG-ACRIN	Oncology: Non-Small Cell Lung Cancer	NCI CIRB EA5152 A Randomized Phase II Trial of Nivolumab, Cabozantinib Plus Nivolumab, and Cabozantinib Plus Nivolumab Plus Ipilimumab in Patients with Previously Treated Non-Squamous NSCLC
997456-9	Shipstone, Asheesh	Cooperative Group	Drug	NCI NRG	Oncology: Ovarian	NCI CIRB NRG-GY005 A Randomized Phase II/III Study of the Combination of Cediranib and Olaparib Compared to Cediranib or Olaparib Alone, or Standard of Care Chemotherapy in Women with Recurrent Platinum-Resistant or Refractory Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (COCOS)
1203215-3	Kramer, Paul	Industry	Drug	TESARO	Oncology: Ovarian	TESARO 3000-02-004 A PHASE 2, SINGLE-ARM, OPEN-LABEL STUDY TO EVALUATE THE SAFETY AND EFFICACY OF NIRAPARIB COMBINED WITH BEVACIZUMAB AS MAINTENANCE TREATMENT IN PATIENTS WITH ADVANCED OVARIAN CANCER, FALLOPIAN TUBE CANCER, OR PRIMARY PERITONEAL CANCER FOLLOWING FRONT-LINE PLATINUM-BASED CHEMOTHERAPY WITH BEVACIZUMAB
138989-33	Shipstone, Asheesh	Cooperative Group	Drug	NCI CALGB	Oncology: Prostate Cancer	NCI CIRB CALGB 90203: A Randomized Phase III Study of Neoadjuvant Docetaxel and Androgen Deprivation Prior to Radical Prostatectomy vs. Immediate Radical Prostatectomy in Patients with High Risk Clinically Localized Prostate Cancer
139243-25	Shipstone, Asheesh	Cooperative Group	Drug	NCI RTOG	Oncology: Prostate Cancer	NCI CIRB RTOG 0534: A Phase III Trial of Short Term Androgen Deprivation with Pelvic Node or Positive bed Only Radiatherapy (SPORT) in Prostate Cancer patients with A Rising PSA after Radical Prostatectomy
257057-27	Shipstone, Asheesh	Cooperative Group	Drug	NCI RTOG	Oncology: Prostate Cancer	NCI CIRB RTOG 0924 Androgen Deprivation therapy and High Dose Radiotherapy with or without Whole Pelvic Radiotherapy in Unfavorable intermediate or favorable high risk prostate cancer: A Phase III Randomized Trial
964111-13	DaSilva, Marco	Industry	Drug	F. Hoffmann-La Roche Ltd	Oncology: Renal	WO39210 A PHASE III, MULTICENTER, RANDOMIZED, PLACEBO-CONTROLLED, DOUBLE-BLIND STUDY OF ATEZOLIZUMAB (ANTI−PD-L1 ANTIBODY) AS ADJUVANT THERAPY IN PATIENTS WITH RENAL CELL CARCINOMA AT HIGH RISK OF DEVELOPING METASTASIS FOLLOWING NEPHRECTOMY
256958-28	Shipstone, Asheesh	Cooperative Group	Drug	NCI SWOG	Oncology: Renal	NCI CIRB SWOG S0931 EVEREST: EVErolimus for Renal Cancer Ensuing Surgical Therapy, A Phase III Study
393968-24	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Renal Cancer	NCI CIRB E2810 Randomized, Double Blind Phase III study of Pazopaninb vs Placebo in patients with Metastatic Renal cell carcinoma who have no evidence of disease following metastatectomy
204172-22	Shipstone, Asheesh	Federal	Drug	NCI	Oncology: Salivary Gland	RTOG 1008 A Randomized Phase II Study of Adjuvant Concurrent Radiation and Chemotherapy Versus Radiation Alone in Resected High Risk Malignant Salivary Gland Tumors
138941-37	Shipstone, Asheesh	Cooperative Group	Drug	NCI CALGB	Oncology: Small Cell Lung Cancer	NCI CIRB CALGB 30610: Phase III Comparison of Thoracic Radiotherapy Regimens in Patients with Limited Stage Small Cell Lung cancer also Receiving Cisplatin and Etoposide
1242140-2	Shipstone, Asheesh	Cooperative Group	Drug	NCI ECOG-ACRIN	Oncology: Small Cell Lung Cancer	NCI CIRB EA5161 Randomized Phase II Clinical Trial of Cisplatin/Carboplatin and Etoposide (CE) alone or in Combination with Nivolumab as Frontline Therapy for Extensive Stage Small Cell Lung Cancer (ED-SCLC)
1137057-4	Shipstome, Asheesh	Cooperative Group	Drug	NCI-Alliance	Oncology: Urinary System	NCI CIRB A031501 PHASE III RANDOMIZED ADJUVANT STUDY OF MK-3475 (PEMBROLIZUMAB) IN MUSCLE INVASIVE AND LOCALLY ADVANCED UROTHELIAL CARCINOMA (AMBASSADOR) VERSUS OBSERVATION

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
1228480-4	Shipstone, Asheesh	Federal	Drug	NCI	N/A	NCI CIRB EA8153 Cabazitaxel with Abiraterone versus Abiraterone alone Randomized Trial for Extensive Disease following Docetaxel: the CHAARTED2 Trial
139114-26	Shipstone, Asheesh	Federal	Drug	NCI	N/A	ECOG E2805 ASSURE: Adjuvant Sorafenib or Sunitinib for Unfavorable Renal Carcinoma
659114-17	Shipstone, Asheesh	Federal	Drug	NCI	N/A	NCI CIRB A151216 Adjuvant Lung Cancer Enrichment Marker Identification and Sequencing Trial (ALCHEMIST)
759119-10	Shipstone, Asheesh	Federal	Drug	NCI	N/A	NCI CIRB 9671 Exceptional Responder Initiative
1122087-1	Aziz, Mark	Industry	HUD	St. Jude Medical	N/A	AMPLATZER Post-Infarct Muscular VSD Occluder; HUD #07-0178; Wellmont Holston Valley Medical Center, 130 W. Ravine Road, Kingsport, TN 37660
449118-1	Abdel Nour, Souheil	Not Funded	Literature Review	Not funded	N/A	Mediastinal signet-ring cell adenocarcinoma of unknown primary site in a young male patient: clinical course and review of the literature
1134542-1	Bledsoe, Matthew as of 7/10/2018	Not Funded	Non-Drug	Not funded	N/A	Implementation of Naloxone Education, Training, and Distribution to High Risk Populations at a Community Teaching Hospital
553264-65	Shafiei, Fereidoon	Industry	Observational	Boston Scientific	N/A	LSS of 4-SITE Study: The Longitudinal Surveillance Study of the 4-SITE Lead/Header System
674278-71	Metzger, D. Christopher	Industry	Observational	Cardiovascular Systems, Inc.	N/A	LIBERTY 360: Prospective, Observational, Multi-Center Clinical Study to Evaluate Acute and Long Term Clinical and Economic Outcomes of Endovascular Device Intervention in Patients with Distal Outflow Peripheral Arterial Disease (PAD)
653895-14	Shao, Ryan	Industry	Observational	Incyte	N/A	REVEAL/ INCB-MA-PV-401: Prospective Non-Interventional Study of Disease Progression and Treatment of Patients With Polycythemia Vera In United States Academic Or Community Clinical Practices
979951-7	Shao, Ryan	Industry	Observational	Incyte	N/A	INCB-MA-MF-401: Prospective, Longitudinal, Non-Interventional Study of Disease Burden and Treatment of Patients with Low-Risk Myelofibrosis (MF) or High-Risk Essential Thrombocythemia (ET) or ET Patients Receiving ET-Directed Therapy
1104913-2	Shipstone, Asheesh	Not Funded	Observational	N/A	N/A	A Pilot Investigation of Comprehensive Fatigue Management Model in a community cancer center setting for breast cancer survivors who suffer moderate-severe fatigue during surveillance period.
139125-24	Shipstone, Asheesh	Federal	Observational	NCI	N/A	PACCT-1: Program for the Assessment of Clinical Cancer Test Trial Assigning Individualized Options for Treatment- The TAILORX Trial
879277-11	Shipstone, Asheesh	Federal	Observational	NCI	N/A	NCI CIRB DCP-001, Use of a Clinical Trial Screening Tool to Address Cancer Health Disparities in the NCI Community Oncology Research Program (NCORP)
1251920-2	Shipstone, Asheesh	Cooperative Group	Observational	NCI ECOG-ACRIN	N/A	NCI CIRB EAQ162CD Longitudinal Assessment of Financial Burden in Patients with Colon or Rectal Cancer Treated with Curative Intent
137994-138	Merrill, James	Federal	Observational	NIH	N/A	VEST/PREDICTS: The Vest prevention of Early Sudden Death Trial Prediction of ICD Therapies Study
1175284-1	Marchessault, Jeffrey	Not Funded	Observational	Not funded	N/A	Outcomes Following Thumb MCP Joint Arthrodesis with LRTI
1058429-5	Nakhoul, Ibrahim	Industry	Observational	Pfizer	N/A	A5481082 POLARIS: Palbociclib in Hormone Receptor Positive Advanced Breast Cancer: A Prospective Multicenter Non-Interventional Study
1150854-2	Whitaker, Jack	Industry	Observational	Sanofi	N/A	ODYSSEY LEGACY Disease Observational Study: Long-term legacy effects of LDL-C lowering alirocumab: observational follow-up of the ODYSSEY OUTCOMES study
811400-34	Metzger, D. Christopher	Industry	Observational	TriVascular, Inc.	N/A	LUCY Study: TriVascular Evaluation of Females who are Underrepresented Candidates for Abdominal Aortic Aneurysm Repair; Protocol 771-0016

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
1133542-1	Metzger, D. Christopher	Industry	Observational	UT Southwestern Medical Center and VA North Texas Health Care System	N/A	XL PAD Registry: Multicenter Registry for Peripheral Arterial Disease Interventions and Outcomes
1204508-9	Beckner, David	Not Funded	Population Study	Not funded	N/A	Population-Based Lifestyle Intervention: Translation of the Pritikin Program to the Community Pilot Study
1140452-3	Shipstone, Asheesh	Industry	Registry	Janssen Scientific Affairs, LLC	N/A	NOPRODMMY4001 Multiple Myeloma Patient Registry
435924-264	Shafiei, Fereidoon	Industry	Registry	Medtronic	N/A	Product Surveillance Registry (PSR)
619195-2	Gall, Stanley	Not Funded	Registry	N/A	N/A	MAZE - Results of concomitant MAZE procedure for atrial fibrillation (Retrospective Data Collection)
619219-3	Gall, Stanley	Not Funded	Registry	N/A	N/A	Results of aortic root replacement in a community hospital (Retrospective Data Collection)
496613-12	Shipstone, Asheesh	Federal	Registry	NCI	N/A	NSABP MPR-1 NSABP Patient Registry and Biospecimen Repository
1149706-1	Cooze, Derek	Investigator	Sample Collection	Healthstar Physicians	N/A	Diagnostic QC and Pre-Clinical Sample Collection Project
1128245-1	Fredo, Melody	Not Funded	N/A	N/A	N/A	Evaluating the Effects of Aromatherapy on Neonates with Neonatal Abstinence Syndrome
1104149-1	Johnson, Alicia	Not Funded	N/A	N/A	N/A	Therapy Gcodes, Evaluation Complexity & Discharge Disposition
1128244-1	Lee, Jordan	Not Funded	N/A	N/A	N/A	Evaluation of a Vancomycin Nomogram in an Obese Patient Population
1156510-2	Testerman, George	Not Funded	N/A	N/A	N/A	Mandatory State Helmet Safety Laws Affect ATV Crash Mortality Rates At A Tennessee Trauma Center
1156914-2	Testerman, George	Not Funded	N/A	N/A	N/A	Mandatory State Helmet Safety Laws Affect Motorcycle Crash Mortality Rates at a Tennessee Trauma Center
1133892-1	Weaver, Jennifer	Not Funded	N/A	N/A	N/A	Comparing Opioid As-Needed Range Orders versus Opioid Fixed-Dose Orders and the Effects on Patient Safety and Pain Management
434472-7	Reynolds, Justin	Institutional	N/A	Atlanta Head and Neck Cancer Coalition	N/A	Knowledge and perception of Head and neck cancer risk
430331-1	Boren, Kyle	Investigator	N/A	Dan Krenk DO, Greg Purnell MD	N/A	Subclavian vein compression following a displaced fracture of the clavicle: a case report
919608-3	Hurst, Joseph	Investigator	N/A	Daniel Krenk, DO	N/A	Single Surgeon Second Operative Suite-Impact On Operating Room Efficiency and Cost Analysis
963310-2	Ramos, Trevy	Investigator	N/A	Dr. Tiffany Lasky	N/A	Gallbladder Cancer in Rural Appalachia: Incidence, Prevalence and Stage at Diagnosis
786605-1	Ladley, Herbert	Not Funded	N/A	Exempt	N/A	The National Neurosurgery Quality and Outcomes Database
1123489-1	Knight, Michael	Industry	N/A	Jeffrey Marchessault, MD	N/A	Denervation of the thumb carpometacarpal joint
754630-4	Metzger, D. Christopher	Not Funded	N/A	N/A	N/A	Live Case Consents for: - Complex Cardiovascular Catheter Therapeutics (C3) - New Cardiovascular Horizons (NCH) - Leipzig Interventional Course (LINC)
1251125-1	McCormack, Meredith	Federal	N/A	NIH	N/A	Protocol Title: Environmental Health Disparities in Rural Appalachia: The impact of air pollution, obesity and diet on COPD morbidity (ETSU) Application No.: IRB00071209 Sponsor: National Institute of Health

Research topics

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description
531593-1	Boschee, Tracy	Not Funded	N/A	Not funded	N/A	Acute Hallucinations: Where Did That Come From? A Unique Case of Acute Onset Hallucinations
426122-1	Bundren, Kealey	Not Funded	N/A	Not funded	N/A	Concurrent Vancomycin and Zosyn use and their Association with Acute Renal Failure: A Retrospective Review
442673-1	Butler, Leroy	Not Funded	N/A	Not funded	N/A	Case Report: Norcardia infected Baker's cyst
460986-1	Butler, Leroy	Not Funded	N/A	Not funded	N/A	Cost-Effectiveness of polyethylene exchange versus Revision Total Knee Arthroplasty for instability following failed Total Knee Replacement
372306-1	Harris, Wesley J	Not Funded	N/A	Not funded	N/A	Use of Prophylactic Closed Suction Drainage in Vaginal Hysterectomy
531725-1	Hunley, Lawson	Not Funded	N/A	Not funded	N/A	Primary deep vein thrombosis of the upper extremity in a 21 year old male – A Case Report of Paget-Schroetter syndrome
393455-1	Hylton, Ann	Not Funded	N/A	Not funded	N/A	Emergency Department Use of Tigecycline for the Management of Skin and Soft Tissue Infections
823643-3	Lasky, Tiffany	Not Funded	N/A	Not funded	N/A	Effect of Acute Care Surgical Program Implementation in a Rural Level One Trauma Center
1253305-2	Long, Michael	Not Funded	N/A	Not funded	N/A	Incidence and Risk Factors for Acute Kidney Injury Following Total Hip or Knee Arthroplasty
481536-20	Mamudu, Hadii	Not Funded	N/A	Not funded	N/A	Cardiovascular health management: Assessments of effects of Coronary Artery Calcium Screening
1230985-2	Mamudu, Hadii	Not Funded	N/A	Not funded	N/A	Cardiovascular health management: studies in atherosclerosis
385891-1	McHenry, Kristen	Not Funded	N/A	Not funded	N/A	A Study of the Relationship Between APACHE II Scores and the Need for a Tracheostomy
319346-14	Metzger, D. Christopher	Not Funded	N/A	Not funded	N/A	Graftmaster RX; HDE #000001; Wellmont Bristol Regional Medical Center, One Medical Park Boulevard, Bristol TN 37620
400718-1	Mitoraj, Thomas E.	Not Funded	N/A	Not funded	N/A	ONC Measure Testing: Reliability and Validity Testing
1074257-3	Nounou, Joseph	Not Funded	N/A	Not funded	N/A	Evaluation of Current Methods for Pressure Point Padding in the Operating Room Setting
991340-2	Perrin, Hunter	Not Funded	N/A	Not funded	N/A	Evaluation of Penicillin Allergy Documentation on Antibiotic Selection
716782-4	Perry, Anita	Not Funded	N/A	Not funded	N/A	Medevac Transport of the STEMI Patient
1214054-2	Powers, Pius	Not Funded	N/A	Not funded	N/A	iNICQ 2018 VON Day Quality Audit: Choosing Antibiotics Wisely
531178-1	Robbins, Thomas	Not Funded	N/A	Not funded	N/A	Late Onset and Refractory Schizophrenia in the Primary Care Setting: A Case Review
642540-12	Shipstone, Asheesh	Not Funded	N/A	Not funded	N/A	E7208 A Randomized Phase II Study of Irinotecan and Cetuximab with or without the Anti-Angiogenic Antibody, Ramucirumab (IMC-1121B), in Advanced, K-ras Wild-type Colorectal Cancer Following Progression on Bevacizumab-Containing Chemotherapy
1055489-5	Summers, Jeffrey	Not Funded	N/A	Not funded	N/A	Causes and Prevention of Hospital Readmissions in Rural Northeastern Tennessee and Southern Virginia Compared to the Entire United States
378813-1	Watkins, Jeff	Not Funded	N/A	Not funded	N/A	Implementation and Evaluation of a unit-based decentralized pharmacy staffing model
425715-1	West, Kelli	Not Funded	N/A	Not funded	N/A	Optimizing Neonatal Abstinence Syndrome Management
541065-1	Yorns, Lindsay	Not Funded	N/A	Not funded	N/A	Microcystic Lymphatic Malformations of the Tongue: A Case Study
937769-3	Mears, Holly	Institutional	N/A	ORAU	N/A	A Pilot Investigation of Male and Female Breast and Ovarian De-Identified Cancer Data to Evaluate and Enhance the CDC's Know:BRCA Clinical Decision Support Tool
268376-11	Shao, Ryan	Industry	N/A	Physcians Plasma Alliance	N/A	Physicians Plasma Alliance Pre Clinical Drug Development and Callibration/Control and Chemistry Analyzers Study/ VMR #0602
1123047-1	Chesley, Colin	Not Funded	N/A	N/A	N/A	Organizational Culture Changes Following Seminal Events

Funded projects and expenditures

IRB#	Principal Researcher	Sponsor Type	Primary Methodology	Sponsor	Area	Research Topic Description	Revenue	Expense
0318.15sd	Stepanov, Nonna	Industry	Chart Review	Tobacco Region Revitalization Committee	Cancer	Identifying Barriers to Screening and Treatment of Women's Cancers in the Appalachian Region of Virginia	$ 5,200.00	$3,000.00
0616.14	Shams, Tanzid MD	Industry	Device	Jan Medical Inc.□	Neurology	Non-Blinded Data Collection Study of Concussion using the BrainPulse	$26,806.00	$2,150.00
1015.9f	Colvett, Kyle, MD	Industry	Drug	Galera	Radiation Oncology	A Phase 2, Randomized, Double-Blind, Placebo-Controlled, Multi-Center, Trial of the Effects of Intravenous GC4419 on the Incidence and Duration of Severe Oral Mucositis (OM) in Patients Receiving Post-Operative or Definitive Therapy with Single-Agent Cisplatin plus IMRT for Locally Advanced, Non-Metastatic Squamous Cell Carcinoma of the Oral Cavity or Oropharynx	$ 1,106.00	$ 75.00
0315.3f	Shah, Darshan, MD	Industry	N/A	INC Research , LLC/Astella Pharma Europe B.V.	N/A	A Phase 3, Multicenter, Investigator-blind, Randomized, Parallel Group Study to Investigate the Safety and Efficacy of Fidaxomicin Oral Suspension or Tablets Taken q12h, and Vancomycin Oral Liquid or Capsules Taken q6h, for 10 Days in Pediatric Subjects with Clostridium difficile-associated Diarrhea	$1,125	$ -

ATTACHMENT 16

COMPARISON OF FINANCIAL RATIOS

Ballad Health

Statement of Revenue and Expense
For The Ended June 30, 2018

	Twelve Months Year to Date Actual
Patient Revenue	
Inpatient	4,109,855,766
Outpatient	5,709,010,146
Total Patient Revenue	**9,818,865,912**
Deductions From Revenue	
Contractual Adjustments	7,148,971,115
Charity	217,692,678
Contra Revenue - Charity and Bad Debt	172,431,193
Uninsured Discounts	261,313,388
Total Deductions	**7,800,408,373**
Net Patient Revenue	**2,018,457,539**
Other Operating Revenue	58,704,603
Total Operating Revenue	**2,077,162,142**
Operating Expenses	
Salaries & Wages	687,197,712
Provider Salaries	180,932,631
Contract Labor - Providers	16,153,161
Contract Labor - Other	31,722,927
Employee Benefits	160,389,358
Fees	221,448,798
Drugs & Supplies	402,352,670
Other Expense	176,776,016
Depreciation & Amortization	137,200,771
Interest & Taxes	50,476,717
Total Operating Expense	**2,064,650,761**
Net Operating Income before Support Allocation	**12,511,381**
Support Allocation - Salaries, Contract Labor & Benefits	(0)
Support Allocation - Other	0
Net Operating Income after Support Allocation	**12,511,381**
Net Investment Income	29,027,602
Realized Gain on Investments	20,257,369
Gain / (Loss) from Affiliates	1,549,521
Gain / (Loss) on Discontinued Operations & Disposal	(129,265)
Loss on Extinguishment of LTD / Derivatives	(24,812,173)
Minority Interest	(21,010,765)
Incentive Pay	(2,596,967)
Other Non Operating Income / (Expense)	(27,643,973)
Total Non Operating Income / (Expense)	**(25,358,650)**
Total Revenue Over Expense Before CFV of Derivatives	**(12,847,269)**
Change in Fair Value of Interest Rate Swaps	411,452
Total Excess Revenue Over Expense	**(12,435,817)**
Net Unrealized Gain / (Loss) on Investments	27,228,416
Increase in Unrestricted Net Assets	**14,792,599**
EBITDA (Operations)	**200,188,869**
EBITDA (Operations) as % of Net Patient Revenue	9.9%
Operating Margin	0.6%
EBITDA	**199,642,392**
EBITDA as % of Net Patient Revenue	9.9%
Total Margin	0.6%

Ballad Health

Comparative Balance Sheet

	June 30 2018
ASSETS	
CURRENT ASSETS	
Cash and Cash Equivalents	86,843,707
Current Portion AWUIL	8,526,640
Accounts Receivable (Net)	288,085,728
Other Receivables	34,965,462
Due From Affiliates	1,322,174
Due From Third Party Payors	(0)
Inventories	48,439,110
Prepaid Expense	17,359,164
	485,541,985
ASSETS WHOSE USE IS LIMITED	59,143,475
OTHER INVESTMENTS	1,203,943,419
PROPERTY, PLANT AND EQUIPMENT	
Land, Buildings and Equipment	3,080,374,780
Less Allowances for Depreciation	1,801,223,387
	1,279,151,393
OTHER ASSETS	
Pledges Receivable	824,392
Long Term Compensation Investment	32,211,612
Investments in Unconsolidated Subsidiaries	17,562,549
Land / Equipment Held for Resale	6,646,369
Assets Held for Expansion	11,361,384
Investments in Subsidiaries	0
Goodwill	209,602,215
Deferred Charges and Other	12,329,037
	290,537,558
TOTAL ASSETS	3,318,317,830
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES	
Accounts Payable and Accrued Expense	138,767,994
Accrued Salaries, Benefits, and PTO	105,687,610
Claims Payable	1,953,448
Accrued Interest	9,486,141
Due to Affiliates	0
Due to Third Party Payors	14,608,326
Call Option Liability	0
Current Portion of Long Term Debt	14,036,863
	284,540,380
OTHER NON CURRENT LIABILITIES	
Long Term Compensation Payable	16,318,189
Long Term Debt	1,341,728,650
Estimated Fair Value of Interest Rate Swaps	8,949,730
Deferred Income	6,819,324
Professional Liability Self-Insurance and Other	56,474,925
	1,430,290,820
TOTAL LIABILITIES	1,714,831,200
NET ASSETS	
Restricted Net Assets	20,612,107
Unrestricted Net Assets	1,341,069,857
Noncontrolling Interests in Subsidiaries	241,804,666
	1,603,486,630
TOTAL LIABILITIES AND NET ASSETS	3,318,317,830

	2017 Fitch Median[1]	2017 S&P Median[2]	2017 Moody's Median[3]	FY18 Total
Total Margin[6]	4.2%	4.1%	2.0%	0.6%
Operating Margin	2.1%	1.8%	0.0%	0.6%
Excess Margin	4.2%	4.1%	2.0%	0.7%
EBITDA to Revenue	11.2%	9.9%	9.3%	9.4%
Operating EBITDA to Net Revenue	9.2%	8.2%	N/A	9.7%
Current Ratio	N/A	N/A	2.1	1.5
Days in Patient A/R	47.4	46.0	47.3	51.2
Avg Payment Period	57.9	N/A	58.7	76.4
Total Days Cash on Hand	242.0	183.4	172.0	240.3
LT Debt to Capitalization	34.3%	36.1%	42.0%	45.9%
Unrestricted Reserves to LT Debt	N/A	152.3%	N/A	96.3%
Cash Flow to Total Debt[7]	26.3%	N/A	22.2%	11.0%
Capital Expenditures to Depreciation Expense	112.5%	129.9%	N/A	63.2%
Debt Service Coverage	3.6	2.5	2.9	2.3
FTEs per AOB[8]	N/A	N/A	N/A	4.72
Labor Exp / Net Patient Rev[9]	55.8%	59.3%	N/A	53.7%

ATTACHMENT 17

TOTAL CHARITY CARE

Ballad Health TOC 6.04(b)(xiv), Exhibit G
FY18 Internal Spending Report ending June 30, 2018

***Schedule H; Part I, line 7:**	**Total**
a. Financial assistance (charity)	35,991,008
b. Medicaid and TennCare	44,020,765
Total Charity Care	**80,011,773**

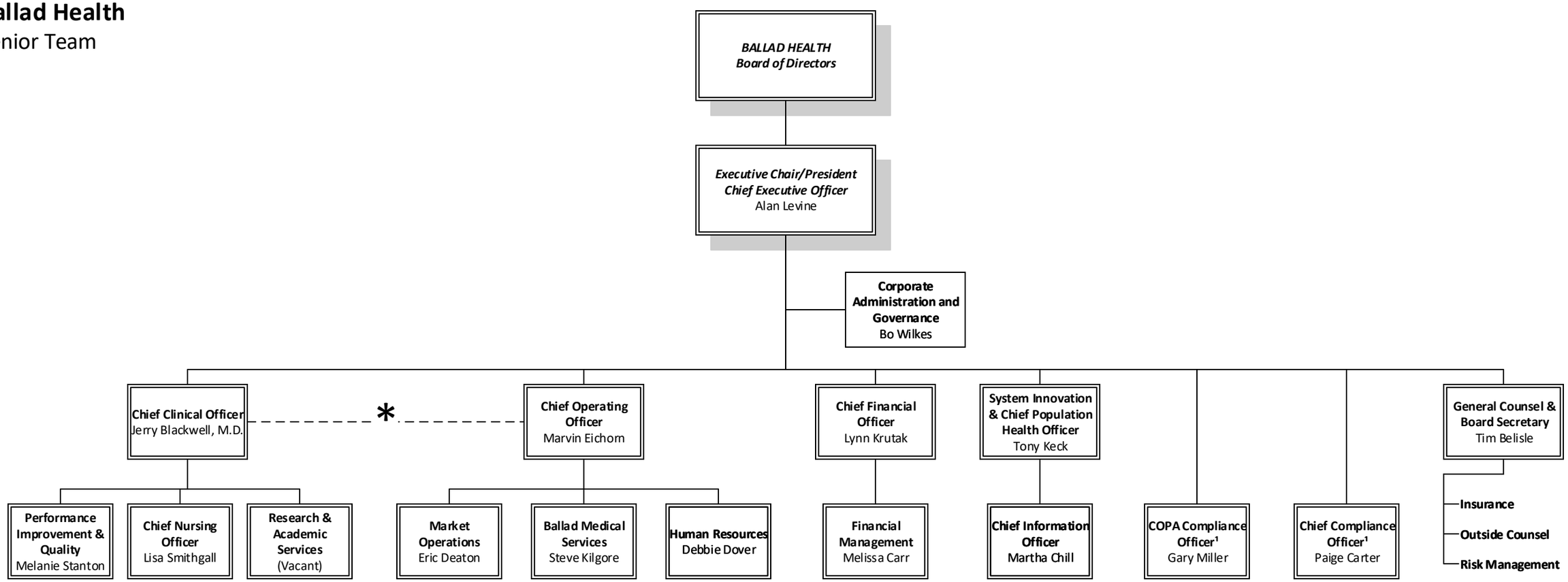
**If applicable, Ballad Health will disclose any material deviations once the IRS Form 990s are filed.*

ATTACHMENT 18

ORGANIZATIONAL CHARTS

Ballad Health

Senior Team

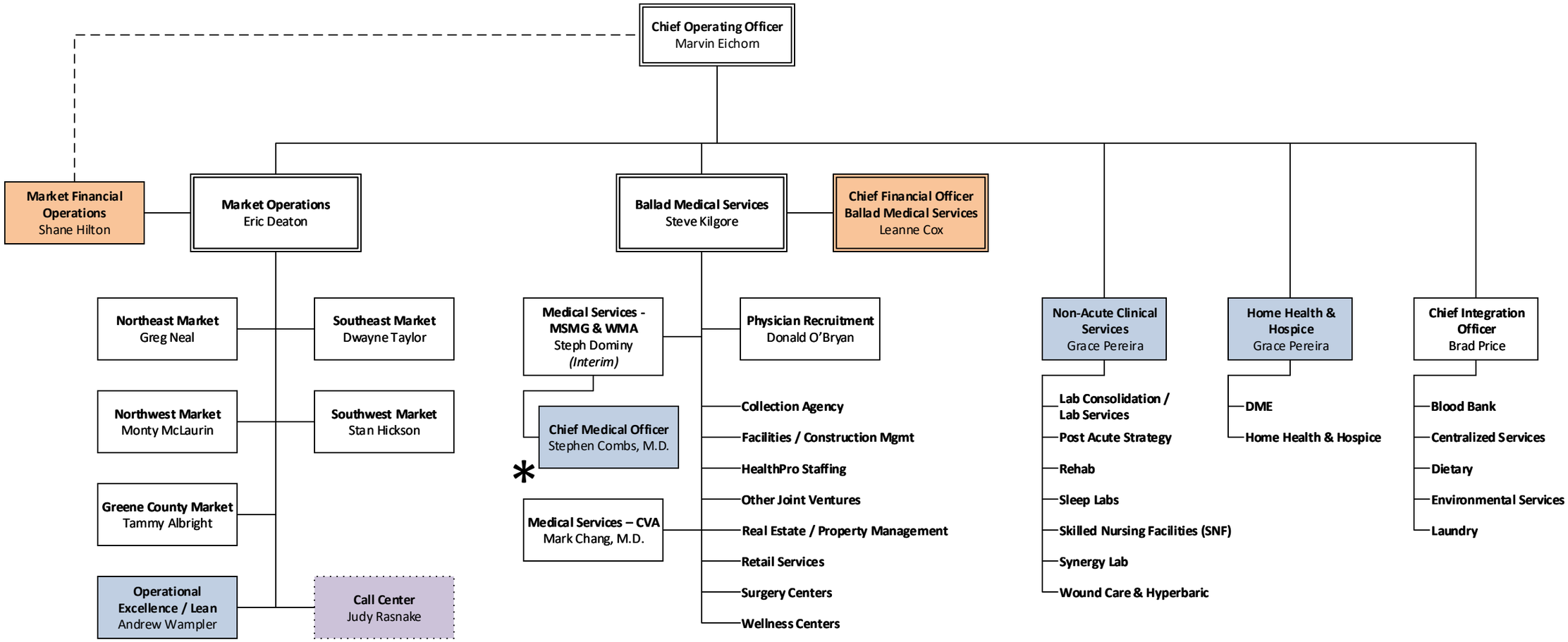


*** "As an organization dedicated to physician collaboration and leadership, operational decisions shall be made with input and guidance from physician leadership. This approach is infused throughout the organization as Chief Medical Officers operate collaboratively with administrative leadership and under the guidance of the Chief Clinical Officer."**

[1] Reports to Audit Committee of Ballad Health Board of Directors and Executive Chairman/President/Chief Executive Officer

Ballad Health

Operations



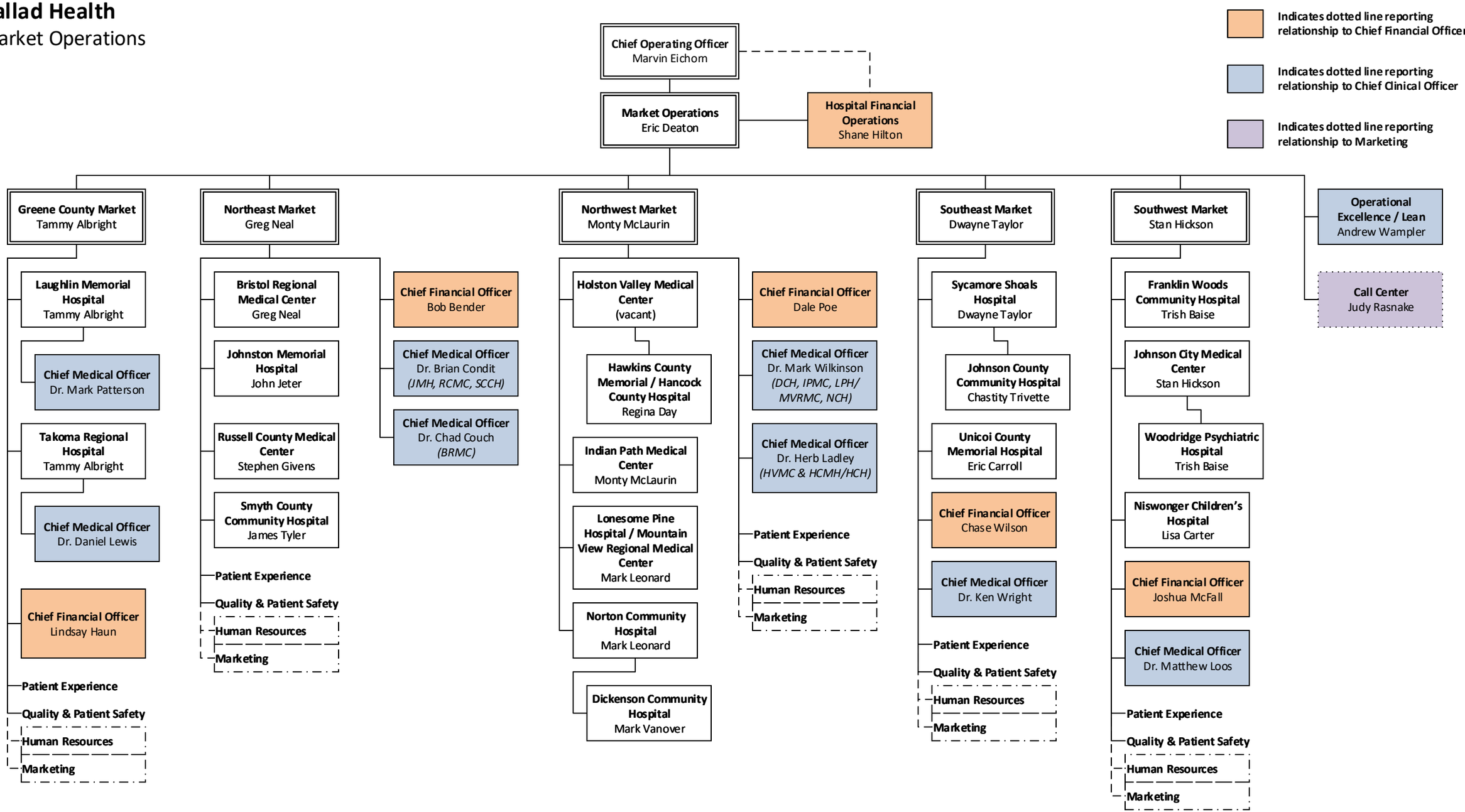
Indicates dotted line reporting relationship to Chief Financial Officer

Indicates dotted line reporting relationship to Chief Clinical Officer

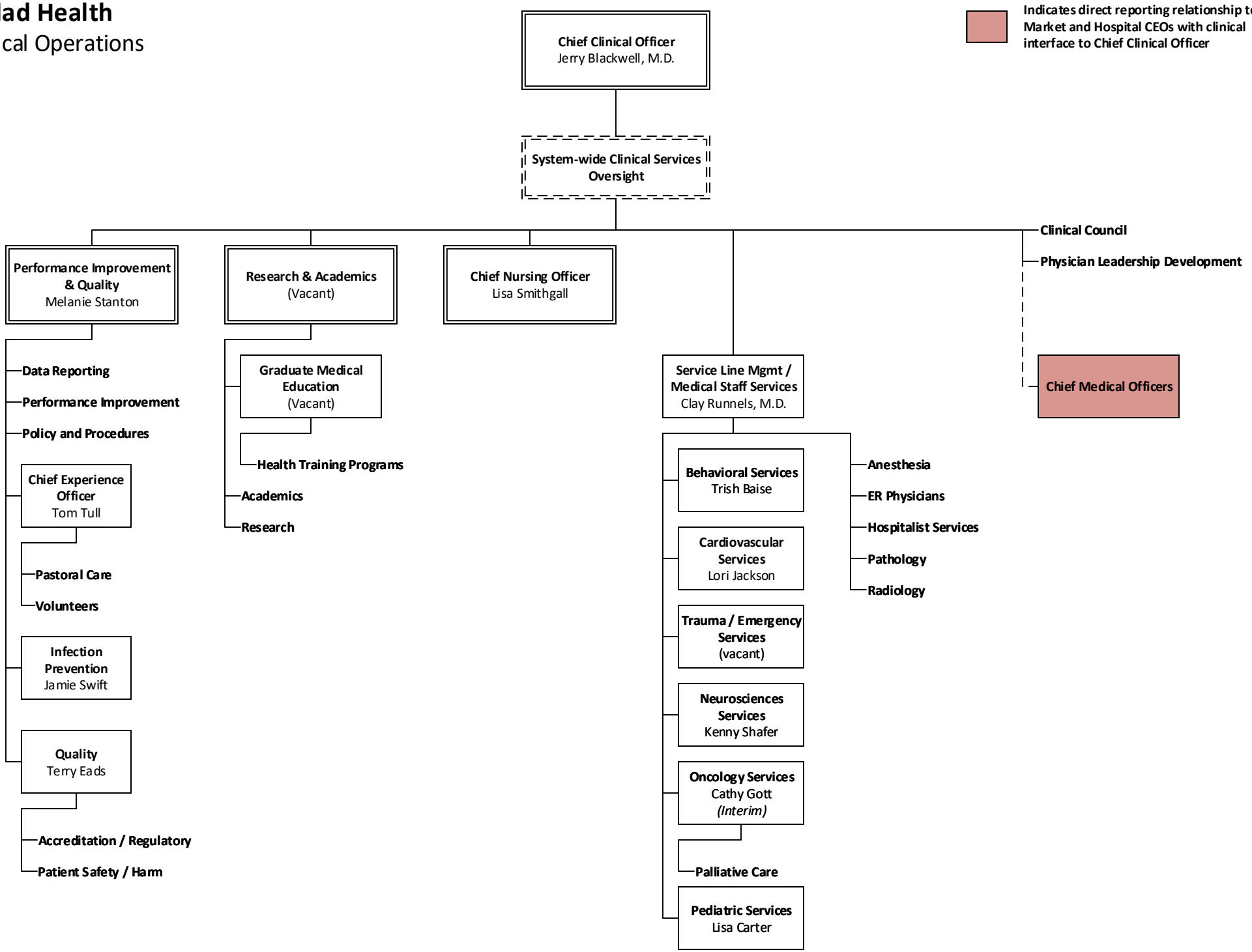
Indicates dotted line reporting relationship to Marketing

*** "As an organization dedicated to physician collaboration and leadership, operational decisions shall be made with input and guidance from physician leadership. This approach is infused throughout the organization as Chief Medical Officers operate collaboratively with administrative leadership and under the guidance of the Chief Clinical Officer."**

Ballad Health
Market Operations

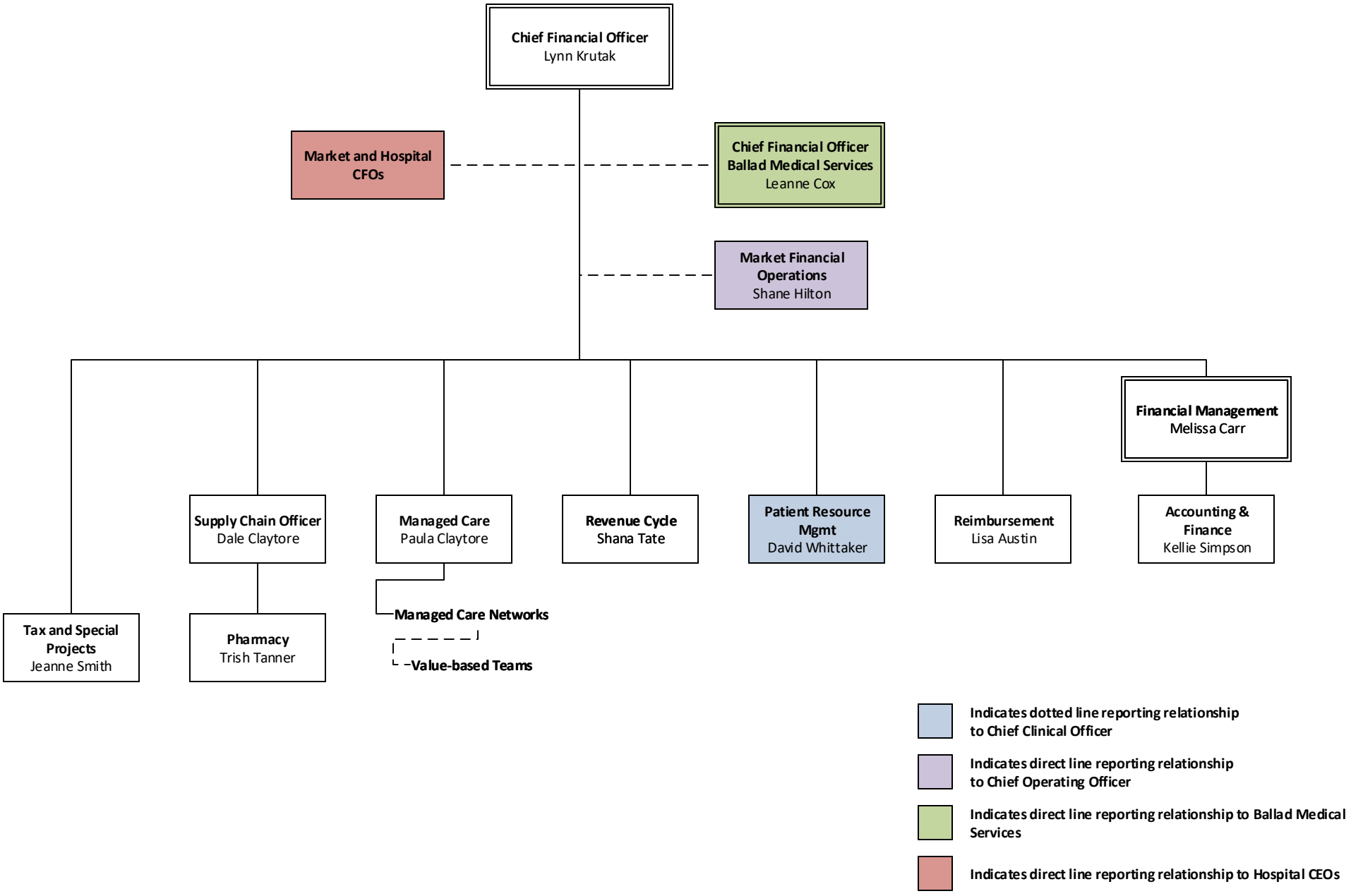


Ballad Health
Clinical Operations



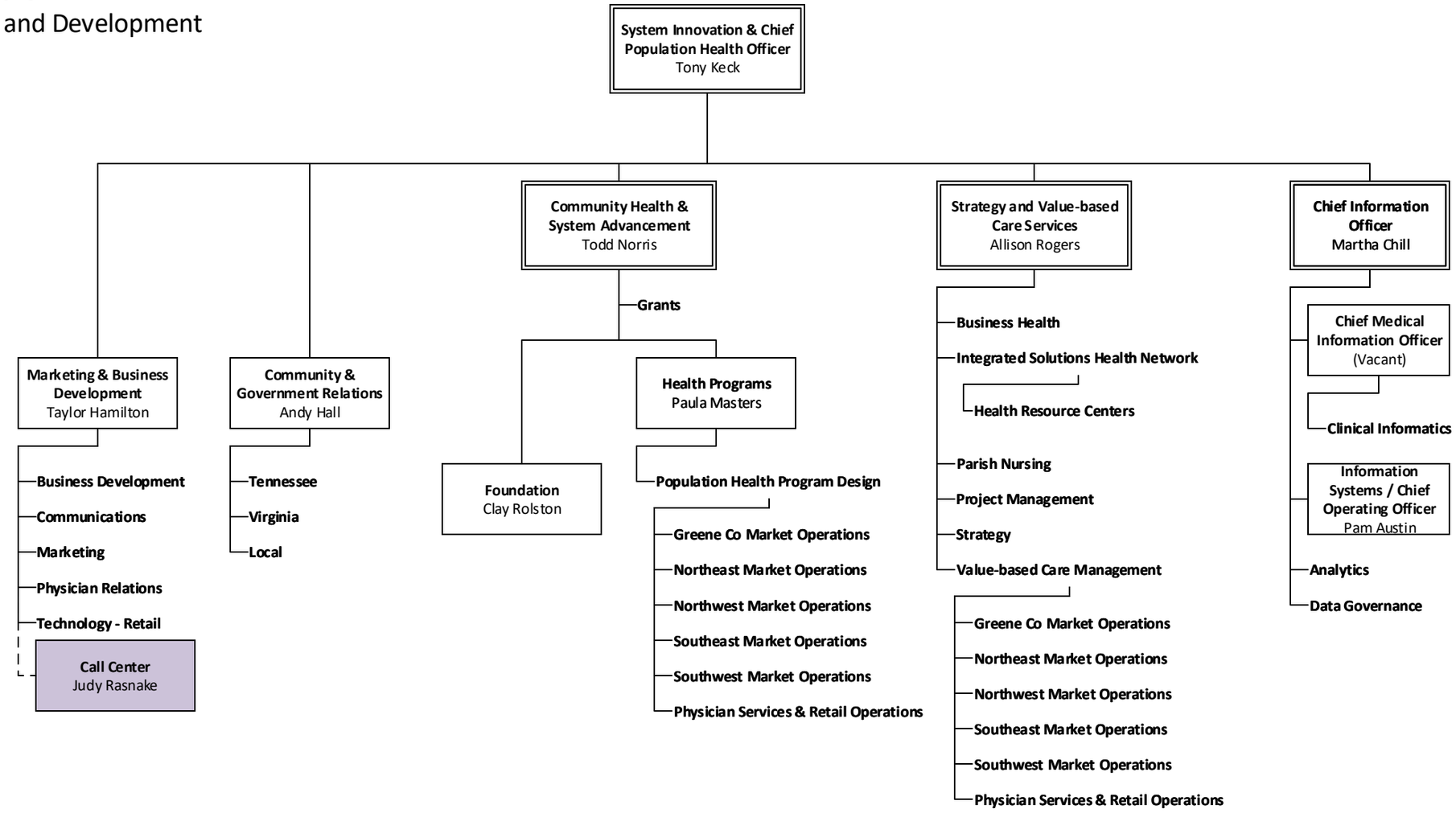
Ballad Health

Finance



Ballad Health

Innovation and Development



Indicates direct reporting relationship to Market Operations

Indicates direct reporting relationship to Chief Clinical Officer

ATTACHMENT 19

PROGRESS REPORT OF ACCOUNTABLE CARE COMMUNITY

Accountable Care Community Progress report

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Accountable Care Community Plan

- Accountable Care Community
  - Ballad Health will fund and take a lead role in the governance of a multi-stakeholder Accountable Care Community, which will serve as an integrator of multiple efforts across the region and organize around the pursuit of a limited number of complex population health challenges, such as third-grade reading improvement, reduction in teen pregnancy, tobacco use, physical activity, etc.

Current Status

-Selection of two lead support organizations completed: Healthy Kingsport and the United Way of Southwest Virginia

-Steering committee convened by April 30

-Contracts signed with lead support organizations

-Conducting bi-weekly calls between Ballad Health and lead support organizations

-Crosswalk of community health needs assessments completed to guide prioritization completed (Appendix 1)

-Comprehensive inventory of community partners completed

-Development of ACC development timeline completed (Appendix 2)

-Creation of focus area prioritization methodology completed (Appendix 3)

-Development of potential organizational members completed (Appendix 4 – currently recruiting members)

-Creation of ACC membership agreement completed (Appendix 5)

-Secured dates and venues for community focus group meetings in Southwest Virginia and Northeast Tennessee (Appendix 6)

Appendix 1

Community Health Needs Assessment Crosswalk

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		Tobacco Use			Obesity				Breastfeeding / Birth Outcomes						Substance Abuse			Vaccinations												
		Smoking	Smoking During Pregnancy	Youth Tobacco Use	Physically Active Adults	Physically Active Students	Obesity - Counseling and Education	Overweight/Obese Public School Students	mPINC Score	Breastfeeding Initiation	Infants Breastfed at 6mo	Infant Mortality	Low Birthweight	Teen Birth Rate	NAS Births	Drug Deaths	Adults - Prescription Drugs	Children - On-time Vaccinations	HPV Vaccines - Females	HPV Vaccines - Males	Flu Vaccine - Older Adults	Dental Sealants	3rd Grade Reading Level	Frequent Mental Distress	Pre-Diabetes Counseling	Premature Death				
Ballad Health CHNA	Legacy Wellmont	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓				
	DCH	✓	✓		✓	✓									✓	✓														
	FWCH	✓			✓	✓	✓	✓							✓	✓		✓	✓		✓		✓	✓						
	IPMC	✓	✓				✓	✓							✓			✓	✓	✓	✓		✓	✓	✓					
	JCMC	✓			✓	✓	✓	✓							✓	✓		✓	✓	✓	✓		✓	✓						
	JCCH	✓	✓		✓	✓	✓	✓							✓	✓								✓						
	JMH	✓	✓		✓	✓	✓	✓		✓	✓				✓	✓								✓						
	LMH	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓							✓						
	NCH	✓	✓				✓	✓							✓	✓														
	RCMC	✓	✓		✓	✓									✓	✓									✓					
	SCCH						✓	✓							✓	✓														
	SSH	✓		✓	✓	✓	✓	✓							✓	✓		✓	✓	✓	✓				✓					
	TRH	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓													
	UCMH	✓			✓	✓	✓	✓							✓	✓							✓	✓						
Other CHNA	Morristown Hamblen	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓							✓						
	Carilion Tazewell				✓	✓	✓	✓							✓	✓	✓													
	Buchanan General Hospital																													
VA CHA	Wise/ Norton	✓	✓		✓		✓			✓		✓		✓	✓	✓		✓				✓	✓							
	Scott	✓	✓		✓		✓			✓		✓		✓	✓	✓		✓				✓	✓							
	Mount Rogers				✓			✓						✓	✓	✓	✓					✓		✓						
SWVA Blueprint		✓	✓		✓		✓	✓		✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓				
ETSU Plan		✓	✓	✓	✓	✓				✓				✓	✓	✓	✓							✓						
TN Health Improvement	State Plan	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓													
	Sullivan County	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓													

Appendix 2

ACC Development Timeline

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	6-Aug	13-Aug	20-Aug	27-Aug	3-Sep	10-Sep	17-Sep	24-Sep	1-Oct	8-Oct	15-Oct	22-Oct	29-Oct	5-Nov	12-Nov	19-Nov	26-Nov
Membership Development Strategy																	
Each pop health/ACC team member develops territory partner list																	
Submit lists																	
Compilation of lists																	
Meet to coordinate enagement efforts across region																	
Reach out to potential members																	
Construct listing of members recruited																	
Submit list																	
Focus Area Prioritization Strategy																	
Create schedule of group meetings across region																	
Secure venue, etc. for meetings																	
Invite members to meetings																	
Conduct meetings																	
Compile findings from meetings																	
Develop roll up report of findings																	
Finialize regional focus areas from findings																	
Final report due																	

Appendix 3

Focus Area Prioritization Methodology

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Accountable Care Community
Regional focus area prioritization
Methodology

Purpose

The purpose of the Accountable Care Community's regional focus area prioritization effort is to better understand the current capacity, readiness and potential partnerships in regional communities to develop next steps for those focus areas already identified for health improvement. Upon a crosswalk evaluation of the 1) Ballad Health Community Health Needs Assessments, 2) Virginia Department of Health Community Health Assessments, 3) State of Tennessee's Population Health Improvement Plan, 4) Southwest Virginia Health Authority's Blueprint for Better Health and the 5) East Tennessee State University's Key Priorities for Improving Health in Northeast Tennessee and Southwest Virginia report, communities identified the following areas for population health improvement:

-Substance use/behavioral health

-Tobacco use

-Overweight/obesity

-Third-grade reading

These areas align with the current COPA/CA population health metrics and assist to help narrow the focus to three-five key focus areas for the responsibility of the Accountable Care Community.

Meeting format

There will be a total of six meetings; three in Tennessee and three in Virginia. The meetings will be conducted to gain the largest geographical representation in each state. Each meeting will contain the same content and will be approximately 1-1 ½ hours in length. The meeting will contain the following agenda elements: 1) introduction of the Accountable Care Community, its purpose and invitation to become a member, 2) purpose of the meeting, 3) presentation of identified focus areas and 4) stakeholder input session. Meeting facilitators will be responsible for all four elements, and those facilitators will be representatives from leadership in the Accountable Care Community and/or department of population health at Ballad Health. Target attendance will be 20-25 organizational participants for each meeting.

Stakeholder input guiding questions

Current capacity

•What services/programs currently exist in the area that focus on these priorities?

Readiness

•What assets exist that can contribute to focusing on these areas?

Co-investment opportunities

•What resources (financial, human, technical) exist that can be used to focus on these areas?

Partnerships

•Who else is involved in focusing on these areas, but is not in the room?

Barriers

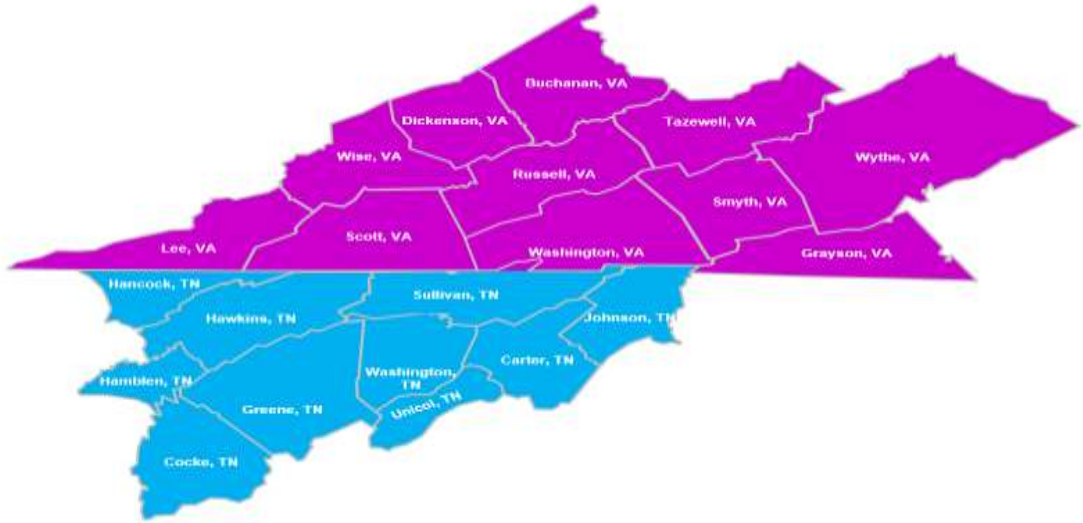
•What barriers currently exist that might impede our success in these areas?

Data capture and reporting

Each meeting will record the input by capturing the responses to questions, utilizing note-taking and group notepads. Those responses will be compiled into a report that represents aggregate findings, proposed next steps and tailored implementation plans. This process will serve as an important piece in strategic planning for the Accountable Care Community. It can also be used for communities as they prepare efforts to address those identified as shared focus areas.

Geography

The area of interest for the focus area prioritization being conducted by the Accountable Care Community is the 21-county Northeast Tennessee and Southwest Virginia geographical service area shown in the map below.



Appendix 4

Potential Organizational Members

CONFIDENTIAL-NOT CONFIRMED

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Teresa Kidd, Frontier Health	TN (Hancock, Hawkins, Greene, Washington, Sullivan, Unicoi, Carter, Johnson) VA (Lee, Wise, and Scott)
Linda Buck, Rural Health Services Consortium	Hawkins, Johnson, Washington, Greene, Carter, and Sullivan
Lottie Ryans, First Tennessee Development District	Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington
Scott Wilson, Bluecorss BlueShield of TN	All of Tennessee
Greg Allen, Cigna	All of Tennessee and Virginia
CeeGee McCord, Eastman	NETN and SWVA
Josh Davis, Eastman	NETN and SWVA
Rebekah English, NETN Regionanl Health Office	Hancock, Hawkins, Greene, Washington, Unicoi, Carter, Johnson
Gary Mayes, Sullivan County Regional Health Dept.	Sullivan
Janet Ridley, Hamblen County Health Dept.and Cocke County Health Dept.	Hamblen and Cocke
Lisa Cofer, Bristol TN/VA United Way	Sullivan County, TN and Washington County, VA for statistical purposes
Beth Rhinehart	Sullivan County, TN and Washington County, VA for statistical purposes
Dr. Nancy Dishner, Niswonger Foundation	Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington
Tony Seals, Hancock County Schools	Hamcock
Dr. Jeff Moorhouse, Kingsport City Schools	Sullivan
Steve Starnes, Greeneville City Schools	Greene and Hawkins
Dr. Bo Shadden,Kingsport City Schools	Sullivan and Unicoi
Sara Holt, Hancock County Schools	Hancock
Dr. Barry Staubus, Sullivan County District Attorney General	Sullivan
Jim Harlan, East Tennessee Foundation	Carter, Cocke, Greene, Johnson, Sullivan, Unicoi, and Washington
James and Laura Rogers Foundation	NETN and SWVA
Jason Abernathy, Insight Alliance	Washington
Raven Kirkbaum	Hawkins
Dr. Joe Smiddy	NETN and SWVA
John Harrison, Central Baptist Church	Sullivan
Delores Bertruso, St. Dominic Catholic Church and Parish Nurse	Sullivan
Amy Carter, Eastsman Credit Union	NETN and SWVA
Nicholas Pinchuck, Snap-on Tools	Carter
Chris Finley, BAE Systems	NETN and SWVA
Michele Moser, ETSU - Clinical Psychologist	NETN and SWVA
Dr. Moulton or May, SOFA	NETN and SWVA
Kayla Smith, Healthier TN	NETN
Claudia Byrd, Speedway Children's Charities	NETN and SWVA
Dr. Randy Wykoff, ETSU Collge of Public Health	NETN and SWVA
Jerry Flannery, MRFM	NETN and SWVA
Margaret Feierabend, Bristol Promise & Mayor of Bristol	NETN and SWVA
Dr. Davis Wood, ETSU Physicians	NETN and SWVA
Paul Montgomery, NESCC	NETN and SWVA
Jill Stott, TN Commission on Children and Youth	Tennessee
Mary Fabick, Blountville United Methodist & Milligan College	Sullivan
Dr. Linda Nelms, Walter's State Community College	Hamblen
Helen Scott, Healing Hands	NETN and SWVA
Bruce Sites, Friends In Need and Appalachian Miles for Smiles	NETN and SWVA
Maria Ketron, Kingsport Housing and Redevelopment Authority	Sullivan
Chris Campbell, Kingsport Area Transit Service	Sullivan
Candace Gump, First TN Housing Resource Agency and NET Trans	Carter, Greene, Hancock, Hawkins, Sullivan, Johnson, Unicoi, and Washington
Rhonda Chafin, Second Harvest Food Bank	NETN
Margot Seay, Neighborhood Commission	Sullivan
Roger Leonard, The Summitt Companies	NETN and SWVA
John Clark, City of Kingsport Mayor	Sullivan
David Tomita, Johnson City Mayor	Washington
Erica Phillips, Hawkins County Schools	Hawkins
Keith Coss, Greater Kingsport Family YMCA	NETN
Linda Brittenham, Retired Sullivan County Regional Health Department	Sullivan

Smyth County DSS	Director	Chris	Austin	Marion
Lee County Public Schools	Superintendent	Brian	Austin	Jonesville
Bristol City	Councilwoman	Catherine	Brillhart	Bristol
Russell County Public Schools	Superintendent	Greg	Brown	Lebanon
Tazewell County Public Schools	Superintendent	George	Brown	Tazewell
Russell County DSS	Director	Patrick	Brunty	Lebanon
Lenowisco HD	Medical Director	Sue	Cantrell	Wise
Smyth County Public Schools	Superintendent	Dennis	Carter	Marion
Virginia Department of Social Services	Regional Director	Tommy	Casteel	Abingdon
Chamber of Commerce - Wise County / City of Norton		Rick	Colley	Norton
Virginia Highlands Community College	President	Gene	Couch	Abingdon
Appalachian Community Federal Credit Union	Regional Community Development Coordinator	Adam G.	Dickson	Gray
Appalachian Community Action		Lil	Dupree	Gate City
TEDS	President	Joe	Ellis	Atkins
Pleasant View United Methodist Church	Associate Pastor	Barbara	Farmer	Bristol
Chamber of Commerce - Washington County		Neta	Farmer	Abingdon
Scott County Public Schools	Superintendent	John	Ferguson	Gate City
Highlands Community Services Board	Executive Director	Jeff	Fox	Abingdon
Dickenson County Department of Social Services		Michael	Gardner	Wise
Lee County DSS	Director	Trevor	Hensley	Jonesville
Buchanan County Public Schools	Superintendent	Melanie	Hibbitts	Grundy
New River Mt. Rogers Workforce Development Board	Director	Marty	Holliday	Radford
Buchanan County DSS	Director	Ruth	Horn	Grundy
Highlands Fellowship	Senior Pastor	Allen	Jessee	Abingdon
Frontier Health	President & CEO	Teresa	Kidd	Gray
SBA	District Director	Carl	Knoblock	Richmond
People Inc.	Health Services Coordinator	Lydia	Landis	Abingdon
Wise County DSS	Director	Jennifer	Lilly	Wise
The Thompson Charitable Foundation	Program Director	Jeffrey	Mansour	Knoxville
Appalachian College of Pharmacy		Susan	Mayhew	Oakwood
Southwestern Virginia Mental Health Institute	Director	Cynthia	McClaskey	Marion
Occupational Enterprises (OEI)	Executive Director	Felicia	McNabb	Lebanon
People Inc.	Community Services Director	Linda	Midgett	Abingdon
Mount Rogers Community Services Board	Executive Director	Lisa	Moore	Wytheville
Dickenson County	County Administrator	David	Moore Jr.	Clintwood
Scott County DSS	Director	Lana	Mullins	Gate City
Wise County Public Schools	Superintendent	Greg	Mullins	Wise
Washington County 4-H		Crystal	Peek	Abingdon
Bristol Virginia Public Schools		Keith	Perrigan	Bristol
Virginia Community Capital	Community Impact Advisor - Southwest Virginia	Sandy	Ratliff	Abingdon
Washington County Public Schools	Superintendent	Brian	Ratliff	Abingdon
Bristol Chamber of Commerce		Beth	Rhinehart	Bristol
City of Norton DSS	Director	Sara	Ring	Norton
Children's Advocacy Center	Executive Director	Kathi	Roark	Abingdon
Dickenson County Public Schools	Superintendent	Haydee	Robinson	Clintwood
Linwood Holton Governor's School	Director	Michael	Robinson	Abingdon
Emory & Henry College	President	Jake	Schrum	Emory
Mt. Rogers HD	Director	Karen	Shelton	Marion
Grayson County	County Administrator	William L.	Shepley	Independence
SVAM Center of Excellence		Stephanie	Surrett	Abingdon
Tazewell County DSS	Director	Rex	Tester	Tazewell
Mountain Empire Community College	President	Kris	Westover	Big Stone Gap
Norton City Schools	Superintendent	Gina	Wohlford	Norton

Appendix 5

Membership Agreement Form

Northeast Tennessee Example

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Northeast Tennessee Accountable Care Community
Membership Agreement
July 1, 2018 – June 30, 2021

ACC goals and objectives

The NETN ACC is a formal collaboration between leading organizations to create a multi-sector, multi-geography effort to positively impact the health and wellness of the 10 counties of Northeast Tennessee through collective impact. Members of the ACC will develop a strong consensus for collective work on three to five major priority issues that have a disproportionate impact on health status, community well-being and economic viability. Issues such as the opioid crisis, third-grade reading levels, tobacco use and obesity have been identified as potential areas of focus and will continue to be refined by through the ACC's work

The ACC will function as a cohesive body of partners to influence change through collective regional action and local community action by convening interested parties, educating community members, aligning supporting resources, influencing policy and practice and rallying community action.

ACC Membership Commitments

As an ACC member, _____ agrees to the following:
(Organization Name)

- Leadership appointment of an engaged representative who will attend the bulk of meetings and contribute positively to efforts
- Leadership understanding of the ACC's goals and commitment to advancing those goals through a variety of organizational resources to be defined over time
- Using the influence of my organization to advance the goals of the ACC, both within my organization and in the community
- Advocating for the goals of the ACC with other community leaders and policymakers
- Supporting local community action team efforts by allowing employee participation, based on interest
- Utilizing organizational resources (including financial resources when possible) to support efforts within my organization or regionally to advance programmatic solutions to ACC priority areas
- Utilize the communication channels available to my organization to advance ACC educational efforts, messaging and program offerings applicable to employees and their families

On behalf of _____

Signed by _____ Date _____

Title _____

Appointed Leadership Information

Name: _____

Telephone Number: _____

E-Mail: _____

Appendix

Community Focus Group List

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NETN ACC Community Focus Groups:

Friday, Oct. 19
9:30 – 11 a.m.
Bristol VA Public Schools – Main Office
220 Lee St.
Bristol, VA 24201

Tuesday, Oct. 23
9:30 – 11 a.m.
Walter's State Community College
500 South Davy Crockett Parkway
Morristown, TN 37813

Wednesday, Oct. 24
3 – 4:30 p.m.
East Tennessee State University's Allandale Campus
1501 University Blvd.
Kingsport, TN 37660

SWVA ACC Community Focus Groups:

Wednesday, Oct. 17
1:30 p.m. - 3 p.m.
Scott County Community Services Building
190 Beech St.
Gate City, VA 24251

Thursday, Oct. 18
1:30 p.m. - 3 p.m.
SWCC Lebanon Center for Education and Training
141 Highland St.
Lebanon, VA 24266

Friday, Oct. 19
1:30 p.m. - 3 p.m.
Virginia Highlands Small Business Incubator
851 French Moore Jr. Blvd.
Abingdon, VA 24210