# RESPONSES TO QUESTIONS

# SUBMITTED NOVEMBER 22, 2016

# BY

# TENNESSEE DEPARTMENT OF HEALTH

# IN CONNECTION WITH

# APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE

Submitted by: Mountain States Health Alliance
Wellmont Health System

# Ballad Health[1]
# Overview of Approach

**Executive Summary:** In response to the Tennessee Department of Health's Request for Information dated November 22, 2016 (the "Request for Information"), we provide an overview of Ballad Health's transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system responsible for providing value-driven community health improvement to the communities served by the combined system. This overview is intended to inform the series of responses that will be submitted addressing each individual request identified in the Request for Information.

Ballad Health has a unique opportunity to deliver unprecedented value and public advantage by realigning the two existing health systems of the region into a single integrated delivery system of healthcare providers to provide a coordinated, continuum of services to the community. Ballad Health will be accountable, both clinically and fiscally, on its own and as required with partners, for the clinical outcomes and health status of the population it serves, and will put systems in place to manage and improve them.

In addition to its transformation to a single and fully integrated delivery system, Ballad will reach beyond the clinical settings to expand its focus from medical care delivery alone to broader community health with a substantial focus on prevention. The combined impact of fully integrated delivery system and increased focus on prevention and community health will lead to a reduction in the development, prevalence, and progression of diseases, creating a more direct path to improved health and health outcomes. Though the specific pace of improvement toward these outcomes will be difficult to anticipate because of the variety of factors impacting them in a large, diverse population, measures should be identified for tracking and continual improvement of specific efforts designed to derive the desired outcomes. Focus on intermediate outcomes and effective implementation of best practice prevention and intervention efforts will allow research and learning to occur in collaboration with Ballad Health, state and local public health, academic partners, and community partners. Central to this is the development of annual plans which support the strategic, long-term Community Health Improvement Plan. Fulfillment of the requirements set forth in the annual plan will be central to ongoing, active supervision and evaluation of COPA progress.

Evolution to this broader model entails an effective interface between the healthcare delivery system and its internal partners with all of the key attributes of integrated delivery system, clinical protocols, infrastructure and facilities and population health medicine and largely external partners focused primarily on community health improvement.[2] Ballad Health will engage directly as an integrated

[1] Since filing the Application for a Certificate of Public Advantage in February, 2016, the Parties have announced "Ballad Health" as the name the New Health System will adopt if the merger is approved and the Certificate of Public Advantage is issued. The responses to the Tennessee Department of Health's Request for Information dated November 22, 2016, may use "Ballad Health" and the "New Health System" interchangeably to refer to the merged health system.

[2] For purposes of this response, we define "population health medicine" as the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated. We define "community health improvement" to mean efforts to improve health outcomes in targeted populations by addressing priority health needs and social determinants of health with

delivery system to align incentives around the Triple Aim goals of the healthcare delivery system and to align with insurers and other stakeholders to seek to reduce costs, improve outcomes, and enhance patient access and experience across all of the area populations it serves. Ballad Health will create a new Department of Population Health Improvement, staffed with internal resource personnel who will work to coordinate and connect internal and external systems to lead, convene, facilitate, influence, and implement change management plans to realize this transformation.

We have included a timeline overview which will guide the initial development of the Department and the Accountable Care Community, which will be the primary vehicle for the coordination of activities around community health improvement. Additionally, we have addressed the priorities and funding for these components, the sustainability of these efforts, and an explanation for why these two initiatives are specific to the merger.

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## I. Overview of Approach.

Ballad Health seeks to redefine the current approach to traditional health care delivery in order to become an integrated delivery system that serves as the basis for a broader value-driven community health improvement organization. This involves two important and highly complementary aspects:

1) Ballad Health will transform the medical care system in the region from two traditional healthcare systems to a fully integrated delivery system with the ability to take on greater risk and to provide significantly enhanced value for its communities. Enhanced value includes coordination across the healthcare delivery system on best location of care, care closer to home, and approaches that rely on enhanced IT, physician leadership, and clinical alignment around health, outcomes, access and quality. This will require an ongoing shift of clinical and leadership focus from the volume of services provided to the patient outcomes achieved, as well as supporting infrastructure and new financial commitments by Ballad Health. In place of the existing fragmented system this fully integrated healthcare delivery system will develop systems of care and embedded protocols through clinically aligned networks and common, clinically integrated electronic medical record system to serve patients with improved results across diverse locations, and enable independent physicians and other providers not only to actively participate, but to benefit from Ballad's investments and infrastructure.[3] In addition, the newly developed leadership, clinical council, investments, infrastructure and quality initiatives will further facilitate enhanced partnering with payers on risk-based and value-based initiatives that serve the common interests of improved outcomes and savings.

2) Ballad Health will also establish an Accountable Care Community to reach beyond the traditional healthcare delivery system to impact community health improvement with our partners. Ballad

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evidence-based initiatives resulting in a positive change in health outcomes." Of necessity, Ballad Health as a healthcare delivery system, will be intimately involved in population health medicine, and also engaged in community health improvement activities, for example, by its engagement with prevention efforts with its primary care physicians.

[3] We note that Ballad Health will take on the financial commitments and investments in the healthcare delivery system, and motivate and make available the benefits of platforms and other infrastructure to independent physicians and other providers to improve their ability to deliver higher value care to residents.

Health will establish a new Department of Population Health to bridge the healthcare delivery and clinical alignment efforts for the health system and the community health improvement efforts being expanded on through the Accountable Care Community. This component will impact the population as a whole.

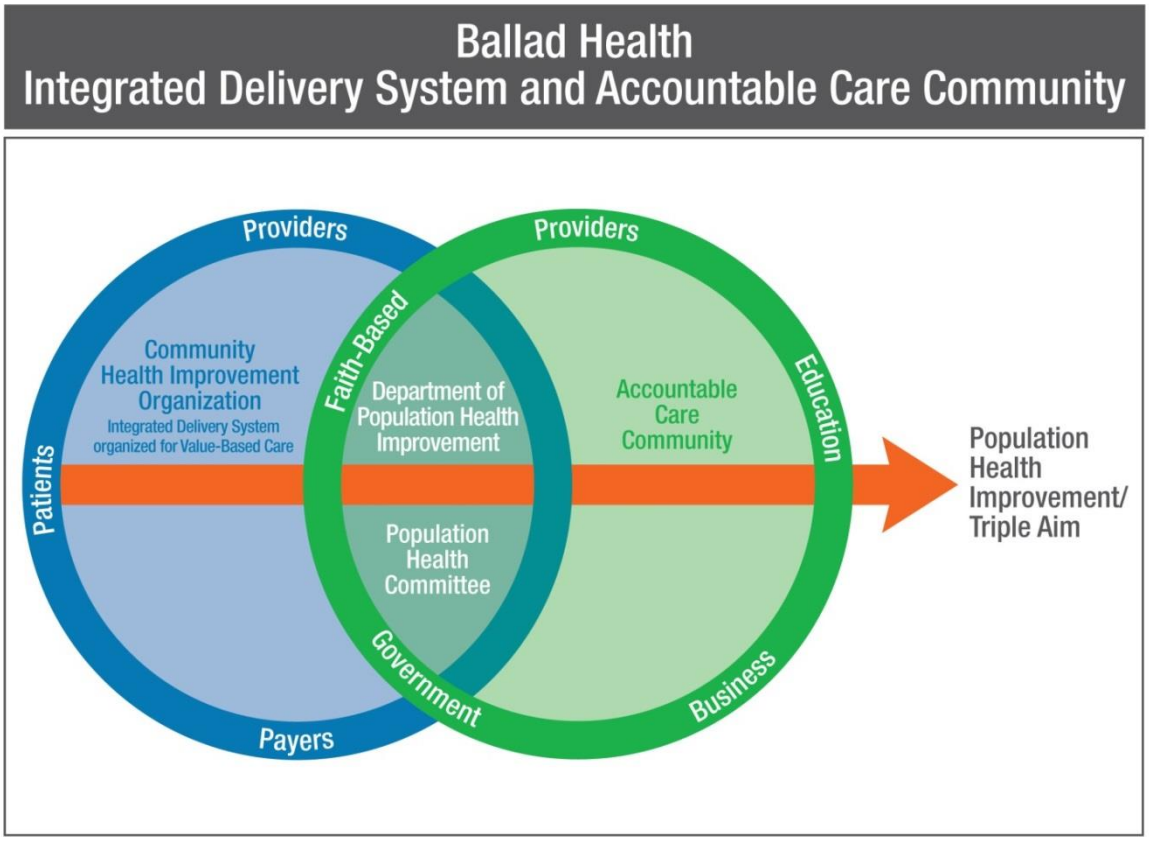
Through this combined strategy of integrated care delivery and community health improvement, Ballad Health will transcend the traditional role of health care provider to become a community health improvement organization. This dual approach has the best chance of achieving Triple Aim objectives both through the healthcare delivery system and through community-based initiatives, and would establish one of the first Accountable Care Community models in the state of Tennessee. Our strategy captures a key community value-proposition of Ballad Health.

The move towards more fully integrated healthcare delivery systems with aligned incentives for value-based care is an attempt to address an unsustainable regional and national health care model with unpredictable and untenable rate increases for employers and the subs medical and productivity costs plaguing employers and their employees. While there is much uncertainty about the direction of health care reform in the current political environment, particularly the fate of the Affordable Care Act, experts generally agree that value-based care and risk-based payment models are here to stay.[4] Most importantly, providers, employers, insurers, and communities are unlikely to change the imperative to address critical health, access, cost and quality needs at the local level – the level generally recognized as the point at which transformative change can most readily occur. We believe that value-based care is not a destination but a path, and Ballad Health's course must include as a priority the alignment of incentives and investments in a local delivery system that meets the significant population health needs of Tennessee and Virginia.

As Ballad Health prepares to transform two individual and traditional health care delivery systems into a fully integrated and aligned health care delivery system, it must embrace a strategy built upon locally-driven and value-driven community health improvement.[5]

[4] *See* Elizabeth Whitman, *Will value-based payment initiatives continue under Trump?*, MODERN HEALTHCARE (November 11, 2016) (*stating* "President-elect Donald Trump's promise to dismantle the Affordable Care Act is unlikely to also undo widespread efforts to nudge the U.S. healthcare system toward value-based payment, including experiments devised by the ACA-funded Center for Medicare & Medicaid Innovation."), *available at* http://www.modernhealthcare.com/article/20161111/MAGAZINE/161109907.

[5] *See* Bruce Hamory & Dan Shellenbarger, *Value-Based Care Under President-Elect Trump? Here to Stay* (November, 2016) ( *stating* "No matter what happens with the ACA, now is not the time for providers to ease off their transformation efforts."), *available at* http://health.oliverwyman.com/maximize-value/2016/11/value-based_careund.html.




## II. Key Organizational Components Defined.

Several important organizational components are referenced in this overview, each of which contributes uniquely to the goal of achieving the broad goal of community health improvement:

**Integrated Delivery System:** Ballad Health intends to transform the two traditional delivery systems into a single, fully integrated healthcare delivery system of hospitals, outpatient facilities, physicians, and other providers in the Ballad Health system aligned to meet the needs of the full population of the Geographic Service Area in the most effective and appropriate location of care with the requisite investments and financial commitments. Ballad Health will be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population it serves, and will put systems in place to manage and improve them. The healthcare delivery system will be the basis by which Ballad Health will work with payers to align incentives and initiatives; independent physicians and providers will be able to access the system and obtain its benefits.

**Accountable Care Community:** The Accountable Care Community is an organization that Ballad Health will establish and lead to meaningfully and measurably impact the health of the whole population with our partners. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community better to address specific population health needs. The goal will be to create a model of self-sustainability and broad-based community ownership of these external initiatives. The Accountable Care Community will be essential to a successful fulfillment of the Community Health Improvement Plan and regionally coordinated and scaled efforts around common objectives. We

envision that state or regional Department of Health leaders will serve in key roles for the Accountable Care Community.

**Department of Population Health Improvement:** The Ballad Health Department of Population Health Improvement will be created and led by a senior executive who reports directly to the President and Executive Chair of Ballad Health. This department will be instrumental in the development of the Accountable Care Community as well as serve as the primary liaison to all regulatory agencies and to the Ballad Health Board Committee on Population Health and Social Responsibility. The Department of Population Health Improvement will be staffed with key leaders whose roles will ensure that all relevant COPA commitments are fulfilled and supported by strong planning, implementation, evaluation, and improvement efforts driven both directly by Ballad Health and/or through the Accountable Care Community.[6] Funding for community health improvement efforts will be managed through this Department.

**Population Health and Social Responsibility Committee of the Board:** This standing committee of the Ballad Health Board of Directors will include regional and multi-sector representation and will be responsible for oversight and compliance with all COPA commitments and reporting requirements. It will also be responsible for governing the alignment of COPA Funding, Social Responsibility strategies, and COPA efforts to produce health improvement in the community. Members of the Committee will include Ballad Health directors and other community members appointed by the Ballad Health Board. Leaders from this committee will also serve on the Accountable Care Community board.

**Physician Clinical Council:** Ballad Health will form a Physician Clinical Council which will be instrumental in guiding Ballad's work to achieve the Triple Aim and creating a shared culture of health care quality, transparency, and population health improvement. It is envisioned that the Physician Clinical Council will be independent of the Accountable Care Community, and that its efforts will focus on key aspects of clinical integration and development of the integrated delivery system. Led by the Quality Committee of the Ballad Health Board and Ballad Health's Chief Medical Officer, the Physician Clinical Council will be appointed jointly by the medical staffs of Ballad Health hospitals and by the Ballad Health Board of Directors. This will facilitate the connection back to each hospital's medical staff and to community-based physicians in order to influence physician practice patterns and to receive and incorporate best practices across the system. It is anticipated that the Ballad Health Chief Medical Officer and other members of the Physician Clinical Council will serve in the Accountable Care Community leadership and on the Population Health and Social Responsibility Committee of the Board to further these mutually supportive efforts.

## III. The Integrated Delivery System.

The merger provides a unique opportunity to transform two independent health care delivery systems with duplicative services and equipment into one fully integrated healthcare delivery system. The integrated delivery system will operate more effectively and efficiently by allocating resources to the highest priority needs of the system and the community health, realigning facilities and clinical services to best purposes and supporting coordination of care and efforts to shift and support care delivery at the most cost effective and best location for the patient. The merged, integrated system will be more

[6] It is envisioned that several COPA commitments involving population health, health metrics, and improvements will be the primary responsibility of this Department.

readily able to take on and manage risk for the populations it serves because synergies can be reinvested in the infrastructure and human resources needed to succeed with population health. The savings from the synergies will be reinvested in the implementation of the Common Clinical IT Platform, the alignment of clinical protocols, and the implementation of new data analytics and case management programs. Ballad Health will now have the ability to work with the complete population of each payer and the community to achieve and share in the cost savings and improved outcomes provided by its commitments and investments in healthcare delivery. Ballad Health will be fully committed, and accountable, for achieving the benefits made possible by the merger and committed to under the COPA, and will work to align incentives with payers, the State, other providers, and the community to achieve improved access, lower costs of care, and improve outcomes in a way that yields substantial savings for residents, employers, insurers, and the State. As healthcare transformation experts have noted, there are huge opportunities for improving value through the development of integrated delivery systems.[7] Specifically, the elimination of fragmentation and duplication of care and to optimize the types of care delivered in each location.

**A. Managing the Transformation to an Integrated Delivery System**.

We will work internally to position Ballad Health for a smooth and effective transition to a value-based approach to health care delivery that includes enhanced pay-for-value and risk-based models of population health medicine, and most importantly for alignment of care delivery and location along with treatment in the most cost effective and high valued way. The essential pathways include greater alignment of both incentives and operations under a single physician-led council and overall leadership to use the resources available in the most effective way to address needs, improve outcomes, provide for greater financial stability and sustainability of care, and lead to the way to greater ability for enhanced risk-based approaches. This may also include the development of a clinically integrated network in partnership with the independent physician community. Under these risk-based, value-based payment models and other initiatives, Ballad Health will be incentivized for achieving cost and outcomes of care, and have incentives to keep people well. These plans are further outlined in responses relating to clinically aligned systems and the IT platform, as well as in the cultural alignment response.

**B. Challenges and Strategies**

We recognize that challenges will exist in the transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system.[8]

- Challenge: Achieving integrated care will require changing health-care culture and how clinicians think about care delivery.[9]
    - Strategy: Ballad Health acknowledges that a move to integrated care will require a cultural change. Ballad Health has specifically addressed its plans for cultural transformation in Response #7: The Cultural Alignment Plan.

[7] *See* Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV. (October 2013), *available at* https://hbr.org/2013/10/the-strategy-that-will-fix-health-care.

[8] *See* Kenneth W. Kizer, Professor at UC Davis Inst. for Population Health Improvement, Achieving integrated health care: Nine key lessons, Address to the International Integrated Care Conference (April 4, 2014), *summary available at* http://www.ucdmc.ucdavis.edu/publish/news/newsroom/8847.

[9] *See id*. (*stating* "Achieving integrated care first and foremost requires changing health-care culture and how clinicians think about care delivery.").

- Challenge: Strong and respected clinical leadership will be essential for achieving clinical integration.[10]
    - Strategy: Ballad Health recognizes that effective clinical leaders will be needed to promote and maintain focus on the vision of integrated care over the long term. Ballad health will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce error and overlap, shorten length of stay, reduce costs, and improve patient outcomes. Additional information about the Clinical Council is included in Response #8: The New Clinical System. Under any clinically integrated network that Ballad may form in partnership with independent physicians, governance would be primarily physician-driven.

- Challenge: Financial payment methods will need to be aligned with and support the desired outcomes of the integrated delivery system.[11]
    - Strategy: As Ballad Health transitions from a traditional health care delivery system to a combined and integrated healthcare delivery system and then on to a more fully developed value-driven community health improvement organization, it will work with commercial payers and participate in government payer programs to implement more value-based approaches to health care delivery that include pay-for-value and risk-based models of population health medicine. Any clinically integrated network which Ballad may form in partnership with independent physician groups will allow Ballad and these groups to align financial incentives to produce value in a manner not possible otherwise. Ballad Health's strategy to move increasingly towards value-based contracting and risk-based models is detailed in Response #2: The Insurance and Value Payment Transition.

- Challenge: Information management and administrative infrastructure will be needed to facilitate a culture of collaboration and continuous improvement.[12]
    - Strategy: The parties have committed to the adoption of a Common Clinical IT Platform to ensure that information needed to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. In addition, the parties have committed to meaningful participation in a region-wide health information exchange to promote coordination among community providers, including those providers not part of the New Health System. Both health systems also have developed process and quality improvement departments which focus on lean management principles for continuous improvement. These efforts will be unified and targeted. Ballad will also reorganize and expand its analytics capabilities under a new Analytics department, and is currently in process of developing a common analytics Request for Proposal under pre-merger planning. Additional details about Ballad Health's plans to use information technology to facilitate

[10] *See id*. (*stating* "Strong and respected clinical leadership is essential for achieving clinical integration.").
[11] *See id*. (*stating* "[R]emoving financial disincentives to providing integrated care may be as important, or even more important, than providing positive financial incentives.").
[12] *See id*. (*stating* "Achieving integrated care requires an enabling information management and administrative infrastructure, but to be optimally effective these must be embedded in a culture of collaboration and continuous improvement.").

a culture of collaboration and continuous improvement are addressed in Response #9: The IT Strategy.

- Challenge: Clinical care delivery assets will need to be significantly restructured to provide integrated care.[13]
    - Strategy: As the Parties have outlined in the Application, Ballad Health will adopt a comprehensive Alignment Policy that sets forth a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients when making decisions regarding changes that may leave a community without services traditionally provided in that immediate area. This Policy will allow the new health system to ensure that the care delivery decisions of the New Health System are aligned with the interests of the community. In addition, the Ballad strategic plan will place priority focus on the need for new and expanded population medicine resources such as analytics, case management, health coaching, new modes of access such as telemedicine and expanded clinical call centers, the clinically integrated network structure and effective use of a common EHR and HIE system. Additional details about this process are addressed in Response #3: The Structure for the Future.

- Challenge: Communicating the change process will require a strategic communications plan.[14]
    - Strategy: The Parties will establish a strategic communications and organizational development plan to affect the change management process. Physicians and nurses will be prepared to communicate the plan's key messages because they are generally viewed as the most credible messengers to patients.[15] Ballad Health has specifically addressed its plans for communicating the cultural transformation in Response #7: The Cultural Alignment Plan.

## IV. The Accountable Care Community.

The second component of the move to a value-driven community health improvement organization will be the establishment of an Accountable Care Community that will allow Ballad Health to work with its partners to more meaningfully and measurably impact the health of the whole population. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community to address the agreed upon population health needs.

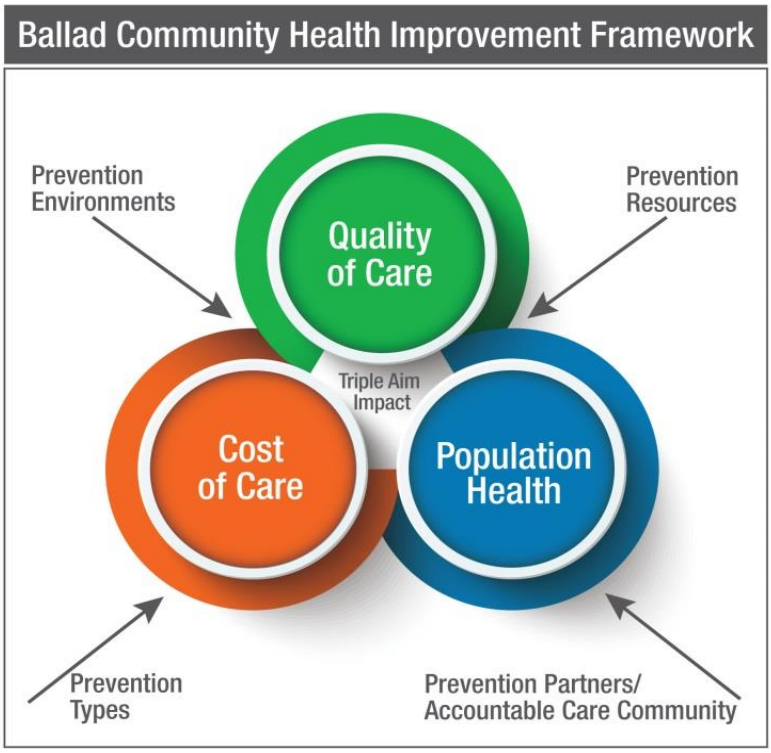
### A. Establishment of the Accountable Care Community

An Accountable Care Community encompasses leadership and stakeholders not only from the medical care delivery system, but also from the public health system, employers, community stakeholders at the grassroots level, and community organizations whose work often encompasses the entire spectrum of

[13] *See id*. (*stating* "Clinical care delivery assets in most health-care organizations will need to be significantly restructured to provide integrated care.").
[14] *See id*. (*stating* "An essential but often overlooked element in achieving integrated care is a strategic communications plan.").
[15] *See id*. (*stating* "Experience has shown that physicians and nurses are usually viewed as the most credible messengers for communicating the plan's key messages.").

the determinants of health.[16] Through collaborative partnerships and multi-sector oversight, an Accountable Care Community can streamline efforts across the community and across numerous health issues for health promotion and disease prevention, access to quality services, and access to healthcare delivery. As public health experts have noted, Accountable Care Communities are well-positioned to comprehensively address a broad range of health issues while maximizing the community's assets.[17]

To that end, Ballad Health will take responsibility for establishing an Accountable Care Community model in the Geographic Service Area and will utilize resources to drive regional community health transformation. Members of the Accountable Care Community will be recruited based on their multi-sector leadership and their willingness to commit to be an accountable partner in the development of cohesive regional community health improvement efforts. A leadership council or board will govern the work of the Accountable Care Community and sub-committees may be developed based on sub-regional designations such as cities, counties, or other connected geographies. Members of the Ballad Health Population Health and Social Responsibility Committee and Department of Population Health Improvement will serve in standing leadership roles.




## B. Ballad Health's Role in the Accountable Care Community

Ballad Health will work to align the components of the Accountable Care Community and target health improvement in our region in a way that creates clear advantage for payers (individuals, insurance companies, government payers, and employers), providers (physicians, hospitals, ancillary services), and

[16] *See* FAEGREBD CONSULTING, *Healthier By Design: Creating Accountable Care Communities* (February 2012), *available at* http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf.
[17] *Id.*

the people and communities we serve—including underserved populations or those experiencing health disparities.

Within the Accountable Care Community framework, Ballad Health will be responsible for the roles outlined below to ensure that regional health transformation occurs. These defined roles will facilitate activities which shape policy and environment/infrastructure through local, state, and national level discourse and positively shape individual and group behavior through coaching, training, provider interaction, and community and personal education, engagement, and resource provision.

**Ballad Health as Leader:** Ballad Health will set the mission and the vision for regional health improvement through influential leadership and initiate corporate leadership within our communities and own organization through the development of community health policies and practices. In addition, we will create internal governance and compliance structures that are accountable to the Population Health and Social Responsibility Committee of the Ballad Health Board of Directors. This board committee will be responsible for oversight and compliance with all COPA commitments, including the Community Health Improvement Plan. Key members of this committee and Ballad staff leaders assigned to it will have dual roles associated with participation and leadership in the Accountable Care Community.

**Ballad Health as Convener:** Ballad Health will identify essential accountable partners across the region and recruit them to establish a regional Accountable Care Community model focused on the Community Health Improvement Plan. The Partners will adopt mutually accountable covenant commitments and focus comprehensive efforts around common objectives. The partners will include the breadth of organizations that are able to help the Accountable Care Community fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in the Geographic Service Area.

**Ballad Health as Facilitator:** Ballad Health will be a catalytic force for change in our region, deploying human resources, educational resources, and advocacy resources to work hand in hand with accountable partners, providers of care, community members, and patients to accomplish regional goals.

**Ballad Health as Grantor:** Ballad Health will provide the basic funding to sustain the infrastructure for the Accountable Care Community. As required under the Community Health Improvement Plan we will provide financial investments to accountable partners to focus on priority efforts with clear, contractual expectations for how those funds will be used and a clear system for evaluating compliance, evaluation, and success.

**Ballad Health as Implementer:** Where gaps exist in community resources, Ballad Health will seek to fill those gaps by enhancing the capacity and capability of accountable partners or by creating Ballad Health departments, programs, or structures where needed.

**Ballad Health as Evaluator:** Ballad Health will ensure that effective evaluation mechanisms exist to drive ongoing accountability through a system of active supervision and evaluation for the Accountable Care Community initiatives. This may include working with outside evaluators from academic or other settings.

In order to connect and coordinate the clinical alignment efforts within Ballad Health and the community health improvement efforts being developed through the Accountable Care Community, Ballad Health will establish a new Department of Population Health. Oversight for this Department will

be vested with a senior executive, and staffed with leaders charged with financial compliance, physician relations, and community relations. The Department will be responsible for bridging the internal health system transformation with the external community health improvement efforts.

## C. Challenges and Strategies

An Accountable Care Community is a locally-driven and locally-relevant organization. We recognize that challenges will exist in the development and implementation of the Accountable Care Community as we partner and collaborate with community organizations, but members of our executive teams have been instrumental in an extensive array of multi-stakeholder collaborative efforts as set forth in Exhibit A and have developed a host of significant regional relationships which will empower this work. We have also studied the experiences of accountable communities for health across the United States to identify the challenges each encountered and the lessons learned from their experiences. Among those Accountable Care Communities studied were the Live Healthy Summit County initiative in Akron, Ohio, the Pueblo Triple Aim Coalition in Pueblo County, Colorado, the Live Well San Diego initiative in San Diego County, California, the Trillium Community Health Plan in Lane County, Oregon, and the Pathways to a Healthy Bernalillo County initiative in Bernalillo County, New Mexico.[18] Research by the Institute of Medicine (now the National Academy of Medicine) illustrates that successful stakeholder and business engagement involves close alignment of providers, insurers, and businesses and community leaders with common data, common priorities, and focused investments in highest priority areas.[19] While successful engagement and action may face hurdles, local communities have overcome these hurdles where there is very strong common interest and high need for engagement given health status and other issues.

Based on the experience of these organizations that have implemented accountable communities for health, and our own executive team's experience in implementing multi-sector collaborative efforts, we have identified the following as the challenges we are most likely to encounter in the development of our Accountable Care Community and propose to address these challenges with the following strategies:

- Challenge: Building strong relationships to establish the Accountable Care Community partnerships.
    - Strategy: To effectively implement the Accountable Care Community, Ballad Health will build upon its existing relationships with community organizations and articulate clear responsibilities and expectations for each partner organization. The Work Groups

[18] The Prevention Institute was engaged by the Department of Vermont Health Access to identify national examples of innovative healthcare–community partnerships to improve population health. The Prevention Institute published their findings in a comprehensive report entitled "Accountable Communities for Health: Opportunities and Recommendations" which was published in July 2015. The report noted that "[r]elatively few communities in the country are implementing healthcare delivery and payment reforms that include environmental change strategies as a key pillar for improving population health" but identified these five initiatives as examples of national healthcare-community partnerships supporting community-wide environmental change efforts.

[19] *See, e.g*., Lawrence Pyrbil et. al, *Improving Community Health through Hospital – Public Health Collaboration* (November 2014), *available at* http://www.aha.org/content/14/141204-hospubhealthpart-report.pdf; *and* Lawrence Prybil et. al, *A Perspective on Public–Private Collaboration in the Health Sector*, NAT. ACAD. OF MED. (November 2015), *available at* https://nam.edu/wp-content/uploads/2015/11/NAM-Public-Private-Collaboration-Perspective.pdf.

formed by the Applicants, which included many community organizations, will serve as an organizing base for this effort. Ballad Health has specifically addressed its strategy for recruiting and working with its accountable partners in Response #11: Plan for Community Partnership and Collaboration.

- Challenge: Aligning goals of partner organizations with the goals of the Accountable Care Community.
    - Strategy: To ensure that the goals and incentives are aligned within the Accountable Care Community membership, Ballad Health will recruit those partnership organizations that can effectively fill a need or serve a role within the Accountable Care Community structure. The development of the mutually accountable covenant commitments with each partner organization will allow the participating organizations to understand and accept shared responsibility for that organization's individual role within the Accountable Care Community. Details about Ballad Health's plans to align the goals of partner organizations may be found in Response #11: Plan for Community Partnership and Collaboration.

- Challenge: Coordinating Accountable Care Community partners and resources across multiple sectors operating with independent goals and under various constraints, including their knowledge base.
    - Strategy: It is necessary to have a leadership function whose responsibility includes ensuring communication pathways between activities and stakeholders. Ballad Health will establish the Ballad Health Department of Population Health to serve in this role and the Department will be responsible for coordination of the mission, vision, and implementation strategy with the Accountable Care Community to extend across all sectors and to all partners. In addition, Ballad Health will work through the Accountable Care Community to assess organizational capabilities and develop resources and training opportunities to help build the expertise and capacity of other organizations to contribute to overall success. Additional information about Ballad Health's strategy for coordinating partners and resources is included in Response #11: Plan for Community Partnership and Collaboration.

- Challenge: Utilizing data to effectively drive community health improvement.
    - Strategy: Large population wellness initiatives require changing the business culture to be more data-driven and evidence-based. Through its more robust analytic capability Ballad Health will have the capability needed to collect data from many sources, including from national and local sources and potentially from providers throughout the Geographic Service Area. The Accountable Care Community structure will allow Ballad Health to provide relevant and actionable data for use by the Accountable Care Community and to individual community organizations in support of prevention and care strategies. Ballad Health's plans to use data to effectively drive community health improvement are included in Response #9 The IT Strategy.

- Challenge: Setting the appropriate goals and measurements of success.
    - Strategy: In reaching across the multi-sector partnerships, it will be necessary to communicate the goals, proposed initiatives, measurements and engagement opportunities very clearly and simply. Ballad Health will use the work conducted by the State's Advisory Group and the Community Health Work Groups to develop a clear and straight-forward Community Health Improvement Plan. The overall measurements of

success will be developed with the Tennessee Department of Health and those measurements will be broken down into component measurements of success that can be addressed at the Accountable Care Community level and the individual partner level. Additional information about the appropriate goals and measurements of success are included in Ballad Health's Response #6: The Performance Measurement System. Ballad Health will be accountable for specific measures and metrics as agreed upon with the State.

## V. Key Activities and Timing

### Prior to Closing

Integrated Delivery System:

- Ballad Health will form the hospital operations and physicians group functional teams and initiate planning meetings.
- The Physician Clinical Council Charter will be finalized and Ballad Health will organize the initial meeting of the Physician Clinical Council.
- The IT Functional Team will continue meeting and develop a Request for Proposals for new IT system and a Request for Proposals for Population Health Analytics. The IT Functional Team will also be responsible for development of the IT Implementation Timeline and Plan.

Accountable Care Community:

- Establish Ballad Health governance, policy, and organization structures for oversight, management, implementation, and evaluation of the Community Health Improvement Plan and Population Health Medicine infrastructure, including development of the Population Health and Social Responsibility Committee of the Board.

### First Three to Six Months After Closing

Integrated Delivery System:

- Ballad Health will establish the IT and Health Information Exchange ("HIE") leadership teams and governance structure to evaluate the IT and HIE options. These teams will begin the Intermediate work to derive IT functionality for shared information in two IT systems.
- The Physician Clinical Council will convene to identify the priority areas of focus and the foundational elements for the integrated delivery system, including mutually supportive covenants, with participation from all physician stakeholders.
- Determine structure for combination of the existing accountable care efforts.
- Determine feasibility for formation of a regional clinically integrated network
- Develop structure for integrated case management.

Accountable Care Community:

- Establish the Ballad Health Department of Population Health Improvement to include executive oversight, policy compliance, financial compliance, and staff roles that connect to each of the four component parts and their associated partners included in the Population Health Improvement Framework above.
- This Department will be led by a senior executive of Ballad Health whose primary responsibility will be achievement of the community health improvement aspects set forth in the COPA commitments. The senior executive will be the administrative liaison

to the Population Health and Social Responsibility Committee of the Ballad Health Board of Directors. The Committee will have governance oversight for compliance with the COPA commitments, providing strategic direction and reporting progress to the Ballad Health Board of Directors on a regular basis.

- Department personnel will have functional roles that include COPA policy and financial compliance and tracking, physician liaison roles to drive practice strategies, and community liaison roles to drive community based approaches and interface with collaborating organizations. In addition, the Department will partner with other areas of Ballad Health such as government relations and communications to drive policy decisions, and strategic planning to enact project management functions. Specific operational functions that need to be created to ensure that goals are achieved will either be housed directly in this Department or have dotted line reported relationships for accountability.

**First Year After Closing**

Integrated Delivery System:

- Ballad Health will select the new Common Clinical IT Platform vendor and systems and begin functional preparation for implementation with particular emphasis placed on organizational responsibility alignment, staffing needs assessment, and timeline development.
- Implementation planning for the new IT systems will be coordinated with the leadership of the Physician Clinical Council and the Ballad Board's Quality Committee.
- The Physician Clinical Council will identify initiatives focused on cross-facility collaboration to develop clinical protocols, reduce variation and waste, and increase quality based on identified best practices.
- Ballad Health's executive leadership will manage the intermediate work on systems integration or dual path functionality that will be required prior to full implementation of the integrated systems.
- The Physician Clinical Council will identify and coordinate medical staff leadership opportunities to encourage system-wide collaboration.

Accountable Care Community:

- Ballad Health will work with the ETSU College of Public Health, Community Health Work Groups, and the Tennessee Department of Health Officials to Finalize a Ten Year Community Health Improvement Plan, including gap analysis for needed regional services. Ballad Health will also develop annual tactical plans, target goals, and budgets to empower internal and external stakeholders to advance the long-term plan in an organized fashion.
- Ballad Health will identify the essential Accountable Care Community Partners, conduct readiness reviews of their staffing and organizational structures, and convene and charter the Accountable Care Community organization to support the activities outlined in the Community Health Improvement Plan, including measurement and evaluation systems developed with the State.

**Twenty-Four Months After Closing**

Integrated Delivery System:

- Ballad Health will utilize its operational expertise to facilitate the cultural evolution needed to become a model Community Health Improvement Organization that encompasses the best of traditional health care with innovation in population health management/medicine in order to enact community health transformation. This will include values development, brand implementation, as well as training and communication with internal staff and physician partners regarding the transformation strategy and implementation. In addition to high level focus on vision, specific training will occur with key areas such as case management, physician practices, urgent care centers, emergency departments, and behavioral health areas.
- Ballad Health will have established capabilities that may be needed with internal partners to support the Common Clinical IT Platform and Health Information Exchange functions to drive actions such as social need screenings, health risk identification, and immunization delivery and create effective tracking and evaluation systems.

Accountable Care Community:

- Ballad Health will identify needed alignment between the Common Clinical IT Platform, Health Information Exchange systems, and the tools of partners such as social agencies, state agencies, and community service boards in order to support health improvement goals through embedded protocols and analytic tools.

**Annually**

Ballad Health will conduct ongoing annual evaluations of activity effectiveness with its Accountable Care Community partners to ensure a strong system of process evaluation and continual improvement with plan adjustments made as needed. Success will be measured ultimately by our ability to achieve community health improvement related COPA measures, including long-term improvements in rates of disease. Incremental or process step measures will include successful implementation of the internal and external organizational structures needed to empower the plan including the Accountable Care Community model and the clinical alignment across the health system, the development of programs and their associated investments, and the achievement of incremental goals.

## VI. Prioritization of Efforts and Associated Funding

The commitments outlined in the Application, such as the plan for community health improvement and its associated $75 million ten-year investment, were made based on conservative estimates of savings generated through merger-specific efficiencies. A nationally-recognized healthcare consulting firm was hired to verify these estimates. As such, we are highly confident in our ability to achieve and sustain the needed funding in the absence of any highly extraordinary or catastrophic event. If such an event were to occur, Ballad Health would work with the Department of Health to reprioritize efforts under the COPA.

## VII. Sustainability of Efforts

While the timeframe for COPA investments set forth in the Application is for ten years, the ongoing annual investments, such as the investment in community health improvement, will continue as long as the COPA is in force. This ongoing investment will be essential to ensure continuing progress and that achievements are maintained. Ballad Health will work through the Accountable Care Community to build the organizational capacity of key partners and ensure

sustainability of efforts, rather than solely focusing on one-time funding mechanisms. In addition, we will require that sustainability mechanisms are in place for those organizations receiving grants. This will ensure that efforts can be scaled to more organizations, rather than creating a reliance on funding by a few.

## VIII. Merger Specificity

Integrated Delivery System:

- The savings needed to fund the financial commitments, including the funding necessary to create an integrated delivery system, will only be generated by the merger. Investments and planning related to the consolidation of services and the standardization of practices and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems in a joint venture arrangement.
- The creation of a fully integrated delivery system aligned around local community needs with financial support and effective resource use with the capabilities and benefits identified herein, in other filings, and in the Application is only achievable with the merger of the organizations, and would not be pursued under alternative arrangements if the parties remained competitors.
- As detailed in previous submissions, the Parties have pursued joint ventures for certain initiatives in the current competitive market.[20] However, none of those options would be substantial enough to drive the kind of fundamental system transformation noted here. Federal antitrust limitations make it impossible for the parties to achieve meaningful alignment of clinical resources substantial enough to derive the efficiencies needed to fund a plan of this magnitude. A merger is needed to achieve a meaningful reduction in the current clinical duplication and realign clinical resources.

Accountable Care Community:

- The ability to execute on, and move forward with, community health improvement and population health medicine strategies is dependent on the funding created by the merger efficiencies and the cohesiveness of efforts that will result from merger integration. Without the merger, any efforts will be significantly under-funded, disjointed, and insufficient in scale to achieve true progress. Without the COPA, there is no enforceable commitment to ensure this funding is made available or continues to be made available.
- While some activities, such as the formation of a regional Accountable Care Community could be accomplished without a merger, regional organizations do not have the financial capacity to drive the pace and scope of community health improvement set forth in the Application. The merger-specific savings will be critical to funding this plan. The Accountable Care Community and its partnerships provide a critical means of aligning all of the community into a collaborative effort and makes Ballad Health accountable for overall success.

[20] *See* Application, pages 12-14 for a description of the Parties' attempts to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.

- The merger aligns the incentives of Wellmont and Mountain States with those of the community and insurers and provides the requisite infrastructure and financial support to address the critical goals of the Accountable Care Community. Through the Accountable Care Community, Ballad Health will provide for resources, funding of initiatives, and align incentives to target critical health needs in the community.
- Today, Wellmont and Mountain States only produce margins sufficient to fund their essential capital improvements and retain the cash flow needed to pay debt and sustain current bond ratings. Neither organization has the financial capacity to make the merger specific investments set forth in the Application without the elimination of duplication and increased operational efficiency. This efficiency cannot be derived while the two organizations remain separate.

**Exhibit A**
**Experience with Multi-Stakeholder Collaborative Efforts**

Members of the Wellmont and Mountain States' executive teams have extensive experience in developing, implementing, and managing multi-stakeholder collaborative efforts designed to coordinate action and resources to improve the health of a region. A representative sample of this experience includes:

Representative Experience in Development of Multi-Stakeholder Collaborative and Public Health Efforts

- Designed and later oversaw the implementation of the Primary Care Access and Stabilization Grant from the Federal Government after Hurricane Katrina, which rebuilt primary care for the uninsured in New Orleans under a capitated and NCQA certified PCMH model. This was later converted to a 1115 Medicaid waiver.
- Implemented a statewide effort to improve child immunizations. By applying financial incentives through Medicaid, and partnering with organizations throughout Louisiana (including companies like Walmart), Child Immunizations were improved in two years from ranking 48th in the nation to ranking 2nd in the nation - behind only Massachusetts.
- Negotiated and implemented the creation of a new teaching hospital in Baton Rouge, combining the use of Medicaid special funding with integration of the state's public research university (LSU).
- Sought and received approval by the Louisiana legislature to transform Medicaid and public funding to a new integrated care model. Called BayouHealth, this initiative began transitioning the state's payment systems from Fee for Service Medicaid to coordinated networks of care by region of the state.
- Negotiated the governance of the major teaching hospital in New Orleans, Charity Hospital (now University Medical Center) by developing an MOU between Tulane University, LSU, Xavier, Delgado and other stakeholders. This governance agreement was necessary in order to receive more than $400 million from FEMA. The deal was done, and the new hospital now stands in New Orleans as a private not-for-profit entity.
- Partnered with the Louisiana Healthcare Quality Forum on multiple initiatives to drive improvement of certain health care metrics.
- Passed the most sweeping reforms of the mental health system in Louisiana through the legislature, creating regional collaboratives in Mental and behavioral services through human service districts. By moving toward local collaboratives with authority and accountability for metrics, we saw improvement in the deployment of services, such as forensic assertive community teams, child and adolescent response teams, and community-based services.
- Negotiated the most sweeping federal 1115 waiver in the 45 year history of the federal Medicaid program, moving the entire state of Florida away from fee for service to coordinated networks of care (either risk-based managed care or what we called Provider Service Networks - which are now referred to as ACOs). Our reform in Florida actually predated the current ACO model. Received approval from the President of the United States and HHS Secretary, and Sought and received state legislative approval to implement this initiative. The initiative was later independently evaluated by the University of Florida Center for Medicaid and the Uninsured, and found to have reduced overall cost of care without sacrificing quality or patient satisfaction.

- Worked with drug companies and local collaboratives to improve utilization of medications. Florida led the nation by being the first to implement disease management initiatives in collaboration with providers and drug companies. This dramatically improved appropriate utilization of preventive medications for people with high utilization, and reduced overall costs for the Medicaid program.
- Collaborated with the University of South Florida to establish a mental health initiative to deploy appropriate mental health drug utilization for people with significant need.
- Implemented prepaid dental programs in Miami, where only a very small percentage of children were receiving dental care. Focus was to increase ability to measure who was responsible for the kids, and to infuse accountability for outcomes. Moved away from Fee for service altogether to the prepaid capitated model.
- Operated the state's largest provider based Provider Service Network in the Medicaid program. Integrated care with our own employed practices, and also collaborated with community based HIV/AIDS clinics, programs for children with serious health care needs, and community-based organizations.
- Developed the Louisiana Healthcare Quality Forum, a private, not-for-profit organization dedicated to reshaping health care. Led by a volunteer Board of Directors, the Quality Forum serves as a neutral convener, bringing providers, purchasers, payers and consumers together to drive improvements in health care quality, safety and value for Louisiana residents.
- Established the Alliance for a Healthier South Carolina, a coalition of more than 50 executive leaders from diverse organizations across the state working together to ensure that all people in South Carolina have the opportunity to have healthier bodies, minds, and communities while reducing the future cost of care.
- Developed the South Carolina Birth Outcomes Initiative, an effort by the South Carolina Department of Health and Human Services (SCDHHS) and its partners to improve the health of newborns throughout the state.
- Implemented the South Carolina Healthy Outcomes Program which now provides case management, primary care and behavioral health services to approximately 12,000 high-need, high-risk uninsured individuals through every hospital in the state.

<u>Representative Service in Multi-Stakeholder Collaborative Efforts</u>

- Participated in the Tennessee Institute of Public Health and ETSU Multi-sector Collaborative, a joint effort to strengthen community-based efforts to improve health, wellness and prevention in the identified distressed and at-risk Tennessee counties of Appalachian Tennessee by offering training, technical assistance, and mini-grants to enhance multi-sector collaboration.
- Board Member, Kingsport Chamber of Commerce
- Board Member, Virginia Center for Health Innovation.
- Board Member Virginia Hospital and Healthcare Association
- Founding Member of the Alliance for a Healthier South Carolina
- Founder of the South Carolina Medicaid Birth Outcomes Initiative
- IT and Communications Chair, Louisiana Health Care Quality Forum
- Board Chair, Greater New Orleans Fair Housing Action Council
- Health Committee Co-Chair, St Thomas Irish Channel Community Council
- Board member of managed care companies in Kansas and Kentucky
- Interim executive director of managed care company in Kansas

- Board member of community health clinics in Kansas and Kentucky (co-founder in Kentucky)
- Auditor of managed care companies in Florida
- Board of Directors, Kingsport United Way
- Fundraising Council, Bristol United
- Appalachian College Association
- Member, Northeast Tennessee Technology Council

**Ballad Health**
**1. Strategy for Transitioning from Fee-For-Service to Value-Based and Risk-Based Models**
**2. Insurance and Value Payment Transition**
**3. The Structure for the Future**
**5. Plan for the New Infrastructure**

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**Executive Summary:** In this response, we discuss the experience Wellmont and Mountain States have with value-based and risk-based payment arrangements, their strategy to move from traditional fee-for-service to more value-based and risk-based models, and the timeline for their progression. We also address the structure and infrastructure needed to enact effective risk-based population health management.

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As described in the Overview section, Ballad Health is committed to pursuing a transition to a value-based approach to health care delivery that includes enhanced pay-for-value and risk-based models of population health medicine. The essential pathways include greater alignment of both incentives and operations under a single physician-led council and overall leadership to use the resources available in the most effective way to address needs, improve outcomes, provide for greater financial stability and sustainability of care, and lead the way to greater ability for enhanced risk-based approaches. This may also include the development of a clinically integrated network in partnership with the independent physician community. Under these risk-based, value-based payment models and other initiatives, Ballad Health will be incentivized for achieving cost and outcomes of care, and have incentives to keep the population well.

## I. Background

Successful navigation to risk-based models has proven challenging for many providers. Even though there is a vision for a new world order where providers take on more accountability and share more risk with payers, there is little consistency in the paths that either payers or providers are pursuing. As a result, experts have noted that there is a complex and narrow corridor to success.[1]

In Ballad Health's case, there are also unique challenges and barriers to success. The rural Appalachia region we serve is beset with poor health, low income levels, a declining and aging population, and the ongoing effects of economic decline.[2] Both Wellmont's and Mountain States' inpatient, emergency room, diagnostics, and pharmaceutical use rates are high by national standards and will be declining rapidly over the next ten years, creating a mandate for change in the traditional approach to health care delivery. The current infrastructure of Mountain States and Wellmont was built during a time of increasing utilization, much better economic conditions, and was designed for a fee-for-service model. Movement to a risk-based model requires significant investment in clinical and financial data systems, data analytics, care management processes and expertise, transparent close partnership relationships with the payers/employers, substantial capital resources, all connected by a well-developed vision and strategy. Health systems in regions of population growth are able to offset this decline in utilization and

[1] *Aim High*, J. HEALTHCARE CONTRACTING (June 2012) ("As an organization moves along the corridor, falling off either way can hurt the organization… Unfortunately, in a fee-for-service world, if you're effective at reducing utilization, you can hurt yourself. On the other hand, if you assume risk but you're unable to coordinate care, financially, you can find yourself in a very difficult position."), *available at* http://www.jhconline.com/aim-high.html.
[2] *See* Application for Certificate of Public Advantage, State of Tennessee, at 2.

maintain the necessary revenues to fund these investments. Because of the stagnant population growth in the applicants Geographic Service Area, this is not an option. Funding through synergies of the merger is required.

While both systems could continue to explore value-based models and assume more risk independently over time, neither system currently has the capital, resources, appropriate distribution of primary care practitioners and specialists, ambulatory network, or right infrastructure to successfully accomplish a comprehensive transition without a dramatic shift of emphasis and strategy. Since most risk-based models are structured around primary care practitioners (PCPs) neither system has a broad enough primary care network, geographically or numerically, to manage the critical mass of covered lives necessary to go "at risk" with our five largest payers. This critical mass of covered lives is required for spreading actuarial and utilization risk.[3] Therefore, a clinically aligned network must be developed which includes both employed and independent physicians who share financial and clinical incentives.

**Wellmont and Mountain States have identified several keys to success with this transition which include:**

- The financial flexibility to pursue risk on a large scale beyond the level of experimentation
- The financial ability to make up-front investments in needed infrastructure and personnel to manage health data and optimize electronic health records, to build analytic capabilities to stratify, prioritize, and track care management strategies, and to manage/coordinate the care of populations served
- Access to experience and expertise in development of risk-based models
- The existence of a cohesive clinically integrated network spanning the continuum of care, including a high-performing primary care network that encompasses a sufficient network of community physicians
- Community-level support for health improvement to complement clinical strategies for prevention and disease management (Accountable Care Community)
- Effective resources for development of strategy and evaluation of clinical processes for continual improvement
- A critical mass of patients large enough to cover the actuarial risks within a given population
- Transparent and closely aligned working relationships with payers to ensure reliability of data and strong engagement with members of the population served
- Achievement of shared risk-based goals across payer categories for application of broad population health management strategies
- Aligned incentives to drive collective strategy

Part of the rationale for the merger of Wellmont and Mountain States is that neither health system independently has the available resources to make these investments up front or access to a population large enough to merit the transition. The opportunity to make this transition with the resources and population needed for success is specific to the merger and is based on the clinical integration that can be achieved through Ballad Health. While an out-of-market merger would increase scale, it would not

[3] James Pizzo & Mark Grube, KAUFMAN HALL, *Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs* (2011) ("To be fully successful in creating healthcare value, an organization needs to get to a point of having a 'critical mass' so that infrastructure and programs can be leveraged across a significant proportion of patients."), *available at* http://www.advocatehealth.com/documents/app/ci_to_aco.pdf.

result in clinical integration that inherently requires proximity of resources and shared patient experiences.

Further, the poor health status of our region creates a unique challenge for the transition to value-based care. Commitments to assume risk in an area of the country where health literacy is low and rates of disease and poor health behaviors are high requires an approach that focuses substantial resources on community health improvement. Without the savings generated from the merger, these investments would not be possible and the transition to risk-based models would be even slower or less likely in our region.

Our vision is to advance the process of value-based payment design with payers such that Ballad Health will be paid more for the value of the care it delivers than for the volume of that care. This will require Ballad Health to assume more risk for quality, cost, and outcomes while working with community partners to improve the overall health of the population.

## II. Current Experience with Value-Based and Risk-Based Contracts

Wellmont and Mountain States each have experience with value-based models, including the formation of Accountable Care Organizations under the Medicare Shared Savings Program. In addition, both are participants in the current CMS Oncology Care Model, a highly competitive national model for care management of cancer patients. Mountain States participates in a shared savings arrangement for TennCare with AmeriGroup through its Integrated Solutions Health Network subsidiary. Both systems are fully participating in the "Episodes of Care" program that TennCare is rolling out over a five year period that started on January 1, 2015. Beyond this, the two health systems participate in scores of other value-based arrangements with various payers. The top five value-based programs for each system (ranked by population served) are summarized in Exhibit 1.1 (Mountain States) and Exhibit 1.2 (Wellmont) and submitted separately as confidential and proprietary information.

## III. Strategy for Move to Risk-Based Models

During the first two years of the merger, Ballad Health will focus on the development of infrastructure and other key components of a successful transition roadmap:

### Achieving financial flexibility and access to capital

Ballad Health will work to achieve the synergies and efficiencies outlined in the Application to generate the savings needed for capital investments. Ballad Health will also evaluate debt capabilities and cash flow options that would only be possible through the merger of the two systems.

### Accessing expertise in development of risk-based models

Ballad Health will seek external resources to assist with the transition to risk-based models, such as third-party expertise related to best practices in risk-based strategy, and will identify partners through Requests for Proposals to achieve the IT and analytics capabilities needed to operationalize higher levels of population health strategy.

### Making up-front investments in needed infrastructure and personnel

Ballad Health will develop the internal resources and acquire the infrastructure needed to manage health data and optimize electronic health records, build analytic capabilities to stratify, prioritize, and track care management strategies, and to manage/coordinate the care of populations served.

**Developing a cohesive clinically integrated network spanning the continuum of care**

Ballad Health will explore clinical integration opportunities including a high-performing primary care network that encompasses a sufficient network of community physicians, needed specialty physicians, ancillary services, home health, rehabilitation, pharmacy and other needed clinical resources to serve the needs of patients comprehensively and manage costs and outcomes across the continuum.

**Building community-level support for health improvement to complement clinical strategies for prevention and disease management**

Ballad Health will work with community partners to develop a robust Accountable Care Community, focused significantly on prevention and health education, and will resource its work to achieve long-term community health improvement goals in support of overall population health strategies.[4]

**Solidification of systems for strategic planning and evaluation of clinical processes for continual improvement**

Ballad Health will develop and/or re-align strategic planning systems and personnel to ensure continual process improvement efforts around clinical processes and to enhance efficiency of operations.

**Achieving transparent and closely aligned working relationships with payers to ensure reliability of data and strong engagement with members of the population served**

Ballad Health will work to reframe existing relationships with payers, including insurance companies and self-insured businesses, to move beyond the traditional contract relationship and connect strategic and operational components. These relationships will be structured around aligning goals for improved quality and lower cost in furtherance of shared business objectives.

**Achieving shared risk-based goals across payer categories and within payer categories for application of broad population health management strategies**

Ballad Health will position itself for sophisticated risk arrangements by working with payers to achieve shared goals across their populations. While some diversity in individual payer population goals is expected, too much variation will result in disparate or under-resourced efforts which are not conducive to the assumption of greater levels of population risk.

[4] *See* Responses to Questions Submitted November 22, 2016, Overview & Response 11 (Plan for Partnership and Collaboration with Community Organizations) for a more detailed discussion.

Alignment of goals and objectives across the regional population will allow Ballad Health to make greater investments and assume higher levels of risk. This focus will include alignment of goals within similar commercial populations, similar Medicaid populations, and similar Medicare populations as these categories of patients have distinct health characteristics.[5]

**Aligning incentives for performance and outcomes under risk-based models**

Ballad Health will work to facilitate aligned incentives between providers and payers to achieve a shared approach to quality metrics, service metrics, cost metrics, and access metrics. This alignment will ensure a collective focus on progress and the ability to succeed in increasingly sophisticated risk-based arrangements. Better alignment and focus on the current array of measures will be essential to the transition to risk-based models.

## IV. Addressing Variation Between Payer Populations

Variation exists between major payer categories due to the different populations served. The Parties have addressed the variations between public sector and private sector payers and their strategies for managing these variations below:

A. Public Sector (Medicare/Medicaid) Strategy

High-need, high-cost patients are concentrated principally in the Medicare and Medicaid populations.[6] In the elderly Medicare population, the high-need, high-cost patient profile often includes those beneficiaries with multiple chronic conditions, or those who are nearing the end of life.[7] Among Medicaid populations, mental illness or social determinants, such as homelessness, are drivers of persistently high spending patterns. While programs like the Medicare Shared Savings Program offer promising approaches and resources for Medicare Fee-for-Service populations, it is often challenging to extend these expanded services to Fee-For-Service patients. Similar dynamics exist on the Medicaid side. As a result, patients with similar clinical profiles in the very same practice may not be able to access the same level of care management services.

One strategy for dealing with this is to align goals within certain patient categories. Research has shown that aligned patient intervention programs operate most efficiently when all the patients with complex conditions are eligible to participate in the program, regardless of payer.[8] This leads not only to better population health outcomes, but ultimately drives down the cost of care. By aligning multiple payers, Ballad Health can coordinate quality measurement and reporting requirements in a way that amplifies incentives to undertake certain performance improvement activities. These incentives can then be used to invest in the infrastructure needed for complex care management.

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[5] *See* Section IV, *infra*.
[6] *Payment to Promote Sustainability of Care Management Models for High-Need, High-Cost Patients: Insights from the Healthcare Transformation Task Force*, HEALTH CARE TRANSFORMATION TASK FORCE; *available at*: http://www.pbgh.org/storage/documents/publications/HCTTF_Payment_to_Promote_Sustainability_of_Care_Management_Models.pdf.
[7] *Id.*
[8] *Id.*

As value-based payment programs are evaluated for public sector patients, it will be critical for Ballad Health to develop care management and coordination processes that improve quality and patient experience, but avoid unnecessary health care costs. Elements that may be considered as part of the care management processes include:

- Rapid identification of high-need, high-cost, and rising-risk patients
- Engagement of patients and family caregivers
- Utilization of health assessments and social/behavioral screening tools
- Scalable care teams
- Coordination of care across patients, caregivers, and providers
- Targeted disease management programs
- Cost-effective treatment
- Timely transition of care to the most appropriate service level and
- Rigorous measurement and evaluation

Ballad Health will look for ways to align care management programs across the system so that all patients may access the same level of care management services regardless of payer. This will be particularly important for those high-need, high-cost patients typically covered by public programs. By aligning care management processes throughout the whole organization, Ballad Health will be able to test, implement, and expand care management processes to patients with similar clinical profiles regardless of payer source.

B. Private Sector (Insurers, employers, and individual consumers)

Private sector patients are generally younger and healthier than public sector patients and demonstrate more episodic care needs. Patients covered by private sector payers usually place more emphasis on access to care, patient experience and convenience because of the episodic nature of their health care needs. In addition, since almost all private sector payers require some level of cost-sharing, out-of-pocket costs are crucial to provider choice.

Leveraging healthcare data analytics, innovative reimbursement structures, and patient-centric outreach will be important elements of Ballad Health's strategy to successfully move private sector patients to value-based care. The implementation of the Common Clinical IT Platform will allow providers across the region to access patient records in an efficient manner. Aggregation of patient data at the system level will allow Ballad Health to pursue sophisticated data analytics programs that can drive quality initiatives and improved outcomes.

On the cost side, Ballad Health will explore bundled payments and reimbursement for episodes of care that include financial incentives for providers. These initiatives will be especially important in areas like orthopedics and oncology where significant savings can be achieved through coordination of care and reduction of variation. The Physician Clinical Council will play an important role in implementing best practices across the system to achieve higher quality outcomes and reducing clinical variations which should yield significant savings.[9] Ballad Health

[9] See Responses to Questions Submitted November 22, 2016, Overview at 5 and 13-14 for a more detailed discussion of the Physician Clinical Council.

will also invest in cost-effective and accessible care options, like urgent care centers and telehealth, that allow patients to access care in a timely and affordable manner.

Coordination of patient engagement and population health management programs may help reduce the administrative and financial burden on providers who wish to deliver these services to their patients, but lack the time, manpower, or budget to do so. Working together with employers, community partners, payers, and providers through the Accountable Care Community, Ballad Health can help coordinate prevention and diagnostic care services and improve chronic disease management. These early intervention efforts have the potential to drive down long-term health care spending on some of the most costly conditions patients may face over their lifetimes.

## V. Timeline for Movement to Risk-Based Models with Payers

The merger will allow Ballad Health to pursue risk-based models on a significantly larger scale, with a more integrated structure, and at a much faster pace than if either Wellmont or Mountain States were pursuing these models separately. The primary details and the proposed timing for this transition are listed below:

- Spring 2017
    - Merger closes.
    - Rate cap and rate reduction commitments go into effect for all Principal Payers.

- 2017- 2018
    - Separate Mountain States and Wellmont charge masters are replaced by a Ballad Health charge master that includes all inpatient and outpatient services.
    - Separate Mountain States and Wellmont managed care contracts are replaced by Ballad Health managed care contracts with all Principal Payers. The Ballad Health managed care contracts with the Principal Payers are expected to include value-based and risk-based model components. For the risk-based model components, Ballad Health plans to establish go-live dates as follows:
        - All risk-based model components of existing Mountain States and Wellmont contracts would continue from the date of closing into the future.
        - One new risk-based model contract would commence on January 1, 2019.
        - One new risk-based model contract would commence on January 1, 2021.
        - Ballad Health would initiate risk-based model contracts for any remaining Principal Payers that do not already have at least one risk-based model component in their contracts no later than January 1, 2022.

      By January of 2022, all of the Principal Payers are expected to have a risk-based model/population health/partnership relationship with Ballad Health that includes aligned incentives.

- 2017-2019
    - Separate Mountain States and Wellmont contracts are replaced by Ballad Health managed care contracts for all non-Principal Payers. The Ballad Health managed care contracts with non-Principal Payers may include value-based components and

may include elements of risk if connected to the broader shared goals of the Principal Payers.
    - No later than October 1, 2019, all of Ballad Health's managed care contracts have been completed with all payers.

- 2019 and Beyond
    - Following the development of the needed infrastructure within the first two years following the merger, Ballad Health will pursue progressively higher levels of risk-based contracting with payers. This may include the potential for some full-risk arrangements depending on payer interest.

## VI. The Structure and Infrastructure Needed for the Future

The transition to more risk-based contracts requires a focus on population health management. The following are the component systems needed to enact effective risk-based population health management. Not only are these elements required, but they must function together cohesively and strategically to drive successful outcomes. Each area inherently includes leadership resources, personnel resources, information management resources, and technological resources.

### A. Health Information Systems

A robust, health information system is necessary to build a scalable platform for population health management. The Common Clinical IT Platform will serve as the backbone of Ballad Health's population health strategy, but it is the effective use of multiple, connected health information systems that will facilitate the population health management mission.

The parties have committed to the adoption of a Common Clinical IT Platform to ensure that information needed to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Specifically, the Common Clinical IT Platform will assist with the new structure in the following ways:

- It will allow providers in Ballad Health the ability to quickly obtain full access to patient records at the point of care.
- It will facilitate the increased adoption of best practices and evidence based medicine implemented by Ballad Health's Clinical Council.
- It will be used to implement immediate system-wide alerts and new protocols to improve quality of care.
- It will help reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

In addition, to the adoption of the Common Clinical IT Platform, the parties have committed to meaningful participation in a region-wide health information exchange to promote coordination among community providers. Participation in the health information exchange will facilitate the population health management efforts in the following ways.

- It will support access to health information across the community for Ballad Health providers as well as independent providers, medical groups and facilities.
- It will encourage and support patient and provider connectivity to Ballad Health's integrated information system.
- It will provide key data security and relevant protocols to all users.

- It will further facilitate better patient care, coordination of care, and decrease the unnecessary duplication of health care services.

These health information systems will support improved clinical-decision making for all providers and leverage real-time data in support of more sophisticated population health management strategies. Together these systems will position Ballad Health to pursue more risk-based contracts.

**B. Financial and Clinical Analytic Systems**

Risk-based contract models require a new type of financial skill set. If the organization is inaccurate when modeling medical expenses, significant losses can be experienced. On the other hand, with accurate modeling, the ability to manage care, and no unexpected occurrences, there can be significant returns. While both Wellmont and Mountain States have experience with risk-based and value-based contracting, the shift towards population health management will require new and refined financial information systems. Specifically, Ballad Health will need to cultivate or acquire the following competencies:

- Actuarial expertise to model medical expenses;
- Insurance risk management to identify appropriate stop-loss and reinsurance needs;
- Networking and contracting strategies;
- Predictive modeling to identify rising risk patients and; and
- Physician-level reward systems.

Ballad Health will need to track the unit and case cost for all services for which it will be at risk under a value-based contract to ensure that costs are managed while quality and outcome targets are pursued. As a result, the availability and accuracy of this financial information will be critical to Ballad Health's transformation. Not only will Ballad Health need to track its own cost of care, but it will also need to determine the care costs of partners that will be sharing risk. Strong relationships with outpatient providers will be particularly important to for capturing and accessing data on outpatient costs.

**C. Quality Information Systems**

As a first step in the transition toward population health management, Ballad Health will seek to expand contracts that offer patient satisfaction and care quality bonuses. Incentivizing patient satisfaction will encourage providers to engage patients in their care, and engaged patients tend to be healthier and less costly at the population level.[10] Incentivizing quality may reduce costs by increasing adherence to evidence-based care protocols that lead to improved outcomes.[11]

As Ballad Health moves towards more risk-based contracting, more emphasis naturally will be placed on reducing costs. It will be critical for Ballad Health to maintain a dual focus on quality while it pursues these types of contracts. A strong data infrastructure and expertise also will be required in order for providers to meet quality targets and proactively, effectively, and efficiently manage the care of a specific patient population under a value-based contract. For contracting purposes and

[10] Terri Welter, et. al, ECG MGMT. CONSULTANTS, *Steps for Transitioning to Population Health Management* (Winter 2015), *available at* http://www.ecgmc.com/thought-leadership/articles/steps-for-transitioning-to-population-health-management-1.
[11] *Id*.

population health purposes, Ballad Health will invest in development of quality information systems to track quality of care across the continuum.

Many of the initiatives to reduce variation and improve quality across the system will be tied to new contracting practices designed to ensure collaboration between Ballad Health and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and Ballad Health to reduce cost and improve the overall patient outcome. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and to then collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

Ballad Health has also committed to transparency on quality measures. The Parties will report on a common and comprehensive set of measures and protocols that will be part of the integrated delivery of care across the entire health system, as well as track and monitor opportunities to improve health and access to care at the right place and right time for consumers. Timely information will be available to the public, which will impact choice and further incentivize the provision of high quality of care. Increased transparency will provide consumers with information for their use to make better health care decisions.

**D. Care Management and Coordination Functions**

Care coordination systems will be critical to the efficiencies needed for successful risk-based contracting. Case management software is important to support the workflow of case managers, provide actionable care management plans at the point of service, and to provide the data for analysis of risk and care plan adherence and efficacy. Ballad Health's Clinical Council has been charged with developing the uniform guidelines, protocols, and outcome measures that will be implemented across the system. Data from multiple locations and providers, both employed and independent, will be collected and synthesized into comprehensive care plans, allowing providers to understand an individual patient's goals. At the same time, personnel in the Ballad Health Department of Population Health will be measuring population-level goals that affect all patients.

Primary-care led strategies, like patient-centered medical homes ("PCMHs"), will be an important component of the system's population health management efforts. PCMHs include a multi-disciplinary care team, led by a primary care provider, that provide coordinated, continuous care. While a few PCMHs already exist in the area, Ballad Health will need to expand the support structure for these organizations and resources available as the number of managed lives grows.

**E. Clinically Integrated Provider Network**

Effective population health management requires continuous integration of clinical services across providers, care settings, and medical conditions—but not necessarily under single ownership.[12] Roughly 70% of the physicians in the Geographic Service Area are independent, and Ballad Health is

[12] Lola Butcher, *Clinical Integration Supports Population Health Management*, LEADERSHIP+ (Nov. 17, 2016), *available at* http://www.hfma.org/Leadership/Archives/2016/Fall/Sidebar_Clinical_Integration_Supports_Population_Health_Management/.

committed to developing structures that align clinical services with these groups as the population health and risk-based contracting efforts grow.

While organizations that share significant financial risk can technically perform joint contracting without being clinically integrated, they often struggle to manage risk. Ballad Health will need to invest in clinical integration core competencies and build structures to share risk and rewards with independent providers. These include selection of high quality providers committed to cooperating to achieve common goals, mechanisms to monitor and control utilization of health care services and resources, initiatives to support care coordination, quality improvement and cost management, and data collection and dissemination

**F. Accountable Care Community Support Systems**

Finally, in furtherance of its population health management and risk-based contracting goals, Ballad Health will need to invest significant resources in the systems needed to support the Accountable Care Community. These systems and resources are more fully described in the Overview Section and Response #11 - Plan to Partner and Collaborate with Community Organizations.

**Exhibit 1.1**

**Top Five Value-Based Programs Currently in Place at Mountain States**

*To be submitted pursuant to CID.*

**Exhibit 1.2**

**Top Five Value-Based Programs Currently in Place at Wellmont**

*To be submitted pursuant to CID.*

**Ballad Health**
**4. Comprehensive Regional Strategy to Deliver Equitable and Efficient Care**

**Executive Summary:** In this response, we outline the strategy for Ballad Health to deliver equitable and efficient care across the entire service area. Ballad Health will accomplish these objectives through (i) the establishment of an integrated health delivery system with a focus on population health that includes strategies for equitable access and care coordination to reduce disparity; (ii) a liberal charity care and self-pay policy that is consistent with the IRS 501(r) regulations; and (iii) a cultural and linguistically appropriate approach to services that formalizes Ballad Health's expectations for all employees who interact with disadvantaged individuals and people living with disabilities.

According to the Centers for Disease Control and Prevention, health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1] The types of health care inequity that exist in the Geographic Service Area include similar factors to those that exist nationally including inequities resulting from race, disability, educational attainment, and economic status.[2] In addition, there are distinct characteristics of the Geographic Service Area that contribute to disparity, especially characteristics that affect rural populations and their ability to access services.[3] The region is also disproportionately impacted by low educational attainment levels and poverty in relation to other factors such as race or ethnicity.[4] A locally based health system, governed by people who live, work, play, and pray in the community, has the best opportunity to address the unique needs of the region. By adapting national best practice interventions to the specific aspects of this area and its Southern Appalachian culture, Ballad Health has the opportunity to make meaningful improvement in an area plagued with health inequities.[5]

Ballad Health strives to be a health care system that (i) operates effectively and efficiently to ensure all people get the care they need and (ii) invests in keeping them healthy. To do this, Ballad Health must specifically address the health inequities and inefficiencies in the region. Community Catalyst, a national non-profit organization, has done extensive work on health inequities and recommends the following six reforms to reduce disparities in healthcare:

1) Expand coverage and access to care;
2) Improve data collection and metrics on disparities;
3) Implement socioeconomic risk adjustments in payment reform;
4) Ensure providers are culturally competent;
5) Reallocate resources to address social determinants of health; and

[1] *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, HEALTH EQUITY, *available at* https://www.cdc.gov/chronicdisease/healthequity/.
[2] *See, e.g.*, DIV. OF HEALTH PLANNING, TENN. DEP'T OF HEALTH, 2014 STATE HEALTH PLAN, *available at https://www.tn.gov/assets/entities/hsda/attachments/2014_Update_to_the_Tennessee_State_Health_Plan.pdf.*
[3] *Id.*
[4] Application of Certificate of Public Advantage, State of Tennessee, Exhibit 8.1 (Tennessee counties comparison in poverty and education as compared to Tennessee averages).
[5] Although producing a small overall negative impact on total population health given the relative size of their population, a small non-white population could experience even greater disparities given their underrepresentation.

6) Promote a more diverse workforce and use of community-based providers such as Community Health Workers.[6]

These policy recommendations provide guidance to the disparities strategy proposed for Ballad Health. Ultimately, a health system governed by people who live, work, play, and pray together has the best opportunity to address the unique needs of the region. Ballad Health will do this by adapting national best practice interventions to the specific aspects of our area and its Southern Appalachian culture.

## I. Strategies for Equitable Access and Care

Ballad Health's approach to addressing disparities is shaped by the not-for-profit orientation of Wellmont and Mountain States—to meet the health care needs of patients regardless of their ability to pay, and provide outreach services to those who are geographically limited in their access. These efforts have been supported by a variety of efforts, including direct contributions of care by the systems, contributions of dollars by the systems to community-based organizations which organize access to care, and through our foundations, raising funds to meet non-medical patient needs which are often not met elsewhere through insurance coverage or government assistance programs. Both systems have also availed themselves of grant funding to provide assistance for vulnerable individuals. But these sources of funding are often inconsistent, often restricted to specific populations or problems, and are almost always too little regardless of the best intentions. The merger has the opportunity to create greater discretionary financial resources within Ballad Health as a result of the synergies generated. The Parties believe the new health system will be better positioned to proactively address health disparities experienced by patients and the broader population.

Though Wellmont and Mountain States collectively provide $164 million[7] in charity care and support for self-pay patients, those resources primarily cover clinical care in our hospitals and clinics. To better address health disparities and increase the provision of equitable care, Ballad Health will use merger efficiencies to invest in systems of care coordination, including social screening, navigational, and case management resources that do not currently exist or cannot be appropriately scaled in the current resource constrained environment. These plans will be fulfilled through the $140 million of expanded services committed through the merger.

According to Kevin Fiscella in the *Annals of Family Medicine*, "Equitable health care means more than elimination of bias, it also means creation of patient-centered systems of care that support healing and caring relationships that are responsive to patients' needs, wishes, and context. Improving equity requires aligning health care resources and capability with patient needs, particularly patients who have been historically underserved."[8]

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[6] Marcia Hams & Josh Sager, COMMUNITY CATALYST, *Demographic Health Disparities and Health System Transformation: Drivers and Solutions* (Nov. 2015), *available at* http://www.communitycatalyst.org/resources/publications/document/Policy-Brief-Demographic-Health-Disparities-Final.pdf.

[7] 2013 Figures. *See* Application for Certificate of Public Advantage, State of Tennessee, at Exhibit 8.4 (Consolidated Financial Statements).

[8] Kevin Fiscella, *Health Care Reform and Equity: Promise, Pitfalls, and Prescriptions*, 9:1 ANN. FAMILY MED. 78-84 (Jan. 2011), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3022050/.

Like efforts nationally to build Health in All Policies,[9] it is our intent to build disparities strategies into all clinical and business policies and processes throughout Ballad Health. To achieve this, Ballad Health plans to take the following steps:

- Use data and analytics to (i) not only identify vulnerable individuals in our patient population, but importantly to identify vulnerable individuals in the community who are not connected with a regular source of care and (ii) design strategies and services to reach individuals and motivate them to action and remove barriers in their way.
- Embed systems for equitable care within all administrative and clinical processes rather than considering health equity as the problem of the population health department. This includes creating work flows at hospital, clinic and urgent care registration as well as at the bedside to identify individual needs and translate them into navigation and case management action plans that connect people to community-based resources to help meet transportation, food, housing, behavioral health, and substance abuse needs.
- Develop and deliver education and prevention resources connected to the Community Health Improvement Plan including screenings and immunizations.
- Develop, deliver, or connect people to family support services for early childhood development, perinatal resources, effective parenting, and Neonatal Abstinence Syndrome avoidance and treatment.
- Connect people to primary care and medical home programs either within Ballad Health, the network of community physicians, Federally Qualified Health Centers or Rural Health Centers and incentivize providers to invest time in patient engagement around social needs.
- Work with payers, especially Medicare and Medicaid managed care plans, to develop more cohesive systems of care coordination and to incentivize accessible, high-quality, and efficient care for these populations and reward effective management of social needs and determinants of health in addition to traditional payment for service.
- Work specifically with vulnerable populations, such as the high-need, high-utilizing uninsured individuals suffering from mental health and addictions, including pregnant women, as noted in the Application.[10]

## II. Charity Care and Self-Pay Policies

In order to ensure low income patients who are uninsured or under-insured are not adversely impacted due to pricing, Ballad Health has committed to adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rule. For patients who qualify, Ballad Health will provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred percent (200%) of the federal poverty level. For patients who do not qualify for full write offs, Ballad Health will discount services in compliance with rule 501(r) according to the ability of individuals and families to pay and will communicate discounts according to policy prior to service delivery or at the point of service to avoid creating any barrier to essential care.[11] Practices will include payment plans that are manageable for patients and their families

[9] LINDA RUDOLPH ET. AL, HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND LOCAL GOVERNMENTS (2011), *available at* http://www.phi.org/resources/?resource=hiapguide.

[10] *See* Application at page 99.

[11] This is a new commitment that the Parties have agreed to adopt as a result of discussions with the Southwest Virginia Health Authority. This commitment represents a higher level of charity care than Wellmont and Mountain States collectively offer now.

according to their individual circumstances. Ballad Health will work to connect people to insurance coverage and state and federal programs for which they qualify.

Ballad Health will inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site. The activities related to charity care will occur immediately upon closing of the merger and will remain in place as long as the Certificate of Public Advantage remains in effect.

Ballad Health will also commit that neither Uninsured Patients nor Underinsured Patients will be charged more than amounts generally billed ("AGB") to individuals who have insurance covering such care in case of Emergency Services or other Medically Necessary Services.[12]
Financial assistance eligibility for patients of Ballad Health will be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Ballad Health's financial assistance determinations will be based on National Poverty Guidelines for the applicable year. Ballad Health will adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

The commitments to patients who qualify for charity and the uninsured or underinsured will be implemented on a consistent basis across the Geographic Service Area and will apply to all Ballad Health facilities, thus ensuring equitable treatment for all.

## III. Cultural and Linguistically Appropriate Approach to Services

Ballad Health is committed to building a culture of responsiveness and proactive engagement with underserved populations across the organization. This will require continuing education related to equitable care and redesign of associated processes as well as a deeper, more comprehensive understanding of the distinct characteristics of different populations in different geographic regions.

Ballad Health will use the National Standards for Culturally and Linguistically Appropriate Services in Health Care (the "National CLAS Standards") as a guide for this effort.[13] According to the HHS Office of Minority Health, “The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.”[14]

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[12] “Uninsured Patients" are those with no level of insurance or third-party assistance to assist with meeting payment obligations. “Underinsured Patients" are those with some level of insurance or third-party assistance but with out-of-pocket expenses that exceed financial abilities. The AGB percentage will be determined using the look-back method utilizing the lowest percentage for all facilities per the IRS regulatory guidelines set forth in 501(r). "Emergency Services" are defined in accordance with the definition of “Emergency Medical Conditions” in Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. "Medically Necessary Services" are defined by Medicare as services of items reasonable and necessary for the diagnosis or treatment of illness or injury and are Services not included in the list of “particular services excluded from coverage” in 42 CFR § 411.15.

[13] DEPT. HEALTH & HUMAN SERVS., NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE, *available at* https://www.thinkculturalhealth.hhs.gov/clas/standards.

[14] OFFICE OF MINORITY HEALTH, DEP’T HEALTH & HUMAN SERVS., A BLUEPRINT FOR ADVANCING AND SUSTAINING CLAS POLICY AND PRACTICE (Apr. 2013), *available at* https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf.

These fifteen standards are grouped according to one principal standard and three themes. The principal standard states the organization will strive to:

> *"Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs."*

The three themes of the remaining standards are (1) Governance, Leadership and Workforce, (2) Communication and Language Assistance and (3) Engagement, Continuous Improvement and Accountability.[15]

Within 12 months of closing, Ballad Health will complete an assessment of the organization's capability to meet these voluntary standards and assemble a work plan designed to advance the goal of the principal standard. The health system will work with the Offices of Minority Health and Health Equity in Virginia and the Office of Minority Health and Health Disparities Elimination in Tennessee to develop this work plan.

## IV. Why The Promotion of Health Equity and Reduction of Disparities is Merger Specific

Promotion of health equity and reduction of disparities has gained increasing attention in health services and public health circles, yet progress has been slow.[16] One reason is because health systems tend to set their strategies at the least common denominator – typically federal or state law. For example, where the ADA provides guidance and standards related to treatment afforded to individuals living with disabilities, systems find they may reduce or eliminate their business risk by simply meeting the minimum standards and going no further. The National CLAS Standards outlined above are voluntary, not mandatory, and charity care requirements are spelled out in detail by federal regulation.[17] Another reason health systems haven't pursued more aggressive health equity policies is because they have little financial incentive to do so. While incentives for quality and patient safety improvements are common, few payers or industry organizations have adopted health equity requirements or incentives to address these disparities.

The Applicants have proposed to voluntarily exceed the minimum requirements of the law because (i) the merger frees up resources to be devoted towards vulnerable populations and (ii) because the reduction in disparities is important to state goals. The COPA provides a mechanism to ensure these goals are pursued faithfully by the new health system. Without the financial synergies of the merger, both health systems would lack the financial resources to pursue these strategies in the absence of payer incentives. Without the enforceable commitments made under the COPA, neither health system would be compelled to offer more generous commitments to disadvantaged and disabled individuals than required by state and federal law.

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[15] *See* DEPT. HEALTH & HUMAN SERVS., NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE, *available at* https://www.thinkculturalhealth.hhs.gov/clas/standards.

[16] Joseph R. Betancourt, *Ushering In The New Era Of Health Equity,* HEALTH AFF. (October 31, 2016) ("Aside from progressive leaders and early adopters who began to place equity on the same footing as the other pillars of quality, the overwhelming majority either remained reluctant to admit that disparities existed in the health care settings they oversaw, or went on the slow burn, multiyear path of 'studying the issue and what could be done.'"), *available at* http://healthaffairs.org/blog/2016/10/31/ushering-in-the-new-era-of-health-equity/.

[17] *See* IRS 501(r) Regs. (26 C.F.R. Parts 1, 53 & 602).

**Ballad Health**
**6. Performance Measurement and Management**

**Executive Summary:** In this response, we describe the current state of performance measurement systems within Wellmont and Mountain States and outline the performance measurement approach that is needed to transition to, and thrive under, a value-based population health model. This performance measurement system will evaluate both internal strategies for population medicine and external strategies for community health improvement.

## I. Current State of Performance Measurement Systems

Mountain States and Wellmont both utilize performance management and measurement systems designed to link the mission, vision and values of each organization to the work performed at the point of care and produce the desired outcomes. While each organization currently organizes and operates these systems differently, they have several components in common:

- **Governing Structures**: Board Quality Committees, Board Finance Committees, Facility Medical Staff Committees, and Executive Leadership Teams are all involved in distinct ways in setting organizational performance goals for financial, service, and quality performance.
- **Management Support Departments and Functions**: Quality, Strategy, Performance Improvement, Organizational Development and Training, Human Resources, Finance, Managed Care Contracting, and Analytics departments are all involved in the development of strategic and tactical plans and budgets and in the oversight of implementation and evaluation efforts.
- **Processes**: Strategic Planning, Budgeting, Incentive Pay, Team Member Evaluation & Development, Performance Reporting, Lean/Value Optimization, and Project Management processes all support a system of continual improvement, evaluation, and feedback.
- **Tools**: A variety of Performance Dashboards, Project & Performance Management Tools and Learning Platforms support the work of data collection, management, and evaluation within both organizations. Both organizations use a variety of outsourced tools to complement internal capabilities for measurement and analysis. One such set of resources is provided by MedeAnalytics—a company which provides tools to manage cost, quality, revenue, and risk.
- **Standards**: Both external and internal standards drive performance including Accrediting & Certifications (e.g. Joint Commission, State Trauma), Value Based Contracting (e.g. HEDIS, HCAPS, QHIPS), Public Reporting (e.g. Leapfrog, Healthgrades, Carechex), Bond Rating Agencies (e.g. Moody's, S&P), Evidence Based Care (e.g. Choosing Wisely, ACO, bundles) and organizational balanced scorecards.[1]

These components support a continuous improvement feedback loop for each organization's governing board, management, and team members that is used to set goals and objectives, deploy resources, and measure, report, modify and reward performance.

[1] *See* Response #1 Exhibit 1.1 (Mountain States) & Exhibit 1.2 (Wellmont) (both submitted under CID).

## II. Process for Establishing Ballad Health Performance Measures

Pending approval by both Tennessee and Virginia, it is anticipated that the merger will close in the first quarter of calendar year 2017. The FY18 strategic planning, budgeting and performance management process for each separate organization will be well underway in preparation for a July 1 fiscal year start.[2] Given this anticipated timing, the leadership of both organizations has determined that the FY18 strategic planning, budgeting and performance management process will progress for each Ballad facility and business unit under their respective organization's current model (i.e. Mountain States facilities will proceed with Mountain State's performance management process for FY18). The performance management processes will be unified for FY19.

The parallel performance management processes for FY18 will be "seeded" by executive management with high-level unified goals for Ballad Health's productivity and financial performance, quality and service, and major initiatives (including any COPA initiatives required during the time period). Both organizations will proceed in parallel to develop strategies and metrics at the facility/business unit/corporate support level. The results of this effort will be reconciled on the back-end to eliminate duplicative efforts and expenditures or competing strategies.

After an iterative process to refine goals, strategies and metrics, unified system-level balanced scorecards/dashboards will be constructed for quality and service, financial performance, value-based purchasing, and incentive pay. An additional Dashboard will be created based on the COPA Index in Tennessee and the Quantitative Measures in Virginia. These dashboards will serve as performance review mechanisms for the Ballad Board's Finance, Quality and newly created Social Responsibility and Population Health Committees, as well at the newly formed Clinical Council.

Each dashboard will cascade down to the facility and business unit level. The strategic initiatives in place to pursue these goals will be entered into a corporate-wide performance management system which combines analytics with action planning, resource assignment, progress tracking and performance monitoring to ensure that everyone in the organization is on the same page at the same time, working toward the right goals and achieving the best possible results. Corporate management review of these dashboards and timelines will take place at regularly scheduled Senior Executive Operations Meetings (weekly), Market Operations Reviews (monthly), Market/Facility Quality Meetings (monthly), and Market Financial Reviews (monthly).

Organizational Development and Training will produce new education and training modules as necessary and will be offered through a common on-line learning platform or in person. Onboarding agendas will be modified to reflect the unified goals and objectives of Ballad. Merged project management and Lean/Value Optimization System assets will be allocated by management to select strategic initiatives according to an agreed upon prioritization process.

A new Ballad Health incentive pay system will be implemented which appropriately connects system goals and performance to departmental and individual goals and performance on an annual basis. All levels of the organization will have access to performance Dashboards and progress as appropriate. Directors, managers and supervisors will continue to be critical in developing and monitoring individual performance evaluations, communicating overall performance and identifying action plans when goals are not being met at the individual or departmental level. All management, from front line-supervisors to executive management will be required to attend quarterly Leadership Development Institutes which

[2] Both Wellmont and Mountain States operate on a July 1 to June 30 fiscal year. FY18 begins July 1, 2017 and runs to June 30, 2018. It is anticipated that Ballad Health will also operate on a July 1 to June 30 fiscal year.

include review of system level dashboards, keynote speakers from outside the organization, and several small group break-out sessions designed to transfer necessary information, develop and refine skills, and receive feedback from directors, managers and supervisors.

## III. Criteria for Establishing Ballad Health Performance Measures

### A. Population Health Measurement

As population health experts have noted, "despite its importance, population health measurement efforts in the United States are poorly developed and uncoordinated."[3] Ballad Health has a tremendous opportunity to lead in the development of measures that support the transition to a value-based population health management system. Ballad Health will seek to develop measures which are:

- Connected to COPA priorities established by the Department of Health;
- Appropriate to the Ballad Health Population Medicine and Community Health Improvement Framework;
- Collaboratively developed with key stakeholders in the Accountable Care Community and the Physician Clinical Council;
- Authorized by the Ballad Board Quality Committee, Finance Committee, and Social Responsibility and Population Health Committee;
- Connected to risk-based agreements with payers;
- Effectively connected to efforts with priority populations;
- Measured from an established baseline or denominator;
- Connected to reliable data resources for accurate and timely measurement;
- Understood by team members and physicians;
- Clearly connected to an aligned or shared system of incentives; and
- Transparent and timely for reporting to all stakeholders.

## IV. Challenges and Strategies

Merging performance management processes and deploying best practices across a newly merged organization is not without potential challenges. We have identified the following key challenges and recommend strategies to handle each:

- Challenge: Potential confusion around goals and incentives.
    - Strategy: The transition in the process of setting, communicating, incentivizing and monitoring goals could result in some confusion among management and staff. This confusion could lead to missed organizational goals and missed expectations from staff. Beginning with FY19, all Ballad Health team members will participate in a common incentive plan driven by common Ballad Health performance dashboards. The incentive program and performance dashboards will be communicated through department meetings, Ballad Health team member newsletters, and on-line messages from leadership. Organizational development and training will produce on-line education modules explaining the new incentive plan and the systems annual performance goal. At

[3] Michael Stoto, *Population Health Measurement: Applying Performance Measurement Concepts in Population Health Settings*, 2:4 eGEMs (2014), *available at* http://repository.edm-forum.org/cgi/viewcontent.cgi?article=1132&context=egems.

each quarterly Leadership Development Institute all management will review year-to-date performance against goals, and breakout sessions will be held to address areas of common deficiency. Monthly updates on performance will be made available on the Ballad Health intranet to each employee. This work and the cultural alignment plan will mutually support one another in the transition to becoming a high-performing community health improvement organization.

- Challenge: Resistance to change.
    - Strategy: Systems in most organizations are designed for stability and predictable results, so, at some level, they inherently resist change. If the merger is approved, it will be especially important to demonstrate quick wins related to system redesign. Whether a new Ballad solution is adopted from one organization or the other, or designed de novo, it will be critical to begin the change process immediately and build on momentum. Ballad Health executives will identify opportunities for quick wins and allocate project management and performance improvement assets as necessary to achieve results. These results will be communicated throughout the organization as models for change management in furtherance of the commitment to population health priorities.
- Challenge: Limits on organizational band-width and resources.
    - Strategy: Businesses are always challenged to match internal resources with organizational demands. Hospitals closely monitor labor productivity and routinely flex staff up and down on a daily or even hourly basis. With the intense demands of day-to-day operations, there is often little time available for thoughtful change management or pursuit of innovation. This is one of the key barriers to cultural transformation for Wellmont and Mountain States in the current status quo model. It is also an important reason why the transition to the new population health model is merger specific. Through both organizations' experience with lean management, we have found that an executive level commitment must be made that allows, encourages and rewards efforts to improve - even if there are short term negative effects on productivity. In Mountain States, for example, all Value Optimization System efforts have executive level sponsors who are responsible for securing the time and attention necessary for staff at all levels of the organization to participate in Rapid Improvement Events. Mountain States also actively rewards participation in these efforts through its Annual Quality Awards. Similarly, Wellmont rewards innovation through its Operational Excellence efforts, including the encouragement of innovation through employee driven Kaizen projects[4] aimed at continual improvement in workplace practices and efficiency. These practices will be carried over into Ballad Health.

## V. Merger Specific Performance Improvement Opportunities

Creating a unified health system in an overlapping geography with common goals, objectives and performance management structures provides the opportunity to deploy best practices across the organization that would (i) otherwise not be achievable or (ii) require significant duplicative investment over an extended implementation period. Further, it provides the opportunity through derived merger efficiencies to advance priorities for innovation and performance under value-based population health models which require significant financial and human resources.

[4] Kaizen is a form of continuance performance improvement where the main goals are to reduce waste and to increase value through continuous small improvements.

If the merger is approved, the leadership teams focused on the Functional Team areas will shift their focus to deployment of common Ballad Health systems, policies and procedures. These will either be designed anew or adopted from one of the systems as a best practice.[5] The Functional Teams will be supported directly by the merged project management and performance improvement assets of the two systems.

The parties have identified a number of high performing systems and functions within both Wellmont and Mountain States that may be replicated in Ballad Health. These include:

**A. Mountain States Systems/Functions**

1. Mountain States Value Optimization System

Mountain States partnered with Simpler Consulting in 2012, for the purposes of creating transformational change through lean principles in line with the Institute for Healthcare Improvements Triple Aim Initiative.[6] Successes have been realized in quality, clinical performance, and financial (operational) performance across the system. To date, Mountain States has recognized dramatic improvements through over 100 value stream efforts resulting in savings in excess of $75 million and improved clinical performance.

Consistent adherence to a proven process is resulting in continued improvements and performance breakthroughs. Relying first on Simpler for on the job teaching and training, internal subject-matter-experts have now been developed to accelerate the spread of the system and tools across Mountain States. Team member education has been paramount to the success through the completion of education on LEAN methodologies and tools to be used in events and in daily standard work.

Wellmont began process improvement work under the Toyota model in 2006 and has continued to advance that process in a variety of ways since, significantly resourcing and ramping up LEAN training in 2015. Since the program is in its initial stages, focus has been on leadership training working with the Business Excellence Institute, a program noted for success in achieving and replicating Malcolm Baldridge criteria and systems. Together, the stage is set to expand these efforts across Ballad Health. Because of the number of lean experts who have been developed inside Mountain States, the existence of well-established methodologies, and the on-going assistance of Simpler coaches (sensei), the Mountain States Value Optimization System model is well positioned to be expanded into legacy Wellmont clinical business units at a lower cost and more rapid pace than could be done alone. An outside merger would not provide the locally available lean resources that Mountain States can bring to Ballad Health.

2. AnewCare Collaborative

Organized under Mountain States' subsidiary Integrated Solutions Health Network, AnewCare Collaborative performs network management, case management, analytics, quality management and auditing, and practice performance improvement services on behalf of the participating physicians in the collaborative's current Medicare Shared Savings Program ("MSSP") and Amerigroup TennCare contracts.

[5] *See* Response #7, Exhibit 7.1.

[6] SIMPLER, http://www.simpler.com/p/about-us.

These agreements currently cover approximately 14,000 lives in a Track 1 Medicare Shared Savings Program ACO and 17,000 lives under an Amerigroup TennCare Contract. Approximately 13,000 of the total 31,000 lives are attributed to Mountain States Medical Group Physicians, the remaining are attributed to independent physicians throughout the region. AnewCare is one of a limited number of MSSP ACO's that received shared savings payments in each of the first three years of the program.

Wellmont operated an MSSP program for one year before the decision was made to shut the program down. At that time the program covered around 9,000 lives. The addition of these lives to the AnewCare current population would significantly reduce the per member cost of providing ACO services by spreading current overhead and would also leverage proven network management, case management, analytics, quality management and auditing, and practice performance improvement services for the benefit of Wellmont physicians and their attributed MSSP patients. These Wellmont lives could be added in September of 2017 during the annual practice attribution process. This would only happen with an in-market merger.

**B. Wellmont Systems/Functions**

1. Wellmont Health System Epic Optimization

After an Epic Electronic Health Record Implementation in 2014, Wellmont shifted focus to optimization and has been working to get the full value from this advanced clinical information platform. In 2016, Wellmont achieved Level 8 out of 10 in its use of the Epic platform for the health system's electronic health record. Wellmont was one of only eight Epic users in the world to attain at least this level as part of the software company's Gold Stars program. In reaching this status, the health system has implemented 87 percent of Epic's functionality just two years after instituting the platform across the organization. Wellmont is working diligently on securing Level 9, a status earned by only four users across the globe.

The organizational expertise, as well as the system set-up and design parameters and clinical protocols already worked through by Wellmont, would significantly reduce implementation time and costs at legacy Mountain States facilities and practices should Ballad choose Epic as their common EHR platform. While merger with an outside organization could possibly bring the experience to Mountain States necessary for a planned EHR conversion, it is unlikely to be as sophisticated and successful as that which Wellmont could provide, as evidenced by the achievement levels noted above.

2. Wellmont CVA Heart Institute Clinical Process Innovation and Research Combined with Mountain States' Investment In Clinical Research Is Powerful and has the Potential to Create a Compelling New Competitor In the National Research Space.

The Wellmont CVA Heart Institute has received significant national recognition for clinical and process improvement research related to interventional cardiology. For example, three times in one year, an internationally renowned and respected interventional cardiologist with the Wellmont CVA Heart Institute has been published in the country's premier medical journal. Chris Metzger, M.D., recently co-authored an article about a nine-year study called ACT 1, a landmark clinical trial in which the heart institute was the No. 1 worldwide enroller of patients. The heart institute has served as the No. 1 or No. 2 enroller in the United States and across the globe in at least 25 top research trials, including being the current leading enroller in four major trials. The heart institute now has about 25 studies that are actively enrolling patients or soon will. Similar research activity

and an internal Institutional review board drive efforts for 80 active oncology research trials within Wellmont Cancer Institute.

Mountain States currently has more than 60 clinical trials active within the system, and utilizes the IRB associated with East Tennessee State University. The merger of the research programs will have several benefits available only through the merger. First, the current clinical trial patient base will be greatly expanded – helping Ballad Health better meet clinical trial enrollment goals and by opening up clinical trials previously available only to patients of Wellmont or Mountain States. This will enable Ballad Health to become more competitive in attracting partnerships with leading institutions and funding internationally to bring research trials to the region. The region is not as attractive to these potential partners if each system is acting independently with lower volumes and without the benefit of nearly 100,000 discharges and millions of patient contacts supported by a common IT platform and data and a partnership with local research faculty. These research trials will be a benefit to our patients. Second, by merging existing resources, and taking advantage of the sizeable investment made by Wellmont in administrative infrastructure, the administrative costs of the research enterprise will decrease relative to the amount of research being conducted. Ballad Health will devote the resources of the Wellmont investment into cardiovascular research into expansion to the entire population of the combined system, and will integrate the robust trials being conducted by Mountain States with the Wellmont patient population and administrative infrastructure. The population variety and volumes represented at Ballad Health will be incredibly attractive to organizations conducting novel research, and the existing infrastructure scaled across Ballad will draw not only new clinical trial opportunities but also opportunities for funding of new translational research for population health management and community health improvement strategies (especially those impacting rural populations) by working with academic partners.

**Ballad Health**
**7. Cultural Alignment Plan**

**Executive Summary:** A strong organizational culture focused on the Triple Aim will be essential to Ballad Health's organizational performance. To achieve these aims under the merger, first, Ballad must integrate and align the two existing health system cultures. A cultural audit of the two organizations was conducted during due diligence which exhibited that the two cultures are very similar and that the two workforces and leadership teams should mesh well.[1] Second, the integrated Ballad Health organization must be continually educated, incentivized and measured to move from a traditional health care delivery system designed to produce volume toward a community health improvement organization culture centered on the Triple Aim. Both elements will require a concerted focus in the first twenty-four months of the merger and thereafter.

## I. Cultural Alignment Plan.

Mergers and acquisitions almost always involve some level of transformational change, but health system mergers involve particularly complex human organizations where culture is critical to mission.[2] Leaders from both Wellmont and Mountain States have been involved in mergers in the past and not only understand the importance of success with cultural alignment and transformation but also have direct experience with it. For Ballad Health's organization to be successful, it will be essential for Wellmont and Mountain States to fuse their existing cultures into a new, strong organizational culture focused on the Triple Aim.

### A. Planning for Cultural Alignment.

Mountain States and Wellmont recognized early in their discussions that cultural integration would be a key component to a successful merger. Beginning with the Term Sheet executed between the parties in April, 2015, the leaders of the two organizations began the important work of assimilating a joint board, a joint management team, and establishing a culture in the new organization that would bring the two organizations together as one.[3]

#### 1. Shared Vision and Guiding Principles.

As a first step in bringing the two systems together, the Wellmont and Mountain States' CEOs and Board Chairmen articulated their Shared Vision and Guiding Principles to facilitate the merger as part of the Term Sheet executed on April 2, 2015.[4] The Shared Vision and Guiding Principles were then adopted unanimously by both the Wellmont Board and the Mountain States Board and incorporated into the Master Affiliation Agreement and Plan of Integration executed by the Parties on February 15, 2016. This

[1] This study was submitted during the application process, and we will outline the essential elements for integration in this document.
[2] Marty Stempniak, *The Art of Blending Cultures,* HOSPITALS & HEALTH NETWORKS, July 8, 2014 ("There's an emotional side to an integration of two organizations that hospital leaders can't ignore. 'People are born and die and miracles occur in these places every day, and it happens right before the eyes of the employees and physicians.'"), *available at* http://www.hhnmag.com/articles/4117-the-art-of-blending-cultures.
[3] *See* TN DOH Response April 22, 2016, Exhibit 6 - Copy of the Nonbinding April 2, 2015 Term Sheet.
[4] *See id*.

Shared Vision outlines the Parties' intent to come together as equal partners to develop a brand new health system for the region with a new leadership structure, a new board, a new name, and a new kind of vision. The Guiding Principles set forth the Parties' commitment to patients, physicians, employees, clinical services and quality, population health, and management.

**2. The Joint Board Task Force.**

After the Term Sheet was executed, Wellmont and Mountain States formed the Joint Board Task Force to oversee the integration of operations and cultures.[5] The Joint Board Task Force is a committee of the two boards acting as a liaison and providing information and guidance during the transaction process. Wellmont and Mountain States each nominated an equal number of their existing board members to become members of the pre-closing Joint Board Task Force and the CEOs of Wellmont and Mountain States each serve on the Joint Board Task Force. The members represent a cross section of regional and physician leadership from the community, incorporating those with experience in governance, administration, business and strategy – both in health care and in the business community. The Joint Board Task Force has met regularly since April, 2015, to guide the pre-closing activities, including the evaluation of cultures, a plan for aligning operations and cultures, and establishment of the mission and vision for the new system.

**3. The Integration Council.**

In addition to forming the Joint Board Task Force, the parties also established an Integration Council responsible for overseeing the pre-merger planning. The Integration Council is made up of an equal number of executives from Wellmont and Mountain States' leadership teams. This group has been charged with the undertaking a comprehensive analysis of the clinical, operational and financial functions of Wellmont and Mountain States. The Integration Council has been meeting regularly to analyze the capabilities of both organizations and prepare plans for operational and cultural alignment once the appropriate approvals have been received. Among other tasks, the Integration Council was charged with hiring a consultant to conduct a cultural assessment of the two organizations. The Integration Council is also responsible for guiding the work of seventeen functional teams made up of leaders from each organization who are formulating plans to outline the work that must occur to prepare for the merger and the work that must occur immediately after the merger. These teams are also considering the functional steps needed to bring the two operational cultures together effectively and represent each functional area of the new health system including finance, human resources, supply chain, IT, and others.

**4. The Cultural Assessment.**

In order to better inform the integration of the two organizations from a human relations and cultural standpoint, the Parties engaged the Hay Group, a third party consultant, to conduct a culture audit of the two organizations. The internationally recognized consulting firm, which focuses on improving organizational effectiveness, was engaged to look at areas of alignment between the systems that would enable the proposed merger, the areas of differences between the systems that might impact the proposed merger, best practices within each system that might be leveraged in the merged

[5] *See* Press Release, Wellmont Health System, Mountain States Health Alliance Name Members of Joint Board Task Force, *available at* http://www.wellmont.org/News/2015/Wellmont-Health-System-and-Mountain-States-Health-Alliance-Name-Members-of-Joint-Board-Task-Force.aspx.

organization, the compatibility and alignment of each system with the Shared Vision and Guiding Principles of the proposed merged entity, and strategies to facilitate success of the proposed merger.

While the specifics of that culture audit remain confidential, the Hay Group found that there is considerable alignment between the systems that will serve to greatly facilitate the merger.[6] Specifically, they found that the current mission, vision and values of Wellmont and Mountain States overlap and are highly compatible. Additionally, after reviewing the Share Vision and Guiding Principles, the Hay Group determined that the fundamental elements of the Shared Vision and Guiding Principles were embodied in Wellmont and Mountain States' existing cultures. For example, both systems already place great emphasis on patient focus and quality, which is a foundation of the Shared Vision and Guiding Principles. The Hay Group believes these alignments will serve to greatly facilitate the merger.

**B. <u>Alignment of the Cultures.</u>**

If the merger is approved, specific steps will be taken to align the cultural identities of the two organizations, including establishment of a new competency based governing board with of new, independent board members with experience in integration, selection of executive leadership, implementation of a new system-wide Physician Clinical Council, and implementation of a single information technology platform to implement common clinical standards for improvement of patient quality and promote system-wide communication and clinical cultural integration.[7]

**1. New Governance.**

Cultural alignment starts with the governing board. Ballad Health's Board of Directors will be composed of board members from both Wellmont and Mountain States who have now been working together for several months on merger implementation planning as the Joint Board Task Force. The new Board of Directors which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman. The president of East Tennessee State University will also serve on the Board of Directors as an ex-officio non-voting member of the Board because of the significant emphasis on the development of an academic medical center model in partnership with Ballad Health and ETSU.

The design of the new governing Board for the merged organization was completed with the assistance of Accord Limited, an independent consulting group that works with health system boards across the United States. Accord reviewed the existing governance cultures of both Wellmont and Mountain States and considered these cultures in the context of the Shared Vision and Guiding Principles. The specific details of the report remain confidential, but Accord found that the two boards have a good deal in common.[8] Accord encouraged the two boards to begin working together through board education, trust building, team-building, utilization of best practices, and to focus on the new shared vision as this will be the key success factor for the Ballad Health Board.

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[6] The results of that culture audit were provided to the Tennessee Attorney General's Office under CID on June 16, 2016.

[7] Application for Certificate of Public Advantage, State of Tennessee, Section 11.h.iv at 78-80.

[8] The results of that governance assessment were provided to the Tennessee Attorney General's Office under CID on June 16, 2016.

Both Wellmont and Mountain states have agreed that the new board will embrace evidence-based practices for good governance as recommended by Accord. These practices are enumerated in the organization's new bylaws[9] and further described in the governing policies that are currently being developed.

**2. New Management Team.**

Research indicates that leadership is the most important driver of employee engagement. During periods of transition, employees look first to leaders for guidance about how to react and behave, for motivation, and for focus.[10]

Ballad Health will be managed by an executive team with representatives from both organizations, including Executive Chairman/President Alan Levine (currently Mountain States' CEO) and CEO Bart Hove (currently Wellmont's CEO). The roles of each are clearly defined.[11] The CEO will have full responsibility for daily operations of Ballad Health, and the COO, CFO and CMO will each report directly to the CEO. The CEO will report directly to the Executive Chairman/President of Ballad Health. The Executive Chairman/President will chair the governing board and will have overall responsibility for the strategic direction of Ballad Health. This position will be supported by the departments of strategy, marketing and communications, government affairs and the population health. The Executive Chairman/President will be evaluated by the Ballad Health governing board.

**3. New Culture.**

Integrating and redefining the culture and corporate values of merged organizations is essential for the integration process.[12] The board, executives, and leadership teams of Mountain States and Wellmont are fully committed to the concerted work of establishing a new Ballad Health culture, incorporating the best of the two existing cultures and a new common vision. Central to this has effort been the uniform agreement and support of the Shared Vision and Guiding Principles unanimously approved by both boards at the beginning of the discussions between Wellmont and Mountain States.[13] Already, the Joint Board Task Force (which will become the Ballad Health board) and the Integration Council have successfully formed key elements of Ballad Health and are actively conducting in-depth integration planning through 17 functional teams.[14]

The selection of a new name and new mission, vision, and values statements will help ensure evolution beyond the two existing cultures to form a new, cohesive Ballad Health culture and way of doing business. The newly established "Ballad Health" brand, Mission, Vision and Values which will focus each

[9] *See* Exhibit 8 to the April 22, 2016 DOH Response (NewCo, Inc. Bylaws).
[10] *See* Richard M. Able, HUMAN CAPITAL INSTITUTE, *The Importance of Leadership and Culture to M&A Success* (January 16, 2007), *available at* https://imaa-institute.org/docs/m&a/towersperrin_09_the%20importance_of_leadership_and_culture_to_M-and-A_success.pdf.
[11] *See* Exhibits D-2 and D-3 to the Cooperative Agreement (provided as Exhibit 11.1 to the Application, *supra* n7).
[12] *See* Aliah D. Wright, SOCIETY FOR HUMAN RES. MGMT., *Successful Mergers Integrate Cultures* (June 30, 2010), *available at* https://www.shrm.org/hr-today/news/hr-news/pages/successfulmergersintegratecultures.aspx.
[13] *See* Exhibit B to the Cooperative Agreement (provided as Exhibit 11.1 to the Application, *supra* n7).
[14] *See* attached Exhibit 7.1 - Description of the Functional Teams.

team member on the uniqueness of each patient and community we serve and how we engage with them—an orientation to listen, understand, and respond effectively to the story of each person we serve, including the spectrum of factors that impact health outcomes. We have placed this value at the center of our brand and must ensure that the experience of those we serve matches the brand promise.

Ballad Health intends to ensure that pursuit of the Mission, Vision and Values is embedded in the recruitment, hiring, onboarding, evaluation, development and incentives of Ballad employees. Each team member should develop an understanding of their unique role and our collective approach to Ballad's foundational identity and relate their individual performance to the system's mission, vision, and values.

For this reason, it was determined that the employees of the new organization should participate in identifying the core values under which they would pursue their work and hold themselves and each other accountable. This process will begin upon approval of the merger where will create a set of initial rallying activities and ask each team member and physician to contribute directly to defining our collective values and relating them to our mission, vision, and guiding principles. Human resources, organizational development, marketing/communications, and leadership teams will help to facilitate this effort and cross organizational learning and relationship building will be emphasized. The results will be ratified by the newly formed governing board of Ballad. An intentional set of activities and engagements will follow a kick-off event through the first twenty-four months and after as we continually seek to reinforce the culture we need and relate it to our engagement with one another, with patients, and with the communities we serve.

**4. New Clinical Leadership.**

Transformation to an integrated delivery system is a key element of the merger, but it will be essential to align the clinical culture across the new organization for the transaction to realize this goal.

Ballad Health is already working to establish a Physician Clinical Council charged with setting common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States as well as large independent practices and a regional mix. Medical staff leadership will nominate representatives. The charter for this group and a description of its membership criteria is attached.

Ballad Health will also adopt a Common Clinical IT Platform that will allow all providers to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care. Use of this common platform will immediately break down inter-facility barriers in establishing uniform practice protocols in the hospitals across the system and in setting a common clinical language for all medical staff members and hospital staffs. This combined with the work of the Physician Clinical Council will support a common culture of quality expectations and performance across the system.

Cultures will be further aligned by the increased emphasis on quality through the use of a common set of measures and protocols and the timely public reporting of many quality measures, as discussed in the application. This combined emphasis on quality and public reporting of quality measures will significantly contribute to promoting a common culture emphasizing quality in the New Health System.

**C. Cultural Transformation to a Community Health Improvement Organization**

As noted in the Overview, achieving integrated care and the transition to a community health improvement organization will require changing the health-care culture and how clinicians think about care delivery. We believe that our team members and physicians, throughout the organization, desire to keep each patient healthy and live in a community that is healthy and thriving. The design of our national health system, however, from the legacy emphasis and fixed cost of hospitals, to the still prevalent nature of the fee-for-service payment, has trapped them in a system where everyday workflow largely encourages volume over value. Given the chance, as well as the necessary tools, training and incentives, we believe that team members and physicians alike will not only embrace, but help drive, Ballad's efforts to become a Community Health Improvement Organization.

How can we, through each key interaction, be cognizant of our desire to achieve the Triple Aim to be efficient, high quality, and accessible/highly engaged and responsive and how can the culture we create internally shape the culture of our community? Some of the key elements needed to ensure this shift in emphasis are included below:

- Elicit a shift from what it means to be a health care system to what it means to be a health improvement organization.
- Impart an understanding of how the actions we take as health improvement professionals (vs. health care professionals) impact the cost of care, quality of care, and accessibility of care for the people and communities we serve, including underserved populations. The role belongs to everyone.
- Impart an understanding of the spectrum of factors that contribute to health outcomes and encourage each team member to be aware of and interact with those we serve around behavioral and social determinants of health.
- Embed protocols or mechanisms of engagement in clinical settings that emphasize prevention activities such as screenings and immunizations as well as critical conversations about behavioral contributors such as diet, exercise, tobacco use, and substance abuse as well as embedded screenings for social needs and connectivity to social resources.
- Enact new job responsibilities, exemplified through leadership, that align how we spend our time with the commitments we have made. We will be healthy examples through our dining services, vending machines, empowerment of exercise programs, allocation of resources, and service in schools and community organizations—as reading tutors or through the provision of water bottle filling stations, for example.
- Intentionally move key activities outside of the clinical setting to the community setting to increase accessibility and raise awareness. In addition to mobile strategies and enhanced telemedicine strategies, we should be embedded in schools, religious organizations, businesses, and neighborhoods to engage, educate, and deliver resources.
- Ensure that the goals set forth in our COPA commitments are understood across the organization and spend time with each department and team member connecting their work to the COPA outcomes we seek to achieve, so that goals are owned by each person in the organization to drive collective impact.
- Demonstrate leadership and re-orient our corporate citizenship to exemplify a changing orientation internally and to encourage other organizations to join us in partnership. This will play out through our establishment of a multi-sector approach to the Accountable Care

Community (which is designed to break down barriers) along with concerted engagement with non-health sectors such as education, government, and business through the extension of expertise and resources.

- Work with both employed and independent or community physicians to achieve alignment of vision and clinical approaches around the Triple Aim and to influence practice patterns and ultimately align incentives supported by a clinical alignment, a common IT platform, the use of a common HIE, and the leadership of the Physician Clinical Council.
- Create integral partnerships with payers and businesses to align payment systems and incentives with community health and population medicine objectives and to reach populations.
- Ensure that these strategies and their expected outcomes are reflected clearly in our strategic plans and budget allocations.
- Use effective internal and external communications strategies to drive the desired culture and exemplify its development through success stories.
- Include this list in the ongoing work of the Population Health and Social Responsibility Committee of the Board as they seek to achieve compliance with our COPA commitments.

## II. Challenges and Strategies

We recognize that challenges will exist both in the alignment of the two existing cultures and in the move to a shared culture of community health improvement, and we have identified the following strategies to address each of these challenges:

- Challenge: Underestimating the importance of culture and not emphasizing it significantly enough.[15]
    - Strategy: To overcome the risk of failure, leaders must focus on understanding and developing the new entity's culture. If leaders show up unaligned, the two merging companies will be unaligned. Ballad Health's leaders have already begun the work needed to come together as “one team” through aligning their vision and strategy for the new health system. In April, 2015, the parties announced formation of the Integration Council, which is made up of executive and physician leaders from both systems to further develop plans in the best interest of clinical quality and the patients served. The Integration Council has been meeting regularly to oversee the merger analysis and preparations, including the culture audit conducted by the Hay Group, and plan for the integration of the proposed combined system. As evidenced by the work done to date, the Parties understand the culture of the combined organization will set the tone for Ballad Health's success and have committed significant resources early in the process to ensure that the cultures are aligned efficiently and effectively.

- Challenge: A mismatch of cultures at the local level can cause challenges across the system.
    - Strategy: Even when merging organizations' purposes are similar, their operating procedures, or "how things get done," can vary significantly. The leaders of Ballad Health recognize that it will be crucial to understand how hospitals and operating

[15] *See* Brooke Fernandez & Andrew Giger, *Three Prescriptions for Successful Healthcare Mergers*, GALLUP BUS. J. (Nov. 19, 2014) (*stating* "Myriad factors can lead to M&A failure, but cultural mismatch is one of the most frequently cited reasons."), *available at* http://www.gallup.com/businessjournal/179486/three-prescriptions-successful-healthcare-mergers.aspx.

divisions within the two organizations achieved results prior to the merger, so a plan may be developed for integrating these procedures and best practices going forward. The cultural audit performed by the Hay Group has helped identify areas where cultural identity and consistency could be improved. The Integration Council intends to use this information, along with their deep knowledge of their own facilities and operating divisions to address areas at the local level that may need additional attention or communication.

- Challenge: Keeping quality of care front and center.
    - Strategy: The importance of clinical quality and performance improvement can often get overshadowed in healthcare merger planning. [16] To ensure that the culture of quality remains a primary focus throughout the planning and integration process, Ballad Health has given both employed physicians and independent physicians an important role in post-closing integration as members of the Physician Clinical Council. The Council will be charged with setting common standards of care, credentialing standards, quality performance standards and best practices. Their work will help drive the transformation to a community health improvement organization and to ensure that quality of care remains the central focus of the Ballad Health culture.

- Challenge: Setting the right pace for integration of cultures.
    - Strategy: Cultural integration and operational integration has to happen at a thoughtful and deliberate pace.[17] If an organization moves too slowly, it could fail to achieve its potential synergies, but if it moves too quickly, it could lose key people along the way. In an effort to address this, Ballad Health has established functional teams made up of leaders from each organization who are formulating plans for the work that must occur in each functional area to prepare for the merger and the work that must occur immediately after the merger. These teams are also considering the functional steps needed to bring the two operational cultures together effectively and the timeline needed to do so. By planning for the specific timelines needed for integration in each functional area, Ballad Health will be able to manage the cultural process change to an integrated delivery system in a systematic and organized way.

**III. How are these activities merger specific?**

While payers' movement towards Value Based Contracting will continue to drive the health systems towards assuming more risk for the health of populations, the potential for truly managing a population that is not split by two competing health systems, resourced as a result of synergies, and actively supervised under a COPA can only occur with the proposed in-market merger of Wellmont-Mountain States merger. In the current environment, the two health systems are exploring more value-based purchasing or pay for performance arrangements and are embracing those opportunities to expand payment paradigms and test capabilities. However, two important exercises have demonstrated that short of a merger of the two systems, movement toward higher levels of risk is unlikely. First, Cigna attempted to focus their network several years ago to derive higher quality outcomes at lower costs—

[16] *See* Maggie Van Dyke, *When Two Cultures Merge: Creating a New and Improved Healthcare Organization,* HEALTHCARE EXEC. MAG. 21 (Nov./Dec. 2015), *available at* https://www.towerswatson.com/en-US/Insights/IC-Types/Reprints/2015/when-two-cultures-merge-creating-a-new-and-improved-healthcare-organization.
[17] *See id*.

including only one of the regional systems in the network. The experiment did not succeed in large part due to pressure from employees of businesses with Cigna to expand the network to include both health systems and their related physicians, hospitals, and specialty services. This experiment confirmed that people who live and work across the region are more likely to support population health systems as willing participants if they include both health systems—a situation which is unlikely if the two systems remain separate and most likely participate in diverse value-based arrangements. Second, Mountain States' venture to provide insurance through Crestpoint revealed that the population under management needed to be significantly larger in order to absorb the actuarial risk that would result in success. Even though Ballad Health has no plans to develop an insurance product, the alignment of risk-based population health incentives and effective management of risk being placed on the systems by payers are similar. In addition, a larger population is needed to support the cost of infrastructure essential for analytic capabilities, case management, care coordination, and administrative management functions. Though expert opinions vary on the size population needed for the effective assumption of significant risk, both Mountain States and Wellmont are reluctant to take on the assumption of significantly more risk independently because neither has envisioned a sound fiscal model or can afford the needed infrastructure separately. Under the merger, however, risk can be spread over a larger population and resources can be developed and deployed more efficiently.

The creation of a new health system with a new name and new mission, vision and values will create a pivotal moment for cultural transformation to occur and for expectations to be reset, not only within the health systems themselves, but within the communities. Many leading businesspeople and community leaders view the merger as a critical opportunity to break down walls which heretofore have kept communities in the region from collaborating on education, economic development and social programs.

**Exhibit 7.1**

**Description of Functional Teams**

The Parties recognize the vital role they play in their local communities. They understand the importance of assuring that the integration of Mountain States and Wellmont into Ballad Health occurs smoothly with no disruption to critical services. For this reason, the Parties worked diligently to develop a roadmap for integration planning that would assure their readiness to operate as one entity once all necessary regulatory approvals were obtained.

Until all such approvals are obtained, the Parties remain competitors. Consistent with this fact, the Parties' integration planning framework was developed in close consultation with legal counsel to assure full compliance with the antitrust laws.

The Parties' integration planning framework is organized around a joint Integration Council. The Integration Council is comprised of senior management from each health system, including each system's general counsel. The members of the Integration Council are responsible for planning key operational functions for post-closing implementation. The Integration Council established 15 Functional Teams are responsible for planning in discrete operational areas, including:

- Clinical council
- External affairs
- Finance
- Governance
- Hospital operations
- Human resources
- Information technology
- Managed care
- Physician operations
- Post-acute operations
- Quality
- Research and academics
- Retail operations
- Strategy, and
- Supply chain

Each Functional Team has a detailed project plan with pre-close tasks designed to assist with planning of key operational functions for post-close implementation. The project plans were reviewed and approved by counsel and the Integration Council.

The integration planning teams held a kick-off meeting in March 2016 to outline their scope of work. Antitrust counsel advised the Functional Teams about the antitrust laws that apply to integration planning activities. The Functional Teams began meeting on a bi-weekly basis in September 2016 once the Applications were deemed complete in both Tennessee and Virginia. Antitrust guidelines are read before every Functional Team meeting and a representative of one of the legal departments participates in each meeting.

**Ballad Health**
**8. The New Clinical System**

**Executive Summary:** In this response, we describe the proposed care team models that will be developed within Ballad Health, we discuss Mountain States and Wellmont's current experiences with care teams, we identify the strategies that will be utilized to address challenges encountered during implementation, and we explain how the merger would facilitate these new care models.

## I. A Proposed Care Team Model

According to the Institute for Healthcare Improvement:

> *"The current infrastructure for primary care in the US is not sufficient to meet the population management needs of a primary care patient panel. Researchers have estimated that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 primary care patients (similar to the average US primary care panel of 2,300), plus 10.6 hours to adequately manage this panel's chronic conditions. If you include the estimate that it takes 4.6 hours per day for acute care, this adds up to 22.6 hours per day. It's also been estimated that an average of only 54.9% of adults in the United States received recommended care in each of those areas.* ***It is not possible to achieve improved population health without substantial (versus incremental) change****."*[1]

Efforts to build a better care model have existed for some time. For example, in the 1990s, with input from national experts and support from the Robert Wood Johnson Foundation, The MacColl Center for Health Innovation produced the Chronic Care Model, which identifies the essential elements of a health care system that encourage high-quality chronic disease care. "These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise."[2]

Over time and with successful application of the CCM, it became clear that modifications were necessary for the model to be successfully applied in a population health context. The Expanded Chronic Care Model (ECCM) displayed in Figure 1 now integrates population health promotion into *prevention* & management of chronic disease. There is now more emphasis on supporting people and communities

[1] Cindy Hupke, INST. FOR HEALTHCARE IMPROVEMENT, *Team-Based Care: Optimizing Primary Care for Patients and Providers* (May 2014), *available at* http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?list=0f316db6-7f8a-430f-a63a-ed7602d1366a&id=29.

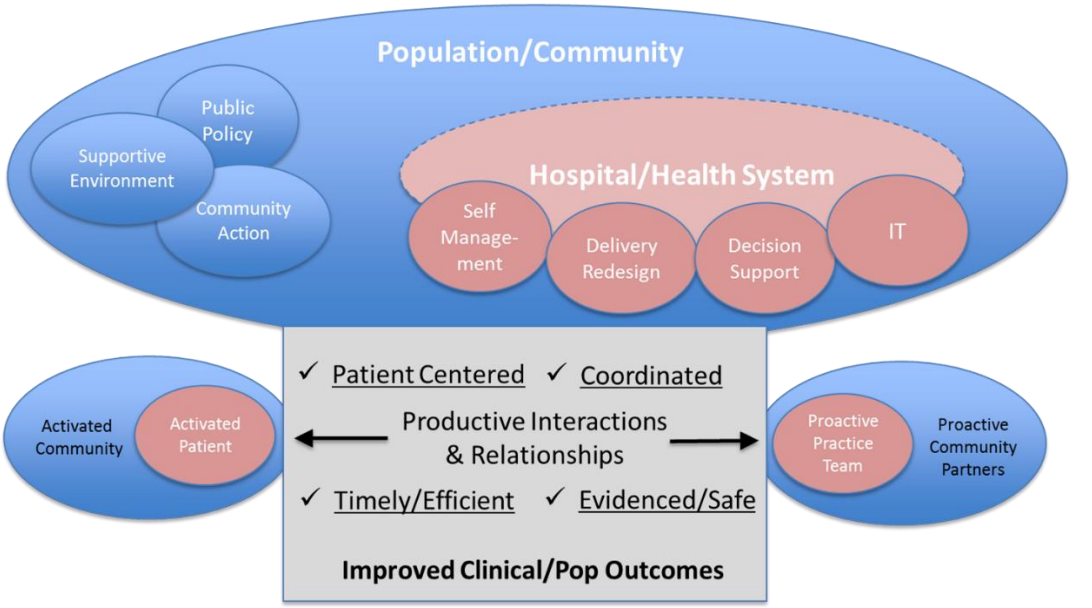
[2] GROUP HEALTH RESEARCH INST., THE CHRONIC CARE MODEL, *available at* http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18.

to be healthy with greater focus on social determinants of health as well as delivering high-quality healthcare services.[3]

Although each component of the model deserves discussion, the proactive practice (care) teams' interaction with proactive community partners and activated patients and community is core to the ECCM's success. A widely accepted definition of "team-based care" is:

> *"The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable."*[4]

**Figure 1: Expanded Chronic Care Model**




Barr, Robinson, Marin-Link, Underhill, Dotts & Ravensdale (2002)

Productive interactions between a proactive practice team and the activated patient are crucial. In order to achieve success, the proactive practice team must have the information, decision support and resources need to deliver high quality care, and the activated patient must have the motivation, information, skills and confidence to effectively manage his or her health. A productive interaction should include:

- assessments of clinical status, self-management skills and confidence (possibly using a valid patient activation measure survey);
- individualizing of clinical management potentially using stepped protocols;
- a care plan built by collaborative goal-setting and problem solving; and

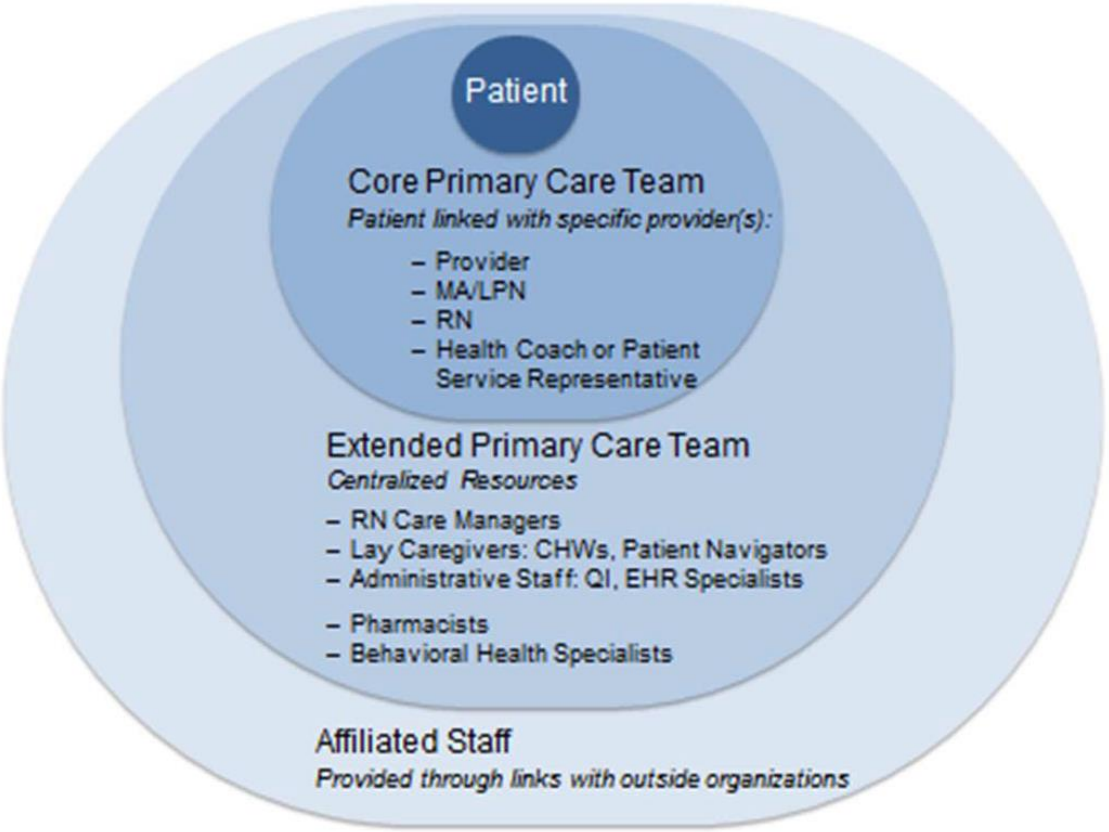
[3] Kathryn Kash, Jefferson School of Population Health, Address to the 11th Population Health & Care Coordination Colloquium, Pre-Conference Boot Camp (March 14, 2011) (slideshow), *available at* http://www.ehcca.com/presentations/pophealthsummit1/kash_pc.pdf.

[4] MD Naylor, et. al, *Team-Based Primary Care for Chronically Ill Adults: State of the Science, Advancing Team-Based Care* (American Board of Internal Medicine Foundation 2010).

- sustained follow-up.[5]

It is important to recognize the expanded definition of the Primary Care Team, which is necessary to achieve both better population health outcomes and individual clinical and functional outcomes. The ECCM specifically adds the support of proactive community partners to the clinical practice. Figure 2 depicts a model for this expanded concept of the Primary Care Team developed as part of the MacColl Center *Learning from Effective Ambulatory Practices (LEAP)* project funded by the RWJ Foundation. A core team is collectively responsible for a defined patient panel linked with a specific provider, clinical assistants, RN, health coach, and front desk staff. This core is supported by extended team members who serve as shared resources available to patients of multiple core primary teams. An additional outer layer includes staff not employed by the practice but proactively included as part of an individual's care team through case management plans and formal links with community partners.[6]

**Figure 2: The LEAP Primary Care Team Conceptual Diagram**




[5] Kathryn Kash, Jefferson School of Population Health, Address to the 11th Population Health & Care Coordination Colloquium, Pre-Conference Boot Camp (March 14, 2011) (slideshow), *available at* http://www.ehcca.com/presentations/pophealthsummit1/kash_pc.pdf.

[6] ROBERT WOOD JOHNSON FOUNDATION: IMPROVING PRIMARY CARE, *The Primary Care Team: Conceptual Diagram* http://www.improvingprimarycare.org/sites/default/files/topics/Team-Step2-Care%20Team%20Conceptual%20Diagram-DC.pdf.

Both Wellmont and Mountain States operate NCQA Patient Centered Medical Home (PCMH) practices, which provide a baseline standard for a care team that is focused on better-coordinated management of patients. This certification was pursued over time as payers increasingly incentivized or required this, or similar, certification. NCQA PCMH certification has, over time, required more components of the ECCM with an emphasis on team-based care, focusing the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow up with external support organizations. A number of roles listed above in the extended primary care team are increasingly utilized, including RN care management, patient navigators, QI specialists and pharmacists.

Both health systems are pursuing further implementation of the ECCM and the LEAP Primary Care Team model. Several examples are listed below.

**A. CareScope 360**

In anticipation of the merger, Mountain States and Wellmont applied for and received a $205,000 grant from the Virginia Health Care Foundation to provide care coordination and linkages to community resources for uninsured individuals with high utilization of the emergency department (ED) and at least one hospital admission at either Norton Community Hospital in Norton, VA (Mountain States Health Alliance), or Lonesome Pine Hospital in Big Stone Gap, VA (Wellmont Health System). The goal of the grant is to reduce ED utilization rates and avoidable hospital admissions by improving health status through better identification and management of medical needs and social barriers before they reach crisis stage. The timeframe is June 1, 2016, through November 20, 2017, and 175 individuals are expected to be served.

CareScope 360 takes a "360 degree view" of a patient's strengths and needs, both medical and social. The target population for this project is uninsured individuals with high utilization of the ED and who were ultimately admitted to the hospital on at least one occasion. Operating at the core of the program are dedicated care coordinators and one community health worker who work to connect each individual to primary care, behavioral health and social support services.

Our grant partners are the Health Wagon for primary care services, the Wise County Community Service Board and Frontier Health for behavioral health needs, and the Virginia Department of Health's Lenowisco Health District for training, education and other support for the community health worker. In addition, we are now working with Mountain Empire Older Citizens Area Agency on Aging (MEOC) to help with transportation issues with the CareScope 360 participants, and the Stone Mountain Federally Qualified Health Center (FQHC) as a second primary care option that may be closer to their homes.

Care coordinators focus on identifying needs and creating a plan of care, and the community health worker works to facilitate the plans of care. Individuals meeting the selection criteria are contacted by the care coordinators and offered the chance to opt-in to the program. Those who can be reached and eventually enroll are screened for their unmet social needs (such as food and housing insecurity, domestic violence, lack of adequate transportation, etc.) and level of patient engagement in their own care. A second screening determines if the patient has a primary care physician, if they need medication assistance, and if they need more in-depth education on any current or chronic health conditions. Patients also receive a behavioral health screening to determine if a referral to Frontier Health is appropriate. Finally, patients will be

screened for eligibility for Medicaid or for enrollment into a health plan on the Health Insurance Marketplace.

**B. Community Paramedicine**

Mountain States and Washington County EMS are currently exploring the creation of a community paramedicine program that would provide home-based care and well checks for individuals who are frequent ER utilizers but who do not qualify for other forms of home health. The program would involve EMS, ER, home health, social work, and case management and would seek to improve health outcomes and decrease ER/hospital utilization by having specially trained paramedics conduct regular home visits to provide full body assessments, wound care, medication administration, blood pressure and blood sugar checks, education and referrals to community resources, and emergency action as needed.

Referrals to the program would be made through the hospital ER. Patients in the program would be frequent ER utilizers who do not have primary care, do not qualify for other forms of home health, and/or have other risk factors such as food or housing insecurity. Weekly case conferences would evaluate patients' progress, and other community agencies and partners would be looped in where appropriate, including the ETSU Community Health Center, housing services, food banks and others.

Paramedicine makes sense because it reaches patients who otherwise tend to fall through the cracks, and it is provided free of charge to the patient. It is targeted to help improve compliance with care plans and lower ER utilization. Paramedics are an excellent resource and partner for such a program because they are highly trained health care professionals who have available down time between emergency calls. The program can be built into a paramedic's regular day without disrupting ability to respond to emergency calls, and makes good use of the paramedic's skills and resources. The special training required in Tennessee for paramedics to become community paramedicine-certified is an asset to the EMS agency as well as the community at large.

Mountain States and Washington County EMS have agreed to fund a pilot program of 10 patients to determine viability of the program and gather outcomes data. The pilot is currently pending legal approval. It is estimated that as many as 500 patients in Washington County alone could benefit from a full-fledged program. The full program would require grant funding; with documentation of positive outcomes, the program would explore reimbursement mechanisms with payers.

**C. Primary Care - Behavioral Health Integration**

Mountain States Medical Group has contracted with local behavioral health agency, Frontier Health, for the services of a behavioral health care navigator (BHCN) with extensive experience in the field.

The BHCN is a part of the care management team working directly with the AnewCare Medicare Shared Savings Program population attributed to this practice. Currently this individual has 109 patients in her case load. Most of her interaction with patients is during home visits.

Providers, the nurse case manager or any member of the care team may refer patients through the Allscripts IT system to the BHCN. Once a referral is made, the BHCN does a chart review and assesses the behavioral health and social needs of the patient. The navigator provides an assessment of the referred individual's social determinants of health; strengths, needs, abilities and preferences (SNAP); and other relevant assessments to assist in identifying and accessing needed services that will maximize the individual's overall health and well-being. Major duties and responsibilities include:

- Conducting interviews with individuals and/or family members in a therapeutic manner so as to obtain critical and thorough information,
- Providing clinical assessments, service planning, crisis assistance, daily living assistance and linkage, referral and advocacy to/for referred individuals.
- Active involvement with primary care physicians, case managers, and other supportive staff to include ongoing communication and participating in integrated treatment team meetings.
- Providing in-home face to face connection to engage patient in needed services.
- Coordinating with community providers to assist and attend primary and behavioral health care, specialist, community resources, pharmacy, etc. and remaining current in knowledge of community resources and how to access those resources.
- Assisting and attending Primary and Behavioral Health Care appointments with consumers.
- Staying involved in the admission, hospital stay and discharge of individuals on caseload who are admitted to an inpatient primary/psychiatric facility.
- Attending and participating in regularly scheduled staff meetings, in-services and individual program planning staffing as needed.

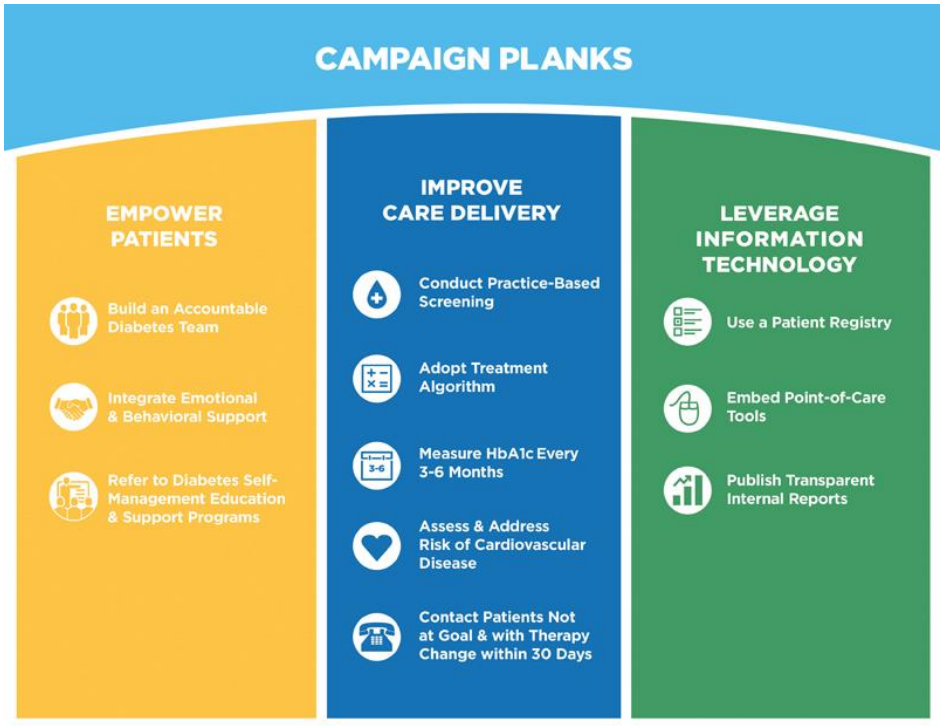
The BHCN addresses limited gap closure when he/she interacts with the patient. Examples include fall risk assessments and substance abuse screenings as may be deemed appropriate. The BHCN documents any interaction information and assessments within the Allscripts medical record. The BHCN records patient interaction in Allscripts through the "Social Determinants of Care Plan." The BHCN is an integral part of the team and interacts with care coordinators, nurses and physicians. The close connection to Frontier Health affords our patient population direct access to other behavioral health professionals. The cornerstone of the BHCN work is the focus on community outreach, and the majority of the contact with patients is through a home visit. This affords the primary care team the ability to learn about patient barriers that would almost never come up during a regular provider office visit.

**D. Core Primary Care Team Example**

To prepare primary care teams for their work in value-based performance models, Wellmont and Mountain States have worked significantly to re-orient and re-prioritize our approach to primary care and to work with payers to incentivize proactive care management to reduce health costs. Through the American Medical Group Association's Together 2 Goal initiative, Wellmont has adopted a set of primary care campaign planks and training around the model, along with transparent reporting of quality metrics and population risk scores across the medical group's primary care practices. Campaign planks are designed to empower patients to manage their own care, improve care delivery, and leverage information technology through an

integrated approach that includes an accountable diabetes care team, integrated emotional and behavioral support, and diabetes self-management education. In addition, care delivery mechanisms are imported through concerted screenings, a uniform treatment algorithm, regular measurement of HbA1C levels, cardiovascular risk assessment, and communications and coaching for patients who are not achieving goal. A patient registry with point-of-care alerts and embedded tools is used along with transparent and frequent outcomes reported to drive performance.

In this environment, the patient-centered focus is enhanced and team-based care is embedded across all practices with commitment for adherence. The roles of the team include defined responsibilities and goals and the patient and family are considered part of the care team. The stage is set for cross-practice collaboration, especially with specialty practices that support co-related conditions such as cardiology and endocrinology in this example. And, everyone in the practice environment, including the patient, is involved in process improvement and evaluation. This is just one example of the many efforts currently employed by both Wellmont and Mountain States to coordinate and manage care through care teams. As the previous examples set forth, the next manifestation of this coordination under population health is to extend the reach of coordination into community environments or across organizations to gain behavioral health support, social needs support, and deliver care and screening elements in community settings.




**E. Pritikin Intensive Cardiac Rehabilitation**

Wellmont's Pritikin program is an example of the development of care teams in clinical settings extending engagement into personal and family dynamics to impact lifestyle and behavior change. The program has been proven to reduce the progression of heart disease in patients

with diagnosed disease through a concerted program of education, exercise, diet, sleep, and stress management. Cardiologists and their office staffs reinforce the protocols in the total care regimen. The program also has application for other metabolic conditions where behavior modification is key to the prevention or progression of disease.

Health coordinators join with cardiac rehabilitation specialists and providers in a holistic approach that involves patients and family members both inside and outside of the clinical setting to empower behavior change and a supportive environment for continued success. The traditional exercise elements of cardiac rehab are bolstered by cooking classes, food shopping experiences, de-stressing activities such as yoga, meditation, and flexibility training and healthy sleeping habits. Social and relational reinforcement is also recognized as an important factor to long-term success and participants join with groups of individuals facing similar health challenges for encouragement and shared successes.

## II. Challenges and Strategies for Care Team Models

We recognize that challenges will exist in the development of care team models and we have identified the following strategies to address these challenges.

- Challenge: Lack of trained personnel for "new" care team roles.
    - Strategy: Well-trained care coordinators, community health workers, and navigators are not easily available in the market. Education and training programs for these positions do not exist in the local market, and most training must be completed on the job. For example, the Department of Health in Wise County had to develop its own program for community health workers, and it is this program that we partnered with to train the community health workers associated with CareScope360. Oncology navigators at both systems are generally RNs; however, they have also been trained on the job and through out-of-market continuing education. Ballad will work with local two- and four-year colleges to develop curriculum to educate and train individuals to work in these fields.

- Challenge: Greater collaboration and trust.[7]
    - Strategy: According to IHI Director Cindy Hupke, "Team-based care requires greater collaboration than some providers might initially be comfortable with. Across the country, the biggest struggles we see and hear about are when physicians don't trust that another care team member can do a job as well as they do. …they are often unwilling to let go of some of their responsibilities to others who can perform the tasks within their level of licensure and training. Organizations need to mitigate this issue through small-scale testing, training, observation, and collecting data on processes and outcomes to demonstrate reliability and accuracy of the processes."

- Challenge: Differing business models between health care and social support services

[7] Cindy Hupke, INST. FOR HEALTHCARE IMPROVEMENT, *Team-Based Care: Moving from Ideas to Action* (Jan. 2016), *available at* http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?list=7d1126ec-8f63-4a3b-9926-c44ea3036813&id=192.

- Strategy: As health care systems begin to reach out to social support services, either public or private, they may find that different rules, regulations, and motivations may conflict. For example, through a community health worker's home visit, a primary care team may identify that an elderly diabetic individual does not have access to sufficient food appropriate for his/her condition. A natural referral to a support agency providing home meals would be an appropriate solution. If, however, referral protocols are not worked out in advance, that individual could end up on a waiting list for services or could be denied for a variety of eligibility reasons. Ballad will build out its community partner relationships *proactively* and *formally* so both organizations may smooth referrals and other interactions as a matter of policy and procedure, not by chance.

**III. How the Merger will Benefit the Deployment of New Care Models**

Under the fee-for-service model, many payers still do not explicitly reimburse for services that (i) are not delivered by a physician, (ii) occur outside the clinic, (ii) occur through telemedicine, (iv) are considered "not medical" (such as temporary housing), or (v) occur in a group setting - services that are all hallmarks of the concept of the ECCM. This has hindered the expansion of these models nationally, and locally. As noted in the examples above, a number of the two systems' current efforts are still on a relatively small scale.

As Wellmont and Mountain States have noted, there are limitations placed on their ability to accept greater medical cost risk given the current split of patients and physicians in a community with low population density.[8] With at-risk contracting, payers are more willing to pay a per-member, per-month management fee for care coordination or gap closure important to the ECCM. As a combined health system, Ballad Health will be able to take on more risk, especially through clinically integrated partnerships. It will be able to provide services that are not explicitly reimbursed through direct payments that are designed to drive down the total cost of care and improve quality, resulting in shared savings payments. As outlined in the commitments, Ballad Health will actively seek out these risk-based contracts.[9]

During the transition from fee-for-service to pay for value/risk, Ballad Health will apply funding from the synergies in order to build out the new care teams and other ECCM capacity to specifically address those populations that have no source of reimbursement. As noted in the public health commitments, Ballad Health will implement the Expanded Chronic Care Model approach to high-need high-utilizing uninsured individuals based on the learnings in the CareScope360 pilot discussed above. This would not be possible but for the synergies generated by the merger.

Without the merger it would be extremely difficult, if not impossible, to form fully effective clinically integrated partnerships would can help promote the ECCM. While the Qualuable ACO and the Anewcare ACO, for instance, are both operating in the region, two limits remain. First, Wellmont physicians are not participating because of the initial difficulties experienced in their ACO start-up. But more importantly, there is significant patient leakage that impacts both ACOs because the services in

[8] *See* Response #1 discussing the experience Wellmont and Mountain States have with value-based and risk-based payment arrangements and their strategy to move from traditional fee-for-service to more value-based and risk-based models.
[9] *See* Application, pages 80-81.

the area are not integrated. More than 50% of all spending in Mountain States' AnewCare ACO happens outside Mountain States. A significant portion of these services are delivered by Wellmont or Wellmont-aligned physicians, so it is very difficult to co-manage these patients. By aligning the two systems, this challenge will be greatly reduced to the benefit of both ACOs and any future clinically integrated networks.

Finally the merger will allow for more sophisticated partnerships with community agencies such as Frontier, EMS, Area Councils on Aging, etc. As noted in the Challenges Section above, these organizations all have business models that differ from the core business models of Wellmont and Mountain States. By establishing a single integrated system, Ballad Health will be able to establish common policies, procedures and contractual agreements needed to create a unified system of community partners/affiliated staff in support of these new care models.

**Ballad Health**
**9. Define the IT Strategy**

**Executive Summary:** The transformation to an integrated delivery system will require a significant investment in information technology ("IT") systems. In this section, we describe how Ballad Health will 1) determine the IT components necessary for the transformation and identify where gaps exist; 2) develop the IT governance structure to connect the business strategy with the supporting IT infrastructure; and 3) create a roadmap for implementation of technology to enable the new operational and care delivery processes of Ballad Health.

Encompassed in any population health management strategy is the requirement for supporting information technology and analytics.[1] The investment in electronic health records is a foundational element, but it is the investment in the accompanying IT and analytic systems that will position Ballad Health to successfully pursue population health and risk-based contracts. There will be three aspects to building the IT roadmap for the new organization: 1) determining the IT components necessary and where gaps exist; 2) developing the IT governance to connect the business strategy with the supporting IT infrastructure; and 3) creating a roadmap for implementation of technology to enable the new operational and care delivery processes of Ballad Health.

## I. Components of the IT System

Organizations embracing the transformation from traditional fee-for-service to value-based population health require significant investments in IT capabilities. Today, there is no single IT solution that can offer the many components necessary for the transformation, so various systems must be established and connected to achieve the business goals.

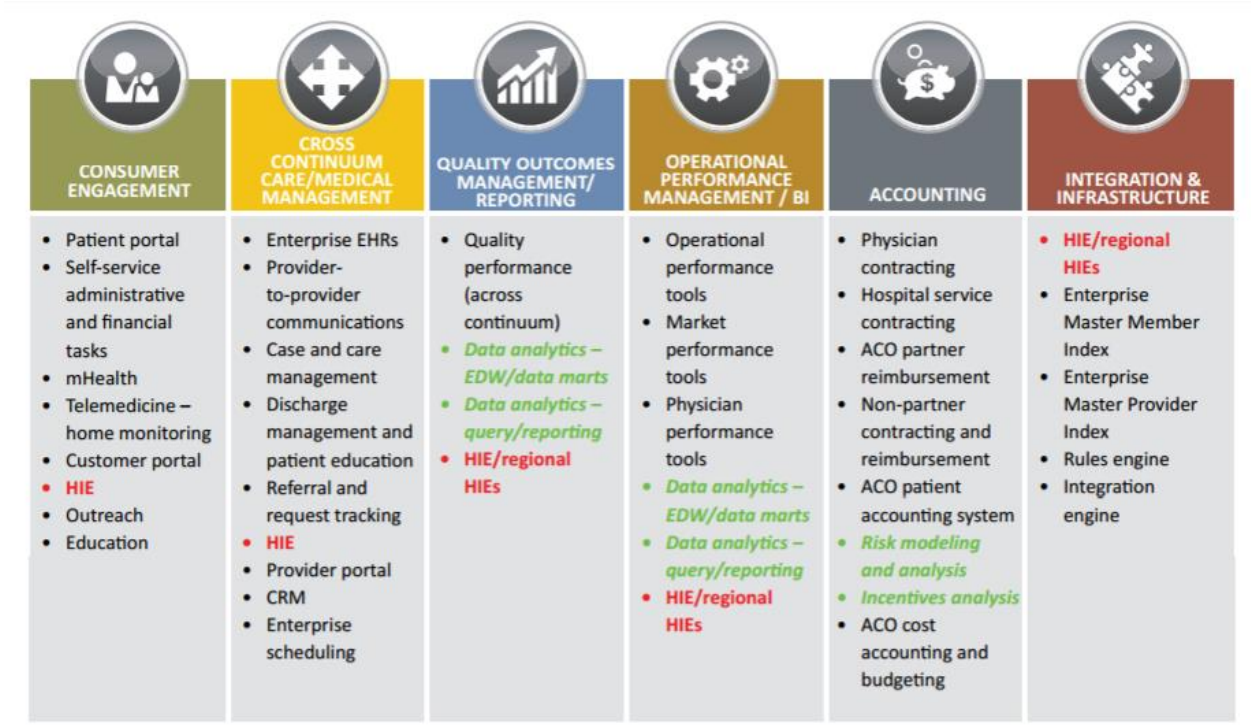
### A. IT Assessment

As a first step in identifying what IT system components are needed and what Wellmont and Mountain States are bringing to the merger, the IT Functional Team has begun assessing the IT assets of each the merging entities, including applications, infrastructure, and IT contract portfolios to determine gaps. From this assessment, they will form recommendations and identify the required IT "stack" necessary to deliver a total solution. In this assessment, the IT Functional Team will consider the organization's population health strategy as well as the anticipated value-based contracting strategy. They will consider such factors as:

- Existing IT infrastructure and data sources
- Services provided by public health and social service agencies
- Potential for nontraditional health care data sources (e.g., public health, social services agencies, and consumer purchasing patterns)
- Existing care process strengths and opportunities based on available cost and quality data
- Projected outcome of revenue shift from fee-for-service to value-based contracts

[1] Jacquelyn Hunt et. al, *Guide for Developing an Information Technology Investment Road Map for Population Health Management*, 18(3) POPULATION HEALTH MGMT. 159-71 (June 2015), *available at* http://online.liebertpub.com/doi/full/10.1089/pop.2014.0092.

As demonstrated in the graphic below, IT systems cut across core competencies making IT selection decisions very challenging. The electronic health records ("EHR") and Health Information Exchange ("HIE") capabilities will be needed to support almost all of the foundational areas. Analytic capabilities will be needed for various areas as well, including management, quality outcomes management, and accounting.




*Source*: *Building a Technology Roadmap that Supports YOUR Organization's Value-Based Care Model*

The IT assessment will be critical to creating an IT road map for population health that inspires confidence across the numerous internal departments that will rely on the IT system. It will be critical to engage the IT, informatics, and business intelligence staff as key partners in the expanded population health planning efforts. It will also be important to engage employed and independent providers in the discussions so they are aware how the IT strategy may affect their practice and/or business.

**B. The Infrastructure of the IT System**

Once the IT Assessment is completed, the IT Functional Team will determine what core components need to be acquired and what legacy systems may be utilized. The Parties have identified the following components as necessary elements of the IT infrastructure, but others will likely be added once the IT Assessment is complete.

1. Common Clinical IT Platform

The Common Clinical IT Platform will serve as the backbone of the Ballad Health IT System.[2] This common platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care and will also facilitate the development and increased adoption of best practices and evidence-based medicine recommended by the Clinical Council. In its Application, Ballad Health has committed to the investment of approximately $150 million over ten years to ensure a Common Clinical IT Platform is implemented and interoperability is available among the New Health System's hospitals, physicians, and related services. The cost of implementation of a Common Clinical IT Platform is built into the capital model for Ballad Health. Standardized order sets, collection of data and standardization of data sharing with physicians are all benefits that would be immediately achieved with the Common Clinical IT Platform once fully implemented. The unified platform will replace the four separate platforms that Wellmont and Mountain States currently operate. The common platform and standardization of process improvements will provide better and almost complete clinical transparency for our patients, their families, and clinicians. It is anticipated that the IT Functional Team will develop a Request for Proposals for the new Common Clinical IT Platform prior to closing. The goal of this group is to be positioned to select an appropriate platform in the first year after closing and begin functional preparation for implementation with particular emphasis placed on organizational responsibility alignment, staffing needs assessment, and timeline development.

2. Region-Wide Health Information Exchange

An HIE has the potential to improve coordination of care and quality of health care services across the region. To ensure that independent physicians and other health care providers in the proposed Geographic Services Area will not be disadvantaged by lack of access to patient information necessary for the management of their patients, Ballad Health has committed to participating in an HIE open to community providers and will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians.

A region-wide HIE that includes Ballad Health, independent providers, medical groups and facilities in an effective collaborative model will encourage and support patient and provider connectivity to the integrated information system. In conjunction with the Common Clinical IT Platform, the HIE can be utilized for the management of shared patients between physicians, hospitals, and outpatient settings especially for the avoidance of unnecessary duplication of testing and care coordination to close care gaps. Among other benefits, the seamless sharing of this information will reduce unnecessary cost, mitigate risk to patients and enable improved productivity among providers. After the transaction, the New Health System will commit financial resources to the utilization of an effective HIE. These incremental resources will contribute to the sustainability of an effective HIE model.

[2] Jacquelyn Hunt et. al, *Guide for Developing an Information Technology Investment Road Map for Population Health Management*, 18(3) POPULATION HEALTH MGMT. 159, 160, (June 2015) ("It is clear, however, that successful EHR adoption serves as a foundation to enable [population health management]. The value of health IT investments will be maximized further when coupled with care redesign and incentive changes promoted by value-based payment models."), *available at* http://online.liebertpub.com/doi/full/10.1089/pop.2014.0092.

3. Analytic Systems

Investment in the Common Clinical IT Platform and participation in the region-wide health information exchange will not be enough to support the analytic requirements needed for population health management and risk-based contracting. To allow Ballad Health to successfully pursue these initiatives, the organization will need to invest in sophisticated business analytic systems that facilitate predictive modeling, financial modeling, and cost tracking.

Predictive analytics will be an important component of the IT strategy. Models that predict negative health outcomes before they happen or identify areas for improvement help focus the attention of clinicians, care managers, and administrative staff to do the most good with the fewest resources. By analyzing the enormous amount of data that users collect in the course of their normal workflows, Ballad Health can start to identify historical trends and develop models to predict future events.

Financial modeling will be critical to the financial success of the organization. Risk-based contract models require a new type of financial analysis. If the organization is wrong on modeling medical expenses, significant losses can be experienced. On the other hand, with accurate modeling, the ability to manage care, and various risk-mitigation strategies, there can be appropriate returns.[3] While both Wellmont and Mountain States have experience with risk-based and value-based contracting, the shift towards population health management will require new and refined financial information systems.

Population Health Management will also require sophisticated cost data analytics to better understand the population as a whole and to help identify where the greatest opportunities exist to improve outcomes and lower costs in the setting of limited time and resources. For example, Ballad Health will need to track the unit and case cost for all services for which it will be at risk under a value-based contract to ensure that costs are managed while quality and outcome targets are pursued. The availability and accuracy of this information will be critical to Ballad Health's success. Ballad Health will also need to coordinate with outpatient providers for capturing and accessing data on outpatient costs.

## II. IT Governance Structure

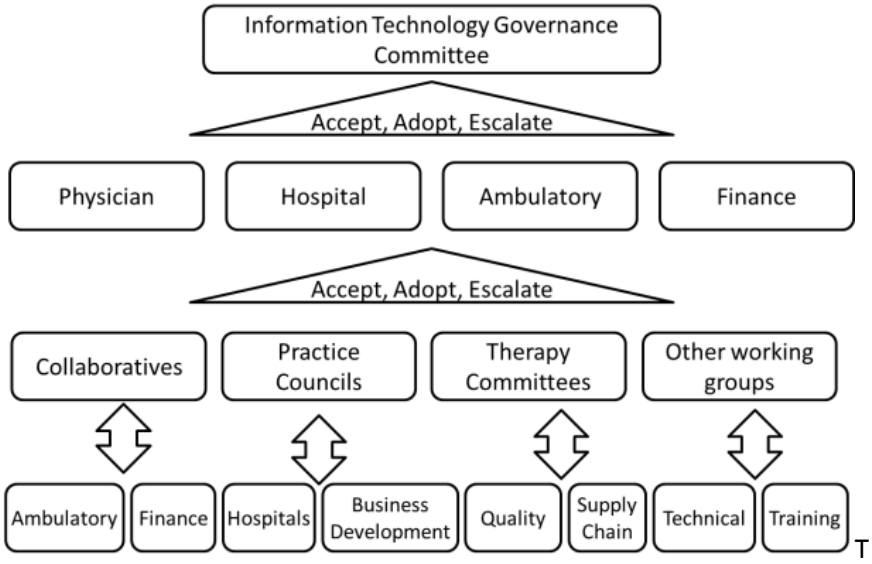
IT governance will be the critical link between business strategy and IT systems for value creation. The overarching Ballad Health population health strategy will drive the transformation, and the IT systems support the clinical and business functions of the organization. To achieve this strategy/support relationship, Ballad Health will design, approve, and socialize an IT governance process that aligns the investments with the population health business strategy.

As a first step, Ballad Health will deploy a fully cross functional Information Technology Governance Committee ("ITGC"). The ITGC will meet monthly (as needed) to receive, consider and validate prospective technology needs, possible solutions, infrastructure compatibility and resource capacity. The ITGC will be co-chaired by both physician and management leadership. The committee will consist of senior executive leadership representation from all geographical markets, senior corporate leadership

[3] *See* Response #1, Section IV.B for more detailed discussion.

representation from operations, finance, information technology and legal, designated facility Chief Nursing Officer and Chief Medical Officer, and subject matter experts as needed.

The ITGC will be charged with determining if projects and associated expenditures meet with the strategic direction of Ballad Health and whether the Information Technology department has sufficient capacity to meet the desired project on-time and on budget. The following diagram represents the anticipated IT governance workflow.




## III. Roadmap for Implementation

If the COPA is approved, the Parties expect to build upon the work the IT Functional Team has already done to determine the roadmap for implementation. Ballad Health will fully assess the IT assets of each of the merging entities including applications, infrastructure, and IT contract portfolios to best determine gaps, form recommendations and secure the required IT stack to deliver a holistic solution. The IT assessment is expected to take at least six months after Ballad Health is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform has been submitted to the state for reference.[4] Additionally, estimates for how and when the $150 million will be spent on the Common Clinical IT Platform has also been provided to state.[5]

The following graphic outlines the approach Ballad Health intends to take as it pursues an IT Strategy that will successfully support the transition to a community health improvement organization.

[4] *See* Responses to Questions Submitted April 22, 2016, Exhibit 17.
[5] *See* Responses to Questions Submitted April 22, 2016, Exhibit 18

## Population Identification

| Requirements | Systems |
|---|---|
| • Data acquisitions and aggregation<br>• Analytics-based population definition and contracting<br>• Predictive modeling<br>• Algorithmic population identification<br>• Patient-provider attribution | • Data aggregation platform:<br>EMR clinical data repository (CDR): clinical data warehouse (CDW).<br>• Claims data source<br>• Statistical modeling tools<br>• Algorithms and analytics for inclusion/exclusion criteria by population<br>• Process, algorithms for attribution |

## Population Tracking

| Requirements | Systems |
|---|---|
| • Populations: High risk/high utilization; Chronic disease group; Preventive care<br>• Map against care guidelines<br>• Map against care over time | • Disease / population registries |

## Care Delivery

| Requirements | Systems |
|---|---|
| • Clinical data view, e-prescribing, clinical documentation<br>• Patient-centered view of interventions due<br>• Decision support for interventions | • EMR or physician portal<br>• Registry: patient-centered view<br>• 3rd Party Clinical Systems |

## Cross-Continuum Care Management

| Requirements | Systems |
|---|---|
| • Care manager: patient data access, clinical documentation, communication tools<br>• Care plan mapped against patient data<br>• Remote data acquisition: vital signs, lab values<br>• Real-time video interaction at remote locations | • Patient portal<br>• Text-based communication system<br>• Provider mobile devices<br>• Call center<br>• Case management tool |

## Administration Performance Monitoring, and Reporting

| Requirements | Systems |
|---|---|
| • Contract negotiation and management<br>• Revenue distribution<br>• E-measure calculation and reporting<br>• Performance data at clinical, practice, organization-wide levels<br>• Value based metrics | • Data aggregation and analysis platform<br>• Dashboards, self service display tools<br>• Linked contract management and financial systems<br>• Revenue cycle systems<br>• Financial decision support/cost accounting |

**Ballad Health**
**10. Evidence and Rationale for Investment in Residential Addiction Treatment Capacity**

**Executive Summary:** The state of Tennessee is disproportionately struggling with the prescription drug abuse epidemic. Tennessee has experienced a 250% increase in opioid-related overdose deaths from 2001 to 2010 and the counties in Northeast Tennessee have some of the worst substance abuse measures in the state. As the need for substance abuse treatment services increases, the types of services available at each level of the care continuum must be expanded. Residential treatment facilities occupy an important role for treatment of complex and severe substance abuse cases. Due to the rampant substance abuse issues in the region and the prevalence of behavioral health issues, it is necessary to invest resources in all levels of the substance abuse care continuum, but particularly in resources like residential treatment facilities that are capable of addressing complex and severe substance abuse issues.

The extent of the addiction crisis is well documented in the applicant's service area.[1] In addition, during the Community Health Roundtable meetings, where ETSU brought together 225 people across ten separate events between August-October, 2015, substance abuse was identified as the second largest topic of concern in the community.[2] Nationally, the CDC recently reported that in 2015 opioid deaths surpassed 30,000 for the first time in history and that heroin overdoses now kill more people than fire-arm related homicides.[3] As a result, substance abuse prevention and treatment services were identified as top priorities in the Applicants' suggested investments in public health initiatives[4] and improved specialty services access.[5]

While prevention of substance abuse is preferred, and the applicants include investments for prevention in their proposed public health initiative plan, according to the NIH National Institute on Drug Abuse ("NIDA") "the 'treatment gap' is massive—that is, among those who need treatment for a substance use disorder, few receive it. In 2011, 21.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem, but only 2.3 million received treatment at a specialty substance abuse facility."[6]

NIDA identifies several steps in successful drug treatment: detoxification, behavioral counseling, medication, evaluation and treatment for co-occurring mental health issues, and long-term follow-up to prevent relapse.[7] The American Society of Addiction Medicine ("ASAM") identifies five broad levels of

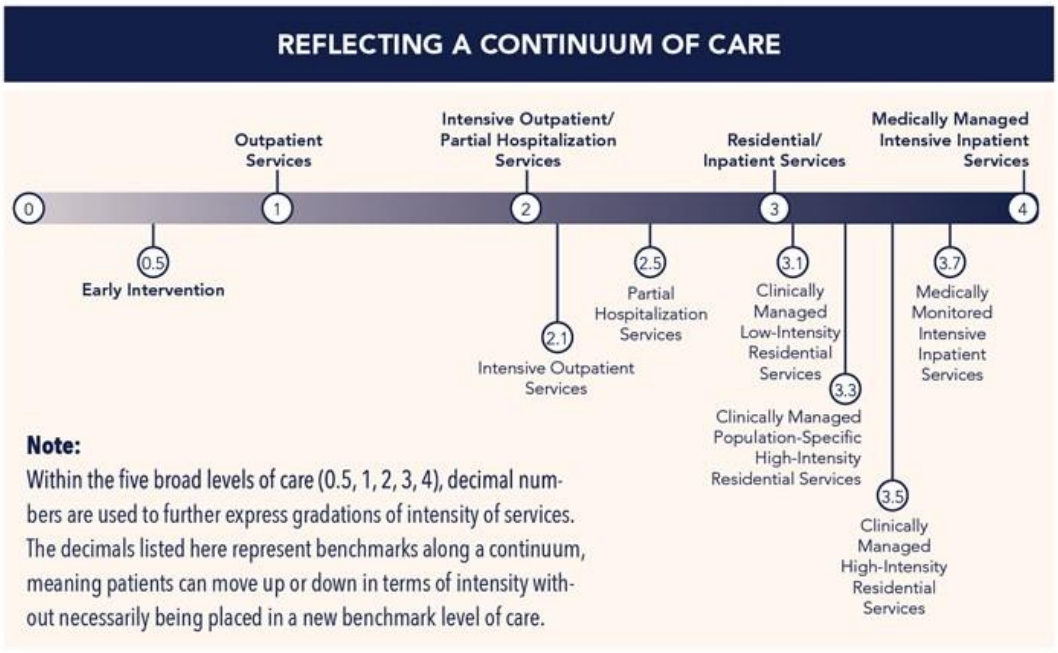
[1] *See* Application for Certificate of Public Advantage, State of Tennessee, at 32.
[2] *See* Attachment E to the Pre-Submission Report (provided as Exhibit 10.1 to the Application).
[3] *See* Christopher Ingraham, *Heroin Deaths Surpass Gun Homicides for the First Time, CDC Data Show*, THE WASHINGTON POST, December 8, 2016, *available at* https://www.washingtonpost.com/news/wonk/wp/2016/12/08/heroin-deaths-surpass-gun-homicides-for-the-first-time-cdc-data-show/?utm_term=.ba15a2ff5215 .
[4] Response to Questions Submitted April 22, 2016, at 20-21.
[5] Application for Certificate of Public Advantage, State of Tennessee, at 7.
[6] NAT. INST. ON DRUG ABUSE, *Principles of Drug Addiction Treatment: A Research-Based Guide* 15-16 (3d ed. 2012), *available at* https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-do-we-get-more-substance-abusing-people.
[7] NAT. INST. ON DRUG ABUSE, *DrugFacts* 2 (July 2016), *available at* https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction.

care (see Figure 1) across a continuum of service intensity, ranging from early intervention for individuals with known risk factors through the medical management of intensive inpatient services. Full-time facility based residential and inpatient services comprise levels three and four of this continuum. Residential services range from medically managed detoxification to lower intensity recovery housing in post-residential after care.

Detoxification is a necessary first step in addiction treatment, not only because the process of withdrawal for some addictions is often physiologically difficult, painful and dangerous, but also because the nature of addiction corrupts the rational thought processes of the addicted individual. Residential settings are often required to provide the medical management and structure necessary to complete the detoxification process, especially in the case of individuals with co-occurring mental illness, medical complications, or criminal justice and social services involvement often associated with individuals with substance abuse disorder.[8]

A sufficient number of detoxification and residential beds is important because research has shown that successful treatment depends on quick access to treatment and length of time in treatment.[9,10] When individuals are placed on waiting lists, 25-50 percent never enter treatment. [11] Lengths of stay in residential treatment greater than 90 days show significantly better results in one-year post follow up than shorter lengths of stay.[12]

**Figure 1: ASAM Continuum of Service Intensity**




[8] *Id.*
[9] *Id.*
[10] NAT. INST. ON DRUG ABUSE: RESEARCH REPORT SERIES, *Therapeutic Community* (2012), *available at* https://archives.drugabuse.gov/pdf/RRTherapeutic.pdf.
[11] JongSerl Chun, et. al, *Drug Treatment Outcomes for Persons on Waiting Lists*, 34:5 AM. J. DRUG ALCOHOL ABUSE 526 (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2766557/.
[12] *Therepeutic Community*, *supra* n10.

The State of Tennesee Department of Mental Health and Substance Abuse Services has found that overall the state suffers from a lack of medically monitored detoxification services and services for pregnant women with addictions.[13] In the Departments 2017-2019 Year One Plan, the Division of Substance Abuse Services sets specific objectives for year one to "make available programs that serve individuals who have been convicted of a non-violent crime and have a substance use or co-occurring disorder, provide an array of recovery support services for adult and adolescent consumers to supplement their treatment and to increase their chances of long term sobriety, and establish new recovery homes statewide."[14] The Tennessee Department of Mental Health Planning and Policy Council 2016 Needs Assessment Summary finds specifically that in Regions I and II which encompass the Applicants' Geographic Service Area, that there is a need for recovery focused housing, and residential bed and detoxification services for individuals without insurance and the underinsured.[15]

In addition, local mental health experts in Northeast Tennessee and Southwest Virginia serving on the Mental Health and Addictions Steering Committee organized by the Applicants last year were:

> "…*universally in agreement that an even greater need than inpatient beds for adults in the region is the need for additional and longer term residential treatment and medically monitored residential detoxification services. Although the inpatient psychiatric beds for adults could be restructured to meet the need, there simply is not sufficient availability of residential treatment for substance dependence in our region.*"

Dr. Terri Kidd, President and CEO for Frontier Health, reports that there is currently a 125 person waiting list for medically managed detoxification services at their Magnolia Ridge facility, which equates to a four to six week wait time. As stated earlier, 25-50 percent of indiviudals seeking treatment who are placed on waiting lists later decide not to seek or accept treatment. According to Dr. Kidd "as soon as you put them on a waiting list, you've lost them."

Ballad Health's proposed residential treatment services will include additional medical detoxification services, and will build longer-term residential services based on the "theraputic community" model. Theraputic communities are designed around two fundamental concepts: the community as change agent and the efficacy of self-help.[16] The focus is recovery which "is seen as a gradual, ongoing process of cognitive change through clinical interventions" where "participants progress through the stages of recovery, they assume greater personal and social responsibilities in the community."[17] Interventions include clinical groups, community meetings, and vocational, educational, community, and clinical

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[13] Mario Lehenbauer-Baum, DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, STATE OF TENNESSEE, *Needs Assessment Data Report 2015*, January 2016, *available at* https://tn.gov/assets/entities/behavioral-health/p-r-f/attachments/FY2015_Needs_Assessment_Data_Report.pdf.

[14] DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, STATE OF TENNESSEE, *2017-2019 Three-Year Plan*, Slide 12, *available at* https://tn.gov/assets/entities/behavioral-health/p-r-f/attachments/2017-2019_Three-Year_Plan_FINAL.pdf.

[15] OFFICE OF PLANNING, DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, STATE OF TENNESSEE, *2016 Needs Assessment Summary*, at 1-2, April 4, 2016, *available at* https://tn.gov/assets/entities/behavioral-health/p-r-f/attachments/2016_TDMHSASPPC_Needs_Assessment_Summary.pdf.

[16] *Therepeutic Community*, *supra* n10 at 4.

[17] NAT. INST. ON DRUG ABUSE: RESEARCH REPORT SERIES, *Therapeutic Communities* 1-3 (July 2015), *available at* https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-therapeutic-communitys-approach.

activities.[18] In addition to serving the general populations, programs for specific groups will be developed, intially beginning with youth and adolescents and pregnant women with substance abuse disorders.

As noted in the Application, investments will be made in community based support services to support graduates of residential programs. Aftercare services typically include individual and family counseling, self-help groups and supported employment and education services.

[18] *Therepeutic Community*, *supra* n10 at 5.

# Ballad Health
# 11. Plan for Community Partnership and Collaboration

**Executive Summary:** In this response, we outline the plans for community partnership and collaboration which complement Ballad Health's transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system responsible for providing value-driven community health improvement. A key component of that transformation is new kinds of partnership and collaboration efforts with providers of care and community stakeholders through the development of the Accountable Care Community together with a Community Health Improvement Plan and regionally coordinated and scaled efforts around common objectives. We envision that state or regional Department of Health leaders will serve in key roles for the Accountable Care Community.

## Building the Key Partnerships and Collaborations

This response focuses on Ballad Health's plans for community partnership and collaboration. Aligning existing organizations and resources for community health improvement provides an important underpinning for community health improvement within the Geographic Service Area.

As mentioned in the Overview, the establishment of the Accountable Care Community will allow Ballad Health to work with its partners to meaningfully and measurably impact the health of the whole population. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community to address the agreed upon population health needs.

### A. The Community Health Improvement Framework

Our over-arching model for community collaboration and partnership is defined by the **Community Health Improvement Framework** outlined below and the interface of its components—the three environments of prevention activity (clinical settings, personal settings, and community settings), the three types of prevention (primary, secondary, and tertiary), and the engagement of essential cross-sector partners through an Accountable Care Community with utilization of the right resources to improve health proactively.

It is important to note that we include the clinical setting in the Community Health Partnership Framework even though we make a clear distinction between population medicine and community health improvement. These strategies can and should be connected, and the engagement of physicians with their patients is absolutely essential to improving the overall health of the community. Physicians, nurses, and other clinical professionals have a significant ability to influence their patients to make sound decisions which will affect their health outcomes.

Prevention Environment Strategies

1. Clinical Settings - Increase the use of clinical preventative services with provider partners (optimize clinical engagements)

2. Personal Settings - Provide services that extend outside the clinical setting with community partners and patients (mobile and community based screenings, immunizations, educational programs, and home-based programs)
3. Community Settings - Implement interventions that reach whole populations with community partners and patients (policy, environment, behavior)

In order to effectively impact the three areas of the Triple Aim comprehensively across a diverse population, it is essential to create strategies that reach into each of these environments. Auerbach describes these environments as The Three Buckets of Prevention in the *Journal of Public Health Management Practice* (2016).[1]

It is also essential to impact all three types of prevention—with a significant focus on primary prevention strategies:

Prevention Type Strategies

1. Employ primary prevention strategies to keep disease from developing. Examples:
    - Population Medicine Strategy: In order to fully advance primary prevention practice, clinical providers must be engaged and informed of the strategies necessary to address prevention issues within the clinical context. Clinicians often do not grasp how they can have an impact on the factors that lead to many illnesses and injuries in the first place.[2] Part of the plan will include trainings on community prevention for clinical providers and other health care organizations to build a team of individuals that are deeply versed on community prevention principles and strategies.

    - Community Health Improvement Strategy: In order to reach people effectively, especially those in rural or underserved populations, we will use mobile health resources and partnerships with community organizations to enact elements of the Community Health Improvement Plan, including screenings for risk factors, immunizations, preventative dental services, and risk assessments to connect individuals to primary care and social supports. We will also enact community based health education and interventions to increase health literacy and engage people in behavior change such as healthy eating and moving more.

2. Employ secondary prevention strategies to slow or stop the progression of disease. Examples:
    - Population Medicine Strategy: Through the implementation of the Common Clinical IT Platform, protocols and alerts will be embedded in the IT system to identify individuals with health risks who need intervention or lifestyle changes to prevent the progression of heart disease, behavior related cancers, and diabetes.

    - Community Health Improvement Strategy: Mobile and community based screenings will allow the identification of high risk individuals who need educational resources,

[1] John Auerbach, *The 3 Buckets of Prevention*, 22:3 J. PUB. HEALTH MGMT. AND PRAC. 215 (2016).
[2] *See* PREVENTION INST., *Opportunities for Advancing Community Prevention in the State Innovation Models Initiative* (Feb. 2013), *available at* https://www.preventioninstitute.org/sites/default/files/editor_uploads/images/stories/Documents/CMMI_SIM_Initiative_Memo_February_2013.pdf.

connection to primary care, or specific tools to enact lifestyle changes to avoid the progression of high-blood pressure to heart disease or high AIC levels to type II diabetes, for example.

3. Employ tertiary prevention strategies through population medicine strategies and community health improvement strategies to manage disease effectively and mitigate negative effects. Examples:
    - Diabetes Management: Effective clinical management of diabetes will allow the avoidance of complication and hospitalization
    - Heart Failure Management: Effective heart failure management strategies, shared between cardiologists and primary care physicians will allow the avoidance of re-hospitalization and disease progression
    - Intensive Cardiac Rehab: Intensive cardiac rehabilitation opportunities such as the Pritikin program will allow individuals to slow or reverse the progression of heart disease through lifestyle change and to also influence the behavior of family and friends in support networks
    - Community Health Improvement Strategy: We will work to connect community partners that address social factors with discharged or chronically ill patients in way that positively impacts the health. Programs like Meals on Wheels and organizations that offer assistance with housing and utilities can offer resources in the community setting that will have a significant impact on the health status of disease patients.

Finally, the right resources will need to be developed to inform strategy, drive actions, and ensure effective evaluation within the framework. By mobilizing resources around a specific goal, the opportunity to coordinate services across the community and limit duplication of parallel or competing efforts is improved.[3] To that end, the Accountable Care Community will conduct an inventory of resources to identify gaps and strengthen connections between prevention resources with a specific focus on the following:

<u>Prevention Resources</u>

1. Human Resources. Examples:
    - Ballad Health staff members and physicians
    - Independent physicians
    - Community partners
    - Community service boards
    - School systems
    - Faith-based organizations
    - Resource agencies such as housing departments, courts, and non-profits (e.g. Meals on Wheels)

2. Financial Resources. Examples:

[3] *See* FAEGREBD CONSULTING, AUSTEN BIOINNOVATION INST., *Healthier By Design: Creating Accountable Care Communities* (Feb. 2012), *available at* http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf.

- Eliminating the duplication in medical care delivery to free up resources that can be redeployed to upstream activities that address underlying behavioral, environmental and social determinants of health
- Pursuing value-based and risk-based payment arrangements that reward population health management/medicine
- Using financial capital to increase the community's social capital through the development of effective partnerships
- Utilizing the funding set forth in the COPA commitments to empower activities and plans
- Identifying common funding and activities within the Accountable Care Community membership that can be better leveraged if coordinated
- Identifying public and private grant opportunities to support and advance the community goals

3. Health IT Resources. Examples:
    - Implementing a Common Clinical IT Platform to coordinate health care across the region
    - Utilization of a Health Information Exchange to share community health data with health care providers across the region
    - Using electronic health record and data analysis capabilities to promote linkages with other sectors' data and create a dashboard to track progress on community health indicators

4. Education/Training/Communication Resources. Examples:
    - Partnering with local organizations, including faith-based and educational institutions, to educate individuals on disease prevention and health screening opportunities
    - Educating and training local healthcare providers in prevention strategies in the clinical context
    - Supporting important local and state public health initiatives, such as opioid abuse prevention efforts and water fluoridation programs, through communications campaigns and advocacy efforts
    - Establishing communications platforms to coordinate resources and initiatives across the multi-sector partnerships, increase buy-in amongst the partners, recruit new members, and attract grant investment to support the Accountable Care Community, as well as share best practices across the multi-sector partners

5. Best Practice Intervention Resources. Examples:
    - Utilizing inter-professional teams including, medicine, pharmacy, public health, nursing, social work, mental health, and nutrition, to align care management and improve patient access and care coordination
    - Coordinating community-wide immunization programs and educational efforts
    - Adopting evidence-based screening assessments by clinical partners
    - Implementing screening programs by healthcare and social service providers to improve referral policies and services for mental health and substance abuse patients
    - Establishing health coaching programs
    - Utilizing transition programs and acute care networks to reduce hospital readmissions
    - Exploring programs such as Centering Pregnancy and Nurse Family Partnership

## B. Recruiting and Organizing the Members

By serving as a central organizer in the Accountable Care Community, Ballad Health can improve efficiency and reduce redundancy in community efforts by strengthening the links between existing programs, capitalizing on current resources, and building novel solutions to all health issues. Through the inclusion of these broad-base community-wide partnerships, the interconnections can be strengthened and duplication of efforts will be reduced. By mobilizing the coalition in coordinated and collaborative efforts, the goal of the ACC to improve the physical, social, intellectual, emotional, and spiritual health of the community will be realized.

Ballad Health will identify essential accountable partners across the region and engage them in the establishment of the Accountable Care Community focused on the Community Health Improvement Plan using the following steps:

### 1. Surveying Interest and Capabilities

Part of the process of establishing the Accountable Care Community will be the development of a survey or other assessment or response tool which will allow regional organizations to outline their capabilities and interest in participation. This will be followed up with one on one interaction and assessment of interest. Though we have not yet conducted this survey, our interactions with regional organizations and their participation in the Community Work Groups led by ETSU are a strong indication of support and interest. Many relationships exist but will have to be strengthened and become more interdependent to achieve success.

### 2. Identification and Recruitment of Members

Members of the Accountable Care Community will be recruited based on their multi-sector leadership and their willingness to commit to be an accountable partner in the development of cohesive regional community health improvement efforts. This includes identifying common goals and building each organization's contribution to these goals into organization-specific workplans.

This coalition is a multi-sector partnership with robust participation from the community with a diverse membership including representation from: public health, medicine, health systems, higher education, secondary education, safety-net health services, academic researchers, practicing health care providers, alcohol/drug/mental health services, local chapters of national health organizations, the faith and service community, local issue-focused coalitions and multiple community-based programs.

Fortunately, the leaders of Wellmont and Mountain States have cultivated strong working relationships over the last several decades with numerous community organizations. These relationships will provide the foundation for the Accountable Care Community partnerships. Ballad Health will utilize mutually accountable covenant commitments to establish the responsibilities and expectations for the Accountable Care Community partnerships. Both existing health systems have strong relationships with regional organizations which need to be further developed under the Accountable Care Community model.

**C. Defining Common Objectives.**

Based on the Community Health Improvement Plan, Ballad Health and its partners will articulate the common vision of community health, identify stewardship priorities, and develop an action and investment agenda around shared goals and measures. This step will be essential to the broad aim of impacting all of the factors leading to improved health outcomes including behavioral and social determinants of health. One of the major premises of this approach is to activate community-based prevention, particularly interventions that look upstream to address the root causes of disease and affect proactive change through prevention activities in environments that are typically outside of the clinical realm and the traditional clinical environments.

**D. Creating Accountability.**

A leadership council or board will govern the work of the Accountable Care Community and sub-committees may be developed based on sub-regional designations such as cities, counties, or other connected geographies.

The Partners, including Ballad Health, will adopt mutually accountable covenant commitments and focus comprehensive efforts around common objectives. Each partner commits to building their specific contribution to the Accountable Care Community goals into their own organization's goals and objectives. The partners will include the breadth of organizations that are able to help the Accountable Care Community fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in the Geographic Service Area.

Ballad Health will provide financial investments to accountable partners to focus on priority efforts with clear, contractual expectations for how those funds will be used and a clear system for evaluating compliance, evaluation, and success.

Through these efforts, Ballad Health intends to align the components of the Accountable Care Community and aim them effectively to target health improvement in our region in a way that creates clear advantage for payers (individuals, insurance companies, government payers, and employers), providers (physicians, hospitals, ancillary services), and the people and communities we serve—including underserved populations or those experiencing health disparities.

**Ballad Health**
**12. The State of Regional Program Support for Population Health Improvement**

**Executive Summary:** In this response, we outline the state of regional program support for population health improvement including an overview of the current status of efforts by partnership category along with the penetration of those programs regionally and a description of the new Ballad Health strategy related to each category. We seek to build on these key partnerships and collaborations to enact the transformation needed to substantially improve regional health through community health improvement and population medicine strategies. The partnership groups outlined are those essential to the development of a multi-sector Accountable Care Community as well as those needed to impact the personal, clinical, and community settings essential to shaping prevention efforts across the population and the social and behavioral determinants of health. Clinical Partners, Public Sector Partners, and Private Sector Partners and Payers are all needed to inform strategy, drive actions, and ensure effective evaluation within the Community Health Improvement Framework referenced in Response 11. Importantly, many of the partners mentioned here participated actively in the Community Work Group Process led by the ETSU College of Public Health which will serve as the foundation for a Ten Year Community Health Improvement Plan to be driven by the Accountable Care Community. Those organizations feel ownership for this plan and are anxiously awaiting next steps in the process.

To address the social and economic factors that affect health, population health improvement initiatives must reach beyond the traditional boundaries of the health care system.[1] Ballad Health intends to use community-based partnerships that bring a wide range of stakeholders— clinical partners, public sector partners, private sector partners and payers —together to promote healthy behavior, improve access to primary and preventive care, and reduce health disparities. This approach has shown to be an effective means of improving population health.[2]

Ballad Health will not be building these partnerships from scratch. Wellmont and Mountain States have long-standing relationships with stakeholders in each of these categories that have been cultivated over decades of community work. Because of these long-standing relationships, the community is primed for an Accountable Care Community model under the leadership of Ballad Health. Below is a summary of the existing relationships with each of the categories of stakeholders, the regional penetration of that existing partnership, and a description of Ballad Health's plans to build upon that relationship to successfully implement an Accountable Care Community.

[1] According to a widely cited model from the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, population health is determined by several different factors—with access to and the quality of clinical care accounting for just 20 percent.

[2] *See* THE COMMONWEALTH FUND, *Improving Population Health Through Communitywide Partnerships* (Feb./Mar. 2012) ("Community health partnerships that bring clinicians together with civic groups, social service providers, and educational leaders among many others are proving to be an effective means of improving population health.").

## I. Clinical Partners

### A. Hospitals

**Current Status:** Mountain States and Wellmont are the two primary health systems operating in the Geographic Service Area. Their tertiary and ambulatory networks work hand in hand with smaller area hospitals, including those operated by the two health systems, as well as a variety of home health, rehab, and other post-acute providers and thousands of independent physicians. As comprehensive health systems, Wellmont and Mountain States include a full spectrum of care options for patients in a traditional fee-for-service, hospital-centric care delivery model. Both health systems have experience managing ventures into population medicine or risk-based models including Accountable Care Organizations. Each system also manages a substantial number of value-based-purchasing, pay-for-performance, or bundled payment models - including those with insurance companies, state Medicaid programs, and CMS. The health systems currently support community health improvement activities in partnership with other organizations, such as Healthy Kingsport, and support the social needs of community members through their own foundations' patient assistance funds. Under their social responsibility requirements both systems also provide significant donations to a number of community organizations that provide education and relief across the region, and employees of the two health systems actively volunteer in the community.

In addition to the hospitals owned by Wellmont and Mountain States, independent hospitals and hospitals associated with other health systems operate in Morristown, Newport, and Greeneville, Tennessee and in Tazewell, Grundy, Wytheville, and Richlands in Virginia.[3]

**Regional Penetration:** Hospitals are located in nearly every county within the Geographic Service Area, with tertiary hospitals centered in the Tri-Cities and community hospitals located in more rural markets.[4]

**New Ballad Health Strategy:** Ballad Health will create a cohesive regional approach to population medicine, which allows the current fee-for-service and hospital-centric model to further develop into a community health improvement organization. The new model will proactively seek to prevent disease, in addition to treating it effectively, and will center its existence on the Triple Aim. Ballad Health will expand internal mechanisms needed to assume more risk for the health status of the populations it serves and will work with partners to establish an Accountable Care Community organization capable of high-performing collaboration to enact community health improvement. In addition to sustaining the current investments in community benefit, Ballad Health will invest $450 million over ten years to empower its new focus, both internally and externally, in support of the population health plan and will work with partners to implement and actively supervise that investment.

[3] General acute care hospitals in the Geographic Service Area not operated by Wellmont or Mountain States include: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, and Newport Medical Center. *See* Application for Certificate of Public Advantage, State of Tennessee, Exhibit 5.2.

[4] *See* Application for Certificate of Public Advantage, State of Tennessee, Exhibit 5.1.

## B. Physician Groups

**Current Status:** Thousands of physicians operate in the Geographic Service Area, the vast majority of which are independent from the two health systems.[5] Large physician groups in the area include State of Franklin Healthcare Associates, Holston Medical Group, ETSU physicians, Medical Care, and Mountain Region Family Medicine.

Two Accountable Care Organizations ("ACOs") also operate in the area, including Qualuable, a Medicare Shared Savings Program ACO based in Kingsport, Tennessee, which manages approximately 21,000 Medicare Shared Savings Program ("MSSP") lives and includes the large independent physician groups. Through its Integrated Health Solutions Network subsidiary Mountain States operates the Anew Care Collaborative ACO based in Johnson City, Tennessee, which manages approximately 14,000 MSSP lives and 17,000 TennCare lives under contract with Amerigroup. Both ACOs are among the few MSSP programs which have received shared savings during each year of their existence and both received high quality scores in excess of 2015. In 2013, Wellmont established the Wellmont Integrated Network ACO, which allowed the health system to develop important resources for care management for approximately 9,000 lives. Wellmont was unable to achieve a critical mass of lives necessary to financially support the ACO and ultimately discontinued the program in 2014.

While Wellmont Medical Associates and Mountain States Medical Group are owned and operated by the two health systems, both health systems work with all of the physicians on the medical staffs, as well as community-based physicians and post-acute care providers, to care for mutual patients. Both Wellmont and Mountain States manage provider networks. Mountain States' Integrated Health Solutions Network maintains a provider network in Tennessee and Virginia. This network is made available to a variety of insurers, including BlueCross BlueShield of Tennessee. Wellmont similarly participates in Highlands Wellmont Health Network, a physician-hospital organization which provides a network of providers and contracts with insurance companies as well as providing services for self-insured businesses.

Both Wellmont and Mountain States currently participate in the One Partner HIE as contributing providers, meaning they provide data to the HIE which helps all participating physicians manage care more effectively and efficiently. In addition, through its Epic EHR system, Wellmont offers Epic Carelink at no cost to regional physicians who need to access to health system based patient records from their offices or for their own care management efforts.

Most of the larger medical groups in the Geographic Service Area, including Wellmont and Mountain States, have established patient-centered medical homes employing the national standards set forth by the American Medical Group Association and similar organizations to manage the care of patients. These patient-centered medical home initiatives manage chronic disease such as diabetes and contributors to the development of disease such as obesity and tobacco use. The development of these initiatives, together with regional ACO strategies and their associated care management departments, have helped to create a new orientation to

[5] Of the more than 2,000 physicians in the Geographic Services Area, approximately seventy percent (70%) are independent. *See* Application for Certificate of Public Advantage, State of Tennessee, Exhibit 6.1E.

patient care especially in the major medical groups. This new orientation has contributed to area physician groups' ability to succeed in value-based payment models.

Federally Qualified Health Centers, Rural Health Centers, and Charity Clinics also house important physician resources, especially for primary care and dental services. These centers are especially important to bridging care gaps in rural areas and in reaching underserved and uninsured populations in both rural areas and cities. Federally Qualified Health Centers include the Rural Health Consortium operating in Northeast Tennessee and Stone Mountain Health Services and Southwest Virginia Health Systems operating in Southwest Virginia. Charity Clinics include Friends in Need and Healing Hands operating in Kingsport, Tennessee and Bristol, Tennessee respectively, and The Health Wagon and Crossroads Medical Mission operating in Southwest Virginia. A variety of other faith-based or community clinics also contribute to serving the underserved and uninsured populations of the area.

**Regional Penetration:** Physician practices are concentrated in the more populated areas of the Geographic Service Area but span the area, and the majority of independent physicians operate in proximity to the more populated areas. Specialty physicians are also primarily based in population centers, with a few exceptions. Physician needs in the more rural areas are primarily supported by the two health systems, independent hospitals or Federally Qualified Health Centers, along with notable independent practices such as Medical Care LLC in Tennessee and C-Health in Virginia. Because of difficulty recruiting physicians to rural areas, Mountain States and Wellmont both employ larger percentages of physicians in these rural areas than they do in the more populated areas.

**Ballad Health Strategy:** Ballad Health seeks to build on the work that has already begun in the regional ACOs to further align clinical efforts through a more cohesive clinical network that includes employed and independent physicians. This strategy will emphasize the mutually supportive contributions to common population health medicine strategies aimed at reducing cost, improving quality, and increasing access to prevention and best practice treatment resources. As described in the Overview Section, physician group leaders will be important leaders for the Accountable Care Community and a cross-section of regional physicians will contribute to the Physician Clinical Council—where clinical protocols and strategies to derive efficiency and improve quality will be vested for Ballad Health. Each of these organizations will be a cornerstone for community health improvement. The sharing of health information will be essential to this network as well, so Ballad Health will not only work to develop the Common Clinical IT Platform but will also meaningful participate in a regionally accessible health information exchange. Ballad Health will seek to empower independent group participation in cooperation with large regional medical groups.

### C. Non-Acute Care Providers

**Current Status:** This clinical category includes rehabilitation centers, nursing homes, home health and hospice, and pharmacies - organizations which touch patients both before and after acute care experiences. Mountain States and Wellmont, as well as our physician networks, work closely with a variety of these non-acute care providers to manage the care of patients, but much of that work is disconnected and uncoordinated today. Some exceptions exist, for instance, where the two health systems have integrated programs such as home health and hospice, long-term care and rehab, or where post-acute care networks have been developed for

more strategic management of patient care with agreed upon protocols and effective hand-offs. However, many of these relationships could benefit from a coordinated approach to care.

**Regional Penetration:** There are scores of such providers throughout the Geographic Service Area which share important roles in the non-acute care of patients.

**Ballad Health Strategy:** Ballad Health will work to establish a shared information network with these non-acute care providers and to establish a best practice set of protocols for the management of patients. The protocols will solidify Ballad Health's relationship with the providers that commit to a shared approach to best practices. Ballad will expand on Mountain States current preferred SNF network to include discharges from previous Wellmont hospitals. This approach has demonstrated outcomes for reducing readmissions and improving care outcomes across the continuum of care[6] and will be mutually supportive for these providers, Ballad Health, and managing physicians, especially where payers are aligning incentives, such as around the avoidance of re-admissions.

**D. Behavioral Health and Substance Abuse Providers**

**Current Status:** Behavioral health providers in the Geographic Service Area include Wellmont and Mountain States, which provide the inpatient behavioral health services in the region, and Frontier Health and Highlands Community Services, which provide the majority of outpatient services in the area, along with a host of independent practitioners. Both health systems have relationships for the management of crisis patients and those in need of inpatient placement, most notable are the relationships with Frontier Health. Good partnerships exist and significant work has been done to strengthen the care pathways for patients, but much progress still needs to be made. As with most of the country, the Geographic Service Area is under-resourced and under-staffed. While progress is being made on the integration of primary care and behavioral health, the full continuum of care would benefit from further integration. Both outpatient and inpatient resources for behavioral health and addiction are in significant demand.

**Regional Penetration:** Overall, behavioral health resources in the Geographic Service Area are not sufficient or not sufficiently aligned to meet needs, especially in the rural areas. Most available behavioral health resources are concentrated in the more populated areas, and crisis stabilization for patients is difficult overall, but especially in the rural areas. Inpatient resources are located in Johnson City, Tennessee at Woodridge, which is operated by Mountain States and at Ridgeview in Bristol, Virginia and Bristol Regional Medical Center, both operated by Wellmont. Inpatient behavioral health units are also operated at Russell County Medical Center in Lebanon Virginia, Dickenson County Community Hospital in Clintwood, Virginia, and Takoma Regional Hospital in Greeneville, Tennessee. Despite the rampant substance abuse issues in the area, there is currently no regionally cohesive strategy for best-practice outpatient or inpatient substance abuse treatment and rehabilitation.

[6] *See* Melanie Evans, *Hospitals select preferred SNFs to improve post-acute outcomes*, MODERN HEALTHCARE (May 9, 2015), *available at* http://www.modernhealthcare.com/article/20150509/magazine/305099987.

**Ballad Health Strategy:** Ballad Health plans to make a major investment in behavioral health and substance abuse resources in the Geographic Service Area. As outlined in the Application, Ballad Health has committed $140 million towards the expansion of needed services which includes $85 million for mental health and addiction recovery.[7] This approach will require working closely with regional partners such as Frontier Health and others to develop and resource a comprehensive plan for prevention, crisis intervention and stabilization, accessible outpatient resources and community support, and needed inpatient resources—all working in a more effective and cohesive continuum of care.

## II. Public Sector Partners

Public sector partners include public pre-school, primary, secondary, and higher education institutions, public health, local and state governments, county commissions, local health councils, public health departments, community service boards, economic development agencies, housing and welfare agencies, courts, and law enforcement agencies.

**Current Status:** As with private sector partners, these organizations work in important ways to meet community needs which contribute to health outcomes and have existing partnerships with the two health systems, but currently, the overall efforts are disjointed and not centered on common goals and objectives.

**Regional Penetration:** Organizations operating in the public sector span the region and reach thousands of individuals and families through a variety of social and educational services.

**Ballad Health Strategy:** Ballad Health will include public sector partners in (i) the development of the Community Health Improvement Plan, (ii) the Academics and Research Plan and (iii) in the formation, governance, and operation of the Accountable Care Community. Public Schools will be especially important to the prevention efforts of Ballad Health, and strong relationships already exist with many of these schools for the provision of tele-health services for clinics, exercise equipment and training, pre-diabetes assessment and education, and walking and reading programs. It will be critical for Ballad Health to work with the public sector to leverage new and existing spending and resources. Certain public sector partners will have significant involvement with Ballad Health. While the Tennessee Department of Health will be the primary public agency responsible for regulation and active supervision of the COPA, the expertise and partnership of regional health departments will be essential to informing and guiding the work of the Accountable Care Community. Local public health offices can have a significant role in development of the needs assessment, performance measurement and improvement, health promotion, and patient engagement necessary for a successful Accountable Care Community. They may also be able to assist with the collection of population health data related to risk factors and disease incidence, and provide technical assistance in reporting quality performance measures. The College of Public Health at ETSU will also have a central partnership role in the establishment of the Academic Medical Center model, the shared research infrastructure, which will be instrumental to studying the population health and community health improvement measures enacted under the COPA and in attracting translational research funding from outside sources. The Academic Medical Center model will be integrally connected to the overall plan for Academics and Research but will have its own plan and budget with the goal of advancing research collaboratively with Ballad Health and ETSU. This

[7] *See* Response to Questions Submitted April 22, 2016, for a more detailed description of this commitment.

will ensure new economic opportunities and research findings for the region. By working with the public sector partners, Ballad Health will be able to provide a range of services to the population, including population-based primary prevention services, support for minority health initiatives, support for primary care providers, oral health, pharmacy, disease screening, and home healthcare services.

## III. Private Sector Partners

Private sector partners include a variety of non-profit and academic institutions including United Way agencies, Chambers of Commerce, businesses, faith-based organizations, relief agencies, food pantries, family support agencies and the like, along with local private schools, colleges, and universities.

**Current Status:** Wellmont and Mountain States have important relationships with these organizations, including board membership, financial support, and key partnerships. Some of the more integral relationships include the provision of clinical educators or adjunct faculty members for private nursing programs or physician assistant programs, or fully integrated residency programs, as in the case of the existing partnerships with the Debusk College of Osteopathic Medicine and the Via College of Osteopathic Medicine. In many cases, the health systems are founding or sustaining partners for community organizations dedicated to health improvement - such as Healthy Kingsport, a regional health improvement organization, or Project Access, which provides regional access to specialist physicians and case management services along with navigation services. There are many other examples. This work is important, but today, much of it is disconnected and lacks cohesive regional strategy.

**Regional Penetration:** Organizations operating in the private sector span the region and reach thousands of individuals and families with a variety of social and educational services.

**Ballad Health Strategy:** Ballad Health's strategies in the private sector are similar to its strategies in the public sector. Ballad Health will focus on three strategic directions with private sector partners (i) the development of the Accountable Care Community and the Community Health Improvement Plan, (ii) the development of the Academics and Research Plan, and (iii) the development of integral relationships with businesses, schools, and faith-based organizations to implement prevention strategies. Through the formation of the Accountable Care Community, Ballad Health will identify essential private sector partners and outline the key contributions each will commit to making in support regional systems for community health improvement. These partners will be engaged in the development and implementation of the Community Health Improvement Plan, and Ballad Health will work to scale best efforts and increase capacity through the committed $75 million investment with a focus on those which align most closely with community health improvement goals. Ballad Health has also committed to working with existing academic partners to identify needs for clinical education and graduate medical education to increase the pipeline of nursing, allied health, and physician professionals serving in the area through an $85 million investment in Academics and Research. Finally, Ballad Health will work with regional businesses, faith-based organizations and schools to extend prevention education and resources in order to help reduce health risk in populations. These efforts will include the provision of onsite, tele-health, and embedded resources such as health coaches and health educators.

## IV. Payers

Payers and healthcare providers are complementary but distinct stakeholders. Payers can advance population health by creating a financial model that incentivizes physicians and delivery systems to

focus on better health, affordability and patient experience. These relationships will be critical to the move from fee-for-service to value-based reimbursement.

**Current Status:** Wellmont and Mountain States work with government and private payers, including self-insured companies and insurance carriers, to serve those covered under their plans. Though the historic relationship has been between payer and payee, the relationship is evolving to a more integral level of partnership. As incentives to manage the care of patients evolve into savings in pay for performance models, Ballad Health will become more involved with employers in helping to manage the health risks of employees proactively through various business health departments.

**Regional Penetration:** A very high percentage of existing patients are Medicare and Medicaid patients or are patients covered by managed care plans for those agencies. The majority of commercial beneficiaries in the region participate in employer-based plans or through third-party administrator arrangements offered by Humana, Cigna, BlueCross BlueShield of Tennessee, Anthem, or United. Wellmont and Mountain States participate in all of these plans and the vast majority of these plans include both health systems in their networks.

**Ballad Health Strategy:** The goal of Ballad Health is to move from the traditional payer-payee relationship to a partner role where the goals of the health system and the payer are aligned. This will result in shared savings for both the payer and Ballad Health through improved efficiency and quality of care. Ballad Health will work with payers to align systems of prevention and education to reduce both the incidence and progression of disease and to keep those populations it serves well. Ballad Health's aim is to create a fourfold relationship that includes Ballad Health, its physician partners, patients/beneficiaries, and payers to develop a cohesive set of strategies around population health improvement. With a relatively small number of major payers and a regionally integrated delivery system, Ballad Health has a phenomenal opportunity to align goals, incentives, and resources to support the singular goal of community health improvement in the Geographic Service Area. Payers, including insurance companies and businesses, will be invited to play an essential role in the development of the Community Health Improvement Plan and the Accountable Care Community.