Population Health Plan
For the State of Tennessee
FINAL

Introduction

- Final versions of the following Plans were requested by the State of Tennessee in the September 18, 2017 Terms of Certification, and were subsequently submitted on July 31, 2018. Feedback from multiple meetings and conversations with the state has been incorporated into these Plans.
  - Behavioral Health Plan
  - Children's Health Plan
  - Rural Health Plan
  - Population Health Plan
- The content of these Plans is consistent with requirements as outlined in the Terms of Certification governing the Certificate of Public Advantage and represent those actions to be taken by Ballad Health deemed by the State of Tennessee to constitute public benefit.

Spending Requirements

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

Important Dates

Plans Due in First Six Months (July 31, 2018)

- Behavioral Health Plan*
- Children's Health Plan*
- Rural Health Plan*
- Population Health Plan*
- Capital Plan

Plans Due in First Twelve Months (January 31, 2019)

- HIE Plan
- Health Research/Graduate Medical Education (HR/GME Plan)

** Consistent with the The Commonwealth of Virginia Department of Health request, Ballad previously submitted draft versions (on June 30, 2018) of these Plans and provided those copies to the State of Tennessee. This document presents the final versions of these plans, incorporating feedback received from the State following review of the draft submissions during an on-site meeting at Ballad's corporate offices on July 10, 2018, submission of the updated plans on July 31, 2018, and a second review session at the Tennessee Department of Health offices on August 10, 2018.*

Process for Plan Development

Initiate

- Engaged Resources
- Named Executive Steering Team

Plan

- Gathered Internal and External Stakeholder Input
- Developed Initial Plans/Prioritize

Review

- Socialized Plans to Internal and External Stakeholders
- Provided Tennessee Department of Health (TDH) with Draft Plans Submitted to Virginia Department of Health (VDH)
- Reviewed Draft Plans with TDH and VDH

Finalize

- Incorporated TDH and Stakeholder Feedback
- Finalized Investment Schedules
- Submitted Final Plans to TDH
- Make final revisions with State Input during 30 day state review and 30 day Ballad response period
- Obtain Ballad Health Board Approval

Process and Participation for Plan Development

In developing these plans, Ballad has referenced previously developed plans and analyses and solicited extensive stakeholder input including:

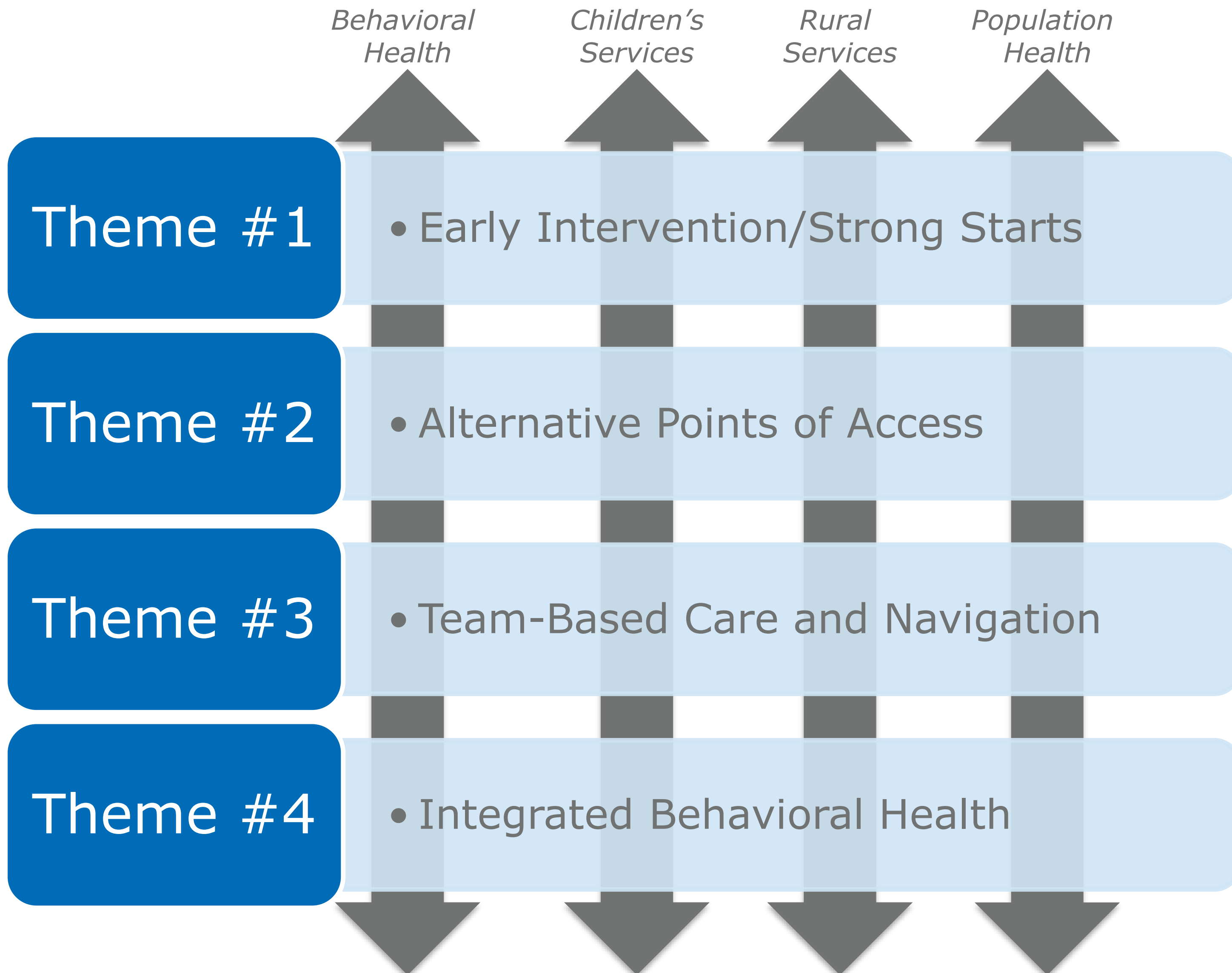
- Reviewing the following documents and plans:
  - Tennessee State Health Plan
  - Key Priorities for Improving Health in Northeast Tennessee and Southwest Virginia: A Comprehensive Community Report [1]
  - Legacy WHS and MSHA Community Health Needs Assessments
- Conducting approximately individual 150 interviews
- Holding approximately 40 meetings with external groups
- Convening the Population Health Clinical Committee
- Presenting the plan overview to a number of Ballad community boards in Tennessee and in an open meeting in Kingsport

[1] *Report published by the East Tennessee State University College of Public Health*

Process and Participation for Plan Development (continued)

- Convening the Accountable Care Community Steering Committee
  - Healthy Kingsport and United Way SWVA were selected through an RFP process to co-manage this effort for both TN and VA
  - Obtained cross-state participation in initial meeting with discussion of metrics with special focus on those most amendable to community intervention
  - Conducting bi-weekly calls with lead organizations
- Provided draft Virginia plans to the State of Tennessee on June 30, 2018. Additionally, Ballad representatives and representatives from the State of Tennessee and the Virginia Commonwealth met on July 10, 2018 to review and discuss the draft plans. Feedback from that meeting and subsequent communications were incorporated into the July 31, 2018 plan submissions.
- Ballad representatives and representatives from the State of Tennessee and the Virginia Commonwealth met on August 10, 2018 to review and discuss the July 31 version of the plans. Feedback from that meeting has been incorporated into this submission.

Strategic Themes Across All Plans



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Strategic Themes Across All Plans (continued)

1. Early intervention and strong starts

- Efforts will be designed around the concept of primary, secondary and tertiary prevention, with a special population focus on children.
- Example: Prevent cervical cancer through HPV vaccinations AND detect in early stages through effective screening.

2. Alternative Points of Access

- Preventive and acute services must be easily accessible by the population and designed with their preferences and limitations in mind.
- Example: Mobile blood pressure and diabetes screening co-located at food assistance delivery sites.

Strategic Themes Across All Plans (continued)

3. **Team Based Care and Navigation**
   - Care teams should be designed around the needs of the whole person and include perspectives and skills from pharmacists, social workers, community health workers, navigators and case managers.
   - Example: Embed behavioral health navigators in primary care practices to link patients with necessary behavioral health services at Ballad Health and our CSB partners.
4. **Integrated Behavioral Health**
   - We should design a behavioral health perspective into all care processes and systems.
   - Example: Perform Screening, Brief Intervention and Referral to Treatment on ED and Inpatient admits to identify behavioral health risk and initiate treatment in patients regardless of their presenting problem.

Table of Contents for the Population Health Plan

- Plan Overview
  - TN Certificate of Public Advantage Requirements
  - Key Metrics Assessed
  - Key Strategies
  - Crosswalk to Conditions
  - Investment Plan
- Strategic Approach
- Implementation Roadmap

Population Health Plan

1. Plan Overview

Plan Overview
TN COPA Population Health Services Plan Requirements

TN COPA Requirement
Develop, perform and execute a plan, for the first three (3) full Fiscal Years, to make investments in new population health improvement initiatives and in existing population health initiatives for which resources are already being expended but which warrant additional resources (the "Population Health Plan"). The initial Population Health Plan shall take into account, among other things, the Measures set forth in the Population Health Report and in the Population Health Sub-Index. No later than six (6) months after the Issue Date, the New Health System shall establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing the Population Health Plan and improving the overall health of the Population. This department shall be shall be staffed with leaders charged with financial compliance, physician relations and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the Board of Directors.

Source: Tennessee Certificate of Public Advantage Section 3.04 (b-c)

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Plan Overview
Population Health Key Metrics

Category	Measure
Breastfeeding	• Average mPINC score • Breastfeeding initiation • Infants breastfed at six (6) months
Child health	• 3rd grade reading level • Dental sealants (adolescents 13-15) • Dental sealants (children 6-9) • Infant mortality • Low birthweight • Teen pregnancy rate
Diabetes	• Increase the number of people with pre-diabetes who are identified and referred to a prevention program
Mental health	• Frequent mental distress
Mortality	• Ratio of premature deaths (higher density/lower density counties)
Obesity	• Physically active adults • Physically active students • Obesity - counseling and education • Overweight and obesity prevalence among Tennessee public school students
Smoking	• Mothers who smoke during pregnancy • Smoking (percent of adults self-reported as smokers) • Youth tobacco use
Substance abuse	• Adults - prescription drugs • Drug deaths • NAS births
Vaccinations	• Children - on-time vaccinations • Vaccinations - HPV females • Vaccinations - HPV males • Vaccinations - flu vaccine, older adults

Plan Overview

Access Key Metrics

Category	Measure
ED	• Asthma ED visits - age 0-4 • Asthma ED visits - age 5-14 • Excessive ED wait times • Pediatric readiness of ED
Mental health	• Antidepressant medication management - effective acute phase treatment • Antidepressant medication management - effective continuation phase treatment • Follow-up after hospitalization for mental illness (adults 18+) • Follow-up after hospitalization for mental illness (children 6-17)
Patient access	• Personal care provider • Specialist recruitment and retention
Patient experience	• Patient satisfaction and access surveys • Patient satisfaction and access surveys - response report
Perinatal	• Prenatal care in the first trimester
Screenings	• Screening - breast cancer • Screening - cervical cancer • Screening - colorectal cancer • Screening - diabetes • Screening - hypertension
Substance abuse	• Engagement of alcohol or drug treatment • Rate of SBIRT administration - ED visits • SBIRT administration - hospital admissions
Utilization	• Preventable hospitalizations - adults • Preventable hospitalizations - Medicare

Geographic Access
• Population within 25 miles of an urgent care center • Population within 25 miles of an urgent care center open nights and weekends • Population within 10 miles of an urgent care or emergency department • Population within 15 miles of an emergency department • Population within 15 miles of an acute care hospital

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Plan Overview
Population Health Services Estimated Investment Summary

Population Health Plan	Year 1	Year 2	Year 3	Year 1-3 Total
Community Health Department	$1,250,000	$1,250,000	$1,250,000	$3,750,000
Accountable Care Community	$250,000	$250,000	$250,000	$750,000
Awareness Campaigns	$550,000	$550,000	$550,000	$1,650,000
Programs	$0	$500,000	$2,950,000	$3,450,000
Total	**$2,050,000**	**$2,550,000**	**$5,000,000**	**$9,600,000**
COPA-Mandated Minimum Expenditures	*$1,000,000*	*$2,000,000*	*$5,000,000*	*$8,000,000*
Potential Funding Needed in Excess of Minimum Spending Requirements	***$1,050,000***	***$550,000***	***$0***	***$1,600,000***

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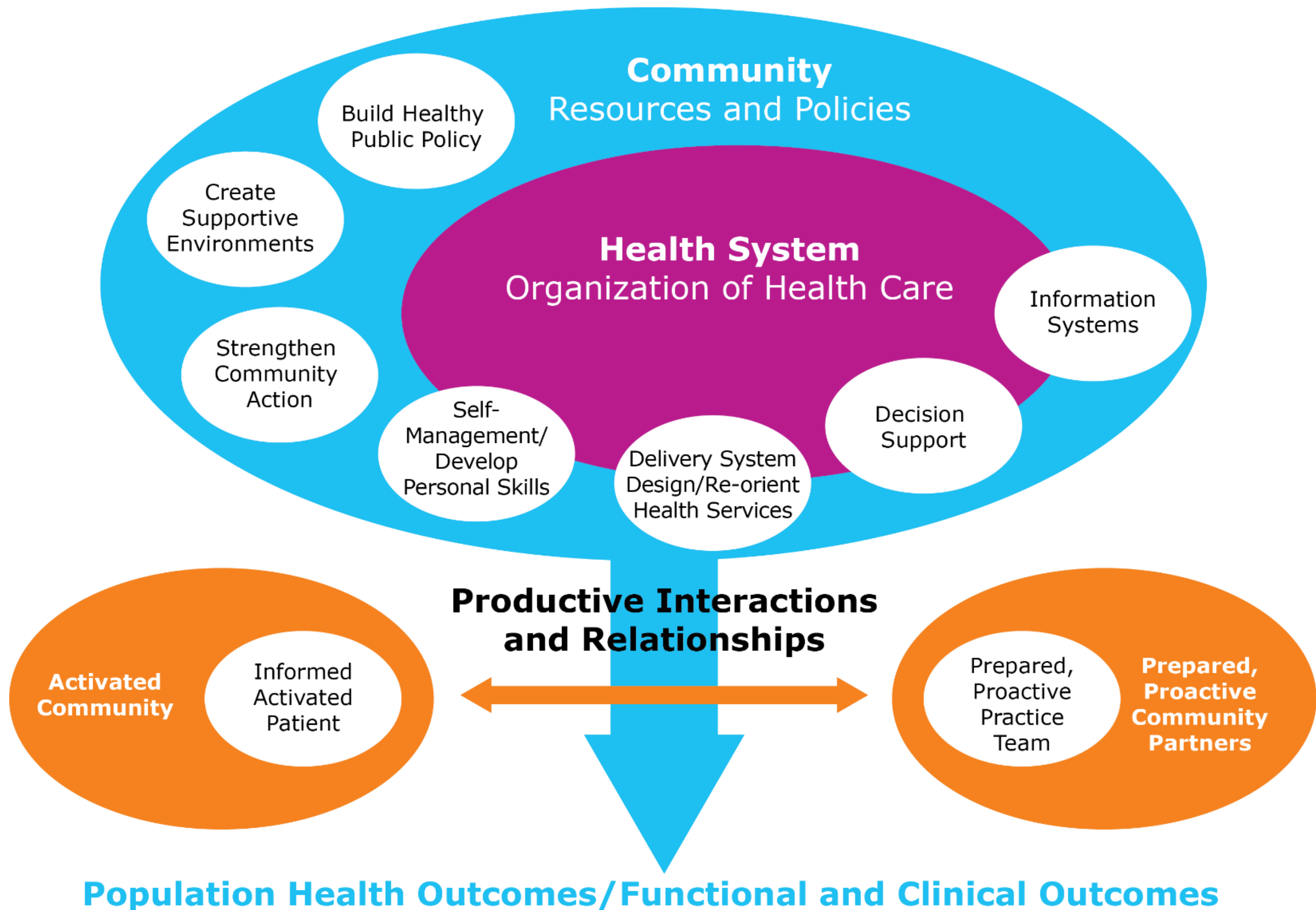
Population Health Plan

2. Strategic Approach

Population Health Model of Design
Strategic Context & Line of Sight to Impact

- The **Expanded Chronic Care Model** includes the key elements needed to effect our desired long-term health improvement impacts. The model demonstrates that the health system, while an important component, is insufficient to derive community level impact on its own. It also establishes that community impact is driven by individual behavior change that is supported and resourced .
- The early stages of the plan are focused on Ballad Health's work to build a supportive environment both inside the system of care regionally and in the community—by re-organizing and re-orienting the ***Organization of Health Care*** and influencing ***Community Resources and Policies*** to create a supportive environment which will empower behavior change over time and lead to long-term improved community health status.
- Ballad Health's Focus and Strategies for Population Health are organized by the elements of the **Expanded Chronic Care Model** as necessary building blocks to achieve **Productive Interactions and Relationships** with an **Activated Community, Informed and Activated Patients/Community Members, a Prepared and Proactive Practice Team, and Prepared and Proactive Community Partners.**

Population Health Model of Design: Expanded Chronic Care Model



Adapted from Edward H. Wagner, MD, MPH, Chronic Disease Management. Originally published: Effective Clinical Practice, Aug/Sept 1998, Vol 1

Pathway to Productive Interactions & Relationships

Strategic Elements

Media & Education Campaigns
Community Partners (all sectors)
Accountable Care Community
Ballad Patient Engagement
Ballad Team Member Engagement
Business Health Engagement
Effective Electronic Medical Record/Person Health Record

Team Based Care:
Care managers
Community health workers
Peer Coaches
Navigators
Primary Care:
Ballad Health
FQHCs
Participating Independent Providers
(With IT and Decision Support)

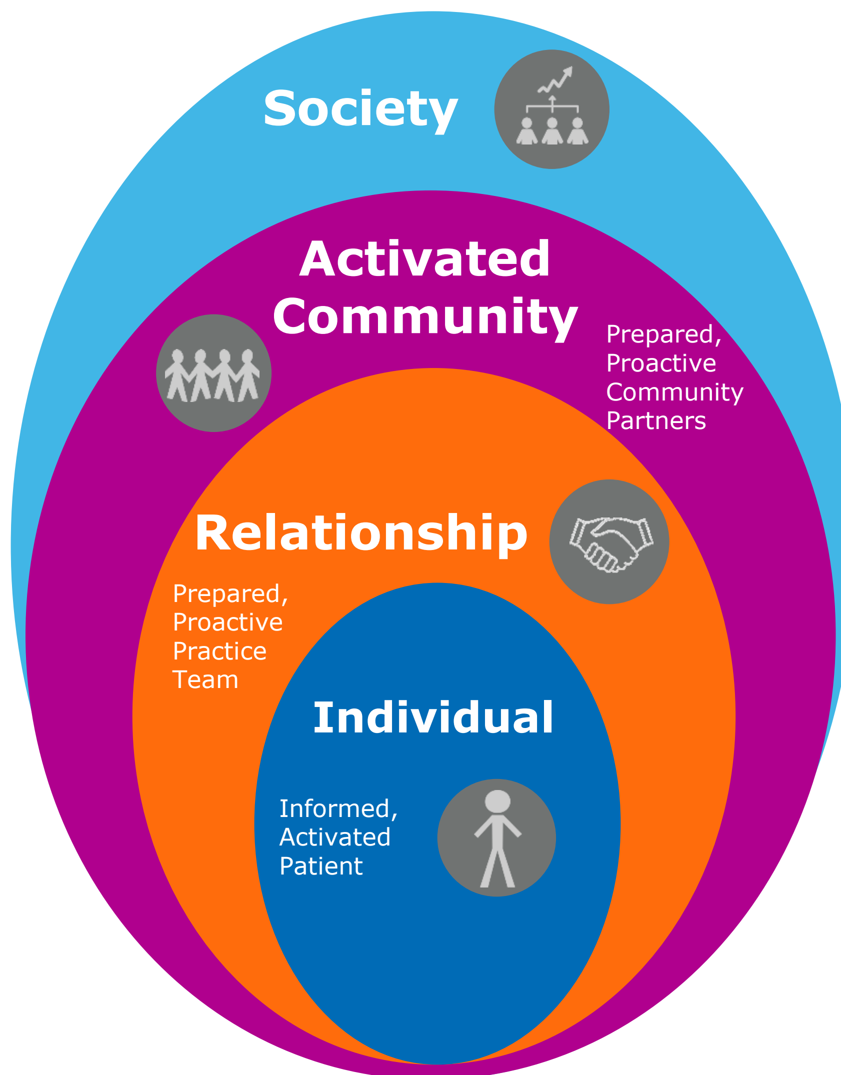
Sector, Organizational, Accountable Partners

Social Needs Solutions

Effective Policies and Supportive Environments

Population Health Outcomes/Functional and Clinical Outcomes

Society
The media
Law & governmental policy
Social Norms
The Environment
Activated Community
Local politics
School Systems
Employers
Culture
Relationship
Family
Friends
Intimate relationships
Practice-patient
Individual
Beliefs & values
Education
Life experience
Choices
Behaviors



Partnership Development

Building Collective Impact Through Engagement & Partnership

- **Sector Partnerships**—Offerings across entire sectors designed to reach target populations

  Example: Working with the regional chambers of commerce to provide business health offerings focused on wellness and prevention and designed to reduce cost—modeled from programs tested with Ballad Health team members (see slides 23 and 24)

  Example: Working with schools to place BEAR Buddies as volunteer reading coaches for children at risk of not achieving third grade reading level and initiate Morning Mile programs to get children active before school. Over the past four years, more than 1 million miles have been logged by participants in this program. *(see Exhibit A for a list of partners)*

- **Individual Program Delivery Partnerships** —Direct contractual arrangements with organizations to deliver agreed upon interventions/programs to impact behavior change (see slide 33)

  Example: Working with health departments to increase participation in dental sealant programs and with organizations such as Appalachian Miles for Smiles to add new access points for sealants.

  Example: Working with physician practices through Clinically Integrated Networks (CIN) or Health Quality Efficiency Program (HQEP) models to increase screening rates

- **Community-wide Accountable Partnerships** –Accountable Care Community members will join together to impact a prioritized number of measures that require collective impact using their own resources (see slide 29)

  Example: Payor members take action to invest in new incentive mechanisms for members and providers which drive participation and increase resources for tobacco cessation

  Example: Providers universally screen for tobacco use and increase anti-tobacco prescriptions

  Example: Faith-based organizations host anti-tobacco support groups

Development of Wellness Initiatives Within Ballad Health

Ballad Health seeks to be at the leading edge in the development of new, tested approaches to improved wellness and disease management, to pilot programs within Ballad Health (*"Ballad Health as an Example"*), and to scale those approaches to other businesses and to the community in general.

- **Pritikin:** Ballad has a strong relationship with the Pritikin Longevity Center and the Pritikin Intensive Cardiac Rehabilitation program and are currently researching a new primary prevention program with Pritikin which may demonstrate clear application and translation of Pritikin concepts to the reduction of disease development risk in high risk individuals.
- **Cleveland Clinic:** Ballad has an emerging relationship with Cleveland Clinic to test programs implemented with their employee population within Ballad Health. The leading edge of this work will be deployment of the Stress Free Now program with team members.
- **Chronic Disease Management:** Ballad is currently studying best practice approaches to develop more advanced chronic disease management programs within Ballad Health, including diabetes management.
- **Informatics and Claims Data:** Ballad Health is utilizing team member (covered lives) claims data and health risk assessment data to identify high risk individuals in need of coaching and care management support, which Ballad then provides.

The Employer Sector Partnership
Our Role as a Business Health & Wellness Leader

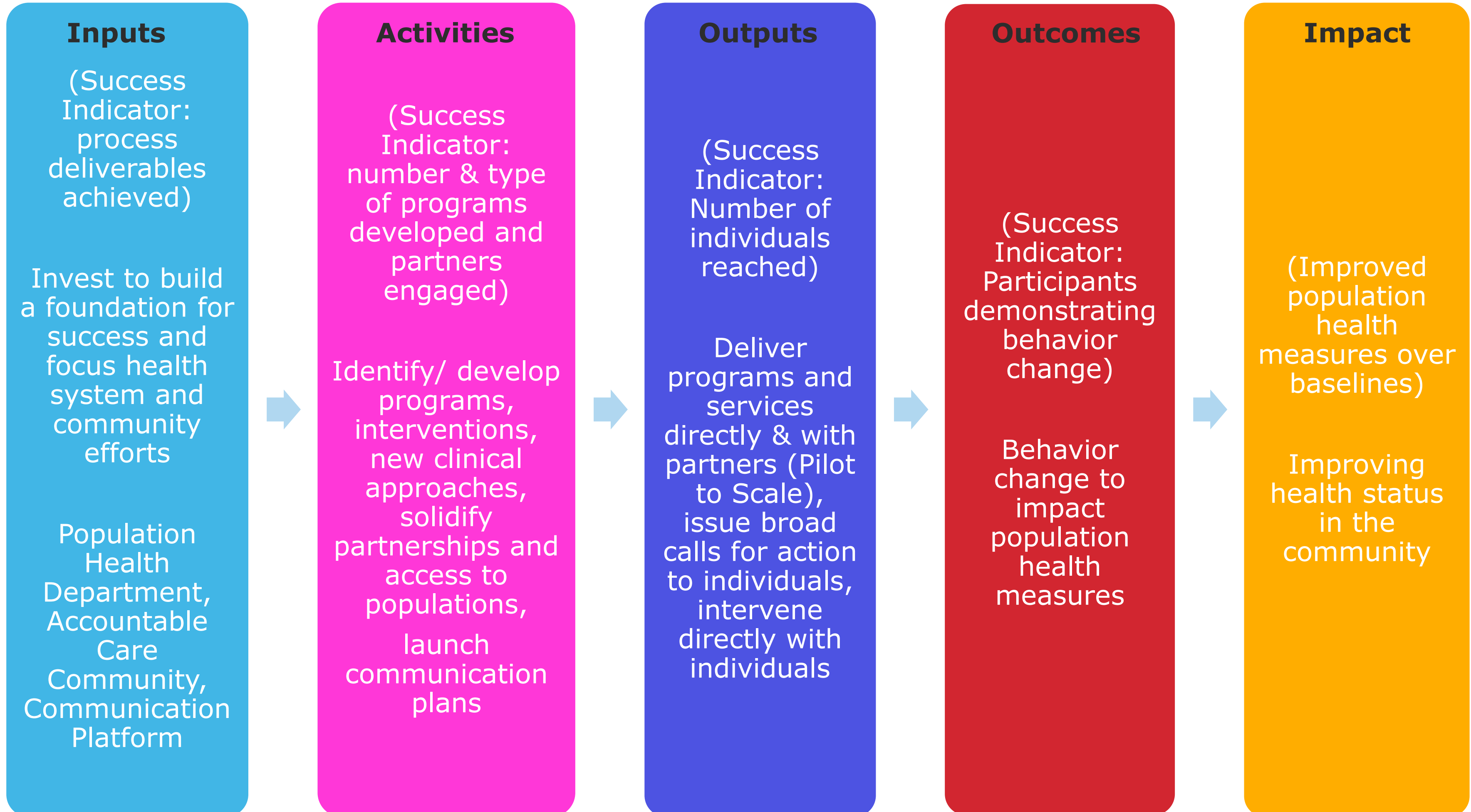
Ballad Health seeks to create model health & wellness programs to improve the health status of our team members and their families and to extend those programmatic approaches to other employers. Regional employers are an important channel to populations. Working with them to improve health and prevent disease will reduce direct healthcare costs and improve productivity. As we learn from our own experience within Ballad Health (*"Ballad Health as an Example"*), our approach will include:

- **Health Plan Consultation:** We will first work within Ballad Health team members, then expanding to local businesses (and their advisors), to help structure incentives, reward programs, and penalties to encourage best practice participation in health promotion and wellness efforts.
- **Health Risk Assessment:** We will first work within Ballad Health team members, then expanding to local businesses, to institute strong programs to assess individual health status and health risk (including claims data) and to stratify and manage or reduce that risk individually and across the entire population served. Health Risk Assessment includes using personal health survey tools together with biometric data to identify employees with higher levels of disease risk and potentially higher health care utilization and cost.
- **Health Risk Reduction and Cost Management:** We will first work within Ballad Health team members, then expanding to local businesses, to reduce risk for the development of obesity, pre-diabetes, diabetes, heart disease, and cancer by partnering to accomplish health improvement goals through creation of a healthy workplace environment, provision of education and health resources (including mobile and onsite resources), and provision of coaching/intervention services for those ready to change. We will also offer chronic disease management programs for conditions such as diabetes and hypertension along with stress reduction programs.

Communication Strategy - Leading a Social Movement

- Regionalism as a rallying point: Before Ballad can effectively address the most critical health challenges facing Northeast Tennessee and Southwest Virginia, the system must address many underlying cultural and social challenges, and this will require the cooperation of multiple stakeholders and leading organizations throughout the region. In order to set the stage for the kind of cooperation that will be necessary, Ballad will launch a regional campaign to help define the region's unique identity, fostering cohesiveness and regional pride as a first step.
- Brokering Hope: Building on the regional identity, Ballad will deploy messaging of possibility and progress, showcasing people who have overcome challenges to serve as an inspiration to others. This messaging will broker hope and demonstrate that help and support does exist. The campaign will also seek to celebrate what is possible when the region works together to tackle common problems.
- Community Education: To create informed, activated communities and individuals, Ballad will utilize or develop public service messaging to build awareness and make the case for change relative to the region's specific priority measures. This will include attainable, practical actions like "smart swaps" campaigns.
- Calls to Action: Using community education as a foundation, Ballad will issue specific calls to action for people who are ready to change and to access resources in concert with anti-smoking campaigns, physical activity and nutrition campaigns, and more.
- Leadership: Ballad Health leaders, with its chairman and CEO at the forefront, are actively engaged in growing the regional economy as a convener through new regional network strategies. The vision of regionalism is to unite the work of the chambers of commerce, economic development agencies, city and county governments, and the private sector.

Strategic Approach
Logic Model & Path Forward



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Strategic Approach
Focus 1: Develop Population Health Infrastructure Within the Health System and the Community

Strategic Approaches:

- Ballad Health Department of Population Health
  - Ballad Health will construct a team of competent community health and value based services staff who will engage both internally and externally on strategies to improve population health and address the metrics. This will be supplemented by a newly convened Population Health Clinical Committee.
- Accountable Care Communities
  - Ballad will initially fund and take a lead role with other community organizations in the governance of a multi-stakeholder, multi-geography Accountable Care Community. The ACC will serve to identify leading organizations in each community who are best positioned to integrate and align efforts in that community. Ballad Health will work with those integrator organizations and resource efforts to form community action teams or work with existing teams such as health councils to derive local impact. The ACC will pursue a limited number of complex population health challenges such as third-grade reading improvement, reduction in teen pregnancy, tobacco use, and so on.

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Strategic Approach
Focus 1: Develop Population Health Infrastructure Within the Health System and the Community

Examples/Partnerships:

- Population Health Clinical Steering Committee
  - This clinical team will be comprised of Ballad and community clinical providers representing MD, DO, APP, and PharmD disciplines to provide guidance toward the transformation of Ballad Health into a community health improvement system. (*See Exhibit B for draft charter and listing of providers who attended the first meeting.)*
- Community Benefit and Population Health Committee
  - Ballad established the Community Benefit and Population Health Committee of the Ballad Health Board of Directors. This group includes regional and multi-sector representation and is responsible for the oversight and compliance with all COPA/CA commitments and reporting. It is also responsible for governing the alignment of COPA/CA funding, social responsibility strategies and COPA/CA efforts to produce health improvement in the community. Members of the committee include Ballad Health directors and other community members appointed by the Ballad Health Board. *(See Exhibit C for listing of members)*

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Strategic Approach
Focus 1: Develop Population Health Infrastructure Within the Health System and the Community

Examples/Partnerships continued:

- Accountable Care Communities
  - Ballad will fund and take a lead role in the governance of a multi-stakeholder Accountable Care Community which will have two lead support organizations, one leading Tennessee efforts and the other leading Virginia. These lead supports will solicit organizational membership from across the service region, leveraging existing grass roots groups and coalitions, to organize itself around the pursuit of a focused number of complex population health challenges such as third-grade reading improvement, reduction in teen pregnancy, tobacco use, obesity, etc. These local groups may be developed around a geography and/or topical focus. *(See Exhibit D for a listing of invited/attending organizations for the first Accountable Care Community Leadership Team meeting and Exhibit E for Future Business Plan.)*

Strategic Approach
Focus 2: Ballad as a Community Health Improvement Organization

Strategic Approaches:

- Delivery System Improvement and Re-Design
  - Ballad will align operational excellence efforts and incentive programs to improve population health and access metrics amenable to health care in populations managed under Ballad Medical Group and other physician groups through mechanisms such as a Clinically Integrated Networks and Hospital Quality and Efficiency Programs (See Rural Health Plan). Initial focus populations will include Ballad's team members, ACO and other full risk contracts. Ballad will expand the total number of lives under management.
  - *See Exhibit F for potential opportunities to address health disparities*
- Information Systems, Decision Support and Information Exchange
  - Ballad will move to a common Epic platform region-wide which will enable community clinical and social registries for population health improvement, improve clinical flow and gap closure and allow patients more engagement with their own health and health information.
- Self Management & Development of Personal Skills
  - Ballad will invest in internal and external programs, people, and technologies which enable patients to better manage their health and health care services and prevent disease.

Strategic Approach
Focus 3: Enable Community Resources & Sound Health Policy

Strategic Approaches:

- Strengthen Community Action
    - Ballad will fund and manage community efforts to implement evidence based and promising public health programs and practices throughout the region.
- Build Healthy Public Policy
    - Ballad will engage in research and advocacy at the local, state and federal level to promote the population health and access goals included in the Tennessee COPA.
- Create Supportive Environments
    - Ballad will implement broad based communication strategies to promote a culture of health in the region and to communicate specific health messages. Ballad will also invest in the built environment and other infrastructure necessary to make healthier choices easier choices.

Strategic Approach
Focus 3: Enable Community Resources & Sound Health Policy

Examples/Partnerships:

- Strengthen Community Action
  - Ballad is currently working with individual and sector partners to identify best and promising practices, both through guidance provided by the evidence playbook and local programs of impact. The Community Engagement team is partnering with the ACC, health councils, anti-drug coalitions, healthy community teams, and other grass roots groups to collectively identify those programs that contain best or promising practices to evaluate for resourcing and support. Once identified, programs will be selected for piloting resources and evaluation of impact and further assessment for scaling and replication. (See Exhibits G and H for future business plans of the Accountable Care Community.)
- Build Healthy Public Policy
  - Ballad is currently providing educational sessions with local government groups to better inform on the requirements of the COPA/CA and solicit input for legislative interest and advocacy development.
- Create Supportive Environments
  - Ballad currently is working to create a multi-level, multi-year campaign media and education campaign (see slide 25) which will include a regional brand and identity strategy, a strategy to raise awareness of the issues we face and reduce stigma, and a strategy to promote and encourage healthy choices and individual action.

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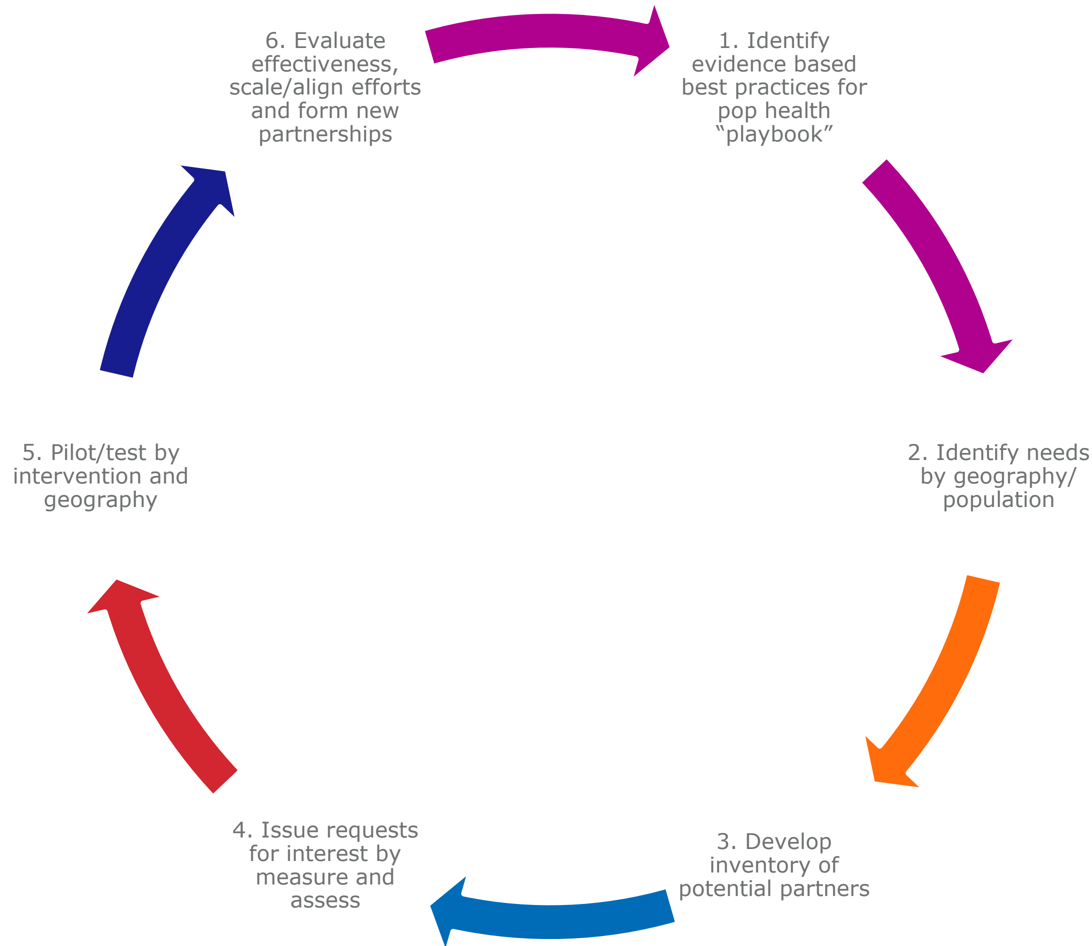
Line of Sight from Intervention to Impact to Scale with Individual Program Delivery Partners



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Strengthening Community Action Individual Program Delivery Partners

1. Identify evidence based best practices for pop health "playbook"

   Ballad has worked with BRG to compile evidence based best and promising practices related to each population health metric. That playbook, along with other similar products, will be used to guide identification and evaluation of programs and services in the area.

2. Identify needs by geography/ population

   The Department of Population Health, along with the ACC, will engage communities to evaluate current needs in each of the geographies and populations. Evaluation of current and available Community Health Needs Assessments (CHNAs) and Community Health Assessments (CHAs) will also be assessed.

3. Develop inventory of potential partners

   A comprehensive repository of community resources will be developed for use by the community engagement team and the ACC. This inventory will be arranged into categories for targeting such as county, current programming, potential metric impact, etc.

Strengthening Community Action Individual Program Delivery Partners (continued)

4. Issue requests for interest by measure and assess

   Using the inventory, Ballad will use both a Request for Interest (RFI) and Request for Proposal (RFP) process to ask community organizations to demonstrate capacity to provide best practice or suggest other promising practices. Community organizations selected from this process will enter into contractual agreements to pilot interventions and programs.

5. Pilot/test by intervention and geography

   Pilot organizations and locations will be selected based on their readiness to deploy best practice interventions and the profile of the population they serve. Consideration will be given to populations that are high risk or experiencing health disparities.

6. Evaluate effectiveness, scale/align efforts and form new partnerships

   Ballad will conduct comprehensive evaluation on all pilots for success, impact, scalability and replicability. The next step will be to identify additional partners to expand successful pilots.

Ballad Health
Population Health Plan

3. Implementation Roadmap

Overview of 3-Year Phasing

Yr1 INPUTS: Building a foundation

Standing up Population Health Department and Accountable Care Community

Aligning providers with population health and access metrics and redesigning care

Identifying and assessing community partners

Launching Communication Plans

Yr2 ACTIVITES: Engagement and pilot testing

Piloting first community population health engagements

Implementing new care models to improve metrics amendable to health care

Expanding Epic connectivity to non-Ballad Health providers

Yr3 OUTPUTS: Intense implementation

Expanding successful pilots to new geographies or populations

Expanding at-risk lives under management through new payor contracts

Expanding Ballad Health's primary care base or alignment with new physician groups

Implementing Epic system wide

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Implementation Roadmap – Population Health Plan
Focus Area One 2019 Quarterly Milestones and Metrics
Develop Population Health Infrastructure

Implementation Milestones and Metrics: Q1 and Q2

Strategies	Q1 Milestones	Q1 Metrics	Q2 Milestones	Q2 Metrics
1. Develop the Ballad Health Population Health Department	• Select candidates to hire • Form Clinical Committee with internal and external representation • Develop Clinical Committee charter, roles & responsibilities	• *Hires vs. Staffing Plan* • *Completed committee membership list* • *Charter completed* • *Fill 100% of 10 Full-time Positions*	• Develop relationship tracking and management systems	• *System developed* • *Establish and complete training with 10 end users*
2. Create and activate an Accountable Care Community (ACC)	• Recruit TN and VA steering team for the ACC • Begin ACC membership recruitment	• *Completed steering team list* • *List of members by region*	• Identify 3-5 areas of ACC focus • Develop ACC charter, roles & responsibilities	• *Focus areas selected* • *Charter completed*

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Implementation Roadmap – Population Health Plan
Focus Area One 2019 Quarterly Milestones and Metrics
Develop Population Health Infrastructure

Implementation Milestones and Metrics: Q3 and Q4

Strategies	Q3 Milestones	Q3 Metrics	Q4 Milestones	Q4 Metrics
1. **Develop the Ballad Health Population Health Department**	• Extend reach of the department by establishing population health leadership teams at each Ballad facility and practice division to promote local population health initiatives	• *Accomplished in all Ballad hospitals and practice divisions*	• Evaluate department personnel • Identify Y2 quarterly targets and timelines	• *Y2 milestones and metrics accepted*
2. **Create and activate an Accountable Care Community (ACC)**	• Members to elect TN and VA leadership councils • Leadership councils to develop strategic plan for focus areas	• *Leadership councils selected (list)* • *Strategic plan developed*	• Identify ACC Y2 quarterly targets and timelines	• *Y2 milestones and metrics accepted*

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Implementation Roadmap – Population Health Plan
Focus Area Two 2019 Quarterly Milestones and Metrics
Ballad Health as a Community Health Improvement Organization

Implementation Milestones and Metrics: Q1 and Q2

Strategies	Q1 Milestones	Q1 Metrics	Q2 Milestones	Q2 Metrics
1. **Delivery system improvement and re-design**	• Initiate alignment of Ballad Medical Associates (BMA) & COPA/CA metrics	• *List of initial priority metrics provided* • *Identify top 3 priorities applicable to practices*	• Secure initial provider participants in CIN/HQEP • Develop BMA & COPA/CA priority metric workplan • Determine external CIN/HQEP structure	• *Participant Agreement(s) signed* • *Completed workplan* • *Plan structure outlined*
2. **Information systems, decision support and information exchange**	• Configure Epic for Unicoi and Laughlin • Applied Health Analytics deployed for Ballad Health Team Members	• *Epic configuration completed* • *Deadline met* • *Utilize AHA for 100% of Ballad team member health risk assessments*	• Epic Go-Live Unicoi • Epic Go-Live Laughlin • Deliver Draft VA HIE Report to TN	• *Deadline met* • *EPIC LMH and Unicoi Go-Live complete* • *Draft completed*
3. **Self management and development of personal skills**	• Expand Health Risk Assessment and coaching to Ballad Health Team Members (TM) • Assess team members for launch TM diabetes management program	• *Program Launched* • *Coaches assigned to qualifying participants* • *Conduct biometric testing on 100% of Ballad team members participating in employee wellness program*	• Develop Ballad Health TM Stress Reduction Pilot Plan • Develop "*Ballad Health as an Example*" charter, roles & responsibilities	• *Program developed* • *Charter completed*

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Implementation Roadmap – Population Health Plan
Focus Area Two 2019 Quarterly Milestones and Metrics
Ballad Health as a Community Health Improvement Organization

Implementation Milestones and Metrics: Q3 and Q4

Strategies	Q3 Milestones	Q3 Metrics	Q4 Milestones	Q4 Metrics
1. Delivery system improvement and re-design	• Implement BMG & COPA/CA priority metric workplan • Submit New Ballad Health MSSP ACO application (subject to CMS timeline)	• *Workplan milestones met* • *MSSP Deadline met (subject to CMS timeline)*	• Sign Ballad Health MSSP ACO Contract (subject to CMS timeline) • Launch CIN/HQEP • Identify Y2 quarterly targets and timelines	• *Contract signed (subject to CMS timeline)* • *Program launched* • *Y2 milestones and metrics accepted*
2. Information systems, decision support and information exchange	• Epic configured for SBIRT pilot • Deliver Final HIE Report to VA and TN	• *Epic configured* • *Deadline met*	• Identify Y2 quarterly targets and timelines	• *Y2 milestones and metrics accepted*
3. Self management and development of personal skills	• Develop "*Ballad Health as an Example*" strategic plan	• *Plan completed* • *Establish 4 action teams to develop strategies in the areas of healthy eating/food policies; physical activities; healthy plan design; and health education and resources*	• Pilot first "*Ballad Health as an Example*" effort • Identify Y2 quarterly targets and timelines	• *Pilot(s) launched* • *Y2 milestones and metrics accepted*

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Implementation Roadmap – Population Health Plan
Focus Area Three 2019 Quarterly Milestones and Metrics
Enabling Community Resources and Sound Health Policy

Implementation Milestones and Metrics: Q1 and Q2

Strategies	Q1 Milestones	Q1 Metrics	Q2 Milestones	Q2 Metrics
1. Strengthen community action	• Work with internal and external Subject Matter Experts to complete first round research of interventions and programs found to be best or promising clinical and community practices • Complete inventory of potential community partners to engage with in order to address population health metrics	• *Completed document* • *Completed inventory*	• Using inventory created in Q1, distribute RFI to identify local capabilities and receive feedback on first round of research	• *RFI distributed*
2. Create supportive environments	• Develop framework to leverage Ballad Health Business Health service offerings • Develop regional awareness campaigns with Marketing Department	• *Frameworks completed* • *Campaign plan completed* • *Develop at least one regional awareness campaign and establish projected reach and impressions targets*	• Activate Business Health Collaborative with Chambers of Commerce • Begin regional ad campaigns • Create customizable package of Business Health offerings for employers	• *Collaborative activated* • *Campaign launched* • *Package completed* • *Host 1 regional chamber of commerce forum to review needs, current solutions and strategies* • *Regional awareness campaign projected reach and impressions*
3. Build Healthy Public Policy	• Identify best practice approaches to legislation that supports healthy choices	• *Begin development of legislative playbook to support intervention playbook*	• Identify gaps in current laws and policies that support regional health	• *Gap analysis*

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Implementation Roadmap – Population Health Plan
Focus Area Three 2019 Quarterly Milestones and Metrics
Enabling Community Resources and Sound Health Policy

Implementation Milestones and Metrics: Q3 and Q4

Strategies	Q3 Milestones	Q3 Metrics	Q4 Milestones	Q4 Metrics
1. **Strengthen community action**	• Evaluate RFIs received • Incorporate feedback received into best or promising clinical and community practices	• *Evaluations completed* • *Feedback incorporated*	• Distribute RFPs for pilot interventions and programs to selected community partners • Identify Y2 quarterly targets and timelines	• *RFPs distributed* • *Y2 milestones and metrics accepted*
2. **Create supportive environments**	• Develop strategic plan for the Collaborative with Chambers of Commerce • Identify pilot program opportunities in collaboration with Chambers of Commerce	• *Plan completed* • *Pilots identified*	• Identify Y2 quarterly targets and timelines	• *Y2 milestones and metrics accepted*
3. **Build Healthy Public Policy**	• Develop legislative advocacy plan	• *Plan developed*	• Develop strategic approach for advocacy together with each regional legislator and their staff	• *Number of meetings with each legislative office*

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Implementation Roadmap
Focus Area One 2020 Milestones and Metrics
Develop Population Health Infrastructure

Strategies	2020
1. Develop the Population Health Department	• *Review and revise budget* • *Evaluate staff* • *Evaluate tracking systems* • *Population Health Clinical Committee to evaluate and revise, if needed, clinical systems and protocols* • *Evaluate and expand, if needed, Population Health Clinical Committee membership*
2. Create and activate an Accountable Care Community	• *Begin rollout of ACC strategic plan pilots* • *Develop partnership arrangements in any remaining counties* • *Conduct leadership development with ACC and county partners*

Implementation Roadmap
Focus Area Two 2020 Milestones and Metrics
Ballad Health as a Community Health Improvement Organization

Strategies	2020
1. Delivery system design	• *Evaluate BMG performance on key metrics* • *Evaluate CIN/HQEP performance on key metrics* • *Identify opportunities to expand covered lives through new payor contracts or provider partners*
2. Information System and Decision Support	• *Launch Ballad Health MSSP ACO* • *Begin implementation of HIE report recommendations* • *Epic ambulatory Go-Live at legacy MSHA* • *Epic acute Go-Live at legacy MSHA*
3. Self Management/ Develop Personal Skills	• *Evaluate Ballad Health Team Member coaching, stress reduction and diabetes management performance and revise as appropriate.* • *Expand additional Ballad Health Team Member wellness initiatives* • *Evaluate "Ballad Health as an Example" performance and revise as appropriate* • *Expand "Ballad Health as an Example" initiatives according to strategic plan* • *Identify opportunities to expand "Ballad Health as an Example" and Team Member wellness initiatives to community and Chamber of Commerce partners*

Implementation Roadmap
Focus Area Three 2020 Milestones and Metrics
Enabling Community Resources and Sound Health Policy

Strategies	2020
1. Strengthen community action	• *Negotiate contracts with partners* • *Implement interventions* • *Evaluate intervention effectiveness*
2. Create supportive environments	• *Launch Business Collaborative pilot interventions* • *Launch customized Business Health offerings* • *Evaluate regional awareness campaign* • *Develop and implement thematic campaigns to build awareness around key pop health metrics and community initiatives*
3. Build Healthy Public Policy	• *Meet with each regional legislator in VA and TN Geographic Service Area to review legislative agenda and seek advocacy support*

Implementation Roadmap
Focus Area One 2021 Milestones
Develop Population Health Infrastructure

Strategies	2021
1. Develop the Population Health Department	• *Review and revise budget* • *Evaluate staff* • *Evaluate tracking systems* • *Population Health Clinical Committee to continue to evaluate and revise, if needed, clinical systems and protocols* • *Continue to evaluate and expand, if needed, Population Health Clinical Committee membership*
2. Create and activate an Accountable Care Community	• *Review and revise, if needed, strategic plan* • *Provide ongoing leadership training* • *Develop partnership arrangements/community action committees in all counties*

Implementation Roadmap
Focus Area Two 2021 Milestones
Ballad Health as a Community Health Improvement Organization

Strategies	2021
1. Delivery system design	• *Evaluate current contracts and strategies* • *Expand sites and contracts* • *Evaluate clinical systems and protocols* • *Evaluate CIN/HQEP performance on key metrics* • *Review and revise, if needed, CIN/HQEP metrics* • *Identify opportunities to expand covered lives through new payor contracts or provider partners*
2. Information System and Decision Support	• *Evaluate system effectiveness* • *Construct progress reports and communicate internally and externally* • *Continued implementation of HIE report/recommendations*
3. Self Management/ Develop Personal Skills	• *Expand "Ballad Health as an Example" to address more focus areas and to more team members* • *Engage communities in "Ballad Health as an Example"*

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Implementation Roadmap
Focus Area Three 2021 Milestones
Enabling Community Resources and Sound Health Policy

Strategies	2021
1. Strengthen community action	• *Evaluate contracted partners for accomplishment of agreed upon intervention targets* • *Implement interventions* • *Evaluate intervention effectiveness*
2. Create supportive environments	• *Evaluate current business health contracts* • *Identify new engagement targets and approaches for business health* • *Develop and implement thematic campaigns to build awareness around pop health metrics and community initiatives*
3. Build Healthy Public Policy	• *Review and refine approaches* • *Track agenda elements*

Population Health Plan

Exhibits

Population Health Plan

Exhibit A – Morning Mile and BEAR Buddies Partners

Exhibit A

Morning Mile School Partners

Johnson City, TN

- Cherokee Elementary
- Indian Trail Intermediate
- Mountain View Elementary
- South Side Elementary
- Towne Acres Elementary
- Woodland Elementary
- University School

Kingsport City, TN

- John Adams Elementary
- Andrew Jackson Elementary
- John F. Kennedy Elementary
- Abraham Lincoln Elementary

Elizabethton City, TN

- East Side Elementary
- West Side Elementary
- Elizabethton Christian Homeschool

Washington Co, TN

- Boones Creek Elementary
- Boones Creek Middle School
- Fall Branch Elementary
- Grandview Elementary
- Ridgeview Elementary
- South Center Elementary
- Sulphur Springs Elementary
- West View Elementary

Sullivan Co, TN

- Ketron Elementary
- Miller Perry Elementary
- Sullivan Gardens Elementary
- Tri-Cities Christian School

Hawkins Co, TN

- Carter's Valley Elementary
- Clinch School
- Joseph Rogers Primary
- Keplar Elementary
- McPheeter's Bend Elementary
- Mooresburg Elementary
- Rogersville Elementary
- St. Clair Elementary
- Surgoinsville Elementary

Greene Co, TN

- Camp Creek Elementary
- Chuckey Elementary
- Chuckey Doak Middle/High
- Glenwood Elementary
- West Pines Elementary

Greeneville City, TN

- Hal Henard Elementary
- Highland Elementary
- Tusculum View Elementary

Bristol City, TN

- Avoca Elementary
- Haynesfield Elementary
- Holston View Elementary

Bristol City, VA

- Virginia Middle

Carter Co, TN

- Cloudland Elementary
- Central Elementary
- Happy Valley Middle
- Hunter Elementary
- Hampton Elementary
- Unaka Elementary
- Valley Forge Elementary

Hamblen Co, TN

- Fairview Marguerite Elementary
- Lincoln Heights Middle

Unicoi Co, TN

- Unicoi Middle

Washington Co, VA

- Abingdon Elementary
- Glendale Elementary

Scott Co, VA

- Hiltons Elementary
- Yuma Elementary

Wise Co, VA

- Coeburn Primary
- Coeburn Middle
- JW Adams
- Norton Elementary/Middle
- St. Paul Elementary
- Wise Primary

Russell Co, VA

- Castlewood Elementary
- Copper Creek Elementary
- Lebanon Primary
- Lebanon Middle

Smyth Co, VA

- Sugar Grove Elementary

Dickenson Co, VA

- Clintwood Elementary
- Sandlick Elementary

Exhibit A
BEAR Buddy Partners

Approximately 100 children are participating in this reading program

- Boys & Girls Club of Johnson City (Johnson City, TN)
- Wandall Early Learning Center (Elizabethton, TN)
- Southside Elementary School (Johnson City, TN)
- Town Acres Elementary School (Johnson City, TN)
- Woodland Elementary School (Johnson City, TN)

Exhibit B – Charter and Attendees of Population Health Clinical Steering Committee

Exhibit B
Charter of Population Health Clinical Steering Committee

Ballad Health Population Health Clinical Steering Committee Charter
2018

The name of the committee shall be "**Population Health Clinical Steering Committee**" ("PHCSC") of Ballad Health.

MISSION

The mission of the **Population Health Clinical Steering Committee** is to provide guidance towards the transformation of Ballad Health into a community health improvement system.
The committee will embrace four transformational pillars:

1) Early Intervention / Strong Starts
2) Alternative Points of Access
3) Team-Based Care and Navigation
4) Integrated Behavioral Health

The work of the PHCSC will embrace the expanded chronic care model.

ROLES AND RESPONSIBILITIES

The PHCSC team will be responsible for the following;

1) Embrace the four transformational pillars
   a. Early Intervention / Strong Starts
   b. Alternative Points of Access
   c. Team-Based Care and Navigation
   d. Integrated Behavioral Health
2) Provide guidance towards the development of translational principles that support the four transformational pillars.
3) Help formulate strategy that is imperative to system re-design.
4) Identify and support evidence-based best practices that promote transformational change.
5) Incorporate and invite the voice of the patient at every stage in the system of care.

MEMBERSHIP

Section 1. **Eligibility.**
A clinical provider (MD, DO, APP, Pharmacist) is eligible to serve. This individual will be nominated by the co-chairs, the department of Population Health and other system leaders in Ballad.
This group will represent both Ballad and community providers/ provider groups.

Section 2. **Committee Makeup.**
The committee will be comprised of physicians, mid-levels from various specialties and pharmacists who have an interest in population health. The group will also have representation from the department of Population Health at Ballad.

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Exhibit B
Charter of Population Health Clinical Steering Committee

Section 3. **Participation.**
Members are expected to participate in a majority of meetings and should make a co-chair aware of an inability to participate as soon as possible. Members will also be expected to provide input via email when needed.

Section 4. **Membership Term.**
A term consists of 2 years, beginning at the member's initial meeting of the PHCSC. This is renewable for two consecutive terms (four years total). This need not apply to administrative champions, administrative members or sponsors of this initiative.

Section 5. **Vacancies/Leaves of Absence.**
Committee members may resign or request a Leave of Absence from the Committee at any time during their term. A member may request a Leave of Absence when unusual or unavoidable circumstances require that the member be absent from two consecutive quarterly meetings. The member will submit his/her request in writing (this can be emailed to a co-chair, stating the reason for the request and the length of time requested. The co-chair will note and accept the request.
If a member cannot return at the end of the requested leave, he/she will resign from the committee. With any resignation, the co-chairs may choose to appoint a replacement at that time or leave the position open until the next rotation of members.

REPORTING STRUCTURE

Section 1. **Reporting Structure**
The PHCSC will be responsible to the Population Health and Social Responsibility Committee of the Board.
The PHCSC will also provide updates to the Ballad Clinical Committee.

OFFICERS

Section 1. **Officers and Duties.**
There shall be two co-chairs. The chairpersons will coordinate the meeting schedule. The chairpersons will usually be a Physician Administrator and a Community Provider.
The vice chair will be the Director of Clinical Engagement for the Population Health Department.
The Co-chairpersons will be responsible for setting committee meeting agendas, chairing and conducting meetings, coordinating between committee members and staff, providing leadership for the committee members and serving on the Ballad committees when the "chair" is specifically requested. The work of the co-chairs will be supported by the Population Health department.

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Exhibit B
Charter of Population Health Clinical Steering Committee

Other officers may be appointed as recommended by the co-chairpersons and approved by the Committee.

Section 2. **Nomination Procedure.**
Candidates for positions will be nominated by Committee members or by Ballad Health Leadership.

Section 3. **Election Procedure.**
Officers will be elected by the affirmative vote of the majority of members present and voting. The quorum for this vote is outlined elsewhere in this document.

Section 4. **Terms of Officers.**
The standard term will be two years, and an officer may be re-elected for a second term. The term of office will begin at the close of the meeting at which the officer is elected, unless otherwise specified.

Section 5. **Vacancies.**
A co-chair, vice chair, officer or committee member may resign from office at any time. The Committee will choose or elect a replacement to complete the term of the member. A special election may be held in order to select a new officer/ committee member.

MEETINGS

Section 1. **Regular Meetings.**
Regular meetings of the PHCSC will be every 4 months. Additional meetings may be called, with sufficient notification (approximately 4 weeks), on an as needed basis.

Section 2. **Quorum.**
A quorum will consist of 51% of the total membership of the Committee.

Section 3. **Voting.**
In addition to voting in person at the Committee meetings, votes may be conducted electronically (i.e. e-mail/fax/survey monkey), except where specifically requested to be in person. Electronic votes will require a response (yes, no, or abstain) from a quorum of all members. Due to availability of electronic absentee voting; proxy voting will not be permitted. Absentee voting must be provided to a Chair prior to the meeting in which the vote is being taken.

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Exhibit B

Charter of Population Health Clinical Steering Committee

Ballad Health Population Health Clinical Steering Committee Charter
2018

SUBCOMMITTEES

Section 1. **Subcommittees.**
The Committee may have subcommittees as appointed by the co-chairs. All committees shall be chaired by a committee member.

Section 2. **Ballad Committees**
Committee members may be invited to serve on Ballad internal committees, projects, or ad hoc work groups, in addition to the committees. Membership does not exclude participation on other committees or projects in Ballad.

Section 3. **Special Committees.**
From time to time, the co-chairs may deem it necessary to create a special committee or task force in order to further the work of the committee.

AMENDMENT PROCEDURES

Amendments to the charter will be presented at a meeting for a vote.
The charter may be amended by majority vote (51%).
All charter amendments are subject to Ballad administrative approval.

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Exhibit B

Attendees of Population Health Clinical Steering Committee

(First Meeting Held May 15, 2018)

Name	Area/ Affiliation
Angott, Allison A MD	Ballad / PC
Beckner, David	Ballad / Cardiology & Pritikin Center
Blackwell, Gerald	Ballad System CMO
Bos, Krystle	Ballad RN
Boys, John	Ballad/ Radiation Oncology
Combs, Stephen	Ballad Medical Group CMO
Condit, Brian	VP CMO / Northeast Market
Hinchey, Toni B	Ballad APP / PC
Jeansonne, Susan	Ballad Medical Group Pediatrics
Kamali, Kyahn	Consultant
Keck, Tony	VP, Chief Population Health Officer
Kerr, John	Vice Chair, Clinical Council
Loos, Matthew	VP CMO / Washington County
May, David	Chair, Quality Committee of the Board
May, Grover	OB/ GYN at SOFHA
Merrill, Jeffrey	Med Director of Clinician Experience Project
Myers, Pam	Independent Pediatrician
Patterson, John	Ballad / Cardiology
Pearson, Linda	Ballad / Pain Management
Pote, Douglas	Ballad/ PC
Rajoo, Shari	AVP, Medical Director of Population Health Services (Medical Group)
Redmon, Patrick	BRG
Rogers, Alllison	SVP, Strategy & Value Based Care
Schneider, Kathleen	BRG
Schwob, Timothy	Medical Director Urgent Care
Shams, Tanzid	Ballad/ Neurology
Vashist, Amit	Chair of the Clinical Council/ Hospitalist
Vogt, Doug	
Zegietowsky, Gary	BRG
Karakattu, Monika	Mountain Region Family Medicine
Wayt, Marta	Ballad/ PC/ Regional Medical Director

Population Health Plan

Exhibit C – Members of Community Benefit and Population Health Committee

Exhibit C
Members of Community Benefit and Population Health Committee

First Name	Last Name	Company Name	Current or Former Role
Barbara	Allen	Stowaway Storage	General Manager
Sue	Cantrell	Virginia Department of Health (VDH)	District Director, Lenowisco and Cumberland Plateau
Marvin	Eichorn	Ballad Health	EVP, Chief Operating Officer
Rachel	Fowlkes	SWVA Higher Education Center (Retired)	Founder and CEO (Retired)
Joanne	Gilmer	General Shale (Retired)	Manager, HR Benefits, (Retired)
Andy	Hall	Ballad Health	Community & Government Relations
Tony	Keck	Ballad Health	EVP, System Innovation & Chief Population Health Officer
Martin	Kent	The United Company	President & Chief Operating Officer
Steve	Kilgore	Ballad Health	SVP, Ballad Medical Services
Alan	Levine	Ballad Health	Executive Chair, President/CEO
Matt	Luff	Ballad CVA Heart Institute	Noninvasive Cardiology, Chair of Operations
Gary	Miller	Ballad Health	SVP, COPA Compliance Officer
Rick	Moulton	SoFHA	Medical Director of Clinical Integration
Roger	Mowen	Healthy Kingsport; Eastman (Retired)	SVP, Corp. Strategy, Eastman Chemical Company (Retired)
Todd	Norris	Ballad Health	SVP, Community Health & System Advancement
Donnie	Ratliff	Commonwealth Connections, Inc; Alpha Natural Resources (Retired)	President, Commonwealth Connections
Scott	Richards	Emory & Henry College School of Health Sciences	Department Chair/Program Director
Allison	Rogers	Ballad Health	SVP, Strategy & Value Based Care Services
Suzanne	Rollins	Legacy WHS (Retired)	Chief Nursing Officer, VP Clinical Services (Retired)
Doug	Springer	Gastroenterology Associates of Kingsport	Physician (Retired)
Keith	Wilson	Northeast Tennessee Media Group	President
Randy	Wykoff	ETSU College of Public Health	Dean and Professor

Population Health Plan

Exhibit D –Accountable Care Communities Leadership Team Partners

Exhibit D
Accountable Care Communities Leadership Team Partners

Ballad Health	Tony Keck, Paula Masters, Todd Norris, Allison Rogers
Healthy Kingsport	Kandy Childress
United Way of Southwest Virginia	Travis Staton
Bank of TN—President	Roy Harmon
Bristol TN/VA Chamber of Commerce	Beth Rhinehart
Bristol TN/VA United Way	Lisa Cofer
Cumberland Plateau Health Department	Dr. Sue Cantrell
East Tennessee State University	Dr. Randy Wycoff Dr. David Wood Dr. Wilsie Bishop
Eastman	Josh Davis
Emory & Henry—VP for School of Health Sciences	Dr. Lou Fincher
First Tennessee Development District	Chris Craig, Lottie Ryans
Food City (K-VAT)	Lori Hamilton
Frontier Health	Dr. Terry Kidd Eric Greene
Greater Kingsport Family YMCA	John Lyon
Hamblen and Cocke County Health Departments	Janet Ridley
Johnson City United Way	TBD
Johnson City/Washington County Chamber of Commerce	Gary Mabrey
Kingsport Area Chamber of Commerce:	Miles Burdine
Kingsport Area United Way:	Danelle Glasscock
Lenowisco Health Department	Dr. Sue Cantrell
Lenowisco Planning District	Skip Skinner
Mount Rogers Health Department	Dr. Karen Shelton
Niswonger Foundation	Dr. Nancy Dishner
Northeast Tennessee Health Department	Rebekah English
Southwest Virginia Health Authority	TBD
Sullivan County Health Department	Gary Mayes
Sullivan County Schools	TBD
UVA Wise/Health Appalachia Institute:	Margie Toman
Washington County VA Schools	TBD

Green cells indicate the ACC Support Organizations

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Population Health Plan

Exhibit E – Future Business Plan

Exhibit F – Examples of Opportunities to Address Health Disparities

Exhibit F
Examples of Opportunities to Address Health Disparities

Addressing health disparities is a principle of ***Delivery System Improvement and Re-design***

- Ballad is one of 31 organizations across the nation participating in the CMS Accountable Health Communities grant through which Ballad will screen 75,000 Virginia Medicaid and Medicare enrollees annually for Social Determinants of Health (SDoH). Any eligible enrollee seeking care at one of the participating hospitals, EDs or physician practices will be screened for issues with transportation, utilities, food insecurities, housing, and interpersonal violence. If screened positive, they will be provided a listing of community resources available to address that specific need. A certain portion of high-risk individuals with a SDoH issue will also receive support from a navigator housed at the one of the five local Community Service Boards (CSBs) who are partnering with Ballad on this grant (listed below). Demographic information will also be collected through this process which Ballad can leverage to potentially reveal insights into health disparities for those participating in the initiative.
  - Cumberland Mountain Community Services Board;
  - Dickenson Behavioral Health Services;
  - Highlands Community Services Board;
  - Mount Rogers Community Services Board; and
  - Planning District One Behavioral Health Services.

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Exhibit F
Examples of Opportunities to Address Health Disparities

- Ballad already collects demographic information on the patients seeking care from its facilities. There is an opportunity to leverage this demographic information to utilize hot-spotting techniques to proactively identify where health disparities may exist. By utilizing certain demographic data elements (such as race, gender, and income), Ballad will be able to map where individuals also have substance abuse issues as identified through the SBIRT data. Already noted in the Behavioral Health Plan, Ballad will utilize the SBIRT data to identify gaps in community resources. Leveraging demographic data will elevate the sophistication of the assessment and potentially reveal insights into health disparities for those struggling with substance abuse.

Population Health Plan

Exhibit G – Future Business Plan

Exhibit H –Future Business Plans

Population Health Plan
For the State of Tennessee
FINAL

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It's your story. We're listening.